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Management response and follow-up note
Joint Evaluation of Support to the National Response to HIV/AIDS in Uganda 2007 – 2012

This note contains the main findings, lessons learned and recommendations from the final report of the Joint Evaluation of Support to the National Response to HIV/AIDS 2007-2012. It also includes Danida's reaction (management response) and follow-up to the evaluation. The management response is inserted after the recommendations.
The evaluation was commissioned and managed by the evaluation department in Danida on behalf of the three donors, Denmark, Ireland and USAID who have all supported the joint response to HIV/AIDS in Uganda. The evaluation benefitted from inputs from government and civil society stakeholders in Uganda (members of the Evaluation Reference Group). It was conducted from March 2013 to January 2014 by an independent evaluation team of international and local consultants selected by Swedish Indevelop.

Executive Summary

The assignment

This summary condenses the evaluation findings and recommendations of the joint support provided by Denmark, Ireland and United States Agency for International Development (USAID)[1] to the Ugandan response to HIV & AIDS from 2007 until 2012.

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

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

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

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

> 2.1 Have the donors' areas of support conformed to the needs, priorities and policies of Uganda?
> 2.2 Has the policy dialogue regarding the 2007/2012 period and the new national AIDS strategy been relevant and effective?

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

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

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

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

The methodology

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

(1) key informant interviews with GoU personnel, CSOs' staff and volunteers, and donor staff;
(2) semi-structured group discussions conducted with service users, beneficiaries, their families, and groups of people in communities served by CSO programmes; and
(3) observation of the programmes and services.

The HIV/AIDS situation in Uganda

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

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

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

The response to the epidemic has been guided by the goals of the National HIV & AIDS Strategic Plan 2007/08 to 2011/12 (NSP), to reduce the incidence of HIV, improve the quality of life of people living with HIV (PLHIV), mitigate the social, cultural and economic effects of HIV and AIDS and build an

effective support system for service delivery. Although increasing numbers of PLHIV are accessing treatment, prevention activities have not yet reduced new infections.

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

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

Funding modalities

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

The AIDS Partnership Fund

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

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

Box 1: Donor Contributions to the Partnership Fund 2007-2012

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

The Civil Society Fund

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

Box 2: Donor Contributions* to the CSF 2007-2012

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

*According to UAC statistics.

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

Main findings and conclusions

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

1. Has Uganda made progress towards the AIDS transition?[2] Is the epidemic under control or is it still growing?

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

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

The NSP was developed through a broad consultative process, aligned to the Country's Poverty Eradication Action Plan. The National Strategic Framework that integrates all sectors in the AIDS response was the basis upon which policies were developed and implemented within the thematic areas of prevention, treatment, care and support.
The joint donor support to the Partnership Fund has been vital to enabling UAC coordination of the national response. It has provided support to certain CSO self-coordinating entities ensuring their existence and removing the financial struggle to survive. Self-coordinating entities are defined as "clusters of HIV & AIDS stakeholders that have something in common[3]. The joint donor support has also been important for funding CSO prevention and care and support programmes. Whereas care and support programmes have been effective, prevention interventions predominantly use individualistic approaches that focus on influencing knowledge, attitudes and behaviour of individuals in defined populations.

Prevention interventions have not been directed at structural determinants of behaviour including overarching society and familial influences that limit individuals' self-determination in decision-making and behaviour. Hence, the greatest barriers on attaining a reduction in new infections are structural, and they have not been directly influenced by the donor support.

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

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

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

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

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

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

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

(1) enhance coordination of the Ugandan AIDS response, and implementation of the NSP and revised NSP (National HIV & AIDS Strategic Plan 2011/12 to 2013/14);
(2) further enable, coordinate and harmonise civil society participation, reducing duplication and gaps; and
(3) reduce development assistance administrative costs.

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

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

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

From 2007 to 2010, the Danish policy towards the support to the NSP focused on enhancing coordination and leadership and to promote effective civil society contribution to the national HIV/AIDS response. In 2010, in a strategic response to gaps Danida perceived in the NSP, new features were brought up by Danida. These were integration of SRHR and funding to MARP in the

support to the Uganda AIDS response efforts. This was directly funded to UNFPA and the MARPs Network. Danida's strategic provision of direct funding from 2010 for SRHR programmes in part compensated for the gap in funding for SRHR through the CSF.

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

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

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

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

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

Government

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

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

(1) prevention in Uganda socio-cultural settings that reduce individuals' ability to make decisions and change their behaviours;
(2) addressing the needs of MARPs who are frequently bridge populations; and
(3) youth.

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

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

Donors

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

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

Civil society

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

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

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

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

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

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

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

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

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

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

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

Recommendations

Future joint donor support

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

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

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

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

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

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

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

Donor and Government commitments to the Uganda AIDS Response

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

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

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

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

donors and the government should continue to seek government commitment to significantly increasing it's funding of the AIDS response, and adequately funding the MoH to provide HIV and related health services.

Civil Society role within the Ugandan AIDS Response

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

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

Policy dialogue

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

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

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

Human rights

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

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

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

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

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

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

Denmark's general comments to the evaluation

Danida welcomes the joint evaluation of support to the national response to HIV/AIDS in Uganda 2007 – 2012 by Denmark, Ireland and the United States Government (USAID). The evaluation provides timely and critical guidance to the development partners' contribution to the national Ugandan response especially with regards to the issue of Most-At-Risk Populations (MARPs) and the issue of prevention. Danida appreciates the evaluation's efforts in generating specific and tangible recommendations and is in general agreement with the recommendations provided in the report. Danida would however have welcomed a stronger focus on the policy dialogue and the context within which assistance took place in order to understand decisions taken.

Focus on MARPs and prevention
Combatting HIV/AIDS in Uganda is very much a battle between religious/moral views and human rights based values that are not always compatible. Denmark has been at the forefront of bringing up sensitive issues, where a human rights perspective seemed to prevail with the authorities acknowledging that there should be equal access to services for all no matter their sexual orientation, gender and profession. Challenges of translating the accepted views on equal access to the actual service delivery in the clinic setting appear to be increasing. Government and donors are collaborating to address this. This includes Danish support through the International HIV/AIDS Alliance to establish MSM (men who have sex with men) friendly health services in Uganda.

A large proportion of the HIV transmissions takes place among married couples in Uganda, and MARPs forms a bridge between the general population and most-at risk-persons because married people engage in extramarital sex, at times with MARPs and thereby bringing HIV into the family. Denmark has continuously raised the importance of MARPs - particularly the stigmatised and discriminated groups. It is a dialogue that has been undertaken with the HIV/AIDS donor group, in bilateral and multilateral partner dialogue with Government of Uganda, through the Partnership Forum, during Joint Annual HIV/AIDS reviews and the CSF Steering Committee.

Denmark has also brought up the unfortunate bias towards biomedical prevention and the need to balance and combine efforts with behaviour change and addressing structural barriers in the policy dialogue with government and donors.

National leadership and policy dialogue
The report states that a major hindrance for progress in the Uganda HIV/AIDS response is the lack of national leadership from the highest level, through Uganda Aids Commission and all the way down to local/community leadership. However, the evaluation does not emphasize what the development partners have done to advocate for this leadership. It is an issue that development partners have consistently brought up in formal and informal dialogues with the Government of Uganda. The

ambassadors of the main bilateral partners to HIV, including Denmark, as well as key UN agencies brought up the issue in different high level fora in order to re-engage the national leadership.

Addressing gaps in the National Strategic Plan (NSP)
While concluding that the implementation of the NSP has not given sufficient attention prevention and efforts towards MARPs, the evaluation highlights Danida's response to bridging the gaps. Danida has been working with UNFPA and a local organisation, the MARPs Network, to overcome some of these gaps over the period 2007–2012. The CSF was rolled out, and for the first time civil society started participating in the response in a more coordinated manner. At this time, work with MARPs began taking shape and Denmark has continuously worked to maintain focus on MARPs within the CSF. In collaboration with UNFPA, Denmark has worked to expand access to condoms, particularly among high risk groups including commercial sex workers. This has included promoting the female condom which more effectively enables commercial sex workers to protect themselves. The work through UNFPA has also focused on youth which represents another highly vulnerable group. Youth friendly corners in health facilities have been established, enabling young people access to information about their sexual and reproductive lives. This has been coupled with direct Danish support to the national civil society organisation Straight Talk Foundation for its work on sexuality education for youth in and out of school.
Moreover, it is important to recognize that also other donors, including USAID, have provided support to bridging the NSP gaps.

Advocacy for a prevention focus
Efforts by donors have also been made to get the right balance between prevention, care/support and treatment. Towards this end, the National Prevention Strategy (NPS) was developed in 2011 in an effort to bring prevention back at the forefront of the national response. While Danida agrees that the NPS has its omissions and weaknesses, it should also be noted that without development partner engagement there may not have been a prevention strategy in the first place.
The NPS represents a genuine opportunity to re-invigorate HIV prevention efforts throughout the country and advocates for "Expanding and Doing HIV Prevention Better". It strengthens the engagement and participation of all stakeholders working in HIV prevention in Uganda. Donor efforts are being continued in order to provide a needed strengthening of the focus of the NPS towards addressing behavioural and structural barriers to HIV/AIDS services uptake and Danida is actively participating in this through the relevant dialogue fora. Further, the Partnership Fund and CSF are mainly supporting prevention activities and also the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) are beginning to channel funds to support prevention activities. However, in terms of funding, treatment and care still gets the lion's share at the expense of prevention. This is continuously brought up by among others Denmark in the national policy and budget dialogue.

Specific comments on recommendations

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

Danida agrees that a joint logic model with a hierarchy of inputs and expected results and full involvement of civil society in alignment with national strategies should stand as the ideal approach for the future. However it should be recognised by the evaluation that the support of the three development partners was not intended and therefore not designed as a joint programme from the outset. It became joint over the course of implementation and through policy dialogue between the three partners. The joint support was based on a common wish to harmonize to the extent possible the support of on-going interventions by the three parties to the National Strategic Plan. This was with a view to maximize impact, eliminate duplication and rationalize activities, thereby increasing aid

efficiency and effectiveness and reduce transaction costs. This joint approach helped to enhance the coherence of the development partners' policy dialogue on HIV/AIDS with the government and has improved the effectiveness of individual aid programmes. In addition, it facilitated joint monitoring and managing for results by using and helping the further development of the capacity of the Government of Uganda's existing monitoring and evaluation systems. The Government of Uganda welcomed this harmonisation initiative.

Civil Society was not adequately involved from the beginning, but is today strongly represented on the Partnership Committee which oversees the operation of the Partnership Fund and also on the Civil Society Fund Board that oversees the operations of the CSF. They have already actively participated in the review of the National Strategic Plan and National Prevention Strategy.

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

Danida agrees to the recommendation and has in the current phase of the programme in conjunction with the two remaining donors, Ireland and Sweden, supported the Partnership Fund and CSF. The three donors have been instrumental in setting up a framework for joint periodic assessments of Uganda AIDS Commission's readiness to manage both the Partnership Fund, the Civil Society Fund and to carry out the establishment of a coming HIV/AIDS Trust Fund. The focus of any continued support to the sector beyond the present programme should be to support efforts towards identifying reliable sources of funding and establishing systems to ensure sustainable results.

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

The CSF Steering Committee was restructured during 2013 in terms of representation and roles and responsibilities. It is re-constituted as 'the CSF Board' with 13 members, 6 (up from 4) of whom are from civil society; 2 from the Uganda AIDS Commission; 3 from line ministries; and 2 donor representatives. Ultimately, the CSF Board is going to be responsible for recruiting the CSF management unit and will therein be given a bigger say in the operations of the CSF. It is expected that the stronger presence on the CSF Board of the CSO representatives will give these more influence and opportunities to articulate CSO issues. It should be noted that out of the 5 key donors supporting the sector through the Civil Society Fund, USAID has now backed out while DFID is expected to leave the sector in 2014. Sweden and Ireland are awaiting the result of ongoing country programming exercises before deciding on future support to CSF beyond the current phase.

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

Danida agrees with this recommendation. Funding to the Partnership Fund and the Civil Society Fund is currently being managed by an external agent and a new contract extension has been agreed upon till the 31st of December 2014. During this period, an assessment of the Government of Uganda's commitment in leading the HIV/AIDS response will be conducted to determine whether the management of the Partnership Fund could be transferred to UAC if sufficient commitment and goodwill has been built by the end of the year.

As for the CSF, assessments and consultations on how to set up an autonomous Project Management Unit (PMU) will be conducted. The CSF Board shall have the ultimate oversight responsibilities over the PMU so as to guarantee that the CSF will be able to function effectively independent of Government bureaucracy and politics and thereby avoid being encumbered by official legal problems with some of the MARPs that the CSF will inevitably have to work with.

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

Danida agrees that the Government of Uganda should contribute more to the Partnership Fund and the Civil Society Fund. The issue is part of Danida's dialogue with Government. However, Danida also believes that it is important that political commitment is shown from the highest level in order to ensure success of the Ugandan HIV/AIDS response.

6: The GoU and donors should explicitly define their commitments to the Uganda AIDS response for the next 5 or more years.

Government of Uganda operates a Medium Term Expenditure Framework (MTEF) which only projects expenditure over a three year period. The different development partners also have different start and end times for their respective programmes/projects and this makes it challenging to align programmes/projects and predict a 5 year horizon. The United States Government for one can only guarantee annual commitments.

7: The role of civil society in the Ugandan AIDS response should be defined.

Danida agrees that the role of civil society in the Ugandan AIDS response should be defined and Danida has pledged support to civil society in order for them to work on a plan together with Uganda Aids Commission and development partners to define their role within the National Strategic Plan.

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

Danida sees dialogue as a continuous process and endeavours to enrich it. In that respect, the issues raised in the recommendation on the balance between prevention and treatment and between biomedical prevention interventions and the comprehensive behaviour change interventions needed will form crucial elements of the process.

The Partnership Committee is the main dialogue forum between the Government, development partners and other stakeholders regarding sectoral issues; and within the Committee issues regarding harmonization and alignment are discussed. Meetings in this forum are regularly held with appropriate, senior representation by participating institutions.

Joint Annual Reviews are now held every year led by the Uganda AIDS Commission and the main objective of these reviews is to provide a forum in which the various HIV and AIDS stakeholders participate in reviewing the performance of the national response to HIV/AIDS in the previous year and planning for the upcoming year. Participants typically include line ministries, departments and agencies of Government, civil society, private sector, networks of People Living with HIV/AIDS, faith-based organisations, bilateral AIDS developments partners and the UN family.

The Partnership Forum provides a formal and representative coordination structure bringing together members of all constituencies, including district representatives for discussion, information sharing, consensus building, joint planning, sharing of experiences and practices and mutual support, including among district representatives. This is now also an annual event. During the Partnership Forum, discussions on the major issues emerging from the epidemic are held and agreements on the response and priorities/strategic steps for achieving agreed targets affirmed. Denmark uses this opportunity to advocate for a better balance between prevention, care/support and treatment; better services for the MARPs; increased sustainable public funding for the sector and better leadership of the HIV/AIDS response right from the centre down to the communities.

To support the Partnership, the development partners in the sector hold monthly AIDS Development Partner Group meetings to promote and facilitate donor coordination and harmonization. The Chair rotates among the key development partners and there is a sense of shared responsibility to make the donor coordination and harmonization work effectively and efficiently.

9: The international society should advocate for improving human rights in Uganda.

Improving human rights in Uganda is a continuous part of the Article 8 dialogue between the European Union and the Government of Uganda. A number of laws stand directly in the way of addressing and improving the HIV/AIDS situation among MARPs, but Denmark will continue efforts of ensuring that the MARPs have equal access to services without discrimination and stigmatisation. Danida provides core support to the MARPs Network for its work to build capacity, alliances and sharing of experience and knowledge among organisations advocating the rights of the different MARPs groups. Further, Danida has explored possibilities of further enhancing services to the MARPs by engaging another long term implementing partner already working with the MARPs around Kampala. Specifically relating to MSM, at the regional level, Denmark supports the International HIV/AIDS Alliance in its work for equal and non-discriminatory access to health services for men having sex with men. The intervention covers four African countries; Uganda, Tanzania, Kenya and Zimbabwe.

10: Uganda Aids Commission must show leadership on and affect change in relation to human rights issues.

Danida agrees that the Uganda AIDS Commission must show leadership on and affect change in relation to human rights issues if the National Strategic Plan is to be effective in achieving an AIDS transition. In this respect, it is encouraging that the specific recommendations on Uganda's ratification of the East Africa Community HIV and AIDS Prevention and Management Bill (2012) have already been fulfilled.

11: In the near term, donors should work with Uganda Aids Commission and the Civil Society Fund to address the omissions in the National Strategic Plan and its implementation in relation to fishing communities and other MARPs.

Uganda AIDS Commission and CSF conduct joint annual reviews as referred to under recommendation 8. These fora provide opportunities to address the mentioned omissions. Secondly, a Mid-Term-Review of the National Strategic Plan is scheduled to take place this year (2014) and this will provide an opportunity to address any omissions in plan. Danida will actively participate in the MTR with this in mind.