THE REPUBLIC OF UGANDA

The National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/1 - 2005/6

Partners

Government of Uganda
Uganda AIDS Commission
Joint United Nations Programme on AIDS
Other Stakeholders in HIV/AIDS

March, 2000

TABLE OF CONTENTS

List of Acronyms iii
Executive Summary vi

CHAPTER ONE
INTRODUCTION
1.1 Introduction 1
1.2 Government Policy on HIV/AIDS 1
1.3 Focus of the National Strategic Framework (2000/1-2005/6) 1
1.4 Purpose of the Framework 2
1.5 HIV/AIDS in Government Planning 2
1.5.1 The Poverty Eradication Action Plan (PEAP) and the Uganda Vision (2025) 2
1.5.2 The National Health Policy 3
1.5.3 The Local Government's Act of 1997 3
1.6 Goals of the National Strategic Framework 2000/1-2005/6 3
1.7 Process of Drafting the National Strategic Framework 3
1.8 Institutional Arrangements 4
1.9 Layout of the National Strategic Framework Document 5

CHAPTER TWO
STATUS AND IMPACT OF HIV/AIDS
2.1 Special features of HIV/AIDS 6
2.2 Uganda's HIV/AIDS Status 6
2.2.1 Mode of Transmission 6
2.2.2 Risk Factors 7
2.2.3 Predisposing Factors 7
2.2.4 Incidence and Prevalence 7
2.2.5 HIV Prevalence/AIDS Cases 8
2.2.6 HIV Incidence 10
2.2.7 Under-five Children 10
2.2.8 Young People aged 10-24 years 11
2.2.9 Women 11
2.2.10 Men 12
2.2.11 HIV/AIDS and Culture 12
2.2.12 HIV/AIDS and Migration 12
2.3 The Impact of HIV/AIDS 13
2.3.1 HIV/AIDS and the under-five Children 13
2.3.2 HIV/AIDS and Young People aged 10.24 13
2.3.3 HIV/AIDS and Women 14
2.3.4 HIV/AIDS and the Community 14
2.3.5 HIV/AIDS and the Health Sector 15
2.3.6 HIV/AIDS and Productive Labour 16
2.3.7 HIV/AIDS and the Workplace 16
2.3.8 HIV/AIDS and Regional Affiliation 17

CHAPTER THREE
REVIEW OF PROGRESS
3.1 Government Response 18
3.2 Review of progress 19
3.2.1 Goal I: Reduce the rate of HIV infection 19
3.2.2 Goal II: Mitigate the Health and Socio-economic impacts of HIV/AIDS at individual, household and community levels 25
3.2.3 Goal III: To strengthen the national capacity to respond to the epidemic 29

3.3 Summary of findings and priorities areas for the period 2000/1 – 2005/6 32
3.3.1 Findings 32
3.3.2 Priority Areas for 2000/1 - 2005/6 33

CHAPTER FOUR
RECOMMENDATIONS FOR 2000/1 – 2005/6
4.1 Introduction 34
4.1.1 To reduce HIV prevalence by 25% by the year 2005/6 34
4.1.2 To mitigate the health and socio-economic effects of HIV/AIDS at the individual, household and community level 34
4.1.3 To Strengthen the national capacity to respond to the HIV/AIDS epidemic 34
4.2 Strategies and Activities for 2000/1 – 2005/6 35
4.3 Lead Actors in the Log frame 35
4.4 Costing 36
4.4.1 Background 36
4.4.2 Basic Assumptions 36

CHAPTER FIVE
IMPLEMENTATION AND COORDINATION
5.1 Implementation 68
5.2 Co-ordination 68
5.2.1 Mandate, Mission and Functions of UAC 68
5.2.2 Co-ordination Mechanisms 69

CHAPTER SIX
MONITORING AND EVALUATION
6.1 The Context 72
6.2 Organisational Linkages for Monitoring and Evaluation 72
6.3 Outstanding Gaps 73
6.4 Recommendations for Monitoring and Evaluation 74

REFERENCES 75
APPENDIX I COSTING AND FINANCIAL ANALYSIS 77
APPENDIX II REVIEW AND COSTING TEAM OF THE NATIONAL STRATEGIC FRAMEWORK 2000/1 – 2005/6 78

LIST OF ACRONYMS

ACP	:	AIDS Control Programme
AIC	:	AIDS Information Centre
AIDS	:	Acquired Immunodeficiency Syndrome
ANC	:	Antenatal Clinic
ART	:	Anti-Retroviral Therapy
AZT	:	Zodovidine
CBOs	:	Community Based Organisations
CD-ROM	:	Compact Disc Read Only Memory
CG11	:	Core Group of Eleven Members
CHUSA	:	Church Human Services for the Province of the Church of Uganda
COMESA	:	Common Market for Eastern and Southern Africa
DACCs	:	District AIDS Co-ordination Committees
DFID	:	Department for International Development, UK
DHT	:	District Health Team
DIBs	:	District HIV/AIDS Information Bases
EAC	:	East African Co-operation/Community
EP	:	End-of-Programme
ESAs	:	External Support Agencies
FALP	:	Functional Adult Literacy Programme
FOCA	:	Friends of Children Association
FP	:	Family Planning
GLIA	:	Great Lakes Initiative on AIDS
GOU	:	Government of Uganda
GTZ	:	German Development Co-operation
HBC	:	Home-Based Care
HIV	:	Human Immunodeficiency Virus
IDEAs	:	Information, Discovery and Solutions Limited
IDP	:	Internally Displaced Persons
IEC	:	Information, Education and Communication
IGADD	:	Inter Governmental Authority on Drought and Development
IGPs	:	Income Generating Projects
ISAE	:	Institute of Statistics and Applied Economics
IMAU	:	Islamic Medical Association of Uganda
JCRC	:	Joint Clinical Research Council
KABP	:	Knowledge, Attitude, Beliefs and Practices
LCs	:	Local Councils
MACA	:	Multi-Sectoral Approach to the Control of AIDS
MCH	:	Maternal and Child Health
MISR	:	Makerere Institute of Social Research
MIS	:	Management Information System
MoE & S	:	Ministry of Education and Sports
MoFA	:	Ministry of Foreign Affairs
MoFPED	:	Ministry of Finance, Planning and Economic Development
MoGLSD	:	Ministry of Gender, Labour and Social Development

MoH	:	Ministry of Health
MoI	:	Department of Information, Office of the President
MoIA	:	Ministry of Internal Affairs
MoJ	:	Ministry of Justice
MoLG	:	Ministry of Local Government
MoPS	:	Ministry of Public Service
MoTTI	:	Ministry of Trade, Tourism and Industry
MRC	:	Medical Research Council
MSI	:	Marie Stopes International
MTCT	:	Mother-to-Child Transmission
NACWOLA	:	National Community of Women Living with HIV/AIDS
NADIC	:	National Documentation and Information Centre
NCC	:	National Council for Children
NCPA	:	National Committee for the Prevention of AIDS
NDA	:	National Drug Authority
NGEN+	:	National Guidance and Empowerment of people living with HIV/AIDS
NGOs	:	Non Governmental Organisations
NHRB	:	National HIV/AIDS Research Body
NJPT	:	National Joint Planning Team
NOP	:	National Operational Plan
NOTU	:	National Organisation of Trade Unions
NURP	:	Northern Uganda Reconstruction Programme
PEAP	:	Poverty Eradication Action Plan
PEARL	:	Programme for Enhancing Adolescent Reproductive Life
PHA	:	Persons Living with HIV/AIDS
PHC	:	Primary Health Care
PLI	:	Philly Lutaaya Initiative
PTA	:	Preferential Trade Area
REACH	:	Reproductive, Educative and Community Health Project
RH	:	Reproductive Health
SACCs	:	Sub-county AIDS Co-ordination Committees
SOMARC	:	Social Marketing for Change
STD	:	Sexually Transmitted Disease
STIs	:	Sexually Transmitted Infections
SWOT	:	Strength, Weaknesses, Opportunities and Threats
TASO	:	The AIDS Support Organisation
TB	:	Tuberculosis
TBAs	:	Traditional Birth Attendants
THETA	:	Traditional and Modern Health Practitioners together against AIDS
UAC	:	Uganda AIDS Commission
UDHS	:	Uganda Demographic and Health Survey
UGANET	:	Uganda Network on Law and Ethics
UNAIDS	:	United Nations Joint Programme on AIDS
UNASO	:	Uganda Network for AIDS Service Organisations
UNCST	:	Uganda National Council for Science and Technology
UNDP	:	United Nations Development Programme

UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations Children Fund
USAID	:	United States Agency for International Development
UVRI	:	Uganda Virus Research Institute
UWESO	:	Uganda Women Efforts to Save Orphans
UYNAS	:	Uganda Youth Network on AIDS and STD
WHO	:	World Health Organisation

EXECUTIVE SUMMARY

This document is a review of past performance and a statement of the nation's planned response to the HIV/AIDS problem particularly in the period 2000/1 - 2005/6. This report is sequel to and builds upon similar previous documents, namely; the Multi-sectoral Approach to the Control of AIDS (MACA) concluded in 1993; and a National Operational Plan for HIV/AIDS/STD Prevention, Care and Support 1994 - 1998. A National Strategic Framework for HIV/AIDS activities was drawn up to cover the period 1998 - 2002. However, subsequent review and utilisation indicated that the document had a number of gaps. In particular, there was a need to place the HIV/AIDS problem in the broader context of national development and relate it to other national policies on health and the poverty eradication Programme. This report addresses some of the gaps and updates the previous document.

The National Strategic Framework for HIV/AIDS Activities (2000/1 - 2005/6) in Uganda was an outcome of a protracted process of consultation among a wide range of stakeholders involved in the field of HIV/AIDS in Uganda. This included government and non-governmental organisations (NGOs), networks and associations of persons living with HIV/AIDS (PHAs), research institutions; religious and socio-cultural institutions; individuals knowledgeable in the field of HIV/AIDS and a team of consultants1. The process also benefited from inputs from ACPs of line ministries that were simultaneously undertaking their planning exercises.

The objectives of the National Strategic Framework are:

- To provide a brief review of trends in HIV sero prevalence;
- To describe the efforts undertaken to mitigate the adverse health and socio-economic efforts of the epidemic in Uganda;
- To provide overall guidance for activities geared towards preventing the spread of HIV/AIDS and mitigating its effects;
- To serve as the basis for the mobilisation of resources to implement the national AIDS Programme.

This framework comprises of six chapters. Chapter one traces the national response to HIV/AIDS since 1982 when the disease was first identified. The government has been consistently vigilant and the response has been characterised by a policy of openness and has benefited from support and commitment from the highest level of Government. There is full recognition that HIV/AIDS has far-reaching consequences beyond the health sector.

Chapter two gives the situation analysis of the HIV/AIDS problem. It contains information on trends, differentials by age, sex, and geographical regions. Chapter three reviews the progress made so far, identifies the critical needs and makes recommendations. In the fourth chapter, the recommended actions are cast in a log frame format indicating the activities, key players, indicators, means of verification and a list of *sine qua non* conditions for carrying out these activities. Chapter five gives the implementation and co-ordination arrangement for HIV/AIDS activities. The sixth chapter makes suggestions for monitoring and implementation.

Major findings

The main observations made in this report include the following:

- There has been an overall decline in HIV positive sero prevalence rates observed at designated sentinel points;
- The decline in HIV positive sero prevalence rates has led to a convergence of rates between the various categories of the population (e.g. rural-urban, and the geographic regions of the country);
- Surveillance data is mainly based on blood samples from women attending ante-natal clinics, and sero prevalence rates for large sections of the population remain uncertain (i.e. children, men, and post menopausal women);
- Despite the acknowledged decline in sero- prevalence rates, the mechanisms that produced this reduction are not fully understood. Owing to weak monitoring, it is not possible to apportion the observed decline between the three factors of abstaining, being faithful to one's partner, and condom use;
- Although HIV sero prevalence declined from 30 to about 10 per cent between 1992 and 1996, it appears to have stagnated since then. A sero prevalence rate of 10 per cent is still high given that HIV/AIDS results in certain death;
- The HIV/AIDS interventions did not fully benefit from reference to a common national Programme of action. As a

1 Emmanuel Sekatawa (Ph.D.), Stephen K. Kiirya , Fred Odongkara and Eniola Adiniyi (Professor).

result, a number of agencies and line ministries did not make their due contribution;

- Government has introduced a decentralisation policy, which has *inter arlia* devolved public service delivery to local governments. This policy has brought the issues of HIV/AIDS closer to the grassroots and local governments should play an active role in the implementation of parts of the National Strategic Framework. Local governments are also encouraged to design interventions specific to their jurisdictions and in response to the special nature of their HIV/AIDS problem;
- The HIV/AIDS problem has clear adverse implications for the attainment of national goals for socio-economic development. For some sectors, HIV/AIDS threatens to erode the achievements already made. At the individual level, the failure to access prompt treatment for opportunistic infections prevents PHAs from full participation's in social and economic activities;
- HIV/AIDS spread is influenced by trends in neighbouring countries. For example, civil conflict, which may lead to an influx of refugees, would also affect Uganda's ability to control the spread of the disease. Similarly, lack of access to condoms in other countries would have a direct bearing on HIV/AIDS trends in Uganda.

Recommendations

- The current sero prevalence rate (of about 10 per cent) is still high and is no cause for complacency, especially given the fact that HIV/AIDS still has no cure. To implement the necessary interventions would require a corresponding increase in resources devoted to HIV/AIDS. This would mean increased donor funding as well as greater budgetary allocations by both national and local government administrations. In addition, other potential sources of funding, such as the private sector, should be explored. In this regard, advocacy and IEC should play a leading role in ensuring that HIV/AIDS issues are kept high on the national and district agendas for social and economic advancement;
- The country should pursue a coherent national Programme on HIV/AIDS. In this context, a mechanism for monitoring and evaluation should be established and located within the UAC and be made integral to the implementation of this National Strategic Framework. Other implementing agencies should also undertake the monitoring function as part of their respective operations.
- As part of the monitoring strategy early during the plan period (2000/1 - 2005/6) a baseline survey of the sero prevalence rate of the general population should be undertaken. This should be done in conjunction with an inquiry to ascertain the Knowledge, Attitude, Beliefs and Practices (KABP) regarding HIV/AIDS. These should be repeated at mid-term and at the end of the plan period to gauge the efficacy of the interventions;
- In recognition of the decentralisation policy, local governments should review their respective HIV/AIDS situation and design appropriate interventions to fulfil their mandates;
- In view of the foreseen increase in the number of PHAs, more resources should be devoted to ensuring greater access to prompt treatment of the opportunistic infections related to HIV/AIDS. Young people (10 – 24 years old) are particularly vulnerable to STD and HIV infection because they often lack awareness, materials or skills for protection against HIV infection. They should also be considered a priority target group in this phase of the national response; and
- Given the international nature of the HIV/AIDS problem, regional efforts to combat the disease such as GLIA should be fostered.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter describes government policy on HIV/AIDS, states the purpose of the Framework and indicates the role of HIV/AIDS in government planning. The goals of the National Strategic Framework 2000/1 - 2005/6, the process that was followed in the development of the Framework, and the layout of the document are stated.

1.2 Government Policy on HIV/AIDS

A structured Government response to the HIV/AIDS epidemic dates back to 1986 when an AIDS Control Programme (ACP) was created in the Ministry of Health. This was the result of the work of a committee constituted in 1985 to promote resource mobilisation. In recognition of the fact that HIV/AIDS has causes and consequences far beyond the health sector, the Uganda AIDS Commission (UAC) was constituted in 1992 by Statute of Parliament and placed under the Office of the President. By 1994, UAC had prepared a Multi-sectoral Approach, called MACA, and a National Operational Plan to be used as guidelines for project implementers. In order to strengthen the multi-sectoral approach, Programs for AIDS Control (ACP) were created in 12 other line ministries.

Government response to HIV/AIDS is based on the fact that AIDS affects all strata of the population, and poses a serious threat to the socio-economic life and development of the country. The national response to HIV/AIDS has therefore been characterised by a policy of openness backed by effective political and resource support from the highest level of Government.

The government policy of openness and political commitment to HIV/AIDS control has created high levels of awareness in the population about the dangers of the epidemic and possible means of prevention. The establishment of UAC and the creation of AIDS control programs outside the health sector have strengthened the multi-sectoral response to the epidemic.

1.3 Focus of the National Strategic Framework (2000/1 - 2005/6)

Although much has been achieved in terms of creating awareness of HIV/AIDS, promoting testing and facilitating care for those infected, a lot needs to be done to reduce HIV infection further and mitigate the socio-economic impact of the epidemic at individual, household and community levels.

The impact of the epidemic has been felt in several sectors. Although AIDS is not diagnosed as a disease, it is the principal underlying factor for a number of diseases including TB, meningitis, and several opportunistic infections. In the health sector, HIV/AIDS has increased the demand for health care and drugs and has exerted immense pressure on scarce resources. This has reduced the accessibility of health care for everyone, and hurt the poor more (Kayita & Kyakulaga, 1997).

One of the most visible and immediate social impacts of the epidemic is the rapidly growing number of AIDS orphans. In 1998 it was estimated that a cumulative total of 1.9 million Ugandan children had lost either one or both parents due to AIDS (UNAIDS, 1998). Given that HIV infected persons will continue to progress to full-blown AIDS and die, this figure is likely to increase. Although relatives have largely been absorbing the burden of AIDS orphans, surveys suggest that extended family caregivers are over-stretched by the ever-increasing number of orphans. The children affected by HIV/AIDS are still exposed to stigmatisation and neglect. When orphaned, gender disparities and cultural practices tend to render the girl child particularly exposed to exploitation and heavy responsibilities, especially in areas of housekeeping and agricultural production. Poverty and

orphaned also expose the girl child to a greater risk of HIV infection through early marriage, sexual abuse, and prostitution.

The AIDS epidemic has also adversely affected the economic sector. Unlike other illnesses, it selectively affects adults in their prime productive years. Sickness and death due to HIV/AIDS affects places of work through absenteeism and loss of skilled or trained employees. At the household level treatment cost of AIDS financed from household savings reduce the capital available for investment in agriculture, education and other areas. Furthermore, the time spent by relatives on care for AIDS patients is deducted from the time spent on production and income generating activities. This tends to worsen poverty and increases inequality.

Various sectors and line ministries have played an important role in HIV/AIDS prevention, care and mitigation of the socio-economic impact of HIV/AIDS during the last decade. Therefore, this National Strategic Framework recognises that HIV/AIDS should be integrated into all aspects of developmental work, service provision, planning and implementation by line ministries, local governments, religious and cultural organisations, the private sector and NGOs/CBOs. The framework is the national guideline and source of inspiration to the sector wide HIV/AIDS planning and implementation and lays emphasis on collaboration and co-ordination among all stakeholders working towards HIV/AIDS prevention and care.

1.4 Purpose of the Framework

The purpose of the national Strategic Framework for HIV/AIDS activities in Uganda for 2000/1 - 2005/6 is to:

- Relate the fight against HIV/AIDS to the development goals and action plans particularly the Vision 2025 and Poverty Eradication Action Plan (PEAP);
- Bring to the fore the active involvement of all stakeholders in the planning, management, implementation, monitoring and evaluation of HIV/AIDS interventions over the 2000/1 - 2005/6 period;
- Establish indicators for measuring the progress and impact of HIV/AIDS interventions in the country with a view to taking appropriate action for the subsequent plans;
- Provide a basis for costing and mobilisation of resources for HIV/AIDS interventions in Uganda.

1.5 HIV/AIDS in Government Planning

Given the pervasive effect of HIV/AIDS on the social and economic life of the country, and its implications for implementing poverty eradication strategies, the framework is to be seen as subordinate and complementary to key policy documents and action plans to fight poverty in Uganda. These include the Poverty Eradication Action Plan (PEAP), the National Health Policy and the Local Government's Act of 1997.

1.5.1 The Poverty Eradication Action Plan (PEAP) and the Uganda Vision 2025

The PEAP is the principal guide to all developmental activities of the central and local governments in Uganda in the medium term. Vision 2025 outlines the national aspirations in the long term and provides the context in which shorter term plans are drawn. The PEAP and Vision 2025 set out the commitment of the Government to reduce the incidence of absolute poverty to 10 percent and relative poverty to 30 percent of the total population by the year 2017. The fact that HIV infection rates are still high poses a serious threat to what has been achieved already in reducing poverty and is an obstacle to the realisation of national goals. Within the context of PEAP, the fight against

HIV/AIDS will therefore require a multi-sectoral approach and be an integral part to efforts aimed at poverty eradication and overall developmental activities in Uganda.

1.5.2 The National Health Policy

The National Health Policy is based on the philosophy that for development to be sustainable, health and economic growth must be mutually reinforcing. The overall goal is the attainment of a good standard of health by all people in Uganda, in order to promote a healthy and productive life. The National Health Policy therefore provides a major reference point for the development of this National Strategic Framework.

This Framework is consistent with the National Health Policy and further articulates the interventions specifically related to the HIV/AIDS problem. The Framework also integrates the health and bio-medical aspects of HIV/AIDS with its other ramifications including those among the non-infected.

1.5.3 The Local Government's Act of 1997

The focus of the Local Government's Act is the decentralisation of governance and service delivery with devolution of powers to the Districts. The central government is responsible for policy, setting standards, and providing guidelines. As a result, some responsibilities for HIV/AIDS prevention and care have also been transferred to the Districts. Recognising the devolution of powers to the Districts, this Framework seeks active participation of the various tiers of local government in the planning and co-ordination of the HIV/AIDS activities. The Framework also recognises the potential for variations across the Districts regarding the intensity and nature of the HIV/AIDS problem, and therefore the preferred interventions.

1.6 Goals of the National Strategic Framework 2000/1 - 2005/6

Given the adverse impact of HIV/AIDS on health, and social and economic development in Uganda and the national policy aiming at poverty eradication by year 2017, the overall aim of the National Strategic Framework is to contribute to the attainment of these broader goals. The three principal goals shall be:

- Reduction of HIV prevalence by 25% by the year 2005/6;
- Mitigation of health and socio-economic effects of HIV/AIDS at individual, household and community levels;
- Strengthen the national capacity to respond to the epidemic.

1.7 Process of Drafting the National Strategic Framework

The preparation of this National Strategic Framework was undertaken in two stages. The first draft was prepared and adopted by stakeholders to cover the period 1998 - 2002. However, following a period of implementation and review by a number of stakeholders, it was found to contain gaps. In particular, a number of policy and action plans of the Government have emerged since the drafting of the 1998-2002 framework and this called for the re-orientation of HIV/AIDS programmes and activities. The Strategic Framework was revised from October 1999 to February 2000.

The earlier draft of the Framework emerged from a protracted process of consultations organised by the Uganda AIDS Commission together with a group of stakeholders involved in the fight against HIV/AIDS. Among the stakeholders, a Core Group of 11 members was constituted and specifically charged with drafting the Strategic Framework. The CG11 included representatives from the Ministry of Health (MoH), Ministry of Local Government (MoLG), Ministry of Finance, Planning and

Economic Development (MoFPED), and other line ministries. In addition, this group drew membership from NGOs, research institutions and organisations of people living with HIV/AIDS.

The work of the CG11 was organised around the thematic areas of prevention, care, mitigation and research and drew on expertise beyond its membership. The whole group through workshops and meetings subjected drafts for the respective subjective areas to review. These were later merged and a consensus workshop was held to adopt the framework. The consensus workshop included a broad spectrum of stakeholders.

This revision of the Strategic Framework has similarly been undertaken as a collaborative and multi-sectoral undertaking of all Government Ministries, local governments, Non-Governmental Organisations (NGOs), the private sector, development partners and other stakeholders in the fight against HIV/AIDS. External Support Agencies made invaluable contributions during this process.

The following materials were the major sources of information in the drafting of the National Strategic Framework 2000/1 - 2005/6:

- The National Strategic Framework, which was to cover the period 1998 – 2002;
- The Poverty Eradication Action Plan (PEAP) of the Government;
- The Local Government's Act of 1997;
- The National Health Policy, August 1999;
- The Health Sector Strategic Plan of the Ministry of Health, October 1999;
- National AIDS Control Policy Proposals (1996);
- Periodic Reports of various stakeholders;
- Annual Reports of the Uganda AIDS Commission;
- Reports of ACPs in line ministries;
- STD/HIV Sentinel Surveillance Reports of the Ministry of Health (1991 - 1999);
- Review Reports on HIV/AIDS policy, legal and ethical issues (1997);
- Review of HIV/AIDS activities in Uganda (1996);
- HIV/AIDS research inventory (1997);
- Summary of the HIV/AIDS research results (1997);
- HIV/AIDS status Report (1997);
- NGO/CBO inventory (1997); and
- Several Documents from UNAIDS, Uganda and AIDS Information Centre.

1.8 Institutional Arrangements

Although a participatory approach is recognised as vital for promotion of ownership and responsibility of all key stakeholders to the fight against the epidemic, it should also be emphasised that the institutional base for effective implementation and monitoring of the Framework is of special importance to effective planning and implementation. The need to promote a national political, structural and technical framework of Cupertino and co-ordination between key sectors and between the central and district levels that will enable Uganda to strengthen its multi-sectoral response to HIV/AIDS is therefore vitally important.

For success to be achieved the programmatic approach advocated for in this Framework depends on the Co-operation of all stakeholders with special emphasis on sustaining political and financial commitment at National and District levels. Strengthening the local/district capacity for planning, resource management and implementation, and promoting the utilisation of existing expertise and institutions or structures in HIV/AIDS prevention, care and support is of vital importance in this regard. The multi-sectoral response to HIV/AIDS also depends on strong links of Co-operation between the private sector, NGOs, CBOs and religious organisations and the public sector. Greater

involvement of the private sector, co-operative movements, religious groups, People Living with HIV/AIDS and traditional and cultural institutions in HIV/AIDS activities should therefore be promoted.

Continued resource allocation and technical assistance from the government, districts and International Agencies is indispensable during the Plan Period. Regular consultations on how best to achieve the defined objectives and co-ordinate funding for AIDS activities is therefore also a necessary part of the framework and its overall objectives.

Finally, the essence of Monitoring and Evaluation of all activities at all stages is recognised and provided for. The Framework provides for a Baseline Survey, Mid-term Review and End-of-Programme (EP) Evaluation.

1.9 Layout of the National Strategic Framework Document

In addition to this introductory chapter, the document is arranged in five (5) Chapters. These are:

Chapter Two provides a detailed description of the present status of the HIV/AIDS epidemic in Uganda. This includes recent trends, variations across social, economic and geographic categorisations, and projections.

Chapter Three contains a review of past interventions, the achievements, and indicates the outstanding issues. Recommendations are made for addressing the identified challenges.

Chapter Four outlines the Log frame indicating the strategies and activities to be undertaken, sectors to be involved, indicators and means of verification and indicative cost of the activities.

Chapter Five articulates the implementation and co-ordination arrangement for HIV/AIDS activities. It also presents some of the weaknesses in implementation and co-ordination and recommendations for the program.

Chapter Six provides for methods and tools for monitoring and evaluation to ensure that each implementing agency contributes to the accomplishment of the goals and objectives of the framework.

CHAPTER TWO

STATUS AND IMPACT OF HIV/AIDS

2.1 Special features of HIV/AIDS

Although the AIDS epidemic, locally known as 'Slim', began to spread in Uganda on the shores of Lake Victoria during the late 1970s, AIDS was first identified in 1982. Current estimates indicate that there are 1.9 million people living with HIV/AIDS in Uganda since the onset of the epidemic (UNAIDS 1999). Currently, AIDS is responsible for up to 12 per cent of annual deaths and has surpassed malaria and other conditions as the leading cause of deaths among individuals aged 15-49. It is estimated that approximately 10 per cent of the adult population is HIV infected (WHO, 1999).

The concern over the HIV/AIDS epidemic in the world generally and in Uganda particularly stems primarily from its unique features. First, it is one of the current epidemics whose principal route of transmission is through sexual contact (both heterosexual and homosexual). Owing to this feature, it mainly affects the sexually active population and sexual activity is the main defining risk factor for the variation of its incidence and prevalence according to sex, geographical location, culture, and socio-economic status. Since socio-cultural values and economic relations underlie sexual interaction between individuals, these have a strong a bearing on the spread of HIV/AIDS. Another notable aspect of this epidemic is that those infected often remain asymptomatic for a long period before they develop full-blown AIDS; meanwhile they can infect others and re-infect themselves. Moreover, HIV/AIDS has a wide set of symptoms; it manifests itself in a variety of ways and can only be confirmed through laboratory HIV tests. These tests are currently inaccessible and unaffordable for a majority of Ugandans. Additionally, many features of the HIV/AIDS epidemic are not well understood and it is as of now not curable.

The age group most affected (15 - 50 years) also occupies a very critical position in families and communities as a whole: as heads of households, the labour force, and leaders in society. As a result, HIV/AIDS has touched on every aspect of national life and development including individual behaviour, the roles and functions of the family, communities, the economy, and care and support systems. In the absence of a cure or vaccine, change in sexual behaviour remains the most important approach towards preventing HIV infection. However, this method of prevention together with the need to mitigate the effects of the disease among those already infected has raised a number of conceptual, legal, ethical, research, policy and programmatic issues that warrant further exploration and attention.

2.2 Uganda's HIV/AIDS Status

2.2.1 Mode of Transmission

According to the HIV/AIDS surveillance report 1997, the main routes of HIV transmission in Uganda include:

- Heterosexual contact with an infected partner accounting for about 75 – 80 per cent of new infections;
- Infected mother-to-child transmission (MTCT) including breast feeding which accounts for 15 – 25 per cent of cases;
- Use of infected blood, blood products and aseptic conditions in health facilities which accounts for less than 2 - 4 per cent of HIV infection; and
- Sharing non-sterile sharp-piercing instruments with an HIV infected person, who accounts for less than 1 per cent).

However, more research is still needed to establish the extent of other modes of HIV transmission such as through homosexuality and drug use through injection.

2.2.2 Risk Factors

Since the dominant route for the transmission of HIV infection in Uganda is through sexual contact, the risk factors are closely associated with the frequency of unprotected sex with infected partners. The main risk factors for heterosexual HIV infection are:

- Unprotected sex with an infected person;
- High number of reported lifetime sexual partners;
- The presence of an STD;
- Sexual contact with a menstruating partner; and
- Sexual intercourse before sexual organs is mature.

According to STD/HIV surveillance report (1999), young women aged 15 - 24 are at a higher risk of HIV infection than men owing to an earlier age at first sex. Overall, about 54 percent of the reported AIDS cases are females.

2.2.3 Predisposing Factors

The predisposing factors include *inter arlia*:

- Little knowledge on the dynamics of HIV infection and prevention;
- Inadequate life and negotiation skills;
- Poverty;
- Negative cultural practices such as widow inheritance, polygamy, and female genital cutting;
- Consumption of alcohol and other intoxicants leading to irresponsible and/or unprotected sex;
- Child abuse;
- Extensive sexual network;
- Civil strife and armed conflict and war in parts of the country.

It should be noted that the relative importance of each of these factors has been changing over time and across geographical areas.

2.2.4 Incidence and Prevalence

The term incidence and period-prevalence respectively refer to the number of new cases (over a given period) and the total number of cases in a given population during a given period. Clearly, the two concepts are related although they convey different messages. Incidence refers to the rate at which healthy people are being infected while prevalence denotes the total cumulative disease burden on the population. The prevalence rate depends on the level of incidence and the rate at which those infected are removed from the population (through death or migration).

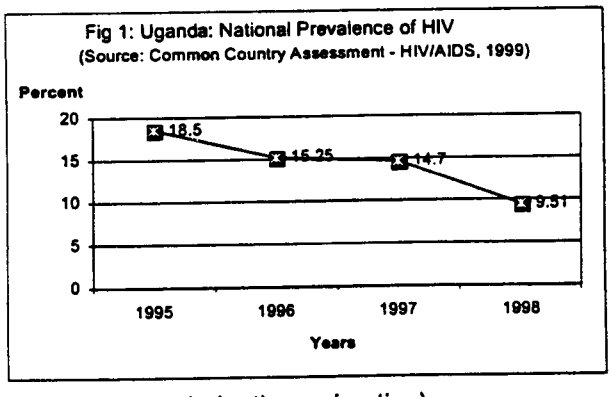


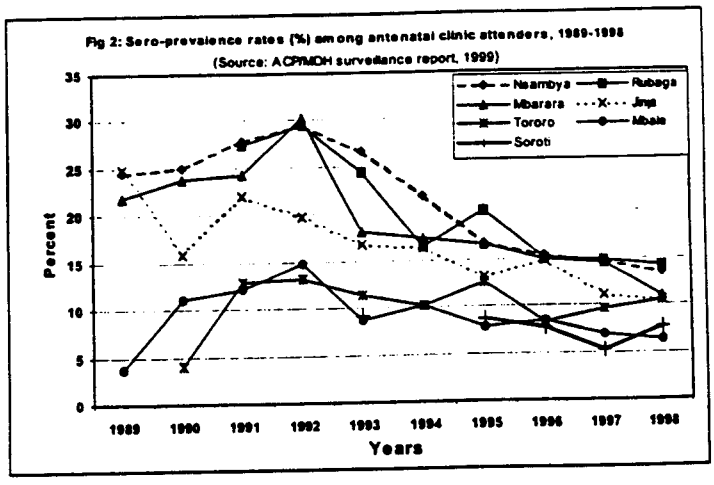
Fig 1: Uganda: National Prevalence of HIV
(Source: Common Country Assessment - HIV/AIDS, 1999)

Available data suggest that the prevalence of HIV has been declining significantly in Uganda since 1992. Figure 1 indicates that HIV prevalence has declined among pregnant women especially those

attending antenatal clinics in urban sites. Similar results are also evident in Lacor and Fort Portal Hospitals (Sandro, et. al, 1998), and in the population-based cohort studies carried out in the districts of Masaka and Rakai MRC/UVRI, 1997). Overall, HIV prevalence rate seems to have stagnated at about 10

Data from sentinel sites since 1989 indicate that the decline is particularly pronounced among urban pregnant women, aged 15 - 19, followed by women aged 20 - 24. In one of the sites in Kampala, HIV prevalence rate was 29.5 per cent in 1992, but this had declined to 13.4 per cent in 1998.

HIV sentinel surveillance data also show that the infection rates among ANC attendees in Mbarara, Rubaga and Nsambya have declined substantially. Figure 2 indicates that HIV prevalence was as high as 25% beginning 1989, peaked in 1992 then it steadily declined from 1993 to 1996, and stagnated at 10-15% for the period after. However, HIV prevalence among antenatal clinic attendees in Tororo has shown a small but consistent increase since 1996.



Surveys on knowledge, attitudes and practices conducted by Ministry of Health also indicate an increase in the age at first sex, a reduction in number of casual sexual partners, and an increase in general condom use, especially between casual sexual partners. These findings suggest that the decline in HIV prevalence in Uganda is likely to be causally linked to changes in high-risk behaviour.

Given that there is yet no cure and AIDS often results to certain death, the disease still poses a major challenge.

2.2.5 HIV Prevalence/AIDS Cases

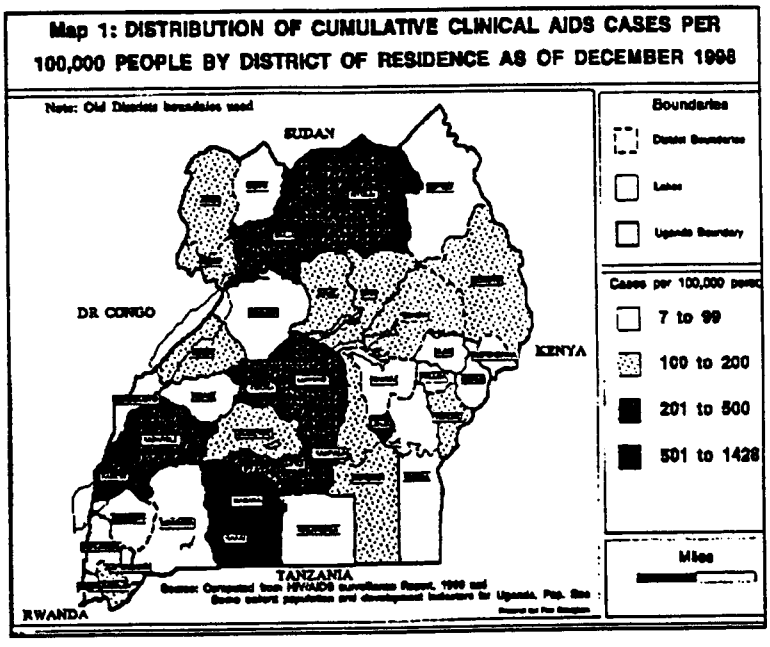
(a) *Overview*

Uganda has for the last 15 years experienced an ever-increasing number of individuals who are HIV infected and it is projected that HIV will infect 10 per cent of the adult population by 2000 (Kayita & Kyakulaga, 1997), thus suggesting that the population of PHAs to be catered for is significant
By the end of 1998, there were 54,712 cumulative reported AIDS cases (STD/ACP-MoH, 1999), of these AIDS cases, 50,757 (92.8 per cent) were adults aged 12 years and above while 3,955 (7.2 per cent) were children below 12 years. Of the 49,869 cases 46.1 per cent were males and 53.9 per cent were females. Data generated at the AIDS Information Centre (AIC) further indicate a consistently higher sero-prevalence rate among women. However, these rates may not be representative since a small fraction of cases is known and/or reported to health facilities and AIC data is based only on voluntary HIV counselling and testing.

(b) *Regional Variations*

The establishment of sentinel surveillance sites for HIV and AICs has made it possible to keep track of the HIV/AIDS trends. According to these data, the prevalence rates in Uganda have varied from 5 per cent at the sites in most rural districts like Moyo to as high as 30 per cent at some urban ones like Mbarara (Kayita & Kyakulaga, 1997).

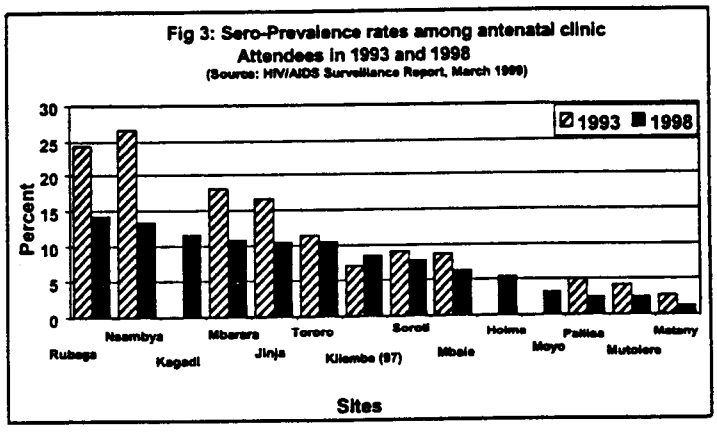
Map 1 illustrates that Kampala, Masaka, Jinja and Rakai have more than 500 AIDS cases per 100,000 residents. The large number of cases in Kampala and Jinja is attributed to the high concentration of urban residents while in Masaka and Rakai it is mainly due to the fact that HIV/AIDS was first identified in these districts. Another category of districts that recorded 200 - 500 AIDS cases per 100,000 residents is Gulu, Kitgum, Luwero, Kiboga, Kabarole, Kasese and Mpigi. The common characteristic in these districts is that they have been affected by war, thus suggesting that war situations aggravate the spread of HIV/AIDS.



(c) *Rural-Urban Variation*

In the districts of Rakai and Masaka where the epidemic was first reported, HIV prevalence ranges between 10 - 13 per cent. The prevalence rates are higher in the trading centres along major roads. However, basing on data generated since 1995, the trend of infection in urban and rural areas is changing. A number of urban sites recorded a downward trend in infection rates. Some rural sentinel surveillance sites have also begun to record a drop in infection rates (GTZ, 1996; STD/HIV surveillance report, 1997).

Sentinel surveillance data further indicate that there has been a general decline in HIV infection rates in the 14 sites between 1993 and 1998. Figure 3 shows that HIV prevalence among ANC attendees dropped at all sentinel surveillance sites except Kilembe, which recorded a slight increase of one percent. This suggests that HIV infection is increasing in some rural areas.



In addition, given that some individuals who could be infected do not go for HIV tests or treatment at sentinel surveillance sites, it is probable that the HIV infection rate is higher than that recorded. Therefore, the current average HIV prevalence rate of 9.5 per cent in 1998 is still considered high, and would most likely increase paediatric AIDS cases particularly if HIV infected women continue reproducing (UNAIDS, 1999).

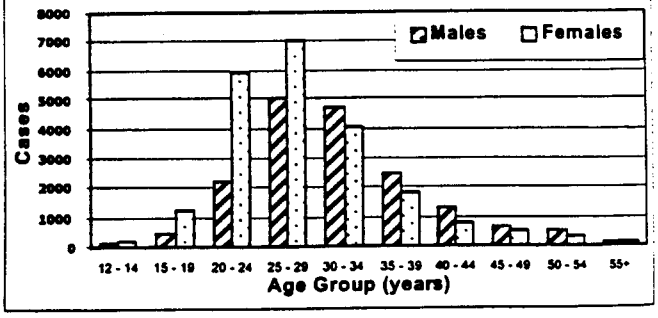
(d) *Differentials according to Age and Sex*

The HIV infection rate also varies significantly with age. HIV prevalence is very low between age 0-5 and 5–14, but begins to rise in the age group 15-19 particularly among girls. Mother-to-child

transmission of HIV is responsible for the HIV prevalence among children. About 15 percent of the children fed on breast milk of infected mothers acquire the virus (WHO/UNICEF/UNAIDS, 1999).

Data from the sentinel sites and AIC further indicate that girls in the age group 15 – 19 are three to six times more likely to be infected by HIV than the boys. This suggests that girls commence sexual activity at an earlier age. Figure 4 indeed shows that HIV prevalence is higher among the females than males aged 15 - 24, but the gap reduces between ages 24 –29. The prevalence rate among males then supersede that for the females aged 30 and above.

Fig 4: Age/Sex Distribution of adult AIDS cases in Uganda, December 1998
(Source: HIV/AIDS Surveillance Report, March 1999)



(e) *Quality of Surveillance Data*

Three types of time series sero-prevalence studies are currently being undertaken. The first type includes population based cohort studies in Rakai, Masaka, Entebbe, Kabarole and Gulu Districts. The second type is the AIC voluntary counselling and testing (VCT) in various parts of the country. According to the AIC, p (1998) people seek VCT mainly for prenuptial reasons, to plan for the future, frequent illness and need for babies. If the proportions of people attending VCT remain stable, then the time series information generated can provide useful indication of trends in prevalence. Data from the AIC have particularly helped to identify the risky or vulnerable groups, predict the future direction of the epidemic and may be used to prioritise interventions and target groups. The third type of time series information is from the new antenatal sentinel sites. Although this data is not representative of the general population (since it is based on women alone) they provide a more realistic HIV prevalence situation, geographical pattern, and relationship to STD.

2.2.6 HIV Incidence

Estimates of rates of new HIV infections are rare in Uganda. Longitudinal community studies are therefore required in this area. Estimating incidence requires following up a cohort of initially healthy people and note the rate at which they become infected. Studies in Rakai and Masaka districts show rates of less than 2 per cent (i.e. less than 20/1000 HIV uninfected adults become infected in the course of one year) in a rural general population (Kayita & Kyakulaga, 1997). These studies also show that the incidence rate in Masaka and Rakai is lower than it was in the 1980s. HIV incidence is 4.2 per 1000 for 1996 in the Kyamulibwa cohort; in the Rakai cohort, HIV incidence did not change significantly among all adults aged 15 -59 years (MRC/UVRI, 1997). A study of 2,300 secondary school students in Gulu found HIV incidence of 2.8 per 1000 (Sandro et. al, 1998).
The decline in HIV prevalence in younger individuals (15 and under) may indicate increased prevention efforts. The observed patterns and trends could also be the result of intrinsic dynamics of the epidemic in its mature stage. Epidemiological and related studies are required to keep trace of the changing dynamites of the epidemic.

2.2.7 The under-five Children

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

100 per cent

Paediatric HIV infections occur before and during delivery through mother-to-child blood mixing, and after delivery through breast milk. Currently, a child breast-feeding from a mother who is HIV positive has a 15% risk of infection by this route (WHO/UNAIDS/UNICEF, 1999). A small proportion of children acquire HIV from blood products containing HIV and from contact with non-sterile skin-piercing instruments. Of the paediatric AIDS cases, about 66 per cent die by the age of three. The mean age at death for paediatric AIDS cases is 2.2 years. As a result, the age group 5 - 9 is relatively free of HIV infection. However, they share the burden of other consequences of HIV/AIDS with other children.

2.2.8 Young People aged 10 – 24 years

Young peoples' increased vulnerability to HIV infection is attributed to the fact that a number of them initiate sex early (15.6 years for girls and 17.6 years for boys), and with older partners. Most of the sexual encounters are without the benefit of consistent and correct condom use, and are often a result of rape and defilement (Olowo-Freers & Barton, 1992).

According to the National Policy proposals on HIV/AIDS and Young People, (1998), normal transition from childhood to adulthood is often cut short by early marriages at an average tender age of 17 years for girls and 19 years for boys. One fifth of these marriages are polygamous. By age 19, about 62 per cent of girls would have had a pregnancy. Of the females who carry the first pregnancy, 43 per cent are teenagers (DHS, 1995). This is a likely to contribute to the heavy disease burden and the high mother to child HIV transmission rates.

In addition teenagers who become pregnant hardly benefit from on-going reproductive health programmes targeting young people. The girls are also unlikely to benefit fully from those programmes that target women (Kiirya, 1996). Meanwhile young people who become household heads upon the death of both parents often seek employment in the informal sector where they are underpaid, and often sexually abused. Child headed households already occur in most districts particularly in Rakai and Masaka, and are expected to increase in Uganda if the epidemic is not effectively contained (MoFPED, 1995).

Civil strife and armed conflict in Uganda have led to massive movements of people, and family disintegration. In these circumstances, young people are subjected to sexual abuse through rape and defilement (Laenkholm & Cuijspers, 1997). These forms of abuse increase HIV transmission especially among women and girls.

Furthermore, owing to the AIDS pandemic, a number of AIDS related orphans have found their way on the streets and slums in urban areas. A survey conducted by Fehling, Muhumuza and El-Wambi (1996) found that many street children are orphans who left their homes in search of company and new ways of survival. These children have had little or no education; engage in criminal or risky behaviour such as theft and prostitution. In addition, about 27 per cent of the street children use psychoactive substances such as Marijuana, "Mairungi", and alcohol. These factors coupled with low knowledge on HIV/AIDS and limited access to services tend to make young people who live on the streets especially vulnerable to HIV infection.

2.2.9 Women

Some of the factors responsible for the high HIV infection rate among women in Uganda include:

- The larger mucosal surface area which increases the chance of HIV infection;
- Greater risk of receiving contaminated blood and/or blood products as they undergo surgical

operations associated with pregnancy;
- Exposure to many other risks owing to their gender roles such as dependency on men for socio-economic survival and decision-making;
- Limited access to formal education and information on HIV/AIDS.

2.2.10 Men

HIV/AIDS surveillance data show that more men above 30 years of age are more infected. Unprotected sex is the main cause of HIV infection among men. Men view sex as a process of exploration, a rite of passage as a way to establish their masculinity and virility, and a means of building self-esteem (Cravero, 1995). In spite of the fact that the socially sanctioned behaviours of the male partners are more likely to be the cause of the initial infection, women are often blamed for bringing HIV into a family

Some of the factors that expose men and their partners to HIV infection include:

- Multiple sexual relationships including polygamy and sex with prostitutes;
- Unprotected penetrative sex;
- Homosexuality particularly among prison inmates, students in single sex schools and in major urban centres where some men engage in sex for pay.

Because men generally assume the more assertive and directive role in sexual decision-making, they need to be targeted not only as beneficiaries but also as partners in the fight against HIV/AIDS.

2.2.11 HIV/AIDS and Culture

A number of studies show that traditional practices such as widow inheritance and polygamy are factors of etiologic significance in HIV transmission. According to Barton and Butiti (1994), irresponsible sexual behaviour and alcohol consumption during burials, last funeral rites and other traditional ceremonies are common. Female genital cutting is one of the cultural practices that may increase HIV transmission and other reproductive health problems for the Sabiny (REACH, 1996). Other cultural behavioural norms such as polygamy, wife sharing and wife replacement, blood brotherhood, treatment for barrenness and male circumcision rituals create conducive environment for the spread of HIV.

Many ethnic groups also practice widow and children inheritance by a brother of the deceased. Traditionally, inheritance serves the purpose of protecting the widow and orphaned children within the clan while funeral rites are traditional mechanisms of giving social support to the bereaved. These practices are gradually changing owing to the fact that community members are becoming aware that such cultural practices expose them to HIV infection. For example, some areas have began supporting widows and their children without direct inheritance (Olowo-Freers and Barton, 1992), and the Sabiny particularly those who are young and educated are beginning to change their perceptions towards female genital cutting (Kiirya 1997& Kabombo, 1999).

Other cultural factors that perpetuate HIV infection include inadequate family life education because parents and other adults often avoid talking to young people about sex. There are also stereotype roles, which encourage submissiveness on the part of girls and aggressiveness on the part of boys. For example, many cultures place a high premium on the virginity in girls while promoting early and active sexual behaviour for boys.

2.2.12 HIV/AIDS and Migration

In the Great Lakes Region, people tend to move mainly due to civil conflict and search for better job

and trading opportunities. Uganda is currently host to a large number of refugees and internally displaced persons.

Refugees and internally displaced persons (IDPs) comprise of mainly women, children and the elderly. These persons are highly concentrated in temporary rural camps. Although data on HIV prevalence amongst refugees and IDPs are not available they are considered a high-risk group due to social economic and psychological breakdown. The risk factor in refugee settings include:

- Transactional sex to secure life, escape to safety, gain access to shelter or other services;
- Deliberate use of sex as a weapon to demonstrate power, inflict pain and humiliation committed by men against women, children and other men;
- Breakdown of social support system leading to poor parenting and high rate of partner change;
- Alcohol and substance abuse due in part to frustration, idleness, worries and fears;
- Insecure situations promote sexual immorality like prostitution, indecent assault and adultery;
- Unprotected sexual intercourse due to poor social services;
- High underlying HIV/STD prevalence.

According to Barton and Butiti (1998), STD prevalence is high in the region, and linked to army movements, camp following and prostitution. Early sexual activity among boys and girls and unwanted pregnancies are also high.

2.3 The Impact of HIV/AIDS

The HIV/AIDS epidemic has had far-reaching consequences for individuals, families, communities, and the country as a whole. This section outlines the impact of HIV/AIDS on different segments of society according to age, sex groups and the various sectors of the economy.

2.3.1 HIV/AIDS and the under-five Children

The following are some of the ways through which HIV/AIDS affects the under-five population in Uganda:

- They experience orphan-hood at the age parental guidance and socialisation is needed most;
- Those who develop symptoms much later in childhood tend to experience stigmatisation and discrimination;
- The quality of care-giving, education, nutrition and socialisation is often poor for children with parents who are bed-ridden or dead for example, the girl child is usually withdrawn from school to care for the younger siblings and ailing parents, and manage households (Barnett & Blaikie, 1992);
- Failure of the traditional support systems to cope with an ever-increasing number of HIV/AIDS orphans has contributed to an increase in the number of street children; and
- Sexual abuse by adults, especially those who think that children are free from HIV/AIDS.

2.3.2 HIV/AIDS and Young People aged 10 - 24

Young people[2] are yet another group of individuals who have been affected greatly by HIV/AIDS. Sentinel surveillance data indicate that HIV infection cases begin to increase in the 15 - 19 age group and peak in the age range 20 – 40 (ACP/MoH 1999). In the former age group, the number of girls with HIV is three to six times more than that of boys while among those aged 20 -24, the rates for women are twice as high. The main impact of HIV/AIDS on this category is the diminished

[2] This term is adopted from the World Health Organization (WHO), United Nations Children Fund (UNICEF) and United Nations Population Fund (UNFPA) who define young people as individuals aged 10 - 24

capacity to engage in economic activities.

2.3.3 HIV/AIDS and Women

In Uganda, the impact of HIV/AIDS on women has been considerable. The national sero-survey conducted in 1987 revealed that females were more infected by the virus than males although the ratio was close to 1. Recent studies however indicate that for certain age groups, the HIV prevalence among women is much higher than for men: females aged below 25 are two to three times more likely to be infected by HIV than men (Kayita & Kyakulaga, 1997).

Apart from the greater risk of being HIV infected, women are also disproportionately affected by HIV/AIDS. Women bear the burden of caring for the sick, orphans and coping with the emotional trauma of the dying parents. They often forego productive activities including employment in order to fulfil this duty. Infected women are likely to suffer more anxiety about their own health and the future of the children and family.

2.3.4 HIV/AIDS and the Community

The impact of HIV/AIDS on the community can be identified at three levels i.e. the individual, family, and community. The proportion of households, which have AIDS patients in Uganda, is not known, but it is believed that nearly every household is affected by the epidemic in some way.

HIV/AIDS and the Individual

Besides the physical suffering from the sickness itself, most persons living with HIV/AIDS have been isolated and denied the needed care and psychosocial support. As a result, they often experience trauma, distress, stress and depression. Their savings drop because they have to spend most of or all income on treatment. Moreover, productivity at individual level declines because of inability to cultivate or report for work; and at household level because family members spend most of the productive time giving care to the sick. Sometimes PHAs engage in self-destructive behaviour such as denial: suicide, increased level of criminality, alcoholism and other forms of drug use, and deliberate spread of the disease.

However, despite the psychological trauma, some respond with courage and determination to live positively through publicly announcing their HIV status and becoming AIDS educators, counsellors and prevention advocates.

HIV/AIDS and the Family

Generally, women are the most important actors in giving care to HIV/AIDS patients at household level. Sometimes children become caregivers, rather than attending school and receiving care from their parents. However, care-giving is often limited by the many other household tasks and responsibilities; lack of or inadequate supply of basic care necessities such as soap, antiseptics, cloths and medicines; limited knowledge on how to care for HIV/AIDS patients and prevent infection. Also, poor understanding and communication of the HIV/AIDS patient's emotions and well being; and inadequate knowledge on and means of good nutrition for HIV/AIDS patients.

In situations where households are unable to cope, extended family members step in to help. According to Jolting (1996) these relatives often help by:

- Providing help in domestic tasks;
- Extending financial and material contributions;
- Providing a person to care for the sick; and

- Accommodating the patient particularly if the relative's household is near the health centre.

Although extended family members have played these roles, they are becoming apprehensive of extending care to HIV/AIDS patients and their children owing to the ever-increasing number of HIV/AIDS-related problems faced at household level (Hunter, 1990). According to Joling (1996), these include:

- Increased patient care thus cultivating less land;
- Increased spending on Medicare;
- Selling-off agricultural produce and livestock to meet the cost of treating the patient;
- A general reduction in cash income at household level resulting in children dropping out-of-school; and
- Increased psychosocial stress and trauma.

Consequently, a number of households are restructured, with increasing number of orphaned children being left to care for each other and/or by ageing grandparents. Often they are left without money and the orphaned children inevitably drop out of school. Small female-headed households dependent on hired labour and cash remittances from absentee members are the most vulnerable group.

HIV/AIDS and the Community

Studies also indicate that a number of community members are not willing to give care and social support to HIV/AIDS patients owing to fear of HIV infection, the stigma associated with HIV/AIDS, and because some think that they are "reaping what was sown." Close neighbours occasionally extended assistance, but this is usually done only when they are asked to do so.

2.3.5 HIV/AIDS and the Health Sector

In Uganda, health care services are only accessible to a small percentage of the population. According to the Demographic and Health Survey (DHS, 1995), about 49 per cent of the population live within five kilometres of a health service unit. However, access to health facilities varies enormously and rural communities are particularly affected. There are also marked variations in access to health care both within and between districts, and the population within 5 km of a facility varies from 9-100%, between Kotido and Kampala Districts, respectively.

The demand for palliative care services by patients with HIV/AIDS is expected to further increase as more people are infected. According to the Health Facility Inventory of the MoH/HPD (1996), the current health system capacity is already under considerable strain due to the ever-increasing number of patients with AIDS-related diseases. The annual population per hospital bed had risen to 800. Likewise, health personnel are now attending to many more patients as a result of the HIV/AIDS epidemic. The doctor to person ratio is 1 to 18,700, while the nurse to person ratio is 1 to 4,300. As of 1997, patients with HIV/AIDS-related illness occupied more than 55 per cent of the hospital beds. Furthermore, health workers also experience psychosocial stress due to fear of being infected, while some may exhibit stigma. This implies that a proportion of PHAs are turned away.

Opportunistic Infections

Tuberculosis (TB) has been identified as one of the common HIV-associated infections. A study conducted among a paediatric cohort revealed that 18 per cent of HIV infected infants developed TB compared to 1.4 per cent of HIV non infected, and the successful response to treatment was 31 per cent and 83 per cent respectively (Mudido-Musoke, et al., 1996). Also common among HIV sero-positive individuals are pneumonia, crypto coccal meningitis, kaposis sarcoma, cryptosporidial diarrhoea, and candidiasis of the oesophagus and herpes infections.

Because the cost of TB treatment spreads over a long period of time, the capacity of hospitals/dispensaries is often over-stretched. The management of other infections commonly associated with HIV/AIDS also generally involves long periods of stay in hospitals and is expensive. Consequently, there is a general shift of emphasis from hospital-based care to home-based care as a means of reducing the pressure on hospitals and health units, and accessing similar services to PHAs and community members wherever they may be. It is also recognised that integrating Primary Health Care (PHC), AIDS care and counselling into the home-based care (HBC) would enhance the quality of care for PHAs while reducing the cost of care (Kayita & Kyakulaga, 1997).

Treatment with Herbal medicine

The use of traditional medicine as a form of therapy for AIDS is steadily growing. A number of individuals including PHAs believe that some herbal medicines actually work. As a result, funding agencies, governmental and non-governmental organisations have supported research in HIV/AIDS herbal/traditional medicines. A collaborative effort between practitioners in herbal and modern medicine was started in 1992. One of the achievements has been the development of herbal treatments for *Herpes Zoster* and chronic diarrhoea. There has also been a notable positive change in attitude on the role of herbal medicines in the treatment of AIDS. However, more support is needed to promote research in this area, and increase accessibility to traditional medicines that work within the region.

Anti Retroviral Therapy (ART)

Although Anti Retroviral Therapy is not yet available in health units, it is privately administered in authorised health facilities and research institutions. It is also proven that these medications prolong life for PHAs. However, the ART optimal cost per month is priced at 1.5 million shillings (excluding monitoring cost) (JCRC, 1996). The Drug Access Initiative currently being piloted by UNAIDS and Ministry of Health has lowered the cost of ART medication to shillings 700,000 per PHA per month but this cost is still high and unaffordable by a majority of PHAs (UAC, 1998; JCRC, 1998). Further, PHAs often seek medical care late when they are sick with full-blown AIDS and require hospitalisation (Bahendeka, 1999).

2.3.6 HIV/AIDS and Productive Labour

Over 80 per cent of the reported AIDS cases are among people aged 15 – 45 of these, a majority are adults and parents (MoH, 1999). This age group constitutes the largest part of the potential and most productive labour force. The death of the people in this age bracket has therefore correspondingly affected the labour force supply in particular and the economy in general.

The HIV/AIDS-related sickness and eventual death reduces the family labour force and land under cultivation, income, food security, and children's opportunity of being educated. A survey done in Rakai districts showed that 25 per cent of the households were cultivating less and less lands. Of these, 35 per cent attributed it to HIV/AIDS-related sickness or death. There was also a shift from high to low labour-intensive crops, a decline in production of cash crops, and an attempt to sell food crops for cash (Barnett & Blaikie, 1992). In areas where the staple crops grown (millet, sorghum, etc.) are seasonal and labour-intensive, the AIDS impact on the economy has been even more pronounced. Such crops are often left to over grow due to the fact that most of the time is spent on giving care to the sick. These factors have threatened the food security of affected families, worsened the nutritional status at household level, and led to a decline in cash crop production.

2.3.7 HIV/AIDS and the Workplace

HIV/AIDS has caused employment insecurity and discrimination in the labour force. Some organisations subject prospective employees to a mandatory but covert HIV screening test before

recruitment, and the infected ones are denied job opportunities. Those who get infected during employment are often discriminated against and their job contracts terminated on the basis of their sero-status.

In addition, HIV/AIDS appears to have contributed to a decline in labour productivity at individual and institutional level. This is partly because opportunistic diseases, which PHAs often encounter, call for increased institutional and individual level spending on treatment and socio-economic support.

The cost of labour at company level also increases due to increased health costs borne by an enterprise in the treatment of opportunistic diseases. According to Sekatawa (1998), the estimated cost of HIV/AIDS patient when hospitalised is 300 times the cost of an average employee. He also found that the HIV/AIDS pandemic has more than doubled the expected number of deaths occurring among the workforce of some enterprises. It was found that as many as 34 per cent of theatre artistes had extramarital relationship within the institution. Among the risk factors identified were night rehearsals, work away from usual residence, social interaction among work-mates and position held in the firm. The more affected are mobile employees and those working in large establishments where employees often meet for social events.

The epidemic also seems to have considerably affected the educated more. A study of 443 HIV infected people drawn from different backgrounds indicated that a majority of them were educated up to senior four. It also reveals that the infection rate tends to reduce with higher educational status (GTZ, 1996). Another study found that in urban areas, small scale business men/women and salary/wage earners are more at risk of HIV infection than the medium and large businessmen, farmers, vendors and skilled tradesmen (Kayita and Kyakulaga, 1997). Since it takes more than 15 years of education for one to attain professional training, the same time would be required to replace a single death of such quality labour force.

2.3.8 HIV/AIDS and Regional Affiliation

Uganda is closely tied to her neighbours through culture, shared ethnic groups, and a common history. As a result, there is considerable movement of persons and goods across its borders. Most imports destined for Rwanda, Burundi, South Sudan and Eastern Congo pass through Uganda. Apart from the railway and road networks, Lake Victoria is shared between Kenya, Uganda and Tanzania and provides another transport link between them. The country is a member of regional economic groupings: for example the East African Community (EAC), the Kagera Basin Authority, Preferential Trade Area (PTA), the Common Market for Eastern African (COMESA), and the Inter-Governmental Authority on Drought and Development (IGADD).

In recognition of the close association between population movements and the spread of the HIV/AIDS, countries of the Great Lakes region started the Great Lakes Initiative on AIDS (GLIA) in March 1998, with a co-ordinating Secretariat located in Kigali. Through this forum, the member states (Kenya, Uganda, Tanzania, Rwanda, Burundi) share experience and resources in the combat against HIV/AIDS. GLIA focuses on cross-border issues and other problems of common concern related to HIV/AIDS in the participating countries.

CHAPTER THREE

REVIEW OF PROGRESS

3.1 Government Response

Uganda's response to HIV/AIDS has been a collective effort by the government, NGOs, religious groups, individuals, PHAs, local and international donors. Openness, political support and commitment at the highest level of Government have characterised the national response to the epidemic. There have also been notable efforts to mobilise and unify response to the epidemic, at the international, national, district and community levels, including the establishment of AIDS Control Programmes in Government ministries, NGOs and CBOs.

The first response of government was the establishment of the National Committee for the Prevention of AIDS (NCPA) in 1985. In October 1986, the AIDS Control Programme (ACP) was established in the Ministry of Health with the following functions:

- Epidemiological surveillance;
- Ensure a safe blood supply (for transfusion);
- Provide HIV/AIDS information, education and communication;
- Provide patient care and counselling; and
- Prevent and control other STD.

Following the 1988 review of the ACP, it was recognised that AIDS control activities needed to involve all sectors, levels of government and the community.

In 1990/91, government adopted a multi-sectoral approach to the control of HIV/AIDS (MACA) in dealing with the epidemic. This approach emphasised the notion of collective responsibility of individuals, community groups, different levels of government and other agencies for the prevention of HIV infection. It also emphasised building and strengthening organisational capacity among government sectors and non-governmental organisations to sustain AIDS activities. Uganda AIDS Commission was therefore established in 1992 by Act of Parliament to address the HIV/AIDS problem in this broad context. The National Operational Plan for HIV/AIDS prevention, care and support (1994-1998)) was drawn up to provide guidance for agencies involved in HIV/AIDS –related work.

The Strategic Framework for HIV/AIDS prevention and care for the 1998-2002 period was developed and organised under seven goals:

- To stop the spread of HIV infection
- To mitigate the adverse health and socio-economic impact of the HIV/AIDS epidemic;
- To strengthen the national, district and lower level capacity to respond to the HIV/AIDS epidemic;
- To establish the national information base on HIV/AIDS;
- To strengthen the national capacity to undertake research relevant to HIV/AIDS;
- To provide care, support and protection of rights of PHAs; and
- To reduce the vulnerability of individuals and communities to HIV/AIDS with a focus on children, youth and women.

Following a period of implementation, it was observed that the document for the 1998 - 2002 period had some gaps that necessitated revision. The current Strategic Framework 2000/1-2005/6 is therefore designed to minimise duplication of efforts, engender more focused interventions and

simplify monitoring and evaluation. The present document also places the HIV/AIDS in the broader context of social and economic development in which it is a significant factor.

The original seven goals were therefore regrouped as follows:

- To reduce the rate of HIV infection;
- To mitigate the health and socio-economic impacts of HIV/AIDS at individual, household and community levels; and
- To strengthen the national capacity to respond to the epidemic.

In addition, this review takes into account the developments that have taken place since the completion of the previous document.

3.2 Review of progress

The following review is structured along the three goals outlined above. Within each of the three goals, broad strategies have been reviewed, indicating progress and constraints. Recommendations are made for each strategy.

3.2.1 Goal I: Reduce HIV the rate of HIV infection

Previous plans have pursued the objective of prevention using a three-way strategy comprising of:

- Prevention of HIV transmission through sexual contact with an infected partner;
- Prevention of mother-to-child HIV transmission (MTCT) including through breast feeding; and
- Prevention of blood borne HIV transmission.

The implementation of these strategies was done through IEC to promote behaviour change, expansion of Voluntary Counselling and Testing (VCT), promotion of syndromic and etiologic management of STIs, vaccine trials, promotion of anti-retroviral therapy, use of the universal precautions, safe blood transfusion in health care settings and PMTCT.

IEC to promote Behaviour Change and reduce Vulnerability

Information, Education and Communication (IEC) centred on the promotion of safer sexual practices and helping PHAs live positively with HIV/AIDS. Both government institutions and NGOs were involved in IEC development and distribution. According to the inventory of CBOs /NGOs (1997) out of close to 1,500 agencies involved in HIV/AIDS, nearly 70 per cent were involved in IEC work.

Progress

The intensive HIV/AIDS information provision alongside VCT at community levels has had a considerable impact on the population. The main outcomes include:

- Increased knowledge on HIV/AIDS. Two in every three persons are able to cite at least two acceptable ways of protection against HIV (UDHS, 1995);
- Increased proportion of sexually active persons who ever used a condom from 7 percent in 1989 to 42 percent in 1995, particularly in Kampala (MoH, 1996);
- Reduction in number of sexual partners. About 57% of women and 64% of men reportedly changed their sexual behaviour by restricting to one or fewer sexual partners (UDHS, 1995);
- Increase in the median age at first sex in girls by about six months between 1989 and 1995 to about 16 years; and

- Establishment of a condom promotion strategy, and co-ordination mechanism among the social marketing groups.

Constraints

In spite of the achievements made, there are constraints that have been identified in the promotion of IEC for behaviour change. These are:

- High awareness has not been translated into a positive change in behaviour mainly due to inadequate IEC messages and limited personal perception of the risk of HIV infection. Only 62 per cent of women and 83 per cent of men ever changed their sexual behaviours due to the threat posed by HIV/AIDS (UDHS, 1995);
- Condoms are still inaccessible and unaffordable to a majority of people particularly in rural areas.
- Although there is reported increase in the proportion of people using condoms, the proportion who use the condoms properly and consistently is not known;
- Social and cultural obstacles to behaviour change;
- Inadequate/lack of research on the impact of IEC messages on change in behaviour in the different categories of the population;
- Inappropriate IEC messages in terms of medium, context, target group and proposition of safer behavioural alternatives. For example, special IEC messages should be developed for the vulnerable population such as children, adolescents, women and high-risk groups such as men, IDPs and refugees, the military, truck drivers and commercial sex workers.

Recommendations

Based on these observations the following recommendations have been identified:

- Conduct national KABP surveys and IEC impact assessment studies;
- Review the IEC messages produced by the different stakeholders;
- Repackage and disseminate IEC messages in appropriate form for the different age-sex categories of the population and tailored towards individual risk perception and behaviour. In planning and implementing IEC activities, social and sectoral obstacles to behaviour change should be addressed. Also, mobile film shows should be used to inform, educate and communicate to rural residents about HIV/AIDS;
- Sensitise the public on the dangers of early sex, infidelity, unprotected sex and alcohol/substance abuse in relation to HIV/AIDS;
- Promote AIDS education and counselling to students in schools, colleges and institutions of higher learning;
- Increase condom accessibility and affordability;
- Intensify awareness on the rights of children, youth and women vis-à-vis HIV/AIDS; and
- Intensify life and psychosocial skill development of youth and other vulnerable groups.

HIV Voluntary Counselling and Testing (VCT)

Progress

The rationale for the HIV VCT strategy is to encourage safe sex practices to ensure prevention and positive living for those already infected. Since the implementation of the VCT strategy, considerable progress has been made. This includes:

- Promotion of Voluntary Counselling and Testing and integration of VCT into health services at

district levels;
- Over 400,000 individuals have been tested for HIV countrywide since large-scale counselling and testing was initiated;
- Expansion in the supply of HIV/AIDS information and increased demand for STD treatment and counselling, particularly among those aged 15 – 24;
- Promotion of peer social support and positive living through post-test clubs;
- Improved quality of information provided by networks and associations for PHAs; and
- There is an approved plan of extending VCT services to health centres at sub-county level;

Constraints

Although HIV/AIDS counselling and testing facilities have been expanded considerably, there are still a number of constraints. These include:

- Inadequate HIV testing and counselling services, particularly in rural areas;
- Fear of breach of confidentiality which has made many people prefer being tested at a health unit far from their place of residence;
- Self-stigmatisation which has led to a high proportion of people not being tested;
- Limited VCT counsellors.
- Low quality of testing facilities (e.g. staff, laboratories and consumables) available at some sites; and
- High population mobility, which makes it difficult for certain populations, such as children and youth to access VCT services.

Recommendations

Based on this analysis, the following key recommendations have been identified in the strategic framework for 2000/1 – 2005/6.

- Expand HIV testing and counselling facilities to all districts through:
  - Development and provision of VCT guidelines to NGOs undertaking VCT and all districts;
  - Training VCT counsellors and technical staff;
  - Establishment of additional HIV VCT sites in other districts and sub-counties;
  - Carrying out VCT outreach activities;
  - Integration of VCT into IEC messages related to HIV/AIDS;
  - Sensitisation of community members on VCT; and
  - Consistent supervision and monitoring of VCT services.

Prevention of Blood Borne HIV Transmission

Progress

HIV Transmission through blood accounts for about 2 - 4 percent HIV infection in Uganda. Uganda Blood Transfusion Services (UBTS) addressed the prevention of blood borne HIV transmission through mandatory screening for HIV before transfusion. As a result blood safety has been increased to 98%.

Reduction in infection through blood transfusion has been achieved through the following activities:

- Development of national guidelines for blood transfusion;
- Continued recruitment of low risk blood donors;
- Screening blood for HIV and hepatitis virus infection is in place and is part of the system for storage.

- Distribution to hospitals and supervision of the utilisation of safe blood;
- Sensitisation of blood donors, medical workers and the public on the dangers of excessive use of blood transfusion and sharing of non-sterile skin piercing instruments with another person has been conducted;
- Establishment of regional blood screening and transfusion services; and

Constraints

Despite this progress, there are still a number of constraints that have been identified in prevention of infection through blood borne HIV transfusion. These include.

- Inadequate blood quality control and supply, and prevention of blood borne HIV transmission through appropriate use of blood and blood products during service delivery;
- Inadequate dissemination of new techniques for detecting contaminated blood; and
- Lack of specific training for TBAs, traditional healers, and barbers in HIV prevention.

Recommendations

Based on these foregoing observations, the following recommendations have been identified:

- Strengthen blood quality control and supply, and prevention of blood borne HIV transmission through:
  - Appropriate use of blood and blood products throughout the country
  - Establishment of a nationally co-ordinated blood transfusion service;
  - Development and distribution of the national blood transfusion policy and guidelines;
  - Recruitment of non-remunerated blood donors/volunteers from the schools and community;
  - Regular training for health staff on the changing technologies of blood management; and
  - Carrying out community education on the procedures of blood donation, testing and transfusion, and the privileges for blood donors.
- Sensitisation and supervision of traditional healers, TBAs, and individuals involved in circumstances such ass clarification, blood sharing, and other forms of skin-piercing practices on new techniques for preventing blood borne HIV transmission.

STD prevention and treatment

Given the close association between the presence of an STD and HIV infection, STD prevention and treatment have been some of the strategies adopted in the prevention of HIV transmission.

Progress

A number of activities were implemented to address issues related to STD care. These include development and provision of IEC on std at selected health delivery points; development and distribution of guidelines on syndromic management of std; training service providers in diagnosis and syndromic management of STD; and integrating STD services with PHC and MCH/FP services.

As a result of these efforts:

- The IEC unit of the MoH has developed guidelines on the development of IEC materials, condom promotion and community sensitisation;
- Health care workers in selected districts, NGOs and CBOs have been trained in the management of AIDS patients, with support from the care and support unit of MoH;
- Counsellors and community AIDS care providers have been trained; and
- Drugs for the management of opportunistic infections including tuberculosis have been

provided. These efforts have registered modest declines in the rates of infection.

Constraints

In spite of the progress realised, there are still a number of constraints in implementing the strategy of preventing HIV transmission through the prevention and treatment of STD. These include:

- Limited number of trained personnel in STD syndromic management;
- Irregular supply of STD drugs and condoms at health units;
- Poor delivery systems of STD drugs to districts and lower level health units;
- Inadequate monitoring and management of STD drug resistance;
- Low partner notification of STD infection. About 5 – 15 per cent of STD patients ever notified the partners about their STD status (MoH, 1999); and
- Inadequate treatment of STD resulting to resistance to drugs.

Recommendations

Based on the foregoing analysis, the following recommendations have been identified:

- Strengthen syndromic management of std through comprehensive screening and treatment, and special studies to keep track of STD transmission and prevalence in the core groups;
- Integrate STD prevention and treatment into other health services; and
- Strengthen the drug procurement, delivery and management system.

Prevention of HIV infection through Mother to Child Transmission (MTCT)

Progress

Given the heavy disease burden due to HIV/AIDS associated with pregnancies, and recognising the potential benefits of averting vertical transmission of HIV/AIDS, prevention of transmission from Mother to Child has been a focus area for intervention in Uganda. Since 1992, a number of achievements have been recorded in the prevention of HIV through MTCT. These include:

- A pilot study and research on transmission of HIV/AIDS from mother-to-child has been carried out; based on this study a "mother-baby package" which contains essential safe motherhood requirements has been introduced;
- TBAs have also been provided with the kits which contain sterile gloves and other materials that are essential in preventing HIV transmission among mothers, newly born babies and the service provider;
- Policy guidelines for reduction of MTCT have been launched;
- A project for prevention of mother to child HIV transmission in Uganda, involving the administration of anti-retroviral drugs to pregnant mothers has been planned. The project involves a comprehensive package of care before, during and after delivery. This includes voluntary counselling and testing of pregnant women and their partners, including counselling on issues related to breast feeding after delivery; and
- There is a plan to pilot the prevention of MTCT of HIV in six sites in the country.

Constraints

The following constraints have been identified in prevention of MTCT of HIV:

- In a cultural context where large family sizes are traditionally associated with security and

supremacy, prevention of MTCT of HIV services may encourage HIV positive couples to have children;
- Inadequate alternatives to breast-feeding and the fact that breast feeding is the norm, means that children born of HIV positive mothers stand a high risk of acquiring HIV through breast-milk;
- Inadequate supervision and adherence to medical precautions of mothers who give birth at home; and
- Limited capacity of the health care system to offer counselling, testing and follow up of clients especially men after delivery.

Recommendations

Based on these observations the following recommendations have been proposed for the subsequent plan period:

- Initiate a phased implementation of PMTCT in selected health units;
- Strengthen awareness and sensitisation on PMTCT in order to facilitate informed decision making and reduce pregnancies among HIV positive and discordant couples;
- Promote utilisation of disposable or sterile and other necessary MCH/FP and safe motherhood equipment; and
- Promote cheaper alternative feeding programmes to breast feeding for HIV positive mothers

HIV Vaccine

Progress

Discussions on the ethical and legal issues related to vaccine trials in Uganda began in 1997 and actual trials commenced by mid 1999. Phase one of the vaccine trial will be concluded by the end of the year 2000. The notable achievements in vaccine development and trial are:

- Close collaboration between the Government of Uganda and UNAIDS in HIV Vaccine development and evaluation;
- Participation in HIV vaccine development and trials;
- Review of the ethical, legal issues related to vaccine development;
- Enrolment of 40 people for the vaccine trial;
- Consultations on the phase one trial of a therapeutic vaccine which is intended to delay disease progression and minimise HIV transmission; and
- Uganda has strengthened its capacity to participate in vaccine research and trials more effectively.

Constraints

In spite of the progress so far made in vaccine development and trial, there are still a number of constraints to be addressed. These include:

- Lack of guidelines to address ethical and legal issues particularly those relating to the participation of the public in the vaccine trials; and
- Lack of public sensitisation and awareness about the vaccine development and trials.

Recommendations

Based on these observations, the following recommendations are being made:

- Review the National Vaccine Development Plan and develop guidelines relating to vaccine trials;
- Build consensus on the revised vaccine development plan
- Sensitise key stakeholders about ethical issues and progress in vaccine trials; and
- Accelerate preparations for phase I trial of other therapeutic and preventive vaccines in Uganda; and
- Government in collaboration with UNAIDS and other institutions should support other initiatives in HIV vaccine development.

3.2.2 Goal II: Mitigate the Health and Socio-economic impact of HIV/AIDS at individual, household and community levels

Previous plans identified two broad strategies for the mitigation of the health and socio-economic impact of HIV/AIDS in Uganda. These were health care and social support.

AIDS Care and treatment

Progress

In the absence of a cure or vaccine and given the long period that elapses between infection and actual death, provision of AIDS care and social support are important components of previous plans. Current estimates indicate that 1.9 million people may be infected with HIV and 400,000 - 500, 000 are living with full-blown AIDS (STD/HIV Surveillance Report, 1998). These people and their families need psychosocial support, health care and sources of income.

Despite the limited capacity of the health sectors, a number of achievements have been made in partnership with the NGO/CBO sectors. These include:

- Promotion of improved health care services for PHAs through home based care and community outreaches by NGOs/CBOs and hospitals;
- Training of counsellors at the hospital level and over 500 others by a number of organisations;
- Training of officers from districts in infection control techniques;
- Development of the Nursing Care Guidelines and a Training Guide for counsellors;
- Distribution of drugs for the treatment of opportunistic infections and home-care kits to government and NGO health units;
- Training a number of service providers to administer drugs for opportunistic infections; and
- Provision of ARV treatment to some PHAs.

Constraints

In spite of these achievements, shortcomings have been identified in the care and treatment of HIV/AIDS. These are:

- Inadequate involvement of PHAs and their networks in HIV/AIDS prevention and control;
- A considerable proportion of PHAs do not acknowledge their sero-status;
- Stigmatisation and discrimination against PHAs by community members including medical personnel;
- Although there are now agreed regimens for treating various opportunistic diseases related to HIV/AIDS, they are too expensive for a large proportion of PHAs;
- Some herbal medicines that have been identified to be effective in the treatment of certain infections, have proved too expensive;

- Inadequate mechanism for distribution of drugs
- Inadequate advocacy/lobbying for the reduction of the cost for ARVs hence resulting to limited accessibility and affordability of appropriate AIDS care especially among the poor and rural residents;
- Inadequate diagnostics, use and monitoring of anti-retroviral drugs;
- Inadequate/lack of clear policies on HIV drugs including ARVs;
- Lack of evaluation of the impact of herbal treatment for opportunistic infections; and
- Inadequate involvement of AIDS caregivers, and referral system between the home, health unit, hospitals and specialised palliative care centres.

Recommendations

Based on the foregoing analysis, the following recommendations have been proposed:

- Provide more support to local NGOs/CBOs providing AIDS care and treatment;
- Strengthen palliative care for PHAs through:
  - Carrying out a survey on the families most affected by HIV/AIDS[3]
  - Integration of palliative care at all levels of health care;
  - Training service provider, religious leaders, traditional healers, home care giver, teachers and community workers in palliative care; and
  - Integration of palliative care in the pre-service training curriculum for health workers and teachers.
- Strengthen modern and herbal treatment for opportunistic infections through:
  - Developing and distributing appropriate drugs for opportunistic infections;
  - Introducing use of prohylaxis in the prevention and treatment of opportunistic and post exposure infections;
  - Procurement and distribution of appropriate drugs for opportunistic infections;
  - Utilisation and evaluation of herbal medicines in treatment of opportunistic infections;
  - Sensitisation of PHAs and community members on the appropriate modern and herbal treatment for opportunistic infections;
  - Advocacy for subsidy on the cost for ARVs and drugs for treatment of the various opportunistic diseases;
  - Establishment of a referral system between the home, health units, hospitals and specialised palliative service centres.
- Sensitise and educate community members on health care delivery, counselling, hygiene, nutrition and other relevant issues for PHAs.

Socio-economic support

It was recognised early that the HIV/AIDS epidemic would result in serious social and economic consequences due to a changed pattern of public expenditures and private savings. The morbidity and mortality rates of the workforce would increase leading to a serious loss of manpower. Although the earlier National Operational Plan (1993) did not provide solutions to these problems, it provided a starting point for addressing them.

It was proposed that a working group should be established under the ACP of the Ministry of Finance and Economic Planning to address budgetary implications of the AIDS epidemic. The Plan also proposed reviews of existing policies and legislation on social support in order to develop guidelines for legal advisors, counsellors and the operation of district AIDS support funds. NGOs and CBOs have been the lead agencies in the provision of social support to PHAs. Government

3 This refers to: families with a large number of AIDS orphans; child headed households due to AIDS; and families both of whose household heads are bedridden or dead due to AIDS.

ministries, through their ACPs have also extended social support to the respective employees and their dependants.

Progress

The following are some of the contributions Government, NGOs and community efforts have made towards the mitigation of the socio-economic impact of the epidemic:

- Development and support of income generating projects (IGPs) as one of the means of minimising the adverse socio-economic effects on PHAs;
- Provision of the following social support to PHAs by NGOs/CBOs, religious groups and community:
  - Foodstuffs;
  - Counselling services;
  - Mutual support activities;
  - Encouraging HIV testing;
  - Provision of spiritual and moral support; and
  - Supporting income-generating activities (IGPs) for PHAs.
- Training community-based counsellors to enable community members to handle HIV/AIDS issues;
- Integration of STD and family life IEC activities in counselling sessions;
- Setting up peer post-test clubs; and
- There is a growing understanding of the concept of comprehensive health care[4] for PHAs.

Other achievements that were not envisaged under NOP and not based on formal research include:

- Involvement of PHAs and their networks in providing counselling, encouraging the public to seek HIV testing, sensitising community members on the risk of HIV/AIDS, including IGPs for their families, and in the distribution of foodstuffs and preventive drugs to fellow PHAs;
- Decreased stigmatisation and discrimination due to the shared confidentiality which minimises denial and increases use of voluntary testing and counselling services;
- Improved quality of life and minimal weight loss by AIDS patients due to better management of opportunistic diseases;
- Increased community responsiveness to the needs for AIDS care. This was evidenced by the ever increasing number of volunteers, Co-operation from district authorities, and involvement of religious and other opinion leaders; and
- Increased proportion of PHAs receiving AIDS care at home. This is obviating the need for hospital bed space;
- Addressing the educational needs of AIDS orphans through the universal primary education (UPE);
- Increase in number of NGOs/CBOs and local governments providing support to AIDS orphans;
- Assessment of the impact of HIV/AIDS on agricultural production patterns and the legal implications of AIDS orphan-hood and widowhood; and
- Absorption of AIDS orphans by the relatives and families.

4 Nursing Care (personal hygiene, washing, counselling, bathing, clean bedding); nutritional support (balanced diet within available foods, appropriate food preparation); clinical management (treatment of infections); socio-economic support (finances to meet social needs such as school fees, clothing, shelter, food); mobilization of community support, and guidance and counselling.

Constraints

Despite these achievements, shortcomings have been identified in the provision of socioeconomic support to infected and affected families. These include:

- Inadequate foodstuffs donated to PHAs;
- Some IGPs have lacked personnel with basic knowledge of business and have failed.
- Counselling services at community level and in schools are still poor;
- Inadequate information on the socio-economic impact of HIV/AIDS;
- Inadequate involvement of the private sector and government social departments in socio-economic support to people infected and affected by HIV; and
- Gender disparities and cultural practices tend to render the girl child particularly exposed to exploitation and heavy domestic responsibilities.

Recommendations

Based on the foregoing observations, the following recommendations have been proposed:

- Promote special palliative care, social and spiritual support for children infected and affected by HIV/AIDS through:
  - Development and distribution of appropriate guidelines on advocacy and nursing care for children infected/affected by HIV/AIDS;
  - Development, distribution and sensitisation of stakeholders on utilisation of manuals on palliative car, social and spiritual support for children affected by HIV/AIDS;
  - Establishment child/adolescent friendly multi-service centres at community level;
  - Training service providers and other care-givers in delivery of child friendly palliative care, social and spiritual support services; and
  - Provision of financial and material support (shelter, food, school fees) to AIDS orphans, child headed households, and guardians/foster families.
- Promote economic and material assistance to PHA families through:
  - Review of the existing information on socioeconomic status of PHA families;
  - Development of income-generating projects (IGPs) that are packaged with skills development;
  - Training family members in management and monitoring IGPs;
  - Identification of NGOs or micro financing institutions with good track record to extend credit to the families most affected by HIV/AIDS; and
  - Mobilisation of the private business sector to contribute in kind or cash towards the welfare of PHAs.
- Promote the protection of legal, ethical and social rights of PHAs through:
  - Assessment of human rights, legal and ethical needs of PHAs;
  - Review, development and distribution of policies to address the needs, rights and responsibilities of the elderly and young people affected by HIV/AIDS;
  - Advocacy for enactment of appropriate laws that protect rights of PHAs;
  - Sensitisation of media groups, health service providers, AIDS workers and law enforcement agents on human rights and other legal and ethical issues of PHAs;
  - Sensitisation of PHAs on human rights and utilisation of existing structures to address their legal and ethical needs;
  - Integration of HIV/AIDS issues in the legal aid and counselling services; and
  - Monitoring and documentation of cases of human rights abuse related to HIV/AIDS.
- Incorporate HIV/AIDS concerns within the personnel management policy

3.2.3 Goal III: To strengthen the national capacity to respond to the epidemic

Strengthening the national capacity to respond to the epidemic is vital to the reduction of infection and mitigation of the socio-economic impact of the epidemic. It is also intended to safeguard the achievements so far made. Two main areas were identified for the strengthening of the national capacity to respond to the epidemic: These are:

- Resource mobilisation and institutional capacity building for effective implementation, co-ordination, monitoring and evaluation of HIV/AIDS activities; and
- HIV/AIDS information and research.

Resource mobilisation and institutional capacity building

Progress

It was recognised that mobilisation of resources and institutional capacity building is essential in ensuring a viable and sustainable AIDS Programme. This was addressed through government budgetary allocation, creating new structures to deal specifically with the HIV/AIDS problem, and mobilising support form donors, NGOs and the community.

Initially, a National AIDS Control Programme (NACP) was set up in the Ministry of Health. Upon the realisation that HIV/AIDS had far reaching consequences beyond the health concerns, Uganda AIDS Commission (UAC) and ACPs in line ministries were set up to co-ordinate and implement the national response to the epidemic. Since then, the following achievements have been made:

- Development and distribution of guidelines for AIDS prevention and control to stakeholders;
- Establishment of ACPs in line ministries and committees responsible for HIV/AIDS at district and lower levels;
- Increase in the number of personnel trained to plan, implement, co-ordinate, and undertake research related to HIV/AIDS;
- Increase in sharing of HIV/AIDS information through study tours and other means;
- On-going multi-sectoral approach to planning HIV/AIDS activities;
- The growing commitment by community members to fight the epidemic has enabled the initiation and implementation of a range of HIV/AIDS activities, and has resulted in.
- Establishment of national and regional networks related to HIV/AIDS for PHAs, Law and Ethics, Youth, Traditional Healers and AIDS Service organisations;
- Establishment of a legal framework (Uganda AIDS Commission) to co-ordinate the national AIDS control program; and
- Establishment of research institutions related to HIV/AIDS such as the National Blood bank and JCRC.

Constraints

The national framework for co-ordination and project implementation has been faced with a number of problems. The reasons for this include:

- Inadequate human/technical capacity and logistical support for UAC to effectively undertake its co-ordination roles and functions;
- Poor utilisation of available resources due to the ineffective co-ordination and networking mechanisms;
- Inadequate advocacy on the incorporation of HIV/AIDS as a national priority in the PEAP hence the limited budgetary provisions for HIV/AIDS in plans for line ministries, religious and other

organisations;
- Inadequate resources have hampered effective targeting of high risk population groups such as the out-of-school youth, children, armed forces, refugees, commercial sex workers, and fishermen;
- Line ministries have not been fully aware of their strategic role and linkage with UAC, other line ministries and districts in HIV/AIDS activities;
- Limited distribution and utilisation of guidelines for co-ordination and implementation;
- Limited involvement of private sector;
- Low levels of awareness and negative attitudes to HIV/AIDS issues among a number of leaders at various levels. Limited understanding about the implication of HIV/AIDS is partly responsible for its low priority ranking among the leaders at various levels;
- Inadequate participation of a number of potential human and institutional resources in the religious, traditional/cultural, private and co-operative movement sectors; and

Recommendations

In order to further strengthen institutional capacity to respond to the HIV/AIDS epidemic, there is need to:

- Strengthen planning, co-ordination, monitoring and evaluation of HIV/AIDS activities in the various sectors at national, district and community through:
  - Review and provision of logistical support to UAC to be able to effectively undertake its co-ordination roles and functions;
  - Training staff in planning, co-ordination, monitoring and evaluation of HIV/AIDS in sectors, districts and the community;
  - Development and distribution of guidelines for implementation and evaluation of HIV/AIDS activities; and
  - Sensitisation of stakeholders in planning, co-ordination, monitoring and evaluation of HIV/AIDS activities.
- Adopt a programmatic approach in planning, implementing, monitoring and evaluating HIV/AIDS activities;
- Strengthen capacity, and promote the utilisation of existing expertise and institutions or structures in HIV/AIDS activities at various levels;
- Strengthen collaboration, advocacy and networking in HIV prevention and AIDS care support in the region;
- Enhance and sustain civic and political commitment/leadership on HIV/AIDS activities at all levels;
- Strengthen and promote effective resource mobilisation approaches for HIV/AIDS activities/programs;
- Ensure that funds accruing from the debt relief are allocated to HIV/AIDS activities;
- Increase resource allocation for HIV/AIDS at district and community levels; and
- Strengthen HIV/AIDS resource management at national, district and community level;

HIV/AIDS information and research

Progress

It was recognised that information and research are essential components in monitoring HIV trends and understanding the mechanism underlying the HIV/AIDS epidemic. Hence the following activities were undertaken to strengthen the national information base and capacity to undertake research related to HIV/AIDS.

- Government through the Ministry of Health set up an epidemiology and surveillance unit to

monitor HIV/AIDS trends, and provide demographic information that is useful in planning, monitoring and evaluation;

- A National AIDS Documentation and Information Centre (NADIC) was set up and equipped. The centre gathers documents and disseminates to the public visual, audio and audio-visual information regarding HIV/AIDS in Uganda. So far more than 5000 items have been deposited at the centre. These include books, newsletters, published papers and films.
- NADIC regularly acquire CD-ROMs from several data bases and has maintained public access to appropriate data;
- A web site on HIV activities in Uganda has been developed and is accessible by local and international users;
- There is an inventory of HIV/AIDS research undertaken up to 1997, this listed more than 1,000 studies;
- Research has been undertaken covering the major aspects of HIV/AIDS including prevention, laboratory and clinical, epidemiological and socio-economic issues.
- Several studies have identified socio-economic correlates of HIV/AIDS; and
- There is strong research collaboration in herbal and modern medicine.

Constraints

Although Uganda has gone a long way in HIV surveillance, information gathering and documentation much remains to be done so as to create a comprehensive understanding of the spread and course of the epidemic. The main constraints include:

- Inadequate mechanism for co-ordination of data collection, dissemination and utilisation of data;
- Inadequate data regarding geographical and population subgroups coverage, quality, and missing parameters for effective monitoring trends and behaviour. This is associated with inadequate monitoring and reporting mechanisms of the true and suspected AIDS cases as well as STIs at the health delivery points and in the community respectively;
- HIV/AIDS monitoring systems have not been established in all sectors;
- Only a small proportion of available research and information is being deposited with NADIC, making access to and use of research less than optimal;
- Training public and community-based health workers in monitoring, recording and periodically upgrading AIDS surveillance data has not been sufficiently planned for and is an obstacle to effective data collection;
- Epidemiological and surveillance units are not spread throughout the country;
- Lack of a mechanism for strengthening AIDS information base at district and lower levels;
- Inventory of HIV/AIDS research has not been updated; and
- Studies do not always provide answers that would be translated easily into policy action.

Recommendations

Based on this analysis, the following recommendations were identified:

- Strengthen the HIV/AIDS surveillance system to ensure representative data by geographical location and population category through:
  - Carrying out national HIV sero-prevalence surveys before and after intervention;
  - Expansion of the HIV sentinel surveillance sites to every district;
  - Incorporation of behaviour surveillance alongside the available sentinel surveillance sites;
  - Development of community/population-based indicators for monitoring the AIDS epidemic;
  - Establishment of HIV/AIDS information collection and recording systems at national, district and community levels; and

- Training community-based health workers in AIDS related surveillance, information collection and recording.

- Conduct local and international symposia, workshops, seminars and conferences on emerging issues and research in the area of HIV/AIDS and making them intelligible and accessible to the local population;
- Encourage exchange and sharing of authentic visual and audio-visual information on HIV/AIDS through NADIC;
- Strengthen the HIV/AIDS information base;
- Re-organise national structures to co-ordinate research in the areas of HIV/AIDS through:
  - Identify areas of research and integrate them in the action plans for the various sectors;
  - Development of a national research plan based upon the sectoral needs and priorities
  - Review of the National Vaccine Plan;
  - Development and dissemination of a priority list to potential research institutions;
  - Advocacy for proposals on priority HIV/AIDS research issues; and
  - Promotion of collaborative research related to HIV/AIDS;
- Carry-out occasional surveys on a cross-section of HIV/AIDS issues through:
  - Promotion of community participation in research related to HIV/AIDS; and
  - Mobilisation and allocation of more resources towards HIV/AIDS research, particularly behavioural and laboratory ones.
- Strengthen the protection of legal and ethical rights of subjects and the intellectual property rights of researchers through:
  - Development and distribution legal and ethical guidelines in HIV/AIDS research; and
  - Sensitisation of researchers on the legal and ethical issues related to HIV/AIDS research.

3.3 Summary findings and Priorities for the period 2000/1 – 20005/6

The foregoing analysis points to a number of noteworthy developments since the HIV/AIDS disease was identified in 1982. These changes have implications for future strategies for dealing with the epidemic and defining the context in which this framework is to be implemented. The summary of major findings are presented, and based on this, a number of priority areas are proposed.

3.3.1 Findings

- There has been an overall decline in the HIV sero-prevalence rates between 1992 and 1996, in certain surveillance sites. However, these rates have been stagnant since 1996, at a high level;
- Sero-prevalence rates have only been determined for special groups e.g. blood donors, VCT clients, antenatal and STD clinic attendees;
- Although the decline in HIV sero-prevalence rates is acknowledged, the mechanisms underlying this reduction are not fully understood. Monitoring has been weak in the past and the trends in sero-prevalence cannot be properly apportioned between abstinence, being faithful and condom use;
- The balance between persons living with HIV/AIDS and new infections has changed. It is estimated that there are 1.9million PHAs most of whom play key roles in society as parents in the family and as the labour force in the economy;
- The presence of 1.9 million PHAs has an adverse impact on the quality of life of the population especially the health of the labour force and through this affects the performance of all sectors and the nation's ability to attain its social and economic goals;
- HIV/AIDS related interventions in districts may not necessarily be uniform given the policy of decentralisation and the possible variations in the prevalence and nature of HIV spread across districts;
- Integration of HIV/AIDS activities in the sectoral and departmental work plans and budgetary allocation to HIV/AIDS activities by Government has been very limited;

Strategies	Activities	Location	Sectors to be involved	Indicators	Means of verification	Recommendations	Cost US $
	b) Advocate for local mobilisation of resources to fund HIV/AIDS activities.	District and sub-county level.	MoFPED; **MoLG;** UAC; MoPS; Local Governments; MoGLSD; MoAAIF; NCC; NGOs/CBOs; Private and non profit organisations; PHA, Youth/Women net works; Religious, Cultural and Research Organisations	a) Proportion/number of districts, sub-counties with a budget line on AIDS and operating an AIDS development for families/individuals affected by HIV/AIDS b) %/Number of community members who benefited from the fund.	a) District and sub-county annual financial estimates/budgets. b) Records indicating specific PHA families/individuals that have benefited from the fund.		-
	c) Identify and attract new/additional support agencies for HIV/AIDS activities.	District and sub-county level.	MoFPED; MoLG; **UAC;** MoPS; Local Governments; MoGLSD; MoAAIF; NCC; NGOs/CBOs; Private and non profit organisations; PHA, Youth/Women net works; Religious, Cultural and Research Organisations	a) Proportion of new agencies supporting HIV/AIDS activities in Uganda. b) Amount of resources committed	a) Inventory of agencies supporting AIDS work in Uganda. b) Records indicating the amount committed by each support agency.		-
	d) Advocate for integration of HIV/AIDS in the annual budget lines at national, district and lower levels.	National district and lower levels	MoFPED; MoLG; **UAC;** MoPS; Local Governments; MoGLSD; MoAAIF; NCC; NGOs/CBOs; Private and non profit organisations; PHA, Youth/Women net works; Religious, Cultural and Research Organisations	a) % of sectors using own resources to undertake HIV/AIDS activities.	(a) Sectoral AIDS plans and budgets for HIV/AIDS activities.		-
	e) Advocate for designation of staff in line ministries, and local governments to HIV/AIDS work.	National level	MoFPED; MoLG; **UAC;** MoPS; Local Governments; MoGLSD; MoAAIF; NCC; NGOs/CBOs; Private and non profit organisations; PHA, Youth/Women net works; Religious, Cultural and Research Organisation	a) % of government ministries and local governments, and private sectors with staff designated for HIV/AIDS.	(a) Sectoral surveys.		-
	f) Conduct donors conference and local fund raising activities for HIV/AIDS activities (Integrate HIV/AIDS activities into the SWAP process)	National & district level	UAC; **MoFPED**; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private and non-profit organisations; PHA, Youth and Women Net works; Religious, Research and Cultural Organisations.	a) Proportion of HIV/AIDS activities being undertaken using locally mobilised resources.	(a) Records indicating amount of resources committed for different AIDS activities.	Local mobilisation of resources is the cornerstone for sustainability of AIDS programs. There should be a policy that would ensure that Internal mechanism for raising funds locally are instituted in each sector.	50,000
	g) Direct resources accruing from the debt relief towards HIV/AIDS activities.	National level	UAC; **MoFPED**; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private and non-profit organisations; PHA, Youth and Women Net works; Religious, Research and Cultural Organisations.	a) Amount/proportion of resources accruing from the debt relief committed to HIV/AIDS work.	a) Debt relief resource utilisation records.		-

Note: The bold and underlined organizations/ministries/agencies represent the lead actor. These will be responsible for intra-sectoral coordination (linking with the sectors that are undertaking the listed activities).

Strategies	Activities	Location	Sectors to be involved	Indicators	Means of verification	Recommendations	Cost US $
6. Strengthen HIV/AIDS resource management at national, district and community levels.	a) Develop and distribute procedural guidelines on funding HIV/AIDS proposals.	National, district and community level	UAC; **MoFPED**; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private and non-profit organisations; PHA, Youth and Women Net works; Religious, Research and Cultural Organisations	a) %/Number of stakeholders having access to guidelines for funding HIV/AIDS proposals	b) Projects designed and being implemented.		20,000
	b) Conduct regular consultative meetings with donors of HIV/AIDS projects.	National and district level	UAC; **MoFPED**; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private and non-profit organisations; PHA, Youth and Women Net works; Religious, Research and Cultural Organisations	a) % of stakeholders who report having attended consultative meeting with funding agencies.	a) Reports for the consultative meetings indicating specific issues addressed, resources committed and attendance list.	This is very essential for purposes of ensuring effective monitor of resource utilisation and accountability for HIV/AIDS funds in Uganda.	-
	c) Train managers for HIV/AIDS activities in resource mobilisation, utilisation and management.	National and district level	UAC; **MoFPED**; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private and non-profit organisations; PHA, Youth and Women Net works; Religious, Research and Cultural organisations	a) %/Number of Managers for HIV/AIDS activities trained in resource mobilisation. b) % of resources raised locally and committed/spent on HIV/AIDS activities.	a) Records indicating specific issues addressed during training and resources raised locally b) Interview stakeholders c) Analysis of budgets.		121,500
7. Enhance and sustain civic and political commitment/leadership in HIV/AIDS activity.	a) Target civic opinion and political leaders during HIV/AIDS sensitisation seminars/meetings at national, district and community levels.	National, district and community level	**President's Office**; . MoGLSD, MoLG, MoH, MoE, MoAAIF, other relevant government ministries, Religious and cultural organisations, NGOs/CBOs, media and journalist associations	a) Number % of civic, opinion and political leaders sensitised at various levels	a) Seminar reports		721,500
	b) Advocate for inclusion of HIV/AIDS issues on the agenda for civic, opinion and political leaders.	As above	**President's Office**; . MoGLSD, MoLG, MoH, MoE, MoAAIF, other relevant government ministries, Religious and cultural organisations, NGOs/CBOs, media and journalist associations	a) % number of community members having access to HIV/AIDS information/education through civic, opinion and political leaders.	b) Interviews with community members		160,000

Note: The bold and underlined organizations/ministries/agencies represent the lead actor. These will be responsible for intra-sectoral coordination (linking with the sectors that are undertaking the listed activities).

Objective 2: To strengthen the information base on HIV/AIDS at national, district and lower levels

Outcome: By the end of 2005/6 to have increased the n number and type of HIV/AIDS materials collected, and information users by at least 50%

Strategies	Activities	Location	Sectors to be Involved	Indicators	Means of Verification	Recommendations	Cost US $
1. Strengthen the HIV/AIDS surveillance system to ensure that it is representative by geographical location and population category.	a) Conduct sero-prevalence surveys in the general population	National level	**MoH;** Local Governments ; and Research Institutions	a) Availability of HIV sero-prevalence/epidemiological data for different categories of the population.	a) National sero-prevalence survey reports.	National sero-prevalence surveys are needed before and after intervention to keep track of the HIV prevalence and trends in the general population over a five-year period.	400,000
	b) Consolidate HIV/AIDS sentinel surveillance in 20 sites distributed in the country.	District level	**MoH** ; UAC; Government Ministries; Local Governments; Media and Journalists Association;; UNASO; Private sector; PHA, Youth and Women Net works; Religious, Research and Cultural Organisations.	a) Proportion of districts/sub-districts with surveillance sites. b) Proportion of districts/sub-districts with data on HIV prevalence and behavioural trends.	a) Records indicating the coverage of surveillance sites. b) District/sub-districts analyses of surveillance data.	The extension of sentinel surveillance sites is essential for monitoring trends of HIV in rural areas. More sites should therefore be established as low as the health sub-districts.	961,280
	c) Incorporate behavioural surveillance along side the available surveillance sites	District and community level	**MoH** ; UAC; Government Ministries; Local Governments; Media and Journalists Association;; UNASO; Private sector; PHA, Youth and Women Net works; Religious, Research and Cultural Organisations.	a) Proportion of sensitisation surveillance sites with data on behaviour trends	a) Records indicating trends in different aspects of behaviour related to HIV/AIDS.		-
	d) Set up and support HIV/AIDS information collection and recording system at national district and community level.	National district and sub-county level	**MoH** ; UAC; Government Ministries; Local Governments; Media and Journalists Association;; UNASO; Private sector; PHA, Youth and Women Net works; Religious, Research and Cultural Organisations	a) % of districts/sub-districts with information collection and recording points. b) % of districts/sub-districts with comprehensive surveillance data on HIV/AIDS.	a) Records indicating the surveillance data and analyses for each site.	District and lower level authorities would be instrumental in setting up and managing this HIV/AIDS information collection and recording system in collaboration with UAC.	660,000
	e) Train community based health workers in HIV/AIDS related surveillance information collection and recording.	National, district and sub-county level	**MoH;** UAC; Government Ministries; Local Governments; Media and Journalists Association; UNASO; Private sector; PHA, Youth and Women Net works; Religious, Research and Cultural Organisations.	a) Proportion of key stakeholders trained in HIV/AIDS information collection at national and lower levels .	a) Records indicating the specific issues addressed and attendance list.		428,400
2. Conduct local and international symposia, workshops, seminars and conferences on the emerging issues and research in the	a) Organise local symposia, workshops, seminars and conferences.	National, district and community level	**UAC** ; MoH;; Government Ministries; Local Governments; Media and Journalists Association; UNASO; Private sector; PHA, Youth and Women Net works; Religious, Research and Cultural Organisations	a) Number of local symposia workshops, and conferences related to HIV/AIDS held at various levels. b) Number of stakeholders who participated in local and international seminars related to HIV/AIDS.	a) Reports on the symposia, workshops and conferences attended.	Organising and attending workshops would not only serve as a means for generating new ideas in the area of HIV/AIDS but also for sharing/disseminating information at all levels	400,000

Note: The bold and underlined organizations/ministries/agencies represent the lead actor. These will be responsible for intra-sectoral coordination (linking with the sectors that are undertaking the listed activities).

Objective 3: To strengthen the capacity to undertake research related to HIV/AIDS at various levels
Outcome: By the year 200/6 increased research related to HIV/AIDS; by at least 25% and improved co-ordination of HIV/AIDS research at various levels.

Strategies	Activities	Location	Sectors to be Involved	Indicators	Means of Verification	Recommendations	Cost US $
1. Reorganise national structures to plan and co-ordinate research in the area of HIV/AIDS.	a) Set up an inter-institutional/ sectoral body to co-ordinate HIV/AIDS research	National and district level	**UAC**; Research Institutions; NCST; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private sector; PHA, Youth and Women Net works; Religious, and Cultural Organisations.	a) of sectors with body co-ordinating HIV/AIDS research. b) National HIV Research Body (NHRB) co-ordinating HIV/AIDS research.	a) Records/minutes indicating the specific issues AIDS research undertaken. b) Interviews.	A multi-disciplinary approach can be achieved through having an umbrella organisation in which personnel representing the different dimensions of HIV/AIDS are involved.	-
	b) Establish and support Technical Research Committee (TRCs) within the National HIV/AIDS research body (NHRB) and sectors.	National and district level	**UAC**; Research Institutions; NCST; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private sector; PHA, Youth and Women Net works; Religious, and Cultural Organisations.	a) Number of TRCs meetings conducted each year.	a) Records/minutes indicating the specific issues AIDS research undertaken. b) interviews.		30,000
	c) Analyse HIV/AIDS research inventory and identify research gaps	National level	**UAC**; Research Institutions; NCST; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private sector; PHA, Youth and Women Net works; Religious, and Cultural Organisations	a) Summary of the gaps in HIV/AIDS research	a) Records indicating the specific topics of research.	Community members should guide/participate in HIV/AIDS research prioritisation	100,000
	d) Identify research areas related to HIV/AIDS and incorporate them in the action plans for the different sectors.	National and district level	**UAC**; Research Institutions; NCST; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private sector; PHA, Youth and Women Net works; Religious, and Cultural Organisations	a) Number of research areas identified and operational research undertaken by the different sectors.	a) Operational research reports.		-
	e) Develop a national research plan based upon the needs and priorities of the different sectors	National and district level	**UAC**; Research Institutions; NCST; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private sector; PHA, Youth and Women Net works; Religious, and Cultural Organisations	a) National research plan available	a) National research plan indicating the specific sectoral needs and priorities.		25,000

Note: The bold and underlined organizations/ministries/agencies represent the lead actor. These will be responsible for intra-sectoral coordination (linking with the sectors that are undertaking the listed activities).

Strategies	Activities	Location	Sectors to be involved	Indicators	Means of Verification	Recommendations	Cost US $
	f) Mobilise resources for HIV/AIDS research at various levels.	National and district level	**UAC**; Research Institutions; NCST; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private sector; PHA, Youth and Women Net works; Religious, and Cultural Organisations	a) % of stakeholders with budget line for HIV/AIDS research. b) Number of HIV/AIDS researches funded/Number of researchers having access to resources for HIV/AIDS research.	a) Records indicating the organisations and individuals funded to undertake HIV/AIDS research.		2,500,000
	g) Draw up and disseminate a priority list to potential research institutions.	National and district level	**UAC**; Research Institutions; NCST; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private sector; PHA, Youth and Women Net works; Religious, and Cultural Organisations.	a) % of stakeholders having access to prioritised list of HIV/AIDS research.	a) Interviews.		-
	h) Facilitate collaborative HIV/AIDS research.	National and internation al level	**UAC**; Research Institutions; NCST; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private sector; PHA, Youth and Women Net works; Religious, and Cultural Organisations.	a) Number of collaborative HIV/AIDS research undertaken.	b) Records indicating collaborative research in the field of HIV/AIDS by type.		100,000
2. Carry out occasional surveys on a cross section of priority HIV/AIDS issues in various sectors such as the impact of HIV/AIDS on public and informal sectors, agricultural systems, etc.	a) Call for research proposals on a range of priority HIV/AIDS issues.	National and district level	**UAC**; Research Institutions; NCST; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private sector; PHA, Youth and Women Net works; Religious, and Cultural Organisations.	a) Number of research proposals received at each research grant competition. b) Number of progress reports for approved research	a) List and copies of approved research proposals	This is important in order to maximise use of the research available.	2,250
	b) Disseminate research findings at national and community levels.	National and community level	**UAC**; Research Institutions; NCST; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private sector; PHA, Youth and Women Net works; Religious, and Cultural Organisations	a) %/Number of stakeholders who report having access to results of the research undertaken in their areas. b) Strategy initiated to address findings.	a) Records indicating progress of research b) Research reports and records indicating the specific issues addressed during dissemination and recommended action, and attendance list		100,000
3 Promote community participation in research on HIV/AIDS issues.	a) Design guidelines for community involvement in data collection, management and dissemination of information related to HIV/AIDS	National and district level	**UAC**; Research Institutions; NCST; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private sector; PHA, Youth and Women Net works;	a) % of stakeholders having access to guidelines for community involvement.	a) Records indicating the specific ways in which community members were involved.	Community involvement in HIV/AIDS research would ensure rapid and effective utilisation of research findings.	20,000

Note: The bold and underlined organizations/ministries/agencies represent the lead actor. These will be responsible for intra-sectoral coordination (linking with the sectors that are undertaking the listed activities).

Strategies	Activities	Location	Sectors to be involved	Indicators	Means of Verification	Recommendations	Cost US $
	related to HIV/AIDS.		Youth and Women Net works; Religious, and Cultural Organisations				
4 Strengthen protection of legal and ethical rights of subjects, and the intellectual property rights of researchers.	a) Prepare and distribute guidelines on the legal and ethical issues and intellectual property rights related to HIV/AIDS research.	National District level	**MoJ**; MoH; UAC; Research Institutions; NCST; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private sector; PHA, Youth and Women Net works; Religious and Cultural Organisations	a) % of stakeholders having access to the legal and ethical guidelines of HIV/AIDS research.	a) Interviews.	This is necessary in order to strengthen Uganda's capacity to conduct future HIV/AIDS and similar research.	20,000
	b) Carry out sensitisation seminars for researchers on legal and ethical standards of HIV/AIDS research.	National District level	**MoJ**; MoH; UAC; Research Institutions; NCST; Government Ministries; Local Governments; Media and Journalists Association; NCC; UNASO; Private sector; PHA, Youth and Women Net works; Religious and Cultural Organisations	a) % of researchers who report having access to information regarding the legal and ethical standards of HIV/AIDS research.	a) Interviews.		30,375

Note: The bold and underlined organizations/ministries/agencies represent the lead actor. These will be responsible for intra-sectoral coordination (linking with the sectors that are undertaking the listed activities).

CHAPTER FIVE

IMPLEMENTATION AND COORDINATION

5.1 Implementation

The agencies implementing HIV/AIDS activities can be identified with four functional categories:

(a) Implementation:
This class includes all the front-line and grassroots organisations in the provision of HIV/AIDS-related services (e.g. hospitals, PHA organisations, CBOs, NGOs, ACPs, religious and cultural organisations, research groups, etc). This tier interfaces with individuals and their families.

(b) Co-ordination:
This group includes those agencies that undertake vertical or horizontal linkages of other organisations (e.g. UACS, district and lower level co-ordination committees, UYNAS, PHA networks, Government Ministries, etc.) Their main functions are monitoring and evaluation, providing opportunity for networking and sharing of information and supervision.

(c) Advisory:
These have an advisory role on both policy and technical matters (e.g. UAC, Government Ministries, PHA networks, external support agencies, etc.)

(d) Policy-Making:
These provide overall guidance to HIV/AIDS activities (e.g. UAC, Government Ministries, President's office, Cabinet, Parliament).

The implementation of the Strategic Framework for HIV/AIDS activities in Uganda (2000/1 - 2005/6) therefore require a comprehensive institutional arrangement for co-ordination so as to achieve effective linkages among the various tiers of organisations. Collective responsibility of government ministries and institutions, NGOs, communities, families, individuals, and continued political commitment and support for HIV/AIDS activities at all levels is also essential. In recognition of district variations and taking into account the decentralisation Programme, it is envisaged that the districts and sub-counties will play a pivotal role in the implementation of the Framework.

5.2 Co-ordination

Co-ordination arises because the functions of the sectors and sub-sectors in the multi-sectoral HIV/AIDS Programme are inter-related and geared towards achieving common goals and objectives. This requires clearly defined policies, guidelines, a legal framework, and well-developed action plans based on the National Strategic Framework for AIDS activities.

5.2.1 Mandate, Mission and Functions of UAC

Uganda AIDS Commission (UAC) was established by statute in 1992 to oversee, plan and co-ordinate AIDS prevention and control activities throughout Uganda. The UAC members are drawn from government ministries, Parliament, non-governmental organisations, religious organisations and individuals active in the field of HIV/AIDS. Uganda AIDS Commission established a national co-ordination structure, which consisted of sectoral ACPs in 13 ministries, Technical and Advisory Committees. AIDS Co-ordination Committees were also established to oversee the implementation of HIV/AIDS activities at the district and sub-county levels.

Mandate of UAC

Uganda AIDS Commission is an independent agency established by statute. The Commission has a Secretariat, which undertakes its day-to-day work. The mandate of UAC is to:

- Liase with the line ministry and other ministries on policy issues;
- Provide leadership to all partners in the HIV/AIDS response;
- Ensure the fulfilment of national goals; and
- Ensure co-ordination, monitoring and evaluation of the progress in the implementing the national plan.

Mission Statement

Uganda AIDS Commission exists to provide leadership in co-ordination of HIV/AIDS programmes and activities of all stakeholders in Uganda through advocacy, joint planning, monitoring and evaluation for the eventual elimination of the AIDS scourge in Uganda.

Roles and functions of UAC

Uganda AIDS Commission is the lead agency for the co-ordination of the implementation of this Programme. Its principal role shall be that of providing overall leadership, guidance and co-ordination of HIV/AIDS partners and activities in planning, implementing, managing and evaluating the National Programme. To do this effectively, UAC shall:

- Formulate policy and establish Programme priorities;
- Spearhead National Joint Planning, Supervision, Monitoring and Evaluation
- Advocate for HIV/AIDS programmes and activities;
- Identify obstacles for policy and Programme implementation;
- Mobilise and monitor utilisation of resources for HIV/AIDS activities;
- Foster sectoral and district linkages;
- Disseminate HIV/AIDS information; and
- Promote HIV/AIDS research.

According to the Inter-Ministerial Committee Review (1997), various public and private institutions were independently undertaking HIV/AIDS activities without being effectively co-ordinated by the Commission. For example, the Commission has not been effectively involved in mobilisation and monitoring utilisation of resources for AIDS control programmes and activities as stipulated in the statute. District and lower level co-ordination has also been weak mainly because of inadequate guidance from Uganda AIDS Commission, lack of financial support, lack of local ownership and clear co-ordination mechanisms within and between sectors. These have made it difficult to know the activities undertaken in the different sectors and guard against duplication. In addition, the national policy of decentralisation had not fully evolved.

Effective co-ordination requires a Commission with a strong Secretariat, which is currently understaffed and inadequately funded. Besides the need for adequate logistical support, UAC Secretariat should be equipped with qualified personnel to be able to provide the required guidance and leadership in the implementation of the National AIDS Programme.

5.2.2 Co-ordination Mechanisms

The central and local governments shall put in place mechanisms or organs for co-ordination, planning and monitoring of HIV/AIDS activities at national, district and lower levels. Co-ordination of

the national Programme be done through:

- Joint planning;
- Joint supervision, monitoring and evaluation;
- Information documentation and exchange; and
- Fostering inter-sectoral and district linkages.

At national level, the main mechanism of co-ordination shall be through the National Joint Planning Team (NJPT) to be comprised of representatives from the line Ministries, Non-Governmental Organisations, Religious Organisations and the Private Sector. In order to obtain the highest level of commitment, members of the NJPT should be Permanent Secretaries or heads of institutions/organisations. The organisations/ministries to constitute the NJPT shall be determined and appointed based upon a criteria developed by UAC and its partners. The NJPT shall be convened on quarterly basis, chaired by the Uganda AIDS Commission, and supported by technical standing committees for planning, monitoring and support supervision. These committees shall be constituted along thematic lines such as AIDS care, VCT and socioeconomic support. To this end, the NGOs and the private business enterprises shall be part and parcel of these committees in their individual or networking capacities.

In addition, each line ministry set up committees to assist in defining the co-ordination, implementation and monitoring mechanisms within their mandates up to community level, and linkages with the NJPT. These committees shall also comprise of representatives of NGOs and/or the private business sector they often network with when undertaking their mandates.

The main objective of the NJPT is to harmonise the HIV/AIDDS plans of all sectors before approval by Government. The NJPT will periodically review the implementation of the agreed plans. Key outputs of the NJPT should include:

- Shared analysis and perspective on the National Multi-sectoral Programme;
- Agreed policies;
- Common milestones and indicators of implementation of the National Programme;
- Mutually acceptable working arrangements and responsibilities such as national co-ordination mechanisms, monitoring and evaluation;
- Agreed resource mobilisation plans, drawing on all partners;
- Mechanisms for including diverse and non-traditional partners, both at district and national level;
- Mechanisms for ensuring timely resource transfer and technical support to district and community levels; and
- Agreed guidelines for co-ordination of activities at district levels.

Co-ordination of HIV/AIDS at district and sub-county levels should adopt an integrated approach. District leaders should be adequately sensitised on the need for co-ordination. The roles, specific composition, location and additional mandate of these organs shall be determined by the respective local councils taking into account the magnitude and nature of the HIV/AIDS problems in their areas and their proposed course of action.

Each district shall have a committee to co-ordinate HIV/AIDS activities, and ensure that similar co-ordination mechanisms are replicated at lower levels. This committee shall be headed by the Chairman LCV, supported by the District Planning Team and headed by the Chief Administrative Officer.

In order to ensure that HIV/AIDS is main streamed in the district budget and provide a sustainable

linkage between the district and UAC in HIV/AIDS monitoring and information sharing, the Chief Administrative Officer shall be the district focal officer. In so doing, UAC shall continue to develop guidelines regarding co-ordination of HIV/AIDS activities at district level, and receive, update, harmonise and disseminate information to all key actors and the public. Consequently, the National AIDS Documentation and Information Centre (NADIC) should be strengthened so as to develop and strengthen national and district level communication linkages.

CHAPTER SIX

MONITORING AND EVALUATION

6.1 The Context

The Country's needs and aspirations for socio-economic development and strategic actions for their achievements in the medium and long-term are articulated in the Poverty Eradication Action Plan and the Uganda Vision 2025 initiative. These plans are designed to ensure that economic growth in Uganda continues and that its benefits are spread widely. These plans also stress the importance of empowering households to earn decent incomes and the provision of basic services such as education, health, housing and water and sanitation so as to improve the quality of life of the population. It is evident that the continued presence of the HIV/AIDS problem and its attendant consequences will deny the achievement of these broad goals. There is a need therefore to view HIV/AIDS issues in the broader context of the socio-economic development goals and gauge the related interventions as contributions to the attainment of those aspirations. To this end, the monitoring and evaluation function should cover a wide array of issues including the effect of HIV/AIDS on the various sectors such as agriculture, education and health.

In spite of the remarkable achievements in the combat against HIV/AIDS, Uganda still faces a serious problem. The trends in HIV infection showed an initial decline, followed by stagnation at high rates. Although the past general trend in HIV infection is known, there is little understanding regarding the mechanisms that produced that trend. HIV/AIDS programmes suffer from a general lack of supervision, monitoring and evaluation necessary to guide implementation of activities and future adjustments in Programme design and strategy. As a result, successive project designs have tended to perpetuate the same approaches often with the same relative emphases without regard to their efficacy.

Given the dwindling resources and rising expectations, there is need for a more efficient delivery of services and more effective management of resources. In this regard, there is an urgent need to strengthen and design mechanisms and tools for supervision of HIV/AIDS programmes. Capacity for supervision, monitoring and evaluation needs to be specifically developed and resources should be allocated to these functions.

6.2 Organisational Linkages for Monitoring and Evaluation

The effective implementation of activities outlined in the Strategic Framework will largely depend on the existence of an efficient mechanism for monitoring and evaluation. In this connection, the main objective shall be to ensure that each implementing agency contributes to the accomplishment of the policy aims. Monitoring and evaluation shall be the main function of those agencies carrying-out the co-ordinating role and will depend heavily on the flow of information from the implementing organs. This activity should be seen as mutually beneficial for the implementing agencies to assess their performance and seek corrective measures, and for the co-ordinating bodies to form policy. Since a good monitoring and evaluation system is crucial to ensuring resources are well used, it is generally recommended that about 10 per cent of the HIV/AIDS budget be allocated to monitoring and evaluation activities excluding the routine surveillance of HIV and risk behaviour.

The Uganda AIDS Commission through its Secretariat shall be primarily responsible for the periodic evaluation and monitoring of the implementation of the National Strategic Framework. Lower level co-ordinating agencies (e.g. at Sub-county level, Districts, ACPs-MoH, MoFPED and other line ministries) will directly monitor and evaluate projects under their purview. The implementing line ministries, institutions, NGOs, shall develop a regular reporting system using guidelines from the

Secretariat. In addition to designing a system of collecting, collating and analysing information from the implementing agencies, the Commission shall cause the Secretariat to develop their in-house capacity for monitoring and evaluation. In particular, the Secretariat will specify the data needs for monitoring and evaluation.

The Commission shall assess progress of the implementation of the Framework, and carry out a Baseline Survey prior to the start of its implementation. In addition, a Mid-term and End-of-term Programme reviews will be conducted after two and five years, respectively. The review reports will be summative, covering all Programme areas of the plan and will indicate the strength and weaknesses in the implementation of the framework over the activity period and outline opportunities and foreseen challenges. Other co-ordinating agencies will prepare more frequent reports (half-yearly, quarterly, monthly) in order to feed into the national report. In particular, ACPs and AIDS co-ordinating bodies at district and lower levels shall prepare quarterly reports. The aim of this set of activities shall be to improve the effectiveness of individual organisations in the implementation of the National Strategic Framework.

The Commission shall from time to time, commission special impact assessments and other relevant studies. These exercises shall be undertaken along thematic lines (e.g. prevention, counselling, care, social support, etc) and shall include a range of implementing partners. The Commission shall create a forum for all concerned agencies to review periodically their roles and work progress.

The stated objectives and strategies for the Strategic Framework provide a logical basis around which to organise the monitoring and evaluation activities. A sound monitoring and evaluation plan should aim at yielding information on the inputs as well as indications on the progress of implementation (outputs). In this regard, the Uganda AIDS Commission shall undertake a review of the project documents for some of the major partners in HIV/AIDS activities with a view to assess the amount and type of resources available to these agencies. The main output of this review shall be to collate information on the implementation process and advise on the necessary re-orientation of the Programme.

6.3 Outstanding Gaps

There are at least three problems observed regarding the monitoring and evaluation of HIV/AIDS interventions in the past:

- Exclusion of the monitoring and evaluation function from many interventions;
- Lack of information on KABP regarding HIV/AIDS and clearly linking this to trends in sero prevalence rates; and
- Absence of sero prevalence statistics representative of the general population.

Monitoring is usually viewed as an integral part of the management information system and is intended to enhance co-ordination, permit the anticipation of bottlenecks at an early stage and allow corrective action. However, the bulk of periodic reports available contain only lists of activities undertaken without reference to the broader objectives to which they are meant to contribute. In addition, there is no system in place for summing up reports to derive a national picture regarding performance according to strategy (e.g. sensitisation).

Since many HIV/AIDS programmes did not include monitoring and evaluation as major integral components of their work, there is a severe lack of information linking observed trends in sero prevalence rates and past interventions. As a result, while the decline in positive sero prevalence rates is acknowledged, it is difficult to determine the relative importance of the strategies that were

adopted. For example, nationally the reduction in the proportion of HIV positive persons cannot be apportioned between abstinence, being faithful, and condom use. A representative survey on knowledge, attitudes, beliefs and practices regarding HIV/AIDS needs to be carried out during the early part of the implementation of this framework. This should provide basis for prioritising strategies and subsequently guide the re-orientation of the programmes towards the more efficacious approaches.

Current information on sero prevalence rates is based on data collected in selected sentinel sites using blood taken from clients attending antenatal and STD clinics. Although this data may be sufficient to outline the overall national trends, its being non-representative imposes limits to its interpretation and use. For example, sero prevalence rates among men, older women, and those using contraception are unknown. Yet the design of interventions both for the prevention of further spread of HIV/AIDS and mitigation of its adverse effects should be based on a detailed picture of its variation across population sub-groups. Provision should be made for a sero prevalence survey at the beginning of the implementation of the Strategic Framework, to be followed by a similar exercise at the mid-term and end of the plan period.

6.4 Recommendations for Monitoring and Evaluation

While the log frame (Chapter 4) has outlined the various indicators on which information should be collected to gauge progress a sound monitoring and evaluation is necessary. These are:

- Each implementing agency should set aside resources for undertaking the monitoring and evaluation within the context of its mandate and action plan. For example, an agency that has a three-year plan should review progress more frequently as compared to those with a five-year plan.
- Monitoring and Evaluation should not be limited to activities undertaken (processing indicators). It should include outputs (e.g. change in sexual behaviour); track infection rates and the resources utilised. Thus a comparison of the cost-effectiveness of various approaches should be a major outcome of a periodic review.
- A data collection and analysis plan should be integrated in the monitoring and evaluation system. In drawing up such a plan, advantage should be taken of existing data bases (e.g. from TB programmes or Reproductive Health) and try to influence planned data gathering activities (e.g. by inclusion of an AIDS module in a Demographic and Health Survey).
- A centralised database or library of HIV/AIDS/STD-related material should be kept up-to-date (at NADIC) and this should contribute immensely to the efficiency of the M & E efforts.
- A record of research protocols and questionnaires should be maintained at UAC so that they can be easily repeated to achieve consistency across populations over time. This list should include on-going data collection efforts as well as those already completed.

REFERENCES

Barnett, T., & Blaikie, P. (1992). AIDS in Africa: It's present and future impact. London: Belhaven.

Barton. T., & Mutiti. A. (1998). Northern Uganda Psychosocial Needs Assessment. Kampala: Ministry of Gender, Labour and Social Development

Fehling, K., Muhumuza, J., & El-Wambi, W. (1996, January). A Baseline Survey of Full-time Street Children in Kampala. Kampala: MoGLSD & FOCA.

Hampton. J. (1991). Living positively with AIDS: The AIDS support organisation (TASO) Nairobi: AMREF.

Hunter. S. (1990). Project for enumeration and needs assessment of orphaned children in Uganda. Unpublished. Survey Report, Institute of Statistics and Applied Economics, Makerere University.

Joling, M. (1996). AIDS in the family: "It's just like that". A research report.

Kagimu, M., Marum, E., Natukunda, E., Emasu, S., Were, B., Pickering, H., Forsythe, S., Fasan, P., Baine, S., & Tereka, S. (1996, November). A Review of AIDS Prevention and Control Activities in Uganda. Unpublished Review Report. Kampala: UAC.

Kayita, J., & Kyakulaga, J. B. (1997, August). HIV/AIDS Status Report. Kampala: Uganda AIDS Commission.

Kiirya S. K., & Kibombo. R. (1999, December). Community knowledge, attitude and practices related to female genital cutting in Kapchorwa district, Kampala: FPAU/REACH/UNFPA/MISR

Kiirya. S. K. (1996, October). Programme for Enhancing Adolescent Reproduction Life (PEARL) in Uganda. Final evaluation report. Kampala: UNFPA, MoGLSD.

Kiirya, S. K. (1997, April). Reproductive, Educative and Community Health (REACH) Project in Kapchorwa District. Final Evaluation Report. Kampala: UNFPA.

Laenkholm, A. S., & Cuijspers, R. (1997). Rapid Appraisal Results on the Reproductive Health Care in Refugee Settlements/Camps in Uganda. Paper presented at a workshop on reproductive health care in refugee areas, Cardinal Nsubuga Leadership and Training Centre, June 12 - 14, 1997. Nsambya: UNFPA/UNHCR.

Mayambala, E. N., Musumba, S., & Byaruhanga-Akiiki, A. B. T. (1997). Critical Areas Requiring Formulation of Guidelines for and HIV/AIDS Policy, Legal and Ethical Framework. Consultancy Report. Kampala: Uganda AIDS Commission.

MoH/HPD (1996). Health Facility Inventory. Entebbe: Ministry of Health.

MoH (1996, October). Results of the population based KABP survey of on HIV/AIDS and Std in four districts in Uganda. Kampala: STD/ACP Ministry of Health

Ntozi, J. P. M., Sekatawa, E. K., Konde-Lule, J., Tumushabe, J., Kirunga, C. T., Nakayiwa, S., Ahimbisibwe, F. E., Lubaale, Y. A. M., & Zirimenya, S. (1997, July). HIV/AIDS Research Results and its Summary. Consultancy Report. Kampala: Uganda AIDS Commission.

Olowo-Freers, B. P. A., & Barton, T. G. (1992). In Pursuit of Fulfilment: Studies of Cultural Diversity and Sexual Behaviour in Uganda. An overview essay and annotated bibliography. Kisubi: Marianum.

PEARL (1995). Programme for Enhancing Adolescent Reproductive Life (PEARL) in Uganda. Kampala: UNFPA.

REACH (1996). Project Document of the Reproductive, Educative and Community Health Project in Kapchorwa District. Unpublished project Document UNFPA.

Sandro, A., Massimo, F., Lukwiya, m., Corrado, B., Awil Onek, P., & Declich, H. (1998). Coping with the impact of the AIDS epidemic in Northern Uganda. Analysis of six years of activities of Lacor Hospital, Gulu (92-97): Instituto Supreiore Di Sanita.

Sewankambo, N., & Kirumira, E. (1997, June). HIV/AIDS Research Inventory. Kampala: Uganda AIDS Commission.

Statistics Department (Uganda) & Macro International Inc. (1996). Uganda Demographic and Health Survey, 1995. Calverton, Maryland: Statistics Department (Uganda) & Macro International Inc.

STD/ACP (1991 - 1999, March). STD/HIV Surveillance Reports. Entebbe: Ministry of Health.

UAC (1997, September). NGO/CBO Inventory. Kampala: UAC/UNAIDS.

UAC (1997). Concept Paper for the Development of the National Strategic Framework for HIV/AIDS, 1998 - 2002. Kampala: Uganda AIDS Commission.

UAC (1994). Uganda AIDS Commission Annual Report for 1994. Kampala: UAC.

UAC (1993, October). Uganda National Operational Plan for HIV/AIDS Prevention, Care and Support (1994 - 1998). Kampala: Uganda AIDS Commission.

UAC (1993, February). AIDS Control in Uganda: The Multi-Sectoral Approach. Kampala: Uganda AIDS Commission.

UAC (1996). National AIDS Control Policy Proposals. Kampala: Uganda AIDS Commission.

UNAIDS (1996, December). Global Epidemic Estimates. Geneva: UNAIDS.

UNAIDS (1997, June). Children Living in a World with AIDS: World AIDS Campaign Media Briefing. Geneva: UNAIDS.

WHO/UNICEF/INAIDS (1999, September) WHO/UNICEF UNAIDS statement on current status of policy guidelines. Geneva: WHO/UNAIDS/UNICEF.

UNAIDS (January, 1999). International partnership against HIV/AIDS in Africa. Meeting of the UNAIDS sponsoring agencies and Secretariat: Annapolis, Maryland 19-20 January 1999.

APPENDIX I:

COST AND FINANCIAL ANALYSIS

The National HIV/AIDS response is estimated to cost US$ 181, 466, 030 over the 5 year period. As a percentage of Government of Uganda expenditure, it is expected to constitute 3.31%, while it takes 0.51% of GDP. Of the total cost estimate, about 16% is estimated to come from the provisions under the Health Sector Strategic Plan, while an estimated 16%-30% is hoped to come from other Government sectors. Tables 1 and 2 show HIV/AIDS estimated cost versus Government of Uganda funding as well as estimated funding from the Health Sector Strategic Plan. This reflects an estimated total of US $ 60m-88m from the Government sectors, leaving a funding gap of US $ 94m-122m. This is likely to be reduced by the existing funding for NGOs that may not have been reflected in the financing of the plan.

Table 1: Estimated cost for HIV/AIDS Strategy versus GoU Expenditure and GDP

	2000/01 million US $	2001/02 million US $	2002/03 million US $	2003/04 million US $	2004/05 million US $	5 yr total million US $	% of GoU	% of GDP
Total GoU Expenditure#	896.03	974.76	1081.87	1192.47	1332.22	5477.34		
GDP*	6218.75	6575.88	6977.22	7647.70	8382.82	35802.37		
HIV/AIDS Strategy						181.47	3.31	0.51

Note: * =source is the 22 Oct 99 MTEF projections of MoFPED
= For the 1st 3 years, figures are derived from 19 Jan 2000 MTEF projections (MoFPED); for the last 2 years, the figures are derived from 22 Oct 99 MTEF projections of MoFPED.

Table 2: Estimated funding from the Health Sector Strategic Plan (in US $)

	2000/01	2001/02	2002/03	2003/04	2004/05	5 yr total
STI/HIV/AIDS (100%)	1,646,999	1,687,501	1,723,059	1,772,690	1,839,009	8,669,258
Tuberculosis (60%)	847,695	868,541.4	886,842.6	912,387	946,521	4,461,987
Sexual and Reproductive Health (30%)	2,972,119.2	3,045,209.1	3,109,375.2	3,198,937.8	3,318,614.7	15,644,256
IEC (30%)	389,556.3	372,462.6	363,499.8	362,946.3	352,597.8	1,841,062.8
UAC (100%)	470,647	470,647	470,647	470,647	470,647	2,353,235
Total	**6,329,016.5**	**6,444,361.1**	**6,553,423.6**	**6,717,608.1**	**6,927,389.5**	**32,9669,798.8**

As is shown in table 3 below, the priority has been placed on the reduction of the rate of HIV infection (i.e. prevention), taking a share of 46.1% of the estimated total cost. Mitigation of the health and socio-economic effects of HIV/AIDS follows with a share of 32.9%, while strengthening national capacity to respond to the epidemic takes 21.0% of the total estimated cost.

Table 3: Breakdown of cost estimate for the HIV/AIDS Plan by goal/major activity (in US $)

Item	5 year cost estimate	%
Goal 1: Reduction of HIV Infection by 25% by 2005/6	83,707,680	46.1
Goal 2: Mitigation of effects of HIV/AIDS	59,672,693	32.9
Goal 3: Strengthening National Capacity for Response	38,085,657	21.0
Grand Total	**181,466,030**	**100.0**

APPENDIX II:
REVIEW AND COSTING TEAM OF THE NATIONAL STRATEGIC FRAMEWORK 2000/1 - 2005/6

Review Consultants

1. Adeniyi E (Professor)	United Nations Joint Program on AIDS, Geneva
2. Kiirya. S. K	Makerere Institute of Social Research
3. Odongkara F	Information, Discovery and Solutions Limited
4. Sekatawa E (Ph.D.)	Institute of Statistics and Applied Economics

Costing Consultants

1. Bridgitte I	United Nations Joint Program on AIDS, Geneva
2. Tumusiime P	Ministry of Health

Uganda AIDS Commission

1. Bishop Halem'Imana B R	Chairman
2. Kihumuro-Apuuli D N	Director General
3. Rwomushana J (Professor)	Co-ordinator, Health and Research
4. Namulondo Kadowe J	Technical Officer, Social and Economic Sector
5. Tindyebwa D	Consultant
6. Kindyomunda Mwesigwa R	Co-ordinator, Documentation and Information
7. Nakaweesi A	Co-ordinator Human Resource and Administration
8. Were E	Statistics and Information Analyst
9. Kiconco Turyamureba C	Secretary
10. Namata L	Support Secretary for Consultants

UNAIDS Representatives

1. Kosia A	World Health Organisation, Kampala
2. Lawson A	United Nations Joint Program on AIDS, Kampala
3. Mikklesen M	United Nations Joint Program on AIDS, Kampala
4. Njie H	World Health Organisation, Kampala

Government Partners

1. Achaye	Office of the President
2. Barungi	Ministry of Internal Affairs (Police)
3. Batala C	Ministry of Tourism Trade and Industry
4. Biryahwaho B	Uganda Virus Research Institute
5. Cwinya-Ai	Ministry of Agriculture, Animal Industry & Fisheries
6. Gipwola J	Ministry of Information
7. Kagimba J	Presidential Advisor
8. Kaweesa D	Ministry of Health
9. Mugyimba E	Ministry of Gender, Labour and Social Development
10. Nankunda H	National Council for Children
11. Nsubuga P	Ministry of Health (STI Project)
12. Nyabwana B	Ministry of Internal Affairs (Prisons)
13. Obbo H	Ministry of Public Service
14. Ssonko J	Ministry of Local Government

International Partners

1. Bigirimana Z	AMREF
2. Bunnell R	United States Agency for Internal Development
3. Ibanda S	United Nations Development Programme
4. Kabiswa D	ACET
5. Mawejje D	Save the Children Fund
6. Moss V	Mildmay International
7. Okwero P	World Bank

Local Partners

1. Byamugisha G (Rev)	Church of Uganda
2. Kabatesi D	Traditional Healers Together against AIDS
3. Katana M	National Guidance & Empowerment Network for PHAs
4. Kitonsa S	Uganda Network on Law and Ethics
5. Kyabita J	National Community of Women Living with HIV/AIDS
6. Mahoro F	AIDS Information Centre
7. Mugarura E (Rev)	Church Human Service AIDS Prevention Programme
8. Mukasa Monico S	The AIDS Support Organisation
9. Munyagwa R	Islamic Medical Association of Uganda
10. Ouma M	ITF
11. Ruranga R (Major)	National Guidance & Empowerment Network for PHAs
12. Wamimbi R	Uganda Network for AIDS Service Organisations
13. Wangalwa S	AIDS Information Centre