The National HIV Prevention Strategy for Uganda 2011-15

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

The National HIV Prevention Action Plan for 2011-13

Final Version Submitted to
The Uganda AIDS Commission
And
The National HIV Prevention Committee

Volume 3: The National HIV Prevention Action Plan

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Acronyms

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

1. Introduction

Uganda has developed a National HIV Prevention Strategy to guide national efforts in the next phase of HIV prevention in the country in order to significantly reduce new HIV infections by about 30% by 2015. This, in line with the targets in the NDP would result in 40% reduction of the projected number of new infections in 2015, and avert about 200,000 new infections over five years. Virtual elimination of vertical infections is part of this overall goal. This will be achieved through:

i. Increased coverage and utilization of HIV prevention services. Attainment of this goal and outcomes is also contingent on
ii. Increased adoption of safer sexual behaviors and reduction in risk taking behaviors,
iii. A strengthened and sustainable enabling environment that mitigates underlying factors that drive the HIV epidemic,
iv. Strengthened leadership and coordination of HIV prevention programs, and
v. Strengthened information systems for HIV prevention.

The HIV prevention strategy is based on the latest scientific evidence of what drives the epidemic in the country, and outlines measurable targets and timelines as well as accountability mechanisms for the results. This action plan for the first two years of the *National HIV Prevention Strategy 2011-2015* presents the National Plan for moving towards the strategy goals and outcomes, and includes immediate and short-term actions for 2011 – 2013. The longer term actions are not highlighted in the action plan, but can be derived from the overall HIV prevention strategy. More specific actions will be developed after the first two years. The specific activities will be developed annually by line ministries responsible for various sectors, district teams and other implementing agencies. The UAC, NPC and MoH will provide technical guidance.

The HIV Prevention Strategy and the Action plan are living documents that will be updated after the midterm review. In addition, as new technical policies are developed as new evidence emerges from HIV prevention research e.g. PREP, microbicides, vaccines development, Test-and-Treat studies, the plan will be updated and new activities identified.

The implementation of this strategy will not and should not be undertaken by the UAC or MoH alone. All key stakeholders, public sector including the decentralized response, and the private sector implementing partners including NGOs/CSOs should work together to better coordinate their responses to HIV/AIDS at national, district and community levels. This strategy should therefore serve as a catalyst for stakeholders at all levels to develop their implementation plans for achieving the goals of the *National HIV Prevention Strategy*.

This document outlines the main actions to be undertaken by various stakeholders to meet the targets laid out in the Strategy. It was developed based on input solicited from stakeholders during National Planning meetings, sectoral planning meetings that were managed by a separate team of consultants, district consultations in six districts and working with stakeholders that

organized their own planning meetings. The team of consultants leading the process, as well as the expert think tank and the National HIV Prevention Committee reviewed the recommendations arising from the consultative meetings, assessed their scientific evidence and came up with final recommendations for the action plan.

This plan is not intended to be an exhaustive list of activities that are necessary to meet the goals of the strategy. Rather, it is a concise plan that identifies a set of priorities and strategic actions tied to measurable outcomes. The plan outlines specific actions to be undertaken by various stakeholders to support high level implementation of the strategy.

The quantitative targets in the strategy and action plan are ambitious. It will require reallocation of existing resources and focusing on the most effective interventions. There is still a strong case for making new investments in HIV prevention to reduce costly new infections in the future. Achieving these goals, however, requires stronger partnerships between National, district, facility and community implementing partners, faith groups, private sector and community-based organizations.

Summary of the Implementation Strategy

The Implementation of the priority activities for HIV prevention in the country outlined in this Action Plan will be undertaken by various stakeholders working together under the auspices of the multi-sectoral approach. Each implementing entity will conduct activities in line with its mandate and comparative advantages. All implementing entities will be required to develop annual HIV prevention plans aligned to the overall National HIV Prevention Strategy. The plans will continue to be part of the overall HIV/AIDS control plans for the various sectors. The multi-stakeholder involvement in the implementation of combination HIV prevention requires a high level of coordination, and collaboration across sectors, implementing entities, local governments, and service delivery entities.

Role of the Uganda AIDS Commission:
In the HIV prevention strategy, UAC will continue with its oversight role of nation-wide efforts in HIV prevention. This will include coordination of policy development, planning, resource mobilization and allocation, as well as monitoring and reporting on progress. UAC will support sectors and districts to develop annual plans, and collate the plans and progress reports to compile annual progress reports on HIV prevention to be shared with the Office of the President and stakeholders through various fora including the Joints AIDS Programme Review (JAR). UAC through its NPC will from time-to-time hold stakeholder meetings on HIV prevention to monitor implementation reports, identify gaps and draw the attention of stakeholders.

Role of the Ministry of Health:
The MoH is central to the implementation of this strategy. It will be responsible for coordination and technical guidance of the public health response which comprises the majority of the HIV prevention services. Within the MoH, the ACP will be responsible for coordinating service delivery in public and private facilities and other public health programmes. The MoH will also be responsible for quantification, procurement and supply chain management of commodities for HIV prevention, oversee integration of services in the sector, track the magnitude and dynamics of the epidemic through surveillance systems, as well as trackimplementation of HIV prevention in districts and other implementing partners. The MoH will be expected to develop annual plans on HIV prevention, as well as compilation of regular progress reports from the sector.

Roles of Other Line Ministries:
At the inception of the strategy, all sectors will be required to review their policies and come up with steps that they will take to support implementation of the strategy. They will also be required to develop annual plans for HIV prevention aligned to the National HIV Prevention Strategy, including plans for supporting sub-national entities as well as tracking implementation of HIV prevention endeavours within respective sectors. To facilitate this role, each line ministry will identify a responsible desk officer to coordinate HIV prevention in the sector, and be accountable for compilation of quarterly progress reports on HIV prevention in the sector. The

reports will outline progress being made in meeting the goals of the HIV Prevention Strategy. These reports will be shared with UAC and other stakeholders.

Role of Districts and Local Governments:

Since district and local governments are responsible for service delivery, UAC, MoH and line ministries will work with district teams to develop district strategic and annual multi-sectoral workplans for HIV prevention as part of their overall HIV/AIDS plans. The plans will be aligned to the National HIV prevention Strategy in order to adequately focus on the drivers of the epidemic. The plans will incorporate activities of all IPs operating in the district, including activities funded from national, local and external sources. Districts will also be responsible for coordination of various IPs in the district irrespective of source of funding, and ensure that linkages and referral mechanisms between IPs and other district entities are established and functional in order to offer the complete package of HIV prevention services. Districts also will be required to indentify a lead officer and department that will be responsible for coordination and compilation of regular progress reports. Specific technical departments and IPs will continue to develop their own plans which will be integrated into the district plan. They will also be responsible for providing regular reports to respective line ministries. Districts will also collaborate with networks of PLHIV to ensure that they are effectively represented and involved in all steps of planning, implementation and monitoring of all HIV/AIDS programames. Furthermore, districts and local government will be required to mobilize local resources for investment in HIV/AIDS prevention, care and treatment as one measure of ensuring sustainability of HIV prevention endeavours.

Role of Implementing Partners, NGOs, CBOs:

In line with the multisectoral approach, IPs, NGOs, FBOs, CBOs, research and academic institutions, private sector entities, health facilities, etc at all levels will also play significant roles in HIV prevention in order to meet the goals of HIV prevention laid out in the strategy. The specific roles will be in line with their mandates and comparative advantage. For example, NGOs are often more efficient in reaching MARPs, as well as supporting community dialogue to address social-cultural and gender norms. Coordination of the various entities will be critical to ensure delivery of a complete package of HIV prevention services to communities and individuals. All stakeholders will be required to harmonise their plans with the district plan and to provide regular reports to districts and line ministries so that they can be incorporated in district-wide and national reports of HIV prevention.

Summary of the Targets for the National HIV Prevention Strategy

Results	Indicators and Targets
Goal: To Reduce New HIV infections countrywide by 30% based on the 2009 levels, which will achieve a 40% reduction of the projected new HIV infections in 2015	• New HIV Infections reduced by 30% of the 2009 levels to achieve a 40% reduction of the projected new infections in 2015 • PMTCT Rate Reduced to less than 10% by 2015 • 180,000 new HIV infections averted over 5 years
Outcomes	
i) Increased coverage and utilization of HIV prevention services	• The proportion of HIV-infected mothers and exposed infants accessing PMTCT increased to 90% • The proportion of adults who have recently tested for HIV increased to 80% • The proportion of adults males that are circumcised increased to 80% • The proportion of clinically eligible ART clients enrolled on treatment increased to 80% • The proportion of risky sex encounters (multiple partnerships, casual and sex with partners of unknown HIV sero-status) that are consistently protected by condoms increased to 80% • All HIV care and treatment outlets will have integrated HIV prevention • All facilities implementing blood transfusion safety and universal infection control measures
ii) Increased adoption of safer sexual behavior and reduced risky behaviors	• Recent multiple partnerships reduced by 50% among men and women respectively • Transactional sex among men and women reduced by 50% • Cross-generational sex and early sex reduced by at least 50% • Casual sex reduced by at least 50%
iii) A strengthened and sustainable enabling environment that mitigates underlying factors that drive the HIV epidemic	• Increased women emancipation e.g women who make decisions about their SRH independently or jointly with partners increased from 61% to 80% • SGBV among women reduced from 39% to 10% • % SGBV survivors helped by social service organizations increased from 23% to 60%. • Reduced Stigma and discrimination e.g. % expressing fear of contracting HIV from casual contact with PLHIV reduced by 50% from 19% women & 28% men) • % of adults who believe that a wife is justified to refuse sex with her husband if he has an STD increased to 100% from 84 % women and 90% men. • Ratio of orphans: non-orphans (10-14 yrs) attending school increased from 0.9 to 0.96 • % OVC and non-OVC (5-17 years) whose basic needs (i.e. clothing, shelter, nutrition/food) are met increased from 28% to 50%
iv) Achieving a more coordinated HIV prevention response at all levels	• National Composite Policy index for coordination increased from 67.5% (2005) to 85% • All districts having functional HIV coordination structures • All districts having functional PHA networks • HIV/AIDS spending increased from 3% (baseline for 2004) to 5% of total annual national budget • HIV Prevention expenditure increased from 25% (UNGASS 2010) to 40% of HIV/AIDS budget • 100% local governments allocating funds from local revenues for HIV prevention
v) Strengthened information systems for HIV prevention	• Data on new HIV infections tracked annually and disseminated • Population/facility surveys of HIV prevention outcomes conducted every 3-5 years • Major HIV prevention interventions evaluated for impact in the country • Annual reports of HIV prevention comparing outcomes/outputs against targets, produced • All significant HIV Preventions programmes have M&E systems and plans • Population size and HIV burden of at least five MARPs determined by 2015

Outcome 1: Increased Coverage, and Utilization of HIV prevention services

Under combination HIV prevention, delivery of a core packed of evidence-based interventions that will be scaled up to achieve critical levels of coverage. The core components of the HIV prevention package will comprise of: PMTCT, HCT (couple CT with disclosure of results to partners and risk-reduction counseling), SMC, Condom promotion, and ART for prevention. This will be augmented with complementary services comprising of Medical Infection control and PEP, Blood transfusion safety, HIV Prevention with positives, and STI screening and treatment tailored to specific population groups. These will be reinforced by behavior change communication and demand creation activities. There is also need to prepare for roll out of new HIV prevention technologies that are still under clinical evaluation e.g. PreP, microbicides, Test and Treat, HIV vaccines etc. Condom promotion and IEC/BCC are discussed under Outcome 2.

Indicators and targets:

- The proportion of HIV positive mothers and exposed infants accessing PMTCT (option B) increased to 80%
- The proportion of adults who know their HIV sero-status increased to 80% by 2015
- The proportion of risky sex acts (multiple partnerships, casual and sex with partners of unknown HIV serostatus) that are consistently protected by condoms increased to 80%
- The proportion of adults males that are circumcised increased to 80%
- Increase coverage of ART for eligible clients to 80%
- The proportion of risky sexual encounters that are protected by condoms increased to 80%
- At least 80% of HIV Prevention care and treatment integrate HIV Prevention
- At least 100% blood transfusion safety in facilities
- All facilities in the country implementing universal infection control measures

Strategies and Priority Actions:

The main strategies for addressing the biomedical drivers of the epidemic in the next phase of HIV prevention in the country are:

1.1.Scaling up HIV Prevention Services to attain critical coverage of core services:

In the next phase of HIV prevention, it is imperative that various population groups have uninterrupted access to a comprehensive package of services. The core HIV prevention services in the minimum package comprise of PMTCT, HCT, SMC, ART and Condom use and Behaviour change interventions. Complimentary services in the package comprise of medical infection control, blood transfusion safety, and STI treatment. These services will be tailored to specific population groups. For instance, STIs services should be tailored for MARPs where their effectiveness in prevention of HIV transmission has been demonstrated. Expansion of IEC/BCC initiatives is discussed separately under outcome 2. The priority activities for the short to medium-term to attain critical coverage of core services will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions

1.1.1.	By end 2011	Map core HIV prevention services for the general population and other priority groups at national and district level to identify districts and facilities in need of urgent support	**MoH**, **District teams**, IPs
1.1.2	By mid 2012	Update scale up plans for core HIV prevention services to fill identified gaps to achieve critical coverage	**MoH**, **District teams**, IPs
1.1.3	By mid 2012	Review and update policies, technical guidelines and standards for delivery of the core HIV prevention services	**MoH**, UAC
1.1.4	By Mid 2012	Develop guidelines to ensure that RFAs and any funding for HIV prevention demonstrates appropriate partnerships and referral linkages that will ensure that beneficiaries receive a complete package of HIV prevention services	**UAC, MoH, ADPS,**
1.1.5	By end 2012	Strengthen facility capacity for quality service delivery through training of facility staff, provision of equipment and supplies and other resources	**MoH**, UAC, IPs, DHTs, Facilities, Local Gvts
1.1.6	2011 – 13	Ensure provision of uninterrupted core package of HIV prevention services in all service outlets	**MoH**, UAC, IPs, DHTs, DACs, Facilities
1.1.7	By end 2012	Introduce or scale up provider-initiated HCT and couple counseling and testing to all health facilities	**MoH**, UAC, IPs, DHTs, DACs, Facilities
1.1.8	By end 2012	Introduce / scale up SMC services to all facilities from HC IV onwards, augmented with outreaches to all HC IIIs, and dedicated mobile SMC teams	**MoH**, UAC, IPs, DHTs, DACs, Facilities
1.1.9	By end 2012	Introduce / scale up comprehensive PMTCT services based on option B, FP and infant feeding counseling to all ANC facilities, SRH outlets	**MoH**, UAC, IPs, DHTs, DACs, Facilities
1.1.10.	By end 2013	Integrate HIV prevention into all HIV care, support and treatment outlets countrywide	**MoH**, UAC, IPs, DHTs, DACs, Facilities
1.1.11	By End 2011	Develop policies, guidelines and pilot projects for ART for HIV prevention (early ART and PREP), including regimen selection, adherence support mechanism, etc	**MoH, NPC, NAC,** UAC, IPs, ADPs
1.1.12	2011-13	Institute and implement pilot projects for combination HIV prevention in selected geographical areas with rigorous impact evaluation and documentation of Best practices	**GoU,** ADPs, CSOs,
1.1.13	2011-13	Expand provision of HIV Prevention Services at the workplace for the public sector	**MoPS**
1.1.14	2012-13	Set up outreach or dedicated clinics for hard-to-reach population groups e.g. STI services for sex workers, moonlight clinics for truckers, etc	**District Teams,** IPs

1.2 Distribution and Promotion of Condoms:

Increasing the use of male latex condoms and the female condom as a key component of combination HIV prevention in the next phase of HIV prevention in the country is critical. In the short-to-medium term, emphasis will be on increasing condom procurement and distribution, as well as promotion of use especially during casual sex, among HIV sero-discordant couples, where HIV sero-status is unknown, long standing relationships etc. The priority activities will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
1.2.1	By end	Quantify national and local condom requirements, procurement and	**MoH**, IPs, District teams

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
	of 2011	distribution to outlets	
1.2.2	By end of 2012	Expand condom distribution outlets for the general population and special groups, in facilities, community and commercial outlets, lodges, bars, hotels, etc to ensure that there at least 20 condoms per adults/ yr	**MoH**, Condom promotion and MARPs IPs, Districts,
1.2.3.	2011-13	Develop a strategy and implement concerted condom distribution for MARPs	**MoGLSD**, UAC, MoH, CSOs
1.2.4	2011-13	Condom promotion campaigns using a dynamic mix of channels including mass media, fetes, etc	**IPs**, Districts
1.2.5	By end 2012	Expand promotion, procurement and distribution of female condoms to urban and peripheral outlets	**MoH**, Condom and MARPs IPs, Districts,
1.2.6	2011 – 13	Expand social marketing of condoms to all urban areas, hot spots,	Condom socio-marketing IPs, MoH
1.2.7	2011 - 13	Concerted condom use education campaigns, paying attention to misconceptions and other barriers to condom use	Condom socio-marketing IPs, MoH

1.3 Strengthening the supply chain management of HIV prevention medical and pharmaceutical supplies

The weaknesses in the supply chain management of medical and pharmaceutical supplies for HIV prevention affecting ARVs, HIV and STI test kits, condoms, infection control commodities etc need be addressed to ensure effective HIV prevention services. This will involve a review of current systems, and specific measures to strengthen quantification, procurement, inventory management and distribution of the commodities to peripheral service outlets. Specific activities for the short-medium term will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
1.3.1.	By end of 2011	Review and streamline the supply chain management of medical, pharmaceutical, laboratory and other commodities for HIV prevention	**MoH, UAC,** NMS,
1.3.2	By mid 2012	Quantify national, district and facility level needs for the various medical, pharmaceutical and laboratory supplies for HIV prevention	**MoH**, DHTs, IPs, Facility teams
1.3.3	2011-13	Procure adequate quantities of medical, pharmaceutical and laboratory supplies for HIV prevention	**MoH**, DHTs, IPs, NMS, JMS, Facility teams
1.3.4	2011-13	Strengthen the capacity for inventory and supply chain management of medical, pharmaceutical and laboratory supplies for HIV prevention	MoH, NMS, DHTs, IPs, Facilities
1.3.5	2011-12	Track and address recurrent PSM bottlenecks	**MoH**, DHTs, IPs, NMS, JMS, Facility teams
1.3.6	2011-13	Support facilities with equipment and supplies for safe disposal of medical waste in all facilities	**MoH**, DHTs, IPs, NMS, JMS, Facility teams

1.4 Integration of HIV prevention services in clinical and community settings:

In order to increase efficiency and access to services, integration of services is critical. This includes integration of HIV prevention with SRH, MCH, care and treatment, TB and curative services. Integration will enable clients to receive complimentary services from one service

delivery point. Integration across health services will require considerable investment in various building blocks of the health system. The key actions for the medium term will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
1.4.1	By 2012	Develop of guidelines for integration of HIV prevention into other HIV prevention, care and treatment services and SRH	**MoH**, UAC, IPs
1.4.2	2011-13	Strengthen capacity for delivery of integrated services through multi-skilling, coaching, mentoring, joint planning in all districts	**MoH**, UAC, IPs, DHTs, DACs, Facilities
1.4.3	By 2013	Scale up integration of HIV prevention into all AIDS care, support and treatment outlets	**MoH**, UAC, IPs, DHTs, DACs, Facilities
1.4.3	2011-13	Conduct joint planning meetings and field visits to monitor delivery of integrated services	MoH, IPs, District Teams
1.4.5	2011-13	Develop guidelines and implement integration of HIV prevention into other community services and activities	MoGLSD, IPs, District teams
1.4.6	2011-13	Mainstream HIV prevention into development programmes at community level countrywide	MoFPED, MoGLSD

1.5 Expand provision of targeted Combination HIV prevention services for MARPs:

Some population groups bear a disproportionate burden of HIV infections, and bridge to the general population. Mapping of these population groups and availability of HIV prevention services for them will be done at national and local level. In addition, ethnographic studies, profiling the population groups will be implemented. Minimum HIV prevention packages for the various groups will be adapted and systematic scale up of services in the package for MARPs through a combination of dedicated services and referral linkages through coalitions of IPs will be instituted. The structural drivers of the epidemic in the various groups will be simultaneously assessed and addressed. Communities, IPs and districts will be supported to build capacity to monitor delivery of comprehensive services for the various groups. Specific actions for the intermediate term will be as follows:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
1.5.1	By end 2011	Develop technical guidelines for provision of effective HIV prevention services for MARPs basd on a minimum combination package	**UAC**, MoH, NPC,
1.5.2	By mid 2012	Map MARPs and coverage of dedicated comprehensive HIV Prevention services	UAC, MoH, MoGLSD, IPs, Districts, MoIA, MoD
1.5.3	By end 2013	Conduct ethnographic studies to profile MARPs including structural factors affecting the population groups	UAC, MoH, MoGLSD, IPs, District Teams
1.5.4	2012 – 2013	Planning, delivery and monitoring of comprehensive HIV prevention services for various MARP groups	UAC, MoH, MoGLSD, IPs, Districts MoIA, MoD
1.5.5	By 2013	Develop a plan of action to address the structural factors that disproportionately affect MARPs	UAC, MoGLSD, MoLG, Districts, MoIA, MoD
1.5.6.	2011-13	Roll out of innovative educational and service delivery models for mobile MARPs e.g. wellness centres for truckers, or mobile clinics for fisher folk	**MoTW, MoAAF,** UAC, MoHCSOs

1.6 Demand Creation for HIV Prevention services, while addressing barriers:

It will be critical that uptake of HIV prevention services is increased side by side with roll out of services. Therefore, demand creation, and addressing barriers to uptake of services will be addressed through communication endeavours. The priority action to achieve this in the short term will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
1.6.1	By mid 2012	Develop / standardise / translate of IEC/BCC messages and materials for demand creation of existing HIV prevention services at various levels	MoH, UAC, Districts, IPs
1.6.2	2011-13	Disseminate demand creation IEC/BCC messages and materials for the general and specific population groups using a mix of channels e.g. mass media, interpersonal, peer network, campaigns, community dialogue, etc	MoH, UAC, Districts, IPs
1.6.3	2011-13	Conduct dialogue on barriers to health seeking behavior during community dialogue sessions countrywide	MoGLSD, UAC, Districts, IPs, Facilities
1.6.4	2011 – 13	Sensitisation of HUMCs and health workers on appropriate communication and user friendly attitude	DHTs, MoGLSD, IPs
1.6.5	By end of 2012	Build the capacity of VHTs, peer support groups, PHA networks, community leaders and other CHWs to support mobilization and referral for HIV prevention services	MoH, MoLG, LG UAC, IPs/CSOs
1.6.6	2011-13	National HIV Prevention and HIV testing week every quarter	MoH, District and Facility teams, UAC and CSOs

1.7 Preparedness for new HIV Prevention Technologies

Since there are some promising HIV prevention research studies on new HIV preventions methods underway, there is need for preparedness to rapidly roll out the successful interventions. Among the promising studies that are likely to have a long-term impact are vaccines and microbicides, and innovative use of ARVs for HIV prevention such as pre-exposure prophylaxis, early ART initiation and "Test and Treat". Some of these studies promise to change the landscape of HIV prevention. The HIV prevention community should prepare to ensure that any emerging evidence is promptly disseminated and discussed, and appropriate policy and technical guidelines developed. Operational and feasibility, as well as local acceptability studies should also be conducted promptly to inform the role out plans. Key actions for this comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
1.7.1	2011-13	Organise dissemination and technical and stakeholder discussion of any new scientific evidence on HIV Prevention	NPC, UAC, UNAIDS, MoH, Research Institutions, UNHRO
1.7.2	2011-13	Feasibility and local acceptability studies for the roll out of new HIV prevention technologies	NPC, UAC, UNAIDS, MoH, Research Institutions, UNHRO
1.7.3	2011-	Develop and disseminate policy and technical guidelines and training	MoH, UAC, CSOs

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
	13	materials on new HIV prevention technologies	
1.7.4	2011-13	Develop IEC/BCC messages and materials on new HIV prevention technologies	MoH, UAC, CSOs
1.7.5	2011-13	Capacity building of service providers and service outlets to roll out new HIV prevention technologies	MoH, UAC, CSOs

Key Outputs:

Outcome 2: Increased adoption of safer sexual behaviors and reduction in risk taking behaviors

In the *National HIV Prevention Strategy* cost-effective evidence-based approaches for adoption of safer sexual behavior and reduction of risk taking behavior in the general population and specific population groups are emphasised. National and sub-national level stakeholders will implement programmes efforts to modify sexual behaviours that are driving the epidemic.

Indicators and targets:

The targeted outcomes of behavior changes programmes based on the corresponding indicators are as follows:

- Recent multiple partnerships reduced by 50% among men and women respectively
- The proportional of adult men and women that engage in transactional sex in the previous 12 months reduced by 50%
- Cross-generational sex and early sex reduced by at least 50% by 2015
- Casual sex reduced by at least 50% by 2015

Strategies and Priority Actions:

The strategies and priority actions for adoption of safer sexual behaviour and reduction of risky behaviour in the next phase of HIV prevention will be as follows:

2.1 Behaviour Change Interventions among all population groups with focused messages on multiple partnerships, transactional/early/cross generational sex:

Shifts in high risk sexual behaviour will require effective approaches, involving coordinated multi - channel communication (mass media, community mobilization, working with peers, and simultaneously addressing the socio-cultural and structural context that underpin the behaviours). The priority actions for the first two years of the strategy will be as follows:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
2.1.1.	By end of 2011	Update, launch and disseminate IEC/BCC communication strategy aligned to the drivers of the HIV epidemic	**UAC**, MoH
2.1.2	By end of 2011	Develop / standardise / translate IEC/BCC messages and materials on the drivers of the epidemic for use by stakeholders at various	**MoH,** Line Ministries, IEC/BCC IPs

		levels	
2.1.3	2011 – 13	Disseminate IEC/BCC messages and materials to the general population and specific groups using a dynamic mix of mass media, interpersonal, peer network, campaigns, and community dialogue avenues	**CSOs**, Districts, IEC/BCC IPs, MoH, Line Ministries
2.1.4	2011-13	Expand provision of HIV education for in-school youth with focus on multiple partnerships, cross-generational, transactional and early sex using curricular, life skills, and peer network channels	**MoES**, MoH,CSOs, DEOs, schools
2.1.5	2011-13	Expand provision of life skills training, peer networks, and youth friendly SRH services for out of school youths	**MoGLSD**, MoH, CSOs, DHTs, facilities
2.1.6	2011 - 13	Expand provision of quality educational, counseling and SRHs services to all tertiary education institutions	**MoES**, MoH, Tertiary institutions, CSOs

2.2 Strengthen policy guidance, quality assurance and capacity to design, implement and monitor IEC/BCC at all levels

In order to address the capacity gaps among stake holders that impede delivery of effective IEC/BCC messages and campaigns, it is necessary to establish mechanisms for capacity building of IEC/BCC IPs to plan, design and monitor. There is also need for policy guidance, quality assurance and minimum standards for IEC/BCC delivery. The following priority actions for the short-to medium term will facilitate the realization of this need.

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
2.2.1	By end 2011	Develop implementation guidelines, and minimum quality standards for IEC/BCC activities of all stakeholders in the country	**UAC**, **MoH, NPC,** IPs, ADPs, Line ministries
2.2.2	2011-13	Sensitise districts, IPs, community leaders and other stakeholders on effective HIV Prevention interventions, IEC/BCC guidelines and approaches	**UAC, MoH**, District teams, IPs
2.2.3	By 2012	Review and update IEC/BCC training manuals and guidelines of various IPs (e.g. peer group leader training) to ensure consistency with the National HIV Prevention Strategy	**UAC**, all IPs
2.2.4	2011-13	Facilitate IEC/BCC committee to provide ongoing monitoring, QA and a clearing house for IEC/BCC messages and materials	**UAC**, **MoH,** MoLG, Line ministries
2.2.5	2011-13	Regular meetings / guidance to media houses on HIV information dissemination in the mass media	UAC, MoH, MoI, UCC
2.2.6	2012-13	Conduct regular impact evaluation of IEC/BCC activities of various stakeholders	**UAC, MoH**, all IPs, Research Institutions

2.3 Promote increased participation of PLHIV in HIV prevention initiatives:

Provision of comprehensive HIV prevention, care, and treatment services to HIV-positive individuals is a proven effective HIV prevention initiative. Provision of HIV/AIDS care and treatment avails unprecedented opportunities for the health system to interact with PLHIV and offer them risk reduction counseling. In the next phase of HIV prevention, the coordinated provision of a core package of HIV prevention services to PLHIV will involve the following:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
2.3.1	By end 2012	Roll out delivery of minimum package of HIV prevention services to all AIDS care and CT service outlets	**MoH,** CSOs, District teams
2.3.2	By end 2012	Develop / update guidelines for involvement of PLHIV in HIV prevention service delivery for PwPs	**MoH**, UAC, IPs, MoGLSD, Networks of PLHIV
2.3.3	2011-13	Orientation / sensitization PLHIV in PwP	**Networks of PLHIV**, MoH, UAC, IPs, MoGLSD
2.3.4	2011-13	Task-shifting of some HIV prevention tasks to PLHIV as expert patients, lay counselors etc. to PLHIV	**Networks of PLHIV**, MoH, UAC, IPs, MoGLSD
2.3.5	2011-13	Capacity building of networks of PLHIV and individuals to plan, implement and monitor HIV prevention initiatives	**Networks of PLHIV**, MoH, UAC, IPs, MoGLSD
2.3.6	2011-14	Advocate for and support provision of HAART to all clinically eligible PLHIV, PMTCT option B, early ART initiation among HIV sero-discordant couples, PREP for high risk or sero-negative individuals	**MoH,** UAC, CSOs,

Outcome 3: Strengthened Sustainable Enabling environment that mitigates Underlying Factors Driving the HIV Epidemic

In Ugandan, the key drivers of the epidemic currently comprise of harmful cultural norms, beliefs and practices; gender disparities, weak enforcement laws and violation of their rights, wealth and poverty, HIV-related stigma and discrimination, poor governance and accountability, inequitable targeting of existing HIV services and weak leadership and coordination of HIV response especially at the local government level. The HIV Prevention Strategy seeks to influence these factors that increase risk and vulnerability to HIV infection.

Indicators and Targets:

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

- Increased women emancipation (a) women who make decisions about their SRH independently or jointly with partners increased from 61% to 80% (b) adults who believe that a wife is justified to refuse her husband sex if he has an STD increased to 100% from 84% women, 90% men.
- Sexual and Gender-Based Violence among women reduced from 39% to 10%
- Survivors of SGBV seeking help from service organizations increased from 23% to 60%.
- Stigma and discrimination reduced as seen from adults expressing fear of contracting HIV from casual contact with PLHIV reduced by 50% from 19% women & 28% men;
- Ratio of orphans: non-orphans (age 10-14 yrs attending school increased from 0.9 to 0.96
- Secondary-school children aged (13-18 yrs) attending school increased from 16.3% to 25%
- OVC and non-OVC 5-17 years whose basic needs (i.e. clothing, shelter, and nutrition/food) are met increased from 28% to 50%
- Improved legislative and policy framework that promotes HIV prevention for vulnerable and most-at-risk populations.

Strategies and Priority Actions:

The strategies and priority actions to influence change in factors that increase risk and vulnerability to HIV infection are as follows:

3.1 Reviving political leadership for HIV prevention at all levels

Reviving political leadership commitment and leadership support for HIV prevention will be crucial to realizing HIV prevention results in the next phase. Political leaders at all levels will be mobilized and empowered to take the lead in promoting change in the factors that increase risk and vulnerability to HIV infection. They will also be engaged in creating demand for HIV preventive services. Priority actions for the short term will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
3.1.1	By end 2011	Advocacy for revival of political leadership for HIV prevention from Presidency, parliament, local governments , religious and cultural leaders	UAC, MoLG, Parliamentary HIV/AIDS Committee, MoGLSD
3.1.2	By end 2011	Develop tools and simple guidelines for political leaders to mobilize communities for HIV prevention.	UAC, MoLG, LG, MoGLSD, IPs
3.1.3	By mid	Sensitise political leaders to mobilise communities for HIV prevention	UAC, MoGLSD, MoH, IPs

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
	2012	and monitor HIV prevention services	
3.1.4	2011-13	Mobilise specific leaders to serve as role models, ambassadors or champions of specific HIV prevention initiatives e.g. PMTCT or HCT	UAC, IRC, Cultural leaders
3.1.5	2011 – 13	Expand and implement workplace policies and educational programmes for workers incorporating multiple partnerships and transactional sex	MoH, MoGLSD, MoLG

3.2 Changing Harmful Socio-cultural and gender norms, beliefs and practices:

In the next phase of HIV prevention, there will be increased focus on socio-cultural factors that hinder behaviour change. Communities and families will be empowered to address the socio-cultural drivers of HIV through context-specific interventions. Furthermore, best practices in influencing change in masculinity and gender norms that make women and men vulnerable to HIV will be documented and shared in order to improve how organizations, families and communities respond to HIV. This will entail the following priority actions in the short term.

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
3.2.1	By end 2011	Undertake research on socio-cultural factors that hinder sexual behaviour change	MoGLSD, UAC, Research Institutions
3.2.2	By 2012	Documentation and sharing best practices for motivating change in harmful gender norms	MoGLSD, UAC, IPs Academic/Research
3.2.3	2011 - 13	Community dialogues on factors that hinder behaviour change and uptake of HIV prevention services in all communities countrywide	MoGLSD, NGOs/CSOs, IPs, Districts
3.2.4	By end 2012	Build capacity of community leaders to mobilize for change of harmful cultural norms and practices	UAC, MoH, MoGLSD and IPs
3.2.5	By end 2012	Support communities to design and implement context specific interventions that address harmful socio-cultural and gender norms	MoJ, MoGLSD, UAC

3.3 Strengthening capacity of health and social services to provide services for SGBV.

Advocacy to ensure that SGBV victims and survivors access quality and timely health and social support services will be stepped up. Community level interventions will focus on strengthening the capacity of existing structures and networks (LCs, Police, health units, legal aid structures) so that they can enable women and other vulnerable groups to access health and social support service. Key actions in the short term comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
3.3.1	By mid 2012	Research the causes and manifestation of SGBV in different contexts , and design and implement appropriate interventions based	**MoGLSD**, MoH, MoJ, MoLG, MoIA (Police)
3.3.2	By end 2012	Advocacy workshops to support service providers to support SGBV survivors to access services at all times	**UAC**, Districts, MoGLSD, , LG, IPs, CSOs, MoIA, MoJ
3.3.3	2011-13	Expand provision of services for timely management SGBV using the standard package	**MOH**, IPs/CSOs, MoLG
3.3.4	2011-13	Liaise with existing health services providers to make basic equipment and supplies for forensic examination available in	**MOH,** UAC, LG IPs

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
		examination rooms	
3.3.5	By mid 2012	Train nurses and doctors countrywide to provide comprehensive SGBV related services	**MoGLSD**, MOH, LG, UAC, IPs/CSOs
3.3.6	By end 2012	Develop and disseminate facility-level protocols for collecting forensic evidence and referring SGBV survivors	**MoIA**, MOH, , LG, IPs/CSOs/
3.3.8	By end of 2012	Strengthen referrals from the health facility to other social and legal support services for survivors of SGBV	**MoGLSD,** MOH, UAC, LG, IPs/CSOs/

3.4 Strengthening the legislative and policy framework for HIV prevention

In the next phase of HIV prevention, there will be focus on influencing implementation of laws and policies that facilitate HIV prevention, especially those that address SGBV and other rights violations against women and other vulnerable and most-at-risk groups. Advocacy to strengthen institutions to enforce the requisite laws will be undertaken, as well as advocacy to re-examine existing laws to identify inherent gaps/structural impediments that make some groups vulnerable to HIV infection. Community level interventions will focus on advocating for strengthening the capacity existing structures and networks (LCs, police, and health units) in order to adequately support women and other groups to access justice. The priority actions for the short term are:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
3.4.1.	2011-13	Create awareness of existing laws and institutions that address SGBV among community leaders	**MoGLSD**, MoJ, MoIA, and UAC, & IPs/CSOs
3.4.2	2011-13	Analysis of existing legislation and advocate for the amendment of laws that restrict provision of HIV prevention services to some groups	**UAC**, MoGLSD, and IPs/CSOs, HRC, LRC, MoJ
3.4.3	By end 2011	Lobby government to increases resources for enforcement and monitoring of laws regarding SGBV, girl education	**UAC**, MoIA, MoGLSD & IPs/CSOs, ADPs, MoE
3.4.4	By mid 2012	Advocate for effective implementation of policies and laws addressing SGBV and other structural drivers of HIV	**MOH**, UAC, MoJ, MoIA
3.4.5	By end 2012	Establish and /or build the capacity of existing community-based structures and networks (LCs, police and health units) to support women and other vulnerable groups to access justice	**MoIA**, MoGLSD & IPs/CSOs, MoLG, MoJ, LCs

3.5 Incorporating HIV prevention needs of Women and other groups in development programs

In the next phase of HIV prevention, there will be focus on advocating for affirmative action in livelihood and development programs to be more responsive to needs of MARPs and women, and therefore contribute to reducing their vulnerability. The capacity of line ministries and district local governments will be built to strengthen mainstreaming of HIV all livelihood and development programmes at all levels. The priority actions for the short term will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
3.5.1	2011-	Advocate for affirmative action in development and livelihood	UAC, MoT&C, IPs /

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
	13	programmes for population groups that are most vulnerable to HIV in communities	CSOs MoGLSD, MoIA, MAAIF, MoD, MoE&S
3.5.2	By end 2012	Build the capacity of institutions to monitor the mainstreaming of HIV in livelihood programs	UAC, MFPED, IPs/CSOs
3.5.2	By end 2012	Advocacy for introduction / scale up of community health insurance to address the needs of vulnerable groups	MoGLSD, UAC, MFPED, IPs/CSOs

3.6 Promoting male involvement in HIV prevention

The HIV Prevention Strategy engenders male involvement in HIV prevention through activities at various levels. Males will be mobilized and empowered to become major partners in HIV prevention. There will be partnerships with schools, families and religious institutions to create awareness on the impact of hegemonic masculinities and gender norms in increasing HIV risk and vulnerability. Service providers will be equipped with appropriate communication skills that attract male involvement in HIV prevention programs. In the short term, this will involve:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
3.6.1.	By end 2012	Establishment and training networks of men through the workplace	MoGLSD, UAC, MoPS, LG & IPs/CSOs
3.6.2	2011-2013	Conduct BCC/IEC interventions to empower men and boys to resist peer pressure of norms of masculinity, e.g. having many sexual partners	MoGLSD, , MoE&S, LG & IPs/CSOs
3.6.3.	By mid 2012	Conduct community and school-based interventions for boys at an early age to adopt safer behaviours	MoGLSD , MoES and IPs/CSOs
3.6.4	By end 2011	Disseminate HIV prevention messages delivered in context specific activities/events that are popular with men e.g. sports, workplaces, entertainment etc.	MoGLSD, MoH, UAC & IPs, CSOs
3.6.5	2011 - 13	Conduct grassroots based community dialogue meetings to develop positive, and respectful attitudes and behaviours towards women and girls	MoGLSD, UAC, LG and IPs/CSOs
3.6.6	By Mid 2012	Advocate for enactment of appropriate bye-laws for male involvement in HIV prevention and SRH	UAC, MoGLSD, District teams, MoJ, MoLG

3.7 Reduction of stigma and discrimination

Stigma and discrimination will be addressed through actions that target various stakeholders at different levels. These strategies will include research, capacity building and continuous dialogue with specific audiences to increase knowledge and motivate change in beliefs, attitudes and practices that generate and sustain stigma and discrimination against PLHA. Priority ctions in the short term will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
3.7.1	By mid 2012	Research on stigma to inform development of effective interventions against the drivers of stigma	**MoGLSD**, UAC, IPs/CSOs Academic/Research, UHRC

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
3.7.2	2012 - 2013	Conduct public dialogues on HIV-related stigma and discrimination in the community	**MoGLSD**, UAC, LG, CSOs, district., IRC, UHRC
3.7.3	By end 2012	Capacity building for community leaders to speak against HIV-related stigma and discrimination	**MoGLSD**, UAC, LG, districts, cultural leaders, IPs/CSOs, MoI, Media houses, UHRC
3.7.4	By end 2012	Strengthen psychosocial support services for affected individuals through training service providers and communities in counseling	**MoGLSD**, UAC, MoPS, LG, IPs/ CSOs, IRC, UHRC
3.7.5	2012-13	Develop and implement Stigma Reduction Framework to reduce stigma at service delivery points	**MoGLSD**, MoJ, UHRC, CSOs

3.8. Strengthening the capacity of families to protect and care for orphans and OVCs:

The thrust of this strategy will be to advocate for increasing social protection of OVC within their family settings. The prime focus will be on strengthening capacity of families to meet the basic and strategic needs of OVC. The priority actions for the immediate term are as follows.

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
3.8.1	By end 2012	Train front-line care providers for OVC in basic counseling skills,	MoGLSD, UAC, LG, IPs/CSOs, PHAs
3.8.2.	From 2012	Advocate for legal and appropriate social and community safety nets to benefit OVC and their families,	MoGLSD, UAC, LG, IPs/CSOs, MoJ, MoIA
3.8.3	By end 2011	Train community-based referral systems to organize and monitor referrals between OVC caregivers and service providers	MoGLSD, MoH, UAC, LG, IPs/CSOs, IRC
3.8.4	By end 2012	Advocate for building capacity of families to provide food security for OVC through training in modern farming practices, and basic nutrition.	MoGLSD, MAAIF, LG,IPs, CSOs, PHA networks
3.8.5	2012-13	Advocate for provision of non-tuition costs and essential requirements for OVC education	MoGLSD, MoES and IPs/CSOs, MoLG

3.9 Promoting efficient and effective use and management of resources for HIV Programs

Advocacy for good governance, accountability and transparency in management of HIV/AIDS programme resources will be promoted to ensure effective implementation and realization of the impact of HIV prevention interventions. There will be advocacy for strengthening internal governance and accountability systems in government and CSO programmes. The priority actions for the short term in this area will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
3.9.1	By end 2012	Promoting adherence to established procurement and financial guidelines for HIV service providers	**PPDA**, AG IPs/CSOs, MoH, UAC and MoIA
3.9.2	By end 2012	Empower the community as watch dogs for public and CSO HIV resources, demanding transparency and accountability	**MoLG** and IPs/CSOs, IRC

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
3.9.3	2011-13	Advocate for the sharing of budget and workplans with stakeholders for all public and SCO projects	**UAC**, CSOs, Line Ministries, Districts

HIV and population growth

Outcome 4: Achieving a more Coordinated HIV Prevention response at all levels

Improving leadership and coordination is key to meeting the goal and targets that have been set in the National HIV prevention strategy. In order to address the emerging gaps in the leadership and coordination of HIV prevention response at all levels, the following indicators, targets and strategies will be pursued:

Indicators and targets:

- National Composite Policy index increased from 67.5% (2005) to 85%
- All districts having functional HIV coordination committees by 2015
- All districts having functional PHA networks by 2015
- All district HIV plans are aligned to the national planning and budgeting frameworks
- The /percentage of the total annual budget for committed to HIV/AIDS programmes in last financial year increased from 3% (baseline for 2004) to 5%
- Percentage age of HIV funds spend on Prevention increased from 25% (UNGASS 2010) to 40%
- Percentage local governments allocating funds from local revenues for HIV prevention increased to 100%

Strategies and Priority Actions:

The main strategies and priority actions for addressing the emerging gaps in the leadership and coordination of HIV prevention at all levels include the following:

4.1 Building the capacity of district HIV coordination structures.

Given that local governments are the mandated to plan and deliver services, in the next phase of HIV prevention, promotion of actions that ensure effective coordination of HIV programmes at district level will be crucial.The priority actions in the short term to support this will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
4.1.1	2011-12	Streamline the roles and relationships of DACs with other technical committes e.g. DHT and DPTC	**UAC**, MoPS
4.1.2	By end 2012	Build capacity of structures at the district and community level to effectively coordinate and manage HIV prevention	UAC, MOLG, LGs Districts & IPs/CSOs
4.1. 3	2011-13	Implement a results-based framework for monitoring and holding accountable for performance of different structures at all levels	MoPS, UAC, MoLG, LG
4.1.4	2011-13	Facilitate district, sub-county and community-based HIV coordination structures to effectively monitor,and coordinate HIV interventions.	UAC, MoLG, LGs, IPs/CSOs
4.1.5	By end 2012	Facilitate regulatory and quality assurance institutions for HIV prevention services especially at local government level	MOH, UAC, MoLG, LG & IPs
4.1.6	2011 - 13	Enforce and monitor the alignment of CSO HIV interventions to the district HIV prevention plans and priorities	MoLG, LG (e.g. DPTC, DAT and DAC)
4.1.7	2011-13	Regular tracking of budget performance in respect to HIV/AIDs, mainstreaming in work plans and budgets of local governments	UAC, MoIG, MOFPED, LGs, IPs/CSOs

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
4.1.8	2011-12	Facilitate formation and functionality of networks of PLHIV, IPs, MARPs etc at all levels in all districts	UAC
4.1.9	2011-12	Advocate for and monitor allocation of resources for HIV Prevention from local district revenues	UAC, MoFPED, MoLG, LGFC
4.1.10	2011-12	Advocate for performance contracts of Accounting officers at district level to include HIV prevention	MoPS, MoLG

4.2 Strengthening intra and inter-sector coordination of the HIV response

Strengthening the coordination between sectors and of stakeholders within sectors is crucial for effective HIV prevention in the next phase. Emphasis will be on ensuring that line ministries, inter-ministerial committee, sector working groups, technical working groups and CSOs and IPs in the sector meet regularly to share experiences, plan jointly, coordinate efforts and address emerging HIV prevention issues. To ensure this, the actions for the short term will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
4.2.1	By end 2011	Streamline coordination and relationships between line ministries, decentralized departments, CSOs and other implementers in the sector planning and implementation of HIV prevention interventions	UAC, MoLG, MoPS, LG
4.2.2	By end 2012	Build capacity for functional HIV coordination desks at the sector and district levels with focal persons having HIV/AIDS responsibilities as part of ther TOR and performance appraisal	UAC, MoPS, MoFPED, MoLG, LG & IPs/CSOs
4.2.3.	By end 2012	Coordinate reporting channels between the NGOs and the district and sector HIV coordination structures.	UAC, MoLG, LG
4.2.4	2011-13	Support regular meetings for joint planning, progress review and sharing of experiences among sectors	MoPS, UAC, Line Ministries

4.3 Advocating for increasing domestic and external funding of HIV prevention

Substantial resources will be required in order to achieve the desired HIV prevention results. Therefore, advocacy campaigns will be undertaken to ensure that Parliament and Local government councils prioritize and allocate resources to HIV prevention. The private sector will also be mobilized to fund workplace and community-based HIV prevention efforts. Priority actions in the short term to mobilise additional resources will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
4.3.1	2011-13	Advocacy for structured increase and sustained funding from external, central and local governments	UAC, MoH, MoFPED, IPs/CSOs
4.3.2	By end 2012	Advocacy for increased domestic resource mobilization (including GoU budgetary support, establishment of local HIV/AIDS fund) and allocation to HIV prevention	UAC, MoFPED, IPs/CSOs
4.3.3	By end	UAC and MoFPED will develop guidelines and indicative ceilings for line	**UAC, MoFPED**, MoLG

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
	2011	ministries and local governments to include in their mid-term expenditure frameworks and budget cycles	
4.3.3	2011-13	Advocacy campaigns to encourage the private sector to invest in the HIV prevention in and beyond their respective workplaces as part of their corporate investments.	UAC, UIA, PSF, UMA, IPs/CSOs,
4.3.4	2011-13	Developing and implementing advocacy strategy for additional domestic funding commitments by political leaders	UAC, CSOs, PLHIV networks

4.4 Strengthening partnerships and referral linkages for combination HIV prevention service delivery

Provision of comprehensive HIV prevention packages to grassroots communities requires partnerships and functional referral linkages between facility and community level service providers. This will also involve strengthening referral linkages between the various service providers, VHT, peer support groups, PHA networks, and community groups. It will be vital for community leaders to monitor the functionality of the referral linkages for delivery of the minimum HIV prevention package. Therefore, the priority actions in the short term to realize this will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
4.4.1	By Mid 2012	UAC / MOH will develop a framework for establishment of coalitions involving public sector, CSOs, FBOs, the private sector and community groups in all areas of the country to effectively deliver the minimum combination HIV prevention package	UAC, MoH, IPs, CSOs
4.4.2	By End 2012	Map HIV Prevention services in each administrative area, and districts, facilities, IPs and communities will establish or strengthen referral linkages based on guidelines from MoH, UAC etc.	UAC, MoH, DHTs, CSOs, IPs
4.4.3.	By end of 2012	Build capacity of DHTs, Community and political leaders to monitor functionality of referral linkages and delivery of the minimum package of HIV prevention services to communities	MoH, MoLG, LG UAC, IPs/CSOs
4.4.4	By end of 2012	Regular health facility and community based networking and experience sharing forums for stakeholders in HIV prevention	MoLG, LG (e.g. DPTC, DAT and DAC)
4.4.5	2012-13	Regular meetings for joint planning, reviews and sharing of experiences between IPs, health facilities, CBOs and VHTs	MoH, LG, DHT, DPTC, DAC)
4.4.6	2011-13	Advocacy for Health System Strengthening activities to support implementation of Combination HIV prevention	MoH, UAC, CSOs, District teams

4.5 Strengthening the Multi-sectoral Coordination of HIV Prevention by UAC

The next phase of HIV prevention requires unprecedented levels of coordination, leadership and accountability. At the helm of these responsibilities is the UAC with its structures, as well as the MoH. In order to effectively execute the responsibilities, restructuring of governance and

coordination will be required to equip them with the requisite capacity. The priority actions for the short term will be as follows:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
4.5.1	End 2011	Sharing and implementing the recommendations of UAC Organisational Development review	UAC, Ministry for the Presidency
4.5.2	2011-13	Hold regular JARs and Annual Reviews of HIV Prevention	UNA, NPC, Line Ministries,
4.5.3	End 2011	Strengthen the capacity of the HIV Prevention Unit at UAC through filling the vacant positions, procurement of necessary equipment and organizing refresher training courses of staff at the unit	UAC
4.5.4	By mid 2012	Streamline and build capacity of umbrella CSOs and PHA networks to coordinate other CSOS to facilitate their coordination as SCEs	UAC, CSO network organisations
4.5.5	By end 2012	Restructure UAC and health governance to streamline HIV prevention with reduced transactional costs	UAC, MoH, Office of Presidency, OPM
4.5.6	By end 2011	Enhance functionality of the NPC through developing a comprehensive work plan and budget	UAC, NPC

Outcome 5: Strengthened Information Systems for HIV prevention

In the next phase of HIV prevention, accurate and timely strategic information will be vital not only to inform strategic planning of programmes, but also to track attainment of results and impact of interventions. This will require enhanced HIV/AIDS and behavioral surveillance to track overall HIV programme impact and outcomes, and improved results reporting to track outputs and coverage of services. This will be augmented by operational research or impact evaluation. This will go hand in hand with improved information management. It is critical to harmonise national and IP M&E plans, and results reporting systems' under the principle of the "*three ones*". The National HIV Prevention strategy outlines strategies for the next phase of HIV prevention that will address weaknesses highlighted in our review of strategic information for HIV prevention in Uganda[1].

Indicators and Targets:

Strengthening of strategic information for HIV prevention as part of the National HIV prevention strategy will aim to achieve the following results:

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

Strategic priorities for strengthened information systems for HIV prevention

The strategies for strengthening information systems for HIV prevention in the National HIV Prevention Strategy, and the priority actions for the short term are as follows.

5.1 Strengthening annual HIV surveillance and periodic monitoring of impact and outcomes of HIV Prevention Efforts:

In order to track the impact of HIV prevention programmes in the expanded phase of HIV prevention, timely data on new HIV infections will be critical. In addition, data on behavioural outcomes as well as quality of health facility services is required to track outcomes of HIV prevention interventions. This will involve strengthening the surveillance systems and implementation of population-based and facility-based surveys, including detailed analysis to obtain baseline and follow up data on these indicators. The priority actions in the short term will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
5.1.1	By end	Detailed analysis of the 2011 UAIS and 2011 UDHS to obtain baseline	MoH, UAC, Research

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

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
	2011	population-baseline data for all indicators in the national HIV prevention strategy	Institutions
5.1.2	2011-13	Regular triangulation of data from various sources, and additional tests (BED, Avidity assays) of blood samples from surveys and surveillance systems to obtain reliable estimates of HIV incidence	MoH, UVRI, UAC, Research Institutions
5.1.3	By end 2012	Follow-on modes of transmission (MoT) synthesis to update information on new HIV infections and their sources	MoH, UAC, UNAIDS
5.1.4	By mid 2012	Advocate for preparatory activities and resources for a Services Provision Assessment in health facilities.	MoH, UAC, ADPs
5.1.5	By mid 2012	Review and support the national HIV surveillance system to ensure that it generates and disseminates timely and comprehensive data on HIV incidence at national and sub-national level	MoH, UAC, ADPs
5.1.5	2011-13	Advocacy for regular population and facility-based surveys / assessments of HIV/AIDS programme indicators	UAC, MoH, UNAIDS, UBOS, ADPs,
5.1.6	By end2013	Conduct National and district-wide mapping and size estimation of at least 3 MARP groups	MoH, CSOs, UAC, ADPs

5.2 Strengthen reporting systems to track coverage, outputs, and utilization of HIV prevention programs:

Tracking of outputs of behavioral and biomedical HIV prevention services, in order to monitor coverage and utilization as well as service gaps will be enhanced through the Health Management Information System (HMIS) in the MoH, vertical data collection of some output indicators conducted by ACP and other IPs, and information systems of other line ministries. Collection and aggregation of data on community level activities will also be streamlined. Compilation of data from various sources and preparation and dissemination of relevant reports will also be enhanced: Key actions for the short term will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
5.2.1	End 2011	Review data variables that are captured by the HMIS and recommending additional variables required for tracking additional HIV prevention indicators	**UAC**, MoH, IPs
5.2.2	End 2011	Work with the Resource Centre in MoH on new additional variables that can be captured in the electronic version of the HMIS	**UAC**, MoH, IPs
5.2.3	Mid 2012	UAC will establish horizontal reporting linkages with sector Management information systems	**UAC**
5.2.4	Mid 2012	Assessment of sector M&E systems and recommending appropriate strengthening measures	**UAC**, MoH, Other line ministries
5.2.5	2011-13	Advocate for regular compilation, analysis and dissemination of HMIS data	**UAC**, MoH, IPs
5.2.6	By mid 2012	Develop a reporting system, and guidelines for regular collection and compilation of data on community services	**UAC**, MoH, IPs, MoGLSD

5.3 Strengthening the management of HIV Prevention data and documentation of best practices:

Information arising from program M&E, HIV surveillance, population and facility surveys, operational and basic science research will be routinely consolidated and packaged for stakeholders. A one-stop centre or information hub will be established to be responsible for dissemination of strategic information on HIV prevention. At the hub, HIV prevention information will be catalogued for easy access. The priority actions in the short-term will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
5.3.1	2011 – 13	Compilation and analysis of HIV prevention M&E data and production of quarterly and annual HIV prevention Reports	**UAC**, NPC, MoH, Line Ministries, Districts
5.3.2	By end 2011	Establish or strengthen a one stop centre or knowledge hub for HIV prevention information, and similar centres at district level	**UAC**, NPC, MoH, ADPs, District teams
5.3.3	By mid 2012	Establish linkages and reporting relationships with IPs, research institutions and research coordination entities	**UAC**, NPC, MoH
5.3.4	2011-13	Regular dissemination of information, brainstorming sessions, debates, data use workshops etc	**UAC**, NPC, MoH

5.4 Periodic evaluation / reviews of HIV prevention programmes and approaches:

In the next phase of HIV prevention in the country, operational research or public health evaluations to assess impact of specific intervention approaches will be strengthened. A HIV prevention evaluation agenda will be developed and UAC will spearhead mobilization of resources to support periodic evaluation of priority HIV prevention interventions. Priority activities for the short term will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
5.4.1	By mid 2012	Develop of a HIV prevention evaluation and research agenda	**UAC**, NPC, Research Institutions
5.4.2	By mid 2012	Mobilise resources to support evaluation of priority HIV prevention interventions in the HIV prevention research agenda	**UAC**, NPC, IDPs, IPs
5.4.3	2011-13	Periodic evaluation of HIV prevention interventions and approaches, and sharing of best practices and lessons learned	**UAC**, NPC, IPs, Research Institutions
5.4.4	By end 2013	Conduct Mid-term evaluation and update the national HIV prevention strategy	**UAC**, NPC, UNAIDS

5.5 Instituting a mechanism for regular tracking of HIV Prevention Resources:

During the next phase of HIV prevention, tracking of HIV prevention resources to track whether expenditure is aligned to the sources of new infections will be instituted. A financial tracking system to routinely track data on financial resources for HIV/AIDS programmes, that supports disaggregation of data on HIV prevention expenditure will be set up. The system will in the

future, feed into National Health Accounts (NHA), National AIDS Spending Assessments (NASA), and UNGASS Reports; which currently have most HIV prevention spending data not categorized. With disaggregated HIV prevention expenditure data, it will be possible to link allocation of resources to the drivers of the epidemic and consequently areas of greatest need. The priority actions for the short term under this strategy will comprise of:

Code	Time Frame	Key actions to be performed	Accountable Institution / Other Institutions
5.5.1	2012-13	Strengthen financial management systems among HIV Prevention implementing partners with disaggregation of HIV prevention resources	**UAC**, MoFPED CSOs,
5.5.2	2012-13	Institute an ongoing mechanism for tracking HIV prevention expenditure, disaggregated by expenditure groups and beneficiary population	**UAC,** MoFPED

Progress Monitoring and Evaluation of the National HIV Prevention Strategy

Monitoring and periodic evaluation of HIV prevention initiatives in this strategy will be essential to maintain an informed and strategically guided response. Progress in meeting the goals of the strategy will be reported on annually by the UAC. Enhanced Monitoring and Evaluation will be necessary to ensure that HIV prevention efforts are aligned to the drivers of the epidemic, are based on effective approaches, and are on course to meet the targets set in the strategy.

Monitoring and Evaluation efforts will continue to be based on the existing M&E, and surveillance systems, procedures and mechanisms. In addition, information systems of major IPs such as MEEP will also be harnessed. However, significant strengthening measures are required to effectively track progress and impact of HIV prevention. The monitoring indicators for HIV prevention in the performance monitoring plan of this strategy are aligned to these plans.

The UAC through its National HIV Prevention Committee and Directorate of Planning and monitoring will provide oversight for multi-sectoral monitoring and evaluation. However, UAC will work very closely and strengthen horizontal linkages with sector information systems that will continue to perform monitoring functions within respective sectors. The UAC will be responsible for regular consolidation of the information obtained from the sectors and produce annual performance reports of HIV prevention, reflecting performance against set targets, for consideration by NPC, and stakeholders during Annual Joint HIV/AIDS Program Review (JAR). The UAC and sector M&E function has been weak and will require strengthening of human resources, skills and infrastructure to execute these roles. As a first step:

- UAC will complete the development of the HIV prevention M&E framework with reporting linkages with various sectors, as well as an evaluation plan for various interventions
- UAC working with various sectors will convene a multisectoral meeting to clearly identify the M&E and reporting roles and timelines of the various sectors
- UAC will prepare the first annual HIV prevention report in 2011on the implementation of the National HIV prevention strategy based on reports received from various sectors and IPs

The ACP in MoH and other line ministries will to obtain, analyze, and prepare reports of sector-specific HIV prevention activities, and provide regular reports to UAC highlighting progress made towards meeting the targets of the National HIV Prevention Strategy. The frequency of reporting will depend on the type of information and the systems used to collect the information, as highlighted in the performance monitoring framework. Sector M&E units will also share the information within sectors and use it to refine HIV prevention priorities.

The HIV surveillance system will also provide annual surveillance data for evaluation of the impact of HIV initiatives.

The health sector's Health Management Information System (HMIS), the surveillance system and other sector MIS being the main avenues for collection and reporting of data on HIV prevention from within the sectors will also require specific strengthening measures. At the onset of the strategy, M&E systems will be assessed to ascertain their strengths and weaknesses and identify strengthening measures for the M&E units as well as reporting systems to effectively execute these responsibilities. Within six months of the launch of the strategy, UAC will lobby the Office of the President / Prime Minister to require that all line ministries commit to strengthen sector M&E systems and provide regular reports to UAC.

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

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

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

The mid-term evaluation of this HIV Prevention Strategy will be conducted in 2013, based on terms of reference that will be developed by the NPC and stakeholders, and will form the basis for revision of the *National HIV Prevention Strategy.* An end of term evaluation will be conducted in 2015 and will inform the direction of the next steps in HIV prevention.

Details of the monitoring and evaluation of this strategy will be expounded in the performance monitoring plan that will be developed after the adoption of the *National HIV Prevention Strategy*.