HIV AND AIDS

URC is working with national HIV programs and partners in many of the world’s highest HIV-burdened countries to achieve UNAIDS and PEPFAR 95-95-95 goals. Our work aims to:

- Improve the quality, availability, and consistency of HIV testing and treatment;
- Prevent HIV transmission, including reducing the stigma for getting tested and seeking treatment; and
- Conduct research that helps us to carry out the most effective programs possible.

THE CHALLENGE

Approximately 36.9 million people are living with HIV. Nearly 1 million people die every year because they don’t know they have HIV or they start treatment too late. Many people with HIV—and those at risk for HIV infection—do not have access to prevention, treatment, and care. Adolescent girls and young women, in particular, have difficulty obtaining quality, youth-friendly sexual and reproductive care and HIV prevention and treatment services.

HIV impacts households, communities, and the development and economic growth of nations. Many of the countries hardest hit by HIV also face serious health and social challenges, such as tuberculosis, sexually transmitted infections, malaria, poor access to clean water, and economic and political instability.

IMPROVING HIV TREATMENT

As coverage of HIV prevention, care, and treatment services expands and programs mature, greater attention is being paid to the ability of health systems to provide and sustain high-quality HIV and AIDS services. URC-led programs are working to ensure that health professionals are performing at their highest levels and that health centers and hospitals are...
employing best practices and have the appropriate tools for HIV and AIDS testing and treatment.

In Uganda, URC and our partners are implementing a range of health improvement initiatives—including HIV and AIDS prevention, testing, and treatment measures—through the USAID Regional Health Integration to Enhance Services-North, Acholi Project. The five-year effort is working in eight districts in northern Uganda to ensure that district health systems follow HIV and AIDS best practices and support healthy behaviors at individual and community levels. For example, during the last three months of 2018, the project enrolled 2,379 new HIV-positive adults and children on antiretroviral therapy (ART)—183 percent of the project’s goal. URC also implements the USAID Regional Health Integration to Enhance Services in East Central Uganda (RHITES-EC) Project. RHITES-EC is supporting the Uganda Ministry of Health to increase the use of high-quality health care services within 11 districts in east-central Uganda.

In Burundi, URC is implementing quality improvement (QI) activities for the Reaching an AIDS-Free Generation (RAFG) Activity, a five-year USAID/PEPFAR-funded project. URC is ensuring QI activities are integrated in all the targeted provinces for the program, which is scaling up ART for people living with HIV using an integrated, community-based approach in high-prevalence provinces. We have helped establish QI teams at all RAFG-supported sites. These teams are implementing best practices and designing new ways of ensuring testing is linked to ART, that there is treatment adherence and retention at facility and community levels, and that patients are regularly tested for viral loads.

URC is working with the U.S. Centers for Disease Control and Prevention (CDC) in several countries in Africa and Central America to strengthen HIV testing and treatment. In Eswatini for example, URC is strengthening local capacity to deliver sustainable, quality coverage of clinical HIV and tuberculosis services in the Lubombo Region and provide technical assistance to the Eswatini National AIDS Program. We have supported the scale-up of adult and pediatric HIV clinical services at 42 sites throughout the region and increased the number of facilities providing ART and combined non-communicable disease/HIV services from 36 to 42. URC developed and disseminated the Lubombo Regional health work plan for 2017/2018 and continues to monitor this tool for improving system performance.

Also for the CDC, URC is implementing a five-year lab services improvement project in Malawi to provide mentorship and training to facilitate the development and implementation of the National Lab Strategic Plan and quality improvement and accreditation programs. The project’s priority areas are: expanding viral load testing and early infant diagnosis; quality assurance; strengthening laboratory management toward national accreditation standards; and improving transportation of test samples.

In 2018, the project’s fourth year, it:
- Achieved 110 percent of its goal of testing 374,357 viral load samples;
- Trained dozens of lab technicians and personnel in quality control, internal auditing, and early infant diagnosis and viral load testing; and
- Helped 100 percent of labs pass viral load external quality assessment testing.

And in Lesotho, URC is increasing access to diagnosis and monitoring services by scaling-up cost-effective technologies and improving lab quality.

**PREVENTING HIV TRANSMISSION AND REDUCING STIGMA**

HIV transmission is aided by misinformation, myths, and stigma. For example, the more shame associated with contracting HIV, the less likely people living with
the virus will seek treatment. The most effective treatment for HIV is to prevent its transmission. URC is leading programs to reduce HIV stigma, improve public knowledge of HIV, and limit the spread of HIV.

For many women living with HIV, giving birth to a HIV-negative child seems unlikely, if not impossible. But women in east-central Uganda are learning their fears are not necessarily true thanks in part to the efforts of the USAID RHITES-EC Activity. RHITES-EC is supporting the Uganda Ministry of Health to increase the use of high-quality health care services within 11 districts in east-central Uganda. For example, RHITES-EC worked with Jinja Regional Referral Hospital to create peer support groups and other prevention of mother-to-child transmission activities. From January-November 2018, 166 pregnant women participated in these activities. More than 95 percent of their babies were born HIV-free and will receive follow-up care until 18 months of age.

Voluntary medical male circumcision (VMMC) reduces the risk of female-to-male sexual transmission of HIV by approximately 60 percent, according to the World Health Organization. URC and our partners have been implementing continuous quality improvement in VMMC services in eight countries since 2012, including ongoing programs in Uganda, Lesotho, and South Africa. For example, URC is leading a consortium of organizations implementing USAID VMMC South Africa, which has been carrying out public campaigns to reduce men’s fear of the procedure and the mandatory six-weeks of abstinence following a circumcision. The project circumcised more than 300,000 men in an 18-month period beginning in 2017, averting many HIV infections.

The URC-led PrevenSida Project, working in five Central American countries through 2020, is helping to reduce HIV and AIDS transmission among key populations: men who have sex with men, transgender women, sex workers, people living with HIV, the indigenous Garifuna people in Honduras, and others. The project’s central focus is helping local academic institutions and civil society organizations in Guatemala, Honduras, El Salvador, Nicaragua, and Panama improve their ability to research and manage knowledge related to the HIV epidemic among these populations. PrevenSida, which began in 2010, has helped dozens of civil society organizations obtain financial grants and coaching to improve their administrative and financial processes, among other assistance. In 2018, the project supported an HIV Social Determinants of Health analysis gathering, attended by 22 civil society organizations and 178 people from Guatemala, Honduras, and Nicaragua. The event helped attendees improve their ability to understand and react to the cultural influences affecting HIV transmission.

FROM RESEARCH TO RESULTS ON HIV

URC conducts research that sheds light on the hidden factors influencing the success—and failure—of HIV and other health initiatives. Why do some people living with HIV decline to begin treatment? How can we encourage young women to avoid risky behavior that puts them at risk
of contracting HIV? What’s the association between health worker morale and the performance of their facilities?

In Uganda more than 6 percent of the country’s population is living with HIV. But enrolling all who need ART requires overcoming cultural barriers that deter people from seeking treatment, according to research by the USAID Applying Science to Strengthen and Improve Systems (ASSIST) project. ASSIST conducted a root cause analysis in March 2018 with 341 people from the north, east central, eastern, and southwest Uganda who had tested positive for HIV in the last month but who had not started ART. Many of the interviewees, no matter the region, said they did not begin treatment because of concerns about starting a lifelong ART regimen, such as side effects from the drugs or not having enough food to consume with the drugs. However, some interviewees also were afraid of the stigma of being associated with HIV. Still others felt healthy and didn’t believe the accuracy of the test results.

Preventing vulnerable populations from contracting HIV—including adolescent girls and young women (AGYW)—is an important tactic in getting the HIV epidemic under control. AGYW account for 74 percent of new HIV infections among adolescents in sub-Saharan Africa.

DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) is an ambitious public-private partnership to reduce rates of HIV among AGYW in the 10 sub-Saharan African countries with the highest HIV burden: Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. DREAMS works to empower not only AGYW, but also those that influence them, including parents, caregivers, and male sexual partners. DREAMS, launched in 2015, is supported by the U.S. President’s Emergency Plan for AIDS Relief, the Bill & Melinda Gates Foundation, Girl Effect, Johnson & Johnson, Gilead Sciences, and ViiV Healthcare.

The ASSIST Project carried out HIV-prevention efforts in four of the 10 DREAMS-implementing districts in Uganda for more than two years, achieving significant reductions in HIV incidence rates among AGYW. The project formed QI teams composed of AGYW, caregivers, and influential members of the community who were willing to discuss, plan, implement, monitor, and evaluate HIV prevention efforts. This QI approach allowed the teams to address barriers to behavioral change among AGYW at high risk of HIV infection. It also empowered the teams to mobilize community resources to stop risky behavior. Church leaders stepped up to act as points of condom distribution, male sexual partners allowed their spouses to participate in regular meetings in the community, girls and their partners agreed to test for HIV, and there was a new willingness to prevent and report domestic violence.

Follow-up research indicates that the proportion of AGYW experiencing sexual and other forms of gender-based violence decreased from 49 percent at baseline to 19.5 percent due to QI teams targeting parents and partners. The program registered an HIV incidence rate of 0.76 per 1,000 participants during its two years—significantly below Uganda’s incidence rate of 2.98 per 1,000 adults between 15 to 49 years old.

In Tanzania, the ASSIST Project examined the association between levels of health worker engagement—a measure of employee job satisfaction—and facility performance. Using data collected from 1,329 health workers and 183 health facilities across six regions in Tanzania, ASSIST found four main characteristics of engagement: job satisfaction, being accountable, being a team player, and delivering equitable care. All four characteristics of engagement were associated with improved HIV care and outcomes. This shows that interventions to improve job satisfaction—a characteristic of engagement—can positively impact facility performance. However, facility performance cannot be improved through engaged workers alone and should be coupled with other efforts to address gaps beyond human resources.