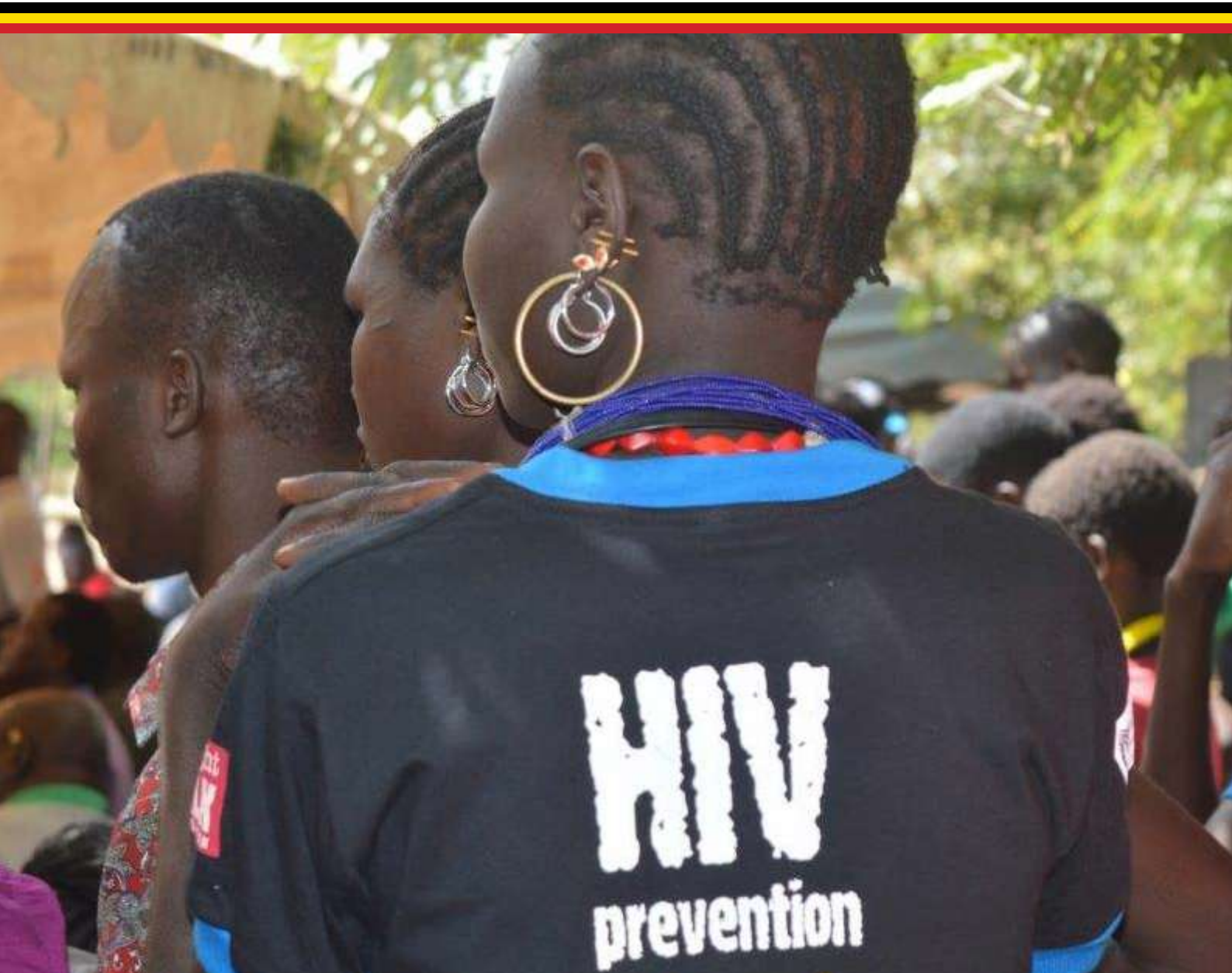


ACCELERATION OF HIV PREVENTION IN UGANDA

A road map towards zero new infections by 2030



THEME: Towards sustainability, ownership and resilient HIV prevention systems



THE REPUBLIC OF UGANDA



Uganda AIDS Commission

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Uganda AIDS Commission

NOVEMBER 2018



His Excellency The President of Uganda General Yoweri K Museveni Launches the Presidential Fast Track Initiative to End AIDS in Uganda, June 2017

FOREWORD

Over the years, the Uganda HIV prevention response has registered considerable progress. With support from our partners, we have succeeded in bringing down HIV prevalence from as high as 18% in the general population during the 1990s to 6% in 2016. During the last seven years, there have been significant improvements in the reduction of new HIV infections and deaths from AIDS-related causes. These achievements have been the result of the scale-up of HIV combination prevention interventions, including structural, behavioural and biomedical interventions. Core interventions have included: abstinence, faithfulness and condom use (ABC); safe male circumcision; HIV counselling and testing; elimination of mother-to-child transmission; HIV care and treatment, especially antiretroviral therapy; and ensuring the empowerment of women to reduce gender inequality.

Despite these achievements, challenges remain, including high levels of new infections among adolescent girls and young women, and low involvement of men in HIV programs. As a result, HIV remains a major challenge, and it continues to impact negatively on the realization of Uganda's Vision 2040 of becoming "a transformed society from a peasant to a modern prosperous country¹."

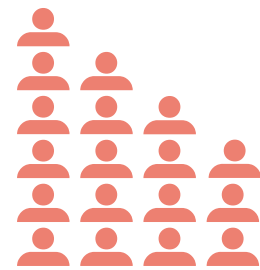
This road map has been developed with the goal of ending AIDS by 2030. It provides all of the strategic information needed to make decisions for well-coordinated and efficient HIV prevention interventions. Implementation will require the concerted efforts of a multisectoral response involving all Ugandans.

For this reason, I call upon all Ugandans and political, religious, cultural and civic leaders to embrace this road map. I also urge all sectors—public, private, civil society, media and development partners—to ensure that we end AIDS as a public threat in Uganda.



DR EDDIE MUKOOYO SEFULUYA
CHAIRMAN, UGANDA AIDS COMMISSION

HIV PREVALENCE



18%
in the
1990s



6%
in
2016

¹ Government of Uganda: Vision 2040. <http://npa.ug/wp-content/themes/npatheme/documents/vision2040.pdf>

ACKNOWLEDGEMENTS

This national HIV prevention road map (2018–2030) was developed using an inclusive and broad consultative process among HIV prevention stakeholders in the country. The process was led by the Uganda AIDS Commission (UAC). The road map was developed based on review of existing HIV prevention interventions in the country and consultations with stakeholders in the public and private sector, including people living with HIV and development partners. It also includes recommendations from an expert think tank that was set up by the National HIV Prevention Committee. The road map complements existing planning frameworks, including the National HIV/AIDS Strategic Plan and the Health Sector Development Plan.

UAC acknowledges the contributions of the United Nations Joint Team on HIV and AIDS led by UNAIDS and the United Nations Population Fund (UNFPA), and the United States President's Emergency Plan for AIDS Relief (PEPFAR)/Centers for Disease Control (CDC) country teams that contributed generously to ensuring the successful development of this road map.

Special thanks go to Dr. Andrew Balyeku and Dr. Brian Katungi, the two consultants who led the process of developing this road map. Editing was done by the Uganda AIDS Commission, UNAIDS, the Uganda Ministry of Health and CDC teams under the leadership of Dr Zepher Karyabakabo and Dr Byamukama Daniel (UAC). Notably, the following persons deserve mention for their special contributions in editing this work: Dr Peter Mudiope (Ministry of Health), Ms Rosemary Kindyomunda (UNFPA), Dr Karusa Kiragu (UNAIDS), Dr Komiljon Akhmedov (UNAIDS), Mr Trouble Chikoko (UNAIDS) and Dr Stella Alamo (CDC).

UAC would like to thank all those who helped expand this road map, who provided information and data, or who critically reviewed earlier drafts. Particular thanks go to colleagues and staff at the Ministry of Health, the Ministry of Gender, Labour and Social Affairs, and the Ministry of Education and Sports. The members of the National HIV Prevention Committee and the expert think tank are duly acknowledged for their professional guidance and the technical input they provided during the process.

The development of this road map and related activities was supported through a grant from UNFPA and UNAIDS. All development partners—including CDC, PEPFAR, USAID, Irish Aid, and the United Nations Joint Team on AIDS—are greatly applauded for their technical input to this task.



DR NELSON MUSOBA

DIRECTOR GENERAL, UGANDA AIDS COMMISSION

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ABBREVIATIONS AND ACRONYMS

| | | | |
|----------------|--|---------------|---|
| AIS | AIDS Indicator Survey | PIASCY | Presidential Initiative on AIDS Strategy to Youth |
| DQA | data quality assessments | PITC | provider-initiated testing and counselling |
| EIMC | early infant male circumcision | PrEP | pre-exposure prophylaxis |
| EMIS | education management information system | SBCC | social and behaviour change communication |
| EMR | electronic medical records | SGBV | sexual and gender-based violence |
| eMTCT | elimination of mother-to-child transmission | SRH | sexual and reproductive health |
| HMIS | health management information systems | SMC | safe medical circumcision |
| IGA | income generation activities | STIs | sexually transmitted Infections |
| LGA | local government authority | UAC | Uganda AIDS Commission |
| LQAS | Lot Quality Assurance Surveys | UDHS | Uganda Demographic Health Survey |
| M&E | monitoring and evaluation | UNAIDS | Joint United Nations Programme on HIV/AIDS |
| MGLSD | Ministry of Gender, Labour and Social Development | UNICEF | United Nations Children’s Fund |
| MOES | Ministry of Education and Sports | UNFPA | United Nations Population Fund |
| MOH | Ministry of Health | UPHIA | Uganda Population-based Impact Assessment |
| MoLG | Ministry of Local Government | UWA | Uganda Wildlife Authority |
| MoT | modes of transmission study | VCT | volunteer counselling and testing |
| MTR | midterm review | VMMC | voluntary medical male circumcision |
| NSP | National Strategic Plan | WHO | World Health Organization |
| PEPFAR | United States President’s Emergency Plan for AIDS Relief | | |

GLOSSARY

Adolescent: Any person between the ages of 10 and 19 years.

Adolescent-friendly and youth-friendly health services: Health services that are both responsive and acceptable to the needs of adolescents and youth, and which are provided in a non-judgmental, confidential and private environment, in times and locations that are convenient for adolescents and youth.

Comprehensive sexuality education: Provision of age-appropriate, culturally relevant, scientifically accurate, realistic and non-judgmental information about sex and relationships. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality.

Discrimination: Refers to action based on stigma. HIV-related discrimination follows stigma, and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status.

Gender-based violence: All acts perpetrated against women, men, boys and girls on the basis of their sex that causes (or could cause them) physical, sexual, psychological, emotional or economic harm, including the threat to take such acts, or to undertake the imposition of arbitrary restrictions on (or deprivation of) fundamental freedoms in private or public life in peacetime and during situations of armed or other forms of conflict. It covers domestic violence, sexual harassment in the workplace, human trafficking and sexual and emotional abuse (to name a few examples). It is not just about the act of violence, but also about education, prevention and victim assistance.

HIV-related stigma: A process of devaluing people either living or associated with HIV and AIDS.

Key affected populations: These populations bear a disproportionate burden of HIV and play special roles in bridging infections to the general population. In the Ugandan context, key population groups currently include sex workers and their partners, fishing communities, uniformed services, long distance truckers, injecting drug users and men who have sex with men.

Linkages: The bi-directional synergies between laws, policies, programmes, services and advocacy around sexual and reproductive health (SRH) and HIV and AIDS. It is recognized that sexual and reproductive health and HIV and AIDS share root causes that include poverty, gender inequality, gender-based violence and social marginalization. SRH and HIV and AIDS should therefore be addressed in a holistic manner.

Reproductive rights: The basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. These rights also include the right to the highest attainable standard of SRH and the right of all people to make decisions concerning reproduction, free from discrimination, coercion and violence.

Rights-based approach: The recognition that citizens of Uganda have a right to health services, products and information, and that the individual States have an obligation to ensure that their citizens realize this right. Citizens have a corresponding responsibility to seek health services and live healthy lifestyles.

Sexual and gender-based violence (SGBV): Any sexual act or unwanted sexual comments or advances using coercion, threats of harm or physical force, by any person, regardless of their relationship to the survivor, in any setting. SGBV is usually driven by power differences and perceived gender norms. It includes forced sex, sexual coercion and rape of adult and adolescent men and women, and child sexual abuse.

Social determinants of health: These are the social, cultural, religious, economic and political conditions in which people are born, grow, live, work and age that influence their access to and utilization of health services, products and information.

Structural factors: The characteristics of the social, economic, legal and cultural environment that determine HIV risk for whole populations and influence how this risk is distributed within populations.

Transactional sex: Non-commercial, non-marital sexual relationships motivated by the implicit assumption that sex will be exchanged for material support or other benefits.

Young people: Any person between the ages of 10 and 24 years.



CHAPTER 1

INTRODUCTION

1.1 BACKGROUND

1.3 million

UGANDANS LIVING
WITH HIV

74%

KNEW THEIR
HIV-POSITIVE STATUS

67%

WERE ON
TREATMENT

60%

WERE VIRALLY
SUPPRESSED

95%

MOTHERS LIVING WITH
HIV ARE ACCESSING
EMTCT SERVICES

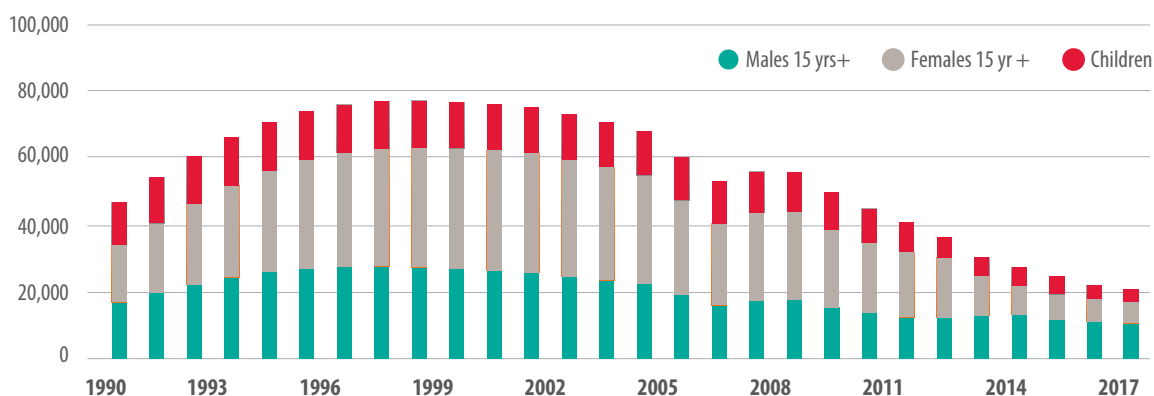
Uganda has made great strides in reducing overall HIV incidence, AIDS-related mortality, new infections among infants, and HIV prevalence. While the current improvements have been made, the scope, coverage and intensity of interventions are still inadequate to move the country to epidemic control and sustain the trend in reducing new HIV infections.

According to the Uganda HIV/AIDS Country Progress Report 2017-2018, the HIV epidemic continues to be severe, mature, generalized and heterogeneous, with an estimated 1.3 million Ugandans living with the infection². According to recent statistics from the Ministry of Health, AIDS-related mortality has steadily declined over the past 10 years, down to about 26,000 in 2017. The Uganda Population-based Impact Assessment (UPHIA) report also indicates that the country has made significant progress in reducing the HIV prevalence from 7.3% in 2011 to 6.2% in 2017 among adults aged 15 – 64 years, but that prevalence remains higher among females (7.6%) than males (4.7%). Young people, especially adolescent girls and young women, continue to be disproportionately affected by HIV, accounting for just over one third of new HIV infections. Data from the Ministry of Health/UPHIA indicate that of all persons living with HIV in the country in 2017, 74% knew their HIV-positive status, 67% were on treatment and 60% were virally suppressed³. There has been scale-up of services for the elimination of mother-to-child transmission (eMTCT): currently more than 95% of pregnant mothers living with HIV are accessing eMTCT services.

² Uganda AIDS Commission: Uganda HIV/AIDS Country Progress Report July 2017- June 2018.

³ Ministry of Health: The Uganda Population-Based Impact Assessment (UPHIA), 2016; Preliminary Findings, August 2017.

FIGURE 1: AIDS-related deaths steadily declined over the past 15 years

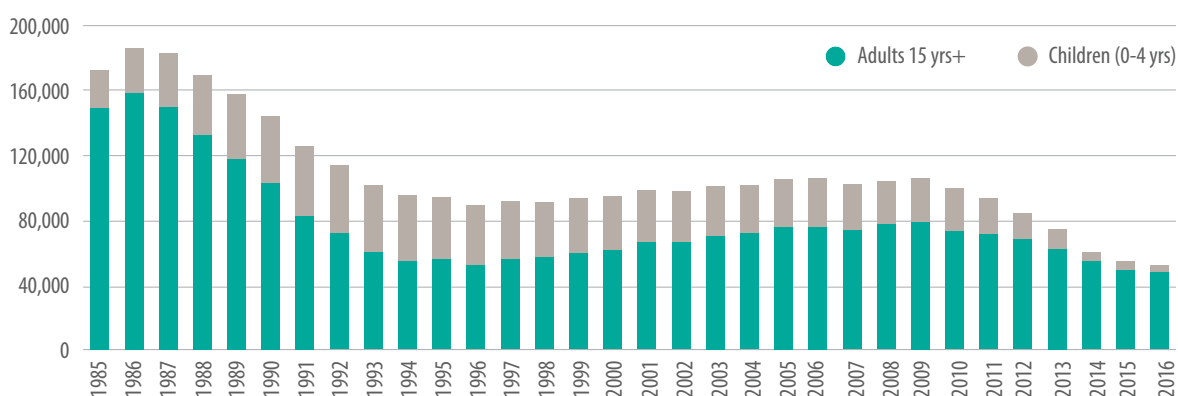


Like the rest of the world, Uganda has committed to the 2016 Political Declaration on HIV and AIDS, which aims to reduce new infections to fewer than 500,000 globally by 2020 (a 75% reduction), and to the global goal of ending AIDS as a public health threat by 2030. Achieving these goals requires the acceleration of efforts to combat the epidemic and the implementation at an adequate scale of interventions that have been known to produce desired results.

This road map is largely anchored on *The case for more strategic and increased HIV investment for Uganda 2015–2025*, and it draws on inspirational targets for eliminating the HIV epidemic by 2030. It amplifies intentions of the Presidential Fast-Track Initiative on Ending AIDS as a Public Health Threat, which was launched in June 2017. It also draws inspiration from evidence in various national HIV/AIDS studies, including the Modes of Transmission (MOT) Study 2014, the 2016 UPHIA and the global UNAIDS guidance documents for Fast-Tracking HIV prevention. It draws from the Global HIV Prevention Coalition which was launched in October 2017, bringing together over 25 United Nations Member States to strengthen and sustain political commitment for primary prevention by setting a common agenda⁴.

The road map responds to key remaining challenges to push the prevention response towards attaining zero new infections in the country and contributing to national development intentions and commitments to sustain the response. It acknowledges HIV as a development issue and therefore is subordinate to both national development frameworks and to targets to inspire integration of HIV into development programming.

FIGURE 2: New HIV infections have been falling since 2010



⁴ UNAIDS: The Global HIV Prevention Coalition, <https://hivpreventioncoalition.unaids.org/>, Geneva, October 2017.

TABLE 1: Current challenges in accelerating prevention response towards zero new infections

| KEY ISSUE | HIGHLIGHTS |
|--|---|
| 1. Despite progress in reducing new HIV infections, the pace is still slow and needs to be accelerated | There have been significant declines over the past seven years, but the number of new HIV infections in Uganda remains among the highest in the world, at 50,000 in 2017. Uganda ranks 6th in this metric after South Africa (270,000), Nigeria (210,000), Mozambique (130,000), Tanzania (65,000), and Kenya (53,000). New HIV infections in Uganda have declined 51% since 2010, but all the same, 950 Ugandans a week acquired HIV in 2017 ⁵ . |
| 2. Combination prevention needs to be expanded | The country pursues the combination HIV prevention strategy, which expanded focus on proven HIV prevention interventions such as male circumcision and test-and-treat. There has been expansion of antiretroviral therapy, with 67% of persons living with HIV already on treatment, and 60% of all persons living with HIV already virally suppressed. About 74% of Ugandans living with HIV are aware of their status. Nationwide coverage of Option B+ is over 95%. According to UPHIA, 42 percent of men aged 15–64 have been circumcised, either by traditional means or medically ⁶ . |
| 3. Earlier gains have not been sustained despite increased availability of services | Efforts to coherently address structural issues (such as gender inequality, economic inequities, harmful cultural norms and deep-seated stigma) in order to impact the course of the epidemic are insufficient. Behaviour change efforts — including age-appropriate sex education, community-based behavioural prevention, condom use and prevention programmes among populations at greater risk of HIV exposure—also have not been sufficiently implemented to scale to result in significant and sustainable declines in new HIV infections. These inadequacies perpetuate risk and vulnerability, sustaining the cycle of new infections from one generation to the next or spreading infections from one population group to another. |
| 4. Even with significant external support, primary HIV prevention funding has been limited and dwindling external funding for HIV generally creates further threats to sustainable programming | The HIV response in the country has benefitted from external support over the years, largely through vertical programming to address HIV as an emergency. There is still limited exploitation of socioeconomic and health systems for expanded delivery of HIV services for the holistic empowerment of individuals to protect themselves and sustain their healthy behaviours. There is need to Fast-Track the transition from the emergency mode to integrate HIV fully into development programming, especially to address the generalized epidemic for wider and more sustainable impacts. |

5 UNAIDS AIDS Info, 2018. <http://aidsinfo.unaids.org/>

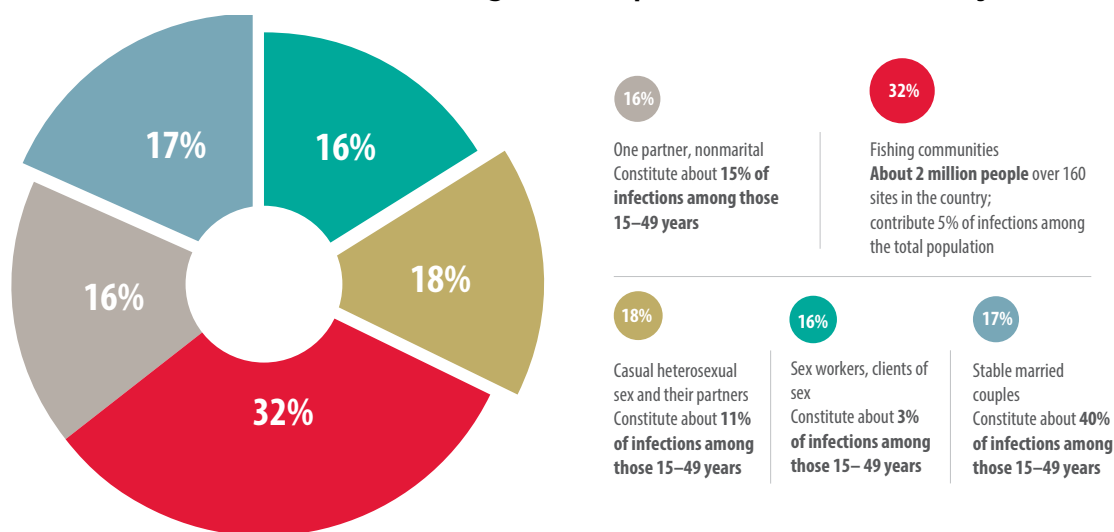
6 PEPFAR COP, 2018

1.2. HIV PREVENTION SITUATION ANALYSIS

Variations in HIV: There is higher HIV prevalence in particular demographic groups, with HIV varying by gender, age and geographic regions. HIV prevalence is higher among females (7.6%) than males (4.7%). In relation to age, HIV prevalence among children is 0.5%, both for those under the age of five and those aged 5–14 years. HIV prevalence is highest among men aged 45–49 years (14%) and women aged 35–39 years (12.9%) and 45–49 years (12.8%). It is also higher among residents of urban areas (7.1%) than those in rural areas (5.5%). The magnitude of HIV varies considerably among the 10 geographic regions in the survey, from a low of 2.8% in West Nile to 7.7% in the South-West (UPHIA, 2016⁷).

Higher incidence in key populations: Incidence is higher among all key populations (including fishing communities, sex workers, clients of sex workers and members sexual minority groups), averaging about 4300 new infections per 100,000. This excludes injecting drug users, who have the highest incidence: about 18,000 new infections per 100,000. Localized studies estimate HIV prevalence among sex workers to be as high as 35%, 13.7% among men who have sex with men and 23–35% among fishing communities⁸. Incidence is considerably lower among general population groups, averaging about 940–1400 new infections per 100 000 adults. Key populations—who constitute 5% of the population—contribute 21% of new infections annually.

FIGURE 3: **Source of new infections in Uganda, computed data from MOT Study 2014⁹**



Disproportionate burden among adolescents and young women: In 2017, 17,700 young people ages 15 to 24 years acquired HIV, accounting for 35% of new HIV infections. In the same year, 7,400 adolescents ages 10 to 19 years, acquired HIV, accounting for 15% of new infections. Adolescent girls and young women continue to be particularly affected: 250 young women in Uganda aged 15–24 acquired HIV every week in 2017 (approximately 13,000 for the year), compared to 90 of their male counterparts (approximately 4,700 for the year). Young people also belong to other key affected populations, such as fishing communities, sex workers, men who have sex with men and people who inject drugs.

7 Ministry of Health: The Uganda Population-Based HIV Impact Assessment (UPHIA), 2016; Summary Sheet, Preliminary Findings, August 2017

8 Uganda AIDS Commission and Ministry of Health: Analysis of HIV Prevention Response and Modes of Transmission in Uganda. Final Synthesis Report, 2014

9 Uganda AIDS Commission and Ministry of Health: Analysis of HIV Prevention Response and Modes of Transmission in Uganda. Final Synthesis Report, 2014

Insufficient and uneven coverage of high-impact prevention interventions: Combination HIV prevention—comprised of a strategic mix of behavioural, biomedical and structural interventions of proven efficacy, delivered consistently and at critical levels of coverage within a defined geographical location to population groups—is the recommended HIV prevention approach to turn the tide of the HIV epidemic in Uganda. Selected prevention interventions show that coverage is grossly uneven, and that the lowest coverage tends to be for adolescents, young people and males.

All regions of the country are experiencing a generalized HIV epidemic, but HIV prevention programming has focused largely on urban hotspot areas where most new infections are expected. This, in turn, creates opportunities for an expanding epidemic in rural areas. For example, the HIV prevalence for North-East, increased from 4.4% in 2011 to 5.1% in 2017¹⁰. Other than the universal coverage of the antiretroviral treatment program, there is insufficient programming for the mixed epidemics, with most of the focus on the concentrated epidemic. While this is crucial to reach epidemic control levels by 2020 (a situation when the total number of new HIV infections falls below the total number of deaths from all causes among HIV-infected individuals), Uganda may fail to reach and sustain epidemic elimination levels by 2030 without conscious focus on the vulnerabilities and risk factors fuelling the various running epidemics.

Failure to confront social structural drivers: Sociocultural and economic factors render individuals susceptible to high-risk sexual behaviours and constrain their access to the sexual and reproductive health information and services they need to protect themselves from infection or enroll on (and adhere to) treatment. The combination HIV prevention approach acknowledges the importance of such structural factors, particularly in the perpetuation of the sexual transmission of HIV. Such factors include: (a) elevated school dropout rates, especially for girls; (b) the low socioeconomic status of women and girls, which creates power imbalances that hamper the autonomy of females to protect themselves; (c) high rates of sexual violence; (d) persistent harmful sociocultural norms and practices, such as constructions of masculinity that discourage health-seeking behaviours; and (e) social exclusion for some key populations such as sex workers. The combination prevention package, however, has not been delivered equitably, and coverage of programs addressing structural and behavioural factors has been limited.

Limited HIV prevention funding: The HIV response in Uganda has benefitted from high volumes of external funding over the years. Despite this, primary HIV prevention funding has been limited, and the dwindling external funding for HIV generally creates further threats to sustainable programming. Furthermore, HIV programming has largely been through vertical programming to address the epidemic as an emergency. National guidance for HIV mainstreaming has been provided and integration of HIV into sexual and reproductive health and rights (SRH) service delivery is expanding, but there still is limited exploitation of existing systems for delivery of expanded socioeconomic and integrated health services for holistic empowerment of individuals to protect themselves from HIV infection, sustain preventive behaviours and access available services. This ultimately also demands mixed approaches, especially sustaining the emergency mode that enables rapid reduction of the epidemic in high-priority population groups, in order to nurture a transition to development programming that enhances focus on all vulnerable populations groups to eliminate risk and promote access to rights-based services.

10 Ministry of Health: The Uganda Population-Based Impact Assessment (UPHIA), 2016; Preliminary Findings, August 2017

1.3 COVERAGE OF KEY PREVENTION INTERVENTIONS

TABLE 2: **Prevention gaps in the current HIV response**

| | |
|--------------------------------|---|
| CONDOMS | <ul style="list-style-type: none"> • Condom use at high-risk sex remains low (21% among females and 22% among males). • Weak coverage and targeting for female condoms. • Lack of education about correct and consistent condom use, especially among young people. |
| TREATMENT AS PREVENTION | <ul style="list-style-type: none"> • HIV treatment coverage of 67% among all people living with HIV • Only 60% of people living with HIV are virally suppressed. • Access to treatment and viral suppression is lower among key populations, adolescents, children and men. • Stigma and discrimination deter people from seeking HIV testing services and compromise sustained antiretroviral therapy adherence. • The preventative benefits of treatment are not being realized fully due to late initiation and increasing loss to follow-up. • The promising pre-exposure prophylaxis (PrEP) are not yet fully rolled out. • Stock-outs of antiretroviral medicines at some sites. |
| VMMC | <ul style="list-style-type: none"> • Following years of rapid increase, annual numbers of performed circumcisions have declined. • The percentage of eligible men who have received voluntary medical male circumcision (VMMC) is 42%. • PEPFAR funds 95% of the voluntary medical male circumcision (VMMC) in the country. Under this program, the cumulative number of VMMCs have risen from 9000 in 2010 to over 3.6 million in 2017. • The annual number of circumcisions must more than double to reach the 2020 target of approximately 6.2 million men; 1 million procedures annually⁹ |
| SBCC | <ul style="list-style-type: none"> • Most young people lack the knowledge required to protect themselves from HIV. • Comprehensive HIV knowledge has stagnated; the Uganda Demographic Health Survey (UDHS) 2016 reports it at 45%. • Slow progress on partner reduction: there has been a 24.5% increase in multiple concurrent partnerships from UDHS 2011 to UDHS 2016. • Systematic implementation of social and behaviour change communication (SBCC) and demand generation has not taken place. • Gender-based violence remains high at the community-level, rendering many vulnerable to infection. • Weak use of existing socioeconomic programs addressing HIV. |
| EMTCT | <ul style="list-style-type: none"> • Loss to follow-up of mother–baby pairs, with 57% at first PCR and 36% at second PCR. Only 32% of HIV-exposed infants complete the treatment cascade. • The number of new infections among women of reproductive age (aged 15 to 49 years) is high. • Large unmet need for family planning. • Treatment dropout rates among women who are pregnant and breastfeeding. • Low retention on ARVs and adherence to treatment. • Limited focus on partners in eMTCT programming. |

11 Uganda Draft Health sector HIV/AIDS strategic plan 2018-2023

| | |
|----------------------|--|
| HIV TESTING SERVICES | <ul style="list-style-type: none"> • More than 90% who received HIV testing services were adults (aged 15 years and over) and two thirds (66%) were women. • Low uptake of couples testing. • Only two thirds of the 3000 antenatal care facilities providing HIV testing services also dispense antiretroviral treatment. • Many people, especially men living with HIV, do not know their HIV status. • Poor reporting of community testing and index testing under provider-initiated testing and counselling (PITC) and volunteer counselling and testing (VCT). |
| ADOLESCENT SERVICES | <ul style="list-style-type: none"> • New HIV infections in adolescents (15–19 years) are not declining as rapidly as for other age groups. • Coverage of prevention is low. • Young people among key populations have the highest risk. • There is a growing number of young injecting drug users. • Only 20% of adolescents complete secondary school. • Of all adolescents aged 15–19 who were diagnosed as HIV-positive, two thirds are girls. |
| SOCIAL-STRUCTURAL | <ul style="list-style-type: none"> • Domestic gender-based violence remains unacceptably high, with 22% of ever-married women reporting physical or sexual violence from a spouse in the preceding 12 months. • The recent national stigma index studies conducted among (a) people living with HIV in Karamoja region, (b) adolescents and young adults living with HIV in Busoga region, (c) sex workers living with HIV and (d) the Uganda Wildlife Authority (UWA) indicate widespread self-stigma (25.7% in Karamoja, 24% in Busoga region, 38.5% among sex workers and 28.3% in UWA¹⁰). |

1.4 KEY IMPLEMENTATION BOTTLENECKS

This road map targets the following key bottlenecks, which need to be addressed to ensure that all core combination HIV prevention interventions are delivered with the same high coverage and quality.

TABLE 3: **Key implementation bottlenecks**

| | |
|---|--|
| 1. Fragmented combination prevention interventions | <p>Combination prevention interventions have not been delivered as a package to scale. Interventions are not well-coordinated in design and implementation. This means that the coverage and quality of individual interventions is highly variable. Biomedical interventions have been expanding, but there are gaps towards realizing integrated health service delivery. Programming addressing social-structural barriers in the context of HIV is weak, not fully integrated into high-impact biomedical interventions due to funding conditions, and poorly integrated and tracked in non-health sector development programming as part of efforts to ensure sufficient alignment for sustainable impacts.</p> |
| 2. Inadequate targeting | <p>Priority prevention interventions are not fully reaching those most in need, mostly due to inadequate funding. This leads to inefficiency and inequality. While funding targeting concentrated epidemics around urban centre hotspots has increased, targeting for the vulnerable and hard to reach in the general population is still weak. Prevention interventions targeting critical structural barriers are continually underfunded and funding for primary prevention has decreased.</p> |

12 UNAIDS AIDS Info, 2018. <http://aidsinfo.unaids.org/>

| | |
|--|--|
| <p>3. Insufficient scale</p> | <p>Delivery of the combination prevention packages for the different population groups has not reached coverage levels as defined in the Investment Case¹¹. All biomedical interventions are unlikely to reach the 90% universal coverage targets by 2020; the limited integration of HIV into development programs constrains sufficient reach of comprehensive SRH and HIV services for the vulnerable and socially excluded. Social-structural determinants as a specific component of the national multisectoral HIV response do not have the corresponding budget, resource provisions and actions.</p> |
| <p>4. Insufficient funding</p> | <p>The volume of investment into HIV programming has been increasing over the years, with 80% from external sources, largely for biomedical interventions (including antiretroviral therapy). Even then, the funding gaps remain high and the limited support for structural and behavioural interventions from external sources severely constrains primary prevention programming. Similarly, the weak integration of HIV into other health and socioeconomic programs (e.g., for sexual reproductive and maternal health) constrains optimization of locally available resources. While external support is crucial to expand scale, intensity and quality in the short-term, Uganda needs a transition from dependency on dwindling, volatile and often conditional external funding to innovative domestic funding to assure universal coverage and sustainability.</p> |
| <p>5. Weak strategic information system</p> | <p>There is inadequate strategic information on coverage of combination HIV prevention. This is partly owing to weak coordination of combination interventions. There are major data system gaps on the process and output level indicators that are essential for monitoring performance in structural and behavioural prevention interventions; there also is insufficient analytical association of structural issues and the monitoring of HIV interventions. Monitoring program coverage for some critical indicators by the health sector, such as specific population groups, is limited due to the lack of capture in the health management information systems (HMIS) tools. The country needs a one-stop report for HIV prevention program tracking to inform harmonized action.</p> |
| <p>6. Population dynamics</p> | <p>Uganda's population has grown from 9.5 million in 1969 to 34.9 million in 2014 and is expected to reach 83 million by 2040. The overwhelmingly young population (52% are 15 years or younger and 70% are aged 24 or younger) and increasing new HIV infections among these groups calls for increasing emphasis on adolescents. This requires significant investment for the large economically dependent population group commencing their sexual careers. It will need sharp focus to reach targets for comprehensive HIV knowledge and universal access to prevention and treatment services.</p> |
| <p>7. Individual and community accountability</p> | <p>HIV prevention programming will only achieve sustainable impacts if empowered community members take charge of their lives, practice responsible health-seeking behaviours, including exercising rights to demand for quality and acceptable services. It will require sustained and serious leadership both at the community and household level, with adults setting good examples. It will also require boldness to reach key populations, as well as difficult groups such as males.</p> |

13 Uganda AIDS Commission: The case for more strategic and increased HIV investment for Uganda 2015-2025



CHAPTER 2

ACCELERATING HIV PREVENTION: THE ROAD MAP TO HIV ELIMINATION

Dr Eddie Mukooyo Sefuluya, UAC Chair, presenting The 1st Annual Report for the Presidential Fast Track Initiative on Ending AIDS as a Public Health Threat in Uganda by 2030 to RT Hon. Rebecca Kadaga, Speaker of Parliament, Uganda

THE GOAL

To realize epidemic control by 2020 and sustain gains in HIV prevention.

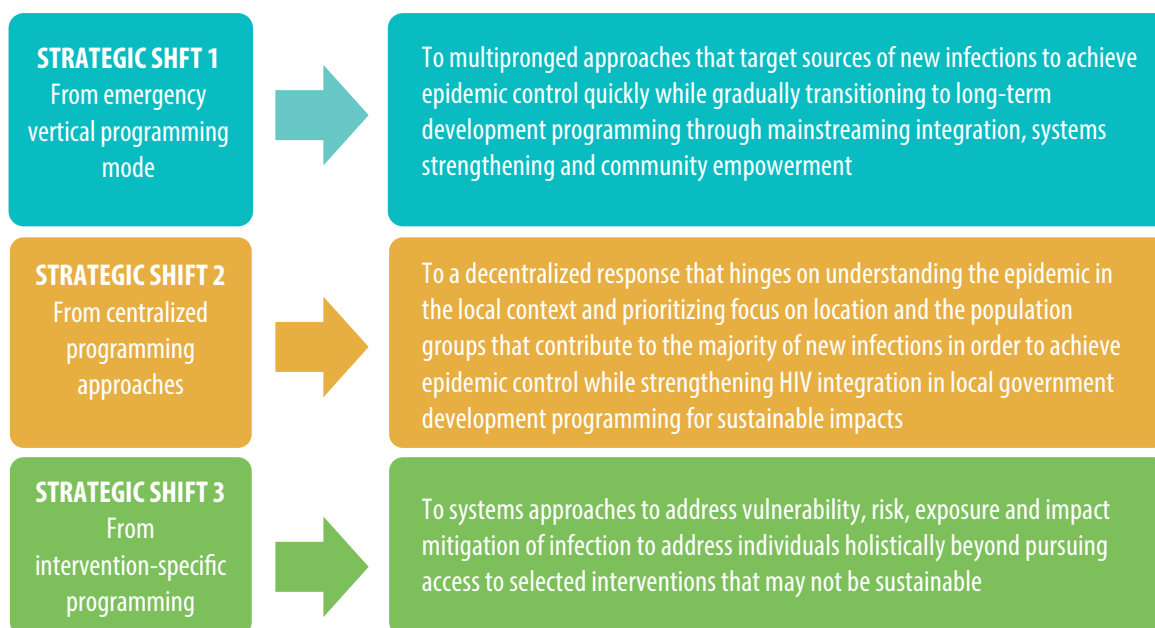
OBJECTIVES OF THE ROAD MAP

1. To identify and align critical actions needed to accelerate and sustain reductions in new HIV infections in Uganda.
2. To set broad performance targets that guide implementation of optimal combination prevention interventions needed to reach zero new infections.
3. To set broad guidance for addressing HIV prevention from development perspectives.

KEY PRINCIPLES

1. Closing bottlenecks, addressing challenges and accelerating HIV prevention interventions.
2. Epidemic control while transitioning to development programming for universal coverage and sustainable impacts.
3. Integration in national development planning and sustainable financing mechanisms.

FIGURE 4: **Strategic shift to strengthen HIV prevention in Uganda**



STRATEGIC SHIFT 1

FROM EMERGENCY VERTICAL PROGRAMMING TO EPIDEMIC CONTROL AND LONG-TERM DEVELOPMENT PROGRAMMING

Moving from the current level of implementation to attain epidemic control —where the total number of new infections falls below the total number of deaths from all causes among HIV-infected individuals — and transition to long-term development programming, will require (a) multipronged approaches that target sources of new infections using implementation science and (b) mainstreaming and integrating HIV into the government development agenda at all levels. It will require acceleration in terms of scope and intensity of current HIV combination prevention interventions. This also will take commitment, political will and funding for this new approach using a development programming approach.

PRIORITY ACTION 1: ATTAIN CRITICAL COVERAGE OF THE CURRENT HIV PREVENTION INTERVENTIONS BY 2020 (THE 90–90–90 TARGETS)

While there has been tremendous progress towards achieving the 90–90–90 targets nationally, there is need to accelerate progress in order to realize this target by 2020¹⁴.

- The first 90 (90% of people living with HIV know their status): This would mean that 1.2 million of the 1.3 million people living with HIV in Uganda know their HIV status. However, only 74% definitively know their HIV status, well below the 90% target.
- The second 90 (90% of people who know their HIV-positive status are accessing treatment): Under the second 90 target, at least 81% of all HIV-positive people who are aware of their status would be enrolled in antiretroviral therapy. Uganda had met this goal -- by December 2017, 89% of all

14 UNAIDS AIDS Info, 2018. <http://aidsinfo.unaids.org/>

persons living with HIV who knew their status were on treatment. However when the estimate is based on the treatment cascade method, whereby the denominator is all people living with HIV – not just those who know their status – the data suggest that the country has a long way to go as only 67% of all people living with HIV are on treatment.

- The third 90 (90% of people on treatment have suppressed viral loads): In order to meet the targets for this indicator, 73% of all people on treatment would need to be virally suppressed. Uganda has met this target, as 78% of all people on treatment are virally suppressed. Again using the treatment cascade method, where the estimate is based on all people living with HIV – not just those who are on treatment – the data show that only 60% of all people living with HIV are virally suppressed.

The progress to 90-90-90 suggests that the main bottleneck in Uganda is diagnosing the 24% of persons living with HIV who do not yet know they have it, approximately 312,000 individuals.

PRIORITY ACTION 2: SELECTING CRITICAL INTERVENTIONS TO MOVE TO EPIDEMIC CONTROL BY 2020

1. Finding HIV-positive people not yet tested, getting them on treatment and retaining them in care
 - Finding missing men and putting them on treatment (men aged 20–24 and 35–49 years).
 - Index partner testing and putting them on treatment.
 - HIV-exposed children and putting them on treatment.
 - Finding missing women and putting them on treatment.
 - Finding missing adolescent girls and young women and putting them on treatment.
 - Finding missing children and orphans and vulnerable children and putting them on treatment.
2. Focus on hard-to-reach and at-risk populations
 - Focus on key populations, improve case finding and linkage to care
 - Do not overlook hidden key populations such as prisoners, sexual minorities, and persons who inject drugs
3. Expansion of proven prevention programs to support epidemic control
 - Scaling evidence-based HIV combination prevention package
 - Monitoring scale with fidelity and quality
4. Increasing program impact and outcomes
 - Identifying gaps in relevant prevention pillars, setting targets and planning key actions to fill gaps.
 - Ensure UPHIA results are informing programmatic alignment to the right geographic locations and populations.
 - Targeting highest impact sites at the local government levels.
 - Focus attention on districts with low antiretroviral coverage and/or viral suppression.
 - Focus attention on non-virally suppressed populations, including children, adolescents and pregnant/breastfeeding women.

5. Increasing efficiency and effectiveness
 - Strengthening coordination at the national and sector levels.
 - Strong leadership, ownership and engagement.
 - Quality assurance.
 - Commodity security.
 - Strategic information.

PRIORITY ACTION 3: CONSCIOUSLY IMPLEMENT A FULL DOSE OF COMBINATION HIV PREVENTION INTERVENTIONS

Combination prevention is a blend of (1) biomedical, (2) behavioural and social, and (3) cultural/structural interventions implemented at scale. High coverage of biomedical interventions reduces new primary infections, but on its own, it will not bring about the long-term gender, cultural and equality changes that are necessary to break the cycle of new infections from one generation to the next or the spread of infections from one population group to another.

1. Biomedical HIV prevention interventions:

The Uganda HIV Investment Case (2015–2025) defines a package of high-impact interventions and targets that have to be met for the country to achieve epidemic elimination targets¹⁵. These include condoms, HIV treatment as prevention, voluntary medical male circumcision (VMMC), eMTCT and HIV testing services. These need to reach more than 90% of the targeted population by 2020.

- **Condoms:** Male and female condoms are at the centre of combination HIV prevention, and they also provide protection against sexually transmitted infections (STIs) and unintended pregnancies when used correctly and consistently. Condom use among sex workers and their clients and other sexual partners—as well as among fishing communities, key populations and bridging populations—must be 100% or combined with pre-exposure prophylaxis (PrEP) to prevent HIV transmission. Female condoms are currently the only widely available method that gives women and adolescent girls greater control over protecting themselves from HIV, other STIs and unintended pregnancy. Modelling indicates that if consistent condom use were to be scaled up in Uganda to 80% of high-risk sexual encounters, it would independently avert about 140 000 new HIV infections during 2014–2020 (approximately 10% of all new HIV infections that would occur during this period). It is necessary to procure 500 million condoms annually (the rate is currently 109 million/year)¹⁶.
- **Antiretroviral therapy-based prevention:** If one adheres to ARVs as prescribed, one can interrupt the replication of the virus to a point where it is not detectable in blood. This condition is known as viral suppression. Individuals who have achieved viral suppression can not transmit HIV in condomless sex, as long as they continue to take their medicine and as long as they have their viral load monitored. Reduction of the amount of HIV circulating in the blood ultimately reduces the amount of HIV in the community, achieving a community-level viral load suppression. This also leads to a reduced risk of HIV acquisition, and hence the prevention dividend of HIV treatment. In Uganda, 40% of people living with HIV are not virally suppressed and so the country is not benefiting fully from treatment as prevention.

¹⁵ Uganda AIDS Commission: The case for more strategic and increased HIV investment for Uganda 2015-2025

¹⁶ Uganda AIDS Commission: The case for more strategic and increased HIV investment for Uganda 2015-2025

TABLE 4: **Prevalence of male circumcision, Uganda, 2016**

| REGION | MEDICALLY CIRCUMCISED | NON-MEDICALLY CIRCUMCISED | UNCIRCUMCISED | UNKNOWN |
|--------------|-----------------------|---------------------------|---------------|------------|
| Central 1 | 28.4 | 18.9 | 45.5 | 7.1 |
| Central 2 | 27.4 | 20.1 | 48.5 | 4 |
| Kampala | 32.2 | 19.1 | 40.8 | 7.8 |
| East Central | 19.8 | 34.3 | 41.5 | 4.4 |
| Mid-Eastern | 14.6 | 54.1 | 30 | 1.4 |
| North-East | 13.7 | 5.6 | 79.8 | 0.8 |
| West Nile | 23.9 | 23.3 | 50.9 | 1.8 |
| Mid-North | 13.1 | 0.6 | 85.7 | 0.6 |
| Mid-West | 23.4 | 25.7 | 48.5 | 2.4 |
| South-West | 20 | 4.9 | 73.6 | 1.5 |
| TOTAL | 21.7 | 20.7 | 54.5 | 3.2 |

Source: 2016 UPHIA

- VMMC:** A cost-effective, one-time intervention, VMMC provides lifelong partial (60%) protection against female-to-male HIV transmission (female circumcision confers no protection to either sex and may be particularly harmful to women). Safe male circumcision (SMC) using new circumcision devices that simplify the process can be used by professionals other than doctors, which will speed up roll-out in the country. Table 4 shows that the majority of men in Uganda are not circumcised, and this partly explains the persistence of HIV in the country. It is necessary to work towards 80% coverage by 2020 (approximately 6.2 million men, with 1 million procedures annually) and to target programs for men 15–29 years in order to improve quality service delivery. Because some cultural forms of male circumcision in Uganda are accompanied by sexual activity to demonstrate manhood, it is important that health care providers advise VMMC clients against unprotected sex. It is also important for implementers to help communities understand the difference between medical and traditional circumcision, as there many variations of traditional circumcision and it may not always be effective For sustainability, there is also need to increase demand, including introducing early infant male circumcision (EIMC).
- eMTCT:** While Uganda is on track on eMTCT, a high burden of HIV persists among adolescent girls and young women and their partners. According to the DHIS2 report of 2017, about 54% of the newly identified HIV-positive cases in PMTCT settings are from mothers below the age of 25 years¹⁷. Half the population of Uganda is under the age of 15 years. The large cohort of young people yet to commence their reproductive careers means that intensive primary prevention of HIV is essential. It also means that there will be substantial demand for services for preventing mother-to-child transmission for the foreseeable future. There is also an urgent need to deliver effective voluntary contraception (to reduce unwanted pregnancies) to both women with or without HIV. In addition there is need to ensure that all women living with HIV who become pregnant do so while on ART and are virally suppressed. Such are the efforts needed to truly eliminate new HIV infections among children in Uganda.

17 Ministry of Health, Uganda: 2017 DHIS2 report

Strategic focus interventions for Fast-Track will include: (a) targeting for elimination of new HIV infections among children by 2020 (<1000 infections/year) by implementing all four prongs; (b) consolidating coverage of Option B+ for pregnant women at 97%, above the NSP target of 95%; (c) increasing early infant diagnosis at two months to 90% in 2020; and (d) enhancing early infant diagnosis linkages with Young Child Clinics and integration of RMNCH (syphilis, cervical screening and family planning). Pediatric viral suppression must be addressed nationally and more efficient testing (higher yield) will be needed to reach pediatric coverage targets.

- **HIV testing and counselling:** Whether or not HIV testing itself reduces behavioural risk, it remains a critical entry point for combination prevention packages that aim to link HIV-positive persons to appropriate clinical and prevention services. Differentiated testing approaches and models are currently promoted nationally in communities and facilities, including partner testing, self-testing and index-linked referrals under the test-and-treat protocol for older and younger men and partners in sero-discordant relationships.

2. Social and behavioural change for HIV prevention

Evidence shows that social and behavioural change communication (SBCC) plays an important role in supporting HIV prevention and care outcomes¹⁸. Programmes should seek to promote safe norms related to reducing HIV transmission and acquisition through the following (see Figures 5 and 6):

- Minimizing sexual risk behaviours or increasing protective practices.
- Improving care seeking and treatment adherence behaviours, especially the uptake of HIV testing services, SMC, adherence to antiretroviral therapy, positive prevention and proper condom use.
- Positive health dignity and prevention.
- Stigma reduction.

This road map prioritizes behaviour change interventions to address issues such as inter-generational sex, gender and masculinity roles, gender-based violence, multiple partnerships, widow inheritance and other harmful social norms. To date, structural HIV prevention approaches have been systematically under-resourced, poorly targeted, undermined by a lack of data and information, and delivered inefficiently. That is why HIV reductions are not well-sustained and disparities remain in the country. This situation must improve so that interventions are systematized and delivered at scale within combination HIV prevention.

18 JAIDS Supplement, 2014: Health Communication in HIV Prevention and Care <http://www.healthcommcapacity.org/jaids-health-communication-plays-hiv-prevention-care>

FIGURE 5: **Social and behavioral elements for HIV prevention**

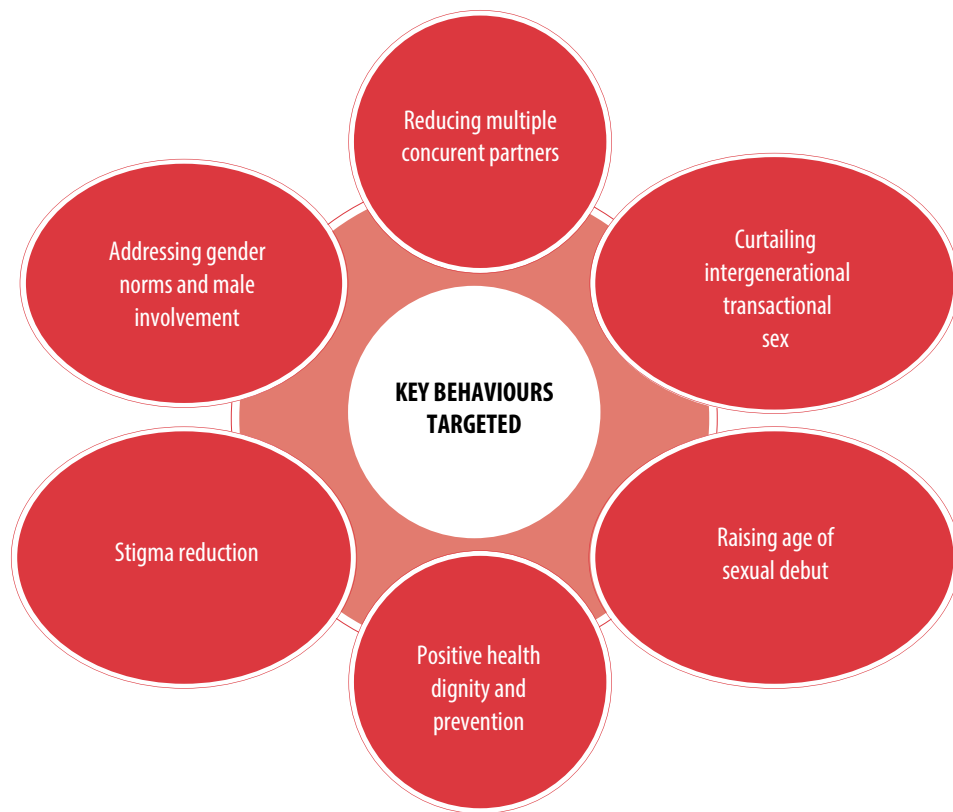
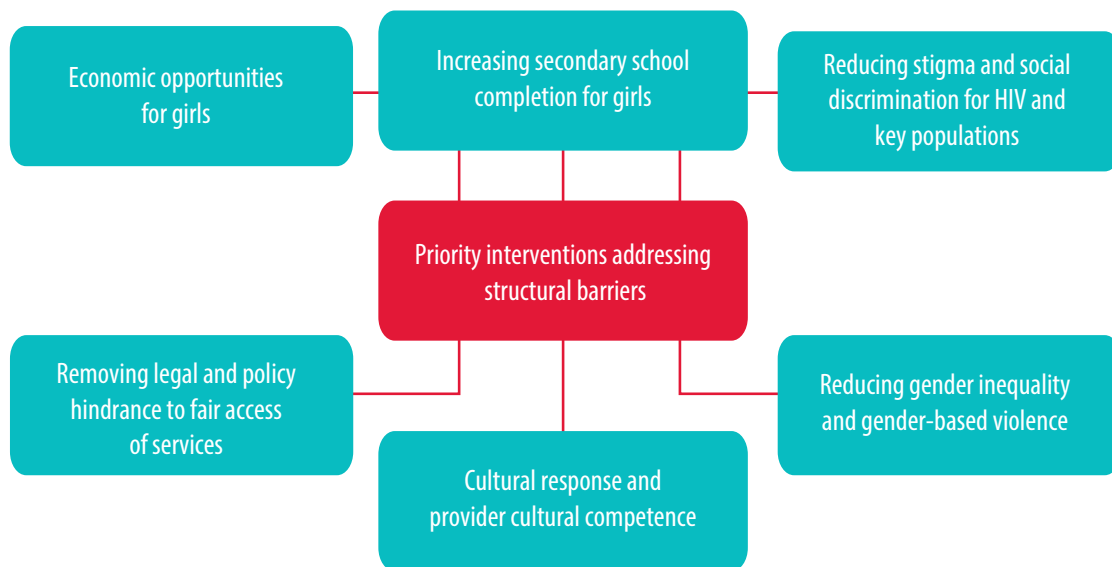


FIGURE 6: **Priority interventions for priority structural barriers**



STRATEGIC SHIFT 2

FROM CENTRALIZED PROGRAMMING TO DECENTRALIZED RESPONSES GROUNDED ON THE LOCAL EPIDEMIC

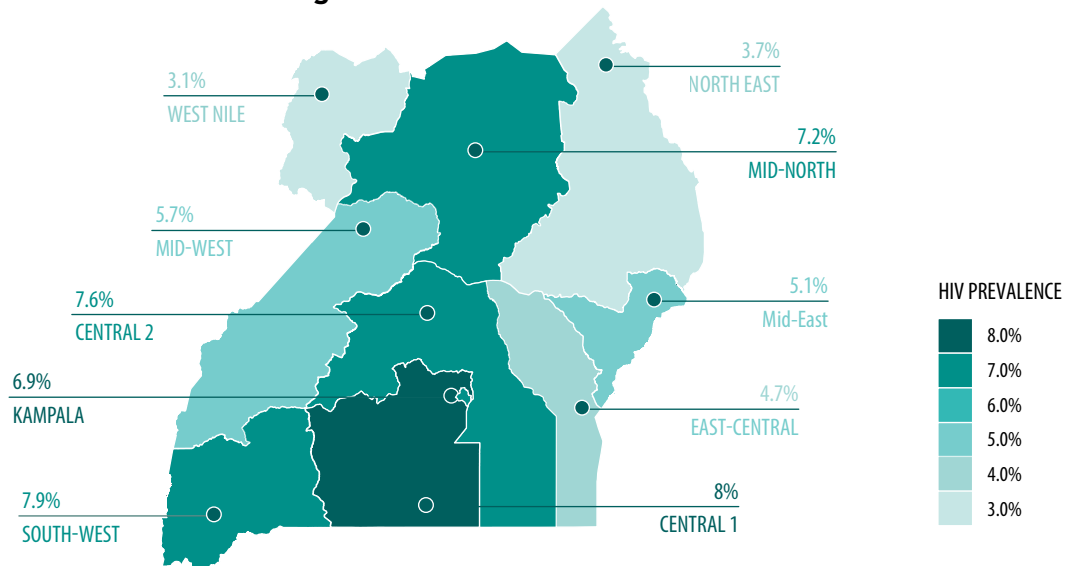
One of the major strategic shifts in this road map is prioritizing attention to geographic locations and population groups that contribute disproportionately to the number of new infections. Identifying where infections are coming from will help close the tap and bring Uganda closer to epidemic control while also strengthening HIV integration in local government programming for sustainable impacts.

Supporting local governments to plan, mainstream and effectively target locations and populations is a key element of this road map. Data exist at national and decentralized levels on geographical prevalence and disease burden, specific population groups and highest impact sites, and this can be used to scale up evidence-informed intervention packages.

PRIORITY ACTION 1: UTILIZING DATA AND LOCAL EPIDEMIOLOGY TO TARGET GEOGRAPHICAL PREVALENCE AND DISEASE BURDEN IN LOCAL GOVERNMENTS

According to UPHIA 2016¹⁹, HIV is higher among residents of urban areas (7.1%) than those in rural areas (5.5%). Geographically, it is highest in Central 1 (8.0%), South-West (7.9%), Central 2 (7.6%) and Mid-North (7.2%) and lowest in West Nile (3.1%) and North-East (3.7%; See Figure 7). This road map prioritizes national programmatic scale-up based on geographical prevalence and disease burden where high prevalence/high burden districts will be linked to the Fast-Track Cities Initiative. As coverage rises and the epidemic profile changes, new groups will be identified based on monitoring data.

FIGURE 7: HIV Prevalence among adults 15-64



Moving away from a national-wide approach to geographical focus will enable more strategic and targeted interventions. Data can identify which locations are contributing majority of new cases, and

¹⁹ Ministry of Health: Uganda The Uganda Population-Based HIV Impact Assessment (UPHIA), 2016; Summary Sheet, Preliminary Findings, August 2017

enable more efficient implementation of combination prevention interventions. Awareness of which indicators to collect is essential to optimize time and money. Supporting prevention programs to utilize their local epidemiology and to strengthen data collection and management will enable timely decision making and impact assessment, and will improve the ability to monitor scale and quality.

PRIORITY ACTION 2: FOCUSING ON SPECIFIC POPULATIONS AND HIGH-RISK AGE GROUPS MISSED IN PROGRAMMING, GETTING THEM ON TREATMENT AND RETAINING THEM IN CARE

Utilizing national and district evidence-informed data, based on the most informative and triangulated indicator, the road map strategies will include the following groups:

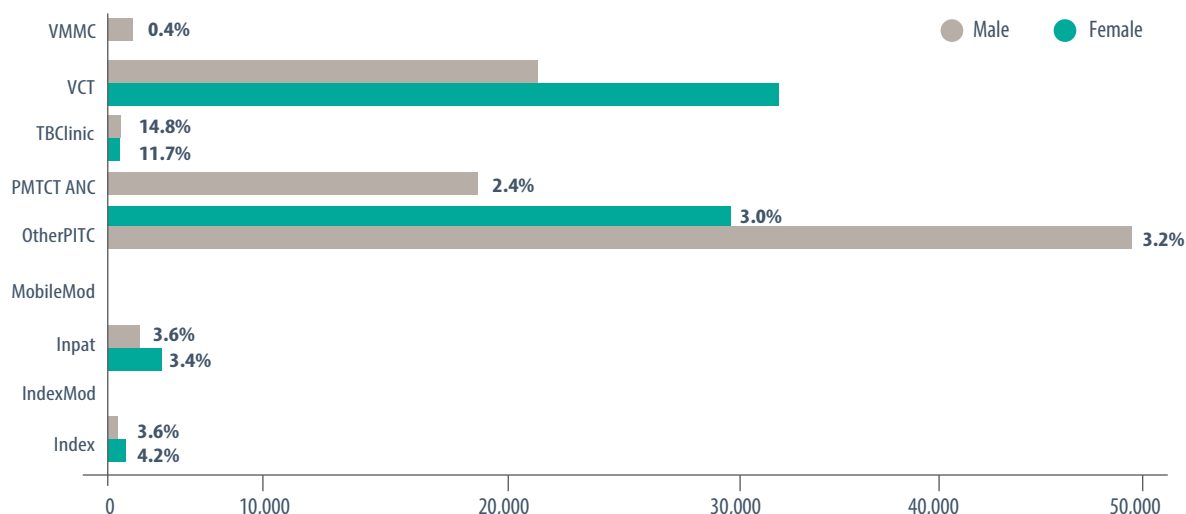
- Men and women by age group, in order to determine the programmatic response.
- Partners and family of those who test positive (index cases)
- HIV-exposed infants and their siblings.
- Adolescent girls and young women.
- Orphans and other children at high risk of HIV including those in out patient, in-patient, TB clinics, and in clinics.
- Key populations, including sexual minorities.

Their inclusion should ensure that these people are prioritized for resource allocation and the introduction of new prevention strategies.

PRIORITY ACTION 3: IMPROVE DATA QUALITY, TARGETING AND REPORTING

The Uganda AIDS Commission and Ministry of Health prioritize routine health facility reports, completeness and timeliness. The Ministry of Health is scaling up the OpenMRS system, so that health care facilities can generate routine reports easily. This roadmap is advocating for access to granular data at local government levels to ensure that prevention interventions are informed and appropriately aligned to the geographic locations and populations. It advocates for continuation of scale-up of data quality assessments (DQAs) and electronic medical records (EMRs) nationally and sub-nationally, and to share findings with implementing partners during regular meetings.

FIGURE 8: Current reporting of community testing and index testing

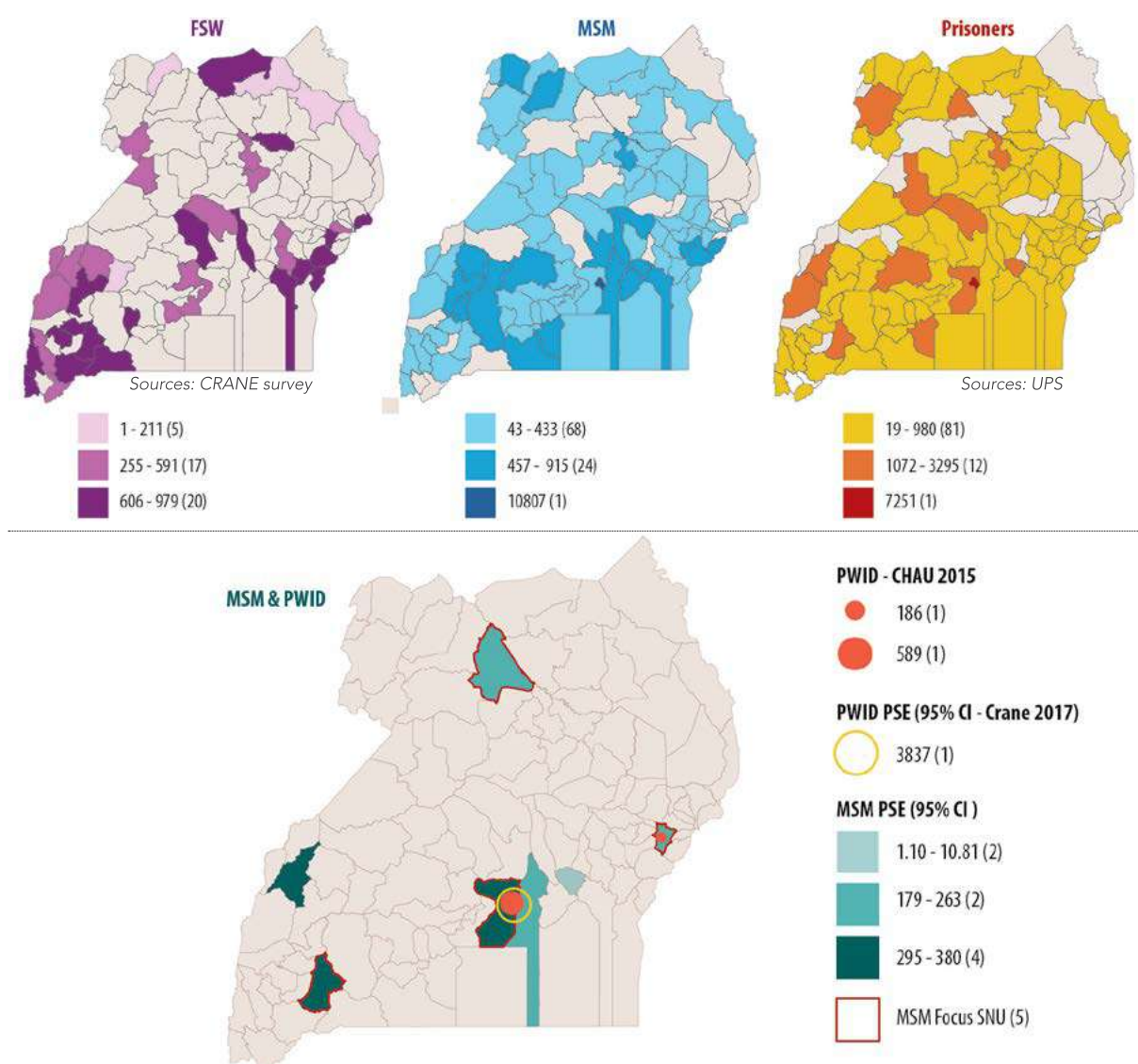


Source: PEPFAR, 2017

PRIORITY ACTION 4: MAPPING OF KEY POPULATIONS GEOGRAPHICALLY AND TARGETING INTERVENTIONS TO THOSE HOTSPOTS, URBAN AUTHORITIES AND DISTRICTS

Key population groups should be core to the HIV prevention programme. Geographical mapping, size estimations and targeted interventions based on mapped hotspots provide an essential intervention under this road map. Local governments need to be supported to map hotspots and tailor packages and service delivery models that are enhanced for key populations through the use of hotspot programming. They should ensure that outreach activities are in places that reach key populations, and that existing services meet the needs of these groups (for instance, in their location and opening hours).

FIGURE 9: **New size estimates could be used to select geographical locations and determine targets**



EXAMPLE

- First time estimates for HIV services intended for people who inject drugs in Kampala.
- A total of 257 prisons nationally are supported by 53 facilities. Ten are antiretroviral therapy- accredited.

OPPORTUNITIES FOR ATTAINING 90–90–90 TARGETS AND SUSTAINING GAINS

A number of opportunities exist at the national level that will be utilized in the acceleration and consolidation progress. Several policies and guidelines have been developed to support Fast-Track, including the *National HIV testing services policy and implementation guidelines 2016*, which includes the following:

- Assisted partner notification.
- HIV self-testing.
- Certification of HIV testing service testers and testing sites.
- VMMC guidelines with device-based VMMC approaches, such as Shang Ring, that are recommended for adoption.
- PrEP guidelines.
- Revised National Consolidated Prevention and Treatment Guidelines that transition from efavirenz-based fixed-dose combination to dolutegravir based combination (TLD) as the preferred first-line regimen, a viral load algorithm for children, pregnant and lactating women, and advanced disease management (including TB).

The Presidential Fast-Track Initiative on Ending HIV and AIDS in Uganda was launched on 6 June 2017, providing avenues for leveraging political leadership and support in the country's drive to achieve epidemic control by 2030. Also, a framework for addressing the issues of adolescent and young women has been developed by the Inter-Ministerial Task Force (chaired by Uganda's First Lady) to guide all sectors on issues underlying the vulnerability to HIV of that group, and a National Sexuality Education Framework has been finalized to provide guidance to various actors when reaching in- and out-of-school children, adolescents and young people. Finally, the National Parenting Guidelines, Gender Priority Action Plan, Gender-based Violence Policy and Action Plan all guide HIV activities.

These policies and guidelines are in addition to various innovations, such as the Presidential Initiative on AIDS Strategy to Youth (PIASCY), which was implemented in 42 districts²⁰, or the United States President's Emergency Plan for AIDS Relief (PEPFAR) DREAMS initiative, which is implemented in 13 districts²¹. These activities can be utilized to scale up integrated social and economic empowerment for adolescents. Implementing the National Demographic Dividend Framework and leveraging the rapid scale-up of antiretroviral therapy and eMTCT through major external funding streams (PEPFAR and The Global Fund to Fight AIDS, Tuberculosis and Malaria) will also yield dividends. There also is a growing national momentum to mainstream the HIV agenda in the development programming of both public and private sector schemes. Guidelines and budgeting compliance plans have been developed and endorsed to support the process.

²⁰ UAC data

²¹ PEPFAR: Uganda Country Operational Plan (COP) 2018 Strategic Direction Summary

STRATEGIC SHIFT 3

TRANSITING FROM INTERVENTION-SPECIFIC PROGRAMMING TO SYSTEMS APPROACHES TO ADDRESS VULNERABILITY, RISKS, EXPOSURE AND IMPACT MITIGATION

While current national intervention-based programming (based on implementation science) has yielded some success, there is a need for a paradigm shift to a systems approach that addresses vulnerability, risks, exposure and impact mitigation. Without sufficient investment and a real willingness to tackle issues such as gender inequality, gender-based violence, length of time in education (and the quality of education) and economic opportunities for young women within gender and traditional roles, HIV prevention interventions will not bring about sustained change. This roadmap calls for special efforts to address the unique vulnerabilities of adolescents (young girls) and people living with HIV. Numerous cultural practices increase HIV risk for young women and adolescent girls; the practices of teenage marriages, norms about condoms and prejudices against key populations are some of the cultural drivers.

PRIORITY ACTION 1: ENHANCING ECONOMIC OPPORTUNITIES FOR GIRLS AND YOUNG WOMEN

Economic opportunities for girls and young women can reduce incidences of engagement in transactional sex for money, favours or gifts, and increase schooling. There is need for expand innovations like cash transfers, social transfers and economic empowerment programs for in- and out-of-school youth.

PRIORITY ACTION 2: INCREASING SECONDARY SCHOOL COMPLETION, SEXUALITY EDUCATION AND LIFE SKILLS FOR GIRLS

Despite current efforts, adolescents, especially girls, continue to drop out of school early, with associated early marriages. There is a need for branded campaigns around keeping girls in schools and sexuality education. Initiatives that improve school attendance are many and will be explored.

PRIORITY ACTION 3: ADDRESSING HIV AWARENESS AMONG YOUNG PEOPLE

Although HIV prevalence among young people (aged 15–24 years) is 3.7%, it is 9.1% among females aged 20–24 years. Uganda registers an estimated 48 new HIV infections per day among young people between the ages of 15 and 24 years, and comprehensive knowledge of HIV—as well as uptake of HIV prevention and treatment services—remains low in this population.

PRIORITY ACTION 4: INTENSIFYING PROGRAMMES FOR RESPONSE TO CROSS-GENERATIONAL SEX

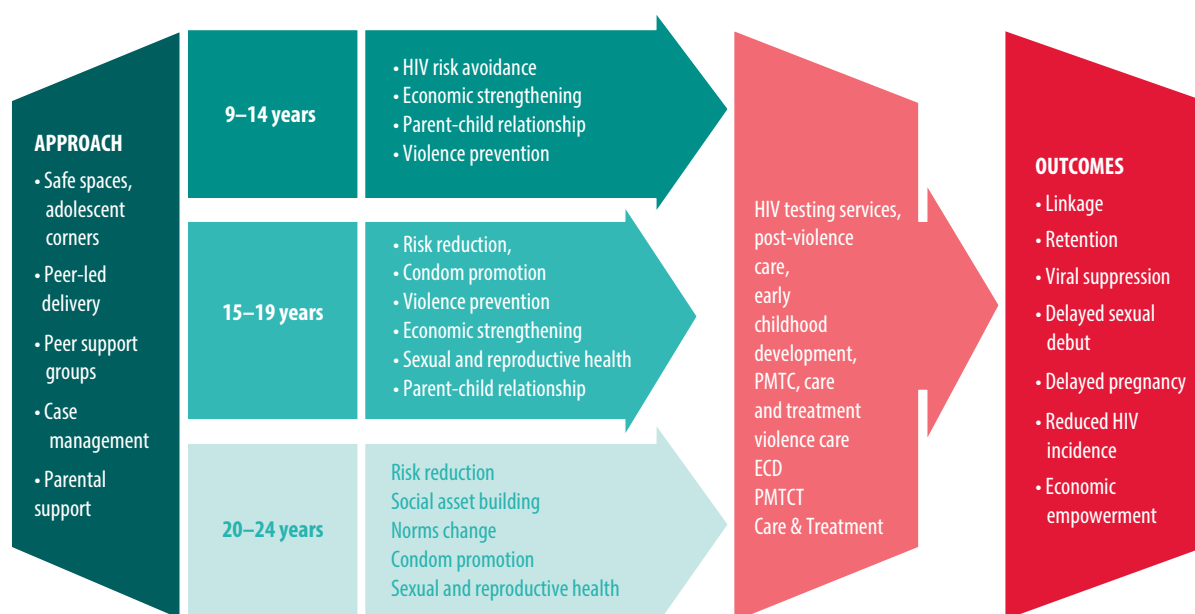
Overall, 19% of young women aged 15–19 years who had sexual intercourse in the past 12 months had sex with a man ten or more years older²². Moreover the highest concentration of HIV by age and sex is among men ages 45-49 years at 14% prevalence. There is thus need to deepen public and cultural awareness of the inappropriateness of relationships where there are large age disparities, due to the potential for abuse and power imbalance. Focus will be on proven programmatic interventions that work with men and women together to identify and address individual and cultural drivers of cross-generational sex that increase the spread of HIV.

²² UAC data

PRIORITY ACTION 5: IMPLEMENT AGE-APPROPRIATE AND AGE-FOCUSED PROGRAMMES FOR ADOLESCENT GIRLS AND YOUNG WOMEN

One of the major strategic shifts for the road map is to scale up comprehensive HIV and SRH programs for adolescents (both in-school and out-of-school) and young people. Adolescent girls and young women continue to be at high risk of HIV infection: evidence shows that a third of new HIV infections in Uganda are occurring among young people aged 15–24 years, especially young women. In 2017, there were 43,000 new HIV infections among adults aged 15 years and older; of these, 30% were among adolescents and young women aged 15–24 years²³.

FIGURE 10: Adolescent girls and young women age-appropriate service packages



PRIORITY ACTION 6: IMPLEMENT CULTURALLY RELEVANT AND SENSITIVE HIV PREVENTION INTERVENTIONS FOR THE GENERAL COMMUNITY

Cultural gender norms and societal expectations of how men and women behave are among the most powerful factors still fuelling HIV transmission in the general population in Uganda. The strong traditional cultures promote unequal gender relations that limit communication about sexual matters and promote SGBV. Most social norms, values, beliefs and practices that are learned, shared and transmitted across generations occur within traditional cultural systems. Factors such as gender roles, sex communication patterns, beliefs relating to personal control, individualism, collectivism and other inherently cultural drivers (such as stigma) must be addressed within those traditional customs, moral values and belief systems.

In relation to HIV/AIDS—where behavioural factors figure so prominently in transmission, prevention and treatment—cultural appropriateness is crucial to providing effective patient education and care. When providers are insensitive to culture, many people remain at risk of not getting the services and support they need; worse yet, they may receive assistance that is more harmful than helpful. For that reason, there is a need to train service providers in cultural sensitivity.

23 UNAIDS AIDS Info, 2018.

PRIORITY ACTION 7: REDUCE STIGMA AND SOCIAL DISCRIMINATION AGAINST PEOPLE LIVING WITH HIV AND KEY POPULATIONS

Stigma and discrimination for people living with HIV and key populations remains a significant structural bottleneck affecting HIV prevention in Uganda. Widespread stigma and discrimination towards people living with HIV can adversely affect their willingness to seek treatment. Recent national stigma index studies conducted among (a) people living with HIV in Karamoja region, (b) adolescents and young adults living with HIV in Busoga region, (c) sex workers living with HIV, and (d) Uganda Wildlife Authority (UWA)²⁴ indicate widespread self-stigma (25.7% in Karamoja, 24% in Busoga region, 38.5% among sex workers and 28.3% in UWA) . Reduction of these practices is an important indicator of the success of programmes aimed at preventing and controlling HIV.

PRIORITY ACTION 8: ADDRESS ALCOHOL ABUSE

Unhealthy alcohol consumption increases the risk of HIV acquisition by two to five times (compared with non-drinkers), especially in communities where incidence is very high. Alcohol consumption is strongly correlated with having multiple sexual partners, sex with non-regular partners and engagement in transactional sex; it is not correlated with consistent condom use. Alcohol is also a key factor for commercial sex workers. Interventions to reduce alcohol consumption should be integrated in prevention activities for populations where both HIV and alcohol consumption are highly prevalent.²⁵

PRIORITY ACTION 9: FIGHT FOR GENDER EQUALITY AND ELIMINATION OF GENDER-BASED VIOLENCE

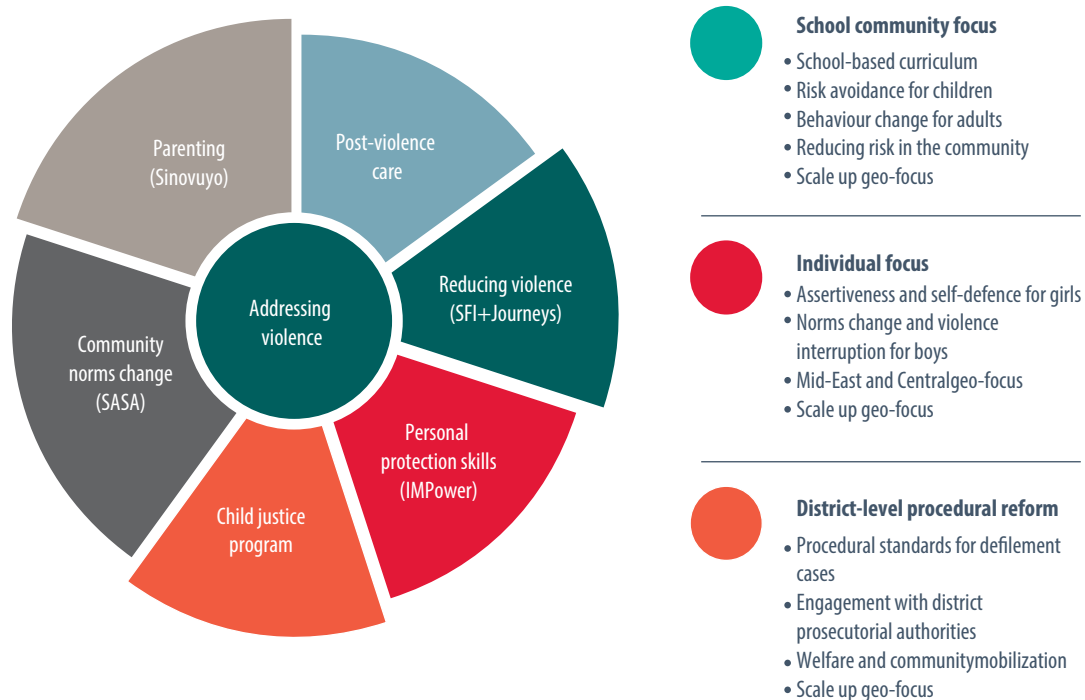
Discrimination against women in Uganda results from traditional practices that explicitly exclude girls and women or that give preferential treatment to boys and men. The overall prevalence of domestic gender-based violence remains unacceptably high, with 22% of ever-married women reporting physical or sexual violence from a spouse in the preceding 12 months²⁶ Figure 12 highlights some of the interventions that should be considered in developing a comprehensive HIV prevention program.

24 UAC data

25 Kiwanuka N, Ssetaala A, Ssekandi I, Nalutaaya A, Kitandwe PK, Ssempiira J et al. Population attributable fraction of incident HIV infections associated with alcohol consumption in fishing communities around Lake Victoria, Uganda. PLOS One. 2017: <https://doi.org/10.1371/journal.pone.0171200>

26 2016 Uganda Demographic and Health Survey

FIGURE 11: **Strengthening the GBV violence prevention response**



PRIORITY ACTION 10: PROMOTE THE REDUCTION OF MULTIPLE CONCURRENT PARTNERSHIPS

In Uganda, HIV risk has been closely related to the number, pattern and change frequency of sexual partnerships. The 2016 Uganda Demographic Health Survey (UDHS) indicates that nearly 30% of all men aged 15–49 years reported having two or more sexual partners in the previous year, compared to 15% of women. This roadmap is recommending a target is to reduce multiple concurrent partnerships to less than 5% by tackling underlying factors that drive the behaviour, and to promote condom use between non-marital and non-cohabiting partners.

PRIORITY ACTION 11: REMOVE LAWS, LEGAL POLICIES AND PRACTICES HINDERING FAIR ACCESS TO SERVICES

Some recent legislation has been deemed to be repressive, and it might encourage stigma and discrimination, affecting uptake of HIV prevention services among people living with HIV and key populations. It is crucial to address the negative legal and policy environment that affects uptake of services among key populations. This includes legal and policy reform to ensure fair access to HIV prevention services for key populations and young people, and to address policy enforcement on SGBV.

PRIORITY ACTION 12: CREATE PROGRAMMATIC SYNERGIES THAT DIRECTLY ADDRESS STRUCTURAL FACTORS

These synergies ensure HIV-sensitive, cross-sectoral programming, especially with social protection, poverty reduction, education, gender and social development, workplace practices and legal reform.

PRIORITY ACTION 13: PROMOTE POSITIVE TRADITIONAL CULTURAL INSTITUTIONS TO ENABLE LONG-TERM IMPACT

Engaging community, cultural, religious and political leaders will build community resilience to infection and challenge stereotypes, norms, values and practices that fuel stigma. If behaviour patterns are to be changed in a lasting way, traditional culture institutions are indispensable: catalysing meaningful and longer-term shifts in social norms and behaviour requires working with traditional cultural leaders to implement culturally grounded interventions that are family-centred and that engage men as agents of positive change.



UNAIDS Executive Director, Michel Sidibé, presenting a plaque to the Omukama of Bunyoro-Kitaara Kingdom in recognition of the King's efforts to end AIDS by 2030 in the kingdom, Hoima District, March 2018



CHAPTER 3

INTEGRATION OF HIV PREVENTION INTO DEVELOPMENT PROGRAMMING FOR SUSTAINABLE UNIVERSAL COVERAGE

While moving towards epidemic control, this road map emphasizes the need to consciously pursue interventions that gradually transition to long-term development programming through mainstreaming, integration, system strengthening and community empowerment. This involves four key strategic actions:

STRATEGIC INTERVENTION 1: INTEGRATION WITHIN LOCAL GOVERNMENT DEVELOPMENT PROGRAMMING

Uganda now generates district-level HIV estimates of people living with HIV, new infections and AIDS-related deaths, linking them to data on treatment and other service provision within maps to identify geographical gaps in service coverage. The country will strengthen the decentralized HIV services delivery in districts to provide differentiated care with strong community engagement: all districts have HIV burden disparities, irrespective of district prevalence.

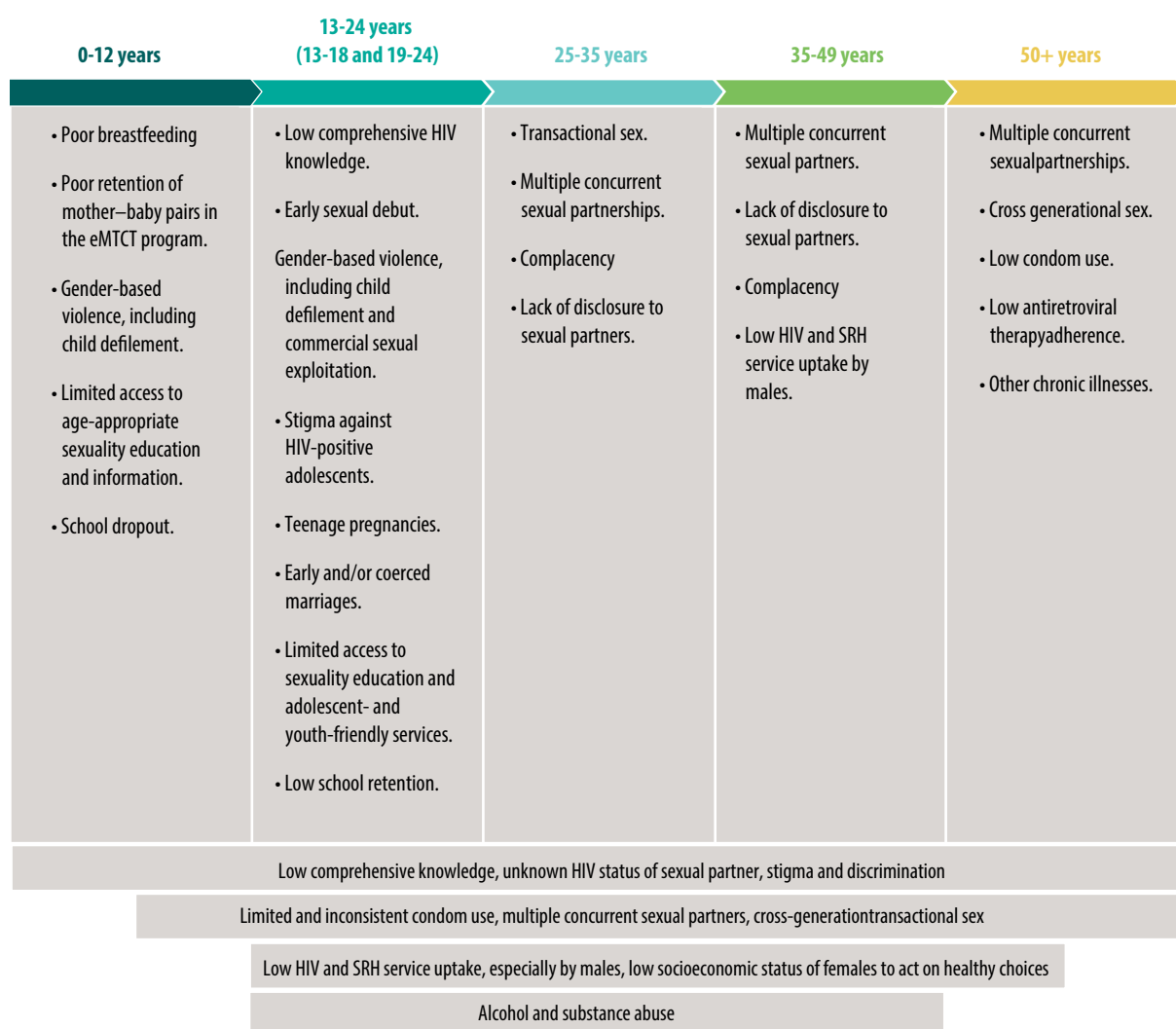
This approach combines local authorities and leaders with public and private players to organize local partnerships that jointly devise actions to address HIV prevention barriers. The use of available HIV incidence, prevalence, behavioural and epidemiological data from health management information systems (HMIS) to target priority areas will enable the district and national response to localize spatial clustering of HIV infections.

STRATEGIC INTERVENTION 2: INTEGRATION ALONG THE LIFE CYCLE

The human life cycle is a journey of change, where a person faces different sets of HIV risks during infancy, childhood, adolescence, adulthood and advanced age. The structural challenges of managing risk, mitigating vulnerability and accessing prevention services and solutions are different at each of these stages of life. This road map uses the life cycle as a lens to analyse and address the complex structural dynamics of the HIV epidemic and the prevention response for each stage. These issues are addressed through broader development programming by various sectors of government to reduce vulnerability and empower individuals to make and act on healthy choices (see Figure 12).

To date, there is limited systematic prioritization of HIV in the broader development programs to inspire coherent accountability. This promotes opportunities to link with other important development programmes working on behaviour and social structural barriers such as education and economic empowerment, in addition to more “vertical” programmes, such as PMTCT, malaria control and immunization programmes.

FIGURE 12: **Summary of interventions: addressing risk factors along the life cycle stage continuum**



STRATEGIC INTERVENTION 3: LEVERAGING LOCAL RESOURCES AND SUSTAINABLE FINANCING

Uganda has developed a national HIV Investment Case that promotes effective, efficient and sustainable investments in the HIV response by focusing on specific locations and populations²⁷. The Government of Uganda is also committed to establishing the AIDS Trust Fund, an innovative option for domestic financing of the AIDS response. The regulations governing the Fund were approved by the Parliament of Uganda in 2018.

There are many opportunities to integrate prevention efforts within existing strategies in order to improve efficiencies. Therefore, as the country moves to epidemic control, there is a need for a paradigm shift to development-oriented programming to sustain the gains, with HIV prevention becoming part of national development planning and budgeting. Efficient allocation and use of existing resources also must be ensured, as must mobilization of additional resources from public and private sectors and zero tolerance for corruption.

STRATEGIC INTERVENTION 4: LEVERAGING OTHER KEY SECTORS FOR THE HIV PREVENTION REVOLUTION

Sustaining gains will also require addressing socioeconomic and structural barriers through engagement of non-health actors by apportioning their roles and responsibility and by properly coordinating and leveraging their contributions through development programming and budgeting (see Table 5).

TABLE 5: **Leveraging other key sectors for the HIV Prevention Road Map**

| SECTORS | FOCUS POPULATIONS | PRIORITY RESPONSIBILITY IN HIV PREVENTION |
|--|---|--|
| Ministry of Works and Transport | Mobile and migrant (bridging populations) ²⁸ | <ul style="list-style-type: none"> Prevention messages at all public transport stops and stages for vehicles, trucks and boda bodas. All stations/truck stops and hotspots have condom dispensers and information on other HIV prevention services. Truck drivers have access to HIV testing services and linkages to other HIV prevention services. Integrate programmes into Ministry development programming and budgeting. |
| Ministry of Agriculture, Animal Industry and Fisheries | Fishing communities ²⁹ | <ul style="list-style-type: none"> HIV prevention messages to reduce high-risk sexual behaviours. Regulations on alcohol consumption and drinking hours by Beach Management Units. Mobile services for HIV testing services and linkages to other HIV prevention services. Integrate programmes into Ministry development programming and budgeting. |

27 Uganda AIDS Commission: The case for more strategic and increased HIV investments for Uganda 2015 to 2025, 2014

28 Transport workers spend prolonged periods of time away from home and may resort to casual sex or develop regular, non-marital sexual relationships while in transit. Truck routes have many roadside truck stops where sex workers create the opportunity for transactional sex with multiple sex partners, often with minimal condom use.

29 These communities include men and women who fish (boat crews), boat owners, fish processors, boat makers, local fishing gear makers or repairers, fishing equipment dealers and managers, and fishmongers and traders

| | | |
|---|--|---|
| Ministry of Defence and Ministry of Internal Affairs | Uniformed services, including those in prison settings, police, Uganda People's Defence Force (UPDF) and other security agencies²⁸ | <ul style="list-style-type: none"> • HIV prevention services to reduce high-risk sexual behaviours while on duty and away from home. • Ensure regular supplies of condoms with correct messaging on their correct and consistent use. • Regulation on alcohol consumption among uniformed personnel. • Integrate programmes into development programming and budgeting of the ministries. |
| Ministry of Justice and Constitutional Affairs | Addressing enabling political environment for HIV prevention and legal and structural reforms²⁹ | <ul style="list-style-type: none"> • Facilitate anti-discrimination campaigns for key populations using a public health approach, gender-based violence campaign, human rights advocacy (free SMS and platforms). • Ensure justice centres promote HIV prevention and reform laws and policies. • Integrate HIV prevention packages into judicial training. • Integrate programmes into Ministry development programming and budgeting. |
| Ministry of Tourism, Wildlife and Antiquities | Tourism and hotels, including bars, lodges and casinos | <ul style="list-style-type: none"> • Integrate HIV prevention messages and a regular supply of free condoms into hotel facilities (reception, bars, toilets and washrooms). • Create safe spaces for sex workers and their clients, men who have sex with men and injecting drug users within establishments. • Link with health facilities for prevention services and outreach services for key populations. • Integrate programmes into Ministry development programming and budgeting. |
| Private sector | Include banks, microfinance institutions, private clinics, industries and markets | <ul style="list-style-type: none"> • HIV prevention messages in the workplace (including HIV workplace policies). • Institute preferential loan packages for key populations. • Fund scholarship projects for keeping young girls in school. • Invest at least 30% to HIV corporate social responsibility. • Budget for HIV prevention campaign. • Contribute to funds/awards for good leadership on HIV prevention, HIV testing services, and linkages and referrals of staff for HIV prevention. • Integrate programmes into private sector programming and budgeting. |
| Ministry of Gender, Labour and Social Development | Adult males and females, out-of-school youth, orphans and children made vulnerable by AIDS, cultural institutions and religious leaders | <ul style="list-style-type: none"> • Address sociocultural issues, including gender-based violence, harmful cultural practices (such as female genital mutilation, early marriages and widow inheritance), gender roles, inequality and issues surrounding masculinity. • Use the platforms of cultural and religious leaders to address men about issues that escalate HIV transmission. • Programming for adolescents, orphans and children made vulnerable by AIDS to reduce vulnerability. • Integrate programmes into social sector development programming and budgeting. |
| Ministry of Education and Sports | Adolescents and young people in school | <ul style="list-style-type: none"> • Age-appropriate messages and sexuality education. • Early child development programmes. • Adolescent-friendly messages and clubs. • Integrate programmes in education sector development programming and budgeting. |

30 Uniformed forces are mobile and face high risks of acquiring or transmitting HIV infection through high-risk sexual behaviour during placements away from home. They operate in hotspots of sex during night security duties in cities and urban centers and may participate in transactional sex.

31 The passing of the Anti-Homosexuality Bill in February 2014 created a short-term that threatened to affect the national response,



CHAPTER 4

OPERATIONALIZING THE ROAD MAP

*The First Lady, Minister of Education and Sports
Hon. Janet Kataha Museveni with school children at Munyonyo*

Using a multisectoral response and political leadership, Uganda had succeeded in reducing HIV prevalence from 18% in the 1990s to 6.2% in 2016. A road map to prevent HIV and end AIDS by 2030 will require a well-coordinated, multisectoral response led by the Government of Uganda, with the participation, engagement and mobilization of all stakeholders including the following:

- People living with HIV.
- The business community.
- Public and private sectors.
- Implementing partners, foundations and agencies.
- Pharmaceutical companies.
- Scientific, medical, social work and public health professionals.
- Faith communities.
- Cultural institutions.
- Multi-sectoral ministries, entities and organs.
- All Ugandans.

Already Uganda has an active multi-sectoral HIV Prevention Technical Working Group that meets frequently at the UAC, and has been steering prevention actions in the country. Uganda is also a member of the Global HIV Prevention Coalition, having been represented at the inaugural meeting by the Minister of Health in October 2017 in Geneva. The minister also attended the first progress review of the Coalition on the sidelines of the World Health Assembly in May 2018, also in Geneva. At present, the HIV Prevention Technical Working Group is in the final stages of organizing the country's HIV Prevention Symposium, which will be on 21st and 22nd November 2018.

In operationalizing the road map, three aspects are critical: stewardship, accountability and tracking progress.

4.1 STEWARDSHIP OF THE ROAD MAP

Uganda's HIV prevention effort continues to be largely based on various HIV prevention interventions rather than the roll-out of a comprehensive, long-term and evidence-informed interventions in a structured combination, as envisaged under the HIV Prevention Strategy. This is largely because of the following:

1. Lack of adequate and long-term predictable financing, so that the limited resources are used to provide antiretroviral treatment.
2. Lack of implementation guidelines and a robust monitoring and evaluation framework to inform the roll-out of the interventions.
3. Weak HIV prevention coordination mechanisms.
4. Complexity of prevention, and misunderstanding of the process of human behaviour change.
5. Shortage of evidence-informed affordable HIV prevention packages that can be implemented at scale.

To attain the HIV prevention targets, the next phase of HIV prevention in Uganda should be based on the effective roll-out of combination HIV prevention. The necessary stewardship actions include the following:

- Reinvigorating high-level political advocacy to engage and raise awareness about HIV prevention.
- Strengthening HIV prevention coordination for the national response and putting government in the lead of combination prevention.
- Strengthening capacity of traditional cultural institutions to lead culturally rooted response.
- Building the capacity of a workforce of prevention personnel at the national, regional and sub-district level in planning, implementation and monitoring of combination HIV prevention.
- Update implementation guidelines for combination HIV prevention, and the M&E Framework that will assess the outcomes.

4.2 ACCOUNTABILITY FRAMEWORKS

Program accountability for results—based upon performance assessment, annual reviews and more—requires three essentials:

1. A robust results framework for prevention so that what constitutes performance can be identified.
2. A robust M&E system, so that data about prevention performance can be collected.
3. Links between these systems and the institutional frameworks so that performance data drive decision-making and financial flows.

These are accountability frameworks within which institutional accountabilities for HIV prevention will be identified.

The gaps identified in prevention are as follows:

- Lack of clarity in hierarchical structures in HIV prevention accountability, which (if present) would ensure that all actors in the response are answerable to the community, district, UAC, Office of the President and Parliament.
- Lack of clarity in how accountability functions in practice, thus complicating accountability. Nowhere in any of the NSPs is there a statement of how the UAC can hold institutions accountable (whether it is “name and shame,” “turn off the tap,” or something else). Similarly, districts lack clear descriptions of institutional accountability, and confusion arises between coordination, authority, control and identifying and attributing accountability at the various levels.
- Collecting reliable data on behavioural and structural interventions remains a challenge.

This road map pursues a three-level accountability framework to ensure that accountability is a more explicit strategic planning element.

1. **Mutual accountability:** While mutual accountability for overall national stakeholder consensus on strategic prioritization and resource allocation is well-developed, the actual mechanisms through which it is realized are still under developed.
2. **Institutional accountability:** Similarly, greater attention is needed regarding what institutional accountability entails and how it is to be achieved.
3. **Program or performance accountability:** The precise mechanisms and processes through which accountability for performance is attributed and implementers are held responsible are still vague. Data collection is important, but the ways in which data are used for decision-making are still weak.

To help drive improvement, performance measurement will include the following:

- Trends over time that show changes in performance.
- Targets that forecast the expected performance and can cascade through performance agreements and national and district plans.
- Benchmarks that allow performance to be compared in relative terms between districts and populations.
- Constantly developing thresholds that define the performance measures .

4.3 TRACKING PROGRESS

National HIV monitoring and evaluation data for HIV prevention come through existing mechanisms in the country. Sectors and districts already have established systems and structures for information, and a parallel system would simply duplicate efforts and cause double reporting. Therefore, monitoring and evaluating the implementation of this Prevention Road Map is best done through effective coordination of existing surveillance systems.

SURVEILLANCE

Progress in HIV reduction will only be measurable with an accurate and detailed tracking of trends in HIV incidence. Currently, national estimates of the HIV burden in Uganda are largely based on HIV prevalence data and mathematical modelling. In accordance with the Three Ones principles, HIV prevention M&E efforts will continue to be based on existing M&E and surveillance systems, procedures and mechanisms. For prevention interventions, the goal is not to provide the maximum number of prevention activities, but rather to prevent the maximum number of infections. Furthermore, the reporting incentives for this road map shift from providing a lot of services for the people who are easiest to reach towards those who need services the most.

Going forward, the UAC will compile all information obtained from sectors and produce annual performance reports of HIV prevention in the country, reflecting performance against targets. This will be mirrored at the district level. The UAC will also identify opportunities for integrated strategic information platforms at the national and subnational levels. UAC will update the current prevention indicators, and a sample of possible measures are provided on Table 6.

TABLE 6: **Illustrative outcome indicators for HIV prevention**

| INDICATOR DEFINITIONS | BASELINE 2016 | TARGETS | |
|--|-------------------|---|--------------------|
| | | 2020 | 2025 |
| 1. New HIV infections among adults 15+ | 57,000 | 14,250 (75% reduction) ³² | > 95% reduction |
| 2. New HIV infections among children | 4,600 | 230 (95% reduction) | Zero |
| 3. New HIV infections among pregnant women | 28,000 | 7,000 | 1% |
| 4. MTCT rate | 4% | 2% | 1% |
| 5. Adolescent girls and young women aged 15–24 years kept in school | 35% ³³ | 65% | 90% |
| 6. Key population contribution to new HIV infections | 21% | 9% | 2.1% |
| 7. Proportion of HIV budget allocated to prevention | 22% | 35% | 50% |
| 8. Proportion of adults 15–49 with stigma and discriminatory tendencies towards people living with HIV | Women: 22% | 17% | 3.4% |
| | Men: 34% | | |
| 9. Reduction in sexual and gender-based violence cases 15–49 | Women: 22% | 10% | 5.5% ³⁴ |

³² UAC NSP 2020 target.

³³ Percentage represents completion of senior four

³⁴ Anticipated 75% reduction from the baseline.

DATA MONITORING AND SOURCES

Targeting HIV/AIDS interventions is prioritized and should be monitored and evaluated so that it is not neglected. The monitoring should include understanding the pattern of the next 1000 infections and identifying which groups are reached by services and which are likely to require targeted support to benefit from the roll-out of new technologies. Further monitoring should provide answers to the following questions:

- Where will the next 1000 people acquiring HIV infection in the country be located?
- Why will the next 1000 people acquire HIV infection in the country?
- How can they be prevented from becoming infected with HIV?

The existing data sources are the following:

- District Health Management Information System (DHIS2), based on facility/outreach reporting systems: patient monitoring data, case reporting data and outreach data.
- Program and sectoral reports.
- Special and routine surveys.
- Financial and health systems data: budgets, financial records, national health accounts (NHA) and NASA.
- Vital registration.
- People living with HIV Stigma Index.
- Community score card.



Hon. Esther Mbayo, Minister for Presidency presiding over the candle light memorial, Namayingo District 2018

ANNEXES

ANNEX 1: CORE TECHNICAL PACKAGE PER DELIVERY PLATFORM FOR HEALTH SECTOR

| | | KEY POPULATIONS | | | | | | | | |
|---------------------|---|--|---|---|---|---|---|--|---|---|
| GENERAL POPULATIONS | | FISHING COMMUNITY | SEX WORKERS | MEN WHO HAVE SEX WITH MEN | TRUCKERS | PEOPLE WHO INJECT DRUGS | UNIFORMED SERVICE PERSONNEL | MIGRANT AND MOBILE POPULATIONS | BODA BODA TAXI MEN | |
| 0-12 YEARS | 13-24 YEARS | >25 YEARS | | | | | | | | |
| Community | HIV testing services, early childhood development | HIV testing services, male and female condoms, VMMC | HIV testing services, condom adherence support | HIV testing services, condoms SMC, STI | Community empowerment, HIV testing services, condoms and lubricants | HIV testing services, SMC, condoms, STI | HIV testing services, harm reduction, condoms | HIV testing services, condoms, SMC, STI | HIV testing services, condoms, SMC | HIV testing services, condoms, SMC |
| Facility | Infant SMC, early infant diagnosis (up to 12 months), HIV testing services (over 12 months) | HIV testing services, antiretroviral therapy, SMC, PEP, adolescent-friendly services, family planning, eMTCT | HIV testing services, SMC, antiretroviral therapy, eMTCT, Option B+ | HIV testing services, SMC, antiretroviral therapy | HIV testing services, PrEP, condoms and lubricants | HIV testing services, SMC, STI, antiretroviral therapy, condoms | HIV testing services, PrEP, harm reduction, antiretroviral therapy, condoms | HIV testing services, SMC, antiretroviral therapy, STI, condom | HIV testing services, SMC, STI, antiretroviral therapy, condoms | HIV testing services, SMC, STI, antiretroviral therapy, condoms |

ANNEX 2: TARGETS SETTING AROUND FIVE HIV PREVENTION PILLARS

| | INDICATOR | BASELINE (2016) | TARGET 2020 | COMMENTS/GUIDANCE |
|--|---|---|---|--|
| Impact | Number of new adult HIV infections (age 15+ years) | 47 000 | 14 100 | Source: UNAIDS Country factsheet 75% reduction from 2010 |
| | Number of new infections among women 15–24 (high-prevalence countries only) | 15 000 | 4500 | Source: UNAIDS Country factsheet High-prevalence countries only |
| Condoms | Number of condoms distributed/sold | 175 891 270 (condom strategy, although 301 415 120 were procured) | 503 500 000 (500 million male condoms and 3.5 million female condoms) | Source: National Condom Strategy 2017–2020 |
| | No of condoms distributed/sold per man age 15–64 years | 14 (condom strategy) | 71 (condom strategy) | Source: National Condom Strategy 2017–2020 |
| VMMC (14 countries only) | Condom use at last sex with non-regular partner | 57.3% males 37.3% females | 90% (condom strategy) | |
| | Percentage of men age 15–29 circumcised | 43% | 80% (NSP target for 15–49 age group) | Sources: UDHS 2016, Jan 2017. Data source for this indicator is the AIDS Indicator Survey (AIS). However, the JAR 2017 showed 43% circumcision for men aged 15–49 |
| | Number of VMCMCs conducted per year | 751 975 | 1 million | Source: PEPFAR APR Report 2017 Waiting for midterm review results |
| | Percentage of annual VMMC target achieved | 74.4% | N/A | Source: PEPFAR APR Report 2017 |
| Key populations (outcome and coverage) | Cumulative number of VMCMCs conducted | 3 222 201 | 4.6 million | Source: UPHIA 2017 |
| | Number of PrEP sites | 16 sites in 10 districts | 73 sites in 28 districts | |
| | Population size: sex workers | 198 376 | | |
| | Sex workers reached twice with programs in last three months | TBD | | This indicator is not monitored. So far, country is reporting for six months |
| | Number of dedicated sites providing services to sex workers | 30 subnational units | 38 subnational units | |
| Percentage of sex workers who used a condom with last client | 69.4% | 90% | | |

| Key populations (outcome and coverage) | INDICATOR | BASELINE (2016) | TARGET 2020 | COMMENTS/GUIDANCE |
|---|---|---------------------------|---------------------|--|
| | Population size: men who have sex with men | 46,679 | | Sources: Crane survey report: population size estimates. Unpublished data. Kampala: MUSPH, 2018; Size estimation of key populations in Uganda. Unpublished data. Kampala: PLACE, 2018. Also specify the subpopulation size for men who have sex with men at high risk. |
| | Men who have sex with men reached twice with programs in last three months | No data | No data | Country doesn't collect such data |
| | Number of dedicated sites providing services to men who have sex with men | 5 subnational units | 8 subnational units | Country targets to reach 8297 MSM with prevention programmes |
| | Percentage of men who have sex with men who used a condom at last anal sex | 39% | 50% (NSP) | Target to be revised in the ongoing midterm review of the NSP |
| | Population size: people who inject drugs | 3837 | | Sources: Crane survey report: population size estimates. Unpublished data. Kampala: MUSPH, 2018; Size estimation of key populations in Uganda. Unpublished data. Kampala: PLACE, 2018. |
| | People who inject drugs reached twice with programs in last three months | 220 | 2,400 | Source: Uganda Harm Reduction Network program report. Only those under the care of the Uganda Harm Reduction Network program |
| | Number of dedicated sites providing services to people who inject drugs | 4 | 16 | Source: Uganda Harm Reduction Network program report. Only those under the care of the Uganda Harm Reduction Network program |
| | Percentage of people who inject drugs who used safe injecting equipment during last injection | 13% | 32% | Source: Uganda Harm Reduction Network program report. Only those under the care of the Uganda Harm Reduction Network program Only if funding is secured to continue/sustain the just concluded Needle and Syringe Programme demonstration in Uganda. |
| | Needles and syringes distributed per person who injects drugs | 48 per quarter per person | 576 | Only those under the care of the Uganda Harm Reduction Network program Country yet to embrace and track PWID Indicators |
| | Percentage of opioid users who receive opioid substitution therapy | 0% | 0% | 0% (Opioid substitution therapy has not yet been rolled out in the country) |

| | INDICATOR | BASELINE (2016) | TARGET 2020 | COMMENTS/GUIDANCE |
|---|---|---|-------------|---|
| Adolescent girls and young women (only countries with high-prevalence) | Number of high-incidence districts/locations | 36 | 9 | Prevalence above 0.3 per 100 person years (high), above 1.0 per 100 person years (very high), above 2.0 per 100 person years (extremely high) |
| | Number of high-incidence districts/locations covered with dedicated program packages | 13 DREAMS districts (supported under PEPFAR COP 17) | 36 | Dedicated programs refer to availability of a standard package including community outreach for young women (and male partners) |
| | Population size: adolescent girls and young women in high-incidence districts/locations | 789,400 | | See above for definitions |
| | Percentage of adolescent girls and young women in high-incidence districts/locations reached in the past 12 months with dedicated program package | 31% | TBD | Source: PEPFAR PROGRAM Reports See above for definitions |
| | Percentage of girls completing lower secondary education | 6.9% | TBD | Source: (UBOS) |
| | Percentage of condom use at last sex with non-regular partner | 22% | 90% | Source: PEPFAR PROGRAM Reports |
| | Total spending on the five pillars (US\$) | 52,329,236 | 78,141,784 | Source: COP 2018 Use last year with available data as baseline |
| | HIV prevention among key populations (US\$) | 9,977,547 | 57,213,835 | |
| | HIV prevention among adolescent girls and young women (US\$) | 961,792 (through DREAMS, this was 15,717,000 in 2016) | TBD | |
| | Condoms (US\$) | 9,000,000 | 27,900,000 | |
| HIV prevention financing | Voluntary medical male circumcision (US\$) | 23,689,473 | TBD | Source: COP2017 |
| | PrEP (US\$) | Only a pilot was done prior to 2016 by The AIDS Support Organization and should be able. By January 18, about 1048 were initiated on PrEP. There currently are 2.1 million people on PrEP pilot with Walter Reed as part of DREAMS funding. In COP 17, the PrEP targets were 11 575 with a budget of US\$ 811 222. COP 18 has a target of 16 841 with a budget of US\$424 | TBD | Sources: COP 2017 and 2018 |
| | Percentage of total HIV spending that is allocated to the (three or five) priority pillars | TBD | TBD | Subject for further work during midterm review and NASA process |
| | | | | |

ANNEX 3: SOCIOCULTURAL/STRUCTURAL PREVENTION PACKAGE ALONG THE LIFE CYCLE (AGE GROUPS)

| ACCOUNTABLE SECTOR | | AGE GROUP | | | | | ADDITIONAL FOR KEY POPULATIONS ³⁵ |
|---|--|---|---|---|---|--|--|
| | | 0–12 YEARS | 13–24 YEARS | 25–35 YEARS | 35–49 YEARS | 50+ YEARS | |
| Ministry of Gender, Labour and Social Development Sociocultural/behavioural enablers | <p>Address traditional beliefs related to illness, cultural practices related to birth, breast-feeding among eMTCT mothers and communities.</p> <p>Intensify campaigns for male involvement, gender roles in antenatal and post-natal care, and parenting.</p> <p>Improve cultural competence of health workers.</p> | <p>End child marriages.</p> <p>Run campaigns to keep adolescent girls in school.</p> <p>Promote campaigns targeting alcohol and drug abuse among young people.</p> <p>Build the capacity of community institutions and networks to address violence against women, girls, men and boys.</p> | <p>Community dialogues on cultural norms and behaviours related to intimate partner violence, fidelity, safe HIV disclosure and risk reduction.</p> <p>Targeted behaviour change interventions.</p> <p>Use the STEPPING STONES innovations.</p> | <p>Community dialogues on cultural norms and behaviours related to intimate partner violence, fidelity, safe HIV disclosure and risk reduction.</p> <p>Intensify campaigns for male involvement in HIV prevention, gender roles through mass media, interpersonal channels, popular male hangouts and football.</p> <p>Use the STEPPING STONES innovations.</p> | <p>Support HIV prevention programs for those 50+ years of age, including reduction in high-risk sexual behaviours, cross-generational sex, low condom use and partner violence.</p> | <p>Support programs for increasing comprehensive HIV knowledge among key populations in Uganda³⁶.</p> <p>Condom promotion using peer-to-peer mechanisms.</p> <p>Anti-stigma and anti-discrimination programs for key populations for the general public and health workers.</p> <p>Combined skills-building activities, peer support and opportunities to discuss stigma and its effects.</p> <p>Opportunities for people living with HIV to speak as a community in challenging stigma and discrimination.</p> | |
| | <p>By-laws against child abuse (e.g., child labour, sexual abuse and other forms of rights violations).</p> <p>Birth and death registration.</p> | <p>Dissemination of the National Framework on Sexuality Education, including related policies and other guidelines³⁷.</p> <p>Enforce child labour laws in communities and workplaces.</p> <p>Develop regulations on teenage pregnancy in schools, and provide mechanisms for retention in school of school age girls who give birth while in school.</p> | <p>Strengthen institutions and sectors to implement laws and policies addressing SGBV and other rights violations among women, people living with HIV and other vulnerable groups.</p> <p>Create awareness of existing laws and institutions that address SGBV among community leaders.</p> | <p>Strengthen institutions and sectors to implement laws and policies addressing SGBV and other rights violations among women, people living with HIV and other vulnerable groups.</p> <p>Create awareness of existing laws and institutions that address SGBV among community leaders.</p> | <p>Health insurance policy for the old age.</p> | <p>Promote social rights and dignity for sex work, drug use and men who have sex with men, and review by-laws that promote stigma.</p> | |
| Ministry of Gender, Labour and Social Development Legal and policy enablers | | | | | | | |

³⁵ Key populations here refers to those highlighted in the National HIV and AIDS Preventions Strategy, 2015/2020 (page 21), including existing, emerging and other vulnerable populations.

³⁶ Priority interventions for addressing social, behavioural, structural and biomedical actions for key populations are highlighted in the UAC 2015/2017 MARPs Priority Action Plan and Multi-sectoral programming frameworks.

³⁷ Examples of these policy documents include the Education Sector HIV Strategic Plan 2017–2022 and the Adolescent Health Policy.

| ACCOUNTABLE SECTOR | | AGE GROUP | | | | | ADDITIONAL FOR KEY POPULATIONS ³⁵ |
|--|---|--|--|--|---------------------------------------|--|--|
| | | 0-12 YEARS | 13-24 YEARS | 25-35 YEARS | 35-49 YEARS | 50+ YEARS | |
| Ministry of Education and Sports (Schools) Ministry of Gender, Labour and Social Development (workplaces) | <p>Promote responsible parenting and early child development programmes and campaigns nationally.</p> <p>Support training programmes for pre-school teachers and community health workers as agents for infant HIV testing.</p> | <p>Formal education system to reach adolescents and young people with correct, timely, age-appropriate and accurate HIV prevention information (36).</p> <p>Utilize the PIASCY programme model of pre-service curriculum review and development of a module on HIV, SRH, TB, malaria, gender-based violence, and stigma reduction for national teacher training colleges and vocational institutions.</p> <p>Training of primary, secondary and high school teachers as agents of communication for adolescent HIV testing.</p> <p>Target prevention and mechanisms for retention of pregnant girls in schools (37).</p> <p>Alcohol and drug use reduction campaigns in learning and community institutions for adolescents and young people (38).</p> | <p>Workplace policies and educational programmes for workers incorporating multiple concurrent partnerships and transactional sex.</p> <p>Expand provision of HIV prevention services at the workplace for the public sector to include gender-based violence, stigma reduction, SRH, HIV, TB and male involvement.</p> <p>Establish and/or build the capacity of existing community-based structures and networks (LCs, police and health units) to support, report and address issues related to gender-based violence.</p> <p>Develop and implement the Stigma Reduction Framework to reduce stigma in workplaces and institutions.</p> <p>Create by-laws regulating the hours of alcohol consumption in communities.</p> | <p>Expand and implement workplace policies and educational programmes for workers, incorporating multiple concurrent partnerships and transactional sex.</p> <p>Expand provision of HIV prevention services at the workplace for the public sector to include gender-based violence, stigma reduction, SRH, HIV, TB and male involvement.</p> <p>Develop and implement the Stigma Reduction Framework to reduce stigma in workplaces and institutions.</p> <p>Create by-laws regulating the hours of alcohol consumption in communities.</p> | <p>Old age benefits and packages.</p> | <p>Establish and/or build the capacity of existing community/hotspot peer mechanisms or structures to support key populations to access HIV prevention services.</p> <p>Conduct public dialogues on HIV-related stigma and discrimination against key populations.</p> | |
| | <p>Socioeconomic support and empowerment for people living with HIV.</p> | <p>Develop life and livelihood skills for out-of-school adolescents and young people 12-24 years.</p> <p>Implement national schemes for preferential loans, income generating activities IGAs for out-of-school adolescents and young women.</p> <p>Develop national policy guidelines for cash transfers and pilot programmes to increase schooling, meet survival needs and prevent adolescent girls from engaging in transactional and age-disparate relationships.</p> | <p>Institute appropriate livelihood and economic empowerment programmes and coordinate existing national socioeconomic empowerment schemes to reach vulnerable women and households using district and CDO community structures.</p> | <p>Institute appropriate livelihood and economic empowerment programmes and coordinate existing national socioeconomic empowerment schemes to reach vulnerable women and households using district and CDO community structures.</p> | <p>Old age benefits and packages.</p> | <p>Cash transfers and IGAs.</p> | |
| Ministry of Gender, Labour and Social Development | <p>Socioeconomic support and empowerment for people living with HIV.</p> | <p>Develop life and livelihood skills for out-of-school adolescents and young people 12-24 years.</p> <p>Implement national schemes for preferential loans, income generating activities IGAs for out-of-school adolescents and young women.</p> <p>Develop national policy guidelines for cash transfers and pilot programmes to increase schooling, meet survival needs and prevent adolescent girls from engaging in transactional and age-disparate relationships.</p> | <p>Institute appropriate livelihood and economic empowerment programmes and coordinate existing national socioeconomic empowerment schemes to reach vulnerable women and households using district and CDO community structures.</p> | <p>Institute appropriate livelihood and economic empowerment programmes and coordinate existing national socioeconomic empowerment schemes to reach vulnerable women and households using district and CDO community structures.</p> | <p>Old age benefits and packages.</p> | <p>Cash transfers and IGAs.</p> | |

| ACCOUNTABLE SECTOR | | AGE GROUP | | | | | ADDITIONAL FOR KEY POPULATIONS ³⁵ |
|--------------------|-----------------------------------|---|--|--|---|--|--|
| | | 0–12 YEARS | 13–24 YEARS | 25–35 YEARS | 35–49 YEARS | 50+ YEARS | |
| Ministry of Health | Health system structural enablers | <p>Strengthen existing community structures to sensitize and mobilize antenatal care mothers to utilize HIV prevention services and conduct regular referrals, follow-ups and service use tracking.</p> <p>Massive engagement with Traditional Complimentary Medical Practitioners (TCMP) in HIV prevention and referrals for antenatal care at the national level.</p> <p>Incentives for mothers to attend antenatal care, increase in supervised deliveries, post-natal care and retention.</p> | <p>Comprehensive and integrated adolescent-friendly SRH services. Health choices campaigns in schools and institutions.</p> <p>Peer models to increase condom use.</p> <p>Expand social marketing of condoms to all urban areas and hot spots, and enhance ability of adolescents and young women to negotiate condom use.</p> <p>Support school mobilization and sensitization for HIV testing services and reinforce key communication messages to increase sexual risk perception among the age group.</p> <p>Strengthen existing community peer structures to sensitize and mobilize out-of-school adolescents and young people for HIV prevention services, referrals, follow-ups and service use tracking.</p> | <p>Develop guidelines for integrating SRH, HIV, TB, gender-based violence and stigma reduction into community-based services, such as agriculture extension work.</p> <p>Expand condom distribution outlets and saturate condom supplies for the general population, focusing on popular hangouts for men (e.g., bars, lodges and sports betting locations).</p> <p>Expand social marketing of condoms to all urban areas and hot spots.</p> <p>“Stay Negative” campaigns to increase male uptake of HIV prevention services.</p> <p>Comprehensive services related to SGBV, and expand provision of services for timely management of such SGBV using the standard package.</p> <p>Strengthen referrals from the health facility to other social and legal services for cases of SGBV.</p> <p>Reduction of alcohol use and high-risk sexual behaviours campaigns—for clients on antiretroviral therapy (38–41).</p> | <p>Develop guidelines for integrating SRH, HIV, TB, gender-based violence and stigma reduction into community-based services, such as agriculture extension work.</p> <p>Expand condom distribution outlets and saturate condom supplies for the general population, focusing on popular hangouts for men (e.g., bars, lodges and sports betting locations).</p> <p>Expand social marketing of condoms to all urban areas and hot spots.</p> <p>“Stay Negative” campaigns to increase male uptake of HIV prevention services.</p> <p>Reduction of alcohol use and high-risk sexual behaviours campaigns—and abstinence campaigns—for clients on antiretroviral therapy (38–41).</p> | <p>Provision of integrated HIV prevention services for old age, including non-communicable diseases.</p> <p>Reduction of alcohol use and high-risk sexual behaviours campaigns—and abstinence campaigns—for clients on antiretroviral therapy (38–41).</p> | <p>HIV testing, antiretroviral therapy and viral load suppression.</p> <p>Expand condom distribution outlets for the key population and special groups using facilities, hotspots and commercial outlets (e.g., lodges, bars and hotels).</p> <p>Expand social marketing of condoms to all urban areas and hot spots.</p> <p>Develop a strategy and implement concerted condom distribution for key populations.</p> <p>Harm reduction strategies for people who use drugs.</p> <p>Outreach or dedicated clinics for mobile key populations in hotspots and hard-to-reach areas.</p> |
| | Health system structural enablers | | | | | | |



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