GOVERNMENT OF UGANDA

UNGASS COUNTRY PROGRESS REPORT UGANDA

January 2008-December 2009

March 2010

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1.3 List of Acronyms

ACORD	Agency for cooperation in Research and Development
ACP	AIDS Control Programme
ADPs	AIDS Development Partners
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
ANC	Ante-Natal Care
ART	Anti-retroviral Therapy
ARV	Anti-retroviral drugs
ASO	AIDS Service Organizations
BCC	Behaviour Change Communication
CBOs	Community Based Organizations
CDC	Centre for Diseases Control
CRIS	Country Reporting Information System
CSF	Civil Society Fund
CSOs	Civil Society Organizations
CSWs	Commercial Sex Workers
CTX	Co-trimoxazole
DACs	District AIDS Committees
DATs	District AIDS Taskforces
DHS	Demographic Health Survey
DOTS	Directly Observed Treatment Strategy
DPs	Development Partners
FBOs	Faith Based Organizations
FSWs	Female Sex Workers
GFATM	Global Fund for AIDS, TB and Malaria
GIPA	Greater Involvement of People Living with AIDS
GoU	Government of Uganda
HBCT	Home Based Counseling and Testing
HC	Health Centre
HCT	HIV Counseling and Testing
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
HSV	Herpies Simplex Virus
HTC	HIV Testing and Counselling
IBFAN	International Baby Food Action Network
IDPs	Internally Displaced Persons
IDUs	Intravenous Drug Users
IEC	Information Education and Communcation
IPC	Interpersonal Communcation
IR	Inception Report
IRCU	Inter-Religious Council of Uganda
KAPB	Knowledge, Attitudes, Perceptions and Behaviour
KIs	Key Informants
LLINs	Long lasting Insecticide-treated bedside nets
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MARPs	Most-at-Risk Populations
MDG	Millennium Development Goal
MEEPPS	Monitoring and Evaluation of Emergency Plan Progress

MMIS	Making Medical Injections Safer
MoES	Ministry of Education and Sports
MoFPED	Ministry of Finance, Planning and Economic Development
MoGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
MoT	Modes of Transmission Study
MRC	Medical Research Council
MSI	Marie Stopies International
MSMs	Men who have Sex with Men
MTC	Mother-to Child Transmission of HIV
NACWOLA	National Community of Women Living with HIV&AIDS
NAFOPHANU	National Forum of People Living with HIV&AIDS Networks in Uganda
NCPI	National Composite Policy Index
NMS	National Medical Stores
NSAs	Network Support Agents
NSP	National Strategic Plan
OIs	Opportunistic Infections
OTP	Outreach and Training Programme
OVCs	Orphans and other Vulnerable Children
PACE	Programme for Accessible Health, Communication and Education
PC	Partnership committee
PCR	Polymerase Chain Reaction testing
PEP	Post-exposure Propylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PHAs	People Living with HIV&AIDS
PHC	Primary Health Care
PIASCY	President’s Initiative on AIDS Strategy for Communication to Youth
PMTCT	Prevention of Mother to Child Transmission
PNFP	Private-not-for-profit
PSI	Population Services International
PWDs	Persons with Disabilities
RCT	Routine Counseling and Testing
RHSP	Rakai Health Sciences Project
SACCOs	Savings Credit & Cooperative Organizations
SCEs	Self Coordinating Entities
STAR	Societies Tackling AIDS through Rights
STDs	Sexually Transmitted Diseases
STF	Straight Talk Foundation
STI	Sexually Transmitted Infections
SWS	Safe Water Systems
TB	Tuberculosis
ToTs	Trainer of Trainers
TWG	Technical Working Group
UA	Universal Access
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UHSBS	Uganda HIV Sero-Behavioral Survey
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV&AIDS
UNASO	Uganda Network of AIDS Service Organisations
UNDP	United Nations Development Programme

UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children Fund
UPE	Universal Primary Education
USAID	United States Agency for International Development
USD	United States Dollars
USE	Universal Secondary Education
VHTs	Village Health Teams
WHO	World Health Organization
YEAH	Young Empowered and Healthy

1.4 Foreword

The Uganda UNGASS Country Report (January 2008 to December 2009) sets out to detail the progress in national HIV&AIDS response since the last UNGASS Report of January 2006 to December 2007.

The compilation of this UNGASS Report followed the provided Reporting Guidelines. It highlights the status of the epidemic at glance, a detailed overview of the epidemic, the national response, best practices, major challenges and remedial actions, support from development partners, and finally the monitoring and evaluation environment. I wish to implore all stakeholders in our national response—government line ministries and sectors, civil society, bilateral agencies and UN organizations to internalize this Report so that together we can build on a number of achievements and the progress that have been ably articulated in this Report. In the same vein, there is a high call in this Report to reinvigorate our effort so as to address the challenges that have been identified. Although commendable progress has been made; we are still far in terms of achieving our targets in prevention, care and treatment as well as social support.

The methodology adopted in the compilation of this Report was consultative and highly participatory. The consultations were wide ranging in order to ensure that all constituencies were given opportunity to contribute so as to have a Progress Report that was representative of all stakeholders' efforts and challenges in the national response.

I take this opportunity to register my sincere and deepest gratitude to all our Development Partners co-ordinated by UNAIDS for supporting this process, and in particular UNDP and UNICEF. I want to thank everyone from line ministries/sectors, Civil Society, Bilateral and other UN organizations who provided input during the compilation of the report. All participants who attended the national Stakeholder Validation Workshop are greatly acknowledged for their input into the process. I further wish to express my sincere thanks to the national M&E Technical Working Group that provided technical guidance to the Consulting Team.

Last but not least, my special commendation goes to Dr. Narathius Asingwire for ably leading the team of Consultants; Dr. Andrew Balyeku and Dr. Paul Bukuluki and their Assistants; Mr. Swizen Kyomuhendo, Mr. Peter Kayiira Byansi and Ms. Jill Kadoma who compiled this Report.

Dr. Kihumuro Apuuli
Director General, Uganda AIDS Commission

2.0 STATUS AT GLANCE

2.1 Introduction

This Section presents the methods and approach (process) used in compiling the United Nations General Assembly Special Session (UNGASS) Country Progress Report for Uganda. Further presented in this Section is a snapshot on the epidemic in the country, a brief on the policy and programmatic response, and the UNGASS Indicator Table.

2.2 The Report Writing Process

The overall co-ordination of compiling the UNGASS Country Progress Report was provided by Uganda AIDS Commission (UAC) with support from UNAIDS. A Team of three Consultants; a Team Leader, an Epidemiologist and a Social Scientist were engaged to collect and analyze both primary and secondary data, and compile the Report. Three Research Assistants were hired to help the Consultants with literature search and taking notes during interviews and meetings with various stakeholders. UNAIDS and UAC M&E Officer provided day to day guidance to the team, and assisted the consultants in locating and accessing required sources of data; documents, reports, identification of stakeholders and key informants. At the Ministry of Health (MoH), the AIDS Control Programme (ACP) Manager provided overall leadership in linking the consultants with a team of staff at the ministry including the Epidemiologist, the Health Management Information System (HMIS) and M&E Officer.

The national Monitoring and Evaluation (M&E) Technical Working Group (TWG) was tasked and mandated to provide technical input and support to the team of Consultants. See Annex 1 for details of the process and members of TWG. A sub-committee of the M&E TWG was also constituted to serve as a core group by providing technical back-up support to the team on a regular basis. The sub-committee consisted of UAC, MoH, UNAIDS, WHO, UNICEF and Uganda Bureau of Statistics (UBOS). The core group of the TWG received updates from the consultants, critiqued the updates and provided technical input before they were formally presented to the wider TWG for discussion.

The wider TWG met weekly while the core group met about twice a week to discuss the progress and drafts presented by the consultants, provided technical guidance, filled data gaps where they existed and tried to reach agreement on areas that generated controversies in the response. The primary purpose of the TWG and the core group was to ensure accuracy, authenticity and comprehensiveness of the data presented as well as building consensus on the reported results. In the course of compiling the Report, a workshop was held (March 10, 2010) to discuss the first Report Draft. The comments and observations made by participants were incorporated and a second draft produced, which was presented during the Validation Workshop held on March 23, 2010. See Annex 1 for the List of Participants. The second Draft was adopted by stakeholders during the Validation Workshop with a few modifications, which the Consultant addressed in this current version.

The process of collecting data as well as compiling the report writing was, therefore, highly participatory. Data collection techniques included desk review, in-depth interviews with key informants, group discussions and consultative meetings. Data were collected at national level in terms of stakeholders' interactions and search for secondary sources. Using a National Composite Policy Index (NCPI) questionnaire data were collected from key informants in government ministries/sectors, representatives from civil society organizations (CSOs), bilateral agencies and UN organizations. The filled NCPI questionnaires were synthesized by the Consultants and results presented to the TWG for discussion. See Annex 2 for the final systhesised NCPI questionnaire, Part A (for Government) and Part B (for CSOs, Bilateral Agencies and UN Organisations).

2.3 The Status of the Epidemic

As per the last Uganda HIV&AIDS Sero-Behavioral Survey--UHSBS (2004/05), the country has a generalized HIV epidemic with a prevalence of 6.4% in adults and 0.7% in children[1]. Therefore, approximately 1.1 million people in Uganda are HIV-infected[2] in a total country population of 30 million. The incidence rate by far outstrips AIDS related mortality and the numbers of clients enrolling into chronic AIDS care. It has to be noted, however, that apart from the data from UHSBS (2004/05 and Uganda Demographic Health Survey—UDHS (2006), the country has no new published data. What is, however, clear is that the wave of new as well as old infection has shifted to older age groups[3] with both HIV incidence and prevalence in Uganda's mature HIV epidemic having stopped declining around 2000 and hence remaining more or less stable[4,5]. Women, urban dwellers and residences of the post conflict northern Uganda region are more disproportionately affected.

Sexual transmission continues to contribute 76% of new HIV infections while mother to child transmission contributes 22%. Currently, estimates indicate that over 100,000 new infections occur annually (during 2008, an estimated 110,694 new HIV infections occurred countrywide and approximately 61,306 people died from AIDS related illness in 2008)[6]. There is evidence of trends of apparent reversals in uptake and practice of preventive sexual behavior in the general population, especially among adults and men.

Despite the above, Uganda has confirmed itself to Universal Access (UA) to HIV&AIDS prevention, care and treatment in line with WHO/UNAIDS recommendations[7]. In recent years, intensified efforts to re-invigorate HIV prevention have been pronounced and a Road Map towards accelerated HIV prevention developed and adopted[8], based on

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[1] Uganda AIDS Commission (June 2009), National HIV&AIDS Stakeholders & Services Mapping Report

[2] Ministry of Health, Kampala, ORC Macro.Uganda HIV&AIDS Sero-Behaviural Survey 2004-5. Calverton, Maryland

[3] Kirungi W,Opio A, Musinguzi J, al, HIV Prevalence and Heterogeneity of risk in Uganda; Results of a National Representative-Based Serological and Sexual-Behavioul Survey. In Press, 2008

[4] Kirungi WL, et al, Sex Transm Infect 2006 Apr, 82 Suppl ;i36-i41

[5] Shafer LA, et al, Presented at the XVI International AIDS Conference, Toronto 13-18th August 2006 [Late Breaker[Abstract THLB0108]

[6] MoH 2009, The HIV/AIDS epidemiological Surveillance report , GoU/MoH/ACP, Kampala

[7] UNAIDS, Intensifying HIV prevention (UNAIDS policy position paper). UNAIDS/05.18E. Geneva, Switzerland;2005, pp. 1-5

[8] UAC 2006, Accelerated HIV Prevention, The roadmap towards Universal Access to HIV Prevention Uganda. Kampala, Uganda

careful analysis of the current drivers of the HIV epidemic in the country[9]. Uganda's new National HIV&AIDS Strategic Plan (NSP) 2007/08-2011/12[10] and the second Health Sector Strategic Plan 2005-2010 (HSSP-11)[11] spell out the country's priority of comprehensive, evidence-based HIV prevention interventions to be implemented on a scale commensurate with the current HIV transmission dynamics to meet the targets for UNGASS and UA.

2.4 The Policy and Programmatic Response

The Multi-sectoral Approach to Control of AIDS (MACA) developed by the UAC in 1992 is the overall framework that guides the policy and programmatic national response to the epidemic. The Approach calls for the involvement of everyone; individually or collectively to fight the epidemic at all levels within their mandates and capacities. Within the framework of the MACA, the country has developed a National AIDS Policy, which, is before the Cabinet of Uganda, and hence yet to be passed. There are, however, various inset policies and national guidelines that support the national response. These include the HIV Counseling and Testing (HCT) policy, Anti-Retroviral Therapy (ART), Orphans and Other Vulnerable Children (OVC) and several others such as Universal Primary Education (UPE) and Universal Secondary Education (USE) that directly or indirectly respond to impact created by HIV&AIDS.

At the programmatic level, the country has a National HIV&AIDS Strategic Plan (NSP) 2007/08-2011/12, which was formulated through a highly consultative process. All HIV&AIDS actors are guided by the NSP in their programmatic response. The NSP provides the direction of the programmatic response under four main themes, vis; prevention, care and treatment, social support and systems strengthening.

2.5 UNGASS Indicator Data

Data for filling the UNGASS Indicator Table were collected or extracted from official Government of Uganda (GoU) documents, bilateral and UN organisations' documents and also from studies done in the last two years. See Table 1.

Table 1: UNGASS Indicator Table

Indicator	Current
National Commitment and Action	
Domestic and international spending by categories and financing sources (US$Million)	Total =USD 270,793,888 Approximately=270.8 million
National composite Index	See Annex 2
National Programmes:	

[9] UAC 2006, A rapid Assessment of the drivers of the HIV/AIDS epidemic and effectiveness of prevention interventions, Kampala, Uganda

[10] UAC 2008, National HIV and AIDS Strategic Plan for Uganda, 2007/08 to 2011/12, Kampala, Uganda, 2007

[11] Ministry of Health: Health Sector Strategic Plan II 2005/06-2009/2010, Volume 1. 2005, Kampala, Uganda

Indicator	Current
Percentage of donated blood units screened for HIV in a quality assured manner	100%[12]
Percentage of women and men with advanced HIV infection receiving antiretroviral therapy	53.5%[13] (200,413/373,383)
Percentage of HIV-positive pregnant women who received antiretroviral medication to reduce the risk of mother-to-child transmission	51.6%[14] (46,948/91,000) Types of regimen Combination regimen 25% (11,737/46,948) HAART 17% (7,982/46,948 Sd NVP 58% (27,229/46,948)
Number of HIV-infected pregnant women who received antiretroviral medicines (by regimen) to reduce the risk of mother-to-child transmission in the last 12 months	46,948
Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV[15]	60%[16] (18,062/30,032)
Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results[17]	4.0% Women and 3.8% Men as of end of 2005
Percentage of MARPs who received an HIV test in the last 12 months and who know their results[18]	No new data
Percentage of most-at-risk populations reached by prevention programmes[19]	No new data
Percentage of orphaned and vulnerable children whose households received free basic external support in caring for the child[20]	10.7% receiving at least one type of school related support) for ages 5-17 completed years. 4.1% received medical support in past 12 months 0.9% received emotional support in past 3 months 2.9% received social / material support in the past 3 months and 6.1% received school related assistance in past 12 months[21].

[12] This annual indicator is based on data from the Uganda National Blood Transfusion Programme, Ministry of Health data January to December 2009

[13] This Millennium Development Goals indicator is obtained from the 2009 National Data Quality Assessment report, MoH referring to end of September 2009. The 2008 denominator was based on a CD4 cutoff of<200 and the 2009 is based on a cut off of <250. Data was obtained from the 2009 National Data Quality Assessment report, MoH

[14] Obtained from the 2009 National Data Quality Assessment report, MoH

[15] Number of incident TB cases estimated at 15% among people living with HIV for the period of October 2008 to September 2009, PEPFAR supported sites only, PEPFAR 2009 annual report, Oct 08-Sept 09, was 60% as of end of 2006 as per previous Report

[16] Number of incident TB cases estimated at 15% among people living with HIV for the period of October 2008 to September 2009

[17] This indicator is based on UDHS and is estimated every 4 to 5 years, 4.0% Women and 3.8% Men as of end of 2005

[18] Would be generated from more recent Behavioral surveillance or other special surveys but these are not available

[19] Would be generated from more recent Behavioral surveillance or other special surveys but these are not available

[20] PEPFAR Partners only, PEPFAR 2009 annual report, 253,449, denominator not available thus % not filled

Indicator	Current
Percentage of schools that provided life-skills based HIV education in the last academic year[22].	Was reported as 15% in 2008
Current school attendance among orphans and non-orphans aged 10–14 • Current school attendance rate of orphans aged 10–14 • Current school attendance rate of children aged 10–14 both of whose parents are alive and who live with at least one parent	81.9%[23]
Knowledge and Behaviour	
Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission[24](disaggregated by the age groups 15–19 and 20–24 years)	Women 15-24 years 31.9% and Men 15-24 years 38.2%.
Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission[25]	82.6% cited two preventive practices
Percentage of young women and men aged 15–24 who have had sex before the age of 15[26] (disaggregated by sex and age (<25; 25+))	Women 12% for age group 15-19 and 17% for 20-24. Men 16.3% for age group 15-19 and 10.8% for 20-24.
Percentage of adults aged 15–49 who have had sex with more than one partner in the last 12 months[27]	Women 3.8% Men 29.3%
Percentage of adults aged 15–49 who have had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse[28]	Women 9.1% Men 16.1%
Percentage of female and male sex workers reporting the use of a condom with their most recent client	No data
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No data
Percentage of injecting drug users reporting using sterile injecting equipment the last time they injected[29]	No data
Percentage of injecting drug users reporting the use of a condom the last time they had sex	No data
Impact of the Epidemic	
Percentage of young women and men aged 15–24 who are HIV-infected	Women 4.3% Men 1.1%
Percentage of most-at-risk populations who are HIV-infected[30]	No data

[21] This is collected from UDHS 2005/6 and thus expected every 4-5 years.

[22] Primary and Secondary schools with trained teachers in life-skills as of 2005, PIASCY Program supported schools only, PEPFAR 2009 annual report, denominator not available thus % not filled

[23] This is based on UDHS 2004/5. The ratio for the age group 10-14 years is not available but for ages 6-17 years the ratio is 0.96 as of end of 2006.

[24] Comprehensive knowledge about HIV & AIDS based on Uganda Demographic and Health Survey 2004/5, UDHS 2006

[25] Based on KAPB and Sero Survey on HIV/AIDS and STDs CSWs in Kampala City, June 2003

[26] This is an indicator based on UDHS 2004/5

[27] Ibid

[28] Ibid

[29] About 994 IUDs are estimated in the country (MoT) but no special study done

Indicator	Current
Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy	86%[31]
Percentage of infants born to HIV-infected mothers who are infected[32]	9.9%

In comparison with the situation at last UNGASS reporting, there is noticeable progress in most of the indicators such as the increased number of women and men with advanced HIV infection receiving antiretroviral therapy and HIV positive women receiving antiretroviral medication to reduce the risk of mother to child transmission.

[30] Based on The Crane Survey June 2008 to April 2009 covering 947 participants
[31] Based on a chort in 17 facilities July –September 2009
[32] National EID Database, 2009; was estimated 30% without intervention

3.0 OVERVIEW OF THE AIDS EPIDEMIC

3.1 Introduction

The status of the epidemic in Uganda, including trends in prevalence and incidence in the general population and among specific groups, vertical transmission, and the magnitude of the impact are presented in this Section using data from multiple sources. Sources included the national antenatal HIV sentinel surveillance, sero-behavioural survey, programme monitoring data, and data from cohort studies. Other data, for instance, on mortality and morbidity estimates are derived from modeling.

3.2 Status of the epidemic in Uganda

3.2.1 Overview

Epidemiology review[33] indicates that the previously heralded decline in HIV prevalence from a peak of 18% in 1992 to 6.1% in 2002 may have ended. There is stabilization of prevalence between 6.1 and 6.5% in some antenatal care (ANC) sites and even a rise in others. This is accompanied by worsening of behavioural indicators especially an increase in multiple concurrent partnerships. There has also been a shift in the epidemic from people in single casual relationships to those in long-term stable relationships. Incidence modeling reveals that 43% of new HIV infections are among monogamous relationships while 46% are among persons reporting multiple partnerships and their partners. See Table 2.

Table 2: Populations and Percentage of incidence by Mode of Transmission

Mode of Transmission	Total number with risk behaviour (n)	Percentage with risk behaviour	Incidence per 100,000	% of incidence
Injecting Drug Use (IDU)	994	0.0%	258	0.28
Partners IDU	252	0.0%	10	0.01
Sex workers	32,652	0.3%	833	0.91
Clients	189,381	1.5%	7,172	7.83
Partners of Clients	108,676	0.8%	1,660	1.81
MSM	3,976	0.0%	559	0.61
Female partners of MSM	1,569	0.0%	92	0.10
Multiple partnership	1,808,919	13.9%	21,722	23.73
Partners MP	1,417,881	10.9%	19,925	21.76
Mutual monogamous heterosexual sex	6,022,317	46.1%	39,261	42.89
No recent risk	3,474,169	26.6%	0	0.00
Medical injections	13,060,787	100.0%	54	0.06
Blood transfusions	134,053	1.0%	0	0.00

Source: MoT (2008), The Uganda Country Synthesis Report, GoU/UNAIDS/UAC Oct.2008

Commercial sex workers (CSWs), their clients and partners of clients contribute 10% of new infections. Men who have sex with men (MSM) and intravenous drug users (IDUs) contribute less than 1%. There has also been a shift in concentration of the epidemic

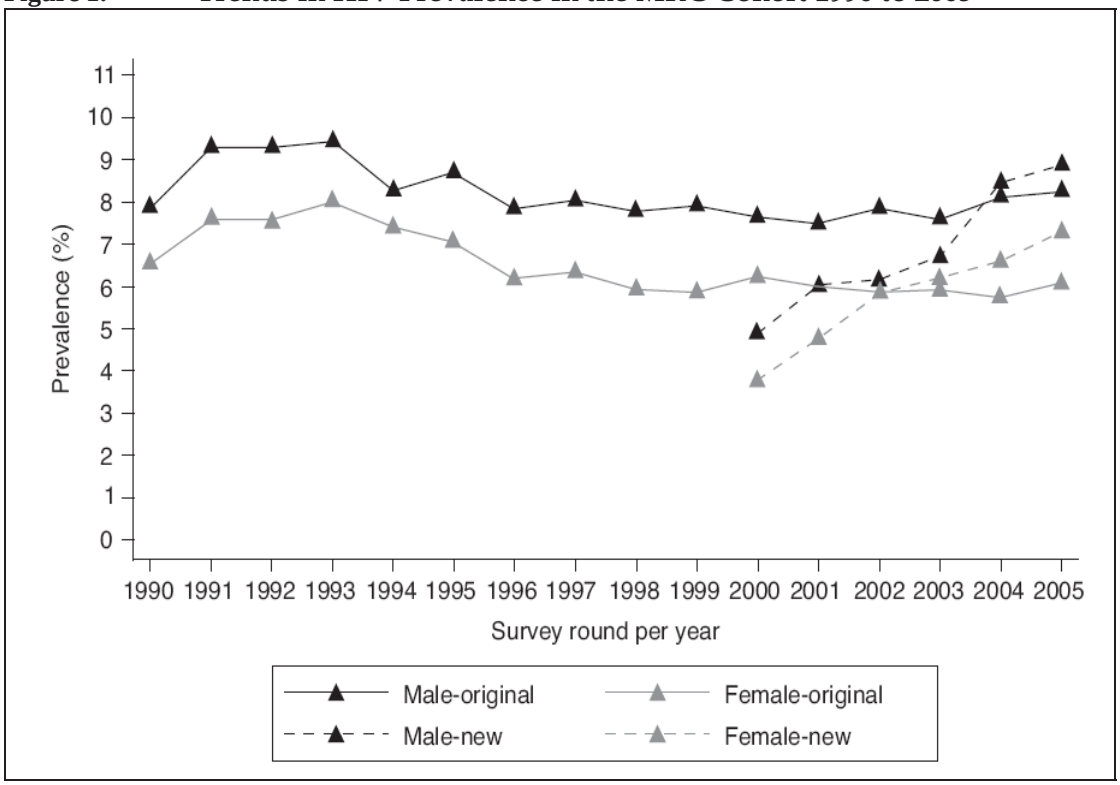
[33] Wabwire-Mangen F. (2008), A Review of the Epidemiology of the HIV/AIDS Epidemic in Uganda, Modes of Transmission Study: Uganda, GoU/UNAIDS/UAC Oct.2008

from younger to older individuals with the highest prevalence for men (9.9%) being among 35 – 39 year olds while for women (12.1%) it is among 30 – 34 year olds[34].

Incidence modeling reveals that 43% of new HIV infections are among monogamous relationships while 46% are among persons reporting multiple partnerships and their partners. Commercial sex workers (CSWs), their clients and partners of clients contribute 10% of new infections. Men who have sex with men (MSM) and intravenous drug users (IDUs) contribute less than 1%. There has also been a shift in concentration of the epidemic from younger to older individuals with the highest prevalence for men (9.9%) being among 35 – 39 year olds while for women (12.1%) it is among 30 – 34 year olds[35].

Data from the two population-based longitudinal cohort studies in Uganda i.e., the Medical Research Council (MRC) cohort as shown in Figure 1 and the Rakai Health Sciences Project (RHSP) cohort show that HIV prevalence and incidence rates might be rising in some population sub-groups in Masaka and Rakai[36]

Figure 1: Trends in HIV Prevalence in the MRC Cohort 1990 to 2005



[34]Wabwire-Mangen F., M. Odiit, W. Kirungi, D. Kaweesa Kisitu (2008), Modes of Transmission Study, Analysis of HIV Prevention Response and Modes of HIV Transmission, The Uganda Country Synthesis Report, GoU/UNAIDS/UAC Oct.2008

[35]Wabwire-Mangen F., M. Odiit, W. Kirungi, D. Kaweesa Kisitu (2008), Modes of Transmission Study, Analysis of HIV Prevention Response and Modes of HIV Transmission, The Uganda Country Synthesis Report, GoU/UNAIDS/UAC Oct.2008

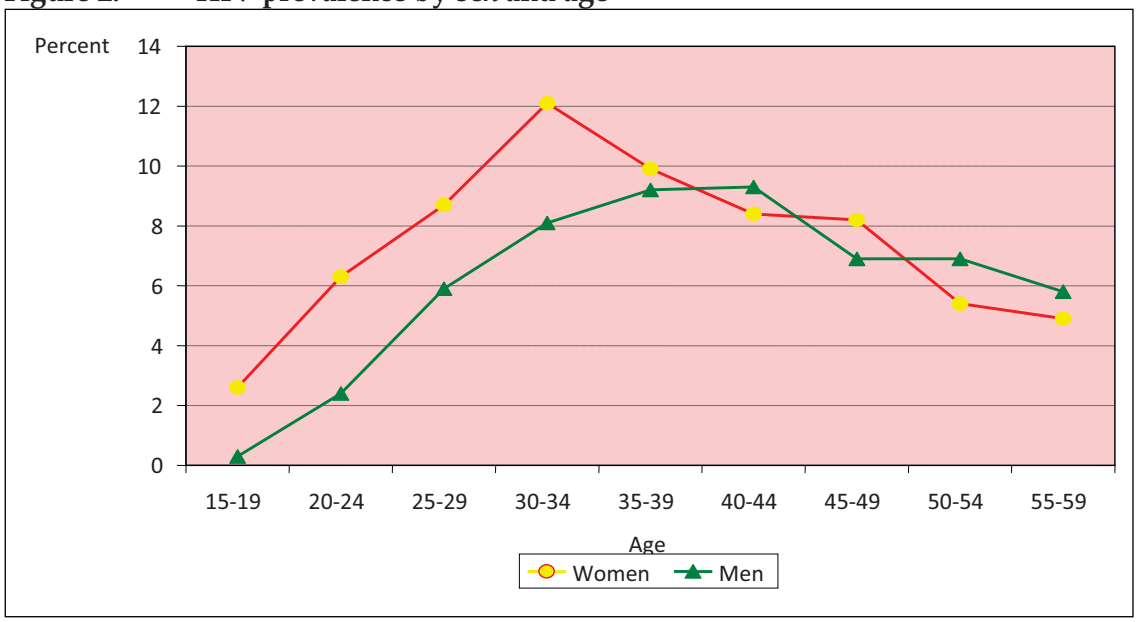
[36] Shafer L.A, et al. (2008), HIV Prevalence and Incidence are no longer falling in southwest Uganda: evidence from rural population cohort 1989 – 2005. AIDS 2008, 22:1641-1649

Source: GoU/UNAIDS/UAC Oct.2008, A Review of the Epidemiology of the HIV&AIDS Epidemic

3.2.2 *HIV Prevalence by sex and age*

The Uganda HIV Sero-Behavioral Survey (UHSBS) of 2004-05 (MoH&ORC Macro, 2006) found that HIV prevalence was higher in women compared to men and that it increased with age until it reaches a peak, which for women is attained at ages 30-34 (12%) and for men at ages 35-44 (9%). Women are more highly affected at younger ages compared with men. As shown in Figure 2, at ages 50-59, the pattern reverses and prevalence is slightly higher among men than women.

Figure 2: HIV prevalence by sex and age

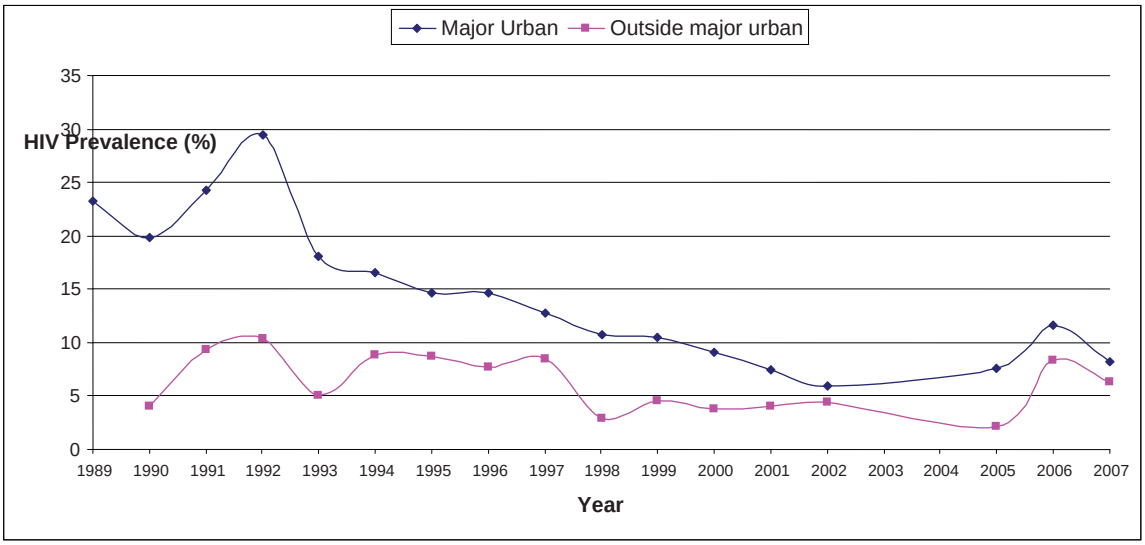


Source: MoH &ORC Macro (2006), UHSBS Survey, 2004-05

3.2.3 *HIV Prevalence by locality: urban and rural*

Since the onset of the epidemic in Uganda in the early 1980s, the prevalence has remained high in major urban areas compared to other localities—small urban centres and villages, although this gap started narrowing sharply since 2000 as shown in Figure 3.

Figure 3: HIV prevalence in major urban and rural communities



Source: MoH (2009), The HIV/AIDS Epidemiological Surveillance Report 2005-2007

More recent insights about the HIV epidemic by rural versus urban locations in Uganda have been provided by the analysis of the social, biological and behavioral factors associated with HIV[37]. The analysis shows that at a prevalence of 10%, urban residents have a significantly higher risk of HIV infection than rural residents (6%). This is true for both sexes, though the urban-rural difference is much stronger for women than for men.

The HIV&AIDS epidemic is heterogeneous with significant intra-regional variations according to Uganda HIV&AIDS Sero-Behavioral Survey (2004/05). See Figure 4.

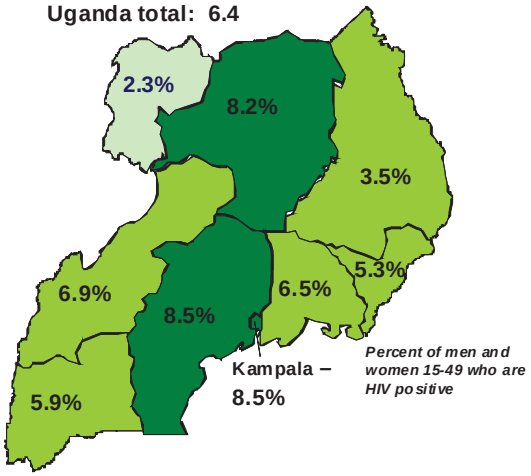


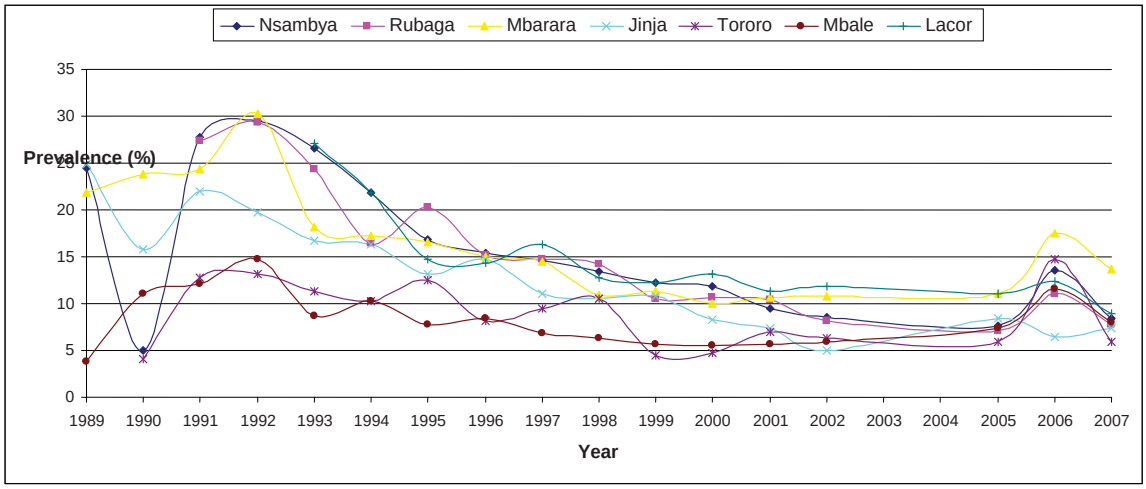
Figure 4: HIV prevalence by region

The HIV epidemic shows regional variations. Central, Kampala, and North Central regions all have rates of infection above 8% while West Nile and Northeast regions have the lowest prevalence at 2% and 4% respectively. In all regions, women have a higher prevalence of HIV infection than men. HIV prevalence is higher among those who are working than those who are not and there is a gradual increase in HIV infection with wealth quintile.

[37] Biraro S., Shafer L.A., Kleinschmidt I., et al. (2009), Is sexual risk taking behaviour changing in rural south-west Uganda? Behaviour trends in a rural population cohort 1993- 2006, Sexually Transmitted Infections, 85(Suppl I):13-111.

Sentinel surveillance sites from the mid-north generally record the highest overall prevalence in the country at 11.1% and 9.0% in 2005, 2006 and 2007 respectively The Central region has intermediate levels of ante-nantal HIV sero-prevalence and minimal intra-regional variation at 4.9%-7.6%, 9.7%-13.6% and 6.3%-8.4% for 2005, 2006 and 2007 respectively. The Eastern region also records intermediate levels of HIV prevalence in the urban sites of Mbale, Soroti, Tororo, and Jinja. The Western region has by far, the most marked variability and antenatal HIV prevalence ranges are 1.3%-11.1%, 4.0%-17.5% and 2.4%-13.7% for 2005, 2006 and 2007 respectively. Mbarara sentinel site in the west has the highest HIV prevalence in the country at 11.1%, 17.5%, and 13.7 for 2005, 2006, and 2007 respectively. Conversely, Arua hospital in West Nile has the lowest HIV prevalence in most of the years of trend observation. See Figure 5.

Figure 5: HIV prevalence in selected sentinel sites in Uganda



Source: MoH (2009), The HIV/AIDS epidemiological Surveillance report 2005-2007

3.2.4 Trends in antenatal HIV sero-prevalence

Studies[38] show that vertical transmission of HIV accounts for 18.1%. Available data reflect only a partial picture since a significant proportion of births in Uganda take place outside the health facility settings[39]. During the period July 2007 - June 2008, 739,656 pregnant women attended antenatal care at health facilities providing prevention of mother to child transmission (PMTCT) services. Of these, 700,471 (95%) received HIV counseling, 600,682 (82%) were tested for HIV, 39,328 (6%) tested HIV positive, 31,990 (81%) pregnant women and 16304 (41%) babies born to HIV positive pregnant women received antiretroviral drugs for PMTCT.

During July 2008-June 2009, 1,079,214 pregnant women attended ANC for the first time at health facilities providing PMTCT services. Of these mothers, 1,047,425 (97%) received HIV counseling, 968,157 (92.4%) were tested and received their results on the same day, 57,301 (5.92%) tested HIV positive. Of the pregnant women who tested HIV positive,

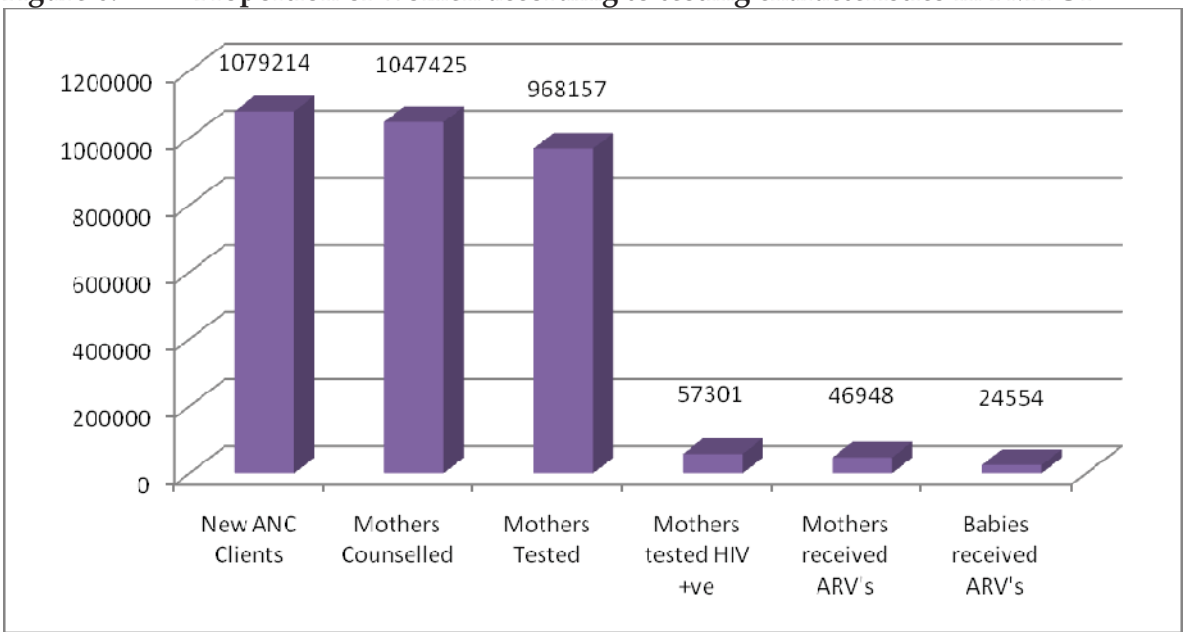
[38] Wabwire-Mangen F., M. Odiit, W. Kirungi, D. Kaweesa Kisitu (2008), op.cit

[39] UDHS (2006) shows that only 41% of deliveries take place in hospital settings, i.e. 29% in public health facilities and 12%in private health facilities.

46,948 (82%) received ARV medicines for PMTCT in ANC. This constitutes 51.6% (46,948/91000) of all the expected HIV positive pregnant women.

However, only 24,554 (42%) of the HIV exposed babies whose mothers tested positive received ARV medicines for PMTCT constituting about 27% of all the expected exposed babies. See Figure 6.

Figure 6: Proportion of women according to testing characteristics in PMTCT



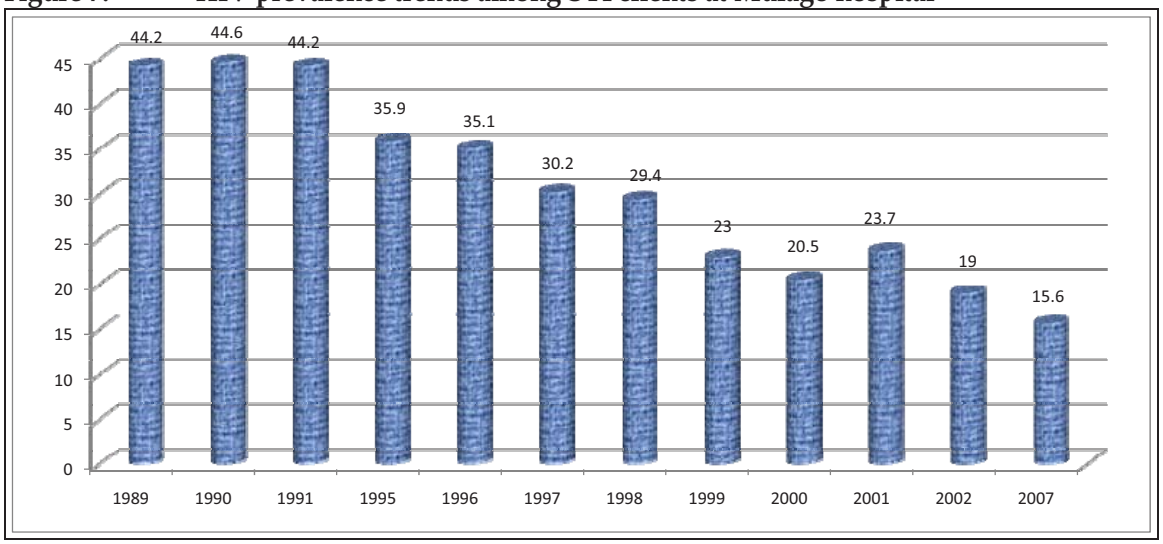
Source: MoH (2009), PMTCT Annual Report

3.2.5 Prevalence trends among STI clients

Prevalence trends among STI clients from a national sentinel surveillance site at Old Mulago Hospital in Kampala shows HIV decline in prevalence estimates from a peak of 44.2 percent in 1989 to 15.6 percent in 2007[40].

[40] MoH (2009), The HIV/AIDS epidemiological Surveillance report 2005-2007

Figure 7: HIV prevalence trends among STI clients at Mulago hospital



Source: MoH (2009), The HIV/AIDS epidemiological Surveillance report 2005-2007

3.3 Impact of the Epidemic

The impact of the epidemic is epitomized by HIV&AIDS related morbidity and mortality in the country. Based on the triangulation of antenatal HIV population sero-prevalence and population as well as demographic parameters, it is estimated that 1,101,317 people were living with HIV&AIDS in Uganda as of December 2008, of whom, 120,000 were children 0-14years. During 2008, an estimated 110,694 new HIV infections occurred countrywide. Approximately 61,306 people died from AIDS in 2008[41].

Table 3: Estimates of magnitude of HIV&AIDS, Dec 2008

Number of people living with HIV&AIDS	
Total	1,101,317
Males	470,122
Females	631195
Children(0-14years)	120,000
New HIV infections	
Total	110,694
Males	50,046
Females	60,648
Children(0-14years)	25440
AIDS deaths in 2008	
Total	61,306
Males	27,457
Females	33,849
Total need for ART	
Total	322,819
Males	130,766
Females	191,053
Adults(15years+)	279,679
Children(0-14years)	42,140
Total receiving ART (September 2008)	
Total	153,718
Adults(15years+)	140,305
Children(0-14years)	13,413

[41] *Ibid*

Source: MoH (2009), The HIV/AIDS Epidemiological Surveillance Report 2005-2007

4.0 NATIONAL RESPONSE TO THE AIDS EPIDEMIC

4.1 Introduction

The national response to the AIDS epidemic in the last two years i.e., 2008 and 2009 is presented in this Section. Policy development as well as implementation during the reporting period is unraveled, and progress made in prevention, care and treatment, and knowledge and behavior are presented. The final part of the Section examines changes in key programs and strategies in relation to impact alleviation.

4.2 Policy Development and Implementation

4.2.1 Overall progress in policy development

Many policies, guidelines and plans have been developed over the years, including the draft National AIDS Policy; the NSP, and several other policies and guidelines such as HCT, ART, PMTCT, OVC and Condom. There are number of other national planning frameworks and policies that address the control of HIV&AIDS in general such as the Poverty Eradication Action Plan (PEAP); National Vision for 2025; the National Health Policy and the Health Sector Strategic Plans (HSSPs), Universal Primary Education (UPE) and Secondary Universal Education (USE). The national response to HIV&AIDS has been manifested by evident political commitment at the highest level and support, policy of openness enhancing better dialogue and communication, multi-sectoral interventions and co-ordination.

In order to effectively facilitate and coordinate a comprehensive multi-sectoral response in Uganda, implementation roles of partners are steered under the Uganda HIV&AIDS Partnership; an innovative and systematic coordination mechanism at national level bringing to the fore the role of civil society together with the public sector. Currently, the constituencies, as Self-Coordinating Entities (SCEs)-in the Partnership, include Parliament, Ministries of Government, United Nations (UN) and Bilaterals, the Decentralized Response, PHA organizations, Private Sector, National NGOs, International NGOs, FBOs, Media and Youth, and Research, Academia and Science. This arrangement is nearly replicated at lower levels with the decentralized governance system in form of District Coordination Structures. However, these lower level structures are less active and inadequately guided

The SCEs operate within the realm of the National Strategic Plan[42] (NSP) for HIV&AIDS, which offers overarching guidance to the country response. The NSP was developed for the period 2007/08 to 2011/12 to give direction to efforts in addressing the HIV&AIDS

[42] Uganda AIDS Commission (UAC) 2007, National HIV&AIDS Strategic Plan 2007/8-2011/12, Moving Towards Universal Access

issues. The overall goal of the new NSP is to achieve universal access targets for HIV&AIDS prevention, care, treatment and social support by 2012. It aims at:

- Reducing the incidence rate of HIV by 40% by the year 2012,
- Improving the quality of life of PHAs by mitigating the health effects of HIV & AIDS by 2012,
- Mitigating the social, cultural and economic effects of HIV & AIDS at individual, household and community levels, and
- Building an effective support system that ensures quality, equitable and timely service delivery

The plan for the five (5) years (2007/8-2011/12) takes cognizance of the challenges that lie ahead to reduce new infections, prevent mother to child transmissions, and facilitate universal access to associated services. The critical emphasis of the plan is to integrate the continuum of HIV prevention, care and treatment; and reverse the trend in the number of people living with HIV. In addition, to consolidate and scale up access to ART, while providing much improved social support to reduce the socio-economic impacts of the epidemic.

In order to realize the goal of the NSP, Government, with the support of various development partners (DPs), CSOs and other stakeholders is implementing various programs including re-energizing HIV&AIDS control activities across the country, scaling up ART, HCT and PMTCT within the framework of the HSSP II and mitigating the impact of the epidemic.

To enable various institutions and organizations to effectively contribute the the national response in their day to day activities, a National Policy on Mainstreaming HIV&AIDS was developed. This is further meant to guide all development and humanitarian programmes of all government units, private sector and the Civil Society to mainstream HIV&AIDS and subsequently attain sustainable improvement in the livelihoods of all people in Uganda. In this way, all sectors of government and the Civil Society are mandated to operationalize the MACA and management of the associated effects. The policy is premised on principles of commitment to the cause, partnership and synergy building, respect of diversity and unity.

4.2.2 Policy development in relation to prevention

The country response to HIV prevention is spelt out in the NSP (2007/8-2011/12) and Road Map to Accelerating HIV Prevention 2008. The NSP has prevention as one of the three service thematic areas. The goals and objectives under this area are tabulated in Table 4:

Table 4: HIV Prevention component in NSP 2007/8-2011/12

Thematic area	Goal	Objectives
Prevention	The incidence of HIV and AIDS is reduced by 40% by the year 2012	The prevention of sexual transmission of HIV and AIDS is accelerated, targeting vulnerable and high-risk groups
		The HIV transmission from mother to child is prevented
		Blood transfusion safety, universal precautions and PEP are ensured

Thematic area	Goal	Objectives
		Sexually transmitted infections are controlled
		New HIV intervention technologies and approaches proven to be effective, are implemented

The HIV Prevention Roadmap specifically highlights the following:

- Prevention of the sexual transmission of HIV,
- Prevention of mother-to-child transmission of HIV,
- Promotion of greater access to HIV counseling and testing (HCT) while promoting principles of confidentiality and consent,
- Integration of HIV prevention, care and support services with other health care and social services,
- Integration of prevention into care and support programs for PHAs;
- Prevention and treatment of STIs,
- Focusing prevention on vulnerable and higher risk groups including young people,
- Advocating for protection of rights of women, girls, children, PHAs, IDPs and other minority groups within existing policy and legal frameworks,
- Preparation for access to and use of promising new technologies for HIV prevention
- consideration of appropriate and safe response to new evidence such as circumcision, HSV2 suppression therapy, microbicides and vaccines,
- Ensuring blood safety and reduce HIV transmission in the health care and other settings.

Management of STIs as a measure for prevention of HIV is fully embraced and in place are National Syndromic STI Management Guidelines. However, provision of STI treatment services is still limited. Although STI services are available in 60% of public health care (PHC) facilities, less than half of clients are being appropriately managed according to National Guideline[43]. On the other hand, condom distribution in the country has continued through provision of free condoms in public sector and social marketing. Also to be noted is that government has successfully rolled out Routine Testing in the clinical settings (RCT) starting with the Regional Referral Hospitals.

It is important to note that there has been a steady increase of PMTCT service delivery in the country. Changes include use of Combivir (AZT/3TC) plus single dose Nevirapine for PMTCT prophylaxis in higher level facilities while the lower level health facilities with constraints in human resource continue to use single dose Nevirapine only.

4.2.3 Policy development in relation to care and treatment

Care and treatment are prioritized under the NSP (2007/8-2011/12) as one of the three service thematic areas. The goals and objectives under this area are shown in Table 5.

Table 5: HIV care and Treatment component in NSP 2007/8-2011/12

Thematic area	Goal	Objectives

[43] MoH and ORC Macro International Inc, 2008, op.cit.

Care and Treatment	The health effects of HIV and AIDS are mitigated, improving the quality of life of people living with the disease	Equitable access to ART increased
		Access to prevention and treatment of opportunistic infections including TB and non ART care is increased
		HIV counseling and testing scaled up to facilitate universal access
		Prevention is integrated into care and treatment services
		The provision of home based care and improved referral systems with other health facilities are supported and expanded

A network of public, private not for profit (PNFP) and private for profit facilities provides care, treatment and support services. The PNFP facilities are mostly owned by NGOs, mainly FBOs. Functional village health teams (VHTs) comprising 9-10 people to facilitate the process of community mobilization and empowerment for health actions are also evident in many parts of the country. Progress in strengthening care and treatment is evident in various developments in the health sector under the overall stewardship of MoH. The following policy and implementation guidelines as well as other relevant materials are notable:

- The policy on feeding infants and young children in the context of HIV&AIDS which was reviewed to include all the aspects of Infant and Young Child Feeding
- Home Based Care Policy Guidelines
- Review and update of the protocol for conducting Anti-Natal Care and Sexually Transmitted Infection (STI) clinic based HIV surveillance
- Guidelines for Health Workers for Early HIV Diagnosis and Care among Infants
- Guidelines for nutrition among PHAs – ("Improving the Quality of Life through Nutrition: Guides for Feeding People Living with HIV & AIDS")
- Post Exposure Prophylaxis (PEP) policy and implementation guidelines
- HIV&AIDS handbook for life planning skills for Health Educators
- ART advocacy IEC/BCC materials

Although the policies and guidelines exist, large sections of the population still find it difficult to access health services. Health Centre (HC) IIs which are supposed to be nearest to local people are not adequately functioning in most districts and others have limited capacity to handle cases. Facilities, reagents and medical supplies, drugs and health service providers are considerably inadequate especially in public health facilities.

The critical challenge is to improve treatment, care and support systems for all people affected with HIV&AIDS by providing ARV therapy to ensure UA. This necessitates requiring the expansion of all essential care and treatment services to all district health units and health sub-districts, equipping all health units with ARVs and essential drugs for opportunistic infections and making them accessible all the time. Meeting this challenge requires building the capacity of the service delivery system including training of health workers, laboratory support, logistics and procurement. Issues of adherence and ART literacy call for more active involvement of the family, the PHA community, and other support systems to supplement the medical efforts.

4.2.4 Policy development in relation to support/mitigation of impact

The NSP (2007/8-2011/12) has Social Support as one of the three service thematic areas. The goals and objectives of this area are tabulated below:

Table 6: HIV support/mitigation component in NSP 2007/8-2011/12

Thematic area	Goal	Objectives
Social Support	The social, cultural and economic effects of HIV and AIDS are mitigated at individual household and community levels	Sustained and practical formal and informal education; and vocational and life skills development for OVCs, PHAs and other disadvantaged groups promoted and supported
		Sustainable livelihoods and economic empowerment of affected communities and households facilitated
		Access to basic social services for PHAs ensured
		Legal and appropriate social and community safety nets benefiting PHAs, OVC and other disadvantaged groups, ensured

Apart from UPE and lately USE, supported by the GoU, much of social support is by CS—NGOs, FBOs and CBOs, which are also challenged by big numbers of OVCs, PHAs and their families.

4.3 Prevention: changes in key programs and strategies

4.3.1 Blood safety

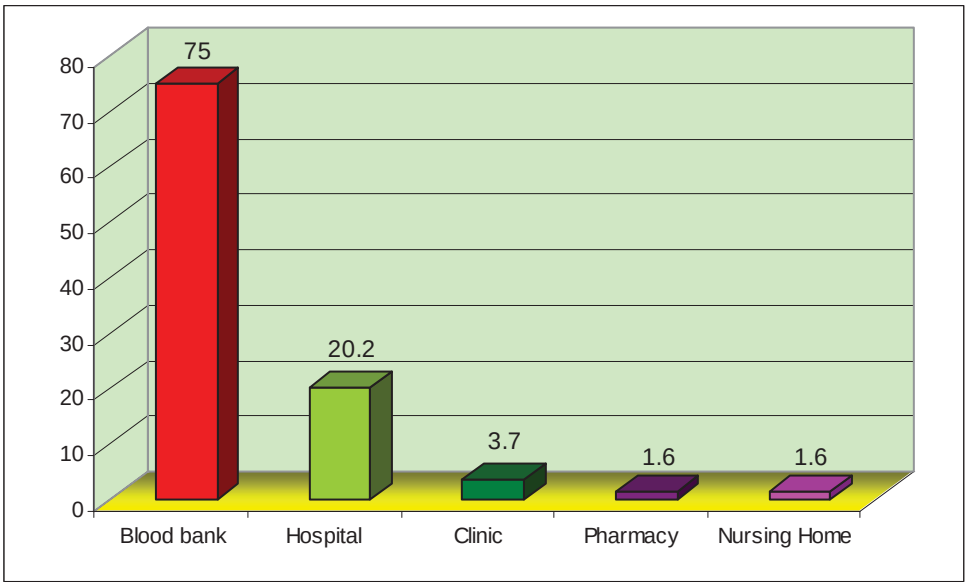
UNGASS Indicator 3: Percentage of donated blood units screened for HIV in a quality assured manner (2007=100%-All blood units collected were screened, 2008=100%, 2009=100%)

All blood donated is screened for HIV in a quality assured manner. Facilities involved in blood transfusion services access blood/blood products from blood banks. Public and PNFP agencies supporting blood transfusion services have in a place a number of interventions to ensure blood safety. These include; providing alternative blood products, mobilizing low risk donors, reducing blood wastage in facilities and providing HIV&AIDS testing facilities. All blood and blood products for transfusion in the country are screened for HIV, syphilis, HBV and HCV and other markers of infectious diseases. Most of the blood is screened from either the Blood bank or at hospital level. Very few service providers have their blood/blood products screened from clinics, pharmacies and nursing homes.

As at end of 2009, infrastructure for UBTS had expanded, with a number of regional blood banks increased from five to seven located in Arua, Gulu, Fort Portal, Kitovu, Mbarara, Nakasero. See Figure 7. The MoH through its departments of Quality Assurance, Curative Services, Nursing and ACP developed guidelines for PEP and

continues to over see implementation of medical infection control in peripheral health facilities.

Figure 8: Place of blood screening used by service providers, 2009



Source: UAC (2009), national Stakeholders and Services Mapping report

Through donor support, Making Medical Injections Safer (MMIS) project has undertaken to strengthen health care waste management, advocacy, community education, assessment of standards for incinerators and supporting facilities waste management capacity development. This includes training health care workers and medical waste-handlers in waste management, support to the provision of supplies such as syringes and needles with auto-destruct and waste disposal boxes.

4.3.2 Prevention of mother-to-child transmission

UNGASS Indicator 5: Percentage of HIV-positive pregnant women who received antiretroviral medication to reduce the risk of mother-to-child (June 2009 = 51.6% (46,948/91,000)

Number of HIV-infected pregnant women who received antiretroviral medicines (by regimen) to reduce the risk of mother-to-child transmission in the last 12 months
Types of regimen Combination regimen 25% (11,737/46,948), HAART 17% (7,982/46,948 and Sd NVP 58% (27,229/46,948)

The Uganda Ministry of Health began offering free PMTCT services in a small number of antenatal clinics in January 2000. A national PMTCT policy has since been developed which supports the four-prolonged PMTCT strategy (primary prevention, family planning, provision of ARV prophylaxis, care and support) in its PMTCT programme. It consists of HCT for mothers and giving ART to the infected ones during labor as well as to the new born baby. It also includes consolidation of services to increase uptake, male involvement, strengthening of family planning services and improvement of comprehensive care for HIV positive women and their spouses and their exposed children through early HIV diagnosis and linkages to care.

Currently, PMTCT is provided in all districts, in some places up to Health Centre II level. The quality of PMTCT services has greatly improved across many districts. The number of facilities providing routine HIV counseling and testing for pregnant women has continued to increase, raising the uptake of HIV testing from 70% of all clients attending ANC at health facilities providing PMTCT in 2005/06 to 80% in 2006/07. By December 2007, 43% of health facilities had PMTCT services available[44]. This has since been scaled up.

The scale up plan targets availability of PMTCT services in all health units that provide MCH services up to HC III level. The programme scaled up to 314 HC III's and 148HC II's in the FY 2008/09. By the end of June 2009, 947 health facilities up to HC III level were providing PMTCT services in the country. Overall 87% of hospitals, 93.2 % of HC IV's, 73.2% of HC III's and 12.4% of HC II's offer PMTCT services.

Table 7: Number of PMTCT sites by level, 2009

Level of facility	Total number	Coverage by June 2007	Coverage by June 2008	Coverage by June 2009
Hospitals	113	98	102	98
Health Centre IV	161	151	159	150
Health Centre III	955	258	385	699
Health Centre II	1887	61	86	234
Total up to HC III	**1229**	**507 (41.3%)**	**646 (52.6%)**	**947 (77%)**

Source: PMTCT Annual Report MoH

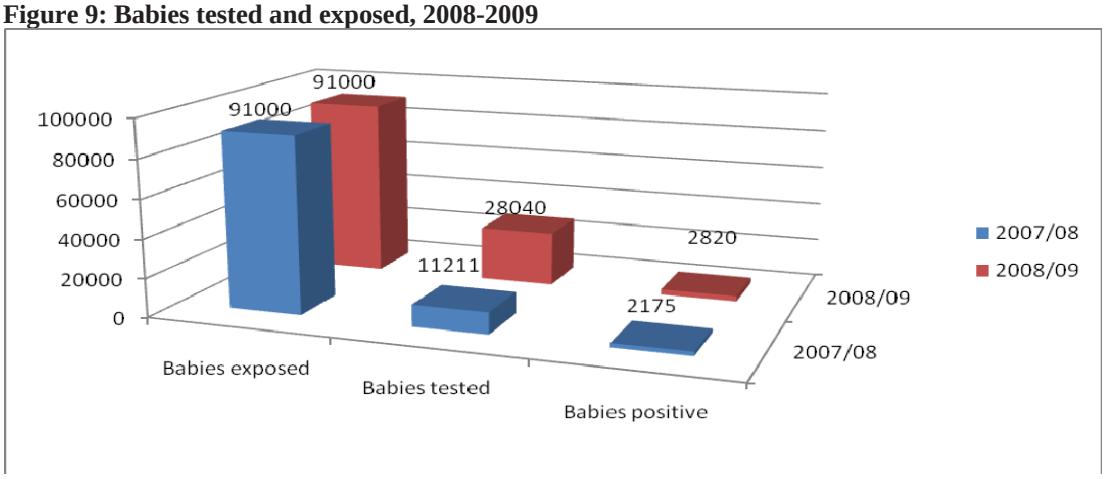
Current data for the period of July 2007 to June 2008[45] shows that at least 20172 (22%) out of the 91,000 potentially infected were tested positive and 18,530 (92%) of them were given ARVs for prophylaxis. In 2008/09, 42% of HIV positive mothers received combination regimens including HAART compared to only 23% of the mothers who received combination regimens in 2007/08. By the end of June 2009, 42% of mothers had received Combination ARV's for prophylaxis including HAART while 58% had received sdNVP

[44] Wabwire-Mangen F., M. Odiit, W. Kirungi, D. Kaweesa Kisitu (2008), Modes of Transmission Study, Analysis of HIV Prevention Response and Modes of HIV Transmission, The Uganda Country Synthesis Report, GoU/UNAIDS/UAC Oct.2008

[45] Report on Implementation of National HIV and AIDS Strategic Plan FY 2007/2008, October 2008

Missed opportunities in administration of antiretroviral drugs to HIV positive mothers has greatly reduced; 92% of all clients diagnosed HIV positive are given ARVs as opposed to 64% of clients who tested HIV positive in 2005. In January 2007, the country started providing services for Early HIV diagnosis among infants and 5,300 clients from 150 health facilities have been tested of which 20% were HIV positive[46].. By the end of June 2008, 193 health facilities were providing EID services From July 2008 to June 2009, the PMTCT programme scaled up EID services to 424 health facilities. During the reporting period, 28,040 HIV exposed babies were tested using DNA PCR between 6 weeks and 18 months of age representing only 31% (28,040/91000) of all HIV exposed babies. Out of those who were tested, about 10% (2820/28,040) tested HIV positive as at the time of taking off the sample from the baby. Of those found positive, 1,300 were initiated on ART. See Figure 9.

Figure 9: Babies tested and exposed, 2008-2009



Source: PMTCT Annual Report, 2008/09

Despite the tremendous efforts in PMTCT, it remains the 3rd leading source of HIV infections (24%) in the country. Uptake is still low, it is below 50%[47]. A lot has to be done if HIV transmission from MTC is to be halved by 2012. More health centers have to be equipped, along with more trained personnel and improved monitoring and evaluation tools. Some of the concerns during 2008-2009 included:

- Continuing missed opportunity for averting prenatal HIV infections from the PMTCT cascade because the programme currently reaches less than 50% of eligible women.
- Low male partner involvement especially in cases of HIV-infected women continues to compromise the programme.
- The limited support for other elements of the PMTCT package such as generic infant formula.
- Insufficient linkage to other services for treatment and care, family planning and reproductive health

[46] Report on Implementation of National HIV and AIDS Strategic Plan FY 2007/2008, October 2008
[47] National HIV and AIDS strategic Plan 2007/8- 2011/12

4.3.3 HIV testing in the general population

UNGASS Indicator 7: Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results (2009= about 20%, was 4.0% Women and 3.8% Men as of end of 2005)

In Uganda, there are various categories of HCT. These include voluntary counseling and testing (VCT). In 1999 MoH started a voluntary door-to-door HIV screening programme using rapid tests in an effort to make HIV screening services accessible to more people, especially in rural areas where there were neither modern laboratories nor electricity to run standard HIV tests[48]. Routine Counseling and Testing (RCT) has also been scaled up to enable the health care system introduce patients found to have HIV to appropriate clinical care early enough. Uganda has revised the VCT policy and included RCT and home-based counseling and testing (HBCT). The HCT services are now available in all districts but uptake is still low, though the numbers are slowly increasing[49]. More has to be done since reports show that only 20% of Uganda's population know there sero status.

4.3.4 Most-at-risk- Populations (MARPs): Prevention programs

UNGASS Indicator 8: Percentage of MARPs who received an HIV test in the last 12 months and who know their results (49.3% CSWs had ever had VCT as of year 2003)

UNGASS Indicator 9: Percentage of MARPs reached by prevention programmes (denominator not known for MARPS**)**

Although, the HIV epidemic has become generalized, there are still sections of the population that are at relatively higher risk of HIV infection compared to the general population. Within the Uganda context, the MARPs have been identified to include commercial sex workers (CSWs); fishing communities; displaced people (IDPs) and refugees; persons in uniformed services; and persons with disability (PWDs). Prevalence of HIV&AIDS is overwhelmingly high among the MARPs. Although, national data on the prevalence rate of HIV is not available, reported prevalence from participants of project studies shows the rate is higher than the national average. The lack of up-to-date data in itself is driving the epidemic. For instance, the CSWs, their clients and partners of clients contribute 10% of new infections.

4.3.5 Life-skills based HIV education in schools

Percentage of schools that provided life-skills based HIV education in the last academic year (PIASCY 2009 annual report=18,062 total number. Primary and Secondary schools with trained teachers in life skills as of 2005 = 15)

A number of IEC/BCC programmes have been implemented in schools at all levels including President's Initiative on AIDS Strategy for Communication to Youth (PIASCY), Straight Talk Foundation (STF) and anti-cross generational sex campaign. PIASCY is premised on the belief that, if parents did not want to talk to children about

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[48] Moodie, Rob et al. (1993) 'Confronting the HIV epidemic in Asia and the Pacific: successful strategies to minimise the spread of HIV', AIDS

[49] **WHO/UNAIDS/UNICEF (2009) 'Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector'**

sex, their teachers would teach them about it. This program includes some aspects of the ABC program i.e Abstain, Be faithful, or *Condomize*. There are different messages for Peer 1-3, Peer 3-5, and Peer 5-7. STF has been implemented in secondary schools since 1993. This initiative is part of the Education Sector Strategic Plan which also includes MoES HIV&AIDS Sector Policy Guide and MoES HIV&AIDS Workplace policy

One aspect of STF is the Outreach and Training Program (OTP) that started in 2001 involving face-to-face communication, which complements the newspapers and radio programs. It focuses sensitizing and training teachers as well as students at different levels. Organizations and programmes such as the Programme for Accessible Health, Communication and Education (PACE) Uganda has implemented anti-cross generational sex campaigns using the mass media and interpersonal communication (IPC) to target young women and parents through peer education and parent child communication training. Others such as the Y.E.A.H Initiative is a multi-channel communication campaign by and for young people that combines mass media, person-to-person dialogue, and community media.

4.4 Care and Treatment: Changes in Key Programs and Strategies

4.4.1 HIV treatment: antiretroviral therapy

UNGASS Indicator 4: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy (Sept 2009=53.5% for men and women**,** signifies an increase from 39% (91,500) by end of 2006 based on cut-off CD4 <250 = 373,383**)**

Significant progress has been registered over the last couple of years in provision of treatment and care for People Living with HIV&AIDS (PHAs). This includes providing Antiretroviral Therapy (ART), Cotrimoxazole Prophylaxis (CPT), treatment of Tuberculosis (TB) and other related opportunistic infections and related support services. Initially there was a fee-for-service programme, but in June 2004 Uganda started offering free ARVs with support from the World Bank and GFATM. PEPFAR and USAID projects later supported Uganda with free ARVs[50].

In addition, three quarters of all health facilities routinely provide CTX prophylaxis while over two thirds of facilities offering HIV&AIDS care and support services also have medicine to treat bacteria infections like pneumonia and other basic pain management.

Table 8: Number of ART accredited sites by level (2007-2008)

Health Facility	Total	Coverage June 2007 (%)	Coverage June 2008 (%)
National Referral	2	2(100%)	2(100%)
Regional Referral	11	11(100%)	11(100%)
Other Hospitals	88	88(100%)	88(100%)
HC IV	165	103(62%)	117(70%)
HC III	905	29(3%)	29(3%)

Source: Report on Implementation of National HIV and AIDS Strategic Plan FY 2007/2008, October 2008

[50] Uganda National UNGASS 2007 report

By June 2008, about 141,416 individuals were receiving ART, compared to 67,525 in 2005[51] [52]. The NSP target is 240,000. The uptake of ART services has considerably increased and by the end of September 2009, there were 200,213 clients on antiretroviral therapy country wide (i.e. 8.5 % children aged <15 years, and 91.5% adults aged over 15 years). The annual numbers of active clients since 2003 to September 2009 is shown in the adjacent figure. By end of 2008, an estimated 373,836 adults and children were severely immuno-suppresed with CD-4 T cell count of less than 250 cells per microlitre. This represents, approximately 54 % of individuals in need of ART according to national guidelines on treatment by end of 2009. The figure 200,213 clients on ART that is reported amounts to slightly over half of those in urgent need. The number of accredited ART sites increased from 220 in December 2006 to 349 by June 2008. More progress was registered during 2009 as shown in Table 9.

Table 9: Coverage of ART services by level of facility as of Sept 2009

	Total	Providing ART	
Health Facility Level	**N**	**n**	**%**
National Referral Hospitals	2	2	100%
Regional Referral Hospitals	11	11	100%
District/general Hospitals	98	98	100%
Health Centre IV	166	130	78%
Health Centre III	905	40	4%
Health Centre II	1887	2	0.1
Research Programme[53]	NA	4	
Specialised clinics[54]	NA	31	
Private for Profit Clinics)	U	52	
Total		374	
NA: Not applicable, U: Unknown			

Source: MoH ACP 2009

Overall, only a fraction of facilities in the country prescribes ART and this is mostly at hospitals and Health Centre IVs[55]. Other challenges during 2008-2009 include the following[56]:

- There is inequity in access; some populations with high risk are under-served (e.g. CSWs, fishing communities, and PWDs).
- Understaffing, low staff motivation and high attrition, added to staff transfer and redeployment after training which affects continuity
- Stock out of ARVs especially through the GFATM mechanisms and the long term institutional arrangement that was recommended is not yet fully functional.

[51] Report on Implementation of National HIV and AIDS Strategic Plan FY 2007/2008, October 2008
[52] Uganda National UNGASS 2007 report
[53] Research Programmes include Makerere University / John Hopkins University Collaborative Project, Home-Based AIDS Care Project in Tororo, Medical Research Council, Rakai Health Sciences Project etc
[54] These include dedicated ART treatment centres ran by TASO, JCRC Regional Centres of Excellence, Mbuya Reach out etc
[55] MoH (2008), Uganda Service Provision Assessment Survey 2007, Kampala, Uganda
[56] Report on Implementation of National HIV and AIDS Strategic Plan FY 2007/2008, October 2008

- The capacity of National Medical Stores (NMS) logistics management to deliver/distribute ARV drugs and other supplies to cover 300 sites is constrained.
- There is under reporting from the facilities to the MoH with only 40% reporting in a timely manner on the quantity of drugs required.
- At higher level, there are also delays in release of funds for the purchase of drugs and clearance of drugs that have been procured

4.4.2 Co-management of tuberculosis and HIV treatment

UNGASS Indicator 6: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV (Oct 08-Sept 09=60% [18062/30,032], was 60% as of end of 2006

Reports[57] show that as at end of 2007, a significant proportion of facilities were providing TB services, diagnostic services were available at 97% of the hospitals, 98% of HC IV, 50% of HC III, and 9% of HC II while treatment and follow up was available at 93% of hospitals, 98% HC IV, 70% of HC III and 11% of HC II. Among facilities providing TB treatment and follow up 68% of the hospitals, 84% of the HC IV, 85% of HC III and 94% of HC II were following the DOTS strategy. Therefore, gaps also exist here.

Some of the key gaps documented[58] include the following:

- Integration of TB and HIV care and treatment has not been fully achieved and the referral systems are still weak.
- The case detection rate for TB in the country is still very low and stands at 50.2% (30). The case holding and follow-up is also a challenge and affects the completion and cure rate.
- Missed opportunity for HIV testing among TB patients still exists. A significant proportion of the 218 surveyed facilities that were providing TB services did not routinely refer TB patients for HIV testing[59].Only 79% of hospitals, 62% of HC IV, 42% of HC III and 13% of HC II routinely referred TB patients for HIV testing[60].
- There is not sufficient data to show extent of drug resistant TB. Some studies in the country have documented its existence.

4.4.3 ART adherence support

UNGASS Indicator 24: Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy

Data from a sample of facilities[61] in July to September 2009 showed that at the end of 12 months, 86% of clients were presumed to be still alive and on treatment (82.5% at the original facility and 4.1% had transferred to other facilities; 5.2 % had died, 7.1% had defaulted or were lost to follow-up and 1.1 % had stopped treatment.

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[57] Uganda Service Provision Assessment survey, 2007
[58] UAC 2008, Report on Implementation of national HIV&AIDS strategic Plan FY 2007/2008
[59] *USPA 2007 survey, op.cit*
[60] *Ibid*
[61] *Information gathered from reports available at AIDS Control Program of MoH, 2010*

It has long been revealed that a major challenge to the ART programme is adherence, maintenance of care and retention of clients since follow up is still very minimal[62]. This situation has not changed significantly except where there are Network Support Agents (NSAs) for PHAs. These have remained active especially in places where CSOs have strong partnerships with the health facilities to provide both counseling and general HIV&AIDS at facility level, and in the communities.

4.4.4 Pediatric HIV

UNGASS Indicator 25: Percentage of infants born to HIV-infected mothers who are infected (National EID Database, 2009=9.9%, was estimated 30% without intervention)

The MoH developed a national network for early diagnosis for HIV infection and by June 2008, 135,000 children had been tested since December 2006. Estimates put a total of 47,000 children who require treatment but by June 2008, 27% had received treatment (12,577), an improvement from the 6,000 by December 2006. Other reports[63] show that only 27% of the eligible children are on ART. The estimated number of such infants that would be eligible for ART is 25,000 annually.

With the increase of counseling and testing services, the uptake of HIV testing steadily rose from 70% of all clients attending ANC at health facilities providing PMTCT in 2006/07 to 97% in 2008/09. On the other hand, it is shown that only 24,554 (42%) of the HIV exposed babies whose mothers tested positive received ARV medicines for PMTCT constituting about 27% of all the expected exposed babies. In general, majority of the mothers who attended ANC were counseled and tested. In addition, majority of the identified HIV positive mothers received ARV medicines for PMTCT.

Thus, more than 50% of the babies whose mothers tested positive did not receive ARV's for PMTCT of HIV. In order to address the low coverage of infant ARV prophylaxis, Uganda with support from UNICEF, embarked on using repackaged Nevirapine (NVP) in outlets.

Despite the above, over the reporting period, Infant and Young Child Feeding (IYCF) Policy Guidelines were updated. A process to disseminate the guidelines together with International Baby Food Action Network (IBFAN) was started. However, incorporation in PMTCT policy and implementation guidelines was not done pending release of new WHO guidelines for PMTCT.

It is important to note that inadequate community mobilization and education to support pediatric care impacts on linkage to care for infected children. The number of implementers and clinic providing child and adolescent friendly services including reproductive issues for children remain limited.

4.5 Knowledge and behavior: Changes in key programs

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[62] *Mafigiri, D., Rundall, S., McGrath, J., & Kakande, I. (2004) Barriers to ARV treatment: perspectives of women on ARV Treatment in Uganda, Paper presented at the XV International AIDS Conference, Bangkok, Thailand*

[63] *UAC (2008), report on implementation of national HIV&AIDS Strategic plan FY 2007-2008*

4.5.1 Knowledge about HIV&AIDS

UNGASS Indicator 13: Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (UDHS 2006= Women 15-24 years 31.9% and Men 15-24 years 38.2%)

UNGASS Indicator 14: Percentage of MARPs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (Based on KAPB and Sero Survey on HIV&AIDS and STDs among CSWs 2003=82.6% cited two preventive practices

In order to operationalize the country plan and road map to prevention, Uganda has a plethora of information, education and communication (IEC)/behavioral change communication (BCC) campaigns for cross-sections of the population using mass media and interpersonal communications (IPCs). A number of sex education programmes even for young people that are outside the school system are in place including Young Empowered and Healthy (Y.E.A.H) and STF Outreach and Training Programme. FBOs under their Umbrella of Inter-Religious Council of Uganda (IRCU) are notably active in prevention efforts. Their approach basically emphasizes abstinence and faithfulness in marriage, and care and support for PHAs.

Overall, awareness about HIV&AIDS and correct knowledge about modes of transmission and, therefore, ways of prevention is significant. Differences are depicted in knowledge of specific aspects related to the epidemic as information about HIV&AIDS continues to advance. The only recent national survey (UDHS 2006) shows that of the age group of 15-49 years, 28.3% women and 35.8 % men have comprehensive knowledge about HIV&AIDS while for the ages 15-24 years 29.5% women and 35.3% men do have a comprehensive knowledge.

Full attainment of the targets on knowledge about HIV&AIDS is affected in a number of ways:

- There is growing concern that living with HIV&AIDS for over two and a half decades but still without an ultimate cure has tended to create anxiety among people. Lately, there has developed a problem of complacency, which is serving to increase risk of infection.
- Some people have developed a passive attitude to prevention. In the recent past, studies have consistently shown lapses in IEC and tendencies towards complacency or prevention fatigue.
- The vigilance in IEC is gradually changing from personal communication methods (IPCs) to electronic and print media channels and greater focus on the availability of ARVs. The new Roadmap is partly expected to reverse this trend.
- Interpersonal (face to face) channels of communication were not adequately rolled out to compare mass-media-based communication.

4.5.2 Age at onset of sexual intercourse

UNGASS Indicator 15: Percentage of young women and men aged 15–24 who have had sex before the age of 15 (2005= Women 12% for age group 15-19 and 17% for 20-24,

Men 16.3% for age group 15-19 and 10.8% for 20-24,based on UHSB survey 2004/05)

The country has registered positive changes in delay of sexual debut over time largely owing to concerted IEC/BCC strategies targeting adolescents, youths and unmarried people. Programmes have been run to promote abstinence in and out of school environments e.g. PIASCY. Mass media abstinence messages using radio, television, and print media have been rolled by government institutions and civil society. For instance, 2 million young people were reached with abstinence programmes through face to face communications through PIASCY during the 2007/2008. Additionally, approximately 60% of 10 million young people aged 10-12 years are reported to have been reached by Straight Talk Foundation and the YEAH campaign with mass media abstinence messages using print media and radio.[64] Debates, drama groups and youth peer education have been used to educate the youth about HIV&AIDS and thus promoted safer sexual behavior among the youth.

However, further progress during 2008-2009 to increase age of sexual debut was affected in several ways, including the following:

- Limited scope of programmes, for instance, the PEARL project in MoGLSD which supports peer education and sexual reproductive health activities for out-of-school youth in several districts, scaled down operations from the 19 districts it previously supported.
- The coverage and outputs of these efforts such as YEAH, Uganda Youth anti-AIDS Association, SFT and other CSOs implementing life skills education activities for in and out-of-school youth on national scale have not been consolidated.
- Programmes of several CSOs such as PSI/PACE which conducted anti-cross generational sex campaigns among high school and university students in the last five years have come to an end

4.5.3 Casual sex and condom use

UNGASS Indicator 16: Percentage of adults aged 15–49 who have had sex with more than one partner in the last 12 months (2005= Women 3.8%, Men 29.3%,based on UHSB survey 2004/05)

Early in the response, the number of Ugandan men reporting three or more non-marital sexual partners fell from 15 percent to 3 percent between 1989 and 1995.[65] However, more recently, it has been revealed that 43% of new HIV infections now occur among people in mutual monogamous heterosexual relationships[66]. In response, a campaign to encourage faithfulness in this group has been started, to add impetus to efforts already directed towards those involved in casual sex. Religious institutions like churches, mosques, Inter Religious Council of Uganda (IRCU), Catholic Relief Services have supported increased mutual fidelity among couples.

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[64] Report on Implementation of National HIV and AIDS Strategic Plan FY 2007/2008, October 2008

[65] Bessinger and Akwara (2003) 'Sexual Behavior, HIV and Fertility Trends: A Comparative Analysis of Six Countries Phase I of the ABC Study'

[66] Wabwire, F., Odiit, M., Kirungi, W., & Kisitu, D. K. (2008), The Modes of Transmission Study. Analysis of HIV Prevention Response and Modes of HIV Transmission: The Uganda Country Synthesis Report

The practice of extramarital sex though still highly prevalent continued to be the focus of programmes promoting the ABC+ strategy among agencies during 2008-2009, especially those promoting mutual infidelity. However, during 2007-2009, the country still grappled with long standing challenges to risk reduction, in particular apparent reversal in sexual behavior patterns especially among young people and men. These include decrease in primary abstinence, condom use and multiple partners. Some of the outstanding gaps include the following:

- Most adults in Uganda do not know their own HIV sero-status, and even fewer know the sero-status of their partners.
- Lack of coordination and technical guidance to the multiple partners involved in behavioral interventions. The quality of the messages is highly variable and at times contradictory.
- Apparent society's tolerance of men's premarital and extramarital sex
- Length of postpartum sexual abstinence and lactational amenorrhea
- Communities still considering sex as a sacrosanct matter and to divorce discussions about sexual behaviour and practices from everyday discourses

UNGASS Indicator 17[67]: Percentage of adults aged 15–49 who have had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse (Women= 9.1%, Men =16.1% (UHSB Survey, 2004/05)

Initially, condoms were not heavily promoted and distributed during the early years of the AIDS epidemic in Uganda, as they were considered to offer false hope that the epidemic could be stopped without curbing multiple sexual partnerships. This changed in mid-nineties when condoms were widely distributed, rising the number delivered and promoted by international groups from 1.5 million in 1992 to nearly 10 million in 1996[68]. About 130.7 million condoms were procured and distributed by MoH, MSI, PSI (now PACE) and AFFORD as compared to 107.5 in 2006 or 39.1 in 2004[69]. During 2008-2009, government received condom procurement support from organizations mainly UNFPA, AHF Uganda Cares, AMREF and Marie Stopes International. Messages on condom use have been passed using print media and broadcast. Many billboards and posters have messages like 'use a condom correctly and consistently'. Condom use is emphasized for all sexually active people, especially those in the more risky situations like when one has multiple sexual partners, when the partner's HIV&AIDS status is not known and for discordant couples.

Although, there are National Condom promotion guidelines, risk is still perpetuated by limited targeting of services to MARPs and low levels of condom use and promotion in long standing relationships. Less than half of risky sexual acts are protected by condoms[70]. Attainment of the NSP targets on risk reduction is still affected due to several programmatic challenges:

- Peer support networks especially for young people, workers, uniformed forces and other targeted sub-groups are implemented with variable scope and

[67] Millennium Development Goals indicator
[68] Africomnet (2007) 'Uganda's Early Gains Against HIV Eroding'
[69] Uganda National UNGASS 2007 report
[70] UAC (2008), National Guideline for HIV prevention in Uganda

coverage largely due to inadequate resources available to implementing agencies.

- Despite having public sector condom distribution outlets in communities and organizations doing social marketing, distribution especially commercial distribution is limited mostly to urban centres.
- Insufficient funding for condoms procurement as well their supply chain management. There are frequent stock-outs as well as insufficient quantities for distribution.
- Female controlled prevention technologies such as the female condoms are not widely used.

4.6 Impact Alleviation: Changes in Key Programs and Strategies

UNGASS Indicator 10: Percentage of OVCs whose households received free basic external support in caring for the child (PEPFAR 2009 annual report=253,449 total number)

UNGASS Indicator 12[71]: Current school attendance among orphans and non-orphans aged 10–14 (2007=81.9% orphans attended school. The ratio for the age group 10-14 years is not available)

There have been efforts to improve care and support for and consequently alleviate the impact of HIV&AIDS on PHAs, OVCs and their families. Some of the work documented[72] in mitigating the effects of HIV&AIDS includes the following:

- Development of policies and guidelines for nutritional care and support for PHAs, feeding of infants and young children in the context of HIV&AIDS
- Provision of nutrition and other care and support to OVCs in parts of the country
- Developing IEC materials and training of various care and support providers in the a number of communities and districts of the country
- Implementation of HBC especially by NGOs/CBOs in various modes
- Expansion of various psychosocial support services especially to OVC, including life skills, counseling and guidance, formal education and vocational training
- Training of various categories of duty bearers to promote rights through legal, social and community support for OVCs and other vulnerable groups.

The outstanding gaps include the following:

- Information gaps concerning geographical coverage and the types of organizations providing OVC services.
- Inequity in funding and coverage of psychosocial support services to needy OVCs in all districts, and extending psychosocial training beyond the service providers.
- Very few OVCs are receiving a comprehensive package of psychosocial support services.

[71] Millennium Development Goals indicator
[72] UAC (2008), report on implementation of national HIV&AIDS Strategic plan FY 2007-2008

- Even though vocational and apprenticeship infrastructure have been established through public and NGO initiatives, few OVCs are served.
- Overall, little progress has so far been registered regarding actual provision of essential entitlements to OVCs and other affected groups.

5.0 BEST PRACTICES

5.1 Introduction

The section on best practices is guided by the definition of "best practice" by UNAIDS[73]. The best practices have been carefully selected to reflect the achievements attained based on four goals of the NSP. In choosing each based practice, the UNAIDS criteria has been applied where possible; effectiveness, replicability, ethical soundness, sustainability, cost effectiveness, relevance and innovativeness.

5.2 Use of Community-Based Volunteers (CBVs)

CBVs are referred to differently depending on contexts and organizations such as HIV&AIDS treatment supporters (HATS), peer promoters, community health workers, expert clients and community-based workers (CBWs). Regardless of the name, they serve their respective communities voluntarily with little or no monetary incentive. In this report, the term CBV refers to all CBWs. The World Health Organization (WHO 1987 in Gilson et al, 1989)[74] defines CBWs as individuals that live in the community they serve, are selected by the community, are accountable to the community they work in, receive a short defined training and are not necessarily attached to any institution.

Several organisations in Uganda such as The AIDS Support Organization (TASO, Kamwokya Christian Caring Community, Kitovu Mobile, Integrated Community-Based Initiatives (ICOBI), Mild May, Uganda Reproductive Health Bureau, Nsambya Home Care, THETA, Africa Social Development and Health Initiatives, Uganda Youth Anti AIDS Association and Kasana-Luwero Diocese use CBVs as mobilizers and conduits for the delivery of HIV&AIDS services. Such services include home visiting, follow up on patients who are on ART and OIs treatment, basic counseling, peer education and social support to clients and their families, among others. These institutions and AIDS programs also use and rely on CBVs as a strategy for promoting and strengthening community participation and support, increasing service coverage, promoting and strengthening treatment adherence.

In identifying and selecting CBVs, organizations use a number of criteria, but mainly personality and character attributes (e.g. approachability, self-respect and respect for others, trustworthiness, hardworking, empathy, commitment to the ideal of service, ability to mobilize others, integrity, reliability and responsibility), contextual factors (e.g. residence in the area, understanding and identification with local context, cultural values and norms and problems being addressed), active participation in

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[73] See UNAIDS Best Practice-Responses That Work and Lessons Learned. Available at: http://www.aids.md/information/best-practices/what-best-practices-are [Accessed on 1st February 2010]. Pragmatically, this definition refers to a "best practice" as any undertaking that has contributed in one way or another to progress in the field of HIV&AIDS work or shed new light on relevant issues. UNAIDS further argues that best practices refer not only to the most successful practices that demonstrate new techniques that can be adapted or built on, but also the ones that help identify certain weaknesses, so that they can eventually be avoided or more easily overcome.

[74] Gilson L, Walt G, Heggenhougen K, et al. *National community health worker programs: How can they be strengthened?* Journal of Public Health Policy 1989; 10(4): 518-532.

community/village activities and distinguished as opinion leader, recommendation by community leaders, prior training under other related programs (implying one has basic knowledge and skills). In some institutions and communities, an invitation is circulated and interested members register to work as volunteers. The names of those registered are then read to the community members for selection and appointment as CBVs during village and parish meetings (Khanya-ICDD, 2006).

In some of the organisations, the CBVs are clients already accessing treatment, commonly known as *expert clients*. Others use a combination of selected community members and the expert clients. Each selected CBV is assigned a given number clients whom s/he follows on a weekly basis and gives regular reports to the implementing agency.

Existing studies[75] indicate that CBVs are relevant to both communities and institutions because of their numerous functions in community. These include, providing services that are more relevant to the needs of the poor and underserved populations, following up their clients at home regularly, identifying health and psychosocial social problems early and make timely referrals. Besides, CBVs are less expensive and cover a bigger area, which ensures that the poor and vulnerable can also be reached by services at low cost. Furher, reports of CSOs in Uganda that use CBVs reveal that they have been instrumental in helping organizations achieve and/or even exceed their targets. A Study by Khanya-ICDD (2006) showed that CBVs had improved adherence among clients accessing ART and treatment for OIs at Kamwokya Christian Caring Community, Kampala district and Bulo STI/AIDS Awareness Group, Mpigi district. This in turn led to fewer deaths and reduced orphan-hood, stigma, and increased productivity in the beneficiary families and communities. There is evidence in annual and progress reports of a number of CSOs, MoH, MoES and FBOs in Uganda that the CBV strategy has facilitated increase in service coverage.

Although the use of CBVs transfers costs to communities, the benefits manifested in the capacity built, knowledge management, increased treatment that reduces mortality, morbidity and orphanhood and increased productivity at the family and community level seem to outweigh the costs. CBVs are community-based structures whose capacity has been built over the years to respond to the AIDS pandemic. They therefore constitute a critical mass of AIDS activists and volunteers at the community level with the capacity to sustain HIV&AIDS conversations beyond the life of many projects.

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[75] (a) ibid, (b) Berman, P, Davidson, R, Gwatkin and Burger, S (1987) *'Community based health workers: head Start or false start towards health for all?'* Social Science and Medicine 25 (5) 443-459, (c) Walker, D., G., and Jan, S., 2005. *How Do We Determine Whether Community Health Workers Are Cost-Effective? Some Core Methodological Issues*, Journal of Community Health, 30(3): 220-229, (d) Khanya-ICDD, 2006. Report on the evaluation of the impact and cost-effectiveness of using Community-Based Workers in HIV and AIDS interventions: the case of KCCC and BUSTHA in Uganda

Table 10: Case studies of CBVs addressing HIV&AIDS

Societies Tackling AIDS Through Rights (STAR)	*Expert clients enhancing ART & OI treatment adherence*
Supported by ActionAid Uganda, STAR is an integrated approach to HIV&AIDS using a tri-focal lens of gender, human rights and HIV&AIDS; facilitating the link with poverty, vulnerability and injustice in 21 districts of Uganda. A total of 25–30 volunteers in participating communities called "Star Communities" come together to form a circle. The circles come together to tackle common concerns and priorities. They also mobilize other community members to change traditions that fuel HIV transmission and also put pressure on institutions to increase responses to the epidemic. They link up with the general public, CBOs, NGOs and other institutions to bring about the desired outcomes. Circles have successfully advocated and obtained services for whole communities to address not only for prevention of HIV&AIDS, but also CD4 count services and issues of expiry of ARVs. In some communities condom-distribution points at village level are now established. Many STAR circle members reported to be well informed about HIV prevention, care and treatment	Expert clients are people living with HIV&AIDS who have not only overcome stigma but are knowledgeable and experienced role models for other PHAs. Currently, expert clients are found in almost every ART site in Uganda. They are involved in various activities in the ranging from managing the records office (filing), triage, providing psychosocial support, promoting use of basic care products and services, health education, pre-test and post test counseling to bleeding new testers for HIV. Expert clients are selected by managers of the ART clinics in the various ART sites and are trained or given apprenticeship at site. The criteria for selection are basic, i.e., the persons should be trainable, literate, possess leadership skills and open about their HIV status. Selection, training, responsibility and remuneration of expert clients are dependent upon the health facility and available support especially from partner organizations. Utilization of expert clients reduces stigma and discrimination, boosts uptake of the basic care services and fosters adherence to ART. Relate easily with peer PHAs, play the role of peer educators as well as health educators.

5.3 Using the Basic Care Starter Kit to support HIV care for PHAs

With support from CDC, Population for Accessible Health, Communication and Education (PACE), formerly Population Services International (PSI), has in the past five years implemented HIV services including care and support for PHAs through the Basic Care Program (BCP). The evidence based BCP aims to help reduce morbidity and mortality caused by OIs in PHAs and to reduce HIV transmission to unborn children and sexual partners through prevention with positives interventions (PWP).

Through IEC and training of health workers and Peer Educators (PEs), many of them "expert clients", the BCP promotes use of co-trimoxazole prophylaxis (CTX), safe water systems (SWS), and family planning and PMTCT services. Items provided to PHAs in the BCP Starter Kit include four (4) bottles of purifying solution - Waterguard, two (2) long lasting insecticide treated bed nets (LLINs), a filter cloth, a guidebook on positive living, and sixty (60) condoms. BCP also has arrangements for refill any time the recipient runs out of any of the items. Other components of the BCP include Advocacy, Integration and Monitoring and Evaluation (M&E).

The PHAs are identified through facility and family based counseling and testing. Distribution of the BCP kits is done through both public and private not for profit (PNFP) health facilities (hospitals, health centres, and PHA service organizations) referred to as BCP partner sites. Distribution of kits is managed through a supply chain

constituting of PACE's warehouse, logistics department, regional BCP coordinators and the BCP site supervisors.

A multi-channeled communications campaign that educates PHAs on how to prevent OIs, live healthier lives through CTX prophylaxis, prevention of diarrhoeal diseases using household water treatment and safe storage, use of LLIN for malaria prevention, and Prevention with Positives interventions has been implemented. Radio programs, peer education sessions and health talks as well as print IECs are variously used. Training of health service providers and peer educators is one of the fundamental pillars of the BCP program. As matter of procedure, before any BCP partner site starts distributing or providing BCP products and services, its health workers are taken through a series of targeted trainings.

BCP program maximizes utilization of the existing infrastructure and human resource in the partner sites, organizes an integrated package of the basic care kits, using local manufacturers for some of the commodities, extending holistic products to the clients while reducing the handling costs. Refresher trainings, supportive supervision and home visits are arranged as and when needed.

The BCP is relevant since it fills a critical gap and improves the quality of life of individuals and families affected by HIV&AIDS. For instance, malaria is the number one cause of morbidity and mortality, which is controlled by adherence to the program by PHAs beneficiaries of the kit. Though all the people living in Uganda are at the risk of being infected with malaria parasites, the threat is greater for PHAs because their immunity is often compromised. Malaria in PHAs is associated with more severe diseases and death[76]. When malaria combines with diarrhea arising from using unsafe (contaminated) water and foodstuffs, the results are fatal for PHAs. Therefore,

Implementation of the BCP and particularly provision of a comprehensive care kit to PHAs has proven a valuable intervention in reducing morbidity and mortality caused by OIs among PHAs. Overall, there is clear evidence of success of the mass media campaign, the Interpersonal Communications (IPCs), creation of ownership and acceptance of the various components of the BCP starter kit, and ultimately reduction in prevalence of OIs among PLHIV who have received and used the BCP starter kit. BCP program beneficiaries, the counselors and other health workers acknowledge a significant decline in cases of malaria and diarrhea among PHAs, and significant change of behaviour to living positively.

The BCP strategy/concept can replicated in other areas with HIV and malaria. Rollout of the concept only requires adequate funding and partnering with existing structures and networks proving care and support to PLHIV. There is no need to establish parallel structures. However, care should be taken to ensure that the contents of the kit respond to the felt needs of the PLHIV in that community. This means that prior to its implementation, a baseline study should be undertaken to assess the needs of the

[76] Ter Kuile, F.O. et al, 2004. The Burden of co-infection with human immunodeficiency virus type 1 and malaria in pregnant women in sub-Saharan Africa. *American Journal of Tropical Medicine and Hygiene* 71(Suppl.2) 41-54

beneficiaries and determine how to market and implement the project. In addition, as much as possible, the components of the kit should be readily available in the market to enable clients to access them whenever they need hem. The BCP kit is integrated in existing HIV programs and not a stand-alone program, which reduces the stigma that would be borne by beneficiaries. Besides its implementation is based on research which take into account the needs and concerns of the target group.

Though the BCP saves lives and substantially reduces costs borne by health facilities and families, it is entirely dependant on donor funding and support from the government. This is because most of the PHAs that need it are poor yet when they come down with HIV&AIDS their production and productivity also goes down. The BCP Kit is quite expensive for the public sector to meet, each kit costs USD 25. Without PACE and the development partner, it would be impossible for the PHAs to continue receiving the health commodities, save perhaps for health talks at point-of-service. At the moment, no systematic studies have been done to assess the cost-effectiveness of the BCP kit. Nonetheless, given the impact of malaria on health and poverty levels in Africa, it makes both economic and public health sense to invest in its prevention and/or treatment using approaches such as the BCP Kit. According to World Bank, the annual economic burden of malaria in Africa is US $12 billion[77]. In Uganda, the direct cost of treating an episode of suspected malaria is US $4.10 in urban areas and US $ 1.8 in rural areas[78]. World health organization and UNICEF estimate that the proportion of household expenditure on malaria may reach up to 34 percent among the poor[79].

5.4 Harmonization and alignment of donor support: A Case of Civil Society Fund (CSF)

The CSF is a landmark effort among the Government of Uganda, civil society and development partners (DPs) to effectively coordinate and harmonize support to civil society. It seeks to effectively mobilize civil society's contribution towards attainment of the national targets in line with the Universal Access Initiative. The purpose of the CSF is to bring together multiple donor funds and disperse grants to CSOs that are fully aligned with national plans and decision taking processes and enable an effective, scaled up and comprehensive response to HIV&AIDS, TB and malaria. Before CSF, several donors were supporting civil society through multiple granting mechanisms operating in the country. Beginning in 2004, a number of bilateral agencies, led by DFID and IrishAid, collaborated to establish a granting mechanism that harmonized and streamlined donor support to CSOs. At the same time, USAID had been supporting the development of a civil society granting mechanism through which Ministry of Gender, Labor and Social Development (MoGLSD) would partner with civil society to support orphans and other vulnerable children (OVC) and HIV prevention among youth.

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[77] World Bank, 2008 in the Uganda Service provision Assessment Survey 2007. *What do you know about malaria in Africa?* Washington, DC: World Bank. Available at *www.measuredhs.com/pubs/pdf/SPA13/SPA13.pdf.* Accessed March 10, 2010.

[78] Ministry of Health (MoH) Uganda, 1998. *Uganda Malaria Control Policy,* Kampala, Uganda: MoH

[79] WHO and UNICEF, 2003. *The Africa Malaria report 2003* in the *Uganda Service provision Assessment Survey 2007*. Available at *www.measuredhs.com/pubs/pdf/SPA13/SPA13.pdf.* Accessed March 10, 2010

In an effort to merge these initiatives and create a more streamlined approach, a partnership was formed between UAC, various line ministries, AIDS Development Partners (ADPs) and representatives of Civil Society to establish a pooled funding mechanism, referred to as CSF. The objective of the CSF is to efficiently disburse funds to civil society and ensure a coordinated, aligned approach. The CSF was finally established in 2007 and was officially launched in May 2008 with a grant portfolio of approximately $33 million from contributing donors for Years 1 & 2. By the end of 2009, the CSF had a funding portfolio of US $ 41,216,926.36. The CSF is the first of its kind in the health sector in Uganda. The overall leadership, guidance and direction of this unique funding mechanism are provided by a Steering Committee, which serves as a sub-committee of the UAC Partnership Committee[80] while day-to-day operations are executed by the technical, financial and M&E management agents, in partnership with the CSF Secretariat.

CSF harmonizes donor funding and aligns it to key elements of the NSP, increases transparency and accountability for funds allocated to various entities and minimizes duplication of services since major development partners put their resources in a basket. Beneficiary CSOs are thoroughly assessed to establish their capacity to effectively use funding to meet the needs of the target populations. Since its inception, the CSF has so far disbursed over Uganda sh.70 billion in 142 grants to over 100 CSOs, including local CBOs, FBOs and large national NGOs. CSF has also made nine (9) non-competitive grants to national NGOs undertaking unique or innovative activities, such as NGO networking and large-scale service delivery. A further 80 grants have been given to District Governments to support OVC services by CBOs, and 17 grants to OVC psychosocial and livelihood services. The pooling of funds has set a positive precedent for a common ownership of strategic responses and increased transparency and accountability, which is the very essence of the Uganda HIV&AIDS Partnership.

Putting resources into a basket by different ADPs minimizes administrative costs previously borne by the different ADPs when funding the myriad CSOs. It also simplifies monitoring resource allocation and usage. More importantly, the CSF ensures that resources go to interventions responding to the NSP elements and address the identified gaps in the AIDS response. The set-up and running of a CSF can be replicated anywhere provided the ADPs can agree to pool and channel funds under a basket funding mechanism. They must also agree to create and support a representative body to manage the resources.

Despite all the above, the CSF depends on the willingness of ADPs to continue pooling resources. If and when such partners opt for managing their funding processes, the CSF concept becomes unsustainable. Nonetheless, the way the Uganda CSF is structured, CSO capacity is built to a level that enables them to develop sustainability and investment plans, compete for resources from donors and effectively use existing resources. A critical part of the CSF is the focus on knowledge management (i.e. documentation of best practices, publication of training resources/materials etc), which transforms benefiting CSOs into professional and competitive agencies. As part of their

[80] UAC Partnership Committee (PC) serves as the Board of Directors or the custodian of the Fund.

sustainability plan, a local indigenous CBO will be identified. Its capacity will be built to take over the functions of the TMA, MEA and FMA. If this is done, it will constitute a good exit strategy for the agencies that are currently managing CSF. In addition, although the initial investment for setting up the fund is quite high because of the costs of the agencies managing the technical and financial components and producing materials, these reduce over time as capacity is built for the local indigenous agencies to take over management of the fund.

5. 5 Providing HIV&AIDS Services at the Workplace

Provision of HIV&AIDS services at the workplace involves mainstreaming HIV&AIDS into an organization's systems, practices and policies. Several agencies within the private sector have embarked on providing HIV&AIDS prevention and treatment services at the workplace. The Agency for Co-operation in Research and Development (ACORD), an international NGO operating in Uganda, through its Stop AIDS Now! (SAN) Project has for example supported 76 organizations in the country to introduce this scheme at their workplaces.

Provision of HIV&AIDS services at the workplace starts with aiding staff in the organization, managers and board members to recognize the reality of HIV&AIDS. It involves supporting the staff to analyse how HIV&AIDS can affect them at their place of work and at home in order for them to take action to prevent the spread of HIV, and improve the quality of life of PHAs. The range of services to be provided at the workplace is determined by conducting a risk and vulnerability assessment as well as on self-organizational assessment on level of AIDS competence.

The second step is development of HIV&AIDS Workplace Policy which details all the services and products that will be availed to staff and their families to prevent the spread of HIV and improve the quality of life of PHAs. It is in the workplace policy that organizational commitments with regard to provision of HIV&AIDS services are documented. An organization reviews its policies, systems, practices and activities to identify opportunities they provided for responding to HIV at the workplace. With support from CSF, the SAN project supports efforts to increase the number of people getting tested. In recognition of the importance of VCT for a successful workplace policy response, ACORD also supports the *"Know Your Status"* campaign, popularly known as "Customized Family Day Events." These events make it possible to bring testing and counseling services near to individuals at their workplaces. So far the project initiative has involved 32 local NGOs reaching a total of 2,401 staff and family members.

Most of the existing HIV services provided by government and CSOs are provided at times when their potential clientele are busy, which signifies the relevance of this practice. Workplace based HIV services ensure that such busy people also have a chance to access services at convenient times and venues. There is evidence in Uganda that several organizations have started providing HIV&AIDS related services at workplace.

For instance, a study undertaken by the Emerging Markets[81] among 82 Ugandan employers selected from the membership rolls of the Federation of Uganda Employers (FUE) and the Uganda Manufacturers Association (UMA) showed that 50% of the 'Large' companies in Uganda are providing ART services while 75% of employees living with HIV in these companies have access to ART services. Companies such as Hima Cement Limited, British American Tobacco, Uganda Clays, Uganda Breweries, provide HCT, condom promotion and distribution, HIV education and ART for company employees and dependents. In particular, Hima Cement Limited covers the costs for CD4 monitoring tests for their employees and dependants.

In organizations where HIV&AIDS workplace services are provided, awareness and knowledge levels on the basic facts of the HIV&AIDS are high and many employees are willingly testing for HIV. Open discussion about HIV&AIDS related issues in everyday discourse at workplace is notable. Further, everyone is aware that their job security is not threatened by their HIV status. Similarly, a study undertaken in one of the multinational companies providing ART in Uganda to its employees showed that AIDS services reduce absenteeism and medical care costs borne by the company and employees, death benefits, hiring and training of replacement workers, supervisory time and the decline in productivity while the sick worker remains on the payroll[82]. Prior to provision of ART to employees, the cost per worker lost was approximately 15.5 million Ushs. Providing treatment at a cost of US $363 per worker per year, reduced mortality, attrition related costs in the company studied from 1% of the total annual labor costs to 0.11%, a reduction of almost 90%. Another study by the Emerging Markets Group[83] indicated that formal sector employers in Uganda are an important source of medical services for their employees. If such companies stopped offering these services, the burden on the public health system would be immense.

With regard to ethical soundness, provision of HIV services at workplace follows MoH Guidelines on VCT and ART. Organisations also adhere to confidentiality and non-discrimination principles enshrined the company HIV and AIDS workplace policies. Provision of workplace service has been adopted and adapted by several companies in Uganda especially the multinationals. However, smaller companies are still unable to provide similar services at the level of large companies.

Chances of sustainability of this practice are high since provision of HIV related services has been integrated into company policies and systems for providing employees and their dependants. Since provision of treatment minimizes attrition due to morbidity and death it contributes to the retention of skilled and experienced staff. This ensures that companies continue to be profitable and therefore in position to meet employee healthcare costs. Employees kept alive are able to mentor and pass on relevant skills,

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[81] Busulwa, I., Guariguata, L. 2009. *The Role of Uganda Businesses in Providing Health Services: Report of a Survey of Uganda Employers on Employee Attrition, Sick Leave and Health Services provided,* Kampala: Emerging Markets Group

[82] See Bukuluki, 2009 above.

[83] See Busulwa and Guariguata, 2009 above.

institutional memory and ethos, which is an effective succession planning mechanism that keeps companies competitive.

5.6 Utilizing Socio-cultural structures and Resources to Prevent HIV

Spearheaded by Traditional and Modern Health Practitioners together against AIDS and other Diseases (THETA), this practice entails identify existing socio-cultural structures, resources and networks to work with in promoting HIV prevention and/or treatment, care and support for those living with and affected by HIV&AIDS. THETA employees a cultural approach[84] that aims at identifying and optimally utilizing the cultural resources in a given community to deal with problems such as AIDS and other diseases.

In Uganda, within the framework of the cultural approach to HIV&AIDS prevention and care, THETA identified and equipped *sengas* and *Kojjas*[85] with skills and information for engaging communities in discussing how to prevent and mitigate **HIV risk factors** (i.e. concurrent partnerships, discordance and non-disclosure, transaction sex, cross-generation sex, alcohol and drug use, behavioural dis-inihibition due to ART) and the **socio-cultural factors** (i.e. polygamy, social pressure to bear children, widow inheritance, condoning early marriages, glorifying non-marital sex and multiple sexual partners; looking for children especially male children outside marriage, expectation to have unprotected sex whatever the circumstance) that increase their vulnerability and susceptibility to HIV infection. It also mobilized other cultural resources such as traditional healers, TBAs, and kinship structures to participate in the fight against HIV and AIDS in their communities. The *Sengas* and *Kojjas* are identified through a baseline survey which identifies community members and structures that are consulted about sex and sexuality issues. This process leads to the selection of those to train during workshops in integrating HIV counselling in their routine practice. The training workshops delve deep into the socio-cultural issues that increase people's vulnerability to HIV infection; equip the trainees with skills in basic counseling, group discussion facilitation, record keeping and referral.

The relevance of this practice is derived from its ability to promote community dialogue, couple discussions and communication in relation to sex and sexuality matters, which affect peoples' relationship and make them vulnerable to HIV infection. It also tackles socio-cultural issues that have been documented86 as key drivers of HIV infection in Uganda. Analysis of existing literature shows that such informal and culturally

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[84] Sengendo et al, 2000 have defined the cultural as a strategy for identifying, understanding and appreciating existing cultural resources and networks in the community and innovatively utilize them to address problems and integrate cultural perspective in development discourse. For details see Sengendo, J. Bukuluki, P and Walakira E. (2000). The cultural approach to HIV/AIDS prevention and care, Kawempe Project. Studies and reports, special series, issue No. 15 division of cultural policies, UNESCO, 2001

85 "Sengas" literally means "paternal aunt" while Kojja literally refers to "maternal uncle". The "Sengas" is a woman who traditionally offers couples and young people guidance on relationships, marriage strengthening, sexuality, reproductive health practices, and promotes traditional cultural values among community members using traditional counseling methods. The Kojja is a male peer promoter whose roles are similar to those of a Sengas only that he is responsible for the male gender.

[86] See Wabwire-Mangen F., Odiit. M, Kirungi. W and D. Kaweesa Kisitu, 2008. *Analysis of HIV Prevention Response and Modes of HIV Transmission: The Uganda Country Synthesis Report*, Kampala: Uganda AIDS Commission & UNAIDS

appropriate dialogues were instrumental in influencing behaviour change in the face of HIV& AIDS[87]. A study undertaken by MRC and Rakai Health Sciences Program (formerly Rakai Project) in Masaka and Rakai districts in Uganda showed that using *sengas* in sex education contributes to increased knowledge about HIV, sexual communication skills, consistent condom use and family planning service use in the intervention group of girls over the study period and compared to control girls[88]. Further, evidence from THETA's work in 8 districts (i.e. Kayunga, Mpigi, Kaliro, Kiboga, Mukono, Apac, Mbarara, Hoima) in Uganda shows that this practice mobilizes and sensitizes people about HIV& AIDS, most especially the men, commercial sex workers and young people involved in cross-generational sexual relationships.

With regard to replicability and sustainability, in most African societies, there is an abundance of such socio-cultural structures, resources and networks that can be tapped into to promote HIV prevention. They may be called different names but have such roles as educating people about sex and sexuality issues. What is critical is to understand who they are, where to find them, what they do and how they do it, who they influence and how to target them in the fulfilment of HIV prevention objectives. Empowering existing kinship structures such as the *Sengas* and *Kojja*s to integrate HIV education in their work, community capacity is built to address health and psychosocial problems in a sustainable and context-specific manner. Those empowered continue to serve the community beyond the lifecycle of most projects. *Sengas* and *Kojjas* in most cases provide their services on a voluntary basis. The costs involved in engaging them relate only to the initial training workshops, on-going follow-up, support and supervision. Since they are based in the communities where they serve, there are minimal or no costs incurred by their clients as they access their services.

Lastly, it can be noted that integrating HIV education existing community-based support structures and networks is an innovative approach since it enables individuals and communities to continuously dialogue and find community-grown solutions to HIV& AIDS and other social challenges in a culturally appropriate manner that they value deeply and are accustomed to.

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87 See for instance (a) Green E.C, 2003. Rethinking AIDS Prevention, Westport, Ct: Praeger, (b) Green, E C, Halperin, DT, Nantulya, V., Hogle J.A, 2006. *Uganda's HIV Prevention success: The role of Sexual abstinence and the National response*, AIDS and Behaviour, Vol. 10. No. 4: 335-344, (c) Green, E.C. 2003. *Faith-based Organisations: Contributions to HIV Prevention*, a report by the Synergy Project implemented by TvT Global Health and Development Strategies, a division of Social and Scientific Systems, (d) Kaleeba, N, Namulondo, J, Kalinaki, D, and Williams, G., 2000. *Open Secret: People facing up to HIV and AIDS in Uganda* (strategies for Hope series No. 15) London: Action Aid

88 Muyinda H, Nakuya J, Pool R, Whitworth J., 2003. *'Harnessing the Senga institution of adolescent sex education for the control of HIV and STDs in rural Uganda'*, AIDS Care 15(2): 159-167

6.0 MAJOR CHALLENGES AND REMEDIAL ACTIONS

6.1 Introduction

This Section examines the major challenges during the reporting period and the remedial actions being taken. As per reporting guidelines, the Section begins with a highlight on the challenges identified in the last UNGASS Report and the progress made.

6.2 Challenges in Last UNGASS Report and Remedial Actions

Three key challenges were identified in the last UNGASS Report, namely, missing baseline values, overstretched service levels and, policy and guideline implementations.

6.2.1 Missing baseline values in the NSP

i. Challenge

The first challenge in the last UNGASS was that some indicators in the NSP 2007/08 – 2011/12 lacked baseline values. It was recognized that in order to measure the progress of implementation of the NSP 2007/08 – 2011/12, presence of baseline values was vital for measurement of progress, although some of the indicators required a sizable amount of resources.

ii. Progress

Some effort is being made to obtain baseline values in NSP through the respective line GoU Ministries, and districts. At the district level, with support from Irish Aid, the Ministry of Local Government (MoLG) embarked on supporting 32 districts to develop their own district-focused HIV plans that are aligned with the NSP, and include baseline values. By Year-end 2009, 10 of these districts had completed developing such plans.

6.2.2 Over stretched service levels

i. Challenge

Noted in the previous UNGASS was that a great deal of progress in fighting HIV&AIDS in Uganda had been made through the provision of ART, Home-Based HIV Counseling and Testing (HBHCT) and child healthcare. However, it was observed that as HIV related deaths reduce, the numbers requiring treatment, care and support services increases. It was noted in the Report that "*the demand for care and support services is, therefore, ever increasing over and above the available service thus overloading the available services. This further compounds an already existing problem of low human resource at the health facility especially in PMTCT and ART. These are the same health facility staff to train and implement other activities like counseling and treatment of opportunistic infections within the health facility. There is a weak sub-national public and private capacity in implementing the health sector response to HIV prevention*".

ii. Progress

Although overstretched service levels still remains a challenge, some deliberate efforts have been done to improve on service delivery in the last two years. For instance, all

Health Centre IVs in the country provide ART. Similarly, services such as HCT and PMTCT have been expanded in the last two years. Despite this improvement, the need still remains high. At this reporting period, it has to be emphasized that service provision has not reached a level of creating much impact as planned in the NSP, and hence much more needs to be done.

6.2.3 Policy and guideline implementation

i. Challenge

Policy and guideline implementation was identified as a challenge in the sense that available policies guidelines at national level at the last time of reporting were not presented in an easily understandable package for sub-national structures or in some cases were non-existent.

ii. Progress

Effort has been made to identify vital policies and prepare simplified versions for use at sub-national levels. Through workshops of stakeholders UAC has endeavored to disseminate some of the policies and guidelines, although much more need to be done in the area of dissemination. In a related manner, the MoLG was able to undertake district mapping of services and deal with governance issues related to HIV&AIDS such as establishment, strengthening and coordination of District AIDS Committees and District AIDS Task Forces (DATs), Sub-county AIDS Committee (SACs) and Sub-county AIDS Task-forces (SATs).

The UN and other partners supported UAC to plan for and hold the 2008 Joint AIDS Review (JAR). Through this process, UAC working with CSOs and other government sectors was able to review progress in the implementation of the first year of the NSP, develop the National Priority Action Plan (NPAP) and the Performance Measurement and Management Plan (PMMP). National and district technical staff and other stakeholders have been oriented on both the NPAP and PMMP.

It is worthy noting that in the last two years there have been developments in the area of policy as part of the national response to the epidemic. For instance, a policy on Medical Male Circumcision (MMC) has been finalized, and it is hoped that by June 2010 it will be out[89]. The Home-Based Care Policy was also finalized in this reporting period, and is available for use by stakeholders.

6.3 Challenges Faced Jan 2008-Dec 2009

Several challenges have been reported by key actors contributing to the national response to the epidemic. These were captured in the filled NCPI and synthesized by the consultant. They include the following:

[89] Personal Communication by the MoH official during the TWG meeting of March 10, 2010

6.3.1 Policy implementation and M&E environment

Despite the successes registered in the planning and policy environment, there are challenges that need to be addressed. For instance, the enactment of the National HIV&AIDS Policy has not happened. The Draft National HIV&AIDS has been before Parliament for sometime now. What is happening is that instead, laws on HIV&AIDS are being proposed ahead of the policy, which might result in un-cordinated policy environment and contradictions in the national response. It is also important to note that although there is a National M&E Framework for HIV&AIDS, there are noticeable policy and programmatic challenges that relate to M&E such as uncoordinated data bases at national level, unclear system for information sharing, improper data validation system and scattered data collection tools. See Section 8.0 for more details.

6.3.2 Challenges in prevention

Although there have been major inroads and achievements in the thematic area of prevention, there is evidence that the pace of behavioral change has either been slow or stagnant. Studies have shown that people have knowledge/information but the response in terms of behavioural change has not been encouraging. Further, although significant strides have been made in the area of prevention, the services remain inadequate in scope and coverage. For instance, there is high unmet need for HCT, low coverage for PMTCT and challenges in addressing infection control and infection safety especially in the context of TB-HIV. Some of the policies that can help curb the spread of HIV are yet to be implemented and rolled out e.g., the MMC.

Thus, inadequate coverage of services especially HCT, PMTCT and Early Infant Identification of exposed adults, mothers and babies still pose a big challenge. Though the Turn Around Time for results in HCT and PMTCT has been reduced, it is still unacceptably long for EID. Linkages of identified mothers and babies into ART are still a big challenge as well as loss to their follow up.

6.3.3 Treatment, care and support

The country faces daunting challenges to mobilize adequate funding for the national HIV response especially for UA to treatment, care and support. Although the relationship between effective ART care and prevention of new infections is recognized, starting people on ARTs early enough when their CD4 count is still high continues to elude the country response. It has to be pointed out that Uganda is yet to develop an adequate human, logistical, supply and other systems resource base to cope with the demands of the HIV&AIDS epidemic to effectively manage the National HIV&AIDS response. As a result, provision of treatment is largely donor-driven and evidently this makes it unsustainable.

6.3.4 Challenges in Social Support

The amount of resources needed to reach all in need of support services—i.e., PHAs, OVCs and their families poses a serious challenge to all actors involved in the provision support services. There are numerous pressing demands and an overstretched national budget for a resource poor country such as Uganda. Thus, whereas funding is limited, the scope and magnitude of needs of OVCs, PHAs, affected families and whole

communities is increasing. This is further exacerbated by the inadequacy of human resource capacity to provide services.

Given the fact that this area of HIV&AIDS response has been largely performed by civil society in Uganda, it also constitutes a challenge in itself. For instance, CSF is not fully owned and run by CSOs. There has been externalization of the Technical Management Agent, M&E Agent and the Financial Management Agent. The cost of these management agencies are considered to be high.

6.4 Remedial Actions

6.4.1 Actions required in policy environment

- Pursue an orderly policy framework to respond to the current scope and dynamics of the HIV&AIDS epidemic, first by enacting an enabling national policy to guide subsequent legislative and administrative measures. This, among others, calls for expediting the enactment of National HIV&AIDS Policy that has been before Cabinet for a long time.

6.4.2 Actions required in prevention

- Update and disseminate the IEC/BCC communication strategy and use it to guide community education activities for prevention of sexual transmission of HIV, and to address the issue of complacency steadily cropping up in the population.
- Strengthen the linkages between PMTCT programmes and AIDS care as well as early infant HIV diagnosis. Assess all HIV infected women for ART eligibility. Link up all ART eligible women and all HIV infected infants diagnosed to long term AIDS care including co-trimoxazole prophylaxis and HAART.
- Adopt and step up MMC and rapidly roll out inline with the evidence.

6.4.3 Actions required in care and treatment

- Deliberate and conscious effort to institute measures and mechanisms that can make the response sustainable. For instance, develop strategies to generate internal resource that can contribute to strengthening the procurement and supplies management system for drugs including ARVs, medical supplies and logistics at national, district and facility level.

6.3.4 Actions required in social support

- Build capacity of CSOs including structures of PHA networks in the delivery of social support services.
- Promote CBOs and build their capacity to provide HBC and psychosocial services to PHAs, OVCs and affected families. The urgent need is to mobilize funds for effective service delivery, capacity development, governance and organizational systems especially among CSOs and private sector agencies that serve vulnerable populations.

7.0 SUPPORT FROM DEVELOPMENT PARTNERS

7.1 Introduction

This Section focuses on the support from Development Partners (DPs) during the reporting period, challenges and gaps as well as actions required.

7.2 Key Support Received from DPs

In this reporting period, a number of development partners contributed to the National HIV&AIDS response. These included: Ireland, Denmark, Italian Cooperation, Norway, Sweden, United Kingdom, UNAIDS and other UN agencies, United States Government, Global Fund for AIDS, Tuberculosis, and Malaria (GFATM) and Clinton Foundation, among others.

Support provided by the partners included technical, logistical and financial assistance towards the key thematic HIV areas of prevention, care and treatment, orphans and vulnerable children, program management and administration, incentives for human resources, social protection and social services, enabling environment and community development.

As was the case in last reporting period, it was not possible to obtain complete data on funding by Government of Uganda (GoU) to the AIDS response. Although funds are allocated from the central government to the Ministry of Health and District Local Governments, due to the integrated approach to health and social services delivery and the fact that HIV is a cross-cutting issue, it is still not possible to delineate the funding specifically spent from government.

Due to lack of a National AIDS Spending Assessment (NASA), data captured in this report does not include all the funding to Civil Society Organizations and government departments in Uganda which they received from Foundations, the Private Sector, Faith-based organizations and other international support agencies that provide funding directly to such entities and not through the development partners cited in this report. See Table 11 for summary of expenditure by financing source.

Table 11: Summary AIDS Spending by Financing Source

Summary of AIDS Spending by Financing Source				
Financing Source	**FY2007/08**	**FY2008/09**	**Total**	**%**
Government of Uganda	11,135,573,239	62,876,185,048	74,011,758,287	7
Bilateral Partners	461,266,174,400	484,947,476,428	946,213,650,828	89
Multilateral Partners			-	
UN Agencies	25,063,920,300	12,783,935,300	37,847,855,600	4
Global Fund		3,739,000,000	3,739,000,000	0
Other Internationals	9,155,681	8,456,536	17,612,217	0
Total	**497,474,823,620**	**564,355,053,312**	1,061,829,876,932	100

Table 11 shows that in the Financial years 2007/2008 and 2008/2009, GoU spent UGX 11,135,573,239 and UGX 62, 876,185,048 respectively on the procuring ARVs, anti-malarias and coordinating the national AIDS response. This constitutes seven percent of the total funds spent on the AIDS response in the reporting period. Bilateral partners contributed 89 percent of the resources to the AIDS response while multilateral partners contributed four percent (see table below for details on the contributions of the bilateral and multilateral partners to the AIDS response). Overall, as shown in Table 12, the United States Government contributes over 80 percent of the resources to the AIDS response. See also Annex 3—the Funding Matrix.

Table 12: Detailed breakdown of contributions of DPs to the AIDS response

Where funds were Quoted in Euros, average exchange 1€=UGX 2650		
Where funds were Quoted in US Dollars, average exchange 1$=UGX 1900		
Swedish Embassy funded TASO, Straight Talk Foundation, Kampala City Council NaguruTeenage Centre. Funds were converted from SEK to USD then to UG. Shs. 1USD= 7SEK		
Bilateral Partners contribution to the Civil Society Fund (CSF)		
DFID	7,193,976,400	7,523,460,000
DANIDA	5,901,853,598	17,452,579,930
US Government /USAID	6,902,933,262	16,934,539,982
IRISHAID	5,739,526,100	22,335,519,519
ITALIAN COOP		152,347,500
Interest on Income	36,356,858	66,780,125
Sub-total Bilateral CSF	**25,774,646,218**	**64,465,227,056**
Funding to Uganda AIDS Commission from Bilateral Partners for HIV/AIDS Partnership Fund		
DFID	466,142,108	1,074,104,571
DANIDA	1,470,588,236	1,333,333,333
Irish Aid	493,808,000	945,824,000
SIDA		91,555,000
Sub-total Partnership Fund-Bilateral	**2,430,538,344**	**3,444,816,904**
Other Bilateral		
IRISHAID to Ministry of Local Government	265,000,000	1,632,983,000
Irish Aid internal Spending on AIDS for its own capacity strengthening (i.e. AIDS mainstreaming, program management, participation in AIDS day celebration)	132,500,000	452,166,850
Irish AID and DFID to UN Agencies	4,700,605,700	3,227,533,800
Sub-total Other Bilateral	**5,098,105,700**	**5,312,683,650**
US Government/PEPFAR-Bilateral (less funds disbursed to CSF)	427,962,884,138	411,724,748,818
TOTAL Bilateral Partners	**461,266,174,400**	**484,947,476,428**
Funding to UAC from Other International partners for HIV/AIDS Partnership Fund		
ASBL/GLIA	9,155,681	
World Fish Center		8,456,536
UN Agencies-Multilateral	25,063,920,300	12,783,935,300

7.3 Needed Actions

Several areas that need action have been presented under Sub-section 6.3 on "Remedial Actions". Development Partners need to aid the GoU to implement the identified remedial actions to ensure achievement of the UNGASS targets. In addition, DPs need to support the GoU to undertake studies and track expenditure on HIV&AIDS. Such studies as the NASA and National Health Accounts (NHA) need to take into account the contributions made by volunteers, families and communities in caring for PHAs and promoting HIV prevention.

DPs need to scale up support to UAC in joint coordination and planning activities that support the National AIDS Plan. Importantly, partners need to devote resource to strengthening governments' capacity to monitor and report on programs at all levels.

8.0 MONITORING AND EVALUATION ENVIRONMENT

8.1 Introduction

The current Monitoring and Evaluation (M&E) system for the national response to HIV&AIDS is described along with the challenges in the implementation of the system. This section also presents the remedial actions required to fully operationalize a robust M&E framework, pointing out specifically the M&E technical assistance and capacity-building that is needed.

8.2 Description of the current M&E Environment

In order to create a shared vision of a single national HIV&AIDS M&E system articulated by the "Three Ones Principle" for the coordination and management of the response, a review of the previous national Strategic Framework (NSF) 2001-2006, was undertaken. Based on the findings and in line with UAC mission to provide overall leadership in the coordination and management of the HIV&AIDS national response and as part of fulfilling its mandate, UAC in collaboration with MoH, sectors, CSOs and Development Partners developed the NSP (2007/08 – 2012), a National M&E Plan – the Performance Measurement and Management Plan (PMMP) and an operational handbook for the PMMP to track performance of the national response.

The M&E for the national response to HIV&AIDS involves a number of players from Government and Civil Society. In the period under review, M&E of the HIV&AIDS national response has been based on a multi-sectoral approach that was adopted in 1992, which involves key sectors such MoH, MoGLSD, Ministry of Local Government (MoLG), Ministry of Education and Sports (MoES) as well as Civil Society, Bilateral Agencies and Development Partners each of which has its own M&E System and Management Information System (MIS). Apart from being multi-sectoral, the national response focuses on the thematic areas of prevention, care and treatment, social support and systems strengthening.

The MoH as one of the key ministries provides leadership for the health sector response to HIV&AIDS by working closely with other partners. The Ministry has a surveillance system and working group responsible for monitoring the public health response and an M&E system as well as Health Information Management System (HMIS). The Ministry has parallel systems for capturing data on ART, PMCTC and Tuberculosis that are not part of HMIS. Thus, the Ministry has harmonized data collection and reporting tools for PMTCT, ART, TB and HCT for all partners and these are being rolled out in the country. This will help in data quality, support and integration of the reporting system.

Currently, a review of the health sector response to HIV&AIDS in Uganda which commenced last year is almost complete. On the other hand, the MoLG has an M&E system and the Local Government Information Communication System (LOGICS). However, like the HMIS, it does not capture all HIV indicators for the national response. The MoGLSD is yet to develop its M&E system for OVCs, although it has finalized developing OVC indicators, while the MoES has an Education Management System

(EMIS) but, still, not all HIV&AIDS indicators for the national response are integrated in the system.

On the part of Development Partners such as the United States Government (USG) whose support to the national response accounts about 90% is monitored by Monitoring and Evaluation of Emergency Plan Progress (MEEPP). The USG support is channeled through PEPFAR, USAID, CDC and other US Development Agencies. To avoid double counting and improve quality assurance, data from MEEPP are usually synchronized with that of MoH and validated before dissemination. CSOs are monitored by the Civil Society Fund Agent (CFS) with clearly articulated CSO indicators with the support from a Financial Management Agency, Deloitte & Touch, to track expenditure in line with approved activities and indicators.

An M&E Sub-Committee composed of various key stakeholders from Government, Non- Government and Development Partner was established in 2005 to guide in the national M&E functions. The sub-committee has since played a key role in guiding the development of the Performance Measurement and Management Plan (PMMP) and operational handbook for the NSP (2007/08 – 2011/12) which addresses the concerns raised in the 2005 Evaluation of the M&E Framework for the NSF 2001/02 to 2005/06. It outlines 58 national indicators to track the priority areas of HIV&AIDS prevention, care and treatment, social support and strengthening service delivery

In the M&E environment, progress has been made in the country in this reporting period, but more needs to be done as highlighted in the Section on "Challenges and Remedial Actions". Key documents have been disseminated to districts and sectors based on the multi-sectoral approach. In addition to 58 outcome indicators at national level intended to monitor the national level response, there are 47 output indicators for district level for monitoring service delivery outputs from districts which are updated on quarterly basis for district planning and decision making. There are also 29 district indicators for monitoring district level outcomes that are aligned with the national level outcome indicators. Data collation forms for sectors and districts have been developed and disseminated to districts and sectors as well CSOs, partners and relevant stakeholders

With Support from Irish Aid, UAC in collaboration with other partners has helped 58 districts to develop their 5-year HIV&AIDS Strategic Plans including mainstreaming HIV&AIDS in all sectors. Eighty (80) districts held their District HIV&AIDS partnership forums in 2009 to establish the status and trends in the epidemic as well as prevalence rates based on priorities set for the previous year 2008. In these forums achievements, challenges, recommendations and priorities for following are set.

In collaboration with MoH, other key ministries such as GLSD, Education and Sports, working with CSO partners and key stakeholders, UAC led the assessment of the national M&E systems for HIV, Tuberculosis and Malaria using the M&E systems strengthening tool developed by Measure in 2009. A costed M&E Plan for HIV&AIDS, Tuberculosis and Malaria was developed.

Further, with support from UNAIDS, the HIV&AIDS M&E systems for 10 districts were assessed in 2009 and two districts of Kiruhura and Kasese have been selected for piloting as M&E centres of excellence to be rolled out to other districts subsequently. Currently, Trainer of Trainers (ToTs) for Lot Quality Assurance Sampling (LQAS) are being trained at UNAIDS to in turn train selected district officials to implement LQAS to be able to collect baseline data on district indicators.

For the last two years, districts have also undertaken Annual AIDS Forums, a replica of the Joint Annual Reviews (JARs) held at national level since 2005. The district forums precede the JAR and Annual National Partnership Forums, respectively, to facilitate district input and participation into annual performance and identification of priorities, provide a reality check for the national plan and proposals and contribute to the vision of universal access, the goal of equity and improved access and effectiveness of services.

Overall, UAC is strengthening its M&E unit with more skilled staff and in-house training. It is also strengthening its linkages with HIV&AIDS stakeholders through a partnership arrangement in order to champion information sharing and feedback system both at national and decentralized levels.

8.3 Challenges in the Implementation of M&E System

Much as the M&E systems in place are meant to aggregate data to inform national programmes and priorities while guiding delivery of high quality services in the thematic areas above by assessing processes, outcomes and impact to measure success, M&E systems face several challenges.

While some challenges are intrinsic to the overall context in which programmes are being implemented, others are reflective of the manner in which health services are organized. In some cases, these challenges have limited progress towards a shared vision of a single national M&E system articulated by the "Three Ones" Principle for the coordination of the national AIDS response.

The following are some of the challenges in the implementation of M&E system:

- Although UAC has a monitoring framework (and accompanying handbook with key HIV indicators and targets), the M&E system of the UAC has not been adequately operationalised. This is a challenge to stewardship role of the UAC around M&E needs development and implementation. For example, UAC does not receive regular information from the line ministries and other key stakeholders. Consequently, UAC's database is not up to-date with information regarding the key HIV indicators.
- Sector specific HIV&AIDS strategic plans to operationalise the NSP are available for a few sectors e.g. MoH and specific projects, but none have corresponding M&E plans. Still, with regard to MoH, there is no formalized coordination between the UAC and the MoH to report. Similarly, there is no formal data flow between MoGLSD and UAC. This results into more or less parallel M&E systems.

- There appears to be no plans for collection of data for some indicators e.g. condom availability survey. For other indicators, there is no provision for annual collection of data, but for every 2 years even where rapid annual changes are expected. Some indicators lack baseline data and most indicators cannot be disaggregated by socio-economic status.
- The management units have human resource constraints with insufficient time devoted to M&E because of multi-tasking of the few staff at all levels. Inadequate training in M&E, episodes of staff turnover and budget constraints. There have been a number of reviews and assessments of the M&E systems related to malaria HIV&IDS and TB in Uganda, including the MEEST workshops in October 2007; the HSSPII mid-term review; assessments of the principal recipient for Global Fund and so on. The reviews point to lack of capacity and skills at all levels of the country M&E system.
- M&E reports are often irregular with documentation of reporting requirements not always fulfilled.
- Different organizations and sectors at district and national level have different tools and reporting formats. While their management information tools may differ, monitoring tools need to be harmonized with clear guidelines for data collection and recording and aggregation especially at district level.

8.4 Planned Remedial Actions

According to sources at UAC, stakeholders and implementers are going to be oriented and trained in the new Performance Measurement and Management Plan for the NSP 2007/08 – 2011/12 so as to guide the gathering of information that is useful for the M&E. It was reporting that UAC plans to undertake the following actions:

- Continually review and cost the National M&E plan and include operational output level indicators and annual targets for key interventions
- Support all sectors to develop roll out plans for various interventions and sector specific M&E plans consistent with the NSP, with corresponding indicators, annual targets in line with the sector mandates
- Strengthen and sustaining M&E capacities at sector and decentralised levels and support reporting systems to collect and report accurate data
- Harmonise and standardise data collection tools and reporting formats of various sectors and implementing partners
- Strengthen integrated web-enabled reporting by districts and health facilities
- Establish and support a system to monitor quality of services, beneficiary assessment surveys, adherence to treatment and monitoring drug resistance, quality control/quality assurance for Lab results.

8.5 M&E Technical Assistance and Capacity-Building

Technical and financial assistance is required to fill the existing gaps in the PMMP indicator baseline values, to support and advocate for the process of institutionalizing data identified in the PMMP and in rolling out of the PMMP, estimation of a HIV incidence, implementing the NRP and the mid-term review of the NSP. As reported in UNGASS Country report 2007, the general M&E system for HIV&AIDS across the GoU Ministries requires short-term, medium-term and long-term Technical Assistance to

strengthen various weak points. The following are some of the areas which require particular attention;

- A formalized mechanism for reporting should be established and supported to work between the UAC and the sectors. Program assessments and evaluations should be scheduled by the various sectors to inform policy and programming. These should be costed and budgeted for by the various sectors. In the same vein, the annual JAR should be carried out regularly and on time.
- Development of clear M&E plans governing all MoH and other sector activities; this should be supplemented by clear, formal written guidelines covering all aspects of data management and use.
- All M&E activities should, in practice, fall under the framework of the TWG (M&E) which should meet regularly and provide quarterly review of key indicators to UAC senior management, all sectors and the entire HIV&AIDS partnership.
- There should be a single official repository of information which should be housed in the resource centre databases and all individual programme reports containing indicators should be synthesized for to ensure internal agreement on these indicators.
- There should be a commitment to a continuous process of improvement of data. This process should be accelerated by regular analysis of all routine data, quarterly feedback to districts from the central level, regular supervision of districts including the M&E processes. Special attention should be paid to the flow of data from hospitals.
- Web-based data transmission should be phased in, starting with pilots in selected districts with attention given to all relevant logistical issues such as support, back-up of data, uninterrupted power supplies and human resources.
- Institutions responsible for health research e.g. Uganda Council of Science and Technology should set up a functional resource center that provides information e.g. progress reports, research findings on all health research that is conducted in Uganda. Access to such information will greatly enhance the compilation of national and international reports, inform policy and programming, and, provide valuable information to all.
- The PMMP has a timeline on key studies to be conducted and inform the HIV epidemic in Uganda; UAC should therefore work with the responsible sectors to establish progress made in achieving this, and, ensuring that the results are in the public domain. In a word, support is required to ensure UAC works with all HIV&AIDS stakeholders to develop and support a system to facilitate timely and accurate national and international reporting.

Annex 1: Consultation/Preparation Process

The Process of Compiling the UNGASS Report January 2008 to December 2009 was highly consultative and co-ordinated by UAC supported by UNAIDS. Several meetings were held between the Consultants and the M&E TWG to discuss drafts presented by the Consultant as work in progress. The core TWG i.e., the sub-committee of the TWG was constituted to provide technical guidance to the Consultant on a regular basis. In these meetings, the consultants presented and shared work in progress and received feedback from members of the TWG.

Government ministries, representatives of Civil Society and Development Partners participated in the process in different ways including filling the NCPI and providing primary data through consultative and group meetings, and reviewing the drafts presented by the Consultant. Notably among these were, UAC, MOH, MOES, MOGLSD, MOFPED, and MOWT, MOLG. Key representatives of CS included UNASO, NAFOPHANO, ICW, AIC, TASO, IRCU and Reach the Aged. The Development Partners that participated in the process included UNAIDS, UNICEF, WHO, UNFPA, PEPFAR, CDC, SIDA, UNDP.

Upon compilation of the First Draft, a Workshop for TWG and selected officials form various sectors and constituencies was convened to discuss the draft. The comments and suggestions made were incorporated and a Second Draft was produced by the Consultant. The Second Draft was presented and shared in the Stakeholder Validation Workshop where the Report was adopted with modifications. See Table 13 for the list of participants. The modifications and comments that arose were addressed, and a Final Draft was produced.

Table 13: List of Participants for the Validation Workshop – March 12, 2010

Name	Organization
Rwakimari Beatrice (Hon), Chair HIV&AIDS Standing Committee	Parliament
Kihumuro Apuuli (Dr), Director General	UAC
Bungudu Musa (Dr), Uganda Country Coordinator	UNAIDS
Strong Michael, Coordinator	PEPFAR
Acayo Connie	MAAIF
Agaba J	AMICAALL
Alupo Evelyne	Vision Group
Arinaitwe Jim (Dr)	UAC
Asingwire Narathius (Dr)	MUK
Atai N Betty (Dr)	MoH
Aturinde John	GCOWAU
Babi James	UAC
Bagorogoza Benson	UAC
Baguma Eva	KSDC
Bagyendera Julian	CSF MEA

Name	Organization
Balyeku Andrew (Dr)	MUK
Barasa Catherine	UNAIDS
Basimaki Jolly	GCOWAU
Bizimana Enosh	UAC
Bogere Paul	MoPS
Bukuluki Paul (Dr)	MUK
Byansi Peter	KCC
Byaruhanga Moses (Dr)	MoIA – Police
Byenkya Julius	UNAIDS
Chaka Carol	PMFI
Crahay Beatrace	WHO
Ekwanga Morris	NAFOPHANU
Engeu J Bosco	MAAIF
Esiru Godfrey	MoH
Halage Abdullah Ali	MUSPH
Kabatesi Donna (Dr)	CDC
Kabishanga Emmanuel	UGANET
Kadoma Jill	Consultant
Kadowe Namulondo Joyce	UAC
Kagandu Rogers	CDC
Kaharuza Frank (Dr)	CDC
Kalweo Jane	UNAIDS
Kambugu Andrew (Dr0	IDI – Makerere
Kamoga Joseph	PEPFAR
Kasozi Julius (D)	UNHCR
Katamba H S (Dr)	AIC
Katongole Mbidde Edward (Dr)	UAC
Kindyomunda Rosemary	UNFPA
Kinkumu Godfrey	CDC
Kisubi W K (Dr)	CSF MEA
Kizza Prossy	Vision Group
Kuseerwa Miriam	MoFPED
Kyeyune Godfrey	UAC
Kyomuhendo Swizen	MUK
Kyomukama Flavia	GCOWAU
Mabonga Wanyoto Harriet	TASO
Madaala James	TASO
Mangali Okello J G	Min of Foreign Affairs
Manji Kur	Independent Consultant
Matovu Charmaine	CDC
Mayebo Mercy	DFID
Monja Minsi	URAA

Name	Organization
Mugimba Edward	MGLSD
Mugisha Bitature Joseph	URAA
Mugisha Geoffrey	MARPS – Network
Mugyema S	MoLG
Mukalazi Deus	YEAH
Mukasa Gerald	UVRI
Mushabe Elizabeth	UAC
Musiime Michael	UGANET
Musinguzi K Dorah	UGANET
Muttu David	UAC
Mutungi E W	CDFU/YEAH
Nabbanja Scovia	UAC
Nabitaka Linda (Dr)	MoH
Nakanjako Aidah	UAC
Nalumu Muguwa Grace	Office of the Prime Minister
Namanya Bharam	UNASO
Namisi Charles (Dr)	Mulago – UPA
Nampewo Solome (Dr)	SIDA
Nangobi Teddy	UNFPA
Nannyonga Maria (Dr)	Nsambya Home Care
Ngambi Wilbroad	UNICEF
Nkoyooyo Abdallah (Dr)	TASO
Nsaano George	UAC
Nsabagasani Xavier	USAID
Nuwagira Innocent (Dr)	WHO
Ocen Sam	UYD
Odoi Judith T	MTTI
Oduka Mary	Irish Aid
Odunge Josephine	UAC
Ojok Thomas	Kitgum Local Govt
Oketch Richard (Dr)	UNICEF
Okullo Dolorence	CDC
Okullo Joel (Dr)	UAC
Onyango Saul (Dr)	UAC
Rukidi Henry	UAC
Ruteikara Sam (Rev)	COU/CICC
Samson Iga	NYC
Sanya James	Min of Works
Ssebadduka Bernaddette	IOM
Ssendege Agnes	MU-JHU
Tibagwa Christine	Office of the President
Tigawalana David (Dr)	UAC

Name	Organization
Tinka Connie	Katelemwa Chashire Home
Tukesiga Julius	MoES
Tumusiime Jennifer	UAC
Tumwine Mark	HealthNet Consult
Twijukye C	IDI – Makerere
Waswa Patrick	Katelemwa Chashire Home
Watson Cathy	Straight Talk Foundation

Annex 2: National Composite Policy Index (NCPI)

National Composite Policy Index (NCPI) Questionnaire
Part A
[to be administered to government official]

I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?
(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes ✓	No	Not Applicable (N/A)

Period covered: [2007/08-2011/12]

IF NO or NOT APPLICABLE: briefly explain why.

IF YES, complete questions 1.1 through 1.10; IF N, go to question 2.

1.1 How long has the country had a multi-sectoral strategy?

Number of Years: Since 1992 *[18years]*

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities

Sectors	Included in strategy		Earmarked budget	
Health	Yes✓	No	Yes✓	No
Education	Yes✓	No	Yes✓	No
Works, transport and housing	Yes✓	No	Yes✓	No
Military / Police (Uniformed Forces)	Yes✓	No	Yes✓	No
Gender, Labour and social development (including young people, Women)	Yes✓	No	Yes✓	No
Other* *[Write in]*				
Other – Agriculture	Yes✓	No	Yes✓	No
Other – Finance and Planning	Yes✓	No	Yes✓	No
Other – Public service	Yes✓	No	Yes✓	No
Other – Local Government	Yes✓	No	Yes✓	No
Other – Justice and Constitutional Affairs	Yes✓	No	Yes✓	No
Other – Minerals and Energy	Yes✓	No	Yes✓	No

* Any of the following: Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

Other – Water and Environment	Yes✓	No	Yes✓	No
Other – Trade and Industry	Yes✓	No	Yes✓	No
Other – Fisheries	Yes✓	No	Yes✓	No
Other – Forestry	Yes✓	No	Yes✓	No
All Others	Yes✓	No	Yes✓	No

IF NO earmarked budget for some or all f the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities:

1.3 Does the multisectoral strategy address the following target populations, setting and cross-cutting issues?

Target populations		
a. Women and girls	Yes✓	No
b. Young women/young men	Yes✓	No
c. Injecting drug users	Yes	No✓
d. Men who have sex with men	Yes	No✓
e. Sex workers	Yes✓	No
f. Orphans and other vulnerable children	Yes✓	No
g. Other specific vulnerable subpopulation**	Yes✓	No
Settings		
h. Workplace	Yes✓	No
i. Schools	Yes✓	No
j. Prisons	Yes✓	No
Cross-cutting issues		
k. HIV and poverty	Yes✓	No
l. Human rights protection	Yes✓	No
m. Involvement of people living with HIV	Yes✓	No
n. Addressing stigma and discrimination	Yes✓	No
o. Gender empowerment and/or gender equality	Yes✓	No

1.4 Were target populations identified through a needs assessment?

Identification of the target groups is done on a continuous basis. Several assessments have been undertaken through consultations with stakeholders (see below) in this regard	Yes✓	No

IF YES, when was this needs assessment conducted?
Uganda HIV and AIDS sero-behavioural Survey (2004/05); Uganda Modes of Transmission Study (2007/2008); Situational Analysis of orphans and Vulnerable Children(2004, 2009), Uganda Demographic and Health Surveys(1995, 2000, 2006) and various sectoral and agency level baseline and evaluation studies and capacity assessments conducted from time to time

Year: *[write in]*

IF NO, explain how were target population identified?

** Sub-populations other than injecting drug users, men who have sex with men and sex workers, that have been locally identified as being at higher risk of HIV transmission (e.g. clients of sex workers, cross-border migrants, migrant workers, internally displaced people, refugee, prisoners)

1.5 What are the identified target population for HIV programmes in the country
[Youth, Women, married couples, pregnant women, Health Workers, Children and exposed babies, Orphans and Vulnerable Children, Discordant couples, Commercial Sex Workers, civil servants, uniformed services, Mobile populations, Internally Displaced Persons, fishing communities, People with disabilities, Persons living with HIV and AIDS, Truck drivers, prisoners, Minorities and other MARPS]

1.6 Does the multisectoral strategy include an operational plan?

Ye s ✓	No

1.7 Does the multisectoral strategy or operational plan include:

Formal programme goals?	Yes✓	No
Clear targets or milestones?	Yes✓	No
Detailed costs for each programme area?	Yes✓	No
An indication of funding sources to support programme implementation?	Yes✓	No
A monitoring and evaluation framework	Yes✓	No

1.8 How the country ensured "full involvement and participation" of civil society*** in the development of the multisectoral strategy?

Active involvement✓	**Moderate involvement**	**No involvement**

IF active involvement, briefly explain how this was organized
Civil society has actively engaged in policy formulation processes, planning and programming, procedures and implementation. Civil society actors participate in the development of all national and district level planning frameworks including the current National Strategic Plan for HIV&AIDS. CSOs are part of the Partnership Committee and actively participate in the National and district partnership forums. The above are exemplified by;

- Civil Society Fund
- PHA forums and networks
- Young people

IF NO or MODERATE involvement, briefly why this was the case

1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes ✓	No

1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners ✓	**Yes, some partners**	**No**

IF SOME or NO, briefly explain for which areas there is no alignment/harmonization and why.

*** Civil society include among others networks of people living with HIV; women's organizations; young people's organizations, faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, sex workers, injecting drug users, migrants, refugees/displaced populations prisoners); workers organizations; human rights organizations, etc. For the purpose of the NCPI, the private sector is considered separately.

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment/UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes ✓	No	N/A

2.1 IF YES, in which specific development plan(s) is support for HIV integrated?

a.	National Development Plan	**Yes ✓**	**No**	**N/A**
b.	Common Country Assessment/UN Development Assistance Framework	**Yes✓**	**No**	**N/A**
c.	Poverty Reduction Strategy	**Yes ✓**	**No**	**N/A**
d.	Sector-wide approach (SWaPs)	**Yes ✓**	**No**	**N/A**
e.	Other *[Write in)*	**Yes**	**No**	**N/A**

2.2 IF YES, which specific HIV-related areas are included in one or more of the development plans?

HIV-related area included in development plan(s)		
HIV Prevention	**Yes ✓**	**No**
Treatment for opportunistic infections	**Yes ✓**	**No**
Antiretroviral treatment	**Yes ✓**	**No**
Care and support (including security or other schemes)	**Yes✓**	**No**
HIV impact alleviation	**Yes✓**	**No**
Reduction of *gender* inequalities as they related to HIV prevention/treatment, care and/or support	**Yes✓**	**No**
Reduction of *income* inequalities as they related to HIV prevention/treatment, care and/or support	**Yes✓**	**No**
Reduction of stigma and discrimination	**Yes ✓**	**No**
Women's economic empowerment (e.g. access to credit, access to land, training)	**Yes ✓**	**No**
Other [Write in]	**Yes**	**No**

3. Has the country evaluated the impact of HIV on its socio-economic development for planning purposes?

Yes✓	No	N/A

3.1 IF YES, to what extent has it informed resource allocation decision?

Low					**High**
0	1	2	3✓	4	5

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes ✓	No

4.1 IF YES, which of the following programmes have been implemented beyond the Pilot stage to reach a significant proportion of the uniformed services?

Behavioral change communication	**Yes ✓**	**No**
Condom provision	**Yes✓**	**No**
HIV testing and counseling	**Yes ✓**	**No**

Sexually transmitted infection services	**Yes ✓**	**No**
Antiretroviral treatment	**Yes✓**	**No**
Care and support	**Yes ✓**	**No**
Others [Write in]	**Yes**	**No**

IF HIV testing and counseling is provided to uniformed services, briefly describe the approach taken to HIV testing and counseling (e.g. indicate if HIV testing is voluntary or mandatory, etc.)

HCT is provided both in static centers (20) hospitals and mobile outreaches. Most HIV testing is voluntary but also mandatory for police, prisons and troops going for UN and African Union deployment, and training in foreign countries. Testing is also done for new UPDF and police recruits. However counseling is mandatory. Those that test positive are immediately linked to care and treatment and assessments are conducted wherever they are deployed.

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable sub-populations?

Yes ✓	No

5.1 IF YES, for which subpopulation?

a.	Women	**Yes ✓**	**No**
b.	Young people	**Yes ✓**	**No**
c.	Injecting drug users – Not applicable	**Yes**	**No**
d.	Men who have sex with men– Not applicable	**Yes**	**No**
e.	Sex workers	**Yes ✓**	**No**
f.	Prison inmates	**Yes ✓**	**No**
g.	Migrants/mobile populations	**Yes ✓**	**No**
h.	Other *[Write in)* Internally Displaced Persons and refugees	**Yes**	**No**

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

There are institutional arrangements and mechanisms for investigation, enforcement, rehabilitation and prosecution e.g. Inspector General of Government, Police, probation and social welfare, Judiciary, Human Rights Commission as well as the Equal opportunities Commission. Implementers have some resources allocated to enforce laws

Briefly comment on the degree to which these laws are currently implemented:

When cases are reported, they are dealt with accordingly by the relevant law enforcement agencies.

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

Yes	No✓

6.1 **IF YES,** for which subpopulation?

a.	Women	**Yes**	**No** ✓
b.	Young people	**Yes**	**No** ✓
c.	Injecting drug users	**Yes**	**No**✓
d.	Men who have sex with men	**Yes**	**No**✓
e.	Sex workers	**Yes**	**No**✓
f.	Prison inmates	**Yes**	**No**✓
g.	Migrants/mobile populations	**Yes**	**No**✓
h.	Other *[Write in)*	**Yes**	**No**✓

IF YES, briefly describe the content of these laws, regulations or policies:

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes ✓	No

7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes ✓	No

7.2 Have the estimates of the size of the main target population been updated?

Yes ✓	No

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs	**Estimates of current needs only**✓	**No**

7.4 Is HIV programme coverage being monitored?

Yes ✓	No

(a) **IF YES,** is coverage monitored by sex (male, female)?

Yes✓	No

(b) **IF YES,** is coverage monitored by population groups?

Yes✓	No

IF YES, for which population groups?

- People Aged between 15-24 and 15-49 also Less than 15years
- Commercial sex workers,
- Partners of commercial sex workers
- Fishing communities & couples.
- Other MARPS

Briefly explain how this information is used:

Information is used to project incidences and prevalence of HIV in these groups
Planning, implementation and monitoring programmes targeting these groups

(c) Is coverage monitored by geographical area?

Yes✓	No

IF YES, at which geographical levels (provincial, district, other)? Regional, district and national **Briefly explain how this information is used:** Resource allocation, projections and programming of interventions are planned with assistance of Service Mapping reports, Tracking and Hot spot marking

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities and logistical systems to deliver drugs?

Yes✓	No

Overall, how would you rate strategy planning effects in the HIV programmes in 2009?

Very Poor										**Excellent**
0	**1**	**2**	**3**	**4**	**5✓**	**6**	**7**	**8**	**9**	**10**

Since 2007, what have been key achievements in this area:

Reviewed and disseminated the NSP
Aligning programme areas with current study findings such as MoT study
Attempted evidence based planning
Produced and disseminated the national Priority Action Plan
Developed monitoring forms for Local Governments
Identification of human resource and other capacity and systems issues
Mainstreaming guidelines
PMMP performance monitoring and Management plan
National development Plan

What are remaining challenges in this area:

Inadequate resource allocation / Funding
Monitoring and evaluating systems are not harmonized
Limited capacity in planning especially at local government level
There are concerns about the country's overall strategic direction given the less than impressive changes in major indicators over several years of the response

II. POLITICAL SUPPORT

Strong political support includes government and political leaders who speak out often about AIDS and regularly chair important AIDS meetings, allocation of national budgets to support HIV programmes; and, effective use of government and civil society organization to support HIV programmes.

1. **Do high officials speak publicly and favorably about HIV efforts in major domestic forums at least twice a year?**

President/Head of governance	**Yes ✓**	**No**
Other high officials	**Yes ✓**	**No**
Other officials in region and/or districts	**Yes ✓**	**No**

2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent?

Uganda AIDS Commision

Yes ✓	No

IF NO, briefly explain why not and how AIDS programmes are being managed:

2.1 IF YES, when was it created?

Year: *[1992]*

2.2 IF YES, who is the Chair?

Name: Bishop Emeritus Halem' Imaana **Position/Title**: Chair of Uganda AIDS Commission

2.3 IF YES, does the national multisectoral AIDS coordination body:

Have terms of reference?	**Yes ✓**	**No**
have active government leadership and participation	**Yes ✓**	**No**
have a defined membership **IF YES,** how many members *[9]*	**Yes ✓**	**No**
Include civil society representatives? **IF YES,** how many *[1]*	**Yes**	**No✓**
include people living with HIV? **IF YES,** how many *[1]*	**Yes✓**	**No**
include the private sector	**Yes**	**No✓**
have an action plan?	**Yes ✓**	**No**
have a functional Secretariat?	**Yes ✓**	**No**
meet at least quarterly?	**Yes ✓**	**No**
review actions on policy decisions regularly?	**Yes ✓**	**No**
actively promote policy decisions?	**Yes✓**	**No**
provide opportunity for civil society to influence decision-making?	**Yes ✓**	**No**
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and report?	**Yes ✓**	**No**

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes ✓	**No**	**N/A**

IF YES, briefly describe the main achievements:

Through the partnership arrangement all entities including CSOs, the private sector, FBOs actively participate and influence decisions. The coordination of the response is guided through self coordinating entities (SCEs), including representatives of PHA Networks and Associations, national and international NGOs, youth and media, academia and science, in addition to UN & Bilaterals, Parliament, ministries of government and private sector representatives. The major outcome is a shared vision, harmonized plan of action and dialogue on the roadmaps for stemming the epidemic.

Production of the NSP, JAAR(Joint Annual Aids Review), NPAP(National Priority Action Plan)

Briefly describe the main challenges: Human and financial incapacities:
Dynamic nature of the epidemic, new issues including knowledge about the disease, modes of transmission, technologies and promising practices keep emerging over which the actors have to plan and strategize. Overlapping programs and harmonizing stake holders is difficult.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

Percentage: 30% *[write in]*

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs	**Yes ✓**	**No**
Technical guidance	**Yes ✓**	**No**
Procurement and distribution of drugs or other supplies	**Yes**	**No✓**
Coordination with other implementing partners	**Yes ✓**	**No**
Capacity-building	**Yes✓**	**No**
Other: *[Write in)*	**Yes✓**	**No**
Financial resource mobilization		

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes	No✓

6.1 IF YES, were policies and laws amended to be consistent with the National AIDS Control policies?

Yes	No

IF YES, name and describe how the policies/laws were amended:

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

National M&E Framework does not monitor the technical i.e. Ministry of Health performance well

Overall, how would you rate the political support for HIV programmes in 2009?

Very Poor										Excellent
0	1	2	3	4	5	6	7✓	8	9	10

Since 2007, what have been key achievements in this area:

- There has been active involvement in policy, plan and program development at various levels
- Advocacy- intensified targeting of the most at risk populations and to Global Fund for

more resources
- Aligned thematic areas with new evidence
- Government contributed to access to care and treatment and ARVs
- Government commitment in terms of funds for support and prevention

What are remaining challenges in this area:
- Insufficient resource mobilization especially for care and support
- Very low funding from Government of Uganda

III. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?

Yes✓	No	N/A

1.1 IF YES, what key messages are explicitly promoted?

√ Check for key message explicitly promoted.

	Be sexually abstinent	✓
	Delay sexual debut	✓
	Be faithful	✓
	Reduce the number of sexual partners	✓
	Use condoms consistently	✓
	Engage in safe(r) sex	✓
	Avoid commercial sex	✓
	Abstain from injecting drugs	x
	Use clean needles and syringes in health facilities	✓
	Fight against violence against women	✓
	Greater acceptance and involvement of people living with HIV	✓
	Greater involvement f men in reproductive health programmes	✓
	Males to get circumcised under medical supervision	✓
	Know your HIV status	✓
	Prevent mother-to-child transmission of HIV	✓
Other:	*[write in]*	

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes✓	No

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes ✓	**No**	**N/A**

2.1 Is HIV education part of the curriculum in:

primary schools?	**Yes ✓**	**No**
secondary schools?	**Yes ✓**	**No**
teacher training?	**Yes ✓**	**No**

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes✓	No

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes✓	No

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk or other vulnerable sub-populations?

Yes ✓	No

3.1 IF YES, which populations and what elements of HIV prevention do the policy/strategy address?

√ Check which specific populations and elements are included in the policy/strategy

	IDU*	**MSM***	**Sex Workers**	**Clients of sex workers**	**Prison inmates**	**Other populations[write in)**
Targeted information on risk reduction and HIV education			✓	✓	✓	Truck drivers
Stigma and discrimination reduction			✓	✓	✓	✓
Condom promotion			✓	✓		✓
HIV testing and counseling			✓	✓	✓	✓
Reproductive health, including sexually transmitted infections prevention and treatment Vulnerability reduction (e.g. income generation)			✓	✓	✓	✓

* IDU = injecting drug user
* MSM = men who have sex with men

Drug substitution therapy			N/A	N/A	N/A	✓
Needle and syringe exchange			N/A	N/A	N/A	

Overall, how would you rate policy efforts in support of HIV prevention in 2009?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8✓	9	10

Since 2007, what have been key achievements in this area:

- Roadmap for HIV/AIDS Prevention
- Revision of OVC policy
- Revision of PMTCT policy
- MMC (Medical Male Circumcision)

What are remaining challenges in this area:

- Consolidation of the National HIV/AIDS policy
- Implementation gaps
- Coordination challenges

4. Has the country identified specific needs for HIV prevention programmes?

Yes✓	No

IF YES, how were these specific needs determined?

- Population based surveys
- Surveillance
- Roadmap to HIV/AIDs Prevention
- Key studies e.g. Modes of transmission study
- Most at risk populations study

IF NO, how are HIV prevention programmes being scaled-up?

4.1 To what extent has HIV prevention been implemented?

HIV prevention component	**The majority of people in need have access**		
Blood safety	**Agree✓**	**Don't Agree**	**N/A**
Universal precautions in health care settings	**Agree✓**	**Don't Agree**	**N/A**
Prevention of mother-to-child transmission of HIV	**Agree**	**Don't Agree✓**	**N/A**
IEC* on risk reduction	**Agree**	**Don't Agree✓**	**N/A**
IEC* on stigma and discrimination reduction	**Agree**	**Don't Agree✓**	**N/A**
Condom promotion	**Agree**	**Don't Agree✓**	**N/A**

* IEC = Information, education, communication

HIV testing and counseling	**Agree**	**Don't Agree✓**	**N/A**
Harm reduction for injecting drug users	**Agree**	**Don't Agree**	**N/A✓**
Risk reduction for men who have sex with men	**Agree**	**Don't Agree**	**N/A✓**
Risk reduction for sex workers	**Agree**	**Don't Agree✓**	**N/A**
Reproductive health services including sexually transmitted infections prevention and treatment	**Agree**	**Don't Agree✓**	**N/A**
School-based HIV education for young people	**Agree✓**	**Don't Agree**	**N/A**
HIV prevention for out-of-school young people	**Agree✓**	**Don't Agree**	**N/A**
HIV prevention in the workplace	**Agree**	**Don't Agree✓**	**N/A**
Other: *[write in]*	**Agree**	**Don't Agree**	**N/A**

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

Very Poor										**Excellent**
0	**1**	**2**	**3**	**4**	**5✓**	**6**	**7**	**8**	**9**	**10**

Since 2007, what have been key achievements in this area:

- Increasingly, more people accessing prevention services e.g PMTCT scaled up and also couple HCT
- Reintroduction of female condom
- Innovative strategies e.g. moonlighting

What are remaining challenges in this area:

- Accessibility service coverage is still challenging for many people
- Behavioral change remains sluggish; many have the information but the response is slow.
- People have lived with HIV for too long and have normalized it.

III. TREATMENT, CARE AND SUPPORT

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counseling, psychosocial care, and home and community-based care).

Yes ✓	No

1.1 IF YES, does it address barriers for women?

Yes	No✓

1.2 IF YES, does it address barriers for most-at-risk populations?

Yes	No✓

2. Has the country identified the specific needs for HV treatment, care and support services?

Yes ✓	No

IF YES, how were these determined?

- Supervision findings

- PHA voices
- MoT study findings
- Sensitization of people on how to seek the se services
- Studies- like the sero – behavioral survey

IF NO, how are HIV treatment, care and support services being scaled-up?

To what extent have the following HIV treatment, care and support services been implemented

HIV treatment, care and support services	**The majority of people in need have access**		
Antiretroviral therapy	**Agree✓**	**Don't Agree**	**N/A**
Nutritional care	**Agree**	**Don't Agree✓**	**N/A**
Pediatrics AIDS treatment	**Agree**	**Don't Agree✓**	**N/A**
Sexually transmitted infection management	**Agree**	**Don't Agree✓**	**N/A**
Psychosocial support for people living with HIV and their families	**Agree**	**Don't Agree✓**	**N/A**
Home-based care	**Agree**	**Don't Agree✓**	**N/A**
Palliative care and treatment of common-related infections	**Agree**	**Don't Agree✓**	**N/A**
HIV testing and counseling for T.B patients	**Agree✓**	**Don't Agree**	**N/A**
TB screening for HIV-infection people	**Agree✓**	**Don't Agree**	**N/A**
TB prevention therapy for HIV-infection people	**Agree**	**Don't Agree✓**	**N/A**
TB infection control in HIV treatment and care facilities	**Agree**	**Don't Agree✓**	**N/A**
Cotrimoxazole prophylaxis in HIV-infected people	**Agree✓**	**Don't Agree**	**N/A**
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	**Agree**	**Don't Agree✓**	**N/A**
HIV treatment services in the workplace or treatment referral systems through the workplace	**Agree**	**Don't Agree✓**	**N/A**
HIV care and support in workplace (including alternative working arrangements)	**Agree**	**Don't Agree✓**	**N/A**
Other: *[write in]*	**Agree**	**Don't Agree**	**N/A**

3. **Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?**

Yes✓	No

4. **Does the country have access to regional procurement and supply management mechanisms for crucial commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?**

Yes	No✓

IF YES, for which commodities? *[write in]*

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

Very Poor										**Excellent**
0	**1**	**2**	**3**	**4**	**5**	**6✓**	**7**	**8**	**9**	**10**

Since 2007, what have been key achievements in this area:

- 53% of those who need ARVs are on treatment
- Increase in number of ART sites

- EWI studies are being conducted
- IMAI trainings are being undertaken

What are remaining challenges in this area:

- Inadequate stock of all medicines including ARVs, CTX, HIV supplies and commodities
- Starting people on ARTs early enough not yet possible
- Adherence
- Logistics in pediatric care are lacking

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes✓ **No** **N/A**

5.1 IF YES, is there an operational definition for orphans and vulnerable children in the Country?

Yes✓	No

5.2 IF YES, does the country have a national action plan specifically for orphans and Vulnerable children?

Yes✓	No

5.3 IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes✓	No

IF YES, what percentage of orphans and vulnerable children is being reached?

23 % *[write in]*

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?

Very Poor										Excellent
0	1	2	3	4✓	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

- Defining the OVC service package
- Review of policy and action plan
- Situational Analysis of orphans and Vulnerable children
- Setting up the structure at district level

What are remaining challenges in this area:

- EID costs are high, children challenging to access & exercise tedious
- Funding is limited and yet the scope and magnitude of OVC needs is increasing.
- The human resource capacity to provide services is not adequate and there is no streamlined and coordinated plan of strengthening the human resource capacity especially at the local government level

IV. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) Plan?

Yes✓	In progress	No

IF NO, briefly describe the challenges:

1.1 **IF YES,** years covered: 2007/08 - 2011 /2012
[write in]

1.2 **IF YES,** was the M&E Plan endorsed by key partners in M&E?

Yes✓	No

1.3 **IF YES,** was the M&E Plan developed in consultation with civil society, including people living with HIV?

Yes✓	No

1.4 **IF YES,** have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E Plan?

Yes, all partners	**Yes, most partners**	**Yes, but only some partners✓**	**No**

IF YES, but only some partners or IF NO, briefly describe what the issues are:
There are implementation challenges of the M&E framework and harmonization including ownership of the framework and its dissemination to all the key actors in the country

2. Does the national Monitoring and Evaluation Plan include?

a data collection strategy	**Yes✓**	**No**
IF YES, does it address: routine programme monitoring	**Yes✓**	**No**
behavioural surveys	**Yes✓**	**No**
HIV surveillance	**Yes✓**	**No**
Evaluation/research studies	**Yes✓**	**No**
a well-defined standardized set of indicators	**Yes✓**	**No**
guidelines on tools for data collection	**Yes✓**	**No**
a strategy for assessing data quality (i.e. validity, reliability	**Yes✓**	**No**
a data analysis strategy	**Yes✓**	**No**
a data dissemination and use strategy	**Yes✓**	**No**

3. Is there a budget for implementation of the M&E Plan?

Yes✓	**In progress**	**No**

3.1 **IF YES,** what percentage of the total HIV programme funding is budgeted for M&E activities?
1.13 % *[write in]*

3.2 **IF YES,** has full funding been secured?

Yes	No ✓

IF NO, briefly describe the challenges:
Limited Resources
Poor costing
Lack of prioritization for M & E

3.3 **IF YES,** are M&E expenditures being monitored?

Yes	No✓

4. Are M&E priorities determined through a national M&E system assessment?

Yes✓	No

IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves:

- The country has an Technical Working Group which meets quarterly
- JAAR meets annually

They meet to make annual sector reviews and agree on progress to forge way forwards

IF NO, briefly describe how priorities for M&E are determined

5. Is there a functional national M&E Unit

Yes✓	**In progress**	**No**
IF NO, What are the main obstacles to establishing a functional M&E Unit?		

5.1 YES, is the national M&E Unit based

in the National AIDS Commission (or equivalent)?	**Yes✓**	**No**
in the Ministry of Health N/A	**Yes**	**No**
Elsewhere? [PEPFAR]	**Yes**	**No**

5.2 IF YES, how many and what of professional staff are working in the national M&E Unit?

Number of permanent staff: 3		
Position: Monitoring and Evaluation Coordinator *[write in]*	**✓Full time/Part time?**	**Since when? late 2009**
Position: Data Manager *[write in]*	**✓Full time/Part time?**	**Since when?**
[Add as many as needed}		
Number of temporary staff:		
Position: *[write in]*	**Full time/Part time?**	**Since when? N/ A**
Position: *[write in]*	**Full time/Part time?**	**Since when? N/ A**
[Add as many as needed} N/A		

5.3 IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in national M&E system?

Yes	No✓

IF YES, briefly describe the data-sharing mechanisms:
What are the major challenges?

6. Is there a national M&E Committee or Workshop Group that meets regularly to coordinate M&E activities?

No	**Yes, but meets irregularly**	**Yes, meets regularly✓**

6.1 Does it include representation from civil society?

Yes✓	No

IF YES, briefly describe who the representatives from civil society are and what their role is:

Uganda National AIDS Service Organization, National Forum for People Living with HIV/AIDS. They

are part of the National M& E Technical Working Group.

7. Is there a central national database with HIV-related data?

	Yes	No✓

7.1 **IF YES,** briefly describe the national database and who manages

[write in]

7.2 **IF YES,** does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

a. Yes, all of the above
b. Yes, but only some of the above *[write in]*
c. No, none of the above

7.3 Is there a functional* Health Information System?

At national level	**Yes✓**	**No**
At sub-national level **IF YES,** at what level(s)? *[write in]*	**Yes✓**	**No**

*(*regularly reporting data from health facilities which are aggregated at district level and sent to national level; and data are analyzed and used at different levels)*

8. Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data?

Yes	No✓

9. To what extent are M&E data used

9.1 In developing/revising the national AIDS strategy?

Low					**High**
0	1	2	3✓	4	5

Provide a specific example:

- M& E data is used to develop the National Strategic Plan, NSAP.
- It is also used for planning, budgeting, decision making and programming
- The UHBS 2004/5 found multiple partner rates very high. This raised issues of discordance and since then, the country has embarked on reinvigorating HIV prevention and couple counseling campaigns.

What are the main challenges, if any?

- Complexity of measuring behavioral trends
- No proper data validation system, uncoordinated M&E reporting system

9.2 For resource allocation?

Low					**High**
0	1	2✓	3	4	5

Provide a specific example:

Mid-Term Expenditure Framework. Some funds for prevention have been allocated and earmarked

What are the main challenges, if any?

- Limited funding ; the global crunch is affecting all
- There is need for new preventive strategies

9.3 for programme improvement?

Low					**High**
0	1	2✓	3	4	5

Provide a specific example:

- There has been policy change from VCT to HCT

What are the main challenges, if any?

- High demand for services including HCT
- Low Human Resource in facilities
- Inadequate data

10. Is there a plan for increasing human capacity in M&E at national, sub-national and service-delivery levels?:

a. Yes, at all levels
b. Yes, but only addressing some levels: ✓ [ACP of MoH hired M&E staff]
c. No

10.1 In the last year, was training in M&E conducted?

At national level?	**Yes**	**No✓**
IF YES, Number trained	*[write in]*	
At sub-national level? (district M&E officers)	**Yes✓**	**No**
IF YES, Number trained	*[write in]*	
At service delivery level including civil society?	**Yes✓**	**No**
IF YES, Number trained	*[write in]*	

10.2 Were other M&E capacity-building activities conducted other than training?

Yes✓	No

IF YES, describe what types of activities: *[write in]*

Orientation of national and district technical staff and other stakeholders on the performance measurement and management plan (PMMP), National Priority Action Plan (NPAP) and the National HIV/AIDS Strategic Plan (NSP).
Computerization of data
Updated systems e.g SQL
Recruited staff CSO's

Overall, how would you rate the M&E efforts of the HIV programme in 2009?

Very Poor										**Excellent**
0	**1**	**2**	**3✓**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Since 2007, what have been key achievements in this area:

- Developed the PMMP
- Joint Annual AIDS Review (JAAR). This is where stakeholders come together and share experience to improve on the M&E performance systems
- Conducted district partnership forum meetings: findings from District partnership forums feed into the JAAR.
- Began the process of establishing a central database for HIV and AIDS related data. The process is still ongoing.

- Developed and pre-tested data collection forms for both national and district level indicators.

What are remaining challenges in this area:
- Human resource capacity is still inadequate
- Inadequate funding

Part B
[to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations]

I. HUMAN RIGHTS

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care, etc.)

Yes✓	No

1.1 **IF YES,** specify if HIV is specifically mentioned and how or if this is a general non-discrimination provision: *[Specified in sector policies and guidelines e.g. Ministry of Education, Ministry of Gender, Labour and Social Development etc)]*

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable sub-populations?

Yes✓	No

2.1 **IF YES,** for which population

a. Women	**Yes✓**	**No**
b. Young people	**Yes✓**	**No**
c. Injecting drug users	**Yes**	**No✓**
d. Men who have sex with men	**Yes**	**No✓**
e. Sex workers	**Yes**	**No✓**
f. Prison inmates	**Yes✓**	**No**
g. Migrants/mobile populations	**Yes✓**	**No**
h. Other: *[write in]*	**Yes**	**No**

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented.

The Police, Judiciary, Uganda Human Rights Commission, Equal Opportunities Act, Industrial Court (in MGLSD), Family and Child Protection Units of the Police, Probation and Social Welfare departments, Children Courts, National Council for Children , Women Councils are some of the key institutional frameworks in place to enforce the various laws. CSOs also have arrangements for legal protection and social defense. They are a number of CSOs running Legal AID Clinics that offer legal protection. These are all mechanisms through which people can appeal.

Briefly describe the content of these laws:

The 1995 Constitution and supporting legislations emphasize non-discrimination on the basis of sex, race, and economic/social status. Sectors also have work place policies and guidelines that outlaw discrimination.

Briefly comment on the degree to which they are currently implemented

Although there are some weaknesses in enforcement of the laws and policies, by and large if a case is reported, it is investigated and action is taken. Discrimination is currently more covert than overt; overt discrimination can easily be detected and investigated leading to disciplinary action.

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable sub-populations?

Yes	No✓

3.1 IF YES, for which sub-populations?

a. Women	**Yes**	**No**
b. Young people	**Yes**	**No**
c. Injecting drug users	**Yes**	**No**
d. Men who have sex with men	**Yes**	**No**
e. Sex workers	**Yes**	**No**
f. Prison inmates	**Yes**	**No**
g. Migrants/mobile populations	**Yes**	**No**
h. Other: Women who Have Sex with Women *[write in]*	**Yes**	**No**

IF YES, briefly describe the content of these laws, regulations or policies:

Briefly comment on how they pose barriers:

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes✓	No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

The National Strategic Plan for HIV/AIDS addresses the rights of PLHIV. It takes a human rights based approach to policy and programming for prevention, treatment, care and support services. The OVC policy is also hinged on the key principles of the CRC which emphasizes the rights of OVC including those infected and affected with HIV and AIDS. However, Uganda does not have an explicit HIV and AIDS Policy. A draft was developed but is still before cabinet. There is a draft HIV/AIDS Prevention Bill still undergoing consultations.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable sub-populations?

Yes✓	No

IF YES, briefly describe this mechanism:

There are mechanisms by Government and Civil Society Organizations:
Government: Structures like Uganda Human Rights Commission and the Equal Opportunities Commission exist. However they are yet to develop clear and precise mechanisms on how to address cases of discrimination for PLHIV and Most at Risk Populations (MARPs).

CSOs like UGANET and FIDA have programs for following up cases human rights violations

especially for PHAs and OVC. These CSOs do engage in documentation and lodge complaints with the Uganda Human Rights Commission for redress.

6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?

Yes✓	No

IF YES, briefly some examples:
All stakeholders including PLHIV and some MARPs like sex workers are involved in the NSP development and revision and implementation processes. PLHIV are involved in policy formulation through their alliances and networks.

People Living with HIV (PLHIV) as a self-Coordinating Entity receives funding from the Partnership Fund of the Uganda AIDS Commission.

People Living with HIV (PLHIV) are represented on the national committees such as Partnership Committee (PC), National and District Partnership Forum etc.
However, several minorities are not recognized by law (MSM, WSW and IDUs)

7. Does the country have a policy of free services for the following?

a. HIV prevention services	**Yes ✓**	**No**
b. antiretroviral treatment	**Yes✓**	**No**
c. HIV-related care and support interventions	**Yes✓**	**No**

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different population

Government has allocated some resources but they are not adequate. Government has not yet met its commitment to the Abuja Declaration of 15% to the health budget.

Barriers to access: Services are free but access is limited by stock outs, non-efficiency of the health facilities, inadequate human resources and in some cases legal restrictions (MSM and IDU).

Given the unit cost of treatment, it quite clear that it is unaffordable and unsustainable without support from AIDS Development Partners. An estimated 350.000 t0 400,00o0 people need ART but only about 190,000 are on treatment. This notwithstanding, the steps taken towards increasing focus on prevention are not adequate.

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes✓	No

In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes✓	No

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

Yes✓	No

IF YES, briefly describe the content of this policy:

The NSP clearly identifies the MARPs and strategies to reach them through various approaches.

Services are provided irrespective of the level of vulnerability. However, services to MARPs are limited in as far as the law recognized them. Thus for those not recognized by the law, there are obstacles in respect to access to services.

9.1. **IF YES**, **does this policy include different types of** approaches **to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations?**

Yes✓	No

IF YES, explain the different types of approaches to ensure equal access for populations:
Routine Counseling and Testing in health facilities, home/community based HCT and ART, Social Support for OVC and youth, Programme for Children and Youth in Difficult Circumstances, Programme for enhancing Adolescent Reproductive Health Life. The Fishing sector has a ten year strategy for reaching out to key populations with high risk of exposure to HIV in fishing communities.

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes✓	No

11. Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes✓	No

11.1 IF YES, does the ethical review committee include representatives of civil society including people living with HIV?

Yes	No✓

IF YES, briefly describe the approach and effectiveness of this review committee:

12. Does the country have the following human rights monitoring and enforcement mechanisms?

- Existence of independent national institutions for the promotions and protection of human rights, including human rights commissions, law reform commissions, watchdogs e. g UGANET, FIDA, Transparency International, Human Rights Foundation and ombudspersons which consider HIV-related issues with their work.

Yes✓	No

- Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment e.g Transparency International and Foundation for Human Rights Initiative (FHRI)

Yes✓	No

- Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts.

Yes✓	No

IF YES on any of the above questions, describe some examples:

The Uganda Human Rights Commission; and
Uganda Law Reform Commission.

13. In the last 2 years, have members of the judiciary (including labour courts/employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?

UGANET Carried out sensitization of the Judiciary

Yes✓	No

14. Are the following legal support services available in the country?

- Legal aid systems for HIV casework

Largely provided by CSOs like UGANET, NACWOLA, Uganda Law Society and FIDA. Government also has structures like the Administrator General and Probation and Social Welfare Officers at district level. However, CSOs have been more active in this area especially in relation to HIV/AIDS

Yes✓	No

- Private sector law firms or university based centres to provide free or reduced-cost legal services to people living with HIV

Makerere University, Law Development Centre operates a legal aid clinic; it among others things addresses property rights violation issues for widows and OVC affected by AIDS. The Uganda Law Society also operates legal aid clinics that offer services to vulnerable groups including PLHIV.

Yes✓	No

- Programs to educate, raise awareness among people living with HIV concerning their rights

Yes✓	No

15. Are there programs in place to reduce HIV-related stigma and discrimination?

Yes	No

IF YES, what types of programs?

Media	**Yes✓**	**No**
School education	**Yes✓**	**No**
Personalities regularly speaking out	**Yes✓**	**No**
Other: *People Living with HIV network, FBO's- anti stigma campaigns* *[write in]*	**Yes✓**	**No**

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?

2009	**Very Poor**									**Excellent**
	0	**1**	**2**	**3**	**4**	**5✓**	**6**	**7**	**8**	**9**	**10**

Since 2007, what have been key achievements in this area:

- Designing of the national Strategic Plan. This plan has strategies for applying the human rights based approach to delivery of HIV/AIDS services.
- Equal Opportunities Act
- Domestic Violence Act (addresses GBV issues relating to HIV and AIDS)

What are remaining challenges in this area:

Discrimination: Bills being drafted have contentious clauses. For example, the HIV Prevention Bill seeks to criminalize HIV transmission. It is controversial; it may contribute to increasing stigmatization and discouraging disclosure of HIV status.

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2009?

2009	Very Poor									Excellent
0	1	2	3	4	5✓	6	7	8	9	10

Since 2007, what have been key achievements in this area:

Reviewing NSP and the PMMP to suit current trends
Scaling up HCT/VCT access by the private sector and NGOs in the country

What are remaining challenges in this area:

- Amount of resources needed to reach every body in need of services
- Lack of adequate infrastructure and human resources to meet the increasing demand for HIV and AIDS services
- Existing law is not adequately disseminated

II. CIVIL SOCIETY* PARTICIPATION

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

Low					High
0	1	2	3	4✓	5

Comments and examples

- CSOs involved in development and implementation of the NSP
- CSOs championed innovative strategies for HCT, ART and HIV prevention.
- CSOs have actively participated in advocacy. They have challenged Bills and legislations that are perceived not to be supportive of PLHIV and the national HIV/AIDS response in general.
- CSOs part of the Technical Working Groups of the National HIV/AIDS response. They are also part of the District AIDS Committees and members of the district HIV/AIDS forums.

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

a. the national AIDS Strategy?

Low					High
0	1	2	3	4	5✓

b. the national AIDS budget?

Low					High
0	1	2✓	3	4	5

c. national AIDS report?

Low					High
0	1	2	3✓	4	5

* Civil society include among others networks of people living with HIV; women's organizations; young people's organizations, faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, sex workers, injecting drug users, migrants, refugees/displaced populations prisoners); workers organizations; human rights organizations, etc. For the purpose of the NCPI, the private sector is considered separately.

Comments and examples

- NSP development
- Represented in sector working groups using SWAP(Sector Wide Approach)

4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. developing the national M&E Plan?

Low					High
0	1	2	3✓	4	5

b. participating in the national M&E committee/working group responsible for coordination of M&E activities?

Low					High
0	1	2	3✓	4	5

c. M&E efforts at local level?

Low					High
0	1	2	3✓	4	5

Comments and examples
CSOs have been involved in M&E especially at the national level. They are represented in the M&E Technical Working Group at national level. CSOs also carry out M&E as Self-Coordinating Entities. Structures for M&E established at the district level but they are not effective.

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations?

Low					High
0	1	2	3✓	4	5

Comments and examples
Inter-Religious Council Uganda and National Forum of People with HIV /AIDS in Uganda (NAFOPHANU) which are umbrella organisations of FBOs and PLHIV are represented. These are Self-Coordinating Entities. Each of the networks has a self coordinating entity except the organisation of sex workers.

6. To what extent is civil society able to access:

a. Adequate financial support to implement its HIV activities?

Low					High
0	1	2	3✓	4	5

b. adequate technical support to implement its HIV activities?

Low					High
0	1	2	3✓	4	5

Comments and examples
Apart from donors, the civil society has not received adequate support from the government. Technical

support to CSOs is limited.

7. What percentage of the following HIV programs/services is estimated to be provided by civil society?

Prevention for youth	<25%	25-40%	51-75%✓	>75%
Prevention for most-at risk-populations	<25%	25-40%	51-75%	>75%
- injecting drug users	<25%	25-40%	51-75%	>75%
- Men who have sex with men	<25%	25-40%	51-75%✓	>75%
- Sex worker				
Testing and Counselling	<25%	25-40%	51-75%✓	>75%
Reduction of Stigma and Discrimination	<25%	25-40%	51-75%✓	>75%
Clinical services (ART/OI)*	<25%	25-40%	51-75%✓	>75%
Home-based care	<25%	25-40%	51-75%	>75% ✓
Programmes for OVC**	<25%	25-40%	51-75%✓	>75%

*ART = Antiretroviral Therapy; OI = Opportunistic infections
**OVC = Orphans and other vulnerable children

Overall, how would you rate the efforts to increase civil society participation in 2009?

2009	**Very Poor**									**Excellent**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7✓**	**8**	**9**	**10**

Since 2007, what have been key achievements in this area:

Government has made serious efforts in recognition of the role and value addition from the civil society.

Increasing public-private sector partnerships in delivery of HIV/AIDS services

What are remaining challenges in this area:

Supplementary funding from government, CSOs sometimes perceived as competitors rather than partners, and there is need to properly coordinate services offered by the civil society.
Engagement of CSo's in planning and budgeting.
Civil Society Fund not fully owned and run by CSOs. There has been externalization of the Technical Management Agent, Monitoring and Evaluation Agent and the Financial Management Agent. The costs of these management agencies are high. There is also inadequate reach of grassroots CBOs and NGOs.

III. PREVENTION

1. Has the country identified the specific needs for HIV prevention programs?

Yes✓	No

IF YES, how were these specific needs determined?

The Modes of Transmission study was a key element in enabling policy makers and programmers do targeted HIV prevention. It brought to light the key drivers of the HIV epidemic and the MARPs.

IF NO, how are HIV prevention programs being scaled-up?

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	**The majority of people in need have access**		
Blood safety	**Agree✓**	**Don't Agree**	**N/A**
Universal precautions in health care settings	**Agree✓**	**Don't Agree**	**N/A**
Prevention of other-to-child transmission of HIV	**Agree**	**Don't Agree✓**	**N/A**
IEC* on risk reduction	**Agree✓**	**Don't Agree**	**N/A**
IEC* on stigma and discrimination reduction	**Agree✓**	**Don't Agree**	**N/A**
Condom promotion	**Agree✓**	**Don't Agree**	**N/A**
HIV testing and counseling	**Agree✓**	**Don't Agree**	**N/A**
Harm reduction for injecting drug users	**Agree**	**Don't Agree**	**N/A✓**
Risk reduction for men who have sex with men	**Agree**	**Don't Agree**	**N/A✓**
Risk reduction for sex workers	**Agree**	**Don't Agree✓**	**N/A**
Reproductive health services including sexually transmitted infections prevention and treatment	**Agree✓**	**Don't Agree**	**N/A**
School-based HIV education for young people	**Agree✓**	**Don't Agree**	**N/A**
HIV prevention for out-of-school young people	**Agree✓**	**Don't Agree**	**N/A**
HIV prevention in the workplace	**Agree✓**	**Don't Agree**	**N/A**
Other: *[write in]*	**Agree**	**Don't Agree**	**N/A**

***IEC** = Information, education, communication

Overall, how would you rate the efforts in the implementation of HIV prevention programs in 2009?

2009	**Very Poor**									**Excellent**
0	**1**	**2**	**3**	**4**	**5**	**6✓**	**7**	**8**	**9**	**10**

Since 2007, what have been key achievements in this area:

PMTCT coverage increased

- Mass media and IEC programs wide spread
- Condoms wide spread through public and commercial outlets

What are remaining challenges in this area:

* IEC = Information, education, communication

- High unmet need for HCT/VCT (70% have never had an HIV test)
- High unmet need for PMTCT-low coverage
- Infection control and infection safety still remains a challenge especially in the context of TB-HIV

IV. TREATMENT, CARE AND SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes✓	No

IF YES, how were these specific needs determined?

- Consensus building meetings during the processes of developing the NSP and PMMP
- HIV national surveillance reports
- Special studies

IF NO, how are HIV treatment, care and support services being scaled-up?

1.1 To what extent has HIV treatment, care and support services been implemented?

HIV treatment, care and support service	**The majority of people in need have access**		
Antiretroviral therapy	**Agree✓**	**Don't Agree**	**N/A**
Nutritional care	**Agree✓**	**Don't Agree**	**N/A**
Paediatric AIDS treatment	**Agree**	**Don't Agree✓**	**N/A**
Sexually transmitted infection management	**Agree✓**	**Don't Agree**	**N/A**
Psychosocial support for people living with HIV and their families	**Agree✓**	**Don't Agree**	**N/A**
Home-based care	**Agree✓**	**Don't Agree**	**N/A**
Palliative care and treatment of common HIV-related infections	**Agree✓**	**Don't Agree**	**N/A**
HIV testing and counseling for TB patients	**Agree✓**	**Don't Agree**	**N/A**
TB screening for HIV-infection people	**Agree✓**	**Don't Agree**	**N/A**
TB prevention therapy for HIV-infected people	**Agree**	**Don't Agree✓**	**N/A**
TB infection control in HIV treatment and care facilities	**Agree✓**	**Don't Agree**	**N/A**
Cotrimoxazole prophylaxis in HIV-infected people	**Agree✓**	**Don't Agree**	**N/A**
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	**Agree✓**	**Don't Agree**	**N/A**
HIV care and support in the work place (including alternative working arrangement)	**Agree✓**	**Don't Agree**	**N/A**
Other: *[write in]*	**Agree**	**Don't Agree**	**N/A**

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programs in 2009?

2009	**Very Poor**									**Excellent**
0	**1**	**2**	**3**	**4**	**5✓**	**6**	**7**	**8**	**9**	**10**

Since 2007, what have been key achievements in this area:

Provision of treatment to at least half of the people who need it.

What are remaining challenges in this area:

Provision of treatment is largely donor driven. This makes it unsustainable. While focusing on treatment, prevention is marginalized yet the cost of treatment is very high.
Drug Stock-outs
Supply chains for drugs and supplies are not efficient

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes✓ No Not Applicable (N/A)

2.1 IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes✓	No

2.2 IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes✓	No

2.3 IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes✓	No

IF YES, what percentage of orphans and vulnerable children is being reached?

23 % *[write in]*

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?

2009	Very Poor									Excellent
0	1	2	3	4	5✓	6	7	8	9	10

Since 2007, what have been key achievements in this area:

Rolled out the Technical Service Organisation model which involves strategic and functional partnerships between CSOs and government sectors (Ministry of Gender Labour and Social Development)

- Created OVC coordination mechanisms at the national and sub-national
- Developed national and sub national OVC strategic plans
- Conducted a new situational analysis for OVC
- OVC Management Information System has been rolled out in 8 districts
- Developed guidelines and standards for OVC service providers
- Many CSOs have committed resources towards OVC especially in terms of school fees, nutrition and housing/shelter.

What are remaining challenges in this area:
There is need for continuous and targeted capacity building at the district and sub-county levels.

Annex 3: National Funding Matrix

AIDS Spending by Thematic Area										
	PEPFAR(only Obligated Funds)		Civil Society Fund		UN Agencies		UAC		MoH	
Expenditure by Broad thematic areas	**2007/08**	**2008/09**	**2007/08**	**2008/09**	**2007/08**	**2008/09**	**2007/08**	**2008/09**	**2007/08**	**2008/09**
Prevention	104,233,963,910	93,198,440,494	17,896,478,234	14,907,666,479	8,194,700,000	10,056,372,098				
Care and Treatment	196,896,599,028	197,193,050,962	5,547,256,999	4,980,190,843	2,947,850,000	1,031,256,084			8,000,000,000	63,739,000,000
Orphans and Vulnerable Children	39,887,159,265.1	28,498,550,485		402,234,214	9,036,400,000					
Program Management and Administration	93,848,095,197	109,769,246,859	5,809,494,921	5,203,905,736	1,537,290,000	2,156,550,274			50,000,000	50,000,000
Incentives for Human Resources										
Social Protection and Social Services, excluding Orphans and Vulnerable Children						1,761,697,746				
Enabling environment and Community Development					3,203,400,000	2,960,658,698	2,952,622,271	2986573795		
Research excluding operations										
TOTAL	**434,865,817,400**	**428,659,288,800**	**29,253,230,154**	**25,493,997,273**	**24,919,640,000**	**17,966,534,900**	**2,952,622,271**	**2,986,573,795**	**8,050,000,000**	**63,789,000,000**

Data presented in this Funding Matrix was obtained from USG particularly PEPFAR, UAC, Ministry of Finance, Planning and Economic Development (MoFPED), Irish Aid, Swedish Embassy and CSF and UN Agencies reports. As already pointed out in Section 7.2, due to lack of a NASA, what is presented in this the Matrix does not represent all the funding towards the national HIV&AIDS since it does not include all the funding to CSOs from foundations, private sector and other contributors within and outside of Uganda. According to available data, 25% of the resources were spent on prevention, 43% on care and treatment, 8% on orphans and vulnerable children, 22% on program management and administration, and 1% on enabling environment and community development. The Matrix above shows that United States Government (USG) Agencies through PEPFAR contribute the largest portion of funds. They obligated 434,865,817,400 Uganda Shillings in Financial Year (FY) 2007/08 and 428,659,288,800 in FY 2008/09. The CSF also contributed considerable funding to the response. Excluding funding from the USG, CSF spent 29,253,230,154 during FY 2007/08 and 25, 493, 997,272 Uganda Shillings in FY 2008/09. Other contributors to CSF apart from the USG included: DFID, Irish Aid, DANIDA and Italian Cooperation.

UN agencies spent a total of UGX 24,919,640,000 in 2008 on the HIV&AIDS response. Of this, UGX22, 571,397, 700 was raised by the agencies themselves from their core budget and supporters while UGX 2,348,242, 300 of funds were received by the UN from Irish Aid and DFID and managed through pooled pass through funding mechanism. By June 2009, UN agencies had spent a total of UGX 17,966,534,900 for the Joint AIDS Programme. Of this, the UN had mobilize UGX 12,783,935,300 from its own resources and a balance of UGX1,917,065,800 extra budgetary resources from DFID and Irish AID from 2008.

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