



Uganda AIDS Commission Civil Society Fund Request For Applications (RFA) #08-003: Reaching CBOs with Grants, Technical Support and Capacity Building



The Uganda AIDS Commission's Civil Society Fund seeks to effectively harmonize and coordinate multiple donor resources for grants to civil society organizations supporting Uganda's National Strategic Plan for HIV/AIDS. This solicitation focuses on efforts to reduce HIV infection. With applicants responding to this solicitation, the CSF will support a program to expand targeted HIV Prevention services in Uganda through an extensive and substantial partnership with civil society. The CSF anticipates awarding grants to civil society partners expanding the availability and quality of integrated and comprehensive approaches to HIV prevention.

In its first HIV Prevention solicitation, the CSF supported 31 national and district level NGOs. An additional 60+ are slated for support under Global Fund Round 7. In this round, the CSF seeks to make a larger number of smaller grants to HIV Prevention partners working at the grassroots and community level, principally through Community Based Organizations.

Community based organizations are better positioned to reach deep rural areas, and more directly involved with program beneficiaries, better positioning themselves to design programs that are sensitive to the particular needs of the communities they serve as well as the risks and challenges faced by their vulnerable and high risk populations. Community based organizations have a critical role to play in the provision of HIV/AIDS prevention, care and treatment, and with their roots in local communities, represent an essential component of the national response in fighting the HIV/AIDS pandemic.

The CSF notes that there is no legal definition of a CBO, and hereby indicates that in seeking to grant CBOs during this round, the CSF anticipates that implementing partners will have the following characteristics:

- Non profit organization providing social services at the local level
- Service oriented (social services are the major part of their mission)
- Headquartered in the local community to which they provide services
- Activities supported primarily through volunteer efforts (Ten or fewer full time employees)
- An annual operating budget of less than 200,000,000 US\$hs, often made up of voluntary contributions of time, material and financial resources
- Membership based (owned and managed by members)

- Community focused, community owned, community rooted
- Members take the lead in selection of their leaders, identification of community needs and program planning and implementation

During this round, the CSF anticipates reaching up to 200 Community Based Organizations with grants totaling 5 billion US\$. CSF anticipates that awards made to CBOs will not exceed US\$ 50,000,000. Most may be smaller than that ceiling. Individual grants will be supported for an initial period of one year beginning 01 July 2008. CBOs may not obtain grants to operate in more than one district.

In this round, the CSF anticipates awarding CBO grants that support the following components of the NSP's Comprehensive Prevention Package:

- Prevent the sexual transmission of HIV
- Prevent mother-to-child transmission of HIV
- Promote greater access to HIV counseling and testing (HCT) while promoting principles of confidentiality and consent
- Integrate HIV prevention, care and support services with other health care and social services
- Integrate prevention into care and support programs for PHAs
- Prevent Sexually Transmitted Infections
- Focus prevention on vulnerable and higher risk groups including young people, IDPs, PWDs, women and girls, adults especially in marriage relationships, fishing communities, mobile populations, migrant workers, CSWs, etc
- Advocate for protection of rights of women, girls, children, PHAs, IDPs and other minority groups within existing policy and legal frameworks

The CSF will accept and review proposals from national and district NGOs, faith based organizations, community based organizations and other members of Uganda civil society.

Under this solicitation, CBOs may access CSF funding through one of two separate mechanisms, as follows:

A. CBOs may apply directly to the CSF as individual grant recipients.

To be eligible for a grant directly from the CSF, CBOs must meet the following criteria:

- 1) Applicants must have been legally registered at the district level before before 01 July 2007, and have a current registration.**
- 2) Applicants must have at least two years of experience successfully providing HIV prevention services, and provide a report on their most recent program activities**
- 3) Applicants must provide a letter from the district CAO stating that the CAO is aware of their presence in the district, and recommends their proposal for funding**

B. CBOs may apply for grants through a lead agency responsible for grants management, capacity building, and/or technical support.

To reduce the administrative effort of managing multiple CBO level grants directly, the CSF anticipates that a number of grants will be made to lead agencies that in turn provide CBO level grants to the proposed applicants. It is hoped and envisioned that multiple CBOs will effectively network and collaborate to be included on a single proposal from a lead agent.

In this case, the proposal submitted will be from the lead agent, and include the scopes of work and budgets for the CBOs that the lead agent will subsequently grant. Grants to lead agents will also be for a one year period, and will have a ceiling of US\$ 400,000,000. Lead agents are expected to apply the criterion above to the CBOs they propose to fund. Lead agents may not support CBO grants serving more than one district. The CBO implementing partners proposed by a lead agent do not all have to provide services in the same district, although it remains expected that any one CBO's operations will be within a single district.

Lead Agents submitting proposals are required to meet the following criteria.

- 1) Applicants must provide documentation (such as a registration certificate) establishing that they are currently and legally recognized by the GOU as having permission to conduct business in Uganda, and must have obtained such recognition before 01 July 2006.**
- 2) Applicants must have at least three years of experience managing grants to implementing partners.**
- 3) Applicants must have at least 5 years of experience supporting HIV Prevention programs**
- 4) Applicants must provide their most recent annual program report**
- 5) Applicants must provide their most recent audit or certified financial statement.**
- 6) Applicants must establish that the conditions listed above for CBO grant submissions are applied to the CBOs they expect to fund.**
- 7) Lead agents may retain no more than 15% of funds provided to CBOs to support their own operational, administrative and program support costs.**
- 8) Applicants must provide a letter from the district CAO stating that the CAO is aware of the lead agent's presence in the district, aware of the CBOs the lead agent will fund, and recommends their proposal for funding**

Refer to the following section on Strategic Partnering for additional detail.

Under its call for concept papers supporting the GOU's application for Round 7 of the Uganda Global Fund for AIDS, TB and Malaria, the UAC reviewed and selected concept papers for inclusion in the Round 7 proposal. Once Global Fund support is received, selected concept papers will be developed into proposals and funded through

subsequent rounds of CSF funding utilizing Global Fund resources. Applicants that submitted concept papers for the Global Fund Round 7 proposal may submit proposals under this RFA that comply with this RFA's Application Guide, but are advised that the CSF does not intend to award one applicant a grant from this round as well as a grant supported through Global Fund Round 7. The CSF reserves the right to choose which, if any, of the proposals submitted under the two rounds to award.

Current grant recipients of the Civil Society Fund may not apply for funding under this solicitation.

Issuance of this RFA in no way obligates the CSF. The CSF reserves the right to not make any awards, to make fewer than expected, and to make more than expected. The CSF will not be liable for any costs incurred in an applicant's preparation of its response to this RFA. Furthermore, the CSF may issue written amendments to this solicitation at any time before the proposal due date.

Applications are due by **1PM Friday 13 June 2008**. Late applications will not be reviewed. Instructions regarding the preparation and submission of an application are provided in the Application Guide, attached.

Promoting Strategic Partnerships

The CSF strongly encourages potential applicants to form strategic partnerships in addressing proposed objectives. Applications that draw on the applicants competitive advantages to expand the availability and quality of integrated approaches to HIV Prevention are strongly encouraged.

Civil Society Organizations are spread countrywide in both rural and urban areas. They have a range of characteristics that place them in unique and strategic positions to contribute to the delivery of targeted services for prevention of HIV infection.

To promote the participation of various categories of civil society in the delivery of community based services and encourage linkages between small and medium and large scale CSO/FBOs, the CSF encourages applications that demonstrate strategic partnerships for increased delivery of quality services for prevention of HIV among youth.

"Partnership" refers to two or more organizations agreeing to work together to achieve common goals and outputs in the proposed HIV prevention interventions. A partnership may include any of the following:

- Partnerships addressing different program areas in a common geographical coverage area, including clearly detailed referral mechanisms between civil society supported outreach and public sector health centers
- Partnerships addressing the same program area in different geographical coverage areas

- Partners that have divided up various program management and implementation responsibilities, such as one partner providing technical assistance, administrative and/or management oversight and other partners focusing on service provision

Partnerships may be organized around two or more organizations working as equal partners, each receiving their own award directly, or alternatively, organized such that one lead partner is responsible to the CSF for the overall award and in turn issues and manages subagreements to other partners.

Various programming and organizational capacities are required to manage a quality HIV prevention program. Examples of capacities critical for successful program execution include: sound practices and successful experiences of community-based service delivery, strong organizational policies, systems and guidelines, technical capacity in HIV/AIDS, monitoring and evaluation expertise, supportive supervision systems and capacity building. Recognizing that many organizations may be very good in one aspect of a program but weak in another, the CSF encourages the formation of partnerships that will enable each partner to do what they do well and together support a quality program. Partnering is thus intended to encourage organizations to focus on areas where they have competitive advantage and benefit from others in their areas of weakness. It is anticipated that partnerships will enable members to

- Enhance the impact and/or expand the coverage of proposed interventions
- Enhance growth of small and medium level organizations through coordination and linkages
- Allow organizations to focus on areas where they have expertise and experience
- Improve technical support, advice and capacity building services for CSO/FBOs for expanded delivery of HIV Prevention services
- Promote dissemination of information, technology development and transfer

The CSF anticipates partnership-based proposals to demonstrate the following principles for creating and running their partnerships

- Agreement from all partners to the partnership
- Development of a shared vision of what might be achieved and clear purpose
- Realistic goals
- Shared mandates and agendas
- Development of compatible ways of working together
- Development of key interests for the partner organizations
- Effective organizational management plan including communication plan
- Time involved in building the partnership and or collaboration history between the partner organizations

Situation Analysis

The current status and trends of the epidemic pose significant challenges to Uganda's national response, with the number of HIV-positive individuals likely to increase from 1.1 million to 1.3 million in 2012.

Uganda's HIV prevalence rate appears to have increased slightly to 6.7%, following after a rapid decline from a high of 18% in the 1980s to a low of 6.4% in the 1990s.

The Uganda national sero-survey (2005) underscored the importance of understanding the distribution of HIV infection within a population. In conjunction with a survey of seroprevalence, an analysis of the social, biological, and behavioural factors associated with HIV infection was performed. HIV prevalence was higher in women than men, and it increased with wealth.

Women are infected more than men across the age spectrum from birth to age 45-49 years (prevalence among women being 7.5% compared to 5.0% among men) and the gender impacts of the disease are significant. Women are often unable to negotiate safer sex due to lower status, economic dependence and fear of violence. Women bear the brunt of caring for sick family members and are more likely to be rejected, expelled from the family home and denied treatment, care and basic human rights.

When data is disaggregated by age and sex, it shows that women are more highly affected at younger ages compared with men. The age- and sex-specific prevalence of HIV for both women and men increases with age – reaching a peak for women at ages 30-34 (12%) and for men at ages 35-44 (9%). Women are more affected at younger ages compared with men; for instance, the male to female ratio among teenagers aged 15-19 years is 1:9, while among young people 15-24 years is 1:4. Prevalence for women is generally higher than for men in almost all the reproductive ages (15-49 yrs). At ages 50-59, the pattern reverses and prevalence is slightly higher among men than women.

Urban residents have a significantly higher prevalence of HIV infection (10.1%) than rural residents (6.7%). This is true for both sexes, though the urban-rural difference is much stronger for women than for men.

By region, HIV prevalence ranged from a low of 2.3% in the West Nile region to 8.5% in the Central region. The Central region, Kampala and Mid-northern regions of the country have the highest HIV prevalence with prevalence exceeding 8% in the general population. Indirect estimates of recent HIV infections (HIV incidence) based on the BED assay reveals that the Northern region that has seen civil strife for the last two decades also has the highest HIV incidence that is about two times that of other areas in the country. Other population groups that had disproportionately higher HIV prevalence included currently married, widowed, divorced or separated individuals, people with other sexually transmitted infections (STI), uncircumcised men, and women in the highest wealth quintile.

There are pockets of population that are vulnerable and at higher than average risk of HIV infection. These vulnerable population groups include commercial sex workers (CSWs); fishing communities; long distance truck drivers, internally displaced people (IDPs); uniformed services; and people with disability.

However, while population groups with disproportionately higher HIV prevalence can be identified in Uganda, the HIV infection is generalized affecting virtually all adult population groups. Further analysis of the sero-behavioural data has revealed that 77% of HIV+ individuals in Uganda are sexually active and that 84% of them do not use condoms. It has also been revealed that risky sexual behaviours were highly prevalent especially among spouses (79%) and these included multiple and concurrent partnerships and higher-risk sex. There has been deterioration in several indicators of risky sexual behaviours especially among men, including: a rise in the number of sexual partners; increase in sex with non-regular partners; and a decline in condom use during higher-risk sex.

Results of the national sero-behavioural survey revealed that about 80% of Ugandans do not know their HIV sero-status; and that only 10% of the couples in Uganda have observed life-time faithfulness. Current evidence also shows that HIV-positive individuals who had had an HIV test were 3 times more likely to use a condom during their last sexual encounter, and that 8.1% of married or cohabiting couples in Uganda have one or both partners infected with HIV with 57% of these being in a discordant relationship. The 2004/05 national survey further revealed that 77% of all adult HIV infections in males and 58% in women were among people older than 30 years of age. Of all new infections, 66% occurred among married people while 74% occurred among people older than 25 years of age. In light of these findings, there is need for focused, evidence-based, HIV prevention programs that address changing HIV transmission dynamics.

Program Principles

In seeking to ensure that efforts to prevent sexual transmission of HIV are as effective, integrated and comprehensive as possible, the CSF anticipates that proposed interventions will support the following programming principles:

- Programmatic approaches must be locally endorsed, relevant to the indigenous social and cultural context and respectful of human rights. Interventions must also be epidemiologically grounded, addressing the main sources of new infections.
- The ABC (**A**bstain, **B**e faithful/reduce partners, use **C**ondoms) approach can play an important role in reducing the incidence of HIV. All three elements of this approach are essential to reducing HIV incidence, although the emphasis placed on individual elements needs to vary according to the target population.

- When targeting young people, for those who have not started sexual activity the first priority should be to encourage abstinence or delay of sexual onset, hence emphasizing risk avoidance as the best way to prevent HIV.
- After sexual debut, returning to abstinence or being mutually faithful with an uninfected partner are the most effective ways of avoiding infection.
- For those young people who are sexually active, correct and consistent condom use should be supported. Young people and others should be informed that correct and consistent condom use lowers the risk of HIV (by about 80–90% for reported “always use”) and of various sexually transmitted infections and pregnancy, and they should be cautioned about the consequences of inconsistent use.
- Prevention programmes for young people in and out of school should be expanded, and parents should be supported in communicating their values and expectations about sexual behaviour.
- When targeting sexually active adults, the first priority should be to promote mutual fidelity with an uninfected partner as the best way to assure avoidance of HIV infection.
- People who have a sexual partner of unknown HIV status should also be encouraged to practise correct and consistent condom use and to seek counseling and testing with their partner.
- When targeting people at high risk of exposure to HIV infection, the first priority should be to promote correct and consistent condom use, along with other approaches such as avoiding high-risk behaviours or partners.
- Community-based approaches involving religious organisations, women’s and men’s associations, care groups, youth organisations, health workers, local media, and both traditional and governmental leadership can foster new norms of sexual behaviour. Prevention programmes need to address issues such as stigma, gender inequality, sexual coercion, cross-generational relationships and transactional sex and directly involve people living with HIV/AIDS, in order to maximally achieve the behavioural objectives necessary to reduce HIV incidence at the population level.

Program Description

Uganda’s national response to HIV/AIDS is guided by the National Strategic Plan (NSP) for HIV/AIDS, covering the period 2007/08 to 2011/12. The main emphasis of the new NSP is to reinvigorate prevention as the main stay of HIV control and to strengthen the national health system for effective and efficient HIV/AIDS services delivery.

The Comprehensive Prevention Package

The NSPs Comprehensive Prevention Package includes 8 elements within which roles for community based organizations can be expanded

- 1) Prevent the sexual transmission of HIV

- 2) Prevent mother-to-child transmission of HIV
- 3) Promote greater access to HIV counselling and testing (HCT) while promoting principles of confidentiality and consent
- 4) Integrate HIV prevention, care and support services with other health care and social services
- 5) Integrate prevention into care and support programs for PHAs
- 6) Prevent and treat Sexually Transmitted Infections
- 7) Focus prevention on vulnerable and higher risk groups including young people, IDPs, PWDs, women and girls, adults especially in marriage relationships, fishing communities, mobile populations, migrant workers, CSWs, etc
- 8) Advocate for protection of rights of women, girls, children, PHAs, IDPs and other minority groups within existing policy and legal frameworks:

Each of these components of the Comprehensive Prevention Package are discussed in detail below, and within each component the potential roles of CBOs and the activities they may propose for grant funding are presented.

Prevention of Sexual Transmission

Uganda's approach to accelerating the prevention of sexual transmission includes the following strategic actions. The CSF believes that Uganda's large and active network of community based organizations are ideally suited to address them:

- Promote ABC+ - which includes Abstinence, Being faithful (fidelity), and Condom use with risky sexual encounters, plus other strategies to reduce sexual risk
- Develop and implement strategies for prevention interventions targeting key population groups at higher risk and interventions for the general population
- Ensure that all the youth in and out of school access life skills that integrate HIV prevention
- Empower service providers with appropriate communication skills and facilities to handle vulnerable and marginalised target groups such as PWD
- Develop and implement effective IEC interventions for reduction of high-risk sex among all groups, especially the key risky behaviours, including: sex with non-marital, noncohabiting partners; unprotected sex, sex with partners of unknown HIV status; cross-generational sex; transactional sex, and early sex;
- Reduce HIV transmission among discordant couples and married people by couple counselling, testing and Disclosure
- Promote abstinence among youths in and out of school;
- Focus prevention on key population groups at higher risk by addressing socio-economic and cultural factors and promoting prevention among PHAs;
- Improve the relevant legislative and policy framework to promote the support of populations at higher risk and criminalising the deliberate transmission of HIV and AIDS;
- Utilise all social, religious, health, economic, and cultural institutions for delivery of HIV prevention messages and advocacy services

- Prevention interventions for the groups of women and children at higher risk in conflict areas, including work with the uniformed services, and using IEC and HCT support;
- Focus prevention on fishing communities through HCT support.

1. Prevent the sexual transmission of HIV

Uganda is widely heralded for its success in reducing HIV prevalence, and its success is generally attributed to its extensive ABC campaigns, promoting abstinence, fidelity, behaviour change, and condom utilization. Paradoxically, the widely acclaimed reduction in Uganda's national HIV prevalence rate may have predisposed youth to be less vigilant in protecting themselves and their partners from HIV infection. While knowledge levels about HIV and AIDS among youth in Uganda remain high, and while researchers have observed both an increase in age of sexual debut and a reduction in premarital sexual activity there is a danger that risk perception of HIV infection has decreased among youth. Further, cross generational and transactional sex remain widespread. Cross-generational sex and transactional sex continue to place primarily adolescent girls at risk. Both leave young women and men powerless to negotiate safer sex, heighten their vulnerability to HIV infection and sexual violence and continue to fuel the spread of HIV and AIDS in sub-Saharan Africa. Teenage girls in Uganda are 6 times more likely than teenage boys to become HIV infected, and among girls aged 15-19 years in Uganda, the risk of HIV infection doubles for those young women with male partners 10 or more years older. Further, HIV infection among married couples is an increasingly recognized problem and marriage itself has not provided protection against HIV infection. Couples rarely test before marriage, and often enter into marriage without knowing the other's or their own, status. Across all ethnic groups, there is strong social pressure for a young bride to prove her fertility early in marriage, thus newly-wed couples usually refrain from using condoms in order to bear children immediately. Research shows that sometimes newly-wed husbands or wives are already infected with HIV when they enter wedlock and that a significant number of married men engage in sexual relations with multiple partners. In marriage, young wives have little negotiating power in sexual behaviour and practices, putting them at greater risk of contracting HIV and other sexually transmitted infections. Among couples that know their status and are discordant, condoms remain the only means through which they can remain faithful to each other and reduce the risk of one infecting the other.

The CSF strongly encourages applications that demonstrate the applicant's commitment to involving youth in the design, implementation, monitoring and evaluation of the projects which intend to serve them. In particular, the CSF seeks projects that will be particularly responsive to the needs of out-of-school youth, and that will aggressively seek input and collaboration from out-of-school youth in developing projects that succeed in meeting their needs.

The goal of the condom promotion program is to contribute to reduction in STI and HIV transmission as well as unplanned pregnancies by increasing correct and consistent condom use amongst sexually active individuals. It ensures availability of a high standard of condoms at all stages of procurement, storage and distribution to end users.

There are two main strategies used for distribution, free and social marketing. In 2005, 120 million condoms were expected to be distributed (UNGASS) but the actual was less than 70 million due to challenges with the PSM. Other challenges include the under-procurement of condoms. It is expected that in Uganda there should be 9 condoms per male in the 15 – 49 year age-group per year but in 2005, only 5 condoms were available per male, up from 4 in the previous year. There was also a gap caused by issues related to the acceptability of free condoms, and male involvement in HIV care programmes which are reaching women.

a. ABC+

Protecting young people from contracting HIV is unquestionably one of the most important missions of the Government of Uganda. Young people who have not had their sexual debut must be encouraged to practice abstinence until they have established a lifetime monogamous relationship. For those youth who have initiated sexual activity, returning to abstinence must be a primary message of prevention programs.

For 10-to-14-year-olds, grants will fund age-appropriate and culturally appropriate “AB” programs that include promoting (1) dignity and self-worth; (2) the importance of abstinence in reducing the transmission of HIV; (3) the importance of delaying sexual debut until marriage; and (4) the development of skills for practicing abstinence.

For older youth (above age 14) grants will fund programs that promote (1) dignity and self worth; (2) the importance of abstinence in reducing the transmission of HIV; (3) the importance of delaying sexual activity until marriage; (4) the development of skills for practicing abstinence, and where appropriate, secondary abstinence; (5) the elimination of casual sexual partnerships; (6) the importance of marriage and mutual faithfulness in reducing the transmission of HIV among individuals in long-term relationships; (7) the importance of HIV counseling and testing; and (8) provide full and accurate information about correct and consistent condom use as a way to significantly reduce—but not eliminate—the risk of HIV infection for those who engage in risky sexual behaviours.

ABC+ is defined as a behavioural intervention taking into account the social, cultural and economic environments around the individual that influence behaviours and linking to other prevention and care interventions to enhance risk perception and internalization and life skills building to support individuals to adopt and sustain positive behaviours of abstinence, mutual faithfulness to a partner of known status, and correct consistent condom use at every high risk sexual encounter.

The ABC+ strategy refers to the implementation of activities that

- Promote safer behaviours and sexual norms including abstinence (delayed sexual debut and secondary abstinence)
- Promote being faithful to a partner with mutually known HIV test results
- Promote correct and consistent condom use with an HIV positive partner or a partner whose sero-status is unknown (Promote correct and consistent condom

use especially with non-marital and non-consensual partners and for the positives)

- Promote reduction of multiple sexual partners (Develop communication and skills development programs that address internalization and personalization of risk as well as reduction of normalization of HIV/AIDS for both young people and adults

Community Based Organizations can also help reverse the disturbing trend in the number of actors involved in IEC for behavior change in the context of HIV/AIDS prevention, which has decreased over the years. Currently only 17% of agencies implementing HIV/AIDS interventions have a component for community sensitization and education for prevention, a fall from 78% in 1997. Furthermore, support to relevant institutions and structures dealing with life-skills training especially for the out of school young people has not received priority attention in recent times. There has been a shift of focus towards service access messages as opposed to behavior change messages which were at the centre of the life skills education programs. The few actors who have remained in provision of IEC for behaviour change have limited contact with the communities; there is an apparent shift towards impersonal channels of IEC e.g. media.

Adults are also critical beneficiaries of renewed ABC+ program efforts. Under this grants program, activities will be supported that encourage couples to practice fidelity in marriage as a critical way to reduce risk of exposure to HIV. In addition, grant applicants are encouraged to support activities that encourage HIV counseling and testing for couples that do not know their HIV status. Grant activities supported under this component may focus on the following:

- The elimination of casual sexual partnerships;
- The development of skills for sustaining marital fidelity;
- The importance of mutual faithfulness with an uninfected partner in reducing the transmission of HIV among individuals in long-term sexual partnerships;
- The importance of correct and consistent condom use in a mutually faithful relationship with an infected partner
- HIV counseling and testing with their partner for those couples that do not know their HIV status
- Condom education, promotion and distribution among faithful but discordant couples (couples in which one partner is infected and the other is not)
- The endorsement of social and community norms supportive of refraining from sex outside of marriage, partner reduction, and marital fidelity, by using strategies that respect and respond to local cultural customs and norms; and
- The enforcement of existing laws and regulations pertaining to age at marriage and child protection

The CSF anticipates that proposed activities in grant applications will for the most part take place outside of school environments, and seeks in particular grant applications addressing the needs of out-of-school youth. Applicants with activities proposed in school settings are also advised that grant funds may not be used to physically

distribute or provide condoms in school settings, and that grant funds may not be used in schools for marketing efforts to promote condoms to youth.

b. Advocating for positive change in cultural and sexual norms which encourage high risk sex

High Risk Sex includes sex with multiple partners especially non-marital, non-consensual; inconsistent or no condom use; commercial, transactional and intergeneration sex including sex for survival; alcohol consumption and drug abuse before sex; unprotected sex with someone whose status one does not know; sex without testing and disclosure.

Commercial Sex is defined as the perpetual dependency on sex for money or other items as an occupation. Although the initial push factor into the sex trade may be survival, the person turns it into a life long occupation.

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 socioeconomic situation.

Trans-generation Sex (also cross-generational sex) is defined as sex with a partner considered much older than his or her sexual partner. In most cases it involves an element of exploitation due to economic and social vulnerability.

Despite high levels of knowledge on HIV/AIDS, there is evidence that higher risk sex may still be the main driver of the HIV/AIDS epidemic in Uganda. Higher risk sex includes sex with multiple partners especially non-marital, non-consensual; inconsistent or no condom use; commercial, transactional and intergeneration sex including sex for survival; alcohol consumption and drug abuse before sex; unprotected sex with someone whose status one does not know; sex without testing and disclosure in marriage relationships, and early sex. It has been argued that from the above definition, the majority of the population is thus having higher risk sex as normal sex and may not know that they are at risk. It has also been further argued elsewhere that knowledge of one's sero-status may or may not influence sexual behavior (AIM, 2006; Matovu et al., 2005; UNIVAF/UAC, 2003; Nyblade et al., 2001; The VCT Efficacy Study Group, 2000; UNAIDS, 1999). The main factor that influences the continuation of higher risk sex despite the high levels of knowledge and risk of transmission is the lack of internalization and personalization of HIV risk. There is evidence to suggest that having been within the population for now 20 years, HIV/AIDS may be viewed by some people as no longer an immediate threat of death or serious illness, but something normal in life; a concept referred to as normalization. Secondly, IEC strategies have focused more on AIDS as a threat to life but have not paid adequate attention to the social role of sex or the concepts of sex and sexuality in the design of intervention strategies.

Extramarital sex has been a tolerated practice for men (but not for women) since traditional times. Recent data shows that the proportion of men reporting extramarital sex has not declined substantially since 1995 (Kirungi et al, 2006). Moreover, according

to secondary data analysis of the UHSBS, approximately 60% of new infections are occurring within married relationships. This is a very significant finding that points to higher risk sex occurring in this cherished cultural institution, especially brought about by the men through multiple extra-marital partners, very low condom use, lack of testing and disclosure as well as a high rate of discordance. It appears that even in the event of HIV/AIDS, some beliefs and perceptions about “maleness” in relation to sexuality have largely remained. Male partners tend to justify extra-marital relationships in terms of unsatisfying sexual relationships and thus seek satisfaction outside their marital or regular relationships (Sengendo, et al. 2001; IPPF, 2005). Further the practice is perpetuated due to cultural beliefs; a number of women continue to accept that it is by nature that men have such “privileges” in marriage.

Young girls and boys are at particular risk of sexual exploitation. Cross-generational sex and transactional sex continue to place adolescents at risk. The CSF encourages applicants to effectively counteract the acceptance or tolerance of multiple casual sex partnerships, cross-generational and transactional sex, forced sex, the unequal status of women, and the sexual coercion and exploitation of young people. While effectively empowering young people to resist sex for gain and avoid sexual relationships that increase their risk is a critical element of the program, the CSF also seeks proposals from applicants that will effectively target the causes of such practices and reduce such practices by addressing not only the norms and values that support them but also directly target a) the older partners engaged in cross-generational sex, b) those procuring transactional sex, and c) those that force or coerce others into sex.

The CSF encourages grant activities that generate public discussion and problem solving about harmful social and sexual behaviours through a variety of means at both the community and national levels, focusing primarily on cross generational and transactional sex, and the heightened risk that such activities pose to young women in general and young out-of-school women in particular.

Community based organizations are ideally suited to support the following activities:

- Address Extra-marital sex
 - Focus on activities for married and co-habiting partners aimed at reducing extra-marital sexual partners
 - Use existing cultural structures to strengthen the institution of marriage
 - Promote couple counseling and testing and mutual disclosure of results before and during marriage
- Organizing activities and events to educate local communities about sexual violence against youth and strengthen community sanctions against such behaviours
- Implementing workplace programs for older men to stress male sexual and familial responsibility, and school-based programs for younger males to provide education about preventing sexual coercion and violence

- Training health care providers, teachers, law enforcement officials, traditional healers, and peer educators to identify, counsel, and refer young victims of rape, incest, or other sexual abuse for other health care
- The adoption of social and community norms that denounce cross-generational sex; transactional sex; and rape, incest, and other forced sexual activity, and linkages with existing legal aid and support services for sexually abused youth

2. Prevent mother-to-child transmission of HIV

Transmission of HIV from an infected mother to a child is the second most common means of transmission of HIV in Uganda. Available data shows that MTCT including breastfeeding accounts for 15-25% of new infections (UAC, 2004-a). At the end of 2000, a cumulative total of 58,165 AIDS cases had been reported to the STD/ACP in Uganda and 4,286 of these were children below 12 years, 90% of whom had acquired infection through MTCT. Studies in Mulago have shown that only one third of babies infected with HIV live to see their second birthday which inadvertently affects progress made in reduction of childhood mortality (MoH, 2003-a). MTCT has continued to drive the epidemic despite availability of an effective and affordable PMTCT intervention using Nevirapine. The number of women enrolling for PMTCT as a primary prevention approach is very low. This is due to some socio-cultural and economic factors that have been identified as major deterrents of women towards utilization of PMTCT services and their failure to come back to the health facilities for deliveries as recommended under PMTCT. Although over 80% of pregnant women attend ante-natal care at least once during pregnancy, only about 30% deliver in health facilities (UDHS, 2000). The social cultural factors include lack of or limited male involvement in PMTCT programs, stigma and the quality of services provided by service providers compared to traditional birth attendants (TBAs). The community attachment and trust towards the TBAs need to be addressed. PMTCT program is also affected by staff levels and quality of counseling at the health facilities as well as by the low levels of community awareness and mobilization.

CBOs can play an essential educational and promotional role in reducing MTCT of HIV, by:

- Working within communities to promote knowledge of HIV status before pregnancy
- Promoting and supporting linkages with health services during pregnancy, labour and after birth
- Promoting early diagnosis and support for appropriate infant feeding
- Supporting home-based PMTCT programs to address the 70% of pregnant women who do not deliver in health care facilities
- Linking the mother, father and baby to other prevention and care services (MTCT+)
- Providing targeted communication for PMTCT highlighting roles and benefits to girls, pregnant women and their partners, parents, families and communities
- Facilitating engagement of male partners to provide appropriate support

3. Promote greater access to HIV counselling and testing (HCT) while promoting principles of confidentiality and consent

Tremendous progress has been made with regard to expansion of service coverage for VCT services however the services have been limited in linking to other services including care and support systems especially for those who test negative. Some providers of VCT operate in isolation with weak referrals to district hospitals for treatment. Voluntary, confidential and good quality HIV counseling, testing and referral needs more improvement. Key challenges in the provision of VCT services have included; lack of adequate infrastructure and personnel, as well as stock-out of HIV testing kits and reagents which have characterized the service in recent years. There has also been limited progress in the promotion of couple testing and dealing with discordant couples at service level.

Counseling and testing aims at facilitating access to HIV care services and promoting risk reduction behavior for HIV negative and positive persons. It is regarded as an entry point for all HIV prevention, care and treatment interventions and promotes knowledge of HIV serostatus. It is estimated that about 12% of the population have been reached with this service through 500 facilities currently providing C&T in all districts. Seventy percent of the 1.1 million estimated HIV infected individuals do not know their sero status (UHSBS 2005). There is however a high demand for counseling and testing as from the unmet need for HCT (UDHS 2002). Strategies include both client and provider initiated HIV counseling and testing services and the plan is to scale up testing and counseling to all HC III by the year 2010. This will take into consideration special strategies such as couple counseling for discordant couples as well as targeted IEC for counseling and testing. Plans exist for further scale up through training of service providers and monitoring and ensuring quality control for HIV counseling and testing.

HIV discordance and non-disclosure. The 2004-05 Uganda HIV-sero Behavioural Survey (MoH and ORC Macro, 2006) shows that overall, 5% of the married or cohabiting couples, are HIV discordant, that is one partner is infected and the other is not. Of all couples where at least one partner is infected, about 50% are HIV discordant. Data from the Rakai Health Sciences Program also shows that HIV sero-discordance among couples is high (Serwadda et al., 1995). Moreover, most of these discordant cohabiting couples are not aware of their HIV status and therefore not motivated to take action towards prevention such as using condoms consistently. Studies show that couples who test individually are more likely to disclose to persons other than their spouses and even when they do disclose to their partners they may take as long as two years to disclose (Oundo and Siu, 2005). Moreover, females may not disclose to their spouses for fear of domestic violence and marital disruption (Koenig et al., 2003). This may be a significant driver of the epidemic since the low level of testing among couples, the lack of disclosure HIV status to the partner and the low condom use in marriage put the uninfected partner at a very high risk. In these situations sex in marriage may become higher risk sex. Studies have shown that the risk of HIV transmission among discordant couples is as high as 10 times the risk of transmission among the general population (Serwadda et al., 1995).

Community based organizations can support

- outreach and home-based VCT
- Provide post-test referral and support services to those who test positive and negative
- Promote awareness about discordance and put emphasis on couple counseling and testing
- Advocate for couple counseling and testing
- Encourage mutual disclosure of test results to partner
- Advocate for consistent condom use among discordant couples
- Expand the VCT package emphasizing disclosure and linking the positives and negatives to appropriate services
- Promote home-based counseling, testing and disclosure to family members
- Promote couple counseling, testing and disclosure
- Develop programs for discordant couples among married and co-habiting partners

Applicants' proposals should specifically address how they will support voluntary counseling and testing, in particular for adults in relationships in which the status of the partner is unknown, and for adults in discordant relationships.

Applicants are advised that funding under this round of grants from the CSF is NOT expected to support the procurement of testing kits.

4. Integrate HIV prevention, care and support services with other health care and social Services

Community based organizations can promote service integration by

- Integrating prevention into community based HIV/AIDS care and support services
- Establish linkages between different components of HIV prevention e.g. STI management, HCT, PMTCT, etc
- Integrate HIV/AIDS prevention efforts into community extension work for health, social and economic programs

5. Integrate prevention into care and support programs for PHAs

Community based organizations can:

- Promote prevention with positives
- Promote condom use among positives
- Integrate HIV prevention in support counselling

6. Prevent and treat Sexually Transmitted Infections

There is both biological and epidemiological evidence linking concurrent STIs to the risk

of HIV transmission. Genital ulcer diseases, such as herpes simplex are very common and yet are associated with an increased risk of HIV transmission and acquisition (Serwadda et al., 2003; MoH and ORC Macro, 2006). Data from the Uganda Serobehavioral survey indicate that HSV-2 is widespread with close to 50% of Ugandans infected. Approximately 49% of women and 38% of men aged 15 – 49 were infected. Of all couples in which at least one partner is infected with HSV-2, almost half (45%) were discordant. Furthermore, HIV increases severity and duration of herpes symptoms and may reduce efficacy of treatment.

Control and prevention of STI is recognized as a strategic intervention in the prevention of HIV infection in Uganda. The objective of the STI response in the Health Sector HIV and AIDS Strategic Plan is to contribute towards prevention of HIV transmission through prevention and control of STIs. The strategies used for prevention and management of STI in the country are IEC, early detection and seeking of medical care, condom use to prevent STIs and syndromic management for treatment. These control strategies go hand in hand with HIV interventions. However, there are stand alone training materials and treatment guidelines. Similarly, job aides for health worker targeted for STIs are also stand alone although integrated into the national clinical guidelines and training documents. They are currently being used even in the light of challenges of health worker attrition and irregular STI drug supplies. Currently, a need has arisen for updating of the STI guidelines as the results of the recently conducted sero-prevalence survey demonstrated a 46% prevalence of HSV-2 in adults 15-49 and also that HSV2 infection was strongly associated with HIV infection. This would be followed by training of service personnel to address and capture data on HSV-2 for appropriate recognition and case management. Planned activities include those geared towards reducing HSV-2 infection, an informative assessment of male circumcision, addressing fear, stigma and violence against women, training of service providers on STI management, improving drug supply and supportive supervision. Other planned STI prevention activities include strategies for strengthening targeted interventions for most at risk populations (fishing communities, refugees, IDPs, CSWs) and for addressing chronic problems of inadequate STI drug supplies

Applicants are advised that funding under this round is not expected to support the procurement of drugs, or the direct management of STI. Rather, funding is expected to support referral mechanisms and linkages that ensure adults being reached with integrated ABC prevention messages are aware of, and know where to access, STI treatment.

7. Focus prevention on vulnerable and higher risk groups including young people, IDPs, PWDs, women and girls, adults especially in marriage relationships, fishing communities, mobile populations, migrant workers, CSWs

According to a rapid assessment conducted by the Uganda AIDS Commission and its partners (UAC, 2006), the HIV epidemic in Uganda may be driven by populations with high HIV prevalence and incidence since they are more prone to higher risk behavior. These populations include commercial sex workers (CSW), those who are widowed, divorced and separated, persons living in internally displaced persons (IDP) camps, the

uniformed forces and fishing communities. As expected, CSWs serve several clients a day, and every sexual encounter is associated with some form of risk so the higher the client turnover the higher the risk. There is also evidence that while 99% of CSWs report ever use of condoms, consistent use is very low (STD/AIDS Control Program, 2003). Such sexual practices of multiple partners a day, with inconsistent condom use, make CSWs not only high risk groups but also profound drivers of HIV, given the fact that some (12.3%) of the CSWs reported having stable partners (married or cohabiting) as well.

In IDP camps, both men and women are reportedly involved in risky sexual behavior that may predispose them to HIV infection. This is exacerbated by high rates of STDs, sexual interaction with uniformed personnel (another high risk group), alcohol use, idleness, child abduction and defilement as well as lack of access to preventive services including IEC and VCT. Uniformed personnel face increased risks of contracting or spreading HIV infection through risky sex during deployment away from home. Some of them experience long separation from spouses or partners. For those affected, and in the absence of family and community support systems, they are more likely to engage in risky behaviors and potentially pass those risks on to their own family and community members including IDPs.

People living in fishing communities are highly mobile, moving between fish landing sites. Given their migratory nature, fishing communities have limited social cohesion, and socio-cultural norms that regulate behaviour in stable communities are non-existent. Moreover, a culture of 'hyper-masculinity' has been reported among fishermen. Allison and Seeley (2004) reveal how fishermen's beliefs and expectations about the number and type of sexual contacts increase men's susceptibility to HIV/AIDS. In the fishing communities, having more than one wife is a sign of man-hood, and it attracts respect. Given the burden shouldered by society towards the care of OVCs, several children have been compelled to participate in paid work to cater for themselves or other siblings, while others are heads of households. As a result, orphans and vulnerable children (OVC) are likely to be at greater risk in various aspects of life including early sexual initiation. The MoH Uganda and ORC Macro (2006) indicate that orphans and vulnerable children are slightly more likely to have sex by age 15 than other youth. Young female children classified as OVC are 1.5 times more likely to initiate sex before age 15 than other younger women, while young men who are OVC are 1.1 times as likely. 14.6% of female orphans had had sex before age 15 while 18% of male orphans had had sex by age 15 (MoH Uganda and ORC Macro, 2006).

To date, two cross-sectional surveys have been conducted among Commercial Sex Workers in Kampala, the first in 2001 and the second in 2003. The main objectives of these studies were to estimate the prevalence of HIV and assess HIV related knowledge among CSWs. Of the 195 and 216 CSWs studied in 2001 and 2003, respectively 28.2 and 47.2% were found to be HIV-positive. This indicates that HIV infection went up by almost 75% during the two-year interval. When data was disaggregated by age, the general pattern of HIV infection remained the same. The 20-24 year old age group had the highest HIV prevalence in both 2001 and 2003, followed

by the 25-29 year old age group; then the 15-19 year old age group. These studies show that commercial sex is significant, especially in Kampala, and that the magnitude of commercial sex is on the increase. Moreover, CSWs come from all adult age categories, different religious groups, people of different sexual relationships, and they interact sexually with members of the general population.

Fishing communities are the foundation for an important sector of the national economy. Fisheries contribute over 6% of the GDP and some studies¹⁹ calculate the contribution to be as high as 12%. The fisheries sector is highly vulnerable to HIV and AIDS and the limited surveillance data shows HIV prevalence as much as three times the national average. In Kasenyi (Lake George), 81% of the few people who were able to access HCT services in 2004 were HIV-positive. Recorded AIDS cases up to the end of 2002 showed the highest number of cases in districts situated along the shores of Lake Victoria, i.e., Masaka, Mpigi and Jinja²¹. Furthermore, access to HIV and AIDS services is limited in fishing communities. A mapping study²² found that the district of Kalangala (Lake Victoria) consistently scored in the lowest ranges for HIV-related services, including condom distribution, HCT services, STI treatment and PMTCT. Poor roads, low education, few health centres, and little electricity or safe water exacerbate this situation. In addition to these living conditions, the fluctuating livelihoods of fishing communities are not associated with a settled, secure and risk-averse existence, which means that HIV is more likely to spread.

In the case of uniformed services²³, military personnel frequently face family separation and deployment away from home, which increase the likelihood of contracting or spreading HIV infection through risky sex. Other factors contributing to risky sex by uniformed service personnel include peer pressure (masculinity issues), binge drinking (masculinity and stress reduction), and cash in the pocket, which is a big factor when assigned to regions of the county affected by chronic conflict and poverty. UNAIDS estimates military populations²⁴ generally have HIV and STI prevalence levels that are up to 2-5 times higher than those of civilian populations at peace²⁵. The rates may even be higher in conflict-affected regions. The high prevalence of HIV in military groups is predominantly due to heterosexual transmission; virtually all serving military personnel are within the known sexually active age groups for Uganda. Minimum age of entry in the army is 18 years and the average retirement age is 56 years.

Other mobile occupational groups, such as the mobile labour force that moves with road construction sites, share the same mobility-related risk factors that are associated with uniformed services. Conflict affected areas, such as in Northern Uganda, tend to have high HIV prevalence levels. In 2005, the prevalence in the war-affected areas of Northern Uganda stood at 8.3% compared to the national rate of 6.4%²⁶. In conflict zones, and perhaps especially in areas chronically affected by conflict, the surrounding populations tend to look at uniformed personnel as having privilege and power, resulting in unbalanced sexual relationships. Military men and women have a steady income, albeit small, which means that they are often considerably better off than those in the surrounding communities²⁷. In these situations, soldiers have often been branded as the ones spreading HIV infection.

Internally Displaced Persons (IDPs) and other migratory populations are also quite vulnerable to HIV infection. Manmade conflicts and natural disasters bring together populations with different levels of HIV infection, thereby increasing the potential for new infections. Social protection, health, and other socio-economic structures and services begin to break down as populations are displaced. Uganda has had a significant number of its citizens staying in IDP camps. Conflict-associated displacement and poverty in Uganda have contributed to an escalation of actions that increase vulnerability of women and girls to HIV infection – abductions, rape, school drop-out, early marriages, trafficking, and sexual and domestic violence. While the UHSBS shows regional patterns, there have so far been no special surveys conducted to determine the magnitude of HIV infection among Ugandan IDPs and migrant populations. Little information exists about the burden of HIV among People with Disability (PWD) but their vulnerability and risk to HIV infection have been globally recognised. Risk factors among people with disability are not very different from the general population but their access to services is much more limited. For example, although condom knowledge is very high in the general population, 11% of PWD respondents in a recent survey had never heard about condoms²⁸. By the latest population census (2002), PWD comprise 3.5% of the total population (838,000). This size and nature of this group present a big challenge that will require carefully designed interventions. It is also important that the dual causality of HIV and disability has not been strategically addressed. While disability increases vulnerability to HIV infection, HIV infection can also cause various kinds of disability.

AIDS has become one of the leading causes of orphanhood in Uganda. Nationally, there are an estimated two million orphans. Many boy and girl orphans are compelled to participate in paid work, or the girls to marry early, and some have to become young heads of households. As a result, Orphans and Vulnerable Children (OVCs) are likely to be at greater risk in various aspects of life including early sexual initiation. Youth who are orphans or vulnerable children are more likely to have sex by age 15 than other youth²⁹. Young women classified as OVCs are 1.5 times more likely to initiate sex before age 15 than other young women, while young men who are OVCs are 1.1 times as likely.

Married people – A follow-up analysis³⁰ of Uganda's 2005 sero-survey suggests that up to 65% of new HIV infections are occurring among married people³¹; and discordant couples may comprise up to 50% of these transmissions. These data underscore the vital importance of couple testing and counselling – data suggest³² that testing and counselling is the most effective strategy available to promote condom use in stable unions. Effective, targeted work with married adults, especially discordant couples and older men, will be needed to reduce transmission within the plan period, and the strategy could give much more attention to this.

Regional mobility - Uganda is a member country of the Great Lakes Region where there is a long history of conflict, natural disasters and socio-economic difficulties. These phenomena have caused numerous population movements within and across the

region. At times, these movements make it difficult to reach the populations involved with the necessary services since the providers have largely been facility based. There are some regional initiatives to target mobile populations, like the Great Lakes Initiative on AIDS, the IGAD region IRAPP project, and the EAC-AMREF Lake Victoria (EALP) HIV and AIDS programme. These programmes are designed to complement national responses of the member countries by targeting the hard to reach. It is planned to create the necessary political environment and systems to maximise the outputs of these initiatives.

Current and planned strategies for high risk and vulnerable groups are specific to the individual groups and include

- IDPs and Post-Conflict Communities
- Fishing communities
- CSWs and their clients
- Truckers
- Street children
- Market vendors
- Uniformed personnel
- Victims of domestic violence
- Elderly persons, including care givers
- Persons with disabilities

Applications focusing specifically on one or more high risk and vulnerable groups are encouraged.

a. Identifying and addressing causes of vulnerability, and socio-cultural and economic situations that predispose individuals to infection, targeting social change and life skills development

Programs serving high risk and vulnerable groups may not only focus on the provision of age and risk appropriate HIV Prevention services, but also focus on mitigating the impact of the beneficiaries' specific vulnerabilities or seek to address, and eliminate, the underlying causes of the beneficiaries' specific vulnerabilities.

Community Based Organizations are ideally situated to

- Address Socio-economic causes of vulnerability
- Advocate for focus on causes of vulnerability: poverty, displacement, gender inequity, spare unplanned for income e.g. for fishermen, etc. (This should serve as the entry for other non-AIDS driven services)

b. Promoting couple counselling and testing prior to initiation of long-term sexual relationships and within marriage relationships and especially support safe transition from single-hood to marriage

c. Support HIV prevention efforts

The CSF is fully aware that proposed strategies for reducing the risk of HIV infection among the groups above will be specific to the individual groups. Applicants are thus encouraged to ensure that submitted proposals demonstrate a solid understanding of the needs of the groups to be served, and that proposed activities specifically address the needs of the groups proposed for coverage. While applicants may propose serving more than one group, and are encouraged to form partnerships that do so, it is anticipated that applicants will select the groups to be served based on their experience and expertise, and not propose generic interventions across multiple groups that each have their own unique needs.

The CSF strongly encourages applications that demonstrate the applicant's commitment to involving project beneficiaries in the design, implementation, monitoring and evaluation of the projects which intend to serve them.

8. Advocate for protection of rights of women, girls, children, PHAs, IDPs and other minority groups within existing policy and legal frameworks

Community based organizations may propose activities that include:

- Advocate against sexual and gender-based violence
- Advocate for the rights of the infected and affected
- Confront and mitigate HIV-related stigma and discrimination in communities, workplaces, and service delivery points

Expected Impact

HIV Prevention efforts are expected to contribute to the following level impact indicators included in the National Strategic Plan:

- Percentage of youth and adults who are HIV infected (HIV prevalence)
- Percentage of people who both correctly identify at least two ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
- Percentage of sexually active people who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months
- Percentage of sexually active people who have had sex with more than one sexual partner in the last 12 months
- Percentage of young women and men aged 15-24 years who had sex before the age of 15
- Median age at which young people aged 15-24 years first have penetrative sex.
- Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year
- Percent of schools in the district with teachers who have been trained in life skills based HIV/AIDS education and who taught it in the last academic year
- The percentage of sexually active people reporting the use of a condom during sexual intercourse with a non-regular sexual partner.

- The percentage of young people aged 15-24 years who used a condom in the last of act of sexual intercourse.
- The percentage of sexually active people (women 15-49 years and men 15-54 years) who have ever used a condom.
- Ratio of condoms available for distribution to the total population aged 15-49
- Number of male condoms distributed in the past 12 months
- Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results.
- The percentage of women aged 15-49 and men aged 15-54 who know at least two benefits of VCT
- The percentage of women aged 15-49 and men aged 15-54 who have ever voluntarily requested an HIV test, received the test, and received the results.
- Percentage of married or cohabiting couples receiving HCT as a couple and disclosing to partners
- The percentage of sexually active people (women 15-49 years, men 15-54 years) who both correctly identify common symptoms of STIs.
- Percentage of [most-at-risk population(s)] who are HIV-infected
- Percentage of Most-at-Risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results