National HIV & AIDS Strategic Plan 2007/8 – 2011/12

Moving Toward Universal Access

Uganda AIDS Commission

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Foreword

Uganda pioneered a politically led, multisectoral and open national response to the HIV epidemic in Sub-Saharan Africa as far back as the mid 1980s. The fight has resulted in significant reductions of adult HIV prevalence from a peak of 18% in 1992 to the current 6.4%. This new National Strategic Plan for HIV/AIDS is evidence of our determination to further reverse the trend of the epidemic that threatens to erode the positive benefits of the country's socio-economic efforts. HIV affects human capacity – a key national factor of production. The current 6.4% HIV prevalence level among adults (15-49 years), the changing pattern of persons affected and the likely rise in new infections compel us to change strategy while maintaining approaches that have proved effective in reducing the impact of the epidemic. Political commitment and leadership in prevention campaigns have been documented as best practice in Uganda and will be maintained. Prevention as a cornerstone of this new Strategy will be tactically integrated in all government programmes.

HIV remains high among the national development agenda priorities and, through the multisectoral approach, all government sectors are urged to effectively mainstream and scale-up HIV/AIDS programmes in their respective constituencies. The Office of the Presidency, through the Uganda AIDS Commission, is committed to strengthen the coordination and management of the national response, monitor and track the utilisation of all resources to ensure value addition of HIV funding to national development.

I applaud the continuous support of all the AIDS Development Partners, donors, Civil Society, the Private Sector and all stakeholders. Government will devote its efforts to provide the necessary environment for all to participate and contribute to the achievement of the goals of the National Strategic Plan of substantially reducing new infections especially among youth. I urge married couples to take personal responsibility to avoid risky sexual behaviours that could contribute to an upsurge in new infection and increase the burden of the epidemic. Abstain, Be Faithful and those who cannot practice these two should use condoms. I call upon all the three arms of Government – the legislature, executive and the judiciary – to be vigilant in mobilising the community to use HIV and AIDS services. It is my sincere hope that with renewed commitment we can effectively stop the further spread of infection by HIV.

Yoweri K. Museveni

PRESIDENT OF THE REPUBLIC OF UGANDA

Preface

This five-year National Strategic Plan (NSP) for HIV and AIDS is a coordination tool for the national response developed from the efforts and experiences of the national HIV/AIDS Partnership. The Plan sets priorities for the three thematic service areas of Prevention, Care and Treatment and Social Support as well as outlining imperatives for strengthening systems for service delivery. The priorities and imperatives reflect the hard choices made to ensure maximum impact in reducing the incidence of new HIV infections within the limited financial and human resources.

The essence of the NSP as a departure from the previous National Strategic Framework (NSF) 2000-2006 is the evidence supporting anecdotal knowledge about the main sources of new infections. The evidence justifies the two-pronged strategy that maintains the well established ABC approach complemented with a refocus on the most cost-effective prevention interventions, balancing care, treatment and prevention costs and embracing new prevention technologies. All efforts should be geared towards reducing new infections by 40% in the next five years.

Within the response to a generalised epidemic, the NSP also identifies key population groups at higher risk for whom a special focus is advocated. The key groups include: fishing communities, people with disability, uniformed services, persons internally displaced through conflict and commercial sex workers. The commonality of these groups is that they have been hard to reach or they cannot benefit from general population programmes.

The multisectoral approach will remain the core implementation modality and, as such, the NSP will serve to guide stakeholders of all kinds on deciding priority interventions in their respective areas of competency and interest. The NSP recognises the need to strengthen systems for service delivery, i.e., optimising utilisation of the social, community and health infrastructure; streamlining the institutional arrangement at national and local government levels; efficient use of human resources; and enhancing research, monitoring and evaluation.

Mainstreaming Gender, Sexual, Reproductive Health and Rights will be crucial and enable strategic positioning to address the phenomena of high discordance rates, the vulnerability of women and the observed increasing new infections within marriage. Deepening the response at Local Government level is expected to translate into improved access and utilisation of services and will result from better and stronger governance and implementation modalities, an enhanced role of the Ministry of Local Government, effective mainstreaming of HIV in all sectors and strategic engagement of Civil Society.

It is only through alignment to the NSP that the goals and objectives of the national response to HIV and AIDS will be achieved by 2012. The NSP will be operationalised through Annual National Priority Action Plans (NPAPs) developed through the annual technical Joint AIDS Reviews (JAR). Wide consultations will be undertaken for the purpose of ensuring ownership and accountability for the NPAP by the various stakeholders. Overall, assessing progress of implementation will be guided by Performance Management and Monitoring Plan (PMMP) developed as one of the support documents of the NSP.

Government is committed to design effective resource mobilisation strategies and mechanisms for accountability and their application for greater impact. The

estimated total cost of US$2,011 million for financing the five-year NSP resulted from a realistic consideration of the implications of alternative levels of impact and allocation patterns of resources to the different thematic service areas.

The participatory process through which the NSP was developed has renewed Uganda AIDS Commission's commitment, motivation and thinking about the road map to the country's vision of a population free of HIV. The NSP will be a key tool for coordination and oversight for the national response for the next five years. It is my sincere hope that partners, donors and implementers will, to every extent possible, align their support and interventions to the priorities of the NSP and collectively contribute to the achievement of the targets in the most cost-effective way.

Dr. David Kihumuro Apuuli
DIRECTOR GENERAL,
UGANDA AIDS COMMISSION

Acknowledgements

The process of developing the National Strategic Plan (NSP) 2007/8-2011/12 benefited from experiences and technical knowledge of a wide range of stakeholders who tirelessly worked for months to discern the evidence that has made this Plan a reality. Uganda AIDS Commission is greatly indebted to all who participated in various ways in the process.

Special thanks are extended to:

- The external lead consultant – Dr. Pat Youri;
- The costing consultants – Dr. John Stover, Lori Bollinger of Futures Group, Julius Mukobe and James Muwonge;
- The national thematic consultants who provided leadership for the invaluable extensive technical analysis – Dr. Wilford Kirungi, Dr. Kamya Moses, Dr. Rhoda Wanyenze, Dr. Emanuel Sekatawa, Ms Rebecca Mukyala, Mr. John Bosco Kavuma, Mrs Sarah Mangali, and Dr. Amone;
- The external author who drafted the Plan - Mr. Shaun Samuels; and
- The consultant for professional guidance in prioritisation, editing and layout of the document – Dr. Tom Barton.

All the development partners and the United Nations group are applauded for providing the necessary resources, both technical and financial, for the entire planning process and for supporting the studies that bridged the data gaps. The UNAIDS Country Coordinator, Ms Mai Harper is acknowledged for coordinating and organising input from all the development partners and sourcing reference documents from the region and elsewhere.

The quality of the NSP is equally attributed to members of the Task Force and the UAC Board who provided oversight and guidance throughout the process and the AIDS Strategy and Action Plan team of the World Bank for peer reviewing the draft.

I wish to thank all the district technical and political staff, government sectors, civil society and private sectors who participated in the process. Your involvement was an indication of your continued commitment to further strengthen the HIV partnership in the national response to the HIV epidemic and to deepen the response at districts and in the sectors.

Special acknowledgements go to the staff of the Uganda AIDS Commission Secretariat who professionally and diligently led the process.

Together we share the challenge,

Rt Rev. Barnabas R Halem'Imana
Bishop Emeritus of Kabale
CHAIRMAN OF UGANDA AIDS COMMISSION

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Executive Summary

Background

After a quarter of a century of a generalised HIV epidemic, Uganda continues to experience a severe and mature HIV epidemic. Currently, 6.4% of adults and 0.7% of children are infected with HIV, i.e., about one million people nationwide.

The epidemic has geographic, socio-demographic and socio-economic heterogeneity: women, urban residents and people residing in Kampala, and in the central and mid-northern regions are disproportionately more affected. As the epidemic matures, the population groups most severely affected have shifted from young unmarried individuals to older and married or formerly married individuals. Currently, HIV prevalence peaks among women aged 30-34 years and men aged 40-44 years, a shift of five to ten years later from the pattern in the early 1990s. Women are infected more than men across the age spectrum from birth to age 45-49 years (60% to 40%). Gender impacts of the disease are significant.

International attention has been drawn to the 'recent' reversal of Uganda's prevention success. Sub-national longitudinal studies and indirect estimates indicate a rising rate of new infections with HIV incidence ranging from 0.2-2.0% in different regions of the country. The annual incidence reached 132,500 new cases in 2005. This includes 25,000 mother-to-child transmissions.

The stagnant and worsening HIV trends in Uganda actually date from about 2002. There is a strong possibility that the negative HIV trends are at least partially attributable to phasing out of 'zero grazing' and other partner reduction/fidelity-focussed campaigns of the late 1980s. It may also signal declines in political commitment and practice of self-protective behaviours in the general population. Trends in demographic and health surveys from 1995 to 2005 have suggested that increasing numbers of sexually active adults were engaging in sex with multiple partners[1].

The most important source of new infections continues to be sexual transmission.

The most important source of new infections continues to be sexual transmission, which accounts for 76% of new HIV infections. According to the national sero-survey in 2005, HIV

[1] Editorial (2007) Why is HIV prevalence so severe in Southern Africa? The role of multiple concurrent partnerships and lack of male circumcision: Implications for AIDS prevention. Southern African Journal of HIV Medicine, March

transmission is currently highest within marital sex (42%), with commercial sex workers (21%) and from casual sex (14%). This evidence is compelling and is now a critical consideration underpinning national HIV prevention strategies. As a cause of 22% of new infections, mother-to-child transmission represents the other critical target area for intervention. At the heart of the NSP is the prevention of new HIV infections, including mother-to-child transmission.

The total number of people in need of ART is growing faster each year than the care and treatment systems for helping them.

Despite reaching 42% of the population in need of ART in 2005, the number of those in need of ART continues to grow each year. It is estimated that there are 270,000 PHAs eligible for ART in 2007; this number is projected to reach 332,000 in 2012 – far outstripping system capacity and available finances. The combination of huge increases in the general population (3.2% per annum in 2006) coupled with a high number of new infections are making it extremely difficult to stay ahead of the epidemic.

Developing the plan

The NSP was achieved through a participatory development process and was carried out in four inter-related phases: documenting the evidence for the NSP, district consultations, drafting the NSP, and modelling and costing the NSP. The Uganda HIV/AIDS Partnership Committee provided oversight, and a Task Force of the Partnership Committee provided guidance and technical assistance to a lead consultant and eight thematic consultants working intensively with seven Technical Working Groups (TWGs) responsible for documenting the evidence. The TWG members were drawn from the twelve Self-Coordinating Entities (SCE) of the Uganda HIV/AIDS Partnership.

Highlights of the plan

The NSP aims to achieve the following:

> *The incidence of HIV and AIDS is reduced by 40%, social support is expanded and scaled up interventions of care and treatment are accessible to 80% of those in need by the year 2012.*

The plan has three thematic service areas: Prevention, Care and Treatment and Social Support. The thematic service areas are supported by strengthened systems of delivery that include the following:

- Institutional arrangements and human resource requirements;
- Research and development;
- Resource mobilisation and management;
- Monitoring and evaluation; and
- Infrastructure requirements.

The goals and objectives of the three thematic service areas and systems strengthening are presented in the table below:

Thematic area	Goal	Objectives
Prevention	To reduce the incidence rate of HIV by 40% by the year 2012	To accelerate the prevention of sexual transmission of HIV through established as well as new and innovative strategies
		To reduce HIV transmission from mother-to-child by 50% by 2012
		To maintain 100% blood transfusion safety, and ensure 100% adherence to universal precautions and promote 100% access to PEP at ART centres by 2012
		To control sexually transmitted infections, increasing appropriate uptake from 36-70% by 2012
		To promote use of new HIV prevention technologies & approaches proven to be effective
Care and Treatment	To improve the quality of life of PHA by mitigating the health effects of HIV/AIDS by 2012	To increase equitable access to ART by those in need, from 105,000 to 240,000 by 2012
		To increase access to prevention & treatment of opportunistic infections including TB
		To scale up HIV counselling & testing to facilitate universal access to treatment by 2012
		To integrate prevention into all care & treatment services by 2012
		To support and expand the provision of home based care and strengthening referral systems to other health facilities and complementary services
		To provide complementary support including nutrition to PHA
Social support	To mitigate the social, cultural and economic effects of HIV and AIDS at individual, household and community	To increase provision of quality psychosocial support to PHAs, OVCs, PHAs, PWD and other disadvantaged groups by 2012
		To promote and support sustained formal and informal education, vocational and life skills development for OVC, PHAs IDPs, PWDs & other disadvantaged groups
		To enhance livelihoods & economic empowerment of affected communities & households
		To increase access to basic needs for PHAs and OVCs

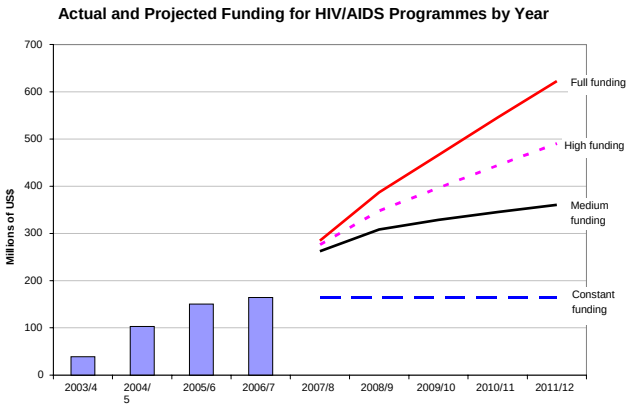
A clear framework for ongoing monitoring and evaluation focussed on performance monitoring and management is part of the NSP. This is designed to collect, collate and interpret data to monitor and evaluate the effects of interventions under the NSP and its contribution to the PEAP.

The NSP is aligned to the Country's Poverty Eradication Action Plan (PEAP) under Pillar 5, which focuses on Human Development and emphasises preventive health care and commodities for basic curative care. The Pillar is a further translation of MDG Goal 6 aiming at combating HIV/AIDS and Target 7 aiming at halting and reversing its spread.

Meeting the NSP goals and targets will require a massive increase in resources.

Supporting the plan

To meet the goals and targets in the NSP and reverse the trend in the epidemic requires a massive increase in the resources available, rising by over 30% a year from about US$263 million in 2007 to US$513 million in 2012 (High funding



scenario at left). However, increasing the resources alone is not enough and development partners will need to refocus and better realign their inputs to attain the objectives laid out in the NSP.

Population growth alone accounts for an increase in resource needs of about 25% over this period. Most of the increase, however, is caused by scaling up coverage to an average 75% by the end of the NSP[2]. Over the five years of the NSP, 29% of the resources are needed for prevention, 44% for care and treatment, 19% for support of OVCs, and 8% for programme support.

The resources needed for prevention are allocated to the most cost-effective interventions and those that provide entry to other care and support services. These interventions include HIV Counselling and Testing (HCT), meaningful involvement of People Living with HIV (prevention for the positives), community mobilisation and Prevention of Mother-to-child Transmission (PMTCT).

Antiretroviral treatment accounts for most of the resources (88%) required for care and treatment programmes, while food and clothing account for most (75%) of resources required for support to orphans and vulnerable children. Within programme support, the areas of management, administration and coordination account for 40%, while enabling environment, research and M&E each account for about 20% of requirements.

The NSP is aiming toward universal access to HIV and AIDS services for prevention, care and treatment, and social support.

Anticipated outcomes of the plan

The National Strategic Plan (NSP) for the next 5 years (2007/8-2011/12) takes cognisance of the challenges that lie ahead to reduce new infections, prevent mother-to-child transmissions, and facilitate universal access to essential services. The critical emphasis is to integrate the continuum of HIV prevention, care and treatment services; and to reverse the trend in the number of people living with HIV. In addition, the plan aims to consolidate and scale up access to ART, while providing much improved social support to reduce the socio-economic impacts of the epidemic and reduce vulnerability to HIV infection.

[2] This refers to a projected average of service coverage for prevention, care and treatment, and social support.

The cornerstone of the NSP is the aim to reduce the incidence levels of new HIV infections by 40% by 2012; this is the basis for prioritising resource allocations to fully fund the most cost-effective HIV prevention measures. Achieving this cornerstone is projected to have the following impacts on the AIDS epidemic:

- Increased funds and commitment to prevention-related interventions could decrease the annual number of new infections from 135,000 to just over 100,000 by 2012. This would imply that as many as 150,000 to 160,000 new infections could be averted over the period of the NSP, thereby saving lives and decreasing future expenditures on treatment. One key intervention will be including male circumcision within the broader framework of male reproductive and sexual health.
- Support for orphans and vulnerable children would increase significantly during the NSP, improving the proportion of OVCs receiving public support to 54%. In the long term, prioritising prevention would also reduce the incidence of OVCs and other associated socio-economic effects since far fewer people would be getting infected with HIV, thereby reducing the numbers of persons getting sick and dying from AIDS.
- The allocation for care and treatment could support an increase in the number of people receiving ART from 80,000 in 2005 to 216,000 by 2012. This level of scaling up would substantially address the support needs for those already on treatment as well as starting treatment for those newly needing it. Indeed, the proportion of those needing ART who do receive it would increase, reaching about 80% in 2011/12. This increase in coverage would extend life for many people and avert additional 60,000 – 90,000 AIDS-related deaths during the NSP period.

While ensuring massive commitments to care, treatment and social support, the key strategy of the NSP is to apply proven and cost-effective means of HIV prevention to reduce the numbers of people newly infected.

Summary

In conclusion, the NSP must be seen as a dynamic and living document that will be subject to regular critical review. Universal access is a key pillar of the NSP with scaled-up coverage targets projected to an average 75% across the various interventions. It is believed that when all parties, led by the Uganda AIDS Commission, mobilise their collective strengths and resources and pull together, the country will be able to show evidence of reduced new infections and the mitigation of HIV and AIDS impacts on the lives of millions of peoples – in effect realising the aim and objectives of the NSP.

List of acronyms

ABC .....Abstinence, Being Faithful, & Condom use
ADPs.....AIDS Development Partners
AIC .....AIDS Information Centre
AIDS.....Acquired Immune Deficiency Syndrome
ANC .....Antenatal Care
ART .....Anti-Retroviral Therapy
ARVs .....Antiretroviral drugs
BCC.....Behaviour Change Communication
CBOs.....Community Based Organisations
CSOs .....Civil Society Organisations
CSWs.....Commercial Sex Workers
DACs.....District AIDS Committees
DAT.....District AIDS Task Force
FBO .....Faith Based Organisation
FPO.....Focal Point Officer
GDP.....Gross Domestic Product
GFATM .....Global Fund to Fight AIDS, Tuberculosis and Malaria
GoU.....Government of Uganda
HBC .....Home Based Care
HBCT.....Home Based Care Treatment
HC .....Health Centre
HCT.....HIV Counselling and Testing
HIV.....Human Immunodeficiency Virus
HSV-2.....Herpes Simplex Virus - type 2
IDPs.....Internally Displaced People
IEC .....Information, Education & Communication
IMR .....Infant Mortality Rate
IPH .....Institute of Public Health
JAR .....Joint AIDS Review
JCRC.....Joint Clinical Research Council
M&E.....Monitoring & Evaluation
MAP.....Multi-Country AIDS Program
MDGs.....Millennium Development Goals
MoES.....Ministry of Education and Sports
MoH .....Ministry of Health
MTCT.....Mother-to-Child Transmission
NPAP .....National Priority Action Plan
NSF .....National Strategic Framework
NSP.....National Strategic Plan
OVC.....Orphans & Vulnerable Children
PEAP .....Poverty Eradication Action Plan
PEP .....Pre or Post-Exposure Prophylaxis
PEPFAR .....President's Emergency Plan for AIDS Relief
PHAs.....People Living with HIV/AIDS
PMMP .....Performance Measurement & Management Plan
PMTCT.....Prevention of Mother-to-child Transmission
PWD .....People with Disability
PWP .....Prevention with Positives
RCT.....Routine Counselling & Testing
SCEs .....Self Coordinating Entities
SRH.....Sexual & Reproductive Health
SRHR .....Sexual & Reproductive Health & Rights
STIs.....Sexually Transmitted Infections
TASO .....The AIDS Support Organisation
TB.....Tuberculosis
TWGs.....Technical Working Groups
UAC .....Uganda AIDS Commission
UHSBS .....Uganda HIV/AIDS Sero-Behaviour Survey
UNAIDS .....United Nations Joint Programme on AIDS
UNGASS.....United Nations General Assembly Special Session
UVRI .....Uganda Virus Research Institute
VCT .....Voluntary Counselling and Testing

Section 1: Background

1.1 Introduction

Uganda has braved a severe generalised HIV epidemic for almost a quarter of a century. Currently, almost one million people are infected with HIV, i.e., 6.4% of all adults aged 15-49 years. The Uganda HIV epidemic appears to have progressed through three distinct phases since the early 1980s. The first phase had a rapidly rising HIV prevalence that peaked around 1992 with an antenatal HIV prevalence ranging between 6-25% in major urban areas. The second phase (1992-2000) showed a declining HIV prevalence and incidence, particularly in urban areas. Nationally, HIV prevalence declined during the 1990s among antenatal clinic attendees[3] and voluntary counselling and testing clients[4]. Similarly, there were declining HIV incidence and prevalence levels in population-based cohorts in rural areas of Masaka district[5] and Rakai district. The decline in HIV incidence and prevalence has been attributed to the increased age of sexual debut[6]; reduction in sexual partnerships outside of marriage[7]; and increased use of condoms.

The HIV/AIDS epidemic in Uganda is 'mature' but also continuously evolving and different groups are now more vulnerable than in the past.

The third phase of the Uganda HIV epidemic (since 2000) has been characterised by stabilisation of the HIV prevalence at a level ranging from 6-7%[8]. However, there are anecdotal indications from the national surveillance system corroborated by data from longitudinal cohort studies of an apparent increase in HIV prevalence and incidence during the last few years (although this evidence is not yet compelling[9]). According to the national sero-survey results of 2004-5, HIV prevalence is highest in the Kampala, Central and

[3] Kirungi, W.L. et al (2006) Trends in antenatal HIV prevalance in urban Uganda associated with uptake of preventive sexual behaviour. Sex Transm Infect 2006; 82((Suppl. 1)):i36-i41. Also, Asiimwe-Okiror, G. et al (1997) Change in sexual behaviour and decline in HIV infection among young pregnant women in urban Uganda. AIDS 1997; 11(14):1757-1763.

[4] Baryarama, F. et al (2005) Changing from anonymous to confidential HIV voluntary counseling and testing in Uganda. AIDS: Volume 19(16)4 November 2005p 1930-1931

[5] Mbulaiteye, S.M. et al (2002) Declining HIV-1 incidence and associated prevalence over 10-years period in a rural population in South-West Uganda: a cohort study. Lancet 2002; 360(9326):41-46

[6] *op cit*: Kirungi, W., et al (2006) ; Asiimwe-Okiror et al (1997)

[7] Stoneburner, R. et al (1998) Simulation of HIV incidence dynamics in the Rakai population-based cohort, Uganda. AIDS 1998; 12(2):226-228

[8] MoH and ORC Macro (2006) Uganda HIV/AIDS Sero-Behavioural Survey 2004/2005. March. MoH and ORC Macro

[9] Shafer LA, et al (2006) HIV prevalence and incidence are no longer falling in Uganda - a case for renewed prevention efforts: evidence from a rural population cohort 1989-2005, and from ANC surveillance. Sixteenth International AIDS Conference, Toronto, abstract ThLB0108.

North Central regions (over 8%), and lowest in the Northeastern and West Nile regions (below 4%). Overall, more women (7.5%) than men (5.0%) have the virus. In Kampala, 11.8% of women are positive compared with 4.5% of men. Men and women in the West Nile region are least likely to be positive (1.9% and 2.7% respectively)[10].

In response to the challenges posed by the epidemic, a number of national plans and frameworks have been initiated to combat the disease and mitigate its impacts. Some of the major points on the Uganda timeline of HIV and AIDS and national responses are:

1982: A new disease pattern, locally known as "Slim" disease is tracked down in Rakai district and identified as HIV/AIDS by doctors from Makerere.

1986: AIDS Control Programme established in the Ministry of Health (MoH).

1987: The AIDS Support Organisation (TASO) formed as support organisation for PHAs.

1988: National Sero-Survey conducted to assess the magnitude of the epidemic.

1992: Joint Clinical Research Centre (JCRC) formed to conduct clinical research on HIV/AIDS and care and treatment.

1992: The AIDS Information Centre (AIC) formed to provide voluntary counselling and testing services.

1992: Uganda AIDS Commission (UAC) formed to coordinate the multisectoral approach to AIDS control; development of the multisectoral National Operational Plan and HIV/AIDS Policy Guidelines.

1993: Development of the multisectoral National Operational Plan (NOP) and HIV/AIDS Policy Guidelines.

1997: Five-year National Strategic Framework (NSF) for HIV/AIDS 1997 developed and up-graded in 2000 to the NSF 2000/1 – 2005/6.

2002: Partnership arrangement established to provide technical and financial support to UAC and a mechanism to share information on the national response.

The new NSP drew on a rich background of national experience and expertise in preparing the next phase of the national response to HIV and AIDS.

It is in the context of the above efforts that the new NSP for 2007/8 to 2011/12 is drafted with the intent of intensifying the national HIV and AIDS response, particularly in responding to and reducing the sources of new infections; while expanding efforts towards universal access to HIV and AIDS-related services.

[10] UAC (2005) National HIV/AIDS Stakeholders & Service Mapping Atlas. UAC, Uganda HIV/AIDS Partnership. December.

1.1.1 Process of developing the National Strategic Plan (NSP)

The NSP development process was conceptualised at three levels:

- Technical level that was participatory and fully interactive;
- Policy level to ensure an enabling policy environment exists for implementing the NSP;
- Political level to obtain political commitment and ensure the NSP is the supreme guide of the country for the control of HIV.

The NSP development process was so participatory and interactive that it involved more than 1,000 stakeholders and took place over a period of eight months (see Annexes 4, 5). This consensus building process ensured buy-in and ownership of the NSP by the key stakeholders who will be involved in implementing the national response to HIV and AIDS.

The NSP process was evidence-based and consultative; and the resulting NSP was prioritised and costed.

The technical process was carried out in four inter-related phases: a) documenting evidence for the NSP; b) district consultations; c) drafting the NSP; and d) modelling and costing the NSP. The Uganda AIDS Commission (UAC) Board provided broad policy guidance on the development of the NSP document; the Uganda HIV/AIDS Partnership Committee provided oversight. A Task Force of the Partnership Committee provided guidance and technical assistance to a lead consultant and eight thematic consultants working intensively with seven Technical Working Groups (TWGs) responsible for documenting the evidence. The TWG members were drawn from the 12 Self-Coordinating Entities (SCE) of the Uganda HIV/AIDS Partnership.

The three thematic service areas involved in developing the NSP were: Prevention, Care & Treatment and Social Support. The TWGs for management and support systems included Infrastructure Requirements; Institutional Arrangements and Human Resource Requirements; Research and Development; and Resource Mobilisation and Management. The M&E Sub-Committee of the Partnership Committee spearheaded the development of the M&E design for the NSP.

Evidence was collected and synthesised for each of the three thematic service areas. Data and background for documenting the evidence were gathered using a mix of methodologies including documentation reviews, key informant interviews, focus group discussions, and district visits. A synthesis report was then developed for each thematic area by the thematic consultants under the guidance of the appropriate TWGs and the final reports, approved by the TWGs, were sent by the thematic consultants to the lead consultant for consolidation with the

M&E report into a single first draft document – the Draft NSP 2007/8-2011/12 Outline - which was the primary document used in consultations with stakeholders.

The Futures Group performed the modelling and costing of the NSP. The United Nations family and the European Union supported preparation of issues papers on selected areas of critical importance to the NSP where accurate information and analysis was needed. Issues papers were developed for Sector-based Assessment of AIDS Spending; Nutrition and HIV/AIDS; Gender and Gender Mainstreaming; Sexual and Reproductive Health and Rights (SRHR); Children and HIV/AIDS; the Military and HIV/AIDS; and for the Greater Involvement of PHAs (GIPA) Principle. Verbal inputs were provided for People with Disability (PWDs) and HIV/AIDS, Older People and HIV/AIDS and Youth and HIV/AIDS.

Stakeholder consultations were held during the following: the Joint Annual Review (JAR) of the Uganda HIV/AIDS Partnership; District Consultations that were organized in eight regional groups and attended by stakeholders from all the districts; the AIDS Development Partners (ADPs) meetings, and meetings with the Sector Ministries, CSOs, and the Parliamentary Sub-Committees on HIV/AIDS. A group of about 45 people selected to represent a wide spectrum of key stakeholders met and decided on the final priority areas for the NSP at a 2-day retreat. The World Bank also supported a peer review process aimed at validating the imperatives and content of the NSP. This ended the technical level of the development of the NSP. The next consultations were at policy and political levels; these involved submission of the NSP to the Partnership Committee, UAC Board and Cabinet for approval.

The NSP focus is on two broad and inter-related areas: Thematic Service Areas and Strengthening Systems for the Delivery of Services.

1.1.2 Structure of the NSP

To effectively respond to the epidemic, the NSP has identified two broad and inter-related areas that it will focus on: Thematic Service Areas (three thematic areas) and Strengthening Systems for the Delivery of Services. The three Thematic Service Areas are: HIV Prevention, Care & Treatment, and Social Support. Strengthening Systems for the Delivery of Services consists of Institutional Arrangements and Human Resource Requirements, Infrastructure Requirements, Research and Development, Resource Mobilisation and Management, and Monitoring and Evaluation.

1.2 Situation Analysis

A thorough understanding of the nature, dynamics and characteristics of an epidemic is critical in informing strategies that can be reviewed and adapted to fit local conditions. By

definition, the Ugandan HIV and AIDS epidemic is generalised. However, it also is comprised of multiple, changing and overlapping micro-epidemics, each with its own nature (populations most affected); dynamics (patterns of change); and characteristics (severity of impact).

1.2.1 National demographic and socio-economic profile of Uganda

Uganda's high population growth rate negatively affects its capacity to keep up with the HIV/AIDS epidemic.

Briefly, the demographics of Uganda suggest the following:

- Uganda has a generalised epidemic.
- There are 29 million people in the country. The Total Fertility Rate is 6.7[11]. The population Growth Rate stands at 3.2(4)% per annum, one of the highest in the world.
- Life expectancy at birth is: Male = 48 years, Female = 50 years; projected to be 55 years without AIDS. The infant mortality rate (IMR) is: 76 per 1000 live births.

At the socio-economic level, the following is evident:

- Uganda has experienced solid economic growth of 6-7% per annum over the last decade but this is not reflected in the quality of life for most people, particularly the 20% poorest people[12];
- The Human Development Index position is 145/177 (2006 ranking);
- Uganda is a low income country with a per capita GDP of $300/annum; with 31% of its people living below the poverty line (2006)[13];
- There has been a marked increase in inequality (Gini coefficient increasing from 0.35 in 1997/8 to 0.43 in 2003) primarily due to a slowdown in agricultural growth, insecurity, and population growth rate at 3.2% per annum;
- Significant adult underemployment is pervasive in Uganda;
- It is generally a peaceful country with insecurity and conflict concentrated in the northern part of the country.

1.2.2 Patterns and trends of HIV & AIDS in Uganda

The current status and trends of the epidemic pose significant challenges to designing, implementing and supporting an appropriate response over the next five years.

The current status and trends of the epidemic pose significant challenges to the country, particularly for designing, implementing and supporting an appropriate response to the disease over the next five years. The number of HIV-positive individuals is likely to increase from 1.1 million in 2006 to about 1.3 million in 2012. If this trend continues, then the number of new cases (incidence), the number of People Living with HIV and AIDS (PHAs) who need ART and the number of AIDS deaths will all increase.

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[11] UBOS (2006) Uganda Demographic and Health Survey 2006: Preliminary report. Uganda Bureau of Statistics, Kampala, Uganda and ORC Macro, Calverton, Maryland, U.S.A. November.

[12] UBOS (2003) Report on the Uganda National Household Survey 2002/2003. Uganda Bureau of Statistics; November

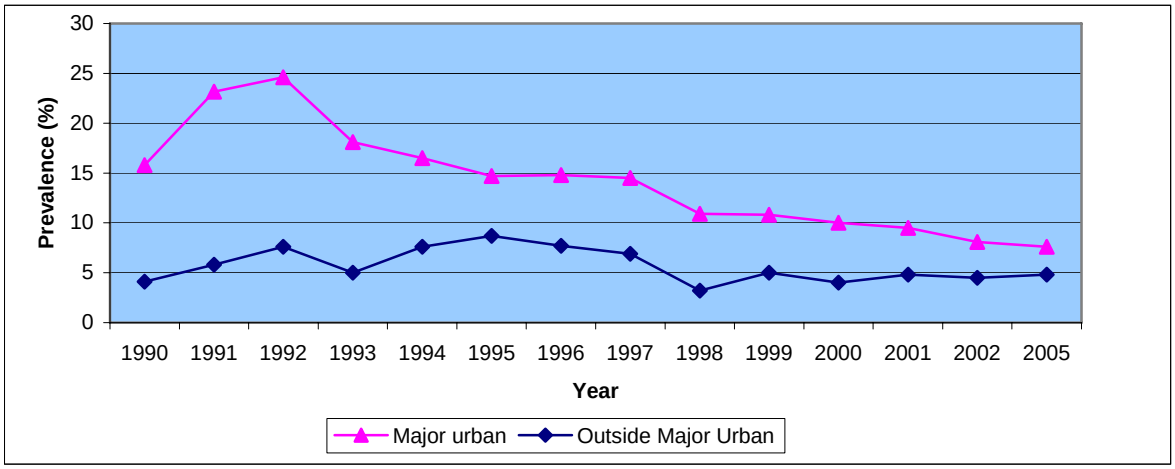
[13] *ibid*

Women are infected earlier and more than men across most age groups and the gender impacts of the disease are also significantly different.

The patterns of the disease[14] demonstrate the challenges that need response over the next five years. First, Uganda has seen a levelling off in prevalence at around 6.4 to 6.7%. This has happened after a rapid decline in prevalence from a high of 18% in the 1980s to a low of 6.4% in the 1990s. Meanwhile, evidence of new infections (incidence) has shown an increase over the last five years with 132,500 new cases estimated in 2005. This includes 25,000 mother-to-child transmissions. Women are infected more than men across the age spectrum from birth to age 45-49 years (60% for women versus 40% for men) and the gender impacts of the disease are significant. Women are often unable to negotiate safer sex due to lower status, economic dependence and fear of violence. Women bear the brunt of caring for sick family members and are more likely to be rejected, expelled from the family home and denied treatment, care and basic human rights.

Figure 1 shows the trends of median HIV prevalence in both major urban areas and outside. For all the years under study, the level of HIV prevalence in areas outside major towns has been lower than in major urban areas but with a nearly similar trend pattern. The median HIV prevalence peaked around 1995 and was lowest in 1998. It started stabilising in 1999. There is more evidence of stabilisation of HIV prevalence in sentinel sites outside major urban areas compared to those in the major towns. Given that Uganda is 85% rural, the trend in outside major towns is more likely to reflect the situation in the whole country[15].

Figure 1: Median HIV prevalence of Antenatal Care (ANC) attendees, 1990-2005



Source: HIV Prevention in Uganda: The Road towards Universal Access, June 2006

[14] UAC (2006) The Uganda HIV/AIDS Status Report, July 2004 – December 2005. Uganda AIDS Commission, March

[15] Wabwire, F.; Tumwesigye, N.M.; and Opio, A. (2006) Accelerating HIV Prevention in Uganda: The Road towards Universal Access: I. A Review of the Trends and Projections of HIV/AIDS Prevalence and Incidence in Uganda. For UAC, June.

The Uganda national sero-survey (2005)[16] underscored the importance of understanding the distribution of HIV infection within a population. In conjunction with a survey of sero-prevalence, an analysis of the social, biological, and behavioural factors associated with HIV infection was performed. HIV prevalence was higher in women than men, and it increased with wealth. The results showed that the overall HIV prevalence among the 15-49 and 15-59 age groups was 6.4 and 6.3%, respectively (Table 1).

Table 1: HIV prevalence by age

	Women		Men		Total	
Age	% HIV positive	Number tested	% HIV positive	Number tested	% HIV positive	Number tested
15-19	2.6	2,062	0.3	1,932	1.5	3,994
20-24	6.3	1,803	2.4	1,184	4.7	2,987
25-29	8.7	1,679	5.9	1,123	7.6	2,802
30-34	12.1	1,374	8.1	1,139	10.3	2,513
35-39	9.9	1,029	9.2	868	9.6	1,897
40-44	8.4	823	9.3	745	8.8	1,568
45-49	8.2	621	6.9	524	7.6	1,145
50-54	5.4	513	6.9	452	6.1	965
55-59	4.9	322	5.8	332	5.4	654
Total 15-49	7.5	9,391	5.0	7,515	6.4	16,906

Source: Report of the 2004-05 Uganda HIV/AIDS Sero-behavioural survey

When data is disaggregated by age and sex, it shows that women are more highly affected at younger ages compared with men. The age- and sex-specific prevalence of HIV for both women and men increases with age – reaching a peak for women at ages 30-34 (12%) and for men at ages 35-44 (9%). Prevalence for women is generally higher than for men in almost all the reproductive ages (15-49 yrs). At ages 50-59, the pattern reverses and prevalence is slightly higher among men than women.

Urban residents have a significantly higher rate of HIVprevalence than rural residents.

Urban residents have a significantly higher prevalence of HIV infection (10.1%) than rural residents (6.7%). This is true for both sexes, though the urban-rural difference is much stronger for women than for men. Prevalence among urban women is 13% compared with 7% for rural women, and prevalence among urban men is 7% compared with 5% for rural men.

Less than 1% of **children** are HIV-positive[17]. There is no difference in HIV prevalence between males and females. Like in adults, HIV prevalence is higher among urban children

[16] MoH and ORC Macro (2006) Uganda HIV/AIDS Sero-Behavioural Survey 2004/2005. March. MoH and ORC Macro

[17] MoH and ORC Macro (2006) Uganda HIV/AIDS Sero-Behavioural Survey 2004/2005. March. MoH and ORC Macro

than it is among those from rural areas. Prevalence is also higher among children whose mothers are widowed, divorced, or separated.

Vulnerable and most at risk populations

The HIV epidemic in Uganda is generalised; however, there are pockets of population that are vulnerable and at higher than average risk of HIV infection. These vulnerable population groups include commercial sex workers (CSWs); fishing communities; internally displaced people (IDPs); uniformed services; and people with disability. A few studies have been conducted that illustrate the nature of vulnerability among these populations; some key points are extracted in the paragraphs that follow.

Commercial sex is significant, especially in Kampala, the magnitude of commercial sex is on the increase, and commercial sex workers are highly vulnerable to HIV.

To date, two cross-sectional surveys have been conducted among **Commercial Sex Workers** in Kampala, the first in 2001 and the second in 2003. The main objectives of these studies were to estimate the prevalence of HIV and assess HIV-related knowledge among CSWs. Of the 195 and 216 CSWs studied in 2001 and 2003, respectively 28.2 and 47.2% were found to be HIV-positive. This indicates that HIV infection went up by almost 75% during the two-year interval. When data was disaggregated by age, the general pattern of HIV infection remained the same. The 20-24 year old age group had the highest HIV prevalence in both 2001 and 2003, followed by the 25-29 year old age group; then the 15-19 year old age group. These studies show that commercial sex is significant, especially in Kampala, and that the magnitude of commercial sex is on the increase. Moreover, CSWs come from all adult age categories, different religious groups, people of different sexual relationships, and they interact sexually with members of the general population.

The fisheries sector is highly vulnerable to HIV and AIDS; the limited evidence available shows HIV prevalence as much as three times the national average.

Fishing communities are the foundation for an important sector of the national economy. Fisheries contribute over 6% of the GDP and some studies[18] calculate the contribution to be as high as 12%. The fisheries sector is highly vulnerable to HIV and AIDS and the limited surveillance data shows HIV prevalence as much as three times the national average. In Kasenyi (Lake George), 81% of the few people who were able to access HCT services in 2004 were HIV-positive[19]. Recorded AIDS cases up to the end of 2002 showed the highest number of cases in districts situated along the shores of Lake Victoria, i.e., Masaka, Mpigi and Jinja[20]. Furthermore, access to HIV and AIDS services is limited in fishing

[18] Banks, R. (2003) The Uganda Fisheries Authority: Draft Business Plan. MAAIF, March.
[19] Grellier, R. et al (2004) The Impact of HIV/AIDS on Fishing Communities in Uganda: Situation Analysis. DfID, MRAG, Options. October
[20] *Ibid*

communities. A mapping study[21] found that the district of Kalangala (Lake Victoria) consistently scored in the lowest ranges for HIV-related services, including condom distribution, HCT services, STI treatment and PMTCT. Poor roads, low education, few health centres, and little electricity or safe water exacerbate this situation. In addition to these living conditions, the fluctuating livelihoods of fishing communities are not associated with a settled, secure and risk averse existence, which means that HIV is more likely to spread.

Mobile occupational groups, like the military, face frequent or extended family separation, which increases the risk of contracting or spreading HIV infection through risky sex.

In the case of **uniformed services[22]**, military personnel frequently face family separation and deployment away from home, which increase the likelihood of contracting or spreading HIV infection through risky sex. Other factors contributing to risky sex by uniformed service personnel include peer pressure (masculinity issues), binge drinking (masculinity and stress reduction), and cash in the pocket, which is a big factor when assigned to regions of the county affected by chronic conflict and poverty. UNAIDS estimates that military populations generally have HIV and STI prevalence levels up to 2-5 times higher than the civilian populations during peace time[23]. The rates may even be higher in conflict-affected regions. The high prevalence of HIV in military groups is predominantly due to heterosexual transmission; virtually all serving military personnel are within the known sexually active age groups for Uganda. Minimum age of entry in the army is 18 years and the average retirement age is 56 years. Rarely, transmission may happen due to homosexual acts and intravenous drug use. Other mobile occupational groups, such as the mobile labour force that moves with road construction sites, share the same mobility-related risk factors that are associated with uniformed services.

Conflict zones and IDP camps are vulnerable and show higher than national average levels of HIV prevalence.

Conflict affected areas, such as in Northern Uganda, tend to have high HIV prevalence levels. In 2005, the prevalence in the war-affected areas of Northern Uganda stood at 8.3% compared to the national rate of 6.4%[24]. In conflict zones, and perhaps especially in areas chronically affected by conflict, the surrounding populations tend to look at uniformed personnel as having privilege and power, resulting in unbalanced sexual relationships. Having a steady income, albeit small, means that service men and women are often

[21] UAC (2005) National HIV/AIDS Stakeholders and Service Mapping Atlas. UAC, Uganda HIV/AIDS Partnership.

[22] The military community includes regular forces (infantry, air force and marines, police), spouses and children of uniformed men and women, auxiliary forces (home guards, militias, LDUs), civilian communities surrounding areas of operation and encampments

[23] UNAIDS 2003: Developing a Comprehensive HIV/AIDS/STI Programme for Uniformed Services

[24] MoH and ORC Macro (2006) Uganda HIV/AIDS Sero-Behavioural Survey 2004/2005. March. Ministry of Health and ORC Macro

considerably better off than those in the surrounding communities[25]. In these situations, soldiers have often been branded as the ones spreading HIV infection.

Conflict and poverty increase the vulnerability of women and girls to high risk sexual behaviours and relationships.

Meanwhile, **Internally Displaced Persons** (IDPs) and other migratory populations are quite vulnerable to HIV infection. Military conflicts and natural disasters bring together populations with different levels of HIV infection, thereby increasing the potential for new infections. Social protection, health, and other socio-economic structures and services begin to break down as populations are displaced. Uganda has had a significant number of its citizens staying in IDP camps. Conflict-associated displacement and poverty in Uganda have contributed to an escalation of actions that increase vulnerability of women and girls to HIV infection – abductions, rape, school drop out, early marriages, trafficking, and sexual and domestic violence. While the UHSBS shows regional patterns, there have so far been no special surveys conducted to determine the magnitude of HIV infection among Ugandan IDPs and migrant populations.

Risk factors among people with disability are not very different from the general population but their access to services is much more limited.

Little information exists about the burden of HIV among **People with Disability** (PWD) but their vulnerability and risk to HIV infection has been globally recognised. Risk factors among people with disability are not very different from the general population but their access to services is much more limited. For example, although condom knowledge is very high in the general population, 11% of PWD respondents in a recent survey had never heard about condoms[26]. By the latest population census (2002), PWD comprise 3.5% of the total population (838,000). This group presents a big challenge that will require carefully designed interventions. It is also important to note that the dual causality of HIV and disability has not been strategically addressed. While disability increases vulnerability to HIV infection, HIV infection can also cause various kinds of disability.

Orphans and vulnerable children are at higher risk for early initiation of sexual activity.

AIDS has become one of the leading causes of orphanhood in Uganda. Nationally, there are an estimated two million orphans. Many boy and girl orphans are compelled to participate in paid work, or the girls to marry early, and some have to become young heads of households. As a result, **Orphans and vulnerable children** are likely to be at greater risk in various aspects of life including early sexual initiation. Youth who are orphans or vulnerable children are more likely to have sex by age 15 than other youth[27]. Young women

[25] UNAIDS (2003) On the frontline: A review of policies and policies to address AIDS among Peacekeepers and Uniformed services; Page 9-10.
[26] Kanyesigye, J., et al (2007) Promotion of a disability perspective into Uganda's national HIV/AIDS response: Baseline survey report. NUDIPU, February
[27] MoH and ORC Macro (2006) Uganda HIV/AIDS Sero-Behavioural Survey 2004/2005. March. MoH and ORC Macro

classified as orphans and vulnerable children (OVC) are 1.5 times more likely to initiate sex before age 15 than other young women, while young men who are OVCs are 1.1 times as likely.

Discordant couples – A follow-up analysis[28] of Uganda's 2005 sero-survey suggests that up to 65% of new HIV infections are occurring among married people; and discordant couples may comprise up to 50% of these transmissions. These data underscore the vital importance of couple testing and counselling – data suggest[29] that testing and counselling is the most effective strategy available to promote condom use in stable unions. Effective, targeted work with married adults, especially discordant couples and older men, will be needed to reduce transmission within the plan period, and the strategy could give much more attention to this.

Up to two-thirds of new HIV infections are happening among married people, and half of these are happening among discordant couples.

Regional mobility - Uganda is a member country of the Great Lakes Region where there is a long history of conflicts, natural disasters and socio-economic difficulties. These phenomena have caused numerous population movements within and across the region. At times, these movements make it difficult to reach the populations involved with the necessary services since the services have largely been facility based. There are some regional initiatives to target mobile populations, like the Great Lakes Initiative on AIDS, the IGAD region IRAPP project, and the EAC-AMREF Lake Victoria (EALP) HIV and AIDS programme. These programmes are designed to complement national responses of the member countries by targeting the hard to reach. It is planned to create the necessary political environment and systems to maximise the outputs of these initiatives.

Snapshot overview of patterns of HIV and AIDS in Uganda

A snapshot overview of the patterns of HIV and AIDS is shown in Table 3 using selected indicators. This represents a summary view of the key indicators as of 2006.

Table 3: HIV &AIDS indicators as at 2006

HIV/AIDS Indicators	General population
Prevalence of HIV	6.7%
Adults total	6.4%
Adult women	7.3
Adult men	5.2
Children (0-14)	0.7%
Incidence of HIV	132,500 (2005)
Mother-to-child transmission of HIV	25,000 (2005)
AIDS related deaths (cumulative)	900,000
Total number of orphaned children	2,000,000
People on ARV treatment	85,000
Other key indicators	
Birth rate	3.2% (2006)
Life expectancy	48/50 yrs

[28] Mermin, J., et al (2006) HIV incidence among adults in Uganda : a population-based, nationally representative study.

[29] Bunnell, B., et al (2006) HIV transmission risks from HIV-infected persons in Uganda: results of a nationally representative, population-based survey. Draft in press.

1.2.3 Key drivers of the epidemic and sources of new infections

A number of factors, both behavioural and economic, can be considered as 'drivers of the epidemic'. These drivers are important to articulate, as they become critical strategy considerations in combating the epidemic. If these drivers are successfully addressed, the incidence of HIV and AIDS and the prevalence of negative epidemic outcomes will be reduced. Some of key drivers for Uganda are noted below:

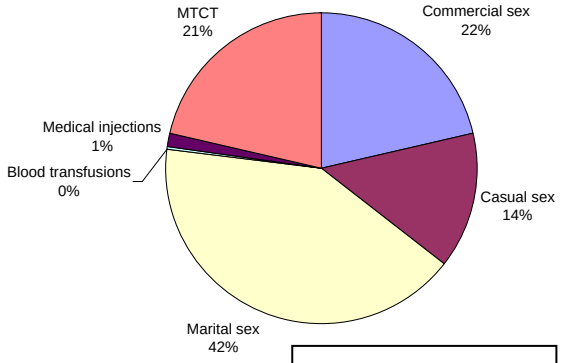
Drivers of the HIV and AIDS epidemic in Uganda are mostly behavioural, socio-cultural, and economic.

- **Individual behaviours influencing risk of sexual transmission:** age at first sex, condom use (inconsistent or incorrect), casual sex, multiple sex partners, extramarital sex; alcohol and drug abuse; health seeking behaviour, especially for STIs.
- **Discordance with partner:** Lack of knowledge of status; poor disclosure.
- **Occupations associated with greater risk of transmission:** CSWs, fishing communities, IDPs, uniformed services, truckers, alcohol brewers and sellers (due to mobility and patterns of sexual behaviour).
- **Economic factors linked with sexual risk:** poverty (transactional sex); OVCs and child-headed households (poverty and risk of transactional sex; early marriage and risk of intergenerational sex)
- **Socio-cultural and other factors influencing relationship risks:** changing role of the family, cultural obligations and practices; age at first marriage, age difference with partner; polygamy; stigma and discrimination; human rights abuses;
- **Gender factors influencing relationship risks:** imbalanced gender relations - domestic and sexual violence, women often unable to negotiate safer sex due to lower status, economic dependence and fear of violence; caretaker roles (women bear the brunt of caring for sick family members); gender aspects of HIV, stigma for STIs in women (especially among the elderly and PWDs) where HIV positive women are more likely to be rejected, expelled from home and denied treatment, care and basic human rights. All of these issues increase women's vulnerability to HIV infection.
- **Medical/biological factors associated with transmission risk:** HSV-type2 is now known as an important driver of the disease (recurrent local ulceration that enhances transmission) in addition to other ulcerative STIs; male circumcision, especially before sexual debut is accepted to be significantly preventive; access to ART and services.
- **Geographic locations associated with greater risk of transmission:** conflict-affected areas such as Northern Uganda and its IDP camps (poverty, exposure to uniformed services, mobility, limited health and HIV services); urban and periurban areas (mobility)
- **Nutrition -** food insecurity and low nutritional status can be a causal factor for HIV infection as well as a consequence.

Proper nutrition improves the immune system and helps delay the progression from HIV to AIDS.

Sources of new HIV infections:
Information about the sources of new infections underpins the strategy imperatives of the NSP. The sources of new infections (see figure 2) suggest that a rethink about priorities is needed compared to past efforts if we are to reduce the incidence of HIV. Sexual transmission accounts for 76% of new HIV infections. HIV transmission is the highest during marital sex (42%), compared with commercial sex workers (22%) and casual sex (14%). This is compelling evidence and is now a critical consideration underpinning prevention strategies. Mother-to-child transmission stands at 21% and it is the other critical target area for intervention. The increased vulnerability of women within the reproductive age group directly increases MTCT. Meanwhile, medical injections account for 1% of new HIV infections. At the heart of the NSP is the aim to prevent new HIV infections, including mother-to-child transmission.

Figure 2 Distribution of new infections by source, 2005



Source: MOH, 2006

1.2.4 Impacts of the epidemic

The impacts of the epidemic on the fabric of life in Uganda are far reaching. There are many people who do not know their status. Only 10-12% of men and women between the ages of 15-49 years have tested for HIV and received the results[30]. At the same time, about 70% of people have expressed the desire to be tested. The cumulative number of AIDS deaths stands at 900,000. The 2002 Population Census found 1,763,300 orphaned children aged 1-17 years in the country. Life expectancy at birth is decreasing, due at least in part to AIDS; current life expectancy considering the impact of AIDS is estimated to be 48/50 years; without AIDS, the projected life span in Uganda would be 55/56 years. There are 105,000 PHAs on ART (which constitutes about 50% of those who need it[31]). This includes 10,500 children (i.e., about 15% of children who need ART).

HIV is responsible for up to 20% of all deaths, and is the leading cause of death in the 15-49 y/o age group.

HIV and AIDS contribute to very high morbidity and mortality rates in Uganda. HIV is responsible for up to 20% of all deaths, and is the leading cause of death in the 15-49 year old age group. AIDS is also the fourth leading cause of under-5

[30] MoH and ORC Macro (2006) Uganda HIV/AIDS Sero-Behavioural Survey 2004/2005. March. MoH and ORC Macro
[31] Based on a CD4 cutoff point of 200.

mortality. Health facilities are overwhelmed by the numbers; 50-70% of medical admissions are HIV related. There has been a resurgence of tuberculosis, and 60-65% of with confirmed TB cases are also HIV infected.

No family has been left untouched. When parents are infected and affected, the girl children often have take up the burden of illness care, leading to a high drop out from school. Early marriages, discrimination, property grabbing and disinheritance are all more common for children in HIV-affected families. There is a growing burden of orphans to be cared for, but the culture of extended family support and fostering by the elderly is being overstretched, so much so that adolescents are sometimes becoming heads of families or being lost to life on the street.

Early marriages, discrimination, property grabbing and disinheritance are all more common for children in HIV-affected families.

AIDS has compromised all of the productive sectors of society – professionals and non-professionals alike. Agricultural growth has been affected by the reduced labour supply due to HIV and AIDS, with negative impacts on overall economic growth and inequality. A sharp increase in the proportion of investors reporting AIDS as a key constraint is indicative of poor growth in the industry and services sectors. Public sector service delivery, household savings and the inter-generational transmission of knowledge are all compromised.

HIV and AIDS also lead to important impacts on human rights including discrimination, stigmatisation and other violations. The sexual and reproductive health and rights of PHAs can be compromised, special needs are created, and service delivery and the economy are burdened. Gender-based human rights violations and HIV-related discrimination aggravate the situation of women and girls, who constitute the majority those currently being infected with HIV.

The above listing of impacts is not exhaustive but does demonstrate the significant negative effects on the quality of life in the country, and further accentuates the urgency and resolve to combat the epidemic.

1.3 NSF Performance Review

1.3.1 Achievements during the NSF (2000/1-2006/7)

Many achievements during the past NSF period are apparent and need to be accentuated and reinforced, for example:

- Improved social support for OVCs (school enrolment has increased due mainly to Universal Primary Education);
- Strong surveillance of the epidemic;
- Improved coordination of the national response;

- Improved funding mobilisation (from just under $40million in 2000/1 to nearly $170million in 2006/7);
- Significant advent of policy frameworks and technical guidelines;
- Improved blood screening countrywide (100% blood units screened and HIV transmission through blood transfusion halved from 2-4% to 1-2%);
- Maintained focus on community mobilisation and participation as the cornerstone of a sustainable national response;
- Scaled-up HCT (HCT + RCT) services nationwide;
- Rapid expansion of PMTCT service delivery sites from 7 pilot sites in 1999/2000 to 334 sites by May 2006;
- Scaled-up ART services (accredited ART sites increased from 48 in 2003 to 220 in 2006).

Despite all of the achievements, there has been no significant decline in the trends of the epidemic in the past five years.

1.3.2 Challenges of the NSF (2000/1-2005/6)

However, despite the achievements, many critical challenges have been noted and deserve serious consideration in the strategy imperatives of the new NSP. Some of these are articulated below:

- Despite all the achievements, there has been only a slight decline in the trends of the epidemic during the NSF time frame (2000/1-2005/6) - Prevalence was 8.1% end of 1999 when NSF was being developed;
- Human resources: chronically inadequate and poor skills base; many more trained staff are needed;
- Financial resources: increased but heavily donor driven through project funding with conditionality and ring-fencing; funding sustainability remains an ongoing concern;
- Infrastructure: physical infrastructure needs refurbishing and equipment replacing; community level social mobilisation left to under-resourced NGOs and CBOs;
- Inequitable access to services: urban more than rural, Northern Uganda disadvantaged due to insecurity, issues of older people and PWD;
- Linkages to and integration of services: many vertical projects - resulting in loss of harmonisation and synergies;
- Supply chain management: inefficient with much stock-outs;
- M&E: under-resourced and under-performing;
- Coordination: difficult but improving at national level; more fragmented at the decentralised level;
- Mainstreaming HIV/AIDS into sectors: little improvement in line Ministries as there is no budget code in the present chart of accounts to support HIV/AIDS activities;
- Women and girls: most affected, least served. Women account for 55-60% of cumulative AIDS cases. Gender mainstreaming inadequate;
- Limited access and uptake of services, for example VCT and ART services.

There has been limited uptake of some key services, e.g., VCT and ART, due in part to inequities in the distribution and access to services.

1.4 Rationale & assumptions for NSP 2007/8-2011/12

The above factors demonstrate the rationale and need for a NSP that essentially shifts gear in the national response to the HIV epidemic, with a greater sense of urgency to rapidly scale up access to HIV/AIDS-related services and mitigate the many debilitating impacts of AIDS.

The NSP has been newly designed to address the current and predicted patterns of an evolving epidemic and its emerging challenges.

The new NSP was developed based on the key challenges that emerged from the performance evaluation of the NSF 2000/1-2005/6, and the recent National Sero-behaviour survey 2004/5, which showed no decline in the trend of the epidemic during the NSF time frame (2000/1-2005/6). Greater effort is needed to achieve universal access (scale up) and new strategies are required to reduce new infections and to respond to the new sources of infections.

The NSP speaks to new challenges that are substantially different from the older plan. Meanwhile, many of the imperatives of the older plan are still retained and emphasised. In addition, a number of assumptions are made that legitimise the need for new strategy imperatives and define key enablers to the success of the NSP. The assumptions include the following:

- NSP developed within the context of Uganda's Vision 2025 and the Poverty Eradication Action Plan (PEAP);
- Increased and sustained funding;
- Reinvigorated and sustained political commitments at all levels;
- Strengthened commitment to the "3-Ones" Principle (One National Plan, One Coordinating Authority, One M&E Plan);
- Continued multisectoral, multidimensional, and multilevel national response: the multisectoral approach was the main mechanism for achieving the previous decline in HIV prevalence and mitigating the impact of the disease. This must continue, and mainstreaming of HIV/AIDS in all sectors must be evident together with meaningful assistance for coordinating a decentralised NSP at the district level;
- Increased and sustained funding and technical assistance with improved alignment among the AIDS Development Partners (ADPs) and other funding sources. The assistance from ADPs has been commendable and helped to ensure Uganda's leadership in fighting the epidemic. ADPs should maintain faith in Uganda's ability to deliver on the NSP by continuing to provide increasing financial and technical support;
- Increased internal resource mobilisation including GoU budgetary support: about 90% of the funding for the NSF is provided by ADPs. This is not sustainable in the long term. All efforts must be made to generate increasing funding levels during the NSP period from the private sector and especially from the GoU budgetary support. The GoU budgetary support should be additional and not merely a reallocation of, or redistribution from existing portfolios;

We can now foresee the need for a long-term response to HIV and AIDS well beyond the duration of this NSP and current partner commitments; it will be crucial to increase internal resource mobilisation to improve national HIV and AIDS response sustainability.

- The health infrastructure will be strengthened and expanded to support the expected increased demand for services and access to these services;
- The community infrastructure will be strengthened and expanded to support the expected increased demand for services and access to these services;
- HIV/AIDS research will be supported to improve the efficiency, effectiveness and relevance of NSP interventions;
- Monitoring and evaluation systems will be in place to effectively monitor programme outcomes and track resources.

1.5 Guiding principles in developing the NSP

The conceptualisation of the NSP has been driven by a number of guiding principles that are summarised below:

- Personal responsibility: every person in Uganda has a responsibility to protect themselves and others from HIV infection, to know their HIV status and to seek appropriate care and support;
- Advancement of best practice, especially the ABC+, the multisectoral response, and effective partnership at all levels;
- Evidence based planning and implementation: the choice of interventions outlined in the NSP shall, where feasible, be evidence based;
- Adherence to the "Three Ones" by all stakeholders;
- Observation of HIV-related international treaty obligations; and
- Effective mutual integration and mainstreaming of HIV/AIDS in all SRH interventions and SRH in HIV/AIDS interventions.

The NSP is committed to being 'strategic' in advancing best practices based on current and emerging evidence, including increased emphasis on the ABC+ approach.

Section 2: Strategy framework

2.1 Introduction

This section will introduce the overall strategy framework, which includes the aim, vision, objectives and strategic actions of the four thematic areas - three service areas and the systems strengthening area. Each objective is supported by strategic actions.

2.2 Aim of the NSP

In 2006, UNAIDS called on all nations to scale-up interventions to ensure Universal Access to HIV and AIDS Prevention, Care, and Support by 2010. Uganda is committed to this call. In the NSP 2007/8-2011/12, Uganda demonstrates commitment towards universal access for three priority service areas - prevention, care and treatment, and social support**.** Thus, it is planned to reduce new HIV infection by 40%, to scale up and reach 80% of those in need of care and treatment, and to expand social support to 54% by the year 2012.

The NSP is committed to moving toward universal access to three priority service areas – prevention, care and treatment, and social support.

2.2.1 Vision

The vision of **a population free of HIV and its effects** has been maintained.

2.2.2 Overall goal

To achieve universal access targets for HIV/AIDS prevention, care, treatment and social support by 2012.

2.2.3 Specific goals

Goal 1: To reduce the incidence rate of HIV by 40% by the year 2012.

Goal 2: To improve the quality of life of PHAs by mitigating the health effects of HIV/AIDS by 2012.

Goal 3: To mitigate the *social, cultural and economic effects of HIV and AIDS at individual, household and community levels.*

Goal 4: To build an effective support system that ensures quality, equitable and timely service delivery.

2.3 Policy and legal framework

The overall goal of the NSP is supported by an enabling policy environment that includes important HIV/AIDS policies and guidelines such as HCT, ART, OVC, condom policy and strategy, PMTCT guidelines, HIV/AIDS and the World of Work. These policies and guidelines have been instrumental in the success of the national HIV/AIDS response for which Uganda has been internationally applauded. The Draft Overarching HIV/AIDS Policy is currently before Cabinet. This policy will address the multisectoral nature of the response by bringing together all sectoral HIV/AIDS policies into one document. Other existing policies that influence HIV/AIDS include the National Health Policy, Local Government Act, the Plan for the Modernization of Agriculture; and Universal Primary Education. Uganda's Poverty Eradication Action Plan (PEAP) is the blueprint for national development. The PEAP identifies HIV/AIDS as a crosscutting issue and mandates all public institutions to factor HIV/AIDS into their development plans.

The NSP is enabled by a supportive national policy environment with many important HIV and AIDS-related policies and guidelines.

The NSP is also responsive to international and regional HIV and Rights agreements (see box). These international agreements are crucial because they inform the work of development actors, help set common standards, sensitise stakeholders on their role as duty-bearers, and respond to the obligation to promote, assist, protect, and fulfil human rights. 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.

Uganda's commitment to international agreements

A. International and regional human rights instruments to which Uganda is signatory:

- 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

B. UN declarations and programmes of action that Uganda has endorsed:

- 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

2.4 Thematic service areas of the NSP

The NSP has three thematic service areas[32], each with specific objectives and strategic actions. This section outlines each of the thematic service areas, which include the following: Prevention; Care and treatment; and Social Support.

[32] See also 'strengthening systems to deliver services' in Section 3 below.

2.4.1 Thematic service area: Prevention

The HIV epidemic in Uganda has 'matured' and now has different risk factors and affects different groups, e.g., HIV-discordant married couples.

Implementing an effective HIV prevention programme requires information about the factors driving the HIV epidemic in the country. The HIV epidemic in Uganda has progressed from a concentrated epidemic in high-risk groups, to a generalised and mature epidemic. Accordingly, the risk factors for HIV infection have also changed. In changing epidemics, the population-attributable risk of behavioural and biological factors varies with the stage of the epidemic. For instance, in mature epidemics, substantial transmission occurs among HIV-discordant married couples – who may not be helped by the earlier HIV preventive interventions that focussed on reducing risks among young unmarried people.

There is need for focussed and evidence-based HIV prevention programmes to effectively address the changing national HIV transmission dynamics.

Uganda fits this latter pattern - evidence from the UHSBS shows an increased HIV incidence among large groups of people who are not the focus of current prevention programmes and for whom data is limited, such as married couples and people in their mid-adult years. In the UHSBS, 77% of the HIV infections occurring in adult men and 58% of those in adult women happened among persons older than 30 years of age[33]. Furthermore, it now appears that up to 65% of all new infections are occurring among married people, and 77% among persons older than 25 years of age[34].

In light of these findings, there is a need for focussed and evidence-based HIV prevention programmes that address changing national HIV transmission dynamics. A more in-depth analysis of the Uganda HIV Sero-Behavioural survey has recently highlighted the factors that may be currently driving the Uganda HIV epidemic[35].

The NSP has prioritised evidence-based HIV prevention programmes that will cost-effectively address the trends in the epidemic.

Drawing from the UHSBS and other studies, modelling has been carried out for different funding and intervention scenarios, allowing NSP planners to review the projected effects and costs of various combinations. As mentioned earlier in this chapter, the stakeholders have decided to prioritise cost-effective HIV prevention and high funding. The long term (10 years or more) benefits of choosing the HIV preventive cost-effective model include: fewer new infections, fewer children made vulnerable due to parental HIV infection, fewer people needing ART and opportunistic infection treatment, and fewer AIDS-related deaths occurring in the future. Results from the modelling exercise reveal, for

[33] MoH and ORC Macro (2006) Uganda HIV/AIDS Sero-Behavioural Survey 2004/2005. March. MoH and ORC Macro

[34] Mermin, J., et al (2006) HIV incidence among adults in Uganda : a population-based, nationally representative study.

[35] Many papers based on the secondary analysis are in preparation; they will highlight independent risk factors for HIV/STI infection in Uganda. See also the list of drivers of the epidemic in section 1.2.3 of the previous chapter in this NSP.

example, that the incidence rate of new HIV infections can be reduced by 40% with male circumcision as one of the cost-effective HIV preventive interventions, compared with a decrease of 25% without male circumcision.

The goal of the Prevention thematic service area is:

Goal 1: To reduce the incidence rate of HIV by 40%[36] by the year 2012

Priority areas associated with prevention include:

- Accelerating prevention of sexual transmission of HIV targeting vulnerable and most at risk populations;
- Promotion and scale-up of PMTCT;
- Ensuring blood transfusion safety, universal precautions and PEP;
- Controlling sexually transmitted infections;
- Developing appropriate policies and programmatic guidelines for implementation of new HIV preventive technologies proven to be effective.

One of the key targets is to substantially reduce the rate of new infections – the NSP aims to decrease incidence by 40% over the coming five years.

The prevention goal of reducing the incidence of HIV and AIDS has five associated objectives. These are summarised below along with their specific strategic actions. (For indicators and targets, see ANNEX 1: Results table)

Objective 1: *To accelerate the prevention of sexual transmission of HIV through established as well as new and innovative strategies.*

Strategic actions:

- Promote ABC - Abstinence, and for those who are sexually active, promoting safer sex, especially Being faithful (fidelity) and use of the male and female Condoms;
- Develop and implement strategies for prevention interventions targeting key population groups at higher risk[37] and interventions for the general population;
- Ensure that all the youth in and out of school access life skills that integrate HIV prevention;
- Empower service providers with appropriate communication skills and facilities to handle vulnerable and marginalised target groups such as PWDs;
- Develop and implement effective IEC interventions for reduction of high-risk sex among all groups, especially the key risky behaviours, including: sex with non-marital, non-

[36] At current incidence rates, by 2012 there will be an estimated 163,000 new infections. Reducing this by 25% would bring the level down to 122,290 new infections, close to today's level of 135,000, which would mean that the burden of those needing ART and social support would continue to rise. A 40% incidence reduction by 2012 would bring new HIV infections down to below 100,000 per year – well below today's rate and thus enabling the NSP to get ahead of the epidemic. Benefits of a 40% incidence reduction – fewer new cases, less need for ART, and less social support burden – extend well into 2030 and far outweigh those possible with a 25% incidence reduction.

[37] Key population groups at higher risk include: CSW and their clients, the military (uniform services), people engaging in transactional sex, truckers, fishermen, people who use condoms inconsistently, people engaging in multiple sexual relations, and people engaging in extramarital sexual relations.

In order to reach groups at most risk and the general public, the NSP urges the use of all social, religious, economic, cultural, and health institutions for delivering HIV prevention and advocacy services.

cohabiting partners; unprotected sex, sex with partners of unknown HIV status; cross-generational sex; transactional sex, and early sex;
- Reduce HIV transmission among discordant couples and married people by couple counselling, testing and disclosure;
- Promote abstinence among youths in and out of school;
- Focus prevention on key population groups at higher risk by addressing socio-economic and cultural factors and promoting prevention among PHAs;
- Improve the relevant legislative and policy framework to promote the support of populations at higher risk and criminalising the deliberate transmission of HIV and AIDS;
- Utilise all social, religious, health, economic, and cultural institutions for delivery of HIV prevention messages and advocacy services, e.g., food distribution points[38];
- Prevention interventions for the groups of women and children at higher risk in conflict areas, including work with the uniformed services, and using IEC and HCT support;
- Focus prevention on fishing communities through HCT support.

Objective 2: To reduce the HIV transmission from mother-to-child by 50% by 2012

Strategic actions:

In response to limited PMTCT uptake, the NSP calls for exploring innovative approaches to increase the administration and uptake of PMTCT services.

- Integrate SRH services, especially family planning and HIV/AIDS service delivery targeting both women and men;
- Roll out PMTCT programme to all HC-IIIs;
- Explore innovative approaches to increase the administration and uptake of PMTCT services including Nevirapine or other ART combination prophylaxis and developing a home-based PMTCT program;
- Link mothers, fathers and babies to other prevention, care and treatment services;
- Enhance targeted communication for PMTCT highlighting roles and benefits to girls, pregnant women and their partners, parents and communities as well as facilitating engagement of male partners to provide appropriate support;
- Strengthen integration of food and nutrition support in PMTCT and maternal and child health programmes.

Objective 3: To maintain 100% blood transfusion safety, ensure 100% adherence to universal precautions and promote 100% access to PEP at ART centres by 2012

Strategic actions:

- Increase access to safe blood in health care facilities through the following:
- Ensure availability of rigorously screened blood under appropriate quality control in all health facilities (public and private) out to HC-IV level;

[38] A food distribution point includes all locations where food aid is distributed to individual affected by HIV and AIDS.

- Provide counselling for blood donors and link them to HCT uptake and comprehensive HIV awareness;
- Increase coverage of universal precautions in health and community care settings;
- Reduce blood waste through improving selection of HIV-free blood donors.

Objective 4: To control sexually transmitted infections, increasing appropriate uptake to 70% by 2012

Strategic actions:

- Review technical guidelines for effective management of STIs to include HSV2;
- Strengthen capacity of health facilities for improved diagnosis and treatment of STIs;
- Provide commodities and social services for STI case management in health facilities;
- Integrate HCT into management of STI patients;
- Provide targeted services for key populations at higher risk;
- Explore and pilot innovative approaches[39] to containing emerging STIs, e.g., HSV-2.

The NSP calls for continued exploration, piloting and documenting of innovative approaches to address the drivers of the epidemic, e.g., for the prevention and management of HSV-2 infections.

Objective 5: To promote use of new HIV prevention technologies and approaches proven to be effective.

Strategic actions:

- Facilitate policy and guideline formulation on male circumcision (as part of a comprehensive prevention package)[40];
- Facilitate development of policies and guidelines on new preventive technologies and approaches.

The NSP will facilitate the process of developing new policies and guidelines when evidence supports the use of new technologies, e.g., male circumcision.

2.4.2 Thematic service area: Care and Treatment

Antiretroviral therapy (ART) has been rapidly scaled up over the last NSF period to reach 85,000 patients on treatment by 2005 – far in excess of the WHO target of 60,000 by 2005. The number of ART sites accredited by the MoH has increased from 48 to 220 over the past three years. Increased funding, falling prices of antiretroviral drugs (ARVs) and improved laboratory services have enabled more people to access treatment. However, these efforts have been outstripped by the rapidly rising demand for care; current numbers covered would represent 70% of those eligible for care three years ago but only 42% of those in need today. The increasing demand for ART, which is largely due to new infections, disease progression and population increase, needs to be addressed if the current achievements are to be sustained.

[39] Innovative approaches for HVS-2 are routine screening, suppressive therapy, and vaccine development

[40] The Kenya and Uganda trials replicated the landmark findings of the South African Orange Farm study, the first randomised controlled trials to report a greater than 50% protective benefit of male circumcision.

Expanding the number of people on ART to reach 240,000 by 2011/12 would avert 140,000 AIDS deaths during the NSP period, i.e., 43% of those that would otherwise occur.

Expanding the number of people on ART from 91,500 at the end of December 2006 to 240,000 by 2011/12 would avert 140,000 AIDS deaths during the NSP period, i.e., 43% of those that would otherwise occur. If ART coverage does not continue to expand, the number of AIDS deaths may rise again in the future. However, an expansion of ART and PMTCT would result in a continued downward trend in AIDS deaths at least for the next several years. Meanwhile, the integration of PMTCT and treatment services remains limited – the majority of ART-eligible mothers only receive prophylaxis to prevent infections in their infants and do not get treatment for their own HIV infection.

The ART National Policy Guidelines are in place and are currently being updated. Implementation of post-exposure prophylaxis is still limited but a policy is also underway. There is, however, a growing need for coordination, infrastructure (space, laboratory, logistics management, monitoring and evaluation systems) and other quality improvements, including adherence support and resistance monitoring, as many individuals continue to take ARVs for prolonged periods. The sustainability and continuous availability of lifelong ARVs for those on treatment remain major concerns since most ART programmes are externally funded.

The care and treatment goal articulated below proposes to increase access to ART and expand a range of related services, including HIV counselling and testing, prevention and treatment of opportunistic infections, palliative care, home based care, and improved nutritional support.

The goal of the Care and Treatment thematic service area is:

A second goal of the NSP is to improve the quality of life of PHAs over the coming five years by mitigating the many health effects of HIV and AIDS.

Goal 2: To improve the quality of life of PHAs by mitigating the health effects of HIV/AIDS by 2012

Priority areas associated with this goal include:

- Increase equitable access to Anti-Retroviral Treatment;
- Scale-up HIV Counselling and Testing (HCT);
- Increase access to prevention and treatment of opportunistic infections including TB;
- Integrate prevention into care including nutrition counselling and education;
- Support and expand Home Based Care (HBC), palliative care and improve referral systems between HBC and health facilities.

This thematic area has five objectives, as outlined below.

Objective 6: To increase equitable access to ART by those in need to reach 240,000 by 2012

Strategic actions:

- Promote health care seeking behaviour among males;

- Scale up access and uptake for ART services among those in need, especially women of all age groups where the highest incidence of HIV and AIDS is reflected;
- Promote and expand specialised paediatric and adolescent HIV care;
- Strengthen laboratory and infrastructure at all service levels;
- Strengthen logistics management;
- Strengthen M&E for ART services (for quality, efficiency and effectiveness);
- Provide for increased coverage of ART treatment to mothers receiving PMTCT.

The NSP urges scaling up access and uptake for ART services among those in need, especially for women of all age groups as they are having the highest incidence of HIV and AIDS.

Objective 7: To increase access to prevention and treatment of opportunistic infections, including TB

Strategic actions:

- Promote universal access to the basic care package;
- Scale up integrated TB and HIV services;
- Support and expand provision of palliative care;
- Support expansion of programmes and use of alternative, complementary and traditional medicine;
- Use innovative approaches to promote care-seeking behaviour;
- Integrate HIV and AIDS services and sexual and reproductive health;
- Ensure availability of commodities for opportunistic infection diagnosis, prevention and treatment including basic HIV care package, especially targeting women and girls

Objective 8: To scale up HIV counselling and testing to facilitate universal access

Strategic actions:

- Strengthen capacity for HCT training by increasing the number of trainers and accredited training institutions;
- Scale up RCT, HCT, and HBCT[41];
- Strengthen the management of logistics systems;
- Scale up HCT support to sero-discordant couples;
- Ensure availability of trained counsellors throughout the health care systems[42];
- Enhance coordination support, supervision and quality assurance of HCT[43].

The NSP encourages the development and application of innovative approaches to address gaps in care-seeking behaviour.

Objective 9: To integrate prevention into all care and treatment services by 2012

Strategic actions:

- Promote positive living and empower PHA networks to lead prevention of HIV transmission;
- Empower care providers and communities to provide care and support for Prevention with Positives (PWP) to reduce stigma and discrimination;

[41] Crosscutting with prevention
[42] Crosscutting and links Care and Treatment with the Social Support thematic area
[43] Crosscutting with Prevention

- Ensure availability of prevention and reproductive health services and supplies[44] including family planning services and supplies at HIV/AIDS care and treatment service delivery points;
- Ensure availability of innovative IEC approaches for prevention and care[45];
- Provide comprehensive training on HIV prevention, care and treatment (including PEP) to health care providers;
- Integrate family planning counselling into all phases of HIV care and treatment, including pre-test and post-test counselling and follow-up care.

The NSP advocates for the horizontal integration of HIV & reproductive health services, ensuring that HIV prevention, HIV care and treatment and family planning are all available at the same time to the same clients.

Objective 10: To support and expand the provision of home based care and strengthen referral systems to other health facilities and complementary services

Strategic actions:

- Ensure supportive home based care policy is in place;
- Ensure rehabilitation services are strengthened to manage HIV/AIDS complications;
- Facilitate and empower existing community structures, e.g., PHA networks to provide ART adherence support;
- Strengthen HBC programmes and an effective system for monitoring and support tracking of patients on ART;
- Specific action is needed to promote sexual and reproductive health among adolescents and to address the sexual and reproductive health needs of adolescent PHAs, as they are especially vulnerable.

2.4.3 Thematic service area: Social Support

The impact of HIV/AIDS has affected all realms of social life. Discrimination on the basis of sero status sets in motion a string of human rights violations and calls for legal protection. Persons affected by HIV especially orphans and widows are largely powerless and vulnerable to many kinds of rights abuse. PHAs, those affected by HIV and AIDS, and those in situations that place them at risk of HIV require legal protection as part of their social support.

Inequities in health are rooted in social and political stratification and the nature of social power relations. Promotion of health equity is not so much about equalising health outcomes. Rather, a rights based approach is advocated, where the underlying social conditions affecting health are improved by addressing: a) actual and potential disadvantages that lead to risks and vulnerabilities within

[44] Prevention services including Prevention with Positives (PWP) are crosscutting themes with Care and Treatment. Sexual intercourse is a common denominator between pregnancy and HIV infection. It is therefore important that Reproductive Health and family planning services and supplies are made available at HIV/AIDS care and treatment service delivery points

[45] IEC material should be accessible and in alternative formats, e.g., Braille for the visually impaired, and should be packaged for young HIV+ females before they become pregnant. Young HIV positive females should have access to SRH and family planning services.

affected populations; b) gaps in access to health services and; c) health differentials across the whole range of social and economic positions. The focus is on social systems that shape people's chances to be healthy and the enabling factors that enhance healthy living and deepen the impacts of support services when people are affected by illnesses[46]. This service area also acknowledges the interrelatedness of economic stability and the emotional and physical well-being of individuals.

The NSP social support theme will focus on social systems that affect people's chances to be healthy and ways to enhance the impact of support services.

The key areas of social support include: addressing the legal and political environment; provision of social rights including education; counselling and psychosocial support; food security and social protection initiatives for key populations at higher risk. The vulnerable populations include: PHAs, OVCs, PWDs, the elderly, youth, women, IDPs, and rural and urban poor communities. There is also a focus on environmental security and promoting community participation in improving appropriate support for positive living and better quality of life. (For indicators and targets, see ANNEX 1: Results table)

The goal of the thematic service area: Social Support is:

Goal 3: To mitigate social, cultural and economic effects of HIV and AIDS at individual, household and community levels

The third goal of the NSP is to show positive change in how the social, cultural and economic effects of HIV and AIDS are coped with at individual, household and community levels.

The priority areas associated with the goal include:

- Provide psychosocial support to PHAs, OVC, and other disadvantaged groups, specifically targeting women and girls;
- Provision of formal and informal education, vocational and life skills development for OVC, PHAs, IDPs, PWD and other disadvantaged groups;
- Ensure sustainable community and household livelihood and economic empowerment;
- Ensure access to services that meet basic social needs of PHAs, OVC, PWD, IDPs, women, girls and other disadvantaged groups affected by HIV and AIDS;
- Ensure legal and appropriate social and community safety nets to benefit PHA households, OVCs, women, girls and other disadvantaged groups affected by HIV and AIDS;
- Ensure there is sensitisation and awareness creation on human rights and protection mechanisms;
- Ensure provision of the non-tuition costs and essential requirements to OVCs in formal education.

The objectives of the social support goal are outlined below.

Objective 11: To provide complementary support, including nutrition, to PHAs

Strategic actions:

[46] Diderichsen et al., 2001 (check background paper on social support)

The NSP urges stakeholders and implementers to be sensitive to gender equity in supporting interventions that reduce insecurity and vulnerability, including nutritional gaps, for persons affected by HIV/AIDS.

- Disseminate national food and nutrition policies/guidelines for PHAs and establish mechanisms for their implementation at national and local government levels;
- Strengthen mechanisms that promote sustainable food and nutrition security to the households and communities made vulnerable by HIV and AIDS;
- Enforce appropriate food and nutrition security by-laws at local government level to mitigate the impact of HIV and AIDS on households;
- Enhance gender equity and support interventions that reduce food insecurity and nutrition vulnerability of women and children affected by HIV/AIDS;
- Strengthen collaboration among stakeholders involved in the promotion of food and nutrition security for PHAs and OVCs at all levels.

Objective 12: To increase provision of quality psychosocial support to PHAs, OVCs, PWDs and other disadvantaged groups affected by HIV and AIDS by 2012

Strategic actions:

- Document existing psychosocial support mechanism with a view of identifying gaps;
- Provide appropriate policy recommendations and guidelines;
- Integrate SRHS and rehabilitation services into the psychosocial support package;
- Empower psychosocial support services providers including communities, institutions and peer groups to deliver quality services.

Objective 13: To promote and support sustained formal and informal education, vocational and life skills development for OVC, PHAs, IDPs, PWDs and other disadvantaged groups affected by HIV and AIDS

Strategic actions:

- Ensure provision of the non-tuition costs and essential requirements to OVCs in formal education;
- Empower service providers with appropriate communication skills and facilities to handle vulnerable target groups such as PWD;
- Ensure that all youth access life skills that integrate HIV/AIDS prevention;
- Facilitate increased access to vocational education and apprentice opportunities[47];
- Advocate for affirmative action for OVCs, girl children, PWD and other disadvantaged groups to improve their access to informal education, vocational opportunities and life skills development.

Strengthening traditional coping mechanisms can help to enhance sustainable livelihoods of HIV-affected households.

Objective 14: To enhance economic empowerment and livelihoods of HIV/AIDS affected communities and households

[47] Increase access, e.g., through sponsorships, scholarships, fee waivers, and work placement programmes.

Strategic actions:

- Promote good practices in design and implementation of income generation activities for various beneficiaries;
- Support income-generating programmes for affected families and communities including elderly caregivers;
- Strengthen traditional coping mechanisms to enhance sustainable livelihoods[48] of affected households;
- Integrate SRH services in economic empowerment activities.

Objective 15: Increase access to basic entitlements for PHAs and OVCs

Strategic actions:

- Promote and support food and nutrition security interventions among households and communities affected by HIV and AIDS;
- Operationalise national food and nutritional policies/guidelines to local governments, communities and PHA households;
- Facilitate the provision of financial and essential material support to PHA, OVC, and other disadvantaged households affected by HIV and AIDS.

Objective 16: To ensure legal and appropriate social and community safety nets for PHAs, OVCs and other persons made vulnerable by HIV and AIDS

Strategic actions:

- Identify gaps and develop appropriate policies and laws to protect and promote the rights of PHAs, OVCs, caretakers and their households;
- Promote the implementation of HIV/AIDS workplace policy;
- Advocate for appropriate social safety nets that benefit PHAs, OVCs and vulnerable households;
- Advocate for ratification and implementation of policies that ensure legal and ethical rights for PHAs and HIV/AIDS affected persons.

The NSP advocates for ratification and implementation of policies that ensure legal and ethical rights for PHAs and HIV/AIDS affected persons.

[48] Target financial and material assistance to extended family; parents caring for their sick children and grandparents supporting OVC; refer or link them to other services

Section 3: Systems & national response

3.1 Introduction

The NSP acknowledges the importance of the systems that individually and collectively play crucial roles in ensuring the relevance, efficiency, and effectiveness of the key thematic service areas.

The successful implementation of the NSP depends on a number of key support services and systems. The group of key systems that can strengthen the delivery of services for people infected or affected by the HIV/AIDS epidemic in Uganda are targeted as a critical component of the NSP. These systems include institutional arrangements and human resources, infrastructure, research and development, resource mobilisation and management, and monitoring and evaluation. These systems individually and collectively play crucial roles in ensuring the relevance, efficiency, and effectiveness of the key thematic service areas described above. They are also critical to the accountability and responsibility of government and its partners to deliver on the imperatives of the NSP. The M&E system, in particular, plays a vital role in measuring and documenting progress towards achieving the desired results and impacts of the NSP.

This section presents the existing support systems, and how they will be strengthened to deliver services.

The fourth goal of the NSP is to build effective systems that ensure the quality, equity, and timeliness of HIV services reaching their intended targets.

Goal 4: To build an effective system that ensures quality, equitable and timely service delivery

The key priority areas associated with the goal include the following:

- Ensure effective governance and management capacity of various institutional structures, with clearly defined roles, functions and linkages;
- Ensure necessary infrastructure is in place to enable equitable and timely delivery of services;
- Ensure effective procurement and logistics management;
- Ensure the effective mobilisation, utilisation and management of human and financial resources;
- Ensure evidence based programming and policy development.

3.2 Institutional arrangements

Institutional arrangements are of special importance for effective operationalisation, coordination and management of the NSP. Institutional arrangements are divided into two: coordination and implementation. This section of the NSP will concentrate on coordination[49]. The three key elements in the coordination of the national response framework are the

[49] Institutional arrangements for implementation will be detailed in the operational guidelines that will part of the NSP related documents still in development.

Uganda AIDS Commission (UAC), the HIV and AIDS Partnership and the Local Government Coordination structures. These structures are aligned with the 'Three Ones' principle: one coordinating body, one agreed plan of action and one monitoring and evaluation plan.

Uganda's multisectoral approach to addressing HIV and AIDS has been crucial to the success of national efforts. The efficacy of multisectoral responses to HIV and AIDS is affected by the quality of the political structure and technical framework for coordination between key stakeholders at the central and local government levels. In the previous NSF (2000-2006), the UAC was able to strengthen major institutional components for the HIV/AIDS response, particularly at the national level. This provided an effective framework for coordination and advocacy and further reinforced the multi-sectoral approach, which is central to the national response to HIV/AIDS. At local government level, a coordination mechanism was established based on existing local government structures; however, coordination bodies remain non-operational in over half of all the districts in the country. The decentralised level has been challenged by a general lack of capacity and of clear linkages among coordination structures to effectively carry out major functions of planning, implementing, coordinating, monitoring and evaluation of HIV/AIDS activities.

The success of the NSP is dependent on partnerships with many groups, including PHAs, civil society organisations, development partners, private sector, all spheres of government; and the people of Uganda.

The success of the NSP is dependent on partnerships including PHAs, civil society organisations, development partners, private sector, all spheres of government, and the people of Uganda. There is a need to galvanise the structures and resources and orchestrate and strengthen collaboration and coordination among partners. Furthermore, the decentralisation of the response to HIV and AIDS is critical, accentuating the importance of the coordination role of the UAC to ensure that local government level structures such as District AIDS Committees (DACs) and District AIDS Focal Point offices are adequately resourced, fully functional and achieve sustained collaboration between local government and non-governmental stakeholders.

Uganda AIDS Commission

The Uganda AIDS Commission (UAC) was established as a corporate body[50] for the prevention and control of the AIDS epidemic. The UAC has a Board of Commissioners[51] and a secretariat with a Director General (presidential appointee) as the chief executive and accounting officer; a senior

[50] By Statute No. 2 of 1992

[51] The ten Commissioners are appointed by the President and the Chairperson's role is a full-time position tasked with the responsibility of supervising the Director General.

management team of three directors, and technical and support staff. The secretariat has to ensure implementation of the decisions and programmes of the UAC and advise government on all matters pertaining to the UAC's objectives.

The NSP facilitates the key role of the UAC in planning & coordination of all AIDS policies & programmes.

The key functions of the UAC are planning and coordination of all AIDS control policies and programmes within the overall programme strategy; identifying obstacles to the implementation of AIDS control policies and programmes; ensuring the implementation and attainment of programme activities and targets; mobilising, expediting, and monitoring resources for the AIDS Control Programme activities; and disseminating information on the AIDS epidemic and its consequences in Uganda.

HIV and AIDS Partnership

The UAC established the multi-sectoral HIV/AIDS Partnership in 2002 to provide an opportunity for all stakeholders to participate in the coordination of the national response. The UAC provides the secretariat for the HIV/AIDS Partnership. The coordination structures of the Partnership include:

The multisectoral HIV/AIDS Partnership provides an opportunity for all stakeholders to participate in the coordination of the national response.

- **Self-Coordinating Entities** – a set of separate HIV/AIDS-related constituencies that meet independently as well as participating in the Partnership Forum and having representation on the Partnership Committee. As of late 2006, the following groups comprised the SCEs: decentralised levels of government; FBOs; government ministries; international NGOs; media, arts and culture; national NGOs; networks of people living with HIV/AIDS; Parliament; private sector organisations; research institutions and academia; United Nations and bilateral development group; and young people.
- **HIV/AIDS Partnership Committee** – Steering Committee for NSP; meets monthly; includes representation of Ministries/Sectors, Self-Coordinating Entities, and donor partners; works through sub-committees and technical working groups such as M&E, Information and Advocacy, Prevention and Resources Management.
- **HIV/AIDS Partnership Forum** – meets annually; includes government officials, all members of SCEs; provides an opportunity for wider representation from all constituencies to review the response and agree on annual priorities.
- **HIV/AIDS Partnership Fund** - a jointly managed fund covering coordination costs of the Uganda HIV/AIDS Partnership and assisting the UAC in coordinating the national multisectoral response; supported by the AIDS Development Partners.

The purpose of these structures is to provide representative coordination fora for all stakeholders in the national HIV/AIDS response to enhance and facilitate the coordination task of UAC. Through these structures, stakeholders play an advisory role in policy and programme development and service delivery at the various levels to the UAC. The UAC maintains an oversight role in the implementation of agreed national priorities. These structures are also important in pooling resources and creating linkages that enhance the HIV/AIDS strategic information flow within and amongst partners in the response at national and district levels.

Government adopted an institutionalised coordination mechanism for managing HIV and AIDS at the Local Government level, involving both technical and political leaders.

Local Government Structures

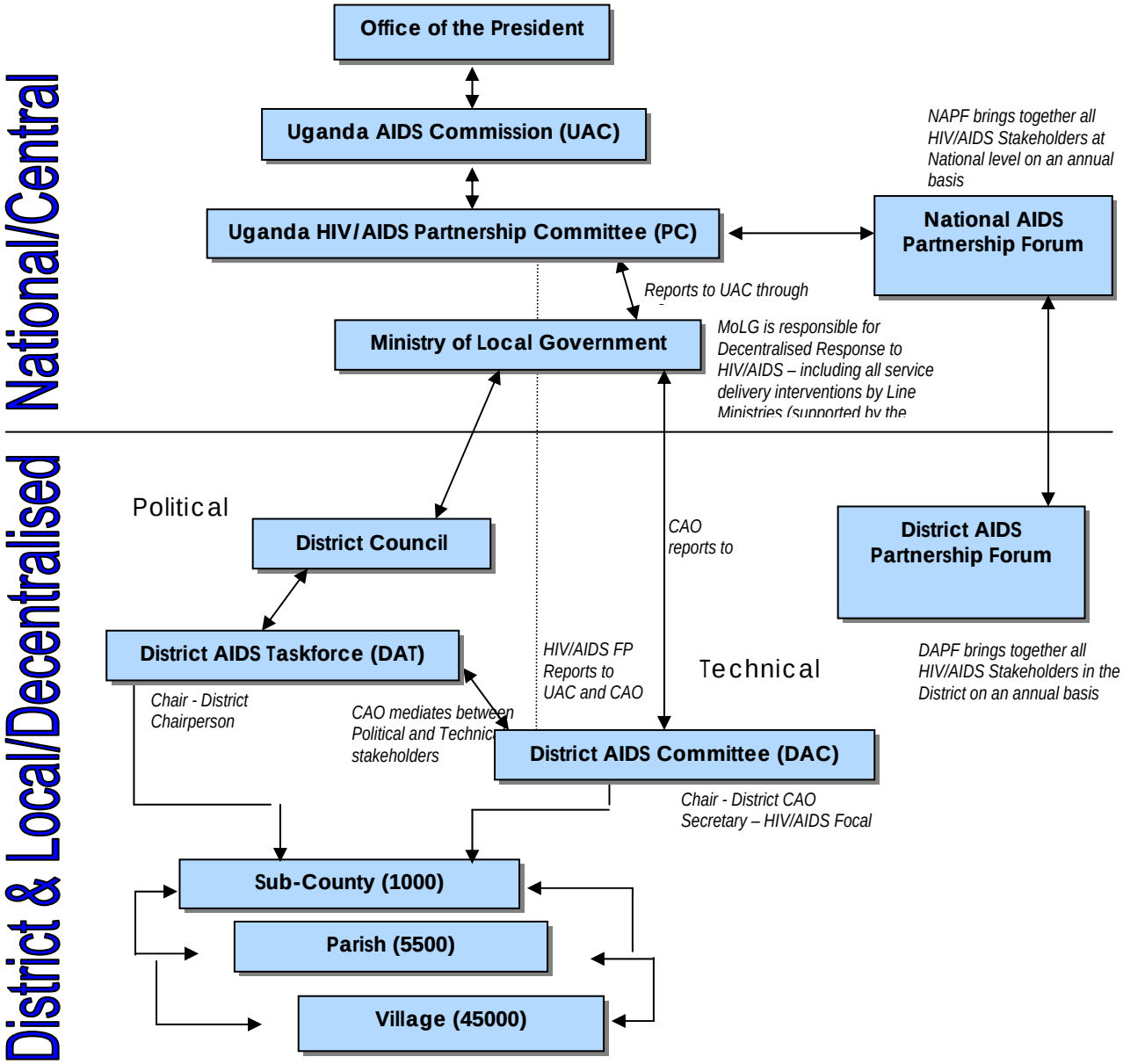
The constitution of the Republic of Uganda 1995 provides for a decentralised system of guidance and service delivery based on the district local government and lower local councils. The second schedule of the Local Government Act 1997 mandates local governments to directly manage and monitor delivery of services, including those for HIV and AIDS, within their areas of jurisdiction.

Government adopted an institutionalised coordination mechanism for the management of HIV/AIDS in local governments, involving technical and political leaders. Under this arrangement, AIDS committees and taskforces have been established at all local council levels. In the case of urban councils, the Chief Administrative Officer or Town Clerk is the head of the AIDS committee; whereas AIDS taskforces at district/county/municipality levels are headed by popularly elected chairpersons.

AIDS committees develop technical issues, activities and policies on HIV/AIDS and submit them to AIDS taskforces for review before submission to councils for adoption and inclusion in their development plans and budgets. Civil society institutions, faith based organisations , PHA networks, and other non-government Institutions enabled to participate in HIV/AIDS work at the various levels of local councils.

Annual District AIDS Partnership meetings provide a key opportunity for joint dialogue between policy makers, technical representatives, community representatives and other stakeholders in a local government. The aim of these meetings is to broaden participation in sharing information, knowledge and experiences on HIV/AIDS.

Figure 3. Institutional arrangements for coordination and management of the NSP



Institutional relationships

National Level

At the highest level of Government is Office of the President. The Minister for the Presidency (part of the Cabinet) is responsible for providing policy advice to the Uganda AIDS Commission Secretariat (UACS).

The Parliamentary Standing Committee on HIV/AIDS coordinates the HIV/AIDS activities of Parliament, providing a link with the Uganda AIDS Commission. The Chairperson of this committee is a member of the Uganda HIV/AIDS Partnership Committee.

Below is the Uganda AIDS Commission, which reports to both the Presidents' Office and the Parliamentary Standing Committee on HIV/AIDS.

The Partnership Committee, which includes representation of the various self-coordinating constituencies of HIV/AIDS stakeholders, plays a policy advisory role to the UAC and provides a forum for collective oversight of the management of the national response.

Local Government Level

AIDS Taskforces, Committees coordinate the HIV/AIDS response at various levels of Local Government. The HIV/AIDS Focal Person provides the secretariat for HIV/AIDS.

Many districts have serious institutional challenges that constrain their capacity for a coordinated response to HIV and AIDS.

The linkages between district and national levels are through the Chief Administrative Officer (CAO); in each district, the CAO links the DAT and DAC with the Ministry of Local Government. This linkage is also facilitated by the District HIV and AIDS Focal Point Officer and the District HIV and AIDS Partnership structure. However, the total number of districts has increased from 56 to 80, including Kampala. Many of these districts face serious institutional challenges including lack of personnel capacity, weak institutional systems, procedures and guidelines, infrastructure, and limited financial resources. They are also likely to have little or no experience in coordination of HIV and AIDS and interpreting HIV and AIDS coordination guidelines. Besides the need to plan for more HIV/AIDS focal persons, there is a need for more capacity building activities in all the districts.

PHA networks and service organisations should be involved to ensure that community level realities are embraced in the district response to HIV and AIDS.

PHA networks, post-test clubs and relevant service organisations have demonstrated their abilities to help deliver critical prevention and care messages, and have linked remote communities to health care providers and critical services for those in need. These networks and organisations need to be sustained to ensure the community level reality of the district response to HIV and AIDS. The UAC and Partnership Committee will need to strengthen mechanisms for channelling HIV and AIDS resources to implementing agencies at all levels, including the lowest and most decentralised.

THE key imperatives for institutional arrangements are twofold:

Objective 17: To effectively coordinate and manage the response at various levels

Strategic actions include:

- Operationalise the long term institutional arrangements;

- Enhance integration and mainstreaming of HIV/AIDS in development programming, budgeting and service delivery;
- Strengthen coordination structures, partnerships and synergies at various levels of local government;
- Strengthen the capacity of local governments to effectively deliver HIV/AIDS services.

3.3 Infrastructure requirements

A well functioning and equitably distributed infrastructure is needed to support the services indicated in the National Strategic Plan. The kind of infrastructure needed is subdivided into physical infrastructure and social infrastructure or social capital.

Physical infrastructure refers to:

- Hospitals, health centres, and clinics: the vast majority are under MoH; some are under NGOs, and a few are private.
- Schools: the vast majority are under MoES, and a few are in the private sector, particularly in rural areas.
- Community centres, youth centres, churches, mosques; many for NGOs, FBOs, CBOs, communities.

Physical infrastructure, particularly in the public sector, is inadequate in quality, quantity and distribution to meet HIV/AIDS service needs.

The state of the physical infrastructure, particularly those in the public sector, is inadequate for the delivery of HIV/AIDS services. The scale of HIV/AIDS needs was not anticipated at the time of its development. Most health facilities lack any space designated for HIV/AIDS services, e.g., for provision of VCT. Many health facilities have not been upgraded in accordance with the new developments in medical technology such as testing for HIV. The majority of health units lack appropriate laboratory technology; many facilities face shortages of running water, stable power sources, improper drainage systems, no storage facilities and poor ventilation. Even many newly constructed health units have remained non-operational due to lack of staff and equipment.

Effective logistics management is hampered by weaknesses in forecasting, procurement, and in the distribution/supply chain. This leads to frequent stock outs, thereby hampering HIV testing, basic care and treatment programmes. Streamlining procurement, storage and distribution of HIV/AIDS drugs, reagents, commodities, supplies, and equipment is essential to improving supply chain management. Without serious financial investments, the current physical infrastructure and its management will not be able to support the requirements for an expanded and scaled-up delivery of HIV Counselling and Testing (HCT) services and the increasing numbers of people on ART.

Social infrastructure refers to networks of PHAs, youth clubs, post-test clubs, and church clubs. These represent a ready pool of volunteers to provide HIV and AIDS services, e.g., HIV prevention through BCC and condom distribution, HBC, support to ART adherence, and support to referral systems. There is a need to strengthen the social infrastructure that is strategically positioned close to the communities through empowerment of communities to implement and manage HIV/AIDS services.

A key imperative is to strengthen physical, technical and social infrastructure capacity to effectively and efficiently support implementation of the NSP, with special attention to underserved and highly affected areas.

The key imperative is to strengthen the infrastructure capacity to effectively and efficiently support the implementation of the National Strategic Plan, with particular attention to the under-served areas, and areas with relatively high HIV prevalence levels and high population densities.

Objective 18: To develop infrastructure for equitable and timely access to HIV and AIDS services

Strategic actions:

- Strengthen physical infrastructure to enhance its functionality and accessibility for delivery of HIV/AIDS services;
- Streamline forecasting, procurement, storage, distribution and reporting on medicines, reagents, and other health supplies/commodities;
- Strengthen laboratory services for the provision of comprehensive HIV/AIDS services;
- Strengthen community mobilisation and empowerment to enhance provision of HIV/AIDS services at community level.

3.4 Research and development

Most of the HIV and AIDS studies in Uganda are cross sectional, with a few longitudinal ones, e.g., the Rakai Health Sciences Project and the Medical Research Council project in Masaka. Some progress has been registered in bio-medical and socio-anthropological research to support all the areas of prevention, care and treatment, and social support. Among the examples of bio-medical research carried out so far in Uganda are: vaccine development trials, microbicide studies, male circumcision, and Uganda HIV/AIDS sero-behavioural surveys. These studies have been led by several large institutions, such as the MoH, Makerere University Walter Reed project, MUJHU, and MRC/UVRI Rakai Project.

In addition, a great amount of socio-economic research on various aspects of the epidemic has been undertaken by individual researchers, as well as academic institutions, civil society organisations and government. Some examples in this vein include: the LQAS studies by the Uganda HIV/AIDS

control project and the ongoing study on the macro-economic impact of the epidemic by the Ministry of Finance.

However, a number of challenges face research capacity development, including: lack of institutionalisation of research and funding; lack of coordination and inability to address a prioritised research agenda; limited sharing of research findings; and gaps in adoption and application of research findings. There are also many research areas that have not been addressed largely because they have not been prioritised by funding agencies.

The NSP has great potential to drive and coordinate the research agenda of HIV/AIDS in the country; enhance the effectiveness of research; and disseminate and use research findings for policy and programme implementation. In this regard it has to strengthen its own research capacity and the coordination of the HIV and AIDS research agenda in the country.

A key driver for HIV and AIDS research in Uganda should be the effort to find evidence about the effectiveness, efficiency and relevance of the national HIV and AIDS response so that it can be continuously improved.

The key imperative for HIV and AIDS research in Uganda is to generate evidence about the effectiveness, efficiency and relevance of the national HIV and AIDS response interventions so that they can be continuously improved. It should provide evidence on what works and does not work for current interventions; help in developing new technologies and approaches; map out new trends of the epidemic; and provide information to guide appropriate responses to policy and management challenges. A number of priority areas for research and development have been identified that are relevant to service delivery and access to services. These include a focus on HIV prevention – risk factors and drivers of the epidemic; care and treatment; and social support.

Objective 19: To strengthen national capacity to undertake and coordinate priority HIV and AIDS-related research and utilise outcomes

Strategic actions:

- Operationalise the national HIV and AIDS research coordination framework;
- Define national HIV and AIDS-related research priorities based on the NSP;
- Advocate for funding towards HIV and AIDS-related research priorities;
- Promote targeted dissemination of research findings;
- Enhance the epidemiological surveillance systems to monitor new infections and epidemic trends;
- Build research capacity at local government levels.

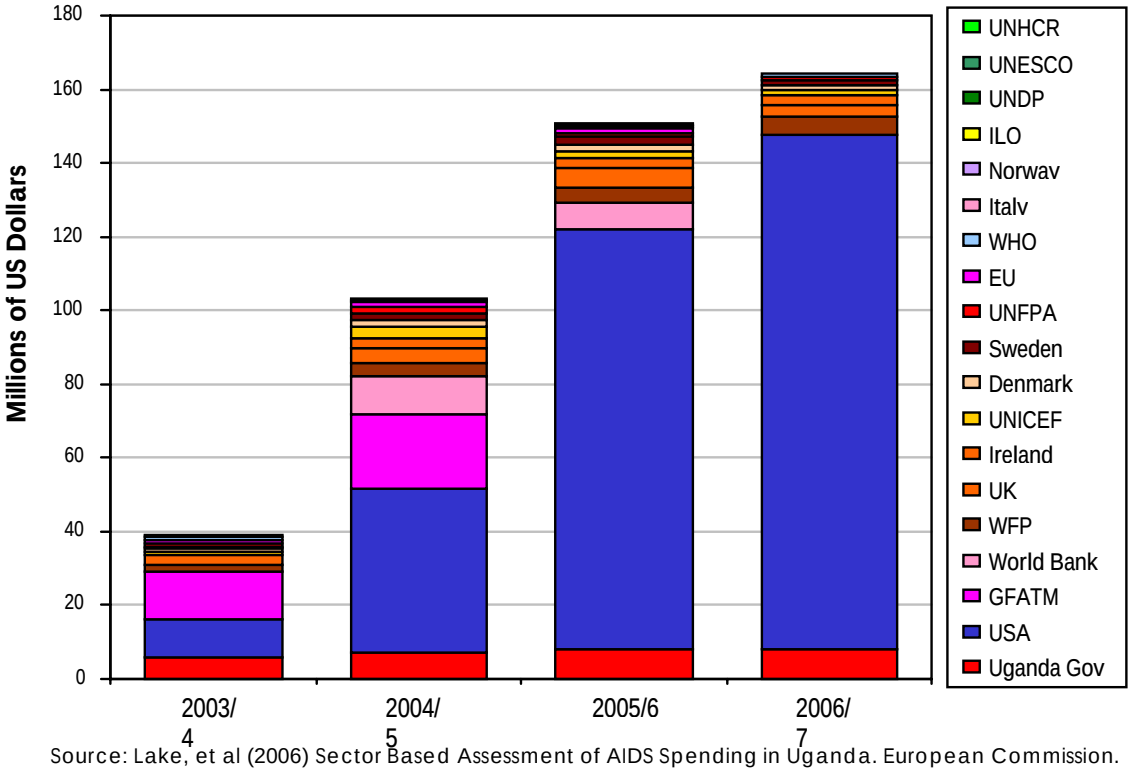
3.6 Resource mobilisation and management

Resource mobilisation and management are critical to ensure effective implementation of the NSP. Resources for the national response from the various sources have increased exponentially from about US$40 million in 2003/04 to nearly US$170 million in 2006/7 (see Figure 4, below).

The NSF (2000/1 –2005/6) period featured several national level funding programmes, including the MAP/World Bank, Global Fund and PEPFAR; the establishment of the Partnership Fund for coordination and management of the response; and some increase in public budget support from local and external sources. Despite increasing levels of funding, the current resource base is not adequate to support the country's universal access agenda. Moreover, large additional increases can have implications on the national fiscal space and macro-economic stability.

Despite increasing levels of funding, the current resource base is not adequate to support the country's universal access agenda.

Figure 4. Actual Funding for HIV/AIDS Programmes by Year



Source: Lake, et al (2006) Sector Based Assessment of AIDS Spending in Uganda. European Commission.

There are various challenges relating to the adequacy and efficient management of the available resources:

- Currently, the national response is principally funded through external support (85-90%) compared to government (7-8%). This has implications on resource predictability and sustainability.
- Mechanisms for tracking utilisation and effectiveness of HIV/AIDS resources are not streamlined at all levels.

- The slow pace of mainstreaming HIV/AIDS in development programming has constrained efforts for mobilising domestic resources for the response.
- Some external funding is not aligned to national priorities. The allocation of current resources has been inadvertently skewed to develop the country's capacity to deliver ART to all those in need. This has to some extent diverted attention from other HIV/AIDS services, including prevention and social support.
- Support to the civil society sector to participate in the response is not harmonised.
- Absorption capacity and timely financial reporting are challenged at all levels due to human resource capacity gaps and procurement delays.

Current funding levels will have to increase to meet future needs, while at the same time ensuring sustainability and predictability for planning the response.

These considerations have informed the costing of the NSP and the projected needs for enhanced resource mobilisation by the various stakeholders to the national response. There is need to increase current funding levels while ensuring sustainability and predictability for a comprehensive response.

Specifically, the resource mobilisation imperatives are:

- Government funding for the response should increase by about 100% to at least 16% of the total budget per annum over the next five years. This will require innovations and learning from experiences from elsewhere in the developing world for example using a percentage of the Value Added Tax (VAT) to fund the response.
- Development Partners should increase funding to the Partnership Fund and the recently established Civil Society Fund to support coordination and enable implementation. The UNGASS Political Declaration 2006 indeed obligates development partners coordinated by the United Nations to galvanise their collective resource strengths and agency modalities to support the national response.
- Public and civil society sectors should operationalise agreed long term institutional arrangements to strengthen financial management structures, enhance equitable disbursement and manage resources to ensure effectiveness.
- The private sector should be encouraged to invest in the response through their corporate investment processes beyond their respective workplace programmes.

The NSP urges stakeholders to develop and implement a national resource mobilisation strategy that targets both Ugandan and external sources.

Objective 20: To mobilise adequate resources and streamline management for efficient utilisation

Strategic actions:

- Develop and implement a national resource mobilisation strategy targeting local and external sources;
- Strengthen mainstreaming of HIV and AIDS in public sector budgeting tools at sector and local government levels;
- Popularise and operationalise long-term institutional arrangements to ensure alignment, equitable disbursement and efficient management of financial resources in the public and civil society sectors;

- Establish an efficient resource tracking mechanism to monitor utilisation and effectiveness;
- Develop capacity of stakeholders at all levels for resource mobilisation and efficient management.

3.7 Monitoring and evaluation

The National Strategic Plan for HIV/AIDS activities (NSP) is the national planning framework that articulates the Government of Uganda's approach to managing the response to the HIV/AIDS epidemic. In order to manage for development results, the NSP needs a Performance Monitoring and Management Plan (PMMP). The PMMP will help to ensure that a culture of evidence-based planning and decision-making is mainstreamed in the National HIV/AIDS programme. It will harmonise the existing systems of data collection, reporting and review and thereby facilitate the use of monitoring and evaluation information in HIV/AIDS policymaking, implementation and resource allocation.

The PMMP will help to ensure that a culture of evidence-based planning and decision-making is mainstreamed in the National HIV/AIDS response.

It is a statutory mandate of the Uganda AIDS Commission to monitor and evaluate the national response to HIV/AIDS and to have a database for HIV/AIDS interventions. In addition to providing information for tracking progress and evaluating the progress and impact of the national response, a national performance monitoring and management plan coordinated by the UAC will provide:

- Opportunities to develop integrated national and sector specific M&E systems to guide a national response to HIV/AIDS;
- A coherent and all encompassing framework to collect, collate and interpret data to monitor and evaluate the effects of the interventions under the NSP;
- Well-coordinated and standardised tools and indicators to measure efforts towards attaining the NSP goals in the areas of prevention, mitigation and care, and national capacity. Indicators will be disaggregated by sex to reflect the gender dimensions of the various targets;
- A National Plan to enhance the sharing and utilisation of information at various levels for effective programme implementation;
- A framework for generating annual reports on the current status of the NSP in Uganda that clearly identify gaps within the response, thereby enabling all partners to agree on strategic priorities and action for the next year;
- A guide for funding bodies to harmonise their reporting requirements, minimise duplication and reduce transaction costs between government and partners;
- A platform for partnership, networking, and collaboration between national-level and local-level stakeholders in monitoring and evaluating national and decentralised responses to HIV/AIDS;
- A framework for responding to the regional and international reporting requirements;

- A means to promote appropriate and useful documentation.

The new PMM plan acknowledges the focus of the NSP on prevention and on scaling up efforts in favour of high-risk and vulnerable populations. In this regard, the PMMP has more indicators on prevention and for monitoring the most-at-risk populations. Secondly, the new PMM plan will also have more indicators to track the management of systems strengthening for HIV/AIDS service delivery. The new PMM plan will therefore be results oriented and have a strong management-tracking component.

Objective 21: To effectively coordinate collection, analysis, use, and provision of information that will enable tracking the progress made in the national response to HIV/AIDS

Strategic actions:

- Develop a coordinated national HIV/AIDS Performance Monitoring and Management system for the national response;
- Build the capacity of UAC, sectors, districts, CSOs and FBOs to collect and use data;
- Promote the utilisation of Monitoring and Evaluation data in the further planning of HIV/AIDS interventions;
- Monitor the success of the national response as well as the identification of specific successful intervention or "best practices";
- Provide an information base for Uganda's timely reporting on its UNGASS commitment;
- Develop an HIV/AIDS M&E Handbook for national and district M&E practitioners to support the above;
- Develop a strategy for the dissemination of the National HIV/AIDS PMM Plan 2007 to 2012;
- Support baseline data gathering for HIV/AIDS indicators where no data is currently being collected.

The NSP strongly advocates using Monitoring and Evaluation data in the further planning of HIV/AIDS interventions.

Section 4: Resource requirements

4.1 Introduction

The resources required to achieve the NSP coverage and impact goals have been calculated from estimates of the number of people receiving each service and the cost per person. Service estimates are based on the population in need of the service and the coverage level. Coverage is assumed to increase from current levels to the plan targets by 2011/12. The unit costs for most services are based on information collected from organisations currently implementing those interventions.

The resources to reach the NSP goals have been calculated from estimates of the numbers of people receiving each service and the cost per person.

The costing over the next few years is based on priority populations and service delivery requirements as suggested in table 8 below.

Table 8: Number of people reached and services delivered*

	2007/8	2008/9	2009/10	2010/11	2011/12
Priority populations (Number of people reached)					
Female sex workers	15,000	21,000	24,000	28,000	32,000
Internally displaced persons	262,000	317,000	345,000	372,000	400,000
People living with HIV/AIDS	204,000	250,000	273,000	295,000	318,000
Prisoners and prison staff	166,000	183,000	193,000	202,000	212,000
Primary school teachers	29,000	37,000	43,000	50,000	57,000
Secondary school teachers	11,000	15,000	17,000	20,000	22,000
Youth	7,300,000	8,990,000	10,040,000	11,170,000	12,380,000
Formal sector employees	363,000	434,000	480,000	529,000	581,000
Service delivery (Services provided)					
Number of condoms provided (millions)	122	145	160	176	193
STI cases treated	493,000	548,000	578,000	610,000	641,000

*Note – the various population categories are not mutually exclusive.

Estimates of resources needed are based on three models that have been developed to support strategic planning and have been used for similar purposes in a number of countries in sub-Saharan Africa and elsewhere:

- The *Spectrum* model[52] uses trends in adult prevalence derived from surveillance data to estimate the number of

[52] Stover, J. and Kirmeyer, S. (2005) DemProj, Version 4: a computer program for making population projections. Spectrum System of Policy Models. POLICY Project, Futures Group, CEDPA.

new HIV infections among adults and children, the number of those in need of treatment, the impact of treatment in extending life and the annual number of AIDS deaths.

- The *Resource Needs Model*[53] estimates the resources needed to meet the coverage targets of the plan based on the population in need, the current coverage and the unit costs to provide each service.
- The *Goals Model*[54] uses information about current behaviours to estimate the sources of new infections today and the number of infections that can be averted by scaling up prevention interventions.

4.2 Programme Support

An estimate of global resources needed[55] includes detailed estimates of programme costs built on assumptions about personnel and supply costs in low and middle-income countries. That analysis yielded the following estimates of the expenses for programme support given as a percentage of direct expenditure[56]: advocacy and communications 0.6%, administration and management 2%, M&E 0.8%. Table 9 shows the assumptions we have used in the Uganda NSP for the percentage of direct expenditures required for programme support services.

Table 9: Programme support as % of direct service expenditures

Programme support area	Percentage of direct service expenditures
Administration, management and coordination	4%
Research	2%
Monitoring and evaluation	2%
Policy, advocacy and legislative reform	1%
Human rights, stigma reduction, participation of PHA	1%

Scaling up ART beyond current levels will require a substantial investment in training costs.

4.2.1 Human Capacity

A 2005 study of the costs of scaling up ART in Uganda[57] provides an estimate of training costs based on appropriate facility staffing. It uses training costs from TASO and the MoH to estimate total resources needed to train staff in 56 district hospitals, 214 HC-IV and 200 lower-level facilities; the costs of refresher training are included for staff in referral hospitals.

[53] Futures Group (2005) Resource needs for HIV/AIDS: Model for estimating resource needs for prevention, care, and mitigation. Futures Group/Constella.
[54] Stover, J., et al (2003) Goals Model: for estimating the effects of resource allocation decisions on the achievement of the goals of the HIV/AIDS strategic plan. Version 3.0. Futures Group, Population Council, Horizon Project, USAID.
[55] UNAIDS (2005) Resource Needs for an Expanded Response to AIDS in Low- and Middle-Income Countries. August
[56] i.e., expenditures for prevention, care and treatment and social support thematic service areas
[57] Chandler, R. et al (2005) Estimating Resource Requirements for Scaling Up Antiretroviral Therapy in Uganda, PHRplus, Abt Associates, USA, August

The study estimated total training costs at US$2.2 million to US$ 3.1 million annually over the next 6 years.

4.2.2 Capital Costs

Capital costs are included for the expansion of ART because it relies on special equipment and laboratories. The PHR*plus* study of the costs of scaling up ART[58] assumed that laboratory equipment and facility renovation would cost US$100,000 per hospital and US$10,000 per health centre and estimated the costs for all district hospitals and HC-IV; the total for capital costs was estimated at US$ 11.9 million for the 2005-2012 period. From the current NSP perspective, these costs will all need to occur in the next two years to handle the rapid scale up of ART coverage.

4.3 Estimated Resources required

According to the Sector Spending Assessment[59], the total resources available to the HIV/AIDS sector increased from US$ 39 million in 2003/04 to US$ 170 million in 2006/07. The annual expenditure required to achieve full coverage of all interventions by the end of the NSP would climb to over US$ 600 million in the final year of the NSP. Such a large increase in five years may not be feasible. The NSP Steering Committee has considered various future funding scenarios (Figure 5) and selected a high scenario where funding increases to US$ 513 million by the final year of the plan, which is about triple the current level of spending. Since this figure falls short of the funds required to achieve full coverage of every intervention, some targets had to be scaled down. The final targets were selected by giving priority to scaling up the most cost-effective prevention interventions, achieving the most rapid expansion of ART coverage possible within the funding limits and tripling resources for OVC support, even though this does not achieve full coverage.

The NSP is based on a 'high' funding scenario that will increase resource support to about triple the current levels by the end of the plan period.

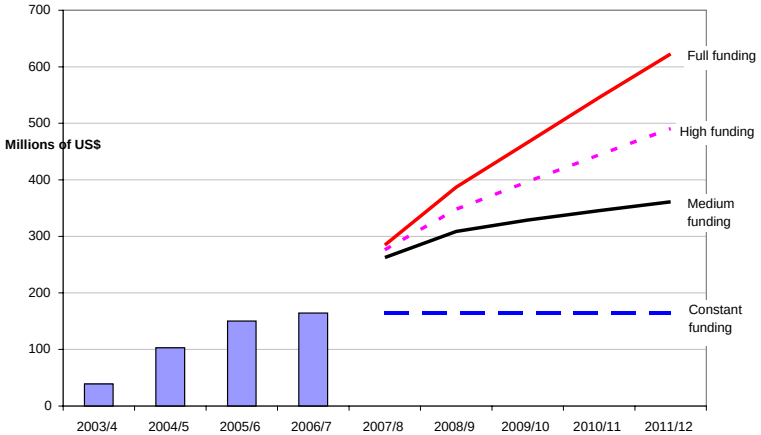


Figure 5: Actual and projected funding for HIV and AIDS Programmes by Year, showing alternative funding scenarios

4.3.1 Resources needed

[58] *Op cit:* Chandler et al (2005)

[59] Lake, S.; Mwijuka, B. (2006) Sector Based Assessment of AIDS Spending in Uganda. European Commission, November

Population growth alone accounts for an increase in resource needs of about 25% over the NSP period.

to achieve the goals and targets of the NSP

The total resource requirements grow rapidly over the strategic plan period; they are more than three times higher in 2011/12 than in 2006/7. Population growth alone accounts for an increase in resource needs of about 25% over this period. Most of the increase, however, is caused by scaling up coverage to the target levels by the end of the NSP. Based on prioritisation of the 'high funding scenario', figure 6 below shows the anticipated distribution of costs for the thematic focus areas: 28.3% of the resources are needed for prevention, 38.7% for care and treatment, 24.7% for support for orphans and vulnerable children, and 8.3% for programme support.

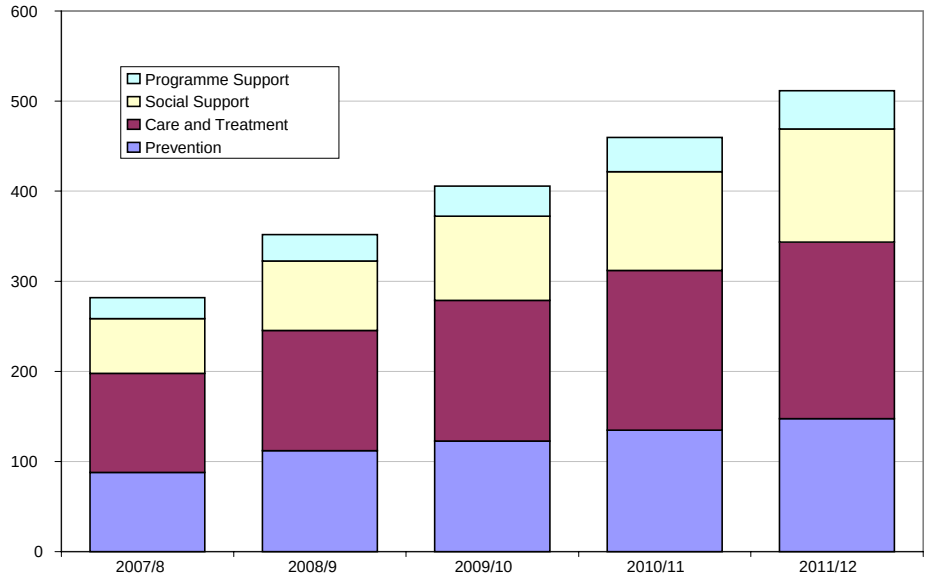


Figure 6: Resources required for the NSP by year by thematic area (Millions of US$)

Two-thirds of the resources needed for prevention are for five principal interventions: HCT, prevention for PHA, male circumcision, community mobilisation and PMTCT. Antiretroviral treatment accounts for over 90% of the resources required for care and treatment programmes. Within programme support, management, administration and coordination account for 40%, while enabling environment, research and M&E each account for about 20% of requirements.

The resources needed over the NSP period are tabulated on the next page in table 10.

Table 10: Resources needed to achieve the goals and targets of the NSP[60]

Millions of US$	2005/6	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	Totals 2007/8-2011/12
Prevention	41.9	54.6	82.7	104.9	114.6	125.6	137.3	565.1
Priority populations								
Youth focussed interventions	2.5	3.7	6.1	7.8	8.9	10.1	11.4	44.2
PHA prevention	2.3	3.2	5.1	6.2	6.8	7.4	8.0	33.5
Prisoners, prison staff & police	3.8	4.2	5.0	5.5	5.8	6.1	6.4	28.7
Internally displaced persons	1.5	2.0	3.1	3.7	4.1	4.4	4.7	19.9
Workplace	1.4	1.7	2.4	2.9	3.2	3.5	3.9	15.9
Military	1.0	1.0	2.0	2.5	1.6	1.4	1.1	8.6
Fishing communities	0.0	0.0	1.1	0.2	0.2	0.2	0.2	1.7
People living with disabilities	0.1	0.3	0.3	0.3	0.3	0.3	0.3	1.6
Female sex workers & clients	0.0	0.1	0.2	0.2	0.3	0.3	0.4	1.4
Behavior change								
Community mobilisation	1.5	3.5	7.4	10.1	11.7	13.4	15.2	57.9
Mass media	2.0	2.3	3.0	3.4	3.6	3.8	4.0	17.8
Service delivery								
VCT	13.3	17.2	24.0	28.6	31.3	34.3	37.5	155.6
PMTCT	3.1	4.5	7.7	10.3	12.0	13.8	15.9	59.8
Condom provision	4.1	5.0	6.7	7.9	8.7	9.5	10.4	43.2
STI management	4.0	4.4	5.4	6.0	6.3	6.6	7.0	31.3
Male circumcision	0.0	0.0	0.0	6.5	6.7	6.9	7.2	27.3
Health care								
Universal precautions	0.5	0.7	1.1	1.3	1.5	1.7	1.9	7.5
Blood safety	0.7	0.9	1.1	1.3	1.4	1.5	1.6	6.8
Safe injection	0.0	0.1	0.1	0.1	0.1	0.2	0.2	0.7
Post-exposure prophylaxis	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Care and treatment services	71.2	85.0	109.9	133.5	156.2	177.3	195.9	772.8
ARV therapy	60.4	71.4	96.6	118.6	139.6	159.2	175.9	690.0
Capital costs for ART	1.5	3.8	3.8	4.4	5.1	5.8	5.8	24.9
Basic care package	1.8	1.9	2.5	3.2	4.0	4.9	6.9	21.4
Training for ART	2.2	3.1	2.2	2.4	2.6	2.7	2.8	12.7
Routine offer of C&T	1.6	1.6	1.9	2.2	2.5	2.8	3.1	12.5

Summary of anticipated resources

The Table 10 shows that taking the high funding scenario, the total resources required are equal to US$ 1,995 million for the five years of the NSP. The commitments to date from various sources are as shown in the Table below:

[60] Budget sub-categories have been listed in rank order (within their larger categories) on the basis of total investment over the plan period. Totals in the right hand column are calculated from 2007/8 onward.

Table 11: Committed and anticipated HIV-related resources by source by financial year

Source of funds	Financial year (amounts in millions of US$)					Total
	2007/8	2008/9	2009/10	2010/11	2011/12	
Government of Uganda						
PEPFAR	285					
Global Fund – Round 3 Phase II	42					
Civil Society Fund (DANIDA, DFID, Irish AID	22.5	25				
Global Fund – Round 7 application						258

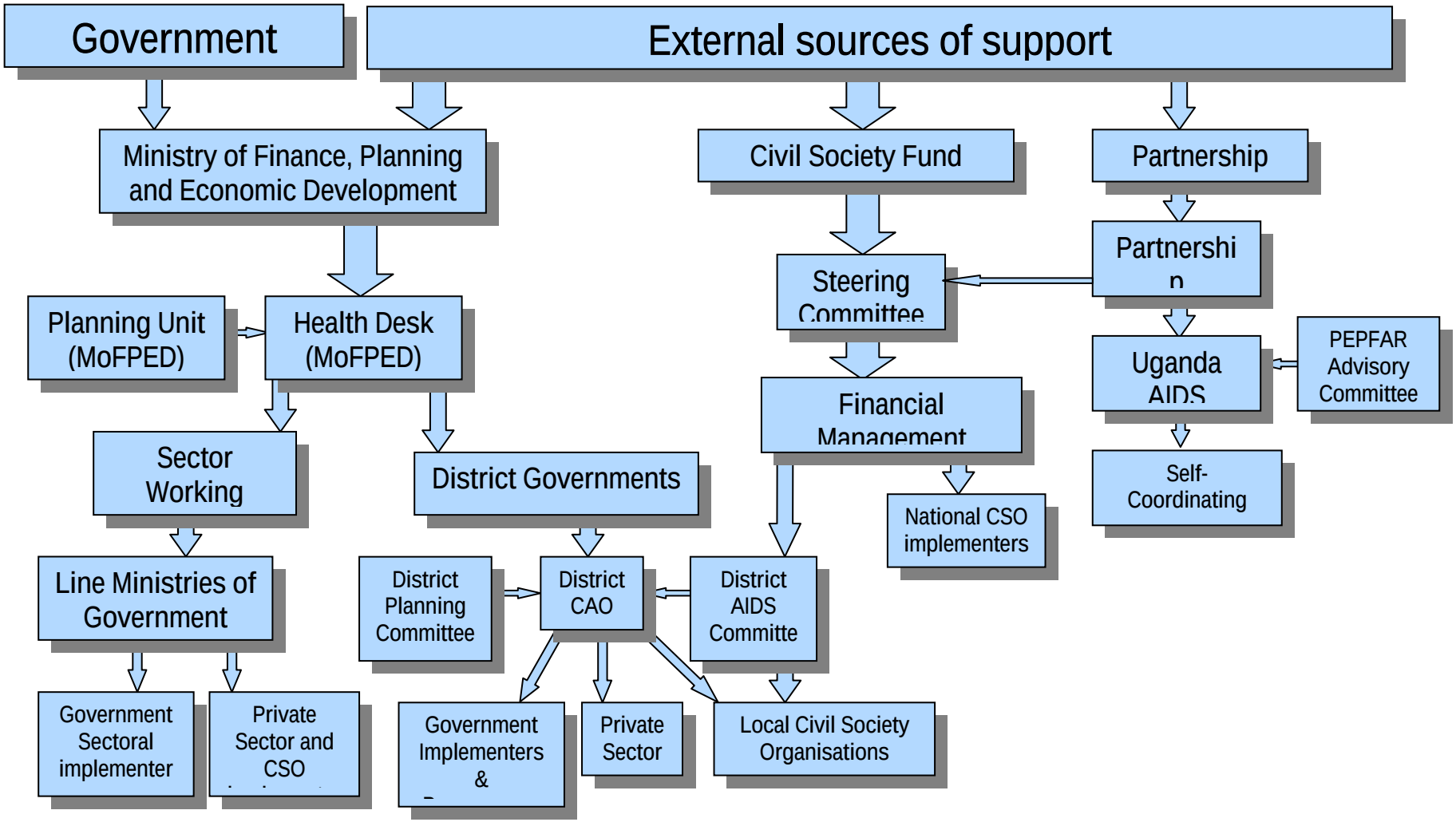
[table not yet complete – data to be added]

The expectation is that Government will provide 15% of the total resources required, i.e., US$ 299.25 over the 5 years of the NSP.

4.4 Financial resource flows and accountability

[Explanatory paragraph to come]
Refer to diagram on next page

Proposed pathway for HIV/AIDS financial resource flows and accountability



Section 5: Operationalising and implementing

5.1 Results framework

Detailed annual National Priority Action Plans and targets will be prepared each year based on this five-year strategy and emerging evidence from the PMMP and research.

The results framework that links objectives, indicators, baselines and targets for the next five years is attached as Annex 1. The five-year results framework covers all the thematic service areas as well as the systems for strengthening delivery of the NSP. Each objective is presented along with its associated indicators, baselines and targets. The targets are reflected for the mid-term period of the NSP (by end of 2009) and for the end of the NSP timeline (summative in 2012).

An annual National Priority Action Plan (NPAP), with more detailed outputs and targets for the coming operational year will be developed separately each year. The NPAP process will be a direct product of this five-year strategy (see more discussion below).

5.2 Implementation approaches

Operationalisation and implementing

Operationalising and implementing the NSP will involve turning the priority issues into action plans, delegating to stakeholders and assigning measurable outputs to the actions. The ever-changing landscape of the HIV epidemic will call for flexibility during programming, while still abiding by a set of core principles. These principles include commitment to cost effectiveness, innovation, decisions and strategies being informed by evidence, and scaling up best practices.

The multisectoral approach will be maintained and enhanced, and action deepened at the local level

Implementation effectiveness will be supported by strengthening mechanisms for financial and program accountability and building stakeholder capacity. The diversity of interventions and implementers will present challenges, particularly in harmonising alignment with the NSP by all the stakeholders.

Efforts will be made for effective integration, harmonisation and mainstreaming of HIV intervention in all development programs. The multisectoral approach will be maintained and enhanced through reviewing the partnership arrangements and deepening action at the local level. Special attention will be put on sectors that are mandated to

provide services to the most at risk to HIV populations identified through the prioritisation process of the NSP.

There are several helpful implementation and operationalisation processes that have been previously adopted in the national response that now need further refinement. Among these processes are joint planning and monitoring, advocacy, knowledge management and resource mobilisation. Many of these processes lack standard implementation guidelines and tools; hence, it will be a challenge for this NSP produce such guides.

Networking, negotiating and lobbying for the collaboration of stakeholders will be critical advocacy efforts in implementing the NSP.

The partnership arrangement will remain a key institutional structure through which national implementation will be realised. Specific attention will be put on two areas: one is improving and documenting the annual Joint AIDS Review (JAR) process. The other is mainstreaming and harmonising HIV and AIDS planning and budgeting within the national government planning and budgeting calendar. A bottom-up approach will be promoted, as it is expected to result in greater involvement of districts and communities. Ideally, district reviews will precede and provide input into the national processes.

Effective implementation of the NSP will be dependent on many factors in the overall socio-economic development arena beyond the control of UAC. Networking, negotiating and lobbying for the collaboration of stakeholders will be critical components in operationalising and implementing the NSP.

Annualisation of the NSP

National Annual Priority Action Plans (NPAPs) will serve as the operational work plan for flexibly responding to the changing conditions of the epidemic. The NPAPs will describe what has to be done on an annual basis in order to realise the goals of the NSP. They will contain details of costed actions/activities to be executed, expected outputs/milestones, annual targets and responsible actors. The Action Plan is expected to drive the NSP implementation, improve oversight, and emphasise results. It will support the "Three Ones" principle, and also facilitate alignment of partner support with related efforts to strengthen HIV mainstreaming in government sectors and engage civil society.

National Annual Priority Action Plans will be the operational work plan for flexibly responding to the changing conditions of the epidemic.

The Annual Joint AIDS Review (JAR)

Uganda AIDS Commission has so far held two Joint AIDS Reviews that took place at very critical stages in the implementation of the past NSF. The first JAR discussed the mid-tem review results and the second JAR was part of the

development of the NSP process to share and discus the results of the evaluation of the NSF and to suggest strategies for the new national response.

The annual Joint AIDS Review provides a participatory forum where all interested HIV stakeholders come to review together the performance and results of the national response over the previous year.

The JAR provides a participatory forum where all interested HIV stakeholders are able to come together to review the performance and results of the national response over the previous year. They serve as a mechanism for identifying and addressing gaps and overlaps, especially in the process of prioritising actions and targets for the coming year. It is intended to institutionalise the JAR process and to use it as an annual means of joint planning and progress tracking progress for the NSP. There are, of course, challenges in harmonising the JAR process with the other national planning processes, district planning cycles and the planning and budgeting cycles of the various stakeholders. These constraints are noted and will have to be addressed.

Monitoring and evaluation

The multisectoral approach is innovative, but presents challenges in monitoring and tracking progress of the national response, largely because of the diversity in capacities and methods of work of the implementers. Systems for routine monitoring of the plan, including coordination, will have to be strengthened at both national and local government levels. This process has been started by the preparation of clear guidelines for monitoring and evaluating the NSP in the National Performance Measurement and Management Plan.

5.3 Dynamic issues and challenges

The flexibility built into the NSP will enable stakeholders to continuously monitor the many emerging and dynamic issues about HIV in Uganda and to regularly update the national response.

This section identifies some of the emerging issues that were not or could not yet be prioritised during the NSP. Many of these issues were debated at length during the NSP development, and it is anticipated that they will be dynamic and changing in significance during the NSP period (2007/8-2011/12). The flexibility built into the NSP, particularly the annual JAR and NPAP steps, will enable stakeholders to continuously monitor these issues and to update the Ugandan national response to HIV and AIDS as needed.

New prevention technologies, e.g., male circumcision – There is considerable debate on the level of efficacy and cost-effectiveness of this intervention for preventing HIV infection. In addition, there is also concern because no positive effect for the women has been established – and yet, currently, women are disproportionately vulnerable to HIV but have fewer directly controllable prevention technologies as compared to men. Another debate centres on the appropriate age for circumcision – what will be the "return on

investment" if small boys are circumcised in a setting where infant and child mortality from other causes remains quite high. Finally, there has been a strong high-level political discontent with the intervention – even the President is not convinced about the value of circumcision as a prevention intervention.

Shifts in international funding mechanisms and priorities – The funding mechanism of the international GFATM grant promotes the integration of HIV, TB and Malaria. In Uganda, however, the management and coordination of these diseases are structurally separated – HIV is handled by the UAC and the other two are dealt with by the MOH. As such, effective management of the grant requires carefully thought out governance arrangements. Considerable effort has been put into articulating the LTIA – and there will undoubtedly be challenges to be addressed as implementation starts.

The previous NSF focussed more attention on unmarried youth, but evidence is emerging to suggest that significant HIV transmission is now occurring within marriage – thereby presenting many challenges in developing a good response.

Addressing HIV infection issues in marriage – A follow up analysis of HIV incidence based on the sero-behavioural survey (2004/5) found that up to 65% of new HIV infections appear to be occurring among people who are married. This finding has flagged a number of related issues.

- **ABC debate** – Although this sero-behavioural evidence is strong, some stakeholders, especially faith-based organizations, are not comfortable with statements identifying HIV risks with marriage. There is also difficulty and debate about what could be cost effective interventions – what should be done to reduce infection in marriage?
- **Coping with discordance** – a recent incidence study[61] suggests that up to half of the HIV transmission occurring within marriage is happening among HIV discordant couples. There is still no clear answer about what interventions can effectively and ethically address the discordance phenomenon. It is important that intervention strategies keep in mind the sexual and reproductive rights and responsibilities of couples in such relationships.
- **Reproductive rights and choices of PHAs –** Once infected, PHAs in their reproductive years face many pressures and hard decisions about their reproductive life, from their own desires to the wishes of their partners, families, and society – often in settings with insufficient information and resources for good PMTCT. Uganda is a strongly pro-natal society, and women

[61] Mermin, J., et al (2006) HIV incidence among adults in Uganda : a population-based, nationally representative study.

and men living with HIV and AIDS are not exempt from the many social and cultural pressures to have children. At the same time, there is considerable media and medical communication about the risks of HIV and childbearing, for the child and the family.

The new NSP continues the past history in Uganda of an open, experimental approach that is continuously looking for evidence about the best and most cost-effective ways to address the very dynamic and changing qualities of the HIV epidemic.

CD4 counts and the decision point for treatment – The typical clinical course of HIV infection progressing to AIDS disease involves a declining CD4 (helper cell) count in the blood. At the present time, the official MOH decision point for treatment (often called cut-off point) is 200 while WHO is now recommending 350. In a resource limited setting, a lower cut-off point means that drugs can be limited to the sickest persons who are in greatest need. While a higher cut off point increases the numbers of people on treatment and therefore, the treatment costs, there is another argument that early treatment is a preventive measure, at least for some groups. It is argued that when the number of viruses in a person's body (the viral load) is lowered through ART, the less infectious they are. This strategy may be particularly useful for addressing prevention for discordant couples (see above).

Response for displaced populations/undergoing rehabilitation/ returnees – Currently, Northern Uganda has an HIV prevalence above the national average, which has been attributed to the chronically and intensely fluctuating social conditions of the region – especially conflict and poverty. As of this writing, there are also massive displacements and disruption, particularly in Northern and Eastern Uganda due to prolonged and severe flooding. The on-going question is - What are the best approaches for delivering HIV-related services in such changing circumstances?

Cost-effective counselling and testing strategies – there is on-going debate about the relative merits of voluntary counselling and testing (self-selected VCT) versus routine HIV counselling and testing (HCT), e.g., for all inpatients and pregnant women. Extensive research indicates that stand-alone VCT is not cost-effective, but counselling and testing is an important component of good quality HIV and AIDS care and treatment. As such, there is need for referral and linkage mechanisms between VCT service centres and prevention, care and treatment services.

Updating analysis – The HIV/AIDS epidemic is dynamic and the open approach toward it in Uganda has encouraged experimentation and adaptation of local and external ideas to generate effective responses. Continuous monitoring of local and international solutions will be critical in searching for evidence about the best and most cost-effective practices during the NSP implementation.

ANNEXES

ANNEX 1: Results framework [incomplete][62]

Thematic area: Prevention

Objectives for Prevention	Indicators	Baseline	Mid-term – end of 2009	2011/2012
Obj 1: *To accelerate the prevention of sexual transmission of HIV through established as well as new and innovative strategies*	Decrease early sexual debut by 50% (before the age of 15 years)	14%	10.5%	7%
	Increase comprehensive knowledge and awareness of HIV transmission by 80%	28% (F) 38% (M)	40% (F) 50% (M)	50.4% (F) 68.4% (M)
	Decrease high risk behaviour by 50%	15% (F) 37% (M)	12% (F) 25% (m)	8% (F) 18% (M)
	Increase condom use with high risk partners by 50%	47% (F) 53% (M)	55% (F) 65% (M)	70% (F) 79% (M)
	Number of condoms distributed annually	117 million	149 million	181 million
	Percentage of couples counselled and tested who receive their results			
Obj 2: *To reduce HIV transmission from mother-to-child by 50% by 2012*	Percentage of health facilities including HC-III providing comprehensive PMTCT	40%	60%	80%
	Number of HIV+ pregnant women accessing Nevirapine/ART services	40,000	75,000	110,000
Obj 3: *To maintain 100% blood transfusion safety, ensure 100% adherence to universal precautions, and ensure 100% access to PEP at ART centres by 2012*	Units of safe blood screened	272,000	337,500	403,000
	Percentage of health facilities using safe blood for transfusion			100%
	Percentage of health facilities observing universal precautions for infection control			80%
	Percentage of public and private health facilities with functional PEP programmes			80%
	Proportion of health workers exposed to HIV that access care			80%
	Proportion of large enterprises / companies with HIV and AIDS workplace policies and programmes			100%
Obj 4: *To control STIs, increasing appropriate uptake*	Proportion of STI patients attending health facilities that receive appropriate care according to national guidelines	36%	53%	70%

[62] (This table is not yet complete; to be reviewed with new data from UDHS, sero-survey and PMMP - RN)

Objectives for Prevention	Indicators	Baseline	Mid-term – end of 2009	2011/2012
to 70% by 2012				
Obj 5: *To promote use of new HIV prevention technologies and approaches proven to be effective*	Increase comprehensive knowledge of male circumcision as a prevention measure when guidelines are developed			80%
	Prevalence of male circumcision by sexual debut			25%
	Percentage of HC-IV level health facilities equipped to perform male circumcision following development of programmatic guidelines			80%
	Number of medical doctors with skills to perform surgery stationed at HC-IV level			2

Thematic area: Care and Treatment

Objectives for Care and Treatment	Indicators	Baseline	Mid-term – end of 2009	2011/2012
Obj 6: *To increase equitable access to ART for those in need to reach 240,000 by 2012*	Number of those in need accessing ART	85,000	162,500	240,000
	Percentage of hospitals, HC-IVs and HC-IIIs accredited for ART services			100%
	Percentage of hospitals performing CD4 counts, full blood count and chemistry			100%
	Percentage of referral hospitals carrying out PCR tests			100%
	Percentage of health facilities providing paediatric HIV and AIDS services			?
Obj 7: *To increase access to prevention and treatment of opportunistic infections, including TB*	Percentage of hospitals, HC-IVs, HC-IIIs that provide non-ART care			100%
	Percentage of hospitals, HC-IVs, HC-IIIs that provide integrated TB-HIV services			100%
	Percentage of efficacy and safety studies conducted on commonly used TCM			25%
	Percentage of heath care levels providing palliative care package			100%
Obj 8: *To scale up HIV counselling and testing to facilitate universal access by 2012*	Percentage of hospitals and HC-IIIs providing HCT			100%
	Percentage of HC-IVs and HC-IIIs providing HIV diagnostic testing			100%
	Number of individuals provided			500,000

Objectives for Care and Treatment	Indicators	Baseline	Mid-term – end of 2009	2011/2012
	with HCT (HCT, RCT) services			
Obj 9: *To integrate prevention into all care and treatment services by 2012*	Percentage facilities providing care and treatment to integrate Prevention with Positives (PWP) activities			100%
	Number of trained PWP personnel at HC-IV and community levels			
Obj 10: *To support and expand the provision of home based care and strengthen referral systems to other health facilities and complementary services*	Percentage of treatment sites with, or linked to, home based care services			90%

Thematic area: Social Support

Objectives for Social Support	Indicators	Baseline	Mid-term – end of 2009	2011/2012
Obj 11: *To provide complementary support, including nutrition, to PHAs*	Percentage of PHAs, OVCs and other disadvantaged groups receiving psychosocial support			
	Number of service providers offering emotional and spiritual support			
	Timeline for achieving referral linkages between community service providers and support systems and formal sector		By end of 2009	
Obj 12: *To increase provision of quality psychosocial support to PHAs, OVCs, PWDs and other disadvantaged groups affected by HIV and AIDS by 2012*	Percentage of OVCs receiving education support	15%	32.5%	50%
	Percentage of those in need accessing psychosocial support	10%	20%	30%
Obj 13: *To promote and support sustained formal and informal education,*				

Objectives for Social Support	Indicators	Baseline	Mid-term – end of 2009	2011/2012
vocational and life skills development for OVC, PHAs, IDPs, PWDs and other disadvantaged groups affected by HIV and AIDS				
Obj 14: *To enhance livelihoods and economic empowerment of HIV and AIDS-affected communities and households*	Percentage of the very poor affected by HIV and AIDS who are provided with basic support services			20%
	Percentage Universal Access target for those needing social support services			80%
Obj 15: *To increase access to basic entitlements for PHAs and OVCs*	Evidence of PHAs, OVC and disadvantaged caretakers and their households having access to legal and ethical rights	No value available	Mid-term review compiles evidence of access to ethical and legal rights	Summative evaluation gives evidence of access and associated impacts
	Evidence of social support promoted through community participatory dialogue and action planning	No value available	Evidence shown through mid-term review	Summative evaluation gives evidence
	Percentage male participation in social support provision			
Obj 16: *To ensure legal and appropriate social and community safety nets for PHAs, OVC and other persons made vulnerable by HIV and AIDS*				

Strengthening systems for delivery: Institutional arrangements and human resource development

Objectives for institutional arrangements and human resources	Indicators	Baseline	Mid-term – end of 2009	2011/2012
Obj 17: *To effectively coordinate and*	Timeline for adoption and implementation of broad policy framework	No value available	2008	

Objectives for institutional arrangements and human resources	Indicators	Baseline	Mid-term – end of 2009	2011/2012
manage the HIV and AIDS response at various levels	Evidence of strengthening of coordination modalities	No value available	Mid-term review presents evidence	Summative evaluation gives evidence
	Evidence of staff development outcomes for senior management	No value available	Mid-term review presents evidence	Summative evaluation gives evidence
	Evidence of capacity development outcomes for SCEs	No value available	Mid-term review presents evidence	Summative evaluation gives evidence
	Timeline for development of funding mechanisms and channels	Current funding mechanisms	2008	
	Timeline for development of strategies for cost effective coordination mechanisms	Current partnership mechanisms	2008	
Obj 18: *To develop infrastructure for equitable and timely access to HIV and AIDS services*				

Strengthening systems for delivery: Research and development

Objectives for Research and development	Indicators	Baseline	Mid-term – end of 2009	2011/2012
Obj 19: *To strengthen national capacity to undertake and coordinate priority HIV and AIDS-related research and utilise outcomes*	Funds mobilised for research	$	$	$
	Evidence of research outcomes having an impact on the national response to HIV and AIDS	No value available	Mid-term review shows evidence	Summative evaluation gives evidence
	Timeline for development of policy and programmatic timelines for research findings		2008	

Strengthening systems for delivery: Resource mobilisation

Objectives for Resource mobilisation	Indicators	Baseline	Mid-term – end of 2009	2011/2012
Obj 20: *To mobilise adequate resources*	Evidence of HIV and AIDS budget line in the budget framework	No value available	Mid-term review shows evidence	Summative evaluation gives evidence

Objectives for Resource mobilisation	Indicators	Baseline	Mid-term – end of 2009	2011/2012
and streamline management for efficient utilisation	Timeline for the development of an institutionalised mechanism for major funding mechanisms (PEPFAR, World Bank and GFATM)	No value available	End 2007	
	Evidence of special budget line for HIV and AIDS in PAF	No value available		
	Evidence of annual priority action plans (NPAPs)	No value available	Evidence of plans each year	Summative evaluation of NPAPs
	Evidence of strengthened capacity and systems to influence local government and line ministries HIV and AIDS planning and budgeting	No value available	Mid-term review shows evidence	Summative evaluation gives evidence
	Timeline for the development of the monitoring and evaluation system		2008	
	Timeline for the development and operationalisation of a comprehensive procurement plan		2008	
	Frequency of resource tracking and cost-benefit studies		Annual and mid-term assessment	Annual and summative evaluation

Strengthening systems for delivery: Monitoring and evaluation

Objectives for M&E	Indicators	Baseline	Mid-term – end of 2009	2011/2012
Obj 21: *To effectively coordinate collection, analysis, use, and provision of information that will enable tracking the progress made in the national response to HIV/AIDS*	Timeline for the development of the M&E handbook	No value available	2008	
	Evidence of an up-to-date documentation and information centre		Annual and mid-term assessment	Annual and summative evaluation
	Timeline for the development of a monitoring and evaluation dissemination strategy		2008	
	Evidence of quality and timely reporting by UAC and all programme implementers		Annual and mid-term assessment	Annual and summative evaluation
	Evidence of partnership, networking, and collaboration between national-level and local-level stakeholders in monitoring and evaluating national and decentralised responses to HIV/AIDS		Annual and mid-term assessment	Annual and summative evaluation

ANNEX 2: Technical support arrangement and needs

[Pending – material not yet available. If not available by 04 November, will need to exclude this section]

ANNEX 3: Glossary of terms

ABC+ – A behavioural 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 internalisation; 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 PHAs 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.

Decentralised response – Involves building capacity of Local Government levels so that they are AIDS competent and able to plan, implement and mobilise 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 organisation'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 focussed 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 organisation.

Multisectoral 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 – The support meant to address the challenges of isolation, depression, anxiety, other psychiatric impairment and serious interpersonal problems as a result of HIV/AIDS. The purpose of psychosocial support is to ensure that quality of life and motivation to live are effectively optimised. Psychosocial support is understood to include spiritual support.

ANNEX 4: The NSP development process

The key stages, steps, participants, timing and outputs of the NSP process are outlined in the following table. [convert to graphic when all data available?]

Stage	What	Who	When	Milestones, outputs
Preparations	• Joint review of the NSF 2000/1-2005/6		Dec. 2005	• Assess availability of data and establish gaps • Issues selected for background papers
	• Meeting on resource mobilisation	ADPs		• Process buy-in and ownership • Commitment of funds to implement the planning
	• Preparation of detailed planning strategy and process			• NSP strategy paper prepared to guide the process • Tools prepared • Consultants procured • TWGs constituted
	• Launch of the NSP planning process			• Political commitment
	• Orientation meeting for stakeholders and consultants			• Key team built • Review approach clarified
Strategising	• Evaluation review of the NSF • Focus background studies undertaken • Costing studies of strategic options			• Evidence assembled about performance and achievements • Identified challenges and gaps • Defined prioritisation criteria
	• Analysis of evaluation and study results	TWGs		• Priority strategies and targets set
	• Joint Annual Review • Discuss outcomes of evaluation and background studies	HIV/AIDS Partnership		• Establish desired impact and ?? • Funding scenarios • First NSP outline
	• District consultation in 8 regional meetings (based on sero-survey regions • SCE consultation	All districts All SCEs		• Reality check of the priorities with participation by all
Consensus building	• Technical prioritisation workshop			• Coverage, goals, priority objectives
	• Review of priorities	Task Force		•
	• Consensus and validation	SCEs Parliament		• Second outline • Agreed priorities
	• Lobbying for political commitment and funding	Standing Committee of Parliament		• Political buy-in • Decision to prepare a Cabinet memo on the

				NSP
	• Drafting the NSP • Editing the NSP			• Printable copy
	• Presentation to Cabinet			• Policy document
	• Printing and dissemination			• Copies for distribution

ANNEX 5: Participants in the NSP process

Participant names are presented within working groups; chairs and co-chairs are listed first, and the rest are in alphabetical order of their identified organisations. See acronym list for organisations and projects at end of this annex.

Task Force Members

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Acronyms for organizations and projects

ACE .....AIDS Capacity Enhancement Project, USAID
ACET ..... AIDS Care Education and Training
ACFODE..... Action for Development

AFFORD ..... Health Marketing Initiative, USAID
AIC ..... AIDS Information Centre
AMICALL..... Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa
CAWA ..... Campus Alliance to Wipe out AIDS
CCF..... Christian Children's Fund
CDC ..... Centers for Disease Control & Prevention
CRC ..... Creative Research & Evaluation Centre
CRS ..... Catholic Relief Services
DELIVER..... John Snow International project with USAID
DFID..... Department for International Development
FC ..... Feed the Children Uganda
FFC ..... Food for Children
HAU ..... Hospice Africa Uganda
HPI ..... Health Partners International
IAVI ..... International AIDS Vaccine Initiative
ICW ..... International Community of Women Living With HIV/AIDS
IDI..... Infectious Diseases Institute
IPH ..... Institute for Public Health
IRCU ..... Inter-Religious Council of Uganda
ISAE..... Institute of Statistics and Applied Economics
IYF..... International Youth Foundation
JCRC..... Joint Clinical Research Council
KCC..... Kampala City Council
MAAIF ..... Ministry of Agriculture, Animal Industries and Fisheries
MEEPP..... Monitoring and Evaluation of Emergency Plan Progress
MEMD ..... Ministry of Energy and Mineral Development
MISR ..... Makerere Institute for Social Research
MJAP..... Mulago-Mbarara Teaching Hospitals' Joint AIDS Program
MoD..... Ministry of Defence
MoES ..... Ministry of Education and Sports
MoFPED..... Ministry of Finance, Planning and Economic Development
MoGLSD ..... Ministry of Gender, Labour and Social Development
MoH..... Ministry of Health
MoIA..... Ministry of Internal Affairs
MoLG ..... Ministry of Local Government
MoPS ..... Ministry of Public Service
MRC ..... Medical Research Council
MTAC..... Management Training and Advisory Centre
MUJHU..... Makerere University /Johns Hopkins University AIDS Programme
MUWRP..... Makerere University Walter Reed Project
NAFOPHANU National Forum for PHA Networks in Uganda
NCC..... National Council for Children
NCRL..... Natural Chemotherapeutic Research Laboratory
NDA ..... National Drug Authority
NPA ..... National Planning Authority
NUDIPU..... National Union of Disabled Persons of Uganda
PEPFAR ..... President's Emergency Plan for AIDS Relief
PSI Uganda . Population Services International
SCOT..... Strengthening HIV/AIDS Counsellor Training
STF..... Straight Talk Foundation
TASO..... The AIDS Support Organisation
TSF ..... Technical Support Facility
UAC..... Uganda AIDS Commission
UACP..... Uganda AIDS Control Programme
UBOS ..... Uganda Bureau of Statistics
UCU..... Uganda Christian University
UGANET..... Uganda Network on Law, Ethics and HIV/AIDS
UMI..... Uganda Management Institute
UNAIDS..... United Nations Joint Programme on AIDS
UNAS ..... Uganda National Academy of Science
UNASO ..... Uganda Network of AIDS Service Organisations
UNCST ..... Uganda National Council for Science and Technology
UNFPA ..... United Nations Fund for Population Activities
UNICEF..... United Nations Children's Fund
UPHOLD..... Uganda Programme for Human and Holistic Development
USAID..... United States Agency for International Development
UVRI..... Uganda Virus Research Institute
UYDEL..... Uganda Youth Development Link
UYP ..... Uganda Young Positives
WFP..... World Food Programme
WHO..... World Health Organisation
YEAH ..... Young Empowered and Healthy Campaign
YPSCE ..... Young People's Self Coordinating Entity

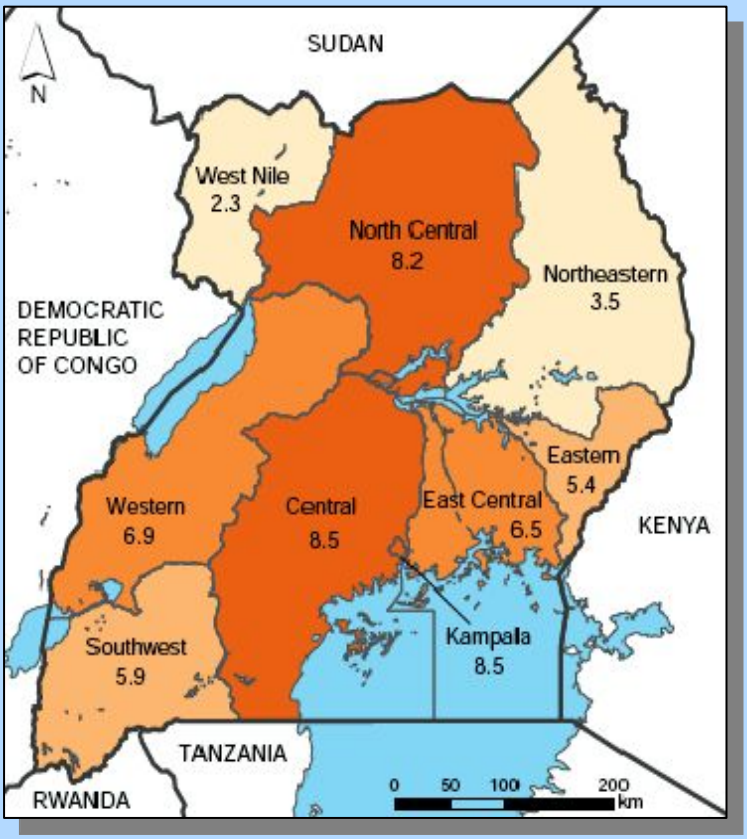
Back cover credits

All maps except HIV prevalence are from:
UAC (2005) National HIV/AIDS Stakeholders & Service Mapping Atlas. UAC, Uganda HIV/AIDS Partnership. December.

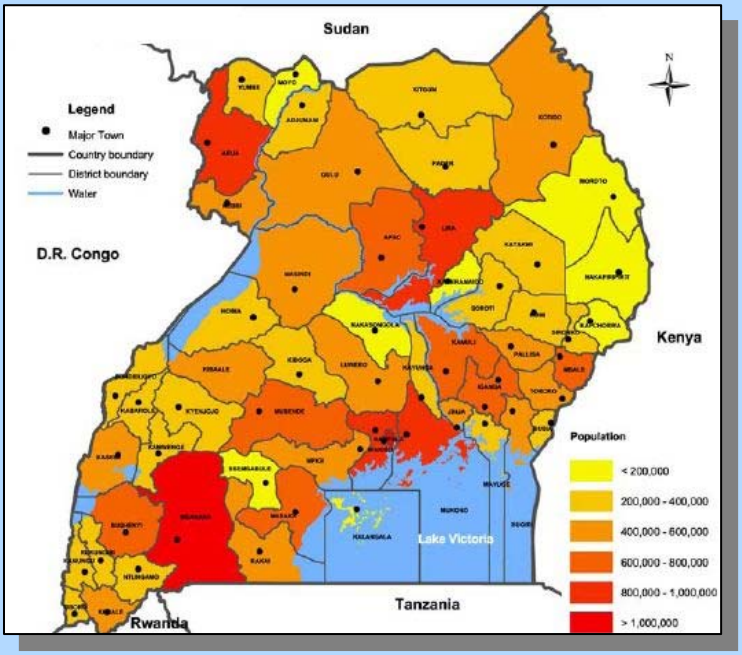
HIV Prevalence map is from:
MoH and Macro (2007) Uganda Atlas of HIV/AIDS Indicators: Based on the 2004-05 Uganda HIV/AIDS Sero-Behavioural Survey. Ministry of Health, Kampala, Uganda and Macro International Inc., Calverton, Maryland, USA. September

Moving toward Universal Access is the goal of the NSP 2007/8–2 011/12. As the accompanying figures show, there are many imbalances between the distribution of the national population and the population infected by HIV versus the location of the key prevention, care and treatment and social support services.

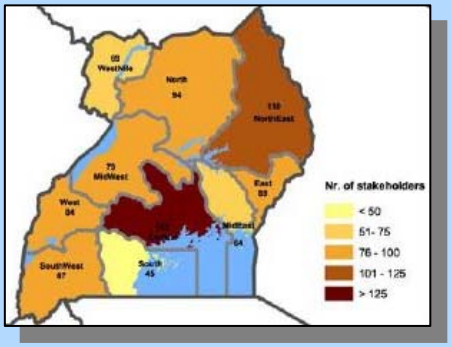
HIV Prevalence 2004-5



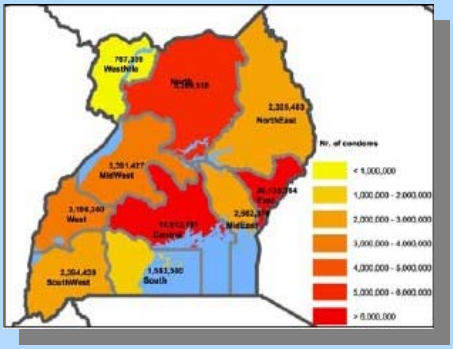
Uganda Population 2002



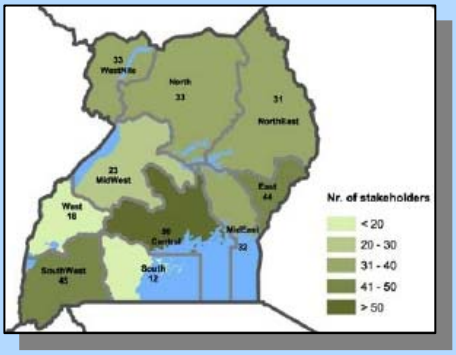
IEC Providers 2005



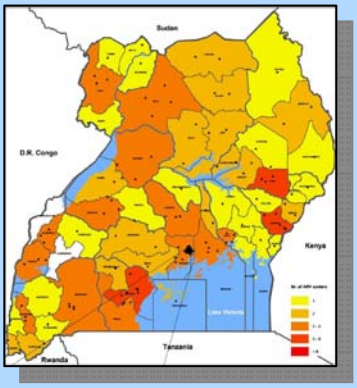
Condom Distribution 2005



VCT Services 2005



ART Providers 2005



OVC Care Providers 2005