FOLLOW-UP TO THE DECLARATION OF COMMITMENT ON HIV/AIDS

(UNGASS)

UGANDA COUNTRY REPORT

January - December 2002

Uganda AIDS Commission

March 2003

Table of Contents

Acronyms

ACP	AIDS Control Project
ACRiA	AIDS Care Research in Africa
ADA	African Dialogue for AIDS Care
AIDS	Advanced Immuno-Deficiency Syndrome
AIM	AIDS/HIV Integrated Model
ANC	Ante Natal Clinic
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Vaccine
AYA	African Youth Alliance
BAT	British American Tobacco
BOU	Bank of Uganda
CBO	Community Based Organisation
CCF	Country Co-operation Framework
CSW	Commercial Sex Workers
DHS	Demographic Health Survey
DRI	District Response Initiative
EdData	Educational Data
EPID	Epidemiology
FBO	Faith Based Organisation
FUE	Federation of Uganda Employers
GOU	Government of Uganda
HIV	Human Immuno-Deficiency Virus
IEC	Information Education Communication
JCRC	Joint Clinical Research Centre
MAP	Multi-sectoral AIDS Programme
M&E	Monitoring and Evaluation
MOE	Ministry of Education
MOFPED	Ministry of Finance Planning and Economic Development
MOGLSD	Ministry of Gender Labour and Social Development
MOH	Ministry of Health
MRC	Medical Research Council
NGO	Non Governmental Organisation
NSF	National Strategic Framework
NSSF	National Social Security Fund
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PEAP	Poverty Eradication Action Plan
PHA	People with HIV/AIDS
PIASCY	Presidential Initiative AIDS Strategy for Communication to the Youth
PMTCT	Prevention of Mother To Child Transmission
SCE	Self-Coordinating Entities
SHEP	School Health Education Project
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TASO	The AIDS Support Organisation
UAC	Uganda AIDS Commission
UACP	Uganda AIDS Control Project
UBCOA	Uganda Business Council on AIDS

UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCST	Uganda National Council for Science and Technology
UNICEF	United Nations Children Fund
UNMHCP	Uganda National Minimum Health Care Package
USAID	United States Agency for International Development
UVRI	Uganda Viral Research Institute
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

I. STATUS AT A GLANCE

NATIONAL COMMITMENT AND ACTION	
1. National Composite Policy Index	75 out of 100 points
2. Government funds spent on HIV/AIDS	2.7 billion Uganda Shillings = US$1.5m (1US$=Ushs1,800) *(Source: MOFPED (2001), Approved Estimates of Revenue and Expenditure: Recurrent & Development 2001/2002)*
NATIONAL PROGRAMME AND BEHAVIOUR	
Prevention	
3. Percentage of schools with teachers and who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year	Information not available as a proportion. *However, 15,000 primary teachers were trained and equipped to teach life-skills based HIV/AIDS education under the School Health Education Project (SHEP) jointly funded by UNICEF and the Government of Uganda. Subsequently every Government primary school received a SHEP teacher.*
4. Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes	17% Combined private and public 20% Private Source: Comparison of a list of 25 largest employers, identified through amount of their contributions to NSSF, and an inventory from a survey of workplace HIV/AIDS interventions among UBCOA members. The public sector ministries have not yet established HIV/AIDS Workplace policies or interventions.
5. Percentage of HIV+ pregnant women receiving a complete course of ARV prophylaxis	4.6% Estimate based on Crude Birth Rate 47.3/1000 in 24,700,000 population Expected pregnancies per year 1,168,310 HIV prevalence in pregnant women 6.5%. Estimated no of pregnant women with HIV 75,940. Pregnant Women currently on ARVs for PMTCT 3525. *(Sources: UBOS (2002), Uganda Population and Housing Census: Provisional Results, and MOH (2002) HIV/AIDS Surveillance Report)*
Care and treatment	
6. Percentage of Patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled (based on a 1998 evaluation).	1) History taking 65% 2) Examination 5 3% 3) Diagnosis and treatment 56% 4) Advised condom use & partner referral 28% 5) Properly managed according to national guidelines 20.6% *(Source: Kirungi W et al (1999), Midterm Evaluation of STD Case Management in Primary Health Care Facilities in Uganda)*
7. Percentage of people with advanced HIV infection receiving ARV combination therapy	6.3% Calculated based on 10,000 people currently on ARV therapy in the country. 1,050,555 people living with HIV/AIDS and an estimated 15% or 157,583 people with advanced HIV. *(Sources: Zainab A. et.al (2002), A Report on Rapid Assessment of Access to Antiretroviral Therapy in Uganda, 2002; MOH (2002) HIV/AIDS Surveillance Report)*

Knowledge and Behaviour	
Percentage of people 15- 24 years of age with knowledge of two ore more programmatically important ways of preventing the sexual transmission of HIV, i.e. abstinence, use of condom and limiting number of sexual partners. *(Target: 90% by 2005; 95% by 2010)*	Males 89.6% Females 80.2% *(Source: UDHS 2001/2002)*
8. Percentage of people aged 15 –24 reporting the use of a condom during sexual intercourse with a non-regular partner	Males 61.9% Females 44.2% *(Source: UDHS 2001/2002)*
9. Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV (where applicable)	Data not available
Impact alleviation	
10. Ratio of orphaned to non-orphaned children 6-17 years old (Not the UNGASS indicator age group 10- 14 limit for which there was no information) Non-orphaned (6 –12) in primary school	% in school % out of school Single orphans (6 -17) 82.6 17.4 Double orphans (6 –17) 82.9 17.1 Non-orphaned (6 –12) 87 13 *(Sources: UNICEF (2001), Baseline Study National Report: 2001-2005 Government of Uganda-UNICEF Country Programme and UBOS (2002) Uganda DHS EdData Survey 2001)*
NB. The ratio could not be accurately calculated because of the differences in the age groups. However, the Situation Analysis of Orphans in Uganda carried out in 2001/2 also found no significant difference in school attendance rate between orphans and non- orphans. It attributed this finding to the free Universal Primary Education programme (Wahweya, et. Al. 2002). Earlier studies had found significant differences with the orphans clearly disadvantaged.	(*Source: Wakhweya, A., et. al (2002), Situation Analysis of Orphans in Uganda)*
Percentage of children less than 15 years old who are orphans	*12%* *(UDHS 2000 – 2001)*
In Uganda an orphan is defined as a child under 18 years old who has lost, at least, one of the biological parents. Accordingly, the percentage of children less than 18 years old who are orphans:	14% *(UDHS 2000 – 2001)*
IMPACT	
11. Percentage of people aged 15-24 years of age who are HIV infected (*Target 25% reduction in most affected countries by 2005; 25% reduction globally by 2010)*	8.7% among 15 – 24 age group 6.3% among 15 -19 age group 11.1% among 20 – 24 Sources. *MOH HIV/AIDS 2002 Surveillance Report on HIV Prevalence among ANC attendees at St. Mary's Hospital, Gulu.* Proportion of females 15 – 24 in urban residence 15%. *Source . Uganda Bureau of Statistics 2002 Statistical Abstract*
12. Percentage of infants born to HIV infected mothers who are infected *(Target 20% reduction by 2005; 50 % reduction by 2010)*	27.5% (without any intervention) 27.0% (with ARV therapy for PMTCT) (*Source: MOH Policy for Reduction of MTCT in Uganda , 2001.)*

II. Overview of the HIV/AIDS epidemic.

HIV Prevalence in adults

The Uganda STD/AIDS control programme monitors HIV infection using 20 sentinel surveillance sites that are geographically distributed to represent all parts of the country. The sites are based in antenatal clinics in hospitals and one STD referral clinic in the country.

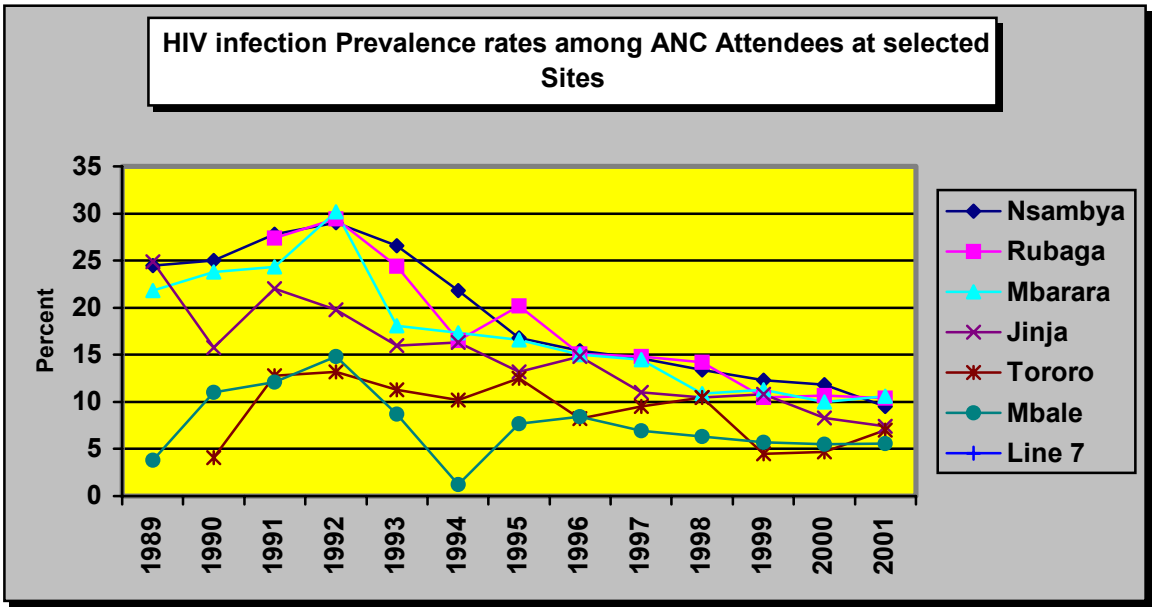
The sentinel surveillance protocol involves the collection for HIV testing of residual aliquots of blood samples from antenatal and STD clients providing blood samples for routine care. 250 – 600 blood samples are collected quarterly from each of the sentinel sites using unlinked anonymous methodologies. The samples are tested at the Uganda Virus Research Institute.

The Surveillance Unit of the STD/AIDS control programme collates STD/HIV/AIDS surveillance data from the different sources. The data that were available for the age group 15 –24 are from one rural hospital and may not be representative of the situation in the country.

Table 2: HIV prevalence at a glance

Percent of young people 15-24 years of age who are HIV infected *(Target 25% reduction in most affected countries by 2005; 25% reduction globally by 2010)*	8.7% among 15 – 24 age group 6.3% among 15 -19 age group 11.1% among 20 – 24 Sources. *MOH HIV/AIDS 2002 Surveillance Report on HIV Prevalence among ANC attendees at St. Mary's Hospital, Gulu.* Proportion of females 15 – 24 in urban residence 15%. *Source . Uganda Bureau of Statistics 2002 Statistical Abstract*
Percent of infants born to HIV infected mothers who are infected* *(Target 20% reduction by 2005; 50% reduction by 2010)*	27.5% (without any intervention) 27.0% (with ARV treatment for PMTCT) (*Source: MOH Policy for Reduction of MTCT in Uganda July 2001)*
NB. No national study has actually been done to verify the reduction in incidence of HIV in the new born as a result of ARV therapy for PMTCT.	

Figure 1: HIV Infection Prevalence Rates Among ANC Attendees at Selected Sites



Source HIV/AIDS Surveillance Report, June 2002 MOH/UAC programme

According to the HIV/AIDS Surveillance Report 2002, HIV prevalence in an urban hospital fell from 9% in 2000 to 8.2% in 2001 and from 12.2% in 2000 to 6.7% in 2001 among the age 15 –19

and 20 – 24 year age groups respectively. The over all antenatal prevalence rate in 2001 was 6.5% . The rates for urban and rural sites were 8.8% and 4.2% respectively.

According to the 12th MRC/UVRI Cohort Prevalence Survey, the crude HIV prevalence in adults aged 13 and above in the study villages ranged from 2.8% to 8.3%. The overall HIV-1 prevalence was 5.4% in 2001 compared 5.8% in 2000. The age standardised HIV-1 prevalence for the old and new cohort villages were 5.6% and 5.2% respectively compare to 5.6% and 6.1% in 2000. The median age of all HIV positive and negative adult males was 35 and 24 years respectively while for females it was 31 and 26 years. The median age at first sex among HIV positive and negative males was 18 and 20 years respectively while for females it was 16 and 17 years.

HIV Prevalence in Children.

In a 2001 survey among 2,627 children, the median age for both males and females seen was 3 years. The overall HIV-1 prevalence among the children was 1.4% made up as follows: 1.7% in the 0-1, 0.8% in 2-4; 1.7% in the 5-12 year old.

Table 3 Child HIV-1 serostatus by age groups

Age Group	Total children bled	HIV Positive			HIV prevalence
		Male	Female	Total	
0-1	712	5	7	12	1.7
2-4	718	5	1	6	0.8
5-12	699	5	7	12	1.7
Total	2,129	15	15	30	1.4

The Government policy and strategy on PMTCT focuses on VCT, ART for PMTCT, infant feeding, supportive interventions for mothers and infants and community education. However, PMTCT is still only benefiting a small fraction of HIV positive pregnant mothers and has hardly made any impact on infection rates among infants born to HIV positive mothers. Only 3525 HIV positive pregnant women are currently on ART for PMTCT.

III National Response to the HIV/AIDS Epidemic.

1 National Commitment and Action

a) Increased resources

Table 4: National Commitment at a glance	
National Composite policy index	75 out of 100 points
Government funds spent on HIV/AIDS	2.7 billion Uganda Shillings = US$1.5m (1US$=Ushs 1,800) *(Source: MOFPED (2001), Approved Estimates of Revenue and Expenditure: Recurrent & Development 2001/2002)*

Uganda Government financial commitment to HIV/AIDS activities increased approximately four fold from Uganda Shillings 633.5 million in 2000/2001 fiscal year to Uganda Shillings 2.7 billion in fiscal year 2001/2002. Although this figure appears large, when seen in context it is still only approximately $0.06 per capita and 0.5% of total budgetary allocation for 2001/2 fiscal year. It should also be noted that currently it is not possible to disaggregate donor budget support from direct government input. The 2.7 billion shillings, therefore, includes budgetary support provided by Uganda's development partners. Furthermore, as Uganda progressively moves toward mainstreaming HIV/AIDS it will become increasingly difficult to disaggregate commitment for HIV/AIDS from sectoral commitments. Funds locally raised by individual districts are not included in centrally administered allocations.

It is worth noting that the US$ 5.60m shown under donors in Table 4 below is a World Bank loan for the Multi-sectoral AIDS Programme (MAP) while the UShs. 800m is counterpart fund provided by the Uganda Government to match the World Bank loan.

Table 5: Government of Uganda Funds for HIV/AIDS

Programme/Project	2000/2001		2001/2002	
	Donors (US$ m)	GOU (Shs m)	Donors (US$ m)	GOU (Shs m)
UAC Secretariat	-	108.50	-	280.00
Uganda AIDS Control Project	-	-	5.60*	800.00
ACP-EPID/Surv/Res	1.25	-	-	-
HIV/AIDS & Right to Self Protection	1.34	-	-	207.90
Strategies for HIV/AIDS & Girl Education	-	-	-	420.00
Decentralised HIV Testing & Counselling	1.60	525.00	3.00	-
Sexually Transmitted Infections	-	-	4.30	1,000.00
AIDS Palliative Care Project	0.54	-	0.04	-
Support to TASO	0.87	-	1.28	-
Totals	**5.6**	**633.50**	**14.22**	**2,707.90**

Source: Adapted from MOFPED Development Expenditure 2000/1 & 2001/2

Segregation of the 2.7 billion shillings into the UNGASS specified categories (STD control activities, HIV prevention, HIV/AIDS clinical care and treatment and, HIV/AIDS impact mitigation) was not possible as the expenditures had not been itemised according to this format. Furthermore, the UNGASS specification did not include funding for coordination activities, which constituted approximately 10% of Government allocation for 2001/2002. UAC has however, recently designed a Resource Tracking System, which incorporates the above categories, including coordination, and will be reflected in the 2005 UNGASS report.

b) Expanded Partnership

The environment in which the national HIV/AIDS response is taking place in Uganda has changed considerably over the past few years:

- The number of active partners has increased several fold.
- New initiatives, strategies and interventions have been introduced, notably in the area of care with the introduction of anti-retroviral therapy.
- The centre of gravity of the national response has shifted from national to the district and lower levels, including the grassroots community.

These developments were posing new coordination challenges to the Uganda AIDS Commission (UAC).

i) Coordination at national level: The Uganda HIV/AIDS Partnership.

It is in this light that UAC, in 2001, embarked on a comprehensive review of its roles and functions, which led to the establishment of the "Uganda HIV/AIDS Partnership", an innovative coordination mechanism at national level that brings together several constituencies working at different levels in the area of HIV/AIDS.

Constituencies in the Partnership, also referred to as Self-Coordinating Entities (SCE), include the Ministries of Government, District representation, people living with HIV/AIDS (PHA) organisations, private sector, international NGOs, national NGOs, faith based organisations, the UN & Bilaterals, and research institutions. Representatives of these SCEs meet once every month in a

Partnership Committee meeting. The Ministries of Health and Finance, together with the Board of UAC and the UNAIDS Secretariat each have a permanent seat on the Committee. The main task of the HIV/AIDS Partnership Committee is to update and monitor the implementation of the national response which is guided by the five year National Strategic Framework for HIV/AIDS activities (2001-2005). The Committee thus helps the UAC to facilitate and harmonize HIV/AIDS policies, programmes, plans and budgets in order to ensure that agreed priority areas and identified gaps are addressed.

The Partnership Forum brings together all members of the nine identified SCEs including district representation to review progress and make recommendations on the implementation of the national response against HIV/AIDS. It has proven to be instrumental in minimizing duplication i.e. in the area of monitoring and evaluation and has been successful in pooling efforts for scaling up the response. The Forum is held once or twice a year and is chaired by the UAC.

The Partnership provides a formal and representative forum for all stakeholders in the national response to HIV/AIDS. The partnership has mobilization power and organisational capacity and it meets the demands of many voiceless implementers at all levels. This was clearly demonstrated in the National HIV/AIDS Conference/First Partnership Forum during which an overwhelming number of partners were mobilised to present, participate, facilitate and/or fund the event in which more than 2000 persons from all over the country attended.

The Partnership promotes transparency and accountability and has set up a Partnership Fund, which is sponsored by partners to cover its coordination costs, and support some of the SCEs such as PHA to strengthen their coordination capacity. The Fund also covers initial costs involved in the process of establishing HIV/AIDS coordination mechanisms at the district level. The pooling of funds sets a positive precedent for the common ownership of products, which is the very essence of the Uganda HIV/AIDS Partnership.

ii) Collaboration for improved Care

The goals of the National Strategic Framework for Expansion of HIV/AIDS Care and Support for the period 2001/2 –2005/6 are to reduce morbidity, disability and mortality due to HIV/AIDS, and to improve the quality of life of people living with HIV/AIDS. It has seven specific objectives:

- To build capacity needed for provision of HIV/AIDS care.
- To standardise HIV/AIDS care
- To provide essential drugs and supplies for HIV/AIDS care
- To advocate for and increase public awareness on the importance of HIV/AIDS care
- To strengthen the physical infrastructure for the provision of a comprehensive care for PHA
- To promote operational research on HIV/AIDS care
- To build capacity for monitoring and evaluating HIV/AIDS care.

The framework, which is designed to provide context of comprehensive HIV/AIDS care and support, focuses on three major strategies

- Counselling for HIV infection including VCT
- Prevention of Mother to Child Transmission of HIV (PMTCT)
- Clinical management comprising of Chemo prophylaxis, Treatment of Opportunistic Infections, Anti-retro viral therapy, Palliative care ,Paediatric AIDS care

The framework takes into consideration the NSF, existing programmes and the National Minimum Health Care Package. It is to being implemented by all the stakeholders and in phases. Any proposals on HIV/AIDS care are being implemented within this strategic framework.

An example of the private-public collaboration within this framework is the partnership between *Pfizer International, the Government of Uganda* and *faith-based organisations.* The partnership is to improve accessibility to fluconazole for treatment of fungal opportunistic infections. The drug donated by Pfizer is availed through 13 centres including faith-based institutions in 10 districts of the country.

For strengthening infrastructure for improved delivery of care the Academic Alliance for AIDS Care and Prevention in Africa, Pfizer International and Makerere University are in a joint effort that is aimed at constructing a state-of-the-art Infectious Disease Institute to facilitate access to the latest medicines for treating this disease.

A number of research programmes under taken at the *Joint Clinical Research Centre* have been a result of collaboration between Ugandan and international scientists and institutions. Among such efforts has been the first HIV vaccine trial in Africa that was officially closed in May 2002. Three pioneering studies to define friendlier, more cost effective and less toxic ARV drug use are under way. These constitute the most scientifically advanced and biggest ART trials in Africa. JCRC is also hosting the secretariat for the African Dialogue for AIDS Care (ADAC) that was commissioned by the Rockefeller Foundation. It is primarily composed of leading African researchers. A Small Grants Programme "AIDS Care Research in Africa (ACRiA)" to accelerate research in AIDS care in Sub-Saharan Africa in being implemented by ADAC and administered by JCRC. This new relationship gives JCRC a new role of hosting a project of Pan-African proportion, conceived to advance research and management of AIDS on the African continent.

iii) The decentralised response to HIV/AIDS

The *HIV/AIDS District Response Initiative* (DRI) is a strategy to scale-up community-based responses to HIV/AIDS in order to reduce prevalence rates and improve the quality of life of people living with or affected by HIV/AIDS. In Uganda, the DRI was initiated by the Uganda AIDS Commission in collaboration with UNAIDS and is executed by the UNICEF-GoU Country Program in the 31 focus districts. The DRI aims to develop a community's capacity to assess and analyse their HIV/AIDS situation and take concrete actions to address the prioritised problems, thereby explicitly acknowledging and building further on the wide range of existing responses in the Ugandan districts.

The DRI also aims to build partnerships between duty-bearers (local government and service providers) and right-holders (key-social groups) to open avenues of skills and knowledge both horizontally and vertically.

The Uganda HIV/AIDS Control Project financed by a World Bank credit through the Multi Country AIDS Programme (MAP) aims at scaling up the national response to HIV/AIDS especially by incorporating all sectors including the Civil Society Organizations (CSO) and facilitating greater participation of local communities throughout the country. The project places Civil Society Organizations, NGOs, Faith-Based Organizations, Community-Based Organizations (CBOs), Private Sector Organizations, and PLWA Networks at the forefront to undertake direct service delivery for the prevention and mitigation to the populace. It is promoting and supporting Community-led HIV/AIDS initiatives (CHAIs) to mobilise and organise communities to respond to HIV/AIDS through developing relevant sub-projects

The *AIDS/HIV Integrated Model District Programme (AIM)* is yet another example of a district based program, which facilitates community, driven initiatives through partner collaboration. This is a five-year initiative that was launched in March 2002. The goal of AIM is increased access and utilization of appropriate, available, affordable and quality HIV/AIDS prevention, care and support services by men, women and children in selected districts. This is achieved through:

- strengthening of the capacity of government, NGOs, civil societies and private sector actors to plan, manage and implement services at national, district and sub-district levels,
- improving access to and utilization of quality preventive, clinical , community and home-based care,
- increasing access to quality social support services for people infected and affected by HIV/AIDS.

AIM's main strategy is an integrated approach designed to be driven by the needs of the community and includes a comprehensive plan centring on:

- networking through partner collaboration,
- comprehensive, integrated and multisectoral services,
- district-based, community driven, owned and managed services
- capacity building through training and IEC
- sub-granting through districts and directly to NGOs and CBOs

The two main areas of interventions are HIV primary prevention and AIDS care and support. Specific attention is given to VCT, PMTCT, orphans and vulnerable children, young people and community care.

c) Multi-sectoral policy development

Mainstreaming of HIV/AIDS activities into the general development plans.

The realisation that HIV/AIDS had causes and consequences far beyond the health sector led Uganda into being the first country in the world to introduce the multi-sectoral response to HIV/AIDS, which was launched in 1993. The Uganda AIDS Commission was established by Act of Parliament and housed under the office of the President to liase with all sectors to ensure the success of the multi-sectoral response. The five-year National Strategic Framework (NSF) 2000/1-2005/6 and National Operational Plan guide the national response to the epidemic. The NSF is an integral component of the Poverty Eradication Action Plan (PEAP) which is the country's Comprehensive Development Framework. NSF has three overall goals.

Table 6: Goals of the National Strategic Framework (NSF)
1. To reduce HIV Prevalence by 25% by year 2005/6
2. To mitigate the health and socio-economic effects of HIV/AIDS at individual, household and community
3. To strengthen the National Capacity to respond to the HIV/AIDS epidemic

The goals of NSF will be achieved through the following PEAP pillars: 1) Rapid and sustainable economic growth and structural transformation; 2) Good governance and security; 3) Increased ability of the poor to raise their incomes and 4) Enhanced quality of life of the poor.

The Uganda HIV/Aids Control Project (UACP):

The Uganda HIV/AIDS Control Project was established under the Uganda AIDS Commission to support the Government's National Strategic Framework for HIV/AIDS. With funding from the World Bank ($47.5m) and GoU ($2.5m) the project is supporting 12 line ministries and 27 national level civil society organisations at the central level to

review policies, curriculum development to include HIV/AIDS, development of guidelines and technical support to districts, strengthening co-ordination mechanisms, HIV/AIDS surveillance and monitoring and evaluation. It is also supporting 30 districts with activities that include service delivery including prevention, mitigation of HIV/AIDS, institutional strengthening and facilitation of community led HIV/AIDS initiatives. A third component of the support is to communities of which 470 community sub-projects in 16 of the 30 districts have received support. Most sub-projects have focussed on orphan support, creation of awareness on HIV/AIDS, care for PWHs, Youth and Women programmes. A final component is that of procurement of large ticket items. Items procured or being procured include mainly HIV/AIDS test kits, TB drugs, drugs for sexually transmitted infections (STIs), condoms, infection control sundries, microscopes for hospitals, IEC equipment, and vehicles for districts including film vans.

AIDS Control Programmes in Line Ministries:

The *Ministry of Public Service* is mandated with the formulation and establishment of Public Human Resource Management policies and regulations. In this respect, the ministry is responsible for establishing policy guidelines and practices for the entire Public Service to take account of HIV/AIDS concerns. These policy guidelines are yet to be established and workplace interventions are yet to be put in place.

To exercise its national mandate, *Ministry of Health* has an AIDS Control Programme, which is engaged in:

- Preventive activities which consist of IEC campaigns especially promotion of condom use, VCT, control and management of ST and PMTCT.
- Care and support activities include palliative care for PHA, management of OIs and infection control.
- Epidemic surveillance, monitoring and programme evaluation.

MOH also has a central role in technical policy formulation and strategy development

Ministry of Education is training Heads of Teacher Training Institutions and district based education mangers on HIV/AIDS and the role of the education sector in the fight against HIV/AIDS. To this end communication guidelines have been developed to mainstream HIV/AIDS in school health education.

Ministry of Defence is implementing activities aimed at HIV/AIDS prevention, care and support among its soldiers through educational material and peer educators for creating awareness, pre and post test counselling and mitigation of AIDS impact among soldiers living with HIV/AIDS

Ministry of Internal Affairs has similar programmes for Police personnel while the Prisons Department provides education material, VCT, and palliative care for both Prison Staff and inmates.

Ministry of Gender, Labour and Social Development developed a sector investment plan that is aiming at mainstreaming HIV/AIDS activities. Senior staffs were trained on planning and implementing HIV/AIDS activities. Achievements realised include review of the Social Workers and Community Development Officers curricula to include aspects of HIV/AIDS and, with support from USAID and UNICEF, a situation analysis of status of orphans in Uganda was undertaken.

The other ministries are yet to come up with definitive workplans and strategies to address HIV/AIDS concerns within their official mandates.

Development of An Overarching HIV/AIDS Policy in Uganda

As Uganda scales up the fight against HIV/AIDS, it has been expedient to continually develop a strong and supportive legal and policy environment. There are a number of existing policy guidelines in the various sectors, however, they need to be reviewed and updated to make them consistent and relevant to the current HIV/AIDS situation coupled with current development in the country and international level.

During 2002, the Uganda AIDS Commission embarked on an exercise to develop an Overarching HIV/AIDS policy aimed at providing a harmonized national policy and regulatory framework for all actors. The policy development process is continuing.

2. National programmes and behaviour

a) Prevention

According to Ministry of Health, 2001/2002 Annual Health Sector Performance report, the main achievements of preventive efforts were: universal awareness in both rural and urban districts; sustained high level of knowledge (ability to site at least 2 or more prevention intervention in surveys) over 90% in urban and around 80% in rural districts; sustained increase in age at first sex from 14 years in 1989 to over 16 in 2001; sustained high condom use in non regular partners at last sex particularly in the urban areas (50 million male condoms and 110,000 female condoms were distributed within the first six months of 2002 with special emphasis to improving accessibility by high-risk groups. A comprehensive condom distribution strategy is being finalised); Overall HIV prevalence in antenatal mothers stabilising at 6.5% in 2001.

HIV/AIDS school programme activities

Heads of Teacher Training Institutions and Education managers at district levels have been trained on the role of their institutions in the fight against HIV/AIDS.

Table 7: National Programme at a glance

Prevention: School Programmes	
Percentage of schools with teachers who have been trained in life-skills based HIV/AIDS education and who taught it during the last academic year	No documented information available. *HIV/AIDS was included in the primary school curriculum in 1996 and 15,000 primary teachers were trained and equipped to teach life-skills based HIV/AIDS education under the School Health Education Project (SHEP) jointly funded by UNICEF and the Government of Uganda. Subsequently every Government primary school received a SHEP teacher. However there has not been any further developments to ensure sustaining of the programme*
Percent of primary and secondary schools where life skills-based HIV/AIDS education is taught.	

The Ministry of Education also produced draft communication guidelines on HIV/AIDS to be used by Primary School teachers to educate children on HIV/AIDS. Following the Presidential Initiative on AIDS Strategy for Communication to the Youth (PIASCY) the MOE in collaboration with UAC and MOH IEC Unit developed draft Assembly Messages for all Government schools. PIASCY is an initiative that arose from the President' s call for a communications strategy to improve HIV prevention support to the youth throughout the country. It aims at increasing and sustaining HIV/AIDS education for school-going children and the youth.

HIV activities by MOE are complemented by a number of NGOs including The African Youth Alliance (AYA), Straight Talk, Youth Alive, Action AID and others. Their programmes include advocacy for youth friendly policies and services, behaviour change through communication and

education, integration of ASRH into existing livelihood programmes, institutional capacity building to manage and sustain programmes and fostering coordination and information sharing to actualise lessons learned.

HIV/AIDS at workplace

Private Sector

The business community has generally not sought a leadership role in confronting the HIV/AIDS epidemic. The response has in the past been slow and largely a defensive one, characterised by some companies making occasional philanthropic contributions to the wider society. However, during 2002 and with the advent of the private sector SCE, positive signs indicating the beginning of the private sector response were noted: A Uganda Business Council on AIDS was established and more companies initiated workplace HIV/AIDS policies

Table 8: National Programme at a glance	
Prevention: HIV/AIDS at workplace	
Percentage of large enterprises/companies that have HIV/ ADS Work place policies and programmes	17% Combined private and public 20% Private Source: Comparison of a list of 25 largest private employers, identified through amount of their contributions to NSSF, and an inventory from a survey of workplace HIV/AIDS interventions among UBCOA members. The public sector ministries have not yet established HIV/AIDS Workplace policies or interventions.

According to information from the Federation of Uganda's Employers and the MOGLSD a number of Companies e.g. Standard Chartered Bank, New Vision, NSSF, BOU, BAT, Coca Cola, Railways and all the oil companies have initiated HIV/AIDS services such as condom distribution, VCT, STD care and treatment, ARVs and peer education. In order to scale up HIV/AIDS initiatives at work place FUE embarked on a mobilization drive among its members to establish HIV/AIDS policies and services at work place. Uganda Business Council has also meanwhile carried out an inventory of businesses that are providing various HIV/AIDS services at the workplace with the aim of promoting HIV/AIDS interventions within the private sector. However, the private sector still remains one of the weak constituencies in the Uganda HIV/AIDS Partnership and has recently initiated the set up and coordination of its constituency o fully participate in the national HIV/AIDS Partnership.

Public Sector

As already noted, the public sector is yet to come up with definite policies and practices for HIV/AIDS at work place for the civil servants.

Prevention of Maternal to Child HIV Transmission

Mother to Child HIV transmission is the second major mode of spread of the virus in Uganda and the main route by which children get infected. The relatively high prevalence of HIV among women of reproductive age, coupled with a high fertility rate implies that without intervention, the number of children who are likely to be infected with HIV is very high. Based on trials carried out in the country and research findings else where, the government has formulated policy for reduction of MTCT to guide the interventions in this area.

In 2002, reports on PMTCT activities at 19 sites in 14 districts indicated that about 75% of the antenatal clinic clients were counselled for HIV testing and 68% of those counselled accepted to have the test.

Table 9 National Programme at a glance	
Prevention: PMTCT	
Percent of HIV+ pregnant women receiving a complete course of ARV prophylaxis	4.6% Estimate based on Crude Birth Rate 47.3/1000 in 24,700,000 population Expected pregnancies per year 1,168,310 HIV prevalence in pregnant women 6.5%. Estimated no of pregnant women with HIV 75,940. Pregnant Women currently on ARVs for PMTCT 3525. *(Sources: UBOS (2002), Uganda Population and Housing Census: Provisional Results, and MOH (2002) HIV/AIDS Surveillance Report)*

Sixty three percent of those who were HIV positive enrolled for PMTCT and 3525 pregnant women were on ART for PMTCT. They constituted 4.6% of all pregnant women

Challenges to scaling up PMTCT include extensive development of the infrastructure both physical and human resource. Currently most pregnant women who are HIV positive are not identified in time due to the poor ANC attendance and even of those who do attend ANC it is noted that a large proportion do not deliver in health facilities partly attributed to cost sharing. Implementation costs for coordination, sensitisation, training, supplies, and M&E are yet other challenges. Community sensitisation, education and mobilisation are still lacking in most districts. Integration of VCT with ANC requires upgrading the facilities to be able to carry out the HIV tests. As yet, involvement of spouses is still very low and replacement feeding for children is, in most, cases not feasible.

PMTCT is as a result still only benefiting a small fraction of HIV positive pregnant mothers and has hardly made any impact on infection rates among infants born to HIV positive mothers.

b) Care and Treatment

The Ministry of Health is implementing a National Strategic Framework for Expansion of HIV/AIDS Care and Support as one of the priority interventions for accelerating access to comprehensive HIV/AIDS care and support in Uganda.

Sexually Transmitted Disease Control

The STD programme was established in 1990 and integrated into an STD/AIDS control programme in 1993. Varying degree of care for STDs are carried out at all health facilities of and above the level of Health Centre II depending on available capacity. An STD Control Unit based at the national referral hospital provides referral dermatology and STD services.

There has also been an increased emphasis on training of health workers at the middle and lower level health facilities in STD syndromic management. A new algorithm chart for STD diagnosis and treatment was introduced in 2002. However, availability of STD drugs continued to be a major constraint.

Table 10: National programme at a glance	
Care/Treatment: STI	
Percentage of patients with sexually transmitted infection at health care facilities who are appropriately diagnosed, treated and counselled	1) History taking 65% 2) Examination 53% 3) Diagnosis and treatment 49% 4) Advised on condom use and partner referral 28% *Evaluation of STD Case Management in primary health care facilities based on WHO/GPA prevention indicators (PI) is undertaken every five years. The last one (under reference) was in 1998. Preparations are underway for the 2003 study.*
Percent of public STI clinics where VCT services for HIV are provided and/ or are referred to other facilities.	*Apart from the national referral STI specialist clinic at Mulago, management of STI is integrated in the general health services available at and above Health Centre II. In theory, at least, 1651 clinics offer STI services with varying capacity or refer. VCT services are available at over 96 service delivery points.*

Starting in 2002 the national STD/ACP realised that to further reduce the HIV infection, there was need to target core groups. One such important group is the Commercial Sex Workers (CSWs) with a reported prevalence rate of 28.2% (*SCU 2003*). There are other equally important core groups such as male partners of commercial sex workers, long distance truck drivers, military and paramilitary groups, street youths, bar maids and commercial travellers. While interventions have been undertaken among several of these groups, for example there are HIV/AIDS and STD control programmes in the army, police, prisons and for truck drivers, there are however no programmes specifically targeting CSWs.

Anti-retroviral Therapy

Table 11: National programme at a glance	
Care/Treatment: ARV	
Percentage of people with advanced HIV infection receiving ARV combination therapy	6.3% *Currently, there are an estimated 10,000 people on ARV therapy in the country* *Based on the 2002 Surveillance report, people living with HIV/AIDS are 1,050,555.* *People with advanced HIV are estimated to be 15% or 157,583.*

Anti-retroviral drugs (ARVs) were introduced in the country in 1992 through a clinical trial initiated by the Joint Clinical Research Centre (JCRC). In 2001 anti-retroviral therapy was Integrated in the Ministry of Health National Programme for Comprehensive HIV/AIDS Care and Support after the pilot phase of the Drug Access Initiative had demonstrated that it was possible to provide ARVs even in resource-poor countries such as Uganda.

Provision of ARTs in Uganda widened from 7 centres in 2000 to 23 in 2002 benefiting about 10,000 people. The majority (67%) of clients on free ART are females while there are more males than females on paid ART. ARVs are currently available at a markedly reduced cost at the JCRC, private clinics, accredited government health facilities and Pharmaceutical companies. Nevertheless, Antiretroviral drugs are still not affordable by the majority of patients who need them. Inadequate staffing, high costs of ARVs and laboratory tests are the major constraints hindering wider access to anti-retroviral therapy.

In an effort to address these concerns the Ministry of Health has established a national ART (Access to Anti-Retroviral Treatment) Committee which, in consultations with all partners and technocrats is charged with developing a National Policy and framework for managing Antiretroviral therapy in

the country. The Committee has five sub committees respectively concerned with policy development, logistics, clinical care, advocacy and finances. It will develop a costed ARV plan; establish channels and mechanisms for ARV drug distribution. The committee is also charged with developing clinical and training guidelines for managing ART and mobilize and sensitize the community.

c) Behaviour

The STD/ACP is implementing behavioural surveillance as part of the STD/HIV/AIDS second-generation surveillance. The activities for behavioural surveillance have included the conducting of repeat population based surveys in 3 districts to establish trends in a number of behavioural indicators. Additional behavioural data is drawn from the findings of the UDHS that was conducted in 2002-2001.

Table 12: National behaviours at a glance

Percentage of people 15- 24 years of age with knowledge of two ore more programmatically important ways of preventing the sexual transmission of HIV, i.e. abstinence, use of condom and limiting number of sexual partners. *(Target: 90% by 2005; 95% by 2010)*	*Men 89.6%* *Women 80.2%*
Same indicator among age groups 20 – 24	Men 94.1% Women 82.5%
25 – 49	Men 90.3% Women 76.4%
Women 15- 49	Urban 91.6 % Rural 75.3%
Men 15- 54	Urban 95.0% Rural 88.7% *(Source: UDHS 2000/2001)*
NB. The indicator surveyed during UDHS, and quoted above, is different from the UNGASS core indicator which is Percentage of young people 15 –24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major conceptions abut HIV transmission.	
Percentage of young people 15–24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner	Men 61.9 % Women 44.2% No data on urban /rural residence in this age group
Same indicator among age groups 20 -24	Men 71.0% Women 36.9%
25 - 49	Men 58.1% Women 28.3%
Men Age group 15 - 54	Urban 80.7% Rural 50.2%
Women Age Group 15 - 54	Urban 58.4% Rural 29.7% *(Source: UDHS 2000/2001)*
Median age at first sex among 25-29 (not 15 – 24) age group	Women 16.8 years Men 19.4 years *No data was available on age group 15 – 24. However, median age at first intercourse across age groups is similar indicating no recent change in the pattern of initiation of sex,* *(Source: UDHS 2000/2001)*

Higher–risk sex in the last year Percent of 15 – 24 year-olds who have been sexually active in the past 12 months with non-marital, non-cohabiting partner	*Married* *Women 3.% Men 15.7%* *Unmarried.* *Women 25.9% Men 30.9%* *(Source: UDHS 2000/2001)*
Condom use during last commercial sex.	95% use during last commercial sex. However, consistent use of a condom was found to be 50% in the same study group. Source. KABP survey on HIV/AIDS and STDS among CSW in Kampala carried out in 1998. (Asiimwe-Okiror, et, al. 1998)
Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV (where applicable)	Data not available *There is no specific programme component that identifies and targets injecting drug users*

The UDHS findings indicate there was increasing levels of awareness and knowledge of preventive practices; an increasing trend of condom use while age at first sex has been sustained at around 16 years.

Table 13: Comparison of Key Behavioural Parameters in Kampala (Urban) and Lira (Rural) viz 1998 and 2001

Key parameters	**Kampala**			**Lira**		
	1995	**1998**	**2001**	**1995**	**1998**	**2001**
Number of respondents	1438	1501	1329	1358	1705	1378
Awareness on HIV/AIDS (%)	99.6	99.7	100	93.5	99.7	99.1
Knowledge on preventive practices	84.2	87.5	93.6	72.1	87.4	90.0
Median Age at first sex (years)	16.4	16.3	16.6	16.0	16.1	16.2
Ever used condom (%)	42.0	50.7	46.9	9.0	10.6	13.2
Condom use at last sex with non-Regular Partner (%)	57.6	76.0	85.0	14.3	13.8	28.2

Source: Ministry of Health, (2002), STD/AIDS Control Programme, HIV/AIDS Surveillance Report

d) Impact Alleviation

The ratio of orphans to non-orphans in school could not be accurately calculated because of the differences in the age groups. However, the Situation Analysis of Orphans in Uganda carried out in 2001/2 also found no significant difference in school attendance rate between orphans and non-orphans aged 6–17 years. It attributed this finding to the free Universal Primary Education programme. (Wakhweya, A., e*t. a*l: 2002)

Table 14: Impact alleviation at a glance

Ratio of orphaned to non-orphaned children 6- 17 (not as limited in the UNGASS guidelines indicator 10–14) years of age who are currently in school	Percent in school	Percent out of school	NB. In Uganda, an orphan is one below 18 years that has lost both or one of the biological parents. This differs from other sources in which an orphan is one who has lost both parents and the age cut off is below 15 years.
Single orphans (6-17)	82.6	17.4	Sources. 2001 Baseline Study National Report (The 2001 – 2005 Government of Uganda- UNICEF Country Programme)
Double orphans (6 –17)	82.9	17.1	
Primary School enrolment (6-12) for all children	84.5	15.5	
Non-orphaned (6 –12) in primary school	87	13	Uganda DHS Education Data Survey 2001.

The number of orphans infected and affected by HIV/AIDS has created a social crisis. It is estimated that the cumulative number of orphans stands at more than two million, which represents 19% of children in Uganda or one in five children nationwide. As a result the traditional family and community systems have become overwhelmed and increasingly unable to support the realisation of the children's rights and protection from abuse and exploitation (Ibid).

IV Major challenges faced and actions needed to achieve the goals/targets

The implementation of the NSF is currently underway involving a large number of stakeholders. The main challenges to be addressed include:

a) The youthfulness of the population and the need to intensify prevention among young people. Several agencies have programmes on the youth in the country. What is required is a systematic and comprehensive evaluation of these interventions, identification of best practises and formulate a mechanism of scaling up those most effective strategies in a coordinated manner.

b) The still limited access to comprehensive care, including ARVs needs to be addressed urgently. While the National Strategic Framework for Expansion of HIV/AIDS Care and Support identifies areas of focus and defines objectives to be achieved, there are however, limited mechanisms for mobilizing resources.

c) The general threat of complacency due to the declining trend of the epidemic. New and innovative methods of IEC need to be developed to emphasis continued vigilance, awareness, and taking into consideration the new dimensions of the epidemic such as PMTCT and ARVs.

d) Recognition and appreciation of the need for effective strategies among high risk groups such as commercial sex workers, internally displaced persons, long distance truck drivers, military and paramilitary groups, street youths, bar maids and commercial travellers. A clear understanding of the dynamics of the HIV/AIDS epidemic among these groups through well designed behaviour and practise studies will assist in developing effective and sustainable programmes that meet the special circumstances prevailing in these sub-populations.

e) Adaptation of the NSF to meet new challenges and dimensions of the epidemic requires that there be a major review of the Strategic Framework focus, relevancy and organizational environment to identify its strengths, weaknesses, opportunities and threats and to translate what apparently is a *many sectors* approach into a truly *multi-sectoral* approach. The HIV/AIDS Partnership is a positive effort to this end.

Table 15: Data Collection Plan

Data collection plan for 2005 reporting	**2003**	**2004**	**2005**
Household surveys	√	√	√
Health Facility surveys		√	
School-based surveys		√	
Workplace surveys		√	
Desk Review			√

V. Support required from country's development partners

Uganda requires support from development partners to cover;

- Funds for antiretroviral drugs to treat all who need them in the country and opportunistic infections
- Funds to for orphans and Vulnerable children
- Funds for development of Impact Assessment Models
- Fund for capacity building at both central and sector level for hands on / orientation
- Advocacy support for Regional Collaboration
- Funds to support participation in Global initiatives such as District Response Initiatives, CRIS, International and local conferences and exchange visits
- Funds to support Research

VI. Monitoring and evaluation environment

Indicators for which no current data is available
Table 16 Gaps in current Indicators

NATIONAL COMMITMENT AND ACTION	
Missing Indicator	**Actions to be taken**
National Composite Policy Index	
Impact on socio-economic status	MOFPED needs to put some priority on this long-overdue requisite.
IEC policy and strategy for high-risk groups,	The Communication Strategy for Prevention and Control of STIs and HIV/AIDS should include specific section that address high-risk groups such as CSWs, prison in-mates, long-distance truck drivers, refugees, IDPs, and cross-border migrants
Laws and regulations that protect against discrimination of PHAs	Recommendations made by The Uganda Network on Law, Ethics and HIV/AIDS should be given serious attention by the relevant law-making bodies.
Government funds spent on HIV/AIDS Currently the Approved Estimates of Revenue and Expenditure does not segregate expenditure into STD control activities, HIV prevention, HIV/AIDS clinical care and treatment and, HIV/AIDS impact mitigation.	The MOFPED to reorganise their financial database to reflect the indicators as required under the UNGASS. Operationalisation of the newly developed Resource Tracking will facilitate segregation of financial information at the central level. A special resource tracking study will have to be carried out at district level to capture locally generated funds.
NATIONAL PROGRAMME AND BEHAVIOUR	
Prevention	
Percent of schools with teachers and who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year	School based survey on education every two years to be undertaken by MOES
Percent of large enterprises/companies that have HIV/AIDS workplace policies and programmes	Uganda Bureau of Statistics Business Register should include this indicator in the business surveys
Percent of HIV+ pregnant women receiving a complete course of ARV prophylaxis	This should be included in both the annual HIV/AIDS Surveillance Surveys and the Uganda Demographic and Health Survey. It should also be included in the routine

	monitoring of ante-natal attendances.
Care and treatment	
Percent of Patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled (based on a 1998 evaluation).	Preparation are under way for another evaluation of STD Case management in primary health care facilities in Uganda to be carried out in 2003A survey due in 2003 . However, the tool needs to be modified in order to capture this indicator according to UNGASS specifications.
Percent of people with advanced HIV infection receiving ARV combination therapy	Establish a framework for pooling data from the various sites
Knowledge and Behaviour	
Percent of respondents 15- 24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission *(Target: 90% by 2005; 95% by 2010)*	*Modify the tool in the Demographic and Health Survey to have the same age group indicated in the UNGASS to capture this indicator directly* *Same as above*
Percent of people aged 15 –24 reporting the use of a condom during sexual intercourse with a non-regular partner	
Percent of injecting drug users who have adopted behaviours that reduce transmission of HIV (where applicable)	Data not available
Impact alleviation	
Ratio of orphaned to non-orphaned children 10-14 years of age who are currently attending schools.	This indicator needs to be captured in the UDHS and the Education Statistical Abstract
IMPACT	
Percent of infants born to HIV infected mothers who are infected *(Target 20% reduction by 2005; 50 % reduction by 2010)*	Periodic sample surveys in the PMTCT programme areas

Developing a Monitoring and Evaluation Plan of the Expanded National Response on HIV/AIDS in Uganda 2001/2 – 2005/6

Uganda AIDS Commission through its Secretariat is primarily responsible for periodic monitoring and evaluation of the implementation of the National Strategic Framework. A national M&E framework is currently being developed. The objectives of the plan which is still in draft form and is yet to be refined are to :

- To track the implementation of NSF activities and establish whether the objectives have been achieved
- To increase the understanding of trends in HIV/AIDS prevalence and explain the changes in state and levels of HIV/AIDS prevalence over time to allow for appropriate response to the epidemic
- To strengthen the capacity of UAC, sectors, districts, NGOs and civil society organizations to collect and use HIV/AIDS data.

An M&E subcommittee of the HIV/AIDS Partnership was established in 2002 to assist UAC to review progress and set milestones for finalising and implementing the M&E strategy at different levels; assess M&E capacity overtime and recommend solutions; ensure a harmonised development and management of national M&E databases and ensure adequate dissemination of data.

ANNEX 1

Preparation/consultation process for the National Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

1) Which institutions/entities were responsible in filling out the indicators forms?

a) NAC or equivalent

Yes ✔
No

b) NAP

Yes ✔
No

c) Others

Yes ✔
No

2) With inputs from:

Ministries:

Education
Yes ✔
No

Health
Yes ✔
No

Labour
Yes ✔
No

Foreign Affairs
Yes ✔
No

Others
Yes ✔
No

Others include; Ministries of Internal Affairs, Defence, Agriculture, Works Transport and Communications, Information and Justice

Civil society organizations

Yes ✔
No

People living with HIV/AIDS

Yes ✔
No

Private sector

Yes ✔
No

UN organizations

Yes ✔
No

Bilaterals

Yes ✔
No

International NGOs

Yes ✔
No

Others

Yes ✔
No

Others include Faith Based Organisations and Community Based Organisations

3) Was the report discussed in a large forum

Yes ✔
No

4) Are the surveys results stored centrally?

Yes ✔
No

5) Is data available for public consultation?

Yes ✔
No

Name/Title: Dr David Kihumuro Apuuli / Director General

Date: 15th April 2003

Signature: _____

ANNEX 2

NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE

Strategic plan

1. Has your country developed multisectoral strategies to combat HIV/AIDS?

Yes: √	No	N/A
AIDS Control in Uganda, The Multisectoral Approach. It was realised early that the impact of HIV/AIDS epidemic went beyond the domain of health and that it cut across all aspects of individual, family, community and national life. In response, the government adopted a multisectoral AIDS control strategy in 1992. The policy states that All Ugandans have individual and collective responsibility to be actively involved in AIDS control activities in a coordinated way at the various administrative and political levels. The fight against AIDS is not only directed at the prevention of the spread of HIV but also addresses the active response to and management of all perceived consequences of the epidemic. The approach has three goals: i). To stop the spread of HIV infection ii). To mitigate the adverse health and socio-economic HIV/AIDS epidemic at individual , household and community levels iii) To strengthen national capacity to respond to the HIV/AIDS epidemic. This multisectoral approach was further re-emphasised in the National Strategic Framework for HIV/AIDS activities in Uganda 2000/1 – 2005/6.		

2. Has your country integrated HIV/AID into general development plans

Yes √	No	N/A
PEAP. One of the four PEAP goals is enhanced quality of life of the poor. It specifically calls for activities to ensure that further spread of the AIDS epidemic is halted. Although the PEAP provides the framework for focussing on HIV/AIDS activities, actual mainstreaming of HIV/AIDS in sectoral development plans in form of policy and resource allocation and is yet to be realised. **UNDP Country Co-operation Framework (CCF) for Uganda 2001-2005** accords particular attention to three crosscutting concerns: gender, HIV/AIDS and environment. UNDP will support advocacy to HIV/AIDS prevention and control and catalytic interventions within the framework of the bi-annual integrated workplans of UNAIDS.		

3. Does your country have a functional national multisectoral HIV/AIDS management/ coordination body?

Yes √	No	N/A
Uganda AIDS Commission was established by statute in 1992 to oversee, plan and coordinate HIV/AIDS prevention and control activities throughout Uganda. UAC members are drawn from government ministries, parliament, NGOs, religious organizations and individuals active in the filed of HIV/AIDS. UAC leads a national coordination structure which consists of Sectoral AIDS Control Programmes in 12 ministries, Technical and Advisory committees and AIDS Coordination Committees established to oversee the implementation of HIV/AIDS activities at district and sub-country levels.		

4. Does your country have a functional national HIV/AIDS body that promoted interaction among government, the private sector and civil societies.

Yes: √	No	N/A

The Uganda HIV/AIDS Partnership was established in January 2002. It is an innovative coordination mechanism at national level that brings together several constituencies working at different levels in the area of HIV/AIDS.

Constituencies in the Partnership, also referred to as Self-Coordinating Entities (SCE), include the Ministries of Government, District representation, people living with HIV/AIDS (PHA) organisations, private sector, international NGOs, national NGOs, faith based organisations, the UN & Bilaterals, and research institutions. Representatives of these SCEs meet once every month in a Partnership Committee meeting. The Ministries of Health and Finance, together with the Board of UAC and the UNAIDS Secretariat each have a permanent seat on the Committee. The main task of the HIV/AIDS Partnership Committee is to update and monitor the implementation of the national response which is guided by the five year National Strategic Framework for HIV/AIDS activities (2001-2005). The Committee thus helps the UAC to facilitate and harmonize HIV/AIDS policies, programmes, plans and budgets in order to ensure that agreed priority areas and identified gaps are addressed.

The Partnership Forum brings together all members of the nine identified SCEs including district representation to review progress and make recommendations on the implementation of the national response against HIV/AIDS. It has proven to be instrumental in minimizing duplication i.e. in the area of monitoring and evaluation and has been successful in pooling efforts for scaling up the response. The Forum is held once or twice a year and chaired by the UAC.

The Partnership provides a formal and representative forum for all stakeholders in the national response to HIV/AIDS. The partnership has mobilization power and organisational capacity and it meets the demands of many voiceless implementers at all levels. This was clearly demonstrated in the National HIV/AIDS Conference/First Partnership Forum during which an overwhelming number of partners were mobilised to present, participate, facilitate and/or fund the event in which more than 2000 persons from all over the country attended.

The Partnership promotes transparency and accountability and has set up a Partnership Fund, which is sponsored by partners to cover its coordination costs, and support some of the SCEs such as PHA to strengthen their coordination capacity. The Fund also covers initial costs involved in the process of establishing HIV/AIDS coordination mechanisms at the district level. The pooling of funds sets a positive precedent for the common ownership of products, which is the very essence of the Uganda HIV/AIDS Partnership.

5. Does your country have a functional HIV/AIDS body that assists in the coordination of civil society organizations?

Yes: √	No	N/A

The Uganda Network of AIDS Services Organization (UNASO) was formed in 1997 by a number of NGOs carrying out AIDS work in Uganda. Its mission is to coordinate HIV/AIDS services organization in Uganda so that prevention, quality care and support services are available to all.

Its objectives are

- Promote cooperation and coordination through common resource mobilization . sharing of information and expertise
- Promote common standards through developing of guidelines/ standards for planning. Counselling, homecare, monitoring and evalautionin for use by AIDS service organizations in Uganda
- Strengthen organizational development activities among NGOs/CBOs/FBOs for effective delivery of their services
- Advocate for common interests of the service providers and beneficiaries so as to influence policy making issues of importance to PHAs

UNASO's membership is over 400 Agencies.

6. Has your country evaluated the impact of HIV/AIDS on its socio-economic status for planning purposes?

Yes	No: Not yet.	N/A
No evaluation has as so far published results.		

7. Does your country have a strategy that addresses HIV/AIDS issues among its national uniformed services including armed forces and civil defence forces?

Yes √	No	N/A

The country has AIDS Control Programmes in the Ministry of Defence targeting soldiers and their families and in the Ministry of Internal Affairs for the police and prisons services. These programmes are directly supported by funds channelled through the Uganda AIDS Control Project. While various prevention activities have been carried out, the development of comprehensive HIV/AIDS strategies however is still on going.

Prevention

1. Does your country have a general policy or strategy to promote information, education and communication (IEC) on HIV/AIDS?

Yes: √	No	N/A
Comments: **Communication Strategy for Prevention and Control of STIs and HIV/AIDS (2003-2007).** This strategy was initially developed in 1998 and revised in 2002. While its development was spearheaded by the Ministry of Health it is for use by all stakeholders of HIV/AIDS initiatives, including NGOs, line ministries, District Directorate of Health Services and CBOs. It builds on previous interventions like STDs, HIV prevention and encompasses the new areas such as PMTCT, VCT, ARV, HBC and IEC.		

2. Does your country have a policy or strategy promoting reproductive and sexual health education for young people?

Yes: √	No	N/A
Comments **National Adolescent Health Policy.** This policy is an integral part of the National Development process. It complements all sectoral policies and programmes and recognises the critical role adolescents themselves can play in promoting their own health and development. The policy further seeks to strengthen and to provide an enabling social and legal environment for the provision of high quality accessible and adolescent friendly interventions.		

3. Does your country have a policy or strategy that promotes IEC and other health interventions for groups with high or increasing rates of HIV infection?

Yes:	No √	N/A
Comments: The Communication Strategy for Prevention and Control of STIs and HIV/AIDS strategy only provides general guidelines for designing IEC messages. Specific interventions targeting the high risk groups such as commercial sex workers (CSWs), prison inmates, long distance truck drivers, refugees and internally displaced people have primarily been implemented by NGOs working independently without direct guidance or support from the MOH.		

4. Does your country have a policy or strategy that promoted IEC and other health interventions for cross-border migrants?

Yes	No √	N/A
Comments: Although Uganda's history has been characterised by large movement of persons across its borders it does not have a specific strategy targeting cross- border migrants.		

5. Does your country have a policy or strategy to expand access, including among vulnerable groups, to essential preventative commodities?

Yes √	No	N/A
Comments: **The National Strategic Framework for Expansion of HIV/AIDS Care & Support in Uganda 2001/2-2005/6** Promotion of condom use – distribution of condoms is an integrated service within the country's primary health care system and the MOH has issued a guide on how to increase the accessibility of condoms to the grassroots especially to the high risk target populations. STI control – improved access to STI control and management through the use of algorithms for syndromic management of STDs IEC – there is uninhibited access to information through use of mass media to reach all categories of the population VCT – There were 96 VCT services 31 districts in 2001. Services were expected to spread to 34 districts in 2002 and there are plans to expand to a further 12 districts in 2003. PMTCT – services are available at 18 sites in 13 districts. Community based initiatives - the decentralisation of services through community-based initiatives under the CHAI (Community led HIV/AIDS Initiatives) has been instrumental in accessing support to grassroots. However to ensure quality among these diverse groups and services requires a strong and well-established system of coordination.		

6. Does your country have a policy or strategy to reduce mother to child HIV transmission?

Yes √	No	N/A
Comments: **Policy document for Reduction of the Mother to Child HIV Transmission in Uganda** formulated in 2001 addresses key issues related to prevention of MTCT of HIV, which are ARV therapy, VCT, infant feeding, quality obstetric care and recommends other interventions for the reduction of MTCT. **Policy Guidelines on Feeding of Infants and Young Children in the Context of HIV/AIDS** have also been formulated which gives guidance on the appropriate options that mothers and their spouses can consider in order to ensure that their babies get adequate nutrition while at the same time reducing the risk of transmitting HIV.		

Human Rights

1. Does your country have laws and regulations that protect against discrimination of people living with HIV/AIDS?

Yes	No √	N/A
Comments: However, in 1996 Uganda Network on Law, Ethics and HIV/AIDS (a local NGO) undertook a study to review the adequacy of existing legal and policy framework in Uganda with regards to the HIV/AIDS epidemic. The study identified the following major problems: the non-existence of any law to govern particular problem areas relating to HIV/AIDS epidemic; poor or non-enforcement and lack of respect for the law and human rights even in cases where a law exists; lack of preparedness of the legal framework in responding to outbreaks of epidemics of this nature. However, while there are no explicit laws or regulation against discrimination the law courts in Uganda have advised that existing laws may be utilised in their stead.		

2. Does your country have laws and regulations that protect against discrimination of groups of people identified as being especially vulnerable to HIV/AIDS discrimination?

Yes	No √	N/A
Comments: Same as above		

3. Does your country have a policy to ensure equal access, for men and women, to prevention and care, with emphasis on vulnerable populations?

Yes √	No	N/A
Comments: **The Health Sector Strategic Plan** in principle aims at improving access of the population to the Uganda National Minimum Health Care Package (UNMHCP). Special attention is placed in increasing effective access for the poor, the difficult to reach and the otherwise disadvantaged and to reduce inequalities between various segments of the population in accessing quality services. HIV/AIDS care is delivered in an integrated manner in the existing health infrastructure. Through partnerships with private, non-governmental organizations, bilateral and multilateral agencies a wider section of the population is accessed to both specialised and general services as well as specific HIV/AIDS interventions. However, resource limitations curtail coverage and quality of care.		

4. Does your country have a policy to ensure that HIV/AIDS research protocols involving human subject are reviewed and approved by an ethics committee?

Yes √	No	N/A
The Uganda National Council for Science and Technology (UNCST) was established by Statute No.1 of 1990 as a corporate body to rationalise the integration of science and technology in the socio-economic development process through explicit science and technology policies. The Council receives, reviews and approves all applications for permission to conduct research in Uganda. All research projects involving human subjects are screened and must satisfy the ethical requirements of the Council through a research registration and clearance process. The Guidelines for the Conduct of Health Research involving Human Subjects in Uganda has been produced for this purpose. The Council also has an AIDS Research Board that vets AIDS research prior to submission for final approval to the UNCST.		

Care and Support

1. Does your country have a policy or strategy to promote comprehensive HIV/AIDS care and support, with emphasis on vulnerable groups? (Comprehensive care includes, but is not limited to, VCT, psychosocial care, access to medicines, and home and community-based care).

Yes √	No	N/A
If yes, please list Groups: Pregnant mothers Children Youth	 Commodities: VCT, Counselling, treatment of OI, ARV for MTCT Paediatric AIDS care Counselling, reproductive health	
Comments: **The National Strategic Framework for Expansion of HIV/AIDS Care & Support in Uganda 2001/2-2005/6** that was designed in the context of Comprehensive HIV/AIDS care and support focuses on 3 major components: • Counselling for HIV infection including VCT, • Prevention of Mother To Child Transmission (PMTCT), • Clinical Management comprising of chemoprophylaxis, treatment of opportunistic infections, ARV therapy, palliative care and paediatric AIDS care.		

2. Does your country have a policy or strategy to ensure or improve access to HIV/AIDS related medicines, with emphasis on vulnerable groups?

Yes √	No	N/A
If yes, please list Groups: Pregnant mothers Armed forces	 Commodities: OIs, ARV for PMTCT, Vitamin A supplements, anaemia prophylaxis OIs, ARVs	

Comments:
The National Strategic Framework for the Expansion of HIV/AIDS Care & Support in Uganda - Uganda is one of the countries that have been participating in the Drug Access Initiative. Through this public-private partnership, Uganda has been successful in achieving significant price reductions for medicines for people with HIV/AIDS. For example, prices for ARVs dropped dramatically due to the importation of generic drugs through the Joint Clinical Research Centre (JCRC). Consequently it has been able to open several accredited centres to offer ARTs

Policy for Reduction of Mother-to-child HIV Transmission in Uganda has various components, which include ARV, VCT, infant feeding, vitamin supplements, anaemia prophylaxis, STI diagnosis and treatment, modification of obstetrical care and family planning. PMTCT services are currently available at 18 sites in 13 districts. In introducing new programmes such as reduction of MTCT, the Ministry of Health is aware of the need to develop inter-sectoral links and re-affirm Government's policy of multi-sectoral approach to combat HIV.

Activities of the **ACPs in the uniformed forces** include the procurement and distribution of drugs and supplies.

3. Does your country have a policy or strategy to address the additional needs of orphans and other vulnerable children?

Yes √	No	N/A

Comments:
A comprehensive national policy and programme plan on orphans and vulnerable children is currently under preparation under the leadership of Ministry of Gender, Labour and Social Development (MOGLSD), with support from UNICEF, USAID, Centre for International Health Boston, and Uganda AIDS Commission. The final OVC policy and programme plan is expected to be completed by mid December 2003. The aim is to articulate a comprehensive vision, provide clear guideline and catalyse a concerted and sustained programming effort across all sectors of Ugandan society to mitigate the crisis of orphans and other vulnerable children.

ANNEX 4

COUNTRY M&E SHEET

COUNTRY:_____ **AS OF:**_____

1. **Existence of national M&E plan**

Yes: Years covered:	In progress: ✔ Years covered:2002-2005/6	No:

2. **Existence of a national M&E budget**

Yes: Amount: Years covered:	In progress: Years covered:	No:

3. **Amount secured as of today;**_____

4. **Existence of an M&E unit for HIV/AIDS within**

National AIDS Council	Ministry of Health	Elsewhere:
Yes: ✔ No:	Yes: ✔ No:	Ministries, Civil Society Organisations

5. **M&E focal person on HIV/AIDS within the government**

Name: Dr Kasheeka Emmanuel Baingana
Telephone: 256 77 401 907
Email: Baingana_manuel@yahoo.co.uk

6. **Existence of information systems:**

Health Information System

Yes: ✔ National level: ✔ Sub-national*: Districts	No

** If yes, please specify the level i.e. district*

Education Information System

Yes: ✔ National level: ✔ Sub-national*: ✔ Districts	No:

**If yes, please specify the level, i.e. district*

Bibliography

Asimwe-Okiror, G. et al. (1998). Results of a KABP Survey on HIV/AIDS and STDS among Commercial Sex Workers in Kampala, Uganda: STD/AIDS Control Programme, Ministry of Health, Uganda.

Federation of Uganda Employers. Employers Statement of Recommended Practices on HIV/AIDS at the Workplace. Kampala, 2002.

Jacobi J. Activty Report, September 2000 to November 2002, UNAIDS/Uganda, 2003.

Joint Research Centre. Annual Report. Kampala Uganda, 2002.

Kirungi L et al. Midterm Evaluation of STD case management in primary health care facilities in Uganda. MOH STD Control Unit, 1999.

Lwanga-Ntale C. Report on PLA Field Work carried out in Kasese, Kabarole, Kampala….on the adolescent sexual and Reproductive health, , African Youth Alliance, 2003.

Ministry of Health. HIV/AIDS Surveillance Report. STD?AIDS Control Programme, Kamapala Uganda, 2002.

The Republic of Uganda. Guidelines and Procedures for research Registration and clearance. Ugandas National Council for Science and Technology, 2001.

The Republic of Uganda, MOH. Policy Guidelines on feeding of infants and young children in the context of HIV/AIDS, 2001

The Republic of Uganda, MOH. National Adolescent Health Policy (Draft). 2000

The Repblic of Uganda, MOH. Communication Strategy for Prevention and Control of STIs and HIV/AIDS (Draft), 2003.

The Republic of Uganda, MOH. Health Sector Strategic Plan 2000/01 –2002/05.

The Republic of Uganda, MOH. Policy for Reduction of Mother-to – Child HIV Transmission in Uganda. 2001.

The republic of Uganda, MOH. The Natioanal Strategic Framework for Expansion of HIV/AIDS Care and Support in Uganda 2001/2 – 2005/6. 2002.

The Republic of Uganda, MOH. Annual Health Sector Performance Report 2001/2002. 2002.

The Republic of Uganda.. Poverty Eradication Action Plan (2001 – 2003), Ministry of Finance, Planning and Economic Development; Kampala, 2001. Volume I

The Republic of Uganda. The Monitoring and Evaluation Plan of the Expanded National Response on HIV/AIDS in Uganda: 2001/2 – 2005/6., Uganda AIDS Commission, 2002.

Uganda AIDS Commission. AIDS Control in Uganda, The Multi-sectoral Approach. Uganda AIDS Commission Secrtariate. Kampala, Uganda. 1993.

Uganda Bureau of Statistics. A report on the Uganda Business Register, 2001/2002. The directorate of Business Industry, Agriculture and Energy Statistics, 2003.

Uganda Bureau of Statistics and ORC Macro. Uganda Demographic and Health Survey 2000 – 2001. Calverton, Maryland, USA, 2001.

Uganda Bureau of Statistics and ORC Macro. Uganda DHS EdData Survey 2001: Education Data for Decision Making. Calverton, Maryland USA , 2002.

Uganda Bureau of Statistics. 2002 Uganda Population and Housing Census. Provisional Results. National Census Office, Entebbe, 2002.

Uganda HIV/AIDS Control Project. Progress Report January – June 2002.

UNASO. Annual Report. Kampala Uganda , 2001.

UNASO. Community Response to HIV/AIDS. UNASO News, 2002.

Zainabu A et al. A report on Rapid Assessment of Access to Antiretroviral Therapy in Uganda. WHO/Ministryof Health Uganda, 2002.