
THE REPUBLIC OF UGANDA

# HIV AND AIDS UGANDA COUNTRY PROGRESS REPORT; 2013

Plot 1-3 Salim Bey Road, Ntinda Nakawa Division;
P.O. Box 10779, Kampala- Uganda Tel: +256-414-288065
Fax: +256-41-347447 Email: uac@uac.go.ug
Website: http://www.aidsuganda.org

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**ABBREVIATIONS AND ACRONYMS**

| | |
|---|---|
| ACP | AIDS Control Program |
| AIDS | Acquired Immune Deficiency Syndrome |
| AIS | AIDS Indicator Survey |
| ANC | Antenatal care |
| ART | Antiretroviral Therapy or Treatment |
| ARVs | Antiretroviral Drugs |
| BCC | Behaviour Change Communication |
| CDC | Centres for Disease Control |
| CPHL | Central Public Health Laboratory |
| CSO | Civil Society Organization |
| DHS | Demographic and Health Survey |
| EID | Early Infant Diagnosis |
| eMTCT | Elimination of Mother-to-Child Transmission (of HIV) |
| FBO | Faith Based Organization |
| FP | Family Planning |
| GARPR | Global AIDS Response Progress Report |
| GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GOU | Government of Uganda |
| HBC | Home Based Care |
| HC | Health Centre |
| HCT | HIV Counselling and Testing |
| HIV | Human Immunodeficiency Virus |
| HMIS | Health Management Information System |
| HRH | Human Resources for Health |
| IRCU | Inter Religious Council of Uganda |
| JAR | Joint AIDS Annual Review |
| JMS | Joint Medical Stores |
| M&E | Monitoring and Evaluation |
| MAAIF | Ministry of Agriculture, Animal Industry and Fisheries |
| MARPs | Most-at-Risk Populations |
| MDGs | Millennium Development Goals |
| MEEPP | Monitoring and Evaluation of PEPFAR Progress |
| MOES | Ministry of Education and Sports |
| MOFEP | |
| MOGLD | Ministry of Gender Labour and Social Development |
| MOH | Ministry of Health |
| MOIA | Ministry of Internal Affairs |
| MOLG | Ministry of Local Government |
| MSM | Men who have Sex with Men |
| MTCT | Mother to Child Transmission |
| MTR | Mid-Term Review |
| NACWOLA | National Community of Women Living with HIV/AIDS |
| NAFOPHANU | National Forum of People with HIV/AIDS Network in Uganda |
| NASA | National AIDS Spending Assessment |
| NDP | National Development Plan |
| NGO | Non-Governmental Organization |
| NMS | National Medical Stores |

| | |
|---|---|
| NPAP | National Priority Action Plan (for HIV/AIDS) |
| NSP | National Strategic Plan (for HIV/AIDS) |
| NTLP | National TB and Leprosy Control Program |
| NTRL | National TB Reference Laboratory |
| OI | Opportunistic Infection |
| OVC | Orphans and Vulnerable Children |
| PACE | Program for Accessible health, Communication and Education |
| PCR | Polymerase Chain Reaction |
| PEP | Post-Exposure Prophylaxis |
| PEPFAR | US Presidential Emergency Fund for AIDS Relief |
| PITC | Provider Initiated HIV Testing and Counselling |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of Mother To Child Transmission (of HIV) |
| PNC | Post Natal Care |
| PREFA | Protecting Families Against HIV/AIDS |
| PrEP | Pre-Exposure Prophylaxis |
| QPPU | Quantification and Procurement Planning Unit |
| SCM | Supply Chain Management |
| SRH | Sexual and Reproductive Health |
| STI | Sexually Transmitted Infection |
| SWs | Sex Workers |
| TASO | The AIDS Support Organization |
| TB | Tuberculosis |
| THETA | Traditional and Modern Heath Practitioners Together against AIDS |
| TWG | Technical Working Group |
| UAC | Uganda AIDS Commission |
| UNAIDS | Joint United Nations Program on HIV/AIDS |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| UPDF | Uganda People's Defence Force |
| USAID | United States Agency for International Development |
| VCT | Voluntary Counselling and Testing |
| VHT | Village Health Team |
| WHO | World Health Organization |

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**ACKNOWLEDGEMENTS**

This report on the progress made in the Uganda AIDS response between January and December 2013 was developed through a consultative process involving all the major stakeholders in both the public and non-public sectors. It highlights the achievements, challenges and lessons in the Uganda response, under the thematic areas of HIV prevention; care, treatment and support; and system strengthening; in line with the UNAIDS guidelines for global reporting and the Uganda AIDS response National Strategic Plan 2011-2015.

The process to develop this report was led by the Uganda AIDS Commission (UAC); through the National HIV/AIDS Monitoring and Evaluation Technical Working Group (TWG). UNAIDS and UNICEF provided financial and technical support to the report writing process.

I wish to express my sincere thanks to the TWG and all partners for the able and effective leadership in this regard.

I also take this opportunity to convey our great appreciation to all the stakeholders in the national response. These include: 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 national AIDS response over the year of reporting – 2013. I pay special tribute to the stakeholders that participated directly in the reporting process, in providing data and information; and through participating in the different consultations held.

Lastly, I would like to thank Dr Nathan Nshakira and Dr. Hudson Balidawa, who facilitated the entire process of assembling and synthesizing the information for the report; and guiding the drafting and completion of the report.

Dr. Christine J. D. Ondoa
**Director General, Uganda AIDS Commission**

**Executive Summary**

**HIV Prevalence:** The HIV epidemic in Uganda continues to be generalized, and has not changed pattern in the last three decades. The country achieved impressive success in the control of HIV during the 1990's, bringing down HIV prevalence among adults aged 15-49 years from a national average of 18.5% in 1992 to 6.4% as reported in the 2005 sero-survey. The 2011 AIDS Indicator Survey in Uganda reported HIV prevalence at a national average of 7.3% and important variations by sex and in specific regions. HIV prevalence in Uganda has consistently been higher among women compared to men since the early years of the epidemic. Between the 2004/2005 and 2011 AIS, there was notable decline in HIV prevalence among women in Kampala, Eastern and Central Eastern regions. These improvements may be a reflection of penetration of effective HIV prevention interventions across communities in the respective regions. However, the overall picture is of increased prevalence nationally and across the sexes.

**HIV Burden:** The total burden of HIV in Uganda, as represented by the number of persons in the country that are living with HIV, has continued to increase. This is a result of continuing spread of HIV, and increased longevity among persons living with HIV. Between 2007 and 2013, the estimated number of people living with HIV increased from 1.2 million to 1.6 million. In 2012, the PLHIV constituted 93% adults 15 years and above, women being 56% of these adults. The MOH projections based on Spectrum indicate a total of 1,618,233 people living with HIV in 2013; comprising of 1,441,285 adults, and 176,948 children below 15 years. The same source indicates a decline in AIDS-related deaths between 2011 and 2013; from 72,928 in 2011, 70,262 in 2012, and 61,298 in 2013.

**HIV Incidence:** Although Uganda continues to experience a high rate of new HIV infections; the trend over the last three years shows a decline, from an estimated 162,294 in 2011 and 154,589 in 2012, to 140,908 in 2013. However, HIV incidence increased in adults from 134,634 in 2011 to 139,178 in 2012, and only declined to 131,279 in 2013. Decline in incidence has been more pronounced among children; from 27,660 in 2011, to 15,411 in 2012; and further down to 9,629 in 2013. The key drivers of HIV incidence in Uganda include: a) Personal understanding of and attitude towards HIV; b) Awareness about personal and/or partner HIV status; and c) high risk sexual behaviors including early sexual debut, multiple sexual relationships, limited and inconsistent condom use; and transactional, cross-generational and commercial sex. Other factors include: sexual relations accompanied by alcohol drinking; high fertility rate because of low utilization of family planning; and low utilization of ANC and delivery services.

**National AIDS Response:** The Uganda AIDS response has evolved over the last three decades through a 3-phase cycle: a) Aggressive response to an evident threat, mainly through mobilization for a combined and supported action (from 1984 to 1989); b) Concerted and coordinated action that yielded good results (especially in the early 1990s); and c) Change in the context and in the response; which compromised the good results (beginning in the 1990s, through 2000 to 2009). The years between 2010 and 2013 were characterized by a revitalized response to a new threat – a clear reversal in the long experienced decline in HIV prevalence and incidence. At policy level, the National AIDS Policy 2010; the National Strategic Plan (NSP) 2011-2015, the National Prevention Strategy (NPS) 2011-2015, and the Health Sector Strategic Investment Plan (HSSIP) 2011-2015 were important milestones and a basis for other policies, strategies and guidelines to guide and strengthen specific elements in the AIDS response. Coordination of the national response was bolstered through a review and reconstitution of the UAC Board and Secretariat; and of the Uganda AIDS Partnership Mechanism. Key elements and results from 2013 are presented below, along the

GARPR 10 targets. The detailed results for the listed GARPR and Universal Access indicators are presented in Table 1 below this Executive Summary.

**Target 1: Reduce sexual transmission of HIV by 50% by 2015:**
Over all there has been a reduction in new HIV infections; with Spectrum projections at 162,294 in 2011; 154,589 in 2012 and 140,908 in 2013. Coverage with key prevention services between October 2012 and September 2013 included:

- 1,639,649 individuals reached with behavioral change interventions; including 287,302 targeted with MARPs interventions; and 1,352,347 reached through ABC interventions for the general population (including 760,185 specifically targeted with AB only).
- 8,208,188 individuals received HCT; 91.5 percent of them adults 15 years and above. Two-thirds (65.4 percent) of the adults 15-49 years old that received HCT were women;
- 801,678 males were reached with SMC, contributing to a cumulative total of 1,411,798;
- 187 million male and 5.8 million female condoms procured into the country;
- 525,495 adults on ART and thus contributing to 'treatment for prevention'.

Over 3,000 sex workers, MSM and related key populations received a comprehensive prevention and care package for STI/HIV services through the MARPI clinic in Mulago Hospital, and other sites in Kampala. A cumulative total of 280 MARPs have been enrolled on ART at a dedicated ART clinic within the MARPI services, operational since July 2013.

**Target 3: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths**
A remarkable reduction in new infections among children was achieved; from 27,660 in 2011; 15,411 in 2012, and 9,629 in 2013. The elimination of Mother-to-Child Transmission (eMTCT) Option B+ approach was scaled up country-wide. It reached 1,726,177 mothers of known and documented HIV sero-status; 123,754 of them (7.2 percent) HIV positive. While 71.7 percent of the positive mothers received ARVs for eMTCT; only 36.7 percent of the exposed infants received ARVs for eMTCT.

**Target 4: Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015**
By 30 Sept 2013; a cumulative total of 793,893 PLHIV were enrolled on ART; and 570,373 were active on treatment. This achievement underpinned the sustained drop in AIDS-related deaths; from 72,928 in 2011; 70,262 in 2012 and 61,298 in 2013.

Based on the 2010 WHO guidelines for ART, the proportion of all ART-eligible PLHIV that were on treatment by the end of September 2013 was 69.4 percent. However, this proportion falls to only 40.0 percent if the 2013 WHO guidelines for ART eligibility are used.

A total of 162,232 eligible PLHIV were enrolled on ART between October 2012 and September 2013; higher than the estimated 140,908 new infections in 2013

**Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015**
Between 1 July and 30 Sept 2013, 668,203 HIV positive clients under care (76.1% of a total 877,486 attending in the quarter) were assessed clinically for TB. Over the same period, 4,121 HIV positive clients that had active TB were started on TB treatment. Overall, the estimated proportion of HIV positive incident TB cases that received treatment for both TB and HIV was 53.4 percent.

**Target 7: Eliminating gender inequalities**
PEPFAR-supported programs reached:

- 543,833 individuals with interventions that explicitly addressed GBV and coercion.
- 609,020 individuals with interventions and services that addressed legal rights and protection of women and girls impacted by HIV.
- 943,964 individuals with interventions that explicitly addressed norms about masculinity related to HIV

Service delivery promotion and support in private sector workplaces achieved:

- 353, 575 people reached with HIV prevention messages
- 4,638,942 pieces of condoms distributed in private sector companies and organizations.
- 31 Abstinence Clubs were formed and trained in company supported schools.
- 2,805 people were put on ART and care in company supported clinics.
- 15,488 people reached with HCT.
- 528 were provided with SMC services.
- 113 mothers received with EMTCT services in company supported clinics

MOGLSD disseminated and promoted implementation of 9 laws and policies related to GBV; and trained 28 regional trainers and 128 key duty bearers on the revised Police Form 3. A total of 300 cultural leaders in 9 cultural institutions trained in community dialogue and supported to conduct dialogue and community planning to address HIV, GBV, and SRH. Religious leaders and community leaders were mobilized and trained on GBV, HIV and SRH through the Catholic Church (nationally) and IRCU (in Busoga region)

**Target 8: Eliminating stigma and discrimination**
The 2013 stigma index study in Uganda reported experiences of both external and internal stigma. External stigma was mainly experienced as gossip (by 60.5 percent of total surveyed); verbal harassment (by 35.9 percent); and sexual rejection (by 21.5 percent). The forms of internal stigma commonly experienced include: low self-esteem (reported by 35.4 percent); self-blame (by 36.8 percent); shame (by 30.6 percent); guilt (by 28.8 percent); and blaming others (by 25.2 percent). Experiences of all forms of internal stigma were higher among females compared to their male counterparts.

High level advocacy was undertaken by civil society, ADPs and other stakeholders, with particular focus on the Anti-Homosexuality and the HIV Prevention and Control bills. This process contributed to the major revisions to the Anti-Homosexuality bill; as reflected in the Act that was passed in 2013.

**Target 10: Strengthening HIV integration**
School attendance among orphans and non-orphans aged 10–14: Education sector reports indicate that 14.7 percent of all children enrolled in primary school in 2013 were orphans. The proportion is similar for boys and girls (15.3% and 14.5%). It compares closely with the 13.9% of children 5-14 years old reported to have one or both parents dead in the 2011 DHS.

District-based surveys in 2013 in 66 districts with USG-supported OVC-support programs reported 12% of the poorest households as reached with external economic support in the previous 12 months.

**Strengthen governance and leadership of the HIV response at all levels**

**UAC Institutional Review:** was finalized; a zonal coordination sub-structure was instituted and initiated in 3 of the 8 planned zones; staff were recruited and deployed in 11 positions at national and zonal level.

**Partnership Mechanism Review:** was conducted in 2013; results were used to restructure and re-vitalize the mechanism; with three main coordination clusters – civil society; decentralized and district-based response, and central government sectors.

**HIV-related policy and strategy development, review and implementation:** nine key policies and strategies were developed or reviewed in 2013: the National Youth Policy; School Health Policy; The Uganda National Plan for eMTCT; National SRH/HIV Linkages and Integration strategy; National Condom Strategy 2013-2015; National Comprehensive Condom Programming Strategy; Revised guidelines and Strategic Plan 2013-2015 for TB-HIV collaboration; Leadership Advocacy Strategy on HIV and AIDS; and Guidelines for HIV/AIDS Coordination at Decentralized levels in Uganda, 2013

**Target 6: Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22–24 billion in low- and middle-income countries**

Sustained financing for the national AIDS response was realized for 2013; and applied to key elements of the service delivery system:

- ***Human Resources****:* staffing level in district health services increased from 55% in 2012 to 61% in 2013; with recruitment of 7,211 staff; training of staff at all levels (service delivery, supervision and management, etc.)
- ***Strengthening Supply Chain Management (SCM) for HIV-related commodities:*** rationalizing quantification, supply planning, procurement and distribution of HIV commodities; and strengthening district and service-point capacity (projection, ordering, storage and managed utilization)
- ***Improving laboratory services:*** initiated construction of the national health laboratory; and further development of the hub-based laboratory referral and communication system (especially for EID)
- ***Community systems strengthening:*** strengthening the capacity of CBOs as service delivery partners; improving local level partnership, coordination and capacity sharing

**Establish a coordinated and effective national system for management of strategic information for the HIV response**

***Upgrade and revisions in key service delivery MIS:*** in health sector (DHIS2, Web-based ARV ordering and reporting, open MRS, PMTCT mTrac); social development sector (OVC-MIS)

***Strengthening coordination and consolidated national-level reporting:*** online mapping of district-based stakeholders in HIV services; JAR used for in-depth reporting by SCEs; assessment and revitalization planning for the National AIDS Documentation and Information Centre

**Indicators Summary Table**

**Table 1: Indicators summary table**

| Targets and Indicators | Status as at December 2013 |
|---|---|
| **Target 1: Reduce sexual transmission of HIV by 50% by 2015** | |
| ***General population*** | |
| 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 – 38.6%<br>Men – 39.3%<br>Total – 38.9%<br>*Source: AIS 2011* |
| 1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 | Women – 13.1%<br>Men – 11.9%<br>Total – 12.6%<br><br>*Source: AIS 2011* |
| 1.3 Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months | Women – 3.0%<br>Men – 18.7%<br>Total – 13.3%<br>*Source: AIS 2011* |
| 1.4 Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse | Women – 15.8%<br>Men – 14.8%<br>Total – 15.0%<br><br>*Source: AIS 2011* |
| 1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results | 59.3%<br>(7,120,069/12,000,450)<br><br>*HMIS (Oct 2012 – Sep 2013)* |
| 1.6 Percentage of young people aged 15-24 who are living with HIV | Women – 4.9%<br>Men – 2.1%<br>Total – 3.7%<br><br>*Source: AIS 2011* |
| ***Sex workers*** | |
| 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 | 66%<br>*Source: CRANE 1 study in greater Kampala – 2008/09 (n=947)* |
| 1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results | Ever tested – 54%<br>*Source: CRANE study in greater Kampala – 2008/09 (n=947)* |
| 1.10 Percentage of sex workers who are living with HIV | 34.2%<br>*Source: CRANE study in greater Kampala – 2008/09 (n=866)* |
| ***Men who have sex with men*** | |
| 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 | Casual partner – 43%<br>Steady Partner – 50%<br>*Source: CRANE study in greater Kampala – 2008/09 (n=306)* |

| Targets and Indicators | Status as at December 2013 |
|---|---|
| 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 | Ever tested – 44%<br>*Source: CRANE study in greater Kampala – 2008/09 (n=306)* |
| 1.14 Percentage of men who have sex with men who are living with HIV | 13.2%<br>*Source: CRANE study in greater Kampala – 2008/09 (n=306)* |
| ***Testing and Counselling*** | |
| *1.16 HIV Testing in 15+*<br>Number of women and men aged 15 and older who received HIV testing and counselling in the last 12 months and know their results | 7,512,048<br>*HMIS (Oct 2012 – Sep 2013)* |
| *1.16.1 Rapid test kits stock-outs*<br>Percentage of health facilities dispensing HIV rapid test kits that experienced a stockout in the last 12 months | 44%<br>(1303/ 2,987)<br>*HMIS (Oct 2012 – Sep 2013)* |
| ***Sexually Transmitted Infections*** | |
| *1.17 Sexually Transmitted Infections (STIs)* | |
| *1.17.1 Percentage of women accessing antenatal care (ANC) services who were tested for syphilis* | 15.5%<br>(234,310/1,516,130)<br>*HMIS (Oct 2012 – Sep 2013)* |
| *1.17.2 Percentage of antenatal care attendees who were positive for syphilis* | 2.0%<br>(30,018/1,516,130)<br>*HMIS (Oct 2012 – Sep 2013)* |
| *1.17.3 Percentage of antenatal care attendees positive for syphilis who received treatment* | No data |
| *1.17.4 Percentage of sex workers with active syphilis* | No data |
| *1.17.5 Percentage of men who have sex with men with active syphilis* | No data |
| *1.17.6 Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months* | No data |
| *1.17.7 Number of reported congenital syphilis cases (live births and stillbirth) in the past 12 months* | No data |
| *1.17.8 Number of men reported with gonorrhoea in the past 12 months* | No data |
| *1.17.9 Number of men reported with urethral discharge in the past 12 months* | 73,153<br>*HMIS (Oct 2012 – Sep 2013)* |
| *1.17.10 Number of adults reported with genital ulcer disease in the past 12 months* | 125,282<br>*HMIS (Oct 2012 – Sep 2013)* |
| ***Male circumcision*** | |
| *1.22 Male circumcision, prevalence* | 26.4%<br>*(AIS 2011 among men 15 to 49 years)* |
| *1.23 Number of men circumcised last year* | 801,678<br>*HMIS (Oct 2012 – Sep 2013)* |
| **Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015** | Not tracked in Uganda |
| **Target 3: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths** | |
| 3.1 Percentage of HIV-positive pregnant women who receive anti-retrovirals to reduce the risk of mother-to-child transmission | 71.7%<br>(88,792/123,754)<br>*HMIS (Oct 2012 – Sep 2013)* |
| 3.1a Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding | No data |
| 3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth | 41.9%<br>(42,667/101,907)<br>*HMIS (Oct 2012 – Sep 2013)* |
| 3.3 Estimated percentage of child HIV infections from HIV-positive | 9.2% |

| Targets and Indicators | Status as at December 2013 |
|---|---|
| women delivering in the past 12 months | (9,625/105,059)<br>*Spectrum Estimates; 2013* |
| *3.4 Pregnant women who were tested for HIV and received their results*<br>Percentage of pregnant women who know their HIV status | 93.0%<br>(1,410,598/1,516,130)<br>*HMIS (Oct 2012 – Sep 2013)* |
| *3.5 Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months* | 19.7%<br>(298,254/1,516,130)<br>*HMIS (Oct 2012 – Sep 2013)* |
| *3.6 Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing* | 71.1%<br>(53,650/75,430)<br>*HMIS (Oct 2012 – Sep 2013)* |
| *3.7 Percentage of infants born to HIV-infected women provided with ARV prophylaxis to reduce the risk of early mother-to-child transmission in the first 6 weeks* | 36.7%<br>(37,423/101,907)<br>*HMIS (Oct 2012 – Sep 2013)* |
| *3.9 Percentage of infants born to HIV-infected women started on co-trimoxazole (CTX) prophylaxis within two months of birth* | 30.1%<br>(30,655/101,907)<br>*HMIS (Oct 2012 – Sep 2013)* |
| *3.10 Distribution of feeding practices for infants born to HIV-infected women at DPT3 visit* | No data |
| *3.11 Number of pregnant women attending ANC at least once during the reporting period* | 1,516,130<br>*HMIS (Oct 2012 – Sep 2013)* |
| **Target 4: Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015** | |
| 4.1 Percentage of adults and children currently receiving antiretroviral therapy | 69.4%<br>(570,373/821,721)<br>*(Based on CD4 < 350)*<br><br>*HMIS (Oct 2012 – Sep 2013)* |
| 4.2a Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy | 83.0%<br>(30,602/36,860)<br>*HMIS (Oct 2012 – Sep 2013)* |
| *4.2b HIV Treatment: 24 months retention* | No data |
| *4.2c HIV Treatment: 60 months retention* | No data |
| *4.3 Health facilities that offer antiretroviral therapy*<br>4.3.a Number of health facilities that offer antiretroviral therapy (ART)<br>4.3.b Number of health facilities that offer paediatric antiretroviral therapy (ART) | <br>1,478<br>834<br>*HMIS (Oct 2012 – Sep 2013)* |
| *4.4 ARV stock-outs*<br>Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in the last 12 months | 6%<br>*SPARS Quarterly survey (Jul-Sep 2013)* |
| *4.6 HIV care*<br>4.6.a Total number of people enrolled in HIV care at the end of the reporting period<br>4.6.b Number of adults and children newly enrolled in HIV care during the reporting period<br>(2013) | <br>883,736<br><br>162,232<br>*HMIS (Oct 2012 – Sep 2013)* |
| *4.7 Viral Load*<br>4.7 a) percentage of people on ART tested for viral load (VL) who have an undetectable viral<br>load in reporting period (2013)<br>4.7 b) percentage of people on ART tested for viral load (VL) with VL | No data |

| Targets and Indicators | Status as at December 2013 |
|---|---|
| level below ≤ 1,000 copies after 12 months of therapy (2013) | |
| **Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015** | |
| 5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV | 53.4%<br>(17,926/33,589)<br>*HMIS (Oct 2012 – Sep 2013)* |
| *5.2 Percentage of people living with HIV (PLHIV) newly enrolled in care who are detected having active TB disease (new)* | No data |
| *5.3 Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)* | No data |
| *5.4 Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit* | 76.4%<br>(675,373/883,736)<br>*HMIS (Oct 2012 – Sep 2013)* |
| **Target 6: Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22–24 billion in low- and middle-income countries** | |
| 6.1 Domestic and international AIDS spending by categories and financing sources | Refer to Table 17 and Figure 6 in the main report for financing sources; and Table 20 and Figure 8 for spending categories) |
| **Target 7: Eliminating gender inequalities** | |
| 7.1 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 | 33.3%<br>*(Source: DHS 2011)* |
| **Target 8: Eliminating stigma and discrimination** | |
| 8.1 Discriminatory attitudes towards people living with HIV<br><br>*Percentage of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV* ***(on 1 or more of the 4 standard indicators for accepting attitudes)*** | *Proportion with accepting attitudes on all 4 standard indicators*<br><br>Women – 80.3%<br>Men – 68.9%<br>Total – 75.3%<br>*(Source: AIS 2011)* |
| **Target 10: Strengthening HIV integration** | |
| 10.1 Current school attendance among orphans and non-orphans aged 10–14<br><br>*10.1a Percent of children 10-14 years with both parents not alive that are attending school*<br>*10.1b Percent of children 10-14 years with both parents alive, living with at least one parent, who are currently attending school*<br>*Ratio of 10.1a to 10.1b* | <br><br>83.5%<br><br>95.6%<br><br>0.87<br>*(Source: DHS 2011)* |
| 10.2 Proportion of the poorest households who received external economic support in the last 3 months. | 12%<br>*(Source: District-based surveys in 66 districts)* |

## 1.0 Introduction and Overview of the AIDS Epidemic in Uganda

Uganda is party to the 2011 United Nations Political Declaration on HIV and AIDS, which commits all countries involved to "provide to the General Assembly an annual report on progress achieved in realizing the commitments made in the Declaration". To meet this commitment, Uganda developed this Global AIDS Response Progress Report (GARPR) for 2014; which focuses on progress in the national HIV response as realized during 2013. The process to develop this report was based on the UN Guidelines for the 2014 GARPR process. The guidelines provide for a three-part process for developing the report: a) consolidation of progress and results from 2013 activities as captured in the 'one M&E system' for the HIV response; b) completion of a two-part National Commitments and Policies Instrument (NCPI); Part A for government sectors and Part B for civil society and AIDS Development Partners (ADPs); and c) a consensus meeting to review and agree on the drafted report from the two processes.

The report writing process was coordinated by the National HIV/AIDS Monitoring and Evaluation Technical Working Group (TWG) at Uganda AIDS Commission (UAC). The process was highly participatory and included separate consultative meetings with civil society, ADPs and government sectors. The respective parts of the NCPI were circulated on e-mail to 9 civil society stakeholder institutions; the ADP group, and 10 government sectors. Necessary follow up was done by e-mail, telephone, and physical visits; to ensure completion and timely return. Consolidation of results from the 2013 HIV response was based on the following key documents and databases:

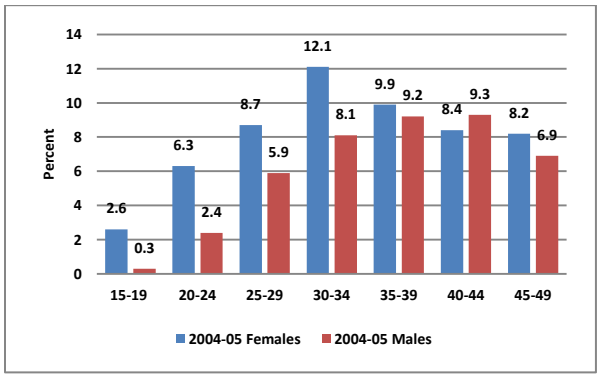
a) The reports presented by different stakeholder constituencies at the 2013 Joint Annual Review (JAR) for the national HIV response; and the UAC Annual Report for 2013
b) Management Information Systems (MIS) in the health, social development and education sectors
c) The Annual Health Sector Review Report for 2013, and the 2013 Mid-Term Review Report for the Health Sector Strategic Investment Plan (HSSIP)
d) The 2013 Investment Case for HIV, and the accompanying HIV and AIDS Situation Analysis for 2013
e) The Uganda CCM Request for Interim Funding to the Global Fund of September 2013

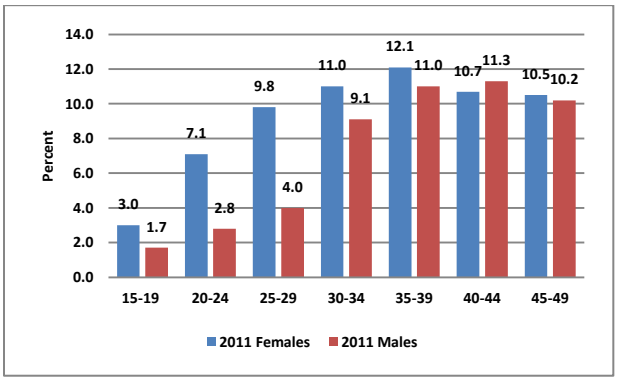
The first draft of the report was reviewed and approved by the TWG for M&E at UAC. An improved version of the report was presented, discussed and adopted at a 1-day consensus meeting at which 38 persons from 22 stakeholder institutions and agencies participated.

### 1.1 HIV Prevalence

Uganda has experienced a generalized HIV epidemic for more than two decades. The country achieved impressive success in the control of HIV during the 1990's, bringing down HIV prevalence among adults aged 15-49 years from a national average of 18.5% in 1992 to 6.4% in 2004/2005. However, the 2011 AIDS Indicator Survey in Uganda reported HIV prevalence at a national average of 7.3%. The HIV epidemic in Uganda continues to disproportionately affect young women; but overall prevalence shifted to the older age groups between the 2004-05 and 2011 surveys (Figure 1 below)

**Figure 1: Change in HIV Prevalence by age and sex - 2004/05 and 2011**




HIV prevalence in males and females varied by region; as demonstrated in the two surveys (2004-05 and 2011 AIS) and illustrated in Table 2.

**Table 2: Trends in HIV Prevalence 2004 and 2011 AIS**

| Region | 2004-05 Prevalence | | | 2011 Prevalence | | | Progress | | |
|---|---|---|---|---|---|---|---|---|---|
| | Female | Male | Total | Female | Male | Total | Female | Male | Total |
| Central | 10.2 | 6.6 | 8.5 | 11.1 | 8.2 | 9.8 | **-0.9** | **-1.6** | **-1.3** |
| Kampala | 11.8 | 4.5 | 8.5 | 9.5 | 4.1 | 7.1 | **2.3** | **0.4** | **1.4** |
| East Central | 7.5 | 5.2 | 6.5 | 6.7 | 4.8 | 5.8 | **0.8** | **0.4** | **0.7** |
| Eastern | 6.2 | 4.4 | 5.3 | 4.4 | 3.8 | 4.1 | **1.8** | **0.6** | **1.2** |
| Northeast | 3.6 | 3.2 | 3.5 | 5.3 | 5.2 | 5.3 | **-1.7** | **-2.0** | **-1.8** |
| North Central | 9.0 | 7.1 | 8.2 | 10.1 | 6.3 | 8.3 | **-1.1** | **0.8** | **-0.1** |
| West Nile | 2.7 | 1.9 | 2.3 | 4.7 | 5.0 | 4.9 | **-2.0** | **-3.1** | **-2.6** |
| Western | 7.8 | 5.7 | 6.9 | 9.1 | 7.1 | 8.2 | **-1.3** | **-1.4** | **-1.3** |
| Southwest | 7.1 | 4.4 | 5.9 | 9.0 | 6.6 | 8.0 | **-1.9** | **-2.2** | **-2.1** |
| **Total (15-49 yrs.)** | **7.5** | **5.0** | **6.4** | **8.3** | **6.1** | **7.3** | **-0.8** | **-1.1** | **-0.9** |

**Key:**

| |
|---|
| Decreased incidence by 1.0% or more |
| Decreased incidence by less than 1.0% |
| Increased incidence by less than 1.0% |
| Increased incidence by 1.0% or more |

The epidemic was consistently higher among women compared to men across all regions except in West Nile. In the capital city of Kampala, HIV prevalence among women was more than twice that for men in both the 2004/2005 and 2011 surveys. Although the 'prevalence gap' between women and men has narrowed between the two surveys; it remains above 30 percent nationally and in five of the nine regions. This difference has been consistently smallest in the northeast region.

Between the 2004/2005 and 2011 surveys, there was notable decline in HIV prevalence among women in Kampala, Eastern and Central Eastern regions. A smaller decline was noted among men in the same regions, and also in the north central region. These improvements may be a reflection

of penetration of effective HIV prevention interventions across communities in the respective regions.

Other notable differentials in HIV prevalence reflected in the 2004/2005 and 2011 AIS include:

- ***Residence:*** prevalence in 2011 was much higher among women resident in urban areas compared to those in rural areas (10.7 percent and 7.7 percent respectively); but similar for men resident in both settings (6.1 percent). The prevalence rate among urban women declined by 2.1 percentage points, from 12.8 percent in 2004-05 to 10.7 percent in 2011. In contrast, the rate among rural women increased by 1.2 percentage points over the same period; from 6.5 percent in 2004-05 to 7.7 percent in 2011. Over the same period, the prevalence among men evened out from 6.7 percent in urban residents and 4.7 percent in rural residents in 2004-05, to 6.1 percent in both settings.

- ***Education:*** Among both men and women, prevalence in the 2011 survey was lowest among those who have had at least secondary education (6.4 percent in women; 4.9 percent in men). However, prevalence has increased in all education status categories for both men and women, except among women with at least secondary education (reduced from 7.6 percent to 6.4 percent); and in women that completed primary education (slight decline from 9.8 percent to 9.7 percent).

- ***Wealth:*** HIV prevalence was highest among women in the highest wealth quintile in both surveys; at 11.0 percent in the 2004/2005 survey and 9.9 percent in the 2011 survey. There is a clear trend of higher HIV prevalence with greater wealth status among women; more pronounced in the 2011 survey compared to the 2004/2005 survey. A similar but less pronounced trend was observed among men, with respect to the second, middle and fourth quintiles.

- ***Marital status:*** In both the 2004/2005 and the 2011 surveys, HIV prevalence was highest among women and men that are widowed, closely followed by those who are divorced or separated. Further details on prevalence by marital status are presented in Table 3 below.

**Table 3: Trends in HIV Prevalence by Marital Status – 2004 and 2011 AIS**

| Marital status | Prevalence 2004/2005 | | | Prevalence 2011 | | |
|---|---|---|---|---|---|---|
| | **Female** | **Male** | **Total** | **Female** | **Male** | **Total** |
| **Never married** | 2.7 | 0.8 | 1.6 | 3.9 | 2.0 | 2.8 |
| **Married/Living together** | 5.9 | 6.8 | 6.3 | 7.2 | 7.6 | 7.4 |
| **Divorced/separated** | 16.0 | 10.8 | 13.9 | 17.8 | 14.9 | 16.9 |
| **Widowed** | 31.2 | 32.2 | 31.4 | 32.4 | 31.4 | 32.3 |
| **Total (15-49 yrs.)** | **7.5** | **5** | **6.4** | **8.3** | **6.1** | **7.3** |

- ***Discordant couples:*** the proportion among men and women living together and in sexual union that had one party HIV positive and the other negative increased from 4.5 percent in the 2004/2005 survey to 6.2 percent in the 2011 survey. This increase was larger with respect to HIV positive women (from 1.8 percent in 2004/2005 to 3.0 percent in 2011); compared to the HIV positive men (from 2.8 percent in 2004/2005 to 3.2 percent in 2011). The HIV negative parties in these couples are at high risk of getting infected, especially because of limited mutual knowledge of each other's HIV status, and inadequate specific action to reduce the risk.

### 1.1.1 HIV prevalence among key populations

In line with global UNAIDS guidance, the Uganda National HIV/AIDS Strategic Plan (NSP) and National HIV Prevention Strategy (NPS) 2011/12 – 2014/15 define several population groups that are important in the national AIDS response because of a combination of high HIV prevalence and extensive sexual networks. These populations include: sex workers and their sexual partners, fishing communities, uniformed services, mobile populations such migrant workers, men who have sex with men, and persons with disability. It is recognized that specific individuals may belong to more than one among such population groups, and thus be at heightened risk of acquiring and/or transmitting HIV. The prevalence of HIV in these key populations as estimated in recent years is presented in Table 4 below.

**Table 4: HIV Prevalence in Key Populations – Sub-national studies**

| Population Group | HIV Prevalence | Study year and Geographical coverage |
|---|---|---|
| **Female sex workers** | 33% | CRANE 1 2008/2009; Greater Kampala region |
| **Male partners of female sex workers** | 17.5% | CRANE 1 2008/2009; Greater Kampala region |
| **Men that have sex with men** | 13.2% | CRANE 1 2008/2009; Greater Kampala region |
| **Fishing communities**<br>***Males***<br>***Females*** | 37.1%<br>*32.4%*<br>*42.3%* | MOH 2012; Kalangala District (6 sampled landing sites) |
| **Plantation workers**<br>***Males***<br>***Females*** | 6.8%<br>*13.4%*<br>*4.5%* | MOH 2010; 4 sites in Bugiri, Jinja, Kalangala and Mubende Districts (Rice, Sugar, Palm Oil, Coffee estates) |

A study in Kampala in 2012 contracted out by the MARPs Network found HIV prevalence at 35.7 percent among sex workers (n=503); 16.7 percent among injecting drug users (n=54); 9.3 percent in fisher folk (n=321); 9.1 percent in MSM (n=398), 6.6 percent in truckers (n=213), and 1.9 percent in uniformed forces (n=415).

A number of studies to map and estimate the size of key populations in the greater Kampala area were conducted in 2012 and 2013. However, these have not yet established agreed projection of the size of specific population groups such as sex workers, MSM, people that inject drugs, etc.

### 1.1.2 HIV burden

The total burden of HIV in Uganda, as represented by the number of persons in the country that are living with HIV, has continued to increase. This is a result of continuing spread of HIV, and increased longevity among persons living with HIV. Between 2007 and 2013, the estimated number of people living with HIV increased from 1.2 million to 1.5 million. In 2012, the PLHIV was constituted by 93% adults who are +15 years, women being 56% of these adults. MOH projections based on Spectrum indicate a total of 1,618,233 people living with HIV in 2013; including 1,441,285

adults, and 176,948 children below 15 years. The same source indicates a decline in AIDS-related deaths between 2011 and 2013; from 72,928 in 2011, 70,262 in 2012, and 61,298 in 2013.

## 1.2 HIV Incidence

Although Uganda continues to experience a high rate of new HIV infections; the trend over the last three years shows a decline, from 162,294 in 2011 and 154,589 in 2012, to 140,908 in 2013. Table 5 below shows the incidence trend among adults and children between 2010 and 2013

**Table 5: Trends in HIV Incidence 2010–2013 using mathematical modelling**

| Population group | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|
| **Adults ≥15 years** | 129,133 | 134,634 | 139,178 | 131,279 |
| **Children < 15 years** | 27,139 | 27,660 | 15,411 | 9,629 |
| *Total* | 156,272 | 162,294 | 154,589 | 140,908 |

*Source: 2013 MOH Spectrum estimates*

Close to half (43 percent) of new infections projected in the 2008 Modes of Transmission (MOT) model were among persons in mutually monogamous heterosexual relationships; while another 46 percent were among persons in multiple sexual unions. Another 11 percent of the new infections were projected to be among sex worker clients, partners of sex workers, and sex workers themselves. The MOT report is appended to this report for further details.

### 1.2.1 Key Drivers of HIV Incidence

The main drivers of HIV incidence in Uganda as documented by MOT and other studies are:

- Ones level of knowledge and understanding of HIV, and especially its relationship to perceived personal risk of HIV infection; and its influence on negative and stigmatizing attitudes towards persons living with HIV (PLHIV)
- Knowledge of one's HIV sero-status, as established through HIV Counseling and Testing (HCT); and associated willingness for mutual disclosure of that status between sexual partners
- Risky sexual behavior – including adolescent sex, multiple and concurrent sexual relationships, transactional and cross-generational sex, and unprotected sex
- Level of male circumcision
- Alcohol drinking – especially to levels of getting drunk; and closely associated with sexual activity

These factors underpin the national efforts to prevent new infections, and are discussed further in Section 2.0 of this report alongside the specific HIV prevention strategies. Other contextual factors that have a bearing on HIV transmission and prevention include: a) High fertility rate; low utilization of family planning; b) Low utilization of ANC and delivery services; and c) Coverage and utilization of media and communication channels such as radio and cell phones.

## 2.0 National response to the AIDS epidemic in 2013

### 2.1 Overview

The Uganda AIDS response has evolved over the last three decades through a 3-phase cycle:

a) Aggressive response to an evident threat, mainly through mobilization for a combined and supported action (in 1984 to 1989);
b) Concerted and coordinated action that yielded good results (especially in the early 1990s);
c) Change in the context and in the response; which compromised the good results (beginning in the 1990s, through 2000 to 2009).

The years between 2010 and 2013 were characterized by a revitalized response to a new threat – a clear reversal in the long experienced decline in HIV prevalence and incidence. At policy level, the National AIDS Policy 2010; the revised NSP 2011-2015, the NPS 2011-2015, and the HSSIP 2011-2015 were important milestones and a basis for other policies, strategies and guidelines to guide and strengthen specific elements in the AIDS response. Coordination of the national response was bolstered through a review and reconstitution of the UAC Board and Secretariat; and of the Uganda AIDS Partnership Mechanism. The 2011 UN General Assembly, and its resolution 65/277: Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS, were a true reflection and timely support to these on-going efforts in Uganda.

Implementation of the current Uganda NSP is based on two-year priority action plans; developed and implemented in a participatory and multi-sectoral approach. The objectives and targets in the 2011/2012 – 2012/2013 National Priority Action Plan (NPAP) (as Annexed to this report) formed the key basis for all HIV response activities in 2013. The following sections (2.2 to 2.5) discuss the design, focus and results from these activities, under the four thematic areas of focus in the NSP and NPAP.

## 2.2 Prevention

**KEY 2013 ACHIEVEMENTS ON HIV PREVENTION**

**Target 1: Reduce sexual transmission of HIV by 50% by 2015:**

Over all there has been a reduction in new HIV infections; with Spectrum projections at 162,294 in 2011; 154,589 in 2012 and 140,908 in 2013. Coverage with key prevention services between October 2012 and September 2013 included:

- 8,208,188 individuals received HCT; 91.5 percent of them adults 15 years and above. Two-thirds (65.4 percent) of the adults 15-49 years old that received HCT were women;
- 801,678 males were reached with SMC, contributing to a cumulative total of 1,411,798;
- 187 million male and 5.8 million female condoms procured into the country;
- 525,495 adults on ART and thus contributing to 'treatment for prevention'.

**Target 3: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths**

A remarkable reduction in new infections among children was achieved; from 27,660 in 2011; 15,411 in 2012, and 9,629 in 2013. The elimination of Mother-to-Child Transmission (eMTCT) Option B+ approach was scaled up country-wide. It reached 1,726,177 mothers of known and documented HIV sero-status; 123,754 of them (7.2 percent) HIV positive. While 71.7 percent of the positive mothers received ARVs for eMTCT; only 36.7 percent of the exposed infants received ARVs for eMTCT.

The Uganda 2013 NPAP targets are fully aligned to the global prevention targets 1 and 3. Persons that inject drugs do not contribute significantly to new HIV infections; and are therefore not explicitly targeted in the UGANDA HIV response. Focus for HIV prevention in 2013 was on service delivery scale up and concerted communication for demand creation; within the broad framework of combination prevention, with a focus on:

- Scaled up HCT – as a key entry point and first service in eMTCT, SMC, and promotion of safer sex (especially condom use)
- Accelerated roll-out of Option B+ for eMTCT to attain service coverage in all 112 districts in the country
- Specific targeted interventions in key populations such as fishing communities; migrant workers in the transport industry, roads and mining sectors, and in plantation agriculture; sex workers and their clients
- Revitalized delivery of SMC services through public and private health facilities

High level advocacy through and targeting political and cultural leaders were vital and especially effective in the 2013 HIV prevention effort. Highlights in this regard include: a) the First Lady playing the lead role as Champion in eMTCT promotion across the country – a process personally

joined by the UNAIDS Executive Director in September 2013; and b) the President of Uganda publically taking an HIV test in November 2013, as demonstration of the high value of HCT and political commitment to the national response.

**His Excellency President Museveni publically testing for HIV – November 2013**


**First Lady/eMTCT Champion with UNAIDS Executive Director at eMTCT Launch in Karamoja region – September 2013**

### 2.2.1 Delivery of HIV prevention services in 2013

#### a) HCT

**Scale up HCT coverage and uptake:** 3,418 HCT service delivery points were active in 2013 (on site and through outreach)

- A total of 8,208,188 individuals received HCT between 1 October 2012 and 30 September 2013. A total of 696,140 (8.5 percent) were children below 15 years old. Among the 7,120,069 adults aged 15 – 49 years that received HCT, 65.4 percent were women.
- Among the 4,653,129 women aged 15-49 years that received HCT, 35.6 percent were reached through eMTCT services

Awareness of HIV status can motivate individuals to further protect themselves against infection or to protect their partners from acquiring the disease. Knowing where to get an HIV test, and motivation to get tested once or more times are important steps in the process of getting tested and taking appropriate follow up action based on the HIV result. Uganda pioneered voluntary HIV counseling and testing in 1990 as a central piece in the national AIDS response; and a key entry point to a continuum of HIV and AIDS services. However, penetration of HCT services across the population remained low until recently; as illustrated in Table 6 below. The proportion of adults aged 15-49 who have ever been tested for HIV and received the results increased from 12.7 percent in 2004/2005 to 65.8 percent in 2011 among women; and from 10.8 percent to 44.9 percent for men.

**Table 6: Persons ever tested for HIV and received results – DHS 2000 to 2011**

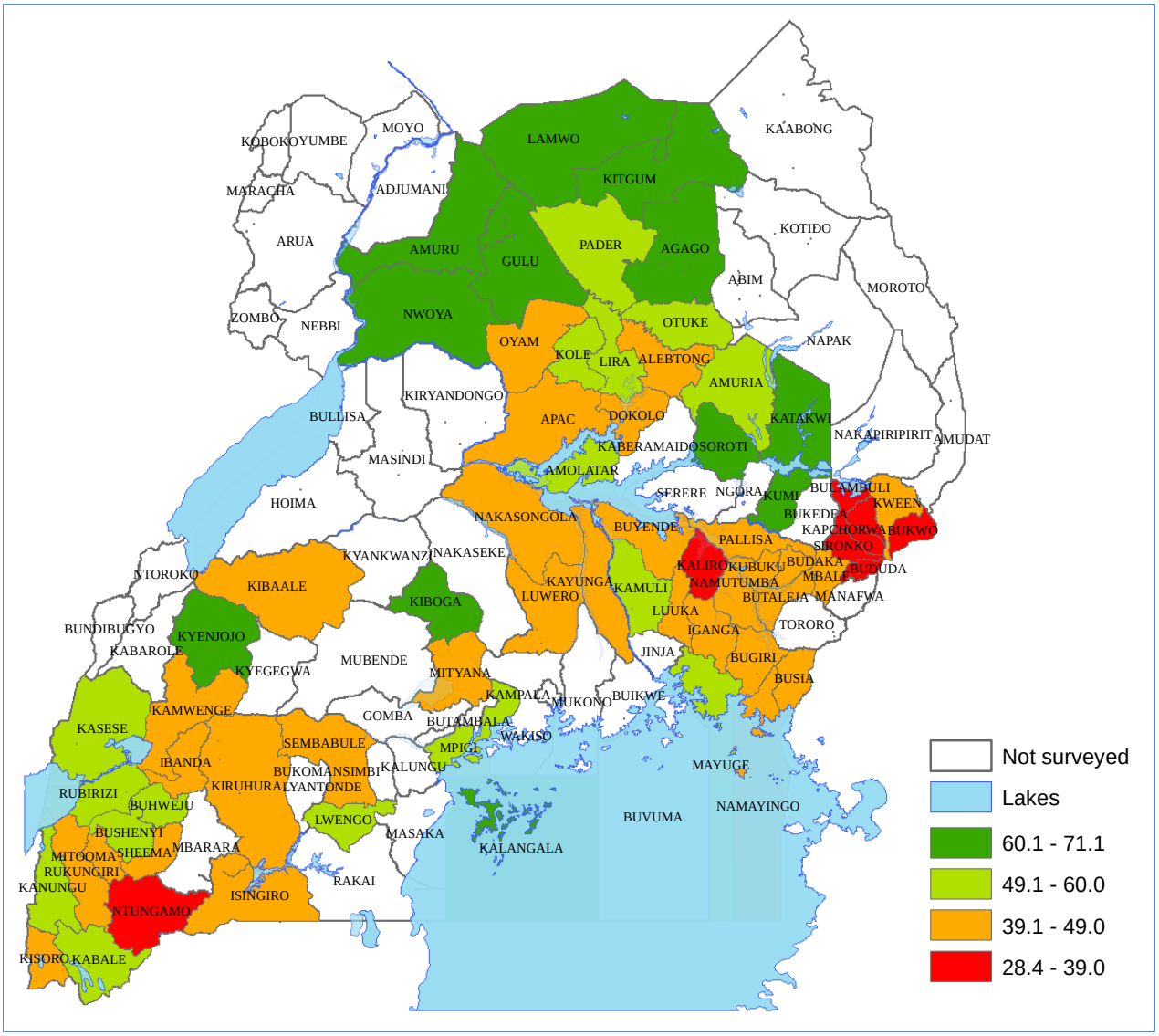
| DHS Year | Females | Males |
|---|---|---|
| **2000** | 8.4% | 12.0% |
| **2006** | 24.8% | 20.6% |
| **2011** | 71.3% | 55.7% |

HCT services in 2013 were delivered through a combination of on-site services at health facilities, outreach services at designated meeting points, and as home-based services. Emphasis continued to be placed on HCT integration in antenatal services (especially as part of eMTCT scale-up) and in-patient care; and in selected out-patient clinics such as STI and TB care. Outreach HCT services were delivered with deliberate targeting of persons in situations of high HIV prevalence and high risk of HIV transmission, and in previously under-served geographical settings and demographic groups. Because of these intensified efforts, there was increased attention and reporting on HCT services from health facilities; from 2,425 health facilities reporting in 2011; 2,397 in 2012; and 3,418 in 2013. The map below (Figure 2) the HCT coverage in 66 districts where district-based surveys were conducted for 2013.

A total of 8,208,188 persons of all ages were recorded in the MOH Health Management Information System (HMIS) as reached with HCT between 1 October 2012 and 30 September 2013. The achieved HCT coverage by 30 September 2013 was much higher than the 3.5 million target set for December 2013 in the National Priority Action Plan (NPAP) for 2011/12 to 2012/2013.

The individuals that received HCT included 696,140 children below 15 years (8.5 percent of the total); 7,120,069 (86.7 percent) adults aged 15-49 years; and 391,979 (4.8 percent) adults aged 50 years or older. Nearly two-thirds (65.4 percent) of the adults aged 15-49 years that received HCT were women.

**Figure 2: Proportion received HCT in previous 12 months**




*Source: MSH Report; 2013 LQAS in 66 districts*

**b) eMTCT**

**eMTCT:** 2,993 health facilities served as ANC service delivery points and entry points for the full scope of eMTCT services

- A total of 1,726,177 women had their HIV status established or verified in eMTCT services
- 123,754 among those with a known status (7.2 percent) were HIV positive
- 88,792 (71.7 percent) among the positive mothers received ARVs for eMTCT (including those already on ART prior to pregnancy, and those started on Option B+);
- 37,432 (36.7 percent) infants among those HIV-exposed received ARV for eMTCT

Prevention of Mother-to-Child Transmission (PMTCT) in Uganda was, and continues to be, the flagship program that integrates HIV and SRH services for women and infants; and more recently as an opportunity to expand male participation in SRH and HIV services. Uganda pioneered PMTCT research in 1988; and this resulted in the 1999 study that demonstrated the safety and efficacy of nevirapine for mothers and infants in reducing the risk of transmitting HIV from the mother to the child by almost 50%. This intervention, and its subsequent modifications, became the cornerstone of PMTCT policies and programs globally.

In keeping with its pioneering and pace-setting practice with regard to PMTCT, Uganda adopted Option B+ in April 2012, and a policy in this respect was launched in October 2012. In 2013, there was high level advocacy by Uganda's First Lady and other political leaders; religious and cultural leaders, and by persons living with HIV to promote eMTCT. The overall eMTCT service coverage by March 2013 was 2,138 health facilities (129 hospitals, 187 HC IV, 1,034 HC III and 733 HC II); 48 percent of all health facilities in the country. By the end of 2013, all 112 districts in the country had at least one health facility providing the full scope of eMTCT services.

Out of a total of 1,516,772 attending ANC between 1 October 2012 and 30 September 2013, 1,410,598 (93.0 percent) received HCT. An additional 246,141 mothers were enrolled into eMTCT through other health care settings (e.g., Maternity, Post Natal Care, Immunization, etc.); and 69,438 had a known and documented HIV status by the first ANC attendance. Out of the total 1,726,177 women enrolled in eMTCT services and with a known HIV status, 123,754 (7.2 percent) were HIV positive.

A total of 88,792 (71.7 percent) among the positive mothers received ARVs for eMTCT; including those already on ART prior to pregnancy, and those started on Option B+. This was just below the 2013 NPAP target, which was set at 75 percent of all HIV positive pregnant mothers. However, only 37,432 (36.7 percent) of the infants born alive to HIV positive mothers (and thus HIV-exposed) received ARV for eMTCT. The HSSIP mi-term review showed that health facility deliveries are still low (at 41 percent); and post-natal care service delivery is still poor. This contributes to the high level of missed opportunity for infant protection.

As a result of this extensive eMTCT service coverage, the projected number of new vertical infections fell from 15,411 in 2012 to 9,629 in 2013. This surpassed the NPAP target of 10,000 projected new vertical infections by 2013.

**c) SMC**

**SMC:** 1,117 health facilities in all 112 districts provided SMC services

- 801,678 males received SMC between 1 Oct 2012 and 30 Sep 2013; contributing to a cumulative total of 1,411,798.

The 2004-2005 AIS reported that only 24.8 percent of men in Uganda were circumcised. The survey further showed that, circumcised men were less likely to be infected with HIV (3.7 percent compared to 5.5. percent). A similar pattern was found in the 2011 AIS, with only 26.4 percent of the men circumcised; and HIV prevalence at 4.5 percent among the circumcised men and 6.7 percent among the uncircumcised men.

Ground-breaking research in Uganda and two other African countries (Kenya and South Africa) provided evidence for the protective effect of male circumcision in HIV prevention. Results from the Uganda study published in February 2007 showed an estimated efficacy of circumcision as an HIV prevention intervention of 51 percent among men aged 15-49 without behavioural disinhibition.

Between 2007 and 2010, a comprehensive communication campaign was conducted in the country, aimed at educating health workers, leaders and the media on male circumcision and its link to HIV prevention. This effort included public debates, radio and television talk shows, educational materials for health workers and their clients, and education and counselling through a national Health Hotline.

In September 2010 a national safe male circumcision policy and communication strategy were launched, focused on promoting voluntary safe male circumcision for all men 15 years and older as an essential health service. The policy seeks to increase the number of circumcised men by educating the population about safe male circumcision, increasing the number of health facilities that provide circumcision services and equipping health providers with the skills they need to conduct the procedure. A mass communication campaign to increase demand and uptake of SMC services among men 15-49 years old was launched in December 2011.

Currently, Uganda uses a mixed model approach for SMC service delivery; with: a) a common standard for strengthening SMC capacity at all health facilities with pre-existing staff and infrastructure capacity for basic surgery; and b) roving teams for SMC outreaches and camps. The year 2013 witnessed scaled up demand creation communication and intensified service delivery for SMC. The number of health facilities providing SMC increased from 420 (in 105 districts) in 2012 to 1,117 (in all 112 districts) in 2013.

A total of 801,678 males across all ages received SMC between 1 Oct 2012 and 30 Sep 2013. This brought the cumulative total number of males receiving SMC 1,411,798; higher than the NPAP target of 1.25 million males by the end of 2013. Of the total 801,678 males reached with SMC, 685,699 (85.5 percent) had the age recorded.

**d) ABC**

**BCC to increase ABC:**

- 1,639,649 individuals reached with behavioral change interventions; including 287,302 targeted with MARPs interventions; and 1,352,347 reached through ABC interventions for the general population (including 760,185 specifically targeted with AB only).

**Condom promotion among MARPs and the general population:**

- 187, 000,000 male and 5,800,000 female condoms were procured into the country; and 101,729,000 male and 2,400,000 female condoms were deployed out of central warehouses between 1 Oct 2012 and 30 September 2013

The combined ABC approach and message has been central to the Uganda HIV prevention effort since the early years of the epidemic. The importance of this approach and its role in the progress realized in the Uganda AIDS response is underscored by the key drivers of HIV transmission as discussed below.

***Adolescent sex:*** Adolescents, especially females, have historically constituted a large proportion of incident HIV cases in Uganda. This is attributed to a high level of sexual activity among adolescents. However, there has been sustained decline in adolescent sexual activity in Uganda, as presented in Table 7 below.

**Table 7: Sexual experience among adolescents 15-19 years – DHS 1995 to 2011**

| | 1995 | 2000 | 2006 | 2011 |
|---|---|---|---|---|
| **Females 15-19 years:** | | | | |
| Had first sex by 15 years | 23.8 | 14.2 | 11.8 | 12.2 |
| Had first sex between 15-19 years | 37.8 | 37.9 | 31.2 | 32.9 |
| Never had sex | 38.4 | 47.9 | 57.0 | 54.9 |
| Never married | 50.2 | 67.7 | 77.6 | 77.3 |
| Married younger than 18 years | 14.2 | 6.6 | 3.0 | 3.2 |
| Had sex in the 4 weeks prior to survey | 40.9 | 30.0 | 19.7 | 18.7 |
| **TOTAL** | **100.0** | **100.0** | **100.0** | **100.0** |
| | | | | |
| **Males 15-19 years:** | | | | |
| Had first sex by 15 years | 19.2 | 15.5 | 13.9 | 17.9 |
| Had first sex between 15-19 years | 28.4 | 23.2 | 21.4 | 22.2 |
| Never had sex | 52.4 | 61.3 | 64.7 | 59.9 |
| Had sex in the 4 weeks prior to survey | 18.9 | NR | 9.3 | 7.5 |
| **TOTAL** | **100.0** | **100.0** | **100.0** | **100.0** |

A similar trend was reflected in the 2004/2005 and 2011 AIS, which showed a 13.7 percentage points decline in the proportion of female adolescents 15-19 years old indicating that they had sex in the 12 months prior to the survey; from 37.3 percent to 23.6 percent. A similar but smaller decline was reported among male adolescents; at only 4 percentage points decline from 25.5 percent to 21.5 percent.

***Transactional, cross-generational and commercial sex:*** The DHS 2006 reported the rate of transactional sex (exchange of money or other favours) in the 12 months prior to the survey at 6.6 percent among women; and 6.5 percent among men; substantially higher among adolescents 15-19 years (15.9 percent in females, and 18.2 percent in males); persons who have never married (24.6 percent in females, 12.7 percent in males); those who are divorced, separated or widowed (20.5 percent among females, 19.1 percent among males); and those in the highest wealth quintile (12.3 percent in females, 12.5 percent in males).

The 2011 AIS reported giving of sex among females in exchange for cash at 2.6 percent ever, and 1.4 percent in the previous 12 months; and giving sex for other favours at 3.1 percent ever, and 1.7 percent in the previous 12 months. Both experiences are much higher among females that are widowed, divorced or separated; never married; younger (15-19 years); completed primary education; or in higher wealth quintile.

Only 2.4 percent of men in the 2011 AIS reported paying for sex in the previous 12 months. Men that are widowed, divorced or separated; resident in western region; or completed primary school were more likely to have paid for sex. The proportion among men that had sexual intercourse in the 12 months prior to the survey and acknowledge paying for sex in that period rose from 1.6 percent in DHS 2000, to 2.9 percent in DHS 2006 and dipped slightly to 2.3 percent in DHS 2011.

***Multiple sexual partnerships:*** Multiple sexual partnerships, especially when ones HIV status has not been established (or is not revealed to the partner), increases the risk of HIV transmission or acquisition. Results on this indicator from recent national surveys are presented in Table 8 below.

**Table 8: Prevalence of multiple sexual partnerships**

| Year; survey | Females | Males | Denominator |
|---|---|---|---|
| 2000 DHS | 2.5 | 12.0 | Currently married |
| 2006 DHS | 2.4 | 28.7 | Had sex in 12 months prior to survey |
| 2011 DHS | 1.6 | 18.6 | All respondents |
| 2004-05 AIS | 3.8 | 29.3 | Had sex in 12 months prior to survey |
| 2011 AIS | 4.0 | 25.4 | Had sex in 12 months prior to survey |

Results from the AIS indicate a stable rate of multiple sexual partnerships for females (around 4.0 percent); and a decline among males (from 29.3 percent to 25.4 percent). The different denominators used in reporting of DHS make it difficult to assess trends on this indicator.

***Protected sex:*** use of condoms during penetrative sexual intercourse reduces the risk of HIV transmission. This is particularly important in circumstances when the HIV status of either partner is not known (or not mutually revealed); or when there is known discordance. Table 9 below presents the trend in condom use. Although condom use continues to be a commonly practiced strategy to reduce HIV infection risk; its use declined substantially between 2005 and 2011.

**Table 9: Condom use for HIV prevention**

| Year; survey | Indicator | Females | Males |
|---|---|---|---|
| **1995; DHS** | Proportion of those ever heard about AIDS, ever had sex that have adopted condom use | 2.1% | 10.7% |
| **2000; DHS** | Proportion of those that had sex in the 12 months prior to the survey who used condoms during the last sexual intercourse | | |
| | • With any partner | 6.9% | 14.7% |
| | • With a co-habiting partner | 2.5% | 3.9% |
| | • With a non-cohabiting partner | 37.8% | 58.9% |
| **2006; DHS** | Proportion of those that had sex with 2 or more partners in the 12 months prior to the survey who used condoms during the last sexual intercourse | 23.9% | 20.4% |
| **2011; DHS** | Proportion of those that had sex with 2 or more partners in the 12 months prior to the survey who used condoms during the last sexual intercourse | 31% | 19.0% |
| | | | |
| **2004-05; AIS** | Proportion of those that had sex in the 12 months prior to the survey who used condoms during the last sexual intercourse | 9.1% | 16.1% |
| | Proportion of those that had 'higher risk sex' in the 12 months prior to the survey who used condoms during the last higher risk sexual intercourse | 46.7% | 53.2% |
| **2011; AIS** | Proportion of those that had sex in the 12 months prior to the survey who used condoms during the last sexual intercourse | 9.7% | 14.7% |
| | Proportion of those that had 'higher risk sex' in the 12 months prior to the survey who used condoms during the last higher risk sexual intercourse | 29.4% | 37.9% |

*Higher risk sex = sex with a non-marital and non-cohabiting partner*

In 2013, an estimated 20,649,497 individuals 10 years and older were eligible for behavior change interventions. However, behavior change interventions with the necessary intensity and depth of reach remained limited. Efforts to promote sexual abstinence were mainly focused on schools and FBO settings. FBOs and other CSOs were also active in promoting mutual sexual faithfulness; especially working with couples, including a unique focus on discordant couples. PEPFAR-supported programs targeted a total 1,631,310 individual in 2013; only 7.9 percent of the total eligible population; and reached 1,639,649 individuals between October 2012 and April 2013. The number of individuals reached with behavior change interventions has remained low, and even declined between 2010 and 2013 (details in Table 10 below).

**Table 10: Annual reach with behaviour change interventions – PEPFAR-supported programs**

| Year | Reach |
|---|---|
| **2010** | 2,374,129 |
| **2011** | 1,663,840 |
| **2012** | 1,811,592 |
| **2013** | 1,639,649 |

*Source: PEPFAR 2013 Report*

Geographical targeting of the PEPFAR-supported programs for behavior change and the achieved reach were was aligned to the HIV prevalence variation by region, as illustrated in Table 11 below.

**Table 11: Relative reach of PEPFAR-supported behaviour change interventions – by region**

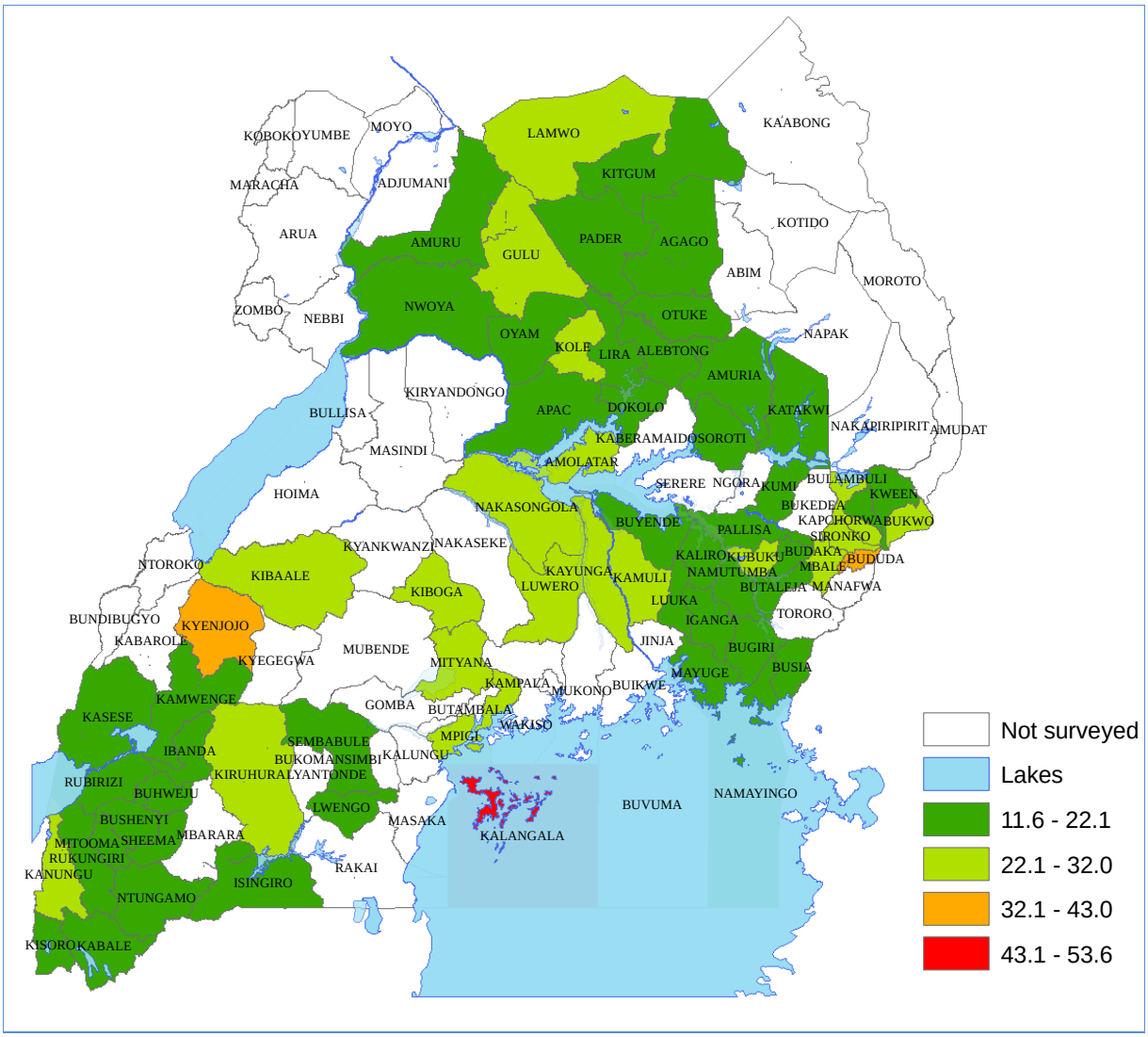
| Region | HIV prevalence | Eligible population | Population reached | Percent reach |
|---|---|---|---|---|
| **Central 1** | 10.6 | 1,978,048 | 245,931 | 12.43 |
| **Central 2** | 9.0 | 1,444,982 | 96,901 | 6.71 |
| **North** | 8.3 | 2,376,319 | 338,546 | 14.25 |
| **Western** | 8.2 | 2,019,006 | 117,195 | 5.80 |
| **Southwest** | 8.0 | 2,179,755 | 207,319 | 9.51 |
| **Kampala** | 7.1 | 254,221 | 33,303 | 13.10 |
| **East Central** | 5.8 | 1,619,888 | 237,355 | 14.65 |
| **North East** | 5.3 | 2,868,910 | 112,654 | 3.93 |
| **West Nile** | 4.9 | 2,193,851 | 52,532 | 2.39 |
| **Eastern** | 4.1 | 3,714,519 | 197,913 | 5.33 |
| **Uganda** | **7.3** | **20,649,497** | **1,639,649** | **7.94** |

Of the 1,639,649 individuals reached with behavioral change interventions; 287,302 (17.5 percent) were targeted with MARPs interventions; and 760,185 (46.4 percent) were targeted with interventions that only addressed abstinence and mutual sexual faithfulness. The remaining proportion (592,162; 36.1 percent) was reached through ABC interventions for the general population.

Strengthening the supply chain for both male and female condoms, and a coordinated approach to consistent condom promotion as an integral element in the ABC strategy, are core elements in re-vitalization of the national HIV prevention efforts based in the 2011-2015 National HIV Prevention Strategy. However, Uganda experienced condom stock outs in 2012 and in January to February 2013 partly due to limited stocks coming into the country. In 2013, key efforts to mitigate this included: a) development and adoption of a comprehensive condom programming strategy for all levels of the health system; b) streamlining condom post-shipment handling and quality verification to ensure efficiency and uninterrupted supplies; and c) strengthening national and district level coordination and monitoring of condom supply, distribution and promotion initiatives, to ensure sustained demand that is well balanced with adequate supply.

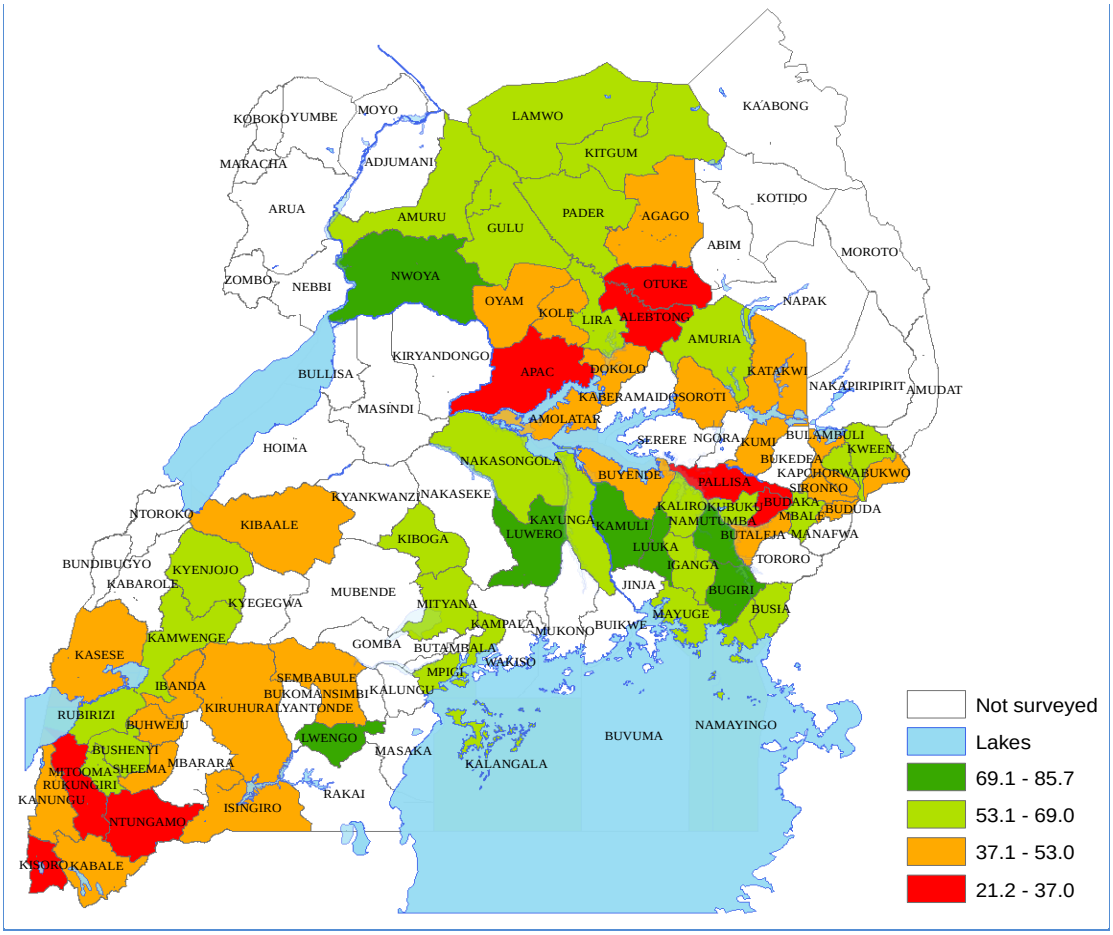
The maps below (Figure 3 and 4) illustrate the frequency of higher risk sex, and the reported use of condoms in such situations.

**Figure 3: Proportion had non-marital sex in previous 12 months**




*Source: MSH Report; 2013 LQAS in 66 districts*

**Figure 4: Proportion used a condom at last non-marital sex**




*Source: MSH Report; 2013 LQAS in 66 districts*

**e) Targeted interventions in key populations:**

**MARPs-focused HIV Prevention:**

- Over 3,000 sex workers, MSM and related key populations received a comprehensive prevention and care package for STI/HIV services through the MARPI clinic in Mulago Hospital, and other sites in Kampala. A cumulative total of 280 MARPs have been enrolled on ART at a dedicated ART clinic within the MARPI services, operational since July 2013

Key population groups in Uganda in whom HIV prevalence and risk of transmission is particularly high, and are often inadequately reached with health and other services, include: migrant workers (including fisher folk, agricultural estate and forestry workers, road construction crews, etc.); prisoners; sex workers; men having sex with men; uniformed forces; and transport industry workers. These groups are prioritized in the 2011-2015 NSP and NPS, and have been targeted by HIV prevention programs for the general population, and interventions specifically designed for selected population groups. Targeted funding streams (e.g., Civil Society Fund, USG/CDC, DFID) have been made available in the different government and non-government service support programs to reach selected key populations. A MARPs Network was formed in 2007 to coordinate mobilization, advocacy and service interventions in this constituency.

The main activities in 2013 with respect to HIV prevention among key populations focused on: a) strengthening high level strategic support to MARPs-focused HIV services; b) enhancing national level technical capacity for programming and service delivery among MARPs; and c) scale up of decentralized service delivery to MARPs through health facilities and community settings. Key achievements in strengthening high level strategic support to MARPs-focused services included the following:

- A Strategy Note and Programming Framework for MARPs mapping and targeted service development was developed and approved by the National Prevention Committee (NPC). A MARPs Task Team/Technical Working Group was established as a sub-committee of the NPC, and was active in driving the MARPs programming agenda in 2013
- A specific self-coordinating entity for key populations was established in 2013 as part of the AIDS Partnership Mechanism, to coordinate and promote prevention and care services in this category of stakeholders
- Mobilized $130,000 from UBRAF to undertake MARPs interventions at national level including the development of a planning framework, population size estimation and other activities of the MARPs TWG

Efforts at enhancing national level technical capacity for programming and service delivery among MARPs in 2013 were mainly focused at the STI/MARPs Unit at MOH; the STI/MARPI clinic at Mulago Hospital; and the national MARPs Network. Key activities in this respect included:

a) ***Deepening understanding of key populations:*** A number of studies on mapping, size estimation and access to services analysis for selected MARPs were conducted and/or disseminated. These include: the 2008/2009 CRANE 1 study on sex workers, MSM, and persons that inject drugs; the 2012 MARPs Network study on HIV sero-prevalence among key populations in Kampala; the 2013 KCCA/AMICAALL study on a wider range of MARPs and health service provision to them; the 2010 MOH study on HIV sero-prevalence among agricultural plantation workers; and the 2012 MOH sero-prevalence survey in fishing communities in Kalangala district. These studies and their dissemination resulted in greater public awareness about the unique needs and opportunities of MARPs; and increased partnerships to promote and deliver MARPs-targeted services.
b) ***MARPs Learning Centre established:*** A one stop centre for learning about the delivery of HIV intervention to key populations has been initiated at the Mulago Hospital STI/MARPI clinic. The centre is intended to develop practical, innovative approaches in delivery of services to key populations; building capacity for scale up of service delivery to MARPs; and generating evidence on progress and impact of MARPs services. One of the innovations at the centre is an ART clinic dedicated to sex workers and MSM; operational since July 2013, and has reached a cumulative total of 280 clients. Uganda has adopted the policy of 'test and treat' among MARPs, which will be rolled out in 2014. A learning exchange program was established between the centre and the Indian Bridge Project; to draw lessons from the successful experience in HIV programming for key populations in India. The MARPS planning framework provides for a total of 15 such learning centres across the country.

Scaling up of decentralized service delivery to MARPs was mainly achieved through district-based and multi-sectoral programming for MARPs services within the district health systems. This was supported by JUPSA, in partnership with the Ministry of Works and Transport (MOWT), and the Ministry of Agriculture, Animal Industry and Fisheries (MAAIF); together with District Local Governments in 10 districts (Arua, Busia, Gulu, Kalangala, Kampala, Kasese, Kiryandongo,

Lyantonde, Pader and Rakai). This initiative focused on sex workers, transport sector workers and the fishing communities. There was scaled-up MARPs service provision in Kampala in 2013, where over 3,000 female sex workers received a comprehensive prevention and care package for STI/HIV services through outreaches and dedicated clinics.

Other HIV prevention interventions implemented in 2013 include:
***1. Ensuring safety in blood transfusion:*** All 201,365 units of blood collected for transfusion across the country between 1 July 2012 and 30 June 2013 were screened for HIV.
***2. Comprehensive STI management:*** All 5,033 health facilities in the country offered STI management as an integral element in routine clinical services

## 2.3 Treatment and Care

**KEY 2013 ACHIEVEMENTS IN HIV TREATMENT AND CARE**

**Target 4: Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015**

By 30 Sept 2013; a cumulative total of 793,893 PLHIV were enrolled on ART; and 570,373 were active on treatment. This achievement underpinned the sustained drop in AIDS-related deaths; from 72,928 in 2011; 70,262 in 2012 and 61,298 in 2013.

Based on the 2010 WHO guidelines for ART, the proportion of all ART-eligible PLHIV that were on treatment by the end of September 2013 was 69.4 percent. However, this proportion falls to only 40.0 percent if the 2013 WHO guidelines for ART eligibility are used.

A total of 162,232 eligible PLHIV were enrolled on ART between October 2012 and September 2013; higher than the estimated 140,908 new infections in 2013.

**Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015**

Between 1 July and 30 Sept 2013, 668,203 HIV positive clients under care (76.1% of a total 877,486 attending in the quarter) were assessed clinically for TB. Over the same period, 4,121 HIV positive clients that had active TB were started on TB treatment.

The strategic focus in Uganda for scaling up HIV treatment and care is on decentralizing all such services to the lower level health facilities; including private health facilities. These services include: adult and pediatric ART, prevention and treatment of opportunistic infections, TB-HIV co-management, nutrition in the context of HIV, and home-based care. Integration was the central theme in treatment, care and support in 2013; at three main levels:

a) ***Integrating prevention and treatment:*** by linking all people who test HIV positive to immediate and sustained care, support and treatment as needed; with special focus on eMTCT services as an entry point into care and treatment for HIV positive mothers and infants.
b) ***Integrating HIV treatment with other critical and related health care services:*** with special attention to comprehensive maternal, newborn and child care for HIV positive mothers and their families; sexual and reproductive health services for all HIV positive women, men and adolescents under care; and consolidating linkage between HIV and TB services to ensure that all HIV positive children and adults receive necessary TB-related diagnosis and treatment, and in the same manner, all TB patients are assessed for possible HIV infection and promptly enrolled into care if positive.
c) ***Integrating HIV care and treatment with PLHIV support:*** such as psychosocial support, economic empowerment and social/legal support; and with similar support to HIV-affected families and other individuals and families in unique circumstances of HIV-related vulnerability.

### 2.3.1 ART

**Increase equitable access to ART (from 50 to 80%):**

- 1,478 health facilities in all 112 districts provided ART services
- A cumulative total of 793,893 were enrolled on ART by 30 Sep 2013; 570,373 (69.4% of those eligible) were active on treatment
- Retention at 12 months (July-Sep 2013 cohort) was 83%; at 84% in adults (84.4% in females, 83.6% in males), and 73% in children

Accelerated scale up of ART is the cornerstone in AIDS treatment and care, and a key element in HIV prevention. The action priorities in 2013 in ART scale up included: a) consolidating the capacity for quality and integrated HIV treatment and care at existing ART sites; b) continued ART accreditation of public and private health facilities to further enhance access in underserved rural settings; and c) strengthening laboratory services, with particular attention to consolidating the EID referral and communication system to cover all sites with eMTCT services.

There was accelerated accreditation of ART sites in 2013 to match the rapid roll out of eMTCT introduced country-wide in October 2012; and to address the gap in access to ART among children and TB-HIV co-infected patients. The number of facilities providing ART increased from 407 at the end of 2011 to 532 by December 2012, but jumped to 1,073 at the end of June 2013; and further increased to 1478 by the end of 2013. However, over the same period the increase in sites providing paediatric ART was not as dramatic; only increasing from 332 in 2011, to 834 in 2013 (Details in Table 12 below). By the end of December 2013, a total of 144 sites were accredited for ART but not yet activated.

**Table 12: Provision of adult and paediatric ART by health facility categories – Sep 2013**

| Level | Adult ART | | Pediatric ART | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| **Referral Hospitals (n=15)** | 15 | 100.0 | 15 | 100.0 |
| **General Hospitals (n=140)** | 118 | 84.3 | 111 | 79.3 |
| **HC IV (n=206)** | 186 | 90.3 | 171 | 83.0 |
| **HC III (n=1,309)** | 927 | 70.8 | 451 | 34.4 |
| **HC II (n=2,777)** | 186 | 6.7 | 54 | 1.9 |

Within the uniformed forces, the number of accredited ART sites has markedly increased: the UPDF has 17 ART sites, up from 15 in 2012, Uganda prisons has 8 sites up from 2 in 2012, and Police has 5 ART sites up from one site in 2012.

One of the innovations at the centre is an ART clinic dedicated to sex workers and MSM; operational since July 2013, and has reached a cumulative total of 280 clients. Uganda has adopted the policy of 'test and treat' among MARPs, which will be rolled out in 2014.

Specific effort to further improve paediatric ART included training a total of 277 regional coaches/mentors for paediatric HIV care and quality improvement in the 10 regions across the country. These will be used by the districts and implementing partners to support the scale up of quality paediatric HIV services in the country. In addition, the paediatric HIV care and treatment scale up strategies were disseminated to districts and implementing partners through regional pediatric HIV stakeholder meetings; attended by a total of 520 people in all 10 regions.

An assessment of adolescent access to HIV testing, care and treatment services was conducted in 2013 in 1,020 facilities. The assessment revealed high acceptability for HIV testing among adolescents who enter HCT services; with 2.5 percent of those tested reported as HIV positive (similar to the 2.4 percent reported in the 2011 AIS among 15-19 year old adolescents). Although there was good linkage to care among adolescents who test HIV positive (at 88 percent); only 17 percent of estimated adolescent living with HIV are currently in care; and just 29 percent of the estimated ART-eligible adolescents are receiving ART. Access to cotrimoxazole among adolescent was good (at 80 percent); but only 48 percent had accessed CD4 testing. These findings highlight the need to further strengthen HIV service targeting to positive adolescents.

The number of individuals accessing ART based on the 2010 WHO treatment guidelines, increased from 329,060 in 2011 to 569,298 by Sept 2013. The corresponding number of children below 15 years on ART was 26,699 in 2011, and 43,803 in September 2013. Details on the trend over this period are presented in Table 13 below.

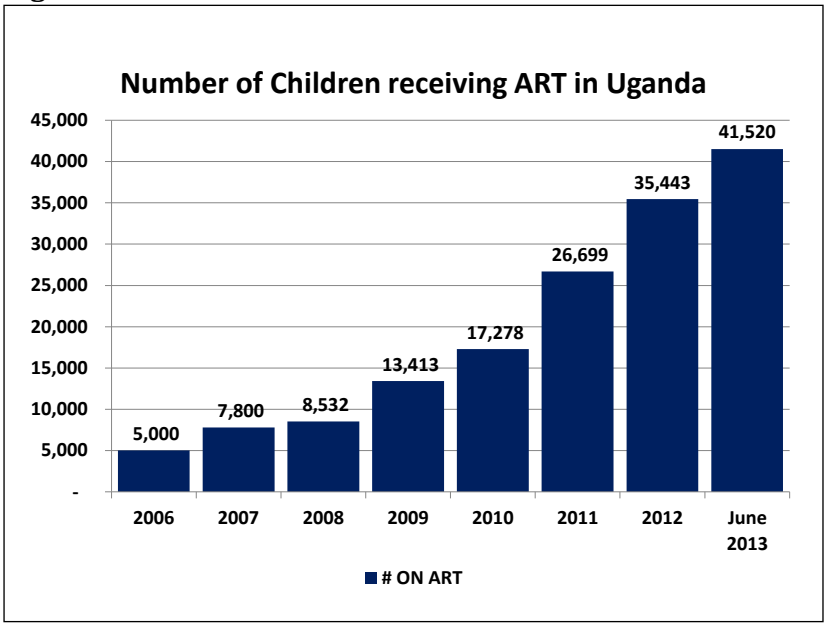
**Table 13: Trend of ART coverage – 2011 to 2013**

| | Female adults | Male adults | Children | Total |
|---|---|---|---|---|
| **December 2011** | 189,701 | 107,667 | 26,699 | 324,067 |
| **December 2012** | 262,000 | 141,089 | 35,443 | 438,532 |
| **September 2013** | 349,068 | 171,582 | 43,803 | 564,453 |

By end of September 2013, uptake of ART services had increased to 570,373 active clients country-wide, 526,487 of whom were adults aged 15 years +, and 43,886 children aged 0-14 years. This was 10 percent increase from mid-2013, and 131,831 more clients since the beginning of the year. Adult clients increased from 403,089 to 526,487 during January – September 2013, while children increased to 43,886 from 35,453 during the same period. Among adults, female clients predominated with a ratio of 2:1 (349,068 female versus 174,582 male clients). Among clients with ART regimens categorized, approximately 97% of adults and 92% of children were on first line regimens. About a third of adult and paediatric clients were from facilities located in the Kampala (central) region, while Moroto region had the smallest proportion of clients (<1%). By end of September 2013, the cumulative number of clients ever enrolled for ART had grown to 793,893.

According to current Ministry of Health estimates, there were 821,712 individuals (721,020 adults aged over 15 years, and 100,701 children younger than 15 years) eligible and in need of ART across the country based on the 2010 Treatment guidelines where ART eligibility is based on a cut of at least 350 CD-4 T-cells/ul. With 570,486 HIV-infected individuals already enrolled on ART by end of the third quarter, 69% of ART-eligible individuals were already on treatment countrywide. The coverage among adults was higher at 73%, which is close to the national target of 80% by 2015. Coverage among children remained low at 44%%, - still far from the target of enrolment of 80% by 2015. However when the new ART eligibility criteria based on 2013 WHO guidelines with ART eligibility cut off of at least 500 CD-4 T-cells/ul among other criteria is considered, 1,323,013 individuals (1,176,478 adults, and 146,535 children) are eligible for treatment. ART coverage based on this criteria falls to 43% overall, 45% among adults and 30% among children.

**Figure 5: Number of children on ART 2006-2013**




There has been major and sustained increase in paediatric ART coverage between 2011 and 2013; as illustrated in Figure 5. While only 17,278 children were on ART in 2010, close to 10,000 children were added in 2011; and similar high numbers in 2012 and 2013. The 41,520 children on ART by June 2013 represent 41 percent of the estimated 107,000 children eligible for ART in 2013.

Retention on ART at 12 months after initiation was 83% in September 2013; higher for adults (at 84%) compared to children (at 73%). Retention rates were similar among female and male adults.

### b) Prevention and treatment of OI

**Increase access to prevention and treatment of OI (including TB):**

a) **CTX for all HIV positive people under care:** Of the total 883,736 HIV positive people under care as at 30 Sept, 2013; 718,694 (81.3%) were on CTX prophylaxis

b) **TB assessment, treatment and prevention in HIV positive people:** guidelines for geneXpert diagnosis were rolled out countrywide to support implementation; guidelines for IPT were finalized, ready for roll out in 2014.
- Between 1 July and 30 Sept 2013, 668,203 HIV positive clients under care (76.1% of a total 877,486 attending in the quarter) were assessed clinically for TB.
- Over the same period, 4,121 HIV positive clients with active TB were started on TB treatment.

c) **HIV assessment, treatment and prevention in TB patients:**
- HIV testing among TB patients increased from 86% in 2012 to 89% in June 2013

**Cotrimoxazole prophylaxis:** Of the total 883,736 HIV positive people under care as at 30 Sept, 2013; 718,694 (81.3%) were on CTX prophylaxis.

**TB-HIV collaboration:** Uganda is among 22 high TB burden countries in the world; and 50 percent of the 40,581 notified TB cases in 2012 were also HIV positive. The dual TB and HIV epidemics potentiate one another. While HIV is the leading risk factor for developing TB, TB is the most common cause of death causing approximately 30% of deaths among PLHIV. Close TB-HIV collaboration since 2006 resulted in improved screening for TB among PLHIV (from 27% in 2006 to

over 90% in 2012); and increased HIV testing in TB patients – from 26% in 2006 to 86% in 2012. Cotrimoxazole Preventive Therapy (CPT) coverage among TB/HIV co-infected patients rose from 4% in 2007 to 93% in 2012.

In 2013, the 2006 national policy guidelines for TB/HIV collaborative activities in Uganda were revised and updated, especially with regard to:

a) Provision of isoniazid preventive therapy to all eligible PLHIV;
b) Establishing mechanisms for delivering TB/HIV collaborative activities in an integrated manner;
c) Expanding HIV testing to patients with presumptive TB, and to the family and community members of TB patients;
d) Early initiation of anti-retroviral therapy in all HIV co-infected TB patients irrespective of their CD4 count; and
e) Providing HIV prevention services to TB patients, their family and community members.

Guidelines for geneXpert TB diagnosis were rolled out country-wide to support implementation; and guidelines for IPT were finalized, ready for roll out in 2014. Performance on the majority of TB/HIV collaborative activities has improved as demonstrated by the increased HIV testing among TB patients from 86 percent in 2012 to 89 percent in June 2013; and Anti-Retroviral Treatment (ART) uptake among TB-HIV co-infected patients from 54 percent in 2012 to 60 percent by June 2013. Between 1 July and 30 Sept 2013, 668,203 HIV positive clients under care (76.1% of a total 877,486 attending in the quarter) were assessed clinically for TB at 1,299 health facilities. Over the same period, 4,121 HIV positive clients (among those assessed at 1,026 health facilities) were found with active TB and started on TB treatment. The estimated percentage of HIV positive incident TB cases that received treatment for both TB and HIV between October 2012 and September 2013 was 53.4 percent.

**STI treatment:** Uganda uses the syndromic approach for STI management, and currently only tracks burden indicators. A total of 73,153 men reported with urethral discharge, 125,282 reported with genital ulcer disease between 1 October 2012 and 30 September 2013. However, the occurrence of urethral discharge and genital ulcer disease may be much higher, since many people with these symptoms may prefer self-treatment, or do not seek care.

Health facilities that conduct medical examination for persons involved in sexual and gender-based violence (both victims and perpetrators) are required to check and report on occurrence of STI. Between October 2012 and September 2013, a total of 32,351 females and 18,657 males with a history of SGBV were reported to have also had an STI.

## 2.4 Support for PLHIV, HIV-affected families and other vulnerable households

**KEY 2013 ACHIEVEMENTS IN SOCIAL SUPPORT AND PROTECTION**

**Target 7: Eliminating gender inequalities**
PEPFAR-supported programs reached:

- 543,833 individuals with interventions that explicitly addressed GBV and coercion.
- 609,020 individuals with interventions and services that addressed legal rights and protection of women and girls impacted by HIV.
- 943,964 individuals with interventions that explicitly addressed norms about masculinity related to HIV

MOGLSD disseminated and promoted implementation of 9 laws and policies related to GBV; and trained 28 regional trainers and 128 key duty bearers on the revised Police Form 3. A total of 300 cultural leaders in 9 cultural institutions trained in community dialogue and supported to conduct dialogue and community planning to address HIV, GBV, and SRH. Religious leaders and community leaders were mobilized and trained on GBV, HIV and SRH through the Catholic Church (nationally) and IRCU (in Busoga region)

Service delivery promotion and support in private sector workplaces achieved:

- 353, 575 people reached with HIV prevention messages
- 4,638,942 pieces of condoms distributed in private sector companies and organizations.
- 31 Abstinence Clubs were formed and trained in company supported schools.
- 2,805 people were put on ART and care in company supported clinics.
- 15,488 people reached with HCT.
- 528 were provided with SMC services.
- 113 mothers received with EMTCT services in company supported clinics.

**Target 8: Eliminating stigma and discrimination**
The 2013 stigma index study in Uganda reported experiences of both external and internal stigma. External stigma was mainly experienced as gossip (by 60.5 percent of total surveyed); verbal harassment (by 35.9 percent); and sexual rejection (by 21.5 percent). The forms of internal stigma commonly experienced include: low self-esteem (reported by 35.4 percent); self-blame (by 36.8 percent); shame (by 30.6 percent); guilt (by 28.8 percent); and blaming others (by 25.2 percent). Experiences of all forms of internal stigma were higher among females compared to their male counterparts.

High level advocacy was undertaken by civil society, ADPs and other stakeholders, with particular focus on the Anti-Homosexuality and the HIV Prevention and Control bills. This process contributed to the major revisions to the Anti-Homosexuality bill; as reflected in the Act that was passed in 2013.

**Target 10: Strengthening HIV integration**
School attendance among orphans and non-orphans aged 10–14: Education sector reports indicate that 14.7 percent of all children enrolled in primary school in 2013 were orphans. The proportion is similar for boys and girls (15.3% and 14.5%). It compares closely with the 13.9% of children 5-14 years old reported to have one or both parents dead in the 2011 DHS.

District-based surveys in 2013 in 66 districts with USG-supported OVC-support programs reported 12% of the poorest households as reached with external economic support in the previous 12 months.

The 2011-2015 NSP provides for a three-pronged approach to social support and protection for PLHIV, HIV-affected families and other individuals and households with HIV-related vulnerability. These are:

1. Delivery of comprehensive, quality psychosocial services to PLHIV, affected households and persons most vulnerable to exposure to HIV; with focus on psychosocial support to PLHIV and their families; and comprehensive services to OVC (at least 3 basic needs met)
2. Empowerment of HIV-affected households and most vulnerable groups with livelihood skills and opportunities to cope with socio-economic demands; focused on households that host OVC.
3. Scale up of comprehensive social support and protection to the most vulnerable PLHIV and other affected groups; including promotion of stigma reduction, and ensuring that HIV/AIDS workplace policies and programs are instituted in all large workplaces (20 or more staff)

Support to children and families affected by HIV, and those with other HIV-related vulnerability, is further provided for in the 2011-2015 National Strategic program Plan of Interventions (NSPPI) for OVC. This plan focuses on the needs of 51 percent of all children in Uganda, who are considered to be critically or moderately vulnerable; and has four strategic objectives:

1. Strengthen the capacity of families, caregivers and other service providers to protect and care for orphans and other vulnerable children
2. Expand the provision of essential services for orphans and other vulnerable children, their caregivers and families/households
3. Increase access to protection and legal services for orphans and other vulnerable children, their caregivers and families/households
4. Strengthen the institutional, policy, legal and other mechanisms that provide supportive environment for a coordinated OVC response

**a) Comprehensive social support and protection**

**Sexual and gender-based violence:**

543,833 people reached with interventions that explicitly addressed GBV and coercion related to HIV.
609,020 people reached with interventions and services that addressed legal rights and protection of women and girls impacted by HIV.
943,964 people reached with interventions that explicitly addressed norms about masculinity related to HIV

MOGLSD disseminated and promoted implementation of 9 laws and policies related to GBV; and trained 28 regional trainers and 128 key duty bearers on the revised Police Form 3

300 cultural leaders in 9 cultural institutions trained in community dialogue and supported to conduct dialogue and community planning to address HIV, GBV, and SRH

Religious leaders and community leaders mobilized and trained on GBV, HIV and SRH through the Catholic Church (nationally) and IRCU (in Busoga region)

Empowerment of women and girls, and reducing gender inequity is a central tenet in the Uganda Constitution of 1995; and all government development undertakings. This includes recognition and commitment to address sexual and gender-based violence in all its forms. The Domestic Violence Act and the Prohibition of Female Genital Mutilation Act, both enacted in 2010, are examples of policy and legal support to effective interventions in this regard. As a result of these undertakings, gender parity has been attained at primary and secondary school levels.

Evidence from the 2006 and 2011 DHS in Uganda show decline in domestic gender based violence. There was a decrease in the proportion of ever-married women that experienced spousal physical violence in the preceding 12 months from 34.9 percent to 24.9 percent; and those that experienced spousal sexual violence from 24.8 percent to 20.9 percent. In addition, the proportion of women that experienced emotional violence from spouses decrease from 39.0 percent to 32.6 percent. However, the overall prevalence of domestic gender-based violence remains high; with 50.5 percent of ever-married women reporting physical or sexual violence from a spouse in the preceding 12 months in the 2011 DHS. This proportion was particularly high in the regions of Eastern (64.2 percent), North (60.6 percent), West Nile (55.2 percent), and East Central (52.1 percent).

In 2013, PEPFAR-funded programs reached 543,833 individuals across the country with interventions that explicitly addressed GBV and coercion related to HIV. Furthermore, 609,020 individuals were reached with interventions and services that addressed legal rights and protection of women and girls impacted by HIV. In addition, 943,964 individuals were reached with interventions that explicitly addressed norms about masculinity related to HIV.

The activities in 2013 to address GBV included: a) dissemination and promotion of implementation of key laws and policies that address GBV; b) capacity building to strengthen enforcement and protection related to GBV response; c) enhancing advocacy and coordination for expanded and sustained support to GBV action; and d) specific support programs to address experiences of GBV. The Ministry of Gender, Labour and Social Development (MOGLSD) disseminated key laws and policy briefs related to GBV, including: the Succession Act, Prevention of Trafficking in Persons Act, Prohibition of Female Genital Mutilation Act, Female Genital Mutilation Act regulations, Domestic Violence Act, and Domestic Violence Regulations. Other key documents developed and disseminated area: National Guidelines for Standard Operating Procedures and Referral Pathways for GBV Prevention and Response; Standard Guidelines for Provision of Psycho-social Support in GBV Response Services; and Guidelines for Establishment and Management of GBV Shelters.

Capacity building and support supervision by MOGLSD included training of 28 regional trainers and 128 key duty bearers on the revised Police Form 3 (PF3) used in reporting and follow up of cases of GBV. The ministry conducted GBV-focused supervision in 22 districts in the regions most affected by GBV:

- Eastern: Bukwo, Kween, Kapchorwa,
- North: Gulu, Amuru, Lira, Dokolo, Kitgum, Pader, Oyam
- West Nile: Yumbe,
- East-Central: Jinja, Kamuli, Namutumba, Mayuge, Iganga, Kaliro, Bugiri.
- Northeast: Amuria, Katakwi,, Moroto, Kotido, Kaabong, Amudat, Nakapirit,
- Central: Mubende,
- Southwest: Kanungu,

The close link between SGBV and HIV is a new frontier where FBOs are leading in breaking the silence and taking action. Progress was made in 2013 in helping FBO leaders in understanding SGBV, and acknowledging its presence and consequences. A good example that is providing services in this area is the Sexual and Gender-Based Violence (SGBV) action program supported by IrishAid through the Catholic Church (through Trócaire) and the Inter Religious Council of Uganda (IRCU) for the other faiths. The IRCU part of the program is focused on the East Central region of Uganda, and works closely with the Anglican and Islam communities. Some of the specific elements of focus under this CPA include: a) protection of children from abuse, exploitation, violence and

family separation; b) vital statistics – access to birth registration; death registration; c) ensuring access to inheritance rights.

Nine (9) cultural institutions have been supported since 2012 to generate evidence on socio-cultural factors that impact on HIV prevention, maternal health and GBV. Over 300 cultural leaders have been trained in community dialogue skills and supported to conduct dialogues that result in community action plans. Six (6) major religious denominations of Anglican, Orthodox, Roman Catholic, Moslem, Seven Day Adventist, and Pentecostal have been supported to develop leadership manuals on HIV prevention, maternal health, FP, ASRH and GBV and have utilized them to mobilize their congregations at community levels. These community approaches combined with radio programming reached over 1m people in the 8 target districts in 2013.

**Workplace protection and services:**

**Private sector workplace interventions:**

1. **Human capacity** – mobilization, training and advocacy: 137 CEOs/Managers oriented; 1,330 Peer Educators/Mentors trained and deployed as champions for HIV prevention and care in the workplace
2. **Policy development and implementation:** 47 companies initiated, developed and implement HIV workplace policies and programs
3. **Service delivery promotion and support in workplaces:**
   - 353, 575 people reached with HIV prevention messages
   - 4,638,942 pieces of condoms distributed in private sector companies and organizations.
   - 31 Abstinence Clubs were formed and trained in company supported schools.
   - 2,805 people were put on ART and care in company supported clinics.
   - 15,488 people reached with HCT.
   - 528 were provided with SMC services.
   - 113 mothers received with EMTCT services in company supported clinics.

In 2013, workplace interventions for HIV prevention and treatment were the main model used to target and reach MARPs, e.g., in sex work, transport industry workers, fisher folk and plantation workers. A large proportion of the HCT campaigns and outreach services were also based in workplaces. In addition, the statutory instrument on employment and HIV-non-discrimination regulations was finalized in 2013; and development of the multi-year action plan for its implementation was initiated.

The Self-Coordinating Entity (SCE) for the Private Sector in the AIDS Partnership Mechanism was a major actor in coordinating and mobilizing resources for workplace interventions in the private sector. The SCE reported the following key achievements in 2013:

4. Human capacity – mobilization, training and advocacy
   - 137 Chief Executives and Managers oriented on the impact of HIV&AIDS on business and the world of work.
   - 1,330 Peer Educators and mentors (68% men) were trained and deployed as champions for HIV prevention and care in the workplace
5. Policy development and implementation
   - 47 companies initiated, developed and implement HIV workplace policies and programs

- Specific support provided to the hospitality sector (through the Uganda Hotel Owners Association); retails sector (3 Supermarket Chains); and entrepreneurs with disabilities (through National Union of Disabled Persons in Uganda) to develop and implement HIV workplace policies and programs
- Private Sector SCE is represented on the Partnership Committee, the Global Fund CCM, and the Civil Society Fund Board

6. Service delivery promotion and support in workplaces
   - 353, 575 people reached with HIV prevention messages
   - 4,638,942 pieces of condoms distributed in private sector companies and organizations.
   - 31 Abstinence Clubs were formed and trained in company supported schools.
   - 2,805 people were put on ART and care in company supported clinics.
   - 15,488 people reached with HCT.
   - 528 were provided with SMC services.
   - 113 mothers received with EMTCT services in company supported clinics.

### b) Eliminating stigma and discrimination

The national PLHIV stigma index study was completed and disseminated in 2013; and used as a key basis for enhanced programming for stigma reduction interventions

National capacity to reform laws and policies that constrain HIV and AIDS responses was enhanced through training of parliamentarians, CSOs and law enforcement officers on HIV, stigma and discrimination.

High level advocacy was undertaken by civil society, ADPs and other stakeholders, with particular focus on the Anti-Homosexuality and the HIV Prevention and Control bills. This process contributed to the major revisions to the Anti-Homosexuality bill; as reflected in the Act that was passed in 2013.

The PLHIV Stigma Index Survey was finalized and disseminated in 2013, and is currently in use as advocacy platform for the reduction of stigma and discrimination. PLHIV networks initiated development of action plans to implement the recommendations from the survey. The survey reported stigmatizing experiences especially in the form of gossip (60.5 percent) verbal harassment (35.9 percent) and sexual rejection (21.5 percent). Other forms of stigmatization experienced include: exclusion from social gatherings (16.1 percent); physical harassment (14.6 percent); Loss of job or income (13.2 percent); and physical assault (10.3 percent). Experiences of internal stigma and fears were also reported by respondents in the survey, as presented in Table 14 below.

**Table 14: Experiences of internal stigma by PLHIV**

| Internal Stigma Category | Females | Males | Total |
|---|---|---|---|
| I have low self-esteem | 40.8% | 31.7% | 35.4% |
| I blame myself | 45.0% | 31.1% | 36.8% |
| I feel ashamed | 38.6% | 25.2% | 30.6% |
| I feel guilty | 35.0% | 24.6% | 28.8% |
| I blame others | 35.0% | 18.5% | 25.2% |
| I feel suicidal | 10.0% | 7.7% | 8.6% |
| I feel I should be punished | 7.5% | 5.8% | 6.5% |

*Source: 2013 stigma index study*

The survey also explored the awareness of respondents about, and personal engagement with, the UN Declaration about HIV and AIDS, and the Uganda national policy on HIV and AIDS. Both documents have specific provisions for respect and protection of the rights of PLHIV. Respondents were also asked about personal experience challenging stigma, and knowledge about a place that provides help to deal with stigma and discrimination. Responses to these questions are presented in Table 15.

**Table 15: PLHIV knowing their rights; and confronting stigma**

| Item | Females | Males | Total |
|---|---|---|---|
| Have heard about the UN Declaration of commitment on HIV and AIDS | 50.1% | 41.9% | 45.2% |
| Have ever read or discussed the content of this declaration | 22.6% | 16.8% | 19.2% |
| Have heard about the Uganda national policy on HIV and AIDS | 42.8% | 36.6% | 39.1% |
| Have ever read or discussed the content of this policy | 19.1% | 14.6% | 16.4% |
| | | | |
| Have confronted, challenged or educated someone who was stigmatizing and/or discriminating against you | 59.2% | 44.9% | 50.7% |
| Know of any organizations or groups that you can go to for help if you experience stigma or discrimination | 71.6% | 52.8% | 60.5% |

*Source: 2013 stigma index study*

In 2013, National capacity to reform laws and policies that constrain HIV and AIDS responses was enhanced through training of parliamentarians, CSOs and law enforcement officers on HIV, stigma and discrimination. High level advocacy was undertaken by civil society, ADPs and other stakeholders, with particular focus on the Anti-Homosexuality and the HIV Prevention and Control bills. This process contributed to the major revisions to the Anti-Homosexuality bill; as reflected in the Act that was passed in 2013. Engagement is continuing on the HIV Prevention and Control bill, which is still under consideration by Parliament.

### c) Strengthening HIV integration

**Comprehensive; quality psycho-social support services:**
**Support economic activities for households of PLHIV and those most vulnerable to exposure to HIV:**
District-based LQAS in 2013 in 66 districts with USG-supported OVC-support programs reported 12% of the poorest households were reached with external economic support in in the previous 12 months. Capacity was strengthened for government and CSO staff in OVC service delivery and supervision

- 3,273 community based para-social workers received curriculum based child protection training
- 1,345 Community Development Officers (CDOs) and other frontline social services workers from 1,089 sub-counties in 80 districts completed an in-service training program on Child Protection.

**Support enrolment, retention and completion of OVC in primary, secondary and vocational formal education:**
Education sector reports indicate that 14.7 percent of all children enrolled in primary school in 2013 were orphans

- The proportion is similar for boys and girls (15.3% and 14.5%)
- This compares closely with the 13.9% of children 5-14 years old reported to have one or both parents dead in the 2011 DHS.

**Economic support:** District-based LQAS in 2013 in 66 districts with USG-supported OVC-support programs reported 12% of the poorest households were reached with external economic support in in the previous 12 months

**Education support:** Education sector reports indicate that 14.7 percent of all children enrolled in primary school in 2013 were orphans. Data from the Education Management Information System (EMIS) indicates that this proportion rose from 6.8 percent in 2003 to 17.0 percent in 2004; and has been stable since then in the range of 17.7 and 14.7. The rate was above 17 percent between 2004 and 2008, and has since been slightly lower, at 16 percent between 2009 and 2011, and 15 percent in 2012 and 2013. The change between 2003 and 2004 may be attributed to increased financing for OVC support programs from PEPFAR, Global Fund, the World Bank MAP program, etc.

## 2.5 System Strengthening

**KEY 2013 ACHIEVEMENTS IN SYSTEM STRENGTHENING**

**Strengthen governance and leadership of the HIV response at all levels**
**UAC Institutional Review:** was finalized; a zonal coordination sub-structure was instituted and initiated in 3 of the 8 planned zones; staff were recruited and deployed in 11 positions at national and zonal level.

**Partnership Mechanism Review:** was conducted in 2013; results were used to restructure and re-vitalize the mechanism; with three main coordination clusters – civil society; decentralized and district-based response, and central government sectors.

**HIV-related policy and strategy development, review and implementation:** nine key policies and strategies were developed or reviewed in 2013: the National Youth Policy; School Health Policy; The Uganda National Plan for eMTCT; National SRH/HIV Linkages and Integration strategy; National Condom Strategy 2013-2015; National Comprehensive Condom Programming Strategy; Revised guidelines and Strategic Plan 2013-2015 for TB-HIV collaboration; Leadership Advocacy Strategy on HIV and AIDS; and Guidelines for HIV/AIDS Coordination at Decentralized levels in Uganda, 2013

**Target 6: Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22–24 billion in low- and middle-income countries**
Sustained financing for the national AIDS response was realized for 2013; and applied to key elements of the service delivery system:

- ***Human Resources****:* staffing level in district health services increased from 55% in 2012 to 61% in 2013; with recruitment of 7,211 staff; training of staff at all levels (service delivery, supervision and management, etc.)
- ***Strengthening Supply Chain Management (SCM) for HIV-related commodities:*** rationalizing quantification, supply planning, procurement and distribution of HIV commodities; and strengthening district and service-point capacity (projection, ordering, storage and managed utilization)
- ***Improving laboratory services:*** initiated construction of the national health laboratory; and further development of the hub-based laboratory referral and communication system (especially for EID)
- ***Community systems strengthening:*** strengthening the capacity of CBOs as service delivery partners; improving local level partnership, coordination and capacity sharing

**Establish a coordinated and effective national system for management of strategic information for the HIV response**

***Upgrade and revisions in key service delivery MIS:*** in health sector (DHIS2, Web-based ARV ordering and reporting, open MRS, PMTCT mTrac); social development sector (OVC-MIS)

***Strengthening coordination and consolidated national-level reporting:*** online mapping of district-based stakeholders in HIV services; JAR used for in-depth reporting by SCEs; assessment and revitalization planning for the National AIDS Documentation and Information Centre

### 2.5.1 Leadership and governance

**1. UAC Institutional Review:** Finalization of UAC institutional review and implementation of the recommendations was an area of key progress in 2013. Staff were recruited and deployed in 11 positions at national and zonal level. The process to fully operationalize three zonal offices for north, western and central Uganda was initiated.

**2. Partnership Mechanism Review:** An in-depth review of the multi-sectoral AIDS Partnership Mechanism (PM) was conducted in 2013, to inform re-alignment of the mechanism to changes in the epidemic and response focus over the last 10 years. The review covered the AIDS Partnership and all it structures including AIDS Partnership Committee and all its sub committees, Self-Coordinating Entities, Partnership Fund and Partnership Forum. It also covered the decentralized level partnership structures to establish relevancy, suitability and value added to national and sub national AIDS Coordination.

**4. HIV-related policy and strategy development, review and implementation:** key policies and strategies developed or reviewed in 2013 are presented in Table 16 below. These documents were an important basis for activities implemented in 2013 as described in Sections 2.2 to 2.4.

**Table 16: Policies and Strategies developed and reviewed in 2013**

| Policies | Strategies and Guidelines |
|---|---|
| National Youth Policy<br>School Health Policy | • The Uganda National Plan for Elimination of Mother to child Transmission of HIV 2012 – 2015<br>• National SRH/HIV linkages and integration strategy<br>• National Condom Strategy 2013-2015<br>• National Comprehensive Condom Programming (CCP)<br>• TB-HIV collaborative activities Strategic Plan 2013-2015<br>• Leadership Advocacy Strategy on HIV and AIDS<br>• Guidelines for HIV/AIDS Coordination at Decentralized levels in Uganda, 2013 |

### 2.5.2 Resources to support HIV service delivery

1. **Financing for the AIDS response:** As indicated in the Uganda CCM request for Interim Funding to the Global Fund, government financial allocation towards the procurement of malaria, HIV, and TB drugs increased from $30 million in 2010 to $40 million in 2013. Additionally, $2 million USD is allocated to support the coordination of the GF grants at MOH. GOU also funds the Uganda AIDS Commission to the tune of about $2.5 million. Table 15 below show the external inflows for 2011/12 and 2012/13; and the projected allocations for 2013/14 and 2014/15.

**Table 17: External financing for HIV and AIDS – 2011/2012 to 2014/2015 (US$ million)**

| Agency | 2011/12 | 2012/13 | 2013/14 | 2014/15 | Totals |
|---|---|---|---|---|---|
| Irish Aid | 8.6 | 8.6 | 8.6 | 9.2 | 34.9 |
| DFID – | 4.8 | 8.2 | 6.5 | 5.4 | 24.9 |
| DANIDA | 7.1 | 7.1 | 7.1 | 7.1 | 28.4 |
| SIDA | 3.3 | 2.6 | 2.6 | 0 | 8.5 |
| UNITAID / Clinton Health Access Initiative | 15.7 | 8.8 | 0.8 | 0.8 | 26.1 |
| PEPFAR | 324.0 | 324.0 | 324.0 | 324.0 | 1,296.0 |
| UN Agencies | 13.8 | 12.6 | 11.0 | 11.2 | 48.6 |
| GFATM | 8.6 | 8.6 | 8.6 | 9.2 | 34.9 |
| **Total** | **377.4** | **371.9** | **360.5** | **357.7** | **1,467.5** |

*Source: NSP (2011/12 to 2013/14), Interim Global fund Application (2014/15)*

**Sources of funding for HIV and AIDS:** The National AIDS Spending Assessment (NASA) completed in 2012 covered investments for the period 2008/09 and 2009/10. Figure 6 and Table 16 show that a total of 1,109 billion shilling (**586.6 million USD**) and 1,167 billion shillings (**579.7 million USD**) were spent on HIV/AIDS in 2008/9 and 2009/10, respectively. Note that these figures are nominal and not adjusted for inflation. The difference in total funding (basing on the Shilling values) is only a 5.2 percent increase from 2008/9 funding levels to 2009/10. Of the total HIV funding in these years, about 68 percent came from external sources, 21 percent from private sources and 11 percent from public sources.

**Figure 6: Sources of funding for HIV/AIDS in Uganda (2008/9 and 2009/10) – UGX Billions**

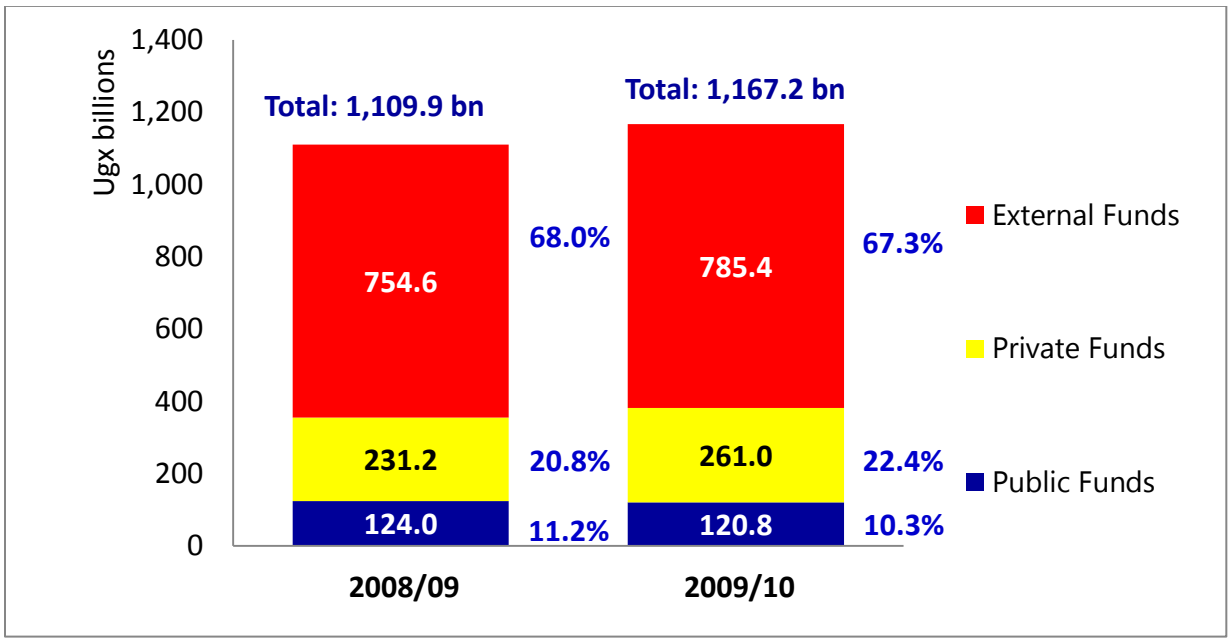


**Table 18: Total HIV/AIDS funding by source (2008/9 and 2009/10)**

| SOURCE | Funding 2008/09 | | Funding 2009/10 | |
|---|---|---|---|---|
| | (UGX millions) | (USD millions) | (UGX millions) | (USD millions) |
| **Public Funds** | 124,029 | 65.6 | 120,752 | 60.0 |
| **Private Funds** | 231,206 | 122.2 | 260,998 | 129.6 |
| **External Funds** | 754,622 | 398.8 | 785,436 | 390.1 |
| **TOTAL** | **1,109,856** | **586.6** | **1,167,187** | **579.7** |

**Figure 7: Sources of funding for HIV/AIDS in Uganda – further disaggregated**

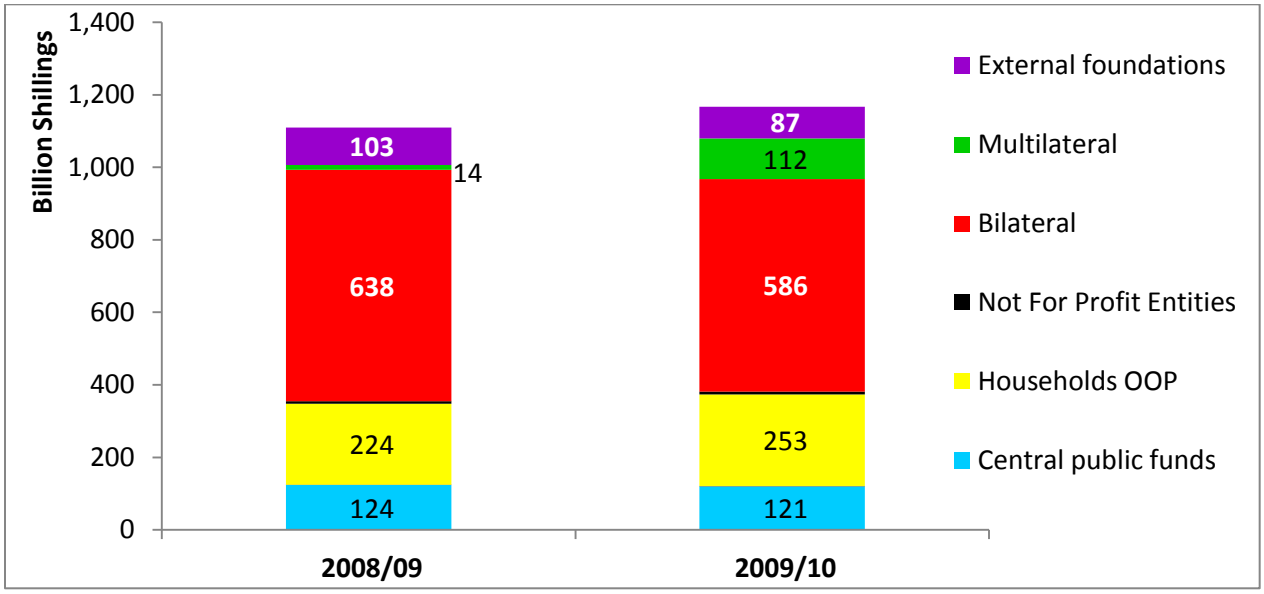



**Table 19: HIV/AIDS funding by source – 2008/09 and 2009/10**

| Sources | 2008/09 (Bn UGX) | % | 2009/10 (Bn UGX) | % |
|---|---|---|---|---|
| Central public funds | 124.02 | 11.2% | 120.68 | 10.3% |
| Local and other public funds | 0.01 | 0.0% | 0.01 | 0.0% |
| Business Entities/Firms | 0.38 | 0.0% | 0.41 | 0.0% |
| Households OOP | 223.62 | 20.1% | 252.72 | 21.7% |
| Not For Profit Entities | 7.20 | 0.6% | 7.86 | 0.7% |
| Private financing sources | 0.01 | 0.0% | 0.01 | 0.0% |
| Bilateral | 637.64 | 57.5% | 586.03 | 50.2% |
| Multilateral | 13.56 | 1.2% | 112.29 | 9.6% |
| External foundations | 103.42 | 9.3% | 87.11 | 7.5% |
| **Totals** | **1,109.86** | **100%** | **1,167.13** | **100%** |

The results presented in Figure 7 and Table 19 show that:

- The highest proportion of external funds is from bilateral sources – 57.5% of total funding in 2008/9 and 50% of total funding in 2009/10;

- Funding from multilateral sources increased markedly between 2008/09 and 2009/10 (from UShs14 bn to UShs112 bn). This was mainly due to the fact that there were no funding disbursements for HIV/AIDS from Global Fund in 2008/9, while a significant amount of funding from this source was available in 2009/10;
- External foundations are a steady source of funding for HIV/AIDS, contributing up to 9.3% & 7.5% of total funding in 2008/09 and 2009/10, respectively;
- Private sources contribute between 20% and 22% of total funding, and these are largely out-of-pocket spending on HIV/AIDS by households/individuals;
- Public sources contribute the least amount of funds; i.e. 11.2% and 10.3% of total funding in 2008/09 and 2009/10, respectively;
- Public funds are largely from central government

**HIV/AIDS Spending by AIDS Spending Categories:** Results in Figure 8 and Table 18 show the details of how the HIV/AIDS resources were spent in 2008/9 and 2009/10, broken down by the standard NASA AIDS Spending Categories.

**Figure 8: Expenditure by AIDS Spending Categories – 2008/9 and 2009/10**

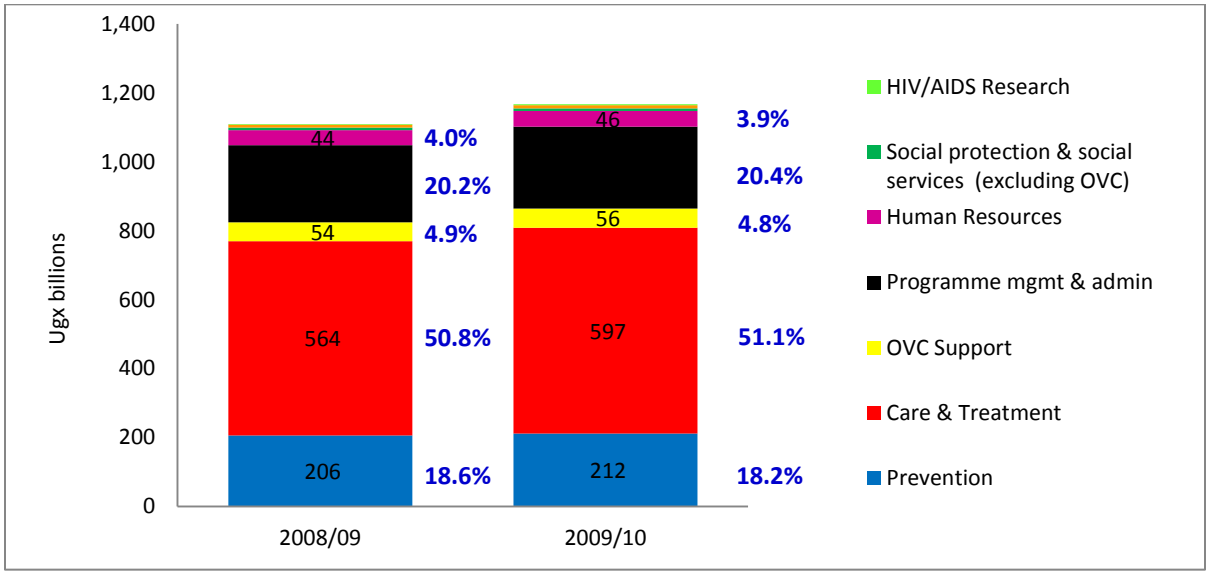



**Table 20: Spending by AIDS Spending Categories (2008/09 and 2009/10) – UGX Billion**

| | 2008/09 | % | 2009/10 | % |
|---|---|---|---|---|
| Prevention | 206.1 | *18.6%* | 212.0 | *18.2%* |
| Care & Treatment | 564.1 | *50.8%* | 596.5 | *51.1%* |
| OVC Support | 54.1 | *4.9%* | 56.1 | *4.8%* |
| Programme management & admin | 223.7 | *20.2%* | 237.7 | *20.4%* |
| Human Resources | 44.2 | *4.0%* | 45.7 | *3.9%* |
| Social protection & social services (excluding OVC) | 7.0 | *0.6%* | 7.3 | *0.6%* |
| Enabling environment | 8.2 | *0.7%* | 8.8 | *0.8%* |
| HIV/AIDS Research | 2.5 | *0.2%* | 2.9 | *0.3%* |
| **TOTAL** | **1,109.9** | ***100.0%*** | **1,167.2** | ***100.0%*** |

Table 20 and Figure 8 show that Care and Treatment (51%), Program management and administration (20%) and Prevention (18%) take up the largest share of the total resources for HIV/AIDS in Uganda. These findings are consistent over the two-year period studied. Note that these three spending categories have small nominal increases in resources between 2008/9 and 2009/10, with care and treatment receiving the highest increase (of about 32 billion shillings), programme management received a nominal increase of 14 billion shillings, while Prevention received a nominal increase of about 6 billion shillings. Human resources and OVC support each received about 4% of total resource envelope, and each had a nominal increase of about 2 billion shillings between 2008/9 and 2009/10.

**2a. Human Resources – health sector**: government has continued to invest in expanding staffing in the health sector, as the main setting for HIV service delivery. Specific emphasis has been on lower level health facilities (HC IV, HC III and HC II); within the broader framework of strengthening district health services. Attained improvements in staffing in district health services are presented in Table 21 below.

**Table 21: Staffing levels in district health services – trends in positions filled 2011 to 2013**

| Facility category | 2011 | 2012 | 2013 |
|---|---|---|---|
| **HC II** | 42% | 45% | 45% |
| **HC III** | 60% | 56% | 70% |
| **HC IV** | 61% | 60% | 71% |
| **General Hospital** | 63% | 62% | 61% |
| **Overall district health staff*** | 55% | 55% | 61% |

** Include District Health Office and all government health facilities in the district*

Government approved a budget of UGX 49.5 billion to support recruitment of a total 10,210 health staff of different cadres in 2013. A total of 7,211 staff were recruited and deployed across the country (Details on cadres in Table 22).

**Table 22: Government recruitment of health personnel in 2013**

| Cadre | Advertised | Filled | Fill rate |
|---|---|---|---|
| **Nurses (all categories)** | 3,108 | 2,688 | 86.5% |
| **Clinical Officers (all categories)** | 1,254 | 989 | 78.9% |
| **Laboratory staff (all categories)** | 1,246 | 905 | 72.6% |
| **Midwives (all categories)** | 1,610 | 1,067 | 66.3% |
| **Other cadres** | 1,997 | 1,270 | 63.6% |
| **Doctors (all categories)** | 371 | 196 | 52.8% |
| **Dispensers** | 179 | 43 | 24.0% |
| **Anaesthetic staff (all categories)** | 445 | 53 | 11.9% |
| TOTAL | **10,210** | **7,211** | **70.6%** |

Additional recruitment of health workers for hospitals and HC II in both the public and private-not-for-profit (PNFP) sectors was supported in 87 districts by USG/PEPFAR. Funding from GFATM

supported recruitment of midwives and nurses in 22 districts; and deployment of 12 Regional Performance Monitoring Teams for coordination of HIV activities in the districts.

Inadequate staff accommodation (available housing units, size, and quality) continues to be a major constraint to staffing at health facilities. The situation on 30 June 2013 reflect an 83.4 percent shortage in staff housing; with only 3,590 housing units available out of a total 21,612 required for staff in place.

**2b. Human Resources – Social Protection sector:** In 2013, capacity was strengthened for government and CSO staff in OVC service delivery and supervision. A total of 3,273 community based para-social workers received curriculum based child protection training and are consistently conducting home visits reaching vulnerable families with protection, social care services and referrals. A total of 1,345 Community Development Officers (CDOs) and other frontline social services workers from 1,089 sub-counties in 80 districts completed an in-service training program on Child Protection.

### 2.5.3 Direct investments to HIV service delivery systems

***Rationalisation of Supply Chain Management (SCM) for HIV-related commodities:*** In October 2012, MOH and PEPFAR rationalized the quantification, supply planning, procurement and ordering of HIV commodities. The national supply chain for HIV commodities has been rationalized to three national level warehouses: National Medical Stores (NMS), Joint Medical Stores (JMS) and Medical Access Uganda Limited (MAUL). All warehouses now do direct deliveries of commodities to the health facilities (last mile delivery system). NMS and JMS use third party distribution providers and MAUL uses their own fleet.

***Strengthening District and facility capacity in medicines management:*** The Supervision, Performance Assessment and Recognition Strategy (SPARS) program in 3,637 health facilities all 112 districts. This program is designed to address in a holistic and systematic manner many of the supply chain system weaknesses at the district and facility level that have been cited by numerous pharmaceutical sector surveys and assessments, including the recent GF Special Procurement and Supply Management Review (SPSMR) conducted in Uganda between December 2012 and February 2013. Improvements were made in 2013 in all areas including storage management, stock management, ordering and reporting, prescribing and dispensing. Detailed district and national reports are prepared quarterly to track progress. Special SPARS modules were developed for TB and laboratory commodities and will be rolled out this year.

***Establishment of the Quantification and Procurement Planning Unit (QPPU):*** In order to effectively plan, monitor and coordinate EMHS for the country, the QPPU was established as part of the Pharmacy Division of the MoH. The QPPU ensures optimum use of GoU and donor financing for pharmaceutical products by providing a single centralized system in the MOH for projecting and quantifying national requirements for EMHS and coordinating contributors' supply planning ensuring appropriate products in adequate quantities are supplied on a timely basis. The Pharmacy Division/QPPU leads an integrated commodity security group which meets monthly to discuss commodity procurement and supply chain issues related to HIV, Malaria and TB commodities. The group includes MOH technical staff as well as key national and international stakeholders who are directly involved in commodity procurement and programming.

***Web-based ARV ordering and Reporting System (WAOS):*** This centralized ordering and reporting system was officially started in April 2013 and rolled out to all districts. WAOS is a module in the MOH DHIS2 system and links facility orders directly to the three central warehouses. Through the WAOS ART sites report logistics data (issues, stock on hand, consumption etc.) and the number of patients by drug regimen. The system is hampered by internet, server and user access problems. These challenges have been addressed by expanding internet and server capacity. Facilities without internet connectivity submit their orders through the DHO's office.

***Improving storage capacity at health facilities:*** MoH Pharmacy Division in collaboration with SURE instituted a process to conduct quarterly surveys of health facility stores in both public and PNFP sectors. The survey in June 2013 established that over 60% of the stores were deemed inadequate in terms of shelving, space, and other criteria. SURE procured 3,000 high quality shelving units which were installed in 1,270 facilities in 45 districts.

***Improving laboratory services:*** In line with the 2011 Laboratory Policy and 2010-2015 Strategic Plan for laboratory services, construction of the National Health Laboratory (NHL) complex started in June 2013. The number of government health facilities with functional laboratories was 1,589 in 2013. Laboratory commodity supplies procurement was fully harmonized with essential drugs, and stock out of lab commodities reduced from 90% in 2012 to 60% in June 2013. In addition, laboratory equipment procurement was harmonized nationally.

Laboratory data management tools have been developed and incorporated into national HMIS and there are ongoing efforts to strengthen the LMIS to improve data management through the DHIS. Rationalization of the lab commodity supply chain is ongoing. District capacity to quantify lab needs and place orders to NMS has been strengthened by the, Performance Assessment and Recognition Strategy (SPARS) mentorship strategy. Through support from PEPFAR/SUSTAIN project, a lab equipment maintenance system has been established with regional workshops.

### 2.5.4 Community systems strengthening

In 2013, focus in CSS continued to be on: a) strengthening the capacity of community based organizations as service delivery partners; b) partnership building at the local level to improve coordination and capacity sharing; and to avoid duplication; c) enhancing delivery of the Basic Care Package (BCP) through PLHIV Networks, Village Health Teams (VHT), and other HIV care and support organizations. Priority actions included:

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

Other CSS activities in 2013 included empowering of various community structures and individuals (volunteers) to support and advocate for adoption of practices that maximize community response to HIV service delivery. Specifically, several interventions along the continuum of care used PLHIV for demand creation and support for individuals in care, especially for eMTCT and ART services. The mobilization activities were geared towards engaging communities to address negative cultural beliefs and practices, stigma and discrimination that affect uptake of HIV services

## 3.0 Best practices

The continued evolution of the HIV and AIDS epidemic demands for continued learning and adoption of best practices in the AIDS response. Over the years, different stakeholders in the Uganda AIDS response, such as UNAIDS, UNASO, IRCU, etc.; have provided guidelines and tools; and supported capacity building in Best Practice analysis and documentation. Best Practice analysis and documentation is recognized as a key monitoring and evaluation method and approach in the health system and the national AIDS response. However, national criteria and standards for best practice analysis and documentation are not yet developed.

Best practice examples from the Uganda AIDS response documented by UNAIDS in the past include: a) the AIDS Information Centre (AIC) model for VCT; b) HCT in ANC as a mechanism for population level HIV surveillance and client entry into other HIV services; and c) the experiences of the Islamic Medical Association of Uganda (IMAU) in establishing faith-based HIV education and service development.

The Civil Society Fund (CSF), a multi-donor funding pool established in 2007 as a common support framework for civil society contribution to the Uganda AIDS response, published a synthesis of success stories in 2012, based on the funded services of 38 sub-grantees between 2007 and 2012. The 69-page booklet presents successful experiences in HIV prevention, care and support for PLHIV, economic support for vulnerable households, child protection and empowerment, and capacity strengthening for CSOs.

Examples of Best practice analysis and documentation in Uganda in 2013 include: a) ***SRH interventions for adolescent sex workers*** – by the Uganda Youth Development Link (UYDEL) in Kampala area; and b) ***Tackling HIV from a Faith Foundation*** – an analysis by the Inter-Religious Council of Uganda (IRCU), based on self-completed questionnaires by 60 IRCU-supported HIV service programs by FBOs; and 11 examples summarized in one publication. Other examples of best practice mentioned in the different documents reviewed are presented below; under the following thematic areas: Policy and Political Leadership; Scaling up effective prevention programs; Scaling up of care, treatment and/or support programs; System strengthening; and Monitoring and Evaluation.

### 3.1 Best Practice Examples in Policy and Political leadership

**Leadership Advocacy Strategy on HIV and AIDS:** was developed and approved by the National HIV Prevention committee.

### 3.2 Best Practice examples in scale-up of effective prevention programmes

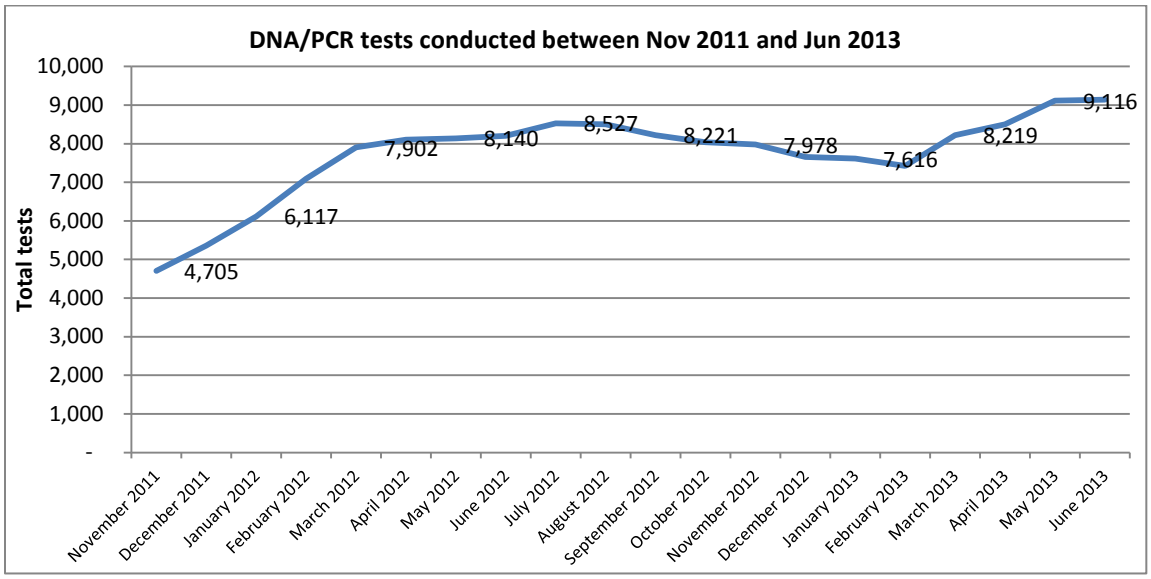
Examples captured in the 2013 mid-term review of the HSSIP 2011-2015, and the 2013 JAR include:

- **Condom promotion:** distribution to non-medical facilities and key populations such as boda boda riders
- **PMTCT:** adoption of Option B+ which was initiated simultaneously across all regions; with regional launches involving high level political and cultural leaders

- **HCT:** Provider Initiated Testing and Counselling (PITC) and other community models of HCT as well as couples HIV testing
- **EID:** consolidation of EID testing in one central laboratory to enhance efficiency; scaled up specimen referral hubs (from 19 to 78), and expanding transportation means to include motorcycles to enhance efficiency

***Establishment of lab hubs**:* The Ministry of Health successfully established 19 hubs serving 625 facilities. To improve access to quality laboratory services including EID, the MoH together with support from its Partners, decided to invest in a comprehensive national sample transport system and more 53 hubs are to be established to reach 1700 facilities by end of 2013. This system involves setting up local networks centred around regional, district hospitals and health facilities, called hubs. Each hub is given a motorbike and a sample transporter is assigned to each hub. The transporter visits 20-30 health facilities within 20-40km radius around the hub, bringing all referred samples from each facility and delivers results on a weekly basis. The system has reduced turnaround time, increased services uptake, and reduced unit cost; as illustrated in Figure 9 below.

**Figure 9: Trend in EID testing – 2011 to 2013**




GSM printers are used to deliver EID test results to health facilities and enhance follow up of HIV infected infants. The printers are based in the Laboratory/Transport hubs and enable real time printing of EID results at these hubs. This reduced the delay in delivery of results to the health facilities. The GSM printers will also be used to send names of positive infants to facilities to prompt follow up and initiation on ART enhancing accountability for these infants. An online dashboard for monitoring performance of EID services has been developed. This dash board is linked to the EID database at the central public health laboratories. MOH, Districts, partners can now monitor and as well improve performance in real time of EID services.

### 3.3 Best Practices in scale-up of care, treatment and/or support programmes

***Use of stickers to improve Paediatric ART Initiation***:
A Yellow sticker to highlight files of children who are eligible for ART but not on treatment was innovated. Paediatric ART initiation rates improved from 66% to 100% and 90% to 100% at TASO Entebbe and TASO Jinja respectively. Stickers also reduced the average 40 to 10 days and 90 to 10 days in TASO Entebbe and Jinja respectively. The stickers have now been rolled out to all the 10 regions which had mentors trained in paediatric QI.


Family support groups were strengthened in 2013 as a key mechanism to enhance integration of Option B+ with ART care.

A web-based approach for assessment and accreditation of health facilities for ART services was adopted.

### 3.4 Best Practice Examples in System Strengthening

Examples under this area include: a) Rationalization of supply chain management; b) QPPU stock monitoring; and c) Human resource improvements as discussed in details in Section 2.4.2 and 2.4.3.

## 4.0 Major challenges and remedial actions

### 4.1Progress made on key challenges reported in the 2012 Country Progress Report

The 2012 Country Progress Report and the 2013 mid-term review of progress against the 2011 ten targets for the UN Political Declaration on HIV and AIDS highlighted key challenges, and indicated specific commitments to address these. Progress in 2013 in implementing the actions against each of the challenges is presented in Table 23 below.

**Table 23: Progress in addressing challenges from 2012 GARPR and the June 2013 MTR**

| Challenge | Recommended/Planned Action | Progress in 2013 |
|---|---|---|
| **Policy implementation:**<br>Weak UAC Secretariat<br>• Thin staffing structure, not well aligned to core UAC functions; some key positions unfilled<br>• Slow process of review and revision of the UAC statute; and institutional restructuring<br><br>Policies, strategies and guidelines that remain under/un-implemented<br>• Inadequate follow-through of the entire policy process (translation into practice actions, actual implementation, progress review and necessary adjustments, etc.)<br>• Inadequate human resources – limited action to accommodate required changes in staff numbers and deployment arrangements, unfilled positions, staff attrition<br><br>Inadequate, un-sustained and | Expedite implementation of the UAC institutional review recommendations<br>A comprehensive review and recalibration of national and decentralized coordination of the AIDS response and the Partnership Mechanism<br>Review and address the issues relating to recruitment, retention and motivation of staff in health and AIDS-related services in all settings (public and non-public institutions)<br><br>Expedite establishment of the proposed AIDS Trust Fund | Institutional review recommendations were implemented with respect to staffing at national level and establishment of zonal coordination offices<br><br>A concept on the AIDS Trust Fund was developed; and its discussion initiated with Parliament<br>The country has rationalized HIV services nationwide, in order to improve efficiencies in utilization of funds.<br>The HIV Investment case was developed |

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| unpredictable financing | | and will be used to guide investment in areas of high impact |
| **Prevention:**<br>Limited coverage with full scope of 'combination prevention' interventions<br>• Inadequate alignment of prevention interventions to the key drivers and distribution of incident cases<br>• Limited delineation and specific targeting of some MARPs (e.g. sex workers, MSM)<br><br>Sub-optimal mainstreaming of HIV prevention in development programs<br><br>Quality gaps in PMTCT services<br>• Limited ARV stocks to ensure universal multi-drug regimens (beyond NVP only)<br>• Weak male involvement<br>• Poor coverage with EID | Scale up combination prevention; expand MARPs-focused services and safe male circumcision<br>Improve linkage of more HIV infected individuals to care, treatment and support systems<br><br>Improve on coordination and scaling of prevention interventions in all sectors.<br><br>Promote male involvement in PMTCT programs<br>Scale-up HIV testing, with a focus on reaching more first-time testers | All HIV prevention implementation process in 2013 was based on combination prevention<br><br>A pilot was designed and initiated in 6 districts for intensified implementation of combination prevention, to demonstrate impact.<br><br>The limited comprehensive programming for most at risk populations (MARPs) has been resolved following a south-to-south exchange visit that has resulted in consensus to develop a key population implementation action plan. There is also emerging government commitment to take lead on MARPs harmonized programming with potential for expanded funding.<br><br>Evidence was generated through mini-studies on MARPs, to inform targeted programming for these key populations. A draft profiling and size estimation of MARPs was prepared and is under review. A draft MARPs programming framework was developed and is under review<br><br>A male involvement strategy was developed and is in use. EID was strengthened through the hub-based approach, as a central element in scale up of Option B+ |

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| **Care and treatment:**<br>Inadequate linkage and integration between TB and AIDS care<br><br>Weaknesses in ARV supply chain management<br>• Multiple supply systems; with common stock-out experiences<br>• No unified and fully functional data tracking system on ARV stocks, distribution, etc.<br><br>Quality gaps in general AIDS care<br>• Inadequate attention to OIs (including TB)<br>• Limited attention to pre-ART care needs<br>• Limited integration with other health services | Scale-up TB-HIV interventions with specific targets<br><br>Streamline and improve on ARV supply chain management<br><br>Increase access to OI diagnosis and management, beyond the basic care kits and co-trimoxazole<br>Improved guidance for, and quality of, pre-ART care<br>Enhance SRH and HIV prevention integration with AIDS care and treatment | Guidelines for IPT and geneXpert utilization were developed in 2013, as key elements in enhancing TB-HIV collaboration<br><br>Rationalized the quantification, supply planning, procurement and ordering of HIV commodities. The QPPU was functionalized rationalized<br><br>Option B+ was used a key basis and framework for enhancing integration of HIV care and routine SRH |
| **Social support:**<br>Inadequate programmatic and financial capacity of implementers to provide the full scope and depth of core support and protection services<br><br>Poor (inadequately developed; under-utilized) data capture and reporting systems on OVC distribution, needs and services | Prioritize family economic empowerment to restore/strengthen the household and community safety-net for PLHIV, OVC and other affected groups<br>Enhance social protection through law and policy interventions that integrate protection for all vulnerable groups (PLHIV, OVC, PWD, the elderly, etc.)<br>Strengthen OVC data capture and reporting systems to inform national and global planning. | A total of 3,273 community based para-social workers received curriculum based child protection training and are consistently conducting home visits reaching vulnerable families with protection, social care services and referrals<br>A total of 1,345 Community Development Officers (CDOs) and other frontline social services workers from 1,089 sub-counties in 80 districts completed an in service training program on Child Protection.<br><br>A total of 1,100 civil society organizations participated in service provider coordination and networking activities for protection and support services to |

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| | | vulnerable children and families.<br><br>By Dec, 2013, 70 districts were consistently making online OVC MIS reports, producing quarterly service provision analysis reports and disseminating them during district and sub county coordination committee and service provider coordination meetings. |

### 4.2 Challenges in 2013 and remedial actions for 2014

This section presents a synthesis of key challenges from the 2013 AIDS response; and key commitments to address these challenges in 2014 and 2015, to ensure achievement of agreed targets. These are discussed under the 4 thematic areas in the NSP; as presented in Table 24 below.

**Table 24: Challenges in 2013 and planned remedial actions in 2014 and 2015**

| **Key Challenges in 2013** | **Planned remedial action in 2014 and 2015** |
|---|---|
| **Prevention** | |
| Piece-meal programming, implementation and monitoring for the constituent elements in combination prevention | **Comprehensive approach to finely targeted HIV prevention interventions:** Combination prevention strategies including behavioral, biomedical and structural and interventions targeting specific population groups will be implemented.<br>• Integrated ABC programming will be revitalized |
| Limited comprehensive programming for key populations | **Targeting of specific population groups and particular contexts:** will be guided by modeling and survey evidence on the key drivers of the epidemic; and the distribution of projected incident cases.<br>• A critical initial step toward addressing key populations will be to conduct a national size estimation to develop a profile of these groups.<br>• Innovative approaches for providing novel HIV prevention services for mobile populations (e.g., fishing communities, oil industry and road construction workers, etc.); and for sex workers, MSM, and people that inject drugs, will be prioritized. |
| Inadequate coverage of MARPs and other key populations with HIV prevention and | **Increase HCT targeting to key populations where incident HIV infections are most likely to occur:** greater emphasis will be put on PITC in health care settings; on couple |

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| care services | testing; and on repeat testing among persons in settings where instances and experiences of higher risk sex are common. |
| Linkages between HIV care and routine SRH services are still weak, | **Comprehensive strengthening and integration of reproductive, maternal, newborn and child health services as the foundation for eMTCT:** including strengthening integration of EID and EPI services; and paediatric ART capacity at all health facilities providing eMTCT (Option B+) services. |
| Service demand for SMC still outstrips available services | **Scaled-up delivery of safe male circumcision services:** Efforts will be made to increase SMC coverage through: (a) dedicated circumcision teams in all districts to conduct outreach services in lower level health facilities and at community level; (b) expanding task-shifting and task-sharing of specific roles in SMC to nurses or other lower-tier health workers; and (c) community education and mobilization to enhance sustained demand for SMC, and to deter behavioral disinhibition after SMC. |
| **Treatment and care** | |
| Inadequate capacity to roll out the 2013 WHO guidelines for ART | **Bold ART scale up based on a foundation of a continuum of comprehensive HIV prevention and care services:** with a focus on continuous quality improvement; and ART adherence and retention in care<br>• Strengthen integration and linkages across services at HC III; as the fulcrum for entry and follow up for an integrated service package for reproductive health; maternal, newborn and child health; HIV prevention; and AIDS care and treatment services.<br>• Efficiencies will be further enhanced through strengthening linkages and referral mechanisms at household, community and HC II level, and up through the different health facility levels |
| **Weak procurement and supply chain management systems:** which result in erratic supplies of some ARVs | **Procurement, distribution and disposal of HIV-related goods and supplies will be further improved** through the rationalization and supply bundling of essential commodities (e.g. ARVs, cotrimozaxole, test kits and SMC commodities)<br>• NMS has initiated the process of establishment of regional medicines and supplies stores |
| **Inadequate laboratory personnel:** limited numbers and inadequate skills of those in place | **Improve laboratory capacity for HIV-related testing and diagnosis:** The laboratory hubs for EID and other services will be increased from the current 77 to 100.<br>• Necessary staffing, training, infrastructure modifications and quality assurance support will be ensured through government investments and support from development partners. |
| **Social support and protection** | |
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| High levels of stigma; and persistent low | **Integrated stigma reduction, social protection and socio-economic empowerment** |

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| capacity for social protection services | **and support**<br>Based on the results and recommendations from the 2013 stigma index study, a robust stigma reduction initiative will be implemented<br>• This will include strengthening cultural and religious institutions and their role in HIV-related spiritual and psychosocial support. |
| Measurement and reporting of SGBV occurrence and service provision is still a major challenge for many FBOs. | |
| **System strengthening** | |
| **Gaps and other weaknesses in AIDS response financing:** the level of funding remains woefully inadequate, and has even declined. Resource allocation across elements of the AIDS response (especially in prevention and social support) is not aligned to the stated programming priorities<br>• Inadequate financing for behavioural interventions, psychosocial support and stigma reduction. | **Refine and initiate implementation of the investment case:**<br><br>**Institutionalization of regular resource tracking mechanisms and improving efficiency of HIV/AIDS spending especially on those interventions that have big impact based on evidence.** |
| **Weak coordination and leadership structures and systems at national and decentralized/district levels**<br>• Lack of a formal UAC Strategic Plan thus hindering implementation of more organized institutional development initiatives.<br>• Inadequate district structures, systems, and technical capacity to coordinate the decentralized response | **Strengthen national level coordination of the AIDS response**<br>Institutional strengthening of the UAC Secretariat will continue to be prioritized, including:<br>a) Expediting development and utilization of the UAC Strategic Plan as the blueprint for operations of the UAC Secretariat;<br>b) Increasing UAC visibility through branding and sustained engagement of all stakeholders in the coordination of the national response; and<br>c) Strengthening NADIC as the main hub for mapping and regularly updating records on stakeholders and their activities.<br><br>**Sustain roll-out and capacity building to revitalize decentralized coordination of the AIDS response**<br>a) Reconstitute and strengthen monitoring of the functionality of the coordination structures in Districts and urban authorities.<br>b) Institute a follow up mechanism to validate, update and utilize the stakeholder mapping database with local governments.<br>c) In order to increase accountability, spearhead the adoption of a district based and led |

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| | HIV planning/programming where resources will be tagged to the District HIV/AIDS Strategic and integrated operational plans and information management. |
| **Under-developed community systems:** for support to community-level HIV service delivery and utilization<br>▪ Inadequately developed and popularized home-based care and its distinct role in ART; no structured data collection and integration into the formal health system reporting systems | **Community systems will be strengthened: to further support key elements in the AIDS response such as:**<br>• Referral and enrolment of PLHIVs in community and facility-based services.<br>• Strengthening community-based psychosocial support (PSS) in HIV/AIDS care and support services. |
| **Inadequate human resources:** | **Improving human resources for health:** develop and implement a comprehensive staff accommodation development plan; consider a living wage for all health workers; establish enhanced salary package and priority training for health worker in hard to reach/hard to stay settings – as an integral element in the transition to performance-based contracting for government workers |

## 5.0 Support from AIDS development partners

In 2013, ADPs continued to play a major role in financing the national AIDS response; in targeted technical support to response management and coordination; and in reinforcing implementation and scale up of specific interventions. This was largely accomplished through the ADP Self-Coordinating Entity; a key element in the national Partnership Mechanism for the HIV response. ADPs are well represented on all the major governance and oversight groups in the national response, including the Partnership Committee, the Country Coordinating Mechanism, the Civil Society Fund Steering Committee, etc. The Joint UN Programme of Support on AIDS (JUPSA) continued to be an important framework for mobilization and engagement of the UN family in Uganda into the national response.

### 5.1 Key support received from ADPs

The 2012 GARPR identified specific action priorities for ADPs. Progress in implementation of these actions is presented in Table 25 below.

**Table 25: ADP actions on priorities identified in the 2012 GARPR**

| Priority actions for ADPs identified in the 2012 Country report | Progress in actions in 2013 |
|---|---|
| **Deepen engagement with government particularly MFPED for (a) ensuring that HIV/AIDS is mainstreamed in the budget and activities of all sectors and (b) expanding the health sector budget to accommodate the provision of the ever increasing ART services.** | • The ADPs supported high-level advocacy, learning mission and the development of the concept note for the establishment of HIV Trust fund, this has been presented and discussed by parliament. There are other consultations being lined up for inclusion to reach consensus between MoH, UAC and MOFPED before submission to cabinet. This is an innovative financing mechanism for funding HIV response.<br>• The Country has been supported to develop an HIV investment case,<br>• High level advocacy contributed to increased financing to health sector and HIV response that resulted in increased recruitment of human resources for health.<br>• The HIV and AIDS response in Uganda has moved from complacency to high priority at various levels of government, including the office of the presidency, parliament, the office of the first Lady, ministerial, district leaders, cultural and religious leaders.<br>• Effective and efficient coordination of ADPs has increased commitment from the bi-lateral and multi-lateral partners in providing both technical and financial support to the HIV response in the country, and contributing to flow of GF resources. |
| **Sustain the CSF while making access to the resources by small NGOs and Community-based Organizations easier and equitable** | A new agreement has been signed with Deloitte to continue managing the CSF beyond January 2014. Funds were specifically earmarked for district level NGOs and CBOs |

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| **Align their support plans and contributions with the national strategic plan and supporting the implementation of the prevention plans developed by different sectors** | • The AIDS Development Partners' Group (ADPG) has become an effective mechanism/forum to harmonise and align development assistance to the national policies and strategies, thereby minimizing duplication, and overlaps. This has been possible given its periodic unified voice and frank monthly targeted meetings with wide membership drawn from bi- and multilateral organisations.<br>• ADPs programmatic plans and activities are aligned to national strategies.. An evidence-based, costed NSP with clear targets and goals will be an important tool for measuring annual progress and holding stakeholders accountable. |
| **Support the coordination arrangements including UAC and other structures like Partnership mechanism, Sector and District coordination committees, civil society networks etc.** | ADPs have continued to support UAC, the sectors and districts for an improved coordination. The key milestones include;<br>• Review of partnership mechanism<br>• Operational mechanisms for the Zonal Coordination structures to promote decentralization of the national AIDS response were finalized. Consensus has been reached with district leadership for phasing of the implementation of zonal structures<br>• HIV/AIDS Partnership Mechanism Review was finalized, disseminated and results used to restructure the self-coordinating entities for the effective coordination of the response.<br>• Uganda AIDS Commission staff underwent a week long orientation and training on change management<br>• Technical support provided to CCM, to develop and peer review GF applications.<br>• The ADPG has continued to support the functional of HIV prevention coordination and management structures at national sector and focus districts namely Partnership Committee, the Condom Committee , National Prevention Committee (NPC), MARPS TWG, SMC NTF, CT 17, EMTCT and ART national advisory committee,<br>• The ADPs will continue to support civil society as strong advocates and catalysts for programmatic and policy improvement.<br>• Overall there has been significant improvement in the capacity of the Uganda AIDS Commission and Key CSOs to plan coordinate and implement the national AIDS response |
| **Strengthen M&E at UAC, institutionalizing the NASA and integrating HIV/AIDS in sector M&E systems** | During the year the ADPs supported key M&E interventions;<br>• The Assessment and revamping of the NADIC<br>• The development of the Uganda HIV investment case<br>• Learning mission, development and presentation of HIV AIDS trust fund that has been discussed by parliament and is due for presentation to cabinet.<br>• The development of the National M&E database to capture data about the key indicators<br>• Harmonization of Partners indicators with those in the M&E plan and supporting district-based programming approach |

### 5.1.1 Targeted ADP support to HIV prevention

PEPFAR has shifted its prevention activities away from stand-alone behavioral interventions to combination approaches, which integrate appropriate prevention messaging and condom promotion with biomedical interventions, e.g. eMTCT and SMC. PEPFAR continues to refine its behavioral prevention portfolio to better target Key Populations and prioritize proven biomedical and structural interventions. In 2014-15, PEPFAR will prioritize continued SMC scale up; ensuring a balanced portfolio that addresses prevention needs across generational subgroups; eliminating bottlenecks that impede condom access and use; and targeting Key Populations with tailored programs. PEPFAR will continue its support for blood safety, medical infection, post-exposure prophylaxis (PEP), and sexually transmitted infection (STI) management.

JUPSA supported advocacy and normative guidance for the realization of key elements in the national HIV prevention strategy: including a) Comprehensive Condom Programming - national strategy completion and implementation roll-out, supplementary male and female condom procurement; b) strengthening SMC programmatic scale-up and M&E; c) scale up of eMTCT to all districts; and d) district-focused support for intensified implementation of combination prevention and integration programming focused on key populations such as sex workers, fishing communities.

High-level advocacy for eMTCT (Option B+) was supported by ADPs at both the national and district level; championed by the First Lady of the Republic of Uganda. It drew participation of the political, cultural and religious leaders. An intensified focus on six districts in this process yielded 76% coverage of HIV positive pregnant mothers with ARVs for eMTCT.

In ADP efforts to support the implementation of national HIV prevention interventions, seven focus districts were supported to establish baseline values for combination HIV prevention. These have been utilized in the development of district planning and evaluation guides for implementing the NPS. Evidence was also generated on SRH/HIV integrated service delivery to young people and MARPs in selected districts. Further evidence on socio-cultural factors, which influence HIV prevention, maternal health and GBV, was gathered to support implementation in the Karamoja region. Community systems have been strengthened targeting enhanced service uptake and sustained actions including establishment of peer education/support structures for MARPs, young people and mothers in selected districts.

### 5.1.2 Targeted ADP support examples in treatment, care and support

The JUPSA supported the updating of the policy guidelines on Post Exposure Prophylaxis (PEP) and TB/HIV collaboration as well as the NCD screening guidelines. Furthermore, new ART guidelines were developed and adopted in 2013, with WHO guidance. JUPSA continued to support the finalization and field-testing of the comprehensive HIV Training Package. This initiative saw 66 health workers trained as Trainers of Trainers (TOTs) to support rapid scale-up of Option B+ at lower level facilities. An additional 210 frontline health workers were trained. In other efforts, support supervision for integrated pediatric HIV/AIDS care was conducted in 50 health facilities.

ART data collecting tools were revised and customized in an effort to upgrade the open eMRS system in line with the revised HMIS tools; this was initiated during the course of the year. A total of 44 health facilities were facilitated to use the Open EMRS system in order to track patients on

HIV/ART services. The JUPSA also provided technical support to MoH to generate the Early Warning indicator report on ARV resistance. High-level advocacy and engagement by ADPs contributed to extension of WTO TRIPS for 8 years; a key ingredient in continued access to ARVs in Uganda.

In strengthening of OVC support and protection, two aspects attracted key ADP focus: a) review of social protection responses, policy and legal frameworks in Uganda to enhance specific inclusion and targeting of people living with HIV and households affected by HIV and AIDS; and b) integration of the three factor criteria (orphaned, disabled and out of school) with the vulnerability index tool to determine and track levels of child vulnerability. A total of 23 districts were supported to use this approach to map and coordinate OVC service providers. This process resulted in an additional 22,291OVCs (47% girls) being identified and linked to social services in 15 of the districts.

### 5.1.3 ADP support to system strengthening governance and human rights

***Strengthening the capacity of UAC:*** ADPs provided focused support for operational startup of the UAC zonal coordination structures. JUPSA supported establishment of the first four zonal bases; in Wakiso district for the central region, Mbarara for the western region, Mbale for the eastern region, and Gulu for the northern region. CDC and Irish Aid made commitment to support the other 4 zonal bases. UAC was further supported in the generation, packaging and dissemination of strategic information on the response, including preparation of the 2012 GARPR, and the 2013 mid-term review of progress on the 10 targets of the 2011 UN Political Declaration on HIV and AIDS.

***Improving capacity for HIV/AIDS and gender mainstreaming in development:*** Over 200 local government leaders (in 24 urban authorities) were trained on gender and HIV. This training aimed at addressing gender barriers of key population groups in urban municipalities. As a result, all 24 municipalities integrated gender and HIV activities in their annual work plans; and four of them (Ntungamo, Kitgum, Lubaga and Masindi) initiated specific HIV services targeting MARPs.

A study to review the status of HIV and gender mainstreaming was conducted in five selected local governments. This study is meant to identify bottlenecks and promising practices in integrating gender and HIV in local government structures, policies and strategies. Results from this study were used to strengthen HIV and gender mainstreaming the 2013/2014 annual work plans for district local governments. Aspects of emphasis in this respect include: a) building technical capacity for HIV and gender mainstreaming; b) promoting accountability on the delivery of gender equality and HIV; and c) creating a supportive organizational culture for HIV and gender mainstreaming.

***Strengthening capacity for sustainable response financing and accountability monitoring:*** ADPs provided technical and financial backstopping for development of the 2013 Uganda interim application to the Global Fund under the new funding mechanism; and preparation of the Investment Case for HIV. In support to greater transparency and accountability, support was provided to develop and implement a national score card study on the national HIV response.

***Monitoring and responding to violation of HIV-related rights:*** support was provided to complete and disseminate the first HIV-related stigma index study for Uganda; a process led and coordinated by the National Forum of PLHIV Networks in Uganda (NAFOPHANU). A national reference team on HIV laws and policies was created; composed of eminent Ugandans to support visible monitoring

and advocacy on HIV-related rights. It includes: Noreen Kaleeba, Chairperson AMREF and founder of TASO; Lady Justice Dr. Esther Kisakye, Judge on the Supreme Court of Uganda; Prof. Ben Twinomugisha, Dean Faculty of Law Makerere University; Ms. Beatrice Were, Human rights and Gender Activist; and, Hon. Dr. Jeremiahs Twa-twa, MP and Chair of the Parliamentary Committee on HIV and AIDS.

***Greater harmonization of M&E systems:*** PEPFAR supports increased harmonization of national data systems and realization of a single M&E system. PEPFAR expects to transition away from its parallel HIBRID data collection system and pulling data directly from the GoU's DHIS II in 2014. Given that DHIS II does not collect all required PEPFAR indicators, some information will continue to be collected through HIBRID or other sources. To facilitate and support the transition, PEPFAR's monitoring and evaluation (M&E) partner will begin providing additional TA to the MoH's Resource Center.

## 5.2 Key concerns in relation to ADP support

**Donor funding is not a guarantee, is unpredictable and less is available:** Uganda experience shows that donor funding comes with conditions that may not be in accordance with national goals. At times this may make the donors appear to be seen as driving the health and HIV/AIDS agenda because donors' priorities are sometimes not aligned with national and local ones. In any case, foreign assistance is usually unpredictable as is illustrated below. Indeed, while DfID is pulling out of funding HIV/AIDS, many other donors have already done the same. Access to GFATM is slow with serious implications to the national response.

Globally, there are indications that the contributions of development partners to HIV and AIDS is levelling off; in particular, PEPFAR funding is leveling off. PEPFAR is the major contributor to the international funding of HIV and AIDS in the world and particularly to African countries including Uganda. However, there are indications that PEPFAR globally is facing (a) competing health and development demands across Africa, (b) an ever rising burden of HIV/AIDS treatment, and (c) continuous resource constraints due to global financial crisis and increasing domestic deficit. Indeed, the goals of PEPFAR II that include (i) transition from an emergency response to promotion of sustainable country programs and (ii) strengthening of partner government capacity to lead the response to the HIV/AIDS epidemic and other health demands, is an indication that more efforts have to be made by recipient countries to increase their domestic resource mobilization.

The concentration of donor funding for HIV among a very small number of donors – particularly, the United States and the Global Fund – in Uganda suggests potential vulnerability should the scope and/or magnitude of their funding commitments change in the future.

### 5.3 Actions that need to be taken by ADPs to ensure achievement of targets

**Continued support to the national AIDS response:** Development partners need to recommit themselves to support the national response through longer-term and predictable investments on HIV and AIDS. This is especially important in view of the financing projections in the Investment Case for HIV, as presented in Table 26 below.

**Table 26: Financing Projections for Implementing the Investment Case – 2014 to 2018**
***(Amounts in US $ Millions)***

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|
| **GOU** | 36.8 | 38.0 | 41.8 | 50.0 | 63.0 |
| **Multi laterals** | 355.8 | 354.8 | 354.8 | 354.8 | 354.8 |
| **Bi lateral Agencies** | 29.1 | 21.3 | 21.3 | 21.3 | 21.3 |
| Total Commitments | **421.7** | **414.1** | **417.9** | **426.1** | **439.1** |
| Country Need | **684.6** | **694.6** | **704.6** | **724.6** | **746.6** |
| *Financing gap* | ***262.9*** | ***280.5*** | ***286.7*** | ***298.5*** | ***307.5*** |

Over the next five years, external resources are projected to continue constituting most of the funding for the national response in Uganda. Efficient planning and sustainability of required services in such a context will depend on substantial and predictable ADP support.

**Strengthening evidence and accountability:** as key contributors to financing the national response, and in keeping with the principle of shared responsibility and global solidarity, ADPs will continue to play a key role in promoting accountability and value-for-money evidence. All stakeholders will need to be held accountable to their contribution commitments; and duly acknowledged when they meet their promises.

**Support in implementation of the Investment case:** there is need for ADPs to support the process to start using the Investment Case to mobilize resources from government and all other sources. This will include dissemination of the final document to key government stakeholders (especially MOF and MOH) to ensure understanding and effective implementation. There will be need to revise the NSP and prepare annual operational plans that are aligned to the Investment Case. The process of developing the plans to operationalize the Investment Case should be consultative and begin early to feed into government planning and budgeting cycle for FY 2015/16 which starts in October/November 2014.

Regular monitoring of the implementation of the Investment Case and the NSP will be necessary; to track progress in achievement of targets and provide appropriate feedback to implementers. It will be useful to conduct operational research to provide basic information/data for further improving programming and targeting of key priority interventions.

## 6.0 Monitoring and evaluation environment

### 6.1 Overview of the current monitoring and evaluation (M&E) system

The M&E system for the Uganda AIDS response is based on the 'third-one' in the UNAIDS 'three-ones' principle. Table 27 below outlines the elements in the Uganda AIDS M&E system along the key components envisaged in the UNAIDS guidelines for ***One agreed M&E framework for overall national monitoring and evaluation.***

**Table 27: Key components of the one M&E system for a national AIDS response**

| **Key component** | **Uganda system (status and performance in 2013)** |
|---|---|
| **Global level alignment:** | |
| M&E that enables accountability for funds and evidence-based programming | UAC JAR and Annual Health Sector reviews are used for this purpose |
| A common set of core elements of a country-level M&E system to meet global needs | The Uganda core outcome and impact indicators are to the global indicators |
| **Core national M&E system:** | |
| Linked to the National HIV/AIDS Action Framework (e.g., NSP, NPAP, Annual Operational Plan) | Sector indicators are linked to indicators in the AIDS M&E Plan |
| Under the leadership of the National AIDS Coordinating Authority | UAC is responsible for M&E of the national response |
| An agreed M&E unit – coordinating M&E activities implemented by various partners | UAC has an M&E department to coordinate the National M&E backed by the National M&E TWG constituted by sector and CSO Technical M&E resource persons |
| A national multi-sectoral M&E plan with clear goals and targets included in or derived from in the national strategic plan<br>• Should include data collection, dissemination, and use strategies<br>• Should have secured funding (10% of NSP budget) | An M&E Plan 2011-2015 is in place; based on the NSP; with clear indicators and targets. |
| One national set of standardized indicators comparable over time<br>• Comparable across countries; endorsed by all stakeholders; reflecting the country needs, and existing data collection and analysis capacities | Indicators in the M&E plans were developed using a multi-secoral approach incorporating the sector and CSO interest. The indicators are used as a guide to develop the sector indicators |
| One national level information system containing key data on:<br>• Serological surveillance,<br>• Behavioural surveillance,<br>• Coverage of essential services,<br>• Financial tracking,<br>• Socio-economic and sector impact of the epidemic | In the final stages of development of the National M&E database to capture data about the key indicators |

| Key component | Uganda system (status and performance in 2013) |
|---|---|
| Strategic information flow from sub-national to national level and among different national level actors feeding into the national information system for effective use | It is included in the M&E plan. This is however hindered by lack of National HIV M&E database linked to the sector databases |
| Harmonized M&E capacity building efforts among all the training providers in countries | Developing a M&E training curriculum |
| **Agreed investment strategies for data quality:** | |
| Assessment of existing M&E systems, to inform agreed action for improvement | Integrated support supervision is done on a quarterly basis; and it includes regional review meetings |
| Establishment of a shared core system that provides high-quality data for analyzing country performance. | Sector data collection tools and system is currently manual |
| **Investment in national capacity:** | |
| All stakeholders (national governments, AIDS authorities; ADPs, AIDS action partnerships, etc.) make the case for necessary investment in building essential human capacity to meet national M&E needs. | Harmonization of PEPFAR indicators with those in the M&E plan: PEPFAR has 75% of its indicators incorporated. CDC's is supporting a district-based programming approach |

### 6.1.1 Functioning of the M&E system in 2013

The Joint AIDS Review (JAR) of 2013 included discussion of progress made in the undertakings made during the 2012 JAR. It also reviewed progress in implementation of the two-year NPAP 2011-2013, and generated priorities for the 2013-2015 NPAP. Prior to the national JAR meeting, pre-JAR regional meetings were held in nine regions of the Country to allow for district participation at that level. These reports fed into the sector reports that informed the national meeting.

**M&E training of local governments and civil society:** In order to improve and strengthen capacity of Local Governments and other HIV/AIDS stakeholders to effectively plan, monitor and evaluate the HIV/AIDS response, a training on M&E for staff of 8 district local governments and CSOs was conducted in the first quarter. The training covered the districts of Nwoya, Zombo, Kyegegwa, Jinja, Mayuge, Buikwe, Kole, Alebtong and Otuke. The training was conducted by technical staff from UAC, MOH, MGLSD, Civil Society Representatives and UNAIDS. District-based training in M&E targeted records and information management staff in district offices. Each district contributed 50 participants. In addition, Kasese was supported to train 23 DAT members, strengthen the office of Focal person, orientation of 25 records officers in data management, and holding of annual district forum.

**Other strengthening of district and zonal offices:** Five district offices were equipped with computers and internet connectivity to enhance efficiency in M&E data collection and onward transmission.

**Development of key reports on the national response:** A number of consolidated reports on the national response were produced in 2013; including:

- The 2011-2013 NPAP review report

- The JAR synthesis report
- The Mid-Term review report on global commitments to the 10 targets of the 2011 UN Political Declaration on HIV and AIDS.

**Strengthening the data and information sharing function at UAC:** A comprehensive assessment of the National AIDS Documentation and Information Center (NADIC) performance and capacity needs was carried out. Based on the recommendations, and a system strengthening proposal were given with an aim of strengthening NADIC at UAC to become a one stop center for all HIV and AIDS information in the national response. These recommendations are to be implemented over a period of three years.

**Develop the national AIDS M&E database:** The process of developing an M&E database at UAC is ongoing. An E-mapping database has been developed to map all HIV/AIDS stakeholders in the National response. This is meant to capture who does what and where in districts and also output data to them, especially the non-biomedical output data. Linkages with existing information systems like HMIS, OVCMIS, EMIS will be ensured.

**Developed an M&E framework for HIV/AIDS interventions in the health sector:** This was initiated through a process to harmonize reporting tools as a way of identifying additional variables to be included in HMIS and DHIS2. In the same vein the following activities were conducted: revision of ART and PMTCT patient and programme monitoring materials, to ensure alignment with HMIS; review of the Open MRS which has been rolled out at some sites; printing of HIV care and treatment patient monitoring tools and distributed to facilities; printing and distribution of materials for HMIS to 28 districts.

**Roll-out of DHIS2:** MOH worked with partners to roll out the District Health Information System (DHIS2) to all districts. This is a centralized web-based health information management system aimed at enhancing timely and accurate reporting by the districts. Individual reports from facilities are aggregated before onward transmission to the Resource Center. Other DHIS2 functionalities include data analysis, two way feedback, and communication within the system. The MOH continues to work with all stakeholders to incorporate all their reporting needs into the DHIS2.

**Roll-out of Open MRS:** The MOH has continued to roll out Open MRS over the past year. This is an electronic medical records management system that supports not only individual patient care but also facility reporting and cohort analyses. The system has rolled out to more than 150 health facilities which have reported improved quality of care and patient scheduling in implementing sites. All regional referrals hospitals and other high volume ART sites have been covered. Retrospective data entry was done to capture records of all patients ever enrolled in care at these facilities to enable cohort analysis. An SMS reminder component has been incorporated for patients who miss their appointments and data importation module also added for health units that were using different information systems before.

**SMS reporting for PMTCT –MTRac:** Working with UNICEF, the MOH is implementing the use of mTRAC; an innovation that uses SMS technology for reporting on medicines in real time. Weekly reporting through mTRAC has been adopted by the PMTCT program to ensure uninterrupted drug supplies at the facilities.

**Web based ARV ordering and reporting:** was rolled out to all districts to support the ARV drugs supply chain. Data from 45 districts indicated that stock-out of ARVs occurred in less than 5% of facilities.

**Research to inform programming and implementation:** To better understand the current state of HIV prevention activities in the country, a baseline assessment was conducted in 6 districts of Kasese, Gulu, Arua, Mayuge, Rakai, and Kabale with support from DFID, UNFPA, World Bank, and PEPFAR.

The Ministry of Education, in collaboration with USAIDS/School Health and Reading programme carried out baseline survey on HIV Knowledge, Attitudes and Practices in schools was conducted to track measurable increases in HIV-related knowledge, attitudes, practices and skills amongst pupils, students and school workers. A total sample of 11,520 learners and 1,536 teachers in 384 primary and post primary (secondary & BTVET) education institutions spread across 15 districts were targeted. The districts were: Wakiso, Gomba (Intervention Central), Mpigi (Control Central), Katakwi, Kumi, Serere (Intervention East), Kaberamaido (Control East), Kole, Apac, Lira (Intervention North), Oyam (Control, North) and Kabale, Kiruhura, Bushenyi (Intervention, West), Rukungiri (Control, West).

**Strengthening OVC M&E:** In an effort to highlight existing opportunities for improving social support and protection of households affected by the effects of the HIV epidemic, the UN Joint Programme of Support on AIDS undertook a study to review and analyze HIV sensitive social protection responses in Uganda. The study noted the need to promote HIV inclusive social protection, in terms of its ability to ensure inclusion, address rights of access and participation of persons with HIV and households affected by HIV and AIDS. Key recommendations included: development of guidelines and promotion of approaches that will enhance understanding and implementation of HIV sensitive social protection programming to benefit persons with HIV and households affected by HIV and AIDS.

### 6.1.2 Best Practices in Monitoring and evaluation

As good M&E practice, UAC conducts JAR. This is aimed at assess the progress of implantation of the NSP bearing in mind the indicators in the M&E fanwort.

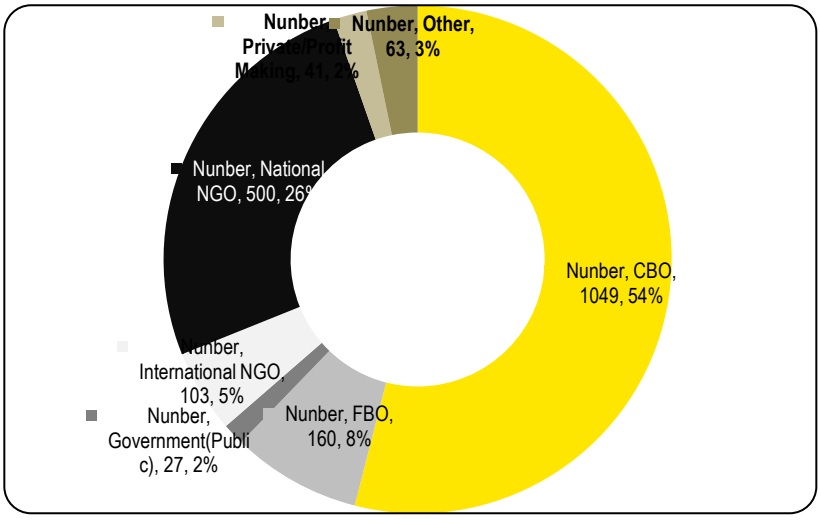
Harmonization of PEPFAR indicators with those in the M&E plan: PEPFAR has 75% of its indicators incorporated. CDC is supporting a district-based approach for HIV programming.

**Mapping of all HIV/AIDS Partners in Uganda for better coordination:** As part of the on-going re-vitalization of the National HIV/AIDS response, UAC conducted a country-wide update of the directory of HIV/AIDS service providers in May-June 2013. The process is part of a new initiative to establish an online database of HIV/AIDS service providers across Uganda reflecting places where they are operational, and the services that they are providing.

The online database is aimed at giving the Government of Uganda and UAC a comprehensive data source and up to date directory of HIV/AIDS service providers, what they do specifically in line with HIV/AIDS service provision, how they are distributed across the country, and the service needs that

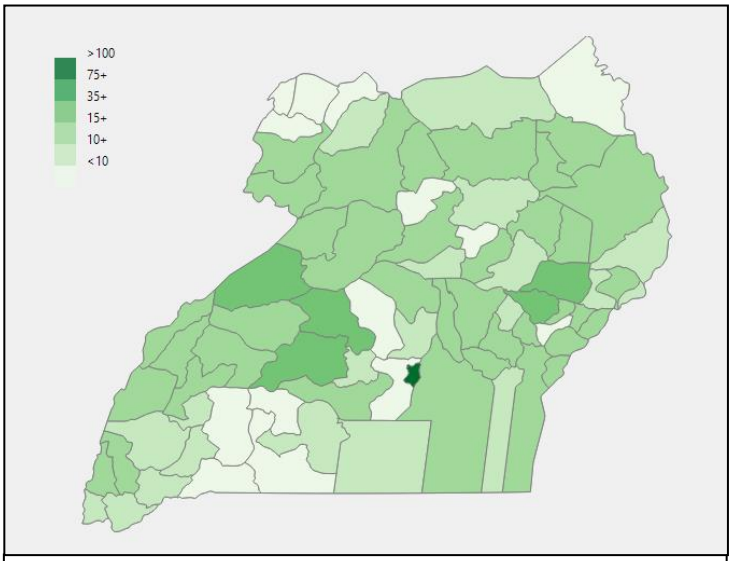
remain unmet. It is in line with the Government of Uganda's decentralization policy, and coordination of the HIV/AIDS response that is devolved to the district and sub-county levels.

**Figure 10: Categories of mapped organizations – 2013 online mapping**




Of the 1,943 organizations captured by the mapping exercise as distinct district-based stakeholders across the country, 54% (1,049) are Community Based Organizations (CBOs), 26% (500) National NGOs, 8% (160) Faith Based Organizations (FBOs), 5% (103) International NGOs, 2% (41) Private and profit making organizations. Only 1% (27) were identified as government (Public) organizations; and 3% (63) did not have a specified category. Distribution of the number of organizations mapped in each district is illustrated in the map below.

**Figure 11: Distribution of mapped organizations – by district**




**Districts coded with the darkest green have over 100 agencies while the lightest green represents districts with less than 10.**

Review of the database conducted as part of the process to develop this report found a total of 1,893 records of district-based stakeholders; including the following:

a) 1,218 non-government stakeholder agencies that appear once in the database

b) 9 local government departments that appear once in the database

c) 170 non-government stakeholder agencies that appear between 2 and 43 different times in the database – thus reflecting their presence in more than one district

A total of 61 health facilities were also included in the database. However, health facilities were to be excluded in the mapping process, since they are already included in the MOH database of health service providers.

## A good practice example in M&E

**Uganda's mTrac Initiative Wins Top Africa eHealth Award**
KAMPALA, Tuesday, 9 July, 2013 – The African Development Bank (AfDB) has recognized the Ugandan Ministry of Health's mTrac initiative as one of the top ten eHealth projects of 2013. The first AfDBeHealth award aims to encourage the production and sharing of knowledge on eHealth solutions.

Led by the Ugandan Health Ministry, mTrac is a joint initiative supported by UNICEF and the World Health Organization (WHO) with funding from UKAID, and implemented through a variety of partners including the Medicines and Health Services Delivery Monitoring Unit, National Medical Stores, Malaria Consortium and the Stop Malaria Programme.
"mTrac addresses a crucial need of the Ministry of Health, ensuring that accurate, real-time information from every health facility is available to national and local government stakeholders for action. Timely delivery of this information can greatly improve health sector performance," Minister of Health, Dr RuhakanaRugunda explains.

mTrac is a Rapid SMS-based health tool designed to strengthen health systems in Uganda. It was launched in December 2011 to improve Health Management Information System (HMIS) reporting on disease surveillance and medicine tracking systems in all 5,000 health facilities in Uganda, as well as speeding up response time and bolstering health sector accountability.
Data derived from mTrac shows that health facilities without stock-outs of anti-malarial medicines have increased from 74.8% to 88.1% In addition, 5,472 actionable reports were received via mTrac's anonymous hotline in 2012 of which 3,234 high priority cases were forwarded to the Medicines and Health Services Delivery Monitoring Unit for investigation.
Nearly 70 percent of these cases were successfully resolved. MoH is exploring new ways to strengthen the national health system using mTrac.

"mTrac is proving instrumental to multiple UN agencies by providing timely information on critical bottlenecks within the health system, allowing for course correction during programme implementation," says Ahunna Eziakonwa-Onochie, United Nations Resident Co-ordinator in Uganda. "This has allowed us to work closely with government counterparts to quickly correct problems while highlighting structural issues which require larger support," she adds.
In April 2013, the Uganda National Expanded Programme on Immunization (UNEPI) used mTrac to conduct a rapid survey to identify bottlenecks in the vaccine supply chain.
mTrac is being recognized internationally for real time monitoring of diseases, tracking of essential medicines, and improving health service delivery. Other AfDB award winners include Health Information Systems Programme's DHIS2 and Grameen Foundations' MoTECH. The awards will be presented in Tunisia in September, later this year.

## 6.2 Challenges faced in the implementation of a comprehensive M&E system

***Poor data management:*** inadequate documentation, data management, and reporting are a result of inadequate staffing and challenges associated with reporting community based HCT

- The existing challenge of effective systems and the generation and access to quality data for decision making has persisted. Key emerging issues included the lack of access to the Web-based ARV Ordering System (WAOS) and associated data processes, parallel reporting systems to DHIS2, poor documentation practices, a lack of understanding of systems and tools available and therefore an inability to conduct monitoring or evaluation. The underlying challenge brought to light was the inability of units to access and thereby generate complete, regular and timely data and therefore allow for systems strengthening.
- Although there has been significant improvement in the health systems to support HIV.AIDS services, majority of challenges are still related to these systems. Data management is still a major challenge. Following transition from multiple and parallel reporting channels to DHIS2, there are major data gaps. Data on most of the indicators was unavailable at the time of reporting as data cleaning is ongoing.
- Information management is still a challenge at all levels. Sectoral Information systems are lacking and greatly fragmented.This affects sector ability to generate useful and adequate data that can be used by all stakeholders in the sector planning, resource allocation, decision making and advocacy for HIV and AIDS in the sector.

**Inadequately developed M&E systems specific to the full requirements of the AIDS response:** The detailed and often complex data gathering and reporting of requirements for HIV-related services continue to be largely developed as additional tasks in existing health and social service settings, which already have extensive data capture and reporting requirements. The deployed personnel to meet this need and their specific data management skills are still inadequate. In many cases, data management responsibilities are not explicitly and adequately reflected in job descriptions and periodic performance appraisals.

There is poor coordination of biomedical research initiatives hindering dissemination of research outputs. There have been limited resources for conducting operations research and studies among Key populations. The process for ethical review of research protocols and IRB approval for public health evaluations is protracted despite the fact that these are operation research category of studies. This renders the implementation of program evaluation laborious.

In addition, there is a long bureaucratic procurement system for laboratory consumables and test kits as such affecting the implementation schedule. This has been the major cause of delay in release of HIV surveillance results. After the surveillance round is conducted, samples may be stored for long periods at UVRI before the testing can be performed.

The transition from parallel reporting systems to the DHIS2 is still challenged. Currently there is a data vacuum in majority of program areas. Challenges have been related to internet connectivity, user skills, understaffing, and access to the system

### 6.3 Remedial actions planned to overcome the challenges

**Strengthen M&E function at UAC:** Development of the National M&E database at the Uganda AIDS Commission will be finalized. In addition, the NADIC assessment recommendations will be implemented, to ensure real-time linkages of the various information systems in the national response; and availability of timely and up to date data and information for decision making. Training of national and district teams and printing of client monitoring tools and registers will be maintained and scaled up as necessary.

**Strengthen M&E function within STD/ACP:** There is need to strengthen the M&E function within the program. The SI unit plans to assist in the development of a performance monitoring plan. All units of STD/ACP will participate in setting targets for various indicators upon which their performance will be monitored. ACP will also conduct biannual programme review meetings that will feed into the annual report.

**Finalize development and roll out the health sector HIV M&E framework:** Further work planned to finalize the framework include: a) refining the indicators in the framework, with necessary delineation of district and national level indicators; b) developing reporting formats for the different indicators; c) developing and establishing the district and national level databases for the framework. The M&E framework database will require collection and updating data related to the indicators generated from the system. Data quality and timely reporting will be enhanced through continuous Data Quality Audits, timely mentorships and M&E training.

**Strengthening AIDS research collaboration:** There will be strengthening of collaboration between UAC and the Uganda National Council for Science and Technology (UNCST). Thus, UAC will work with UNCST, academia, other sectors and stakeholders to ensure critical studies are carried out and the findings disseminated as widely as possible to influence future programming and implementation. Priority areas of research include: (a) mapping and estimating key populations (b) operational research into costs of interventions (c) sustainability analysis etc.

Government of Uganda will engage its partners to support its national research agenda. Similarly, more robust evaluations of the national response will be conducted from time to time and analysis from national population based surveys re-analyzed to give more insight for service specific needs of implementing partners as necessary. The case of size estimation for most at risk population will receive top priority.

**HIV Drug resistance monitoring:** This will be enhanced, especially in view of the current rapid scale up of ART and the proposed further scale up. The annual HIV early-warning indicator survey conducted by UVRI; and national pharmaco-vigilance program under NDA are further contributions in this area.

### 6.4 Need for M&E technical assistance and capacity-building

- **Costing of the M&E plan:** As part of the requirement of the NSP, a National M&E plan was developed with output, outcome and impact indicators. Issues of data and information management and implementation of the plan were detailed. However the plan was not costed to establish what is required to fully implement it. Therefore costing of the plan will enable estimate funds required for implementation and also use it for resources mobilization.
- **Capacity building for M&E:** Monitoring and Evaluation is key at all levels. Review of the Local Government and other CSO plans reveals limited capacity to handle M&E. Resources allocated to M&E are either nonexistent or very meager. This is attributed to lack of appreciation and lack of skills for M&E. There is need to build capacity for M&E at all levels through short courses, hands on training and fellowships among others
- **Development of the M&E database:** is in its final stages, however, there is need to detail both hardware and software needs which link to the database so that these are procures, installed and functionalized to enable data/information flow and dissemination. This requires direct support to sectors and Local Governments
- **Harmonization of the data collection tools:** There are efforts to harmonize data collection tool e.g. PEPFAR indicators capture about 75% of those in the M&E plan. There is urgent need to harmonize these by all partners so that a single data collection tool is developed to abolish the existing multiple tool.
- **Harmonization of the reporting systems:** All stakeholders should feed into the existing data collection and reporting systems to avoid parallel reporting and duplication. With harmonization of the data collection tools, one reporting system e.g. HMIS/DHIS 2 should be strengthened to have 'one data centre' for all stakeholders
- **Strengthen the Zonal Coordination offices:** to support districts ensure that data is collected, analyzed and reported. The officers can provide hands on training to the districts and ensure continuous data quality.

**ANNEX 2: National Commitments and Policy Instrument (NCPI) results**

**ANNEX 3: Objectives and Targets of the 2011-2013 HIV National Priority Action Plan**

| | |
|---|---|
| GOAL 1: To reduce HIV incidence by 30% by 2015 | |
| Objective 1.1: To scale up coverage, quality and utilization of proven biomedical and behaviour HIV prevention interventions by 2015 | Target 1.1.1: Reduce the estimated number of new infections from 129,000 annually to 111,917 by 2013<br>Target 1.1.2: Estimated number of vertical HIV infections reduced from 19,544 annually to 10,000 by 2013<br>Target 1.1.3: Percentage of HIV positive pregnant women who received antiretroviral drugs to reduce risk of mother to child transmission increased from 52% to 75%<br>Target 1.1.4: Percentage of randomly selected retail outlets and service delivery points that have condoms in stock increase from 45% to 60%<br>Target 1.1.5: 1,250,000 males (14-49 years) circumcised by 2013 |
| Objective 1.2: To scale up HIV counseling and testing (HCT), increasing coverage and uptake by 2015 | Target 1.2.1: 3,500,000 adults (14-49 years) counseled, tested and received results by 2013 |
| Objective 1.3: To mitigate underlying social, culture, gender and other factors that drive the HIV epidemic by 2015 | Target 1.3.1: Stigma Index Finalized and disseminated |
| GOAL 2: To improve the quality of life of PLHIV by mitigating the health effects of HIV/AIDS by 2015 | |
| Objective 2.1: To increase equitable access to ART by those in need from 50% to 80% by 2015 | Target 2.1.1: Percentage of adults and children in need, receiving antiretroviral therapy increased from 50% to 65% by 2013<br>Target 2.1.2: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy: increased from 84% to 85%<br>Target 2.1.3: Percentage of hospitals, HC-IVs accredited for adult/paediatric ART services: increased from 91% of HCIV to 100% and increased from 6% of HCIII to 10% by 2013<br>Target 2.1.4: All accredited ART sites performing or linked to laboratories with CD4 and full blood count (100% of HCIV and 10% of HCIII) by 2013 |
| Objective 2.2: To increase access to prevention and treatment of opportunistic infections including TB | Target 2.2.1: Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV increased from 34.2% to 60% by 2013<br>Target 2.2.2: Percentage of HIV patients in care that receive Cotrimoxazole for prophylaxis increased from 93% to 95% by 2013<br>Target 2.2.3: Percentage of hospitals and HCs providing PITC increased to 100% of HCIV and 100% of hospitals by 2013 |
| Objective 2.3: To integrate sexual and reproductive health (including HIV prevention) into all care and treatment services by 2015 | Target 2.3.1: Unmet need for FP among HIV infected individuals <10% |
| Objective 2.4: To support and expand the provision of home based and community based care and support | Target 2.4.1: Percentage of health facilities linked to operational HBC services increase to 80% |

| | |
|---|---|
| GOAL 3: To improve the level of access of services for PLHIV, OVC and other vulnerable populations by 2015 | |
| Objective 3.1: To scale up delivery of comprehensive quality psychosocial services to PLHIV, affected households and persons most vulnerable to exposure to HIV | Target 3.1.1: Percentage of House Holds that receive economic strengthening support increased from 41.2% to 60% by 2013<br>Target 3.1.2: Percentage of OVC who have access to a comprehensive service package increased from 24.8% to 40% by 2013 |
| Objective 3.2: To empower HIV affected households and most vulnerable groups with livelihood skills and opportunity to cope with socio-economic demands | Target 3.2.1: Percentage of PLHIV and vulnerable households receive IGA support increase to 60% by 2013 |
| Objective 3.3: To scale up coverage of a comprehensive social support and protection package to most vulnerable PLHIV and other affected groups | Target 3.3.1: Percentage of PLHIV and persons most vulnerable to exposure to HIV reporting cases of SGBV reduced from 39% to 25%<br>Target 3.3.2: Percentage of large work places (employing 20 or more persons) that have HIV/AIDS policies increased from 83% to 90% by 2013 |
| GOAL 4: To build an effective and efficient system that ensures quality, equitable and timely service delivery by 2015 | |
| Objective 4.1: To strengthen the governance and leadership of the multi-sectoral HIV/AIDS response at all levels | Target 4.1.1: National Composite Policy Index (NCPI) increase from 54.6% in 2010 to 70% by 2013<br>Target 4.1.2: Proportion of functional HIV coordination structures increase from 30% (for DACs) and 90% (for PHA networks) in 2010 to 50% and 95% in 2013 respectively. |
| Objective 4.2: To ensure availability of and access to resources for strengthening systems for delivery of quality HIV/AIDS services | Target 4.2.1: Percentage of facilities (Public and non- Public) reporting non stock outs of drugs, laboratory reagents and other commodities including condoms and non-health goods increased<br>Target 4.2.2: Improve domestic (Public, 11%) and international (68%) AIDS spending. |
| Objective 4.3: To establish a coordinated and effective national system for management of strategic information for the HIV/AIDS response | Target 4.3.1: Percentage of indicators in the national M&E plan that are reported on according to reporting schedule increased from 35% in 2010 to 60% in 2013 |