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

THE REPUBLIC OF UGANDA

NATIONAL HIV&AIDS STRATEGIC PLAN

2011/12 -2014/15

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UGANDA AIDS COMMISSION

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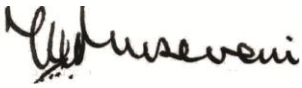
Foreword

It is almost three decades since the first AIDS case was diagnosed in Uganda in 1982. Over the last 30 years, the HIV/AIDS epidemic has had a devastating impact on Uganda. Since 2000, the Country's Response has been guided by two major references, namely, the National Strategic Framework (NSF) for HIV/AIDS (2000-2006) and the National Strategic Plan (2007-2012). We have achieved a lot of success in some aspects of our response, but also experienced challenges in the last five years that might threaten our initial success story. The country has now prepared this Revised NSP that comes at a time when we are challenged to go back on the drawing board to reinvigorate and re-energize our initial efforts and commitment to reverse the epidemic. The revised National Strategic Plan for HIV/AIDS (2011-2015) that is aligned to the National Development Plan (NDP) 2010-2015 will galvanize an expanded, multi-sectoral, national response to the HIV epidemic.

I recognize that resources to fight the epidemic are reducing and particularly from our external partners. In the circumstances of well coordinated, concerted efforts, enhanced accountability and clear focus, our Government shall harness all the available resources to bring the HIV prevalence down, currently stagnating between 6-7%. With more political support and commitment, we shall use the available resources in a frugal manner to reduce new infections, aim at providing treatment to all those eligible, provide support and protection to People Living with HIV (PLHIV), orphans and other vulnerable children (OVC), Persons With Disability (PWD), the elderly groups and communities affected by the epidemic.

The inadequate translation of universal awareness of HIV into behaviour is the biggest challenge in the HIV/AIDS response. Despite awareness of the modes of HIV transmission, HIV infections are being witnessed majorly among the married couples and prevalence rates have generally stagnated during the past five years. We shall therefore aim at stopping new infections, and if we can achieve this, then we shall meaningfully provide care and treatment of all those eligible as well as providing support and protection to the affected.

I therefore wish to take this opportunity to call upon all Ugandans and all stakeholders to use this revised NSP as a point of reference in planning and implementing HIV/AIDS interventions so that together we can realize "a population free of HIV and its effects". HIV remains a priority among the national development agenda and, through the multi-sectoral approach, all government sectors are urged to effectively mainstream and scale-up HIV/AIDS programmes in their respective constituencies. The Office of the Presidency, through the Uganda AIDS Commission, is committed to strengthen the coordination and management of the national response, monitor and track the utilisation of all resources to ensure value addition of HIV funding to national development. I urge all Ugandans; political and civil leaders not to be complacent and reinvigorate our response. We must stop new infections in a co-ordinated manner and care for all those affected so that in the next four years we can witness change.



YOWERI K. MUSEVENI
PRESIDENT OF THE REPUBLIC OF UGANDA

Preface

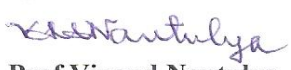
The Government of Uganda through Uganda AIDS Commission and with support from the national HIV/AIDS Partnership revised the National Strategic Plan (2007/08-2011/12) for HIV/AIDS and aligned it to the National Development Plan (NSP). This four-year NSP for HIV/AIDS is a national multi-sector tool for guiding the national response. A participatory and consultative process was used in conducting the Mid-Term Review (MTR) of NSP whose results shaped the development of this Plan. This Plan provides a clear strategic direction for the next four years, sets priorities for the service thematic areas and systems for their delivery.

The Revised NSP outlines the goals, objectives and strategic interventions upon which players in the national HIV response will hinge their HIV programming as they build on the gains attained during the last four years of NSP. With Uganda AIDS Commission as a National Co-ordinating Agency, all stakeholders will be co-ordinated in reaffirming their commitment to achieving the ideals envisaged in this Revised NSP. The NSP values the partnership between Government and the key HIV players towards achieving universal goals of prevention, care and treatment, social support and protection and underscore the need to effectively build the systems for the response in the next four years.

The evidence adduced in the MTR calls upon players to engage in evidence-based planning and programming. The evidence justifies the two-pronged strategies that maintain the ABC approach and accelerating the proven HIV prevention interventions such as safe male circumcision, balancing care, treatment and prevention costs while embracing social support and protection as a cross-cutting matter. All efforts should be geared towards reducing new infections by 30% in the next four years as we aim at realizing *"a population free of HIV and its effects"*.

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

Finally, Uganda Aids Commission (UAC) reiterates to maintain the participatory process through which the NSP was developed while ensuring that this NSP is a national tool and point of reference for national response for the next four years. It is my sincere hope that all stakeholders will align their support and interventions to the priorities of the NSP in order to make our response most effective.



Prof.Vinand Nantulya
Chairman, Uganda AIDS Commission

Acknowledgments

The process of revising this NSP benefitted from many organizations and individuals to whom we owe gratitude. UAC is grateful to all our Development Partners for the support not only provided in undertaking the Mid-Term Review and Revising the NSP, but also extending tremendous support to the national response. The Partnership and the Steering Review Committees provided invaluable leadership and guidance throughout the entire Review and Revision processes for which we are most grateful.

We owe a great debt of gratitude to all the Consultants and their Assistants who carried out the MTR and the Revision of the NSP under the guidance of the Technical Working Groups (TWG). The Consultants were led by Dr. Narathius Asingwire who also was a Theme Consultant for Social Support and Protection. The other Consultants include Mr. Joseph Matovu (Prevention), Prof. Moses Kamya (Care and Treatment), Dr. Romano Larry Adupa (Strengthened Systems), Ms. Sarah Asiimwe (Monitoring and Evaluation), and Mr. Julius Mukobe (Resource Mobilisation and Costing). The TWG members and respective Chairpersons are most appreciated for their guidance and input during the entire process.

UAC acknowledges the significant contribution and technical guidance of the midterm review and revision of the NSP by UAC technical staff. Special gratitude goes to the UAC Secretariat team led by Dr. Grace Murindwa assisted by Ms. Elizabeth Mushabe as Head of the MTR Secretariat. All thematic conveners including Mr. Benson Bagorogoza, Dr. Zepher Karyabakabo, Mr. Denis Busoobozi, Dr. David Tigawalana and Ms. Joyce Kadowe are heartily appreciated for the tireless effort.

At national and district level, UAC wishes to register its sincere gratitude to all the technical and management teams including Chief Administrative Officers (CAOs), and all the District Technical Officers, Civil Society Organization (CSO), agency Coordinators, Directors, Program Officers and other staff) who devotedly participated in district meetings and provided valuable information as well as reports for additional analysis. We wish to acknowledge input of all those individuals and stakeholders in Government and Civil Society at national level including networks of people living with HIV (PLHIV) for their keen involvement in this process.

Dr David Kihumuro Apuuli
DIRECTOR GENERAL

List of Abbreviations and Acronyms

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

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

TSR	Treatment Success Rate (for TB)
TWG	Technical Working Group
UA	Universal Access
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UHSBS	Uganda HIV/AIDS Sero-Behavioral Survey
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UPE	Universal Primary Education
USAID	United States Agency for International Development
USE	Universal Secondary Education
VCT	Voluntary Counselling and Testing
VHTs	Village Health Teams
WHO	World Health Organization
XDR-TB	Extremely Drug Resistant Tuberculosis
YEAH	Young Empowered and Healthy

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Definitions of Key Terms

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

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

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

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

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

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

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

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

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

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

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

Psychosocial Support*:* Refers to all actions and processes that enable PHA, other HIV/AIDS affected persons including elderly, Persons With Disability (PWD), Orphans and Other

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

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

Social Support: Includes a broad range of responses to deal with vulnerabilities at intra-family level (high dependency, intra-household inequality, household breakup, family violence, family break-up).

It also encompasses all efforts against gender discrimination (unequal access to productive assets, access to information, capacity building opportunities). It may also include support to education/literacy and access to information among others.

Executive Summary

Background and Approach

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

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

Situation of HIV/AIDS

Since 1993, Uganda has succeeded in lowering its very high HIV infection rates. Among pregnant women, a key indicator of the epidemic progress, the rates have been more than halved in some areas and dropped by over a third among men seeking treatment for STIs. Subsequently, the annual rate of new HIV infections stabilized, leading to a stable adult HIV prevalence of 6-7% in the past 10 years (Spectrum estimates).

Despite this success, there are serious concerns that overall, HIV incidence increased from 115,775 in 2007/08 to 124,261 during 2009/2010 based on mathematical models ran by MoH, using EPP and Spectrum. Concerns are now being raised about the amount of attention (leadership, funds, and systems) committed to proven prevention and treatment interventions. Drivers of the HIV epidemic include the structural, contextual and social factors, such as poverty, gender inequality, poor access to health care, stigma, discrimination and other human rights violations. Like elsewhere, Uganda's response is expected to utilize the game changing scientific advances, scale-up out interventions to realize universal access target for services. It is within this context that a Revised NSP was formulated to guide response in the next four years—2012-2015.

Linkage with other Policy, Planning and Legislative Frameworks

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

Vision, Mission, Goal, Strategic outcomes, Core Values and Principles Our Vision is "*A population free of HIV and its effects", while the* **overarching Goal** is "t*o achieve universal access targets for HIV&AIDS prevention, care, treatment social support and protection by 2015"*

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

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

Overall Strategic Direction of the National HIV/AIDS Response

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

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

Care and Treatment: To fulfill this, the country's strategic focus is on providing treatment of all eligible, roll out pre-ART care to HCII and HCIII, accredit more health facilities including private health facilities for HAART. We also intend to improve early TB diagnosis, strengthen linkages with prevention through peers and village Health teams (VHTs). Primary attention will be placed on ensuring Early Infant Diagnosis (EID) and capacity of HCIII to offer pediatric care including adolescent friendly services with strong linkages to HCT. The above are possible with recruitment of more staff, introduction of point of care CD4 testing and formulation of guidelines for task shifting, stronger drug resistance tracking, surveillance and case management systems accompanied by palliative care services.

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

Systems Strengthening: During the plan period, the country aims to review existing co-ordination structures at national and decentralized levels for appropriateness and clarity of roles and responsibilities, support integrated HIV/AIDS Plans and also enforce policies, laws and guidelines aimed at improved collaboration, partnerships and networking among implementing partners at all levels. To support universal access, this thematic area shall pay attention to Human Resource and Infrastructure Development mainly to strengthen national capacity for forecasting, logistics management,

procurement and disposal of health goods and services. It also includes streamlining of donor support in procurement systems for drugs and supplies.

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

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

Implementation, Management, Coordination, and Collaboration

The three key elements in the coordination of the national response framework are UAC, the HIV/AIDS Partnership and the Decentralised Response Coordination structures. These structures are aligned with the 'Three Ones' principle. At the highest level of Government is Office of the President. The Minister for the Presidency is responsible for providing policy advice to UAC. The Parliamentary Standing Committee on HIV/AIDS coordinates the HIV/AIDS activities of Parliament, providing a link with UAC. The PC, which includes representation of the various self-coordinating constituencies (SCEs) of HIV/AIDS stakeholders, plays a policy advisory role to the UAC and provides a forum for collective oversight on the management of the NSP. At decentralized level, AIDS Taskforces and Committees coordinate the HIV/AIDS response at various levels of Local Government.

The HIV/AIDS Focal Person provides the secretariat for the committees. The linkages between district and national levels are through the Chief Administrative Officer (CAO).

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

SECTION ONE

INTRODUCTION AND BACKGROUND

1.1 Introduction

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

These estimates point to difficulties in Uganda's national HIV/AIDS response that had initially been very successful in stemming the HIV/AIDS epidemic resulting in a marked decline in HIV prevalence from a national average of 18% in 1992 to 6.2% in 2002. Since then the HIV response has been characterised by challenges which have led to a stagnation of the epidemic.

Coverage of prevention interventions remains low due to inadequacies in the health system and despite expanded access to antiretroviral therapy (ART), a major treatment gap remains. It is estimated that 570,000 PHA are currently eligible for anti-retroviral treatment under the new eligibility Treatment Guidelines (of CD4 count of <350), adopted in 2010, but only about 290,000 (50%) are receiving this treatment according to Uganda AIDS Commission (UAC). One in five new infections is through vertical transmission, creating a completely avoidable epidemic of pediatric HIV. Furthermore, the resources to finance the response are dwindling partly due to the global economic crisis, which calls for intensified efforts to mobilize and harness additional national resources to respond to HIV/AIDS. To this end, the Revised National Strategic Plan (NSP) for HIV/AIDS was deemed necessary not only to guide the national response, but also to act as a resource mobilisation tool.

1.2 Background

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

- To reduce the incidence rate of HIV by 40% by the year 2012
- To improve the quality of life of PHA by mitigating the health effects of HIV/AIDS by 2012

- To mitigate the social, cultural and economic effects of HIV/AIDS at individual, household and community levels
- To build an effective support system that ensures quality, equitable and timely service delivery.

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

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

In June 2011, a Review of the NSP 2007/08-2011/12 for HIV/AIDS activities in Uganda was commissioned by the Uganda Government through the UAC to identify key achievements, challenges, and emerging issues in the management of the national HIV/AIDS response. The Review was intended to offer the country an opportunity to redefine the key priority areas for the national response to the HIV/AIDS epidemic, identify key activities, indicators and targets that Uganda should focus on, during the next four years in tandem with the National Development Plan (NDP) 2010/11-2014/15.

This coupled with the Global Response of three-zeros ***(zero infection, zero death and zero discrimination)***, together with the following specific factors provided the rationale for re-planning in the national response:

- The Revised NSP aligned to the NDP and in view of the NHP and HSSIP was required to continue driving the timely and effective management of the national HIV/AIDS response for the next four years (2011-2015).
- Since the development of NSP 2007/08-2011/12, a number of issues have emerged in the response as well as opportunities in the fight against HIV/AIDS, which necessitated a revision of the NSP to capture these emerging issues and enable the country seize on the existing opportunities.
- Since 2007 when the implementation of the NSP began, Uganda has developed several policies and guidelines that are supportive of the national response. Key policies and guidelines include, among others, the National HIV&AIDS Policy (2011); the Updated National ART Policy Guidelines, the National HIV Prevention Strategy (2011-2015), the National Strategic Programme Plan for Orphans and other Vulnerable Children (NSPPI 2), and National Policy on Mainstreaming HIV/AIDS in Uganda (2008). The Revised NSP was, therefore required not only to help in translation of these national policies and guidelines into action, but also to take advantage of the enabling and conducive policy and planning environment in the response.
- Important new scientific advances in HIV treatment and prevention indicate for the first time the opportunity to end AIDS. These interventions are high impact and cost effective—very appropriate for the least developed countries with generalized epidemics such as Uganda. These developments require revision of the current strategic plan and approach to ensure that Uganda fully operationalizes these evidence based, high impact interventions. Uganda's rising incidence rates indicate

the current approaches are not fully effective, and the NPS provides a critical opportunity to assess, strengthen, and correct the response.

- Uganda has committed herself to the Millennium Declaration and the Millennium Development Goals (MDGs), which are spelt out in the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). Goal six of the MDGs focuses on halting and reversing the trend in the spread of HIV infection by 2015. The Revised NSP was therefore envisaged to keep on guiding the response towards the attainment of this goal.
- The HIV prevalence at the beginning of implementation of the NSP in 2007 was estimated at 6.4% according to Uganda HIV/AIDS Sero-Behavioral Survey (UHSBS) of 2004/05. Recent estimates suggest that the annual number of new HIV infections increased by 11.4% from 115,775 in 2007/08 to 128,980 in 2010/11 (UAC 2011). Among adults, the annual number of new HIV infections rose by 16.4% during this period but there was a 6.2% decline in new infections among children <15 years of age, most likely because of improvements in prevention of mother to child transmission (PMTCT) uptake registered during this period. On the other hand, the number of PHA increased from 1,140,379 in 2007/08 to 1,192,372 in 2009/10. Thus, translating the universal awareness of HIV into behavior change remains a challenge in the response, which this Revised NSP that aims at translating the National Prevention Strategy seeks to address in order to reverse the epidemic.

1.6 Process and Approach for revising the NSP

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

1.6.1 Desk review

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

1.6.2 National, district and community consultations

Consultations with key primary and secondary stakeholders were conducted at national, district and community levels. At the district level, consultations were held with all the technical and management teams in group sessions including Chief Administrative Officers (CAOs), and all the District Technical Officers, Civil Society Organization (CSO), agency coordinators, directors, program officers and other selected staff. Individual in-depth interviews were conducted with key informants from public and private organizations at national and district level. Consultations were also made from Civil Society and networks of PHA.

1.6.3 Technical Working Groups (TWGs)

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

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

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

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

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

1.6.5 The Annual Joint AIDS Review (JAR)

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

SECTION TWO

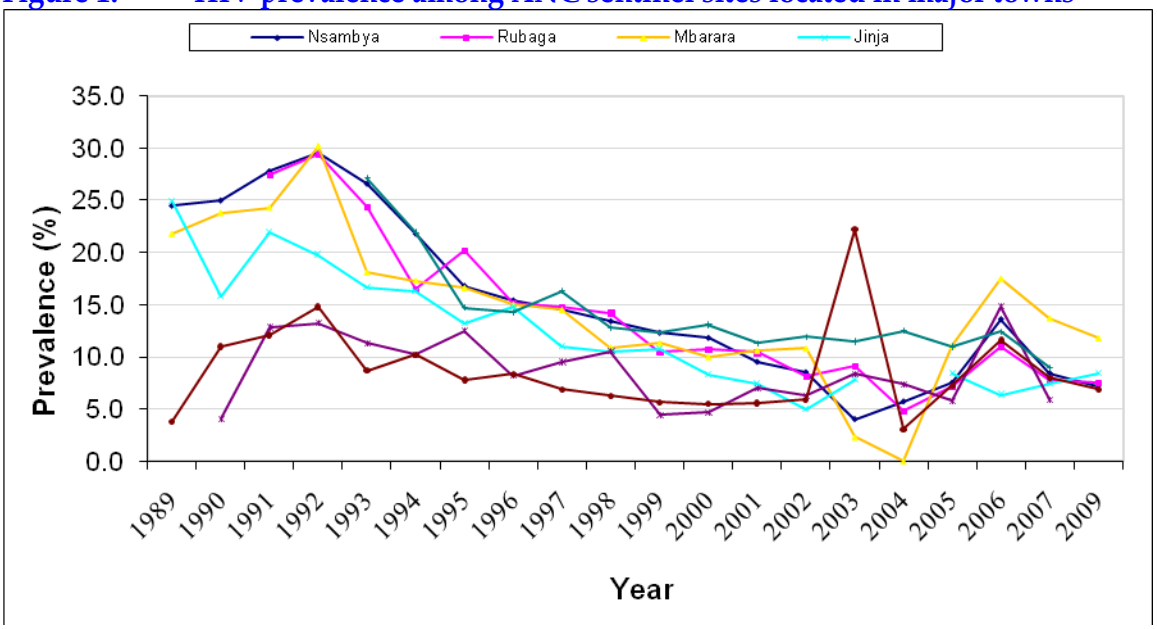
HIV/AIDS SITUATION AND RESPONSE ANALYSIS

2.1 Magnitude of the HIV/AIDS Problem

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

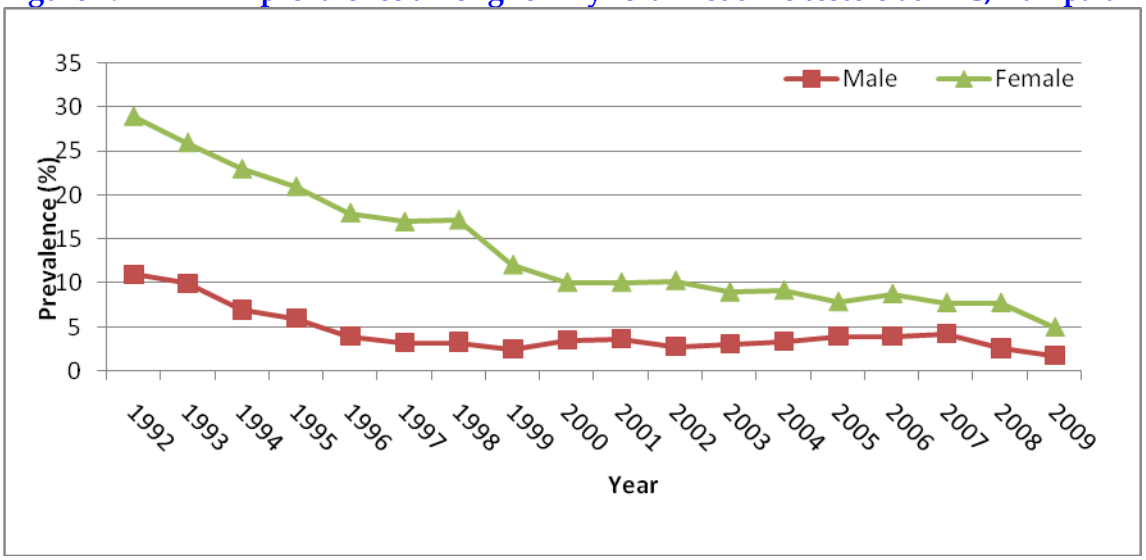
Subsequently, the annual rate of new HIV infections stabilized, leading to a stable adult HIV prevalence of 6-7% in the past 10 years (Spectrum estimates). The unprecedented contraction of the Ugandan epidemic was explained by evidence of reductions in multiple partners, an increasing trend in condom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

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



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

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



Source: MoH 2010; HIV&AIDS Epidemiological Surveillance Report

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

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

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

Source: MoH Estimation and Projections Group, 2010

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

Recent estimates suggest that the annual number of new HIV infections increased by 11.4% from 115,775 in 2007/08 to 128,980 in 2010/11 (UAC 2011). Among adults, the annual number of new HIV infections rose by 16.4% during this period but there was a 6.2% decline in new infections among children <15 years of age, most likely because of improvements in PMTCT uptake registered during this period. On the other hand, the number of PHA as noted earlier increased from 1,140,379 in 2007/08 to 1,192,372 in 2009/10 during this period. National HIV prevalence averaged 6.4% according to the Uganda HIV&AIDS Sero-Behavioral Survey (UHSBS) of 2004/05. However, HIV prevalence among pregnant women remained higher than the national average: in 2009/10, HIV prevalence among pregnant

women attending antenatal clinics (ANC) was 8.4% in urban and 5.7% in rural antenatal surveillance sites. Overall, median HIV prevalence among women attending ANC declined from 7.4% in 2007 to 7.0% in 2009.

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

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

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

Like elsewhere, Uganda's response is expected to utilize the changing scientific advances which show that access to HIV treatment brings a 96% reduction in the risk of HIV transmission through sex. While there are notable concerns about the cost of universal access to treatment, Uganda doing more (with a constrained budget) to scale up of proven interventions will ultimately, pay for itself; there will be a dramatic impact in bringing down rates of incidence (new HIV infections). In the medium and long-term, accelerated scale-up of these proven services are likely to be cost-saving. For example, recent models of accelerated treatment scale up in Kenya—starting with people in pre-ART care with CD4>350, sero-discordant couples at all CD4 cell counts, and pregnant women at all CD4 cell counts—show a potential for a 31% decline in incidence by 2015, as well as significant cost savings compared with current treatment enrollment rates—which are not high enough to halt new infections (see: Blandford, John M. PEPFAR Scientific Advisory Board, 14 Sept 2011, Washington DC). Treating people earlier saves more lives, prevents more infections,

and saves more money.

2.3 Drivers of the HIV epidemic: A synthesis

The MOT and other surveys done in the country have identified drivers of the HIV epidemic to include the structural, contextual and social factors, such as poverty, gender inequality, inequity and poor access to health care, as well as stigma and discrimination plus other human rights violations. These factors shape or constrain individual behaviour such as condom use, uptake of PMTCT or HCT services etc, and therefore act as barriers to the effectiveness of individual-level behavioral interventions. Unfortunately, these factors are complex, intertwined and tend to be diffusely defined. Negative cultural expectations relating to sex and gender power relations are known to enhance HIV transmission. The normalization of HIV/AIDS by some sections of the community also contributes to some form of disengagement from preventive behavior.

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

2.4 Recent Evidence about Selected aspects about HIV/AIDS

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

In early 2011, the HIV Prevention Trials Network (HPTN) 052 trial established that use of antiretroviral therapy (ART) by HIV-positive individuals reduced transmission to their partners by 96%. Importantly, earlier access to HIV treatment was associated with the greatest prevention benefit. There was also an important reduction in extra-pulmonary TB among those who started earlier. Finally, on 13th July 2011, the Partners Pre-Exposure Prophylaxis (PrEP) Study team released its findings which showed that daily oral PrEP taken by HIV-negative partners in HIV sero-discordant heterosexual couples significantly reduced risk of HIV transmission by 62% with tenofovir alone and by 73% with tenofovir/emtricitabine and that the effect was similar in men and women. These findings provide compelling evidence for use of ARVs for HIV prevention, as well as saving lives.

It has also emerged that social support and protection plays a big role in effective national response; it is evident that individuals who have the social support they need are, more likely to adhere and comply with complicated schedules of taking their medicine. Likewise, community involvement in demand creation, testing, follow up and adherence support are critical elements of any effective program. There is overwhelming evidence on the contribution of social support and protection in stimulating acceptance, disclosure and stress management. Association between partner-reported general social support and safer sexual behaviors. Thus providing effective social support and protection is not simply an issue of mitigation of adverse effects of AIDS; it will leverage prevention, care and treatment . The evidence that over 90% of PLHIV on good adherence to care and treatment are less likely to infect their partners is also a compelling reason for scaling up HCT and linking this to psychosocial support and treatment programs; HCT expansion must move hand in hand with attendant care, treatment and support services to maximize benefits at population level.

The above emerging scientific findings need to be urgently operationalized by Uganda and all partners—and together must seize the opportunity to end the epidemic through a transformed response.

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

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

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

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

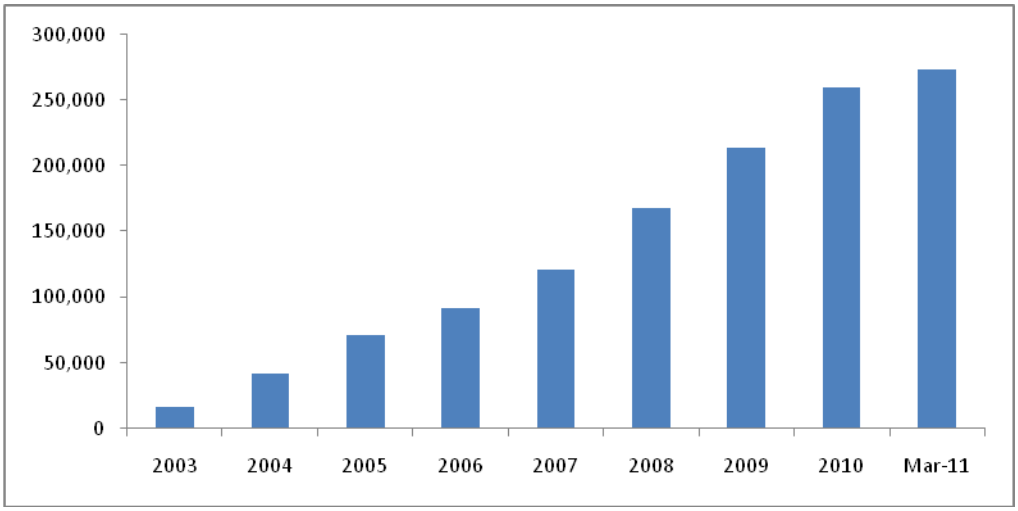
Period	No/% of HIV+ pregnant mothers who received ARVs for PMTCT	% of all expected HIV+ pregnant mothers who received ARVs for PMTCT
Baseline data (2005)	10,289	12%
2007/08	31,990 (81%)	35.3%
2008/09	46,948 (82%)	52%
Mid-term target (2009)	-	50%
2009/10	44,167 (73%)	48.5%

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

Care and Treatment: ART sites increased from 328 in 2008 to 443 in 2011; number of adults on ART increased from 105,000 to 290,000 by 2011; quality of ART improved with over 60%

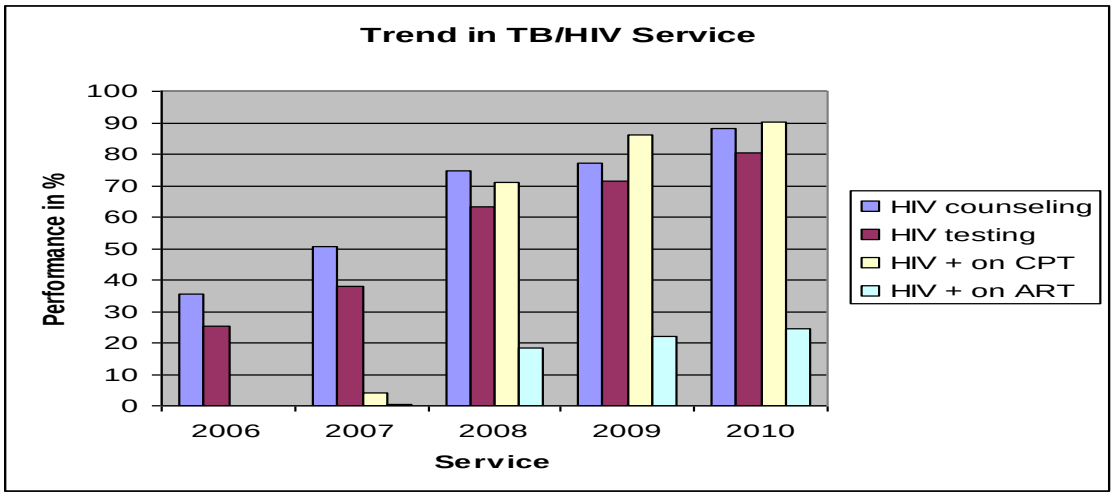
of ART recipients receiving baseline CD4 counts compared to 30% and improvement in the median CD4 T cell count over 5 years period. See Figure 3.

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



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

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



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

Table 3: Scope of Social Support Services

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

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

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

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

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

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

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

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

Overall, 80% of the commitments were honored amounting to US $ 931.8 million; Guidelines for Mainstreaming HIV/AIDS issues into planning and budgeting processes were developed and disseminated. HIV/AIDS mainstreaming recorded an improvement both at

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

sector and local government levels; Better appreciation of the findings from the study on macroeconomic impact of HIV/AIDS in Uganda.

Monitoring and Evaluation: The Performance Measurement Management Plan (PMMP) was prepared along with Operational Guidelines consistent with the NSP; MoH revised the HMIS to include more HIV/AIDS indicators and harmonized reporting tools for PMTCT, ART, TB and HCT; MoH made extensive use of HMIS data/other sources for performance-based requirements of GF Round 7 grant; Ministry of Gender, Labour and Social Development (MoGLSD) designed and launched an OVC Management Information System (OVC MIS); The Country prepared, and disseminated a series of performance reports. These include HIV/AIDS Epidemiological Surveillance Reports, ANC sentinel surveillance, routine data, special studies and UNGASS Reports.

Lot Quality Assurance Sampling (LQAS) methodology was also used in 51 districts to collect population based data (2011) and used in annual planning; Capacity-building in M&E for districts through support for district-level HIV&AIDS strategic plan and for Civil Society Organization through M&E support for CSF grantees was conducted. The AIDS Indicator Survey is currently on going and results will further inform the NPAP development.

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

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

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

Whereas funding in the last plan period was limited for nearly all key interventions (prevention, care and treatment, and social support, systems) except perhaps for free and socially marketed condoms, there were also glaring inequities in levels of support to some of the thematic areas such as systems for national coordination and M&E. This also includes research and documentation, social support and protection (which had scattered responses mostly by CSO actors, mainly FBOs and CBOs). During the implementation of the Revised

NSP more work will be needed to support especially internal mobilization for resources for strengthening coordination and rationalization use of existing sources.

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

2.7 Opportunities and Lessons at MTR

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

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

Similarly, PMTCT is a cornerstone for addressing the burden of the epidemic and therefore strategic focus would be necessary to maximize the benefits in PMTCT; for instance 98% of all pregnant women who accessed ANC, PNC, and delivered from a health facility between July 2009 and June 2010 were tested for HIV (MoH, 2010); 9.9% of infants born to HIV+ mothers under the PMTCT program in 2009 were infected with HIV; these could have been protected from HIV infection with appropriate care and treatment (including ART) offered to mothers at points-of-service. Let us introduce effective treatment for mothers who come into contact with the HC system, while also ensuring access to effective Family Planning methods so that HIV infected individuals who do not desire more children can prevent pregnancy.

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

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

2.8 Policy, Legislative, Planning and Institutional Framework for NSP

2.8.1 International level

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

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

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

ultimately empower rights claimants through ensuring their participation in programmes designed to address gender inequity and HIV&AIDS.

2.8.2 National level

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

Though not explicitly stated about HIV/AIDS, the Constitution of the Republic of Uganda (1995) in chapter 4, Article 20, states that the GoU is committed to the protect and uphold the rights of all its citizens. The importance of `Vision 2025` i.e., Uganda's broad and long-term development proposals over a period of 25 years is rooted in its status as a blueprint for all other planning frameworks.

Its key focus is reflected in the main objectives of the NDP. The NDP is the principal guide to all developmental activities of the central and local government in Uganda. This overarching framework is cognizant of the challenges HIV/AIDS posses on development. It recognizes that addressing constraints caused by HIV/AIDS, is instrumental to achieving Uganda's poverty eradication goals.

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

2.9 Possible Risks Associated with the Revised NSP

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

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

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

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

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

SECTION THREE

STRATEGIC FRAMEWORK

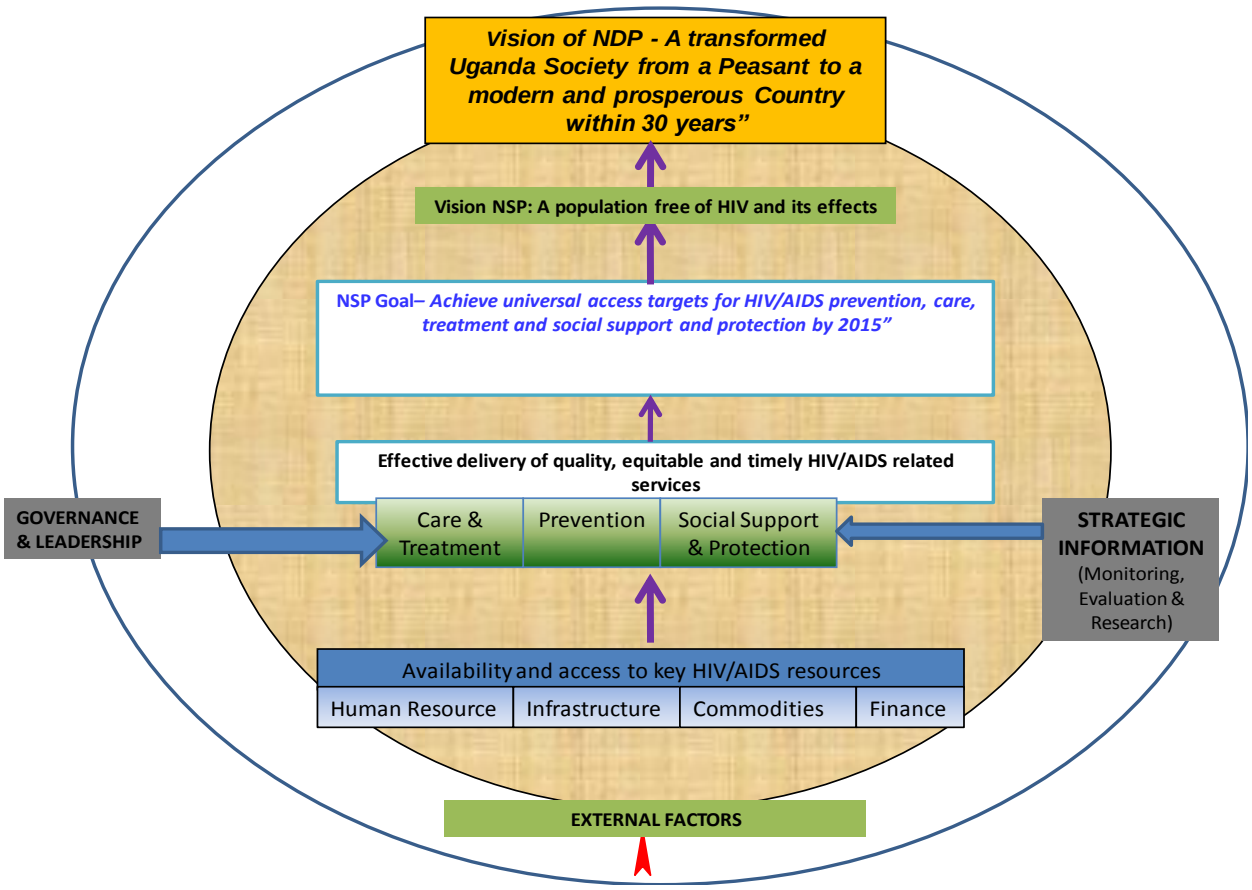
3.1 Introduction

The revised National Strategic Plan for HIV/AIDS (NSP) 2011/12-2014/15 will operationalize the Vision of the national HIV/AIDS response of ***"A Population free of HIV and its effects".*** The NSP therefore articulates the goals; strategic objectives; priority strategic actions/interventions for addressing the critical issues identified in the HIV/AIDS Situation and Response analysis. It further aims at contributing to the attainment of the vision of the national response as articulated in the indictors and targets (See the Result Framework) for assessing the progress of implementation.

3.2 Conceptual Framework for the Revised NSP

This section describes the conceptual framework of the revised NSP. This framework illustrated in Figure 5 links the broader vision, goals and strategic objectives of the revised NSP to the vision of the National Development Plan (NDP) 2010-2014/15).

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



In order for the Revised NSP to achieve its goals and contribute to the goals and vision of the NDP, the following will be required:

(i) The multi-sectoral response to HIV/AIDS must effectively deliver the priority strategic actions that have been identified under the major thematic service areas of prevention, care and treatment, social support and protection that are pertinent to the HIV/AIDS epidemic;

(ii) Adequate resources (human, infrastructure, commodities and financial resources) must be availed to the implementing partners to support and facilitate the delivery of the priority strategic actions;

(iii) Effective governance and leadership must be in place for providing the necessary institutional, legal and policy environment for coordination and stewardship of the response

(iv) Strategic information must guide key decisions in the response at central, decentralized and community levels.

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

3.3 Vision

The Vision of the Revised NSP is *A Population free of HIV and its effects*

3.4 Overarching Goal of the Revised NSP

The overarching goal of the revised NSP is to achieve universal access targets for HIV/AIDS prevention, care, treatment and social support and protection by 2015

3.5 Broad Outcomes expected of the Revised NSP

Each Thematic Area is defined by a broad expected outcome or a goal that the national response aims at realizing at the expiry of this Revised NSP. Table 6 below summarizes the expected outcomes of the revised NSP in each thematic area.

Table 5: Thematic Areas and Broad expected Outcomes of Revised NSP

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

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

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

Table 6: Alignment between the NDP and NSP

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

3.7 Guiding Principles

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

1. Personal responsibility: Every person in Uganda has a responsibility to protect himself/herself and others from HIV infection, to know their HIV status and to seek appropriate care and support;
2. Non-discrimination: That no person shall be discriminated from accessing HIV/AIDS services;
3. Adherence to the multi-sectoral response, and effective partnership at all levels;

4. Meaningful Involvement of People Living with HIV;
5. Human rights based approach to programming
6. Gender sensitive
7. Evidence based planning and implementation
8. Adherence to the "Three Ones Principle" by all stakeholders;
9. Adherence to national and obligations
10. Effective mainstreaming of HIV/AIDS in all sectors and Plans
11. Country ownership and Accountability for results

3.8 Assumptions for Revised NSP

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

SECTION FOUR

STRATEGIC INTERVENTIONS

4.1 Introduction

In order to achieve the specific goals of the Revised NSP and contribute to the attainment of the Vision and Goal of the NDP, a number of strategic objectives and strategic interventions have been formulated. The Strategic Objectives (SO) and interventions for the Revised NSP have been grouped under three Service Thematic Areas, and one Support Thematic Area.

The Service thematic Areas are:

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

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

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

The Service Thematic areas of the national response are related and interlinked. Deliberate steps will therefore be taken to ensure that the delivery of the strategic actions in the different service thematic areas is well coordinated and integrated in order to harness the synergies and linkages among the thematic service areas. Resources for systems strengthening service delivery provide the opportunity which stakeholders can use to foster a coordinated and integrated delivery of thematic service areas strategic actions. The Revised NSP will therefore advocate for efficient and well coordinated use of HIV/AIDS resources to foster increased coordinated and integrated delivery of thematic service areas strategic actions.

4.2 Prevention

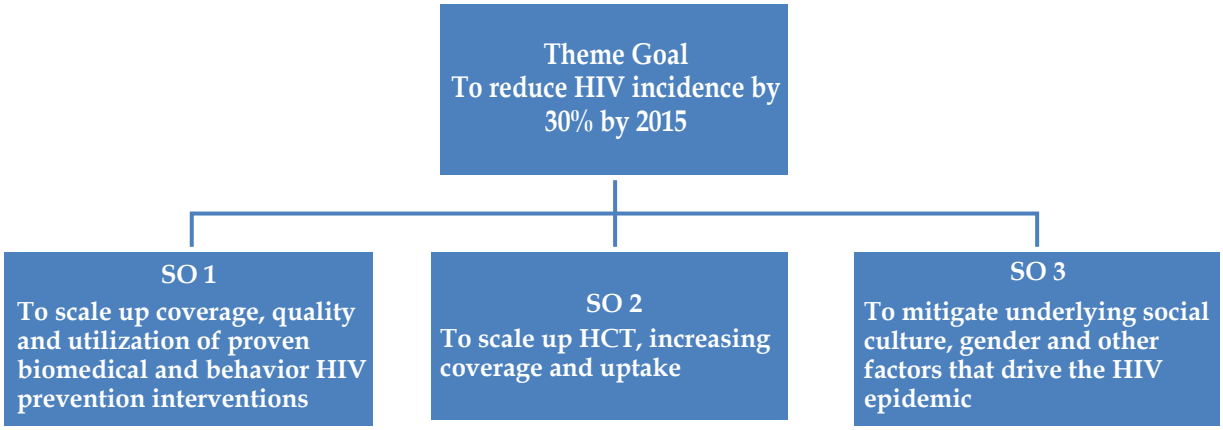
4.2.1 Context and justification

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

The focus of the prevention thematic area under this Revised NSP shall therefore be 4-fold, namely to scale up biomedical interventions to achieve universal access targets, uphold behavioral interventions articulated in the National Prevention Strategy, address socio-cultural and economic drivers of the epidemic and re-invigorate the political leadership at all levels to enlist their commitment to HIV prevention. In scaling up proven evidence-based interventions, the country shall use HCT to attempt virtual elimination of MTCT by adopting Option B+ (lifetime access to HIV treatment for pregnant women regardless of CD4 count), roll out SMC, and use ART as a springboard to prevention by targeting all eligible PLHIV with ART including all children and pregnant women living with HIV, sero-discordant couples and other key populations while maintaining universal blood safety precautions.

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

4.2.2 Specific Goal and strategic objectives (SO) for HIV Prevention



4.2.3 Strategic Objectives and strategic activities for HIV prevention service area

1. ***Objective 1: To scale up coverage, quality and utilization of proven biomedical and behavior HIV prevention interventions***

Strategic Actions

- Scale up PMTCT using Option B+
- Scale up access and uptake for ART services among those in need.
- Scale-up Safe Male Circumcision
- Increase correct and consistent condom use during risky sexual encounters
- Sustain 100% blood transfusion safety and adherence to universal precautions
- Promote medical infection control
- Promote 100% access to Post-Exposure Prophylaxis (PEP)
- Promote safer sexual behavior among key/target population
- Strengthen Behavior change communication programmes to address socio-cultural, gender and other underlying drivers in communication endeavors
- Promote ABC+ for HIV prevention

2. ***Objective 2: To scale up HIV Counseling and Testing (HCT), increasing coverage and uptake***

Strategic Actions

- Scale up HIV Counseling and Testing
- Enhance HCT linkage to care

3. ***Objective 3: To mitigate underlying social, culture, gender and other factors that drive the HIV epidemic***

Strategic Actions

- Promote interventions that reduce stigma and discrimination
- Strengthen the capacity of health and social services to manage SGBV cases
- Build partnerships with cultural/religious leaders to address socio-cultural drivers
- Promote the involvement of men as key partners in HIV prevention intervention
- Reduce vulnerability of OVC

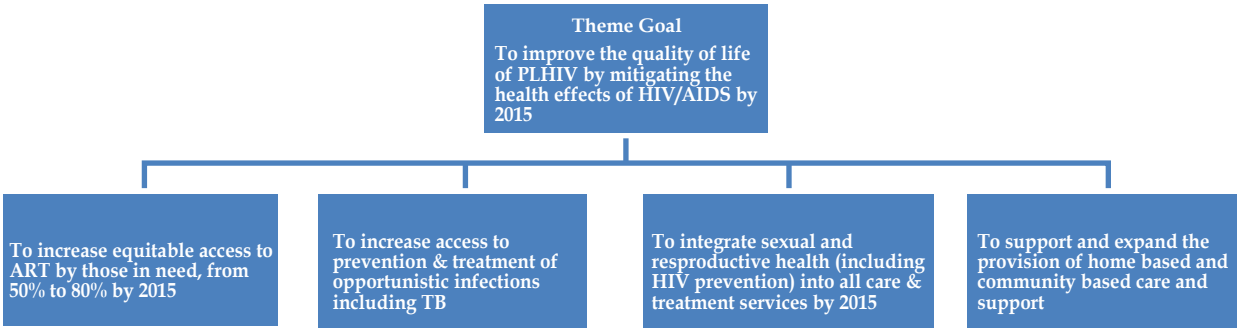
4.3 Care and Treatment

4.3.1 Context and justification

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

Uganda commits to doubling the current pace of treatment scale up this year, and further acceleration thereafter, in order to save lives and dramatically reduce the rate of new infections. This requires all partners uniting to implement a new commitment to support and fund universal access, as a key opportunity to stem the tide of the crisis in Uganda. An urgent priority is new modeling based on new definitions of patients in need of treatment— not only numbers of patients CD4<350, but also pregnant women regardless of CD4 count, serodiscordant couples and other key populations. This modeling will form the basis for a new numeric target and associated costing and budgeting.

4.3.2 Specific Goal and strategic objectives (SO) for Care and Treatment



4.3.3 Strategic Objectives and Strategic Actions for Care and Treatment service area

1. ***Objective 1: To increase equitable access to ART by those in need from 50% to 80% by 2015***

Strategic Actions

- Promote health seeking behavior among males
- Scale up access and uptake for ART services among those in need
- Increase coverage of ART treatment to mothers receiving PMTCT regardless of CD4 counts, and expand earlier initiation of treatment for other populations, such as sero-discordant couples, people in pre-HAART care, etc
- Promote and expand specialized pediatric and adolescent HIV care and treatment
- Strengthen HIV drug resistance surveillance and prevention

2. ***Objective 2: To increase access to prevention and treatment of opportunistic infections including TB***

Strategic Actions

- Increase proportion of infected individuals enrolled and retained in HIV care
- Promote universal access to the basic care package
- Scale up integrated TB-HIV services (site coverage and number of individuals served)
- Support and expand provision of palliative care
- Ensure availability of commodities for opportunistic infection diagnosis, prevention and treatment
- Provide nutritional assessment and therapeutic support to PLHIV

3. ***Objective 3: To integrate sexual and reproductive health (including HIV prevention) into all care and treatment services by 2015***

Strategic Actions

- Integrate Positive Health Dignity and Prevention (PHDP) into HIV care and treatment services
- Integrate family planning counseling and support for adults and adolescents in HIV care
- Build capacity of providers and empower communities to support PLHIV in their SRH choices and provide the entire range of SRH services
- Provide support for HIV sero-discordant couples including disclosure and partner testing and new effective prevention interventions
- Ensure availability of prevention and reproductive health supplies

4. ***Objective 4: To support and expand the provision of home based and community based care and support***

Strategic Actions

- **Fac**ilitate and empower existing community structures, e.g. PHA networks and VHT to provide HIV prevention, treatment, care and support services
- Ensure strong linkages and referral systems between health facilities and community structures

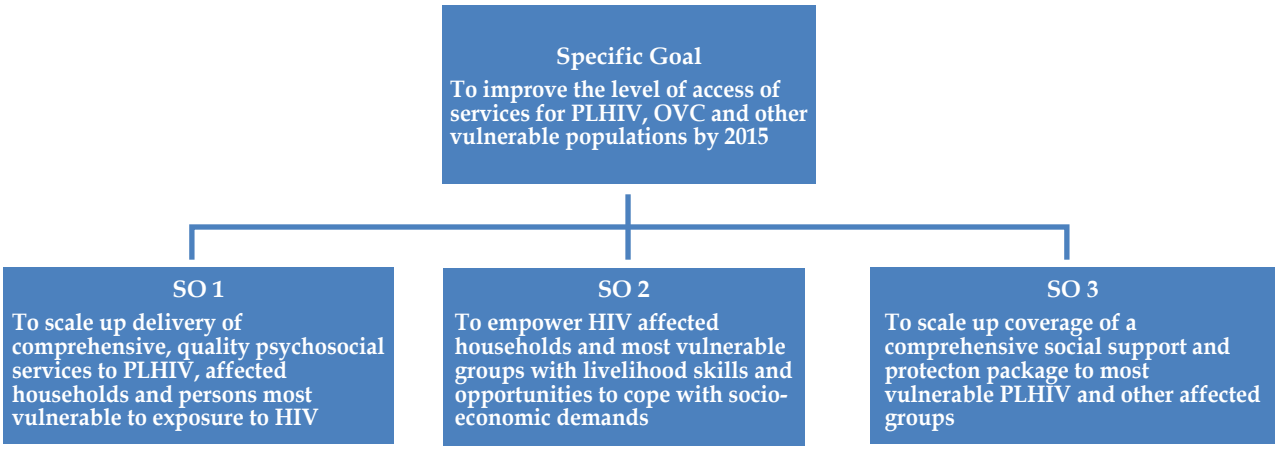
4.4 Social Support and Protection

4.4.1 Context and justification

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

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

4.4.2 Specific Goal and strategic objectives (SO) for Social Support and Protection



4.4.3. Strategic Objectives and Strategic Actions for Social Support and Protection Thematic Area

1. ***Objective 1: To scale up delivery of comprehensive quality psychosocial services to PLHIV, affected households and persons most vulnerable to exposure to HIV***

Strategic Actions

- Scale-up counseling services provisions at health care points and in communities for PLHIV and persons most vulnerable to exposure to HIV
- Provide training of service providers, PLHIV networks and care takers to identify and respond to psychosocial support needs of PLHIV and persons most vulnerable to exposure to HIV
- Develop and deliver a package of direct psychosocial support services for PLHIV, affected households and persons most vulnerable to exposure to HIV

2. ***Objective 2: To empower HIV affected households and most vulnerable groups with livelihood skills and opportunity to cope with socio-economic demands***

Strategic Actions

- Support most vulnerable households of PLHIV and of articulated beneficiary categories to meet immediate needs for proper nutrition and food security
- Support economic activities for households of PLHIV and those most vulnerable to exposure to HIV
- Advocate for affirmative action to support vulnerable PLHIV and articulated categories to benefit from existing initiatives and programs

3 ***Objective 3: To scale up coverage of a comprehensive social support and protection package to most vulnerable PLHIV and other effected groups***

Strategic Actions

- Support enrollment and retention of OVC, PLHIV of school-going age and other identified beneficiary groups.
- Promote informal education, vocational and life skills development for OVC, PLHIV of school-going age and persons most vulnerable to exposure to HIV
- Support provision of appropriate shelter for deserving vulnerable groups
- Mainstream gender and disability into social support program initiatives
- Provide legal and social services for the protection of women and young people against gender based and sexual violence (GBSV) on account of HIV
- Promote rights awareness and sensitization to address cultural norms, practices and attitudes that perpetuate gender based and sexual violence in the context of HIV
- Build capacity to develop and enforce litigation related to HIV through justice enabling structures

4.5 Systems Strengthening

4.5.1 Context and Justification

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

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

As part of systems strengthening, focus shall be placed on using research outcomes to appropriately improve policy and planning, scaling up LQAS to all LGs and prioritizing dissemination of results, and particularly for UAC to provide a clear framework to guide HIV/AIDS research efforts at national and local government level.

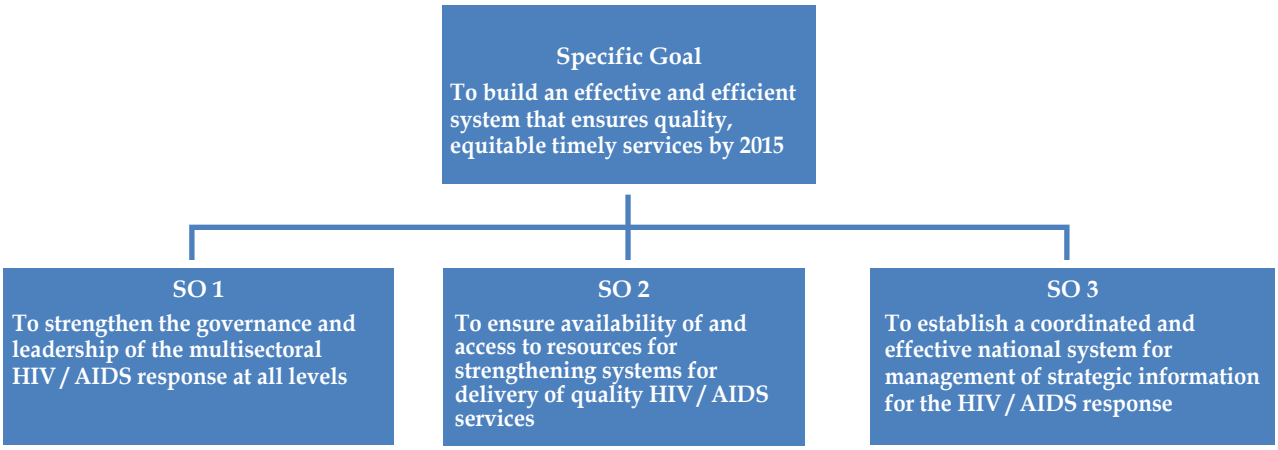
In addition, the country requires a revitalized NADIC, M&E data collection, aggregation, analysis, reporting and utilization systems with well established organizational structures at national, sectoral and district levels for M&E.

Perhaps most important for the Revised NSP is the focus on resource mobilization for the entire national response to HIV/AIDS; strategic attention shall be placed on developing an

integrated and comprehensive national resource mobilization strategy and alignment of donor funds to national planning, budget and financial accountability systems to improve predictability of resources and efficiency.

Equally important shall be the institutionalization of regular resource tracking mechanisms and improving efficiency of HIV/AIDS spending especially on those interventions that have big impact based on evidence.

4.5.2 Specific Goal and Strategic Objectives (SO) for Systems Strengthening



4.5.3 Strategic Objectives and Strategic Actions for Systems for Strengthening Thematic Area

1. ***Objective 1: To strengthen the governance and leadership of the multi-sectoral HIV/AIDS response at all levels***

Strategic Actions

- Mobilize political and technical leadership, management and stewardship of the multi-sectoral response at all levels
- Institute, implement and monitor the necessary legal, policy and operational instruments and guidelines
- Strengthen the capacity of UAC to coordinate the national multi-sectoral HIV/AIDS response
- Strengthen coordination, linkages, networking and collaboration within and across sectors and at national, decentralized and community levels
- Mainstream HIV/AIDS gender, disability and human rights perspectives in all major development programmes in public and non-public sectors
- Align HIV/AIDS related plans of sectors, districts, key stakeholders, development partners and funding mechanisms to the NSP
- Promote social participation, self regulation and accountability in the multi-sectoral response

- Build strong linkages and referral systems between institutionalized facilities and community structures

2. ***Objective 2: To ensure availability and access to resources for strengthening systems for delivery of quality HIV/AIDS services***

Strategic Actions

- Develop the infrastructure for enhancing the multi-sectoral HIV/AIDS services delivery
- Build capacity of human resources for delivery of the multi-sectoral response to the HIV/AIDS epidemic at all levels.
- Develop the capacity for procurement, distribution and disposal of HIV and AIDS related goods and services at all levels
- Expand the capacity of laboratories at different levels for delivery of HIV/AIDS related services
- Mobilize adequate resources for HIV and AIDS services
- Promote efficient allocation and use of HIV and AIDS resources
- Align and harmonize resources to the National HIV/ AIDS plans

3. ***Objective 3: To establish a coordinated and effective national system for management of strategic information for the HIV/AIDS response***

Strategic Actions

- Build partnerships among producers and users of HIV/AIDS information for the national HIV/AIDS response
- Promote ownership of the national HIV/AIDS monitoring and Evaluation framework
- Develop and disseminate national policies, guidelines and plans to all partners at national and sub-national levels
- Build the capacity for collection, analysis, dissemination, and utilization of HIV/AIDS data/information for the national response
- Develop a national HIV/AIDS data base for capture, storage and retrieval of HIV/AIDS data /information shared by all partners in the response for national and global commitment
- Promote and co-ordinate HIV/AIDS research

SECTION FIVE

INSTITUTIONAL AND IMPLEMENTATION ARRANGEMENTS

5.1 Introduction

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

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

5.2 Institutional Arrangements for coordinating HIV/AIDS response

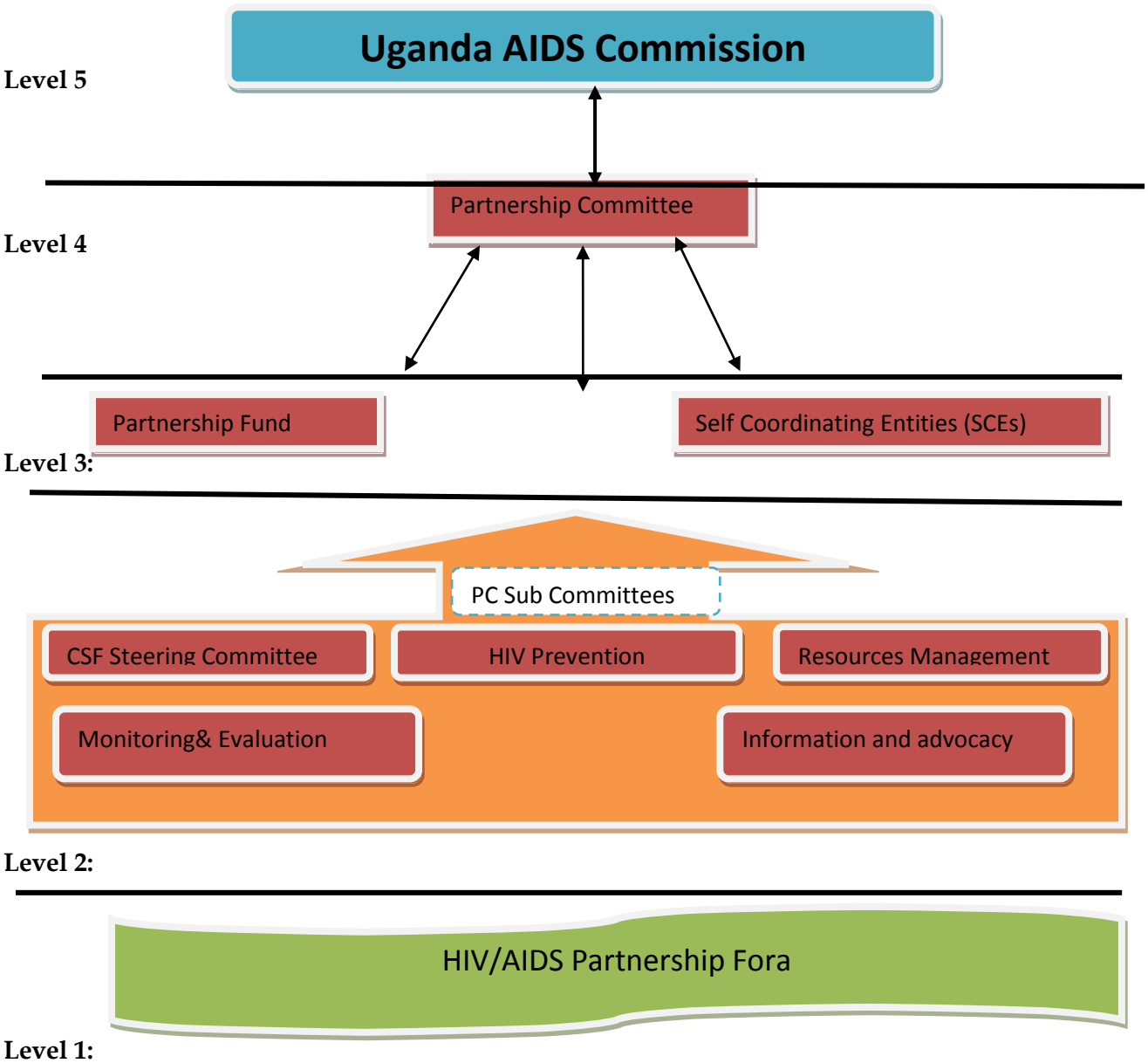
5.2.1 Uganda AIDS Commission

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

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

5.2.2 HIV/AIDS Partnership

UAC established the multisectoral HIV/AIDS Partnership to enhance inter and intra constituency coordination at national and sub national levels. This is achieved through the Partnership Committee (PC), the self coordinating entities (SCEs) and the annual Partnership Forum. The PC is the central feature of the Partnership and works through technical subcommittees. The Partnership Forum on the other hand serves as the general assembly allowing wider participation for all constituencies to review and agree on annual priorities. Coordination and management of the NSP has greatly benefited from the HIV/AIDS Partnership Fund. The illustration below provides a conceptual framework for the national HIV/AIDS Partnership.



The Partnership Forum **(level 1)** serves as a pool from which implementing partners are drawn. It is the General Assembly for the National HIV/AIDS Partnership. The Forum convenes once a year. At **level 2, 3 and 4** is the Self Coordinating entities, Partnership Committee and its subcommittees. These provide technical support to UAC for the overall coordination of the response. Membership to the Partnership Committee includes representatives from 12 self coordinating entities of Parliament, Ministries of Government, Local governments, AIDS Development Partners, Persons living with HIV, Research academia and Science, International NGOs, Local NGOs, Young people, Media Arts and Culture, Faith Based Organizations and Private sector. The Partnership Fund that supports all coordination activities of the SCEs, the subcommittees of PC and the UAC Secretariat. All decisions at level 1-4 are used by the Uganda AIDS Commission Board **(Level 5)** to inform policy and programming.

5.2.3 Government ministries departments and agencies (MDAs)

These shall be responsible for coordinating HIV and AIDS responses within their mandates guided by the revised National Strategic Plan. Deliberate effort shall be made to mainstream HIV/AIDS in all development plans and budgets. Resources will be set aside to address the effect HIV and AIDs has on the respective sector performance. This highlights the central role that Sector Working Groups plays in planning, mobilizing resources, implementation and monitoring sector HIV/AIDS responses.
Most government ministries need to revive their HIV/AIDS control and management committees.

The SCE of line ministries shall provide a unique opportunity for all public sector MDAs to harmonize and foster linkages within and outside their constituency.

5.2.4 Local government level

There are several stakeholders in the district level response comprising local government authorities, Civil Society and Networks of People Living with HIV/AIDS.

5.2.4.1 Local authorities

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

5.2.4.2 Civil Society

In Uganda Civil Society is highly diverse, including faith based organizations, local and international non government organizations, organizations of people living with HIV, media, private sector, academia. Uganda AIDS Commission acknowledges the role played by civil society in reaching communities and implementing programs.

This underscores the need for better coordination, focused resource mobilization and alignment to revised NSP strategic actions.

It also calls for deliberate effort to build capacity of the different players in civil society for delivery of quality HIV and AIDS services.

5.3 Implementation Arrangements for the revised NSP

5.3.1 Roles of stakeholders

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

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

5.3.2 Operationalization of the revised NSP

In order to operationalize the NSP, HIV stakeholders will develop a National Priority Action Plan (NPAP). The NPAP will articulate the priority activities that should be implemented by stakeholders for each of the strategic actions, spelling output results and timeframe for implementation.

Although some activities will be measured on annual basis, their implementation will be multi-year. The NPAP will provide annual targets for annual progress monitoring. The NPAP will also specify both the lead agencies and collaborating partners responsible for the implementation of the specific activities.

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

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

5.3.3 Monitoring and Evaluation of plan Implementation

The national M&E system for the HIV/AIDS response that outlines national results, indicators and targets for the national response will be strengthened to measure the progress towards attainment of the NSP objectives. The M&E matrix (outlined in Annex ....) details the indicators and targets for the national response for national and sector levels over the revised NSP period.

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

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

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

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

SECTION SIX

COSTING AND FINANCIAL FRAMEWORK

6.1 Introduction

Estimating the cost and mobilization of adequate resources for financing the plan is crucial in ensuring effective implementation of the revised National Strategic Plan for HIV/AIDS.

The midterm review report of the NSP 2007/08-11/12 indicates that resources inflow for the HIV/AIDS during the period grew from about US$ 270.17 million in the year 2007/08 to about US $ 360.35 million in the year 2010/11.

Table 1: Financing of the HIV AIDS National response 2007/08-2010/11

Source	**Annual Releases in US $ millions**					
	2007/08	**2008/09**	**2009/10**	**2010/11**	**Totals**	**% age**
GoU	**14**	**28**	**36**	**38**	**116**	**9%**
Bilateral	**243**	**293**	**274**	**304**	**1,114**	**86%**
Multilateral	**13**	**7**	**34**	**18**	**72**	**5%**
Totals	**270**	**328**	**344**	**360**	**1302**	**100%**

Source: Mid-Term review of the HIV/AIDS NSP 2011.

The report however, noted that the overall funding fell short of what would qualify as the mid-term accumulated flows based on the NSP projections. Despite annual increment in Government of Uganda contribution, the target of 15% of the total resources requirement for the national response was not attained. Other funding sources that recorded less than projected commitment included the Global Fund for AIDS, Tuberculosis and Malaria.

Over 90% of the funding for the national response was solicited from development partners with bilateral donors contributing 86% and multilateral 5%. It should be noted however that these proportions do not include out of pockets and other individual households resources. The need to increase GoU funding for the NSP cannot therefore be over emphasized.

Enhancing resource mobilization and improving efficiency in the management of HIV/AIDS funding therefore remains a core strategy of the NSP. Intertwined with this strategy is the need to cost the NSP to be able to estimate the resource requirements for meeting priority interventions of the NSP over the year period.

6.2 Costing of the NSP

6.2.1 Costing Methodology

The estimates for the resource requirement for the National Strategic Plan for HIV/AIDS (2011/12-2014/15) were derived by use of a set of tools, the Spectrum Software and the Resources Needs model.

The Spectrum software a computer program was used to map the HIV epidemic and determine the consequences' of the epidemic. These consequences were derived from previous measures of the diseased prevalence and other sets of program data. Consequences of the epidemic included: number of person living with the disease, number of new infections, numbers of HIV positive pregnant mothers, Males needing circumcision, Orphans and Vulnerable children, Treatments need etc are some of the outputs from this software.

The Resource Needs Model was used to calculate the financial resources needed to implements a set of HIV interventions. The model contains three sub-models:- the Prevention model, Care and Treatments, and the Social support and Protection models.

The **prevention model** calculates the cost of specific prevention interventions, whiles the care **and treatment model**, calculates the cost of care and treatment programs. The **Social Support and protection Model**- calculates the cost of interventions to support orphans and vulnerable children.

The above three models had three main elements (assumptions) in their methodologies. These were the Population target groups :- (largely derived from the Spectrum program), Unit costs and the Coverage or access targets. The final costing for any specific program was a product of Target populations, Unit costs and the Coverage targets.

Target Populations

The population to be served is the priority populations identified by the thematic areas. The target population was then determined by factoring the service coverage of the various interventions.

It is important to note that many of the population are not mutually exclusive as programmatic interventions are not conducted as stand alone. The effects of the overlap of populations and double counting were minimized by discounting unit's costs of interventions for programs targeting mass populations such as the Youth interventions and Community mobilization.

Unit Costs

The unit costs used in the resource estimates were derived from the Cost of service provision data available at service delivery points. Where unit costs were not available from implementing agencies, the costing team applied the Regional unit costs and sub-Sahara Africa costs where the regional costs were missing. In the rare cases, where the Regional costs are not available the international default unit costs were used.

Service Coverage

The service coverage levels were set from the thematic areas as the levels of services coverage that would enable the attainment of the overall NSP goals and objectives. It should be noted that the goals and targets for this plan were ambitious for the period of the plan.

Cost Centers

Several cost centers were identified and applied in the costing of the revised NSP. The cost centers included:

i) System strengthening costs

In addition to the three sub-models of the Resource Needs Model, different system strengthening and other program-level costs were derived as percentages of the total program resource estimates. Table below shows the breakdown of proportion of programme costs attributed to different elements of system strengthening costs.

Table 2: System strengthening costs

Program Areas	%age of program costs
Enabling environment	1%
Prevention of violence against women	1%
Programme Management	3%
Research	2%
Monitoring and evaluation	7%
Strategic Communication	1%
Leadership and Governance	2%
Procurement and stores	3%
Programme-level HR	4%
Training	3%
Laboratory equipment	3%
Infrastructure development	3%

Source: Resource Need model.

ii) Other Cost Centers

The costing of the NSP paid attention to some cost centers that have not been particularly targeted in the previous NSPs. These include:- human resources development, cost investment in health sector in general and HIV subsector in particular.

The decisions were informed by the findings that, the need to scale up HIV interventions has in the past been constrained by inadequate staff leveling at all levels of service delivery and lack of adequate equipment and facilities.

Human resource costs estimates

The 2010 Human resources for all Health report , puts the overall national Health staffing level at 55%[3]. This gives a staffing gap of 45% in the health system. There is therefore urgent need to recruit and retain health workers to sustain the roll out of HIV services. For effective delivery of the revised NSP, the Human resources for health report study 2009 recommended that staffing in health sector should be improved to at least 70%. The model factored in the estimated growth in health sector staffing and apportioned it in the cost of service delivery.

Capital Expenditure in HIV sub sector

These arise mainly in cases of expansion of ART services to new geographical areas. This will necessitate the modifications and renovation of laboratories, physical infrastructures and acquisition of equipment such as the CD4 machines, Point of Care analyzer units etc[4]. Capital costs in the plan will include costs of Laboratory modifications and procurement of ART monitoring equipment.

6.2.2 Resource Requirements for the Revised NSP

Using the Resource Needs Model and the projections from the Spectrum software model, the estimates of the resources required to implement the NSP was calculated. The estimates of the resource envelope needed were based on full funding scenario, the allocations to different expenditure centers and the funding sources and their anticipate contributions.

The priorities for the revised NSP were therefore costed and the total resource requirements estimated. Table 3 shows the total estimates of the resources needed to implement the revised NSP at full funding scenario.

[3] **Human resources for health report 2009**

[4] **MOH GFATM RD 7 Phase 2 ART monitoring forecast requirements, 2012-2016**

Table 3: NSP Resource Estimates based on Full Funding Scenario.

	Millions of US$				
	2011/12	**2012/13**	**2013/14**	**2014/15**	**Totals**
Prevention	***177.97***	***233.51***	***280.22***	***331.68***	***1,023.38***
Priority populations					
Youth focused interventions	11.13	15.02	19.19	23.66	68.99
Female sex workers and clients	0.68	1.03	1.50	2.11	5.32
Workplace	8.72	14.85	21.47	28.61	73.67
Community mobilization	7.18	9.29	11.56	14.00	42.04
Fishing Folks	8.86	11.46	14.17	16.97	51.46
Uniformed Services	3.93	4.61	5.32	6.07	19.92
Long Distance truckers	0.44	0.55	0.71	0.88	2.58
People Living with HIV	8.36	10.76	13.46	16.50	49.07
Persons with Disability	2.04	3.88	5.77	7.73	19.42
Service delivery					
Condom provision	10.07	11.94	13.93	16.04	51.99
STI management	4.12	4.74	5.36	5.98	20.20
HCT	19.59	30.28	41.81	54.25	145.93
Safe Male circumcision	43.18	48.26	41.64	36.42	169.50
PMTCT	44.78	61.01	77.51	94.60	277.90
Mass media	2.51	3.03	3.55	4.08	13.18
Health care					
Blood safety	1.07	1.12	1.16	1.21	4.56
Post-exposure prophylaxis	0.03	0.03	0.04	0.04	0.14
Safe injection	0.15	0.16	0.16	0.16	0.62
Universal precautions	1.11	1.50	1.91	2.36	6.88
Care and treatment services	***212.85***	***264.77***	***330.29***	***411.27***	***1,219.19***
ARV therapy	188.88	239.85	305.43	387.71	1,121.87
Pre ART Care	22.60	23.28	22.92	21.28	90.09
Diagnostic testing	0.64	0.72	0.80	0.89	3.05
Tuberculosis	0.73	0.91	1.13	1.40	4.18
Social Support amd Protection.	**50.95**	**72.54**	**93.78**	**114.78**	332.05
Education	6.17	9.95	13.86	17.92	47.89
Health care support	2.32	2.99	3.64	4.27	13.23
Family/home support	32.55	45.60	58.26	70.61	207.01
Community support	3.26	4.54	5.79	7.01	20.60
Organization costs	6.65	9.46	12.23	14.97	43.31
Subtotal	***441.77***	***570.82***	***704.30***	***857.73***	***2,574.62***
System Strengthening	***143.58***	***185.52***	***228.90***	***278.76***	***836.75***
Enabling environment	4.42	5.71	7.04	8.58	25.75
Prevention of violence against women	2.21	2.85	3.52	4.29	12.87
Programme Management	13.25	17.12	21.13	25.73	77.24
Research	8.84	11.42	14.09	17.15	51.49
Montioring and evaluation	30.92	39.96	49.30	60.04	180.22
Strategic Communication	4.42	5.71	7.04	8.58	25.75
Leadership and Governance	8.84	11.42	14.09	17.15	51.49
Procurement and stores	13.25	17.12	21.13	25.73	77.24
Programme-level HR	17.67	22.83	28.17	34.31	102.98
Training	13.25	17.12	21.13	25.73	77.24
Laboratory equipment	13.25	17.12	21.13	25.73	77.24
Infrastructural developments	13.25	17.12	21.13	25.73	77.24
Total Millions of USD	**585.35**	**756.33**	**933.20**	**1,136.50**	**3,411.37**

Source: Resource Needs Model

The costing for the NSP was therefore based on the more ambitious "full funding scenario". This scenario aims at attaining universal access for the NSP interventions and therefore sets

ambitious targets. The estimates are needs-driven and aim at reducing the number of new infections by 30% and effectively managing the epidemic.

Based on the resource requirements using the "full funding scenario", the total resource envelope is estimated at USD 3,411.37 million for the four year period. The cost will rise from USD 585.35 million in 2011/12 to USD 1,136.50 million in the final year of the plan. The resources were distributed to the thematic areas as followings: Prevention 30%, Care and treatment 35%, Social Support 10% and system strengthening 25%. The estimated resource requirement over the NSP period by thematic areas and key interventions per annum for the full funding scenario is presented in table 4 below.

Costing of the revised NSP also considered alternative funding scenarios based on the desired level of scale up of the priority interventions. The two other alternative funding scenarios included the "Constant funding coverage" and the "medium funding" scenario.

The Constant funding coverage assumed maintaining the same level of the coverage attained with the monetary equivalents of 2010 funding. As a result of the recent global economic crisis and the shrinking global envelop for HIV/AIDS, the country would endeavor to maintain the programmatic interventions at the same level as 2010 coverage.

The "medium funding" scenario considers a scaling up evidence-based and proven prevention interventions faster which would result into greater impact in reducing the number of new infections.

These alternative funding scenarios resulted into resource estimates of US $ 2,304.65 million for the constant funding scenario and US$ 2,707.78 million for medium funding scenario over the plan period. The detailed costs under the constant and medium alternative funding scenarios are provided in Annex III and IV

The comparative cost estimates between the three scenarios is showed in Table 4 below.

Table 4: Comparison of the NSP cost estimates by funding Scenarios

S/No	Thematic Area	Funding Scenario. Amounts in US $ millions.		
		Full	**Medium**	**Constant**
1.	Prevention	1,023.38	752.12	532.09
2.	Care and Treatment	1,219.19	1,118.62	1,067.27
3.	Social Support and Protection	332.05	172.86	140.00
4.	System strengthening	836.75	664.17	565.29
Totals		**3,411.37**	**2,707.78**	**2,304.65**

Source: Resources Need Model. 2012

6.3 Financing of the NSP

Financing of the NSP necessitates identification of financing mechanisms that are able to sustainably raise substantial amount of funds in the short and medium term. There are two compelling goals in the financing of the NSP:- i) to mobilize substantial amount of resources to match expansion in service coverage and bridge the funding gap, and ii) to enhance predictability in flow of funding and improve program efficiency.

In order to achieve the stated goals, the country will continue focusing at mobilizing external sources to finance the HIV/AIDS national response, as well as domestically mobilized resources.

6.3.1 Financing Gap

The funding gap for the revised NSP is estimated at US $ 1,668.08 million over the four year period. The funding gap was determined by ascertaining the commitments (projected resource inflows) for the four years of the plan and compared with the total financing requirements based on full funding scenario. The gap is primarily driven by the expansion in the service coverage.

During implementation of the plan however, the funding gap may also be driven by other factors such as inflations and the bleak global economic situation, which may either result into reduced or unpredictable flows of funding.

Table 5. Financial Gap under the Full Funding Scenario.

Agency	2011/12	2012/13	2013/14	2014/15	Totals
NSP estimates (Full funding)	**585.35**	**756.33**	**933.2**	**1,136.50**	**3,411.37**
Projected Inflow	**US$ m**	**US$ m**	**US$ m**	**US$ m**	**US$ m**
GoU	42	42	42	42	168.00
Bilateral					0.00
Irish Aid - 1Euro- 1.320US$	8.58	8.58	8.58	9.24	34.99
DFID (16.3 Million pounds-converted to US$) (1pound= 1.61348 US$)	4.84	8.23	7.83	5.41	26.30
DANIDA (US$ million)	7.10	7.10	7.10	7.10	28.40
SIDA	1.40	1.40			2.80
UNITAID / Clinton Health Access Initiative	15.70	8.80	0.80	0.80	26.10
Italian Cooperation					0.00
USG/PEPFAR (Million dollars)	324.00	324.00	324.00	324.00	1296.00
Multilaterals					0.00
UN Agencies	14.46	13.19	11.63	11.88	51.16
GFATM		41.60	37.60	51.10	130.30
Other international donors					0.00
Total Projected inflows	**$418.08**	**$454.90**	**$439.54**	**$451.53**	**$1764.05**
Funding Gap	**167.27**	**301.43**	**493.66**	**684.97**	**1647.32**

6.3.2 Funding sources and modalities

The financing of the National Strategic Plan for HIV/AIDS (2011/12-2014/15) will continue to be a joint effort by the Government of Uganda (GoU) and the Development Partners.

The GoU budget will largely be in form of GoU allocation towards the HIV and AIDS components in the health sector, HIV & AIDS research, and coordinating HIV/AIDS in the country. Government HIV/AIDS expense also includes allocation by government ministries, departments and agencies (MDAs) to HIV/AIDS activities in their plans and budgets. It should however be noted that government also spends a sizeable budget on opportunistic infections such as TB, Malaria, and STIs, which directly form part HIV/AIDS spending in addition to meeting general wages and salaries for medical staff who handle HIV/AIDS related cases. For the purpose of tracking increment in Government HIV/AIDS, only direct allocation to HIV/AIDS interventions and activities are considered.

Development partners' contribution – AIDS Development Partners (ADPs) currently finance about 90% of the entire HIV/AIDS national response. Though this may not be the

most desirable situation, it is likely to be the trend at least over the medium term period. The capacity to mobilize resources domestically has remained low with the revenue/GDP ratio stagnating between 12% and 13% annually while demands to the national coffers are growing by the day.

In the face of current global financial meltdown, there is need to identify new and innovative sources of funding for the national response. In addition, other suggested measures include: ensuring accountability and transparency in the resource utilization, plus efficiency in HIV programming.

Efficiency in HIV/AIDS programming may be enhanced by undertaking evidence based and proven interventions that will bear a greater impact on reducing the number of new infections, and improving the quality of life of PLHIV by mitigating the health effects of HIV/ AIDs.

Broadly the financing mechanisms for the plan will include budget support, basket and project funding. In line with the Paris Declaration and Accra Agenda for Action, development partner funding and other donations for HIV/AIDS. It will also harmonize and align the national planning and budgeting mechanisms. Building on success of the outgoing NSP, increasing amount of development partner funding will be channeled through existing multisectoral coordination mechanisms.

a. Basket funding –Partner resources will be channeled through the two multi-sectoral pooled funding arrangements: the Partnership Fund (PF) and the Civil Society Fund(CSF). While the PF will pool resources needed for multisectoral coordination by UAC and Self Coordinating Entities (SCEs), the CSF will continue to be a competitive grant for civil society organizations dealing in HIV/AIDS service delivery. Mechanism will be put in place to enable national NGOs to quickly access and effectively utilize and account for the funds through the CSF.

b. Project support – whilst the harmonization and alignment objectives tend to prioritize the general budget support, there are instances where direct support targeting programmes/projects such as supply of commodities have proven to be an effective alternative. Under this plan, project support going direct to procurement of HIV/AIDS drugs and other commodities will be emphasized. The plan however discourages project support to magnitude of small projects, which would lead to duplication of efforts and multiple reporting and accountability.

c. **Other mechanisms -** will include institutional based funding and allocation to HIV/AIDS workplace programs, household and community based initiatives, which largely draw from in-house/local resources and expertise.

6.3.3 Sustainability of the HIV/AIDS National Response

In the face of the global financial meltdown there is urgent need for the Government of Uganda to explore new avenues for raising funds for the HIV /AIDS national response. In

order to enhance mobilization and management of resources for HIV/AIDS over the plan period, the Government of Uganda will be required to:

i). Develop an integrated and comprehensive national resource mobilization strategy for the HIV and AIDS national response. This will facilitate orderly, effective and efficient mobilization of resources on a sustainable basis. In addition, government and stakeholders should put in more efforts in the setting up of an AIDS Trust Fund which will service a pool for resources mobilized for the AIDS response.

ii). Uphold, scale up and sustain good practice and progress registered in pooling of funds for harmonized coordination of the national response such as the CSF. Focus should be geared towards empowering small NGOs and Community-Based Organizations (CBOs) to effectively access the HIV AIDS funding, building their capacities to be able to generate additional resources internally.

With raising unit cost for delivery of the minimum healthcare package and basic HIV/AIDS services, there must be corresponding adjustment in health budget. The sector should engage with Ministry of Finance, Planning and Economic Development (MoFPED) and other stakeholders with view of increasing the health sector budget to at least a level sufficient for implementation of HSSIP III.

iii). Institutionalize and carry out annual resource tracking mechanism building on the results of the NASA.

iv). Continuously engage with and guide implementing agencies on the most cost effective interventions which will result into greater incidence reduction. This will guide rolling out of national HIV reprogramming functions that will minimize waste and duplication of services.

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3. Health Sector HIV&AIDS Strategic Plan 2010/11-2014/15
4. Health Sector Strategic and Investment Plan (HSSIP) 2010/11-2015/16
5. Second National Health Policy, July 2010
6. Status of the HIV Epidemic: 2010
7. Annual Health Sector Performance Report, Financial Year 2009/2010
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    ii. PMTCT: Policy, Scale-up Plan, Situation Analysis 2008Report
    iii. HIV Testing and Counseling Policy (HTC) (revised 2011)
    iv. Post-exposure prophylaxis policy-PEP, PSEP
    v. TB-HIV collaborative Policy and communication strategy
    vi. TB Strategic Plan
    vii. PWP policy / guidance
    viii. Nutrition Policy
    ix. MOH Training materials launched by SCOT
9. Other Sector & District HIV&AIDS Plans: MoH, MoGLSD, MoES, Public Service
10. National HIV&AIDS Stakeholders Service Mapping Atlas
11. PEPFAR Uganda Annual Reports
12. Global Fund Plans and Reports
13. MoH/ACP ART, PMTCT and other quarterly Reports
14. MoH Drug Resistance Reports: TB MDR survey report, HIV EWI reports
15. Modes of Transmission Study Report, 2009
16. Uganda HIV&AIDS Sero-Behavioral Survey 2004/05
17. Annual Health Sector Performance Report, October 2005 plus others
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Annexes

Annex I: Revised NSP Results Framework

Overall Goal of NSP: To achieve universal access targets for HIV AND AIDS prevention, care, treatment and social support and protection by 2015					
	Indicators	**Baseline (2010)**	**Target 2014/2015**	**Data Sources**	**Frequency of collection**
Impact Indicators:	1. HIV Incidence (Number/Rate of new infections)***	Total-102,157	71,510	(MOH Modeling projections)	5 years
		Males- 44,472	31,130		
		Women-57,685	40,380		
		Children <15 yrs-24,142	16,899		
		Rate 0.72%	0.46%		
	2. Percentage of pregnant women aged 15-49 attending ANC who are HIV infected	7% (2009)	5%	HIV&AIDS Epidemiological Surveillance Report	Annually
	3. Percentage of infants born to HIV infected mothers who become infected	7.4% (2010)*	2.7%	PMTCT& Pediatric HIV&AIDS Care Program Annual Report	Annually
	4. Percentage/number of adults aged 15-49 years who are HIV infected ***	Total 6.7%	6.3%	AIS Report (Present figures from HIV and AIDS Epidemiological Surveillance Report)	Every 5 years
		Males: 5.6%	Males****		
		Females: 7.7%	Females****		
		Children 149,661			
		Rural 14.6 % (2006)	Rural		

OUTCOME INDICATORS

Prevention

Objective	Indicators	Baseline status	Target 2014/2015	Proposed Data Sources	Frequency of Collection
To scale up HIV Counseling and Testing	5. Percentage of women and men (15-49 years) who tested for HIV in the last 12 months and know their	25% (Male female)	80% (prevention strategy)	AIS Report	5 years

Objective	Indicators	Baseline status	Target 2014/2015	Proposed Data Sources	Frequency of Collection
(HCT), increasing coverage and uptake	results***				
	6. Percentage of most at risk populations who have received an HIV test and know their results (FSW, Fishermen, Truckers) MARP groups)	CSW - 49.2%		MARP Surveys	Biannual
		Fishermen TBD			
		Truckers TBD			
	7. Percentage of HIV-positive pregnant women who receive antiretroviral drugs to reduce risk of mother-to-child transmission of HIV***	86% (2011)	95%	PMTCT& Pediatric HIV&AIDS Care Program Annual Report	Annual
To scale up coverage, quality and utilization of proven biomedical and behavior HIV prevention interventions	8. Percentage of exposed infants who have received ARV prophylaxis to reduce risk of mother-to-child transmission of HIV	27% (2010)	80%	PMTCT& Pediatric HIV&AIDS Care Program Annual Report	Annual
	9. Percentage of infants born to HIV Positive women receiving a virological test for HIV within 2 months of birth. ***	30 %	50%	PMTCT& Pediatric HIV&AIDS Care Program Annual Report	Annual
	10. Percentage of males and females 15-49 years reporting consistent condom use	Males: 82.3%	Males 80%	AIS Reports	Every 5 years
		Females: 76.4%	Females 80%		
	11. Percentage of MARPS 15-49 yrs reporting consistent condom use	CSW : TBD	80%	MARPS Surveys	Biannual
		Fishermen TBD	80%		
		Trackers TBD	80%		
	12. Percentage of adult males (15-49 years) that are circumcised	23.6%	5 million 80%	Survey	Annual
	13. Percentage of STI patients that are managed (diagnosed, treated and counseled on risk reduction) according to national guidelines	38% (2007)	80%	Health Facility Survey	Bi-Annual
	14. Percentage of donated blood units in the country that have been adequately screened for HIV according to national or WHO guidelines during the past 12 months***	100%	100%	UBTS Reports	Annual

Objective	Indicators	Baseline status	Target 2014/2015	Proposed Data Sources	Frequency of Collection
	15. Percentage of adults (15-49) who have had sexual intercourse with more than one partner in the last 12 months***	Men 17.8% Females 2.9%	12 % 1 %	AIS Reports	Every 5 years
	16. Percentage of young women and men aged 15-24 years who correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission***	Males: 41.1% Females: 33.8%	Male: 20% Female: 5%	AIS Report/UDHS Report	Every 5 years
	17. Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their last casual sex.***	Males 13.3% Females 15.7%	80% 80%	AIS Report	Every 5 years
	18. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Males TBD AIS Females TBD AIS	50% of Baseline	AIS/UDHS	Every 5 years
To mitigate underlying social, culture, gender and other factors that drive the HIV epidemic	19. Percentage of women who experience sexual and gender-based violence	39%	10%	Survey	
	20. Percentage of men & women (15-49) who are able to negotiate for safer sex with their sexual partners Percentage of adults that believe that a woman is justified to refuse sex or demand condom use if she knows that her husband has a STI	No Data Males 90% Females: 84%	 100% for both	Special Surveys	

Care and Treatment

Objective	Indicators	Baseline value year	Target 2014/2015	Proposed Data Sources	Frequency of collection
To increase equitable access to ART by those in need, from 50% to 80% by 2015	21. Percentage of eligible adults and children currently receiving ART (disaggregate by sex age)***	Total: 290,563 Adults 50%, Children 25% (24,141)	80%	ART Quarterly reports	Annually
	22. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy***	84%	85%	ART Quarterly reports	Annually
Increase access to prevention & treatment of opportunistic infections including TB	23. Percentage of estimated HIV-positive incident TB cases receiving both TB and HIV treatment ***	34.2%	80%	Program Reports	Annually
To integrate sexual and reproductive health (including HIV prevention) into all care & treatment services by 2015	24. Unmet need for FP among PLHIV – See indicators in PMTCT on Family Planning Integration	Not Available	<10%	UDHS	Every 5 years

Social Support and Protection

Objective	Indicators	Baseline value year	Target 2014/2015	Proposed Data Sources	Frequency of Collection
To support delivery of comprehensive, quality psychosocial services to PLHIV, affected households and persons most vulnerable to exposure to HIV	25. Percentage of PLHIV who received psychosocial support in past 12 months	19% (2005)	25%	AIS Report	Every 5 years
	26. Percentage OVC who have access to a comprehensive OVC service package (at least 3 basic needs met)	24.8% OVC possessing 3 basic needs	70% OVC	OVC MIS	Annually

Objective	Indicators	Baseline value year	Target 2014/2015	Proposed Data Sources	Frequency of Collection
To empower HIV affected households and most vulnerable groups with livelihood skills and opportunities to cope with socio-economic demands	27. % of OVC households that received economic strengthening support	41.2%	80% of PLHIV households	OVC MIS	Annually
To scale up coverage of a comprehensive social support and protection package to most vulnerable PHLIV and other affected groups	28. Ratio of Current school attendance among orphans and non-orphans aged 10–14 ***	0.9	0.96	EMIS/UDHS	Annually
	29. Percentage of population with accepting attitudes towards PLHIV	Males – 32.6% Females – 20%	50%	AIS	5 years
	30. Percentage of large work places (employing 20 or more persons) that have HIV&AIDS workplace policies and programs	25 out 30 largest companies (83.3%)	95% of 30 largest companies	Work Place Survey MoGLSD)	

Systems Strengthening

Objective	Indicators	Baseline value year	Target 2014/2015	Proposed Data Sources	Frequency of Collection
To strengthen the governance and leadership of the multi-sectoral HIV and AIDS response at all levels	31. National Commitments and Policy Instrument (NCPI) ***	NCPI=54.6%	95%	NCPI Survey	Bi-Annually
	32. Functional HIV coordination structures/committees in public and non-public sector institutions and departments at central and decentralized levels	DACs=30%; PHA Networks = 90%	DACs=95% PHA=95%		
To ensure availability of resources for strengthening systems for delivery of quality HIV and AIDS health and non-	33. Percentage of facilities reporting stock outs of (HIV test kits, ARVs and Condoms	TBD	TBD	Supply Chain Management System Reports	
	34. Domestic and international AIDS spending by categories and financing sources *** (of total annual	Domestic Source: Government: 8.9%	15%	NASA	

health services	budget)	ADPs: 90%			
To establish a coordinated and effective national system for management of strategic information for the HIV and AIDS response	35. Proportion of indicators in the national framework that are reported on according to reporting schedule	35%	100%	Program Reports	

Annex II: List of Consultants, Technical and Research Assistants

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

Annex II: List of Consultants, Technical and Research Assistants

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

Annex III: Thematic Working Groups

1. Prevention

Name	**Title**	**Organization**
Fred Wabwire-Mangen	Chair	MakSPH
Sam Okware	Vice Chair	UNHCO
David Tigawalana	Convener	UAC
Catherine Barasa	Member	UNAIDS
Catherine Watson	Member	Straight Talk
Godfrey Esiru	Member	ACP-MOH
Jackie Katushabe	Member	UAC
Joseph Okia	Member	OoP
Joshua Kitakule	Member	IRCU
Juliana Akoryo	Member	MoFLSD
Margaret Achom	Member	CDC
Michael Muyonga	Member	MoH
Monica Dea	Member	CDC
Paddy Masembe	Member	PHA Network
Raymond Byaruhanga	Member	AIC
Rita Nalwadda	Member	WHO
Robinah Ssempebwa	Member	USAID
Rosemary Kindyomunda	Member	UNFPA

Name	Title	Organization
Steven Kusasira	Member	UPDF
Susan Mpanga Mukasa	Member	PACE
Wolfgang Hlardrick	Member	CDC
Yusuf Nsubuga	Member	MoES
Draecabo Charles	Member	UNESCO
Annah Rutebuka	Member	UNRA
Joseph Matovu	Member	MakSPH
Aggrey Mukose	Member	MakSPH
Sylvia Nakasi	Member	UNASO
Florence Aliba Edin	Member	IRCU
Teopista Agutu	Member	Straight Talk Foundation
Dorothy Namutamba	Member	ICWEA
Christine Serwadda	Member	UAC

2. Care and Treatment

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

3. Social Support and Protection

Name	Title	Organization
Noerine Kaleeba	Chairperson	Founder, TASO Uganda
Edward Mugimba	Vice Chair	MoGLSD
Joyce Kadowe	Convener	UAC
Narathius Asingwire	Consultant	Makerere Univ
Swizen Kyomuhendo	Consultant	Makerere Univ
Ronald Luwangula	Res. Assistant	Makerere Univ
Flavia Kyomukama	Member	Global Coalition of Women with AIDS
Betty Kwagala	Member	TASO, Uganda
Monja Minsi	Member	Uganda Reach the Aged Association
Flavia Birungi	Member	ACORD
Sheila Marunga Coutinho	Member	Civil Society Fund
Grace Mayanja	Member	Alliance International
Denis Nuwagaba	Member	Inter-Religious Council of Uganda
Florence Bulumba	Member	NACWOLA
Prossy Namakula	Member	Global Coalition of Women with AIDS Uganda
Mercy Mayebo	Member	USAID
Sam Ocen	Member	Uganda Red Cross
Consolatta Aywek	Member	Uganda Red Cross
Connie Acayo	Member	MAAIF
Meredith Lwanga	Member	UNAIDS
Tina Achilla	Member	TASO, Uganda
Lucy Acom	Member	AIC
John Kitimbo	Member	POMU
Irene Sejjemba	Member	Maama's Club
Dean Musitwa	Member	Young Positives
David Muttu	Member	UAC
James Kigozi	Member	UAC

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

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

4b. Systems Strengthening (Monitoring and Evaluation)

Name	Title	Organization
Byakika Sarah	Chairperson	MOH
Sarah Asiimwe	Consultant	
Denis Busobozi	Convener	UAC
Grace Murindwa	Member	UAC
James Guwani	Member	UNAIDS
Benson Bagorogoza	Member	UAC
Odunge Josephine	Member	UAC
Jotham Mubangizi	Member	UNAIDS
Susan Candiru	Member	UAC
Elizabeth Mushabe	Member	UAC
Sarah Kyokusingura	Member	MEEPP
Vincent Owarwo	Member	MEEPP
Daniel Kyeyune	Member	UAC
Nkoyooyo Abdallah	Member	TASO
Vincent Bagambe	Member	MOH/FCO
Sylvan Kaboha	Member	Deloitte Uganda
Walter Obiero	Member	CDC
Kamoga Joseph	Member	PEPFAR
Abbot Ntwali	Member	UNASO
Tatwebwa Lilian	Member	UAC

Henry Katamba	Member	ACP/MOH
Kashemeire Obadiah	Member	MoGLSD
Mark Tumwine	Member	CDC
Mulumba Mathias	Member	UNASO
Moses Asiimwe	Member	CSF
Simon Peter Mayanja	Member	CSF
Charmaine Matovu	Member	CDC

4c. Systems Strengthening (Resource Mobilization and Costing)

Name	Title	Organization
Joel Okullo	Chair	UAC
Benson Bagorogoza	Convener	UAC
Alaethea Musa	Member	USAID
Charles Birungi	Member	UNDP
Henry Tabifor	Member	UNAIDS
John Bosco Kavuma	Member	NPA
Mary Oduka Ochan	Member	Irish Aid
Michael Aliyo	Member	MoFPED
Patrick Jatiko Onyo	Member	UAC
Peter Ndawula	Member	Deloitte Uganda
Peter Ogwal	Member	DANIDA
Peter Okwero	Member	World Bank
Rachael Waterhouse	Member	DFID
Rogers Enyaku	Member	MoH
Solome Nampewo	Member	SIDA
Strong Michael	Member	PEPFAR
Titus Kajura	Member	MoFPED
Wilfred Ochan	Member	UNFPA
Zainab Akol	Member	MoH

Annex iv: Steering Committee

Name	Title
Edward Katongole-Mbidde	Chair
Grace Murindwa	Convener
David Kihumuro Apuuli	Member
Musa Bungudu	Member
Aleathea Musah	Member
John Mugisa	Member
Lillian Mworeko	Member
Fred Wabwire	Member
Patrick Mutabwire	Member
Beatrice Rwakimari	Member
Jesse Kagimba	Member
Robert Waweru	Member
Peter Okwero	Member
Paul Mugambi	Member