THE REPUBLIC OF UGANDA

THE HIV AND AIDS UGANDA COUNTRY PROGRESS REPORT 2014

The First Lady of the Republic of Uganda and national EMTCT champion taking a public HIV test at Kololo grounds at the launch of the EMTCT campaign in KCCA

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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
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	Mellineum Development Goals
MEEPP	Monitoring and Evaluation of PEPFAR Progress
MOES	Ministry of Education and Sports
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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The Uganda HIV and AIDS Country status report for 2014 obtains most of its data from the Ministry of Health and Uganda AIDS Commission National Documentation and Information Centre (NADIC) archives. To fill in data gaps for the reporting period, additional information was drawn from the Monitoring and Evaluation of Emergency Progress Plan (MEEPP), Management Sciences for Health (MSH), Medical Research Council Uganda(MRCU) and several other implementing partners as referenced in the report.

This report will be used to meet the UN reporting requirements on HIV and AIDS but also serve as a national key reference for annual progress on implementation of key HIV and AIDS interventions for the year 2014.

We appreciate all players who participated in the implementation of HIV and AIDS interventions and whose efforts led to the results reflected in this report, including the public health response led by the Ministry of health and all the different multi-sectoral players in the response at both national and sub national level.

I would like to pay glowing tribute to the support provided by the Development Partners in funding the various HIV and AIDS interventions.

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Dr. Christine J. D. Ondoa
DIRECTOR GENERAL

2014 Uganda HIV and AIDS Country Progress report

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1 Executive Summary

The 2014 Uganda HIV Country progress report was prepared through a consultative government led process involving all key players to give the status of the HIV response in 2014 and also met the Country's reporting obligations to national and international commitments. The report details key milestones achieved in 2014 in the areas of prevention, treatment, care and support and systems strengthen as aligned to the ten Global HLM targets. Uganda being a signatory to a number of global pronouncements including the commitments in the 2011 UN Political Declaration on HIV and AIDS, the report will feed into the Global AIDS report for presentation to the UN General Assembly on the progress achieved in realising the commitments made in the declaration against the 2011 ten HLM targets.

This 2014 report is the third report on the progress to the HIV response since 2011 and this reporting round, being just one year to the end of the commitments 2015, attempts to describe not only the 2014 annual progress but also a glimpse of the trends towards 2015.

The GARPR reporting period from January to December 2014 has been prepared through consolidation and analysis of national Survey and Surveillance data, service utilization reports –from HIV testing and counselling (HTC), treatment, prevention, care and support centres; monitoring and evaluation (M&E) data of the National AIDS Control Programmes (ACP) and interviews with key informants from Government, multilateral, civil society and community- based organizations (CBOs), including the National Forum of People with HIV/AIDS Network in Uganda. Information in the present report, has been validated by the national HIV stakeholders. The indicators comprehensively describe various facets of the epidemic in Uganda as well as progress of the national response to date.

The year 2014 featured a thorough review of the national response, an intensified implementation and undertook to prepare for resource mobilization amidst the global funding contraction and response to a new threat – a clear reversal in the long experienced decline in HIV prevalence and incidence. The year also witnessed hastened political and high level advocacy that resulted into the intensified implementation and scale-up of service delivery.

The intensified HIV response in 2014 has resulted in increased uptake of HIV prevention, treatment and care services leading to continued reduction in number of new HIV infections among adults and children, and aids related deaths to about 95,000, 52,000 and 31,000 respectively. Despite this, Uganda is still classified as a high burden country with high number of persons living with HIV which has continued to increase partly due to continued spread of HIV, and increased longevity among persons living with HIV.

In terms of prevention, a package of combination interventions were implemented in the country resulting into; a) HCT being scaled-up with eight millions people accessing services compared to seven million in 2013 b) There has been sustained expansion of the national eMTCT Programme with continued stewardship by the First Lady of the Republic of Uganda resulting into to about 95% (112,909 mothers) of pregnant HIV positive mothers accessing Anti-retroviral (ARV) drugs, and a drastic reduction in the number of babies born HIV positive to about 5,200 by end of 2014. C) There has also been intensified condom programming with endorsement of comprehensive condom programming strategy and increase in number of condoms from 187 Million condoms in 2013 and to about 230 million condoms by the end of 2014. D) The country further intensified safe medical circumcisions by adoption of various methods including Prepex leading to about 878, 109 circumcision out of planned 1 million bring the total coverage of SMC to about 35%. .

Under treatment and care, the country took an aggressive treatment scale up effort by adoption of 2013 WHO ART guidelines and increased enrolment of people on ART from 570,373 in 2013 to 750,896 in 2014. Uganda achieved the programmatic tipping point in 2013 and 2014 of having fewer (<140,000) new infections than the net increase in adult patients on treatment of above 160,000 per year. Treatment coverage for children is still lagging at 31% (56,269/183,969) although this is expected to improve with the test and treat and EID services.

TB/HIV: The collaboration and integration of TB/HIV services has been realized from planning, resource mobilization to service delivery resulting in about 81% of HIV-positive TB patients on antiretroviral therapy (ART) in 2014.

Financing: Overall HIV funding: Funding for HIV/AIDS in Uganda remains predominantly donor funded. The national AIDs Spending assessment report (NASA 2012) shows that government of Uganda contributed 12%, development partners contributed 68% and the balance of 20% was financed from private sources including out of pocket. GOU Funding for Health and HIV/AIDS: While releases to the Health sector grew, the sector allocations as a percentage of the total budget decreased from 8.9% in 2010/11 to 7.9% by 2012/13. The development partners contributed US$ 355M in 2012/13 and US $ 401M for 2013/14. PEPFAR contribution accounted remained steady at about US$ 323.4M in 2013 and 2014.

Systems strengthening: In terms of programme response, the Country continued to implement the 2011/12- 2014/15 HIV strategic plan that was aligned to the Global HLM targets. In addition, a review of the Strategic plan was conducted and informed the development of the 2015/16-2019/2020 HIV strategic plan that is further aligned to the global targets of 90x90x90 and Fast-tracking approach. Other key planning and strategic documents developed include; The ten year case for a more strategic and increased Investment in HIV and AIDS Programmes for Uganda (2015-2015), the national M&E Plan (2015/16-2019/2020), and the 2015/16-2017/2018 National Plan of action.
The country also developed the MARPs frame work to address HIV prevention and care as previous reports have shown soring HIV rates in this population. Mobilisation of resources for the response was also characteristic of this reporting period. There was continuing evidence of the stewardship of the highest political leadership in response. To strengthen the system for the HIV response the district coordination mechanism were revitalised the partnership coordination committee meetings supported and SCE and MDAs Technical support provided.

The country has continued to mitigate the effects of the epidemic **through psychosocial support, protection and empowerment** particularly for the youth, PLHIV and OVC. Innovations included The SALT ("the Support on AIDS and Life through the Telephone) program that provides counselling services through the telephone and the HIV Psychosocial support to PLHIV. The Y+ Beauty Pageant 2014 was developed to address beauty with Zero Discrimination among the HIV positive youth and to reduce stigma in Uganda. 11,735 para-social workers from communities such as VHTs, VSLAs, PHAs, CBOs and Functional Adult Literacy (FAL) groups were skilled in child protection.

Legal environment: During the year, the country passed key laws; the HIV prevention and Control Act with provision of establishment of an HIV Trust Fund as a mechanism for increased sustainable domestic financing and the Anti-homosexuality 2014 Act that was later repealed to improve access to health services. The country developed the HIV&AIDS guidelines for the Collective Bargaining Agreements (CBA) to act as a negotiation tool that legally binds enterprises to promote HIV&AIDS

prevention, care and support among workers. The statutory instrument on employment and HIV-Non Discrimination and the statutory instrument on Labour Inspection were developed including a handbook on HIV and AIDS for judges and legal profession.

Challenges: Uganda is still registering high level of new HIV infections yet interventions for primary HIV prevention, specifically targeting risky behaviours and structural drivers, are still not conceptualized and delivered systematically which constrains quality, efficiency and coverage. There is limited funding for comprehensive Social and Behavioural Change Communication despite the low HIV/AIDS comprehensive knowledge.

There is still lack of common technical programming guidelines for SBCC that would inform systematic monitoring and evaluation of such interventions. The non-functionality of the BCC Team in 2014 partly curtailed progress in this area. The country continued to experience stock outs of key items including test kits, STI drugs and other supplies. This negatively affects the expanded demand generation processes through leadership and other SBCC programmes. It is hoped that the Global Fund resources will narrow the gap.

The passing of the Anti-Homosexuality Bill in February 2014 created a short-term that threatened to heavily affect the national response. Persistent human capacity gaps in terms of skills and numbers in implementing partner agencies was a major bottleneck. Staffing challenges at ACP/MoH delayed take off and timely implementation of key planned activities considering that the Ministry shoulders over 70% of the response. Similar capacity gaps at UAC also resulted in delayed activity implementation e.g. for the MOT study.

Procurement and human resource capacity constraints result into limited resource absorption at various levels and also impacts on efficiency and effectiveness for the absorbed resources yet the response is still suboptimal requiring more resources to achieve sustained impacts. The country still faces challenges on quality and timely reporting especially at sub national level. Absence of data on MARPS has specifically resulted into data gaps (size estimation) which greatly affect programming.

Looking forward, the impact of the HIV/AIDS epidemic on the country's economy and human development index remains high also affecting the Country's Gross Domestic Product. The Country will in the short term and long term intensify implementation of proven combination interventions to consciously reverse the trend of HIV in the Country. Strategic and feasible interventions have been cleared articulated in the ten year HIV Investment case, the five year National HIV strategic and these are in harmony with the global targets for fast tracking HIV response and to realize a 90% reduction in new adult HIV infections, zero new infections among children, 90% reduction in stigma and discrimination faced by PLHIV, and 90% reduction in AIDS related deaths.

The program will continue to focus on HIV prevention as the key intervention to ending the epidemic, mobilising resources for the epidemic and building strategic partnerships with national and global stakeholders in the fight of the epidemic

I STATUS AT GLANCE

1.1 Introduction

Uganda has been reporting on its progress to the global targets since the early times of the HIV epidemic. The 2011 United Nations Political Declaration on HIV and AIDS, commits all countries involved to "provide to the General Assembly an annual report on progress achieved in realizing the commitments made in the Declaration". Uganda as a signatory to this commitment has been submitting regular reports since 2011. The 2014 GARPR will provide data on the annual progress in the HIV response but will also present trends for the last four years since 2011 when the HLM targets were adopted.

This is the second last report to the year 2015 the end of the HIV related MDGs targets and the 10 targets of the 2011 United Nations General Assembly Political Declaration on HIV and AIDS. It will also give the inkling to the efforts towards achieving the set targets by 2015 and the next targets. The data therefore for this report will span back from2011 to 2014 siting key documents, studies, surveys and policies. Where national representative information is not available, individual program or project data will be presented and quoted.

Data from Lot Quality Assurance Sampling (LQAS) in the report is presented for about 66 districts that are supported by USAID projects in Uganda since 2012. Variations in this compared to the national data may show effect of intensive support for implementation as compared to the general population data.

This Section presents the methods and approach (process) used in compiling the 2015 Uganda Country Progress Report. Further presented in this Section is a snapshot on the epidemic in the country, a brief on the policy and programmatic response, and the Indicator Table

1.2 The Report Writing Process

The overall co-ordination of compiling the Country Progress Report was provided by Uganda AIDS Commission (UAC) and Ministry of Health with support from AIDS Development Partners. Unlike previous years where the narrative was prepared and submitted together with the online data by 31st March, in this round of reporting, the narrative report was prepared after submission of the Global online reporting tool to provide for harmonization of figures generated by Spectrum/HIV estimates and those reported in the online Global AIDS reporting.

Following the February 2015 HIV and Estimation training in Johannesburg, South Africa, a two day technical meeting of programme and Data managers from Uganda AIDS Commission, Ministry of Health, PEPFAR, Ministry of Gender Labour and Social development, United Nations and CSOs was held in Entebbe Uganda in March 2015, to review data and undertake the on line Global AIDS Reporting. In addition a resource person was engaged to prepare the narrative report and align it to the data entered in the online global reporting tool. The draft report was reviewed by the national M&E Technical working group and a small committee of the M&E TWG was constituted to provide technical back-up support to the completion of the report. The sub-committee consisted of UAC, MoH, UNAIDS, WHO, UNICEF and Uganda Bureau of Statistics (UBOS).

The TWG discussed the progress and drafts presented, provided technical guidance, filled data gaps and reached consensus on areas needing harmonisation. The purpose of the TWG and the core group was to ensure accuracy, authenticity and comprehensiveness of the data presented as well as building consensus on the reported results. The Draft report was then presented and adopted by

stakeholders during the 10th June 2015 Hotel Africana validation workshop with a few modifications, which were addressed in this current version.

1.3 The Status of the Epidemic

HIV prevalence:
The two rounds of AIDS Indicator Survey show that HIV prevalence in the general population in Uganda increased from 6.4% in 2004/5 to 7.3% by 2011, this tally with the 2013 HIV estimates which show that HIV prevalence stabilised around 7.4% in 2012/2013. This however undermines the fact that the country that waswell known for earlier interventions that drastically reduced the prevalence in the earlier years of the epidemic is seeing a reversal. However the stagnation of HIV prevalence could be partly due to the high coverage of ART program where the number of PLHIV enrolled on ART increased from about 330,000 in 2011 to about 750,896 in 2014 and the reduction in AIDS related deaths from 67,000 to 63,000 in 2010 and 2013 respectively. The 2014 HIV estimates has shown a further reduction in AIDS related deaths to about 31,000, to note that the estimates are lower mainly because the 2014 national population census came out with a 8% population lower than previously projected by UBOS and UNPD

There are still marked variations in the prevalence rate by social dynamics and geographical areas. The AIS indicated high HIV prevalence up to 10.6% in the central region and lowest in Mid-Eastern 4.1% a difference of 6%. In absence of population studies, estimation of HIV prevalence can be estimated from annual ANC sentinel surveillance surveys or sero-prevalence in large testing canters.

Data from selected annual ANC sentinel surveillance survey in Uganda do indicate a decline in HIV prevalence within ANC sites from about 30% in 1990 to about 7% in 2012 with some sites recording prevalence of about 5%.

HIV burden: Uganda is still classified as a high burden country with high number of persons living with HIV which has continued to increase. This is a result of continuing spread of HIV, and increased longevity among persons living with HIV. The national projections[1] based on Spectrum estimates indicate an increasing number of people living with HIV; 1.4million in 2011 to 1.6M in 2013, and to 1,500,000 in 2014 and high number of orphans due to AIDS of about one million.; However, there is a window of hope as evidenced by reduction in number of new infections among the adults over the last five years from 160,000 in 2010 to 140,000 in 2013 and to 95,000 in 2014. Similarly the new infections among the children reduced from 31,000 in 2010 to 15,000 in 2013 and to 5200in 2014. Other remarkable improvements have been witnessed in the reduction of annual AIDS related deaths from 67,000 to 63,000 in 2010 to 2013 respectively and to 31,000 in 2014.

1.4 The policy and Programmatic response

The Country continued to implement a Multi-Sectoral AIDS Control Approach (MACA) due to the social, economic and legal implications of HIV and AIDS that remain beyond the mandate of the health sector. Thus Uganda AIDS Commission continued to coordinate and provide leadership to

[1] The Estimates that are based on the National Population figures appear lower than previously reported because of the population correction that was made when the national population determined in the 2014 Census came out 8% lower than the previous projections by UBOS and UNPD. The differences should be viewed partly in light of that

sectors and partners for the development and approval of sector specific policies and guidelines and programmes.

The multi-sectoral policy and strategy adopted in the early 1990s continued the involvement of everyone, individually and collectively and for mobilization of all stakeholders resulting in a strong and coordinated response involving government and non-governmental stakeholders as well as public-private partnerships.

In line with the National AIDS Policy, the Country continued to implement various policies and national guidelines that include: the HIV Counselling and Testing (HCT) policy, Anti-Retroviral Therapy (ART), Orphans and Other Vulnerable Children (OVC) and several others such as Universal Primary Education (UPE) and Universal Secondary Education (USE) that directly or indirectly respond to impact created by HIV&AIDS.

During the year, the country passed key laws; the HIV prevention and Control Act with provision of establishment of an HIV Trust Fund as a mechanism for increased sustainable domestic financing and the Anti-homosexuality 2014 Act that was later repealed to improve access to health services. The country also adopted the 2013 ART guidelines for increased access to ART services and its preventive benefits. The country developed the HIV&AIDS guidelines for the Collective Bargaining Agreements (CBA) to act as a negotiation tool that legally binds enterprises to promote HIV&AIDS prevention, care and support among workers. The statutory instrument on employment and HIV-Non Discrimination and the statutory instrument on Labour Inspection were developed including a handbook on HIV and AIDS for judges and legal profession.

In terms of programme response, the Country continued to implement the 2011/12- 2014/15 HIV strategic plan that was aligned to the Global HLM targets. In addition, a review of the Strategic plan was conducted and informed the development of the 2015/16-2019/2020 HIV strategic plan that is further aligned to the global targets of 90x90x90 and Fast-tracking approach. Other key planning and strategic documents developed include; The ten year case for a more strategic and increased Investment in HIV and AIDS Programmes for Uganda (2015-2015), the national M&E Plan (2015/16-2019/2020), and the 2015/16-2017/2018 National Plan of action. All HIV&AIDS actors are guided by the NSP in their programmatic response. The NSP provides the direction of the programmatic response under four main themes, of; prevention, care and treatment, social support and systems strengthening.

The response will need more leadership drive, to pursue interventions to raise a generation of babies and youth free of HIV, to protect communities from HIV and find resources for the campaign against HIV epidemic in Uganda

1.5. Summary data table for both GARPR and Universal Access indicator

The indicator summary table below presents a quick view of the key achievements and performance by end of 2014 and further compares with the previous three years; 2011, 2012 and 2013. The data filled in in this table was collected, extracted or analysed from official Government of Uganda (GoU) documents, bilateral and UN organisations' documents and also from studies. The data table presents progress since 2011; the year when the HLM targets were adopted. Programmatic results are compared to national estimates that are mainly got from spectrum modelling.

Indicators Summary Table

Table 1: Indicators summary table

Targets and Indicators	Status as at 31st December 2011	Status as at 31st December 2012	Status as at December 2013	Status as at December 2014
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	Total – 38.9% Women – 38.6% Men – 39.3% *Source: AIS 2011*	*Total – 32.2%* *Men – 36.9%* *Women – 29.6%* *Source: LQAS in 60 districts under USAID*	*Total – 35.7%* *Men – 40.3%* *Women – 33.1%* *Source: LQAS in 60 districts under USAID*	38.5% *Men – 42.3%* *Women – 35.7%* *Source: LQAS in 60 districts under USAID, 2014*
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Total – 12.6% Women – 13.1% Men – 11.9% *Source: AIS 2011*	*Men – 9.9%* *Women – 5.6%* *Total – 7.6%* *Source: LQAS in 60districts under USAID, 2012*	*Total – 8.8%* *Men – 10.3%* *Women – 7.5%* *Source: LQAS in 60districts under USAID, 2013*	*Total – 7.7%* *Men – 9.4%* *Women – 6.2%* *Source: LQAS in 60districts under USAID, 2014*
1.3 Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	Total – 13.3% Women – 3.0% Men – 18.7% *Source: AIS 2011*	*Total – 16.87%* *Men – 25.6%* *Women – 8.9%* *Source: LQAS in 60districts under USAID, 2012*	*Total – 14.4%* *Men – 22.3%* *Women – 7.2%* *Source: LQAS in 60districts under USAID, 2013*	*Total – 14.9%* *Men – 21.5%* *Women – 7.7%* *Source: LQAS in 60districts under USAID, 2014*
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	Total – 15.0% Women – 15.8% Men – 14.8% *Source: AIS 2011*	*Total – 59.2%* *Men – 63.2%* *Women – 52.9%* *Source: LQAS in 60districts under USAID, 2012*	*Total – 55.8%* *Men – 60.6%* *Women – 47.1%* *Source: LQAS in 60districts under USAID, 2013*	*Total – 56.2%* *Men – 62.6%* *Women – 45.2%* *Source: LQAS in 60districts under USAID, 2014*
1.5 Percentage of women and men aged 15-49 who received	56%	*Total – 42.7%*	*Total – 51.0%*	*Total – 51.4%*

Targets and Indicators	Status as at 31st December 2011	Status as at 31st December 2012	Status as at December 2013	Status as at December 2014
an HIV test in the past 12 months and know their results	(11,220/19,895) *Source: AIS 2011*	*Men – 37.4%* *Women – 47.7%* *Source: LQAS in 60districts under USAID, 2012*	*Men – 45.2%* *Women – 56.6%* *Source: LQAS in 60districts under USAID, 2013*	*Men – 45.6%* *Women – 57.1%* *Source: LQAS in 60districts under USAID, 2014*
1.6 Percentage of young people aged 15-24 who are living with HIV	Total – 3.7% Women – 4.9% Men – 2.1% *Source: AIS 2011*	Total – 3.28% Women – 4.01% Men – 2.54% *Source: 2014 HIV estimates*	Total – 3.16% Women – 3.88% Men – 2.44% *Source: AIS 2011*	Total – 3.02% Women – 3.72% Men – 2.32% *Source: AIS 2011*
Sex workers				
1.7 Percentage of sex workers reached with HIV prevention programmes			No data	No data
1.8 Percentage of sex workers reporting the use of a condom with their most recent client	66% *Source: CRANE 1 study in greater Kampala – 2008/09 (n=947)*	No new data	No new data	42% (472/1115) *Source: MRC clinic in Kampala*
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	Ever tested – 54% *Source: CRANE study in greater Kampala – 2008/09 (n=947)*	No new data	No new data	55% (1501/2749) *Source: MRC clinic in Kampala*
1.10 Percentage of sex workers who are living with HIV	34.2% *Source: CRANE study in greater Kampala – 2008/09 (n=866)*	No new data	No new data	9%(1083/2749) *Source: MRC clinic, Kampala*
Men who have sex with men				
1.11 Percentage of men who have sex with men reached with HIV prevention programmes			No data	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% Steady Partner – 50% *Source: CRANE study in greater Kampala – 2008/09 (n=306)*	No new data	No new data	No new data
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	Ever tested – 44% *Source: CRANE study in greater Kampala – 2008/09 (n=306)*	No new data	70% *Source: CRANE study II in greater Kampala May 2011 – August*	No new data

Targets and Indicators	Status as at 31st December 2011	Status as at 31st December 2012	Status as at December 2013	Status as at December 2014
			2013	
1.14 Percentage of men who have sex with men who are living with HIV	13.7% *Source: CRANE study in greater Kampala – 2008/09 (n=306)*	No new data	13% *Source: CRANE study II in greater Kampala May 2011 – August 2013*	No new data
Testing and Counselling				
1.16 HIV Testing in 15+ Number of women and men aged 15 and older who received HIV testing and counselling in the last 12 months and know their results	913,164 *HMIS (Jan – Dec 2011)*	5,112,821 *HMIS (Jan – Dec 2012)*	7,512,048 *HMIS (Oct 2012 – Sep 2013)*	8,638,851 *DHIS2 (2014)*
1.16.1 Rapid test kits stock-outs Percentage of health facilities dispensing HIV rapid test kits that experienced a stock out in the last 12 months	No data	No data	44% (1303/ 2,987) *HMIS (Oct 2012 – Sep 2013)*	11% (376/ 3,365) (DHIS 2014)
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 (At any ANC visit)	30,862	254,711	15.5%(234,310/1,516,130) *HMIS (Oct 2012 – Sep 2013)*	17% (268,845 / 1,561,477) *DHIS2 (2014)* 277,264
1.17.2 Percentage of antenatal care attendees who were positive for syphilis	5,541	30,884	2.0% (30,018/1,516,130) *HMIS (Oct 2012 – Sep 2013)*	6.7% (17,987 / 268,845) *DHIS2 (2014)*
1.17.3 Percentage of antenatal care attendees positive for syphilis who received treatment	No data	No data	No data	No data
1.17.4 Percentage of sex workers with active syphilis			No data	No data
1.17.5 Percentage of men who have sex with men with active syphilis	No data	No data	3% *Source: CRANE study II in greater Kampala May 2011 – August 2013*	No data
1.17.6 Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months			No data	*75,532 DHIS2 (2014)*
1.17.7 Number of reported congenital syphilis cases (live births and stillbirth) in the past 12 months			No data	No data

Targets and Indicators	Status as at 31st December 2011	Status as at 31st December 2012	Status as at December 2013	Status as at December 2014
1.17.8 Number of men reported with gonorrhoea in the past 12 months			No data	No data
1.17.9 Number of men reported with urethral discharge in the past 12 months			73,153 *HMIS (Oct 2012 – Sep 2013)*	*72,712 DHIS2 (2014)*
1.17.10 Number of adults reported with genital ulcer disease in the past 12 months			125,282 *HMIS (Oct 2012 – Sep 2013)*	115,613 *DHIS2 (2014)*
Male circumcision				
1.22 Male circumcision, prevalence	26.4% *(AIS 2011 among men 15 to 49 years)*	*31.4% Source: LQAS in 60districts under USAID, 201*	*35.8% Source: LQAS in 60districts under USAID, 2013*	40% *Source: LQAS in 60districts under USAID, 2014*
1.23 Number of men circumcised last year	57,132 *HMIS 2011*	368,490 *HMIS 2012*	801,678 *HMIS (Oct 2012 – Sep 2013)*	878,109 *DHIS2 (2014)*
Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015			Not tracked in Uganda	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	ART 86.2% Combination 35% HAART 19% AZT 49% (UN GASS,2012)		71.7% (88,792/123,754) *HMIS (Oct 2012 – Sep 2013)*	94 % (112,909/120,000) *DHIS2 (2014)*
3.1a Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding			No data	No data
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	40.2% (UNGASS, 2012)		41.9% (42,667/101,907) *HMIS (Oct 2012 – Sep 2013)*	33% (35,083/105,059) *DHIS2 (2014)*
3.3 Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	N=32,000	N=15,000	9.2% (15,000/105,059) *Spectrum Estimates; 2013*	4.6% (5200/112538) *Spectrum estimates 2014*
3.4 Pregnant women who were tested for HIV and received their results. ***LQAS Proxy indicator:*** *Mothers of children who were counseled and tested for HIV during pregnancy and know their*		83.3%	93.0% (1,410,598/1,516,130) *DHIS2 (Oct 2012 – Sep 2013)* 87.3%	93.0% (N=1,811,647)) *DHIS2 (2014)* *93%*

Targets and Indicators	Status as at 31st December 2011	Status as at 31st December 2012	Status as at December 2013	Status as at December 2014
results		*Source: LQAS in 60districts under USAID, 2012*	*Source: LQAS in 60districts under USAID, 2013*	*Source: LQAS in 60districts under USAID, 2014*
3.5 Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months			19.7% (298,254/1,516,130) *HMIS (Oct 2012 – Sep 2013)*	23.5% (366,272/1,561,477) *DHIS2 (2014)*
3.6 Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing			71.1% (53,650/75,430) *HMIS (Oct 2012 – Sep 2013)*	85% (53,580/170,000) *DHIS2 (2014)*
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% (37,423/101,907) *HMIS (Oct 2012 – Sep 2013)*	25% (41,356/120,112) *DHIS2 (2014)*
3.9 Percentage of infants born to HIV-infected women started on co-trimoxazole (CTX) prophylaxis within two months of birth			30.1% (30,655/101,907) *HMIS (Oct 2012 – Sep 2013)*	30% (43,052/ 120112) *DHIS2 (2014)*
3.10 Distribution of feeding practices for infants born to HIV-infected women at DPT3 visit			No data	No data
3.11 Number of pregnant women attending ANC at least once during the reporting period			1,516,130 *HMIS (Oct 2012 – Sep 2013)*	No data
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	(N=329,060) 54.3% (UNGASS, 2012)	N=438,542 ART Report	69.4% (588,039/821,721) (Based on CD4 < 350) Oct-Dec 2013 ART report	50.1% (750,896 / 1500000) *(Based on CD4 < 500) DHIS2 (2014)*
4.2a Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	84.1% (UNGASS, 2012)		83.0% (30,602/36,860) *HMIS (Oct 2012 – Sep 2013)*	84.9% (54,012/63618) *DHIS2 (2014)*
4.2b HIV Treatment: 24 months retention			No data	No data
4.2c HIV Treatment: 60 months retention			No data	No data
4.3 Health facilities that offer antiretroviral therapy	N=475	N=735	N=1,552	1,603

Targets and Indicators	Status as at 31st December 2011	Status as at 31st December 2012	Status as at December 2013	Status as at December 2014
4.3.a Number of health facilities that offer antiretroviral therapy (ART) 4.3.b Number of health facilities that offer paediatric antiretroviral therapy (ART)	N=400 (Oct-Dec 2011 ART report)		N=869 (Oct-Dec 2013 ART report)	1,062 *DHIS2 (2014)*
4.4 ARV stock-outs Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in the last 12 months			883,736 62,232 *HMIS (Oct 2012 – Sep 2013)*	47.9% (768/1603) HMIS, 2014
4.5 Percentage of HIV positive persons with first CD4 cell count < 200 cells/µL in 2014			No data	47% (47/100) *DHIS2 (2014)*
4.6 HIV care: 4.6.a Total number of people enrolled in HIV care at the end of the reporting period 4.6.b Number of adults and children newly enrolled in HIV care during the reporting period(2014)	623,571 (Oct-Dec 2011 ART report)		897,063 New: 263,911 (Oct-Dec 2013 ART report)	930,793 New:245,600 *DHIS2 (2014)*
4.7 Viral Load: 4.7 a) percentage of people on ART tested for viral load (VL) who have an undetectable viral load in reporting period (2014) 4.7 b) percentage of people on ART tested for viral load (VL) with VL level below ≤ 1,000 copies after 12 months of therapy (2014)			53.4% (17,926/33,589) *HMIS (Oct 2012 – Sep 2013)*	90% (135,000/150,000) VL testing was done for 3 months and only 10% had VL>1,000Copies/ml
Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015 No data				
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV			14.7%(8,250/35,000, *(WHO TB Global report ,2013*	81% (15, 877)
5.2 Percentage of people living with HIV (PLHIV) newly enrolled in care who are detected having active TB disease (new)			8.1% (18,138/224686) *HMIS (Oct 2012 – Sep 2013)*	8% (19,612/245,609)
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	33.3% *(Source: DHS 2011)*			76.4% (729,268/930,793) *DHIS2 2014*
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				

Targets and Indicators	Status as at 31st December 2011	Status as at 31st December 2012	Status as at December 2013	Status as at December 2014
6.1 Domestic and international AIDS spending by categories and financing sources NASA: 2011: Prevention (18.6%), Care and Treatment (50.8%), OVCs (4.9%), Programme Management (20.2%), Human Resources(4%), Social Protection & Social Services (1%), Enabling Environment and Research. MOT2014: Prevention (22%), Care and Treatment (53%), OVCs (7%), Programme Management (17%), Human Resources(4%), Social Protection & Social Services (1%), Enabling Environment and Research	Public Sources (11.2%) Private Sources 20.8% and International Sources 68% (NASA, 2011)	No new data	No new data	Public Sources (11%) Private Sources 21% and International Sources 68% (MOT, 2014)
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 *Proportion with accepting attitudes on all 4 standard indicators*	Women – 80.3% Men – 68.9% Total – 75.3% *(Source: AIS 2011*	*No new data*	No new data*)*	*No new data*
Target 8: Eliminating stigma and discrimination				
8.1 Discriminatory attitudes towards people living with HIV *Percentage of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV* A composite indicator combines all four of these attitudes	Women – 20% Men – 30% *(Source: AIS 2011)*	Women – 22.3% Men – 34.2% *(Source: UDHS 2011), August 2012*	*No new data*	*No new data*
Target 10: Strengthening HIV integration				
10.1 Current school attendance among orphans and non-orphans aged 10–14 *10.1a Percent of children 10-14 years with both parents not alive that are attending school* *10.1b Percent of children 10-14 years with both parents alive, living with at least one parent, who are currently attending school; Ratio of 10.1a to 10.1b* ***LQAS data**: Percentage of OVC 5-17 years who are currently in school*	83.5% 95.6% 0.87 *(Source: DHS 2011)*	No new data *Total – 35.7%* *Men – 40.3%* *Women – 33.1%* *Source: LQAS in 60districts under USAID, 2012*	No new data *Total – 77.7%* *Men – 77.2%* *Women – 78.3%* *Source: LQAS in 60districts under USAID, 2013*	No new data No new data No new data *Total – 76.3%* *Men – 75.6%* *Women – 77.1%* *Source: LQAS in 60districts under USAID, 2014*
Proportion of orphans Children to total enrolment	15.60% (EMIS)	15.10% (EMIs)	17.45% (EMIS)	No data
10.2 Proportion of the poorest households who received external economic support in the last 3 months.		*17.3%* *Source: LQAS in 60districts under USAID, 2012*	12% *(Source: District-based LQAS in 66 districts*	*29.2%* *Source: LQAS in 60districts under USAID, 2014*

All figures from the MOH program database reflect results for 2014 as the most updated 12 months data available. For ART the number reported refer to the end of the quarter quoted

II Overview of the AIDS epidemic

1.1 HIV Prevalence

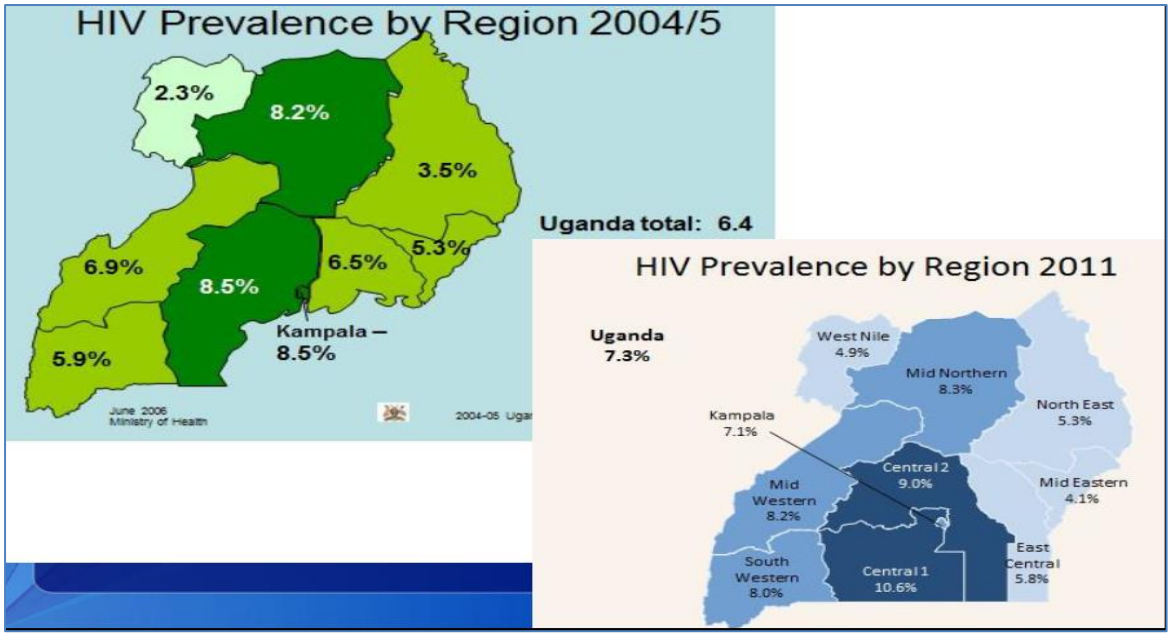
The Country last conducted the AIDS indictor survey in 2011 and the latest ANC data is for 2012, however the 2015/16 AIS study is being planned and in addition, the 2013 ANC data is being analysed, thus it is hoped that the 2016 Country progress report will provide more detailed status of HIV prevalence in the country. The preceding paragraphs discusses the HIV prevalence based on the 2011 AIS, the 2012 ANC data and the 2012 MRC study.

The HIV prevalence in the general population increased among adults in the country from 6.4% in 2004/5 to 7.3% by 2011. This was mainly due to high new HIV infections of about 160,000 in 2010, high enrolment and retention of PLHIV on ART and related reduction in death among HIV infected persons (AIDS Deaths 110,000 in 2001 to 63,000 in 2013).

Uganda has been spearheading innovations in the HIV response since the early 80's when the HIV epidemic was first reported in the country. The increasing prevalence rates in the recent population surveys indicate a need to revisit and appeal to the intervention that led to the decline observed earlier on.

There were marked variations in the prevalence rate by social dynamics and geographical areas. The 2011 AIS indicated high HIV prevalence up to 10% in the central region with 4.1% as the lowest in Mid Easter Uganda. The HIV prevalence increased in all regions and even doubled in the West Nile region (2.3% to 4.9%). The median prevalence for urban sites was 8.4% (range: 4.4 to 13.5) while in rural sites it was 7% HIV prevalence was higher among women (8.3%) compared to men (6.1%). Overall, 3.7% of young women and men age 15-24 are HIV-positive. HIV prevalence was lowest among children under the age of 5 years (0.6%) and highest among Most at Risk Populations (Key Populations) including fishing communities, female sex workers and their partners, uniformed services and mobile populations

Figure 1: HIV Prevalence by region: 2004/5 and 2011

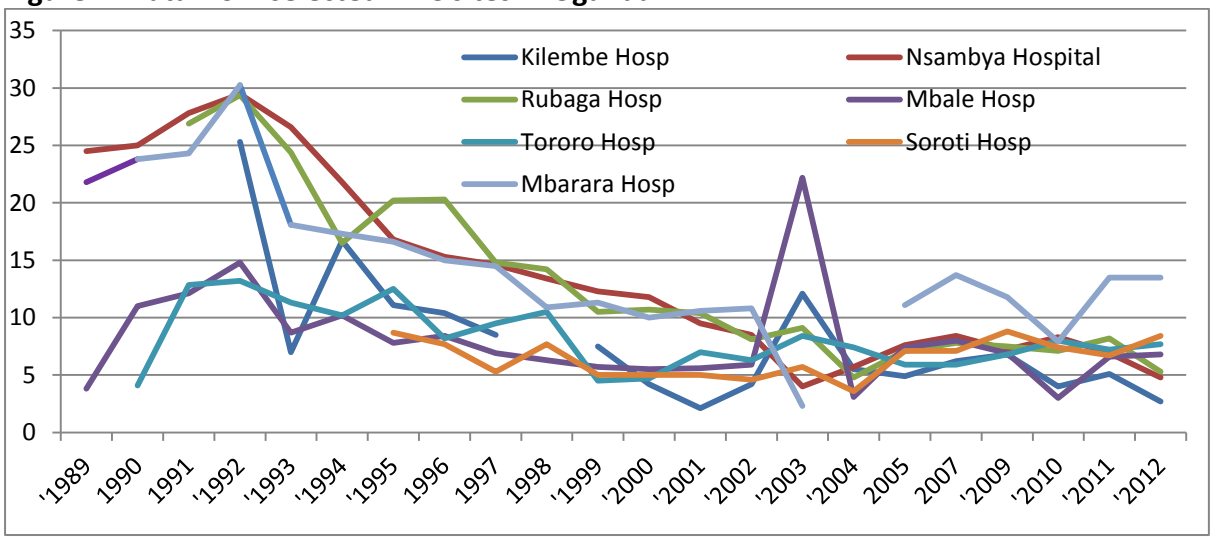


Data to estimate prevalence without general population surveys can only be got from annual ANC sentinel surveillance surveys, longitudinal cohort studies or large volume HIV testing sites. Data from general population cohort studies have indicated rising HIV prevalence around 2010 and

2012 in both sexes; 8.9% in 2010 (Asiki et. al., 2012), reaching 9.1% for males and 11.1% for females in 2012.

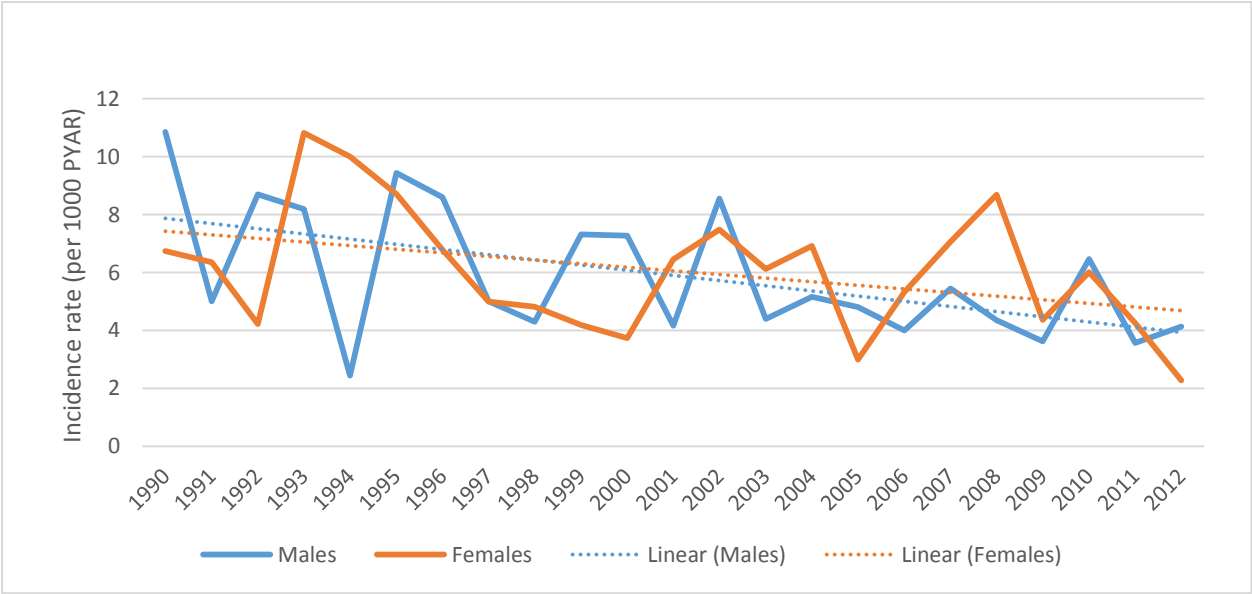
The trends from ANC HIV surveillance survey shows rapid reduction in HIV prevalence at the selected sites up to early 2000's and stabilisation (around 5-7%). There are observed tendencies of increasing prevalence in 2011 in sites like Mbarara in Western and Tororo in Eastern Uganda.

Figure 2: Data from selected ANC sites in Uganda



Most recent annual ANC sentinel surveillance survey results of 2012 indicated a prevalence in the range of 13.5% to 4.8% among the different selected sites. These figures align well with the MRC general population cohort study from 1990 to 2012

Figure 3.11 HIV incidence trends by sex in the MRC General Population Cohort, 1990-2012



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 as indicated by the 2014 MOH Spectrum estimates. This is a result of continuing spread of HIV, and increased longevity among persons living with HIV. Between 2011 and 2014, the estimated number of people living with HIV increased from

1.3 million to 1.5 million. The 2014 MOH Spectrum estimates indicates a decline in AIDS-related deaths between 2013 and 2014 to 31,000 in 2014, as noted earlier the estimate values are lower due to the 2014 lower population compared to an earlier estimate.

Table 2: Estimation of burden of HIV in Uganda

Indicator	2013	2014
New HIV infections (All)	100 000	95 000
Adults new HIV infections	92 000	90 000
Children new HIV infections	12 000	5200
PLHIV	1 400 000	1 500 000
PLHIV Adults	1 300 000	1 300 000
AIDS related deaths	38 000	31 000

Source: 2014 Preliminary HIV estimates

Indicator	2011	2012	2013	2014
Estimated percentage of pregnant women living with HIV who received antiretroviral for preventing mother-to-child-transmission	49	87	82	>95
Estimated ART coverage of adults living with HIV	24	32	42	51
Estimated ART coverage of children living with HIV	15	23	30	39
Estimated ART coverage (All ages) living with HIV	24	32	42	51

Source: 2014 Preliminary HIV estimates

1.2 HIV Incidence

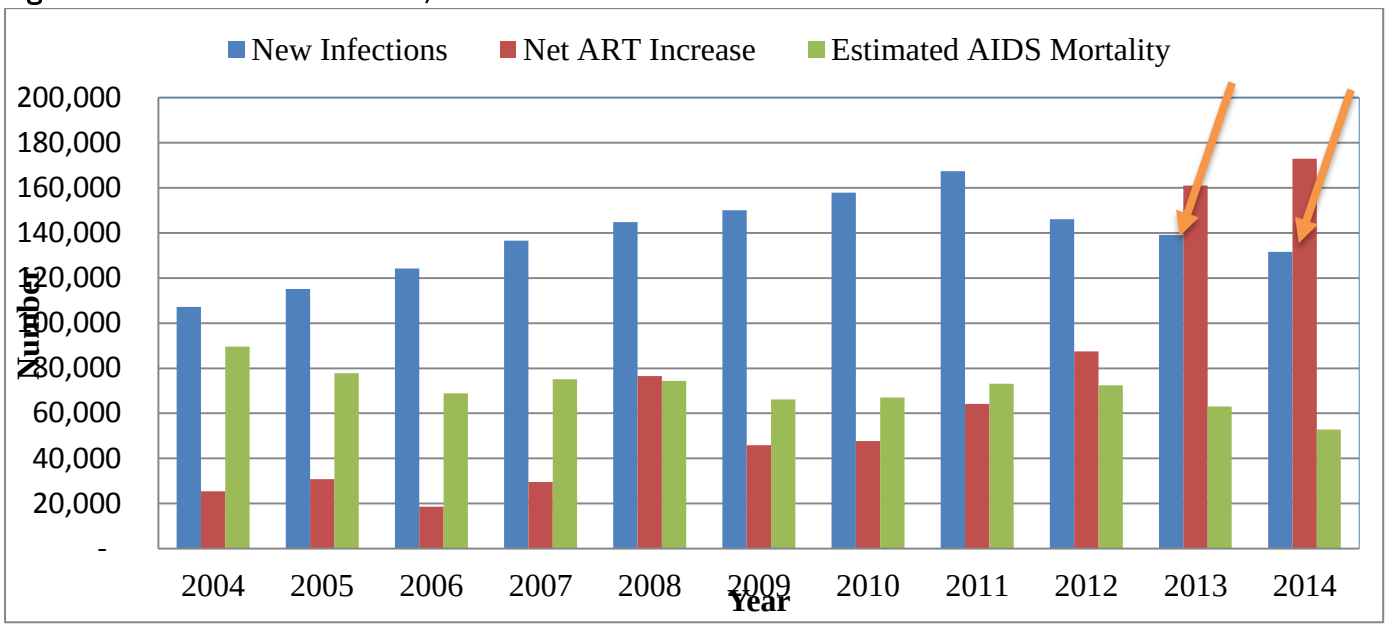
The HIV incidence in Uganda has been decreasing over the last three years as indicated from work by the Ministry of Health Estimation and Projections Technical Working Group. The EPP and SPECTRUM are used to estimate the number of people newly infected with HIV on an annual basis. These data are then used to monitor the trends of the number of new infections over time. The incidence trends have declined from 160,000 in 2010 and, to 95,000 2014. Despite this observation the rates are still very high above the target of 71,510 an indication that the country will continue to register high proportions of people with HIV.

Measuring trends in incidence, defined as new infections per population at risk in a specified period of time, is the most reliable method for monitoring the HIV epidemic. Reductions in incidence, if present, imply successful behaviour change campaigns encouraging abstinence among the youth, faithfulness among those in stable relationships and condom use especially with non-regular partners. However, very few sources of data on HIV infection at the national level can provide data on incidence. Methods that can be used to measure incidence include: longitudinal (cohort) studies, laboratory methods, modelling and using prevalence among the age-group 15 – 25 as a proxy measure of incidence.

The country has taken up an aggressive treatment scale up effort and current data shows that Uganda achieved the programmatic tipping point in 2013 of having fewer new adult infections of 140,000 than the net increase in adult patients on treatment of 161,028 per year. The figure bellow shows the comparison of the estimated number of annual new infections, the number of adults on treatment and estimated death overtime from 2004 to 2014. The estimated AIDS death declined by 19,583 between 2012 and 2014. HIV incidence rate is projected to fall from

approximately 0.76% in 2014 to 0.46% in 2020, and annual new infections from 139,086 in 2013 to just over 100,000 in 2020 according to the Uganda Investment case 2014.

Figure 3: Trends of new infections, Net ART increase and estimated AIDS death



The arrows in figure 2 above indicate that Uganda achieved the programmatic Tipping Point (having fewer new adult infections than the net increase in adult patients on treatment) in the year 2013 and 2014 due to an aggressive treatment scale up effort

1.2.1 Key drivers of HIV incidence

There has not been any reliable population survey since the 2008 Modes of Transmission Study (MOT) to analyse and document the drivers of HIV incidence in Uganda. The last analysis indicated drivers based on individual, programmatic, policy and service delivery failures. The table below summaries the key drivers by 2008 which are expected to have also played a part in determining the trends of the incidence during the last three years and 2014 in particular. Treatment as prevention is gradually and markedly reducing the incidence of HIV among the new born children. Trends of HIV infections have also been observed to reduce during the era of rapid scale up of ART (Figure 4, 2011-2014).

Key drivers of the HIV incidence in Uganda
1. High risk sexual behaviours coupled with Low Knowledge of ones HIV sero-status. (Including early sexual debut, multiple sexual relationships, inconsistent condom use; and transactional sex etc.) 2. low individual level risk perception; 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) 3. high STI prevalence; 4. low utilization of antenatal care (ANC) and delivery services; 5. low uptake of SMC services leading to low prevalence of SMC; 6. high numbers of HIV positive patients not on ART; 7. Sexual and Gender based violence resulting from gender inequalities. 8. Alcohol consumption – especially to levels of getting drunk; and closely associated with sexual activity 9. Poverty

The high fertility rate (5.97 children born/woman (2014 est.), high unmet need for Family Planning at 34% (UDHS 2011), low utilization of ANC and delivery services, low coverage and utilization of media and communication channels such as radio and cell phones are other factors that increase missed opportunities for prevention of HIV transmission in Uganda. All the above factors form the basis for the national HIV prevention strategies and interventions which are further discussed in section 2 below.

II National response to the AIDS epidemic in 2014

2.1 Overview

The year 2014 featured a thorough review of the national response and undertook to prepare for resource mobilization amidst the global funding contraction and response to a new threat – a clear reversal in the long experienced decline in HIV prevalence and incidence. Work on the NSP 2015/16- 2019/2020, the NPAP and the M&E plan as key policy guidelines were initiated. Uganda finalised the HIV Investment Case early in the year through evaluation and reallocation of funds to evidence based activities that can specifically address the epidemic challenges to get more effective and efficient long term results. The country also developed the MARPs frame work to address HIV prevention and care as previous reports have shown soring HIV rates in this population. Mobilisation of resources for the response was also characteristic of this reporting period. There was continuing evidence of the stewardship of the highest political leadership in response.

The focus on global guidance and national evidence were the basis for the results of the 2014 national HIV response; Intensifying country Efforts to Eliminate HIV and AIDS, the goal of "***Towards zero new infections, zero HIV/AIDS-related mortality and morbidity and zero discrimination, the 90,90,90 targets,*** Towards an AIDS-free Generation ,

This section describes the main HIV responses in the year 2014 along the four thematic areas in the NSP 2011/12 -2014/15 namely; Prevention, Treatment, social support and Systems strengthening. With in each thematic area, deliberate efforts have been done to analyse the progress towards the achievement of the 10 HLM targets. The section further analyses the progress made as it links to key planning and development frameworks of the government and development partners; namely:. National Development Plan, National Health Sector Plan, Millennium development goals, the UN Joint Programme of Support on AIDS in Uganda the National Strategic Program Plan of OVC Interventions (NSPPI), The 2014-2017 Strategic Plan – "Realizing the rights of every child, especially the most disadvantaged" etc.

To reverse the spread of HIV/ AIDS, Government scale-up interventions and revitalised the prevention strategies responsible for the remarkable progress achieved in the 1990s. Recent assessment of the progress towards achieving the MDG targets (MDG report 2013) indicates that the targets directly related to HIV response are either slow, stagnant or in reverse except Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it which is on track.

2.2 Progress under Prevention thematic areas

2.2.0 Summary key achievements in 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 170,000 in 2011; 150,000 in 2012, 140,000 in 2013 and 95,000 in 2014;
- 8,638,851 adult tested; over 1.7M higher than 6,982,715 adults tested in 2013(surpassing the NPAP target for 2013);
- 878,109 males reached with SMC (contributing to a cumulative total of 2,100,000; doubling the NPAP target for 2013);
- Increase in the quantities of male condoms procured and received in the country from 87 million in 2012 to 187 Million condoms in 2013 and about 230 million condoms by the end of 2014. 120 million male condoms and 5.5 million female condoms
- There was increase in the number of adults receiving ART from 525,495 in 2013 to 750,896 by December 2014 rising the contribution to 'treatment for prevention'.

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

- 112,909 positive mothers received ARVs for eMTCT (including those already on ART prior to pregnancy, and those started on Option B+);
- 41, 356(25%) infants among those HIV-exposed received ARV for eMTCT
- Marked reduction in new infections among children; from 31,000 in 2011; 15,000 in 2013, and 52,000 in 2014 thus achieving the NPAP target for 2013 (at 10,000).
- eMTCT (Option B+) was scaled up country-wide;

2.2.1 Delivery of HIV prevention services in 2014

a) HIV Counselling and Testing HCT

- Facilities providing HCT services increased from 3418 in 2013 to 3,565 in 2014
- There was increase in the number of individuals receiving HCT from 8,208,188 by end of 2013 to 9,564,992 individuals in 2014; 90 percent of them adults ≥15 years
- About two-thirds (66 percent) of the adults 15-49 years old that received HCT were women;

As indicated above the number of facilities providing HCT services increased to 3,565 in 2014; including all private and private hospitals and HC IVs. There has been a progressive increase in the numbers of individuals tested since 2011 from 5,524,327 individuals, to 9,564,992 in 2014 with nearly two thirds of these being women, and about 10 percent being children under age of 15 years. About 1,727,465 were pregnant women during ANC visits.

Despite the observed progress in numbers testing in terms of proportions this is quite small. Over the last three years the percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results has ranged from 42% to 51.4% (LQAS 2012/14, AIS 2011). While this may be explained by the increase in the population it still shows that there are many missed opportunities for HCT.

The country has continued to use the National HCT Guidelines[2] and the HCT Policy[3] to provide HIV testing services. The different approaches included: i) Provider initiated HCT (PITC) or Routine

[2] MoH/ACP: Uganda National Policy Guidelines for HIV Counselling and testing, Kampala, Uganda, 2012

[3] MoH/ACO: The National Policy for HIV Counselling and Testing in Uganda, Kampala, Uganda

Counselling and testing (RCT) in health facilities, Client-initiated HCT or Voluntary Counselling and Testing (VCT) in facilities or outreaches, and Community or Home-based testing (HBHCT). There was more emphasis to promote HCT services for couples (or couple HIV counselling and testing), workplaces testing campaigns, and outreaches for high risk groups in hot spots such as moon light HCT (for sex workers and truckers) and mobile or mass testing especially during testing campaigns.

There was also promotion of HCT through various channels including mass media, other educational programmes and specific clinics and referrals. Linkage to HIV/AIDS care and prevention and provision of post-test services was an essential element. Knowledge about the benefits of an intervention is key to behavioural change. According to recent LQAS survey in 60 USAID supported district the proportion of individuals who know two or more benefits of HCT has remained at about 71% for the last three years with no variation by gender. This mean the 20% of those who said they knew HIV do not know the benefits of testing.

Disclosure is one of the tools for behavioural change and copying mechanism in HIV especially if done to the closest person. Recent surveys in Uganda indicate that overall about 70-80% of individuals who were tested for HIV and received their results and disclosed to their spouse/partner in the last 12.

According to The HIV Investment Case, it was estimated that at least 50% (over 8 million) adults annually will be tested to realise impact on investment. These will include all pregnant women in health facilities, MARPs and other at-risk groups. In 2014 the coverage was above the annual target of 8 million.

The expansion of HCT coverage in recent years has been aided by many factors including the high level political support particularly by the President in 2013 and the First Lady during public testing in 2013 and during the country wide eMTCT launch.

The continued stock out of HIV test kits experienced during the year tends to undermine the hyped demand for HCT services and their benefits to HIV prevention including linkage to care and prevention when eligible patients are started on ART. One of the perceived reason for the shortages was the high rate of repeat testing estimated at 40% which makes quantification very difficult and the rationale not easy to explain to the development partners.

b) Elimination of mother to child transmission (eMTCT)

- A total of 1,811,647 pregnant women who know their HIV status (tested for HIV and received their results-during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status
- a total of 131,495 (5%) among those tested or with a known status (5%) were HIV positive
- 112,909 positive mothers received ARVs for eMTCT (including those already on ART prior to pregnancy, and those started on Option B+);
- 41, 356(25%) infants among those HIV-exposed received ARV for eMTCT
- Continued marked reduction in new infections among children was achieved; from 31,000 in 2011; 15,000 in 2013, 52,000 in 2014 thus achieving the NPAP target for 2013 (at 10,000).
- 23 % male involvement in PMTCT services

- A total of 1,493,164 pregnant women attended ANC, were tested during ANC and received their results or knew their positive status. Of those 8% (122,753) were found to be HIV positive

- During the reporting period a total of 1,408,982 pregnant women with unknown HIV status attending ANC were tested during ANC and received their results; 3.4% (51,849) of those were found to be HIV positive.
- Overall the proportion of pregnant women attending ANC who get tested and receive their result has been increasing from 93.6% to 94% in 2012 and 2013 respectively
- There were 70, 904 pregnant women with known HIV+ infection attending ANC for a new pregnancy
- The percentage of positive mothers who received ARVs for eMTCT; including those already on ART prior to pregnancy, and those started on Option B+ increase from 71.7% (88,792) in 2013 to 84% (112,909) in 2014.
- eMTCT has reduced the HIV prevalence among the HIV exposed infants from 9.5% in 2012 to 5.3% in 2014

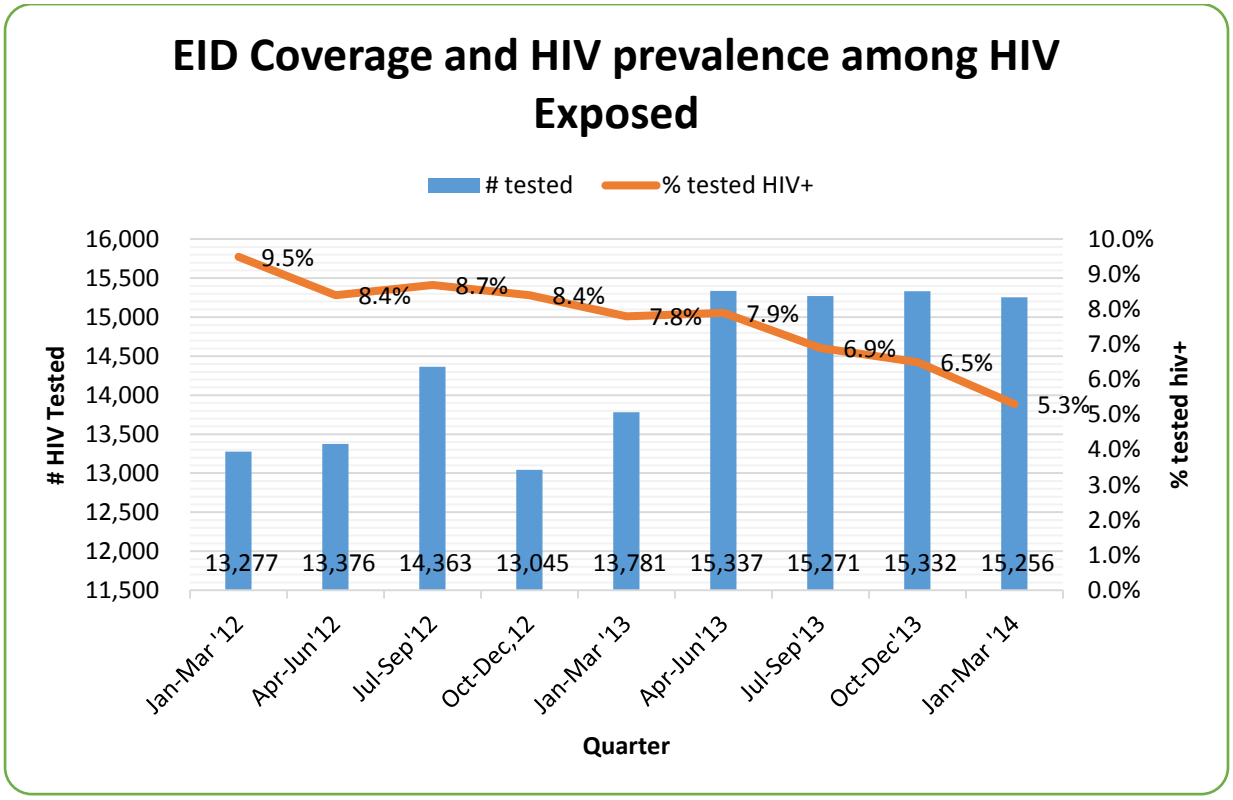
This section elaborates on the 2014 performance on TARGET 3 of the GARPR: eliminate new HIV infections among children by 2015 and substantially reduce aids-related maternal deaths.
Access to reproductive services in Uganda greatly affects the effectiveness of programs for elimination of HIV among children. The HSSIP MTR 2013 indicates that 57% of deliveries occur at health facilities and as noted above there is high unmet need for Family Planning at 34% (UDHS 2011). Although slightly increasing (34% in 2009/10, 39% in 2011/12), the progress to the 2015 target of 90% by financial year 2014/15 may not be achieved; drastically affecting the eMTCT programs. The MDG report for Uganda 2013 indicates that there is stagnation in target 5.A; Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio and a slow progress for target 5.B; Achieve, by 2015, universal access to reproductive health.

The percentage of HIV exposed children receiving ARV prophylaxis remained low at 25% (41, 356) compared to 37,432 (36.7 percent) in 2013. This is mainly because there is still low rate of health facility based deliveries (41%)[4] and poor attendances for postnatal care services. About 33% (35,083/105,059) of infants received an HIV test within two months of birth (compared to the 2013 values of 42%; 42,667/101,907) which shows the increasing missed opportunities for HIV positive children to be started on ARV and consequently explaining the low proportions of children in care. Low coverage is still being experienced in provision of Nevirapine to exposed infants, this is mainly due to low facility deliveries. The country is planning to develop innovative ways to increase the number of infants who are provided with Nevirapine syrup through mothers during ANC given pouches of a single daily dose of Niverapine starting at 32 weeks.

The number of DBS samples tested has increased from 13,277 in 2012 to 15,256 by mid-2014 and the prevalence of HIV positive samples has progressively declined from 9.5% in 2012 to 5.3% in 2014[5]; again reflecting the effectiveness of Option B+ program since its inception in 2012

Figure 4: EID Coverage and HIV prevalence among HIV Exposed

[4] MoH Annual Health Sector Review 2014
[5] MoH 2014



One of the key limitations in EMTCT and SRH in general is the low male involvement; current evidence indicates that male involvement in PMTCT and other family planning activities can reduce the risks of vertical HIV transmission (mother-to-child) and Infant Mortality by more than 40 percent. The new Male involvement guidelines were finalised and disseminated countrywide but their impact may be hampered by poor sensitisation and cultural perception coupled by patriarchal based traditions which are dominant in Uganda.

Although male involvement as indicated by the number of ANCs tested as a couple increased from 19.7% in 2013 to 23.5% in 2014, there was still low male involvement in E-MTCT. This low involvement may indicate low support for mothers during MCH since men are the decision makers in Ugandan societies. There are still opportunity for improvement as demonstrated by some projects that have applied coercive means to involve men in MCH services. LQAS data in USAID supported districts indicate that there has been progressive increase in Proportion of mothers of children 0-11 months who were tested for HIV and received their results as couple (from 92.9% in 2012 to 94.4% in 2014). The country recently launched the Male Involvement Strategy to support male engagement in Reproductive health services through roll out of male support groups, male champions and male peers across all districts and implementing sites. This is hoped to increase the number of men giving support.

Overall notwithstanding the aforementioned challenges, there has been extensive eMTCT service coverage, resulting to a considerable reduction in the number of new vertical infections from 30,000 in 2011 to 52,000 in 2014. This surpassed the NPAP target of 10,000 projected new vertical infections by 2013.

c) Safe male circumcision (SMC)

SMC: Cumulative number of SMC of 2.1million since 2010

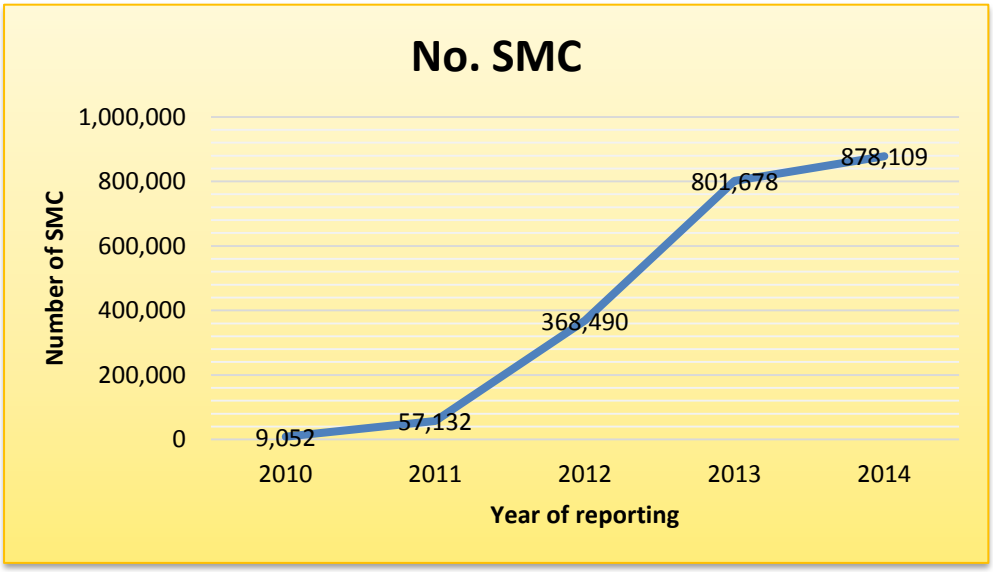
- 878,109 by December 2014 a coverage of 80%;
- Strengthened the use of SMC camps and outreaches
- Regional sensitization on SMC were conducted
- Low funding level and poor integration in health facilities are key limitations to SMC

The number of SMCs have progressively increased to 878,109 by December 2014 a coverage of 80%; but this is still below the annual target of 1Million. The PEPFAR APR 2014 report indicates that USG support alone resulted in 906,615 Safe Male Circumcision (SMC) of eligible males conducted. The difference in the results this report is due to the reporting period of APR 2014 being from October 2013 to Sept 2014. The cumulative number by 2014 is 2.1Million; an indication that the country may not be able to achieve the projected target of 4.2Million by 2015. This target was the coverage if the country has to make impact by investing in this prevention intervention. Current data shows that 70% of SMC conducted are from outreaches but the country is progressively strengthening static sites in health facilities to provide SMC. The country started strengthening and integrating SMC into routine preventive services in public and private health facilities in all districts and the use of re-usable surgical equipment.

Funding for SMC is largely provided by PEPFAR and WHO for training of healthcare workers (HCW), service delivery through IPs and procurement of commodities. The main method used in the SMC program is the surgical method but the Prepex method was introduced later on in the year. In 2014 the program had setbacks with four cases of tetanus which have affected the PREPEX method, although later WHO re-approved this procedure with a requirement for Tetanus immunisation.

Uganda has continued with the use 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 2014 witnessed a slow scaled up of service delivery for SMC amidst intensified demand creation communication. SMC massages are still not clearly placed as part of the combination prevention strategy guiding prevention in Uganda. Of all the circumcised individuals <1% experienced an adverse event (moderate or severe).

Figure 5: Annual trends of SMC in Uganda



Source: APR 2014

The demand for circumcision is still large however the main source of funding for this intervention has been reduced to only 321,000 SMC per year (300,000 from PEPFAR and 21,000 supported from GF). While traditional and religious circumcisions are ongoing they are far limited in their coverage and safety to contribute to the success of this HIV prevention intervention.

WHO procure about 300 re-usable SMC kits as part of integrating SMC services at the health facilities and reducing the high and costly burden of disposal of the currently disposable kits.

d) Abstinence, Being faithful and Condom Use (ABC)

BCC to increase ABC:
AB

- leadership in Uganda has spearheaded the AB
- Messages clearing house at UAC was established
- Dissemination of the behaviour change communication message book
- Established a message clearing committee

Condom promotion among the general population and MARPs :

- There was an increase in the quantities of male condoms procured and received in the country from 187 Million condoms in 2013 to about 230 million condoms by the end of 2014; female condoms 2,400,000 in 2013 to 5million by end of 2014.
- 54% report use of condom in their last causal sexual encounter

The majority of HIV infections in Uganda are through unprotected sex with HIV infected partners or those with unknown status. Uganda was credited with drastic reduction in the HIV prevalence in the early 1990's by adaption of the ABC strategy. With maturation of the epidemic over the 30 years and the roll out of ART there has been reluctance in focusing on the ABC interventions. This has been shown by the disproportionate funding for the BCC versus treatment activities over the years; GF 90% of the funding was for ART procurement. In addition different components like the condoms were not focused on by the big funders like PEPFAR in the early 2000s there by lagging behind in terms of coverage, scope and quality.

Although general awareness about HIV is high AIS 2011, the Proportion 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 is low; ranging from 32% in 2012 to 38.7% in 2014(LQAS, 2014).the gender variation is in favour of men at 43% against 35% for women.

ABC is the main component in the behavioural Combination HIV prevention intervention as described in the National HIV Prevention Strategy 2011-2015 (NPS). The NPS guides on implementation of a combination of priority behavioural, biological and structural interventions to achieve critical levels of coverage in order to attain the target HIV incidence reductions. Particular sets of interventions are defined for the general population and various at-risk groups.

The country introduced an HIV messages Clearing House at UAC to standardize and harmonize all message that are produced in the national HIV program. A message clearing committee was also established and launched to support the functions of the house. During the last half of 2014, the Committee convened 6 message clearing meetings submitted by Uganda Christian AIDS Network, Marie stops, KMCC, USAID'S Communication for Healthy Communities, MildMay, Uganda Cares, among others.

In addition a behaviour change communication message book (Communications' tool kit) was developed and disseminated which guides on how the country can use the notion of Protecting yourself, your child and spouse to reach the goal of "Zero new infections", "Zero discrimination" and "Zero AIDS related death". To tap into the influence religion has on individual behaviour, a pastoral letter by IRCU targeting all religious leaders in the country was developed and disseminated. During the year 2014 there were more engagements with the cultural, traditional

and religious leaders as key community gate keepers to strengthen behavioural response to HIV epidemic. Targeted interventions for cultural institutions (targeting clan leaders and youths in Buganda, Bugisu, Lango, Bunyoro, Busoga, Toro and Bugwere) were developed.

To bolster the ABC component of the combination prevention strategy, the country has support for "OBULAMU campaign" that produces integrated health massages, including those for HIV, via various media; TV, Radio, SMS alerts etc. The campaign dubbed 'Obulamu?' is built upon the interactive nature of our communities where asking 'how is life' is part of greeting. The campaign has life stages thus: family with children, adolescents, Young people in relationships, and couples in longer term relationships. The first stage of the roll-out was focusing on young people and adults in relationships for which community shows, radio programs and inter-personal communication materials were being disseminated. Many IPs in collaboration with Communication for Health Communities (CHC) under USAID started rolling out advocacy campaigns to increase service coverage and retention. They were supporting community demand creation through radio, community shows, Television and dialogue meetings. This was to be supported by the BCC Working Group which unfortunately is not fully functional.

A new campaign targeting young people dubbed, „Zip-up 256" was launched. As a result of these efforts, in 2013 alone, a total of 1,639,649 individuals were reached with behaviour change interventions, representing 7.9% of an estimated 20,649,497 individuals aged 10 years and above who were eligible for behaviour change interventions in that year.

The country has also focused on the prevention of HIV among the youth in and out of school using mass mobilization. In collaboration with the UN family (UNAIDS, UNFPA, WHO, UNICEF, WFP,) and other partners the country renewed commitment to support advocacy for HIV/AIDS prevention and control towards an AIDS-free generation by launching a national campaign named "Protect the Goal Campaign. The "Protecting the Goal campaign" uses the popularity and convening power of sports to unite Ugandans towards the goal of an AIDS-free generation. The campaign raised awareness around HIV prevention and focused young people and all Ugandans to get actively involved in both the national and global response to HIV and support the UNAIDS' ambitious target of 90-90-90 by 2020

Following the launch of the "Protect the Goal Campaign" by MoH, district based football leagues have been supported in northern districts of Uganda through Youth Social Work Association. Eight districts in the Northern Uganda have started the pre-qualification matches and the full league will be done in 2015.

President Museveni of Uganda showed football skills before the match between two teams representing the Ugandan Parliament and the Cabinet, UN agencies and development partners at the Nelson Mandela National Stadium, Kampala, Uganda, 09th November 2014.

The country has started engaging with the young people living with HIV on ASRH/HIV together with the national legislators through inter-generation dialogues that are always presented in the public media. Over 60,000 Young people were reached with information on ASRH services and Rights.

The media is a very important country entity in the HIV response in Uganda dating back in the early years of the epidemic and it is one of the Self Coordinating Entity (SCE) in the response. 2014 was characterized with closer engagement with the media through regional meetings in all the 8 regions of the country. As part of the monthly Media briefings on HIV, 60 Media reports collected for evaluation, Vision and Mission for the SCE was drafted and communication and, Publicity awareness plan for the Protect the Goal Campaign and the Mayor HIV/AIDS campaign developed

The country conducts Mentorship of young & upcoming Artists, Musicians, Dancers, comedians, dramatists, actors and players to come up with messages on HIV&AIDS A total of 57 young and upcoming Artists were trained in coming up with works that will help their fans stay safe and prevent HIV&AIDS.

The importance of BCC 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.

High adolescent sexual activity: The high sexual activity remains a risk factor for acquiring HIV in Uganda. Although previous surveys have shown sustained declining rates of adolescent sexual activity in Uganda, it remains a high risk especially in this era of increase in social media. There has been intensified efforts to target HIV prevention among adolescents through sex education and the youth HIV prevention campaigns. In addition the UN family in Uganda is supporting a programme to end AIDS among adolescents code named "ALL IN Initiatives that is harmony with PEPFAR initiative of DREAMS"
The Ministry of Education and Sports was supported to undertake an in depth evaluation of Life Skills Sexuality Education (LSSE) in upper primary schools in Uganda. The main objective of this study was to evaluate life-skills and sexuality education in upper primary school. As part of continued efforts for development of a sexuality education curriculum for secondary schools, there has been orientation of tutors/lecturers as Master trainers on Comprehensive Sexuality Education and a clear road map for introduction CSE in Teacher Training institutions was developed.

Transactional, cross-generational and commercial sex:
There is a high proportion of new infections among commercial sex workers, their clients and partners of their clients; 16% among CSW and clients, and partners of clients constitute 3% of the total population. As noted in earlier reports this has remained a driver for new HIV infections in the country.

Delivery of services specifically targeting sex work settings was key focus for the year 2014. The National STD Clinic in partnership with MARPI, regional implementing partners and other NGOs have played a key role in sustaining initiatives to reach commercial sex workers. The new national HIV treatment program guidelines target MARPS for test and treat and the implementation started with the National STD Clinic which was accredited to provide ART services largely targeting key populations. Over 400 clients were accessing ART by end of 2014 and now works as Learning Hub in delivery of friendly services to MARPs. About 10,000 sex workers, MSM, and members of communities they interact with have been reached with services in the target districts of Kampala, Kalangala, Gulu, Arua, Pader, Rakai and Kiryandongo.

Multiple sexual partnerships: Having multiple sexual partners has been reported in Uganda as contributing to high HIV sexual transmission MOT 2008. This risk can mainly be reduced through behavioural change through initiatives targeting individuals, community get keepers like cultural and religious leaders and the media. New social media platforms have the potential to promote this risk factor but also the opportunity for the response to launch awareness campaigns against this risk factor.

The AIS 2011 showed that there is a gender disproportionality for multiple sexual partners with about 20% of all men surveyed aged 15–49 reported having two or more sexual partners in the previous year, compared to 3% of all women. LQAS data shows a worse scenario with 16% to 14% of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months. And again indicating higher values among men up to 25% The AIS 2011 report indicates regional heterogeneity; among men, multiple sexual partnerships are most common in the East Central (31%) and Mid-Western (25%) regions. This means interventions targeting men would have a high impact in reducing HIV infection through multiple sexual partnerships especially in targeted regions. The "Obulamu" campaign has been promoting behavioural change against multiple sexual partnerships.

Unprotected sex*:* The majority of HIV transmission in Uganda is through sexual encounters without use of protected sex with HIV infected or unknown status. Promotion of correct and consistent use of condoms is one of the core elements in the Behavioural interventions of the National Combination Prevention Strategy.

In the year 2014, the country did not experience major national condom stock-outs. There was intensified advocacy efforts for increased local and external resources for condom programming. Overall, the 2014 annual target of consistently availing male condoms at designated community distribution points was achieved. There was an increase in the quantities of male condoms procured and received in the country from 87 million in 2012 to 187 Million condoms in 2013 and about 230 million condoms by the end of 2014. Partners mainly the UN contributed all the 5.5 million female condoms. The first National Comprehensive Condom Programming endorsed by the Ministry of Health was printed and disseminated and the ACP/MoH generated a draft Condom M&E Framework that awaits stakeholder consultations. The Framework targets establishment of a management information system that will support among others quantification of condom needs from programme performance. National campaigns were initiated to promote correct and consistent female and male condom use at high-risk sexual encounters continued in 2014 reaching over 3.5 million people.

Previous national surveys have indicated declining rates of condom use during the last high risk sexual encounters (Uganda AIDS Indicator Survey, 2011). The recent LQAS data shows that overall about 60% 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. Used of condom has been observed to much lower among women. In 2004-05, 47 percent of women age 15-49 who had higher risk sex in the 12 months before the survey said they used a condom at the most recent higher risk sex. By 2011, this proportion had declined to 29 percent. Among men, the proportion using condoms at the most recent higher risk sex declined from 53 percent in 2004-05 to 38 percent in 2011

Data from LQAs done in selected districts in Uganda in 2013 indicated low usage of condoms despite high distribution rates There was an observed decline in the proportion of married and co-habiting individuals who used condoms with 54 percent reporting condom use in the last casual sex encounter in 2013 as compared to 71% in 2011.

Other factors that were sustained in 2014 to improve condom programming included; streamlining condom post-shipment handling and quality verification to ensure efficiency and

uninterrupted supplies; and 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.

e) Targeted interventions in key populations:

MARPs-focused HIV Prevention:

- Initiated mapping study for all key populations
- MARPS actions plan in development
- Finalised the MARPS Frameworks The MARPs programming framework will guide stakeholders in the implementation of CHP in MARPs sub population, improve services delivery by MOH/MARPI project and also strengthen the MARPs coordination desk at UAC
- A mapping study for all key populations was completed in 2014 with an estimated two million fisher-folks, 54,549 female sex workers, 10,533 MSM, 650,000 uniformed forces and 31,588 truckers
- Planning for MARPS integration into resource mobilisation and strategic plans
- The Health Sector MARPS steering committee established

The definition of MARPS and Key populations was elaborated on in the NSP (2011-2015) and the NPS (2011-2015). Documentation of the risk of HIV among key populations is evident in various national reports and survey literature and notably the risk of HIV varies among the different types of MARPS. Recent studies indicate that HIV prevalence is highest 15-40% among fishing communities and 37% among sex workers; 18% in the partners of sex workers, 13% in men with a history of having sex with men and 18.2% among men in uniformed services (PEPFAR 2014; Sigirenda et al., 2012; Seeley, Nakiyingi-Miiro, et al., 2012; Asiki et al., 2011; Opio, Muyonga, & Mulumba, 2011).

The country experienced setbacks in the implementation of MARPS interventions initiated in the country earlier on. This was mainly sparked off by the enactment of the Anti-homosexual Bill with the subsequent cancellation of funding to many programs and activities supporting the entire HIV response.

Despites this, the 2011-2015 NSP and NPS still recognizes the high HIV infection rates among the various categories of MARPS in the country; 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. It specifies strategic actions to reduce the HIV infection among the KP.

Using the guidelines and initiatives started in 2013, the country has continued to seek for resources and partnerships to support interventions for MARPS Partners like GF, PEPFAR and the UN family have indicated funds for MARPS services including studies. Key in the approaches to successful implementation of services adapted by the country include the use of peer support to reach the MARPS, use of test and treat and procurement of lubricants to promote condom use among the MARPS.

The Knowledge Room at Mbuya continued to provide HIV counseling and testing, condom distribution, outreaches for ART refill, Health Education and sensitization, games and sports to MARPS especially truck drivers, sex workers and other communities around the area. October - December quarter had 5584 people served.

Other noted outputs include the following;

- The country is preparing the MARPS actions plan with support from country partners which is expected to be complete by 2015

- The health sector technical working group is now functional with specific terms of reference and meets regularly at the MOH
- Resources to support implement MARPS activities based on evidence from current surveys have been allocated mainly from UN and USG partners.
- The JUPSA report of 2014 indicates reaching 10,000 MARPS with targeted services and conduction sensitization sessions for this group through regional meeting as well as empowering the district to take over the interventions. PEPFAR report for Oct 2013 to Sept 2014 indicate reaching additional 63,498 different categories of Key Population.
- The country is in the process of applying for USD 1.3 million grants from GF to accelerate implementation of Combination HIV Prevention activities in the MARPs sub populations as guided by the PLACE project recommendations.
- The country lacks harmonised mechanisms for managing data for Key Population.

Indicative coverage in specific program for Sexual and Behavioural Change Interventions including the key populations from the PEPFAR funded areas show marked effort to reach communities with defined prevention packages:

Table 3: Number of Targeted Individuals Reached with Sexual and Behavioural Change Interventions:

APR 2014 Indicator	Total	Male	Female
Number of individuals from priority populations who completed a standardized HIV prevention intervention including the specified minimum components (GPY)	2,321,029	1,236,348	1,084,681
Youth (AB)	1,172,112	594,670	577,442
Adults (ABC)	854,270	453,640	400,630
Other vulnerable population2	294,647	188,038	106,609
Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	63,498	1,662	61,836
Female CSW	61,836		61,836
MSM	1,662	1,662	

Building on the plans of Ministry of Health to establish a MARPs hubs Network with the National STD Clinic/MARPI as the learning site, 50 health workers and 50 peers from Mbarara and Mbale were trained on delivery of friendly services to SWs and other sexual minority groups. The process also engaged district leaders in Arua, Gulu, Pader, and Kalangala to achieve ownership of the programme and pave way for development of urban level MARPs programmes. (JUPSA, 2014)

The number of key populations reached with HIV prevention interventions has increased from 139,758 in 2010 to 287,302 in 2013; these data were not stratified by specific key populations reached. In a study population by MRC in 2014 in Kampala, the 38% (1093 FSW) of sex workers were living with HIV and the 42% of sex workers reporting use of a condom with their most recent client.

There are increasing efforts to gather data, identify and reach MARPs with specified packages of services despite the prevailing legal and policy limitations in country. ADPs have shown interest to support national efforts to reduce the HIV burden among MARPS. More robust operational approaches to MARPS are still lucking.

f) Other HIV prevention interventions:

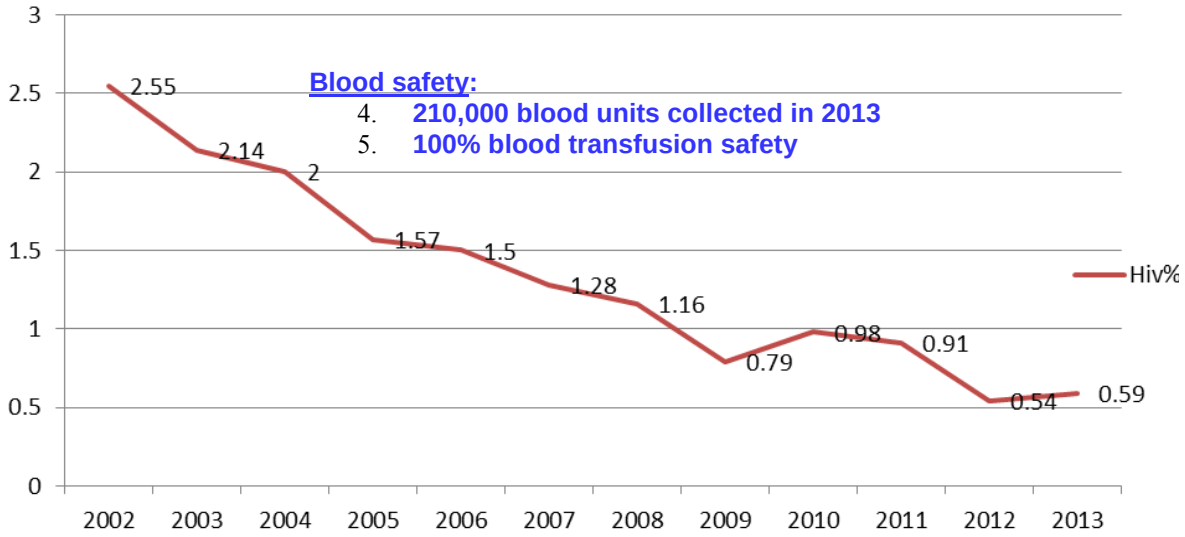
1) Ensuring safety in blood transfusion:
   - UBTS supplied 213,952 safe blood units In FY 2014

2) Comprehensive STI management: 75,532 of adults reported with syphilis during the reporting period.
   - 115,613 adults reported with genital ulcer disease during the reporting period
   - 6.7% of antenatal care attendees were positive for syphilis

The NSP targets to sustain 100% blood transfusion safety and adherence to universal precautions. The lead program entity is the Uganda Blood Transfusion Services (UBTS) whose Key strategy is to strengthen counselling and testing at blood donation sites and bolster safe blood reserves. There are seven regional blood banks and six blood collection centres in the country which are responsible for mobilisation, collection and ensuring safety for the blood. The MTR 2014 also indicated that the national blood transfusion services continued intensify screening of blood for HIV to reduce transmission. All blood is tested for HIV and other transfusion transmissible infections (TTIs). A total of 156,916 blood donors were recruited of which 60% were repeat blood donors. UBTS supplied 213,952 safe blood units In FY 2014, PEPFAR set a target of supporting supply of 242,000 safe blood units which is over 88% of the FY 2014.

Figure 4 shows that the HIV prevalence among blood donors declined to 0.91% in 2011 (from 0.98% a year earlier) and further dropped to 0.59% in 2013.

Figure 6: HIV prevalence among blood donors



Source: UBTS 2014

Funding for blood safety is the main challenge as there are fears that PEPFAR may reduce its contribution in the coming years.

Sexually transmitted infection particularly those with genital ulcers are a recognised risk for transmission of HIV. The HIV programs data shows that there was increased focus on testing pregnant women for syphilis from 30,867 in 2011 to 268,845 in 2014. The 2014 coverage of only 17% (268,845 out of 1,561,477) of women accessing antenatal care (ANC) services tested for syphilis at any ANC visit is still very low. Of those women tested for syphilis 10.4% were found to be positive for syphilis however the data for treatment is not captured in the reporting tools. To show increasing risk factors for HIV transmission, about 72,712 men reported with urethral discharge in the past 12 months and 115,613 (males 42,985, females 72,628) of adults reported with genital ulcer disease during the reporting period.

2.3 Treatment, Care and support thematic areas

1. Increase equitable access to ART (from 50 to 80%)	• 750,896 individuals were receiving ART by Dec 2014 compared to.... in 2013 • 125,744 Persons were newly initiated on ART 2014 • 963,272 number of patients in HIV care by June 2014 • New treatment guidelines further scaled up • Site providing ART were 1658 at end of December 2014
2. Increase access to prevention and treatment of OI (including TB)	CTX for all HIV positive people under care: Of the total 963,272 HIV positive people under care as at 30 June, 2014; 681,328 (79.2%) were on CTX prophylaxis • TB assessment, treatment and prevention in HIV positive people: guidelines for geneXpert diagnosis have rolled out countrywide to support implementation; TOT for IPT were conducted in 2014. Between 1 Jan and 30 June 2014, 594,398 HIV positive clients under care (73.3% of a total 963,272 attending in the quarter) were assessed clinically for TB. Over the same period, 4,601 HIV positive clients (among those assessed) were started on TB treatment. • 95% (43, 883)of TB patients had their HIV status known • 45% of the TB patients were HIV-positive • 98% of the HIV-positive TB patients were on co-trimoxazole preventive therapy (CPT) • 81% of HIV-positive TB patients were on antiretroviral therapy (ART) • HIV-positive people screened for TB • HIV assessment, treatment and prevention in TB patients:
3. Integrate SRH (including HIV prevention) into all HIV care and treatment services	• over one million members of the general public were reached with SRH/HIV integrated services in target districts

HIV treatment, care and support services have become one of the cornerstones for the HIV epidemic response in globally. Modelling for the HIV response indicate that HIV treatment is critical to ending the AIDS epidemic and making HIV transmission rare as well as being a smart form of investment. This is further reflected in the UNAIDS global targets of 90, 90, 90 that drive the world towards ending the HIV epidemic by 2030. These targets have been adapted in Uganda and have been used for national HIV epidemic estimates and investment.

The HIV Investment Case for Uganda indicates that increasing treatment access to 80% will contribute to: (a) aversion of 2,160,000 new infections between 2015 and 2025 (a 77% reduction, (b) reduction of new infections in children from 14,200 to 4,040 between 2014 and 2025 (c) Uganda will avoid 570,000 deaths by 2025 and (d) the lives of 42,620 children will be saved from AIDS related death by 2025. Scaling up of HIV care has been central in the HIV response in the country since the era of the “3 By 5” and it has been associated with reductions in new infections, morbidity and death.

Integration of TB/HIV services has predominated the HIV response in 2014. The country developed the Joint TB/HIV concept Note through Joint gap analysis through to costing of priority interventions. Integrating TB care; Screening for TB among HIV positive clients is the key

intervention to TB/HIV integration that requires all these patients to be routinely screened for TB. As a result, the facilities fully implementing TB/HIV collaborative activities increased from 30% in 2010 to 50% by 2014. According to the Dec 2014 ART report about 1,290 facilities reported on routine screening for tuberculosis among clients in chronic HIV/AIDS care during the second quarter using the TB screening guidelines. About three-quarters (73%) of clients were screened for tuberculosis at their last visit in the quarter in line with Guidelines on TB/HIV integration. Tuberculosis screening was least performed among male children aged less than two years of age where over one third of clients were not screened. In 575 facilities, 4,061 clients were diagnosed with active TB and started on anti-TB treatment.

Implementation of the IPT guidelines to reduce the burden of TB among HIV patients commenced through conducting regional Training of Trainers which will support the scale up in all health facilities in the 122 districts in Uganda. Consolidating eMTCT program has required more integration of SRH and HIV services as a priority for national program. The country is revising the MCH data tool to capture longitudinal data for HIV and SRH

2.3.1 Treatment and Care

- As in the previous reports there were more female on ART than the male. Of the 750,896 HIV positive on ART by Dec 2014, 242,880 were male and 470,864 (66%) were female.
- By age group: 56,269 PLHIV ≤ 15yrs were on ART, and, 694,627yrs were above 15years.
- There were 125,705 new active patients on ART by end of 2014 and of these 114,506 were 15years and above while 11,119 were children below 15 years
- Cotrimoxazole prophylaxis: The total number of patients in care has increased from 883,736 in 2013 to 930,793; 718,694 (81.3%) were on CTX prophylaxis.
- There 3,028 antenatal care facilities providing HIV testing and counselling services and of these 1,976 dispensing antiretroviral.

ART services are offered country wide in both public and private facilities. Regional implementing Partner are assigned to cover specific regions under the health systems strengthening programming. Most of the services are largely donor supported; the US Government through PEPFAR; Global Fund and to a smaller extent domestic financing by the Government of Uganda.

The 2013 Uganda epidemiologic estimate and projections indicated that the number of HIV positive individual living with HIV were 1,500,000 for the year 2014. Of these 750,896 (50% coverage) were active on ART by Dec 2014. This was using the new treatment guidelines which increased the eligibility to ART from CD4 350 to 500 cell/m^3 and test and treat for patients with HIV if they are, pregnant, have TB, MARPS or in sero-discordance relationships.

Table 4 Coverage of ART Services by level of Facility as of Sept 2014, MoH 2014

Health Facility Level	Total	Providing Adult ART		Providing Pediatric ART	
Facilities providing ART Services by end of Quarter					
	N	N	%	N	%
Referral Hospitals	15	15	100	14	93
General Hospitals	140	112	80	107	76
Health Centre IV	206	185	90	178	86
Health Centre III	1,309	1,078	82	732	56
Health Centre II	2,777	193	7	77	3
Specialised clinics	NA	29		26	

Other Private Clinic NA	NA	30		15	
Total (Facilities from HC IV)	351	312	86	299	83
Total (Facilities from HC III)	1670	1390	83	1031	62
Total (All Facilities)	1631			1149	
New Facilities Accredited during the Quarter to provide ART services					
General Hospitals					
Health Centre IV					
Health Centre III		9			
Health Centre II		22		5	
Others		2			

The program has put in place interventions to eliminate paediatric HIV through eMTCT and EID as described earlier in section 2.2.1f and those found positive are started on ART. Despite these approaches the increase in paediatric ART has been slow in the rage of 10,000 children enrolled per year instead of the projected 35,000 children per year. The 2014 spectrum projections for children eligible for HAART by 2014 was 66,229 yet the by December 2014 only 56,269 children had been were active on ART; this is 31% coverage compared to 48% for adults.

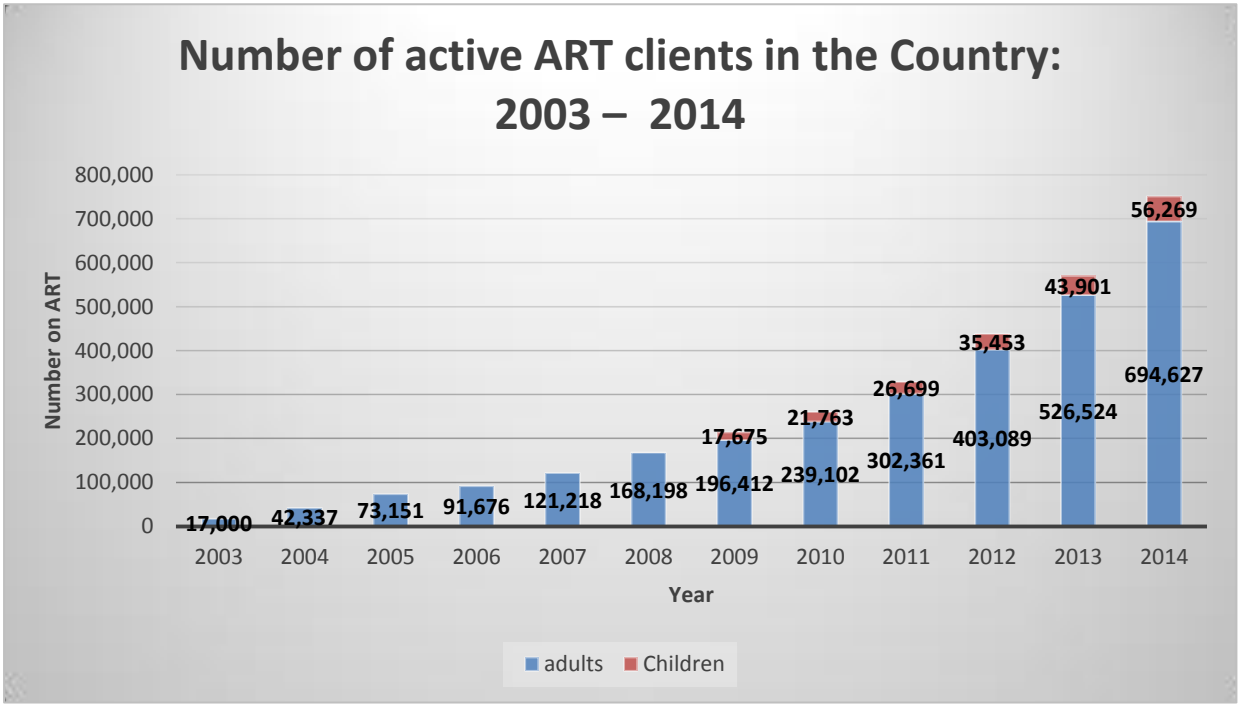


Figure 7: Number of active ART clients in Uganda Dec 2014

The enrolment of paediatric patients on ART almost tripled between 2010 and 2014 probably as a result of easy access to EID services rapid scale up of ART but also the adaptation of the 2013 treatment guideline to treat all HIV positive children up to 15 years of age.

Patient once enrolled in ART must be retained in care for life in order to achieve the benefits of HIV treatment and to avoid development of resistance. The program monitors retention on ART on a quarterly basis. The table below show retention on ART in the first half of 2014.

The current HMIS version caters for only one follow up outcome i.e. patient retention at 12 months. The detailed information beyond 12 months is no longer available. In the current version of HMIS, patient attrition is not disaggregated by cause (i.e. LTFU, death or transfers out, etc.); follow up outcomes beyond 12 months are also not reported, and it does not report on immunological markers. These short comings will be addressed in the revised HMIS.

The ACP reports for the quarters Jan-Mar and April-Jun 2014 indicate that overall ART retention at 12 months of follow up was about 85% but for the quarter ending September there was a decline to 75% with marked regional difference. ART retention was marginally higher among children (88 percent) compared to adults (85 percent) but has greatly declined in September report to as low as 60%. The retention among women was also marginally lower 84 percent versus 86 percent among men. Among children, retention on treatment was least among children less than two years old (86 percent), compared to children aged 5-14 years (89 percent).

Table 5: Retention on ART for Treatment cohorts completing 12 months in the first 3 quarters of 2014, MoH 2014

Retention on ART for Treatment cohorts completing 12 months during the first 3 quarters of 2014

	January – March 2014			April – June 2014			July – June 2014			July – September 2014		
	Net Current Cohort	Number Retained	%	Net Current Cohort	Number Retained	%	Net Current Cohort	Number Retained	%	Net Current Cohort	Number Retained	%
Total	32,125	27,428	85.4	31,474	26,584	84.5	63,599	54,012	84.9	42347	31778	75
Adults 15 years +	30,169	25,725	85.3	29,730	25,028	84.2	59,899	50,753	84.7	39408	29627	75.2
Males	9,459	8,346	88.2	7,779	6,480	83.3	17,238	14,826	86	11217	8600	76.7
Females	20,710	17,379	83.9	21,951	18,548	84.5	42,661	35,927	84.2	28191	21017	74.6
Children	1,956	1,703	87.1	1,744	1,556	89.2	3,700	3,259	88.1	2939	2151	73.2
< 2 year	480	394	82.1	473	422	89.2	953	816	85.6	714	500	67.5
Males	223	187	83.9	247	223	90.3	470	410	87.2	368	250	67.9
Females	257	207	80.5	226	199	88.1	483	406	84.1	373	250	67
2 < 5 yrs	549	476	86.7	562	504	89.7	1,111	980	88.2	853	607	71.2
Males	264	220	83.3	270	249	92.2	534	469	87.8	402	287	71.4
Females	285	256	89.8	292	255	87.3	577	511	88.6	451	320	71
5- 14 yrs	927	833	89.9	709	630	88.9	1,636	1,463	89.4	1345	1044	77.6
Males	383	351	91.6	309	273	88.3	692	624	90.2	595	454	76.3
Females	544	482	88.6	400	357	89.3	944	839	88.9	750	590	78.7

TB-HIV integration and collaboration: The country has consolidated the Joint TB/HIV programming through joint planning, patient care and resource mobilization. Screening of HIV patients for active TB was 92%, testing HIV among TB patients 98% and cotrimoxazole among confected patients stands at 95%. By end of 2014 over 80% of the patients co-infected with TB and HIV were treated with both ART and TB drugs. This trend has been rapidly increasing from 45% in 2012, 65% in 2013 and 80% in 2014. In total 8,250 patients co-infected with TB and HIV were treated with both ART and anti-TB drags.

The GeneXpert which was initially used for diagnosis of TB and MDR-TB cases has been rolled out countrywide through the National Laboratory specimens Transportation Hubs. Of the 200 Genexpert machine projected up to 2015, 70 were available in the country by end of 2014 and more 60 are expected in 2015 from CDC, GF and USAID. In addition to diagnosis the machines will have a key role in scaling up IPT with additional prospect of viral load monitoring for patients on ART. Other notable outputs in an effort to accelerate implementation of the TB/HIV integrated services in 2014 include: disseminations for the integrated TB/HIV guidelines, training of health workers in 10 out of 125 ART facilities in prison on screening for both TB and HIV among inmates and development of TB/HIV chart-booklet as well as printing and distribution of 3500 copies in order to facilitate quick management of patients with TB/HIV co-infection.

HIV-SRH integration: The national response has continued to prioritize HIV-SHR integration and support mainly using the four prongs of eMTCT and systems strengthening approaches. The main focus for the year was in the far and underserved area of North-Eastern Uganda. There was support to increase and scale of eMTCT services through increased accreditation assessment of 27 out of the 50 HCIIs in Karamoja for EMTCT services; improved EID services through integrated outreaches (11 outreaches by Baylor, and at least 20 by CUAMM and training of 120 HCWs and 223 VHTs in Pediatric HIV care and treatment. Ministry of Health has been provided with financial support for courier services of DBS samples.

The country with support from the UN system piloted delivery of services in 17 target districts to learn from and to inform policy and programming for implementation of SRH/HIV interventions targeting women, young people and key population groups. According to the JUPSA report of 2014, over one million members of the general public were reached with SRH/HIV integrated services in target districts including about 150,000 new users on family planning who also accessed HIV services through outreach camps and static services. It also indicates that about 500,000 adolescents and young people were reached with friendly services through 35 youth friendly facilities in schools, health facilities and FBO establishments/systems.

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

NSP objective and key result areas	Progress in 2014
Social support and protection	
1. Support delivery of comprehensive, quality psychosocial services to PLHIV, affected households and persons most vulnerable to exposure to HIV	
Psychosocial support to PLHIV	• SALT ("the Support on AIDS and Life through the Telephone) program that provides counselling services through the telephone HIV • Psychosocial support to 49,460 (90%) PLHIV
Comprehensive services to OVC (at least 3 basic needs met)	• Number of OVC receiving Social care support under CPA2 Jan - Sept 2014: 16,908 (Males 7,803 & Females 9,105). Source - OVC-MIS - UNICEF: Besides the numbers, the following achievements have been realised: (a).283, 246 (Females 130,014 & Males 153,232) OVC identified using the 3 factor creteria have been linked to services. (c).DOVCCs and SOVCCs have been formed in all the 32 supported districts. (d).Regular coordination meetings have been conducted. (e). PSWO in all the 32 focus districts have been trained on OVC-MIS. (f).There has been regular (Quarterly) reporting on OVC work in the OVC-MIS. • Revision and finalisation of the Vulnerability index tool for OVC

	identification, targeting, monitoring and graduation • Launch of the first ever National toll free Child helpline for reporting and responding to Child abuse cases • 1,347 frontline social service workers from 1,056 Sub counties trained in Practice-oriented in service training • 11,735 para-social workers from communities such as VHTs, VSLAs, PHAs, CBOs and Functional Adult Literacy (FAL) groups were skilled in child protection. •
2. Empower HIV-affected households and most vulnerable groups with livelihood skills and opportunities to cope with socio-economic demands (focus on OVC households)	• MGLSD has developed a draft Program Plan of Intervention for Social Protection with a section that outlines specific interventions for strengthening social care and support for most vulnerable people including OVC. This will be submitted to Cabinet for approval together with the Social Protection Policy draft.
3. Scale up coverage of comprehensive social support and protection to the most vulnerable PLHIV and other affected groups	
Promote stigma reduction	The Y+ Beauty Pagent was held by the Uganda network of young people living with HIV/AIDS (UNYPA) to address Beauty with Zero discrimination and to pioneer fighting stigma and discrimination against young HIV/AIDS victims. The UNYPA Ambassador will be for zero New Infection, Zero Stigma and discrimination, and Zero related diseases

In addition to the 2011-2015 NSP, the 2011-2015 National Strategic program Plan of Interventions (NSPPI) for OVC guides the HIV response in this thematic area of the national response. The three-pronged approach of the NSP details provision for social support and protection for PLHIV, HIV-affected families and other individuals and households with HIV-related vulnerability.
It stipulates the following approaches:

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; with focus on households that host OVC.
3. Scale up of comprehensive social support and protection to the most vulnerable PLHIV and other affected groups; including specific promotion of stigma reduction, and ensuring that HIV/AIDS workplace policies and programs are instituted in all large workplaces (20 or more staff)

The 2011-2015 National Strategic program Plan of Interventions (NSPPI) for OVC guides support to children and families affected by HIV, and those with other HIV-related vulnerability. 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

The 2014 focus has been put on documentation, planning, social mobilization, empowerment and technical and logistical support. The following part of the section presents key achievements per strategic objectives and actions of the NSP 2011-15:

2.4.1 To scale up delivery of comprehensive quality psychosocial services to PLHIV, affected households and persons most vulnerable to exposure to HIV

The NSP intended to achieve this objective through several strategic Actions including a) Scale-up counseling services provisions at health care points and in communities for PLHIV and persons most vulnerable to exposure to HIV, b) Provide training of service providers, PLHIV networks and care takers to identify and respond to psychosocial support needs of PLHIV and persons most vulnerable to exposure to HIV and c) develop and deliver a package of direct psychosocial support services provision for PLHIV, affected households and persons most vulnerable to exposure to HIV

Efforts in 2014 largely focused on consolidating initiatives of the previous year particularly counselling and support to the youth to reduce stigma as follows:

- Between FY13 and FY14, there was a 55.5% increase in CSF sub grantees providing PLHIV counselling
- The country through NAFOPHANU innovated the SALT ("the Support on AIDS and Life through the Telephone) program that provides counselling services through the telephone HIV
- CSF sub grantees offered psychosocial support to 49,460 (90%) PLHIV in the period of July 2013 to June 2014,
- For the three years 2011, 2012 and 2013, at least 12,063 schools had one or more clubs that provide psychosocial support to PLHIV and affected members of the community
- Learners, teachers and non- teaching staff within primary and secondary schools disclosed their status to the school administrators (66,455 in 2011; 57,416 in 2012 and 49,038 in 2013)
- The country is in the process of developing a fact sheet on available HIV sensitive social protection programs.
- Revision and finalisation of the Vulnerability index tool for OVC identification, targeting, monitoring and graduation
- Launch of the first ever National toll free Child helpline for reporting and responding to Child abuse cases.
- A total of 1,347 frontline social service workers from 1,056 Sub counties trained in Practice-oriented in service training.
- To build capacity in child protection 11,735 para-social workers from communities such as VHTs, VSLAs, PHAs, CBOs and Functional Adult Literacy (FAL) groups were provided with skills.

2.4.2 To empower HIV affected households and most vulnerable groups with livelihood skills and opportunity to cope with socio-economic demands

To achieve on this key area the NSP priorities 3 main action areas these included; a) Support most vulnerable households of PLHIV and of articulated beneficiary categories to meet immediate needs for proper nutrition and food security, b) Support economic activities for households of PLHIV and those most vulnerable to exposure to HIV and c) Advocate for affirmative action to support vulnerable PLHIV and articulated categories to benefit from existing initiatives and programs

Innovative approaches were initiated in targeted communities to reduce vulnerability factors to HIV infection and its effect.

Communities vulnerable to HIV were supported to increased resilience and empowered to be food and nutrition secure. Planning meetings to develop subsidiary laws on food security and nutrition to prevent/mitigate the impact of HIV and AIDS with Ministry of Agriculture and training of district local governments have been held. Similarly there are intensified efforts to integrate and implement social economic enhancement interventions for PLHIV following the training of national and district local government authorities.

The country has conducted mobilization and sensitization of targeted districts on HIV and AIDS, food and nutrition security, marketing knowledge and skills; particularly focusing on those with vulnerable communities and specifically fishing communities. The trainings on agronomy and demonstrations highlighted the practices, management and technologies for enhancing production and productivity.

To strengthen capacity of government to implement OVC policy and Plans for vulnerable children operationalized, the following outputs were realized:

The country received technical, financial and logistics support for improved targeting and coordination of delivery of social and protection services to OVCs by government and non-governmental organizations. There were trainings of district probation officers; procuring and supplying equipment (computers and internet facilities); supporting coordination of actors at the national, district and sub county levels; harmonization of guidelines and dissemination of such guidelines; facilitating timely collection, collation and inputting of data on OVC service provision into the OVC MIS; facilitating case response by probation and social welfare officers at the district level; rolling out the national Child Help Line to facilitate case response and monitoring by senior government officials to district, district to sub county .The capacity building initiative of districts resulted in 23,260 children being reached with various services in line with the national OVC policy. The OVC MIS is fully functional in all the 112 districts.

With the OVC services in the districts, financial support has been extended for review and implementation of their respective action plans that reflect new and emerging priorities of communities related to HIV, to ensure improved service delivery of OVCs. A Baseline on the financial needs of the PLHIV was conducted in 5 districts. Other AIDS support organizations trained 53,719 OVC caregivers in the provision of comprehensive care and psychosocial services, 38 health care workers in OVC care, 40 PLHIV in the Stigma Index methodology, and 218 UNYPA members in HIV communication and life skills education
Strengthened coordination up to at all levels (NOSC, DOVCC & SOVCCs), over 2,700 service providers participate in these service provide and coordination linkage activities.

A total of 478 district and CSO leaders Trained in Leadership Development Program (LDP) to build their leadership and management capacity, applying new skills to OVC challenges and resource mobilisation for OVC.

2.4.3 To scale up coverage of a comprehensive social support and protection package to most vulnerable PLHIV and other effected groups

The NSP stipulate key actions that guided implementation in this area; Support enrolment and retention of OVC, PLHIV of school-going age and other identified beneficiary groups, promote informal education, vocational and life skills development for OVC, PLHIV of school-going age and persons most vulnerable to exposure to HIV, Support provision of appropriate shelter for deserving vulnerable groups, mainstream gender and disability into social support program initiatives, provide legal and social services for the protection of women and young people against gender based and sexual violence (GBSV) on account of HIV and promote rights

awareness and sensitization to address cultural norms, practices and attitudes that perpetuate gender based and sexual violence in the context of HIV

In 2014 the country focused on identifying and operationalising mainly relevant Laws, policies and practices that undermine and support effective responses to AIDS, building National capacity to reform laws, policies and practices that block effective AIDS response enhanced and rolling out the Action framework on women, girls, gender equality and HIV/AIDS. Below is an outline of the key results:

- Through strategic engagement and advocacy with government and partners at the highest level, government and concerned ministries (i.e. Health, Internal Affairs, Foreign Affairs) issued assurances that LGBT/MSM are protected from violence and harassment; and ensure access of LGBTI to health and HIV-related services without any discrimination. The government also issued a statement on AHA 2014 reaffirming its commitment to the protection of the rights of all Ugandans and ensuring that nobody takes the laws into their hands and basic services including Health/HIV are provided to all.
- The industrial property bill was passed into Act and assented to by the president; the Law was passed with provisions of access to medicines. UNDP has also facilitated the drafting of industrial property regulations with guidelines focusing on enabling PLHWAs' to access cheap generic medicines.
- High level Advocacy & lobbying by the UN (including regional and HQ) was provided for the case of the Nurse as well as Technical assistance and support to the Uganda Network on Law Ethics & HIV /AIDS that has mobilized a legal team that provided legal support to the case of the nurse. The Nurse was arrested for allegedly infecting a child with HIV while administering a drug to a child. She was charged with attempted murder and later criminal negligence doing an act likely to spread infection. She was tried and later convicted to and sentenced to a custodial sentence of three years in prison that was appealed and she was set free in November 2014.

The country engaged members of the Judicial Studies Institute to develop a strategy outline of integrating HIV and AIDS and labour rights into the Judicial training programme.

To address gender related discrimination and rights violations cases especially those that have potential to exacerbate the AIDS pandemic among women and girls, legal Aid was given girls in districts to enhance their property inheritance rights. A number of more women and girls, regained, claimed over property after receiving free paralegal services.

Data for the financial year 2013/14 indicate that 3439 HIV positive OVCs were supported. Between July 2013 to June 2014,43,6,313 PLHIV attached to CSF sub grantees received psychosocial support.

Table 6: PSWO OVC SERVED PER Core Programme Area for the period 2013/2014

NO.	Core Programe Area	Total
1	Economic strengthening	2,789
2	Food & Nutrition Security	740,470
3	Health, Water, Sanitation & Shelter	14,631
4	Education	353,510
5	psychosocial Support & Basic Care	436,313
6	Child Protection & Legal Support	10,808
7	Legal, Policy & Institutional Mechanisms.	414

OVCMIS 2014

Uganda conducted a gender review and gender issues were mainstreamed into the National HIV strategic Plan II and the Global Fund application (TB/HIV/HCSS). There was continued support to more districts to increase access to SRHR and EMTCT with activities implemented through CSOs ICWEA & UGANET.

2.5 System Strengthening

System strengthening	Noted achievements
1. Strengthen governance and leadership of the multi-sectoral AIDS response at all levels	• New UAC board in place to lead the coordination • Filled in senior positions at the UAC • Revitalised district coordination mechanism • Partnership coordination committee meetings • Technical support provided to SCE and MDAs
2. Ensure availability of necessary resources to support service delivery	• Sustained funding from ADPs with over 500m per year • Establishment of AIDS trust fund • Increase in the government allocation to UAC and the health sector • Approval of the TB/HIV concept Note by GF • Allocation of UGX800m from GoU to the Uganda CCM • Country participation in the CoP 15
3. Establish a coordinated and effective national system for management of strategic information for the HIV and AIDS response	• Revitalisation of the NADIC(M&E data base, e-mapping data base, Knowledge management portal, research repository, skilled human resource, • Review of the new M&E plan • Institutionalisation of regional scientific conferences

System strengthening: the NSP 2011/12-2014/15 prioritizes system strengthening for the multi-sectoral HIV response and indicated approaches and strategies to build on the previous achievements and forge new innovations. It seeks to build an effective and efficient system that ensures quality, equitable and timely service delivery by 2015. Specifically the plan was to implement through three key objectives namely; to strengthen the governance and leadership of the multi-sectoral HIV/AIDS response at all levels, ensure availability of and access to resources for strengthening systems for delivery of quality HIV/AIDS services and establish a coordinated and effective national system for management of strategic information for the HIV/AIDS response

2.5.1 Strengthen the governance and leadership of the multi-sectoral HIV/AIDS response at all levels

This was undertaken largely by targeting the operationalisation of decentralisation approach to the response. There was focus on strengthened capacity of national institutions to lead and coordinate the national HIV response. This targeted national and subnational institutions and key leaders that are pivotal in the response. Key notable actions included:

- Parliament enacted HIV Prevention and Control bill into law which was accented to by HE. the President Uganda. This law provided for the establishment of the AIDS Trust Fund
- Media SCE was brought on board with some media houses offering space free of charge for dissemination of messages
- UNASO spearheaded the development of the Uganda AIDS Accountability Score Card.
- AMICAALL Through AMICAALL Urban leaders have been effectively mobilized countrywide and sensitized, as well as their capacity built to mobilize urban communities for increased awareness and service uptake and creating an enabling environment through formulation and enactment of appropriate by-laws and ordinances to advocate and promote urban HIV response

- A national gender assessment was conducted in 2014 to generate evidence on gender and HIV to inform the national processes such as the development of the new national HIV/AIDS Strategic Plan.
- Network of young women living with HIV was supported to participate in the Beijing +20 Africa review that came up with the Beijing +20 Africa Declaration, which identifies gender and HIV/AIDS as an unfinished priority to be included in the new global development agenda for women, to be discussed in 2015.

There has been re-engagement of urban leaders to improved local planning, coordination and reporting as reflected at the national level i.e Ministry of Health and Uganda AIDS Commission reports. Annually, AMICAALL conducts regional and national urban leaders' fora which bring together all technical and political leaders with other stakeholders including NGOs, AIDS development partners to deliberate on HIV and AIDS issues in urban and peri-urban areas and define appropriate actions for urban HIV and AIDS response. These fora feed into the National Joint AIDS Reviews conducted by UAC and Joint Health Reviews at the Ministry of Health. During this years' urban leaders fora a UNAIDS supported campaign was launched on increasing access to HIV and AIDS services in Urban centers. The camping aims at mobilizing multiple stakeholders including the private sectors on possible partnerships to respond to the HIV within the urban areas.

Urban leaders have been effectively mobilized countrywide and sensitized, as well as their capacity built to mobilize urban communities for increased awareness and service uptake and creating an enabling environment through formulation and enactment of appropriate by-laws and ordinances to advocate and promote urban HIV response.

2.5.2 Ensure availability of and access to resources for strengthening systems for delivery of quality HIV/AIDS services

Overall HIV funding: Funding for HIV/AIDS in Uganda remains predominantly donor funded. The national AIDs Spending assessment report (NASA 2012) shows that government of Uganda contributed 12%, development partners contributed 68% and the balance of 20% was financed from private sources including out of pocket. During the 5 year period, an estimated total of US $ 1,304 bn was realised against a mid-term projection of US$ 2.274 bn presenting a 57% resource out turn. It should be noted that based on the dynamics of the HIV response and changes in the implementation modalities, funds realised turn out to be far lower as the need grew exponentially as a result of emerging priorities including the changes in the ART eligibility criteria.

GOU Funding for Health and HIV/AIDS: While releases to the Health sector grew, the sector allocations as a percentage of the total budget decreased from 8.9% in 2010/11 to 7.9% by 2012/13.

The low funding to the health sector would inevitably be felt across most of the disease components including HIV/AIDs, since individual disease budgets including the HIV and AIDS budget are integrated within the Health sector funding

GoU funding earmarked specifically for HIV /AIDS increased from at 5% of the total country HIV budget in 2007/08 to 12% in 2012/13.

Development Partner Funding for HIV/AIDS: The development partners contributed US $ 407 M in 2011/12 and US$ 355M in 2012/13 and US $ 401M for 2013/14. PEPFAR contribution accounted for US $ 298.4M in 2011, US$ 299 M in 2012 and US$ 323.4M in 2013, and 2014. Of this about 51% was allocated to care and treatment, 13% to Governance and systems, 5% to management and operations, while 23% and 8% was allocated to Prevention and OVC respectively.

3.1 Partnership Fund: The Partnership fund was established in 2002 as a pooled source of funds from Uganda's AIDS Development partners' funds whose objectives included: support operations of the UAC partnership mechanism, enhance UAC coordination capacity and the self-coordinating entities' organisational development; and plan, monitor and evaluate information and resource. The Partnership Fund was critical as a major source of funding for leadership, advocacy and

coordination of the multi-sectoral HIV/AIDS response at the national and sub national levels through the Uganda Aids Commission.
The years 2012/12, to 2013/14 had partners contributing a total of US$ 5.013 M to the Partnership fund. This was raised as follows: US $2.086M for the year 2011/12, US $ 0.919M for year 2012/13 and US $ 2.017M for 2013/14. Several partners have exited the basket funding mechanism approach as their priorities and approaches change.

3.2 The Civil Society Fund: The Civil Society Fund (CSF) was established in 2007 to address the burdens posed by HIV/AIDS, and to orphans and other vulnerable children (OVC) in Uganda. CSF funds were largely directed to the Prevention interventions about 92% of the total CSF basket. System strengthening and OVC intervention were allocated 4% each while Care and Treatment had less than 1% over the period of the review. This funding mechanism was set up as a partnership involving, the development partners, the UAC and Civil society Organisations to offer grants and capacity building to scale-up effective, comprehensive HIV prevention and care services. It aimed to support a coordinated capacity building and technical assistance, harmonised national efforts and accountability towards achieving the goals laid out in the NSP and the CSF Strategic Plan.

3.3 Global fund for AIDS, Tuberculosis and Malaria: The HIV/AIDS funding from the Global Fund was secured to accelerate the scaling up of Prevention, Care and treatment and strengthening the health system for HIV interventions. During the period under review the GFATM disbursed a total of USD $ 58.98, 13.3 and 30.24 in 2011/12, 2012/13 and 2013/14 respectively for HIV and AIDs interventions. GFTAM funding has largely targeted the care and treatment interventions, these accounting for 75% of the resources, 13% for prevention and 12% targeting the Health system strengthening.

3.4 Clinton Health Access Initiatives (CHAI): The Clinton Health Access Initiative was established with the aim of bringing care and treatments to people living with HIV/AIDS and to strengthen health systems in resource-poor countries. CHAI funding was directed principally towards the ART, Diagnostics and commodities for the Paediatrics which accounted for 94% while Prevention and health system interventions had 1% and 5% respectively.

3.5 Joint UN Program support for AIDS (JUPSA):

The UN family in Uganda through the Joint UN Programme of Support on AIDS (JUPSA) is a strategic partner in the national HIV prevention response currently implementing the final year of the 5-year JUPSA Strategic Plan 2011/15. JUPSA provides support for upstream work on the generation of strategic evidence, policy formulation, development of strategic and technical normative guidance in identified priority areas, and advocacy for an expanded and effective response at national, sector, district and community levels. JUPSA strategies and activities target contribution to positive change at systems level and increase in service uptake at community level. JUPSA has continued to support the national AIDS response with an annual budget of about $13million. There was however a noted increased from $12,297,616 in 2013 to $20,422,760 in 2014. During the period 2016-2020 the UN in their United Nations Development Assistance Frame (UNDAF) has earned about $227 million to support the broader health response and $53million for HIV coordination.

Alignment and Harmonization of Resources to the NSP: The implementation of the NSP was largely influenced by the resource availability. As a result the alignment and harmonisation of was largely funder driven based on programmatic evidence available. The lack of routine tracking systems for AIDS financing and spending means lack of access to timely information to support planning and resource allocation for the response.

Development of the HIV and AIDS Sustainable Financing Options for Uganda report: In 2014, UNAIDS supported UAC in coordinating a dialogue of stakeholders on sustainable financing

options for Uganda. This resulted into a draft report that will be validated by stakeholders before implementation takes place. A number of options were generated and will be discussed by stakeholders for adoption: (1) efficiency gains; (2) increased budget allocations; (3) innovative funding mechanisms; and (4) borrowing to close the gap. This financial sustainability analysis will give Uganda further evidence to support the HIV investment decisions made earlier.

2.5.3 Establish a coordinated and effective national system for management of strategic information for the HIV/AIDS response

The NSP aimed to achieved results on this objective through several strategic actions including: a) Build partnerships among producers and users of HIV/AIDS information for the national HIV/AIDS response, b)Promote ownership of the national HIV/AIDS monitoring and Evaluation framework, c, Develop and disseminate national policies, guidelines and plans to all partners at national and sub-national levels, d)Build the capacity for collection, analysis, dissemination, and utilization of HIV/AIDS data/information for the national response, e)Develop a national HIV/AIDS data base for capture, storage and retrieval of HIV/AIDS data /information shared by all partners in the response for national and global commitment and f) Promote and co-ordinate HIV/AIDS research. The NSP did not organise the health systems approach according to the six WHO building blocks; (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance, The report presents results against the intended actions over the year 2014 but also keeping the perspective of the building blocks

a) Build partnerships among producers and users of HIV/AIDS information for the national HIV/AIDS response: The PEPFAR Hybrid DHIS was merged with the MoH DHIS2 by end of 2014 and now the country uses one database for health. This was done as part of capacity building for health system.

b) Promote ownership of the national HIV/AIDS monitoring and Evaluation framework: The national M&E TWG is functional and holding regular meetings to advocate, promote and support use of monitoring and for implementation of the response. The strengthened M&E team has been critical in reviewing and clearing important national and international reports including the 2014 country progress report, the 2014 Modes of transmission study and the Midterm of National Strategic Plan

c) Develop and disseminate national policies, guidelines and plans to all partners at national and sub-national levels, The country passed The HIV and AIDS prevention and control Act 2014 which provides for prevention of HIV and AIDS and establishing of the AIDS Trust Fund to boost domestic and external funding for HIV and AIDS.

d) Build the capacity for collection, analysis, dissemination, and utilization of HIV/AIDS data/information for the national response: MoH has been supported with technical assistance under the AIDS control programme for improved reporting, and six facilities have been oriented on open EMRS in a bid to increase expansion of open EMRS system, patient tracking and quality of care monitoring initiatives including in humanitarian settings.

e) Develop a national HIV/AIDS data base for capture, storage and retrieval of HIV/AIDS data /information shared by all partners in the response for national and global commitment.

- The NADIC has been finalized and by end of 2014 was pending for launching.

- The HMIS tools have been revised and are in the process of printing and distribution and the DHIS2 have been and updated to capture the revisions in the new HMIS tools
- In collaboration with PEPFAR, a capacity building training in HIV estimation, modeling, and estimation of resource use was conducted benefiting staff from Uganda AIDS Commission, the Ministry of Health, the private sector, CDC and USAID and UNAIDS. This training will improve data generation and estimation at country level.
- The results of the risk and awareness assessment survey were disseminated and sensitization campaigns were conducted among university students in the four universities and four health clubs were launched in these Universities. This was in an effort to addressing HIV among Youth in conjunction with Non communicable diseases

f) Promote and co-ordinate HIV/AIDS research : The M&E TWG leads the role of drawing up a national research agenda and collecting and compilation of the studies. These studies support the national HIV response to design and implement evidence based interventions. Below is the outline of the key studies on going or completed in 2014

- The UN provided both technical and financial support for updating the 2008/09 Modes of Transmission study report to provide current evidence of where new infections are coming from, and also respond to Global fund related requirements.
- MoH was provided with technical assistance to update the spectrum with programme data and surveillance data for the subsequent generation of 2013 HIV estimates. This followed a capacity building in HIV projection and estimates held in South Africa that was attended by officials from UAC, MOH and UN family.
- A study about Gender and HIV mainstreaming in local governments was commissioned. The study highlighted HIV resource allocation, utilization management, program Implementation, Monitoring and Evaluation and systems plus procedures. This was part of the effort to achieve equality in the distribution, access and utilization of services at the local government level.
- In 2013, the country with support from the UN supported a risk and awareness assessment survey carried out on a total 2000 students from four universities Makerere University Kampala, Nkumba University, Uganda Christian University (UCU) and Kampala International University, which showed that 67% of students did not know what NCDs yet almost 48% of the respondents were smoking and drinking alcohol.
- In November 2013 the HIV Knowledge, Attitudes and Practices and Population Size Estimates of Fisher folk in Six Districts in Uganda supported by IOM was completed.
- The study on BARRIERS AND OPPORTUNITIES FOR INCREASING ACCESS TO HIV SERVICES AMONG MEN WHO HAVE SEX WITH MEN AND SEX WORKERS IN UGANDA conducted by Makerere University with support from Global fund was completed in November 2014. The study revealed the gap between policy and implementation of services for key populations across various levels was evident for all groups
- There ongoing study on implementation of option B+ in Uganda: Assessing the uptake of mothers and infants into PMTCT services. This is also being conducted by Makerere with support from GF and MoH
- Near elimination of HIV transmission in a demonstration project of PrEP and ART follow up study to demonstrate the effectiveness of PrEP among discordant couples.

2.5.4 Community systems strengthening

Support Capacity for community systems to adopt and support social and behaviour change for HIV response continued to be a focus for the country. More efforts to strengthen community systems were realised in the year 2014. Building on JUPSA support to systems strengthening processes in 12 cultural and 6 religious institutions, about 500,000 local leaders in various regions were reached through orientations, consultations and community dialogues targeting building a critical mass of change agents to enhance social and individual behavioural change. Through mass media including prayer congregations and radio programming, cultural and religious leaders have reached over 2m people including young people, couples and the general

public in the supported regions. The experiences gained and tools developed will support expanded systematic programming with specific focus on couple and ASRH programming.

There was continued support to on-going SRH/HIV national mass media campaigns including the healthy choices campaign that involves community level structures such as VHTs who were provided with radio equipment to organize community listening groups to both live and pre-recorded radio programmes in English and local languages. The condom campaign was expanded in both scope to include messaging on the female condom and geographical coverage with the coming on board of USAID to support the campaign. It is estimated that the healthy choices campaign reached over 2.5m people in the targeted regions while the condom campaign that involves both TV and radio programming has reached over 3.5m people.

The has designed strategies to reaching young people with information and skills for Comprehensive Sexuality Education with focus on building champions to advocate for CSE and Adolescent HIV Prevention and Treatment Literacy and engaging parents/guardians and other adults to promote community involvement in the delivery of CSE in schools

IV. BEST PRACTICES

This section provides examples of best practices in key areas of the national AIDS response

a. **Political leadership** : In relation to involvement of political leaders in the response, over the reporting period, high political and cultural leaders played various roles as champions of Uganda's HIV/AIDS response. The Parliamentary HIV/AIDS Standing Committee, Sessional Committee on Social Services and Presidential Affairs Committee actively participated in discussing matters concerning HIV/AIDS and the performance of the health sector in general.

b. **Rapid scale up of elimination of mother to child transmission:** There has been sustained expansion of the national eMTCT Programme with continued stewardship by the First Lady of the Republic of Uganda. The launch of the 8 regional eMTC campaigns leading to increased service uptake, marshalled leadership engagement, expanded partnerships and ownership for a locally-led response and strengthening of the eMTCT real-time data management system. There has been increased capacity among health workers and Village Health Teams (VHT), to accelerate the roll out of Option B+ with staff training in paediatric HIV and AIDS care treatment. The Ministry of Health was supported to develop a complete set of training tools using the IMAI/IMPAC modules for health workers to support integrated SRH/MNCH/EMTCT services. These efforts have in part contributed to about 95% (112,909 mothers) of pregnant HIV positive mothers accessing Anti-retroviral (ARV) drugs, and a drastic reduction in the number of babies born HIV positive from 31,000 in 2011 to 15,000 by end of 2013.

c. **Supportive policy environment:** Laws, policies, strategies, technical guidelines and tools have been developed and/or adopted to support rapid scale-up of the response to optimal levels. The partners stood firm to spearhead engagement with government, bilateral, cultural and religious leaders on key sensitive issues including debate on sexual orientation, the partners led the advocacy for dialogue and diplomacy during the Uganda anti-homosexuality bill and and HIV Prevention and control Bill that contributed to the annulment of the AHA . Establishing public-private referral partnerships with the local private health service providers like drug shops, medical clinics, pharmacies and maternity centers can be an effective means of increasing the number of PLHIV who enroll and access care, support and treatment services

d. **Scale-up of effective prevention programmes:** Introduction of mother baby care points in MCH to improve on follow up of mother in PMTCT and their babies. The files of the pair are kept together and medication, counselling and appointments are given together for 18 mother of follow up . Use of continuous quality improvement to consolidate ART programs at the facility level through the country with support from all regional IPs

- **Prevention:** *Innovative approaches especially to target KPs*: The moonlight HIV testing strategy has improved HCT uptake particularly among key populations. *Demand creation through engagement of champions*: Involvement of all leaders including cultural, religious and political leads to better results. *Involvement of communities/PLHIV*: There are several interventions related to community systems strengthening to support mobilization, retention, adherence and psycho-social support. These have contributed to the success of the program.

- **Care and Treatment :**The test and treat approach will increase the number on life-long medication. The adherence, disclosure and frequent clinic visits for clinical monitoring, laboratory tests, and counselling will demand patient and provider commitment. For many patients, the indirect costs including transport, missed employment days, and out-of-pocket expenses are major causes for loss to follow-up (LTFU). The number of HIV infected persons accessing ART in Uganda is increasing rapidly and, particularly, the earlier start of ART using the Test and Treat approach has consequences for the emergence and spread of drug resistance

- **Social Support and Protection:** Reducing gender inequality in all its facets and manifestations and transforming gender stereotypes and relations is possibly the most effective strategy in enhancing the capabilities of individuals, households and communities to cope with the consequences of HIV/AIDS (UNAIDS 2005:8). NAFOPHANU's SALT program a best practice of gender and rights-based driven program.

- The Y+ Beauty Pagent was held by the Uganda network of young people living with HIV/AIDS (UNYPA) to address Beauty with Zero discrimination and to pioneer fighting stigma and discrimination against young HIV/AIDS victims. The UNYPA Ambassador will be for zero New Infection, Zero Stigma and discrimination, and Zero related diseaseA total of 40 young people living with HIV (male & female) from four (4) districts Kampala, Mukono, Wakiso and Luweero were trained in Human rights, evidence based advocacy and Sexual reproductive Health, more than 10 young people living with HIV were selected to participate in Y+ Beauty Pageant 2014 edition, out of these two (2) were crowned as Mr. and Miss Y+ 2014 and these became the face of change together with other contestants who also become ambassadors of change in fighting stigma & discrimination in their relevant communities. The campaign provided a platform to young people living with HIV to come out and speak openly about the stigma, discrimination they face every day from family, society and within themselves. Young people successfully developed Advocacy messages against ending stigma and discrimination More than 400 young people received services during the campaign community outreaches and dialogues, many of these were referred to public health facilities hence linking young people to these facilities.

e. **Scale of care, treatment and or support pgrammges: The adoption of Anti-Retroviral Therapy (ART) guidelines has increased enrolment of people on ART:** The ART Addendum disseminated, health workers trained, and Monitoring and Evaluation (M&E) tools reviewed and in use. This was coupled with advocacy and AIDS Development Partners (ADP) support the country was able to enrol more new clients on ARV than the new HIV infections. Overall 750,896 People Living with HIV (PLHIV) were receiving whom 66% were women. These

efforts have contributed to a sustainable reduction in number of new HIV infections and AIDS related deaths since 2011

f. Monitoring and evaluation: **Improved data generation reporting and use in the country partly due to an effective national M&E technical working group:** The country has adopted a number of initiatives for improved data reporting and use and these include the launch of the State of Art documentation centre, the mapping of AIDS partners in the country, harmonization to one tool the DHIS2, the adoption of LQAS at district level, the development and submission of the 2013 global AIDS report; the 2013 national HIV estimates and projections, compilation of a key issues paper on HIV and AIDS that informed the 2015/16 to 2019/20 NDPII; and development of the national M&E plan 2015/16-2019/2020 and holding of the first national family planning conference that featured significant evidence on SRH and HIV integration especially on prong Two of eMTCT; and the national pediatric conference with priority focus on adolescent HIV.

g. **Launching of regional approaches to advocate and sensitise communities on HIV prevention, care treatment and support**

h. **Build partnerships among producers and users of HIV/AIDS information for the national HIV/AIDS response:** The major achievement in this area was the merger of the PEPFAR Hybrid system with the MoH DHIS2. The transition exercise was undertaken using various approaches in order to ensure a successful transition from the PEPFAR partner reporting system (HIBRID) to the national M&E system (DHIS2).
    a. Additional activities were also undertaken, mainly to build the trust and confidence of the USG in using data from the national system for PEPFAR reporting.
    b. **The HIBRID system** which was built on the same platform as the national DHIS2 and had almost similar datasets as the DHIS2, enabled data entry directly from the sections of the HMIS reports. This was done to ensure that the PEPFAR partners get familiar with the both the DHIS2 software and also with the HMIS reporting tools. Additionally, the partners were also encouraged to ensure that they first support the district/sites to ensure that data is entered into the DHIS2 and later extract the data and use it for PEPFAR reporting in the HIBRID.
    c. **The next step was continuous Comparison of PEPFAR sites in the DHIS2 and those in the HIBRID**. This process helped to identifying the PEPFAR sites not included in the national DHIS2, they were verified and the majority were accordingly included. The process also helped to ensure that the national DHIS2 has a complete/comprehensive list of all Public, PNFP and PHP health facilities in the county.
    d. **Then finally the PEPFAR team directed that all PEPFAR data in the national HMIS will be obtained directly from the national DHIS2. This meant that** PEPFAR partners were no longer required to enter this data in the HIBDRID (HIBRID was only left for entry of OVC data and data not captured in the national HMIS). As a result, all PEPFAR partners were forced to make sure that all their sites and respective data is entered in the national DHIS2 before closure of the PEPFAR reporting period.

V MAJOR CHALLENGES AND REMEDIAL ACTIONS

4.1 Progress made on key challenges reported in the 2013 Country Progress Report

The 2013 Country Progress Report identified challenges and planned remedial actions in 2014/15. The 2014 mid-term review of progress against NSP 2011/12- 2014/15 and other program reports indicated specific commitments to address these challenges. Progress in 2014 in implementing the actions against each of the challenges is presented in Table 8 below.

Table 7: Progress in addressing challenges from 2013 GARPR and the June 2014 MTR

Key Challenges in 2013	Planned remedial action in 2014 and 2015	Progress in 2014
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. • Integrated ABC programming will be revitalized	There was scale-up of Couple counselling alongside the implementation of the male involvement intervention. To revitalize the ABC programming a Messages clearing committee was formed at the UAC.
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. • A critical initial step toward addressing key populations will be to conduct a national size estimation to develop a profile of these groups. • 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.	The MARPS framework was finalized to guide harmonized programming for this population. The country adapted the Peer to peer approach to reach MARPS. The national size estimation was still under preparation. Scaling up MARPI settings in more regions to improve access to HIV services and Call-IN-Centers for psychosocial support. Moon light activities continued to be a model of service delivery to MARPS.
Inadequate coverage of MARPs and other key populations with HIV prevention and care services	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 testing; and on repeat testing among persons in settings where instances and experiences of higher risk sex are common.	Outreaches to MARPS with comprehensive HIV services
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.	All health III offering eMTCT have been accredited as ART centers and MCH staff capacity built to manage chronic care. Mother-Baby Care point has been established in all eMTCT sites to be offer care until the exposed baby is 18 months of age.
Service demand for SMC still	Scaled-up delivery of safe male circumcision services:	The country has continued to use a mixed

outstrips available 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.	approach of outreach camps and health facility base procedures. The prepex method which had side effects attributed to it has been re-introduced. integration of SMC in routine services of the health facilities is ongoing with the increase in capacity building and procurement of reusable SMC kits
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 • 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. • 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	New guidelines were scaled up to more sites particularly those offering EMTCT services. IPT guidelines were finalised More HCIII were accredited to offer ART and EMTCT services. There were regular mentorships on continiuous quality improvement in all sites that had started providing chronic HIV care services. Linkage facilitators have been trained to support the VHT in follow up of clients, linkages and referral, and sensitization of communities about care.
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)	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. • Necessary staffing, training, infrastructure modifications and quality assurance support will be ensured through government investments and support from development partners.	The national Laboratory Hub network has expanded to 60 and performing integrated services for all laboratory sample including Geneexpert and Viral load Coordination and staffing remain a challenge

Social support and protection		
High levels of stigma; and persistent low capacity for social protection services	Integrated stigma reduction, social protection and socio-economic empowerment and support Based on the results and recommendations from the 2013 stigma index study, a robust stigma reduction initiative will be implemented • This will include strengthening cultural and religious institutions and their role in HIV-related spiritual and psychosocial support.	Cultural and religious institutions and their role in HIV-related spiritual and psychosocial support have been Strengthening
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 • Inadequate financing for behavioural interventions, psychosocial support and stigma reduction.	Refine and initiate implementation of the investment case: Institutionalization of regular resource tracking mechanisms and improving efficiency of HIV/AIDS spending especially on those interventions that have big impact based on evidence.	The TV/HIV concept Note was developed the first activity in implementation of the Investment case The concept note to institutionalize the NASA was drafted and awaiting
Weak coordination and leadership structures and systems at national and decentralized/district levels • Lack of a formal UAC Strategic Plan thus hindering implementation of more organized institutional development initiatives. • Inadequate district structures, systems, and technical capacity to coordinate the decentralized	Strengthen national level coordination of the AIDS response Institutional strengthening of the UAC Secretariat will continue to be prioritized, including: a) Expediting development and utilization of the UAC Strategic Plan as the blueprint for operations of the UAC Secretariat; b) Increasing UAC visibility through branding and sustained engagement of all stakeholders in the coordination of the national response; and c) Strengthening NADIC as the main hub for mapping and regularly updating records on stakeholders and their	• New UAC board in place to lead the coordination • Senior positions at the UAC were filled to strengthen coordination of the response. • District coordination mechanism were revitalised and zonal coordinators recruited • Partnership coordination committee meetings • Technical support provided to SCE and MDAs

response	activities. Sustain roll-out and capacity building to revitalize decentralized coordination of the AIDS response a) Reconstitute and strengthen monitoring of the functionality of the coordination structures in Districts and urban authorities. b) Institute a follow up mechanism to validate, update and utilize the stakeholder mapping database with local governments. c) In order to increase accountability, spearhead the adoption of a district based and led HIV planning/programming where resources will be tagged to the District HIV/AIDS Strategic and integrated operational plans and information management.	• The DAC and SAC were supported by regional Implementing partners to carry out their functions. • E-Mapping was finalized pending launching.
Under-developed community systems: for support to community-level HIV service delivery and utilization ▪ 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: • Referral and enrolment of PLHIVs in community and facility-based services. • Strengthening community-based psychosocial support (PSS) in HIV/AIDS care and support services.	The country has built skills of community linkage facilitators, VHTs and Expert clients to work with the health facilities and the communities in follow up of care community counselling, sensitization and mobilization. Through PEPFAR support PLHA were provided with the basic care Kit and offered psychosocial support. The scope of the services with widen during the next reporting period
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	There has been recruitment of more staff at the UAC and in the Zonal coordination offices. USG IPs supported some staff in their respective regions. There is hope that the GoU will enhance salaries during the FY 2015/16

4.2 Challenges in 2014 and remedial actions for 2015

The section below summarizes the challenges experienced during the year and the remedial actions planned to ensure achievement of agreed targets:

The proceeding narrative provides a summary of the delays and the nature of constraints and challenges, and lessons learned in the process.

Uganda is still registering high level of new HIV infections yet interventions for primary HIV prevention, specifically targeting risky behaviours and structural drivers, are still not conceptualized and delivered systematically which constrains quality, efficiency and coverage. There is limited funding for comprehensive Social and Behavioural Change Communication despite the low HIV/AIDS comprehensive knowledge. There is still lack of common technical programming guidelines for SBCC that would inform systematic monitoring and evaluation of such interventions. The non-functionality of the BCC Team in 2014 partly curtailed progress in this area.

The Female condom was successfully reintroduced in 2009 by Ministry of Health and there has been steady increase in demand and distribution of the commodity. Inadequate forecasting and quantification at national level however is constraining universal coverage. Whereas there is a need to get the FC to every user who wishes to access the product to establish acceptability, there is persistent focus on whether the female condom is acceptable resulting in fewer quantities requested and procured which in turn curtails many from accessing it. This impasse at decision-making levels has interrupted the momentum gained in expanding the female programme. MoH plans an FC user assessment to address the bottlenecks.

The country continued to experience stock outs of key items including test kits, STI drugs and other supplies. This negatively affects the expanded demand generation processes through leadership and other SBCC programmes. It is hoped that the Global Fund resources will narrow the gap.

The passing of the Anti-Homosexuality Bill in February 2014 created a short-term that threatened to heavily affect the national response. The Act for example affected decision on funds allocations among some ADPs and there was reported service interruption at one of the MARPs research sites in KCCA. However, intensified advocacy resulted in court nullification of the Act that mitigated prevailing challenges at the time and the situation was back to normal by the end of the year.

Protracted processes for development of policy frameworks and guidelines and slow procurement processes in government institutions continue to delay implementation of programmes. Some partners request JUPSA agencies to, for example, take on procurement tasks, which curtail capacity building of national systems as prescribed in the Paris Declaration.

Persistent human capacity gaps in terms of skills and numbers in implementing partner agencies was a major bottleneck. Staffing challenges at ACP/MoH delayed take off and timely implementation of key planned activities considering that the Ministry shoulders over 70% of the response. Similar capacity gaps at UAC also resulted in delayed activity implementation e.g. for the MOT study.

Procurement and human resource capacity constraints result into limited resource absorption at various levels and also impacts on efficiency and effectiveness for the absorbed resources yet the response is still suboptimal requiring more resources to achieve sustained impacts.

The country still faces challenges on quality and timely reporting especially at sub national level. Absence of data on MARPS has specifically resulted into data gaps (size estimation) which greatly affect programming.

4.2.1 Prevention challenges

The country adapted the combination prevention strategy in line with UNAIDS recommendations (UNAIDS, 2009). The implementation is guided by the National HIV Prevention Strategy 2011 - 2015. The combination of HIV prevention strategies comprises a structured package of proven behavioural, biomedical, and structural interventions; challenge are aligned to these main components of the strategy

Behavioural change Interventions: The lack of a nationally agreed and fully functional M&E system for sexual and behavioural change prevention interventions. There is lack of national tools and indicators making it challenging to monitor these activities.

As indicated in the MTR 2014 there is limited interventions addressing key populations, which is exacerbated by inadequate knowledge about the context and extent of the problem of key population groups. Moreover, the legal environment and programing design issues intervene to undermine interventions for KPs. To date, there is no consensus on the definition of KPs, specifically who to include in the bracket of KPs (e.g fisherfolks in non-fishing communities). The current classifications may not be inclusive of all key populations that may need to be reached with HIV/AIDS behavioural change interventions.

In addition, conflicting data makes it difficult to estimate the size of key populations across the country. In 2013, sex workers in Kampala were enumerated as ~2,000 by AMICAALL and ~13,000 by Crane Survey. In the same year, MSM in Kampala were enumerated as ~253 by the Alliance AMICAALL and ~8,000 by the Crane Study. A recent review report commissioned by the Ministry of Health and Uganda AIDS Commission in 2014 provides a different picture of key populations in Uganda. According to this report, there is an estimated 2,000,000 fisher-folks; 54,549 sex workers; 10,533 MSM; 650,000 uniformed forces; and 31,588 truckers in Uganda.

Inadequate coverage of comprehensive combination prevention interventions: HIV prevention interventions are not implemented in combination; e.g., SMC not delivered as part of a comprehensive prevention strategy (not integrated into formal system, focus on 'cutting' alone). The annual national action plan for implementation of the NPS for 2011 discusses combination prevention with reference to an approach to deliver the different biomedical interventions as a combined package of clearly linked services. The specific elements highlighted in the plan include: HCT, EMTCT, SMC, condom promotion and ART for prevention; with due attention to both service delivery and demand creation communication. However, the plan does not define how the combination of these different services will be structured and implemented in the different service contexts (e.g., in health facilities, specialized HIV service sites, community-based outreach services, etc.). The plan does not explicitly include behavioural and structural interventions within the combination prevention package. An initiative for intensified district-based implementation and measurement of combination prevention was started in six districts in 2013.

Limited comprehensive knowledge of HIV/AIDS: Although knowledge of the modes of HIV transmission and prevention is generally universal, the proportion of Ugandans with comprehensive knowledge of HIV remains low (38% in women and 43% in men – UDHS 2011), and in some areas, there are still misconceptions about the causes of AIDS.

Biomedical interventions: Implementing partners supporting HCT services reported several challenges including among others;

The frequent stock outs of HIV test kits at central and facility levels. This was mainly due to irregular supply of test kits and poor quantification of needs at facility level to include requirements for HCT outreaches conducted by IP coupled with near 40 rate of repeat testing.

Scaling up Couples counselling still remains a challenge despite the existence of guidelines in the ART and PMTCT implementation protocols. This is largely due to the fear of testing outcome but also there is lack of skills among health workers and low sensitization of communities to promote couples counselling. Currently it is difficult to track repeat testers a fact that makes it difficult to control for possible double counting.

SMCs: There was poor follow-up, some clients don't return for review especially if accredited site is far Infrastructure challenges as some settings in the facilities are not suitable for SMC Human resource: High staff attrition coupled with frequent transfers of health workers disrupting established clinical teams, hence the frequent need to train the new members and inadequate human resources for health. This is coupled with heavy workload for the limited staff limits attention to labour intensive procedures like SMC. Most of the SMC surgical equipment are disposable making waste management difficult at the sites. Cultural and religious barriers have emerged as older males do not want to be circumcised and in some communities religious leaders are hampering demand creation for SMC services e.g. have been telling their followers that SMC converts the circumcised males to Islam

4.2.2 Care and treatment

- Male health seeking behaviour is still low, only 42% of ART eligible men are accessing treatment, compared to 55% of eligible women.
- Despite improvements in geographical coverage for ART, persistent disparities in sex, age and districts ART coverage continue
    - Very wide variation in Cure rate and Treatment Success Rate across districts
    - Gender ratio of patients on Palliative care has remained stable at 60% female
- Even before the test and treat approach, many clients still on waiting lists for ART in all the regions
- Loss to follow up continued to be the leading cause of patient attrition. The first 6 months of ART have remained the biggest problem for attrition with more than half (51%) of attrition happening in the first 6 months of starting ART. There is also increasing level of loss-to-follow up from 6.3 %in 2011 to 7.3 in 2013 by 6 months of follow up. At 5 years of follow up, the proportion of lost to follow-up increased from 17.5% in 2011 to 27% in 2013. Though overall mortality among patients on treatment has halved, most mortality continues to occur during the first 12 months of treatment. Private health practitioners have the highest LTFU, poor retention on first-line and appointment keeping (EWI, 2010)

- Poor retention and adherence especially among infants, adolescents and mothers to care due to weak follow-up systems, leading to loss of clients at all levels

- Although the paediatric ART coverage increased from 23% in 2013 to 30% in 2014 of eligible patients this coverage is still low and indicated the existence of many missed opportunities in care for children. This was largely due to limited capacity in many facilities especially the peripheral units for Paediatric care and treatment, frequent stock outs and loss to follow up.

- An assessment of adolescent access to HIV testing, care and treatment services conducted in 2013 in 1,020 facilities showed that only 17% of estimated adolescent living with HIV are currently in care; and just 29% of the estimated ART-eligible adolescents are receiving ART. Most adolescents are still recruited in model adolescent HIV clinics established at Mildmay, Baylor Uganda, JCRC, Nsambya Home Care, MU-JHU, AIC and IDI.

- There is still fragmented program management approach for TB and HIV especially at district and facility levels with inadequate collaboration mechanisms between managers to foster integrated services at facility level. Mobilisation for and delivery of TB and HIV services including home based care, drug refills and adherence monitoring are not integrated and duplication of efforts as well as missed opportunities for diagnosis, treatment and support still exist. TB status assessment among ART patients decreased from 82% to 76% between 2011 and 2013, implying weaknesses in intensified TB case-finding. Also, Community structures to support TB/ interventions

- Public sector palliative care provision is extremely limited. The major reasons being limited coverage of the service, inadequate staff with palliative care skills and hence drugs cannot be supplied to health centres with not trained staff, poor knowledge about the service and the available drugs.

- Low coverage of therapeutic and supplemental feeding which is predominantly dependent on implementing partners. Sub-optimal infant feeding practices among mothers within the PMTCT program with only two-thirds (67%) of all the infants who had first PCR testing breastfeeding. The EID assessment 2012 also showed that only 8% of HIV positive infants at first PCR were breastfeeding and by second PCR testing, 20% of all infants were breastfeeding. The background population burden of malnutrition is very high thus increasing demand for services.

4.2.3 Social Support and Protection

The coverage of comprehensive psychosocial services is still low. This is due to a number of factors namely: lack of funding for activities; inadequate knowledge on what constitutes a complete psychosocial support package; absence of leadership in some support groups; shifting away from emphasis on positive living activities to ART; limited knowledge among teachers, caregivers, family members and the community in handling psychosocial needs of Young People Living with HIV (YPLHIV); and lack of psychosocial support services for YPLHIV (UAC, 2013).

The quality of counselling has deteriorated. Health care providers have put more attention on achieving targets rather than quality of work. Integration of services without increasing the number of health workers has worsened the situation. The MTR 2014 indicated that PLHIV interacted with during the assessment detested the current quality of counseling they receive more particularly from the public health facilities. This was partly attributed to the overwhelming number of clients amidst few health workers. PLHIV also noted that most health care workers providing counseling services were not fully accredited to do so. Most have training in nursing or midwifery but not in professional HIV/AIDS counseling. It was noted that such health workers do not uphold the ethics and principles that guide provision of quality counseling services as they at times reveal the status of clients without their consent.

It was also reported that most community counseling and home based care services were phased out. In places where it seldom happens, it is done by PLHIV networks, which lack the required financial capacity to sustain such arrangements.

The MTR 2014 indicated that the role of PLHIV networks and expert clients in provision of counseling services was widely acknowledged and appreciated in different districts, and there was a call to see that such PLHIV get the necessary training. Proposals for government to consider inclusion of expert clients in health care delivery structure were presented. This was premised on the fact that where expert clients exist, tangible benefits have been forthcoming for example in TASO. These expert clients were applauded by PLHIV as being compassionate, empathetic as one PLHIV shared.

PLHIV have a limited access to a comprehensive service package. Although there is a well-defined package for OVC as stipulated in the NSSPI, there is no defined package for PLHIV. The NPAP recommends that the package be defined for PLHIV in order to ensure meaningful delivery of psycho and social protection services. This has not been done and therefore many CSO and government institutions are providing a varying range of services to fit in the comprehensive package. When asked what package they delivered; a significant number of respondents noted that they did not have any package for the PLHIV they were serving.

There exists limited funding for nutrition and food security related activities. As a result few organizations have scaled down food security activities and also a small number of service providers have been trained in nutrition care for PLHIV.

There is poor access to credit, loans or inputs since there exist stringent qualification procedures. Therefore few PLHIV and other vulnerable persons or groups access products from economic empowerment and microfinance schemes.

There exists little effort to promote affirmative action for PLHIV among government led development projects. It is common to exclude a PLHIV on the basis of his or her health status. Thus a number of PLHIV are surviving on unstructured support whose sustainability is very much questionable. For instance some are dependent on friends, neighbours and local church leaders.

Majority of the PLHIV especially OVC, women living with HIV have limited knowledge on their rights for example property rights, health rights. This has in part contributed to the high levels of exploitation and abuse that these girls, women and OVC are currently facing.

Programming for GBV has been marred with low reporting, documentation, and follow up and handling of SGBV and abuse cases. This could be explained by limited knowledge on what constitutes abuse; fear of animosity from the perpetrator and other members of the community; corruption; stringent procedures and high cost of litigating abuse cases; and weaknesses of the legal system in handling SGBV cases of children and fear of stigmatizing the victim (UAC, 2012a). Rural women do not usually report sexual and mental abuse by their spouses or other men for fear community stigma (CSF, 2014).

There are very few public vocational institutions and even where they exist there is deliberate provision by the national government or local governments to secure slots for OVC and other vulnerable groups to access this education freely. Essentially, BTVET (Business, technical and Vocation Education and Training) institutional programming has not been tailored to the needs of OVCs. For the private institutions are profit-motivated. It is only in CSO where OVC are prioritized but still the number supported is low compared to the number of OVC in need. On this note, it was a firm recommendation that government (central and local) should make deliberate attempts to facilitate OVC access to vocational skills training.

There still exist high levels of stigma and discrimination among PLHIV and in the wider community. Stigma and discrimination is still institutionalized as often PLHIV are excluded from government economic empowering programs, are denied from accessing credit, lose employment, and also fail to access health insurance on the basis on their health status.

There are still several socio-cultural factors that are increasing HIV stigmatization (MTR 2014).
The OVC response is still largely donor funded with little direct funding from central and Local government Closure of USAID/SUNRISE-OVC project which has been supporting most of the OVC activities is likely to leave a gap in service delivery
There is low staffing levels, coupled with high staff turnover and low motivation for community development staff. This is made worse by the current OVC coordination that stops at Sub county level yet the OVC leave in communities.

Low focus on OVC at decentralised levels because OVC and children issues are not one of the assessment areas at the district level which makes it of less priority by district administrators.

4.2.4 Infrastructure, Governance and Leadership

There is still limited capacity and interest among most political, technical and cultural leaders in championing the campaign on HIV/AIDS within their respective mandates and communities. Thus, very few of these leaders in government actively participate in matters of HIV/AIDS, which have been left in the docket of MoH and UAC. The technocrats that are involved are mainly the lower cadre who have been assigned the responsibility as focal point persons for HIV/AIDS in the sectors.

The capacity of UAC to coordinate the national multi-sectoral HIV/AIDS response is undermined by limited understanding and adoption of these policy guidelines and legal instruments, itself a function of limited dissemination of HIV/AIDS related policies, strategies and plans. When legislations come into force, there is limited effort to interpret, re-package and translate the popular versions into vernacular for wider dissemination and consumption by the public.

According to MTR 2014, it was found that coordination of HIV/AIDS in most districts is increasingly becoming monetized; at the decentralized level, most DACs are non-functional while SACs and PACs are either not established or non-functional. Only where a development partner is active and picks to fund these structures are they working. This means that without any funds, very limited coordination function can take place, even within the existing district institutions and the fact that HIV/AIDS mainstreaming/ integration is one of the key performance indicator[6] in the annual assessment manual[7] of local governments. The recent deployment of the UAC regional coordinator is just beginning to take root because where they are located, there si some activity as the UAC has provided some resources for this purpose.

Intra-sector coordination of HIV and AIDS within most sectors remain weak with the focal point persons being the lone player with 'some' knowledge on the national response that is not shared within the MDAs through meetings or electronic mechanisms. Most sectoral HIV/AIDS coordinating committees are not functional. In addition, CSO linkages with the Local Governments are still weak. Consequently, the CSO work plans are not fully aligned with national and local government plans and many CSOs are not participating in coordination meetings for HIV and AIDS implementers. Indeed, it was found that there is limited information at LGs on work being done by CSOs as most CSOs only reported to their donors.

There is no evidence to show that the NPAP is costed as an annual plan for the national response to HIV and AIDS epidemic that is subsumed into the MTEF through the budge. There is also no comprehensive and costed operational plan with clear outputs and deliverables by each sector, district etc. Indeed, there is no guidance on how to convert the strategic plan into annual results/performance based outputs that can be used to hold a sector, partners, district etc accountable. Hence, most implementers do not work according to the NSP and or sector specific

[6] The indicator looks are five issues (a) Existence of a functioning HIV/AIDS coordination office in the district (b) District development plan reflects sound analysis of HIV/AIDS issues (c) Evidence that plan implementation covers mainstreamed, as well as stand-alone HIV/AIDS interventions (d) District gives support to community based organizations to implement HIV/ AIDS interventions (e) HIV/ AIDS mainstreaming/ awareness training for district officials planned for and undertaken during the previous financial year.

[7] MOIG (2009). Assessment Manual of Minimum Conditions and Performance Measures of Local Governments. Ministry of Local Government, April 2009.

HIV and AIDS related plans; although the NSP was found in most districts, the NPAP was generally unheard off by most stakeholders particularly among the civil society.

The level of HIV and gender responsiveness of district development plans (DDPs) varies widely across districts and sectors. Thus, while gender and HIV issues are highlighted in sectors like education, health, production and marketing, sectors like works and technical services, energy, finance and administration do not pay attention to these concerns.

Despite the improvement in the capacity of the laboratories noted earlier, there are frequent shortages in laboratory supplies due to apparent absolute dependence on donor financing for laboratory supplies for critical and priority programmes. Secondly, it was found that some service providers indicate that there is still need to transport viral load testing to Kampala, which is far from upcountry sites.

4.2.5 Monitoring and Evaluation

- Lack of a comprehensive national reporting mechanism that captures biomedical and behavioral/ structural data (non-biomedical) on HIV and AIDS interventions from all actors.
- Limited popularization of the M&E plan: There is limited awareness about the reporting systems, tools and timelines.
- Insufficient tracking of the National HIV and AIDS M&E plan indicators: The indicator performance table is not routinely populated.
- Lack of standard reporting tools and schedules: Sectors have no standard data aggregation and reporting tools, and timelines that are known to them. "UAC does not appear on our reporting calendar, we are only obliged to report to the Office of the Prime Minister (OPM)", said a respondent from one of the sectors.
- Inadequate reporting on behavioral and structural community HIV and AIDS interventions (non-biomedical): Behavior change communication (BCC) and HIV Care data is not captured at the national level. There are no national tools for HIV prevention BCC and other non-biomedical interventions.
- Stock out of the National MOH registers: A number of districts said that they had run out of MOH registers saying that the revised MOH registers were supposed to be rolled out in August 2014, but this had not been done by the end of August, yet the old tools were getting used up.

- Weak coordination mechanisms and partnerships: Although the DACs were recently revitalized, they had been inactive for some years, hence affecting coordination of the response. Most of the Sub County Coordination Committees (SACs) were inactive. Limited regular coordination and review meetings with Implementing Partners (IP) to review the implementation progress.
- Limited district level HIV and AIDS M&E Funds: Some districts said HIV and AIDS had no vote in district budget; hence they rely on HIV and AIDS actors funding districts to monitor them which compromise their position and make the monitoring irregular.
- Lack of an explicit data use plan: There are no deliberate efforts in the M&E plan to step up and track data use. The information products are not necessarily tailored to different audiences.
- Insufficient M&E staffing levels at national and lower levels: The M&E unit at UAC is highly understaffed; there is no Database Manager to support users once the database is rolled out. There is no sufficient manpower to perform data collection, aggregation, analysis and use of local government and health facility; coupled with limited computer and data analysis skills.
- The implementation of online OVCMIS still experience challenges of ICT inadequacy (poor access to internet, lack of computer and computer skills by district staff)

- Limited of gender based analysis and reporting: The districts reported having gender mainstreaming sections in district plans as a requirement by MoLG, but it is hardly traced during implementation and reporting.

4.2.6 Financing and Costing

There is inadequate funding for the health sector. As indicated in the MTR 2014, although releases to the Health sector grew, the sector allocations as a proportion of the total budget decreased to 7.9% in 2012/13 from 8.9% in 2010/11. This indicates that Abuja Declaration target of 15%, and the HSSIP target of 10 % by 2015 are not likely to be met. Consequently this directly impacts on the individual disease budgets as well. Recent revisions in the treatment guidelines for ART, new technologies and approaches to tackle the HIV epidemic innovations, high population growths have exponentially increased the need HIV services. This has however not been matched with an equal increased in resources both locally and globally. A case to this effect is the conditional grants to District local governments and health units which have not significantly changed yet populations, and costs of service delivery have increased significantly.

MTR 2014 noted that the flow of resources needs to be reviewed as this impacts on program implementation. Resources from central government starts to flow rather late but at the same time the treasury requires all accounts to cease operation at the end of the financial year. It also indicated that the implementation period for Local governments is for that reason short
The report further noted that external funding such as the GFATM had it challenges with predictability of inflow. The shift to commoditisation has resulted into a less resources for Program activities and yet the GoU and partners have not been able to fully fill the gap.

Off-budget sector funding: A number of health improving activities are funded outside the sector wide mechanism yet this was established to align funding to sector priorities. This leads to efficiency losses associated with funding activities that may be duplicative or outside the priorities identified to achieve health outcomes.

Joint planning and Harmonisation of the national HIV response is still faced with some challenges. While the rationalisation of partners in terms of logistics management played a key role in streamlining the procurement system, other program activities would need to be harmonised to minimise duplicative tendencies as well.

The lack of a standard health care packages and harmonized budgeting and costing data for the HIV Response has made it difficult to compare services across different sector and implementing partners. This has resulted into wastes and missed opportunities for efficiencies gains due to duplicative nature of service delivery.

While the MOH conducts the National health accounts, the absence of the regular NASAs, creates a gap in the planning cycles as HIV funding not within the health sector cannot be captured fully.

Weaknesses in the LGs and CSOs capacity in areas of planning, leadership financial reporting, financial management. This subsequently results into poor planning, poor accountabilities of resources, These coupled with any slight disruptions in fund disbursement results into, low absorptive capacities, low service uptakes and hence inability to meet set targets.

REMEDIAL ACTIONS PLANNED TO ENSURE ACHIEVEMENT OF AGREED TARGETS:

Informed by the implementation challenges and lessons learnt the Country has developed the 2015/16- 2019/2020 National HIV strategic plan that articulates the goal, objectives and strategic actions to implemented as mechanism of addressing the challenges faced. In addition,

the national M&E Plan 2015/16-2019/2020 has been meticulously discussed to articulate the targets to be achieved and means of verification. To indeed ensure effective implementation and monitoring a two year (2015/16 -2017/2018 national action plan has been developed and clearly articulate the actions to be implemented force with.

Below is the summary of the priorities to be implemented

Prevention

1. Uganda needs to intensify effective HIV prevention, starting with testing and immediate linkage to treatment and focusing combination prevention first on key populations where we know incidence is high.
2. Scale-up biomedical and behavioral HIV prevention interventions
3. Increase safe male circumcision coverage through multiple service delivery models
4. Address Low levels of comprehensive HIV knowledge, Multiple Concurrent sexual Partnerships, Low condom use, Gender (SGBV) & Human rights
5. Define and Scale up programming for Key Populations, Adolescents and Young people
6. Design and implement National and sub national systematic Social and Behavioral Change Communications programmes including data collection

Care and Treatment

1. Focus on both pre-ART care and treatment activities for ART-eligible clients, to ensure an increasing number of PLHIV access care and support across the continuum and to decrease LTFU.
2. Improve of paediatric enrolment at all ART sites
3. Scale up of care and treatment interventions at all PMTCT sites.
4. Strengthen retention in care and adherence through community and health facility linkage using; unique patient identifiers, national IDs, DHTs and VHTs/CHWs
5. Strengthen EID to ensure that children at risk are identified, investigated, receive results and are followed-up
6. Strengthen TB/HIV and RH/HIV integration

Social Support and Protection

1. Scale up psychosocial support services to PLHIV, OVC and other vulnerable groups through community based structures
2. Strengthen the legislative, policy and programming framework for social support and protection services
3. Incorporate needs of PLHIV, OVC and other vulnerable groups including KPs into GoU and CSO development programs
4. Strengthen the Stigma reduction campaign
5. Build capacity of cultural and religious institutions in the national HIV response including psycho-social support
6. Promote interventions that are community based and driven to enhance ownership and sustainability and build capacity for community development services
7. Support implement and monitor the HIV &AIDS workplace policies
8. Revise the OVC policy which has been in use since 2004 and the National Strategic Program Plan of Interventions (NSPPI) for OVC which is expiring in 2016.
9. Continue lobbing for inclusion of OVC and Children issues as one of the assessment areas by districts.
10. Strengthen Coordination at all levels
11. Implement the recommendations of the OVCMIS assessment report.
12. Strengthen the operationalization of the National toll free child helpline.

Gender- priorities

1. Build capacity for gender and Human rights based analysis in planning/programming, implementation, monitoring and Evaluation
2. Affirmative action for community-based interventions that raise awareness and build community level capacity to change negative gender norms, beliefs and practice.
3. To ensure a well-coordinated and gender mainstreamed multi-sectoral HIV/AIDS response

Infrastructure, Governance and Leadership

1. Strengthen coordination between (i)public and non-public sector agencies, (ii) donors and central institutions and also between donors/implementing partners and districts.
2. Develop a clear strategy for repackaging, production, disseminating and monitoring the implementation of the various policies, laws and bills that have been/may be passed by central or local government as widely as possible needs to be worked out.
3. Enhance district led HIV/AIDS programming through development of District HIV/AIDS Strategic and operational plans including strengthening Information Management
4. Mobilize and strengthen capacity of community leaders (political, religious and cultural) including; Clear definition of roles and responsibilities in the HIV/AIDS response
5. Strengthen community systems (Health Unit Management Committees, Parish development Committees, Village Health Teams) to ensure ownership, sustainability through community-led programming
6. Improve the infrastructure and capacity at HC IIIs and selected HC IIs to provide comprehensive HIV/AIDS and TB services
7. Develop and implement a strategy to address disparities in human resources for health and HIV (including; education & Community services) taking into consideration both public and non-public sectors
8. Strengthen the coordination of supply chain management system through enhanced information management

Financing and Costing

1. Institute a protected funding for health services supervision and monitoring to minimize the effect of item ceilings and cuts in government budgets on requisite services support supervision and monitoring.
2. Institutionalise the bi annual NASAs to complement the NHAs.
3. Enhance periodic supervision, reporting to ensure efficient budget monitoring and Performance.
4. Map out & harmonize the GOU and Partners' planning & budgeting cycles - to ensure sustainability of existing interventions & minimize disruptions in service delivery
5. Institutionalize the tracking of resources for HIV and TB responses
6. Improve linkages of the Implementing Partners' and other stakeholders at the regional and community levels with the local governments to reduce duplication and over centralization of activities
7. Review & harmonize unit cost of HIV interventions, activities and standardize intervention packages

5.0 Support from AIDS development partners

5.1 Key support received from ADPs

The AIDS Development Partners in Uganda have continued to play a strategic role for the realisation of prevention, treatment targets. The Partners that finance about 80% of the AIDS response in the Country have sustained financial contribution of about US$500 Million per year. That have contributed to sustaining more than 700,000 PLHIV on ART treatment, in addition, there is noted improvement in systems strengthening, adoption of international guidance to national contexts. This has been achieved through provision of financial, technical and functional assistance, though the forum of AIDS Development Partners Group (ADPG)-the aggregate coordinating body for all bilateral and multilateral Agencies active in the area of AIDS in Uganda. The ADPG have continued to provide a forum for coordination between the development partners

working in the area of AIDS. The ADPs have effectively shaped the multi-sectoral AIDS response through improved coordination and harmonization of Development Partners' engagement in Uganda and greater alignment with Government of Uganda's priorities in the National Strategic Plan, processes and systems.

Table 8: AIDS Development partners Contribution to the national AIDS response

Agency	2011/12	2012/13	2013/14	2014/15	Totals
NSP estimates (Full funding)	585.35	756.33	933.2	1,136.50	3,411.37
GoU Contribution	42	42	42	42	168.00
AIDS partners Contribution					
Irish Aid	8.58	8.58	8.58	9.24	34.99
DFID	4.84	8.23	7.83	5.41	26.30
DANIDA)	7.10	7.10	7.10	7.10	28.40
SIDA	1.40	1.40	0	0	2.80
UNITAID/CHAI	11.51	9.63	7.10	2.85	31.10
PEPFAR	324.00	324.00	324.00	324.00	1296.00
UN Agencies	10.9	14.46	15.9	15.3	56.56
GFATM		41.60	37.60	51.10	130.30
Funding Gap	170.83	300.16	489.39	681.55	1641.92

The major enabling factors have been effective and constructive engagement and dialogue between the Development Partners, the Government of Uganda, Civil society and Private sector. The AIDS Development Partners continued to play a key facilitator role in the development of key national planning frameworks like the Midterm review of NSP, the development of 2015/16-2019/20 NSP, the single TB/HIV concept note and Joint Annual AIDS review. Similarly, the Government of Uganda and CSOs have participated and contributed greatly to the review of Development Partners technical assistance to the country, the development of bilateral and multilateral programme support and participation in the periodic monthly ADPs meetings.

The ADPs continued to play a major role in financing the national AIDS response. The ADPs offered targeted technical support to response management and coordination and in reinforcing implementation and scale up of specific interventions. The ADPs continue working 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, and the Civil Society Fund Steering Committee. The ADPG supported the attainment of the following objectives in 2014: Improved coordination for an effective multi-sectoral AIDS response, Harnessed and contributed to Government efforts in reduction of new infections, Supported roll-out and implementation of NEW ART guidelines, Supported systems for improved delivery of HIV services, social support and protection for orphans and vulnerable children and PLHIV. In 2014, the country experienced setbacks in the ADP financing largely due to the general global financial resource contraction with most ADPs levelling funding, reduced or left out HIV as their funding priority. The passing of the anti-homosexual Bill also worsened the situation with budget re-allocation and holding on some funding. Despite these shortcomings

5.2 Key concerns in relation to ADP support

- Low and unclear domestic funding for the response

- Legal limitations for access to HIV services by the MARPS
- Low burn rate of funds by implementing entities
- Accountability of funds for the response is still poor and comes late
- Performance targets need to be defined early and harmonised across all actors in the response

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

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. The ADPs will in the next five year support government in the realisation of the AIDS Trust Fund, so as to eventually increase the Government contribution to HIV and cover the financing gap as forecasted the Investment case.

Table 9: Projected Resources Availability and Funding Gap

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Totals
	US $ Millions												
Investments case need	521.80	730.70	874.10	1,017.50	926.70	926.70	924.20	854.60	860.50	866.10	872.10	877.60	**10,252.60**
GOU/ Domestic resources	53.00	56.00	56.00	56.00	56.00	56.00	56.00	56.00	56.00	56.00	56.00	56.00	**669.00**
Bilaterals													
Irish Aid	15.64	8.54	8.54	8.54	8.54	8.20	7.86	7.52	7.17	6.83	6.49	5.12	**98.99**
DFID -	6.50	8.10	8.10	8.10	8.10	7.78	7.45	7.13	6.80	6.48	6.16	4.86	**85.56**
DANIDA	7.10	7.10	7.10	7.10	7.10	6.82	6.53	6.25	5.96	5.68	5.40	4.26	**76.40**
SIDA	2.60	2.30	2.30	2.30	2.30	2.21	2.12	2.02	1.93	1.84	1.75	1.38	**25.05**
PEPFAR	358.00	324.00	324.00	324.00	324.00	311.04	298.08	285.12	272.16	259.20	246.24	194.40	**3,520.24**
Mutilateral													-
UNITAID / CHAI	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	**9.60**
UN Agencies	28.30	20.50	20.50	20.50	20.50	20.50	20.50	20.50	20.50	20.50	20.50	20.50	**253.80**
GFATM		75.00	95.00	95.00	95.00								**360.00**
Total Commitments	**471.94**	**502.34**	**522.34**	**522.34**	**522.34**	**413.34**	**399.34**	**385.34**	**371.33**	**357.33**	**343.33**	**287.32**	**5,098.63**
Funding Gap	**49.86**	**228.36**	**351.76**	**495.16**	**404.36**	**513.36**	**524.86**	**469.26**	**489.17**	**508.77**	**528.77**	**590.28**	**5,153.97**

Source: Uganda HIV Investment case

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.

The AIDS Development Partners will supplement and compliment the Government of Uganda for actual realization of the implementation of the HIV Investment Case, by rapidly scaling up selected combination interventions, with a focus on targeting location and populations that remain the key bleeding grounds. This will be further aligned to the global targets to realize a 90% reduction in new adult HIV infections, zero new infections among children, 90% reduction in stigma and discrimination faced by PLHIV, and 90% reduction in AIDS related deaths.

In particular the ADPs will purpose to achieve the following: Improve coordination for an effective multi-sectoral AIDS response; harness and contribute to Government efforts in reduction of new Infections, support epidemic control, support systems for improved delivery of HIV, contribute the strengthening and scaling up of comprehensive adolescent services under the DREAMS, ALL IN initiatives and accelerating HIV service delivery FOR Fishing communities

VII 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'

The approach to monitoring the HIV epidemic in well described in the NSP, The National HIV prevention strategy, the National M&E Plan, NPAP and all sector strategic Plans. There are challenges with the reporting systems and periodic reports are either non-existent, of poor quality or very much delayed for guiding decision making. In Uganda, there is need for operational plan or research agenda for national priorities and improvement on the ongoing initiatives to sharing of lessons learned and best practices.

1) **Organisational structure:** UAC had instituted a fairly equipped M&E Unit. The key sectors, which contribute data, were using electronic national databases.

2) **Human capacity for HIV M&E:** There was dedicated and trained M&E staffs at UAC and two zones, there is a Strategic Information (SI) team at ACP/MOH, and 12 regional performance monitoring teams. There are M&E Units in all sectors levels, as well as M&E units at implementing partners (IP) level. Health Center (HC) IIIs and above had Records Assistants who manage data and Bio-Statisticians manage the Health Management Information System (HMIS) data.

3) **Partnerships to plan, coordinate and manage the HIV M&E System**: There is a multi-sectoral M&E TWG and Self-Co-ordinating Entities (SCEs); the District Health Information System (DHIS 2) and President's Emergency Plan for AIDS Relief (PEPFAR) reporting systems were harmonized. The PEPFAR data management system {the HIV Based Real Time Database (HIBRID)} heavily supported the rolling out of the DHIS 2. The HMIS was revised to be responsive to both government and partner reporting requirements. The multi-sectoral annual Joint AIDS Review (JAR) and regional review meetings provide a good forum for interaction and reviewing progress, challenges and making program improvement decisions. Implementing partners were supporting districts to ensure DHIS 2 functionality. Most District AIDS Committees (DACs) had been revitalised.

4) **Annual Costed National HIV/ AIDS M&E Work Plan**: There was a costed M&E Plan, which was 7% of the total NSP cost.

5) **Routine HIV Programme Monitoring**: Routine Process and Output Monitoring is done by the sector databases though not on all NSP M&E plan indicators are reported on. Routine data is disaggregated by sex, age and type of service. There are standardised national data collection tools for both public and private sector and the country is progressively shifting manual to web based reporting systems that provide real-time data. These data bases have been rolled out at lower levels and this improved sector reporting rate in the main sector databases of DIHS2 in the MOH and OVCMIS.

6) **National and sub-national HIV Databases:** The HMIS, Education Management Information System (EMIS) and DHIS2 were functional and were regularly updated. OVCMIS implemented in all 112 districts, the capacity of district staff has been strengthened to collect, analyse and utilise data for planning and advocacy for OVC issues. A detailed OVCMIS assessment was also done and we hope it will inform proper implementation of OVCMIS.
To support evidence based coordination, the National AIDS Documentation and Information Centre was revitalised. NADIC is a Knowledge management unit within the Uganda AIDS

Commission whose mandate is to coordinate the flow of strategic information and serve as a one stop Centre for HIV and AIDS information in the country. The National AIDS Documentation and Information Centre (NADIC) underwent a capacity assessment in 2012 with an aim of enhancing its performance.

Following the assessment, a systems strengthening proposal for NADIC was implemented in 2013 and 2014. The following are some of the achievements realized in the year 2014:

- **E-mapping Database:** The country wide electronic mapping database for HIV and AIDS Stakeholders developed earlier in 2013 was updated and a section to cater for the community data component included and testing of concept was done. The electronic mapping database provides information about all HIV and AIDS Stakeholders in the response including areas of operation especially of behavioural and structural interventions up to sub-county level. It can be accessed via the Uganda AIDS Commission Website; www.aidsuganda.org. Details of actual data management are being worked out.

- **HIV and AIDS Knowledge & Information Management Portal:** An online resource center was developed to enhance access to HIV and AIDS information resources by all stakeholders. The resource centre, known as the HIV and AIDS Knowledge Management Portal houses key databases in the Uganda AIDS Commission and allows for interaction with HIV/AIDS stakeholders through the Social media. This portal also allows for access to strategic and policy documents on HIV and AIDS. The Resource center can also be accessed via the Uganda AIDS Commission Website, www.aidsuganda.org.
- **Research Repository:** A National HIV and AIDS research database was developed to ease access to all HIV/AIDS research conducted in Uganda. This was done in partnership with the Research, Academia and Sciences Professional entity which coordinates research on behalf of Uganda AIDS Commission. The database has over 400 peer reviewed articles and continues to be updated. The database serves as a repository for research and will also support the development of a National AIDS Research Agenda.
- **Knowledge and Information Management Policy:** A Knowledge and Information Management policy was developed to provide guidance to all stakeholders in the Response. Development of the strategy and information management toolkit has been started following recent approval of the policy.
- **Capacity Building**: The staffs at Uganda AIDS Commission were introduced to methods to gather/collate, synthesize/translate and share HIV and AIDS information enable them respond to the expectations of the various stakeholders. Plans are almost final to provide the tools and train them in knowledge management planning, coordination and actual technics so that most of the tasks can be fully handled in house.
- There is need to scale up the data bases to more facilities and institutions to improve on quality and timeliness of the data.

7) **Advocacy, communication and culture for HIV M&E**: There is a supportive M&E culture and most of the AIDS Development Partners (ADPs) are willing to support the M&E functions.

8) **Surveys and surveillance for Impact Evaluation**: There are routine and impact evaluations done to monitor the response in the country. The MoH HIV surveillance system tracks the impact of HIV programmes in the country based on HIV prevalence although is adapting measures of new HIV infections (HIV incidence). The last report was released in 2010. Data

from the ANC sentinel surveillance sites for the period 2010 to 2014 is available. The country conducted EPP and Spectrum to estimate recent infections in March 2014. The next MoT analysis is underway which will also provide additional information on HIV incidence and modes of transmission in 2008 and this assessment is part of this effort Additional information through collaboration with research programmes conducting sub-national population-based serological surveys for the general population in Rakai and Masaka provide HIV incidence and prevalence estimates among the respective longitudinal cohorts. Other HIV sero-prevalence information is obtained from serological surveys targeting specific population groups. More recently, surveys were conducted among sex workers and their clients, university students, plantation workers, fisher folk etc, although current estimates vary widely. Preparations for the demographic and health surveys (DHS) which provide very useful data on HIV/AIDS indicators as well as HIV/AIDS-related behavioural indicators started in 2014

9) **M&E support supervision and data quality assessments** – Some support supervision and data quality assessments (DQAs) were conducted.

10) **Data dissemination and use:** Program data was used for decision making for instance in making ART and HCT stock projections. There is timely reporting against the national and international obligations.

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

Although there have been efforts to improve the functioning of the national comprehensive M&E systems, several assessment have indicated outstanding constraint. The 2014 MTR for the NSP and HSSIP, the PEPFAR APR 2014 and the JUPSA 2014 have all emphasised areas to focus on for better evidence based response in all components of the health systems implementation.

- Lack of a comprehensive national reporting mechanism that captures biomedical and behavioral/ structural data (non-biomedical) on HIV and AIDS interventions from all actors.
- Limited popularization of the M&E plan: There is limited awareness about the reporting systems, tools and timelines, this is coupled with insufficient tracking, poor data management, storage and retrieval at facility level.
- Access to the national HMIS system was poor making it hard for district partners monitor their support to the national system.
- Lack of standard reporting tools and schedules: Sectors have no standard data aggregation and reporting tools, and timelines that are known to them. “UAC does not appear on our reporting calendar, we are only obliged to report to the Office of the Prime Minister (OPM)”, said a respondent from one of the sectors.
- Inadequate reporting on behavioral and structural community HIV and AIDS interventions (non-biomedical): Behavior change communication (BCC) and HIV Care data is not captured at the national level. There are no national tools for HIV prevention BCC and other non-biomedical interventions.
- Stock out of the National MOH registers: A number of districts said that they had run out of MOH registers saying that the revised MOH registers were supposed to be rolled out in August 2014, but this had not been done by the end of August, yet the old tools were getting used up.
- Weak coordination mechanisms and partnerships: Although the DACs were recently revitalized, they had been inactive for some years, hence affecting coordination of the response. Most of the Sub County Coordination Committees (SACs) were inactive. Limited regular coordination and review meetings with Implementing Partners (IP) to review the implementation progress.
- Limited district level HIV and AIDS M&E Funds: Some districts said HIV and AIDS had no vote in district budget; hence they rely on HIV and AIDS actors funding districts to monitor them which compromise their position and make the monitoring irregular.

- Insufficient M&E staffing levels at national and lower levels: The M&E unit at UAC is highly understaffed; there is no Database Manager to support users once the database is rolled out. There is no sufficient manpower to perform data collection, aggregation, analysis and use of local government and health facility; coupled with limited computer and data analysis skills.
- Limited of gender based analysis and reporting: The districts reported having gender mainstreaming sections in district plans as a requirement by MoLG, but it is hardly traced during implementation and reporting.
- The national and partner HIV/AIDS M&E systems, plans and indicators for tracking various aspects of HIV prevention focus on outputs and processes of biomedical HIV prevention services. Behavioural and structural interventions do not appear to have well developed processes for tracking outputs and processes. The reporting systems are underdeveloped, sometimes duplicated and compilation and timely dissemination of the information to stakeholders is still weak
- Although process monitoring is often done, there are usually no national annual targets to compare performance against. The efforts to develop national and district level targets through the MoH are not yet complete.
- Although there are indicators for tracking various aspects of HIV prevention, and they align with international indicators, they are not regularly reviewed to ensure adequate performance monitoring of the evolving HIV prevention needs. For instance, standardised indicators are needed for monitoring of new interventions such as combination HIV prevention, assessing new demands, e.g. unmet need for family planning, tracking of structural interventions, sero-sorting of interventions, etc.
- The planned impact evaluation of combination HIV prevention was not done, yet it would have provided empirical data to inform for scale up of combination HIV prevention.

6.3 Remedial actions planned to overcome the challenges

The remedial actions are aligned to the recently finalised NPAP 2015-2018 and NSP 2015/16-2019/20 **as described below:**

Objective 1 is to strengthen the national mechanism for generating comprehensive, quality and timely HIV/AIDS information for M&E of the NSP 2015/16-2019/20

The key actions planned for Monitoring and Evaluation in the next period will include:

1. Operationalize and roll out the National HIV/AIDS M&E Database through training users, popularizing the database, ensuring regular data entry and cleaning and recruiting a Database Manager.
2. Establish mechanisms for capturing community data from non-government implementers, particularly the non-biomedical interventions. Appraise the three proposed options: incorporating and betting non-biomedical data from sectors, OPM or establishing a system to capture that at UAC.
3. Increase the M&E Staffing to ensure that more time is dedicated to data analysis, dissemination and use.
4. Support comprehensive preparation of the next GARPR as the last report on targets for HLM and the MDG.
5. Capacity building for sector M&E staff and HIV&AIDS Focal Persons
6. Support the process of stakeholder consensus on national targets at outcome and output level with appropriate disaggregation.
7. Finalise the indicate definitions for the national M&E plan.
8. Conduct the impact evaluation of combination HIV prevention

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

There will be need for TA to conduct Drug Resistance survey, preparing and synthesis of the next GARPR 2015, further building of the national capacity for epidemic modelling and projections and impact evaluation of combination HIV prevention

ANNEXES

ANNEX 1: Consultation and preparation process for the country report

Uganda initiated the report-writing process for the Global AIDS Response Country Progress Report (GARPR) in early 2015. The UAC, in collaboration with, MOH Uganda, UNAIDS and other members of the Joint UN Team on AIDS, started the process by writing Team which included representatives from the UAC,ACP, USG, UN agencies (UNICEF, UNODC, and WHO), and civil society organizations (CSOs): The first meeting of the TWG took place beginning February 2015 in which members of the writing team agreed upon the relevant indicators to report on, the timeline and process of data collection, analysis, validation and report-writing. The data on core indicators was compiled and submitted online on by 31st March 2015.

Validation and consensus on the indicators and narrative were reached with national, sub-national stakeholders representing the Government, UN agencies, CSOs and Non-Governmental Organizations (NGOs) in a National Consultation held 4th June 2015 at Hotel Africa Uganda. Inputs received during the meeting were incorporated. A final meeting of the writing team was held virtually on 10th June 2015 following the national consultation to review the final draft, ensure inputs from the consultation were incorporated and to sign off on the final draft before submission.