
THE REPUBLIC OF UGANDA

# NATIONAL STRATEGIC PLAN FOR HIV&AIDS 2011/12 -2014/15

## Draft

**NOVEMBER 2011**


# *Foreword*

# *Preface*

# *Acknowledgments*

## *List of Abbreviations and Acronyms*

| | |
|---|---|
| ADPs | AIDS Development Partners |
| AIC | AIDS Information Centre |
| ANC | Ante-Natal Care |
| ANC/PNC | Antenatal care / Post natal care |
| ART | Anti-retroviral Therapy |
| ARVs | Antiretroviral Drugs |
| CBOs | Community-Based Organizations |
| CBVs | Community-Based Volunteers |
| CD4 cells | T lymphocyte cells with CD4 marker molecule |
| CDDs | Community Drug Distributors |
| CDR | Case Detection Rate (for TB) |
| CMDs | Community Medicine Distributors |
| CSF | Civil Society Fund |
| CSOs | Civil Society Organizations |
| d4T | Stavudine |
| DACs | District HIV/AIDS Committees |
| DII | Development Initiatives International |
| DOTS | Directly Observed Therapy, short course |
| EID | Early Infant Diagnosis |
| FDCs | Fixed Dose Combination (drugs) |
| FGDs | Focused Group Discussion(s) |
| GF | Global Fund |
| GHI | Global Health Initiative |
| GoU | Government of Uganda |
| HAART | Highly Active Antiretroviral Therapy |
| HBC | Home Based Care |
| HBHCT | Home Based HIV Counseling and Testing |
| HC | Health Center |
| HCT | HIV Counseling and Testing |
| HIPS | Health Initiatives for the Private Sector |
| HIVDR | HIV Drug Resistance |
| HIVQUAL | HIV Quality Improvement project |
| HMIS | Health Management Information System |
| HRH | Human Resources for Health |
| HSSIP | Health Sector Strategic and Investment Plan |
| HTC | HIV Testing and Counselling |
| ICF | Intensified Case Finding (for TB) |
| ICOBI | Integrated Community Based Initiatives |
| IDC/IDI | Infectious Diseases Clinic/ Infectious Diseases Institute |
| IDU | Intravenous drug users |
| IGAs | Income-Generating Activities |
| JAR | Joint AIDS Annual Review |
| KII | Key Informant Interview |
| KIs | Key Informants |
| LTFU | Lost To Follow-Up |

| | |
|---|---|
| M&E | Monitoring and Evaluation |
| MARPs | Most At Risk Populations |
| MDGs | Millennium Development Goals |
| MDR | Multiple Drug Resistance |
| MoGLSD | Ministry of Gender, Labour and Social Development |
| MoH | Ministry of Health |
| MoLG | Ministry of Local Government |
| MOT | Modes of Transmission Study |
| MSM | Men who have Sex with Men |
| MTCT | Mother to Child Transmission |
| MTR | Mid-Term Review |
| NDP | National Development Plan |
| NGO | Non-Governmental Organization |
| NPAP | National Priority Action Plan |
| NSP | National Strategic Plan (for HIV/AIDS) |
| NSPPI | National Strategic Programme Plan for OVC |
| NUSAF | Northern Uganda Social Action Fund |
| OI | Opportunistic Infection |
| OVC | Orphans and other Vulnerable Children |
| PC | Palliative Care |
| PCR | Polymerase Chain Reaction |
| PEP | Post-Exposure Prophylaxis |
| PEPFAR | US Presidential Emergency Fund for AIDS Relief |
| PEs | Peer Educators |
| PHA | People Living with HIV/AIDS |
| PHDP | Positive Health Dignity and Prevention |
| PIASCY | President's Initiative on AIDS Strategy for Communication to Youth |
| PICT | Provider Initiated HIV Counseling and Testing |
| PHA | People Living with HIV |
| PMTCT | Prevention of Mother to Child Transmission (of HIV) |
| POC | Point of Care technology (for CD4 testing) |
| PPDA | Public Procurement and Disposal Act |
| PREFA | Protecting Families against HIV/AIDS |
| PrEP | Pre-Exposure Prophylaxis |
| PWDs | Persons with Disabilities |
| PWP | Prevention with Positives |
| QPPU | Quantification and Procurement Planning Unit |
| SCOT | Strengthening Counselor Training project |
| SdNVP | Single Dose Nevirapine |
| SGBV | Sexual and Gender Based Violence |
| SOP | Standard Operating Procedures |
| SPEAR | Supporting Public Sector Workplaces to Expand Action & Responses to HIV/AIDS |
| SRH | Sexual and Reproductive Health |
| STAR | Societies Tackling AIDS through Rights |
| STAR-EC | Strengthening TB and HIV/AIDS Responses in East Central Uganda |
| STD | Sexually Transmitted Diseases |

| | |
|---|---|
| STF | Straight Talk Foundation |
| STI | Sexually Transmitted Infections |
| SUSTAIN | Strengthening Uganda's Systems for Treating AIDS Nationally |
| SWs | Sex Workers |
| TB | Tuberculosis |
| TDF | Tenofovir |
| TSR | Treatment Success Rate (for TB) |
| TWG | Technical Working Group |
| UA | Universal Access |
| UAC | Uganda AIDS Commission |
| UBOS | Uganda Bureau of Statistics |
| UDHS | Uganda Demographic and Health Survey |
| UHSBS | Uganda HIV/AIDS Sero-Behavioral Survey |
| UNAIDS | The Joint United Nations Programme on HIV/AIDS |
| UNGASS | United Nations General Assembly Special Session |
| UPE | Universal Primary Education |
| USAID | United States Agency for International Development |
| USE | Universal Secondary Education |
| VCT | Voluntary Counselling and Testing |
| VHTs | Village Health Teams |
| WHO | World Health Organization |
| XDR-TB | Extremely Drug Resistant Tuberculosis |
| YEAH | Young Empowered and Healthy |

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## *Definitions of Key Terms*

**ABC+:** A behavioral intervention taking into account the social, cultural and economic environments around the individual that influence behaviours; linking to other prevention and care interventions to enhance risk perception and internalization; and life skills building to support individuals to adopt and sustain positive behaviours of abstinence, mutual faithfulness to a partner of known status, and correct consistent condom use at every high risk sexual encounter.

**CD4:** White blood immune response cells that are disabled during HIV infection; another name for 'helper T cells'.

**Comprehensive Care & Treatment:** A holistic approach to care for people living with HIV/AIDS (PHA) that involves clinical management, nursing care, palliative care, and psychosocial support.

**Coordination:** A process of facilitation, communication, sharing, planning and monitoring of resources, risks, and rewards for purposes of efficiency and effectiveness in scaling up all efforts in response to the HIV/AIDS epidemic. Coordination does not mean control. The aim of coordination is timely delivery of equitable and quality services.

Decentralized Response*:* Involves building capacity of Local Government levels so that they are AIDS competent and able to plan, implement and mobilize communities to utilise HIV services

***HIV+***: HIV positive, i.e., infected with HIV, but may or may not have AIDS disease.

**Incidence:** Defined as new infections per population at risk in a specified period of time

**Mainstreaming:** Adapting a ministry or an organization's core business to cope with the realities of HIV/AIDS. The key principles of mainstreaming include: (i) understanding/being aware of the impact that the issue is having on development, (ii) identifying focused entry points, (iii) working within existing structures and strategies, (iv) working to your comparative advantage, (v) identifying and working through strategic partnerships, and (vi) understanding the impact of HIV/AIDS on the ministry or organization.

**Multi-sectoral Approach:** A policy programming strategy, which involves all sectors and sections of society in a holistic response to the HIV/AIDS epidemic

**PCR tests***:* Tests to directly detect the genetic material of HIV (not the immune response to HIV)

**Prevalence**: Defined as the total number of cases of HIV at a point in time per base population

**Psychosocial Support***:* Refers to all actions and processes that enable PHA, other HIV/AIDS affected persons including elderly, persons with disability (PWD), orphans and other

vulnerable children (OVC) and their families or communities to cope with stressors in their own environment and to develop resilience and reach their full potential.

***Social Protection:*** Interventions by public, private and/or voluntary organizations as well as informal networks which support communities, households and individuals in their efforts to prevent, manage and overcome risks and vulnerabilities.

***Social Support:*** Includes a broad range of responses to deal with vulnerabilities at intra-family level (high dependency, intra-household inequality, household breakup, family violence, family break-up). It also encompasses all efforts against gender discrimination (unequal access to productive assets, access to information, capacity building opportunities). It may also include support to education/information/literacy

# *Executive Summary*

## Background and Approach

In 2006, the Uganda AIDS Commission (UAC) in collaboration with stakeholders prepared the Five Year National HIV/AIDS Strategic Plan (2007/08 – 2011/12). The overall goal of the NSP was to achieve Universal Access targets for HIV/AIDS prevention, care, treatment and social support by 2012. In June 2011, a Review of the National Strategic Plan (NSP) 2007/08-2011/12 for HIV/AIDS Activities in Uganda was commissioned to offer the country an opportunity to redefine the key priority areas for the national response, identify key activities, targets and indicators during the next four years in tandem with the National Development Plan (NDP) 2010/11-2014/15.

A highly participatory and consultative approach in which all the relevant stakeholders participated in the Mid-Term Review of NSP 2007/08 – 2011/12 was adopted to provide input into the Revised NSP. An extensive desk review was undertaken while consultations at national, district and community levels were conducted by a team of six consultants with their assistants and staff of Uganda AIDS Commission. The process benefited from the input of thematic Technical Working Groups (TWGs), Steering Committee (SC) and Partnership Committee (PC), and the Annual Joint AIDS Review (JAR) Conference.

## Situation of HIV/AIDS

Since 1993, Uganda has succeeded in lowering its very high HIV infection rates. Among pregnant women, a key indicator of the progress of the epidemic, the rates have been more than halved in some areas and dropped by over a third among men seeking treatment for STIs. Subsequently, the annual rate of new HIV infections stabilized, leading to a stable adult HIV prevalence of 6-7% in the past 10 years (Spectrum estimates). Despite this success, there are serious concerns due to the fact that overall, HIV incidence increased from 115,775 in 2007/08 to 124,261 during 2009/2010 based on mathematical models ran by MoH, using EPP and Spectrum. Concerns are now being raised about the amount of attention (leadership, funds, and systems) committed to proven prevention and treatment interventions. Drivers of the HIV epidemic include the structural, contextual and social factors, such as poverty, gender inequality, inequity and poor access to health care, as well as stigma and discrimination and other human rights violations. Like elsewhere, Uganda's response is expected to utilize the game changing scientific advances, scale-up out interventions to realize universal access target for services. It is within this context that a Revised NSP was formulated to guide the response in the next four years—2012-2015.

## Linkage with other Policy, Planning and Legislative Frameworks

The Revised NSP is responsive to international and regional HIV and Rights agreements, policies and Declarations, including global obligations such as the MDGs, UNGASS and Universal Access targets to HIV/AIDS services, the Abuja Declaration of Heads of States, and ILO conventions, among others. This Revised NSP is also cognizant of, and builds on national policies and frameworks including the Constitution of the Republic of Uganda, National Development Plan, HSSIP, Vision 2025, National Health Policy, National HIV/AIDS Policy, OVC Policy, National Strategic Programme Plan of Intervention for OVC (NSPPI 2) and Local Governments Act.

## Vision, Mission, Goal, Strategic outcomes, Core Values and Principles

**The Vision** is "*A population free of HIV and its effects", while the* **overarching Goal** is "*to achieve universal access targets for HIV&AIDS prevention, care, treatment and social support and protection by 2015"*

**The guiding principles** are "Accountability and Personal responsibility, Advancement of best practice, Greater Involvement of People Living with HIV, Protecting Human Rights, Evidence-based planning and implementation, Adherence to the "Three Ones", Effective mutual integration and mainstreaming of HIV/AIDS, Beneficiary involvement and Accountability for results". Each thematic area is defined by an expected broad outcome or goal articulated as follows:

| Thematic Area | Goals |
|---|---|
| Prevention | To reduce HIV incidence by 30% by 2015 |
| Care and Treatment | To improve the quality of life of PLHIV by mitigating the health effects of HIV/AIDS by 2015 |
| Social support and Protection | To improve the quality of life of PLHIV, OVC and other vulnerable populations by 2015 |
| Systems Strengthening | To build an effective and efficient system that ensures quality, equitable and timely service delivery by 2015 |

## Overall Strategic Direction of the National HIV/AIDS Response

The Revised NSP provides an overall strategic of the national HIV/AIDS response in the next four years per each of the thematic areas.

***HIV Prevention:*** Guided by the wisdom of adopting ***Combination Prevention***, the focus of the prevention thematic area shall be **fourfold**, namely (i) to scale-up biomedical interventions to achieve universal access targets, (ii) uphold behavioral interventions, (iii) address socio-cultural and economic drivers of the epidemic and, (iv) re-invigorate the political leadership at all levels to enlist their commitment to HIV prevention. In scaling up proven evidence-based interventions, the country shall use HCT as an entry point to aim for virtual elimination of MTCT by adopting Option B+/or other effective regimens, roll-out safe male circumcision (SMC), and use ART as a springboard to prevention by targeting all eligible PLHIV with ART including all HIV+ children and pregnant women living with HIV while maintaining universal blood safety precautions. In order to register a stronger mark on sexual behaviour, the way to proceed is, first, to articulate key target population groups and packages based on evidence, coordinate prevention communication messaging, promote risk reduction including use of male and female condoms and continue to invest in research to understand sexual behavior.

***Care and Treatment:*** To fulfill her commitment to universal access to care and treatment, the country's strategic focus is to provide treatment of all eligible, roll out pre-ART care to HCII and HCIII, accredit more health facilities including private health facilities for HAART, improve early TB diagnosis and strengthen linkages with prevention through peers and village Health teams (VHTs). Primary attention shall be placed on ensuring early infant diagnosis (EID) and capacity of HCIII to offer pediatric care including adolescent friendly services with strong linkages to HCT. The above are possible with recruitment of more staff, introduction of point of

care CD4 testing and formulation of guidelines for task shifting, stronger drug resistance tracking, surveillance and case management systems accompanied by palliative care services.

***Social Support and Protection:*** Under this thematic area, the Revised NSP shall focus, first on advocacy for universal coverage (scope & scale) to a comprehensive social support and protection package to articulated beneficially groups. Second, attention shall be placed on empowerment of households and communities with livelihood skills and opportunities (including linkages to development programmes such as NAADS, NUSAF & SACCOs; and Cash Transfer initiatives) to cope with social and economic demands. In addition to rights education, and legal support, the major entry point for social support and protection shall be through organized structures of PLHIV, PWDs, elderly and categories most vulnerable to the effects of HIV to respond to own needs. At workplaces and agencies, focus shall be on supporting institutionalization of workplace policies in the formal and informal sectors and their implementation.

***Systems Strengthening:*** During the plan period, the country aims to review existing co-ordination structures at national and decentralized levels for appropriateness and clarity of roles and responsibilities, support integrated HIV/AIDS Plans and also enforce policies, laws and guidelines aimed at improved collaboration, partnerships and networking among implementing partners al all levels. To support universal access, this thematic area shall place particular attention to Human Resource and Infrastructure Development mainly to strengthen national capacity for forecasting, logistics management, procurement and disposal of health goods and services including streamlining of donor support in procurement systems for drugs and supplies.

***Research, M&E and Documentation:*** As part of systems strengthening, focus shall be placed on using research outcomes to appropriately improve policy and planning, scaling up LQAS to all LGs and prioritizing dissemination of results, and particularly for UAC to provide a clear framework to guide HIV/AIDS research efforts. In addition, the country requires a revitalized National AIDS Documentation Information Centre, M&E data collection, aggregation, analysis, reporting and utilization systems with well established organizational structures at all levels for M&E.

***Resource Mobilization:*** Most important for the Revised NSP is the focus on resource mobilization for the entire national response to HIV/AIDS; strategic attention shall be placed on developing an integrated and comprehensive national resource mobilization strategy and alignment of donor funds to national planning, budget and financial accountability systems. Equally important shall be the institutionalization of regular resource tracking mechanisms and improving efficiency of HIV/AIDS spending especially on those interventions that have big impact based on evidence.

## Implementation, Management, Coordination, and Collaboration

The three key elements in the coordination of the national response framework are UAC, the HIV/AIDS Partnership and the Decentralised Response Coordination structures. These structures are aligned with the 'Three Ones' principle. At the highest level of Government is Office of the President. The Minister for the Presidency is responsible for providing policy advice to UAC. The Parliamentary Standing Committee on HIV/AIDS coordinates the HIV/AIDS activities of Parliament, providing a link with UAC. The PC, which includes

representation of the various self-coordinating constituencies (SCEs) of HIV/AIDS stakeholders, plays a policy advisory role to the UAC and provides a forum for collective oversight on the management of the NSP. At decentralized level, AIDS Taskforces and Committees coordinate the HIV/AIDS response at various levels of Local Government. The HIV/AIDS Focal Person provides the secretariat for the committees. The linkages between district and national levels are through the Chief Administrative Officer (CAO).

Implementation of the Revised NSP will require commitment to promoting cross-sectoral linkages at all levels. National, district and sub-county technical personnel, the political arm, AIDS Development Partners, CSOs, private sector, and all other actors are brought together as the multi-sectoral actors under a coordinated framework. At Parish (LC2) level, the Parish Development Committees (PDCs) brings together all the stakeholders while at Local Council 1 level, the LC1 Chairperson bring together the Village Health Team (VHT) and other stakeholders to address HIV&AIDS issues.

# *SECTION ONE*

# *INTRODUCTION AND BACKGROUND*

## 1.1 Introduction

Thirty years since the first case of AIDS was described in 1981 (Gottlieb et. al., 1981), HIV continues to pose the greatest public health and socio-economic challenge to mankind threatening the attainment of the Millennium Development Goals (MDGs). Despite significant breakthroughs in prevention and, treatment and care, the HIV epidemic continues unabated especially in sub-Saharan Africa. According to the latest UNAIDS Report, *AIDS at 30: Nations at the crossroads*, some 34 million people are living with the HIV virus globally and nearly the same number has died since the first case was reported in 1981 (UNAIDS, 2011). In Uganda, the Ministry of Health (MoH) estimates that there were 1,192,372 people living with HIV, 124,261 persons newly infected with HIV and 64,016 AIDS deaths as of December 2009 (Estimation and Projection Package (EPP) and Spectrum).

These estimates point to difficulties in Uganda's national HIV and AIDS response that had initially been very successful in stemming the HIV/AIDS epidemic resulting in a marked decline in HIV prevalence from a national average of 18% in 1992 to 6.2% in 2002. Thus, since then the HIV response has been characterised by challenges which have led to a stagnation of the epidemic. Coverage of prevention interventions remains low due to inadequacies in the health system and despite expanded access to antiretroviral therapy (ART), a major treatment gap remains. It is estimated that 570,000 PHA are currently eligible for anti-retroviral treatment under the new eligibility Treatment Guidelines (of CD4 count of <350), but only about 290,000 (50%) are receiving this treatment according to Uganda AIDS Commission (UAC). Furthermore, the resources to finance the response are dwindling partly due to the global economic crisis, which calls for mobilization and harnessing of local resources to respond to HIV/AIDS. To this end, a Revised National Strategic Plan (NSP) for HIV/AIDS was deemed necessary not only to guide the national response, but also to act as a resource mobilisation tool.

## 1.2 Background

In 2006, the Uganda AIDS Commission (UAC) in collaboration with stakeholders prepared the Five-Year National Strategic Plan (2007/08 – 2011/12) for HIV/AIDS. The NSP was developed in a participatory and consultative manner, and intended for use by all stakeholders in Uganda's response to HIV/AIDS. The overall goal of the NSP was to achieve Universal Access (UA) targets for HIV/AIDS prevention, care, treatment and social support by 2012. The specific goals included:

- To reduce the incidence rate of HIV by 40% by the year 2012
- To improve the quality of life of PHA by mitigating the health effects of HIV/AIDS by 2012
- To mitigate the social, cultural and economic effects of HIV/AIDS at individual, household and community levels
- To build an effective support system that ensures quality, equitable and timely

service delivery.

The NSP was implemented by all stakeholders in the multi-sectoral HIV/AIDS response at national, local government and community levels since July 2007 with financial and technical support from the Government of Uganda (GoU) and Development Partners (DPs). The implementation of the Plan occurred during the period of increased donor and government interest in alignment and harmonization of approaches as well as procedures by all stakeholders to government systems. Similarly, International agreements such as The Paris Declaration of Aid Effectiveness and the principle of Three Ones heavily impacted on the plan implementation.

## 1.3 Rationale for Revising NSP 2007/08-2011/12

In June 2011, a Review of the NSP 2007/08-2011/12 for HIV/AIDS activities in Uganda was commissioned by the Uganda Government through the UAC to identify key achievements, challenges, and emerging issues in the management of the national HIV/AIDS response. The Review was intended to offer the country an opportunity to redefine the key priority areas for the national response to the HIV/AIDS epidemic, identify key activities, indicators and targets that Uganda should focus on during the next four years in tandem with the National Development Plan (NDP) 2010/11-2014/15. This, coupled with the Global Response of three-zeros ***(zero infection, zero death and zero discrimination)***, together with the following specific factors provided the rationale for re-planning in the national response:

- A Revised NSP aligned to the NDP and in view of the NHP and HSSIP was required to continue driving the timely and effective management of the national HIV/AIDS response for the next four years (2011-2015).
- Since the development of NSP 2007/08-2011/12, a number of issues have emerged in the response as well as opportunities in the fight against HIV/AIDS, which necessitated a revision of the NSP to capture these emerging issues and enable the country seize on the existing opportunities.
- Since 2007 when the implementation of the NSP began, Uganda has developed several policies and guidelines that are supportive of the national response. Key policies and guidelines include, among others, the National HIV&AIDS Policy (2011); the Updated National ART Policy Guidelines, the National HIV Prevention Strategy (2011-2015), the National Strategic Programme Plan for Orphans and other Vulnerable Children (NSPPI 2), and National Policy on Mainstreaming HIV/AIDS in Uganda (2008). A Revised NSP was, therefore required not only to help in translation of these national policies and guidelines into action, but also to take advantage of the enabling and conducive policy and planning environment in the response.
- Uganda has committed herself to the Millennium Declaration and the Millennium Development Goals (MDGs), which are spelt out in the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). Goal six of the MDGs focuses on halting and reversing the trend in the spread of HIV infection by 2015. A Revised NSP was therefore envisaged to keep on guiding the response towards the attainment of this goal.

- The HIV prevalence at the beginning of implementation of the NSP in 2007 was estimated at 6.4% according to Uganda HIV/AIDS Sero-Behavioral Survey (UHSBS) of 2004/05. Recent estimates suggest that the annual number of new HIV infections increased by 11.4% from 115,775 in 2007/08 to 128,980 in 2010/11 (UAC 2011). Among adults, the annual number of new HIV infections rose by 16.4% during this period but there was a 6.2% decline in new infections among children <15 years of age, most likely because of improvements in prevention of mother to child transmission (PMTCT) uptake registered during this period. On the other hand, the number of PHA increased from 1,140,379 in 2007/08 to 1,192,372 in 2009/10. Thus, translating the universal awareness of HIV into behavior change remains a challenge in the response, which this Revised NSP that aims at translating the National Prevention Strategy seeks to address in order to reverse the epidemic.

## 1.6 Process and Approach for Revising the NSP

A highly participatory and consultative approach in which all the relevant stakeholders participated was adopted in revising the NSP. The process of revising the NSP was preceded by a comprehensive midterm review of the implementation of the NSP during the first four years. A multi-disciplinary Steering Committee (SC) was formed to provide overall guidance to the Review and Revision process of the NSP. A team of six consultants was recruited to facilitate the Mid-Term Review (MTR) and revision of the NSP. Six thematic Technical Working Groups were constituted to review the reports and plans prepared by consultants. The MTR of NSP documented the progress attained, challenges experienced/emerging issues and recommendations/priorities for the revised NSP. Both the Steering and Partnership Committees endorsed the results of the MTR of the NSP, and subsequently the Revised NSP 2011/12-2014/15 before its launch. The specific process undertaken during the MTR that provided input into the Revised NSP included an extensive desk review, consultations at national, district and community levels, engagement with Technical Working Groups, Steering Committee (SC) and Partnership Committee (PC), and the Annual Joint AIDS Review (JAR) Conference.

### *1.6.1 Desk review*

A desk review was undertaken by each of the thematic area consultants. The review followed a systematic process of abstracting relevant information to address the tasks under the terms of reference (ToR). Particular emphasis was put on reviewing available literature to document progress of implementation of the NSP against set targets during the years 2007/8, 2008/09, 2009/10, 2010/11 and for the first four years of the Plan. Information on the indicators under each thematic area was sought from program reports, annual performance reviews and from annual surveys.

### *1.6.2 National, district and community consultations*

Consultations with key primary and secondary stakeholders were conducted at national, district and community levels. At the district level, consultations were held with all the technical and management teams in group sessions including Chief Administrative Officers (CAOs), and all the District Technical Officers, civil society organization (CSO), agency Coordinators, Directors, Program Officers and other selected staff. Individual in-depth interviews were conducted with key informants from public and private organizations at

national and district level including informants from civil society and networks of PHA were also consulted to provide input into the entire process.

### *1.6.3 Technical Working Groups (TWGs)*

Six (6) Technical Working Groups (TWGs) were duly constituted and launched during the Inception Phase. Each TWG worked with the Theme Consultant who was assisted by a Technical Advisor and a Research Assistant. Each TWG comprised of stakeholders with expertise in the respective theme area either as implementers or policy-makers. The following TWGs were constituted as per the themes in the NSP:

1. Prevention
2. Care and Treatment
3. Social Support
4. Strengthened Systems (Co-ordination and Infrastructure)
5. Strengthened Systems (Monitoring and Evaluation)
6. Strengthened Systems (Resource Mobilisation and Management)

Each TWG had a Convener or a Focal Person at Uganda AIDS Commission (UAC), a Chairperson from the line ministry or a key implementing agency.. Series of TWG meetings were held to review and provide input into desk review reports, review the tools, individual thematic MTR Reports, and finally to discuss and agree on the Revised NSP strategic objectives, actions, indicators and targets for each theme area. TWGs did not only provide technical guidance and input, but were an important source for data. Through several meetings conducted, the TWG provided data on various aspects of the Review. See Annex IV for compositions of TWGs.

### *1.6.4 Steering Committee (SC) and Partnership Committees (PC)*

The NSP review and revision processes were centrally managed by UAC in close collaboration with the Partnership Committee and the Steering Committee overseeing the overall exercise. From the TWGs, the Steering Committee received all key deliverables of the MTR—(i.e., individual thematic reports and the main Consolidated MTR Report) for further review and input before presentation to the Partnership Committee. These deliverables were utilized to revise this NSP.

### *1.6.5 The Annual Joint AIDS Review (JAR)*

The Mid Term Review report of the NSP was presented and discussed at the 2011 National Joint Annual AIDS Review (JAR) Conference that was held from 1st to 3rd November 2011. The JAR was attended by participants with representatives from: Parliament, Local Governments, Ministries, Departments and Agencies of Government, Civil Society, Private Sector, Networks of People Living with HIV&AIDS, Faith-Based Organizations, Bilateral AIDS Developments Partners (ADPs) and the UN family. Guided by the Thematic and Consolidated MTR Reports, indicative priorities and strategic actions for the Revised NSP were discussed, agreed and consolidated in this NSP. Thus, the JAR provided an opportunity to all stakeholders to dialogue and to consider emerging issues, constraints and recommendations for NSP Revision.

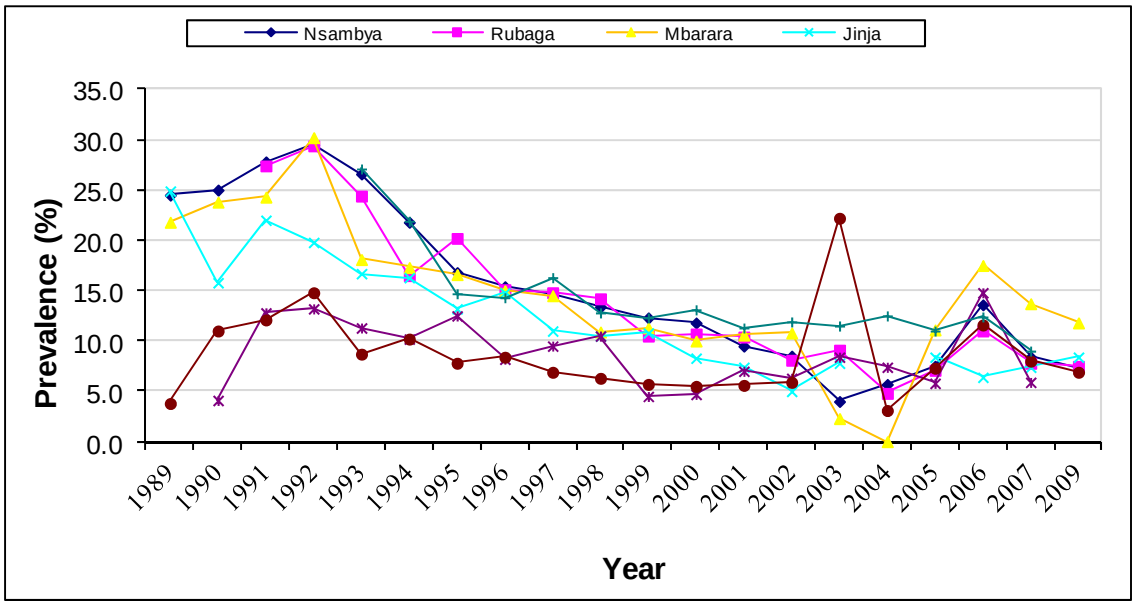
# *SECTION TWO*
# *HIV/AIDS SITUATION AND RESPONSE ANALYSIS*

## 2.1 Magnitude of the HIV/AIDS Problem

Uganda, one of the first countries in sub-Saharan Africa to experience the devastating impact of HIV/AIDS and to take action to control the epidemic, is one of the rare success stories in a region that has been ravaged by the HIV epidemic. While the rate of new infections continues to increase in most countries in sub-Saharan Africa, Uganda succeeded in lowering its very high infection rates. Since 1993, HIV infection rates among pregnant women, a key indicator of the progress of the epidemic, have been more than halved in some areas and infection rates among men seeking treatment for sexually transmitted infections dropped by over a third.

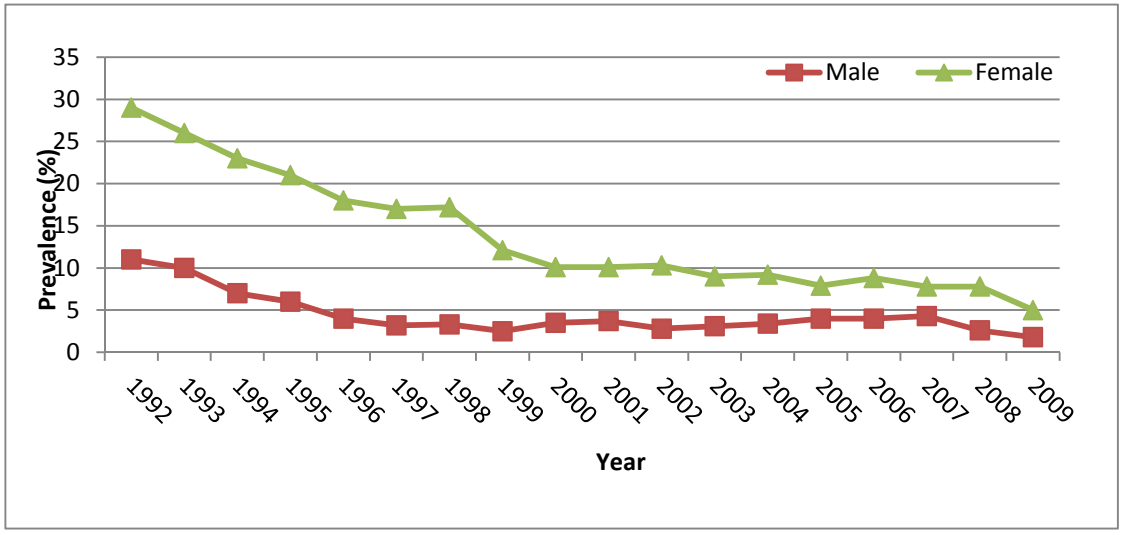
Subsequently, the annual rate of new HIV infections stabilized, leading to a stable adult HIV prevalence of 6-7% in the past 10 years (Spectrum estimates). The unprecedented contraction of the Ugandan epidemic was explained by evidence of reductions in multiple partners, an increasing trend in condom use, and the fear of AIDS. See Figures 1 and 2.

**Figure 1: HIV prevalence among ANC sentinel sites located in major towns**




*Source: MoH (2010) HIV&AIDS Epidemiological Surveillance Report*

**Figure 2: HIV prevalence among 15-24 yr old first time testers at AIC, Kampala**




*Source: MoH 2010; HIV&AIDS Epidemiological Surveillance Report*

Despite the noted successes, the scale of Uganda's predominantly heterosexually driven HIV epidemic remains enormous - about 1.2 million Ugandan people are HIV infected. Recent estimates put the number of annual new HIV infections at 128,980 in 2010; the fourth highest number of all 53 countries in Africa (Spectrum estimates). See Table 1.

**Table 1: Trends in HIV incidence 2007–2010 using mathematical modeling**

| Indicator | Population | December 2007 | December 2008 | December 2009 | December 2010 |
|---|---|---|---|---|---|
| People newly infected with HIV | Total | 115,775 | 119,258 | 124,261 | 128,980 |
| | Adults | 87,727 | 91,967 | 97,163 | 102,157 |
| | Women | 49,566 | 51,948 | 54,873 | 57,685 |
| | Children < 15 yrs | 25,746 | 24,878 | 24,548 | 24,142 |

***Source: MoH Estimation and Projections Group, 2010***

The number of new HIV infections exceeds the AIDS-related deaths by two-fold, and was almost three-fold the net enrolment into ART in 2009. There is high population growth, which means that although the *rate* of new HIV infections is stable (ca. 0.74%), the absolute number of newly HIV infected people is growing – from an estimated 84 000 in 1994 to 128,980 in 2010. This translates into a 48% increase in annual incident HIV infections over this 15 year time period, despite the delivery of HIV prevention services and increasing numbers of people with advanced HIV infections enrolled in the ART program.

Recent estimates suggest that the annual number of new HIV infections increased by 11.4% from 115,775 in 2007/08 to 128,980 in 2010/11 (UAC 2011). Among adults, the annual number of new HIV infections rose by 16.4% during this period but there was a 6.2% decline in new infections among children <15 years of age, most likely because of improvements in PMTCT uptake registered during this period. On the other hand, the number of PHA as noted earlier increased from 1,140,379 in 2007/08 to 1,192,372 in 2009/10 during this period. National HIV prevalence averaged 6.4% according to the Uganda HIV&AIDS Sero-Behavioral Survey

(UHSBS) of 2004/05. However, HIV prevalence among pregnant women remained higher than the national average: in 2009/10, HIV prevalence among pregnant women attending antenatal clinics (ANC) was 8.4% in urban and 5.7% in rural antenatal surveillance sites. Overall, median HIV prevalence among women attending ANC declined from 7.4% in 2007 to 7.0% in 2009.

## 2.2 Uganda's HIV/AIDS Situation in a Regional and Global Context

Cast with a wider regional and global context, Uganda's rising HIV incidence, the only PEPFAR focus country with this distinction, is quite glaring. Concerns are now being raised about the amount of funding committed to proven prevention and treatment interventions and, put differently, whether less effective prevention interventions could be receiving relatively more significant resources. The country's response to the evidence on safe medical male circumcision (MMC) has been cited as a case in point. As is happening in several countries even within the region, the country is increasingly being urged to seize some of the tremendous opportunities to improve the AIDS response, for instance by undertaking the following:

- Leveraging treatment as prevention, through accelerating access for people CD4<350 and beginning to initiate treatment earlier with sexually active HIV positive people.
- Ensuring access to quality PMTCT, through rolling out "Option B+"—treatment for life for pregnant women regardless of CD4 count, to improve her health and reduce the risk of transmission.
- Aggressive scale up of proven prevention programs for couples and for most at risk populations (MARPs), in particular sex workers (SWs), their partners and clients, men who have sex with men (MSM), and fishing communities.
- Rejection of discriminatory policies and legislation, such as some clauses in the proposed HIV Prevention and Control Bill
- Task shifting to allow community health workers to do rapid HIV testing in the public sector, and nurses to be trained to initiate HIV treatment
- Shift to less toxic, more effective first line regimens of *tenofovir, emtricitabine*, and *efavirenz*.

Like elsewhere, Uganda's response is expected to utilize the changing scientific advances which show that access to HIV treatment brings a 96% reduction in the risk of HIV transmission through sex. While there are notable concerns about the cost of universal access to treatment, Uganda doing more (with a constrained budget) to scale up of proven interventions will ultimately, pay for itself; there will be a dramatic impact in bringing down rates of incidence (new HIV infections). In the medium and long-term, accelerated scale-up of services will likely be cost-saving.

## 2.3 Drivers of the HIV epidemic: A synthesis

Drivers of the HIV epidemic include the structural, contextual and social factors, such as poverty, gender inequality, inequity and poor access to health care, as well as stigma and discrimination and other human rights violations. These factors shape or constrain individual behaviour such as condom use, uptake of PMTCT or HCT services etc, and therefore act as barriers to the effectiveness of individual-level behavioral interventions. Unfortunately, these factors are complex, intertwined and tend to be diffusely defined. Negative cultural

expectations relating to sex and gender power relations are known to enhance HIV transmission. The normalization of HIV/AIDS by some sections of the community also contributes to some form of disengagement from preventive behavior. On the other hand, some socio-cultural beliefs influence the uptake of some HIV prevention services such as appropriate breast feeding practices to reduce maternal-to-child HIV transmission or negotiation of safer sex by women. A spurious association between wealth or poverty and HIV confounded by factors related to mobility and sexual behavior has also been revealed. Poverty in particular is known to influence people to engage in transactional sex as well as in cross-generational and survival sex without the benefit of appropriate risk reduction ability. Similarly, HIV/AIDS are still stigmatizing conditions in Uganda in many cases perpetuating discrimination and denial. In addition, inadequate or low quality HIV counseling, psychosocial support, care and treatment compound the poor health care status of PHA and may increase progression as well as transmission of HIV.

## 2.4 Recent Evidence about Selected aspects about HIV/AIDS

A growing body of evidence is emerging which supports the use of treatment as prevention. The landmark study in 2000 by Quinn et al. which showed that HIV transmission is reduced when the plasma viral load is low, paved the way for research into interventions to reduce viral load as a means of reducing HIV transmission. These have been the basis for recommendations for the ambitious strategies of "test and treat" or "treatment as prevention". In July 2010, the CAPRISA 004 trial team announced that the use of 1% tenofovir vaginal gel reduced women's risk of HIV infection by 39%, providing the first proof that a microbicide could be a possible HIV prevention tool. In November 2010, the iPrEx trial team reported that daily oral tenofovir/emtricitabine had reduced risk of HIV infection by an estimated 44% overall in MSM and transgender women, and proved for the first time that HIV prevention using PrEP would be possible.

In early 2011, the HIV Prevention Trials Network (HPTN) 052 trial established that use of antiretroviral therapy (ART) by HIV-positive individuals reduced transmission to their partners by 96%. Finally, on 13th July 2011, the Partners Pre-Exposure Prophylaxis (PrEP) Study team released its findings which showed that daily oral PrEP taken by HIV-negative partners in HIV sero-discordant heterosexual couples significantly reduced risk of HIV transmission by 62% with tenofovir alone and by 73% with tenofovir/emtricitabine and that the effect was similar in men and women. These findings provide compelling evidence for use of ARVs for HIV prevention.

It has also emerged that social support and protection plays a big role in effective national response; it is evident that individuals who have the social support they need are more likely to adhere and comply with complicated schedules of taking their medicine. There is overwhelming evidence on the contribution of social support and protection in stimulating acceptance, disclosure and stress management; association between partner-reported general social support and safer sexual behaviors. Thus providing effective social support and protection is not simply an issue of mitigation of adverse effects of AIDS; it will leverage prevention and, care and treatment as well. The evidence that over 90% of PLHIV on good adherence to care and treatment will less likely infect their partners is also compelling reason

for scaling up HCT and linking this to psychosocial support and treatment programs; HCT expansion must move hand in hand with attendant care, treatment and support services to maximize benefits at population level.

## 2.5 Achievements of NSP 2007/08-2011/12 for HIV/AIDS at MTR

Overall, progress was registered in all the thematic areas of the NSP with varying levels at MTR of NSP. Some of the notable achievements in each of the thematic areas of NSP were documented as follows:

***HIV Prevention***: At MTR, notable achievements were registered in reduction in new infections among children; increase in number of Ugandans who knew ways of preventing HIV; increase in PMTCT access indicators (e.g., testing during pregnancy, enrolling on ART); 100% safety of blood for transfusion and expanded coverage of Uganda Blood Transfusion Services (UBTS); increased focus on prevention programming for key population groups and capacity building for friendly service provision; articulation of policy frameworks and operational guidance in key intervention areas including PMTCT, HCT, SMC and SRH/HIV integration; and development of the National HIV Prevention Strategy. Also see Table 2.

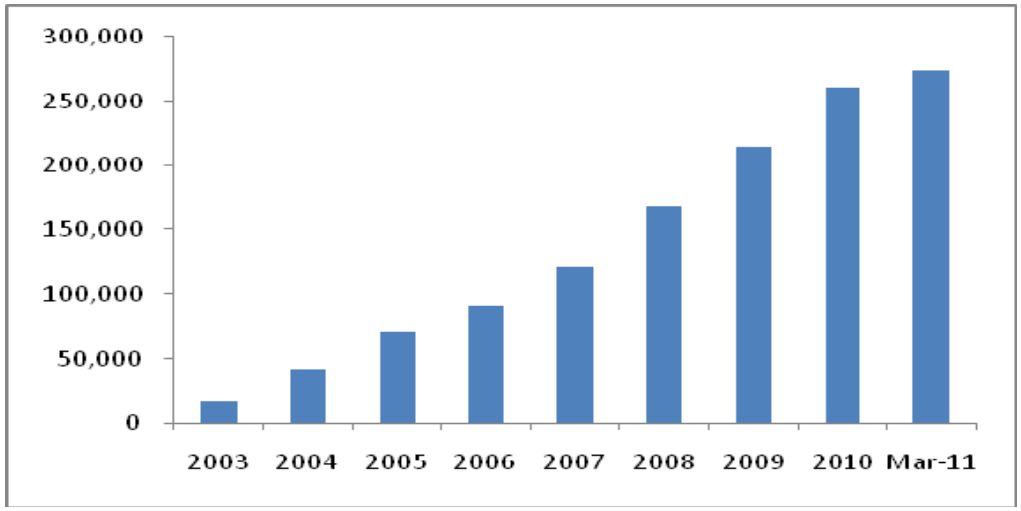
**Table 2: Proportion of HIV positive pregnant women receiving ARVs for PMTCT**

| Period | No/% of HIV+ pregnant mothers who received ARVs for PMTCT | % of all expected HIV+ pregnant mothers who received ARVs for PMTCT |
|---|---|---|
| Baseline data (2005) | 10,289 | 12% |
| 2007/08 | 31,990 (81%) | 35.3% |
| 2008/09 | 46,948 (82%) | 52% |
| Mid-term target (2009) | - | 50% |
| 2009/10 | 44,167 (73%) | 48.5% |

***Source: PMTCT& Pediatric HIV&AIDS Care Program Annual Report, July 2007 to June 2010-MoH***

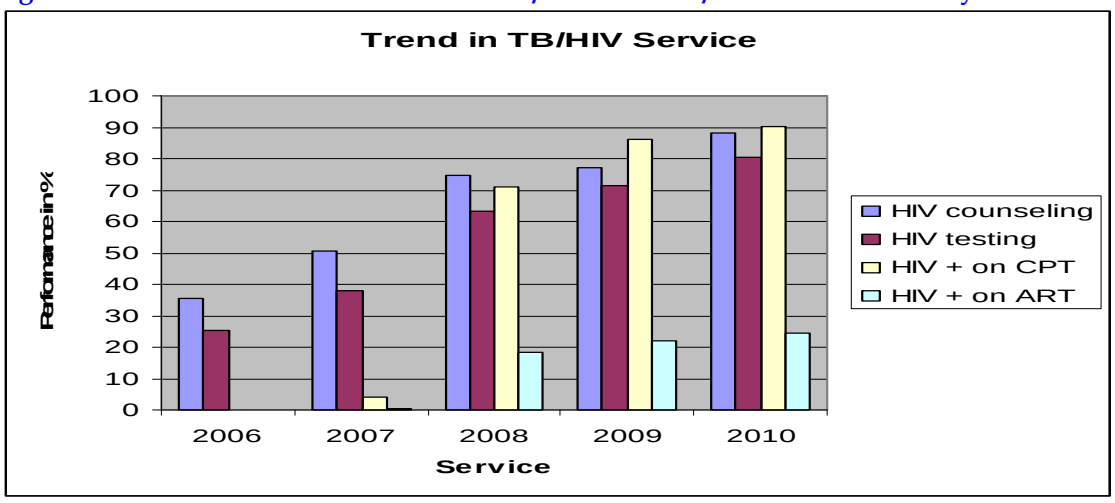
***Care and Treatment***: ART sites increased from 328 in 2008 to 443 in 2011; number of adults on ART increased from 105,000 to 290,000 by 2011; quality of ART improved with over 60% of ART recipients receiving baseline CD4 counts compared to 30% and improvement in the median CD4 T cell count over 5 years period. See Figure 3.

**Figure 3: Number of active ART clients across all facilities in Uganda 2003-March 2011**




A total of 93% of clients in active care received cotrimoxazole and 78% of facilities had cotrimoxazole in stock compared to 44% in 2007; TB/HIV collaboration indicators improved with proportion of TB patients tested for HIV increasing from 25.4% in 2006 to 80.5% in 2011. See Figure 4.

**Figure 4: TB-HIV indicators 2006-2010/ National: TB/HIV Service Delivery**




***Social Support***: Achievements in social support at MTR include the expanded Government Universal Primary Education (UPE) and the introduction of Universal Secondary Education (USE) leading to increased enrollment; more OVC have benefited from informal education through vocational skills training; expanded scope of the social support package and implementing partners especially the civil society sector; increasing number of actors involved in advocacy role to reduce stigma and discrimination. See Table 3.

**Table 3: Scope of Social Support Services**

| Activity | Percentage of HIV/AIDS organizations involved |
|---|---|
| Advocacy | 82.0 |
| Home Based Care and Support | 57.1 |
| Direct Material Support | 56.2 |
| Psychosocial Support/Counseling | 66.7 |
| Scholastic materials for OVCs | 57.1 |
| Training in vocational skills | 38.9 |
| Food security support | 50.9 |
| Others | 7.0 |

*Source: UAC Stakeholder & Service mapping Report (2009, p. 54)*

A number of structures exist both at community and local government level to provide social protection to vulnerable groups.

***Systems Strengthening***: Operationalization of the institutional arrangements that had been identified in the NSP; the establishment of a Civil Society Fund (CSF), mobilization of additional resources from development partners through mechanisms such as PEPFAR, GFATM, Partnership Fund; the amendment of the UAC Statute; the development and dissemination of key policies such as the National HIV/AIDS Policy, HIV/AIDS Mainstreaming Policies and guidelines; at local government level, (a) a standard Local Government HIV&AIDS Strategic Planning Guide was developed by Ministry of Local Government (MoLG); MoH constructed new health facilities, refurbished some dilapidated facilities and upgraded some health facilities to higher categories; Government continued to allocate resources for procuring ARVs

***Resources Mobilization and Management:*** There was a progressive increase in the share of GoU funding to the total national response from 5% in 2007/08 to 11% in 2009/10. External funding accounted for about 90% of the total funding.

**Table 4: Committed donor contributions to CSF, 2007/08-2011/12in USD**

| DONOR/FY | 2007/8 | 2008/9 | 2009/10 | 20010/11 |
|---|---|---|---|---|
| DANIDA | 3,800,000 | 4,200,000 | 4,407,190 | 4,409,091 |
| IRISH AID [1] | 3,340,000 | 5,124,000 | 6,300,000 | 5,850,000 |
| USAID [2] | 7,204,678 | 10,490,438 | 13,704,884 | 10,826,303 |
| DFID | 4,200,000 | 4,200,000 | 4,784,000 | 4,500,000 |
| ITALIAN COOP | - | - | 69,930 | - |
| SIDA | - | - | - | 1.400.000 |
| TOTAL | 18,544,678 | 24,014,438 | 29,266.004 | 26.985.394 |

***Source: EASE International (2011). MTR of CSF Uganda***

Overall, 80% of the commitments were honored amounting to US $ 931.8 million; Guidelines for Mainstreaming HIV/AIDS issues into planning and budgeting processes were developed and

[1] Irish Aid in Euro €2,371,705 (2007/8), €3,360,000 (2008/9) €4,500.000 ( 2009/10) €4,500,00 ( 2010/11)
[2] USG provided US $ 7 M for managements costs of the CSF

disseminated. HIV/AIDS mainstreaming recorded an improvement both at sector and local government levels; Better appreciation of the findings from the study on macroeconomic impact of HIV/AIDS in Uganda.

***Monitoring and Evaluation:*** The Performance Measurement Management Plan (PMMP) was prepared along with Operational Guidelines consistent with the NSP; MoH revised the HMIS to include more HIV/AIDS indicators and harmonized reporting tools for PMTCT, ART, TB and HCT; MoH made extensive use of HMIS data/other sources for performance-based requirements of GF Round 7 grant; Ministry of Gender, Labour and Social Development (MoGLSD) designed and launched an OVC Management Information System (OVC MIS); The Country prepared, and disseminated a series of performance reports including; HIV/AIDS Epidemiological Surveillance Reports, ANC sentinel surveillance, routine data and special studies and UNGASS Reports; Lot Quality Assurance Sampling (LQAS) methodology was used in 51 districts to collect population based data (2011) and used in annual planning; Capacity-building in M&E for districts through support for district-level HIV&AIDS strategic plan and for civil society organization through M&E support for CSF grantees was conducted. The AIDS Indicator Survey is currently on going and results will further inform the NPAP development.

## 2.6 Gaps and Challenges in the Implementation of NSP 2007/08-2011/12 at MTR

It is noted in the MTR that the national response, which since the 1990s and 2000s has been multi-sectoral is increasingly changing its character—indeed becoming more or less biomedical; even here, the country is far are far from the universal access targets of 80%. On the other hand, with more biomedical prevention interventions emerging, such as SMC and the move towards option B for PMTCT, more interventions beyond treatment will also be revolving around the health sector. This means that, concurrently, Uganda needs to scale out more biomedical interventions and to re-energize the "social vaccine" which contributed to the dramatic reduction in HIV infection a decade back, and use the evidence to tease out the interventions with the greatest impact to bring change.

Across all the thematic areas, significant resource gaps to support the national response and concerns about the efficiency of the models of interventions and accountability in the use of existing resources were documented. The country at MTR faced inadequate funding to cover the Uganda National Minimum Healthcare Package (UNMHP) including universal access to prevention, care and treatment, providing socio-economic and psychosocial support to the infected and affected, and finally supporting systems for HIV/AIDS. Whereas the NSP resource inflow at MTR estimated at US$ 923.7million representing 90% of Midterm projected estimates; and equaled 79% in terms of commitments from partners, the funding gaps were actually bigger due to scale up of interventions than was originally planned at onset of NSP. In the Revised NSP, the focus for the national response is to fit into the global goal of 3 zeros; (i) zero transmission, (ii) zero death, and (iii) zero discrimination, implying that the funding challenge will be significantly bigger.

Whereas funding in the last plan period was limited for nearly all key interventions (prevention, care and treatment, and social support, systems) except perhaps for free and

socially marketed condoms, there were also glaring inequities in levels of support to some of the thematic areas such as systems for national coordination and M&E including research and documentation, and also social support and protection (which had scattered responses mostly by CSO actors, mainly FBOs and CBOs). During the implementation of the Revised NSP more work will be needed to support especially internal mobilization for resources for strengthening coordination and rationalization use of existing sources.

All the thematic areas faced the challenge of lack of country most recent population-based and services data of national character regularly collected, which could be used for reporting on progress or lack of it along the various indicators in the NSP. Across most thematic areas as at MTR, no recent data were available on many indicators of the NSP. Extensive lack of data was partly a result of insufficient ownership of the PMMP by sectors and other stakeholders. The response also suffered uncoordinated effort that led to *ad hoc* studies that did not provide results that could be generalized nationally. The bigger consequence was the inadequate research evidence with impact on national response; a weak National AIDS Documentation Information Centre (NADIC) for synthesized data that would guide policy decision-making; besides, the research was mainly donor funded with weak coordination among UNCT, UNHRO, UAC and MoH.

## 2.7 Opportunities and Lessons at MTR

The evidence adduced from Modes of Transmission (MoT) studies, Longitudinal and Cohort studies provides clear information on the drivers of new infections. This, together with current wisdom espoused globally in support of "combination prevention" provides sufficient guidance on accelerating prevention by; 1) improving quality, access to and utilization of a core package of HIV prevention services the country, 2) increasing adoption of safer sexual behaviors in the general population and targeted MARPs and, 3) improving work and living environment for individuals, groups and communities conducive to HIV prevention to address the key drivers of the behaviours. In addition, the country needs to improve capacity of actors to plan, implement, monitor and coordinate HIV prevention activities at national, sector and decentralized level.

The MTR also pointed to a number of opportunities that the country seemed to be missing, particularly in care and treatment, and prevention.; for instance in Pediatric Care;- 29% of exposed infants tested, 39% of those tested do not receive results; 35% of those who receive results are not enrolled into care; 42% of those enrolled are lost to follow-up. The number of ART eligible children receiving treatment increased from 13,413 in 2008 to 22,798 by end of March 2011. However, the proportion of eligible children receiving treatment dropped from 27% in 2008 to 23% in 2011, due to increasing demand (change of eligibility guidelines). The opportunity is that 72% of ART facilities are able to provide pediatric treatment, if given support (funds, logistics, reagents, equipment, drugs, human resources at point of service for follow up etc). Besides over 80% of children come into contact with the healthcare system through immunization.

Similarly, PMTCT is a cornerstone for addressing the burden of the epidemic and therefore strategic focus would be necessary to maximize the benefits in PMTCT; for instance 98% of all

pregnant women who accessed ANC, PNC, and delivered from a health facility between July 2009 and June 2010 were tested for HIV (MoH, 2010); 9.9% of infants born to HIV+ mothers under the PMTCT program in 2009 were infected with HIV; these could have been protected from HIV infection with appropriate care and treatment (including ART) offered to mothers at points-of-service. Let us introduce effective treatment for mothers who come into contact with the HC system, while also ensuring access to effective Family Planning methods so that HIV infected individuals who do not desire more children can prevent pregnancy.

Several other emerging issues were noted under ART including use of new regimens for HAART (e.g. use of tenofovir as part of the first line regimen); introduction of the Point of Care (POC) technology for CD4 testing; HIV drug resistance seemingly on the increase; issues related to HIV treatment for prevention and adoption of option B for PMTCT need special consideration since many of these changes if scaled up would dramatically increase demand and cost of ART delivery. The increased global attention to virtual elimination of MTCT is a great opportunity to enhance all PMTCT interventions including Option B.

The MTR also revealed how protection issues were weakly articulated in the national planning framework. Being a country renowned for spearheading best practices especially early in the global response, Uganda should have more responsive, enabling legislation for PLHIV, OVC and other groups at risk of exposure to HIV. Legislation around issues of HIV/AIDS should echo the new dynamics of the epidemic and international frameworks and best practices as well. The country also needs to consider the relevant social and legal interventions to address gender-based violence (GBV), promote sexual reproductive health and rights (SRHR) and employment rights of PLHIV, and develop capacity to enforce workplace policies.

## 2.8 Policy, Legislative, Planning and Institutional Framework for NSP

### *2.8.1 International level*

The Revised NSP is responsive to international and regional HIV and Rights Agreements, Policies and Declarations. These international agreements are crucial, as they inform the work of development actors, help set common standards, sensitize stakeholders on their role as duty-bearers, and respond to the obligation to promote, assist, protect, and fulfill human rights. The NSP aligns with international development frameworks, conventions and commitments to which Uganda is signatory. The regional and global obligations on HIV/AIDS include the MDGs, UNGASS and Universal Access targets to HIV/AIDS services, the Abuja Declaration of Heads of States, and the ILO conventions, among others. Furthermore, it is expected that key development partners and initiatives especially PEPFAR/USAID, UNAIDS, DFID, Irish AID, DANIDA, SIDA and others will align their HIV programmes and plans with the NSP

International and regional human rights instruments to which Uganda is signatory include the Universal Declaration on Human Rights; Convention on the Elimination of all Forms of Discrimination against Women; Convention on the Rights of the Child; International Convention on Economic, Social and Cultural Rights; International Convention on Civil and Political Rights; African Charter on Human and People's Rights; Optional Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women.

In addition, UN declarations and programmes of action that Uganda has endorsed include the UN General Assembly Session on HIV&AIDS Declaration of Commitment, 2001; Millennium Declaration and Development Goals, 2000; Fourth World Conference on Women (Beijing); Declaration and Platform for Action, 1995; Beijing +5, 2000; ICPD +5, 1999; World Conference on Human Rights Declaration and Programme of Action (Vienna Declaration), 1993. These agreements also promote a human rights approach that will ultimately empower rights claimants through ensuring their participation in programmes designed to address gender inequity and HIV&AIDS.

### *2.8.2 National level*

This Revised NSP is cognizant of, and builds on key national policies and frameworks including the Constitution of the Republic of Uganda, NDP, Vision 2025, National Health Policy, National HIV/ AIDS Policy, NSPPI 2, National OVC Policy and Local Governments Act which articulate the need to address the causes and effects of HIV&AIDS.

Though not explicitly stated about HIV/AIDS, The Constitution of the Republic of Uganda (1995) in chapter 4, Article 20, states that the GoU is committed to the protection and upholding the rights of all its citizens. The importance of `Vision 2025` i.e., Uganda's broad and long-term development proposals over a period of 25 years is rooted in its status as a blueprint for all other planning frameworks. Its key focus is reflected in the main objectives of the NDP. The NDP is the principal guide to all developmental activities of the central and local government in Uganda. This overarching framework is cognizant of the challenges HIV/AIDS posses on development. It recognizes that addressing constraints caused by HIV/AIDS, is instrumental to achieving Uganda's poverty eradication goals.

The National Health Policy (1999) recognizes HIV/AIDS among the top causes of morbidity and mortality in the country and makes urgent the drive to strengthen decentralization of implementation of HIV control activities to the districts, recognizing AIDS not only as a disease but also a socio-economic threat. The National OVC Policy (2004) recognizes HIV/AIDS among the top causes of orphanage. AIDS deaths have contributed significantly to the current population of OVC. The Local Governments Act (1997) regulates the decentralization and devolution of functions, powers and services. This Act provides the basis for district and lower level participation in the design and implementation of HIV/AIDS activities. The NDP pronounces HIV&AIDS and its impact on the productive segments of the population, reduction of the labour force thus affecting food security. Gender Policy recognizes women's vulnerability both socially and physically to HIV and how this compounds existing gender inequality. This Plan also aligns with the Agriculture Sector Development Strategy and Investment Plan; the Education Sector Investment plan; Social Sector Development and Investment Plan, and the Peace, Recovery and Development Plan for Northern Uganda.

## 2.9 Possible Risks Associated with the Revised NSP

In Revising this NSP a number of risks were identified and the proposed mitigation measures highlighted.

*External funding and sustainability*: Currently, AIDS Development Partners provide most of the funding for HIV/AIDS interventions in Uganda. Any significant reduction of this support would negatively affect the implementation of this Plan. Given the above, there is an urgent need for a shift in funding modalities. Primarily, UAC should focus on securing increased funding from GoU. In addition, there should also be deliberate effort through advocacy and policy guidance to ensure Local Governments also contribute funds for HIV/AIDS interventions from locally generated revenue.

*Partnership commitment and capacity*: Successful NSP implementation will require a stronger multi-sectoral response involving partners from public and private sectors and civil society. UAC and sectors should implement a comprehensive partnership framework, to mitigate this risk.

*Financial flow and management*: Some sectors/agencies are unable to spend and account for funds remitted to them within a desirable timeframe. This poses challenges for longer term sustainability of the HIV/AIDS response. This calls for strengthening public sector and civil society financial management systems for expenditure tracking and accountability, and capacity building for financial management and reporting at all levels.

*Systems strengthening:* Provision of strong leadership, governance and co-ordination across government, combined with effective coordination of all stakeholders by UAC, is vital to the achievement of the outcomes under the Revised NSP. UAC, with the support of key Government and ADPs, should undertake continuous advocacy to ensure wide political commitment towards the Revised NSP

# *SECTION THREE*

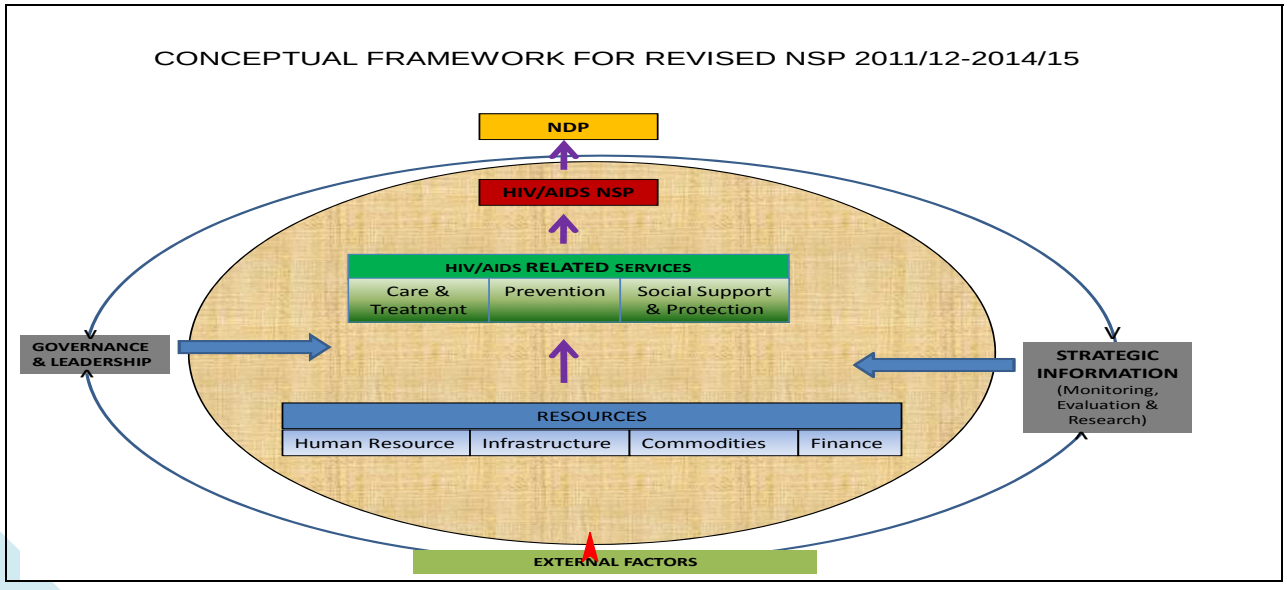
# *STRATEGIC FRAMEWORK*

## 3.1 Overview

In order for the NSP to contribute to the goals of the NDP: (i) priority strategic actions have been identified under the major thematic areas of prevention, care and treatment, and social support and protection that are pertinent in the multi-sectoral response to the HIV/AIDS epidemic (ii) adequate resources need to be availed to the implementing partners for the delivery of the strategic actions (iii) strong governance and leadership need to be in place for providing the necessary institutional, legal and policy environment for coordination and stewardship of the response (iv) strategic information need to guide key decisions in the response at central, decentralized and community levels.

The strategic actions under prevention include those that address biomedical, behavior and structural factors related to the spread of the virus while those for care and treatment cover access to ART and treatment of OIs as well as sexual and reproductive health in health facilities and communities; social support and protection strategic actions address provision of psychosocial and livelihood support to PLHIV, affected households and most vulnerable groups. Resources necessary for the response are perceived to include human resource (skilled and unskilled labour force), infrastructure (buildings, equipment, transport, etc), commodities (e.g. medical drugs, laboratory commodities, non-health commodities etc) and finances (monies and other convertible financial instruments that can be used in the procurement and distribution of goods and services necessary in the national response). The need to constantly monitor external factors that could adversely affect the national response cannot be underestimated. See Figure 5.

**Figure 5: The conceptual framework for the Revised NSP 20011/12-2014/15**



## 3.2 The Linkage between the NDP 2010/11-2014/15 and Revised NSP

The Revised NSP is situating the national response within the overarching broader National Development Plan. The linkage of the Revised NSP and NPD is articulated in Table 5.

**Table 5: Alignment between the NDP and NSP**

| | NDP (2010/11-2014/15) | NSP(2011/12-2014/15) |
|---|---|---|
| **Vision** | A transformed Uganda Society from a Peasant to a modern and prosperous Country within 30 years | A Population free of HIV and its effects |
| **Overarching objective** | Increasing Access to quality social services- incidence of communicable diseases and HIV/AIDS | To achieve universal access targets for HIV/AIDS prevention, care, treatment and social support and protection by 2015 |
| **Goals** | 1. Build and maintain an effective national HIV/AIDS response system<br>2. Reduce the incidence of HIV by 40%<br>3. Enhance livelihood and economic development of affected communities and households | 1. To reduce HIV incidence by 30% by 2015<br>2. To improve the quality of life of PLHIV by mitigating the health effects of HIV/AIDS by 2015<br>3. To improve the quality of life of PLHIV, OVC and other vulnerable populations by 2015<br>4. To build an effective and efficient system that ensures quality, equitable and timely service delivery by 2015 |

## 3.3 Vision

***A Population free of HIV and its effects***

## 3.4 Overarching Goal of the Revised NSP

***To achieve universal access targets for HIV/AIDS prevention, care, treatment and social support and protection by 2015***

## 3.5 Broad Outcomes expected of the Revised NSP

Each Thematic Area is defined by a broad expected outcome or a goal that the national response aims at realizing at the expiry of this Revised NSP. See Table 6.

**Table 6: Thematic Areas and Broad expected Outcomes of Revised NSP**

| Thematic Area | Goals |
|---|---|
| Prevention | • To reduce HIV incidence by 30% by 2015 |
| Care and Treatment | • To improve the quality of life of PLHIV by mitigating the health effects of HIV/AIDS by 2015 |
| Social support and Protection | • To improve the quality of life of PLHIV, OVC and other vulnerable populations by 2015 |
| Systems Strengthening | • To build an effective and efficient system that ensures quality, equitable and timely service delivery by 2015 |

## 3.6 Guiding Principles

The NSP is revised considering key principles of implementation of HIV programs. The principles utilized include:

1. Personal responsibility: Every person in Uganda has a responsibility to protect himself/herself and others from HIV infection, to know their HIV status and to seek appropriate care and support;
2. Non-discrimination: That no person shall be discriminated from accessing HIV/AIDS services;
3. Adherence to the multi-sectoral response, and effective partnership at all levels;
4. Meaningful Involvement of People Living with HIV;
5. Human rights based approach to programming
6. Gender sensitive
7. Evidence based planning and implementation
8. Adherence to the "Three Ones Principle" by all stakeholders;
9. Adherence to national and obligations
10. Effective mainstreaming of HIV/AIDS in all sectors and Plans
11. Country ownership and Accountability for results

## 3.7 Assumptions for Revised NSP

1. Increased internal resource mobilisation including sustained GoU budgetary support
2. Increased and sustained financing and with improved alignment to national priorities
3. Reinvigorated and sustained leadership commitment at all levels;
4. Sustained economic development

# *SECTION FOUR*

# STRATEGIC INTERVENTIONS

## 4.1 Introduction

Strategic interventions in this NSP fall under three Service Areas, and one support thematic area. The Service thematic areas are:

1. Prevention
2. Care and Treatment, and
3. Social Support and Protection

The Service Thematic Areas that are directly supported by the Strengthened Systems of Delivery, which has the following sub-areas:

- Governance and Leadership
- Institutional Arrangements, Human Resource and Infrastructure Requirements
- Research and Development
- Resource Mobilisation and Management
- Monitoring and Evaluation

## 4.2 Prevention

### *4.2.1 Context and justification*

The National HIV Prevention Strategy (2011-2015) defines the direction that Uganda should take in reducing new infections by adopting combination HIV prevention. Combination HIV prevention involves implementing multiple (biomedical, behavioral and structural) prevention interventions with 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, combination prevention will be most effective if these interventions impede different points in the 'transmission cycle' by combining strategies to reduce both infectiousness of HIV infected persons and strategies to reduce susceptibility of uninfected individuals. These interventions are, therefore, expected to contribute to reductions in HIV incidence through: (i) increasing knowledge of HIV status among PLHIV and their partners; (ii) reducing risk of HIV transmission from PLHIV; and (iii) reducing HIV acquisition among persons at risk of HIV.

The focus of the prevention thematic area under this Revised NSP shall therefore be 4-fold, namely to scale up biomedical interventions to achieve universal access targets, uphold behavioral interventions articulated in the National Prevention Strategy, address socio-cultural and economic drivers of the epidemic and re-invigorate the political leadership at all levels to enlist their commitment to HIV prevention. In scaling up proven evidence-based interventions, the country shall use HCT to attempt virtual elimination of MTCT by adopting Option B+, roll out SMC, and use ART as a springboard to prevention by targeting all eligible PLHIV with ART

including all HIV+ children and pregnant women living with HIV while maintaining universal blood safety precautions.

In order to register a stronger mark on sexual behaviour, the focus of the Revised NSP shall be, first, to articulate key target population groups and packages based on evidence, coordination for prevention communication messaging, promote risk reduction including use of male and female condoms and continue to invest in research to understand sexual behavior. Over and above this, the country shall place particular attention on addressing structural factors, specifically, the socio-cultural and economic drivers of the epidemic including stigma and discrimination, SGBV and defilement, as well as the gaps in male involvement and in commitment of the entire country leadership at all levels to prevention of HIV. This way it will be possible to roll out combination prevention and support convergence of partners at all levels to target common goals for HIV prevention.

### *4.2.2 Goal, strategic objectives and actions*

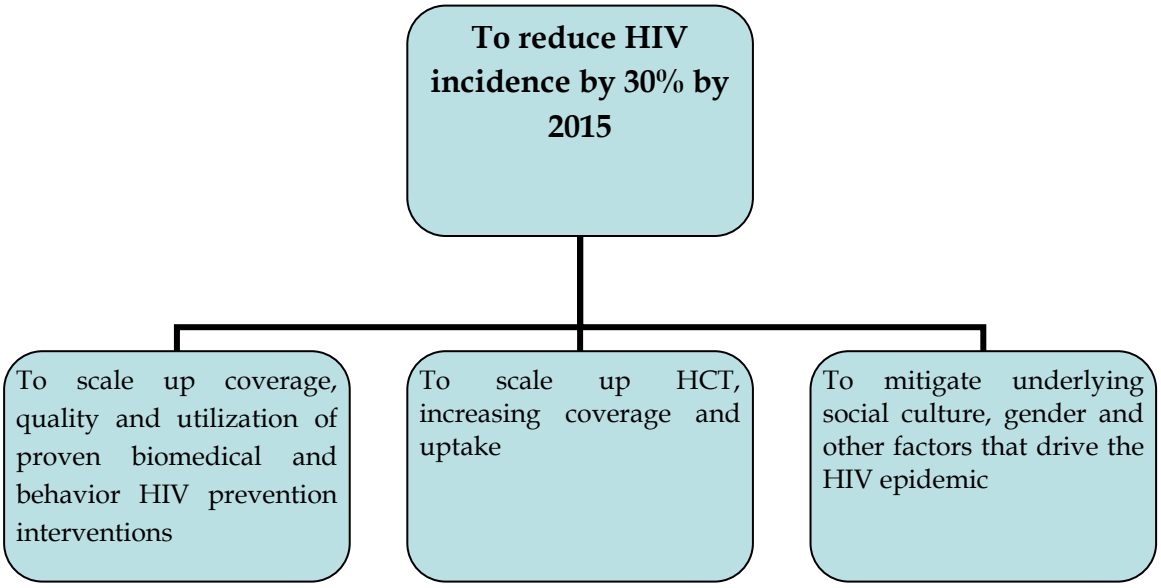



**Table 7: Prevention objectives and strategic actions**

| *Objectives* | *Strategic actions* |
|---|---|
| Objective 1: To scale up coverage, quality and utilization of proven biomedical and behavior HIV prevention interventions | 1. Scale up PMTCT<br>2. Scale-up SMC, increasing coverage & uptake to 80%<br>3. Increase proportion of risky sexual encounters protected by condoms to 80%<br>4. Control STIs, improving appropriate uptake of STI services by 80% by 2015<br>5. Ensure 100% blood transfusion safety and adherence to universal precautions<br>6. Promote medical infection control<br>7. Promote 100% access to Post-Exposure Prophylaxis (PEP)<br>8. Promote of safer sexual behavior among priority groups with emphasis on current drivers of HIV<br>9. Strengthen Behavior change communication Programmes to address socio-cultural, gender and other underlying drivers in communication endeavors<br>10. Promote ABC+ for HIV prevention |

| | |
|---|---|
| Objective 2<br>To scale up HCT, increasing coverage and uptake | 1. Scale up HCT<br>2. Enhance HCT linkage to care<br>3. Improve the management of logistics systems for HCT<br>4. Ensure availability of trained Counselors throughout the health care systems<br>5. Enhance coordination support, supervision and Quality assurance of HCT<br>6. Promote HCT for SGBV survivors<br>7. Improve HCT at blood donation sites<br>8. Increase identification and referral of discordant couples for appropriate prevention, care and treatment services. |
| Objective3<br>To mitigate underlying social culture, gender and other factors that drive the HIV epidemic | 1. Implement interventions that reduce stigma and discrimination<br>2. Strengthen the capacity of health and social services to manage SGBV cases<br>3. .Engage communities in conversations/dialogue on context specific and community-owned interventions that challenge socio-cultural and gender norms that increase vulnerability to HIV.<br>4. Build partnerships with cultural/religious leaders to address socio-cultural drivers<br>5. Promote the involvement of men as key partners in HIV prevention intervention<br>6. Develop and implement interventions that reduce vulnerability of OVC to unsafe sex |

## 4.3 Care and Treatment

### *4.3.1 Context and justification*

To fulfill her commitment to universal access to care and treatment, the country's strategic focus under the Revised NSP is to provide treatment of all eligible through decentralization of ART to lower levels, roll out pre-ART care to HCII and HCIII, accredit more health facilities including private health facilities, improve early TB diagnosis, prioritize home-based HCT, PITC outreaches and create demand through peers and VHT. Primary attention shall be placed on ensuring Early Infant Diagnosis (EID) and capacity of HCIII to offer pediatric care including adolescent friendly services with strong linkages to HCT. The above are possible with recruitment of more staff, introduction of point of care CD4 testing and formulation of guidelines for task shifting, stronger drug resistance tracking, surveillance and case management systems accompanied by palliative care services.

### *4.3.2 Goal, strategic objectives and actions*

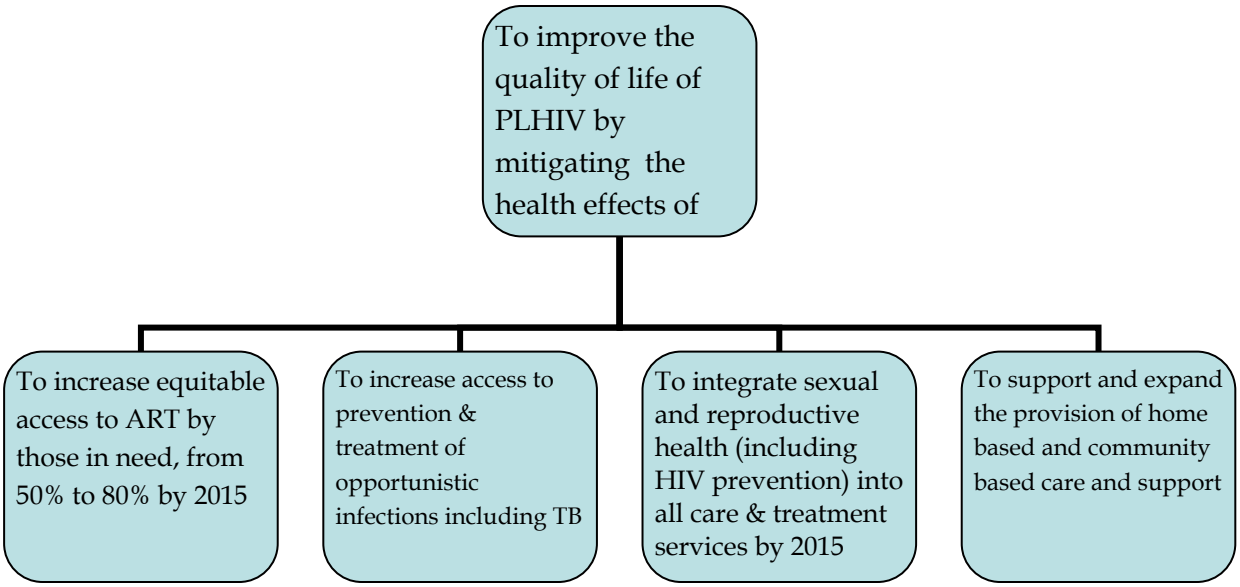



**Table 8: Care and treatment objectives and strategic actions**

| *Objectives* | *Strategic actions* |
|---|---|
| Objective 1<br>To increase equitable access to ART by those in need, from 50% to 80% by 2015 | 1. Promote health seeking behavior among males<br>2. Scale up access and uptake for ART services among those in need<br>3. Increase coverage of ART treatment to mothers receiving PMTCT<br>4. Promote and expand specialized pediatric and adolescent HIV care and treatment<br>5. Strengthen HIV drug resistance surveillance and prevention |
| Objective 2<br>To increase access to prevention & treatment of opportunistic infections including TB | 1. Increase proportion of infected individuals enrolled and retained in HIV care<br>2. Promote universal access to the basic care package Scale up integrated TB-HIV services (site coverage and number of individuals served)<br>3. Support and expand provision of palliative care<br>4. Ensure availability of commodities for opportunistic infection diagnosis, prevention and treatment<br>5. Provide nutritional assessment and therapeutic support to PLHIV |
| Objective 3.<br>To integrate sexual and reproductive health (including HIV prevention) into all care & treatment services by 2015 | 1. Integrate Positive Health Dignity and Prevention (PHDP) into HIV care and treatment services<br>2. Integrate family planning counseling and support for adults and adolescents in HIV care Build capacity of providers and empower communities to support PLHIV in their SRH choices and provide the entire range of SRH services<br>3. Provide support for HIV sero-discordant couples including disclosure and partner testing and new effective prevention interventions Ensure availability of prevention and reproductive health supplies |
| Objective 4<br>To support and expand the provision of home based and community based care and support | 1. Facilitate and empower existing community structures, e.g. PHA networks and VHT to provide HIV prevention, treatment, care and support services<br>2. Ensure strong linkages and referral systems between health facilities and community structures |

## 4.4 Social Support and Protection

### 4.4.1 Context and justification

Given the foregoing, there is an urgent need to re-conceptualize social support and protection as a cross-cutting issue to enhance prevention of new infections, up-take and adherence to taking ARVs, among other potential synergetic benefits. More than ever before, the need for quality psychosocial support, other social support and protection interventions is quite vivid to leverage advancements in prevention, care and treatment. Also the increased funding opportunities for PMTCT will enhance prevention efforts but will also require enhanced social support and protection efforts for women and their families in general. Similarly, a national SRH-HIV integration strategy has been developed which, to be effective, will require social support and protection actions to promote SRHR of HIV positive women and young people including family planning. All the above call for advocacy work for universal coverage (scope & scale) to a commonly agreed comprehensive social support and protection package to all deserving, clearly articulated beneficially groups.

The Revised NSP shall focus, first on advocacy for universal coverage (scope & scale) to a comprehensive social support and protection package to articulated beneficially groups. Second, attention shall be placed on empowerment of households and communities with livelihood skills and opportunities (including linkages to development programmes such as NAADS, NUSAF & SACCOs; and Cash Transfer initiatives) to cope with social and economic demands. The major entry point for social support and protection shall be through organized structures of PLHIV, persons with disabilities (PWDs), elderly and categories most vulnerable to the effects of HIV to respond to own needs. At workplaces and agencies, focus shall be on supporting institutionalization of workplace policies in the formal and informal sectors and their implementation.

### 4.4.2 Goal, strategic objectives and actions

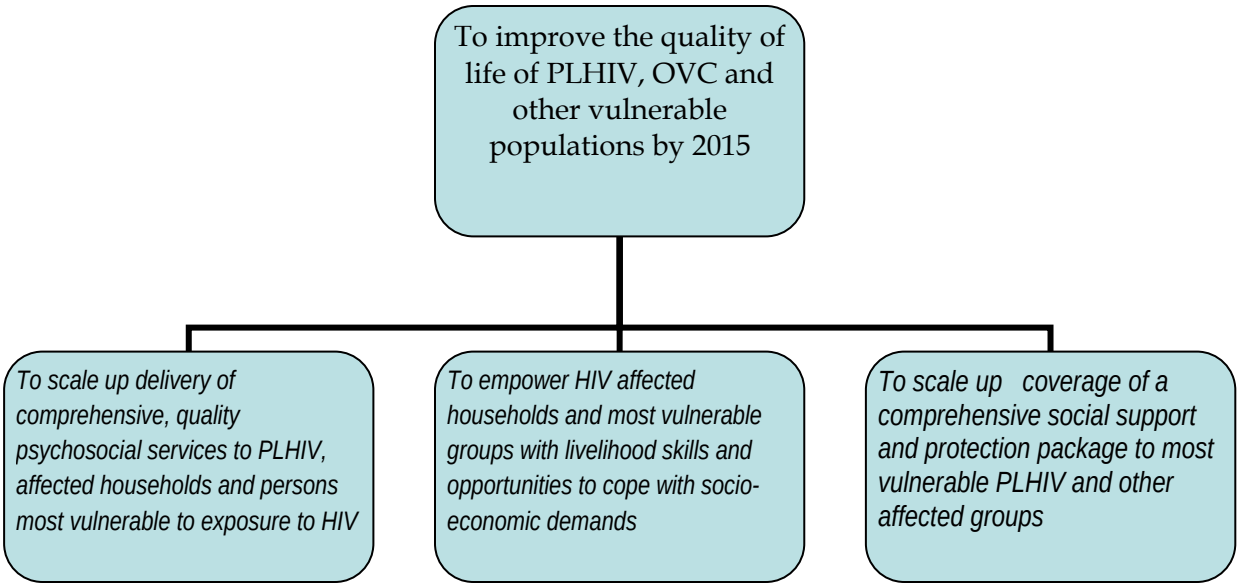


**Table 9: Social Support and protection objectives and strategic actions**

| *Objectives* | *Strategic actions* |
|---|---|
| Objective 1<br>*To scale up delivery of comprehensive, quality psychosocial services to PLHIV, affected households and persons most vulnerable to exposure to HIV* | 1. Scale-up counseling services provisions at health care points and in communities for PLHIV and persons most vulnerable to exposure to HIV<br>2. Provide training of service providers, PLHIV networks and care takers to identify and respond to psychosocial support needs of PLHIV and persons most vulnerable to exposure to HIV<br>3. Develop and deliver a package of direct psychosocial support services provision for PLHIV, affected households and persons most vulnerable to exposure to HIV |
| Objective 2<br>*To empower HIV affected households and most vulnerable groups with livelihood skills and opportunities to cope with socio-economic demands* | 4. Support most vulnerable households of PLHIV and of articulated beneficiary categories to meet immediate needs for proper nutrition and food security<br>5. Provide direct assistance to most vulnerable PLHIV households to address socio-economic deprivation<br>6. Support economic activities for households of PLHIV and those most vulnerable to exposure to HIV<br>7. Advocate for affirmative action to support vulnerable PLHIV and articulated categories to benefit from existing initiatives and programs |
| Objective 3<br>*To scale up coverage of a comprehensive social support and protection package to most vulnerable PLHIV and other affected groups* | 1. Support enrollment and retention of OVC, PLHIV of school-going age and other articulated beneficiary groups.<br>2. Promote informal education, vocational and life skills development for OVC, PLHIV of school-going age and persons most vulnerable to exposure to HIV<br>3. Support provision of appropriate shelter for deserving vulnerable groups<br>4. Mainstream gender and disability into social support program initiatives<br>5. Provide legal and social services for the protection of women and young people against gender based and sexual violence (GBSV) on account of HIV<br>6. Promote rights awareness and sensitization to address cultural norms, practices and attitudes that perpetuate gender based and sexual violence in the context of HIV<br>7. Enforce Domestic Violence Act and other related policies on violence against women and girls to address the violence arising due to HIV status disclosure, discordance or sero-difference<br>8. Support civil and community-based responses identified as best practices in prevention and handling of sexual and gender based violence<br>9. Build capacity of Justice, Law and Order Sector and non-state actors to develop and enforce litigation related to HIV through justice-enabling structures |

## 4.5 Systems Strengthening

### *4.5.1 Context and justification*

In response to challenges in systems strengthening, , calls have been made for the need to identify and adopt cost-effective approaches to prevention, care and treatment, advocate for additional GoU funding, and ensure Global Fund resources are accessible. Similarly, coordination and accountability by stakeholders needs to be further strengthened, including periodic review of the implementation of the existing policies and laws. Suggestions are also made for institutionalization of the position of Focal Point Persons in sectors and decentralized governments, counselors at ART clinics and use of task shifting. Regarding infrastructure, expansion of the availability of HIV/AIDS related services to HC-IIIs and IIs which are more accessible to the rural population has long been proposed.

During the plan period, the country aims to review existing co-ordination structures at national and decentralized levels for appropriateness and clarity of roles and responsibilities, support

integrated HIV/AIDS Plans and also enforce policies, laws and guidelines aimed at improved collaboration, partnerships and networking among implementing partners al all levels. To support universal access, this thematic area shall place particular attention to human resource and infrastructure development mainly to strengthen national capacity for forecasting, logistics management, procurement and disposal of health goods and services including streamlining of donor support in procurement systems for drugs and supplies.

As part of systems strengthening, focus shall be placed on using research outcomes to appropriately improve policy and planning, scaling up LQAS to all LGs and prioritizing dissemination of results, and particularly for UAC to provide a clear framework to guide HIV/AIDS research efforts at national and local government level. In addition, the country requires a revitalized NADIC, M&E data collection, aggregation, analysis, reporting and utilization systems with well established organizational structures at national, sectoral and district levels for M&E.

Perhaps most important for the Revised NSP is the focus on resource mobilization for the entire national response to HIV/AIDS; strategic attention shall be placed on developing an integrated and comprehensive national resource mobilization strategy and alignment of donor funds to national planning, budget and financial accountability systems to improve predictability of resources and efficiency. Equally important shall be the institutionalization of regular resource tracking mechanisms and improving efficiency of HIV/AIDS spending especially on those interventions that have big impact based on evidence.

### *4.5.2 Goal, Objectives and strategic actions for Systems Strengthening*

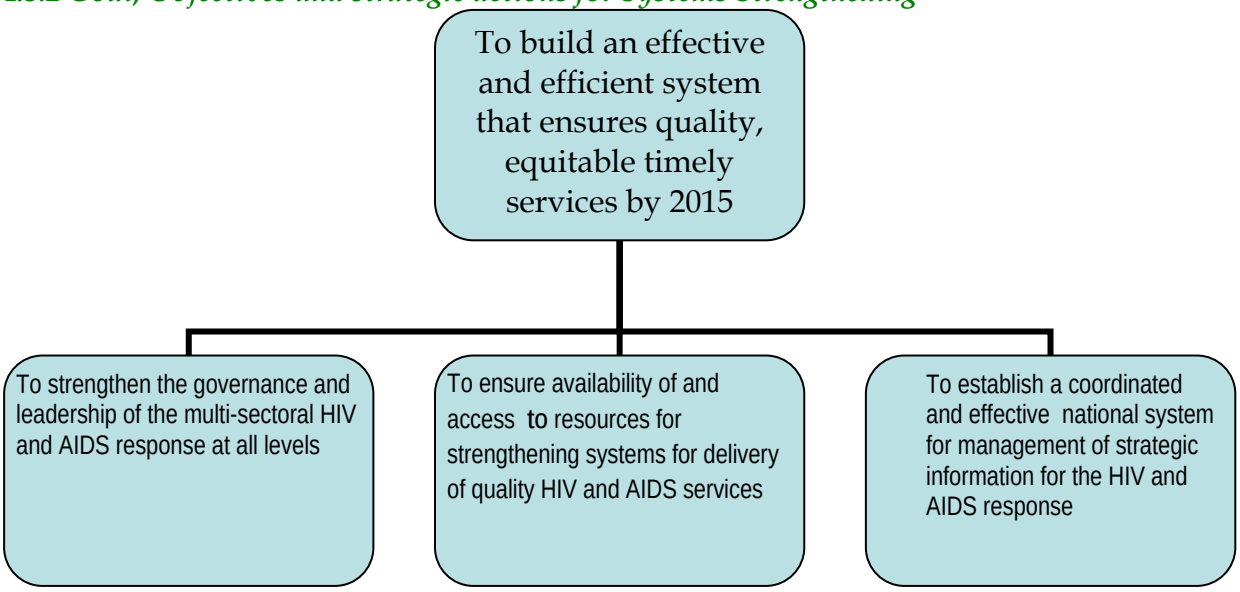


**Table 10: Systems strengthening objectives and strategic actions**

| *Objectives* | *Strategic actions* |
|---|---|
| Objective 1<br>To strengthen the governance and leadership of the multi-sectoral HIV and AIDS response at all levels | 1. Mobilize political and technical leadership, management and stewardship of the multi-sectoral response at all levels<br>2. Institute, implement and monitor the necessary legal, policy and operational instruments and guidelines<br>3. Strengthen the capacity of UAC to coordinate the national multisectoral HIV/AIDS response<br>4. Operationalize coordination, linkages, networking and collaboration within and across sectors and at national, decentralized and community levels<br>5. Mainstream HIV/AIDS gender, disability and human rights perspectives in all major development programmes in public and non-public sectors<br>6. Align HIV/AIDS related plans of sectors, districts, key stakeholders, development partners and funding mechanisms to the NSP<br>7. Promote social participation, self regulation and accountability in the multi-sectoral response<br>8. Build strong linkages and referral systems between institutionalized facilities and community structures |
| Objective 2<br>To ensure availability of and access to resources for strengthening systems for delivery of quality HIV and AIDS services | 1. Develop the infrastructure for enhancing the multi-sectoral HIV/AIDS services delivery<br>2. Build capacity of human resource for delivery of the multi-sectoral response to the HIV/AIDS epidemic at all levels<br>3. Develop the capacity for procurement, distribution and disposal of HIV and AIDS related goods and services at all levels<br>4. Expand the capacity of laboratories at different levels for delivery of HIV/AIDS related services<br>5. Mobilize adequate resources for HIV and AIDS services<br>6. Promote efficient allocation and use of HIV and AIDS resources<br>7. Align and harmonize resources to the National HIV/ AIDS plans |
| Objective 3<br>1. To establish a coordinated and effective national system for management of strategic information for the HIV and AIDS response | 1. Build partnerships among producers and users of HIV/AIDS information for the national HIV/AIDS response<br>2. Promote ownership of the national HIV and AIDS monitoring and Evaluation framework<br>3. Develop and disseminate national policies, guidelines and plans to all partners at national and sub-national levels<br>4. Build the capacity for collection, analysis, dissemination, and utilization of HIV/AIDS data/information for the national response<br>5. Develop a national HIV/AIDS data base for capture, storage and retrieval of HIV/AIDS data /information shared by all partners in the response for national and global commitment<br>6. Promote and coordinate HIV/AIDS research |

# *SECTION FIVE*

# *CO-ORDINATION AND INSTITUTIONAL ARRANGEMENTS*

## 5.1 Introduction

The overall mandate for coordinating the national response lies with Uganda AIDS Commission (UAC) but sectors, districts and lower local government structures are also responsible for coordinating and managing the response in their areas of jurisdiction especially to ensure harmonized participation o civil society. While UAC is responsible for ensuring consensus on national policies, priorities and implementation arrangements, ministries and local governments are responsible for integration of HIV/AIDS in their core business and implementation agendas to achieve national goals. This process is currently enhanced by the national HIV/AIDs partnership structures that allow collective action and accountability.

Institutional arrangements are of special importance for effective operationalisation, co-ordination and management of the revised NSP. The three key elements that are critical for an effective response to HIV/AIDS include **UAC, the HIV/AIDS Partnership and Local governments.** UAC shall assume full leadership for coordination, monitoring and accountability. This is possible through stronger partnerships that provide an opportunity for all stakeholders to participate in the coordination and management of the national response. This is consistent with the Paris declaration on Aid effectiveness, the Rome Declaration on harmonization, and the Marrakech roundtable on managing for development results and Global task team recommendations for a more effective AIDS response.

## 5.2 National Level

### *5.2.1 Uganda AIDS Commission*

The Uganda AIDS Commission was established as a corporate body for coordination of the AIDS response in the country. The UAC has a Board of Commissioners and a Secretariat. Through its Board, the UAC oversees the implementation of the revised NSP goals and objectives. The Commission also offers guidance to sectors, local governments and civil society actors. The recently concluded institutional review recommended establishment of zonal offices to provide direct linkage between UAC and local government partners.

The key functions of UAC include planning and coordination of all AIDS control policies and programmes within the overall NSP; identifying obstacles to AIDS control policy and program implementation; ensuring implementation and attainment of program activities and targets; mobilizing, expediting, and monitoring resources for the AIDS control program activities; and disseminating information on the AIDS epidemic and its consequences in Uganda.

### *5.2.2 HIV/AIDS Partnership*

UAC established the multisectoral HIV/AIDS Partnership to enhance coordination inter and intra constituency at national and sub national levels. This is achieved through the Partnership

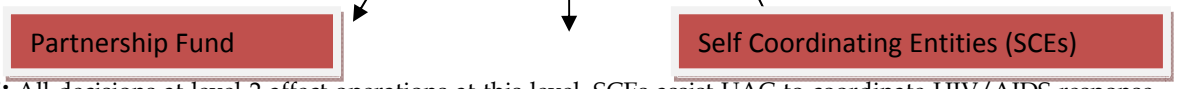
Committee (PC), the self coordinating entities (SCEs) and the annual Partnership Forum. The PC is the central feature of the Partnership and works through technical subcommittees. The Partnership Forum on the other hand serves as the general assembly allowing wider participation for all constituencies to review and agree on annual priorities. Coordination and management of the NSP has greatly benefited for the HIV/AIDS partnership Fund. The fund is a clear demonstration of development partner's support to nationally agreed priorities. The illustration below provides a conceptual framework for the national HIV/AIDS Partnership.


**Level 1**

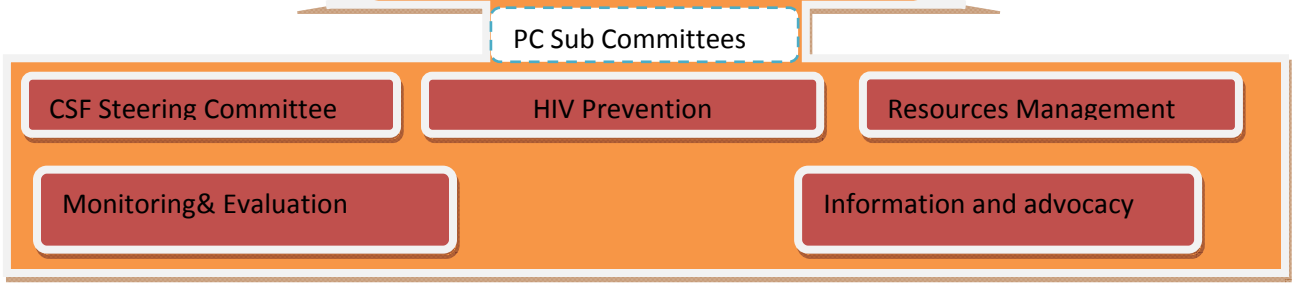
Effcetive scale up of national response necesistates a government led coalition approach, which accomodates and coordinates all partners working within a conmmon national strategic Plan

**Level 2**


PC provides technical advice to UAC for implementation of the revised NSP priorities. PC meets every Month. Assisted by technical committees such as HIV Prevention, M&E, information and Advocacy, CSF steering Committee, the PC handles all programmatic aspects relating to NSP implementation.




**Level 3:** All decisions at level 2 affect operations at this level. SCEs assist UAC to coordinate HIV/AIDS response activities in their constituencies. The Fund supports all activities of PC (UAC and SCEs) in bid to provide effective leadership to coordinate the national response.




**Level 4:** The Subcommittees assist UAC Secretariat to implement, routinely monitor and support supervise the work of the SCEs. Guidelines and standards are drafted by the respective sub committees. Thematic assessments and evaluations are also guided by the thematic Sub committees. Often times, there are deliberate efforts to work with Thematic sub committees that are not provided for under PC. Examples include the ART TWG under MoH, OVC steering Committee under MoGLSD, etc. PC constitutes task oriented teams whose lifespan ceases on completion of the specific assignment.


**Level 5:** The Partnership Forum serves as the pool from which all membership for the 1st 4 levels is drawn. It serves as the General Assembly for the national HIV/AIDS Partnership. All decisions made at the levels above are binding to the Forum and vice versa. The Forum convenes once every year.

### 5.2.3 Government ministries departments and agencies (MDAs)

These shall be responsible for coordinating HIV and AIDS responses within their mandates guided by the revised national strategic plan. Deliberate effort shall be made to mainstream HIV/AIDS in all development plans and budgets. Resources need to be set aside to address the effect HIV and AIDs has on the respective sector performance. This highlights the central role that sector working groups plays in planning, mobilizing resources, implementation and monitoring sector HIV/AIDS responses. Most government ministries need to revive their HIV/AIDS control and management committees. The SCE of line ministries shall provide a unique opportunity for all public sector MDAs to harmonize and foster linkages within and outside their constituency.

### 5.2.4 Local government level

There are several stakeholders in the district level response comprising local government authorities, civil society and networks of people living with HIV/AIDS.

### 5.2.5 Local authorities

Rural and urban local governments are mandated to directly manage and monitor delivery of quality social services including HIV/AIDS. The anticipated functions for coordination and monitoring service delivery by all implementing partners at local government level shall be performed through the recommended structures of the AIDS Committees and AIDS taskforces or their equivalent at that level. Uganda AIDS Commission working with the ministry of local government recommended establishment of district AIDS Committees (DACs) and District AIDS taskforces (DATs) to promote joint decision. Similar structures exist at municipal, Sub County and lower local government levels. These structures or their equivalent shall be responsible for development and mobilizing resources for implementation of Aids plans in line with the revised NSP.

### 5.2.6 Civil society

In Uganda civil society is highly diverse, including faith based organizations, local and international non government organizations, organizations of people living with HIV, media, private sector, academia. Uganda AIDS Commission acknowledges the role played by civil society in reaching communities and implementing programs. This underscores the need for better coordination, focused resource mobilization and alignment to revised NSP strategic actions. It also calls for deliberate effort to build capacity of the different players in civil society for delivery of quality HIV and AIDs services.

## 5.3 Planning, Monitoring and Evaluation

### *5.3.1 Roles of stakeholders*

The revised NSP will be implemented by all the stakeholders in the mult-sectoral HIV/AIDS response at national, local government and community levels. Different stakeholders, including government ministries, departments and agencies (MDAs), local governments, civil society organizations, development partners, and private sector will implement the revised NSP depending on their defined constitutional (public sectors) and organizational mandates, comparative advantages and technical capacity.

Uganda AIDS Commission will be responsible for providing overall leadership in the coordination, management, resource mobilization and monitoring and evaluation of the HIV/AIDS national response. National level ministries, departments and agencies will be responsible for providing guidelines, setting standards and ensuring quality of service delivery, providing technical support, capacity building, resource mobilization and monitoring and evaluation of overall respective sector, department and agency performance. National level CSOs will be responsible for providing technical support to respective implementing CSOs. The District Local Governments will be responsible for providing service delivery to the communities. The Development Partners will be responsible for mobilization and allocation of resources for funding the revised NSP

### *5.3.2 Operationalization of the revised NSP*

In order to operationalize the NSP, HIV stakeholders will develop a National Priority Action Plan (NPAP). The NPAP will articulate the priority activities that should be implemented by stakeholders for each of the strategic actions, spelling output results and timeframe for the implementation. Although some activities will be measured on annual basis, their implementation will be multi-year. The NPAP will provide annual targets for annual progress monitoring. The NPAP will also specify both the lead agencies and collaborating partners responsible for the implementation of the specific activities.

In addition to the NPAP, specific components of the NSP will be operationalized through complimentary strategies, plans and policies, for example the National Prevention Strategy (2011-2015), and a variety of sectoral plans that as aligned to the NSP and NPAP.

Individual implementing partners will be encouraged and supported to harmonize their strategic plans or operational plans with NSP or NPAP as much as possible. Capacities will be developed on appropriate skills for harmonization and alignment processes.

### *5.3.3 Monitoring and Evaluation of plan implementation*

The national M&E system for the HIV/AIDS response that outlines national results, indicators and targets for the national response will be strengthened to measure the progress towards attainment of the NSP objectives. The M&E matrix (outlined in Annex ....) details the indicators and targets for the national response for national and sector levels over the revised NSP period. The M&E Framework of the NSP will enable monitoring and self-assessment of progress towards results and facilitate reporting on performance. Districts will prepare and submit

reports to their respective sectors, which in turn will submit data on key agreed upon indicators to the national M&E system at UAC. HIV/AIDS stakeholders will routinely conduct support supervision to lower levels of the respective constituencies on a quarterly basis to monitor progress of implementation of the Annual Workplans, validate the reports submitted and build capacity for effective plan implementation. Using the data from sectors and supervision reports, UAC will then prepare quarterly reports on national HIV/AIDS response for submission to National Integrated Monitoring and Evaluation System (NIMS) in Office of Prime Minister.

Under the leadership of UAC, stakeholders will hold annual Joint AIDS Review to assess progress of implementation of the NSP and NPAP against targets and agree on priorities for the upcoming year. The JAR will therefore assess the outputs/outcomes of every year as a key accountability mechanism to assess the implementation of the NSP/NPAP. The JAR will also assess the planning and programming process, in time to make recommendations for the next annual work planning cycle or long term strategic planning.

In addition to the JAR, HIV stakeholders will also hold an annual Partnership Forum (PF) to provide opportunity for wider representation by all constituencies to review performance of the response and agree on priorities for the upcoming year. Annual Regional (District) Partnership Fora will also be organized for a group of districts to provide opportunity for wider representation in the districts to review performance of the response and agree on priorities for the upcoming year. The outputs of Regional Partnership Fora will feed into the national level Partnership Forum.

The implementation of the NSP will be externally evaluated at mid-term (mid 2013). A final external evaluation will be conducted at the end of the NSP period (mid 2015), in time for the results to feed into the planning process for the next NSP.

# SECTION SIX

# COSTING AND FINANCIAL FRAMEWORK

## 6.1 Costing and Financing of the NSP

## 6.2 Costing Methodology and Assumptions

These estimates of resources required achieving the targets and goals of the revised strategic plan have been prepared through an iterative process that involved comparing estimates of resources required, resources available and expected impact. The Costing made use of three programs to derive the resource estimates:

- The Spectrum software to run the demographic projections of key population's to be targeted by the interventions.
- The Resource Need Model- to estimate the resources required to meets the targets population derived from the spectrum
- The Goals Model- used to estimate the impact of given resources -mix set to achieving particular the goals of the NSP.

The resources estimates are

i) a product of the targets populations, the levels of coverage and the unit cost of providing the interventions and
ii) Summation of other costs that are not directly linked to individual of intervention outputs. These include overheads, program support, Monitoring and Evaluation, research etc.

The Technical Working Groups of the thematic areas, proposed intervention, targets and possible levels of coverage for the various interventions. The costing team then estimated the cost of achieving these targets by estimating the number of people in need of each service and the unit costs of providing each service. Estimates of populations in need were derived from the census, national surveys and health statistics. Information on unit costs was collected from organizations implementing each intervention. The team ran a series of estimates for impact of achieving these targets in terms of reductions in HIV incidence and AIDS deaths. Initial estimates of resources required were compared to the resources expected to be available from all sources.

The next three sections present information on these three components.

Unit Costs.

How these are derived.

Target Populations

How key populations targets are estimated- basisi and assumptions

Service Coverage.

Set coverage from the thematic TWGs

1. Presentation of Costs

   The resource estimates for the NSP will be categorized annually based on the NSP thematic and a section for the program and other cross cutting support overheads.

   a. Summary costing

      Table with the costing summary

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

      Detailed Assumptions on the cost build ups.

2. Financing of the plan

   a. Mechanisms for financing the plan -

      i. GoU budget- will describe the GOU budgeting process for the health sector and how the HIV funding is allocated.

      ii. Donor partners

         1. Pooled funding

         2. Donor projects

      iii. Others

         1. NGO

         2. Households

   A mention will be made of the above two (NGO and Household).Currently there is no comprehensive study done to estimate the contributions of these. May recommend a study as part of the NPAP???

3. Resource projections from all mechanism (resource envelope)

Have a table of resource inflow projections from the GOU, ADPs and other identified sources.

a. Determine the financing gap – comparison of projected costs with available funding

Demonstrate the financing gap- thus Estimates for the NSP less the projected resource inflows.

b. Addressing the financing gap

i. Growth in GoU budget

ii. Improving efficiency

iii. Exploitation of linkages and intersectoral collaboration

## 6.3 Costing of Interventions

**Table 11: Estimated NSP Budget Projections for 2012/13 - 2014/15**

| THEMATIC AREA | COST ('000) | | | | | TOTAL |
|---|---|---|---|---|---|---|
| | | | | | | |
| **PREVENTION** | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| **SUB TOTAL** | | | | | | |
| **CARE AND TREATMENT** | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| **SUB TOTAL** | | | | | | |
| **SOCIAL SUPPORT AND PROTECTION** | | | | | | |

| THEMATIC AREA | COST ('000) | | | | | TOTAL |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| **SUB TOTAL** | | | | | | |
| SYSTEMS STRENGTHENING | | | | | | |
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| | | | | | | |
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| | | | | | | |
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| | | | | | | |
| | | | | | | |
| **SUB TOTAL** | | | | | | |
| COORDINATING THE RESPONSE | | | | | | |
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| **SUB TOTAL** | | | | | | |

| THEMATIC AREA | COST ('000) | | | | | TOTAL |
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| | | | | | | |
| TOTAL COST | | | | | | |

## 6.4 Financing of Strategic Actions

## 6.5 Key Assumptions

## 6.6 Transparency and Accountability

## 6.7 Sustainability

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3. Health Sector HIV&AIDS Strategic Plan 2010/11-2014/15
4. Health Sector Strategic and Investment Plan (HSSIP) 2010/11-2015/16
5. Second National Health Policy, July 2010
6. Status of the HIV Epidemic: 2010
7. Annual Health Sector Performance Report, Financial Year 2009/2010
8. National/MoH Policies related to HIV
    i. Care and Treatment policy: ART guidelines – revised 2011
    ii. PMTCT: Policy, Scale-up Plan, Situation Analysis 2008Report
    iii. HIV Testing and Counseling Policy (HTC) (revised 2011)
    iv. Post-exposure prophylaxis policy-PEP, PSEP
    v. TB-HIV collaborative Policy and communication strategy
    vi. TB Strategic Plan
    vii. PWP policy / guidance
    viii. Nutrition Policy
    ix. MOH Training materials launched by SCOT
9. Other Sector & District HIV&AIDS Plans: MoH, MoGLSD, MoES, Public Service
10. National HIV&AIDS Stakeholders Service Mapping Atlas
11. PEPFAR Uganda Annual Reports
12. Global Fund Plans and Reports
13. MoH/ACP ART, PMTCT and other quarterly Reports
14. MoH Drug Resistance Reports: TB MDR survey report, HIV EWI reports
15. Modes of Transmission Study Report, 2009
16. Uganda HIV&AIDS Sero-Behavioral Survey 2004/05
17. Annual Health Sector Performance Report, October 2005 plus others
18. Uganda National AIDS Policy, July 2005
19. Palliative Care Reports
20. Guidelines for handling of Class A Drugs
21. Guidelines on Management of Opportunistic Infections
22. International Reports and Guidelines
23. PEPFAR II Goals and Principles, GHI – Global Health Initiative principles, Dr Friedens "Winnable battles", 2011 GAP meeting slides and report, 2011 PEPFAR meeting report on Uganda's performance
24. UNAIDS terminology document
25. Cancer /HIV: policy on Ca Cx

# Annexes

## Annex I: Revised NSP Results Framework

### Prevention

| Objective | Indicators | Baseline status | 2014/2015 |
|---|---|---|---|
| To scale up HCT, increasing coverage and uptake | 1. %ge of men and women aged 15-49 who have ever tested for HIV and received their results (?N) | 38% (2009), 2.2 million in 2010 | 80% |
| | 2. %ge of women and men (15-49 years) who tested for HIV in the last 12 months and received their results (N) | TBD | 25% |
| | 3. %ge of most at risk populations who have received an HIV test and know their results (N) Consider Prevalence | 49.3% (2003) | 80% |
| | 4. %ge of district providing district-wide home based HCT (N) | TBD | TBD |
| To scale-up coverage, quality, demand, uptake and utilization of proven biomedical HIV prevention services in the general population and among most-at-risk populations | 5. %ge of HIV-positive pregnant women who received antiretroviral drugs to reduce risk of mother-to-child transmission of HIV ) (N) | 44,167 (48.5%) (2010) | 95% |
| | 6. %ge of exposed infants who have received ARV prophylaxis to reduce risk of mother-to-child transmission of HIV (N) | TBD | 80% |
| | 7. %ge of males and females reporting consistent condom including MARPS use | TBD | TBD |
| | 8. %ge of adult males (15-49 years) that are circumcised (N) | 15,000 (2010) | 5 million/80% |
| | 9. %ge of ART eligible individuals enrolled onto antiretroviral therapy by category (HIV+ pregnant women, HIV+ children, HIV+ partners in HIV-discordant relationships, etc) (N) See no 44 under care & Tx) | 50% | 80% |
| | 10. %ge of STI patients that are managed (diagnosed, treated and counseled on risk reduction) according to national guidelines | 38% (2007) | 80% |
| | 11. % of screened blood that is safe (N) | 100% | 100% |
| To increase adoption of safer sexual behaviors and reduction of risk taking behaviours expand | 12. %ge of adults (15-49) who have had sexual intercourse with more than one partner in the last 12 months | Males: 20%<br>Females: 5%(2009) | Male: 10%<br>Female: 2.5% |
| | 13. %ge of young women and men aged 15-24 years who correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission (N) | TBD | TBD |
| To create a strengthened and | 14. %ge of adults with accepting attitudes towards people living with HIV | TBD | 80% |

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| sustainable enabling environment that mitigates underlying socio-cultural, gender, and other underlying factors that drive the HIV epidemic | (PLHIV) | | |
| | 15. %ge of women who experience sexual and gender-based violence | 39% | 10% |
| | 16. institutions that provide for protection of vulnerable groups including SGVB, | Men: 90%<br>Female: 84% | 100% for both men & women |

## Care and Treatment

| Objective | Indicators | Baseline value year | Target 2014/2015 |
|---|---|---|---|
| | 17. | | |
| To increase equitable access to ART by those in need, from 50% to 80% by 2015 | 18. %ge of eligible adults and children currently receiving ART (N) | %ge eligible on treatment: 290,563 (50%); Adults 50%, children 25% | 80% (of 577,000) |
| | 19. %ge of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (N) | %ge on treatment 12 months after initiation: 84% | 85% |
| Increase access to prevention & treatment of opportunistic infections including TB | 20. %ge of estimated HIV-positive incident TB cases that received treatment for both TB and HIV (N) | %ge HIV positive incident TB receiving both TB and HIV treatment | 80% |
| To integrate sexual and reproductive health (including HIV prevention) into all care & treatment services by 2015 | 21. Unmet need for FP among HIV infected individuals (include in AIS) (same as 51) Survey (N) | Unmet FP need among PLHIV; no national level data | <10% |
| Support and expand the provision of home based and community based care and support | 22. | TBD/data not available | 80% |
| | 23. %ge of health facilities linked to operational HBC services (systems) | TBD/data not available | 80% |

## Social Support and Protection

| Objective | Indicators | Baseline value year | Target 2014/2015 |
|---|---|---|---|
| To support delivery of comprehensive, quality | 24. %ge of PLHIV whose households received psychosocial support in past 12 months | TBD/data not available | TBD |

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|---|---|---|---|
| psychosocial services to PLHIV, affected households and persons most vulnerable to exposure to HIV | 25. % OVC who have access to a comprehensive OVC service package[3] (N) | 1 % OVC have access to a comprehensive OVC service package | 30% OVC |
| To empower HIV affected households and most vulnerable groups with livelihood skills and opportunities (including linkages to development programmes) to cope with socio-economic demands | 26. )<br>27. Percentage of vulnerable HH that food insecure | 34,334 OVC HHs served with emergency food during 2010[4]<br>9% HHs took only 1 meal a day during 2009/2010[5]<br>Acute food shortage affects 1.1m[6] | TBD |
| | 28. %ge of households of PLHIV that benefited from IGAs in last (S)year | 41.2%<br>(UAC-LQAS) | 80% of PLHIV households |
| To scale up coverage of comprehensive social support and protection package to most vulnerable PHLIV and other affected groups | 29. %ge of OVC completing their education cycle | TBD/data not available; | TBD |
| | 30. No. of improved shelter facilities for OVC No of OVC that have shelter | TBD | TBD |
| | 31. %ge of agencies that have mainstreamed gender equity and disability into their support program initiatives in relation to HIV | TBD/data not available | All agencies |
| To strengthen protection systems at national, decentralized and community levels to effectively prevent rights violations on account of HIV and ensure survivors of rights violations have access to legal and rehabilitative services | 32. %ge of general population with correct knowledge and positive attitudes about rights and obligations in the context of HIV | TBD/data not available | TBD |
| | 33. % children who have experienced abuse (in last 12 months) | TBD/data not available | TBD |
| | 34. %ge of OVC reporting cases of rights violations | TBD/data not available; | TBD |
| | 35. % OVC who live under the protection of an adult care-giver[7] | | |
| | 36. %ge of OVC receiving survivor support services | TBD/data not available; | TBD |
| | 37. %ge of law enforcement actors responding to OVC rights | TBD/data not available; | TBD |
| | 38. Existence of specific enabling pieces of legislation to protect most vulnerable groups on account of HIV status | None currently | TBD |
| | 39. %ge of PLHIV and persons most vulnerable to exposure to HIV whose | TBD/data not available | 90 % |

[3] Survey captured access to any service including medical, emotional, social/material and school related assistance. Comprehensive service needs to be defined. UDHS 2006 shows 11% accessed any form of support
[4] Existing data for OVC indicators from the MoGLSD
[5] UBOS (2010), Uganda National Household Survey (UNHS) 2009/10
[6] Uganda's current population is estimated at 32.3 million people (2010 CIA FactBook).
7 Indicator considers for the head of household of 60+ years as an adult caregiver

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| | incidents of rights violations are successfully disposed of | | |
| | 40. %ge of cases of rights violations reported to appropriate authorities for redress | 27,047 child abuse and neglect cases reported to PSWO quarterly | TBD |
| | 41. %ge of OVC versus non-OVC aged 15-17 who had sex before age 15 years[8] | 1.3:1 Ratio of proportion of OVC versus non-OVC aged 15-17 who had sex before age 15 years | 1:1 OVC versus non-OVC aged 15-17 |
| | 42. %ge of PLHIV and persons most vulnerable to exposure to HIV reporting incidents of rights violations | TBD/data not available; | TBD |
| | 43. %ge civic and political leaders with knowledge and appropriate skills related to human rights, legal, policy and ethical issues related to HIV&AIDS | TBD/data not available; | TBD |
| | 44. %ge of lower local governments with paralegals supporting communities to address rights | 13,540 Paralegals trained in providing paralegal guidance and referral services of OVC[9] | All lower local governments have paralegals |
| | 45. %ge of reported cases related to HIV disposed of | TBD/requires special tools to capture data from JLOS | 90 % |
| | 46. %ge of workplaces and agencies with mechanisms for HIV internal mainstreaming | TBD/data not available | TBD |
| | 47. %ge of large work places (employing 20 or more persons) that have HIV&AIDS workplace policies and programs | 25 out 30 largest companies (83.3%) | 95% of 30 largest companies |
| | 48. %ge of workplaces and agencies implementing HIV workplace policies | TBD/data not available | TBD |
| | 49. %ge of workers reporting rights violations at workplaces on account of HIV | TBD/data no available; requires special workplace studies | TBD |
| To support legal and social actions for the protection of women and young people against gender based and sexual violence (GBSV) on account of HIV | 50. %ge of general population with correct knowledge about SGBV and positive attitudes supporting elimination SGBV in the context of HIV | TBD/data not available; requires national behaviour and services survey | TBD |
| | 51. %ge of women of reproductive age reporting violence arising due to HIV status disclosure, discordance or sero-difference | TBD/data not available; requires national behaviour and services survey | TBD |
| | 52. %ge of AIDS support agencies and CBOs undertaking initiatives for prevention of SGBV | TBD/data not available | TBD |
| | 53. %ge of OVC with new HIV infections | An estimated 25440 new HIV infections amongst children aged 0- | TBD |

[8] UDHS data is captured for reproductive age groups of women 15-49 and men 15-54. Available data show that Median = 14.4 years for women 15-17 years (UDHS2006).
[9] Existing data for OVC indicators from the MoGLSD website accessed 11/21/2010

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| | | 14yrs[10] | |
| | 54. %ge of sexually abused children with HIV infection | 41,617 eligible HIV+ OVC that have access to prophylactic treatment & ARVs[11] | TBD |

## Systems Strengthening

| Objective | Indicators | Baseline value year | Target 2014/2015 |
|---|---|---|---|
| To strengthen the governance and leadership of the multi-sectoral HIV and AIDS response at all levels | 55. National Composite Policy Index (NCPI) | NCPI=54.6% | 95% |
| | 56. Functional HIV coordination structures/committees (THAT ARE GENDER SENSITIVE??) in public and non-public sector institutions and departments at central and decentralized levels | DACs=30%; PHA Networks = 90% | 95% for sectors and levels |
| | 57. %ge of CSOs with functional governance and management structures | TBD | 95% |
| To ensure availability of resources for strengthening systems for delivery of quality HIV and AIDS health and non-health services | 58. Distribution of service outlets and services by districts and providers | TBD | TBD |
| | 59. %ge clients expressing satisfaction with (HIV/AIDS multi-sectoral) services provided by different providers | TBD | TBD |
| | 60. %ge of facilities (service providers and CSOs) reporting non stock outs of drugs, laboratory reagents and other commodities including condoms and non-health goods | TBD | TBD |
| | 61. Domestic and international AIDS spending by categories and financing sources | TBD | TBD |
| To establish a coordinated and effective national system for management of strategic information for the HIV and AIDS response | 62. %ge local governments reporting dissemination and availability of documents on the national response | TBD | All higher LGs |
| | 63. Proportion of indicators in the national framework that are reported on according to reporting schedule | 35% | 100% |

[10] UNGASS report, 2008-2009
[11] Existing data for OVC indicators from the MoGLSD

## Annex II: List of Consultants, Technical and Research Assistants

| **Overall Management and Co-ordination** | |
|---|---|
| Dr. David Kihumuro Apuuli | UAC |
| Dr. Grace Nyerwanire Murindwa | UAC |
| Ms. Elizabeth Mushabe | UAC |
| Dr. Narathius Asingwire | Lead Consultant |

## Annex II: List of Consultants, Technical and Research Assistants

| **Consulting Team and UAC Conveners** | | | |
|---|---|---|---|
| **Thematic Area** | **Theme Consultant** | **Technical Assistant** | **UAC Convener** |
| Prevention | Mr. Joseph Matovu | Dr. Aggrey Mukose | Dr. David Tigawalana |
| Care and Treatment | Prof. Moses Kamya | Dr. Rhoda Wanyenze | Dr. Zephar Karyabakabo |
| Social Support and Protection | Dr. Narathius Asingwire | Mr. Swizen Kyomuhendo | Ms. Joyce Kadowe |
| Systems Strengthening | Dr. Larry Adupa | Mr. Ellias Abaine Rukundo | Ms. Elizabeth Mushabe |
| Resource Mobilisation and Costing | Mr. Julius Mukobe | Mr. John Bosco Kavuma | Mr. Benson Bagorogoza |
| Monitoring & Evaluation | Ms. Beth Ann Plowman | Ms. Sarah Asiimwe | Mr. Denis Busobozi |

## Annex III: List of Steering Committee

| **Name** | **Title** | **Organization** |
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# Annex IV: Thematic Working Groups

## 1. Prevention

| Name | Title | Organization |
|---|---|---|
| Fred Wabwire-Mangen | Chair | MakSPH |
| Sam Okware | Vice Chair | UNHCO |
| David Tigawalana | Convener | UAC |
| Catherine Barasa | Member | UNAIDS |
| Catherine Watson | Member | Straight Talk |
| Godfrey Esiru | Member | ACP-MOH |
| Jackie Katushabe | Member | UAC |
| Joseph Okia | Member | OoP |
| Joshua Kitakule | Member | IRCU |
| Juliana Akoryo | Member | MoFLSD |
| Margaret Achom | Member | CDC |
| Michael Muyonga | Member | MoH |
| Monica Dea | Member | CDC |
| Paddy Masembe | Member | PHA Network |
| Raymond Byaruhanga | Member | AIC |
| Rita Nalwadda | Member | WHO |
| Robinah Ssempebwa | Member | USAID |
| Rosemary Kindyomunda | Member | UNFPA |
| Steven Kusasira | Member | UPDF |
| Susan Mpanga Mukasa | Member | PACE |
| Wolfgang Hlardrick | Member | CDC |
| Yusuf Nsubuga | Member | MoES |
| Draecabo Charles | Member | UNESCO |
| Annah Rutebuka | Member | UNRA |
| Joseph Matovu | Member | MakSPH |
| Aggrey Mukose | Member | MakSPH |
| Sylvia Nakasi | Member | UNASO |
| Florence Aliba Edin | Member | IRCU |
| Teopista Agutu | Member | Straight Talk Foundation |
| Dorothy Namutamba | Member | ICWEA |
| Christine Serwadda | Member | UAC |

## 2. Care and Treatment

| Name | Title | Organization |
|---|---|---|
| Emmanuel Luyirika | Chair | Mildmay |
| Zepher Karyabakabo | Convener | UAC |
| Moses Kamya | Consultant | MakSOM |
| Alice Namale | Member | CDC-Uganda |
| Flora Banage | Member | CDC-Uganda |
| Francis Adatu | Member | NTBLP |
| Francis Ssali | Member | JCRC |
| Innocent Nuwagira | Member | WHO |
| Jackie Calnan | Member | USAID |
| Jackie Katana | Member | IRCU |
| Jim Arinaitwe | Member | GF Coordinator |
| Raymond Byaruhanga | Member | AIC |
| Robert Ochai | Member | TASO |
| Seyoum Dejene | Member | USAID |
| Stella Alamo Talisuna | Member | Mbuya |
| Stephen Watiti | Member | NAFOPHANU |
| Zainab Akol | Member | MoH |
| Rhoda Wanyenze | Member | MakSPH |
| Adeodata Kekitiinwa | Member | Baylor Uganda |
| | | |
| Andrew Kambugu | Member | IDI |
| Donna Kabatesi | Member | CDC |
| Elizabeth Namagala | Member | MoH |
| Fred Semitala | Member | MJAP |
| Christine Karugonjo (Secretary) | Member | UAC |

## 3. Social Support and Protection

| Name | Title | Organization |
|---|---|---|
| Noerine Kaleeba | Chairperson | Founder, TASO Uganda |
| Edward Mugimba | Vice Chair | MoGLSD |
| Joyce Kadowe | Convener | UAC |
| Narathius Asingwire | Consultant | Makerere Univ |
| Swizen Kyomuhendo | Consultant | Makerere Univ |
| Ronald Luwangula | Res. Assistant | Makerere Univ |
| Flavia Kyomukama | Member | Global Coalition of Women with AIDS |
| Betty Kwagala | Member | TASO, Uganda |
| Monja Minsi | Member | Uganda Reach the Aged Association |
| Flavia Birungi | Member | ACORD |
| Sheila Marunga Coutinho | Member | Civil Society Fund |
| Grace Mayanja | Member | Alliance International |
| Denis Nuwagaba | Member | Inter-Religious Council of Uganda |
| Florence Bulumba | Member | NACWOLA |

| Name | Title | Organization |
|---|---|---|
| Prossy Namakula | Member | Global Coalition of Women with AIDS Uganda |
| Mercy Mayebo | Member | USAID |
| Sam Ocen | Member | Uganda Red Cross |
| Consolatta Aywek | Member | Uganda Red Cross |
| Connie Acayo | Member | MAAIF |
| Meredith Lwanga | Member | UNAIDS |
| Tina Achilla | Member | TASO, Uganda |
| Lucy Acom | Member | AIC |
| John Kitimbo | Member | POMU |
| Irene Sejjemba | Member | Maama's Club |
| Dean Musitwa | Member | Young Positives |
| David Muttu | Member | UAC |
| James Kigozi | Member | UAC |

## 4a. Systems Strengthening (Co-ordination, Infrastructure, HR, Commodities)

| Name | Title | Organization |
|---|---|---|
| Bharam Namanya | Chairperson | UNASO |
| Elizabeth Mushabe | Secretary | UAC |
| Larry Adupa | Consultant | Consultant |
| Ellias Abaine-Rukundo | Research Assistant | KYU |
| Abbie Hope Kyoya | Member | UAC |
| Annette Biryetega | Member | UAC |
| Christina Mwangi | Member | CDC |
| Elizeus Rutebemberwa | Member | MUSPH |
| Flavia Kyomukama | Member | NAFOPHANU |
| Fred Ssengooba | Member | MUSPH |
| Geoffrey Sseremba | Member | OoP |
| Jennifer Tumusiime | Member | UAC |
| Juliet Bataringaya | Member | WHO |
| Lillian Mworeko | Member | ICW |
| Macharia Githegia | Member | NAFOPHANU |
| Morris Okumu | Member | Technical Assistant |
| Muhanguzi Petterson | Member | UNHCO |
| Patrick Muhereza | Member | OoP |
| Paul Bogere | Member | MoPS |
| Robert Downing | Member | CDC |
| Rosemary Kabugo | Member | UAC |
| Rosemary Rujumba | Member | UAC |
| Stella Kentutsi | Member | NAFOPHANU |
| Vento Ogora Auma | Member | CDC |

## 4b. Systems Strengthening (Monitoring and Evaluation)

| Name | Title | Organization |
|---|---|---|
| Byakika Sarah | Chairperson | MOH |
| Beth Ann Plowman | Consultant | |

| | | |
|---|---|---|
| Sarah Asiimwe | Consultant | |
| Denis Busobozi | Secretary | UAC |
| Grace Murindwa | Member | UAC |
| James Guwani | Member | UNAIDS |
| Benson Bagorogoza | Member | UAC |
| Odunge Josephine | Member | UAC |
| Jotham Mubangizi | Member | UNAIDS |
| Susan Candiru | Member | UAC |
| Elizabeth Mushabe | Member | UAC |
| Sarah Kyokusingura | Member | MEEPP |
| Vincent Owarwo | Member | MEEPP |
| Daniel Kyeyune | Member | UAC |
| Nkoyooyo Abdallah | Member | TASO |
| Vincent Bagambe | Member | MOH/FCO |
| Charmaine Matovu | Member | CDC |
| Walter Obiero | Member | CDC |
| Kamoga Joseph | Member | PEPFAR |
| Abbot Ntwali | Member | UNASO |
| Tatwebwa Lilian | Member | UAC |
| Henry Katamba | Member | ACP/MOH |
| Kashemeire Obadiah | Member | MoGLSD |
| Mark Tumwine | Member | CDC |
| Mulumba Mathias | Member | UNASO |
| Moses Asiimwe | Member | CSF |
| Simon Peter Mayanja | Member | CSF |

## 4c. Systems Strengthening (Resource Mobilization and Costing)

| Name | Title | Organization |
|---|---|---|
| Alaethea Musa | Member | USAID |
| Benson Bagorogoza | Member | UAC |
| Bernard Rwakihembo | Member | UAC |
| Bonnie Gansusure | Member | UAC |
| Charles Birungi | Member | UNDP |
| George Bekunda | Member | MoGLSD |
| Henry Tabifor | Member | UNAIDS |
| J B Kanakulya | Member | UAC |
| Joel Okullo | Member | UAC |
| John Bosco Kavuma | Member | NPA |
| Mary Oduka | Member | Irish Aid |
| Michael Aliyo | Member | MoFPED |
| Patrick Jatiko Onyo | Member | UAC |
| Peter Ndawula | Member | Deloitte and Touche |
| Peter Ogwang | Member | DANIDA |
| Peter Okwero | Member | World Bank |
| Rachael Waterhouse | Member | DFID |
| Rogers Enyaku | Member | MoH |
| Solome Nampewo | Member | SIDA |

| Name | Title | Organization |
|---|---|---|
| Strong Michael | Member | PEPFAR |
| Titus Kajura | Member | MoFPED |
| Wilfred Ochan | Member | UNFPA |
| Zainab Akol | Member | MoH |