



**THE REPUBLIC OF UGANDA**

# **GLOBAL AIDS RESPONSE PROGRESS REPORT**

**COUNTRY PROGRESS REPORT  
UGANDA**



Uganda AIDS Commission

April 2012  
Kampala

## TABLE OF CONTENTS

<b>TABLE OF CONTENTS .....</b>	<b>ii</b>
<b>List of Tables .....</b>	<b>iv</b>
<b>List of Figures.....</b>	<b>v</b>
<b>ACKNOWLEDGEMENTS.....</b>	<b>vi</b>
<b>ACRONYMS.....</b>	<b>vii</b>
<b>1. STATUS AT A GLANCE.....</b>	<b>1</b>
<i>1.1 The Report Writing Process.....</i>	<i>1</i>
<i>1.2 The Status of the Epidemic .....</i>	<i>1</i>
<i>1.3 The Policy and Programmatic Response.....</i>	<i>2</i>
<i>1.4 The Indicator Table.....</i>	<i>4</i>
<b>2.OVERVIEW OF THE AIDS EPIDEMIC.....</b>	<b>6</b>
<i>2.1 HIV Prevalence.....</i>	<i>6</i>
<i>2.2 Incidence of HIV Infection.....</i>	<i>10</i>
<i>2.3 The Impact of the Epidemic .....</i>	<i>11</i>
<b>3. NATIONAL RESPONSE TO THE AIDS EPIDEMIC .....</b>	<b>13</b>
<i>3.1 National Commitment and Action.....</i>	<i>13</i>
3.1.1 Sources of Funds .....	13
3.1.2 Spending of Funds .....	15
<i>3.2 Policy / Strategy Development and Implementation.....</i>	<i>15</i>
3.2.1 Government Officials Assessment.....	15
3.2.2 Non-Government Assessment .....	16
<i>3.3 Prevention .....</i>	<i>17</i>
3.3.1 People Living with HIV .....	17
3.3.2 HCT .....	19
3.3.2 PMTCT .....	20
3.3.3 HIV Prevention Programmes for MARPs .....	25
3.3.4 Knowledge and Behaviour .....	27
<i>3.4 Care and Treatment .....</i>	<i>34</i>
3.4.1 ART .....	34
3.4.2 Tuberculosis and HIV Collaboration .....	36
<i>3.5 Social Support.....</i>	<i>36</i>
3.5.1 Physical and Sexual Violence.....	36
3.5.2 School Attendance among OVCs and Non-OVCs.....	37
3.5.3 Economic Support .....	38
<b>4. BEST PRACTICES.....</b>	<b>40</b>
<b>5. MAJOR CHALLENGES .....</b>	<b>42</b>

5.1 Challenges in UNGASS Report 2010 and Remedial Actions .....	42
5.1.1 Challenges .....	42
5.1.2 Remedial Actions .....	42
5.2 Challenges faced January 2010-December 2011.....	44
5.3 Remedial Actions January 2012-December 2013 .....	46
<b>6. SUPPORT FROM DEVELOPMENT PARTNERS .....</b>	<b>48</b>
6.1 Key Support from AIDS Development Partners .....	48
6.2 Actions Needed from AIDS Development Partners .....	50
<b>7. MONITORING AND EVALUATION ENVIRONMENT .....</b>	<b>52</b>
7.1 Overview of Current Monitoring and Evaluation System.....	52
7.2 Challenges in Implementation of Monitoring & Evaluation System .....	52
7.3 Planned Remedial Actions.....	53
7.5 M&E Technical Assistance and Capacity Building Needed .....	53
<b>ANNEXES .....</b>	<b>54</b>
Annex 1: Consultation / Preparation Process .....	54
Annex 2: National Commitments and Policy Index (NCPI) .....	57
Part A .....	57
Part B.....	58
Annex 3: National Funding Matrix.....	59
<b>REFERENCES.....</b>	<b>60</b>

**List of Tables**

Table 1: National Policies and Guidelines produced, 2010-2011 .....	3
Table 2: Global AIDS Response Progress Indicators .....	4
Table 3 : Trends in HIV incidence 2007–2010 using mathematical modelling .....	10
Table 4: Trends in People Living with HIV2007–2010 using mathematical modelling .....	11
Table 6: Projection Figures using Spectrum Model .....	23
Table 7: Annual Procurement and Distribution of Male Condoms in Uganda, 2007/08-2010/11	33
Table 8: Distribution of ART Accredited Sites by Level, 2010 and 2011 .....	35
Table 9: Distribution of Clients on ART after 12 Months of Treatment Initiation .....	35
Table 10: Contribution of Development Partners to AIDS Response .....	48
Table 11: Committed donor contributions (USD) to the Civil Society Fund, 2007/08-2011/12 ..	49
Table 12: Contribution to Partnership Fund by Bilateral Agencies .....	50

## List of Figures

Figure 1: Trend in HIV Prevalence in Uganda, 1991-2010 .....	6
Figure 3: Median HIV prevalence of ANC attendees from major towns and outside, 1989- 2009	7
Figure 2: HIV Prevalence in Uganda by age groups, 2004/5-2011 .....	7
Figure 4: Regional Variation in Prevalence of HIV, 2004/05 and 2011.....	8
Figure 5: Transition in HIV Prevalence among Regions, 2004/05-2011.....	8
Figure 6 : HIV Prevalence among Most at Risk Populations in Uganda, 2009-2010 .....	9
Figure 7 : HIV Prevalence by Wealth Quintile, 2004/05 and 2011 .....	10
Figure 8: Funding of the National AIDS Response .....	13
Figure 9: Sources of Funds for National Response 2008/9 and 2009/10.....	14
Figure 10: Government Officials' Ranking of Key Components of NCPI, 2005-2011 .....	16
Figure 11: Civil Society and Other Key Stakeholders' Ranking of Key Components of NCPI, 2005-2011 .....	16
Figure 12: Prevalence by Gender age 15-24 .....	18
Figure 13: Change in Prevalence of HIV among the same Age Groups between 2004/05- 2011	18
Figure 14: Prevalence of HIV among Sex Workers .....	19
Figure 15: Percentage Men and Women who received HIV Test Results, 2004/05-2011 .....	19
Figure 16 : Percentage Distribution of people who received HIV Test Results by Age Groups ..	20
Figure 17: Women and Babies Cascading through the PMTCT Services, 2009 and 2010 .....	21
Figure 18: Access to ART services.....	22
Figure 19: Prevalence of HIV among Exposed Children.....	23
Figure 20: PMTCT Projections, 1995-2015.....	24
Figure 21: Access to HIV/AIDS Services by MARPs in Uganda.....	25
Figure 22: Use of Condoms by Sex Workers .....	27
Figure 23: Comprehensive Knowledge of HIV/AIDS by gender.....	28
Figure 24: Comprehensive knowledge by age groups .....	29
Figure 25: Sexual Intercourse among Young People by Age 15 by Gender, 2004/05-2006 .....	30
Figure 26: Sexual Intercourse among Youths before Age 15 by Age Groups, 2004/5 - 2006 .....	30
Figure 27: Percentage of men and women who had sexual intercourse with 2+ partners .....	31
Figure 28: Percentage of people who had 2+ partners in past 12 months by age groups .....	32
Figure 29: Percentage People with 2+ partners using condom during last sexual intercourse by Gender .....	33
Figure 30: Percentage People with 2+ partners using condom during last sexual intercourse by Age Groups.....	33
Figure 31: Eligible adults and children receiving ART .....	35
Figure 32: Sexual and Physical Violence.....	37
Figure 33: School Attendance among OVCs and Non-OVCs .....	38
Figure 34: Support Provided to OVCs, UDHS-2006.....	39
Figure 35: Resource allocation under PEPFAR .....	49
Figure 36: Utilization of CSF in the AIDS Response .....	50

## **ACKNOWLEDGEMENTS**

This country report on the progress made in the national response between January 2010 and December 2011 highlights the achievements, challenges and best practices under the various thematic areas of HIV prevention, care and treatment and impact alleviation as contained in both the guidelines for global reporting and indeed in the Nationals Strategic Plan 2007/08 -2010/12.

The report was compiled through an inclusive consultative and participatory process involving desk reviews and extensive consultations with key HIV/AIDS stakeholders in both the public and non-public sector. The process was supported by the National HIV/AIDS Monitoring and Evaluation Technical Working Group. The report writing process was guided by Uganda AIDS Commission and The Joint United Nations Programme on HIV and AIDS.

This document therefore is a product of wide consultation with key stakeholders in the country to ensure that what is contained in it is not only factual, balanced and helpful to our course as a nation but is also representative of the major efforts and challenges of the key stakeholders' in the multi-sectoral response to the epidemic in the period reported. On this note, I wish to express my sincere thanks all the partners that provided financial, material and technical support for producing the Report.

I would also like to take this opportunity to convey our great appreciation to all the stakeholders in the national response including government line ministries and sectors, district local governments, civil society, private sector, bilateral and multi-lateral agencies and UN organizations that have been active in the implementation of the NSP and without whose contributions to the response there would have been very little to report. In particular, I would like to thank UNAIDS for providing financial and technical support during the report preparation process.

Lastly, I would like to thank enormously Dr Romano Larry Adupa (Team Leader) and Mr Mathias Mulumba who compiled this Report.

Dr. David Kihumuro Apuuli  
**Director General, Uganda AIDS Commission**

## ACRONYMS

ACT	Artemisinin Combination Therapy
ADPs	AIDS Development Partners
AIC	AIDS Information Centre
ANC	Ante-Natal Care
ART	Anti-retroviral Therapy
ARVs	Antiretroviral Drugs
CBOs	Community-Based Organizations
CBVs	Community-Based Volunteers
CD4	Cluster of Differentiation 4
CDC	Centres for Disease Control and Prevention
CDR	Case Detection Rate (for TB)
CICC	Civil Society Inter-constituency Coordinating Committee
CICT	Client Initiated HIV Counseling and Testing
CPHL	Central Public Health Laboratory
CR1	Central Region 1
CR2	Central Region 2
CSF	Civil Society Fund
CSOs	Civil Society Organizations
DACs	District HIV&AIDS Committees
DANIDA	Danish International Development Authority
DfID	Department for International Development (UK)
DOTS	Directly Observed Therapy, short course
EID	Early Infant Diagnosis
FBO	Faith Based Organization
FGDs	Focused Group Discussion(s)
FY	Financial Year
GF	Global Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoU	Government of Uganda
HAART	Highly Active Antiretroviral Therapy
HBC	Home Based Care
HBHCT	Home Based HIV Counselling and Testing
HBHCT	Home Based HIV Counseling and Testing
HC	Health Center
HCT	HIV Counseling and Testing
HMIS	Health Management Information System
HRH	Human Resources for Health
HSSIP	Health Sector Strategic and Investment Plan
HTC	HIV Testing and Counselling
ICF	Intensified Case Finding (for TB)
IDU	Intravenous drug users
IEC	Information, Education and Communication
IGAs	Income-Generating Activities
JAR	Joint AIDS Annual Review
JUPSA	Joint UN Programme for AIDS
KC	Kampala City
KII	Key Informant Interview
KIs	Key Informants
LTFU	Lost to Follow Up

M&E	Monitoring and Evaluation
MARPs	Most At Risk Populations
MDGs	Millennium Development Goals
MDR	Multiple Drug Resistance
ME	Mid Eastern
MN	Mid Northern
MoGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
MOT	Modes of Transmission Study
MOU	Memorandum of Understanding
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
MTR	Mid-Term Review
MW	Mid Western
NAFOPHANU	Forum of PHA Networks in Uganda
NDP	National Development Plan
NDP	National Development Plan
NE	North Eastern
NGO	Non-Governmental Organization
NPAP	National Priority Action Plan
NSP	National Strategic Plan
NSP	National Strategic Plan (for HIV&AIDS)
OVC	Orphans and other Vulnerable Children
PCR	Polymerase Chain Reaction
PEPFAR	US Presidential Emergency Fund for AIDS Relief
PEs	Peer Educators
PHA	People Living with HIV&AIDS
PIASCY	President's Initiative on AIDS Strategy for Communication to Youth
PICT	Provider Initiated HIV Counseling and Testing
PITC	Provider Initiated Testing and Counselling
PMMP	Performance Measurement and Management Plan
PMTCT	Prevention of Mother To Child Transmission (of HIV)
PWDs	Persons with Disabilities
PWP	Prevention With Positives
SCE	Self-Coordinating Entity
SdNVP	Single Dose Nevirapine
SGBV	Sexual and Gender Based Violence
SMC	Safe Male Circumcision
SRH	Sexual and Reproductive Health
STAR-EC	Strengthening TB and HIV&AIDS Responses in East Central Uganda
STI	Sexually Transmitted Infections
SW	South Western
SWs	Sex Workers
TASO	The AIDS Support Organization
TB	Tuberculosis
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UAIS	Uganda AIDS Indicator Survey
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey



UHSBS	Uganda HIV&AIDS Sero-Behavioral Survey
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UNAIDS	The Joint United Nations Programme on HIV&AIDS
UNASO	Uganda Network of AIDS Support Organizations
UNDP	United Nations Development Programme
UNFPA	United Nations Family Planning Association
UNGASS	United Nations General Assembly Special Session
UPE	Universal Primary Education
USAID	United State Agency for International Development
USE	Universal Secondary Education
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WN	West Nile
YEAH	Young Empowered and Healthy

## **1. STATUS AT A GLANCE**

### **1.1 The Report Writing Process**

This report was compiled using information from three sources, namely, reports on Mid-term Review (MTR) of National Strategic Plan (NSP) 2007/08-2011/12, recent National Surveys reports<sup>1</sup> and Administration of National Commitments and Policy Instrument (NCPI) Questionnaires<sup>2</sup>. The MTR had been conducted in 2011 during which information was collected, analyzed and consolidated from program reports, annual performance reviews and annual surveys covering the period 2007/08-2009/10; these were supplemented with those from national and district level consultations including key informant interviews, focus group discussions and meetings. That review culminated in a Joint Annual AIDS Review Conference where consensus was built and a Revised National Strategic Plan 2011/12-2014/15 was endorsed. In addition to integrating up-dates of national statistics from program reports for period 2010/2011 which had not been covered in NSP MTR, the national surveys whose findings have been integrated in this report are the Uganda AIDS Indicator Survey (UAIS) 2011, Uganda Demographic and Health Survey (UDHS) 2011 and the National AIDS Spending Assessment (NASA) 2011.

The NCPI report data gathering and validation involved desk reviews, consultations with public sector agencies, civil society organization (CSO) networks and bilateral agencies, United Nations (UN) organizations and other development partners during which the questionnaire Part A (for Government) and Part B (for CSOs, Bilateral Agencies and UN Organisations) were self administered by the targeted respondents as indicated in Annex I. Questionnaires were synthesized by the consultants and the generated draft report was first reviewed by the National HIV/AIDS Monitoring and Evaluation (M&E) Technical Working Group (TWG) and finally validated at a national stakeholder's workshop.

The report writing process was guided by Uganda AIDS Commission (UAC) and The Joint United Nations Programme on HIV and AIDS (UNAIDS) and the M&E-TWG. A workshop was held (March 21, 2012) to discuss the first Draft Report and the comments and observations made by participants were incorporated and a second draft was discussed during the Validation Workshop held on March 23, 2012. The stakeholders included a wide cross-section of participants from central and local governments, development partners, faith based organizations, private sector and media, national and district based NGOs/CBOs; the PHAs were represented by NAFOPHANU.

### **1.2 The Status of the Epidemic**

In Uganda, the national average adult HIV prevalence reduced from a high of 18.5 % in 1992 to about 5% in 2000 due to, among other reasons, strong political leadership, open approach to combating the epidemic and a strong multi-sectoral, decentralised and community response. In 2004/05, the prevalence had reached 6.4%. However, the UAIS 2011 reported an increase in

---

<sup>1</sup> National AIDS Indicator Survey 2011, Uganda Demographic and Health Survey 2011 and National AIDS Spending Assessment 2011

<sup>2</sup> Was previously called National Composite Policy Index.

prevalence to 6.7%. Thus, (a) Uganda's epidemic is generalized (b) has stabilized in the last 5 years but (c) the level of prevalence is still unacceptably high.

To-date, more women than men are infected as the prevalence among women in age group 15-49 is 7.7% while that of men is 5.6%. Although the youths in age group 15-19 have only 2% prevalence, the peak in prevalence of the epidemic is among those in the age group 35-39 at 10.3%. There is also regional<sup>3</sup> variation with the highest prevalence at 10.7% found in Central Region 1 while the lowest is at 3.7% for Mid Eastern region.

The epidemic is still predominantly heterosexually transmitted with 80% of infections attributable to heterosexual transmission. Mother to child transmission accounts for 20% while blood borne and other infections account for less than 1%. The Mode of Transmission Study (MOT) study<sup>4</sup> indicated that the risk factors responsible for the spread of HIV transmission are of two types, namely, modifiable and non-modifiable. The modifiable risk factors comprise of multiple partnerships, HIV sero-discordance, inconsistent condom use, infection with sexually transmitted infections (STIs) especially HSV-2, and lack of male circumcision<sup>5</sup> while the non-modifiable factors include urban residence, older age, being married or formerly married, being female, and residence in northern Uganda, implying the need for focused interventions among these groups. The UAIS indicated that comprehensive knowledge of HIV/AIDS is at 33.8% for women in age group 15-49 and 41.1% for men in the same group. Women who know that HIV can be transmitted by breastfeeding and risk of mother to child transmission (MTCT) can be reduced by mother taking special drugs during pregnancy is 65.2% while only 55.7% of the men are in the know. Circumcision stands only at 23.6% among men in age group 15-49.

The National HIV Prevention Strategy 2010 documented that an estimate 1.2 million people in Uganda are HIV infected, of whom 57% are females and 13% children aged less than 15 years. On the other hand, cases of new infection were estimated at 124,000.

### **1.3 The Policy and Programmatic Response**

The period 2010 and 2011 could be taken as time in which the national efforts to combat HIV/AIDS were re-launched. Thus, UAC Board was re-constituted by the President of Uganda while the National HIV and AIDS Policy was developed and disseminated. During the period, the NSP was reviewed and on World AIDS Day 2011, the President of Uganda launched the revised NSP that is expected to re-invigorate the fight against the epidemic. The revised NSP with the goals to (a) reduce HIV incidence by 30% by 2015 (b) improve the quality of life of PLHIV by mitigating the health effects of HIV/AIDS by 2015 (c) improve the level of access of

---

<sup>3</sup> The ten regions of Uganda are Central 1: Kalangala, Masaka, Mpigi, Rakai, Sembabule, Wakiso and Lyantonde; Central 2: Kiboga, Luwero, Mubende, Nakasongola, Mityana, Mukono, Nakaseke and Kayunga; Kampala: Kampala; East Central: Bugiri, Iganga, Jinja, Kamuli, Mayuge, Kaliro and Namatumba; Mid Eastern: Busia, Kapchorwa, Mbale, Pallisa, Sironko, Tororo, Bududa, Manafwa, Butaleja, Budaka and Bukwa; North East: Kaberamaido, Katakwi, Kotido, Kumi, Moroto, Nakapiripirit, Soroti, Abim, Kaabong, Amuria and Bukedea; Mid Northern: Apac, Gulu, Kitgum, Lira, Pader, Amuru, Oyam, Amolatar and Dokolo; West Nile: Adjumani, Arua, Moyo, Nebbi, Yumbe, Koboko and Nyadri; Mid Western: Bundibugyo, Hoima, Kabarole, Kamwenge, Kasese, Kibaale, Kyenjojo, Masindi and Buliisa; South Western: Bushenyi, Kabale, Kanungu, Kisoro, Mbarara, Ntungamo, Rukungiri, Ibanda, Isingiro and Kiruhara.

<sup>4</sup> MOT (2008). Uganda HIV Modes of Transmission and Prevention Response Analysis

<sup>5</sup>Mermin J, Musinguzi J, Opio A, Kirungi W, et al. Risk factors for recent HIV infection in Uganda. JAMA 2008 Aug 6;300(5):540-9.

services for PLHIV, OVC and other vulnerable populations by 2015 and (d) build an effective and efficient system that ensures quality, equitable and timely service delivery by 2015, represents a new compact of national commitment in responding to the epidemic. In the same period too, noting that prevention is the core stone for the national response, the national prevention strategic plan and eight sector prevention strategic plans were developed and launched. In general, during the period 2010 and 2011, many policy documents and guidelines developed and disseminated are shown in Table 1. Thus, these policies, plans and guidelines will not only maintain and indeed increase the momentum already achieved in the national response but will also improve on the country's chance of realizing its vision of a population free of HIV and its effect. In general, the implementation of most of the policies were started in 2011.

**Table 1: National Policies and Guidelines produced, 2010-2011**

POLICIES DEVELOPED	POLICIES / GUIDELINES REVIEWED
<ol style="list-style-type: none"> <li>1. Second National Health Policy, 2010</li> <li>2. National HIV/AIDS policy, 2011</li> <li>3. Safe Male Circumcision Policy, 2010</li> <li>4. Public Private Partnership for Health Policy, 2010</li> <li>5. HIV/AIDS Workplace Policy (MoIA), 2010</li> <li>6. Nutrition Policy - policy on infant and young child feeding, 2010</li> <li>7. Care and Treatment policy, revised 2011</li> <li>8. Uganda Antiretroviral Treatment Policy, 2011</li> <li>9. Home Based Care Policy, 2011</li> <li>10. HIV/AIDS Policy for the Roads Sub-Sector, 2010</li> </ol>	<ol style="list-style-type: none"> <li>1. HIV Counselling and Testing Policy, 2011</li> <li>2. Infant and Young Feeding Policy, 2011</li> <li>3. Integrated ART Guidelines for Feeding 2011</li> </ol>
	BILLS INITIATED / PROCESSED
	<ol style="list-style-type: none"> <li>1. Marriage and Divorce Bill, 2010</li> <li>2. HIV Prevention and AIDS Control Bill 2010</li> </ol>
BROADER PLANS	HIV/AIDS RELATED SECTOR PLANS
<ol style="list-style-type: none"> <li>1. National HIV/AIDS Strategic Plan 2011/12-2014/15</li> <li>2. National Prevention Strategic Plan 2010/11-2014/15</li> <li>3. Health Sector Strategic and Investment Plan 2010/11-2015/16</li> </ol>	<ol style="list-style-type: none"> <li>1. Health Sector HIV/AIDS Strategic Plan 2010/11-2014/15</li> <li>2. Sector HIV Prevention Strategic Plans 2010/11-2014/15: MOES, MOPS, MOGLSD, MAAIF, MOWT, MOIA (Prisons)</li> <li>3. National Health Laboratory Services Strategic Plan 2010-2015</li> <li>4. National Condom Strategy, 2011</li> <li>5. Scale-up Plan for Prevention of MTCT of HIV and Care of Exposed Infants 2010-2015</li> </ol>

## 1.4 The Indicator Table

The main sources of data used in filling the Global AIDS Response Progress Indicator Table shown below were (a) AIDS Indicator Survey Report 2011 (b) Demographic and Health Survey Report 2011 (c) National AIDS Spending Assessment Report 2011.

**Table 2: Global AIDS Response Progress Indicators**

TARGET / INDICATOR	2010	2011	COMMENTS
<b>Target 1: Reduce sexual transmission of HIV by 50 per cent by 2015</b>			
1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission		Women 36.7% Men 37.8%	UAIS
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15		No Data	Pending analysis of UAIS
1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months		Women 2.9% Men 17.8%	UAIS
1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse		Women 15.7% Men 13.3%	UAIS
1.5 Percentage of women and men aged 15–49 who received an HIV test in the past 12 months and know their results		No Data	Pending analysis of UAIS
1.6 Percentage of young people aged 15-24 who are living with HIV		Women 4.4% Men 1.9%	UAIS
1.7 Percentage of sex-workers reached with HIV prevention programmes		No Data	
1.8 Percentage of sex workers reporting the use of a condom with their most recent client		No Data	
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results		No Data	
1.10 Percentage of sex workers who are living with HIV		No Data	
1.11 Percentage of men who have sex with men reached with HIV prevention programmes		No Data	
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner		No Data	
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results		No Data	
1.14 Percentage of men who have sex with men who are living with HIV		No Data	
<b>Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015</b>			
2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes		No Data	
2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse		No Data	
2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected		No Data	
2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results		No Data	
2.5 Percentage of people who inject drugs who are living with HIV		No Data	
<b>Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths</b>			
3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	ART 73% Combination 49% HAART 18% Sd NVP 33%	ART 86.2% Combination 35% HAART 19% AZT 49%	
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	43.5%	40.2%	
3.3 Mother-to-child transmission of HIV (modelled)			No breakdown
<b>Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015</b>			
4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy		54.3%	MOH
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	83.6%	84.1%	

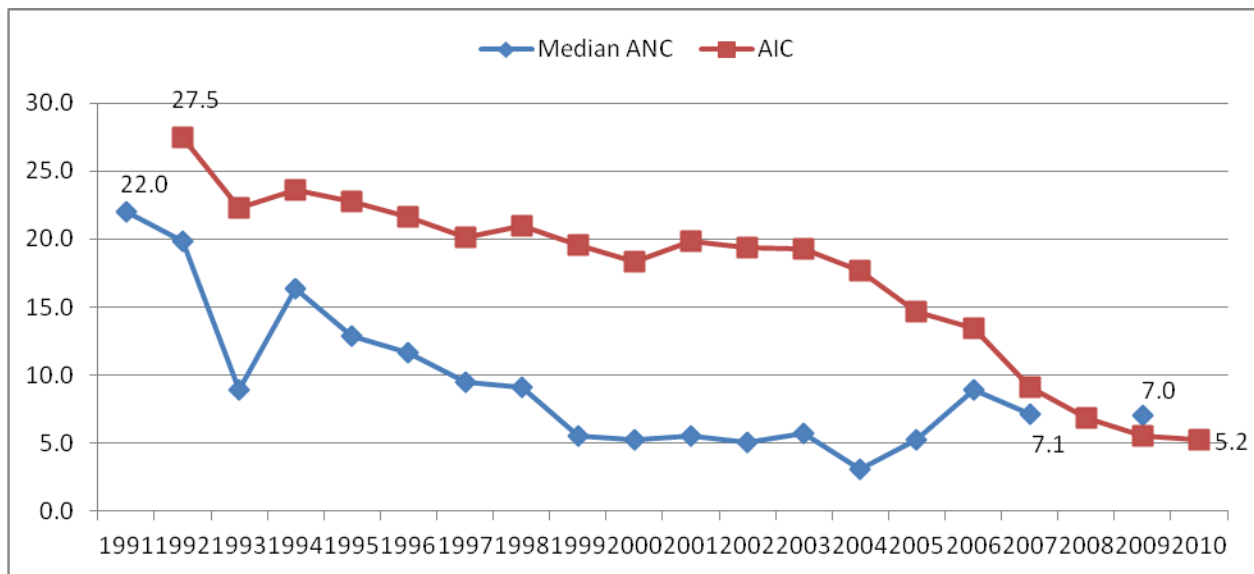
*Global AIDS Response Progress Report: Uganda Jan 2010-Dec 2012*

TARGET / INDICATOR	2010	2011	COMMENTS
<b>Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015</b>			
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV			
<b>Target 6: Reach a significant level of annual global expenditure (US\$22-24 billion) in low- and middle-income countries</b>			
6.1 Domestic and international AIDS spending by categories and financing sources			
<b>Target 7: Critical enablers and synergies with development sectors</b>			
7.1 National Commitments and Policy Instruments (NCPI) (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)			See Annex
7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months		No data	
7.3 Current school attendance among orphans and non-orphans aged 10-14		No data	
7.4 Proportion of the poorest households who received external economic support in the past 3 months		No data	

## 2.OVERVIEW OF THE AIDS EPIDEMIC

### 2.1 HIV Prevalence

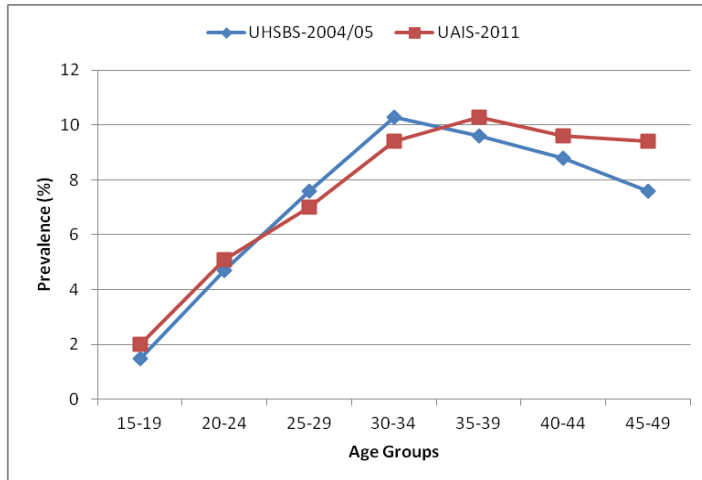
**Trend:** Data from Ante natal clinic (ANC) sentinel sites and those from AIDS Information Centre (AIC) indicate that generally, there has been a general decline in trend of HIV prevalence in the country from a high of between 22.0% and 27.5% in early 1990’s to a low of between 5.2% and 7% in the population as indicated by median ANC prevalence among pregnant women attendees and prevalence among AIC attendees (Figure 1). This has been corroborated by data from the UHSBS 2006 and UAIS 2011 which indicated that the prevalence was at 6.4% and 6.7% in 2004/05 and 2011 respectively; this difference in prevalence of HIV however is not statistically significant.



**Figure 1: Trend in HIV Prevalence in Uganda, 1991-2010**

**Prevalence by Sex and Age:** In Uganda, the prevalence of HIV is generally higher among women than men; in 2004/05 it was 7.5% for women and 5.0% for men but in 2011 it had increased and remained still higher at 7.7% for women and 6.7% for men. While still comparing the prevalence in 2004/05 and 2011, it is clear that (a) prevalence has decreased among adults in the age 25-34 but increased among those in 15-24 and 35-49 age groups (b) the peak in prevalence was among adults in age group 30-34 in 2004/05 but has shifted to those in age group 35-39 by 2011.

Figure 2: HIV Prevalence in Uganda by age groups, 2004/5-2011



**Prevalence by Residence and Region:**

There is also an urban-rural disparity in HIV prevalence in Uganda with prevalence in major urban areas being higher than that in areas outside major urban locations. This urban-rural disparity has remained consistent throughout the years 1997-2009 as illustrated with the only available data from MOH (Figure 3). However, there is also an apparent decline in prevalence between 1997 and 2009 with rural areas showing a greater overall decline (70%) than urban areas (65%), the reduction in rural areas was from 10% to 7% compared to that in the urban areas from 13% to 8.4%.

rural areas was from 10% to 7% compared to that in the urban areas from 13% to 8.4%.

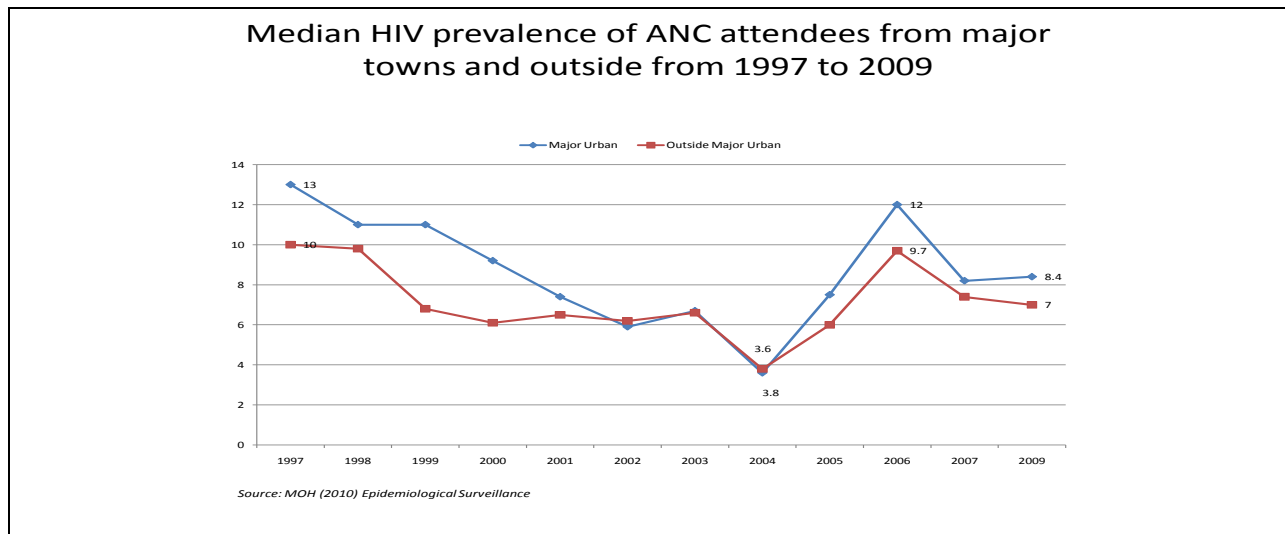


Figure 3: Median HIV prevalence of ANC attendees from major towns and outside, 1989- 2009

During the period 2005 and 2011, there has also been changes in the level of prevalence of HIV in the different regions. Thus, while in Kampala (KC), Mid Eastern (ME), Mid Northern (MN) and East Central (EC) regions there were reductions in prevalence between 2004/05 and 2011, in the other regions, there was instead an increase in prevalence (Figure 4 ).



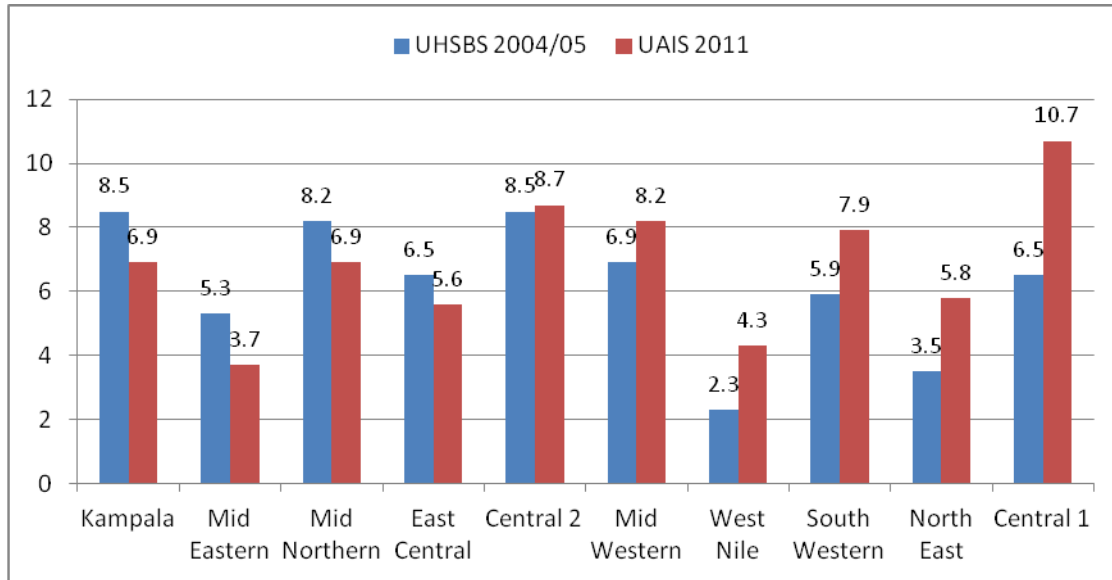
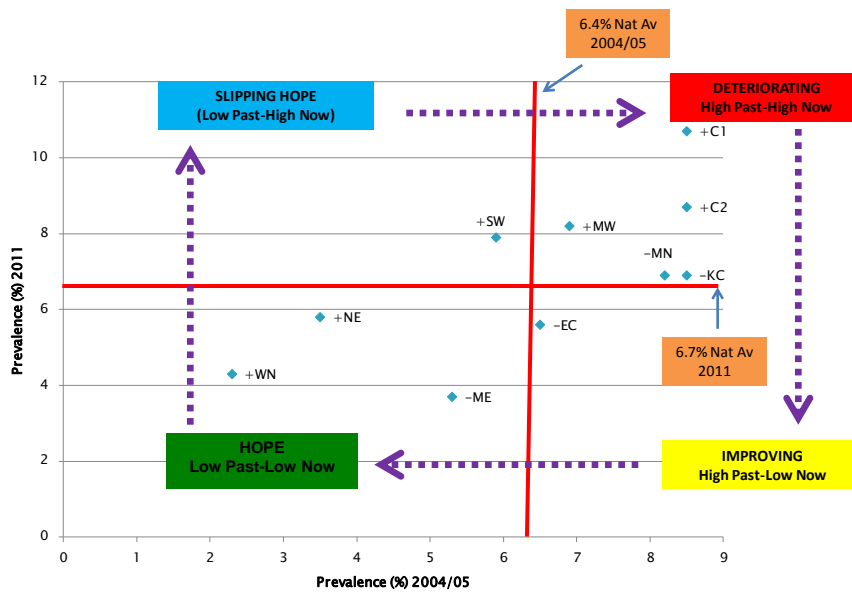


Figure 4: Regional Variation in Prevalence of HIV, 2004/05 and 2011

A closer look at the levels of HIV in the nine regions (Figure 4) shows that only East Central (EC) region has improved during period because it had prevalence above the national average of 6.4% in 2004/05 but now is below the current 6.7%. On the other hand, while taking cognizance of the change in a given region between 2004/05 and 2011, Kampala, Central regions 1 and 2 as well as Mid Western (MW) and Mid Northern (MN) regions have remained above the national average level in both periods of the surveys. Only West Nile (WN), North Eastern (NE) and Mid Eastern (ME) have consistently remained below the national average in the two surveys, i.e. despite the prevalence of HIV increasing or decreasing during the period, they have remained stable in this category of relatively low prevalence.

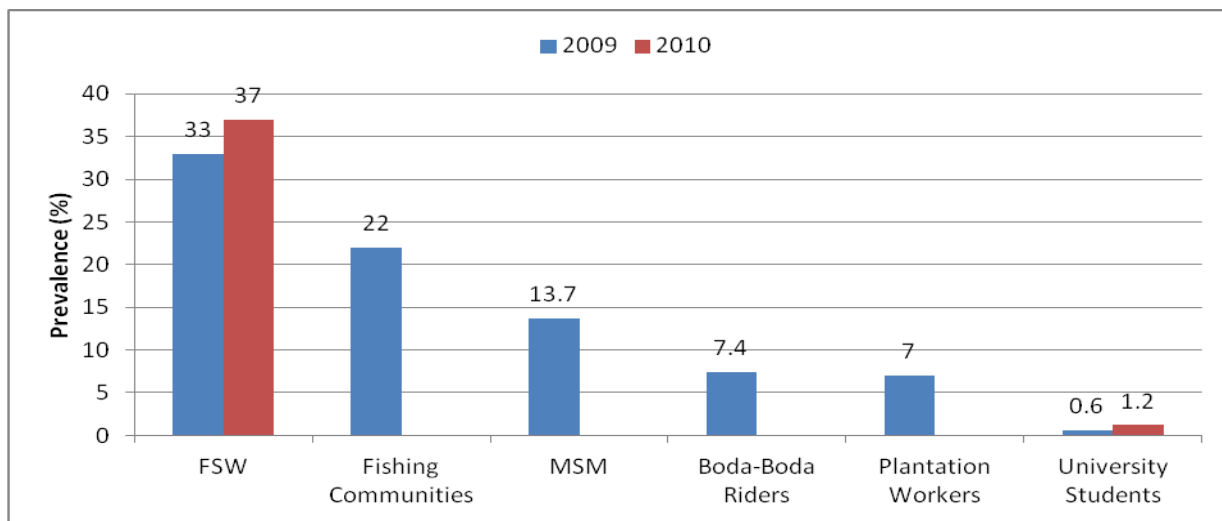


Note: + Means prevalence has increased between 2004/05 and 2011; - means it has decreased

Figure 5: Transition in HIV Prevalence among Regions, 2004/05-2011

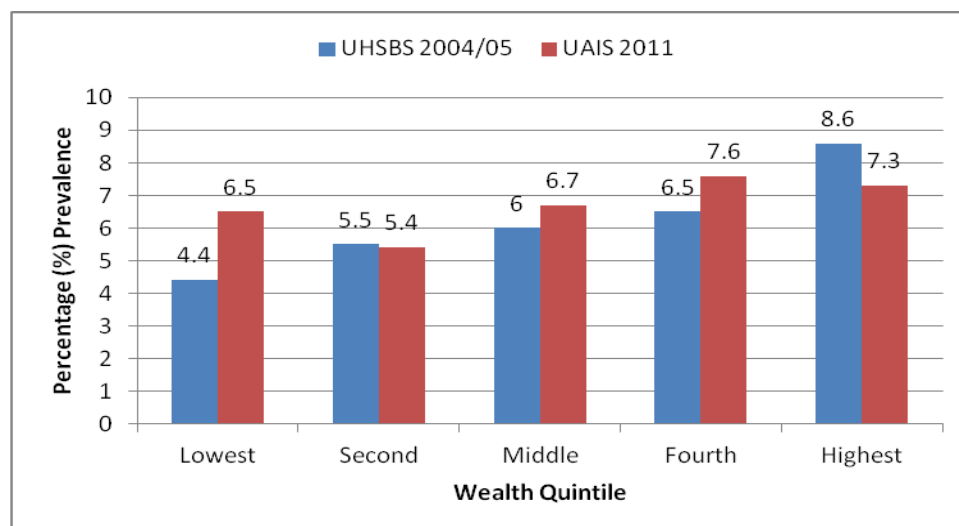
**Prevalence by Categories:** The NSP and Performance Measurement and Management Plan (PMMP) defined most-at-risk populations (MARPs) as female sex workers (FSW), fishing communities, uniformed services, internally displaced persons (IDPs), mobile populations and migrant workers as well as persons living with disability (PWD). There is no data available for most of these MARPS. However, available data on some of them indicate that the highest prevalence was recorded among FSWs, fishing communities, Men having sex with men (MSM), boba-boda men and plantation workers. In particular, the Crane Survey of 2010 found that HIV prevalence was 33% among FSWs and 18% among partners of FSWs; another study by the Medical Research Council among 1,027 FSWs in Kampala (conducted between April 2008 and May 2009) had found that HIV prevalence was 37% among the FSW surveyed, with HIV prevalence increasing with age from 29% among those aged <25 years to 48% among those aged 35 or more years. Data collected by MOH through its STD Clinic at Mulago Hospital in Kampala shows that the prevalence of HIV among the 1,000 members that constitute the CSW cohort was at 35% in 2011.

A sero-behavioral study conducted among (a) 911 participants in 46 fishing communities in Lake Victoria Basin of Uganda in 2010 found HIV prevalence to be 22% among those surveyed and (b) 1,432 men and women interviewed at four agricultural plantations in 2010 found 7% of the plantation workers were infected with HIV. The Crane Study found that the prevalence of HIV was 13.7% among MSMs; it was 7.4% among boda boda riders who are constituted primarily by male youths. University students had the lowest HIV prevalence of 0.6% (Crane Survey, 2010) although this rate was noted to be 1.2% in another HIV/AIDS sero-behavioral survey conducted among 3,718 students randomly selected from six Universities in Uganda (Makerere University, Gulu University, Kampala International University, Islamic University in Uganda, Mbarara University of Science and Technology and Uganda Christian University, Mukono), the highest prevalence was noted in Gulu (1.8%) and the lowest in Mbarara University (0.4%). Collectively, these findings suggest that FSWs, partners of FSWs, MSM, boda-boda riders, people living in fishing communities, and plantation workers are at an elevated risk of HIV infection compared to the rest of the sexually active Uganda population and students are lower than the national average or even age group national average.



**Figure 6 : HIV Prevalence among Most at Risk Populations in Uganda, 2009-2010**

**Prevalence by Status** The surveys of 2004/5 and 2011 indicate that infection rates tend to increase with the level of wealth. Thus, the adults in the population in the lowest quintile have prevalence below the national average. However, those in the fourth and fifth quintile have their prevalence above the respective national prevalence levels.



**Figure 7 : HIV Prevalence by Wealth Quintile, 2004/05 and 2011**

Regarding marital status, the prevalence decreased in all categories except among those that were divorced/separated or not in a union/never married between 2004/05 and 2011. Thus it decreased from 31.4% to 30.7% for those widowed and from 6.3% to 4.1% for those currently married/in union while it increased from 13.9% to 16.3% for those divorced/separated and from 1.6% to 2.7% for those never married/in a union between the two survey periods.

## 2.2 Incidence of HIV Infection

**New Cases of HIV infection:** Recent estimates as is shown in the table below indicate that the annual number of new HIV infections in the country (i) increased by 11.4% from 115,775 in 2007/08 to 128,980 in 2009/10 and (ii) rose among adults by 16.4% during this period although there was a 6.2% decline in new infections among children <15 years of age, most likely because of improvements in PMTCT uptake. The number of new HIV infections in 2010 also indicated that apart from the rate being the fourth highest number of all 53 countries in Africa, it also suggested that every hour in Uganda around 15 people were newly infected with HIV and hence permanently sero-converted.

**Table 3 : Trends in HIV incidence 2007–2010 using mathematical modelling**

Indicator	Population	December 2007	December 2008	December 2009	December 2010
People newly infected with HIV	Total	115,775	119,258	124,261	128,980
	Adults	87,727	91,967	97,163	102,157
	Women	49,566	51,948	54,873	57,685
	Children < 15 yrs	25,746	24,878	24,548	24,142

Source: MoH Estimation and Projections Group, 2010

**Transmission of HIV Infection:** Uganda’s HIV epidemic is still predominantly heterosexually transmitted (80% of infections), and vertical infections accounting for 20% while blood borne and other modes of transmission probably account for less than 1%<sup>6</sup>. According to the Mode of Transmission studied carried out in 2008, it was found that (a) most of the new infection are in the context of stable long term partnerships, driven in part by multiple (especially concurrent) partnerships, extra-marital relations, and transactional, early and cross generational sex and (b) the drivers of the HIV epidemic include behavioural, socio-economic and structural factors.

- Behavioural factors include multiple sexual partnerships, cross-generational, early and transactional sex and sex work, alcohol and substance abuse
- Socio-economic factors include harmful socio-cultural practices, gender norms, gender-based violence, violation of rights of women and girls, polygamy, widow inheritance, inability to negotiate for safer sex by women etc; other factors that relate to economy are mobility, migrant work, poverty and wealth
- Structural factors are policy related issues that comprise of: inequitable access to health services, governance, accountability, coordination, and stigma and discrimination.

By operating at distal level to influence the proximate risk factors for HIV infection, these complex and intertwined factors shape or constrain individual behaviour such as condom use, number of sexual partners, comprehensive knowledge about HIV/AIDS, uptake of HIV/AIDS services including IEC/BCC communication, HCT, PMTCT, ART services etc, and therefore act as barriers to the effectiveness of individual-level behavioral interventions that should normally protect oneself from infection.

## 2.3 The Impact of the Epidemic

**People Living with HIV/AIDS:** Ministry of Health estimated that there were 1,140,739 people living with HIV in 2007 (991,191 adults and 149,549 children < 15years) and 1,192,372 in 2009 (1,042,711 adults and 149,661 children). This represented an increase of 4.5% among adults and <1% among children between 2007 and 2009. Among adult women, there was an increase of 5% in the number of people living with HIV from 577,562 to 606,154.

**Table 4: Trends in People Living with HIV 2007–2010 using mathematical modelling**

	Population	December 2001	December 2007	December 2009
Number of people living with HIV	<i>Total</i>	1,033,725	1,140,739	1,192,372
	Adults	880,978	991,191	1,042,711
	Women	516,723	577,562	606,154
	Children < 15 yrs	152,747	149,549	149,661

**PLHA in Need and Receiving ART:** In 2010, a total of 540,994 people living with HIV/AIDS were eligible for treatment. Of this, about 49.950% were adult females while children constituted 14.2% and adult males were 35.8%. Although MOH estimates that there are 577,000 PLHA that

<sup>6</sup>Uganda AIDS Commission, UNAIDS. Uganda HIV Prevention Response and Modes of Transmission Analysis. Kampala, Uganda; 2009 Mar 10.

were eligible for ART, there was no breakdown by gender and age. However, a total of 77,768 were initiated on ART in 2011.

**Deaths due to AIDS:** The number of deaths due to AIDS increased from 61,000 to 64,000 between 2008 and 2009. However, relatively more women than men died due to AIDS because 55.1% of the deaths were reported to have occurred among women. Specifically, in 2008 and 2009, at least 33,849 and 35,205 women died of AIDS respectively.

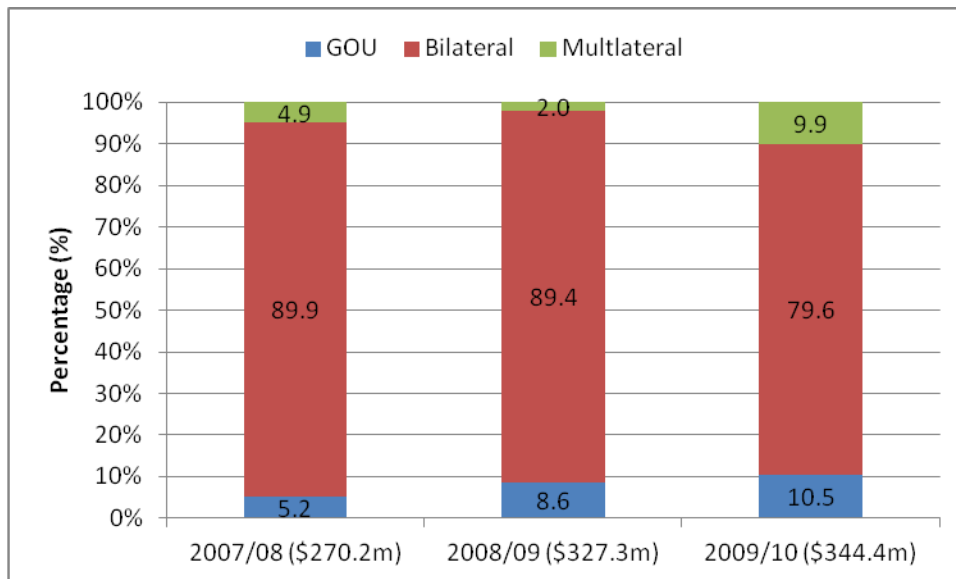
**Orphans and Vulnerable Children:** There are no current statistics on OVCs in Uganda. However, the UDHS, 2006 showed that one in five Ugandan children (21%) are orphaned or vulnerable (OVC).

### 3. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

#### 3.1 National Commitment and Action

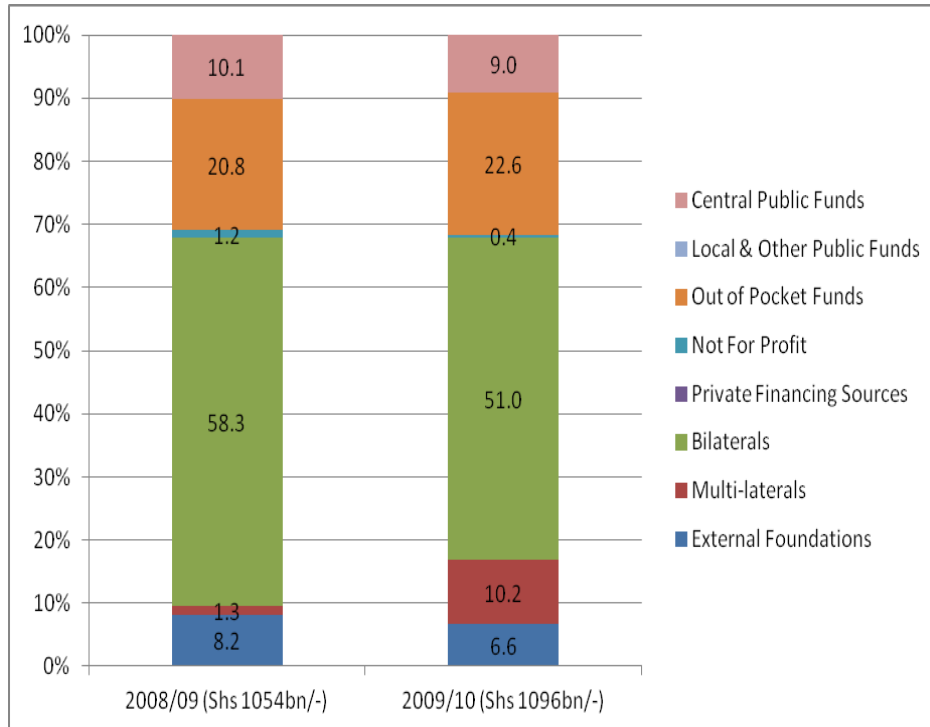
##### 3.1.1 Sources of Funds

According to the MTR of the NSP 2007/08-2011/12, the annual spending for HIV/AIDS in Uganda has continued to increase from \$270.2m in 2007/08 to \$378.3m in 2010/11 (which did not include the contributions of GoU and UN agencies that had not yet been determined by the time of the review). The percentage contribution by GoU to this overall resource envelop increased from 5.2% to 10.5% between 2007/08 and 2009/10. Although actual expenditure was not determined, in 2010/11 the planned contribution of GoU at \$70m was 17.4% of the overall budget for HIV/AIDS in the year. GoU mobilizes resources for HIV/AIDS spending primarily through domestic taxation that is channelled through the budget of the health sector.



**Figure 8: Funding of the National AIDS Response**

**Figure 9: Sources of Funds for National Response 2008/9 and 2009/10**



The NASA 2011 that is still being analyzed has shown that over 50% of HIV and AIDS financing in the recent past was by bilateral partners while the central government contributed just between 9 and 10%. However, it is also apparent that contributions from out of pocket that hitherto had not been captured accounts for over a fifth of the resources used in the national response to the

epidemic in the period 2008/09 and 2009/10.

In 2011, the newly constituted Uganda AIDS Commission Board noted that (a) the share of domestic revenue devoted to HIV/AIDS spending is very limited, yet in the absence of donor funds the total national spending on HIV/AIDS would be 15% of domestic revenue that is neither realistic nor sustainable (b) when all the 540,000 eligible PLHIV are put on ART according to the new WHO recommendations, Uganda would need \$270m annually for ART treatment that far exceeds the current per capita expenditure on health of only \$25 (c) the contribution by government in funding HIV/AIDS is a substitution rather than addition to health and HIV/AIDS spending by development partners. In addition to this, there were also global and local challenges in funding from development partners. Consequently, the Board embarked on spearheading the establishment of a National AIDS Trust Fund (NATF) whose purpose will be to mobilize resources for funding the national response to HIV and AIDS in the country and also to disburse funds and monitor the utilization of the funds according to the national priorities set out in the National Strategic Plan (NSP) and National Priority Acton Plan (NPAP).

External funds for supporting HIV/AIDS in Uganda have come from two sources, namely, bilateral and multilateral partners. Indeed over 80% of the national spending on HIV/AIDS is funded through bilateral support thus leaving less than 10% to come from multilateral agencies whose inflows have been fluctuating between 2% and 9.9% between 2007/08 and 2009/10. Regarding bilateral support, it should be noted that over 80% is contributed to by USG as discussed further under Section 6 of this report.

### **3.1.2 Spending of Funds**

The NASA 2011 are still being processed hence there is no new information to report.

## **3.2 Policy / Strategy Development and Implementation**

The implementation of HIV/AIDS activities requires conducive policy and strategy environment that can be measured using the National Composite Policy Index (NCPI), a composite of policy indicators. The first component of NCPI captures how a country has been able to develop policies and strategies on HIV/AIDS in the broad areas of; strategic planning; political support; HIV prevention policy; HIV prevention policy implementation; treatment, care and support; OVC and M&E. The second component against which civil society provide information captures human rights legislation; Human Rights enforcement of legislation; civil society participation; civil society in prevention and civil society involvement in treatment, care and support.

### **3.2.1 Government Officials Assessment**

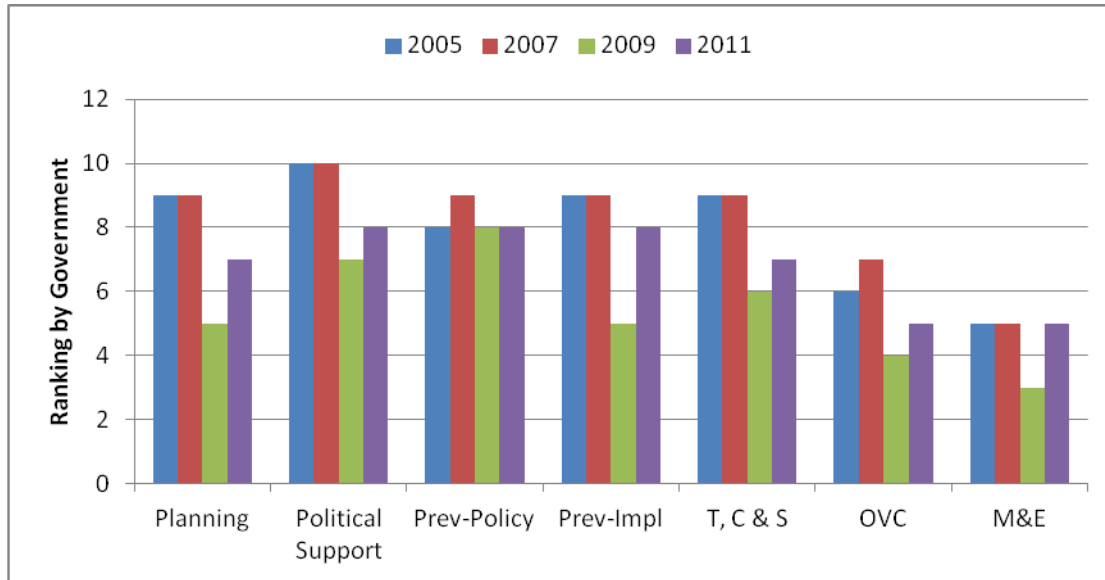
The NCPI for Uganda as assessed by the government officials between 2009 and 2011 indicate that the ranking on 6 of the 7 indicators increased generally between the period; only for prevention policy did it remain static at a ranking of 8.

Planning has improved because, among others, Uganda has aligned its HIV and AIDS strategic plan to the National development plan (NDP) 2010/11-2014/15 and also produced national prevention strategy and revised the PMTCT plan. In the period too, there was increased realization and consciousness of political and technical leaders and their involvement in the national response. For instance politicians lead by the President are increasingly talking and engaging in the national response.

There has also been an increase in appreciation for implementation of the prevention policy, HIV integration in treatment and targeting of vulnerable groups; in addition to the National Prevention Strategy that was developed, many sectors have also prepared their HIV prevention strategies while PMTCT strategies changed to accommodate WHO recommendations. The SMC policy and communication strategy were developed and rolled-out.

There has been increased support from Government and development partners, reduced number of children born with HIV and AIDS and more eligible people living with HIV have been put on ART treatment. Similarly, more CSOs have targeted and reached OVCs while government with other development partners embarked on a programme for expanding support to OVCs and the elderly. Monitoring and Evaluation had been identified as weak in 2009. During the reporting period, there has been increased and deliberate efforts to put systems in place to address this. For instance, a new national M&E plan has been developed, midterm review of implementation of the plan and preparation of the new M&E plan were initiated, developing an M&E database at UAC in which stakeholders especially sectors can report information was embarked upon.

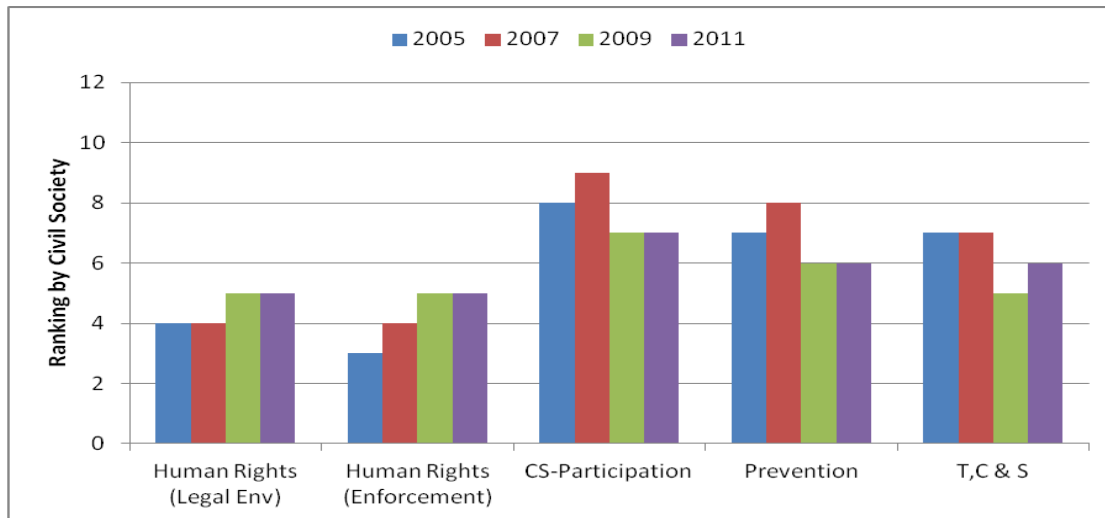




**Figure 10: Government Officials' Ranking of Key Components of NCPI, 2005-2011**

### 3.2.2 Non-Government Assessment

The rankings for four of the five indicators by civil society showed that in general there was stagnation in the level of civil society engagement in development and enforcement of legislation for the national response by the civil society between 2010 and 2011. For Treatment, Care and Support, however, there was an improvement in their scores from five to six points.



**Figure 11: Civil Society and Other Key Stakeholders' Ranking of Key Components of NCPI, 2005-2011**

According to Civil Society response, there was a rise in development and enforcement of legislation for the national response between 2005 and 2009, but this has stagnated between 2009 and 2011. This is because there were areas of concern for Human Rights defenders, lack of dissemination and implementation of the policies, lack of structures to support the implementation of the policies, implementation of the policies remained weak, and some policies contradict each other. Some provisions in the proposed law such as criminalizing intentional

transmission of HIV and mandatory disclosure of HIV infection if maintained are likely to increase human rights violation in future.

Civil Society has been adequately represented during the JAR/MTR processes and development of the HIV prevention strategy, revised and costed NSP and M&E Plans. However, it was noted that some of the Civil Society activities like provision of legal aid as a form of social support have not been considered in the national HIV budget and is seldomly included in HIV reports. It was also noted that although a large proportion of HIV services are provided by the civil society, a large component of their budget is outside the national budget.

The civil society have noted that there has been considerable effort in the implementation of HIV prevention programmes in 2010- 2011; this includes HCT and PMTCT programmes being scaled up, mandatory testing for pregnant mothers, several messages being sent out to prevent HIV among married couples, scaling up and redefining prevention approaches etc. However, stagnation in scoring was reported because of limited coverage of prevention services/interventions, insufficient services by service providers, inadequate human resource in the health facilities and non-targetting of some MARPs.

The CS appreciated that there were increased efforts in the implementation of HIV treatment, care and support programmes between 2010-2011. Thus, there has been increase in the ART enrollment and services for care and support, scale up of treatment, care and support to persons living with HIV, Some challenges mentioned include; limited coverage of ART and other treatment related services, limited dissemination of guidelines to all implementers, stock outs of ART and TB drugs.

### **3.3 Prevention**

Prevention will continue to be the cornerstone for Uganda's HIV/AIDS response if the country is to avert new infection and reverse the trend in the epidemic. However, the ambitious primary prevention goal of the country to reduce the national HIV incidence rate by 40% by 2012 was reduced in the revised NSP to 30% in incidence by 2015. Thus, while by 2011 the objectives were to prevent sexual transmission and MTCT of HIV through promotion of blood transfusion and new proven intervention technologies and approaches, in the revised NSP, the objectives are to scale-up coverage, quality and utilization of HCT and proven biomedical and behavioral interventions in addition to mitigating the underlying social, cultural, gender and structural factors that drive the HIV epidemic. Against this background, the following section presents the progress made under prevention that guided the revision of the strategies.

#### **3.3.1 People Living with HIV**

**People living with HIV aged 15-24:** The UAIS 2011 indicated that prevalence of HIV among youths in 15-19 and 20-24 was higher among women (4.4%) than in men (1.9%); these were higher than the corresponding values (1.1% and 4.3%) in 2004/05.

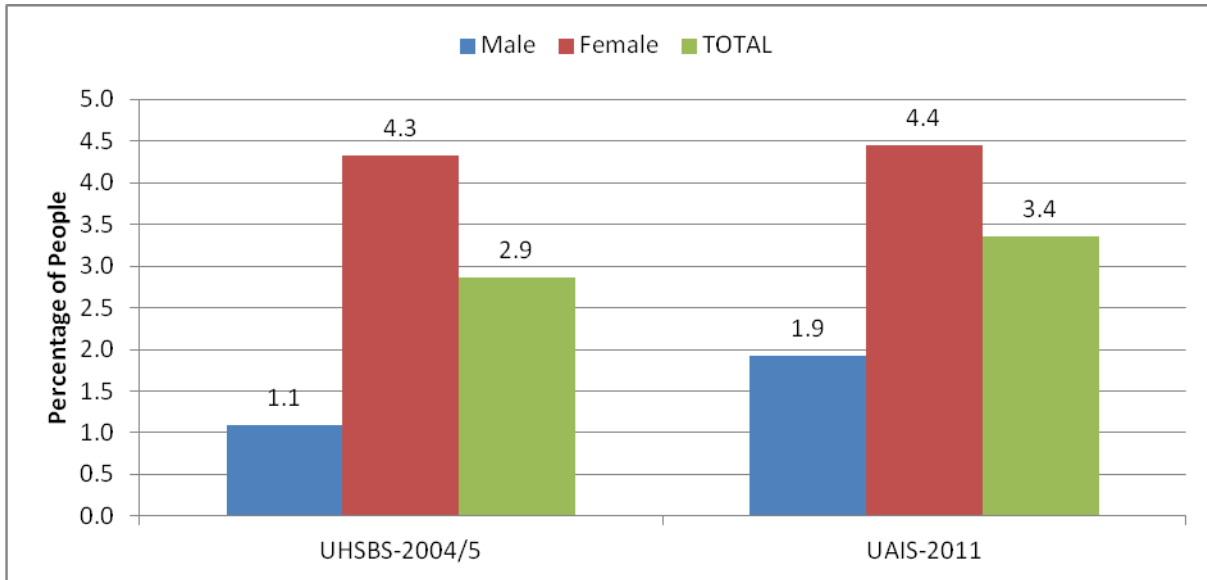


Figure 12: Prevalence by Gender age 15-24

Based on the 2004/5 and 2011 surveys, when the situation among the youth cohorts in the age group 15-19 and 20-24 age groups are followed, it is apparent that their HIV prevalence increased from 1.5% in 2004/5 to 5.1% for the youths that were 15-19 years in 2004/05 and became 20-24 years of age in 2011; similarly, the prevalence also increased by 3.7% (from 4.7% to 7.0%) for those that were 20-24 and are now in 25-29 age group. For the other age groups, the increase was only 1.8% (25-29 age group) and 0.6% (40-44 age group) but zero for 30-34 and 35-39 age groups.

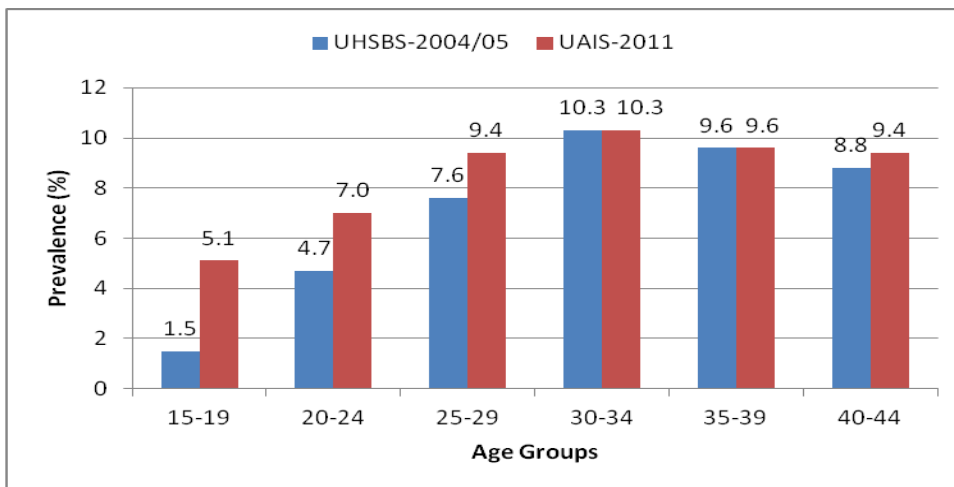
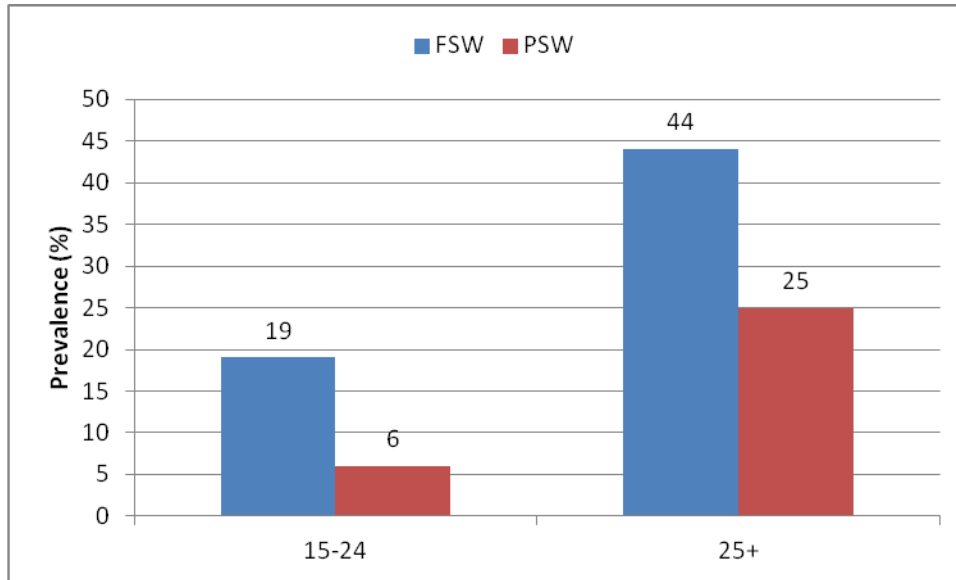


Figure 13: Change in Prevalence of HIV among the same Age Groups between 2004/05- 2011

**Sex Workers Living with HIV:** There is very limited data on sex workers in the country on this aspect of the epidemic. However, the Crane Study (2010) found that with an average of 33% prevalence among FSWs, the older ones were over two times (44%) more likely to be infected with HIV than their younger counterparts (19%). Similarly, the older partners of sex workers were four times more likely to be infected than the younger PSWs.

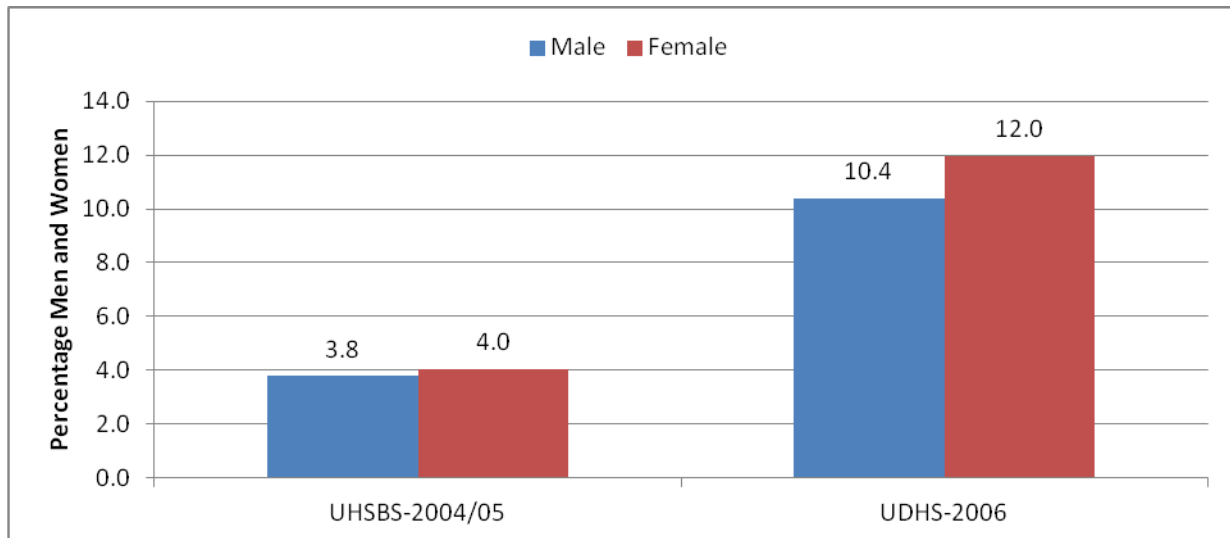


**Figure 14: Prevalence of HIV among Sex Workers**

**Men who have sex with men living with HIV:** Among men who have sex with men, the prevalence among the older ones (>25 years of age) was nearly five times that of the younger ones (<25 years) which was at only 3.9%.

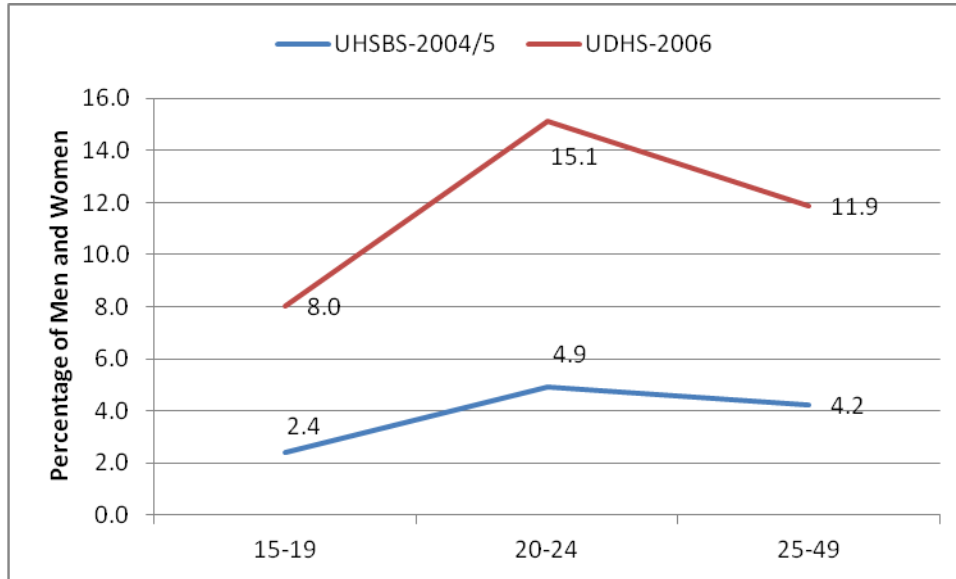
### 3.3.2 HCT

**HCT for general population:** An estimate of the proportion of people who probably know their current HIV status is usually taken as the percentage of those that received an HIV test in the past 12 months and received their results. The UDHS 2006 found that 82% of women and 87.1% of men in age group 15-49 knew where to obtain an HIV test but only 24.8% of women and 20.7% of men had ever tested and received the results of their test. In this regard, between 2004/05 and 2006, the percentage of those receiving an HIV test in the past 12 months and knowing their results among both men and women, increased from 3.8% to 10.4% in males and from 4% to 12% in females.



**Figure 15: Percentage Men and Women who received HIV Test Results, 2004/05-2011**

In both 2004/5 and 2006, the practice of testing and receiving the results in the last 12 months was more common among youths in the age group 20-24 than those in the group 15-19 and 25-49. Once again, the proportions across the age groups were higher in 2006 than those in 2004/05 indicating an increased interest in knowing one's sero-status. Data for plantation workers and fishing communities were not disaggregated.



**Figure 16 : Percentage Distribution of people who received HIV Test Results by Age Groups**

In order to promote the increase in access to HIV counseling and testing (HCT), in Uganda HCT is hinged on consent, confidentiality and counselling and the approaches used include (a) Client Initiated HCT (CICT), previously called Voluntary Counselling and Testing (VCT) which can be either facility-based or outreach; (b) Provider Initiated HIV Testing and Counselling (PITC) in the health care setting, previously called Routine HIV Counselling and Testing (RCT); and (c) Home Based HIV Counselling and Testing (HBHCT). In addition, AIC has introduced HCT at the workplace, moonlight HCT (provided at night for high risk groups such as sex workers), couple testing campaign (with slogan ‘Go together know together’ aimed at increasing the proportion of married couples receiving their HIV test results together) as well as various forms of mobile and mass testing. Thus, in the period 2010 and 2011, there has been a rapid scaling up of HCT resulting in the HCT services being available at all Hospitals and HC-IVs, 80% of HC-III and 22% of HC-II facilities. However, only 5% of HCT facilities offer youth-friendly HIV counselling and testing services and these are mainly hospitals and HC-IVs and especially in Kampala.

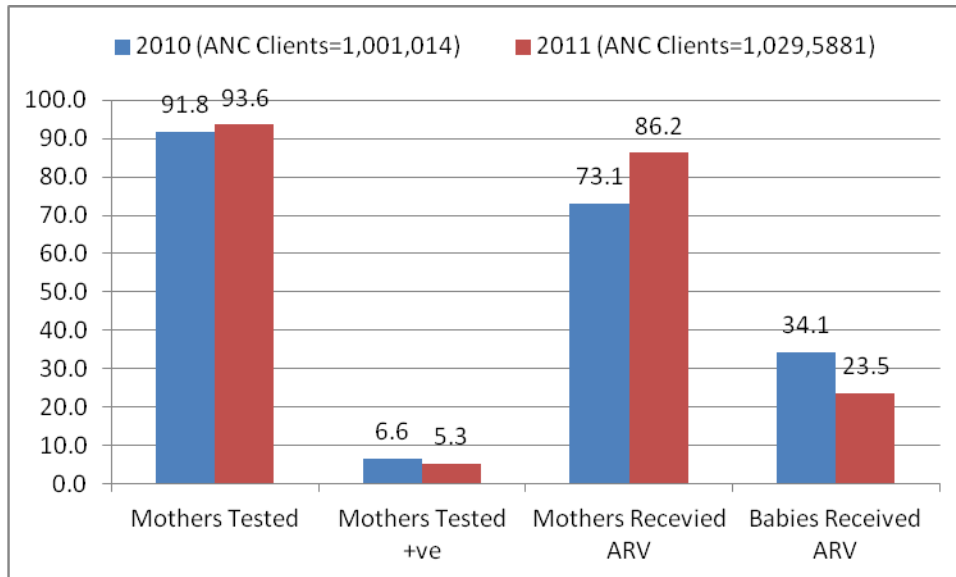
As a result of the above efforts, in the period 2008-2010, the number of clients tested for HIV 2008-2010 increased from 1,176,822 in 2008 to 1,846,175 in 2009 and 2,037,342 in 2010. In 2011, upto 5,524,327 out of 15, 152,308 projected individuals in the age group 15 and above in 2011.

### **3.3.2 PMTCT**

According to the PMTCT annual report for 2010, it is estimated that 1,550,000 pregnancies occurred in Uganda in 2010, projected to 1,600,000 in 2011. This translates into 100,750 and 104,000 pregnant women living with HIV in 2010 and 2011 respectively.

Between 2004/05 and 2011, the proportion of women age 15-49 who know that HIV can be transmitted through breastfeeding and also know that transmission can be reduced by a mother taking special drugs during pregnancy has increased from 36% in 2004/05 to 65% in the UAIS 2011. The proportion of men age 15-49 who know these two facts has also increased from 35% in the UHSBS 2004/05 to 56% in the UAIS 2011.

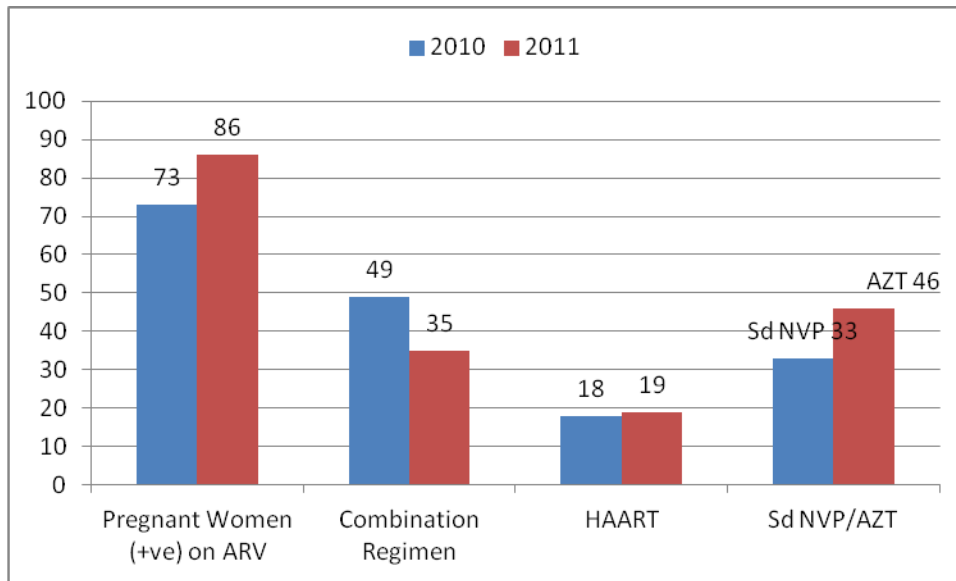
**HIV-positive pregnant women on ART:** Against the above background, the number of pregnancies seen at the health facilities providing PMTCT services were 1,001,014 in 2010 and 1,029,588 in 2011; the later was 66.4% of the 1,550,000 expected pregnant women in the year. However, there was an increase from 91.8% to 93.6% in the proportion of these new ANC clients that were counselled and tested between 2010 and 2011. While the proportion of mothers that were counselled and tested and received their results increased, two undesirable outcomes occurred. These are (i) the proportion of the tested mothers that were positive decreased from 6.6% to 5.3%, (ii) the percentage of infected pregnant women who received ART drugs to reduce the risk of MTCT increased from 73.1% to 86.2% between 2010 and 2011. However, 23.5% of the HIV exposed babies whose mothers tested positive received ART medicines in 2011 compared to 34.1% in 2010.



**Figure 17: Women and Babies Cascading through the PMTCT Services, 2009 and 2010**

Out of the 1,229 health facilities in the country, those providing PMTCT services increased from 947 to 1,150 between 2009 and 2010. This includes all the public and private hospitals and HC-IVs and an increase from 68% to 90% of HC-IIIs and addition of 10% HC-IIs to offer PMTCT services in 2010. However, the ART program has only reached 6% of HC-III facilities and the linkage and referral system from one facility to another is still weak.

Among the HIV positive pregnant women who received ARV for PMTCT at ANC facilities, the proportion receiving combination regimen increased from 25% to 49% between 2009 and 2010 while those on Sd NVP decreased from 58% to 33%. This is because the national PMTCT program phased out the use of Sd NVP and instead strengthened the use of combination regimens and HAART, in line with the WHO guidelines<sup>7</sup>. In this regard, in 2011, of all the HIV positive mothers (47,965) who received ARV medicines during pregnancy, 35% got AZT+3TC while 19% got HAART and 46% got AZT<sup>8</sup>.



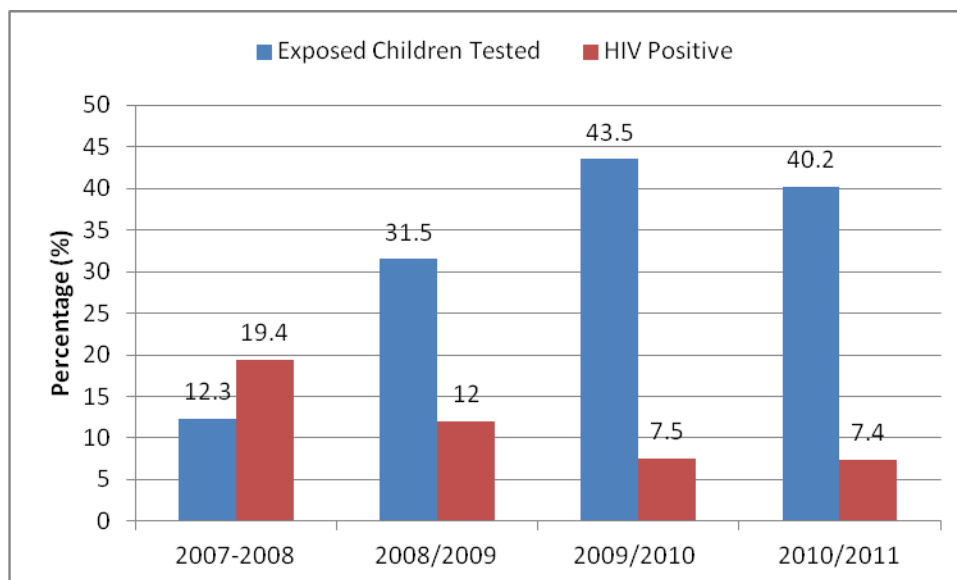
**Figure 18: Access to ART services**

**Infants born to HIV-positive women:** In Uganda, early infant diagnosis (EID) services and network were established in 2007 to enhance diagnosis and linkage to care for HIV infected infants. However, in 2009, a review of EID services in regional referral hospitals revealed that overall, only 40% of exposed infants testing HIV-positive through the EID program ever enrolled for care and treatment at an ART clinic. This was because only 718 out of 1,268 (57%) exposed infants were tested over a 12-16 month period. Of the 244 HIV-positive infants, only 150 of them ever received their results, representing a loss of 39%. Out of the 150 who received results, only 98 ever enrolled into care/treatment at an ART clinic—a 35% loss. Finally, only 57 of the 98 who enrolled at the ART clinic were still alive and active in care/treatment at the time of data collection. Factors responsible for the high loss to follow-up included (i) loopholes in identifying and testing or referral for testing of HIV exposed infants at various venues (ii) failure to return results to parents and care givers due to delays in processing and returning results to facilities and weaknesses in the tracking of tested children (iii) poor linkage to care for infants diagnosed with HIV infection due to weaknesses in the referral mechanisms and limited integration between EID and HIV chronic care sites.

<sup>7</sup> WHO guidelines for PMTCT provide for HAART through option A or B. The implementation of option A has been ongoing but there is a move to option B. Option B calls for treatment with HAART for all HIV infected pregnant women irrespective of their CD4 counts; treatment is initiated immediately on diagnosis and continued through the period of pregnancy and breastfeeding after which it is discontinued for women with CD4 counts above 350 and continued for those with CD4 counts below 350.

<sup>8</sup> MOH (2011). Prevention of Mother to Child Transmission of HIV and Pediatric HIV/AIDS Care Programme. Annual Report July 2010 to June 2011. STD/AIDS Control Programme, Ministry of Health.

In view of the above, a consolidated laboratory at the Central Public Health Laboratories (CPHL) was established in 2010 and launched in 2011 with appropriate transport hubs at district level. Hence, by 2010 EID was being offered in 616 health facilities (51% of the recommended health facilities) including all 112 hospitals, 96% of 163 HC-IVs, 27% of 955 HC-IIIs and also in 60 HC-IIs and 30 special clinics/research laboratories in the country. This number increased to 800 in 2011.



**Figure 19: Prevalence of HIV among Exposed Children**

As a result of the above, the number of infants tested has continued to grow from 11,211 in 2008 to 28,645 in 2009; in 2010 they were 39,575 while in 2011 they reached 36,575. As shown in the figure above, there has also been an increase in the number infants tested as a percentage of all the estimated HIV exposed children from 12.3% in 2007/08 to 40.2% in 2010/11. However, there has been a consistent decline in the percentage of infants found HIV positive from 19.4% in 2008 to 7.4% in 2011 indicating that the PMTCT services is having a positive impact on newly born children. Indeed, the PMTCT and Paediatric HIV/AIDS care project report of 2011 shows that positivity rate was only 6.3% for babies of mothers who went through PMTCT compared to 12.8% for babies whose mothers didn't go through PMTCT. Thus demonstrating that the PMTCT interventions are reducing the HIV transmission from mothers to children.

**Mother-to-Child Transmission Projections:** Recent spectrum projection estimates by MOH indicate that in the worst case scenario in which there is no ART and No PMTCT, there would have been 30,205 new cases of infection in 2009 rising to 38,717 in 2014, representing an increase of 28.2% (Table 6 and Figure 20)

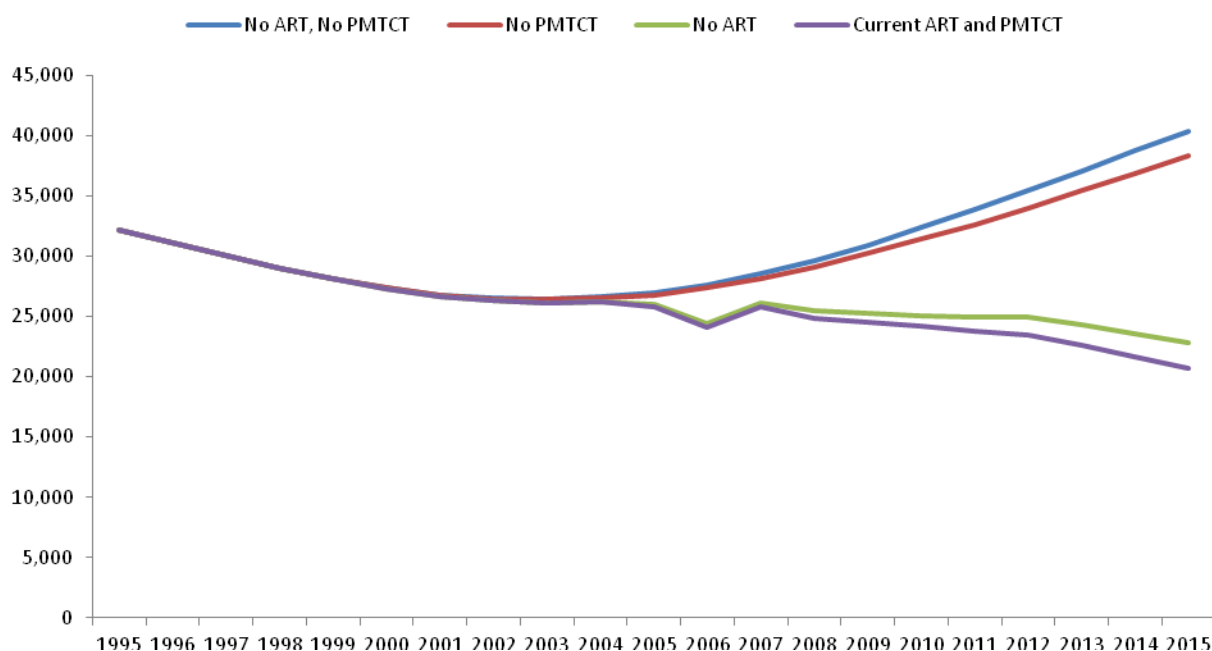
**Table 5: Projection Figures using Spectrum Model**

YEAR	No ART, No PMTCT	No PMTCT	No ART	Current ART & PMTCT



2009	30,205	30,205	24,548	24,548
2010	31,394	31,394	24,142	24,142
2011	33,809	32,617	24,953	23,752
2012	35,411	33,969	24,936	23,478
2013	36,864	35,409	24,263	22,578
2014	38,717	36,864	23,561	21,673
2009-2014 (%)	28.2	22.0	-4.0	-11.7

On the other hand, using 2009 as the base year, under the best case scenario in which there is ART and PMTCT services being provided, the number of new infections would have been reduced by 18.7% to 24,548 instead of 30,205 in 2009; new infections would be reduced further by 28.2% to 21,673 in 2014 compared to the 30,205 in 2009. The benefit of this scenario is further discerned by it being able to project new cases to only 21,673 that is 44% less than the new infections (38,717) under the worst case scenario in the same year.



**Figure 20: PMTCT Projections, 1995-2015**

Thus because vertical infections in the country were less than if there were no PMTCT programmes at all, the national prevention strategy has planned to work towards virtual elimination of MTCT through efforts aimed at (a) eliminating the unmet need for family planning among antenatal women, (b) halving HIV incidence among women of reproductive age, (c) having over 90% of HIV-positive antenatal women on triple ARVs through breast feeding, and (d) Reducing the median breast feeding period for HIV positive women to six months. When this is achieved it was further projected that in 2015 there would be approximately only 6,200 new child infections compared to 32,900 (74% decline).

### 3.3.3 HIV Prevention Programmes for MARPs

**Prevention Programmes in general for Sex-workers:** MOH<sup>9</sup> in 2009 conducted a study involving 472 respondents consisting of commercial sex workers (i.e. males and females who engaged in sex in exchange for Money) and clients of sex workers (i.e. individuals whether male or female who paid money in exchange for sex); 90% were Female sex workers, 3% male sex workers, 1% female clients of male sex workers and 6% male clients of female sex workers. The HIV/AIDS related services studied included condoms, information and education messages, STD/HIV/AIDS treatment, STD/HIV counselling and testing, social rehabilitation, family planning and training in income generation. In general, the findings indicated that (a) over 96% of respondents had access to condoms but (b) only 17% of respondents did not have access to IEC messages while 31% did not have access to HCT services and 28 percent did not have access to STD care; over three quarters of the respondents did not have access to contraception and other family planning services. While the younger and less educated respondents were more likely to have access to IEC messages and STD/HIV/AIDS services, the older and more educated respondents were more likely to access HCT services.

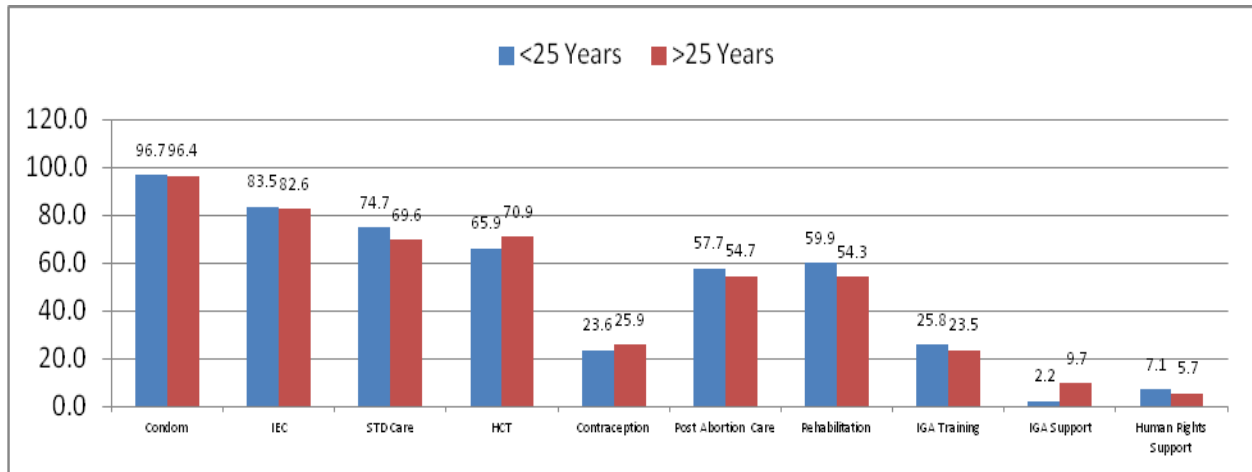


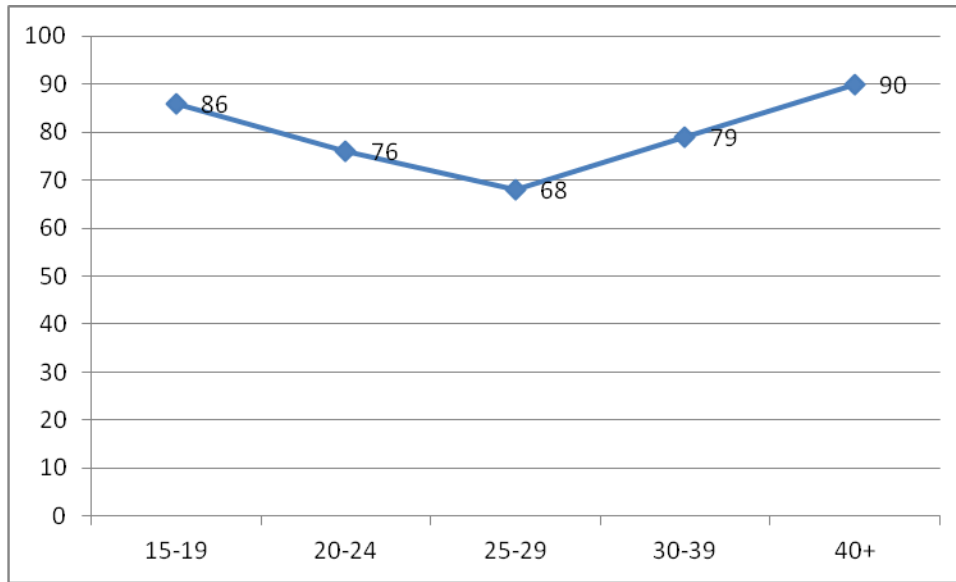
Figure 21: Access to HIV/AIDS Services by MARPs in Uganda

Although more than half of the CSWs were able to access rehabilitation services, only a quarter received IGA training and less than 10% got the actual IGA support. The young CSWs were more likely to access rehabilitation services and IGA training services than their older counterparts while for IGA support, the reverse was true with the older ones getting more than the younger ones.

**Condoms among sex workers:** There is no national survey information on percentage of sex workers reporting the use of a condom with their most recent client. However, in the Crane Study (2009), while only 15% of partners of sex workers (PSW) always used condoms, 19% of PSWs had never used condoms. The most frequent reasons for not using a condom were (a) not having one when it was needed, reported by 21% of the respondents (b) did not thinking of it, 15% (c) believed their partners were HIV uninfected 14%, (d) did not like them, 10%, (e)

<sup>9</sup> MoH (2009). Magnitude, Profile and HIV/STD Related Knowledge and Practices of Commercial Sex Workers in Kampala, Uganda.

partners rejected, 9%. In survey conducted by MOH (2009), it was noted that over 95% of the CSWs were able to access condoms irrespective of their age groups but less than 80% actually used them implying that they probably had a poor negotiation capacity.



**Figure 22: Use of Condoms by Sex Workers**

**HCT among sex workers:** There is no data on the percentage of sex workers who have received an HIV test in the past 12 months and know their results.

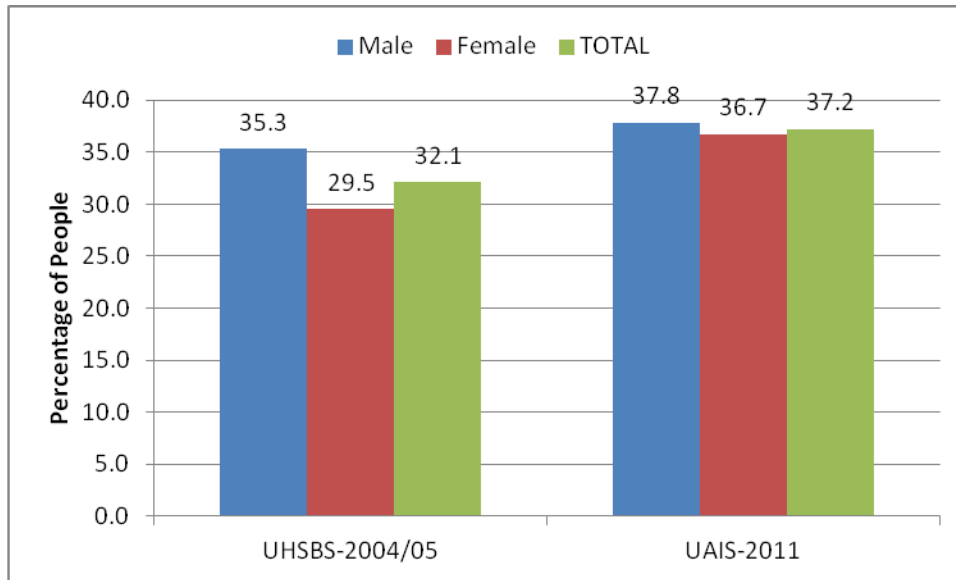
**Prevention Programmes for MSM:** In Uganda, sexual intercourse between consenting adults of the same sex is a crime in Uganda. In this regard, (a) the proposals in the Anti-Homosexuality Bill aims to extend this criminal sanctions even further (b) a number of provisions of the HIV/AIDS Prevention and Control Bill prohibit of Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) persons from practicing their sexual beliefs. This is despite the findings from a study conducted by the School of Public Health of Makerere University and the AIDS Control Programme of the Ministry of Health on Men who have Sex with Men (MSM) that: 31% of MSM had ever been married and 20% of them were currently married; 78% of them had ever had sex with a woman; 44% had ever lived with a female sex partner; 16% were currently living with a female sex partner and 29% had fathered children. Against this background the NSP 2007/08-2011/12 did not cover MSM. Hence, there are virtually no tailored services available for MSM; the minimal services such as sensitization and awareness are mainly provided by CSOs and no direct service at all for MSM is provided by government facilities.

### **3.3.4 Knowledge and Behaviour**

**Comprehensive Knowledge about HIV Transmission:** Knowledge of HIV/AIDS is an important cornerstone in the prevention of sexual transmission of HIV and other STIs. Although it has been argued that knowledge alone is not adequate to lead to behaviour change, knowledge of modes of HIV transmission and prevention can be a significant step leading to behaviour change. In this regard, the percentage of people who correctly identify ways of preventing sexual transmissions of HIV and who reject major misconceptions about HIV transmission is a composite indicator that is regarded as comprehensive knowledge about HIV/AIDS; it combines several individual indicators which capture the percentage of respondents who say that (i) people can reduce the chances of getting the AIDS virus by using a condom every time they

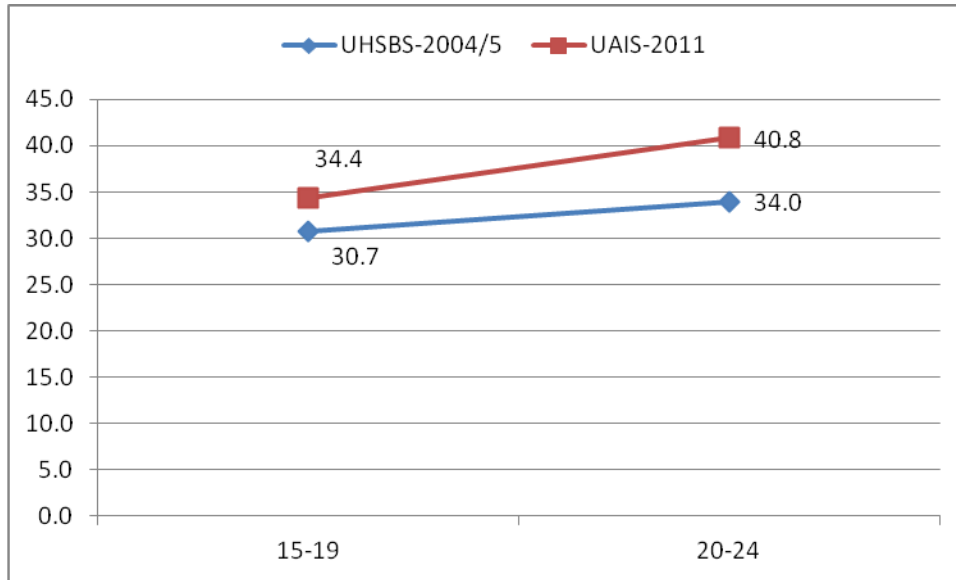
have sex (ii) people can reduce the chances of getting the AIDS virus by having sex with just one partner who is not infected and who has no other partners (iii) people cannot get the AIDS virus from mosquito bites (iv) people cannot get the AIDS virus from sharing food with a person who has AIDS, and (v) that a healthy-looking person can have the AIDS virus.

According to the UHSBS 2004/05 and UAIS 2011, in general the proportion of youths in the age group 15-24 who had a comprehensive knowledge about HIV/AIDS was higher among men than in women in a given year. There was also an increase in the proportion of knowledge between 2005 and 2006 particularly among men from 35.3% to 38%. The level of knowledge however declined slightly from 38% to 37.8% for males but increased from 31.6% to 36.7% for in females between 2006 and 2011.



**Figure 23: Comprehensive Knowledge of HIV/AIDS by gender**

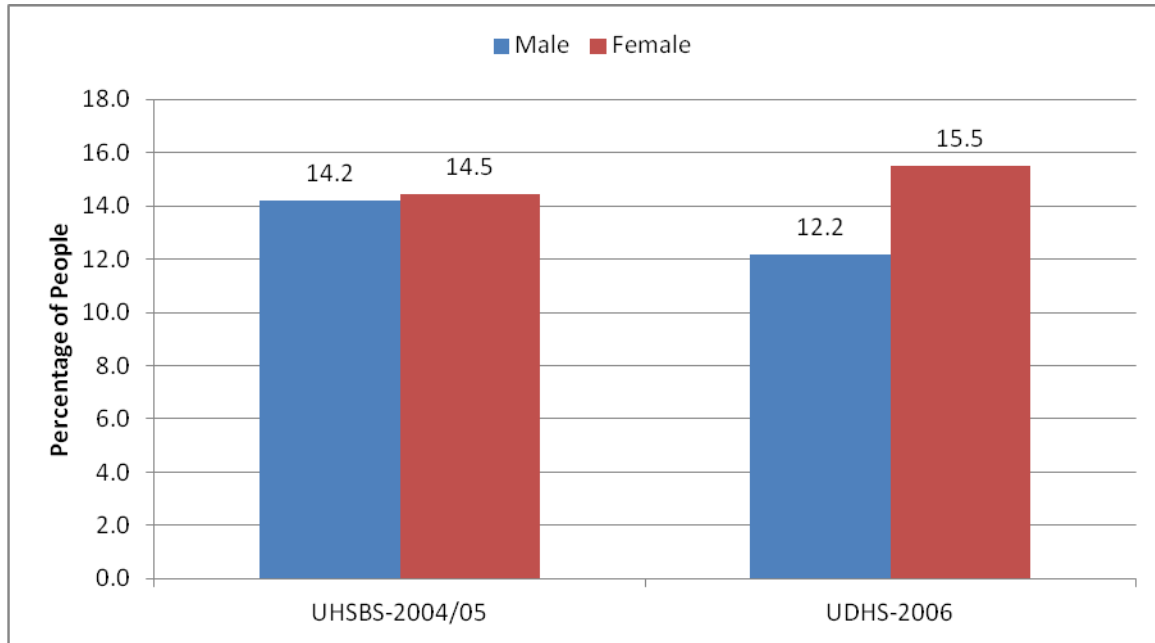
In terms of age, there has been an increase in the level of comprehensive knowledge about HIV transmission among the youths in the age groups 15-19 and 20-24 in the period 2004/05 and 2011. Thus, within each of the two age groups, the level has increased from a lower level in 2004/05 to a higher level in 2011. It increased from 30.7% to 34.4% for those in 15-19 age group and from 34% to 40.8% in 20-24 age group in 2004/05 and 2011 respectively. Consequently, for both age groups together, there is an apparent elevation in the level of knowledge between 2004/05 and 2011.



**Figure 24: Comprehensive knowledge by age groups**

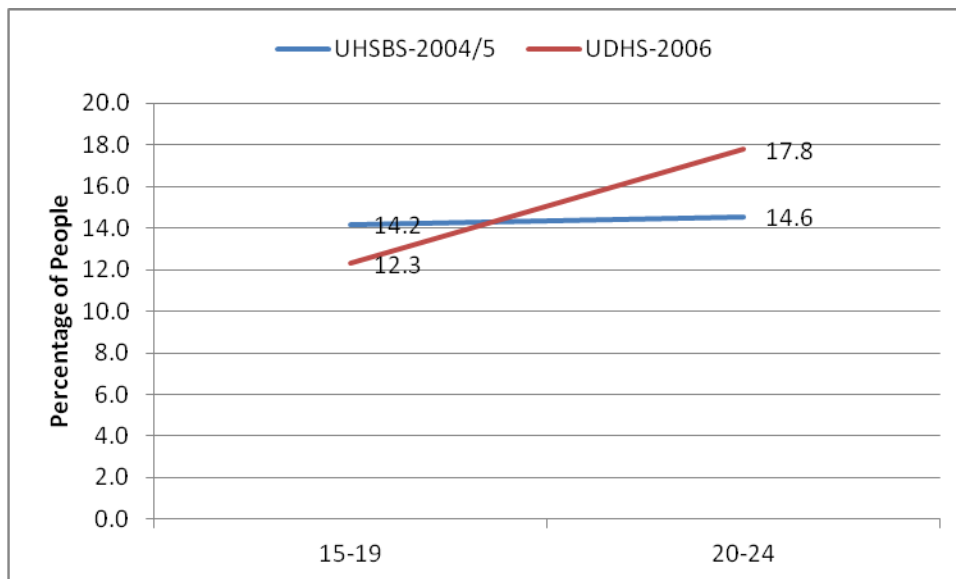
HIV preventions programs have targeted young people in order to (a) raise awareness and advocacy against cross-generational, commercial and transactional sex (b) promote behavior change and challenge existing masculinity and gender norms that make young people vulnerable to HIV infection. The major programs include YEAH (“Be a Man” Campaign and “Something for Something Love”), Presidential Initiative on AIDS Strategy for Communicating to the Youth (PIASCY) in primary and secondary schools; they use a mix of strategies including mass media, radio, television, and print media as well as interpersonal communication strategies such peer education, teacher change agents and community conversations/community action teams; and music, dance and drama. Noting that the young people are not homogeneous, some agencies segment young people by age into the 10-12 years and the older young people (13- 24 years) and others target youths in and out-of-school while recognizing the unique needs of girls and boys.

**Sexual Intercourse before age of 15:** The proportion of men and women in age group 15-24 who had sexual intercourse before the age 15 declined among men from 14.2% in 2004/05 to 12.2% in 2006 but increased slightly for women from 14.5% to 15.5% respectively during the period. According to the UAIS, however, the percentage of men in age group 15-49 who had first sexual intercourse by 15 was 12.1% and 11.1% respectively for men and women; this decreased to 8.6% in men but increased for women to 14.2%.



**Figure 25: Sexual Intercourse among Young People by Age 15 by Gender, 2004/05-2006**

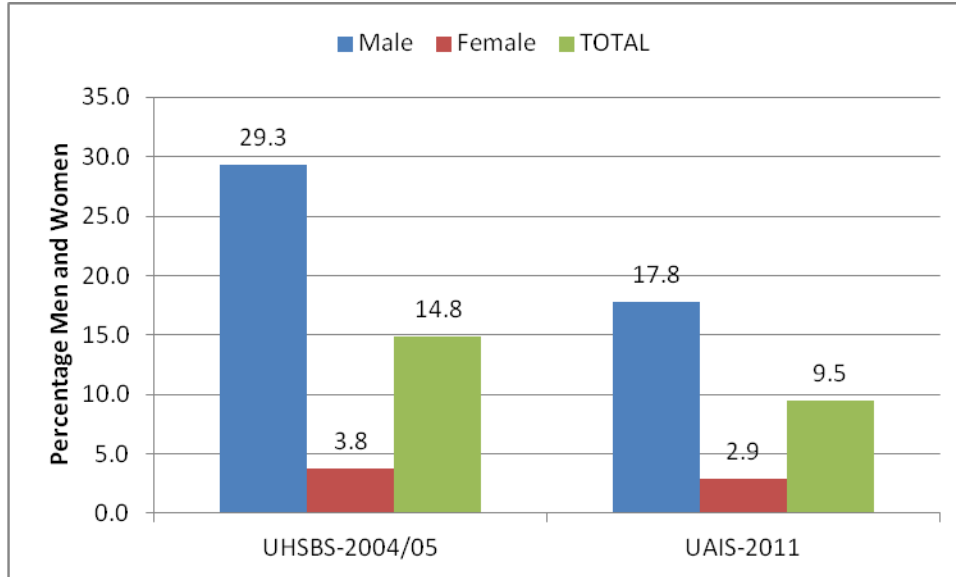
Regarding the distribution of youths according to age group and engagement in sexual intercourse before the age of 15, it is clear that fewer youths in the age 15-19 compared to those in the age group 20-24 had been involved in early sex in a given year. For instance, in 2006 only 12.3% of the youths in age group 15-19 were involved compared to 17.8% in age group 20-24 for the same year.



**Figure 26: Sexual Intercourse among Youths before Age 15 by Age Groups, 2004/5 - 2006**

In Uganda, abstinence promotion interventions include a package of comprehensive sexuality education, addressing both abstinent and sexually active young people, and therefore covering issues ranging from delaying sex to family planning and preventing abortion; they also include peer support clubs for in-school and out of school youths.

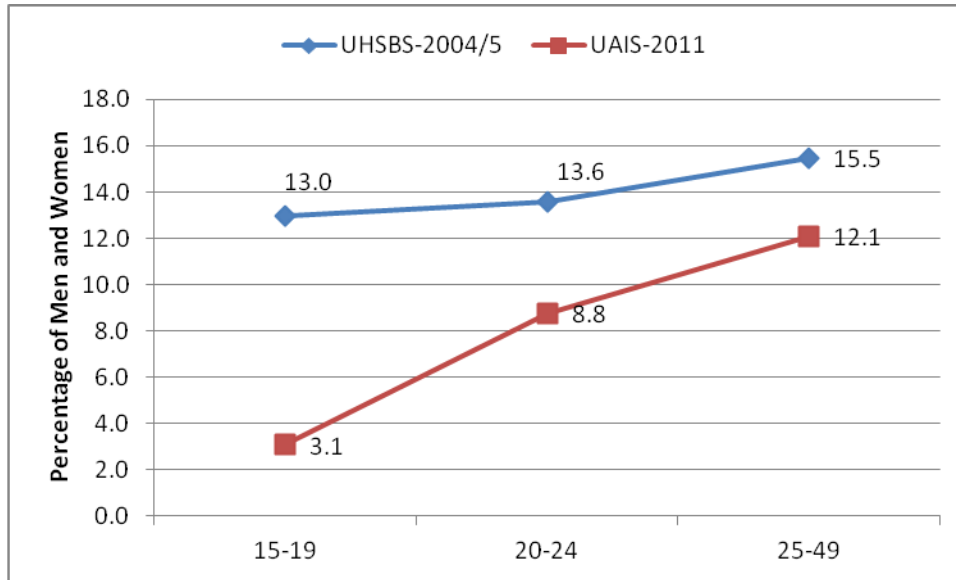
**Sexual intercourse with more than one partner in past 12 months:** There has been a consistent decline in the proportion of men and women who had more than two sexual partners in the past 12 months. Among men, there was a decline from 29.3% in 2004/05 to 17.8% in 2011. However, for females, the decline was rather low from 3.8% to 2.9% between the same period of time.



**Figure 27: Percentage of men and women who had sexual intercourse with 2+ partners**

In a given year, the proportion of those engaged in multiple sexual partner relationship was higher among the people in the 25-49 age group compared to those in 20-24 and 15-19 age groups. Secondly, there was a reduction in the proportion of people engaged in multiple relationship across all age groups in 2004/05 compared to level for their counterparts in 2011. This decline was more pronounced in the age group 15-19 (13% to 3.1%) compared to that in age group 20-24 (13.6 to 8.8%) and 25-49 (15.5% to 12.1%).





**Figure 28: Percentage of people who had 2+ partners in past 12 months by age groups**

Several organizations implement programs meant to promote fidelity among married couples and other people in long-term sexual relationships; these include faith-based organizations (all religious denominations), PACE, Inter-religious Council of Uganda, etc. The programs focus was promoting faithfulness among married people and those in long-term relationships. For instance, a program targeting married couples using the “Go RED<sup>10</sup> for fidelity” campaign slogan was implemented with the aim of (a) reversing the belief that unfaithfulness is a harmless and acceptable norm (b) promoting mutual faithfulness in marriage as the ultimate behaviour and (c) effective communication for partner reduction and increased risk perception. Campaign materials included strategically placed billboards, posters and television and radio ads among others.

**Condom use during last sexual intercourse in multiple relationship:** In 2004/05, more men (16.1%) were using condoms than females (9.1%) however, this situation was reversed according to the UAIS-2011 with fewer men (13.3%) than women (15.7%) using condoms in their sexual intercourse with more than one partner. Secondly, while there was a decline in condom use among men from 16.1% to 13.3% between 2004/05 and 2011, in the same period of time, there was instead an increase for women from 9.1% to 15.7%.

<sup>10</sup> RED is an acronym that stands for Reliable, Exceptional, and Dependable

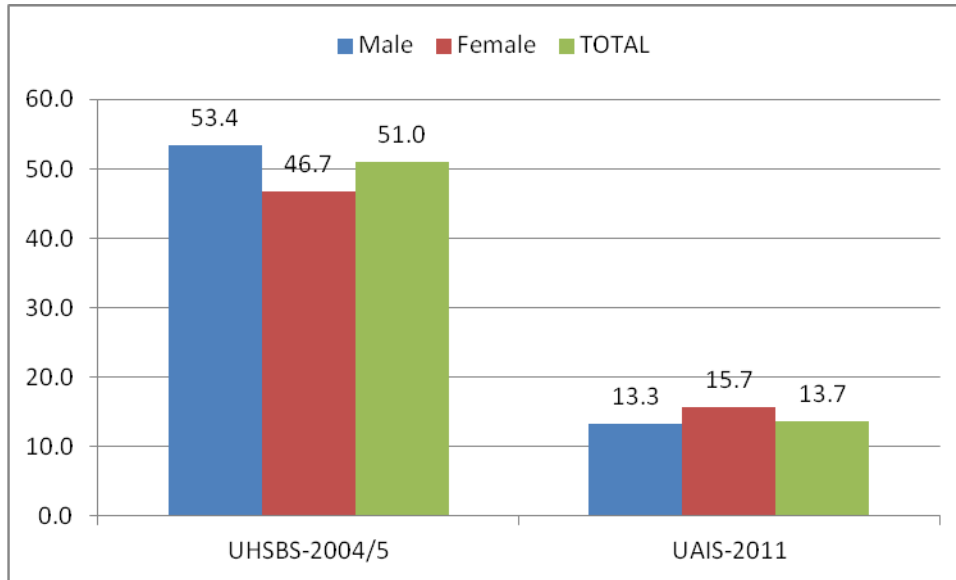


Figure 29: Percentage People with 2+ partners using condom during last sexual intercourse by Gender

There has been a consistent decline in the proportion of people using condoms during the last sexual intercourse between 2004/05 and 2011. This decline was more pronounced among those in age group 25-49 (from 47.5% to 9.7%) compared to those in the age group 20-24 (56% to 25.2%); the decline for those in 15-29 was not very pronounced (52.7% to 30.2%)

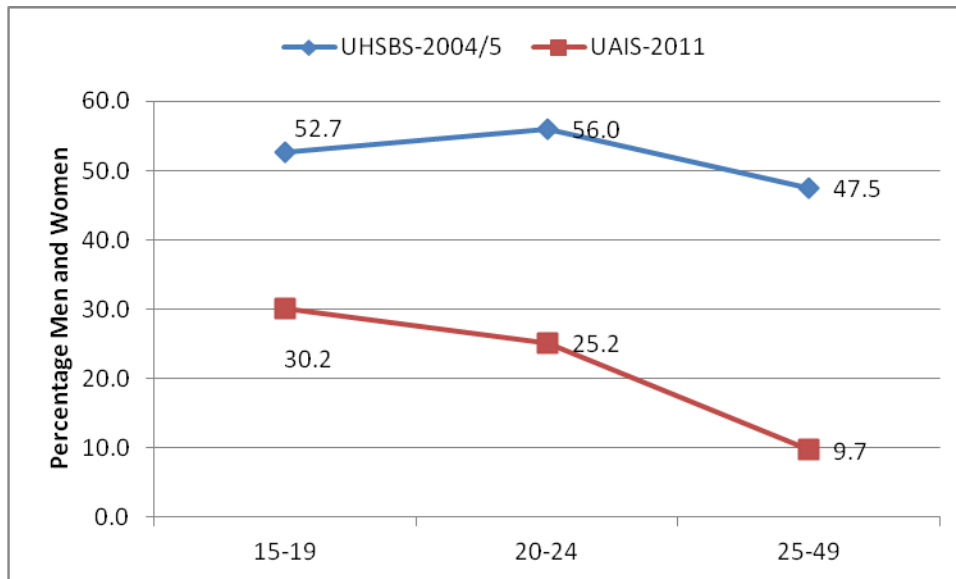


Figure 30: Percentage People with 2+ partners using condom during last sexual intercourse by Age Groups

Condoms are distributed mainly through public health facilities, and also through community-based distribution outlets using peer-networks, social marketing and commercial sales in drug shops and supermarkets. Thus, 56.5% of the 170 million male condoms distributed between 2009/10 and 2010/11 were by the Ministry of Health.

Table 6: Annual Procurement and Distribution of Male Condoms in Uganda, 2007/08-2010/11

Provider	NUMBER OF CONDOMS			
	2007/08	2008/09	2009/10	2010/11
Public				
MoH	80,999,148	51,596,150	61,292,338	35,000,000
Private				
MSI	18,227,232	15,786,120	18,834,438	8,786,301
PACE	2,616,150	6,047,250	4,012,710	8,051,700
UHMG	16,536,519	8,044,740	17,449,790	17,024,840
<b>Total</b>	<b>118,379,049</b>	<b>81,474,260</b>	<b>101,589,276</b>	<b>68,862,841</b>

*Source: MoH, MSI, PACE & UHMG*

The Female Condom (FC2) was reintroduced in Uganda in October 2009 and a total of 300,000 pieces had been distributed by 2010 on a research / pilot basis. To-date it is being scale-up to cover more districts, all AIC branches and hot spots on Busia-Katuna highway by targeting FSWs, family planning clients, students in tertiary institutions, Uniformed Forces, Truckers and the fishing community.

### 3.4 Care and Treatment

The Revised NSP has maintained the goal of the Care and Treatment component by remaining focused on improving the quality of life PLHIV through (a) increasing equitable access to ART (b) increasing access to prevention and treatment of OIs (c) supporting the expansion of HBC and CBC and support (d) integrating sexual and reproductive health into all care and treatment programmes/interventions. The following section presents the progress made under care and treatment that guided the revision of the strategies alluded to here.

#### 3.4.1 ART

**Eligible adults and children receiving ART:** In the revised policy, the ART eligibility for adults was changed from CD4 250 to 350 while eligibility for children was changed to include treatment for all children below two years of age, irrespective of their CD4 count/percentage. In addition, all TB patients co-infected with HIV are eligible. Thus, in 2010, the estimated need of ART was 540,094 under the <350 eligibility criterion and 442,103 for <250. This number translates into over 40,000 individuals initiating treatment every year for FY 2008/2009 and 2010/2011. However, overall, in 2010 only 260,865 accessed treatment in the year. In 2011, the number on ART increased to 290,971. Thus, based on estimated need of 540,094<sup>11</sup> there was an increase from 48.3% to 58% in number of ART active client among adults and children. Among the adults only, the increase was from 52% to about 62% while in children it was only 28% to 32%. This growth in ART access was also noted across the sexes where it was more pronounced among women than men. For females it increased from 50% to 68% while for men it only increased from 39% to about 54%. Access by children below 15 years remains limited, having increased from 21,763 to 24,735 in 2011.

<sup>11</sup> Because the estimate by MOH of 577,000 eligible clients had no breakdown by gender and age groups, the figure 540,094 from the previous estimate was used.

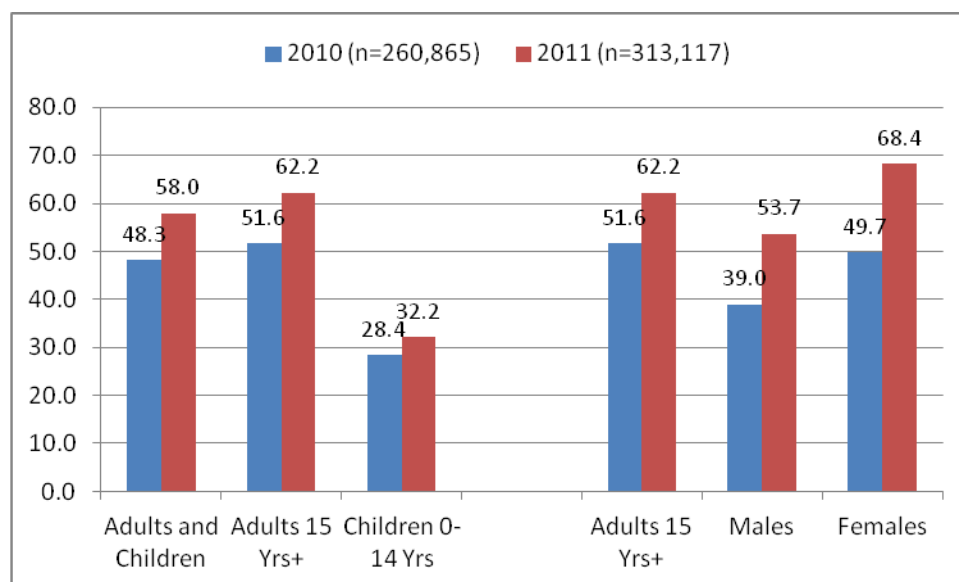


Figure 31: Eligible adults and children receiving ART

The above success is partly attributed to the number of facilities providing adult and paediatric ART services that increased from 1187 to 1424 between 2010 and 2011. These ART sites are distributed across 108 of the 112 districts and in terms of facility coverage by level of service delivery, over 90% of HC IV facilities and 6% HC III facilities were providing ART services by end of June 2011.

Table 7: Distribution of ART Accredited Sites by Level, 2010 and 2011

HEALTH FACILITIES	TOTAL 2010	Providing ART (%)		TOTAL 2011	Providing ART (%)	
		Adults	Children		Adults	Children
National/Regional Referral Hospitals	15	100.0	100	15	100	100.0
General Hospitals	101	100.0	90.1	112	93.0	83.9
Health Centre IV	166	86.1	74.1	177	88.1	80.8
Health Centre III	905	6.2	4.4	1119	6.4	5.3
Health Centre II	1887	0.2	0.1	2993	2.0	0.7
Facilities from HC IV Onwards	282	91.8	79.8	305	90.2	82.6
Facilities from HC III Onwards	1187	26.5	22.3	1424	24.4	21.8

**ART clients on treatment after 12 months of initiation:** In 2009, the proportion of clients still on treatment was 82.5% after 12 months. This has however increased to 83.6% and 84.1% in 2010 and 2011 respectively. This improvement in longitudinal ART outcomes has also been recorded in terms of the facilities providing data that also increased from 186 in 2010 and 191 in 2011.

Table 8: Distribution of Clients on ART after 12 Months of Treatment Initiation

STATUS	2010 (n=31,713)	2011-June (n=9,159)
Still on ART	83.6	84.1
Lost to Follow Up	8.7	8.1
Died (%)	4.5	4.3

Stopped	0.7	0.8
Lost	0.9	2.8
TOTAL	100	100

### **3.4.2 Tuberculosis and HIV Collaboration**

The national TB/HIV indicators have continued to improve. Patients counselled for HIV testing progressively rose from 35.6% in 2006 to 88% in 2010 and those tested from 25.4% in 2006 to 80.5% (target 85%). The proportion of the HIV positive TB patients started on cotrimoxazole also progressively increased from 70.9% in 2008 to 90% in 2010 (target 100%) while those on ART rose from 18.5% in 2006 to 24.4% in 2010. The proportion HIV positive TB patients remained constant 54.0% in 2009 as compared to 53.7% in 2010. During 2010, it was also noted that more women (59.4%) than men (50.2%) were HIV positive.

In terms of TB screening for HIV infected patients, the April-June 2010 ART quarterly report shows that out of 320,894 clients that received HIV chronic care, 81.7% were assessed for TB. Among the patients who were screened 1.1% had active tuberculosis and were initiated on anti-TB treatment. This report also shows declining trend for active TB among HIV patients who were screened between 2006 and 2010, from 1.9% to 0.3%. There is also a decline in the prevalence of active tuberculosis ascertained during screening for ART eligibility within the same period, from 4.3% to 2.4%. In 2011 upto 553,057 were screened out of 640,113 giving 86% of number of adults and children enrolled in HIV care in 2011. On the other hand, the percentage of estimated HIV positive incident TB cases was 54.5% of those who received treatment for both TB and HIV (i.e. 20,725 incident cases against estimated cases of 38,000).

These achievements have been realized because (i) significant improvement have been made in intensified TB case finding and TB Infection control (ii) Decentralized TB care called Community Based DOTS has been expanded to all districts (iii) the National TB Reference Laboratory (NTRL) capacity has been enhanced (iv) a National Coordination Committee (NCC) composing of members from NTLP, National AIDS Control Program, WHO, District health services, AIDS Development Partners, implementing agencies, and support organizations for PLHIV was established and has worked on review of TB/HIV collaborative activities policy guidelines, capacity building, communication, community activities, and resources mobilization.

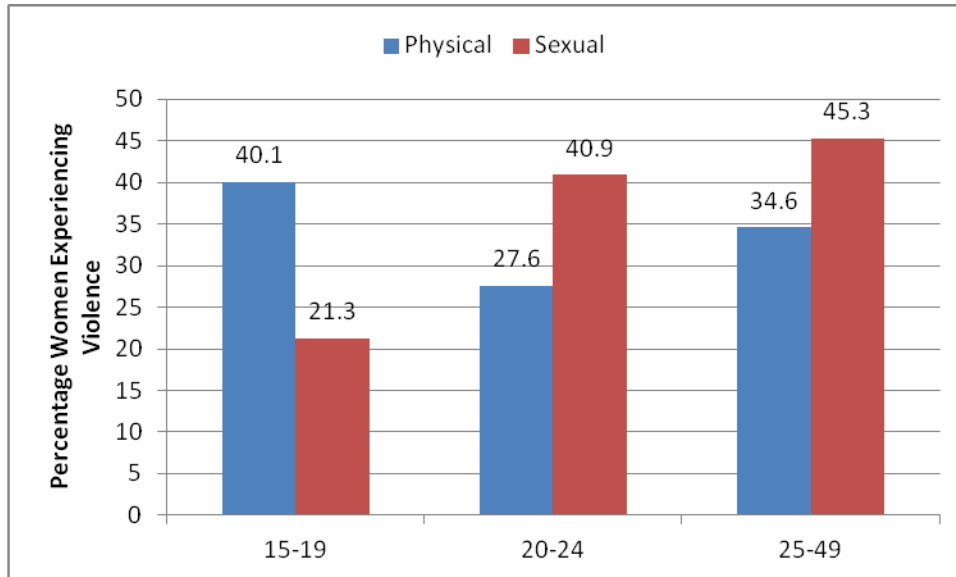
### **3.5 Social Support**

There was a shift in the goal of social support in that in the new NSP, the focus changed from broad mitigation of effects of HIV/AIDS at individual, household and community levels to improving access to all services for all vulnerable population. This will be achieved by scaling up delivery of comprehensive quality social services and empowering HIV affected households with livelihood skills and opportunities for coping. Accordingly, the following section presents the progress made under social support during the period of reporting.

#### **3.5.1 Physical and Sexual Violence**

Gender Based Violence (GBV) has been found to be a significant social problem in Uganda which manifests itself in a wide range of human rights violations. These include; sexual abuse of

children, rape, child abuse, discrimination against girls, child labour, political violence/discrimination, intimate partner abuse, defilement, incest, domestic violence, sexual assault and harassment, trafficking of women and girls, pornography, female circumcision, forced control over reproductive functions of women. The 2006 UDHS showed that six in ten women and 53% of men have experienced physical violence since age 15. More recently, according to the 2010 Police Crime Report, over 8500 people experienced sexual violence.



**Figure 32: Sexual and Physical Violence**

In Uganda, gender based violence issues have been found to originate from institutionalized male dominance as opposed to female subordination, leading to unequal power distribution in the home and the society. Some of the GBV have been in the form of widow inheritance, dowry payment, and early marriages among others. Critical GBV areas which have a bearing on HIV transmission and thus need to be addressed include: forced marriage, rape, defilement, forced sex in marriage, and sexual harassment and exploitation.

### **3.5.2 School Attendance among OVCs and Non-OVCs**

School attendance among orphans compared to non-orphans aged 10–14 is the major indicator provided under the NSP to measure promotion of sustained education, vocational and life skills. Reports show that 2007 (at onset of NSP), 81.9% orphans attended school; overall national primary enrolment was 8.3 million in 2009<sup>12</sup>, orphans constituted 15.7 % of the entire primary enrolment figure<sup>13</sup> while 264,098 orphans accessed secondary school<sup>14</sup>.

The UDHS 2006 indicated that the ratio of non-OVC versus OVC aged 10-14 years who were attending school<sup>15</sup> was 5.1 meaning that there was no significant variation between OVC and

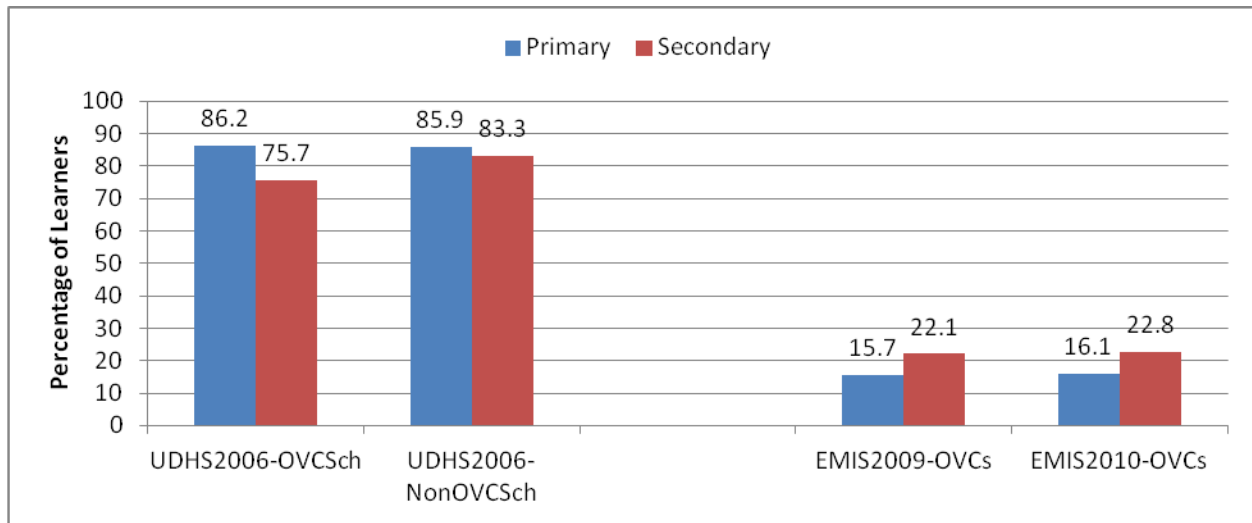
<sup>12</sup> UBOS (2010), statistical abstract

<sup>13</sup> MOES, EMIS Statistical abstract 2009

<sup>14</sup> MOES, EMIS, 2009.

<sup>15</sup> UNHS2005/06, UDHS2006; no significant variation between OVC and Non-OVC (UDHS2006) Guide to Monitoring & Evaluation of the National Response for Children Orphaned and made Vulnerable by HIV/AIDS: UNAIDS, Geneva 2005

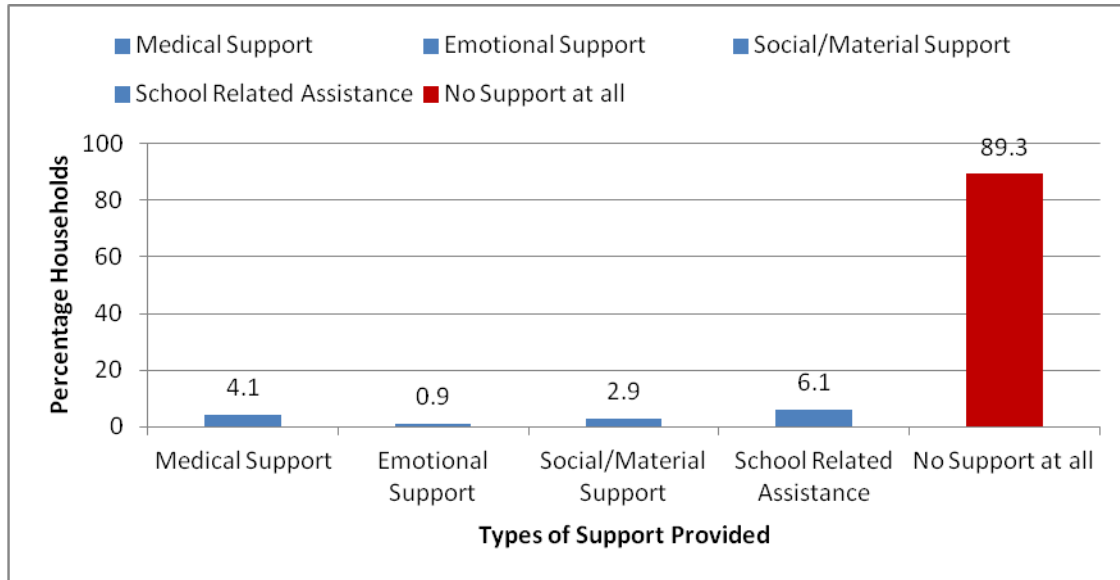
non-OVC. Specifically, while 86.2% of OVCs in the primary school going age 10-14 were in school, only 85.9% of non-OVCs counterparts were in primary school. At the secondary school level, the percentages were 75.7% and 83.3% for OVCs and non-OVCs respectively. Although government has put in place both UPE and USE throughout the country, a relatively larger proportion of non-OVCs than OVCs are in secondary level. Nonetheless, the proportion of orphans among the learners in primary and secondary schools continued to increase between 2009 and 2010 from 15.7% to 16.1% in primary and 22.1% to 22.8% in secondary.



**Figure 33: School Attendance among OVCs and Non-OVCs**

### **3.5.3 Economic Support**

The UDHS 2006 collected information on the extent to which free external care and support services are reaching orphans and vulnerable children. around nine in ten orphaned and vulnerable children lived in households that did not receive any type of support. Among those children who lived in households that did receive some type of support, the most common type of support received was schooling support (6 percent), followed by medical support (4 percent).



**Figure 34: Support Provided to OVCs, UDHS-2006**

The more recent data available shows a few CSOs have interventions addressing household food insecurity and malnutrition. Other agencies offer food handouts such as maize flour, milk, *soya* and so on. Some reports show that about 34,334 OVC households were served with emergency food during 2009-2010<sup>16</sup> while others indicate that 51,700 received varying levels of food aid<sup>17</sup>, while 89,365 OVC were provided with food and nutritional supplements<sup>18</sup>. Data for OVC indicators from the MoGLSD MIS (2010) also show that a total of 110,956 caregivers were trained in food preparation and storage<sup>19</sup>. In addition to this, MOGLSD has initiated the Social Assistance Grants for Empowerment (SAGE) for supporting the transfer of regular and predictable social grants to poor households.

<sup>16</sup> Existing data for OVC indicators from the MoGLSD MIS

<sup>17</sup> FEWSNET, June 2010, Uganda Food Security Outlook Update, USAID

<sup>18</sup> Existing data for OVC indicators from the MoGLSD MIS 2010

<sup>19</sup> Existing data for OVC indicators from the MoGLSD MIS 2010



#### **4. BEST PRACTICES**

***Young, Empowered and Healthy (YEAH) Initiative:*** This is an initiative that targets reaching young people (15-24 years old) by their colleagues through strategic health communication programming; thus, the YEAH campaign is a sustainable mechanism that supports coordinated social and behaviour change communication for young people in Uganda. The campaign has designed, implemented and evaluated two national multi-channel social and behaviour change communication efforts by and for youth. The first campaign was the “Something for Something Love” defined as exploitative relationships given in exchange of favours, material objects or money. The second campaign was “Be a Man” which addressed masculinity and male gender norms that reduce their vulnerability to HIV infection by stopping behaviours such as transactional sex, concurrent multiple sexual relationships, alcohol abuse and gender based violence. Evaluations of these interventions have suggested that they have helped to influence positive behaviour change among young people reached with messages.

***Family-centred Approach in the Provision of Holistic Care Package:*** This approach involves identification of the ‘index’ family member (the first individual - child or adult - to come in contact with the health facility system), usually through HCT. The ‘index’ individual is then used to obtain information on the other family and household members, defining both sexual and non-sexual relationships. Spouse(s), children, siblings, parents and other people living in the household of the index client or related to the client (sexually or non-sexually) are identified and followed up either by an invitation through the ‘index’ client to access care, a phone call inviting them to come to the facility for specific interventions or a home visit by a team of professionals to follow up the ‘index’ clients family. The services offered at the facility may include; HCT, treatment and prevention of OIs, including malaria and TB, routine immunization against early childhood diseases, management of common infections, pain and other symptom control, functional rehabilitation, nutrition and food security interventions. This approach has (a) made counselling and uptake for the use of HIV transmission risk reduction interventions easier (b) encouraged disclosure within the family thereby enhancing availability of more than one treatment supporter within the family. It has proved to be particularly important for adherence support for children on ART.

***Use of Expert Clients and other Community-Based Volunteers (CBVs):*** Expert clients are people living with HIV&AIDS who have not only overcome stigma but are knowledgeable and experienced role models for other PLHIV. Currently, expert clients are found in almost every ART site in Uganda undertaking various activities ranging from managing the records office (filing), triage, providing psychosocial support, promoting use of basic care products and services, health education, pre-test and post test counselling to bleeding new testers for HIV. They are trained or given apprenticeship at site. Utilization of expert clients reduces stigma and discrimination, boosts uptake of the basic care services and fosters adherence to ART. Relating easily with peer PLHIV, play the role of peer educators as well as health educators.

***Coalition for advocacy:*** Over 30 HIV related CSOs formed a Consortium of Advocates for Access to Treatment (CAAT) comprising of treatment providers and the beneficiaries (PLHIV), government and development partners, private not for profit and private for profit organizations, health action groups and human rights and advocates groups. The consortium has been meeting

every month to discuss issues related to availability and consistency in drug supply especially ARVs, change of regimen without prior notice to PLHIV, bouncing at health centers when patients return for refills because of drug stock outs or missing files, client monopoly by some service providers among other issues, etc. The district forums and PLHIV networks as well as district focal point persons are selected from various regions to represent others and report on the status of treatment in their respective areas are invited to the meetings; target districts are selected on a rotational basis. This has helped to get information from across the country that is used to successfully lobby policy makers and other relevant stakeholders for reliable and consistent access to treatment.

## **5. MAJOR CHALLENGES**

### **5.1 Challenges in UNGASS Report 2010 and Remedial Actions**

#### **5.1.1 Challenges**

The challenges that had been identified in the last UNGASS report are highlighted here and thereafter the remedial actions taken presented.

**Policy implementation:** The enactment of the National HIV&AIDS Policy has been very slow resulting in laws on HIV&AIDS being proposed ahead of the policy.

**M&E environment:** Policy and programmatic challenges such as uncoordinated data bases at national level, unclear system for information sharing, improper data validation system and scattered data collection tools.

**Prevention:** Prevention services remain inadequate in scope and coverage (e.g. high unmet need for HCT, low coverage for PMTCT and challenges in addressing infection control and infection safety especially in the context of TB-HIV) and some of the policies that can help curb the spread of HIV are yet to be implemented and rolled out e.g., the MMC.

**Care and Treatment:** Late starting of people on ARTs when their CD4 count is still high continues to elude the country response while provision of treatment is largely donor-driven with questionable sustainability.

**Social Support:** Country's budget is overstretched yet the scope and magnitude of pressing needs and demands of OVCs, PHAs, affected families and whole communities are increasing while the inadequacy of human resource capacity to provide services is further exacerbating the situation.

**Funding of Civil Society:** CSF is not fully owned and run by CSOs in the national response yet the cost of externalization of the management agencies is considered to be high.

#### **5.1.2 Remedial Actions**

**Policy implementation:** The National HIV and AIDS Policy was developed and launched thus providing the necessary strong, coherent, supportive, human rights and gender-balanced legal and policy environment necessary for the implementation of the NSP. It was disseminated to the key stakeholders during the Joint Annual AIDS Review conference. The process of reviewing the Uganda AIDS Commission statute was initiated.

**M&E environment:** The MOH revised HMIS by incorporating many HIV/AIDS indicators and harmonizing the reporting tools for PMTCT, ART, TB and HCT; these tools along with the reports on analysis of selected key performance indicator are now available on its web portal <http://www.health.go.ug/hmis/> for sharing with key stakeholders and the general public. The MOGLSD also designed and launched its OVC management information system (OVC MIS);

the system which is hosted on [www.mglsd.go.ug.ovc](http://www.mglsd.go.ug.ovc) allows service providers to upload information on children and families reached and to generate performance reports that are accessible to the public.

UNASO established a database on its partners at [www.unaso.or.ug](http://www.unaso.or.ug). The CSF established a database that captures information on prevention (people reached with BCC, HCT, PMTCT, Care and Treatment) and OVC (service providers, clients reached) services. These are posted on their website <http://www.csf.or.ug/database.aspx>. Under PEPFAR support, in addition to MEEPP, a LQAS was carried out in 52 districts of the country and the information collected used in supporting planning at the district level.

**Prevention:** MOH revised and rolled out the Uganda HIV Counseling and Treatment Policy<sup>20</sup> and the Uganda Antiretroviral Treatment Policy<sup>21</sup>. In addition, the Safe Male Circumcision Policy<sup>22</sup> and The National Communication Strategy<sup>23</sup> for Safe Male circumcision for HIV prevention were launched and rolled out. Following the pilot initiative for the re-introduction of the female condom, a national condom strategy that addresses sustainable access and utilization of quality male and female condoms was launched in 2011. In addition to these, a National HIV Prevention Strategy and Plan was developed and launched alongside those for other ministries, namely, Agriculture, Animal Industry & Fisheries; Defence; Education & Sports; Gender, Labour & Social Development; Health; Internal Affairs (Police and Prisons); Local Government; Public Service; and Transport and Works.

In terms of coverage, the number of facilities providing HCT has continued to increase to the extent that HCT is now available at all Hospitals, all HCIV, 80% of HCIII and 22% of HCII facilities. HCT for PMTCT which is available in all hospitals has also reached almost 100% of the HCIIIs and about 40% of HCIIIs. Consequently, for instance, 2,243,765 individuals were tested in September 2010 to March 2011 compared to 1,059,598 in the previous reporting period by PEPFAR.

**Care and Treatment:** In the revised treatment policy, (a) the ART eligibility for adults was changed from CD4 250 to 350 (b) eligibility for children was changed to include treatment for all children below two years of age, irrespective of their CD4 count/percentage and (c) all TB patients co-infected with HIV became eligible.

The funding for ART in Uganda is largely from PEPFAR, Global Fund, GOU, and CHAI/UNITAID. The Government of Uganda (GOU) contribution to ARV procurement has increased over the years. In the FY 2010 the GOU allocated 90 billion Uganda shillings for procurement of Malaria and HIV drugs (ACTs and ARVs), an increase from 60 billion shillings in 2009. Currently 206 billion shillings has been approved for NMS for 2011/12 and the budget is projected to increase to 234 billion in 2012/13 and to 267 billion in 2013/14 respectively.

---

<sup>20</sup> MOH (2011). Uganda HIV Counselling and Testing Policy. Kampala

<sup>21</sup> MOH (2011). Uganda Antiretroviral Treatment Policy. Kampala

<sup>22</sup> MOH (2010). Safe Male Circumcision Policy. Kampala

<sup>23</sup> MOH (2010). The National Communication Strategy for Safe Male circumcision for HIV Prevention. Kampala.

**Social Support:** The free universal education was expanded from UPE to include USE; a loans scheme was to be put in place for post secondary education. For the youths out of school, in FY 2011/12<sup>24</sup> government allocated (a) Shs 25 billion for Youth Entrepreneurship Venture Capital Fund to support youth start or expand their business enterprises (b) Shs 3.5 billion for Youth Entrepreneurial Training Programme to instill business management skills among the youth, to enable them join the job market or create their own enterprises and (c) Shs 1 billion for Business Development Skills clinics in order to impart technical skills to youth, using non-formal vocational training programmes. A Social Assistance Grants for Empowerment (SAGE) has also been put in place for regular transfer of social grants to poor households in the country.

**Funding of Civil Society:** During the last two years, efforts were made for identifying a local organization to take over the work carried out by the three Agencies (TMA, FMA and MEA); as a start, the functions TMA and MEA were to be merged. This would not only reduce the cost of management but would also enhance sustainability of CSF structures particularly if management shifted to local agencies. Although the process stalled, in late 2011 the TMA was instructed to initiate a new bidding process.

## **5.2 Challenges faced January 2010-December 2011**

**Policy implementation:** The overall capacity of the UAC to fulfill its expansive coordination mandate was weak because (a) the staff establishment at managerial and coordination levels was lean for the envisaged UAC functions at centre (headquarters) and in the increasing number of districts (b) there was a large number of positions not filled. Furthermore, the amendment of the UAC Statue has been very slow.

The roles of the civil society were not clearly indicated making it difficult to hold them accountable for their action or inaction. In any case, it was noted that CSOs are weak in their capacities for governance, management, advocacy and service delivery; there is no comprehensive strategic plan for capacity building for CSOs that various partners may contribute to.

Although many policies and guidelines had been developed and disseminated, the MTR found that there were challenges with human resources include inadequate staffing, retention and motivation that are critical for implementing such policies and guidelines. In particular, inadequate staffing in care and treatment was more prominent for clinical, laboratory and counseling cadres; this has resulted in task shifting but with insufficient guidance and variations across implementers.

Sustainability and predictability of funding has remained a major challenge in financing the HIV response thus significantly affecting the flow and availability of funds. In this regard, the level of increase in GOU funding is far below the increase in demand for ART and there are concerns about cost-efficiencies in the models of care as well as continued challenges with ensuring access to funding through the Global Fund. Against this, the CSF gives grants to CSOs on a competitive

---

<sup>24</sup> MOFPED (2011). Budget Speech - Promoting Economic Growth, Job Creation and Improving Service Delivery. Kampala

arrangement yet some of the potential beneficiary district based NGOs and community based organizations lack the technical capacity to compete with national NGOs and have thus not benefited from CSF funding.

**Prevention:** The coverage of behavioural, biomedical and structural HIV prevention interventions were not on a scale of universal coverage with rural areas and MARPS particularly underserved. Although none of the interventions being implemented is 100% efficient in prevention new infections in all population groups, there was limited efforts towards a structured combination package and integration of services was a big challenge. IEC/BCC interventions lacked clear guidelines, policies, standards and were often not aligned to factors driving the epidemic while social cultural norms that influence behavior were often neglected. In general, mainstreaming of HIV prevention in development programmes remained sub-optimal.

Although PMTCT services were being provided in all hospitals, HC IVs and IIIs and some HC IIs, not all HIV positive pregnant mothers have access; in any case, in some health units the mothers do not get quality PMTCT services – some get single dose Nevirapine which offers low protection and have no capacity to try alternatives to breastfeeding and thus continue to expose babies. Besides, the low male partner involvement in PMTCT programmes remained a big challenge yet male spouses could positively influence uptake of PMTCT/RH services especially adherence to ARV and Septrin prophylaxis, breast-feeding in the context of HIV and psychosocial support to the mother.

Most MARPs face structural inequalities and are less accessible to both preventive and curative services because, among other reasons, there is limited access, uneven distribution, poorly linked care, treatment and referral services in most of the MARPs' programs. On the other hand, some MARPs such as FSWs, men who have sex with men (MSM) and injecting drug users are highly marginalized because they are illegal in Uganda. Thus precluding them from easy access to HIV/AIDS services which leads to their elevated risk for HIV transmission and infection.

**Care and Treatment:** In the MTR, it was found that there were gross inequities in access to ART across sub-populations with only 23% of ART eligible children, 42% of ART eligible men and 55% of ART eligible women accessing treatment and very limited access to treatment among MARPs and fishing communities. Only 33% of women received SdNVP while 39% women received combination regimens and 18% of women received HAART. Regarding Early Infant Diagnosis (EID) only 29% of exposed children were tested for HIV and in 2009/10. This low rate of access to treatment was largely attributed to differential levels of decentralization of ART and PMTCT services and weak linkages/referral mechanisms from one health facility category to another.

A major challenge is that TB services are more decentralized and available in rural facilities than HIV treatment services. Besides, at the community level, mobilisation for and delivery of various TB and HIV services including HBHCT, drug refills and adherence monitoring are not always integrated and duplication of efforts as well as missed opportunities for diagnosis, treatment and support still exist.

A review of the HIV Supply Chain Management (SCM) in March 2011 identified five independent ARV supply chains in the country. The review note that these multiple systems created several challenges including ( a) limiting access to medicines since there are often stock-outs in one system, while there are drugs available in another supply chain ( b) most facilities receive ARVs from two supply chains, creating confusion over when and how much to order from each and (c) poor national data (double/under-counting) that affect planning.

**Social Support:** The MTR noted that many district LGs and partner organizations provide various basic services such as education, healthcare and health education, psychosocial support (PSS), nutritional support and IGAs as a form of economic empowerment and that a few PLHIV, OVC, PWD, the elderly, youth, women, and rural and urban poor and other vulnerable groups are receiving a comprehensive package of social support services. There is inequity in funding and coverage of such social support services to needy groups, including rural and urban poor. However, such support services can be regarded as ‘a simple drop in an ocean’ due to the fact that the number of people needing such support is significantly larger than the capacity of the available service providers can handle. Secondly, the legal and policy related issues for social support has many challenges. Thirdly, there is still limited data available for the Global AIDS Response Reporting on OVCs.

### **5.3 Remedial Actions January 2012-December 2013**

**Policy implementation:** Expedite the implementation of the UAC institutional review recommendations. A comprehensive evaluation of the architecture, functionality, cost and financing of the national and decentralized coordination mechanism (including Partnership Forum, SCEs, DACs, DATs etc) needs to be carried as a basis for recalibration of coordination structures.

There is need to review the issues relating to recruitment, retention and motivation of staff engage in health and HIV/AIDS related service delivery in public sector (at national and decentralized levels) and also for non-state agencies (both within and between agencies).

There is need to expedite the establishment of the proposed HIV and AIDS Trust Fund. At the same time, maintain support for the CSF and streamline resource allocation for empowering small NGOs and Community-based Organizations (CBOs) to effectively access the CSF funding. In the meantime, the irregular flow in GF grants needs to be addressed.

**Prevention:** There is need to scale up the use of combination prevention and expand the MARPs and medical male circumcision programmes. These is also need to promote male involvement in PMTCT programs by highlighting the role of men and family significant others in improving sexual and reproductive health of their female partners. Scale-up HIV testing to reach more first-time testers and improve linkage of more HIV infected individuals to care and community prevention, treatment and support systems. There is need to improve on coordination and scaling of prevention interventions as captured in the strategic plans.

**Care and Treatment:** Scale up ART access according to the new guidelines and streamline/improve on logistical supply chain. Scale-up of the TB-HIV interventions with

specific targets, and expansion of the reach for the ‘3 Is’ as well as MDR TB interventions. This should be in addition to increased access to OI diagnostics and management, beyond the basic care kits and cotrimoxazole as well as improved guidance for, and quality of pre-ART care and enhancement of the SRH and prevention integration with care and treatment. The currently non-disaggregated pharmaceutical budget in the national budget needs to be more specific for ART so easing follow-up and tracking.

**Social Support:** The weak and overwhelmed extended family safety-net should be re-energized to cater for PLHIV, OVC and other affected groups through economic empowerment/IGAs. Support should include training and capacity building of organized structures of PLHIV, elderly, PWD and other categories in various aspects including resource mobilization, management of member projects, advocacy, and other fields. There is also need to enact laws to protect PLHIV, OVC, PWD, the elderly, youth, women, and rural and urban poor and other vulnerable groups on account of HIV status. And these should be disseminated to all stakeholders and OVC caregivers. There is need to collect the relevant data on OVCs for national and global reporting.



## 6. SUPPORT FROM DEVELOPMENT PARTNERS

### 6.1 Key Support from AIDS Development Partners

It is appropriate to recognize the effective engagement of the ADPs in the major policy and technical forums on HIV/AIDS including UAC-Partnership Committee, Civil Society Fund, Global Fund CCM etc. Secondly, the ADPs have continued to hold their regular meetings which is exemplary for all other constituencies in the national response.

The overall funding of HIV/AIDS in Uganda is predominantly supported by bilateral and multilateral donors. The major bilateral donors are USG/PEPFAR, Irish Aid, DfID, DANIDA, SIDA and Italian Cooperation while multilateral donors are UN agencies and GFATM. Most of the support by bilateral agencies are provided through the Civil Society Fund and Partnership Fund.

**Table 9: Contribution of Development Partners to AIDS Response**

	2007/08	2008/09	2009/10	2010/11
<b>BILATERALS</b>				
Irish Aid	3.63	13.01	6.93	6
DFID	4.43	4.75	4.78	4
DANIDA	4.65	4.88	5.43	4
SIDA	1.2	0.05	-	1
Italian Coop	0.22	-	0.07	
USG/PEPFAR	228.88	269.83	256.99	289
<b>MULITLATERALS</b>				
UN Agencies	13.19	6.56	10	TBD
GFATM	-	-	24.17	4.35
Other donors	0	0	-	
World bank			-	
<b>TOTAL</b>	<b>256.2</b>	<b>299.08</b>	<b>308.37</b>	<b>308.35</b>

**USG/PEPFAR:** USG/PEPFAR is the major and dominant funder for the national HIV/AIDS response. Indeed, the contribution of USA in 2009/10 and 2010/11 were respectively 83% and 93% of all the resources availed by all the external funders as is shown in the table above. In addition to funds, the USG has (a) provided TA to GOU, CSO, NGOs and national advisory bodies (b) supported service delivery at the district level and national programs (c) built capacity building of individuals, organisations and systems through programmes such as SURE projects supporting PSM, Capacity supporting HRH, MEEPP supporting M&E, etc. Against this background, while over 40% of USG spending has been used in the expansion of care and treatment services in Uganda, the annual expenditure on prevention activities has consistently accounted for a quarter of PEPFAR support in the country.

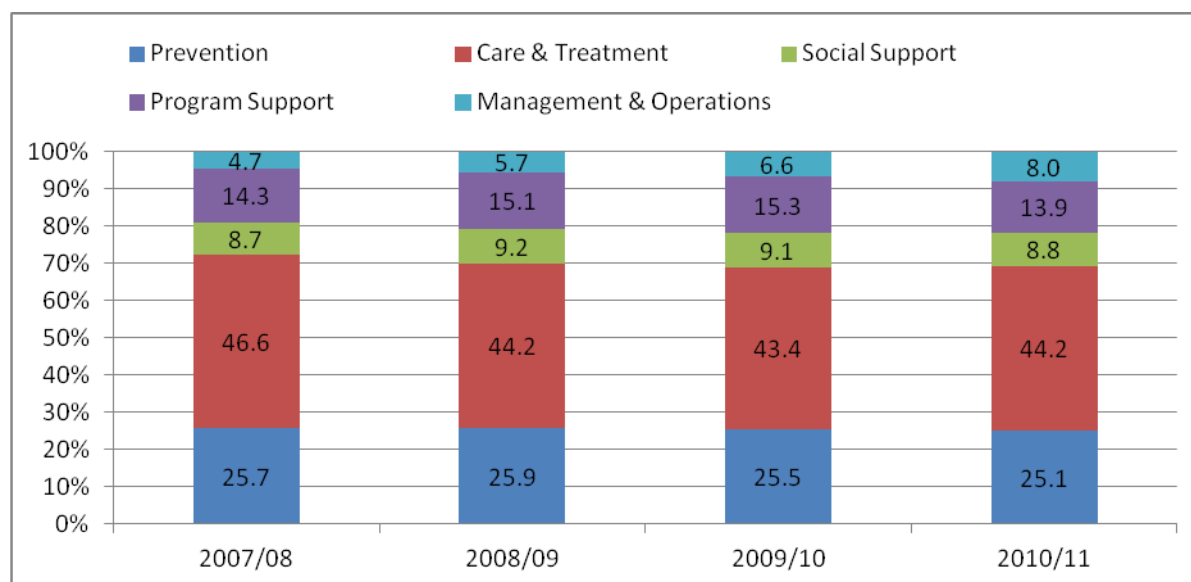


Figure 35: Resource allocation under PEPFAR

**GFATM:** Since 2007 when NSP was launched, GFATM made calls for proposals for Rounds 7, 8, 9 and 10 to which Uganda responded to all except Round 8. Round 7 application was successful and the grant amount was US\$241m (Phase I \$70.2m and Phase II, \$171m) was approved. Round 9 application was unsuccessful and Round 10 failed because Uganda had (a) a sizable balance of Rd. 7 funds (b) weakness in gap analysis and contributions of other actors (c) did not address the human rights of most-at-risk populations and (d) weakness in soundness of approach. During the period June 2007 and May 2011, three disbursements were received: the first installment amounting to \$4,250,995 was disbursed in August 2009 for emergency ARV procurement; the second installment of \$19,920,025 was released in May 2010 mainly for procurement of ARVs, other drugs, medical supplies, human resources and M&E while the third installment worth \$4,391,196 was disbursed in September 2010 for training and IEC materials.

**UN Agencies:** The UN agencies have been implementing a Joint UN Programme Support for HIV/AIDS through which they have provided technical assistance to UAC, Civil Society and the public sector in implementing the NSP.

**Civil Society Fund:** The CSF was established for the purpose of bringing together multiple donor funds under one policy and management arrangement so that the CS can be supported in a harmonized and streamlined manner. Since its inception in 2007, USAID, DfID, DANIDA, Irish Aid, Italian Cooperation and SIDA have provided support to the fund for onward disbursement to the CS organizations as is shown in the table below.

Table 10: Committed donor contributions (USD) to the Civil Society Fund, 2007/08-2011/12

DONOR	2007/8	2008/9	2009/10	2010/11	2011/12
DANIDA	3.800.000	4.200.000	4.407.190	4.409.091	4.409.091
IRISH AID	3.340.000	5.124.000	6.300.000	5.850.000	6.370.000
USAID	204.678	3.490.438	6.704.884	3.826.303	3.826.303
DFID	4.200.000	4.200.000	4.784.000	4.500.000	3.500.000
ITALIAN COOP	-	-	69.930	-	-
SIDA	-	-	-	1.400.000	1.400.000

<b>TOTAL</b>	<b>11.544.678</b>	<b>17.014.438</b>	<b>22.266.004</b>	<b>19.985.394</b>	<b>19.505.394</b>
--------------	-------------------	-------------------	-------------------	-------------------	-------------------

Source : EASE International (2011). Mid-term Review of Civil Society Fund Uganda. Civil Society Fund, Kampala.

In both 2009 and 2010, CSF had been able to disburse funds to national NGOs, lead agencies, district NGOs, community based organizations and local governments resulting in over 50% of CSF resources to be used for prevention of HIV transmission and OVC service delivery.

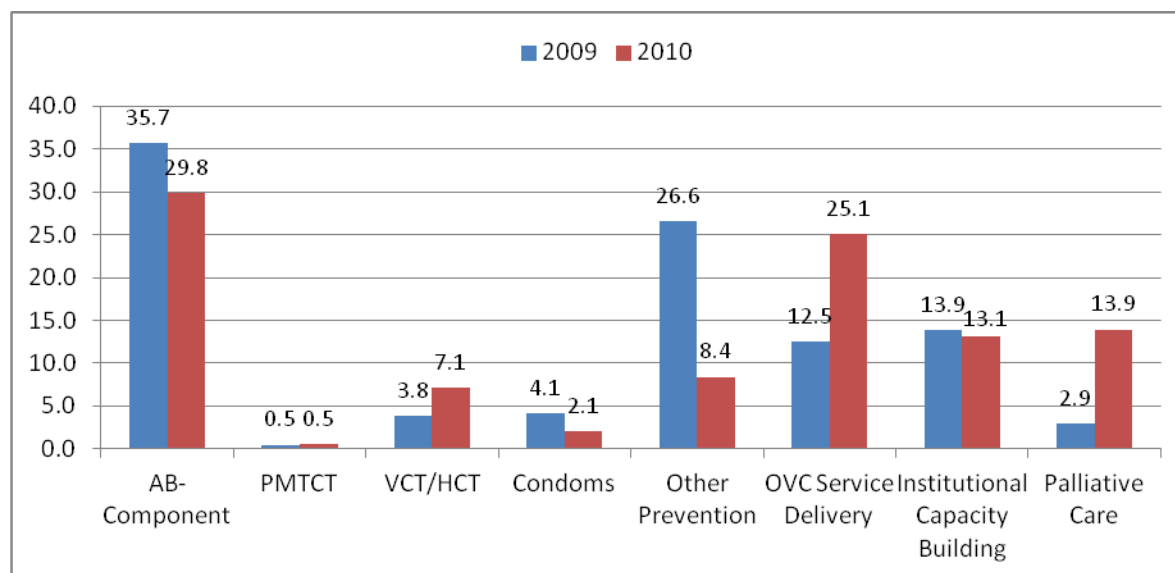


Figure 36: Utilization of CSF in the AIDS Response

**Partnership Fund:** ADPs have continue to provide resources to the HIV/AIDS Partnership Fund whose purpose is to support the coordination operations of the Partnership mechanism that includes Partnership Committee, Partnership Forum, the 12 SCEs and UAC Secretariat. While the fund has registered an average annual growth of 24%, the consitnet contributors have been DANIDA and Irish Aid.

Table 11: Contribution to Partnership Fund by Bilateral Agencies

Source	AMOUNT IN US			
	2007/08	2008/09	2009/10	2010/11
DFID	275,010.09	556,530.87	-	270,417.42
DANIDA	867,603.68	690,846.29	1,106,859.51	117,802.20
Irish Aid	291,332.15	490,064.25	683,497.54	615,200.00
SIDA	-	47,437.82	-	-
<b>TOTAL</b>	<b>1,433,946</b>	<b>1,784,879</b>	<b>1,790,357</b>	<b>1,003,420</b>

Source: UNGASS (2010) and UAC Review (2011)

## 6.2 Actions Needed from AIDS Development Partners

In order to enhance government contribution to the national response, the ADPs need to deepen their engagement with government particularly MFPED for (a) ensuring that HIV/AIDS is mainstreamed in budget and activities of all sectors and (b) expanding the health sector budget to accommodate the provision of the ever increasing ART services.

ADPs also need to sustain the CSF while making access to the resources by small NGOs and Community-based Organizations easier and equitable across the country and for interventions focusing on the MARPs that may not be covered by government institutions. The ADPs also need to support government in the implementation of the 3-ones principles, namely, (i) one plan by aligning their plans and contributions with the national strategic plan and supporting the implementation of the prevention plans developed by different sectors (ii) one coordinating agency by supporting the coordination arrangements including UAC and other structures like Partnership mechanism, Sector and District coordination committees, civil society networks etc and (iii) one national M&E system by strengthening M&E at UAC, institutionalizing the NASA and integrating HIV/AIDS in sector M&E systems.

## **7. MONITORING AND EVALUATION ENVIRONMENT**

### **7.1 Overview of Current Monitoring and Evaluation System**

The Uganda AIDS Commission (UAC), by statutory mandate, is responsible for the overall coordination of the HIV response nationally, including monitoring and evaluating the national response to HIV/AIDS. In this regard, the NSP included a specific objective on M&E which aimed to effectively coordinate collection, analysis, use, and provision of information that will enable tracking the progress made in the national response to HIV/AIDS. A Performance Measurement and Management Plan (PMMP) was developed as an accompaniment to the NSP to (a) guide coordinated and efficient collection, collation, analysis, interpretation and dissemination of information for HIV/AIDS programmes and (b) enable UAC to have required information to track the impact of the national response. UAC has accordingly established a database at its Secretariat for monitoring the national response. The sectors, district, civil society etc are expected to provide the data for populating the database.

The Ministry of Health has upgraded its HMIS for collecting different types of data including HIV/AIDS. The Ministry also continues to conduct surveillance of the epidemic at selected ANC sites against which it produces the HIV/AIDS Epidemiological Surveillance Report<sup>25</sup>, the latest was in 2010 and it includes information from routine data and special studies conducted by MOH and other partners. On the other hand, MOES has the Education Management Information System (EMIS) through which it annually produces information on the sector including HIV/AIDS. Similarly, the MOGLSD has established an OVC MIS for collecting information on OVCs. Efforts are underway to integrate HIV/AIDS in the LOGICS in MOLG.

Among the development partners, USG/PEPFAR has established the Monitoring and Evaluation of Emergency Plan Progress (MEEPP) to provide technical support and oversight for M&E among the partners it supports through USAID, CDC and other US development agencies, to compile and consolidate performance data. Thus, working to see that their guidance is consistent with existing national systems, MEEPP also conducts special studies to synchronize and validate data with the MOH prior to dissemination. On the other hand, the CSF has also established its own database for tracking performance by their implementers.

Efforts have also been made to generate population based information for monitoring and evaluating the national response. Thus, UDHS and UAIS were carried and provisional reports produced in 2011. In addition to this, Lot Quality Assurance Surveys (LQAS) supported through the PEPFAR-funded STAR projects have been carried and, indeed, efforts are being made to have LQAS institutionalized in the health and education sectors in the country. In 2011, a National AIDS Spending Assessment Survey was also undertaken for the first time in the country.

### **7.2 Challenges in Implementation of Monitoring & Evaluation System**

---

<sup>25</sup> Ministry of Health (2010). The HIV/AIDS Epidemiological Surveillance Report 2010. Kampala June 2010.

The NSP review found that the insufficient staffing for M&E compounded by under-staffing, unclear roles and responsibilities, lack of M&E skills, vertical programme demands and multiple reporting arrangements greatly impede the performance of the HIV/AIDS M&E system. For instance, the Directorate of Planning, Monitoring and Evaluation of the UAC was found to be operating with only 37% of the intended staffing<sup>26</sup>.

A nationally coordinated capacity building strategy for M&E is absent; this significantly affects availability, quality, access and utilization of strategic information by stakeholders at different levels and regions of the country. Uganda also lacks a costed M&E work plan that clearly identifies activities, actors, costs and timeframes for collection of data to guide the management of the national response. In the meantime, the parallel M&E systems in the country do not talk to each other.

There is currently no centralized database to track key indicators of the epidemic or the national response; thus, there are very many indicator in NSP for which no baseline data was available and no apparent plans were in place to collect the information; of the 58 indicators included in the PMMP, it was estimates that 65% were not collected with the planned frequency.

Lastly, most of strategic M&E actions identified in the NSP are highly dependent on development partner inputs such that when external funds are not available, the activities tend to stall.

### **7.3 Planned Remedial Actions**

In order to address the issues related to M&E, the NSP review recommended that there is need for UAC and ministries to provide adequate human and logistical support for quality M&E to be undertaken; this should be supported by a proactive capacity building effort for M&E. The roles and responsibilities of UAC and sectors need to be defined and operationalized. There is also need to streamline the national HIV/AIDS M&E framework by differentiating high-level indicators of the national response from implementation-level indicators that should be left to the respective sectors to monitor and report to UAC. A one stop information centre for knowledge management and sharing will need to be established.

UAC should develop its own organizational M&E plan and regularly review in order to gauge progress in its coordination function. Across all levels, a lack of human resources was consistently expressed as a major limitation in HIV/AIDS monitoring and evaluation. However, UAC and ministries need to consider dedicating M&E staff to liaise on sector specific M&E issues.

### **7.5 M&E Technical Assistance and Capacity Building Needed**

The NCPI Survey has identified that priority areas for technical assistance and capacity building required for Uganda are as follows:

---

<sup>26</sup> Information acquired from the Directorate of Planning and Monitoring and approved organization structure and the length of time each position was occupied/vacant.

## **ANNEXES**

### **Annex 1: Consultation / Preparation Process**

#### **THE GENERAL REPORT WRITING PROCESS**

The UNGASS Country Progress Reporting process was highly participatory. Data collection techniques included desk review, in-depth interviews with key informants, group discussions and consultative meetings. Data were collected at national level in terms of stakeholders' interactions and search for secondary sources. Overall co-ordination was provided by Uganda AIDS Commission (UAC) with support from UNAIDS. Two Consultants were engaged to collect and analyze both primary and secondary data, and compile the NCPI Report. UNAIDS and UAC M&E Officers provided day to day guidance to the team, and assisted the consultants in locating and accessing required sources of data; documents, reports, identification of stakeholders and key informants. UAC provided overall leadership in linking the consultants with a team of staff at the ministry including the Epidemiologist, the Health Management Information System (HMIS) and M&E Officer.

The national Monitoring and Evaluation (M&E) Technical Working Group (TWG) was tasked and mandated to provide technical input and support to the team of Consultants. See Annex 1 for details of the process and members of TWG. The TWG discussed the progress and drafts presented by the consultants, provided technical guidance, filled data gaps where they existed and tried to reach agreement on areas that generated controversies in the response. The primary purpose of the TWG and the core group was to ensure accuracy, authenticity and comprehensiveness of the data presented as well as building consensus on the reported results. In the course of compiling the Report, a workshop was held (March 23, 2012) to discuss the first Report Draft. The comments and observations made by participants were incorporated and a second draft produced, which was presented during the Validation Workshop held on April.....

#### **PROCESS USED FOR NCPI DATA GATHERING AND VALIDATION:**

The National Composite Policy Index assessment report is a summary of the existing HIV and AIDS national policies, strategies and plans in Uganda. The NCPI report data gathering and validation involved desk reviews, consultations with public sector agencies, CSO networks and Bilateral agencies, UN organizations and other Development Partners during which the questionnaire Part A (for Government) and Part B (for CSOs, Bilateral Agencies and UN Organisations) were self administered by the targeted respondents. The respondents included; UAC, MOH, MOES, MOGLSD, MOFPED, and MOWT. CSO representatives included UNASO, TASO, IRCU, NAFOPHANO, ICW, AIC, CEPARD, AGHA, UHSP, AMICALL, UGANET, HEPS, NACWOLA, . Projects included; MEEP, CSF, Global fund. Development partners included; UNAIDS, UNDP, UNICEF, WHO, UNFPA, PEPFAR, CDC, SIDA, Irish AID and World Bank. Questionnaires were synthesized by the Consultants and the generated draft reports were first reviewed by the National HIV/AIDS M & E Technical Working Group and finally validated at a national stakeholder's workshop.

## National Composite Index Respondents list

### NCPI PART A: Government Officials

No.	Name	Institution
1	Dr. Katumba Gubala	Ministry of Health (MOH)
2	Dr. Henry Stanley Katamba	Ministry of Health (MOH)
3	Dr. Grace Murindwa	Uganda AIDS Commission (UAC)
4	Mugimba Edward	Ministry of Gender, Labour and Social Development (MGLSD)
5	Wandera Ibrahim	Office of the Prime Minister (OPM)
6	Robert Kahuka	Ministry of Agriculture Fisheries and Animal industry and fisheries (MAAIF)
7	Roland Baryahwaho	Ministry of Education and Sports (MOES)
8	Dr. Balinda Julius (DHO)	Kyegegwa District Local Government
9	Businge Lawrence (DHE/ DFP)	
10	Muhumuza Edward (Biostatistician)	
11	Kasaija Kalya (DCDO)	
12	Dr. Mwesigye B. Gerald (DFP0)	Kiryandongo District Local Government
13	Dabanja Geoffrey (Ag. DCDO)	
14	Atuha N. Moses (AG. D/Planner)	
15	Dr. Mutyaba Imaam (Ag. DHO)	
16	James Mukwaya (Senior Planner)	Buvuma District Local Government
17	Tabula Dennis ( DFP)	
18	Dr. Nsubuga Fred (DHO)	
19	Galiwango Isaac (DCDO0)	
20	Mugerwa Moses (Planner)	Kyankwanzi District Local Government
21	Nakaggwa Prossy (MCO/DVO)	
22	Dr. Serebe Johnbosco (DHO)	
23	Muhanguzi Abel .K. (DCDO)	
24	Mayanja Christopher (D/Planner)	Buikwe District Local Government
25	Dr. Bbosa Richard (DHO)	
26	Ssewanyo Kiganda Sam (DCDO)	
27	Bernadette Nabuuma (DFP)	
28	Kato Patrick Perry( DFP0)	Butambala District Local Government
29	Kaggwa John Hannington( Ag, DCDO)	
30	Kakeeto Dominic Savio (For DHO)	
31	Ssenyomo Isaac	
32	Kakembo Richard (VoV)	
33	Kawalya Morgan Aden (DCDO)	
34	Kiyaga Deo (DFP)	
35	Dr. Bemba Moses (DHO)	
36	Golooba Rogers (D/ Planner)	



**NCPI PART B: Civil Society Organisations, Bilateral, UN and Agencies and Projects**

<b>No.</b>	<b>Name</b>	<b>Institution</b>
1.	Bram Namanya	Uganda Network of AIDS Service Organisations (UNASO)
2.	Johnson Masiko	Inter Religious Council (IRCU)
3.	Florence Baluba	NACWOLA
4.	Stella Kantutsi	NAFOPHANU
5.	Lillian Mworeko	ICW
6.	Agiresaasi Apophi	Action group for Health and Human Rights and HIV/AIDS (AGHA UG)
7.	Rosette Mutambi	HEPS
8.	Dora Kichoncho	UGANET
9.	Professor Opolot Samson	Center For Participatory Research and Development (CEPARD)
10.	Dr Henry Tabifor	UNAIDS
11.	Charles Birungi	UNDP
12.	Rosemary Kindyomunda	UNFPA
13.	Sarah Kyokusingura	MEEP

**Annex 2: National Commitments and Policy Index (NCPI)**

**Part A**

(Submitted through the UNAIDS Global Reporting Tool On-line)

**Part B**

(Submitted through the UNAIDS Global Reporting Tool On-line)

**Annex 3: National Funding Matrix**

CATEGORIES	TOTAL USD \$	PUBLIC			INTERNATIONAL			PRIVATE	
		Central (National)	Sub- National	Development Bank Re- imbursables	Bilateral	Multilateral		Corporations	Out-of- Pocket
						UN	GF		
Prevention									
Care & Treatment									
Orphans & Vulnerable Children									
Program Management Costs									
Incentives for Human Resources									
Social Mitigation									
Community Development and Enhanced Environment									
Research									
<b>TOTAL</b>									

## REFERENCES

1. EASE International (2011). Mid-term Review of Civil Society Fund Uganda. Civil Society Fund, Kampala.
2. Initiative Consultants (2011). Uganda AIDS Commission Institutional Review–2011: Volume I UGANDA AIDS COMMISSION Board, UGANDA AIDS COMMISSION Secretariat and National HIV/AIDS Response. Kampala
3. Mayega. R et al. HIV/AIDS Sero-behavioral Survey in six Universities in Uganda 2010
4. Mermin J, Musinguzi J, Opio A, Kirungi W, et al. Risk factors for recent HIV infection in Uganda. JAMA 2008 Aug 6;300(5):540-9.
5. Ministry of Health (2011). Status of Antiretroviral Therapy Services in Uganda. Quarterly ART Report for October-December 2010. March 2011. Kampala
6. Ministry of Health (2011). Status of Antiretroviral Therapy Services in Uganda. Semi-Annual ART Report for January-June 2011. November 2011. Kampala
7. MOES (2009), EMIS Statistical Abstract. Kampala.
8. Ministry Of Health (2010). Health Sector Strategic and Investment Plan 2010/11-2015/16. Kampala.
9. Ministry Of Health (2010). National Health Laboratory Services Strategic Plan 2010-2015, Kampala.
10. Ministry Of Health (2010). Prevention of Mother to Child Transmission of HIV and Paediatric HIV/AIDS Care Programme. Annual Report July 2009 to June 2010.
11. Ministry Of Health (2010). Public Private Partnership for Health Policy. Kampala.
12. Ministry Of Health (2010). Safe Male Circumcision Policy, Kampala.
13. Ministry Of Health (2010). Scale-up Plan for Prevention of MTCT of HIV and Care of Exposed Infants 2010-2015, Kampala.
14. MINISTRY OF HEALTH (2010). Second National Health Policy, Kampala.
15. Ministry of Health (2010). Sexual reproductive health & rights (SRH&R), HIV/AIDS linkages & integration in Uganda. Rapid Assessment Study. Final Report.
16. Ministry Of Health (2011). National AIDS Indicator Survey 2011. Kampala
17. MINISTRY OF HEALTH (2011). Prevention of Mother to Child Transmission of HIV and Pediatric HIV/AIDS Care Programme. Annual Report July 2010 to June 2011. STD/AIDS Control Programme, Ministry of Health.
18. Ministry Of Health (2011). The Integrated National Guidelines on Antiretroviral Therapy, Prevention of Mother to Child Transmission of HIV and Infant and Young Child Feeding. Oct 2011. Ministry of Health, Kampala
19. MOIA (2010). HIV/AIDS Workplace Policy (MoIA), Kampala.
20. National AIDS Spending Assessment 2011
21. Opio, Muyonga and Mulumba (2010). HIV Sero-Behavioral Survey in four agricultural plantations of the Lake Victoria basin of Uganda. July 2010.
22. Opio, Muyonga and Mulumba (2010). HIV Sero-Behavioral Survey in fishing communities of Lake Victoria basin of Uganda. December 2010.
23. Sector HIV Prevention Strategic Plans 2010/11-2014/15: MOES, MOPS, MOGLSD, MAAIF, MOWT, MOIA (Prisons)
24. STAR –EC LQAS 2009 and 2010 Household Surveys. Survey progress report, September 2010. Results from nine districts in East Central Uganda.
25. The Crane Survey Report (2010). High Risk Group Surveys Conducted in 2008/09. Kampala, Uganda.
26. Uganda AIDS Commission (2008). Uganda HIV Modes of Transmission and Prevention Response Analysis. Kampala

27. Uganda AIDS Commission (2011). Joint Annual Review, Mid-Term Review and Revision of the National HIV/AIDS Strategic Plan for HIV/AIDS in Uganda 2007/08-2011/12: Care and Treatment Report. Kampala
28. Uganda AIDS Commission (2011). Joint Annual Review, Mid-Term Review and Revision of the National HIV/AIDS Strategic Plan for HIV/AIDS in Uganda 2007/08-2011/12: Prevention Thematic Areas Report. Kampala
29. Uganda AIDS Commission (2011). Joint Annual Review, Mid-Term Review and Revision of the National HIV/AIDS Strategic Plan for HIV/AIDS in Uganda 2007/08-2011/12: Systems Strengthening Report. Kampala
30. Uganda AIDS Commission (2011). Joint Annual Review, Mid-Term Review and Revision of the National HIV/AIDS Strategic Plan for HIV/AIDS in Uganda 2007/08-2011/12: Consolidated Report. Kampala
31. Uganda AIDS Commission (2011). Mid-Term Review of National Strategic Plan 2007/8-2010/11. Kampala
32. Uganda AIDS Commission (2011). National HIV/AIDS policy, Kampala.
33. Uganda AIDS Commission (2011). National HIV/AIDS Strategic Plan 2011/12-2014/15. Kampala.
34. Uganda AIDS Commission (2011). National Prevention Strategic Plan 2010/11-2014/15. Kampala.
35. Uganda AIDS Commission (2011). National Strategic Plan 2011/12-2014/15. Kampala
36. Uganda Bureau of Statistics (2010), Statistical Abstract, Kampala.
37. Uganda Bureau of Statistics (2011). Uganda Demographic and Health Survey 2011. Kampala
38. Uganda AIDS Commission (2011). Creating a National AIDS Trust Fund as a Sustainable Domestic Financing For HIV/AIDS Response in Uganda: A Working Paper. July 2011. Kampala

## NATIONAL COMPOSITE INDEX RESPONDENTS LIST

### 1. NCPI PART A: Government Officials

No.	Name	Institution
1.	Dr. Katumba Gubala	Ministry of Health (MOH)
2.	Dr. Henry Stanley Katamba	Ministry of Health (MOH)
3	Dr. Grace Murindwa	Uganda AIDS Commission (UAC)
4	Mugimba Edward	Ministry of Gender, Labour and Social Development (MGLSD)
5	Wandera Ibrahim	Office of the Prime Minister (OPM)
6	Robert Kahuka	Ministry of Agriculture Fisheries and Animal industry and fisheries (MAAIF)
7	Roland Baryahwaho	Ministry of Education and Sports (MOES)
8	Technical Planning Committee (TPC) Members (DHO, Planner, CDO)	Buvuma District Local Government
9	TPC members	Gomba District Local Government
10	TPC members	Kyankwanzi District Local Government
11	TPC members	Buikwe District Local Government
12	TPC members	Kiryandongo District Local Government
13.	TPC members	Butambala District Local Government
14.	TPC members	Kyegegwa District Local Government

No.	Name	Institution
1	Dr. Katumba Gubala	Ministry of Health (MOH)
2	Dr. Henry Stanley Katamba	Ministry of Health (MOH)
3	Dr. Grace Murindwa	Uganda AIDS Commission (UAC)
4	Mugimba Edward	Ministry of Gender, Labour and Social Development (MGLSD)
5	Wandera Ibrahim	Office of the Prime Minister (OPM)
6	Robert Kahuka	Ministry of Agriculture Fisheries and Animal industry and fisheries (MAAIF)
7	Roland Baryahwaho	Ministry of Education and Sports (MOES)
8	Dr. Balinda Julius (DHO)	Kyegegwa District Local Government
9	Businge Lawrence (DHE/ DFP)	
10	Muhumuza Edward (Biostatistician)	
11	Kasaija Kalya (DCDO)	
12	Dr. Mwesigye B. Gerald (DFP0)	Kiryandongo District Local Government
13	Dabanja Geoffrey (Ag. DCDO)	
14	Atuha N. Moses (AG. D/Planner)	
15	Dr. Mutyaba Imaam (Ag. DHO)	
16	James Mukwaya (Senior	Buvuma District Local Government

	Planner)	
17	Tabula Dennis ( DFP)	
18	Dr. Nsubuga Fred (DHO)	
19	Galiwango Isaac (DCDO)	
20	Mugerwa Moses (Planner)	Kyankwanzi District Local Government
21	Nakaggwa Prossy (MCO/DVO)	
22	Dr. Serebe Johnbosco (DHO)	
23	Muhanguzi Abel .K. (DCDO)	
24	Mayanja Christopher (D/Planner)	
25	Dr. Bbosa Richard (DHO)	Buikwe District Local Government
26	Ssewanyo Kiganda Sam (DCDO)	
27	Bernadette Nabuuma (DFP)	
28	Kato Patrick Perry( DFP0	
29	Kaggwa John Hannington( Ag, DCDO)	Butambala District Local Government
30	Kakeeto Dominic Savio (For DHO)	
31	Ssenyomo Isaac	
32	Kakembo Richard (VoV)	
33	Kawalya Morgan Aden (DCDO)	
34	Kiyaga Deo (DFP)	Gomba District Local Government
35	Dr. Bemba Moses (DHO)	
36	Golooba Rogers (D/ Planner)	

**1. NCPI PART B: Civil Society Organizations, Bilateral, UN Agencies and Projects**

<b>No.</b>	<b>Name</b>	<b>Institution</b>
1.	Bram Namanya	Uganda Network of AIDS Service Organisations (UNASO)
2.	Johnson Masiko	Inter Religious Council (IRCU)
3.	Florence Baluba	NACWOLA
4.	Stella Kantutsi	NAFOPHANU
5.	Lillian Mworeko	ICW
6.	Agiresaasi Apophi	Action group for Health and Human Rights and HIV/AIDS (AGHA UG)
7.	Rosette Mutambi	HEPS
8.	Dora Kichoncho	UGANET
9.	Professor Opolot Samson	Center For Participatory Research and Development (CEPARD)
10.	Dr Henry Tabifor	UNAIDS
11.	Charles Birungi	UNDP
12.	Rosemary Kindyomunda	UNFPA
13.	Sarah Kyokusingura	MEEP