The National HIV Prevention Strategy for Uganda: 2011-15

"…..EXPANDING AND DOING HIV PREVENTION BETTER…."

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List of Acronyms

ABC	Abstinence, Be-faithful and Condom use
ACP	AIDS Control programme
ADP	AIDS Development Partners
AIS	AIDS Indicator Survey
IEC/BCC	Information, Education, Communication / Behaviour Change Communication
CDC	US Centers for Disease Control and Prevention
DfID	Department for International Development (UK)
DHT	District Health Team
DoD	United Stated Department of Defense
EID	Early Infant Diagnosis of HIV
GHI	Global Health Initiatives
GoU	Government of Uganda
HC	Health Centre
HCT	HIV Counseling and Testing
HMIS	Health Management Information System
HSHASP	Health Sector HIV/AIDS Strategic Plan -2
HSS	Health System Strengthening
HSSIP	Health Sector Strategic and Investment Plan 2010/11-14/15
HSSP	Health Sector Strategic Plan
IDPs	International Development Partners
IP	Implementing partner
JAR	Joint AIDS Programme Review
MARP	Most-at-Risk Population Group
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MoES	Ministry of Education and Sport
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MoLG	Ministry of Local Governments
MoU	Memorandum of Understanding
NDP	National Development Plan
NPC	National HIV Prevention Committee
NSP	National HIV/AIDS Strategic Plan
PEP	Post HIV Exposure Prophylaxis
PEPFAR	US Presidents Emergency Plan for AIDS Relief
PIHCT	Provider-Initiative HIV Counseling and Testing
PLHIV	People living with HIV
PMMP	Performance Monitoring and Measurement Plan
PwP	Prevention with HIV-positives
SCE	Self-coordinating Entities
SGBV	Sexual and Gender-based Violence
SMC	Safe Medical Circumcision
SRH	Sexual and Reproductive Health
UAC	Uganda AIDS Commission
UBTS	Uganda Blood Transfusion Service
UNGASS	UN General Assembly Special Session on HIV/AIDS
UNRHO	Uganda National Health Research Organisation
UPDF	Uganda Peoples Defense Forces
USG	United States Government
VHT	Village Health Teams

Executive Summary

The Government of Uganda has identified HIV prevention as a priority in its National Development Plan 2010-15 (NDP), and set a target of 40% reduction of new infections by 2015. Although the country has experienced stable overall national adult HIV prevalence of 6% - 7% during the past decade, the number of new HIV infections, (approximately 124,000 in 2009) remains unacceptably high. There are multiple reasons why despite 25 years of implementing various HIV prevention interventions, new HIV infections remain high. First, most interventions have been on a scale insufficient to make significant impact. Secondly, most HIV prevention interventions are not aligned to sources of new infections. Thirdly, comprehensive knowledge of HIV prevention in the population is still low, with widespread risky sexual behavior. While scaling up HIV/AIDS care and treatment in recent years has been fairly successful, provided relief to HIV-infected individuals and prevented some new infections, long-term sustainability of the HIV/AIDS programs requires intensified and increased effectiveness of HIV prevention.

The *National HIV Prevention Strategy* sets forth opportunities and guidance for intensified efforts to significantly stem new HIV infections. Its vision builds on that of the National HIV/AIDS Strategic Plan (NSP), - *"A Uganda where new HIV infections are rare, and where everyone, regardless of age, gender, ethnicity or socio-economic status has uninterrupted access to high quality and effective HIV prevention services free from stigma and discrimination".* The overall goal of the strategy is to reduce new HIV infections by 30% based on the baseline of 2009 which would result in 40% reduction of the projected number of new HIV infections in 2015, in line with the targets in the NDP. This would avert about 200,000 new infections over five years. Virtual elimination of vertical infections is part of this overall goal.

The *National HIV Prevention Strategy* aligns with the NDP, the NSP, the Second National Health Policy, and the Health Sector Strategic and Investment Plan (HSSIP) (2010-15). It will contribute to attainment of Universal Access, UNGASS and MDG 5, 6, and 7 targets. The strategy is the outcome of public, private, and civil society consultation, facilitated by UAC.

The Strategy calls for increased focus, coordination and collaboration to comprehensively scale-up HIV prevention efforts aligned to the drivers of the epidemic. In line with the epidemiology of HIV in the country, global best practices and recommendations, it calls for strategic shift to "combination HIV prevention", comprising of a structured package of behavioral, biomedical, and structural interventions. This approach will be informed in a robust and continuous manner by a sound analysis of what drives the epidemic within specific contexts, and evolving epidemic patterns ("know your epidemic") as well as the focus and scope of HIV prevention efforts ("know your response"), and evolving scientific evidence of various interventions.

Based on what we know now as the key drivers of HIV transmission in Uganda today, the *National HIV Prevention Strategy's* priority objectives are:

- Expand coverage quality and uptake of biomedical HIV prevention services,
- To increase adoption of safer sexual behaviors and reduction in risk taking behaviors.
- To create a sustainable enabling environment that mitigate the underlying socio-cultural and other structural drivers of the epidemic,

- Achieve a more coordinated HIV prevention response, and
- To strengthen information systems for HIV prevention at all levels.

The strategy presents a concise plan that identifies a set of priorities and strategies to attain measurable outcomes. Along with the strategy is an Action Plan that outlines the specific actions and steps to be taken by implementing partners to support the priorities laid out in the strategy. It sets ambitious goals that challenge IPs to meet the targets. The HIV epidemic in Uganda will continue to evolve; in this regard, the strategy calls for ongoing research in the dynamics of populations and specific behaviors that have the potential to increase HIV transmission.

In line with the principles of combination HIV prevention, the *National HIV Prevention Strategy* has identified a minimum HIV prevention packages for the general population, most-at-risk (MARPs), and other population groups. The key evidence-based interventions that comprise the package are: PMTCT, SMC, HCT, ART and condom promotion. Other complimentary services comprise of IEC/BCC, STI treatment, medical infection control and HIV prevention with positives. Furthermore, programmes should address underlying factors that constrain HIV 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 integral component of all initiatives in order to track achievement of results. The ambitious targets in the strategy and plan holds institutions and stakeholders accountable for results, and all IPs are urged to redouble efforts to attain them.

The strategy encourages IPs to build partnerships to support referral linkages so that individuals and communities receive the minimum set of complementary services in the HIV prevention package. This includes collaboration in programme design and implementation, close coordination, and genuine engagement of stakeholders at all levels. Community leaders should demonstrate leadership by ensuring the functionality of the partnerships at various levels.

Along with improved coordination and leadership, under *the National HIV prevention strategy,* partners face the difficult decisions of mobilizing additional resources for the expanded programme, and to re-align HIV prevention resources to support interventions likely to have the greatest impact on new infections. This shift is vital in view of the fact that the HIV epidemic has evolved, and risk factors and drivers of the epidemic have also changed.

The *National HIV Prevention Strategy* should not just another planning document. It represents a genuine opportunity to reinvigorate HIV prevention efforts throughout the country. It advocates for doing "*More HIV Prevention Better*". It is a document that will evolve and strengthen through engagement of and participation of all stakeholders working in HIV prevention throughout Uganda. It builds on all previous HIV prevention guidelines and plans.

1. Introduction

Uganda is still experiencing escalating rate and number of new HIV infections. Currently, the annual number of new HIV infections (over 124,000 in 2009) outstrips by far, AIDS-related mortality and the annual enrolment into antiretroviral therapy (ART). There are multiple reasons why despite 25 years of implementing various HIV prevention interventions, new HIV infections remain high. First, most interventions have been on a scale that is insufficient to make significant impact. Secondly, most HIV prevention interventions are not aligned to sources of new infections. Thirdly, comprehensive knowledge of HIV prevention in the population is still low, with widespread risky sexual behavior. While scaling up HIV/AIDS care and treatment in recent years has been fairly successful, provided relief to HIV-infected individuals and prevented some new infections, long-term sustainability of the HIV/AIDS programs requires intensified and increased effectiveness of HIV prevention.

The Government of Uganda (GoU) has identified HIV prevention as a priority in its National Development Plan 2010-15 (NDP), and set a target of 40% reduction of new infections by 2015. To achieve this, the GoU conceived the need for a new HIV prevention strategy in 2010. It builds on previous efforts including the National HIV/AIDS Strategic Plan (2007/8-11/12), The 2006 Road Map Towards Accelerated HIV Prevention, as well as efforts by various stakeholders and external funding agencies. The strategy aligns with the HIV prevention goals and targets in NDP, and other broader national and international development frameworks such as the Millennium Development Goals (MDGs) 5,6 and 7, Universal Access commitments and targets, and the UNGASS Declaration of Commitment.

The *National HIV Prevention Strategy* aims to guide the re-invigoration of HIV Prevention in the country. It aims to increase the coverage and effectiveness of HIV prevention through a framework that aligns a set of priority and effective HIV prevention interventions to the known sources of new HIV infections and to population groups most at risk. Its foundation is the current epidemiology and drivers of the HIV epidemic in Uganda, the coverage and scope of existing HIV prevention efforts, international and regional best practices, and evidence of effectiveness of the various interventions. The central theme of this new strategy is combination HIV prevention.

Development of the National HIV Prevention Strategy

The development of the *National HIV Prevention Strategy* was preceded by a review of the epidemiology and drivers of the HIV epidemic, and the scope, coverage and effectiveness of existing biomedical, behavioural and structural HIV prevention interventions in the country[1]. The HIV prevention review was followed by a participatory process of development of the strategy and action plan. It involved iterative discussions with technical working groups of key HIV prevention interventions including HCT, SMC, PMTCT, Strategic Information, Gender, MARP network etc, and stakeholders such as the Gender and HIV/AIDS Sub-Committee, UN Joint HIV/AIDS team, and ADPs. Sector consultants leading the development of HIV strategic plans for priority sectors were also involved at various stages of the process. Consultations were also conducted with ADPs especially PEPFAR, DfID and the Joint UN

[1] Development of Uganda National HIV Prevention Strategy: Report of the Background Review of the Epidemiology, Drivers, coverage, Scope and Effectiveness of HIV Prevention Efforts: Draft Consultancy Report to UAC, Kampala, Uganda, October 2010:

Country Team to ensure that their efforts are aligned with the national strategy. Arrangements have been made for consultations with the Parliament HIV/AIDS Standing Committee and self coordinating entities. District teams in six districts representing regions as well as unique HIV population groups or interventions, i.e. Busia, Kayunga, Gulu, Lyantonde, Wakiso and Bushenyi were also consulted. In order to enhance stakeholder involvement and ownership of the strategy, national level stakeholder workshops have been organized for the public sector, FBOs, PLHIV and CSOs.

This activity was led by national consultants, who worked closely with sector level consultants for eight key sectors. The overall activity was supervised by the National HIV prevention Committee (NPC). The NPC co-opted an expert Think Tank to provide peer review and validation of recommendations, targets and priorities. Finally, the NPC validated and approved the *National HIV Prevention Strategy* and Action Plan.

Guiding Principles in the Development of the Strategy

This strategy takes into account the following principles of effective HIV prevention[2]:

- Prevention of new HIV infections will be a national priority, and an integral part of the development policy of the country. The strategy is aligned to the NDP - the overall development framework in the country, and other international development frameworks and initiatives that Uganda subscribes to.
- Prevention of HIV infections needs the involvement and participation of the entire society and will require 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 is 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 must be respected and their participation in HIV prevention policy development, programming, implementation and evaluation will be ensured.
- Programs and interventions are "people-centered", empowering communities, families and individuals to develop responses to challenges and threats, and to learn from experiences of others in similar areas

Alignment with the NDP and other Planning Frameworks

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

[2] UNAIDS: Intensifying HIV Prevention: UNAIDS Policy Position Paper. Geneva, Switzerland, August 2005

The HIV Prevention Strategy also aligns with other international development frameworks, conventions and commitments to which Uganda is signatory. These include the MDGs, UNGASS and Universal Access targets, the Abuja Declaration of Heads of States, etc. Furthermore, key development partners and initiatives especially PEPFAR, UN Joint programme, DfID etc, 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, the scope and coverage of the current HIV prevention programmes in the country and Section 4 sets out the national vision, goals, expected outcomes, indicators and targets as well as key HIV prevention priorities. In section 5, the priorities and strategies for increased coverage and utilization of HIV prevention services are highlighted, while Section 6 outlines priorities and strategies for reduction of risky sexual behavior. Section 7 discusses the strategies for a sustainable environment that 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, the implementation arrangements and the performance and impact measurement for the strategy are presented. Finally section 11 outlines the resource requirements. The HIV Prevention Action Plan is a separate volume.[3]

This strategy has been develop for use by all stakeholders and implementing partners involved in the planning, implementation and financing of HIV prevention activities in the country. It is hoped that stakeholders will find it a useful guide for planning and implementing effective and expanded interventions urgently needed to significantly reduce the number of new HIV infections in the country during the next phase of HIV prevention.

[3] National HIV Prevention Action Plan 2011-2012/13: Draft Report to UAC, March 2011

2. Background and Context

Uganda is still experiencing a severe generalized HIV epidemic. Current estimates indicate that about 1.2 million people in the country are HIV infected, 57% of them female and 13% children under the age of 15 years [4]. There were about 124,000 new HIV infections in 2009, 20% of them among children and 55% among women. This number of new HIV infections was two-fold the AIDS-related mortality, and almost three fold the net enrolment into ART in 2009. In the 2004-05 UHSBS, 6.4% of adults were HIV-infected, and current estimates indicate the same level of HIV prevalence, although the absolute number of HIV-infected people is greater owing to the high population growth. Among adults aged below 50 years, women consistently had higher HIV prevalence than their male counterparts[5]. Although these statistics are old, a national AIDS Indicator Survey is currently underway, and will update estimates before the end of the year.

Uganda's HIV epidemic is still predominantly heterosexually transmitted with 75-80% of infections due to heterosexual transmission, and vertical infections accounting for 20%. Blood borne and other modes of transmission probably account for less than 1%[6]. Although still predominantly hetero-sexually transmitted, the population groups most affected, and the risk factors and drivers of HIV infections 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, and transactional, early and cross generational sex. HIV transmission involving sex-worker networks and bridging to the general population probably accounts for about 10% of new HIV infections. In line with this, the peak of the epidemic has shifted from unmarried younger individuals to older individuals aged 30 – 35 years, who are more likely to be married or in long-term relationships.

Although Uganda has a generalized HIV epidemic, the geographical and socio-demographic and economic heterogeneity of HIV prevalence revealed in the 2004-05 UHSBS probably still persist, with the Mid-north and Central regions and Kampala having the highest HIV-prevalence (over 8%). This heterogeneity reflects the distribution of factors such as multiple partnerships, STIs especially herpes simplex virus (HSV-2) infection, and lack of male circumcision. More recent data also shows heterogeneity of HIV prevalence among population groups. For instance, population groups with HIV prevalence exceeding that in the general population comprise of: sex workers (37%)[7], fishing communities (15%), partners of sex workers (18%), the small group of men with a history of having sex with men (MSM) (13%), and men who operate motor-cycle transport - known as "*boda boda*" (8%)[8]. Students in six universities with recent data[9] on the other hand had lower prevalence 1.2% (0.4 – 1.8%).

Despite significant declines in HIV prevalence and incidence during the 1990s, the HIV epidemic in Uganda remained more or less stable during the past decade. There are even indications of increasing

[4] MoH - AIDS Control Program. The Status of HIV/AIDS in Uganda: The Epidemiological Surveillance Report 2009 - Draft. Kampala, Uganda; 2010
[5] Ministry of Health , Kampala, ORC Macro. Uganda HIV/AIDS Sero-Behavioural Survey 2004-5, USA: MoH and ORC Macro; 2006.
[6] Uganda AIDS Commission, UNAIDS. Uganda HIV Prevention Response and Modes of Transmission Analysis. Kampala, Uganda; 2009 Mar 10.
[7] Vandepitte J, Bukenya J, Weiss H, et al. HIV and Other Sexually transmitted Infections in a cohort of women involved in High Risk Sexual Behaviour in Kampala, Uganda. *Sex. Transm. Diseases*, April 2011 38 (4): 316-24
[8] MUSPH,CDC: The Crane Survey Report-High Risk Group Survey Conducted in 2008/9 Kampala, Uganda
[9] EALP/IUCAE: Preliminary Report of the HIV/AIDS Sero-behavioural Survey in 6 Universities in Uganda, August 2010

HIV prevalence in some groups or areas[10]. Although recent population-wide sexual behavior 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. At the same time, primary abstinence among young men and condom use during casual sex tended to deteriorate. In fact, half of all risky sexual acts in 2006 were not protected.

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 the modifiable risk factors for HIV transmission in Uganda comprise of multiple partnerships, HIV sero-discordance, inconsistent condom use, infection with STIs especially HSV-2, and lack of male circumcision[11]. These factors operate amidst a milieu of other non-modifiable socio-demographic factors such as urban residence, older age, being married or formerly married, being female sex and residence in northern Uganda, implying the need for focused interventions among these groups.

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

- Behavioural factors such as multiple sexual partnerships, cross-generational, early and transactional sex and sex work, alcohol and substance abuse;
- Harmful socio-cultural practices and gender norms, SGBV, violation of rights of women and girls, polygamy, widow inheritance, etc
- Socio-economic factors e.g. mobility, migrant work, poverty, wealth;
- Policy related factors e.g. inequitable access to health services, weak governance, accountability, and coordination, and stigma and discrimination.

These factors are discussed in detail in the review report.[12]

Most-at-risk populations groups that are susceptible to the above factors, and therefore bear a disproportionate burden of HIV, play a special role in bridging infections to the general population. They comprise of sex workers and their clients, migrant workers such as transportation workers, uniform services, fisher folk etc. Injecting drug users (IDU) and MSM that play a big role in HIV transmission elsewhere are not common in Uganda.

The National HIV prevention strategy has taken into account the above epidemic dynamics as a prerequisite for making a significant dent in the tide of new HIV infections in the country.

[10] Biraro S, Shafer LA, Kleinschmidt I, Wolff B, Karabalinde A, Kirungi W, Opio A, Whitworth J, Grosskurth H.Is sexual risk taking behaviour changing in rural south-west Uganda? Behaviour trends in a rural population cohort 1993-2006 : Sex Transm Infect. 2009 Apr;85 Suppl 1:i3-11.

[11] Mermin J, Musinguzi J, Opio A, Kirungi W, et al. Risk factors for recent HIV infection in Uganda. JAMA 2008 Aug 6;300(5):540-9.

[12] Development of Uganda National HIV Prevention Strategy: Report of the Background Review of the Epidemiology, Drivers, coverage, Scope and Effectiveness of HIV Prevention Efforts: Draft Consultancy Report to UAC, Kampala, Uganda, October 2010

3. Status of Current HIV Prevention in Uganda

Uganda has been implementing various HIV prevention interventions for over twenty five years. Specific interventions have evolved over time as more knowledge scientific emerged. However, the existing behavioural, biomedical and structural HIV prevention interventions in the country have not attained universal coverage, nor in a structured combination package. They are also often not adequately monitored for their effectiveness is not routinely evaluated.

Currently, the educational and behavioural interventions comprise of mass media (mainly electronic and print), interpersonal communication, community mobilization campaigns, work-place educational programmes and life skills training in schools, etc, all with varying coverage

The biomedical HIV prevention services in the country currently comprise of PMTCT, treatment of STIs, HIV counseling and testing (HCT), medical infection control and post HIV exposure prophylaxis (PEP), condom promotion, and blood transfusion safety. More recently, prevention with People living with HIV[13] (PwP) and safe medical male circumcision (SMC) have been added. Without exception, all these interventions have not yet achieved universal coverage in the country, with rural areas and MARPs[14] being particularly underserved. However, most of these interventions are based on up-to-date national policies and guidelines that are consistent with the latest evidence and global best practices.

The effectiveness of these interventions varies widely. Only blood transfusion has 100% effectiveness. Other interventions achieved only partially effectiveness in clinical trials, and probably less in programme settings. For instance, SMC reduced HIV acquisition by 50-60% among men, and ARV prophylaxis for PMTCT halves the risk of MTCT, (although more efficacious ARV regimens do better). The evidence of syndromic management of STI in reducing HIV incidence is inconclusive. The effectiveness of male latex condoms at population level is affected by inconsistent use, though effectiveness has been demonstrated with casual partners and MARPs. Condom use was demonstrated to reduce HIV incidence among sero-discordant couples by 85% in one cohort study. However, even inconsistent use has some level of protection[15].

The coverage of all the biomedical interventions is still sub-optimal. For instance:

- Only 52% of HIV-positive antenatal women had access to PMTCT in 2009,
- Approximately 30-40% of adults have ever tested for HIV.
- In 2007, < 10% of facilities had supplies required for medical infection control and PEP,
- 60% of facilities had integrated STI case management[16] in 2007.
- Nearly half of risky sexual acts were not protected by condoms in 2005
- The scope and coverage of PwP especially integration of HIV prevention in ART services, as well as risk reduction counseling in HCT are still inadequate.

[13] In this report, HIV prevention interventions among HIV-infected individuals is referred to as prevention with PLHIV or prevention with positives. The new terminology recommended by UNAIDS is …… However, in this report, the old terminology has been retained.
[14] The new terminology recommended for "MARPs" is "Key Populations". However in this report, the old term has been used.
[15] Weller S., Davis K., Condom effectiveness in reducing heterosexual transmissions, Cochrance Meta-analysis, 2001:3:CDO03255
[16] Ministry of Health, and Macro International: Uganda Service Provision Assessment: Draft Report, Kampala, Uganda, 2008

Integration of services remains a challenge. For instance, the implementation of PMTCT prongs 1, 3 and 4 (primary HIV prevention, family planning, ART and long term family HIV/AIDS Care and Treatment for PMTCT 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 SRH all have sub-optimal coverage. Furthermore referral linkages between various HIV prevention services e.g. HCT, SMC and blood transfusion remains low, yet synergies between them would be mutually beneficial and contribute to significant reductions in HIV infections.

Educational and behavior change interventions that aim at sustainable behavior change currently lack clear guidelines, policies, standards and are often not aligned to factors driving the epidemic. Social cultural norms that influence behavior are often not addressed in IEC/BCC initiatives which also often don't include promotion of the uptake of HIV prevention services. The coverage of these initiatives is not universal, and MARPs such as fishing communities, sex workers, and road construction workers are not adequately targeted. Comprehensive knowledge of HIV prevention is still low (less than 40% in 2005). Furthermore, behavioural data already referred to showed increasing risky behavior (especially multiple partnerships, decreased abstinence and decreased condom use especially among men).

Implementation of structural interventions and mainstreaming of HIV prevention in most programmes remains sub-optimal, yet this would provide opportunities for mainstreaming HIV in the work place and development programmes, providing avenues for addressing the structural drivers. Although, HIV/AIDS has been mainstreamed in the NDP 2010-15, and other sector policies, engagement of communities, cultural structures and networks to address harmful socio-cultural norms and practices is still low and often lack guidelines. Vocational and apprenticeship skills and micro-credit schemes for reducing vulnerability also have limited coverage. The policy and legal frameworks with a potential to address gender imbalances e.g. the Marriage and Divorce Act, Domestic Violence Act, National gender policy, etc, are constrained by enforcement weaknesses. GoU development programmes such as Universal Primary and Secondary Education; Expanding Social Protection Programme (ESPP) etc, have a potential to reduce inequality and vulnerability HIV/AIDS, but mainstreaming of HIV in these efforts is still sub-optimal.

Funding of HIV prevention:

Although Uganda has made progress in macro-economic stability and reduced donor dependence in recent years, currently, HIV prevention programs in the country are almost entirely funded from external bilateral and multilateral assistance. During the fiscal year 2007/08, UShs 130,965,713,573 was spent on HIV prevention, but this declined by 9% in 2008/09. In the same period, AIDS care and treatment accounted for 43% and 48% respectively of all HIV/AIDS expenditure. Expenditure figures disaggregated by specific interventions or beneficiary groups were not available. However, for one entity, the Civil Society Fund, by June 2009, it had disbursed 51% of its HIV prevention resources (UShs 21,180, 360, 653) to abstinence and be faithful (AB) activities, 0.7% to PMTCT, 5.4% to HCT, 5.8% to condoms and 38% to other HIV prevention activities (MARPs, medical infection control, and circumcision). These are not aligned to the MoT. Similarly, PEPFAR that funds the largest component of Uganda's HIV response, obligated 33% of the HIV prevention resources in 2008/09 (UShs. 86,481,519,769) to PMTCT, and 34% to AB. Just like the 2008-MoT synthesis, AB receives

disproportionately more funding than other HIV prevention activities. Although GoU has increased its domestic contribution to HIV care and treatment in recent years (US $ 30 million in 2010/11), all this is for care and treatment, with about US $ 0.5 million for HIV prevention.

In view of the fact that the HIV epidemic has evolved in recent years, under the new HIV prevention strategy, partners face the difficult decision to re-align HIV prevention resources to interventions likely to have the greatest impact on new infections. Fortunately, there are promising signs. For instance, USG that funds most of the national HIV prevention response has committed that USG funds are provided to support the implementation of the national strategy, and has already taken steps to align its funding to priorities aligned to MoT. However, it should be noted that it is unwise for one donor alone to contribute so much to the national response.

Strategic information for HIV prevention

Uganda has systems and plans for tracking strategic information on outcomes and coverage of HIV prevention, but they are inadequate, especially for behavioural and structural interventions. Although the need to use HIV incidence data in tracking impact of HIV prevention programmes is recognised, the surveillance systems often unable to provide timely and comprehensive data. Tracking programme outcomes is mainly through periodic population- and facility-based surveys, but available data was collected over five years ago. However, a new national population-based AIDS indicator Survey (AIS) and a DHS are already underway and will likely provide baseline data for this strategy. While the coverage of biomedical interventions is fairly well tracked by existing health sector monitoring and reporting systems (HMIS), such information on behavioural and structural interventions is lacking. In addition, the evaluation of effectiveness of various HIV prevention interventions and approaches is often adhoc. Furthermore, strategic information on HIV prevention is rarely consolidated and disseminated to stakeholders timely to inform HIV prevention planning and evaluation. The National Performance Monitoring and Measurement Plan (PMMP) at UAC is not operational and has weak linkages with sector information systems. Periodic reports on HIV prevention are often not available to inform programme planning and evaluation. The new strategy will require improved monitoring and reporting systems, as well as consolidation and sharing of data among stakeholders.

Coordination of HIV Prevention:

4. The Vision, Goals and Key Outcomes of the HIV Prevention Strategy

Mission:

The mission of the *National HIV Prevention Strategy* is to serve as a resource to stakeholders to strengthen planning, implementation, and monitoring of high quality, evidence-informed, and universally accessible HIV prevention initiatives within a multi-sectoral response in the country. The purpose of the strategy is to improve the effectiveness of HIV prevention programmes in Uganda through improved targeting of at-risk groups, prioritising evidence-based prevention interventions, delivering combination HIV prevention packages at multiple levels, and strengthening coordination, monitoring and evaluation of HIV prevention.

Vision:

The vision of the Strategy, consistent with the NSP, is "*A Uganda where new HIV infections are rare, and where everyone regardless of age, gender, ethnicity or socio-economic status has uninterrupted access to high quality and effective HIV prevention services free from stigma and discrimination".*

Goal:

The goal of the *National HIV Prevention Strategy* is to significantly reduce new HIV infections by 30%[17] based on the 2009 level of new HIV infections, which would results in 40% reduction of the projected number of new infection in 2015[18]. Virtual elimination of mother-to-child HIV transmission is part of this overall goal. This is in line with the targets of the NDP and MDG 6, and would avert about 200,000 new infections over the five years.

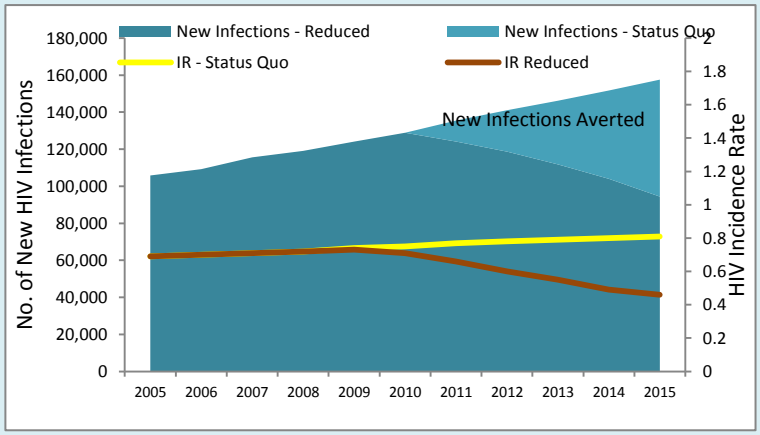

Fig 5.1. Annual Numbers of new HIV infections (and new infections averted) and HIV IR under 2 scenarios – i) Status Quo, and ii) New HIV infections reduced by 30%

Outcomes, Indicators and Targets:

The National HIV prevention strategy aim to achieve the following outcomes:

i. Increased coverage, and utilization of HIV prevention services
ii. Increased adoption of safer sexual behaviors and reduced risky behaviors

[17] The Task Team considered various scenarios in setting targets for this goal. A reduction of 30% of new HIV infection based on current numbers of new HIV infections equates to a 40% reduction of the projected number of new HIV infections in 2015 in line with the NDP, and would bring down 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% would result in over 100,000 infections in 2010, implying that would not be getting ahead of the epidemic.

[18] The task team considered the scenarios required to meet the target of reducing MTCT infections to less than 10% from the current estimate of 29%. It requires simultaneously reducing new HIV infections among reproductive age women by 50%, elimination of the unmet need for family planning among HIV-infected women, enrolment of at least 90% 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.

iii. A strengthened and sustainable enabling environment that mitigates underlying factors that drive the HIV epidemic

iv. Achieving a more coordinated HIV prevention response at all levels

v. Strengthened information systems for HIV prevention

The targets and indicators for tracking attainment of these outcomes are summarized in table 4.1 below

Table 4.1 Outcomes, Monitoring Indicators and Targets for the National HIV Prevention Strategy:

i) Increased coverage, quality and utilization of HIV prevention services	ii) Increased adoption of safer sexual behavior and reduced risky behaviors	iii) A strengthened and sustainable enabling environment that mitigates underlying factors that drive the HIV epidemic	iv) Achieving a more coordinated HIV prevention response at all levels	v) Strengthened information systems for HIV prevention
• The proportion of HIV-infected mothers and exposed infants accessing PMTCT increased to 80% • The proportion of adults who have ever tested for HIV increased to 80% by 2015 • The proportion of risky sex encounters (multiple partnerships, casual and sex with partners of unknown HIV sero-status) that are consistently protected by condoms increased to 80% • The proportion of adults males that are circumcised increased to 80% • At least 80% of care and treatment services integrate HIV prevention • At least 100% blood transfusion safety in facilities • All facilities in the country implementing universal infection control measures	• 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 • The proportion of risky sexual acts that are protected by condoms increased to 80%	• % women who make decisions about their SRH independently or jointly with their husbands increased from 61% to 80% • SGBV among women reduced from 39% to 10% . • % Survivors of SGBV seeking help from social 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 sex with her husband if he has an STD increased to 100% from 84 % for women and 90% for 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%	• National Composite Policy index increased from 67.5% (2005) to 85% • All districts having functional HIV coordination committees by 2015 • All districts having functional PHA networks by 2015 • All district HIV plans are aligned to national planning and budgeting frameworks • HIV/AIDS spending as a percentage of the total annual national budget increased from 3% (baseline for 2004) to 5% • HIV Prevention expenditure as a percentage of total HIV budget increased from 25% (UNGASS 2010) to 40% • % local governments Percentage local governments allocating funds from local revenues for HIV prevention increased to 100%	• New HIV infections tracked annually and results disseminated • Population and facility surveys of HIV prevention outcomes conducted every 3-5 years • All HIV prevention interventions evaluated for impact and effectiveness in past 5 years • Annual reports of HIV prevention comparing outcomes against targets, produced • All significant HIV Preventions programmes have M&E systems and plans • The population sizes and HIV burden of at least five MARPs determined by 2015

HIV Prevention Priorities

The N*ational HIV Prevention Strategy* provides guidance on how to target efforts in line with the drivers of the epidemic. HIV prevention approaches in Uganda will be based on "combination prevention" involving defined packages of effective behavioural, biomedical and structural interventions tailored to specific population groups. This is in line with the recommendation that an "HIV prevention approach based solely on one element doesn't work; that countries should use a mix of behavioral, biomedical and structural HIV prevention actions that suit their epidemic and the needs of those most at risk"[19]. This requires coordinated evidence-informed strategies that together work to achieve shared HIV prevention goals, based on a sound analysis of what drives the epidemic in different contexts.

The first priority for HIV prevention in Uganda is to align HIV prevention interventions to the drivers of the epidemic. With approximately 80% of HIV infections arising from sexual transmission, vertical infections, 20%, and blood borne infections probably less than 1%, the priority for Uganda is to adequately address the key driver of the epidemic within a generalized epidemic, i.e. HIV transmission through unprotected sex. In Uganda's generalized HIV epidemic, there are geographic hotspots typical of a concentrated epidemic and most-at-risk-population groups (MARPs) with risk behaviors that make them more vulnerable to HIV infection than the general population.

Behavioural interventions should aim to reduce multiple sex partnerships, early sex debut, and cross-generational and transactional sex.

The priority evidence-based biomedical interventions addressing the epidemic drivers will comprise of:

- HIV Counseling and Testing either as couples or with disclosure of test-results to partners
- Promoting correct/consistent condom use in the general population and high risk groups,
- Safe medical circumcision of males
- Prevention of Mother-to-Child Transmission of HIV (PMTCT)
- Reducing community viral load through anti-retroviral therapy

Furthermore, individual factors, socio and gender norms that promote masculinity and femininity, GBV, and acceptance of multiple partnerships, stigma and discrimination, and structural constructs that facilitate sexual transmission of HIV should be concurrently addressed, along with behaviors that increase risk, such as excessive alcohol consumption.

The priority target audiences include:

- Adults and youth involved in multiple sexual partnerships,
- youth engaged in cross-generational sex relationships and their partners,
- men and women who engage in transactional sex and their clients, and
- adults working away from home, e.g. transport and migrant workers, uniformed services

Initiatives should prioritize high prevalence areas and epidemic hotspots such as urban slums and northern Uganda, transportation corridors, border crossing points, and fishing landing sites.

Other HIV Prevention Priorities:

[19] UNAIDS (2009:1). UNAIDS promotes combination HIV prevention towards universal access goals. Geneva: UNAIDS

Even if the first priority is reducing HIV infections from sexual contact, other priority interventions include scaling up high quality services for prevention services for HIV positives; medical infection control, blood safety, and STI control.

Epidemic dynamics and patterns evolve, therefore it is possible that factors that drive the HIV epidemic today will change in the future. Thus, the *National HIV Prevention Strategy will be* reviewed and updated as the knowledge base and experience grow. There should also be ongoing vigilance and data collection on risk behaviours such as IDUs and MSM that have a potential for upsurge of new infections, but for which there is inadequate data to warrant ranking them high among HIV prevention priorities. The strategy should evolve as HIV prevention initiatives themselves evolve.

The Minimum Package of HIV Prevention Services for Adults

Core Components:

1. PMTCT
2. Male circumcision
3. HIV counseling and testing
4. Antiretroviral Therapy
5. Condom promotion

Complimentary Components:

6. BCC integrated into existing structures (religious institutions, work places, school, etc)
7. IEC Messages and social norms reinforced through mass media
8. STI screening and treatment
9. Blood Transfusion Safety and Infection Control
10. Supporting policy and advocacy

The Core Package of HIV Prevention Services:

The main approach in this *National HIV Prevention Strategy* is that all IPs should ensure that individuals in Uganda receive a core package of HIV prevention services based on their HIV risk profile. A minimum package of HIV prevention services is designed to offer individuals a set of priority, evidence-informed services. The components of the HIV prevention package for adults is highlighted in the box above.

Since it is not expected for any one organization or partner to provide all services in the package to a target audience, it is critical for partners to establish and maintain functioning coordination and referral systems at national, district, and community levels within and between sectors. All development partners and other funding entities should make it a requirement for programmes to demonstrate that the referral linkages and partnerships exist or are established.

For a generalized epidemic, HIV prevention interventions must be woven into existing systems and structures, with messages supported by widespread mass media. For MARPs and populations in geographic hotspots, HIV prevention programs should be mainly out-reach based.

Stakeholders should review and codify core packages of effective services for specific groups. This includes service packages for:

- Adults engaged in multiple partnerships in the general population
- Sexually active youth, especially those engaged in cross-generational and transactional sex
- MARPs, including sex workers and clients, military, transport and migrant workers, etc.
- Sero-discordants couples

5. Outcome 1: Increased Coverage, Quality and Utilisation of HIV Prevention Services

Most HIV preventions services in the country are at a scale that is insufficient to turn the tide of the epidemic. In addition, there is no intervention that has been proven to be 100% effective in preventing HIV transmission in all settings. Scaling up priority HIV prevention services in a structured package will be essential for improved HIV prevention outcomes.

Under this framework, a core packed of evidence-based interventions that will be scaled up as part of combination HIV prevention package comprising of: PMTCT, HCT (couple CT with disclosure of results to partners and risk-reduction counseling), SMC and ART for prevention. Complementary services will include Medical Infection control and PEP, Blood transfusion safety, Condom promotion, HIV Prevention with positives, and STI screening and treatment especially for MARPs. There is also need to prepare for roll out of new HIV prevention technologies that are still under clinical evaluation e.g. PreP, microbicides, Test and Treat, HIV vaccines etc.

Indicators and targets:

The targets for this outcome and corresponding indicators for tracking attainment are as follows:

- Proportion of HIV-infected mothers and exposed infants accessing PMTCT increased to 80%
- The proportion of adults who have ever tested for HIV increased to 80% by 2015
- Consistent use of condoms during risky sex[20] acts increased to 80%
- The proportion of adults males that are circumcised increased to 80%
- At least 80% of HIV Prevention care and treatment programmes integrate HIV Prevention
- All health facilities ensuring blood transfusion safety
- All health facilities implementing universal infection control measures

Strategies:

The strategies to achieve increased coverage and utilization of priority HIV prevention services in the next phase of HIV prevention in the country will comprise of:

i) Increasing coverage of the core package of evidence based HIV prevention services to at least 80% of the population
ii) Increasing coverage and utilisation of complimentary HIV prevention services to the general population and other population groups,
iii) Strengthening supply management of medical and pharmaceutical HIV prevention supplies
iv) Integration of HIV prevention services in clinical and community settings
v) Provision of targeted combination HIV-prevention package services for MARPs
vi) Preparing for roll out and implementation of new HIV prevention technologies and services.

5.1 Increasing Coverage and utilization of Core HIV Prevention Services:

The core package of evidence-based HIV preventions services under combination HIV prevention will comprise of PMTCT, HCT, SMC, expanded ART and condom promotion and distribution. Achieving a

[20] Risky sex in the context of this strategy includes (multiple partnerships, casual and sex with partners of unknown HIV serostatus)

critical coverage, uptake and utilisation of these key services in the general population and among specific groups is a prerequisite for attainment of the HIV prevention outcomes in this strategy.

5.1.1 Increasing Coverage and Effectiveness of PMTCT

Although Uganda has implemented PMTCT programmes for over 10 years, universal access to services has not yet been attained. Currently, 20% of new HIV infections are through MTCT.

Key steps to expand and increase effectiveness of PMTCT services during the next phase of HIV prevention will require strengthening the four prongs of PMTCT namely: i) primary prevention of HIV among reproductive-age women and their partners; ii) provision of family planning for HIV-infected women and their partners; iii) HCT for pregnant women and ARV prophylaxis or HAART for HIV-infected mothers and infants; and iv) clinical/CD-4 T-cell counts to determine eligibility for ART and provision of treatment, care and support to HIV-infected women, their partners, infants and families.

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

- PMTCT services outlets will be increased to all ANC facilities from the 77% that offered the service in 2009. The uptake of HCT by mothers which increased to 98% largely due to routine CT will be maintained. However, losses in the PMTCT cascade where only 52% of HIV-positive women in Uganda received ARV prophylaxis in 2009, with over half given single dose Niverapine prophylaxis, and less than 30% of exposed infants were given ARVs shortly after delivery, will be the focus of innovative efforts. Partners will aim to increase maternal and infant uptake of ARVs to at least 90%, and roll out of more efficacious combination ARVs regimens, and phase out single dose Niverapine prophylaxis.
- Programmes will rapidly roll out the revised WHO guidelines for PMTCT, which require HIV-infected mothers and their infants to be on triple ARV prophylaxis from labour, through delivery and breast feeding (Option A with transition to Option B).
- PMTCT programmes will also strengthen referrals and linkages with several related services such as: adult / pediatric AIDS care and ART, home-based care, immunization and EID. Comprehensive PMTCT services will include other child health services, e.g. cotrimoxizole prophylaxis, TB screening, family planning, referrals, and mosquito bed nets. modeling scenarios (figure 7.1) indicate that virtual elimination of MTCT will only be achieved if there is:
    - Elimination of the unmet need for family planning among antenatal women,
    - Halving HIV incidence among women of reproductive age,
    - Over 90% of HIV-positive antenatal women on triple ARVs through breast feeding, and
    - Reducing median breast feeding period for HIV positive women to six months.

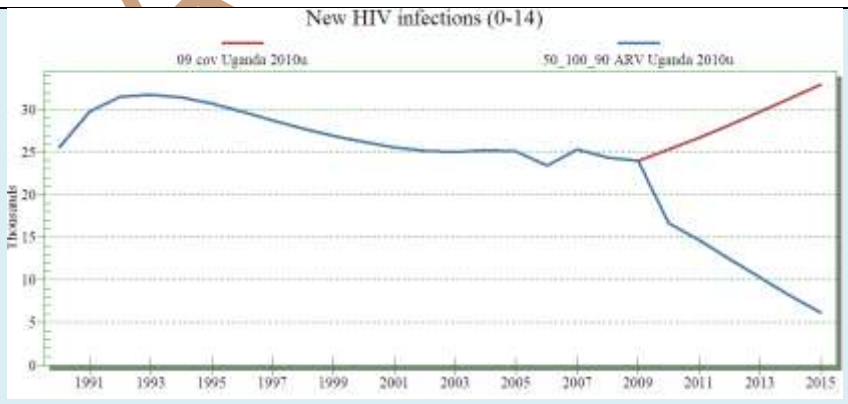

Fig. 7.1. Scenarios required for virtual elimination of MTCT:
09 coverage – base scenario: 2009 programme coverage maintained through 2015
50_100_90 ARV coverage – intervention scenario: 50% reduction in HIV incidence, eliminate unmet need for family planning, provide ARVs or ART to 90% of women in need.

- Educational and BCC efforts should stress demand creation, *parent*-to-child transmission, family responsibility, women and men's role in PMTCT, family planning, and couple CT with risk reduction counseling and post-delivery risk reduction for infants through modified breast feeding practices.

5.1.2 Expanding Quality and Coverage of HIV Counseling and Testing:

Universal access to HIV testing and knowledge of HIV status is fundamental for combination HIV prevention as HTC is the entry point into the three evidence-based interventions i.e. SMC, ART, and PMTCT. Knowledge of HIV serostatus also influences practice of preventive sexual behavior. Uganda has made great accomplishments in supporting individuals to know their HIV serostatus. In the 2005, 57% of HIV-infected individuals had HIV-sero-discordant) partners. Uninfected partners in this situation have elevated risk of HIV infection, representing a high unmet need for HIV prevention.[21] With most discordant couples unaware of their sero-discordant HIV serostatus, and given the low condom use in marital and other 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 set ambitious goals for CT, i.e. at least 80% adults should have tested for HIV by 2015. To achieve these targets, partners should address several issues that will ultimately improve the quality of HCT services as well as its effectiveness in prevention of new HIV infections. These include:

- 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 CT services for couples and families, a proven HIV prevention intervention. Emphasis should also be placed on services for men, particularly since CT is a core component of SMC. IEC/BCC campaigns should address couples counseling and disclosure of HIV serostatus.
- Structural barriers for HIV prevention as well as stigma and discrimination should also be addressed. For instance, barriers to disclosure of HIV positive status should be addressed, and through couple HCT, strengthen screening and care for GBV victims during HIV pre- and post-test counseling and make appropriate referrals to safe shelters for women, support groups and to legal services.
- Logistical and management support essential to achieve CT roll out include: ensuring steady supply of commodities (test kits and lab supplies); coordination of strategies; providing policies/guidelines (e.g. HBC and lay counselors); fostering synergy and collaboration among stakeholders; and advocating for adoption of practices that will streamline CT, including the use of lay counselors and focussing on "testing literacy".
- Building capacity to collect accurate, timely, and complete CT data. M&E tools for data capture at community and in clinical CT settings will be developed and used in all programmes. Facilities should fully capture and report the numbers of individuals counseled, tested and received results through all CT service outlets, including variables that enable determining what proportion of CT clients are repeat testers.
- Strengthening pediatric CT including updating and disseminating relevant policies and guidelines.

[21] Gray RH, Wawer MJ, Brookmeyer R, Sewankambo NK, Serwadda D, Wabwire-Mangen F, et al. Probability of HIV-1 transmission per coital act in monogamous, heterosexual, HIV-1-discordant couples in Rakai, Uganda. Lancet 2001 Apr 14;357:1149-53

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

5.1.3 Structured Roll out Safe Medical Circumcision:

Medical circumcision for HIV prevention has been adopted in Uganda, following on evidence from clinical trials in Sub-Saharan Africa that showed it to reduce HIV acquisition by about 50% among uninfected men[22] over two years. It is estimated that wide-scale SMC could reduce at least six million new HIV infections and three million deaths in Sub-Saharan Africa[23,24]. Expanding SMC to 80% of adults in Uganda by 2015 could avert 428,000 new HIV infections countrywide by 2025[25].

In the 2004-05 USBS, 25% of adults in Uganda were already circumcised with three regions having very low prevalence of MC i.e. Mid-north (2.4%), North East 4.9% and South West 7.6%.

The MoH has developed national policies and technical guidelines[26], and a draft strategic plan to roll out of SMC. Feasibility and acceptability studies have been conducted, and pilot schemes implemented in Kayunga district (by Walter Reed Institute), the UPDF in a collaboration with the US DoD, and in eastern Uganda by the STAR-E project. The USG/ PEPFAR has obligated US $ 5 million under its HIV prevention portfolio to roll out of SMC.

This strategy sets ambitious targets for medical circumcision i.e. at least 80% of adults circumicised by 2015. Under this strategy, as part of combination HIV prevention, focus should be on:

- All IPs should provide a comprehensive SMC service package comprising of CT, STI treatment, infection control, risk reduction counseling, condoms, and referrals to other social support services. Patient follow up should include assessment of counseling effectiveness, monitoring of adverse effects, and sero-conversion.
- Formulation of operational guidelines, training materials, standards, and national scale up of services that balance general access to high quality, comprehensive services with the need to reach high risk males drawing on lessons from the pilot projects that assessed the feasibility and acceptability of MC in a range of cultural, demographic, and epidemiological contexts.
- Partners should roll out SMC in a project like manner, through surgical camps, outreach, and mobile teams, starting with high HIV prevalence areas and at-risk adult men while at the same time, gradually integrating into routine facility services.
- Functional referral linkages with other services, especially CT should be established, for instance, HIV-negative individuals from CT can be referred for SMC and vice versa.

[22] Gray RH, et al. Lancet 2007, Bailey RC, et al.Lancet 2007, Auvert B, Plos Med 2005.
[23] Wilson D, de Beyer J. Male Circumcision, Evidence and Implications. Washington, World Bank, 2006
[24] SADC: Report of the Expert Think Tank on HIV Prevention
[25] USAID, Health Policy Intitative: The Potential Cost and Impact of Expanding Male Circumcision in Uganda
[26] MoH: National Policy and Technical Guidelines for Rolling Out Medical Circumcision of Males in Uganda, Kampala, 2010

- Service provision will be complemented by demand creation and education, paying attention to the potential for behavioural dis-inhibition or risk compensation.

5.1.4 Expanding Antiretroviral Therapy for HIV Prevention:

Antiretroviral treatment among HIV-infected individuals is now one of the most promising HIV prevention interventions, since it reduces viral load and consequently the risk of HIV transmission. A recent clinical trial demonstrated that early ART initiation was 96% effective in preventing HIV transmission among HIV sero-discordant couples[27]. This finding confirmed earlier findings from observational and epidemiological studies. For instance, a 2009 meta-analysis, reported zero risk of sexual transmission from ART patients when HIV-1 viral load was <400 copies/ml[28]. Another analysis of sero-discordant couples estimated a 92% reduction in HIV transmission risk after controlling for CD-4 T-cell counts[29]. Our projections (figure 7.2) estimated the impact of ART on new HIV infections in Uganda.

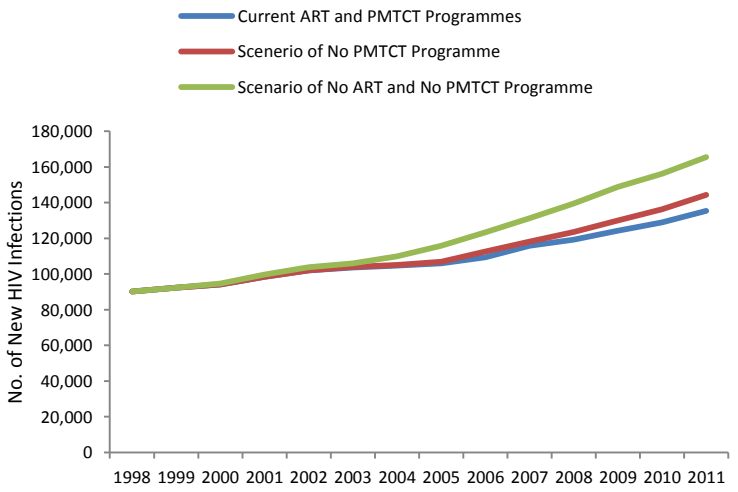

Fig 7.2: The Estimated Impact of PMTCT and ART Programmes on New HIV Infections in Uganda

This makes a compelling case for universal CT and immediate ART for HIV-infected individuals. However, the cost-effectiveness of ART for patients with CD4 counts >350 cells/ul as a prevention strategy is still unknown.

Although ART is one of the most promising biomedical HIV prevention interventions, currently, less than 50% of ART-eligible patients (patients with CD4 <350 cells/ul, or stage III/IV disease) in Uganda are receiving therapy[30]. The low coverage of ART, in due in part, to low coverage of HTC, and inadequate systems to ensure that eligible patients are initiated and retained on ART.

Therefore, for combination prevention, scaling-up of ART for prevention will require:

- Formulation of appropriate policies and guidelines for ART as HIV prevention including regimen selection, adherence support mechanisms, etc
- Strengthening of treatment - prevention linkages and integration that include adherence support. Scaling up ART to all these in need will be particularly critical
- Expanding CT especially for couples to identify discordant couples and empower them to make evidence-based decisions about HIV preventions options open to them

5.2 Increase coverage of complimentary HIV prevention services tailored to specific population groups

[27] 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

[28] Anglemyer A, Rutherford G, et al: Antiretroviral therapy for prevention of HIV transmission in HIV-discordant couples: Cochrane Database Syst Rev. 2011 May 11;5

[29] Donnell D, Baeten JM, Kiarie J, et al: Heterosexual HIV-1 Transmission after initiation of antiretroviral therapy: a prospective cohort analysis: *Lancet* 2010

[30] MoH: The Status of Antiretroviral therapy Services in Uganda: Quarterly Report for July – September 2010: Kampala, Uganda

Complimentary HIV prevention services will comprise of STI screening and treatment, medical infection control, PEP, blood transfusion safety, and prevention for positives, and educational interventions (discussed in the next section). These will be tailored to specific population groups.

5.2.1 Expanding 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-USPA found that only 6% of health facilities in the country had the basic requirements for infection control (water, soap, gloves, disposal boxes for sharps etc). About 6% of health units had facilities for adequate disposal of sharps and other biohazard materials while only 15% had guidelines for infection control, and only 6% of facilities had access to PEP services for staff.

The MoH has developed guidelines on medical infection control, trained health workers, and established infection control committees in most facilities. However, gaps remain in all areas. In this HIV Prevention HIV strategy, as part of combination HIV prevention, focus will be on:

- MoH and its partners should expand capacity building for universal precautions for prevention of medical transmission of HIV. Efforts should include injection safety training, needle stick surveillance, roll out of PEP and hepatitis B vaccination for health care 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.
- Communities should be sensitized about infection control practices, decrease demand for unnecessary injections, and house-hold safe disposal procedures, particularly for home based care.
- Disposable syringes and bio-safety boxes are included in the essential drug list.

5.2.2 Expanding Coverage and Scope of Blood Safety

Prevention of HIV transmission through transfusion with contaminated blood is a key component of the HIV prevention package. 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 (UBTS) 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, challenges and constraints for blood transfusion safety include lack of universal coverage of quality assured services. Furthermore, the number of repeat non-remunerated donors is limited, and blood collected falls just short of national

Minimum package of Services for Prevention with PLHIV

1. Risk reduction counseling, including skill building in safe sex negotiation and practices
2. Disclosure of HIV sero-status to partners and family and partner testing
3. CT particularly with partners
4. PMTCT services
5. STI screening and treatment services
6. Condom distribution
7. Care and treatment, including screening for SGBV and substance abuse
8. Other health services: RH and FP, TB, safe water, sanitation, malaria, nutrition, etc.
9. Facility and community based psychosocial and spiritual support
10. Support groups with PLHIV and couples
11. ART and ART adherence counseling and support

requirements. For instance, only 90% of the national need for blood units was collected in 2009[31].

Under combination HIV prevention in the new Strategy Blood Transfusion safety is an important component: Main activities include:

- The UBTS should continue to identify and sustain HIV-negative voluntary non-remunerated recurrent blood donors throughout the country. One strategy is through blood donor clubs consisting of individuals counseled, tested, and committed to remaining HIV free that is currently supported by URCS and UBTS. A database of such donors to be maintained.
- 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, whereby HIV-negative individuals are referred as potential donors should be strengthened.
- The private sector and workplace programmes 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

5.2.3 Expanding HIV Prevention with PLHIV[32]

The roll out of HIV/AIDS care and treatment and HCT services avails increased opportunities for the health system to interact with PLHIV and offer risk reduction counseling. Provision of comprehensive HIV prevention, care, and treatment services to HIV-positive individuals is a proven effective HIV prevention initiative. Initiatives for "Prevention with HIV-infected people" empower HIV-infected individuals to avoid onward transmission of HIV. Prevention with positives (PwP) delivery platforms are facility and community based, and require coordinated provision of a core package of HIV prevention services. PwP core messages must emphasize risk reduction and the limitations of ART.

In the new HIV Prevention Strategy:

- Partners should strengthen integration of HIV prevention into ART/ chronic AIDS care, identification of sero-discordant couples and risk reduction counseling.
- PwP guidelines addressing PLHIV transmission sexual behavior should be developed.
- 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 PwP services expand, community components, including integration of services into home-based care and psychosocial services should be done. Successful PwP programs require functioning, multi-directional referral systems, close follow up and support, and should use this platform to strengthen community - facility dialogue.

5.2.4 STI Prevention, Screening and Treatment:

Some interventions have not been consistently associated with reducing HIV transmission, but may still contribute to HIV prevention. For example, having an untreated STI such as HSV-2 substantially increase

[31] MoH: Annual Health Sector Performance Report for 2009/20, 2010, Kampala, Uganda
[32] UNAIDS Recommends use of the term ……, for these interventions, but in this document, the preferred term is prevention with PLHIV

the chance of acquiring HIV, but research has shown contradictory results regarding the effect of treating STIs on HIV transmission at a population level. Nevertheless, all people screened for STIs should also be screened for HIV because these infections are driven by the same risk behaviors. However, the evidence of the impact of STIs on HIV transmission among MARPs is compelling. In spite of this, the Uganda STI programme has developed without special focus on MARPs that are often not adequately reached by existing services.

In the new HIV Prevention Strategy, strengthening STI screening and treatment should:

- Focus on MARPs with targeted services in the context of a core package of services
- Increasing quality of STI services in health facilities through training of health workers, and provision of pharmaceutical supplies necessary for the revised STI treatment[33] guidelines

5.3 Strengthening supply management of medical and pharmaceutical supplies for HIV Prevention

5.4 Preparedness for the Roll out of Potential New HIV Prevention Technologies:

Current approaches for HIV prevention should be coupled with research on new methods that can have a long-term impact. Among the promising approaches are vaccines and microbicides, but safe and effective vaccines and microbicides are still under evaluation and perhaps far off. Another promising area is use of HIV/AIDS treatment as prevention of new infections, i.e:

i. Pre-exposure prophylaxis (PrEP), i.e. the use of antiretroviral agents by high-risk uninfected individuals such as HIV-negatives in HIV sero-discordant relationships,
ii. 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[34],
iii. Microbicides containing antiretroviral agents.
iv. 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 the Uganda and at multiple sites in other countries. In the CAPRISA study, in South Africa ARV-containing microbicides (1% Tenofovir) reduced HIV transmission by 39% in about 900 HIV-negative women[35], with higher reduction among individuals with high adherence.

Even if these prevention strategies are successful, additional research will be needed to assess cost effectiveness and adaptability outside of carefully controlled studies. They will also need to be coupled with behavioral interventions to ensure that any positive outcomes are not erased by changes in risk behavior. Under the new strategy, it will be necessary that:

- New evidence is disseminated, policy implications discussed and guidelines developed
- Feasibility studies and cost implications for roll out of the interventions conducted promptly

[33] MoH: The Revised STD Treatment Guidelines for Uganda: 2009, Kampala, Uganda
[34] Donnell D, Baeten JM, Kiarie J, et al. Heterosexual HIV-1 transmission after initiation of antiretroviral therapy: a prospective cohort analysis. *Lancet*. 2010.
[35] Quarraisha Abdool Karim, Salim S. Abdool Karim, et al, On Behalf of the CAPRISA Team. Effectiveness and Safety of Tenofovir Gel, an Antiretroviral Microbicide, for the Prevention of HIV Infection in Women. *Science* 2010: 329 (5996), 1168-1174.

6. Outcome 2: Increased Adoption of Safer Sexual Behaviour and Reduction in Risky Behaviour

Sexual behavior is at the root of HIV transmission in Uganda. Multiple (especially concurrent) partnerships, cross-generational sex, transactional and commercial sexual relationships, casual sex, and low condom use constitute the main risky behaviours currently driving the Uganda HIV epidemic. It is the main priority of the new HIV prevention strategy to modify these behaviours.

Indicators and Targets:

The behavior outcomes necessary to make a dent in the epidemic will be as follows:

- Recent multiple partnerships reduced by 50% among men and women respectively
- The proportional of adult men and women that engage in transactional sex in the previous 12 months 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
- The proportion of risky sexual encounters that are protected by condoms increased to 80%

Strategies

The main strategies for achieving these results will comprise of:

i. Behavioural Change Interventions among all population groups with focused messages to address multiple partnerships, transactional/early/cross generational sex
ii. Provision of policy guidance, minimum standards and strengthening capacity at all levels to design, implement and monitor effective IEC/BCC
iii. Promotion and Distribution of condom use
iv. Demand Creation for HIV prevention services, while addressing barriers

Priority actions under these strategies will be found in the Action Plan.

6.1 Behavioural Change Interventions among all population groups with focused messages to address multiple partnerships, transactional/early/cross generational sex

Shifts in high risk sexual behaviour will require effective approaches, involving coordinated multi - channel communication (mass media, community mobilization, working with peers, and simultaneously addressing the socio-cultural and structural context that underpin the behaviours).

6.1.1. Reducing Multiple Sexual Partnerships:

The role of multiple sexual partnerships in HIV transmission 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 epidemic in the African sub-region[36]. The practice is influenced by underlying gender, socio-cultural,

[36] Halperin, D. & Epstein, H: The role of multiple concurrent partnerships and lack of male circumcision. Southern Africa Journal of HIV Medicine. April 2007.

socio-economic and other factors including mobility, that have to be factored in any educational campaign to change this behavior.

Multiple sexual partnerships in Uganda is still high, for instance, during 2001 – 05 recent multiple sexual partnerships increased from 25% to 29% among men and from 2% to 4% among women. Extra-marital sex during the same period increased from 14% to 29% among men. Multiple partnerships was found to be independently associated with HIV prevalence, and HIV incidence[37], with HIV prevalence increasing proportionately with number of sexual partners.

HIV prevention efforts to reduce partner reduction will be challenging. Experience in Uganda shows that well articulated partner reduction campaigns can be successful; e.g. the *"Zero Grazing"* campaign of the 1990s which resulted in a 60% reduction in the number of people reporting two or more sexual partners[38], with greater reduction among people with three or more partners. There are currently no specific guidelines for partner reduction activities in Uganda.

Under combination HIV prevention with other services in the new phase of HIV prevention in Uganda, efforts will aim to halve multiple partnerships over five years. This will require:

- Addressing both serial and concurrent multiple partnerships in BCC/IEC campaigns.
- Research to explore social, cultural and economic reasons for concurrent partnerships to inform development of appropriate prevention messages and approaches.
- The MoH and stakeholders should design guidelines based on behavioural theory for IEC/BCC approaches to reduce multiple partnerships for use by implementing partners.
- Workplace programme should support employees to reduce motivation for multiple sexual partnerships, especially work involving frequent mobility. For instance, this could be done through reucing the frequency of transfers of workers away from homes.
- The MoGLSD and stakeholders should support community dialogue on socio-cultural and gender dimensions of multiple partnerships.
- Partners should promote couple communication, HCT within ethical principles of privacy and choice since fidelity within longstanding relationships is not necessarily protective due to high prevalence of HIV sero-discordance.

6.1.2 Reducing Transactional Sex

Transactional sexual relationships involve people exchanging money or goods for sex. Transactional sex, in the context of multiple concurrent partnerships or serial relationships, manifests in several ways in Uganda. One form of transactional sex is sex work (discussed under 6.1.3). Cross generational sex is also often in the context if transactional sex.

Transactional sex, not necessarily seen culturally as sex work, has been in existence for long in the country. It is often condoned within the practice of polygamy in many communities in Uganda, where there is social acceptance of receiving something in exchange for sex, usually from male to the female partners. Like other forms of multiple partnerships, there are risks to transactional sex. Recent case

[37] Mermin J, Musinguzi J, Opio A, Kirungi W, et al. Risk factors for recent HIV infection in Uganda. JAMA 2008 Aug 6;300(5):540-9

[38] Halperin, D. &Epstein, H: The role of multiple concurrent partnerships and lack of male circumcision. Southern Africa Journal of HIV Medicine. April 2007.

studies confirm that often, whenever sex is part of an economic exchange, women's ability to protect themselves from STIs and HIV is limited.

Owing to the widespread acceptance and practice of transactional sex, efforts should:

- Be embedded within existing structures and programs, such as school and work place, or interpersonal communication.
- Address the underlying socio-cultural context through interaction with community leaders.

6.1.3 Addressing HIV Risk Associated with Sex Work

Sex workers are often females who solicit money or goods in direct exchange for sex, either regularly or occasionally. In Uganda, sex work is common in urban areas and other hot spots such as fish landing sites, truck stops on highways, and border crossings. Many sex workers 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 a high turnover has also been documented[39]. Some sex workers have long-term or even marital partners alongside clients.

The magnitude and demand for sex work in Uganda is has not been determined, and there are many gaps in understanding the full range of related motivations, correlations, behaviors, and the role of coercion and GBV. Sexual net works involving individuals bridging to the general population are also not well understood. The motivation of clients of sex workers is also unclear.

Ugandan law prohibits sex work (commonly referred to as prostitution), so sex workers often face stigma and discrimination through negative attitudes, harassment and arrest by law enforcement agents. This presents barriers to seeking health and HIV services by sex workers.

HIV prevention strategies for sex workers and their clients should include a specific core package of HIV prevention services[40]. This includes:

- Risk reduction counseling, condoms, targeted IEC/BCC, HCT, STI screening and treatment, and referrals to HIV prevention, care and treatment.
- HIV positive sex workers should have access to non-stigmatizing risk reduction services, as well as care, and treatment.
- Address structural barriers and build supportive environments, including policies, legislation, and practices that limit access to HIV/AIDS services, or condone violence and abuse, and norms and practices that punish sex workers, but ignore the widespread demand for paid sex.
- Support programmes e.g. legal support and skill building for women who quit sex work

The Core Package of Prevention Services for MARPs

1. Community-based peer education and outreach
2. Risk reduction counseling (through peer outreach or in clinic settings)
3. Condom promotion and distribution
4. HIV counseling and testing
5. STI screening and treatment
6. Family planning and SRH services
7. Post Exposure Prophylaxis
8. HIV care and treatment
9. Access to health/social services
10. Structural issues (community mobilization initiatives and policy level initiatives, including those which address stigma and discrimination)

[39] MoH, UNDP, Profiling of sex work in Kampala Uganda. 2010, Kampala, Uganda
[40] UNAIDS: UNAIDS Guidance Note on HIV and Sex Work: Geneva Switzerland, March 2009

6.1.4 Reducing Cross-generational and Early Sex

There are different situations youth experience regarding their choice - or lack thereof - to engage in sexual relationships, and these situations should be reflected in HIV prevention strategies. This includes approaches for youth who are not yet sexually active, in order to delay sexual debut, as well as for sexually active youth to promote fidelity with one uninfected partner with correct and consistent condom use and knowledge of HIV serostatus.

Many youth, particularly females, engage in cross-generational sexual relationships, often transactional, motivated by money, gifts or an aspiration for higher social standing. Youth exchange sex for money and other materials in all types of relationships, casual and long term.

Under Combination HIV Prevention approach, initiatives addressing cross generational sex:

- HIV prevention programmes must be firmly rooted in formative research with sound understanding of the context and relationship dynamics. They need to be aware that not all youth can control whether or not they have sexual relationships. Strategies must consider the lack of control that youth, particularly girls, might have over their choices. For instance, female youth may be encouraged or required by their families to engage in sex for money. Females are vulnerable to SGBV, including sexual abuse and rape. There are particular groups of young people, such as adolescent OVCs, who are vulnerable to HIV infection, but for whom little data exist.
- Programmes should also target youth who might be seen to be better off than their peers. For instance, some young women with strong perceptions of self-efficacy perceive themselves as exploiting older men for money or gifts.
- Need to be rooted in communities with engagement of a wide range of opinion leaders in order to influence underlying socio norms.
- Should simultaneously address older peoples' behaviors, and empowerment of young people to make choices or build negotiation skills, and issues of coercion and violence.
- Should involve youth in the design and implementation of initiatives.
- Communities should play a role in identifying and reaching older partners who engage in cross-generational sex, and most-at-risk youth, including out-of-school youth and OVCs.
- Targeted outreaches should engage youth with age appropriate risk reduction messages.
- Referral mechanisms should be established for youth to access a full package of HIV prevention services, e.g sexually active youth should receive condoms and referrals for HCT.
- Should include mitigation for those with negative consequences, such as HIV, pregnancy, abortion or STIs. HIV-+ve youth and older partners should be referred for care and treatment.
- Should incorporate empowerment, gender, social norms and gatekeeper components to create safe and enabling environments for youth, particularly young women and girls. Youth who have experienced SGBV should be referred to youth-friendly counseling services and PEP.

6.1.5 Delay of Sexual Debut Among Youth

Early Sexual debut is still common in Uganda. Reaching out to youth with age- and context-specific messages based on evidence is necessary to delay of sexual debut. Under combination HIV prevention:

- Messages for delaying sexual debut must be integrated into wider BCC messages including life skills education.

- Incorporate promotion of HCT prior to engagement in sexual relationships, as well as condom use, STIs, and pregnancy counseling. These messages should be incorporated into existing programs, such as school curricula, out-of-school, and faith-based programs. Programmes for youth must move away from "abstinence only education" to provision of a holistic package that equips youth for future challenges
- Communities must take a key role in identifying and helping youth who are at risk of engaging in risky sex, and support the decision of those who have the ability and choice to delay.
- Mass media should reinforce these messages, and help create conducive social norms.
- Action research to identify the causes of the vulnerabilities and simultaneously address them. This includes groups of youth who are vulnerable, but for which little data exist. For instance, the vulnerability of OVC regarding their ability to delay sexual debut, or to engage in coercive or cross-generational sexual relationships.

6.2 Provision of policy guidance, minimum standards and strengthening capacity to design, implement and monitor effective IEC/BCC 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/AIDS knowledge, which is only an important first step since high knowledge levels are not enough to foster behavior change. Most programmes often focus more 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 programmes to translate the prevailing high knowledge levels into factors that influence behavior change, including accurate risk perception and self-efficacy, and design interventions that incorporate these elements. Findings of formative research need to be used to help identify solutions for barriers to behavior change.

This will require:

- Strengthened coordination of IEC/BCC activities to align messages to target audience and drivers of the epidemic,
- Coordination of the appropriate mix of communication channels that balances mass media and interpersonal communication. 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.,
- building capacity in the design and implementation of behaviorally-sound programs, through appropriate training, apprenticeships etc
- IEC/BCC quality assurance mechanisms and standards at national and district level. This will involve establishing a clearing house for IEC/BCC messages, standardized training curricular for IEC/BCC stakeholders, and an accreditation system for IEC/BCC implementers at national and district level.

6.3 Increased Condom use especially during high risk sex

Condom use among adults in Uganda is still low. Among adults who engage in casual sex (with a non-marital, non-cohabiting partner), nearly half of such acts, especially among women were not protected by condoms in 2006. Condom use is even lower among couples in long standing relationships, including

among HIV-sero-discordant couples. There is little data on the consistency of condom use among MARPs.

Currently in Uganda, condoms are available through health facilities, socio marketing, community distribution networks and private sector outlets such pharmacies and stores. The MoH and Implementing Partners also conduct condom promotion activities to address barriers and negotiation skills. The number of male and female condoms procured and distributed in the public health system and social marketing has increased considerably over the past 10 years despite persisting unmet needs and constant shortage 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 about them. 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 or women, MARPs, such sex workers, may feel stigmatized if they seek condoms from outlets. Married couples might feel the same. Community leaders may either neglect to promote condoms, or actively bar their use, due to misconceptions.

In the next phase of HIV prevention:

- Programmes must integrate 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 infected, should have access to condoms within their own communities.
- Condoms will be widely available from various outlet, including pharmacies, clinics, bars, and hotels. Involvement and capacity building of outlet workers and owners, including barmaids and pharmacy staff to promote condom use will be emphasized, to ensure condom availability and accessibility during times of need.
- The low condom use especially by individuals in long standing relationships will be a key area of focus, especially dispelling misperceptions around partner type and condom use.
- Increased attention will be paid to barriers such as stigma, socio-cultural, and gender issues
- Advocacy with key gatekeepers, including religious and community leaders on condom use, particularly within discordant relationships and among at-risk youth will be emphasised
- Public, NGO, and private partners will ensure increased number of youth- and MARPs- friendly distribution points.
- The MoH will develop a plan to address the supply chain management bottlenecks.
- Promotion of female condoms and their provision in non-traditional outlets such as hair salons, VCT centres, peer networks etc, will be strengtheed. Female condoms constitute an important female-controlled product within a market niche. Best practices for female condoms include product positioning and supporting promotion for specific target audiences, e.g. women engaged in transactional sex will be used to expand the reach of female condoms.

6.4 Demand Creation for HIV Prevention Services:

7. Outcome 3: A Strengthened and Sustainable Enabling Environment that Mitigates the Underlying Factors that Driver the HIV Epidemic

The Uganda HIV epidemic is driven in part by structural factors that constrain individual or group's ability to adopt and sustain behaviours and lifestyles that minimize risk and vulnerability to HIV[41]. These factors include, social, cultural, economic, legal, and policy features of the environment[42]. They are embedded and inextricably linked to prevailing societal norms, values, practices, social structures and networks[43]. Current studies indicate that these drivers are "complex, fluid, non-linear, contextual and interact with biological and behavioural factors to increase the risk of HIV infection"[10]. In Uganda, the main drivers identified include harmful cultural norms and practices; gender norms, weak enforcement laws and violation of their rights, wealth and poverty, HIV-related stigma and discrimination, poor governance and accountability, inequitable targeting of existing HIV services and weak leadership and coordination of HIV response especially at local government levels.

The major targets and indicators of change in these drivers over the next five years include:

- Percentage of women who make decisions about their sexual and reproductive health rights independently or jointly with their husbands increased from 61% to 80% in 2015.
- Reduction of the percentage of women who experience sexual violence from 39% to 10% .
- Percentage of survivors of SGBV seeking help from social service organizations increased from 23% to 60% and those seeking help from Police increased from 6% to 30% by 2015.
- Percentage of adults expressing fear of contracting HIV from casual contact with PLHIV reduced by 50% (baseline 19% for women and 28% men)
- Increase the Percentage of adults who believe that when a wife knows her husband has an STD or HIV, is justified to refuse sex or demand for condom use from 84 % for women and 90% for men to 100% for men and women respectively.
- Ratio of current school attendance among orphans vs. non-orphans, aged 10-14 increased from 0.9 to 0.95[44]
- Percentage of orphaned and vulnerable children (OVC) and non-OVC 5-17 years whose basic needs (i.e. clothing, shelter, and nutrition/food) are met increased from 28%[45] to 50%

The key strategies for creating change in these structural drivers include:

i. Community dialogue on context specific interventions that challenge socio-cultural and gender norms that increase vulnerability to HIV.
ii. Advocating for strengthening the legal and institutional framework for enforcement of laws address SGBV and other rights violations
iii. Advocating for structured mainstreaming of HIV in national livelihood programs
iv. Promoting the involvement of men as key partners in HIV prevention interventions

[41]Sumartojo E. Structural factors in HIV prevention: concepts, examples, and implications for research. AIDS 2000; 14 (Supplement 1): S3–S10.
[42]Gupta G, Parkhurst J, Ogden J, Aggleton P, Mahal A. Structural approaches to HIV prevention. Lancet 2008; August: 52–63.
[43]Auerbach JD, JO Parkhurst, CF Caceres, KE Keller. Addressing Social Drivers of HIV/AIDS: Some Conceptual, Methodological and Evidentiary considerations. New York: aids 2031 Working Paper #24: August 2009. Accessed at http://www.aids2031.org/working-groups/social drivers
[44] MDG and UNGASS indicator
[45] UDHS 2006. Lack of basic needs makes children vulnerable to child labour, transactional and cross-generational sex

v. Developing and implementing interventions that reduce stigma and discrimination

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. Mobilising for increase access and uptake of HIV prevention services
4. Peer education and Community-based support groups/clubs
5. Integrating HIV prevention messages into communities activities such as religious worship, funerals, weddings/marriage ceremonies, rites of passage rituals
6. Socialize men and boys to adopt positive values and norms that respect the rights of women and resist pressure to live up to expected norms of masculinity
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, family planning and other SRH services for women
10. SRH rights education for men/boys, women/girls
11. Village savings and investment opportunities targeting MARPs, women and families affected by SGBV and HIV/AIDS
12. Empowering communities to assert their rights and demand for accountability and services from duty-bearers 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 issues in order to challenge secrecy and pretence sub-cultures around sex
16. Community level dialogues; community 'cell' level conversations
17. Pre-commitment' to instrumental values (i.e. those that protect against HIV infection)
18. Building personal initiative, ability to safely navigate day-to-day pressures and expectations

7.1 Change Harmful Socio-cultural norms, beliefs and practices

Within families and communities there are still exists 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[46]. Others include: risky practices associated with rites of passage[47] (e.g. belief among the Bagisu that a newly circumcised man will heal faster if he indulges in unprotected sex with a married woman). There are also risky sexual practices arising from social pressure to bear children especially males; forced and early marriage and superstitious association of HIV with misfortune and spiritual causes and widow inheritance[48].

To address the harmful cultural beliefs and practices, individuals, families and communities should be engaged to understand linkages between the cultural beliefs and practices and vulnerability to HIV infection. In the new strategy, IPs should:

- Promote sustainable mechanisms for on-going community conversations/dialogue on harmful cultural beliefs and practices.
- 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.

8.2 Change in Gender norms and practices that increase vulnerability

[46] SengendoJ,et al. (2001), A cultural Approach to HIV/AIDS prevention and care. UNESCO/UNAIDS Research Project. Studies and Reports, Special Series, Issue No. 15, Division of Cultural Policies, UNESCO

[47] PACE, 2010. Community Driven Response towards HIV Prevention Interventions: Community Assessment Report, Kampala: PACE

[48] Whyte, S.R. (1997). Questioning Misfortune; the Pragmatics of un-certainty in Eastern Uganda.Oxford University Press.

Why women/girls are at risk?

- Women are biologically more vulnerable
- Inability to negotiate terms of sexual relations and use of condom
- Lack of education on sex and sexuality
- Inadequate access to SRH services and commodities
- Gender based violence
- May be involved in cross-generational relationships
- Poverty and dependency
- Lack of economic opportunity
- Unequal property and inheritance rights
- May be forced into sex work/transactional sex
- Women as the cultural caretakers bear the burden of tending and nursing the sick leaving them less ability to get income, creating more dependence

Why men/boys are at risk?

- Multiple partners or concurrent relationships
- Poverty makes it difficult to seek medical services both because of cost as well as time spent away from work
- Concepts of masculinity demand dominance and strength from men, whereas the idea of disease indicates weakness (Expectations to be a' real man'
- Violence and sexual abuse lead to higher rates of transmission
- Work requiring them to be in geographically isolated places with little healthcare infrastructure
- Work requiring them to live away from partner

In most communities in Uganda there are gender norms that make men and women at risk of and vulnerable to HIV infection. Despite progress made in addressing gender disparities, in most communities women and girls continue to be culturally excluded from owning property and productive assets[49]. They are also excluded from education and marketable skills training opportunities, which preclude them from the job market thus increasing their dependence on men. Widows and orphans are often denied their property[50].This situation is exacerbated by the weak enforcement of existing laws and institutional frameworks for protecting the rights of women and children[51]. Prevailing masculinity and gender norms also condone multiples sexual partnerships. Furthermore, women are culturally accorded a low status. This unequal power relationship limits women and girls' abilities to choose or refuse partners, and to negotiate for safe sex.. The social pressures for men to reproduce and maintain dominance masculine characteristics and expectations make it difficult for men to change behaviour. In most communities, men are socialized to control women in all aspects of relationships including decisions on when and a girl or woman will marry, will have sexual relationship and the number of children. They also control where and how women and girls seek health services.

This strategy prioritizes interventions to change masculinity and gender norms and disparities. that increase and sustain women, girls and men's vulnerability to HIV infection and create an environment that enable women to have a voice in decisions that affect their SRHs. Gender norms that make it difficult for women and men to adopt and sustain HIV prevention behaviours need to be addressed.[52]. Interventions need to promote gender equality and make men key partners in addressing such norms. Families and communities should be engaged in community conversations and dialogue in order to develop context specific interventions that challenge these norms and create an enabling environment for changing these practices. Interventions should take a rights-based approach to address rights issues, especially women vulnerable to HIV.

7.3 **Promoting Women's employment, income and livelihood opportunities**

Women's economic dependence on men and unequal access to resources, increases the likelihood of women and girls engaging in avariety of unsafe sexual behaviors. Married women and women in partnerships often accept risky behavior by their partners due to the need for economic security.

[49]Uganda Land Alliance, 2009. The Impact of National Land Policy and Land reform on women in Uganda, Kampala: Uganda Land Alliance and Centre for Housing Rights and Evictions

[50]Kamusiime, H.,et al: (2004). Integrating HIV/AIDS in the land Reform Process, Kampala: Associates for Development

[51] McPherson, D. (2006). Property grabbing and Africa's orphaned generation: A Legal analysis of the implications of the HIV/AIDS pandemic for inheritance by orphaned children in Uganda, Kenya, Zambia and Malawi.
Availableat:http://www.law.utoronto.ca/documents/ihrp/hivproject_summaries.doc

[52]UNAIDS, 1998. Facing the challenges of HIV/AIDS/STDs: a Gender-based response, Geneva: Kit, SAFAIDS, and UNAIDS

Studies show that economic empowerment does note enhance women's ability tonegotiate for safe sex.[53,54]

This strategy will promote interventions that increase access of women to gainful employment and increasing their ability to negotiate for safer sex. Interventions integrating income generating activities with rights awareness, life skills education and advocacy for enforcement of laws that protect women's rights should be priorities in all development endeavours in all sectors. Structured gender mainstreaming in sustainable livelihood interventions such as NAADS,NUSAF, Wealth for All, and, Peace, Recovery and Development Programmes should be done in order to increase women's access to resources and skills. Interventions that increase access of women and girls to vocational skills training, and opportunities to develop practical and business enterprises should also be supported in all sectors. Women's access to financial resources to support the establishment of small businesses enterprises should also be supported. Studies have shown that skill sets taught by microfinance programs, such as assertiveness, adult literacy may enhance capacity of women to negotiate safer sex.[55]

7.3 **Strengthening the capacity of families to protect and care for OVCs**

Uganda has one of the highest numbers of OVCs in Sub-Saharan Africa. A recent survey by Population Council[56] 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. Approximately 8–9 percent of the children can be defined as critically vulnerable. Vulnerability of children has potential to exacerbate the risk exploitation through being subjected to child labour, transactional and cross-generational sex. This is worsened by the fact that the capacity of families especially the extended family to look after OVC has been affected by HIV/AIDS, poverty and conflict. The strategy prioritizes strengthening the capacity of families to care and protect OVCs through:

- Supporting household and community based sustainable livelihood programmes
- Increase community involvement in intervention design and delivery
- Promote block grants and community coverage of interventions especially in areas where the OVC and poverty is wide spread
- Build capacity of leadership and technical structures at all levels to effectively coordinate and respond to the needs of OVC
- Review UPE and USE to ensure that OVC significantly reduce drop outs of OVC
- Address the needs of the older categories of OVC with a focus on enabling them to acquire self reliance skills

7.4 Strengthening enforcement of laws and increasing access to Services for SGBV

Sexual and gender-based violence acts such as rape, abandonment, forced sex in marriage, defilement, early marriages, verbal and physical abuse and denial of women and girls to access information and services are still a challenge in Uganda[57]. Violence precludes women from seeking HIV prevention and SRH services such as family planning, CT and treatment for STIs. It also inhibits disclosure of HIV sero-

[53]Phinney, H. 2008. 'Rice Is Essential but Tiresome; You Should Get Some Noodles: DoiMoi and the Olitical Economy of men's Extramarital Sexual Relations and Marital HIV Risk in Hanoi, Vietnam." *American Journal of Public Health* 98(4): 650-660.

[54]IMAGE study cited in Parkhurst JO, 2007.Analysis of social transformative / structural approaches to HIV prevention, London: DFID

[55]Dworkin, S. and K. Blankenship. 2009. "Microfinance and HIV/AIDS Prevention: Assessing its Promise and Limitations." *AIDS Behavior* 13: 462-469.

[56]Kalibala, Samuel, and Lynne Elson. 2010. "Situation analysis of vulnerable children in Uganda," *Final Report*. New York: Population Council.

[57] MGLSD and UNAIDS, 2009. A desk review on the national situational analysis of gender based violence and its impact on increased vulnerability to HIV/AIDS in Uganda, Kampala: UNAIDS and MGLSD.

status. SGBV increase feelings of unworthiness, lower the victims' self-esteem and breeds mistrust, which makes women engage in revenge sex and/or multiple sexual relationships in search of love and acceptance[20].

Though Uganda has developed progressive laws and policies that prohibit sexual abuse and violence against women, implementation is still weak. Additionally, medical surgeons who have the mandate to carry out examinations and provide evidence to magistrates are very rare in most of districts[58]. Furthermore, access to HIV prevention services such as PEP and HCT for survivors of SGBV is limited. The linkage between the laws/policies and customary norms is not clear yet most people seek for redress from traditional leaders and elders whose capacity and knowledge in handling cases is encumbered by personal interests and cultural mandates.

This strategy promotes a comprehensive response, based on principles of human rights and ensuring survivor centered and empowering approaches to address the linkages between violence against women and HIV infection. These include political commitment and resource mobilization, enforcement of legal and judicial reform that protect women against SGBV, strengthening health sector responses, response from the education sector, use of mass media and community mobilization.[59] The strategy will also promote comprehensive GBV policies that include primary prevention targeting men and boys to challenge the acceptance of violence against women; financial, psychosocial support and health services (including PEP) for survivors of violence.[60] The strategy will also prioritize interventions that increase capacity of women's advocacy organizations to play a role in raising awareness and working with governments to strengthen the institutional framework for enforcement of laws on violence against women. The strategy will particularly promote community-based participatory learning approaches involving men and women to create more gender-equitable relationships, thereby decreasing violence. It also prioritizes establishing comprehensive post-rape care protocols, training teachers about gender-based violence, and integrating HIV prevention into services for survivors of SGBV.

7.5 Reduced HIV-related stigma and discrimination

In Uganda, despite the efforts made to address AIDS-related stigma, it is still prevalent. Studies categorize stigma and discrimination to include[61,62] anticipated stigma[63], self stigma[64], enacted stigma[65], and secondary[66]. Enacted stigma refers to what people do to disadvantage a person known or suspected to be HIV positive while anticipated stigma refers to what people expect from others if they were known to be HIV positive. On the other hand self-stigma refers to internalized. Stigma and discrimination in whatever form continue to impede disclosure of HIV status, uptake of HIV prevention services, inhibits open discussion of HIV and appropriate responses[67]. Lack of disclosure encourages denial and precludes

[58] Care International 2010

[59] UNIFEM. 2010. Continually updated website on evidence, best practice and protocols for violence against women. Website: www.endvawnow.org.

[60] Barker, G., M. Greene, E. Siegel, M. Nascimiento, C. Ricardo, J. Figueroa, J. Redpath, R. Morrell, R. Jeskes, De. Peacock, F. Aguayo, M. Sadler, A. Das, S. Singh, A. Pawar and P. Pawlak. 2010. *What Men Have to Do with It: Public Policies to Promote Gender Equality.* Washinton, DC and Rio de Janeiro, Brazil: International Center for Research on Women and InstitutoPromundo.

[61] Deacon H,(2005.Understanding HIV/AIDS stigma.A theoretical and methodological analysis.ResearchMonograph. London: HSRC Press, 2005

[62] M Roura, M Urassa, J Busza, D Mbata, AWringe, B Zaba, 2008.Scaling up stigma? The effects of antiretroviral rollout on stigma and HIV testing. Early evidence from rural Tanzania, Sex Transm Infect 2009;85:308–312

[63] "What people expect from others if they were known to be HIV positive"

[64] "Internalized feelings of shame or blame derived from accepting stigmatizing judgments of one's identity"

[65] " what people do to unfairly disadvantage known or suspected HIV positive persons, such as exclusion from shared activities"

[66] "Stigma which, by association, affects those related to the infected"

[67] ActionAid International Africa, 2005. My right to belong: Stories of Stigma reduction efforts across Africa, Nairobi: ActionAid International Africa

those infected with HIV from seeking timely care and support[68]. Stigma negatively affects "openness about AIDS yet this is prerequisites for the successful mobilization of government, communities and individuals to respond to the epidemic"[69]. HIV AIDS-related stigma is gender biased and is partly driven by limited understanding of HIV/AIDS, myths and misconceptions about how HIV is transmitted, fear of contracting HIV from casual contact, PLHAs being perceived as a burden, lack of access to treatment, moralization of HIV and irresponsible media reporting[1]. Gender biases in HIV/AIDS related stigma are manifested in the way society (especially parents) blames women for infecting or causing death of husbands.

This strategy prioritizes increasing awareness and action on the sources of HIV-related stigma and discrimination. This requires continuous engagement of individuals, families and communities in understating the nature and effects of HIV-related stigma and discrimination through increasing access to HIV services and integration of HIV in other health services at the facility and community level. The overall aim of interventions addressing stigma will be to promote accepting attitudes towards PLHIV. Success will be manifested through:

- Willingness of family members to care for a relative who is sick with HIV/AIDS in their own household
- Individuals not discriminating vendor and allowing PLHAs to continue working.
- Openness of families about relatives living with HIV
- Reduced moralization of HIV transmission

Interventions dealing with stigma and discrimination should engage with government and other officials, media, civil society, institutions (e.g. hospitals, schools, workplaces), NGOs, FBOs, organizations of PLHIV and the general population with a comprehensive package of information on the transmission dynamics of HIV through a combination of: Behaviour change communication strategies (e.g. mass media); participatory education; and free telephones hotlines/help lines; inter-personal communication; behavioural and social change communication; equipping stigmatised individuals and groups with knowledge and skills to challenge stigma and discrimination and to change behaviour; advocacy and awareness campaigns; community involvement in planning for stigma and discrimination reduction. In addition, PLHIC should be educated about their rights through rights campaigns and supported to access legal assistance and litigation services against discrimination in various contexts.

Improving access to SGBV care services

- Centralizing SGBV services in dedicated service delivery rooms or spaces
- Ensuring that SGBV services are offered at all times when the facility is open and that survivors know
- Where to seek care when facilities are closed.
- Training both doctors and nurses to provide SGBV services; sensitize all providers within the facility.
- Strengthening forensic evidence collection within health facilities
- Developing facility-level protocols, algorithms for managing and referring SGBV survivors
- Ensuring all facilities maintain adequate records on SGBV survivors
- Strengthen referrals from the health facility to other support services by developing more formallinkages with other CBOs providing SGBV services.
- Strengthen linkages with the community by empowering health care workers to conduct community levelsensitization activities.

Source: Elson, Lynne and Jill Keesbury. 2010. "PEPFAR special initiative on SGBV Baseline report." Lusaka: Population Council

[68]UNAIDS, 2005. HIV - Related Stigma, Discrimination and Human Rights Violations : Case studies of successful programmes, Best Practices Collection, Geneva: UNAIDS

[69] UNAIDS, 2005:pg 4

8. Outcome 4: Achieving a Coordinated HIV prevention response at all levels

Implementation of combination HIV prevention will be based on the existing multi-sectoral approaches. However, this requires a high level of coordination and leadership at national, local government, facility and community level. The existing coordination mechanisms have inherent challenges and constraints. Furthermore, the level of political leadership for HIV programmes in Uganda has also waned during the past decade. Although resources for HIV control have increased in recent years, HIV prevention funding is still inadequate, and not optimally allocated.

During the next phase of expanded HIV prevention, the GoU will have to demonstrate effective leadership and commitment. This will include streamlining coordination mechanisms, re-invigorating political involvement at all levels, and mobilization additional resources from domestic and external sources to finance the expanded HIV prevention initiatives.

Indicators and Targets

- National Composite Policy index forHIV/AIDS policy and programme coordination increased from 67.5% (2005) to 85% (UNGASS Indicator)
- All districts in Uganda will have functional HIV coordination committees by 2015
- All districts in Uganda will have functional PHA networks by 2015
- All national, sector and district HIV strategies and plans will be aligned to national planning frameworks and budgeting cycles
- The percentage of national budget (including donor support) for line ministries and districts committed to HIV/AIDS programmes increased from 3% (baseline 2004) to 5%.
- Domestic and donor AIDS spending on HIV prevention increased from 25% to 35%.

Main Strategies:

- Advocating for pro-active political leadership and commitment at all levels
- Strengthening National level intra and inter-sector coordination.
- Strengthening coordination of HIV prevention at the district and local levels
- Health system strengthening to effectively deliver HIV prevention in the health sector
- Advocating for increasing domestic and donor funding of HIV prevention
- Mainstreaming HIV prevention in all government development plans
- Strengthening referral linkages between health facility and community based HIV prevention services

Strengthening National Level Coordination of HIV Prevention

At the central level, UAC is responsible for overall planning and coordinating of comprehensive multi-sectoral HIV control initiatives. Line ministries are responsible for technical coordination within respective sectors. In fulfilling its role, UAC works in partnership with the HIV/AIDS Partnership[70] composed of Self Coordinating Entities (SCEs), the Partnership Forum and the Partnership Fund. The

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

HIV/AIDS Partnership Committee (PC) is the steering committee of the NSP. The National HIV Prevention Committee (NPC) is a sub-committee of the PC that provides technical and policy advisory support on HIV prevention to the PC. The scope of work of the NPC comprises of: reviewing and guiding development of goals, strategies and targets for universal access to HIV prevention; advising on coordination, mobilization, allocation and harmonization of funding for HIV prevention; oversight of integration of HIV prevention in other services; recommending actions to eliminate fragmentation and align interventions, and strengthening overall HIV prevention. The NPC works in partnership different Technical Working Groups responsible for specific interventions. However, it has no formal linkages since most of the committees report directly to sector programmes.

Regarding its specific HIV prevention role, although UAC has now established a HIV prevention desk, the human resource capacity, including staff numbers remains inadequate for coordination of HIV prevention. In the next phase of HIV prevention, in order to strengthen national level coordination:

- The HIV prevention desk at UAC will be strengthened with human resources, and continuous training of staff to cope with emerging needs.
- The ongoing organizational development review process that is reviewing structural, human resource, resource as well leadership challenges affecting coordination of the HIV response will be leveraged 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.

Strengthening Coordination in the Health Sector:

The MoH is responsible for coordination of the public health response, especially biomedical HIV prevention interventions. The technical coordination function of MoH in the multi-sectoral HIV response is not clearly spelt out in the existing HIV coordination mechanisms. The MoH central technical support and coordination role should be comprehensively conceptualized and strengthened. The regulatory framework for interventions such as IEC/BCC, quality assurance framework for ARTs, and of training for the various thematic areas has gaps that MoH should address in addition to other health system challenges. In the expanded phase of HIV prevention,

- The MoH will be strengthened to provide technical support to other sectors. The current restructuring of the organizational structure of ACP in MoH will create a specific unit to coordinate HIV prevention in the sector[71]. It is also proposed to elevate the profile of ACP to a Division or Department in MoH which will give it higher profile.
- District Heath Teams will be strengthened to provide technical guidance to other stakeholders, quality assurance; HIV/AIDS surveillance, and routine information gathering activities necessary to track performance of HIV prevention

Strengthening Sectoral Coordination:

Line ministries are responsible for technical coordination within the respective sectors. However, the level of coordination within sectors is quite weak, for instance, the extent to which line ministries coordinate with other stakeholders beyond the line ministry is inadequate. Most HIV coordination focal

[71] MoH: Draft Health Sector HIV/AIDS Strategic Plan 2010-15, December 2010, Kampala, Uganda

points within sectors are not adequately supported with human, financial and infrastructural resources to effectively undertake intra-sector coordination. Save for MoH which has a fully-fledged departments with full time staff, in other sectors and local governments, AIDS focal point persons have other roles and HIV work is just an add-on. This makes them devote little time to HIV and AIDS coordination. This strategy will:

- build on the ongoing organizational development review of HIV/AIDS coordination to achieve streamlining of relationships and mandates of the different key players in the national HIV response.
- Other sectors will also need to strengthen their coordination of HIV prevention
- The results based framework that holds different key players and/ or SCEs accountable for fulfilling their mandates in respect to coordination of the response should motivate sectors to pay more attention to their roles.

Strengthening Leadership for HIV Prevention:

There has been slackening of leadership for the HIV response at all levels. In the new phase of HIV prevention, there is need for visible, unequivocal leadership all levels of government and society similar to one that achieved reductions in HIV incidence in early 1990s. In order to achieve this, the next phase of HIV prevention will focus on:

- Strengthening coordination and ensuring that GoU provides the necessary leadership. The GoU must demonstrate that it has HIV prevention as a priority, and is unambiguous in its commitment to fund HIV prevention programmes.
- Mechanisms for creating a climate that facilitates continuing conversation to facilitate behaviour change, reduce stigma; and keep HIV visible in the public agenda at the highest level must be explored. Reinvigorated leadership will be demonstrated by clear, succinct communication by political, traditional and religious leaders. Standardized but context sensitive communication will ensure all leaders convey the same basic messages, which will be amplified by health professionals and other forms of communications. A nation-wide commitment to HIV prevention by leaders will be evidenced by visibility about HIV/AIDS through prominent use of outdoor media, radio and television; and increased domestic budgetary commitments and disbursements for HIV prevention

Strengthening Districts and Community Level Coordination of HIV Prevention:

The District HIV/AIDS Committees (DACs), District AIDS Taskforces (DATs) and corresponding committees at Sub-county, parish and village level established with World Bank-supported Multi-sectoral HIV/AIDS Project and the Irish AIDS funding for decentralized response through UAC /MoLG are currently not active in most districts in the country. Several districts developed district HIV/AIDS plans under these projects, but their implementation has been limited by resource constraints and inadequate human resources. The focal points for districts are not well facilitated. HIV mainstreaming in District Planning Technical Committees (DPTC) is weak yet all members of the DAC drawn from district departments are also part of the DPTC. This has affected the alignment and coordination of HIV services in districts, with most CSOs, FBOs and private entities not aligning their work with district plans[72]. This

[72] 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.

creates duplication and disparities in access to services especially in rural areas. In order to make DACs more active and sustainable, the strategy recommends:

- integrating DACs into the existing DTPC that are more effective and sustainable.

The mentorships of local government departments by the 'mother' departments at ministries also continues to be weak in some sectors. This has affected alignment of district HIV strategic plans and sector priorities and plans.

9. Outcome 5: Systems for Strategic Information for HIV Prevention Strengthened.

Accurate and timely strategic information is vital to inform strategic planning and monitoring of programmes. Strategic informs helps programmes to track whether they are on course to meeting targets or achieve desired outcomes and impact. Our review of strategic information for HIV prevention in Uganda[73] has highlighted constraints that should be addressed during the next phase of HIV prevention.

A strengthened information system for HIV prevention will require enhanced HIV/AIDS and behavioral surveillance to track programme impact and outcomes, as well as enhanced results reporting system to track outputs and coverage of services. This should be augmented by operational research, including evaluation of interventions as well as improved information management systems. It will be critical to harmonise and align national and IP M&E plans, information and results reporting systems' under the principle of the "*three ones*".

Indicators and Targets:

- Data on new HIV infections tracked annually and results disseminated to stakeholders
- Population and facility surveys for tracking HIV prevention outcomes conducted every 3-5 years and data disseminated to stakeholders
- All HIV prevention interventions evaluated for impact and effectiveness every three years
- Annual reports of HIV prevention that compare outcomes/outputs against targets, produced and disseminated
- All significant HIV Preventions programmes have M&E systems and Plans
- At least five MARPs will have their population sizes and HIV burden determined by 2015

Strategies for Strengthening Information Systems for HIV prevention

The priority strategies for strengthened information base for the next phase of HIV prevention are as follows[74].

- Strengthening annual HIV surveillance and periodic surveys for programme impact and outcome evaluation
- Strengthening tracking of coverage and outputs of HIV prevention programmes
- Strengthening the management and dissemination of data for program planning and documentation of best practices
- Periodic evaluation of HIV prevention programmes / approaches to gauge their effectiveness
- Regular tracking of HIV prevention resources

9.1 Strengthening Impact Monitoring of HIV Prevention:

[73] UAC: Development of the National HIV Prevention Strategy: Review of the Epidemiology of HIV Epidemic in Uganda and the Scope, Coverage and Effectiveness of HIV Prevention Programme in Uganda: Draft Consutancy Report, October 2010

[74] Please note that details for the two year action plan and targets for each of these can be found in the M&E matrix, *Annex 2*.

Tracking the impact of HIV prevention in Uganda is increasingly based on HIV incidence measures since HIV prevalence data are confounded by antiretroviral therapy and HIV/AIDS care and treatment services. However, HIV Incidence data is difficult to obtain. In Uganda such data is obtained from proxy measures such as mathematical modeling of HIV prevalence data, 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. This is augmented by sub-national longitudinal cohort studies. Each of these data sources has inherent limitations.

In the new HIV Prevention Strategy, strengthening impact evaluation will involve:

- Strengthening annual HIV/AIDS surveillance
- Regular triangulation of data from various sources to obtain estimates and trends of new infections, e.g. modes of HIV transmission assessments.
- Regular MARPs size estimations to track changes in the characteristics/dynamics of HIV transmission in these groups. Already, PEPFAR is funding various initiatives aimed at estimation of the sizes of some MARPs.
- Production and dissemination of annual HIV surveillance reports with HIV incidence data.

9.2 Strengthening Outcome Evaluation of HIV Prevention Programmes:

National HIV prevention programme outcome evaluation is based on HIV/AIDS knowledge and sexual behavior of the general population or specific population groups, as well as quality of health services. These data are obtained from periodic population-based and health facility-based surveys. Uganda has been implementing AIDS indicators surveys (AIS), DHS, and service provision assessments (SPA) every 5-6 years. However, current data are out of date. Currently, anational AIS and a DHS are currently underway, and are expected to provide up-to-date data.

Under the new HIV Prevention Strategy:

- Advocacy for improving the periodicity and comprehensiveness of surveys will be done.
- The scope of the surveys should be expanded or augmented with special surveys to capture information on MARPs and other sub-national population groups.
- Detailed analysis and dissemination of information from surveys should be enhanced. Particular attention should be placed on gender disaggregation of data.
- Evaluation of specific programmes and interventions should be strengthened to provide evidence base on best practices for HIV prevention in the country.
- The drivers, risk behaviors and corresponding program goals and output indicators should be evaluated.

9.3 Strengthening Tracking of Coverage and Outputs of HIV prevention programs

Tracking of outputs of behavioral and biomedical HIV prevention services, is vital for monitoring coverage and utilization as well as service gaps. The Health Management Information System (HMIS) in the MoH is the main source of coverage and output data for biomedical interventions from health facilities. It is complemented by vertical data collection of some output indicators conducted by ACP and other IPs. Furthermore, there is currently no system that captures and aggregates national data on community level activities. There is currently no integrated system to consolidate all the data into

regular reports for dissemination. Consequently, there is often lack of adequate up-to-date data on coverage and outputs of most HIV prevention services at all levels in the country. In the new HIV prevention Strategy:

- As part of the health systems strengthening, routine reporting systems will be supported. Expanding the number of indicators in the new web-based HMIS that can accommodate additional indicators is a logical starting point.
- UAC through its Directorate of Planning and Monitoring and the M&E sub-committee as well as sector M&E units should strengthen reporting systems and establish horizontal reporting linkages at national level. UAC should not set up parallel reporting systems to obtain data from implementation units.
- Mechanisms for regular data quality assessment should be instituted.

9.4 Tracking HIV Prevention Resources:

Currently, there is no financial tracking system that routinely tracks data on financial resources for HIV/AIDS programmes. Also, disaggregated data on HIV prevention expenditure is currently not documented, even in National Health Accounts (NHA), and National AIDS Spending Assessments (NASA). The only attempt to disaggregate HIV prevention spending was done for Uganda in the 2009 UNGASS Report, even then, most HIV prevention spending was 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.

Under the new HIV Prevention Strategy:

- GoU will institute financial tracking processes, to include disaggregated data on HIV programmes.
- The GoU will institute financial reporting systems at all levels and regularly assess alignment of expenditure and HIV transmission dynamics.

9.5 Operational Research

Operational research, including public health evaluations is necessary to inform impact of specific intervention approaches. A national research agenda with priority areas of focus will be developed. Furthermore, dissemination of study results will be enhanced to promote utilization of data in programme design. In addition, funding for operational research based on priorities in the national agenda will be enhanced. Specifically:

- The GoU will streamline and prioritize research to better understand the complex factors around HIV transmission and effective HIV prevention approaches.
- A HIV prevention research agenda will be developed for IPs and specialised research institutions to coordinate plans for HIV prevention research. The agenda will be coordinated with the recently established Uganda National Health Research organization (UNHRO).
- Investment in research particularly studies based on the national research agenda should be prioritised.
- Priority research will include tracking the dynamics of HIV among MARPs and establishing the size of at-risk populations. PEPFAR has already allocated $600,000 to mapping of MARPS in Uganda.

- Additional priority research include: sexual behavior of HIV infected individuals, ethnographic studies exploring drivers, social dynamics, and supportive behaviors, HIV-related vulnerability, gender relations, culture, poverty and under-development and how these might be effectively addressed.
- Dissemination of research findings to HIV prevention programmes will be strengthened through the one-stop information centre that will be established at UAC.

9.6 Management of Strategic Information:

Strategic information arising from program monitoring and evaluation, HIV surveillance, population surveys, and operational research is routinely consolidated and packaged for stakeholders. Unfortunately, there is currently no one stop centre where this information is well catalogued and where it can be readily accessed. In the next phase of HIV prevention in the country:

- A one stop information centre is to be established and supported to carry out this vital role. A system for regular reporting to the hub and dissemination of findings will also be developed and supported by IDPs and GoU
- The information centre or knowledge hub will establish functional linkages with similar centres such as UNHRO and other centres with related activities.

10. Implementation Strategy

The implementation and coordination of the *National HIV Prevention Strategy* will be based on the multisectoral institutional and coordination framework. However, these mechanisms will have to be strengthened to effectively discharge the requirements of expanded combination HIV prevention. In addition mobilizing adequate resources to finance expanded HIV prevention initiatives, and monitoring and evaluation will be critical. These will be approached as follows:

Launch of the Strategy:

The National HIV Prevention Strategy will be launched at the national level at an event that will be attended by several stakeholders. At the launch, all stakeholders will be requested to commit themselves to implementation of expanded HIV prevention, by signing a declaration of undertaking. Following the national launch, regional workshops will be organized to further support the launch of the strategy at sub-national level.

Within 90 days of the launch of the strategy, line ministries and other important stakeholders will be required to present a report of policy changes, and steps they will take to implement the strategy and report on progress towards meeting the targets. Equally, each district will also be asked to report on the necessary policy changes and steps they will take to implement expanded HIV prevention initiatives and report on progress.

10.1 Implementation of Combination HIV Prevention:

Effective implementation of combination HIV prevention will require repositioning of the implementation and coordination arrangements to support referral linkages between HIV prevention, care and treatment services at all levels, integration of services, and appropriate health systems strengthening (HSS) measures.

***Referral Linkages between HIV Prevention Services**:* Most IPs or entities won't have capacity to implement the full range of priority HIV prevention services required by communities. Partnerships or collaboration between IPs, backed by functional referral linkages will be established to ensure that individuals receive a comprehensive package of services. Therefore:

- Sectors, IPs and UAC will develop a framework and establish coalitions involving public sector, CSOs, FBOs, the private sector and community groups in all areas of the country.
- HIV Prevention service in each administrative area will be mapped, and guidelines for districts, facilities, IPs and communities to establish referral linkages will disseminated.
- Community leaders, and district authorities will be empowered to establish and monitor functional referral linkages in their areas.
- UAC working with sector mechanisms will develop indicators to track functional referral linkages and set up appropriate monitoring mechanisms
- To address structural drivers of the epidemic, programmes will link with broader poverty reduction and development initiatives.

***Integration of HIV Prevention with other health services**:* In order to increase efficiency and access to services, integration of services is critical. This includes integration of HIV prevention with SRH, MCH,

care and treatment, TB and curative services. Integration will enable clients to receive complimentary services from one service delivery point. Integration across health services will require considerable investment in various building blocks of the health system.

- The MoH will update guidelines and monitor integration of services in the health sector. Strong coordination at national and district level, capacity building, regular supervision, coaching and mentoring designed to increase multi-skilling and performance will be undertaken. The MoH will spearhead joint planning of related programmes at all levels.
- Integration of HIV prevention with other activities beyond the health care system such as poverty reduction, sports, social and community groups (e.g. Village Savings and Cooperatives), and community activities such as cultural ceremonies, clan meetings and faith-based activities are also necessary to increase opportunities community dialogue about HIV including social cultural, gender and related factors.
- MoGLSD will develop guidelines and monitor integration of community level activities, and mainstream HIV prevention in workplace settings in the public, private and informal sectors.
- MoFPED will guide mainstreaming HIV prevention development programmes, especially in post-conflict settings.
- MoES will strengthen integration of HIV prevention in school-based curricular and extra-curricular activities.

Family and community centered approach: Family and community centered approach to HIV prevention is not yet part of mainstream health service delivery. This approach increases male involvement and builds support for those that test for HIV, by engaging households for instance, to test for HIV and encourage disclosure. At the community level, it increases participation in, and ownership of HIV programs, and supports communities to fight stigma. The MoH will develop guidelines for this approach, drawing on lessons from some IPs such as MJAP that have implemented this approach in HIV/AIDS care and CT for several years.

Health Systems Strengthening: Health systems' strengthening (HSS) will be critical for improved access, coverage and quality[75] of HIV prevention services. All building blocks of health systems are crucial for expanding HIV prevention especially in the context of integration with other services. Current challenges and constraints in leadership/governance, human resource, health financing, health information systems, service delivery, laboratory and medical products that affect delivery and sustainability HIV prevention services have been empirically documented in the health sector HIV/AIDS programme review[76]. The new HSHASP2 attempts to address some of the challenges. For instance, HSS will be funded by the Global Fund under Round 10.This will provide resources to address some of the challenges. Secondly, PEPFAR II has a component of HSS which provides opportunities for additional resources.

To implement HSS strengthening in support of combination HIV prevention:

- MoH will provide leadership to galvanize stakeholders to harness the resources from the Global Health Initiatives (GHI) and deploy them to address HSS challenges and constraints.

[75] WHO (2007). Every Body's Business: Strengthening Health Systems to improve Health Outcomes-WHO's Framework for Action. Geneva: WHO
[76] MoH: Reports of the Review of the Health Sector HIV/AIDS Programme, Draft Reports for all the Building Blocks, 2010, Kampala, Uganda

- 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.

10.2 Mobilization and Efficient use of Resources for HIV Prevention:

Mobilization of additional resources from domestic and external sources, and efficient resource utilization through prudent financial management and accountability will be crucial to expanded HIV prevention. Strengthening the institutional framework for governance, accountability for resources is perhaps beyond the scope of the HIV prevention strategy. However:

- Linkages will be established with relevant institutions to ensure efficient resource utilization.
- UAC will spearhead advocacy for increased GoU resource allocation for HIV prevention, as well as mobilization of additional resources from external sources and private sector. The costing of the resource requirements for HIV prevention during this process, will highlight resource gaps that will form the basis for mobilization of additional resources.
- All stakeholders should strive to mobilise resources to bridge the funding gaps.

10.3 Institutional Arrangements for Implementation of the Strategy:

HIV prevention will continue to be implemented in different sectors, by various IPs and at different levels according to mandates and comparative advantages. It is neither possible nor necessary to merge all HIV prevention programmes under one entity. However, a strong coordination framework that will ensure that all entities work in closer collaboration is vital.

The institutional arrangements for coordination of HIV prevention in the next phase, will be based on the framework of the HIV/AIDS multi-sectoral approach as articulated in the NSP. Under this framework, the roles of various principals in HIV prevention will be as follows:

The Uganda AIDS Commission will be responsible for oversight of the multisectoral implementation of HIV prevention. Currently, UAC is supporting line ministries to develop strategic plans aligned to this strategy. UAC will lobby the Office of the President / Prime Minister to require that all line ministries provide a report within 90 days of the launch of the strategy, outlining the steps they will take to implement of the strategy. In addition, UAC will be responsible for:

- Ensuring that the strategy is adopted, regularly reviewed, effectively coordinated, implemented and monitored
- Resource mobilization and advocate for resource allocation for HIV prevention
- Ensuring that guidelines to operationalise the strategy are developed and disseminated and HIV prevention is mainstreamed in sector policies, development programmes and budgets.
- Coordinate the development and implementation of a national HIV prevention performance monitoring plan, with an information management system

Roles of Line Ministries: Line ministries will continue their roles in line with their mandate and comparative advantages. All line ministries will be requested to identify a coordination desk for HIV prevention to coordinate planning, implementation and compile regular progress reports. They will also

be tasked to review their policies and identify steps to support implementation of the strategy. The specific roles of key sectors are as follows:

***The Ministry of Health*:** MoH is central to expanded HIV prevention initiatives, providing technical leadership and coordination especially for biomedical HIV prevention services. The ministry's HSHASP-2[77] will facilitate this role. The specific tasks for MoH will comprise of:

- Providing technical guidance and standards to other stakeholders and IPs.
- Provide leadership in scaling up coverage, quality and utilization of HIV prevention services i.e HCT, PMTCT, SMC, IEC/BCC and ART in health facilities across the country
- Conduct surveillance, evaluations, surveys and other routine information gathering activities necessary to track performance and inform HIV prevention strategies.
- Procurement and supply chain management of medical and pharmaceutical commodities necessary for HIV prevention.
- Establish systems for accreditation and quality control of services offered by IPs
- Provide technical guidance to design and implement evidence-based interventions

***The Ministry of Local Government*:** The MoLG in line with its mandate in the Local Government Act will ensure effective decentralized HIV prevention. Specifically, it will:

- Oversee the coordination roles of DACs[78] and their lower local government committees.
- Ensure that HIV prevention is adequately catered for in plans and budget of all departments. District performance reviews should integrate an explicit indicator on HIV prevention mainstreaming in the various departments
- Ensure that all PHA networks, CSOs, FBOs and private sector agencies in districts work in line with this strategy and align their interventions with district plans.
- Put in place mechanisms to hold officers accountable for targets, and ensure that disbursement of funds is tied to progress in meeting targets in district plans.

The Ministry of Justice and Constitutional Affairs: This Ministry will address rights violation-related drivers of HIV infection. It will develop and enforce regulations against SGBV and gender-based drivers of HIV, enforce regulations that promote good governance and accountability, develop regulations against stigma and discrimination and review and revise laws that constitute barriers to HIV prevention

The Ministry of Gender, Labour and Social Development, will support mainstreaming of Gender in HIV prevention policies, programmes, and budgets in public, private entities, coordinate integration of HIV prevention in cultural and religious institutions, coordinate workplace HIV prevention services, and programmes for special populations and OVCs.

The Ministry of Finance, Planning and Economic Development: The MoFPED will mobilise additional resources for HIV prevention, ensure an independent vote for HIV prevention, and that budgets of

[77] MoH: Draft Health Sector HIV/AIDS Strategic Plan 2010-15, Kampala, Uganda, January 2010

[78] 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

various ministries, departments and institutions provide for, and disburse funds for HIV prevention. It will also ensure prudent financial management, procurement and accountability, and periodic tracking of HIV prevention resources.

The Ministry of Education and Sports: **I**n line with its mandate, MOES will ensure implementation of HIV prevention in educational institutions and design curricular and extra-curricular based HIV prevention interventions for all levels, provide guidelines for peer education for youth in schools and implement HIV workplace programs in the education system

Ministry of Agriculture, Animal Industry and Fisheries will provide leadership in integration of HIV prevention in livelihood programmes such as NAADs, ensure integration of HIV prevention in agricultural extension services, and HIV mainstreaming in the agricultural sector.

Districts:

Under decentralization, districts are responsible for service delivery including HIV prevention. Under expanded HIV prevention, district governments and technical departments will:

- Spearhead coordination of HIV prevention at district and in lower local governments
- In collaboration with the DHO and health facilities, provide technical support and quality assurance of HIV prevention programmes implemented by to all stakeholders in the districts
- Ensure mainstreaming of HIV prevention activities in the district development plans
- Carry out mapping of HIV prevention services to ensure equity
- Plan and monitor the delivery of the minimum HIV prevention packages to the general population and specific at-risk population groups identified during mapping exercises.

Civil Society Organizations and FBOs*:*

These agencies are instrumental in HIV prevention service delivery, in the next phase, they will:

- Enter MoUs with ministries and districts to undertake HIV prevention programmes
- Develop and implement HIV prevention programs at the workplace and other target audiences
- Collaborate with other partners to provide comprehensive services

The Private sector*:*

As the engine of growth in Uganda with a big constituency of employees, dependants and customers, the private sector will be harnessed to support increasingly HIV prevention. The private sector will develop and implement HIV prevention programs especially at the work place, mobilize resources to complement public sector, adopt relevant plans / guidelines on HIV prevention mainstreaming, and ensure that PHAs are not discriminated at the place of work.

International Development Partners:

Bilateral and multilateral international development partners are instrumental in supporting local HIV prevention efforts. Important for a for coordination of IDPs include the AIDS Development Partners, Health Development Partners, the UN Joint Programme etc. These for a will continue to play an important role in harmonizing donor initiatives with national efforts. In the next phase of HIV prevention, IDPs will continue to provide technical assistance to local public and private sector

initiatives, mobilization additional resources from external sources to be invested in country-led expanded HIV prevention initiatives, share best practices in programme implementation and coordination.

National HIV Prevention Committee:

10.4 Monitoring and Evaluation

Monitoring and periodic evaluation of HIV prevention initiatives in this strategy is essential to maintain an informed and strategically guided response. Enhanced M & E will also track whether HIV prevention efforts are aligned to the drivers of the epidemic, are based on effective approaches, and are on course to meet the targets of the strategy.

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 IPs such as MEEP will also be harnessed. The monitoring indicators for HIV prevention in this strategy (Annex 2) are aligned to existing M&E plans.

To increase focus on results, a joint results-based framework for the strategy that tracks progress will be used. Regular reporting of outputs will strengthened in order to sustain attention of all stakeholders and to hold political and technical leadership and other stakeholders accountable for results. All sectors, IPs, districts and communities will develop monitoring plans aligned to the results framework in order to track their contribution to national HIV prevention goals. Within 6 months of the launch of the strategy, line ministries and key IPs will have their M&E systems assessed and appropriate strengthening measures identified.

The UAC through its National HIV Prevention Committee and Directorate of Planning and Monitoring will provide oversight for multi-sectoral monitoring and evaluation. However, UAC will work very closely and strengthen horizontal linkages with sector information systems that will continue to perform monitoring functions within respective sectors. The ACP in MoH and HIV prevention desks in other line ministries will continue to obtain, analyze programme M&E data in their sectors, and prepare reports of sector-specific HIV prevention activities, and report to UAC on a regular basis. The frequency of reporting will depend on the type of information and the systems used to collect the information, as highlighted in the performance monitoring framework. Sector M&E units will also share the information within sectors and use it to refine HIV prevention priorities. The HIV surveillance system will also provide annual surveillance data for evaluation of HIV programme impact.

The UAC will be responsible for regular consolidation of the information obtained from the sectors and produce annual performance reports of HIV prevention, reflecting performance against set targets, for consideration by NPC, and stakeholders during Annual Joint HIV/AIDS Program Review (JAR). The first annual report of HIV prevention will be due in mid 2012

The UAC and sector M&E function will require investment in human resources, skills and infrastructure to execute these roles. The health sector's Health Management Information System (HMIS), the surveillance system and other sector MIS being the main avenues for collection and reporting of data on HIV prevention from within the sectors will also require specific strengthening measures. At the onset of

the strategy, M&E systems will be assessed to ascertain their strengths and weaknesses and identify strengthening measures for the M&E units as well as reporting systems to effectively execute these responsibilities. Within six months of the launch of the strategy, UAC will lobby the Office of the President / Prime Minister to require that all line ministries commit to strengthen sector M&E systems and provide regular reports to UAC.

Partners implementing various programs will be encouraged align reporting mechanisms with the respective sectors, including supporting the development of these systems. They will also conduct regular evaluation of the impact of specific interventions or approaches. In addition, all IPs will also be encouraged to document and disseminate best practices in HIV prevention.

The UAC Directorate of Policy and Research will coordinate all evaluation efforts. It will develop an evaluation agenda to guide stakeholders. All data arising from these research efforts and documentation of best practices will be shared with stakeholders through the joint annual reviews. Furthermore, research findings will be provided to the knowledge hub that will be established at UAC, and disseminated for use in planning and policy formulation.

At district, and sub-district levels, similar processes will be replicated, with technical departments collecting, analyzing, and disseminating local data to stakeholders. At these levels, M&E operation will revolve around coverage and output indicators, monitoring performance against targets. Standard indicators to facilitate this will be in line with indicators formulated at national level to ease consolidation. Within 12 months of the launch of the strategy, UAC working with MoH will elaborate a plan for strengthening M&E operations at district level.

The mid-term evaluation of this HIV Prevention Strategy will be conducted in 2013, based on terms of reference that will be developed by NPC, and will form the basis for revision of the *National HIV Prevention Strategy.* 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 the adoption of the *National HIV Prevention Strategy*.

11. Resource Requirements

……. This section will be completed in consultation with the costing consultant when he gets on board. Terms of reference were submitted to UNAIDS and we await recruitment ……

Annex 1: National HIV Prevention Strategy: Design Summary

Goal:
To Reduce New HIV infections countrywide by 30% based on the 2009 levels, which would achieve a reduction of 40% of the projected new HIV infections in 2015

Indicators and Targets:
- New HIV Infections among adults and children reduced by 30% by 2015
- PMTCT Rate reduced to less than 10% by 2015

Priority Outcomes:

1. Increased coverage, quality, demand, uptake and utilization of HIV prevention services

Indicators and Targets:
- 80% HIV-infected mothers and exposed infants accessing PMTCT
- % adults who have ever tested for HIV increased to 80% by 2015
- % risky sex encounters (multiple partnerships, casual and sex with partners of unknown HIV status) that are consistently protected by condoms increased to 80%
- The proportion of adults males that are circumcised increased to 80%
- 80% of care and treatment services integrate HIV prevention
- 100% blood transfusion safety in facilities
- All facilities in the country implementing universal infection control measures

2. Increased adoption of safer sexual behaviors and reduction of risk taking behavior

Indicators and Targets:
- 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
- The proportion of risky sexual acts that are protected by condoms increased to 80%

3. *Strengthened sustainable enabling environment that mitigates underlying factors that drive HIV epidemic*.

Indicators and Targets:
- % 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:
- National Composite Policy index increased from 67.5% (2005) to 85%
- All districts having functional HIV coordination committees by 2015
- All districts having functional PHA networks by 2015
- All district HIV plans are aligned to national planning and budgeting frameworks
- HIV/AIDS spending as % of the total annual national budget increased from 3% (baseline for 2004) to 5%
- HIV Prevention expenditure as a percentage of total HIV budget increased from 25% to 40%
- % local governments allocating local revenues to HIV prevention initiatives increased from to 100%

5. Strengthened information systems for HIV prevention.

Indicators and Targets:
- New HIV infections tracked annually and results disseminated
- Population and facility surveys of HIV prevention outcomes conducted every 3-5 years
- All HIV prevention interventions evaluated for impact and effectiveness in past 5 years
- Annual reports of HIV prevention comparing outcomes against targets, produced
- All significant HIV Preventions programmes have M&E systems and plans
- The population sizes and HIV burden of at least five MARPs determined by 2015

Strategies:

1.1 Increasing Coverage and utilization of core HIV Prevention Services i.e. HCT, PMTCT, ART, SMC and Condoms in the general populations / specific groups
1.2 Increasing coverage of complimentary HIV Prevention Services i.e. STI, medical infection control, blood transfusion safety, PwP tailored to specific population groups,
1.3 Strengthening supply management of medical and pharmaceutical HIV prevention supplies
1.4 Integration of HIV prevention in clinical and community settings
1.5 Targeted services for MARPs as part of combination HIV-prevention package
1.6 Preparation for roll out of new HIV prevention technologies

2.1 Behavioural Change Interventions among all population groups with focused messages to address multiple partnerships, transactional / early /cross generational sex
2.2 Provide policy guidance, minimum standards and strengthen capacity at all levels to design, implement and monitor effective IEC/BCC
2.3 Promote condom use
2.4 Promote health seeking behaviors to increase utilization of HIV prevention services, while addressing barriers

3.1 Engaging communities in conversations/dialogue on context specific and community-owned interventions that challenge socio-cultural and gender norms that increase vulnerability to HIV.
3.2 Build partnerships with cultural/religious leaders to address socio-cultural drivers
3.3 Advocating for strengthening framework for enforcement of laws address SGBV and other rights violations against women
3.4 Strengthen the capacity of institutions to respond to gender issues that drive HIV epidemic
3.5 Advocacy for structured mainstreaming of HIV in national livelihood programs
3.6 Promote the involvement of men as key partners in HIV prevention intervention
3.7 Develop and implement interventions that reduce stigma and discrimination

4.1 Advocating for pro-active political leadership at all levels
4.2 Health system strengthening to effectively deliver HIV prevention
4.3 Strengthening intra and inter-sector coordination.
4.4 Strengthening national, sector, district and community structures to coordinate HIV prevention
4.5 Strengthening coordination of HIV prevention at district and local level
4.6 Advocating for increasing domestic and donor funding of prevention
4.7 Mainstreaming HIV prevention in all government development plans
4.8 Strengthening referral linkages between health facility and community based HIV prevention services

5.1 Strengthening annual HIV surveillance and periodic surveys for programme impact and outcome evaluation
5.2 Strengthening tracking of coverage and outputs of HIV prevention programmes
5.3 Strengthening the management and dissemination of data for program planning
5.4 Periodic evaluation of HIV prevention programmes / 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 in 2015) • 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]			EPP & Spectrums Projections
B: Outcomes of HIV Prevention (Intermediate Results)					
Outcome 1: Increased coverage, quality and utilization of HIV Prevention Services • Improved coverage and quality of PMTCT, HCT, STI, blood safety, medical infection control • 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 facilities that meet the core standards for infection control	6% [2007 USPA]		80%	Service provision assessment surveys
	13. Percentage of AIDS care facilities that have integrated HIV prevention and offer a comprehensive package of prevention with positives	TBD		80%	Service provision assessment surveys
Reduced risk of HIV transmission during exposure to high-risk sex • Increased consistent condom use • Increased coverage of male circumcision	14. Percentage of adult males (15-49 years) that are circumcised	TBD [2011 UAIS]	60%	80%	UAIS, DHS
	15. 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
	16. 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
	17. Percentage of males who used a condom during the last sex with a sex worker	TBD	80%	90%	Special Surveys
	18. Percentage of HIV discordant couples consistently using condoms	TBD [2011 UAIS]	70%	90%	UAIS, DHS

Results to be achieved	Indicator to measure whether result has been achieved	Baseline/year	2013 Target	2015 Target	Data sources / Comments
	19. Percentage of female & male sex workers consistently using condoms	TBD	80%	95%	Special Surveys
Outcome 2: Increased adoption of safer sexual behaviors and reduction of risk taking behaviors • Reduced no. of sex partners • Reduced transactional sex • Reduced early sex • Reduced cross generational sex	20. 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
	21. 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
	22. 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
	23. Percentage of girls (15-19 years) reporting cross-generational sexual partnerships	TBD [2011 UAIS]	75% of Baseline	50% of Baseline	UAIS, DHS
	24. 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
	25. 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 • Social and gender norms changed to protective HIV-related behavior and attitudes	26. Percentage of adults with accepting attitudes towards PLHIV	TBD [2011 UAIS]		80%	UAIS, DHS
	27. Percentage of women that experience Sexual and Gender Based Violence against	TBD [2011 UAIS]		10%	UAIS, DHS
	28. 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	HIV/AIDS spending as % of the total annual national budget	3% [2004]	4%	5%	NASA
	HIV Prevention expenditure as a percentage of total HIV budget	25%	22%	40%	
6.**Improved Systems for Strategic Information for HIV Prevention Improved**	29. Percentage of Districts and Implementing partners with M&E plans for HIV Prevention	TBD		100%	Programmes reviews
	30. Percentage of districts that have mapped or estimated the sizes of various MARPs	TBD	50%	80%	Programmes reviews
C: Outputs of HIV Prevention Efforts (Immediate Results)					
HCT	31. Number of adults (15-49 Yrs) counseled & tested for HIV, and receiving result in the past 12 months	TBD	3.5 million	4 million	HMIS, Program M&E
	32. Number of sites providing HCT services				Service statistics
	33. Percentage of facilities above HC III providing Routine CT services	TBD	60%	80%	Service statistics
	34. Percentage of districts with at least 6 HCT service delivery outlets	TBD	80%	100%	Service statistics
PMTCT	35. Number of PMTCT Service delivery outlets in the country				
	36 Percentage of MCH/FP facilities that provide a complete PMTCT service package				
	37 Percentage of pregnant women attending ANC who are counseled, tested, and receive test results	98% [2009]	100%	100%	HMIS, PMTCT M&E
	38. Percentage of HIV+ pregnant women attending ANC who receive a complete course of ARV				

Results to be achieved	Indicator to measure whether result has been achieved	Baseline/year	2013 Target	2015 Target	Data sources / Comments
	prophylaxis for PMTCT				
	39. Number of HIV positive mothers accessing PMTCT services for preventing negative born children from being infected				HMIS, PMTCT M&E
Male circumcision	40. Percentage of facilities (from HC IV) routinely providing SMC services	TBD	60%	100%	Service statistics
	41. Number of males circumcised per year	TBD	2 million	2 million	HMIS
ART	42. Percentage of ART eligible individuals enrolled onto Antiretroviral therapy	50%	60%	80%	HMIS, EPP Estimates
Condom distribution Sufficient number of condoms available especially for MARPs, hotspots, rural areas	43. Number of male and female condoms distributed to end users in the last 12 months (UA5)	TBD			
Blood Transfusion Safety	44. Percentage of donated blood units screened for HIV in a quality assured manner(UNGASS 3)	100%	100%	100%	Service statistics
STI management	45. Percentage of public and private facilities providing STI services	60%[2007USPA]	80%	90%	Service statistics
Medical Infection Control	46. Percentage of health facilities providing post-exposure prophylaxis	6% [2007 USPA]	50%	80%	Service statistics
	47. Percentage of Health facilities with Infection Prevention and Control Committees	TBD	50%	80%	Service statistics
PwPs					
BCC /IEC	48. Number of individuals reached with HIV prevention programs, by target group				
	49. Percentage of large[79] workplaces (public & private) that have HIV prevention and care policies and programs				
PLWHA Involvement	50. Number of networks and organizations with prevention for positives programs				
	51. Percentage of caregivers and healthcare workers who receive post-exposure prophylaxis				Service statistics
Social Change Opinion leaders able to facilitate processes to change harmful gender& social norms					
Improved Coordination and Leadership for HIV Prevention	52. Percentage of districts with functional multisectoral HIV coordination structures	TBD	80%	100%	M&E Reports
	53. Percentage of districts funding HIV prevention initiatives with local revenues	TBD	60%	100%	M&E Reports
Improved Strategic Information for HIV Prevention	54. Percentage of districts and IPs with M&E plans with indicators of HIV prevention	TBD	50%	100%	Service Statistics
	55. Number of MARPs with HIV burden and population size established at National level	0	4	8	Service Statistics
	56. No. of national quarterly comprehensive[80] 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

[80] Comprehensive HIV prevention reports will compare achievements against targets