

Analysis of HIV Prevention Response and Modes of HIV Transmission:

The UNAIDS-GAMET Supported Synthesis Process

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1. INTRODUCTION

From June 2007 to July 2008 UNAIDS and GAMET led a five-country Modes of Transmission (MoT) process. A process evaluation was undertaken of the process, and an impact evaluation is planned at a later stage, once countries have disseminated the results of the study.

The primary motivation for initiating the Modes of Transmission (MoT) process was the recognition that, in many countries, there is a lack of alignment between programmatic and financial HIV prevention needs and the prevailing prevention responses. Significant resources continue to be invested into a variety of biomedical and behavioural prevention interventions that are not systematically evaluated for their impact or quality. At the same time, efforts at addressing underlying social norms that hinder the capacity of individuals to prevent HIV infection or to deliver services consistent with human rights and service standards remain weak, inconsistent or completely absent.

In short, there is a need to “know your epidemic” and “know your response”, and make better policy decisions about how to improve the HIV prevention response.

The broader aim of the MoT process was to build capacity within countries and the region to be able to undertake similar studies in the future as part of HIV response reviews. Furthermore, the intention was to build capacity to be able to “synthesize” this information, interpret it and propose recommendations and policy interventions. It is hoped that, if this initial round of the synthesis work were to be fruitful, the methods and approaches will be integrated into the ongoing HIV-related evaluation and planning processes within these countries and others in the region.

The direct objectives are for the 5 participating countries to produce national HIV synthesis reports that will, over the coming months, feed directly into existing policy development initiatives in the various countries.

2. BACKGROUND TO THE MOT PROCESS

a) MOT rationale: The rationale for the MoT process in each of the countries was:

1. To understand better the heterogeneity of the HIV epidemic, where and among whom new cases of HIV are occurring and what the drivers of the epidemic are.
2. To describe and understand better the extent and reach of the various HIV interventions and programmes.
3. To determine the degree of alignment between HIV prevention resource allocation and where and how HIV transmission is occurring.
4. To make recommendations for adjustment of policies and practices in order to ensure optimal targeting and resourcing of a focused and relevant evidence informed national HIV prevention strategy.

b) MOT methods: Each country undertook an analysis based on 4 components:

1. **Epidemiological review:** analysis of national behavioural, biological, socioeconomic and demographic data to identify and explain the factors involved in driving the local epidemic.
2. **Incidence modeling:** use of national HIV and STI prevalence and behavioural data to determine the likely distribution of HIV infections in the adult population (aged 15 – 49 years) based on modes of HIV transmission.
3. **Prevention Response Review:** analysis of the scope and scale of the key prevention interventions implemented in the country and the prevention policy and strategic information environments. ,
4. **Response review:** analysis of the degree of alignment of national prevention resources with the priorities highlighted by this evidence

Based on these 4 analytic components, each country prepared a synthesis report featuring recommendations for prevention policy and programmatic action to ensure a stronger and more effective national prevention strategy.

The analysis and synthesis process in some countries, also aimed to facilitate the formation or strengthening of technical and policy leadership mechanisms for prevention.

Towards the end of the country processes, a process evaluation was conducted.

3. PROCESS EVALUATION METHODOLOGY

The process evaluation involved two parts:

- a) Country team survey (stakeholder survey) completed by each country team.
- b) Key respondent Interviews conducted by an independent researcher.

Data was collected from 21 participations involved in the MoT process using a semi-structured interview. Respondents included government representatives, country consultants, UNAIDS representatives in the 5 countries and members of the regional team that supported the country analyses.

Data was then analysed using qualitative content analysis¹. Such analysis allows for similarities and differences between respondents to be analysed, rather than individual specific issues and circumstances to be highlighted. As such the process evaluation provided by this analysis, gives an 'overview' and is used to identify salient themes that emerge from the data.

¹ Flick (1998) *An Introduction to Qualitative Research*. Sage Publications: London

4. RESULTS OF PROCESS EVALUATION

a) Overall comments:

First and foremost, it is apparent from country reports, country meetings, the recent survey of stakeholders, informal interactions and the final Regional Review Meeting held in July 2008, that the MoT process has been a worthwhile initiative. No individual or organization has suggested that the MoT concept or its implementation so far was seriously flawed.

Each country and those involved within countries have all suggested that this is a useful process that needs to be repeated in the future.

The key factors identified by country and regional participants in this success were:

1. Extensive international and in-country consultation.
2. The rationale for the MoT process was well constructed and well motivated.
3. Adequate financial and human resources were committed to the process.
4. The NACs within each country played a key role in mobilizing support and technical expertise.
5. Process was driven by in-country Technical and Policy teams rather than only by consultants.
6. High level expertise and experience in doing synthesis work brought into the process by GAMET.

Each of these factors is further outlined below.

b) Participatory approach to planning:

Key to the success of the process was the extensive consultation process that preceded the launch of the MoT in the 5 countries. The UNAIDS-led initial consultations were primarily with UN agencies and other international organizations such as the World Bank, CDC and SADC. At these meetings, high-level presentations were made which provided a clear and strong rationale for the need for such work to be undertaken. Subsequently, clear criteria were established for choosing appropriate countries to participate in the MoT process. Consultations then shifted to obtaining support from the NACs and other role players within the selected countries.

Although the consultation process took several months to complete, it did ensure that the MoT process was accepted and received support from international and national role players.

Having secured support for the MoT process from the various NACs, the next step was to bring on board the various in-country stakeholders. In general, this process of inclusion was successful. However, in some countries it was perceived that the MoH was not sufficiently engaged and, in some cases, that academic institutions did not play a very active role. In one country however, leading experts from academic institutions, WHO, CDC and the Medical Research Council were engaged to serve as a peer-review team to support the HIV incidence modeling and this mechanism, proved extremely valuable in ensuring quality of the analysis.

The central role played by the NACs in most countries was critical to the success of the MoT process. In Uganda, Kenya and Swaziland the NACs were key to mobilizing support within each country and in setting up the technical and policy teams. In Lesotho, the NAC committed substantial

technical resources of its own to ensure coordination and technical support to the process to counter initial setbacks due to key staff turnover and limited availability of consultants to form the core MOT team.

c) Significant financial and human resources committed to the MoT process:

The entire process has been well supported in terms of the provision of funding and in terms of organizational and technical support and this has clearly contributed to the success of the MoT process.

Support for the MoT process was provided in the following areas:

- Financial support from UNAIDS and GAMET.
- Provision of Lead Epidemiologists in 4 countries by GAMET and supervision by GAMET.
- In-country and inter country coordination provided by UNAIDS.
- Establishment of a Regional Technical Team coordinated by UNAIDS.
- Regular technical support and inter-country teleconferences and monthly regional reports.
- Basic standard “Terms of Reference” for consultants that were adapted as necessary by countries.
- Standard methods, guidelines and templates.
- Process orientation and training workshops held in country.
- Limited in-country “mentoring” support.

d) Importance of establishing in-country technical and policy teams:

Within each country a Technical Working Group (TWG) of local experts was set up and tasked with the responsibility of supervising the consultants and assisting with the data collection, analysis and report writing. It is clear that these TWGs played a significant role in providing support to the consultants.

In an attempt to ensure that the MoT process will filter into the ongoing HIV prevention planning activities in each country, a Policy Advisory Group was established or existing structures were used for this function. It remains to be seen whether the MoT process will actually impact on policy.

e) Provision of technical assistance to countries:

Technical assistance was provided through several channels. Most obviously, funding was provided to be able to hire consultants and GAMET provided epidemiologists to four of the countries.

One of the biggest challenges to countries was the difficulty in contracting high quality consultants. The reality is that in many countries there are not many high-level researchers/consultants who are available for relatively short term contracts at short notice.

The Regional Technical Team was a useful resource. The team assisted in developing guidance documents and templates, facilitating workshops, providing direct in-country technical assistance and reviewing country outputs. One regional training workshop on using the HIV incidence model was held in December and many country-level workshops were held.

However, some respondents noted in the process evaluation interview that the required technical assistance was not always available and this limited the in-country mentoring. While workshops were helpful in building some aspects of required capacity more intensive and sustained in-country mentoring was

required in this process.

Responses of respondents to the stakeholder survey in regards to the guidelines and templates was mixed. Most found the documents useful but a few found them not so useful. One junior researcher was dismissive of the guidelines as being too complex and difficult to use.

f) Organisational support:

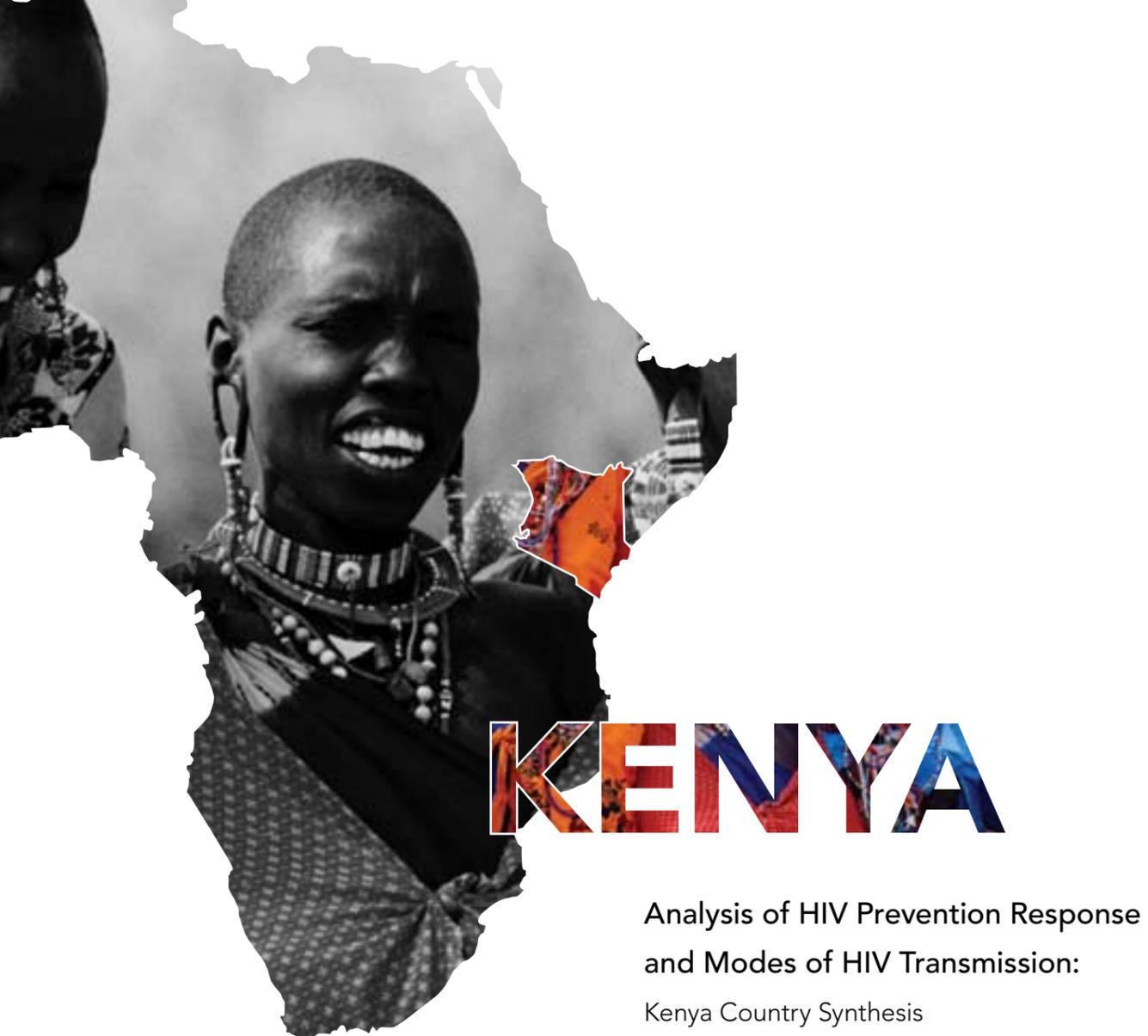
UNAIDS initiated this MoT process and took primary responsibility for assisting with coordination on a regional and in-country basis. The UNAIDS Regional Support Team for Eastern and Southern Africa provided the regional support through their Johannesburg office and hired a coordinator for the duration of the study. In-country organizational support was provided by the country UNAIDS team.

Feedback from the stakeholders survey was very positive about the level of support from UNAIDS and GAMET. Contact between countries was mediated through monthly reports produced by the coordinator and through teleconferences.

Most respondents to the stakeholders survey believed that there was sufficient ownership of the process by the countries. However, a few respondents thought that the process was essentially being driven by UNAIDS and GAMET.

5. CONCLUSION

In conclusion, this has been a very successful process and collaboration between UNAIDS, GAMET and all 5 countries. The process set out to provide an improved understanding of the epidemic and response in the 5 countries and to provide evidence based recommendations for strengthened and more focused prevention. The abstracts presented here highlight the high quality of the analysis and the success of the country processes.



Analysis of HIV Prevention Response and Modes of HIV Transmission:

Kenya Country Synthesis

Supported and funded:
UNAIDS, GAMET (World Bank) and Kenya Government

BACKGROUND

In recent years, with the HIV & AIDS epidemic well-established, but with treatment programs now in place, questions have arisen as to whether those groups who have traditionally been at risk are still the source of new infections. The importance of “knowing your epidemic” (KYE) has become evident, and Kenya became part of the exercise, along with UNAIDS and the World Bank, to initiate a series of epidemiologic synthesis studies in the country. HIV epidemiological and incidence modelling data are synthesised to obtain an epidemiological synthesis (‘KYE’ synthesis), while the HIV prevention review and resources data are synthesised to obtain an HIV response synthesis or “knowing your response” (KYR) synthesis. The two syntheses are then compared to understand the gaps in HIV prevention programming, leading to recommendations as to how the response can be improved.

METHODS

The study was conducted (December 2007 – July 2008) by a team of three Kenya-based consultants, and co-ordinated by UNAIDS-Kenya M&E Adviser and the Head of the Strategic Research & Monitoring Unit of NACC. The study was supervised and guided by a Kenya MOT Technical Team (KMoTTT) through regular meetings, reviews and updates. The Kenya team underwent training in applying the UNAIDS incidence model, reviewed data sources, consulted with experts at both the national and international levels, and worked closely with the National AIDS Control Council (NACC), UNAIDS and the Global AIDS Monitoring and Evaluation Team (GAMET) from the World Bank. Regular consultations were held with the Regional Coordinating Team and monthly updates sent.

FINDINGS: HIV EPIDEMIC AND RESPONSE SYNTHESIS

From both the epidemiological analysis and the modelling, it is clear that **heterosexual transmission is the most prominent mode of transmission in all areas of Kenya**, but that this represents several different situations, including both casual and long-term partnerships and assorted degrees of transactional alliances, all hinging on the concept of **multiple concurrent partnerships as a primary driver of the epidemic**. The epidemic is heterogeneous, with marked regional variations. MOT modelling confirms that 80% of new infections are due to heterosexual sex (including in fishing communities). IDUs, clients of sex workers and MSM (at least in the major urban centres) are also significant contributors to new infections.

Geographic and special population variations are influenced by prevalent behaviours and cultural practices, most notably male circumcision and multiple concurrent relationships.

The modelling has allowed not only the gathering of incidence data, but also the disaggregation and categorization of most-at-risk groups and regions.

SYNTHESIS OF HIV EPIDEMIC AND RESPONSE FINDINGS

Approximately half of the prevention resources are going towards counselling and testing or PMTCT, while youth-oriented programmes claim less than 5% of prevention resources, and government funding aimed at most-at-risk groups, such as sex workers and their clients, MSM and IDUs are negligible or non-existent. While there are funds for behaviour change and communication, there is hardly any funding aimed at mobilizing communities. The amount of total funding available at the national level for prevention activities has fallen to less than 25% of the total HIV & AIDS funding since 2005.

RECOMMENDATIONS

- Review national AIDS strategy KNASP to focus prevention strategies towards most at-risk populations.
- Research to understand and monitor geographical and community variations, MSM and IDU communities, factors affecting behaviour change.
- Operationalise the new national circumcision policy. This should also be supported by an approach that takes cultural challenges of the communities into consideration.
- Revise policies and laws that hinder provision of services to MSMs, IDUs, FSWs etc
- Intensify couple-based HIV prevention programs, including discordant couple counselling and prevention for positives.
- Scale up, revitalize and initiate programs among most-at-risk populations
- Capacity to design and implement prevention programmes at the district level needs to be strengthened.
- Improve access to research results, and interpretation of those research results into understandable knowledge that most implementers can utilise in planning, management and monitoring.
- Increase spending on most-at-risk populations, programmes to change social norms in the community, and on prevention programmes for prevention with positives.

NEXT STEPS

- Recommendations from the MoT to be reviewed by the Kenya National Prevention Task Force and findings to be shared at the upcoming Kenya National Prevention Summit (September 2008) and key strategic directives obtained.
- Consolidated recommendations from the National Prevention Summit, together with detailed recommendations from the MoT Study presented at the Mid-term Review of the KNASP (Oct. 2008) as part of influencing policy based on evidence gathered by the MoT.
- Prioritise and initiate research to address data gaps recommended by the MoT study.
- Review the current synthesis of the MoT using the new findings from the Kenya AIDS Indicator Survey (2007), (not yet launched when this report was submitted to the July 2008 Regional Peer Review Meeting held in Johannesburg).
- UNAIDS and WB to determine ways in supporting NACC to institutionalise the MoT synthesis into an annual exercise.

FUNDING AND TECHNICAL SUPPORT

1. UNAIDS – funded the study in Kenya by paying for two consultants and for all the training exercises and the contributed towards the National Prevention Summit while providing full technical support through out the study period.
2. World Bank Global AIDS Monitoring and Evaluation Team (GAMET) – Provided technical support for quality assurance and provided one consultant to the study team in Kenya.
3. National AIDS Coordinating Authority (NACC) – supported all regular in-country meetings by providing venue, secretariat support and documentation, as well as opening access to information and data gathering.



LESOTHO

Analysis of HIV Prevention Response and Modes of HIV Transmission:

Lesotho Country Synthesis

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BACKGROUND

Lesotho's hyperendemic situation has been characterized, but there is a suspected poor match of prevention priorities with epidemic dynamics. There has been little focus on incidence and recent new evidence has not been seen side-by-side. The reduction of new infections in adults and children is an absolute priority, and the MOT study will help to define the future HIV prevention response in Lesotho.

METHODS

Know your epidemic (KYE) involved literature review of published and unpublished materials from Lesotho and the region, and application of UNAIDS incidence model (limited by availability of data on HIV prevalence and behaviour on risk populations).

Know your response (KYR) involved data collection and analysis on policy context, strategic information

and prevention interventions through key informant interviews and district review meetings on prevention. *Synthesis of KYE-KYR* was done using GAMET synthesis process. The process was coordinated by NAC in collaboration with a steering committee ('core team'), supported by reference teams on M&E and Prevention. Capacity building of local stakeholders included NAC, MOHSW, other government ministries, NUL & NGOs on use of incidence model and synthesis writing.

FINDINGS: HIV EPIDEMIC AND RESPONSE SYNTHESSES

Population prevalence stabilized at 23.2%; excess mortality in adults and children combined with reduced fertility leads to stagnant population growth. Estimated annual HIV incidence in adults in 2007 at 1.7% (down from 3.6% in 1995); incidence in children halved in the last 8 years to 0.17%. Incidence modeling suggests that casual sex contributes 65% of all new infections in adults, and that 23% of new infections arise through sex with a single marital or cohabiting partner. There may be a considerable number of new infections in MSM, but there is a lack of local data. Key determinants of epidemic are high frequency of multiple partners (24% of adults with a partner have other concurrent partners, trend is decreasing), unprotected sex especially among longer-term partners, and low male circumcision (only about 15% of men circumcised).

Lesotho has created enabling policy environment for prevention, but there is a need to improve operationalisation of policy commitments. National HIV and AIDS Bill and the Child Welfare Bill to be passed, BCC strategy in draft form, but comprehensive prevention strategy lacking. PMTCT and HCT interventions have been scaled-up. The majority of interventions focus on changing knowledge, attitudes and beliefs. Main target audiences are youth and general population. According to NASA prevention expenditure is at 13% of total AIDS expenditure 2007/08.

SYNTHESIS OF HIV EPIDEMIC AND RESPONSE FINDINGS

Multiple partnerships, sexual networks and underlying social norms not adequately addressed in policies and programmes. Scale-up of male circumcision is at planning stage. Distribution of free condoms fluctuates. Some prevention interventions are underfunded, e.g. BCC interventions (3% of total prevention expenditure). Lack of understanding whether certain interventions work, e.g. impact of KYS campaign and social mobilisation.

KEY RECOMMENDATIONS

- 1) Strengthen commitment on implementation of existing policies by capacitating providers and ensure quality services;
- 2) Integrate "partner reduction" as a key element of HIV prevention into all future policies, strategies and guidelines;
- 3) Fast-track the process of creating the policy context for a scale-up and standardization of male circumcision (including traditional sector as appropriate);
- 4) Strengthen research and evaluations alongside interventions in order to understand "what works" in Lesotho;
- 5) Revise content of prevention messages to address underlying social norms regarding multiple concurrent partnerships;
- 6) Introduce a harmonized planning system at district level for all prevention implementers to ensure synergistic action and longer-term continuity of interventions;
- 7) Institutionalise MOT as a planning tool.

NEXT STEPS

- 1) Finalizing of synthesis report
- 2) Dissemination of findings country-wide
- 3) Preparation of policy briefs
- 4) Translation into policy and programme

FUNDING AND TECHNICAL SUPPORT

UNAIDS, GAMET, NAC, MOHSW, BOS

MOZAMBIQUE

Analysis of HIV Prevention Response and Modes of HIV Transmission:

Mozambique Country Synthesis

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BACKGROUND

The first National HIV/AIDS Strategic Plan 2000/2002 was first elaborated in response to alarming data from sentinel surveillance sites that prevalence was high and increasing. This led also to the establishment of the National AIDS Council (CNCS) tasked with leading and coordinating the national response. The NSP was later revised, resulting in the current NSP (PEN II) 2005-2009, which adopted a fully multisectoral approach to combating the spread of the disease. In 2008, the process of revision of the PEN will begin. According to the 2007 ANC sentinel surveillance data, the epidemic appears to be stabilizing in the Central and Northern regions, but appears to still be rising in the South, reaching alarming levels. A Prevention Reference Group, headed by the Minister of Health, was established in 2008, and is currently reviewing best practices for prevention, which, together with the results of the MOT study will be incorporated into the revised NSP.

METHODS

The Modes of Transmission Study in Mozambique is being undertaken in coordination with a similar exercise, Data Triangulation, led by the CDC and University of California San Francisco. A joint DT/MOT coordinating committee was formed to oversee both processes and ensure that the two are coordinated to the greatest advantage. The epidemiologic review was carried out in three stages, beginning with a national 2007 Annotated Bibliography compiled by the Ministry of Science and Technology 2) The DT team complemented this with a further in-country search for grey literature and published and unpublished studies. The MOT then commissioned

a search of grey literature in seven provinces. The first round of Data Triangulation chose a research question focusing on identifying the key drivers of the epidemic in order to provide the greatest amount of synergy with the MOT process. The first DT synthesis workshop was held together with the MOT inception workshop. This was followed by an Incidence Model Workshop in June 2008. During this workshop, participants discussed and decided on values to use for the input variables for the model based on national and regional data and estimates.

The MOT team commissioned a private consulting firm to undertake a Review of Prevention Policies and Programs. The team traveled to seven provinces to gather data about prevention programs from private and public entities, NGOs and the CNCS databases in each province, and interviewed policymakers about policies and programmes. These, together with a review of the PEN II, provided input into a Prevention Review paper. This paper, together with the results of the 2008 NASA report provided the basis for a comprehensive review of prevention policies, programmes, and financial resources. A final synthesis workshop was held July 23, 2008 to present the findings and draw conclusions and make recommendations for the upcoming review of the PEN.

FINDINGS: HIV EPIDEMIC AND RESPONSE SYNTHESSES

The 2007 ANC sentinel survey report indicates that national HIV prevalence in pregnant women has reached 16% and is leveling off. However, this masks significant regional differences. The epidemic in the North is leveling off at a lower prevalence of 9%, the Central Region has peaked at about 18%, but the South has reached 21% and is still rising. The incidence model predicts that 23% of incidence is the direct result of casual partnerships, with another 48% of new cases occurring in people in steady partnerships, with 68% of heterosexual transmission occurring in adults over 25 years of age. Sex work contributes directly and indirectly to another 19% of new infections, and 3% of new cases result from injection drug use, 5% in men who have sex with men, and 2% result from medical injections. Factors that most influence transmission are male circumcision (highly protective), multiple concurrent partnerships and mobile populations engaging in risky sex. A significant amount of transmission occurs among discordant couples. The high prevalence of sexually transmitted infections is another important factor.

The current prevention response is oriented toward prevention in youth, counseling and testing, condom social marketing and STI diagnosis and treatment. While there are programs targeting mobile populations, very few target sex workers and their clients, and none target MSM or IDUs. Few resources or programs are

dedicated to reducing multiple concurrent partnerships in adults. Male circumcision is under study by the Prevention Reference Group, but as yet there are no policies or programs in place.

SYNTHESIS OF HIV EPIDEMIC AND RESPONSE FINDINGS

Current evidence points to partner reduction and circumcision as the most effective strategies for reducing HIV transmission, with increasing condom use in selected populations at risk. The current prevention response, which focuses on youth, abstinence, testing and counseling, condoms in the general population, and STI diagnosis and treatment, is unlikely to reduce heterosexual transmission. There is an urgent need for further information on factors characterizing multiple concurrent partnerships, potential acceptability of male circumcision, and to define the population of IDUs and MSM in order to target programs.

RECOMMENDATIONS

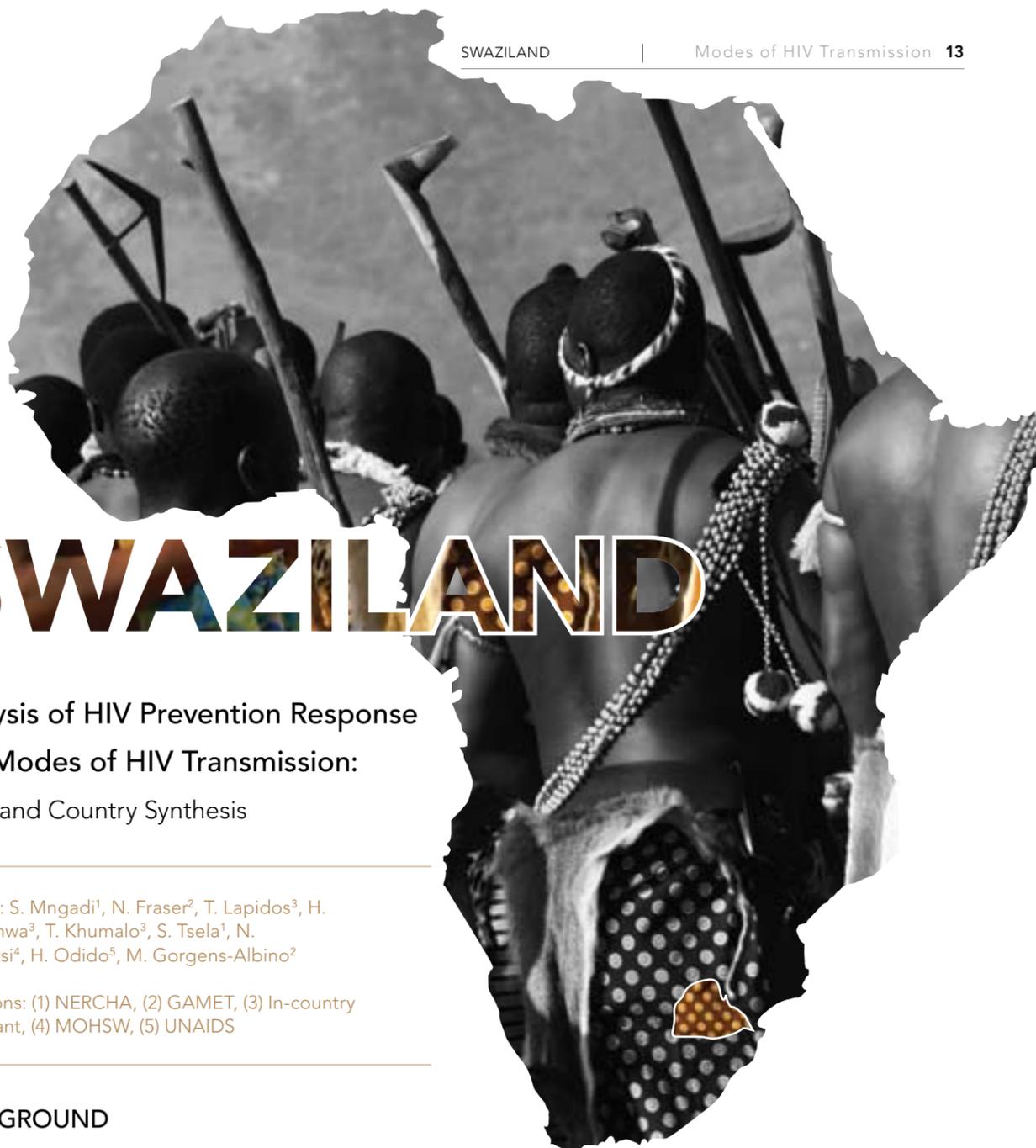
The revision of the PEN should include specific strategies for reducing multiple concurrent partners, policies and strategies regarding male circumcision, and targeting adults, both men and women. Specific condom promotion policies and programs that focus on risk groups, including mobile populations, sex workers and others should be considered. The definition of mobile populations should be broadened to include the sedentary populations with whom they interact.

NEXT STEPS

The results will be presented to the Prevention Reference Group for inclusion in policy revisions for prevention programs. In addition, they will form the basis for the revision of the prevention policies in the PEN beginning in 2008. A wealth of new data will become available in 2009, including the results of the AIDS indicator Survey, BSS+ and others. UNAIDS is planning to sponsor subsequent rounds of DT/MOT revision in 2009 that will allow the incorporation of this new information and revision of the recommendations.

FUNDING AND TECHNICAL SUPPORT

National AIDS Coordinating Authority, UNAIDS, GAMET,, CDC/University of California San Francisco and the joint DT/MOT Coordinating Committee.



SWAZILAND

Analysis of HIV Prevention Response and Modes of HIV Transmission:

Swaziland Country Synthesis

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BACKGROUND

Given the high HIV prevalence in Swaziland, reducing new HIV infections is an absolute priority. The Swaziland National Multisectoral AIDS Strategic Plan 2006 - 2008 is currently under review: the MOT study will help define the future HIV prevention response in Swaziland by providing key evidence on the sources of new infections and the current alignment between the epidemic and the prevention response.

METHODS

Know your epidemic (KYE): Desk review of local and international published and grey literature, application of UNAIDS incidence model (application of incidence model in Swaziland limited by availability of data on risk populations, HIV prevalence and sexual behaviour data); *Know your response (KYR):* Data collection on policy context, strategic information and prevention

interventions through key informant interviews, using standard MoT data collection tools. *Synthesis of KYE-KYR*: using GAMET synthesis process. Local epidemiologist, prevention consultant and sociologist to support process coordinated by NERCHA; implementation supervised by steering committee (the 'core team'), use of findings ensured by 'policy team'. Multi-stakeholder effort regarding data provision and review process. Capacity building through workshops especially on incidence modeling and synthesis writing.

FINDINGS: HIV EPIDEMIC AND RESPONSE SYNTHESSES

Population prevalence stabilized at 26% leading to negative population growth and life expectancy of just 37 years. Estimated annual HIV incidence in 2008 of 3% (down from 6% in 1999). In 2008, approximately 72% of adult HIV incidence in individuals aged 25+, about 62% of adult HIV incidence in females, and about 19% of all new infections in children aged 0-14. Transmission mainly through heterosexual contact between longerterm partners and partners aged 25+, condom use higher among non-regular and commercial partners than regular partners. Key determinants of epidemic are low male circumcision (8%), high frequency of multiple partners (which have cultural resonance, but show early signs of decline) and probably oscillating short-term migration by men and women.

Prevention benefits from mostly supportive policy context, but there is some clash with traditional law, and key policies on gender, male circumcision, sexual offences and domestic violence bill remain in draft form. Prevention interventions scaled up, many focusing on changing knowledge, attitudes and beliefs. Main targets are youth and general population; lack of targeting of older adults, and sex-specific targeting. Prevention third most important NASA spending category (17%).

SYNTHESIS OF HIV EPIDEMIC AND RESPONSE FINDINGS

Not enough messages address partner reduction, sexual networks and social norms, although first results of MCP campaigns are promising. A strategy and implementation plan for male circumcision have been developed. Risk of infection in discordant couples, positive prevention, and vulnerability through migration not addressed adequately. Spending on prevention may need to be increased in view of protecting the 74% of the population who are HIV negative. Lack of understanding whether "collective action" approaches and peer education work, and how they should be changed to maximum benefit.

KEY RECOMMENDATIONS

- 1) Put in place policies and strategies in order to build a prevention/social change movement at community level
- 2) Ring-fence a considerable proportion of the AIDS budget for prevention (not below 20%)
- 3) Strengthen the legislative environment
- 4) Fast-track processes required to launch large-scale male circumcision (adoption of policy and strategy, implementation of MC plan)
- 5) Target steady couples with tailored integrated prevention and sexual health programs
- 6) Accompany innovative and key interventions by research in order to understand "what works"

NEXT STEPS

- 1) Finalizing of synthesis report by GAMET/NERCHA/UNAIDS
- 2) Dissemination of findings by NERCHA
- 3) Preparation of policy brief (actor to be defined)
- 4) Translation into policy and programme by Policy Team, NERCHA & stakeholders

FUNDING AND TECHNICAL SUPPORT

UNAIDS, GAMET, NERCHA



UGANDA

Analysis of HIV Prevention Response and Modes of HIV Transmission:

Uganda Country Synthesis

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BACKGROUND

Since the identification of the first AIDS cases in Uganda in 1982, HIV has spread throughout the country resulting into a severe, mature, and generalized epidemic. The epidemic in Uganda has evolved into a heterogeneous epidemic affecting different population sub-groups. It is probable that the risk factors and drivers of the epidemic may have changed over time as evidenced, for instance, by the occurrence of a significant proportion of new infections among discordant couples in union rather than with casual partnerships as was the case early on in the epidemic. There is therefore a need to conduct a study that will describe the current drivers of the epidemic, the modes of transmission of HIV in Uganda, identify the source of new infections and review the allocation of prevention resources.

METHODS

We used the standard Modes of Transmission methodology as described in the UNAIDS/GAMET guidelines. In brief, we conducted a review of the epidemiology of HIV in Uganda, applied the UNAIDS incidence model to predict the distribution of new infections, used the MoT prevention review tool to describe the current prevention policies and programs and reviewed the current allocation of resources for HIV prevention. Finally, the GAMET synthesis process was used to assess whether prevention policies, programs and resources are aligned to the populations in need. The study was implemented by a team of 4 national experts coordinated by the UAC and the UNAIDS Country Office with technical support from UNAIDS RST. A national Technical Steering Committee provided oversight and a group of epidemiologists and modelers peer reviewed the process.

FINDINGS: HIV EPIDEMIC AND RESPONSE SYNTHESSES

The epidemiology review indicates that the previously heralded decline in prevalence from a peak of 18% in 1992 to 6.1% in 2002 may have ended. There is stabilization of prevalence between 6.1 and 6.5% in some ANC sites and even a rise in others. This is accompanied by deterioration in behavioral indicators especially an increase in multiple concurrent partnerships. There has also been a shift in the epidemic from single casual relationships to long-term stable relationships. Incidence modeling reveals that 43% of new HIV infections are among monogamous relationships while 46% are among persons reporting multiple partnerships & their partners. Commercial sex workers, their clients and partners of clients contribute 10% of new infections. MSMs and IDUs contribute less than 1%. There has also been a shift in concentration of the epidemic from younger to older individuals with the highest prevalence for men (9.9%) being among 35 – 39 year olds while for women (12.1%) it is among 30 – 34 year olds. Furthermore, the high burden of HSV-2 of 44% has fueled the epidemic.

The prevention review revealed that policies exist for many of the prevention programs implemented in Uganda. Significantly, there are no policies for media and IEC, behavior change interventions, male circumcision and interventions for MARPs. The key stakeholders in the prevention response include government, non-governmental and civil society organizations. Only 31% of the US \$249 million was toward prevention while the bulk of funding (53%) went towards care and treatment. Program support and mitigation both took 8% each.

SYNTHESIS OF HIV EPIDEMIC AND RESPONSE FINDINGS

The synthesis shows a mismatch between the epidemiology, policies & programs and resource allocation. Despite the evidence of the risk factors and drivers of the epidemic, there are no policies targeting MARPs, circumcision and the contextual factors. There are no programs or funding targeting concurrent partnerships or marital or co-habiting partnerships especially discordant couples. Funding is not targeted to prevention with positives but rather to ART and care.

RECOMMENDATIONS

- Institutionalize MoT in NAC and MoH operations
- Strengthen capacity for the conduct and utilization of MoT
- Encourage evidence-based planning and programs
- Re-align prevention effort to where the new infections are occurring and to the populations most in need
- Develop repository for strategic information on national response
- Strengthen routine sources of program data eg HMIS,
- Conduct sero-behavioral surveys for MARPs
- Conduct MoTs regularly after every AIS i.e every 3 years

NEXT STEPS

- Finalize synthesis process and report
- Consult NAC and MoH on best strategy for in-country dissemination
- Disseminate to the National Prevention Policy Steering Committee meeting in September
- Present a discussion paper during the Joint AIDS Review in September
- Plan to contract out development of communication strategy for GRIPP

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