THE REPUBLIC OF UGANDA

UGANDA AIDS COMMISSION

OFFICE OF THE PRESIDENT

UGANDA AIDS COMMISSION

NATIONAL HIV AND AIDS ACTION PLAN FOR CULTURAL INSTITUTIONS & TRADITIONAL LEADERS IN UGANDA 2024/25 – 2029/30

THE REPUBLIC OF UGANDA
MINISTRY OF GENDER, LABOUR & SOCIAL DEVELOPMENT

THE GLOBAL FUND

September 2024

THE REPUBLIC OF UGANDA

UGANDA AIDS COMMISSION

OFFICE OF THE PRESIDENT

UGANDA AIDS COMMISSION

NATIONAL HIV AND AIDS ACTION PLAN FOR CULTURAL INSTITUTIONS AND TRADITIONAL LEADERS IN UGANDA 2024/2025 – 2029/2030

THE REPUBLIC OF UGANDA

MINISTRY OF GENDER, LABOUR & SOCIAL DEVELOPMENT

THE GLOBAL FUND

September 2024

FOREWORD

Since the 1980s, H.E President Yoweri Kaguta Museveni, the President of the Republic of Uganda, has provided visionary leadership and rallied all stakeholders in the fight against the HIV and AIDS epidemic. As a result, the country has achieved tremendous progress, as demonstrated in the decline in HIV prevalence from 18% in the 1990s to 5.1% in 2023, new HIV infections declined from 86,000 in 2010 to 38,000 in 2023, and AIDS related deaths declined from 48,000 in 2010 to 19,000 in 2023. The initial efforts that led to these achievements were largely based on the promotion of abstinence and faithfulness among sexual partners. At that time, the positive cultural and traditional norms and beliefs among the various cultural groups that preserved the family structure, community unity and stand against bad morals that would otherwise propagate the spread of HIV among the population significantly contributed to the fight. In the 2000s, the scientific innovations and introduction of the life saving antiretroviral therapy (ARVs) further contributed to this fight and have indeed saved millions of lives of people living with HIV in Uganda. Having HIV infection is no longer a death sentence like was the case in the 1990s.

In June 2017, H.E the President launched the Presidential Fast Track initiative for Ending AIDS by 2030 as a Public Health threat in Uganda with 5 Pillars. The key elements of the Presidential Fast Track Initiative include: (i) Engage men in HIV Prevention and close the tap on new infections particularly among Adolescent Girls and Young Women; (ii) Accelerate Implementation of Test and Treat for attainment of the Fast Track 95-95-95 targets particularly among men and young people; (iii) Consolidate progress on Elimination of Mother-to-Child-Transmission of HIV (E-MTCT); (iv) Ensure financial sustainability for the HIV response; and (v) Ensure institutional effectiveness for a well-coordinated multi-sectoral response. This is meant to accelerate interventions aimed at ending AIDS by 2030 in the country. Key stakeholders like Cultural and Traditional Leaders, Clan Leaders, Elders, Faith Leaders, have contributed to the success and progress that Uganda has achieved.

This Cultural Action Plan has been developed as part of HIV mainstreaming in all sectors, and will go a long way to ensure that implementation is aligned with other Government key policy and strategy documents for addressing HIV and AIDS. These documents are the National HIV and AIDS Strategic Plan 2020/21 – 2024/25, The Presidential Fast Track Initiative (PFTI) 2017, Ministry of Gender, Labour and Social Development National Action Plan on Women, Girls, Gender Equality and HIV & AIDS 2016/17 and other frameworks that are critical to the fight against HIV and achieving the 2030 target of ending AIDS as a public health threat in Uganda.

I therefore urge and call upon all the Cultural Leaders, the Council of Traditional Leaders in Africa, Uganda Chapter (COTLA) Kings Forum, the Clan Heads and all Traditional Leaders from all the Cultural Institutions and Elders Associations to embrace this important document that provides a minimum package that guides all efforts towards the fight against HIV as the country runs the last mile towards ending AIDS as a public health threat by 2030.

For God and my Country

Hon. Babirye Milly Babalanda
Minister for the Presidency

PREFACE

Uganda has experienced HIV epidemic for more than 40 years since the 1980s when the first case was reported in Rakai District. Not much was known about this epidemic and because of the knowledge gap, Uganda lost many people to AIDS. HIV was perceived as a curse, witchcraft, a death sentence for the people that had contracted the disease.

When the National Resistance Movement Government (NRM) came to power in 1986, H.E the President, General Yoweri Kaguta Museveni led the country in the fight against the HIV epidemic and much success has since been registered to date. Today, we have about 1.49m People Living with HIV and 1.2m of these people are on treatment. This shows progress in the fight against HIV. Some of the drivers and risk factors fueling the epidemic in the country include; Stigma and Discrimination, Cultural Beliefs and Negative Socio-Cultural Practices, Wealth, Income Inequality and Poverty, Gender Inequality, Human Rights, Inequity Access to Prevention, Care and Treatment Multiple Concurrent Partners, Transactional Sex, Sexually Transmitted Infections, Cross-Generational Sex and Early Sex, Discordance and Non-Disclosure, Lack of Circumcision, and Alcohol Use among others.

The role of Cultural and Traditional Leaders in ending AIDS by 2030 is critical; they play significant roles in modeling behaviors, creating sensitization and awareness in the society, demystifying the bad social cultural practices and norms that have bearing in fueling HIV and AIDS.

The development of the National Action Plan for Cultural and Traditional Leaders 2024/25-2029-2030, therefore comes in a timely manner to provide a minimum package that guides and consolidates the efforts of all Cultural Institutions in Uganda to support their response towards accelerating the

interventions towards achieving the PFTI objectives for ending AIDS by 2030 in Uganda.

I therefore, commend Uganda AIDS Commission in collaboration with Ministry of Gender Labour and Social Development for spearheading the development of this very important guide. I also recognize the Cultural Leaders and Prime Ministers of the Chiefdoms and other stakeholders who provided ideas and inputs on how this guide will be used to engage the communities on HIV and AIDS in the country.

For God and my Country

Hon. Amongi Betty Ongom
Minister for Gender, Labor and Social Development

ACKNOWLEDGEMENTS

Uganda AIDS Commission takes this opportunity to recognize and appreciate H.E the President of Uganda, Cabinet, Parliament, the Development Partners, the Ministry of Gender Labour and Social Development that coordinates all Cultural Institutions in the country, all the Cultural and Traditional Leaders in Uganda, Uganda AIDS Commission Board, Management and staff at all levels for leading the fight against the HIV and AIDS epidemic.

The process of developing this HIV Action Plan for the Cultural Institutions and Traditional Leaders in Uganda was highly participatory drawing together key participants and key respondents from Cultural Institutions, Key Informants and stakeholders from Government and Civil Society Organizations coordinated by Uganda AIDS Commission. It was further made possible with financial and technical support from the Global Fund and Government of Uganda.

I take this opportunity to thank the Directorate of Partnerships team for leading the development of this document and all UAC staff for providing their invaluable input into the document. I further acknowledge the Self Coordinating Entity of Culture working with Kings, Cultural Leaders Association, Local Government staff, MDAs and others. Appreciation goes to the Technical Facilitator Dr Denis Muhangi who supported the process of development of this Action Plan.

I call upon all the Cultural and Traditional Leaders across the country to work together to achieve all the set targets and thereby contribute to the goal of ending AIDS by 2030 in Uganda.

Dr Nelson Musoba
Director General
Uganda AIDS Commission

ACRONYMS AND ABBREVIATIONS

ADPs	-	AIDS Development Partners
AGYW	-	Adolescent Girls and young Women
AHD	-	Advanced HIV Disease
ART	-	Anti-retroviral Therapy
BBC	-	Bring Back to Care
COTLA	-	Council of Traditional Leaders in Africa
CSO	-	Civil Society Organization
DACs	-	District AIDS Committees
DHO	-	District Health Officer
EID	-	Early Infant Diagnosis
EMTCT	-	Elimination of Mother to Child Transmission
GBV	-	Gender Based Violence
GOU	-	Government of Uganda
HTS	-	HIV Testing Services
IDP	-	Internally Displaced Persons
IEC	-	Information, Education and Communication
MGLSD	-	Ministry of Gender, Labour and Social Development
NCDs	-	Non-communicable Diseases
NGO	-	Non-Governmental Organization
NSP	-	National Strategic Plan for HIV/AIDS
OVC	-	Orphans and Vulnerable Children
PHPD	-	Positive Health, dignity, and Prevention
PLHIV	-	Persons Living with HIV
POC	-	Point of Care
PM	-	Partnership Mechanism
PrEP	-	Pre-exposure Prophylaxis
PWDs	-	Persons with Disabilities
PWID	-	People who inject drugs
SBC	-	Social Behaviour Change
SBCC	-	Social Behaviour Change Communication
SCE	-	Self-Coordinating Entity
SDGs	-	Sustainable Development Goals
SGBV	-	Sexual and Gender Based Violence
SMC	-	Safe Male Circumcision
SRH	-	Sexual and Reproductive Health
SRHR	-	Sexual and Reproductive Health and Rights
SWAROP	-	Sabiny Women Alternative Rites of Passage
SWOT	-	Strengths, Weaknesses, Opportunities and Threats
TB	-	Tuberculosis
TCMP	-	Traditional and Complimentary Medical Practitioners
UAC	-	Uganda AIDS Commission
UDHS	-	Uganda Demographic and Health Survey
UPHIA	-	Uganda Population-based HIV Impact Assessment
UCCM	-	Uganda Country Coordinating Mechanism
VCCM	-	Voluntary Medical Male Circumcision

TABLE OF CONTENTS

DEFINITION OF KEY TERMS

Anti-Retroviral Treatment (ART): Treatment with life-long antiretroviral (ARV) medicines that inhibit the ability of HIV to multiply in the body and markedly improved health, survivaland quality of lives of people living with HIV

Combination HIV Prevention: Refers to focused combination of different HIV prevention tools or approaches that cut across behavioural, biomedical and structural dimensions (either at the same time or in sequence) in order to offer high-impact packages of HIV prevention interventions to specific target groups. Combination prevention is based on the recognitionthat no single HIV prevention approach can act alone to stop the HIV epidemic.

Comprehensive knowledge of HIV: Persons able to recall having seen or heard aboutHIV and AIDS can name the 3 recommended behaviours of HIV prevention and reject 2 misconceptions about HIV transmission (UDHS 2011).

Culture: A system of shared beliefs, norms, values, customs, and behaviours that are traditionally upheld and practiced by a fairly large group of people in a particular society or organization, and are passed on from generation to generation.

Cultural Institution: For purposes of this action plan, a cultural institution is one that is recognized as such under the Institution of Traditional or Cultural Leaders' Act 2011. All other structures of a cultural nature including clan systems, associations and any other such groupings or affiliations will be referred to as traditional leadership structures.

Cultural/Traditional Leader: A king or similar traditional leader who derives allegiance from the fact of birth or descent in accordance with the customs, traditions, usage or consent of the people led by that traditional or cultural leader.

Denial: A refusal to accept something as true, serious or as demanding individual and /or collective action and focused attention

Discrimination: Refers to unjust or prejudicial treatment of different categories of people especially on the grounds of race, age, disability or gender/sex. It may also be exhibited against persons (known or suspected to be) living with HIV or suffering from AIDS.

Gender-Based Violence (GBV): Any act of violence vetted against a person because of theirgender that results in physical, sexual or psychological harm or suffering, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or privatelife. The forms of GBV are sexual, physical, emotional, psychological and socio-economic violence, harmful traditional practices and trafficking in persons.

Health Rights: The right to the enjoyment of the highest attainable standard of physical and mental health.

HIV Mainstreaming: This refers to the process by which sectors and institutions address the causes and effects of HIV and AIDS in an effective and sustained manner, both throughtheir usual work and within their workplaces.

Human Rights: These are indivisible, inalienable fundamental freedoms to which a person is inherently entitled simply because she or he is a human being. Human rights are conceivedas universal (applicable everywhere), egalitarian (the same for everyone), and interdependent recognized in both national and international law. Human

rights are based on shared values like dignity, fairness, equality, respect and independence. These values are defined and protected by law.

Key Populations: As defined in NSP, refers to people who are most likely to be exposed to HIV or to transmit HIV and whose engagement is critical to a successful HIV response i.e.they are key to the epidemic and key to the response. Uganda considers men who have sexwith men (MSM); sex workers; transgender people, people who inject drugs (PWID) and prisoners and other incarcerated people as the main key population groups.

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

Norms: *(see social norms)*

Priority Populations: Populations which by virtue of socio-demographic factors (age,gender, ethnicity, disability, income level, education attainment or grade level, marital status)or behavioural factors or health care coverage status or geography are at increased risk of HIV. In Uganda, they mainly include uniformed personnel, fisher folk and long-distance truck drivers; and refugees

Psychosocial Support: Refers to all actions and processes that enable people living with HIV, other HIV and AIDS affected persons including elderly, PWDs, OVC and their families orcommunities to cope with stressors in their own environment and to develop resilience andreach their full potential.

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

Social and Behavioural Change Communication: This is the strategic use of advocacy, communication and social mobilization to systematically facilitate and accelerate changein the underlying determinants of HIV risk, vulnerability and impact.

Social norms: Social norms are the perceived informal, mostly unwritten, rules that define acceptable and appropriate actions within a given group or community, thus guiding human behaviour. Social norms are learned and accepted from an early age, and held in place by social sanctions ('punishments') for non-adherence to the norm and social benefits ('rewards') for adherence.

Social Support: This 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 access to education/information/literacy

Stigma: Refers to a dynamic process of devaluation that significantly discredits an individual in the eyes of others. It refers to attitudes of practices that define an individual's status asdiscreditable or unworthy within particular cultures or settings.

Traditional Leadership Structures: Systems or procedures of governance recognized, utilized or practiced by a group of people based on customary or traditional sources of authority such as clan, tribal or ancestral/ hereditary authority.

Traditional Leader: *(See Cultural leader)*

Traditions: Long-established customs or beliefs that have been passed on from one generation to another.

Vulnerable Populations: Groups of people exposed to a high-risk of HIV infection or greatereffects of HIV due to their lifestyle, low incomes, and living/working environments. They include OVC, PWDs, migrant populations, mining workers; persons aged 50+ years, and other mobile men and women.

EXECUTIVE SUMMARY

This Action Plan for Cultural Institutions and Traditional Leadership Structures covers the period 2024/25 to 2029/30 and seeks to contribute to Uganda's HIV response towards the goal of eliminating AIDS as a public health threat by 2030. The Action Plan was developed through a participatory and consultative process involving cultural institutions from different parts of Uganda, as well as other stakeholders in Uganda's HIV response at national and local levels. The Action Plan was formulated in the context of existing legal, policy, planning and implementation frameworks including the Global HIV/AIDS Strategy 2021-2026, the National HIV and AIDS Strategic Plan (NSP) 2020/21 – 2024/25, the Uganda HIV Prevention Roadmap (UAC 2018), The Institution of Traditional or Cultural Leaders Act 2011, and the National Culture Policy 2006 among others.

The Goal of the Action Plan is "**To ensure a coordinated, sustained and meaningful contribution to the multi-sectoral HIV response by cultural institutions and traditional leadership structures to end AIDS as a public health threat by 2030 in Uganda".**

The specific objectives of the Action Plan are:

- To enhance access to evidence-informed, culturally appropriate HIV and TB stigma reduction and HIV prevention messages by all age groups in all communities by 2030,
- To promote the availability, accessibility of and demand for HIV/AIDS care and treatment services and for related services including SGBV, SRH, ART Adherence, and positive living for PLHIV,
- To promote access to social support and protection services for vulnerable groups, promote social and economic empowerment to reduce vulnerability to HIV, and mitigate the impacts of HIV and AIDS,
- To build the capacity of the cultural and traditional leaders to implement the National HIV Action Plan for Cultural Institutions and Traditional Leadership Structures 2024/25 – 2029/30 for a consolidated, coordinated and sustained HIV response.
- To strengthen advocacy by cultural and traditional leaders against social-cultural beliefs and practices, and structural barriers that propagate the spread of HIV and delay the ending of AIDS.

The Action Plan leverages the strengths, energies and resources of cultural institutions in the multi-sectoral response to HIV. In particular, the Action Plan seeks to address the social-cultural drivers of the HIV epidemic, in recognition of the fact that biomedical interventions alone cannot reverse or tame the tide of the epidemic.

Cultural institutions and traditional leadership structures coordinated under their Self-Coordinating Entity (SCE) of cultural institutions are well positioned to play a key role in the response to HIV/AIDS, as they are the custodians of culture, they wield a lot of influence on people's beliefs and behaviours, and they have great potential to leverage their positions to inculcate desired norms and behaviours in the context of HIV prevention, and to discourage undesired ones. They can guide their communities to redefine existing social norms such as harmful patriarchal practices in favor of more progressive and protective ones. The Action Plan is therefore to be implemented through cultural institutions and their structures at different levels, including the Uganda Kings and Cultural Leaders Forum, the Prime Ministers' Forum, the Elders' Forums, the Clan leaders, and other structures including those in areas of the country with no formally recognized cultural institutions. The apex institutions that bring different cultural institutions together, such as the Council of Traditional Leaders in Africa, Uganda Chapter (COTLA), Uganda Kings and Cultural Leaders Forum, the Prime Ministers' Forum are expected to spearhead the implementation of the Action plan.

The Action Plan outlines a minimum package of services and interventions to be delivered by cultural institutions. These are grouped in accordance with the thematic areas of the NSP, namely, prevention, care and treatment, social support and protection, and systems strengthening. The Action Plan further includes an implementation framework that outlines the strategies, activities, expected outputs and targets for each activity.

The key strategies outlined are grouped under the thematic areas of the NSP, and include, under Prevention: (a) IEC/SBC whose cornerstone is integrating HIV prevention and stigma reduction messages in all cultural events; (b) sexuality education for adolescents and young people, (c) social norm and mindset transformation, (d) parental modelling and promotion of positive masculinity, (e) by-laws, (f) royal pronouncements, (g) HIV prevention services, and (h) stigma reduction interventions; Under Care and Treatment: (a) treatment literacy, (b) nutrition literacy, (c) medical camps, (d) integration on non-communicable diseases, (e) referral and linkage; under Social Support and Protection: (a) household income and food enhancement, (b) counselling and psycho-social support; Under Systems Strengthening: (a) organizational capacity assessments, (b) training of cultural leaders, (c) Revive and strengthen traditional conflict resolution mechanisms, (d) coordination, and (e) budget allocation. There is also a cross-cutting strategy on advocacy. The actors to be involved in the implementation and the time schedule are also provided.

Finally, the Action Plan proposes coordination and monitoring modalities, with leadership being provided by Uganda AIDS Commission through the Cultural Institutions Self Coordinating Entity, in collaboration with the Department of Culture at the Ministry of Gender, Labour and Social Development. Other key actors in the coordination consist of the Council of Traditional Leaders in Africa, Uganda Chapter (COTLA), with its secretariat at the Ministry of Gender and Social Development and the Prime Ministers Forum. At local government level, cultural institutions and leaders should work closely with established government structures at district and sub-county levels.

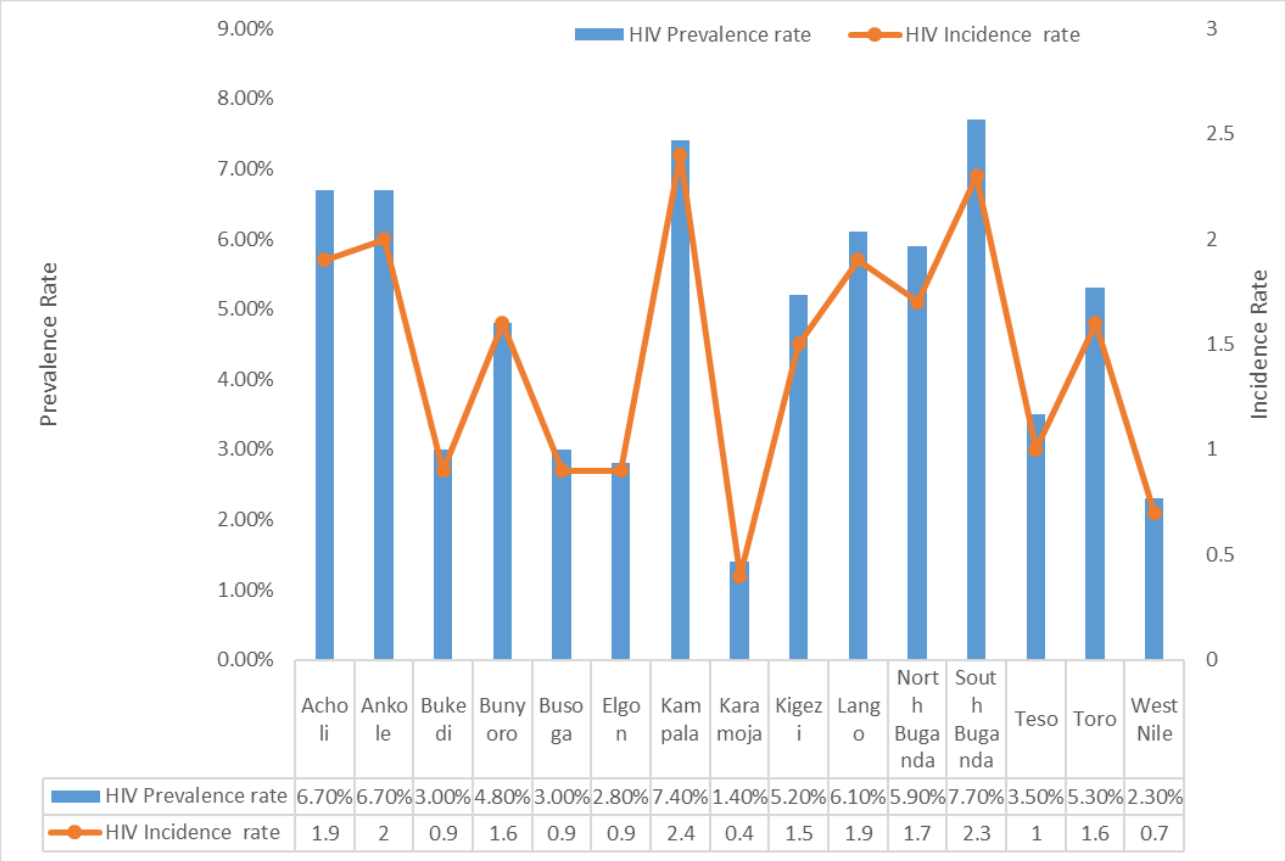
Cultural institutions and traditional leadership structures are urged to use this Action Plan in the following ways: (i) as a guiding framework in their response to HIV, (ii) to fundraise for resources to take action on HIV, and (iii) as an accountability framework to demand for results from the respective actors.

1.0 INRODUCTION

1.1 Background

Uganda has made tremendous strides in the fight against HIV/AIDS since the first case was discovered in the early 1980s. The Government of Uganda is now committed to the goal of ending AIDS as a Public Health threat by 2030. The country's success is most demonstrated in the reduction of the adult HIV prevalence from about 18% in the early 1990s to below 6% in the last few years. Recent Ministry of Health (MoH) HIV estimates for 2023 show that HIV prevalence in Uganda stands at 5.1% among adults 15-64 years (6.6% for females and 3.6% for males). The new infections stands at 38,000, while the number of people living with HIV is 1,492,407. Despite this tremendous success, levels of HIV prevalence are still unacceptably high, and the potential for the epidemic to continue to impact various sectors of the economy and various gender and age groups is not in doubt. Recent estimates for 2023 show that up to 70% of the new infections were among young people specifically adolescent girls.

There are wide variations by region with the lowest prevalence of 1.4% recorded in Karamoja region and the highest of 7.7% recorded in Central 1 region (South Buganda). Other regions with high prevalence rates include Kampala (7.4%), Acholi (6.7%), Ankole (6.7%), and Lango (6.1%) as shown in Figure 1 below (Ministry of Health 2023 HIV Estimates). The prevalence by district shows that HIV is highly concentrated in urban areas with Fort Portal City in the Rwenzori Mid-Western with the highest prevalence at 14.1% and Nabilatuk in North East Karamoja sub-region with the lowest at 0.5%. There is therefore still a great need to strengthen the country's efforts to address HIV/AIDS if the goal of ending AIDS as a public health threat by 2030 is to be achieved.



	Acholi	Ankole	Bukedi	Bunyoro	Busoga	Elgon	Kampala	Karamoja	Kigezi	Lango	North Buganda	South Buganda	Teso	Toro	West Nile
HIV Prevalence rate	6.70%	6.70%	3.00%	4.80%	3.00%	2.80%	7.40%	1.40%	5.20%	6.10%	5.90%	7.70%	3.50%	5.30%	2.30%
HIV Incidence rate	1.9	2	0.9	1.6	0.9	0.9	2.4	0.4	1.5	1.9	1.7	2.3	1	1.6	0.7

Figure 1: HIV prevalence and Incidence rates by region – 2023 (MoH estimates).

The successes pointed to above were largely an outcome of the multi-sectoral response approach adopted by the Government of Uganda (GoU) through the coordination of the Uganda AIDS Commission (UAC). UAC established the Uganda HIV/AIDS Partnership Mechanism (PM) to bring together several constituencies working in the area of HIV and AIDS at different levels in the country. The Partnership Mechanism consists of Self-Coordinating Entities (SCEs), which are clusters of stakeholders that represent specific constituencies in HIV and AIDS. Currently, there are twelve SCEs, namely: (i) Civil Society Organizations [CSOs] (includes National Organizations, International Organizations and Young People), (ii) Cultural Institutions, (iii) Faith Based Organizations, (iv) People Living with HIV (PLHIV), (v) Media, (vi) Private Sector, (vii) Parliament, (viii) Line Ministries, (ix) Decentralized Response, (x) Research, Academia and Scientists (RASP), (xi) the Uganda Country Coordinating Mechanism of the Global Fund (UCCM), and (xii) the AIDS Development Partners (ADPs).

1.2 Rationale for the Action Plan

While Uganda has made tremendous progress in addressing the spread of HIV and managing its impacts, many gaps remain. For instance, while almost every adolescent and adult in Uganda has heard about HIV and AIDS, levels of comprehensive knowledge remain sub-optimal. In addition, levels of stigma towards PLHIV both in community and institutional settings remain high 24% external and 34% internal stigmarespectively[1]. Persistent stigma and discrimination contributes to low HIV testing, low HIV status disclosure, low ART utilization and adherence, poor linkage to treatment and care; poor retention in care,and low levels of viral suppression in Uganda. Incidents of HIV-related GBV and violations of human rights also continue. In addition, structural barriers and unequal gender norms continue to perpetuate the spread of HIV and poor responses to it.

Cultural and traditional leaders and institutions coordinated under their SCE of cultural institutions are well positioned to play a key role in the response to HIV/AIDS. Cultural institutions are the custodians of culture and all the associated beliefs, norms, values and practices that individuals, families and communities subscribe to. Cultural and traditional leaders wield a lot of influence on people's beliefs and behaviours. They have regular platforms – during funerals, traditional marriage ceremonies and weddings, sports events, cultural events – to talk to large audiences. Others have family fireplace gatherings such as *Ekeno* in Karamoja and youth retreats such as *Ekisaakaate kya Nnabagereka* in Buganda and *Ekigangu kya Busoga wang o (Acholi) /ka - oi in Alur, embale (Rwenzururu), Isaazi (Batooro), Langa (Lugbara), Kitumiko (Bwamba) and Eki kome (Bakiga and Banyankole) among others*, where elders talk to young people about all sorts of topics ranging from their family history to life skills and matters of reproductive health. They have the potential to inculcate desired norms and behaviours in the context of HIV prevention, and to discourage undesired ones. They can leverage all the above attributes and their leadership positions to drive the HIV response. As such, there is a critical need to systematically define their role and clarify how they would perform that role. The proposed Action Plan seeks to contribute to this endeavor.

The cultural institutions' response to HIV constitutes one of the arms of the multi-sectoral approach, and the combination HIV prevention approach. The cultural response in particular addresses the social-cultural drivers of HIV, in recognition that biomedical interventions alone are not adequate to reverse the trend of the epidemic.

The Action Plan is also a tool and an opportunity to accelerate the shift from a centralized to a decentralized response in line with the National HIV Prevention Roadmap (UAC 2018). The Action Plan is an important tool to harness the contribution of cultural institutions to the NSP 2020/21 – 2024/25.

1 NAFOPHANU, 2019; The PLHIV Stigma Index, Country Assessment, Uganda

Cultural institutions and traditional leaders are expected to use this action plan to direct and guide their efforts to address the challenge of HIV from a cultural context; mobilize their members and subjects to participate in and support HIV prevention and mitigation efforts, adopt recommended safer behaviors and halt HIV-related stigma and discrimination; mobilize resources for HIV interventions; rally their networks and partners to support their HIV response; and provide accountability for their actions in the national HIV response.

1.3 Target Groups/Audiences for the Action Plan

The Action Plan for Cultural Institutions and Traditional Leadership Structures' response to HIV is to be implemented by cultural institutions, leaders and communities. The cultural institutions include those formally recognized by GoU as well as informal leaders that exist in areas without established kingdoms such as Ankole and Kigezi.

2.0 PROCESS AND METHODOLOGY FOR DEVELOPING THE ACTION PLAN

2.1 Overall Approach

The development of the HIV Action Plan for Cultural Institutions and Traditional Leadership Structures was undertaken through a participatory and consultative process that involved relevant members and stakeholders in the HIV response. The process entailed a number of phases as shown in Figure 1 below:

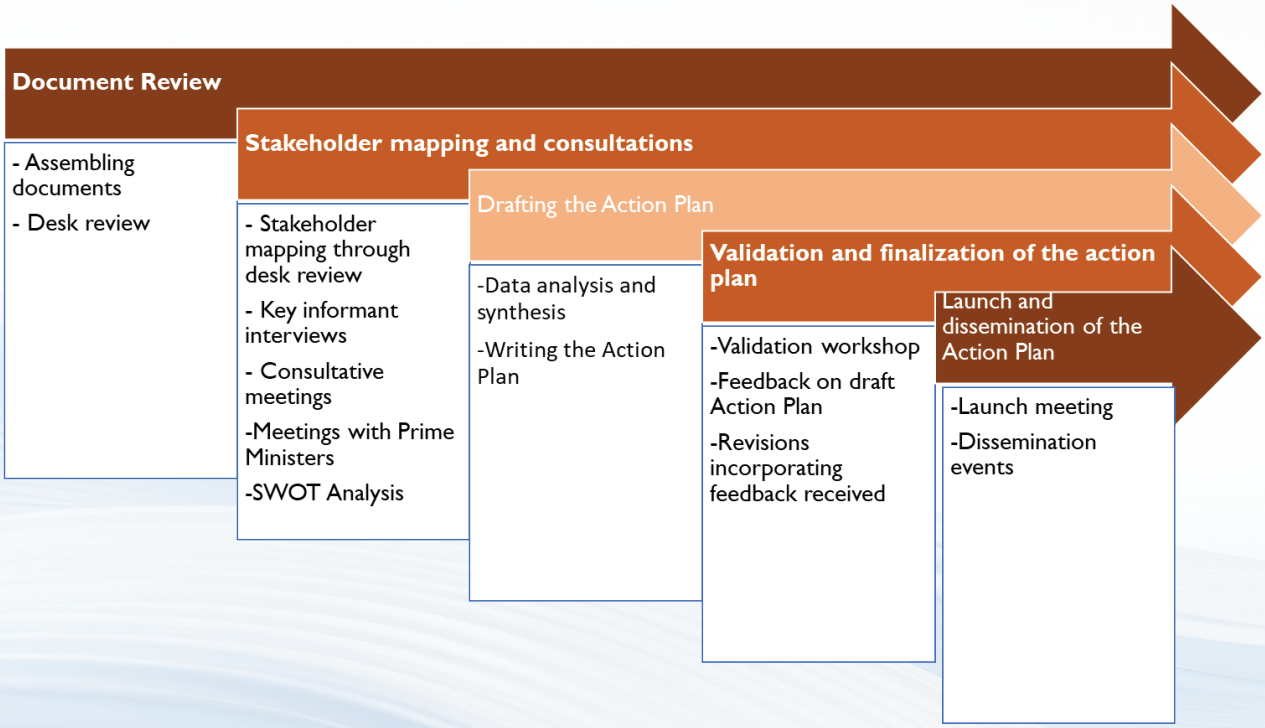


Figure 1: Phases in the Development of the Action Plan

2.2 Review of Documents

An extensive review of policy and programme documents was undertaken to provide the context for this Action Plan. These included the HIV policy documents, strategic plans and reports of recent surveys and other studies. They also include any previous documents relating to culture and HIV, and to the work of cultural institutions. Some of the documents reviewed include: The Constitution of the Republic of Uganda (1995), The Institution of Traditional or Cultural Leaders Act 2011, The Uganda AIDS Commission Act, 1992, The HIV and AIDS Prevention and Control Act 2014, The National HIV and AIDS Strategic Plan 2020/21-2024/25, The National HIV and AIDS Monitoring and Evaluation Plan 2020/21-2024/25, The National HIV and AIDS Priority Action Plan (NPAP) 2020/21-2022/23, The Presidential Fast Track Hand book, 2017, The National HIV Prevention Road Map 2020, The National Action Plan on Women, Girls, Gender Equality and HIV&AIDS 2016/17 -2020/21, The National Culture Policy (2011) The Anti-stigma Policy (2018), The Uganda Gender Policy 2007, The Stigma Index report, 2019, The Uganda Population-based HIV Impact Assessment (UPHIA) Report, UAC reports, and MGLSD reports.

2.3 Stakeholder meetings and engagements

Consultative/action planning meetings were held with representatives of cultural institutions from different regions of Uganda. The meetings helped to generate critical information on the contexts, existing needs, and conduct a SWOT analysis of the cultural institutions' response to HIV. The meetings also helped to reach consensus on the focus and content of the Action Plan. Stakeholder meetings and consultations included representatives from the cultural institutions of: Ker Kwaro Acholi, Ker Alur, Obukama bwa Bunyoro, Obukama bwa Tooro,

Obwakyabazinga bwa Busoga, Obwakamuswaga Wa Kooki, Obusinga bwa Rwenzururu, Obwakabaka bwa Buganda, Lango Chiefdom, Buruuli Chiefdom, Teso Chiefdom, Tieng Adhola Chiefdom, Inzu ya Masaba, and Karamoja Elders Association.

In areas of the country where there are no legally recognized kingdoms, the Action Plan targets other cultural/ traditional structures, even if informal, such as Elders' Forums, as well as government structures such as Community Based Services Departments.

2.4 Key informant Interviews

To supplement the consultative meetings, interviews were conducted with key stakeholders identified. Interviews focused on their appreciation of the HIV/AIDS epidermic in the country and in the regions, its social-cultural dimensions, the role of cultural institutions, and their previous, current and envisaged future roles in the response.

2.5 Drafting of the Action Plan

Following the above processes, a draft HIV Action Plan for Cultural Institutions and Traditional Leadership Structures was produced.

2.6 Validation of the Draft Action Plan and production of the final plan

The Draft Action Plan was subjected to a validation workshop attended by key stakeholders. The stakeholders deliberate on the draft Action Plan, filled gaps, and provided feedback for finalization of the Action Plan. Based on the outcomes of the validation workshop, a final version of the Action Plan was produced.

3.0 SITUATION ANALYSIS OF HIV AND AIDS IN UGANDA

3.1 General Trends and Patterns

The HIV/AIDS epidemic has had a devastating impact on the Ugandan population since the first case of HIV was identified in the early 1980s.

The prevalence by district shows that HIV is highly concentrated in urban areas with Fort Portal City in the Rwenzori Mid-Western with the highest prevalence at 14.1% and Nabilatuk in North East Karamoja sub-region with the lowest at 0.5%. The number of new HIV infections was 38,000 in 2023, while the number of AIDS-related deaths was 20,000 in 2023. New infections are higher in particular groups including key populations and adolescent girls and young women (AGYW). While the country has made good progress in addressing the epidemic, some of the indicators are not showing good progress. New infections due to mother-to-child transmission seem to have stagnated around 5%. Data also show an increase in the prevalence of multiple sexual partnerships among both male and females. The percentage of women who experience sexual and gender based violence is at 11%, way above the NSP target of 5%. Meanwhile the percentage of women and men who experience physical gender based violence from intimate partners is 45% and that for sexual gender based violence is 36%, way above the national targets of 11% and 8% respectively.

Uganda is on course to achieve the NSP and UNAIDS 95-95-95 targets of ending AIDS as a public health threat by 2030. By the end of 2023, Uganda had achieved 92-90-94 performance against the 95-95-95 targets. This means that 92% of the 1.4 million people living with HIV were aware of their HIV status; 90% of whom were on ART; and 94% of those on ART were virally suppressed. ART retention and adherence rates (73% and 74% respectively) were still lower than the NSP targets of 95% and 100% respectively.

Key remaining challenges include gender inequalities and structural barriers which hinder access to HIV prevention, care and treatment services; sub-optimal services for adolescent girls and young women; persistence of stigma and discrimination against PLHIV; persistence of SGBV and poor handling of identified and reported cases; limited capacity building for multi-sectoral actors; and inadequate mobilization of non-state actors to contribute to the response.

3.2 Culture and HIV Risks and Impacts

Culture consists of a set of shared beliefs, values, traditions and behavours practiced by a fairly large group of people passed on from generation to generation. Culture has for a long time now been known to be an underlying influence of social and sexual behaviours, and ultimately on sexual risk. The influence of culture on social-cultural behaviours, sexual behaviours and HIV risk manifests in different ways across different cultural contexts in Uganda.

Widow inheritance - In many Ugandan cultures such as among the Acholi[2], a practice of widow inheritance has traditionally existed and persists to date[3], despite the risk for HIV transmission associated with it. In such cultures, when a woman is married, it is believed that she is not just married to an individual man, the husband, but she is married into a family or a clan. Moreover, it is the family that often will have raised the resources to marry her in form of bride price (Amone 2021). The children born to this woman also belong to family and not to the couple. In the event that the husband of this woman dies, a brother to the dead husband inherits the woman as a wife, so that she remains within the family. This was also meant to both ensure that the woman and the children have someone to offer them support (Amone 2021). In some cases, inheritance of widows is also a cover up to take over the dead man's property.

2 Amone, 2021
3 Mujuzi, 2012

It should be noted that widow inheritance often happens even against the woman's free will. If a woman refuses to be taken over by her in-laws she risks being chased from the home and disowned of all her husband's property. The practice also exists despite the provisions of the Constitution of Uganda and international human rights instruments that Uganda has ratified[4] which provide that marriage between individuals should be out of free will by both parties. In a few cases, widows may also strategically seek to marry their in-laws to secure their stay in the family. For instance, a study by Asiimwe and Crankshaw (2011) shows that in case the widow has no sons, she would 'because of her insecure position in the family, ... get married to her brother in-law in order to continue having user rights to the home'[5]. In the context of HIV, the practice of marrying widows carries a great risk of HIV transmission in case the dead husband was infected with HIV or indeed died of an AIDS related illness. Moreover, such inheritance happens without undertaking an HIV test by either the inherited woman, the man who takes her over or both. The practice also violates the rights of women and undermines their dignity. While many campaigns have been going on to discourage the practice of widow inheritance, it persists to date.

Wife sharing - A related cultural practice is that of wife sharing, documented to be a practice dating from many years ago among tribes in South-Western Uganda.[6] In some Ugandan cultures, men who are from the same family were traditionally free to have sexual relations with a woman married to their brothers, since it was believed that a woman is married to the family not to the individual.[7] In some cases, a practice exists where a father of the boy (father-in-law to the bride) has sexual relations with a newly married bride, under the claim that he wants to check "where the cows (that were used to pay bride price) went" – meaning to check it the payment was worthwhile. In other cases, young women were allowed sexual access to the wives of their older brothers[7]. Such practices puts the woman, the husband and the brothers in law and father in-law and their wives in a very high risk sexual network. If any of the people in the network is infected with HIV, it can easily spread to other people in the network. Doyle (2012) actually notes that even in the past centuries, men who practiced wife sharing were often infected with sexually transmitted infections as a result of these sexual exchanges. While such practices have reduced in prevalence, they are believed to be still existent.

Polygamy - Another common practice in Uganda is polygamy, with between 6 and 11% of households in Uganda estimated to be polygamous.[8] Polygamy exists when a man is married to more than one wife. Polygamy practically exists in all cultures in Uganda. Marriage is a recognised risk factor for HIV transmission (Johnson-Peretz, 2024), and polygamy may increase the risk of HIV infection in a marital setting. Some studies have found that men in polygamous relationships have triple the rates of HIV than men in monogamous marriages, while women in polygamous marriages have twice the rate of HIV compared to their monogamous counterparts.[9] Other studies have also associated polygamy with a higher risk of HIV infection[10]. Polygamy means that there is a sexual network of more than two people. Moreover, in a polygamous relationship, it may be harder to ensure mutual faithfulness. Others[11] have reported that women in polygamous relationships diagnosed with HIV are less likely to disclose their HIV status. Clearly therefore, the cultural practice of polygamy has implications for addressing HIV infection and management and needs to be tacked from a cultural perspective.

Early and forced marriages for girls – Early marriage is highly prevalent in Uganda, despite the legal age for marriage being 18 years. UBOS data from 2011 shows that over a third (35%) of the girls who drop out of school do

4 Article 16 (1) (b) of the Convention on the Elimination of all forms of Discrimination against Women
5 Asiimwe and Crankshaw, 2011:8
6 Roscoe, 1907
7 Doyle, 2012
8 Johnson-Peretz, 2024
9 Magadi et al, 2021
10 Nyathikazi, 2013
11 Bulterys, 2021

so because of marriage. Over 15% of ever-married women aged 20-49 are married by the age of 15 and nearly half (49%) by the age of 18[12]. Globally, Uganda was at one time ranked 16th among 25 countries with the highest rates of early marriage, with nearly half (46%) of all girls marrying before the age of 18, and more than 1 out of 10 (12%) before the age of 15.[13] These levels of early marriage are partly a results of cultural beliefs in many Ugandan cultures that girls are old enough for marriage as soon as they hit puberty and grow breasts. Parents also tend to marry off their daughters early in order to get cows or other forms of bride-price that come from giving away a girl in marriage. Teenage pregnancy rates are also high, at 24% nationwide. In Karamoja region, early marriage takes the form of courtship rape, by which young men of warrior age (adolescence and young adulthood) rape girls aged between 10 and 12 years as a way of 'securing' them for marriage.[14] Early marriage exposes girls to the risk of HIV infection as they are in most cases married off to older, dominant men with greater sexual exposure, and yet the girls have low bargaining and decision-making power on sexual matters[15]. Girls married off early are also likely to experience other sexual and reproductive challenges such as miscarriages, fistula and obstructed labour. Most of the early marriages are not out of the girls' free will, but are forced by parents and caregivers. Forced marriages have been reported in most regions of Uganda, with many adolescent girls being subjected to marriage at an early age, in marriages arranged by parents (Bantebya et al, 2014). Besides the desire for bride-wealth, parents often justify early marriage of daughters as a means of protecting them from premarital sex and pregnancy in order to keep the family's dignity. Others find it acceptable to marry off their young girls due to low value placed on the education of girls. It ought to be noted that in legal terms, early marriage (i.e for a girl below the age of 18) constitutes defilement, although its rarely interpreted as such.

Beliefs and norms about sexuality – In some cultures, it is believed that a woman is not supposed to refuse the sexual advances of a man. In other words, men are entitled to have sexual relations with any woman they admire. Such beliefs no doubt put women in an inferior position and takes away their right to self-determination and choice of a sexual partner. It also means that women are not in a position to make decisions necessary to protect themselves from risks of HIV infection.

Masculinity, poor male health seeking behaviour and low male involvement in health – Men are generally recorded to have poor health seeking behaviour, including low affinity to test for HIV. Men are also more likely to be less involved in the health lives of their wives and children, such as antenatal care and child health seeking, with the result that they miss out on essential health information and services that would be accessed upon visits to health centres. These behaviours tend to be related to men's notions of masculinity, rooted in their cultural upbringing. Several studies have reported findings which indicate that a sense of masculinity amplifies men's tendency to engage in risky sexual behaviour, and yet affects their health seeking behaviour. Equally, men's masculinity tendencies rooted in their culture may affect their ability to disclose their HIV status[16]. Men may also shy away from couple testing in order not to expose their extra-marital relationships.[17,18] Masculinity influences also apply to boys. In many cultures, boys are expected to show that they are growing into men if they chase after girls and show indications that they have started sexual activity. It is little surprising therefore that first age at sexual debut is as low as 15 years[19].

12 UBOS, 2012.
13 World Vision, 2013
14 Crawford and Kasiko 2016
15 Bantebya et al, 2014
16 Mburu et al, 2014
17 Siu et al, 2014
18 Sileo et al, 2018
19 Bukenya et al, 2020

Relatedly, many cultures subjugate women in ways that limit their access to HIV related services and constrain their ability to make decisions that can protect them. In many Ugandan cultures for instance, a woman who wishes to seek or utilize medical services is expected to first get permission from her husband.

Practices surrounding initiation ceremonies – Some practices around cultural initiation ceremonies such as male circumcision among the Bamasaaba, and *Asapan* among the Karamojong, some of which are reported to encourage sexual experimentation and promiscuity. Among the Bamasaaba of Eastern Uganda, it is reported that recently circumcised boys are encouraged to have sexual intercourse with an older woman as part of the initiation. Such practices carry the risk of spreading HIV. Yet in other cases there have been reports of some cultural groupings refusing to adopt male medical circumcision in preference for their traditional forms of male circumcision.

Last funeral rites and burial ceremonies – In some cultures, burial ceremonies and last funeral rites are characterised by binge alcohol drinking, dancing and celebration through the night. Amidst all this, casual sexual activity takes place, much of it unprotected. Several writers have noted that traditionally, in many Ugandan cultures, funerals lasted several days and sexual activity among non-relatives often happened in the belief that they would be able to bear children to replace the dead (Ntozi and Nakayiwa 1999, Mukiza-Gapere and Ntozi, 1995). While the extent of this practice may have reduced, funerals and last funeral rites are still associated with alcohol drinking, dancing and other festivities, that sexual encounters during these festivities cannot be ruled out.

Alcohol consumption – In many cultures, alcohol is a cultural drink, associated with various cultural events and practices. It is taken at ceremonies, funerals, and as a way of life. With excessive alcohol consumptions comes other ills such as domestic violence, promiscuity and other undesired behaviours. Some studies have found a strong association between a history of alcohol consumption and sero-positivity.[20] In addition, alcohol consumption has been identified as a barrier to ART adherence.[21] Other studies have shown that alcohol consumption is generally accepted in many cultures, without due regard to its negative consequences.[22]

Sexual and Gender Based Violence – Some cultures have traditionally normalized sexual and gender based violence, while others actively promote it. In some cultures, for instance, a woman is not supposed to refuse sex to a husband under whatever circumstances. This means that a woman may not refuse sex to a husband even if she suspects or knows that he has had extra-marital relations and without protection or an HIV test. In many Ugandan communities, under-age marriage, though a form of violence is normalized.[23] In other cultures, wife beating by men is encouraged and sometimes taken as a sign of love for the woman[24]. In many other cases, wife beating is justified and condoned if a wife is believed to have been sexually unfaithful to the husband, or disobedient, failed to take care of children, went out of home without the husband's permission, burned food or argued with the partner.[25] Overall such violence condoning practices put women in an inferior position, making them less able to negotiate for safer sex in a marital relationship.

A qualitative survey report on violence conducted in Uganda by UBOS (2020) confirms that violence against women is sustained, produced and reproduced within unequal gender relations[26]. The report adds that violence

20 Mbulaiteye et al, 2000.
21 Sileo et al, 2019
22 Ssebunnya et al, 2019
23 Bukuluki et al, 2013
24 Crawford S and Kasiko M 2016
25 UBOS, 2020
26 UBOS, 2020

is used by men to control women's sexual behaviour and is perpetuated by gender norms rooted in culture. Women survivors of violence live a state of constant fear and insecurity. Gendered expectations on women are drawn on to rationalize and justify men's violence. In such a complex system that sustains and reproduces violence, women have limited means to protect themselves from HIV or seek appropriate care and treatment if they have HIV. The report concludes that women's experience of violence has negative impacts on women's wellbeing and ability to participate in development processes. This includes limiting their ability to protect themselves from HIV.

Traditional healing practices and birth attending – Many Ugandan cultures have for a long time undertaken practices such as male circumcision, female circumcision, incisions on the body to administer herbal treatments, removal of lower teeth, extraction of babies' false teeth, and home delivery with the assistance of traditional birth attendants (TBAs). It is also a common practice for people to simultaneously seek care from multiple sources, both traditional and modern, in what has come to be known as medical pluralism[27]. While some of these practices such as circumcision and incisive treatment have their benefits, they carry the risk of HIV transmission if unsterilized equipment is used, and if no protective wear is used. Traditional healing practices may also be used instead of proven medical treatment to manage HIV related infections and AIDS, with the risk of patients missing recommended care and treatment and instead degenerating their health further. Seeking care from traditional healers may also delay or interrupted care.[28] Yet such practices are deeply entrenched, and they persist despite many years of campaigns to reduce them.

Night Funeral fundraising: In some part of Uganda such Tororo and Busia, in Bukedi region, there is a common practice of holding funeral fundraising events (also known as disco matanga) for several nights. The events are meant to help a bereaved family to raise resources to hold a descent funeral for deceased person. During these nights, alot of sexual activity takes place, including gang rape and other forms of sexual violence. The night fundraisings are also associated with alcohol consumption and marijuana smoking[29]. These events are also believed to be fueling teengae pregnancies, school drop out and HIV transmission.

Vulgar language and naming of Markets - Key informants also pointed to vulgar and obscene language used widely in public discourse and in particular in the naming of markets in many Ugandan communities with the effect that such naming tends to normalize risky sexual behaviours and thereby contribute to HIV transmission. Examples include in Acholi region, Northern Uganda such as *Mit Pa coo (the sweetness of men), Anyaka lokke (girl, turn this way (for sex), Wat bongo (open your dress (for sex), and Bong tiko (touch the beads (of a girl/woman);* and in Ankole, South West Uganda such as Kabanshwere (let them have me for sex), *Kabagarame (Let them lie facing up for sex), Bakazi mugahwe (women should lose all hope (in their husbands returning home).* Similar or related names are reported for markets in other part of Uganda.

27 Audet et al, 2015
28 Audet et al, 2015
29 https://www.monitor.co.ug/uganda/special-reports/busia-women-girls-dancing-their-way-into-sexul-abuse-4702158

4.0 THE GLOBAL AND NATIONAL RESPONSE TO HIV

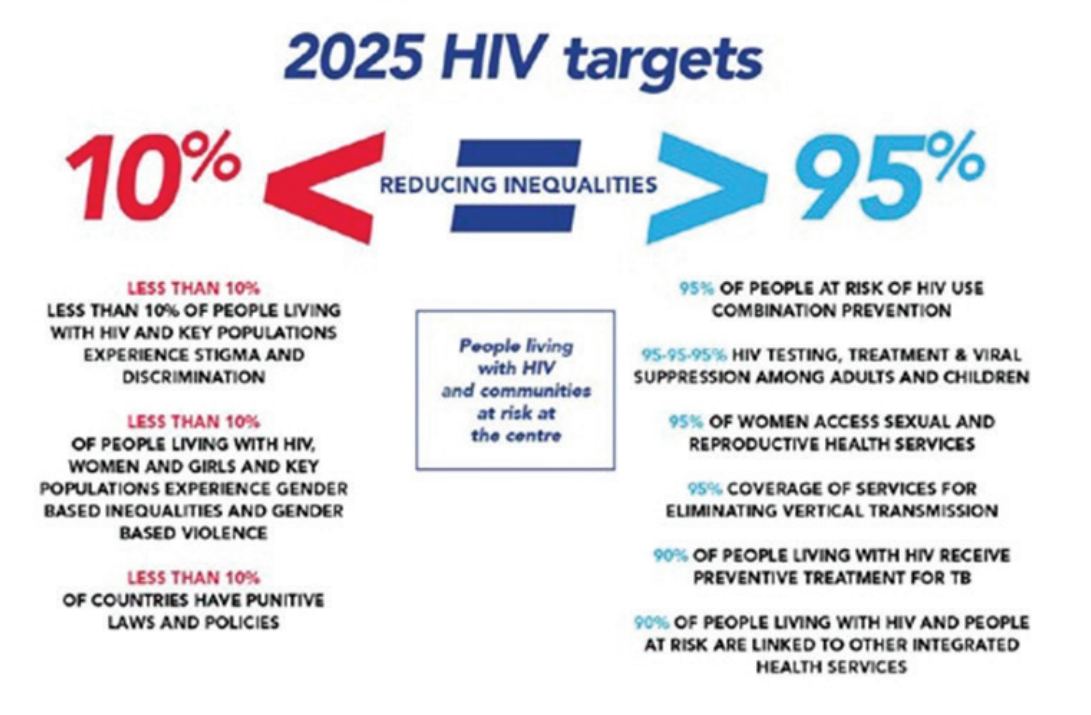
4.1 The Global Response

The global response to HIV is guided by the Global AIDS strategy 2021-2026, which aims at zero new HIV infections, zero AIDS-related deaths and zero discrimination to end AIDS as a public health threat by 2030.

The Global AIDS strategy is explicitly linked to 10 Sustainable Development Goals. These are SDG 1 No Poverty; SDG 2 Zero Hunger; SDG 3 Good Health and Well-Being;SDG 4 Quality Education; SDG 5 Gender Equality; SDG 8 Decent Work and Economic Growth; SDG 10 Reduced Inequalities; SDG 11 Sustainable Cities and Communities; SDG 16 Peace, Justice and Strong Institutions; and SDG 17 Partnerships for the Goals(The *Global AIDS Strategy 2021-2026; End Inequalities, End AIDS*).

The Global AIDS Strategy 2021-2026 uses an inequalities lens in an attempt to close the gaps that remain in ending AIDS as a public health threat by 2030. It does this by aiming to address inequalities that continue to drive the HIV epidemic. The Strategy sets ambitious targets as shown in the figure below.

Figure 1: Global AIDS Strategy 2021–2026 targets and commitments



Some of the inequalities pointed out by the Global Strategy such as stigma and discrimination, gender based violence, and punitive practices and laws are fueled by cultural factors, rooted in the beliefs, values, norms and practices. Cultural institutions and leaders therefore have a key role to play to address such inequalities, by for instance taking a lead in tackling harmful social-cultural norms that expose women and girls to HIV infection. Cultural institutions and leaders can also spearhead culturally relevant sexuality education for young people to protect them from HIV.

4.2 The National HIV Response

Uganda has been widely hailed for its early and firm response to HIV/AIDS. Uganda is widely credited for its success in reducing the adult HIV prevalence from 18% in 1992 to 6.2% in 2016 and 5.5% in 2020. During the past decade the national HIV response registered significant progress in reducing new HIV infections as well as AIDS-related morbidity and mortality in most population groups. These successes have been a result of multiple strategies and interventions implemented over the last four decades.

Following the identification of the first cases of HIV in the country in the early 1980s, Uganda has been actively implementing various efforts to address the epidemic. In order to ensure a concerted response, and recognizing that the HIV problem cut across all sectors, the Multi-sectoral Approach to the Control of AIDS was developed and adopted in 1992. The multi-sectoral approach to AIDS control in Uganda assigned individual and collective responsibility to all Ugandans to be actively involved in AIDS control activities. All sectors of government were required to mainstream HIV/AIDS control in their plans and programmes.

Early in the response, Uganda adopted what was termed the 'ABC' strategy to HIV prevention (A for **A**bstinence from premarital sex, B for **B**eing faithful to one marriage partner, and C for **C**ondom use for the high risk behaviour group or those could not use A or B). In absence of a cure for AIDS, the preventative strategy became the main thrust of the response.[30]

Political openness, support and leadership have as such been pointed out as key factors in Uganda's success in bringing down HIV prevalence rates. In a country where talking openly about sexual matters was traditionally a taboo (Labov, 2002; Kaleeba, 2004) and where AIDS has been associated with witchcraft by some and sexual promiscuity by others, overcoming stigma was essential to the overall success of prevention efforts. The Ugandan response has been characterized as one guided by high political commitment at various levels, openness about HIV/AIDS that enhanced behaviour change communication interventions, unprecedented support from international development partners, and action from sectors of government and civil society.

The HIV response in Uganda has progressed and incorporated new issues and challenges as they emerge. In recent years, we have witnessed particular focus on critical areas such as adolescent and young women (AGYW) programming, programming for key populations, adoption of new prevention technologies such as self-testing and PrEP, implementation of differentiated service delivery models, and a focus on addressing stigma and discrimination, among others.

The response to HIV and AIDS in Uganda is still constrained by a number of challenges including reduced funding, inefficiencies in services, complacency among the population, and a number of structural barriers to accessing services such as stigma and discrimination, gender inequalities, and harmful socio-cultural norms and practices.

The Government of Uganda is currently focusing on the goal of ending AIDS as a Public Health threat by 2030. Nevertheless, there is recognition that this goal cannot be achieved unless the structural barriers to accessing HIV-related services are addressed.

4.3 The Cultural and Traditional Leaders Response to HIV in Uganda

Based on the interviews and consultations conducted, cultural institutions in Uganda reveal the following characteristics in the context of the HIV response: The characteristics are both protective and enabling in some respects, while they are also harmful in others:

30 Muhangi, 2009

4.3.1 Protective and Enabling Attributes of the Cultural Institutions' s Response

Commitment to the HIV Response– Based on the consultations conducted, cultural leaders express/have commitment to support government programmes, and to address the spread of HIV and manage its effects in their communities.

They also recognise that as cultural leaders they can be effective agents in the implementation of government interventions aimed at the reduction of HIV prevalence.

Concern and Recognition of HIV – Cultural and traditional leaders recognize that HIV is a huge problem in their communities. Leaders identify HIV hotspots in their communities are able to explain the drivers of HIV, including commercial sex work, poverty and lack of meaningful livelihood sources in households, social-cultural norms, alcoholism, and economic exploitation by employers, etc. Others include new economic activities such as mining activities in the Karamoja region, and oil exploration activities in the Bunyoro region.

Protective Values, Norms and Practices – Cultural institutions hold sets of values, some of which may be supportive to the prevention of HIV. In Teso for instance, and in many other communities, virginity for girls before marriage is cherished. Similarly male circumcision in practiced in several cultural groupings, including among the Bakonzo and Bamba of Rwenzururu and the Bamasaba of Eastern Uganda.

Leadership Structures – Cultural institutions have structures right from the family unit, clans, upwards up to the King or cultural leader. At national levels, apex or coordinating structures exist, including the Prime Ministers' Forum and the Council of Traditional Leaders in Africa, Uganda Chapter (COTLA). COTLA is a pan-African movement of progressive traditional leaders, established in 2020 to create pathways through which traditional and cultural leaders can engage their communities more constructively to drive social transformation and eradicate negative cultural practices, customs and traditions. It was primarily formed to promote gender equality, end child marriages, end female genital mutilation and cutting (FGM/C), and address other harmful practices in Africa by 2031. Its secretariat is housed in the MGLSD. Most cultural institutions have a Minister for Health who plays a key role in all health related matters. Some cultural institutions such as in Teso have clan leaders' committees at parish and sub county levels, with representative for different interest groups such as youths, women and other groups. Some of these structures work closely with local government structures at district and sub-county levels.

Regular Platforms in form of Cultural Events – Cultural institutions hold different cultural events such as Kings' coronation anniversaries, royal birthday cerebrations, mentorship programmes such as Ekisaakaate kya Nnabagereka in Buganda, among others. They also have cultural ceremonies marking rites of passage (e.g. circumcision ceremonies among the Bamasaaba, Sabiny Women Alternative Rites of Passage [SWAROP]), pre-marital preparation, cultural galas, sports events and others where cultural leaders also pass on messages against HIV.

Mentorship for young people – In many cultural settings in Uganda, they traditionally has arrangements for mentoring young people. These include fire place sittings at night where elders would talk to young people about their culture, family, and any other issues. Examples include Ekigangu kya Busoga, wang o (Acholi) /ka - oi (Alur), embale (Rwenzururu), Isaazi (Batooro), Langa (Lugbara), Omurugo (Banyaro), Kitumiko (Bwamba) and Eki kome (Bakiga and Banyankole) among others.

HIV-related Interventions – Some of the cultural institutions are already undertaking programmes and interventions to prevent HIV or support those affected. Tooro has been educating cultural leaders to desist from being party to child marriage promotion. One of the evident successes of these efforts is the resumption of schooling for about 158 girls who had succumbed to early marriage during the lockdown, many of them having become mothers. We also promote sensitisation against contracting HIV among the girls.

Other interventions by different cultural institutions have included:

- Conducting radio talk shows
- Campaigns amongst lodge or hotel owners to combat commercial sex work
- Enhancement of household incomes to mitigate the vulnerability of the girl child
- Promoting *Omusiri gwa Kabaka* (Meaning the King's garden) in Buganda, by which every homestead must have a garden to ensure food and nutrition security.
- Involving and sensitizing all leaders from the household level upwards
- Equipping leaders with appropriate messages to disseminate to their various spheres of leadership
- Targeting parents and engaging them against alcohol consumption, GBV and early marriages
- Hold medical camps during key cultural events such as the King's birthday, coronation anniversary celebrations, rites of passage/initiation ceremonies and cultural galas.
- Referral and linkage for those who are HIV positive
- Documenting cultural practices, understanding them and devising measures of promoting adjustments in an attempt to reduce the spread of HIV
- Writing policy briefs to advocate against some cultural practices like polygamy and wife inheritance
- Pronouncements against some harmful cultural practices
- Promoting a mindset change about wife inheritance
- Providing customized messages
- Integration of HIV prevention in clan meetings and other cultural platforms
- Working hand in hand with district AIDs committees to have a cultural perspective of the fight against HIV spread.
- Supporting clans to develop bylaws on incest and other practices to reduce the spread of HIV
- Working with partners to deliver HIV related interventions
- Packaging of messages to ensure appropriate communication

On the other hand, the response of cultural institutions and traditional leadership structures also manifests several weaknesses, challenges and unfavorable attributes as outlined below;

4.3.2 Harmful Attributes, Challenges and Gaps in the Cultural Institutions' Response to HIV in Uganda

Weakening of Cultural Institutions – Cultural leaders decry/report that the weakening of their institutions has diluted their capacity to preserve cultural values and educate their communities. For Teso region, it was reported that the displacement of people during the civil wars of the 1980s into internally displaced people's (IDP) camps distorted the work of their cultural institution; when camps were put in place they were led by camp administrators not cultural leaders. Efforts are still on-going to revitalize the cultural institution.

Entrenched harmful social-cultural norms, traditions and practices – Some of the norms, traditions and practices that drive HIV, as well as those that perpetuate the associated ills such as SGBV and stigma are deeply entrenched. **These include traditions such as early marriage –** including courtship rape in Karamoja -, wife inheritance, and polygamy in many cultures, most of which are rooted in systems of patriarchy. In some cultures there is a belief that a woman cannot say no to a man who makes sexual advances to her. There are also traditional healing practices that involve cutting of the skin with the risk of transmitting infections. People have inherited such norms and practices from their forefathers and they have practiced them or seen them being practiced for many decades. Interviews with cultural leaders indicated that many of them find difficulties to convince people to keep away from such traditions and practices. Early/child marriages are widespread in all Ugandan communities. While cultural and traditional leaders are aware that marriage of individuals below the age of 18 is illegal, some cultural leaders turn a blind eye and allow such marriages to continue, or even preside over them.

Weak harmonization amidst Diversity - Uganda has several and diverse cultural institutions, with diverse norms, traditions and practices. This diversity implies that problems such as HIV are likely to be interpreted differently, and similarly, different response strategies are deployed. For instance, while some of the recommended HIV prevention methods such as safe male medical circumcision resonate with cultural practices in some areas such as in Bamasaaba and Rwenzururu, such practices are also alien in other communities such as among the Ateso. Diversity can be both a good attribute and a challenge. The spirit of this action plan is that cultural institutions and leaders should find unity in diversity, identify common areas where they can collaborate even as they maintain their cultural differences.

Weak coordination – Uganda has several and diverse cultural institutions, which have each been working individually to respond to the threat of HIV and its impacts. There has been weak coordination, resulting into scattered efforts and lack of a unified response. Weak coordination also means that available resources may not be deployed cost-effectively. Some of the activities implemented by cultural institutions in response to HIV, as well as some of their HIV messaging are not consistent with national, regional and global best practice for the HIV response. This partly contributes to persistent low comprehensive knowledge of HIV and AIDS; high levels of stigma and discrimination, as well as human rights violations.

Weak planning – Cultural institutions have been characterised by weak planning for their HIV responses. This has been attributed to lack of professional expertise, lack of financing and other forms of support.

Poor financing – Whereas cultural institutions have been making efforts to respond to HIV, they have been operating with limited resources and largely through the work of volunteers. Such resource constraints have limited the scope, reach and quality of their responses to HIV. It has also limited accountability for results.

Lack of technical expertise – Cultural institutions also lack the resources to hire technically competent personnel to run HIV-related programmes. While they can tap onto some volunteers that are technically qualified and experienced, these are usually only available for short term engagements.

In light of the above, a more detailed SWOT analysis was conducted with the representatives from cultural institutions, the results from which are presented below.

4.4 SWOT Analysis of Cultural and Traditional Leaders' Response to HIV in Uganda

Table 1: SWOT Analysis of Cultural and Traditional Leaders in Uganda in the Context of the HIV Response

Strengths	Weaknesses
• Cultural institutions are legally recognized framework by the national constitution and the state. • Availability of persons knowledgeable in HIV and AIDS like doctors who are in the cabinet e.g in Tooro, Adhola, Teso, Buganda • Community support and sodality, respect for elders, extended family system, traditional healing practices, • Cultural events and festivals e.g Empango in Tooro, and Imbalu in Bugisu. • Cultural norms and positive practices like marriage ceremonies, initiation • Existence of leadership structures: Kings and Queens, Parliaments e.g Orukurato in Tooro and Lukiiko in Buganda; and network of elabourate leadership structures at all levels • Availability of human resources e.g. cabinet and clan leaders • Existence of functional secretariats • Some cultural institutions have internal resource allocation to health care e.g Buganda. • Existence of already on- going health and HIV/AIDS initiatives supported by various partners • Recognition by and partnership with leading agencies, e.g. King of Tooro is UNAIDS Ambassador	• Inadequate knowledge of HIV and AIDs in some institutions like Bunyoro, Lugbara, Rwenzururu • Lack of updated and simplified information/data on HIV and AIDS in the regions • Risky socio-cultural norms and practices such as wife inheritance, FGM, polygamy and concurrent partnerships, rooted in patriarchy • Cultural norms that discourage open discussions about sexuality and HIV • Gender inequality and subjugation of women and girls • Reliance on unpaid volunteers for HIV related work • Weak secretariats • Lack of internal financing by majority of Cultural institutions
Opportunity	**Threats**
• Availability of partners that implement HIV and AIDS in the regions such as AIC, TASO Baylor, World Vision, RHU (some institutions have an MOU with these organizations. • Existence of radio stations –most institutions are given free airtime on radio • Multitude of CSOs and NGOs operating in all cultural institutions. • Good working relationship with ministries like ministry of MOH, Gender, UAC, and LGs through DHO's office • Support from the Central Government e.g. recently sixty millions announced by the government • Goodwill, recognition and support from donor agencies and other actors • Liberalisation of the economy, allowing some institutions to develop business opportunities; entry of new economic actors e.g. oil companies	• The partners and their program/ services are not sustainable; sometimes they are a one off. • Lack of regulatory framework for traditional and complementary medicine • Lack of a coordinated and harmonized approach and strategy towards HIV/AIDs and related issues • Cultural norms and values are being eroded, being eroded • Unregulated communication via social media

5.0 INSTITUTIONAL, LEGAL AND POLICY CONTEXT

This Action Plan is conceived within the context of the broader policy and strategic planning frameworks for HIV and AIDS prevention and control in Uganda, including the National HIV and AIDS Strategic Plan (NSP) 2020/21 – 2024/25, the National HIV Prevention Roadmap (UAC, 2018) and the Presidential Fast-Track Initiative on Ending AIDS as a Public Health Threat in Uganda by 2030 (PFTI), The Constitution of the Republic of Uganda, The Institution of Cultural and Traditional Leaders Act, 2011, The HIV Prevention and Control Act, 2015, The National Community Health Strategy 2022, The National Culture Policy 2006, among others.

5.1 The National HIV and AIDS Strategic Plan 2020/21 – 2024/25

This Action Plan for cultural institutions and traditional leadership structures is formulated within the context of the NSP for HIV and AIDS 2020/21 – 2024/25. The NSP 2020/2021–2024/2025 lays out strategies and actions to implement high-impact, evidence-informed interventions and innovations through programme optimization. The vision of NSP 2020/2021–2024/2025 is "a healthy and productive population free of HIV and AIDS and its effects." The overall goal is to "increase productivity, inclusiveness and wellbeing ofthe population through ending the AIDS epidemic by 2030." The NSP is to be implemented under four thematic areas, namely: (1)Prevention, (2) Care and Treatment, (3) Social Support and Protection, and (4) Systems Strengthening Gender and human rights issues are mainstreamed across the four thematic areas. The NSP was aligned to the Third National Development Plan (NDPIII) to ensure a coordinated and harmonized response in line with national development goals.

The NSP adopts a Prioritized Scale-up Scenario that envisions the rapid scale-up of a comprehensive set of interventions to the maximum feasible coverage. The identified critical interventions for accelerated impact include: HIV testing services, ART, condoms, especially male condoms, voluntary medical male circumcision (VMMC), elimination of mother-to-child HIV transmission (eMTCT), early infant diagnosis (EID), and programmes for key populations (KPs). The NSP also identifies social enabler programmes, such as social and behaviour change communication (SBCC), stigma and violence prevention, and interventions focusing on adolescent girls and young women (AGYW). The NSP also sets targets and outlines key interventions, which among others include those to be spearheaded by cultural institutions.

5.2 The National HIV Prevention Roadmap[31]

This Action Plan is also formulated within the context of the Roadmap for HIV Prevention, towards zero new infections by 2030 (UAC 2018). The road map responds to key challenges towards attaining zero new infections by 2030 and implementing the commitments to sustain the response. It acknowledges HIV as a development issue. To realize its goals, the National HIV Prevention Roadmap outlines three key strategic shifts in HIV programming, namely; (i) a shift from emergency vertical programmimg mode to multi-pronged approaches that target sources of new infections to achieve epidemic control quickly while gradually transitioning to long-term development programming through mainstreaming integration, systems strengthening and community empowerment, (ii) a shift from centralized programming approaches to a decentralized response that hinges on understanding the epidemic in the local context and prioritizing focus on location and the population groups that contribute to the majority of new infections in order to achieve epidemic control while strengthening HIV integration in local government development programming, (iii) a shift from intervention-specific programming to systems approaches to address vulnerability, risk, exposure and impact mitigation, in order to address individuals' needs holistically.

31 Ekisaakaate kya Nnabagereka is a biannual holiday mentorship and training camp spearheaded by the Queen (Nnabagereka) of Buganda Kingdom. It targets children and adolescents.

This action plan for cultural institutions and traditional leadership structures fits in well with the above mentioned shifts in programming, as it seeks to tap into the strengths of the cultural institutions and part of decentralized actors, and localize their responses to suit their local contexts, while at the same time maintaining harmony, alignment and coordination with the broad parametres of the national response.

5.3 The Third National Development Plan (NDP III)

Uganda has been implementing NDPIII which will expire in June 2025 and be replaced by NDPIV which is still under formulation. This action plan is aligned to the provisions of NDPIII seeking to contribute to its objective 4, which relates to improving population health, safety and management, and to the Human Capital Development programme Implementation and in particular the health-related objectives, expected outcomes, and targets. Relevant updates to the Action Plan can be made to align with NDPIV when it is finalized.

5.4 The Constitution of the Republic of Uganda, 1995 (As Amended)

The Constitution of the Republic of Uganda is the supreme law of the country. Chapter Four of the Constitution guarantees the rights and freedoms of all persons. The National Objectives and Directive Principles of State Policy (NODPSPs) in the Constitution include the right to social justice and economic development and oblige the State to ensure that "all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security...".[32] These services include HIV related services.

Under the NODPSPs, the Constitution has a set of objectives that include cultural objectives. It states that 'cultural and customary values which are consistent with fundamental rights and freedoms, human dignity, democracy, and with the Constitution may be developed and incorporated in aspects of Ugandan life'. More specifically, it states that the State shall 'promote and preserve those cultural values and practices which enhance the dignity and well-being of Ugandans'[33]. The Constitution also under Article 37 recognizes the right to of every Ugandan 'to belong to, enjoy, practice, maintain and promote any culture, cultural institution, language, tradition, , creed or religion in community with others'[34]. Under Article 33, the Constitution prohibits laws, cultures, customs or traditions that are against the dignity, welfare and interest of women or which undermine their status[35].

In addition, Chapter 16 (Article 246) of the Constitution provides for and recognizes the institution of traditional and cultural leaders.

5.5 The HIV Prevention and Control Act, 2014

The HIV Prevention and Control Act (2014) is one of the key laws providing for non-discrimination, equality, and provision of and access to HIV services for all. The HIV Prevention and Control Act (2014), puts the state under obligation to promote awareness of the rights of PLHIV; to promote and ensure non-discriminatory participation of PLHIV in HIV and AIDS government programmes; to provide care and support to PLHIV; and to provide adequate funding for HIV and AIDS programmes[36]

5.6 The Presidential Fast Track Initiative

The Presidential Fast Track Initiative to end AIDS as a public health threat by 2030 was launched in 2017. The

32 Constitution of the Republic of Uganda, Objective XIV (ii).
33 Constitution of the Republic of Uganda, Objective XXIV.
34 Constitution of the Republic of Uganda, Article 37
35 Constitution of the Republic of Uganda, Article 33
36 The HIV Prevention and Control Act, 2014, Section 24.

initiative was revised in 2020 with a Five Point Plan: (1) Engage men in HIV prevention to address infection among AGYW; (2) Accelerate the implementation of Test and Treat and attainment of 90-90-90 targets among men and young people; (3) Consolidate progress on EMTCT; (4) Ensure financial sustainability for the HIV response; and (5) Ensure institutional effectiveness for a well-coordinated multi-sectoral response.166 The President's Initiative message is targeted at men, youth, parents, and leaders, to involve men in prevention of EMTCT.[37]

5.7 The Institution of Traditional or Cultural Leaders Act, 2011

The Institution of Traditional or Cultural Leaders Act 2011 was put in place to operationalize article 246 of the Constitution which provides 1for the institution of traditional or cultural leaders. The Act also provides for the existence, operations and roles of traditional or cultural leaders in any parts of the country. Article 9 of the Act prescribes the role of a traditional or cultural leader and states that 'A traditional or cultural leader shall: (a) promote and preserve the cultural values, norms and practices which enhance the dignity and well-being of the people where he or she is recognized as such; and (b) promote the development, preservation and enrichment of all the people in the community where he or she is recognized as such'.[38] These roles can be broadly interpreted to include promoting HIV prevention and treatment services, as well as mobilizing communities and other actors to address HIV related issues. Under article 14, the Act prohibits a traditional or cultural leader from practicing any custom, culture, usage or tradition that detracts from the rights of any person as guaranteed under the Constitution or contravenes the Constitution or any other law[39]. This implies that whatever a traditional or cultural leader does, even in response to HIV and AIDS, must be in conformity with existing laws in the country.

5.8 The National Culture Policy 2006

The Uganda National Culture Policy recognizes that Uganda is endowed with rich and diverse cultures, with deeply embedded beliefs, values, norms and practices. The policy recognizes how these values, beliefs and practices have been subjected to multiple influences, and are under threat. The policy also recognizes that the rich cultural values, beliefs and practices in the country sometimes conflict with modern laws and recommended standards of behaviour. The policy outlines strategies for enhancing the integration of culture into national development efforts. Such strategies include advocacy for cultural dimension to development, capacity building of cultural institutions, research and documentation of cultural matters, collabouration with other sectors, and resource mobilization. The policy also outlines key priorities. One of the priorities is to promote cultural beliefs, traditions and values, and the key interventions under this priority area include, promoting the role of the family, promoting beliefs, values and traditions that preserve and enhance human dignity, among others. Such proposed interventions are critical for the prevention of HIV and mitigation of its impacts.

The policy also recognizes cultural and traditional institutions such as kingdoms, chiefdoms and clans as the custodians of culture, and the related aspects of identity, mutual protection, and collective action. Accordingly, the policy assigns them roles and responsibilities in promoting national development, including mobilizing resources, promoting intra-cultural exchanges, and collabourating with government and other actors to promote different aspects of culture.

5.9 The National Community Health Strategy 2022

This action plan is also aligned to the National Community Health Strategy (NCHS) formulated by GoU through the MoH in 2022. The mission of the NCHS is to ensure that health services are, among others aspects, culturally acceptable to the population through community participation. The NCHS also recognizes cultural factors such as cultural beliefs and practices as one set of determinants of health in Uganda. As such the Strategy identifies

37 Uganda AIDS Commission (UAC) (2020). The Presidential Fast-Track Initiative on Ending AIDS in Uganda: A Presidential Handbook—Revised Edition

38 The Institution of Traditional or Cultural Leaders Act, 2011, Article 9

39 The Institution of Traditional or Cultural Leaders Act, 2011, Article14

and recognizes cultural leaders and institutions among the key actors and structures to implement its provisions. Cultural leaders are among the various categories of community leaders to be empowered to take lead in making decisions about community health. They are expected to utilize the available platforms to support efforts geared towards achievement of health targets. The specific roles of community leaders including cultural leaders are listed to include: i) mobilization of communities to access and utilize health services, ii) creating awareness to enhance behaviour change, iii) supporting advocacy on identified community needs, and iv) participating in the development of by-laws and guidelines.

6.0 THE HIV ACTION PLAN FOR CULTURAL INSTITUTIONS AND TRADITIONAL LEADERSHIP STRUCTURES

6.1 Goals and Objectives of the Action Plan

6.1.1 Goal

The Goal of the National HIV Action Plan for Cultural Institutions and Traditional Leadership Structures 2024/25 – 2029/30 is:

To ensure a coordinated, sustained and meaningful contribution to the multi-sectoral HIV response by cultural and traditional institutions to end AIDS as a public health threat by 2030 in Uganda.

6.1.2 Specific Objectives

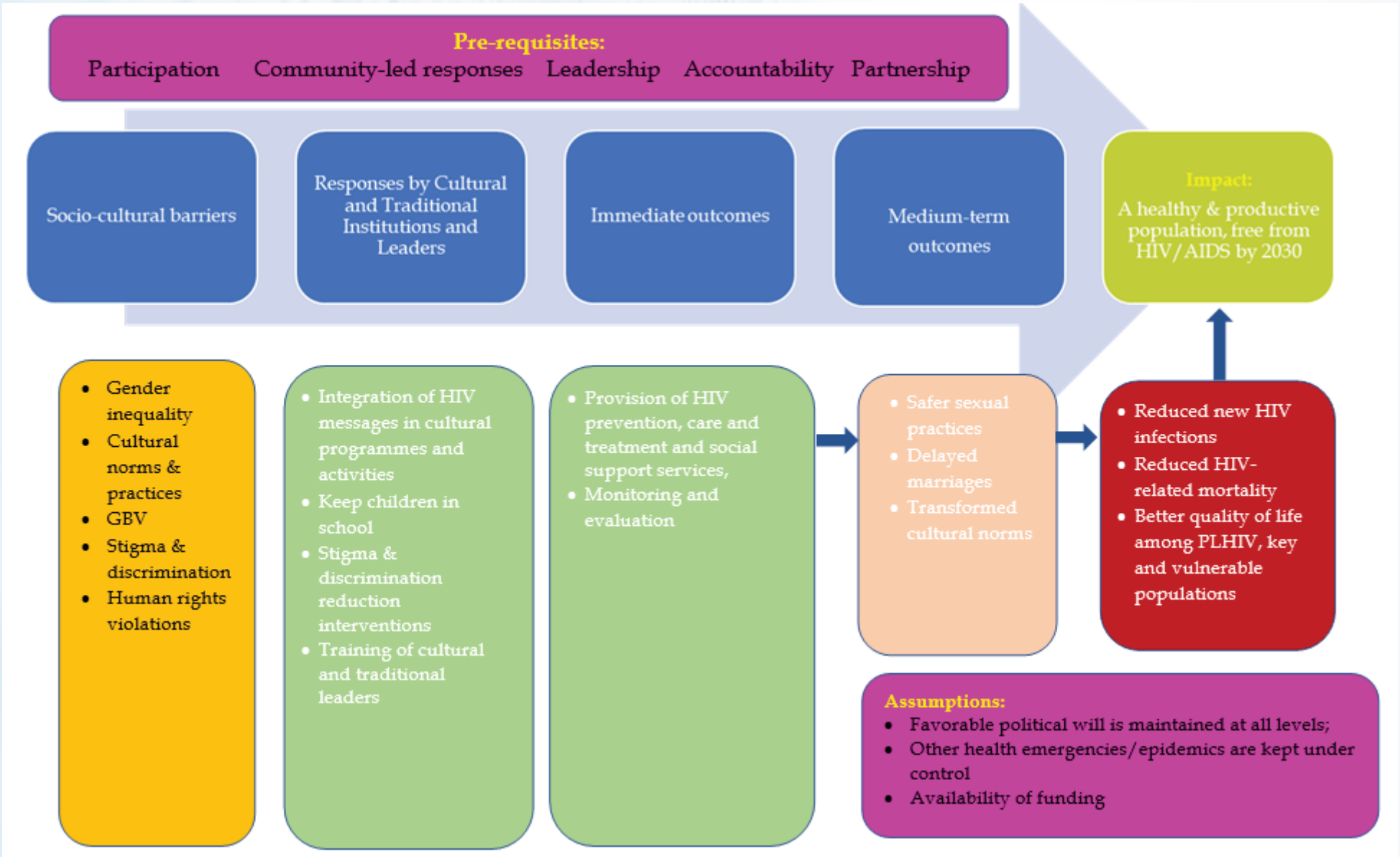
The specific objectives are aligned to the four thematic areas of the NSP, while the fifth one is crosscutting. They are:

i) To enhance access to evidence-informed, culturally appropriate HIV and TB stigma reduction and HIV prevention messages by all age groups in all communities by 2030,
ii) To promote the availability, accessibility of and demand for HIV/AIDS care and treatment services and for related services including SGBV, SRH, ART Adherence, and positive living for PLHIV,
iii) To promote access to social support and protection services for vulnerable groups, promote social and economic empowerment to reduce vulnerability to HIV, and mitigate the impacts of HIV and AIDS,
iv) To build the capacity of the cultural and traditional leaders to implement the national HIV Action Plan for Cultural Institutions and Traditional Leaders 2021/22 – 2024/25 for a consolidated, coordinated and sustained HIV response.
v) To strengthen advocacy by cultural and traditional leaders against social-cultural beliefs and practices, and structural barriers that propagate the spread of HIV and delay the ending of AIDS.

6.2 Guiding Principles

i) Prioritization of High impact, evidence-based, game-changer interventions
ii) Participation and ownership by leaders and members of cultural institutions
iii) Gender equality and inclusion of vulnerable groups
iv) Sustainability through integration of HIV responses /interventions into Cultural Institutions programmes and activities
v) Upholding respect, unity in diversity and cross-cultural networking
vi) Partnership and Collaboration amongst cultural institutions, as well as with other actors including government agencies, religious/faith sector and other civil society actors.

6.3 Theory of Change



The above theory of change posits that:

- If specific social cultural drivers of HIV are identified, in particular, those related to social-cultural norms and practices, stigma and discrimination, sexual and gender-based violence, and human rights violations, and;
- If cultural institutions plan and implement a number of interventions such as stigma reduction interventions, social norm transformation, appropriate HIV messaging through trained leasers, and;
- If cultural institutions work in partnership with other actors to provide HIV prevention, care and treatment, social support and protection, and systems strengthening services to their constituents, then;
- These interventions will contribute to desired outcomes such as safer sex practices, delayed marriages, more supportive social norms to HIV prevention, which will in turn contribute to long-term outcomes/ impacts such as reduced new HIV infections, reduced HIV-related mortality, and better quality of life among PLHIV.

For the above to happen, it is assumed that there will be political will and support at all levels, availability of funding, and that other epidemics such as COVID-19 will be kept under control.

6.4 HIV Interventions Minimum Package under the Cultural Institutions and Traditional Leadership Structures' HIV and AIDS Action Plan

The proposed minimum package of service is aligned to the Global AIDS Strategy 2021-2025, the NSP 2021-2024/25, and Uganda's National HIV Prevention Roadmap (UAC 2018). It is organised along the four thematic areas of the NSP, and seeks to address social-cultural barriers and drivers of the epidemic.

Table 2: The Minimum HIV and AIDS Interventions Package under the Cultural Institutions and Traditional Leadership Structures' HIV and AIDS Action Plan

Thematic Area	Interventions in the Minimum Package
Prevention	**Promote Combination HIV Prevention services through mainstreaming HIV prevention messages in all cultural events such as Kings' birthday celebrations, coronation anniversary celebrations, rites of passage/initiation ceremonies, cultural galas, funerals, marriage ceremonies, clan meetings, pre-marital counselling, youth retreats, fireplace gatherings and others.**
	a). Community dialogues to scale up awareness and advocate redefinition of harmful social-cultural norms that perpetuate the spread of HIV such as wife inheritance, wife sharing, and early and arranged marriages.
	b). Campaigns to keep adolescent girls in school and prevent early marriages.
	c). Campaigns targeting to reduce alcohol abuse and new ills such drug abuse, sport betting, child trafficking, and other risky behaviours among young people.
	d). Promotion of condom use for non-marital and non-cohabiting relationships in urban areas, hot spots and rural areas to enhance the ability of all those at risk to negotiate and use condom use for HIV prevention.
	e). Adapt or develop standardized messages that increase or promote SAVE (Safer practices, Access to treatment, Voluntary counseling and testing and Empowerment); to be usedin day to day and routine cultural events such as burial ceremonies, marriage ceremonies, and rites of passage ceremonies to encouragevirtues such as faithfulness, abstinence, caring for the vulnerable, weak and suffering aimed at preventing new infections and improving the quality of life of PLHIV
	f). Integration of HIV prevention messages from a cultural perspective in all print materials such pamphlets, bulletins and other materials to be distributed to members who meet or congregate for cultural events.
	g). Messages and campaigns to prevent and address SGBV as a leading driver of the epidemic by discouraging harmful masculinities and femininities and promoting positive masculinities and femininities that uphold human rights and dignity
	h). Dissemination of sexuality education messages targeting adolescents and young people through cultural structures such as aunts and uncles, and in line with the National Sexuality Educationframework.
	i). Royal pronouncements and by-laws from cultural leaders on selected cultural and traditional norms and practices that may carry risks for HIV infection such as SGBV, wife inheritance, and early and forced marriages marriage.
	j). Addressing traditional beliefs and practices related to related to birth, breast feeding among eMTCT mothers and community members in general.
	k). Update and disseminate standardized Positive Health, Dignity and Prevention (PHPD), as well as Treatment Literacy messages
	l). Awareness creation of existing laws and institutions that address SGBV among community leaders.
	m). Propose to local governments by-laws against child abuse (e.g., child labour, alcohol drinking, and other forms of harmful practices and rights violations).
	n). Promotion of responsible parenting and early child development programmes and campaigns nationally.

Care and Treatment	**Create demand for HIV care and treatment services targeting children, adolescents, youths, adults; and other communities at increased risk of HIV, living with and affected by HIV**
	a). Address traditional beliefs related to illness and healing (claims of cure).
	b). Address harmful cultural practices related to pregnancy, birth, and breast feeding among eMTCT mothers and communities.
	c). Intensify campaigns for positive masculinity, including male involvement in HIV/AIDS care and treatment, gender roles in antenataland post-natal care, and parenting.
	d). Strengthening treatment literacy and particularly ART retention and adherence, and demystify HIV&AIDS through cultural structures to reduce HIV related stigma and GBV
	e). Dissemination of non-stigmatizing messages on TB as the leading cause of death among PLHIV, covering causes, transmission modes, prevention, and treatment and overall management of the disease.
	f). Scale up the dissemination of policy/guidance on treatment for prevention in relation to HIV
	g). Disseminate messages promoting demand for and availability of Point of Care (POC) technologies (CD4 count, EID and viral load services for PLHIV) to diagnose advanced HIV disease (AHD) and pediatric HIV infections early and promote viral load monitoring
	h). Disseminate messages promoting the basic care package for PLHIV (Cotrimoxazole prophylaxis, access to safe water, good nutrition and importance of sleeping under an insecticidetreated mosquito net)
	i). Messages aimed at promoting mental health and positive living for PLHIV
	j). Advocating for availability of POC technologies to diagnose AHD and diseases like TB and cryptococcal meningitis early in order to avert AIDS related deaths
	k). Promotion of the dignity plus quality and length of life of PLHIV, including prevention of non-communicable diseases (NCDs)
	l). Engagement with Traditional and Complimentary Medical Practitioners (TCMP) on HIV prevention and referrals for treatment, antenatal care, eMTCT and other related services
	m). Advocacy for non-discrimination and stigma reduction in relation vulnerable and key populations to promote access to treatment
Social Support and Protection	**Empower individuals and communities through stigma reduction, life-skills and economic interventions, and reducing vulnerability**
	a). Dialogue meetings with cultural and other community leaders such as religious leaders at national and lower level structures for meaningful engagement in addressing HIV related stigma, discrimination, violence and inequalities in communities
	b). Advocacy for school sponsorship schemes to keep vulnerable girls and boys in school
	c). Advocacy for poverty reduction interventions at household and community level targeting priority and vulnerable individuals
	d). Support retention of pregnant girls and child mothers in schools in line with government policies and guidelines
	e). Develop and promote life and livelihood skills for out-of-school adolescents and young people 12–24 years, and collabourate and coordinate with existing national socioeconomic empowerment schemes to reach vulnerable adolescents and women, households.

Systems strengthening	**Strengthening governance, leadership and management capacities of the cultural sector to effectively implement, coordinate and monitor this Action Plan**
	a). Dialogue meetings with and trainings for health workers to improve the cultural competence of health workers to address HIV and AIDS within appropriate cultural contexts.
	b). Build the capacity of cultural and traditional leaders and networks to address violence against women, girls, men and boys.
	c). Strengthening the capacity for cultural sector to mobilize, utilize and account for resourcesinternally and externally
	d). Strengthening indigenous conflict resolution mechanisms including restorative justice to address issues such as SGBV, marital conflicts, paternity conflicts, and other forms of conflict likely to perpetuate the spread of HIV
	e). Periodic cultural sector capacity assessments; and develop and implement capacity improvement plans
	f). Regular mentorship of cultural sector on governance, leadership and management
	g). Collaborate with other sectors, including government agencies, religious/faith sector and other civil society actors to plan and implement joint or harmonized interventions to address HIV/AIDS on page 31 of the doc with tracks

6.5 Interventions and Implementation Framework

The implementation framework of this action plan outlines the key strategies and interventions to be implemented by cultural institutions in an effort to contribute to HIV prevention, care and treatment, social protection and support, and systems strengthening. In areas of the country where there are no legally recognized kingdoms such as parts of Ankole and Kigezi, other structures such as Elders' Forums and District Community Development Departments will play key roles in the implementation of this action plan.

These strategies and interventions are based on documented lessons and experiences from elsewhere, best-practice, evidence-base, and contextual relevance. The implementation framework also outlines key outputs and performance targets for the cultural institutions HIV response. The detailed implementation framework is outlined in the tables below.

Table 3: Implementation Framework

Strategy	Activities	Outputs	Annual Target	Annual Budget (000 UGX)	Lead Actor	Timing
	Thematic Area: Prevention					
	Objective: To enhance access to culturally appropriate HIV prevention and stigma reduction messages by all age groups in all communities by 2030					
	NSP Sub-goals and Strategic Objectives contributed to: **Sub-goal 1: To reduce the number of youth and adult HIV infections by 65% and pediatric HIV infections by 95% by 2025** **SO 1.1 Increased adoption of safer sexual behaviours and reduction in risky behaviours among key populations, priority population groups and the general population**					
IEC/SBC	Disseminate information on HIV prevention and stigma reduction at all available cultural fora.	HIV prevention and stigma reduction disseminated	300,000 people reached with HIV prevention and anti-stigma messages 130,000 leaflets printed and distributed	900,000 75,000	Individual Cultural Institutions & Leaders, Local Governments, IPs, LGs (CDOs, Gender Officers).	Continuous
	Sensitise/empower girls against early marriage / early sexual activity	Teenage and adolescent girls sensitised against early marriage	100,000 girls reached with messages against early sexual activity and early marriage	750,000	Individual Cultural Institutions & Leaders, Local governments, IPs, LGs (CDOs, Gender Officers).	Continuous
	Promote HIV testing before marriage	Adolescents, young people and young adults reached with HIV testing messages	100,000 girls and boys reached with messages promoting HIV testing before marriage	350,000	Individual Cultural Institutions & Leaders, Local governments, IPs, LGs (CDOs, Gender Officers).	Continuous

Strategy	Activities	Outputs	Annual Target	Annual Budget (000 UGX)	Lead Actor	Timing
	Engage owners of hotels, lodges, bars and restaurants regarding hiring of young girls/ to protect the girl child.	Owners of hotels, lodges, bars and restaurants engaged	200 owners of hotels, lodges, bars and restaurants engaged	30,000	Individual Cultural Institutions, UAC, MGLSD	Continuous
	Integrate of HIV prevention in all cultural events and activities such as clan meetings, pre-marital counselling, youth conferences, cultural clubs in schools, marriage ceremonies, initiation ceremonies, cultural galas, fire place gatherings, youth retreats and other cultural celebrations.	HIV prevention messages integrated in cultural events and activities	HIV prevention messages integrated in at least 200 cultural events	300,000	COTLA, Prime Ministers Forum, Ministers of Health in cultural institutions, Elders' Forums, LGs, (CDOs, Gender Officers)	Continuous
	Use events such as pre-marital preparation and initiation ceremonies to pass on messages against HIV.				Individual Cultural Institutions & Leaders	Continuous
Sexuality education	Work with partners to formulate /adapt a culturally appropriate sexuality education messages for adolescents and young people in line with the National Sexuality Education Framework	Sexuality education messages adapted	Appropriate sexuality education messages adapted, translated and printed in at least 13 languages; 130,000 copies printed.	75,000	MGLSD, MoES, Individual Cultural Institutions, IPs, LGs (CDOs, Gender Officers).	2024

Strategy	Activities	Outputs	Annual Target	Annual Budget (000 UGX)	Lead Actor	Timing
	Train selected cultural leaders and agents to provide culturally appropriate sexuality education, counselling and mentorship to adolescents and young people	Cultural leaders and agents trained	500 cultural and traditional leaders trained to provide culturally appropriate sexuality education, counselling and mentorship to adolescents and young people	75,000	MGLSD, MoES, Individual Cultural Institutions & Leaders, IPs, LGs (CDOs, Gender Officers).	Annual
Social Norm and mindset Transformation	Advocate/engage communities and sensitise them about the rights of the girl child	Community engagements held	200 engagement sessions conducted	600,000	COTLA, Prime Ministers Forum, Elders' Forums, Individual Cultural Institutions & Leaders, Local Governments, IPs, LGs (CDOs, Gender Officers).	Continuous
	Conduct community dialogues (involving multiple stakeholders) to identify and discuss socio-cultural norms and practices that drive HIV and those that perpetuate gender inequality and plan ways to change such norms and practices	Community dialogues conducted	200 community dialogues conducted	600,000	Individual Cultural Institutions & Leaders, Academia, IPs, LGs (CDOs, Gender Officers).	Bi annual

Strategy	Activities	Outputs	Annual Target	Annual Budget (000 UGX)	Lead Actor	Timing
Parent Models and positive masculinity	Sensitize/Train parent models to demonstrate responsible parenting in line with the National Parenting Guidelines	Parent models trained	500 parents trained	75,000	MGLSD, Individual Cultural Institutions & Leaders, IPs, LGs (CDOs, Gender Officers).	Continuous
	Sensitize parents to keep children in school	Parents sensitised on keeping children in school	3,000 parents / community members reached with messages to keep children in school	22,500	MGLSD, MoES, Individual Cultural Institutions & Leaders, IPs, LGs (CDOs, Gender Officers).	Continuous
	Promote male involvement in HIV programmes through peer to peer initiatives	Men reached with male involvement messages	2,000 males reached with HIV messages through peer to peer initiatives	15,000	UAC, MoH, Individual Cultural Institutions & Leaders, IPs, LGs (CDOs, Gender Officers).	Continuous
	Promote and support initiatives that keep children in school				Uganda Kings & Cultural Leaders Forum, Prime Ministers Forum, Elders' Forums, MGLSD, MoES, IPs, LGs (CDOs, Gender Officers).	Continuous
	Train male and female parents as GBV champions to spearhead the reduction	Male and female GBV champions trained	200 male and 200 female GBV champions trained	60,000	MGLSD, UAC, Individual Cultural Institutions, IPs, LGs (CDOs, Gender Officers).	Bi annual

Strategy	Activities	Outputs	Annual Target	Annual Budget (000 UGX)	Lead Actor	Timing
By-Laws and law enforcement	Work with local governments to enact locally relevant by-laws for HIV prevention – covering aspects such as times for opening of bars, alcohol consumption, children's school attendance, night discos, and early marriage.	By-laws initiated/ enacted	By-laws initiated / enacted in 50 communities	20,000	COTLA & Cultural Leaders Forum, Prime Ministers Forum, Elders' Forums, MGLSD, MoJCA, Local Governments	Continuous
	Work with police and local governments to ensure enforcement of laws against defilement and early marriage	Engagements with police held	40 engagements with police and local governments	120,000	COTLA & Cultural Leaders Forum, Prime Ministers Forum, Elders' Forums, Individual Cultural Institutions & Leaders, Police, Local Governments (Probation & Social Welfare Officers, Gender Officers)	Continuous
	Work with traditional/cultural enforcement structures e.g. clan askaris to enforce desired behaviours.				COTLA & Cultural Leaders Forum, Prime Ministers Forum, Elders' Forums, Individual Cultural Institutions & Leaders.	Continuous

Strategy	Activities	Outputs	Annual Target	Annual Budget (000 UGX)	Lead Actor	Timing
Royal Pronouncements	Cultural leaders to make pronouncements discouraging harmful cultural / traditional norms and practices such as early and forced marriage, wife sharing, and others that carry the risk of HIV transmission. This may include reviewing pronouncements made in the past and strengthening them.	Pronouncements against harmful cultural norms and practices made	At least 2 pronouncements per cultural institution per year	260,000	COTLA & Cultural Leaders Forum, Prime Ministers Forum, Elders' Forums, MoH, MGLSD, Local Governments	Bi-annual
	Cultural leaders to make pronouncements promoting positive norms and practices that protect young people and vulnerable groups from HIV such as keeping girls in school	Pronouncements that promote protective norms and practices made	At least 2 pronouncements per cultural institution per year	260,000	COTLA & Cultural Leaders Forum, Prime Ministers Forum, Elders' Forums, Ministers of Health in Cultural institutions MoH, MGLSD, Local Governments	Bi-annual
HIV Prevention services	Work with partners to provide HIV prevention services through static clinics, community outreaches, and community-based models such as peer to peer. [*This can be split into several activities*]	HIV services provided	15,000 clients served with HIV services through partnerships and linkages	3,000,000	COTLA & Cultural Leaders Forum, Prime Ministers Forum, Elders' Forums, MoH, Local Governments, IPs.	Continuous

Strategy	Activities	Outputs	Annual Target	Annual Budget (000 UGX)	Lead Actor	Timing
	Hold medical camps annually during important cultural events such as the King's birthday, coronation celebrations, cultural galas and initiation ceremonies; provide information, free HIV testing services and referral and linkage.	Medical camps held	13 medical camps held	585,000	COTLA& Cultural Leaders Forum, Prime Ministers Forum, Elders' Forums, UAC, MoH, Local Governments, IPs.	Quarterly
Stigma reduction	Address stigma associated with seeking HIV services		40,000 people reached with anti-stigma messages	300,000	COTLA & Cultural Leaders Forum, Prime Ministers Forum, Elders' Forums, UAC, MoH, Local Governments, IPs.	Continuous
	Thematic Area: Care and Treatment					
	Objective 2: To promote the availability, accessibility of and demand for HIV/AIDS care and treatment services and for related services including SGBV, SRH, ART Adherence, and positive living for PLHIV					
	NSP Sub-goals and Strategic Objectives contributed to: **Sub-goal 1: To reduce the number of youth and adult HIV infections by 65% and paediatric HIV infections by 95% by 2025** ***SO 1.2 Coverage and utilization of biomedical HIV prevention interventions delivered as part of integrated health care services scaled-up*** **Sub-goal 2: Reduce AIDS-related morbidity and mortality by 2025** ***All SOs***					

Strategy	Activities	Outputs	Annual Target	Annual Budget (000 UGX)	Lead Actor	Timing
Treatment literacy	Disseminate ART treatment literacy and adherence information to cultural leaders, PLHIV and caregivers	ART treatment literacy messages disseminated	30,000 cultural leaders, PLHIV and caregivers reached with ART treatment literacy	225,000	COTLA & Cultural Leaders Forum, Prime Ministers Forum, Elders' Forums, Individual Cultural Institutions & Leaders, MoH, UAC, Local Governments, IPs.	Continuous
Nutrition literacy	Disseminate food security, nutrition and ART adherence information to cultural leaders, PLHIV and caregivers	Food security, nutrition and ART adherenceinformation disseminated	30,000 cultural leaders, PLHIV and caregivers reached with nutrition security and ART adherence messages	225,000	COTLA & Minister of health in cultural institutions, Prime Ministers Forum, Elders' Forums, Individual Cultural Institutions & Leaders, MoH, UAC, Local Governments, IPs.	Continuous
Medical camps	Hold medical camps annually during important cultural events such as the King's birthdays, coronation anniversary celebrations, and initiation ceremonies; provide free HIV testing services and referral and linkage.	Medical camps held	13 medical camps held	585,000	COTLA & Cultural Leaders Forum, Prime Ministers Forum, Elders' Forums, Individual Cultural Institutions, MoH, UAC, Local Governments (DHOs), IPs.	Quarterly

Strategy	Activities	Outputs	Annual Target	Annual Budget (000 UGX)	Lead Actor	Timing
NCD integration	Disseminate messages promoting good physical health and preventing NCDs among PLHIV	Messages promoting good physical health and preventing NCDsamong PLHIV disseminated	15,000 PLHIV reached with messages on NCDs and HIV prevention and management	112,500	COTLA and Ministers of Health in cultural Institutions Prime Ministers Forum, Elders' Forums, Individual Cultural Institutions & Leaders, MoH, UAC, Local Governments, IPs.	Continuous
Referral and Linkage	Refer and link clients to HTS, ART, SMC, PrEP, condom, SGBV, social and HR protection, viral load testing, mFP services to AGYW, adolescents, youths, couples, adults, other communities at increased risk of HIV, living with and affected by HIV	Referrals to services made	15,000 clients referred for different HIV-related services	112,500	Individual Cultural Institutions & Leaders, MoH, Local Governments, IPs.	Continuous
	Promote the Bring Back to Care (BBC) strategy to achieve the goal of ending AIDS as a public health threat by 2030.		15,000 reached with BBC messages	112,500	Individual Cultural Institutions & Leaders, MoH, UAC, Local Governments, IPs.	Continuous

Strategy	Activities	Outputs	Annual Target	Annual Budget (000 UGX)	Lead Actor	Timing
	Thematic Area: Social Support and Protection					
	Objective 3: To promote access to social support and protection services for vulnerable groups, promote social and economic empowerment to reduce vulnerability to HIV, and mitigate the impacts of HIV and AIDS					
	NSP Sub-goals and Strategic Objectives contributed to: **Sub-goal 1: To reduce the number of youth and adult HIV infections by 65% and paediatric HIV infections by 95% by 2025** ***SO 1.3: Mitigated underlying socio-cultural, gender and other factors that drive the HIV epidemic*** **Sub-goal 3: To strengthened social and economic protection to reduce vulnerability to HIV and AIDS and to mitigate their impact on people living with HIV, OVC, KPs and other vulnerable groups** ***All SOs***					
Household income and food enhancement	Promote enhancement of household incomes to address poverty and vulnerability	People reached with poverty reduction messages	30,000 people reached with poverty reduction messages	225,000	COTLA and Ministers of Health in Cultural Institutions , Prime Ministers Forum, Elders' Forums, Local Governments, MGLSD, IPs.	Continuous
	Promote the concept of the *King's garden (Omusiri gwa Kabaka / Gw'omukama* which every homestead must have.	*King's Garden* concept promoted	100,000 people reached with messages on the King's Garden	750,000	COTLA and Ministers of Health in Cultural Institutions , Prime Ministers Forum, Elders' Forums, Individual Cultural Institutions & Leaders, Local Governments (Production Departments, CDOs), MGLSD, IPs.	Continuous

Strategy	Activities	Outputs	Annual Target	Annual Budget (000 UGX)	Lead Actor	Timing
Counselling and psycho-social support services	Train cultural leaders to provide counselling and psycho-social support on matters of HIV and related issues such as SGBV	Cultural leaders trained to provide counselling and psycho-social support	400 cultural leaders trained	60,000	COTLA and Ministers of Health in Cultural Institutions , Prime Ministers Forum, Elders' Forums, Individual Cultural Institutions, MoH, MGLSD, UAC, Local Governments, IPs.	Annual
	Promote and support the formation and training of social support groups among youth, PLHIV and other identified groups	Social support groups formed	700 social support groups formed	105,000	COTLA and Ministers of Health in Cultural Institutions , Prime Ministers Forum, Elders' Forums, Individual Cultural Institutions & Leaders, MGLSD, LGs (CDOs), IPs.	Continuous
	Thematic Area: Systems Strengthening					
	Objective 4: To build the capacity of the cultural and traditional leaders to implement the national HIV Action Plan for Cultural Institutions and Traditional Leaders 2021/22 – 2024/25 for a consolidated, coordinated and sustained HIV response.					
	NSP Sub-goal and Strategic Objectives contributed to: **Sub-goal 4: A resilient multi-sectoral HIV and AIDS service delivery system that ensures sustainable access of efficient and safe services to all the targeted population**					
Organizational Capacity Assessment	Work with partners to conduct organizational capacity assessment of cultural institutions and traditional leaders and develop improvement plans	Organizational capacity assessments conducted	13 organizational capacity assessments completed	39,000	COTLA and Ministers of Health in Cultural Institutions , Prime Ministers Forum, Elders' Forums	2024

Strategy	Activities	Outputs	Annual Target	Annual Budget (000 UGX)	Lead Actor	Timing
Training	Identify and train HIV trainers of trainers among cultural and traditional leaders	HIV Trainers of Trainers identified and trained	130 ToTs trained	19,500	COTLA and Ministers of health in Cultural institutions, Prime Ministers Forum, Elders' Forums, Individual Cultural Institutions & Leaders, Local Governments, IPs.	Annual
	Sensitise cultural and traditional leaders at all levels about the links between cultural norms and practices and HIV.	Cultural and traditional leaders trained about the links between cultural norms and practices and HIV	400 cultural leaders trained	60,000	COTLA and Ministers of health in Cultural institutions, Prime Ministers Forum, Elders' Forums, MGLSD, IPs, Local Governments.	Continuous
	Equip/train cultural and traditional leaders at all levels to communicate about HIV	Cultural and traditional leaders trained to communicate about HIV	400 cultural leaders trained	60,000	COTLA and Ministers of health in Cultural institutions, Prime Ministers Forum, Elders' Forums, MGLSD, IPs, Local Governments.	Continuous
	Equip cultural and traditional leaders to speak about / against culturally entrenched harmful norms and practices such as polygamy	Cultural and traditional leaders trained to speak about / against culturally entrenched harmful norms and practices	400 cultural leaders trained	60,000	COTLA and Ministers of health in Cultural institutions, Prime Ministers Forum, Elders' Forums, MGLSD, IPs, Local Governments.	Continuous

Strategy	Activities	Outputs	Annual Target	Annual Budget (000 UGX)	Lead Actor	Timing
	Collabourate with partners to develop talking points for cultural leaders on HIV prevention and impact mitigation	Talking points for cultural and traditional leaders developed	3 sets of talking points on different topics developed	20,000	COTLA and Ministers of health in Cultural institutions, Prime Ministers Forum, Elders' Forums, MGLSD, UAC, IPs.	Continuous
Revive and strengthen traditional conflict resolution mechanisms	Develop guidelines for traditional conflict resolution mechanisms including restorative justice	Guidelines for traditional conflict resolution developed	Guidelines for different cultural contexts developed and translated into local languages	140,000	COTLA and Ministers of health in Cultural institutions, Prime Ministers Forum, Elders' Forums, MGLSD, IPs, Local Governments.	
	Train and equip cultural and traditional leaders to implement traditional conflict resolution mechanisms including restorative justice	Cultural and traditional leaders trained in traditional conflict resolution mechanisms	400 cultural leaders trained	60,000	COTLA and Ministers of health in Cultural institutions, Prime Ministers Forum, Elders' Forums, MGLSD, IPs, Local Governments.	
Coordination	Promote coordination and harmonization of approaches and standards for HIV control amidst cultural diversity	Harmonized strategies agreed	4 Coordination meetings held	12,000	COTLA and Ministers of health in Cultural institutions, Prime Ministers Forum, Elders' Forums, UAC, MGLSD, IPs.	Continuous
Budget allocation	Allocate funds to cultural activities that contribute to addressing HIV and its impacts as per this action plan	Funds allocated to activities in this action plan	Each cultural institution allocates at least 0.1% of its budgeted resources to HIV/AIDs activities in line with GoU guidelines.	130,000	COTLA and Ministers of health in Cultural institutions, Prime Ministers Forum,	Annual

Strategy	Activities	Outputs	Annual Target	Annual Budget (000 UGX)	Lead Actor	Timing
	Thematic Area: Cross-cutting					
	Objective 5: To strengthen advocacy by cultural and traditional leaders against social-cultural beliefs and practices, and structural barriers that propagate the spread of HIV and delay the ending of AIDS.					
	NSP Sub-goals and Strategic Objectives contributed to: All					
Trainings	Orient all cultural and traditional leaders at all levels on HIV prevention, care and treatment, social support and protection and related issues of TB, SGBV, etc.	Cultural and traditional leaders oriented	400 cultural and traditional leaders oriented	60,000	COTLA and Ministers of health in Cultural institutions, Prime Ministers Forum, Elders' Forums, MGLSD, MoH, Local Governments, IPs.	Annual
	Train cultural and traditional leaders on evidence-based advocacy	Cultural and traditional leaders trained on evidence-based advocacy	400 cultural and traditional leaders oriented	60,000	COTLA and Ministers of health in Cultural institutions, Prime Ministers Forum, Elders' Forums, MGLSD, MoH, Local Governments, Academia, IPs.	Annual
IEC/SBC	Adapt and translate IEC/SBC materials disseminated by government and IPs to make them culturally sensitive and appropriate	IEC/SBC materials adapted translated	IEC/SBC materials in 13 languages adapted and translated; 130,000 leaflets printed and distributed	75,000	COTLA and Ministers of health in Cultural institutions, Prime Ministers Forum, Elders' Forums, MGLSD, MoH, UAC, Local Governments, IPs.	Continuous

Strategy	Activities	Outputs	Annual Target	Annual Budget (000 UGX)	Lead Actor	Timing
Advocacy	Conduct advocacy campaigns on girls' and boys' education and completion of school using different channels including TV, radio, meetings, and other stakeholder engagements.	Advocacy campaigns on girls' and boys' education and completion of school conducted	26 advocacy events conducted on education of boys and girls	78,000	COTLA and Ministers of health in Cultural institutions, Prime Ministers Forum, Elders' Forums, MGLSD, IPs.	Continuous
	Conduct advocacy campaigns on HIV and AIDS stigma and discrimination; Gender based inequalities and GBV; Human rights; and laws and policies	Advocacy campaigns conducted	26 advocacy events conducted on GBV and human rights issues	78,000	COTLA and Ministers of health in Cultural institutions, Prime Ministers Forum, Elders' Forums, MGLSD, IPs.	Continuous
	Use all available platforms such as youth conferences, cultural clubs in schools, marriage ceremonies to pass on targeted messages on HIV prevention and impact mitigation.		300,000 people reached with advocacy messages	900,000	COTLA and Ministers of health in Cultural institutions, Prime Ministers Forum, Elders' Forums, IPs.	Continuous
	Negotiate for free airtime on radios and TV stations in respective regions		15 radio stations signed up for free airtime	2,250	COTLA and Ministers of health in Cultural institutions, Prime Ministers Forum, Elders' Forums, RDCs, Local Governments.	Continuous

6.6 Operationalization of The Action Plan

To operationalize this National HIV and AIDS Action Plan for Cultural Institutions and Traditional Leadership Structures, the Cultural Institutions SCE in collaboration with UAC and MGLSD disseminate this Action Plan to all relevant stakeholders.

The action plan will be implemented by the cultural institutions in Uganda within their mandates as established by law. The overall coordination will be provided by the Uganda AIDS Commission using its monitoring and evaluation framework and through the Self-Coordinating Entities (SCEs). Further oversight will be provided by the MGLSD.

In addition, UAC will take responsibility to review, clear and approve all IEC/SBC materials and messages to ensure factual accuracy and adherence to communication standards.

All implementation is expected to be aligned to the national frameworks such as the NSP and the National HIV Prevention Roadmap.

Cultural institutions and traditional leaders will in addition to working through their structures, collaborate with other actors at national, regional and community levels in the implementation of this action plan. Such actors will include government agencies, civil society actors including religious/faith actors and community level actors such as VHTs, community linkage facilitators and other community level volunteers.

7.0 COORDINATION, MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING

7.1 Coordination

Coordination of implementation of this action plan will be led by Uganda AIDS Commission through the Cultural Institutions Self-Coordinating Entity, in partnership with the Department of Culture at the Ministry of Gender, Labour and Social Development. Key to the coordination roles are also the Ucouncil of traditional leaders in Africa, Uganda Chapter COTLA and the Prime Ministers Forum. At local government level, cultural institutions and leaders should work closely with established government structures at district and sub-county levels such as District Health officers and District AIDS Committees (DACs).

Coordination will entail:

- Regular coordination meetings to receive updates, share lessons and challenges and chart new strategies
- Spearheading joint planning, grant proposal writing, and coordinated implementation
- Cross-institution collaboration among cultural institutions, as well as with other actors such as religious/faith sector institutions to learn lessons and harmonize strategies and activities, and share resources where possible.
- Maintaining coordination with other SCEs and other sectors in the HIV response
- Ensuring use of standardized and approved IEC/SBC messages
- Collection of periodic reports, synthesis of reports and follow up of actions
- Sharing of relevant information, messages, and materials

7.2 Monitoring, Evaluation and Learning

The implementation of this action plan will be monitored through both routine and periodic processes in line with the National HIV and AIDS Strategic Plan (NSP) 2020/21-2024/25 Monitoring and Evaluation framework.

Monitoring activities will consist of monitoring visits and data collection. The implementation will be evaluated both specifically where resources allow and broadly through the evaluation of the NSP.

The Cultural Institutions SCE and UAC will ensure documentation and sharing of lessons learnt through learning events such as workshops, and documentation and publications of lessons learnt. Where resources allow, specific studies to answer specific learning questions will be undertaken.

7.3 Accountability Mechanisms

Effective HIV programming in the context of culture will only achieve sustainable outcomes and impacts if all actors including community members take responsibility, and exercise mutual accountability for their actions. Accountability means that actors are able to show results out of their actions. This therefore calls for every actor to play their roles with commitment and boldness to confront long held, cherished and deeply entrenched cultural norms and practices that perpetuate the spread of HIV and constrain effective care and treatment.

In addition to mutual accountability amongst actors, there also has to be institutional accountability. This requires that specific cultural institutions or traditional leadership structures prioritize attention to the harmful cultural

norms and practices in their unique cultures and contexts and report on what action they have taken to address them. Performance in this regard will be included as part and parcel of the monitoring and evaluation frameworks, and specifically as part of the performance indicators specific to respective institutions.

8.0 FINANCING AND SUSTAINABILITY MECHANISM

This plan will seek to raise resources from the following sources:

Local Resources: Cultural Institutions are expected to allocate from their local resources at least 0.1% of their total budgets annually towards HIV response in line with GoU guidelines.

Local fundraising events: These may include sports events, marathons, dinners and other activities designed to generate resources.

GoU: The Government of Uganda is also expected to allocate resources to cultural institutions. Government has already announced an allocation of 60m Ug. shillings per month to cultural institutions. Part of these resources should be used to implement this action plan.

Donor funding: Cultural institutions are expected to write grant proposals and enter partnerships with funding organizations that allow them to be funded to implement the proposed HIV activities

Other donations and grants: These may include donations from well -wishers, the corporate world, etc.

The implementers of this action plan should seek to ensure sustainability of the planned interventions and activities planned under this action plan through:

- Embedding and incorporating planned interventions into already existing structures of cultural institutions and communities
- Actively involving local communities and structures to enhance ownership of the interventions.
- Building sustainable partnerships with other actors including government agencies, the faith sector, other CSOs, the private business sectors and donor agencies.

Initiating and building local financing mechanisms for HIV responses

REFERENCES

Amone C. (2021): Widow Inheritance in Northern Uganda. Patriarchy or Parenting? In Veronica Fynn Bruey (Ed): Patriarchy and Gender in Africa. Lexington Books, London. Pages 95-108.

Asiimwe F.A. and Crankshaw O. (2011): The impact of customary laws on inheritance: A case study of widows in Urban Uganda. Journal of Law and Conflict Resolution Vol. 3(1), pp. 7-13, Available online at http://www.academicjournals.org/JLCR.

Audet CM, Hamilton E, Hughart L, Salato J. Engagement of Traditional Healers and Birth Attendants as a Controversial Proposal to Extend the HIV Health Workforce. Curr HIV/AIDS Rep. 2015 Jun;12(2):238-45. doi: 10.1007/s11904-015-0258-8.

Bukenya J.N., Nakafeero M., Ssekamatte T., Isabirye N., Guwatudde D. and Fawzi W.W. (2020): Sexual behaviours among adolescents in a rural setting in eastern Uganda: a cross-sectional study. ***Tropical Medicine and International Health***. Volume 25 no pp 81–88 January 2020.

Bukuluki P, Kisuule JD, Bagabo A, Schei B, and Sundby J (2013): Perceptions of the drivers of sexual and gender based violence in post conflict northern Uganda. International Letters of Social and Humanistic Sciences Vol.10, PP 84-102 online. Doi:10.18052/www.scipress.com/ILSHS.10.84

Bulterys, M. A., Sharma, M., Mugwanya K. et al., (2021): Correlates of HIV Status Nondisclosure by Pregnant Women Living With HIV to Their Male Partners in Uganda: A Cross-Sectional Study. JAIDS Journal of Acquired Immune Deficiency Syndromes 86(4):p 389-395, April 1, 2021. | DOI: 10.1097/QAI.0000000000002566

Crawford S and Kasiko M 2016. *Support for Strategic Review and Planning to Strengthen DfID's work on Gender Equality and Women and Girl's Empowerment in Karamoja Region, Uganda*. Coffey International Development and North South Consultants Exchange.

Doyle S. (2012): Sexual behavioural change in Ankole, western Uganda. *Journal of Eastern African Studies* Vol. 6, No. 3, August 2012, doi.org/10.1080/17531055.2012.696899 http://www.tandfonline.com

Government of Uganda (2014): *HIV and AIDS Prevention and Control Act*, 2014.

Johnson-Peretz J, Onyango A, Gutin SA, et al. (2024): Clinical Implications of HIV Treatment and Prevention for Polygamous Families in Kenya and Uganda: "My Co-Wife Is the One Who Used to Encourage Me". *Journal of the International Association of Providers of AIDS Care (JIAPAC)*. 2024;23. doi:10.1177/23259582241255171

Kyomuhendo G.B., Muhanguzi F.K., and Watson C. (2014): Adolescent girls in the balance: Changes and continuity in social norms and practices around marriage and education in Uganda. Country Report. ODI

Magadi M, Gazimbi M, Wafula C, Kaseje M. (2021): Understanding ethnic variations in HIV prevalence in Kenya: The role of cultural practices. Cult Health Sex. 2021;23(6):822–839.

Mbulaiteye SM, Ruberantwari A, Nakiyingi JS, Carpenter LM, Kamali A, and Whitworth J (2000): Alcohol and HIV: a study among sexually active adults in rural southwest Uganda, *International Journal of Epidemiology*,

Mburu, G., Ram, M., Siu, G. *et al.* Intersectionality of HIV stigma and masculinity in eastern Uganda: implications for involving men in HIV programmes. *BMC Public Health* 14, 1061 (2014). https://doi.org/10.1186/1471-2458-14-1061

Ministry of Health *National HIV Testing Services Policy and implementation guidelines in Uganda* 4th edition (2016)

Ministry of Health *Addendum to the HIV Testing Services Policy & Implementation Guidelines: HIV Self-Testing and Assisted Partner Notification* (2018)

Ministry of Health *Consolidated Guidelines for Prevention and Treatment of HIV and AIDS in Uganda* (2020)

Ministry of Health *Leave no-one behind: A National Plan for achieving equity in access to HIV, TB and Malaria services in Uganda 2020-2024* (2019)

Ministry of Health *National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights* (2012)

Ministry of Health (2022): *National Community Health Strategy.* Kampala.

Ministry of Gender, Labour and Social Development *National Action Plan on Women, Girls, Gender Equality and HIV & AIDS 2016/17 -2020/21* (NaWoGGE) (2017)

Ministry of Health *Investment Case: Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan for Uganda 2016/17 – 2019/20* (2016)

Ministry of Health *National Adolescent Health Policy for Uganda* (2004)

Ministry of Health *The National Adolescent Health Strategy 2011-2015* (2011)

Ministry of Health *Adolescent Health Policy Guidelines and Service Standards* (2012)

Ministry of Gender, Labour and Social Development *The Uganda Gender Policy* (2007)

Ministry of Health, PEPFAR, CDC, UVRI, UBOS, UNAIDS Uganda, WHO Uganda, WESTAT and ICAP at Columbia University *Uganda Population-Based HIV Impact Assessment 2016-2017* (2019)

Ministry of Health (MoH) (2019): Uganda population-based HIV Impact Assessment (UPHIA) 2016-2017: Final Report. Kampala.

Ministry of Health (2023): HIV Estimates 2024.

Muhangi (2009): Local Government – NGO partnerships in the HIV response: Policy Narratives and local Reponses in Uganda. PhD Thesis, Queens University of Belfast.

Mujuzi J.D. (2012): Widow Inheritance in Uganda. INT'l SURV. FAM. L. 393. Accessed: Mon Jun 17 01:29:39 2024 from HeinOnline. file:///C:/Users/Admin/Downloads/2012IntlSurvFamL393.pdf

Mukiza-Gapere J. and Ntozi J.P.M (1995): Impact of AIDS on the family and mortality in Uganda: *Health Transition Review* 5 (Supplement): 191-200.

NAFOPHANU (2019): The PLHIV Stigma Index, Country Assessment, Uganda.

Nyathikazi, Thobekile Jacobeth Lungile (2013): Investigating the association between HIV and AIDS and polygamy among practising polygamists in Kwazulu-Natal, North Coast area. Stellenbosch University.

Ntozi J.P.M. and Nakayiwa S. (1999): AIDS in Uganda: How has the household coped with the epidemic? *The Continuing African HIV and AIDS Epidemic*. 155-181.

Republic of Uganda (1995): Constitution of the Republic of Uganda, 1995

Republic of Uganda (2011): The Institution of Traditional or Cultural Leaders Act, 2011.

Roscoe J. (1907): The Bahima: A Cow Tribe of Enkole in the Uganda Protectorate. *The Journal of the Royal Anthropological Institute of Great Britain and Ireland*, Vol. 37 (Jan. - Jun., 1907), pp. 93-118. https://doi.org/10.2307/2843249 • https://www.jstor.org/stable/2843249

Ssebunnya J., Kituyi C., Nabanoba J, Nakku J, Bhana A, and Kigozi F: Social acceptance of alcohol use in Uganda. DOI: https://doi.org/10.21203/rs.2.12941/v1

Sileo KM, Kizito W, Wanyenze R K, Chemusto H, Musoke W, Mukasa B, Kienea SM (2019): A qualitative study on alcohol consumption and HIV treatment adherence among men living with HIV in Ugandan fishing communities. AIDS Care. 2019 January; 31(1): 35–40. doi:10.1080/09540121.2018.1524564.

Sileo KM, Reed E, Kizito W, Wagman JA, Stockman JK, Wanyenze RK, Chemusto H, Musoke W, Mukasa B, Kiene SM. Masculinity and engagement in HIV care among male fisherfolk on HIV treatment in Uganda. Cult Health Sex. 2019 Jul;21(7):774-788. doi: 10.1080/13691058.2018.1516299.

Siu, G.E., Wight, D. & Seeley, J.A. (2014): Masculinity, social context and HIV testing: an ethnographic study of men in Busia district, rural eastern Uganda. *BMC Public Health* 14, 33. https://doi.org/10.1186/1471-2458-14-33

UBOS (Uganda Bureau of Statistics) (2012) Uganda Demographic and Health Survey 2011. Kampala: UBOS.

UBOS 2020: *National survey on violence in Uganda*. Qualitative Report. Kampala

Uganda AIDS Commission *The National HIV and AIDS Strategic Plan 2020/21 – 2024/25* (2020)

Uganda AIDS Commission *The National HIV and AIDS Priority Action Plan 2020/21 – 2022/23* (2020)

Uganda AIDS Commission *Presidential Fast Track Initiative on ending AIDS in Uganda: A Presidential Handbook – Revised Edition* (2020)

Uganda Network on Law, Ethics and HIV (UGANET) *The state of human rights violations of persons living with HIV/AIDS and TB in Uganda in 2020* (2020)

Uganda AIDS Commission (UAC) (2020): Presidential Fast Track Initiative on Ending AIDS: A presidential Handbook. Revised Edition. December 2020. Kampala

Uganda AIDS Commission (UAC) and Ministry of Health (MOH) (2014): Analysis of HIV Prevention Response and Modes of Transmission in Uganda. Final Synthesis Report. Kampala.

UNAIDS HIV Prevention 2020 Road Map: Accelerating HIV prevention to reduce new infections by 75% (2017)

United Nations (2015): *The Sustainable Development Goals. https://www.undp.org/sustainable-development-goals*

UN (1979): Convention on the Elimination of all forms of Discrimination against Women. https://www.un.org/womenwatch/daw/cedaw/

World Health Organization Global Health Sector Strategy on HIV 2016-2021: Towards ending AIDS (2016)

World Vision (2013): Untying the Knot: Exploring Early Marriage in Fragile States. Research Report. World Vision, UK.

ANNEX 1: LIST OF PERSONS AND CULTURAL INSTITUTIONS CONSULTED

SN	NAME	KINGDOMS/AREAS	Designation
1	Lucy Kabanyoro	Kasese/Rwenzururu	Minister External relations and coordinator OBR projects with central Government.
2	Stanley Baluku	Kasese/Rwenzururu	M&E Officer
3	Lubega Patrick	Buruli	Principal Private Secretary to the King and Program Coordinator
4	Bogere Charles	Buruli	Minister for language and History
5	Nyalulu Thomas Okoth	Tororo / Tieng Adhola	Monitoring and evaluation for programs and former Prime minister, chairman Elders Forum Tororo
6	Rt. Hon. Jago Obbo Richard Josel	Tororo / Tieng Adhola	Prime Minister
7	Andrew Ocole	Teso/Iteso Cultural Union	Dep Prime Minister in Charge of Administration
8	Vincent Ochaya Orach	Alur	Deputy Prime Minister and Executive Director Alur Kingdom in Charge of Kingdom Secretariat
9	Prof. Willy Ngaka	Lugbara Kari	Minister for International Affairs
10	Edyau Paul	Kumam	Prime Minister
11	Mr Mulekwa Herbert Pady	Inzu Ya Masaba	Secretary General
12	Angel Immaculate	KKA	
13	Kilima Jacob and Oyet Alex	Ker Kwaro Acholi	Admin Officer
14	Odong Martin	Karamoja Elders Development Association	Ker Elder
15	Inyani Tolu Emmanuel	Lajopi Clan, Adjumani	Chief, Lajopi Clan
16	Akuti Moses	Adropi Alu Cultural Institution, Adjumani	Chokiri Chief
17	Dulu Ereminio	Odrunipi Cultural Institution, Adjumani	Opi (Cultural Chief)
18	Abuni Johnson Kibrai	Oyuwi Cultural Institution, Adjumani	Opi (Cultural Chief)
19	Ukuni Patrick	Palanyila Chiefdom, Adjumani	Gender Focal Person
20	Samuel Niiwo	Uganda Kings and Cultural Leaders Forum	Secretary General
21	Sheila Burungi Gandi	Busoga	Minister of Health
22	Fred Kasoozi	Kooki	Minister of Education and Tourism Kooki Chiefdom
23	Bamanyisa Patrick	Tooro	Information Minister

24	Mr Okumu	Bwenengo	
25	Arafat Egessa Barasa	Bugwe- Samia cultural union / Obwenghengo bwa Bugwe	Second Deputy Prime Minister
26	Alfred Cherop	Sabiny Cultural Institution	Chairman of all clans
27	Robert Rukahemura	Bunyoro Kitara Kingdom	Social affairs and cultural officer
28	Dr Ssembuya Henry	Buganda Kingdom	Head of Health Department Buddu County
29	Hon Steven Kiyingi	Tooro Kingdom	Prime Minister Tooro Kingdom
30	Ruth Muguta	HIV Focal	
31	Dr Vincent Bagambe	Uganda AIDS Commission	Director Planning and Strategic Information
32	Dr Zepher Kalyabakabo	Uganda AIDS Commission	Director Policy Research and Programing
33	Mr Quinto Rwotoyera	Uganda AIDS Commission	Director Finance and Administration
34	Dr Daniel Byamukama	Uganda AIDS Commission	Head HIV Prevention
35	Hope Murungi	Uganda AIDS Commission	Coordinator Private Sector and Civil Society
36	Tom Etii	Uganda AIDS Commission	Coordinator Public Sector and Ag Director Partnership

UGANDA AIDS COMMISSION

Plot 1-3 Salim Bey Road, Ntinda | P.O. Box 10779, Kampala.

+256 414 288 065 | uac@uac.go.ug | https://uac.go.ug

@aidscommission | UgandaAidsCommission