# The Revised National Strategic Framework for HIV/AIDS Activities in Uganda: 2003/04 – 2005/06

February, 2004

# PREFACE

Uganda has registered modest achievements in fighting the HIV/AIDS epidemic. This has been largely attributed to concerted efforts right from community levels, enhanced by support from development partners and political guidance and commitment spearheaded by the President.

While acknowledging the success, we must recognize the challenges ahead. There are glaring gaps in service coverage for both HIV/AIDS prevention and care. Prevalence rates are still high hence there should be no room for complacency in fighting the epidemic. The intricate relationship between HIV/AIDS and poverty pauses serious chalenges to development efforts at household, community and national levels.

This revised National Strategic Framework (NSF) for HIV/AIDS Activities 2003/4-2005/6 has been developed with stakeholder inputs basing on an agreed status of the national response from the Mid-Term Review (MTR) of the NSF2000/1-2005/6.

I wish to take this opportunity to call upon all Ugandans, within their mandates and capacities, to buy into the NSF, develop and implement programs to contribute towards our common target of delivering equitable, timely and quality HIV/AIDS services to the nation. Development of partnerships at all levels is encouraged to promote delivery of integrated services and ensure a coordinated national response.

Together we share the challenge

Rt. Rev. Barnabas R Halem' Imana
Bishop Emeritus of Kabale
Chairman, Uganda AIDS Commission

# FOREWORD

Over two decades have passed since the HIV/AIDS epidemic was first recognized in Uganda with its adverse effects on individuals, families and communities. In order to guide a coordinated national response to the epidemic, the Uganda AIDS Commission and Partners developed *The National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/01-2005/06*.

Progress has been achieved in implementation of the three goals of the National Strategic Framework (NSF), but at the same time there have been new developments in the fight against HIV/AIDS that were not anticipated when the NSF was formulated in 2000/01. A mid-term review of the NSF was conducted to review progress and to identify gaps and emerging issues. This review provided a basis for revision of the NSF—hence this *Revised National Strategic Framework for HIV/AIDS Activities in Uganda: 2003/04-2005/06*.

The revised NSF provides a reference point for priorities for all stakeholders involved in the national response to HIV/AIDS. The revised NSF contains three goals, namely; (i) to reduce HIV prevalence by 25%, (ii) to mitigate the effects of HIV/AIDS, and (iii) to strengthen the national capacity to respond to the epidemic. Each of these goals will be realized through stakeholders' specific HIV/AIDS plans which are based on the aggregated strategies and activities presented in this Framework.

For enhanced coordination of the national response, the revised NSF incorporates a Declaration of Commitment, to be endorsed by all stakeholders as a commitment to fully develop a shared programme framework to implement the revised NSF. A national Monitoring and Evaluation (M&E) Framework has been developed to measure and evaluate progress on the NSF.

It is my sincere hope that all stakeholders will utilize this revised NSF as a critical component of the **"three ones"** concept, namely one national coordinating authority, one national strategic framework for action and one national monitoring and evaluation framework to track the national response, as we continue the fight against HIV/AIDS.

**Dr. David Kihumuro Apuuli**
**DIRECTOR GENERAL,**
**UGANDA AIDS COMMISSION**

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Thanks also go to the Lead Consultants, Narathius Asingwire and Sallie Craig Huber, who directed the Mid Term Review. Romano Adupa, William Bazeyo, Moses Kamya, Joseph Konde-Lule, Brenda Kifuko Malinga and Swizen Kyomuhendo are particularly thanked as theme specific consultants for the MTR process. Further thanks are extended to Narathius Asingwire as Lead Consultant for the revision, and redrafting process of the revised NSF and Sallie Huber for editorial work on the revised NSF.

The input from all members of the six Technical Working Groups, the key informants, and Partnership participants in the launch and consensus workshops for the Mid Term Review of the NSF is also acknowledged with appreciation.

Further thanks are due to all participants in the revision retreat at which the findings of the Mid Term Review were converted into the revised NSF. The names and titles of these individuals are appended to this document as Annex 3.

# LIST OF ACRONYMS

| | | |
|---|---|---|
| ACP | : | AIDS Control Programme |
| AIC | : | AIDS Information Centre |
| AIDS | : | Acquired Immunodeficiency Syndrome |
| ANC | : | Antenatal Clinic |
| ART | : | Anti-Retroviral Therapy |
| ARV | : | Anti-retroviral |
| CBO | : | Community -Based Organisation |
| CDC | : | Centres for Disease Control and Prevention, Atlanta |
| CRIS | : | Country Response Information System |
| CSO | : | Civil Society Organisation |
| CSW | : | Commercial Sex Worker |
| DAC | : | District AIDS Committee |
| DCI | : | Development Cooperation of Ireland |
| DHAC | : | District HIV/AIDS Committee |
| DFID | : | Department for International Development, UK |
| DHT | : | District Health Team |
| EAC | : | East African Co-operation/Community |
| FBO | : | Faith-Based Organization |
| FPP/O | : | Focal Point Person/Officer |
| GDP | : | Gross Domestic Product |
| GFATM | : | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GIPA | : | Greater Involvement of Persons with AIDS |
| GLIA | : | Great Lakes Initiative on AIDS |
| HBC | : | Home-Based Care |
| HCW | : | Health Care Worker |
| HIV | : | Human Immunodeficiency Virus |
| HRM | : | Human Resource Management |
| IDP | : | Internally Displaced Person |
| IEC | : | Information, Education and Communication |
| IGP | : | Income Generating Project |
| IRB | : | Institutional Review Board |
| KABP | : | Knowledge, Attitudes, Beliefs and Practices |
| LC | : | Local Council |
| MACA | : | Multi-Sectoral Approach to the Control of AIDS |
| MAP | : | Multi-country AIDS Programme in Africa (World Bank) |
| MCH | : | Maternal and Child Health |
| M&E | : | Monitoring and Evaluation |
| MIS | : | Management Information System |
| MoAAIF | : | Ministry of Agriculture, Animal Industry and Fisheries |
| MoES | : | Ministry of Education and Sports |
| MoFPED | : | Ministry of Finance, Planning and Economic Development |
| MoGLSD | : | Ministry of Gender, Labour and Social Development |
| MoH | : | Ministry of Health |
| MoIA | : | Ministry of Internal Affairs |
| MoJCA | : | Ministry of Justice and Constitutional Affairs |
| MoLG | : | Ministry of Local Government |
| MoPS | : | Ministry of Public Service |
| MTCT | : | Mother-to-Child Transmission |
| MTEF | : | Mid-term Expenditure Framework |
| NADIC | : | National AIDS Documentation and Information Centre |

| | | |
|---|---|---|
| NGO | : | Non-Governmental Organisation |
| NOPA | : | National Overarching Policy on AIDS |
| NSF | : | National Strategic Framework |
| OI | : | Opportunistic Infection |
| OoP | : | Office of the President |
| OoPM | : | Office of the Prime Minister |
| OVC | : | Orphans and Other Vulnerable Children |
| PEAP | : | Poverty Eradication Action Plan |
| PEPFAR | : | USA President's Emergency Plan for AIDS Relief |
| PHA | : | People Living with HIV/AIDS |
| PHC | : | Primary Health Care |
| PIASCY | : | Presidential Initiative on HIV/AIDS Strategy for Communicating to the Youth |
| PMTCT | : | Prevention of Mother-to-Child-Transmission |
| PNFP | : | Private Not-for-Profit |
| SCE | : | Self-Coordinating Entity |
| STD | : | Sexually Transmitted Disease |
| STI | : | Sexually Transmitted Infection |
| SWAA | : | Society of Women against AIDS in Africa |
| SWG | : | Sector Working Group |
| TB | : | Tuberculosis |
| TOR | : | Terms of Reference |
| TWG | : | Technical Working Group |
| UAC | : | Uganda AIDS Commission |
| UACP | : | Uganda AIDS Control Project |
| UBOS | : | Uganda Bureau of Statistics |
| UBTS | : | Uganda Blood Transfusion Service |
| UDHS | : | Uganda Demographic and Health Survey |
| UNAIDS | : | Joint United Nations Programme on AIDS |
| UNCST | : | Uganda National Council for Science and Technology |
| UNDP | : | United Nations Development Programme |
| UNGASS | : | United Nations General Assembly Special Session |
| UNFPA | : | United Nations Population Fund |
| UNICEF | : | United Nations Children Fund |
| USAID | : | United States Agency for International Development |
| UVRI | : | Uganda Virus Research Institute |
| VCT | : | Voluntary Counselling and Testing |
| WB MAP | : | World Bank Multi-country Project |
| WAC | : | World AIDS Campaign |
| WAD | : | World AIDS Day |
| WHO | : | World Health Organisation |

# TABLE OF CONTENTS

PREFACE ---------- ii
FOREWORD ---------- iii
ACKNOWLEDGEMENTS---------- iv
LIST OF ACRONYMS ---------- v
TABLE OF CONTENTS ---------- vii
GLOSSARY ---------- ix
EXECUTIVE SUMMARY ---------- xi
1.0 INTRODUCTION---------- 1
1.1 Introduction----------1
1.2 The Review and Revision Process ----------1
1.2.1 The Mid-Term Review ----------1
1.2.2 The NSF Revision Process ----------1
1.3 The Purpose and Goals of the Revised NSF ----------2
1.3.1 The Purpose ----------2
1.3.2 Goals for 2003/04-2005/6 ----------2
2.0 BACKGROUND----------4
2.1 Introduction----------4
2.2 Context of NSF ----------4
2.3 Government Policy on HIV/AIDS and Planning----------5
2.3.1 Government policies ----------5
2.3.2 National Planning Frameworks----------5
2.3.2.1 `Vision 2025` ----------5
2.3.2.2. The Poverty Eradication Action Plan ----------5
2.3.2.3 The National Health Policy ----------6
2.3.2.4 Local Governments Act----------6
2.3.2.5 The Plan for Modernisation of Agriculture (PMA 2000) ----------6
2.3.2.6 Universal Primary Education ----------7
2.4 HIV/AIDS Status and Impact----------7
2.4.1 Mode of Transmission----------7
2.4.2 Prevalence and Incidence----------7
2.4.3 Impact of HIV/AIDS on Children----------10
2.4.4 Impact of HIV/AIDS on Young People ----------11
2.4.5 Gender Differences----------11
2.4.6 HIV/AIDS, Culture and Society----------12
2.4.6.2 HIV/AIDS and the Family ----------13
2.4.6.3 HIV/AIDS and the Community----------13
2.4.7 HIV/AIDS, Migration and Displacement ----------14
2.4.8 HIV/AIDS and the Health Sector ----------14
2.4.8.1 Resource Constraints ----------14
2.4.8.3 Treatment with Herbal Medicine ----------15
2.4.8.4 Anti-Retroviral Therapy (ART)----------15
2.4.9 HIV/AIDS, the Labour Force and the Workplace ----------16
3.0 REVIEW OF PROGRESS----------17
3.1 Introduction----------17
3.2 Prevention and Behaviour Change----------17
3.3 Care and Treatment ----------18
3.4 Psychosocial Support, Protection and Human Rights ----------20

3.5 Coordination and Institutional Arrangements ---------- 21
3.6 Monitoring and Evaluation ---------- 24
3.7 Planning, Resource Mobilization, and Resource Management ---------- 26
4.0 REVISED GOALS AND IMPLEMENTATION MODALITIES OF THE NSF, 2003/04 – 2005/06 ---------- 29
4.1 Introduction ---------- 29
4.2 Goals and Objectives for 2003/4 - 2005/6 ---------- 29
4.3 Implementation Modalities ---------- 30
4.3.1 The National M&E Framework ---------- 30
4.3.2 Responsible Government Sector ---------- 30
4.3.3 Shared Programme Framework ---------- 31
5.0 THE LOGICAL FRAMEWORK ---------- 32
BIBLIOGRAPHY ---------- 54
ANNEX 1: NATIONAL LEVEL INDICATORS FOR HIV/AIDS RESPONSE IN UGANDA ---------- 57
ANNEX 2: CONTRIBUTORS TO REVIEW AND REVISION OF THE NSF 2003/04-2005/06 ---------- 61

# GLOSSARY

The definitions apply to the concept in which the relevant terms are applied in this document.

**Advocacy—**Organized efforts to influence policy, leadership and opinion at various levels of action in the national response.

**AIDS Competence—**The ability of all elements of society (individual, families, communities, business, government, and non-governmental institutions of all sectors at all levels) to recognize the reality of HIV/AIDS, to analyze how it affects life at home and at work, and to take action to prevent its spread, maintain and improve the quality of life of PHAs, families affected by AIDS, and the community at large.

**Comprehensive Care and Treatment—**A holistic approach to care for PHAs that involves clinical management, nursing care, palliative care and psychosocial support.

**Co-ordination—**A process of facilitation, communication, sharing, planning and monitoring of resources, risks and rewards for purposes of efficiency and effectiveness in scaling up all efforts in response to the HIV/AIDS epidemic. Coordination does not mean control. The goal of coordination is timely delivery of equitable and quality services.

**Health Worker—**Any provider of health-related services, regardless of level of training or location of work.

**Home-Based Care—**Any form of care given to sick people in their homes, which includes physical, psychosocial, palliative and spiritual activities.

**Mainstreaming—**Adapting a ministry or an organization's core business to cope with the realities of HIV/AIDS. The key principles of mainstreaming include: (i) understanding/being aware of the impact that the issue is having on development, (ii) identifying focussed entry points, (iii) working within existing structures and strategies, (iv) working to your comparative advantage, (v) identifying and working through strategic partnerships, and (vi) understanding the impact of HIV/AIDS on the ministry or organization.

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

**Palliative Care—**An approach that improves the quality of life of patients and their families in facing the problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other physical, psychosocial and spiritual challenges.

**Private Not-for-Profit Sector—**All non-government, including not-for-profit, institutions, such as faith-based organizations, civil society organizations and non-governmental organizations.

**Psychosocial Support—**The support meant to address challenges of isolation, depression, anxiety, other psychiatric impairment and serious interpersonal problems as a result of HIV/AIDS. The purpose of psychosocial support is to ensure that quality of life and motivation to live are effectively optimised. Psychosocial support is understood to include spiritual support.

**Responsible Government Sector—**The body charged with providing policy guidance and ensuring that the resources mobilized and committed for implementation of each activity under its purview are appropriately used to achieve the stated goals and objectives.

**Safe Sexual Behaviour-** A practice that protects an individual from acquiring HIV and other sexually transmitted infections. These practices include abstinence both primary and secondary, faithfulness and protected sexual intercourse.

**Sexually Active**—A description of individuals who engage in sexual intercourse, regardless of age.

**Three by five ("3 by 5")-**The WHO and UNAIDS Global Initiative to provide Antiretroviral Therapy to 3 million people with HIV/AIDS by the end of 2005.

# EXECUTIVE SUMMARY

The National Strategic Framework (NSF) for HIV/AIDS Activities in Uganda was developed to cover the period 2000/01-2005/05. Late in 2003, a forward looking Mid Term Review (MTR) of the NSF was undertaken to assess progress and to identify gaps and emerging issues in implementation of the NSF. This culminated into the revision of the NSF for the period 2003/04-2005/06. This Revised National Strategic Framework for HIV/AIDS Activities in Uganda: 2003/04-2005/06 is the resulting product.

The three goals in this revised NSF remain the same:

- To reduce HIV prevalence by 25%
- To mitigate the effects of HIV/AIDS, and
- To strengthen the national capacity to coordinate and manage the multisectoral response to the epidemic.

In keeping with the findings of the review, three sub-goals have been added to further refine Goal 2. These are:

- Mitigation of the health effects and improving the quality of life of PHAs
- Mitigation of the psychosocial and economic effects
- Mitigation of the impact of HIV/AIDS on the development of Uganda

Each goal and sub-goal is further defined by its related objectives, outcomes, strategies and broad activities. Stakeholders will draw from the aggregated activities and strategies in planning and implementing their approaches to the national response.

The revised NSF takes into account the different environment in terms of changes in the epidemic; changes brought about by wider availability of prevention, care and treatment initiatives including integration of services; new and revised government policies and planning frameworks; and an expanded funding base. A review of the current status and impact of the epidemic in Uganda is presented to document the current situation in which these revisions to the NSF are proposed.

Findings of the Mid Term Review (MTR) are summarized in this document under the headings of progress, constraints/gaps, emerging issues and the way forward for the six thematic areas assessed during that review. These six areas are

- Prevention and behaviour change
- care and treatment
- psychosocial support, protection and human rights

- coordination and institutional arrangements
- monitoring and evaluation, and
- planning, resource mobilization and resource management.

The logical framework of this revised NSF is based on the findings of MTR. Responsible Government Sector(s) are identified in the logical framework denoting which bodies will provide coordination and policy guidance, and ensure that resources mobilized for implementation of each proposed activity are appropriately used to achieve the stated goals and objectives of this Framework.

Implementation of the revised NSF will be strengthened by several tools and instruments. One such instrument will be an official declaration of commitment endorsed by the Uganda HIV/AIDS Partnership, to consolidate the partners in the multisectoral response to jointly embark on complying with the overall framework of the revised NSF Another related to tool is the National Monitoring and Evaluation (M&E) Framework which spells out modalities for harmonised data collection and reporting formats which will be used to measure and evaluate progress of the NSF. National level indicators with their benchmarks and targets are included in this revised NSF.

Finally, during the period of this revised NSF, UAC will undertake an effort with all stakeholders to develop and introduce a shared programme framework to ensure better coordination and harmonisation of the overall national HIV/AIDS programme.

# 1.0 INTRODUCTION

## 1.1 Introduction

The National Strategic Framework for HIV/AIDS Activities in Uganda (NSF) covers the period 2000/01 to 2005/06. In October 2003, a Mid Term Review (MTR) of the NSF was commissioned by Uganda AIDS Commission (UAC) to review progress in the implementation of the Framework, identify gaps and emerging issues, and, on this basis, revised NSF for the remaining period. This Chapter presents the process used for the MTR and revision of the NSF and the purpose and goals of the revised NSF.

## 1.2 The Review and Revision Process

### 1.2.1 The Mid-Term Review

The MTR was largely conducted by six thematic Technical Working Groups (TWG) led by six locally-recruited thematic consultants. The process, overseen by two lead consultants—one external and one local, was guided by the M&E Sub-committee of the Uganda HIV/AIDS Partnership Committee, and was highly participatory including extensive input by all stakeholders and sectors involved with the national response.

A two-day Workshop was held in mid-October 2003 to start off the MTR. After this Launch, data collection and synthesis were undertaken through the review of documents, identification and interviews with key informants in each thematic area. Regular TWG meetings were held to review findings. The review process concluded with a Workshop/Partnership Forum held on 8-9 December 2003 to review the draft MTR. This gathering allowed for further data collection and consensus building and was followed by finalization of the MTR report by the lead consultants. The full MTR document is available from UAC.

### 1.2.2 The NSF Revision Process

The gaps and emerging issues identified through the MTR were the primary focus of the process to update the NSF in order to match the national response with the new realities of the HIV/AIDS epidemic in Uganda.

The revision of the NSF was divided into 3 sub-phases: (i) a synthesis of the main text of the NSF document, (ii) preparing the Logical Framework in a retreat setting, and (iii) sharing of the draft with partners/stakeholders for input before finalization.

## 1.3 The Purpose and Goals of the Revised NSF

### 1.3.1 The Purpose

The purpose of the Revised National Strategic Framework for HIV/AIDS Activities in Uganda for the period 2003/04-2005/06 is to:

- Provide a platform around which all donors and stakeholders will fund and implement HIV/AIDS activities in a co-ordinated and harmonized manner.
- Relate the fight against HIV/AIDS to the development goals and action plans particularly `Vision 2025` and the Poverty Eradication Action Plan (PEAP) 2004;
- Bring to the fore the coordinated involvement of all stakeholders in the planning, management, implementation, monitoring and evaluation of HIV/AIDS interventions over the remaining period of the NSF (2003/04 - 2005/6);
- Establish a base against which the progress and impact of HIV/AIDS interventions will be measured, with a view to taking appropriate action for the subsequent plans;
- Serve as a resource mobilisation tool that provides a basis for costing and seeking support for HIV/AIDS interventions in Uganda.
- Strengthen, expand and sustain systems to generate and manage strategic information for effective and efficient implementation of the current NSF and planning for the next NSF.

### 1.3.2 Goals for 2003/04-2005/6

The principal goals of the revised NSF for the period 2003/04 to 2005/06 are aimed at contributing to the realization of the Poverty Eradication Action Plan (PEAP).

Goal 2 from the original NSF has been subdivided into three sub-goals, based upon the findings and recommendations of the MTR. The other two goals remain unchanged.

**Goal 1:** To **r**educe HIV **p**revalence by 25%

**Goal 2:** To mitigate the effects of HIV/AIDS

**Goal 2 (a):** To mitigate the health effects of HIV/AIDS and improve the quality of life of PHAs

**Goal 2 (b):** To mitigate the psychosocial and economic effects of HIV/AIDS

**Goal 2 (c):** To mitigate the impact of HIV/AIDS on the development of Uganda

**Goal 3:** To strengthen the national capacity to coordinate and manage the multisectoral response to HIV/AIDS

# 2.0 BACKGROUND

## 2.1 Introduction

A structured Government response to the HIV/AIDS epidemic dates back to 1986 when an AIDS Control Programme (ACP) was created in the Ministry of Health. In recognition of the fact that HIV/AIDS has causes and consequences far beyond the health sector, the UAC was constituted in 1992 by Statute of Parliament and placed under the Office of the President (OoP). By 1993, UAC had prepared a Strategy document called the Multi-sectoral Approach to the Control of AIDS (MACA), and a National Operational Plan by 1994, which provided guidance to implementers and other stakeholders up to 1998. All this effort has resulted in remarkable progress in fighting the HIV/AIDS epidemic.

Uganda's progress in this regard can be inferred from the decline in the prevalence and incidence (STD/ACP-MoH, 2003) of HIV/AIDS and the extent to which the country is responding to the socio -economic and health impact created by the epidemic. Therefore the purpose of this Chapter is to summarize the current situation with regard to HIV/AIDS in Uganda.

## 2.2 Context of NSF

Since 2000, when the current NSF was formulated, the Ugandan context for the national response has changed significantly. Several issues have emerged, characterised by a paradigm shift from focusing primarily on prevention to paying equal attention to care and treatment. New interventions including ART, home-based care, palliative care and psychosocial support have attracted increased support. This support is reflected in new and increased funding sources including the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM, the World Bank, Multi-country AIDS programme for Africa (MAP), The Great Lakes Initiative on AIDS (GLIA), the USA President's Emergency Plan for AIDS relief (PEPFAR), UN agencies, Bi-lateral and Government of Uganda inputs.

New and increased funding notwithstanding, the Ugandan population has continued to grow exponentially at a rate of 3.5% outmatching economic growth and development. Although the economy has been growing at a rate of 5-7% per annum, there is widening disparity in incomes attributed largely to the civil strife in foe example in the North and North East of the country.

## 2.3 Government Policy on HIV/AIDS and Planning

### 2.3.1 Government policies

The government policy on HIV/AIDS is characterized by openness and political commitment to combating HIV/AIDS, which has contributed to increased levels of awareness among the population about the dangers of the epidemic and possible means of prevention. This policy environment enabled formulation of key national policies. The National Overarching Policy on AIDS (NOPA) provides the overall policy and planning environment through which the NSF is delivered. Alongside the NOPA there are other policies including The National Orphans and other Vulnerable Children (OVC) Policy, National Condom Policy and Strategy, National Policy on HIV/AIDS and the World of Work, the Voluntary Counselling and Testing (VCT) Policy and the National Antiretroviral Therapy (ART) Policy for Uganda, which further refine and contribute to the NOPA.

### 2.3.2 National Planning Frameworks

Given the pervasive effect of HIV/AIDS on the social and economic life of the country and the impact of the epidemic on successful implementation of poverty eradication strategies, this framework is both subordinate to and complementary with key policies and development planning frameworks to fight poverty in Uganda. These include `Vision 2025`, PEAP, the National Health Policy, the Local Governments Act, the Plan for the Modernization of Agriculture, and Universal Primary Education.

#### *2.3.2.1 `Vision 2025`*

The long term vision for Uganda's development is reflected in `Vision 2025`, which was developed in 1999 and constitutes the country's national development plan. `Vision 2025` carries Uganda's broad and long-term development proposals over a period of twenty-five years. Its two-year formulation process ended in 1999 with a major focus on macro-economic development of the country as the gateway to economic development. The importance of `Vision 2025` is rooted in its status as a blueprint for all other planning frameworks in Uganda. Because its key focus is reflected in the main objectives of the PEAP, the latter serves as the main focal point for development planning in Uganda.

#### *2.3.2.2. The Poverty Eradication Action Plan*

The PEAP is the principal guide to all developmental activities of the central and local government in Uganda. PEAP sets out the commitment of the Government to reduce the incidence of absolute poverty to 10 percent and relative poverty to 30 percent of the total population by the year 2017. International donors use the

PEAP as the basis for their support to Uganda. The PEAP is currently undergoing revision for the next 5-year period and will be finalised by mid-2004.

The fact that HIV infection rates are still high poses a serious threat to what has been achieved already in reducing poverty and is an obstacle to the realisation of national goals. Within the context of PEAP, the fight against HIV/AIDS requires a multi-sectoral approach and has to be an integral part of the sectoral efforts aimed at poverty eradication and overall developmental activities in Uganda. PEAP mandates all sectors and areas of government to treat HIV/AIDS as a cross-cutting issue and to mainstream it within sector plans. There is need therefore in this revised NSF to mainstream HIV/AIDS in line with the five pillars of the proposed revised PEAP namely:

- Economic management
- Security, conflict-resolution and disaster management
- Governance
- Enhancing production, competitiveness and incomes, and
- Human resource development

#### *2.3.2.3 The National Health Policy*

The National Health Policy (1999) provides a major input for implementation of the NSF. The NSF is consistent with the National Health Policy and further articulates the interventions specifically related to HIV/AIDS. The NSF also integrates the health and bio-medical aspects of HIV/AIDS with other aspects of the epidemic's effects, including those affecting the non-infected.

#### *2.3.2.4 Local Governments Act*

The Local Governments Act (1997) regulates the decentralization and devolution of functions, powers and services. It provides for decentralization at all levels of local government to ensure good governance and democratic participation in and control of decision making by the people. As such, this Act provides the basis for district and lower level participation in the development and implementation of HIV/AIDS activities undertaken within this NSF and current coordination modalities are in line with this Act through the decentralized HIV/AIDS response.

#### *2.3.2.5 The Plan for Modernisation of Agriculture (PMA 2000)*

HIV/AIDS has great impact on the productive segments of the population. By reducing the labour force the epidemic affects not only the food security but also the economy more broadly. This has far reaching consequences given that Uganda's development largely depends on agro-economy. Therefore, it is imperative that the revised NSF addresses key elements in line with `PMA 2000',

which provides an environment for poverty eradication through multi-sectoral interventions that enable people to improve their livelihoods in a sustainable manner. The PMA is part of the Government of Uganda's broader strategy of implementation of the PEAP.

*2.3.2.6 Universal Primary Education*

UPE (1997) provides a framework for mitigation of the psychosocial effects of HIV/AIDS amongst orphans and other vulnerable children (OVC). Schools provide an environment conducive for channelling HIV/AIDS messages and life skills development to a wide segment of young people.

### 2.4 HIV/AIDS Status and Impact

## 2.4.1 Mode of Transmission

The first AIDS case in Uganda was diagnosed in 1982 in Rakai District and since then HIV/AIDS has spread to all parts of the country. Due to its primary mode of transmission, HIV affects mainly the sexually active population and sexual activity is the main defining risk factor for variation in the incidence and prevalence of the disease. Sexual and other routes of HIV transmission and the approximate contribution of each to the overall incidence of HIV/AIDS in Uganda include:

- Heterosexual contact with an infected partner accounts for 75-80 percent of new infections
- Infected mother-to-child transmission (MTCT), including breastfeeding accounts for 15-25 percent of cases
- Use of infected blood, blood products, and aseptic conditions in health facilities = less than 2-4 percent of HIV infection, and
- Sharing non-sterile sharp instruments with an HIV infected person accounts for less than 1 percent of infections.

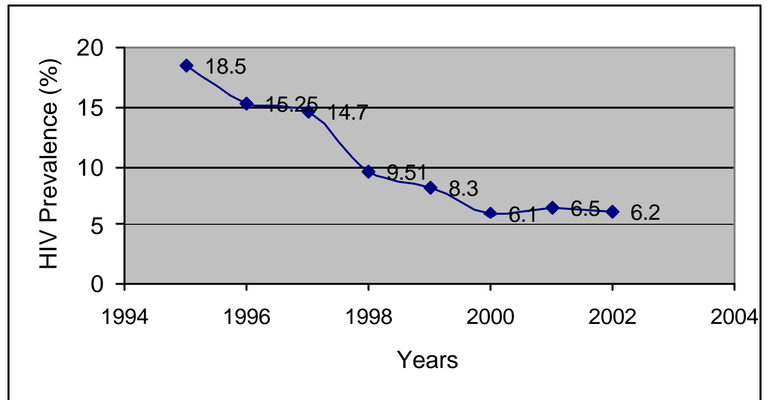
The extent of transmission of HIV through intravenous drug use and through male -to-male sexual transmission in Uganda is not known.

## 2.4.2 Prevalence and Incidence

The terms prevalence and incidence, respectively, refer to the total number of cases of a disease in a given population and the number of new cases over a specified time period. Incidence implies the rate at which healthy people are being infected while prevalence denotes the total cumulative disease burden on the population.

The cumulative number of AIDS reported cases as of 31st December 2002, was 60, 974 AIDS cases both children and adults. Of the 60,974 reported cases 56,451 (92.6%) were adults and 4,523 (7.4%) were children less than 12 years of age (STD/ACP-MoH, 2003).

**Figure 1: National Prevalence of HIV among antenatal Attendees in Uganda**




Source: MoH - STD/ACP Surveillance Report June 2003

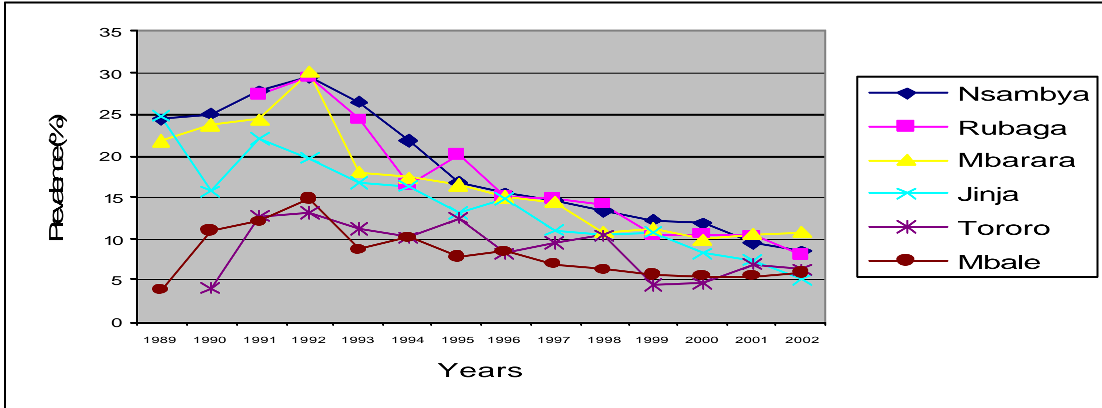
Available data suggest that the prevalence of HIV in Uganda has declined significantly since 1995 (see Figure 1). The HIV prevalence rates in 2002 ranged from a minimum of 0.7 percent in Matany Hospital in Moroto District to a maximum of 11.9 percent in Lacor Hospital in Gulu District with an overall prevalence of 6.2 percent (MoH, STD/ACP, 2003).

Data from sentinel sites since 1989 indicate that the decline in prevalence is particularly pronounced among pregnant urban women aged 15-19, followed by women aged 20-24. In one Kampala site, the HIV prevalence rate dropped from 29.4 percent in 1992 to 14.2 percent in 1998 and 8.1 percent for the year 2002. Similar data regarding falling prevalence rates are also recorded from sentinel surveillance sites for other major towns throughout the country as indicated in Figure 2 below. Comparable results are also evident in the population-based cohort studies carried out in the districts of Masaka and Rakai (MRC/UVRI, 1997).

Currently, the variation in prevalence stands at 4.2 percent in rural areas and 8.8 percent in urban centres (UNDP 2002). However, AIDS case reporting continues to suffer from either underreporting or absence of records and therefore it is probable that these prevalence rates are higher than what has been presented (STD/ACP-MoH, 2003).

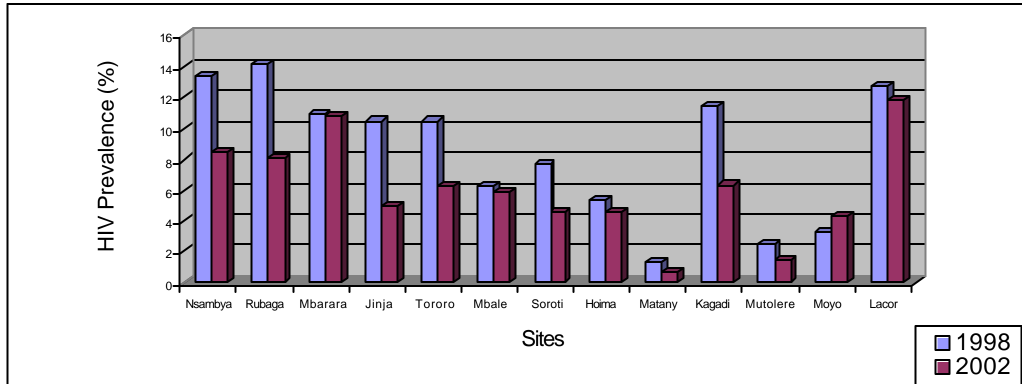
The 2003 sentinel surveillance data indicate a further decline in HIV infection rates between 1998 and 2002 in almost all the designated sites except Moyo where the rate increased from 3.2 percent to 4.3 percent. Figure 3 below shows the comparisons for the 13 out of the 19 sites which had recorded data for both years.

**Figure 2: HIV Infection Prevalence rates among ANC Attendees in Major Towns**



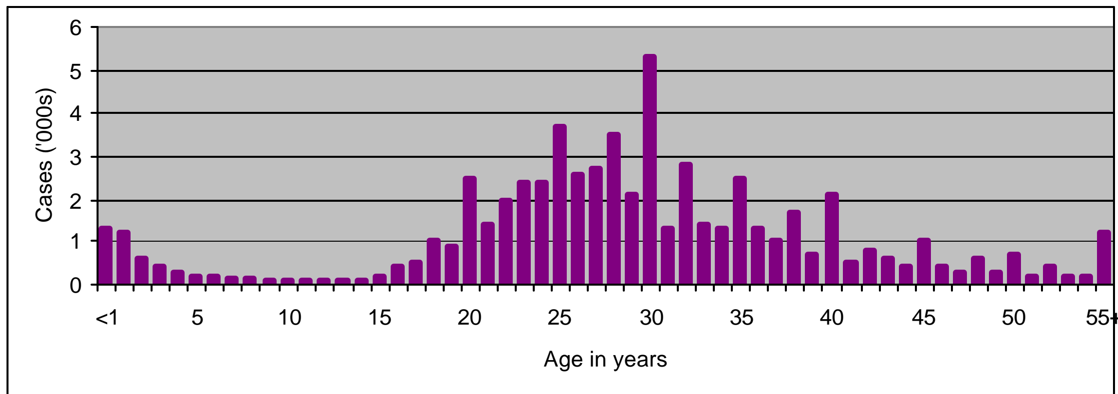

Source: MoH - STD/ACP Surveillance Report June 2003

**Figure 3: Sero-Prevalence rates among ANC Attendees in 1998 and 2002**




Source: MoH - STD/ACP Surveillance Report June 2003

**Figure 4: Differentials in AIDS Cases by Age in Uganda**




Source: MoH - STD/ACP Surveillance Report June 2003

The HIV infection rate also varies significantly with age. As can be seen in Figure 4, the age-based AIDS curve continues to exhibit a short peak in the 0-5 age group before nearing zero in the 5–14 age groups. However, the curve begins to rise again from age 15 peaking at age 30.

According to STD/HIV Surveillance Report, young women aged 15-19 are at a higher risk of HIV infection than men owing to an earlier age at first intercourse. Data from the sentinel sites and AIDS Information Centres (AIC) further indicate that girls in this age group are three to six times more likely to be infected by HIV than the boys while among those aged 20-24, the rates for women are twice as high. The male to female ratio of AIDS cases in the 15-19 year age group was 1:5 for the year (MOH, STD/ACP, 2003).

For the year 2002, the estimate of new infections of HIV/AIDS in Uganda stood at 70,170, of which 54,540 were adults and 15,630 children less than 15 years (STD/ACP-MoH, 2003). However, these rates are not representative as only a small fraction of all new cases is known and/or reported to health facilities. More longitudinal community studies are required to estimate the true incidence of HIV/AIDS.

### 2.4.3 Impact of HIV/AIDS on Children

AIDS is the fourth leading cause of death among children under five years old, significantly increasing the mortality rate of this age group. According to UNAIDS, (1996) virtually all paediatric AIDS cases acquire HIV through mother-to-child transmission. If HIV infection through this route is not contained, AIDS may increase infant mortality by 75 per cent and under-five mortality by more than 100 percent

Of the paediatric AIDS cases, the mean age is 2.3 years as of December 2001 (MOH, STD/ACP, 2002). The age group 5-9 is relatively free of HIV infection, however, they share the burden of other consequences of HIV/AIDS with all children (MoH 2001).

HIV/AIDS affects children in Uganda in several ways including:

- Experience of orphan hood at critical ages when parental guidance and socialisation is needed most. In Uganda, orphans are defined as children under the age of 18 who have lost one or both parents.
- Stigmatisation and discrimination of children who develop HIV related disease
- Lack of quality care giving, education, nutrition and socialisation for children whose parents are bed-ridden or have dead
- Resorting to street life (street children), and
- Sexual abuse by adults

### 2.4.4 Impact of HIV/AIDS on Young People[1]

Young people have been affected greatly by HIV/AIDS. Sentinel surveillance data indicate that HIV infection cases begin to increase in the 15-19 age group and peak in the age range 20-24 (MoH, STD/ACP 2003). The main impact of HIV/AIDS on these age groups is diminished capacity to engage in social economic activities while they are preoccupied with survival.

Young people in Uganda experience increased vulnerability to HIV infection due to the fact that a number of old partners engage them into sex at an early age (16.6 years for girls and 17.4 years for boys). Most of the sexual encounters are without the benefit of consistent and correct condom use and are, at times, a result of rape or defilement (UNDP, 2002; Olowo-Freers & Barton, 1992). This scenario is more rampant in areas characterised by poverty, civil strife and conflict.

The impact of HIV/AIDS on young people is multidimensional, including dropping out of school, being taken to care for sick relatives, early marriages, discrimination and having their assets stripped when their parents die. As a result of HIV/AIDS there are many child-headed households and increasing number of street children.

Furthermore, some districts report that over 50% of teenage pregnancy occurs in orphaned girls, and a number of AIDS-related orphans have found their way to the streets and slums in urban areas. A survey conducted by Fehling, Muhumuza and El-Wambi (1996) found that many street children were orphans who left their homes in search of survival. In addition, about 27 percent of the street children use psychoactive substances such as marijuana (bangi). These factors coupled with low knowledge about HIV/AIDS and limited access to services tend to make young people who live on the streets especially vulnerable to HIV infection.

### 2.4.5 Gender Differences

Women in Uganda are disproportionately at a higher risk of HIV infection than men due to biological, socio-cultural and economic factors. Unprotected sex is the main cause of HIV infection. Society expects men to use sex as a process of exploration, a rite of passage, a way to establish their masculinity and virility, and a means of building self-esteem and a status symbol. As men generally assume the more assertive and directive role in sexual decision-making, they need to be addressed not only as beneficiaries but also as central in the fight

*1 This term is adopted from the World Health Organization (WHO) who defines young people as individuals aged 10-24.*

against HIV/AIDS.

The impact of HIV/AIDS on women has been considerable. Overall, national sero-survey data shows that females are more infected by the virus than males. Apart from the greater risk of being infected, women are also disproportionately affected by HIV/AIDS. They bear the burden of caring for the sick and orphans and coping with the emotional trauma of dying spouses and parents. They often forego productive activities including employment in order to fulfil these duties, while many are striped of their property and discriminated against when they are widowed. Infected women are likely to suffer more anxiety about their own health and the future of their children and family because in the Ugandan setting women are backbone for the families.

Female children are more likely than male children to be taken out of school to care for sick or dying parents and other relatives. Further, there is increased pressure among girls to engage in casual sex especially with older partners ('sugar daddies') as a survival strategy.

### 2.4.6 HIV/AIDS, Culture and Society

Traditional practices such as widow inheritance, polygamy, wife sharing and wife replacement, blood brotherhood, treatment for barrenness and circumcision rituals create an environment conducive for the spread of HIV. Other cultural factors that perpetuate HIV infection include inadequate family life education and life skills training and communication, because parents and other adults often avoid talking to young people about sex.

However, to-date communities have begun to recognize the reality of HIV/AIDS and have revised some of their cultural practices that increase the chance of infection. Never the less, criminalization and stigmatisation of certain sexual practices like commercial sex work, can contribute to a person's vulnerability to HIV and their inability to access services and information. A number of cultural practices such as widow inheritance, wife sharing, and spontaneous sex during rituals have slowly faded away. For instance, the widow inheritance practice is changing so that widows are inherited with no sexual obligations and female genital mutilation cutting are changing to the use of knives provided by those undergoing the procedure (UAC-UNICEF, 2003).

The impact of HIV/AIDS on the community can be identified at three levels, i.e., the individual, family, and community.

#### *2.4.6.1 HIV/AIDS and the Individual*

Although much sensitisation has been undertaken, there are still pockets of discrimination and stigmatisation of people living with HIV/AIDS (PHA). As a result, PHAs often experience trauma, distress, stress and depression. Individual's vulnerability to HIV and the extent to which they are affected by it, depend on a variety of social, cultural and economic constructs. The underlying constructs of vulnerability therefore have to be challenged and changed throughout society. Some of these include gender imbalance, poverty, conflict and criminalisation of certain aspects of sexuality.

#### *2.4.6.2 HIV/AIDS and the Family*

The proportion of households in Uganda that have resident AIDS patients is not known, but it is believed that nearly every household is affected by the epidemic in some way. Generally, women are the most important actors in giving care to HIV/AIDS patients at household level. However, care-giving is often limited by the many other household tasks and responsibilities; lack or inadequate supply of basic care necessities such as soap, antiseptics, cloths and medicines; and limited knowledge on how to care for HIV/AIDS patients and how to prevent infection. Also, family members often have a poor understanding of the HIV/AIDS patient's emotions and well being and how to communicate about the same. They also may not have adequate knowledge about and/or the means to provide good nutrition for HIV/AIDS patients.

Although extended family members have played important roles in caring, they are becoming apprehensive of extending care to HIV/AIDS patients and their children owing to the ever-increasing number of HIV/AIDS-related problems and costs faced at household level (Hunter, 1990; Wakweya et al., 2002). Consequently, a number of households are restructured, with increasing numbers of orphaned children being left to care for each other and/or by ageing grandparents. Often the orphaned children are left without money and they inevitably drop out of school. Small female-headed households, dependent on hired labour and cash remittances from absentee members, are the most vulnerable groups.

#### *2.4.6.3 HIV/AIDS and the Community*

HIV/AIDS-related morbidity and mortality ultimately impact negatively on the community and national economy (Asingwire, 2001; UNDP, 2002; Wakhweya et al., 2002). Labour shortages have been recorded in various communities, particularly in areas hardest hit by the HIV/AIDS epidemic. Loss of labour in the agriculture sector not only erodes the livelihood of small-scale and subsistence

farmers, it also has serious consequences for Uganda's economy since the agricultural sector accounts for 43 percent of GDP, 85 percent of export earnings, and 80 percent of employment. In addition, 85 percent of the total population of Uganda live in rural areas and depend mainly on agriculture for its livelihood (Asingwire, 2001).

The impact of the epidemic on the community is further exacerbated by the growing number of children who have lost one or both parents to HIV/AIDS. It is estimated that there are 1,650,000 orphans in Uganda (Wakhweya et al., 2002). According to the Uganda Demographic and Health Survey 2000-2001, 14% of children under the age of 18 years in Uganda are orphans (UBOS, 2001). The rapid increase in the number of orphans has overburdened traditional community systems of care and support.

### 2.4.7 HIV/AIDS, Migration and Displacement

In the Great Lakes Region, people tend to move mainly due to civil conflict and to search for better jobs and trading opportunities. Uganda is currently host to a large number of refugees (200,000) and internally displaced persons (IDP) numbering to 1.2 million. Refugees and IDPs are comprised mainly of women, children and the elderly who are concentrated in temporary rural camps and communities. Although data on HIV prevalence amongst refugees and IDPs are not available, these are considered to be groups at high-risk for HIV/AIDS due to the socio-economic and psychological breakdown of traditional family structures and support systems.

### 2.4.8 HIV/AIDS and the Health Sector

#### *2.4.8.1 Resource Constraints*

In Uganda, health care services are only accessible to a small percentage of the population. Health care access in rural communities is particularly poor. There is marked variation in access both within and between districts. For example a population residing within 5 kms of a health facility varies from 9 per cent in Kotido to 100 per cent in Kampala (UNDP, 2002).

Uganda is facing a crisis of care and the demand for treatment and palliative care services by patients with HIV/AIDS is expected to further increase as these services become more available. Patients with HIV/AIDS-related illnesses occupied more than 55 percent of the hospital beds (Kayita, 1997) and by 2000 this hospital bed occupancy rate had increased to 70 percent (MOH, STD/ACP, 2001).

#### *2.4.8.2 Opportunistic Infections*

Tuberculosis (TB) is one of the most common HIV-associated infections. A study conducted among a paediatric cohort revealed that 18 percent of HIV infected infants developed TB compared to 1.4 percent of those not infected, and the successful response to treatment was 31 percent and 83 percent respectively (Mudido-Musoke, et al., 1996). Also common among HIV sero-positive individuals are pneumonia, cryptococcal meningitis, Kaposi's sarcoma, cryptosporidial diarrhoea, candidiasis of the oesophagus, and herpes infections. Because TB treatment spreads over a long period of time, the capacity of health care facilities in treating TB is often over-stretched. There is a general shift of emphasis from hospital-based care to home-based care as a means of reducing the pressure on hospitals and health units.

#### *2.4.8.3 Treatment with Herbal Medicine*

The use of traditional medicine in AIDS therapy occupies a prominent position in Uganda. Herbal medicines are becoming increasingly important in the treatment of HIV/AIDS related illnesses. As a result, funding agencies, governmental and non-governmental organisations have supported research in HIV/AIDS herbal and traditional treatments. More support is needed to promote research in this area and to increase accessibility to proven traditional treatments.

#### *2.4.8.4 Anti-Retroviral Therapy (ART)*

Developments regarding anti-retroviral (ARV) therapy in Uganda date back in the early 1990's, when individuals with sufficient resources would visit the UK and USA for AIDS clinical treatment. ARVs later appeared in Ugandan clinics through the Joint Clinic Research Centre around 1996 but were sold at high prices. While prices have declined greatly, many Ugandans still cannot afford ART.

There is increasing pressure from the community for affordable or free ART. The capacity of the health system to respond to this pressure is weak, in terms of laboratory monitoring capacity, counselling services, and the still too high price of drugs. ARVs are already being used in the prevention of vertical transmission in MTCT programmes (UAC 2002). A number of donors, leaders and public private funding mechanisms, e.g. the World Bank, the GFATM, the USA (PEPFAR) and the French governments have or are funding ARV programmes. WHO and UNAIDS have confirmed the global target of providing 3 million people with ARV Therapy by the end of 2005, known by the 3 by 5 target; an ambitious ARV scale up initiative in which Uganda also participates.

### 2.4.9 HIV/AIDS, the Labour Force and the Workplace

Over 80 percent of the reported AIDS cases are among people aged 15-45 years. The majority of these are adults and parents (MoH, STD/ACP Reports, 1999 - 2003). This age group constitutes the largest and most productive segment of the labour force. The death of the people in this age bracket has therefore correspondingly affected the labour force supply as well as the economy, in general.

HIV/AIDS has caused employment insecurity and discrimination in the labour force. Some organisations subject prospective employees to mandatory, but covert, HIV screening tests before recruitment. Individuals found to be infected are denied employment. Those who get infected while employed are often discriminated against and their job contracts are terminated on the basis of their sero-status. All these issues have created the need for and led to the development of the workplace policies and national policy on HIV/AIDS and the world of work, to address HIV/AIDS work place related problems.

# 3.0 REVIEW OF PROGRESS

## 3.1 Introduction

This Section presents a summary of the progress to date in implementing the NSF 2000/01-2005/06. Constraints, gaps and emerging issues are also presented. It draws from the findings of the MTR and forms the basis for the revised goals, objectives, strategies and indicators presented in the logical framework. The following summary is organized around the findings of the six Technical Working Groups of the MTR.

### 3.2 Prevention and Behaviour Change

Prevention and behaviour change strategies and activities fall under Goal I—to reduce HIV prevalence by 25 percent by the year 2005/06. The MTR found that varying progress has been achieved in this thematic area in spite of considerable constraints. Emerging issues and recommendations are recorded below.

## Progress

- The estimated prevalence of 6.2 percent in 2002 (MoH-STC/ACP, 2003) indicates slower than expected progress towards reducing prevalence by 25 percent over the course of this NSF time period.
- Male condom use has steadily increased, especially in urban areas, the female condom is much less accepted and will be reintroduced through the social marketing.
- Voluntary counselling and testing (VCT) services have been established in 51 out of 56 districts, but coverage is still limited within the districts.
- Reducing the risk of blood borne HIV transmission by 50 percent has been substantially achieved from 2 - 4 to 1- 2.
- While most of the planned strategies and activities for reducing sexually transmitted infections (STI) have been substantially achieved, progress against the objective of reducing STIs by 25 percent cannot be measured in the absence of baseline information and a national system to measure STI prevalence.
- The programme for prevention of maternal-to-child transmission (PMTCT) program has been introduced in 35 districts, although coverage and accessibility remain poor.
- Promotion of vaccine development is lagging with only one phase one trial completed, one ongoing, and two in the planning stages.

**Constraints/Gaps**

- There is inadequate capacity among the key implementing partners at both national and district levels to cultivate the necessary human and financial resources to ensure that prevention and behaviour change initiatives are fully implemented
- Numerous national policies which have bearing on prevention and care are still in draft form and require early action to support program activities in this area.

## Emerging Issues

- Increased availability of VCT and ART will have direct bearing on the need for a consolidated and linked approach to prevention and behaviour change.
- Frank and innovative use of sexual education, skills building and active promotion of delaying the age of sexual activity; adherence to one, also faithful, sexual partner, and promotion of condom use should be well balanced (the 'ABC' concept)

## The Way Forward

- VCT will be strengthened and expanded to ensure that this important bridge between prevention and treatment is a readily accessible service throughout the country.
- Approaches to behaviour change communication (BCC) will emphasize all three elements of the ABC approach to prevention, e.g., abstinence, being faithful and condom use, while also improving access to condoms throughout the country.
- Increased attention will be given to moving draft policies related to the HIV/AIDS program, in general, and to prevention, in particular, through the system so that they can be used to enhance programmatic activities.

### 3.3 Care and Treatment

Care and treatment strategies and activities are covered under Goal II—to mitigate the health and socio-economic effects of HIV/AIDS at individual, household and community level. Overall, the MTR revealed significant progress in care with regard to the four strategies listed under this goal and also identified progress in other care and treatment areas that were not included in the original NSF such as ART. Quantifying progress in care and treatment, however, proved difficult because the NSF indicators were primarily process indicators which could not be measured by routine data collection approaches or by the M&E system.

## Progress

- Local private not-for-profit (PNFP) organizations are increasingly involved in the provision of care and support, with recognition of the MoH, Public Private Partnership and the GFATM Country Coordination Mechanism.
- Palliative care is being strengthened, although it is not yet integrated fully into routine health care services
- The cost of ARVs has been reduced significantly
- While guidelines for treatment of opportunistic infections (OI) have been widely disseminated, limited progress has been made in actual treatment of OIs.

## Constraints/Gaps

- PNFP organizations are faced with funding and other capacity and material constraints in providing community and home-based care
- A policy and guidelines for palliative care are needed to enhance developments in this strategic area.
- A policy and guidelines on prevention and treatment of OIs, supported by staff, facilities and materials, are needed to support efforts to address care in this area.
- Lack of collaboration between traditional and modern medicine, lack of evidence of impact, and inadequate funding to develop research on traditional medicine, constrain further development in this area.

## Emerging Issues

As the care and treatment components of the national response have undergone significant change in the period since the current NSF was developed, a considerable number of emerging issues were identified in the MTR as follows:

- A comprehensive national response requires the definition of a continuum of care network with an appropriate constellation of services defined across the life cycle and at different levels of the health care service.
- Movement towards comprehensive and widespread availability of ART is progressing rapidly.
- Home-based care (HBC) initiatives are evolving and additional attention to this area is required in the revised NFS.
- While attention to paediatric AIDS care initiatives has increased, issues unique to this target group including counselling approaches, appropriate treatment formulations, and the needs of adolescents with HIV must be addressed.
- Involvement of private sector and PHAs in care and treatment initiatives

requires additional attention.

## The Way Forward

- All new care and treatment initiatives noted above (ART, HBC, paediatric care, private sector and PHA involvement) will be enhanced and given increased attention and support in the revised NSF.
- Those responsible for on going and new approaches and funding initiatives, e.g. GFATM, World Bank MAP2 and PEBFAR, will be encouraged to fit the planning and implementation for those initiatives to this revised NSF
- Appropriate targets and indicators will be developed in support of the above additions to the revised NSF
- A system and guidelines for linking or networking all these new care initiatives will be developed to ensure they meet their full potential in the national response.

### 3.4 Psychosocial Support, Protection and Human Rights

Psychosocial support, protection and human rights also fall under Goal II of the NSF—to mitigate the health and socio-economic effects of HIV/AIDS at individual, household and community level.

## Progress

- Significant progress has been achieved in building life skills of youth, both those in and out of schools, through the efforts of Government, Civil Society Organisations (CSO) and Faith-Based Organisations (FBO).
- A movement towards greater involvement of persons with AIDS (GIPA) has expanded, including the involvement of PHAs as full partners at the policy and decision making level.
- Limited progress has been attained in promotion of care and social support of orphans and other vulnerable children as well as children infected with HIV.

## Constraints/Gaps

The MTR faced special challenges in addressing this thematic area, first in defining the scope of psychosocial support and then in obtaining a complete inventory of all actors providing these services. This indicates a weakness in the current M&E system of the NSF as psychosocial interventions such as palliative care, are undefined and not captured in existing information systems. Other gaps in this thematic area were also identified.

- Guidelines and policies as well as financial, social and legal support for this thematic area are lacking—possibly due to the need for definitional clarification and elucidation of key players in this area.
- The limited number of agencies providing psychosocial support are understaffed and under funded to meet the growing demand for these services.
- Some relevant laws and policies exist for the protection of the legal, ethical, and social rights of PHAs, but these have not been clarified, widely disseminated, or applied by the Ministry of Justice and Constitutional Affairs (MoJCA).
- Draft policies in support of psychosocial needs of workers, both in private sector and public service, are not yet approved.

## Emerging Issues

- The emerging issues in this theme overlap with those on care and treatment such as the promotion of ART.
- Outreach is needed to attract those community members in need of palliative care who do not yet receive services.
- Those providing palliative care require support to alleviate the stress of their work.
- Income generating activities (IGA) should be provided for PHA families
- Food security and nutritional support as well as the rights of internally displaced persons (IDP) infected and affected by HIV require greater attention.

## The Way Forward

- Mitigation efforts will be clarified and focused so that the response is better coordinated and targeted to the population in need.
- Capacity building and financial assistance must be provided so that the implementing agencies involved in psychosocial support are better equipped to address the identified needs in this thematic area.
- Food security, nutritional support, and rights of vulnerable groups will be addressed.

### 3.5 Coordination and Institutional Arrangements

Goal 3 of the NSF relates to strengthening the national capacity to coordinate and manage the multisectoral response to HIV/AIDS. Strategies and activities include issues of institutional arrangements, capacities, roles and responsibilities; coordination mechanisms; and management arrangements related to implementation of the National HIV/AIDS Programme. The findings and

recommendations on management and process initiatives are summarised below.

## Progress

At the various programmatic levels and in the different sectors, uneven progress was found in planning for coordination and institutional arrangements for programme implementation.

- The Uganda HIV/AIDS Partnership and its 10 Self-coordinating Entities (SCE) representing the various stakeholder groups active in the national response has been formed and is functioning with assistance of a Partnership Fund which pools contributions from a number of donors.
- The annual Partnership Forum has become an effective mechanism for coordination, information sharing and decision-making, including the review and consent process for the MTR in December 2003.
- UAC's capacity to coordinate the national response was assessed with support from UNAIDS and recommendations from that review are being slowly addressed.
- District-level guidelines which recommend the formation of District AIDS Committees (DACs) to coordinate activities at the decentralized level are in place.
- DACs have appointed focal point persons/officers (FPP/O) to guide and coordinate HIV/AIDS activities at the lower levels in some districts.
- Some districts have included HIV/AIDS funds in their budgets, however, the funds are not consistently used for these designated purposes.
- The leadership of Uganda at all levels is well sensitized to issues related to the HIV/AIDS epidemic.
- Some government ministries as well as parastatal and private organizations are undertaking HIV/AIDS interventions, including, in some cases, the provision of ART for their staff and have included funding for these activities in their budgets.

## Constraints/Gaps

- The NSF is not widely known or used by stakeholders when planning and implementing activities to address HIV/AIDS.
- National research priorities have not been set and research is not strategically planned or coordinated effectively.
- Research and other programmatic data are not routinely gathered in a central place for synthesis and distribution.
- UAC's coordination role is constrained by limited human resources and poor infrastructure.
- UAC does not have its full range of essential technical staff in place, and the current ratio of 5:1 administrative to technical staff for a coordinating

body is undesirable.
- The roles and responsibilities of existing UAC staff are not clearly defined or justified in terms of organizational strategy; limited strategic planning has been undertaken by UAC since the current NSF was developed.
- Staff performance is not tied to priority setting neither is their performance monitored.
- UAC's role in strategic information management, including maintenance of NADIC functions, updating the website, and providing an effective library service are stymied by limited staff and physical space.
- While an Advocacy Strategy is currently under development, UAC and the Partnership need to give this initiative immediate priority attention to maintain public support for the national response.
- Advocacy materials and approaches are limited and require updating.
- Adherence to and implementation of district guidelines is inconsistent; districts with externally funded projects are the most advanced in adherence to the guidelines.
- The composition of the DACs is not representative of constituencies, the members are not necessarily AIDS competent, and membership does not generally include PHAs.
- The issue of responsbility for appointment of district-level FPP/Os was raised and debated without clear resolution, although the District Service Commission was indicated as the appropriate body for recruitment.

## Emerging Issues

- Ensuring a common understanding of the term "mainstreaming" followed by application of the concept in all development planning and implementation at the macro and institutional levels is an essential and high priority issue to be addressed in the revised NSF.
- The HIV/AIDS epidemic is impacting the country's development in all areas and must therefore be mainstreamed at all levels of programming, both macro and institutional.
- Building on progress over the past two years since its formation, consolidation and possible expansion of the HIV/AIDS Partnership structure should take place in the remaining years of the revised NSF to prepare this entity to play an even more significant role as Uganda moves towards planning for the following five-year strategy.

## The Way Forward

- The revised NSF will be used as the common platform around which all stakeholders will plan activities and program resources over the next 2two

and half years, resulting in a unified and well coordinated national programme.

- Critical functions in the coordination system (advocacy, policy, resource management, partnerships, and strategic information management) will be strengthened.
- The institutional structure and human resource capacity of the UAC will be improved to ensure its leadership and accountability for the NSF; its capacity and infrastructure will be examined and tailored, if necessary, to better position the organization to fulfil its mandate.
- DACs will be operationalised in all districts in accordance with established guidelines and AIDS competent FPP/Os will be appointed to guide coordination of all programme initiatives at that level.
- The Advocacy Strategy will be finalized and disseminated nationally.
- A Declaration of Commitment will be signed by UAC and its strategic partners in the national response to demonstrate partnership and accountability, and especially dedication to successful operationalisation of the revised NSF.
- Research guidelines and priorities will be examined to design a research strategy for HIV/AIDS.
- A national strategy for strategic information and knowledge management will be developed.

### 3.6 Monitoring and Evaluation

The TWG for M&E was charged with a review and endorsement of the national level indicators within the NSF and draft M&E Plan; a review and endorsement of the M&E Plan; and a review of consistency between the M&E Plan, the NSF and other key related policies, guides, manuals, and documents.

## Progress

- A National M&E Framework for HIV/AIDS has been drafted and is awaiting finalization.
- A Directorate of Planning and Monitoring was established at UAC in 2000.
- An M&E Subcommittee of the Partnership comprised of a cross-section of partners is involved with a review of the National M&E Framework, National and District level indicators and a baseline study.
- The *Inventory of Stakeholders in the National Response to HIV/AIDS* undertaken in June 2001 found that only 6 percent of the stakeholders surveyed include programmatic M&E activities or data management system development.
- A data collection tool and database were developed to track resources in Uganda for HIV/AIDS.

- Training was held on the UNAIDS Country Response Information System (CRIS) and the system has been piloted.
- A National Research Committee has been established by UAC.
- A few externally organized research studies on the epidemic have been undertaken by UN agencies, international research organizations, and individuals.

## Constraints

- The objectives, strategies, and activities of the NSF are silent on the issue of M&E, although there are several objectives related to research, i.e., Goal III, Objective 2 (strengthening the information base) and Objective 3 (strengthening the capacity to undertake research).
- Limited human resources assigned to the Directorate of Planning and Monitoring at UAC constrain the meeting of this NSF goal and related objectives.
- The few partner agencies that have M&E systems are using them to meet their own needs rather than to support needs of the national program.
- The multiplicity of unused or poorly maintained databases and tracking systems and their lack of harmonization present a significant barrier to achievement of M&E objectives.
- Some M&E definitions and reporting procedures should be clarified to ensure common understanding of all stakeholders.
- Districts are requested to complete many different M&E forms for various agencies yet they receive limited feedback about their performance creating a barrier to full participation in the M&E process at the local level.
- Efforts in capacity building to undertake research are basically in their infancy in the Uganda HIV/AIDS program.

## Emerging Issues

- Emerging issues on M&E identified by all the TWGs, as not being fully addressed in the current NSF, will require the development of indicators and possibly new forms of measurement within the revised NSF. These include home based care, VCT, ART, private sector/workplace issues, and the rights of PHAs.
- While some cross-cutting issues, such as gender and equity, are addressed in the current NSF and in the breakdown of a number of the newly defined national indicators, there are other cross-cutting emerging issues, e.g., children and youth and other vulnerable groups such as IDPs and persons with disabilities that will need to be captured in the National M&E Framework.

## The Way Forward

- The M&E framework will be finalized, promoted and disseminated for implementation at all levels of the national program.
- The CRIS will be strengthened to produce timely outputs for national and international reporting.
- UAC will review its leadership function and refine its organizational structure, roles and responsibilities to ensure that the NSF is properly monitored and reported on.
- Monitoring is recognized as an important management tool and, as such, routine monitoring will be encouraged for use by all programs.
- Planning and budgeting for monitoring will be included in regular work plans and will be separated from evaluation and research at the operational level.
- The revised NSF will undergo a summative evaluation during the final year of implementation to prepare for the development of the follow on strategy.

### 3.7 Planning, Resource Mobilization, and Resource Management

## Progress

- At the national level, the NSF itself is a primary example of an effort to shape planning and resources for the national response to HIV/AIDS.
- Other national-level examples of success in this area include the integration of HIV/AIDS into the revised PEAP and the development of strategic and operational plans for HIV/AIDS in Government ministries.
- HIV/AIDS has been integrated in some District Development Plans and some districts have developed strategic and operational plans, primarily for the purpose of acquiring funding from MAP/Uganda AIDS Control Project (UACP) and other funding programmes.
- District leaders have been reasonably sensitised about HIV/AIDS, which provides an important foundation to build upon for future planning, resource mobilisation for implementation of HIV/AIDS activities.
- The UAC has established the Uganda HIV/AIDS Partnership with coordination mechanisms designed to address planning and resource mobilization.
- Resource mobilization is assisted by the guidance provided in the NSF.
- Increased external donor support

## Constraints

- There is an urgent need to foster a "planning mentality" and mechanisms for joint planning among stakeholders in line with NSF. The proposed Shared Programme Framework will serve to begin addressing these needs.
- There is no clear picture or "map" of the national HIV/AIDS programme in terms of geographic coverage, stakeholders, services and funds, which greatly hampers programme planning and implementation.
- The current NSF was not widely disseminated nor was it used as a general guide to planning by most stakeholders leading to independent planning and resource mobilization efforts resulting in uncoordinated and inequitably distributed programmes.
- Many stakeholders are unclear about the expected roles and responsibilities of the lead agencies and key actors designated in the NSF.
- Strategic information, which could be used for planning and resource mobilization, is not readily available at NADIC, due to shortages in human and physical resources.
- Policy and strategy formulation initiatives are designed to gain widespread consensus, but the consensus process has slowed down the approval of key policies that are needed to ensure proper planning and resource mobilization.
- Numerous vertical funding mechanisms have evolved that are not always in accord with the funding priorities agreed upon in the NSF.
- Donor coordination and information sharing about programme funding at national and bcal levels are weak.
- The MoFPED is concerned that the injection of more HIV/AIDS funding may undermine the macro-economic stability of Uganda.
- Institutional capacity and existing structures and expertise of NGOs and FBOs are generally weak, yet these are vital actors in the fight against HIV/AIDS.

## Emerging Issues

- Major new additional financial resources have become available in the last two years with the creation of the GFATM, WB MAP and PEPFAR; while Uganda has been active in trying to benefit from these newly available resources, the growth of multiple financial and reporting mechanisms presents new challenges.
- Model planning guides and training materials, developed by the MoLG as part of the Local Government Development Plan, present the possibility of modification to include HIV/AIDS and thus address the planning gap at the local level.

- The feasibility of a single mechanism to channel, allocate and account for HIV/AIDS funding outside the MTEF has been suggested and should be assessed.

## The Way Forward

- A map of the full scope of the national programme will be developed to delineate which actors are providing what services, in which areas of the country and with what resources, as a high priority acitivity.
- Determining the cost to deliver HIV/AIDS services and the total financial resources required for the revised NSF will be undertaken as an early activity under the revised NSF.
- Donors and programmes bringing new resources to Uganda will be encouraged to use and strengthen existing systems for financial management and M&E to avoid the expensive duplication that currently takes place.
- The multiplicity of resource tracking systems and databases currently in place will be assessed and those deemed appropriate and useful will be further strengthened.
- An analysis of the impact, including an examination of the cost effectiveness, of some of the newly emerging program activities, e.g., VCT, ART, programs for OVC, will be undertaken in the revised NSF.

## 4.0 REVISED GOALS AND IMPLEMENTATION MODALITIES OF THE NSF, 2003/04 – 2005/06

### 4.1 Introduction

This Chapter focuses on HIV/AIDS priorities as out in the revised NSF principal goals, objectives, broad strategies and aggregate activities on which stakeholders including donors and lenders, and implementers will base their plans and activities for the period 2003/04-2005/06.

## 4.2 Goals and Objectives for 2003/4 - 2005/6

In this revised NSF, the 3 goals from the original NSF have been retained, while Goal 2 has been subdivided into 3 parts (a, b and c). Each goal has one or more related objectives and both the goals and objectives are aimed at contributing to the realization of PEAP (2004- 2008).

**Goal 1: To reduce HIV prevalence by 25%**

Objective 1: To promote safe sexual behaviour among particular population categories, especially young people aged 15-24 years

Objective 2: To reduce the current 2-4% (Yr 2000) risk of blood borne transmission by at least 50%

Objective 3: To reduce prevalence of sexually transmitted infections, other than HIV, by 25%

Objective 4: To reduce the current 15-25% risk of mother to child HIV transmission (MTCT) by 30%

**Goal 2: To mitigate the effects of HIV/AIDS**

**Goal 2 (a): To mitigate the health effects of HIV/AIDS and improve the quality of life of PHAs**

Objective 1: To increase and expand access to comprehensive health care and support for people living with HIV/AIDS. At least 50% access to ART ('3 by 5' goal) and 100% to OI Care.

**Goal 2 (b): To mitigate the psychosocial and economic effects of HIV/AIDS**

Objective 1: To reduce HIV/AIDS related vulnerability by 25% among affected individuals through prevention of and protection against violation of rights of those reporting violation of rights

Objective 2: To promote and provide psychosocial and economic support OVCs, PHAs and affected families to at least 50% of those in need

**Goal 2 (c): To Mitigate the impact of HIV/AIDS on the development of Uganda**

Objective 1: To establish the macro-economic impact of HIV/AIDS on the country's development and develop strategies for impact mitigation

**Goal 3: To strengthen the national capacity to coordinate and manage the multi-sectoral response to HIV/AIDS**

Objective 1: Strengthen co-ordination of the multi-sectoral HIV/AIDS response at national, district and lower levels
Objective 2: Strengthen the capacity to co-ordinate and undertake research related to HIV/AIDS at various levels
Objective 3: To promote and strengthen capacity to manage strategic information for HIV/AIDS
Objective 4: To strengthen HIV/AIDS resource mobilization and resource management at national, district and lower levels

## 4.3 Implementation Modalities

### 4.3.1 The National M&E Framework

The combined efforts of the various stakeholders in the progress of implementing the NSF shall be measured and evaluated according to the national and district level indicators contained in the National M&E Framework. The district level indicators will be used to inform district level planning and decision making as well as contributing to national level reporting. The National M&E Framework will provide modalities for harmonized data collection and reporting formats. The national level indicators and their baseline values and targets are summarized in Annex 1.

### 4.3.2 Responsible Government Sector

The Uganda AIDS Commission has the political mandate from the Office of the President to lead, coordinate and monitor the National Strategic Response for HIV/AIDS in Uganda. The UAC shall therefore provide technical advice and guidance to the array of stakeholders, public, civil and private in the implementation of the NSF.

The responsible government sector for NSF activities is the body charged with providing over all coordination and policy guidance, and ensuring that the

resources mobilized and committed for implementation of each activity under its purview are appropriately used to achieve the stated goals and objectives. The OoP (UAC) takes the overall lead role in areas of coordination on cross-cutting issues where the responsibility does not fall under the mandate of one sector.

The partners charged with implementation of strategies and activities outlined in this Framework will be those demonstrating a comparative advantage in the particular area of implementation. The roles of all sectors and organizations in the implementation of the revised NSF are held to be of equal importance.

The principle of harmonisation and partnership should be infused throughout the response, thereby maximising the expertise and systems that already exist in Uganda and minimising the occurrence of unnecessary duplication.

### 4.3.3 Shared Programme Framework

During this period (2003/04-2005/06), the national response will continue to conform to the "three ones" concept/approach;

- one national HIV/AIDS coordinating authority
- one national framework for action
- one M&E framework to track and monitor the national response

UAC will undertake, as part of its coordination role, an effort with all stakeholders to fully develop and introduce a shared programme framework which includes systems for planning, funding requests, harmonised accounting cycles, and synchronized reporting. All attempts will thus be made to capture and harmonise the multitude of different funding sources and mechanisms within this NSF for National HIV/AIDS Action, in order to finance funding gaps based on agreed upon priorities.

All partners are encouraged to undertake programme planning in the context of this revised NSF. This Framework will be used to provide the structure for all partners' strategies and workplans. Thus, the overall NSF goals, objectives, strategies and activities should be referenced in each partner's strategies and workplans as well as in their monitoring and evaluation plans. By using this approach, all partners will report progress in relation to the NSF and to the national and district indicators articulated in the National M&E Framework to UACS.

# 5.0 THE LOGICAL FRAMEWORK

This section of the NSF is the primary reference to be used by all partners in the national response for planning and implementing their programmatic and policy initiatives. The format of the logical framework is organized under three overarching goals one of which contains three sub-goals. Objectives and outcomes are stated for each goal and these are followed by the strategies deemed necessary for their achievement(s). Broad, aggregate activities are presented in relation to the achievement of each strategy. Partners are encouraged to select from among the strategies and activities in developing their own work plans and are further expected to link all their planned activities to this Framework. Any activities which are planned outside the Framework should be discussed with the UAC Board to ensure that they do not contradict or counteract the Framework.

## 5.1 Assumptions

The revised NSF has been developed within the context of Uganda's 'Vision 2025' and the Poverty Eradication Action Plan. It must be acknowledged that HIV/AIDS creates and thrives in an environment of poverty. The fight against the epidemic cannot occur in isolation and must be done in conjunction with an overall development strategy that promotes:

- the development of a functional legitimate state;
- good governance and protection of human rights;
- sustainable economic development
- human capacity development
- Peace and security.

Therefore the revised NSF and the strategies proposed within it are based on the assumption that Uganda's development progress will continue and that the PEAP outcomes and targets are realised.

Individual's vulnerability to HIV and the extent to which they are affected by it will depend on a variety of social, cultural and economic constructs. The ability of an individual to protect him or herself from infection is influenced by skills to negotiate safe sex and access appropriate information and commodities. The expected outcomes of this NSF will not be reached if individuals continue to live in an environment where power dynamics, gender imbalance, poverty, harmful traditions and discriminatory legal frameworks and practices reinforce vulnerability. Therefore, this NSF assumes that the underlying constructs of vulnerability

will be challenged and changed through the implementation of the strategies laid out in the log frame and in line with other relevant policy frameworks.

The NSF is a guiding document that outlines how Uganda, as a country will respond to the HIV epidemic. The NSF acknowledges the roles and contributions of a multitude of actors in implementing the strategies and activities laid out in the log frame. The log frame indicates the lead actor or agency responsible for leading and accounting for the performance of specific strategies. The NSF therefore assumes that the agencies named and the multitude of actors that are unnamed will adopt responsibility for its implementation.

Another underlying assumption of this NSF is that the financial resources necessary for the implementation of the log frame will be made available. It is assumed that the multitude of existing financing mechanisms will be harmonised and lead to transparent and efficient application of funds towards the achievement of the NSF goals and objectives.

Finally, for the success of the NSF, good governance must underpin every aspect of the national strategic response. This will be reflected by a continued high level of political commitment and leadership to tackling the epidemic. As well as transparent and effective coordination, resource allocation, programme implementation, monitoring and evaluation of Uganda's response to HIV/AIDS. Together with increasing AIDS competence for learning and knowledge management, it is assumed that the NSF's goals and objectives will be achieved.

## GOAL1: TO REDUCE HIV PREVALENCE BY 25%

**Objective 1.1: To promote safe sexual behaviour among particular population categories, especially young people aged 15-24**

**Outcome 1: Median age for first penetrative sexual debut raised from 16.7 to 18 years of age**

**Outcome 2: At least 50% of the sexually active population will have adopted safe sexual practices**

*The bold under the column of responsible government sector represents the lead policy sector*

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| 1.1.1. Promote safe sexual behaviour through BCC on STDs/HIV/AIDS | a) Conduct KABP surveys on BCC among general and selected populations | No. of KABP surveys conducted for different population categories | KABP on BCC survey reports | **OoP;** MoH; MoES; MoGLSD | Common understanding of A model; Knowledge leads to behaviour change |
| | b) Develop and disseminate a national BCC strategy to guide implementation of BCC programs for prevention (ABC) and care | % of stakeholders having and using the BCC Strategy | A national BCC Strategy dissemination report | **OoP,** MoH;; MoES; MoGLSD | |
| | c) Develop, implement and monitor BCC programs targeting different population groups (youths, IDPs, CSW, armed services etc) | % of stakeholders implementing BCC programs | Stakeholder & support supervision reports | **MoH;** OoP; MoES; **MoGLSD** | |
| | d) Develop capacity of stakeholders to develop and manage BCC interventions for prevention and care (e.g., training, recruitment, funding) | No. of BCC interventions implemented by trained personnel | Stakeholder & support supervision reports | **MoH; OoP**; MoES; MoGLSD | |
| | e) Expand programs on AIDS education, counselling and life skills for young people in and out of school | No. of programs targeting young people | Program reports | **MoES;** MoH; OoP; **MoGLSD** | |
| 1.1.2. Increase access to condoms for urban and rural populations | a) Disseminate condom (male and female) use information and promotional materials | % of sexually active persons reporting access to condom information and materials | Survey reports on condom access | **MoH** | Demand will be met by suppl People who access condoms will use them. |
| | b) Strengthen the national condom distribution system to ensure universal access to free and affordable quality condoms | % of sexually active persons reporting access to condoms | Survey reports on condom access | **MoH** | |
| | c) Expand condom social marketing programs especially in rural areas | No. and coverage of social marketing programs | Program reports | **MoH** | |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| 1.1.3. Expand HIV VCT services up to Health Center III in all districts | a) Integrate VCT in all health facilities up to HCIII | % of units with functional integrated VCT services | Health facility survey, Program reports | **MoH** | Availability of resources. Zero stock outs of VCT test kits. |
| | b) Strengthen systems and capacity to support expansion of VCT services (training, recruitment, procurement and management of commodities, outreach services) | % of functional VCT sites | VCT facility surveys, Program reports | **MoH** | |
| **Objective 1.2: To reduce the current 2-4% (yr 2000) risk of blood borne HIV transmission by at least 50%** | | | | | |
| **Outcome 1: The risk of blood borne HIV transmission would have reduced by 50%** | | | | | |
| 1.2.1 Strengthen blood quality control, supply and appropriate use of blood and blood products in all health service delivery sites | a) Decentralise blood bank centers to districts | % of districts with functional blood bank centers | Reports on blood bank centers. | **MoH** | Availability of infrastructure a resources. |
| | b) Expand blood donor recruitment campaigns | % increase in units of blood donated | Blood Bank Program report | **MoH** | |
| | c) Support and monitor implementation of blood safety guidelines | % of blood bank centres and health units that adhere to blood transfusion guidelines | Health facility survey | **MoH** | |
| 1.2.2. Ensure financial sustainability of safe blood supply | a) Secure sustainable funding for the national blood transfusion services | Amount and source of funds available for blood bank services on an annual basis | Funding status reports and MTEF | **MoFPED** | Current level of funding maintained |
| 1.2.3. Strengthen the prevention of blood borne HIV transmission | a) Enforce universal precautions for infection control in health care settings | % of health facilities having functional infection control units or following infection control procedures | Health Facility Survey Reports | **MoH** | Appreciation of and adherenc to infection control precautior by health workers |
| | b) Guide, support and monitor the implementation of universal precautions for infection control at various levels and in different settings (e.g., circumcision, salons, accidents) | % of non-health service providers in different setting sensitized in universal precautions for infection control | Non-health service facility survey and program reports | **MoH** | Appreciation of infection contr precautions by all service providers and beneficiaries. Zero stock outs of essential drugs and commodities |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| | c) Expand provisions for universal post-exposure prophylaxis (PEP) to all who will need it (e.g., HCWs, post-rape cases) | No. of eligible persons who have received PEP | Health unit records | **MoH** | |
| **Objective 1.3: To reduce prevalence of sexually transmitted infections (other than HIV) by 25%** | | | | | |
| **Outcome 1: Appropriate diagnosis, treatment and counseling according to national guidelines is afforded to patients with STIs in selected health facilitie** | | | | | |
| 1.3.1 Strengthen syndromic management of STIs | a) Expand the integration of STI prevention and treatment into other health services (PHC, MCH etc) | % of units providing integrated STI services | Health facility survey, Program reports | **MoH** | Availability of resources and increased uptake of services. |
| | b) Improve the STI drug procurement, delivery and management system at national and district levels | Frequency of stock outs in the past six months | Health facility survey | **MoH** | |
| | c) Increase capacity to deliver STI management services at various levels(human resource, infrastructure, supplies) | % of patients with STIs at selected health facilities who are treated according to national guidelines, of all STI patients at those facilities. | Survey or program reports | **MoH** | |
| 1.3.2. Strengthen the STI surveillance system | a) Strengthen the STI data management system | % of health institutions with complete data on STIs, Functional national STI database | STI records, STI program reports | **MoH** | Availability of resources |
| | b) Conduct baseline studies on the prevalence of STIs | Availability of recent STI prevalence data. | STI surveillance reports | **MoH** | |
| | c) Strengthen the laboratory infrastructure and reagent supply | % of health units with functional labs | Health facility survey | **MoH** | |
| **Objective 1.4: To reduce the current 15-25% risk of mother to child HIV transmission (MTCT) by 30%** | | | | | |
| **Outcome 1: MTCT of HIV reduced to 10-17%** | | | | | |
| 1.4.1. Expand PMTCT services up to HCIII within each district | a) Integrate PMTCT in MCH services and in health facilities up to HCIII | % of health units and MCH services that have integrated PMTCT | Health facility survey, Program reports | **MoH** | Availability of resources and increased uptake of services. The population has access to |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| | b) Sensitise preservice and in-service HCWs on HIV/AIDS medical precautions to prevent MTCT during labour and delivery | % of training institutions that have integrated PMTCT into their preservice and in-service training | Pre-service training curricula for the different training institutions | **MoH** | |
| | c) Develop systems and capacity to support the expansion of PMTCT services (e.g., training, recruitment, supplies, infection prevention) | No. of functional PMTCT sites | A survey of PMTCT sites, Program reports | **MoH** | |
| 1.4.2. Enhance the conducive environment for PMTCT implementation | a) Lobby leaders and policy makers at various levels to support health systems development for PMTCT implementation | Amount of funds budgeted and allocated to PMTCT services | Program financial reports | **MoH** | Conducive environment for PMTCT is sustained. |
| | b) Sensitize health workers at national and district levels on benefits of PMTCT | % of health institutions with staff sensitised in PMTCT | Health facility surveys | **MoH** | |
| | c) Sensitize communities, families and partners on benefits of PMTCT and the need to mobilize and support pregnant women | % of pregnant women who accept PMTCT services | Records of women accessing PMTCT | **MoH** | |
| 1.4.3. Promote education on and support alternative infant feeding programs for children of HIV positive mothers | a) Identify /introduce appropriate nutritious and locally available food for children in different communities | % of mothers using alternative feeds | Program Reports | **MoH**; MoAAIF | Mothers will accept and/or be able to afford appropriate alternative food. |
| | b) Sensitise mothers and community members on the available, safe and appropriate alternatives to breast feeding | % of HIV positive mothers who are aware of appropriate alternatives to breastfeeding | Survey reports | **MoH** | |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| **GOAL 2: TO MITIGATE THE EFFECTS OF HIV/AIDS** | | | | | |
| **GOAL 2a: TO MITIGATE THE HEALTH EFFECTS OF HIV/AIDS AND IMPROVE THE QUALITY OF LIFE OF PHAs** | | | | | |
| **Objective 2a.1: To increase and expand access to comprehensive health care and support for people living with HIV/AIDS** | | | | | |
| **Outcome 1: At least 50% of PHAs eligible for ART and 100% PHAs presenting with OIs will have access to comprehensive health care and support** | | | | | |
| 2a.1.1 Strengthen the district level infrastructure, including laboratory services, for the provision of comprehensive care for PHAs | a) Assess existing physical and human resource infrastructure per district and develop strategies to address identified gaps | % of health facilities with human resources and physical infrastructure to deliver care according to MoH standards | Health facility surveys | **MoH** | Anticipated resources from various sources will be available. |
| | b). Ensure availability of appropriate lab services at different levels for the provision of comprehensive HIV care | % of health facilities with the lab infrastructure to deliver care according to MoH standards | Health facility surveys | **MoH** | |
| 2a.1.2 Expand and sustain the human resource capacities at different levels of care to provide comprehensive care and support, including ART, for both children and adults | a) Ensure recommended staffing levels per district (public & non-public) to provide comprehensive care | % of health facilities with personnel trained in and practising delivery of comprehensive HIV care | Health facility surveys | **MoH**; MoPS | Required human resources wi be available. |
| | b) Provide pre-service and in-service training in comprehensive care for different cadres of health workers | % of health workers trained in comprehensive care | Reports by recognized in-service and preservice HIV training institutions | **MoES** | |
| | c) Build the capacity of communities, including PHAs, to provide community based HIV/AIDS care (needs assessment, training) | % of community members trained in community based care | Training program reports | **MoH** | |
| 2a.1.3 .Increase access to quality prevention and treatment of opportunistic infections (OI) to all PHAs seeking the service | a) Complete and popularise guidelines and standards for prevention and treatment of OIs | % of health units having and using OI management guidelines | Health facility surveys | **MoH** | Availability of human and financial resources |
| | b) Strengthen TB treatment and control | Treatment completion rates | TB program reports | **MoH** | |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| | c) Ensure uninterrupted supply of appropriate drugs for the treatment of OIs and other related conditions | Stock out rates | Health facility surveys | **MoH** | |
| 2a.1.4. Support expansion of programs, research and development efforts for alternative, complimentary and traditional medicine | a) Support research and development for herbal remedies and other complimentary treatments for HIV (e.g., aromatherapy, yoga, acupuncture) | No. of research studies<br>No. of effective herbal remedies | Research reports | **MoH** | Availability of human and financial resources |
| | b) Support and guide initiatives in traditional and complimentary medicine (e.g., legal framework, expansion, training, information sharing) | % of stakeholders with capacity to deliver traditional and complimentary care services | Program reports | **MoH**; MoFPED | |
| | c) Facilitate effective coordination and collaboration between traditional, complimentary and modern medicine | % of traditional healers and complimentary care givers trained in basic AIDS care | Program reports | **MoH** | |
| 2a.1.5. Increase equitable access to ART to at least 50% of those requiring treatment | a) Intensify advocacy to address obstacles to equitable access to free/subsidised ART (e.g., resource mobilization, health sector budget ceiling, policy implementation) | % eligible PHAs receiving ART | Reports from ART centres | **OoP** | a) Anticipated funds are available from different sources, b) Additionality issue addressed, c) ART availed fr or at subsidised costs, d) Uganda continues to be able import and use genetic drugs e) Continual availability of VC services throughout the coun |
| | b) Expand ART service to all district hospitals and HC IV and provide follow-up services at lower levels | % of district hospitals and HC IV providing ART services | Health facility reports | **MoH** | |
| | c) Support community (particularly PHA organizations) sensitisation and care programs to ensure adherence to ARV drugs | Adherence rates | Health facility reports | **MoH** | |
| | d) Ensure availability of uninterrupted supply of quality ARVs (needs assessment, procurement and management of commodities) | Stock out rates | Health facility surveys | **MoH** | |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| | e) Develop/adapt models that support increased access to ART and related services | No. of centres accredited to provide ART services | MoH reports | **MoH** | |
| | f) Guide, support and monitor implementation of ART programmes (e.g., development of models and tools, ARV efficacy, operations research) | % of ART centres adhering to MoH ART standards/guidelines | Support supervision reports | **MoH** | |
| 2a.1.6. Promote and expand specialised paediatric and adolescent HIV/AIDS care services | a) Incorporate specialised paediatric and adolescent services in existing HIV care services, including HBC and palliative care. | % of health institutions providing specialised HIV/AIDS paediatric services | Health facility reports | **MoH** | Continued recognition of children and adolescents as groups needing specialised ca and treatment |
| | b) Integrate paediatric/adolescent training in HIV training curriculum | % of pre-service and in-service programs that offer training in integrated paediatric AIDS care | Training curricula | **MoES, MoH** | |
| | c) Advocate for provision of paediatric OIs and ARV drugs formulations | Availability of paediatric ARV formulations | Reports | **MoH** | |
| | d) Build linkages between PMTCT programmes and paediatric care | % of children enrolling in paediatric programs who are referred from PMTCT programs | Paediatric program reports | **MoH** | |
| 2a.1.7. Support and expand provision of home-based care (HBC) | a) Create a supportive environment for the formation of public-private partnerships to expand HBC | No. of public-private partnerships formed to offer HBC | A survey of HBC services, program reports | **MoH** | a) Availability of funding and recognition of HBC as a vital component of HIV care, b) Willingness of public and private sectors to collaborate. |
| | b) Standardise provision of HBC | % of stakeholders having and using HBC guidelines | Support supervision reports | **MoH** | |
| | c) Improve referrals between HBC providers and facility-based care | Functional referral system | Programme reports | **MoH** | |
| | d) Support PNFP health facilities in the provision of HBC | % of PNFP health facilities receiving both government and non-government support and providing community-based care | Health facility reports | **MoH** | |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| | e) Mobilise and support community involvement in the provision of community-based HIV care | No. of PHAs receiving community-based HIV care | CBO reports, stakeholder reports | **MoGLSD**; MoH | |
| 2a.1.8. Support and expand provision of palliative care | a) Create a conducive environment for implementing palliative care programs through public and PNFP partnerships | No. of PHAs receiving palliative care | Programme reports | **MoH** | Stakeholders embrace a common understanding of an guidelines for palliative care f PHAs |
| | b) Standardise provision of palliative care | % of stakeholders having and utilizing palliative care guidelines | Support supervision reports | **MoH** | |
| | c) Integrate palliative care in the national health system and training curricula | % of health facilities offering palliative care Proportion of pre-service and in-service programs that have introduced training in palliative care | Health facility reports, Training curricula | **MoH; MoES** | |
| | d) Support and ensure coordination of PNFP facilities in the provision of palliative care | % of PNFP health facilities receiving both government and non-government support to coordinate provision of palliative care | Health facility reports | **MoH** | |
| | e) Mobilise and support community involvement in community-based and palliative care and support for PHAs. | No. of PHAs receiving community-based/palliative care | CBO reports, stakeholder reports | **MoGLSD**; MoH | |
| 2a.1.9. Ensure a functional continuum of care between health facilities, home, community and other HIV related services | a) Strengthen referral systems that link all HIV service providers involved in prevention, care and mitigation (e.g., VCT, PMTCT, other social services, HBC) | % of patients who reach their referred destinations | Health facility reports | **MoH, MoGLSD, MoES** | Referred patients are willing and able to follow referral advice |
| | b). Strengthen referral systems within health facilities and between different levels of health care delivery. | % of health facilities having and utilizing HIV prevention and care referral guidelines | Health facility reports | **MoH** | |
| 2a.1.10. Promote improved care-seeking behaviour through IEC on care | a) Conduct widespread public education campaigns on HIV care for adults and children | Knowledge of care options and access points | Population-based surveys | **MoH**; MoGLSD | Improved knowledge leads tc changes in behaviour and reduced stigma |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| | b) Conduct behaviour change campaigns on stigma and discrimination | No. of PHAs seeking care | Health facility reports | **MoH; MoGLSD;** MoES | |
| 2a.1.11. Improve the quality of life for PHAs through counselling and nutrition support | a) Integrate nutrition support and counselling for PHAs and their families in the HIV/AIDS comprehensive care package | % of HIV care services offering counselling and/or nutritional support | Health facility and programme reports | **MoH;** MoES, MoAAIF | Capacity to deliver counselling services matches demand. Food aid will be available |
| | b) Update and disseminate counselling protocols and guidelines to include ARVs, PMTCT counselling | % of HIV service providers having and using updated counselling protocols | Availability of updated counselling protocols | **MoH** | |
| | c) Provide counselling skills to PHA care givers | No. of care givers receiving counselling skills | Facility and programme reports | **MoH;** MoES | |
| | d) Provide nutritional education and counselling to PHAs | % PHAs receiving nutritional counselling | Facility and programme reports | **MoH;** MoES | |
| | e) Provide nutritional support to households of PHAs | % of PHA households receiving nutritional support | Facility and programme reports | **MoH** | |
| **GOAL 2b: TO MITIGATE THE PSYCHOSOCIAL AND ECONOMIC EFFECTS OF HIV/AIDS** | | | | | |
| **OBJECTIVE 2b.1: To reduce HIV/AIDS related vulnerability by 25% among affected individuals and communities through prevention of and protection against violation of rights of those who report such violations** | | | | | |
| **OUTCOME 1: The incidence of violation and abuse of the rights of PHAs, OVCs, displaced communities, youth and women reduced by 25%** | | | | | |
| 2b.1.1. Promote the protection of legal, ethical and social rights of PHAs | a) Assess vulnerability and establish the nature and incidence of violation and abuse of the rights of PHAs | Vulnerability and abuse data | Research reports; Records on reported incidence of violence and abuse of rights | **MoGLSD;** MoJCA | Consensus will be reached on what constitutes the rights of PHAs |
| | b) Expedite the process of enacting relevant laws and policies to ensure human rights and fundamental freedoms by PHAs | Relevant laws enacted | Laws and policies in place | **MoJCA;** MoGLSD | |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| | c) Advocate for enforcement of human rights policies and guidelines related to the rights , roles and responsibilities of PHAs | Number of advocacy forums organized | Programme reports | **MoGLSD**; MoIA | |
| | d) Build capacity of key change agents and institutions on the rights, roles and responsibilities of PHAs | No. of trainers and community change agents trained in rights, roles and responsibilities of PHAs | Training reports, Survey reports | **MoGLSD** | |
| | e) Develop and disseminate guidelines on advocacy for prevention of abuse of rights related to HIV/AIDS | % of stakeholders having and using guidelines | Programme and survey reports | **MoGLSD** | |
| | f) Strengthen systems and revitalize existing mechanisms for prevention of violation/abuse of PHAs' rights | Mechanism for reporting cases of violation/abuse of rights revitalised, Village Courts revitalised/constituted | Programme and survey reports | **MoGLSD** | |
| | g) Promote increased awareness of human rights, legal, and ethical needs of PHAs among the media, health providers, AIDS workers, law enforcement agents and the community at large | No. of each target group sensitised about human rights, legal, and ethical needs for PHAs | Reports of awareness-raising programmes | **MoGLSD;** OoP; MoIA, MoH | |
| 2b.1.2. Promote the protection of legal, ethical and social rights of all vulnerable groups in relation to HIV/AIDS (e.g., youth, women, VCs,IDPs) | a) Assess the human rights, legal and ethical needs of all vulnerable groups in relation to HIV/AIDS with focus on displaced persons, OVCs, youth and women | Human rights, legal and ethical needs for all vulnerable groups documented | Needs assessment reports | **MoGLSD;** MoJCA; OoPM; MoES | Handbooks and other materia will be distributed and used |
| | b) Synthesize and popularize a handbook about laws on the protection of rights of vulnerable populations (e.g., PHAs, displaced persons, OVCs, youth, women) in relation to HIV/ADS | No. of stakeholders having and utilizing the handbook on rights | Programme reports | **MoJCA;** MoGLSD | |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| | c) Promote increased awareness about human rights, legal and ethical needs of all vulnerable groups among the media, health service providers, AIDS workers, law enforcement agents and the community at large | No. of each target group trained in human rights and appropriate laws | Programme reports | **MoGLSD**; OoP, MoIA, MoH | |
| | d) Promote increased awareness and skills development of vulnerable groups about their human rights | No. of PHAs and other vulnerable individuals sensitized No. of cases human rights abuse reported and handled | Survey reports | **MoGLSD** | |
| | e) Support translation and conversion of international conventions, guidelines and instruments on HIV/AIDS right s for local use | No. of local guidelines and programmes based on international conventions and instruments available and in use | Programme reports | **MoJCA**; MoGLSD | |
| | f) Integrate HIV/AIDS legal and rights issues into legal aid, counselling services, and social security systems | % of PHAs and other vulnerable individuals having access to legal aid and counselling services | Programme reports; survey reports | **MoGLSD;** MoJCA | |
| 2b.1.3. Incorporate HIV/AIDS concerns within the Human Resource Management policies | a) Assess the situation and impact of HIV/AIDS on human resources in the private and informal sectors | Report of the situation analysis | Assessment reports | **MoGLSD** | a) Employers in all key sector will recognize the link betwee HRM and HIV/AIDS b)Cabinet and Parliament will prioritize debate and enactment of policies on HIV/AIDS |
| | b) Expedite the finalization, popularize and support implementation of Human Resource Management Policy in the public sector | % of stakeholders having and utilizing HRM Policy | Sector reports | **MoPS** | |
| | c)Popularize the Policy on AIDS in the World of Work to all employers and employees | % of stakeholders having and utilizing the policy | Sector reports | **MoGLSD** | |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| **OBJECTIVE 2b.2: To promote and provide psychosocial and economic support to OVCs, PHAs and affected families to at least 50% of those in need** | | | | | |
| **OUTCOME 1: PHAs and affected individuals will have accessed counselling, financial, material, nutritional and family support** | | | | | |
| **Outcome 2: OVCs will have received psychosocial, nutritional and material support and education** | | | | | |
| 2b.2.1 Expand psychosocial support to PHAs and affected families | a) Assess needs and capacities of local NGOs/CBOs involved in provision of psychosocial and spiritual support to PHAs and affected families | Report of the needs assessment | Assessment reports | **MoGLSD;** MoIA | Availability of funding and recognition of psychosocial support as a vital component HIV/AIDS prevention and mitigation |
| | b) Strengthen capacity of local actors involved in the provision of counselling, psychosocial and spiritual support to PHAs and affected families | Proportion of stakeholders providing psychosocial support services according to standard guidelines | Program reports | **MoGLSD;** MoH | |
| | c) Provide financial and technical support to institutions and organizations offering psychosocial and spiritual support for PHAs and the affected families and individuals | No. of institutions/organizations offering social and spiritual support to PHAs; no. of affected persons who are supported | Records indicating form of support extended | **OoP** | |
| | d) Link psychosocial support services to health care services | % of public and PNFP health service providers linking PHAs to psychosocial support services | Programme reports; survey reports | **MoH** | |
| 2b.2.2 Promote psychosocial and spiritual support for both in- and out-of-school OVCs infected/affected by HIV/AIDS and for their care givers | a) Periodically assess the trends and patterns of HIV/AIDS related problems affecting OVCs | No. of studies conducted and disseminated to stakeholders; availability of data on OVC concerns | Study reports | **MoGLSD;** MoES | a) Appreciation of the challen of addressing the OVC crisis that is exacerbated by AIDS and internal displacement; b) The OVC Policy will be operational and supported |
| | b) Provide guidelines on advocacy for OVCs in relation to HIV/AIDS | % of stakeholders reporting utilization of child advocacy, guidelines on HIV/AIDS | OVC advocacy strategy in place | **MoGLSD;** MoES | |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| | c) Document and popularize models on OVC care and community support to stakeholders | No. of models documented; No. of stakeholders using the best practices | Stakeholder reports | **MoGLSD;** MoES | |
| | d) Strengthen and sustain programmes on economic coping capacity at household and community levels for OVC's care givers | % of stakeholders providing economic support to OVC and their families | Stakeholder reports | **MoGLSD;** MoES | |
| | e) Support efforts to impart social and life skills for effective coping and self-management mechanisms to OVCs to reduce vulnerability | % of stakeholders providing social and life skills development services; % of OVCs receiving services for developing social and life skills | Programme reports | **MoGLSD;** MoES | |
| | f) Establish and/or strengthen child- and adolescent-friendly services at district and lower levels | No. of functional child/adolescents multi-service centres at district and lower levels; % of OVCs using child- and adolescent-friendly services | Inventory of actors and programmes | **MoGLSD;** MoES | |
| | g) Extend financial/ material support for OVCs and child-headed households, guardians and foster families | % of stakeholders with budget line for AIDS orphans and child-headed households support; % of OVC families having access to financial or material donations | Programme reports; OVC community surveys | **MoGLSD;** MoES | |
| | g) Ensure enrolment and retention of OVCs (boys and girls) in schools | % of OVCs (boys and girls) enrolled in school | School enrolment records | **MoES** | |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| 2b.2.3. Promote the provision of economic and material assistance to PHAs and affected families | a) Conduct a situational analysis on the socio-economic status of PHA families | Data on socio-economic status of PHA families | Situational analysis reports | **MoGLSD**; OoP | Economic and material resources will be available |
| | b) Support PHAs to design and implement feasible income generating projects (IGPs) | No. of PHA families implementing IGPs | Programme reports | **MoGLSD**; MoAAIF | |
| | c) Advocate for micro-finance programs to support income generating projects (IGPs) for PHAs and their families | No. of PHA families implementing IGPs | Programme reports | **MoFPED** | |
| | d) Strengthen associations of PHAs, widows and widowers to improve the economic status of the affected families | No. of associations supported | Programme reports | **MoGLSD**; OoP | |
| | e) Mobilize the private sector, development partners, local governments and communities to contribute resources (in kind and cash) for support of the welfare of PHAs and the affected families | No. of private firms that contribute in cash or kind towards PHA welfare. No. of PHA families accessing support from Local government and private sector | Records indicating the specific firms that extended the support to PHA families/individuals, and nature of contribution | **OoP** | |
| **GOAL 2c: TO MITIGATE THE IMPACT OF HIV/AIDS ON THE DEVELOPMENT OF UGANDA** | | | | | |
| **Objective 2c.1: Establish the macro-economic impact of HIV/AIDS on the country's development and develop strategies for impact mitigation** | | | | | |
| **Outcome 1: Impact of HIV/AIDS on Uganda's development established and mitigation strategies developed and widely shared** | | | | | |
| 2c.1.1. Deepen the evidence base on the impact of HIV/AIDS on key areas of development | a) Identify information gaps and support research | Availability of impact data | Research reports | **OoP** | Expertise to conduct macro-level research and modelling i available |
| 2c.1.2 Enhance national action on HIV/AIDS mainstreaming and impact mitigation | a) Develop and popularise HIV/AIDS mainstreaming guidelines | % of stakeholdersand districts having and using mainstreaming guidelines | Guidelines for mainstreaming HIV/AIDS | **OoP** | a) Consensus will be develope on HIV/AIDS mainstreaming; Government and partners will support the mitigation strateg |
| | b) Sensitise sector and district leadership on HIV mainstreaming and mitigation | % of stakeholders and districts that have mainstreamed HIV/AIDS | Programme reports | **OoP** | |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| | c) Guide and support sectors and districts to mainstream HIV/AIDS and mitigate its impact | % of stakeholders and districts that have mainstreamed HIV/AIDS within annual plans and devised mitigation strategies. | Programme reports, SWG papers, Government ministry annual plans, District plans | **OoP**; MoLG | |
| | d) Develop and implement a National Mitigation Strategy to address the impact of the epidemic | Nation Mitigation Strategy in place and funded | National Mitigation Strategy document | **OoP** | |
| **GOAL 3: TO STRENGTHEN THE NATIONAL CAPACITY TO COORDINATE AND MANAGE THE MULTISECTORAL RESPONSE TO HIV/AIDS** | | | | | |
| **Objective 3.1: To strengthen coordination of the multisectoral response to HIV/AIDS at national, district and lower levels** | | | | | |
| **Outcome 1: A streamlined and well supported national response** | | | | | |
| **Outcome 2: Functional coordination structures with requisite mandate and authority to lead and coordinate the national response** | | | | | |
| 3.1.1 Support leadership and capacity development of UAC | a) Strengthen technical, management, human resource and infrastructure capacity of UAC | No. of established technical posts that are filled; % of the activities of the annual work plan successfully completed | Management Review Report. Human Resource Records. Annual Report UAC, staff performance monitoring reports | **OoP** | Sufficient human and financia resources available |
| | b) Review and share UAC coordination modalities | % of Partners having a copy of the UAC coordination modalities document. | Dissemination list. | **OoP** | |
| 3.1.2. Utilize the NSF as guide for program development and basis for resource mobilization and management | a) Map the geographical and programmatic coverage and resource gaps in the national response | Comprehensive and current data on service coverage and gaps | Report on inventory of programmatic coverage | **OoP** | NSF will be disseminated and stakeholders will use it as a guide to progamme planning and implementation |
| | b) Foster partner commitment to implement the NSF through signing Declaration of Commitment | % of stakeholders having signed the Declaration of Commitment | Signed Declaration of Commitment | **OoP** | |
| | c) Disseminate the NSF among stakeholders | % of partners having and using the NSF | Distribution list of the NSF | **OoP** | |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| | d) Create an abridged/popular version of the NSF for widespread distribution throughout Uganda | No. of stakeholders with abridged/popular version of NSF | Survey reports; field observations | **OoP** | |
| 3.1.3 Strengthen the capacity of the HIV/AIDS Partnership to assist UAC in expanding and coordinating the national response | a) Strengthen the operations of the HIV/AIDS Partnership Committee, Forum, and Fund | Functional Partnership Structure | Partnership reports, PC minutes | **OoP** | Partnership concept continues to receive support |
| | b) Support and develop capacity of SCEs to effectively participate in the HIV/AIDS Partnership (e.g., planning, M&E, OD, advocacy, and policy implementation) | % of functional SCEs (e.g., having TORs, work plans, information sharing and consensus making mechanisms) | SCE Annual work plans, SCE reports, SCE meeting minutes | **OoP** | |
| | c) Support participation of PHAs in HIV/AIDS response | No. of implementing agencies involving PHAs in the design, implementation and monitoring of programs | Programme reports | **OoP** | |
| 3.1.4. Strengthen the capacity of districts to coordinate and manage the response | a) Popularise and support the implementation of HIV/AIDS coordination guidelines at district and lower levels | % of districts with functional coordination structures | District and programme reports | **OoP**; MoLG | All districts have necessary resources |
| | b) Support the multisectoral and inclusive participation of all partners in district AIDS coordination structures | % of districts with inclusive and functional DACs and lower level structures | District and programme reports | **OoP**; MoLG | |
| | c) Institutionalise and appoint District Focal Persons. | % of districts with HIV/AIDS FPPs appointed and active | District human resource records | **MoLG** | |
| 3.1.5. Strengthen advocacy for the national multisectoral program | a) Develop and operationalise the advocacy strategy for the national and district level | % of stakeholders having and implementing the advocacy strategy | National advocacy strategy dissemination report; programme reports | **OoP**; MoLG | Advocacy Strategy is publicised and used |
| | b) Empower and sustain leadership commitment to HIV/AIDS action at national, regional and global levels | Leadership index developed | UAC annual report | **OoP** | |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| | c) Promote district participation in international and national advocacy events (e.g., WAC, WAD, Candlelight) | % of districts participating in national and international events | Campaign and event reports | **MoLG**; OoP | |
| | d) Enhance participation in global and regional advocacy, leadership and technical initiatives (e.g., GLIA, Synergies Project, CRHS, EAC, SWAA) | % of stakeholders reporting participating in global and regional advocacy, leadership and technical initiatives. | Stakeholder Reports Inventory | **OoP** | |
| 3.1.6. Sustain and enhance the conducive policy environment for the national HIV/AIDS response | a) Finalise, popularise and support implementation of the various HIV/AIDS policies | % of stakeholders having and utilizing the national and sector policies | Dissemination reports of the policies, Programme reports | **OoP**; **Parliament** | Policies are finalized and released |
| | b) Support policy dialogue to continually identify gaps and ensure harmony in policy implementation | % of stakeholders having and utilizing the national and sector policies | Programme reports | **OoP** | |
| | c) Enhance dialogue with national fiscal and macro-economic policy analysts and policymakers on HIV/AIDS funding | Amount of funds available from Government and development partners. | Funding status reports, resource tracking report | **MoFPED**; OoP | |
| **Objective 3.2: Strengthen the capacity to coordinate and undertake research related to HIV/AIDS at national, district and lower levels** | | | | | |
| **Outcome: Capacity to coordinate and undertake HIV/AIDS related research strengthened** | | | | | |
| 3.2.1.Streamline and strengthen structures for coordinating, planning and conducting research in the area of HIV/AIDS. | a) Develop and support implementation of a national HIV/AIDS research plan and priorities | % of stakeholders having and using the National HIV/AIDS Research Plan. | National Research plan dissemination report | **OoP** | Researchers and research institutions are willing to participate in the national response |
| | b) Commission HIV/AIDS research on identified priorities | % of research topics on priority list addressed. | Research reports | **MoFPED** | |
| | c) Harmonise structures for reporting and documenting on research efforts at all levels | % of research institutions/researchers adhering to the research plan | Research Inventory | **OoP**; MoFPED | |
| | d) Strengthen the protection of legal and ethical rights of research study participants and intellectual property rights of the researchers | No. of researchers adhering to legal and ethical rights guidelines | Survey reports | **MoJCA**; MoFPED | |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| | e) Increase utilization of HIV/AIDS research findings in policy and program development | No. of stakeholders using research findings | Programme reports | **OoP** | |
| 3.2.2 Strengthen the development and trials for microbicides and HIV vaccine | a) Harmonise the National Vaccine Plan with the African Vaccine Plan Guidelines and support its implementation | No. of research institutions having and using the harmonised National Vaccine Plan | Vaccine Plan dissemination report, Vaccine trial reports | **MoH** | Human and financial resource are available; communities ar willing to participate in trials |
| | b) Develop and disseminate a vaccine preparedness strategy | No. of research institutions with and utilizing the Vaccine Strategy Document | National Vaccine Strategy dissemination report | **MoH** | |
| | c) Sensitise stakeholders and communities about ethical issues, progress and participation in microbicide and vaccine development and evaluation | No. of research institutions with knowledge on microbicide and vaccine development | Sensitization programme reports | **MoH** | |
| | d) Support microbicide trials | No. of microbicides trials supported and conducted in Uganda | Study reports | **MoH** | |
| **Objective 3.3: To promote and strengthen capacity to manage strategic information for HIV/AIDS** | | | | | |
| **Outcome 1: Strategic information that informs policy, planning and resource allocation generated , disseminated and utilized** | | | | | |
| 3.3.1. Strengthen the HIV/AIDS surveillance system | a) Support sero-prevalence surveys | Sero-prevalence data widely available for use | Sero-prevalence survey reports | **MoH** | Human and financial resource are available |
| | b) Expand the HIV surveillance system to ensure socio-demographic and district representation | District specific data | Surveillance reports | **MoH** | |
| | c) Enhance capacity to generate and disseminate timely national surveillance data/information | Timely surveillance reports disseminated widely | Programme reports | **MoH** | |
| 3.3.2. Promote and operationalize a coherent national M&E framework for HIV/AIDS | a) Complete, popularise and support implementation of the M&E framework at national and district levels | % of stakeholders using the M&E framework to report on activities | Programme reports | **OoP** | Copies of final M&E framewor disseminated to all partners |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| | b) Strengthen the Country Response Information System | Functional national CRIS database (indicators, resource tracking, research inventory) | CRIS reports | **OoP** | |
| | c) Harmonise partners M&E tools and methodologies to be in line with the national M&E framework | % of stakeholders using harmonised M&E tools | M&E reports | **OoP** | |
| | d) Conduct evaluation studies including the summative evaluation of the NSF | No. of evaluation studies conducted; final evaluation of NSF completed | Evaluation reports | **OoP** | |
| 3.3.3 Expand capacity for HIV/AIDS information and knowledge management at national, district and lower levels | a) Strengthen the system for managing HIV/AIDS information at all levels through a network of information units | % stakeholders supported in information and knowledge management | Progress reports | **OoP** | Financial and human resource available |
| | b) Enhance capacity of UAC to guide and implement knowledge and information management strategies (including AIDS competence tools) for the national and decentralised response | Functional NADIC | UAC reports | **OoP** | |
| | c) Sensitise programme managers, political leaders and all change agents in the use of strategic information. | No. of managers and change agents sensitized | Programme reports | **OoP** | |
| **Objective 3.4: To strengthen HIV/AIDS resource mobilization and management at national,district and lower levels** | | | | | |
| **Outcome 1: Increased and equitable distribution of technical and financial resources for HIV/AIDS activities** | | | | | |
| 3.4.1 Mobilize and manage financial resources for the national response | a) Assess existing funding mechanisms and strategise on harmonising the channelling, allocation and accountability of financial resources | Harmonised funding strategy developed | Resource tracking study report; Strategy document | **OoP** | Donors are willing to fund the national response |
| | b) Build skills of stakeholders in financial resource mobilization and management for stakeholders | % of stakeholders trained in resource mobilisation and management. | Programme reports | **OoP** | |
| | c) Operationalise the national resource tracking system | Functional resource tracking system | Resource tracking database | **OoP** | |

| Strategy | Activity area | Indicators | Means of verification | Responsible Government Sector(s) | Assumptions |
|---|---|---|---|---|---|
| | e) Advocate for increased resource allocation for HIV/AIDS in government budgeting processes at all levels | Amount and % of national funding by government on HIV/AIDS in the last year. | Funding status reports | **OoP** | |
| 3.4.2 Promote utilisation of existing expertise in the country | a) Create and maintain a national database of human resources | No. of HIV/AIDS experts identified and included in the human resource database | Human resource database available | **OoP** | Local expertise is available an willing to participate in the national response |
| | b) Strategise on ways of retaining HIV/AIDS expertise in PNFP/public sector | Turnover rate in PNFP sector | Human resource records | **OoP** | |
| | c) Operationalize the Think Tank concept | Think Tank concept formalised and operationalised | Finalised ToR and meeting minutes | **OoP** | |

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# ANNEX 1: NATIONAL LEVEL INDICATORS FOR HIV/AIDS RESPONSE IN UGANDA

| Indicator | Baseline data | Year of data | Targets for 2005/6 | Sources of Data | Institution Responsible for Data Collection | Frequen |
|---|---|---|---|---|---|---|
| **A. PREVENTION** | | | | | | |
| **Impact** | | | | | | |
| 1. Percentage of pregnant women aged 15-24 years old who are HIV positive | Overall: 4.9%<br>Major Towns: 6.6%<br>Rural: 4.1% | 2002 | Overall: 4.2%<br>Major Towns: 5.6%<br>Rural: 4.1% | ANC Sentinel Surveillance sites | MoH | Annual |
| 2. Percentage of HIV-infected infants born to HIV-infected mothers | 27.0% | 2002 | 18.9% | ANC Sentinel surveillance sites | MoH | Annual |
| **Behaviour Change** | | | | | | |
| 3. Percentage of young people aged 15-24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission | 15-24: Males 40%<br>Females 28%<br><br>15-19: Males 40%<br>Females 26%<br><br>20-24: Males 42%<br>Females 32% | 2000/1 | 15-24:Males 50%<br>Females 50%<br><br>15-19: Males 50%<br>Females 50%<br><br>20-24: Males 50%<br>Females 50% | Population-based surveys | UBOS | 5 years |
| 4. Percentage of young people aged 15-24 years of age with knowledge of two or more programmatically important ways of preventing the sexual transmission of HIV, i.e. abstinence, use of condom and limiting the number of sexual partners | 15-24 : Males 89.6%<br>Females 80.2%<br><br>15-19: Males 63.3%<br>Females 78.1%<br><br>20-24: Males 94.1%<br>Females 82.5% | 2000/1 | 15-24 : Males 97%<br>Females 97%<br><br>15-19: Males 97%<br>Females 97%<br><br>20-24: Males 97%<br>Females 97% | Population-based surveys | UBOS | 5 years |
| 5. Percentage of young people aged 15-24 years reporting the use of a condom during sexual intercourse with a non-regular sexual partner. | 15-24 : Males 61.9%<br>Females 44.3%<br><br>15-19: Males 51.5%<br>Females 49.6%<br><br>20-24: Males 71.0% | 2000/1 | 15-24 : Males 75%<br>Females 60%<br><br>15-19: Males 75%<br>Females 60%<br><br>20-24: Males 75% | Population-based surveys | UBOS | 5 years |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Females 36.9% | | Females 60% | | | |
| 6. Median Age at which young people aged 15-24 had first penetrative sex. | Males: 18.3 years<br>Females: 17.3 years | 2000/1 | Males: 20 years<br>Females: 18 years | Population-based surveys | UBOS | 5 years |
| 7. Ratio of condoms available for distribution to the total population aged 15-49 | 5.1 condoms per sexually active person | 2002 | 8 condoms per sexually active person | Condom availability surveys | MoH and UBOS | Annual |
| 8. Percentage of districts that have at least one centre staffed by trained counsellors providing specialized HIV counselling and testing services free or at affordable rates. | No data currently available | --- | 100% | Health facility surveys | MoH | 5 years |
| 9. Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year. | No data currently available | --- | 50% | School-based surveys | MoES | 5 years |
| **Blood Safety** | | | | | | |
| 10. Percentage of donated blood units in the country found to have HIV virus in the last 12 months | 2.3% | 2002 | 1.2% | UBTS or special surveys | UBTS | Annual |
| **STI Services** | | | | | | |
| 11. Percentage of patients with STIs at selected health facilities who are appropriately diagnosed, treated and counselled according to national guidelines, of all STI patients at those centres | 20.6% | 1998 | 15.5% | STI Facility surveys | MoH | 3 – 5 yea |
| **Prevention of Mother to Child Transmission** | | | | | | |
| 12. Percentage of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of mother to child transmission (MTCT) | 3.9% | 2002 | 25% | Health facility records | MoH | Annual |

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|---|---|---|---|---|---|---|
| **B. MITIGATION AND CARE** | | | | | | |
| **Economic and Material Support to People Living with HIV/AIDS and their Families** | | | | | | |
| 13. Number of families of people living with HIV/AIDS that have benefited from IGAs | No data currently available | --- | 40% | IGA programme reports | MoH | Annual |
| **Orphans and Vulnerable Children** | | | | | | |
| 14. Number of OVC receiving psychosocial support | No data currently available | --- | 40% | OVC programme reports | MoLGSD | Annual |
| 15. Number of OVC receiving food and material assistance | No data currently available | --- | 40% | OVC programme reports | MoLGSD | Annual |
| 16. Ratio of current school attendance among orphans to that among non-orphans, aged 10-14 years | Males: 0.90<br>Females: 1.00<br>Both sexes: 0.95 | 2000/1 | Males: 1.00<br>Females: 1.00<br>Both sexes: 1.00 | Population based surveys | UBOS | 3 - 5 yea |
| **Care and Social Support** | | | | | | |
| 17. Percentage of people living with HIV/AIDS receiving palliative care in the last 12 months | No data currently available | --- | --- | Periodic reports, Population based surveys | MoH | Annual |
| 18. Number of people living with HIV/AIDS who received psychosocial support in the last 12 months | No data currently available | --- | 40% | HIV/AIDS programme reports | MoH | Annual |
| 19. Percentage of people with Advanced HIV infection receiving antiretroviral combination therapy | 6.3% | 2001 | 50% | JCRC and UACP | MoH | Annual |
| 20. Percentage of health care facilities with the capacity to deliver care to People Living with HIV/AIDS | 81.7% | 2002 | 100% | Health facility survey reports | MoH | 5 Years |
| **Rights of People Living with HIV/AIDS** | | | | | | |
| 21. Percentage of 30 largest companies in the country that have HIV/AIDS workplace policies and programmes | No data currently available | --- | 25 out of 30 | Special surveys, UBOS | MGLSD | 5 years |
| **C. NATIONAL CAPACITY** | | | | | | |

| **Leadership** | | | | | | |
|---|---|---|---|---|---|---|
| 22. National Composite Policy Index | 75 of 100 points | 2002 | 85 of 100 points | Assessment inquiry results | UAC | Biennial |
| 23. Amount and percentage of national funds spent by government on HIV/AIDS in the last financial year | Ugshs 2.36 billions (0.11% of total budget expenditure) | 2002-03 Fiscal Year | --- | MoFPED | MOFPED | Annual |
| 24. Percentage of sector/line ministries with strategic and implementation plans that incorporate HIV/AIDS within their mandate | Ministry work plans: 100% Ministries with Strategic Plans: 90.5% | 2002 | Ministry work plans: 100% Ministries with Strategic Plans 100% | Ministry sector plans | UAC | Biennial |
| 25. Percentage of districts with functional District AIDS Committees | 73.2% | 2002 | 100% | DAC reports | UAC | Biennial |
| **Information Base** | | | | | | |
| 26. Percentage of districts with HIV/AIDS resource centre | No data currently available | | 25 – 50% | DDHS offices | UAC | Annual |
| 27.National Index for Information Capacity | No data currently available | | 50 of 100 points | NADIC reports | UAC | Annual |
| **Research Capacity** | | | | | | |
| 28. A comprehensive list of HIV/AIDS research projects completed in the last two years | 103/146 (70.5%) research projects completed | 1997-2002 | 85% | Records from UAC, NCST | UAC | Biennial |

# ANNEX 2: CONTRIBUTORS TO REVIEW AND REVISION OF THE NSF 2003/04-2005/06

**1. Review and Revision overall coordination**

| | |
|---|---|
| Arinaitwe Jim Dr | IPH/CDC/UAC, Makerere University |

**2. Review Lead consultants**

| | |
|---|---|
| External; Sallie Huber Craig Ms | Management Sciences for Health, Boston |
| Internal; Asingwire Narathius Mr | SWSA, Makerere University |

**3 Review theme specific consultants**

| | |
|---|---|
| Adupa Romano Larry Dr | Independent Consultant |
| Bazeyo William Dr | IPH, Makerere University |
| Kamya Moses Dr | IPH/Medical School, Makerere University |
| Konde-Lule Joseph Dr | IPH, Makerere University |
| Kifuko Malinga Brend Ms | Independent Consultant |
| Kyomuhendo Swizen Mr | SWSA, Makerere University |

**4. Revision Lead consultant**

| | |
|---|---|
| Asingwire Narathius Mr | SWSA, Makerere University |

**5. Revision Consultants**

| | |
|---|---|
| Kamya Moses Dr | IPH/Medical School, Makerere University |
| Kyomuhendo Swizen Mr | SWSA, Makerere University |
| Nalwadda Rose Ms | Independent Consultant |

**6. Revision Retreat Team**

| | |
|---|---|
| Arinaitwe Jim Dr | IPH/CDC/UAC, Makerere University |
| Asingwire Narathius Mr | SWSA, Makerere University |
| Kadowe Joyce Ms | UAC |
| Kamya Moses Dr | IPH/Medical School, Makerere University |
| Kifuko Malinga Brend Ms | Independent Consultant |
| Kindyomunda Rosemary Ms | UAC |
| Kintu Chrsitine Ms | UAC |
| Kiwanuka Joseph Mr | SWSA, Makerere University |
| Korukiko Lucy Dr | UAC |
| Kyomuhendo Swizen Mr | SWSA, Makerere University |
| Nalwadda Rose Ms | Independent Consultant |
| Oduka Mary Ms | DCI |
| Ruben del Prado Dr | UNAIDS |
| Rwomushana John Dr | UAC |
| Spilsbury Angela Ms | DFID |
| Tack Inge Ms | UNAIDS |
| Thaddeus Sereen Ms | USAID |

**7. Editorial work on Revised NSF**

| | |
|---|---|
| Sallie Huber Craig | Management Sciences for Health, Boston |

**8. Revised NSF Drafts Review Team**

| | |
|---|---|
| Arinaitwe Jim Dr | IPH/CDC/UAC, Makerere University |
| Asingwire Narathius Mr | SWSA, Makerere University |
| Oduka Mary Ms | DCI |
| Ruben del Prado Dr | UNAIDS |
| Spilsbury Angela Ms | DFID |
| Tack Inge Ms | UNAIDS |

**9. Review and Revision Secretary**

| | |
|---|---|
| Nabbanja Scovia | UAC |

**10. Financial Support**

Government of UGANDA
HIV/AIDS Partnership
DCI
DFID
USAID
DANIDA