



THE REPUBLIC OF UGANDA

## **Accelerating HIV Prevention**

### **The Road Map towards Universal Access to HIV Prevention in Uganda**



Uganda AIDS Commission

**Uganda HIV/AIDS Partnership Committee**  
Uganda AIDS Commission



*April 2007*

design + print = Visualeffects

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## Foreword

Uganda is experiencing a mature and generalize epidemic with high HIV prevalence rates at 6.4%. This is worrying considering the grave impacts of the epidemic at individual, household and community levels and national development generally.

While Uganda has witnessed improvements in AIDS related mortality and morbidity due to deliberate efforts to provide access to antiretroviral therapy, the basic pattern of the epidemic is determined by the rate at which new infections are occurring. The trends in increasing numbers of people being infected with HIV year after year are of major concern and a real threat to the whole HIV/AIDS response. Research has revealed a multitude of drivers of the epidemic and gaps in the prevention response that call for stepped up responses.

This Roadmap for accelerating HIV/AIDS prevention provides a synthesis of the key drivers of the epidemic and the response since the early 1980s, proposes an agreed package of comprehensive action at policy, programme and service levels and sets targets for universal access for 2009 and 2012. It is meant to instigate commitment from the various actors to renew focus on actions that will improve the structures and systems for the delivery of set targets. It is envisaged that Road Map will be translated into appropriate priority and costed prevention priorities that will further implementation for the next five years guided by the National Strategic Plan for HIV/AIDS activities 2007/8-2011/12.

I therefore wish to call upon all stakeholders from government, civil society, private sector and development partners to utilize this Roadmap as a guide to intensified HIV/AIDS prevention in Uganda. Prevention should remain the mainstay of our response as we strive to ensure universal access to prevention, treatment, care and support services by 2012.



**Rt Bishop Barnabas Halem'Imana**  
Chairman  
Uganda AIDS Commission.

## Acronyms

AIC	AIDS Information Center
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
ARVs	Antiretroviral Drugs
CSO	Civil Society Organizations
CSW	Commercial Sex Worker
EPP	Estimation and Projection Programme
FGDs	Focus Group Discussions
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCT	HIV Counselling and Testing
HIV	Human Immuno-deficiency Virus
IDP	Internally Displaced Persons
IEC	Information, Education and Communication
JCRC	Joint Clinical Research Centre
LQAS	Lot Quality Assurance Sampling
MACA	Multi-sectoral Approach to the Control of AIDS
MAP	Multi-country AIDS Programme in African (World Bank)
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MRC	Medical Research Council
MTCT	Mother-to-Child Transmission of HIV
NGO	Non-Governmental Organization
NSF	National Strategic Framework
OVC	Orphans and other Vulnerable Children
PEPFAR	Presidential Emergency Plan for AIDS Relief
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission of HIV/AIDS
RCT	Routine Counseling and Testing
RHSP	Rakai Health Sciences Programme
STI	Sexual Transmitted Infections
TASO	The AIDS Support Organization
UAC	Uganda AIDS Commission
UACP	Uganda AIDS Control Project
UDHS	Uganda Demographic Health Survey
UHSBS	Uganda HIV/AIDS Sero-Behavioural Survey
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

## Definition of Key Concepts

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

**Road Map:** A Road Map is a detailed description of a series of critical steps or milestones that guide the implementation of interventions or the determination of a course of action.

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

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

**Commercial Sex Work:** Commercial sex is defined as the perpetual dependency on sex for money or other items as an occupation. Although the initial push factor into the sex trade may be survival, the person turns it into a life long occupation.

**Transactional Sex:** is defined as sex in exchange for money or other items but with an element of exploitation of the sexual partner because s/he is in a vulnerable socio-economic situation.

**Trans-generation Sex:** (also cross-generational sex) is defined as sex with a partner considered much older than his or her sexual partner. In most cases it involves an element of exploitation due to economic and social vulnerability.

**Sexual Abstinence:** The avoidance of sexual intercourse as well as any genital contact or genital stimulation

**Life skills education** refers to training especially for youth in such skills as interpersonal relationships, self awareness and self esteem, problem solving, effective communication, decision-making, negotiating sex or lack thereof, resisting peer pressure, critical thinking, negotiation, formation of friendships, and empathy.

**High Risk Sex** includes sex with multiple partners especially non-marital, non-consensual; inconsistent or no condom use; commercial, transactional and intergeneration sex including sex for survival; alcohol consumption and drug abuse before sex; unprotected sex with someone whose status one does not know; sex without testing and disclosure.

**Comprehensive Knowledge** about HIV/AIDS is a composite indicator which shows the percentage of respondents aged 15 – 49 who say that: 1) people can reduce the chances of getting the AIDS virus by using a condom every time they have sex; 2) people can reduce the chances of getting the AIDS virus by having sex with just one partner who is not infected and who has no other partners; 3) that people cannot get the AIDS virus from mosquito bites; 4) that people cannot get the AIDS virus from sharing food with a person who has AIDS and, 5) that a healthy-looking person can have the AIDS virus

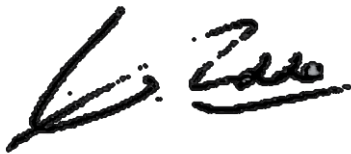
**Prevention with Positives:** This approach inspires HIV positive people to stay healthy, and experience respectful and productive lives with others in their communities. It involves caring for them and their families, promoting testing and mutual disclosure of results, promoting safer sexual practices with their partners, and supporting adherence to treatment to keep viral loads low to reduce chances of transmission.

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**Chair, Uganda HIV/AIDS Partnership Committee  
Uganda AIDS Commission**

**August 2006**

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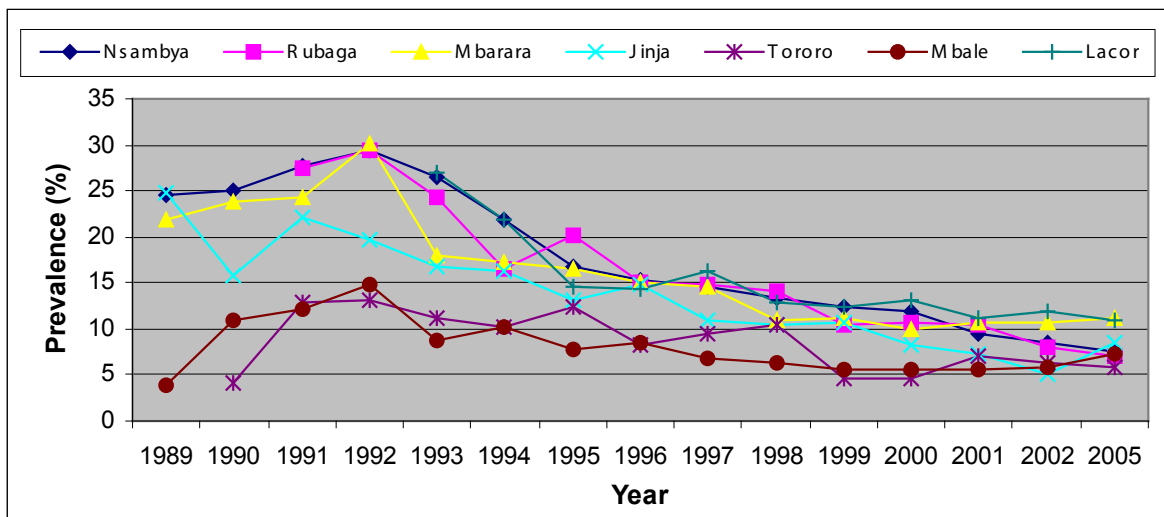
## 1.0 BACKGROUND

### 1.1 The HIV/AIDS Epidemic in Uganda

#### 1.1.1 Burden of HIV/AIDS in Uganda

HIV/AIDS was first reported in Uganda in 1982 from 2 fish landing sites, Lukunya and Kasensero in Rakai District. Thereafter, HIV rapidly spread through out the country resulting into a severe generalized epidemic. By the late 1980s, the virus had spread to all parts of the country, affecting different population groups, with a higher toll in the urban than in rural areas. An analysis of data from the Ministry of Health sentinel surveillance program reveals 3 distinct phases in the trends of HIV prevalence from 1989 to 2005. The first is the phase of rapid increase, between 1989 and 1992 with the prevalence peaking at an average rate of 18%; the second is the phase of rapid decline, between 1992 and 2002; and the third is the phase of stabilization of prevalence at a rate between 6.1 and 6.5 which is observed between 2002 and 2005 (Fig. 1). Overall, the trend of HIV prevalence in rural surveillance sites is much lower than that in major urban sites but with a nearly similar pattern of trend.

**Figure 1: HIV prevalence among ANC attendees in sentinel sites located in major towns from 1989 to 2005**



The 2004-05 Uganda HIV/AIDS Sero-Behavioural Survey (UHSBS) found an HIV prevalence rate of 6.4% among men and women aged 15 – 49 years. By geographic region, Central (8.5%), Kampala (8.5%) and North Central (8.2%) regions had the highest HIV prevalence rates. The lowest prevalence rates were in Northeast (3.5%) and Northwest (2.3%) regions.

The results further showed that urban residents have a significantly higher rate of HIV infection at 10% than rural residents at 6%. 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 percent compared with 5 percent for rural men.

When data was disaggregated by age and sex, the age- and sex-specific prevalence of HIV shows that prevalence for both women and men increases with age until it reaches a peak, which for women is attained at ages 30-34 (12%) and for men at ages 35-44 (9%). Women are more highly affected at younger ages compared with men. Prevalence for women is generally higher than for men at ages 15-49, though at ages 40-44, the male rate is marginally higher than the female rate. At ages 50-59, the pattern reverses and prevalence is slightly higher among men than women.

Other population groups with high HIV prevalence identified by the sero-behavioral survey include; commercial sex workers (CSWs), discordant couples, the widowed, divorced or separated, STI patients, uncircumcised men and both men and women in the highest wealth quintile.

### **1.1.2 Risk Factors and Drivers of the Epidemic**

#### ***Higher Risk Sex***

Despite high levels of knowledge on HIV/AIDS, there is evidence that higher risk sex may still be the main driver of the HIV/AIDS epidemic in Uganda. Higher risk sex includes sex with multiple partners especially non-marital, non-consensual; inconsistent or no condom use; commercial, transactional and intergeneration sex including sex for survival; alcohol consumption and drug abuse before sex; unprotected sex with someone whose status one does not know; sex without testing and disclosure in marriage relationships, and early sex. It has been argued that from the above definition, the majority of the population is thus having higher risk sex as normal sex and may not know that they are at risk. It has also been further argued elsewhere that knowledge of one's sero-status may or may not influence sexual behavior (AIM, 2006; Matovu et al., 2005; UNIVAF/UAC, 2003; Nyblade et al., 2001; The VCT Efficacy Study Group, 2000; UNAIDS, 1999).

The main factor that influences the continuation of higher risk sex despite the high levels of knowledge and risk of transmission is the lack of internalization and personalization of HIV risk. There is evidence to suggest that having been within the population for now 20 years, HIV/AIDS may be viewed by some people as no longer an immediate threat of death or serious illness, but something normal in life; a concept referred to as normalization. Secondly, IEC strategies have focused more on AIDS as a threat to life but have not paid adequate attention to the social role of sex or the concepts of sex and sexuality in the design of intervention strategies.

#### ***Extra-marital sex***

Extramarital sex has been a tolerated practice for men (but not for women) since traditional times. Recent data shows that the proportion of men reporting extramarital sex has not declined substantially since 1995 (Kirungi et al, 2006). Moreover, according to secondary data analysis of the UHSBS, approximately 60% of new infections are

occurring within married relationships. This is a very significant finding that points to higher risk sex occurring in this cherished cultural institution, especially brought about by the men through multiple extra-marital partners, very low condom use, lack of testing and disclosure as well as a high rate of discordance.

It appears that even in the event of HIV/AIDS, some beliefs and perceptions about “maleness” in relation to sexuality have largely remained. Male partners tend to justify extra-marital relationships in terms of unsatisfying sexual relationships and thus seek satisfaction outside their marital or regular relationships (Sengendo, et al. 2001; IPPF, 2005). Further the practice is perpetuated due to cultural beliefs; a number of women continue to accept that it is by nature that men have such “privileges” in marriage.

### ***Mother to Child transmission of HIV***

Transmission of HIV from an infected mother to a child is the second most common means of transmission of HIV in Uganda. Available data shows that MTCT including breastfeeding accounts for 15-25% of new infections (UAC, 2004-a). At the end of 2000, a cumulative total of 58,165 AIDS cases had been reported to the STD/ACP in Uganda and 4,286 of these were children below 12 years, 90% of whom had acquired infection through MTCT. Studies in Mulago have shown that only one third of babies infected with HIV live to see their second birthday which inadvertently affects progress made in reduction of childhood mortality (MoH, 2003-a).

MTCT has continued to drive the epidemic despite availability of an effective and affordable PMTCT intervention using Nevirapine. The number of women enrolling for PMTCT as a primary prevention approach is very low. This is due to some socio-cultural and economic factors that have been identified as major deterrents of women towards utilization of PMTCT services and their failure to come back to the health facilities for deliveries as recommended under PMTCT. Although over 80% of pregnant women attend ante-natal care at least once during pregnancy, only about 30% deliver in health facilities (UDHS, 2000). The social cultural factors include lack of or limited male involvement in PMTCT programs, stigma and the quality of services provided by service providers compared to traditional birth attendants (TBAs). The community attachment and trust towards the TBAs need to be addressed. PMTCT program is also affected by staff levels and quality of counseling at the health facilities as well as by the low levels of community awareness and mobilization.

### ***HIV discordance and non-disclosure***

The 2004-05 Uganda HIV-sero Behavioural Survey (MoH and ORC Macro, 2006) shows that overall, 5% of the married or cohabiting couples, are HIV discordant, that is one partner is infected and the other is not. Of all couples where at least one partner is infected, about 50% are HIV discordant. Data from the Rakai Health Sciences Program also shows that HIV sero-discordance among couples is high (Serwadda et al., 1995). Moreover, most of these discordant cohabiting couples are not aware of their HIV status and therefore not motivated to take action towards prevention such as using condoms

consistently. Studies show that couples who test individually are more likely to disclose to persons other than their spouses and even when they do disclose to their partners they may take as long as two years to disclose (Oundo and Siu, 2005). Moreover, females may not disclose to their spouses for fear of domestic violence and marital disruption (Koenig et al., 2003). This may be a significant driver of the epidemic since the low level of testing among couples, the lack of disclosure HIV status to the partner and the low condom use in marriage put the uninfected partner at a very high risk. In these situations sex in marriage may become higher risk sex. Studies have shown that the risk of HIV transmission among discordant couples is as high as 10 times the risk of transmission among the general population (Serwadda et al., 1995). Lack of couple counseling, failure of disclosure and fear of domestic violence among couples or discrimination among OVCs may hamper prevention intervention programs such as comprehensive VCT and PMTCT.

### ***Economic factors***

Poverty is a leading economic driver of the HIV/AIDS. It influences people to engage in commercial sex, transactional sex and intergenerational sex. Some poor and vulnerable people especially girls may be forced into difficult economic situations and may thus engage in these sexual activities for survival (survival sex). On the other hand for some young people engagement in these sexual activities may not be for survival but for “setting standards” or improving their status in society. This has been mainly described in the type of sexual activity occurring in some of the tertiary institutions of learning. The UNHSBS survey shows the intergenerational sex remains a key factor; 10 percent of women aged 15-19 who had higher-risk sex in the 12 months preceding the survey had sex with a partner who was 10 or more years older. Age groups 15-17 and 18-19 have roughly the same proportion of young women who had sex with a non-marital, non-cohabitating partner more than 10 years older. Ever-married women were more than three times more likely than never-married women to have had higher-risk sex with a partner who was more than 10 years older. Studies conducted by UNAIDS (2004) and UNESCO (1999) observed poverty as the most common explanation why girls in Sub-Saharan Africa engage in transactional sex with older sexual partners.

Conversely, HIV/AIDS is a driver of poverty. The age-group most affected by HIV/AIDS is the most economically productive and ill health contributes to sickness absenteeism from work leading to lost wages and income. Moreover, the expenditure on health care by the individuals and families affected by HIV, leads to catastrophic consequences on household budgets and assets.

On the other hand, the NHSBS shows a gradual increase in HIV prevalence rate from 4% among those in the lowest quintile to 9% among the wealthiest quintile. This trend occurs for both males and females but more significant for females and has been described elsewhere in sub-Saharan Africa. Wealth is known to be associated with high mobility, a factor which influences indulgence in higher risk sex. The Sero Behavioural Survey also shows that the percentage of men who had two or more sexual partners in the past 12 months increased from the middle to the highest quintile and for women the increase in multiple sex partnerships occurred among those in the fourth and highest quintile.

Further socio-economic analysis needs to be done on this issue, to better understand the link between wealth and HIV risk.

### ***Socio-cultural factors***

The two key cultural institutions in most African societies are marriage and family. While the institution of marriage has its strengths, it may also expose some people to vulnerability due to cultural expectations with negative consequences on the transmission of HIV/AIDS that may drive the epidemic. These negative cultural expectations include; condoning early marriages; glorifying non-marital sex and multiple sexual partners; looking for children especially male children outside marriage or even when is HIV positive; expectation to have unprotected sex whatever the circumstance. Furthermore, construction of male and female sexuality or in non-technical language, what it takes to be a man or a woman influences sexual behavior with negative consequences on HIV risk. It is not uncommon for “manliness” to be equated with the number of women one has conquered or “womanliness” to be equated with submissiveness such as the notion that “a woman does not refuse a man”. The latter erodes confidence and assertiveness of women in marriage and other relations. This may influence adoption of preventive measures against HIV transmission such as condom use especially in marriage.

Historically, the family has served as the major vehicle for socialization, including on issues related to sex and sexuality. Moreover, the extensive kin network with an extended family system enabled sex education to be performed by the extended family members, such as the sengas (fathers’ sisters). With increasing urbanization and exposure to foreign media this concept of the African family is being dropped in favor of the more western-type nuclear family network. Yet with HIV/AIDS, the family should play a more pivotal role as it has a key influence on social stigma, isolation and secrecy, stress and coping, social support, communication and disclosure, responses to illness, and changing structure and roles in families (Bor et. al., 1993). There has been a strong case for regulation of the media to prevent further erosion of our family and cultural values.

Cultural values and traditional gender roles increase the vulnerability of women to HIV infection. Women are expected to be obedient to men, cannot question infidelity of their husbands nor can they deny them sex. Sex is obligatory for married women, and there is little communication between spouses about sex and no negotiation. Furthermore, gender relations and power dynamics in marriage favor the man over the woman as regards decision affecting economic needs, health care seeking and number and gender of children. In this situation domestic violence is common and may influence risk of HIV transmission (Koenig, 2003).

### ***Human rights, stigma and discrimination***

Human rights are defined as natural or civic rights or basic entitlements accorded to every human being. They include the right to health, education, shelter, employment, property, food, freedom of expression and movement. Aspects related to HIV transmission risk include the right to determine one’s own sexual behaviour and sexual future; the right to access information and health care services and the right to confidentiality. In ensuring the protection of human rights it is important to balance individual rights *vis-à-vis* benefits to or protection of communities. For example, the right to confidentiality of

an HIV infected individual in a discordant relationship needs to be weighed against the right to protection from adverse health consequences of the sero-negative partner in the discordant couple. Similarly, adolescents and young people may not yet be of legal age but may need to be protected in their rights to privacy and access to adolescent friendly services.

Stigma derives from negative thoughts based on a prejudiced position (out-casting). It affects the thinking and behavior of people whereby a person is looked at in a negative and judgmental way. Stigma has deep roots in culture, personal and social fears, denial, misconceptions, myths and even religious beliefs. It is mainly due to limited knowledge about HIV transmission or fear of risk of HIV infection. Persons most affected by stigma include; PLWHA, OVCs, adolescents especially if pregnant or single mothers. Discrimination on the other hand includes those actions that negatively impact on the rights and entitlements of others based on prejudiced viewpoints or positions. It ensues when a distinction is made against a person resulting in unfair or unjust treatment based on their HIV sero-status or risk status. Whereas there is little evidence to suggest that stigma reduction leads to preventive behavior versus normalization and risk perception, it is well known that stigma affects access to health care services including HIV prevention. On the other hand, it has been conjectured that stigma reduction may lead to heroism and glorification due to being positive with negative consequences on HIV transmission.

### ***High risk population and vulnerable groups***

According to a rapid assessment conducted by the Uganda AIDS Commission and its partners (UAC, 2006), the HIV epidemic in Uganda may be driven by populations with high HIV prevalence and incidence since they are more prone to higher risk behavior. These populations include commercial sex workers (CSW), those who are widowed, divorced and separated, persons living in internally displaced persons (IDP) camps, the uniformed forces and fishing communities. As expected, CSWs serve several clients a day, and every sexual encounter is associated with some form of risk so the higher the client turnover the higher the risk. There is also evidence that while 99% of CSWs report ever use of condoms, consistent use is very low (STD/AIDS Control Program, 2003). Such sexual practices of multiple partners a day, with inconsistent condom use, make CSWs not only high risk groups but also profound drivers of HIV, given the fact that some (12.3%) of the CSWs reported having stable partners (married or cohabiting) as well.

In IDP camps, both men and women are reportedly involved in risky sexual behavior that may predispose them to HIV infection. This is exacerbated by high rates of STDs, sexual interaction with uniformed personnel (another high risk group), alcohol use, idleness, child abduction and defilement as well as lack of access to preventive services including IEC and VCT. Uniformed personnel face increased risks of contracting or spreading HIV infection through risky sex during deployment away from home. Some of them experience long separation from spouses or partners. For those affected, and in the absence of family and community support systems, they are more likely to engage in risky behaviors and potentially pass those risks on to their own family and community members including IDPs.

People living in fishing communities are highly mobile, moving between fish landing sites. Given their migratory nature, fishing communities have limited social cohesion, and socio-cultural norms that regulate behaviour in stable communities are non-existent. Moreover, a culture of ‘hyper-masculinity’ has been reported among fishermen. Allison and Seeley (2004) reveal how fishermen’s beliefs and expectations about the number and type of sexual contacts increase men’s susceptibility to HIV/AIDS. In the fishing communities, having more than one wife is a sign of man-hood, and it attracts respect.

Given the burden shouldered by society towards the care of OVCs, several children have been compelled to participate in paid work to cater for themselves or other siblings, while others are heads of households. As a result, orphans and vulnerable children (OVC) are likely to be at greater risk in various aspects of life including early sexual initiation. The MoH Uganda and ORC Macro (2006) indicate that orphans and vulnerable children are slightly more likely to have sex by age 15 than other youth. Young female children classified as OVC are 1.5 times more likely to initiate sex before age 15 than other younger women, while young men who are OVC are 1.1 times as likely. 14.6% of female orphans had had sex before age 15 while 18% of male orphans had had sex by age 15 (MoH Uganda and ORC Macro, 2006).

### ***Concurrent STIs***

There is both biological and epidemiological evidence linking concurrent STIs to the risk of HIV transmission. Genital ulcer diseases, such as herpes simplex are very common and yet are associated with an increased risk of HIV transmission and acquisition (Serwadda et al., 2003; MoH and ORC Macro, 2006). Data from the Uganda Sero-behavioral survey indicate that HSV-2 is widespread with close to 50% of Ugandans infected. Approximately 49% of women and 38% of men aged 15 – 49 were infected. Of all couples in which at least one partner is infected with HSV-2, almost half (45%) were discordant. Furthermore, HIV increases severity and duration of herpes symptoms and may reduce efficacy of treatment.

### ***Other potential factors driving the epidemic***

Other factors which may be driving the epidemic include the following:

- Lack of prevention programs targeting men
- Lack of focus on programs for married and cohabiting couples
- Lack of programs for the protection of rape and domestic violence victims
- Inadequate legislative and policy framework to ensure reduction of vulnerability
- Inadequate programs for the prevention of HIV transmission in the health care and other work settings
- Inadequate focus on gender in designing interventions
- Inadequate focus on programs that emphasize prevention for positives

## 1.2 National Response to HIV/AIDS in Uganda

Apart from the dramatic decline in HIV prevalence between 1992 and 2002, one of the reasons why Uganda has been cited as one of the world's most compelling national success stories is the nature of its response. Between 1989 and 2002, the hallmark of Uganda's HIV control efforts was prevention intervention to curb the further spread of HIV supplemented by care and support for those infected and affected. HIV prevention in the late 1980s and early 90s was a politically driven agenda that compelled patriotic responsibility at individual, community, organizational and leadership levels. There was political involvement from all levels of society and political, religious and civic leaders used every opportunity to deliver HIV prevention messages to the community. Furthermore, HIV/AIDS related national policies and strategies were systematically translated into actions at sector and decentralized levels through a multiplicity of actors that ensured universal coverage especially with targeted information and education services utilizing local resources supplemented by external funding. This targeted multi-sectoral approach seems to have contributed immensely to the dramatic decline in HIV prevalence rates.

This vigilance however appears to have waned towards the end of the century with a shift away from the more personal methods of communication opting for both electronic and print media to disseminate prevention messages. Unfortunately, it is apparent that this waning of prevention efforts at individual, programme and organizational levels is coinciding with a period of stabilization and threatened increase in HIV prevalence rates in the wake of changing environments. One key aspect of the changing environment is the availability of ARVs which some believe may have contributed to some complacency as regards the prevention response. Prior to 2003, HIV treatment using ARVs was deemed economically unfeasible and unsustainable. This was due to the high costs of the drugs required for treatment using HAART. With time, dramatic price reductions in the cost of ARVs, combined with multiple treatment access initiatives through MAP, PEPFAR and Global Fund, have made HIV treatment in Uganda a possibility. In June 2004 the Ministry of Health launched an integrated program for Universal Access to Free Antiretroviral Treatment in Uganda and over 75,000 patients are on ARVs by mid-2006. It is therefore crucial that the country learns from past experiences and the dynamics of the epidemic to revive the prevention response.

### 1.2.1 Characteristics and Lessons Learnt from the Response

The national response was initially characterized by patriotism that rallied leadership, communities and multiple actors towards implementing a wide range of interventions including delaying sexual debut, reducing number of non-regular sexual partners and increasing consistent condom use with casual sexual partners under the ABC model. While it is difficult to attribute levels of success to A, B or C, it is acknowledged that the ABC approach was the cornerstone of the country's achievements.

Another characteristic of the response was the multi-sectoral policy strategy which guided the response of various sectors within their mandates while a central and neutral coordination promoted shared perspectives on the epidemic and national priorities and implementation approaches across sectors and actors at various levels. The emerging strong partnerships at the central level however need to be emphasized at decentralized levels as well. Non-health public sectors are also yet to fully embrace their roles and utilize their structures to respond.

The national response was underpinned by a supportive political and policy environment from the public health, social and economic perspectives. Besides the policies of openness, the multi-sectoral approach, and the various thematic HIV/AIDS related policies, national policy driven actions in the areas of poverty eradication, universal education, media liberalization and women emancipation enhanced the response by targeting the social and economic contexts that render individuals vulnerable to HIV/AIDS. There is however still limited integration of HIV/AIDS in social, economic and other health services especially reproductive health. There is also need to expedite the approval process of the overarching AIDS policy to guide programming and to widely disseminate the various policy implementation guidelines to assure delivery of quality services

The national response placed emphasis on the most vulnerable and high risk populations especially young people, women and orphans and vulnerable children with encouraging outcomes especially among young people where declining HIV prevalence was most significant. The increasing feminization of the epidemic however demands for a re-examination of the social, economic and health interventions to work with men to empower women and young girls to take and sustain positive decisions about their lives. Similarly targeting should take into account the dynamics of the epidemic such as the shift of the peak of the epidemic to address areas and populations of high and rising epidemics while sustaining focus in situations of low and declining prevalence.

In addition to the policy of openness, the deliberate involvement of PHAs early in the response tremendously decreased stigma and discrimination enhancing service uptake as well as care and support for the infected and affected. It is also acknowledged that effective prevention strategies with those who are positive especially from the care and treatment perspectives crucial in breaking the cycle of new HIV infections. There is therefore need to strengthen strategies for ensuring meaningful involvement of PHAs at all levels of the response especially through capacity building with information, skills and resources to act.

The evolution of the national coordination response to facilitatory and participatory approaches especially at national level has created ownership and shared perspectives in the management and coordination of the response. More recently, coordination of the response has been characterized by establishment of partnerships among the various actors through the Uganda HIV/AIDS Partnership. Partnership approaches are especially crucial for multi-sectoral prevention interventions to understand contexts of target populations

from different perspectives, harmonize messages, build on each others comparative advantages to deliver targeted services and assuring optimal utilization of resources. The partnership approach however requires nurturing and further strengthening especially at sector and decentralized levels

The country's response has been further strengthened by research into the epidemic and the response. Research outcomes also from independent sources and constructive criticism have informed policy formulation, encouraged innovation and continuously improved programming and service delivery. There is however need to encourage and support research initiatives and utilization of outcomes at decentralized levels to enhance targeted services delivery.

The increasing level of resources for the response has been a strong factor for an effective response. Local and external resources have steadily increased over the years supporting the expansion of health and social services to communities. It is however observed that resources without individual and organizational commitment to action might not deliver desired results. Similarly most innovations have been initiated without promise of access to sustainable resources often leading to short-term interventions that leave both the service providers and service beneficiaries frustrated. The need to ensure harmonization and alignment of resources from various sources to national priorities and monitoring resource effectiveness has also been emphasized.

### **1.2.2 Drivers of the Response**

Drawing from the foregoing review of the national response to the HIV epidemic in Uganda, the following are highlighted as the key drivers of the response:

1. High-level political commitment and support right from the highest office in government, the Presidency
2. Openness policy adopted relatively early in the epidemic that enhanced open dialogue and innovation
3. Comprehensive multi-sectoral interventions and co-ordination mechanisms developed very early in the epidemic
4. Multiplicity of partners involved in HIV/AIDS control including central & local governments, NGOs, CBOs, private sector, researchers, media, and development partners
5. Involvement of religious leaders, faith-based organizations and people living with HIV/AIDS on the front lines
6. Decentralized planning and implementation of the response

7. Programmatic targeting to address gender, young people, stigma and discrimination issues
8. Supportive social and economic policy environment
9. Resources and support from both local and external sources
10. Research into the epidemic and the response
11. Community involvement and participation. Community efforts such as starting support organizations eg. TASO ensured ownership of the response

### **1.2.3 Challenges, Gaps and Obstacles in the National Response**

#### ***Policy and Institutional Response***

The response to the HIV/AIDS epidemic has evolved from *ad hoc* policies to a more systematic way of policy formulation. However, policy guidance to actors and communities at various levels in the response is still lacking. In this regard, Uganda has many policies and/or guidelines the various key preventive interventions which are not yet harmonized into one overarching policy on HIV/AIDS. The ABC model also yet to be articulated and fully documented at strategic level to provide guidance to actors interested in these interventions.

#### ***Health Systems Capacity***

Health systems carry out functions of providing or delivering health care services (World Health Report, 2000). The performance of health systems in terms of equity, efficiency and effectiveness is essential to ensure that all consumers enjoy a healthy life free of disease and disability. Physical infrastructure, equipment, human and financial resources, essential medicines and vaccines are key inputs to the functioning of health systems. Unfortunately, the health system in Uganda is faced with severe challenges. Physical access is still low, there is general shortage of human and financial resources, essential medicines, equipment and vaccines required to deliver the essential health care package including HIV/AIDS prevention, care and support.

Human resources for health are a vital part of improving the health situation and making progress towards the MDGs. However in most countries, the number of health care workers is insufficient to meet the demands of the health system. In ideal circumstances, the aim should be to get workers with the right skills to the right place at the right time and improve social compatibility between workers and clients (World Health Report, 2006). Unfortunately, the better trained, better skilled workers tend to be concentrated in the urban areas at the expense of the rural communities. Many times less skilled workers are used to provide care where better skilled professional workers are absent. About 32% of the health workforce in Uganda is made up of nursing assistants who help substitute

for the shortage of professional nurses. Worse still a key cadre of HIV counselors is not established and therefore not catered for on the pay roll. In this situation any intervention to improve the national HIV/AIDS response needs to be cognizant of the status and capacity of the health system.

### ***Social and economic systems***

Delivery of HIV/AIDS services has not fully benefited from existing social and economic structures and systems. This is partly attributed to limited conceptualization of roles and responsibilities and eventually limited integration and mainstreaming of HIV/AIDS within the various sector and development programmes, and limited linkages between social and health services. Similarly the social and economic sectors experience human capacity gaps for delivery of the relevant services. These constrain service coverage more especially for prevention where HIV/AIDS-related services should be delivered in the contexts of users not necessarily in health care facilities.

### ***Service coverage***

Despite tremendous expansion in HIV/AIDS service coverage, intra-district expansion in service coverage has not moved at the same pace as inter-district expansion. For instance, more recent data on ART service coverage shows that almost the entire country with the exception of Nakasongola and Nakapiripirit currently has active MoH ART sites, but within the districts, expansion is still slow. There is also a big information gap with regard to service coverage within the districts. In majority of the districts, mapping indicator information on service coverage is only available in one sub-county. Moreover, actors at the grass root level, have been fluctuating over the years depending on availability of funding

### ***Scope, intensity and uptake of interventions***

**1. IEC for Behavior Change:** The number of actors involved in IEC for behavior change in the context of HIV/AIDS prevention has decreased over the years. Currently only 17% of agencies implementing HIV/AIDS interventions have a component for community sensitization and education for prevention, a fall from 78% in 1997. Furthermore, support to relevant institutions and structures dealing with life-skills training especially for the out of school young people has not received priority attention in recent times.

There has been a shift of focus towards service access messages as opposed to behavior change messages which were at the centre of the life skills education programs. The few actors who have remained in provision of IEC for behaviour change have limited contact with the communities; there is an apparent shift towards impersonal channels of IEC e.g. media.

**2. Condom Promotion:** Most populations are reached with freely distributed condoms. However, recently there have been interruptions in supply due to concerns about the efficacy of the Engabu brand of condoms. Despite high knowledge and awareness levels about the efficacy of condoms, use of condoms has remained markedly low in the country. It has been difficult to achieve widespread consistent, correct use in any high risk sexual relationship other than commercial sex and casual sex.

**3. VCT:** Tremendous progress has been made with regard to expansion of service coverage for VCT services however the services have been limited in linking to other services including care and support systems especially for those who test negative. Some providers of VCT operate in isolation with weak referrals to district hospitals for treatment. Voluntary, confidential and good quality HIV counseling, testing and referral needs more improvement.

Key challenges in the provision of VCT services have included; lack of adequate infrastructure and personnel, as well as stock-out of HIV testing kits and reagents which have characterized the service in recent years. There has also been limited progress in the promotion of couple testing and dealing with discordant couples at service level.

**4. PMTCT:** There is need to review the current program implementation approach with the aim of defining and implementing a comprehensive package of PMTCT services. There is a lack of continuum from antenatal services to postnatal services. Presently postnatal care services for PMTCT clients do not exist and the mothers and infants are not well followed-up. Sustainability issues within the PMTCT program are still a challenge. Throughout the country, implementation of the program and therefore delivery of services is more project-based and has not been integrated adequately into the minimum health care package or the reproductive health services.

**STI treatment:** Sexually transmitted infections are very high and yet health care seeking behavior for STIs is still low among Ugandans. Moreover, many of the STIs are asymptomatic especially among women. Secondly, cases of stock-out of STI drugs at lower level health units have been reported as more apparent in recent years. The key challenge is to adopt an effective strategy for the treatment and control of STIs especially those causing genital ulceration such as herpes simplex virus type 2.

### 1.3 Some key Emerging Issues

1. Effective preventive measures are not necessarily those targeting the behaviours directly and may not necessarily be addressed through AIDS programs
2. Abstinence approaches for young people might be limiting access to information about other preventive measures. There is a need to strengthen and expand current primary abstinence programs to offer a comprehensive and integrated sexual health package
3. There is controversy between principles of young people friendly services and parental consent. While VCT policy allows young people access the services they cannot access care & treatment services unaccompanied
4. There is need for regulation of socio-cultural and economic practices that increase vulnerability especially of women and children.
5. Integration of HIV prevention into other programs such as HIV/AIDS care and

treatment as well as reproductive health is crucial to attaining universal access. Separation of HIV/AIDS from reproductive health is a missed opportunity.

6. Complacency due to ARVs, normalization, etc., need to be addressed cautiously. There may be a feeling of stigmatization if this is singled out as a driver.
7. There are conflicting messages promoting treatment and prevention e.g. you can still have a baby if you are positive. There is need to emphasize safer sex even for those on treatment.
8. There is need for common understanding of Greater Involvement of People Living HIV/AIDS (GIPA) in addition to working with them to break the cycle of HIV infections
9. Monitoring new infections is crucial. There is need to explore establishment of longitudinal cohorts for monitoring incidence in other parts of the country preferably building on existing systems e.g. in Gulu Hospital, Kayunga (Walter Reed), Arua (MSF), Iganga (DSS), GTZ western etc. Similarly the country can also explore incidence monitoring (using the detuned assay) through existing sentinel points. Institution of a legal framework on quality assurance and accessibility to data can also address challenges in this area in the context of limited resources for running longitudinal cohorts.
10. New prevention interventions including circumcision, microbicides, HSV2 suppression and HIV vaccines may be proven within the next 5 years thus need for preparedness through policy formulation and infrastructure development.

## 1.4 Potential Areas for Further Research

1. Conduct secondary data analysis of the 2004-05 Uganda HIV/AIDS Sero-Behavioural Survey to better understand:
  - a. Partner faithfulness in reducing the risk of HIV infection,
  - b. The relationship between wealth quintiles and burden of HIV infection
  - c. Prevalence and Heterogeneity of HIV infection Risk in Uganda, etc
2. Further research to better understand sexual transmission of HIV should include: risk behavior of HIV-infected persons, risk factors for HIV transmission within married couples and home-based counseling, testing and results giving.
3. Conduct research into the feasibility and acceptability of universal administration of nevirapine given the low uptake of PMTCT and the low level of facility-based deliveries.
4. Continue research into new technologies for HIV prevention (microbicides, HSV suppression, circumcision & vaccines) and prepare for access to and use in the near future.

## 2.0 THE ROAD MAP TO ACCELERATED HIV/AIDS PREVENTION

### 2.1 Operational definition and Rationale

A Road Map is a detailed description of a series of critical steps or milestones that guide the implementation of interventions or the determination of a course of action. The Road Map in this context provides advice or direction regarding a course of action. It includes an expression of the desired state (The Vision and goal); what factors we need to consider (Driving factors for the epidemic and response); what we hope to achieve (Targets); what needs to be done (critical steps and processes; and when (Milestones).

The Road Map to universal access to HIV prevention by default sets 100% access to HIV prevention as the target however each country must decide for itself what sustainable quality HIV/AIDS services they can achieve in the stated time period. The government of Uganda and its partners conceptualized this idea of a road map as a reflection of the commitment to intensifying HIV prevention in the context of universal access to prevention, treatment and care. The Road Map acknowledges that some 25 years after the epidemic was first recognized most people at high risk for HIV infection have yet to be reached by HIV prevention. This gap in access to a comprehensive prevention package has contributed significantly to the rising number of new infections especially among women and young people. The key actions that need to be taken to arrest the spread of new infections and turn the tide against AIDS include; bridge the HIV prevention gap; build on synergies between HIV prevention and care; ensure sustainability of HIV treatment scale up.

The process of developing the road map to universal access to HIV prevention is both participatory and consultative. It should involve all key partners and stakeholders in the struggle against HIV/AIDS bringing to the fore experiences and lessons learnt from the national response and evidence from research and monitoring and evaluation of programs.

### 2.2 Vision, Goal and Objectives

The Vision of the Road Map is universal access to a comprehensive package of HIV prevention interventions

The Goal of the Road Map is to galvanize national prevention actions to achieve 80% access to a comprehensive package of HIV/AIDS prevention interventions so as to reduce the rate of new infections of HIV by 40% by 2012.

The objectives of the Road Map are:

1. To highlight the key factors that are driving the HIV epidemic and the prevention response
2. To define the comprehensive package of HIV prevention interventions that will avert new HIV infections
3. To highlight major intervention areas that will guide programming and further prioritization at different levels
4. To set broad targets for halting of the HIV epidemic in the medium and long-term
5. To identify the critical steps and processes needed for accelerating HIV/AIDS prevention and strategies for sustaining actions
6. To mobilize and strengthen financial, human and institutional capacity across sectors for the accelerated response
7. To build and maintain leadership for the AIDS response from all sections of society including government, development partners, UN and civil society

## **2.3 Definition of a Comprehensive Prevention Package**

There is need to define the prevention package in the context of universal access. The following components are proposed to constitute the comprehensive prevention package around which the country aspires to achieve universal coverage. These key components should be translated into appropriate strategies through the National Strategic Plan for HIV/AIDS activities 2007/8 – 2011/12 and other socio-economic development program strategies.

### **The Comprehensive Prevention Package**

1. Prevent the sexual transmission of HIV
  - a. ABC+: Promote safer behaviours and sexual norms including abstinence (delayed sexual debut and secondary abstinence), being faithful to a partner with mutually known HIV test results, correct and consistent condom use with an HIV positive partner or a partner whose sero-status is unknown, and reduction of multiple sexual partners
  - b. Advocating for positive change in cultural and sexual norms which encourage high risk sex, e.g. a man must have multiple sexual partners to be recognized as a man

2. Prevent mother-to-child transmission of HIV
  - a. Preventing HIV infection among women of productive age
  - b. Preventing unintended pregnancies
  - c. Promoting knowledge of HIV status before pregnancy
  - d. Promoting access to health services during pregnancy, labour and after birth
  - e. Promoting early diagnosis and support for appropriate infant feeding
  - f. Linking PMTCT services to reproductive health services and linking HIV positive mothers and babies to appropriate care facilities
3. Promote greater access to HIV counselling and testing (HCT) while promoting principles of confidentiality and consent
  - a. Expand facility-based VCT, outreach and home-based VCT, and RCT for inpatients
  - b. Integrate disclosure in counselling and support services
  - c. Provide post-test referral and support services to those who test positive and negative
  - d. Promote awareness about discordance and put emphasis on couple counselling and testing
4. Integrate HIV prevention, care and support services with other health care and social services
  - a. Integrate prevention in HIV/AIDS treatment, care and support services
  - b. Establish linkages between different components of HIV prevention e.g. STI management, HCT, PMTCT, etc
  - c. Integrate HIV prevention into other health care and social services including sexual reproductive health programs
  - d. Integrate HIV/AIDS into community extension work for health, social and economic programs
5. Integrate prevention into care and support programs for PHAs
  - a. Promote prevention with positives
    - i. Promote condom use among positives
  - b. Integrate HIV prevention in support counselling
6. Prevent and treat Sexually Transmitted Infections
7. Focus prevention on vulnerable and higher risk groups including young people, IDPs, PWDs, women and girls, adults especially in marriage relationships, fishing communities, mobile populations, migrant workers, CSWs, etc, through
  - a. Identifying and addressing causes of vulnerability, and socio-cultural and economic situations that predispose individuals to infection, targeting social change and life skills development
  - b. Promoting couple counselling and testing prior to initiation of long-term sexual relationships and within marriage relationships and especially support safe transition from single-hood to marriage
  - c. Focus HIV prevention in formal and informal work settings

- d. Within existing legal frameworks advocate for rehabilitation and provision of public health interventions among stigmatized and outlawed higher risk groups like CSWs. This acknowledges their high HIV prevalence and extensive sexual networks in society beyond their groups
8. Advocate for protection of rights of women, girls, children, PHAs, IDPs and other minority groups within existing policy and legal frameworks:
  - a. Advocate against sexual and gender-based violence
  - b. Advocate for the rights of the infected and affected
  - c. Confront and mitigate HIV-related stigma and discrimination in communities, workplaces, and service delivery points
9. Prepare for access to and use of promising new technologies for HIV prevention and consider appropriate and safe response to new evidence such as circumcision, HSV2 suppression therapy, microbicides and vaccines
10. Ensure blood safety and reduce HIV transmission in the health care and other settings
  - a. Integrate universal precaution for infection control into routine health services
  - b. Strengthen infection control procedures for non-health settings e.g. hair dressing, tattooing etc

### **Major cross-cutting issues**

Several elements underlie targeted delivery of prevention services under the ten components of the comprehensive package for an effective response:

1. Enhance the legislative and policy framework to address causes of vulnerability and enhance uptake of services
2. Identify and address through programming and advocacy the social, cultural, religious and economic factors that impact on behaviours and service uptake to ensure responsive programming
3. Utilize all social, religious, health and economic facilities and services to identify needs and deliver HIV/AIDS prevention information and services within contexts
4. Emphasize involvement of males in prevention programming and service delivery
5. Build AIDS competence through engaging individuals, households and communities in prevention work targeting enhancing risk perception and personalization within specific settings

## 3.0 BROAD INTERVENTION AREAS AND TARGETS

### 3.1 Key Areas for Action

#### KEY AREA 1: Break the Cycle of HIV Transmission

##### 1.1 Accelerate Reduction of Sexual Transmission of HIV

#### Activity Areas

- Reduce high risk sex through intensified ABC+ campaigns:
  - Encourage abstinence, delayed initiation of sexual activity and mutual monogamy;
  - Target reduction of number of sexual partners especially non-marital and non-consensual;
  - Promote correct and consistent condom use especially with non-marital and non-consensual partners and for the positives;
  - Develop communication and skills development programs that address internalization and personalization of risk as well as reduction of normalization of HIV/AIDS for both young people and adults
  - Develop programs targeting sexual networks of high transmission
  - Provide PEP for rape and defilement victims
- Address Extra-marital sex
  - Focus on activities for married and co-habiting partners aimed at reducing extra-marital sexual partners
  - Use existing cultural structures to strengthen the institution of marriage
  - Promote couple counseling and testing and mutual disclosure of results before and during marriage
- Discordance
  - Advocate for couple counseling and testing
  - Encourage mutual disclosure of test results to partner
  - Advocate for consistent condom use among discordant couples
  - Explore provision of ART to infected partner
- Address Socio-economic causes of vulnerability
  - Advocate for focus on causes of vulnerability: poverty, displacement, gender inequity, spare unplanned for income e.g. for fishermen, etc. This should serve as the entry for other non-AIDS driven services
- Legislative and policy framework
  - Advocate for formulation and enforcement of protective laws to reduce vulnerability
  - Step-up measures for effective implementation of legislative and policy frameworks
  - Provide policy guidance on new public health prevention interventions

including circumcision and microbicides

## **1.2 Prevent Mother-to-Child Transmission of HIV**

### **Activity areas**

- Integrate PMTCT into RH services at policy, program, resource mobilization and management and service levels targeting all women in reproductive stages
- Develop and disseminate implementation guidelines for appropriate infant-feeding in the PMTCT program
- Roll out PMTCT program to all HC III
- Explore the rationale for universal administration of nevirapine given that only 30% deliver in health care facilities
- Explore and develop a home-based PMTCT program to address the 70% of pregnant women who do not deliver in health care facilities
- Link the mother, father and baby to other prevention and care services (MTCT+)
- Enhance targeted communication for PMTCT highlighting roles and benefits to girls, pregnant women and their partners, parents, families and communities
- Facilitate engagement of male partners to provide appropriate support
- Develop guidelines and procedures for early diagnosis of HIV among infants born to HIV infected mothers

### **1.1 Prevent HIV Transmission in the health care and other work settings**

#### **Activity Areas**

- Increase coverage of universal precaution measures programme in all Health care setting (public and private)
  - All healthcare workers exposed accessing PEP
  - Injection safety
  - Disposal and protectives
- Finalize the PEP policy and develop policy implementation guidelines. Increase awareness and operationalization
- Increase access to safe blood
  - Counseling for blood donors
  - Link to HCT uptake and comprehensive awareness
  - Ensure availability of safe blood at all HCIVs
- Develop programs for other work settings: dental practices; pedicure and tattoo parlors; traditional circumcision

## **KEY AREA 2: Promote HIV Counseling & Testing and Disclosure to One's Partner**

### **Activity Areas**

- Expand the VCT package emphasizing disclosure and linking the positives and negatives to appropriate services
- Ensure universal access to routine HIV testing (RCT) and counseling with voluntary disclosure in the health care setting
- Integrate HCT in other healthcare services particularly ANC/PMTCT, ART, SRH/FP
- Promote home-based counseling, testing and disclosure to family members
- Promote couple counseling, testing and disclosure
- Develop programs for discordant couples among married and co-habiting partners

## **KEY AREA 3: Promote Protection of Vulnerable Populations from Social, Cultural and Economic Risk**

### **Activity Areas**

- Reduce constructs of vulnerability at individual level and for vulnerable groups
- Strengthen implementation policies that reduce the vulnerability of women and children
- Life skills education; programs for economic empowerment of women;
- Promote legislation that protects widows and orphans from loss of property at the death of a spouse or parent
- Scale up poverty eradication programs
- Promote positive socio-cultural values regarding marriage, the family and death

## **KEY AREA 4: Ensure Integration of HIV Prevention into Care and Treatment**

### **Activity Areas**

- Develop a comprehensive and integrated program that utilizes every opportunity during care and treatment to deliver HIV prevention messages for both HIV positives and negatives
- Develop programs of prevention for positives including children
- Facilitate post-test clubs and link PHAs to these clubs
- Build a strong PHA movement for mutual support and advocacy
  - o Promote policies for protection of PHAs from stigma, discrimination and violation of their human rights
  - o Strengthen capacity of networks of PHAs to develop and implement programs for their members to seek and utilize prevention, care and treatment services

- o Encourage PHAs to assist in policy dialogue and program development for the national response
- o Promote programs that utilize PHAs as role models and peer educators

## **KEY AREA 5: Prevent and Treat Sexually Transmitted Infections**

### **Activity Areas**

- Intensify STI prevention programs especially through community
- Institutional strengthening for improved diagnosis and treatment of STIs
- HSV II suppressive therapy

## **KEY AREA 6: Monitor Trends of the HIV Epidemic**

### **Activity Areas**

- Establish linkage with longitudinal studies for monitoring of incidence
- Use detuned assay at sentinel surveillance sites to monitor incidence
- Establish behavioural surveillance systems alongside sero - surveillance

## **3.2 Target Setting**

The Road map features ambitious universal access, impact and outcome targets (appendix 1) that are intended to mobilize intensified efforts at various levels. They are based on a detailed assessment of the drivers of the epidemic and effectiveness of prevention interventions in the country and also acknowledge the need for established mechanisms to monitor them. The setting of targets included all key stakeholders including PLWHA and civil society.

## 4.0 IMPLEMENTATION ARRANGEMENTS

### 4.1 Implementation Context of the Road Map

The Road Map highlights country aspirations for achieving universal access to services under the comprehensive package. It is a broad multi-sectoral strategy guideline intended to garner commitment and re-focus prevention interventions and resources at policy, programme and service delivery levels and thus highlights critical steps and process for accelerating the prevention response at national level. It is envisaged that this will be translated into appropriate actions at various levels considering mandates, capacities and resource availability.

At national level, the National Strategic Plan (NSP) for HIV/AIDS Activities 2007/8-2011/12 is the major tool for operationalizing the Road Map highlighting detailed strategies and providing further guidance on prioritization in the context of resource availability.

#### Key implementation principles

To address the identified challenges and obstacles to an effective response, the following principles are highlighted to guide programming, resource mobilization and allocation and service delivery:

- Multi-sectoral approaches bringing on board all potential actors
- Mainstreaming and integration to facilitate comprehensive and multi-pronged approaches to assure a continuum of social, health and HIV/AIDS services
- Partnerships and common approaches to eliminate fragmentation and duplication of efforts while emphasizing delivery of common messages and utilization of all existing systems for wider coverage
- Evidence-based approaches that take into account dynamics of the epidemic and contexts of population groups to enhance service targeting
- Quality assurance informed by central policy guidelines and standards
- Accelerating HIV/AIDS prevention in the context of universal access to prevention, treatment, care and services
- Human rights, equity and gender
- Partnerships with PHAs for their greater involvement in the national response

### 4.2 Management and Co-ordination of the prevention response

The management and coordination of national prevention response will be spearheaded through the National HIV/AIDS Prevention Committee (NHPC), which is a sub-committee of the Uganda partnership Committee.

The NHPC, which features multi-sectoral membership, will design and guide processes for popularizing prevention priority issues, advocating for resources and guiding allocation,

monitoring implementation against targets, and identifying obstacles to effective action.

To enhance coordination and sustainability, actions will be based on government structures and policies to guide actions from both the public and non-public sector. Programming and implementation will therefore take into account mandates of the various government ministries and bodies to provide policy guidance, set standards for service delivery and guide monitoring actions against sector and national targets.

Basing on the broad guidance in the Road Map and the NSP, ministries will be required to develop sector specific strategies in partnership with stakeholders from the non-public sector and implementation should consider comparative advantages of the various actors in the sector and development of partnerships for service delivery

It is acknowledged that all sectors and actors have a role to play in interventions targeting primary HIV prevention driven by behavioral communication interventions. Considering challenges of fragmentation, message inconsistency, capacity and quality assurance however, it is proposed that nationally driven common multi-sectoral and multi-pronged campaigns be initiated targeting the various population groups. This targets optimal utilization of resources, shared perspectives in communication aspects, quality assurance and universal coverage.

All stakeholder actions will feed into respective sector reviews and annual Joint AIDS Reviews, the mid-term review exercise in 2009 and eventually the 2012 review.

### **4.3 Resource Requirements**

The key activity areas highlighted in the Road Map demand for substantial and sustainable financial and human resources as well as extensive infrastructure development in the social and health sectors for an effective response. While the HIV/AIDS specific costs will be articulated in the NSP, there is need to establish and meet the cost of an integrated social, economic and health response beyond the HIV/AIDS-specific actions targeting effectiveness and overall national development. The Road Map and the NSP should therefore inform programme development and budgeting that will feed into resource mobilization at national, sector and organizational levels and eventually harmonized resource allocation to assure equitable service delivery. This takes into account both actions of stakeholders doing HIV/AIDS work alone and the integrated approaches.

Priority funding for pooled HIV/AIDS resources should be extended to those programmes that are based on the identified NSP priorities and Road Map implementation principles from conceptualization to monitoring and evaluation.

## 4.4 Partnerships

The partnership approach was initiated largely to enhance coordination and management of the national response. This should be strengthened and replicated at decentralized levels. There is also need to strengthen partnerships especially between the public and non-public stakeholders and between government sectors for integrated service delivery targeting universal coverage.

Partnerships are crucial to promote ownership of the response, eliminate unnecessary competition especially for resources, address duplication and equitable service delivery, and enhance shared perspectives on the problem and the approaches.

For example in areas of behavioural communication, experiences of PIASCY and YEAH campaigns that have promoted common approaches and partnerships can be enhanced and emulated. Such approaches enhance coordination at the levels of programme conceptualization, development, resource mobilization and monitoring implementation.

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## APPENDICES

### Appendix 1: Targets towards Universal Access to HIV Prevention by 2009 and 2012

<b>PRIORITY AREA 1: Break the Cycle of HIV Transmission</b>				
<b>Sub-Area 1.1: Accelerate Reduction of Sexual Transmission of HIV</b>				
Activity Area	Indicator	Baseline Value	Target for 2009	Target for 2012
Messaging for Increased Public Awareness and Behavior Change	Median age at first sex for those aged 20 - 24	18.3 17.1	18.5 18.0	20.0 19.0
	Males			
	Females			
	% of young men and women aged 15 – 24 who have had sex before age 15	12.2 (F); 16.3 (M) 17.0 (F); 10.8 (M)	Increase baseline levels by 25%	Increase baseline levels by 50%
	** % of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	29.0 (F); 32.5 (M) 30.1 (F); 39.9 (M)	Increase baseline levels by 50%	Increase baseline levels by 80%
	% of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months	45.4 (F); 92.3 (M) 16.2 (F); 63.0 (M)	Decrease baseline levels by 25%	Decrease baseline levels by 50%
	15-19			
	20-24			
** % of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner	55.6 (F); 50.5 (M) 49.1 (F); 59.4 (M)	Increase baseline levels by 25%	Increase baseline levels by 50%	
15-19				
20-24				
Number of condoms distributed annually by the public and private sector	120 million	Increase baseline levels by 50%	Increase baseline levels by 80%	

<b>Sub-Area 1.2: Prevent Mother-to-Child Transmission of HIV</b>			
Scale up of a Comprehensive PMTCT Package	% of Health Care facilities providing comprehensive PMTCT package	30% (2005) 40% (2006)	60% 80%
	% of positive pregnant women accessing the comprehensive PMTCT package	12% (2004) 15% (2005) 25% (2006)	80%
	% of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT	15%	Increase baseline levels by 50% Increase baseline levels by 80%
<b>Sub-Area 1.3: Prevent HIV Transmission in the Health Care and Other Work Setting</b>			
Ensure a Safe Health Care Workplace	% of transfused blood units screened for HIV		100% 100%
	% of Health care facilities providing safe blood by 2010		80% 100%
	% of health care facilities observing universal precautions		50% 80%
	% of health care facilities with a functional PEP program		Increase baseline levels by 50% Increase baseline levels by 100%
	% of those who need PEP accessing it		Increase baseline levels by 50% Increase baseline levels by 80%
	% of large enterprises/companies which have HIV/AIDS workplace policies and programs		Increase baseline levels by 50% Increase baseline levels by 80%

**PRIORITY AREA 2: Promote HIV Counseling & Testing and Disclosure to One's Partner**

Activity Area	Indicator	Baseline Value	Target for 2008	Target for 2010
Scale up Knowledge of One's HIV Sero-status	% of HC IIIs providing a comprehensive HCT package		Increase baseline levels by 50%	Increase baseline levels by 80%
	% of hospitals providing a RCT for inpatients		Increase baseline levels by 50%	Increase baseline levels by 80%
	% of general population or populations at risk who received an HIV test in the past 12 months and were informed of the results	12.7	Increase baseline levels by 50%	Increase baseline levels by 80%
	% married or co-habiting couples receiving HCT as a couple and disclosing to partners	19.1	Increase baseline levels by 50%	Increase baseline levels by 80%

**PRIORITY AREA 3: Promote Protection of Vulnerable Populations from Social, Cultural and Economic Risk**

	% of schools with teachers who have been trained in life-skills based HIV/AIDS education and who taught it during the last academic year		Increase baseline levels by 50%	Increase baseline levels by 80%
	% of orphans and vulnerable children (under 18) whose households received free basic external support in caring for the child		Increase baseline levels by 50%	Increase baseline levels by 80%
	** Ratio of current school attendance among orphans to that among non-orphans, aged 10-14		Increase baseline levels by 50%	Increase baseline levels by 80%

**PRIORITY AREA 4: Ensure Integration of HIV Prevention into Care and Treatment**

Develop a comprehensive Integrated Program	% of HIV Care and Treatment programs with a functional comprehensive HIV prevention program		Increase baseline levels by 50%	Increase baseline levels by 80%
	% of HIV Care and Treatment programs with a program of prevention for positives		Increase baseline levels by 50%	Increase baseline levels by 80%
Build Strong PHA Movement	% of prevention, care and support program with PHAs working with them as role models and peer educators		Increase baseline levels by 50%	Increase baseline levels by 80%
	% of PHA networks with active prevention, care and support programs		Increase baseline levels by 50%	Increase baseline levels by 80%
	Amount of financial inflows to PHA networks		Increase baseline levels by 50%	Increase baseline levels by 80%

**PRIORITY AREA 5: Prevent and Treat Sexually Transmitted Infections**

Activity Area	Indicator	Baseline Value	Target for 2008	Target for 2010
STI management	Proportion of STD patients appropriately managed by national standards	48% (2005)	56%	70%
	Proportion of STD patients advised on condom use and partner notification	41% (2003)	60%	70%
	Proportion of health facilities that have not faced drug stock-outs lasting more than week in preceding 12 months	31% (2003)	60%	70%
	Proportion of health facilities providing a comprehensive integrated STI service		Increase baseline levels by 50%	Increase baseline levels by 80%
	% reduction in STI prevalence		Reduce baseline level by 12.5%	Reduce baseline level by 25%

**PRIORITY AREA 6: Monitor Trends of the HIV Epidemic (Impact Indicators)**

Monitor Trends of New HIV Infections	Total number of new infections	135,000	Reduce baseline level by 20%	Reduce baseline level by 40%
	% of new infections among young women and men aged 15-24		Reduce baseline level by 20%	Reduce baseline level by 40%
	***% of young women and men aged 15-24 who are HIV infected		Reduce baseline level by 20%	Reduce baseline level by 40%
	% of infants born to HIV infected mothers who are infected	23% (2005) 22% (2006)	15%	7%

## Appendix 2: Critical Steps, Processes and Milestones in Accelerating HIV Prevention (A Critical Path Analysis)

Timelines	YEAR 1	YEAR 2	YEAR 3	YEAR 4	Year 5
<b>Critical Steps</b>	<ul style="list-style-type: none"> <li>Re-launch HIV Prevention as the Mainstay of HIV Control</li> <li>Strengthening National Leadership for HIV Prevention</li> <li>Medium and Long-term Strategies for Commodity Procurements (condoms, reagents etc)</li> </ul>	<ul style="list-style-type: none"> <li>Resource mobilization based on costed NSF</li> <li>Strengthening the legal framework of HIV/AIDS</li> <li>Strengthening Capacity for the National Response</li> <li>Revived advocacy for the response</li> </ul>	<ul style="list-style-type: none"> <li>Intensified stakeholder action and implementation</li> <li>Mid-term review of progress in achieving targets</li> <li>Strengthening Capacity for the National Response</li> <li>Revived advocacy for the response</li> </ul>	<ul style="list-style-type: none"> <li>Re-plan based on review outcome</li> <li>Intensified stakeholder action and implementation</li> <li>Revived advocacy for the response</li> </ul>	<ul style="list-style-type: none"> <li>Intensified stakeholder action and implementation</li> <li>Review of outcomes and impact against</li> <li>Assessment of effectiveness of interventions</li> </ul>
<b>Critical Processes</b>	<ul style="list-style-type: none"> <li>Formation of the National HIV/AIDS prevention committee</li> <li>Rapid Assessment exercise</li> <li>Secondary Data Analysis of UHSBS</li> <li>Development of the Road Map</li> <li>Launch of the Year of Prevention</li> <li>Evaluation of NSF and Development of the 2006/07 – 2011/12 NSP</li> <li>Development of the NSP implementation guidelines</li> <li>Development of the M&amp;E Framework</li> <li>Orientation and Sensitization of political and civic leaders at all Levels</li> <li>Development of the Prevention policy guideline</li> <li>Evaluation of BCC interventions &amp; development of Communication Strategy</li> <li>Development of policy guidelines on ABC</li> <li>Development of the ABC Policy guideline</li> </ul>	<ul style="list-style-type: none"> <li>Dissemination of the Road Map and NSF for stakeholder buy-in</li> <li>Approval of the National AIDS Policy</li> <li>Drafting and submission of the HIV/AIDS Bill</li> <li>Development of alcohol and drug abuse Policy</li> <li>Strengthening and development of structures and systems required for the national response (Human capacity development, physical infrastructure, procurement and chain supply management)</li> <li>Development of the mainstreaming policy guideline and budget tools to enhance Integration of HIV/AIDS prevention into other social, economic and health services</li> <li>Replicate the partnership structures at the decentralized levels</li> <li>Development and population of funding mechanisms to promote harmonization and alignment of resources to national priorities</li> <li>Development of Sector strategies</li> <li>Expansion of HIV surveillance systems</li> <li>Roll-out of YR 1 deliverables</li> </ul>	<ul style="list-style-type: none"> <li>Develop national guidelines and policies to protect minors from pornography and exploitation</li> <li>Expand evidence base on effectiveness of interventions and best practices</li> <li>Develop evaluation framework and conduct the mid-term review</li> <li>Roll-out YR 1 &amp; 2 deliverables</li> </ul>	<ul style="list-style-type: none"> <li>Stakeholder assessment of progress in achieving process and outcome targets</li> <li>Development of revised implementation plan based on mid-term review</li> <li>Continue to expand evidence base on effectiveness of interventions and best practices</li> <li>Roll-out YR 1,2,3 deliverables</li> </ul>	<ul style="list-style-type: none"> <li>End of term evaluation</li> <li>Revision of the Road Map</li> </ul>

Timelines	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
<b>Measurable milestones</b>	<ul style="list-style-type: none"> <li>• Rapid Assessment Report</li> <li>• Secondary data analysis Reports</li> <li>• Prevention Road Map</li> <li>• Costed 2006/07 – 2011/12 NSF &amp; implementation guidelines</li> <li>• M&amp;E Framework</li> <li>• HIV/AIDS prevention Policy Guideline</li> <li>• Comprehensive Communication Strategy</li> <li>• ABC Policy Guideline</li> </ul>	<ul style="list-style-type: none"> <li>• National AIDS Policy approved</li> <li>• Agreed national funding mechanisms</li> <li>• Alcohol and drug abuse policy</li> <li>• Sector strategies developed and funded</li> <li>• % of health care facilities equipped with commodities and personnel</li> <li>• Functional district coordination structures</li> </ul>	<ul style="list-style-type: none"> <li>• % of donor funded programs endorsed by the NHPC</li> <li>• Media bill finalized</li> <li>• Handbook of Best Practices</li> <li>• Mid-term review report</li> </ul>	<ul style="list-style-type: none"> <li>• Revised implementation plan</li> <li>• Advocacy plan on emerging issues for prevention</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluation report</li> <li>• New Prevention Road map</li> </ul>

### Appendix 3: Participants to the stakeholder consensus on the Country Road Map for accelerating HIV/AIDS prevention, at Kabira Club, 27<sup>th</sup> July 2006

	Name	Organisation
1.	Achom Margaret	CDC-Uganda
2.	Agali Esther	SCOT
3.	Akena Irene	The Salvation Army
4.	Alamo S Talisuna (Dr)	Reach Out Mbuya
5.	Alastair Robb	DFID
6.	Alice M Ibale	UPHOLD
7.	Allen Kweesa	Health Rights Action Group
8.	Alvin Muhwezi	UNASO
9.	Anne Akia Fiedler	Straight Talk
10.	Antje Becker Benton	AFFORD
11.	Atwine Moses	USAID-ACE Project
12.	Bagorogoza Benson	UAC
13.	Baguma Edna (Dr)	World Vision
14.	Bakika Christopher	UCBHCA
15.	Banage Flora	CDC-Uganda
16.	Bangata Edreda	Children's AIDS Fund
17.	Banoba Paul	PANOS
18.	Bartlett Premila	US Embassy
19.	Bassam Luciana	AVSI
20.	Bazirakye Kaguta (Dr)	ACP Police
21.	Beekunda George	MGLSD
22.	Bukenya Daraus	AMREF
23.	Buluba Florence	NAFOPHANU
24.	Byakatonda Joseph	Reachout
25.	Byamukama Johnson	Concern K.W
26.	Byaruhanga Hope	Member of Parliament
27.	Byenkya	UACP
28.	Catherine Muwanga	UACP
29.	Celina Takali	Youth Alive Uganda
30.	Cwinya-Ai S Peter	UACP
31.	Debra Klein	UNASO
32.	Elizabeth Madraa (Dr)	MoH/ACP/STD
33.	Enid Wamani	MACIS
34.	Esther Kisaakye	UGANET
35.	Galiwango R Moses	Rakai Health Service Prog
36.	Grace Mayanja	CORE Initiative
37.	Isaac Musoke	YEAH Initiative
38.	Kagoya K. Harriet Rachel	World Vision
39.	Kagwire Fred (Dr)	EGPAF
40.	Kamukama Alex	YP SCE
41.	Kamyia Moses	MUK/MJAP
42.	Karugonjo A Christine	UAC

	<b>Name</b>	<b>Organisation</b>
43.	Kataha Dr	UBTS
44.	Kawooya Sheila	UNAIDS
45.	Keith McAdam	IDI
46.	Kibenge A.D	MoES
47.	Kigozi James	UAC
48.	Kihuumuro Apuuli (Dr)	UAC
49.	Kiirya Stephen	UACP – UAC
50.	Kikango Ben (Dr)	MRC/UVRI
51.	Kindyomunda Rosemary	UAC
52.	Kitabire N Florence (Dr)	CDC
53.	Kitcy Mitchell	IRC
54.	Kusasira S. (Maj. Dr)	Ministry of Defence
55.	Kyaddondo Betty (Dr)	Popsec
56.	Kyagaba J Sandra	NACWOLA
57.	Lubwama Brian M	ACET/YP SCE
58.	Lucy Shillingi	UPHOLD
59.	Lukwago John (Dr)	MoFPED
60.	Mabaale John (Dr)	Kamwokya CCC
61.	Manjit Kaur	Hospice
62.	Mayanja Peter	UACP – UAC
63.	Melanie Croce-Galis	Guthmacha Institute
64.	Monoja Luka (Dr)	UNFPA
65.	Mpungu G.Henry	YP SCE
66.	Muganga Joanita Kawalya	Media Arts & Culture
67.	Mugerwa Robert	UACP
68.	Mugisha Allan	IRCU
69.	Mugweri Julius (Dr)	Kumi HBCT( DDHS)
70.	Mugyimba Edward	MGLSD
71.	Muhwezi Dick	TASO
72.	Mukalazi Deus	YEAH
73.	Mukasa Barbara N (Dr)	The Mildmay Centre
74.	Mulyagonja Eseza	USAID ACE
75.	Mungherera Lydia (Dr)	TASO
76.	Muramuzi Emmy (Dr)	IMAU
77.	Mushabe Elizabeth	UAC
78.	Muyita John Alex	AIC
79.	Mworeko Lillian	ICW
80.	Nafuna Wamai	CDC Uganda
81.	Nakinsige Anne	IPH-CDC Fellow
82.	Nalubega F Matovu	UGANET
83.	Nalwadda Rita	WHO
84.	Namawuba Christine	UWONET
85.	Nangwala Oulanyah	HACI-Uganda
86.	Nanyombi Milly Kaggwa (Dr)	Populations Services International
87.	Ngabirano Thomson (Dr)	UPHOLD
88.	Nina Wessel	Norwegia Embassy
89.	Nsubuga Geofrey	UYDEL

	<b>Name</b>	<b>Organisation</b>
90.	Nuwagira Innocent (Dr)	UAC
91.	Oduka Mary	Irish Aid
92.	Odunge Josephine	UAC
93.	Ofumbi Emma	Tororo Network ASO
94.	Ogenga Abwola Peter	CHAIN Uganda
95.	Oketcho John Francis	FOC-REN Ministries
96.	Okot Moses	Cono Foundation
97.	Okullo Joel	UAC
98.	Okwerede Hussein	Kumi – HBCT
99.	Paul Bogere	MoPS
100.	Penniah Mukunda	Health Rights Action Group
101.	Rhoda Wanyenze	MJAP
102.	Ruteikara Sam (Rev)	CHUSA/FBOs
103.	Rwomushana John (Prof)	UAC
104.	Sande P Ndimwibo	Anti AIDS Association
105.	Sereen Thaddeus	USAID
106.	Serukka David (Dr)	PREFA
107.	Serunkuma Richard	Positive Men's Union
108.	Sophie Acan Odeng	Positive Women Leaders in Uganda
109.	Ssebaggala Stephen	CDC
110.	Ssemakula John	WFP
111.	Ssinabulya Z	UACP
112.	Sue Kelly	Baylor College of Medicine
113.	Talima Daudi	ACET-Uganda
114.	Tanga Erasmus	ESWADI
115.	Tatwebwa Lillian	UAC
116.	Teddy Chimulwa	SCOT
117.	Tukwasibwe Francis	UNFPA
118.	Tushabe Basil	CDFU/ YEAH
119.	Twesigye Gordon	US Peace Corps
120.	Wabwire-Mangen Fred (Prof)	IPH
121.	Wajja Musukwe N	SHDI
122.	Wamulongo Alupakusadi	UCBHCA
123.	Wangudi Moses	Health Rights Action Group

## Appendix 4: Members of the National HIV/AIDS Prevention Committee and Core Team on the Road map

### Prevention Committee Membership

Name	Organization	Representation
1. Dr S Okware (Chair)-	Ministry of Health	Government
2. Mrs J Mpagi -	Ministry of Gender	Government
3. Mr Nsubuga -	Ministry of Education	Government
4. Ms M. Harper -	UNAIDS	UN
5. Dr Abdusalad -	WHO	UN
6. Prof. E Kirumira -	MUK	Research & academia
7. Representative -	CDC	Research
8. Ms S. Thaddeus -	USAID	Bilateral
9. Mr R Alistair -	DFID	Bilateral
10. Ms C Watson -	Straigh Talk	NGO
11. CEO -	AIC	NGO
12. Dr L Tumwebaze -	Researcher	Research & Academia
13. Rev. S Ruteikara -	IRCU	FBO
14. Ms F Buluba -	NAFOPHANU	PHA
15. Mr A Luyimbazi -	MUK	Media SCE
16. Mr Brian Lubwama -	ACET	Young People
17. Ms E Kisaakye -	UGANET	NGO
18. Dr E. Madraa -	MoH	Government
19. Major Dr Kusasira S -	MoD/UPDF	Government
20. Dr Joseph Okia -	OoP	Government
21. Mr H. Syahuka -	UNASO	NGOs
22. Prof. J Rwomushana -	UAC	Government

### Core Team Members for the Rapid Assessment Exercise And Road Map

1. Ms Cathy Watson	-	Straight Talk
2. Ms Sheila Kawooya	-	UNAIDS
3. Dr Joseph Okia	-	Office of the President
4. Dr E Madraa	-	MoH
5. Dr Christopher Oleke	-	MoH
6. Ms Rita Nalwadda	-	WHO
7. Dr Benjamin Sensaasi	-	WHO
8. Ms B Bunnel	-	CDC
9. Mr Brian Lubwama	-	Young People SCE
10. Ms Florence Buluba	-	PHA Forum
11. Dr Lorna Tumwebaze	-	INGOs
12. Mr Mugyimba	-	MoGLSD
13. Ms Kindyomunda R.	-	UAC
14. Dr Jim Arinaitwe	-	UAC
15. Prof J. Rwomushana	-	UAC