ANNUAL PERFORMANCE REVIEW OF THE
NATIONAL STRATEGIC PLAN FOR HIV/AIDS
2011/12 – 2014/15

FINANCIAL YEAR 2011/12

October 2012
Foreword

The National HIV/AIDS Strategic Plan (2011/12-2014/15) (NSP) was implemented in the first year by stakeholders in the multi-sectoral response at all levels. Under the leadership of Uganda AIDS Commission (UAC), and as part of good monitoring and evaluation practice, HIV/AIDS stakeholders conducted Joint annual AIDS Review (JAR) of NSP implementation to assess progress of implementation for the financial year 2011/12.

The Annual Performance Review Report of the first year of implementation documents progress attained against agreed NSP indicators and targets. The Report also indicates the progress attained on the planned undertakings at the 2011 JAR. Substantial progress has been attained in improving access to HIV preventive services, care and treatment, social support and systems strengthening. There are however major challenges still constraining achievements of the set targets for NSP in particular prevention and systems strengthening thematic areas.

The methodology adopted in the compilation of this report was consultative and highly participatory including literature review, and consultations with key stakeholders. The consultations were wide ranging in order to ensure that all constituencies were covered in the process.

I wish to implore all stakeholders in the multi-sectoral national response—government line ministries and sectors, civil society, bilateral agencies and UN organizations to internalize this report to inform future HIV/AIDS programming. In the same vein, I call upon all the stakeholders to reinvigorate our efforts so as to improve on our coordination mechanism to ensure increased efficiency and maximum benefits using the available resources to address the challenges that have been identified.

This year's JAR and Partnership Forum therefore present an opportunity to discuss and remind different stakeholders to scale up high results-oriented HIV interventions. These will be captured as undertakings for the year 2012/13.

I take this opportunity to register my sincere and deepest gratitude to all our Development Partners for supporting this process. I want to thank everyone from line ministries/sectors, Civil Society, Bilateral and other UN organizations, and districts who provided input during the compilation of the report.

Dr David Kimumuro Apluli
DIRECTOR GENERAL
Acknowledgement

Uganda AIDS Commission (UAC) is very grateful to the National HIV/AIDS Partnership Committee of the Board Chaired by Prof. Katongole- Mbidde for their invaluable leadership and guidance throughout the review process of the National HIV and AIDS Strategic Plan (NSP) 2011/12-2014/15. We are especially grateful to Dr. Grace Nyerwanire Murindwa, Dr. Mrs. Enid Wamani, Peter Wakooba and Mr. Denis Busobozi for co-coordinating the entire JAR and PF. We are grateful for the technical support and guidance by the Technical Working Group Chairpersons, and UAC Conveners of the Thematic Areas; Dr. Zepher Karyabakabo, Dr. Peter Mukobi, Ms. Joyce Kadowe, Mr. Stephen Cheshewa.

We are also grateful to all members of the Technical Working Groups (TWG) for their guidance, feedback and invaluable comments. The TWG members are most appreciated for their input during the presentations of the draft thematic reports of the review. More so, the TWGs provided data and technical guidance to respective thematic areas that form part of this Report.

The UAC also wishes to register sincere gratitude to all the technical and management staff at district level. UAC further acknowledges the invaluable input of all those individuals and stakeholders in Government and civil society at national level including networks of people living with HIV (PHAs) who participated actively and proposed the way forward.

Finally, but not least, I wish to acknowledge with most gratitude the team of consultants that facilitated the JAR. We appreciate the commitment and team work by the team led by Vincent Owarwo Mugumya. The team including Andrew Baryeku, Emmanuel Luyirika, and Stephen Kirya are hereby acknowledged.

Prof. Vinand Nantulya
Chairman, Uganda AIDS Commission
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DEFINITIONS

The purpose of the social support and protection component is to reduce the vulnerability of disadvantaged persons to situations that could result to HIV infection or transmission and to mitigate the socio-economic, legal and psychosocial effects of HIV and AIDS of individuals infected and affected so as to help them cope with effects of infection.

**Social support** refers to the socio-economic and emotional assistance offered to vulnerable individuals, households and communities to enable them address and cope with the immediate and long-term causes, needs and consequences of the concerns. It includes provision of formal and informal education, vocational training, counselling, material goods (food, farm land and implements, descent shelter, legal protection and litigation, cash and other inputs to initiate economic activities, etc).

**Social protection** refers to the measures that reduce the vulnerability of socially and economically disadvantaged individuals, households and communities to further risk or shocks. This includes provision of social assistance to extremely poor individuals and households, social services to groups deprived of basic services, social insurance to protect people against the risks and consequences of livelihood shocks, and social equity to protect people against social risks such as discrimination or abuse.

Examples of social protection measures include: direct or targeted resource transfers such as cash, handouts and subsidies to people who experience shocks in livelihood; provision of social services to vulnerable groups such as the [abolition](#) of health and education charges or delivery of services to institutions that provide care for people unable to provide for themselves; provision of social insurance such as pension systems, health insurance, retrenchment packages and funeral societies; changes in the regulatory framework such as a statutory minimum wage and maternity benefits, anti-corruption legislation, outlawing of widow inheritance; and sensitisation campaigns to protect rights and address the negative stereotypes of the socially and economically disadvantaged groups such as people living with HIV/AIDS (PLHIV), orphans and other vulnerable children (OVC), persons with disabilities (PWDs), women and young people (Social Protection Task Force in Uganda, 2002).
EXECUTIVE SUMMARY

Introduction
The National Strategic Plan (NSP) 2011/12- 2014/15 was developed by the Uganda AIDS Commission (UAC) to guide implementation of the multi-sectoral response. The NSP provided the overall strategic direction for the response through four broad thematic areas, namely HIV Prevention, Care and Treatment, Social Support and Protection and Systems Strengthening.

The HIV prevention thematic area focuses on:

- Scaling up biomedical interventions to achieve universal access targets
- Upholding behavioural interventions
- Addressing socio-cultural and economic drivers of the epidemic
- Reinvigorating the political leadership at all levels to enlist their commitment to HIV prevention

In the realm of Care and Treatment, the strategic focus is on providing treatment for all those in need through accreditation of more health facilities for ART. The focus is also on efficient TB/HIV management, Early Infant Diagnosis and improved health system capacity to provide quality HIV care.

The Social Support thematic area focuses on advocacy for universal coverage to a comprehensive social support and protection package for the beneficiary groups. Attention is then placed on empowerment of households and communities with livelihood skills to help them cope with their socio-economic demands.

The systems strengthening thematic area provides the support environment for the realization of the NSP vision of having “A population free of HIV and its effects”. The focus is on strengthening the governance and leadership at all levels of the response, mobilizing the requisite resources and ensuring their targeted use in accordance with the NSP priorities, and nurturing the national HIV/AIDS Monitoring and Evaluation system.

In order to operationalize the NSP, a National Priority Action Plan (NPAP) was drawn for the period 2011/12 and 2012/13. The period July 2011 to June 2012 marked the first year of the NSP (2011/12) and this is the period under review.

Objectives of the Review
The main objectives of the review were to assess progress towards achievement of the stated NSP and National Priority Action Plan objectives during the first year of implementation of the NSP, identify gaps and challenges and make realistic recommendations that will inform future implementation.
Methodology

A number of approaches were employed including review of relevant documents, consultations with stakeholders (government and private sectors, district leadership, civil society, policy makers, TWG members) through interviews, meetings, and focus group discussions. We also held consensus meetings with stakeholders to discuss the findings of the review and recommendations.

Findings

Key Findings in the HIV Prevention Thematic Area

Overall, progress in the first year has been on laying the policy and implementation framework for rapid countrywide scale up of core prevention interventions.

Scale up of Biomedical Intervention

The Ministry of Health developed an Acceleration Plan to eliminate Mother to Child transmission of HIV by 2015 and the phased roll out of PMTCT option B+ has started with Central region. Safe Male Circumcision unit has been established to plan and coordinate the expansion of Safe Male Circumcision, which reached only 380,000 of the targeted 1,250,000 men. Correct and consistent condom use during risky sexual encounters was hampered by slump in condom importation experienced since 2010. The MoH thus revitalised the National Condom Coordination Committee at ACP/MoH, which drafted the National Condom Strategy and completed National condom quantification and forecast. Blood transfusion services continued with 100% screening and collected 199,871 out of the targeted 220,000 units of blood. Capacity was increased by procurement of equipment for 4 Regional Blood Banks. Access to Post-Exposure Prophylaxis has increased with reporting 114 health facilities supported by partners reaching 921 people including 303 for Occupational Exposure and 470 people following Rape/Sexual Assault.

Promoting safer sexual behaviour among target populations

The priority areas for ABC+ were strengthening HIV education in schools, faith based and community initiatives encouraging AB and family values and scaling up the YEAH initiative. Activities continued the Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY) programs in Primary, Secondary and Tertiary/Higher institutions of learning. Highlevel advocacy with and training of religious leaders facilitated promotion faithfulness, abstinence and integration of HIV/AIDS pastoral work and events. The Young Empowered and Healthy (Y.E.A.H) continued IEC/BCC activities targeting young people’s vulnerability to HIV and AIDS, early pregnancy and early school dropout. The Young people living with HIV and AIDS (YPLHIV) network expanded forming 52 groups countrywide.

Scaling up HIV counselling and testing and increase coverage and uptake
HIV counselling and testing was implemented in all hospitals and HCIIVs, 90% in HCIIs and 30% in HCIIs. Provider Initiated HIV Testing and Counselling (PITC) is implemented in all hospitals, all HC IVs and at least in 20% HCIIs. Innovative HCT approaches at the workplace were implemented by partners e.g. Moonlight HCT (provided at night for sex workers), ‘Go together know together’ and various forms of mobile and mass testing. Outreaches or dedicated clinics for Key population groups, were implemented by partners especially AIC. Guidelines for enhancing HCT linkage to care were developed and the National RH/HIV linkages and integration strategy was completed to guide RH/HIV linkages.

Mitigating underlying social, culture, gender and other factors that drive the HIV epidemic

Interventions to reduce stigma and discrimination hinged on finalisation and dissemination the National People Living with HIV Stigma Index. Preparatory activities for the survey of the National Stigma Index were started. Government engaged of cultural/religious leadership for HIV prevention at all levels. Ministry of gender, Labour and social development with support from partners initiated dialogue in 17 cultural institutions in the country. Focuses research on structural factors is being implemented in with partners in the area of male partner involvement in Uganda..

Recommendations / priorities for the coming year to attain targets

1. On Scaling up Biomedical and behavioural HIV prevention interventions
   o Rapidly scale up SMC within the formal health sector and strive to set district targets.
   o Integration of female condom procurements and IEC into rationalized supply procurement systems and IEC/BCC programs.
   o Initiate and uphold quality assurance in all the biomedical interventions irrespective of the desire to achieve big targets especially SMC.
   o Avail mechanisms of initiating starter packs for PEP at lower facilities like HCII, VHTs, the police stations and prisons that cannot attain ART accreditation status.
   o Developing local community champions for biomedical interventions.
   o Hasten the process of reconstituting the IEC/BCC TWG.

2. On Scaling up HIV counselling and testing and increase coverage and uptake
   o Strengthen linkages between community and home-based services to other mainstream health services.
   o HCT achievements exceed targets and need revision. Revision of the said targets should be considered before the mid-term review of the NSP.

3. Mitigating underlying social, culture, gender and other factors that drive the HIV epidemic
   o Raise prioritise implementation of Stigma Index
   o The OVC MIS that is already web based should be made fully operational to enable district implementers feed into the national information requirements.
   o Update national and district NGO/CBO databases and reporting to ease the process of follow-up in event of soliciting for information.

Key Findings in the Care and Treatment Thematic Area
Overall, some progress has been noted in the Care and Treatment thematic area.

**Increasing ART access:**

Access to antiretroviral therapy has been steadily improving. Between July 2011 and March 2012, an additional 89 facilities were accredited bringing the total number of sites from 443 to 532 of which 119 are hospitals, 169 HCIVs, 35 specialized HIV clinics and 209 HCIIIs and HCIIs. The NSP target of 100% HCIVs and 10% of HCIIIs by 2013 will most likely be surpassed given that the MOH is planning to accredit all HCIII (100%) by 2013 to support ART delivery. As of March 2012, 356,056 individuals were receiving treatment: 327,949 adults and 28,107 children which is 62% of the 577,024 estimated ART eligible, way below the universal access target of 80% by 2015. The number of ART eligible maybe higher given the rising prevalence. At the current enrolment rate, the NPAP two-year target of 240,000 newly initiated on treatment would be hard to achieve. Roll-out of Option B+ is therefore a major opportunity to increase ART coverage. Among the HIV infected pregnant women, only 52% had accessed ARVs for PMTCT in 2010/11, with majority receiving less effective regimens to prevent MTCT, while only 18-20% received HAART. Coverage among children has improved slightly from 24,141(25%) in June 2011 to 28,107 (29%) in March 2012. The number of males who had ever tested for HIV doubled (from 23% to 45%) between 2006 and 2011. Several workplace programs have been established both in GOU ministries and the private sector. By June 2012, the armed forces had 18 accredited ART sites (2 for Prisons, 1 for Police and 15 for the UPDF). Retention on ART is 84% within 12 months on treatment initiation, slightly below the 85% WHO recommendation and NSP target.

**Increasing access to prevention and treatment of opportunistic infections:**

As of December 2011, there were over 623,571 individuals in care at 838 sites nationally, which represented 53% of the estimated number of HIV infected persons. This proportion is likely to be lower given the increase in number of PHAs from 1.2 million to 1,390,732. Of all individuals in active HIV care, 80% were routinely screened for TB and over 90% prescribed cotrimoxazole for prophylaxis against opportunistic infections in line with national guidelines. A total of 300,000 Basic Care package kits were distributed in 85 districts. The National TB and Leprosy program has revised the 3-year strategic plan to include the 3 ‘I’s (Infection Control, Intensified Case Finding, and INH Preventive Therapy). There has been improvement in the TB/HIV indicators as 80% of TB patients had an HIV test, 93% received cotrimoxazole and 34% were initiated on ART. More GenExpert equipment has been procured for 22 facilities to improve TB diagnosis. National capacity to manage TB Multiple Drug Resistance (MDR) cases has improved with 2 treatment sites established in Gulu and Kampala. Commodity supplies for Opportunistic Infections have been more stable except
for TB medicines in the first quarter of 2012. Procurement and distribution of anti-TB medicines was transitioned from NTLP to NMS.

Integration of sexual and reproductive health into all care and treatment services:

The integration of Sexual and Reproductive Health Services (SRH) is well advanced and the strategy for this action has been approved. Sexual and Reproductive Health Services as part of the strategy to eliminate Mother-to-Child Transmission of HIV has been embraced and HE The President of Uganda pledged an extra $ 5 million dollars annually to go towards SRH.

Expansion of home-based and community-based care and support:

The national Home based Care guidelines (disseminated in 2010) were operationalised in 85/112 districts with a focus is on Positive health and dignity. Community development officers were trained to support PHA networks, and 500 PHA networks were trained in Home based Care, follow up and referral of patients to facilities within their catchment area. Up to 85 Village Health Teams (VHTs) were trained in referral and linkages with facilities. A network was formed at national level and in each of the 85 districts to monitor peer educators, BCP distribution and assess need for BCP.

Recommendations / priorities for the coming year to further increase access to Care and Treatment,

1. Expand access to ART : Support accreditation HCIIIs and HCIVs to provide ART to adults, children and pregnant women on Option B+ to support eMTCT goal. Revise national ART targets (facilities and individuals) to include pregnant women receiving HAART as part of PMTCT Option B+.
2. Strengthen health systems for ART delivery; improve access to CD4 to enable ART eligibility assessment and timely initiation on ART; recruit additional staff at facilities; rationalize supply chain management to ensure uninterrupted commodity supplies; improve reporting plus data use and advocate for use of unique client identifier.
3. Increase number of children in care and treatment through strengthening of the EID program, Know Your Child Status (KYCS) campaigns, Provider Initiated HIV testing (PITC). Standardize paediatric care approach among providers to support improved linkage, retention, and timely ART initiation. Review adolescent specific challenges and devise strategies to mitigate them.
4. Expand PITC and implement strategies that promote immediate linkage to ART and other services such as SMC, PMTCT, Care and Treatment). For SMC, explore integration with workplace programs. Utilize community groups to facilitate linkage between facilities and communities.
5. For TB, strengthen linkage with ART to improve access to treatment, improve access to effective diagnostics such as GeneXpert, strengthen supply chain management for anti-TB drugs to ensure uninterrupted treatment and minimize MDR risk, and expand coverage of the MDR treatment program.

6. HIVDR: Finalize the Early Warning Indicator (EWI) survey and disseminate findings; and strengthen HIV DR surveillance and prevention especially among the PMTCT Option B+ recipients.

Social Support and Protection Key Findings

Several government, civil society and community-based organisations are engaged in the provisions of education, psychosocial support, food/nutritional support, income generation social protection assistances, and legal aid and protection services to other vulnerable groups. Through these organisations, several OVC, PLHIV, PWD, and the elderly were supported with various social support and legal protection services.

Several national development programmes such as NUSA, NAADS and Humanitarian Assistance Programme incorporated concerns of vulnerable groups including PLHIV in their livelihood support initiatives. Some vulnerable groups were assisted with start-up credit and inputs for food security and income generation. Several policy and legal frameworks that have a bearing on social support for vulnerable groups in the context of the HIV epidemic were either reviewed or revised or translated or disseminated. In addition, the OVC MIS in the MOGLSD helped to collect vital data on several OVC indicators that are relevant to social support and protection from several districts.

However, there are still challenges regarding low coverage of vulnerable groups with social support and protection services. This is attributed to inequity of funding social support services of the different needy groups, lack of national multi-sectoral programme that systematically channels support to various AIDS service organisations at the national, district and community levels to undertake prioritised activities, and the glaring decline in direct engagement of vulnerable groups in formulation and implementation of social support and protection services among peers over the last five years.

In addition, the legal and policy frameworks that have direct bearing on social support and protection such as the Domestic Relations Act and the Gender Policy still experience resistance in some influential sections of society and this has hindered its implementation, while the HIV/AIDS prevention and Control Bill have not been presented because it contains provisions that are difficult to implement, have the risk of perpetuating stigma and revengeful practices in society, and violate the civil and human rights of individuals and couples.

Furthermore, the most nationally representative database for OVC support services still has challenges of incomplete district coverage, irregular reporting
and limited linkages with relevant sector management information systems, and the fact that reporting cycle of the key existing OVC data sources are not consistent with the government reporting cycle and therefore omit data of up to three months.

In addition, the M&E plan of the NSP did not identify output or outcome indicators for legal and protection, food and nutrition security, informal and vocational education, shelter provision, gender and disability mainstreaming, and HIV capacity building in JLOS structures. This has contributed to the poor documentation and reporting of data in these areas.

Recommendations

In order to improve the performance of social support and protection services, there is need to:

1. Assess the psychosocial needs of teachers and students in the context of HIV/AIDS; and strengthen school counselling services by revising the guidance and counselling course to include topics on HIV/AIDS/SGBV and adolescent counselling, training senior women and men teachers in first aid and AIDS counselling, and enforcing the establishment of counselling/support clubs and sickbays in schools [MOES].

2. Train more community volunteers in AIDS counselling, and mobilise and support community-based groups and PHA networks to carryout psychosocial services in the community [AIDS Service Organisations].

3. Review the NPAP and incorporate priority activities for AIDS workplace programs. Some of these include development and dissemination of inventory of workplaces with more than 20 workers, development of workplace policies and programs, and implementation of a comprehensive package of workplace activities [UAC & MOGLSD].

4. Support the key Self Coordinating Entities (SCEs) to review their programmes and mainstream gender, disability and HIV concerns [UAC].

5. Facilitate filed offices to train community-based paralegals and conduct periodic dialogues in schools and the community on the relationships between culture, SGBV and HIV/AIDS and on the specific actions to take in instances of abuse [JLOS Agencies].

6. Mobilise and support cultural, religious and community leaders to promote social norms that prevent and protect vulnerable groups against abuse and improper family socialisation processes [MOGLSD].

7. Mobilise, capacitate and directly engage community-based groups in identifying, registering, reporting, following-up and providing counselling and referral services to victims and perpetrators of SGBV. They should also educate PLHIV, OVC the elderly and community on writing memory books and wills [AIDS Service Organisations]
8. Assess the capacity needs of the public, civil society and community structures dispensing legal aid and protection services in handling human rights and HIV related litigation; and train judges, magistrates, prosecutors, administrator general, law enforcers, paralegals and legal aid providers on handling cases involving HIV infected children and youths [JLOS].

9. Support public, civil society and structures (like the Probation and Welfare, Police family and children's unit, community based services office, paralegals and community groupings of PLHIV, OVC, PWD and women) to identify, document, support and refer survivors of SGBV and other HIV abuses to suitable places for legal redress [UAC & ADPs].

10. Develop policy guidelines for addressing psychosocial and the sexual and reproductive needs of young people growing up with HIV infection in the different services [UAC, MOGLSD, MOES & MOH].

11. Organise dialogues to review and build consensus on the controversial provisions in the HIV/AIDS, Anti-Counterfeit, Industrial Property and other Bills that have the potential of undermining an effective AIDS response [UAC, Parliament & MOTI].

12. Initiate a national multi-sectoral HIV/AIDS programme whereby funding is mutually mobilised and directed to various national, district and community organisations to implement prioritised activities [UAC & ADPs].

13. Review and develop appropriate M&E indicators for the omitted intervention areas of social support and protection, and harmonise reporting cycles for the key OVC management information systems such as the OVC MIS and MEEPP [UAC & MOGLSD].

14. Strengthen the M&E capacity of UAC, relevant sectors, SCEs, local governments and umbrella AIDS service organisations to periodically record and report data on the different activities and outputs of their partner organisations [UAC, Line Ministries & MOLG].

**Systems Strengthening Findings**

The Systems Strengthening review focused on the leadership and governance structures; the resources required and available for the delivery of HIV/AIDS services during the period under report; and the state of the national M&E system in terms of providing the necessary strategic information for monitoring the response.

**Leadership and Governance Structures**

Overall, the national commitment to the management of the response as measured by the National Composite Policy Index (NCPI) has registered significant improvement from 54.6 % in 2010 to 65 % in 2012. This performance is largely attributed to the improved environment in the areas of policy development, strategic planning, Civil Society participation and the provision of Care and Treatment. In the same vein, the UAC management index, which had stagnated below the 50 % mark, has now risen to 62.5 %.
On the other hand, leadership and governance at the decentralized level remained weak, especially in the public sector realm. This has been compounded by the general governance mode that focuses more on processes and outputs than outcomes and impact. In order to reverse the current state of events, it is recommended that:

- The on-going review of the partnership structures should be accorded high priority in terms of the timeframe and dissemination of the results and should pay particular attention to the decentralized level response.
- The UAC should proactively build capacity for strategic governance and leadership at the various levels of the response.
- The proposed governance structures of MOH at regional level, UAC at zonal level, MoLG and other stakeholders should exhibit functional linkages that ease the streamlining of the HIV and AIDS governance process.
- The functionality of the various coordination committees needs to be objectively measured using simple standardized tools.
- UAC and partners should provide funding for the operations of decentralized coordination structures.
- A District HIV/AIDS League Table should be put in place and institutionalized to assess the individual decentralized responses on an annual basis.

**Resources for the delivery of quality HIV/AIDS services**

Human resources remain the biggest asset to the national response. However, there remain significant deficiencies of this resource in both quantity and quality at both the facility and community levels. The commodities that the human resource requires to deliver HIV/AIDS services have registered stockouts at the service outlet level during the period under report.

The AIDS Development partners continued to contribute the lion’s share of the financial resource envelope. However, GOU contributions registered an increase in absolute currency units. For the benefit of the response in the coming year, it is recommended that:

- The indicator on tracking availability or stock outs of drugs, laboratory reagents and other commodities should, in the meantime, be disaggregated into three separate components with a tracer item for each of the components until such a time when DHIS 2 can provide the composite indicator data.
- The establishment of the proposed HIV and AIDS trust Fund should be expedited.
- CSF and other HIV/AIDS funding should be aligned to the NSP priorities.
- A national Resources Mobilization Strategy should be put in place
- A resource tracking mechanisms such as NASA should be institutionalised
- There is need to improve efficiency of HIV/AIDS spending by focusing HIV/AIDS spending to those interventions that have big impact on reducing the number of new infections and improving the quality of life and support

**Management of Strategic Information for the HIV/AIDS response**

The HIV/AIDS Monitoring and Evaluation systems at the UAC, various ministries and departments and at the district level, remain weak. The establishment of “One national HIV/AIDS Monitoring and Evaluation System” continues to face many challenges. It is in view of these findings that the following are recommended:

- UAC should assist the various MDAs and districts to assess the strengths and weaknesses of their HIV/AIDS M&E systems so as to develop action plans to strengthen them. Special attention should be paid to the Ministry of Health, as the biggest contributor to the national M&E system data requirements.
- The M&E teams should be proactive in advocating for M&E through providing M&E by-products that are appealing, friendly and valuable to the whole stakeholder team.
- The M&E sub-committee should be involved in monitoring the progress of the consultancy services for the development of the national HIV/AIDS database at the UAC.
Chapter One  Introduction and Background

1.1  Introduction

The Uganda AIDS Commission in consultation with key stakeholders prepared and revised the National HIV and AIDS Strategic Plan (NSP) (2011/12-2014/15). The plan was prepared after an extensive midterm review of the implementation of the National HIV/AIDS Strategic Plan (2007/08-2011/12). The plan was aligned to the National Development Plan (2010/11-2014/15). The overarching goal of the revised NSP is to achieve universal access targets for HIV/AIDS prevention, care, treatment and social support and protection by 2015. The NSP has four specific goals:
1. To reduce HIV incidence by 30% by 2015;
2. To improve the quality of life of PLHIV by mitigating the health effects of HIV/AIDS by 2015;
3. To improve the level of access of services for PLHIV, OVC and other vulnerable populations by 2015; and
4. To build an effective and efficient system that ensures quality, equitable and timely service delivery by 2015

The NSP specific goals constitute the three service thematic areas of the national HIV and AIDS response (HIV prevention, care and treatment and social support and protection) and one support thematic area (strengthened systems of service delivery). The NSP provides strategic objectives and priority strategic actions and targets for each of the thematic areas for the four year period. It provides a common strategic framework that will guide all interventions by all stakeholders in the national response to HIV and AIDS epidemic.

In order to operationalize the NSP, a National Priority Action Plan (NPAP) that elaborates priority activities that must be implemented for each of the agreed strategic actions and the targets to be achieved for the first two years of NSP, was prepared. The NPAP was similarly prepared through a consultative process with key HIV and AIDS stakeholders.

The NSP and its NPAP has been implemented by all stakeholders in the multi-sectoral HIV and AIDS response at national, local government and community levels since July 2011 with financial and technical support from Government of Uganda and Development Partners.

1.2  Rationale for the review of implementation of NSP

As part of good monitoring and evaluation practice, HIV and AIDS stakeholders agreed to conduct annual Joint AIDS Reviews (JAR) of the National HIV and AIDS Strategic Plans. The overall objective of the review is to assess the progress of implementation of the NSP priority interventions in the previous year and plan
for improved implementation in the upcoming year. In order to comprehensively document the progress of implementation of the plan, Uganda AIDS Commission and stakeholders are preparing a report on implementation of Year One of the NSP. The report will document progress attained, challenges and emerging issues, missed opportunities, best practices experienced in the previous year and proposed recommendations for improvements in the coming year. The report will be presented and discussed by all the stakeholders at the Joint AIDS Review.

1.3 Methodology and process for the review of implementation of Year One of NSP.

The report on implementation of Year One of NSP was prepared through a participatory and consultative process, engaging all key stakeholders involved in the implementation of the NSP and the national HIV and AIDS response in order to ensure ownership and accountability of the results. In order to ensure objective assessment of the NSP implementation, a team of four independent consultants (one on HIV Prevention, Care & Treatment, Social Support & Protection and Systems Strengthening) were recruited to review and prepare a comprehensive report on the progress of implementation of the first year of NSP in the respective thematic areas.

A Steering Committee and Coordination Team were constituted with representation from key stakeholders in the national HIV and AIDS response to provide oversight and coordination of the review and report preparation process. Four Thematic Technical Working Groups (TWGs) (one on HIV Prevention, Care & Treatment, Social Support and Protection and Systems Strengthening) were constituted to review and validate the reports prepared by the respective thematic consultants.

The consultants carried out extensive desk review of key resource documents on the national HIV/AIDS response (the documents reviewed are listed in the Annex of this report), conducted structured interviews with some selected key stakeholders especially at the national level. Four consultative meetings were organized with the following key stakeholders in the national response: i). government ministries, departments and agencies (MDAs); ii) civil society organizations working in HIV/AIDS; iii) the four major medical bureaus and iv). private sector organizations. During the consultative meetings, the consultants were able to interface with stakeholders and discussed the major achievements attained and challenges experienced during the year and the proposed recommendations for improvements during the upcoming year with stakeholders. The consultants then synthesized the information and data obtained from the desk review, interviews, consultative meetings and any other sources available to them including websites (local and international) etc to prepare the draft respective thematic reports.
The draft reports were presented and discussed with the respective Thematic TWGs. The consultants incorporated the comments from the Thematic TWGs members to produce the revised thematic reports, which were presented and discussed in the Partnership Committee meetings. The comments provided by the Partnership Committee members were incorporated to produce the final report.

1.4 Limitations for the review

The main limitations for the review of implementation of Year One of NSP were limited information and data on HIV and AIDS programme activities and limited time to consult stakeholders. Not all stakeholders and implementers of HIV and AIDS programmes, especially those at sub-national levels such as districts were consulted and interviewed. Furthermore, there was limited quantifiable strategic information in most of the reports submitted, mainly due to weaknesses and fragmentation in the current national M&E systems.

1.5 Report outline

The outline of the report on the implementation of the Year One of NSP is as follows:

Chapter 1 Introduction and background
Chapter 2 Overview of performance of the national HIV/AIDS response during FY 2011/112
Chapter 3 Prevention thematic service area
Chapter 4 Care and Treatment thematic service area
Chapter 5 Social support and protection thematic service area
Chapter 6 Strengthening systems for service delivery
Chapter 7 Monitoring the implementation of NSP in particular the 2011 JAR Undertakings
Chapter 8 Emerging issues/challenges and recommendations for the national HIV/AIDS response
Annexes

During the revision of the National Strategic Plan, the HIV/AIDS stakeholders agreed to a set of indicators for monitoring the national response and targets were set against these indicators for 2015. In order to operationalize this strategic plan, the National Priority Action Plan (NPAP), covering the period 2011 to 2013, was put in place to provide appropriate guidance to all the stakeholders. It is important to note that the NSP did not identify a set of key indicators that could be used to provide a global overview of the performance of the multi-sectoral response. The NPAP identified a set of indicators for each of the four NSP Goals as benchmarks for progress assessment. Out of the twenty six NPAP indicators, 58 % were extracted from the NSP indicator set while 42 % were completely new indicators.

On the whole, the Care and Treatment Thematic area has registered commendable performance, despite the fact that the data available covers only the first nine months of the period under report. Similarly, the Systems strengthening Thematic area has performed well in terms of financial and national commitment to the response. The progress made by the Prevention and Social Support Thematic areas, in accordance with the NPAP indicators, has been overshadowed by the lack of data. However, some progress has been made against the strategic actions that were stipulated in the NPAP.

1.1 Performance Against the NPAP Indicators

Table 1: Goal 1: To Reduce HIV Incidence by 30 % by 2015

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline Value</th>
<th>NPAP 2013 Target</th>
<th>Status as of June 2012</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction of the estimated number of new infections</td>
<td>129,000</td>
<td>111,917</td>
<td>145,294 in 2011 males 68,097, female 77,197</td>
<td>Targets and outputs based on mathematical modeling</td>
</tr>
<tr>
<td>Reduction in the number of vertical HIV infections</td>
<td>19,544</td>
<td>10,000</td>
<td>No Data</td>
<td>Targets and outputs based on mathematical modeling</td>
</tr>
<tr>
<td>Percentage of HIV positive pregnant women who received antiretroviral drugs to reduce the risk of MTCT</td>
<td>52 %</td>
<td>75 %</td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>Percentage of randomly selected retail outlets and service delivery points that have condoms in stock</td>
<td>45 %</td>
<td>60 %</td>
<td>No Data</td>
<td>Survey not conducted</td>
</tr>
<tr>
<td>Number of males (14 – 49) circumcised</td>
<td>1,250,000</td>
<td>380,000</td>
<td>Incomplete data. Actual output likely to be higher</td>
<td></td>
</tr>
<tr>
<td>Number of adults (14 – 49) counseled, tested and received</td>
<td>3,500,000</td>
<td>No Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Baseline Value</td>
<td>NPAP 2013 Target</td>
<td>Status as of June 2012</td>
<td>Comments</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------</td>
<td>------------------</td>
<td>-----------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Percentage of adults and children in need, receiving antiretroviral therapy (ART) increased</td>
<td>50 %</td>
<td>65 %</td>
<td>62 % (As of Mar. 2012)</td>
<td>More efforts required to hit the 2013 target</td>
</tr>
<tr>
<td>Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (ART) increased</td>
<td>84 %</td>
<td>85 %</td>
<td>84 %</td>
<td>Target achievable</td>
</tr>
<tr>
<td>Percentage of hospitals accredited for adult / paediatric ART services increased</td>
<td>100 %</td>
<td>94 % (As of Dec. 2011)</td>
<td>Target achievable</td>
<td></td>
</tr>
<tr>
<td>Percentage of HC IVs accredited for adult / paediatric ART services increased</td>
<td>91 %</td>
<td>100 %</td>
<td>96 % (As of Dec. 2011)</td>
<td>Target achievable</td>
</tr>
<tr>
<td>Percentage of HC III accredited for adult / paediatric ART services increased</td>
<td>6 %</td>
<td>10 %</td>
<td>8 % (As of Dec. 2011)</td>
<td>Target achievable</td>
</tr>
<tr>
<td>All accredited ART sites performing or linked to laboratories with CD 4 and Full Blood Count capacity</td>
<td>100 % for HC IV and 10 % for HC III</td>
<td>78 % for HC IVs</td>
<td>Target achievable with the recent procurement of 250 CD 4 machines.</td>
<td></td>
</tr>
<tr>
<td>Percentage of estimated HIV positive incident TB cases that receive treatment for both TB and HIV</td>
<td>24%</td>
<td>60 %</td>
<td>34 %</td>
<td></td>
</tr>
<tr>
<td>Percentage of HIV patients in Care, receiving cotrimoxazole prophylaxis</td>
<td>93 %</td>
<td>95 %</td>
<td>90 %</td>
<td>Decline could be due to improved data quality</td>
</tr>
<tr>
<td>Percentage of Hospitals and Health Centres providing PITC</td>
<td>100 % of hospitals</td>
<td>100 % of HC IVs</td>
<td>No Data. PITC provided in all PMTCT ANC sites</td>
<td></td>
</tr>
<tr>
<td>Unmet need for Family Planning among HIV infected individuals</td>
<td>41%</td>
<td>&lt; 10 %</td>
<td>No Data Could use 2010 baseline.</td>
<td></td>
</tr>
<tr>
<td>Percentage of health facilities linked to operational HBC services</td>
<td>80 %</td>
<td></td>
<td>No Data. Need survey</td>
<td></td>
</tr>
</tbody>
</table>

**Table 3 : Goal 3 : To Improve the Level of Access to Services for PLHIV, OVC and other Vulnerable Populations**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline Value</th>
<th>NPAP 2013 Target</th>
<th>Status as of June 2012</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Households that receive economic strengthening and support</td>
<td>41.2 %</td>
<td>60 %</td>
<td>No data</td>
<td>TBD Using LQAS</td>
</tr>
<tr>
<td>Percentage of OVC who have access to a comprehensive service package</td>
<td>24.8 %</td>
<td>40 %</td>
<td>No data</td>
<td>TBD Using LQAS</td>
</tr>
<tr>
<td>Percentage of PLHIV and Vulnerable Households that receive IGA support</td>
<td>60 %</td>
<td>No data</td>
<td>TBD Using LQAS</td>
<td></td>
</tr>
<tr>
<td>Percentage of PLHIV and persons</td>
<td>39 %</td>
<td>25 %</td>
<td>No data</td>
<td>TBD Using LQAS</td>
</tr>
</tbody>
</table>
most Vulnerable to exposure to HIV reporting cases of SGBV

| Percentage of Large Work Places (employing 20 or more persons) that have HIV/AIDS Policies | 83 % | 90 % | No data | Baseline value needs to be revisited |

Table 4: Goal 4: To Build an Effective and Efficient System that Ensures Quality, Equitable and Timely services

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline Value</th>
<th>NPAP 2013 Target</th>
<th>Status as of June 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Composite Policy Index (NCPI)</td>
<td>54.6 %</td>
<td>70 %</td>
<td>65 %</td>
</tr>
<tr>
<td>Proportion of DACs that are Functional</td>
<td>30 %</td>
<td>50 %</td>
<td>30 %</td>
</tr>
<tr>
<td>Proportion of PLHIV Networks that are Functional</td>
<td>90 %</td>
<td>95 %</td>
<td>90 %</td>
</tr>
<tr>
<td>Percentage of health facilities reporting non stock outs of drugs, lab reagents and other commodities</td>
<td>No Targets</td>
<td>Cotrim 92 % ARVs 71% Condoms 87%</td>
<td>Improvement registered mainly in policy, strategic planning, Civil Society participation and provision of Care and Treatment</td>
</tr>
<tr>
<td>Improved Domestic (GOU) HIV/AIDS Spending</td>
<td>11 %</td>
<td>12 %</td>
<td>In tune with anecdotal reports of stockouts</td>
</tr>
<tr>
<td>Percentage of the national M&amp;E plan indicators that are reported on according to schedule</td>
<td>35 %</td>
<td>60 %</td>
<td>49 %</td>
</tr>
</tbody>
</table>

Table 1: Stock-outs of OI/STI medicines in review period of 2009/2010

<table>
<thead>
<tr>
<th>Product</th>
<th>Number of facilities that managed the product</th>
<th># of facilities that had stock out in review period</th>
<th>Mean annual stock-out days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acyclovir 200mg</td>
<td>34</td>
<td>17 (50.0%)</td>
<td>104</td>
</tr>
<tr>
<td>Cotrimoxazole 400mg/80mg</td>
<td>44</td>
<td>20 (45.5%)</td>
<td>56</td>
</tr>
<tr>
<td>Fluconazole 200mg</td>
<td>28</td>
<td>16 (57.1%)</td>
<td>134</td>
</tr>
<tr>
<td>Metronidazole 400mg</td>
<td>44</td>
<td>21 (47.7%)</td>
<td>81</td>
</tr>
<tr>
<td>Benzathine penicillin 2.4 MU</td>
<td>35</td>
<td>12 (34.3%)</td>
<td>67</td>
</tr>
<tr>
<td>Ciprofloxacin 500mg</td>
<td>44</td>
<td>24 (54.5%)</td>
<td>85</td>
</tr>
<tr>
<td>Doxycycline 100mg</td>
<td>45</td>
<td>22 (48.9%)</td>
<td>108</td>
</tr>
</tbody>
</table>
The challenges faced during the period under report remain largely structural. The leadership and governance of the response leave some room for improvement, especially at the decentralized level. The capacity to provide both facility and community based HIV/AIDS services remains greatly constrained. The strategic information management systems at the UAC and in the various sectors have not been able to provide the required data at the required time and in the required quantities.

These challenges are neither new nor insurmountable. Unfortunately, the country has to grapple with rising new HIV Infections in the midst of these challenges. The year 2012/13 should see a strengthened response at the centralized and decentralized levels; an alignment of all HIV/AIDS activities to the NSP; and regular accountability through data and information sharing.
3.1 BACKGROUND

Uganda’s HIV/AIDS epidemic is generalized. The current HIV prevalence is estimated at 7.3% (AIS 2011) among persons aged 15-49 years. About 80% of infections are attributable to heterosexual transmission. Mother to child transmission accounts for about 18% while blood borne and other infections account for less than 1%.

The Government of Uganda in collaboration with stakeholders is implementing the revised National HIV and AIDS Strategic Plan 2011/12 – 2014/15 (NSP). The country’s HIV response is also guided by the National HIV Prevention Strategy (NPS) 2011/15 that defines key prevention priorities and targets. The overarching goal of both documents is to achieve universal access targets for HIV/AIDS prevention, care, treatment and social support and protection by 2015. The National Priority Action Plan (NPAP 2011/12-2012/13) was developed to guide implementing partners in their annual work planning and alignment of resources towards achievement of the NPS and revised NSP goals and targets.

This report details the key achievements in respect to implementation of the HIV thematic area of the NSP, existing challenges and recommends actions for possible improvement.

3.1.1 THE PREVENTION COMPONENT OF THE HIV/AIDS NSP 2011-15

Prevention continues to be the cornerstone for Uganda’s HIV/AIDS response. The overall goal of HIV Prevention is to reduce HIV Incidence By 30% by 2015. The priority actions for HIV prevention in the country as expressed in the NPS and NSP and operationalized through the National Priority Action Plan (NPAP) fall under the following specific objectives of the NSP:

1. To scale up coverage, quality and utilisation of proven biomedical and behavioural HIV prevention interventions
2. To scale up coverage and uptake of HIV counselling and testing (HCT)
3. To mitigate underlying social, cultural, gender and other factors that drive the HIV epidemic

The overall approach dictates implementing multiple biomedical, behavioural and structural HIV prevention interventions with known efficacy in a geographic area at a scale, quality, and intensity that impacts the epidemic.

3.1.2 PURPOSE AND METHODOLOGY

The purpose of this report is to:

(1) Assess progress of implementation of the NSP against targets during the first Year of implementation;
(2) Identify the challenges experienced, lessons learnt and best practices during the first year of NSP and
(3) Propose recommendations for better implementation of the NSP in the upcoming years
The principal methods used included:

- Review of periodic progress reports from selected line ministries, civil society and private sector organisations;
- Face-to-face interviews with managers and HIV/AIDS focal persons of key ongoing programmes in government, civil society and private organisations; and
- Presentation and discussion of progress reports during consultative meetings with Prevention Technical Working Group and the Partnership Committee.

The information was synthesised and is presented according to the planned strategic actions of each HIV prevention strategic objective of the NSP in Chapter 2.

This chapter presents the achievements during implementation of the National priority actions during the period July 2011 to June 2012. It also provides the challenges and recommended actions for improvement in the upcoming years.

**Progress towards the goal**

The overall goal of HIV prevention is to reduce HIV incidence by 30% by 2015. This will translate to a 40% reduction in the number of new infections. The number of new infections was estimated to be 128,000 in 2010 and the target is to reduce the annual infections to 94,503 by 2015.

3.2.1 **SCALING UP COVERAGE, QUALITY AND UTILIZATION OF PROVEN BIOMEDICAL AND BEHAVIOUR HIV PREVENTION INTERVENTIONS**

The priority prevention biomedical interventions are (Prevention of Mother to Child Transmission) PMTCT using Option B+ lead, access and uptake for Anti-retroviral (ART) services, Safe Male Circumcision (SMC), blood transfusion safety, Post-Exposure Prophylaxis (PEP) and adherence to universal precautions.

**STRATEGIC ACTION 1.1: SCALE UP OF PMTCT USING OPTION B+**

- As a move towards elimination of MTCT, the Ministry of Health (MoH) developed an Acceleration Plan to eliminate Mother to Child transmission (eMTCT) of HIV by 2015 and keep mothers alive through PMTCT option B+. The roll out plan for countrywide implementation was completed and resources to a tune of US$ 24M were secured. The eMTCT plan was launched in September 2012.

- Training curricular for PMTCT using option B+ has been harmonized with ART. Following its development and harmonisation, 120 national and regional trainers have been oriented and are expected to conduct lower level training within the districts in the upcoming years. At least 553 health care workers successfully completed an in-service training program in PMTCT.

- About 205,000 packs of Option B+ Anti-retroviral medicines have thus been procured with support from PEPFAR and some sites are already implementing option B+ while others are in advanced preparatory stages.

1 This excludes parasocial community workers trained in PMTCT
• Provider Initiated Counselling and Testing (PICT) services are currently provided in all hospitals and HCIVs, 90% of HCIIIIs and 20% of HCIIIs. Health workers are undergoing an in service training in PICT. The training will build capacity for PICT as well as couple counselling and testing.

The actual increment in number of health facilities providing PICT and HIV Counselling and Testing (HCT) following the training is yet to be ascertained.

• In a bid to improve linkages and referral between PMTCT and HIV care and treatment services, MoH developed the HCT policy implementation guidelines (2011). Within these guidelines indicators were included to facilitate client tracking and improve linkage to other health care services in addition to HIV care and treatment. Policy dissemination is on-going concurrently with implementation.

**STRATEGIC ACTION 1.2: SCALING UP ACCESS AND UPTAKE FOR ART SERVICES AMONG THOSE IN NEED**

• By March 2012, the number of facilities providing ART services in the public and private sector in Uganda had increased from 423 by Dec 2010, to 660 by December 2011 and about 700 by March 2012. However, only 532 facilities actively reported during the period.

• Health facility ART coverage reached 100% of referral hospitals, 93% of district hospitals, 96% of HCIV and 8% of HCIII.

• The uptake of ART services also consistently increased over the years, from 260,817 in December 2010, to 330,000 by Dec 2011 and 356,056 (327,949 Adults and 28,107 Children) by March 2012. This figure far exceeds the 240,000 clients which was the NSP target for 2012.

• The government increased budgetary allocation to the health sector with a commitment to provide treatment to an additional 100,000 Persons Living with HIV (PLHIV) during the FY 2011/12.
ART facility coverage especially in under-served regions and populations such as prisons and other uniformed services, fishing communities, and some rural/hard to reach districts improved over the year.

- Outreaches were conducted including mobile Clinics for fishing communities in some districts where static facilities are not yet available. Outreach services have also been provided to other Key populations through implementing partners like AMICALL, Reach-out Mbuya, and AIDS Information Centre (AIC). The key populations reached include urban slums, fishing communities and minority populations such as sex workers.

- ART eligibility in the country is determined through a CD4 count of < 350 cells per mm$^3$ or WHO clinical stage III and IV. In order to increase access to ART eligibility assessments and CD4 monitoring, 280 PIMA CD4 count machines were procured and distributed to HCIV and selected HCIII. The recipient sites are currently able to perform regular laboratory based ART-patients monitoring.

- Over the year, reorganising the dry blood sample transport hubs by regions was done which improved EID diagnosis and determination of eligibility for treatment in children.

- To ensure uninterrupted supply of ARVs and other health commodities at the central and facility levels, the MoH rationalized the Supply Chain Management (SCM) system to be implemented based on “One Site One Supplier” system. The rationalized SCM system will ensure that public facilities are supplied by NMS, PFP facilities by JMS and, PNFP sites supported through MAUL. To reduce wastage, public facilities will not have direct buffer supplies; instead buffer stocks will be at NMS. A Task Team with the responsibility of collating and consolidating all relevant information in readiness for the transition was constituted and a Transition Plan prepared with commencement date set for 1st October 2012.
In a bid to improve staff recruitment and retention, the budgetary allocation to the health sector was increased by over 40 billion shillings in the FY 2011/12 to cater for increment in staff salaries as well as recruitments.

Advocacy meetings were held between partners including PLHIV, MoH, researchers, donors and others, in effort to drum support for treatment for prevention as a core intervention amongst the HIV prevention strategies of the country.

**STRATEGIC ACTION 1.3: SCALING UP SAFE MALE CIRCUMCISION**

- Safe male circumcision is currently conducted at health facilities, out-reaches and camps that employ trained circumcisers (surgeons).
- Messages on SMC were developed by MoH and disseminated at both national and lower levels thus generating a high demand for the service.
- In December 2011, MOH with partners launched the “Stand Proud, Get Circumcised” demand creation campaign. The campaign strategy was designed to convince men to go for SMC services, while encouraging women to support men to get circumcised and adhere to post-circumcision practices that promote healing. Whereas there is currently high latent demand for circumcision, the AIS 2011 indicated that about 50% of males are not willing to circumcise which calls for concerted communication efforts. A National health Hotline for more information on was set up.
- Over the review period, 418 health workers were trained in SMC. At least 240 outlets performed SMC surgery as part of the minimum care package of SMC for HIV prevention services with a total of 380,000 circumcisions conducted by March 2012 out of the targeted 1,250,000.
- AMICAAL in partnership with UAC, MoH, WHO and district local governments; initiated an approach in which SMC was launched SMC in the districts of Gulu, Arua, Kasese, Rakai and Mayuge. The approach involved engagement of political and cultural leaders (through the urban leaders forum) to mobilise communities for the services.

**STRATEGIC ACTION 1.4: INCREASING CORRECT AND CONSISTENT CONDOM USE DURING RISKY SEXUAL ENCOUNTERS**

Condom distribution and promotion of use is a cost-effective strategy for HIV prevention. Condom use among adults in Uganda is still low.

- During the reporting period, the National Condom Strategy was drafted by the MoH. A National Strategy on Alternative Distribution of Reproductive Health Commodities featuring condoms was also endorsed by MoH and the National Condom Coordination Committee at ACP/MoH revived.
- MoH and stakeholders conducted a National condom quantification of condoms and forecasted the needs for key populations and for

![Imported Condoms](Trend in Condom Imports 2006 – 2011(Source: CCO - MOH))
contraception covering 2012 to 2015.

- A total of 192 million condoms were forecasted for use in 2012. However, based on the available supply, there is a gap of 96 million condoms. From December 2011 to September 2012, the country received 53,253,600 public sector condoms that were procured through UNFPA & USAID support.
- Male and female condoms distribution was promoted through non-health facility based mechanisms like boda-boda riders and sex workers networks. Uganda Red Cross piloted distribution through alternative ways specifically working with boda-boda cyclists who distributed over 5 million condoms in KCCA.
- About 3 million female condom pieces were received by implementing partners including UNFPA and Global Fund in 2011. These partners were STAR SW, STAR E, STAR EC, JCRC, MUJHU, MSIU and AIC. Female condom use has been accepted mainly among sex workers, family planning clients, students at tertiary institutions, Uniformed Forces, long distance truckers PLHIV and the fisher folk. Other activities included training of service providers in public and non-public facilities, procurement of female condom demonstration aides and communication materials as well as distribution of procured items to a few districts.

Despite above figures, the number of male and female condoms distributed in the public health system and social marketing which was rising over the past 10 years, declined sharply during 2011/12.

- Altogether, at least 4,822 targeted condom outlets were established, distribution was also achieved through sectors like MoES that reached university students. Condoms are also distributed at health facilities, through socio marketing outlets, community distribution networks, and private pharmacies as well as some implementing partners like MSI, PACE, Uganda Red Cross, AIC, National STD

![Trend in Condom Imports 2006 – 2011(Source: CCO - MOH)
Clinic (Mulago) targeting key population groups and UHMG.

- 200 self-dispensing facilities were installed in workplaces and to key populations in and around Kampala thus easing access to condoms.

**Condoms distributed per year (2006-11)**

<table>
<thead>
<tr>
<th>Year</th>
<th>UHMG</th>
<th>Pace</th>
<th>MSI</th>
<th>Public Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>16,536,519</td>
<td>2,616,150</td>
<td>18,227,232</td>
<td>67,800,000</td>
</tr>
<tr>
<td>2007</td>
<td>8,044,740</td>
<td>6,047,250</td>
<td>15,786,120</td>
<td>80,999,148</td>
</tr>
<tr>
<td>2008</td>
<td>17,449,790</td>
<td>4,012,710</td>
<td>18,834,438</td>
<td>51,596,150</td>
</tr>
<tr>
<td>2009</td>
<td>17,024,940</td>
<td>8,053,700</td>
<td>8,786,301</td>
<td>61,292,338</td>
</tr>
<tr>
<td>2010</td>
<td>16,034,952</td>
<td>6,615,265</td>
<td>8,740,980</td>
<td>35,000,000</td>
</tr>
<tr>
<td>2011</td>
<td>10,269,510</td>
<td>7,303,972</td>
<td>10,000,000</td>
<td>70,000,000</td>
</tr>
</tbody>
</table>

**STRATEGIC ACTION 1.5: SUSTAINING 100% BLOOD TRANSFUSION SAFETY AND ADHERENCE TO UNIVERSAL PRECAUTIONS**

- In total 199,871 out of the targeted 340,000 units of blood (at least 1% of the total population) were collected during the review period.
- All donated blood was screened for HIV, Hep. B, C, Syphilis in a quality controlled manner. Results of the screening are yet to be accessed.
- Routine blood transfusion safety activities were implemented including procurement of equipment and supplies for laboratories; blood donor recruitment, blood collection, transportation, testing and storage. Standby generators for Arua, Gulu, Fort Portal and Kitovu Regional Blood Banks (RBB) were procured. Two more vehicles were also procured for the blood bank.

**STRATEGIC ACTION 1.6 : PROMOTING MEDICAL INFECTION CONTROL**

- National Policies and Guidelines on medical infection prevention and control are available at health facility level. The policy on single use needles and syringes is being implemented. All (100%) health facilities have and use the re-use prevention injection devices.
- 80% of health facilities have access to at least one copy of the various guidelines.
- Infection Prevention and Control has been institutionalized through establishment of Infection Control Committees at National and facility level; at least 70% of hospitals have the committees in place.
- About 115 health workers completed an in-service training program in injection Safety and waste disposal. The Uganda Peoples Defence Forces (UPDF) trained 64 health workers and procured core equipment/gear for work place safety.
• Infection Prevention and Control was extended to communities targeting saloon operators and People Living with AIDS. 1500 Saloon Operators and 31 People Living with HIV have been trained in infection control practices.

**STRATEGIC ACTION 1.7: PROMOTING 100% ACCESS TO POST-EXPOSURE PROPHYLAXIS (PEP)**

• The first edition of the PEP Policy Guideline is under review for purposes of being updated. The first edition of PEP Policy guidelines considered non-occupational exposures such as rape, defilement and human bites. The revised version has expanded non-occupational exposures to include Road Traffic Accidents and other injuries such as at construction sites; and tragedies as in collapsed buildings.

• Post Exposure Prophylaxis has to date been scaled up to all Public and some Private hospitals, some Health Centre IVs and IIIls. Over the review period, 114 health facilities supported by partners had HIV Post Exposure Prophylaxis (PEP) available. From these facilities, Post-Exposure Prophylaxis was provided to 921 people including 303 that received PEP for Occupational Exposure. PEP was also provided to 470 people following Rape/Sexual Assault.

• The supplies for PEP are now integrated in the ART supply chain and no shortages of ARVs for PEP at the accredited sites were reported. PEP service continued to be provided in ART clinics and where alternative sites are used; supplies were provided and kept at such sites.

• HCT is integrated into management of Sexual and Gender Based Violence (SGBV) and is a pre-requisite for accessing ARVs for PEP.

• There have been efforts to create awareness among the law enforcement leadership about the need to observe PEP as an emergency response. These efforts have yielded results in that survivors of rape and defilement are routinely referred with police forms to health facilities immediately they arrive at police stations.

<table>
<thead>
<tr>
<th>Table: Progress in Biomedical HIV Prevention Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator</strong></td>
</tr>
<tr>
<td>Percentage of HIV positive pregnant women who received antiretroviral drugs to reduce risk of mother to child transmission</td>
</tr>
<tr>
<td>Number of facilities providing PMTCT services</td>
</tr>
<tr>
<td>Number of sites accredited for ART delivery</td>
</tr>
<tr>
<td>Health facilities provided ANC services together provide both HIV testing and ARVs for PMTCT on site</td>
</tr>
<tr>
<td>Proportion of facilities providing PICT</td>
</tr>
<tr>
<td>• Hospital and HCIV</td>
</tr>
<tr>
<td>• HCIII</td>
</tr>
<tr>
<td>• HCCI</td>
</tr>
<tr>
<td>Districts providing Home based HCT</td>
</tr>
<tr>
<td>Number of male circumcisions conducted</td>
</tr>
<tr>
<td>Number of eligible PLHIV of ART</td>
</tr>
<tr>
<td>Indicator</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Number of condoms distributed to end users</td>
</tr>
<tr>
<td>• Male</td>
</tr>
<tr>
<td>• Female</td>
</tr>
<tr>
<td>Number of blood units collected</td>
</tr>
<tr>
<td>Percent of blood units screened according to standards</td>
</tr>
<tr>
<td>Percent of ART sites providing PEP</td>
</tr>
</tbody>
</table>

### 3.2.2 PROMOTING SAFER SEXUAL BEHAVIOUR AMONG TARGET POPULATIONS

ABC+ for HIV prevention is a combination behavioural change approach involving Abstinence, including delay of sexual debut, keeping safer by being faithful to one partner or reducing the number of sexual partners, and correct and consistent Condom use.

**STRATEGIC ACTION 1.8: PROMOTING ABC+ FOR HIV PREVENTION**

Since young people constitute half of the country’s population, they must be a key part of any strategy to combat HIV. Thus, the priority areas for ABC+ were strengthening HIV education in schools, faith based and community initiatives encouraging AB and family values and scaling up the YEAH initiative.

- The Ministry of Education and Sports (MOES) continued implementing the Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY) programs in Primary, Secondary and Tertiary/Higher institutions of learning. Through the initiative, talking compounds and school AIDS clubs continued to thrive in over the year. The education sector was also supported to review the school health policy incorporating HIV/AIDS.
- ICRU trained religious leaders in Comprehensive HIV/AIDS knowledge to enable them promote faithfulness, abstinence and integrate HIV/AIDS in their day to day pastoral work and events.
- The Young Empowered and Healthy (Y.E.A.H) initiative was established in 2004 targeting young people 15 – 24 years. The initiative is led by the UAC in partnership with other organizations working with young people in Uganda and with technical support from both HCP. It address practices that increase young people’s vulnerability to HIV and AIDS, early pregnancy and early school dropout through radio spots and IEC materials encouraging young men to drink responsibly or not at all (True Manhood Alcohol Campaign).
- Y.E.A.H. developed interactive tools and trained peer educators, teachers, and police officers in their use, and reinforced these activities with radio and television programming, billboards, fact sheets, and alcohol self-assessment check lists under the “True Manhood Alcohol Campaign”. This campaign encouraged young men and women to drink responsibly or not at all. The “True Manhood Violence against Women Campaign” aimed to convince men to treat their partners non-violently, while educating men and women about the new Domestic Violence Act. The centrepiece of the Y.E.A.H. initiative was the weekly radio drama and comic book series entitled “Rock Point 256”. Over the last seven years, 293 half-hour episodes in four languages on 16 radio stations have been produced and
broadcasted. Each year, the radio serial drama carries four storylines—each focused on a specific health or social issue.

- Fifty two (52) young people living with HIV and AIDS (YPLHIV) support groups were set up around the country and from these, 60 Young Positive Living Ambassadors were trained. These young ambassadors work in 14 AIC target districts to mobilize young people for testing, usher them into universal access services and follow them up for adherence.
- District level discordant clubs under YEAH led to the development of discordant couple clubs guidelines awaiting partner review.
- The MoH AIDS Control Program continued to develop and disseminate HIV/AIDS prevention messages. The messages were published in several media channels including print, visual and audio. Film vans were also used to air programs in targeted districts.
- UNASO formed an e-forum where topical issues on HIV/AIDS are posted for discussion. On this forum, opportunity has been created for share best practices such as those targeting structural drivers like changing in harmful gender norms.

Missed opportunities

- Opportunity exists to rapidly scale up SMC training at implementing sites supported by partners. More opportunity exists to incorporate SMC reporting within the District Health Information System (DHIS) in MoH. This would facilitate SMC implementers to report to MOH through the district.
- Individuals that are exposed to HIV who reach health facilities after 72 hours are unlikely to get HCT since they are not eligible for ARVs. It is recommended that all SGBV survivors should undergo HCT irrespective of time of arrival at a health facility. Individuals who report to a facility after 72 hours of exposure should benefit from other elements of PEP package that include screening for pregnancy and STIs; management of injury and psychosocial counselling.
- Weak linkages with Uganda Blood Transfusion Services (UBTS) and HCT leads to failure to capture many people for HCT services at blood donation sessions.

Emerging issues

1. Reports from implementing partners show that SMC demand exceeds service delivery. There is need to align the demand creation with available service sites, human resource and procurement of kits and other health supplies.

Lessons learnt

2. Use of Information Technology has been started by some implementing partners to minimise loss to follow up of patients on ART; by Star SW and MUJHU.

3.2.3 SCALING UP HIV COUNSELLING AND TESTING AND INCREASE COVERAGE AND UPTAKE

In order to scale up HIV counselling and testing (HCT) and increasing coverage and uptake, the overall priority NSP Strategic Actions in year 1 and 2 are scaling up HCT and enhancing HCT linkage to care
**STRATEGIC ACTION 2.1: SCALING UP OF HCT**

- HCT is currently being implemented in all hospitals and HCIVs, 90% in HCIIIs and 30% in HCIIs. Provider Initiated HIV Testing and Counselling (PITC) is implemented in all hospitals, all HC IVs and at least in 20% HCIIIs. The cumulative number of people tested over the review period is yet to be ascertained.

- Availability of HCT has increased with introduction of innovative HCT approaches at the workplace by partners like AIC e.g. Moonlight HCT (provided at night for sex workers), couple testing campaign (with slogan ‘Go together know together’ aimed at increasing the proportion of married couples receiving their HIV test results together) as well as various forms of mobile and mass testing. Outreaches or dedicated clinics for Key population groups, are currently implemented by partners especially AIC. The campaign, known as *Go together Know together*, promoted couples’ HIV counseling and testing by getting couples who did not know their HIV status to recognize their risk of HIV, and by building their belief that CHCT will benefit their relationships. AIC reported significant increases in the number of couples counseled and tested since the implementation of the campaign, from 31,093 in 2008 to 100,034 in 2012. 3,386 calls on CHCT and 4,025 calls related to HCT were received at the National Health Hotline between 2010 and 2012.

- Health Communication Partners (HCP) worked closely with AIC to implement intensive community mobilization activities using interactive radio/TV programmes, community drama and video-taped testimonies. They also worked with HCT service delivery partners to brand and publicize CHCT services to improve visibility and access. These activities were reinforced with radio and television spots, billboards, posters, and print and electronic media coverage. To recognize and reward couples who went for CHCT, the MOH and AIC distributed certificates to couples who had tested and gotten their test results together.

**STRATEGIC ACTION 2.2: ENHANCE HCT LINKAGE TO CARE**

- Guidelines for enhancing HCT linkage to care were developed. Furthermore, linkage indicators to track and improve linkage to care have also been incorporated. The National RH/HIV linkages and integration strategy was completed to guide RH/HIV linkages.

- Building capacity for delivery of quality integrated HCT through multi-skilling, multitasking, and coaching, mentoring and joint planning was started with initiation of PITC. National and district HCT mentors have been trained and these will carry on mentoring at national, district and facility levels.

**3.2.4 MITIGATING UNDERLYING SOCIAL, CULTURE, GENDER AND OTHER FACTORS THAT DRIVE THE HIV EPIDEMIC**

Several achievements have made in respect to addressing the enabling or structural factors that drive the HIV epidemic in the country.
STRATEGIC ACTION 3.1: PROMOTING INTERVENTIONS THAT REDUCE STIGMA AND DISCRIMINATION

The key output of this activity was to finalise and disseminate the National People Living with HIV Stigma Index. This tool measures how stigma and discrimination are experienced by People Living with HIV (PLHIV). Preparatory activities for the survey of the National Stigma Index were started. In partnership with UNAIDS and PLHIV networks, the government developed tools and trained 60 data collectors. There is ongoing political clearance after the team visited Kenya for experience sharing on the National Stigma Index survey.

STRATEGIC ACTION 3.2: BUILDING PARTNERSHIPS WITH CULTURAL/RELIGIOUS LEADERS TO ADDRESS SOCIO-CULTURAL DRIVERS

- Over the year under review, government engaged of cultural/religious leadership for HIV prevention at all levels. Ministry of gender, Labour and social development with support from partners initiated dialogue in 17 cultural institutions in the country including Buganda, Teso, Acholi, Lango, Karamoja, Lugbara kingdoms. Cultural HIV/AIDS strategic plans were developed and research done to deepen understanding of "social cultural factors impinging on HIV and maternal health.
- Guidelines for cultural leaders to mobilize communities for HIV prevention were developed and disseminated to the selected 17 cultural institutions.
- IRCU trained religious leaders to integrate HIV prevention communication into their routine religious work such as spiritual guidance, premarital counselling, couple dialogues, etc. The IRCU program covers 43 districts to date.
- AMICALL is conducting gender specific community dialogues to address structural drivers i.e. SGBV, stigma and discrimination and male involvement. They sensitized/trained urban local government leaders (over 500 people) on the multi-sectoral HIV/AIDS response, good governance and accountability.
  - An urban leaders’ MARPs Advocacy Tool Kit was developed to facilitate urban leaders in their advocacy and community social mobilization work.

STRATEGIC ACTION 3.3: PROMOTING THE INVOLVEMENT OF MEN AS KEY PARTNERS IN HIV PREVENTION INTERVENTIONS

Through partnership with the Makerere University School of public health, the Uganda AIDS Commission is conducting a research to assess existing understanding and approaches to male partner involvement in Uganda. This is intended to inform policy guidance on involvement of men as key partners in HIV prevention in the subsequent years of NSP implementation.

STRATEGIC ACTION 3.4: REDUCING VULNERABILITY OF OVC

Several CBOs exist in districts to address the plight of OVC as well as SGBV in families. However, the functionality of most CBOs is suboptimal as a result of limited funding to support their plans. Similarly, information sharing from the CBOs to the district local governments as well as to national level is not adequate.
Chapter Four: THE CARE AND TREATMENT THEMATIC AREA

4.1 INTRODUCTION

In the multi-sectoral national response, the Ministry of Health (MOH) takes the lead in implementation of HIV Care and treatment interventions as seen in the Health Sector Strategic and Investment Plan and the Health Sector HIV/AIDS Strategic plan.

4.2 OVERVIEW OF HIV CARE AND TREATMENT THEMATIC AREA

The goal of Care and Treatment Thematic area is “To improve the quality of life of PHAs by mitigating the health of HIV and AIDS by 2015”\textsuperscript{2} and has four objectives (1) Increase access to ART from 50% to 80% by 2015, (2) increase access to prevention and treatment of opportunistic infections including TB, (3) integrate sexual and reproductive health into all care and treatment services and (4) support and expand provision of home-based and community-based care and support. The thematic area 10 indicators against which progress has been assessed\textsuperscript{3}. Generally, there has been significant progress made towards achievement of the objectives mainly in the areas of policy and guideline development although there still exists gaps in capturing information required to monitor progress.

4.3 PROGRESS OF THE NSP CARE AND TREATMENT THEMATIC AREA

4.3.1 OBJECTIVE 1: TO INCREASE EQUITABLE ACCESS TO ART BY THOSE IN NEED

There are five strategic actions to support this objective;

- Promote health seeking behavior among males
- Scale up access and uptake for ART services among those in need
- Increase coverage of ART treatment to mothers receiving PMTCT regardless of CD4 counts, and expand earlier initiation of treatment for other populations, such as sero-discordant couples, people in pre-HAART care, etc
- Promote and expand specialized pediatric and adolescent HIV care and treatment
- Strengthen HIV drug resistance surveillance and prevention

The four NPAP indicators to monitor progress of this objective are as follows;

a. Percentage of adults and children in need receiving antiretroviral therapy increased from 50% to 65% by 2013
b. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy: increased from 84% to 85%

\textsuperscript{2} National Strategic Plan For HIV/AIDS 2011/12-2014/15

\textsuperscript{3} The National HIV and AIDS Monitoring and Evaluation Plan for the National Strategic Plan for HIV and AIDS in Uganda, 2011/12 - 2014/15
c. Percentage of hospitals, HC-IVs and HC-IIIIs accredited for adult/paediatric ART services: increased from 91% of HCIV to 100% and increased from 6% of HCIII to 10% by 2013

d. Percentage of hospitals, HC-IVs and HC-IIIIs performing/linked to CD4 and full blood count: All accredited ART sites performing or linked to laboratories with CD4 and full blood count (100% of HCIV and 10% of HCIII) by 2013.4

**Strategic Action 2.1.1: PROMOTE HEALTH SEEKING BEHAVIOR AMONG MALES**

Three priority actions were recommended in the National priority Action Plan (NPAP), a) to develop and implement IEC and BCC programs targeting men, b) Re-orient care and treatment interventions to ensure that they are responsive to the needs of men in order to increase male enrolment and retention, and 3) target men through workplace policies and interventions in both formal and informal sectors, and document best practices for replication.

**Progress/achievements**

**Increased uptake of HIV testing among men:** HIV services uptake by men remains a challenge although the trend appears to be improving. According to the 2011 AIS report5, 45% of men have ever had an HIV test compared to 66% of women; up from 21% of women and 25% of men in 20056. Of note, over 90% of adults aged 15-49 years know where to get an HIV test. Of adults enrolled on ART in 2011, males comprised only 36% and among clients in care, 65% are female (MOH ART quarterly Report)7. Higher HCT coverage among women is probably a result of the PMTCT program implementation since 72% of women ever tested had accessed HCT through antenatal care (ANC)Error! Bookmark not defined. The roll-out of Option B+ for PMTCT will further reduce the proportion of males on treatment unless the women are encouraged and facilitated to seek PMTCT services together with their spouses.

**Expanding workplace programs:** A number of workplace programs in both the formal and informal sectors have been successfully implemented8, o The USAID/PEPFAR funded project SPEAR (Supporting Public Sector Workplaces to Expand Action & Responses has continued to support ministries of Internal Affairs (Police, Prisons, Immigration), Education, and Local Government. According the annual report of the SPEAR projects for the period July 2011 to June 2012, some of

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4 The National Priority Action Plan 2011/12 – 2012/13

5 Uganda AIDS Indicator Survey 2011

6 UDHS 2006

7 MOH Quarterly ART Report October – December 2011(March, 2012)

8 Reports from GOU sectors and private sector
the achievements include dissemination of the work place policy to Education institutions, development of a policy monitoring and evaluation plan; training staff in counseling, and M&E, developing a Behavior change communication (BCC) strategy, and training of over 66,948 individuals in BCC. Up to 24,492 were supported to access HCT, and 296 accessed care and support.

- Ministry of Works and Transport (MoWT) finalized and launched the HIV/AIDS Policy, Prevention Strategy and Implementation Plan for the Works and Transport Sector and rolled it out to 8 districts.
- Ministry of Water and Environment (MWE) built the capacity of 72 of its staff in HIV/AIDS mainstreaming as a way of introducing HIV/AIDS mainstreaming activities in the sector. Condoms are also continuously made available to staff.
- The East African Community launched a new HIV/AIDS workplace policy aimed at addressing the challenges faced by employees living with HIV and AIDS.
- In the private sector, HIPS a USAID/PEPFAR funded project has continued to provide HIV prevention care, and treatment services through support to several companies.
- Uganda Manufacturers Association (UMA) supported six companies to come up with health workplace policies and provided health education to 340 individuals from over 30 companies. Some companies were also supported to access health communication materials DVDs, Posters, brochures, banners etc. UMA with support from STRIDES facilitated formation and management of Abstinence Clubs in 25 schools and reached out to 20,000 young people with HIV/AIDS messages. A three-day annual national Nutritional, safety and Health fair was organized by UMA in collaboration with Health Initiative for the Private Sector in conjunction with Ugandan business community in order to find cost effective ways of ensuring access to vital health services for company employees.
- In addition the Association of Mayors (AMICAALL) has intensified its programs which target the various groups, among whom are boda boda riders who are largely men. To this end the association has reached 616 men and provided SMC as well as organizing 89 HCT out reaches that have reached 11,740 with counseling and testing for HIV (5,647 Females and 5,593 Males).
- The Islamic Medical Association of Uganda have provided education, training and support to religious leaders and Islamic health professionals so that they can effectively support AIDS prevention and education activities in their communities in ways that are consistent with Islamic teachings.
- According to the MEEPP report of March 2012, up to 32,603 men were reached by individual, small-group, or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS (MEEPP report 2012 March).  


10 MEEPP Report SAPR 2012
Strategic Action 2.1.2: SCALE UP ACCESS AND UPTAKE FOR ART SERVICES AMONG THOSE IN NEED

Priority actions include 1) Increasing ART facility coverage (accredit more ART facilities) especially in under-served populations such as uniformed services, fishing communities, and some rural/hard to reach districts, 2) Building capacity of health facilities to improve ART eligibility screening and treatment monitoring (onsite CD4 and full blood counts or through linkages with other laboratories), 3) Procurement and distribution of adequate quantities of ARVs to ensure uninterrupted supply at all levels, 4) Initiating ART for an additional 240,000 individuals by 2013, and 5) Training more health care providers in ART delivery, and operationalizing the system for unique patient identifiers to enable patient tracking within and across sites.

Progress/achievements:

**Improved facility coverage for ART delivery:** The total number of accredited ART sites stood at 700 by March 2012 but only 532 were actively providing ART services. Facility level ART coverage has reached 100% of referral hospitals, 93% of district hospitals, 96% of HCIVs and 8% of HCIIIs provide ART. In addition, over 63 HCIs and 35 specialized clinics were providing treatment. The plan to accredit all HCIIIs by 2013 to support Option B+ will dramatically improve facility coverage at the lower levels and definitely surpass the NSP target of 20% of HCIIIs active by 2015. By June 2012, the armed forces had 18 accredited ART sites (2 for Prisons, 1 for Police and 15 for the UPDF).

**Table 3.1: Number of ART accredited health facilities by level – As of Dec 2011**

<table>
<thead>
<tr>
<th>Facility level</th>
<th>2010/11</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Referral</td>
<td>2/2 (100%)</td>
<td>2/2 (100%)</td>
</tr>
<tr>
<td>Regional Referrals</td>
<td>13/13 (100%)</td>
<td>13/13 (100%)</td>
</tr>
<tr>
<td>Other Hospitals</td>
<td>101 (100%)</td>
<td>104/112 (93%)</td>
</tr>
<tr>
<td>HCIV</td>
<td>151/166 (91%)</td>
<td>169/177 (96%)</td>
</tr>
<tr>
<td>HCIII</td>
<td>57/905 (6%)</td>
<td>90/1119 (8%)</td>
</tr>
</tbody>
</table>

**Improved ART coverage at population level:** By March 2012, 356,056 (327,949 Adults and 28,107 Children) individuals were active on ART, up from 260,865 in 2010.

This is 62% of the 577,024 estimated number of ART eligible individuals, up from 50% in 2010. Of those on ART, children constituted 8% and coverage in this population reduced from 25% to 17% partly due to age transition to adulthood. Between January and September 2011, 80,266 were initiated on ART (Dec 2011 MOH ART Quarterly Report. This is in line with the MOH target of enrolling a minimum of 100,000 annually. At this rate of ART scale-up, at least 214,000 will have been initiated on ART by 2013. With the enrollment of pregnant women on ART through the eMTCT program as part of Option B+, the set target will likely be surpassed as 50% of these would otherwise be eligible. Retention on ART at 12 months was estimated at 84%, slightly below the NSP target of 85%.

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11 Mid-Term Review report of the National HIV/AIDS Strategic Plan NSP 2007/8-2011/12- Consolidated Review Report
Introduction of Point-of-Care CD4 Diagnostics/ Improved access to CD4 at HIV care and treatment sites: Poor access to CD4 remains a major barrier to timely ART initiation and patient monitoring. To address this challenge, Ministry of Health conducted an operational evaluation of the PIMA Point-of-Care CD4 Diagnostic technology in seven facilities. The study showed dramatically reduced turnaround time for results and high acceptance by health care workers. Based on this success, Uganda decided to scale the technology to an additional 250 facilities, and has now rolled out the technology, along with a training program, nationwide. As of June 2012, 78% (131/169) of accredited HCIVs were able to perform or had had access to CD4.

Lab System Strengthening: Continued scale up of the sample transport network: With many health facilities facing infrastructural bottlenecks and human resource gaps that inhibit effective laboratory services, lower level health facilities needed to refer samples for lab analysis to higher level health setting. Uganda lacked a national system for sample and results transportation to support this, with facilities and MOH implementing partners supporting sample transport differently. Also, there was low EID testing and partners spent funds on transport (of DBS samples, and the transporter – usually a facility lab staff thus leaving a gap at the health facility. The TAT of the EID test results was long (average of 22.1 days), significantly having a negative impact on pediatric patient care. There were many ad hoc ways to move samples and results between referral laboratories and health facilities for DBS/DNA-PCR infant testing. MOH is now directly linked to 19 regional hubs each serving an average of 30 sites in catchment areas of a 30-40 km radius, intersecting districts and all levels of health facilities. There may also be efforts to broaden the range of samples transported.
beyond EID (viral load, TB, surveillance samples et cetera), and to further scale up to 100 hubs. Current targets include each region having 6 to 8 hubs with a functional lab that ensures QA measures are in place and address sample related issues, and continue to keep EID test TAT time to its current low average of 2 weeks at facilities.

**Rationalization of the ARV drug supply chain:** Previously, health facilities in Uganda received ARVs from two or three different sources (for example from both NMS and JMS). The result was confusion at the facility level, duplication of services at the central level, and an overall lack of transparency and accountability. In January 2012, the Ministry of Health decided to undertake a rationalization process to reduce the number of supply chains from 5 to 3, to a ‘one site, one supply’ system. There will be three warehousing and distribution systems – National Medical Stores (NMS) for the public sector, Joint Medical Stores (JMS) and Medical Access Uganda Ltd (MAUL) for the private sector. Each facility will now receive drugs from only one source. Beginning October 2012, the MOH is implementing a plan aimed at rationalizing the supply chain management of ARVs and other commodities. A Transitional Task Force established by the MOH has prepared for the transition. This plan will improve effectiveness and efficiency in commodity management.

**Increasing Order Rates:** Historically, only 60% of facilities would regularly submit an ARV order form, requesting drugs. This meant that 4 out of 10 facilities go without a regular supply of drugs. The National Medical Stores and Clinton Health Access Initiative jointly created an order form tracking system. The system tracks which facilities submit orders and which do not. NMS then began distributing information on which facilities have and have not ordered to implementing partners, who could then target their technical assistance to poor performing facilities. This initiative has helped contribute to an ARV order rate of >80%.

**Roll-out of web-based ordering and reporting for ARVs:** To support the two initiatives above, the MOH in partnership with SURE/USAID/PEPFAR is rolling out a web based system to ease ordering of ARVs and reporting beginning October 2012.

**Training providers in ART delivery:** Training for health providers in support of ART delivery continues: PEPFAR alone supported training for 228 in laboratory management, 1195 trained in ART management, and 553 in PMTCT (MEEPP SAPR 2012)

**Improved reporting by facilities:** although there are still challenges with timeliness and completeness of reports, submission of reports improved with 85% (407) of facilities submitting reports during 2011. However, the move to have all HIV/AIDS data reported through the HMIS has greatly affected the availability, timeliness and completeness of Care and Treatment data during the period under report.
Missed opportunities

‘Waiting lists’ for ART: As of Dec 2011, over 17,204 clients in care were ART-eligible, but still in the waiting line at ART sites across the country. Apart from insufficient stock of ARVs at sites, reasons for delayed initiation/wait-lists include inadequate staffing, protracted ART preparation time, lack of standard operating procedures to ensure timely enrollment. In Kalangala district, there were 225 patients eligible for ART but not on treatment while ART coverage was only 25%. The MOH has since recommended initiation of ART within two weeks of eligibility determination and is promoting implementation of quality improvement strategies to support service delivery.

Delay in PMTCT Option B+ roll-out: The delay in roll-out of the PMTCT Option B+ strategy which was approved in late 2011 is a missed opportunity for both HIV prevention and treatment. This was partly due to insufficient ARVs in-country and requirement to capacitate and accredit lower level facilities where over 45% of the targeted women attend ANC. Reaching more HIV-infected pregnant women with more effective regimens would translate into faster achievement of elimination of Mother To Child Transmission of HIV (eMTCT), a national and global goal by 2015. As part of this plan, all the HCIIs and selected HCIIs will be accredited to provide ART by December 2013, which will greatly boost access to ART by all populations. Of note, up to half of these women would require ART anyway for their own health while the rest will become eligible for treatment within 2-3 years.

Several accredited but non-functional ART sites: By March 2012, there were 168 sites that were accredited but were not providing ART for various reasons thus depriving the potential recipients from accessing treatment at these facilities. Related to this, there are also facilities that are functional or have capacity but are awaiting formal accreditation. These need accelerated accreditation.

Strategic Action 2.1.3: INCREASING ART COVERAGE IN PMTCT, AMONG SERO-DISCORDANT COUPLES, AND PRE-ART CLIENTS

There are two suggested priority actions a) Integrate and support referral between PMTCT and HIV care and treatment services, and b) Operationalise the new guidelines for option B Plus and increase access to HAART by HIV infected pregnant women.

Progress/achievements:

Roll-out of PMTCT Option B+ program: The MOH is in the process of rolling out PMTCT option B+ that will enable access to ART for all HIV-infected pregnant women using a ‘test and treat’ approach. The program will be launched October 2012 and roll-out

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12 Kalangala District program report of October 2012.
will be phased by region. Activities will include provider training, site accreditation, supervision and mentorship support in partnership with MOH Implementing Partners. Accelerated site accreditation for all HCIIIs (over 1000 in number) is expected to be completed by end of 2013. Accreditation of HCIIIs and provision of ART within ANC sites will reduce the need for referral between ART and PMTCT sites which has been a major bottleneck that resulted in loss to follow-up and low access to ART for PMTCT mothers of 18%-22% (MOH 2011 PMTCT report, MEEPP March 2012). Over the past year, a few sites supported by Implementing Partners have been providing HAART for pregnant women as PMTCT Option B. Data on numbers reached, and acceptability is not currently available.

**Stronger linkages between PMTCT and EID through scale up of the PMTCT EID Strengthening Program:** The PMTCT-EID Strengthening Program was developed and rolled out in 2011 in response to MOH reviews which revealed that only 8% of mother-baby pairs were active after delivery and that only 20% of HIV-positive infants were alive and on ART. The program has been scaled up to all PMTCT facilities in Uganda (over 1500 in number) with 7 targeted interventions that address specific contributors to rate of retention of mother and baby in the PMTCT/EID care cascade. A 2012 Review showed an increase in number of mother-baby pairs from 8 to 40 percent since the program was initiated. Better still, ART initiation and survival of children has increased from 20% to 60% (national target by end of 2012 is 80%). General improvements have been registered in linking and retaining mothers in HIV care, although only 39% are seen to be active after delivery. The review also revealed that retention during ANC has also improved since 2010, though still with challenges, with specific interventions such as a longitudinal register and streamlining of PMTCT counseling playing an immense role. The percentage of HIV+ pregnant women whose babies were tested after delivery has also increased from 20% to 52% since roll out of the program. It should be noted though that in the 2010 PMTCT review, retention (results received) was not captured because data tools did not contain the necessary information.

**Missed opportunities:**

*Delay in Option B+ roll out:* While the Option B+ strategy was approved in 2011, roll-out was delayed due to resource challenges. This has denied potential recipients of an opportunity to improve PMTCT coverage and utilize a more effective regimen. The use of HAART among infected pregnant women does not only reduce HIV transmission to the infant to less than 5% but also improves the health of the mother and breastfeeding infant, and reduces risk of transmission to the spouse.

*Lack of policy on ART initiation among discordant couples and MARPs:* There is as yet no MOH policy guidance on ‘treatment as prevention’ (TasP) among discordant couples or most at risk populations with high HIV prevalence such as Commercial sex workers, fishing communities. TasP is effective in reducing infectiousness by over 96%
(HPTN052)\textsuperscript{13}, while the PreP trial that was conducted in Tororo by CDC and TASO found that use of Truvada or Tenofovir (TDF) alone provides 60% protection from HIV among discordant couples\textsuperscript{14}. All the drug regimens for these interventions are available, but translation of research into practice has been delayed.

**Strategic Action 2.1.4 : PROMOTE AND EXPAND SPECIALIZED PAEDIATRIC AND ADOLESCENT HIV CARE AND TREATMENT**

The recommended priority actions are as follows: a) Train more providers in paediatric and adolescent care, b) build capacity for all accredited facilities to provide comprehensive paediatric, adolescent and adult HIV care and treatment, and c) expand and improve linkages between EID, care and treatment facilities and communities to ensure early and sustained linkage to care and retention for HIV infected children.

**Progress/ achievements**

**Training in pediatric and adolescent care:** - According to the MOH, a number of health workers received pediatric care training in 2011/12. Through PEPFAR support alone, 470 providers were trained in specialized pediatric care in the six months preceding April 2012.

**More children accessing ART:** The number of children receiving treatment increased to 28,107 by March 2012, up from 24,141 in March 2011. However the proportion of ART recipients that is below 15 years fell due to age transition to adult age. Several QI initiatives have contributed to pediatric ART scale-up with support from UNITAID/CHAI.

**Scale up of Pediatric formulation rationalization:** for pediatric patients on ART, there has been an increase in usage of fixed drug combinations (FDCs) . Currently, over 99% of the children on FDCs. In addition, Uganda has been able to significantly reduce the number of pediatric formulations, from 27 formulations in January 2011 to 10 formulations today.

**Continued scale up of EID testing:** MOH has had great success in scaling up its testing of HIV-exposed infants, going from 6,000 tests in 2006 to 45,000 tests in 2010. This is partially the result of the MOH’s new Early Infant Diagnosis laboratory, which is conducting almost all of the testing in the country. The central EID lab, which is linked to over 800 MOH facilities across the country through the sample transport network, processed 62,512 DNA/PCR tests for EID between August 2011 and July 2012. This translates into 60% coverage for exposed infants. It is projected to test 96,000 EID tests in the coming year with increased coverage from the expanding sample transport network/hub system.

\textsuperscript{13} HPTN052 study

\textsuperscript{14} PreP trial
and the increased number of health facilities/communities that will benefit from this expansion. Laboratory turnaround time reduced from 30 days in 2009/10 to less than 3 days. However, there is a need to increase the rate of second PCR testing for negative infants which has been low (less than 10% of all tests performed at CPHL were 2nd PCR). MOH plans to expand the sample specimen referral network to additional hubs, and utilize the same system to transport CD4, viral load, and TB specimens. Other EID program initiatives such as integration into Young Child Clinics, setting up specialized PMTC/EID clinics, establishing EID care points within facilities have improved results delivery to caretakers - up to 69% in July-September 2011, and ART initiation to 49%. 

Annual National pediatric HIV/AIDS conference: was held September 14-16, 2012. The meeting discussed scientific updates and programmatic progress, challenges, lessons learned.

Figure 3.3: National pediatric ART coverage

Strategic Action 2.1.5: STRENGTHEN HIV DRUG RESISTANCE SURVEILLANCE AND PREVENTION

The suggested priority actions as per NPAP include a) strengthening quality of ART services (prescription practices, support mechanisms for patient retention and adherence) to prevent emergence of drug resistance to ARVs, b) building capacity and systems for monitoring HIV drug resistance (Early warning indicator monitoring) to prevent HIV
drug resistance, c) conduct annual HIV drug resistance surveys, and d) compiling and disseminating annual drug resistance and early warning indicator reports to stakeholders.

**Program / Achievements:**
The HIVDR Early Warning Indicator Survey ongoing. The survey is to cover 100 ART sites across the country, and is being conducted by MOH and partners including UVRI and CDC. Study completion is expected soon and the results will be disseminated. An International meeting on HIVDR was held in April in Kampala Uganda. The meeting highlighted the challenge of increasing HIVDR.

In the past year, there has been more national focus on Quality Improvement (QI). QI is an important strategy in improving ART quality. Previously, Uganda QI was project driven specifically by donor support for HIV/AIDS, with special focus on ART, and implemented by HIVQUAL and HCI (both funded by PEPFAR). However, in the past year, QI has been integrated with other diseases and programs. Several important QI meetings have taken place: The MOH organized the first national QI conference in Uganda in February 2012. Participants included District Health Officials for all 112 districts, MOH officials, and Implementing Partners. There was a recognized need for harmonized training materials, and indicators. A National QI Framework that includes HIV/AIDS services was developed – the *Health Sector Quality Improvement Framework and Strategic Plan 2010/11 – 2014/15*. In March 2012, Uganda hosted the All Country Learning Network (ACLN) meeting. In attendance were representatives of the Health Ministries of several countries, representatives from CDC/HRSA, Implementing partners. This year’s theme focused on use of performance data to set national improvement priorities. In October 2011, the Regional Center for Quality of Health care organized the ‘Africa Regional Consultative Workshop on Healthcare Improvement, which focused on institutionalizing quality improvement, developing a training framework for QI.

Between July and December 2011, the MOH Quality of Care team conducted the bi – Annual Performance Measurement at 117 facilities nationally in all regions of Uganda. New baselines for all HIV intervention indicators were determined. For example, of all adults, 87% were assessed by providers for ART and of these, 92% had good adherence. Among children, only 47% had CD4 monitoring, 85% had adherence assessment performed, with a level of 74%. The national Quality Improvement priorities currently include addressing missed appointments, improving ART adherence, CD4 monitoring, TB Screening, and linkage of babies to care.

### Table 3.2: Summary of the performance on key NPAP indicators for Objective 1

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>2010/11 (Baseline)</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of adults and children in need receiving ART increased from 50% to 65% by 2013</td>
<td>65% (375,065/577,024)</td>
<td>Total: 290,563 Adults: coverage 50% Children: 25% (24,141)</td>
<td>62% by March 2012 Total number: 356,056 Adults: 327,946 Children: 28,107</td>
</tr>
</tbody>
</table>

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15 Quality of Care (QoC) 2011 baseline report
% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy: increased from 84% to 85%

| % of hospitals, HC-IVs and HC-III accredited for adult/paediatric ART services | 100% HCIVs & 10% of HCIIs by 2013 | 91% HCIVs & 6% HCIIs | 96% HCIVs & 8% HCIIs (Dec 2011) |
| % of hospitals, HC-IVs and HC-IIIIs performing/linked to CD4 and full blood count: and 10% of HCIIs) by 2013 | 100% | 54% hospitals | 78% accredited HCIV (131/169) |

4.3.2 OBJECTIVE 2: PREVENTION AND TREATMENT OF OPPORTUNISTIC INFECTIONS INCLUDING TB

Under this objective there are six (6) strategic actions; 1) Increase proportion of infected individuals enrolled and retained in HIV care, 2) Promote universal access to the basic care package, 3) Scale up integrated TB-HIV services (site coverage and number of individuals served), 4) Support and expand provision of palliative care, 5) Ensure availability of commodities for opportunistic infection diagnosis, prevention and treatment, and 6) Provide nutritional assessment and therapeutic support to PLHIV.

The three indicators read as follows a) Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV: 80%, b) Percentage of HIV patients in care, receiving cotrimoxazole for prophylaxis: increase from 93% to 95% by 2013, and c) Percentage of hospitals and HCs providing PITC: 100% HCIV and 100% hospitals by 2013.

Strategic Action 2.2.1: INCREASING ENROLLMENT AND RETENTION INTO HIV CARE

The suggested priority actions include a) Scale up of the implementation of provider-initiated HIV testing (PITC) within health facilities, b) Improve linkages and referral between HCT and HIV care and treatment, c) Enhance mechanisms for pre-ART patient retention, and d) Develop guidelines and support health facilities to provide pre-ART care according to guidelines.

Progress/achievements
As of December 2011, over 623,571 people living with HIV were in active chronic care at 838 facilities. This number represents over half (53%) of the estimated number of people living with HIV nationally.

Good retention on ART, TB screening, cotrimoxazole prophylaxis: Retention in care for those on treatment remains good at over 84% within 12 months of initiating treatment (MOH ART Dec 2011 report), against the WHO recommendation of 85%. Of those in care over 80% are routinely screened for TB and over 90% prescribed cotrimoxazole for prophylaxis against opportunistic infections in line with national guidelines. This is close to the findings of the UAIS 2011 on
cotrimoxazole use where it was found that of those adults who reported that they were HIV positive, 82% were taking daily cotrimoxazole.

**Increased enrollment of Infants into care:** Through the EID program, the number of infants enrolled into care has increased. Coverage for EID among exposed infants improved to 60% from 35% in 2009, results delivery to caretakers improved to 69% in 2011 July-September, and more children are linked to HIV care.

**Strategic Action 2.2.2: PROMOTE UNIVERSAL ACCESS TO THE BASIC CARE PACKAGE**

Priority actions included a) Providing adequate uninterrupted supplies for basic HIV care (safe water, insecticide treated mosquito nets and cotrimoxazole prophylaxis), and b) promoting utilization of the Basic Care Package including use of innovative distribution options.

**Progress/achievements:**

**Improved access and utilisation of the Basic Care Package (BCP):** The Program for Accessible health Communication and Education (PACE), together with its affiliate PSI and the Ministry of Health are implementing the Positive Living Project through strategic partnerships with care and support organizations, district local governments and district PLHIV fora to achieve an efficient and sustainable delivery of Basic Care Packages (BCP) with an overall goal of improving the health status of people living with HIV/AIDS in Uganda. The project aims to support 250,000 PLHIVs from the previous BCP program with refills or replacements of commodities; and to reach an additional 150,000 new clients with starter kits so as to reach a total of 400,000 HIV-infected persons in care under the PEPFAR program; revise and update existing IEC materials supplied with the BCP to include comprehensive HIV care information and increase uptake of the BCP among all HIV infected persons who test and know their sero-status.

The program is implemented in 225 BCP sites in 85 districts and since there is a lot of unmet demand in the existing facilities; no more health facilities will be brought on board as had been the plan. A total of 61,877 starter Basic Care Packages were distributed to the districts in addition to 11,074 mosquito net refills, 3.9 million water guard refills and 4.2 million condoms distributed for the period under review. According to the MOH quarterly report Oct-Dec 2011, 548,237 (89.6 %) clients were prescribed Cotrimoxazole at 806 facilities.

**Strategic Action 2.2.3 : SCALE UP OF INTEGRATED TB-HIV SERVICES**

Under this strategic action, the priority actions include a) Supporting the implementation of interventions targeting the 3 ‘I’s (Infection control, Intensified screening and implementation of Isoniazid Preventive Treatment, b) Expanding linkages and referral

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16 PACE program report
between TB and HIV testing, care and treatment services to ensure early diagnosis and initiation of HIV treatment among TB patients, c) Increasing access to more effective TB diagnostic tests (such as GeneXpert) in order to improve TB diagnosis among HIV infected patients and d) Enhancing coordination of TB/HIV collaborative services at national and sub-national level.

Progress/achievements

The 3 ‘I’s integrated in the revised NTLP Strategic Plan: The National TB and Leprosy Program (NTLP) has revised its 3-year strategic plan 2012/13-2014/15 to include the three ‘I’s Infection Control (IC), Intensified Case Finding (ICF) and Isoniazid Preventive Therapy (IPT). The plan aims at improving coverage for IPT from less than 1% to 30%, facilities implementing control measures increased to 60%, and case finding increased from the current 52% to 70%.

Improving TB/HIV indicators: In the past year, TB/HIV collaborative activities have continued to improve. Of the 623,571 individuals in active HIV care nationally, 502,075 (81%) were screened for TB, 7,694 (1.5%) initiated on anti-TB treatment (MOH 2011 report). Within TB clinics, 80% of all patients had an HIV test, of which 19,270 (53%) tested positive for HIV, majority of these (93%) initiated on cotrimoxazole prophylaxis, and 34% received ART up from 24% in 2010 (NTLP report). See table and figure below. For the entire TB program, NTLP has continued to demonstrate improving performance in terms of TB case detection rates, treatment success rates and implementation of DOTS (See table xx). According to the Annual Health Sector Performance Report for 2011, TB case detection increased from 53.9% to 57.2% and TB treatment success rates increased from 70% to 71.1%.

More GeneXpert equipment procured: In a bid to improve TB diagnosis, use of GeneXpert MTB/RIF is increasing: by June 2012, coverage had reached 22 facilities, 17 of these at public sites. Although there are still challenges with supplies for this equipment, it is expected that this will revolutionize TB management.

Capacity to manage MDR TB improved: Following completion of the 2010/11 MDR survey that established the national burden, the MOH has established a program to manage MDR TB with support from Global Fund and other partners. Samples from suspected MDR cases are transported from facilities to NTRL for culture and Drug Sensitivity Testing (DST) using a sample referral system established in 2008. In the year 2011, 52% of smear positive retreatment cases got their sputum samples referred to the NTRL for culture and Drug Sensitivity Testing (DST). Unlike previous years when MDR drugs were unavailable, for the first time, in 2011/12, the GOU and Global Fund provided funding for the procurement of MDR drugs and treatment commenced at two sites in Mulago and Kitgum hospitals. The plan is to expand to all 13 Referral Hospitals by 2015.
**Shift in Procurement and Distribution of anti-TB drugs:** In 2011, the supply chain management for anti-TB medicines has been shifted from NTLP to the Procurement Unit of Ministry of Health and National Medical Stores (NMS). MOH is responsible for the quantification, while NMS procures stores and distributes the anti-TB medicines to the health facilities. NTLP collects patients and laboratory statistics and advises the Procurement Unit of Ministry of Health and NMS on forecasting and quantification of medicines.

<table>
<thead>
<tr>
<th>Table 3.4: TB/HIV collaboration in Uganda 2008-2011 Uganda</th>
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<tbody>
<tr>
<td>Performance</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>TB patients with known HIV status</td>
</tr>
<tr>
<td>% of TB patients with known HIV status</td>
</tr>
<tr>
<td>TB patients that are HIV-positive</td>
</tr>
<tr>
<td>% of tested TB patients that are HIV-positive</td>
</tr>
<tr>
<td>% HIV-positive TB patients started on CPT</td>
</tr>
<tr>
<td>% HIV-positive TB patients started on ART</td>
</tr>
<tr>
<td>HIV-positive people screened for TB</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 3.5: NTLP Performance Uganda 2007-2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Case detection rates</td>
</tr>
<tr>
<td>Treatment Success Rate</td>
</tr>
<tr>
<td>Case Mortality</td>
</tr>
<tr>
<td>Under DOT</td>
</tr>
</tbody>
</table>

**Figure 3.3:** Trends in HIV testing and treatment for TB patients, 2005-2011
Source of data: WHO, country database on TB Treatment outcomes, NTLP annual report, 2011.

Source of data: WHO, country database on TB Treatment outcomes, NTLP annual report, 2011.

**Strategic Action 2.2.4: SUPPORT AND EXPAND PROVISION OF PALLIATIVE CARE**
The priority actions include a) Training more providers at all levels to improve skills for palliative care provision, and b) provision of adequate and uninterrupted supply of pain management drugs (including morphine)

**Progress/ achievements**

*Improved coverage and capacity for palliative care provision:* According to Palliative Care Association of Uganda (PCAU), the number of non-physician prescribers was increased from 120 by 2010/11 to 168 by June 2012. In addition an extra 13 ART programs have integrated palliative care in their HIV care programs including prescription of oral morphine. The number of districts covered by palliative care programs has gone up to 55 from 36 in 2010/11. The use of oral morphine has gone up by 27% from 10.1kg in 2010/11 to 12.8 kg by June 2012.18

**Strategic Action 2.2.5: ENSURING COMMODITY AVAILABILITY FOR OPPORTUNISTIC INFECTIONS**

Priority actions include a) Developing diagnostic and treatment algorithms for OI diagnosis and treatment, and b) Provision of adequate laboratory supplies and drugs for diagnosis and treatment of common OIs.

**Progress/ achievements**

There was improved availability of medicines in the past year due to a number of interventions including the last mile delivery, and increased supervision and monitoring. The National Medical Stores has reported improvement in the stocking of all commodities for management of opportunistic infections. In 2010/11, cotrimoxazole was available in 78% of health facilities visited including district stores and with public sector standing at 73.8% and private facilities at 85.2% (HSR 2010 report). Multiple procurement mechanisms were then noted to hamper effective delivery of the products and contribute stock-outs at health facility level.

**Strategic Action 2.2.6: NUTRITIONAL ASSESSMENT AND THERAPEUTIC SUPPORT TO PLHIV**

Priority actions include a) Integrating nutritional education, assessment and therapeutic support into HIV care and treatment, b) Provider training/improved skills for nutritional education, assessment and therapeutic support, and c) Providing appropriate nutritional support for HIV exposed infants

**Funding for Nutrition services:** Nutritional Assessment Counseling and Support (NACS) funding through PEPFAR was initially to cover 36 districts but the proposal is under review currently and coverage may be expanded to more districts.

**NACs training:** The NACs training package that goes beyond HIV is being reviewed and will address malnutrition in all patients. The training package will

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also include a participant package. In order to build comprehensive capacity, training of all health workers is ongoing in the districts targeting health workers beginning with Training of Trainers who will continue to support the districts in training all health workers.

*Nutrition guideline on HIV and infant feeding:* The guideline on HIV and Infant and young child feeding was reviewed and dissemination is in progress. MoH wrote a proposal for NACs in PMTCT which will handle issues affecting HIV prevention.

*Nutrition commodities included in essential medicines list:* Nutritional commodities like RUTF therapeutic commodities F100 and F75 for management for medical conditions have been included in the Essential medicines list.

*Nutrition indicators to be included in the HMIS:* Nutrition indicators are in the process of being harmonized and they will be included in the national HMIS system. Currently 54 health facilities are supported by PIN with ready to use therapeutic feeds and these will be expanded to other health facilities.

*Provision of Food/Food security:* 62,348 eligible clients received food and/or food security (e.g. food gardens, provision of seeds) (*MEEPP Semi Annual Report 2011/2012*).  

**Table 3.6: Summary of the performance on key NSP indicators for Objective 2**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>2010/11 (Baseline)</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of estimated HIV-positive incident TB cases that received treatment for both TB and HIV</td>
<td>80%</td>
<td>24% in 2010</td>
<td>34.2% in 2011</td>
</tr>
<tr>
<td>% of HIV patients in care, receiving cotrimoxazole for prophylaxis: increase from 93% to 95% by 2013</td>
<td>95% by 2013</td>
<td>93%</td>
<td>90% prescribed cotrimoxazole (Dec 2011 ART report)</td>
</tr>
<tr>
<td>% of hospitals and HCs providing PITC: 100% HCIV and 100% hospitals by 2013</td>
<td>100% of hospitals and HCIVs</td>
<td>No baseline: NB: PITC provided in ANC in all PMTCT sites</td>
<td>No national data on PITC. NB: PITC is provided in ANC in all PMTCT site</td>
</tr>
</tbody>
</table>
4.3.3: OBJECTIVE 3: INTEGRATING SEXUAL AND REPRODUCTIVE HEALTH INTO ALL CARE AND TREATMENT SERVICES

Strategic Action 2.3.1: INTEGRATING POSITIVE HEALTH DIGNITY AND PREVENTION (PHDP) INTO HIV SERVICES

Priority actions include a) Integrating PHDP interventions into HIV care and treatment to support improved health and HIV prevention among PLHIV, b) Building capacity of PLHIV networks for delivery of PHDP services, c) Developing and dissemination of standardized PHDP messages, and d) Developing and dissemination of policy/guidance on treatment for prevention

Progress/achievements

The national SRH strategy which embraces integration of SRH services into all care has been approved and awaits UNFPA support for the launch. The SRH team has worked with the PMTCT team to ensure that this is also part of e-MTCT approaches. Family Planning has been introduced and integrated into all HIV services. HE The President while meeting the stakeholders in July 2012 promised an extra $5 million to go towards the commodities for SRH.

- The MOH has conducted PHDP trainings for Integration of Positive Health Dignity and Prevention (PHDP) in care.
- PEPFAR supported 369,606 (261,761 females and 107,845 males) PLHIV with a minimum package of prevention with PLHIV (PWP) interventions

Strategic Action 2.3.2: INTEGRATING FAMILY PLANNING COUNSELING AND SUPPORT FOR ADULTS AND ADOLESCENTS IN HIV CARE

Progress/achievements

This year, the GOU has pledged additional funding totaling $5m to go towards support of Sexual and Reproductive Health activities. UDHS 2011 data showed increased uptake of FP to 30% in the general population. Use of modern contraceptive methods is 26% by married women, up from 18% in 2006 (UDHS 2011). There is substantial unmet need for family planning in Uganda. FHI and the Uganda Ministry of Health are working to meet this need by revitalizing long-acting and permanent contraceptive methods and promoting the provision of DMPA by community-based health care workers. Service providers often deny DMPA to women who are late for their scheduled re-injection.

FHI is analyzing pregnancy rates among clients up to four weeks late for re-injection to reassure providers that pregnancy is unlikely in these women, thus eliminating one of the barriers women face in continuing use of this method. To
improve access to and client continuation of contraception, FHI also is surveying drug shops to see whether they would be suitable outlets for providing injectable contraception.

Results of a previous study by the POLICY project found that people living with HIV and AIDS in Uganda preferred to receive family planning and HIV/AIDS services in one location. FHI is developing and promoting provider training and job aids that address the family planning needs of couples with HIV or at high risk of HIV infection.

UDHS data showed increased uptake of FP to 30% in the general population. 1. Use of modern contraceptive methods is 26% by married women, up from 18% in 2006 (UDHS 2011)

**Strategic Action 2.3.3: BUILD CAPACITY OF PROVIDERS AND EMPOWER COMMUNITIES TO SUPPORT PLHIV IN THEIR SRH CHOICES**

Priority actions include a) Enhancing provider skills in FP counseling and scale-up innovative FP counseling approaches such as the use of expert clients in FP counseling and b) building capacity of PLHIV networks for delivery of FP services

**Progress/ achievements**

- 61 young females reached by an individual, small-group, or community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS (MEEPP)
  - Provider training: Training of Trainers for RH took place

**Strategic Action 2.3.4 : Supporting HIV Sero-discordant Couples**

The 2011 AIDS Indicator Survey showed that 6% of all couples tested were sero-discordant for HIV which means one partner is HIV-positive and the other is not. Put differently, 65% of infected persons have a partner that is HIV negative. Without antiretroviral treatment (ART), the risk of seroconversion of the HIV negative partner is estimated at 9.2/100 person years among discordant couples (Reynolds, AIDS, 2011), hence the need for effective prevention in this population. Recent studies have demonstrated early ART (at CD4 >350) of HIV-positive people reduces risk of HIV transmission to HIV-negative sexual partners by 96% (HPTN 052 Study). Additionally, Pre-Exposure Prophylaxis (PreP) trials using antiretrovirals (ARVs) have demonstrated reduction in acquisition of HIV by up to 60% by the negative partner in a discordant couple.

Priority actions include a) Integrating interventions to expand partner HIV testing and counseling and disclosure within HIV care and treatment settings, b) Providing comprehensive HIV prevention, care and treatment support for sero-discordant couples including access to effective interventions such as treatment for prevention, and c) Ensuring availability of prevention and reproductive health supplies

**Progress/ achievements**
There are a number of discordant couples that have been identified and are attending regular discordant couple clubs where they receive counseling support, condoms etc. National Data is not readily available.

**Gaps and missed opportunities**

*Lack of national policy:* While effective interventions to minimize risk of HIV transmission among discordant couples are available, access is hampered by lack of a policy. Treatment of this population would significantly reduce incident HIV infections. In addition, earlier ART initiation has been associated with better clinical outcomes.

*Couple testing:* Couple testing is implemented to a variable extent by different partners; however data on HIV status disclosure, partner testing, discordant couple numbers, and use of PreP is not available nationally.

### Table 3.7: Summary of the performance on key NSP indicators for Objective 3

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>2010/11 (Baseline)</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unmet need for FP among HIV infected individuals &lt;10 (No baseline)</td>
<td>Less than 10%</td>
<td>42%</td>
<td>No recent data</td>
</tr>
</tbody>
</table>

**4.3.4: OBJECTIVE 4 : TO SUPPORT AND EXPAND THE PROVISION OF HOME BASED AND COMMUNITY BASED HIV CARE AND SUPPORT**

**Strategic Action 2.4.1: SUPPORTING EXISTING COMMUNITY STRUCTURES TO PROVIDE SERVICES**

Priority actions include a) Training and provision of support for VHTs, PLHIV and other community networks to ensure delivery of quality home based and community based care, b) Developing and dissemination of tools and guidelines for coordination, documentation and reporting of home based and community based services.

**Progress/ achievements**

*Home based care guidelines operationalised:* The national Home based Care guidelines (disseminated in 2010) were operationalised in 85 districts. The focus is on Positive health and dignity. 85 district community development officers have been trained in supporting the PLHIV networks, and 500 of these networks were trained in HBC, follow up and referral of patients to facilities within their catchment area. Up to 85 Village Health Teams (VHTs) were trained in referral and linkages with facilities (out of 112 districts). A PLHIV network was formed at national level and in each of the 85 districts to monitor peer educators, BCP distribution and assess need for BCP.

*Basic Care Packages distributed:* 300,000 BCP (out of a target of 400,000) were distributed in the last year. Support was provided to expert clients through the district community health departments initiated in 85 districts.

A network of young people living HIV and AIDS (YPLHIV) has setup YPLHA groups in the districts and has linkages to some schools were their members study. The network
could be supported to attract more members and link with more schools to support its members while at school. As such issues to do with peer support and adherence to drugs could be handled. Fifty two (52) young people living with HIV and AIDS (YPLHIV) support groups have been set up around the country and from these 60 Young Positive Living Ambassadors have been trained. These young ambassadors work in 14 AIC target districts to mobilize young people for testing, usher them into universal access services and follow them up for adherence.

**Strategic Action 2.4.2: ENSURE STRONG LINKAGES AND REFERRAL SYSTEMS BETWEEN HEALTH FACILITIES AND COMMUNITY STRUCTURES**

The one priority action that was recommended in the NPAP is to enhance referral mechanisms between facilities and home based as well as community based providers

**Progress/ achievements**

Several successful initiatives geared towards enhancing linkages and referral have been implemented by providers such as use of mobile technology, personalized referral, health facility review committees are implemented. UMA has been linking companies and communities to suppliers of low cost health commodities- e.g. Condoms, Mosquito nets. To facilitate community linkages, the Ministry of Water and Environment (MWE) supported districts to sensitize 2066 community members about HIV and AIDS and this was done mainly during community mobilization meetings, water and sanitation committee (WSC) trainings, extension workers quarterly meetings, sub county meetings, hand pump mechanics trainings and advocacy meetings.

**Gaps and missed opportunities**

Data on linkage and referrals is not available nationally. The VHTs are not fully operational since there is limited support from GOU. The existence of organized groups of PLHIV and failure by their coordinating bodies to link them to the needed resources and other HIV and AIDS partners for support is a major missed opportunity.

**Table 3.8: Summary of the performance on key NSP indicators for Objective 4**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>2010/11 (Baseline)</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of health facilities linked to operational HBC services</td>
<td>80%</td>
<td>No baseline</td>
<td>85/112 district have some VHT trained</td>
</tr>
</tbody>
</table>
CHAPTER FIVE: SOCIAL SUPPORT AND SOCIAL PROTECTION

5.1 Introduction

The Uganda AIDS Indicator Survey (2010) indicates that 7.3 percent of the population aged 15 – 59 are HIV infected. Less than one percent of the population under age five are HIV infected. The HIV/AIDS epidemic has had far-reaching consequences for the different segments of society and economy, and still poses a serious threat to realization of millennium development goals.

The national HIV and AIDS strategic plan for the period 2011 -15 recognizes that this epidemic has not only caused huge increases in the number of PLHIV but has also increased morbidity, physical and psychological suffering, death, widowhood, orphan hood, stigma, disruption of livelihoods and schooling, despondency of extended families, increased pressure on social infrastructure and contributed to human rights abuses such as early marriages, property grabbing, discrimination, gender-based violence, child labour and taking up roles of adults prematurely. This epidemic has also disrupted the labour supply and productivity of the professional and non-professional workforce in virtually all service and production sectors particularly agriculture and animal industry, health, education, industry and the security sectors.

The population groups which are most affected include PLHIV, OVC, widows, elderly relatives, persons with disabilities, displaced and refuge persons, street dwellers, rural poor fishing communities, uniformed personnel and track drivers.

5.2 The Social Support Area of the NSP for HIV/AIDS 2011-15

In order to reduce the vulnerability of disadvantaged persons to situations that could result to HIV infection or transmission, and to help the infected and affected cope with effects of infection, the National HIV/AIDS Strategic Plan for 20011-15 recommended provision of social support and protection services to PLHIV, OVC and other populations at risk of HIV infection. The specific objectives of this component are to:

i) Scale up delivery of comprehensive quality psychosocial services to PLHIV, affected households and persons most vulnerable to HIV exposure.

ii) Provide HIV affected households and most vulnerable groups with livelihood skills and opportunities to cope with socioeconomic demands.

iii) Scale up coverage of comprehensive social support and protection package to most vulnerable PLHIV and other affected groups

5.3 Sources of Data

Three methods were used to review the implementation progress of social support and protection activities. These include review of periodic progress reports for selected line ministries, civil society and private sector organisations; face-to-face interviews with managers and focal persons of key ongoing HIV/AIDS and social support programmes in key government, civil society and private organisations; and presentation and discussion
of progress reports during consultative meetings for coordinators of HIV programmes in key line ministries, civil society and private organisations.

The organisations from which data on social support services was obtained include the Ministry of Health (MOH), Ministry of Education and Sports (MOES), Ministry of Gender and Social Development (MOGLSD), Ministry of Defence (MOD), Ministry of Works Transport and Communication (MOWTC), Ministry of Agriculture Animal Industry and Fisheries (MAAIF), Ministry of Local Government (MOLG), Ministry of Internal Affairs (MOIA), and Office of the Prime Minister’s Northern Uganda Social Action Fund (NUSAFA).

The other organisations included the National Agricultural Advisory Services (NAADS), Uganda Police Force, Uganda Prison Services, Uganda Network on Law/Ethics and HIV/AIDS (UGANET), AIDS Information Centre (AIC), National Forum of PLHIV Networks in Uganda (NAFOPHANU), International Community of Women Living with HIV/AIDS (ICW), Private Sector Alliance against HIV/AIDS, Inter-Religious Council of Uganda (IRCU), Palliative Care Association of Uganda (PCAU), Uganda Catholic Medical Bureau (UCMB), Uganda Protestant Medical Bureau (UPMB), the Self-Coordinating Entity on Media, and the Monitoring and Evaluation System for PEPFAR supported Programmes (MEEPP).

Data were synthesised according to the strategic actions of each objective. The results are presented in the next section.

5.4 Achievements

This section presents the achievements and issues on implementation of the specific strategic actions during the period July 2011 to June 2012.

5.4.1 Scale Up Comprehensive Psychosocial Services to PLHIV

The NSP proposed to achieve this objective by providing counselling services to HIV infected and vulnerable persons in health care points and communities; training service providers and care takers in responding to psychosocial needs of HIV infected and vulnerable persons; and providing a comprehensive package of psychosocial support services to HIV infected, affected and vulnerable persons.

Progress on Set Targets

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Base</th>
<th>Achieve 2012</th>
<th>Target 2013</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of OVC who have access to a comprehensive psychosocial service package (at least 3 basic needs)</td>
<td>24.8%</td>
<td>ND</td>
<td>40%</td>
<td>Base UDHS, 2006 Output TBD LQAS</td>
</tr>
<tr>
<td>Percentage of PLHIV who received psychosocial support in past 12 months</td>
<td>19%</td>
<td>ND</td>
<td>–</td>
<td>Base UDHS, 2006 Output TBD LQAS</td>
</tr>
</tbody>
</table>

Strategic Action 3.1.1: Delivery of Comprehensive Psychosocial Support
Comprehensive psychosocial support refers to the provision of a mixture of counselling, life skills education and recreation services to the HIV infected and vulnerable persons.

By the start of the NSP 2011 – 2015, several PLHIV, orphans and other vulnerable groups were in dire need of psychosocial services due to the trauma caused by HIV/AIDS, war, displacement and poverty. Of the agencies involved in AIDS work, approximately 66% provided social support and protection services (UAC, 2009).

The coverage of psychosocial services was still low; PLHIV access to psychosocial support in the past 12 months was 19%, while OVC access to a package of at least three (3) basic requirements was 24.8% (UDHS, 2006). The number of OVC caregivers trained in provision psychosocial services were 93,367, while the OVC and other vulnerable persons receiving psychosocial support from government, civil society and community organisations was unknown (MOGLSD-OVC MIS, 2010).

The NSP therefore proposed to scale-up delivery of comprehensive quality psychosocial services to PLHIV, affected households and persons most vulnerable to HIV by introducing counselling services to HIV infected and vulnerable persons in health care points and communities; training service providers and care takers in responding to psychosocial needs of HIV infected and vulnerable persons; and providing a package of psychosocial support services to the HIV infected, affected and vulnerable persons.

**Progress/Achievements**

*Psychosocial services for OVC were introduced in some health care and community setting:* Data from MEEPP indicate that continuous counselling services for OVC was introduced in 2,293 service outlets, and more than 20,349 HIV positive children were counselled in these service outlets.

In addition, more than 90 community volunteers were given bicycles, gumboots, clothing and nursing kits by Uganda Red Cross Society (URCS) to facilitate psychosocial of services to HIV infected persons, OVC and other vulnerable persons. Community dialogues related to psychosocial support were conducted with 298 leaders who included sub-county and parish chiefs, community development officers, religious and opinion leaders, teachers and OVC guardians.

*Some service providers and caretakers were trained in the provision of psychosocial support to vulnerable groups:* Available data indicate that the URCS trained 180 home care facilitators and these provided psychosocial services to 3120 OVC and 1,531 PLHIV.

In addition, 186 peer counsellors were trained and these provided HIV/SRH counselling services to 12929 in school and 6975 out-of-school youth. Other AIDS support organizations trained 53719 OVC caregivers (21680 male and 32039 female) in the provision of comprehensive care and psychosocial services, 38 health care workers in OVC care, several PLHIV leaders and PWDs living with HIV in positive health, dignity and prevention (PHDP), 44 Network Support Agents in maternal and neonatal child health, 40 PLHIV in the Stigma Index methodology, and 218 UNYPA members in HIV communication and life skills education. Those trained helped to mobilise and provide counselling to OVC, PLHIV and affected communities.
Furthermore, MOES trained 60 TTC students in AIDS counselling, and 308 school nurses and senior women and men teachers, and 135 pre-primary and lower primary school teachers in HIV care and provision of psychosocial support services to HIV infected and affected children. Those who received training were not only communicating with other students and teachers about HIV transmission and prevention, but also counselling and referring peers to health centres and PLHIV clubs for specialized care and support.

Several OVC, PLHIV and other vulnerable groups were given psychosocial services: Data indicate that 1036 HIV infected teachers and their families were supported with clothing and home care kits (MOES, 2011), 32 district leaders (16 district HIV focal persons and 16 coordinators for district PLHIV forum) were sensitised on the International Candle Light Memorial activities and 12 districts successfully organized memorials in remember all persons that passed on due to AIDS, and seven district networks for YPLHIV were established and these mobilized and counselled young positives to seek services.

In addition, several free counselling sessions were conducted with HIV infected and affected persons through the telephone help line established by the Support on AIDS and Life through the Telephone (SALT). Data in Table 5.1 shows the volume of telephone calls made and the successful and failed counselling session conducted by month and sex of the clients.

Table 5.1: Distribution of telephone counselling calls or sessions by month and sex of caller

<table>
<thead>
<tr>
<th>Month</th>
<th>Successful calls or sessions</th>
<th>Failed calls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Both sexes</td>
</tr>
<tr>
<td>January</td>
<td>31</td>
<td>32</td>
<td>3</td>
</tr>
<tr>
<td>February</td>
<td>25</td>
<td>27</td>
<td>-</td>
</tr>
<tr>
<td>March</td>
<td>23</td>
<td>24</td>
<td>6</td>
</tr>
<tr>
<td>April</td>
<td>32</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>May</td>
<td>27</td>
<td>18</td>
<td>7</td>
</tr>
<tr>
<td>June</td>
<td>203</td>
<td>126</td>
<td>9</td>
</tr>
<tr>
<td>July</td>
<td>375</td>
<td>237</td>
<td>24</td>
</tr>
<tr>
<td>August</td>
<td>214</td>
<td>194</td>
<td>38</td>
</tr>
<tr>
<td>September</td>
<td>301</td>
<td>204</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>1231</td>
<td>872</td>
<td>109</td>
</tr>
</tbody>
</table>

In addition, wellness centres were established in the different parts of the country provided recreational and HIV counselling and education services to at least 458 female and 7025 male PLHIV and other interested groups, several dialogues on the health and social wellbeing of PLHIV were conducted in the media and community, while at least 634 PLHIV (296 teachers, 198 police personnel, 92 prison warders, 48 young positives) were given homecare kits.

Furthermore, data in the MEEPP MIS indicate that 135,076 OVC and 10,235 vulnerable youth and adults received emotional support. Table 5.2 shows the gender distribution of beneficiaries.
Table 5.2: Age and sex distribution of persons that received emotional support

<table>
<thead>
<tr>
<th>Service and Age</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orphans and other vulnerable children</td>
<td>66,600</td>
<td>68,476</td>
<td>135,076</td>
</tr>
<tr>
<td>Vulnerable Youth and Adults</td>
<td>4,963</td>
<td>5,272</td>
<td>10,235</td>
</tr>
<tr>
<td>Total</td>
<td>71,563</td>
<td>73,748</td>
<td>145,311</td>
</tr>
</tbody>
</table>

Source: MEEPP-MIS for all USAID-Supported Projects (2012)

The emotional support has enabled several OVC and PLHIV to recover from trauma caused by HIV infection and live positively.

5.4.2 Empower PLHIV, vulnerable groups with livelihood opportunities

The NSP planned to address this objective by supporting food and nutrition security and economic activities in households of HIV infected and vulnerable persons, and advocating the targeting of PLHIV and other vulnerable groups in the existing national programmes.

Progress on Set Targets

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Base</th>
<th>Achieve 2012</th>
<th>Target 2013</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of OVC households that received economic strengthening assistance in past 12 months</td>
<td>12%</td>
<td>ND</td>
<td>60%</td>
<td>Base = NHS 2010 Output TBD by NHS or LQAS</td>
</tr>
<tr>
<td>Percentage of PLHIV households that got economic strengthening assistance in past 12 months</td>
<td>41.2%</td>
<td>ND</td>
<td>60%</td>
<td>Base-LQAS 2006 Output TBD by NHS or LQAS</td>
</tr>
</tbody>
</table>

Strategic Action 3.2.1: Food and Nutrition Security

By the start of the NSP 2011-15, approximately 50% of the agencies involved in HIV/AIDS works provided food security services (UAC 2009). The percentage of food insecure households varied from 29 - 88% (MSH STAR-E LQAS, 2011). Approximately 45% of the vulnerable households had access to agricultural extension services (WFP, 2009). The HIV affected households were more stressed with food insecurity than the non-affected households (FAO, 2012).

With regard to nutritional support, 12 – 59% of OVC in the age group 5 – 17 years were assisted with basic needs including food, while 25 - 55% of OVC consumed three major food groups the night before the survey (MSH STAR-E LQAS, 2011). The number of OVC caregivers trained in food preparation and storage was 110,956, while the number OVC who got food and nutritional supplements was 89,365 (MOGLSD-OVC MIS, 2010). Previous data also indicated that 26.9% of PLHIV registered with an AIDS support organisation received nutritional support in the past three months (UAC-LQAS, 2006).

Therefore the NSP 2011-16 planned to increase the number and percentage of PLHIV, OVC and other vulnerable persons who have access to food and nutrition security by disseminating information on local nutritional options and sources to households of HIV infected and vulnerable persons; and training various community structures to promote...
food production, processing, storage, utilisation and hygiene in households of HIV infected and vulnerable persons.

The other actions include providing emergency and therapeutic feeding to households of PLHIV, OVC and other affected groups that experience frequent food shortage; providing essential farming technologies and inputs to PLHIV households and organised community groups severely affected by the epidemic; and promoting good food, nutrition, hygiene and sanitation practices through community competitions among affected households.

**Progress/Achievements**

*Dissemination of nutrition guidelines on infant and young child feeding, and incorporation of similar topics in the training curriculum for pre and in-service health workers:* MOH distributed nutrition guidelines on infant and young child feeding, while MOES incorporated similar topics in the training curriculum for pre and in health workers.

*Service providers were trained in nutrition:* At least 47666 caregivers were trained in good nutrition and food preparation practices, while several in-service health and social workers were trained in integrated infant and young feeding counselling.

*Provision of agricultural inputs for livestock and crop farming to improve food security in vulnerable households:* At least 62,348 OVC and HIV affected youth and adults were assisted with seeds and food gardens (MEEPP, 2012). NUSAF gave grants to 25253 vulnerable persons were given grants to procure seeds and other agricultural inputs such as livestock and ox-ploughs, while NAADS also provided food security technology inputs to 265785 farmers nationwide who included PLHIV, Youth, Women and PWDs. Table 5.3 shows the groups assisted with food security by two projects.

**Table 5.3: Number of vulnerable groups assisted with food security support**

<table>
<thead>
<tr>
<th>Projects and Vulnerable Groups</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>USAID Projects</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orphans and other vulnerable children</td>
<td>27,842</td>
<td>30,302</td>
<td>58,144</td>
</tr>
<tr>
<td>Vulnerable youth and adults</td>
<td>1,953</td>
<td>2,251</td>
<td>4,204</td>
</tr>
<tr>
<td>Total</td>
<td>29,795</td>
<td>32,553</td>
<td>62,348</td>
</tr>
<tr>
<td><strong>NUSAF-2 subprojects</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People Living with HIV</td>
<td></td>
<td></td>
<td>1423</td>
</tr>
<tr>
<td>Orphans</td>
<td></td>
<td></td>
<td>568</td>
</tr>
<tr>
<td>Child mothers</td>
<td>215</td>
<td></td>
<td>215</td>
</tr>
<tr>
<td>People with Disabilities</td>
<td></td>
<td></td>
<td>1152</td>
</tr>
<tr>
<td>Youth</td>
<td></td>
<td></td>
<td>8172</td>
</tr>
<tr>
<td>Elderly</td>
<td></td>
<td></td>
<td>9498</td>
</tr>
<tr>
<td>Ex-combatants</td>
<td></td>
<td></td>
<td>229</td>
</tr>
<tr>
<td>Returnees from IDP camps</td>
<td></td>
<td></td>
<td>831</td>
</tr>
<tr>
<td>Former abductees</td>
<td></td>
<td></td>
<td>159</td>
</tr>
<tr>
<td>Female heads of household</td>
<td></td>
<td></td>
<td>1145</td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
<td>1861</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>25,253</td>
</tr>
</tbody>
</table>

Source: MEEPP-MIS for all USAID-Supported Projects (2012) and NUSAF-2 Progress Reports (2012)
Some vulnerable groups were given agriculture produce to improve nutrition: MOGLSD OVC MIS data indicate that there was increase in the number of OVC supported with food or nutritional supplements from 89365 in the period July 2010-June 2011 to 94545 (43675 male and 50870 female). On the other hand, 2999 out of 5628 litres of milk produced and 530 trays of eggs out of 1134 trays produced by NUSAF projects was distributed to needy PLHIV, orphans, elderly, youth, PWDs, widows and other vulnerable groups to supplement nutrition.

HIV infected children on ART received therapeutic foodstuffs from their treatment centres: Examples of AIDS care organisations that offered therapeutic feeding to HIV infected children include Mildmay, Baylor College, ACDI/VOCA, AVSI, War Child Holland, SOS Children’s Village, Joint Clinical Research Centre (JCRC), TASO, and World Vision Inc. In addition, some under five children who are malnourished were given milk, maize and soya porridge supplements.

Strategic Action 3.2.2: Economic Strengthening of Households for PLHIV and OVC

By the start of the NSP 2011-15, approximately 29% of the agencies involved in HIV/AIDS works provided income generation activities/services (UAC 2009). An earlier LQAS study also indicated that 41.2% of the PLHIV registered with support organisations received some form of assistance for income generation in the past 12 months of the survey, 39.4% had training in income generation, while only 15.4% had access to loans or in kind cash for income generation (UAC-LQAS, 2006). A recent survey indicate that only 3.9% of OVC households had access to formal loans while 11.9% had access to informal loans (UBOS, 2010).

Therefore, the NSP for 2011-2015 proposed to strengthen economic initiatives among households of HIV infected and vulnerable persons by conducting a needs and capacity assessment of HIV infected and affected households to engage in appropriate income generating activities (IGAs); supporting sustainable IGAs among vulnerable HIV infected and affected households; training beneficiaries of IGAs in essential business management and marketing skills; training community caregivers and other resource persons in IGA, supervision and resource monitoring; providing cash transfers to HIV infected and vulnerable/affected persons; organising households of HIV infected and vulnerable persons involved in economic activities to into joint marketing groups; and lobbying existing national programmes to support HIV infected and vulnerable persons.

Progress/Achievements

Several OVC were trained in essential business management skills: Data in the MOGLSD OVC MIS indicate that at least 17429 male and 27546 female OVC were trained in business management skills.

National youth entrepreneurship empowerment schemes were established: Government allocated UGX 25 billion for Youth Entrepreneurship Venture Capital Fund to support youth start or expand business enterprises, UGX 3.5 billion for Youth Entrepreneurial Training Programme to impart business management skills among youth to create enterprises, and UGX 1 billion for Business Development Skills Clinics for youth to impart technical skills using informal vocational training programs (MOFPED, 2012).
Several vulnerable groups were organised into savings and credit cooperatives where they received training in formulation and start up inputs for livelihood initiatives: Data indicate that PLHIV, youth and other vulnerable groups were mobilised into SACCOs, and those who enrolled were trained in project formulation and implementation and given start up grants and inputs for livelihood initiatives (NAFOPHANU, 2012).

Provision of credit and inputs for small sustainable livelihood projects: At least 84,168 vulnerable persons received income generation support in form of credit or livestock or seeds/seedlings by different programmes to initiate small sustainable livelihood initiatives in poultry, dairy farming, livestock breeding (pigs, goats and rabbits), fish farming, bee keeping, rice growing, brick making, tailoring/sawing, charcoal making, crafts making, catering, retail shops, rice cultivation, vending produce and used clothes, hair-dressing, metal fabrication, carpentry, leather tanning, training in livelihood skills, agro-processing and marketing (grinding, hurling and packaging), agro-forestry (tree nurseries and planting seedlings). Table 5.4 indicates the approximate number of vulnerable persons that received income generation assistance in the period under review from USAID and NUSAF supported projects.

Table 5.4: Groups supported to increase income and productive resources

<table>
<thead>
<tr>
<th>Project and type of beneficiaries</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID Projects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orphans and other vulnerable children</td>
<td>24,561</td>
<td>25,859</td>
<td>50,420</td>
</tr>
<tr>
<td>HIV infected and affected youth, adults</td>
<td>2,465</td>
<td>2,522</td>
<td>4,987</td>
</tr>
<tr>
<td>Northern Uganda Social Action Fund-2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elders</td>
<td>-</td>
<td>-</td>
<td>9,498</td>
</tr>
<tr>
<td>Youth</td>
<td>-</td>
<td>-</td>
<td>8,172</td>
</tr>
<tr>
<td>Widows/Widowers</td>
<td>-</td>
<td>-</td>
<td>3,508</td>
</tr>
<tr>
<td>People living with HIV</td>
<td>-</td>
<td>-</td>
<td>1,423</td>
</tr>
<tr>
<td>People with disabilities</td>
<td>-</td>
<td>-</td>
<td>1,152</td>
</tr>
<tr>
<td>Returnees from IDP camps</td>
<td>-</td>
<td>-</td>
<td>831</td>
</tr>
<tr>
<td>Ex-combatants</td>
<td>-</td>
<td>-</td>
<td>229</td>
</tr>
<tr>
<td>Orphans</td>
<td>-</td>
<td>-</td>
<td>568</td>
</tr>
<tr>
<td>Ex-abductees</td>
<td>-</td>
<td>-</td>
<td>159</td>
</tr>
<tr>
<td>Female household heads</td>
<td>-</td>
<td>-</td>
<td>1,145</td>
</tr>
<tr>
<td>Child mothers</td>
<td>-</td>
<td>-</td>
<td>215</td>
</tr>
<tr>
<td>Other vulnerable groups</td>
<td>-</td>
<td>-</td>
<td>1,861</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>84,168</strong></td>
</tr>
</tbody>
</table>


In addition, some HIV infected teachers were linked with Microfinance Institutions such as Med Net to access loans for IGAs.
Some PLHIV, OVC and other vulnerable groups enhanced their productivity, income and self-sufficiency: Reports of livelihoods projects supported by NUSAF-2 that had reported progress by the end of June 2012, indicate approximately 2629 out of 5628 litres of milk produced was sold, 604 out of 1134 trays of eggs produced were sold. These transactions as well as sales from animal traction generated income of UGX 31 Million from trade in milk, poultry and animal traction. The income was used to expand initiatives and support health and education of needy members of the beneficiary groups (OPM-NUSAF, 2012).

**Strategic Action 3.2.3: Social Protection Measures**

Social protection consists of measures that seek to reduce the vulnerability of socially and economically disadvantaged individuals, households and communities to further risks or shocks. This includes direct or targeted resource transfers such as cash, handouts and subsidies to people who experience shocks in livelihood; and provision of social services to vulnerable groups such as the abolition of health and education charges.

The other actions include provision of social insurance such as pension systems, health insurance, retrenchment packages and funeral societies; changes in the regulatory framework such as a statutory minimum wage and maternity benefits, anti-corruption legislation, outlawing of widow inheritance; and sensitisation campaigns to protect rights and address the negative stereotypes of the socially and economically disadvantaged groups such as PLHIV, OVC, PWDs, women and young people (Social Protection Task Force in Uganda, 2002).

By the start of the NSP for 2011-15, only 1% of female and 2% of male aged 15 – 49 are covered by health insurance. Male and female resident in urban area especially Kampala, educated beyond primary and wealthy are more likely to be covered with health insurance (UDHS, 2012:Pg 34). Except for provision of cash transfers to PLHIV and other vulnerable groups, the NSP did outline priority actions for achieving social protection of vulnerable groups in the context of HIV/AIDS.

**Progress/Achievements**

*Cash grants were provided to some vulnerable persons and families to cater for basic needs:* The Expanding Social Protection Programme (ESPP) in MOGLSD provided small monthly grants of UGX 24,000 to 30,000 elderly persons and 50,000 vulnerable households with low labour capacity and high dependency due to AIDS or disability or poverty to cater for their basic social needs. In the financial year 2011-2012 the Government of Uganda contributed towards the programme.

*The special grants programme for PWDs was extended to other districts:* The special grants programme for persons with disabilities was expanded from 30 to 80 districts representing an overall district coverage of 67%. Through this programme, several persons with disabilities accessed special grants to cater for basic needs.

*Several private companies introduced health insurance for staff that covers chronic illnesses including AIDS:* MOH presented a National Health Insurance Bill was to Parliament. If this Bill is passed into law, it will help vulnerable groups have unlimited
access to health services from any a credited health service provider. In addition, 148 companies introduced staff health insurance that also covers HIV treatment.

5.4.3 Scale-Up Coverage of Comprehensive Social Support Package

The NSP planned to address this objective by supporting school-going age OVC and HIV infected persons to enrol and complete formal, informal, vocational and life skills education; and providing appropriate shelter for deserving vulnerable groups; mainstreaming gender and disability into social support initiatives.

The other actions include providing legal and protection services; promoting education on cultural norms and practices that perpetuate SGBV, and building capacity of institutions in human rights and litigation related to HIV.

Progress on Set Targets

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Base Achieve 2012</th>
<th>Achieve 2013</th>
<th>Target 2013</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratio current school attendance among orphans and non orphans aged 10-14 years</td>
<td>90% ND 96% ND</td>
<td></td>
<td></td>
<td>Base-EMIS 2009 Output TBD by EMIS 2011</td>
</tr>
<tr>
<td>Reduction in percentage of PLHIV and HIV vulnerable persons reporting SGBV</td>
<td>39% ND 25% ND</td>
<td></td>
<td></td>
<td>TBD by LQAS</td>
</tr>
<tr>
<td>Percentage of population 15 - 54 with accepting attitudes towards PLHIV</td>
<td>28.3% 34.3% M 22.3% F ND</td>
<td></td>
<td>50%</td>
<td>TBD by LQAS</td>
</tr>
<tr>
<td>Percentage of large workplaces employing more than 19 persons that have HIV workplace policies/programs</td>
<td>83.3% of 30 large companies ND 95%</td>
<td></td>
<td></td>
<td>Base-MOGLSD Output -TBD by workplace survey</td>
</tr>
</tbody>
</table>

Strategic Action 3.3.1: Enrolment, and Retention of OVC in Formal Education

By the start of the NSP, 97% of the male and 95% of the female net school-age children were enrolled in primary school in 2009, while only 25% of the male and 23% of the female net school-age children were enrolled in secondary in 2010 (UNFPA-SWP, 2011). Majority of the children enrolled in primary school were supported by the Universal Primary Education (UPE) Programme, while a sizeable number in secondary school were supported by the Universal Secondary Education (USE) Programme. Approximately 16% of the children in primary school were orphaned and 3% were disabled, while 22% of the children in secondary school were orphaned and 1% were disabled (EMIS, 2010).

Primary school attendance was quite high since about 81% of male and female primary-school-age children (6 – 12 years) attended formal primary school at any point during the school year. Secondary school attendance was very low since only 16% of male and 18% of female secondary-school-age children attended formal secondary school during the school year. In addition, 84% of the children aged 10 – 14 years who were double orphaned attended school compared to 96% of those who had one or both parents alive.

Data on this indicator will be obtained from the Education Sector Performance Report for 2011/12. This will be accessible in November 2012.
implying that double orphan-hood has negative effect on child school attendance (UDHS, 2011 Pgs 21 - 26).

Primary school completion was also low since less than 65% of children who enrolled in primary school completed the 7th grade at the primary level (EMIS, 2009).

The NSP for 2011-2015 proposed to study the factors and possible solutions of low school enrolment, retention and completion of school-going age OVC and PLHIV; provide a minimum education assistance package (scholastic materials and non-tuition dues) to OVC in primary, secondary and vocational education institutions; advocate private education institutions to provide bursaries to school-going age OVC and PLHIV; and train teachers, matrons and school nurses in provision of psychosocial services to OVC and children and teachers living with HIV.

**Progress/Achievements**

*Some OVC were supported to attend school:* Data in the OVC MIS indicate that 161224 OVC (80,590 male and 80,634 female) were assisted with non-tuition dues and scholastic items to attend pre-primary, primary and secondary school. A half of who received education assistance were female, while 23% were in pre-primary school, 67% were in primary school and only 10% were in secondary school.

Table 5.5: Distribution of OVC assisted with education fees and items by sex and school

<table>
<thead>
<tr>
<th>School Type</th>
<th>Male</th>
<th></th>
<th>Female</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Pre-primary</td>
<td>19465</td>
<td>54</td>
<td>16915</td>
<td>46</td>
<td>36380</td>
<td>100</td>
</tr>
<tr>
<td>Primary</td>
<td>53210</td>
<td>49</td>
<td>55496</td>
<td>51</td>
<td>108706</td>
<td>100</td>
</tr>
<tr>
<td>Secondary</td>
<td>7915</td>
<td>49</td>
<td>8223</td>
<td>51</td>
<td>16138</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>80590</td>
<td>50</td>
<td>80634</td>
<td>50</td>
<td>161224</td>
<td>100</td>
</tr>
</tbody>
</table>

MOGLSD-OVC MIS July 2011-March 2012

**Strategic Action 3.3.2: Informal and Vocational Education for OVC and PLHIV**

Vocational education refers to training in skills development courses such as carpentry, mechanics, moulding, electronics, hair dressing, wielding, building, plumbing and catering attended after completing the Uganda Certificate of Education level from formal or accredited Business, Vocational and Technical Education Training (BTVET) institutions. Informal education refers to the special education programs introduced in hard to reach poverty stricken, socially unstable areas and in communities where formal schools are inaccessible. These include Complementary Opportunity for Primary Education (COPE), Alternative Basic Education for Karamoja (ABEK), Basic Education for Urban Poverty Areas (BEUPA) and Child-Centred Alternative, Non-Formal Community-Based Education (CHANCE), among others (EMIS, 2009).

Because of the importance of education and vocational skills in ensuring social protection of vulnerable groups, it is envisaged that OVC and PLHIV enrolment into informal and vocational education would not only enhance their livelihood skills but also offer a
continuous social safety net to HIV exposure and effects. However the OVC and PLHIV needs and access of informal, vocational and life skills education was not known. The NSP for 2011-2015 therefore proposed to establish the informal, vocational and life skill education needs for OVC; identify the most appropriate apprenticeship and vocational/life skills education opportunities for OVC; provide a minimum education package (scholastic materials, non-tuition dues and start up kits) to OVC in vocational education institutions; mobilise the community on the importance of apprenticeship, vocational and life skills education; establish/renovate and provide essential equipment to vocational, apprenticeship and community centres; and initiate tuition and non-tuition bursaries to orphans and other vulnerable children in vocational and apprenticeship centres.

Progress/Achievements

Some OVC were supported to attend informal and vocational education: At least 33778 male and 35959 female OVC and other vulnerable groups were given tuition fees, kits and other essential vocational education requirements to attend vocational and apprenticeship training courses. Table 5.6 shows the distribution of beneficiaries by sex.

Table 5.6: Number of vulnerable children assisted with vocational training

<table>
<thead>
<tr>
<th>Vulnerable groups</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orphans and other vulnerable children</td>
<td>31,719</td>
<td>33,511</td>
<td>65,230</td>
</tr>
<tr>
<td>Vulnerable youth and adults</td>
<td>2,059</td>
<td>2,448</td>
<td>4,507</td>
</tr>
<tr>
<td>Total</td>
<td>33,778</td>
<td>35,959</td>
<td>69,737</td>
</tr>
</tbody>
</table>

Source: MEEPP-MIS for all USAID-Supported Projects (2012)

Strategic Action 3.3.3: Provision of Shelter

Approximately 75% of the population lives in poor quality houses that lack basic sanitation utilities (UBOS-UNHS, 2010). Due to the devastating effects of the HIV/AIDS epidemic on the health and productive resources, households of OVC, PLHIV and the elderly account for a considerable proportion of the population living in poor quality housing and sanitation facilities.

The NSP 2011-15 therefore prioritized provision of decent shelter to households headed by extremely vulnerable children and elderly, and to deserving PLHIV, OVC and other affected groups

Progress/Achievements

During the July 2011- June 2012, at least 72,402 OVC and 3,693 vulnerable youth and adults received shelter or sanitation facilities. Table 5.7 specifies the distribution of beneficiaries by sex.
Table 5.7: Age and sex distribution of persons that received shelter/sanitation support

<table>
<thead>
<tr>
<th>Service and Age</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orphans and other vulnerable children</td>
<td>35,827</td>
<td>36,575</td>
<td>72,402</td>
</tr>
<tr>
<td>Vulnerable Youth and Adults</td>
<td>1,811</td>
<td>1,882</td>
<td>3,693</td>
</tr>
<tr>
<td>Total</td>
<td>37,638</td>
<td>38,457</td>
<td>76,095</td>
</tr>
</tbody>
</table>

Source: MEEPP-MIS for all USAID-Supported Projects (2012)

**Strategic Action 3.3.4: Mainstreaming Gender & Disability in Social Support Initiatives**

Mainstreaming gender and disability in programmes refers to positive consideration of concerns for women, girls, men, boys and disadvantaged persons such as persons with disabilities during planning and implementation of HIV/AIDS programmes. Mainstreaming gender and disability concerns in HIV programming helps to address the social and cultural factors driving the epidemic. The NSP therefore prioritised Gendered research on the impact of HIV/AIDS on social support programme initiatives, and training implementers and facilitators in gender and disability mainstreaming in social programmes.

**Progress/Achievements**

*Several government and private organisations developed HIV workplace policies and mainstreamed gender and disability issue in their programmes:* For example nine (9) government ministries and 14 private companies developed and disseminated HIV workplace policies to departments and organizations under their supervision. MOES developed the M&E plan and implementation guidelines for the sector HIV workplace policy, and disseminated them to all district education officers, some primary school heads and to head/principals of other educational institutions.

The Private Sector Alliance against HIV/AIDS developed the inventory containing information on the location, business and HIV activities of each member organization. The inventory helped to identify the companies that lacked workplace HIV/AIDS activities. Furthermore, MOGLSD inspected 50 agencies to ensure compliance with policies of HIV/AIDS activities in the workplace.


Four (4) HIV/AIDS Champions were trained in MOGLSD to facilitate HIV sensitisation and mainstreaming in workplaces. MOWE trained 40 staff at the headquarters and 32 staff of Urban Water Authorities in mainstreaming HIV/AIDS activities in environment and water management activities. Further more, NUSAF-2 in the Office of Prime Minister and NAADs in Ministry of Agriculture directly engaged PLHIV and other vulnerable groups in project planning and implementation of project activities. Progress data for the Household Income Support Programme component of NUSAF-2 indicate that 63% of the
vulnerable groups who participate in livelihood activities are female, 33% are elderly, 28% are youth, 12% are widows, 5% are PLHIV, 4% are PWDs and 2% are orphans.

Several HIV/AIDS activities were conducted in workplaces of government and private organisations: For example, MOES trained 100 headquarter staff in reproductive health and adolescent counselling, and 16 headquarter staff in AIDS counselling to specifically provide emotional care to peers and HIV affected staff in their areas of operation. It also sensitized 59 Principals of Teacher Training Colleges, 110 employees of the National Curriculum Development Centre, 339 members of the Uganda National Teachers Union and 134 Heads of Schools in Kamwenge district about the Sector HIV/AIDS Workplace Policy. In addition, MOWE sensitised sector extension workers and water/sanitation committees in 26 districts about mainstreaming HIV/AIDS activities in routine work.

In addition, 22 companies trained 541 peer educators and organised HCT services in their workplaces. At least 45 companies introduced ARV treatment services for employees living with HIV, 132 private companies carried out HIV prevention education and condom distribution among its employees and customers, while 104 companies were mobilised to support HIV and AIDS activities. As a result the Hotel Owners Association agreed to reduce the charges on venue accommodation, meals and equipment for HIV/AIDS activities.

Strategic Action 3.3.5: Legal and Protection Services against SGBV

By the start of the NSP, about 62% of the 27,047 child-abuse cases reported to the Probation and Social Welfare Office in a period of three months were concluded. The MOGLSD-OVC MIS (2010) indicated that at least 13,540 paralegals had been trained to offer guidance and referral assistance to OVC, while 19,115 OVC got legal aid. Additionally, LQAS surveys in 53 district indicated that 15 - 47% of OVC aged 5 – 17 years experienced some form of abuse, while 57 - 80% of individuals knew where to report cases of child abuse (MSH STAR-E LQAS, 2011). While there was no specific data on SGBV services, the available data exposed gaps in access to information and services on legal and protection against various abuses including SGBV. The NSP proposed to promote education of men, women, boys and girls on entitlement and procedures of accessing legal and social protection services; Train communities, families and other potential perpetrators of abuse on the legal implications of SGBV; Support community resource agents, CBOs and NGOs to carryout advocacy, protection and provision of SGBV services to women and young people; and strengthen the capacity of public agencies in SGBV advocacy, protection and service provision.

Progress/Achievements

Child protection structures were created and trained in some districts: Child protection committees were established in 40 parishes and 400 committee members were trained in child protection in Kabarole district.

Several paralegals and duty bearers were trained in legal support and child protection: Data in the OVC MIS indicate that the various organizations trained 1934 paralegals (986 male and 948 female) in the provision of paralegal guidance and referral services, while at least 21832 OVC duty bearers (10600 male and 11232 female) were trained in child
protection. These conducted community dialogues on child rights and SGBV in the context of HIV.

**Several abuse cases were reported to relevant authorities for assistance:** Data in the OVC MIS further indicate that 4528 (2007 male and 2521 female) cases of child abuse and neglect were reported at the Probation and Social Welfare Office or Police or Local Council Authorities in the past three months. Of these, 3130 cases (1292 male and 1838 female) were handled up to the conclusion. In addition, 1497 children without a caregiver were successfully either reunited with their families or placed in an alternative care setting, while 1643 (578 male and 1065 female) children were withdrawn from worst forms of child labour.

**Several SGBV and HIV-related stigma and discrimination cases were given legal and protection services:** Data from MEEPP and UGANET MISs indicate that 68,960 abused children and adults were supported with legal aid services on grievances and disagreements associated with domestic violence, property inheritance, assault, inheritance and care of children, human rights, letters of administration, land disputes and will making. Of these, 3220 SGBV survivors and perpetrators were counselled about GBV and coercion related to HIV/AIDS. Table 5.8 and 5.9 give specifies groups given legal aid by sex and age. The survivors of GBV were helped to resolve their disputes mainly through mediation (56%), specialised counselling and referrals to care points for PEP (29%) and court representation (3%).

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**Story of an HIV Infected Blind Widow who was supported when She Experienced SGBV/HIV-Related Abuses**

This story of Joanita (not the real name), a blind and widowed with four children, depicts how the legal and psychosocial support interplayed in helping vulnerable groups and communities recover from psychological trauma and gender based abuses associated with HIV/AIDS. These community-based legal and social support approaches need to be supported and replicated to safeguard human rights of vulnerable communities and to prevent them from practices that may lead to HIV transmission and more misery.

Joanita, was married to a man who had another wife. The husband started experiencing illnesses similar to AIDS and eventually died. The co-wife and relatives of the husband harassed her and forcefully took away part of the seven acres of land the husband gave in writing - in the presence of local leaders and family members. Even after ceding part of the land, the relatives wanted her off the entire land, which she inherited from the husband. The relatives continually harassed and tormented her so that she leaves the land.

Soon after the death of the husband, Nyakato continually experienced illnesses with symptoms similar to those of the late husband. She sought medical care in a nearby hospital, tested for HIV and learned that she had HIV. When the illnesses intensified, her health deteriorated and later became blind. She was terrified by the HIV positive results and troubled by the imminent loss of land, the possibility of death and the resultant misery of her children.

When the illness intensified, she stopped cultivating and the neighbors and relatives of the husband started to cultivate her remaining land, but none of them gave her food or payments for using her land. One day, the young son aided her to hospital and found a group counseling session organized by TASO, which she attended and shared her experiences with the counselor who helped to enroll her for antiretroviral treatment and link her to UGANET. The field staff of
UGANET notified the police about the abuses Nyakato experienced. They jointly convened a mediation meeting with the family and community members where the land dispute was discussed and the boundaries were demarcated. She was also aided to get letters of administration of the land, but the hostility of the relatives and neighbors continued. An unknown person broke into her house, stole the mattress and other household items, and she informed the TASO counselor about the incident and the TASO counselor together with UGANET lawyers and a police officer visited her home and assisted her to recover the lost items.

Currently, Nyakato is comfortably settled on her land. Her 15-year-old son attends primary school but sometimes leaves school ahead of closing time to cultivate crops for the family. He also helps the mother to sort and take antiretroviral medicines every day [Extracted from UGANET Success Stories, 2012]

Table 5.8: Children and Adults reached with Legal Aid and Protection Services

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Age</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID projects</td>
<td>Children</td>
<td>31,124</td>
<td>33,307</td>
<td>64,431</td>
</tr>
<tr>
<td></td>
<td>Youth and adults</td>
<td>2,044</td>
<td>2,355</td>
<td>4,399</td>
</tr>
<tr>
<td>UGANET</td>
<td>Children, youth, adults</td>
<td>79</td>
<td>51</td>
<td>130</td>
</tr>
<tr>
<td>Total</td>
<td>All</td>
<td>33,247</td>
<td>35,713</td>
<td>68,960</td>
</tr>
</tbody>
</table>


Table 5.9: Number of persons counselled on gender-based violence/coercion related to AIDS

<table>
<thead>
<tr>
<th>Age</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 0 - 14 years</td>
<td>61</td>
<td>0</td>
<td>61</td>
</tr>
<tr>
<td>Young people 15 - 24</td>
<td>924</td>
<td>2,134</td>
<td>3,058</td>
</tr>
<tr>
<td>Adults 25 years and above</td>
<td>50</td>
<td>51</td>
<td>101</td>
</tr>
<tr>
<td>Total</td>
<td>1,035</td>
<td>2,185</td>
<td>3,220</td>
</tr>
</tbody>
</table>

Source: MEEPP-MIS for all USAID-Supported Projects (2012)

**Strategic Action 3.3.6: Rights Education on Norms that perpetuate SGBV and HIV**

Gender Based Violence (GBV) is the violence that occurs as a result of the roles and expectations of men and women, and the unequal power relations between them in the home or the community. Gender based violence usually manifests itself various human rights violations, which include sexual abuse of children, rape, child abuse, discrimination against girls, child labour, political discrimination, intimate partner abuse, defilement, incest, domestic violence such as partner battering, sexual assault and harassment, trafficking of women and girls, pornography, female circumcision, forced control over reproductive functions of women. Some GBV experiences, especially defilement, rape, forced sex in marriage, widow inheritance, forced marriage, and sexual exploitation have a potential of transmitting HIV.

At the start of the NSP 2011 – 2015, 60% of women and 53% of men had experienced some form physical violence (UDHS, 2006), while 58% of the women and 44% of men believed that wife beating is justified (UDHS, 2011 pg 230). In addition, at least 8432 cases of SGBV were reported to the Police in 2010, and 7564 of these were defilement
cases, 709 were rape cases and 159 cases of death related to domestic violence (JLOS, 2012 pg 47).

The NSP therefore prioritized promotion of human rights integration in HIV/AIDS programs of governments and civil society organisations; advocacy of policies, laws and rights of PLHIV, OVC and other vulnerable groups; capacity building for enforcement of relevant laws, policies and fundamental rights and freedom of PLHIV and OVC; engagement of cultural leaders to address cultural norms, practices and attitudes that serve as a blockade to the realisation human rights; development of regulations for implementing the Domestic Violence Act; Enforcement laws and policies on violence related to partner disclosure and difference in HIV status; strengthening of SGBV partnerships and networks among community, government and CSO structures; provision of appropriate services to survivors of abuse, violence and exploitation; and promotion of good practices on SGBV prevention and handling.

**Progress/Achievements**

- There was a general increase in prosecution of reported cases.
- The Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALL) commissioned a study into the socio-cultural factors and practices that promote SGBV and other HIV risk factors and drivers.
- The MOGLSD sensitized 200 cultural leaders and community development officers on the cultural norms and practices that perpetrate HIV and SGBV.
- The UGANET, PLHIV networks and other organizations conducted community dialogues with Local Council leaders and community members such as orphans, widows and PLHIV on human rights, how to prevent and handle abuses related to property and inheritance rights, and how to make wills.
- Several organizations also conducted educative talks and messages on SGBV and HIV were broadcast on radio and television stations and newspapers. Altogether, at least 2052 people were educated about legal rights and protection of women and girls impacted by AIDS. These were distributed as follows:

<table>
<thead>
<tr>
<th>Age</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 0 - 14 years</td>
<td>310</td>
<td>257</td>
<td>567</td>
</tr>
<tr>
<td>Young people 15 - 24</td>
<td>468</td>
<td>380</td>
<td>848</td>
</tr>
<tr>
<td>Adults aged 25 years and above</td>
<td>397</td>
<td>240</td>
<td>637</td>
</tr>
<tr>
<td>Total</td>
<td>1,175</td>
<td>877</td>
<td>2,052</td>
</tr>
</tbody>
</table>

Source: MEEPP-MIS for all USAID-Supported Projects (2012)

Some organisations such as UGANET mobilised community-based paralegals and affected groups were actively engaged in SGBV sensitisations and this approach helped to reduce community barriers to justice among SGBV survivors and perpetrators and ensure sustained community action against SGBV.
Strategic Action 3.3.7: Building Capacity of Structures on Human Rights and Litigation related to HIV

Because of the importance of the Justice Law and Order Sector (JLOS) in enforcing human rights and related litigations, the NSP 2011-15 prioritised capacity building of government and civil society justice, law and order structures in HIV related human rights and litigation; training of community-based paralegals on human rights, legal and ethical needs of HIV infected, OVC and other affected persons; and provision of community education on human, legal and ethical rights of HIV infected, OVC and other affected persons

Progress/Achievement

Uganda police trained 3 officers in DNA profiling and started on the construction of a laboratory for forensic analyses. This will also help to detecting perpetrators of defilement, rape and other crimes related to HIV transmission

5.5 Legal, Policy, Programme and M&E Environment for Social Support

Strategic Action 3.3.8: Reviewing the Legal and Policy Environment

Laws and policies provide the frameworks for ensuring social rights and wellbeing of the population. The review assessed the availability of legal and policy frameworks for enabling provision of HIV-related social protection needs of vulnerable groups.

Achievements/Progress

Several policies that are relevant to HIV/AIDS and social support and protection were reviewed and disseminated: UAC finalised and disseminated the National HIV and AIDS Policy. This policy among others emphasises provision of psychosocial and economic support to HIV infected and affected persons, greater involvement of infected and affected in development efforts, increased address of HIV concerns for populations prone to HIV infection and negative effects, equal access to social support services, and interventions for reducing gender-based vulnerability to HIV/AIDS, and research on impact of the epidemic at individual and community levels (UAC, 2011).

In addition, MOES reviewed the School Health Policy to identify policy gaps on emerging HIV/AIDS issues, while MOGLSD developed the SGBV policy guidelines, produced the community mobilisation guide for HIV counselling, and translated the OVC Policy into Luo and Ateso languages. The translated OVC policies were disseminated to government and civil society organisations in districts located in the Acholi, Lango and Teso sub-regions.

Several legal frameworks that are relevant to HIV/AIDS and social support and protection were presentation to Cabinet or Parliament: The HIV/AIDS Prevention and Control Bill 2010 was presented to Parliament and deferred for more consultations with stakeholders on the controversial provisions. The bill entails legal considerations on HIV testing, treatment, stigmatisation and discrimination. UGANET mobilised 30 civil society
organisations to review this Bill, and advocate the elimination of provisions that violate human rights of HIV infected and affected.

In addition, the Anti-Counterfeit Bill No.22/2010 and 2009 Industrial Property Bill review process was initiated to accommodate Uganda’s obligations on World Trade-Related Aspects of Intellectual Property Rights.

**Strategic Action 3.3.9: Strengthening Programmes for Social Protection of Vulnerable Groups**

Plans and programmes provide the mechanisms for providing essential services to vulnerable groups. This section therefore assessed existence of plans or programmes for addressing social support and protection needs of vulnerable groups within the context of the HIV and AIDS epidemic. The review noted various achievements and challenges/gaps in programming for social protection of vulnerable groups.

**Progress/Achievements**

*Several stakeholders were trained in programming social support services:* Data in the OVC MIS indicate that 4521 (2054 male and 2467 female) programme implementers were trained in programming OVC services.

*Several development programmes integrated social support activities for HIV infected and vulnerable groups:* Some of these include UPE, USE, Youth Entrepreneurship Empowerment Schemes, NUSAF, NAADS, Expanding Social Protection Programme, SUNRISE, NUMAT, STAR Projects, Holistic Empowerment Activism and Legal Project, Support on AIDS and Life through Telephone, Alleviation of HIV Related Vulnerability Project, Intimate Partner Prevention Project, Preventing Violence Against Women and HIV Project, Real Man Project of the Positive Men’s Union, Psychosocial Support by Mentors of HIV Positive Mothers and Fathers Clubs.

*Several ministries, civil society and private organisations developed and disseminated strategic plans that address social needs of vulnerable groups:* These include MOGLSD, MOES, MOD, Uganda Prisons Services, Uganda Police Force, Forum of Kings and Cultural Leaders on HIV/AIDS, 17 Cultural Institutions, 53 district local governments and virtually all AIDS service organisations under UNASO such as TASO, AIC, URCS, UGANET and AMICAALL.

*Tools for facilitating implementation and M&E of social support services of OVC were developed and disseminated:* MOGLSD and partners developed the Monitoring and Evaluation Framework and data tools for the National Strategic Plan of Interventions (NSPPI-2) for Orphans and other Vulnerable Children for 2011-2015. The data developed tools include the OVC vulnerability index, enrolment card, register, service record, CSO registration form and report format, capacity assessment tool, and management information system data collection tool. In addition, advocacy papers were developed on different topics such as resource mobilisation and allocation, institutional and coordination mechanisms, and monitoring and evaluation of OVC interventions at the various levels. These documents were disseminated to organizations implementing OVC interventions at national, district and sub-county levels.
Coordination system and partnerships for OVC service provision were established in some districts: Data indicate that 66 district local governments established OVC coordination mechanisms. Each of which conducted quarterly stakeholder meetings during which OVC activities and experiences were reviewed and shared. In addition partnerships were initiated between the OVC Secretariat and five Universities and the media to increase research, advocacy and information sharing on OVC concerns.

Strategic Action 3.3.10: Monitoring and Evaluation of Social Support and Protection Activities

Monitoring and evaluation helps to periodically track implementation progresses on critical output and outcome indicators. The M&E data is processed and used for management decisions. The NSP 2011-2015 set six (6) indicators for assessing progress towards realisation of the three objectives for social support and protection area. These include the percentage of PLHIV who received psychosocial support in past 12 months; the percentage of OVC who access comprehensive service package (possess at least 3 basic needs); percentage of OVC households that received economic strengthening support; the ratio of current school attendance of orphans and non-orphans aged 10 - 14 years; the number of OVC and non-OVC aged 5 - 14 years attending school; the percentage of the population with accepting attitudes towards PLHIV; and the percentage of work places employing 20 or more persons have AIDS workplace policies/programmes.

The M&E plan of the NSPPI for OVC also set indicators for assessing outputs and outcomes of OVC services such as the number of OVC trained and equipped in vocational skills; the number of OVC reporting incidents of rights violations and receiving legal and protection support. These indicators were to be assessed through annual monitoring data and national surveys.

Progress/Achievements

The MOGLSD established the OVC management information systems in 54 districts, and Internet reporting modems to 112 districts. OVC activities, households service coverage were mapped in 899 sub-counties and 4,708 parishes distributed across 72 districts. In addition, some ministry and CSO staff were trained in basic M&E to effectively collect, report and utilise data.

5.6 Conclusion

Several government, civil society and community-based organisations are engaged in the provisions of education, psychosocial support, food/nutritional support, income generation social protection assistances, and legal aid and protection services to other vulnerable groups. Through these organisations, several OVC, PLHIV, PWD, and the elderly were supported with various social support and legal protection services.

Several national development programmes such as NUSAf, NAADS and Humanitarian Assistance Programme incorporated concerns of vulnerable groups including PLHIV in their livelihood support initiatives. Some vulnerable groups were assisted with start-up credit and inputs for food security and income generation. Several policy and legal
frameworks that have a bearing on social support for vulnerable groups in the context of the HIV epidemic were either reviewed or revised or translated or disseminated. In addition, the OVC MIS in the MOGLSD helped to collect vital data on several OVC indicators that are relevant to social support and protection from several districts.

However, there are still challenges regarding low coverage of vulnerable groups with social support and protection services. This is attributed to inequity of funding social support services of the different needy groups, lack of national multi-sectoral programme that systematically channels support to various AIDS service organisations at the national, district and community levels to undertake prioritised activities, and the glaring decline in direct engagement of vulnerable groups in formulation and implementation of social support and protection services among peers over the last five years.

In addition, the legal and policy frameworks that have direct bearing on social support and protection such as the Domestic Relations Act and the Gender Policy still experience resistance in some influential sections of society and this has hindered its implementation, while the HIV/AIDS prevention and Control Bill have not been presented because it contains provisions that are difficult to implement, have the risk of perpetuating stigma and revengeful practices in society, and violate the civil and human rights of individuals and couples.

Furthermore, the most nationally representative database for OVC support services still has challenges of incomplete district coverage, irregular reporting and limited linkages with relevant sector management information systems, and the fact that reporting cycle of the key existing OVC data sources are not consistent with the government reporting cycle and therefore omit data of up to three months.

In addition, the M&E plan of the NSP did not identify output or outcome indicators for legal and protection, food and nutrition security, informal and vocational education, shelter provision, gender and disability mainstreaming, and HIV capacity building in JLOS structures. This has contributed to the poor documentation and reporting of data in these areas.
Chapter Six: HIV/AIDS SYSTEMS STRENGTHENING

6.1 Introduction

The national HIV/AIDS response Vision of “A population free of HIV and its effects” cannot be realized without strong management and service delivery systems. In order for the national response to achieve the programmatic objectives and outcomes identified under prevention, care and treatment, social support and protection, there is need for a robust system built on the pillars of strong leadership and governance, adequate resources and sound strategic information for enhancing the provision of good quality services at all levels.

The revised NSP 2011/12-2014/15 forth Goal – “To build an effective and efficient system that ensures quality, equitable and timely service delivery by 2015” has three strategic objectives, namely: i). To strengthen governance and leadership of the multisectoral HIV/AIDS response at all levels; ii). To ensure availability of resources for delivery of quality HIV/AIDS services and iii). To establish a coordinated and effective national system for management of strategic information for the HIV/AIDS response.

These objectives provide the framework for all the systems strengthening activities in support of the National Strategic Plan for HIV and AIDS. In the context of this framework, strategic actions were elaborated for each of the strategic objectives. These strategic actions form the backbone of the National Priority Action Plan (NPAP).

This report, covering the first year of operation for the NSP (FY 2011/12), depicts the progress made by all the HIV/AIDS partners, in implementing the systems strengthening components of the national response in alignment with the National Priority Action Plan. The achievements made between July 2011 and June 2012 are presented for each of the strategic actions under each of the strategic objectives.

6.2 ACHIEVEMENTS

6.2.1 NSP Goal 4 Objective 1: To Strengthen the Governance and Leadership of the Multi-Sectoral HIV/AIDS Response at all Levels.

6.2.1.1 Achievements Against Targets

The table below shows targets elaborated in the National Priority Action Plan against each of the performance monitoring indicators for objective 1. The table also provides the performance status against the indicators as of June 2012. Please note that the NPAP provided two year targets and for purposes of this report, status as at June 2012 represents progress made towards attainment of the two year target.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline 2011</th>
<th>Target 2013</th>
<th>Achieved 2012</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCPI</td>
<td>54.6%</td>
<td>70%</td>
<td>65%</td>
<td>Significant progress has been made and the NPAP target should be achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Improvement registered mainly in policy, strategic planning, Civil Society participation and provision of Care and Treatment</td>
</tr>
<tr>
<td>UAC Management Index</td>
<td>50%</td>
<td></td>
<td>62.5%</td>
<td>This is a measure of how well UAC is prepared to provide the requisite leadership for management and coordination of the HIV/AIDS response in Uganda. It is an indicator that has been assessed at a level below 50% for the last two NSPs.</td>
</tr>
<tr>
<td>Functionality of DACs</td>
<td>30%</td>
<td>50%</td>
<td>30%</td>
<td>Defined functional as ability to meet quarterly and able to report on progress. While 71% of LGs have established DACs, only 30% of the DACs are functional.</td>
</tr>
<tr>
<td>Functionality of district level interfaith committees</td>
<td></td>
<td></td>
<td>35%</td>
<td>Interfaith networks have played a significant role in addressing some of the structural drivers of the HIV/AIDS epidemic.</td>
</tr>
<tr>
<td>Functionality of district level AIDS service organization networks</td>
<td></td>
<td></td>
<td>45%</td>
<td>AIDS service organizations are the leading providers of AIDS services at district level. Their capacity to compliment government efforts needs to be boosted.</td>
</tr>
<tr>
<td>Functionality of sectoral (MDAs) AIDS Committees</td>
<td></td>
<td></td>
<td>50%</td>
<td>Defined functional as ability to meet quarterly and able to report on progress. UAC provided funds for 25 MDAs to support AIDS Committee activities during FY 2011/12.</td>
</tr>
<tr>
<td>Functionality of PLHIV networks</td>
<td>90%</td>
<td>95%</td>
<td>90%</td>
<td>A PLHIV network is considered functional if has an elective executive committee, has a bank account with books of Accounts, has policy documents such as Strategic Plan, Human resource Manual etc.</td>
</tr>
</tbody>
</table>

It is important to note that the level of national commitment and action to the HIV/AIDS response, expressed as the National Composite Policy Index (NCPI), has registered significant improvement from the baseline 54.6 % to the 65 % level for 2011/12. This is attributed to the improvement registered mainly in the areas of policy, strategic planning, Civil Society participation and provision of Care and Treatment.

On the whole, the non public governance structures have registered marked progress in their functionality scores in contrast with their public sector counterparts. According to UAC 2012 supportive supervision reports, 71% of the district local governments have established AIDS Coordination committees. However, these decentralized response structures are reported to be weak and

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20 UAC 2012, supportive supervision reports quarter 1.
poorly functioning, largely due to problems of funding for their activities. The Terms of Reference for these structures also need to be reviewed. According to the National Forum of people living with HIV in Uganda, a network of persons living with HIV (PLHIV) is considered functional if it has an elected Committee, has a bank account with books of accounts, has policy documents such as a strategic plan, Human resources manual, etc. Some Forums such as Kitgum, Mityana, Kabale, Kalangala have emerged as a best practice, majority others are good while a few are still struggling due to lack of stable funding.

6.2.1.2 Achievements against the Strategic Actions

Strategic Action 4.1.1: Mobilise political and technical leadership, management and stewardship of the multisectoral response at all levels.

During the year 2011/12, there was a revival in leadership commitment both at political and technical levels. The Parliamentary standing committee on HIV/AIDS and sessional committee for social services actively participated in discussing matters concerning HIV/AIDS and the performance of the health sector in general. The sessional committee for Presidential Affairs, which handles matters arising from the President’s office including UAC matters, was also very active and supportive in discussing the UAC budget performance and ministerial policy statement for FY 2011/12 as well as budget allocations for FY 2012/13. The Committees conducted a joint monitoring exercise that also enabled them to understand the intricacies and challenges of the service delivery system and the interactions that exist in the delivery of HIV/AIDS services amidst several other health and other social service demands.

Working with traditional and cultural leaders is a clear demonstration that the HIV/AIDS response takes cognizance of the potential role played by community practices and beliefs. For the year 2011/12, Ministry of Gender, UNAIDS and UAC worked with the Forum for kings and cultural leaders to mobilize leaders from over 17 cultural institutions, educate and sensitize them about the role cultural beliefs and practices have in fuelling the HIV epidemic among their subjects. The kings and cultural leaders reviewed and renewed their commitment, to the declaration signed in March 2010, to support the national response to HIV/AIDS. All 17 cultural institutions and the forum of Kings developed action plans to guide the response to HIV/AIDS.

Uganda AIDS Commission trained all 32 new district local governments (formed after 2010) in monitoring and evaluation. The weeklong training module covered basic concepts of HIV monitoring and evaluation, database management, supportive supervision and reporting (UAC 2012). Additionally, all higher local

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21 Parliamentary HIV/AIDS Committee, Sessional committee on Social services and Presidential Affairs Committee.

22 UAC 2012; District Monitoring and Evaluation training report
government leadership including LCV chairpersons, Municipality Mayors, Chief Administrative Officers, Town Clerks and heads of departments were engaged in a 3-day long orientation meetings to understand the National AIDS Policy, National Strategic Plan, National Priority action plan, the National Prevention Strategy and the National M&E plan 2011/12-2014/15.

**Strategic Action 4.1.2 : Institute, implement and monitor the necessary legal, policy and operational instruments and guidelines**

Uganda has the relevant HIV/AIDS policies, plans and technical guidelines in place. Some of the upstream policies and guidelines that were revised during FY 2011/12 include the care and treatment policy, ART policy and ART integrated guidelines, Home based care policy, infant and young child feeding policy. Additionally, a number of upstream strategies and action plans were developed during the year 2011/12. These include the National Prevention strategy and action Plan, the condom strategy, EMTCT scale-up plan, the national HIV/AIDS Strategic Plan 2011/12-2014/15 and the national HIV and AIDS Monitoring and Evaluation Plan.

**Strategic Action 4.1.3 : Strengthen the capacity of UAC to coordinate the national multisectoral HIV/AIDS response.**

In 2011/12 UAC conducted a comprehensive institutional review that was concluded in July 2011. The Review process i) Critically analyzed institutional arrangements (UAC Board, UAC Secretariat and AIDS Partnership structures) required to deliver the national HIV/AIDS strategic Plan goals; (ii) Addressed effectiveness or ineffectiveness, efficiencies or inefficiencies and sought to establish clarity of roles and responsibilities of the HIV and AIDS institutional structures and mechanisms; (iii) Provided clarity on the impact of fiduciary requirements set by the government, bilateral and multilateral funding agencies on fund coordination and on the institutional performance; and (iv) Considered options to move towards a significantly improved and more efficient national HIV and AIDS response coordination and implementation framework. As a result of the review, UAC Directorates were increased from three to five and staff increased from 48 to 84. Some posts were phased out while other new posts were created. The directorates include Finance and Accounts; Human Resource Management; Partnership Affairs; Planning and Strategic Information; and Policy, Research and programming. All posts of directors were filled before the end of the year under report. The Audit and Procurement Units were elevated to Departments and staff numbers increased.

Notably, the July 2011 UAC review recommended establishment of zonal/regional coordination focal points that would enable UAC keep in close contact with partners at Local government level. The Staff structure was revised to address the emerging need to ensure continuous interaction and stronger linkages with and within partners, collect and share strategic information in a
timely manner and also provide the requisite policy guidance at national and lower levels.

During the period under review, most of the recommendations of the institutional review had been partially implemented through i) Restructuring and recruitment of new staffs and ii) Development and updating of operational manuals to improve internal controls, and revision of the National HIV/AIDS Strategic Plan.

**Strategic Action 4.1.4 : Strengthen coordination linkages, networking and collaboration within and across sectors, decentralized and community levels**

Uganda subscribes to the global Principle of “the Three Ones” to coordinate the National Response. The revised National Strategic Plan (NSP) 2011/12-2014/15 for HIV/AIDS forms the Action Framework that guides implementation, and the Monitoring and Evaluation plan guides the monitoring and evaluation of the national response and programming. Uganda AIDS Commission (UAC) is the supra-sectoral agency responsible for overseeing, planning and coordination of the national Response in the country. The Commission (Board) reports to the Office of the President. The Partnership Structure (PS) and Forum (PF) are linked to the macro organization structure of UAC. The District HIV/AIDS coordinating structures operate based on the decentralized local governance structures. The linkage between the UAC and decentralized structures is coordinated under the newly created Directorate of Partnerships. During the assessment period, UAC initiated a comprehensive review of the HIV/AIDS partnership with the aim of establishing suitability and responsiveness in the face of a changing epidemic and dynamic response. The overall objective of the review is to carry out a comprehensive assessment of the HIV/AIDS partnership and its structures to establish relevance, suitability for the response, and appropriateness for coordination and accountability. Major strengths, weaknesses, challenges and recommendations should be provided for improving its functionality in view of the changing response.

Civil society networks including the National Forum of People living with HIV/AIDS in Uganda (NAFOPHANU) and the network of AIDS service organizations (UNASO) have continued to grow. For the year 2011/12 NAFOPHANU continued to mobilize resources to support activities of established networks in 100 (90%) out of 111 district Local governments, 10 Districts were supported to commemorate Philly Lutaya Day, 5 Districts for World AIDS Day, 10 Districts for International Women’s Day of 8th March 2012 and 16 Districts for International Candle Light Memorial of 20th May 2012.
UNASO was able to establish networks in 50 (45%) out of 111 district local governments. The interreligious council also initiated and launched district level interfaith committees (DICs) in 39 (35%) out of 111 district local governments.
In FY 2011/12, with funding from the Partnership Fund, the private sector received a cash grant to re-organize and strengthen itself as a Self Coordinating Entity so as to meaningfully contribute to the national response in fighting HIV/AIDS in a project code named “Scaling up HIV/AIDS Response in the Private Sector” – the (SHARPS) project. In the same year, the private sector mobilized 104 private sector CEOs and Heads of workers Unions in the Hotel, Manufacturing, trade Unions and Fish Sector to support HIV/AIDS interventions. The Uganda Hotel Owners Association, agreed to offer a service package privy to all agencies handling HIV/AIDS issues including; i). Free / subsidized / complementary workshop/ seminar venues and ii). Subsidized accommodation, meals and equipment.

Amidst these achievements, there is notable inadequate stakeholder clarity on the roles, mandates and functional relationships between stakeholder groups and the key lead actors in the coordination of the AIDS response at various levels.

**Strategic Action 4.1.5 : Mainstream HIV/AIDS gender, disability and human rights perspectives in all major development programs in public and non-public sectors**

All 111 district local governments and 22 urban local governments do include HIV/AIDS activities in their development plans. HIV/AIDS and Gender were included following an instruction from the Ministry of Finance, Planning and Economic Development. However it was noted that HIV/AIDS is still an option that many local governments tend to drop at budgeting stage and consequently there are no resources committed to this priority area.

During the same period, 25 Central government Ministries, Departments and Agencies (MDAs) were trained on how to mainstream HIV/AIDS in their departmental plans and budgets.

**Strategic Action 4.1.6 : Align HIV/AIDS related plans of sectors, districts, key stakeholders, development partners and funding mechanisms to the NSP**

The National Priority Action Plan (NPAP) was developed to guide all implementing partners, irrespective of their sources of funds, to harmonise and align all their annual operational plans to the priorities espoused in the NSP.

During the year under review a number of civil society organisations and networks revised and developed their plans in line with the revised NSP. These include UNASO, AIC, AMICAAL and TASO among others. In addition, all the SCEs developed annual work plans that were aligned to the objectives of the revised NSP.

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23 UAC 2011; Supportive supervision quarterly report – synthesized report for quarter 1, December 2011.
The Ministry of Local Government (MoLG) oriented 55 districts on the revised NSP, the M&E Plan and HIV prevention strategy. Additionally, the MoLG held consultative meetings in 55 districts to support districts revise their strategic plans in line with the NSP, build capacity to initiate/enhance partnerships with district-level implementing partners and improve harmonization of district-level programs to new priorities as outlined in the NSP, NPS and M&E Plan.

**Strategic Action 4.1.7: Promote social participation, self-regulation and accountability in the multi-sectoral response**

Several activities that depict improved social participation in the response were noted during the year. Candle light memorials were held in several districts during the year. The Philly Lutaya Day was celebrated with the theme “Re-engaging Leadership for Effective HIV Prevention”. The most outstanding activity, however, was the Support on AIDS and Life through Telephone (SALT) helpline that continued to receive and respond to callers (persons living with HIV) through the year.

A Consortium for Access to AIDS Treatment (CAAT) was also established to promote dialogue with various departments of government and ensure availability of AIDS treatment including ARVs at various posts across the country. NAFOPHANU also initiated the Stigma index study albeit that it is work in progress. It is anticipated that results of this study will highlight the primary causes of stigma among persons living with HIV in Uganda.

**Strategic Action 4.1.8: Build strong linkages and referral systems between institutionalized facilities and community structures**

The referral system for HIV and AIDS services to ensure a continuum of care and support remains weak. Many Village Health Teams have been constituted and trained and are expected to play a significant role in the community – to – facility referral chain. A number of grassroot structures of PLHIV have also embarked on providing guidance to their members on accessing services at health facilities. However, there are no specific guidelines to support the service providers and the community-based structures in effecting the referral procedures.
6.2.2 NSP Goal 4 Objective 2: To ensure availability of resources for delivery of quality HIV/AIDS services

6.2.2.1 Achievements against Targets

Table 2: Progress of performance indicators for Objective 2

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline 2011</th>
<th>Target 2013</th>
<th>Achieved 2012</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of facilities reporting non stock-out of drugs, laboratory reagents and other commodities</td>
<td></td>
<td></td>
<td></td>
<td>ARVs - 71% Cotrim - 92% Condoms - 87% Status as at June 2012 in line with MOH AHSPR 2011/12 and only acts as a proxy because it is derived from cross sectional Service Availability and Readiness Assessments (SARA) of a small proportion of health facilities. DHIS 2 expected to generate this data when it becomes fully functional.</td>
</tr>
<tr>
<td>Improve domestic (GoU) financing</td>
<td>10.2%</td>
<td>11%</td>
<td>12% (commitments)</td>
<td>During FY 2011/12 GoU commitments to HIV/AIDS increased in absolute figures from 49 to 53 million dollars between 2010/11 and 2011/12. However the relative contribution was affected by the un-matched increase in donor contributions.</td>
</tr>
<tr>
<td>Improve international financing</td>
<td>90%</td>
<td>68%</td>
<td>88% (commitments)</td>
<td>NASA report 2012 indicates that during FY 2008/09 and 2009/10, international financing was at 68 %, taking into account the 20 % Out Of Pocket contribution.</td>
</tr>
</tbody>
</table>

The indicator for monitoring the availability of drugs, laboratory reagents and other commodities is difficult to follow up because it is a compound indicator with no current source of data. However, it is expected that DHIS 2, when fully functional, will be able to generate this data. For purposes of this report, we have used the results of a cross sectional Services Availability and Readiness Assessment (SARA) exercise conducted by the MOH at less than one hundred health facilities. The results provide a proxy indication of the level of non stockouts of tracer items, namely Cotrimoxazole, three First Line Anti-retroviral drugs and condoms. The findings are fairly in agreement with the anecdotal reports of stock outs of ARVs, TB drugs and other HIV related items like Test Kits and condoms during the period under report.

An analysis of the HIV/AIDS funding commitments for FY 2011/12 indicates that GOU commitments at 12 % are in line with the NPAP target. This is also in line with the findings of the NASA 2012 report, covering the 2008/09 and 2009/10 Financial Years. The NASA report indicates that of the total HIV funding in the two financial years, about 68% came from external sources, 21% from private sources and 10-11% from public (GOU) sources. It is important to note that over the last few years, in absolute figures, domestic (GOU) financing has registered significant increases. However, the percentage contribution has
stagnated between 10 and 13 % because of a greater proportionate increment in donor commitments.

6.2.2.2 Achievements Against Strategic Actions.

**Strategic Action 4.2.1 : Develop infrastructure for enhancing the multi sectoral HIV/AIDS service delivery**

Infrastructure rehabilitation, especially at hospital and HC IV level has been ongoing throughout the year under report. During FY 2011/12 the number of health facilities providing Ante-natal Care (ANC) services that provided both HIV testing and ARVs for PMTCT on site were 1816; the number of outlets providing Male Circumcision (MC) surgery as part of the minimum care package of MC for HIV prevention services within the reporting period was 239. The number of health facilities providing HIV Post Exposure Prophylaxis (PEP) was 114; facilities providing Positive health dignity and prevention (formerly Prevention with Positives) services were 1312; the number of targeted condom outlets was 4822 and the number of service outlets providing Testing and Counselling services (excluding outreaches) was 1448. The number of facilities providing OVC services was 2293; while the number of health facilities that offer ART was 513 (MEEP SAPR 201224)

With funding from GFTAM, 10 health facilities were equipped with CD4+ T cell count, haematology, and clinical chemistry analysis including Moroto RRH, Katakwi HC IV, Apac hospital, Busolwe hospital, Nakaseke hospital, Entebbe Grade B hospital, Kitagata hospital, Bundibugyo hospital and Central Public health Laboratories. Additionally, STAR-SW procured 5 sets25 of CD 4 machines, Baylor College 7 sets, Mildmay 2 sets, IRCU 4 sets, STAR-E 2 sets for Masafu and Kapchorwa hospitals, STAR-EC 2 sets for Iganga and Bugiri hospitals. The Ministry of Health through National Medical Stores procured 250 CD 4 machines and equipped all Health centre IV and HC III ART sites.

**Strategic Action 4.2.2 : Build capacity of human resources for delivery of the multi-sectoral response to the HIV/AIDS epidemic at all levels**

Overall, the percentage of filled public sector posts has increased from 56 percent in 2010/11 to 58 percent in 2011/12 (MoH 201126). The report however notes that public sector vacancy rates remain too high. The staffing situation varies from a high of about 72 percent for regional referral hospitals, 63 percent for General

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25 Set here refers to a CD+ T cell count machine, hematology and clinical chemistry analysis machine.

26 MoH 2011 HRH Audit report
hospitals, 60.2 % at HC IV level, 60 percent at health centre III to as low as 45 percent at health centre II.

For the period under review, 553 health care workers successfully completed an in-service training program in PMTCT (excluding para-social community workers trained in PMTCT); 115 health care workers completed in-service training in injection Safety. Health care workers who successfully completed an in-service training program in Medical Male Circumcision were 418. The number of health care workers who successfully completed an in-service training program in Sexual Prevention-ABC was 32. Five hundred and sixteen health care workers successfully completed an in-service training program in HIV Counselling & Testing; 38 health care workers successfully completed an in-service training program in OVC Care services and 2324 OVC caregivers were trained in comprehensive HIV management.

The number of health care workers who successfully completed an in-service training program in Paediatric treatment was estimated at 470, while 1195 health care workers successfully completed an in-service training program in overall HIV treatment (ART). The number of community health and para-social workers who successfully completed an in-service training program during the reporting period (excluding those trained to cater for individual clients or single households for example treatment buddies & OVC Care givers) were 5227 while 1026 health care workers successfully completed an in-service training program in Strategic information

Number of new health care workers who graduated from a pre-service training institution within the reporting period (excluding para-social workers) were 17 (all non clinical) and 1019 community health and para-social workers successfully completed a pre-service training program during the reporting period-(this number excludes those trained to cater for individual clients or single households for example treatment buddies & OVC Care givers).

**Strategic Action 4.2.3 : Develop capacity for procurement, distribution and disposal of HIV/AIDS related goods and services at all levels**

The Government of Uganda and the Global Fund agreed to the use of Capacity Building Services and the Voluntary Pooled Procurement (VPP) mechanism, as part of the Fund’s Procurement Support Service (PSS) to handle procurements under the Global Fund. The GOU provides the specifications of the supplies required and Global Fund uses a VPP Agent to conduct the procurement. The procured goods are then shipped to Uganda. This system was adopted to cover the procurement of Anti-retroviral medicines, HIV Test Kits, Drugs for Opportunistic Infections, Condoms, laboratory supplies and equipment.
During this period under report, guidelines for equipment standardisation and supply were developed with the intention to harmonise and rationalize procurement and distribution of all lab equipment and other supplies (MoH, 201127).

**Strategic Action 4.2.4 : Expand the capacity of laboratories at different levels for delivery of HIV/AIDS related services**

During the period under review infrastructural developments and enhancements were done by partners through regional projects such as STAR-E, STAR-SW, STAR-EC and NGOs like IDI, Baylor College and bilateral organisations like JICA. Specifically JICA constructed laboratories at Mubende and Masaka Regional Referral Hospitals. SUSTAIN constructed laboratories at Fort-portal and Kabale regional referral hospitals, renovated laboratories at Moroto, Gulu Regional referral hospitals and Nebbi general Hospital. IDI has renovated laboratories at Masindi and Kagadi hospitals.

Prominent among the priorities of the revised National HIV/AIDS Strategic Plan 2011/12-2014/15 was building capacity to cater for the inadequacy in knowledge and skills of laboratory practitioners. During the period under review, in-service training was one of the interventions identified as key for bridging the knowledge and skills gaps for better laboratory service provision. The number of health care workers who successfully completed an in-service training program in Laboratory services provision in the year 2011/12 was 228 and the number of testing facilities (laboratories) with capacity to perform clinical laboratory tests as specified in MOH guidelines was 593.

Additionally, the Central Public Health Laboratory (CPHL) has been strengthened with a training coordination office. Consequently, a National Health Laboratory Training Master Plan (NHLTMP) has been developed. This Master Plan is to provide the framework for implementation of the 5 year National Health Laboratory Strategic Plan (NHLSP) 2010-2015. It will enable proper guidance and coordination, of all in-service training for all laboratory cadres in MOH and other facilities.

It is also important to note that, with additional funding from CDC, the laboratory credit line for laboratory support has grown from a low of US $ 1 m/year in 2005/6 to about US 9 m/year starting with FY 2011/12. However this is still inadequate to meet the Laboratory funding requirements.

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27 MoH 2011, Equipment standardization and supply list stakeholders report
Strategic Action 4.2.5: Mobilize adequate resources for HIV/AIDS services.

During the FY 2011/12, the response continued to get funding from both the Development Partners and Government of Uganda as planned for in the NSP. A major intervention for this strategic action was development of a National resources mobilization strategy, which, is yet to become operational. However, during the FY2011/12 various development partners continued to support the national response using differing strategies. Development Cooperation Ireland, DANIDA, SIDA and DFID continued to pool funds under the Civil Society Fund and Partnership Fund while the US government provided very substantial funding for HIV/AIDS activities through off budget support. A draft working paper geared towards setting up an AIDS Trust Fund was also developed by UAC to explore alternative and sustainable sources of funding for the HIV/AIDS response.

The NSP budget estimate for 2011/12 was USD 585.35 million with projected inflows of USD 418.08 million giving a funding gap of USD 167.27 million. A review of the same period (See Table 4.1), shows the contributions standing at USD 446.022 million.

Table 4.1 Contribution/Commitments to the Uganda HIV/AIDS Response (USD million)

<table>
<thead>
<tr>
<th>Source</th>
<th>2010/11</th>
<th>2011/12</th>
<th>%contribution 2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irish Aid</td>
<td>6</td>
<td>8.58</td>
<td>2.0</td>
</tr>
<tr>
<td>DFID</td>
<td>4</td>
<td>4.84</td>
<td>1.1</td>
</tr>
<tr>
<td>DANIDA</td>
<td>4</td>
<td>7.1</td>
<td>1.6</td>
</tr>
<tr>
<td>SIDA</td>
<td>1</td>
<td>2.1</td>
<td>0.5</td>
</tr>
<tr>
<td>UNITAID/CHAI</td>
<td></td>
<td>15.7</td>
<td>3.6</td>
</tr>
<tr>
<td>USG</td>
<td>289</td>
<td>324</td>
<td>74.7</td>
</tr>
<tr>
<td>UN Agencies</td>
<td></td>
<td>14.46</td>
<td>3.3</td>
</tr>
<tr>
<td>GFATM</td>
<td>4.39</td>
<td>16.55</td>
<td>3.8</td>
</tr>
<tr>
<td>GoU</td>
<td>49</td>
<td>52.692</td>
<td>11.8</td>
</tr>
<tr>
<td>Total</td>
<td>357.39</td>
<td>446.022</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: JUPSA, GOU Budget 2010/11 and 2011/12, GFATM website. Exchange rate 1 Euro = USD 1.320 ; 1 Pound = USD 1.61348; USD 1 = Ug. Shs 2442. Note: the figures provided do not include out of pocket expenditures.

Government of Uganda.

The annual share of the GoU in the total HIV and AIDS funding is reported to have grown from 5 % in 2007/08 to 11.2 % in 2008/09, 10.3 % in 2009/10 and to 13.7% in 2010/11. For FY 2011/12, direct GoU budget contribution has been estimated at about US $ 52.7 million (11.8%), covering a variety of HIV/AIDS

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28 NSP MTR Resources mobilization report November 2011.
service areas, including Social Support and protection for vulnerable households, the youth and the elderly. On the whole, while GOU contributions over the years increased in absolute terms, the percentage contribution fluctuates largely due to a higher proportionate increase in donor contributions.

Specifically, during FY in 2011/12, GoU funding for procurement of malaria and HIV drugs was Ug Shs 90 billion. In addition, Government provided Ug Shs 25 billion for youth Entrepreneurship venture capital fund to help youth start or expand their business enterprises; Ug Shs 3.5 billion for youth Entrepreneurial training program and Ug Shs 1 billion for business development skills. A social assistance grants scheme for empowerment of poor households and the elderly was also established and Ug Shs 4 billion for coordination of the Global Fund. Furthermore, GOU made a contribution of Ug Shs 5.18 billion for coordination of the response by UAC.

**USG/PEPFAR**

United States Government/ U.S. President's Emergency Plan for AIDS Relief (USG/PEPFAR) is the U.S. Government initiative to help countries in the fight against HIV/AIDS around the world. For the period under review, PEPFAR committed an allocation of about US $ 324 million towards Uganda’s national response. This is about 74% of the total commitments for the FY 2011/12.

**Global Fund**

During the year under review, the Global Fund made a contribution of USD 16,550,863 to Uganda for drugs and PSM cost compared to USD 4,391,196 for the preceding year (2010/11) meant for training and IEC materials. The NSP however did not give a projection for GF for the same financial year.

**The UN Agencies**

During the year under review, the United Nations Family contributed over 14 million US dollars, largely to support HIV prevention programmes, the institutional review of the Uganda AIDS Commission and the National AIDS Spending Assessment (NASA).

**Civil Society Fund**

The CSF was established to bring together multiple donor funds to support CSOs implementing interventions aligned to the National Strategic Plan.

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29 Ministerial policy statement 2011/12

30 MoFPED 2011 Budget Speech
For the period under review, the civil society fund continued to finance the national response as one of the main funding mechanisms. The CSF rose by 3.09% from USD 22,650,000 in 2010/11 to a total of USD 23,350,000 for FY 2011/12. The table below shows funding to the CSF from difference partners.

Table 4.2 Actual Contributions to the Civil Society Fund.

<table>
<thead>
<tr>
<th>CSF</th>
<th>2010/11 ($)</th>
<th>2011/12 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DANIDA</td>
<td>4,409,091</td>
<td>4,409,091</td>
</tr>
<tr>
<td>Irish Aid</td>
<td>5,850,000</td>
<td>5,850,000</td>
</tr>
<tr>
<td>USAID</td>
<td>10,900,000</td>
<td>10,900,000</td>
</tr>
<tr>
<td>DFID</td>
<td>4,500,000</td>
<td>4,500,000</td>
</tr>
<tr>
<td>SIDA</td>
<td>1,400,000</td>
<td>2,100,000</td>
</tr>
<tr>
<td>Total</td>
<td>22,650,000</td>
<td>23,350,000</td>
</tr>
</tbody>
</table>

Source: Delloite U Ltd, 2012.

Partnership Fund

The HIV/AIDS Partnership Fund (PF) is an important component of the Partnership mechanism established to support UAC Secretariat in its coordination role at national and lower levels. For the FY 2011/12, a total of USD 2,133,835 was committed for the fund. This gives an increase of 24.5% for the preceding year’s funding of USD 1,714,530.

Table 4.3 Contributions to the Partnership Fund

<table>
<thead>
<tr>
<th>PF</th>
<th>2010/11 ($)</th>
<th>2011/12 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DANIDA</td>
<td>828,913</td>
<td>1,393,035</td>
</tr>
<tr>
<td>Irish Aid</td>
<td>615,200</td>
<td>740,800</td>
</tr>
<tr>
<td>DFID</td>
<td>270,417</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1,714,530</td>
<td>2,133,835</td>
</tr>
</tbody>
</table>

Source: Delloite U Ltd, 2012

Strategic Action 4.2.6: Promote efficient allocation and use of HIV/AIDS resources

During the year under review, UAC successfully conducted a National AIDS Spending Assessment to establish the magnitude and structure of HIV/AIDS financing and expenditure and deduce recommendations that would be used to institutionalize HIV/AIDS resource tracking. The NASA findings will further guide resource mobilization, planning and allocation. The NASA 2012 covered the years 2008/9 and 2009/10, and subsequent assessments will be conducted at an interval of 2-years\(^{31}\).

\(^{31}\) UAC 2012, National AIDS spending Assessment Report (Draft).
**Strategic Action 4.2.7 : Align and harmonize resources to the National HIV/AIDS plans**

The NASA 2012 clearly indicates that the NSP projected resource inputs into the various Thematic areas vary significantly from the actual inputs. This disparity is likely to be due to the fact that the Public Sector is playing a marginal role in funding and managing resources for HIV/AIDS in the country. External entities are playing a very big role, both in financing the national response, and in making decisions about the funds for the response. The biggest players, in terms of both financing and management of resources are the bilateral entities.

**6.2.3 NSP Goal 4 Objective 3: To establish a coordinated and effective national system for management of strategic information for the HIV/AIDS response.**

**6.2.3.1 Achievements Against Targets**

The percentage of M&E indicators that are reported on according to schedule reached 49% during the reporting period. The majority of those indicators that are not reported on fall in the prevention and social support and protection dockets.

**Table 7 : Progress on performance indicators for Objective 3**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline 2011</th>
<th>Target 2013</th>
<th>Achieved 2012</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of M&amp;E indicators reported on according to schedule</td>
<td>35%</td>
<td>60%</td>
<td>49%</td>
<td>The majority of these indicators that are not reported on fall in the prevention and social support and protection areas.</td>
</tr>
</tbody>
</table>

**6.2.3.2 Achievements Against the Strategic Actions**

**Strategic Action 4.3.1 : Build Partnerships among producers and users of HIV Information for the National HIV/AIDS response**

The Government of Uganda through the Uganda AIDS Commission and with support from the national HIV/AIDS Partnership revised the National Strategic Plan (2007/08-2011/12) for HIV/AIDS and aligned it to the National Development Plan (NDP).

Civil society partners under the leadership of UNASO formed a consortium involving UNASO, NAFOPHANU and UGANET to implement a joint project titled: “*Strengthening District Networks in Advocacy and Networking for improved HIV and AIDS Response*” supported by the Civil society Fund in 25 districts across the country. Working under a consortium arrangement has
enabled the three to reduce duplication of effort but also share experiences and best practices amongst their member ASOs.

In the year under review, UNASO continued to place focus on strengthening the institutional capacity of UNASO Secretariat and district networks; increasing effective representation of ASOs on the key decision making forums in Uganda; promoting networking and partnership building among ASOs at national and district levels; increasing access to strategic information by ASOs for effective HIV & AIDS response at national and districts levels; and strengthening the capacity of districts networks in monitoring and evaluation of HIV & AIDS interventions.

**Strategic Action 4.3.2 : Promote ownership of the national HIV/AIDS M&E Framework**

For the year 2011/12, UAC developed and disseminated the national Monitoring and Evaluation Plan to all stakeholders at national and Local Government levels. The National Monitoring and Evaluation working group was reconstituted and was able to meet regularly (at least once every quarter).

**Strategic Action 4.3.3 : Develop and disseminate national policies, guidelines and plans to all partners at national and sub-national levels**

A number of policies, strategies and action plans were developed during the year 2011/12. These include the National Prevention strategy and action Plan, the condom strategy, EMTCT scale-up plan, the national HIV/AIDS Strategic Plan 2011/12-2014/15 and the national HIV and AIDS Monitoring and Evaluation Plan. Others were revised, for example, the care and treatment policy, ART policy and ART integrated guidelines, Home based care policy, infant and young child feeding policy.

All these strategic documents were disseminated to various extents during the year under report. Civil society organisations and networks have adapted the revised NSP and updated their development plans accordingly. Some of these organisations include UNASO, AIDS information Centre (AIC), AMICAAL and The AIDS Support Organisation (TASO).

**Strategic Action 4.3.4 : Build capacity for collection, analysis, dissemination, and utilization of HIV/AIDS data/information for the national response**

Thirty-two Local Governments were trained in M&E including Bulambuli, Kibuku, Kween, Namayingo, Luuka, Buyende, Amudat, Napak, Serere, Ngara, Butambala, Buikwe, Buvuma, Gomba, Kyankwanzi, Kiryandongo and Kyegwana Rubirizi, Lwengo, Bukomansimbi, Sheema, Mitooma, Buhweju, Kalungu, Ntoroko, Agago, Albetong, Kole, Lamwo, Nwoya, Otuke and Zombo.
In addition, UAC conducted LG supportive supervision visits on a quarterly basis with the intention of assisting Local government authorities in understanding the several policy guidelines, resource limitations, as well as resolve partner coordination issues. During the quarterly supportive supervision visits, UAC took the advantage to learn about what LGs do and how they manage their HIV/AIDS responses.

**Strategic Action 4.3.5 : Develop a national HIV/AIDS database for capture, storage and retrieval of HIV/AIDS data/ information shared by all partners.**

The process of procuring services of a consultant to undertake the development of the national HIV/AIDS database is on-going.

**Strategic Action 4.3.6 : Promote and Co-ordinate HIV/AIDS Research**

Under the guidance of the Research, Science and Academia (RSA) Self Coordinating Entity, several research and academic institutions conducted a number of research activities on HIV/AIDS. The development of a national HIV/AIDS research agenda has not effectively taken off. The Research, Academia and Science SCE has been actively updating its inventory of partners undertaking HIV/AIDS research.
1.1 Monitoring the National Strategic Plan
The National Strategic Plan (NSP) 2011/12 – 2014/15 has an in-built Monitoring and Evaluation plan with clear indicators and targets. It is against this background that this annual review is conducted. At the Joint AIDS Review of 2011, a number of priority actions were identified for the year under report as “Undertakings”. The progress made against these undertakings is presented in this chapter.

1.2 A Review of the JAR 2011 Undertakings
The 2011 National Joint Annual AIDS Review (JAR) Conference was held at Imperial Royale Hotel, from 1st to 3rd November 2011. The Conference was attended by more than 400 participants with representatives from: Parliament, Local Governments, Ministries, Departments and Agencies of Government, Civil Society, Private Sector, Networks of People Living with HIV/AIDS, Faith-Based Organizations, Bilateral AIDS Development Partners (ADPs) and the UN family. The stakeholders at the JAR 2011 committed to a number of undertakings. The report provides a synopsis of the status for each of the JAR 2011 undertakings.
## Status on JAR 2011 Undertakings

<table>
<thead>
<tr>
<th>JAR 2011 Undertaking</th>
<th>Progress</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>NSP revised and launched in December 2011</td>
<td>- Disseminated to 112 HLGs, 22 urban LGs, MDAs, 8 Civil society constituencies, and the AIDS Development Partners.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>2.</td>
<td>Developed and implemented an operational framework for disseminating and delivering the National Prevention Strategy (NPS) defining roles and responsibilities of the various stakeholders.</td>
<td>-</td>
</tr>
<tr>
<td>3.</td>
<td>Developed a Working Paper to justify increased financing for HIV/AIDS in Uganda. The paper also highlights the potential revenue sources to guide discussions</td>
<td>-</td>
</tr>
<tr>
<td>4.</td>
<td>2-Year NPAP operationalizing the NSP was developed, costed and disseminated to LGs, MDAs, Civil society and networks of PLHIVs</td>
<td>-</td>
</tr>
<tr>
<td>6.</td>
<td>Procurement for services of a consultant to undertake the project.</td>
<td></td>
</tr>
<tr>
<td>National HIV/AIDS response at UAC in which sectors can report into/send agreed national level sector specific indicators on an agreed time frame</td>
<td>Development of the database in progress</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>7. Prepare and sign MoU at all levels, district and National level detailing the roles of partners.</td>
<td>MOUs prepared and signed at national level only</td>
<td></td>
</tr>
<tr>
<td>8. Scale up safe male circumcision to cover over 1,250,000 males (14-49 years) in 2011/12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Counsel and test 2.5 million adults (15 – 49 years) for HIV in 2011/12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Enrol 21,628 HIV positive pregnant women on antiretroviral drugs to reduce the risk of mother-to-child transmission of HIV in 2011/12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Enrol 100,000 new adults and 20,000 children (total 120,000) on ART in 2011/12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Chapter Eight: EMERGING ISSUES, CHALLENGES AND RECOMMENDATIONS

8.1 HIV Prevention
8.1.1 Key Challenges to Scaling Up Coverage, Quality and Utilisation of Proven Bio-medical and Behaviour HIV Prevention Interventions

- There is limited focus on family planning as a major PMTCT intervention. There are also missed opportunities for delivering and documenting SRH services within the ART and PMTCT programme.
- Guidelines for management of discordant couples were developed although not yet adequately disseminated and utilised in health facilities.
- The post-test clubs need resources to facilitate establishment and routine activities yet this is an area that is not prioritised.
- Site accreditation for ART delivery is still far below PMTCT sites. Since the numbers of sites accredited for ART are not similar to those for PMTCT, linkage and referral between facilities is made weak.
- High-unmet demand for SMC. There is a slow pace of SMC roll out especially in government facilities despite the high demand created. The scramble for numbers may be at the expense of quality.
- Weak implementation of Infection prevention and control. The National Post Exposure Prophylaxis Guidelines earlier rolled out have not effectively been supported. At community level, HBC guidelines were developed but few districts have trained VHTs in infection control. Similarly, the National Infection Control Committee as well as health facility committees are inactive because of lack of clear objectives and resource limitations.
- Low Post exposure prophylaxis uptake. PEP guidelines have been disseminated but to a limited extent. Furthermore, the likelihood of achieving 100% access to PEP services is doubtful as many cases of exposure may not be reported.
- Lack of Surveillance for nosocomial infections including HIV, and occupational exposures that would provide evidence of transmission of HIV and other infections in health care delivery setting is weak.
- Major partners like Protecting Families against HIV/AIDS (PREFA), and YEAH initiatives are scaling down services or have exited. For example, this closing FY (July 2011 – June 2012), PREFA supported 645 health facilities in 40 districts but will scale down to 489 Health facilities in 20 districts next year.
- After launching the SMC Policy in 2010, formal scale-up of SMC has not been done countrywide. Effective linkage between SMC and other HIV services has also not been adequately institutionalised to enable improved care for people who are HIV-infected. In districts where SMC has been launched, a stock out of SMC kits is common. A monitoring and evaluation framework for SMC has also not yet been developed. There are still human resource capacity gaps and lack of harmonized protocols for all partner.
- There is shortage of blood testing reagents at Uganda Blood Transfusion services (UBTS), blood donor fatigue and poor response and inadequate Blood Transfusion Infrastructure with some of the centres operating blood banks in rooms borrowed from Referral Hospitals.
• There are no training curricula for pre-service, in-service and infection control health professionals.

• Slow scale up of PIASCY program as well as uptake. The PIASCY program is hampered by low coverage, low uptake in private schools, inadequate targeting of age appropriate information, and weak referral linkages with specialized counsellors. The high teacher student ratio also hampers individual counselling.

• IEC/BCC communication strategy that is aligned to the drivers of the HIV epidemic has not been developed yet.

Recommendations

✓ Set targets for reaching sexually active individuals of reproductive age group within the PMTC, HCT and HIV care settings. Develop and operationalize appropriate data collection tools to enable capture this information.

✓ Accelerate accreditation of HCIVs and HCIIIIs to enable access to ART for eligible individuals including pregnant women. While the MOH reported over 600 facilities accredited for ART by 2011, only 475 were active. Facilities that are accredited and are not functional should be supported to become functional. Special focus on the Prisons, fishing communities and police is also required.

✓ Efforts should be made to rapidly scale up SMC within the formal health sector and in the context of the district health system. The scramble for numbers should not overshadow the need to deliver quality SMC services.

✓ Integration of female condom procurements and IEC should be done into other health supply procurement systems and other IEC/BCC programs.

✓ There is need to initiate and uphold quality assurance in all the biomedical interventions irrespective of the desire to achieve big targets.

✓ UBTS needs to design new donor recognition schemes to motivate blood donors to continue donating blood on a regular basis.

✓ Avail mechanisms of initiating starter packs for PEP at lower facilities like HCII, VHTs, the police stations and prisons that cannot attain ART accreditation status. This is useful in initiating individuals on PEP at health facilities that are far from ART accredited sites. Districts should also be supported to forecast and include PEP supplies in their work plan.

✓ UAC to hasten the process of reconstituting the IEC/BCC TWG. This will help streamline implementation of the existing IEC/BCC strategies in MoH and other partners.

✓ The multiple on-going Behaviour Change interventions should be assessed for quality and effectiveness

✓ Expedite implementation of HIV Stigma Index Assessment since many communication activities will rely on the findings

8.1.2 Challenges of Scaling Up Priority Behavioural Interventions

○ Low condom utilization. This is basically linked to decreased supply of male condoms and low uptake of the female condom

○ Slow scale up of PIASCY program. The PIASCY program is hampered by low coverage, low uptake in private schools, high school drop out of girls,
inadequate targeting of age appropriate information packages, weak referral linkages with specialized counsellors and lack of a compulsory curriculum. The high teacher student ratio hampers individual counselling.

- **Sustainability of activities under Y.E.A.H is threatened.** Funding for the Y.E.A.H program is ending 2012. Though some activities like radio programs will be continued for up to 6 months after closure of funding, maintaining the momentum of the package of activities will need continued funding.

- Information, Education, Communication/Behaviour Change Communication (IEC/BCC) communication strategy aligned to the current drivers of the HIV epidemic has not been developed yet.

- Little attention is paid to the quality of Behaviour Change Programmes and interventions.

- Implementation of HIV Stigma Index survey has delayed.

- AB strategy not yet updated

### 8.1.3: Challenges of Scaling Up HIV Counselling and Testing

- Home based HCT provision is still very low currently implemented in about 15 districts.

- Provision of technical support supervision to HCT has been weak though all partners have in their program plans the component of HCT Support supervision and mentoring. The creation of regional offices offers an opportunity.

- Establishing functional post-test clubs, as well as their sustainability is poor due to lack of supporting partners.

- Government health facilities continued to provide facility based HCT but have not yet implemented any outreach or dedicated facilities to MARPs. The Plan to have every district to have an outreach program to reach the Key populations and mobilizing leaders to serve as role models for HCT also has no specific targets set for the reporting year.

### Recommendations

- Strengthen linkages between community and home based services to other mainstream health services.

- HCT achievements exceed targets and need revision. Revision of the said targets should be considered before the mid-term review of the NSP.
8.1.4 CHALLENGES OF REDUCING THE VULNERABILITY OF OVC

- There is still an information gap in the extent to which building capacity of health and social services to manage SGBV has been achieved as a result of weak linkages in health, social and law enforcement sectors.
- The functionality of most CBOs is inadequate due to limited funding. Similarly, information sharing from the CBOs to the district local governments as well as to national level is not adequate.
- There exist insufficient responses towards addressing post-conflict effects on people in northern Uganda.

Recommendations

- The OVC MIS that is already web based should be made fully operational to enable district implementers feed into the national information requirements.
- An update of the current national NGO database should be conducted while all districts should endeavour to update their CBO databases. This will ease the process of follow-up in event of soliciting for information.
- Focused interventions should be put in place in the post conflict districts to address the effects like Gender Based Violence (GBV) of war on the psycho-social well-being of persons affected

8.1.5 Cross Cutting HIV Prevention Challenges

- Focus on the Multi sectoral Approach to the Control of HIV/AIDS (MACA) is limited with greater bias towards the health sector interventions.
- There are many guidelines revised churned over to the provider making no consideration for their uptake.
- Planned activities under different funders are not synchronised thus cannot be adequately implemented.
- Several activities planned to hinge on an approved NPS could not be initiated since the NPS was only cleared by UAC at the end of 2011.
- The partners are not delivering as one and this will undermine scaling up prevention packages within the one NSP.
- Late and inadequate reports (monthly reports & other activity reports) hamper progress monitoring as well as timely documentation.
- Delay in reconstituting IEC/BCC TWG has affecting negatively the smooth implementation of IEC/BCC strategies.
- HIV mainstreaming is still a challenge especially for sectors and Local governments.
- Lack of local data for monitoring of prevention activities hampers district planning.
- There are weak linkages between district local governments, cultural institutions and religious institutions.
- Several researches have been conducted by partners without proper coordination of the dissemination and use of their findings.
8.1.6 CROSS CUTTING RECOMMENDATIONS FOR HIV PREVENTION

- HIV prevention efforts at all levels should promote more of the MACA than the health system approach.
- Funding for local governments should be reviewed to provide for an affirmative action for funding towards HIV/AIDS response in urban areas and other hotspots where drivers are highest and greatest impact expected.
- Funding should be provided to local governments to enable functionalize the existing HIV/AIDS coordination structures.
- Research findings should quickly and widely be disseminated at the decentralized level to inform programming and decision making at that level as well as policy development at national level. UAC should also strengthen the functionality of its research and documentation section to enable coordinate effective coordination of HIV/AIDS research.
- Local governments should include cultural and religious leaders on their HIV/AIDS Committees and strengthen linkages with these institutions. There is need to harmonise the various (many) guidelines into a single operational

8.2 CARE AND TREATMENT

8.2.1 Missed Opportunities and Challenges to Increasing Equitable Access to ART

*Missed Opportunity - Roll-out of SMC:* Roll-out of safe male circumcision (SMC) is a potential opportunity for increasing access to HIV services for men as the SMC package includes HCT, BCC and referral into care for the HIV infected. However, the SMC program currently lacks adequate resources for roll-out (surgical kits, and skilled personnel), as well as the added program to engage and retain those men in the HIV response continuum. The program was launched in 2011 and is targeting sexually active males. Effective linkage between SMC and other HIV services would enable improved care for those identified to be HIV-infected within the SMC program and vice versa- i.e. refer those HIV negatives in HCT programs for SMC.

*Funding For Workplace Programmes:* Implementation of workplace programs has been hampered by inadequate funding through the line ministry budgets. Additionally, through the key informant interviews, it was noted that government sectors that receive external funding support for HIV/AIDS activities may suffer budget cuts thus challenging HIV mainstreaming efforts. Workplace programs are not delivered in isolation: the beneficiaries of the programs extend beyond the employees for example 75% of clients in care within UPDF facilities are civilians residing in surrounding communities thus increasing the budget requirements. Infrastructure upgrades are urgently required
especially in prisons to facilitate site accreditation for service delivery, and support isolation for suspected TB cases. Other persistent challenges include lack of trained personnel to coordinate and support the activities, frequent staff transfers, stigma in the workplaces especially in schools and other learning institutions, absenteeism occasioned by ill health, and staff attrition partly due to HIV/AIDS related factors. Poor health services at referral sites are an issue since majority of workplace programs refer clients to health facilities for care once identified as HIV infected. Data available within the sectors is often inadequate to support programming e.g. HIV prevalence among employee, behavioural risk factors such as MSM and others. Linking and learning with public and private organizations, for information sharing, access to free IEC, condoms, training and referral services e.g. company networks like Uganda Employers Association (UEA) and Uganda Manufacturers Association (UMA).

Challenges

**Low ART coverage:** The current national ART coverage of 62% is still way below the universal access target of 80% by 2015 and could be worse given higher eligibility numbers that will be derived from the 2011 AIS. The major bottlenecks to further scale-up include:

- Inadequate CD4 access to enable ART eligibility assessment for clients in HIV care and those newly diagnosed with HIV. Only 55% of ART clients had a CD4 at baseline in 2010/11 while only 18% have a 6 monthly follow-up CD4. According to the 2011 UAIS, of all individuals who knew they were HIV positive, 70% had been offered a CD4 and 67% had the CD4 performed. The HIVQUAL 2011 report also reported access to CD4 within the preceding 6 months was 60%. This implies that 30–40% of individuals maybe unaware of their eligibility status.

- Limited access to ART at lower level facilities: Majority of accredited sites are higher level facilities such as hospitals, HCIVs while only 8% of HCIIs are active thus limiting access for rural communities. The situation is worse in hard to reach areas such as the fishing islands.

- Low paediatric treatment coverage: Paediatric care and treatment numbers are persistently low – only 8% of ART recipients are children below 15 years. ART coverage among children has declined from 25% to 17% partly due to transition to adult age. Despite the MOH policy recommending ART for all infected infants below 2 years of age, a recent assessment by MOH revealed that only 49% of identified HIV positive infants initiated ART. There is need to have Standard Operating Procedures (SOPs) in place to guide providers improve service delivery.

- Access to ART by fisher folk is extremely limited: As of June 2012, of the 6,225 clients in care (4,150 males & 2,075 females), only 948 eligible people (425
males and 523 females) were accessing ART (only 25% of those in need).

Weak linkage between facilities and programs further reduces access especially for some specialized groups: according to the PREFA PMTCT program report on 40 districts, of the 32,817 identified as HIV-infected between July 2011 and June 2012, only about 10% (3,066) received ART; only 34% of TB/HIV co-infected accessed HAART in 2011, and for infants, only 49% of those infants identified in the EID program at the survey sites were initiated on ART by July - September 2012.

Stock-out of ARV drugs: There were insufficient stocks of ARVs in country early 2012 which slowed down ART initiation for new clients and delayed roll-out of Option B+ by the MOH despite policy approval in 2011. According to the MOH Stock Status Report dated March 2012, there were only 3.9 months of stock for TDF, the recommended first line treatment for Option B+, prompting the MOH to postpone implementation of Option B+ and request facilities to use AZT as the alternative first line ARV regimen.

Understaffing at health facilities: Only 57% of approved posts were filled as of 2011. GOU plans to recruit an additional 6,000 health providers in the coming year and increase salaries of doctors.

Retention in Care and Treatment: Retention of clients in care and treatment continues to be a challenge: Loss-to-follow-up among ART cohorts that completed 6 months in the quarter October to December 2011 was reported to be 6% rising to 18% among cohorts that completed 60 months of follow-up in the same period. For the infant population in the EID program, loss had reduced from 71% to 51% between 2009 and 2011.

The QoC 2011 baseline report indicated only 15% of clients on ART keep their appointments. This increased the risk of poor adherence to ART and resultant development of HIVDR. Roll-out of Option B+ among pregnant women is an anticipated challenge for HIVDR prevention and control. This is the first ‘test and treat’ program in a healthy population which may have adherence challenges. There is need to have stronger mechanisms in place to ensure adherence support for pregnant women on ART.

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32 PROTECTING FAMILIES AGAINST HIV/AIDS (PREFA) Program Report To UAC October 2012
33 NTLP draft Strategic Plan 2011/12-2014/15
34 MOH EID Assessment Report July – September 2011/ Presentation to pediatric ART committee
35 MOH Stock Status Reports March 2012
Lack of Unique Patient Identifiers: While the need for unique client identifiers is appreciated by all stakeholders, implementation is challenged by resource constraints. The need for a central data base is also evident.

Increasing Demand for ART: From the 2011 AIS data, the total number of HIV infected individuals has increased from 1.2 million in 2005 to 1,390,732 in 2011. This implies an increasing demand for HIV care and treatment. From the 2011 AIS data, at last 30% of HIV infected persons who were not on treatment were eligible for ART (had a CD4 of less than 350). This implies an estimated 200,000 eligible but not on treatment, perhaps a significant portion unaware of their HIV status.

Adolescent Care – An emerging Challenge: As the paediatric ART cohort gets older, challenges of adherence to treatment, sexuality, and stigma, are increasingly becoming evident. Majority of older children in care prefer to remain with their paediatric providers and are hesitant to be transferred to adult care providers.

Stock Outs of ARVs: While stock outs of ARVs were reported at several facilities, they were difficult to quantify at national level. In one survey conducted between November 2011 and April 2012, and covering 39 facilities in 22 districts, stock out of paediatric ARVs was reported in 2/8 HCIVs and 1/10 hospitals surveyed.

Need to Revise National Targets: The existing national targets will need to be revised upwards to include pregnant women receiving HAART as part of PMTCT Option B+.

Emerging Issues:

HIV Drug Resistance: One of the emerging issues pertinent to ART is HIV Drug Resistance Development. There is a looming threat of increasing resistance of the HIV virus to ARV drugs. Recent data shows transmitted resistance of up to 12% - up from 5% in 2007. This risk will increase with the PMTCT Option B+ roll-out. This program that is scheduled to begin October 2012 is anticipated to have specific challenges related to treatment adherence and retention in care and on treatment since this is the first ‘test and treat’ program in Uganda targeting a healthy population. Special focus on HIV drug resistance prevention and surveillance is therefore needed. Secondly, the increasing HIV prevalence implies


37 HIV drug resistance reports
increasing demand for services in future which call for intensified prevention efforts.

A recent study conducted by MRC (Nanyonjo et al.) has also reported a case of transmitted drug resistance in an infant through MTCT thus highlighting the importance of adherence in the prevention of HIVDR\textsuperscript{38}. Through rationalization of Care and Treatment services over the past couple of years, a number of ART sites have had their Implementing Partner such as TASO transition out of the facility. There are fears that quality of care and treatment may be affected with resultant loss to follow-up and poor retention, adherence etc. Standardizing approaches by all stakeholders may assist allay these fears.

**Lessons learned:**
The national Early Infant Diagnosis (EID) program has registered major successes in the transportation of samples from facilities to the testing lab at CPHL, sample processing, and results turnaround time (TAT) to facilities. In 2009, a program assessment found TAT to be 42 days but following centralization of sample testing and establishment of the hub system, the TAT has reduced to less than 2 weeks. At the same time, up to 60\% of exposed infants are reached as compared to 27\% in 2010\textsuperscript{Error! Bookmark not defined.}. The MOH-CPHL is planning to expand the EID laboratory sample referral network both in scope and geographical coverage to improve CD4 access to individuals newly diagnosed through HCT and those already in care and treatment. These will likely result into better CD4 access, identification of eligible clients, and earlier ART initiation.

*Virtual elimination of MTCT feasible with universal access to services:* TASO Sooty established a specialized PMTCT/EID clinic that implements active linkage of HIV infected mothers from ANC, provides EID, infant care services, and family planning services. As a result, annual enrolment into the clinic has more than tripled since 2009, ARV coverage for PMTCT is over 98\%, EID uptake 100\%, and MTCT rates at 0\% in 2012, as compared to 8\% in 2009. Almost all infected infant initiate ART\textsuperscript{39}.

\textsuperscript{38}Maria Nanyonjo et al., *Screening for HIV Drug Resistance in failure of PMTCT,* (Abstract: 2012 Annual Pediatric HIV/AIDS Conference)

\textsuperscript{39}Olweny Denis et al: Improving access to PMTCT and EID services for HIV infected pregnant women attending ANC services. (2012 Annual Pediatric HIV/AIDS Conference)
Use of mobile phones to strengthen adherence to drugs is being promoted by several partners – utilizing SMS texts to patients as reminder to take their drugs. One example is a Dutch-run non-governmental organization Text to Change.

8.2.2 Missed Opportunities and Challenges to Increasing Access to Prevention and Treatment of Opportunistic Infections, Including TB

**Stock-out of anti-TB drugs:** There were interruptions in the supply of the TB drugs over the past year. This could potentially contribute to treatment interruption (defaulters), poor treatment outcomes and increase risk of development of drug resistant TB.

**Growing MDR challenge:** The emerging problem of drug resistant TB calls for attention to strengthen the basic TB control measures so as to prevent drug resistant TB. Multi-Drug Resistance (MDR) TB among new cases is 1.4% and 12% among previously treated patients.

**Diagnosis of TB still a challenge:** Detection of TB among people living with HIV (PHA) and children remains a challenge due to lack of more sensitive diagnostic tools in the majority of health facilities. GeneXpert coverage remains low and supplies (cartridges) are costly. Of note, only 1.5% of HIV patients in care are diagnosed and treated for TB, which is way below the estimated TB burden among HIV patients. A study conducted at Tororo, Uganda by CDC found TB prevalence to be 7.2% among patients initiating ART, and 5.5% in the first year of ART (Tororo HBAC Study).

**Low ART coverage among TB co-infected patients:** ART coverage in TB/HIV co-infected patients remains low at 34% yet research findings show that ART greatly improves the treatment outcomes of TB Patients and reduces deaths by at least 50%. This is a major missed opportunity as the ARV drugs are available at many TB treatment facilities.

**The 3 ‘I’s not fully implemented:** Lack of implementation of infection control activities in the health facilities may contribute to nosocomial transmission of TB. Isoniazid Preventive Therapy is yet to be rolled out as more support from MOH is awaited.

**Insufficient Pain Management Preparedness:** The major challenges include understaffing and therefore limited numbers of prescribers of oral morphine in remote health facilities which in turn results into overwhelming workload for those at post. The HMIS does not capture palliative care related data which makes it difficult to track progress using the national system. The program is yet to achieve national coverage: There is need for oral morphine, the drug of choice for palliative exists all over the country but not all districts are covered. There
exists a gap in the referral system for patients that need palliative care. There are still limited numbers of prescribers in remote health facilities and therefore high workload. There is still poor information about the role of morphine and myths which abound and prevent access to effective pain control.

8.2.3 Challenges to Integrating Sexual and Reproductive Health

**Access to FP still low:** According to the MOH quarterly report, of the clients newly initiated ART, 16% of women were pregnant highlighting the high unmet need for RH services among PHAs. Moreover, 90% of all family planning supplies are still provided by the private sector and government only provides 10%.

*Increasing number of Young positives:* There is no clear strategy for them, no PHA networks in schools and institutions and yet stigma levels remain high. Handling disclosure and support systems for school going positives is still a gap.

8.2.4 Missed Opportunities and Challenges to Supporting and Expanding Home Based and Community Based Care and Support

**Under funding:** There is no direct funding for functionalizing the VHT system from the GOU although several VHTs trained and functional and are actively supporting services through Partners’ capacity building. Community groups need to be facilitated to work however resources are limited.

*PHA networks need a lot of support which is not readily available*

**Coordination:** Coordination of PHA and VHT at district and community level still weak

*Limited coverage:* This programme which provides the BCP only covers 85 districts and does not cover all health facilities within each district. Coverage is hampered by resources and distribution to the final consumer takes longer and is a challenge. There is also more demand for the service than is being provided.

8.2.5 Recommendations to support Care and Treatment scale-up

- Support accreditation HClIIs and HClIVs to provide ART to adults, children and pregnant women on Option B+. Accreditation of ANC sites for ART delivery will maximize linkage between ART and PMTCT and improve coverage among pregnant women towards the eMTCT goal. As Option B+ is implemented, there is need to strengthen adherence support systems and HIVDR surveillance to minimize risk of resistance development. The existing national targets will need to be revised upwards to include pregnant women receiving HAART as part of PMTCT Option B+.
To support health systems for ART delivery, improve access to CD4 for clients in active HIV care and those newly identified to enable ART eligibility assessment and timely initiation on ART;

Recruit additional staff at facilities to support treatment scale-up;

Harmonize and rationalize the supply chain management to ensure uninterrupted commodity supplies of ARVs, CTX, HIV test kits;

Improve reporting for care and treatment plus data use and advocate for use of unique client identifier.

Explore and replicate effective e-health initiatives such as mobile phone technology to support treatment adherence and retention.

Increase number of children in care and treatment though strengthening of the EID program, KYCS campaigns, PITC, Standardize paediatric care approach among providers to support improved linkage, retention, and timely ART initiation. Review adolescent specific challenges and device strategies to mitigate them.

Extend PITC to other units within facilities (beyond ANC) and implement strategies that promote immediate linkage to ART and retention in care such as POC CD4 testing, active linkage between testing and other services especially Care and Treatment for those testing positive, mobile phone technology to minimize LTFU, and immediate ART initiation after confirming eligibility.

Develop policy guidance on treatment for prevention among populations other than pregnant women. This is urgently needed especially for discordant couples and MARPs who are at high risk of HIV transmission.

Finalize the EWI survey and disseminate findings, and strengthen HIV DR surveillance and prevention especially among the PMTCT Option B+ recipient.

Strengthen linkages across all services (HTC to SMC, PMTCT to Care and Treatment): for SMC, explore integration with workplace programs. Utilize community groups to facilitate linkage between facilities and communities.

Strengthen quality improvement to monitor and improve HIV care and treatment in line with national guidelines. Areas of focus: should include adherence, retention, TB/HIV performance, timely ART initiation, overall health outcomes of HIV positive clients

Train more prescribers for palliative care, improve district coverage, integrate with other services, and work with MOH to capture palliative care data into HMIS

Strengthen TB – ART linkages to improve access to treatment, improve access to effective diagnostics such as GeneXpert, strengthen supply chain management for anti-TB drugs to ensure uninterrupted treatment and minimize MDR risk, and expand coverage of the MDT treatment program.
8.3 SOCIAL SUPPORT AND PROTECTION

8.3.1 Challenges to Scaling up Quality Psychosocial HIV Services

- The coverage of comprehensive psychosocial services is very low. Data indicate that only 59829 OVC and 4064 had access to comprehensive psychosocial service package. This was attributed to inadequate knowledge of what constitutes a comprehensive package of psychosocial services, and the inadequate funding for psychosocial support activities.

- A few students, teachers, and school nurses have been trained in the provision of psychosocial support. This has contributed to the lack of basic counselling and care services for HIV infected students and teachers in most schools.

- There is still high level of discrimination and stigmatisation of HIV infected teachers and children in schools, especially at primary school level. This situation has made some teachers and students to leave school (UNYPA, 2012; NAFOPHANU, 2012).

- Decline in intensity of information sharing, psychosocial support and positive living activities in PLHIV networks/clubs (leadership, ART, lack of funding) and among affected community members.

- The growing number of HIV infected children entering the reproductive age group, and desiring to engage in intimate relationships with other children schools.

- The limited knowledge of teachers, caregivers, family members, and the community in handling reproductive and psychosocial needs of YPLHIV, and the lack of psychosocial support services for YPLHIV in schools and community.

- There limited engagement and support of PLHIV and community-led groups by government and civil society agencies in the provision of psychosocial services. This has led to low community ownership, continuity and coverage of services.

8.3.2 Challenges to Empowerment of HIV Affected Households

- The booklet on local nutritional options and sources has not been disseminated to vulnerable communities in the different parts of the
country due to delay in translation of nutritional materials into various languages.

- Few community workers and caregivers have been trained in nutrition care.
- Most organisations that provide agricultural support to HIV infected and vulnerable groups have scaled down their activities due to limited funding for food security interventions.
- There has been a decline in food production in the community, leading to low supply of locally grown food to vulnerable households.
- There is no system for monitoring the food and nutrition security in households of PLHIV, PWD, elderly and other vulnerable groups.

### 8.3.3 RECOMMENDATIONS

In order to improve the performance of the social support and protection services, the following actions are recommended:

**Psychosocial services**

- The MOES should assess the psychosocial needs of teachers and students in the context of HIV/AIDS; and strengthen school counselling services by revising the guidance and counselling course to include topics on HIV/AIDS/SGBV and adolescent counselling, training senior women and men teachers in first aid and AIDS counselling, and enforcing the establishment of counselling/support clubs and sickbays in schools.
- The AIDS Service Organisations should train more community volunteers in AIDS counselling, and mobilise and support community-based groups and PHA networks to carryout psychosocial services in the community.

**Food and Nutrition Security**

- The MOGLSD, MAAIF and AIDS service organisations should mobilise and provide essential agricultural inputs to households of PLHIV, OVC and other vulnerable groups to enable sustainable food production and nutrition improvement in these households.

**Mainstreaming gender and disability in HIV activities**

- UAC should review the NPAP and incorporate priority activities for AIDS workplace programs. Some of these include development and dissemination of inventory of workplaces with more than 20 workers, development of HIV/AIDS workplace policies and programs, and
implementation of a comprehensive package of HIV/AIDS workplace activities.

- The UAC should encourage and support all SCEs to review their programmes and mainstream gender, disability and HIV concerns.

**Rights education on norms that perpetrate SGBV**

- The agencies responsible for facilitating and or dispensing Justice, Law and Order services should facilitate their extension staff to train community-based paralegals and conduct periodic dialogues in schools and the community on the relationships between culture, SGBV and HIV/AIDS and on the specific actions to take in instances of abuse;
- The MOGLSD should mobilise and support cultural, religious and community leaders to promote social norms that prevent and protect vulnerable groups against abuse and improper family socialisation processes.
- Legal and social support organisations should be supported to mobilise, capacitate and directly engage community-based groups in identifying, registering, reporting, following-up and providing counselling and referral services to victims and perpetrators of SGBV. They should also educate PLHIV, OVC the elderly and community on writing memory books and wills.

**Capacity building of JLOS and community structures in HIV**

- The JLOS should assess the capacity needs of the relevant institutions and community structures in handling human rights and litigations related to HIV; and train the relevant staff and extension workers (judges, magistrates, prosecutors, administrator general, law enforcers, paralegals and legal aid providers) on handling of abuse cases involving HIV infected and affected children, youths and adults.
- UAC and AIDS Development Partners should support the relevant ministry, local government and community structures (particularly the Probation and Welfare, Police family and children's unit, community based services office, paralegals and community groupings of women, youth, PHA and PWD) to identify, document, support and refer victims of SGBV and AIDS-related abuses to suitable places for PEP and legal redress.

**Legal and Policy Environment**

- The UAC, MOGLSD and partners should develop policy guidelines on incorporating sexual and reproductive needs of young positives in the different psychosocial services.
The Ministry of Finance and Development Partners should appropriate funding to government and NGO structures to implement the OVC, SGBV, Cultural Institutions, and Gender Equality and HIV/AIDS activities.

The UAC and Ministry of Trade and Industry should revise the laws and policy provisions in the HIV/AIDS, Anti-Counterfeit, Industrial Property and other Bills that have the risk of undermining an effective HIV/AIDS response.

Ministries, CSOs and Local Governments should integrate the national social protection policies into programs of PLHIV, OVC and other vulnerable groups.

**Monitoring and Evaluation**

The UAC in collaboration with Self Coordinating Entities should institute and enforce the prescribed national HIV/AIDS monitoring and reporting formats and procedures for the public, civil society and local government sector.

Every relevant line ministry and local government department should mainstream sector-specific HIV/AIDS social support and protection indicators in their monitoring and evaluation systems, train relevant staff in basic M&E, provide essential M&E equipment, and share periodic reports with the district and national OVC MIS.

The UAC should facilitate the development of appropriate M&E indicators for the omitted strategic actions under social support and protection, and the harmonisation of reporting cycles for the OVC MIS in MOGLSD, MEEPP in USAID, and MISs of other AIDS organisations that follow different reporting cycles.

### 8.4 SYSTEMS STRENGTHENING

#### 8.4.1 Challenges to Strengthening Governance and Leadership of the Multi-Sectoral HIV/AIDS Response.

**Co-ordination of the Response at the Decentralised level.**

There is a high level of shared understanding that, after ten years of operation, the current HIV and AIDS Partnership structures need to be reviewed in terms of their effectiveness and relevance to the national response. The biggest challenge is at the decentralized response level where the vital response actions take place. UNASO has district ASO networks and persons living with HIV have district networks that help in coordinating their work. Similarly IRCU has established district interfaith networks in 39 Local governments. All these and more are not linked yet they do related work and as such pose a challenge to effective coordination, monitoring and evaluation.
Shift from a Stewardship of Tangible Assets to a Strategic Governance Mode

The current governance mode is predominantly focused on overseeing operations and use of resources. Our performance indicators revolve around tangible assets like the amount of money that has been disbursed or number of meetings that have been held. We need to shift into a “Strategic Governance” mode that focuses on monitoring performance against work plans, looking for evidence of outcomes and impact. This helps to build strategic relationships across the partnerships that focus on outcomes and impact rather than processes and outputs.

The Harmonisation of Legal Instruments

The resolution of the different schools of thought surrounding the National HIV Prevention and Control Bill - 2010 remains a challenge. The bill becomes even more pertinent after the East African HIV and AIDS Prevention and Management Bill that was recently passed by the East African Legislative Assembly. Additionally, the proposed amendments to the law establishing UAC have taken quite sometime and this creates a grey area where several partners remain ignorant of the pertinent role the Commission plays in coordinating the multi-sectoral response to HIV and AIDS.

The Emerging Governance Structures

The UAC institutional review proposed the establishment of eight Zonal Coordination Units. The MOH is in the process of establishing Regional Offices with Performance Monitoring Units based at the Regional Referral Hospitals. The MoLG is developing a proposal for Regional Governments. The Ministry of Gender, Labour and Social Development works through Technical Support organizations (TSOs) to provide technical guidance to OVC programmes in various districts. All these and the many other existing structures have to be taken into consideration in the process of streamlining the governance and leadership structures.

8.4.2 Recommendations on Strengthening Governance and Leadership

- The review of the partnership structures should be accorded high priority in terms of the timeframe and dissemination of the results and should pay particular attention to the decentralized level response
- The UAC should proactively build capacity for strategic governance and leadership at the various levels of the response
- The proposed governance structures of MOH, MoLG, UAC and other stakeholders should exhibit functional linkages that ease the streamlining of the HIV and AIDS governance process
The functionality of the various coordination committees needs to be objectively measured using simple standardized tools
UAC and partners should provide funding for the operations of decentralized coordination structures
A District HIV/AIDS League Table should be put in place and institutionalized to assess the individual decentralized responses on an annual basis

8.4.3 Challenges To ensuring Availability of and Access to Resources for Delivery of Quality HIV/AIDS Services

Insufficient Human Resources at Facility and Community Levels

The human resources providing HIV/AIDS services at health facility level remain grossly insufficient in both quantity and quality. There is need to also address the quantity and quality of community based service providers that largely fall under the Civil Society docket. We need to identify all the other human resource capacities that are vital for the HIV/AIDS response and pay due attention to them. For example we need to develop the communication skills of community based service providers to deliver the appropriately packaged messaging for effective Sexual Prevention of HIV.

Streamlining Programme Planning and HIV Resource Management.

The different partners in the inter-sectoral national HIV/AIDS response tend to plan individually. It is not clear as who is doing what and whether they are best positioned to do what they are doing. The total available resource envelope for HIV/AIDS activities is not known until we do a NASA.

We need to coordinate our investment and implementation in proven and scalable interventions, with emphasis on value for money and a focus on the cost efficiency of our operations. Are the resources being spent on the priorities of the NSP? The table below, extracted from the NASA 2012 report, gives an illustrative example.

Table 4.4: NSP Resource Allocation Versus NASA 2012 Findings

<table>
<thead>
<tr>
<th>Thematic Area</th>
<th>FY 2008 / 2009</th>
<th>FY 2009 / 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NSP (Planned Allocation)</td>
<td>NASA (Estimated Expenditure)</td>
</tr>
<tr>
<td></td>
<td>NSP (Planned Allocation)</td>
<td>NASA (Estimated Expenditure)</td>
</tr>
<tr>
<td>Prevention</td>
<td>30 %</td>
<td>19 %</td>
</tr>
<tr>
<td>Care and Treatment</td>
<td>38 %</td>
<td>51 %</td>
</tr>
<tr>
<td>Social Support</td>
<td>23 %</td>
<td>0 %</td>
</tr>
<tr>
<td>Support and Protection</td>
<td>25 %</td>
<td>0 %</td>
</tr>
</tbody>
</table>
The proportionate resource expenditure on the prevention, Care and Treatment as well as the Social Support and Protection thematic areas for the period 2008 up to 2010 are grossly different from the NSP allocations.

Alignment of Donor Resources

Donors continue to provide the bulk of the resource inputs for the HIV/AIDS response. These resources need to be invested wisely and therefore the GOU needs to take the lead in deciding how they are utilized to maximally benefit the response.

Strengthening the GOU Contribution to the HIV/AIDS Resource Envelope.

The NASA findings clearly indicate that domestic (GOU) contributions to the HIV/AIDS resource envelope continue to fluctuate between 10 and 13%. As long as external sources of funding contribute the majority shareholdings in the HIV/AIDS investment framework, maximization of investment impact and sustainability of the national response will remain difficult to achieve.

8.4.4 Recommendations on Availability of and Access to Resources for Delivery of Quality HIV/AIDS Services

- Staffing levels of health facilities be improved through continuous recruitment and retention of health workers by district local governments.

- The quantity and quality of community based service providers that largely fall under the Civil Society docket be improved. For example there is need to develop the communication skills of community based service providers to deliver the appropriately packaged messaging for effective Sexual Prevention of HIV.

- The indicator on tracking availability or stock outs of drugs, laboratory reagents and other commodities should, in the meantime, be disaggregated into three separate components with a tracer item for each of the components until such a time when DHIS 2 can provide the composite indicator data.

- Expedite the establishment of the proposed HIV and AIDS trust Fund.

- Align CSF and other HIV/AIDS funding to NSP priorities.

- Develop a national Resources Mobilization Strategy.

- Institutionalize resource tracking mechanisms such as NASA.

- Improve efficiency of HIV/AIDS spending by focusing HIV/AIDS spending to those interventions that have big impact on reducing the number of new infections and improving the quality of life and support.

8.4.5 Challenges to Establishing a Coordinated and Effective National System for Management of Strategic Information for the HIV/AIDS Response
Creating an Enabling Environment for the “Third One” of the “Three Ones”.

Development of the National HIV and AIDS Monitoring and Evaluation Plan is one step in the right direction. This needs to be followed up by:

- Coordinating the M&E activities of the different partners
- Overseeing the assessments of the M&E systems of the various partners
- Ensuring clear channels of strategic information flow from the sub-national to the national levels, across different national level actors, and into the national information system
- Harmonising M&E capacity building efforts

Establishing a Functional Database at the UAC

We need to break the cycle of failure to operationalize the national M&E systems. All other factors aside, the biggest impediment to developing a functional database at the UAC level has been the lack of a properly structured set of “System Specification Requirements”. If due attention is not paid to this important step, the final product of the on-going services procurement for the development of the national database may face serious challenges.

Improving Advocacy for and De-mystifying M&E

The M&E function remains an underfunded priority area that is associated with number crunching. We need to break the myth and mystery surrounding the M&E function and help all stakeholders to appreciate the place of M&E in the programming cycle.

Building M&E Capacity at all Levels

The functionality of the national HIV/AIDS M&E system largely depends on the aggregate function of the different stakeholder M&E capacities. There are generally accepted M&E system attributes that cut across the board, namely:

- Inadequate human resources both in numbers and skills
- Multiple reporting arrangements that impede performance of the M&E systems in terms of timeliness and completeness of data.
- Lack of strategic and operational M&E plans

These inadequacies in the various M&E systems adversely affect the aggregate functionality of the national HIV and AIDS Monitoring and Evaluation system.

8.4.6  Recommendations on Strategic Information Management
UAC should assist the various MDAs and districts to assess the strengths and weaknesses of their HIV/AIDS M&E systems so as to develop action plans to strengthen them. Special attention should be paid to the Ministry of Health, as the biggest contributor to the national M&E system data requirements.

The M&E teams should be proactive in advocating for M&E through providing M&E by-products that are appealing, friendly and valuable to the whole stakeholder team.

The M&E sub-committee should be involved in monitoring the progress of the consultancy services for the development of the national HIV/AIDS database at the UAC.
### PROGRESS ON IMPLEMENTATION OF 2011 JOINT AIDS REVIEW UNDERTAKINGS

<table>
<thead>
<tr>
<th>JAR 2011 Undertaking</th>
<th>Progress</th>
<th>Comment</th>
</tr>
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<tbody>
<tr>
<td>Develop a revised National Strategic Plan for HIV/AIDS (2011/12-2014/15) that is aligned to the National Development Plan (2010/11-2014/15)</td>
<td>Revised NSP developed through a consultative and participatory process with HIV stakeholders. Final approved revised NSP was officially launched by the H. E. The Vice President on World AIDS Day of 1st December 2011.</td>
<td>The only constituency that is remaining to be reached is Parliament. Awaiting the Speaker of Parliament to confirm the date when the dissemination can be held.</td>
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<tr>
<td></td>
<td>Revised NSP was disseminated to key stakeholders at national and district levels.</td>
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<tr>
<td></td>
<td>- District level – Political, administrative and technical leadership from all Higher Local Governments (111) and Municipal Councils (22)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- National level – Heads and technical officers from all MDAs, National level NGOs and CSOs, big Private sector organizations and heads of religious institutions from all the denominations and from all districts.</td>
<td></td>
</tr>
<tr>
<td>Develop and implement an operational framework for disseminating and delivering the National Prevention Strategy (NPS) defining roles and responsibilities of the various stakeholders.</td>
<td></td>
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<tr>
<td>Finalise and achieve endorsement as well as buy-in of the strategy for domestic resource mobilization for financing HIV/AIDS (establishing HIV/AIDS Trust Fund)</td>
<td>Working Paper on “Creating a National AIDS Trust Fund for Sustainable Domestic Financing for HIV/AIDS in Uganda” was prepared. Paper was discussed and agreed by UAC Board. Paper has been submitted to MoFPED for review and comments to initiate discussions and dialogue.</td>
<td>UAC management has initiated the process of engaging key stakeholders to discuss the strategy.</td>
</tr>
<tr>
<td>Develop a National Priority Action Plan highlighting the priority HIV/AIDS interventions and cost for the first 2 years</td>
<td>National Priority Action Plan (2011/12-13) for operationalizing the NSP was developed, costed and used in preparation of annual work-plans for different sectors.</td>
<td>NPAP was used in preparation of annual work-plans for different sectors.</td>
</tr>
<tr>
<td>Activity</td>
<td>Status</td>
<td>Challenges</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>years to facilitate resources mobilization and tracking</td>
<td>disseminated along with the NSP to all key stakeholders at national and local government levels.</td>
<td>stakeholders for FY 2011/12</td>
</tr>
<tr>
<td>Finalise National AIDS Spending Assessment (NASA) and disseminate findings</td>
<td>NASA 2012 was finalized. Final report prepared, discussed and endorsed by stakeholders. Report findings have been discussed with key national level stakeholders.</td>
<td>Dissemination pending finalization and printing of the NASA report.</td>
</tr>
<tr>
<td>Establish a national data base for the national HIV/AIDS response at UAC in which sectors can report into/send agreed national level sector specific indicators on an agreed time frame</td>
<td>Procurement for services of a consultant to undertake the development of the database in progress</td>
<td>Long and rigid procurement system has delayed the recruitment of consultants to develop the database.</td>
</tr>
<tr>
<td>Prepare and sign MoU at all levels, district and National level detailing the roles of partners.</td>
<td>Memoranda of Understanding between UAC and Self Coordinating Entities were signed for implementation of the 2012/13 Integrated Annual Work-plan.</td>
<td>Arrangements for preparation and signing of MoUs between UAC ad districts are being worked out.</td>
</tr>
<tr>
<td>Scale up safe male circumcision to cover over 1,250,000 males (14-49 years) in 2011/12</td>
<td>Approximately only 380,000 males (14-49 years) were circumcised during the year (as by March 2012)</td>
<td>Under reporting due to delayed and incomplete reporting from Implementing Partners (weak M&amp;E system).</td>
</tr>
<tr>
<td>Counsel and test 2.5 million adults (15 – 49 years) for HIV in 2011/12</td>
<td>5.5 million adults (15-49 years) were counseled and tested for HIV and received results in the</td>
<td>Targets was apparently set very low.</td>
</tr>
<tr>
<td>Enroll 21,628 HIV positive pregnant women on antiretroviral drugs to reduce the risk of mother-to-child transmission of HIV in 2011/12</td>
<td>Total number of HIV positive pregnant women who received ARVs in FY 2011/12 was 34,533 (out of 40,208 HIV positive pregnant women identified during the year) - MEEP</td>
<td>Under reporting due to delayed and incomplete reporting from Implementing Partners (weak M&amp;E system).</td>
</tr>
<tr>
<td>Enroll 100,000 new adults and 20,000 children (total 120,000) on ART in 2011/12</td>
<td>A total of 65,493 new adults and children were enrolled on ART by March 2012. New adults were 61,524 and new children were 3,966. Total number (adults and children) on ART in 2011/12 was 356,056 (62% of eligible) by March 2012. No. of adults was 327,946 and children was 28,107.</td>
<td>Under reporting due to delayed and incomplete reporting from Implementing Partners (weak M&amp;E system).</td>
</tr>
</tbody>
</table>
ANNEX 1: List of Resource Documents Reviewed.

1. National Strategic Plan for HIV/AIDS 2011/12 - 2014/15
5. The 2011 UDHS Preliminary Results: An Overview of the Health Situation in Uganda
8. MEEEP Report SAPR 2012
10. MOH –HMIS REPORT
11. National OVC-MIS Report from MLGSD
12. HIV Care for the uniformed forces
13. Palliative care report - presented by PCAU
14. Report from the 4 sample districts
15. FBOs (UCMB, UPMB, IMAU, IRCU)
16. Federation OF Uganda Employers Report
17. Reports from UNASO, NAFOPHANU,
18. Report from major insurance players in health (IAA, AAR, UGAMED
19. NTLP draft Strategic Plan 2011/12- 2014/15
20. MOH Stock Status Reports
21. Reports from GOU sectors and private sector
31. MOH EID Assessment Report
32. HIV drug resistance reports
33. HPTN052
34. PreP trial
35. Quality of Care (QoC) 2011 baseline report
36. Highlights Of The Uganda National Quality Improvement Conference Held At Hotel Africana: 27TH TO 29TH FEBRUARY, 2012
37. Africa Regional Consultative Workshop For Health Improvement: Catalyzing And Institutionalizing Quality Improvement 17TH – 21ST October 2011, Kampala – Uganda
39. Wanyenze et al VCT study 2004
40. PACE program report
41. NTLP MDR Report
42. Brief On HIV/ Aids Care & Treatment For Fishing Communities in Kalangala District - October 2012
43. Olweny Denis et al: Improving access to PMTCT and EID services for HIV infected pregnant women attending ANC services. (2012 Annual Paediatric HIV/AIDS Conference)
47. PROTECTING FAMILIES AGAINST HIV/AIDS (PREFA) program report to UAC October 2012