



The Republic of Uganda

NATIONAL HIV PREVENTION STRATEGY 2011-2015

Expanding and Doing HIV Prevention Better

NOVEMBER 2011

UGANDA AIDS COMMISSION



National HIV Prevention Strategy 2011 - 2015

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FOREWORD

About 25 years ago, Uganda became the first country to acknowledge the presence of the devastating Human Immunodeficiency Virus (HIV) epidemic. Since then, over 2.5 million people in the country have died due to AIDS, and more than 120,000 people were infected with HIV in 2010. Currently, there are more than 1.2 million people living with HIV infection in the country. Nearly everyone has lost a close relative or friend to this devastating epidemic.

The epidemic in our country is now at crossroads. On one hand, scientific breakthrough and on the other hand efforts to scale up AIDS treatment have significantly improved the quality of life of those infected. On the other, many HIV-infected people are not yet accessing treatment, and more worryingly, new HIV infections still exceed our ability to provide treatment. Therefore, right now, we are experiencing an expanding epidemic that demands renewed commitment, increased public attention, and leadership.

Our National Development Plan (2010-15) demands accelerated HIV prevention in order to drastically reduce new infections by 2015. This is contingent not only on increased coverage and uptake of HIV prevention services, but also focusing on effective interventions. In order to do this, a National HIV Prevention Strategy has been developed with a clear goal of reversing the trend of the epidemic.

The strategy has five objectives: (1) increasing adoption of safer sexual behaviour and reduction of risk-taking behaviour; (2) attaining critical coverage of effective HIV prevention services; (3) creating a sustainable enabling environment that mitigates the underlying structural drivers of the epidemic; (4) re-engaging leadership and re-energizing coordination for HIV prevention; and (5) improving strategic information for HIV-prevention. The strategy sets ambitious targets and has identified a combination of HIV prevention strategies comprising behavioural, biomedical and structural interventions as the mechanism to attain these targets.

To accomplish these goals, we must undertake a more coordinated national response to the epidemic. In order to achieve this, the government will require a well-resourced multi-sectoral national response at all levels including private sector, communities, faith-based organizations, scientific community, People Living with HIV and others.

This moment represents a unique opportunity. Now is the time to build on and refocus our efforts to deliver better results for our people. The government is committed to renewing national leadership in response to HIV/AIDS and to increase resources. We look forward to working with development partners, communities and other stakeholders to support implementation of this innovative strategy that is grounded in scientific evidence, focuses on current priorities, and provides a clear direction for moving forward together.



Yoweri Kaguta Museveni

PRESIDENT OF THE REPUBLIC OF UGANDA

PREFACE

The National HIV Prevention Strategy aims at mobilizing all stakeholders to work towards eliminating new HIV infections, putting an end to stigma and discrimination, and halting deaths from AIDS-related conditions by the year 2015. The work plans for all sectors including those of our partners are to be aligned to this Strategy. The strategy is ambitious; but ambitious we must be if we are to reverse the trend of this epidemic. The challenge to the public is for you as an individual to play your part. You have the power to protect yourself, your children and others; the power to relate with respect and understanding to fellow citizens afflicted by HIV instead of discriminating against them as well as the power to seek treatment, care and support if you get infected and to advise others to do the same.

The first step is for us to embark on raising a generation of Ugandans who are free from HIV by ensuring that no baby is born with HIV. It calls for every pregnant mother to seek antenatal care as early as after missing two menstrual periods. All facilities offering antenatal care must have the capacity to test every mother for HIV as part of antenatal care and to institute treatment for a mother that tests positive, following guidelines issued by the Ministry of Health. The treatment aims to achieve two objectives i.e. the care for the mother's health and protection of the baby. It is also in the interest of the baby for the father to support its' mother. He should rise to the challenge and get tested too. Evidence suggests that most of the infections could be coming from fathers.

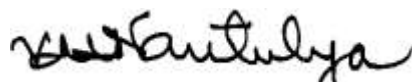
Secondly for the youth in and out of school, they too have the responsibility for HIV Prevention. This should begin with keeping themselves HIV negative, rejection of risky behaviours and ensuring that they protect others from infection and support those in need of treatment, care and social support. In addition, let the parents, teachers and other local community leaders (local council, religious leaders, clan leaders and others) should play their roles in guiding and protecting youth from behaviours and practices that can expose them HIV infection. The youth ought to be guided to stay in school and complete both primary and secondary education and to delay their sexual debut as well as marriage until after maturity as by law established. Young girls need protection from older men who exploit them sexually using all sorts of coercion. All youth need protection from the now rising trend of exposure to pornography and wrong information through mass media and video shows. Health providers should offer youth friendly services so that the youth can access interventions like HIV counseling and testing, information on safe sexual behaviours, safe male circumcision, condom supplies, treatment, care and support for those infected and affected.

Thirdly for the adults, the starting point is to take an HIV test so that you can get to know your sero-status. If you test negative, of which 94% of Ugandans are; there is a package of interventions for you such as advice on safe sex behaviour, condom use, and access to free and safe male circumcision. There is also a package for HIV positive individuals which includes: access to treatment, care and support, condom use to avoid acquiring super infection with drug resistant strains of the virus and advice on positive living so as to stop spread of the infection to other members of society. Recent evidence shows that many Ugandans have become complacent about risk-taking lifestyles such as engaging in multiple concurrent sexual partnerships. Close to 89% of new infections occur in adults engaging in multiple concurrent sexual partnerships while 10% are due to transmission of infections from parents to their babies. Here is a word of caution, if you choose an unsafe sexual lifestyle. Let it be clear to you that although anti-retroviral therapy is life-saving and must not be denied to any Ugandan who needs to be put on treatment, the drugs are not curative. They are to be taken daily for life, are not easy to take because they cause serious side effects and require strict adherence to the treatment regimen. Noncompliance will result in drug resistance with associated consequences of treatment failure requiring

change of drug combinations. Our fellow Ugandans who are on this treatment are taking the drugs not out of choice, but rather that the drugs are life-saving. It is not wise, therefore, to be casual about it and to needlessly expose yourself to the risk of infection.

Fourth, for the strategy to succeed, we must engage our leaders. The Uganda AIDS Commission and Ministry of Health should equip the political leaders at all levels with appropriate messages for delivery to the people in their constituencies as well as engage all leaders to provide an environment of zero tolerance to behaviour and practices that predispose the communities they lead to HIV infection.. Religious leaders played an important role at the beginning of this epidemic by sending clear messages to their flock and requiring HIV testing for brides and bridegrooms as part of marriage counseling. These and many more supportive practices need to be resumed. Cultural leaders too, should re-engage and deliver messages to their subjects. The cultural norms and practices that expose individuals to HIV risk such as widow inheritance, wife sharing and replacement, polygamy, early marriages, sex and gender based violence must be addressed. Legislation and regulations already in place against these practices need to be enforced. The public must in addition be protected from misleading and confusing messages in the mass media and bill boards. This will be through the enforcement of a clearing mechanism for all public health messages about HIV and AIDS by Uganda AIDS Commission and the Ministry of Health.

Finally, interventions by all the sectors need to be well resourced to ensure effective implementation of this strategy. On the other hand, implementers ought to be both accountable for and innovative enough to do more with limited resources.



Prof. Vinand Nantulya
CHAIRMAN OF UGANDA AIDS COMMISSION

ACKNOWLEDGEMENTS

The National HIV Prevention Strategy (2011-2015) was developed using an inclusive and broad consultative process amongst the HIV prevention stakeholders in the country. The process was led by the National HIV Prevention Committee of the HIV/AIDS Partnership and the Uganda AIDS Commission. The strategy was developed during 2010/11, based on a review of existing HIV prevention interventions in the country and consultations with stakeholders in the public and private sector, including People Living with HIV, and development partners. It also includes recommendations from the Expert Think Tank that was set up by the National HIV Prevention Committee. The strategy complements existing planning frameworks including the National HIV/AIDS Strategic Plan and the Health Sector Strategic and Investment Plan. The entire task was led by a team of three consultants: Dr. Wilford Kirungi, Dr. Paulo Bukuluki and Mr. Julius Mukobe; to whom special thanks are offered

Editing was done by UAC and UNAIDS under the leadership of the Chair of the UAC Board. Notably, the following persons deserve mention: Prof. Vinand Nantulya, Dr. David Kihumuro Apuuli, Dr. Jesse Kagimba, Dr. Zepher Karyabakabo, Dr. David Tigawalana, Ms. Catherine Barasa, Mr. Julius Byenkya and Dr. Peter Mukobi.

During the process of developing the strategy and the accompanying action plan, the following constituencies were consulted: Stakeholders in six districts of (Gulu, Bushenyi, Lyantonde, Wakiso, Kayunga and Busia), Public Sector entities including key line ministries, the Ministry of Health AIDS Control Programme (ACP) and related technical units, Civil society organizations and networks of People Living with HIV (PLHIV) and AIDS Development Partners Group (ADPG)

The Uganda AIDS Commission would like to thank all those who helped elaborate this strategy, provided information and data, or critically reviewed the earlier drafts. Particular thanks go to colleagues and staff at Ministry of Health (MoH), District Health Offices and District AIDS Coordination Offices who made it possible for national and district level consultations to take place with an impressive array of representatives from various constituencies. The members of the National HIV Prevention Committee and the Expert Think Tank are duly acknowledged for their professional guidance and technical input they provided during the process.

The development of the strategy was supported through a grant from the United Kingdom (UK) Department for International Development (DFID) Office in Kampala, USAID and Irish AID channeled through the Joint UN Programme on AIDS Country Office in Kampala (UNAIDS). All development partners and the United Nations (UN) Joint Team on AIDS are greatly applauded for their technical input as well as financial support to the task.


Dr David Kihumuro Apuuli
DIRECTOR GENERAL

ABBREVIATIONS AND ACRONYMS

ACP	AIDS Control Program
ADP	AIDS Development Partner
ADPG	AIDS Development Partner Group
AIDS	Acquired Immunodeficiency Syndrome
AIS	AIDS Indicator Survey
ART	Anti-Retroviral Therapy
BCC	Behaviour Change Communication
CDC	US Centers for Disease Control and Prevention
CSO	Civil Society Organization
DAC	District AIDS Committee
DFID	Department for International Development
EPP	Estimations and Projections Package
GoU	Government of Uganda
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSHASP	Health Sector HIV/AIDS Strategic Plan
HSS	Health System Strengthening
IEC	Information, Education and Communication
MDG	Millennium Development Goal
MoFPED	Ministry of Finance, Planning and Economic Development
MoGLSD	Ministry of Gender, Labor and Social Development
MoH	Ministry of Health
NAADS	National Agricultural Advisory Services
NDP	National Development Plan

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NPC	National HIV Prevention Committee
NPS	National Prevention Strategy
NSP	National HIV/AIDS Strategic Plan
PEP	HIV Post Exposure Prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PHDP	Positive Health, Dignity and Prevention
PLHIV	People living with HIV
PMTCT	Prevention of Mother to Child Transmission
SGBV	Sexual and Gender-based Violence
SMC	Safe Male Circumcision
SRH	Sexual and Reproductive Health
UAC	Uganda AIDS Commission
UBTS	Uganda Blood Transfusion Service
UHSBS	Uganda Health Sero Behavioural Survey
UNAIDS	Joint United Nations Program on HIV and AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
USG	United States Government

EXECUTIVE SUMMARY

The Government of Uganda has identified HIV prevention as a priority in the National Development Plan (2010-15) and set a 40 percent target to reduce new HIV infections by 2015. Although HIV prevalence during the past decade has been stable around 6-7 percent among adults, the number of new HIV infections estimated to be over 120,000 last year, is unacceptably high.

There are several reasons why despite 25 years of implementing multiple HIV prevention interventions, new HIV infections remain high. First, most interventions are on a scale that is insufficient to make significant public health impact. Second, most HIV prevention interventions are not aligned with sources of new infections. Third, is complacency which has led to a reversal of widespread risky sexual behaviour and low levels of comprehensive knowledge about HIV prevention. While increasing HIV and AIDS care and treatment in recent years has been fairly successful, saving lives and providing relief to people living with HIV and preventing some new infections, long-term sustainability of HIV and AIDS programs requires intensified and increased effectiveness of HIV prevention to avert the rising new infections.

The vision of this National HIV Prevention Strategy (2011-2015) is based on the global commitment to *zero new HIV infections, zero AIDS-related deaths and zero discrimination*. The overall goal of the strategy is to reduce the HIV incidence by at least 30 percent based on 2009 baseline. This will result into 40 percent reduction of the projected number of new HIV infections by 2015, in line with the HIV prevention targets in the National Development Plan and avert about 180,000 new infections over five years. Virtual elimination of vertical transmission of HIV is an integral part of this overall goal.

Based on current knowledge of the key drivers and risk factors of HIV transmission in Uganda, the objectives of the National HIV Prevention Strategy are:

1. To increase adoption of safer sexual behaviours and reduce risk taking behaviours.
2. To expand to critical coverage and utilization of biomedical prevention interventions.
3. To create a sustainable enabling environment that mitigates underlying socio-cultural and other structural drivers of the epidemic.
4. To achieve a more coordinated HIV prevention response.
5. To strengthen information systems for HIV prevention at all levels.

In line with the epidemiology of HIV in the country and global best practices and recommendations, the strategy calls for effective combination of HIV prevention strategies. The combination of HIV prevention strategies comprises a structured package of proven behavioural, biomedical, and structural interventions. This approach will be informed by robust and sound analysis of drivers of the epidemic in specific contexts and evolving epidemic patterns, as well as the focus and scope of HIV prevention efforts and evolving scientific evidence of various interventions.

The National HIV Prevention Strategy identifies minimum HIV prevention packages for the general population, key populations, People Living with HIV and other population groups. Key evidence-informed interventions in the packages that must be scaled up to critical levels of 80-90 percent coverage are: Evidence-informed behaviour change interventions, Prevention of Mother to Child Transmission, Safe Male Circumcision, Anti-Retroviral Therapy and condom promotion. Other complimentary services comprising Sexually Transmitted Infections treatment, medical infection control and Positive Health, Dignity and Prevention should also be scaled up and tailored to specific population groups. Furthermore, programs should simultaneously address underlying factors that constrain HIV

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prevention at individual level. This includes harmful socio-cultural and gender norms, inequitable access to services, gender-based violence, stigma and discrimination.

Research, monitoring, and evaluation will be integral components of all initiatives in order to track achievement of results. The ambitious targets in the strategy hold institutions and stakeholders accountable for results and all implementing partners are urged to scale-up efforts to attain them.

This National HIV Prevention Strategy (2011-2015) is aligned with the National Development Plan, National Strategic Plan for HIV/AIDS, Second National Health Policy, and Health Sector Strategic and Investment Plan (2010-15). It will contribute to attainment of universal access to HIV prevention, care and treatment, targets of United Nations General Assembly Special Session on HIV and AIDS and Millennium Development Goal 6 targets of halting and reversing the HIV epidemic by 2015. It calls for increased focus, coordination and collaboration to comprehensively scale-up HIV prevention efforts and align them with the drivers of the epidemic.

This strategy identifies a set of priorities and strategies to attain measurable outcomes. Along with the strategy is an Action Plan (2011-2013) that outlines specific actions that need to be taken by implementing partners in the short and medium-term to support the priorities laid out in the strategy. The strategy calls for ongoing research in the dynamics of populations and specific behaviours that have the potential to increase HIV transmission.

Coordinated by Uganda AIDS Commission, the strategy is the outcome of public, private and civil society consultations. Its implementation requires partners to build unprecedented levels of partnerships to support referral linkages so that individuals and communities are provided with a minimum set of complementary services. This includes collaboration in program design and implementation, close coordination and genuine engagement of stakeholders at all levels. Community leaders should demonstrate committed leadership by ensuring effective functionality of partnerships at various levels.

Along with improved coordination and leadership, under the National HIV Prevention Strategy, partners face the task of mobilizing additional resources for the expanded program and to realign HIV prevention resources to support priority interventions that will have the greatest impact on new infections. This shift is vital in view of the evolution of the epidemic and the changes in the risk factors and drivers of the epidemic.

The National HIV Prevention Strategy represents a genuine opportunity to re-invigorate HIV prevention efforts throughout the country and advocates for *“Expanding and Doing HIV Prevention Better”*. It strengthens the engagement and participation of all stakeholders working in HIV prevention in Uganda.

1.0 INTRODUCTION

Uganda continues to experience an increasing number of new Human Immunodeficiency Virus (HIV) infections every year, estimated at 124,000 in 2009 and 128,000 in 2010. The number of new infections outstrips annual enrolment into Anti-Retroviral Therapy (ART) by two-fold. If the *status quo* continues, the HIV burden is projected to increase by 700,000 new infections over the next five years.

There are multiple reasons why, despite 25 years of implementing various HIV prevention interventions, new HIV infections remain high. First, most interventions are still on a scale that is insufficient to make significant public health impact. Second, most HIV prevention interventions are not aligned with sources of new infections. Third, as a result of complacency, there is now a return to widespread risky sexual behaviour and low comprehensive knowledge of HIV prevention in the population as was at the very beginning of the epidemic. While scaling up HIV and Acquired Immune Deficiency Syndrome (AIDS) care and treatment in recent years has been fairly successful saving lives and providing relief to people living with HIV as well as preventing some new infections, long-term sustainability of the HIV and AIDS programs requires intensified and increased effectiveness of HIV prevention.

The Government of Uganda (GoU) has identified HIV prevention as a priority in the National Development Plan 2010-15 (NDP) and set to reduce new HIV infections by 40 percent by 2015. To achieve this, the GoU conceived the need for a new HIV prevention strategy in 2010. The strategy builds on previous efforts of the National HIV/AIDS Strategic Plan (NSP) 2007/8-11/12, the 2006 Road Map towards Accelerated HIV Prevention and efforts of local and international stakeholders.

This National HIV Prevention Strategy will guide the reinvigoration of HIV Prevention in the country. It aims to increase the coverage and effectiveness of HIV prevention through a framework that is aligned through a set of priority and effective HIV prevention interventions, to the known sources of new HIV infections and to population groups that are most at risk.

1.1 DEVELOPMENT OF THE NATIONAL HIV PREVENTION STRATEGY

Development of the National HIV Prevention Strategy (NPS 2011-2015) was a highly participatory process preceded by a review of the epidemiology and drivers of the epidemic as well as the scope, coverage and effectiveness of existing HIV prevention interventions in the country (UAC, 2010). It involved consultations with Technical Working Groups (TWGs) of key HIV interventions including HIV Counseling and Testing (HCT), Safe Male Circumcision (SMC), Prevention of Mother to Child Transmission (PMTCT), networks for key populations and other stakeholders such as the Gender and HIV and AIDS Sub-Committee. Consultations were also conducted with the AIDS Development Partners Group (ADPG), especially United Nations Joint Team on AIDS, United Nations Country Team (UNCT), the President's Emergency Plan for AIDS Relief (PEPFAR) and the Department for International Development (DFID). This was to ensure that the partners' priorities were aligned with the national strategy. Six districts with unique population groups or HIV interventions (Busia, Kayunga, Gulu, Lyantonde, Wakiso and Bushenyi) were also consulted. To enhance stakeholder involvement and ownership of the strategy, national level stakeholder workshops were organized for the public sector, Faith-Based Organizations (FBOs), People Living with HIV (PLHIV) and Civil Society Organizations (CSOs).

The National HIV Prevention Committee (NPC) co-opted a Think Tank to review and validate recommendations, targets and priorities. Finally, the NPC validated the National HIV Prevention Strategy

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(2011-2015) and Action Plan (2011-2013). The Prevention Strategy and Action Plan were approved by the Uganda AIDS Commission Board.

Guiding Principles in the Development of this Strategy:

This strategy takes into account the following principles of effective HIV prevention (UNAIDS, 2005):

- Prevention of new HIV infections will be a national priority and an integral part of the development process of the country. The strategy is aligned with the NDP and other international development frameworks and initiatives that Uganda subscribes to.
- Prevention of HIV infections requires the involvement and participation of the entire society as well as strong political and government commitment.
- Responsibility and accountability for results will be key to achieving high quality and universally accessible HIV prevention services.
- HIV prevention interventions will be based on scientifically and ethically sound approaches, respecting values, rights and diversity of people while promoting gender equity.
- The promotion, protection and respect for human rights are a basic right of the people of Uganda and measures will be taken to eliminate all forms of stigma and discrimination.
- Human rights of PLHIV will be respected and their participation in HIV prevention policy development, programming, implementation and evaluation will be ensured.
- Programs and interventions will be “people-centered”, empowering communities, families and individuals to develop responses to challenges and threats and to learn from experiences of others in similar areas.

1.2 ALIGNMENT WITH THE NDP AND OTHER PLANNING FRAMEWORKS

The National HIV Prevention Strategy is aligned with the major national planning frameworks; specifically, the NDP, third Health Sector Strategic and Investment Plan 2010-15 (HSSIP), Health Sector HIV/AIDS Strategic Plan 2011-15 (HSHASP), NSP and sector plans of key line ministries. In this regard, the strategy will streamline the implementation of the HIV prevention component of these broader development frameworks. In particular, the goals, targets and indicators in this strategy and action plan are aligned with the broader frameworks. It is critical that the strategy is aligned with sector budgeting processes and timelines so that HIV prevention is financed as part of the development processes in the country.

The HIV Prevention Strategy is also aligned with other international development frameworks, conventions and commitments to which Uganda is signatory. These include the Millennium Development Goals (MDGs) 3, 4, 5, 6 and 7, United Nations General Assembly Special Session on HIV and AIDS (UNGASS) and Universal Access targets as well as the Abuja Declaration of Heads of States, among others. Furthermore, it is expected that the development partners will align their HIV prevention strategies and plans with the National HIV prevention Strategy.

The strategy is organized under the following sections. Section 2 summarizes the background and context for the strategy, section 3 covers the scope and coverage of the current HIV prevention programs in the country while section 4 sets out the national vision, goals, expected outcomes, indicators and targets as well as key HIV prevention priorities. Section 5 highlights the priorities and strategies for reduction of risky sexual behaviour while section 6 covers priorities and strategies for increased coverage and utilization of biomedical HIV prevention services. Section 7 focuses on strategies for a sustainable environment that

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mitigates the underlying drivers of the epidemic while section 8 highlights the strategies for coordination of HIV prevention at all levels. Section 9 lays out the strategies for management of strategic information. In section 10, implementation arrangements as well as performance and impact measurement for the strategy are presented. The HIV Prevention Action Plan for the short and medium term is presented in a separate volume (UAC, 2011). The cost estimates for implementing the strategy will be presented separately.

This strategy has been developed to guide all stakeholders and implementing partners involved in the planning, implementation and financing of HIV prevention activities in Uganda.

2.0 BACKGROUND AND CONTEXT

Uganda is experiencing a severe generalized HIV epidemic. Current estimates indicate that about 1.2 million people in the country are living with HIV, 57 percent of them female and 13 percent children less than 15 years (MoH, 2010). There were about 124,000 new HIV infections in 2009, 20 percent of them among children and 55 percent among women. This number of new HIV infections was two-fold the net enrolment into ART in 2009. The 2004-05 Uganda HIV Sero Behavioural Survey (UHSBS) reported that 6.4 percent of adults were living with HIV and current estimates show the same level of HIV prevalence, although the absolute number of HIV-infected people is greater owing to the high population growth. Among adults age below 50 years, women consistently had higher HIV prevalence than their male counterparts (MoH, 2006). A new national AIDS Indicator Survey (AIS) is currently underway and will provide updated estimates before the end of the year.

The mode of HIV transmission in Uganda is predominantly heterosexual, accounting for 75-80 percent of new HIV infections while vertical transmission accounts for 20 percent. Blood borne and other modes of transmission probably account for less than 1 percent (UAC, 2009). Although the main mode of HIV transmission is heterosexual, the population groups most affected and the risk factors and drivers of HIV transmission appear to have evolved in recent years. Currently, the majority of new infections are in the context of stable long term partnerships, driven in part by multiple (especially concurrent) partnerships, extra-marital relations as well as transactional, early and cross generational sex¹. HIV transmission involving sex-workers and bridging to the general population probably accounts for about 10 percent of new HIV infections. In line with this, the majority of people infected has shifted from unmarried younger individuals in the 1980s and 1990s to older individuals aged 30-35 years, who are more likely to be married or in long-term relationships. The new strategy takes this dynamic into account.

Although Uganda has a generalized HIV epidemic; the geographical, socio-demographic and economic heterogeneity of HIV prevalence revealed in the 2004-05 UHSBS probably still persists, with the Mid-north, Central and Kampala regions having highest HIV-prevalence (over 8 percent). This heterogeneity reflects the distribution of risk factors such as multiple partnerships, Sexually Transmitted Infections (STIs) especially herpes simplex virus (HSV-2) infection and low male circumcision. More recent data also show heterogeneity of HIV prevalence among population groups. For instance, population groups with HIV prevalence exceeding that in the general population include: sex workers at 37 percent (Vandepitte *et al.*, 2011), fishing communities at 22 percent (Opio A. *et al.*, 2011), partners of sex workers (18 percent), small group of men with history of having sex with men (13 percent) and men who operate motorcycle transport known as “*Bodaboda*” at 8 percent (MUSPH & CDC, 2009). With recent data, students in six universities had lower prevalence of HIV average 1.2 percent (EALP & IUCAE, 2010).

Despite significant declines in HIV prevalence and incidence during the 1990s, HIV prevalence in Uganda remained stable during the past decade, but with increasing HIV prevalence in some groups or geographical areas (Biraro S. *et al.*, 2009). Although recent population-wide sexual behaviour statistics are not available, data obtained during 2005 indicated a mixed picture. Some behaviours such as primary abstinence among girls continued to show positive trends while at the same time, primary abstinence among young men and condom use during casual sex tended to be low. In fact, half of all risky (casual) sexual acts in 2006 were not consistently protected with condoms.

¹ Throughout this document, cross-generational sex refers to sexual relations between teen-age girls (15-19 years) with male partners that are at least 10 years older.

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It is well known that behavioural and biological risk factors for HIV epidemics evolve with the stage of the epidemic. As HIV epidemics evolve, the associated risk factors and drivers also change. The latest synthesis of data from various sources showed that the current modifiable risk factors for HIV transmission in Uganda comprise multiple partnerships, HIV sero-discordance, inconsistent condom use, infection with STIs especially HSV-2 and lack of male circumcision (Mermin *et al.*, 2008). These factors operate amidst many other non-modifiable socio-demographic factors such as urban residence, older age, being married or formerly married, being female and residence in northern Uganda, implying the need for focused interventions among these groups. This strategy aims to address these changed dynamics.

There is also growing recognition of the importance of socio-cultural, gender, structural and other underlying factors in driving the HIV epidemic in sub-Saharan Africa. These factors operate at a distal level to influence the proximate risk factors for HIV infection, including influencing uptake of HIV prevention services and sexual behaviour. In Uganda, these factors include:

- Behavioural factors such as multiple sexual partnerships, cross-generational, early and transactional sex, sex work, alcohol and substance abuse.
- Harmful socio-cultural practices and gender norms, gender-based violence, violation of rights of women and girls, polygamy, widow inheritance, stigma and discrimination.
- Socio-economic factors driving the epidemic include mobility, migrant work, poverty and wealth.
- Policy related factors include inequitable access to health services, weak governance, accountability and coordination. These factors are discussed in detail in the review report (UAC, 2010).

The approach in this strategy is designed to take the evolving importance of these factors into account.

Key affected populations

Although Uganda's HIV epidemic is generalized affecting all population groups, there are key populations that are more susceptible to the above factors and therefore bear a disproportionate burden of HIV. These groups play special roles in bridging infections to the general population. Hence, research on the demographics and dynamics of the epidemic is needed to guide future actions. The National HIV Prevention Strategy has taken into account these epidemic dynamics as a prerequisite for making a significant dent in the tide of new HIV infections in the country. The strategy makes a case for provision of tailored services for these groups, in addition to services for the general population based on a comprehensive package of appropriate interventions. Currently in the Ugandan context, the key population groups include:

Sex Workers and their partners:

It is estimated that sex workers, their clients and partners of the clients contribute 10 percent of new HIV infections in Uganda. Recent data show that sex workers have 5-6 times higher prevalence of HIV compared to the general population. The high HIV risk among sex workers arises from extensive multiple sexual partnerships with very complex sexual networks involving their clients, partners of their clients and eventually bridging to the general population. They also have high rates of unprotected sex, alcohol and drug abuse. Sex workers often face barriers in access to prevention services for the general population and require targeted services. Other structural factors such as legal barriers and stigmatization, among others, are simultaneously addressed in this HIV prevention strategy.

Fisher folk:

Among fishing communities, vulnerability to HIV stems from their perceived hyper-masculinity norms and subcultures of risk taking. Fishermen are often detached from their families for long periods, and have little appreciation of marriage and fidelity. They have daily cash income that they use for commercial sex and casual sexual relationships. Landing sites also attract sex workers. Health seeking behaviour including for HIV prevention services is often poor and services are often unavailable or offered at inaccessible time. The population size of fishing communities is currently not known; however, the United States Government (USG) is currently supporting GoU to undertake size estimation and mapping. This group needs dedicated and targeted comprehensive HIV prevention services tailored to their life style.

Uniformed services:

People in armed forces are often subject to deployments away from home and to places which are not adequately reached by essential services. They are also often paid their salaries when away from home. Consequently, with liquid cash in pocket, it is easy to be tempted to alcohol and casual sex. The risk of death at the battlefield instigates fatalistic attitudes among soldiers against protection from HIV infection, which they often perceive as a long term or remote threat compared to death at battlefield lines. Comprehensive HIV prevention services at the workplace are therefore necessary for this group.

Long distance truckers:

Long distance truckers constitute a special group of mobile men with money that often spread HIV through engagement with multiple partners along major transit routes. A workplace policy for long distance truckers would be ideal, but it has not been adequately rolled out. There are very few HIV prevention programs along highways, with limited scope and coverage. Further, there is limited strategic information including the number of truckers, HIV burden, behavioural practices and quality and coverage of HIV prevention programs.

Injecting Drug Users (IDU) and Men who have Sex with Men (MSM):

It is globally acknowledged that IDU and MSM play a major role in HIV transmission. However, in Uganda we do not have sufficient information on these population groups. The only available information is limited to small sample sizes and geographical areas. It will be important to keep an eye on these population groups since we do not have sufficient information on them.

3.0 STATUS OF HIV PREVENTION SERVICES IN UGANDA

3.1 EFFECTIVENESS OF HIV PREVENTION INTERVENTIONS

Uganda has implemented various HIV prevention interventions for over twenty five years. The interventions evolved over time as more scientific knowledge emerged. However, the existing interventions in the country have not yet attained universal coverage nor are they always delivered in a structured combination. They are also often not adequately evaluated for effectiveness.

Current educational and behavioural interventions in the country comprise mass media, interpersonal communication, community mobilization, work place programs and life skills training in schools. Biomedical services comprise PMTCT, treatment of STIs, medical infection control, HIV post-exposure prophylaxis (PEP), condom promotion and blood transfusion safety. More recent interventions include Positive Health, Dignity and Prevention (PHDP) and SMC of males. However, the country has not yet achieved universal coverage of these interventions while rural areas and key populations remain particularly underserved.

The effectiveness of the interventions varies widely, with none being 100 percent effective in all population groups. All the interventions achieved only partial effectiveness in clinical trials and are probably less effective in program settings. For instance, SMC in trials reduced HIV acquisition by 50-60 percent among men over two years while combination Anti-Retro Viral (ARV) prophylaxis for PMTCT averted 50-80 percent of vertical infections. Syndromic management of STI was not found to reduce HIV incidence in 8 of 9 randomized controlled trials. The effectiveness of male latex condoms at population level is affected by inconsistent use. Condom effectiveness has been demonstrated with casual partners and key populations and they also reduced HIV incidence among sero-discordant couples by 85 percent in one cohort study. However, even inconsistent use has some level of protection (Weller and Davis, 2001). More recent evidence has demonstrated the effectiveness of combination ARVs in HIV prevention in various settings. For instance, early administration of ARVs to HIV infected partners in discordant couples reduced HIV transmission by up to 96 percent. Pre-exposure prophylaxis (PrEP) with ARVs to the non-infected partner in an HIV sero discordant relationship among MSM reduced HIV acquisition by up to 70 percent. However, there is insufficient evidence that this intervention can work in a generalized heterogeneous epidemic.

3.2 COVERAGE AND INTEGRATION OF HIV SERVICES

The coverage of HIV services in the country is still suboptimal, for instance:

- Only 52 percent of HIV-positive pregnant women had access to ARVs for PMTCT in 2009 (MoH, 2009).
- Approximately 30-40 percent of adults have ever tested for HIV and less know the status of their partners.
- In 2007, less than 10 percent of facilities had effective medical infection control procedures and PEP.
- 60 percent of facilities had integrated STI case management (MoH and Macro, 2008) but access to STI services remains a challenge due to drug stock-outs.
- Nearly half of risky sexual acts were not protected by condoms in 2005.

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- The coverage of PHDP (MoH, 2010)², and risk reduction counseling in HCT are still inadequate.

The new strategy advocates for scaling up of proven interventions to attain critical levels of coverage. Integration of services remains a challenge. For instance, the integration of PMTCT prongs 1, 2 and 4 (primary HIV prevention, family planning, and long term family HIV and AIDS Care and ART) into other services remains low. Risk reduction counseling in HCT and for women who test HIV negative in PMTCT, couple counseling and testing, and integration of HIV prevention into Sexual Reproductive Health (SRH) and maternal health services all have suboptimal coverage. Furthermore, referral linkages between HIV prevention services such as HCT, SMC and blood transfusion is low, yet synergies between them would be mutually beneficial. The new HIV prevention strategy advocates for integration of key HIV prevention, care and treatment, SRH, and other health services.

Although educational and behaviour change intervention guidelines, policies and standards are available, there is limited use for planning and implementation. They are also often not aligned with factors driving the epidemic. Social cultural norms that influence behaviour are often neglected. Key populations such as fishing communities, sex workers and road construction workers are not adequately targeted. Comprehensive HIV prevention knowledge was less than 40 percent in 2005. Furthermore, behavioural data trends showed tendency towards worsening risky behaviour (especially multiple partnerships, decreased abstinence and decreased condom use). This HIV prevention strategy provides for sustainable behaviour change approaches with a focus on behavioural and structural drivers.

Although, HIV and AIDS is a key priority in the NDP (2010-15), mainstreaming of HIV prevention in development programs remains suboptimal, yet this would provide opportunities for mainstreaming HIV in the work place and addressing the structural drivers. Vocational, apprenticeship skills and micro-credit schemes often do not mainstream HIV prevention. Engagement of communities, cultural structures and social networks to address harmful socio-cultural norms and practices is still suboptimal. Relevant policy and legal frameworks with a potential to address gender imbalances such as the Marriage and Divorce bill (2010), Domestic Violence Act (2010), and National Gender Policy (2007), among others, are constrained by enforcement weaknesses. Development programs such as Universal Primary and Secondary Education, and Expanding Social Protection Program (ESPP) have potential to reduce vulnerability to HIV and AIDS, but mainstreaming of HIV in these efforts is still suboptimal. This HIV prevention strategy advocates for leveraging all the development efforts to mainstream HIV prevention.

3.3 FUNDING OF HIV PREVENTION

The government contribution to HIV/AIDS funding has increased over the years, but in order to implement this ambitious strategy more funding is needed. During 2007/08; USh130, 965,713,573 was spent on HIV prevention, but declined by 9 percent in 2008/09. In the same period, care and treatment expenditure increased from 43 percent to 48 percent respectively of all HIV and AIDS expenditure. Expenditure figures disaggregated by specific interventions or beneficiary groups were not available. However, the Civil Society Fund (CSF), by June 2009, had disbursed 51 percent of the HIV prevention resources (Ushs 21,180,360,653) to abstinence and be faithful (AB) activities, 0.7 percent to PMTCT, 5.4 percent to HCT, 5.8 percent to condoms and 38 percent to other HIV prevention areas (key populations, medical infection control, and SMC). This is not aligned with the modes of HIV transmission. Similarly, PEPFAR which funds most of

² MoH: STD/ACP: Status of antiretroviral Therapy Services in Uganda: Draft Annual Report for 2010, MoH, Kampala, Uganda, March 2011

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Uganda's national HIV response, obligated 33 percent of HIV prevention resources in 2008/09 (Ushs 86, 481,519,769) to PMTCT, and 34 percent to A and B behaviour campaigns. Just like in the 2008 Modes of HIV Transmission (MoTs) synthesis, A and B received disproportionately more funding than other HIV prevention activities.

Although GoU has increased its contribution to HIV care and treatment in recent years (US\$30 million in 2010/11), this indirectly contributes to HIV prevention. There is need for efficient and effective use of resources by targeting what works and populations with highest sources of new HIV infections.

In view of the HIV epidemic evolving in recent years, under the new HIV Prevention Strategy, partners will need to re-align HIV prevention resources with interventions likely to have the greatest impact on new infections. There is also need for efficiency gains and a sustainable financing plan. Fortunately, the USG that funds most HIV prevention activities has already taken steps to align its funding priorities with the Modes of HIV Transmission (MoTs) analysis. However, it should be noted that effort will be made to reduce dependency on donor support towards the national response.

3.4 STRATEGIC INFORMATION FOR HIV PREVENTION

Uganda has systems and plans for tracking impact, outcomes and coverage of HIV prevention; however, the systems and plans, especially for behavioural and structural interventions, are inadequate. Although HIV incidence data is used to track the epidemic and impact of HIV prevention, the surveillance system is often unable to provide timely and comprehensive data, and doesn't provide incidence data for sub-national levels. Intermediate program outcomes are tracked mainly through periodic population and facility-based surveys, but available data is out of date; although a new national AIDS indicator Survey (AIS) and Demographic Health Survey (DHS) are already underway and will provide baseline data for this strategy.

While the coverage of biomedical services is fairly well tracked by the Health Management Information System (HMIS), information on behavioural and structural interventions is not. In addition, impact evaluation of interventions is often *ad hoc*. Furthermore, HIV prevention data is rarely consolidated and periodic reports are often not available. The National Performance Monitoring and Measurement Plan (PMMP) at UAC is not operational and has weak linkages with sector systems. This new strategy will require improved monitoring, evaluation and reporting as well as sharing of programmatic and surveillance data.

3.5 COORDINATION OF HIV PREVENTION

The framework for coordination of HIV and AIDS programs is based on the multi-sectoral approach spearheaded by the Uganda AIDS Commission (UAC). UAC works through the HIV and AIDS Partnership composed of Self Coordinating Entities (SCEs) which constitutes the Partnership Forum. The HIV and AIDS Partnership Committee (PC) is the steering committee for the Partnership Forum. For HIV prevention, the National Prevention committee (NPC) provides technical and policy advisory support for HIV prevention, working in partnership with thematic Technical Working Groups (TWGs) such as PMTCT, HCT, SMC, and Information Education and Communication/Behaviour Change communication (IEC/BCC) in MoH and UAC. UAC also works in partnership with networks of private sector organizations such as Uganda National AIDS Service Organization (UNASO), National Forum of People Living with HIV and AIDS Network in Uganda (NAFOPHANU), and Inter Religious Council of Uganda (IRCU) in coordinating these entities.

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At sector level, line ministries are expected to coordinate all stakeholders implementing activities within the sectors. The MoH AIDS Control Program (ACP) is expected to coordinate stakeholders in the health sector. At district level, multi-sectoral coordination is implemented through District AIDS Committees (DACs), and District AIDS Task Teams (DATs).

However, there are leadership and coordination gaps in the national HIV response. The leadership for HIV prevention at all levels has slackened, and UAC faces human, financial and logistical resources as well as organizational challenges. Coordination within the health sector and non-health sectors is weak although remedial steps are being taken. Coordination structures at district level are weak, often non-existent, and underfunded. Similarly, linkages between health facilities and community structures, as well as those between public and civil society programmes are weak.

In view of the crucial role of leadership and coordination, the critical gaps are to be addressed in the expanded phase of HIV prevention as proposed in this HIV Prevention Strategy.

4.0 VISION, GOALS AND OUTCOMES OF THE HIV PREVENTION STRATEGY

This HIV Prevention strategy has been developed to guide planning and implementation of high impact HIV prevention initiatives during the next five years in order to change the trajectory of new infections. It provides guidance on how to target efforts in line with the drivers of the epidemic. The vision, mission and goals of the strategy are as follows:

4.1 VISION

The vision of this strategy is consistent with the UNAIDS Vision to attain “Zero new HIV infections, Zero discrimination and Zero-AIDS-related deaths” by 2015.

4.2 MISSION

The mission of the National HIV Prevention Strategy is to serve as a resource for stakeholders to strengthen planning, implementation, and monitoring of high quality HIV prevention interventions within a multi-sectoral response in the country. This will improve the effectiveness of HIV prevention in Uganda through improved targeting of key population groups, with priority interventions, delivered through effective combinations of strategies at multiple levels.

4.3 GOAL

The goal of the National HIV Prevention Strategy is to reduce HIV incidence by 30 percent³ from the 2009 levels which will result into 40 percent reduction of the projected number of new infections in 2015. Virtual elimination of mother-to-child HIV transmission is part of this overall goal⁴. This is projected to avert about 180,000 new infections over five years as illustrated in the following Figure 1.0.

³ The Task Team considered various scenarios in setting targets for this goal. A reduction of 30 percent of new HIV infection based on 2009 levels numbers of new HIV infections equates to a 40 percent reduction of the projected number of new HIV infections in 2015 in line with the NDP status quo was maintained, and would reduce new HIV infection to less than 100,000 in 2015. This will be less than the current estimate of annual number of infections, and would avert over 180,000 new infections over 5 years. A reduction of less than 30 percent would result in over 100,000 infections in 2010, implying that would not be getting ahead of the epidemic.

⁴ The task team considered the scenarios required to reduce MTCT rate to less than 10 percent from the current 29 percent. It requires simultaneously reducing new HIV infections among reproductive age women by 50%, elimination of the unmet need for FP among HIV-infected women, enrolment of at least 90 percent of HIV-positive women on triple combination ARV prophylaxis from pregnancy, labour and throughout breast feeding, and reduce the median period of breast feeding to 6 months.

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This is an ambitious goal, it reflects the urgency of the challenge and it is in line with NDP and MDG 6 targets. To achieve this goal, it is imperative that critical interventions be scaled up and focused on groups and areas that have the highest incidence of HIV.

4.4 OUTCOMES, INDICATORS AND TARGETS

The National HIV Prevention Strategy focuses on the following interrelated outcomes:

1. Increased adoption of safer sexual behaviours and reduction of risky behaviours;
2. Attained critical coverage and utilization of HIV prevention biomedical interventions;
3. Strengthened and sustainable enabling environment that mitigates underlying factors that drive the HIV epidemic;
4. Strengthened information systems for HIV prevention
5. Increased leadership and coordination of HIV prevention interventions at all levels

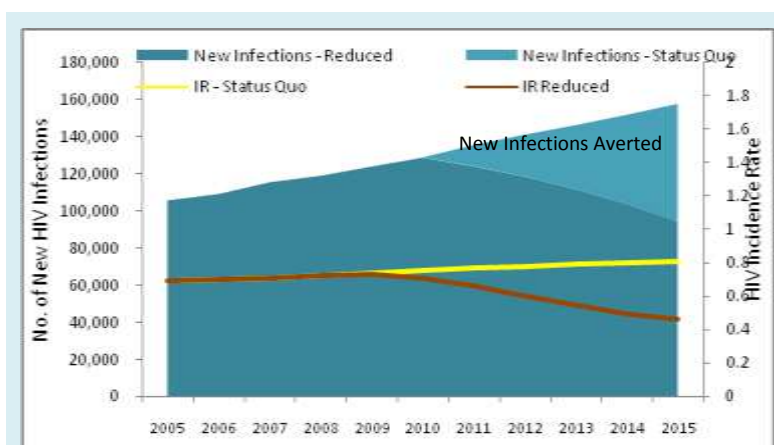


Fig 1.0: Annual numbers of new HIV infections (and new infections averted) and HIV incident rate under 2 scenarios – (i) Status Quo, and (ii) New HIV infections reduced by 30%

The intermediate results and indicators for tracking them are summarized in the following Table 1.0.

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Table 1.0: Outcomes, monitoring indicators and targets for the National HIV Prevention Strategy

Outcomes	Indicators and Targets
1. Increased safer sexual behaviour and reduced risky behaviors	<ul style="list-style-type: none"> • Recent multiple partnerships reduced by 50% among men and women respectively • Transactional sex among men and women reduced by 50% • Cross-generational sex and early sex reduced by at least 50% by 2015 • Casual sex reduced by at least 50% by 2015 • Sexual debut below 18 years eliminated
2. Attained critical coverage and utilization of HIV biomedical prevention services	<ul style="list-style-type: none"> • The proportion of HIV-infected mothers and exposed infants accessing PMTCT increased to 90% • The proportion of adults who have recently tested for HIV (past year) increased to 25% • The proportion of adults males that are circumcised increased to 80% • The proportion of clinically eligible ART clients enrolled on treatment increased to 80% • Consistent use of condoms during risky sex encounters (multiple partnerships, casual sex, and sex with partners of unknown HIV sero-status) increased to 80% • All HIV care and treatment outlets will have integrated HIV prevention • All facilities implementing blood transfusion safety and universal infection control measures
3. A strengthened and sustainable enabling environment that mitigates underlying factors that drive the HIV epidemic	<ul style="list-style-type: none"> • Increased women emancipation e.g. women who make decisions about their SRH independently or jointly with partners increased from 61% to 80% • SGBV among women reduced from 39% to 10% • % SGBV survivors helped by social service organizations increased from 23% to 60%. • Stigma and discrimination eliminated by 2015 • % of adults who believe that a wife is justified to refuse sex with her husband if he has an STD increased to 100% from 84 % women and 90% men • Ratio of orphans: non-orphans (10-14 years) attending school increased from 0.9 to 0.96 • % OVC and non-OVC (5-17 years) whose basic needs⁵ are met increased from 28% to 50% • Childhood marriages eliminated by 2015
4. Strengthened information systems for HIV prevention	<ul style="list-style-type: none"> • Data on new HIV infections tracked annually and disseminated • Population/facility surveys of HIV prevention outcomes conducted every 3-5 years • All major HIV prevention interventions evaluated for impact • Annual reports of HIV prevention comparing outcomes/outputs against targets, produced • All significant HIV Preventions programs have M&E systems and plans

⁵ Basic needs include clothing, shelter, nutrition/food

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Outcomes	Indicators and Targets
	<ul style="list-style-type: none"> Population size and HIV burden of at least five key populations determined by 2015
5. Achieving a more coordinated HIV prevention response at all levels	<ul style="list-style-type: none"> National Composite Policy index for coordination increased from 67.5% (2005) to 85% All districts having functional HIV coordination structures All districts having functional PHA networks HIV/AIDS spending increased from 3% (baseline for 2004) to 5% of total annual national budget HIV Prevention expenditure increased from 25% (UNGASS 2010) to 40% of HIV/AIDS budget 100% local governments allocating funds from local revenues for HIV prevention

4.5 HIV PREVENTION PRIORITIES

The National HIV Prevention Strategy provides guidance on how to align efforts with drivers of the epidemic. Since Uganda is experiencing a mature generalized HIV epidemic with multiple drivers, HIV prevention approaches will be based on a combination of prevention strategies involving a package of effective behavioural, biomedical and structural interventions tailored to specific population groups. This is in line with UNAIDS recommendation that an HIV prevention approach based solely on one element doesn't work; that countries should use a mix of behavioural, biomedical and structural HIV prevention actions that suit their epidemic and the needs of those most at risk (UNAIDS, 2009). This requires coordinated evidence-informed strategies which jointly work to achieve shared HIV prevention goals, based on sound analysis of the drivers of the epidemic in different contexts.

The first priority for HIV prevention in Uganda is to align HIV prevention interventions with the drivers of the epidemic. With approximately 80 percent of HIV infections arising from sexual transmission, 20 percent from vertical infections which themselves are a product of sexual transmission, and less than 1 percent from blood borne infections, the priority for Uganda is to adequately address the key driver of the epidemic within a generalized epidemic, that is, HIV transmission through unsafe sex. Since there are also geographic hotspots typical of a concentrated epidemic and key populations with risk behaviours that make them more vulnerable to HIV infection than the general population, these too should be the focus of HIV prevention efforts.

There are two distinct groups among the youth, those who are not yet sexually active and those who are sexually active. Youth who are not yet sexually active in and out of school should be given sexual education to delay sexual debut and also to acquire skills about the risks associated with sex. The boys should receive safe male circumcision while children born to HIV positive parents should be tested for HIV early and receive appropriate services.

For the sexually active population group, the entry point to intervention services is HCT because results will determine the package of behavioural and biomedical services that are necessary

The priority for behavioural interventions should be to:

- Delay sexual debut
- Eliminate unsafe sex
- Reduce multiple, especially concurrent sexual partnerships

- Discourage cross-generational and transactional sex

The priority biomedical interventions will be evidence-informed, and will include (Figure 2.0):

- Promoting correct and consistent condom use in the general population and high risk groups
- Wide coverage of safe male circumcision
- Prevention of Mother-to-Child Transmission of HIV
- Reducing community viral load through anti-retroviral therapy and appropriate ARV prophylaxis.

Furthermore, harmful socio-cultural and gender norms which promote masculinity and femininity, Sexual Gender-Based Violence (SGBV), and multiple partnerships, stigma and discrimination, and structural constructs that facilitate transmission of HIV should be concurrently addressed, along with behaviours that increase risk, such as excessive alcohol consumption.

The priority target audiences for prevention interventions include:

- Youth prior to sexual debut
- Youth engaged in cross-generational sex relationships and their partners
- Adults and youth involved in multiple sexual partnerships
- Men and women who engage in transactional sex and their clients
- Adults working away from home, e.g. transport and migrant workers, uniformed services
- Residents of high prevalence areas and epidemic hotspots such as urban slums, northern Uganda, transportation corridors, border crossing points and fishing landing sites.

4.6 OTHER HIV PREVENTION PRIORITIES

Even if the first priority is to reduce HIV infections from sexual contact; other priority interventions include scaling up high quality services for prevention with HIV-positives, medical infection control, and blood transfusion safety. However, epidemic dynamics and patterns evolve; therefore it is possible that factors that drive the HIV epidemic today will change in the future. The National HIV Prevention Strategy will be reviewed and updated as the knowledge base and experience grow. There will also be ongoing surveillance of risk behaviours among IDUs and MSM that have potential for upsurge of new infections, but for which there is insufficient data to warrant ranking them high among HIV prevention priorities. However, this presents opportunity for early intervention with preventive messages about the risk associated with these practices and pointing out what safety measures would control HIV transmission in this population sub-group.

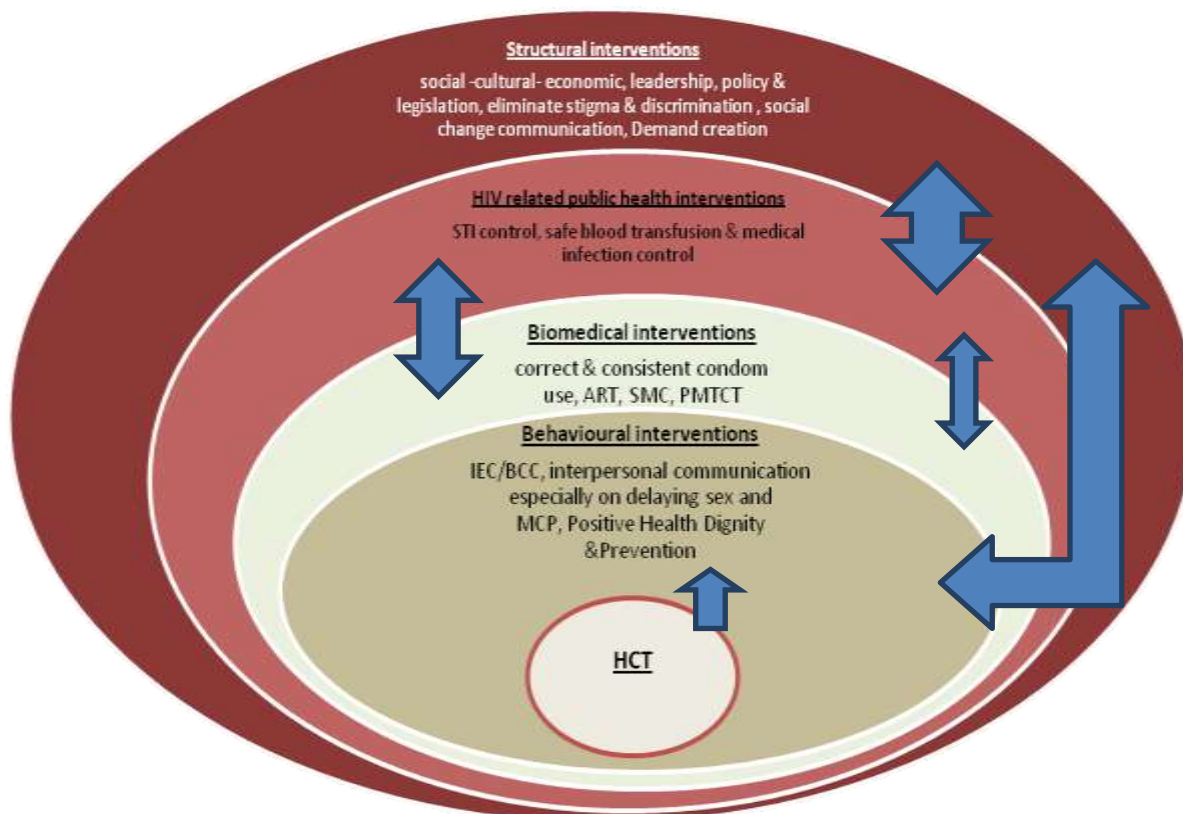
4.6.1 COMBINATION OF HIV PREVENTION STRATEGIES

There is currently no single HIV prevention intervention or “magic bullet” that is sufficient to prevent all HIV transmissions in all population groups in Uganda where the epidemic is driven by multiple behavioural, biomedical and structural drivers. Uganda’s approach to HIV prevention in the next phase will be based on combination approaches, comprising priority and effective behavioural, biomedical and structural interventions.

The strategy of combining prevention approaches involves implementing multiple prevention interventions of known efficacy in a geographic area at a scale, quality and intensity to impact the epidemic. The combination prevention strategies will be most effective if the interventions impede different points in the HIV transmission cycle, by combining strategies to reduce susceptibility of uninfected individuals and strategies to reduce infectiousness of persons living with HIV.

Currently, HIV prevention services in the country are on a scale that is insufficient to change the tide of the epidemic. Therefore, scaling up as well as ensuring a structured combination of HIV prevention interventions to critical levels of coverage will be needed to turn the epidemic around. This is the central aim of this Strategy. The conceptual framework for the strategy is given in the following Figure 2.

Fig 2.0: Conceptual combination HIV prevention interventions in the general population



Adapted from "Turning off the Tap" a book to be published by Vinand M Nantulya

Under this framework, HCT service is an entry point for the population to access appropriate integrated packages of services depending on the test results. For the individuals who test negative, the package of services whose purpose is to help keep the individuals negative includes delayed sexual debut as a positive behaviour, reduction of multiple sexual partners, safe male circumcision and correct and consistent condom use .

For individuals who test positive, the package of services will include behaviour change, linkage to care and treatment, PMTCT, condom use and opportunistic infection management. Family planning is an integral part of the package.

The framework takes into consideration the health and community systems needed to ensure increased demand and provision of quality HIV prevention services including STI management, infection control and blood safety.

Also considered are community-wide and national interventions to mitigate cultural norms and practices, as well as national policy, regulations, leadership and socioeconomic drivers of the epidemic. Under socio-cultural drivers, community dialogue to identify harmful values and norms are recommended.

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The combination of interventions, defined by age, gender and sero-status is summarized in the Table 2 below.

Table 2.0: Minimum packages for HIV prevention interventions disaggregated by sex, age and sero-status

Category	Interventions for HIV Sero-Negative	Interventions for HIV Sero-Positive
Children and youth (in and out of school)	<ul style="list-style-type: none"> Sexual education to delay sex debut and acquisition of skills about risks associated with sex Discourage cross-generation and transactional sex Discourage unsafe sex HCT Safe male Circumcision for boys Blood transfusion safety and infection control Socialize boys and girls against SGBV Address socio-cultural and socio-economic factors that create vulnerability to HIV infection Premarital counseling for youth above 18 years 	<ul style="list-style-type: none"> Sexual education to delay sex debut and acquisition of skills about risks associated with sex Discourage unsafe sex ART and ART adherence STI screening and treatment Blood transfusion safety and infection control Treatment of other health conditions – TB, malaria, sanitation, nutrition Risk reduction counseling Psychosocial and spiritual support Support groups for PLHIV Eliminate stigma and discrimination Address issues of SGBV Address socio-cultural and socio-economic factors to mitigate the effects of HIV/AIDS Premarital counseling for youth above 18 years
Men	<ul style="list-style-type: none"> HCT with risk-reduction counseling and linkage to appropriate services IEC/BCC to address risk factors and drivers of the HIV epidemic Couple counseling and testing Safe Male Circumcision Male involvement in PMTCT Family planning uptake STI screening and treatment Blood transfusion safety and infection control Post- exposure prophylaxis (PEP) Sensitize men against SGBV 	<ul style="list-style-type: none"> IEC/BCC to increase uptake of HIV prevention interventions Risk reduction counseling Disclosure of HIV sero-status to partners and family members and partner testing ART and ART adherence Male involvement in PMTCT Family planning STI screening and treatment Blood transfusion safety and infection control Psychosocial and spiritual support Support groups for PLHIV Eliminate stigma and discrimination Treatment of other health conditions – TB, malaria, sanitation, nutrition Sensitize men against SGBV

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Category	Interventions for HIV Sero-Negative	Interventions for HIV Sero-Positive
Women and girls	<ul style="list-style-type: none"> • IEC/BCC to address risk factors and drivers of the HIV epidemic • HCT with risk-reduction counseling and linkage to appropriate services • Couple counseling and testing • STI screening and treatment • Blood transfusion safety and infection control • Post- exposure prophylaxis (PEP) • Address socio-cultural and socio-economic factors that create vulnerability to HIV infection • Sensitize on SGBV prevention • Address underlying socio-cultural-economic-legal factors to eliminate vulnerability 	<ul style="list-style-type: none"> • IEC/BCC to increase uptake of HIV prevention interventions • Risk reduction counseling • Disclosure of HIV sero-status to partners and family members and partner testing • Family Planning • PMTCT for pregnant women • ART and ART adherence • STI screening and treatment • Blood transfusion safety and infection control • Psychosocial and spiritual support • Support groups for PLHIV • Stigma and discrimination reduction • Treatment of other health conditions – TB, malaria, sanitation, nutrition • Address issues of SGBV • Address socio-cultural-economic-legal factors to mitigate the effects of HIV/AIDS

5.0 OUTCOME ONE: INCREASED SAFER SEXUAL BEHAVIOUR AND REDUCTION IN RISKY BEHAVIOURS

Sexual behaviour continues to be at the root of HIV transmission in Uganda. Multiple (especially concurrent) partnerships, cross-generational sex, childhood marriages, transactional and commercial sex, casual sex, low and inconsistent condom use, widow inheritance and wife replacement constitute the main risky behaviours currently driving the HIV epidemic in Uganda. Behaviour change initiatives will be key to all combination packages with the aim of modifying these behaviours, through evidence-informed and theory-driven interventions based on behavioural theory.

5.1 INDICATORS AND TARGETS FOR OUTCOME ONE

Targets on behaviour change during the next phase of HIV prevention are:

- Delayed sexual debut to 18 years for boys and girls as provided by law
- Multiple partnerships reduced by 50% among men and women by 2015
- The proportional of adult men and women that engage in recent transactional sex reduced by 50% by 2015
- Cross-generational sex reduced by at least 50% by 2015
- Casual sex reduced by at least 50% by 2015
- Consistent use of condoms during risky sexual encounters increased to 80% by 2015.

5.2 STRATEGIES FOR OUTCOME ONE

The main strategies for achieving these results will include:

- Eliminating sexual debut for both boys and girls before the age of 18 years as by law established
- Eliminating childhood marriages as by law established
- Outlawing pornography and enforcing legislation against cultural practices that promote early sexual debut and childhood marriages
- Advocating for a minimum wage to reduce poverty related vulnerability
- Scaling up age-appropriate behaviour change interventions in key population groups with messages targeting multiple partnerships, transactional sex, cross generational sex (sugar mummy and sugar daddy syndrome)
- Scaling up Social Change Communication (SCC) interventions to address societal norms, values and practices that influence individual behaviour
- Linking vulnerable populations to livelihood and economic empowerment programmes
- Strengthening policy guidance, quality assurance and capacity for effective IEC/BCC at all levels by UAC in consultation with Ministry of Health
- Increasing meaningful involvement of PLHIV in HIV prevention endeavors

5.2.1 SCALING-UP AGE-APPROPRIATE BEHAVIOUR CHANGE INTERVENTIONS FOCUSED ON MESSAGES TARGETING EARLY SEX, CROSS GENERATIONAL SEX, TRANSACTIONAL SEX AND MULTIPLE PARTNERSHIPS

To be effective, behaviour change programmes need to combine media communication with face-to-face programmes (at the individual level) aimed at different age groups and levels of society. They need to reach enough people in an intensive, focused and sustained way, and simultaneously address the socio-cultural and structural contexts that underpin them. Mass media is effective in influencing social norms, and transmitting brief but powerful messages. Interpersonal communication is critical for thorough processing of culturally-adapted messages designed to influence risk perception, self-efficacy, and skills at community and individual level.

5.2.2 REDUCING MULTIPLE AND/OR CONCURRENT SEXUAL PARTNERSHIPS

The role of multiple (often concurrent) sexual partnerships in HIV transmission, especially in high HIV prevalence settings has been known for some time. A 2006 Think Tank on HIV prevention in high prevalence countries in Southern Africa concluded that high levels of concurrent multiple sex partnerships by men and women with insufficient condom use, combined with low levels of male circumcision, were the key drivers of the HIV epidemic in the African sub-region (Halperin & Epstein, 2007). Multiple sexual partnerships in Uganda are still high. For instance, during 2001-05, multiple sexual partnerships increased from 25 to 29 percent among men and 2 to 4 percent among women. Extra-marital sex during the same period increased from 14 to 29 percent among men. Multiple and/or concurrent partnerships were independently associated with HIV high prevalence, and high HIV incidence (Mermin *et al.*, 2008), with HIV prevalence increasing proportionately with number of sexual partners. This practice is influenced by underlying gender, social, cultural, economic, and other factors including mobility, that have to be factored in any educational campaign to change this behaviour.

HIV prevention efforts to reduce partner reduction will be challenging. However, experience in Uganda shows that well-articulated partner reduction campaigns can be successful. The “Zero Grazing” campaign of the 1990s resulted in a 60 percent reduction in adults reporting two or more partners (Halperin & Epstein, 2007); with greater reduction among those with three or more partners is a case in point.

The strategies for addressing multiple partnering include:

- Concerted IEC/BCC campaigns will address both serial and concurrent multiple partnerships. Behavioural theory and research exploring the social, cultural and economic reasons for concurrent partnerships will be used to inform development of prevention messages and approaches.
- The Ministry of Health and Uganda AIDS Commission will design guidelines for IEC/BCC approaches for multiple partnerships.
- Workplace programs will support employees to reduce motivation for multiple sexual partnerships, especially work involving frequent mobility. Among others, this will involve advocacy for reducing frequency of transfers of workers away from their homes.
- The Ministry of Gender, Labor and Social Development (MoGLSD) and stakeholders will support community dialogue on socio-cultural and gender dimensions of multiple partnerships.
- Since fidelity within longstanding relationships is not necessarily protective due to frequent HIV sero-discordance, partners should promote couple communication and couple counseling and testing within ethical principles of privacy and choice.
- Religious and cultural leaders to promote HCT for prospective couples to mutually know their sero-status before entering into marriages.

5.2.3 REDUCING TRANSACTIONAL SEX

Transactional sex involves people exchanging money, services or goods for sex. Transactional sex, not necessarily seen culturally as sex work, has been in existence for a long time in the country. This behaviour is often condoned in many communities in Uganda. Transactional sex, in the context of multiple concurrent or serial relationships, manifests in several ways including transactional sex as sex work. Cross generational sex is also often in the context of transactional sex. Like other forms of multiple partnerships, there are risks to transactional sex. Recent case studies confirm that often, whenever sex is part of an economic exchange, women's ability to protect themselves from STIs and HIV is limited.

The strategies for addressing transactional sex include the following:

- Address the socio-economic and cultural factors that drive women and girls into transactional sex
- Eliminate sexual exploitation in education institutions at all levels
- Zero tolerance to exploitation and abuse by employers in workplaces
- Promote family centered approaches to parenting and skills development
- Promote programmes that highlight the dangers of transactional sex among the youth
- Equip young people with life skills to resist transactional sex
- Strengthen laws and regulations regarding pornography and related materials
- Advocate for minimum wage for workers to reduce vulnerability to HIV
- Enforce minimum age for employment to eliminate child labor and exploitation
- Enhance collaboration with law enforcement officers
- Ensure that all school going children are kept in school

All the above strategies will be embedded within existing structures and programs, such as school and work places.

5.2.4 ADDRESSING HIV RISK ASSOCIATED WITH COMMERCIAL SEX

Commercial Sex involves solicitation of money in direct exchange for sex. In Uganda, sex work is common in urban and rural areas, and other hotspots such as fish landing sites, highway truck stops, and border crossings. Most sex workers are females who find their clients through independent means, but there might also be instances of trafficking. Some sex workers engage in sex work only part time, and high turnover has been reported (MoH and UNDP, 2010). Some sex workers have long-term or even marital partners alongside clients. Commercial sexual exploitation of girls less than 18 years of age also goes on unabated.

The magnitude and demand for sex work in Uganda has not been determined and there are many gaps in understanding the full range of related motivations, correlations, behaviours, and the role of coercion and GBV. Sexual networks involving individuals bridging to the general population are also not well understood. Ugandan law prohibits sex work (commonly referred to as prostitution), so sex workers often face stigma and discrimination through negative attitudes, harassment, and arrests. This presents barriers to seeking HIV prevention services by sex workers, arrests, sexual harassment and exploitation by law enforcement agents.

HIV prevention strategies for sex workers and their clients should include specific core package of services (UNAIDS, 2009). This comprises:

- Risk reduction counseling, condoms, targeted IEC/BCC, HCT, STI screening and treatment, and referrals to HIV prevention, care and treatment delivered through appropriate approaches.
- HIV positive sex workers should have access to non-stigmatizing risk reduction services, as well as care, and treatment.
- Addressing structural barriers and building supportive environments, including policies, legislation, and practices that limit access to HIV and AIDS services, or condone violence and abuse, and the practice of punishing sex workers, while ignoring the widespread demand for paid sex.
- Support programs should include legal support and skill building for women who quit sex work; and
- Address socio-economic factors that lead women into sex work.

5.2.5 REDUCING CROSS-GENERATIONAL AND EARLY SEX

Many youth, particularly females, engage in cross-generational sex, often transactional, motivated by money, gifts or aspirations for higher social standing. Youth exchange sex for money and other materials in all types of relationships-casual or long term. There are different situations youth experience regarding their choice to engage in sexual relationships, and they should be reflected in HIV prevention strategies. This includes approaches for youth who are not yet sexually active, in order to delay sexual debut, and sexually active youth to promote fidelity with one uninfected partner with correct and consistent condom use and knowledge of HIV sero-status.

Cross generational sex has been identified as one of the risk factors of HIV transmission and acquisition. It will be addressed through the following strategies.

- Formative research with sound understanding of the context and sexual relationship dynamics. It should be understood that not all youth can have control over whether to have sexual relationships or not. Strategies must consider the lack of control that youth might have over their choices. For instance, female youth may be required by their families to engage in sex for money. There are groups such as Orphans and Vulnerable Children (OVC), who are vulnerable to HIV infection, but for whom little data exists.
- Target youth who might be seen to be better-off than their peers by engaging in sex with older men and women. For instance, some young women perceive themselves as exploiting older men for money or gifts.
- Be community rooted with engagement of opinion leaders in order to influence socio norms.
- Should simultaneously address older peoples' behaviours, and empowerment of young people to make choices or build negotiation skills, and issues of coercion and violence.
- Ensure that communities play a role in identifying and reaching older partners involved in cross-generational sex, and most-at-risk youth, including out-of-school youth and OVC.
- Target outreaches and engage youth with age-appropriate risk reduction messages.
- Establish referral mechanisms for youth to access full package of youth friendly HIV prevention services including mitigation of consequences of HIV, pregnancy, abortion and Sexually Transmitted Infections (STIs).
- Incorporate empowerment, gender equality, and social norms as key components for creating safe and enabling environments for youth, particularly young women and girls.

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5.2.6 DELAYING OF SEXUAL DEBUT AMONG YOUTH

Since early sexual debut is still common in Uganda, reaching out to youth with evidence informed age- and context-specific messages is necessary to delay sexual debut. Strategies for delay of sexual debut in the next phase of HIV prevention must:

- Include messages for delaying sex which are integrated into wider BCC/SCC interventions such as life skills education. These messages should be incorporated into existing programs, such as school curricula, out-of-school and faith-based programs. Programs for youth must move away from abstinence only education to provision of a holistic package that equips youth for future challenges.
- Incorporate promotion of HCT prior to sexual relationships, condom use, STIs, and pregnancy counseling.
- Communities, parents and schools must take a key role in identifying and helping youth who are at risk of engaging in risky sex, and support the decisions of those who have the ability and choice to delay.
- Support Ministry of Education and Sports (MOES) to consolidate and expand Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY) programmes to Primary, Secondary and Tertiary/Higher institutions of learning.
- Develop messages for delaying sex and integrate them into life skills education in formal and non-formal learning environments.
- Reinforce mass media messages and help create conducive social norms and positive values.
- Conduct action research to identify and simultaneously address causes of vulnerabilities among youth.

5.3 IMPLEMENTATION PLAN FOR OUTCOME ONE

Behaviour change programs should aim at (i) preventing new HIV infections in late adolescence and young adulthood and (ii) addressing factors that make older people resistant to change. To be effective, social and behaviour change programs should combine media communication with face-to-face programs, targeted at different age groups and levels of society and focus both on individual behaviours and environments that inform behaviours. They need to reach enough people in intensive, focused and sustained way.

The approaches and content areas for age-appropriate behaviour initiatives are summarized in the following Table 3.0.

Table 3.0: Key content areas for age-differentiated behavioural programs

Age Group (Years)	Focus	Content	Activities
6- 11	<ul style="list-style-type: none"> • Increase knowledge • Shape norms & values 	<ul style="list-style-type: none"> • Healthy living and healthy sexuality; reducing HIV, pregnancy and STI risks; knowledge of status • Pre-commitment to values that protect against HIV infection 	<ul style="list-style-type: none"> • Life skills programs in schools • Social support clubs/networks in and out-of-school (not peer education)
12-17	<ul style="list-style-type: none"> • Increase knowledge and risk 	<ul style="list-style-type: none"> • Adolescent sexuality; risk behaviour (inconsistent condom use, multiple 	<ul style="list-style-type: none"> • Life skills programs in schools (educator led) • Alcohol and drug abuse prevention • Development of social networks

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Age Group (Years)	Focus	Content	Activities
	<ul style="list-style-type: none"> perception • Shape norms and attitudes • Shape ability to respond to life circumstances • Encourage health-seeking behaviour 	<ul style="list-style-type: none"> concurrent partnerships and age disparate sex) and associated factors (coercion and gender violence); reducing HIV, pregnancy and STI risks; knowledge of status • Build personal initiative, ability to safely navigate day-to-day pressures and expectations • Knowledge of when to seek health care and expectations of health services 	<ul style="list-style-type: none"> • Youth leadership in social networks (in-school/out-of-school) • Sustained links to sports and other recreational activities, and to information for personal growth and development • Youth friendly services with good referral from schools, toll-free help-lines
18-29	<ul style="list-style-type: none"> • Reduce risk tolerance • Promote safest reproduction • Address the desire to have children, fertility and risk reduction • Positive prevention • Parenting and Family planning 	<ul style="list-style-type: none"> • New linkages to social support, information and opportunities; develop social intolerance of multiple, concurrent partners and gender violence • Alcohol and harm reduction • Knowledge of HIV status • Promote condom use • Intolerance of multiple and concurrent partnerships (MCP) • Expectations of good health care • Promotion of pre-commitments and openness about sexuality with children • knowledge of resources for support 	<ul style="list-style-type: none"> • Development of social networks and other forms of connection • Programs for institutions of higher learning • Mass media • Expanded information service at ANC and CT facilities • Youth friendly services • Use social networks of PLHIV • Expanded information services at ARV treatment clinics • expanded information services through home-based care and support • Media, community level dialogues
30+	<ul style="list-style-type: none"> • Parenting • Family Planning • desire to have children • Positive Prevention • Risk reduction in long-term relationships 	<ul style="list-style-type: none"> • Promotion of pre-commitments, openness about sexuality with children, knowledge of resources for support • Condom use, intolerance of MCP, knowledge of TB screening and expectations of good health care • Condom use, regular knowledge of HIV status, intolerance of MCP 	<ul style="list-style-type: none"> • Mass media • Community level dialogues • Use social networks of PLHIV, expanded information services at ART clinics, expanded information services through home-based care and support (especially for partners and others in homes)

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5.3.1 STRENGTHENING POLICY GUIDANCE, QUALITY ASSURANCE AND CAPACITY FOR EFFECTIVE BCC/SCC AT ALL LEVELS

Currently, many BCC programs are not implemented to international standards, thus not realizing their full potential. For instance, most BCC interventions in Uganda focus on imparting HIV and AIDS knowledge, which is only an important first step since high knowledge levels, are not enough to foster behaviour change. Most programs often focus on BCC channels (such as drama, or life skills and workplace programs) than on content to be disseminated through these channels. It is necessary for programs to translate the prevailing high knowledge levels into factors that influence behaviour change, including accurate risk perception and self-efficacy, and design interventions that incorporate these elements. Formative research should be used to identify solutions for barriers to behaviour change. In the next phase of HIV prevention, improving policy guidance, quality assurance and capacity for IEC/BCC interventions will require:

- Building capacity in the design and implementation of behaviourally-sound programs, through appropriate training and mentorship for all stakeholders.
- Strengthened coordination of IEC/BCC activities in order to align messages with target audience and drivers of the epidemic.
- Coordination of the appropriate mix of communication channels that balances mass media and interpersonal communication.
- IEC/BCC quality assurance mechanisms and standards at national and district level. This will involve establishing clearing house for IEC/BCC messages, and standardized training curricular for IEC/BCC. The IEC/BCC TWG will be strengthened to provide oversight.

5.3.2 EXPANDING POSITIVE HEALTH, DIGNITY AND PREVENTION

Provision of comprehensive HIV prevention, care, and treatment services to PLHIV is a proven effective HIV prevention initiative. HIV and AIDS treatment and HCT services now present increased opportunities to interact with PLHIV and risk reduction counseling. Initiatives such as Positive Health, Dignity and Prevention (PHDP) empower PLHIV to avoid onward transmission of HIV as well as risk of acquisition of other viral strains. PHDP delivery platforms are facility and community-based and require coordinated provision of a core package of HIV prevention services. PHDP core messages must emphasize risk reduction and the limitations of ART. In this National HIV Prevention Strategy, partners should do the following:

- Strengthen integration of HIV prevention into chronic AIDS care/ART services, counseling and testing, identification of sero-discordant couples and risk reduction counseling.
- Develop guidelines for PHDP addressing sexual transmission of HIV among PLHIV.
- Task-shifting strategies to lower level health care workers, counselors, and trained PLHIV should be designed. PLHIV should be trained and empowered to provide HIV prevention services as community members, peer educators, and expert patients.
- As PHDP services expand, integration of services into home-based care and psychosocial services should be done. This requires functioning, multi-directional referral systems, close follow up and support and strengthened dialogue between communities and health facilities.

6.0 OUTCOME TWO: INCREASED CRITICAL COVERAGE AND UTILIZATION OF BIOMEDICAL PREVENTION INTERVENTIONS

The key biomedical interventions include PMTCT, SMC, ART and condom promotion. Other services such as medical infection control and PEP, blood transfusion safety, and STI treatment especially for Key populations and family planning will also be expanded as part of general health services.

6.1 INDICATORS AND TARGETS FOR OUTCOME TWO

The Intermediate results under this outcome and corresponding tracking indicators are as follows:

- Proportion of mothers living with HIV and exposed infants accessing PMTCT increased to 90% by 2015.
- The proportion of adults who have recently tested for HIV in the past 12 months increased to 80% by 2015.
- The proportion of adult males, aged 15 – 49 years who constitute the majority of sexually active men, that are circumcised increased to 80% by 2015.
- The proportion of clinically eligible ART clients enrolled on treatment increased to 80% by 2015.
- Consistent use of condoms during risky sex⁶ increased to 80% by 2015.
- At least 80% of HIV prevention, care and treatment programs integrate HIV prevention by 2015.
- All health facilities ensuring blood transfusion safety and infection control measures by 2015.

6.2 STRATEGIES FOR OUTCOME TWO

The strategies to achieve critical levels of coverage and utilization of priority HIV biomedical interventions in the next phase of HIV prevention will include:

- Improving quality and scaling up coverage of HIV counseling and testing
- Scaling up core HIV prevention services to attain critical coverage and utilization.
- Strengthening supply chain management of health supplies for HIV prevention.
- Strengthening the integration of HIV prevention services in clinical and community settings.
- Demand creation for HIV prevention Services.
- Expanding targeted HIV intervention packages for key affected populations.
- Preparing for roll out and implementation of new HIV prevention technologies and services.

6.2.1 IMPROVING QUALITY AND EXPANDING COVERAGE OF HIV COUNSELING AND TESTING SERVICES

Universal access to HIV testing and knowledge of HIV status is fundamental for combination HIV prevention as HCT is the entry point into the four evidence-informed interventions (SMC, ART, condom use and PMTCT). Knowledge of HIV sero-status also influences sexual behaviour. Uganda has made great

⁶Risky sex in the context of this strategy includes (multiple partnerships, casual and sex with partners of unknown HIV sero-status)

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accomplishments in supporting individuals to know their HIV sero status. In the 2005, 57 percent of HIV-infected individuals had HIV sero-discordant partners. Uninfected partners in this situation have higher risk of HIV infection, representing a high unmet need for HIV prevention (Gray *et al.*, 2001). With most discordant couples unaware of their sero-discordant status, and given the low condom use in marriage and long standing relationships, there is a compelling case for increasing knowledge of HIV sero-status of partners and tailored HIV prevention interventions for HIV sero-discordant partners.

This strategy sets goals for counseling and testing (at least 25 percent of new testers within the previous 12 months by 2015). To achieve this, several issues that will ultimately improve the coverage and quality of HCT services, and prevent new HIV infections effectively need to be addressed. These include:

- Expanding the coverage and uptake of services, especially Provider Initiated Counseling and Testing (PICT) in health facilities and communities, drawing lessons from pilot projects of PICT in various settings in Uganda.
- Strengthening risk-reduction counseling to individuals who test HIV-positive and those who test negative. This will encourage HIV-positive individuals to protect their sexual partners and themselves from re-infection. In addition, targeted prevention counseling for those who test HIV negative may assist to reduce risk behaviours and increase safer sex practices.
- Increasing counseling and testing services for couples and families. Emphasis should also be placed on services for men, particularly since counseling and testing is a core component of SMC. Information, Education and Communication/Behaviour Change Communication campaigns should address couple counseling and disclosure of HIV sero-status.
- Addressing structural barriers for HIV prevention as well as stigma and discrimination. For instance, barriers to disclosure of HIV-positive status should be addressed. Through couple counseling and testing, strengthen screening and care for SGBV victims during HIV pre- and post-test counseling and linking victims to safe shelters for women, support groups, and legal services.
- Ensuring steady supply of test kits and lab reagents, coordination of strategies, providing policies and guidelines (such as Home-Based Care and lay counselors), fostering synergy and collaboration among stakeholders, and advocating for adoption of practices that will streamline counseling and testing, including the use of lay counselors and focusing on testing literacy.
- UAC and partners to institute National HIV Testing days as a strategy (National HCT Campaigns)
- Building capacity to collect accurate, timely, and complete counseling and testing data. Monitoring and Evaluation tools for data capture in communities and clinical counseling and testing settings will be developed and used in all programs. Facilities should fully capture and report the numbers of individuals counseled, tested and received results through all counseling and testing service outlets, including variables that enable determining what proportion of counseling and testing clients are repeat testers, as well as those subjected GBV.
- Strengthening pediatric counseling and testing including updating and disseminating relevant policies and guidelines.

- Developing strategies to promote continued sustainability for counseling and testing. Approaches to achieve this will include advocating for increased support in national and district plans for counseling and testing, pursuing opportunities for public/private partnerships, and supporting pre-service training.
- Strengthening counseling and testing at blood donation sites and increasing the identification of HIV discordant couples. The historical void in coordination between Uganda Blood Transfusion Services (UBTS) and HCT will be addressed through staff training at transfusion centers and strengthening HIV counseling in UBTS. Clients who test negative in counseling and testing settings should also be encouraged to donate blood in order to bolster blood transfusion reserves.
- MOH to set annual targets proportional to district population and HIV burden.

6.2.2 SCALING UP CORE HIV PREVENTION INTERVENTIONS TO ATTAIN CRITICAL COVERAGE AND UTILIZATION

Achieving critical coverage and utilization of key HIV prevention services in the general population and among specific groups is a prerequisite for attainment of results in this strategy. These evidence-informed services will include PMTCT, HCT, SMC, condom promotion and distribution, and ART for HIV prevention. This should be augmented with evidence-informed behavioural interventions discussed in the previous section.

6.2.2.1 INCREASING COVERAGE AND EFFECTIVENESS OF PMTCT

Although Uganda has implemented PMTCT for over 10 years, universal access has not yet been attained. Currently, about 20 percent of new HIV infections in the country are due to mother-to-child transmission (MTCT). Increasing the effectiveness of PMTCT services will require strengthening all four prongs of PMTCT namely: (i) primary prevention of HIV among reproductive age women and their partners; (ii) provision of family planning services for women living with HIV, (iii) HCT for pregnant women and HAART (option B+) for mothers and infants living with HIV, and (iv) Care and support for women living with HIV, their partners, infants and families.

The uptake of HCT by mothers who attend ANC currently at 98 percent largely due to routine counseling and testing and same day test results will be maintained. However, losses in the PMTCT cascade where only 52 percent of HIV-positive women and 30 percent of HIV-exposed infants received ARV prophylaxis in 2009 will be innovatively addressed. As illustrated in figure 4.0 below, virtual elimination of MTCT will only be achieved through elimination of the unmet need for family planning among women of reproductive age, halving HIV incidence among women of reproductive age, putting over 90 percent of HIV positive antenatal women on triple ARVs to mitigate transmission through breastfeeding.

The most important focus areas for PMTCT services during the next phase will include:

- Increase number of pregnant mothers attending ANC and delivering in health units.
- Expand PMTCT to all facilities to ensure access to all pregnant mothers.
- Enroll all HIV Positive pregnant mothers on to ARVs on Option B+.
- The guidelines and supplies be rolled out, disseminated and made accessible.

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- MOH (ACP) should ensure that adequate supplies are available in health units.
- Encourage men to come for HCT and be involved in the prevention of HIV to their unborn children because prevention of transmission of HIV to the child is a responsibility of both parents.
- Ministry of Health should put in place PMTCT related programmes for men.
- Increasing maternal and infant uptake of ARVs.
- Strengthening referrals and linkages with several related services such as adult/pediatric AIDS care and ART, home-based care, immunization and Early Infant Diagnosis of HIV (EID). Comprehensive PMTCT services will include other child health services such as cotrimoxazole prophylaxis, TB screening, referrals, and insecticide treated nets promotion.
- Educational and BCC efforts should stress demand creation, parent-to-child transmission, family responsibility and planning, women and men's role in PMTCT, and couple counseling and testing with risk reduction counseling and post-delivery risk reduction for infants through modified breast feeding practices.
- Simultaneously addressing structural barriers for PMTCT including gender barriers, stigma and discrimination of mothers that do not breastfeed and limited male involvement. With option B+ mothers will not be stigmatized for not breast feeding.
- Every health facility providing antenatal care services will be expected to test pregnant women for HIV, and ensure that at least 95 percent of HIV-exposed infants receive combination ARV therapy.
- Improve uptake and efficiency of PMTCT as a priority of every district and key District Health Team (DHT) performance indicator. Districts that need urgent attention will be identified for action.

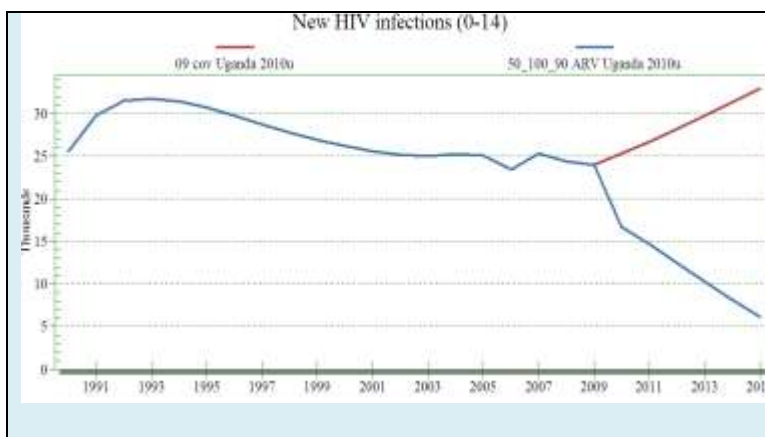


Fig 3.0: Scenarios required for virtual elimination of MTCT

09 coverage – base scenario: 2009 program coverage maintained through 2015
 50_100_90 ARV coverage – intervention scenario: 50% reduction in HIV incidence, eliminate unmet need for family planning; provide ARVs or ART to 90% of women in need.

6.2.2.2 ROLL OUT OF SAFE MALE CIRCUMCISION

Safe Male Circumcision (SMC) for HIV prevention has recently been adopted in Uganda, about four years after clinical trials in Sub-Saharan Africa demonstrated that it reduces HIV acquisition by 50-60 percent among uninfected men (Gray R H. *et al.* 2007). This protective effect has now been demonstrated over longer periods. It is estimated that wide-scale SMC could reduce at least six million new HIV infections and three million deaths (Gray R H. *et al.* 2007; Wilson & Beyer 2006) in Sub-Saharan Africa. Anchored on appropriate behaviour change, expanding SMC to 80% of adults in Uganda by 2015 will avert 428,000 new HIV infections countrywide by 2025.

In the 2004-05 UHSBS, 25 percent of adult males in Uganda were circumcised, with specific low proportions of male circumcision in Mid-North (2.4 percent), North East (4.9 percent) and South West (7.6 percent). The MoH now has national policies, technical guidelines (MoH, 2010), and a strategic plan to roll out SMC.

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Feasibility and acceptability studies have also been conducted and pilot schemes implemented in Kayunga district, Uganda People's Defense Force (UPDF), and Eastern Uganda.

Expansion of SMC will be a key component in the core package of combination HIV prevention services in the next phase of HIV prevention. This strategy sets targets of at least 80 percent of adult males circumcised by 2015. To achieve this, the following will be done:

- Developing operational guidelines, training materials and standards as well as implement the national scale up of services that balance general access to high quality, comprehensive services with the need to reach high risk males. Lessons will be drawn from the pilot projects that assessed the feasibility and acceptability of MC in a range of cultural, demographic, and epidemiological contexts.
- Planning for circumcision of up to one million adult males annually. Implementing partners will be expected to roll out SMC in project like manner, providing services through surgical camps, outreach, and mobile teams, starting with high HIV prevalence areas and at-risk adult men while gradually integrating services into routine facility services.
- Implementing partners should provide comprehensive SMC service package comprising counseling and testing, STI treatment, infection control, male and couple sexual health and risk reduction counseling, condoms distribution, and referrals to other services. Patient follow up should include assessment of counseling effectiveness, monitoring adverse effects, and sero-conversion.
- Functional referral linkages with other services, especially counseling and testing should be established. For instance, HIV-negative individuals from counseling and testing can be referred for SMC and *vice-versa*.
- Service provision will be complemented by demand creation and education, especially on potential for behavioural dis-inhibition or risk compensation.

6.2.2.3 EXPANDING ANTIRETROVIRAL THERAPY FOR HIV PREVENTION

There is increasing evidence of the secondary role of antiretroviral therapy for HIV prevention. This is achieved through two mechanisms; reducing plasma HIV RNA concentration, and consequently the risk of HIV transmission and (ii) HIV acquisition by uninfected partners' individuals. A recent multi-site prevention clinical trial (HPTN 052) demonstrated that early ART initiation achieved 96 percent efficacy in preventing HIV transmission among HIV sero-discordant couples⁷. It also reduced morbidity, mortality and TB. This confirmed earlier observational and epidemiological studies such as the 2009 meta-analysis, which reported zero risk of HIV transmission from ART patients when HIV-1 viral load reduced to <400 copies/ml (Anglemyer & Rutherford, 2011). Analysis of sero-discordant couples estimated 92 percent reduction in HIV transmission risk after controlling for CD-4 T-cell counts (Donnell D. *et al.*, 2010). National projections in Uganda (Figure 5.0) show the impact current ART roll out has had on new HIV infections in Uganda.

⁷ HIV Prevention Trials Network: Initiation of Antiretroviral Treatment Protects Uninfected Sexual Partners from HIV Infection (HPTN Study 052): Press Release, 12th May 2011:

http://www.hptn.org/web%20documents/PressReleases/HPTN052PressReleaseFINAL5_12_118am.pdf

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The findings provide compelling evidence for use of ARVs for HIV prevention (Montaner J S., 2010). They also provide a compelling case for universal counseling and testing and immediate ART for people living with HIV, especially sero-discordant couples, irrespective of CD4 Cell counts. However, the cost-effectiveness of ART for patients with CD4 counts >350 cells/ μ l as a prevention strategy is still unknown. In addition, there are concerns about generalizability of these findings beyond HIV-sero-discordant couples in clinical trial settings, and the fact that early ART initiation wouldn't apply to the acute phase of HIV infection which is characterized by high viremia and where most HIV transmission occurs. Secondly, less than 50 percent of ART-eligible patients (patients with CD4 <350 cells/ μ l, or stage III/IV disease) in Uganda are receiving therapy (MoH, 2010), in part due to low coverage of HCT, and inadequate systems to ensure that eligible patients are initiated and retained on ART. Therefore, provision of ART to individuals with higher levels of CD-4 T-cell counts pose ethical dilemma. However, it is also clearly unethical not to provide ART to sero-discordant couples, regardless of CD-4 T-cell count level.

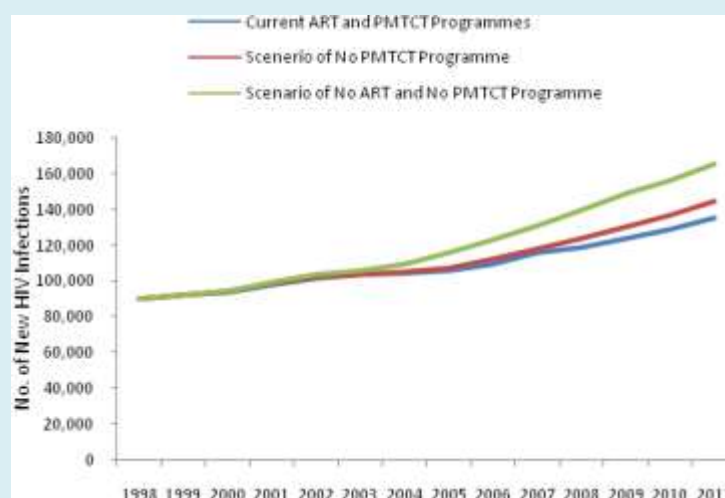


Fig 4.0: The estimated impact of PMTCT and ART programmes on new HIV infections in Uganda

Therefore, in the next phase of HIV prevention in Uganda, scaling-up of ART for prevention as part of the prevention package will involve:

- Expediting the roll out of ART to all clinically eligible clients for treatment purposes to avoid the ethical dilemma of providing ART to more healthy individuals.
- Formulating appropriate policies and technical guidelines as soon as possible. This will include regimen selection, eligibility criteria, and adherence support mechanisms, among others.
- Expanding counseling and testing, especially for couples in order to identify discordant couples.
- Innovative adherence support as well as monitoring of antiretroviral resistance should be key elements of the strategy.

6.2.2.4 STRENGTHENING CONDOM PROMOTION AND DISTRIBUTION

Large scale condom distribution, linked to promotion of use is a cost-effective strategy for HIV prevention. Condom use among adults in Uganda is still low. For instance, among adults who engage in casual sex (with a non-marital and non-cohabiting partner), nearly half of such acts, were not protected by condoms in 2006. Condom use is even lower among couples in long standing relationships.

Currently, condoms are available from health facilities, socio marketing outlets, community distribution networks, and private pharmacies. This is coupled with condom promotion to address barriers and negotiation skills. The number of male and female condoms distributed in the public health system and social marketing has increased considerably over the past 10 years, although there are still pervasive unmet needs and shortages of free condoms in the public sector.

Promotion of condom use continues to be a sensitive issue in most communities in Uganda, and myths about condom use often hamper open discussion. Some people are reluctant to promote condom use among youth, even if they are already sexually active. Gender issues also undermine condom use especially the ability of women to negotiate use with partners. Some individuals such as youth, women, married couples and key populations may feel stigmatized if they seek condoms from outlets. Community leaders may neglect condom promotion, or actively bar their use, due to misconceptions.

In the next phase of HIV prevention, condoms will continue to be a priority component of the combination HIV prevention package. Therefore the following will be done:

- Strengthening systems for forecasting, procurement and warehousing for condoms.
- Integrating condom distribution, promotion, and skills building as core elements of a comprehensive package of HIV prevention services. All individuals who are at risk of HIV infection, or are living with HIV, should have uninterrupted access to condoms within their communities.
- Condoms will be widely availed from various outlets, including pharmacies, clinics, bars, and hotels. Capacity building of outlet workers and owners, to promote condom use will be emphasized.
- Dispelling misconceptions around partner type (marital or casual) and condom use.
- Increased attention paid to barriers such as stigma, socio-cultural, and gender issues.
- Advocating for condom use with key stakeholders, including religious and community leaders particularly within discordant relationships and among at-risk youth. Implementing Partners will ensure increased number of youth- and key populations- friendly distribution points.
- The MoH will develop a plan to address supply chain management bottlenecks.
- Promotion of female condoms and provision in non-traditional outlets such as hair salons, VCT centers and peer networks will be strengthened. Female condoms constitute a female-controlled product within a market niche. Best practices for female condoms include product positioning and promotion for specific target audiences such as women engaged in transactional sex.

6.3 HIV-RELATED PUBLIC HEALTH INTERVENTIONS

Other biomedical interventions of public health importance include:

6.3.1 MEDICAL INFECTION CONTROL

Unsafe injection and other health care practices probably account for a decreasing number of new infections in Uganda. However, there is need to maintain vigilance. Factors contributing to unsafe practices include lack of safe disposal containers and improper disposal procedures. The 2007 Uganda USPA found that only 6 percent of health facilities in the country had the basic requirements for infection control (water, soap, gloves and disposal boxes for sharps, among others). Only 6 percent of health units had facilities for adequate disposal of sharps and other biohazard materials while 15 percent had guidelines for infection control.

The Ministry of Health has guidelines on medical infection control, trained health workers, and established infection control committees in facilities. However, gaps remain. In the next phase, focus will be on:

- Expanding capacity building for universal precautions for prevention of medical transmission of HIV including expanding training, needle stick surveillance, PEP and personal protective wear for health workers.
- Medical infection control and bio-safety capacity building and related procurement should be included in district plans, including infrastructure for safe disposal of medical waste.

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- Communities should be sensitized about infection control practices, decrease demand for unnecessary injections, and household safe disposal procedures, particularly for home based care.
- Disposable syringes and bio-safety boxes should be included in the essential drug list.
- Supervision and enforcement of standards at lower levels by MOH.

6.3.2 EXPANDING COVERAGE AND SCOPE OF BLOOD TRANSFUSION SAFETY

Prevention of HIV transmission through blood transfusion safety has largely been achieved in Uganda. Women and children are at greater risk because of frequent transfusion due to pregnancy and delivery, and malaria-induced anemia. The Uganda Blood Transfusion Service is the MoH unit responsible for ensuring that blood and blood products transfused in the health care system are screened for HIV, HBV, HCV, syphilis and other infectious diseases using rigorous quality assured testing in line with WHO guidelines. The national blood transfusion strategy emphasizes increasing blood collection from voluntary non-remunerated blood donors. However, constraints for blood transfusion safety include lack of universal coverage of quality assured services, limited number of repeat non-remunerated donors, and blood collected falling short of requirements.

In the next phase of HIV prevention:

- Uganda Blood Transfusion Service should continue to identify and sustain HIV-negative voluntary non-remunerated recurrent donors. One strategy is through blood donor clubs consisting of individuals counseled, tested, and committed to remaining HIV free. This is currently supported by URCS and UBTS.
- Communities and other HIV prevention programs should support recruitment and retention of HIV-negative donors, identification of volunteers and support blood donor clubs.
- Collaborative efforts that link blood donation efforts to HCT services, where HIV-negative individuals are referred as potential donors should be observed in all facilities.
- The private sector and workplace programs should support donor recruitment by sponsoring blood donation, IEC materials and other acceptable donor motivational strategies.
- The MoH guidelines on reduction of unnecessary transfusion through malaria prevention and rational use of blood and blood products should be strengthened.

6.3.3 STI PREVENTION, SCREENING AND TREATMENT

Having untreated STIs such as HSV-2 substantially increases the chance of acquiring HIV, but several studies have shown no effect of treating STIs on HIV transmission at a population level. This is largely due to the fact that the majority of STIs in Uganda are due to HSV-2 that is currently not treatable. Nevertheless, STI services constitute a good entry point for counseling and testing and other HIV prevention services. The evidence of the impact of STIs on HIV transmission among key populations is compelling.

In the next phase of HIV Prevention, strengthening STI screening and treatment should be conducted as part of general public health interventions. HIV prevention, STI screening, and treatment efforts should include the following:

Ensure that all individuals screened for STIs are treated effectively and also screened for HIV because these infections are driven by the same risk behaviours.

- Focus on key populations with targeted services as part of a core package of services.

- Improve quality of services in health facilities through training of health workers, and provision of health supplies necessary for the revised STI treatment (MoH, 2009) guidelines.

6.3.4 STRENGTHENING SUPPLY MANAGEMENT OF HEALTH SUPPLIES FOR HIV PREVENTION

Provision of effective HIV prevention services is contingent on steady availability of medical and pharmaceutical supplies for HIV prevention. These commodities include ARVs, HIV and STI test kits, condoms and infection control commodities. However, currently, there are weaknesses in the supply chain management of these commodities that often results in stock-outs and interrupted services. These constraints need be addressed as part of the strengthening of overall health systems to ensure effective HIV prevention services. In the next phase, addressing these constraints will involve:

- Reviewing and streamlining current procurement and supply chain management systems at all levels of the health system.
- Capacity building to strengthen quantification, procurement, inventory management, and distribution of the commodities to peripheral service outlets.

6.4 PROVISION OF TARGETED HIV PREVENTION SERVICES FOR KEY POPULATIONS

Although, Uganda has generalized epidemic, there are population groups that have a disproportionately higher HIV burden. They include sex workers, fishing communities, and individuals in uniformed services. These population groups are disproportionately affected owing to the complex sexual networks, involving multiple partnerships, which often bridge to the general population. These population groups are often not well served by general health services whose times of operation often don't coincide with the life styles of members of this group. These groups also face barriers in access to services which often include legal barriers, and stigma and discrimination. In addition, the population sizes, location, sexual behaviour and other dynamics of these groups are not well understood. Most of these groups, therefore need targeted services, often delivered through outreach or dedicated clinics.

In the next phase of HIV prevention, it is imperative that special attention be focused on key populations, with comprehensive package of HIV prevention services tailored to the dynamics of the group. Furthermore, the structural barriers faced by the various groups should be addressed as part of structural interventions. The main focus will therefore be on:

- Building capacity to reach identified key populations and other vulnerable populations to provide targeted education and HIV prevention services.
- Targeted educational and HIV prevention services for key populations that pay special attention to the unique needs and requirements of each group.
- Providing targeted group-specific, community-based outreach services for key populations.
- Routine monitoring of key populations to assess quality of services provided.
- Addressing structural barriers that key populations face in accessing HIV prevention services.
- Strengthening coordination between government institutions and civil society agencies working with key populations to improve access to services they need.
- Involving key populations in delivery of prevention and other HIV and AIDS services to their peers.
- Improving referral systems and increasing access to HIV and AIDS health care for key populations.
- Instituting and strengthening workplace-based programs for the military, truckers and others similar population groups.

6.5 PREPAREDNESS FOR THE ROLL OUT OF NEW HIV PREVENTION TECHNOLOGIES

Current approaches for HIV prevention should be coupled with research on new methods that can have long-term impact. Currently, the more promising area is use of antiretroviral agents for prevention of new HIV infections. These include (i) Innovative strategy known as ‘test and treat’ to determine whether a community-wide HIV testing (with offer of immediate treatment) can decrease incidence of HIV in communities (Donnell *et al.*, 2010), and (ii) Microbicides containing antiretroviral agents. Another important area of study is how to get better results from HIV prevention by piloting, evaluating, and expanding access to effective combinations of prevention services. Studies are underway to test these strategies in Uganda and at multiple sites in other countries. Some studies have recently released findings that promise to change the landscape for HIV prevention. They include:

CAPRISA study in South Africa demonstrated that ARV-containing microbicides (1 percent Tenofovir) reduced HIV transmission by 39 percent in about 900 HIV-negative women (Quarraisha Abdool Karim *et al* 2010), with higher reduction among individuals with high adherence;

Early initiation of ART among partners living with HIV in sero-discordant relationships demonstrated that early initiation of combination ARVs (CD-4 T-cell counts >350/ μ l) reduced incidence of HIV infection in the uninfected partner, morbidity and TB among the HIV-infected partner (Cohen *et al.*, 2010).

Even with HIV prevention strategies that have demonstrated effectiveness, additional research is needed to assess cost effectiveness and adaptability outside carefully controlled studies. They will need to be coupled with behavioural interventions to ensure that any positive outcomes are not erased by changes in risk behaviour.

In the next phase of HIV prevention, it will be necessary to ensure that:

- For any new interventions to be rolled out, the evidence should be assessed objectively, policy implications should be discussed and appropriate technical guidelines developed.
- Feasibility studies and cost implications to roll out interventions are conducted promptly.
- Appropriate formulation and roll out of plans for the new HIV prevention technologies are developed and disseminated.

7.0 OUTCOME THREE: A STRENGTHENED AND SUSTAINABLE ENABLING ENVIRONMENT

Structural factors that constrain individual ability to adopt and sustain behaviours and lifestyles that minimize risk and vulnerability to HIV (Sumartojo E, 2000) in Uganda range from social, cultural, economic, legal, and policy features of the environment (Gupta G. *et al.*, 2008). These are often embedded and intimately linked to societal norms, values, practices, social structures, and networks (Auerbach J D. *et al.*, 2009). Specifically in Uganda; the main drivers include harmful cultural and gender norms and practices, weak enforcement of laws, rights violation, stigma and discrimination, weak governance and accountability, inequitable access to HIV services, weak leadership and coordination of HIV prevention. Addressing these drivers is a key priority of this strategy.

7.1 INDICATORS AND TARGETS FOR OUTCOME THREE

The following are the main targets over the next five years:

- Appropriate legislative and policy framework that are in place translated into action by 2015;
- Percentage of women who make decisions about their sexual and reproductive health rights independently or jointly with their husbands increased from 61% to 80% by 2015.
- The percentage of women who experience sexual violence reduced from 39% to 10% by 2015;
- Percentage of survivors of SGBV obtaining help from social service organizations increased from 23% to 60% and those obtaining help from Police increased from 6% to 30% by 2015.
- Eliminate fear of contracting HIV from casual contact (shaking hands, hugging, sharing food etc.) with PLHIV by 2015.
- Women emancipation increased as evidenced by increase in the percentage of adults who believe that if a wife knows her husband has an STI or HIV, she is justified to refuse sex or demand for condom use, from 84 % for women and 90% for men to 100% by 2015.
- Eliminate school dropout at primary level among orphans 10 -14 years by 2015.
- Ratio of school attendance among orphans versus non-orphans, aged 10-14 increased from 0.9 to 0.95⁸ by 2015.
- Percentage of OVC and non-OVC 5-17 years whose basic needs (clothing, health, psychosocial support, social protection, education, and nutrition) are met increased from 28% (UDHS, 2006) to 50% by 2015.

7.2 KEY STRATEGIES FOR OUTCOME THREE

Key strategies for creating a sustainable and enabling environment mitigating the structural drivers include:

- Reviving leadership for HIV prevention at all levels.
- Changing harmful socio-cultural and gender norms, beliefs and practices.
- Strengthening legislative and policy framework for HIV prevention, SGBV and other rights violation.
- Strengthening capacity of health and social services to manage SGBV cases.

⁸ MDG and UNGASS indicator

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- Mainstreaming of HIV in development programs such as poverty alleviation, National Agricultural Advisory Services (NAADS) and micro finance to meet the needs of women and key population groups.
- Promoting male involvement in HIV prevention.
- Strengthening efforts against stigma and discrimination.
- Increasing accountability for HIV prevention interventions and resources.

7.2.1 RE-ENGAGING LEADERSHIP FOR HIV PREVENTION AT ALL LEVELS

In the new phase of HIV prevention, there is need for strong leadership at all levels of government and society similar to that achieved in early 1990s. The Executive and Legislative branches of government, cultural, religious and community leaders at all levels will be mobilized to support community HIV prevention efforts. In order to achieve this, there will be:

- UAC will lead the process of developing HIV prevention strategies to engage political leaders at all levels.
- Prime ministers' office will ensure that HIV/AIDS programming and budgeting is included in all sectoral work plans and budgets
- Roll out cultural and religious leaders action plans that are already developed
- Engaging the private sector in HIV prevention
- Engaging professional associations and other civil society groups in HIV prevention.
- Engaging religious, cultural and community leaders in offering premarital and marital counseling.
- Advocacy to ensure that GoU provides the required leadership for HIV prevention at all levels;
- Specific indicators to track revived leadership will be designed and tracked at national and district levels (resource allocation and utilization).
- Facilitate standardized and contextualized communication messages to ensure that all leaders convey the same prevention messages. These should be amplified regularly by media experts and other professionals.
- UAC will lead the process of developing the necessary tools for advocating for increased domestic budgetary allocation and disbursements.

Monitor whether resources have been allocated and utilized for HIV prevention by sectors and districts

7.2.2 CHANGING HARMFUL SOCIO-CULTURAL AND GENDER NORMS, BELIEFS AND PRACTICES

Within families and communities, there still exist harmful cultural beliefs, practices and norms that increase vulnerability to HIV infection. These include acceptance and tolerance of risky sexual practices such as multiple and concurrent partnerships, transactional and cross-generational sex (Sengendo J, 2001), risky rites of passage (PACE, 2010) (such as beliefs among the Bagisu that a newly circumcised man will heal faster if he indulges in unprotected sex with a married woman), social pressure to bear children especially males, forced and early marriage and superstitions linking HIV with misfortune and spirits and widow inheritance (Whyte, 1997).

To address the harmful cultural beliefs and practices, individuals, families and communities should be engaged to understand linkages between these beliefs and practices and vulnerability to HIV infection. Therefore, in the new strategy, implementing partners should:

- Engaging cultural institutions in addressing socio-cultural drivers of the epidemic.
- Promote on-going community conversations and dialogue on harmful cultural beliefs and practices.

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- Identify and harness positive norms, practices, structures and networks that facilitate adoption and sustenance of behaviours and lifestyles that minimize vulnerability to HIV.
- Build partnerships with cultural structures to develop context specific interventions aimed at challenging and changing the risky socio-cultural norms, beliefs and practices.
- Strengthen the school system to ensure promotion of positive values and norms in learners

In most communities, there are gender norms that place men, women, boys and girls at risk of HIV infection. Women and girls continue to be culturally excluded from owning property and productive assets (Uganda Land Alliance, 2009), education and skills training opportunities, which preclude them from the job market. Widows and orphans are often denied their property (Kamusiime *H*, 2004). This situation is exacerbated by the weak enforcement of existing laws and institutional frameworks for protecting the rights of women and children (McPherson *D*, 2006). Prevailing masculinity and gender norms also condone multiple sexual partnerships.

Furthermore, women are culturally accorded a low status. Unequal power relationship limits women's and girls' abilities to choose or refuse partners, negotiate for safe sex, and force them to submit to unfaithful partners. The social pressures for men to reproduce and maintain male dominance and expectations make it difficult for them to change behaviour. In most communities, men are socialized to control women in all aspects including decisions on when a girl will marry, the number of children she will have, where she will deliver, and how women and girls will seek health services.

This strategy prioritizes interventions to change male dominance and gender norms and disparities, and seeks to create environment that enables women to have a voice in decisions that affect their sexual reproductive health through ensuring that:

- All HIV prevention services will promote gender equality and enroll men and boys as key partners.
- Families and communities will be engaged in dialogue in order to develop context specific interventions that challenge these norms and create an enabling environment for change.
- All interventions will take a rights based approach especially for women.

Minimum Package of Community interventions

1. Effective referral networks between communities and HIV prevention services.
2. Engaging existing community, cultural/kinship and religious resources/structures in HIV prevention.
3. Mobilizing for increased access and uptake of HIV prevention services.
4. Peer education and community-based support groups/clubs.
5. Integrating HIV prevention into community activities such as e.g. worship, funerals, marriage ceremonies and rites of passage rituals.
6. Socialize men and boys on positive values and norms that respect the rights of women and resist pressure of male dominance.
7. Creation of a conducive learning and social support environment for girl-child education.
8. Strengthen family and community structures to meet the basic needs of OVC.
9. Male involvement in PMTCT, FP and other SRH services for women.
10. SRH rights education
11. Village savings and investment opportunities targeting key populations, women and families affected by SGBV and HIV and AIDS.
12. Empowering communities to assert their rights and demand for accountability and enforcement of laws that protect women and girls' economic security.
13. Community-owned by-laws against context specific drivers of HIV.
14. Challenging HIV-related stigma and discrimination.
15. Building a culture of open and bold discussions about sex and sexuality
16. Community level dialogues, community 'cell' level conversations.
17. Pre-commitment to instrumental values such as those that protect against HIV infection.
18. Building individuals personal initiative and ability to safely navigate day-to-day pressures and expectations.
19. Zero tolerance to gender insensitivity in HIV programs
20. Zero tolerance on sexual exploitation of children and child marriages

7.2.3 STRENGTHENING THE LEGISLATIVE AND POLICY FRAMEWORK FOR HIV PREVENTION

SGBV including rape, forced sex in marriage, defilement, early marriages, verbal and physical abuse and denial of women and girls to access information and services are still common in Uganda (MGLSD and UNAIDS, 2009). Violence precludes women from seeking HIV prevention and SRH services. SGBV increase feelings of unworthiness lower the victims' self-esteem and breeds mistrust, which forces women into revenge sex and/or multiple sexual relationships in search of love and acceptance (Care International, 2010). Though Uganda has developed progressive laws and policies that prohibit sexual abuse and violence against women, implementation is still weak. Furthermore, medical surgeons who carry out examinations and provide evidence to magistrates are few (UNIFEM, 2010). The linkage between the laws, policies and customary norms is not clear yet most people seek redress from traditional leaders and elders whose

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capacity and knowledge in handling cases is encumbered by personal interests and cultural mandates.

To address these shortcomings, this strategy will:

- Support efforts to create awareness and implementation of laws and policies addressing SGBV and other rights violations against women, girls, other vulnerable groups and key populations.
- Advocate for strengthening institutions to enforce the requisite laws. Community level interventions will focus on advocating for strengthening existing structures and networks (local councils, police, and health units) to support women and other vulnerable groups to access justice.
- Support examination of current laws and identify gaps and structural impediments.
- In line with the Windhoek Declaration on Women, Girls Gender Equality and HIV (2011), advocate for attention to needs of young women and key populations that are vulnerable to SGBV and HIV.
- Promote human rights and ensure survivor centered and empowering approaches to address the linkages between violence against women and HIV infection. These include political commitment and resource mobilization, and enforcement of legal reform that protect women against SGBV.
- Promote comprehensive GBV policies that include targeting men and boys to challenge violence against women; psychosocial support and health services for survivors of violence.
- Prioritize interventions that increase capacity of women's advocacy organizations to play a role in raising awareness and working with governments to strengthen enforcement of laws.
- Promote community-based participatory learning approaches involving men and women to create more gender-equitable relationships to decrease violence.
- Prioritize establishment of comprehensive post-rape care protocols, training teachers about SGBV, and integrating HIV prevention into services for survivors of SGBV.
- Empower cultural leaders to appreciate the dangers of SGBV as well as related legal implications.

7.2.4 INCORPORATING HIV PREVENTION NEEDS OF WOMEN, GIRLS AND OTHER KEY POPULATIONS IN DEVELOPMENT PROGRAMS

Women's economic dependence on men and unequal access to resources increases the likelihood of engaging in risky sexual behaviours. Married women or those in partnerships often accept risky behaviour by their partners due to the need for economic security. However, studies show that economic empowerment does not enhance women's ability to negotiate for safe sex (Phinney H, 2008).

This strategy will promote linkages with interventions that increase access of women to gainful employment and increase their ability to negotiate for their rights.

- Linkages to income generating activities focusing on rights awareness, life skills education and advocacy for enforcement of laws that protect women's rights will be given priority in all sectors.
- In line with the NDP, this strategy will advocate for ensuring that all planning processes integrate concerns of women, girls, gender equality and HIV.
- In line with the Windhoek Declaration on Women, Girls Gender Equality and HIV (April 2011), advocacy for gender budgeting and actions to address barriers to gender equality will be supported.
- All stakeholders will be mobilized to advocate for actions that ensure that sectors and local government budgets allocate funds for women, girls, gender equality and HIV. Key performance indicators on gender sensitive responses will be developed in all sectors at all levels.
- This strategy will build on current achievements in gender mainstreaming to engender structured gender and HIV mainstreaming in development programs such as NAADS, Northern Uganda Social Action Fund (NUSAF), '*Bonna Bagaggawale*' (Wealth for All) and Poverty Reduction and Development Program (PRDP) in order to increase women's access to resources and skills.

- Linkages with programs that increase access to vocational skills training, and opportunities to develop practical and business enterprises will be established. Similarly, advocacy for increasing women's access to financial resources will be done. Studies show that skills taught by microfinance programs such as assertiveness and adult literacy may enhance women to negotiate for safer sex (Dworkin & Blankenship, 2009).

7.2.5 STRENGTHENING THE CAPACITY OF FAMILIES TO PROTECT AND CARE FOR ORPHANS AND OTHER VULNERABLE CHILDREN

Uganda has one of the highest numbers of Orphans and Vulnerable Children (OVC) in Sub-Saharan Africa. A recent survey by the Population Council (Kalibala & Ellison, 2010) indicated that 14 percent of children in Uganda have been orphaned. In addition, the Uganda-specific definition and indicators shows that 51 percent of children in Uganda are considered moderately or critically vulnerable, with 8–9 percent of the children being critically vulnerable. Vulnerability of children has potential to exacerbate the risk of exploitation through child labor, and transactional and cross-generational sex. This is worsened by the low capacity of families to look after OVC due to HIV and AIDS, poverty and conflict. The strategy prioritizes strengthening care of OVCs through:

- Support linkages to sustainable livelihood programs.
- Strengthen community led initiatives and increase community involvement in the design and delivery of interventions.
- Promote block grants especially in areas where OVC and poverty is wide spread.
- Build capacity of leaders at all levels to effectively respond to the needs of OVC.
- Advocate for review of Universal Primary Education (UPE) and Universal Secondary Education (USE) to ensure that efforts are able to significantly reduce drop out of OVC.
- Address the needs of older OVC with a focus on enabling them to acquire self-reliance skills.

7.2.6 ADDRESSING HIV-RELATED STIGMA AND DISCRIMINATION

In Uganda, HIV-related stigma is still prevalent. Stigma and discrimination comprises (Roura M. et.al, 2008) anticipated stigma (what people expect from others if they were known to be HIV positive), self-stigma (internalized), and enacted stigma (what people do to disadvantage a person known or suspected to be HIV positive). Stigma and discrimination impedes disclosure of HIV status, uptake of HIV prevention services and open discussion of HIV (Action Aid International Africa, 2005), yet this is prerequisite for successful mobilization of communities and individuals for HIV prevention. Lack of disclosure encourages denial and precludes those infected from seeking timely care and support (UNAIDS, 2005). HIV AIDS-related stigma is gender biased and is partly driven by limited understanding of HIV and AIDS, myths and misconceptions. Gender biases in stigma are manifested in the way society blames women for infecting their husbands.

In this strategy, increasing awareness and action on HIV-related stigma and discrimination is a priority:

- Roll out the stigma index for and by people living with HIV.
- UAC to support the development of the national program and campaign for elimination of stigma and discrimination.
- Increase understanding of HIV and AIDS to eliminate myths and misconceptions regarding HIV transmission and acquisition.
- Promote the rights of PLHIV.
- Strengthen interventions that support PLHIV to positively fight self-stigma and uphold self-esteem.

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- Encourage continuous engagement of individuals, families and communities in responding to HIV-related stigma and discrimination through community dialogues and social support groups.
- Support scale up of HIV integration in other health services.
- Equip stigmatized individuals and groups with knowledge and skills to challenge stigma and discrimination and to change behaviour.
- Advocate and build skills in planning for stigma and discrimination reduction.
- Educate PLHIV about their rights through rights campaigns and supporting access to legal assistance and litigation services against discrimination in various contexts.
- Strengthen the legal framework for protecting individuals and groups living with and affected by HIV/AIDS.

7.2.7 DEMAND CREATION FOR HIV PREVENTION SERVICES

Alongside the roll out of HIV prevention services and ensuring steady supply of commodities for HIV prevention, it is critical that uptake or demand creation for the services is also increased. Therefore, during the next phase of HIV prevention, demand creation, and addressing barriers to uptake of services will be addressed through communication endeavors as well as improvement of quality of services at provider level. Specific strategies will include:

- Involving communities in planning and monitoring of services. The community dialogue sessions, community leaders, and community groups will be sensitized about the minimum package of HIV prevention services for their communities and encouraged to participate in monitoring the provision of these services.
- Health Unit Management Committees (HUMCs) and health workers will be sensitized about appropriate communication and user friendly attitude to clients to enhance uptake of services.
- Building the capacity of Village Health Teams (VHTs) and other community systems such as peer support groups, women and youth groups as well as PLHIV networks to support mobilization and referral for HIV prevention services.

8.0 OUTCOME FOUR: ACHIEVING A COORDINATED HIV PREVENTION RESPONSE AT ALL LEVELS

Implementation of combination HIV prevention will be based on existing multi-sectoral coordination framework. However, an unprecedented level of coordination and leadership at national, district, facility and community level will be essential. Existing coordination mechanisms have inherent challenges and constraints. The pro-active political leadership for HIV control that was instrumental in the 1980s and 90s has waned and HIV prevention funding remains inadequate, and not optimally allocated to interventions that have the greatest potential to reduce new infections. At national level, UAC has constraints in coordinating and monitoring the response to ensure alignment of partners' programs with national priorities. Similar coordination challenges at sectoral level have also affected the national and decentralized HIV response.

Most HIV prevention interventions are concentrated in urban areas while rural, underserved and hard to reach areas including fish landing sites that have a high HIV prevalence are not covered by most HIV prevention programs. Furthermore, most interventions are sporadic and piecemeal and do not reach the level and intensity necessary to get ahead of the epidemic. These gaps in leadership and coordination have to be addressed in order to deliver effective HIV prevention.

During the next phase of expanded HIV prevention, the GoU will provide effective leadership and coordination of all stakeholders at all levels. This will be achieved through streamlining coordination mechanisms, re-invigorating political leadership at all levels, and mobilizing additional resources from domestic and external sources to finance the expanded HIV prevention initiatives. To ensure equitable distribution of interventions, scaling up service coverage will be guided by mapping of services.

8.1 INDICATORS AND TARGETS FOR OUTCOME FOUR

Following are the main targets for the next phase of HIV prevention:

- National Composite Policy index for HIV and AIDS policy and program coordination increased from 67.5% (2005) to 85% by 2015.
- All districts and line ministries have functional HIV coordination committees by 2015.
- All districts in Uganda have functional PLHIV networks by 2015.
- The percentage of national budget (including donor support) for line ministries and districts committed to HIV and AIDS programs increased from 3% (baseline 2004) to 5% by 2015.
- Domestic and donor AIDS spending on HIV prevention increased from 25% to 40% of the total HIV/AIDS spending by 2015.
- All district governments allocating funds for HIV prevention from local revenues.

8.2 MAIN STRATEGIES FOR OUTCOME FOUR

- Align all sector and partner HIV prevention interventions, programs and funds to the NPS
- Strengthen all national level intra and inter-sector coordination.

Strengthen coordination of HIV prevention at district and lower levels.

- Strengthen health and community systems to effectively deliver HIV prevention to the population.
- Advocate for increased domestic AIDS spending towards achievement of self-sustainability
- Strengthen referral linkages between HIV prevention, care, treatment and other health services.

8.2.1 ALIGNING HIV INTERVENTIONS AND FUNDING TO THE NATIONAL STRATEGY

Uganda AIDS Commission is responsible for ensuring that all HIV interventions and funding are aligned with national priorities. During this phase of expanded HIV prevention;

- UAC working with the local governments, MoH and other line ministries will ensure all work plans and budgets align with this HIV prevention strategy.
- UAC will require all stakeholders, ADPG, FBOs, private sector and CSOs to align their funding and interventions with this national HIV prevention strategy. This will ensure that all resources and interventions focus on national priorities, which will in turn minimize fragmentation, wastage and duplication of efforts. All funding partners on HIV prevention will be sensitized about this strategy and their programs will be scrutinized by the NPC. All Requests for Application (RFAs) by various partners including the Civil Society Fund (CSF) will be scrutinized to ensure that they are aligned with national priorities.
- All line ministries will be required to develop and issue guidelines on aligning efforts with the strategy to stakeholders implementing programs in the sectors. All line ministries, districts and CSOs will be required to report regularly to UAC. UAC working with the local governments, MoH and other line ministries will ensure all work plans and budgets align with the prevention strategy.

8.2.2 STRENGTHENING MULTI-SECTORAL COORDINATION OF HIV PREVENTION

The UAC is responsible for overall planning and multi-sectoral coordination of comprehensive HIV control initiatives, while line ministries are responsible for technical coordination within respective sectors. The UAC will work through the HIV/AIDS Partnership Committee (PC)⁹ comprising Self Coordinating Entities (SCEs), the Partnership Forum and the Partnership Fund. The PC is the steering committee of the NSP while the NPC is the steering committee for the NPS. The UAC has an HIV prevention unit; however, it has human resource capacity constraints (including inadequate staff numbers) for effective coordination of HIV prevention.

In the National HIV Prevention Strategy (2011-2015), multi-sectoral coordination of HIV prevention will require strengthening through:

- Strengthening the HIV prevention unit at UAC with human resources, and continuous training of staff to cope with emerging needs.

⁹These structures described in detail in the NSP have been instrumental in the HIV response at the national level.

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- Leveraging the ongoing organizational development process that is reviewing structural, human resource, as well leadership challenges affecting coordination of the HIV response to strengthen capacity for HIV prevention.
- The NPC will be strengthened to have more regular meetings, and to establish formalized linkages with technical working groups of specific HIV prevention interventions. A work plan and budget will be developed to facilitate its role.

8.2.3 STRENGTHENING COORDINATION OF THE HEALTH SECTOR RESPONSE

The Ministry of Health is responsible for coordination of the health sector response, especially health promotion and biomedical HIV prevention interventions. In the expanded phase of HIV prevention:

- The Ministry of Health core technical support and coordination role will be strengthened. The regulatory framework for interventions such as IEC/BCC, ART, and training for the various thematic areas has gaps that the MoH must address. The current restructuring of the ACP in MoH will create a specific unit to coordinate HIV prevention (MoH, 2010).
- ACP will strengthen integration of HIV prevention into other primary health care programmes
- The Ministry of Health will be supported to provide technical assistance to other sectors. District Health Teams will be supported to provide technical guidance to other stakeholders, quality assurance; HIV and AIDS surveillance, and routine information gathering activities to track country progress in HIV prevention.

8.2.4 STRENGTHENING COORDINATION OF HIV PREVENTION IN ALL SECTORS

Line ministries are responsible for technical coordination within the respective sectors. However, the level of coordination within sectors is weak. For instance, coordination with other stakeholders beyond the line ministry is often limited. Most sector HIV coordination focal points have HIV/AIDS activities as additional responsibilities, not adequately supported by budgets and infrastructure to effectively undertake intra-sector coordination.

In most sectors, HIV focal point persons are at lower cadre level, unable to influence policies and resource allocation. They often devote little time to HIV and AIDS coordination because it is not part of their job description and performance appraisal. Besides, there is presently limited joint sector planning and inter-sectoral sharing of lessons and experiences related to HIV prevention interventions. CSOs implementing interventions in the sectors are not well coordinated, which often results in duplication and fragmentation of efforts. Under this strategy, we will:

- Build on the ongoing organizational development review of HIV and AIDS coordination to streamline relationships of the different stakeholders in the national HIV response.
- Develop and implement tailored capacity building plans for strengthening sector capacity in delivering on their mandate in HIV prevention
- Establish zonal offices to coordinate, supervise, resource, build capacity and monitor clusters of districts
- Utilize results based framework to motivate each sector to pay more attention to their role.

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- Develop specific scope of work as part of the terms of reference for sector HIV focal point persons and make HIV an area of performance assessment at sector and local government levels. In this respect, HIV will be made one of the deliverables in the performance contracts of accounting officers at sector and local government levels.
- Promote sharing lessons and experiences and joint planning by sectors to minimize duplication.
- Empower sectors to effectively coordinate and develop guidelines for CSOs to ensure that they are aligned with the strategic goals of the sectoral plans for HIV prevention. Effective coordination of CSOs will minimize duplication of efforts and the unnecessary competition, and make them utilize their comparative advantages to complement each other and strengthen the HIV response in the sectors.
- Streamline coordination and relationships between sectors and their line departments at district level in planning and implementation of HIV prevention interventions.
- Build capacity for functional HIV coordination desks at the sector and district levels.
- Harmonize reporting channels between NGOs and district and line ministries.
- Undertake regular meetings for joint planning, review of progress and sharing of experiences among sectors, civil society, and PLHIV networks. These meetings should delineate how sectors and CSOs should separately or jointly function in the different geographic areas, the services to be provided by different entities, populations to be served by each organization or sector.
- Drawing on this strategy and the sector HIV plans for the line ministries, activities to be undertaken to achieve HIV prevention objectives will be harmonized. Harmonized interventions will be easier to coordinate because gaps in service delivery will be easier to identify and opportunities to interface with other sectors and organizations will be easier to pursue.
- Improve coordination skills, knowledge and experience through training and raising awareness about the challenges, opportunities, barriers and actions that facilitate coordination.

8.2.5 STRENGTHENING DISTRICTS AND COMMUNITY LEVEL COORDINATION OF HIV PREVENTION

The responsibility for multi-sectoral coordination at district level is vested in District AIDS Committees (DACs). The DACs established during the early part of the last decade are no longer active in most districts. They played a key role in multi-sectoral engagement and coordination of the response at the decentralized level. The district focal point persons and DACs are not adequately funded, thus hindering performance of their roles. DACs were pegged to projects for financing and never mainstreamed into the regular local government funding. HIV mainstreaming in District Planning Technical Committees (DPTC) is weak yet all members of the DAC are also part of the DPTC. This affects alignment and coordination of HIV services with most CSOs, FBOs and private entities¹⁰. In order to make DACs more active and sustainable, this strategy provides for:

- Building the capacity for functional HIV coordination desks at district level.

¹⁰ It should be noted that almost half of the districts in Uganda do not have HIV strategic plans and even some of those that have, their plans have either expired or are about to expire.

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- Mentorship of local government departments by line ministries. This will ensure alignment of district HIV strategic plans with sector priorities.
- Advocating for pro-active political leadership and commitment at all levels in order to sustain HIV prevention high on the agenda.
- Strengthening coordination of reporting channels between NGOs, districts and sector HIV coordination structures.
- Advocacy for increased domestic funding for HIV coordination structures, especially at district level.
- Supporting regular meetings for joint planning, review of progress and sharing of experiences
- Strengthening partnerships, coordination and referral linkages between HIV Prevention, Care and Treatment at health facilities and in communities.
- Encourage districts to promote learning and lesson sharing amongst themselves.

9.0 OUTCOME FIVE: STRENGTHENED INFORMATION SYSTEMS FOR HIV PREVENTION

Accurate and timely strategic information is vital to inform strategic planning and monitoring of programs. A strengthened information system for HIV prevention will require enhanced HIV and AIDS surveillance to track program impact and outcomes, as well as enhanced results reporting system to track outputs and coverage of services. This will be augmented by operational research for impact evaluation. Improved information management will also be critical, as well as harmonization of M&E and results reporting systems of stakeholders under the principle of the “Three Ones” i.e. One coordinating authority, one national strategic framework and one M&E system. Review of strategic information for HIV prevention in Uganda (UAC, 2010) has highlighted key issues that should be addressed during the next phase of HIV prevention.

9.1 INDICATORS/RESULTS FOR OUTCOME FIVE

The results that will be achieved under this component include:

- Overall impact of HIV prevention tracked annually based on data on new HIV infections and findings disseminated to stakeholders.
- HIV prevention outcomes tracked through population and facility surveys every 3-5 years.
- All HIV prevention interventions evaluated for impact and effectiveness every 3-5 years.
- Annual reports of HIV prevention comparing achievements against targets produced.
- All HIV prevention programs have M&E systems and plans.
- At least five key population groups will have their population sizes and HIV burden determined by 2015.

9.2 STRATEGIES FOR STRENGTHENING INFORMATION SYSTEMS FOR HIV PREVENTION

The strategies for strengthening the information base in the next phase of HIV prevention include:

- Strengthen annual HIV surveillance and periodic monitoring of impact and outcomes of HIV prevention efforts.
- Strengthen reporting systems to track coverage and outputs of HIV prevention programs.
- Strengthen management of data and documentation of best practices for program planning.
- Periodic impact evaluation of HIV prevention programs and approaches.
- Track HIV prevention resources regularly.

9.2.1 STRENGTHENING IMPACT MONITORING OF HIV PREVENTION

Tracking the impact of HIV prevention in Uganda is based on HIV incidence measures since HIV prevalence data are confounded by improved HIV and AIDS care and ART services. In Uganda, such data is obtained from proxy measures through mathematical modeling using Estimation and Projection Package (EPP) and

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Spectrum Packages¹¹, HIV sero-prevalence among recent sero-converters such as young antenatal women and HIV incidence assays such as BED or avidity assays applied to cross-sectional samples. These are augmented by sub-national longitudinal cohort studies. However, each of these data sources has inherent limitations.

In this new HIV Prevention Strategy, strengthening overall HIV prevention impact evaluation will involve the following:

- Strengthening the annual HIV and AIDS surveillance system to provide improved annual estimates.
- Regular triangulation of data from various sources to obtain estimates and trends of new infections.
- Production and dissemination of annual HIV surveillance reports.
- Building technical capacities at UAC, ministries and district level for impact evaluation.
- Strengthening partnerships to effect Impact evaluations.

9.2.2 STRENGTHENING OUTCOME EVALUATION OF HIV PREVENTION PROGRAMS

Outcome evaluation of HIV prevention is based on HIV and AIDS knowledge and sexual behaviour of the general population or specific groups, as well as quality of health services. These are obtained from periodic population-based and health facility-based surveys. National AIDS Indicators Surveys (AIS), Demographic Health Surveys (DHS), and Service Provision Assessments (SPA) are conducted in Uganda every 5-6 years. However, current data are out of date, though a national AIS and a DHS are underway, and are expected to provide up-to-date data by the end of 2011. Under this strategy, strengthening outcome evaluation will involve:

- Advocacy for improving the regularity and comprehensiveness of population and facility surveys.
- Expanding the scope of future surveys, augmented with special surveys to capture information on key populations and other sub-national population groups.
- Detailed analysis and dissemination of information from these surveys will be enhanced, paying attention to gender disaggregation of data.
- Impact evaluation of specific programs and interventions will be strengthened to provide evidence base on best practices for HIV prevention in the country.
- Evaluation of drivers, risk behaviours, and corresponding program goals and output indicators.
- Regular size estimation of key populations to track changes in the characteristics and dynamics of HIV transmission in these groups.

9.2.3 STRENGTHENING ROUTINE REPORTING SYSTEMS FOR TRACKING COVERAGE AND OUTPUTS OF PROGRAMS

Tracking outputs of behavioural, biomedical and structural HIV prevention services will be vital for monitoring coverage and utilization as well as service gaps. The main source of biomedical interventions in health facilities is the HMIS. It is augmented by vertical data collection of some variable by AIDS Control Programs and other implementing partners. There are currently no national results reporting systems for community level activities. In addition, these data are not regularly aggregated into reports for dissemination. Consequently, there is often no comprehensive data on coverage and outputs of most HIV prevention services.

¹¹ Futures Institute: EPP and Spectrum: A Policy Modeling System: A system to support policy development and planning for improved Health: Futures Institute, USA

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In this National HIV Prevention Strategy the following will be done:

- As part of Health Systems Strengthening (HSS), there will be advocacy for improved routine reporting systems and expansion of variables in the new web-based HMIS which can accommodate additional indicators.
- The UAC Directorate of Planning and Strategic Information and the M&E Technical Working Group as well as line ministries should strengthen sector reporting systems and establish horizontal reporting linkages. However, UAC should not set up parallel reporting systems to obtain data from implementation units.
- Mechanisms for regular data quality assessment will be instituted as part of the wide information systems strengthening efforts.

9.2.4 TRACKING HIV PREVENTION RESOURCES

There is need for a tracking system to routinely track data on financial and other resources for HIV and AIDS programs. The system should support disaggregation of data on HIV prevention expenditure as well as other resources. This should also involve National Health Accounts (NHA), National AIDS Spending Assessments (NASA), and UNGASS reports; which currently have most HIV prevention spending data not categorized. Without disaggregated HIV prevention expenditure data, it is difficult to link the allocation of resources to the drivers of the epidemic and consequently areas of greatest need.

In this National HIV Prevention Strategy;

- The GoU through the Ministry of Finance, Planning and economic Development (MoFPED) and UAC will institute financial tracking processes that include disaggregated data on HIV programs.
- The GoU will regularly assess alignment of expenditure and other resource utilization with HIV transmission dynamics.

9.2.5 STRENGTHENING OPERATIONAL RESEARCH FOR IMPACT EVALUATION

Operational research or public health evaluation is necessary to assess impact of interventions and approaches. In the next phase of HIV prevention, a national operations research agenda with clear priorities will be developed and approved by the NPC. Furthermore, dissemination of study results and funding for priority operational research based on the national agenda will be enhanced. Specifically:

- The Government of Uganda will streamline and prioritize research to better understand the complex factors around HIV transmission and effective HIV prevention approaches.
- Mechanisms for coordination of HIV prevention research involving implementation partners, research institutions, Uganda National Health Research organization (UNHRO), and National Council for Science and Technology will be explored and standardized.
- Investment in research especially studies based on the national research agenda will be prioritized.
- Priority research will include tracking the dynamics of HIV among key populations, and size estimation for at-risk populations. Additional priority research will comprise sexual behaviour of PLHIV, ethnographic studies of drivers (behaviour and sexuality), social dynamics, vulnerability, gender relations, culture, poverty and how these might be addressed.
- Dissemination of research findings will be strengthened through one-stop information center that will be established at the UAC by strengthening the National AIDS Documentation and Information Center (NADIC) at UAC.

9.2.6 STRENGTHENING THE MANAGEMENT OF STRATEGIC INFORMATION AND DOCUMENTATION OF BEST PRACTICES

To improve management of strategic information; data from M&E, HIV surveillance, population-based surveys, and operational research will be routinely packaged and disseminated to stakeholders. This will involve:

- A one stop information center will be established to regularly consolidate and catalogue vital strategic information. It will develop a system for regular reporting to the hub and dissemination of findings.
- The information center or knowledge hub will establish functional linkages with similar centers such as UNHRO, University libraries, and other centers that generate HIV prevention information.

10.0 ROLL OUT OF IMPLEMENTATION OF THE NATIONAL PREVENTION STRATEGY

The targets in this National HIV Prevention Strategy require a robust implementation framework. Implementation and coordination of expanded HIV prevention initiatives in the next phase will continue to be based on the existing multi-sectoral framework. However, these mechanisms will have to be strengthened to effectively meet the requirements of expanded Combination HIV prevention. Mobilizing additional resources to finance expanded HIV prevention initiatives, as well as increased efficiency in resource utilization will be critical.

10.1 LAUNCH OF THE STRATEGY

The National HIV Prevention Strategy will be launched nationally and at regional and district events involving all key stakeholders. At the launch, all stakeholders will be requested to commit themselves to expand HIV prevention initiatives, and sign a declaration of undertaking and commitment. Thereafter, UAC will launch it at regional level throughout the country, with similar undertakings by district level stakeholders. Line ministries and other stakeholders will be required to develop work plans including costing based on the NPS.

Effective implementation of the strategy requires implementation and coordination arrangements that support referral linkages and collaborations between HIV prevention, care and treatment services at all levels, integration of services, and appropriate health systems strengthening. In addition, there will be need to establish strong partnerships, linkages and referrals between behavioural, biomedical and structural interventions.

There will be need to ensure appropriate understanding and consensus about the strategy. The UAC will lead efforts to popularize it, and develop appropriate operational and implementation guidelines for it.

10.2 REFERRAL LINKAGES BETWEEN HIV PREVENTION SERVICES

Since most implementing partners or entities do not have capacity to implement the full range of priority services, partnerships and collaboration between implementation partners backed by functional referral linkages will be established right from the outset to ensure delivery of a comprehensive package of services. Therefore the following strategies will be employed.

- Uganda AIDS Commission, sectors, and implementing partners will develop a framework and establish coalitions involving public and private sector, CSOs, PLHIV networks, FBOs and community groups in all areas of the country.
- HIV prevention services in each administrative area will be mapped and districts, facilities, implementing partners and communities will establish or strengthen referral linkages based on guidelines from UAC and MoH.
- The UAC and MoH will ensure implementation of guidelines to ensure that HIV prevention RFAs require applicants to demonstrate partnerships necessary to provide a complete HIV prevention package to communities.

- Capacity building for community leaders and district authorities to establish and monitor functional referral linkages in their areas and delivery of Combination HIV prevention will be conducted.
- Indicators to track delivery of Combination HIV prevention, functional referral linkages and their monitoring mechanisms will be developed.
- To address structural drivers of the epidemic, programs will link with broader poverty reduction and development initiatives funded from various sources.
- The MoH and MoGLSD will develop guidelines for family and community centered approach to HIV prevention. This approach increases male involvement and builds support for those that test for HIV by engaging households for instance to test and encourage disclosure. At the community level it increases participation and ownership of HIV programs and supports communities to respond to stigma.

10.3 STRENGTHENING INTEGRATION OF HIV PREVENTION WITH OTHER HEALTH SERVICES

To improve efficiency and access to services, strengthen integration of HIV prevention with Sexual Reproductive health, maternal and child health, care and treatment, TB and other services . This will require considerable investment in all aspects of health systems. Therefore the following strategies will be implemented:

- MoH will update guidelines and monitor integration of services including joint planning of related programs at all levels. Coordination at national and district level, capacity building, regular support supervision, coaching and mentoring to increase multiskilling/tasking should be undertaken.
- The Ministry of Local Government (MoLG) will develop guidelines and monitor integration into community activities and in workplace settings. The integration of HIV prevention with other social-development services such as poverty reduction, community interventions (e.g. Village Savings and Cooperatives) and activities such as cultural ceremonies, clan meetings and religious activities will also be undertaken to increase opportunities for community dialogue on social cultural, gender and related factors.
- MoFPED will lead mainstreaming of HIV prevention into all development programs.
- Ministry of education and sports (MoES) will strengthen integration of HIV prevention into curricular and extra-curricular activities like sports.
- Similarly all government ministries will be required to identify appropriate entry point for HIV prevention integration within their respective mandates.

10.4 HEALTH SYSTEMS STRENGTHENING

Health systems strengthening (HSS) will be critical for improved access, coverage and quality (WHO, 2007) of HIV prevention services. All building blocks of health systems are crucial for expanded HIV prevention. The challenges and constraints in leadership and governance, human resource, health financing, health information systems, service delivery, laboratory, and medical products that affect HIV prevention services have been empirically documented in the health sector HIV and AIDS program review (MoH, 2010). The new HSHASP2 will address some of the challenges. In addition, HSS will be funded by the Global Fund under

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Round 10¹² and PEPFAR II has a component of HSS¹³ which provides opportunities for additional resources to support HSS in the next phase.

To implement HSS strengthening in support of combination HIV prevention in the next phase:

- MoH will provide leadership to galvanize stakeholders to harness resources from the Global Health Initiatives (GHI) and deploy them to address HSS challenges and constraints.
- UAC and all stakeholders will partner with the MoH to address the HSS challenges.
- Benchmarks for progress in addressing HSS challenges will be developed, routinely monitored, and progress against targets discussed during annual review of HIV prevention.

10.5 MOBILIZATION AND EFFICIENT USE OF RESOURCES FOR HIV PREVENTION

Mobilization of additional resources and their efficient utilization is crucial to expanded HIV prevention. This strategy aims at increasing HIV and AIDS spending to 5 percent of the national budget and HIV prevention expenditure to constitute at least 40 percent of all HIV and AIDS programme resources. A rigorous adherence to value-for-money (doing more with fewer resources) will also be essential in an environment of shrinking resources. Service delivery efficiency, institutional efficiency, transactional and administrative efficiency and information efficiency all need to be understood, analyzed and improved if the HIV prevention response in Uganda is to be successful. Therefore, in the next phase of HIV prevention:

- UAC will spearhead advocacy for additional resources from GoU and external sources. The cost estimates of the strategy highlights gaps that should form the basis for mobilizing additional funds. UAC will use this information and work with stakeholders to develop a sustainable financing plan to assess future resource availability, gaps, and how to address them.
- All line ministries and local governments will be required to budget for HIV prevention as part of sector budgeting processes.
- MoFPED will provide relevant guidelines and ceilings.
- All stakeholders will also mobilize resources to bridge the funding gaps and institute efficient resource utilization, cost saving, improved accountability and transparency measures.
- The MoH and UAC will work with various ADPs to rationalize distribution of implementing partners across the country with the aim of reducing transactional costs and ensuring more trickle-down of resources. This will be similar to the rationalization of ART implementing partners currently being undertaken by the MoH and PEPFAR.
- Collaboration with institutions that monitor resource utilization and empowerment of communities to be watchdogs of efficient use of HIV prevention resources will also be undertaken.

¹²Uganda Proposal to the Global Fund Under Round 10 Call for Applications

¹³ Office of Global AIDS Coordinator: The Presidents Emergency Plan for AIDS Relief: Five Year Strategy. www.pepfar.gov/documents/organisation/13305.pdf

10.6 INSTITUTIONAL ARRANGEMENTS FOR IMPLEMENTATION OF THE STRATEGY

In this strategy, HIV prevention will continue to be implemented in different sectors by various implementing partners and at different levels according to their mandates and comparative advantages. However, a strong coordination framework that ensures that all entities work in closer collaboration is vital. Under this framework the roles of various entities in HIV prevention will be as follows:

10.6.1 THE UGANDA AIDS COMMISSION

The Uganda AIDS Commission will be responsible for oversight of multi-sectoral coordination of HIV prevention. The UAC shall support line ministries to develop strategic work plans aligned with this strategy. In addition, UAC will:

- Ensure that all line Ministries, Development Partners and UN partners align their strategies and work plans to the NPS.
- Develop tools to assess compliance to the provisions of this strategy.
- Ensure that this strategy is adopted by all sectors and implementing partners.
- Ensure that this NPS is regularly reviewed, effectively coordinated, implemented and monitored.
- Spearhead mobilization of resources and advocate for increased resource allocation for HIV prevention.
- Ensure that operational guidelines for are developed and disseminated and HIV prevention is mainstreamed in sector policies, development programs, and budgets.
- Coordinate the development and implementation of a national HIV prevention performance monitoring plan with an efficient information management system.
- Establish Zonal Offices to strengthen coordination.

10.6.2 PARLIAMENT

The Parliament of Uganda will ensure that all government budgets include funding for HIV prevention. They will also put in place legislation that is supportive to HIV prevention and hold implementing partners within the national response accountable for results and efficient utilization of resources.

Individual members of parliament will play a key role in community mobilization for HIV prevention within their constituencies which includes utilization of available prevention services.

10.6.3 THE MINISTRY OF HEALTH

The MoH is central to expanded HIV prevention initiatives, providing technical leadership and coordination especially for biomedical HIV prevention services. The HSHASP-2 (MoH, 2010) will facilitate this role. Specific tasks of MoH will include:

- Scaling up of HCT and HIV prevention interventions such as IEC/BC, PMTCT, SMC and ART throughout the country.
- Integration of HIV prevention into other health services; establishment of partnerships, linkages and referral mechanisms necessary for implementation of this HIV Prevention Strategy.
- Technical guidance, standardization, and quality assurance of HIV prevention service packages delivered by other implementing partners and facilities.

- Strengthening HIV surveillance, impact evaluation, surveys and other routine strategic information generation activities.
- Procurement and supply chain management of medical and pharmaceutical commodities for HIV prevention through National Medical Stores.
- Strengthening all the building blocks for health system.

10.6.4 ROLES OF OTHER LINE MINISTRIES

All other line ministries under the leadership of the Prime Minister's office will be required to strengthen their roles according to their mandate and comparative advantage to support expanded HIV prevention initiatives. All line ministries will be required to identify a coordination desk for HIV prevention to coordinate planning, implementation and regular progress reporting. They will also be tasked to review their policies and make adjustments to support implementation of this strategy and report to UAC. The specific roles of key line ministries in expanded HIV prevention will be as follows:

- **The Ministry of Local Government** will oversee the coordination roles of DACs¹⁴ and lower local government, ensure planning and budgeting for HIV prevention by all departments, ensure that all PLHIV networks, CSOs and FBOs align with this strategy and with district plans. The Ministry will also appraise performance of officers against targets and ensure that disbursement of funds is tied to progress in achieving targets. District performance reviews should integrate an explicit indicator on HIV prevention mainstreaming in the various departments.
- **The Ministry of Justice and Constitutional Affairs** will address rights violation-related drivers of HIV infection. It will enforce regulations against SGBV, stigma and discrimination, good governance and accountability, review and revise laws that constitute barriers to HIV prevention.
- **The Ministry of Gender, Labor and Social Development**, will support mainstreaming of gender in HIV prevention policies, programs and budgets in public and private entities and coordinate HIV prevention in cultural and religious institutions, workplace, special populations and OVC.
- **The Ministry of Finance, Planning and Economic Development's** role is to mobilize additional resources. It will provide a special vote for HIV prevention and ensure that line ministries, departments and institutions provide for and disburse funds to HIV prevention. It will oversee effective financial management, procurement and accountability and periodic tracking of HIV prevention resources. It will also ensure that all development initiatives integrate HIV prevention.
- **The Ministry of Education and Sports** will support HIV prevention in educational institutions. It will design curricular and extra-curricular HIV prevention interventions for all levels, provide guidelines for peer education for youth-in-school, and implement HIV workplace programs in the sector.
- **Ministry of Agriculture, Animal Industry and Fisheries** will provide leadership in integration of HIV prevention in livelihood programs such as NAADs, ensure integration of HIV prevention in agricultural extension services and HIV mainstreaming in the agricultural sector.
- **Ministry of Internal Affairs** will provide leadership for workplace programs amongst the police forces, prisons staff and home guards. They will also ensure community education on laws relevant to this strategy.

¹⁴ The role of the DAC is to facilitate timely and quality services, develop integrated District HIV strategic plans, facilitate district departments to mainstream HIV control, facilitate community HIV AIDS competence, ensure timely reporting and accountability for all HIV activities

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- **Ministry of Defense** will ensure service access to men, officers and families of the Uganda Peoples Defense Forces (UPDF) as well as explore opportunities to deliver HIV prevention services to communities within reach of their health facilities and areas of military operations.
- **Ministry of Public Service** will provide a supportive policy environment for HIV prevention within the public service. They will also ensure the preparation of client charters that include commitments on HIV prevention as well as mainstream HIV prevention in their inspection function. The ministry will also ensure that staffing norms including performance management within the public service take into account responsibility for HIV and AIDS.
- **All other ministries and government institutions** not specifically mentioned above will be expected to play roles in HIV prevention within the framework of this strategy and consistent with their mandates.

10.6.5 DISTRICT LOCAL GOVERNMENTS

In Uganda's decentralized structures, districts and lower local governments are responsible for planning and delivery of public health services. Under expanded HIV prevention in this strategy, local governments and their technical departments will:

- Spearhead planning, monitoring and coordination of combination HIV prevention at district and lower local governments' levels.
- Provide HIV prevention services technical support and quality assurance of services provided by all stakeholders in the district.
- Ensure mainstreaming of HIV prevention activities in district development plans.
- Map HIV prevention services to ensure equity and establish referral linkages between stakeholders.
- Plan and monitor the delivery of the minimum HIV prevention package and referral linkages for services to the general population and specific population groups.
- Prepare regular reports on HIV prevention that compare performance against targets, for submission to line ministries, UAC and share with stakeholders at district level.

10.6.6 CIVIL SOCIETY ORGANIZATIONS AND FAITH BASED ORGANISATIONS

The CSOs, FBOs, NGOs and community groups will continue to be instrumental in HIV prevention service delivery. In the next phase of HIV prevention, they will be required to collaborate more with each other and with the public sector to ensure provision of minimum package of services. They will:

- Develop and implement HIV prevention programs at the workplace and for other population groups according to their areas of comparative advantage. They will enter Memorandum of Understanding (MoUs) with line ministries and districts to harmonize their operations and plans.
- Mobilize additional resources for financing priority HIV prevention activities and harmonize efforts with District Health Teams.
- Work out collaborative arrangements with other partners to provide comprehensive HIV services.
- Provide regular progress reports to districts and line ministries.
- Align work plans with district development plans and participate in joint planning, coordination and information sharing activities in respective districts.
- Play a watch dog role to support efficiency and increased accountability for results.

10.6.7 CULTURAL INSTITUTIONS

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In this strategy, cultural institutions and leaders will play a lead role to address drivers of the HIV epidemic which are embedded in cultural norms, values, beliefs and practices. This will be through community dialogue and other social transformative mechanisms.

10.6.8 NETWORKS OF PEOPLE LIVING WITH HIV

The People Living with HIV (PLHIV) have a key role to play in HIV prevention. In this strategy, the national forum as well as district networks of PLHIV will ensure roll out of the national stigma index as well as full scale implementation of the positive health, dignity and prevention package. In accordance with the Greater Involvement of PLHIV (GIPA) and Meaningful involvement of PLHIV (MIPA) principles, PLHIV will be involved at all stages of implementation of this strategy.

10.6.9 THE PRIVATE SECTOR

The private sector has a big constituency of employees, dependents, and customers. The private sector will be harnessed to increasingly support HIV prevention. It will develop and implement HIV prevention programs especially at the work place, mobilize resources, adopt relevant plans and guidelines on HIV prevention mainstreaming, and ensure that PLHIV are not discriminated at places of work.

10.6.10 INTERNATIONAL DEVELOPMENT PARTNERS

Bilateral and multilateral development partners are instrumental in supporting HIV prevention. They currently fund 80-90 percent of HIV prevention costs in the country. In the next phase of HIV prevention, international development partners will continue to provide financial and technical support to local public and private initiatives, mobilize additional resources and share best practices. Since coordination of initiatives is critical to improved effectiveness of HIV prevention endeavors, international development partners will increasingly align their operations and funding mechanisms with national systems as they evolve, in line with the Paris Declaration of aid effectiveness (OECD, 2005).

10.6.11 THE NATIONAL HIV PREVENTION COMMITTEE

The NPC will play a vital role in guidance on HIV prevention in the next phase. Its' scope of work includes:

- Synthesize evidence on HIV prevention, guiding development of goals, strategies and targets.
- Advise on coordination, mobilization, allocation and harmonization of funding for HIV prevention.
- Oversee the integration of HIV prevention in other services.
- Recommend actions to eliminate fragmentation and strengthen overall HIV prevention.
- Serve as the steering committee for this strategy working with the HIV prevention unit at UAC.
- Track implementation and roll out of this strategy as well as review and update it from time to time.
- Establish and facilitate a permanent Think Tank on HIV prevention and Combination HIV Prevention TWG and an HIV Prevention Impact Evaluation TWG.
- Regularly review all HIV prevention reports and advise the UAC on gaps and evolving priorities.
- Establish formal linkages with TWGs guiding specific HIV prevention interventions such as SMC, IEC/BCC, and PMTCT to ensure that policy and technical guidance are regularly updated based on the latest scientific evidence.

10.7 MONITORING AND EVALUATION

Monitoring and periodic evaluation of HIV prevention initiatives will be vital to a strategically guided response. Enhanced M&E will help track delivery of appropriate combination HIV prevention packages and alignment to the risk factors and drivers of the epidemic. It will ensure that the packages are effective and on course to meet the desired targets.

To improve focus on results, a results oriented framework for this strategy will be developed and implemented. All line ministries, implementation partners, and districts will develop M&E plans aligned to the results framework in order to track their contribution to national HIV prevention goals.

M&E efforts will continue to be based on the existing M&E and surveillance systems, procedures and mechanisms. In addition, information systems of major implementing partners such as MEEP will also be harnessed. The monitoring indicators for HIV prevention in this strategy (Annex 2) will be aligned to existing M&E plans. Line ministries, implementing partners and districts will develop M&E plans aligned to the strategy in order to track their contribution to national HIV prevention goals.

The UAC and NPC will provide oversight for multi-sectoral M&E. However, UAC will work to strengthen linkages with sector information systems. The ACP in MoH and HIV Prevention Units in other line ministries will be responsible for obtaining and analyzing program M&E data in their sectors and preparing reports of sector-specific HIV prevention activities. Reporting to UAC on a regular basis will be mandatory. The frequency of reporting will depend on the type of information and systems used to collect the information as will be highlighted in the performance monitoring framework. Sector M&E units will also share the information within sectors and use it for planning and programming. The HIV surveillance system in the MoH will provide improved annual surveillance data for evaluation of HIV program impact.

The UAC will regularly compile all information obtained from sectors and produce annual performance reports on HIV prevention, reflecting performance against targets. The reports will be reviewed by NPC and stakeholders during Annual Joint HIV and AIDS Program Review (JAR). The first annual report of HIV prevention strategy will be due in mid-2012

The UAC and sector M&E functions will require investment in human resources, skills and infrastructure to execute these roles. The HMIS, HIV surveillance system and other sector management information systems (being the main avenues for collection and reporting of data on HIV prevention from within the sectors) will require specific strengthening measures. Following the launch of this strategy, M&E systems in line ministries and key implementation partners will be assessed to identify measures to strengthen M&E as well as reporting systems. In addition, UAC will lobby the Office of the President and Prime Minister to direct that all line ministries commit to strengthening M&E systems and provide regular reports through UAC to their offices.

Partners implementing various programs including CSOs will be required to align reporting mechanisms with their respective sectors and support the development of sector M&E systems. They will also conduct regular evaluation of the impact of their interventions, document and disseminate best practices.

The UAC Directorate of Policy, Research and Special Programs will coordinate all evaluation efforts. Following launch of this strategy, UAC and MoH will jointly develop an evaluation agenda. The World Bank and DFID have already initiated efforts in this regard (World Bank, 2011). All data arising from research efforts and documentation of best practices will be shared with stakeholders through the JAPRs.

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Furthermore, research findings will be provided to the knowledge hub, and disseminated to all stakeholders.

At district and sub-district level, similar processes will be replicated with technical departments collecting, analyzing and disseminating local data and information to stakeholders. At these levels, M&E operations will revolve around coverage and output indicators, monitoring performance against targets. Standard indicators to facilitate this will be in line with those formulated at national level to ease consolidation. UAC working with MoH will develop a plan for strengthening M&E operations at district level.

The mid-term evaluation of this Strategy will be conducted in 2013, based on terms of reference that will be developed by the NPC and will form the basis for revision. An end of term evaluation will be conducted in 2015. Details of the monitoring and evaluation will be expounded in the performance monitoring plan that will be developed after adoption of this National HIV Prevention Strategy (2011-2015).

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ANNEXES

ANNEX 1: NATIONAL HIV PREVENTION STRATEGY: DESIGN SUMMARY

Goal: To Reduce New HIV infections countrywide by 30% based on the 2009 levels, which will achieve a 40% reduction of the projected new HIV infections in 2015		Indicators and Targets: <ul style="list-style-type: none"> New HIV Infections in the country reduced by 30% of the 2009 levels by 2015 PMTCT Rate Reduced to less than 10% by 2015 		
Priority Outcomes - Results:				
1. Attainment of critical coverage, and utilization of HIV prevention services Indicators and Targets: <ul style="list-style-type: none"> % HIV-infected mothers and exposed infants receiving PMTCT increased to 90% % of adults recently tested (past year) for HIV increased to 25% % adults males that are circumcised increased to 80% % clinically eligible ART clients enrolled on ART increased to 80% Consistent use of condoms during risky sex (multiple partnerships, casual and sex with partners of unknown HIV sero-status) increased to 80% All HIV care and treatment outlets will have integrated HIV prevention All facilities implementing blood transfusion safety and universal infection control measures 	2. Increased safer sexual behaviours and reduction of risk taking behaviour Indicators and Targets: <ul style="list-style-type: none"> Recent multiple partnerships reduced by 50% among men and women respectively Transactional sex among men and women reduced by 50% Cross-generational sex and early sex reduced by at least 50% Casual sex reduced by at least 50% 	3. Strengthened sustainable enabling environment that mitigates underlying factors that drive HIV epidemic. Indicators and Targets: <ul style="list-style-type: none"> % women who make decisions about their SRH or with husbands increased from 61% to 80%. SGBV among women reduced from 39% to 10% % Survivors of SGBV seeking help from service organizations increased from 23% to 60%. % expressing fear of contracting HIV from casual contact with PLHIV reduced by 50% from 19% women & 28% men) % of adults who believe that a wife is justified to refuse her husband sex if he has an STD increased to 100% from 84% women, 90% men. Ratio of orphans: non-orphans (age 10-14 yrs. attending school increased from 0.9 to 0.96 % secondary-school age (13-18 yrs.) children attending school increased from 16.3% to 25% % (OVC) and non-OVC 5-17 years whose basic needs (i.e. clothing, shelter, and nutrition/food) are met increased from 28% to 50% 	4. Achieving a more coordinated HIV prevention response at all levels Indicators and Targets: <ul style="list-style-type: none"> National Composite Policy index for coordination increased from 67.5% (2005) to 85% All districts having functional HIV coordination structures All districts having functional PHA networks HIV/AIDS spending increased from 3% (baseline for 2004) to 5% of total annual national budget HIV Prevention expenditure increased from 25% (UNGASS 2010) to 40% of HIV/AIDS budget 100% local governments allocating funds from local revenues for HIV prevention 	Strengthened information systems for HIV prevention. Indicators and Targets: <ul style="list-style-type: none"> Data on new HIV infections tracked annually and disseminated Population/facility surveys of HIV prevention outcomes conducted every 3-5 years Major HIV prevention interventions evaluated for impact in the country Annual reports of HIV prevention comparing outcomes/outputs against targets, produced All significant HIV Preventions programs have M&E systems and plans Population size and HIV burden of at least five key populations determined by 2015
Strategies:				
1.1 Scaling up core HIV Prevention services to attain critical coverage and utilization of i.e. HCT, PMTCT, ART, SMC and Condoms in the general populations / specific groups 1.2 Strengthening supply management of medical and pharmaceutical HIV prevention 1.3 Integration of HIV prevention in clinical and community settings	2.1 Scaling up age-appropriate behaviour change interventions in all population groups with focused messages targeting multiple partnerships, transactional/early/cross generational sex 2.2 Strengthening policy guidance, quality assurance	3.1 Reviving political leadership for HIV prevention at all levels 3.2 Changing harmful socio-cultural and gender norms, beliefs and practices. 3.3 Strengthening the legislative and policy framework for HIV prevention 3.4 Strengthening capacity of health and social services to manage SGBV cases 3.5 Mainstreaming of HIV in development programs to meet the needs of women and key groups	1.1 Aligning all HIV interventions and funding to National Strategic Plans 1.2 Strengthening National level intra and inter-sector coordination. 1.3 Strengthening coordination of HIV prevention at the district and local levels 1.4 Health system strengthening	5.1 Strengthening annual HIV surveillance and periodic monitoring of impact and outcomes of HIV Prevention 5.2 Strengthening reporting systems to track coverage and outputs of HIV prevention 5.3 Strengthening the management of data and documentation of best practices

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Goal: To Reduce New HIV infections countrywide by 30% based on the 2009 levels, which will achieve a 40% reduction of the projected new HIV infections in 2015		<u>Indicators and Targets:</u> <ul style="list-style-type: none"> • New HIV Infections in the country reduced by 30% of the 2009 levels by 2015 • PMTCT Rate Reduced to less than 10% by 2015 		
1.4 Preparing for roll out of new HIV prevention technologies 1.5 Expanding targeted combination services for key populations 1.6 Demand Creation for HIV Prevention services	and capacity for effective IEC/BCC at all levels 2.3 Increasing meaningful involvement of PLHIV in HIV Prevention endeavors.	3.6 Promoting male involvement in HIV prevention 3.7 Strengthening efforts against stigma and discrimination 3.8 Increasing accountability for HIV prevention resources	to effectively deliver HIV prevention in the health sector 1.5 Advocating for increasing domestic and donor funding of HIV prevention 1.6 Strengthening referral linkages between HIV prevention, care, treatment and other health services	5.4 Periodic impact evaluation of HIV prevention programs / approaches 5.5 Regular tracking of HIV prevention resources

ANNEX 2: MONITORING AND EVALUATION MATRIX

Results to be achieved	Indicator to measure whether result has been achieved	Baseline/year	2013 Target	2015 Target	Data sources / Comments
A: Impact of HIV Prevention (Long term Results)					
1. New Infections reduced by 30% (40% of projected new infections 2015) <ul style="list-style-type: none"> Total number of new infections reduced Incidence rate of new infections reduced Vertical Infections reduced 	1. Estimated number of new infections in Uganda in the year	124,261 (2009)	111,917	94,503	ANC HIV surveillance Projections/Estimates
	2. Estimated HIV Incidence rate among adults 14-49 years	0.72%	0.55%	0.46%	EPP/Spectrum/ Other incidence measures
	3. Percentage of young adults aged 15–24 who are HIV infected (UNGASS (22)	3.5%	3.5%	3.1%	Population Surveys / ANC Surveillance
	4. Percentage of infants born to HIV infected mothers who are HIV positive (UNGASS (25)				EPP & Spectrums Projections
	5. Estimated annual number of vertical HIV infections	19,544[2009]	10,000	7,000	EPP & Spectrum Projections
B: Outcomes of HIV Prevention (Intermediate Results)					
Outcome 1: Increased coverage, quality and utilization of HIV Prevention Services <ul style="list-style-type: none"> Improved coverage and quality of PMTCT, HCT, ART, blood safety, Improved demand for and uptake of HIV prevention services Improved logistics and supply management of HIV prevention commodities 	6. Percentage of adults aged 15-49 who have ever tested for HIV and received their results	TBD [2011 UAIS]	60%	80%	UAIS, UDHS
	7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and received their results	TBD [2011 UAIS]	20%	25%	UAIS, UDHS
	8. Percentage of women who were pregnant in the previous 24 months that were offered an HIV tested and received their test results	TBD [2011 UAIS]	60%	80%	UAIS, UDHS
	9. Percentage of HIV-positive pregnant women who received antiretroviral drugs to reduce the risk of mother-to-child transmission (UNGASS (5), UA3)	52%	75%	95%	EPP / Spectrum and Service Statistics
	10. Percentage of randomly selected retail outlets and service delivery points that have condoms in stock	TBD		80%	Condoms availability surveys
	11. Percentage of STI patients attending health facilities that are managed (diagnosed, treated and counseled on risk reduction) according to national guidelines	TBD		80%	Population Surveys, Program M&E
	12. Percentage of districts that have attained critical coverage of critical HIV prevention services	0	50%	80%	Service provision assessments, LQAS
	13. Percentage of randomly selected retail outlets and service delivery points that have	45% [2010]	60%	80%	EPP / Spectrum and

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Results to be achieved	Indicator to measure whether result has been achieved	Baseline/year	2013 Target	2015 Target	Data sources / Comments
	condoms in stock				Service Statistics
	14. Percentage of STI patients attending health facilities that are managed (diagnosed, treated and counseled on risk reduction) according to national guidelines	TBD		80%	Service provision assessment surveys
Reduced risk of HIV transmission during exposure to high-risk sex <ul style="list-style-type: none"> Increased consistent condom use Increased coverage of male circumcision 	15. Percentage of adult males (15-49 years) that are circumcised	TBD [2011 UAIS]	60%	80%	UAIS, DHS
	16. Percentage of women and men aged 15–49 that had more than one sexual partner in the past 12 months who reported use of a condom during the last casual sex (UNGASS (17)	TBD [2011 UAIS]	70%	80%	UAIS, DHS
	17. Percentage of adults aged 15-49 years who had sex with a non-marital, non-cohabiting partner in the past 12 months that used a condom at last sex with such a partner	TBD [2011 UAIS]	70%	80%	UAIS, DHS
	18. Percentage of males who used a condom during the last sex with a sex worker	TBD	80%	90%	Special Surveys
	19. Percentage of HIV discordant couples consistently using condoms	TBD [2011 UAIS]	70%	90%	UAIS, DHS
	20. Percentage of female & male sex workers consistently using condoms	TBD	80%	95%	Special Surveys
Outcome 2: Increased adoption of safer sexual behaviours and reduction of risk taking behaviours <ul style="list-style-type: none"> Reduced no. of sex partners Reduced transactional sex Reduced early sex Reduced cross generational sex 	21. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months (UNGASS (16)	TBD [2011 UAIS]	75% of Baseline	50% of Baseline	UAIS, DHS
	22. Percentage of adults aged 15-49 years who had sex with a non-marital, non-cohabiting partner in the previous 12 months	TBD [2011 UAIS]	75% of Baseline	50% of Baseline	UAIS, DHS
	23. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15 (UNGASS (15), UA6)	TBD [2011 UAIS]	75% of Baseline	50% of Baseline	UAIS, DHS
	24. Percentage of girls (15-19 years) reporting cross-generational sexual partnerships	TBD [2011 UAIS]	75% of Baseline	50% of Baseline	UAIS, DHS
	25. Percentage of never-married teenagers (15-19 years) that have never had sex (primary abstinence)	TBD [2011 UAIS]	75% of Baseline	50% of Baseline	UAIS, DHS
	26. Percentage of men who paid for sex during the last 12 months	TBD [2011 UAIS]	75% of Baseline	50% of Baseline	UAIS, DHS
Outcome 3.A strengthened and sustainable environment that mitigates underlying factors that drive HIV infection <ul style="list-style-type: none"> Social and gender norms changed to protective HIV-related behaviour and attitudes 	27. Percentage of adults with accepting attitudes towards PLHIV	TBD [2011 UAIS]		80%	UAIS, DHS
	28. Percentage of women that experience Sexual and Gender Based Violence	TBD [2011 UAIS]		10%	UAIS, DHS
	29. Percentage of adults that believe a woman is justified to refuse sex or demand condom use if she know the husband has an STD	TBD [2011 UAIS]		100%	UAIS, DHS
Outcome 4: Achieving a coordinated HIV prevention response at all levels	30. HIV/AIDS spending as % of the total annual national budget	3% [2004]	4%	5%	NASA
5.	31. HIV Prevention expenditure as a percentage of total HIV budget	25%	22%	40%	NASA
6.Improved Systems for Strategic Information for HIV Prevention Improved	32. Percentage of Districts and Implementing partners with M&E plans for HIV Prevention	TBD		100%	Programs reviews
	33. Percentage of districts that have mapped or estimated the sizes of various key populations	TBD	50%	80%	Programs reviews
C: Outputs of HIV Prevention Efforts (Immediate Results)					
HCT	34. Number of adults (15-49 Yrs) counseled & tested for HIV, and receiving result in the past 12 months	TBD	3.5	4 million	HMIS, Program M&E

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Results to be achieved	Indicator to measure whether result has been achieved	Baseline/year	2013 Target	2015 Target	Data sources / Comments
			million		data
	35. Percentage of facilities above HC III providing Routine CT services	TBD	60%	80%	Service statistics
	36. Percentage of districts with at least 6 HCT service delivery outlets	TBD	80%	100%	Service statistics
PMTCT	37 Percentage of Maternal and child Health/Family Planning (MCH/FP) facilities that provide a complete PMTCT service package	TBD	80%	95%	
	38. Percentage of pregnant women attending ANC who are counseled, tested, and receive test results	98% [2009]	100%	100%	HMIS, PMTCT M&E
	39. Percentage of HIV+ pregnant women in the country who receive a complete course of ARV prophylaxis for PMTCT	52	75%	95%	Service statistics
	40. Number of HIV positive mothers accessing PMTCT services				HMIS, PMTCT M&E
Male circumcision	41. Percentage of facilities (from HC IV) routinely providing SMC services	TBD	60%	100%	Service statistics
	42. Number of males circumcised per year	TBD	1 million	1 million	HMIS
ART	43. Percentage of ART eligible individuals enrolled onto Antiretroviral therapy	50%	60%	80%	HMIS, EPP Estimates
Condom distribution Sufficient number of condoms available especially for key populations, hotspots, rural areas	44. Number of male and female condoms distributed to end users in the last 12 months (UA5)	TBD			
Blood Transfusion Safety	45. Percentage of donated blood units screened for HIV in a quality assured manner(UNGASS 3)	100%	100%	100%	Service statistics
STI management	46. Percentage of public and private facilities providing STI services	60%[2007USPA]	80%	90%	Service statistics
Medical Infection Control	47. Percentage of health facilities providing post-exposure prophylaxis	6% [2007 USPA]	50%	80%	Service statistics
	48. Percentage of Health facilities with Infection Prevention and Control Committees	TBD	50%	80%	Service statistics
PHDP	49. Percentage of HIV/AIDS care and treatment facilities integrating HIV prevention	TBD		100%	Service statistics
BCC /IEC	50. Number of individuals reached with HIV prevention programs, by target group				
	51. Percentage of large ¹⁵ workplaces (public & private) that have HIV prevention and care policies and programs	TBD		80%	Service statistics
PEP	52. Percentage of eligible caregivers and healthcare workers who receive post-exposure prophylaxis	TBD	80%	100%	Service statistics
Social Change Opinion leaders able to facilitate processes to change harmful gender& social norms	53. Percentage of district implementing community mobilisation activities	TBD		100%	Service statistics
	54. Percentage of district HIV/AIDS work plans with activities targeting social norms	TBS		100%	Service statistics
Improved Coordination and Leadership for HIV Prevention	55. Percentage of districts with functional multisectoral HIV coordination structures	TBD	80%	100%	M&E Reports
	56. Percentage of districts funding HIV prevention initiatives with local revenues	TBD	60%	100%	M&E Reports
Improved Strategic Information for HIV Prevention	57. Percentage of districts and IPs with M&E plans with indicators of HIV prevention	TBD	50%	100%	Service Statistics
	58. Number of key populations with HIV burden and population size established at National level	0	3	5	Service Statistics
	59. No. of national quarterly comprehensive ¹⁶ HIV Prevention reports produced on time per yr	2	4	4	M&E Reports

⁷ The operational definition of 'large' for purposes of this framework will be any workplace which is employing 20 or more persons

¹⁶ Comprehensive HIV prevention reports will compare achievements against targets

