



AIDE MEMOIRE

FOURTH JOINT ANNUAL AIDS REVIEW CONFERENCE 2011

**THE NATIONAL HIV & AIDS STRATEGIC PLAN
2007/08 – 2011/12**



UGANDA AIDS COMMISSION

DATES: 1ST - 3RD NOVEMBER 2011

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1.0 Preamble

The 2011 National Joint Annual AIDS Review (JAR) Conference was held at Imperial Royale Hotel, from 1st to 3rd November 2011. The Conference was attended by more than 400 participants with 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. This Aide Memoire highlights major areas of consensus from the JAR deliberations, indicative priorities for the Review of the National HIV/AIDS Strategic Plan (NSP) 2007/8-2011/12, and the undertakings for the next FY 2012/13. Major documents referenced include the NSP Mid-Term Review Report and the 2011 JAR Conference proceedings.

2.0 Objectives of the JAR conference

The JAR is a mechanism through which various HIV/AIDS stakeholders participate in the planning and monitoring of the national response. The JAR is therefore an evaluation and accountability tool for reviewing the performance of the NSP against targets and plan for upcoming year. The 2011 JAR focused on Mid-Term Review (MTR) of NSP.

Specifically the objectives of the JAR included:

- a) To receive and discuss progress made during the last four years (2007/08 - 2010/11) of implementation of the NSP
- b) To receive and discuss progress made during the last four years (2007/8-2010/11) of application of the Performance Measurement and Management Plan (PMMP)
- c) To provide an opportunity for stakeholder dialogue and joint consideration of the issues emerging, constraints and recommendations for NSP Revision.

3.0 Progress in implementation of NSP during the last four years

Overall, there has been significant progress in the implementation of NSP across all thematic areas notwithstanding the challenges, constraints and emerging issues. Below is the snapshot of the progress over the period under review.

3.1 HIV Prevention

- a. Reduction in new infections among children under fifteen years from 25,746 in 2007 to 24,142 in 2010
- b. Increase in number of Ugandans who know ways of preventing HIV
- c. Increase in PMTCT access indicators (e.g., testing during pregnancy, enrolling on ART)- expectant HIV pregnant women that received ARVs for PMTCT increased 35% in 2007 to 49 % in 2010; proportion of infants born to HIV positive mothers decreased from 19 in 1997 to 7% in 2010
- d. 100% safety of blood for transfusion and expanded coverage of Uganda Blood Transfusion Services (UBTS)

- e. Increased focus on prevention programming and capacity building for friendly service provision to key population groups and
- f. Articulation of policy frameworks and operational guidance in key intervention areas including PMTCT, HCT, SMC and SRH/HIV integration
- g. Development of the National HIV Prevention Strategy 2011/12- 2014/15

3.2 Care and Treatment

- a. ART sites increased from 328 in 2008 to 443 in 2011.
- b. Number of adults on ART increased from 105,000 in 2007 to 290,563 in June 2011.
- c. Quality of care for ART patients improved with over 60% receiving baseline CD4 counts compared to 30% over 5 years period.
- d. By 2010, a total of 93% of clients received cotrimoxazole
- e. About 78% of facilities had cotrimoxazole in stock in 2010 compared to 44% in 2007.
- f. TB/HIV collaboration indicators improved with proportion of TB patients tested for HIV increasing from 25% in 2006 to 81% in 2011.

3.3 Social Support

- a. Expanded government programmes of UPE and USE lead to increased orphan enrollment. In 2009 a total of 260,098 orphans accessed secondary school education.
- b. More OVC have benefited from informal education through vocational skills training
- c. Expanded scope of the social support package and implementing partners especially the civil society sector.
- d. Eight two 82% of actors were involved in advocacy role to reduce stigma and discrimination.
- e. A number of structures exist both at community and local government level to provide social protection to vulnerable groups

3.4 Systems Strengthening

3.4.1 Governance and infrastructure

- a. Institutional arrangement e.g LTIA, HIV partnership structures) identified in the NSP were largely operationalized
- b. Guidelines for mainstreaming HIV and AIDS issues into planning and budgeting processes were developed and disseminated. HIV and AIDS mainstreaming recorded an improvement both at sector and local government levels.
- c. A Local Government HIV/AIDS Strategic Planning Guide was developed and disseminated
- d. New health facilities were constructed, some refurbished and others upgraded to higher levels Conducted an organizational development review for UAC Secretariat and Board

3.4.2 Resources Mobilization and Management

- a. The share of Government of Uganda (GoU) funding to the total national response increased from 5% in 2007/08 to 11% in 2009/10. External funding accounted for about 89% of the total funding. Overall, 80% of the commitments were honored amounting to US \$ 931.8 Million.
- b. Conducted a macroeconomic impact assessment of HIV/AIDS in Uganda, which led to better appreciation of HIV programming. The establishment of a Civil Society Fund, mobilization of additional resources from development partners through mechanisms such as PEPFAR, GFATM, Partnership Fund

3.4.3 Monitoring and Evaluation

- a. HMIS was revised to include more HIV/AIDS indicators and harmonized reporting tools for PMTCT, ART, TB and HCT.
- b. OVC Management Information System (OVC MIS) developed and launched
- c. The Country prepared, and disseminated a series of performance reports including; HIV/AIDS Epidemiological Surveillance Reports, ANC sentinel surveillance, routine data and special studies and UNGASS Reports
- d. Lot Quality Assurance Sampling (LQAS) methodology was used in 51 districts to collect population based data (2011) and used for planning
- e. Capacity-building for local government and Civil society for M&E conducted. Conducted JAR and partnership forum

4.0 Emerging Issues and Challenges

4.1 HIV Prevention

- a. Increasing number of new HIV infections, more women getting infected than males, higher HIV prevalence among key population groups.
- b. Low comprehensive knowledge on HIV/AIDS
- c. Inadequate targeting, weak behavioural communication programming and lack of a streamlined mechanism for clearing prevention messages
- d. Persistent deterioration of sexual behavioural indicators (MCP, condom, early age at first sex)
- e. Low PMTCT uptake, high unmet need for FP and low male involvement
- f. Low PMTCT /SRH service despite existence of tools
- g. Inadequate blood supply for transfusion services. Only 85% of need is covered
- h. High STI prevalence rates, low coverage and poorly targeted STI services,
- i. Lack of technical guidance & weak infrastructure to roll out SMC.
- j. Inadequate commitment of leadership to HIV prevention at all levels

4.2 Care and Treatment

- a. Low coverage of ART for adults, children and MARPs. Pediatric ART is hindered by low EID coverage.
- b. Limited access to CD4 testing services.
- c. Inadequate human resources and lack of guidelines on task shifting.
- d. Low uptake of HCT especially couples, men and high risk groups due to poor access of services.

- e. Emerging MDR TB, and delayed initiation of ART in HIV co-infected due to late diagnosis
- f. Low coverage of palliative care services with only 32 (29%) districts reached
- g. Increasing resistance to 1st line ARVs

4.3 Social Support

- a. Social support though crosscutting is delivered as a standalone component leading to missed opportunities for efficiency and synergetic approaches
- b. Limited consistency on the delivery of the commonly agreed comprehensive social support package and poor articulation of various target population groups (vulnerable, infected and affected)
- c. Limited attention to protection elements of the social support component coupled with weak public and community structures to ensure implementation of legal and policy frameworks
- d. Lack of standardized tools to track delivery of the social support package
- e. Increasing number of individuals, groups and communities affected by HIV/AIDS with more needs, but limited interventions. Overstretching households and community safety nets
- f. Non-holistic interventions for social support and expansion of the scope of basic care provisions to enable the most vulnerable gain dignity
- g. Non-affirmative interventions for HIV/AIDS vulnerable groups to benefit from existing macro-economic initiatives such as NAADS, NUSAF & SACCOs

4.4 Systems Strengthening

4.4.1 Governance and infrastructure

- a. Inadequate functionality of co-ordination structures mainly due to inadequate funding
- b. Lack of clearly defined roles and contribution of Civil society
- c. Multiple procurement and supply systems for HIV/AIDS commodities
- d. Inadequate human resource capacity to match the additional burden HIV/AIDS placed on different sectors
- e. Frequent stock outs for health commodities and essential medicines
- f. Weak community systems.

4.4.2 Resources Mobilization and Management

- a. Escalating costs for the delivery of HIV/AIDS Services
- b. Inadequate funding for HIV/AIDS interventions despite high levels of commitment from partners. Changes in the dynamics of the epidemic and response complicating the response funding requirements
- c. Majority of funding for HIV/AIDS is off budget, which presents major challenges to sustainability and predictability of funding for the HIV response.
- d. Inefficiency in allocation and utilization of HIV/AIDS resources.
- e. Inadequate alignment to priorities and limited convergence of funding streams to focus on common goals and resource gaps.

4.4.3 Monitoring and Evaluation

- a. Limited utilization of the PMMP, which affected the reporting requirements on the stated indicators by the various sectors including CSOs. Majority of indicators (65% of 58 indicators in the PMMP) were not collected.
- b. Lack of a national data management systems at the UAC, sectors and local governments.
- c. Inadequate human resources capacity (both skills and numbers) in monitoring and evaluation at all levels

5.0 Priorities and Recommendations for the Revision of NSP

The revised NSP will be guided by overarching principles of right-based approach, gender equality (rights of women, girls and boys) and multi-sectoral approach for the national response. The national response should consider appropriate linkages for comprehensive HIV services., without compromising into thematic areas.

5.1 HIV Prevention

5.1.1 Biomedical interventions

- a. PMTCT: target Virtual elimination of MTCT, implement four pronged approach, adopt Option B+, and uphold targets in National Prevention Strategy (NPS).
- b. Rapid scale up of safe male circumcision (SMC) to cover 5 million males (14-49yrs) in the next 5 years
- c. ART for prevention; treat all eligible HIV+ with ART, treat all HIV pregnant women and treat all children with HIV+
- d. Maintain 100% blood transfusion safety and increase blood donor recruitment
- e. Ensure universal safety precautions
- f. Scale up HCT - Avail testing services to all HCII, prioritize home-based HCT, PITC outreaches and create demand through peers and VHT

5.1.2 Behavioral interventions

- a. Articulate key target population groups and packages based on evidence
- b. Scale up and streamline coordination , for HIV prevention communication and messaging
- c. Promote age and gender safe sexual behavior, in particular ABC plus Invest in research to understand sexual behavior

5.1.3 Structural interventions – socio-cultural and economic drivers of the epidemic

- a. Advocate for non discriminatory, laws and policies and ensure enforcement
- b. Empower cultural and religious institutions and leaders to spearhead HIV prevention campaign

5.1.4 Structural intervention – leadership, governance, systems

- a. Re-invigorate political leadership at all levels
- b. Integrate HIV prevention services with SRH/MNCH and primary health care.
- c. Roll out combination prevention and support convergence of partners at all levels to target common goals

5.2 Care and Treatment

- a. Ensure access to ART of all eligible persons living with HIV
- b. Accredite more health facilities including private health facilities.
- c. Roll out pre-ART care to HCII and HCIII.
- d. Ensure EID and early infant treatment and capacity of HCIII to offer pediatric care and treatment including adolescent friendly services and exposed babies.
- e. Improve early TB diagnosis (GeneX-pert) and implement MDR strategy/strengthen surveillance and case management
- f. Scale – up palliative care services to all districts
- g. Strengthen drug resistance tracking
- h. Strengthen the linkages between HCT and care and treatment

5.3 Social Support

- a. Define a minimum package of social support to enhance prevention, care and treatment
- b. Empower households and communities with livelihood skills and opportunities (including linkages to development programmes) to cope with social and economic demands
- c. Strengthen socio-economic security, food security and nutrition, education and quality of psychosocial support to targeted affected groups as major interventions
- d. Advocate for affirmative action to support vulnerable members to benefit from existing initiatives such as NAADS, NUSAF and SACCOs; and promote mechanisms for ensuring cash transfer initiatives
- e. Strengthen capacities of organized structures of PHA, elderly, PWD and other categories to respond to own needs
- f. Expand implementation of workplace policies in the formal and informal sectors and their implementation.

5.4 Systems Strengthening

5.4.1 Governance

- a. Review existing co-ordination structures for appropriateness and clarity of roles and responsibilities for the national response.
- b. Provide conditional grants/finances to improve performance of sector and LG coordinating structures
- c. Engage communities in HIV/AIDS planning, implementation, monitoring and evaluation for improved accountability
- d. Establish linkages between the proposed UAC Zonal Offices and LGs and other regional M&E zonal structures (in particular GF M&E officers)
- e. Support local governments to develop, and implement integrated HIV/AIDS Plan

- f. Develop an Action Plan to support implementation of the National HIV&AIDS Policy
- g. Empower LGs to enforce policies, laws and guidelines aimed at improved collaboration, partnerships and networking among implementing partners

5.4.2 Human Resource and Infrastructure Development

- a. Ensure that the special needs of PWDs, PHA are taken care of, in infrastructure development and rehabilitation
- b. Improve staffing and motivation levels for health workers with particular attention to HCIII and lower levels. In addition improve the HR capacity of sectors and line ministries to coordinate the response
- c. Advocate for institutionalization of the position of a focal person and counselor within the local government structure
- d. Explore alternatives for expedited procurement for health commodities e.g. 2nd PR for GFATM
- e. Develop capacity for forecasting logistics management for procurement of health commodities and disposal of health goods and services need to be strengthened within the health sector including health facilities
- f. Review the procurement, distribution and logistics management systems for HIV/AIDS related drugs and supplies and strengthen capacity including coordination, harmonization and streamlining of donor support in procurement

5.4.3 Research

- a. Develop a framework to guide HIV/AIDS research efforts at national and local government.
- b. Ensure regular dissemination of HIV/AIDS research findings
- c. Scaled-up LQAS methodology to all LGs and dissemination of results prioritized
- d. Establish linkages with national level Research Clearance Committees (UNHRO, UNCST, UVRI, Academia, etc)
- e. Finalize HIV Prevention & AIDS Control Bill

5.4.4 Resource Mobilization

- a. Develop an integrated and comprehensive national resource mobilization strategy for the HIV/AIDS national response
- b. Increase GoU funding for HIV/AIDS at national and Local Government levels.
- c. Establish an HIV/AIDS trust fund so as to improve domestic resource mobilization and sustainability
- d. Ensure alignment of donor funds to national planning, budget and financial accountability systems.
- e. Institutionalize regular resource tracking mechanism through identification and ensuring resources and systems are functional
- f. Review MoLG annual assessment tools to capture needed info on HIV/AIDS including tracking of resources
- g. Improve efficiency of spending by focusing HIV/AIDS investment to interventions

that have big impact on reducing the number of new infections and improving the quality of life and support.

5.4.5 *Monitoring and Evaluation*

- a. Revitalize National AIDS Documentation Information Centre and make it operational. NADIC should be a one stop center for HIV information and needs to be automated
- b. Redesign the National M&E data collection, aggregation, analysis, reporting and utilization systems. Ensure reporting from private health facilities
- c. Establish of organizational structures at national, sectoral and district levels for M&E
- d. Build human resource capacity for M&E to collect, analyse and utilize data at sector, local governments and CSO levels
- e. Disseminate key national HIV documents at national, sector and local government levels.
- f. Strengthen the monitoring and tracking systems for social support indicators at national and lower levels.
- g. Strengthen systems for tracking the epidemic and the response at all levels
- h. Conduct joint AIDS annual review and partnership forum

6.0 **Undertakings for 2011/12**

- a. Develop a revised National Strategic Plan for HIV/AIDS (2011/12-2014/15) that is aligned to the National Development Plan (2010/11-2014/15)
- b. Develop and implement an operational framework for disseminating and delivering the National Prevention Strategy (NPS) defining roles and responsibilities of the various stakeholders.
- c. Finalise and achieve endorsement as well as buy-in of the strategy for domestic resource mobilization for financing HIV/AIDS (establishing HIV/AIDS Trust Fund)
- d. Develop National Priority Action Plan highlighting the priority HIV/AIDS interventions and cost for the first 2 years to facilitate resources mobilization and tracking
- e. Finalise National AIDS Spending Assessment (NASA) and disseminate findings
- f. Establish a national data base for the national HIV/AIDS response at UAC in which sectors can report into/send agreed national level sector specific indicators on an agreed time frame
- g. Prepare and sign MoU at all levels, district and National level detailing the roles of partners.
- h. Scale up safe male circumcision to cover over 1,250,000 males (14-49 years) in 2011/12
- i. Counsel and test 2.5 million adults (15 – 49 years) for HIV in 2011/12
- j. Enroll 21,628 HIV positive pregnant women on antiretroviral drugs to reduce the risk of mother-to-child transmission of HIV in 2011/12
- k. Enroll 100,000 new adults and 20,000 children (total 120,000) on ART in 2011/12