
“.....EXPANDING AND DOING HIV PREVENTION BETTER....”

Final Draft Submitted to:
The Uganda AIDS Commission and
National HIV Prevention Committee

Volume 2: The HIV Prevention Strategy

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

The Government of Uganda has prioritized HIV prevention in its National Development Plan 2010-15 (NDP), with a target of 40% reduction of new infections by 2015. Although HIV prevalence during the past decade has been stable at 6% - 7% among adults, the number of new HIV infections, (approximately 124,000 in 2009) and about 1.2 million people were living with HIV, is unacceptably high. There are several reasons why despite 25 years of implementing multiple HIV prevention interventions, new HIV infections remain high. First, most interventions are on a scale that is insufficient to make significant public health impact. Secondly, most HIV prevention interventions are not aligned to sources of new infections. Thirdly, there is widespread risky sexual behavior and low levels of comprehensive knowledge of HIV prevention in the population. While increasing 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 HIV/AIDS programs require intensified and increased effectiveness of HIV prevention to avert an era of rising new infections.

This National HIV Prevention Strategy sets forth opportunities and guidance for intensified efforts to significantly stem new HIV infections during the next five years. 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 HIV Prevention target in the NDP. This would avert about 180,000 new infections over five years. Virtual elimination of vertical infections is an integral part of this overall goal.

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

- To expand coverage and uptake of HIV prevention services to attain critical coverage levels,
- To increase adoption of safer sexual behaviors and reduce risk taking behaviors.
- To create a sustainable enabling environment that mitigates the underlying socio-cultural and other structural drivers of the epidemic,
- To achieve a more coordinated HIV prevention response, and
- To strengthen information systems for HIV prevention at all levels.

In line with the epidemiology of HIV in the country, global best practices and recommendations, the strategy calls for strategic shift to “combination HIV prevention”, comprising of a structured package of proven 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, and evolving scientific evidence of various interventions (“know your response”).

In line with the principles of combination HIV prevention, the National HIV Prevention Strategy identifies minimum HIV prevention packages for the general population, most-at-risk populations (MARPs), PLHIV
and other population groups. The key evidence-based interventions in the package that must be scaled up to critical levels of coverage (80-90%) are: PMTCT, SMC, HCT, ART, condom promotion and evidence based behavior change interventions targeting multiple partnerships and other behavioural drivers of the epidemic. Other complimentary services comprising of STI treatment, medical infection control and HIV prevention with positives should also be scaled up, tailored to specific population groups. Furthermore, programmes should simultaneously 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, etc.

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

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) targets of reducing HIV incidence. It will contribute to attainment of Universal Access to HIV prevention, care and treatment, UNGASS, and Millennium Development Goal (MDG) 7 target of halting and reversing the HIV epidemic by 2015. It calls for increased focus, coordination and collaboration to comprehensively scale-up HIV prevention efforts and align them to the drivers of the epidemic.

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 undertaken by implementing partners in the short-medium term, to support the priorities laid out in the strategy. It sets ambitious goals that challenge and hold stakeholders responsible 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.

The strategy is the outcome of public, private and civil society consultation, facilitated by the Uganda AIDS Commission (UAC). Its implementation requires partners to build unprecedented levels of partnerships to support referral linkages so that individuals and communities are provided the minimum set of complementary services. 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 decision of mobilizing additional resources for the expanded programme, and to re-align HIV prevention resources to support priority interventions that will 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 be 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.
1. Introduction

Uganda is still experiencing a high incidence of new HIV infections, with approximately 124,000 new infections in 2009. This outstripped AIDS-related mortality by two fold and annual enrolment onto antiretroviral therapy (ART) by three fold. At this rate, the HIV burden is projected to expand, with over 700,000 new infections over the next five years if the status quo continues.

There are multiple reasons why despite 25 years of implementing various HIV prevention interventions, new HIV infections remain high. First, most interventions are still on a scale that is insufficient to make significant public health impact. Secondly, most HIV prevention interventions are not aligned to sources of new infections. Thirdly, there is still wide spread risky sexual behavior and low comprehensive knowledge of HIV prevention in the population. 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 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), with 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. The strategy 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 of various stakeholders and external funding agencies.

The National HIV Prevention Strategy will 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.

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 HIV prevention interventions in the country. The HIV prevention review was followed by a participatory process of development of the strategy. It involved consultations with technical working groups of key HIV prevention interventions including HCT, safe male circumcision (SMC), PMTCT, 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. Consultations were also conducted with ADPs especially PEPFAR, DfID and the Joint UN Country Team to ensure that their efforts are aligned with the national strategy. Six districts with unique population groups or HIV interventions, i.e. Busia, Kayunga, Gulu, Lyantonde, Wakiso and Bushenyi were also consulted. In order to enhance stakeholder involvement and ownership

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:
of the strategy, national level stakeholder workshops were organized for the public sector, PLHIV and civil society organisations (CSOs), and AIDS Development Partners (ADPs).

This activity was led by national consultants, who worked closely with 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:

- Prevention of new HIV infections will be a national priority, and an integral part of the development process of the country. The strategy is aligned 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 will 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 major national planning frameworks, especially 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 of key line ministries. In this regard, the strategy will streamline the implementation of the HIV prevention component of these broader development frameworks. In particular, the goals, targets and indicators in this strategy and action plan align with the broader frameworks. It critical that the strategy aligns with sector budgeting processes and timelines so that HIV prevention is financed as part of the development processes in the country.

The HIV Prevention Strategy also aligns with other international development frameworks, conventions and commitments to which Uganda is signatory. These include the MDGs 5,6, and 7, UNGASS and Universal Access targets, the Abuja Declaration of Heads of States, etc. Furthermore, it is expected that

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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, while 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 for the short – medium term is presented in a separate volume. The cost estimates for implementing the strategy will be presented separately.

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 that are urgently needed to turn the trajectory of new HIV infections in the country during the next phase of HIV prevention.

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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 less than 15 years. 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. A new national AIDS Indicator Survey is currently underway, and will provide updated estimates before the end of the year.

Uganda’s HIV epidemic is still predominantly heterosexually transmitted (75-80% of infections), with vertical infections accounting for 20%. Blood borne and other modes of transmission probably account for less than 1%. Although predominantly hetero-sexually transmitted, the population groups most affected, and the risk factors and drivers of HIV transmission appear to have evolved in recent years. Currently, the majority of new infections are in the context of stable long term partnerships, driven in part by multiple (especially concurrent) partnerships, extra-marital relations, 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 in the 1980s and 1990s to older individuals (30 – 35 years), who are more likely to be married or in long-term relationships. The new strategy takes this dynamic into account.

Although Uganda has a generalized HIV epidemic, the geographical 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 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%), 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 “bodaboda” (8%).

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7Throughout this document, cross-generational sex refers to sexual relations between teen-age girls (15 – 19 years) with male partners that are at least 10 years older.
Students in six universities with recent data on the other hand had lower prevalence of HIV 1.2% (0.4 – 1.8%).

Following significant declines in HIV prevalence and incidence during the 1990s, the prevalence of HIV Uganda remained more or less stable during the past decade. There are even indications of increasing HIV prevalence in some groups or geographical areas. Although recent population-wide sexual behavior statistics are not available, data obtained during 2005 indicated a mixed picture. Some behaviors 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 (casual) sexual acts in 2006 were not consistently protected with condoms.

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 current 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. 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, and residence in northern Uganda, implying the need for focused interventions among these groups. This strategy aims to address these changed dynamics.

There is also growing recognition of the importance of socio-cultural, gender, structural and other underlying factors in driving 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, gender-based violence, violation of rights of women and girls, polygamy, widow inheritance, etc;
- Socio-economic factors driving the epidemic include mobility, migrant work, poverty and wealth;
- Policy related factors comprise of: inequitable access to health services, weak governance, accountability, and coordination, and stigma and discrimination.

These factors are discussed in detail in the review report. This approach in this strategy is designed to take the evolving importance of these factors into account.

Although Uganda’s HIV epidemic is generalized affecting all population groups, there are most-at-risk populations groups (MARPs) that are more susceptible to the above factors, and therefore bear a disproportionate burden of HIV. These groups play a special role in bridging infections to the general population. Currently, in the Ugandan context, they comprise of:

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

**Fisher folk**: Among fishing communities, vulnerability to HIV stems from their perceived hyper-masculinity norms and subcultures of risk taking. Fishermen are often detached from their families for long periods, and have little appreciation of marriage and fidelity. They have daily cash income that they use for commercial sex and casual sexual relationships. Landing sites also attract sex workers. Health seeking behavior including HIV prevention services is often poor, and services are often unavailable or offered in inaccessible hours. The population size of fishing communities is currently not well known, but the USG is assisting the GoU with size estimation and mapping. Fisher folk need dedicated and targeted comprehensive HIV prevention services tailored to their life style.

**Uniformed services**: People in armed forces often don’t have permanent residence; and are often subject to deployments sometimes to places which are not reached by essential services. They are also often paid their salaries when away from home. Consequently, with lots of money, they are often tempted to alcohol and casual sex. The risk of death at the battlefront instigates a negative attitude among soldiers against protection from HIV infection which they often perceive as a long term or remote threat compared to death at battle front lines. Comprehensive HIV prevention services at the workplace are therefore necessary for this group.

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

**Injecting drug users (IDU) and men who have sex with men (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. The strategy makes a case for provision of tailored services for these groups, in addition to services for the general population. The services should be based on a comprehensive package of effective interventions.
3. Status of HIV Prevention Services in Uganda

Uganda has implemented various HIV prevention interventions for over 25 years. The interventions evolved over time as more scientific knowledge emerged. However, the existing interventions in the country have not yet attained universal coverage, nor are they always delivered in a structured combination package. They are also often not adequately evaluated for effectiveness.

The review of HIV prevention services established that current educational / behavioural interventions in the country comprise of mass media, interpersonal communication, community mobilization, workplace programmes, and life skills training in schools. Biomedical services 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 recent interventions include prevention with People living with HIV\(^*\) (PwP), and SMC of males. All these interventions have not yet achieved universal coverage in the country, with rural areas and MARPs, particularly underserved. However, most biomedical services are based on up-to-date national policies and technical guidelines.

The effectiveness of the interventions varies widely, with none being 100% effective in all population groups. Only blood transfusion is 100% effective for a small population group. All the other interventions achieved only partially effectiveness in clinical trials, and are probably less effective in programme settings. For instance, SMC reduced HIV acquisition by 50-60% among men over two years; and combination ARV prophylaxis for PMTCT averts 50-80% of vertical infections. 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. Condom effectiveness has been demonstrated with casual partners and MARPs, and they also reduced HIV incidence among sero-discordant couples by 85% in one cohort study. However, even inconsistent use has some level of protection\(^**\). More recent evidence has demonstrated the effectiveness of combination ARVs in HIV prevention in various settings. For instance, early administration of ARVs to HIV infected partners in discordant couples reduced HIV transmission by up to 92%\(^**\), while pre-exposure prophylaxis by the non-infected partner in a HIV-sero-discordant couple reduced HIV acquisition by up to 70%\(^**\). In view of this, HIV prevention in the next phase will be based on structured combination of proven interventions.

The coverage of HIV services in the country is still sub-optimal for most intervention. 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, and less know the status of their partners.
- In 2007, less than 10% of facilities had supplies required for medical infection control and PEP,
- 60% of facilities had integrated STI case management\(^**\) in 2007.

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\(^*\)In this report, HIV prevention interventions among HIV-infected individuals is referred to as prevention with PPHIV or prevention with positives. The new terminology recommended by UNAIDS is Positive Health, Dignity and Prevention (PHDP).

\(^**\)The new terminology recommended for “MARPs” is “Key Populations”. However in this report, the old term has been used.


Nearly half of risky sexual acts were not protected by condoms in 2005

The coverage of PwP of PHDP 21, and risk reduction counseling in HCT are still inadequate.

The new strategy advocates for scaling up of proven interventions to attain critical levels of coverage.

Integration of services remains a challenge. For instance, the implementation of PMTCT prongs 1, 3 and 4 (primary HIV prevention, family planning, and long term family HIV/AIDS Care and ART) 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 HIV prevention services e.g. HCT, SMC and blood transfusion is low, yet synergies between them would be mutually beneficial. The New HIV prevention strategy advocates for integration of key HIV prevention, care and treatment, SRH, and other health services.

Educational and behavior change interventions currently lack clear guidelines, policies, standards and are often not aligned to factors driving the epidemic. Social cultural norms that influence behavior are often neglected. MARPs such as fishing communities, sex workers, and road construction workers are not adequately targeted. Comprehensive HIV prevention knowledge was still less than 40% in 2005. Furthermore, behavioural trends already alluded to showed tendency towards worsening risky behavior (especially multiple partnerships, decreased abstinence and decreased condom use among men). The new HIV prevention strategy provides for sustainable behavior change approaches with a focus on behavioural and structural drivers.

Although, HIV/AIDS is a key priority in the NDP 2010-15, mainstreaming of HIV prevention in development programmes remains sub-optimal, yet this would provide opportunities for mainstreaming HIV in the work place and addressing structural drivers. Vocational, apprenticeship skills and micro-credit schemes often do not mainstream HIV prevention. Engagement of communities, cultural structures and networks to address harmful socio-cultural norms and practices is still suboptimal. 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. Development programmes such as Universal Primary and Secondary Education; Expanding Social Protection Programme (ESPP) etc, have a potential to reduce inequality and vulnerability to HIV/AIDS, but mainstreaming of HIV in these efforts is still sub-optimal. The HIV prevention strategy advocates for leveraging the development efforts to mainstream HIV prevention.

Funding of HIV prevention:
Although Uganda has made progress in macro-economic stability and reduced donor dependence in recent years, HIV prevention in the country is still almost entirely funded from external bilateral and multilateral assistance. During 2007/08, UShs 130,965,713,573 was spent on HIV prevention, but 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

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activities (MARPs, medical infection control, and circumcision). This is not aligned to the modes of HIV transmission. Similarly, PEPFAR that funds the largest component of Uganda’s HIV response, obligated 33% of 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 financing care and treatment.

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, the USG that funds most of the national HIV prevention response has already taken steps to align its funding to priorities to the 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 impact, outcomes and coverage of HIV prevention, but they are inadequate, especially for behavioural and structural interventions. Although HIV incidence data is used to track the epidemic and impact of HIV prevention, the surveillance system is often unable to provide timely and comprehensive data, and doesn’t provide incidence data for subnational levels. Intermediate program outcomes are tracked mainly through periodic population- and facility-based surveys, but available data is out of date, although a new national AIDS indicator Survey (AIS) and a DHS are already underway and will provide baseline data for this strategy. While the coverage of biomedical services is fairly well tracked by the health management information system (HMIS), information on behavioural and structural interventions is not. In addition, impact evaluation of interventions is often adhoc. Furthermore, HIV prevention data is rarely consolidated and periodic reports are often not available. The National Performance Monitoring and Measurement Plan (PMMP) at UAC is not operational and has weak linkages with sector systems. The new strategy will require improved monitoring and reporting, as well as consolidation and sharing of programmatic and surveillance data.

**Coordination of HIV Prevention:**

The framework for coordination of HIV/AIDS programmes are based on the multisectoral approach spearheaded by the UAC. The HIV/AIDS Partnership Committee (PC) is the steering committee for the NSP. For HIV prevention, the National HIV Prevention Committee (NPC), a sub-committee of the PC provides technical and policy advisory support on HIV prevention, working in partnership with thematic TWGs e.g. PMTCT, HCT, SMC, IEC/BCC, in MoH and UAC. UAC also partners with networks of private sector organisations e.g. UNASO, NAFOPHANU, and IRCU in coordinating these entities. At sector level, line ministries are expected to coordinate all stakeholders implementing activities within the sector. At district level, multisectoral coordination should be implemented through DACs, and DAT. However, the leadership for HIV prevention at all levels has slackened, and UAC has human resource, skills, mandate and organizational challenges. Coordination within the health sector is weak although steps are underway to address that. Coordination structures at district level are weak, often non-existent, and often underfunded. Linkages between health facilities and community structures are also often weak. In view of the crucial role of leadership and coordination, the critical gaps in leadership and coordination need to be addressed in the expanded phase of HIV prevention.
4. The Vision, Goals and Key Outcomes for the HIV Prevention Strategy

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

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 HIV prevention initiatives within a multi-sectoral response in the country. The purpose of the strategy is to improve the effectiveness of HIV prevention in Uganda through improved targeting of at-risk groups, with priority interventions, delivered through effective combination packages at multiple levels.

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 reduce new HIV infections by 30% from the 2009 levels which would result in 40% reduction of the projected number of new infections in 2015. Virtual elimination of mother-to-child HIV transmission is part of this overall goal. This will avert about 180,000 new infections over five years, fig 5.1. This is an ambitious goal and it reflects the urgency of the problem. It is in line with the targets of the NDP and MDG 6. In order to achieve this goal, it is imperative to scale up critical interventions and focus on groups and areas that have the highest incidence of HIV.

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%

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22 The Task Team considered various scenarios in setting targets for this goal. A reduction of 30% of new HIV infection based on 2009 levels numbers of new HIV infections equates to a 40% reduction of the projected number of new HIV infections in 2015 if the status quo was maintained, and would reduce new HIV infection to less than 100,000 in 2015. This will 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.

23 The task team considered the scenarios required to reduce MTCT rate to less than 10% from the current 29%. It requires simultaneously reducing new HIV infections among reproductive age women by 50%, elimination of the unmet need for FP among HIV-infected women, enrolment of at least 90% 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.
Outcomes, Indicators and Targets:
The National HIV Prevention Strategy focuses on the following interrelated outcomes:

i. Attaining critical coverage and utilization of HIV prevention services
ii. Increased adoption of safer sexual behaviors and reduction of risky behaviors
iii. A strengthened and sustainable enabling environment that mitigates underlying factors that drive the HIV epidemic
iv. Increased leadership and coordination of HIV prevention at all levels
v. Strengthened information systems for HIV prevention

The intermediate results and indicators for tracking them are summarized in Table 4.1 below

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

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Indicators and Targets</th>
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<tbody>
<tr>
<td>i) Increased coverage and utilization of HIV prevention services</td>
<td>• The proportion of HIV-infected mothers and exposed infants accessing PMTCT increased to 90%</td>
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<tr>
<td></td>
<td>• The proportion of adults who have recently tested for HIV (past year) increased to 25%</td>
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<td></td>
<td>• The proportion of adults males that are circumcised increased to 80%</td>
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<td></td>
<td>• The proportion of clinically eligible ART clients enrolled on treatment increased to 80%</td>
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<td></td>
<td>• 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%</td>
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<td></td>
<td>• All HIV care and treatment outlets will have integrated HIV prevention</td>
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<td></td>
<td>• All facilities implementing blood transfusion safety and universal infection control measures</td>
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<tr>
<td>ii) Increased adoption of safer sexual behavior and reduced risky behaviors</td>
<td>• Recent multiple partnerships reduced by 50% among men and women respectively</td>
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<td></td>
<td>• Transactional sex among men and women reduced by 50%</td>
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<td></td>
<td>• Cross-generational sex and early sex reduced by at least 50% by 2015</td>
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<td></td>
<td>• Casual sex reduced by at least 50% by 2015</td>
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<tr>
<td>iii) A strengthened and sustainable enabling environment that mitigates underlying factors that drive the HIV epidemic</td>
<td>• Increased women emancipation e.g women who make decisions about their SRH independently or jointly with partners increased from 61% to 80%</td>
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<td></td>
<td>• SGBV among women reduced from 39% to 10%</td>
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<td></td>
<td>• % SGBV survivors helped by social service organizations increased from 23% to 60%</td>
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<td></td>
<td>• Reduced Stigma and discrimination e.g. % expressing fear of contracting HIV from casual contact with PLHIV reduced by 50% from 19% women &amp; 28% men)</td>
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<td></td>
<td>• % of adults who believe that a wife is justified to refuse sex with her husband if he has an STD increased to 100% from 84 % women and 90% men.</td>
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<td></td>
<td>• Ratio of orphans: non-orphans (10-14 yrs) attending school increased from 0.9 to 0.96</td>
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<td></td>
<td>• % OVC and non-OVC (5-17 years) whose basic needs are met increased from 28% to 50%</td>
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<tr>
<td>iv) Achieving a more coordinated HIV prevention response at all levels</td>
<td>• National Composite Policy index for coordination increased from 67.5% (2005) to 85%</td>
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<td></td>
<td>• All districts having functional HIV coordination structures</td>
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<td></td>
<td>• All districts having functional PHA networks</td>
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<td></td>
<td>• HIV/AIDS spending increased from 3% (baseline for 2004) to 5% of total annual national budget</td>
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<td></td>
<td>• HIV Prevention expenditure increased from 25% (UNGASS 2010) to 40% of HIV/AIDS budget</td>
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<td></td>
<td>• 100% local governments allocating funds from local revenues for HIV prevention</td>
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<tr>
<td>v) Strengthened information systems for HIV prevention</td>
<td>• Data on new HIV infections tracked annually and disseminated</td>
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<td></td>
<td>• Population/facility surveys of HIV prevention outcomes conducted every 3-5 years</td>
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<td>• Major HIV prevention interventions evaluated for impact in the country</td>
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<td>• Annual reports of HIV prevention comparing outcomes/outputs against targets, produced</td>
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<td></td>
<td>• All significant HIV Prevention programmes have M&amp;E systems and plans</td>
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<td>• Population size and HIV burden of at least five MARPs determined by 2015</td>
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24 Basic needs include clothing, shelter, nutrition/food
HIV Prevention Priorities
Since Uganda is experiencing a mature generalised HIV epidemic with multiple drivers, HIV prevention approaches in Uganda will be based on “combination prevention” involving a package of effective behavioural, biomedical and structural interventions tailored to specific population groups. 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. Since there are also 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, these too should constitute a focus of HIV prevention efforts.

The priority for behavioural interventions should be to reduce multiple especially concurrent sex partnerships, early sex debut, and cross-generational and transactional sex.

The priority biomedical interventions should be evidence-based, and 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,
- Wide coverage of Safe medical circumcision of males
- Prevention of Mother-to-Child Transmission of HIV (PMTCT)
- Reducing community viral load through anti-retroviral therapy and appropriate ARV prophylaxis

Furthermore, harmful socio-cultural and gender norms that promote masculinity and femininity, GBV, and multiple partnerships, stigma and discrimination, and structural constructs that facilitate 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
- Residents of 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:
Even if the first priority is reducing sexual transmission, other priority interventions include high quality services for prevention with HIV-positives; medical infection control, and blood transfusion safety.

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25. This is in line with UNAIDS recommendation that an “HIV prevention approach based solely on one element doesn’t work; that countries should use a mix of behavioral, biomedical and structural HIV prevention actions that suit their epidemic and the needs of those most at risk”: UNAIDS (2009:1). UNAIDS promotes combination HIV prevention towards universal access goals. Geneva: UNAIDS
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. The strategy should evolve as HIV prevention initiatives themselves and knowledge of the epidemic evolve.

There should also be ongoing surveillance of 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.

**Combination HIV Prevention:**
There is currently no single HIV prevention intervention or “magic bullet” that is will be sufficient to prevent all HIV transmission in all population groups in Uganda where the epidemic is driven by multiple behavioural, biomedical and structural drivers. Therefore, Uganda’s approach to HIV prevention in the next phase will be based on combination approaches, comprising of priority and effective biomedical, behavioural, and structural interventions. As the HIV/AIDS epidemic has evolved over recent years, interventions should now go beyond simple ABC approaches that were successful in the 1990s.

The “combination prevention”, approach involves implementing multiple prevention interventions of known efficacy in a geographic area at a scale, quality, and intensity to impact the epidemic. Like combination ART which attacks HIV replication at multiple points of replication, combination prevention will be most effective if the interventions impede different points in the “transmission cycle”, by combining strategies to reduce both *infectiousness* of HIV-infected persons and strategies to reduce *susceptibility* by uninfected individuals.

Based on current evidence, four existing and two new HIV prevention interventions are highly effective in prevention of new HIV infections. They comprise of PMTCT, HCT, Condom use, ART, SMC males and individual, group and community level behavioural interventions targeting multiple and concurrent sexual partnerships. Modeling simulations suggest that high coverage (80% or more, fig. 5.2) of all these interventions is necessary to reduce HIV incidence at the population level in a short time.

Although HTC, MC, ART, condom promotion and use, PMTCT services and individual level behavioural interventions will constitute the minimum set of evidence-based, combination-prevention interventions,
other behavioral, structural, and enabling intervention may play an important role in reducing population-level HIV incidence. These supplemental interventions will also be part of combination prevention. The supplemental behavioral interventions will include mass media behavior-change programmes; and prevention programs for HIV-discordant couples and persons with HIV. Structural interventions include policies and regulations that increase access to HIV/STD prevention and clinical services. Enabling interventions may include community education and mobilization to reduce stigma, and to increase community support for and uptake of MC, HTC, and other HIV prevention services, and early entry and retention in HIV care for those who test HIV-positive.

**Minimum Package of HIV Prevention Services:**

Under combination HIV prevention, a minimum package of HIV prevention services will be designed to offer population groups a set of priority, evidence-informed services that will turn the tide of the epidemic. These services will need to attain critical levels of coverage. All IPs should ensure that groups in Uganda receive a core package of HIV prevention services based on their HIV risk profile. The components of the HIV prevention package for adults are highlighted below. The HIV prevention packages for specific population groups are highlighted later in this document.

Potential components of a combination HIV prevention package should focus on those interventions with demonstrated or promising potential efficacy to reduce HIV transmission (infectiousness) or acquisition (susceptibility), and will differ depending on target population, epidemiological context and varying levels of incidence. There is no single prescription or standard package that will apply universally. Stakeholders should review and devise core packages of effective combination services for specific groups. This includes combination service packages for:

- Adults in the population engaged in multiple partnerships
- Sexually active youth, engaged in cross-generational and transactional sex
- MARPs, including sex workers and clients, military, transport and migrant workers, etc.
- Sero-discordant couples
- HIV-infected individuals

Since it is not expected for any one organization or partner to provide all services in the package to target audiences, 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.

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### 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
6. Individual level BCC integrated into existing structures (religious institutions, work places, school, etc)

**Complimentary Components:**

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

Currently, HIV prevention services in the country are on a scale that is insufficient to turn the tide of the epidemic. However, there is no intervention that has been shown to be 100% effective in preventing HIV transmission in all settings. Therefore, scaling up a structured combination of proven partially effective HIV prevention interventions to critical levels of coverage is required to turn the epidemic around.

Under this framework, a core package of evidence-based interventions will be scaled up to achieve critical level of coverage of typically 80 – 90%. The package comprises of: PMTCT, HCT especially couple CT with disclosure of results to partners, SMC, ART and Condom promotion, augmented with evidence-based BCC targeting the behavioural drivers of the epidemic. Other services such as Medical Infection control and PEP, Blood transfusion safety, and STI treatment especially for MARPs, and Family Planning will also be expanded as part of general health services.

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

- Proportion of HIV-infected mothers and exposed infants accessing PMTCT increased to 90%
- The proportion of adults who have recently tested for HIV in the past 12 months increased to 25%
- The proportion of adults males that are circumcised increased to 80%
- The proportion of clinically eligible ART clients enrolled on treatment increased to 80%
- Consistent use of condoms during risky sex\(^{26}\) increased to 80%
- At least 80% of HIV Prevention, care and treatment programmes integrate HIV Prevention
- All health facilities ensuring blood transfusion safety and infection control measures

Strategies:
The strategies to achieve critical levels of coverage and utilization of priority HIV prevention services in the next phase of HIV prevention will comprise of:

i) Scaling up core HIV prevention services to attain critical coverage and utilization
ii) Strengthening supply chain management of medical and pharmaceutical supplies for HIV prevention
iii) Strengthening the integration of HIV prevention services in clinical and community settings
iv) Demand creation for HIV Prevention Services
v) Expanding targeted combination HIV-prevention services for MARPs
vi) Preparing for roll out and implementation of new HIV prevention technologies and services.

5.1 Scaling up core HIV Prevention Services to attain critical coverage and utilization:
Achieving critical coverage and utilisation of key HIV prevention services in the general population and among specific groups is a prerequisite for attainment of the HIV prevention results in this strategy. These evidence-based services will comprise of PMTCT, HCT, SMC, condom promotion and distribution,

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\(^{26}\)Risky sex in the context of this strategy includes multiple partnerships, casual and sex with partners of unknown HIV sero-status
and ART for HIV prevention. This should be augmented with evidence-based behavioural interventions discussed in the next section.

### 5.1.1 Increasing Effectiveness of PMTCT

Although Uganda has implemented PMTCT for over 10 years, universal access has not yet been attained. Currently, about 20% of new HIV infections in the country are due to MTCT. Increasing the effectiveness of PMTCT services will require strengthening all four prongs of PMTCT namely: i) primary prevention of HIV among reproductive-age women and their partners; ii) provision of family planning for HIV-infected women; iii) HCT for pregnant women and ARV prophylaxis or HAART (option B) 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 comprise of:

- Expanding PMTCT services to all ANC facilities from the 77% that offered the service in 2009.
- The uptake of HCT by mothers, currently at 98% largely due to routine CT and same-day test results will be maintained. However, losses in the PMTCT cascade where only 52% of HIV-positive women, and 30% of HIV-exposed infants received ARV prophylaxis in 2009 must be innovatively addressed. The aim should be to increase maternal and infant uptake of ARVs to at least 90%.
- Rapid roll out the revised WHO guidelines for PMTCT, which comprise of triple ARV prophylaxis or HAART from labour, through delivery and breast feeding (Option A with transition to Option B by 2012), and phase out single-dose Niverapine prophylaxis.
- Strengthening 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.
- Uganda will work towards virtual elimination of MTCT. Modeling, figure 7.1, indicates 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
  - Reduction of the median breast feeding period for HIV positive women to six months.
• 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.

• Structural barriers for PMTCT including stigma and discrimination of mothers that do not breast-feed, limited male involvement, etc should be simultaneously addressed through community-wide socio-change interventions.

**Implementation Strategy:**

• Every health facility providing antenatal care services will be expected to test pregnant women for HIV, and ensure that at least 95% of HIV-exposed infants receive combination ARV therapy.

• Districts that need urgent attention will be identified for action. Improving uptake and efficiency of PMTCT will be a priority of every district and a key DHT performance indicators.

**5.1.2 Expanding Quality and Coverage of HIV Counseling and Testing Services:**

Universal access to HIV testing and knowledge of HIV status is fundamental for combination HIV prevention as HCT is the entry point into the three evidence-based interventions i.e. SMC, ART, and PMTCT. Knowledge of HIV sero status also influences sexual behavior. Uganda has made great accomplishments in supporting individuals to know their HIV sero status. 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. With most discordant couples unaware of their sero-discordant status, and given the low condom use in marriage and long standing relationships, there is a compelling case for increasing knowledge of HIV sero-status of partners and tailored HIV prevention interventions for HIV sero-discordant partners.

This strategy sets ambitious goals for CT, i.e. at least 25% adults should have tested for HIV within the previous 12 months by 2015. To achieve these targets, several issues that will ultimately improve the coverage and quality of HCT services, and effectiveness in prevention of new infections need to be addressed. These include:

• Expanding the coverage and uptake of services, especially provider initiated CT in health facilities and communities, drawing lessons from pilot projects of PICT in various settings in Uganda.

• Strengthening risk-reduction counseling to individuals who test HIV positive and those who test negative. This will encourage HIV positive individuals to protect their sexual partners and themselves from re-infection. In addition, targeted prevention counseling for those who test HIV negative may assist to reduce risk behaviours and increase safer sex practices.

• Increasing 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 sero status.

• 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

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CT, 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 reagents); 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 focusing 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, as well as those subjected GBV.
- Strengthening pediatric CT including updating and disseminating relevant policies and guidelines.
- 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 will 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.

**Implementation Strategy:**

- PICT will be rolled out to all public and private health facilities, and referral linkages established with other HIV prevention, care and treatment service outlets
- CT will be routinely offered to all ANC, STI treatment and FP clients with unknown HIV serostatus. In other instances, CT will be at the discretion of the health care provider. Group counseling will be provided to all CT clients, with every client having the option to opt out.
- Each district will be allocated an annual target proportional to its population and HIV burden. This will aggregate to meet the national target. This will form part of districts’ performance appraisal.

### 5.1.3 Structured Roll out Safe Medical Circumcision:

Medical circumcision for HIV prevention has recently been adopted in Uganda, about four years after clinical trials in Sub-Saharan Africa demonstrated that it reduces HIV acquisition by about 50 - 60% among uninfected men over a two year period. This protective effect has now been demonstrated over longer periods. It is estimated that wide-scale SMC could reduce at least six million new HIV infections and three million deaths in Sub-Saharan Africa. Expanding SMC to 80% of adults in Uganda by 2015 could avert 428,000 new HIV infections countrywide by 2025.

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30 SADC: Report of the Expert Think Tank on HIV Prevention
31 USAID, Health Policy Initiative: The Potential Cost and Impact of Expanding Male Circumcision in Uganda
In the 2004-05 USBS, 25% of adult males in Uganda were already circumcised, with low prevalence of MC i.e. in Mid-north (2.4%), North East 4.9% and South West 7.6%. The MoH now has national policies and technical guidelines\textsuperscript{32}, and a draft strategic plan to roll out SMC. Feasibility and acceptability studies have also been conducted, and pilot schemes implemented in Kayunga district, the UPDF, and in Eastern Uganda. USG/PEPFAR has obligated US $ 5 million under its HIV prevention portfolio to roll out of SMC. Expansion of SMC will be a key component in the core package of combination HIV prevention services in the next phase of HIV prevention. This strategy sets ambitious targets for SMC i.e. at least 80% of adult males circumcised by 2015. In order to do so:

- Operational guidelines, training materials and standards will be developed, and national scale up of services that balance general access to high quality, comprehensive services with the need to reach high risk males will be implemented drawing on lessons from the pilot projects that assessed the feasibility and acceptability of MC in a range of cultural, demographic, and epidemiological contexts.
- Plans call for circumcision of up to one million adult males annually. Therefore, IPs should initially roll out SMC in a project like manner, providing services 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 services into routine facility services.
- 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.
- 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.
- Service provision will be complemented by demand creation and education, paying attention to the potential for behavioural dis-inhibition or risk compensation.

\textbf{5.1.4 Expanding Antiretroviral Therapy for HIV Prevention:}

It has become increasingly evident that antiretroviral drugs have a secondary role of HIV prevention. This is effect achieved through two mechanisms. i) reducing plasma HIV RNA concentration, and consequently the risk of HIV transmission, ii) reducing HIV acquisition by uninfected partners individuals. A recent multi-site HIV prevention clinical trial (HPTN 052) demonstrated that early ART initiation was 96\% effective in preventing HIV transmission among HIV sero-discordant couples\textsuperscript{33}, as well as reducing morbidity, mortality and TB transmission. This confirmed earlier observational and epidemiological studies such as the 2009 meta-analysis, which reported zero risk of sexual transmission from ART patients when HIV-1 viral load reduced to <400 copies/ml\textsuperscript{34}. Analysis of sero-discordant couples estimated a 92\% reduction in HIV transmission risk after controlling for CD-4 T-cell counts\textsuperscript{35}. Our projections (figure 7.2) estimate the impact current ART roll out has had on new HIV infections in Uganda. Another recent study has also definitively demonstrated that prophylactic use of ARVs (TDF or

\textsuperscript{32}MoH: National Policy and Technical Guidelines for Rolling Out Medical Circumcision of Males in Uganda, Kampala, 2010
TDF/FTC) by high-risk sero-negative individuals such as HIV-negative partners in sero-discordant relationships also reduced HIV acquisition\(^\text{36}\) by 73% if high levels of adherence were attained. These findings now provide compelling evidence for use of ARVs for HIV prevention\(^\text{37}\). The findings make a compelling case for universal CT and immediate ART for HIV-infected individuals, especially sero-discordant couples, as well as prophylactic use of ARVs by high-risk individuals, as part of the combination HIV prevention package. However, the cost-effectiveness of ART for patients with CD4 counts >350 cells/ul as a prevention strategy is still unknown. In addition, there are concerns about generalisability of these findings beyond HIV-sero-discordant couples in clinical trial setting, and the fact that early ART initiation wouldn’t apply to the acute phase of HIV infection which is characterized by high vireamia and where most HIV transmission occurs. Secondly, less than 50% of ART-eligible patients (patients with CD4 <350 cells/ul, or stage III/IV disease) in Uganda are receiving therapy\(^\text{38}\), in part due to low coverage of HTC, and inadequate systems to ensure that eligible patients are initiated and retained on ART. Therefore, provision of ART to individuals with higher levels of CD-4 T-cell counts pause ethical dilemma. At the same time, it is also clearly unethical not to provide ART to sero-discordant couples, regardless of CD-4 T-cell count level.

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

- Expediting the roll out of ART to all eligible clients for treatment purposes to avoid the ethical dilemma of providing ART for more healthy individuals
- Formulation of appropriate policies and technical guidelines for use of ARVs for HIV prevention (both PrEP and early ART initiation), including regimen selection, eligibility criteria, adherence support mechanisms, etc. The MoH and stakeholders should initiate policy formulation on ART for HIV prevention as soon as possible.
- Strengthening of treatment-prevention linkages that include adherence support.
- Expanding CT especially for couples in order to identify discordant couples
- As ART is rolled out as a HIV prevention intervention, innovative adherence support as well as monitoring of antiretroviral resistance should be key elements of the strategy.


\(^\text{38}\)MoH: The Status of Antiretroviral therapy Services in Uganda: Quarterly Report for July – September 2010: Kampala, Uganda
5.1.5 Strengthening Condom Promotion and Distribution

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

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

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

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

- 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 uninterrupted access to condoms within their communities.
- Condoms will be widely availed from various outlets, including pharmacies, clinics, bars, and hotels. Capacity building of outlet workers and owners, to promote condom use will be emphasized.
- 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
- 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 provision in non-traditional outlets such as hair salons, VCT centres, peer networks etc., will be strengthened. Female condoms constitute a female-controlled product within a market niche. Best practices for female condoms include product positioning and promotion for specific target audiences, e.g. women engaged in transactional sex.

Other Biomedical HIV Prevention Interventions:

Some interventions have not been consistently associated with reducing HIV transmission at population level, but may still contribute to HIV prevention at the individual level. Such interventions are unlikely to have population-wide impact on HIV transmission in the next five years. However, they have public
health benefits in their own right, and should be expanded for the general population as part of general health services. These interventions are discussed below.

5.1.7 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, and 15% had guidelines for infection control.

The MoH has guidelines on medical infection control, trained health workers, and established infection control committees in most facilities. However, gaps remain in all areas. In the next phase of HIV Prevention, focus will be on:

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

5.1.8 Expanding Coverage and Scope of Blood Safety
Prevention of HIV transmission through transfusion has largely been achieved in Uganda. Women and children are at greater risk because of frequent transfusion due to pregnancy and delivery, and malaria-induced anemia. The Uganda Blood Transfusion Service (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, constraints for blood transfusion safety include lack of universal coverage of quality assured services, limited number of repeat non-remunerated donors, and blood collected falling short of requirements. For instance, 90% of required blood in 2009 was collected\(^\text{39}\).

In the next phase of HIV prevention, Blood Transfusion safety should emphasise:

- The UBTS should continue to identify and sustain HIV-negative voluntary non-remunerated recurrent donors. One strategy is through blood donor clubs consisting of individuals counseled, tested, and committed to remaining HIV free. This is currently supported by URCS and UBTS.
- Communities and other HIV prevention programs should support recruitment and retention of HIV-negative donors, identification of volunteers and support blood donor clubs.
- Collaborative efforts that link blood donation efforts to HCT services, whereby HIV-negative individuals are referred as potential donors should be observed in all facilities.

\(^{39}\)MoH: Annual Health Sector Performance Report for 2009/20, 2010, Kampala, Uganda
• 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.

5.1.9 STI Prevention, Screening and Treatment:
Having untreated STIs such as HSV-2 substantially increase the chance of acquiring HIV, but seven of eight research studies have shown no effect of treating STIs on HIV transmission at a population level. This is largely due to the fact that the majority of STIs in Uganda are due to HSV-2 that is not treatable at the moment. Nevertheless, STI services constitute a good entry point for CT and other HIV prevention services. The evidence of the impact of STIs on HIV transmission among MARPs is compelling.

In the next phase of HIV Prevention, strengthening STI screening and treatment should be conducted as part of general public health interventions. For HIV prevention, STI screening and Treatment should:
• Ensure that all individuals screened for STIs should also be screened for HIV because these infections are driven by the same risk behaviors
• Focus on MARPs with targeted services in the context of a core package of services
• Improve quality of services in health facilities through training of health workers, and provision of pharmaceutical supplies necessary for the revised STI treatment guidelines.

5.2 Strengthening supply management of medical and pharmaceutical supplies for HIV Prevention
Provision of effective HIV prevention services is contingent of steady availability of medical and pharmaceutical supplies for HIV prevention. These commodities include ARVs, HIV and STI test kits, condoms, infection control commodities, etc. However, currently, there are weaknesses in the supply chain management of these commodities that often results in stock-outs and interrupted services. These constraints need be addressed as part of the strengthening of overall health systems to ensure effective HIV prevention services. In the next phase, addressing these constraints will involve:
• A review and streamlining of current procurement and supply chain management systems at all levels of the health system
• Specific measures including capacity building to strengthen quantification, procurement, inventory management and distribution of the commodities to peripheral service outlets.

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

5.4 Provision of targeted HIV prevention Services for MARPs

MoH: The Revised STD Treatment Guidelines for Uganda: 2009, Kampala, Uganda
Although, Uganda has generalized epidemic, there are population groups that have a disproportionately higher HIV burden. They include sex workers; fishing communities; individuals in uniformed services. These population groups are disproportionately affected owing to the complex sexual networks, involving multiple partnerships, which often bridge to the general population. These population groups are often not well served by the general health services whose hours of operation often doesn’t coincide with the life styles of members of this group. Most of these groups therefore need targeted services, often delivered through outreach or dedicated clinics. These groups also face barriers in access to services which often include legal barriers, stigma, discrimination etc. In addition, the population sizes, location, sexual behavior and other dynamics of these groups are not well understood. In the next phase of HIV prevention, it is imperative that there is special focus on MARPs, with comprehensive package of HIV prevention services tailored to the dynamics of the group. Furthermore, the structural barriers faced by the various groups should be addressed as part of structural interventions. The main focus will therefore be on:

- Build capacity to reach identified MARPs and other vulnerable populations to provide targeted education and HIV prevention services
- Targeted educational and HIV prevention services for MARPS that pay special attention to the unique needs and requirements of each group
- Provision of targeted group-specific, community-based outreach services for MARPs
- Routine monitoring of MARPs to assess quality of services provided
- Addressing structural barriers that MARPs face in accessing HIV prevention services
- Strengthen coordination between government institutions and civil society agencies working with MARPs to improve access to services needed by MARPs
- Involve MARPs in delivery of prevention and other HIV/AIDS related services to their peers
- Improve referral systems and increase Access to HIV/AIDS Health Care for the MARPs
- Institute and strengthen workplace-based programmes for the military, truckers, etc

5.5 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 under evaluation are vaccines and microbicides. However, safe and effective vaccines and microbicides are still far off. A more promising area is use of antiretroviral agents for 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-negative partners in HIV serodiscordant 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, iii) Microbicides containing antiretroviral agents. Another important area of study is how to get better results from HIV prevention by piloting, evaluating, and expanding access to effective combinations of prevention services. Studies are underway to test these strategies in the Uganda and at multiple sites in other countries. Some studies have recently released results that promise to change the landscape for HIV prevention include:

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• The CAPRISA study in South Africa demonstrated that ARV-containing microbicides (1% Tenofovir) reduced HIV transmission by 39% in about 900 HIV-negative women\textsuperscript{42}, with higher reduction among individuals with high adherence.
• The Partners PrEP study, discussed in section 5.1.4 demonstrated that TDF and TDF/FTC prophylaxis by HIV uninfected individuals in sero-discordant relationships reduced HIV incidence by 63 and 73% respectively.
• Early initiation of ART among HIV-infected partners in sero-discordants relationships, (discussed in 5.1.4) demonstrated that early initiation of combination ARVs (CD-4 T-cell counts >350/ul) reduced incident HIV infection in the uninfected partner, morbidity and TB among the HIV-infected partner\textsuperscript{43}.

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

In the next phase of HIV prevention, it will be necessary:
• For the new evidence is disseminated, policy implications discussed and appropriate technical guidelines developed
• Feasibility studies and cost implications for roll out of the interventions conducted promptly
• Appropriate roll out plans for the new HIV prevention technologies as part of combination HIV prevention should also be developed and implemented

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

Sexual behavior continues to be at the root of HIV transmission in Uganda. Multiple (especially concurrent) partnerships, cross-generational sex, transactional and commercial sex, casual sex, and low and inconsistence condom use constitute the main risky behaviours currently driving the Uganda HIV epidemic. Behaviour change initiatives will be key to modifying these behaviours, through evidence-based and theory-driven interventions.

**Indicators and Targets:**
This strategy has set ambitious behavioral targets for the next phase of HIV prevention as follows:
- Recent multiple partnerships will be reduced by 50% among men and women respectively
- The proportional of adult men and women that engage in recent transactional sex will fall by 50%
- Cross-generational sex and early sex will be reduced by at least 50% by 2015
- Casual sex will be reduced by at least 50% by 2015

**Strategies**
The main strategies for achieving these results will comprise of:

i. Scaling up age-appropriate behavioural change interventions in all population groups with focused messages targeting multiple partnerships, transactional/early/cross generational sex

ii. Strengthening policy guidance, quality assurance and capacity for effective IEC/BCC at all levels

iii. Increasing meaningful involvement of PLHIV in HIV Prevention endeavours.

### 6.1 Scaling up age-appropriate Behavioural Change Interventions in all population groups with focused messages targeting multiple partnerships, transactional/early/cross generational sex

Effective approaches will involve coordinated multi-channel communication using mass media, community mobilization, working with peers, workplace education and simultaneously addressing the socio-cultural and structural context that underpin them. Mass media is effective in influencing social norms, and transmitting brief but powerful messages. Interpersonal communication is critical for thorough processing of culturally-adapted messages designed to influence risk perception, self-efficacy, and skills at community and individual level.

#### 6.1.1. Reducing Multiple and Concurrent Sexual Partnerships:
The role of multiple (often concurrent) 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 HIV epidemic in the African sub-region. 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 2% to 4% among women. Extra-marital sex during the same period increased from 14%

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to 29% among men. Multiple partnerships was independently associated with HIV prevalence, and HIV incidence\textsuperscript{45}, with HIV prevalence increasing proportionately with number of sexual partners. This practice is influenced by underlying gender, social, cultural, economic and other factors including mobility, that have to be factored in any educational campaign to change this behavior.

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 adults reporting two or more partners\textsuperscript{46}, with greater reduction among those with three or more partners. Under this strategy:

- Concerted BCC/IEC campaigns will address both serial and concurrent multiple partnerships. Behavioural theory, and research exploring the social, cultural and economic reasons for concurrent partnerships will be used to inform development of prevention messages and approaches.
- The MoH/UAC will design guidelines for IEC/BCC approaches for multiple partnerships.
- Workplace programme will support employees to reduce motivation for multiple sexual partnerships, especially work involving frequent mobility. For instance, this will involve advocacy for reducing the frequency of transfers of workers away from their homes.
- The MoGLSD and stakeholders will support community dialogue on socio-cultural and gender dimensions of multiple partnerships.
- Since fidelity within longstanding relationships is not necessarily protective due to high prevalence of HIV sero-discordance, partners should promote couple communication and couple CT within ethical principles of privacy and choice.

6.1.2 Reducing Transactional Sex

Transactional sex involves people exchanging money or goods for sex. Transactional sex not necessarily seen culturally as sex work, has been in existence for long in the country. This behavior is often condoned within the practice of polygamy in many communities in Uganda. Transactional sex, in the context of multiple concurrent 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. Like other forms of multiple partnerships, there are risks to transactional sex. Recent case studies confirm that often, whenever sex is part of an economic exchange, women’s ability to protect themselves from STIs and HIV is limited.

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

- 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 work involves solicitation of 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. Most sex workers are females who find their clients through independent means, but there might also be instances of trafficking. Some sex workers engage in sex work only part time, and a high turnover has been reported.47 Some sex workers have long-term or even marital partners alongside clients.

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

HIV prevention strategies for sex workers and their clients should include a specific core package of services48. This comprises of:

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

### 6.1.4 Reducing Cross-generational and Early Sex

Many youth, particularly females, engage in cross-generational sex, 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. There are different situations youth experience regarding their choice to engage in sexual relationships, and they should be reflected in HIV prevention strategies. This includes approaches for youth who are not yet sexually active, in order to delay sexual debut, and sexually active youth to promote fidelity with one uninfected partner with correct and consistent condom use and knowledge of HIV sero-status.

Under Combination HIV Prevention in the next phase, initiatives addressing cross generational sex:

- Must be firmly rooted in formative research with sound understanding of the context and relationship dynamics. They should be aware that not all youth can control whether to have sexual relationships. Strategies must consider the lack of control that youth, particularly girls, might have

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47 MoH, UNDP, Profiling of sex work in Kampala Uganda. 2010, Kampala, Uganda
48 UNAIDS: UNAIDS Guidance Note on HIV and Sex Work: Geneva Switzerland, March 2009
over their choices. For instance, female youth may be required by their families to engage in sex for money. There are particular groups, such as adolescent OVCs, who are vulnerable to HIV infection, but for whom little data exist.

- Should also target youth who might be seen to be better off than their peers. For instance, some young women perceive themselves as exploiting older men for money or gifts.
- Must be community rooted with engagement of opinion leaders in order to influence 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 ensure that communities play a role in identifying and reaching older partners involved in cross-generational sex, and most-at-risk youth, including out-of-school youth and OVCs.
- Through targeted outreaches, engage youth with age appropriate risk reduction messages.
- Should establish referral mechanisms for youth to access a full package of HIV prevention services, e.g. sexually active youth should receive condoms and referrals for HCT, and include mitigation for those with negative consequences, such as HIV, pregnancy, abortion or STIs.
- Should incorporate empowerment, gender, social norms and gatekeeper components to create safe and enabling environments for youth, particularly young women and girls.

### 6.1.5 Delay of Sexual Debut among Youth

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

- Include messages for delaying sex, integrated into wider BCC messages e.g. life skills education.
- Incorporate promotion of HCT prior to sexual relationships, 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 vulnerabilities and simultaneously address them. This includes groups of youth who are vulnerable, but for whom little data exist, e.g. vulnerability of OVCs regarding their ability to delay sex, or to engage in coercive or cross-generational sex.

### Implementation Strategy:

Behaviour change programmes should follow a ‘trajectory of life’ approach aimed at (i) preventing the burst of new infection in late adolescence and young adulthood and (ii) addressing those factors that make the rate of new infection among older people resistant to change (see table below).

To be effective, behaviour change programmes need to combine media communication with face-to-face programmes (at the individual level) aimed at different age groups and levels of society. They need to reach enough people in an intensive, focused and sustained way.

The approaches and content areas for age appropriate behaviour initiatives are summarised in table 6.1 below.
### Table 6.1. Key content areas for age-differentiated behavioural programmes

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Focus</th>
<th>Content</th>
<th>Activities</th>
</tr>
</thead>
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| 6-11 yrs  | • Increase knowledge  
            • Shape norms, values | • Healthy living & healthy sexuality; reducing HIV, pregnancy and STI risks; knowledge of status  
                              • ‘Pre-commitment’ to values that protect against HIV infection | • Life skills programmes in schools;  
                              • Social support clubs/networks in and out-of-school (not peer education) |
| 12-17 yrs | • Increase knowledge and risk perception  
            • Shape norms and attitudes  
            • Shape ability to respond to life circumstances  
            • Encourage health-seeking behaviour | • Adolescent sexuality; risk behavior (inconsistent condom use, multiple concurrent partnerships and age disparate sex) and associated factors (coercion and gender violence); reducing HIV, pregnancy and STI risks; knowledge of status  
                              • Build personal initiative, ability to safely navigate day-to-day pressures and expectations;  
                              • Knowledge of when to seek health care & expectations of health services | • Life skills programmes in schools (educator led)  
                              • Alcohol and drug prevention  
                              • Development of social networks  
                              • Youth leadership in social networks (in-school/out-of-school)  
                              • Sustained links to sports & other recreational activities, and to information for personal growth & development  
                              • Youth friendly services with good referral from schools; toll-free helplines |
| 18-29 yrs | • Reduce risk tolerance  
            • Promote safest reproduction  
            • Address the desire to have children, fertility and risk reduction  
            • Positive Prevention  
            • Parenting and Family planning | • New linkages to social support, information and opportunities; develop social intolerance of multiple, concurrent partners & gender violence  
                              • Alcohol & harm reduction  
                              • Knowledge of HIV status;  
                              • Promote condom use  
                              • Intolerance of MCP;  
                              • Expectations of good health care  
                              • Promotion of ‘pre-commitments’; openness about sexuality with children;  
                              • Knowledge of resources for support | • Development of social networks & other forms of connection  
                              • Programmes for institutions of higher learning  
                              • Mass media  
                              • Expanded information service at ANC and CT facilities  
                              • Youth friendly services  
                              • Use social networks of PLHIV;  
                              • expanded information services at ARV treatment clinics;  
                              • expanded information services through home-based care & support  
                              • Media ; community level dialogues; |
| 30 yrs +  | • Parenting  
            • Family Planning  
            • desire to have children  
            • Positive Prevention  
            • Risk reduction in long-term relationships | • Promotion of ‘pre-commitments’; openness about sexuality with children; knowledge of resources for support  
                              • Condom use; intolerance of MCP;  
                              • Knowledge of TB screening & expectations of good health care  
                              • Condom use, regular knowledge of HIV status, intolerance of MCP | • Mass media ;  
                              • community level dialogues  
                              • Use social networks of PLHIV; expanded information services at ART clinics; expanded information services through home-based care & support (esp. for partners & others in homes); |

### 6.2 Strengthening policy guidance, quality assurance and capacity for 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. Formative research should be used to identify solutions for barriers to behavior change. In the next phase of HIV prevention, improving policy guidance, quality assurance and capacity for IEC/BCC interventions will require:

- Building capacity in the design and implementation of behaviorally-sound programs, through appropriate training, apprenticeships, etc for all stakeholders.
- Strengthened coordination of IEC/BCC activities in order 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.
- IEC/BCC quality assurance mechanisms and standards at national and district level. This will involve establishing a clearing house for IEC/BCC messages, and standardized training curricular for IEC/BCC. The IEC/BCC TWG will be strengthened to oversee this activity.

6.3 Expanding HIV Prevention with PLHIV\(^\text{49}\) of PHDP

Provision of comprehensive HIV prevention, care, and treatment services to PLHIV is a proven effective HIV prevention initiative. HIV/AIDS care and treatment and HCT services avails increased opportunities to interact with PLHIV, and offer risk reduction counseling. Initiatives for “Prevention with HIV-infected people” (previously referred to as PwP, but now more styled as positive health, dignity and prevention-PHDP) empower PLHIV to avoid onward transmission of HIV. PHDP delivery platforms are facility and community-based and require coordinated provision of a core package of HIV prevention services. PHDP core messages must emphasize risk reduction and the limitations of ART. In the HIV Prevention Strategy:

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

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\(^\text{49}\) UNAIDS Recommends use of the term positive health, dignity and prevention for these interventions, instead of prevention with PLHIV
7. Outcome 3: A Strengthened and Sustainable Enabling Environment that Mitigates the Underlying Factors that Drive the HIV Epidemic

The structural factors that constrain individual ability to adopt and sustain behaviours and lifestyles that minimize risk and vulnerability to HIV\textsuperscript{50} in Uganda range from social, cultural, economic, legal, and policy features of the environment\textsuperscript{51}. These are often embedded and inextricably linked to societal norms, values, practices, social structures and networks\textsuperscript{52}. Specifically in Uganda, the main drivers include harmful cultural and gender norms and practices; weak enforcement laws, rights violation, stigma and discrimination, weak governance and accountability, inequitable access to HIV services and weak leadership and coordination of HIV prevention. Addressing these drivers is a key priority of this strategy.

**Indicators and Targets:**

The main targets for addressing these drivers over the next five years comprise of:

- Improved legislative and policy framework that promotes HIV prevention for the general population and key population groups
- 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.
- The percentage of women who experience sexual violence reduced from 39% to 10%.
- Percentage of survivors of SGBV obtaining help from social service organizations increased from 23% to 60% and those obtaining help from Police increased from 6% to 30% by 2015.
- Percentage of adults expressing fear of contracting HIV from casual contact with PLHIV reduced by 50% form 19% of women and 28% men
- Women emancipation increased as evidenced by increase in the percentage of adults who believe that if a wife knows her husband has an STD or HIV, she is justified to refuse sex or demand for condom use, from 84% for women and 90% for men to 100%.
- Ratio of school attendance among orphans vs. non-orphans, aged 10-14 increased from 0.9 to 0.95\textsuperscript{53}
- Percentage of OVC and non-OVC 5-17 years whose basic needs (i.e. clothing, shelter, and nutrition/food) are met increased from 28%\textsuperscript{54} to 50%

The key strategies for creating a sustainable and enabling environment mitigating the structural drivers comprise of:

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

\textsuperscript{53}MDG and UNGASS indicator
\textsuperscript{54}UDHS 2006. Lack of basic needs makes children vulnerable to child labour, transactional and cross-generational sex
v. Strengthening the mainstreaming of HIV in development programmes to meet the needs of women and key groups

vi. Promoting male involvement in HIV prevention

vii. Strengthening efforts against stigma and discrimination

viii. Increasing accountability for HIV prevention resources

7.1. Reviving Political leadership for HIV prevention at all levels

In the new phase of HIV prevention, there is need for visible, unequivocal leadership at all levels of government and society similar to one that achieved reductions in HIV incidence in early 1990s. The executive, parliament, cultural, religious and community leaders at all levels will be mobilized to support community HIV prevention efforts. In order to achieve this, there will be:

- Advocacy to ensure that GoU provides the necessary leadership for HIV prevention at all levels.
- Creating a climate that facilitates continuing conversation to facilitate behavior change, reduce stigma; and keep HIV on the public agenda at the highest level. Reinvigorated leadership will be demonstrated by clear, succinct communication by political, traditional and religious leaders about HIV prevention. Standardized but context sensitive communication messages will ensure that all leaders convey the same basic messages, which will be amplified by health professionals.
- National and local leaders will also be mobilized to demonstrate increased domestic budgetary commitments and disbursements for HIV prevention. The GoU must demonstrate that it has HIV prevention as a priority, and increase its funding of HIV prevention programmes.

7.2 Changing Harmful Socio-cultural and gender 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, risky rites of passage (e.g. belief among the Bagisu that a newly circumcised man will heal faster if he indulges in

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unprotected sex with a married woman), social pressure to bear children especially males; forced and early marriage and superstitions linking HIV with misfortune and spirits and widow inheritance\(^57\).

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

- Promote 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.

In most communities there are gender norms that put men and women at risk of HIV infection. Women and girls continue to be culturally excluded from owning property and productive assets\(^58\), education and skills training opportunities, which preclude them from the job market. Widows and orphans are often denied their property\(^59\). This situation is exacerbated by the weak enforcement of existing laws and institutional frameworks for protecting the rights of women and children\(^60\). 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 a girl will marry, 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 vulnerability to HIV infection and create an environment that enable women to have a voice in decisions that affect their SRHs.

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

7.3 Strengthening the legislative and policy framework for HIV prevention

SGBV including rape, forced sex in marriage, defilement, early marriages, verbal and physical abuse and denial of women and girls to access information and services are still a challenge in Uganda\(^61\). Violence

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\(^{61}\) 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.
precludes women from seeking HIV prevention and SRH services. SGBV increase feelings of unworthiness, lower the victims’ self-esteem and breeds mistrust, which forces women into revenge sex and/or multiple sexual relationships in search of love and acceptance. Though Uganda has developed progressive laws and policies that prohibit sexual abuse and violence against women, implementation is still weak. Additionally, medical surgeons who carry out examinations and provide evidence to magistrates are few. 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.

To address these shortcomings, this strategy will:

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

7.4 Incorporating HIV prevention needs of Women and other Key Groups in development programmes

Women’s economic dependence on men and unequal access to resources increases the likelihood of engaging in risky sexual behaviors. Married women or those in partnerships often accept risky behavior by their partners due to the need for economic security. Studies show that economic empowerment does not enhance women’s ability to negotiate for safe sex.

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62 Care International 2010
This strategy will promote linkages with interventions that increase access of women to gainful employment and increasing their ability to negotiate for safer sex.

- Linkages to income generating activities focusing on rights awareness, life skills education and advocacy for enforcement of laws that protect women’s rights will be given priority in all sectors.
- In line with the NDP, this strategy will advocate for ensuring that all planning processes integrate concerns of women, girls, gender equality and HIV.
- In line with The Windhoek Declaration on Women, Girls Gender Equality and HIV (April 2011) advocacy for gender budgeting and actions to address barriers to gender equality will be supported.
- All stakeholders will be mobilised to advocate for actions that ensure that sectors and local government budgets allocate funds for women, girls, gender equality and HIV. Key performance indicators on gender sensitive responses will be developed in all sectors at all levels.
- This strategy will build on current achievements in gender mainstreaming to engender structured gender and HIV mainstreaming in development programmes such as NAADS, NUSA, Wealth for All, and PRDP in order to increase women’s access to resources and skills.
- Linkages with programmes that increase access to vocational skills training, and opportunities to develop practical and business enterprises will also be established. Similarly, advocacy for increasing women’s access to financial resources will be done. Studies show that skills taught by microfinance programs, such as assertiveness, adult literacy may enhance women to negotiate safer sex.

7.5 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 indicated that 14 percent of children in Uganda have been orphaned. In addition, the Uganda-specific definition and indicators shows that 51 percent of children in Uganda are considered moderately or critically vulnerable, with 8–9% of the children being critically vulnerable. Vulnerability of children has potential to exacerbate the risk exploitation through child labour, transactional and cross-generational sex. This is worsened by the fact that the capacity of families to look after OVC has been affected by HIV/AIDS, poverty and conflict. The strategy prioritizes strengthening care of OVCs through:

- Supporting linkages to household and community based sustainable livelihood programmes
- Increasing community involvement in intervention design and delivery
- Promoting block grants especially in areas where the OVC and poverty is wide spread
- Build capacity of leadership structures at all levels to effectively respond to the needs of OVC
- Advocating for the review UPE and USE to ensure that efforts significantly reduce drop outs of OVC
- Address the needs of the older OVC with a focus on enabling them to acquire self reliance skills

7. 6 Confronting HIV-Related Stigma and Discrimination

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

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

- It will involve continuous engagement of individuals, families and communities in fighting HIV-related stigma and discrimination through increasing access to HIV services and integration of HIV in other health services. 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 with HIV/AIDS in their own household, openness of families about relatives living with HIV, and reduced moralization of HIV transmission.
- Interventions will engage with government, 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, 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 and community involvement in planning for stigma and discrimination reduction.
- PLHIV will be educated about their rights through rights campaigns and supported to access legal assistance and litigation services against discrimination in various contexts.

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72 “What people expect from others if they were known to be HIV positive”
73 “Internalized feelings of shame or blame derived from accepting stigmatizing judgments of one’s identity”
74 “what people do to unfairly disadvantage known or suspected HIV positive persons, such as exclusion from shared activities”
76 UNAIDS, 2005 pg 4
77 UNAIDS, 2005. HIV - Related Stigma, Discrimination and Human Rights Violations : Case studies of successful programmes, Best Practices Collection, Geneva:
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 coordination framework. However, an unprecedented level of coordination and leadership at national, district, facility and community level will be essential. The existing coordination mechanisms have inherent challenges and constraints. Furthermore, the pro-active political leadership for HIV control that was instrumental in the 1980s-90s has waned. While resources for HIV control have increased in recent years, HIV prevention funding remains inadequate, and not optimally allocated to interventions that have the greatest potential to reduce new infections. At the national level, UAC has challenges in monitoring the response and ensuring alignment of partners’ interventions to national priorities. Most HIV prevention interventions are concentrated in urban areas, rural and hard-to-reach areas such as fishing communities that have high HIV prevalence, underserved. Most interventions are sporadic and piecemeal and don’t reach the level and intensity necessary to get ahead of the epidemic. These gaps in leadership and coordination have to be addressed in order to deliver effective HIV prevention and make a dent in the course of the epidemic.

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

Indicators and Targets
- National Composite Policy index for HIV/AIDS policy and programme coordination increased from 67.5% (2005) to 85%
- All districts in Uganda will have functional HIV coordination committees
- All districts in Uganda will have functional PHA networks
- 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 will be increased from 25% to 40%
- All district governments will be allocating funds for HIV prevention from local revenues

Main Strategies:
- Aligning all HIV interventions and funding to National Strategic Plans
- 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
- Strengthening referral linkages between HIV prevention, care, treatment and other health services

8.1 Aligning all HIV interventions and funding to the Strategy
UAC is responsible for ensuring that all HIV interventions and funding is aligned to national priorities. During this phase of expanded HIV prevention:

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

8.2 Strengthening Coordination of HIV Prevention by the UAC

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 composed of Self Coordinating Entities (SCEs), the Partnership Forum and the Partnership Fund. The 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 UAC has a HIV prevention desk, but 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 of HIV prevention:

- 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 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. A workplan and budget will NPC will developed to facilitate its role.

8.3 Strengthening Coordination in the Health Sector:

The MoH is responsible for coordination of the public health response, especially biomedical HIV prevention interventions. In the expanded phase of HIV prevention during the next phase:

- The MoH central technical support and coordination role will be conceptualized and strengthened. The regulatory framework for interventions such as IEC/BCC, ART, and training for the various

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78These structures described in detail in the NSP have been instrumental in the HIV response at the national level.
thematic areas has gaps that the MoH must address. The current restructuring of the organizational structure of ACP in MoH will create a specific unit to coordinate HIV prevention. 

- The MoH will be supported to provide technical assistance to other sectors. District Heath Teams will be supported to provide technical guidance to other stakeholders, quality assurance; HIV/AIDS surveillance, and routine information gathering activities to track performance of HIV prevention.

8.4 Strengthening Coordination of HIV prevention in Other Sectors:

Line ministries are responsible for technical coordination within the respective sectors. However, the level of coordination within sectors is also weak. For instance, coordination with other stakeholders beyond the line ministry is often limited. Most sector HIV coordination focal points are added on responsibilities, not adequately supported budgets and infrastructure to effectively undertake intra-sector coordination. In most sectors, HIV focal point persons are of a lower level, rendering it difficult for them to influence policies and resource allocation. 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, with HIV work being just an add-on, and often not part of their job description and performance appraisal. They therefore often devote little time to HIV/AIDS coordination. Besides, presently there is limited joint sector planning and inter-sectoral sharing of lessons and experiences related to HIV prevention interventions. CSOs implementing interventions in the sectors are not well coordinated, which often results in duplication and fragmentation of efforts. Under this strategy, the national programme will:

- Build on the ongoing organizational development review of HIV/AIDS coordination to streamline relationships of the different stakeholders in the national HIV response.
- Utilize the results based framework to motivate sectors to pay more attention to their roles.
- Develop specific scope of work as part of the terms of reference for sector HIV focal point persons and make HIV an area of performance assessment at sector and local government levels. In this respect HIV will be made one of the deliverables in the performance contracts of accounting officers at sector and local government levels.
- Promote sharing lessons and experiences and joint planning by sectors to minimize duplication.
- Empower sectors to effectively coordinate and develop guidelines for CSOs to ensure that they are aligned to the strategic goals of the sectors, and the strategy. Effective coordination of CSOs will minimize duplication of efforts and the unnecessary competition, and make them utilize their comparative advantages to complement each other and strengthen the HIV response in the sectors.
- Streamline coordination and relationships between sectors and their line departments at district level in planning and implementation of HIV prevention interventions.
- Build capacity for functional HIV coordination desks at the sector and district levels.
- Harmonisation of reporting channels between NGOs and district and line ministries.
- Regular meetings for joint planning, review of progress and sharing of experiences among sectors, civil society and PHA networks. These meetings should delineate how sectors and CSOs should separately or jointly function in the different geographic areas, the services to be provided by different entities, populations to be served by each organisation or sector.

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79MoH: Draft Health Sector HIV/AIDS Strategic Plan 2010-15, December 2010, Kampala, Uganda
• Drawing on this strategy and the sector HIV plans for the line ministries, activities to be undertaken to achieve HIV prevention objectives will be harmonised. Harmonised interventions will be easier to coordinate because gaps in service delivery will be easier to identify and opportunities to interface with other sectors and organisations will be easier to pursue.
• Improve coordination skills, knowledge and experience through training and awareness raising about the challenges, opportunities, barriers and actions that facilitate coordination

**Strengthening Districts and Community Level Coordination of HIV Prevention:**
The DACs established during the early part of the last decade are no longer active in most districts. Implementation of HIV/AIDS plans developed under this arrangement was limited by resource constraints. The district focal points persons and DACs are not adequately funded which hinders performance of their roles. HIV mainstreaming in District Planning Technical Committees (DPTC) is weak yet all members of the DAC are also part of the DPTC. This affects alignment and coordination of HIV services with most CSOs, FBOs and private entities not aligning their work with district plans. In order to make DACs more active and sustainable, the strategy provides for:
• Building the capacity for functional HIV coordination desks at the district levels
• Mentorships of local government departments by line ministries. This will ensure alignment of district HIV strategic plans and sector priorities.
• Advocating for pro-active political leadership and commitment at all levels in order to sustain HIV prevention high on the agenda
• Strengthen coordination of reporting channels between NGOs, districts and sector HIV coordination structures.
• Advocating for increasing domestic funding for HIV coordination structures especially district level
• Support regular meetings for joint planning, review of progress and sharing of experiences
• Strengthening partnerships, coordination and referral linkages between HIV Prevention, Care and Treatment at health facilities and in communities

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80 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.

Accurate and timely strategic information is vital to inform strategic planning and monitoring of programmes. 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 will be augmented by operational research for impact evaluation. Improved information management will also be critical, as well as harmonization of M&E and results reporting systems’ of stakeholders under the principle of the “three ones”. Our review of strategic information for HIV prevention in Uganda\textsuperscript{81} has highlighted key issues that should be addressed during the next phase of HIV prevention.

**Indicators and Targets:**
The results that will be achieved under this component comprise of:
- 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
- All HIV prevention interventions evaluated for impact and effectiveness every three years
- Annual reports of HIV prevention comparing achievements against targets, produced
- All significant HIV Preventions programmes having 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 strategies for strengthened information base in the next phase of HIV prevention are as follows\textsuperscript{82}.
- Strengthening annual HIV surveillance and periodic monitoring of impact and outcomes of HIV Prevention efforts
- Strengthening reporting systems to track coverage and outputs of HIV prevention programmes
- Strengthening the management of data and documentation of best practices for program planning
- Periodic impact evaluation of HIV prevention programmes / approaches
- Regular tracking of HIV prevention resources

**9.1 Strengthening Impact Monitoring of HIV Prevention:**
Tracking the impact of HIV prevention in Uganda is increasingly based on HIV incidence measures since HIV prevalence data are confounded by improved HIV/AIDS care and ART 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 using EPP and Spectrum packages\textsuperscript{83}, HIV sero-prevalence among recent sero-converters such as young antenatal women, and HIV incidence assays such as BED or

\textsuperscript{81} 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 Consultancy Report, October 2010
\textsuperscript{82} 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.
\textsuperscript{83} Futures Institute: EPP and Spectrum: A Policy Modeling System: A system to support policy development and planning for improved Health: Futures Institute, USA
 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 overall HIV prevention impact evaluation will involve:

- Strengthening the annual HIV/AIDS surveillance system to provide improved annual estimates
- Regular triangulation of data from various sources to obtain estimates and trends of new infections, e.g. modes of HIV transmission assessments.
- Production and dissemination of annual HIV surveillance reports.

### 9.2 Strengthening Outcome Evaluation of HIV Prevention Programmes:

Outcome evaluation of HIV prevention is based on HIV/AIDS knowledge and sexual behavior of the general population or specific groups, as well as quality of health services. These are obtained from periodic population-based and health facility-based surveys. National AIDS indicators surveys (AIS), DHS, and service provision assessments (SPA) are conducted in Uganda every 5-6 years. However, current data are out of date, though a national AIS and a DHS are underway, and are expected to provide up-to-date data by the end of the year. Under this Strategy, strengthening outcome evaluation will involve:

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

### 9.3 Strengthening Routine reporting systems for tracking coverage and outputs of Programmes

Tracking outputs of behavioral and biomedical HIV prevention services will be vital for monitoring coverage and utilization as well as service gaps. For biomedical interventions in health facilities, the MoH’s Health Management Information System (HMIS) is the main source of this data. It is augmented by vertical data collection of some variable by ACP and other IPs. There is currently no national results reporting system for community level activities. In addition, all these data are not regularly aggregated into reports for dissemination. Consequently, there is often no comprehensive data on coverage and outputs of most HIV prevention services. In this Strategy:

- As part of HSS, there will be advocacy for improved routine reporting systems. Expanding variables in the new web-based HMIS that can accommodate additional indicators is a logical starting point.
- UAC’s Directorate of Planning and Monitoring and M&E sub-committee as well as line ministries should strengthen sector reporting systems and establish horizontal reporting linkages. However, UAC should not set up parallel reporting systems to obtain data from implementation units.
- Mechanisms for regular data quality assessment will be instituted as part of the wide information systems strengthening efforts.
9.4 Tracking HIV Prevention Resources:
There is need for a financial tracking system to routinely track data on financial resources for HIV/AIDS programmes. The system should support disaggregation of data on HIV prevention expenditure. This should also involve National Health Accounts (NHA), National AIDS Spending Assessments (NASA), and UNGASS Reports; which currently have most HIV prevention spending data not categorized. Without disaggregated HIV prevention expenditure data, it is difficult to link the allocation of resources to the drivers of the epidemic and consequently areas of greatest need.

Under the new HIV Prevention Strategy:
• GoU through the MoFPED and UAC will institute financial tracking processes, to include disaggregated data on HIV programmes.
• The GoU will regularly assess alignment of expenditure and HIV transmission dynamics.

9.5 Strengthening Operational Research for Impact Evaluation
Operational research or public health evaluation is necessary to assess impact of interventions and approaches. In the next phase of HIV prevention, a national operations research agenda with priority areas of focus will be developed and approved by the NPC. Furthermore, dissemination of study results and funding for priority operational research based 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.
• Mechanisms for coordination of HIV prevention research involving IPs, Research institutions, Uganda National Health Research organization (UNHRO) and National Council for Science and Technology will be explored and standardized.
• Investment in research particularly studies based on the national research agenda will be prioritised.
• Priority research will include tracking the dynamics of HIV among MARPs, and size estimation for at-risk populations. PEPFAR that has already allocated $600,000 to mapping of MARPs. Additional priority research will comprise of: sexual behavior of PLHIV, ethnographic studies of drivers, social dynamics, vulnerability, gender relations, culture, poverty and how these might be addressed.
• Dissemination of research findings will be strengthened through the one-stop information centre that will be established.

9.6 Strengthening the Management of Strategic Information and Documentation of Best Practices:
To improve management of strategic information, data from M&E, HIV surveillance, population surveys, and operational research will be routinely packaged and disseminated to stakeholders. This will involve:
• A one stop information centre will be established to regularly consolidate and catalogue vital strategic information. It will develop a system for regular reporting to the hub and dissemination of findings. The UK government through DfID has already indicated support for such a centre84.
• The information centre or knowledge hub will establish functional linkages with similar centres such as UNHRO, University libraries, and other centres that generated HIV prevention information.

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84 DfID Uganda: Project Memorandum – GIV/AIDS Prevention Programme, Kampala, December 2010
10. Implementation Strategy

The ambitious targets in the National HIV Prevention Strategy require a robust implementation framework. Implementation and coordination of expanded HIV prevention initiatives in the next phase will continue to be based on the existing multisectoral framework. However, these mechanisms have to be strengthened to effectively meet the requirements of expanded combination HIV prevention. In addition mobilizing additional resources to finance expanded HIV prevention initiatives will be critical. These will be approached as follows:

10.1 Launch of the Strategy:

The National HIV Prevention Strategy will be launched at national and regional events involving all key stakeholders. At the launch, all stakeholders will be requested to commit themselves to implementation of expanded HIV prevention, and sign a declaration of undertaking and commitment. Thereafter, UAC will launch it at regional level throughout the country, with similar undertakings from districts.

Within 90 days of the launch of the strategy, line ministries and other important stakeholders will be required to submit a report of policy changes, and other key steps they will take to implement it and continuously report on progress towards meeting the targets. At the local level, 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. The UAC will compile these reports into a national report.

10.2 Implementation Strategy for Combination HIV Prevention:

Effective implementation of combination HIV prevention requires repositioning 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.

10.2.1 Referral Linkages between HIV Prevention Services: Since Most IPs or entities don’t have capacity to implement the full range of priority services, therefore, unprecedented levels of partnerships and collaboration between IPs, backed by functional referral linkages will be established right from the outset to ensure delivery of 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 services in each administrative area will be mapped, and districts, facilities, IPs and communities will establish or strengthen referral linkages based on guidelines from MoH, UAC etc.
- The UAC and MoH will develop guidelines to ensure that HIV prevention RFAs require applicants to demonstrate partnerships to provided a complete HIV prevention package to communities.
- Capacity building for community leaders and district authorities to establish and monitor functional referral linkages in their areas will be conducted.
- Indicators to track functional referral linkages and their monitoring mechanisms will be developed.
- To address structural drivers of the epidemic, programmes will link with broader poverty reduction and development initiatives funded from various sources.
- The MoH and MoGLSD will develop guidelines for family and community centered approach to HIV prevention. This approach increases male involvement and builds support for those that test for HIV.
by engaging households for instance, to test and encourage disclosure. At the community level, it increases participation and ownership of HIV programs, and supports communities to fight stigma.

**10.2.2 Integration of HIV Prevention with other health services:** To increase efficiency and access to services, integration of HIV prevention with SRH, MCH, care and treatment, TB and other services will be strengthened. This will require considerable investment in all aspects of health systems. Therefore:

- MoH will update guidelines and monitor integration of services and joint planning of related programmes at all levels. Coordination at national and district level, capacity building, regular supervision, coaching and mentoring to increase multi-skilling and performance will be undertaken.
- The Integration of HIV prevention with other social-development such as poverty reduction, sports, community groups (e.g. Village Savings and Cooperatives), and activities such as cultural ceremonies, clan meetings and religious activities will also be undertaken. This will increase opportunities for community dialogue on social cultural, gender and related factors. The MoGLSD will develop guidelines and monitor integration into community activities, and in workplace settings.
- MoFPED will lead mainstreaming of HIV prevention into development programmes.
- MoES will strengthen integration of HIV prevention in curricular and extra-curricular activities.

**10.2.3 Health Systems Strengthening:** Health systems’ strengthening (HSS) will be critical for improved access, coverage and quality\(^{85}\) of HIV prevention services. All building blocks of health systems are crucial for expanded HIV prevention. The 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\(^ {86}\). The new HSHASP2 will address some of the challenges. In addition, HSS will be funded by the Global Fund under Round 10\(^ {87}\), and PEPFAR II has a component of HSS\(^ {88}\) which provides opportunities for additional resources to support HSS.

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

- 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.
- 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.

**10.3 Mobilization and Efficient use of Resources for HIV Prevention:**

Mobilization of additional resources, and efficient utilization through prudent financial management is crucial to expanded HIV prevention. In the next phase of HIV prevention:

- UAC will spearhead advocacy for additional funds from GoU and external sources. The Cost estimates of the strategy highlights gaps that should form the basis for mobilising additional funds.

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\(^{86}\)MoH: Reports of the Review of the Health Sector HIV/AIDS Programme, Draft Reports for all the Building Blocks, 2010, Kampala, Uganda

\(^{87}\)Uganda Proposal to the Global Fund Under Round 10 Call for Applications

• All line ministries and local governments will be required to budget for HIV prevention as part of sector budgeting processes. MoFPED will provide relevant guidelines and ceilings.
• All stakeholders will also mobilise resources to bridge the funding gaps and institute prudent resource utilization and transparency measures.
• There will be collaboration with institutions that monitor resource utilization and empowerment of communities to be watchdogs for prudent use of HIV prevention resources.

10.4 Institutional Arrangements for Implementation of the Strategy:
In the next phase of HIV prevention, it is neither possible nor necessary to merge all HIV prevention programmes under one entity. HIV prevention will continue to be implemented in different sectors, by various IPs and at different levels according to their mandates and comparative advantages. However, a strong coordination framework that will ensure that all entities work in closer collaboration is vital. Under this framework, the roles of various principals in HIV prevention will be as follows:

10.4.1 The Uganda AIDS Commission will be responsible for oversight of the multi-sectoral implementation of HIV prevention. The UAC has recently supported 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 expanded HIV prevention. In addition, UAC will:
• Ensure that the strategy is adopted by all sectors and IPs within the first year, is regularly reviewed, effectively coordinated, implemented and monitored
• Spearhead mobilisation of resources and advocate for resource allocation for HIV prevention
• Ensure 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 efficient information management system

To execute these roles, the HIV prevention desk at UAC will be strengthened in line with the recommendations of the ongoing Organisational development review of UAC structures.89

10.4.2 The Ministry of Health: The MoH is central to expanded HIV prevention initiatives, providing technical leadership and coordination especially for biomedical HIV prevention services. The MoH’s HSHASP-290 will facilitate this role. The specific tasks for MoH will comprise of:
• Scaling up HIV prevention services i.e. HCT, PMTCT, SMC, IEC/BCC and ART in the country
• Integration of HIV prevention and other health services
• Technical guidance and standards and quality control of services delivered by other IPs and facilities.
• Strengthening HIV surveillance, impact evaluation, surveys and other routine information activities.
• Procurement and supply chain management of medical and pharmaceutical commodities for HIV prevention.

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90 MoH: Draft Health Sector HIV/AIDS Strategic Plan 2010-15, Kampala, Uganda, January 2010
10.4.3 Roles of Other Line Ministries: Line ministries will be required to strengthen their roles in line with their mandate and comparative advantages to support expanded HIV prevention initiatives. All line ministries will be requested to identify a coordination desk for HIV prevention to coordinate planning, implementation and to compile and provide regular progress reports. They will also be tasked to review their policies and make adjustments to support implementation of the strategy and report to UAC within 90 days of the launch. The roles of key line ministries in expanded HIV prevention will be as follows:

- **The Ministry of Local Government** will oversee the roles of DACs\(^\text{91}\) and lower local government committees, ensure that HIV prevention is provided for in plans and budget of all departments, ensure that all PHA networks, CSOs, and FBOs align with this strategy and with district plans, appraise performance of officers against targets, and ensure that disbursement of funds is tied to progress in meeting targets. District performance reviews should integrate an explicit indicator on HIV prevention mainstreaming in the various departments.

- **The Ministry of Justice and Constitutional Affairs** will address rights violation-related drivers of HIV infection. It will enforce regulations against SGBV, stigma and discrimination, good governance and accountability, 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 and private entities, coordinate HIV prevention in cultural and religious institutions, workplace, and for special populations and OVCs.

- **The Ministry of Finance, Planning and Economic Development**'s role is mobilization of additional resources. It will provide a special vote for HIV prevention, and ensure that line ministries, departments and institutions provide for, and disburse funds to HIV prevention. It will oversee prudent financial management, procurement and accountability, and periodic tracking of HIV prevention resources. It will also ensure that all development initiatives integrate HIV prevention.

- **The Ministry of Education and Sports** will support HIV prevention in educational institutions. It will design curricular and extra-curricular HIV prevention interventions for all levels, provide guidelines for peer education for youth-in-school, and implement HIV workplace programs in the sector.

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

10.4.4. Roles of Districts:

In Uganda’s decentralized administrative set up, districts and lower local governments are responsible for planning and delivery of public services. Under expanded HIV prevention in this strategy, district governments and their technical departments will:

- Spearhead planning and coordination of HIV prevention at district and in lower local governments.
- Through District Health Offices and health facilities, provide HIV prevention services, and technical support and quality assurance of services provided by all stakeholders in the district.
- Ensure mainstreaming of HIV prevention activities in district development plans.
- Map HIV prevention services to ensure equity and establish referral linkages between stakeholders.

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\(^\text{91}\) 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.
• Plan and monitor the delivery of the minimum HIV prevention package and referral linkages for services to the general population and specific population groups
• Prepare regular reports on HIV prevention that compare performance against targets. They will submit regular reports to line ministries and UAC and share with stakeholders at district level.

10.4.5 Civil Society Organizations and FBOs:
The CSOs, FBOs, NGOs, and community groups will be instrumental in HIV prevention service delivery. In the next phase of HIV prevention, they will be required to collaborate more with each other and with the public sector to ensure provision of minimum package of services. They will:
• Develop and implement HIV prevention programs at the workplace and other population groups according to their areas of comparative advantages. They will enter MoUs with line ministries and districts to harmonise their operations and plans.
• Mobilise resources for priority HIV prevention activities, and harmonise efforts with district teams
• Work out collaborative arrangements with other partners to provide comprehensive services
• Provide regular progress reports to districts and line ministries
• Align workplans with districts and participate in all planning, coordination and information sharing activities in respective districts.

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

10.4.7 International Development Partners:
Bilateral and multilateral development partners are instrumental in supporting HIV prevention. They currently fund 80-90% of HIV prevention costs. In the next phase of HIV prevention, IDPs will continue to provide financial and technical assistance to local public and private initiatives, mobilise additional resources, and share best practices. Since coordination of initiatives is critical to improved effectiveness of HIV prevention endeavours, IDPs will increasingly align their operations and funding mechanisms with national systems as they evolve, in line with the Paris Declaration of aid effectiveness\textsuperscript{92}.

10.4.8 The National HIV Prevention Committee:
This technical committee of the PC will play an increasing role in technical and strategic guidance of HIV prevention in the next phase. The scope of work of the NPC comprises of: synthesizing evidence on HIV prevention, 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 with TWGs for specific interventions. It will serve as the steering committee for this

\textsuperscript{92} OECD: The Paris Declaration of Aid Effectiveness. Paris, France, February 2005,
strategy, and working with the HIV prevention desk at UAC, will track implementation and roll out of the strategy, and review and update it from time to time. In addition, it will establish and facilitate a permanent think tank on HIV prevention. It will regularly review all HIV prevention reports and advise the UAC on gaps or evolving priorities. It will establish formal linkages with TWGs guiding specific HIV prevention interventions e.g. SMC, IEC/BCC, PMTCT, etc, to ensure that policy and technical guidance are regularly updated based on the latest scientific evidence.

10.5 Monitoring and Evaluation

Monitoring and periodic evaluation of HIV prevention initiatives will be vital to an informed and strategically guided response. Enhanced M&E will also track whether HIV prevention efforts are aligned to the drivers of the epidemic, based on effective approaches, and on course to meet the targets. To increase focus on results, results-based framework for the strategy that tracks progress will be developed and used. All line ministries, IPs, and districts will develop M & E plans aligned to the results framework in order to track their contribution to national HIV prevention goals.

M&E efforts will continue to be based on the existing M&E and surveillance systems, procedures and mechanisms. In addition, information systems of major IPs such as MEEP will also be harnessed. The monitoring indicators for HIV prevention in this strategy (Annex 2) align with existing M&E plans. Regular reporting of outputs will be strengthened.

The UAC and NPC will provide oversight for multi-sectoral M&E. However, UAC will work very closely and strengthen horizontal linkages with sector information systems. The ACP in MoH and HIV prevention desks in other line ministries will be responsible for obtaining and analyzing programme M&E data in their sectors, and preparing reports of sector-specific HIV prevention activities, and reporting 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. The HIV surveillance system in the MoH will also provide improved annual surveillance data for evaluation of HIV programme impact.

The UAC will regularly compile all information obtained from sectors and produce annual performance reports of HIV prevention, reflecting performance against targets. The reports will be considered 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 functions 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. Within six months of the launch of the strategy, M&E systems in line ministries and key IPs will be assessed to identify strengthening measures for the M&E units as well as reporting systems. In addition, 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 M&E systems and provide regular reports to UAC.
Partners implementing various programs will be required to align reporting mechanisms with the respective sectors, and support the development of sector M&E systems. They will also conduct regular evaluation of the impact of interventions and document and disseminate best practices.

The UAC Directorate of Policy and Research will coordinate all evaluation efforts. Within six months of the launch of the strategy, UAC and MoH will develop an evaluation agenda. The World Bank and DfID have already initiated efforts in this regard. All data arising from 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, and disseminated to all stakeholders.

At district, and sub-district level, similar processes will be replicated, with technical departments collecting, analyzing, and disseminating local data to stakeholders. At these levels, M&E operations will revolve around coverage and output indicators, monitoring performance against targets. Standard indicators to facilitate this will be in line with 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 strategy will be conducted in 2013, based on terms of reference that will be developed by NPC, and will form the basis for its revision. An end of term evaluation will be conducted in 2015. Details of the monitoring and evaluation will be expounded in the performance monitoring plan that will be developed after the adoption of the National HIV Prevention Strategy.

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## Annex 1: National HIV Prevention Strategy: Design Summary

### Goal:

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

### Indicators and Targets:

- New HIV Infections in the country reduced by 30% of the 2009 levels by 2015
- PMTCT Rate Reduced to less than 10% by 2015

#### Priority Outcomes - Results:

<table>
<thead>
<tr>
<th>1. Increased coverage, and utilization of HIV prevention services</th>
<th>2. Increased adoption of safer sexual behaviors and reduction of risk taking behavior</th>
<th>3. Strengthened sustainable enabling environment that mitigates underlying factors that drive HIV epidemic</th>
<th>4. Achieving a more coordinated HIV prevention response at all levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicators and Targets:</td>
<td>Indicators and Targets:</td>
<td>Indicators and Targets:</td>
<td>Indicators and Targets:</td>
</tr>
<tr>
<td>% HIV-infected mothers and exposed infants receiving PMTCT increased to 90%</td>
<td>Recent multiple partnerships reduced by 50% among men and women respectively</td>
<td>% women who make decisions about their SRH or with husbands increased from 61% to 80%</td>
<td>National Composite Policy index for coordination increased from 67.5% (2005) to 85%</td>
</tr>
<tr>
<td>% of adults recently tested for HIV increased to 80%</td>
<td>Transactional sex among men and women reduced by 50%</td>
<td>% Survivors of SGBV seeking help from service organizations increased from 23% to 60%</td>
<td>All districts having functional HIV coordination structures</td>
</tr>
<tr>
<td>% adults males that are circumcised increased to 80%</td>
<td>Cross-generational sex and early sex reduced by at least 50%</td>
<td>% expressing fear of contracting HIV from casual contact with PLHIV reduced by 50% from 19% women &amp; 28% men</td>
<td>All districts having functional PHA networks</td>
</tr>
<tr>
<td>% clinically eligible ART clients enrolled on antiretroviral treatment increased to 80%</td>
<td>Casual sex reduced by at least 50%</td>
<td>% 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.</td>
<td>HIV/AIDS spending increased from 3% (baseline for 2004) to 5% of total annual national budget</td>
</tr>
<tr>
<td>% risky sex (multiple partnerships, casual and sex with partners of unknown HIV sero-status) consistently protected by condoms increased to 80%</td>
<td></td>
<td>% Ratio of orphans: non-orphans (age 10-14 yrs. attending school increased from 0.9 to 0.96</td>
<td>HIV Prevention expenditure increased from 25% (UNGASS 2010) to 40% of HIV/AIDS budget</td>
</tr>
<tr>
<td>All HIV care and treatment outlets will have integrated HIV prevention</td>
<td>All districts having functional PHA networks</td>
<td>% secondary-school age (13-18 yrs.) children attending school increased from 16.3% to 25%</td>
<td>100% local governments allocating funds from local revenues for HIV prevention</td>
</tr>
<tr>
<td>All facilities implementing blood transfusion safety and universal infection control measures</td>
<td>Strengthened National level intra- and inter-sector coordination.</td>
<td>% (OVC) and non-OVC 5-17 years whose basic needs (i.e. clothing, shelter, and nutrition/food) are met increased from 28% to 50%</td>
<td>Strengthened information systems for HIV prevention.</td>
</tr>
</tbody>
</table>

#### Strategies:

<table>
<thead>
<tr>
<th>1.1 Scaling up HIV Prevention services to attain critical coverage and utilization of core services i.e. HCT, PMTCT, ART, SMC and Condoms in the general populations / specific groups</th>
<th>2.1 Scaling up age-appropriate behavioural change interventions in all population groups with focused messages targeting multiple partnerships, transactional/early/cross generational sex</th>
<th>3.1 Reviving political leadership for HIV prevention at all levels</th>
<th>4.1 Aligning all HIV interventions and funding to National Strategic Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2 Strengthening supply management of medical and pharmaceutical HIV prevention supplies</td>
<td>2.2 Strengthening policy guidance, quality assurance and capacity for effective IEC/BCC at all levels</td>
<td>3.2 Changing harmful socio-cultural and gender norms, beliefs and practices.</td>
<td>1.1 Strengthening National level intra- and inter-sector coordination.</td>
</tr>
<tr>
<td>1.3 Integration of HIV prevention in clinical and community settings</td>
<td>2.3 Increasing meaningful involvement of PLHIV in HIV Prevention endeavours.</td>
<td>3.3 Strengthening the legislative and policy framework for HIV prevention</td>
<td>1.3 Strengthening coordination of HIV prevention at the district and local levels</td>
</tr>
<tr>
<td>1.4 Preparing for roll out of new HIV prevention technologies</td>
<td></td>
<td>3.4 Strengthening capacity of health and social services to manage SGBV cases</td>
<td>1.4 Health system strengthening to effectively deliver HIV prevention in the health sector</td>
</tr>
<tr>
<td>1.5 Expanding targeted combination services for MARPs</td>
<td></td>
<td>3.5 Mainstreaming of HIV in development programmes to meet the needs of women and key groups</td>
<td>1.5 Advocating for increasing domestic and donor funding of HIV prevention</td>
</tr>
<tr>
<td>1.6 Demand Creation for HIV Prevention services</td>
<td></td>
<td>3.6 Promoting male involvement in HIV prevention</td>
<td>1.6 Strengthening referral linkages between HIV prevention, care, treatment and other health services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.7 Strengthening efforts against stigma and discrimination</td>
<td></td>
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<td></td>
<td></td>
<td>3.8 Increasing accountability for HIV prevention resources</td>
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</table>
## A: Impact of HIV Prevention (Long term Results)

<table>
<thead>
<tr>
<th>Results to be achieved</th>
<th>Indicator to measure whether result has been achieved</th>
<th>Baseline/year</th>
<th>2013 Target</th>
<th>2015 Target</th>
<th>Data sources / Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. New Infections reduced by 30% (40% of projected new infections 2015)</td>
<td>1. Estimated number of new infections in Uganda in the year</td>
<td>124,261 (2009)</td>
<td>111,917</td>
<td>94,503</td>
<td>ANC HIV surveillance Projections/Estimates</td>
</tr>
<tr>
<td></td>
<td>2. Estimated HIV Incidence rate among adults 14-49 years</td>
<td>0.72%</td>
<td>0.55%</td>
<td>0.46%</td>
<td>EPP/Spectrum / Other incidence measures</td>
</tr>
<tr>
<td></td>
<td>3. Percentage of young adults aged 15–24 who are HIV infected (UNGASS (22))</td>
<td>3.5%</td>
<td>3.5%</td>
<td>3.1%</td>
<td>Population Surveys / ANC Surveillance</td>
</tr>
<tr>
<td></td>
<td>4. Percentage of infants born to HIV infected mothers who are HIV positive (UNGASS (25))</td>
<td></td>
<td></td>
<td></td>
<td>EPP &amp; Spectrums Projections</td>
</tr>
<tr>
<td></td>
<td>5. Estimated annual number of vertical HIV infections</td>
<td>19,544[2009]</td>
<td>10,000</td>
<td>7,000</td>
<td>EPP &amp; Spectrums Projections</td>
</tr>
<tr>
<td>Reduced risk of HIV transmission during exposure to high-risk sex</td>
<td>15. Percentage of adult males (15-49 years) that are circumcised</td>
<td>TBD [2011 UAIS]</td>
<td>60%</td>
<td>80%</td>
<td>UAIS, DHS</td>
</tr>
<tr>
<td></td>
<td>16. Percentage of women and men aged 15–49 that had more than one sexual partner in the past 12 months who reported use of a condom during the last casual sex (UNGASS (17))</td>
<td>TBD [2011 UAIS]</td>
<td>70%</td>
<td>80%</td>
<td>UAIS, DHS</td>
</tr>
<tr>
<td></td>
<td>17. Percentage of adults aged 15-49 years who had sex with a non-marital, non-cohabiting partner in the past 12 months that used a condom at last sex with such a partner</td>
<td>TBD [2011 UAIS]</td>
<td>70%</td>
<td>80%</td>
<td>UAIS, DHS</td>
</tr>
</tbody>
</table>

## B: Outcomes of HIV Prevention (Intermediate Results)

<table>
<thead>
<tr>
<th>Outcome 1: Increased coverage, quality and utilization of HIV Prevention Services</th>
<th>indicator to measure whether result has been achieved</th>
<th>Baseline/year</th>
<th>2013 Target</th>
<th>2015 Target</th>
<th>Data sources / Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved coverage and quality of PMTCT, HCT, STI, blood safety, medical infection control</td>
<td>6. Percentage of adults aged 15-49 who have ever tested for HIV and received their results</td>
<td>TBD [2011 UAIS]</td>
<td>60%</td>
<td>90%</td>
<td>UAIS, UDHS</td>
</tr>
<tr>
<td>Improved demand for and uptake of HIV prevention services</td>
<td>7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and received their results</td>
<td>TBD [2011 UAIS]</td>
<td>20%</td>
<td>25%</td>
<td>UAIS, UDHS</td>
</tr>
<tr>
<td>Improved logistics and supply management of HIV prevention commodities</td>
<td>8. Percentage of women who were pregnant in the previous 24 months that were offered an HIV test and received their test results</td>
<td>TBD [2011 UAIS]</td>
<td>60%</td>
<td>80%</td>
<td>UAIS, UDHS</td>
</tr>
<tr>
<td></td>
<td>9. Percentage of HIV-positive pregnant women who received antiretroviral drugs to reduce the risk of mother-to-child transmission (UNGASS (5), UA3)</td>
<td>52%</td>
<td>75%</td>
<td>95%</td>
<td>EPP / Spectrum and Service Statistics</td>
</tr>
<tr>
<td></td>
<td>10. Percentage of randomly selected retail outlets and service delivery points that have condoms in stock</td>
<td>TBD</td>
<td></td>
<td>80%</td>
<td>Condoms availability surveys</td>
</tr>
<tr>
<td></td>
<td>11. Percentage of STI patients attending health facilities that are managed (diagnosed, treated and counseled on risk reduction) according to national guidelines</td>
<td>TBD</td>
<td></td>
<td>80%</td>
<td>Population Surveys, Program M&amp;E</td>
</tr>
<tr>
<td></td>
<td>12. Percentage of facilities that meet the core standards for infection control</td>
<td>6% [2007 USPA]</td>
<td></td>
<td>80%</td>
<td>Service provision assessment surveys</td>
</tr>
<tr>
<td></td>
<td>13. The proportion of clinically eligible ART clients enrolled on treatment increased to 80%</td>
<td>45% [2010]</td>
<td>60%</td>
<td>80%</td>
<td>EPP / Spectrum and Service Statistics</td>
</tr>
<tr>
<td></td>
<td>14. Percentage of AIDS care facilities that have integrated HIV prevention and offer a comprehensive package of prevention with positives</td>
<td>TBD</td>
<td></td>
<td>80%</td>
<td>Service provision assessment surveys</td>
</tr>
<tr>
<td></td>
<td>15. Percentage of adult males (15-49 years) that are circumcised</td>
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<td></td>
<td>16. Percentage of women and men aged 15–49 that had more than one sexual partner in the past 12 months who reported use of a condom during the last casual sex (UNGASS (17))</td>
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<td>80%</td>
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<tr>
<td></td>
<td>17. Percentage of adults aged 15-49 years who had sex with a non-marital, non-cohabiting partner in the past 12 months that used a condom at last sex with such a partner</td>
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<td>UAIS, DHS</td>
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<tr>
<td>Results to be achieved</td>
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</tr>
<tr>
<td>Increased coverage of male circumcision</td>
<td>18. Percentage of males who used a condom during the last sex with a sex worker</td>
<td>TBD [2011 UAIS]</td>
<td>80%</td>
<td>90%</td>
<td>Special Surveys</td>
</tr>
<tr>
<td></td>
<td>19. Percentage of HIV discordant couples consistently using condoms</td>
<td>TBD</td>
<td>70%</td>
<td>90%</td>
<td>UAIS, DHS</td>
</tr>
<tr>
<td></td>
<td>20. Percentage of female &amp; male sex workers consistently using condoms</td>
<td>TBD</td>
<td>80%</td>
<td>95%</td>
<td>Special Surveys</td>
</tr>
<tr>
<td>Outcome 2: Increased adoption of safer sexual behaviors and reduction of risk taking behaviors</td>
<td>21. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months (UNGASS (16))</td>
<td>TBD [2011 UAIS]</td>
<td>75% of Baseline</td>
<td>50% of Baseline</td>
<td>UAIS, DHS</td>
</tr>
<tr>
<td></td>
<td>22. Percentage of adults aged 15–49 years who had sex with a non-marital, non-cohabiting partner in the previous 12 months</td>
<td>TBD [2011 UAIS]</td>
<td>75% of Baseline</td>
<td>50% of Baseline</td>
<td>UAIS, DHS</td>
</tr>
<tr>
<td></td>
<td>23. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15 (UNGASS (15), UA6)</td>
<td>TBD [2011 UAIS]</td>
<td>75% of Baseline</td>
<td>50% of Baseline</td>
<td>UAIS, DHS</td>
</tr>
<tr>
<td></td>
<td>24. Percentage of girls (15-19 years) reporting cross-generational sexual partnerships</td>
<td>TBD [2011 UAIS]</td>
<td>75% of Baseline</td>
<td>50% of Baseline</td>
<td>UAIS, DHS</td>
</tr>
<tr>
<td></td>
<td>25. Percentage of never-married teenagers (15-19 years) that have never had sex (primary abstinence)</td>
<td>TBD [2011 UAIS]</td>
<td>75% of Baseline</td>
<td>50% of Baseline</td>
<td>UAIS, DHS</td>
</tr>
<tr>
<td></td>
<td>26. Percentage of men who paid for sex during the last 12 months</td>
<td>TBD [2011 UAIS]</td>
<td>75% of Baseline</td>
<td>50% of Baseline</td>
<td>UAIS, DHS</td>
</tr>
<tr>
<td>Outcome 3: A strengthened and sustainable environment that mitigates underlying factors that drive HIV infection</td>
<td>27. Percentage of adults with accepting attitudes towards PLHIV</td>
<td>TBD [2011 UAIS]</td>
<td>80%</td>
<td></td>
<td>UAIS, DHS</td>
</tr>
<tr>
<td></td>
<td>28. Percentage of women that experience Sexual and Gender Based Violence</td>
<td>TBD [2011 UAIS]</td>
<td>10%</td>
<td></td>
<td>UAIS, DHS</td>
</tr>
<tr>
<td></td>
<td>29. Percentage of adults that believe a woman is justified to refuse sex or demand condom use if she know the husband has an STD</td>
<td>TBD [2011 UAIS]</td>
<td>100%</td>
<td></td>
<td>UAIS, DHS</td>
</tr>
<tr>
<td>Outcome 4: Achieving a coordinated HIV prevention response at all levels</td>
<td>30. HIV/AIDS spending as % of the total annual national budget</td>
<td>3% [2004]</td>
<td>4%</td>
<td>5%</td>
<td>NASA</td>
</tr>
<tr>
<td></td>
<td>31. HIV Prevention expenditure as a percentage of total HIV budget</td>
<td>25%</td>
<td>22%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>6. Improved Systems for Strategic Information for HIV Prevention Improved</td>
<td>32. Percentage of Districts and Implementing partners with M&amp;E plans for HIV Prevention</td>
<td>TBD</td>
<td>100%</td>
<td></td>
<td>Programmes reviews</td>
</tr>
<tr>
<td></td>
<td>33. Percentage of districts that have mapped or estimated the sizes of various MARPs</td>
<td>TBD</td>
<td>50%</td>
<td>80%</td>
<td>Programmes reviews</td>
</tr>
</tbody>
</table>

C: Outputs of HIV Prevention Efforts (Immediate Results)

| HCT | 34. Number of adults (15-49 Yrs) counseled & tested for HIV, and receiving result in the past 12 months | TBD | 3.5 million | 4 million | HMIS, Program M&E data |
| 35. Number of sites providing HCT services | TBD | | | Service statistics |
| 36. Percentage of facilities above HC III providing Routine CT services | TBD | 60% | 80% | Service statistics |
| 37. Percentage of districts with at least 6 HCT service delivery outlets | TBD | 80% | 100% | Service statistics |

<p>| PMTCT | 38. Number of PMTCT Service delivery outlets in the country | TBD | 80% | 95% | |
| 39. Percentage of MCH/FP facilities that provide a complete PMTCT service package | TBD | 80% | 95% | HMIS, PMTCT M&amp;E |
| 40. Percentage of pregnant women attending ANC who are counseled, tested, and receive test | 98% [2009] | 100% | 100% | |</p>
<table>
<thead>
<tr>
<th>Results to be achieved</th>
<th>Indicator to measure whether result has been achieved</th>
<th>Baseline/year</th>
<th>2013 Target</th>
<th>2015 Target</th>
<th>Data sources / Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>results</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>41. Percentage of HIV+ pregnant women attending ANC who receive a complete course of ARV prophylaxis for PMTCT</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>42. Number of HIV positive mothers accessing PMTCT services for preventing negative born children from being infected</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male circumcision</td>
<td>43. Percentage of facilities (from HC IV) routinely providing SMC services</td>
<td>TBD</td>
<td>60%</td>
<td>100%</td>
<td>Service statistics</td>
</tr>
<tr>
<td>44. Number of males circumcised per year</td>
<td>TBD</td>
<td>1 million</td>
<td>1 million</td>
<td>HMIS</td>
<td></td>
</tr>
<tr>
<td>ART</td>
<td>45. Percentage of ART eligible individuals enrolled onto Antiretroviral therapy</td>
<td>50%</td>
<td>60%</td>
<td>80%</td>
<td>HMIS, EPP Estimates</td>
</tr>
<tr>
<td>Condom distribution</td>
<td>46. Number of male and female condoms distributed to end users in the last 12 months (UA5)</td>
<td>TBD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sufficient number of condoms available especially for MARPs, hotspots, rural areas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Transfusion Safety</td>
<td>47. Percentage of donated blood units screened for HIV in a quality assured manner(UNGASS 3)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>Service statistics</td>
</tr>
<tr>
<td>STI management</td>
<td>48. Percentage of public and private facilities providing STI services</td>
<td>60% [2007 USPA]</td>
<td>80%</td>
<td>90%</td>
<td>Service statistics</td>
</tr>
<tr>
<td>Medical Infection Control</td>
<td>49. Percentage of health facilities providing post-exposure prophylaxis</td>
<td>6% [2007 USPA]</td>
<td>50%</td>
<td>80%</td>
<td>Service statistics</td>
</tr>
<tr>
<td>50. Percentage of Health facilities with Infection Prevention and Control Committees</td>
<td>TBD</td>
<td>50%</td>
<td>80%</td>
<td>Service statistics</td>
<td></td>
</tr>
<tr>
<td>PwP/PHDP</td>
<td>51. Number of networks and organizations with prevention for positives programs</td>
<td>TBD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCC /IEC</td>
<td>52. Number of individuals reached with HIV prevention programs, by target group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>53. Percentage of large workplaces (public &amp; private) that have HIV prevention and care policies and programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEP</td>
<td>54. Percentage of caregivers and healthcare workers who receive post-exposure prophylaxis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Change</td>
<td>55. Percentage of districts with functional multisectoral HIV coordination structures</td>
<td>TBD</td>
<td>80%</td>
<td>100%</td>
<td>M&amp;E Reports</td>
</tr>
<tr>
<td>56. Percentage of districts funding HIV prevention initiatives with local revenues</td>
<td>TBD</td>
<td>60%</td>
<td>100%</td>
<td>M&amp;E Reports</td>
<td></td>
</tr>
<tr>
<td>Improved Coordination and Leadership for HIV Prevention</td>
<td>57. Percentage of districts and IPs with M&amp;E plans with indicators of HIV prevention</td>
<td>TBD</td>
<td>50%</td>
<td>100%</td>
<td>Service Statistics</td>
</tr>
<tr>
<td>Improved Strategic Information for HIV Prevention</td>
<td>58. Number of MARPs with HIV burden and population size established at National level</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>Service Statistics</td>
</tr>
<tr>
<td>59. No. of national quarterly comprehensive HIV Prevention reports produced on time per yr</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>M&amp;E Reports</td>
<td></td>
</tr>
</tbody>
</table>

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

95 Comprehensive HIV prevention reports will compare achievements against targets