Government of Uganda

UNGASS COUNTRY PROGRESS REPORT
UGANDA

January 2006 to December 2007

Uganda AIDS Commission

January 2008

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List of Abbreviations and Acronyms

ABC	-	Abstinence, Being faithful and Condom use
ART	-	Anti-Retroviral Treatment
ANC	-	Anti-Natal Clinics
CBO	-	Community Based Organisation
CHAI	-	Community-led HIV/AIDS Initiative
CSO	-	Civil Society Organisation
CSW	-	Commercial Sex Worker
DAT	-	District AIDS Taskforce
DLG	-	District Local Government
FBO	-	Faith Based Organisation
GFATM	-	Global Fund for AIDS, TB and Malaria
GLIA	-	Great Lakes Region for Africa
GoU	-	Government of Uganda
HBC	-	Home Based Care
HBHCT	-	Home Based HIV Counselling and Testing
HCT	-	HIV Counselling and Testing
HIV	-	Human Immune- Deficiency
HMIS	-	Health Management Information Stsyem
HSSP II	-	Health Sector Strategic Plan II
HSV-2	-	Herpes Simplex type 2 Virus
IAVI	-	International AIDS Vaccine Initiative
IDP	-	Internally Displaced Persons
IEC/BCC	-	Information Education Communication / Behaviour Change Communication
IGAD	-	Inter-Governmental Authority on Development
IRCU	-	Inter Religious Council of Uganda
KAPB	-	Knowledge, Attitude, Practice and Behaviour
LTIA	-	Long Term Institutional Arrangements
M&E	-	Monitoring and Evaluation
MARP	-	Most At Risk Populations
MDG	-	Millennium Development Goals
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
MUJHP	-	Makerere University John Hopkins Project
MUWRP	-	Makerere University Walter Reed Project
NAFOPHANU	-	NAtional FOrum for PHA Networks in Uganda
NGO	-	Non Governmental Organisation
NMS	-	National Medical Stores
NSP	-	National Strategic Plan
OoP	-	Office of The President
OVC	-	Orphans and Other Vulnerable Children
PAF	-	Poverty Alleviation Fund
PEAP	-	Poverty Eradication Action Plan
PEPFAR	-	President's Emergency Plan for AIDS Relief
PHA	-	People Having AIDS
PIASCY	-	Presidential Initiative on AIDS Strategy for Communicating to Young People
PMMP	-	Performance Measurement Management Plan
PMTCT	-	Prevention of Mother To Child Transmission of HIV & AIDS
PWD	-	People With Disabilities
RCT	-	Routine Counselling and Testing
SCE	-	Self Co-ordinating Entities
STI	-	Sexually Transmitted Infection
UAC	-	Uganda AIDS commission Secretariat
UBoS	-	Uganda Bureau of Statistics
UBTS	-	Uganda Blood Transfusion Services
UDHS	-	Uganda Demographic and Health Survey
UHSBS	-	Uganda Household Sero-Behaviour Surver
Ug. Shs	-	Uganda Shillings
UNAIDS	-	United Nations Joint AIDS Programme
UNASO	-	Uganda National AIDS Service Organisations
UNFPA	-	United Nations Fund For Population Activity
UNGASS	-	United Nations General Assembly Special Session declaration of commitment on HIV & AIDS
UNSBS	-	Uganda National Sero Behavioural Survey
UPE	-	Universal Primary Education
US$	-	United States Dollars
USAID	-	United States AIDS for International Development
USE	-	Universal Secondary Education
USG	-	United States Government
UVRI	-	Uganda Virus Research Institute
VCT	-	Voluntary Counselling and Testing
YEAH	-	Young People Empowered and Healthy

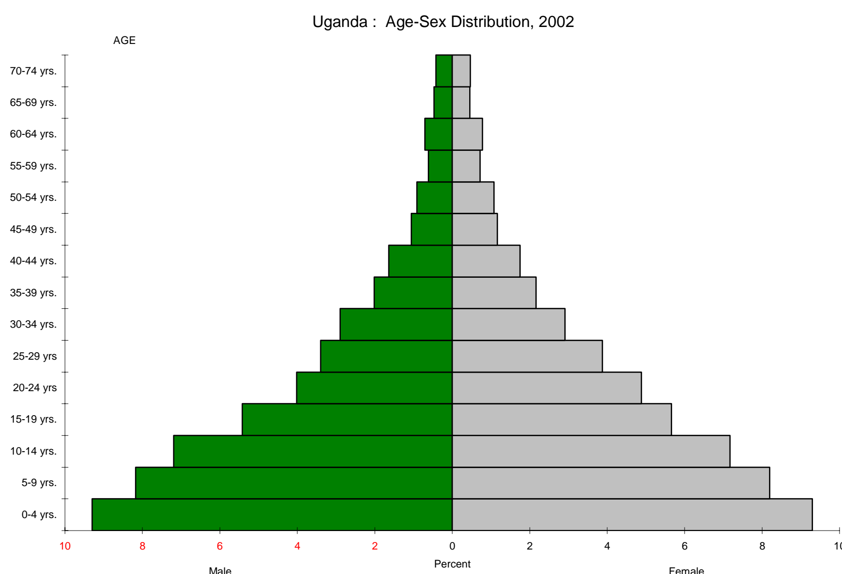
1.0 Uganda HIV & AIDS Status at a Glance

1.1 Introduction

Uganda is a land locked country located in East Africa, bordered by Sudan in the north, Kenya in the east, Tanzania and Rwanda in the south and Democratic Republic of Congo in the west. It covers 241,551 square kilometres, of which 197,323 square kilometres is land area.[1] The country is divided into 79 Districts[2] all of which have a decentralised local governance system. The districts have various land sizes and populations.

With its population growing at the rate of 3.2% per annum, Uganda has one of the highest growth rates in the world and higher than the Sub-Saharan Africa average of 2.4%. The population of Uganda as projected for 2007 is 28.4 million people;[3] 51.5% of these are female and 48.5% male while 13.1% of the population lives in urban areas and 61.2 % is in the working age bracket of 10-59 years. The population distribution is as indicated in *Figure 1.1-1* below.

Figure 1.1-1 : Age distribution of Uganda's Population[4]



Following a number of macro-economic policies, Uganda has experienced solid economic growth of 6-7% per annum over the last decade.[5] Although income poverty is estimated to have reduced from 56% in 1992 to 31% in 2005[6], the country is still facing challenges of equitable distribution of the economic gains. The per capita GDP as of 2006 was Uganda Shillings (Ug. Shs.) 599,030, which is an equivalent of about US$ 330. It is reported that 6.3% of adults aged 15-59 years are infected[7] with the Human Immunodeficiency Virus (HIV) and 46.1% positive for Herpes Simplex type 2 Virus (HSV-2). The Total Fertility Rate

[1] Statistics Abstract Uganda Bureau of Statistics 2006
[2] www.molg.go.ug/generalinfor.htm - 30/11/07
[3] State of Uganda Population Report 2007
[4] Uganda Population and Housing Census, 2002
[5] National Strategic Plan for HIV/AIDS Uganda , 2007/08 – 2011/12.
[6] Uganda Human Development Report 2007
[7] Uganda HIV/AIDS Sero-Behavioural Survey 2004-2005

for ages 15-49 years is 6.7; the under 5 mortality[3] is 137 per 1000 lives and life expectancy at birth is 51.5 years for females and 48.4 years for males. About 12.3% of the population have no education[8]. The population of orphans as recorded in the 2002 population and housing census is 1.8 million. Orphans make 13% of all children under 18 years and 7% of the total country population[4]. It also estimated that 20% of the orphans in Uganda have neither mother nor father, an indicator of level of vulnerability.

Uganda AIDS Commission (UAC) was established in 1992 by Statute No. 2 of Parliament, under Office of the President (OoP). It is mandated to oversee, plan and co-ordinate Acquired Immune-Deficiency Syndrome (AIDS) prevention and control activities.[9] Specifically the functions of the Commission are:

- Guide policy formulation and establishment of programme priorities
- Take the lead in HIV & AIDS national planning and monitoring
- Spearhead advocacy for HIV & AIDS activities
- Identify obstacles to the national response
- Mobilize and monitor resource allocation and utilization
- Foster linkages among partners
- Gather and disseminate information on the epidemic
- Promote HIV & AIDS related research

The production of this UNGASS report is part of the function of national planning and monitoring, as well as gathering and disseminating information on HIV & AIDS.

1.2 Inclusiveness of Stakeholders in Report Writing Process

In order to put this report together, various national level stakeholders from both public and private sectors were contacted to complete the UNGASS data collection instruments. These were drawn from various government departments, the donor community and non-government organisations. A desk review of available documents from various stakeholders and partners was also conducted. The documents included periodic reports, survey reports, in-depth study reports and institutional documents from various stakeholders. Four (4) meetings were convened for a consensus position. A list of both government and non – government respondents are reflected in Appendix 2c and the questionnaires duly filled are shown in Appendix 2e and 2f. A final consensus meeting of about 100 stakeholders was also held to discuss and agree on the contents of the report. The list of participants is also attached in Appendix 2d. The Monitoring & Evaluation (M&E) Sub Committee met and reviewed the report before it was submitted to UNAIDS.

1.3 Status of the Epidemic in Uganda

1.3.1 Trends of the HIV Epidemic in Uganda

The approximately 25 year old epidemic in Uganda was first discovered in the 1980's on the shores of Lake Victoria in Rakai district and spread rapidly, initially in major urban areas and along major road highway network, with heterosexual contact being the major infection route. The first National AIDS Control Programme was set-up in Uganda at the Ministry of Health (MoH) to sensitise and educate the public on the prevention of HIV infection using

[8] Uganda Demographic and Health Survey, 2006
[9] UAC Draft Revised Statute, 2006

the Abstinence, Be faithful, correct/ consistent Condom use (ABC) strategy, ensure availability of safe blood for transfusion, conduct HIV surveillance and to initiate programmes for care and treatment. By the early 1990s a large part of the HIV & AIDS infected population had succumbed to opportunistic infections with a higher prevalence in urban areas as compared to rural areas. It is estimated that the epidemic had its peak during this period with the average**Error! Bookmark not defined.** national antenatal HIV prevalence of 18 % in rural areas and 25%-30% in major urban areas. It was realised that addressing the epidemic needed a collective effort from all stakeholders in their different mandates and areas of comparative advantage and capabilities. Political leadership, political commitment and openness about the epidemic were identified as key in controlling the epidemic. This marked the first phase of the epidemic.

The second phase (1992-2000) showed a declining HIV prevalence and incidence, particularly in urban areas. Nationally, HIV prevalence declined during the 1990s among antenatal clinic attendees and voluntary counselling and testing clients. Similarly, there were declining HIV incidence and prevalence levels in population-based cohorts in rural areas of Masaka district and Rakai district. The decline in HIV incidence and prevalence was attributed to the increased age of sexual debut; reduction in sexual partnerships outside of marriage; and increased use of condoms.

The third phase of the Uganda HIV epidemic (since 2000) has been characterised by stabilisation of the HIV prevalence at a level ranging from 6-7%. However, there are anecdotal indications, from the national surveillance system corroborated by data from longitudinal cohort studies, of an apparent increase in HIV prevalence and incidence during the last few years[5].

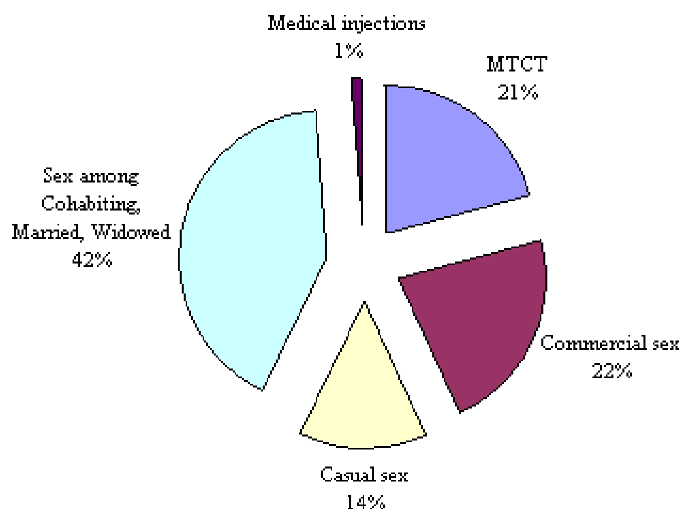
1.3.2 Drivers of the Epidemic

In Uganda, some of the factors driving the epidemic include behavioural factors, social–cultural, socio-behavioural, economic and geographic factors. These include higher risk sex (which include non-marital sex, extra-marital sex, non-consensual sex, commercial sex, transactional sex, intergenerational sex and sex for survival), mother to child transmission, HIV discordance and non-disclosure, poverty, early marriage, glorification of non-marital sex, multiple sexual partners, stigma, discrimination and Sexually Transmitted Infection (STI) prevalence[10].

New infections are found highest among the cohabiting/married/widowed group at 42% as shown in *Figure 1.3-1 below*. Transmission through blood transfusion is estimated as negligible due to the control measures taken to ensure blood safety based on international guidelines.

[10] Accelerating HIV Prevention, The Road Map towards Universal Access to HIV Prevention in Uganda, April 2007.

Figure 1.3-1 : Distribution of New Infections by Sources [5]



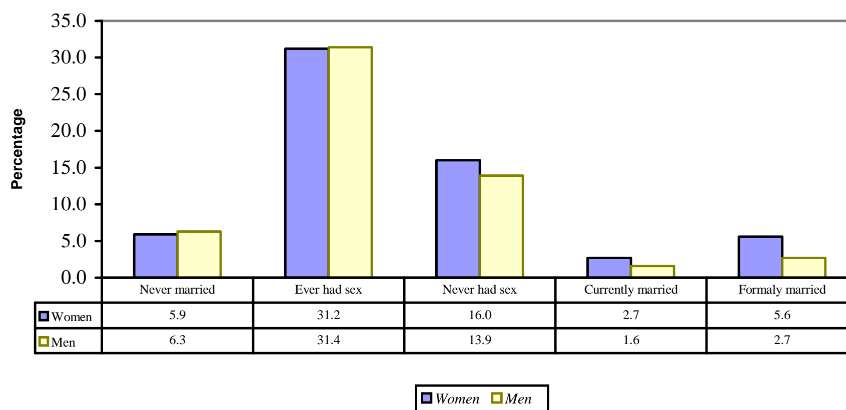
1.3.3 Knowledge, Attitude, Practices and Behaviour on HIV & AIDS

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 according to the results of the Uganda Demographic and Health Survey of 2006 (UDHS). Comprehensive knowledge of HIV & AIDS here is taken to mean (a) those who know that the risk of getting AIDS virus can be reduced by using condoms at every sexual contact or by having only one sexual partner who neither does not have HIV nor any other partner, (b) who know that HIV cannot be transmitted through mosquito bites or sharing food with an infected person and (c) who know that a healthy looking person could have HIV[10].

Comprehensive knowledge about HIV & AIDS shown in *Figure 1.3-2* below is highest in those (men and women) who have ever had sex. Furthermore, 73.3% of women and 62.5% of the men aged between 15-49 years knew that HIV can be transmitted by breastfeeding and 64.8% of the women compared to 63.6% of the men covered the survey knew that the risk of Mother to Child Transmission of HIV (MTCT) of HIV can be reduced by mother taking special drugs during pregnancy. It was also reported that 90.1% of respondent women and 91.3% men were willing to care for a family member with AIDS in the respondent's homes, while 52.5% women respondents and 62% men would rather not disclose that their family member got infected with the virus that causes AIDS. Of the sexually active respondents but aged 15-49 years, 15.9% of the women and 36.2% men engaged in higher-risk sex intercourse in the past six months. Higher risk sex[11] is higher in the age group 15-19 years for both women and men. The Report also indicates that 69.6% women and 89.7% men knew where to get condoms from. Finally, 98.7% of persons living in Internally Displaced People's Camp (IDP) camps aged 15- 49 years were reported to have heard about HIV & AIDS.

[11] Higher risk sex is defined as sex with a partner who was neither a spouse nor who lived with the respondent.

Figure 1.3-2 : Comprehensive Knowledge of HIV Between Age 15-49 Years by Marital Status[7]



	Never married	Ever had sex	Never had sex	Currently married	Formaly married
Women	5.9	31.2	16.0	2.7	5.6
Men	6.3	31.4	13.9	1.6	2.7

1.4 The Policy and Programmatic Response to the HIV & AIDS Epidemic

Since HIV was discovered, the leaders of government have included HIV prevention messages in their speeches to increase awareness about HIV, advocating for attention to People Having AIDS (PHA)s and reduction of stigma and discrimination. Several policies intended to provide direction to the HIV & AIDS response, have been developed and are under review**Error! Bookmark not defined.**. They include HIV Counselling and Testing (HCT), Anti-Retroviral Therapy (ART), Orphans and Other Vulnerable Children (OVC), Condom, Health, Decentralised Local Government, Agriculture, Universal Primary Education (UPE), Universal Secondary Education (USE) and Prevention of Mother-To-Child HIV Transmission (PMTCT). The draft HIV & AIDS policy is currently before the Cabinet and it will addresses the multi-sectoral nature of the response by bringing together all sectoral HIV and AIDS policies into one document. It should be noted that Uganda is committed to International Agreements and UN declarations and programs of action.

Response to the Epidemic

The drivers of the response to HIV & AIDS problem include Political Commitment and Support, Policy of openness enhancing better dialogue and communication, multi-sectoral interventions and co-ordination, Multiplicity of partners, Involvement of religious leaders, decentralised planning, programmatic targeting for discrimination issues, supportive policy and social environment, availability of local and external resources, research and community involvement[10]. As part of its mandate, UAC has continued in its effort to co-ordinate HIV partners and HIV workers, towards a stronger response. MoH and research institutions have continued with research in various aspects of the epidemic including HIV vaccine trials and microbicides. Treatment of opportunistic infections is a major focus. Priority research areas have also been identified. Civil society and PHA organisations are involved in HIV & AIDS planning, implementation, Monitoring and Evaluation of interventions to supplement GoU efforts depending on comparative advantage in performance. However, resource mobilisation and co-ordination still poses a daunting challenge.

Planning for the Response

The National HIV & AIDS Strategic Plan (NSP) 2007/08 to 2011/12 which was developed through a broad consultative process is aligned to the Country's Poverty Eradication Action Plan (PEAP) under Pillar 5. This focuses on Human Development and emphasizes preventive health care and commodities for basic curative care. The Pillar is a further translation of Goal 6 of the Millennium Development Goals (MDGs)[6] that aims at combating HIV & AIDS and target 7 that aims at halting and reversing its spread.

Co-ordinating the Response

Due to adoption of the multi-sectoral approach, GoU has partnered with the non-government organisations to address the HIV & AIDS problem. Currently there are about 1,500 Civil Society Organisations (CSOs)[12] at national level registered with the Uganda National AIDS Service Organisations (UNASO) and many more CSOs at sub-national level. There are about 1,400 People Having AIDS (PHA) organisations registered with the National Forum for PHA Networks in Uganda (NAFOPHANU).

Since 2002, the country's HIV & AIDS efforts are mainly coordinated through the National HIV & AIDS Partnership arrangement. At the central level, the Partnership comprises clusters of homologous organizations and agencies, termed Self-Coordinating Entities (SCEs). The SCEs include: Parliament, Government Ministries, UN & Bilaterals, National NGOs, International NGOs, Private Sector, Faith Based Organisations, PHA Networks, the Decentralized Response, Research Academia & Science, Young People and Media, Arts & Culture which are all represented through a Partnership Committee (PC).

In the Districts, HIV & AIDS coordination is effected through a technical District AIDS Committee (DAC) and a political District AIDS Taskforce (DAT). This arrangement is translated at all Local Government levels, down to the grassroots community.

All stakeholders meet at national level in an annual Partnership Forum to review progress and chart future direction.

1.5 UNGASS Indicator Data

One hundred eighty nine (189) United Nations (UN) member states adopted the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV & AIDS in June 2001. The Declaration reflects global consensus on a comprehensive framework to achieve the Millennium Development Goal of halting and beginning to reverse the HIV epidemic by 2015[13]. The Declaration addresses global, regional and country–level responses to prevent new HIV infections, expand healthcare access and mitigate the epidemic's impact. Its vision extends to the private industry and labour groups, Faith-Based Organizations, non governmental organizations and other civil society entities including PHAs. Success in the response to AIDS is measured by achievement of concrete, time- bound targets.

[12] UNASO and NAFOPHANU internal reports

[13] United Nations General Assembly Special Session on HIV/AIDS Guidelines on construction of Core indicators, 2008 reporting

In June 2006 UN member states met in the General Assembly to review progress and their commitments made in the 2001 based on their findings of the Global Progress Report 2006. Some refinements and additions were made to the indicators and data for Uganda for the reporting period is presented in *Table 1.5-1*.

<table>
<tr><td colspan="2">Table 1.5-1 Summary Performance of Indicators</td></tr>
<tr><th>Indicator</th><th>Achievement 2007</th></tr>
<tr><td colspan="2">National Commitment and Action Indicators</td></tr>
<tr><td>AIDS spending, by categories and financing sources[14]</td><td>
<table>
<tr><th><u>Expenditure by Broad thematic areas</u></th><th><u>2005/06</u>
Ug. Shs.</th></tr>
<tr><td>Prevention</td><td>67,883,659,823</td></tr>
<tr><td>Care and Treatment</td><td>152,789,491,261</td></tr>
<tr><td>Orphans and Vulnerable Children</td><td>24,611,793,105</td></tr>
<tr><td>Program Management and Administration</td><td>80,528,974,729</td></tr>
<tr><td>Incentives for Human Resources</td><td>1,692,999,066</td></tr>
<tr><td>Social Protection and Social Services excluding Orphans and Vulnerable Children</td><td>1,759,592,990</td></tr>
<tr><td>Enabling environment and community Development</td><td>929,011,872</td></tr>
<tr><td>Research excluding operations</td><td>33,004,475,915</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Totals</td><td>363,199,998,761</td></tr>
</table>
</td></tr>
<tr><td>AIDS spending by Financing Source[14]</td><td>
<table>
<tr><th><u>Financing Source Ug. Shs.</u></th><th><u>2005/06</u></th></tr>
<tr><td></td><td></td></tr>
<tr><td>GoU</td><td>22,095,284,821</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Bilaterals</td><td>280,690,303,339</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Multilaterals</td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td>UN Agencies</td><td>1,969,506,664</td></tr>
<tr><td>Global Fund</td><td>16,152,627,657</td></tr>
<tr><td>Development Bank Non-Reimburseable</td><td>15,594,546,520</td></tr>
<tr><td>All Other International</td><td>26,697,729,760</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Total</td><td>363,199,998,761</td></tr>
</table>
</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td>National Composite Policy index</td><td>72% as computed from the questionnaire responses.</td></tr>
</table>

[14] The UNGASS National Funding- AIDS Spending Categories by Financing Source for the Financial Years 2005/06 and 2006/07 - HealthNet Consult 2007.

Table 1.5-1 Summary Performance of Indicators

Indicator	Achievement 2007
	National Programme Indicators
Percentage of donated blood units screened for HIV in a quality assured manner	100% - All blood units collected were screened[5].
Percentage of adults and children with advanced HIV infection receiving Antiretroviral Therapy	39% (91,500) [5.] of those needing ART are receiving as of the end of 2006.
Percentage of HIV-positive pregnant women who receive antiretroviral treatment to reduce the risk of mother-to-child transmission	12% (10,289) of HIV positive[5] pregnant women receive ART to reduce the risk of MTCT as of end of 2005.
Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	60% of the newly registered[5] TB cases were found to have HIV as of end of 2006.
Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	4.0% Women and 3.8% Men[5] as of end of 2005 For Pregnant women during Antenatal Care is (4.8%)[5]
Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	49.3% CSWs had ever had VCT[15] as of year 2003.
Percentage of most-at-risk populations reached with HIV prevention programmes	
Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	10.7% receiving at least one type[8] of support (medical, emotional, social/material, school related) for ages 5-17 completed years. Close to none receives all four types of support. 4.1% received medical support in past 12 months[8] 0.9% received emotional support in past 3 months[8] 2.9% received social / material support in the past 3 months[8] and 6.1% received school related assistance in past 12 months[8].
Percentage of schools that provided life skills-based HIV education in the last academic year	15% (Primary and Secondary schools with trained teachers in life-skills as of 2005)[5]

[15] KAPB and Sero Survey on HIV/AIDS and STDs among Commercial Sex Workers (CSWs) in Kampala City, Uganda, June 2003

Table 1.5-1 Summary Performance of Indicators

Indicator	Achievement 2007
Knowledge and Behaviour Indicators	
Current school attendance among orphans and non-orphans aged 10-14 years	81.9% orphans attend school. The ratio for the age group 10-14 years is not available but for ages 6-17 years the ratio is 0.96[8] as of end of 2006.
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	Comprehensive knowledge about HIV & AIDS - Women 15-24 years 31.9% and Men 15-24 years 38.2%. Comprehensive Knowledge[8] is taken to mean knowing that consistent use of condom during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus, knowing that a healthy-looking person can have the AIDS virus, and rejecting the two most common local misconceptions (mosquito bites and sharing food) about HIV & AIDS transmission or prevention.
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	82.6% cited two preventive practices[15]
Percentage of young women and men aged 15-24 who have had sex intercourse before the age of 15	Women 12% for age[7] group 15-19 and 17% for 20-24. Men 16.3% for age[7] group 15-19 and 10.8% for 20-24.
Percentage of women and men aged 15-49 who have had sex with more than one partner in the last 12 months	Women 3.8% Men 29.3%**Error! Bookmark not defined.**
Percentage of women and men aged 15-49 who have had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse	Among those[7] who had sex in the 12 months preceding the survey - Women 9.1% Men 16.1%
Percentage of female sex workers reporting the use of a condom with their most recent client	15.3% women were categorised[7] as engaging in higher-risk sex in the past 12 months of whom 46.7% used a condom at the last contact

Table 1.5-1 Summary Performance of Indicators	
Indicator	**Achievement 2007**
Impact Indicators	
Percentage of young women and men aged 15-24 who are HIV infected	Women 2.6% for age group 15-19 and 6.3% for 20-24 i.e. 4.3% over 15-24[7]. Men 0.3% for age group 15-19 and 2.4% for 20-24 i.e. 1.1% over 15-24[7].
Percentage of most-at-risk populations who are HIV infected	47.2 % (CSW, 2003)[15]
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	The values for this indicator are not yet available.
Percentage of infants born to HIV-infected mothers who are infected	Estimated 30% without intervention[19]
Global Commitment and Action Indicators	
Amount of bilateral and multilateral financial flows (commitments and disbursements) for the benefit of low- and middle-income countries	Bilateral expenditure for 2005/06 is 280,690,303,339 Ug. Shs.[14] Multilateral expenditure for 2005/06 is 60,414,410,601 Ug. Shs. [14]
Amount of public funds for research and development of preventive HIV vaccines and microbes	• UVRI-IAVI had a budget of 1.3 million US$ for the year 2007. • MUWRP • MUJHP
Percentage of trans-national companies that are present in developing countries and that have workplace HIV policies and programmes	23% of trans-national have HIV & AIDS workplace policies and programmes
Percentage of international organisations that have workplace HIV policies and programmes	90% of inter-national have HIV & AIDS workplace policies and programmes

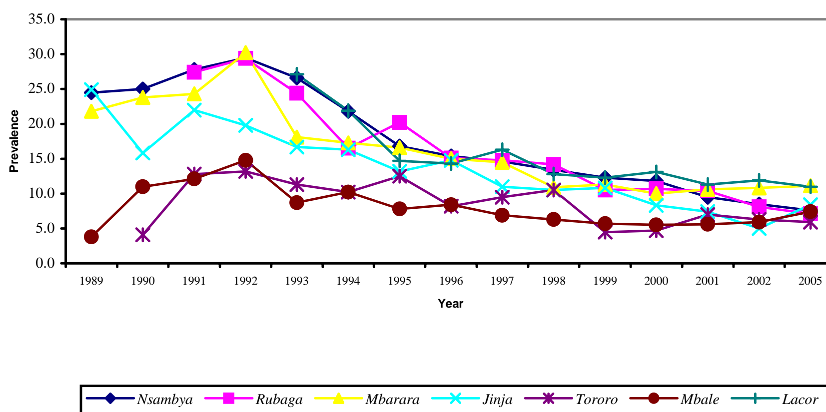
2.0 Overview of the AIDS Epidemic

2.1 Surveillance

The component of Integrated Disease Surveillance in the Uganda Health Sector Strategic Plan II (HSSP II) falls under Programme Objective 4 namely "An Evidence-based Policy, Programme, Planning and Development in place[16]. This is contained in the Health Service Strategy "Effective delivery of an integrated Uganda National Minimum Health Care Package". The programme goal is "Reduced morbidity and mortality from the major causes of ill health and premature death and reduced disparity therein". The development goal is "Expanded Economic growth, increased social development and poverty eradication".

There are currently 25 HIV sentinel surveillance sites based in antenatal clinics that are located both in urban and rural areas and also distributed across Uganda. These are used to gauge the HIV infection trends. A new updated protocol for conducting Anti-Natal Care (ANC) and STD clinic based HIV[17] surveillance is in use and involves collection of residual aliquots of blood samples. The blood samples are tested for syphilis and residual blood is refrigerated and transported to Uganda Virus Research Institute (UVRI) where they are tested for HIV. As can be seen from *Figure 2.1-1* below, HIV sero-prevalence rates appear to have stagnated. Samples for year 2006 are being analysed and report writing is ongoing while samples for 2007 are being collected. The HIV testing kits used include Determine for screening, Unigold for Confirmation and Satapak as Tie Breaker. A major change is that the country depends on development partners to support importation of HIV Testing kits, however occasional stock-outs still occur.

Figure 2.1-1 : Trends in Antenatal HIV Sero-Prevalence in Selected Sentinel Sites[17]



2.2 Specific Studies

2.2.1 HIV and AIDS Sero-Behavioural Survey

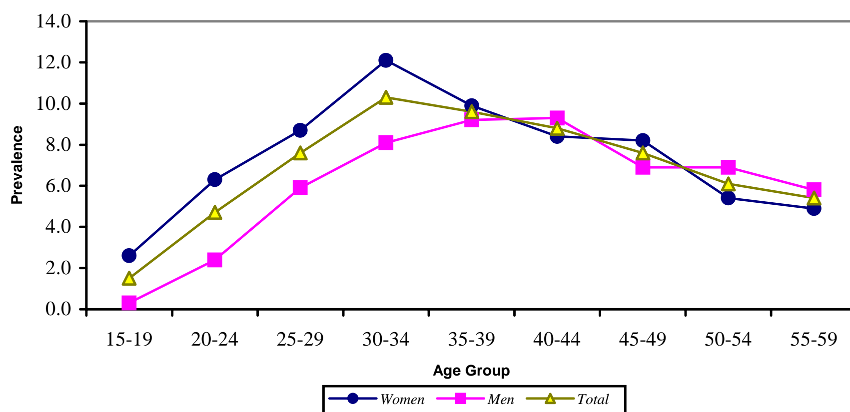
The Uganda HIV and AIDS Sero-Behavioural Survey (UHSBS) 2004/05 is a nationally representative, population-based survey designed to obtain national and sub-national data on the prevalence of HIV and other sexually transmitted infections (STIs), and their social and

[16] Annual Health Sector Performance Report – Financial Year 2006/2007.
[17] HIV/AIDS Surveillance Report STD/AIDS Control Programme Ministry of Health, 2003

demographic variations in the country. The survey was also designed to obtain information on knowledge, attitudes, and behaviour regarding HIV and AIDS. The overall goal of the survey was to provide programme managers and policy makers with strategic information needed to monitor and evaluate existing programmes and to effectively design new strategies for combating the epidemic in Uganda. Specifically, the survey was to obtain accurate estimates of the magnitude and variation in HIV prevalence in Uganda; obtain accurate information on behavioural and care indicators related to HIV & AIDS and other sexually transmitted infections; obtain accurate information on other HIV & AIDS programme indicators; provide information on HIV prevalence to calibrate and improve the sentinel surveillance system; determine the magnitude and distribution of syphilis, herpes simplex 2 and hepatitis B infection.

UHSBS 2004/05 found an average HIV prevalence of 6.4% in the age group 15-49 for both sexes; urban HIV prevalence being 10.1% and rural 5.7%; female HIV prevalence being 7.5% and male 5.0%. Prevalence as shown in *Figure 2.2-1* below was highest in the age group 30 – 34 completed years.

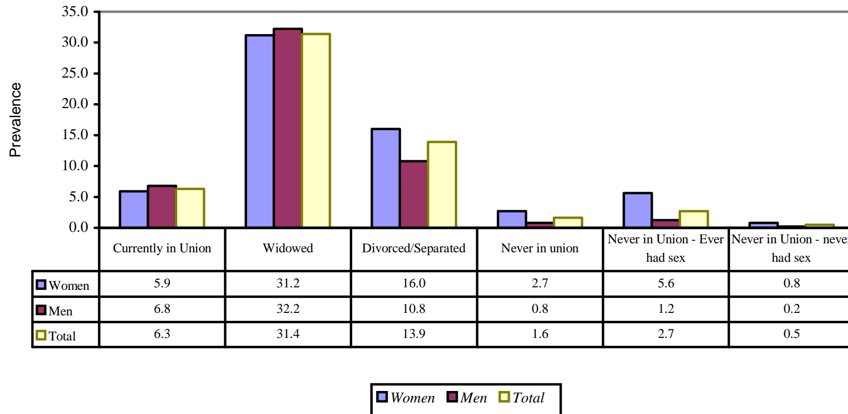
Figure 2.2-1 : HIV Prevalence Between Age 15-59 Years by Age and Sex[7]



The UHSBS reveals that on average, HIV prevalence is higher in urban areas than rural areas and also among the female population than the male population. It is estimated that a total of 2.6 million people have been infected by HIV in the last 25 years of whom 1.6 million[18] have passed away. Most of these were from the productive age groups falling between 15 – 49 years thus affecting the nation's productivity[19]. It is also estimated that about 130,000 new infections occurred during financial year[20] 2006/07 alone. This has left a massive burden of orphans and helpless or bed ridden adults there by stretching the extended family structure. It has also created a large number of orphan headed households, widow headed households, increased school dropout and increased early marriages. Findings from longitudinal studies by Medical Research Council in Southern Uganda reflect rising HIV & AIDS incidence rates in rural setting. Further analysis of secondary data of the UHSBS for ages of 15-49 years revealed that HIV prevalence is highest in the widowed category followed by divorced/separated populations as shown in *Figure 2.2-2* below.

[18] Policy Recommendations Based on the Major Findings of the 2004-05 Uganda HIV/AIDS Sero-Behavioural Study
[19] Ministry of Health records, 2005, 2006, & 2007.
[20] Resources Required to Achieve the Goals of the National Strategic Plan (NSP) 2007/8 – 2011/12.

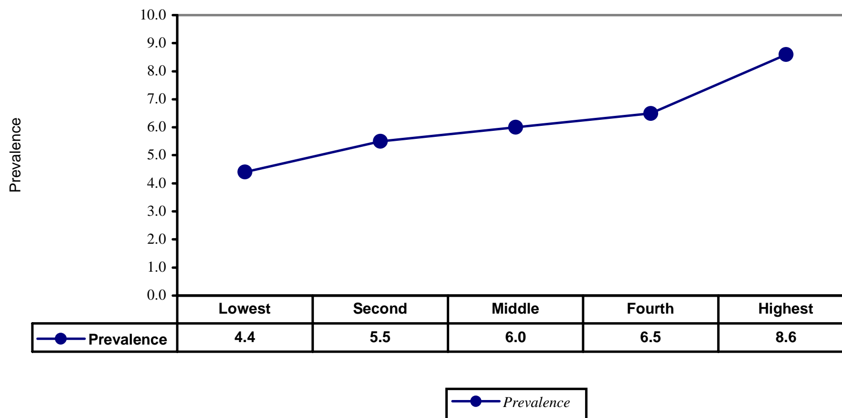
Figure 2.2-2 : Prevalence of HIV Between Age 15-49 Years by Marital Status[7]



	Currently in Union	Widowed	Divorced/Separated	Never in union	Never in Union - Ever had sex	Never in Union - never had sex
Women	5.9	31.2	16.0	2.7	5.6	0.8
Men	6.8	32.2	10.8	0.8	1.2	0.2
Total	6.3	31.4	13.9	1.6	2.7	0.5

The prevalence of HIV appears to increase with increase in wealth as reflected in the *Figure 2.2-3* below.

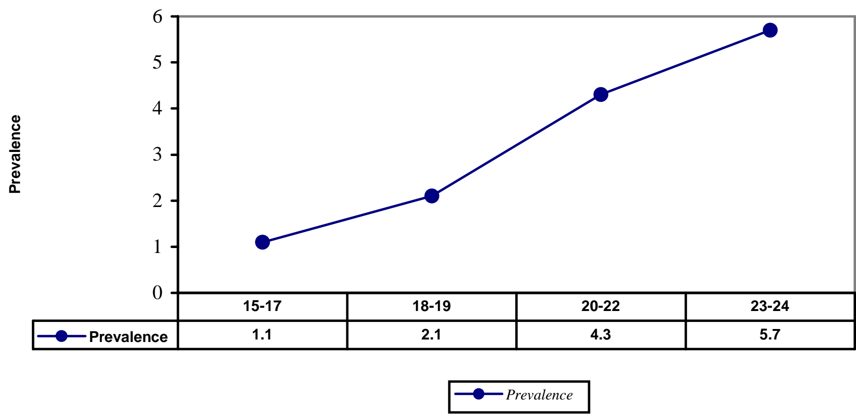
Figure 2.2-3 : HIV Prevalence Among Wealth Quantile[7]



	Lowest	Second	Middle	Fourth	Highest
Prevalence	4.4	5.5	6.0	6.5	8.6

The prevalence also seems to increase by age for young people between 15 – 24 years as depicted in *Figure 2.2-4*.

Figure 2.2-4 : HIV Prevalence Among Young People 15 – 24 Years[7]

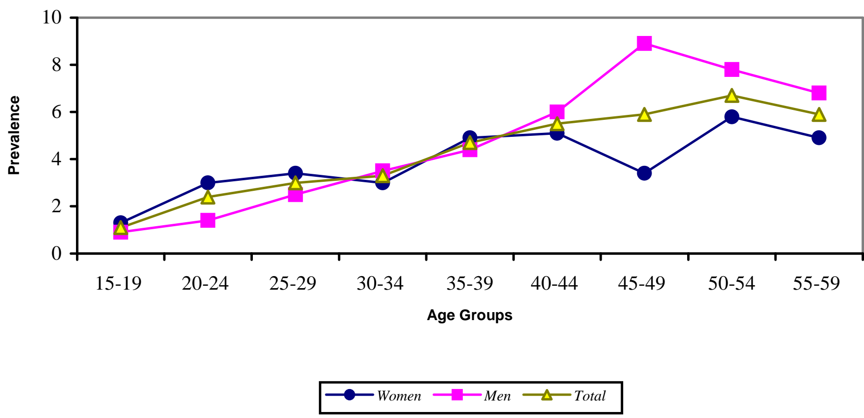


Prevalence of Syphilis

The prevalence of syphilis for the ages 15 – 59 is reflected in the *Figure 2.2-5* below. Syphilis in men gets to a peak at ages 44-49 years, otherwise before that it appears to be increasing generally with age.

It should be noted as a policy, all blood donated is tested by Uganda Blood Transfusion Services (UBTS) for HIV, syphilis and hepatitis before it is given to health facilities for transfusion.

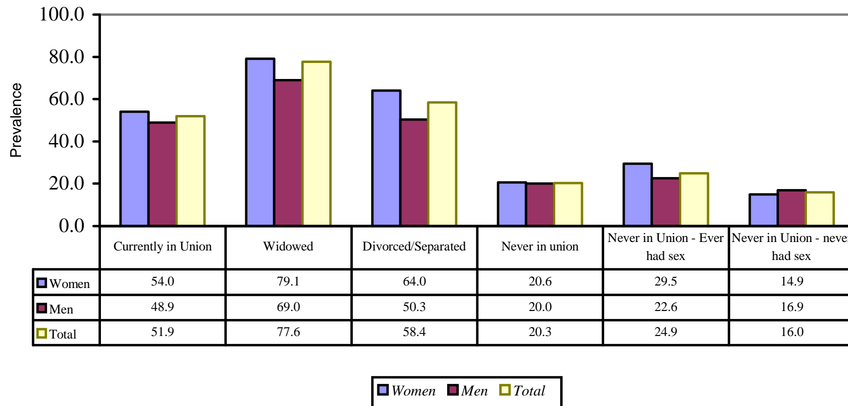
Figure 2.2-5 : Syphilis Prevalence Between 15-59 Years by Age and Sex[7]



Prevalence of HSV-2

Herpes Simplex Virus type 2 (HSV-2) mostly transmitted sexually, is highest amongst the widowed category but also high in divorced/separated and those currently in union as shown in *Figure 2.2-6*. Since HSV-2 causes genital ulcers, its presence suggests increased risk of HIV transmission[7].

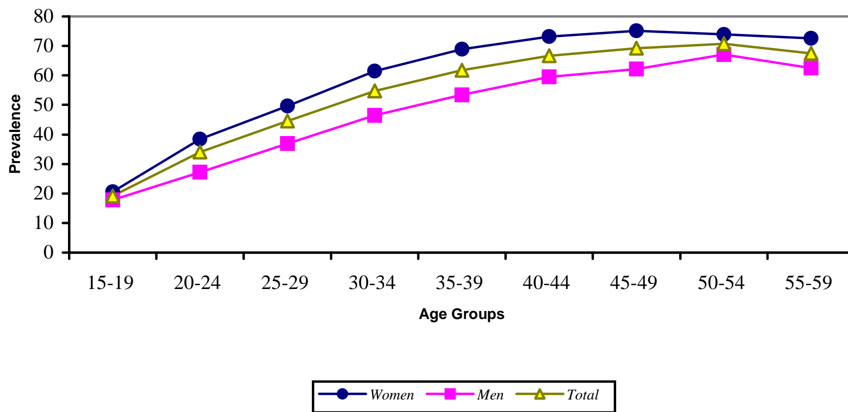
Figure 2.2-6 : Prevalence of Herpes Simplex Type 2 Virus Between Age 15-49 Years by Marital Status [7]



	Currently in Union	Widowed	Divorced/Separated	Never in union	Never in Union - Ever had sex	Never in Union - never had sex
Women	54.0	79.1	64.0	20.6	29.5	14.9
Men	48.9	69.0	50.3	20.0	22.6	16.9
Total	51.9	77.6	58.4	20.3	24.9	16.0

The prevalence of herpes simplex type 2 for persons 15-59 years is as reflected in *Figure 2.2-7* below. It is generally observed that prevalence tends to rise with age.

Figure 2.2-7 : Prevalence of Herpes Simplex Type 2 Virus for Persons 15-59 Years by Age and Sex [7]



The findings above call for specific interventions to address the identified challenges. It is expected that interventions will be in line with the strategies identified and reflected in the NSP 2007/08 to 2011/12.

3.0 National Response To The AIDS Epidemic

A NSP for HIV & AIDS has been developed for the period 2007/08 to 2011/12 to give a national direction to efforts in addressing the HIV & AIDS 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 thus 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.[Error! Bookmark not defined.]

Implementation of the NSP commenced in financial year July 2007 but at a low key. A guide on monitoring the national response to HIV & AIDS has been developed together with its implementation handbook.

There is need to generate evidence about the effectiveness, efficiency and relevance of the national HIV & AIDS response interventions so that they can be continuously improved. One of the objectives of the NSP is to strengthen national capacity to undertake and coordinate priority HIV & AIDS-related research and utilise outcomes[Error! Bookmark not defined.]. This includes :

- operationalising the national HIV & AIDS research coordination framework,
- defining the national HIV & AIDS-related research priorities based on the NSP,
- advocating for funding these priorities,
- promoting targeted dissemination of research findings,
- enhancing the epidemiological surveillance systems to monitor new infections and epidemic trends; and
- building research capacity at local government levels.

In order to realize the goal of the NSP, GoU with the support of various stakeholders has embarked on an ambitious programme of scaling up HIV & AIDS control activities across the country[16] within the framework of the Health Sector Strategic Plan II (HSSP II). This includes HIV Counselling and Testing (HCT) & PMTCT operational at all Health Centre IIIs (HC IIIs) and higher levels and Anti-retroviral Therapy (ART) operational at all HC IVs and higher levels.

3.1 Strengthening Systems for Service Delivery

Strengthening Co-ordination

In order to have a co-ordinated approach to the HIV & AIDS problem, a National AIDS Policy has been formulated and submitted to Uganda’s body of Ministers for consideration and approval. The policy seeks to prevent new HIV infections and eliminate the socio-economic impact of HIV & AIDS on the country and all categories of its population. It seeks to

- ensure coordinated management of the national response to the epidemic,

- prevent the transmission of HIV through sexual contact, mother–to–child, blood and blood products and any other routes,
- mitigate the adverse health impact of HIV & AIDS on the infected through appropriate care, support and treatment interventions,
- minimize the socio-economic consequences of HIV & AIDS on the population and promote involvement of the infected and affected in development efforts,
- reduce vulnerability to HIV and promote equal access to impact mitigation services,
- address all gender-based concerns that increase HIV vulnerability and impact on service access and promote and guide HIV & AIDS-related research to ensure standards, promote innovation and access to reliable information to maximize the attainment of the Policy objectives.

In order for HIV & AIDS to be incorporated in the day to day activities of various institutions and organizations, a National Policy on Mainstreaming HIV & AIDS is being developed. This will guide all development and humanitarian programmes of all government units, private sector and the Civil Society to mainstream HIV and 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 will be compelled to operationalize the multi-sectoral approach to control of HIV & AIDS 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.

In addition to the above, a National Communication Strategy for HIV & AIDS prevention, care and treatment is in the early stages of development.

Finally, Umbrella CSOs, FBOs and PHA organisations have continued to guide and co-ordinate their members so as to avoid duplication, co-ordinate and avail resources to ensure implementation of a co-ordinated partnership, enhancing reporting and accountability.

Strengthening HIV Prevention

The MoH’s goal is to attain a good standard of health by all people in Uganda, in order to promote a healthy & productive life. During the reporting period, the MoH produced and disseminated a video recording on condom testing in Uganda and continued to disseminate the HIV prevention roadmap to district leaders in southern Uganda. This road map contains

- Prevention of the sexual transmission of HIV,
- Prevention of mother-to-child transmission of HIV,
- Promotion of greater access to HIV counselling 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, IDPs, PWDs, women and girls, adults especially in marriage relationships, fishing communities, mobile populations, migrant workers, CSWs, etc, through,
- 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 and consider 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.

Furthermore, MoH developed PMTCT policy and clinical guidelines based on the new WHO recommendations. It also developed & launched the "National Guidelines for Implementation of family support groups in PMTCT".

Strengthening Treatment, Care and Support

In order to strengthen the management and control of TB cases, MoH procured and distributed 300 motorcycles to strengthen capacity for community supervision of TB interventions in districts; conducted operational research on integrated TB & HIV care in VCT services in one hospital; produced a TB modular training manual and job aide to standardise training, practice and care; and established a national co-ordination committee for TB.

Guidelines on management of severe malnutrition have been reviewed to include HIV & AIDS and Community Therapeutic Care. The policy on feeding infants and young children in the context of HIV & AIDS has been reviewed to include all the aspects of Infant and Young Child Feeding. MoH has developed national Home Based Care policy guidelines. It has also reviewed and updated the protocol for conducting Anti-Natal Care and Sexually Transmitted Infection (STI) clinic based HIV surveillance. It has developed and printed guidelines for Health Workers for Early HIV Diagnosis and Care among Infants. It has also launched 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. MoH has also developed, printed and disseminated the HIV & AIDS handbook for life planning skills for Health Educators. MoH developed and pre-tested ART advocacy IEC/BCC materials.

Home Based HIV Counselling and Testing (HBHCT) is a community based approach where HIV counselling is conducted at the clients' home. Counselling and testing are done door to door and results given during the same visit. The home environment has been found to be more convenient and conducive for counselling and testing and eases the workload on the existing health infrastructure. It also ensures partner/couple testing as well as family members testing, which encourages/enhances disclosure and early seeking of care for those who require it.

CSOs are training paralegals on human rights in HIV & AIDS context[21]. The paralegals conduct monitoring and research missions to ascertain human rights violations in schools and prisons for purposes of care & support. They also sensitise the communities on human rights related issues. This helps the PHA parents to plan for their children in the legal context. The paralegals also assist in guiding the training needs as a response to community needs for example requesting for a training Children's Act or HIV & AIDS so as to sensitise the communities.

[21] Foundation for Human Rights Initiative - e-News Letter Vol.5 Issue No. 3, January – September 2007

Regional Efforts

The World Bank has agreed to extend a US$15 million 4 year grant for a regional project through the Inter-Governmental Authority on Development[22] (IGAD) to support Djibouti, Eritrea, Ethiopia, Kenya, Somalia, Sudan, and Uganda. This regional project is intended to, among other things:

- increase preventative action and reduce misconception of cross border and mobile populations, refugees, IDPs, returnees and surrounding host communities concerning HIV & AIDS prevention, treatment and mitigation in selected sites in the IGAD member states, and
- to establish a common and sustainable regional approach to supporting these populations in the IGAD member states.

The World Bank is also funding the Great Lakes Initiative for Africa (GLIA) to run a regional project with the head office in Kigali, Rwanda. The project covers 6 countries Burundi, Democratic Republic of Congo, Kenya, Rwanda, Tanzania and Uganda. The project aims to contribute to

- Improving the health status of individuals and communities within the 6 GLIA member countries. Currently a World Bank funded component is running with the objectives
    - to facilitate the establishment of HIV & AIDS prevention, care, and treatment programs for mobile and vulnerable groups such as refugees, transport sector workers, and highly affected/infected populations in each of the GLIA member countries and
    - enhance prospects for coordinated approaches for HIV & AIDS prevention, care and treatment among the GLIA member countries.

3.2 Prevention

3.2.1 HIV Prevention Road Map

The highest ranking message communication channel according to the UDHS is the radio as identified by 70% of women and 85% by men covered in the survey[10]. The HIV prevalence in Uganda is currently considered to have stagnated with a threat to rise. In the late 1980s and early 1990s the HIV prevention efforts were mainly driven by political forces using the ABC strategy; calling for responsibility and involvement at individual, community organisational and leadership levels using every opportunity to deliver HIV prevention messages. This contributed to the dramatic decline of the HIV prevalence rate. However, the vigilance changed from personal communication methods to electronic and print media channels and later a focus on the availability of ARVs. There is therefore a need to re-focus the prevention strategies to address the current trends of the prevalence.

A detailed description of milestones to guide the course of action has been laid down in a Road Map towards universal access to HIV prevention. This includes an ABC+ strategy that takes into consideration the social, cultural and economic environments that influence the individual's behaviours. The Road Map also links to other prevention and care interventions. These enhance risk perception, internalisation as well as life skills building to support individuals to adopt and sustain positive behaviours of abstinence, mutual faithfulness to a

[22] IGAD Regional HIV/AIDS Partnership Program (IRAPP) Support Project, June 26, 2007

partner of known status and correct consistent condom use at every risky sexual encounter. The national response to the HIV epidemic has evolved from provision of prevention based strategies to comprehensive HIV prevention, care, treatment and support services including psychosocial support, nutritional support and income generating activities to meet basic needs.

During the reporting period, the country continued with implementation of the ABC strategy where interventions include IEC for Behaviour Change Communication (BCC) targeting the general population with a focus on the youth, persons currently in union (married) and Most At Risk Populations (MARP). In the last two years more efforts have been put on prevention among positives and reduction of cross generational sex. Couple counselling/testing, condom use and abstinence have been promoted.

Following the revision of the National HCT Policy Guidelines, the government rolled out Routine Testing and counselling in the clinical settings and other interventions to increase access and uptake of HCT e.g Home Based HCT (HBHCT).

HIV Vaccine Trials

The Uganda Virus Research Institute’s (UVRI's), a GoU research institute, and the International AIDS Vaccine Initiative (IAVI) have been working as partners since August 2001 to accelerate the development and testing of safe, effective, accessible, preventive HIV vaccines to prevent HIV & AIDS, with focus on generating vaccines for use in Uganda and Africa. The UVRI/IAVI HIV Vaccine Program is currently conducting a DNA/MVA Phase I vaccine trial using 50 volunteers enrolled using protocols approved by the UVRI's Science and Ethics Committee and the Uganda National Council for Science and Technology. The trials are monitored by a Trial Steering Committee, a Data Monitoring and Ethics Committee and a Clinical Research Organization. Phase II will aim at acquiring more information on whether the candidate vaccine induces appropriate response. During Phase III, the focus will be to find out whether the candidate vaccine protects people from getting HIV.

Makerere University Walter Reed project (MUWRP) founded in 2002, is a Non Governmental Not for profit HIV research organization dedicated to find a safe and effective HIV vaccine. MUWRP is a collaboration between Makerere University and the US Military HIV Research Program which comprise the Walter Reed Army Institute of Research and The Henry Jackson Foundation. It was setup to monitor trends in the HIV epidemic in Uganda; carry out HIV diagnostics, HIV isolation and qualification and to conduct HIV vaccine trials. During the reporting period MUWRP conducted a Phase I Clinical Trial to evaluate the safety and Immunogenicity of a Multiclade HIV-1 Recombinant Adenovirus-5 vector vaccine, A Phase I/II Clinical Trial to evaluate the safety and immunogenicity of a multiclade HIV-1 DNA 6-Plasmid vaccine and recently conducted a study in collaboration with the Ugandan National Blood Transfusion Service (UNTBS) entitled on Determination of Laboratory Reference Data Using Anonymous Healthy Ugandan Blood Bank Donors".

Condom Availability

Condom distribution in the country has continued through provision of free condoms in public sector and social marketing. Previously there was a decline in use of free condoms due to doubt cast on their quality. This has been addressed through post shipment testing of condoms, community education and sensitization through TV spots and talk shows as well as radio spots to inform the public about measures taken to ensure quality of all condoms in the

country including the re-identified "Engabu" brand. Distribution of condoms has been strengthened through dissemination of the national condom distribution guidelines, training of District Focal Persons in logistic management in addition to training and facilitation of community condom distributors.

During the reporting period of January 2006 to December 2007, 96.6 million condoms with an additional 40m in the pipeline, were procured with support from USAID, UNFPA and GFATM. Of these 157.8 million free (public sector condoms) were distributed and 90.4 million through social marketing.

The government has successfully rolled out Routine Testing[16] in the clinical settings (RCT) starting with the Regional Referral Hospitals. An effort has also been made to ensure control of Sexually Transmitted Diseases (STIs).

3.2.2 Abstinence and Faithfulness

Various organisations have come out to advocate for the A and B of the ABC+ HIV prevention strategy. Straight Talk Foundation[23] is a health communication CSO that produces BCC materials with the broad objective to contribute to the improved mental, social and physical development of Ugandan adolescents (10-19) and young adults (20-24), keeping its audience safe from HIV/STD infection and early pregnancy and to manage challenging circumstances such as conflict and deprivation. It originated out of Straight Talk newspaper that was first published in 1993 and funded by UNICEF. The Foundation produces 53 radio talk shows a week in 11 languages. It produces periodic publications and interactive face-to-face discussions in schools and surrounding communities.

Young People Empowered and Healthy (YEAH) is a national social and behaviour change effort for Uganda's young people that uses mass media, person-to-person dialogue and community media approaches to stimulate dialogue and action and model positive practices. The campaign is designed to contribute to a reduction in HIV incidence and early pregnancy, and an increase in the proportion of young people who complete primary education and beyond.

Faith based organisations have also taken heed to the multi-sectoral collaboration approach to fight the HIV & AIDS individually and collectively through joint bodies. Their approach basically emphasizes abstinence and faithfulness in marriage and care and support for PHAs. The Inter Religious Council of Uganda[24] (IRCU) is an initiative that brings together different religious organizations in Uganda to work together along areas of common interest like HIV & AIDS prevention and promoting the Abstinence and Faithfulness in marriage message. IRCU has a Council of Presidents as the heads of the participating religious organisations and the Executive Council made up of eight representatives, two from each member religious institution. The organisation draws funding from various donors. The efforts include sensitisation and training of the targeted groups such as spiritual leaders, HIV & AIDS Clubs, sensitisation for behaviour change, and care for PHAs. BCC campaigns especially through sermons oriented towards abstinence or faithfulness in marriage and care for the PHAs. Messages are also communicated in places of worship through meetings in places of worship, and during TV and radio shows.

[23] www.straight-talk.or.ug/home/index.html - 30/11/07
[24] www.ecuspace.net/contact.nsf/5e7350302ae36658c1256d0c004edeb3/A08DE9A4101E0F44C1256EA80044F19C?OpenDocument

Young People in School

The Mission of the Public Education Sector of Uganda is to provide for, support, guide, coordinate, regulate and promote quality education and sports to all persons in Uganda for national integration, individual and national development. The Education Sector[25] Strategic Plan includes MoES HIV & AIDS Sector Policy Guide, MoES HIV & AIDS Workplace policy, Presidential Initiative on AIDS Strategy for Communicating to the Young people (PIASCY) and curriculum reviews to integrate HIV & AIDS. These are aimed to guide future policy thrusts, prevention and mitigation of the impact of HIV & AIDS and behaviour change communication to the youth. The formulation of the sector HIV & AIDS policy guidelines and sector HIV & AIDS workplace policy constitutes a major milestone in the sector's efforts to fight the HIV & AIDS.

In terms of progress, over 3,450 teacher trainees and 18,820 primary school teachers were trained in HIV & AIDS competency 151 National Facilitators have been trained, 539 Coordinating Centre Tutors as Trainers and 6,468 master trainers trained in various HIV & AIDS competencies. These are expected to take lead in behaviour change communication activities; provide guidance and counselling to other teachers, pupils and students in their schools and surrounding communities throughout the country. Over 1,000 schools have re-activated School Health Clubs activities in their schools.

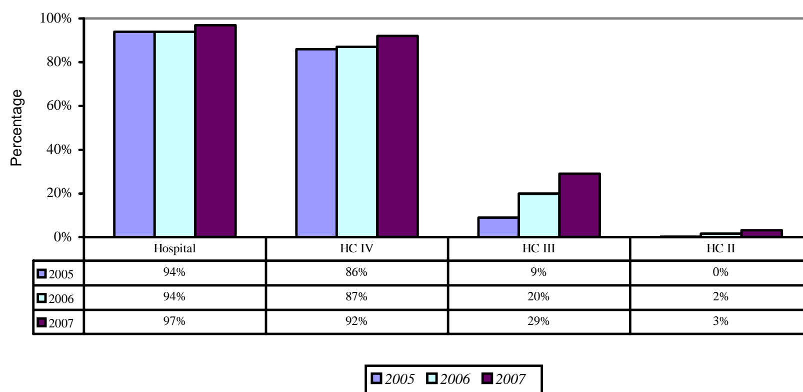
3.2.3 Trends in Prevention of Mother to Child Transmission of HIV

Over the period 2005 to 2007, there has been an increase of PMTCT service delivery sites[19] from 280 to 568 thus taking services nearer to the rural population. Policy guidelines and training manuals have been revised to focus on all the four pronged strategy for PMTCT namely, primary prevention; prevention of unintended pregnancies among PLWHA; reduction of mother to child HIV transmission and provision of comprehensive HIV care for the mother and her family[19]. The country is rolling out 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. Population coverage of services has increased from 12% in 2005 to 30% in 2007 of all expected HIV positive pregnant women receiving ARVs for PMTCT.

Health facility coverage has increased at Hospital level, Health Centre IV (HC IV), Health Centre III (HC III), and Health Centre II (HC II) as shown in Figure 3.2-1. Pregnant women tested for HIV during pregnancy increased from 15.6% in 2005 to 35% in 2007.

[25] The Education and Sports Sector Annual Performance Report (ESSAPR) July 2006 to June 2007

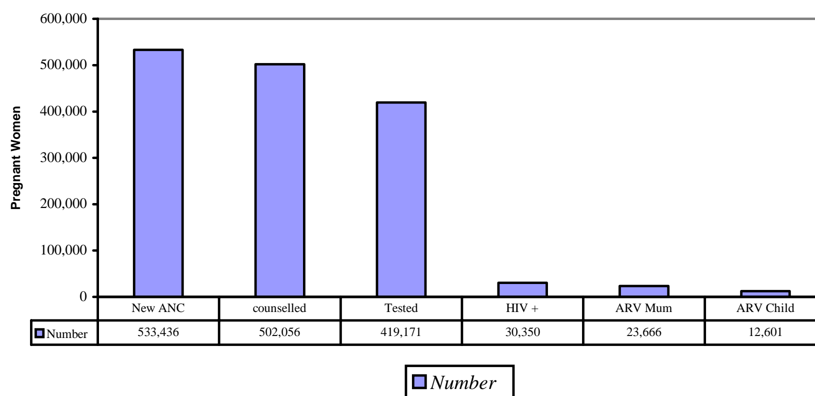
Figure 3.2-1 : Health Facilities Providing PMTCT by Level[16]



	Hospital	HC IV	HC III	HC II
2005	94%	86%	9%	0%
2006	94%	87%	20%	2%
2007	97%	92%	29%	3%

Initially PMTCT was at HC IV and above. The Health Sector Strategic Plan II for 2005/06 to 2009/10 has pushed it to HC III level, which explains this increase.

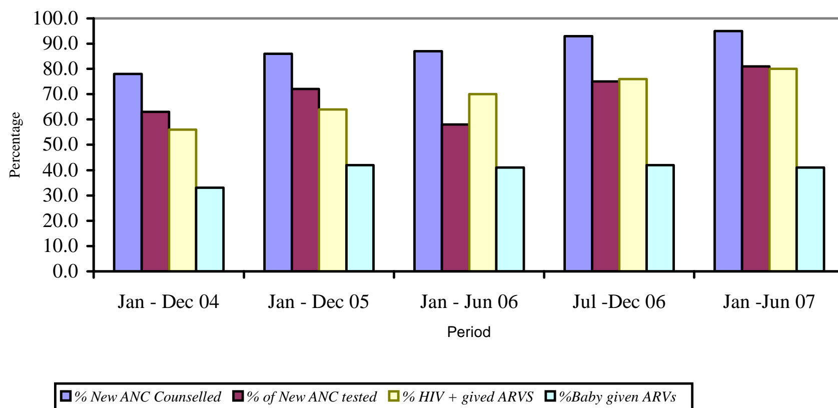
Figure 3.2-2 : National PMTCT Performance July 2006 – June 2007[16]



	New ANC	counselled	Tested	HIV +	ARV Mum	ARV Child
Number	533,436	502,056	419,171	30,350	23,666	12,601

The quality of PMTCT services has greatly improved across many districts. The number of health facilities providing routine HIV counselling and testing for pregnant women increased, 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. *Figure 3.2-3* shows trends in uptake of PMTCT services. In addition missed opportunities in administration of antiretroviral drugs to HIV positive mothers has greatly reduced; 81% of all clients diagnosed HIV positive are given ARVs as opposed to 64% of clients who tested HIV positive in 2005.

Figure 3.2-3 : Trend in Uptake of PMTCT Services[16]



In January 2007, the country started providing services for Early HIV diagnosis among infants and 5300 clients from 150 health facilities have been tested of which 20% were HIV positive. A few of the infants received Polymerase Chain Reaction (PCR) testing. Guidelines for family support groups have been developed and peer psychosocial support groups for women, men and HIV infected children set up in a number of PMTCT sites where clients meet regularly for education and sharing experiences. This has contributed to increased disclosure of HIV test results to spouses, adherence to care and reducing stigma among members.

3.3 Treatment, Care and Support

3.3.1 Treatment and Care

A total of 389 laboratory personnel and 178 non-laboratory health workers were trained in rapid[16] HIV testing ready for work in the various health facilities. Refresher training was given to 280 laboratory workers in routine laboratory procedures. 180 clinicians and 160 counsellors were trained in appropriate use of the laboratory. A total of 25 laboratory technologists were trained in routine servicing and simple repair of CD4 equipment. In order to keep the health facilities in a usable, hygienic state, laboratory infrastructure in 32 Health Centre IVs were rehabilitated and re-modelled to conform to national standards. Two (2) modern regional blood banks at Mbale and Mbarara referral hospitals are being constructed.

MoH developed and pre-tested the HIV & AIDS Handbook for Life Planning skills for health educators. Other activities carried by the Ministry included: development and pre-testing of IEC/BCC materials for ART advocacy; dissemination of HIV prevention road map and facilitated the production and airing of TV and Radio spots and programmes for condom promotion; trained 60 HBC Trainers of Trainers from 10 districts and 47 sentinel surveillance site staff from the 25 sentinel sites were trained in the updated protocol for conducting ANC and STD clinic based HIV surveillance. A number of health workers have been reoriented on infection control measures. MoH has partnered with some CSOs and has scaled up provision of palliative care to over 50% of the districts in Uganda.

All Districts in the country have established a Health Management Information System (HMIS) where medical related data from health facilities is collected and validated.

The AIDS Support Organisation, a national AIDS service organisation for PHAs, has been in existence for 20 years. It currently has 4 regional offices and 11 treatment centres. They carry out training of counsellors, conduct advocacy for HIV & AIDS, counsel PHAs and those affected, provide medical care, conduct research and jointly participate in research activities as well as professional volunteer program. The PHAs are encouraged to live positively which includes among others seeking counselling and testing, accepting their status, seeking medical attention, continuing to work for a living, planning for family and avoiding risky practices. The organisation has cared for over 190,000 clients by the end of 2007 and provided ARVs to over 18,000 clients since inception as of the end of 2007 of whom about 600 are below the age of 14 years.

AIDS Information Centre was established in 1990 to provide VCT for the HIV. It operates 8 branches of Kampala, Mbarara, Jinja, Soroti, Kabale, Mbale, Arua and Lira. Based on 2006 data, slightly over 14% of their HCT clientele was from Internally Displaced People's camps, accessed through outreaches. The organisation provides HIV testing, HIV counselling to over 160,000 persons annually, train over 250 counsellors annually, trains persons in VCT management, trains psychosocial support counsellors, carries out CD4 tests, conducts educational talks for Post Test Clubs focusing on PHAs, and provides recreational activities for the post test clubs for PHAs among other activities. AIDS Information Centre also offers treatment for opportunistic infections and TB.

The Mildmay Centre[26], is a Ministry of Health facility that provides HIV prevention, care and training services. PHAs access clinical services including provision of ARVs from PEPFAR and GoU although some patients access ARVs at their cost. The clinical service includes psychiatric and dental services. The centre operates satellite clinics too. Health workers are trained in care and management of PHAs.

FBOs, for example Uganda Protestant Medical Bureau, Uganda Catholic Medical Bureau, Islamic Medical Association of Uganda, among others, also offer medical support to the community.

The ART policy, as designed by MoH, came into effect in 2003 giving way to the provision of free ARVs by the public sector. Following this, UAC through the MAP funded WB project with technical expertise from MoH launched the public sector free ARVs. The US$ 2.743 million[34] scheme is aimed at serving 2,500 adults and 500 children for a 2 year period. Funding from GFATM was also partly used to procure ARVs. There were also some non-government organisations offering ART. By December 2003, there were 12,868 PHAs who were on ART and this has increased to 106,000 although it is estimated that the demand stands at 200,000 PHAs.

ART provision was pioneered by MoH and Ministry of Defence (MoD) through the Joint Clinical Research Centre in the year 2002 with 6 sites. Currently JCRC has up to 50 static and 25 outreach sites. Services are offered at a cost to the client.

[26] The Mildmay Centre Annual Report 2006 - 2007

3.3.2 Anti-Retroviral Therapy

Figure 3.3-1 : Trends in Provision of Antiretroviral Therapy (ART) for Period 2000 - 2007[19]

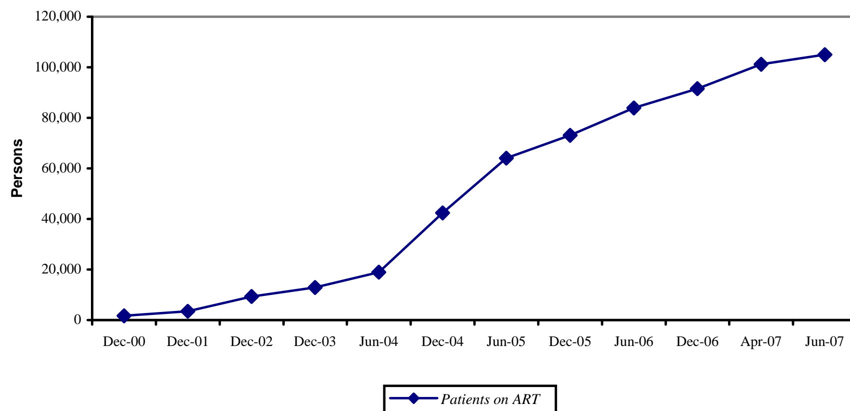


Figure 3.3-1 above shows the rise in ART provision. Uganda has about 286 ART[16] sites and the procurement of CD4 count machines has increased the accessibility of ART to the poorer segments of the population. Community follow up and support is essential for maintaining high levels of adherence to ART. Health facilities providing ART need external support for their community follow-up activities and resource mobilization. The use of peer support groups to support adherence on ART and community follow-up for clients on treatment is vital. Adherence to HIV treatment regiments means taking the medicines in all the prescribed doses at the right time, in the right dosage and the right method. By September 2007, there were 106,000 active clients on ART, of whom 11,000 were HIV positive children.

3.3.3 Social Support

The MoGLSD is the GoU department charged with overseeing the OVCs. Its mission is to create an enabling environment for social protection and social transformation of communities.[27] The Ministry houses the OVC Secretariat, and is developing an information system for capturing and storing OVC indicators.

Within the framework of the National OVC policy and Strategy, and taking account of the decentralised system of governance, various districts like Masaka have been supported and are at various stages of development of OVC Strategic plans. District level OVC technical committees have been established to oversee implementation of OVC issues.

Although HIV & AIDS is not the only contributor to the increase in the numbers of OVCs, it contributes a large percentage. The percentage of children who are orphans and vulnerable[8] was found to be 20.7%. The percentage of children with one or both parents dead is 14.9% while those who live in a household where at least one adult has been very sick for at least 3 months in the past 12 months is 4.7%. The percentage of children who have lost both parents is 3.1 %. The percentage of orphans attending school is 81.9%; while those who have shoes, two sets of un-torn clothes and a blanket are 24.8%. At least 11% of female and 17.8 % of

[27] www.mglsd.go.ug/ 03/12/07

the male OVCs were found to have had sexual intercourse before the age of 15 years. 10.7 % of the OVCs are reported to receive medical support in the past 12 months or emotional support in past 3 months or social/material support in the past 3 months or school-related assistance in the past 12 months. A negligible percentage receives all the four types of support[8].

The prolonged conflict in northern and western parts of Uganda has terrorised, traumatised and caused death to many people. The nature and duration of these conflicts have created humanitarian, social and economic costs for all of Uganda, particularly the children. The protection of the child is a priority for the GoU as reflected by the Child's Policy, OVC policy and corresponding OVC strategic plan to guarantee the child's basic rights not withstanding funding availability. GoU together with various organisations like Uganda Red Cross and World Vision among others are working to help improve the quality of life for these children. Some interventions include "No Child Soldiers" Declaration, Pray for the children and families trapped in the middle of this conflict, financing the organisations implementing activities and negotiations for a peaceful resolution to the conflict.

FBOs, also offer social support to the PHAs and orphans.[28] Orphans are in some cases housed in orphanage homes, attached to families in case of adoption or offered support while left in their original home. The children are offered love, care, spiritual and discipleship. Physical basic needs are also provided. The children are equipping[29] with the essential moral values and life skills that will later on in life enable them to make a significant and lasting impact on society. There is also a focus on widows who are most often abandoned after the death of the husband(s) with assistance of heifers, goats, oxen and home care packages. FBOs also offer support to OVC in conflict affected areas with food, clothing, material support and psychosocial support.

3.4 Planning, Resource Management and Finance

3.4.1 Long Term Institutional Arrangement

Uganda has developed a Long Term Institutional Arrangement (LTIA)[30] with goal of re-aligning all funding mechanisms to existing institutional arrangements thereby minimising duplication and fragmentation of interventions. This is consistent with the Paris Declaration on Aid Effectiveness (March, 2005), the Rome Declaration on Harmonisation (February, 2003), the Marrakech Roundtable on Managing for Development Results (February, 2004) and Recommendations of the Global Task Team (June 2005) for a more effective AIDS response. Under this LTIA arrangement, budget support financing was adopted, ring-fenced in the Poverty Action Fund (PAF) mode following guidelines with MoFPED as the principle recipient. Existing national and sub-national co-ordination structures such as the Health Policy Advisory Committee, AIDS Partnership Committee (PC), District Technical Planning Committee, District Health Team, District Community-Based Services Office and District HIV & AIDS Committee will be used. The structures should ensure meaningful engagement of the civil society. GoU procedures on procurement and finance management under the public finance and management act will be used. Existing reporting, monitoring and audit arrangements used for PAF will be strengthened and used.

[28] paguganda.org/content.php?i=8 30/11/07
[29] www.watoto.com 30/11/07
[30] Proposed Long Term Institutional Arrangement for the Programmes of the Global fund to fight AIDS, Tuberculosis and Malaria (GFATM) in Uganda - 2006.

3.4.2 HIV & AIDS Expenditures

A consultant was hired to generate both public and private expenditures in HIV & AIDS for the financial years 2005/06[14]. The assessment of AIDS spending by categories involved extensive review of documents and stakeholder discussion and meetings with the relevant officials both in the public and private sectors. The donor community, both bilateral and multilateral organisations were the major sources of the data since they constitute the largest source of funding for HIV & AIDS in Uganda. This reflects a 6.1% public funding as reflected in *Table 3.4-1*.

Table 3.4-1 Summary HIV & AIDS Expenditures - for Financial Year 2005/06[14]

AIDS Spending categories	Government	Non-Government	Total	%
Prevention	-	67,883,659,823	67,883,659,823	19%
Care and Treatment	6,464,856,763	146,324,634,498	152,789,491,261	42%
Orphans and Vulnerable Children	-	24,611,793,105	24,611,793,105	7%
Program Management and Administration	15,630,428,058	64,898,546,671	80,528,974,729	22%
Incentives for Human Resources	-	1,692,999,066	1,692,999,066	0%
Social Protection and Social Services excluding Orphans and Vulnerable Children	-	1,759,592,990	1,759,592,990	0%
Enabling environment and community Development	-	929,011,872	929,011,872	0%
Research excluding operations	-	33,004,475,915	33,004,475,915	9%
Totals	22,095,284,821	341,104,713,939	363,199,998,761	100%
Percentage	6.1%	93.9%		

The National AIDS funding matrix based on 8 National AIDS Spending Assessment categories by financing sources mainly public and private, is reflected in Appendix 2a. The private sources of funding are further sub-divided into bilateral and multilateral sources. Under multilateral organisations, further sub-division is done[14]. As can be seen in table 3.4-1, 42% of funding is spent on Care and Treatment activities; 22% is spent on Programme management and administration while 19% is on Prevention and enabling environment and community development is least funded activity.

It was very difficult to obtain all data on expenditure on HIV & AIDS spending by both public and the private sector due to insufficient and incomplete data in different reports as well as methodological differences in data collection. Funds are allocated from GoU to the DLGs but it has not been possible to tease out the proportion that goes to HIV & AIDS due to the integrated approach to service delivery; and the fact that, being a cross-cutting issue, HIV & AIDS has not been accorded a special budget line/vote.

The categories of OVC and Prevention do not reflect any public spending although the GoU spent towards them[14]. This is due to the integrated approach to delivery of services making it difficult to sort out specifically the funding towards HIV & AIDS. Under the Universal Primary Education (UPE) and Universal Secondary Education (USE) OVC are catered for. Disaggregating the PAF to estimate the aggregated HIV & AIDS spending by the DLG and GoU is not possible. HIV & AIDS is looked at as another health problem thus even the advocacy and sensitisation elements are not easy to isolate.

The budget support funding by the development partners that was specifically meant for HIV & AIDS could not be isolated because of the integrated approach of implementation of activities.

It should also be noted that different organisations use different reporting timeframes and thus much data on spending for the financial year 2006/07 was not yet available since the accounts had not yet been audited. This has created a gap in the dataset[14] and thus this period's financial status is omitted.

As a bottom up planning tool, Uganda is in the process of setting up Community[31] Information System (CIS), which is a component of the Rural Development Strategy and Community Mobilisation and Empowerment Strategy, both of which are components of the Poverty Eradication Action Plan (PEAP). The CIS is intended to ensure that households and Communities have access to and make use of reliable and meaningful data and information. Information generated will allow for more precise planning at sub district and higher levels. This is likely to be an advocacy tool for GoU to consider increasing its funding to HIV & AIDS from 6.1% upwards.

Other Funding Sources

Uganda benefits from The United States Government (USG)[32] in four areas related to HIV & AIDS: prevention, care, treatment, policy/systems strengthening through various CSOs. The USG funds over 60 prime government private and faith based organisations.

Additionally the USG funded a program between 2001 and 2006 aimed at enabling persons in selected districts to access and utilise appropriate, affordable and quality HIV & AIDS prevention, care and support services. This included strengthening of capacity of government, NGOs, CBOs, FBOs and the private sector to plan, implement, manage and provide services at the national, district and sub-district levels; integration of HIV & AIDS prevention, care and support services; increasing access to and utilisation of quality HIV prevention services; increasing access to and utilisation of quality HIV & AIDS clinical; and increasing access to and utilisation of quality social support services for people infected and affected by HIV & AIDS, including orphans, vulnerable children, and adolescents in the selected districts and sub-districts.

The USG[33] is also funded a program strategically oriented to increase the utilization, quality, support and sustainability of services in education, health and HIV & AIDS through an integrated approach with the hope to improve educational status; reduce the spread of HIV & AIDS and sexually transmitted infections; decrease child and maternal mortality and stabilize population growth in the districts in Uganda.

The World Bank funded project between 2001 and 2006 under UAC initiated and sustained a national and decentralised multi-sectoral response to the HIV & AIDS scourge through support to the public sector and CSOs and through direct support to Community-led HIV & AIDS Initiatives (CHAIs)[34]. The contribution to the achievement of the three goals of the NSF 2001-2006 was mainly through service delivery and capacity building for implementation at the National, District and Community levels. These were:

- pioneered the widest ever community led HIV & AIDS initiative in Uganda that has guaranteed the delivery of services at the grass roots providing support to very many needy OVCs and PHAs.
- supported 15 line ministries to mainstream HIV & AIDS activities as part of their core business spear headed by an HIV & AIDS focal person appointed and a functional HIV & AIDS committee. They were supported to develop HIV & AIDS policies and guidelines and to carry out HIV & AIDS workplace programmes.

[31] The Community Information System (CIS) booklet, UBOS 2006
[32] The AIDS/HIV Integrated Model District Programme Final Report 2001 – 2006.
[33] http://uphold.jsi.com/ 30/11/07

- greatly supported both 36 national and 233 district level CSOs through the DLG to implement their planned activities.
- supported 30 DLGs and
- 3,629 CHAIs within the districts.

Table 3.4-2 Summary of Fund Commitments by Source of Funding for Financial Years 2007/08 and 2008/09[5]

Source of funds	Financial year (amounts in millions of US$)	
	2007/8	2008/9
Government of Uganda	53.3	59.8
PEPFAR	236	283 (planned)
Global Fund - Round 3 Phase II	35.5	-
Global Fund - Round 7 application	-	31.9
Civil Society Fund	6.8	10.5
Partnership Fund	1.8	2.5
Support to MoLG for decentralised coordination (Irish AID)	0.6	0.9
Total	334	388.6
Projected NSP Requirements	276	347

4.0 Best Practices

A Best Practice is a management notion which asserts that there is a technique that is more effective at delivering a particular outcome than any other. The idea is that with proper processes, checks, and testing. It will yield the desired outcome with fewer short comings and unforeseen complications.

The country's response has since the mid-term review of the NSF 2000/1-05/6 in 2003 registered more good practices in different aspects of the response at various levels. These have formed the basis for a strengthened response targeting universal access to all HIV and AIDS services by 2012.

For this particular reporting period, the criteria for identifying such practices include at least four or all of the following:

1. Innovation at the conceptualisation stage and in intervention approaches within the context of evidence-based programming
2. Stakeholder involvement in the conceptualisation process which usually underlie acceptability and ownership,
3. Appropriate targeting of the intervention that takes into account the social, cultural, economical and structural environments around the beneficiaries
4. Adequate coverage in terms of comprehensiveness, scope and packaging of intervention
5. Demonstrated impact and resource effectiveness
6. Potential for easy and quick replication in other settings

4.1 Supportive Policy Environment

Partnering of Various Implementers

The Partnership approach to the coordination of the multi-sectoral response to HIV & AIDS in the country shapes the direction of the response and promotes stakeholder involvement in decision making especially at policy and strategic levels. This enhances ownership and commitment to the response among the different stakeholders. Initiated in 2002 under the Uganda AIDS Commission, the Partnership Structure spearheaded by the Partnership Committee has registered great achievements in the last two years including:

- establishing approaches for harmonising and aligning donor funding;
- agreeing on a common funding mechanism for civil society stakeholders;
- conducting joint reviews and wider sharing of strategic information to stakeholders at all levels;
- spearheading dialogue and consensus on strategic intentions for the next 5 years; and
- carrying out resource mobilization including involvement of stakeholders in the development of the country proposal for Global Fund Round 7.

In acknowledgement of the performance of the structure, the Partnership Committee was nominated by the local stakeholders and received a no objection from Geneva to serve as the Country Coordinating Mechanism for the HIV & AIDS component of the Global Fund programme in Uganda.

Evidence Based, Consultative & Participatory Approach to Development of the NSP

The evidence based, consultative, participatory and fully interactive process used in developing the NSP 2007/8-2011/12 features among the best practices. This includes involvement of stakeholders in assessing the country's performance under the previous NSF 2001/02 to 2005/06, identifying needs, assessing capacity to respond and shaping priorities for further action. The process was initiated in 2005 during the November Joint Annual AIDS Review (JAR) and was formally launched in August 2006 with stakeholder consensus on the various major phases and their outputs. The process featured extensive stakeholder consultations at national, district and lower levels through technical working groups (TWGs), district consultation fora, an appointed National Task Force, the Partnership Committee and finally the 2007 National Partnership Forum. This has promoted shared perspectives on priorities and approaches to the response among current and potential HIV & AIDS actors.

Condom Post Shipment Testing

UAC initiated in-country post-shipment testing[34] of condoms through a World Bank procurement, under MAP, of the condom-testing machine (US$ 0.190 million) to reduce the costs of post-shipment testing thus making the exercise affordable and therefore sustainable. The machine was handed to the National Drug Authority to ensure a sustained quality of condoms. Testing should therefore continue even when the donor funding is over, since the cost of post-shipment is included in procurement cost.

Strategic Planning at DLGs

GoU and Partners have funded and supported 50% of Ugandan districts to develop 5 year HIV & AIDS strategic plans to enable them to have a long term strategy to handle HIV & AIDS issues within their local governments. Many AIDS Development Partners have bought into these plans and offer funding. It will be easier for donors to fund an existing plan. If these strategic plans can be implemented, they will greatly contribute to the NSP.

Partners of FBOs

The Inter-Religious Council of Uganda (IRCU) has tremendously contributed to the coordination and management of the AIDS response. The IRCU has however established a credible forum for leadership in the religious organisation in Uganda to work together. It has brought together Roman Catholic, Muslims, Anglican and Orthodox communities united against AIDS under the SCE's FBOs. They jointly dialog on the dynamics and impacts of the epidemic and how to utilize their structures and systems to deliver services in collaboration with other stakeholders. The IRCU has even developed financial granting capacity for stakeholders in this sector, which takes resources and eventually services nearer people in all corners of the country. FBOs usually are expected to at a comparative advantage to champion Abstinence and Faithfulness in marriage message.

4.2 Scale-up and Sustaining Programmes

Since the late 1980s, the country's response has hinged on community involvement and ownership of the response that leads to growing AIDS competence. It is acknowledged that even with increasing access to resources, communities will not actively take up services if they are not appropriate to their contexts. The recognition to work with and develop community capacity has been an underlying principle in many national programmes

including funding mechanisms. These have cultivated good practices at community level that form foundations for successive programmes

The Community-led HIV and AIDS Initiative (CHAI) Component of the MAP Project

The CHAI component nurtured many community groups around common problems. CHAI encouraged group members to identify and analyse problems, participate effectively in family and group activities like meetings, farming, home visiting and community mobilization and sensitisation on a voluntary basis. This created ownership and developed skills in leadership at community level that is regarded as an important good practice[34].

After the phasing out of the MAP funding, many CHAI groups took on sustainability approaches through building of alliances and linkages with other support agencies like development partners, Local Government structures, Civil Society Organisations (CSOs) and Community Based Organisations (CBOs). Through such alliances the groups have continued to handle issues related to financial support, skills improvement/development and service provision. Some CHAI groups have grown from small CBOs to resident NGOs thus giving technical support to other CBOs in various areas such as sensitisation, resource mobilisation and financial management. Some CHAIs have engaged in innovative community strategies for sustaining their activities like crop and/or animal husbandry, drama and handicraft making. Income is generated from selling crop or animal produce, etc. The funds are used to support orphan children with scholastic materials & requirements, dues, buying essentials for PHAs or orphans and for transporting PHAs for treatment.

4.3 Effective Prevention Programmes;

The NSF mid-term review revealed waning prevention efforts, which led to the initiation and/or strengthening of several national level programmes to expand the response and featuring some good practices.

The PIASCY school-based programme and the Young Empowered and Healthy (YEAH) Campaign. The development of both pioneered comprehensive partnerships in prevention, targeting message consistency and acceptability across cultural, religious and social differences. The PIASCY programme presents an integrated approach to age-specific growing up issues within the school teaching model that positions the learner's welfare as central. The YEAH campaign targets more of out of school young people with edutainment approaches that address environments that predispose them to risky behaviour and HIV infection thus strategically situating the ABC model. The PIASCY programme is progressively developing the education sector into an AIDS competent sector through structured mainstreaming approaches. The YEAH campaign received a regional BCC award from AfricomNet for innovation in communicating to young people in February 2007.

Home-based HIV Counselling and Testing (HCT): This programme was successfully piloted in the districts of Tororo and Mbarara through American funding with great success. The pilot revealed that the intervention is feasible, acceptable, increases opportunities for couple testing and mutual disclosure of results, offers a safe environment for couples to discuss risk concerns and issues, and allows psychosocial support for all family members. These positive outcomes have informed intensified programming at various levels and also policy formulation.

[34] End of Project Report for Uganda HIV/AIDS Control Project 2001-2006 (Cr. 3459 UG) - December 2006

Abstinence

Some CSOs are enlisting the youth and encouraging them to abstain from sex till marriage, and this is thought to be a good practice. The young people are followed up so as to maintain their commitment.

Prevention with Positives where PHAs sensitise the public through testimony is thought also to be a good practice.

4.4 Treatment, Care and Support Programmes

Treatment

Uganda boasts of centres of excellence in provision of prophylactic and clinical care to the infected. The Joint Clinical Research Centre and Infectious Diseases Institute feature among the best practices in combining quality care and research into clinical care specifically ARV drug adherence, interactions, resistance monitoring, drug switching, etc in the African context. Besides this, both centres have innovatively enhanced treatment and support to children and adolescents. The Joint Clinical Research Centre has OVCs enrolled on free ART with appropriate support services and is championing access to paediatric formulation. The IDI runs one of the largest support facilities in the country that provides friendly services to infected children, adolescents and young people in the country. The Joint Clinical Research Centre's satellite site around the country are a demonstration that quality care can be easily accessible even in the most remote parts of the country

Care and Support

HIV & AIDS Post Test Clubs, mostly coined around HIV & AIDS care centres, are established to provide public awareness about HIV & AIDS through music, drama and / or testimony and provide on-going psycho-social support to the members. This includes the promotion of the ABC+ strategy. The PHAs are also encouraged on a positive living attitude which includes practices like adherence to[35] treatment especially free ART programs, status disclosure to close family members. HIV & AIDS Post Test Clubs have greatly contributed to the reduction of stigma and access to funding sources for material support and income generation.

The AIDS Support Organization: The AIDS Support Organisation continues to innovate around integration of prevention, treatment, care support services to over 100,000 clients and their families around the country. The AIDS Support Organisation has championed access to care and treatment to many of the infected and affected who would not have otherwise afforded the services.

Mildmay Jajja's Home is a unique facility providing comprehensive services to HIV infected and affected children. Located in a semi urban area, the Home receives and actively identifies affected children in communities around the structure for day-care/outpatient and in patient services. Children are provided with rehabilitation services, nutritional support, recreational services, treatment for HIV & AIDS and opportunistic infections and psychosocial support. The Home provides a glimmer of hope to many guardians and parents who do not have time and resources to take care of their affected children and even those who

[35] HIV/AIDS in Africa – Getting Results – World Bank Global AIDS Programme and ACT Africa - 2006

were inadvertently and purposely ignoring infected children waiting for their deaths. The Home is currently among the few facilities providing all round integrated support combining facility-based and home care approaches to children in the face of the epidemic.

5.0 Major challenges and remedial actions

5.1 Progress made on key challenges identified in 2005

In 2005, a number of challenges were identified to be affecting implementation and realisation of NSP targets. This chapter discusses progress made during the reporting period in addressing those challenges and suggests some remedial measures to be taken.

Time Bound Duration of Funding for Existing HIV & AIDS Programmes

Despite the ending of various funding cycles, funding to key HIV & AIDS interventions has continued to be earmark and availed through GoU and AIDS Development Partners. The New NSP 2007/08 to 2011/12 has also identified and costed the National Priorities and various AIDS Development Partners have indicated interest to offer funds. The GFATM Round 7 proposal for Uganda for the HIV & AIDS component was approved, by Geneva Office. These funds are to be managed under the LTIA as agreed upon. The USG has also continued to fund HIV & AIDS interventions. UNAIDS and other UN agencies have also continued to fund HIV & AIDS interventions. This has allowed continuity of key HIV & AIDS interventions. A funding arrangement has been established where AIDS Development Partners contribute to a fund to be accessed by CSOs. The management of these funds is administered following the LTIA.

Poor National Coverage in Implementation of The HIV & AIDS NSF 2001/02 – 2005/06

In the past two years, the national HIV & AIDS programme has been finalising objectives as set for the previous National Strategic Framework 2001/02 to 2005/06 for HIV & AIDS, reviewing its performance and developing a new plan that will enhance achievements and address the identified gaps. The overall goal of the new strategy is to achieve universal access targets for HIV & AIDS prevention, care, treatment and social support by 2012. And the aim is to reduce new HIV infection by 40%, to scale up and reach 80% of those in need of care and treatment, and to expand social support to 54% by the year 2012. It is hoped that these in place together with regular focused reporting and follow up using the PMMP and operational handbook, will address the challenges of reaching all communities with relevant programmes. More resources are being mobilised from local and international sources as mentioned under Chapter 4 to fund the new national HIV & AIDS strategy. There is need to build the capacity of implementers at sub national levels.

Limited Program Coverage and High HIV Prevalence rates in the Conflict Areas of Northern Uganda

In addressing limited coverage in conflict areas, UAC together with other development partners have set up a special programme for Northern Uganda called National AIDS Committee on AIDS in Emergency settings to specifically scale-up HIV & AIDS interventions and coordination efforts in this region. This programme has been operational for the past two years. It is designed to undertake periodic quarterly reviews through fieldwork and meetings and is so far demonstrating progress. Additional funding specifically targeting the conflict area in Northern Uganda includes USG funding for AIDS, TB and Malaria. Various national and international CSOs have extended a hand of assistance to the conflict areas focusing on OVCs, material support, counselling, education, HIV & AIDS sensitisation, provision of relief items, spiritual nourishment, housing e.t.c. There are ongoing

peace talks and cease fire between the GoU and the warring factions. Quite a number of people are returning to their homes in anticipation of peace.

Weak Status of Mainstreaming of HIV & AIDS in the Public and Private Sectors

The 2004/5-2007/8 Poverty Eradication Action Plan (PEAP), which is a four year national development agenda, recognizes HIV & AIDS as a cross cutting issue and a contributing factor in the increase in household poverty and limiting progress in human development. A review of the integration and mainstreaming of HIV & AIDS in planning and budgeting in government sectors shows that sectors have developed varying strategies to address challenges of HIV & AIDS in their sectors. For example, Ministry of Finance, Planning and Economic Development (MoFPED) and Ministry of Public Service provide health care service to their workers that are infected with HIV & AIDS through an agreement with Joint Clinical Research Centre. Ministry of Education developed manuals on HIV & AIDS to address the Youth in school and reduce on their vulnerability. Ministry of Works, Transport and Housing has a HIV & AIDS workplace policy in place.

As a measure to standardise mainstreaming practices in the Public Sector, MoFPED together with UAC and UNDP developed an HIV & AIDS mainstreaming guideline in 2007 through a consultative process, which involved other GoU Ministries, Local Governments and AIDS Development Partners. This guideline is purposed to enhance the strategic management of the national HIV and AIDS response by adding value, increasing relevance and scaling up different interventions of the public sector. Furthermore, the MoFPED budget call circular for financial year 2008/9 has instructed all Government Ministries, Agencies and Local Governments to mainstream HIV & AIDS in their budget framework papers and eventually their budgets. This is expected to be the practice henceforth. A draft policy on mainstreaming is in its final stages of development.

Stock-Outs of Essential Supplies, Drugs and Other Commodities

Due to lack of harmonisation and information exchange regarding procurement and supply chain management by partners supporting HIV commodities management, stock-outs of essential supplies, drugs and other commodities has been experienced. To address this, the Procurement Unit of MoH is being strengthened with Technical Assistance from USAID and expansion of its establishment. In addition a procurements and supply chain management Committee comprising key partners has been formed and meets regularly. By requirement, Partners are expected to inform the Supply Chain Management Committee of the procurement plans and MoH is in the process of preparing a joint procurement plan for all HIV & AIDS commodities.

Human Resource and Infrastructure Constraints

During the reporting period, human resource and infrastructure remained a major constraint especially in the health sector. Fortunately, the Heath Service Commission is in place and efforts are underway to strengthen it to fulfil its objective of ensuring that all positions in the health sector are filled with qualified and competent persons. Furthermore, attention is being paid to the special needs and problems that affect workers in the health services. The Human Resource for Health policy is in use and its corresponding strategic plan (2005 – 2020) has been finalized and awaits publication.

Arrangements to build the capacity of human resource in the health sector are ongoing. This includes in-service training, orientation in new methods, sharing experiences and training workshops, on-the-job training, training on effective use of data, training in M&E e.t.c. Specialised training of users on new and modern methods like HIV testing methods and equipment like CD4 count machines and viral load analysers, is underway and is likely to be a continuous undertaking.

The physical health infrastructure is being further developed and management improved upon. Under the Essential Medical Equipment Credit Line, procurement of essential medical equipment is being undertaken. The National Advisory Committee on medical equipment is reviewing the equipment policy document to update the equipment list for each level and respective technical specification(s). Some health facilities continue to be rehabilitated, refurbished and re-equipped.

Wide Gap Between Level of HIV & AIDS Awareness and Appropriate Behaviour Change

There have been specific campaigns geared at addressing awareness and behaviour gaps following an in-depth study that identified accelerators of the HIV & AIDS epidemic in Uganda. These have focused on prevention among the HIV positives as well as discordant couples, prevention of cross-generation sex, prevention programmes of MARPS like the fishing communities and CSWs, HCT at household levels. Behavioural Change Strategies to address the identified gaps are included in the new NSP ready for implementation. Some CSOs are doing a lot of work in this area especially targeting the youth in and out of school. The FBOs are also critically looking at addressing at an increased level the behaviours among the married.

Institutionalisation of The 'Three Ones' Principle

Efforts to strengthen the 3rd Principle of the 'Three Ones' are underway. UAC as the national co-ordinator on HIV & AIDS has led the nation in developing the NSP following a participatory, consultative and interactive approach. This has created a stakeholder ownership of the NSP. There are plans to ensure wide dissemination of the New NSP. Following a similar approach, a M&E plan for the NSP called the PMMP together with the operational handbook have been developed and are to be disseminated in 2008. An intervention reporting system for all implementers is to be set up using a web enabled interface. This is expected to further strengthen the principle.

5.2 Challenges Faced Throughout the Reporting Period

Many challenges identified in the 2005 UNGASS Country Report are still outstanding; although, to a large extent, some measures have been taken to address them as discussed above.

Missing Baseline Values in the NSP

Some indicators in the NSP 2007/08 – 2011/12 lack baseline values. However, some effort is being made to obtain these values through the respective line GoU Ministries. In order to measure the progress of implementation of the NSP 2007/08 – 2011/12, presence of baseline values is vital for measurement of progress, although some of these indicators require a sizable amount of resources.

Over Stretched Service Levels

A great deal of progress in fighting HIV & AIDS in Uganda has been made through the provision of ART, Home-Based HIV Counselling and Testing (HBHCT) and child healthcare. As HIV related deaths reduce, the numbers requiring treatment, care and support services increases[36].thus over whelming the Treatment, Care and Support services. The demand for care and support services is 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 operationalise, train and implement other activities like counselling 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. This leads to slower scale up of activities at lower levels of service delivery. These need to be strengthened.

Policy and Guideline Implementation

Although policy guidelines are available at national level, they are not presented in an easily understandable package for sub-national structures. There is need to identify vital policies and prepare simplified versions for use at sub-national levels. These could be disseminated widely at implementation levels.

5.3 Concrete Remedial Action to Ensure Achievement of national targets

Uganda is committed to International and Regional instruments[5]. The International and regional human rights instruments to which Uganda is signatory include

- Universal Declaration on Human Rights,
- Convention on the Elimination of all Forms of Discrimination against Women,
- Convention on the Rights of the Child,
- International Convention on Economic, Social and Cultural Rights,
- International Convention on Civil and Political Rights,
- African Charter on Human and People's Rights, and
- Optional Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women

The UN Declarations and Programmes of Action that Uganda has endorsed include[5]:

- UN General Assembly Session on HIV & AIDS Declaration of Commitment, 2001
- Millennium Declaration and Development Goals, 2000
- Fourth World Conference on Women (Beijing) Declaration and Platform for Action, 1995
- Beijing +5, 2000
- ICPD +5, 1999

[36]The AIDS Support Organisation (TASO) 2006 Annual Report. March 2007

- World Conference on Human Rights Declaration and Programme of Action (Vienna Declaration), 1993

There is a new NSP 2007/08 to 2011/12 developed and it has four goals. The goals defined therein have taken into consideration the universal targets as indicated below:

The first goal of the NSP is to reduce the incidence rate of HIV by 40% by the year 2012[5]. The key priority areas associated with this goal include:

- Accelerating prevention of sexual transmission of HIV targeting vulnerable and most at risk populations;
- Promotion and scale-up of PMTCT;
- Ensuring blood transfusion safety, universal precautions and post-exposure prophylaxis (PEP);
- Controlling sexually transmitted infections;
- Developing appropriate policies and programmatic guidelines for implementation of new HIV preventive technologies proven to be effective.

The second goal of the NSP is to improve the quality of life of PHAs by mitigating the health effects of HIV & AIDS by 2012. The key priority areas associated with this goal include:

- Increase equitable access to ART;
- Scale-up HCT;
- Increase access to prevention and treatment of opportunistic infections including TB;
- Integrate prevention, including nutrition counselling and education, into care approaches;
- Support and expand Home Based Care and palliative care, and improve referral systems between Home Based Care and health facilities.

The third goal of the NSP is to mitigate the social, cultural and economic effects of HIV and AIDS at individual, household and community levels. The priority areas associated with the goal include[5]:

- Provide psychosocial support to PHAs, OVC, and other disadvantaged groups, targeting women and girls;
- Provision of formal and informal education, vocational and life skills development for OVC, PHAs, IDPs, PWD and other disadvantaged groups;
- Ensure sustainable community and household livelihood and economic empowerment;
- Ensure access to services that meet basic social needs of PHAs, OVC, PWD, IDPs, women, girls and other disadvantaged groups affected by HIV and AIDS;
- Ensure legal and appropriate social and community safety nets to benefit PHA households, OVCs, women, girls and other disadvantaged groups affected by HIV and AIDS;
- Ensure there is sensitisation and awareness creation on human rights and protection mechanisms;
- Ensure provision of the non-tuition costs and essential requirements to OVCs in formal education.

The fourth goal of the NSP is to build an effective support system that ensures quality, equitable and timely service delivery. The key priority areas associated with the goal include[5]:

- Ensure effective governance and management capacity of various institutional structures, with clearly defined roles, functions and linkages;
- Ensure necessary infrastructure is in place to enable equitable and timely delivery of services;
- Ensure effective procurement and logistics management;
- Ensure the effective mobilisation, utilisation and management of human and financial resources;
- Ensure evidence based programming and policy development.

At operational level annual targets have been set in the NSP together with cost estimates. Each key priority area has corresponding guiding strategic actions. This way it is envisaged to achieve the set targets.

6.0 Support From The Country's Development Partners

6.1 Key Support Received From Development Partners

In order to enhance participation of stakeholders in the co-ordination and management of the HIV & AIDS, UAC and partners adopted the partnership approach**Error! Bookmark not defined.** to facilitate and improve the co-ordination function of the UAC. The Uganda HIV & AIDS Partnership comprising Self Co-ordinated Entities (SCEs) that represent various constituencies was established in January 2002 to facilitate information sharing, consensus building, joint planning(s), sharing of experiences/practices. This culminated into the establishment of the Uganda the Partnership Committee (PC), the Partnership Forum (PF), and the Partnership Fund.

The SCEs include Parliament, Government Ministries, UN & Bilaterals, National NGOs, International NGOs, Private Sector, Faith Based Organisations, PHA Networks, Decentralised Response, Research, Academia and Science, Young People and Media Arts and Culture.

Support received from AIDS development partners includes technical, logistical and financial support through the AIDS Partnership Funding arrangement or otherwise. There are quite a number of AIDS Development partners in Uganda and these include Ireland, Denmark, European Union, ILO, Italian Cooperation, Norway, Sweden, United Kingdom, UNAIDS and other UN agencies, Canada, Australia, United States Government, World Bank, GFATM and Clinton Foundation among others. These partners contribute to a partnership fund for the HIV national response. With this support the following achievements have been realized over the reporting period:

- The partnership committee being approved as the Country Co-ordinating Mechanism for the AIDS component of the Global Fund for AIDS, TB and Malaria.
- Support Self Co-ordinating Entities to co-ordinate the response in their constituencies
- Holding of the National Partnership Fora
- Joint Annual AIDS Reviews
- Funding the National HIV Prevention Fora
- Establishment of the Civil Society Fund Inter-constituency Co-ordination Committee to assist in harmonisation of non-government stakeholders and enhance their contribution in the PC and GFATM resource management.
- Functionality of the Civil Society Fund.
- Co-ordination of activities of the National Committee on AIDS in Emergency Situations
- Enhance regional and international collaborations like Great Lakes Initiative for Africa (GLIA), Inter-Governmental Authority on Development (IGAD) and East African Commission (EAC)
- Improved intervention co-ordination by reducing duplication & overlap e.g partners coming together to address procurement bottlenecks, task force groups like M&E Sub Committee, Prevention Sub Committee, Advisory committees etc.
- Active involvement of PHAs
- Supportive co-ordination bodies like NAFOPHANU, IRCU and UNASO.

Table 6.1-1 below shows the financial contribution of AIDS Development Partners to the national response in broad categories.

Table 6.1-1 Proportion contribution of total expenditure for 2005/06 Ug. Shs [14]

Donor Category	Total Expenditure 2005/06 Ug. Shs.	%
Bilaterals	280,690,303,339	77%
Multilaterals	60,414,410,601	17%
Total	**363,199,998,761**	

The Global Fund to fight AIDS, Tuberculosis and Malaria (GF) approved the Ugandan round 7 HIV & AIDS proposal of $268,800,980 of which $84,358,482 (i.e. 31.4%) will become available upon grant signature. The funding will have duration of 2 years. The total funds so far disbursed under round 3 of GF are $46,362,091 out of an approved $70,357,632.

6.2 Actions That Need to be Taken By Development Partners To Ensure Targets

There are many gaps in the current national efforts to combat the AIDS epidemic that need to be addressed with the support of AIDS Development Partners. They include:

a) AIDS Development Partner interventions to support the National Response should be aligned with the NSP 2007/08 to 2011/12 in line with the Paris Declaration on Aid Effectiveness (March, 2005).
b) Achieving geographical and thematic equity including the hard to reach areas and the MARPs (CSWs, Fisher People, Truck drivers etc).
c) Strengthening the existing systems for delivery of HIV & AIDS systems rather than setting up parallel systems to ensure that universal targets are attained by 2010.
d) Building of skills of stakeholders, including networks in financial resource mobilization and management. This could begin with assistance in developing a clear national capacity development plan.
e) Designing and agreeing on a joint planning approach for improved resource utilisation and coherence. This could include joint reporting approaches and sharing of annual plans, budgets, progress reports etc.
f) Continue supporting and encouraging GoU sectors to mainstream HIV & AIDS NSP strategies/activities into their various operational plans.
g) Assisting the GoU to operationalise the PMMP for the NSP 2007/08 – 2011/12 to ensure a continued development of the M&E process and capacity.
h) Assisting GOU sectors to generate the missing baseline values of the identified NSP indicators.
i) Advocating for increased resource allocation for HIV & AIDS in government budgeting processes at all levels.
j) Supporting the development of a Resource Mobilization and Advocacy Strategy.
k) Advocate for institutionalisation of a resource tracking system e.g. NASA.

7.0 Monitoring and Evaluation Environment

In 2003 a National HIV & AIDS Monitoring and Evaluation (M&E) framework was developed based on the National HIV & AIDS Strategic Framework (NSF) 2001/02 to 2005/06. The Framework was intended to facilitate tracking the impact of the HIV & AIDS response. In 2005 an evaluation of the NSF together with its M&E framework was carried out. It was found out that the M&E framework had some achievements notwithstanding some challenges. Some recommendations were made as a way forward for the M&E of the national response as listed below.

Achievements

- The M&E framework and its abridged version for the NSF 2001/02 to 2005/06 were widely disseminated with majority of stakeholders having a copy of the two documents.
- A mapping exercise that was conducted in 2004 assisted in identifying service gaps in the country.
- An operational manual for the decentralized level was compiled and piloted in 4 districts.

Challenges

- The M&E framework for the NSF 2001/02 to 2005/06 had neither clearly defined uniform data collection tools nor an integrated database that could help provide national oversight for M&E and reporting.
- The M&E framework NSF 2001/02 to 2005/06 had neither an operational plan nor a budget.
- Although HIV & AIDS surveillance was relatively well developed and supported, its reports required complementing with operational and household researches based on national priorities.
- M&E for HIV & AIDS resource tracking was not done in a long time while program activity monitoring required strengthening with tools and capacity.
- The M&E function was subsumed in the planning function in various institutions.
- There was no standard M&E training curriculum thus aggravating the lack of skilled and trained expertise in M&E.

Recommendations

- Improve and sustain funding for the M&E system;
- Standardize and enhance the training for all cadres involved in M&E data collection including data clerks;
- Develop standard HIV & AIDS data collection tools, reporting format and establish schedules with timelines for reporting.

7.1 An Overview Of The Current Monitoring and Evaluation System

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 National Strategic Plan (NSP) 2007/08 – 2011/12 which address the concerns raised in the 2005 evaluation of the M&E framework for the NSF 2001/02 to 2005/06. The new M&E

plan is linked to the National Integrated M&E System (NIMES) of the National Development Plan (NDP), which recognizes HIV & AIDS as a cross-cutting development issue in Uganda.

The 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.

7.2 Challenges Faced In The Implementation of Comprehensive M&E System

Information in form of progress reports, research reports and data submission to UAC by stakeholders is still a major challenge. The UAC, as the national co-ordinating body, is mandated to oversee the implementation of HIV & AIDS interventions. Therefore, it is desirable to generate a routine progress report of stakeholders interventions. This will enable a clear early measurement of the progress made on implementing the strategies of the NSP. and thus collate progress reports for interventions implemented so that at periodic intervals is able to measure the progress on the NSP irrespective of the source of funding.

Some indicators in the new NSP 2007/08 – 2011/12 lack baseline data. These require resources and co-ordination with the line GoU ministries in order to obtain them.

Progress reporting periods i.e. reporting along Financial Year vs. Calendar year is still a challenge. Since UAC is a GoU arm, efforts to align reporting to GoU system of Financial Year and corresponding three month quarters are being pursued.

Another challenge is lack of a system to track resources for HIV & AIDS. The National AIDS Spending Assessment (NASA) may be used to address this challenge.

7.3 Remedial Actions Planned to Overcome Some of the Challenges

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 Monitoring and evaluating; UAC will undertake the following actions:

- Guide the development and strengthening of the stakeholders' Monitoring and Evaluation Systems;
- Assist all HIV & AIDS stakeholders in conceptualizing a coordinated Performance Measurement and Management system;
- Assist all stakeholders to understand trends and explain the changes in the levels of HIV & AIDS prevalence overtime on a regular basis;
- Promote utilization of Monitoring and Evaluation data in planning and generate an information base for Uganda's timely reporting on its UNGASS commitment and MDG targets.
- Set up an implementer web based database based on a standard format of reporting. Basic feedbacks are also to be given to the implementers.
- Establish a system to track resource allocation and utilisation.
- Liaise with the relevant central government sectors to get values for the missing indicators.

7.4 Required Technical Assistance

With specific reference to Monitoring and Evaluation System technical assistance is required over the next two year period to fill the existing gaps in the PMMP indicator baseline values. Furthermore, technical and financial assistance is required to support and advocate for the process of institutionalising data identified in the PMMP.

Finally, there is need for technical assistance in rolling out o the PMMP, estimation of a HIV incidence, implementing the NRP and the mid term review of the NSP.

The general Monitoring and Evaluation system for HIV & AIDS across the GoU Ministries requires short term, medium term and long term Technical Assistance to strengthen various weak points.

Appendix 1 : Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV & AIDS.

In order to put this report together, various national level stakeholders from both public and private sectors were contacted to complete the UNGASS data collection instruments. These were drawn from various government departments, the donor community and non-government organisations. A desk review of available documents from various stakeholders and partners was also conducted. The documents included periodic reports, survey reports, in-depth study reports and institutional documents from various stakeholders. Four (4) meetings were convened for a consensus position. A list of both government and non – government respondents are reflected in Appendix 2c and the questionnaires duly filled are shown in Appendix 2e and 2f. A final consensus meeting of about 100 stakeholders was also held to discuss and agree on the contents of the report. The list of participants is also attached in Appendix 2d. The Monitoring & Evaluation (M&E) Sub Committee met and reviewed the report before it was submitted to UNAIDS.

All key UNGASS indicators have been incorporated into the new NSP for 2007/08 to 2011/12.

Appendix 2. National Composite Policy Index questionnaire

Cover Sheet

Please provide the following information when submitting the completed national Funding Matrix.

Country : UGANDA

Contact Person an National AIDS Authority/Committee (or equivalent) :

Name : David Kihumuro Apuuli (Dr) Title : DIRECTOR GENERAL

Contact Information for the National AIDS Authority/Committee (or equivalent) :

Address : ______ Email : apuuli@uac.go.ug

Telehone : +256414288065 Fax : ______

Reporting Cycle : 2006 Calendar year ______ Or fiscal year ✓

For a fiscal year reporting cycle, please provide the start and end month/year : 07 / 05 to 06 / 07

Local Currency : Ugandan Shillings

Average exchange rate with US dollars during the reporting cycle : 1 US $ to 1794.38 Ug. Shs.

Methodology :

A consultant was hired to compile the sub-component. The information was obtained by review of documents like financial reports, stakeholder discussion and meetings with the relevant officials both in public, private sectors and development partners.

Unaccounted Expenditures :

Appendix 2a. : National Funding matrix for financial year 2005/06

Year 2005/6
Calender Year: Yes____No
(specify beginning /end)
Average Exchange rate for the year

AIDS Spending Categories	TOTAL	Public Sources (Financing Sources)		International Sources (Financing Sources)		Multilaterals			
	(Local Currency)	Public Sub-Total	Central / National	International Sub-Total	Bilaterals	UN Agencies	Global Fund	Dev. Bank Non-Reimburseable	All other International
TOTAL (Local Currency)	344,869,712,216	22,095,284,821	22,095,284,821	322,791,492,336	280,707,368,339	1,969,506,664	16,152,627,657	15,594,546,520	8,367,443,155
1.Prevention (Sub- total)	67,723,716,773	0	0	67,740,781,713	59,346,373,009.20	61,602,463	119,391,550	8,212,888,625	526,066
1.1 Mass media	22,640,354,146	0		22,640,354,146	18,247,768,294.20	53,223,199	29,865,924	4,308,970,663	526,066
1.2 Community Mobilization	10,511,634,506	0		10,511,634,506	10,271,352,851.40			240,281,655	
1.3 Voluntary counselling and testing	21,542,448,297	0		21,542,448,297	20,988,369,004.65			554,079,293	
1.4 Programs for vulnerable and special populations	154,403,419	0		154,403,419				154,403,419	
1.5 Youth in School	100,379,235	0		100,379,235				100,379,235	
1.6 Youth out of school	234,218,214	0		234,218,214				234,218,214	
1.7Prevention programs fo r PLHA	370,568,217	0		370,568,217				370,568,217	
1.8 Programs for sex workers and their clients	140,901,449	0		140,901,449				140,901,449	
1.9 Programs for MSM	0	0		0					
1.10 Harm reduction programs for IDUs	0	0		0					
1.11Work place activities	1,151,645,442	0		1,151,645,442	12,203,042.00			1,139,442,400	
1.12 Condom social marketing	260,232,223	0		260,232,223				260,232,223	
1.13Public and commercial sector condom provision	15,880,054	0		15,880,054	15,880,053.60				
1.14 Female condom	0	0		0					
1.15 Microbicides	0	0		0					
1.16 Improving management of STIs	196,630,436	0		196,630,436				196,630,436	
1.17 Prevention of mother-to-child transmission	10,236,616,925	0		10,236,616,925	9,793,734,823.35	8,379,264		434,502,838	
1.18 Blood safety	78,278,583	0		78,278,583				78,278,583	
1.19 Post- Exposure prophylaxis	0	0		0					
1.20 Safe medical injections	0	0		0					
1.21 Male Circumsicion	0	0		0					
1.22 Universal precautions	0	0		0					
1.99 Others /Not else where classified	89,525,626	0		89,525,626			89,525,626		
2. Care and Treatment (Sub-total)	148,289,406,197	6,464,856,763	6,464,856,763	141,824,549,434	128,112,417,811	107,850,997	8,672,581,819	4,034,609,226	897,289,583
2.1 Outpatient care	0	0		0					
2.2 Provider initiated testing	547,950,078	0		547,950,078				547,950,078	
2.3 Opportunistic infection (OI) PROPHYLAXIS	0	0		0					
2.4 Antitretroviral therapy	106,282,837,861	6,464,856,763	6,464,856,763	99,817,981,098	88,584,992,773.35	71,525,803	8,138,760,347	3,011,402,315	11,299,860
2.5 Nutritional support	754,931	0		754,931					754,931
2.6 Specific HIV Laboratory monitoring	9,839,657	0		9,839,657				9,839,657	
2.7 Dental care	0	0		0					
2.8 Psychological care	535,734,050	0		535,734,050			533,821,472		1,912,578
2.9 Palliative care	40,525,421,733	0		40,525,421,733	39,527,425,037.45	25,696,287		92,642,059	879,658,350
2.10 Home-based care	367,548,305	0		367,548,305		10,428,907		357,119,398	
2.11 Additional /informal providers	0	0		0					
2.12 In patient care	0	0		0					
2.13 Opportunistic infection (OI) treatment	0	0		0					
2.99 Others/ Not- elsewhere classified	19,319,581	0		19,319,581				15,655,717	3,663,864
3. Orphans and Vulnerable Children * (Sub-total)	24,502,208,196	0	0	24,502,208,196	21,105,173,129	0	2,878,494,185	517,553,679	987,202
3.1 Education	1,299,118,579	0		1,299,118,579			1,298,131,377		987,202
3.2 Basic health care	21,105,173,129	0		21,105,173,129	21,105,173,129.20				
3.3 Family /home support	1,580,362,808	0		1,580,362,808			1,580,362,808		
3.4 Community support	517,553,679	0		517,553,679				517,553,679	
3.5 Administrative costs	0	0		0					
3.9 Others/ Not-elsewhere classified	0	0		0					
	0	0		0					
4. Program Management and Administration strengthening (sub-total)	74,867,822,574	15,830,428,058	15,830,428,058	59,037,394,516	52,331,906,956	1,624,574,697	3,807,008,736	1,467,640,097	6,264,031
4.1 Programme management	14,766,130,184	0		14,766,130,184	13,763,346,641.00	943,704,758	59,078,786		
4.2 Planning and coordination	7,826,887,277	3,102,074,728	3,102,074,728	4,724,812,549	4,102,884,214.15	144,070,123	14,944,596	462,913,616	
4.3 Monitoring and evaluation	19,422,260,294	114,715,489	114715489.1	19,307,544,804	17,576,500,891.30	23,999,556	1,193,209,088	512,917,159	918,110
4.4 Operations research	47,630,895	0		47,630,895	33,316,816.00	14,314,079			
4.5 Sero-surveillance	0	0		0					
4.6 HIV drug-resistance surveillance	7,548,884	0		7,548,884			7,548,884		
4.7 Drug supply systems	0	0		0					
4.8 Information technology	0	0		0					
4.9 Supervision of personnel	8,605,080	0		8,605,080			8,605,080		
4.10 Upgrading laboratory infrastructure	19,870,450,461	0		19,870,450,461	16,855,858,393.50	369,072,095	2,153,710,650	491,809,322	
4.11 Construction of new health centres	0	0		0					
4.99 Others/ Not- else where classified	12,718,309,700	12,413,637,841	12,413,637,841	304,671,859		129,414,086	169,911,852		5,345,921
5. Incentives for Human Resources(sub-total)**	1,512,566,407	0	0	1,512,566,407	23,382,188	0	526,499,124	0	962,685,095
5.1 Monetary incentive for physicians	0	0		0					
5.2 Monetary incentive for nurses	0	0		0					
5.3 Monetary incentive for other staff	0	0		0					
5.4 Formative education and build up of an AIDS work for	0	0		0					
5.5 Training	1,512,566,407	0		1,512,566,407	23,382,187.60		526,499,124		962,685,095
5.9 Others/Not- elsewhere classified	0	0		0					
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	1,759,592,990	0	0	1,759,592,990	49,085,851	0	348,652,244	1,361,854,895	0
6.1 Monetary benefits	0	0		0					
6.2 In-kind benefits	49,085,851	0		49,085,851	49,085,851.00				
6.3 Social sevices	0	0		0					
6.4 Income generation	1,710,507,139	0		1,710,507,139			348,652,244	1,361,854,895	
6.9 Others/ Not elsewhere classified	0	0		0					
7. Enabling Environment and community Development (sub-total)	929,011,872	0	0	929,011,872	408,901,525	175,678,507	0	0	344,431,840
7.1 Advocacy and strategic communcation	77,083,994	0		77,083,994	52,917,102.00	22,735,052			1,431,840
7.2 Human rights	343,000,000	0		343,000,000					343,000,000
7.3 AIDS-specific institutional development	489,603,026	0		489,603,026	342,467,093.00	147,135,933			
7.4 AIDS-specific programs involving women	0	0		0					
7.9 Other/ Not elsewhere classified	19,324,852	0		19,324,852	13,517,330.00	5,807,522			
8. Research excluding operations research which is included under (sub-total)	25,485,387,208	0	0	25,485,387,208	19,330,127,871	0	0	0	6,155,259,338
8.1 Biomedical research	0	0		0					
8.2 clinical research	25,485,387,208	0		25,485,387,208	19,330,127,870.50				6,155,259,337.50
8.3 Epidemiological research	0	0		0					
8.4 Social science research	0	0		0					
8.5 Behavioural research	0	0		0					
8.6 Research in economics	0	0		0					
8.7 Research capacity strengthening	0	0		0					
8.8 Vaccine-related research	0	0		0					
8.9 Others/ Not elsewhere classified	0	0		0					

*The term vulnerable children in this context refers to Children whose parent is to ill to take care of them but do not qualify for social support as orphans.
** The item, on the incentives for Human Resources needs to be dissagregated from the costs for service delivery of other activities, e.g . In the in-and out- patient service provision. Efforts need to be made to avoid double counting.

Key
[shaded] Represents that there is no data available. Please refer to specific comments found alongside respective activities, columns and rows in the matrix.

PAF Funds spent 2005/2006 totals = 98,342,286,364

Appendix 2b. : National Composite Policy Index (NCPI) 2007

Country : Uganda

Name of the National AIDS committee Officer in charge : Charles Nkolo Kusasira Lubanga

Signed :

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Tel : +256414 288065

Fax :

E-mail : cnkolo@uac.go.ug

Date of submission : 15th January, 2008

Appendix 2c. : NCPI Respondents

[Indicate all respondents whose responses were compiled to fill out (parts of) the NCP in the below table; add as many rows as needed]

NCPI – PART A [to be administered to government officials]

Organisation	Name/Position	Respondents to Part A [include which parts each respondent was queried on]				
		A.I	A.II	A.III	A.IV	A.V
Ministry of Health – AIDS Control Programme	Dr			✓	✓	
Ministry of Health – AIDS Control Programme	Dr Elizabeth Namagala / ART			✓	✓	
Ministry of Gender Labour and Social Development	Mr Edward Mugyimba - HIV & AIDS Focal Person				✓	
Ministry of Gender Labour and Social Development – Orphans and Other Vulnerable Children Secretariat (OVC)	Programme Manager				✓	
Uganda AIDS Commission	Dr Martin Odiit / NSP (M&E) Consultant	✓	✓			✓
Uganda AIDS Commission	Edward Were / Data Manager					✓
CDC – M&E TWG	Ms. Charmaine Matovu/ CDC – M&E Sub-Committee Member	✓	✓			✓

NCPI – PART B [to be administered to non-governmental organisations, bilateral agencies and UN organisations]

Organisation	Name/Position	Respondents to Part B [include which parts each respondent was queried on]				
		B.I	B.II	B.III	B.IV	
Foundation for Human Rights Initiative	Carol Adoch	✓				
UNYPA	Paddy Masembe	✓	✓	✓	✓	
ACET Uganda	David Kabiswa	✓	✓	✓	✓	
ACTION AID	Elisabeth nakiboneka	✓	✓	✓	✓	
Faith Based Organisations	Rev Sam Ruteikara	✓	✓	✓	✓	
FOCAGIFO	Ritah Busingye	✓	✓	✓	✓	
FORUM	Salome Atim	✓	✓	✓	✓	
FORUM	Namatovu Geraldine	✓	✓	✓	✓	
FORUM	Nakawenda Sarah	✓	✓	✓	✓	
HOSPICE	Mangit Kruar	✓	✓	✓	✓	
ICW	Mwokero Lillian	✓	✓	✓	✓	
ICW	Dorothy Namutamba	✓	✓	✓	✓	
IRCU	John byarugaba	✓	✓	✓	✓	
JCRC	Sergio Abigaba	✓	✓	✓	✓	
Kamwokya Christian caring community	Peter K Byansi	✓	✓	✓	✓	
MAVAP	Angelina Wakapabulo	✓	✓	✓	✓	
MOFED	Mirembe Stella	✓	✓	✓	✓	
NACWOLA	Kyagaba Sandra	✓	✓	✓	✓	
NACWOLA	Masika Hope	✓	✓	✓	✓	
NAFOPHANU	Nanyanzi Prosy	✓	✓	✓	✓	
NAFOPHANU	Kyomukama Flavia	✓	✓	✓	✓	
NAFOPHANU	Mukasa Godfrey		✓	✓	✓	
NAFOPHANU	Mwirumubi Jane		✓	✓	✓	
NUDIPU	Mwesigwa Martin	✓	✓	✓	✓	
PERFECT MEDIA	Prisca M Thembo	✓	✓	✓	✓	
RED CROSS	Prosper Byonanebye		✓	✓	✓	
RED CROSS	Mugisha Sam	✓	✓	✓	✓	
RUBAGA H/CARE	Florence Nalunga	✓	✓	✓	✓	
Straight Talk Foundation	C Watson	✓	✓	✓	✓	
TAAG	Kisakye Julie		✓	✓	✓	
TAAPA	Muhangi Betty		✓	✓	✓	
TASO	Peter Ssembbaja		✓	✓	✓	
The New Vision	Juliet Waiswa		✓	✓	✓	
UNAIDS	DR Brian Wall		✓	✓	✓	
UNASO	Alege Stephen		✓	✓	✓	
UNASO	Syahura Hanington		✓	✓	✓	
UNYPA	Masembe Paddy		✓	✓	✓	
UUP	Birabwa A		✓	✓	✓	
UUP	Florence Kaweesa		✓	✓	✓	
WORLD VISION	Franco Wandabwa		✓	✓	✓	

Note : In the NCPI answers, N/A stands for “Not Applicable”

Appendix 2d. : M&E Sub-Committee Composition (UNGASS)

No.	Name	Organisation
1	Dr Brian Wall	UNAIDS
2	Dr Martin Odiit	REQHC
3	Matovu Chamaine	CDC
4	Rose Nalwadda	DPM, UAC
5	Edward Were	UAC
6	Charles Nkolo	UAC – M&E
7	Atwine Moses	ACE Project – USG
8	Scovia Nabbanja	UAC
9	Rosemary Kindyomunda	UAC – NADIC
10	Rose Kabugo Rujumba	UAC – Decentralised Response
11	Benson Bagorogoza	UAC – Resource Mobilisation

Appendix 2d. : Participants of the Final UNGASS Consensus Meeting

No.	Name	Organisation	Telephone	E-mail
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80	Ssejemba William	UAC	0712996105	
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Appendix 2e. : National Composite Policy Index Questionnaire (Part A)

Part A
[to be administered to government officials]

I. Strategic plan

1. Has your country developed a national multi-sectoral strategy/action framework to combat HIV & AIDS ?
(Multi-sectoral strategies should include, but not limited to, the developed by Ministries such as the ones mentioned under 1.2)

Yes ✓	Period covered : 2007/08 to 2011/12	Not Applicable (N/A)	No
IF NO or N/A, briefly explain.			

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

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

Number of Years : **14**

1.2 Which sectors are included in the multi-sectoral strategy/action framework with a specific HIV budget for their activities ?

Sectors included	Strategy/Action framework		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)	Yes ✓	No	Yes	No ✓
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 ✓
Other – Water and Environment	Yes ✓	No	Yes	No ✓
Other – Trade and Industry	Yes ✓	No	Yes	No ✓

IF NO earmarked budget, how is the money allocated. **Money is allocated at the discretion of the Accounting Officer within Ministry budgets but mainly from projects**

1.3 Does the multi-sectoral strategy/action framework address the following target populations, setting and cross-cutting issues ?

Target populations		
a. Women and girls	**a. Yes ✓**	**No**
b. Young women / Young men	**b. Yes ✓**	**No**
c. Specific vulnerable sub-populations	**a. Yes ✓**	**No**
d. Orphans and other vulnerable children	**b. Yes ✓**	**No**
Settings		
e. Workplace	**e. Yes ✓**	**No**
f. Schools	**f. Yes ✓**	**No**
g. Prisons	**g. Yes ✓**	**No**
Target populations		
h. HIV & AIDS and Poverty	**h. Yes ✓**	**No**
i. Human rights protection	**i. Yes ✓**	**No**
j. PLHIV (PHA) involvement	**j. Yes ✓**	**No**
k. Addressing stigma and discrimination	**k. Yes ✓**	**No**
l. Gender empowerment and/or gender equality	**l. Yes ✓**	**No**

1.4 Were target populations identified through a process of a needs assessment or needs analysis ?

Yes ✓	**No**

IF YES, when was this needs assessment / analysis conducted ? Year : **2005 - 2006**

IF NO how were the target populations identified ?

1.5 What are the target populations in the country ?

General population with special focus on high risk and vulnerable groups. (Youth, Women, Married, Health Workers, Children, OVCs, Discordant couples, Commercial Sex Workers, Armed Forces, Mobile populations, Internally Displaced Persons, fishing communities, PWDs, PHAs, Truckers, Minorities)

1.6 Does the multi-sectoral strategy/action framework include an operational plan ?

Yes	No ✓

1.7 Does the multi-sectoral strategy/action framework or operational plan include :

		Yes	No
a.	Formal programme goals ?	Yes ✓	No
b.	Clears target and/or milestones ?	Yes ✓	No
c.	Detail budget of costs per programmatic area ?	Yes ✓	No
d.	Indications of funding sources ?	Yes ✓	No
e.	Monitoring and Evaluation framework ?	Yes ✓	No

1.8 Has the country ensured "full involvement and participation" of civil society in the development of the multi-sectoral strategy/action framework ?

Active involvement ✓	Moderate involvement	No involvement

IF active involvement, briefly explain how this was done :

Plan developed by HIV & AIDS partnership forum which civil society belong to specific self co-ordinating entities that constitute the partnership i.e. Faith Based Organisations, Private sector, civil society, Persons Having AIDS and the like.

IF NO or MODERATE involvement, briefly explain :

1.9 Has the multi-sectoral strategy/action framework been endorsed by most external development partners (bi-laterals; multi-laterals) ?

By all	Yes ✓	No

1.10 Have external Development Partners (bi-laterals; multi-lateral) aligned and harmonised their HIV & AIDS programmes to the national multi-sectoral strategy/action framework ?

YES, all partners ✓	YES, some partners	No

IF SOME or NO, briefly explain :

2. Has the country integrated HIV & AIDS into its general development plans such as: a) National Development Plans, b) Common Country Assessments/United Nations Development Framework, c) Poverty Reduction Strategy Papers, d) Sector Wide approach ?

YES ✓	No	N/A

2.1 **IF YES**, in which department plans is policy support for HIV & AIDS integrated ?

a) Yes, integrated into the Poverty Eradication Action plan (PEAP) and Poverty Reduction Strategy Papers (PRSP)

2.2 **IF YES**, which policy areas below are included in these development plans ?

✓ Check for policy/strategy included

Policy Area	Development Plans				
	a)	b)	c)	d)	e)
HIV Prevention	✓				
Treatment for opportunistic Infections	✓				
Antiretroviral therapy	✓				
Care and support (including social security or other schemes)	✓				
AIDS impact alleviation	✓				
Reduction of **gender** inequalities as they relate to HIV prevention/treatment, care and / or support	✓				
Reduction of **income** inequalities as they relate to HIV prevention/treatment, care and / or support	✓				
Reduction of stigma and discrimination	✓				
Women's economic empowerment (e.g. access to credit, access to land, training)	✓				
Other:					

3. Has the country evaluated the impact of HIV & AIDS 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/action framework for addressing HIV & AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc ?

Specific for each force	Yes ✓	No

4.1 **IF YES**, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of one or more uniformed services ?

Behavioural change communication	Yes ✓	No
Condom provision	Yes ✓	No
HIV testing and counselling	Yes ✓	No
STI services	Yes ✓	No
Treatment	Yes ✓	No
Care and support	Yes ✓	No
Others : PMTCT	Yes ✓	No

What is the approach taken to HIV testing and counselling ? Is HIV testing voluntary or mandatory (e.g. at environment) ? Briefly explain :

Current Policy Voluntary Counselling and Testing (VCT) for general population and Routine Testing and Counselling (RTC) for in health facilities.

5. Has the country followed up on commitments towards universal access made during the high level AIDS Review in June 2006 ?

Yes ✓	No

5.1 Has the National Strategic Plan / Operational plan and national AIDS budget been revised accordingly ?

Yes ✓	No

5.2 Have the estimates of the size of the main target population sub-groups been updated ?

Yes ✓	No

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

Estimates and projected needs ✓	Estimates only	No

5.4 Is HIV & AIDS 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 sub-groups ?

Yes ✓	No

IF YES, which population sub-groups ?

Children, OVCs, Youth, Women, Married, Discordant couples, PHAs, PWDs, Health Workers, Armed Forces, Mobile populations, Internally Displaced Persons, fishing communities, Commercial Sex Workers, Truckers

(c) **IF YES,** is coverage monitored by geographical area ?

Yes ✓	No

IF YES, at which levels (provincial, district, other) ?

All levels Cross Border, National, Regional, District, Sub-Counties

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

Part of the Global Fund Round 7 proposal, HSSP I and II, NSP,

Yes ✓	No

Overall, how would you rate strategy planning efforts in the HIV & AIDS programmes in 2007 and in 2005 ?

2007	Poor										Good
	0	1	2	3	4	5	6	7	8	9 ✓	10

2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9 ✓	10

Comments on progress made since 2005 :

Emphasized consultation processes and consensus building at sub-regional, national and district.

II. Political support

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

1. Do high officials speak publicly and favourably about AIDS efforts in major domestic fora at least twice a year ?

President/Head of government	Yes ✓	No
Other high officials	Yes ✓	No
Other officials in regions and/or districts	Yes ✓	No

2. Does the country have an officially recognised national multi-sectoral AIDS management/co-ordination body? (National AIDS Council or equivalent) ?

Yes ✓	No

IF NO, briefly explain :

2.1 **IF YES,** when was it created ? Year : **1992**

2.2 **IF YES,** who is the Chair ?

Rt Bishop Emeritus of Kabale, Barnabas R. Halem'Imana

2.3 **IF YES,** does it :

Have terms of reference ?	Yes ✓	No
Have active Government leadership and participation ?	Yes ✓	No
Have a defined membership ?	Yes ✓	No
Include civil society representation ?	Yes ✓	No
IF YES, what percentage ?	33% of the Board	
Include people living with HIV ?	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 action on policy decisions regularly ?	Yes ✓	No
actively promote policy decision ?	Yes ✓	No
provide opportunity for civil society to influence decision-making ?	Yes ✓	No
strengthen donor co-ordination to avoid parallel funding and duplication of effort in programming and reporting ?	Yes ✓	No

3. **Does the country have a national AIDS body or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV & AIDS strategies/programmes ?**

Yes ✓	No

3.1 **IF YES,** does it include ?

Terms of reference	Yes ✓	No
Define membership	Yes ✓	No
Action plan	Yes ✓	No
Functional Secretariat	Yes ✓	No
Regular meetings	Yes ✓	No
	Frequency of meetings : **Monthly**	

IF YES, what are the main achievements ?

- **Development of a Civil Society Fund**
- **Development of the National Strategic Plan (NSP) 2007/08 to 2011/12**
- **Developed the Performance Measurement and Management Plan for NSP 2007/08 to 2011/12**
- **Increased resource mobilisation and alignment to national priorities including Global Fund round 7**
- **Sector Spending Assessment**
- **Development of the long term institutional arrangements**
- **Review of the NSF 2000/01 to 2005/06**
- **Review of the M&E framework for NSF 2000/01 to 2005/06**

NSPPI and indicator framework for OVC

IF YES, what are the main challenges for the work of this body ?

Resource Mobilisation for Universal Access remains a challenge in an increasingly demanding environment

Operationalizeation and Implementation of the M&E for the NSP a challenge

Mainstreaming in Sectoral Development Programmes still a challenge

Co-ordination at decentralised levels

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

Percentage :

5. What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organisations ?

Information on priority needs and services	Yes ✓	No
Technical guidance/materials	Yes ✓	No
Drugs/supplies procurement and distribution	Yes ✓	No
Co-ordination with other implementing partners	Yes ✓	No
Capacity-building	Yes ✓	No
Other : Drugs/supplies procurement and distribution in project support mode		

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

Yes ✓	No

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

Yes	No ✓

6.2 **IF YES,** which policies and legislation were amended and when ?

Policy/Law :	Year

Overall, how would you rate political support for HIV & AIDS programmes in 2007 and in 2005 ?

2007	Poor					Good				
	0	1	2	3	4	5	6	7	8	9	✓ 10

2005	Poor					Good				
	0	1	2	3	4	5	6	7	8	9	✓ 10

Comments on progress made since 2005 :

Sustained political support at national and decentralised response
Popularity of the partnership arrangement

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 policy/strategy included

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	✓
Use clean needles and syringes	✓
Fight violence against women	✓
Greater acceptance and involvement of people living with HIV	✓
Greater involvement of men in reproductive health programmes	✓
Other :	

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

2.1 Is HIV education part of the curriculum in ?

Primary school ?	Yes ✓	No
Secondary school ?	Yes ✓	No
Teacher training ?	Yes ✓	No

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for the 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 vulnerable sub-populations ?

Yes ✓	No

IF NO, briefly explain :

3.1 **IF YES**, which sub-populations and what elements on HIV prevention do the policy/strategy address ?

✓ Check for policy/strategy included

	IDU	MSM	Sex workers	Clients of sex workers	Prison inmates	Other sub-populations
Targeted information on risk reduction and HIV education	N/A	N/A	✓	✓	✓	Youth, Fishing community, Uniformed forces,
Stigma and discrimination reduction	N/A	N/A			✓	Youth
Condom promotion	N/A	N/A	✓	✓	✓	Youth
HIV testing and counselling	N/A	N/A	✓	✓	✓	Youth
Reproductive health, including STI prevention and treatment	N/A	N/A	✓	✓	✓	Youth
Vulnerability reduction (e.g. income generation)	N/A	N/A	✓	N/A	✓	Youth
Drug substitution therapy	N/A	N/A	N/A	N/A	N/A	
Needle and syringe exchange	N/A	N/A	N/A	N/A	N/A	

Overall, how would you rate Policy efforts in support of HIV prevention in 2007 and in 2005 ?

2007	Poor									Good
	0	1	2	3	4	5	6	7	8	✓9	10

2005	Poor									Good
	0	1	2	3	4	5	6	7	✓8	9	10

4. Has the country identified the districts (or equivalent geographical/decentralised level) in need of HIV prevention programmes ?

Yes ✓	No

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

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts in need ?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	The activity is available in		
	all districts	most districts	some districts
Blood safety	✓		
Universal precautions in health care settings	✓		
Prevention of mother-to-child transmission of HIV	✓		
IEC on risk reduction	✓		
IEC on stigma and discrimination reduction	✓		
Condom promotion	✓		
HIV testing and counselling	✓		
Harm reduction for injecting drug users			
Risk reduction for men who have sex with men			
Risk reduction for sex workers			✓
Programmes for other vulnerable sub-populations	✓		
Reproductive health services including STI prevention and treatment	✓		
School-based AIDS education for young people	✓		
Programmes for out-of-school young people	✓		
HIV prevention in the workplace			✓
Other			

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005 ?

2007	Poor					Good					
	0	1	2	3	4	5	6	7	8	✓9	10

2005	Poor					Good					
	0	1	2	3	4	5	6	7	8	✓9	10

Comments on progress made since 2005 : **Reduction in efforts**

IV. 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 counselling, psychosocial care, and home and community-based care).

Yes ✓	No

1.1 **IF YES,** does it give sufficient attention to barriers for women, children and most-at-risk populations ?

Yes ✓	No

2. Has the country identified the districts (or equivalent geographical/decentralised level) in need of HIV & AIDS treatment, care and support services ?

Yes ✓	No	N/A

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

IF YES, to what extent have the following HIV & AIDS treatment, care and support services been implemented in the identified districts in need ?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV treatment, care and support services	The activity is available in		
	all districts	most districts	some districts
Antiretroviral therapy	✓		
Nutritional care			✓
Paediatric AIDS treatment			✓
Sexually transmitted infection management	✓		
Psychosocial support for people living with HIV and their families	✓		
Home-based care			✓
Palliative care and treatment of common HIV-related infections			✓
HIV tested and counselling for TB patients	✓		
TB screening for HIV-infected people		✓	
TB preventive therapy for HIV-infected people		✓	
TB infection control in HIV treatment and care facility		✓	
Cotrimoxazole prophylaxis in HIV-infected people	✓		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)			✓
HIV treatment services in the workplace or treatment referral systems through the workplace			✓
HIV care and support in the workplace (including alternative working arrangements)			✓
Other			

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 critical commodities, such as antiretroviral drugs, condoms and substitution drugs?

Yes	No ✓

4.1 **IF YES,** for which commodities ?

Overall, how would you rate the efforts in Treatment, Care and Support of HIV & AIDS programme ?

2007	Poor									Good
	0	1	2	3	4	5	6	7	8	✓9	10

2005	Poor									Good
	0	1	2	3	4	5	6	7	8	✓9	10

Comments on progress made since 2005 :

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

Yes ✓	No	N/A

5.1 **IF YES,** is there an operational definition for OVC in the country ?

Yes ✓	No

5.2 **IF YES,** does the country have a national action plan specifically for OVC ?

Yes ✓	No

5.3 **IF YES,** does the country have an estimate of OVC being reached by existing interventions ?

Yes ✓	No

IF YES, what percentage of OVC is being reached ? **23%**

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children ?

2007	Poor									Good
	0	1	2	3	4	5	6	✓7	8	9	10

2005	Poor									Good
	0	1	2	3	4	5	✓6	7	8	9	10

Comments on progress made since 2005 :

Improve NGO participation in service delivery and coverage. But more efforts needed in OVCs service delivery.

V. Monitoring and Evaluation

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

Yes ✓	No

1.1 **IF YES,** was the M&E plan endorsed by key partners in M&E ?

Yes ✓	No

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

Yes ✓	No

1.3 **IF YES,** have key partners aligned and harmonised their M&E requirements (including indicators) with the national M&E plan ? **(M&E plan not yet disseminated)**

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

2. Does the Monitoring and Evaluation plan include ?

a data collection and analysis strategy ?	Yes ✓	No
behavioural surveillance ?	Yes ✓	No
HIV surveillance ?	Yes ✓	No
a well-defined standardised set of indicators ?	Yes ✓	No
Guidelines on tools for data collection ?	Yes ✓	No
a strategy for assessing quality and accuracy of data ?	Yes ✓	No
a data dissemination and use strategy ?	Yes ✓	No

3. Is there a budget for the M&E plan ?

Yes ✓	Years covered:	In progress	No

3.1 **IF YES,** has funding been secured ?

Yes ✓ (partly)	No

4. Is there a functional M&E unit or department ?

Yes ✓	In progress	No

IF NO, what are the main obstacles to establishing a functional M&E Unit/Department ?

4.1 **IF YES,** is the M&E Unit/Department based ?

in the NAC (or equivalent) ?	Yes ✓	No
in the Ministry of Health ?	Yes	No ✓
elsewhere ?		

4.2 **IF YES,** how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department ?

Number of permanent staff :		
Position : **M&E Advisor (UNAIDS)**	✓ Full time / Part time ?	Since when ?: **2004**
Position : **M&E Co-ordinator**	✓ Full time / Part time ?	Since when ?: **July 2007**
Position : **M&E Officer**	✓ Full time / Part time ?	Since when ?: **June 2001**
Position : **Data Manager**	✓ Full time / Part time ?	Since when ?: **Nov 1999**

Number of temporary staff :	

4.3 **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/Department for review and consideration in the country's national reports ?

Yes ✓	No

IF YES, does this mechanism work ? What are the major challenges ? Compliance of ministries to report is still a challenge but gradually improving. This is being addressed by dissemination of M&E plan and guidelines with a specific tool for reporting by ministries. UAC will be more proactive in interfacing with them.

4.4 **IF YES,** to what do UN, bi-laterals and other institutions share their M&E results ?

Low					High
0	1	2	3	4✓	5

5. Is there a M&E Committee or Working Group that meets regularly to co-ordinate M&E activities ?

No	Yes, but met irregularly	✓ Yes, meets regularly

IF YES, Date last meeting : **21st December, 2007**

5.1 Does it include representation from civil society, including people living with HIV ?

Yes ✓	No

IF YES, describe the role of civil society representatives and people living with HIV in the working group ? **Members of the core team and they take part in policy and program implementation decision including indicator definition and data collection strategies.**

6. Does the M&E Unit/Department manage a central national database ?

Yes ✓	No	N/A

6.1 **IF YES,** what type is it ? **Microsoft Access linked to ArcView GIS**

6.2 **IF YES,** does it include information about the content, target populations and geographical coverage of programmatic activities, as well a s their implementing organisations ?

Yes ✓	No

6.3 Is there a functional Health Information System ?

National level	✓ Yes	No
Sub-national level **IF YES,** at what level(s) ? **District Health Unit**	✓ Yes	No

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

✓ Yes	No

7. To what extent is M&E data used in planning and implementation ?

Low					High
0	1	2	✓ 3	4	5

What are the examples of data use ?
Projections, Planning, Decision Making, Costing, Budgeting, Trend Analysis and Comparisons, Resource Management and Equitable Distribution

What are the challenges to data use ?
Data Completeness, Accuracy and Timeliness

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

At national level ?	Yes	No ✓
IF YES, Number of individuals trained :		
At sub-national level ?	Yes	No
IF YES, Number of individuals trained :		
Including civil society ?	Yes	No
IF YES, Number of individuals trained :		

Overall, how would you rate the M&E efforts of the AIDS programme in 2007 and in 2005 ?

2007	Poor									Good
	0	1	2	3	4	✓5	6	7	8	9	10

2005	Poor										Good
	0	1	2	3	4	✓5	6	7	8	9	10

Comments on progress made since 2005 :
Reviewed the previous M&E framework and developed the PMMP

Appendix 2f. : National Composite Policy Index Questionnaire (Part B)

Part B
[to be administered to representatives from nongovernmental organisations, bilateral agencies and UN organisations]

I. Human rights

1. Does the country have laws and regulations that protect people living with HIV against discrimination ? (such as general non-discrimination provisions or provisions for vulnerable sub-populations ?

Yes ✓	No

1.1 **IF YES,** specify : General provisions exist; there is a constitutional guarantee of equality that prohibits discrimination on the basis of sex, race, religion, age, gender or social status.

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

Yes ✓	No

2.1 **IF YES,** for which sub-populations ? As above

Women	Yes ✓	No
Young people	Yes ✓	No
IDU	Yes	No
MSM	Yes	No
Sex Workers	Yes	No
Prison inmates	Yes ✓	No
Migrants/mobile populations (including treaties between countries)	Yes ✓	No
Other : PWDs, Children's Act, Immigration Act, UPE ?? **The provision of Article 21 of the Constitution guarantees non-discrimination on the basis of age, gender, religion, race or social status which covers all the above groups.**		

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

There are no specific enforcement mechanisms for these guarantees; it follows the general provisions for other articles in the Bill of Rights

Mechanisms are in place but there is lack of enforcement, (awareness; logistics & HR lacking, exist corruption)

IF YES, Describe any systems of redress put in place to ensure the laws are having their desired effect:

An individual who is aggrieved or who believes that he has been a victim of discrimination can either petition the Constitutional Court or lodge a complaint with the Uganda Human Rights Commission, equal opportunities commission as provided under article 50 and 52 of the Constitution respectively.

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

Yes ✓	No

3.1 **IF YES,** for which sub-populations?

Women	Yes	No
Young people	Yes	No
IDU	Yes ✓	No
MSM	Yes ✓	No
Sex Workers	Yes ✓	No
Prison inmates	Yes	No
Migrants/mobile populations	Yes	No
Other: **For individuals living with HIV & AIDS, PWDs (deaf in communication, blind in reading),**		

IF YES, briefly describe the content of these laws, regulations or policies and how they pose barriers :

THE PENAL CODE AMENDMENT ACT PROVIDES THAT WHEN AN INDIVIDUAL LIVING WITH HIV & AIDS AND WHO KNOWS HIS/HER STATUS COMMITS THE OFFENCE OF DEFILEMENT, THEY ARE GUILTY OF AGGRAVATED DEFILEMENT WHICH IS A CAPITAL OFFENCE. KNOWLEDGE OF ONE'S SERO STATUS IS AN ESSENTIAL ELEMENT OF THE CRIME. HIV & AIDS SUPPORT GROUPS AND VICTIMS HAVE ARGUED THAT THIS WOULD DETER PEOPLE FROM TESTING OR ACCEPTING TREATMENTS AS ANY OF THESE MAYBE EVIDENCE OF KNOWLEDGE OF ONE'S STATUS. LAW PROHIBITS HOMOSEXUALS AND SEX WORKERS.

Some laws silent on PWDs (deaf in communication, blind in reading),

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

Draft National AIDS Policy, Teachers workplace policy, VCT policy

Yes ✓	No

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

Yes ✓	No

IF YES, briefly describe this mechanism

THERE IS PROVISION FOR DOCUMENTATION OF GENERAL ISSUES RELATED TO HIV & AIDS. HOWEVER NOT AWARE OF ANY ORGAN THAT CARRIES OUT DOCUMENTATION OF DISCRIMINATION AND RIGHTS VIOLATIONS OF PEOPLE LIVING WITH HIV & AIDS.

6. Has the Government, through political and financial support, involved most-at-risk populations in governmental HIV-policy design and programme implementation ?

Yes ✓	No

IF YES, describe some examples

For instance in the development of the National Policy Guidelines for HIV Counselling and Testing wide consultations were made with most sectors of the population. OVC desk in …

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

HIV prevention service	Yes ✓	No
Antiretroviral treatment	Yes ✓	No
HIV-related care and support interventions	Yes ✓	No

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies:

One of the greatest constraints have been on availability of drugs, affordability, distribution of drugs and condoms etc, carrying out of testing and counselling in areas where the Government does not have functioning health facilities.

There is increasing involvement of the private sector, distribution of drugs through the National Medical Stores (although this has not proved effective). Involvement of the UAC to coordinate HIV & AIDS related efforts and through the Presidential Initiative and other private measures (like the MildMay centre, support from the Elizabeth Glacier foundation-paediatrics) there is free HIV & AIDS treatment which has enabled access to a large number of people who would otherwise be unable to afford treatment.

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

Yes ✓	No

9.1 Are there differences in approaches for different most-at-risk populations?

Yes ✓	No

IF YES, briefly explain the differences :

Provision of cotrimoxazole prophylaxis to all children exposed to HIV & AIDS until it is ruled out, special programs (most privately run) in slum areas to provide testing and counselling to prostitutes. There are also provision of youth friendly services.

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 AIDS 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 committee include representatives of the civil society and people living with HIV ?

National council of science and technology and institutional committees

Yes ✓	No

IF YES, describe the effectiveness of this review committee :

There are sectoral workplace policies in different government sectors like Education, Works and Housing

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

- Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, laws reform commissions, watchdogs and ombudspersons which consider HIV-related issues within their work

Yes ✓	No

- Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in such areas such as housing and employment

Yes	No ✓

- Performance indicators or bench marks for

a) compliance with human rights standards in the context of HIV efforts

Yes	No ✓

b) reduction of HIV-related stigma and discrimination

Yes	No ✓

IF YES, on any of the above questions, describe some examples : There is a desk in the Human Rights Commission, UGANET and AIDS Control Programme - Ministry of Justice

13. Have members of the judiciary (including labour courts/employment tribunals) been trained/sensitised to HIV & AIDS and human rights issues that may come up in the context of their work ?**

AIDS Control Programme - Ministry of Justice

Yes ✓	No

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

- Legal aid systems for HIV & AIDS casework

FIDA and Legal AID, public defender

Yes ✓	No

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

FIDA and Legal AID

Yes ✓	No

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

Yes ✓	No

15. Are there programmes designed to change societal attitudes of stigmatisation associated with HIV & AIDS to understanding and acceptance ?

Yes ✓	No

IF YES, what types of programmes ?

Media	Yes ✓	No
School education	Yes ✓	No
Personalities regularly speaking out	Yes ✓	No
Other : World AIDS Campeign, Philly Lutaaya and Rev. Byamugisha, PHA networks, post test clubs, NGOs and CSOs		

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV & AIDS in 2007 and in 2005 ?

2007	Poor									Good
	0	1	2	3	✓4	5	6	7	8	9	10

2005	Poor									Good
	0	1	2	3	✓4	5	6	7	8	9	10

Comments on progress made since 2005 :

Uganda Government's efforts are all focused towards the physical; curbing the spread of AIDS, providing treatment and care. Very little efforts have are being made towards the rights aspect. There have been repeated reports of discrimination for instance of HIV+ mothers and babies in government hospitals like Mulago yet no tangible actions have been taken by the Government. HIV & AIDS policy is also still draft

Overall, how would you rate the efforts to enforce the existing policies, laws and regulations in 2007 and in 2005 ?

2007	Poor									Good
	0	1	2	3	✓4	5	6	7	8	9	10

2005	Poor									Good
	0	1	2	✓3	4	5	6	7	8	9	10

Comments on progress made since 2005 :

As above. No deliberate efforts are being made to promote the rights of people living with HIV & AIDS-they are not viewed within the framework of a minority/special interest group deserving of or requiring affirmative actions.

II. Civil Society participation

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

Low — High

0	1	2	✓3	4	5

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

Low — High

0	1	2	3	4	✓5

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included ?

a. In both the National Strategic Plans and National Reports ?

Low — High

0	1	2	3	4	✓5

b. In National Reports ?

Low — High

0	1	2	✓ 3	4	5

4. Has your country included civil society in a National Review of the National Strategic Plan ?

Yes ✓	No

IF YES, when was the review conducted ? Year : 2006/2007 ongoing

5. To what extent have is the civil society sector representation in HIV-related efforts inclusive of its diversity ?

Low — High

0	1	2	3	✓4	5

List the types of organisations representing civil society in HIV & AIDS efforts :

1. People living with HIV
2. International Organisations
3. National NGOs
4. Community Based Organisations
5. Faith based Organisations
6. *** SCEs*

6. To what extent is the 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

Overall, how would you rate the efforts to increase civil society participation in 2007 and in 2005 ?

2007	Poor									Good
	0	1	2	3	4	5	6	7	8	✓9	10

2005	Poor									Good
	0	1	2	3	4	5	6	7	✓8	9	10

Comments on progress made since 2005 :

Member of Civil Society more organised and united, more training and AIDS competence among the civil Society Actors.

III. Prevention

1. Has the country identified the districts (or equivalent geographical/decentralised level) in need of HIV prevention programmes ?

Yes ✓	No

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

IF YES, to what extent have the following HIV & AIDS prevention programmes been implemented in identified districts in need ?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	The activity is available in		
	all districts	most districts	some districts
Blood safety	✓		
Universal precautions in health care settings			✓
Prevention of mother-to-child transmission of HIV		✓	
IEC on risk reduction	✓		
IEC on stigma and discrimination reduction			✓
Condom promotion	✓		
HIV testing and counselling	✓		
Harm reduction for injecting drug users	N/A within current legal		
Risk reduction for men who have sex with men	N/A within current legal		
Risk reduction for sex workers			✓
Programmes for other vulnerable sub-populations			✓
Reproductive health services including STI prevention and treatment	✓		
School-based AIDS education for young people	✓		
Programmes for out-of-school young people			✓
HIV prevention in the workplace			✓
Other			

Overall, how would you rate the efforts to increase civil society participation in 2007 and in 2005 ?

2007	Poor									Good
	0	1	2	3	4	5	6	7	✓8	9	10

2005	Poor									Good
	0	1	2	3	4	5	6	✓ 7	8	9	10

Comments on progress made since 2005 :

IV. Treatment, care and support

1. Has the country identified the districts (or equivalent geographical/decentralised level) in need of HIV & AIDS treatment, care and support services ?

Yes ✓	No

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

IF YES, to what extent have the following HIV & AIDS treatment, care and support services been implemented in the identified districts in need ?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV treatment, care and support services	The activity is available in		
	all districts	most districts	some districts
Antiretroviral therapy		✓	
Nutritional care			✓
Paediatric AIDS treatment			✓
Sexually transmitted infection management	✓		
Psychosocial support for people living with HIV- and their families		✓	
Home-based care		✓	
Palliative care and treatment of common HIV-related infections			✓
HIV tested and counselling for TB patients		✓	
TB screening for HIV-infected people		✓	
TB preventive therapy for HIV-infected people			✓
TB infection control in HIV treatment and care facility			✓
Cotrimoxazole prophylaxis in HIV-infected people		✓	
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)			✓
HIV treatment services in the workplace or treatment referral systems through the workplace			✓
HIV care and support in the workplace (including alternative working arrangements)			✓
Other programmes :			

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2007 and in 2005 ?

2007	Poor									Good
	0	1	2	3	4	5	6	✓7	8	9	10

2005	Poor									Good
	0	1	2	3	4	5	6	✓7	8	9	10

Comments on progress made since 2005 :

Indicator overrated in 2005 report.

2. What percentage of the following HIV programmes or services is estimated to be provided by civil society ?

Prevention for youth	<25 %	25 – 50 %	50 – 75 %	✓ >75 %
Prevention for vulnerable sub-populations				
- IDU	<25 %	25 – 50 %	50 – 75 %	>75 %
- MSM	<25 %	25 – 50 %	50 – 75 %	>75 %
- Sex Workers	<25 %	25 – 50 %	50 – 75 %	✓ >75 %
Counselling and Testing	<25 %	25 – 50 %	✓ 50 – 75 %	>75 %
Clinical services (OI/ART)	<25 %	✓ 25 – 50 %	50 – 75 %	>75 %
Home-based care	<25 %	25 – 50 %	50 – 75 %	✓ >75 %
Programmes for OVC	<25 %	25 – 50 %	50 – 75 %	✓ >75 %

3. Does the country have a policy or strategy to address the additional HIV- and AIDS-related needs of orphans and other vulnerable children (OVC) ?

Yes ✓	No	N/A

3.1 **IF YES,** is there an operational definition for OVC in the country ?

Yes ✓	No

3.2 **IF YES,** does the country have a national action specifically for OVC ?

Yes ✓	No

3.3 **IF YES,** does the country have an estimate of OVC being reached by existing interventions ?

Yes ✓	No

IF YES, what percentage of OVC is being reached ? 10.7 %

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