THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH

National Couples HIV Counseling & Testing Communication Strategy 2009

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List of Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
ART	Anti Retroviral Treatment
CHCT	Couples HIV Counseling and Testing
EPPM	Extended Parallel Process Model
HC	Health Center
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HSSP II	Health Sector Strategic Plan II 2005/2006 – 2009/2010
NPAP	National Priority Action Plan for the National Response to HIV and AIDS 2008/09-2009/10
NSP	National HIV/AIDS Strategic Plan 2007/2008 – 2011/2012
PMTCT	Prevention of Mother to Child Transmission of HIV
RM&E	Research, Monitoring and Evaluation
VCT	Voluntary Counseling and Testing
VHT	Village Health Team

Foreword

The 2004/2005 Uganda HIV Sero Behavioural Survey revealed a high incidence of HIV among married couples. Married persons account for an estimated 65% of new HIV infections, and discordant couples comprise up to 50% of these transmissions. Despite relatively high levels of knowledge around where to get an HIV test, the job of couple HIV counseling and testing (CHCT) remains complex. Less than 13% of men and women currently married have ever tested for HIV and received the results, and only 3.3% of married women and 4.3% of married men have done so in the last 12 months. Moreover, 90% of married women and 89% of married men do not know the HIV status of any of their partners or spouses.

This National Couples HIV Counseling and Testing Communication Strategy has been designed to guide the implementation of a national CHCT campaign in order to address these challenges. The strategy reflects the consensus of experts in the field of communication and CHCT. Its implementation is intended to lead to an increase in the proportion of couples who know their own and their partner's HIV status and make joint decisions to prevent or reduce HIV risk in their relationship.

The Ministry of Health appreciates the many contributions to this campaign made by everyone involved in the process. The collaboration to develop, by consensus, a strategy of this scope and depth is an outstanding achievement. MOH would like to thank particularly the Health Communication Partnership for its partnership in the preparation of this strategy. MOH also appreciates the United States Agency for International Development (USAID), the AIDS Information Centre (AIC) and the many partner organisations and individuals that were involved in developing this strategy.

It is my sincere hope that utilization of the communication strategy will greatly contribute to more couples in this country communicating about HIV/AIDS, testing together for HIV, and actively adopting practices that reduce the HIV risk in their relationship. I urge all partners to join in this CHCT movement. Your support is critical for the campaign's success.

Yours Sincerely,

Dr. Zainab Akol
PROGRAM MANAGER
STDs/AIDS Control Programme - Ministry of Health

Together we can achieve more.

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Background and Rationale

According to the 2004-2005 Uganda HIV/AIDS Sero-Behavioural Survey, 6.3% of men and women age 15-49 who are currently in union are HIV positive, compared to 1.6% of those never in union (Uganda Ministry of Health & ORC Macro 2006). Furthermore, 5% of cohabiting couples are HIV discordant, with the male infected in 3% of couples and the female in 2%, with another 3% of cohabiting couples HIV positive concordant.

Within these couple relationships, multiple sexual partnerships are common, particularly among men. While only 2.6% of currently married women report having 2 or more sexual partners in the last 12 months, nearly one third (29.8%) of currently married men have had 2 or more partners. Furthermore, condom use among married couples is low. While 53% of never married women and 55% of never married men report condom use at last sex, only 3.5% and 4.8% of currently married men and women, respectively, used a condom at most recent sex.

Despite these realities, only 12.5% of currently married women and 12.7% of currently married men have ever tested for HIV and received the results, and only 3.3% of married women and 4.3% of married men have done so in the last 12 months. Incredibly, 90.1% of married women and 88.6% of married men do not know the HIV status of any of their partners or spouses (Uganda Ministry of Health & ORC Macro 2006).

In the midst of these challenges, HIV counseling and testing (HCT) providers, policy makers and experts cite the current state of the HCT context in Uganda as the most favorable it has ever been (Meeting to Review CHCT Strategy 2008). Through extended service delivery networks, more people are providing HCT services. Access to PMTCT and ART have increased, making HCT a first step rather than the last stop. Integration of services as a whole has been strengthened. There are more couples clubs, post-test groups, and PLHA networks in operation than years past. Community groups are better organized, and the Village Health Team (VHT) infrastructure is supportive for outreach. Funders, providers, policy makers, programmers and other stakeholders are ready and eager to collaborate.

The international community has taken a strong stance on the HIV epidemic. Target 7 of Millenium Develop Goal (MDG) 6, to combat HIV/AIDS, malaria and other diseases, is to have halted and begun to reverse the spread of HIV/AIDS by 2015. Uganda is one of several countries that made a commitment to address the recommendations of the International HIV Counseling and Testing Workshop held in Lusaka, Zambia in January 2008, which advocated for a renewed emphasis on innovation to improve the prevention benefits of HCT and capacity building for counselors to provide effective counseling for married and cohabiting couples (International HIV Counseling and Testing Workshop Report 2008).

Uganda's national policies call for accelerated HIV prevention. The Health Sector Strategic Plan II 2005/2006 – 2009/2010 (HSSP II) includes ambitious targets on increasing HIV prevention knowledge, reducing HIV prevalence, scaling up VCT, PMTCT, and ART services, increasing accessibility to information and services, and improving access and availability of condoms. Other such seminal documents, such as the National HIV/AIDS Strategic Plan 2007/2008 – 2011/2012 (NSP), the national Priority Action Plan for the National Response to HIV and AIDS 2008/09 – 2009/10 (NPAP), and those resulting from the 3rd Joint AIDS Review, 6th HIV/AIDS Partnership Forum, and Joint Review of the Prevention of Mother to Child Transmission of HIV and Paediatric AIDS Care Programmes establish similar goals. For World AIDS Day 2008, the country set the goal of testing 1 million Ugandans for HIV.

It is at this time of obvious need and within this conducive environment that stakeholders in Uganda are joining forces to design and implement a national communication campaign for Couples HIV Counseling and Testing (CHCT). The mass media campaign will be national in scope, with a service delivery component and intensified interpersonal and community mobilization approaches in 8 districts[1]. This strategy addresses the communication aspects of the campaign.

[1] As AIDS Information Centre (AIC) is the lead implementing partner, services will be offered as part of the campaign in the 8 districts with AIC stand-alone facilities: Kampala, Arua, Jinja, Kabale, Lira, Mbale, Mbarara, and Soroti.

The Communication Strategy Process

The campaign development process began with a literature review on the current context of HCT in the country; the major barriers and facilitators to uptake of HCT, and emerging issues in the HCT arena, including couples HCT, discordance, and disclosure (Orkis 2008). Literature was also reviewed on HCT campaigns implemented in other African countries, challenges, lessons learnt and major achievements. The Health Communication Partnership shared the literature review and the campaign concept note with HCT stakeholders in an extra-ordinary CT17 meeting on 24 June 2008.

As a result of this meeting, a smaller working group was formed to further develop the concept note. The revised concept note was again presented to the CT17 on 10th October 2008, at which point members proposed that Health Communication Partnership draft the communication strategy. Working group members met further to refine and finalize the strategy. For a list of CT17 and working group members, please see Appendix A.

Theoretical Framework

The Extended Parallel Process Model (Witte 1992) posits that when exposed to a health message, individuals will first assess the susceptibility and severity of the perceived threat. Low perceived susceptibility or severity will result in inaction; the individual will ignore the message if they deem it to be trivial or irrelevant. If the individual does feel at risk of a serious threat, they will then assess the extent to which the recommended behavior effectively prevents the threat (response efficacy), as well as the extent to which they are capable of performing the recommended behavior (self-efficacy). When these efficacy components are sufficiently high, the individual is likely to engage in the recommended behavior.

However, if the individual feels that the recommended behavior is unlikely to prevent the threat, or that they are unable to engage in the recommended behavior (low efficacy component), denial or avoidance result. Thus, health messages and campaigns must strike a careful balance between perceived susceptibility, severity, self-efficacy, and response-efficacy in order to be effective. The CHCT campaign will seek to achieve this balance based on the available evidence.

Behavioral Aspects of HCT

Barriers to HCT

Low HIV Risk Perception

The most commonly cited reason for never having had an HIV test among all women (31.2%) and men (45.6%) 15-49 years is that they do not need to be tested or that they have a low risk of being infected with HIV (Uganda Ministry of Health & ORC Macro 2006). Uganda Demographic and Health Survey data corroborate lack of perceived risk of HIV infection as a major reason for not receiving a test. An estimated 21% of women and 23% of men perceive themselves to be at high risk of getting infected with HIV. Another 36% of women and 35% men perceive their risk as moderate, 18% of women, 17% of men perceive low risk and 12% of women and 13% of men think they have no chance at all of getting HIV (UBOS & Macro International 2007). In other words, perceived susceptibility to HIV infection is low.

A certain apathy seems to exist around HCT; people are unconcerned about their status. Eight percent of men and women report that HCT is not a priority. Thus, the perceived threat of HIV is not enough to warrant the recommended behavior of HIV counseling and testing.

Fear

Fear of knowing one's status, as well as the resulting consequences, is another major behavioral barrier. Sixteen percent of women and 9% of men do not want to know if they have the virus (Uganda Ministry of Health & ORC Macro 2006). Individuals are concerned not only about the health implications of receiving an HIV positive test result, but also about the reactions of their partners (separation, loss of income, physical abuse), family members (blame, neglect), and the community at large (gossip, discrimination).

Many couples are afraid to bring up the subject of going for counseling and testing with their partner, as they fear it will lead to arguments about infidelity. Couple communication around HIV is low; 83-84% of married men and women have not discussed AIDS with any spouses or partners (Uganda Ministry of Health & ORC Macro 2006). In relation to the Extended Parallel Process Model (see Theoretical Framework), perceived self-efficacy to initiate conversation about CHCT with one's partner, as well as one's confidence in their ability to handle the results of the test are low.

Lack of Knowledge

According to the UHSBS, approximately 20% of both men and women do not know where to go for an HIV test, and 11% of women and 7% of men have reported no knowledge of HIV testing (Uganda Ministry of Health & ORC Macro 2006). Furthermore, few people are aware of the benefits of HCT. Only 39% of women and 47% of men age 15-49 could name at least two of the following benefits: to be able to plan one's future, to avoid reinfection if one is already positive, and to learn to live positively with HIV/AIDS (Mukaire et al., 2004).

Structural and Economic Barriers

The cost of an HIV test is cited by 18% of women and 13% of men as a reason for never having had an HIV test (Uganda Ministry of Health & ORC Macro 2006). Distance to the testing site is also given as a reason for not testing by 3% of women and 5% of men.

Lack of Familiarity with Couples HIV Counseling and Testing

Couples HCT in particular faces its own unique challenges (Nwalika 2008). Uganda's current HCT policy is not so explicit on couples counseling and testing, and promotion for CHCT has been low. Providers and clients alike still think of testing as an individual process. Logistically, it is difficult to bring the couple together for HCT at the same time, given different work and home schedules. As with other aspects of health, male involvement is low.

Misconceptions

Importantly, many people do not realize couples can have different HIV test results. Misconceptions around discordance are highly prevalent in Uganda: 75% of both men and women incorrectly believe that if one partner is infected with HIV, the other partner always is, too (Uganda Ministry of Health & ORC Macro 2006). Very few clients or counselors are able to give accurate information about why HIV discordance exists (Bunnell et al. 2005). Clients' four dominant explanations of discordance are that the HIV negative couple member is actually infected; the virus was just taking time to show up in his/her blood; that some people are immune from HIV infection; that HIV infection is only through "rough" sex, and that HIV negative status was viewed as a reward from God. These explanations have the potential to undermine the motivation of discordant couples to engage in HIV risk reduction behaviors.

There is also a belief that monogamy is 'safe'. However, a faithful and/or married individual only knows if he or she is faithful, not necessarily whether or not his or her partner is equally monogamous. Thus, this conviction that being faithful reduces HIV risk is incomplete without taking into account the fidelity of one's partner.

Low Capacity to Provide CHCT

Lack of knowledge about where to go for CHCT, and low capacity of counselors to deliver effective counseling for couples are further barriers. Couples require specialized counseling; hence there is increased need to improve the capacity of counselors. Inadequate support services for couples following HCT reduces the potential long-term benefits of the service. A facility assessment conducted in preparation for this campaign revealed that health units are often understaffed, in some health facilities there are no staff trained in HCT, and referral mechanisms are inefficient (Okiira 2009). Breach of confidentiality by health workers was also given as a key reason why HIV testing services are shunned in the communities; people prefer outreaches to facility-based static HIV counseling and testing.

Facilitators to HCT

Knowledge of HCT

While approximately 20% of Ugandans do not know where to go for an HIV test, 80% do (Uganda Ministry of Health & ORC Macro 2006). According to the 2006 UDHS, knowledge around availability of HCT even higher: 82% of women age 15-49 and 87% of similarly aged men know where to get an HIV test (UBOS & Macro International Inc 2007).

Willingness to Test

Evidence from voluntary, routine, and home-based HIV counseling and testing acceptance studies indicates that willingness to test and acceptance of testing for HIV are exceptionally high in certain circumstances. In a study that systematically sought out household members of ART-eligible clients for HBHCT, 99% of household members accepted (Were et al. 2006). Of these, 95% had not tested previously (it should be noted, however, that these individuals accepted in the context of provision of ART). Another study to determine acceptance of routine counseling and testing (RCT) at Mulago national referral hospital found that 95% of those unaware of their HIV status or who had previously tested negative accepted to test (Nakanjako et al. 2007). Research out of Rakai found that 93% of the cohort initially requested HIV results, and 62% subsequently received their results and post-test counseling (Matovu et al. 2007).

These findings suggest that "low uptake of VCT should not necessarily be interpreted as lack of demand to know results" (Wolff et al. 2005), and implies that the removal of certain social, structural, and other behavioral barriers has the potential to increase HIV testing rates. Notably, public sector facilities offer counseling and testing services free of charge. Outreach can bring testing services closer to the home setting. Anecdotal evidence has shown that people are more likely to test when counselors unaware of partner relationships and unable to disclose status are brought in from other regions to conduct the counseling and testing.

Symptoms

Symptoms of a chronic illness often trigger testing, particularly when these symptoms are apparent to all, when symptoms do not respond to treatment, when symptoms impair one's ability to work normally, or when people know their partner had died of AIDS (Nsabagasani and Yoder, 2006). Oftentimes, friends or family members advise these individuals to go for testing. Hope of obtaining ARVs and resultant improvement also motivate testing; individuals know that ARVs would help them live longer.

Concern About Past Sexual Activity

Concern about past sexual activities is another motivating factor. These include past sexual experiences with a person who later died with conditions similar to AIDS, recent unprotected sex, personal anxiety over having multiple sexual partners, or concern over the condom "leaking." The potential to gain access to support services is also influential, as is concern about initiating or continuing a sexual relationship.

Children

Children can also motivate testing. An HIV positive caretaker typically wants to be able to plan for the future of the children in the event of their own sickness or death. Further, a parent's own HIV positive status may provide reason to have the child tested.

Targeted Promotions

Promotions that target couples with a two-for-one approach and pressure from young couples' families and churches to be tested before marriage have also been found as facilitators to CHCT (Painter, 2001).

Rights-Based HIV Counseling and Testing

Recently, there has been a move toward a rights-based approach to HCT, which emphasizes that both persons in a sexual relationship have equal rights and responsibilities for their mutual pleasure and protection (Dixon-Mueller and Germain, 2007). Individuals' sexual partners' right to protect themselves from HIV corresponds with an obligation to respect a partner's need to know and right to make informed sexual and reproductive health decisions. Clients might be motivated if they are told that they have an obligation to inform your partner if they are HIV positive, and that their partners have a right to protect themselves from HIV. Clients can lead informed, safe, and satisfying sexual lives based on respect for mutual rights and responsibilities.

Campaign Goal and Purpose

The overall program goal of CHCT in this country is to contribute to the reduction in new HIV infections in Uganda.

The communication purpose of the campaign is to:

- Empower couples to initiate and sustain communication around HIV and AIDS
- Encourage couples to seek HCT together
- Encourage HIV status disclosure among sexual partners
- Encourage couples to adopt and maintain positive health practices, including risk reduction strategies and health seeking behaviors
- Link HIV positive couple members to treatment, care and support

Conceptual Framework

The Conceptual Framework on the following page provides an overview of how, given the current context, the campaign will target different audiences with strategic communication interventions to lead to changes in knowledge and attitudes, behaviors and skills, ultimately contributing to the campaign goal.

CHCT Communication Campaign: A Conceptual Framework

Context	Target Audience	Interventions	Knowledge and Attitudes	Skills and Behaviors	Campaign Goal
Low levels of HIV risk perception **Fear of knowing one's status** **Low knowledge of discordance** **Low levels of couple communication** **Low levels of disclosure** **Conflicting schedules for couples** **Low rates of CHCT** **Poor quality of CHCT services**	**Before HCT**				**Contribute to the reduction in new HIV infections in Uganda**
	Couples who do not know their HIV status (1°)	Radio spots, outdoor media, print, branding of service delivery points, video/audio/print testimonials, radio talk shows, community outreaches, flyers indicating availability of services	Accurate knowledge of discordance Knowledge that multiple partners increase HIV risk Feel at risk of HIV Feel it is important to know one's own and one's partner's HIV status	Increased self-efficacy to discuss need to test with partner Go for CHCT Disclose their HIV status to their sexual partner(s)	
	HCT service providers (2°)	CHCT training, pre/post test counseling aids, flipchart, client request forms, radio distance learning program, support supervision	Have the knowledge to counsel couples effectively Willing to counsel couples	Have the skills to counsel couples effectively	
	Religious leaders and faith-based organizations (2°)	Orientations, talking points for sermons, video/audio/print testimonials, existing support materials, flyers indicating availability of services	Accurate knowledge about campaign, CHCT, discordance, availability of services, and the importance of couples testing together Supportive of CHCT and campaign goals	Motivate couples to go for CHCT services Provide support to couples after testing	
	After HCT				
	HIV negative concordant couples (1°)	Risk reduction planning tool, "Testing Negative" brochure, referral form, existing support materials	Know which behaviors increase risk of HIV Believe it is important to stay faithful and reduce multiple sexual partners in order to stay HIV negative	Make and adhere to a risk reduction plan Communicate on HIV-related issues	
	HIV positive concordant couples (1°)	Risk reduction planning tool, disclosure planning tool, PLHA support discussions and home visits, "Testing Positive" brochure, referral form, existing support materials	Know how to live positively Believe they can live a bright future by practicing positive living	Support each other to live positively Make and adhere to a prevention for positives risk reduction plan Seek FP/PMTCT services and/or test children for HIV	
	HIV discordant couples (1°)	Risk reduction planning tool, disclosure tool, "Testing Discordant" brochure, referral form, existing support materials, post-test couple support discussions, home visits	Understand the reality of discordance in their lives Motivated to protect the uninfected partner from infection	Make and adhere to a risk reduction plan to prevent infection of uninfected partner Support infected partner to live positively Seek FP/PMTCT services and/or test children for HIV	

Target Audience

Primary Target Audiences

Before CHCT:

- Couples who do not know each other's HIV status. These couples may or may not already be engaged in a sexual relationship. This includes married, unmarried, cohabiting, long-term, and casual partnerships. The campaign will aim to reach couples within 10km of HCT services, either static or outreach.

During/after CHCT:

After couples of unknown HIV status test together, then will then fall into one of three categories:

- HIV positive concordant couples
- HIV negative concordant couples
- HIV discordant couples

Secondary Target Audience

- HCT service providers
- Religious leaders

Audience Analyses and Communication Strategies

Couples who do not know each other's HIV status	
Audience Analysis	
Demographic Profile	• Women age 20-39 years, men age 25-44 years • Married, unmarried, and co-habiting couples of reproductive age in urban, peri-urban areas • May or may not already be engaged in a sexual relationship • May already have children or be pregnant • Semi- to well-educated, but not excluding lower education levels

Couples who do not know each other's HIV status	
Social Profile	• Man may know own status but not spouse's status • Woman may know own status but not spouse's status • Female couple members are typically housewives; spend a lot of time in the garden • Male couple members have more time to participate in community education activities • High levels of alcohol consumption among the men • Males are typically the decision makers for sexual and reproductive health • Limited financial capacity for HCT, ARVs, etc. • High access to radio • Seek health services individually, rather than as a couple • At church, weddings, and other functions, often find couples sitting apart • Very low couple communication in general, and around HIV/AIDS in particular • Find couples together in the bedroom; may be listening to the radio (FM stations, health or politics related programs) • Couples in rural areas more likely to eat dinner together (8-9pm) • Watch live football matches, drama shows and other entertainment together • Talk about their children, problems in the house (e.g. soap, salt), change in weather, famine, tasks/household responsibilities – applies to rural, peri-urban, and urban couples • Those that belong to Mothers'/Fathers' Unions are more empowered to talk to each other • Feel it is important to keep the marriage, strengthen the partnership
Desired Behavior	• Assess their risk of HIV • Talk to their partner about each others' HIV status and the need to test for HIV • Go for HIV counseling and testing together with their partner • Disclose their HIV status to their sexual partner(s)

Couples who do not know each other's HIV status	
Actual Behavior	• Do not talk about HIV as a couple • Go for HCT alone or not at all • Do not disclose their HIV status to their partner • Do not ask their partner's HIV status • Exposed to HIV messages individually, but do not share information or communicate with each other about HIV in general • Deny HIV risk, do not want to imagine being HIV positive, think it is other people's problem • Continue to engage in risky sexual behavior
Benefits of Actual Behavior	• "Ignorance is bliss". Not knowing each other's status avoids potential blame, tension, and break-up. • Maintain their reputation in the community as a couple that is unaffected by HIV
Barriers to Desired Behavior	Knowledge and Attitudes • Low levels of HIV risk perception—since they are a couple, and they trust one another, they do not think they can be at risk of HIV • Misconception about HIV status. Many people do not realize couples can have different test results. Misconceptions around discordance are highly prevalent. People incorrectly believe that co-infection is inevitable – the HIV-negative couple member is actually infected, the virus was just taking time to show up in his/her blood. Clients also believe that some people are immune from HIV infection, referencing "strong blood" and the "O" blood group in articular, and that HIV infection is only through "rough" sex. HIV negative status is also viewed as a reward from God. All of these beliefs may result in a lack of motivation to practice risk reduction behaviors. • Belief that monogamy is 'safe'. Some are aware that partner's have outside partners, but fear conflict and do not bring it up. Others do not know partners have outside partners. • Belief that women do not have multiple sexual partnerships. • Lack of knowledge about where to obtain CHCT • Unaware of the benefits of CHCT • HCT is not a priority

Couple communication

- Many couples do not want to talk about testing; they think it will lead to arguments about infidelity and which member of the couple was first infected
- Wives who are dependant on husbands financially are less likely to bring up the subject
- Younger and less educated women than men are less likely to bring up the HCT subject for discussion

Fear

- There is a fear of knowing one's HIV positive status and the resulting consequences, including reaction of their partners (separation, loss of income, physical abuse), family members (blame, neglect), and the community at large (gossip, discrimination)
- Both women and men are concerned over fear of separation from sexual partners or losing their marriage in the event of a positive result. Women are afraid that men would "universally condemn the wives for 'bringing the disease into the home,' even if the woman was faithful and the husband knew himself to be promiscuous", and that they would lose a source of income. Men are concerned about who will care for them and their children at home

Structural

- Poor quality of CHCT services (couple counseling) and inadequate ongoing support services for couples following HCT. Low capacity of service providers to deliver couple HCT.
- Access to CHCT: Financial barriers, distances to testing sites
- It is difficult to bring the couple together for HCT at the same time, given different work and domestic schedules

Sociocultural

- There is a "social license" given to men regarding extramarital relations, which is not present for the women. Multiple partnerships are culturally acceptable for men.
- Gender inequality; women do not feel empowered to go for CHCT

Couples who do not know each other's HIV status	
Benefits of Desired Behavior	All couples • Disclosure in CHCT is 100%. You can learn your HIV status together, so there is immediate disclosure and no doubt over each others' results. • You can hear information and messages together, so you have mutual understanding of the issues. • You can learn together about how to adopt safer sex practices. • It is a sign of trust and love. • It can strengthen the relationship and promote mutual understanding. • You can plan for your future and that of your family. • Just because one partner is HIV positive does not mean the other is, too. It is also true that if one partner is HIV negative, the other may be HIV positive. If you are HIV discordant, HCT can help you to avoid transmission to the uninfected partner, and support the positive partner to live longer. • You have a right to protect yourself from HIV by knowing your partner's status and making informed sexual and reproductive health decisions. • You can lead an informed, safe, and satisfying sexual life based on respect for mutual rights and responsibilities. • It is not HIV testing alone, but disclosure of HIV serostatus to your sexual partners that allows couples to make informed decisions about sexual behavior. Couples with at least one HIV positive member • A counselor can support you both to discuss concerns and help you cope with your situation. S/he can help reduce tension and prevent blaming. • Treatment and care decisions can be made together. Infected members of couples may be more likely to follow up on needed medical care and take medication when their partners know their HIV status. • You will have fewer worries and not have to hide your status. It can reduce your stress levels. • It avoids partners finding out from someone else or on their own. • You can plan to avoid re-infection and live together positively.

Couples who do not know each other's HIV status	
	• With your partner knowing your status, it will allow you to openly seek care at health facilities when sick rather than having to get treatment secretly. Your partner can also care for you properly. • You have an obligation to inform your partner if you are HIV positive; they also have a right to protect themselves from HIV. • Your children's future depends on it. If you are considering having a baby, couple HIV services enhance opportunities to prevent mother-to-child transmission of HIV. If you already have children, you owe it to your family to remain healthy so you can take care of them, and to test them to see if they are HIV positive. • Make known their cause of death, so that partners do not think they died from witchcraft or an unknown cause. HIV concordant negative couples • You can celebrate together. • You can strengthen your trust and love.
Key Constraint	• Fear of conflict in the event of an HIV positive test result: blame for promiscuity, for bringing HIV into the marriage, denial of children/wife/property/house/land/investments, separation (especially if woman is positive), loss of status, stigma
Key Benefit	• Disclosure in CHCT is 100%. You can learn your HIV status together, so there is immediate disclosure, and support can be given to avoid blame and conflict.
Communication Strategy Communication Objectives	• Increase HIV risk perception among couples • Increase the proportion of couples who feel it is important to know their partner's and their own HIV status regardless of the possible results • Increase the number of couples that know it is possible for one partner to be HIV positive and the other HIV negative

Couples who do not know each other's HIV status	
Key promise	• If you go for couple HIV counseling and testing, a counselor will be available to help you cope with your fears, avoid blame and conflict, and advise you on how to lead a healthy life.
Desired Action Response	• Now that I know that my partner(s) and I are at risk of HIV, and the benefits of testing with my partner(s), I will go for counseling and testing with him/her.
Support Points	• Testimonies of couples who are HIV discordant, concordant positive or concordant negative who share the benefits they have experienced from testing together. • HCT services are accessible and free in many districts • HIV/AIDS related services are accessible and some are even free • The current National Strategic Plan supports delivery of CHCT services • There is a wide network of HCT service providers and promoters in the country • Statistics indicate increased rate of new HIV infections among people in established relationships Knowing both of your HIV statuses can help you plan for PMTCT if necessary
Key message Content	• If you are already HIV positive, you cannot change your status. Being HIV positive is not the end. So let's learn from the past and focus on the present and the future. • Benefits of CHCT to a couple and children • Where to go for CHCT and related services (PMTCT, ART and other support services) • The concept of discordance and its relationship with CHCT • The influence of CHCT in accessing other services and hence couple's health • The benefits of spousal communication on HCT and other HIV/AIDS related issues: assess HIV risk, make plans, share information regarding HIV and AIDS, can support one another

Couples who do not know each other's HIV status	
Illustrative Communication Channels and Approaches	Couples of unknown HIV status will be targeted nationally through a mass media campaign. In the 8 districts where the testing events will take place, mass media will be supplemented by interpersonal communication and community mobilization approaches. Mass Media • Launch • Radio spots • DJ mentions • TV spots/skits (e.g. before/after news) • Mobile community radio talk shows (kimeza) • Outdoor (billboards, road stars) • Print (posters, newspaper, flyers) • Branding of HCT service delivery points • Promotional materials (e.g. t-shirts) • Video, audio, print testimonials *Interpersonal Communication and Community Mobilization* • Mobilization through: local leaders, health workers, community volunteers, VHTs, PLHA, post-test clubs, couple clubs, ssengas, NGOs, CBOs, FBOs, community groups, Tuko clubs • Approaches: community dramas/theatre for development, community couple dialogue sessions, health talks, couples activities/games, film shows, listening groups

HIV negative concordant couples

Audience Analysis

Demographic Profile	• Women (20 – 39), men (25 – 45) • Married, unmarried, and co-habiting couples of reproductive age in urban and peri-urban areas • May or may not already be engaged in a sexual relationship • May already have children or be pregnant • Engaged in some income generating activity Education of at least primary level
Social Profile	• Men spend most of their time at bars and trading centers • High levels of alcohol consumption among the men • Males are typically the decision makers for sexual and reproductive health • Limited financial capacity for HCT, ARVs, etc. • High access to radio • May engage in multiple sexual partnerships, especially men • Influenced by peers, religious/cultural/local council leaders, family (particularly older relatives)
Desired Behavior	• Make and adhere to a risk reduction plan, which may include mutual sexual faithfulness, correct and consistent condom use for added protection, and /or regular communication around HIV
Actual Behavior	• Some may have low levels of couple communication, extra marital relations, multiple sexual partners, unprotected sex (because they "trust" their partner) • Others may be engaging in couple communication and practicing safer sex to prevent HIV
Benefits of Actual Behavior	• Enjoy unprotected sex • Acceptability among peers • Avoid the reality of the risks involved

HIV negative concordant couples	
Benefits of Desired Behavior	• Prevention of HIV in the couple and their children • Being HIV free makes you financially and socially stable • Avoid cost that would otherwise be incurred due to being HIV positive • Emotional comfort that comes with being HIV negative • Enhances level of trust and communication among couples
Barriers to desired behavior	• Low levels of couple communication • Low quality of CHCT services and capacity of providers to offer risk reduction counseling • Focus of HCT on identifying positives to enroll in ART • Low risk perception • Low levels of social acceptance of condom use among couples • High level of alcohol consumption • Low male involvement
Key Constraint	• Low risk perception: Believe that they are negative and can continue living without HIV
Key Benefit	• If you discuss your HIV status openly with your partner and agree on a plan to protect each other, you will maintain the trust and stability of your relationship.
	Communication Strategy
Communication Objectives	• Increase the proportion of HIV negative couples who are sexually faithful to each other • Increase the proportion of HIV negative concordant couples with high levels of HIV risk perception as reflected in correct consistent condom use
Key promise	• If you remain sexually faithful to each other then it will strengthen your relationship and do away with the fear of transmitting HIV to your children If you use condoms correctly and consistently then you will maintain your HIV negative status and be able to enjoy peace of mind knowing you are both safe from HIV

HIV negative concordant couples	
Desired Action Response	• Now that we understand that we are both HIV-negative, we will make and stick to a risk reduction plan so that we stay un-infected.
Support Points	• Testimonies from concordant negative couples who benefited from CHCT • Existence of support networks within the community • Negative status acts as a motivation/platform for remaining HIV free • Condoms are available and affordable • Use testimonies of couples who have tested concordant negative and lived faithfully and have remained HIV negative • Statistics related to prevalence of HIV amongst couples • Availability of information about HIV prevention
Key message Content	• A concordant couple is where both partners have the same HIV status – they are both negative or both positive. • Most couples tested for HIV will be concordant negative. • The most effective way for you both to stay HIV-negative and to protect each other from HIV is by having sex only with each other. • If either of you has sex with a person whose HIV status is not known and you do not use a condom, you are at very high risk of getting HIV and bringing it into your relationship. • Condoms must always be used if either partner has sex outside the relationship. • The status of other partners can only be determined through HIV testing. • There is a small chance that the test did not detect HIV if you were infected very recently. If you are concerned about a recent exposure to HIV, such as sex with someone whose HIV status you did not know and you did not use a condom, you should get another test in about four weeks. • The package for HIV negative couples should also include information on referrals for services regarding STIs, family planning, care during pregnancy, or support.

HIV negative concordant couples	
	• Condom use: benefits, where to get them, dispel myths • Sexually faithfulness: benefits, dispelling myths and misconceptions
Illustrative Communication	• Video, audio, print testimonials
Channels and Approaches	• Risk reduction planning tool • IEC materials, e.g. brochure on testing negative • Existing support materials: Everyday Health Matters prevention edition (UHMG), others TBD • Referral forms • Supportive counseling/follow up services • Post-test clubs, couples clubs, religious organizations, Tuko clubs (e.g. group sessions, home visits)

HIV positive concordant couples

Audience Analysis

Demographic Profile	• Both partners have had an HIV test and have disclosed to each other • They live in close proximity to HCT services • Older couples who have been married longer more likely to be HIV positive concordant; women (30 – 39 years), men (35 yrs – 45 years) • Middle to high income category • Attained some education • Majority of them have a minimum of primary education • May already have children or be pregnant
Social Profile	• They don't use condoms • Limited discussion of HIV issue prior to taking the test as a couple • Married, unmarried, and co-habiting couples of reproductive age in urban and peri-urban areas • May or may not already be engaged in a sexual relationship • High levels of alcohol consumption among the men • Males are typically the decision makers for sexual and reproductive health • Have access to a radio
Desired Behavior	• Support each other to live positively: Eat well balanced diet, refrain from alcohol, practice OI prevention (eg. sleep under insecticide treated net, screen for TB, boil or purify drinking water, take prophylactic Cotrimoxazole, etc.) • Make and adhere to a prevention for positives risk reduction plan (e.g. couple communication, partner reduction, mutual sexual faithfulness, correct and consistent condom use) • Go for HIV/AIDS and related services together (e.g. ART, TB treatment, STI management, psychosocial support, family planning, PMTCT) • Have their children tested for HIV • Use modern family planning methods to prevent unintended pregnancies • Adhere to their HIV treatment • Join post test couple clubs so as to get support from other positive couples

HIV positive concordant couples	
Actual Behavior	• Often engage in unprotected sex since both members are HIV positive • Unaware of practices to reduce OIs • Rarely test children for HIV • Resigned about life – Why practice prevention if we are HIV positive? • Some break up and move on to other partners who may or may not be HIV positive. No disclosure of HIV status to new partner • Constantly blame each other for transmission of the HIV virus; other relationships break up because of blame and guilt and start new sexual relationships with others without disclosing status or knowing the status of the partner.
Benefits of Actual Behavior	• Live sex • Avoid confronting the problem at hand • Reduced stress and frustration • Saved from costs and time involved in taking children for testing and avoid frustration of knowing children's status
Benefits of Desired Behavior	• Avoid re-infecting each other with a different strain of the virus • Avoid acquiring and infecting each other with STIs • Can plan for the future, such as what to do with your dependents • Can access treatment, care and support to help you live stronger, longer • Can avoid transmitting HIV to future sexual partners • Can avoid transmitting HIV to your children through PMTCT services • Can prolong their lives and stay healthy longer • Can lead a quality life • Can continue to support each other as couples and enjoy the benefit of a healthy relationship

HIV positive concordant couples	
Barriers to desired behavior	• Bitterness and anger about the fact that one has a terminal disease • Anger about having been infected by partner • Stigma and discrimination • Lack of acceptability for use of condoms as a preventive measure • Lack of belief that re infection exists • Feelings of shock, anxiety, depression, and loss may affect the couple's ability to plan effectively for the future • Unaware the children can be tested for HIV or treated for AIDS • Believe that it is expensive to eat a well balanced meal • Believe that ART is expensive and frequently out of stock Fear of being stigmatized
Key Constraint	• Hopelessness about their lives and future
Key Benefit	• Can prolong their lives and stay healthy longer Communication Strategy
Communication Objectives	• Increase the proportion of HIV positive concordant couples who believe they can live a longer, more healthy life by practicing positive living
Key promise	• If you adopt positive living practices you will have a longer, more healthy life
Desired Action Response	• Now that we know we are both HIV positive, we will support each other to live positively.

HIV positive concordant couples

Support Points	• Support networks for PLHA are a source of emotional support • Testimonies from HIV positive concordant couples who tested together and are now living healthy and productive lives • Statistics of HIV positive couples who have lived long and productive lives • Information on the impact of re-infection with other strains of the virus on the immune system • HIV treatment is now available, affordable and free for some groups of people • Supplies and commodities for HIV basic care e.g. Septrin, LLINs, Aquasafe are available and affordable • HIV testing and treatment services are available for children
Key message Content	• The positive living package and how to utilize it • Benefits of the positive living package • Social support groups for PLHA and the benefits of joining such groups • HIV/AIDS related services and where they can be found: ART, PMTCT, TB testing and management, condoms, STI treatment • The benefits of testing children of PLHA for HIV
Illustrative Communication Channels and Approaches	• Video, audio, print testimonials • Risk reduction planning tool • IEC materials, e.g. brochure on testing positive • Existing support materials: Everyday Health Matters prevention and palliative care editions (UHMG), positive prevention brochure (HCP), series of 6 palliative care brochures (UHMG), others TBD • Referral forms • Supportive counseling/follow up services • Post-test clubs, couples clubs, religious organizations, Tuko clubs (e.g. group sessions, home visits)

HIV discordant couples

Audience Analysis

Demographic Profile	• Women (20-39), Men (25-44) • In urban and peri-urban areas • Married or co-habiting • May already have children or be pregnant • May or may not already be engaged in a sexual relationship • Low levels of income and education (have primary education or higher with some steady income and can read and write) • Male spouses have greater access to information and services, as well as financial independence, higher literacy levels than the women
Social Profile	• High levels of alcohol consumption among the men • Males are typically the decision makers for sexual and reproductive health • Limited financial capacity for HCT, ARVs, PMTCT and alternative feedings/options (specifically for women) • High access to radio (consider also media preference and programmes) • In-laws/friends and religious leaders/congregations are influencers
Desired Behavior	• Discuss HIV-status with each other and decide on a plan to protect the un-infected partner • Protect uninfected partner through consistent condom use • Practice mutual sexual faithfulness • Adhere to treatment, care and support plans • Seek HCT services for their children • Go for HIV/AIDS and related services together (e.g. ART, TB treatment, STI management, psychosocial support, family planning, PMTCT)

HIV discordant couples	
Actual Behavior	• Communication breakdown (if they do not separate) • Increase conflict and violence (e.g., sexual and emotional/psychological) • Internal stigma/discrimination (from guilt and shame) • Men (if positive) often demand care from their spouses but will not provide the same if the women are positive • Often decide to separate • Engage in unprotected sex (because of denial, misconception, etc) • Do not test their children for HIV • Fear to nurse spouse for lack of correct information on nursing care/preventive measures
Benefits of Actual Behavior	• Unprotected sex (pleasure) • Temporal relief and postponement of facing reality • Illusion that their children may not be HIV positive • Illusion of being safe
Benefits of Desired Behavior	• CHCT helps reduce transmission among discordant couples by helping couples adopt risk-reduction behaviors, increase condom use, and reduce mother-to-child transmission. • It is very important for the negative partner to stay negative. • The negative partner can be a source of support for the positive partner, both emotionally and in terms of HIV care and treatment. • Should the positive partner become ill or die, having an HIV negative, healthy partner can help ensure the well-being of any children or other household members. • The well-being of the HIV-infected partner directly affects the well-being, welfare, and future of the couple and their family. • Screening children for HIV enhances their well being/ welfare and future of the couple and family

HIV discordant couples	

Barriers to desired behavior	• With HIV discordant couples, the increased risk of infection comes from within stable relationship, rather than from outside sexual partners. Abstinence or condom use within long-term or stable sexual partnerships is rare.
	• Pressures to have children often oblige unprotected sex.
	• Many couples think discordance is very rare, and feel isolated by their test results.
	• Discordance is typically equated with unfaithfulness of the positive partner, which often results in blaming and strained relationships. Couples do not consider that they might have entered their relationship with HIV discordant status.
	• The HIV-infected partner may have greater disclosure concerns.
	• Misconceptions around discordance are highly prevalent:
	  • Co-infection is inevitable – the HIV-negative couple member is actually infected, the virus was just taking time to show up in his/her blood
	  • Some people are immune from HIV infection (referencing "strong blood" and the "O" blood group in particular)
	  • HIV negative status is a reward from God
	  • The virus is sleeping and cannot be transmitted
	  • One partner has been unfaithful
	  • There has been a mistake in the lab
	We have been having sex all this time and never transmitted the virus, so there is no need to start taking precautions now

Key Constraint	• Understanding the reality of discordance
Key Benefit	• Should the positive partner become ill or die, having an HIV negative, healthy partner can help ensure the well-being of any children or other household members.

Communication Strategy

Communication Objectives	• Increase the proportion of HIV discordant couples who understand the reality of discordance in their lives • Increase the proportion of HIV discordant couples who take action to protect the uninfected partner from infection Increase the proportion of HIV discordant couples who support the infected partner to live a healthy and productive life
Key promise	• If you protect the uninfected partner from infection, you will ensure the well-being of any children or other household members
Desired Action Response	• Now that I know that it is possible for one partner to have negative test results while the other is HIV negative, I will choose to use condoms consistently to prevent infection.
Support Points	• Testimonies of PHAs • Existence of post test clubs in the communities • The influence of community groups like mothers' unions in the communities • HIV/AIDS drugs available and free in some health facilities • Condoms are affordable and accessible One out of every 20 couples living together in Uganda is HIV discordant
Key message Content	• The concept of discordance • The benefits of protecting infection to the un-infected partner • How to use condoms • The benefits of joining community support groups • The importance of spousal communication and support • Support required by the infected partner • HIV discordance is NOT a sure sign of infidelity. In many cases, the couple enters their relationship when they are discordant. Less frequently couples become discordant due to outside partners or other exposure to HIV.

HIV discordant couples	
	• A couple can remain HIV discordant for a long time – even more than 10 years. • How to make risk reduction plan
Illustrative Communication Channels and Approaches	• Video, audio, print testimonials • Risk reduction planning tool • IEC materials, e.g. brochure on testing positive • Existing support materials: Everyday Health Matters prevention and palliative care editions (UHMG), positive prevention brochure (HCP), series of 6 palliative care brochures (UHMG), others TBD • Referral forms • Supportive counseling/follow up services • Post-test clubs, couples clubs, religious organizations, Tuko clubs (e.g. group sessions, home visits)

HCT service providers

Audience Analysis

Demographic Profile	• Mostly female • Age range (20-59) • Some married • Some have children • Middle income earners • High literacy levels, speak English • Some of the service providers are living with HIV
Social Profile	• They operate at HC IV, HCIII, Private and NGO clinics • Responsible for provision of other health services, not just HCT, and view HCT as an added responsibility • Have basic training in HCT • Health workers in general • High client load • Work 8-hour days; not available on the weekends • Limited knowledge of other care and support service in the communities • Not trained/skilled in CHCT • Underpaid and de-motivated • Majority have experience of about 5 years • May have stigmatizing attitudes • No mechanisms for addressing burn outs
Desired Behavior	• Facilitate couples to assess their risk to HIV, test for HIV together as a couple and adopt risk reduction plans • Diffuse tension, blaming and conflict in the event of HIV positive test results • Respond favorably toward CHCT clients
Actual Behavior	• Provide low quality CHCT services • Poor attitude towards HCT in general • Rush counseling sessions in order to beat target or address workload • Tend to be impatient with couple duration versus individual duration • For HIV positive service providers there is a tendency to base on personal experience and disregard the uniqueness of the clients Stigmatization of clients occasionally

HCT service providers	
Benefits of Actual Behavior	• Emotional relief for the HIV positive service provider • Reducing service provider workload by rushing through sessions • Able to meet given targets • Do not have to deal with the challenges of testing couples (e.g. blame, tension)
Benefits of Desired Behavior	• With successful couple counseling, the workload for the service provider is reduced if infections are prevented by encouraging risk reduction practices • Recognition and respect for sustained couple relations due to service provider support • Self satisfaction • Self development and career enhancing The opportunity to use lessons from counseling sessions to own life
Barriers to desired behavior Key Constraint Key Benefit	• Limited knowledge and skills for CHCT • Lack of CHCT focused communication tools • Work overload • Lack of motivation • Limited knowledge and skills for delivery of quality CHCT services • Respect and recognition that arise from successfully counseled couples
Communication Strategy	
Communication Objectives	• Increase the proportion of HCT service providers with knowledge and skills to counsel couples • Increase provider willingness to counsel couples
Key promise	• If you make an effort to counsel couples effectively for CHCT, you will be recognized and appreciated in your community.
Desired Action Response	• Now that I have the knowledge and skills to counsel couples, I will help couples to assess their risk for HIV, test for HIV together as a couple and adopt risk reduction plans

HCT service providers	
Support Points	• Testimonies from service providers • Client satisfaction reports • Availability of CHCT trainings and tools on CHCT • HCT policy to be reviewed to address CHCT issues • Information on HIV prevalence among couples
Key message Content	• Concept , benefits of CHCT • CHCT process • Role of service providers in CHCT • HIV/AIDS integrated care service package. • Location of HCT and related services • The influence of positive attitude towards couple on their motivation to adopt risk reduction plans
Illustrative Communication Channels and Approaches	• Updated CHCT training manual and training • Print materials (e.g. risk reduction planning tool, pre/ post test counseling aid, cue cards, client request forms, flipcharts) • Radio program/radio distance learning program • Video, audio, print testimonials • Give-aways for provider recognition, e.g. labeled aprons, pens, diaries, T shirts, calendars • Branded service delivery points

Religious Leaders

Audience Analysis

Demographic Profile	• Male and female • Age 25+ years • May be married, may not be married • Some have children, others do not • Income ranges from low to high • Education levels vary; have religious training
Social Profile	• Highly influential in social and religious matters • Honored and respected in their congregations and in the community • Very knowledgeable about what's happening in the community • Interact regularly with the congregation (at least once/week) • Preside over funerals, weddings • Conduct home pastoral visits, e.g. to pray for the sick, provide spiritual counseling, follow up on those infected and affected • Often used as a medium of communication when there's a problem (e.g. polio outbreak) • Listen well • Some have other vocations (e.g. teachers) • Engage in community meetings, visit schools, make ward rounds in hospitals • Typically devote a day for counseling • Provide pre-marital counseling through group and individual couple sessions • They advocate on behalf of their congregations on priority issues (people's mouth piece)
Desired Behavior	• Integrate CHCT messages into their sermons and other pastoral activities • Mobilize couples to go for CHCT through institutional structures, e.g. Mother's Unions, Father's Unions, Head of Laity • Provide on-going support after testing through institutional structures • Dispel rumors and misconceptions (i.e. preach that "God works through Medical workers using their scientific knowledge to heal) Disseminate facts on HCT and HIV and AIDS in general

Religious Leaders	
Actual Behavior	• Communicate indirectly about CHCT • Often do not directly acknowledge HIV and AIDS but refer to them in the abstract or in an oversimplified way • May reference CHCT in pre-marital counseling sessions, but not in a formal or routine manner Some FBOs provide HIV/AIDS-related health services
Benefits of Actual Behavior	• Can avoid talking about sensitive and difficult issues • Allows religious leaders to communicate in a socially acceptable manner
Benefits of Desired Behavior	• Religious leaders will be in a position to communicate effectively about CHCT • Will feel empowered and more respected by being able to deal with this issue • It will help to strengthen couple relationships within the congregation • It will contribute to overall health of the congregation (e.g. by identifying those who are HIV positive and referring them for treatment, care and support; by preventing infection to negative partners) It is likely to have a "multiplier effect", whereby members of the congregation who have heard the messages then pass them on to others
Barriers to desired behavior	• Limited knowledge on what to communicate, low access to information • Fear of talking about difficult issues • HIV is perceived to be the result of immoral behavior (e.g. associated with promiscuity) • Misconceptions about discordance • Belief in healing powers (if you pray, you will be healed) • Lack of an effective referral system • HIV-related stigma
Key Constraint	• Limited knowledge and access to information about CHCT
Key Benefit	• Feeling of confidence that comes from being able to communicate effectively about CHCT and making a positive contribution to the society. • Couple counseling will enhance fidelity among the married and will promote the marriage institution

Communication Strategy

Communication Objectives	• Increase the number of religious leaders with accurate knowledge about CHCT, discordance, availability of services, and the importance of couples testing together • Increase the number of religious leaders who are supportive of CHCT and campaign goals through institutional structures, sermons and activities • Increase the number of religious leaders who motivate couples to go for CHCT services • Increase the number of religious leaders who provide ongoing support to couples after testing through institutional structures
Key promise	• If you communicate openly with couples around CHCT, you will be a trusted and respected leader in your community.
Desired Action Response	• Now that I know how and what to communicate to couples about CHCT, I will motivate couples to go for CHCT services.
Support Points	• Religious leaders have a captive audience and a platform from which to integrate CHCT messages • CHCT services are available in the community • Multimedia channels will provide reinforcement and supportive information (e.g. radio spots) • Post-test clubs are available for follow-up after testing • Reference materials will be available for religious leaders and members of the congregation • Campaign messages are in line with religious leaders overall mission (e.g. no outside sexual partners); the campaign reinforces what they are already doing, rather that diverting
Key message Content	• Benefits of CHCT • CHCT process • Discordance • Location of HCT and related services Linkages to scripture

Illustrative Communication Channels and Approaches	• Orientation meetings • Talking points • Video, audio, print testimonials • Flyers with locations and times of CHCT services • Print materials (e.g. CHCT campaign posters, Everyday Health Matters, palliative care brochures) • Utilize existing religious structures, e.g. Mothers' Unions, Fathers' Unions, Head of Laity

Implementation Arrangements

The success of the campaign hinges on the expertise and participation of HCT stakeholders throughout the country. The Ministry of Health AIDS Control Programme (ACP) will serve as the major coordinating body for this campaign. AIDS Information Center (AIC) will be the lead implementing agency, given their experience with HCT and couple counseling, and testing and facility readiness to respond to anticipated client needs. The Health Communication Partnership (HCP) will provide technical assistance to the design, implementation, monitoring and evaluation of the communication campaign through funding from USAID/Uganda.

The meaningful involvement of HCT service providers, people living with HIV/AIDS, community members, those implementing HIV prevention activities in the districts and/or communities, those engaged in treatment, care and support services, as well as those dealing in commodities and supplies is also of utmost importance. Partner roles and timelines will be agreed upon and MOUs signed at various levels.

There will be need for a strong and active coordinating body for the communication campaign and testing events. As such, a CT17 subcommittee, known as the national campaign coordination committee, will meet regularly to ensure timely execution of activites, sharing of infomation among partners and address any arising issues pertaining to the campaign. Communication and advocacy, service delivery, and monitoring and evaluation committees will be established within this national campaign coordination committee. HCP will lead the communication team, AIC will lead the service delivery team, and MOH will lead the monitoring and evaluation and coordination committees.

Further, HCP will engage the services of an advertising agency for creative design of campaign concepts and materials, as well as media placement. The Communication and Advocacy and Coordination committees will be responsible for reviewing, pre-testing, and approving all materials prior to production and dissemination.

In keeping with HCP's mandate to build capacity for and institutionalize strategic communication expertise, HCP will assist AIC to manage and oversee the couple counselling and testing campaign on behalf of the ACP. HCP will enter into a sub-agreement with AIC and work closely with its staff to transfer skills, and strengthen its capacity to manage the campaign on behalf of ACP and its partners.

Research, Monitoring and Evaluation

A Research, Monitoring and Evaluation (RM&E) subcommittee will develop a formal RM&E plan for the CHCT communication campaign. It is anticipated that the RM&E plan will have three major components: formative assessments, monitoring of the implementation process, and impact evaluation. Illustrative activities in these categories are outlined below.

Formative Assessments:

- Literature review, to assess the current CHCT context in Uganda
- Facility assessment, to determine health facilities to provide CHCT during the campaign, identify gaps, and map HIV/AIDS services to inform referrals
- Concept testing, to determine the most convincing messages for the target audiences
- Pre-testing of campaign and provider materials, to determine their appropriateness, relevance and acceptability

Monitoring of the Implementation Process:

- Uptake of CHCT services before, after and during the campaign
- Monitoring of test kit/commodities supply
- Regular support supervision visits
- Reports of community/PLHA/faith-based activities
- Assessments of client satisfaction
- Identification of success and challenges in the implementation of provider tools and community mobilization approaches
- Media monitoring

Impact Evaluation:

- Pre/post-training performance assessment for CHCT counselors
- Household survey to determine exposure to the campaign and changes in knowledge, attitudes and practices surrounding CHCT. HCP fielded such a survey in 2008, and has plans for a follow-up in 2010.

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Appendix A: List of CHCT Communication Strategy Partners

Name	Organization
Francis Nahamya Dr. Raymond Byaruhanga Daniel Lukenge	AIDS Information Centre
Penninah Kyoyagala	CCF
Nafuna Wamai	CDC
Ian McConnell	Clinton Foundation
Janet Nerima	Freelance consultant
Lillian Nakato Jennifer Orkis Cheryl Lettenmaier Ruth Musekura	Health Communication Partnership
Dr. Alex Coutinho	IDI
Edrine Namayanja Dr. Jennifer Namusubo	Makerere/Mbarara University Joint AIDS Program (MJAP)
Dr. Namata	Mildmay
Dr. Zainab Akol Michael Muyonga Jane Nabalonzi Sam Enginyu Ruth Kawesa Nina Lugumba Dr. Alex Ario	MOH
John Baguma	NMS
Joy Elizabeth Ogutu	PATCH consultants
Sarah Mbabazi	Population Services International (PSI)
Linda Birungi Demeter Namuyobo	RHU
Karen Drysdale	Salama Shield
Teddy Chimulwa Janet Bahizi	SCOT
Sophie Nantume	TASO
Rose Nalwadda	Uganda AIDS Commission
Wilberforce Musolo	UHMG
Rosemary Kindyomunda	UNFPA
Justine Mirembe Rhobbinah Ssempebwa Andrew Kyambadde	USAID
Beatrice Crahay Dr. Innocent Nuwagira	WHO


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