(Court of Arms)

NATIONAL GUIDELINES FOR HIV/AIDS COMMUNICATION

Guidance for Strategic HIV/AIDS Communication

February 2011 Version

(Insert logo for UAC)

This document was developed with support from the US Government through ACE Uganda and from the UN Family through the United Nations Population Fund (UNFPA)

(US logo) (UNFPA logo)

Foreword

Dr David Kihumuro Apuuli

Director General,

Uganda AIDS Commission

Table of Contents

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
CBO	Community-Based Organisation
CSW	Commercial Sex Worker
FBO	Faith-Based Organisation
FP	Family Planning
GoU	Government of Uganda
HBC	Home-Based Care
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Persons
IDU	Injection Drug User(s)
INGO	International Non-Governmental Organisation
IPC	Interpersonal Communication
IEC	Information, Education and Communication
MARP	Most-at-Risk Populations
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOT	Modes of Transmission
MSM	Men Who Have Sex with Men
MTCT	Mother-to-Child Transmission of HIV/AIDS
NGO	Non-Governmental Organisation
NSP	National Strategic Plan for HIV/AIDS Activities 2007/8-2011/12
OI	Opportunistic Infection
OVC	Orphans and other Vulnerable Children
PEP	Post-Exposure HIV Prophylaxis
PHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission of HIV/AIDS
PWD	People with Disabilities
RH	Reproductive Health
SCC	Social Change Communication
STI	Sexually Transmitted Infection
TB	Tuberculosis
UAC	Uganda AIDS Commission
UDHS	Uganda Demographic Health Survey
UHSBS	Uganda HIV/AIDS Sero-Behavioural Survey
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Definitions of Key Concepts

ABC+ refers to behavioural interventions that take into account the social, cultural and economic environments around an individual which influence adoption of preventive behaviours linking to HIV prevention, treatment and care services that would otherwise enhance risk perception, internalisation and skills building necessary to adopt and sustain positive behaviours of **A**bstinence (it also can be used to describe a delay of sexual debut), **B**eing faithful to a partner of known status, and correct, consistent **C**ondom use at every high risk sexual encounter.

Advocacy is an organised effort to change policies, re-define norms and raise resources for the benefit of groups such as PHAs, MARPs and other vulnerable groups. Effective advocacy raises awareness and contributes to the creation of an environment that favours behaviour and social change.

Behaviour Change Communication is a process of promoting and sustaining healthy changes in individuals' behaviour through the participatory development of appropriately-tailored health messages and approaches that are conveyed through a variety of communication channels (PATH & Save the Children 2003)

Sex Work: refers to perpetual dependency on sex for money or other items as an occupation. In Uganda, the initial push factor into the sex trade is largely for survival and peer pressure, but eventually turns it into a longer term occupation.

Comprehensive Knowledge about HIV/AIDS is a composite indicator, which is assessed in people between 15 and 49 years of age. A person is considered to have comprehensive knowledge about HIV/AIDS if s/he knows that: 1) the chance of getting the HIV virus is reduced when condoms are used consistently and correctly at every high risk sex encounter; 2) the chance of getting the HIV virus is reduced by having only one sexual partner who is not infected and who has no other partners; 3) that HIV is not transmitted through mosquito bites; 4) that people cannot get the HIV virus from sharing food with a person who is infected with HIV or has AIDS; and, 5) that a healthy-looking person can have the HIV virus

Drivers of the HIV/AIDS epidemic are those environmental, structural and social factors, such as poverty, gender inequality and human rights violations, inequitable access to services, etc which increase an individual's vulnerability to HIV infection.

Generalised epidemic is the epidemic state in which HIV is firmly established in the general population. Although sub-populations with higher risk may continue to contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain an epidemic independent of sub-populations at higher risk for infection. The HIV prevalence among pregnant women is consistently above 1% (UAC, MOH & UNAIDS 2009).

High-risk sex includes sex with multiple partners especially non-marital or non-cohabiting partners; non-consensual sex; inconsistent or no condom use; commercial, transactional

and trans-generational sex; alcohol consumption and drug abuse before sex; unprotected sex with someone of unknown HIV status; and sex without testing and mutual disclosure.

Incidence describes the number of new cases of HIV arising within a specified population over a given period of time (commonly one year).

Life skills education refers to training, especially for youth, in such skills as interpersonal relationships, self awareness and self esteem, problem-solving, effective communication, and decision-making, negotiating sex or lack thereof (abstinence), resisting peer pressure, critical thinking, negotiation, formation of friendships, and empathy.

Most-at-Risk Populations (MARPs) those populations in whom there is a concentration of risk behaviours that lend themselves to efficient HIV transmission. These may then drive the majority of new infections in the specific population groups or the general population. The high-risk behaviours that put people at greater risk of HIV infection include: high rates of multiple sexual partnerships, low rates of condom use at high risk sex, high rates of concomitant STIs, unprotected anal sex with partners of unknown sero-status, and injection drug use with shared equipment. Population groups in which these high-risk behaviours are concentrated include: sex workers and their partners, long distance truck drivers, fisher folk, uniformed services, men who have sex with men (MSMs) and injection drug users (IDUs) (Neema 2009).

Prevalence: is defined as the total number of cases of HIV at a point in time per specified population.

Prevention with Positives is a strategy that promotes healthy living and reduction in risky behaviours among HIV-positive individuals. This strategy not only improves the quality of life for the HIV-positive individual, but also reduces the risk of transmission of HIV to non-infected persons, including sexual partners, infants born to HIV-positive women and injection drug users. It involves caring for HIV-positive people and their families, promoting testing and mutual disclosure of results, promoting safer sexual practices, and supporting adherence to treatment.

Primary Audience is the group for whom (and with whom) strategic HIV/AIDS communication messages, materials and activities are designed. Strategic HIV/AIDS communications are intended to influence the knowledge, attitudes and behaviours of the primary audience.

Risk factor is an aspect of personal behaviour or lifestyle or an environmental exposure, which, on the basis of epidemiological evidence, is known to be associated with HIV transmission or acquisition.

Road Map is a detailed description of a series of critical steps or milestones that guide the implementation of interventions or the determination of a course of actio

Secondary Audience includes those people who can influence the primary audience to change behaviour. (For example, the secondary audience of a communication strategy designed to improve health-seeking behaviours among PHAs might include families and caregivers of PHAs.)

Social Change is the transformation of social norms and policies to create an environment that is favourable to individual change.

Social Change Communication refers to "the strategic use of advocacy, communication and social mobilisation to systematically facilitate and accelerate change in the underlying drivers of HIV risk, vulnerability and impact" (UNAIDS 2007).

Social Mobilisation is a process that brings together various segments of society (social groups, political and religious leaders, organisations, etc.) to change social norms and provide sustainable, multi-faceted solutions to broad social problems. It often involves high-level political action and is thus particularly effective when it includes strong advocacy for policy change. Social mobilisation helps create an environment that enables behavioural change (FHI 2005).

Stakeholders are people who have an interest in, who stand to benefit from or who may be affected by the outcome of a programme. Stakeholders may be other key people, including: decision makers, gatekeepers, opinion leaders and policy makers (FHI 2005).

Transactional Sex is defined as sex in exchange for money or other items but with an element of exploitation of the sexual partner because s/he is in a vulnerable socio-economic situation.

Trans-generational Sex (also referred to as *cross-generational* sex) is defined as sex with a much older partner (an age gap of 10 years or more is usually considered "much older"); in most cases it involves an element of exploitation due to economic and social vulnerability.

Vulnerability results from a range of factors that reduce the ability of individuals and communities to avoid HIV.

Executive Summary

From the late 1980s to 2000, co-ordinated, effective approaches to HIV/AIDS communication in Uganda, backed by strong political leadership, played a key role in reducing the prevalence of HIV in the general population from 18% to around 6%. Since 2000, however, HIV/AIDS communication approaches have not kept up with the changing status of the epidemic, nor have they been adapted to address the primary modes of transmission (MOT) and most-at-risk populations (MARPs) that have been recently identified.

Recent studies have shown that the HIV/AIDS epidemic in Uganda has developed into a *severe, mature and generalised epidemic* that affects both rural and urban areas of the country. The characteristics of the epidemic are changing: The downward trend in HIV prevalence is no longer seen and there are indications that both prevalence and incidence are on the rise. The prevalence peak has shifted from young people to older adults, with the highest prevalence seen in men between 35 and 39 years of age and women between 30 and 34 years. Most new infections are occurring in individuals who are married or in long-term relationships, and high-risk sexual behaviour, particularly among men, is increasing.

In recent years, the coverage of HIV prevention services, particularly in the areas of HCT and PMTCT, has improved. Nevertheless, despite the emphasis on accelerating prevention, a significant proportion of the population still does not have access to HIV prevention services. Increased focus has been placed on HIV care, treatment and support services in recent years, but access to services is not equitable, and services, when they are available, are often of poor quality, due to weaknesses in the health sector and generally the social services system.

Until now, HIV/AIDS communications have focused on information, education and communication (IEC) and behaviour change communication (BCC) interventions; there has been little focus on social change. The “ABC “ approach (**A**bstinence, **B**eing faithful and using **C**ondoms correctly and consistently) and other campaigns, such as “Zero Grazing,” were highly successful in Uganda and contributed to widespread behaviour change among the general population. In recent years, however, HIV communications in Uganda have been challenged by the lack of national policies on behavioural interventions; behaviour change messages that are inconsistent and not based on evidence; the emphasis of abstinence and being faithful over condom use; a focus on young people, rather than on older populations, where most new infections are occurring; and a lack of co-ordination between HIV prevention care and treatment communication.

HIV/AIDS communication programmes have been further challenged by decreased funding; a lack of strategic information, and interventions that do not target identified high-risk behaviours or most-at-risk populations.

In order to address the changing characteristics of the HIV/AIDS epidemic in Uganda and to promote universal access to HIV/AIDS information, care, treatment and support services, new, ***strategic communication approaches*** are needed. These new approaches must support the goals of the *National Strategic Plan for HIV/AIDS Activities 2007/8-2011/12* (NSP) to reduce new HIV infection by 40%, expand social support and scale up interventions of care and treatment of those in need by 80% by the year 2012.

The *National Guidelines for HIV/AIDS Communication* (NGC) was developed through an extensive process of dialogue and collaboration. The NGC is intended to provide guidance for initiating, developing and delivering evidence-based, high quality, co-ordinated HIV/AIDS communications at all levels. The primary intended users of the NGC are HIV/AIDS programme managers and communication programmers, who should use the document to help design and implement programmes that respond to the needs of their target audiences. The NGC will also be useful to all HIV/AIDS stakeholders, including policy makers, local and national health officials, staff from NGOs, CBOs, FBOs from health and other sectors, members of the press and media, local and national government officials, etc.

The NGC outlines approaches for strategic HIV/AIDS communications as well as the roles and responsibilities of HIV/AIDS stakeholders at all levels as they relate to strategic communications. The final section of the document presents the monitoring and evaluation framework for the NGC and links it to the goals and objectives of the NSP.

Chapter 1: Introduction and Overview

1.1 Introduction

Since the late 1980s, HIV/AIDS communications in Uganda have primarily consisted of a variety of mass media, information, education and communication (IEC) and behaviour change communication (BCC) approaches to increase awareness and knowledge about HIV/AIDS and to change behaviours among the general population. These communication approaches, backed by strong political leadership, played a key role in reducing the prevalence of HIV in Uganda during the 1990s.

Recent studies have highlighted the changing characteristics of the HIV epidemic in Uganda, which call for the development of new HIV/AIDS communication strategies. The HIV epidemic in Uganda has evolved to a *severe, mature, generalised* epidemic (UAC, MOH & UNAIDS 2009), but the strategic information needed to guide the content and focus of HIV communication interventions has not been available. As a result, HIV/AIDS communication approaches have not kept up with the changing characteristics of the epidemic, nor have they been adapted to address the primary modes of transmission (MOT) and the identified most-at-risk populations (MARPs).

The *National Guidelines for HIV/AIDS Communication* (NGC) is intended to help in the development of both sectoral and institutional communication strategies by providing guidance for initiating, developing and delivering evidence-based, high quality, co-ordinated HIV/AIDS communications. The NGC was developed through an extensive process of dialogue and collaboration, with consultative and technical meetings held with a variety of stakeholders, including representatives from GoU, UN agencies, INGOs, NGOs, CBOs and PHAs.

The NGC provides a framework for strategic HIV/AIDS communication that addresses the priorities established by the *Country Road Map towards Accelerated HIV Prevention* (2006) and the *National Strategic Plan (NSP) for HIV/AIDS Activities 2007/8-2011/12.* It draws from other key national documents including the report of the *2008 Joint AIDS Review (JAR*), the *Uganda Modes of Transmission Study* (2008), the *Profiling of Most at Risk Populations (MARPs) in Uganda and Development of a Plan of Action to Address Vulnerability, Susceptibility and the Growing Epidemic among MARPs* (2009), and the *Assessment of BCC Interventions for HIV/AIDS Prevention, Care and Treatment* (2007).

The NGC is primarily intended to help HIV programme managers and communication programmers design and implement HIV/AIDS programmes that are responsive to the needs of the target populations. All HIV/AIDS stakeholders, such as policy makers, local

and national health officials, staff from NGOs, CBOs, FBOs from health and other sectors, members of the press and media, local and national government officials, and individuals from the private sector, should use the Guidelines for the purposes of HIV/AIDS communications as well as programme design, implementation, monitoring and evaluation.

1.2 Strategic Vision

In line with Uganda's vision of **a population free of HIV/AIDS and its effects,** Uganda's NSP has established the goals of *reducing new HIV infection by 40%, expanding social support and scaling up interventions of care and treatment to 80% of those in need by the year 2012* (UAC, 2008).

> Strategic HIV/AIDS communication in Uganda will lead to long-term behavioural and social change and contribute to the elimination of HIV/AIDS and its effects.

Through the implementation of the *National Guidelines for Strategic HIV/AIDS Communication,* the Uganda AIDS Commission (UAC) envisions that **strategic HIV/AIDS communications in Uganda will lead to long-term behavioural and social change and contribute to the elimination of HIV/AIDS and its effects.**

1.3 Situation Analysis

1.3.1 The Status of the Epidemic

Between 1993 and 2000, the HIV prevalence in Uganda decreased from 18% to 6.2%. This dramatic reduction in the percentage of Ugandans living with HIV can be attributed, at least in part, to a number of programme interventions, which were implemented across the country and supported by government. Through these interventions, Ugandans became more aware of the risks of HIV and they decreased their high-risk sexual behaviours, such as having multiple sexual partners, engaging in unprotected sex and having first sexual intercourse at an early age.

Since 2002, however, the characteristics of the HIV epidemic in Uganda have changed. It is now a *mature, generalised epidemic* that affects both rural and urban populations, although prevalence is significantly higher in urban areas (MOT & Macro 2006). The HIV prevalence among the general population has remained between 6.1% and 6.5% for several years and there are some indications that the prevalence is increasing (UAC, MOH & UNAIDS 2009). There are also indications that HIV incidence has increased during this period, with an estimated 91,546 new infections among adults in 2009 (UAC, MOH &

> The HIV/AIDS epidemic in Uganda is mature and generalised, affecting both rural and urban areas of the country.

UNAIDS 2009). In 2007, there were an estimated 940,000 people living with HIV/AIDS (PHAs) (UNAIDS 2008a); if the current trends continue, there may be 1.3 million PHAs in Uganda by 2012 (UAC 2006).

Most HIV transmission occurs through sexual contact between men and women, which accounts for 65-85% of new HIV infections (Stover 2005). The majority of new infections are occurring in couples who are married or in long-term relationships, in which one of the partners is HIV-positive and infects the other partner (MOH & Macro 2006). Most married couples in Uganda do not know their HIV status (Neema 2009); those people who do know their status often do not disclose to their partners (UBOS & Macro 2007), putting their partners at risk of becoming infected. In addition, condom use within married relationships is low at 11-14% (Neema 2009), which also increases the risk of transmission within discordant couples. The other major sources of new infection are among people with multiple sexual partners and among the partners of people with multiple sexual partners (UAC, MOH & UNAIDS 2009).

Previously, HIV/AIDS primarily affected young men and women. In recent years, however, the burden of HIV infection has shifted to older, married (or previously married) adults. HIV prevalence is highest among men who are between 35 and 39 years of age and among women between 30 and 34 years of age. (MOH & Macro 2006). In the 15-34 year age group, HIV prevalence is significantly higher among women than among men, which highlights the increased vulnerability of women (UAC, MOH & UNAIDS 2009).

STATUS OF THE HIV/AIDS EPIDEMIC IN UGANDA

- There are indications that HIV incidence and prevalence are increasing in Uganda.
- There are currently around 1 million PHAs in Uganda; if current trends continue, there will be 1.3 million PHAs by 2012.
- Most HIV transmission is through sexual contact between men and women.
- Most new HIV infections are in married or long-term couples.
- HIV prevalence is highest in older, married adults.
- In the 15-34 year age group, HIV prevalence is significantly higher among women than men.

Factors that underlie the epidemic can be divided into *individual risk factors* that increase a person's risk of becoming infected or infecting another person with HIV and *contextual (social cultural and economic) factors*, or *drivers* of the epidemic. Table 1 outlines some of these factors.

Table 1: Factors fuelling the HIV/AIDS epidemic in Uganda[1]

• **Individual Risk Factors (Risk Factors)**	• **Contextual Factors Driving the Epidemic (Drivers)**
• Having multiple sexual partners • Being in a discordant relationship in which the HIV-positive partner does not disclose his/her status • Not using condoms or using condoms incorrectly or inconsistently • Engaging in transactional or commercial sex • Engaging in trans-generational sex • Being infected with a sexually transmitted infection (STI) - particularly HSV-2 • Being an uncircumcised male	• Socio-cultural factors such as: Early marriage, Multiple sexual partners, Erosion of traditional African family values • Poverty and wealth • Low status of women and girls • Inequitable distribution of and access to resources and health services • Human rights violations, stigma and discrimination towards PHAs • War and conflict

Among men in particular, high-risk sexual behaviours, such as having multiple lifetime partners, having multiple partners during a particular period of time, and not using condoms during high-risk sex, have increased in recent years (MOH & Macro 2006).

Additionally, recent studies in Uganda have identified the groups that are most at-risk of becoming infected with HIV and transmitting the infection. These most-at-risk populations (MARPs) are summarised in **Table 2**.

[1] Adapted from UNAIDS. *Uganda Modes of Transmission Study: Analysis of HIV Prevention Response and Modes of HIV Transmission, The Uganda Country Synthesis Report.* March 2009.

Table 2: Most-at-risk populations (MARPs)[2]

Most-at-Risk Population	Characteristics of Risk
• **Commercial sex workers (CSW)**	• Commercial sex work (or selling sex) is present in most urban areas of Uganda. • Most people who sell sex do so because of poverty. • The majority of CSW use alcohol or drugs, which may increase the likelihood that they will engage in unprotected sex.
• **Partners (clients) of CSWs**	• An estimated 1% of all men between 15 and 49 years are clients of CSW (MOH & Macro 2006). • Most of these men are married or have regular sexual partners. • 44% of men report that they did not use a condom the last time they paid for sex (MOH & Macro 2006), which puts them at risk of infecting their wives or regular sexual partners with HIV.

[2] From UNAIDS. *Uganda Modes of Transmission Study: Analysis of HIV Prevention Response and Modes of HIV Transmission, The Uganda Country Synthesis Report.* March 2009 and Neema et al, *Profiling of Most at Risk Populations (MARPs) in Uganda and Development of a Plan of Action to Address Vulnerability, Susceptibility, and the Growing Epidemic among MARPs· 4th Draft*, March 2009.

Most-at-Risk Population	Characteristics of Risk
• **Internally displaced people (IDPs)**	• The HIV prevalence in Northern Uganda is 8.2%, which is significantly higher than neighbouring regions of the country, which were not involved in conflict. • Risk factors for HIV include: o loss of traditional values, o alcohol use and idleness, o poverty, leading to transactional sex, o sexual abuse by uniformed personnel and / or humanitarian workers, o sexual violence, o child abduction and defilement, o lack of awareness about and access to HIV- related services and information.
• **Long-distance truck drivers**	• Truck drivers are away from home for long periods of time and may have casual sex or may have long-term sexual partners outside of marriage or the home. • Less then 60% of truck drivers use condoms (Ferguson et al. 2008). • Loneliness, peer pressure and alcohol use contribute to high-risk sexual behaviours. • They have limited access to basic HIV prevention programmes, HCT, ART and basic health services.
• **Fishing communities**	• HIV prevalence among fishing communities is very high, ranging from 20%-81%. (Kipp et al 1995; UAC 2008). • Fishermen are isolated and have limited opportunity for recreation. • CSWs, drugs and alcohol are easily accessible in fishing communities. • There are few health services available in fishing areas, including HIV prevention, HCT and ART.

Most-at-Risk Population	Characteristics of Risk
• **Uniformed services**	• HIV prevalence among soldiers, police and prison services is higher than the national average (Neema 2009). • Risk factors for HIV include: o Long periods away from home; o Several families share housing, which encourages high-risk sexual behaviours (such as sharing women); o Alcohol consumption and idleness are risks; o New recruits have low awareness of HIV and how it is transmitted; o Health services available to uniformed services are poor and they practice poor health-seeking behaviours.
• **Men who have sex with men (MSM)**	• The main risk factor among MSM is unprotected anal sex. • MSM tend to have multiple sexual partners. • MSM may be less likely to use condoms (Kajubi 2008; McGowan 2008). • Because homosexuality is illegal in Uganda and because of the stigma associated with it, MSM may marry and have families, or they may have sex with women, putting their wives or other sexual partners at risk. • There are no specific HIV-related prevention programmes or services for MSM.

Most-at-Risk Population	Characteristics of Risk
• **Injection drug users (IDUs)**	• The percentage of Ugandans who use drugs is not known, as no national studies have been done. o 80% of street children use one or more substances (Kasirye 2000). o 71% of school children in Kampala and Wakiso districts use alcohol or cannabis (marijuana) (Kasirye 2008, 2004, 1992). • Drug use is a problem among urban youth (Kasirye 2008, 2004, 1992). • People who use drugs are more likely to have sex than those who do not use drugs. • Drug use is associated with selling sex, especially among young people in slum areas (Kasirye 2008, 2004, 1992). • Some young people falsely believe that drugs will keep HIV from spreading in the body.

In addition to the MARPs, there are certain groups who are considered *vulnerable* because they are less able to avoid HIV infection, due to various factors. These vulnerable groups include:

- Married people and people in long-term relationships,
- Orphans and vulnerable children (OVCs),
- Adolescents and young people (especially girls),
- Women and girls,
- People with disabilities.

All HIV/AIDS stakeholders need to understand the current trends in the HIV epidemic and ensure that communication interventions increase comprehensive knowledge about HIV and AIDS and promote behaviour change, by addressing not only individual risk factors, but also the drivers of the epidemic. In addition, it is very important that stakeholders take MARPs and vulnerable groups into consideration when designing and implementing communication programmes, so that messages and interventions appropriately target those who are most at risk.

1.3.2 The Status of the HIV/AIDS Prevention Response

Priority HIV prevention interventions in Uganda include awareness raising (IEC and mass media); behaviour change communication (BCC); HIV/AIDS education and life skills training; condom promotion and provision; biomedical interventions (HCT, PMTCT, condom promotion and provision, blood transfusion safety, control of medical transmission and provision of post-exposure prophylaxis - PEP - for HIV); and interventions addressing the environmental factors that affect transmission of HIV, such as GBV and livelihood security (UAC, MOH & UNAIDS 2008b).

Along these lines, the NSP has outlined the following goals for HIV/AIDS prevention for 2007 - 2012 (UAC 2008):

- To accelerate the prevention of sexual transmission of HIV targeting vulnerable and most-at-risk groups;
- To promote and scale up PMTCT;
- To ensure blood transfusion safety, universal precautions and PEP;
- To control STIs;
- To develop appropriate policies and programmatic guidelines for implementation of new HIV preventive technologies proven to be effective.

In recent years, the coverage of HIV prevention services, particularly in the areas of HCT and PMTCT, has improved. Nevertheless, despite the emphasis on accelerating prevention, a significant proportion of the population still does not have access to HIV prevention services (UAC, MOH & UNAIDS 2009):

- More than 75% of Ugandan adults do not know their HIV sero-status;
- Less than half of the pregnant women in Uganda have access to PMTCT services;
- There are few outreach programmes targeting MARPs;
- Condom use, although increased in the general population, is still only about 50% for high risk sexual activities;
- STI treatment services are available in 60% of PHC facilities, but the quality of services is poor and stock outs of essential drugs are common;
- HIV education and life skills programmes for in-school youth are not widely available and out-of-school youth have little access to similar programmes;

- The roll-out of medical male circumcision has been low, despite scientific evidence that demonstrates its important role in preventing HIV transmission in males. (UAC, MOH & UNAIDS 2009).

OVERVIEW OF THE CURRENT HIV PREVENTION RESPONSE

Despite prevention activities over the past 2 decades, HIV prevention services are not available to most Ugandans:

- 3/4 of all Ugandans still do not know their HIV status;
- Less than half of pregnant women can access PMTCT services;
- Condom use remains low for high-risk sexual activities (50%);
- STI services are not widely available and the quality is poor;
- HIV education programmes for in-school and out-of-school youth are lacking;
- The roll-out of medical male circumcision has been low.

1.3.3 The Status of HIV/AIDS Care, Treatment and Support Services

The NSP has the following goals for HIV/AIDS care, treatment and support:

- To increase the equitable access to ART;
- To increase access to prevention and treatment of opportunistic infections (OI), including tuberculosis (TB);
- To scale up counselling and testing to facilitate universal access to treatment;
- To integrate prevention into all care and treatment services;
- To support and expand the provision of home-based care (HBC) and strengthen referral systems to other health facilities and complementary services;
- To provide complementary support, including nutrition counselling and education to PHAs.

Although the number of health facilities providing ART has been scaled up since 2003 (NSP 2007), and the percentage of PHAs receiving treatment is steadily increasing (JAR 2008), ART is still not available to the majority of Ugandans who need it. Access to ART varies among PHAs by region and by age group (Namuwenge et al. 2008):

- By December 2008, there were approximately 360,000 PHAs (adults and children) who needed ART, but only about 154,800 (43%) were on ART;
- Of the 33,000 children who need ART, only 13,200 (40%) are receiving it;
- People living outside of the central region and those who are under 15 years of age are less likely to be on ART; and

- PMTCT and ART services are not well integrated. Most pregnant women and new mothers who are eligible for ART only receive prevention for their infants and do not receive treatment for their own HIV infections (NSP 2007).

There is a risk that resistance to first-line ART will develop, as a result of poor prescribing practices, lack of client follow-up, and stock-outs of drugs at health facilities (Namuwenge et al. 2008). In addition, health information systems for ART are weak, further contributing to the problems of client tracking and drug management (Namuwenge et al. 2008).

Although there is a direct relationship between sexually transmitted infections (STIs) and HIV, little emphasis has been placed on the management of STIs. Mother-to-child transmission (MTCT) remains high, although it has been reduced significantly as a result of ART and PMTCT programmes (UAC 2008).

KEY POINTS: STATUS OF HIV/AIDS CARE, TREATMENT AND SUPPORT SERVICES

- Less than half of the PHAs who need ART are receiving treatment
- Young people and people living outside of central Uganda are less likely to be on treatment.
- Pregnant women who receive PMTCT to prevent HIV infection of their babies are not receiving ART for their own infections.
- There is a risk that drug resistance to ART will develop because of weaknesses in the health system.
- Although STI and HIV infection are linked, STI management has not been prioritised.

1.3.4 The Status of Communications in the National HIV/AIDS Response

Until 2000, HIV/AIDS communications focused on information, education and communication (IEC) and behaviour change communication (BCC) interventions. The "ABC " approach (Abstinence, Being faithful and using Condoms correctly and consistently) and other campaigns, such as "Zero Grazing," were highly successful in Uganda and contributed to widespread behaviour change among the general population. In recent years, however, HIV communications in Uganda have been characterised by the following:

- National policies on behavioural interventions are either non-existent, are very diffuse, or do not target MARPs;
- Behaviour change messages have been inconsistent and have not been based on evidence;
- Abstinence and being faithful have been emphasised more than condom use;

- Prevention efforts have focused mostly on young people rather than on the older populations (where most of the new cases are now occurring); and
- Communication about HIV prevention has not been co-ordinated with communication for care and treatment.

IEC and mass media

IEC and mass media have long been the most popular sources of information about HIV/AIDS among adults and young people in Uganda (Opio et al). These prevention communications have targeted the general population and have been successful in raising awareness about HIV/AIDS (Kirungi et al 2006, Low-Beer et al 2003, Hallett et al 1997, Asiimwe-Okiror et al 1997).

Mass media and IEC communications for HIV prevention have faced several challenges, however, which have limited their impact (UAC, MOH & UNAIDS 2008b). First, reduced funding for prevention has led to limited and irregular coverage of mass media and IEC. Little strategic information has been available to guide the content, focus and monitoring of IEC and mass communication programmes, so it is probable that key at-risk-groups, including MARPs, have not been reached. Mass communication interventions have not been based on evidence, have targeted the general population without specifically addressing MARPs and have focused on increasing awareness, rather than increasing comprehensive knowledge about HIV/AIDS. In addition, some messages have been conflicting, leading to audience confusion.

Behaviour change interventions

Social mobilisation, interpersonal communications, sexuality and life skills education and other forms of behavioural change communication have also been important forms of HIV communications since early in the epidemic and have had the support of government, community and opinion leaders. Particularly during the 1990s, substantial sexual behaviour change took place in Uganda, although it is not clear that these changes can be completely attributed to behaviour change interventions (UAC, MOH & UNAIDS 2008b). Since 2000, however, there has been a reversal in behavioural trends, with worsening of sexual behavioural indicators, such as decreased age of sexual debut, decreased condom use, and increases in multiple sexual partnerships, (MOH and Macro 2006).

Behaviour change interventions have also faced several challenges. First, they have been affected by the reduced funding for HIV prevention. BCC interventions have not targeted high risk groups in the population (married couples, older men and women, the wealthy, etc.), nor have they targeted the behaviours that are responsible for most HIV transmission (UAC, MOH & UNAIDS 2008b). Behavioural interventions have not

adequately addressed the social "norms" (such as "masculinity" among men, "permissiveness" among women, and multiple sexual partnerships) that promote the transmission of HIV. Behavioural interventions have not been based on proven behavioural theory and strategic information has not been available to contribute to programme targeting, planning, monitoring and evaluation (UAC, MOH & UNAIDS 2008b).

KEY POINTS: THE STATUS OF COMMUNICATIONS IN THE NATIONAL HIV/AIDS RESPONSE

- IEC and mass media programmes are the main sources of HIV/AIDS information among adults and young people. These interventions have been very successful in raising awareness among the general population, but have not increased comprehensive knowledge about HIV/AIDS.
- Behaviour change interventions may have contributed to a reduction of risky sexual behaviour in the 1990s, although in recent years, these behaviours have been increasing.
- Communications programmes have faced several challenges:
    - Funding for HIV/AIDS communications has decreased, which has limited the coverage of interventions;
    - Strategic information has not been available to guide and evaluate communication programming;
    - National policies on behavioural interventions are lacking;
    - MARPs and other high-risk groups have not been specifically targeted;
    - The high risk behaviours that are most responsible for HIV transmission have not been targeted;
    - Communication interventions have not been based on proven models, which has limited their effectiveness.

Chapter 2: National Guidelines for Strategic HIV/AIDS Communication (NGC)

2.1 Purpose of the Guidelines

The National Guideline for HIV/AIDS Communication (NGC) is intended to provide guidance for all individuals who are involved in HIV/AIDS communication programming at all levels. It provides strategic communication guidance and identifies priority communication issues in line with the NSP, but does not present specific messages. More specifically, this document will:

- describe the HIV/AIDS communication environment including analysis of current and emerging issues, challenges and opportunities;
- define strategic HIV and AIDS communication priorities and target audiences in line with the National Strategic Plan for HIV/AIDS activities 2007/8-2011/12;
- outline approaches that underlie quality, effective communication interventions;
- identify stakeholder roles and responsibilities;
- define mechanisms for integrated and co-ordinated delivery of communication interventions; and
- Present the monitoring and evaluation framework for strategic HIV/AIDS communications, aligned to the goals and objectives of the NSP and Performance Measurement and Management Plan (PMMP).

Because the HIV/AIDS situation in Uganda is changing, new, strategic communication approaches must be developed to inform stakeholders about the current trends in the epidemic, how HIV is being transmitted and the factors responsible for most of the new infections, and who is most at risk. Strategic communication approaches will also increase awareness about the prevention, care, treatment and support services that are available and encourage the population to use them. Communication approaches therefore must ensure that those who are most at risk of becoming infected with HIV or of transmitting the infection to others:

- have access to accurate and up-to-date information about how they can reduce their own risk and the risk of others; and
- Understand where and how to access the services that they need.

The NGC also outlines approaches for strategic HIV/AIDS communications as well as the roles and responsibilities of HIV/AIDS stakeholders at various levels. The final section of the document presents the monitoring and evaluation framework for the NGC and links it to the Performance Measurement and Management Plan (PMMP).

Targeted and potential users of the Guideline

The primary intended users of the NGC are HIV/AIDS programme managers and communication programmers, who should use the document to help design and implement programmes that respond to the needs of their target audiences. The NGC will be useful to all other HIV/AIDS stakeholders, including local and national health officials, staff from NGOs, CBOs, FBOs from health and other sectors, members of the press and media, local and national government officials, etc.

The primary intended users of the NGC are HIV/AIDS programme managers and communication programmers, who should use the document to help design and implement programmes that respond to the needs of their target audiences.

2.2 Objectives of the Guidelines

The overall objective of the NGC is

- *To guide stakeholders in the development and implementation of effective, co-ordinated, evidence-based HIV/AIDS communications programmes that contribute to the reduction of new HIV infections and to the increased uptake of HIV prevention, care, treatment and support services by all Ugandans*, *including those who are most-at-risk.*

The specific objectives of the NGC encompass the areas of prevention, care and treatment, and support, in line with NSP priorities and targets:

- To promote social change that favors widespread behaviour change through strategic communication interventions that address the drivers of the epidemic, with the aim of reducing HIV incidence and prevalence in Uganda.
- To lower the risk of transmission of HIV and to reduce the spread of HIV/AIDS by advocating for, promoting awareness of, and building skills to support widespread adoption of healthy, low-risk behaviours that result in safer sexual, social and health-seeking behaviours.
- To advocate for and promote awareness, support and utilisation of HIV/AIDS-related medical services and treatment, including improved health-seeking

behaviours for treatment of opportunistic infections, as well as early enrolment in and adherence to anti-retroviral therapies (ART).

- To advocate for and promote awareness, support and implementation of policies and programmes that address: HIV prevention, care and treatment; food security and nutrition; economic empowerment; and community safety nets for populations and individuals that are vulnerable to HIV/AIDS, thus decreasing stigma and discrimination and improving the uptake of social services.

2.3 HIV/AIDS Communication Priorities

The NSP prioritises the reduction of HIV incidence by 40%, and emphasises the prevention of infection and transmission among MARPs and other vulnerable groups and promotion of universal access to care, treatment and support services to all HIV-positive Ugandans who need them, regardless of their age or sex, in all districts of the country.

The national communication priorities for HIV/AIDS are outlined in **Table 3** below. These priorities follow the NSP's goals and objectives and respond to the latest information available on the status of the epidemic in Uganda. HIV/AIDS communication partners should take these priorities into account during all stages of the design, implementation, monitoring and evaluation of communication interventions.

Table 3: National HIV/AIDS Communication Priorities

Prevention	Care and Treatment	Mitigation of Social, Cultural and Economic Effects of HIV/AIDS
• Reduce multiple sexual partners; • Improve uptake of HCT services and promote disclosure of results to sexual partners; • Improve accuracy and consistency of reporting of HIV-related facts and issues in the media; • Increase the age first sexual intercourse (sexual debut); • Increase correct and consistent use of condoms with high risk sex partners; • Increase awareness of discordance among couples; • Increase uptake of PMTCT services by couples; • Avoid unintended pregnancy among discordant couples; • Ensure occupational safety; • Link blood donors to HIV prevention and treatment services; • Increase uptake and usage of STI services; • Increase public awareness of male medical circumcision and	• Promote equitable availability of ART in all regions of the country; • Increase motivation to seek ART services; • Improve adherence and correct use of ART; • Ensure timely and correct treatment of STIs and opportunistic infections; • Increase health workers' capacities in client tracking and drug management • Ensure that TB screening is routinely provided to all HIV clients; • Increase the uptake of HCT and reduce the fear of disclosure of HIV status among routine sexual partners; • Increase public knowledge about discordance; • Increase the information available about HIV testing services for children and adolescents; • Increase the number of HIV-positive children and adolescents who know their status;	• Increase awareness and understanding of national nutrition guidelines, including their implications on gender/human rights; • Increase awareness on quality and integration of psycho-social support services into other services that address needs of PHAs, OVCs, PWDs, IDPs and other disadvantaged groups; • Promote and support equitable access and coverage of sustainable, quality social services (formal education, vocational and life skills) for vulnerable groups; • Support economic and livelihood opportunities for HIV/AIDS - affected communities and households; • Link income-generating activities (IGA) with SRH/HIV/STI related services; • Ensure that PHA

its role and benefits in HIV prevention. • Increase availability of male medical circumcision in all regions of the country	• Increase of understanding and awareness of "Positive Living" concepts; • Ensure that family planning and sexual and reproductive health services are integrated in HIV prevention and service delivery settings; • Advocate for a home-based care (HBC) policy; • Expand knowledge and skills among PHA family members and community volunteers to provide adequate HBC.	and OVC households get the essential materials and financial support they are entitled; • Sensitise on the relation between human rights, HIV status disclosure, confidentiality, routine counselling and testing, and wilful transmission of HIV; • Increase the public knowledge of legal rights and entitlements of PHAs and their families; • Promote the rejection of negative cultural & social practices.

2.4 Characteristics of Strategic HIV/AIDS Communication Approaches

Not only has the status of the HIV epidemic changed, changes in the nature of communications in Uganda have also taken place which highlight the need to re-evaluate HIV/AIDS communication priorities and interventions:

- HIV communication channels are becoming more integrated, with mass media, community-based and interpersonal channels to reinforce one another;
- New technologies are expanding the ways people can be reached;
- De-centralisation has shifted more decision-making and control from the central government to the local governments and lower level communities;
- More stakeholders have joined the HIV communication effort ; and

- More evidence has been gathered at the national and district levels, including information about the modes of transmission and most-at-risk populations, providing data to guide communication programming and strategic decisions.

In order to address the changing AIDS epidemic in Uganda, it is important that HIV/AIDS communications be **strategic**, that they focus on enhancing risk perception and promoting behaviour change - especially among MARPs and vulnerable groups - and that they promote access to HIV prevention, diagnosis, care and support services for all Ugandans.

Strategic HIV/AIDS communication will help Uganda respond to the changing status of the epidemic. A strategic communication approach is evidence-based, comprehensive, and participatory and is intended to result in behavioural and social change (AfriComNet, et al. 2006). The following are characteristics of strategic communication approaches:

- **Evidence-based:** Communication strategies are based on well-documented successful examples. Messages and materials are based on scientific studies and research, and they are designed to address the recent trends in the HIV/AIDS epidemic, including modes of transmission and MARPs. Communications must not spread myths, rumours or other incorrect information about HIV/AIDS.

- **Results-oriented:** Communications are designed in line with a strategic vision and with specific, measurable goals in mind. Monitoring and evaluation is an important part of the communication programme.

- **Consultative:** The target audience, PHAs and other HIV/AIDS stakeholders are involved in the design, monitoring and evaluation of communication programmes.

- **Linked to other programme elements (including HIV/AIDS services):** Communication programmes do not stand alone; rather, they are part of a co-ordinated effort to address HIV/AIDS (for example, prevention communications are linked with care and treatment communications as well as with HIV-related services).

- **Context-specific:** Communication programmes are developed locally. They respond to the current situation of the epidemic, they take the audience's level of awareness of and beliefs about the problem into consideration and they are designed to be both acceptable and accessible to the target audience.

- **Multiple communication channels:** Communication interventions such as mass media campaigns, social marketing, IEC materials, peer-to-peer methods, etc. are used in a co-ordinated way to disseminate different versions of the same key messages (FHI 2005).

- **Advocacy, social mobilisation and behaviour change communication are integrated for social change:** Communications are most successful when advocacy,

social mobilisation and behaviour change communication are integrated (UNICEF 2005) to address not only individual behaviours, but also the underlying factors that drive the epidemic.

- *Advocacy:* Raising awareness about the current HIV/AIDS situation in Uganda among policy makers, community leaders and donors so that policies, programmes and resources respond to the actual needs.

- *Social Mobilisation*: Facilitating partners from MOH, NGOs, CBOs, institutions, community networks, local leaders, religious leaders, the media, and other national and local-level groups to work together in a co-ordinated way to raise awareness about the current HIV/AIDS situation in Uganda, including modes of transmission and MARPs. This encourages community participation and ownership.

- *Behaviour Change Communication:* Changing HIV/AIDS-related knowledge, attitudes and practices through audience-appropriate messages that help individuals to understand their HIV risk and promote healthy behaviours.

Social Change Communication (SCC) is the strategic use of advocacy, communication and social mobilisation "to systematically facilitate and accelerate change in the underlying drivers of HIV risk, vulnerability and impact. It enables communities and national AIDS programmes to tackle structural barriers to effective AIDS responses" (UNAIDS 2007).

SCC interventions address factors such as social and religious norms related to sexual behaviours, gender inequality, stigma and discrimination associated with HIV and AIDS, and national laws and policies that make reaching MARPs more difficult (for example, laws against homosexuality or prohibiting commercial sex work which might inhibit MSM or CSW from receiving HCT, disclosing to their partners, or using condoms). Because they address the societal factors that underlie the drivers of the HIV/AIDS epidemic, successful SCC interventions can have widespread, lasting effects.

There are three elements of SCC (UNAIDS 2007):

1. **A range of levels of focus:** Behaviour change does not only depend on an individual's desire or willingness to change; it is also affected by broader, external factors, such as the individual's family, peer group or societal influences. If factors beyond the individual level (such as social norms, or laws and policies) do not favour a particular behaviour, then it is unlikely that the individual will adopt the

behaviour. SCC interventions facilitate behaviour change by systematically addressing barriers at all levels.

2. **A range of tools for programming at different levels:** SCC interventions use a variety of communication channels (advocacy, social mobilisation, mass media, peer-to-peer methods, etc.) to bring about widespread behaviour and social change.
3. **Roles of participation:** Participation and community ownership are core principles of SCC, but it is also recognised that expert-driven interventions and large-scale interventions (that are not necessarily participatory) are crucial to achieving social change and that these interventions should work synergistically with participatory methods. According to UNAIDS (2007),"social change communication methods support [the] development of locally-owned and implemented solutions for social change that can be measured and tracked over time. Monitoring and evaluation of social change communication fosters both local engagement and quality improvement of change activities."

Table 4 below provides some examples of communication interventions that can be implemented for the purposes of advocacy, social mobilisation and behaviour and social change as well as challenges that communication programmers might face.

Table 4. Communication strategies and interventions[3]

Strategy	Possible Primary Audience	Desired Outcome	Possible Communication Interventions	Challenges
Advocacy	• Political leaders • Decision makers • Opinion leaders • Development partners • Private sector	• Political support for programmes • Policies and laws favouring behaviour change • Policies and laws supporting service utilisation by MARPs • Policies and laws against discrimination • Discouragement of stigma and recognition of human rights • Resource allocation • Workplace policies on HIV/AIDS	• Meetings and Seminars • Special events • Lobbying • Joint planning / review • Negotiation	• Conflicting political interests and priorities • Funding shortages
Social mobilisation **(partners in service delivery)**	• Ministry of Health • Other ministries • NGOs • Service clubs • Media producers • Advertisers • Artists and intellectuals • Curriculum developers	• Multi-sector collaboration in HIV/AIDS communications and service delivery • Alliance formation • Organisational motivation	• Orientation programmes • Meetings and workshops • Special events • Joint events	• Conflicting interests and priorities among partners • Difficult to co-ordinate multiple partners

[3] Adapted from UNICEF and WHO. *Communication Handbook for Polio Eradication and Routine EPI.* November 2000.

Strategy	Possible Primary Audience	Desired Outcome	Possible Communication Interventions	Challenges
Social mobilisation **(partners in the community)**	• Political, traditional and religious leaders • CBOs • Women's / youth organisations • Social, religious, sporting clubs • Co-operatives • Private sector	• Community an private sector participation and support for HIV/AIDS programmes • Community and private sector ownership of programmes • Community empowerment • Increased service utilisation	• Seminars and workshops • Training • Community mobilisation, organisation and participation	• Cultural and religious factors may influence acceptance and support of HIV/AIDS communications and programmes. • Difficult to co-ordinate diverse community partners • Difficult to overcome pre-existing beliefs and attitudes
Behaviour change communication **(users/clients & individuals)**	• Parents • Young people • Men • Women • Individuals • Grandparents • MARPs and vulnerable groups • Caregivers of PHAs	• Increased knowledge and understanding of HIV/AIDS and risk • Decrease in high-risk behaviours • Increased and sustained demand for HIV/AIDS-related services • Reduction of stigma and discrimination	• Inter-personal communications • Health education / promotion by fieldworkers • Dissemination of IEC materials • Mass media campaigns • Social marketing • Special events	• Cultural and religious factors may influence behavioural change • Pre-existing beliefs and attitudes may be difficult to overcome • Marginalisation of at-risk populations makes them difficult to access through normal channels

Strategy	Possible Primary Audience	Desired Outcome	Possible Communication Interventions	Challenges
Behaviour change communication (field workers / other partners in service & information delivery)	• Health workers • Teachers • Extension workers • Co-operative agents	• Improved attitudes toward clients, particularly PHAs and MARPs • Improved communications with clients • Improved service quality • Improved programme planning	• Interpersonal communication training • Seminars and workshops • Organisational motivation • Recognition • On-the-job supervision and feedback	• Pre-existing beliefs and attitudes may be difficult to overcome • Time constraints may limit the ability of health workers, teachers, etc. to participate

2.4.2 Designing and Implementing Strategic HIV/AIDS Communication Programmes

When designing HIV/AIDS communication programmes, communication professionals should use systematic, field-tested methods. Following a proven planning process will help to ensure that the characteristics listed above are incorporated into the programme.

There are many field-tested methods that can be used to guide the design and implementation of strategic communication programmes. **Table 4** below, provides a synthesis of several of these models, which partners implementing HIV/AIDS communication programmes can review, in order to select the model that best suits their programming needs.

Table 5: Strategic Communications Models

Model	Developing Agency	Key Components	Strengths
ACADA (**A**ssessment, **C**ommunication **A**nalysis, Programme **D**esign and **A**ction) (UNICEF 2005a, UNICEF & WHO 2000)	**UNICEF**	• Situational assessment • Analysis of the problem, behaviour, participants, communication channels, implementation, monitoring and evaluation. • Programme design, message development, formative research and pretesting, communication plan development. • Training and capacity building, communication activities, supportive supervision, monitoring of outputs and impacts, mid-term programme revision, end-of-project evaluation, budget management.	• Circular format of the model emphasizes the re-iterative nature of planning • Promotes the development of a research-driven integrated communication programme
BEHAVE **(**The CORE Group & USAID 2004)	**AED, the CORE Group**	• Identification and definition of priority and supporting group(s). • Definition of the desired behaviour. • Identification of key factors that influence behaviour. • Planning of project activities, messages and content. • Evidence-based decision making.	• Names decisions that are not always made consciously • Codifies strategic thinking processes • Allows for many different behavioural theories • Allows community involvement and ownership

Model	Developing Agency	Key Components	Strengths
COMBI (**Co**mmunication for **B**ehavioural **I**mpact) (WHO 2002)	**WHO**	• Overall goal identification. • Identification of the behavioural objective. • Situational market analysis • Definition of the overall strategy for achieving the behavioural result. • Development of a plan of action • Programme management and implementation. • Monitoring implementation. • Assessment of behavioural impact. • Development and maintenance of timeline/work plan. • Detailed budget.	• Developed for communications programmes addressing communicable diseases • Addresses multiple levels of influence

Model	Developing Agency	Key Components	Strengths
P-Principle **(**HCP 2003)	**Johns Hopkins CCP**	• Situational and audience analysis, data review and formative research. • Strategic programme design,, including communication objectives, programme approaches, communication channels and implementation plan. • Message and material development and testing. • Programme implementation and monitoring, mid-term analysis and revisions. • Outcome and impact evaluation and re-planning for subsequent programme cycles.	• The process is dynamic. Programme managers move both ways through the process. Evaluation is linked with re-planning of subsequent cycles. • The analysis component is the foundation of the process. • The system is integrated; each step must be completed in order for the others to be effective.

There are many similarities among the models described in the table above. All involve gathering data through a situational analysis to guide communication programme development. Each of the models uses a strategic approach to programme design. Monitoring and evaluation of programme interventions is key to each of the models, and in most cases, the results of evaluation (and re-analysis of the situation) feed into the planning for future programming.

For illustrative purposes, the NGC uses the “P-Process” to describe strategic programme design and implementation. This model was selected because of the strengths listed in Table 4, because it emphasises capacity building and participation and also because several Ugandan institutions and organisations, including the Makerere University School of Public Health, the Department of Mass Communications at Makerere University, the

International Mildmay Centre and AfricomNet, regularly provide training in the process for HIV/AIDS communication partners in Uganda.

The "P-Process" **(Figure 1**) is a 5-step framework that guides the design and implementation of strategic communication programmes (AfriComNet et al. 2006). The P-Process can be used to develop programmes that stimulate positive change within social-political environments, in health service delivery systems and among communities and individuals (HCP 2003).

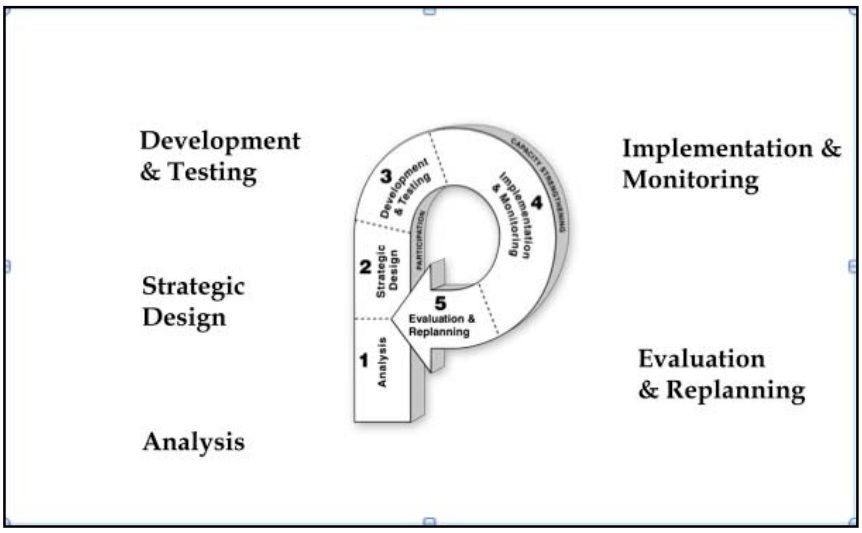


Figure 1. The P-Process (AfriComNet et al. 2006)

The five steps of the P-Process are listed below. It is important to remember that **participation and capacity building** are important elements of each step of the process (HCP 2003):

Step 1. Analysis: Conduct a situation analysis and an audience / communication analysis. Review recent data and research and carry out formative research in order to understand the severity and causes of the problem and the factors that can prevent or facilitate change.

Step 2. Strategic design: Design the communication programme using the following steps:

- *Establish the communication objectives*. Identify the key audiences and determine what changes are desired. Determine the amount of time that will be needed to see the change.

- *Develop programme approaches and positioning.* Select a behaviour change model to use for the programme and explain why and how the program will change health behaviour. Ensure that the benefits to the audience are clear.

- *Determine channels.* Multiple communication channels are desirable.

- *Draw up an implementation plan.* Develop a work plan with benchmarks, a detailed budget and a management plan. Ensure that everyone understands their roles and responsibilities.

Step 3. Development and testing: Using Steps 1 and 2 as a guide, develop the communication messages and materials. Field test them with stakeholders and representatives of the target audience. Make revisions, based on the feedback you receive. Re-test the revised materials and messages before printing or rolling them out.

Step 4. Implementation and monitoring: This step involves participation, flexibility and training. Develop an action plan and co-ordinate the key organisations that will be involved in disseminating the messages or materials. Train trainers and field staff. Monitor the quality and consistency of the programme outputs and monitor the audience's reaction to them. Analyse the results and if necessary, adjust the programme at mid-term.

Step 5. Evaluation and re-planning: Evaluate the outcomes and impact of the programme and disseminate the results. Use the results to determine future communication needs and to make improvements for future programming.

2.4.3 Stages of Behaviour Change

Adopting healthy behaviours does not occur overnight; behaviour change is a process that takes place over time. The Process of Behaviour Change (PBC) framework describes six stages of behaviour change, which begin with "unaware" and end with "advocating" (O'Sullivan 2005). Individuals and audiences pass through each of these stages as they learn about and eventually adopt a desired behaviour (**Figure 2)**. The six stages of behaviour change are:

1. **Unaware** - The audience is unaware that there is a problem and has not considered changing the behaviour.

2. **Aware** - The audience is aware that there is a problem and knows about the desired behaviours.

3. **Concerned** - The audience is concerned about the problem and is in favour of the desired behaviours.
4. **Intending** - The audience is motivated and intends to personally adopt the desired behaviours.
5. **Practising** - The audience has adopted the desired behaviours and is putting them into practice.
6. **Advocating** - The audience is practising the desired behaviours and advocates them to others

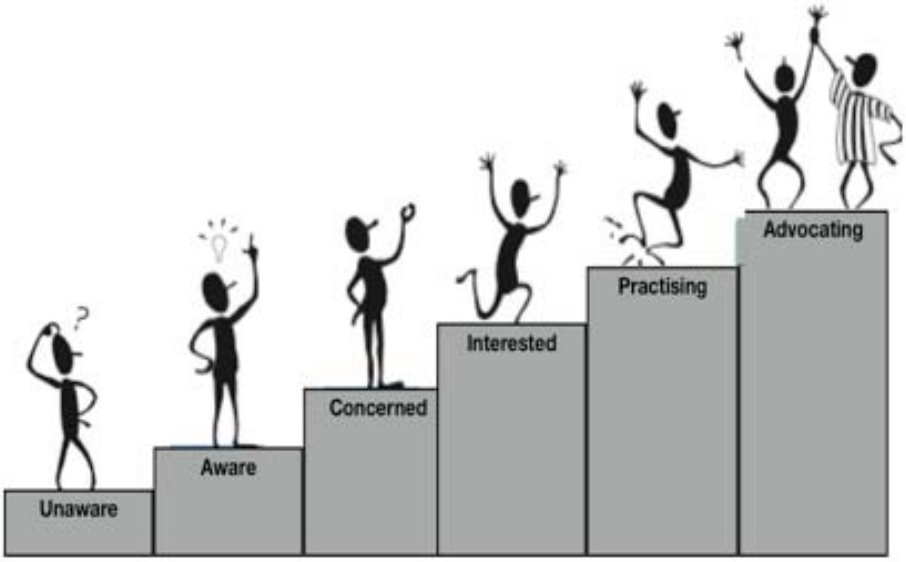


Figure 2. Stages of Behaviour Change (Adapted from: O'Sullivan G et al., *A Field Guide to Designing a Health Communication Strategy,* p.8.)

Before introducing a BCC programme, it is important to know the PBC stage of the target audience so that the proper communication approaches can be selected and appropriate messages can be developed. People progress through the stages of behaviour change at different rates, and they do not necessarily progress in a straight line. It is completely normal to fall back one, or even many, steps during the process (although one can never become "unaware" again!). Different stages require different messages and approaches,

and as the audience progresses, the BCC programme must adapt its methods and messages to the level(s) of the audience(s).

2.5 Roles and Responsibilities in Strategic HIV/AIDS Communication

Strategic HIV/AIDS communication is the responsibility of HIV/AIDS stakeholders at all levels. As mentioned previously, communication approaches are most effective when *advocacy, social mobilisation and behaviour change* are integrated and co-ordinated, presenting different variations of the same key messages to the different target audiences, and promoting both individual and social change.

Each stakeholder has an important role to play in contributing to the national communication priorities. Local NGO and CBO partners, for example, are more likely to focus on behaviour change communication and social mobilisation at the community level, while international NGOs, UN agencies and ministries may focus more on advocacy and social mobilisation among service delivery partners. Depending on the context and capacities, individual partners may assume multiple roles within a communication programme, or multiple partners may work with similar audiences, each addressing a different underlying issue.

When designing and co-ordinating strategic communication programmes among multiple stakeholders, it is important to identify a *lead agency* that will be responsible for overseeing the programme and co-ordinating the various partners and their communication interventions. This agency is responsible for the overall monitoring and evaluation of the communication programme and is also responsible for reporting activities and outcomes to donor agencies, MOH, etc.

Other *collaborating partners* are assigned responsibilities within the strategic communication programme, based on the strengths and capacities of each agency or individual. For example, in a communication programme aimed at increasing the uptake of PMTCT, Agency A, a CBO, may promote behaviour change using peer-to-peer methods of interpersonal communication, while the District HIV/AIDS focal person may take responsibility for training service delivery and community partners.

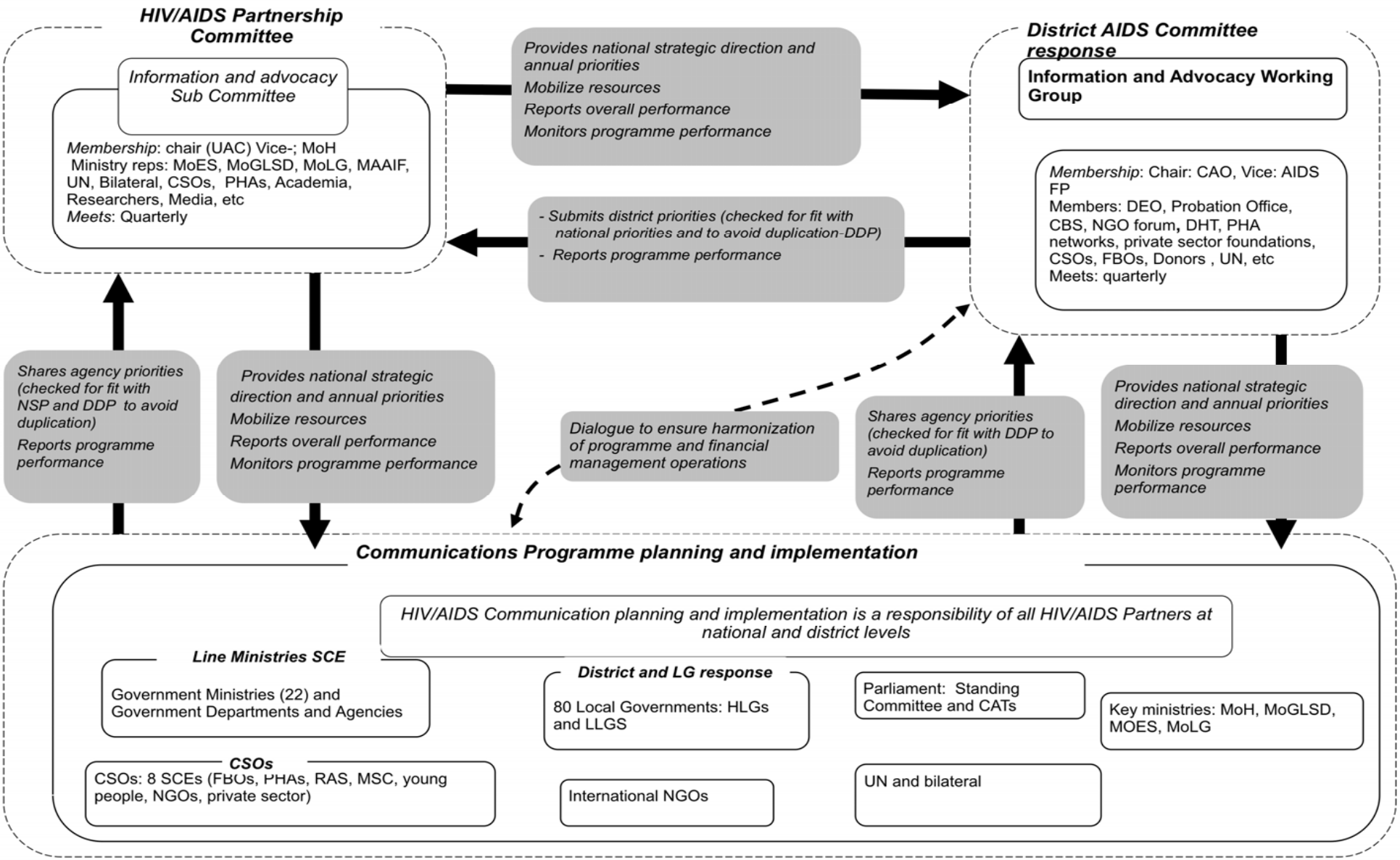
2.5.1 Mechanism for an Integrated Approach to Strategic HIV/AIDS Communication in Uganda

Strategic communication for HIV/AIDS in Uganda is a cross-cutting intervention that is undertaken by many stakeholders from all sectors. This diversity calls for strong co-ordination to ensure message consistency, quality and universal coverage. The Uganda AIDS Commission (UAC) is responsible for coordinating and managing strategic information, communication and advocacy efforts for the national HIV/AIDS response.

UAC is also responsible for bringing together the various communication partners, in order to harmonise behavioural and social change strategies.

Figure 3 below illustrates the relationships among the key communication stakeholders involved in co-ordinating and managing strategic communication activities at the national and district levels

Institutional arrangements for Coordination and Management of HIV/AIDS Communication Interventions



All national-level HIV/AIDS communication interventions will be co-ordinated by the Information and Advocacy Sub-committee of the HIV/AIDS Partnership Committee. The Sub-committee will be responsible for providing strategic direction on priorities in line with the NSP, for mobilising resources for the implementation of communication interventions, and for monitoring and reporting on overall programme performance.

District-level responses will be co-ordinated by the District AIDS Committees. The District AIDS Committees will serve as Information and Advocacy Working Groups and will co-ordinate responses involving the public and civil society implementers at the district level. Specifically, the District AIDS Committees will ensure that all HIV/AIDS communication activities are responsive to district priorities that are stipulated in the District Development Plan. The Committees will also be responsible for monitoring and reporting on overall district programme performance. Finally, the District AIDS Committees are responsible for maintaining dialogue with all implementers to ensure co-ordination between programme implementation and the flow of financial resources.

Planning and implementation of all HIV/AIDS communication activities remains a responsibility of all partners at the national and district levels.

Table 4 in the previous section highlights roles and responsibilities (strategies) that could be undertaken by communication partners and suggests corresponding interventions that could be introduced as part of a strategic communication programme.

Chapter 3: Monitoring and Evaluation Framework

The Monitoring and Evaluation Framework in this section outlines the communication priorities, objectives and desired outcomes that have been established in response to the most recent data regarding the HIV/AIDS epidemic in Uganda. The communication priorities are arranged according to their relation to the goals and objectives of the NSP. Finally, the framework outlines the communication indicators, which provide the basis for the monitoring and evaluation of any strategic HIV/AIDS communication programme.

Detailed guidelines on monitoring and evaluation of HIV/AIDS communications interventions are shown below.

Monitoring and Evaluation of HIV/AIDS Communications Interventions

Prevention Thematic Area: Goal - To Reduce the Incidence Rate of New HIV Infections by at least 40% by 2011/2012					
Priority Actions	Indicators	Baseline	Mid-term 2009	2011/2012	Comments
(i) Reduction of Multiple Sexual partners	Percentage of adults aged 15 -49 years who have had sex with more than one sexual partner in the last 12 months	Male 28.7 % Females 2.4% 2006	Males 22% Females 2%	Males 15% Females 1%	Multiple sexual partnerships are driving Uganda's HIV epidemic
(ii) Improve uptake of HCT services and promote disclosure of results to sexual partners	Percentage of women and men aged 15 – 49 years who were counselled and received an HIV test in last 12 months and know their results	Men 4% Women 3.9% 2004/2005	Men 10% Women 10%	Men 15% Women 15%	This indicator measures the utilization of HCT services
(iii) Improve accuracy and consistency of reporting of HIV-related facts and issues in the media					
(iv) Increase the age at first intercourse (Sexual debut)	Median age at which young people aged 15 – 24 years first have penetrative sex	Male 19.1 Females 18.3	Males 19.5 Females 18.6	Males 20 Females 19 years	This indicator measures the effectiveness of abstinence programmes among the youths
(v) Increase correct and consistent use of condoms with high risk sex partners	Percentage of adults aged 15 -49 years who have had sex with a non-marital, non-cohabiting partner in the last 12 months and used a condom at last high risk sex	Males 57.4% Females 34.9% 2006	Males 66% Females 58%	Males 73% Females 70%	This indicator is used to measure the progress in advocacy for condom use during higher risk sex as part of the ABC strategy. It is

						an indicator for UNGASS and MDG
(vi)	Increase awareness of discordance among couples					
(vii)	Increase uptake of PMTCT services by couples	Number/Percentage of HIV positive pregnant women who receive antiretroviral to reduce risk of MTCT in past 12 months	10,289 (12%) 2005	50%	80%	This indicator measures the progress in preventing mother to child transmission of HIV. The is UNGASS and PEPFAR indicator.
(viii)	Avoid unintended pregnancy among discordant couples					
(ix)	Ensure occupational safety	Percentage of ART sites that provided PEP during the last 12 months	TBD	80%	90%	The indicator measures the proportion of ART sites providing PEP as well
(x)	Link blood donors to HIV prevention and treatment services					
(xi)	Increase uptake and usage of STI services	Proportion of STI patients appropriately managed in PHC facilities according to national guidelines	36% 2005	54%	70%	This is an UNGASS indicator. It assesses the progress in implementation of universally effective STI diagnosis, treatment and coun-

					selling. It measures the competence of health-service providers to correctly identify and treat STIs, the availability of the necessary equipment, drugs and materials and the provision of appropriate counselling to patients.
(xii) Increase public awareness of Safe Male Circumcision and its role and benefits	Percentage of males circumcised	25% 2005	35%	50%	This indicator measures the progress of reducing HIV transmission to males using male circumcision. Data can be disaggregated by urban/rural and age.
(xiii) Increase availability of male medical circumcision in all regions of the country					

Care and Treatment Thematic Area: Goal – To improve the quality of life of PHA by mitigating the health effects of HIV/AIDS by 2012					
Priority Actions	Indicators	Baseline	Mid-term 2009	2011/2012	Comments
(i) Promote equitable availability of	Current number/percentage of people	39%	44%	67%	This is an UNGASS indicator. It

ART in all regions of the country	of people with advanced HIV infection receiving antiretroviral combination therapy				measures the progress in providing ART to all people with advanced HIV infection. *T is used to monitor trends in ART coverage.*
(ii) Increase motivation to seek ART services					
(iii) Improve adherence and correct use of ART	Percentage of adults and children with HIV known to be on treatment 12 months after initiating antiretroviral therapy	TBD	85%	90%	This indicator measures default rates and survival.
(iv) Ensure timely and correct treatment of STIs and opportunistic infections	Number/percentage of PHAs on co-trimoxazole	15%	30%	60%	This indicator is used to track changes over time as the national programme scales up.
(v) Increase health workers' capacities in client tracking and drug management					
(vi) Ensure that TB screening is routinely provided to all HIV clients	Percentage of HIV infected among newly registered TB cases	60%	40%	30%	This indicator is used to measure the degree of TB/HIV collaboration.
(vii)Increase the uptake of HCT and reduce the fear of disclosure of HIV status among routine sexual	Percentage of women and men aged 15 – 49 years who were counselled and received an HIV test in the last 12	Males 4% Females 3.9%	10% 10%	15% 15%	

partners	months and know their results				
(viii) Increase public knowledge about discordance					
(ix) Increase the information available about HIV testing services for children and adolescents					
(x) Increase the number of HIV-positive children and adolescents who know their HIV status					
(xi) Increase understanding and awareness of the concept of "positive living"					
(xii) Ensure that family planning and sexual and reproductive health services are integrated in HIV prevention and delivery service delivery settings					
(xiii) Advocate for a home-based care (HBC) policy	Percentage of health facilities with or linked to operational HBC services	TBD	60%	80%	This indicator measures the capacity of an ART site to ensure continuum of care outside the site and the degree

					of networking among service providers for care and treatment.
(xiv) Expand knowledge and skills among PHA family members and community volunteers to provide adequate HBC.					

Social Support Thematic Area: Goal – To mitigate the social, cultural and economic effects of HIV and AIDS at individual, household and community level					
Priority Actions	Indicators	Baseline	Mid-term 2009	2011/2012	Comments
(i) Increase awareness and understanding of national nutrition guidelines, including their implications on gender/human rights	Percentage of PHAs whose households received nutritional support in the past 12 months	26.9%	40%	60%	The indicator assesses the delivery of psychosocial support by PHA programmes.
(ii) Increase awareness on quality and integration of psychosocial support services into other services that address	Percentage of PHAs whose households received psychosocial support in the past 12 months	86.3%	95%	95%	The indicator assesses the delivery of psychosocial support by PHA programmes.

needs of PHAs, OVCs, PWDs, IDPs and other disadvantaged groups					
(iii) Promote and support equitable access and coverage of sustainable, quality social services (formal education, vocational and life skills) for vulnerable groups	Ratio of current school attendance among orphans to that among non-orphans, aged 10 - 14 years	0.9%	5%	10%	This indicator is used to assess progress in preventing relative disadvantage in school attendance among orphans compared to non-orphans.
(iv) Support economic livelihood opportunities for HIV/AIDS affected communities and households	Percentage of households of people living with HIV/AIDS that have benefited from IGAs in the last year	41.2%	60%	80%	This indicator is used to assess the PHA livelihood support across the country.
(v) Link income-generating activities (IGA) with SRH/HIV/STI related services					
(vi) Ensure that PHA and OVC households get the essential materials and financial support they are entitled	Percentage of orphans and vulnerable children (under 18 years) whose households received free basic external support in caring for children	10.7%	20%	30%	This indicator is used to assess level of OVC livelihood support.
(vii) Sensitise on the relation between human rights, HIV status disclosure, confidentiality, routine					

counselling and testing and wilful transmission of HIV					
(viii) Increase the public knowledge of legal rights and entitlements of PHAs and their families	Number/percentage of 30 largest employers in the country that have HIV/AIDS workplace policies and programmes	25 out of 30 companies (83.8%)	90%	96%	This is a global UNGASS indicator which assesses progress in implementing workplace policies and programmes to combat HIV/AIDS in the 30 largest companies.

Bibliography

AfriComNet, HCP/CCP. “Training of Trainers on Strategic Communication and HIV and AIDS: Facilitator's Guide.” 2006. <http://www.africomnet.org/capacity/toolkit/fulkit.pdf>.

Asiimwe-Okiror G, Opio A, Musinguzi J, Madraa E, Tembo G, Carael M. “Change in Sexual Behaviour and Decline in HIV Infection Among Young Pregnant Women in Urban Uganda.” *AIDS* 11.14 (November 1997): 1757-63.

Family Health International. *Strategic Behavioral Communication (SBC) for HIV and AIDS: a Framework.* Arlington, VA: FHI, 2005.

Ferguson A, Kriitmaa K. “HIV Hot Spot Mapping and Situational Analysis Along the Kampala Juba Transport Route: Final Report.” (2008)

Hallett T, Berle-Grasse J, Bello G, Boulos L, Cayemittes M, Cheluget B, et al. “Declines in HIV Prevalence Can be Associated With Changing Sexual Behaviour in Uganda, Urban Kenya, Zimbabwe and Urban Haiti.” *Sex Transm Infect*. 82.Suppl 1 (April 2006): i1 - i18.

Health Communication Partnership. *The New P-Process, Steps in Strategic Communication.* Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs/Health Communication Partnership, 2003.

Kajubi P, et al. “Correlates of Unprotected Receptive Anal Intercourse Among Gay and Bisexual Men in Kampala, Uganda.” *Oral Abstract Session: AIDS 2008 - XVII International AIDS Conference: Abstract no. TUAD0305*.

Kasirye R. “Empowering Streets and Slum Young People to Prevent HIV/AIDS in Kawempe Division - Kampala City: A Case Study of Uganda Youth Development Link (UYDEL).” Presentation in Chiang Mai, Thailand: UNESCO, March 1-5 2004.

Kasirye R. “Rehabilitating Urban Street and Slum Youth Affected By Drug Use and HIV in Uganda: the Experience of Uganda Youth Development Link (UYDEL).” <http://www.wfad08.org/_downloads/_sp/Rogers-Kasirye.pdf.>.

Kasirye R. “Street Children and AIDS: Uganda Country Experience.” *Unpublished paper* (August 1992)

Kipp W, Kabwa P, Verbeck A, et al. “Prevalence and Risk Factors of HIV-1 Infection in Three Parishes in Western Uganda.” *Trop Med Parasitol* 46.3 (1995): 141-46.

Kirungi W, Musinguzi J, Madraa E, Mulumba N, Callejja T, Ghys P, et al. “Trends in Ante-natal HIV Prevalence in Urban Uganda Associated With Uptake of Preventive Sexual Behaviour.” *Sex Transm Infect* 82.Suppl 1 (April 2006): i36 - i41.

Low-Beer D, Stoneburner RL. “Behaviour and Communication Change in Reducing HIV: Is Uganda Unique?” *African Journal of AIDS Research* 2.1 : 9-21.

Lutalo T, Makumbi F, Serwadda D, Sewankambo N, Kigozi G, Wawer M, Sekansavu J. “Twelve Year Trends in HIV-1 Prevalence and Incidence Among Adults in Rural Rakai District, South Western Uganda.” *Poster presentation at 4th IAS Conference on HIV Pathogenesis, Treatment and Prevention, Abstract number: MOPEC010,*. Sydney Australia, 22-25 July 2007.

Mc Gowan G. “The Invisible Men: Gay Men and HIV/AIDS.” 5 August 2008. *IN Magazine*. <http://www.msmandhiv.org/News_TheInvisibleMen.htm.>.

Morris C, Ferguson A. “Estimation of the Sexual Transmission of HIV in Kenya and Uganda on the Trans-Africa Highway: the Continuing Role for Prevention in High Risk Groups.” *Sex Transm Infect* 200.82 : 368-71.

Namuwenge N, Kirungi W, Akol Z et al. “Report of the Provision of Antiretroviral Therapy in the Public and Private Facilities in Uganda (Draft Report).” (September 2008)

Neema S. “Understanding the Dynamics of Condom Negotiation and Use in Marital Relationships in Generalised HIV Epidemic in Uganda (Preliminary Results).” (December 2008)

Neema S, et al. “Profiling of Most-At-Risk Populations (MARPs) in Uganda and Development of a Plan of Action to Address Vulnerability, Susceptibility, and the Growing Epidemic Among MARPs. (4th Draft).” (March 2009)

O’Sullivan G, Yonkler J, Morgan W, Merritt, A. *A Field Guide to Designing a Health Communication Strategy.* Baltimore, MD: Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs, March 2003.

Opio A, Musinguzi J, Kirungi W, Cross A, Mermin J, Mishra V, Rathavuth H, Bunnell, R. “Trends in HIV-Related Behaviours and Knowledge in Uganda, 1998 to 2005.” *In Press* (2008)

Oundo G, Siu, G. “Sexual and Reproductive Behaviour Among People Living With HIV/AIDS (PHA) in Busia District, a Research Report Funded By Child Health and Development Centre.” (2005)

PATH, Save the Children. *A Guide to Developing Materials on HIV/AIDS and STIs.* Seattle WA: PATH and Save the Children, 2003.

Shafer L, Biraro S, Nakiyingi J, Kamali A, Ssematimba D, Ouma J, Ojwiya A, Hughes P, Van der Paal L, Whitworth J, Opio A, Grossjurth H. “HIV Prevalence and Incidence Are No Longer Falling in South West Uganda? Evidence From Rural Population Cohort 1989 – 2005.” *AIDS* 22 (2008): 1641-49.

Stover J. *A Computer Program for Making HIV/AIDS Projections and Examining the Social and Economic Impacts of AIDS.* Washington, DC: The Futures Group International, 2005.

The CORE Group, USAID. *Applying the BEHAVE Framework: a Workshop on Strategic Planning for Behaviour Change (Facilitator's Guide).,* April 2004.

Uganda AIDS Commission. “A Rapid Assessment of the Drivers of the Hiv/Aids Epidemic and Effectiveness of Prevention Interventions in Uganda.” (July 2006)

Uganda AIDS Commission. “Assessment of the Effectiveness of BCC Interventions for HIV/AIDS Prevention, Care and Treatment.” (August 2007)

Uganda AIDS Commission. “Report of the Third Joint Aids Review and Sixth AIDS Partnership Forum.” (2008)

Uganda AIDS Commission. “The Road Map Towards Universal Access to HIV Prevention in Uganda.” (July 2006)

Uganda AIDS Commission. “National HIV/AIDS Strategic Plan for Uganda 2007/8 to 2011/12.” (2008)

Uganda AIDS Commission, Uganda Ministry of Health, UNAIDS. “Modes of Transmission (MOT) – Uganda Fact Sheet.” (2008)

Uganda AIDS Commission, Uganda Ministry of Health, UNAIDS. *Modes of HIV Transmission Study: Uganda - Review of HIV Prevention Activities in Uganda.* UAC, October 2008.

Uganda AIDS Commission, Uganda Ministry of Health, UNAIDS. *Uganda Modes of Transmission Study: Analysis of HIV Prevention Response and Modes of HIV Transmission, the Uganda Country Synthesis Report.* Uganda National AIDS Commission, March 2009.

Uganda Bureau of Statistics, ORC Macro International. “Uganda Demographic and Health Survey 2006.” (August 2007)

Uganda Ministry of Health, ORC Macro International. “Uganda HIV/AIDS Sero-Behavioural Survey 2004/05.” (March 2006)

UNAIDS. *2008 Report on the Global AIDS Epidemic.* Geneva: UNAIDS, 2008.

UNAIDS. *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations.,* 2008.

UNAIDS. *Male Circumcision & HIV Prevention in Eastern & Southern Africa: Communications Guidance.,* 2008.

UNAIDS. “Report of the Unaids Technical Consultation on Social Change Communication.” September 2007. UNAIDS. <http://data.unaids.org/pub/Report/2007/jc1404-socchangecomm_en.pdf>.

UNAIDS. “Quick Start Guides for Estimation and Projection Package and Spectrum 2009. Draft 13.” May 2009. <(http://data.unaids.org/pub/Manual/2009/20090512_quickstart_2009_en.pdf>.

UNAIDS Reference Group on Estimates Modeling and Projections. “Modeling the Short-Term Incidence of HIV Infections By Exposure Group.” www.unaids.org,

UNICEF. *A Manual on Communication for Water Supply and Environmental Sanitation.* UNICEF, 2005.

UNICEF. *Strategic Communication for Behaviour and Social Change in South Asia.* Kathmandu: UNICEF, 2005.

UNICEF, WHO. “Communication Handbook for Polio Eradication and Routine EPI.” (September 2000)