



The Evaluation Report

for

The Joint UN Programme of Support on AIDS in Uganda (JUPSA 2011-2014)



and

Priorities for the January-December 2015 Work-Plan

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Figure 1: JUPSA Steering and Committee and other UN staff after Validating the JUPSA Evaluation Report in December 2014

Cover page picture: First Lady/EMTCT Champion with UNAIDS EXD at eMTCT Launch

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Acronyms

AA	Administrative Agent
AIDS	Acquired Immune Deficiency Syndrome
AMICAAL	Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa
ART	Anti-retroviral Therapy
ARVs	Anti-retroviral drugs
CAO	Chief Administrative Officer
CEHURD	Center for Health, Human Rights and Development
CSOs	Civil society Organisation
CV	Curriculum Vitae
DTPC	District Technical and Planning Committee
EIAs	Environmental Impact Assessments
ILO	International Labor Organisation
IOM	International Organisation for Migration
HIV	Human Immune-Deficiency Virus
HLO	High Level output
JSC	Joint Steering Committee
JUPSA	The Joint UN Programme of Support on AIDS in Uganda
FAO	Food Agriculture Organisation
FP	Family Planning
LG	Local Government
M&E	Monitoring and Evaluation
MGLSD	Ministry of Gender, Labour and social Development
MoH	Ministry of Health
MoWT	Ministry of Works and Transport
MoLG	Ministry of Local Government
MTR	Mid-Term Review
NAFOPHANU	The National Forum of PHA Networks in Uganda
NGO	Non-Governmental Organization
NPA	National Planning Authority
NSP	National Strategic Plan
OAFLA	Organisation of African First Ladies against HIV/AIDS
OPM	Office of Prime Minister
P&E	Provide and Equip Ltd
PEPFAR	President's Emergency Plan for AIDS Relief
PMCT	Prevention of Mother to Child Transmission
PLHIV	People Living with HIV and AIDS
SAA	Standard Administrative Arrangement
SMC	Safe Male Circumcision
TA	Technical Assistance
TB	Tuberculosis
TOR	Terms of Reference
TWGs	Technical Working Groups

UAC	Uganda AIDS Commission
UGANET	Uganda Network on Law, Ethics and HIV/AIDS
UK	United Kingdom
UN	United Nations
UNASO	Uganda Network for AIDS Support Organisation
UNDAF	United Nations Development Assistance Framework
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commission for Refugees
UNODC	United Nations Office on Drugs and Crime
U.S.	United States
USAID	United States Agency for International Development
USG	United States Government

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Executive Summary

Background: In 2007, the UN in Uganda responded to the UN reform to improve its effectiveness, relevance and coordination to position UN as a strategic partner to the national AIDS response. Hence the Joint United Nations Programme of Support on AIDS (JUPSA) was established in 2007-2012 and a Joint UN Team on AIDS set up to oversee and monitor its implementation. JUPSA was aligned to United Nations Development Assistance Framework (UNDAF) 2010-2014; The National Development Plan (2011-2014); The National HIV Strategic Plan (2011/12-2014/15) and to three priority areas in the UNAIDS vision on getting to *Zero New Infections, Zero AIDS-related Deaths and Zero Discrimination*. This has since been revised to 90-90-90; testing 90% of the population for HIV; treating 90% of the eligible HIV positive population and reducing the viral load by 90%.

JUPSA provides upstream support; it is a coordination mechanism for UN agencies to support HIV and AIDS interventions, and hence JUPSA is not a direct implementer.

Objectives of the Evaluation: The overall objective of the evaluation was to undertake an in-depth analysis of the JUPSA Programme in order to generate comprehensive and specific evaluation feedback on the implementation of the Programme. The evaluation findings informed priorities for the January – December 2015 Bridging Work Plan.

Approach and Methodology: The evaluation employed a highly qualitative, consultative and participatory approach entailing; an inception meeting with the UN Technical Working Group (TWG); documents review, consultative and brainstorming meetings at national and district levels; key informant interviews, validation workshops and thematic analysis of the qualitative data.

Relevance: Overall, almost all stakeholders agreed that JUPSA was very relevant because it addressed the NSP priorities and key priority needs of targeted beneficiaries; supported systems and capacity strengthening through financial and technical support; strengthened the coordination of the HIV and AIDS response through the support to Uganda AIDS Commission (UAC) and other stakeholders; strengthened linkages and networking among stakeholders; availed additional funding for HIV and AIDS, increased demand for HIV and AIDS services and provided technical and financial support to the NSP reviews and development, as well as the NSP Monitoring and Evaluation (M&E) plan. JUPSA design provided for broad stakeholder participation and employed a key strategy of re-engaging the country's leadership that revamped leadership commitment. JUPSA was designed to fill in the response gaps and emerging dynamics identified by the Mid Term Review (MTR) of the 1st JUPSA.

Effectiveness: JUPSA achieved its intended objectives and hence realized the desired outcomes through contributing to the following achievements:

HIV Prevention Achievements: JUPSA was a major contributor to the revitalization of HIV prevention; especially through support to: strategy development and implementation planning for combination HIV prevention at national, sector and district levels; JUPSA implemented focused campaigns promoting of Elimination of Mother to Child Transmission of HIV (eMTCT) and Safe Male Circumcision (SMC) as core elements in combination HIV prevention nationally and increased services to the youth through establishing 34 youth friendly corners in Kampala, Kalangala, Arua, Gulu and Pader districts.

JUSPSA strengthened the institutional and technical capacity for the HIV and AIDS implementers through supporting the adaptation of the National AIDS Spending Assessment (NASA) methodology. Through

high-level advocacy, the First Lady became the champion of eMTCT. JUPSA was a catalyst for intensified focus on reaching key populations (including MARPs) and supported the developed and operationalised numerous national guidance documents for Anti-Retro Viral Therapy (ART), Early Infant Diagnosis (EID), eMTCT, Sexual and Reproductive Health (SRH) and Gender.

Communities were mobilized to demand for and utilize prevention integrated HIV services through conducting eMTCT and 'Protect the Goal' campaigns and launches; supporting increased male involvement in ANC and eMTCT through Maama Clubs; mobilization of all Mayors through Alliance of Mayors and Municipal Leaders on HIV and AIDS in Africa (AMICALL); engagement of cultural leaders; supporting Most At Risk Populations (MARPs) networks, and service organizations to enable demand and access to SRH and HIV services – including peer education and service delivery; supporting targeted service delivery for MARPs and establishing youth-friendly corners in health facilities, religious institutions and school settings. An advocacy paper for meaningful involvement of youth in national decision making processes was finalised and youth friendly centers were established.

Treatment, Care and Support Achievements: JUPSA supported increased access to ART for eligible People Living with HIV and AIDS (PLHIV) through: supporting the customization of international ART and Post-Exposure Prophylaxis (PEP) guidelines to the local context and enhancing capacity for ART service delivery and providing targeted support to further scale up of pediatric HIV care and Early Infant Diagnosis (EID); and integrating ART as an integral element in combination HIV prevention among key populations. As a result, the ART facilities providing PEP for HIV increased from 6% in 2008 to 50% in 2014; number of districts with ART Quality Improvements (QI) Teams increased from 50 out of 112 in 2010 to 80 by 2014; the ART sites providing both adult and pediatric treatment increased from 76% in 2010 to 80% by 2014 and ART facilities in which at least 80% of the clients keep their medical appointments increased from 14.1% in 2008 to 80% in 2014.

JUPSA further supported Tuberculosis (TB) services for PLHIV by undertaking resource mobilization for TB/HIV collaborative activities, supporting the review, update and dissemination of policy guidelines and integrating HIV/TB co-management training into the comprehensive HIV curriculum. As a result, the facilities fully implementing TB/HIV collaborative activities increased from 30% in 2010 to 50% by 2014.

The PLHIV and the households affected by HIV were supported to access to essential care and support. JUPSA supported a study on the analysis of HIV-sensitive social protection responses in Uganda, which gave insight on how the various social protection strategies mitigate the socio-economic impact of HIV and AIDS in Uganda. JUPSA provided support for the establishment of 113 child protection committees in Kabarole and Kyenjojo districts and trained 400 committee members. Support was further provided for boosting the nutritional status of PLHIV and increasing agricultural productivity.

The national capacity to lead, plan, coordinate, implement, monitor and evaluate the national HIV response was enhanced through strengthening governance and management using the Accountability Score Card Index and through supporting the functions of the Partnership Committee and Forum; contributing to the review and a forensic audit of UAC that resulted into restructuring which culminated into enhanced technical capacity; and facilitating the review of HIV sensitive social protection policy and legal frameworks. JUPSA contributed to maintaining the HIV and AIDS response on the development agenda and ensuring that AIDS Development Partners (ADPs) as well TWGs continue to dialogue on issues of transparency and accountability within government and other institutions. The Parliament of Uganda through the HIV and AIDS Committee and the Speaker of Parliament were engaged in leading

the HIV and AIDS response. UNAIDS has addressed over 50% of parliamentarians and some Cabinet Ministers to ensure high-level involvement and participation.

Governance and Human Rights Achievements: JUPSA supported the review of laws that target MARPS; HIV infected and affected persons; that included the HIV and AIDS Prevention and Homosexuality Bills. A legislative policy and institutional review was undertaken to integrate health and social issues (particularly HIV and Gender, into environmental impact assessments (EIAs) for capital projects. A legal audit was conducted with focus on sex workers and a national reference team was constituted to oversee HIV and AIDS laws and policies. A handbook on HIV and AIDS for judges and legal profession as well as a statutory instrument on employment and HIV and AIDS non-discrimination regulation were developed to enhance gender and HIV/AIDS mainstreaming.

Boosting HIV and AIDS resources was a major contribution of JUPSA by contributing to, the ‘un-blocking’ of Uganda from accessing Global Fund (GF) resources and provided support to the Ministry of Health (MOH) and The AIDS Support Organisation (TASO) to manage resources in a timely manner. JUPSA further supported improving the functioning of the GF Country Coordination Mechanism (CCM). JUPSA strengthened private sector engagement in the response whereby some hotels offered free meeting halls for all HIV/AIDS related discussions, whereas some media houses offered free airtime. Through AMICAALL and Ministry of Local Government (MOLG), most districts have allocated funds for HIV and AIDS activities and an ‘All Mayors’ national forum meets annually to deliberate on HIV and AIDS issues. Resource mobilization was done to encourage the ADPs to commit more funds for the response.

Advocacy targeting leadership was strengthened through high-level re-engagements with the President and the First Lady, Cabinet, Parliament and district leadership; the President and First Lady both tested publicly for HIV to motivate the public for increased HIV Counseling and Testing (HCT) uptake. The UN worked through Inter-Religious Council of Uganda (IRCU) to regularly bring together religious leaders and their congregations to discuss key HIV and AIDS issues; a pastoral letter was developed to provide guidance on content and subject matter to be addressed by religious leaders as they preach in their houses of worship JUPSA provided global guidance for implementation of the global advocacy campaign through Civil Society Organisations (CSOs) networks, especially umbrella organizations (Uganda National AIDS Services Organisations (UNASO), National Forum of People Living with HIV/AIDS Networks in Uganda (NAFOPHANU), National Community of Women for Living with AIDS (NACWOLA), Uganda Network on Law Ethics and HIV and AIDS (UGANET), Mama Club) as well as the Uganda Youth Forum (UYF).

JUPSA supported improved coordination as well as M&E by strengthening coordination of the UN agencies and supporting UAC to conduct the Joint Annual Review (JAR) meetings, and supported development of the NSP, National Prevention Strategy (NPS), NSP National Plan of Action (NPAP), the NSP M&E Plan, the Investment Case, the GF proposal. JUPSA supported the implementation of numerous analytical studies and disseminating reports. JUPSA supported the mainstreaming of gender and HIV into the labour inspection checklist; and the development of the National Action Plan on Women, Girls, Gender Equality and HIV and AIDS through Ministry of Gender, Labour and Social Development (MGLSD). JUPSA sensitized cultural leaders on Gender Based Violence (GBV) and developed action plans on mainstreaming gender as well as HIV and AIDS. UN supported UAC to mainstream gender into the NSP 2015-2020. Twenty five (25) districts were supported to develop work plans that are not only gender responsive, but also addressing GBV. Engagement of political and legislative leadership on gender and human rights is another area that JUPSA supported. Financial

support was extended to MGLSD to lead the streamlining and strengthening of a youth self-coordinating entity, for effective youth representation at the national partnership committee.

Efficiency: JUPSA programme attained moderate efficiency through: minimizing duplication and wastage by working through existing systems and structures; use of an Administrative Agent (AA) instead of a parallel funding mechanism; pooling resources and shared responsibility for interventions such as GF proposals and NSP development, high level advocacy, 'Protect the Goal' and eMTCT campaign launches, and analytical studies. Efficiencies were further realized through robust M&E mechanism that ensured timely reporting; prioritizing capacity enhancement as a pre-requisite for attainment of results; sharing of international experience and innovation in cost reduction approaches.

JUPSA Investments were more largely into HIV prevention (53.8%); followed by treatment, care and support (31.7%) and governance and human rights (14.5%); which is likely to impact positively on combating the HIV and AIDS epidemic.

However, full realization of efficiency was limited by inadequate human; high rate of attrition in government departments; low absorption capacities among national implementing partners; late disbursement and delays in accessing funds from headquarters of some Participating UN Organisations (PUNOs affects timely execution of programmes); non-alignment of financial years and reporting systems for the UN, Government of Uganda (GoU) and ADPs hence time and cost implications; inadequate accountability and transparency in government departments; high level of bureaucracy in UN and GoU and the fact that JUPSA relies on partners to deliver services hence limited control of the implementation rate.

Sustainability: The design and implementation of JUPSA entailed elaborate strategies that ensured sustainability through: advocacy targeting political, religious and cultural leaders who are expected to ensure continuity of the response; continued engagement of high level leadership to the HIV and AIDS response; wider participation of key stakeholders in the design and implementation of JUPSA interventions led to increased programme ownership. The laws, policies and strategies that were put in place will transcend JUPSA, such as the HIV and AIDS Trust Fund, which will ensure continued funding of the response. Technical and institutional capacity strengthening for central and local government structures will ensure continued delivery of quality services. JUPSA also invested in empowering communities to demand for services. The documented lessons learnt, best practices and success stories will remain key reference points for future HIV and AIDS programmes. The HIV/AIDS Investment Case Report and the AIDS Trust Fund provides a long-term strategy for continued funding for the response. JUPSA further worked with and through existing structures, hence continuity. The integration of HIV and AIDS into primary level and lower secondary curriculum will further ensure institutionalization and continuity of HIV and AIDS.

Sustainability was constrained by frequent changing of priority focus areas on programme areas; heavy reliance on donor funding; the changing priorities of JUPSA, "JUPSA started with ART then PMCT, SMC hence not enough time spent on each priority to totally ground any programme".

JUPSA Related Challenges: There was limited JUPSA visibility and clarity of UN agency roles; limited stakeholder involvement and ownership; some districts complained that some UN agencies mainly focus on human rights and governance and neglect service delivery especially in the area of TB and mainly worked with the health department in programme implementation and neglected other social services. Prioritizing individual UN agency and IPs work plans as opposed to focusing on the JUPSA interventions

was commonly reported. According to IPs, there were insufficient implementation funds given to them. There was inconsistent and non-systematic tracking of JUPSA logical framework indicators.

IP Related Challenges

There was overwhelming demand for services yet insufficient HIV and AIDS supplies and logistics. Stigma by Health Center (HC) staff against pregnant PLHIV was reported to limit access to Antenatal Care (ANC) and eMTCT services. There were delays in government procurement systems and inadequate staffing levels among HCs across the country, hence negatively affecting service delivery. For instance the UAC 2011 audit revealed a 60% deficiency in UAC staffing. There were delays in approving work plans and releasing funds due to bureaucracies in UN and GoU. Some institutions such as UAC and MOH had low absorption capacity of resources, hence limited implementation of the HIV and AIDS interventions. The different finance and reporting systems and timelines for ADPS, government and UN agencies led to heavy workload for IPs. There was limited government funding to sector level HIV and AIDS programmes.

Lessons Learned: The JUPSA model facilitates realization of efficiency through pooling of resources and employing a coordinated approach to the HIV/AIDS response; thus minimizing duplication and increasing efficiency and effectiveness. The re-engagement of leadership fosters ownership and yields strong political will and better results. The establishment of the multi-sectoral JUPSA Joint Steering Committee (JSC) fosters ownership. Limited involvement of the government at district level in the initial planning processes of JUPSA interventions leads to limited ownership of the programmes, hence limiting its sustainability. Delays experienced by the UN system; followed by delays from GoU and other implementing partners system creates “multiple delays” which is counter-productive.

Best Practices: The following best practices were identified: Planning reporting and implementing as one which enhanced synergies; private sector engagement in HIV and AIDS response increased HIV and AIDS resources; working with cultural institutions through their subjects to address GBV and HIV and AIDS issues was effective; male involvement in HCT to minimize GBV was effective; pooling of funds together in one basket enhanced efficiency; use of faith based model to disseminate HIV and AIDS messages reaches a wide constituency and regular engagement and JUPSA, UAC and other stakeholders.

Conclusions: Relevance: Overall, JUPSA is deemed as a very relevant programme given its alignment to the national and international HIV and AIDS strategic plans; as well as the focus on the drivers of the epidemic and meeting the needs of those infected and affected by HIV and AIDS.

Effectiveness: JUPSA largely achieved its objectives and hence realized the intended outcomes. However, there is still a high unmet need for HIV and AIDS services.

Efficiency: The JUPSA model has brought considerable returns with relatively moderate input due to pooling together of resources, which minimizes duplication of efforts and resource wastage. However, weak accountability and transparency in government and other institutions limits efficiency.

Impact: JUPSA has had commendable impact on the HIV and AIDS response in all the thematic areas evidenced by the reduction in deaths related to HIV and AIDS and reduction in new infections.

Sustainability: JUPSA has a strong element of continuity through great investment in capacity enhancement as well as working through existing service delivery, political, religious and cultural structures, which will ensure sustainability of services.

Recommendations: Improve the JUPSA theory of change by reorganizing the JUPSA results framework so that for instance all capacity strengthening interventions are housed under one result area, though having different agencies contributing to it. JUPSA results framework should focus on outcomes, outputs and indicators that are directly attributable to JUPSA. Scale up advocacy, particularly on HIV prevention and GBV to political, religious, cultural and other leaders, as well as district councillors. Strengthen stakeholder (public and private sector) engagement and coordination. Scale up engagement of cultural and religious institutions to address structural drivers of the epidemic and finance implementation of HIV and AIDS work plans for cultural institutions. Strengthen institutional and technical and capacity for delivering HIV and AIDS services. Strengthen systems and technical capacities of cultural institutions to be able to access and handle resources. Revise strategies of approach and engagement of cultural leaders so that they initiate interventions in their communities. Scale up efforts towards attaining 90-90-90 UN global targets; testing 90% of the population; treating 90% of the eligible HIV positive individuals; reducing the viral load by 90%. Broaden the HIV and AIDS resource base including increasing domestic financing, both from GoU and private sector to reduce reliance on donor funds; operationalizing HIV and the AIDSTrust Fund in line with the Investment Case and targeting the non-traditional ADPs such as those from Asia such as Japan and China. Provide a strategy for financial risk management in view of the weak public financial management system. Consider managing the pooled JUPSA resources centrally for improved ease of access, reporting and more efficiency by IPs. ADPS should collectively review funds given to stakeholders in form of transport refund and sitting allowances in order to improve accountability and transparency among stakeholders. Engage MOH top leadership to address the accountability and the low absorption issues. Strengthen and improve JUPSA visibility, coordination and functioning. Strengthen JUPSA M&E through systematic tracking of JUPSA performance indicators. Continue building capacity in M&E for UN PUNOS and IPs. Institutionalise regular review meetings between UN TWGs and IPs. Maintain the sustainability interventions by working through existing structures and strengthening their capacity; develop a clear and sustainable exit plan when funding projects to enable IPs be better positioned for the transition.

Priorities for January – December 2015 Bridging Work-plan

Based on the analysis of JUPSA 2011-2014 evaluation findings, the following interventions were identified for prioritization during the January – December 2015 Bridging Work-plan period:

- Continue with high-level advocacy, to keep up the momentum. Focus on paediatric AIDS and adolescents.
- Strengthen domestic resource mobilization. Support the establishment and operationalization of the AIDS Trust Fund.
- Scale up private sector engagement to contribute more to the HIV and AIDS response
- Guide discussions on the Homosexuality Bill and the HIV and AIDS Bill
- Further scale up eMTCT efforts to include private clinics
- Scale up HIV and AIDS interventions with a focus on the drivers of the epidemic. Support a vulnerability analysis survey
- Implement more BCC and target sex workers, fishing communities other key populations
- Design deliberate interventions targeting adolescent girls and other youths in secondary schools and higher institutions of learning. Implement youth empowerment interventions entailing life skills and livelihood skills
- Test and treat aiming at the 90-90-90 UN global targets

- Support institutional and technical capacity strengthening for government and community structures, as well as other IPs
- Strengthen and operationalise M&E systems for JUPSA and UAC. Ensure regular tracking and reporting on indicators. Hold a planning retreat for developing JUPSA 2016-2020
- Generate more evidence by supporting the development and implementation of the national HIV and AIDS research agenda. Provide technical assistance to National AIDS Documentation and Information Center (NADIC) to make it more function as a central hub for information sharing
- Participate in the East African HIV and AIDS Conference to be hosted by Uganda in March 2015

1.0 Introduction

1.1 Background

In 2007, the United Nations System in Uganda responded to the UN reform to improve its effectiveness and relevance at country level and adopted guidelines and principles of the Global Task Team on improving coordination of the UN and Multilateral System on AIDS by establishing a Joint Team and a Joint Programme on AIDS. The purpose of this approach was to improve the coherence and effectiveness of UN support and to position UN as a strategic partner to the National AIDS response. This led to the development of a Joint UN Programme of Support on AIDS (JUPSA) 2007-2012 and the establishment of a Joint UN Team on AIDS to oversee and monitor its implementation. This was in line with national HIV priorities articulated in the National Strategic Plan and the UNDAF outcome on HIV and AIDS. The UN family in Uganda instituted a midterm review (MTR) of the JUPSA in November 2010 to determine progress in its implementation from 2007 to 2010. The MTR findings informed the development of a second (2011-2014) generation Joint Programme (JP) that is aligned to the new UNDAF 2010-2014, the National Development Plan (2011-2014), the National HIV Strategic Plan (2011/12-2014/15) and to three priority areas in the UNAIDS vision on getting to Zero New Infections, Zero AIDS-related Deaths and Zero Discrimination.

In developing outcomes and higher-level outputs (HLO), the Joint UN Team on AIDS reviewed national strategic guidance against UNAIDS global strategic guidance and 10 goals articulated in the UNAIDS Strategy. The process enabled the Team to formulate outcomes and HLOs for each three thematic areas of prevention, Treatment and Care and Governance and human rights.

The JUPSA (2011-2014) has seven (7) outcomes and twenty-one (21) HLOs. The seven outcomes are:

1. National systems have increased capacity to deliver equitable and quality HIV prevention integrated services
2. Communities mobilized to demand for and utilize prevention integrated services
3. Access to antiretroviral therapy for PLHIV who are eligible increased to 80 percent
4. Tuberculosis deaths among PLHIV reduced
5. People Living with HIV and AIDS (PLHIV) and households affected by HIV are covered in all national social protection strategies and have access to essential care and support
6. National capacity to lead, plan, coordinate implement monitor and evaluate the national HIV response strengthened, and
7. Laws, policies and practices improved to support gender equality and reduce human rights abuses, stigma and discrimination.

JUPSA UN participating agencies include: UNAIDS, UNDP, UNFPA, WHO, UNCIEF, FAO, UNHCR, UNESCO, ILO, UNWOMEN, IOM, WFP, and UNODC. Implementing partners include; UAC, MoH, Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALL), UGANET, UNASO, CEHURD, MGLSD, MAMA Club and OAFLA.

JUPSA provides upstream support; it is a coordination mechanism for UN agencies to support HIV and AIDS interventions, and hence JUPSA is not a direct implementer.

1.2 Scope and Focus of the Evaluation

The Programme evaluation was result-based and participatory involving key stakeholders ranging from UN participating agencies and implementing partners, line ministries, the parliament and selected districts that provided useful feedback on the programme Implementation and objectives, successes and failures.

The evaluation utilised the Development Assistance Committee (DAC) /Organisation of Economic Cooperation and Development (OECD) evaluation criteria of relevance, effectiveness, efficiency, impact and sustainability, as well as best practices and lessons learnt; the evaluation findings informed priorities for the January – December 2015 bridging work plan.

1.3 Objectives of the Evaluation

The overall objective of the evaluation was to undertake an in-depth analysis of the JUPSA Programme in order to generate comprehensive and specific evaluation feedback on the implementation of the Programme. The evaluation exercise assessed the programme based on the following evaluation criteria:

1. Effectiveness- The extent to which the Programme's stated objectives were achieved. The effectiveness of the Programme was assessed in accordance with the activities, outputs and outcomes.
2. Sustainability - The extent to which benefits from the Programme would continue or are likely to continue (such as follow up projects, strengthened community structures, visible and permanent results).
3. Relevance - The degree to which the Programme was justified and appropriate in relation to the need and situation on the national and regional level.
4. Efficiency - The analysis and the evaluation of the overall Programme performance, the outputs in relation to the inputs, the financial management, and the implementing timetable.
5. Impact - The long-term results that were achieved and are likely to be achieved in the future, measuring the positive and negative, foreseen and unforeseen changes as well as effects on the society caused by the Programme as well as the Programme catalytic effects.

2.0 Technical Approach and Methodology for the Evaluation

This section describes the methodology that was used in executing the assignment and includes discussions on overall approach, data collection and data analysis.

2.1 Overall Approach

The Evaluation of the Joint UN Programme of Support on AIDS in Uganda (JUPSA 2011-2014) and development of a Bridging January-December 2015 Work-Plan was undertaken through a highly consultative and participatory process with wider involvement of all key stakeholders involved in the implementation of the (JUPSA 2011-2014) to ensure ownership and accountability. The evaluation primarily utilised qualitative methods in executing this exercise. Stakeholders that participated in this evaluation were purposively selected at national and local government levels based on their involvement in the implementation of JUPSA 2011-2014. The entire process was supervised and co-ordinated by UNAIDS in close collaboration with JUPSA UN participating agencies including; United Nations Development Programme (UNDP), World Health Organisation (WHO), United Nations Children's Fund (UNICEF), Food and Agriculture Organisation (FAO), United Nations High Commission for Refugees (UNHCR), United Nations Educational, Scientific and Cultural Organization (UNESCO), International Labour Organisation (ILO), UNWOMEN, International Organisation for Migration (IOM), United Nations Office on Drugs and Crime (UNODC) and Implementing Partners including; Uganda AIDS Commission (UAC), Ministry of Health (MoH), Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALL), Uganda Network on Law, Ethics and HIV/AIDS (UGANET), Uganda Network for Aids Support Organisation (UNASO), Organisation of African First Ladies against HIV/AIDS (OAFILA), Center for Health Human Rights and Development (CEHURD), Ministry of Gender, Labour and Social Development (MGLSD) and MAMA's Club.

2.1.1 Technical Approach for the Development of the 2015 Work plan

Based on the evaluation findings regarding the JUPSA achievements, challenges and lessons learnt, the 2015 work plan priorities were identified and agreed upon at the evaluation report validation workshop. The work plan development was also informed by the UNDAF 2010-2014, NDP 2011-2014 and NSP 2011/12-2014/15. The priorities in the next generation of the respective plans were taken into consideration as available.

Provide and Equip Limited (P&E) led a consultative process to develop the draft work plan and budget based on the agreed priorities. Participation was sought from all UN agencies in the country. Existing plans and budgets of individual agencies were used as key reference documents in the planning process.

2.2 Data Collection Methodology

Secondary and primary data for the evaluation was gathered using a desk review checklist, interview guides, brainstorming in consultative meetings, and in depth interviews; Table 1 below shows the different methodologies used and the target respondents.

Table 1: Data Collection Methodology Overview

Data Collection Method	Target
Desk Review	All key relevant documents including program documents, progress reports, workplans, and JUPSA M&E framework
The consultative and brainstorming meetings	JUPSA UN participating agencies that included Civil Society Organizations (CSOs) and the JUPSA Technical Working Groups (TWGs)
District level consultative and brainstorming meetings	District HIV Focal Point Persons and technical planning committee members
Key informant interviews	i. JUPSA UN participating agencies ii. AIDS Development Partners iii. Implementing Partners iv. Parliament, Government Ministries and Agencies <i>(For full list of the above and people contacted see annex 2)</i>
Validation workshop	Key stakeholders that entails UN agencies, IPs, line ministries and local government

The table below shows the districts that were selected for consultative meetings. The selection of districts took into consideration regional representation, and within the region, care was taken to ensure that the districts belong to different sero-behavioral survey regions. Another key consideration was to include the districts that were not recently covered by the UAC HIV and AIDS NSP review meeting that took place in September 2014, as well as districts with key populations were also considered. Table 2 below shows the proposed districts:

Table 2: Selected Districts

SBS Regions	Selected districts for the JUPSA Evaluation
Central	Kampala
East-Central	Mayuge
West Nile	Yumbe
Mid Northern	Gulu
South Western	Kanungu
Karamoja	Moroto
Total	6

Below is the detailed presentation of the data collection methods used:

2.2.1 Secondary Data Review

A detailed review of the following documents was conducted. These included; JUPSA 2011-2014 Programme document, programme Implementation Progress Reports, work plans, and JUPSA M&E framework and results framework, the National HIV and AIDS Strategic Plan (NSP), the NSP M&E framework, the National Priority Action Plan, United Nations Development Assistance Framework (UNDAF), UNAIDS Strategy (2011-2015) and other documents.

2.2.2 National and District Consultative Meetings

The programme implementing partners and their constituents both at regional and national level were engaged in consultative meetings which included; UAC, MoH, MGLSD, and implementing CSO Partners such as AMICAALL, UGANET, UNASO, CEHURD, MAMA Club, OAFLA. Consultative meetings were also held at the districts with District Technical and Planning Committees (DTPC) to obtain information on achievements, challenges, lessons learnt and 2015 priorities.

2.2.3 Key Informant Interviews

Key informants were selected from key stakeholders including both the JUPSA UN participating agencies specifically: Implementing Partners and representatives. The engagement was both at national and local level. Key stake holders included JUPSA Technical, JUPSA Secretariat, UNDP, WHO, UNCIEF, FAO, UNHCR, UNESCO, ILO, UN WOMEN, IOM, UNODC and implementing Partners including: UAC, MoH, AMICAALL, UGANET, UNASO, CEHURD, MGLSD, MAMA Club and OAFLA.

2.3 Data Processing and Analysis

Qualitative data was generated and thematic analysis of data was done, whereby findings were grouped into related themes. P&E then generated the report based on thematic analysis in categories such as achievements, good practices, lessons learnt, challenges, and recommendations.

2.3.1 Validation Workshop

As a mechanism of in-depth analysis, a validation workshop was organized in liaison with UNAIDS after producing the 2nd draft of the report. The workshop validated the evaluation findings and provided input for finalizing the report; and in addition informed the prioritization of the 2015 work-plan. The validation workshop drew participants from the JUPSA UN participating agencies, IPs, government and private sector.



Figure 2: JUPSA stakeholders at Entebbe LAICO Hotel after Validating the JUPSA Evaluation Report in November 2014

2.4 Fieldwork Preparation

P&E attaches value to adequate preparation so as to ensure smooth and effective fieldwork. Prior to the start of the field work, P&E made extensive preparations aimed at ensuring that all the stakeholders involved, that is, the Client staff, field evaluation teams, mobilisers and key consultant personnel fully understood their responsibilities, roles and objectives on this assignment.

During field preparation, the consultant:

- Held meetings with the client
- Reviewed all relevant literature relating to the project
- Recruited and contracted key staff
- Secured introduction letters from UNAIDS and delivered them to intended recipients
- Specified duties and responsibilities of staff
- Purchased and provided staff with relevant work tools
- Procured relevant logistical and transport services

2.5 Quality Assurance

Quality was assured through presentation of an inception report to gain concurrence on approach and methodology; designing and pretesting standards, interview guides; conducting a detailed orientation

session for the evaluation team; close supervision of field teams and holding feedback and weekly review meetings.

3.0 Findings

This section presents findings on the five analytical themes of relevance, effectiveness, efficiency, impact and sustainability. It also includes Lessons learned, best practices as well as challenges.

3.1 JUPSA Programme Relevance

The evaluation found that JUPSA was very relevant to the national HIV and AIDS response in Uganda. Most of the stakeholders affirmed this statement and gave a number of supportive reasons indicating that JUPSA had:

- Addressed the NSP priorities and key priority needs of targeted beneficiaries particularly the people infected and affected by HIV and AIDS.
- Supported systems and capacity strengthening through financial and technical support
- Strengthened the coordination of the HIV and AIDS response through the support to UAC and other stakeholders
- Strengthened linkages and networking among stakeholders
- Availed additional funding for HIV and AIDS, creating demand for HIV and AIDS services
- Provided technical and financial support to the NSP reviews and development, as well as the M&E plan
- Filled in the response gaps and emerging dynamics identified by the MTR of the 1st JUPSA
- Revamped leadership commitment the HIV and AIDS response through high level advocacy

There is close alignment between the JUPSA 2011-2014 intentions and the focus of Uganda's HIV response and development priorities: The JUPSA 2011-2014 is aligned to the UNAIDS vision of getting to Zero HIV infections, Zero AIDS related deaths, Zero discrimination (this has since been revised to 90-90-90; testing 90% of the population for HIV; treating 90% of the eligible HIV positive population and reducing the viral load by 90%). This vision resonates with the goal of the National Strategic Plan (NSP) for Uganda's HIV response of 2011/12-2014/15: to achieve universal access to HIV prevention, care, treatment, social support and protection and systems strengthening. Development of the JUPSA 2011-2014 was specifically aligned to the National Development Plan (NDP) of Uganda for 2010/11–2014/15. JUPSA outcomes were aligned to the outcomes of NSP and UNDAF as illustrated in Table 3 below:

Table 3: Alignment between JUPSA Objectives with NSP and UNDAF Results

Thematic Area	UNDAF outcome	NSP Goal	JUPSA Outcome
HIV Prevention	Outcome 2: Vulnerable segments of the population increasingly benefit from sustainable livelihoods and in particular improved agricultural systems and employment opportunities to cope with the population dynamics, increasing economic disparities, economic impact of HIV and AIDS, environment shocks and recovery challenges by 2014 Outcome 3: Vulnerable populations in Uganda, especially in the north, increasingly benefit from sustainable and quality social services by 2014	To reduce the incidence rate of HIV by 40% by the year 2012	<ul style="list-style-type: none"> National Systems have increased capacity to deliver equitable and quality HIV prevention integrated services Communities mobilized to demand for and utilize prevention integrated services
Treatment, Care and Support	Outcome 2: Vulnerable segments of the population increasingly benefit from sustainable livelihoods and in particular improved agricultural systems and employment opportunities to cope with the population dynamics, increasing economic disparities, economic impact of HIV and AIDS, environment shocks and recovery challenges by 2014 Outcome 3: Vulnerable populations in Uganda, especially in the north, increasingly benefit from sustainable and quality social services by 2014	To improve the quality of life of PLHIVs by mitigating the health effects of HIV/AIDS by 2012; To mitigate social, cultural and economic effects of HIV and AIDS at individual, household and community level	<ul style="list-style-type: none"> Access to antiretroviral therapy for PLHIV who are eligible increased to 80% Tuberculosis (TB) deaths among PLHIV HIV reduced People Living with HIV and households affected by HIV are addressed in all National Social protection strategies and have access to essential care and support
Governance and human Rights	Outcome 1. Capacity of selected Government Institutions and the Civil Society improved to bring about good governance and realization of human rights that lead to reducing geographic, socio-economic and demographic disparities in attainment of Millennium Declaration and Goals by 2014	To build an effective system that ensures quality, equitable and timely service delivery	<ul style="list-style-type: none"> National capacity to lead, plan, coordinate, implement, monitor and evaluate the national HIV response strengthened. Laws, policies and practices improved to support gender equality and reduce human rights abuses, stigma and discrimination

Government and other stakeholders in the national HIV response were key players in the development, implementation and periodic review of JUPSA:

The Government of Uganda contributed to the process of developing JUPSA 2011-2014; especially through the social service sectors (health, education and social development); Ministry of Finance, Planning and Economic Development (MoFPED); and Uganda AIDS Commission (UAC). The major AIDS Development Partners (ADP) in the country, including USG/PEPFAR, DFID and Irish Aid were also consulted in the JUPSA planning process.

The Government of Uganda is represented on the JUPSA Steering Committee by: UAC, MOH and other key line ministries. The Director General of the Uganda AIDS Commission is Co-Chair of the Joint Steering Committee (JSC). The JSC provides overall oversight and governance for JUPSA. Key stakeholders in the national HIV response participated in mid-year and end of year reviews of JUPSA including; Government, People Living with HIV and AIDS (PLHIV), Religious Organizations, civil society actors, UN and other ADPs.

JUPSA relevance is evident in its ‘complementary focus’ in addressing elements of NSP that are not the primary focus for other support opportunities by government and ADPs. It was a key actor in enhancing service delivery and demand creation; especially in enabling service access in previously underserved geographical areas and specific sub-populations. Many respondents perceived JUPSA as a major facilitator of innovations in the national HIV response; especially in combination HIV prevention; in targeting Key Populations with comprehensive services; and in advocating for the Elimination of Mother to Child Transmission (eMTCT) and Safe Male Circumcision (SMC) as key elements in the HIV combination prevention package.

Other aspects of JUPSA relevance to the national HIV response include:

Resource mobilization: This acted as a trigger or catalyst in leveraging additional resources into specific areas of the response; and through direct investments in elements of the NSP not prioritized by other ADPs such as coordination; monitoring and response to HIV stigma; advocacy with Faith Based Organisations (FBOs) and cultural institutions, and in development of policy and guideline documents at national level.

Enhancing coordination: It enabled a coordinated front for UN agencies; and a specific area of investment by JUPSA as illustrated in the quotes below;

“Delivering as one has various benefits; like avoiding duplication of activities and creating synergy through joint planning and implementation. It has almost eliminated overlaps and duplication thereby reducing on resource wastage and haphazard interventions. It has ensured that resources are saved and redirected to priority areas.” [District KI]

“Joint effort meant team work, each knew their strengths, what to ask, where to get it, hence need for one proposal for all actors whereby each picks their interest area unlike before where there was a proposal for each different actor.” [District KI]

JUPSA is acknowledged as a key source of support to UAC for the implementation of the national HIV and AIDS strategic plan. JUPSA was acknowledged by a number of national level

respondents as an important facilitator for the coordinated response by different central government sectors (education, gender, labour and social development, and others).

Integrated capacity building: JUPSA enabled an integrated and programmatic approach to capacity building in HIV service delivery.

However, a minority doubted the relevance of JUPSA as depicted in the statement below:

“UN has used JUPSA to further their mandate. This takes me back to the question of whether JUPSA is justifiable”, [government KI respondent]

The evaluation established that at lower Local Government (LG) and beneficiary level, JUPSA is not felt as one entity but rather as individual UN agencies.

The evaluation however found that the relevance was limited by inadequate understanding of the JUPSA structure, purpose and mandate by stakeholders: Many of the non-UN respondents did not have a clear and in-depth grasp of the JUPSA intentions and mechanisms. A number of them were not aware about JUPSA; indicating that they only knew about the specific UN agencies they collaborate with, as illustrated in the quotes below.

“To be honest; this is the first time I am hearing about JUPSA. We work closely with UNAIDS but we have never been told about JUPSA or its objectives.” [National Implementing Partner KI]

Another illustration of this inadequate understanding came from some of the respondents in the districts; who indicated that JUPSA had limited visibility and impact at the grassroots level; where most action is required to decisively address the HIV epidemic. It was noted that JUPSA was more evident at national level; and to a less extent at district level.

“In work-plans you see JUPSA, in actual activities you see agencies”, said an ADP KI

On the other hand; other respondents were of the view that JUPSA was more of an implementation framework for UN support to the national HIV and AIDS response; which appears to duplicate the function of existing structures for HIV response coordination and implementation.

“UN has used JUPSA to further their mandate; yet it is not supposed to implement. They should instead focus on building the capacity of the relevant implementers. This takes me back to the question whether JUPSA is indeed justifiable.” [National IP KI]

Inadequate stakeholder participation in JUPSA design: implementing partners at national level and district-level respondents shared the view that they had limited participation and contribution to the design of the current JUPSA. This may have resulted in missing out on critical inputs that would have enhanced the relevance and fit of the programme to the national

context. An example given in this regard is the reporting systems adopted in JUPSA, which do not adequately use and strengthen existing systems of the implementing partners.

“We do not know much about JUPSA; how can we get involved in designing if we do not know it? In fact my general view is that there has been poor participation in the design and implementation of JUPSA activities.” [National Level; KII]

3.2 JUPSA Programme Effectiveness

JUPSA annual programme reports for 2011 to 2013; and the mid-year report for 2014 reflect overall progress towards achieving most of the targets as stated in the March 2012 JUPSA programme plan.

Effectiveness was largely acknowledged and appreciated from the specific vantage point of the different stakeholder categories in JUPSA. For example; most responses of UN agencies participating in JUPSA focused on operational effectiveness (the extent to which the JUPSA process harnessed and benefitted from existing systems; and on how collaboration in JUPSA added value to their respective operations. On the other hand; programmatic effectiveness was discussed by all respondent categories based on their specific area of focus in the HIV response (such as prevention, treatment, care and protection, governance and coordination, human rights). The one aspect of recognized JUPSA effectiveness that cut across the different categories of stakeholders is with respect to eMTCT.

Another unique perspective to effectiveness came from district-level stakeholders who felt that JUPSA had a positive influence on service delivery systems, structures and processes.

3.2.1 HIV Prevention Effectiveness

HIV and AIDS prevention has effectively been implemented focusing on the achieved outcomes as illustrated in table 4 below:

Table 4: HIV Prevention Outcomes and Targets

Outcomes	Indicators and targets
Outcome 1.1 National systems have increased capacity to deliver equitable and quality HIV prevention integrated services	<p>1. Percent of ANC sites providing comprehensive PMTCT services: increase from 1,589 out of the estimated 4, 000 health facilities in June 2011; to 100% of HCIIIs and higher level health facilities, and in 80% of HCIIIs target by 2015</p> <p>2. Percent of HCIVs and above providing SMC services as part of a comprehensive SRH/HIV package</p> <p>3. Percent of health units with monthly stock out of (6 tracer drugs) test kits & supplies, condoms, STI drugs, ARVs</p>

Outcomes	Indicators and targets
Outcome 1.2 Communities mobilized to demand for and utilize prevention integrated services	<ol style="list-style-type: none"> 1. Percent of eligible women enrolled in PMTCT: proportion of HIV positive pregnant women receiving ARV's for PMTCT increased from 51.6% in 2010 to 90% by 2015 2. Percent of men 15-49 that report condom use at last high-risk sex increased to 80% from the 2010 baseline level. 3. HIV prevalence among 15-24 year old pregnant women reduced from 6.4% in 2010 to the NSP 2011-2015 target

JUPSA achieved its intended objectives and hence realized the desired outcomes through contributing to the following achievements:

Outcome 1.1: National systems have increased capacity to deliver equitable and quality HIV prevention integrated services

Revitalization of HIV prevention

JUPSA has been a major contributor to the revitalization of HIV prevention; especially through support to the strategy development and implementation planning for combination HIV prevention at national, sector and district levels; enhanced leadership commitment to HIV prevention by His Excellency (H.E) the President of Uganda; the First Lady of Uganda; Members of Parliament (MP), religious and cultural leaders as well as other leaders at district and municipality levels. JUPSA further contributed to the implementation of the intensified combination HIV prevention programme in 9 districts; and focused promotion of eMTCT and SMC as core elements in combination HIV prevention nationally. The programme further increased services to the youth through establishing 34 youth friendly corners in the districts of Kampala, Kalangala, Arua, Gulu and Pader; as well as working through the youth as community change agents. The H.E President Museveni launched the 'Protect the Goal' HIV prevention Campaign in Uganda, November 2014, aimed at making HIV prevention interventions more attractive and better understood by the population, particularly the young people.



Figure 3: H.E President Museveni displaying his Footballing Skills at the Launch of 'Protect the Goal', HIV prevention Campaign in Kampala, Uganda, November 2014.



Figure 4: High Level Officials Getting Ready for the National Launch of 'Protect The Goal' L-R: Musa Bungudu, UNAIDS Country Director for Uganda, Ahunna Eziakonwa-Onochie, UN Resident Coordinator Uganda, Prof. Sheila Tlou, H.E. President Yoweri Museveni, Hon Sarah Opendi (State Minister for Primary Care) Hon. Elioda Tumwesigye (State Minister For Health) Dr. Alemu Wondimagnenhu (WHO Country Representative) and Asumani Lukwago, Permanent Secretary Minister of Health.

Institutional capacity strengthening

JUPSA provided support for institutional and technical strengthening for combination HIV prevention programming and service delivery nine pilot districts of Arua, Gulu, Kabale, Kasese, Mayuge, Rakai, Hoima, Kayunga and Busia. Four main elements in the development and implementation of combination HIV prevention programmes were:

1. Development and roll-out of the pilot program concept in the selected districts – including development of the programme concept; supporting a competitive process to select the target districts; and enabling UAC to establish a Task Team and develop an Operations Manual for the programme
2. Preparing the selected districts for implementation of the programme – including sensitization, advocacy engagements with local and Government leaders, cultural and religious leaders. All seven districts were supported to conduct baseline surveys and to develop implementation plans for the programme.



Figure 5: Hon Frank Tumwebaze (in the Center) the Minister In Charge of the Presidency and Kampala, UAC DG Dr. Christine Ondo City (Right) and Kampala Council Authority Officials, Launching the New Campaign to Increase Access to HIV And AIDS Services in Urban Centers

3. Capacity building for programme implementation – including training of district leaders in management and technical leadership to the programme; training and on-going mentoring and support supervision for health workers and community volunteers involved in programme implementation;
4. Supporting delivery of combination prevention services – mobilizing resources to support program implementation in the districts; and supporting scaled-up procurement and delivery of key supplies including condoms

JUPSA supported establishment, strengthening and operations of a number of HIV prevention committees at national level; including the National Prevention Committee (NPC); National PMTCT Advisory Committee; National SMC Task Force; and the National BCC Technical Team. JUPSA also supported establishment and operations of sector specific HIV coordination committees such as the Ministry of Works and Transport (MoWT) HIV Task Team, and the Ministry of Education and Sports (MoES) HIV and AIDS Technical Working Group. These committees were the leading actors in development of the relevant national policies, strategies and guidelines; and in development of the action plans and budgets for programme implementation. For example, the MOH Condom Coordination Committee (revived in 2011 through JUPSA support) led the process to estimate the national condom needs for 2012-2015; coordinated the JUPSA-supported scale up in condom procurements; and provided oversight for the branding of condoms distributed through the public sector systems.



Figure 6: UNDP Programme Analyst HIV, Health and Development, Sarah Nakku Kibuuka (left) Receives a Certificate of Recognition on behalf of the Organisation from the Executive Director Kampala City Council Authority, Ms. Jennifer Musisi (left).

To enhance HIV prevention programming and management; JUPSA supported orientation of Leaders and Managers in 11 key sectors, 10 selected districts, key national NGOs, UN, religious and cultural institutions in 2012. These included: the 9 sectors supported in 2011 to develop HIV prevention strategies; the 6 pilot districts for combination HIV prevention pilot; and the 5 major religious institutions/groups in Uganda (Catholic, Anglican, SDA, Islam, Pentecostals). The orientation focused on two key (and relatively new) components in combination HIV prevention: elimination of MTCT and SMC.

Development and operationalization of national guidance documents

JUPSA supported the processes to develop and operationalize national guidance documents on HIV prevention over the period of implementation. These documents among others included:

1. National HIV Prevention Strategy (NPS) 2012-2015
2. Two year action plan for intensifying HIV prevention in Uganda
3. HIV prevention strategies and action plans for 9 government sectors (Education; Gender, Labour and Social Development; Defense; Internal Affairs (Police and Prisons Services); Agriculture; Works and Transport; Public Service; Local Government; Health)
4. National Comprehensive Condom Programming Strategy
5. National RH/HIV linkages and integration strategy
6. National Action Plan on SRH/HIV in sex work settings
7. SMC Surgical Manual and training materials
8. Policy for Option B+ for eMTCT
9. HIV Training Package for comprehensive and integrated prevention and care services

Through JUPSA advocacy, the national HIV and AIDS response efforts attained a boost when H.E the President of Uganda and the First Lady publically tested for HIV to stimulate the demand and utilization of HIV prevention services.

Outcome 1.2: Communities mobilized to demand for and utilize prevention-integrated services



Figure 7: SMC Campaign Rally in the Districts

In order to increase the demand and utilization services, the following interventions were undertaken by JUPSA as presented in the text box below:

- Conducted eMTCT campaigns and launches
- Launched 'Protect the Goal Campaign' for HIV prevention
- Supported increased male involvement in ANC and eMTCT through Maama Clubs
- Mobilized all Mayors through AMICAALL
- Engaged cultural leaders



Figure 8: Two HIV Positive Mums who Fully Attended ANC and Delivered At Ruhoko Health Centre IV In Ibanda District, SW Uganda Receiving Gifts from the Head Nurse while from L – R: Francis Mangani (SIDA), Dr Godfrey Esiru (MOH) and Steve Okokwu (UNICEF) are looking on

JUPSA support to enhance community-driven social and behavior change was focused on demand creation for combination HIV prevention and SRH services among the following key populations: MARPs (including sex workers and sexual minorities); young people; and couples. To enhance social and behavior change among MARPS, two main approaches were utilized:

1. Supporting MARPs networks, associations/support groups and service organizations to enable demand and access to SRH and HIV services – including peer education and service delivery; development of key training, education and communication materials; and advocacy for a supportive policy and institutional environment that promotes MARPs access to services
2. Supporting targeted service delivery for MARPs (through peer services, MARPs sensitivity orientation for health workers, and the like); and operations of youth-friendly corners in health facilities, religious institutions and school settings.

3.2.2 Treatment, Care and Support

JUPSA had Treatment, Care and Support as the second thematic area focusing on three outcomes; access to antiretroviral therapy for PLHIV who are eligible increased to 80 percent; Tuberculosis deaths among PLHIV reduced; as well as People Living with HIV and AIDS and households affected by HIV are covered in all national social protection strategies and have access to essential care and support. Table 5 presents the indicators and targets for these outcomes.

Table 5: Treatment, Care and Support Outcomes and Target

Outcomes	Indicators and targets
Outcome 2.1 Access to antiretroviral therapy for PLHIV who are eligible increased to 80 percent	<ol style="list-style-type: none"> 1. Percent of adults and children with advanced HIV infection receiving ART increased from 47.5% in March 2011 to 60% by 2014 2. Percent of children in need of ART receiving it increased from 23% in 2010 to 50% by 2014
Outcome 2.2 Tuberculosis deaths among PLHIV reduced	<ol style="list-style-type: none"> 1. Percent of TB associated deaths among people living with HIV reduced from 30% in 2010 to 20% in 2014 2. Percent of estimated HIV positive incident TB cases that receive treatment for TB and HIV increased from 10% in 2010 to 50% in 2014
Outcome 2.3 People Living with HIV and AIDS and households affected by HIV are covered in all national social protection strategies and have access to essential care and support	<ol style="list-style-type: none"> 1. Percent of orphans and other vulnerable children and their families that receive care, protection and support through case management increased from 4.1% in 2010 to 50% by 2014 2. Percent of PLHIV and OVC households with sustainable livelihood interventions increased by 50% in 2014 compared to the 2011 baseline.

Outcome 2.1: Access to antiretroviral therapy for PLHIV who are eligible increased to 80%

JUPSA supported the customization of international ART guidelines to the local context as highlighted below:

- 5,000 copies of the National Integrated ART guidelines updated and distributed by 2014
- 20,000 copies of updated training materials/job aids on comprehensive HIV services distributed by 2014
- Number of districts with ART Quality Improvements (QI) Teams increased from 50 out of 112 in 2010 to 80 by 2014
- Percent of ART sites providing both adult and paediatric treatment increased from 322/423 = 76% in 2010 to 80% by 2014
- Percent of ART facilities in which at least 80% of the clients keep their medical appointments increased from 14.1% in 2008 to 80% in 2014
- Number of districts with VHTs trained in Home-based care for HIV increased from 85 out of 112 current districts in 2010 by an additional 20 districts by 2014
- Further JUPSA support in 2013 included development of the IMCI Computerized Adaptation and Training Tool (ICATT) for Uganda, to include paediatric ART and trained 22 trainers
- JUPSA supported scaling up of Early Infant Diagnosis (EID) and on-going care for HIV-exposed infants, integrated into paediatric and family-based ART; and ART as an integral element in combination HIV prevention among Key Populations
- JUPSA supported review and update of the PEP policy and implementation guidelines in 2012
 - Percent of ART facilities providing Post-Exposure Prophylaxis for HIV increased from 6% in 2008 to 50% in 2014.
 - 5,000 copies of post-exposure prophylaxis implementation manual disseminated by 2014

JUPSA supported development, review, approval, production and dissemination of key materials to support ART; including: a) Integrated ART Guidelines for adults, adolescents and children (based on the 2013 WHO guidelines); b) Comprehensive HIV curriculum based on IMAI/IMPAC tools; c) Computerized training package for IMCI (ICATT) trainers; and d) Post Exposure Prophylaxis (PEP) guidelines. JUPSA further supported production and roll out of: Standards of Practice (SOPs) and Job Aids for ART; Data and information management tools for HIV care; and guidelines on screening and management of non-communicable diseases (NCDs) within the context of HIV care.



Figure 9: Henry Zakumumpa, a Public Health expert and lecturer with the School of Public Health at Makerere University, Speaking to Journalists at the Sensitisation Meeting on Tobacco Control Law

Although JUPSA targets included increasing the number of districts with ART Quality Improvements (QI) Teams from 50 out of 112 in 2010 to 80 by 2014; this was not explicitly discussed in the programme reports or in the primary data collection processes. The JUPSA Annual Report for 2012 acknowledged that this indicator was not initially tracked; and indicated commitment for deliberate efforts to be made to report on this indicator.

JUPSA provided targeted support to further scale up of pediatric HIV care, especially through partnership with Baylor-Uganda. This support initially focused on training service providers in 20 districts, using the IMAI/ IMPAC/IMCI approach. A total of 309 Health workers were trained in 2012 (through Baylor) through workshop-based sessions; hands-on experiences in care settings; and on going mentoring in their respective workplaces.

Further JUPSA support in 2013 included development of the IMCI Computerized Adaptation and Training Tool (ICATT) for Uganda, to include pediatric ART. A total of 22 Trainers from Universities, nurse training institutions and MOH were oriented on the tool to support region-based cascade training; based on the 2013 WHO guidelines for ART.

JUPSA supported two ART service delivery innovations: a) scaled-up Early Infant Diagnosis (EID) and on-going care for HIV-exposed infants, integrated into pediatric and family-based ART; and b) ART as an integral element in combination HIV prevention among Key Populations (sex

workers; migrant workers; transport workers) in selected ‘hot spot’ districts. The EID innovation had three main elements:

1. Integrated care at the health facility and longitudinal tracking for the exposed infant
2. Lab consolidation, which resulted in reducing the number of laboratories from 8 to 1; with improved efficiency, reduced turnaround time, reduced costs and improved program monitoring and coordination
3. Sample Transport Network – has increased access, improved efficiency and reduced costs of sample referral across all laboratory program areas.

JUPSA supported implementation of HBC policy in all districts. MOH in collaboration with its partners are supporting implementation of the HBC policy guidelines in the communities using the VHTs.

JUPSA supported the review and update of the PEP policy and implementation guidelines in 2012.

NCD screening guidelines were finalized in 2013; key information booklets on cancer, cardiovascular and diabetes in relation to HIV have been produced and widely disseminated. Screening and management of NCDs was integrated in the comprehensive HIV and AIDS training curriculum. Parliamentarians and CSOs have been sensitized on NCDs, to advocate for NCD management as an integral element in the comprehensive services of ART sites.

JUPSA had planned for PSM update to steadily increase local procurement of ARVs but this was not realized due to high unit cost of production in country.

Outcome 2.2: Tuberculosis deaths among PLHIV reduced

JUPSA supported the review, update and dissemination of policy guidelines, training materials and tools to improve management of TB among people living with HIV. HIV/TB co-management training was integrated into the comprehensive HIV curriculum. Mentoring tools for HIV/TB co-management were developed and are in use.

The percentage of facilities fully implementing TB/HIV collaborative activities increased from 30% in 2010 to 50% by 2014. JUPSA undertook resource mobilization for TB/HIV collaborative activities

Outcome 2.3: People Living with HIV and AIDS and households affected by HIV are covered in all national social protection strategies and have access to essential care and support

JUPSA supported a study on the analysis of HIV-sensitive social protection responses in Uganda. The study gave insight on how the various social protection strategies mitigate the socio-economic impact of HIV&AIDS in Uganda. Based on the study results; a fact sheet on available HIV sensitive social protection programs in the country is under development. The study has further informed the on-going development of a national social protection policy framework on inclusion of HIV and AIDS.

Social protection measures are HIV sensitive when they are inclusive of people who are either at risk of HIV infection or susceptible to the consequences of HIV and AIDS. HIV-sensitive social protection can reduce vulnerability to HIV infection, improve and extend the lives of people living with HIV, and support individuals and households.

Support was also provided by JUPSA to establishment and training of Parish Child Protection Committees in all 154 Parishes of Kabarole and Kamwenge Districts. This training has been scaled up to the 32 new districts.

JUPSA support was focused on increasing agricultural production and enabling health sectors to coordinate food and nutrition strengthening as a key element in HIV care and support; and in reducing vulnerability to HIV infection and its impact. It also included CSOs working at community level to enhance food security for families affected by HIV.

At national level, planning was supported to develop subsidiary laws on food security and nutrition to prevent/mitigate the impact of HIV and AIDS; and to integrate social economic enhancement for PLHIV in production interventions.

JUPSA supported scaled up application of the Farmer Field Schools (FFS) approach to empower communities affected by HIV and other disasters, with focus on Kaberamaido District. A key element in this support was enhancement of collaboration between the district local government and the Organization for Development and Solidarity (ODS). Training was provided to 35 staff; 5 from the NGO and 30 from the health and production departments as well as PLHIV leaders; to facilitate community level training and demonstration production in 5 fishing communities and 10 FFS. The community-level training included skills in crop, animal and fisheries production; post-harvest handling and basic food processing; social skills such as gender sensitivity, household level planning and budgeting; and health issues on basic nutrition and food hygiene, and positive living with HIV.

In addition, JUPSA supported the strengthening of Orphans and other Vulnerable Children (OVC) services in the 32 districts created since July 2005; to complement on-going support for OVC services management in the 80 'old' districts by the USAID-supported SUNRISE program. This JUPSA support included enabling MoLGSD to finalize and distribute the OVC plan in the 32 districts; and to support them in developing district-specific OVC Action Plans. Some of the districts such as, Gulu, Kasese, Maracha, Namutumba, Nebbi, and Yumbe demonstrated commitment to implement the plans by allocating funds for OVC support in the district annual plans and budgets.

To enhance technical capacity for support to OVC services, JUPSA supported the National Association of Social Workers of Uganda (NASWU) to revitalize its operations. Specific activities supported included: holding an Annual General Meeting and establishment of local chapters in Arua, Kabale and Kampala; training 50 social workers in child protection (using the national curriculum approved by the MGLSD and the National Council for Higher education); training 96

members on the professional code of conduct; and holding a half day conference on Medical Social Work that brought together 57 medical Social Workers from all over the country.

JUPSA support enabled finalization, production and dissemination of the OVC M&E Framework and Plan (and associated data collection tools) in all 112 districts. The three-factor criterion (orphan, child out of school, child engaged in child labor) was applied to refine identification and targeting of OVC with services. Disability was adopted as a fourth factor to use in Uganda; and this enabled identification of more than 9 in ten (91 percent) of OVC households.

The new 3-factor criteria for OVC selection was used in the 32 districts to identify, register and map OVCs and their distribution. Financial support was provided in 23 districts (72% of the 32 districts targeted) to map and coordinate OVC service providers; and to develop district and sub-county based OVC reporting system, the OVC Management Information System.

Table 6: OVC-MIS Reporting Rates in JUPSA-supported Districts 2011 - 2014

Districts reporting		2011	2012	2013	2014	Proportion agencies reporting	
NO.	District						
1	Agago						Two or more quarters above 50%
2	Alebtong						One quarter above 50%
3	Amudat						Two or more quarters above 10%
4	Buhweju						One quarter above 10%
5	Buikwe						No quarter above 10%
6	Bukomansimbi						
7	Bulambuli						
8	Butambala						
9	Buvuma						
10	Buyende						
11	Gomba						
12	Kalungu						
13	Kibuku						
14	Kiryandongo						
15	Kole						
16	Kween						
17	Kyankwanzi						
18	Kyegegwa						
19	Lamwo						
20	Luuka						
21	Lwengo						
22	Mitooma						
23	Namayingo						
24	Napak						
25	Ngora						
26	Ntoroko						
27	Nwoya						
28	Otuke						
29	Rubirizi						
30	Serere						
31	Sheema						

Districts reporting		2011	2012	2013	2014	Proportion agencies reporting
32	Zombo					

Source of data: OVC MIS

Further support was provided for finalization and dissemination of the National Action Plan on HIV- induced Child Labour. This was accomplished in 4 regions in 2012; and reached a total of 60 districts.

3.2.3 Governance and Human Rights

Under Governance and Human Rights JUPSA addressed two outcomes: national capacity to lead, plan, coordinate implement monitor and evaluate the national HIV response strengthened as well as laws, policies and practices improved to support gender equality and reduce human rights abuses, stigma and discrimination. These outcomes and their respective indicators and targets are presented in Table 7 below:

Table 7: Governance and Human Rights Outcomes and Targets

Outcomes	Indicators and targets
Outcome 3.1 National capacity to lead, plan, coordinate implement monitor and evaluate the national HIV response strengthened	1. HIV national policy composite index scores increased from 70 out of 100 points in 2010 to 85 by 2014 2. Percent of districts with institutional capacity for M&E including harmonized resource tracking, database and information systems increased from 0 to 100% (112 districts) by 2014
Outcome 3.2 Laws, policies and practices improved to support gender equality and reduce human rights abuses, stigma and discrimination	1. National composite policy index score increased from 4.6 in 2010 to 80% in 2014

The most evident effectiveness of JUPSA with respect to governance and human rights is in four key areas: enhanced coordination of the UN support to the national HIV response; strengthened government coordination and leadership of the HIV response at national and sub-national levels; improved capacity of IPs in the implementation of the HIV response interventions and improved generation and utilization of strategic information in the response; boosting resource mobilization. Other areas where JUPSA had impact are in advocacy to enhance human rights protection in national policy-making and review of key laws related to HIV and AIDS.

Outcome 3.1 National capacity to lead, plan, coordinate implement monitor and evaluate the national HIV response strengthened

Strengthen leadership and coordination of the national HIV and AIDS response

JUPSA supported the strengthening of governance and management systems for HIV and AIDS implementing partners. JUPSA supported UNASO to develop the Score Card Index for assessing governance and management functions of IPs. JUPSA further supported the production of the Citizens Score Report that shows the level of citizens' involvement in leadership, governance, programme implementation and service delivery; as well as the Gender Score Card that tracks Gender mainstreaming among MDAs and CSOs. JUPSA also supported the functions of the HIV

and AIDS Partnership Committee and Forum that coordinate and oversee the management and operational functions of the multi-sectoral HIV and AIDS stakeholders. The Partnership Forum brought together both state and non-state actors, as well as biomedical and non-biomedical IPs to jointly contribute to the HIV and AIDS response.

To enhance functioning and effectiveness of the coordination role of government in the national HIV response, JUPSA supported finalization of the institutional review and restructuring of UAC which culminated into enhanced technical capacity. Technical and financial support was provided to hire staff at the national and zonal offices and provided on-going technical mentoring for new personnel. Further support was provided to finalize the review of the HIV Partnership Mechanism, and for the implementation of the restructuring recommendations. This included the updating of the Partnership Manual (initiated in June 2014) as the key tool for operations of the Partnership Mechanism.

JUPSA brokered high-level advocacy to resolve bottlenecks around Global Fund (GF) support; in operational strengthening of the Civil Society Principal Recipient

Scaled up advocacy

JUPSA conducted advocacy for increased youth access to HIV and AIDS services that included the following: supporting the development of an advocacy paper for meaningful involvement of youth in national decision making processes; extending financial support to MGLSD to lead the streamlining and strengthening the Youth Self-Coordinating Entity for effective youth representation at the national partnership committee; as well as supporting the establishment of youth friendly centers for MARPS.

JUPSA has enabled maintaining of HIV and AIDS on the national development agenda. HIV and AIDS have been mainstreamed in the NDP, in the sectoral and district development plans as well as CSOs and the private sector plans.

With the support from JUPSA, ADPs as well JUPSA TWGs are continuing to dialogue on issues of transparency and accountability within government and other institutions.

As part of high-level advocacy by JUPSA, the Parliament of Uganda through the HIV and AIDS Committee and the Speaker of parliament were engaged in leading the HIV and AIDS response. JUPSA has addressed the majority of parliamentarians and cabinet members to ensure high-level involvement and participation.

JUPSA supported the development and utilization of issues papers in HIV-related advocacy in three main areas: leadership commitment; HIV response financing; and mainstreaming HIV across development. Intensive advocacy was conducted, based on a series of briefing papers and engagement sessions; which enabled high level revitalization of leadership commitment and political will for support to the HIV response. The President of Uganda has been personally re-

engaging in open and consistent discussions on HIV as development priority, as demonstrated by the president's public HIV testing. Regular messages to the public and opinion leaders about the need to revitalize HIV prevention were aired. Similar results of JUPSA advocacy interventions on this issue were evident in form of:

1. Intensified and consistent HIV prevention messages within places of worship by religious leaders.
2. Commitment of the First Lady as the national EMTCT champion and her continued engagement with the youth on SRH and HIV as part of promoting combination prevention.
3. Dialogue and sensitization of the parliamentary committee on HIV and Social services; which resulted in increased government budget allocation for Health and HIV.

Expanding a sustainable financing base for the national HIV and AIDS response

An intense and sustained process was supported by JUPSA to expand sustainable financing for the HIV response, based on the Investment Case approach. JUPSA supported UAC and MoFPED in 2013 to participate in the UNAIDS Southern and Eastern African regional technical meeting on the development of an investment case for HIV response. A national task committee was constituted; and a road map worked out for developing the Uganda Investment Case. Briefing Papers were developed for technical and political leaders developed and used in mobilizing necessary support for the process to develop the Investment Case. The process culminated into creation of the HIV and AIDS Trust Fund in July 2014 provided for under the HIV and AIDS prevention and control Act, 2014.

JUPSA brokered high-level advocacy to resolve bottlenecks around Global Fund (GF) support in operational strengthening of the Civil Society Principal Recipient (PR) – a role taken on by TASO since 2010. Other JUPSA support went to key reforms to the Country Coordination Mechanism (CCM) for GF support, which included: Reduced size from 26 to 17; Added a representative of key affected populations; Increased civil society representation to about 40%; Delinked CCM from the PR; and Delinked CCM secretariat from the FCO. Further support was provided for development of the Global Fund interim proposal in 2013 for USD119 million for HIV and USD11 million for TB renewal funding; and for development of the TB-HIV and Health Systems Strengthening Concept Notes for the 2014 application.

Through JUPSA support to AMICAALL and MOLG, most districts allocated funds for HIV and AIDS activities. An 'All Mayors' national forum was established and meets annually to deliberate on HIV and AIDS issues.

Through the JUPSA mechanism, ADPs were able to fund some unanticipated activities that would not have been funded by individual agencies that have stringent financial management modalities.

JUPSA has strengthened private sector participation and contribution to the national HIV and AIDS response for instance some hotels have offered free halls for HIV and AIDS meetings, whereas some media houses have offered free airtime for discussing HIV and AIDS issues.

Strengthening the capacity for mainstreaming gender and HIV and AIDS

JUPSA is a major joint UN program in Uganda; whose focus is on strengthening collaborative mainstreaming of gender into HIV programmes and operations of all UN agencies active in the country.

The judiciary and line ministries were supported to mainstream gender and HIV in their work. The labour sector under MGLSD was strengthened to lead and coordinate the process of HIV mainstreaming. This support included:

- a) Development of guidelines to integrate HIV into the collective bargaining agreement of workers organizations (in agriculture, mining and construction sectors);
- b) HIV and AIDS mainstreamed in the labour inspection checklist;
- c) Training of 8 national and 42 district labour and OSH inspectors in integrating HIV and AIDS workplace response into the labour inspection functions.
- d) Development of the National Action Plan on women, girls, gender equality and HIV and AIDS.
- e) Twenty five (25) districts were supported to develop work plans that are not only gender responsive, but also addressing GBV

The HIV coordination committee for the private sector was trained in mainstreaming HIV in the planning, budgeting, monitoring and reporting functions. Finalization of the private sector HIV and AIDS strategy in 2013 informed implementation of HIV interventions in 5 private sector organizations that included African Textile Mills, Tororo Cement Industries, Uchumi, Tuskys and Shoprite. The leisure and hospitality industry received support to develop and implement HIV and AIDS workplace policies and programmes in 50 hotels in Mbale and Gulu districts.

JUPSA supported UAC to mainstream gender into the NSP 2015-2020 and organized a gender workshop to review the NSP indicators and ensure that gender indicators are adequately incorporated in the NSP.

JUPSA supported high level engagement of political and legislative leadership on gender and human rights, sensitized cultural leaders on GBV and developed two year action plan on mainstreaming gender as well as HIV and AIDS.

JUPSA provided support towards mainstreaming HIV; supported the development of guidelines for integrating HIV into the collective bargaining mechanisms for protecting the rights of workers. Further support was provided to enable 8 public sectors, 6 district local governments, and the private sector foundation to mainstream HIV and AIDS issues in their services to the public and human resources operations. Similar support was provided to the private sector, through the Uganda Manufacturers' Association to facilitate its role as the host agency for the private sector self-coordinating entity.

Strengthened capacity to plan, monitor and evaluate at UAC and sectors

Through JUPSA support towards strengthening capacity of UAC in monitoring and evaluation (M&E), the national M&E TWG on HIV and AIDS was revitalized, and an M&E plan in tandem with NSP was developed. JUPSA further supported filling of all the required M&E positions at UAC; hands-on training and mentoring on M&E for UAC staff; and development of national HIV M&E Plan, indicator handbook in 2012. A core M&E training team was established through training 15 members of the national M&E TWG as TOT in M&E; who in turn conducted M&E training for 140 people and provided on-going mentoring and support supervision in the 32 districts.

JUPSA further supported M&E strengthening in the key sectors of health, education, and in gender, labour and social development. Support was provided for development of the health sector HIV/AIDS M&E plan; and for production and dissemination of the OVC M&E Plan in all districts. The TWG for M&E in the education sector was constituted and supported to coordinate scaled-up training of key staff on mainstreaming HIV and AIDS in the sector; and to oversee the study on the drivers of HIV and AIDS in the education sector (concluded in 2012).

JUPSA enabled timely and comprehensive reporting on progress in the national HIV response to the global audience, through the annual global reports, the monitoring reports on the 2011 UN Political Declaration on HIV and AIDS. JUPSA supported the development of an HIV and AIDS score card, which was noted as an important innovation that has enabled participatory monitoring of progress and public accountability on results.

Annual and mid-year joint reviews have been conducted regularly for JUPSA, which underscored UN commitment to participatory monitoring and accountability. JUPSA also provided technical and financial support to the annual Joint AIDS Reviews and promoted the approach adopted in 2013 to expand the review process to include reports by each self-coordinating entity in the HIV and AIDS Partnership Mechanism. JUPSA also supported the NSP review in 2014; and the updating of the 2008/09 Modes of Transmission study, also initiated in 2014.

Strengthened capacity for resource tracking

JUPSA supported adaptation of the National AIDS Spending Assessment (NASA) methodology, and execution of the NASA in 2011. Rapid assessment of HIV/AIDS resource tracking mechanisms in 2011 led to the full NASA that informed advocacy efforts in 2012 for government to increase domestic resources for HIV/AIDS.

Enhanced capacity for strategic information gathering and dissemination

JUPSA supported the development of the national standards and tools for integrated HIV and SRH services and systems for accountability as well as Health Management Information System (HMIS) reporting.

Technical and financial support was provided to UAC to conduct the post- International Conference on AIDS and STIs in Africa (ICASA) and pre-International AIDS Conference (IAC) to discuss resolutions for adaptation to country needs.

JUPSA supported finalization of the Global Fund M&E System Strengthening Tool (MESST) Report and submission to the Global Fund Secretariat in Geneva. JUPSA supported the development of the Global AIDS Response Progress Report (GARPR) as well as Uganda HIV and AIDS Progress Reports.

Technical and financial support was further provided to UAC and MOH to respond to the GF request for documentation and information to help in the procurement of ARVs.

JUPSA supported the conducting of analytical studies and disseminating reports that included:

AIS 2011, UAR 2011 and 2013 Study on drivers of HIV and AIDS, ANC Surveillance Report, 2012 Global AIDS report, GARP Report, Mid- term HLM Review Report, Mapping of Education Sector HIV and AIDS Partners Report 2013, UDHS 2011, HIV estimation data, Pre- JAR Report, LQAS 2014, Uganda HIV Country Progress Report, AHSPR Report 2013, JAR 2013 Report, MDG Progress Report 2013, HIV Analysis Situation report 2013, Investment Case Report 2014, NADIC Assessment Report 2012, NASA 2012, UNGAS 2014, Early Warning indicator report on ARV resistance

JUPSA supported the design and establishment of an OVC registration, data collection and reporting system and also the development of electronic management of HIV data (Open eMRS for all health data, including HIV services) in 2013. The ART data collecting tools were revised and customized to Open eMRS and 44 health facilities were facilitated to use the Open eMRS system in order to track patients on HIV/ART services.

Strengthened Civil Society engagement

Through IRCU, JUPSA brought together religious leaders and their congregations 4 times to discuss and attain consensus on key HIV and AIDS issues. As a result a pastoral letter was developed to provide guidance on content and subject matter of the HIV and AIDS messages to be used by religious leaders as they preach in their houses of worship. JUPSA further provided global guidance for implementation of the global advocacy campaign through CSOs networks, especially umbrella organizations such as UNASO, NAFOPHANU, NACWOLA, UGANET, Mama Club as well as the Uganda Youth Forum (UYF).

Re-engagement of Cultural Institutions

JUPSA supported re-engagement of Cultural leaders under the current leadership of the King of Bunyoro. As a result, a two and a five-year HIV/AIDS plan for cultural leaders were developed. In addition the King and the Queen of the Buganda Kingdom hold annual 'health days' whereby HIV and AIDS is a core issues for discussion.

Outcome 3.2: Improved Laws, policies and practices to support an effective HIV response:

JUPSA supported the review of laws that target MARPs; HIV infected and affected persons, which included facilitating the discussion of the HIV and AIDS Prevention Bill, and training CSOs to discuss HIV and AIDS Prevention Bill on social media and other fora.

A legislative policy and institutional review was undertaken with a view of integrating health and social issues particularly HIV and Gender, into environmental impact assessments (EIAs) for capital projects.

JUPSA facilitated a number of activities to further improve laws, policies and practices including; a legal audit with focus on sex workers, establishing a national reference team to oversee HIV laws and policies, developed a handbook on HIV and AIDS for judges and legal profession as well as a statutory instrument on employment and HIV and AIDS non-discrimination regulation.

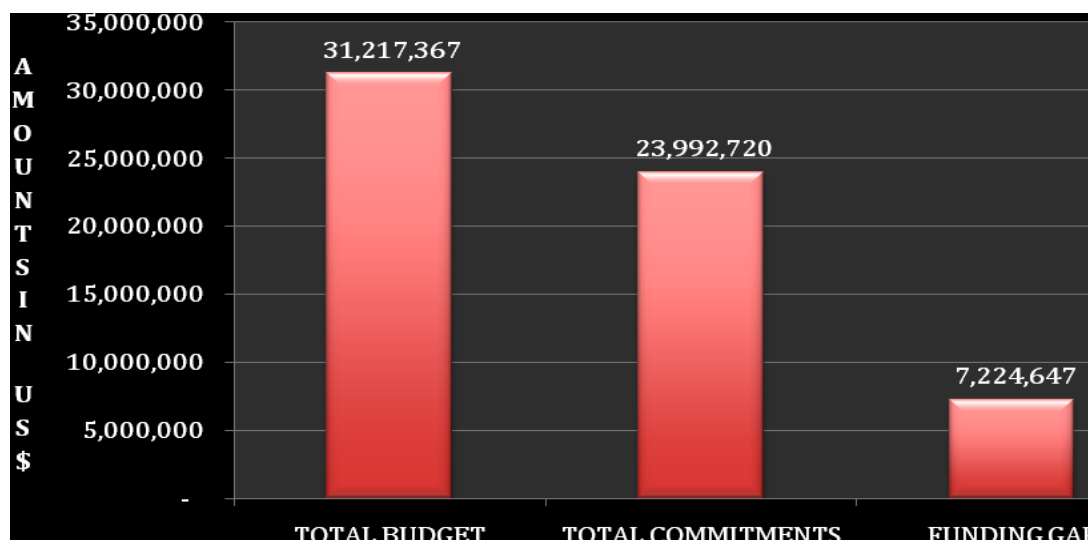
3.3 Efficiency

This section presents findings from the efficiency perspective of the JUPSA 2011-2014. The evaluation conducted efficiency analysis to establish the extent to which JUPSA outputs were justified by the inputs and to establish whether at the design stage efficiency measures were embedded in the programme. Areas examined included; Budget realization, donor fulfillment of pledges, JUPSA investments per thematic area, cost recovery, factors that facilitated or constrained efficiency attainment in the course of JUPSA implementation and proposed ways for improvement in financial reporting.

3.3.1 JUPSA Budget Funding Analysis 2011- 2014

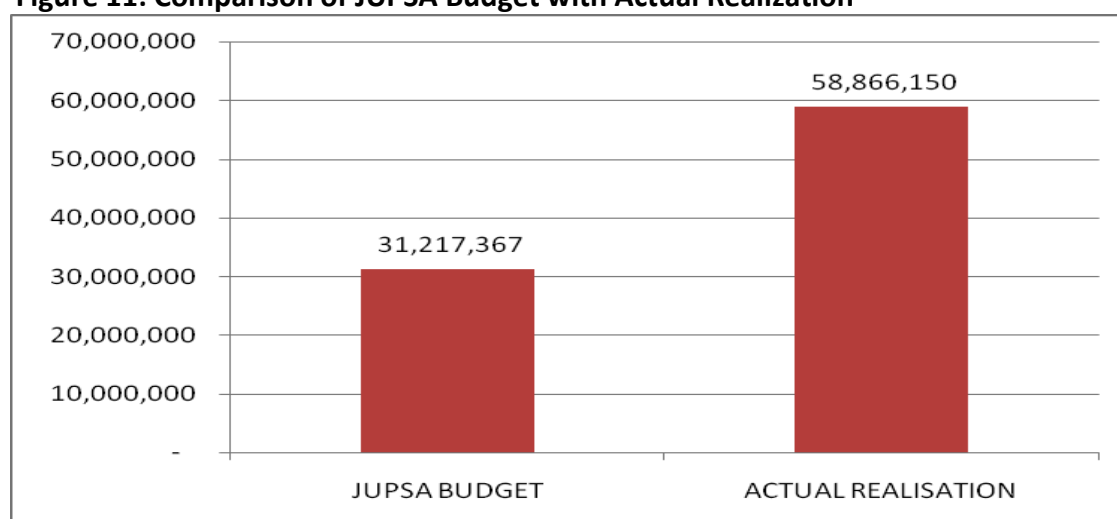
JUPSA was funded from existing agency budgets through pooled and non-earmarked extra budgetary funds and donor contributions from Irish Aid and DFID. The evaluation found that at inception, the estimated budget for JUPSA was USD 31.2m with a total commitment of USD 24m (77%) leaving a deficit of USD 7.2m (23%). Figure 10 shows the JUPSA envisaged funding gap at inception.

Figure 10: JUPSA Funding Gap



However, in the course of implementation, JUPSA received more funding than had previously been envisaged as shown in figure 11.

Figure 11: Comparison of JUPSA Budget with Actual Realization



The evaluation found that in the course of implementation, the programme did not suffer any shortages from the envisaged funding gap as some UN agencies got additional funding that enabled them to exponentially increase their contribution to JUPSA. UNFPA received funding of USD 5m from their headquarters from SIDA for condom programming, USD 7m from SIDA for 3 years for integrated Sexual and Reproductive Health with a component on HIV and AIDS, USD 3m from DANIDA for 3 years and more support came from DFID for Gender Based Violence Programme and Joint programme on Population. UNICEF on the other hand, received funding of USD 2m annually from SIDA. The additional funding received by the two agencies enabled them to make substantial contributions compared to their original commitments. For instance, although UNFPA had not envisaged contributing to JUPSA in 2014, it managed to contribute USD 11.1m, which was 59% of the total funding of USD18.8m for the year. UNICEF had made a

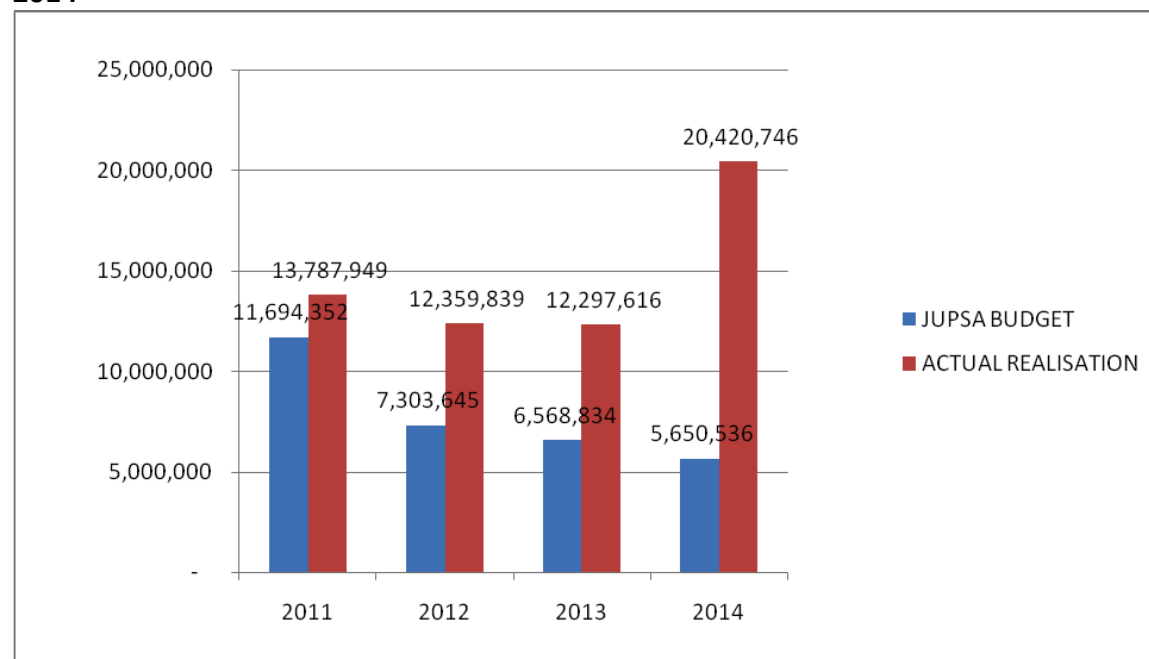
commitment of USD 1m for 2014 but contributed USD 5.6m, which was 30% of the total funding for the year. This additional funding translated into 189% increase from the budgeted USD 31.2m to USD 58.9m. Table 8 shows the source of JUPSA funding and the amount over the four years.

Table 8: Source and Amount of JUPSA Funding 2011-2014

	2011	2012	2013	2014	Total
CORE/UBRAF	10,559,029	10,774,519	10,754,416	18,798,586	50,886,550
Irish Aid	1,631,520	1,585,320	1,543,200	1,622,160	6,382,200
DFID	1,597,400	-	-	-	1,597,400
Total	13,787,949	12,359,839	12,297,616	20,420,746	58,866,150

The evaluation found that for all the years, the programme had surplus funding as illustrated figure 12 below:

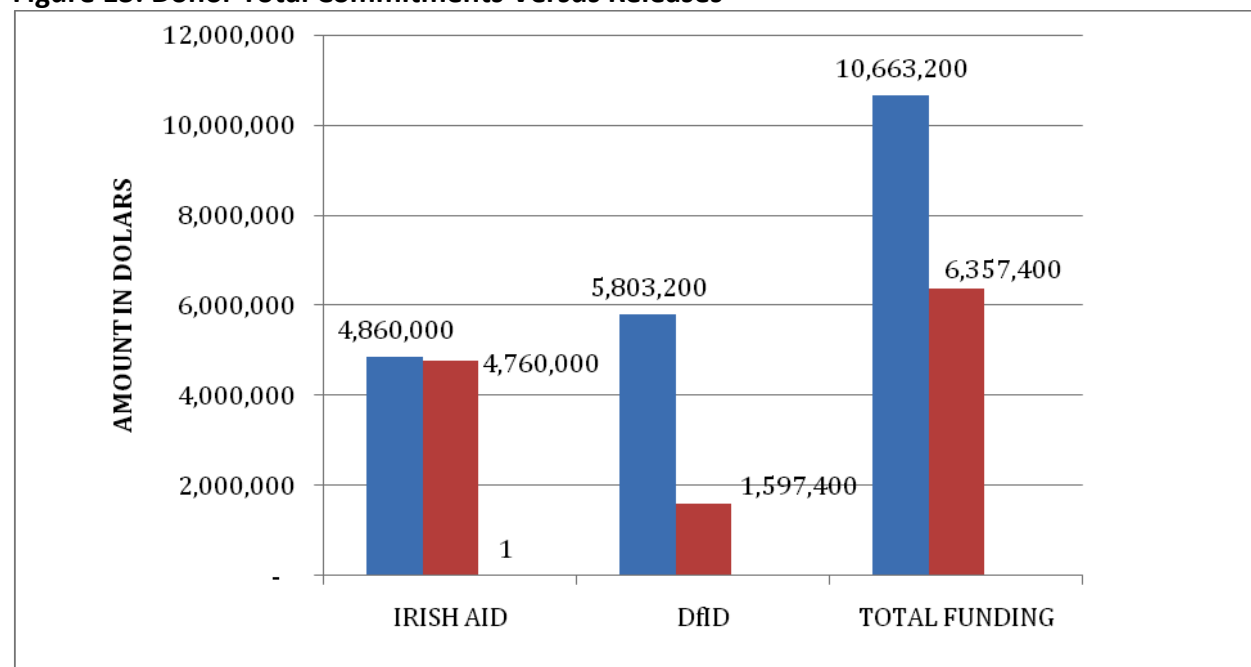
Figure 12: Comparison of JUPSA Annual Budget Commitments with Actual Releases 2011-2014



3.3.2 JUPSA Donor Pledges Versus Releases 2011-2013

The evaluation found that fulfillments of donor commitments from Irish Aid and DFID did not go as planned. Total donor funding was 60 percent with Irish Aid releasing 98% of their commitments and DFID releasing 28%. DFID pulled out in 2012 and did not provide any other funding till the end of the programme. Figure 13 shows financial pledges and release of donor funding for the years 2011-2013.

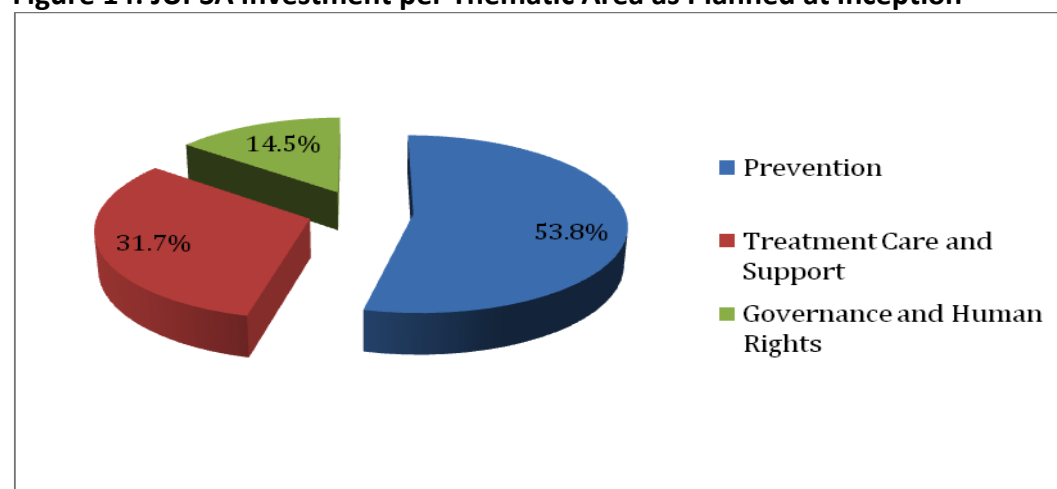
Figure 13: Donor Total Commitments Versus Releases



3.3.3 JUPSA Investment per Thematic Area 2011-2014

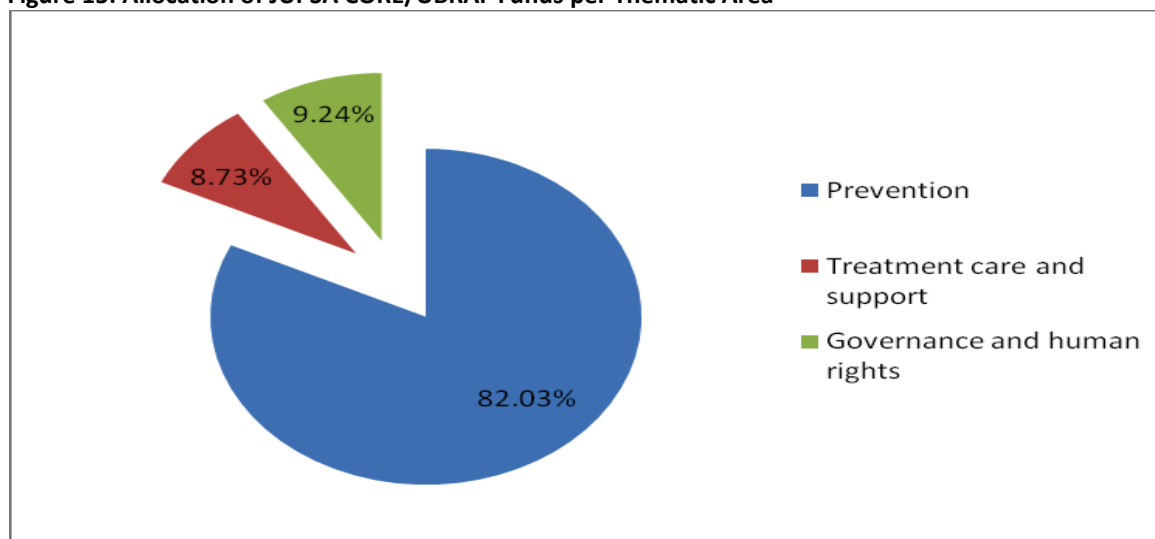
The evaluation made a review of JUPSA investments as regards to the three thematic areas: HIV Prevention, Treatment, Care and Support as well as Governance and Human Rights. It was established that HIV Prevention constituted the highest proportion of the JUPSA funding at 53.8%, which is likely to positively impact on combating the HIV and AIDS epidemic. The Figure 14 shows the Proportion of Investments per Thematic Area.

Figure 14: JUPSA Investment per Thematic Area as Planned at Inception



Review of Core/UBRAF funding also reveals that Prevention thematic area had the largest share as reflected in figure 15 below:

Figure 15: Allocation of JUPSA CORE/UBRAF Funds per Thematic Area



One of the reasons for the Prevention Thematic Area having a high proportion is that it comprises condom procurement that consumes USD 5-7m annually. For instance for the year 2014, Condom procurement was allocated USD 6.5m out of entire budget for the Prevention Thematic Area of USD 14m which constituted 46.4%.

3.3.4 Cost Recovery

The evaluation established that cost recovery policies for funds towards JUPSA were guided by the applicable provisions of the JUPSA Programme document, the Memorandum of Understanding (MOU) concluded between the Administrative Agent (AA) and participating organizations, and the Standard Administrative Arrangement (SAAs) concluded between the AA and contributors, based on rates approved by United Nations Development Group (UNDG.) The policies in place, as of 31 December 2013, were as follows:

The Administrative Agent fee: The AA fee of 1% which is charged at the time of contributor deposit and covers services provided on that contribution for the entire duration of the Fund. For the year 2013 US\$ 15,432 was deducted in AA fees and for the three years US\$ 125,750 had been charged in AA fees.

Indirect Costs of UN Participating Organizations: Participating organizations charge 7% indirect costs. In the year 2013, US\$ 115,597 was deducted in indirect costs by PUNOs. Cumulatively, indirect costs amount to US\$ 99,984 as of 31 December 2013.

Direct Costs: The Fund governance mechanism approved allocations to PUNOs to cover costs associated with secretariat services and overall coordination, as well as fund level reviews and evaluations.

The evaluation found that the above-mentioned policies enabled smooth operation and implementation of the programme.

3.3.5 Factors Responsible for Efficiency Attainment

The evaluation established that the JUPSA programme attained moderate efficiency levels in the course of programme implementation. The factors that are responsible for efficiency attainment are explained below.

Realization of budget surplus

The programme attained more funding than envisaged all through the years, which provided a conducive financial environment for implementation of activities.

Removal of duplication and wastage through Joint approach

The JUPSA has led to reduction in transaction costs, resource wastage and duplication of efforts over the years as expressed by the IPs and government sectors that request support from one UN agency as per the division of Labour. Prior to this, IPs and government sectors would submit one request to more than one UN agency for implementation of a single activity and there was unnecessary competition between agencies, duplications and multiple funding of single activities were common.

Through support of the JUPSA for effective coordination by the Joint Team, the UN has continued to provide secretariat function and coordination to the forum of ADPs. The AIDS Development Partners' Group (ADPG) has become an effective mechanism/forum to harmonize and align development assistance to the Government of Uganda, by minimizing duplication and overlaps. This has been possible given its periodic unified voice and monthly meetings with wide membership drawn from bi- and multilateral organizations.

Through JUPSA the UN was able to harmonize its comparative advantage in Uganda to “Deliver as One” on HIV and AIDS and has continued to keep HIV and AIDS on its top agenda in support of the national HIV response. JUPSA plays a key role in advocacy, coordination, resource mobilization, harmonization and systems strengthening for an expanded HIV response in Uganda. Based on agency comparative advantage and the division of labour, JUPSA has been able to mobilize resources, and facilitate other UN agencies, which have a critical role to play in the national response but have no financial resources as an enabling factor and yet have the mandate, technical expertise and comparative advantage. These efforts have resulted into improved understanding of the concept of ‘harmonization and alignment’.

The capacity of the UN Joint Team was also strengthened to coordinate, plan, implement, monitor and evaluate the Joint Programme (JP) as evidenced in joint planning as well as dialogue with partners; timely and quality reports and working together to deliver as one UN, hence enhanced efficiency.



Figure 16: UN Staff Reviewing JUPSA Progress

The 2013 review of the UNDG noted that the Joint Programme remains a positive model for delivery of programmes, strengthening of partner coordination between the UN, the Government and other partners and increasing awareness and participation in decision-making by various stakeholders. In addition the UN agencies build on their strengths, resources and comparative advantage to deliver programmes while at the same time reducing transaction costs.

Working through existing systems and structures of key stakeholders

The UN works with and delivers the Joint Program through national partners namely government ministries, departments, agencies and CSOs. The UN Division of Labour guided the entry point and the nature of support to each of the partners by PUNOs.

The UN implements the JUPSA through partners and in collaboration with other international and national partners to galvanize support for the delivery of the national response. JUPSA anchored on existing systems within the institutions to implement and deliver the results. The systems included M&E, human resource management, financial management as well as procurement and Logistics. As such, the programme saved resources that would otherwise have been spent to implement the programme.

Use of an Administrative Agent (AA) compared to parallel funding mechanism

The PUNOs selected UNDP/ Multi Partner Trust Fund (MPTF) Office to serve as the AA for the Joint Programme that was used as a 'pass-through' funding modality. The MPTF Office of the UNDP serves as the AA for the pass-through funded portion of the Joint Programme. The AA is responsible for a range of fund management services, including: receipt, administration and management of donor contributions; transfer of funds approved by the Joint Programme to the PUNOs; consolidating statements and reports based on submissions provided to the AA by each PUNO and synthesis and consolidation of the individual annual narrative and financial progress reports submitted by each PUNO for submission to donors through the Joint Steering Committee.

The evaluation established that the AA has effectively performed the assigned responsibilities. For instance during the year 2012, the AA received the annual release from Irish Aid and transferred the funds to PUNOs in a record time of less than a week. The AA has provided timely guidance and provided guidelines for improved reporting focusing on results. The AA published PUNOs' photographic evidence of activities on MPTF Office website; and uploaded JUPSA Annual Reports on the JUPSA website of the MPTF Office GATEWAY at <http://mptf.undp.org/factsheet/fund/JUG00>.

Pooling funds to finance events

Factors that facilitated efficiency Attainment

- ✓ Budget surplus
- ✓ Removal of duplication and wastage through Joint approach
- ✓ Working through existing systems and structures of Key stakeholders
- ✓ Use of an AA compared to parallel funding mechanism:
- ✓ Pooling funds to finance a given event
- ✓ Robust M&E mechanism
- ✓ Effective coordination by UNAIDS and UAC
- ✓ Evidence based implementation
- ✓ Prioritizing training as a prerequisite for attainment of results
- ✓ Sharing international experiences
- ✓ Development and use of guidelines:
- ✓ Prudent financial management culture of the UN
- ✓ Robust stewardship of the JSC
- ✓ Use of electronic MIS
- ✓ Flexibility and respect for use of multiple procurement systems

The PUNOs quite often pooled funds to finance a number of strategic events at national level that included; the launch of eMTCT campaigns, the development GF proposals, NSP development and Protect the Goal campaign as well as co-funding a number of national level studies. Efficiencies were realized as a result of pooling resources together as evidenced by the quote below:

“When we came together, that is when we realized we had a lot of money for HIV and AIDS activities”, (UN Agency KI)

Robust M&E mechanism

JUPSA embedded a robust M&E mechanism that included result based planning and reviews, joint support supervision and reporting.

The programme was monitored based on annual output indicators contributing to the 4-year outcome indicators and specific outputs for activities were agreed in the annual work plans. Monthly Core Management Group meetings and bi-monthly joint team meetings were held during the course of the year to review program implementation. These were supplemented by mid and end of year reviews where the joint team and partners assessed the level of implementation, challenges encountered; and lessons learned and agreed on priorities for successive years. M&E systems for PUNOs were utilized to continually assess progress of implementation vis-a-vis joint programme outputs for which each agency is responsible. Through these processes the programme was able to realize timely compilation and submission of reports. Never the less, IPs expressed concerns that there was increased workload and costs due to producing multiple reports for different UN agencies. This was worsened by the fact that the UN agencies had different financial and reporting systems as well as different reporting timelines from those of ADPs and the Government of Uganda.

‘We spend most of the time writing reports and can hardly do other work besides reporting. For instance, if one IP is funded by DFID, USAID, UN and GoU, one has to prepare an end of year report in April for DFID, July for GoU, October for USAID and December for UN. Moreover all these have different reporting formats’, (District KI)

Effective JUPSA coordination

The UN in collaboration with other development partners provided technical and financial support to UAC to implement recommendations of the institutional review and build staff capacity in order to effectively coordinate the national HIV and AIDS response. The TWGs provide an avenue for quality assurance and performance monitoring of programme deliverables. The TWG and the JT mechanism also serves as a knowledge hub providing technical support to participating agencies in implementation and working with national partners.

The National Prevention Committee (NPC) at UAC was supported to spearhead the development of the NSP, review prevention aspects of the NSP and contribute to the revised NSP. Support was also extended for the functionality of other HIV prevention coordination structures including the National PMTCT Advisory Committee, the National SMC Task Force and the National BCC Team. These coordination structures have enhanced efficiency through minimizing duplication and enabling joint planning.

The respondents particularly appreciated the contribution of UNAIDS office in Uganda in the coordination of JUPSA as illustrated in the quote below;

“The UNAIDS Country Coordinator has personally been very hardworking and passionate about HIV and AIDS work. I believe his personal contribution in achievement of JUPSA results cannot be ignored’, (CSO KI)

Prioritizing capacity enhancement as a prerequisite for attainment of results

The UN employed capacity enhancement as a strategy for improving efficiency and effectiveness in the course of JUPSA implementation. This aimed at ensuring standardization and minimising costs and time wastage that would have otherwise occurred due to lack of common approach and inadequate implementation skills.

Sharing International expertise, innovations and experiences

Sharing international experiences, expertise and innovations assisted in reducing time and resources that would otherwise have been spent on activities. For instance when a team travelled to India to establish how MARPS programming is done, it took a much a shorter time to develop a MARPS action Plan for Uganda.

Prudent Financial Management Culture of the UN

The evaluation found prudent accountability and transparency measures within the UN Finance and Management procedures. One of the ways identified was the development and use of a public website. The UN system and its partners, the MPTF Office developed a public website, the MPTF Office Gateway (<http://mptf.undp.org>) in order to effectively provide fund administration services and facilitate monitoring and reporting. The Website is refreshed in real time every two hours from an internal enterprise resource planning system. The MPTF Office Gateway has become a standard setter for providing transparent and accountable trust fund administration services. A number of respondents expressed trust in the UN due to the fact that it has robust financial management practices including regular internal audits.

“We trust the financial management systems of the UN” (said ADP KI respondent)

Robust stewardship of the JSC

The JSC provided overall oversight of the programme and played its role of among others; discussing JUPSA requirements and priorities, reviewing of funds earmarked by donors to thematic areas, reviewing and approving allocation of funds and reviewing and approving periodic progress reports and making decisions for improved programme performance this translated in results focused and timely implementation of the programme.

Flexibility and respect for use of multiple procurement systems

During the initial stages, the programme faced delayed procurement of supplies and logistics. This was however solved by allowing other systems such as for PUNOs to procure.

3.7 Factors that Constrained Efficiency Attainment

Inadequate human capacity among UN Agencies, Government ministries and IPs

Over the reporting period, some interventions supported under the JUPSA continued to experience concerns of inadequate human capacity within the UN Agencies, government ministries including health facilities which affected timely implementation and delivery of programme activities. The low staffing levels inversely impacted on funds absorption capacity. The programme also experienced setbacks due to high staff attrition especially at the level of government and CSOs.

Inadequate HIV and AIDS supplies

There was reported unprecedented demand for HIV prevention, treatment and care services by communities that surpassed the available supplies of such as condoms, HIV test kits and ARVs.

Low Absorption Capacity and lack of transparency

The programme faced low absorption of funds by implementing partners especially Government sectors occasioned by delayed reporting and accountability, which in turn affected PUNO implementation rates.

Late disbursement of funds due to bureaucracy

The evaluation established that even though funds from the donors may have been disbursed to the UN Agency headquarters in a timely manner, the internal processes of disbursement of the respective funds to the country offices by some respective agencies took a considerable amount of time. This is so because of the need for the UN to adhere to the stringent financial systems and controls, while exuding high respect for contributor funds. Delays in accessing funds at agency country office level delayed implementation often resulting in the need to request for a no cost extension.

Non-Alignment of Financial Years

The programme faced a challenge of different financial reporting systems and timelines between different PUNOs occasioning different experiences. For instance some agencies reported that at the end of the reporting period for a particular donor account, their system configuration required a close down regardless of the fact that only part of the funds had been utilized. Receipt of funds in the middle or at the end of the UN financial year also constrain implementation since PUNOs implement through national partners on the basis of Memoranda of Understanding signed at the beginning of the year. The financial year for Government is July to

FACTORS THAT CONSTRAINED EFFICIENCY ATTAINMENT

- Inadequate human capacity
- High rate of staff attrition
- Low absorption capacity
- Late disbursement of funds affecting timely execution by IPs
- Delays in accessing funds from headquarters of some PUNOs
- Non Alignment of financial years
- Inadequate accountability and transparency in Government MDAs
- High Level of bureaucracy in UN and Government

June while that of the UN is January to December thus creating challenges in harmonising implementation and reporting.

3.4 Impact of JUPSA 2011-2014

JUPSA contributed towards attaining substantial impact on HIV Prevention, Treatment, Care and Support as well as Governance and Human rights as illustrated by the examples in table 9 below.

Table 9: JUPSA Contribution to the Impact

HIV Prevention	
JUPSA Outcomes	Impact to which JUPSA Contributed
Outcome 1.1: National systems have increased capacity to deliver equitable and quality HIV prevention integrated services	<ul style="list-style-type: none">Reduction in new HIV infections (162,294 in 2011 to 140,908 in 2013/14)Modeling shows reduced number of babies born HIV positive (32,000 in 2011 to 15,000 in 2013), though some reports show 9,900.1.4 million males were circumcised as an HIV prevention strategy8.2 million individuals received HCT by the end of 2013; fewer men than women (65.4%)The proportion of pregnant women enrolled on ARVs for eMTCT increased from 52% in 2011 to 72% in 2013Some cultural leaders such as those of Kasese are publicly discouraging traditional circumcision in favour of SMC
Outcome 1.2: Communities mobilized to demand for and utilize prevention integrated services	
Treatment, Care and Support	
Outcome 2.1: therapy for PLHIV who are eligible increased to 80%	<ul style="list-style-type: none">More PLHIV received ART (290,563 in 2010 to 566,046 in 2013/14). Uganda reached the tipping point of the epidemic when it enrolled over 193,000 PLHIV on ART surpassing 137,000 new HIV infections in the same periodThe number of health facilities providing ART increased from 407 in 2011 to 1,552 by mid 2014, of which 269 were paediatric ART sitesMore children both infected and affected living their full potential economically, psycho-socially and received child protection and legal support servicesReduced morbidity and mortality through eMTCT and PLHIV care and treatment servicesContributed to reducing stigmatization against PLHIV through stigma awareness campaigns and the operationalization of the action plan for the Stigma Index
Outcome 2.2: Tuberculosis deaths among PLHIV reduced	
Outcome 2.3: People Living with HIV and AIDS and households affected by HIV are covered in all national social protection strategies and have access to essential care and support	
Governance and Human Rights	
Outcome 3.1: National capacity to lead, plan, coordinate implement monitor and evaluate the national HIV response strengthened	<ul style="list-style-type: none">The National Composite Policy Index (NCPI) increased from 54% in 2010 to 70% in 2014More financial commitment from government from (UGX) 375.38bn (US\$ 156M) in 2008/09 to UGX 852bn (US \$340.8M). The government
Outcome 3.2: Laws, policies and practices improved to	

HIV Prevention	
support gender equality and reduce human rights abuses, stigma and discrimination	<ul style="list-style-type: none"> has further committed to establish an AIDS Trust Fund. Consensus was attained at higher levels of leadership on condom use among those who may not abstain Leadership re- engagement in spearheading the fight against HIV and AIDS
Thematic Area	Area of Minimum Impact
HIV Prevention	<ul style="list-style-type: none"> Condom use by men and women Limited use of female condom
Treatment, care and support	<ul style="list-style-type: none"> A small percentage (41%) of eligible children on ART
Governance and Human rights	<ul style="list-style-type: none"> Accountability Human resource quantity for service delivery and coordination of the national response



Figure 17 A graduation ceremony for 100 HIV negative babies at 18 months who passed through the EMTCT Option B+ programme at Ruhoko Health Center IV in Ibanda District.

However, JUPSA had minimum impact on increasing condom use among the targeted population, scaling up of ART coverage among eligible children, and resolving accountability and human resource issues within IPs.

3.5 Sustainability

The design and implementation of JUPSA programme ensured sustainability through the following:

- Implementing advocacy interventions targeting political, religious and cultural leaders who are expected to ensure continuity of the response in their routine work.
- Wide participation of key stakeholders in the design and implementation of JUPSA interventions has led to increased ownership of the programme.
- The laws, policies and strategies put in place in support of the response will transcend JUPSA, for instance the HIV and AIDS Trust Fund will ensure continued funding of the response.
- Technical and institutional capacity enhancement for UAC, government sectors, CSOs and other IPs; for instance, enhanced capacity for delivery of SMC and eMTCT services.
- The sensitized and empowered community will continue to demand and participate in HIV and AIDS response.
- Documentation of lessons learnt, best practices and success stories will remain as reference points for future HIV and AIDS response.
- The HIV/AIDS Investment Case Report provides long-term strategy and is a resource mobilization tool.
- Working with and through existing structures such as central and local government, cultural and religious institutions, CSOs will ensure continuity.
- Rejuvenating of the HIV and AIDS committees at the districts, the presence of UAC office at national level and the establishment of UAC regional co-ordination centers.
- The established student and community health clubs will continue functioning
- HIV and AIDS has been integrated into the primary level and lower secondary curriculum

3.5.1 Factors Constraining Sustainability

The evaluation noted that the current design and implementation process for JUPSA is entirely dependent on UN agencies and their systems; and direct financing for all JUPSA activities by implementing partners. Coupled with the above is the heavy reliance of IPs on donor funding. These factors were seen as limiting the sustainability of the programme and its operations, in the absence of external donor support. In addition, the short-term nature of JUPSA support to IPs and the frequent changing of priority focus areas affects sustainability and impact of programmes.

4.0 Challenges

In this section, challenges that affected JUPSA as well as others affecting implementing partners in the national HIV and AIDS response, are presented.

4.1 Limited JUPSA Visibility and Clarity of UN Agency Roles

The individual UN agencies had overshadowed JUPSA; the delivering as one entity was not felt at the lower levels. This exemplified in the quote below;

“UN agencies promote themselves above JUPSA”, said one ADP KI respondent

“For sure, I am hearing JUPSA for the first time, from you”, said one of the government KI respondent

“To be honest this is the first time I am hearing about JUPSA. We work closely with UNAIDS but we have never been told about JUPSA and its objectives”, remarked one IP KI respondent

JUPSA does not implement programmes directly, hence its difficult to trace JUPSA outcomes

“In work-plans you see JUPSA, in actual activities you see agencies”, said one ADP KI respondent

The evaluation further noted lack of clarity on the roles of different UN agencies to some IPs. A UN Key informant confirmed this reporting that although different agencies were supporting MoH, one agency might not know exactly what the other is supporting. For instance, within the MGLSD there are five directorates that are supported by different UN agencies but one directorate may not be fully aware of the support being provided to the other directorates.

4.2 Limited Stakeholder Involvement and Ownership

Some LGs and sectors reported that they did not share in JUPSA vision because they claimed lack of involvement in JUPSA programme design. Some LGs further pointed out the fact that their priorities are not the ones funded by JUPSA.

“JUPSA is not supporting our individual institutional priorities”, remarked one district KI respondent.

This resulted into limited ownership of the programme and lack of clarity on the JUPSA objectives.

4.3 Challenges Affecting Service Delivery

The evaluation established challenges that were affecting service delivery at JUPSA level as well as IP level.

JUPSA related service delivery challenges

The respondents cited the seemingly frequent changing priorities of JUPSA; JUPSA started with ART, then PMTCT, after that eMTCT, then on to SMC; hence there was not enough time spent on each priority to totally ground the programme.

Some districts complained that some UN agencies mainly focus on human rights and governance and neglect service delivery especially in the area of TB. Service delivery is a key delivery for local government.

Some LGs complained that the UN implementing agencies only work with the health department in programme implementation and neglect other social service focused departments such as the Community Based Services Department which would yield more results if incorporated.

IP related service delivery challenges

There was overwhelming demand for services such as ARVs, condoms and HIV test kits yet, there were insufficient HIV and AIDS supplies and logistics hence limiting utilization of services.

Stigma by HC workers affected the supervised deliveries particularly for the PLHIV who are often questioned why they have conceived, yet they know they are HIV positive which makes them hesitate to come to HCs for Antenatal Care (ANC) and eMTCT services.

4.4 Legal and policy related challenges

The homosexuality and HIV and AIDS Prevention Bills have negatively affected access to services by stigmatizing the affected groups. The Homosexuality Bill negatively affected the relations between Uganda and some ADPs and consequently HIV and AIDS funds were reduced consequently reducing access to services.

4.5 Human resource challenges

There were inadequate staffing levels among HCs across the country, which negatively affected service delivery. The UAC 2011 Audit Report further revealed a 60% deficiency in UAC staffing levels; and although some staffing gaps were filled, UAC still has a gap of 27 required staff, hence limiting the coordination of the national response.

4.6 Partnerships and collaboration challenges

JUPSA Related partnerships and collaboration challenges

Quite often, most PUNOs prioritize working as individual UN agencies and IPs as opposed to focusing on the JUPSA interventions where by priority is given to agency as opposed to JUPSA work plans.

IPs related partnerships and collaboration challenges

There is an Information gap whereby information sharing is limited across implementing partners and the districts.

4.7 Finance Related Challenges

JUPSA Related finance challenges

Districts felt that JUPSA was reluctant to give them funds because the districts were already supported by district-based mechanisms such as Northern Uganda Health Integration To Enhance Services (NUHITES) and Strengthening Tuberculosis and AIDS Response (STAR), yet the districts still reported service delivery gaps.

The districts reported that there are often delays in approving work plans and releasing funds due to bureaucracies, which slows down the implementation rate of activities.

The funds given for programme implementation are reportedly not reasonable to ensure timely and efficient implementation of programmes.

The ADPS, government and PUNOs have different finance reporting systems and timelines hence heavy workload being created.

There were delays in determining the DFID funded districts of operation, which resulted in late implementation of some JUPSA activities.

IPs related finance challenges

Some institutions such as UAC and MOH were not able to absorb the available resources, which negatively affected the implementation of the HIV and AIDS response.

The level of funding from the government to sector level HIV and AIDS programmes is minimal hence limiting the level of HIV and AIDS activities/interventions.

4.8 M&E Related Challenges

JUPSA M&E related Challenges

The JUPSA logical framework indicators were not consistently and systematically tracked annually, hence making tracking of progress difficult. Different indicators were tracked in different annual reports; and in most cases they differed from those in the log-frame. Most indicators related to direct implementation yet JUPSA is not an implementer.

5.0 Lessons Learned and Best Practices

The section below presents key lessons learned and best practices from the implementation of JUPSA programme in the national HIV and AIDS response:

The JUPSA model facilitated scaling up the resource envelope through pooling of funds and employing a coordinated approach to the HIV and AIDS response; thus minimises duplication of interventions and increases efficiency as well as effectiveness.

The re-engagement of parliament, political, religious and cultural leadership yields stronger political will and better results.

The establishment of the JSC that involves the government, private sector, the UN, development partners and PLHIV fosters national ownership of the JUPSA and collaboration for its delivery.

Limited involvement of the government at district level in the initial planning processes of JUPSA interventions leads to limited ownership of the programs, hence may limit its sustainability.

Delays experienced by the UN system; followed by delays from government and other implementing partners system creates 'multiple delays' which is not desirable.

5.1 Best Practices

The following best practices were noted during the design, planning, implementation, monitoring and evaluation of the JUPSA programme. These practices are highlighted in the text box below:

Best Practices

- Planning reporting and implementing as one has enhanced synergies
- Private sector engagement expanded the resource base in the national HIV and AIDS response
- Working with cultural institutions through their subjects to address GBV and HIV and AIDS issues
- Male involvement in HCT to minimize GBV
- Pooling of funds together in one basket
- Use of faith based model to disseminate HIV and AIDS messages
- Regular JUPSA engagement with UAC and other stakeholders has enhanced ownership, coordination and participation in the national HIV and AIDS response.

6.0 Conclusions

Relevance: Overall, JUPSA is deemed as a very relevant program given its alignment to the national and international HIV and AIDS strategic plans; as well as the focus the divers of the epidemic as well as the needs of those infected and affected by HIV and AIDS.

Effectiveness: The program has largely achieved its objectives and hence realized the intended outcomes, in areas of HIV Prevention, Care and treatment, as well as governance and human rights. However, there is still a high unmet need for HIV and AIDS services.

Efficiency: The JUPSA model has brought considerable returns with relatively moderate input due to pooling together of resources, which minimizes duplication of efforts and resource wastage. The joint and coordinated activities harness synergies of different agencies; and ensure that each agency focuses on its niche. However, weak accountability and transparency in government and other institutions limits further achievements of efficiency.

Impact: JUPSA has had commendable impact on the HIV and AIDS response in all the thematic areas evidenced by the reduction in deaths related to HIV and AIDS and reduction in new infections.

Sustainability: JUPSA has a strong element of continuity through great investment in capacity enhancement as well as working with and through existing service delivery, political, religious and cultural structures, which will ensure sustainability of services.

7.0 Recommendations

The following recommendations were made to further strengthen JUPSA programing, functions and ensure greater impact:

Improve the JUPSA theory of change

Consider reorganizing the JUPSA results framework so that for instance all capacity strengthening interventions are housed in one result area, with different agencies contributing to it. Focus should be put on outcomes, outputs and indicators that are directly attributable to JUPSA.

Scale up Advocacy

Expand and maintain concerted and evidence informed advocacy among political, religious, cultural and other leaders. Expand advocacy target audience to include district councilors. Focus on HIV prevention, including eMTCT efforts.

Continue with high level technical and management dialogue between the UN heads of Agencies, Ambassadors, Minister of Health and UAC Chair to resolve the procurement issues

The Homosexuality Bill and the HIV and AIDS Bill should be re-discussed to reach consensus among key stakeholders.

Prioritize gender especially extramarital related issues and inheritance since they are among the main drivers of HIV and AIDS transmission in the local setting.

Strengthen stakeholder engagement and coordination

Districts need to be involved at all levels of planning processes to ensure smooth service delivery, ownership and sustainability. However, it should be noted that JUPSA is mainly high level/national level therefore a discussion needs to be facilitated on this delivery approach.

More should be done to engage the private sector to commit both financial and in-kind contribution to the HIV and AIDS response.

Improve coordination and information sharing within IPs and other key stakeholders and provide feedback on evaluation results to consulted stakeholders and strengthen the linkages between the ministries and district actors in terms of communication, support supervision and technical guidance.

Scale up the engagement of cultural and religious institutions

The cultural and religious institutions should be supported since they have high potential for mounting an expanded response targeting socio-cultural drivers of the epidemic. Provide funding for implementing the HIV and AIDS work plan for cultural institutions

Scale up systems and capacity strengthening

Advocate for increased investment in the health systems strengthening and increased HR for health services. Invest in continuous capacity building and quality assurance. Strengthen systems and technical capacities of cultural institutions to be able to access and handle resources. Revise strategies of approach and engagement of cultural leaders to see what they can initiate in their communities.

Scale up the efforts towards attaining the HIV and AIDS 90, 90, 90 UN targets

Scale up support to HIV and AIDS interventions so as to attain the global UN goal of testing 90% of the population for HIV; treating 90% of the eligible HIV positive individuals and reducing the viral load by 90%. For high impact interventions to address structural issues there is need to work with cultural and religious leaders.

Employ a holistic approach on prevention. Focus on the drivers of the epidemic and target sex workers, fishing communities and other key populations.

Address adolescent girls' issues as a special category and target institutions of learning to reach the youth with HIV and AIDS services. Establish more youth friendly services and ensure adequate capacity to manage them.

Strengthen HIV and AIDS workplace responses with a focus on both formal and informal sectors.

Prioritize TB prevention among PLHIV to reduce transmission of TB and HIV and AIDS.

Strengthen food security and livelihoods for increased HIV and AIDS care support among the PLHIV.

Broaden the HIV and AIDS resource base

Increase domestic financing, both from government and private sector to reduce reliance on donors. Establish and operationalize the HIV and AIDS Trust Fund in line with the National HIV Investment Case 2015 - 2025. Target the non-traditional ADPs such as those from Asia such as Japan and China.

JUPSA should provide a strategy for financial risk management in view of the weak public financial management system.

Consider managing the pooled JUPSA resources centrally for improved access, reporting and more efficiency by IPs.

Improve accountability and transparency among stakeholders

There is need for ADPs to collectively review funds given to stakeholders in form of transport refunds and sitting allowances of stakeholders in order to address responsiveness and accountability issues. Conduct Senior Level engagement with MOH to address the accountability and the low absorption issues.

Strengthen and improve JUPSA coordination and functioning

Re-brand and improve JUPSA visibility as well as articulate JUPSA role, accomplishments and value addition. JUPSA contributions should be reflected, acknowledged and recognized in work plans and reports at all levels. Put in place a communication strategy that will streamline procedures and guidelines to enhance the visibility of JUPSA.

Increase the participation of ADPs in JUPSA implementation, monitoring and evaluation so as to appreciate JUPSA scope and functions better.

JUPSA should consider moving from focusing at the national level to the sub-national level and create a niche there.

Strengthen JUPSA M&E

Ensure consistent and systematic tracking of JUPSA performance indicators. This may require reviewing the indicators so that only strategic and directly attributable indicators are contained in JUPSA result's framework. JUPSA should consider including the coordination and reporting tool in eMIS.

Best practices from other countries should be documented and shared among key stakeholders to improve programming.

JUPSA should continue enhancing the capacity of PUNOs as well as IPs in M&E to ensure regular tracking of implementation and evaluation of the programme.

Institutionalise regular review meetings between UN TWGs and IPs to review implementation progress, challenges, and lessons learned and best practices. These meetings can also serve as a forum for experience sharing and data use for improved programming.

Use IP quarterly reports to address the issue of different reporting cycles among the UN, ADPs and government institutions.

Maintain the sustainability interventions

Continue working through existing government, cultural and religious structures and strengthen their capacity to provide quality HIV and AIDS services.

JUPSA should develop a clear and sustainable exit plan when funding projects so that the IPs are better prepared for the continuation of their programmes after JUPSA support comes to an end

8.0 Priorities for the January – December 2015 Bridging Work-plan

Based on the analysis of JUPSA 2011-2014 evaluation findings, the following interventions were identified for prioritization in the January – December 2015 Bridging Work-plan period.

- Continue with high-level advocacy, to keep up the momentum. Focus on paediatric AIDS, adolescent girls and fishing communities.
- Strengthen domestic resource mobilization. Support the establishment and operationalization of the AIDS Trust Fund
- Support the development of guidelines and planning meetings between UN TWGs and IPs.
- Scale up private sector engagement to contribute more to the HIV and AIDS response
- Guide discussions on the Homosexuality Bill and the HIV and AIDS Bill
- Further scale up eMTCT efforts to include private clinics
- Scale up HIV and AIDS interventions with a focus on the drivers of the epidemic. Support a vulnerability analysis survey
- Implement more BCC among key populations and MARPS. Target sex workers, fishing communities and other key populations.
- Design deliberate interventions targeting adolescent girls and other youths in secondary schools and higher institutions of learning.
- Implement youth empowerment interventions such as life skills and livelihood skills
- Test and treat aiming at the 90-90-90 targets
- Capacity enhancement for improved government and community systems
- Strengthen and operationalise M&E systems for JUPSA and UAC. Ensure regular tracking and reporting on indicators. Hold a planning retreat for developing JUPSA
- Generate more evidence by supporting the implementation of the national HIV and AIDS research agenda.
- Support the development of the research agenda.
- Engage with SBH team to include gender inequality issues constraining gender.
- Technical assistance to NADIC to make in more function in generating a central source of evidence, DQA and sharing information
- Participate in East African HIV and AIDS Conference to be hosted by Uganda in March 2015

Annex 1 Evaluation Tools



The Evaluation of the Joint UN Programme of Support on AIDS in Uganda (JUPSA) 2011-2014 JUPSA UN Participating Agencies (Country Representatives) Tool (1)

Good morning/afternoon sir/madam, my name isI am on the team that is conducting the end of Programme evaluation of the Joint UN Programme of Support on AIDS in Uganda (JUPSA) 2011-2014 as well develop the priorities of focus for January –December 2015 bridging work-plan.

Please note that the information provided during the interview will be treated with utmost confidentiality.

Do I have your permission to continue? If yes, proceed with interview. If No, End

KEY INFORMANT GUIDE

Date of Interview:	_31_/_10_/_2014_
Interviewer:	
UN Agency:	
Interviewee Name:	
Interviewee Tel:	
Designation	
Email:	
Start Time:	
End Time:	

Effectiveness – To examine the extent to which the Programme’s stated objectives are achieved

1. What do you consider to be the main achievements of JUPSA? (*probe for prevention, care and treatment, governance and human rights, as well as gender*)
2. What were the main constraints/challenges that were encountered during the implementation of JUPSA?

Relevance – Assessment of the degree to which the JUPSA was justified and appropriate in relation to the Uganda HIV response

1. To what extent is the JUPSA justified and appropriate in relation to the Uganda HIV and AIDS National Strategic Plan (NSP)?

(Probe: How JUPSA has addressed the Uganda HIV response as prioritized by NSP, NDP, UNDAF and GF)

Efficiency – To analyze the outputs in relation to the inputs, the financial management, and the implementing timetable

1. What has JUPSA done to enhance efficiency (avoid duplication, overlaps, and resource wastage)?
2. In which ways has partnership with other agencies influenced achievement of JUPSA results? *(Probe for challenges)*
3. In what ways has JUPSA M&E data facilitated decision making at your level?
4. Are there better (more efficient) ways of how JUPSA objectives could have been achieved? Please make suggestions

Impact – To determine the positive and negative, foreseen and unforeseen changes as result of JUPSA

1. What do you consider to be the long term results of JUPSA on the HIV and AIDS response in Uganda?

Sustainability – The extent to which benefits from the JUPSA will continue or are likely to continue

1. In what ways are the interventions and benefits derived from JUPSA likely to continue beyond the lifetime of the programme? *(Probe for which aspects of JUPSA work and results are likely to continue; what factors are likely to influence this continuity)*

Good practices and Lessons Learned

1. What good practices were outstanding in achieving JUPSA results that could be incorporated into the design of future related programs?
2. Are there factors that affected JUPSA implementation and achievement of results? *(Probe for cultural, gender, political or economic)*

Recommendations for Future Program Improvement

1. What recommendations would you give for improving future UN HIV and AIDS response in Uganda?

Priorities January –December 2015 Bridging Work-Plan

1. In view of the JUPSA achievements, gaps as well as International and National priorities for HIV and AIDS response, what should be the priority interventions for the January –December 2015 bridging work-plan

Annex 1 b

The Evaluation of the Joint UN Programme of Support on AIDS in Uganda (JUPSA) 2011-2014 JUPSA TWG TOOL (2)

Good morning/afternoon sir/madam, my name isI am on the team that is conducting the end of Programme evaluation of the Joint UN Programme of Support on AIDS in Uganda (JUPSA) 2011-2014 as well develop the priorities of focus for January –December 2015 bridging work-plan.

Please note that the information provided during the interview will be treated with utmost confidentiality.

Do I have your permission to continue? If yes, proceed with interview. If No, End

KEY INFORMANT GUIDE

Date of Interview:	___/___/___
Interviewer:	
UN Agency:	
Interviewee Name	
Interviewee Tel:	
Designation	
Email:	
Start Time	
End Time	

Theme 1: Relevance – Assessment of the degree to which the JUPSA was justified and appropriate in relation to the Uganda HIV response

1. To what extent is the JUPSA justified and appropriate in relation to the Uganda HIV and AIDS National Strategic Plan (NSP)?
2. To what extent have the stated outcomes correctly addressed the Uganda HIV response NSP priorities?

Please rank the relevance of each of the JUPSA outcomes with respect to the extent to which it addresses the Uganda HIV response NSP priorities on a scale of 0 (not relevant) to 10 (very relevant)

JUPSA Outcomes	Relevance Score	Explain basis for score
1. National systems have increased capacity to deliver equitable and quality HIV prevention integrated services		
2. Communities mobilized to demand for and utilize prevention integrated services		
3. Access to antiretroviral therapy for PLHIV who are eligible increased to 80 percent		
4. Tuberculosis deaths among PLHIV reduced		

5. People Living with HIV and AIDS and households affected by HIV are covered in all national social protection strategies and have access to essential care and support		
6. National capacity to lead, plan, coordinate implement monitor and evaluate the national HIV response strengthened		
7. Laws, policies and practices improved to support gender equality and reduce human rights abuses, stigma and discrimination		

3. Are there JUPSA objectives that had to be revised in order to adapt to changes in the HIV and AIDS response? *(Probe for what they are and the extent of the adjustment)*
4. What were the benefits of UN joint programme approach (delivering as one, as opposed to use of a single agency)? *(Probe for advantages of delivering as one and associated challenges)*
5. To what extent did JUPSA address or meet the identified needs of targeted beneficiaries? *(Probe for institutions and end beneficiaries)*
6. What is the level of stakeholders' participation in the design and in the management/implementation of the JUPSA activities? *(Probe for the role of stakeholders in the design, implementation, progress review)*
7. What were the main risks and assumptions considered at the time of JUPSA 2011-2014 design *(probe for influence of occurrence and non-occurrence on program implementation as well as achievement of results)*

Theme 2: Effectiveness – To examine the extent to which the Programme's stated objectives are achieved

3. To what extent did the JUPSA achieve its stated objectives? *(Tick as appropriate)*

Poor	Fair	Good	Excellent

4. What do you consider to be the main achievements of JUPSA? *(Probe for HIV prevention, care and treatment, governance and human rights, as well as gender)*
5. What were the main constraints/challenges that were encountered during the implementation of JUPSA?
6. What major factors contributed to the achievement /non-achievement of JUPSA objectives?

Theme 3: Efficiency – To analyze the outputs in relation to the inputs, the financial management, and the implementing timetable

5. In your view, how would you rate the financial contribution of JUPSA in relation to the NSP financial requirements (*probe for levels: minimal, moderate, substantial*) Give reasons for your response. TICK AS APPROPRIATE

Minimal	Moderate	Substantial

Give reasons:

6. How has JUPSA enhanced efficiency in the operations of the HIV and AIDS response? (*Probe for avoidance of duplication, overlaps, and resource wastage,*)
7. What particular challenges constrain efficiency attainment in course of programme implementation?
8. Are there better (more efficient) ways of achieving the JUPSA objectives?
9. Please explain the financial management culture of JUPSA as regards (*Rank on scale of 1-5, where by 1=strongly disagree, 2=disagree, 3=neutral, 4=agree, 5=strongly agree*)

No.	Financial Management Culture	Score (1-5)	Remarks
1.	Budget credibility - the budget is realistic and is implemented as intended		
2.	Budget Comprehensiveness and transparency- The budget and the financial risk oversight are comprehensive and financial and budget information is accessible to staff.		
3.	Result oriented budgeting - The budget is prepared with due regard to programme results.		
4.	Predictability and control in budget execution - The budget is implemented in an orderly and predictable manner and there are arrangements for the exercise of control and stewardship in the use of funds.		
5.	Accounting, recording and reporting – Adequate records and information are produced, maintained and disseminated to meet decision-making control, management and reporting purposes.		
6.	External scrutiny and audit - Arrangements for scrutiny of finances and follow up by executive are operating.		
7.	Procurement and logistical management		

Theme 4: Sustainability – The extent to which benefits from the JUPSA will continue or are likely to continue

1. Has there been any capacity strengthening of local systems, structures and persons to continue operating after the JUPSA?

What are some of the examples in this respect?

2. In what ways are the interventions and benefits derived from JUPSA likely to continue beyond the lifetime of the programme? *(Probe for which aspects of JUPSA work and results are likely to continue; what factors are likely to influence this continuity)*

Which aspects are less likely to continue, why?

Theme 5: Impact – To determine the positive and negative, foreseen and unforeseen changes as result of JUPSA

2. What long-term changes are attributable to the JUPSA? *(Probe for positive and negative, foreseen and unforeseen changes in attitudes, behaviours, relationships or practices) among women, men, girls and boys?*
3. Has the JUPSA achieved its goal or can it reasonably be expected to do so, on the basis of the current outputs and outcomes? *(Probe for facilitating or constraining factors)*
4. In what ways has JUPSA ensured gender equity (availing equal opportunities to both females and males) please explain?
5. How has the Uganda HIV and AIDS response situation changed over time and what, if any, has been the contribution of the JUPSA to those changes?
6. How has the JUPSA influenced the HIV and AIDS legal and policy environment in Uganda?

Theme 6: Lessons Learnt

3. What facilitated achievement of JUPSA results that should be incorporated into the design of future similar programmes in future?
4. What constrained achievement of JUPSA results that should be avoided when designing similar programmes in the future?
5. What would you do differently to improve future related programs?

Theme 7: Best Practices – To highlight good practices and exemplary implementation experiences

1. What special techniques used by particular implementers or sectors proved to be effective and efficient that can be replicated in similar programs?

Theme 8: Emerging issues

1. What are the emerging issues in the HIV and AIDS response that need to be taken into consideration in the next planning period?

Theme 9: Recommendations for Future Program Improvement

2. What recommendations would you give for improving future UN HIV and AIDS response in Uganda?

Theme 10: Priorities for Jan-Dec 2015 Bridging Workplan

2. In view of the JUPSA achievements, gaps as well as International and National priorities for HIV and AIDS response, what should be the priority interventions for the January –December 2015 bridging work-plan

Annex 1c

The Evaluation of the Joint UN Programme of Support on AIDS in Uganda (JUPSA) 2011-2014 Implementing Partners tool (3)

Good morning/afternoon sir/madam, my name isI am on the team that is conducting the end of Programme evaluation of the Joint UN Programme of Support on AIDS in Uganda (JUPSA) 2011-2014 as well develop the priorities of focus for January –December 2015 bridging work-plan.

Please note that the information provided during the interview will be treated with utmost confidentiality.

Do I have your permission to continue? If yes, proceed with interview. If No, End

KEY INFORMANT GUIDE

Date of Interview:	___/___/___
Ministry/Agency:	
IPs:	
Interviewee Name	
Interviewee Tel:	
Designation	
Email:	
Start Time	
End Time	

Theme 1: Relevance – Assessment of the degree to which the JUPSA was justified and appropriate in relation to the Uganda HIV response

8. To what extent is the JUPSA justified and appropriate in relation to the Uganda HIV and AIDS National Strategic Plan (NSP)?
9. To what extent has the nature of the issues originally identified and targeted in the JUPSA changed? *(Probe for what has changed; in what ways? What was the JUPSA response to these changes?)*
10. To what extent have the JUPSA objectives been updated in order to adapt to changes in the context?
11. What were the benefits of UN joint programme approach (delivering as one, as opposed to use of a single agency)? *(Probe for advantages of delivering as one and associated challenges)*

12. To what extent did JUPSA address or meet the identified needs of targeted beneficiaries? *(Probe for institutions and end beneficiaries)*
13. To what extent do you as an institution participate in the design and in the management/implementation of the JUPSA activities? *(Probe for the role of stakeholders in the design, implementation, progress review)*

Theme 2: Effectiveness – To examine the extent to which the Programme’s stated objectives are achieved

7. What do you consider to be the main achievements of JUPSA? *(Probe for prevention, care and treatment, governance and human rights, as well as gender)*

Theme 3: Efficiency – To analyze the outputs in relation to the inputs, the financial management, and the implementing timetable

10. In your view, how would you rate the efficiency of JUPSA programme *(probe for levels: minimal, moderate, substantial) Give reasons for your response*
11. What particular challenges constrain efficiency attainment in course of programme implementation?
12. In your view are there better (more efficient) ways of achieving the JUPSA objectives?

Theme 4: Sustainability – The extent to which benefits from the JUPSA will continue or are likely to continue

3. Has there been any capacity strengthening of local systems, structures and persons in your institution to continue operating after the JUPSA?

What are some of the examples in this respect?

4. In what ways will the interventions and benefits derived from JUPSA likely to continue beyond the lifetime of the programme? *(Probe for which aspects of JUPSA work and results are likely to continue; what factors are likely to influence this continuity)*

Which aspects are less likely to continue, why?

Theme 5: Impact – To determine the positive and negative, foreseen and unforeseen changes as result of JUPSA

7. What long term changes in the HIV and AIDS response in Uganda are attributable to the JUPSA? *(Probe for positive and negative, foreseen and unforeseen changes in attitudes, behaviours, relationships or practices among women, men, girls and boys, and in the legal and policy environment)*
8. What are the negative effects (if any) of the JUPSA
9. Has the JUPSA achieved its goal or can it reasonably be expected to do so, on the basis of the current outputs and outcomes? Probe for facilitating or constraining factors.

Theme 6: Lessons Learnt

6. Are there cultural, gender, political or economic factors that affected JUPSA implementation and achievement of results?

Theme 7: Best Practices – To highlight good practices and exemplary implementation experiences

2. What special techniques used by your institution proved to be effective and efficient that can be replicated in future related programs?

Theme 8: Recommendations for Future Program Improvement

3. What recommendations would you give for improving future UN HIV and AIDS response in Uganda?

Theme 9: Priorities for January-December 2015 Bridging Work plan

1. In view of the JUPSA achievements and gaps, the National Development Plan 2 and the HIV and AIDS NSP, what would you suggest as the key priority interventions for JUPSA for the period Jan-Dec 2015 Bridging Work plan?

Annex 1d

The Evaluation of the Joint UN Programme of Support on AIDS in Uganda (JUPSA) 2011-2014 Ministries, OPM and Parliament Tool (4)

Good morning/afternoon sir/madam, my name isI am on the team that is conducting the end of Programme evaluation of the Joint UN Programme of Support on AIDS in Uganda (JUPSA) 2011-2014 as well develop the priorities of focus for January –December 2015 bridging work-plan.

Please note that the information provided during the interview will be treated with utmost confidentiality.

Do I have your permission to continue? If yes, proceed with interview. If No, End

KEY INFORMANT GUIDE

Date of Interview:	___/___/___
Interviewer:	
UN Agency:	
Interviewee Name:	
Interviewee Tel:	
Designation	
Email:	
Start Time:	
End Time:	

Effectiveness – To examine the extent to which the Programme’s stated objectives are achieved

8. What do you consider to be the main achievements of JUPSA? *(probe for prevention, care and treatment, governance and human rights, as well as gender)*
9. What were the main constraints/challenges that were encountered during the implementation of JUPSA?

Relevance – Assessment of the degree to which the JUPSA was justified and appropriate in relation to the Uganda HIV response

2. To what extent is the JUPSA justified and appropriate in relation to the Uganda HIV and AIDS National Strategic Plan (NSP)?

(Probe: How JUPSA has addressed the Uganda HIV response as prioritized by NSP, NDP, UNDAF and GF)

Efficiency – To analyze the outputs in relation to the inputs, the financial management, and the implementing timetable

13. What has JUPSA done to enhance efficiency (avoid duplication, overlaps, and resource wastage)?
14. Who has been your key partners in JUPSA implementation *(probe for benefits/opportunities/challenges of partnerships)*
15. In what ways has JUPSA M&E data facilitated decision making at your level?
16. Are there better (more efficient) ways of how JUPSA objectives could have been achieved? Please make suggestions

Impact – To determine the positive and negative, foreseen and unforeseen changes as result of JUPSA

10. What do you consider to be the long-term results of JUPSA on the HIV and AIDS response in Uganda?

Sustainability – The extent to which benefits from the JUPSA will continue or are likely to continue

2. In what ways are the interventions and benefits derived from JUPSA likely to continue beyond the lifetime of the programme? *(Probe for which aspects of JUPSA work and results are likely to continue; what factors are likely to influence this continuity)*

Good practices and Lessons Learned

7. What good practices were outstanding in achieving JUPSA results that could be incorporated into the design of future related programs?
8. Are there factors that affected JUPSA implementation and achievement of results? *(Probe for cultural, gender, political or economic)*

Recommendations for Future Program Improvement

4. What recommendations would you give for improving future UN HIV and AIDS response in Uganda?

Priorities January –December 2015 Bridging Work-Plan

3. In view of the JUPSA achievements, gaps as well as International and National priorities for HIV and AIDS response, what should be the priority interventions for the January –December 2015 bridging work-plan

Annex 1e

The Evaluation of the Joint UN Programme of Support on AIDS in Uganda (JUPSA) 2011-2014 DISTRICT TPC TOOL (5)

Good morning/afternoon, we are conducting the end of Programme evaluation of the Joint UN Programme of Support on AIDS in Uganda (JUPSA) 2011-2014 as well as develop the priorities of focus for January – December 2015 bridging work-plan.

KEY INFORMANT GUIDE

Date of Interview:	___/___/___
Interviewer:	
District:	
Interviewee Name	
Interviewee Tel:	
Designation	
Email:	
Start Time	
End Time	

Theme 1: Relevance – Assessment of the degree to which the JUPSA was justified and appropriate in relation to the Uganda HIV response

14. To what extent is the JUPSA justified and appropriate in relation to the Uganda HIV and AIDS National Strategic Plan (NSP)?
15. To what extent have the JUPSA interventions correctly addressed the Uganda HIV response NSP priorities?
16. What were the benefits of UN joint programme approach (delivering as one, as opposed to use of a single agency)? *(Probe for advantages of delivering as one and associated challenges)*
17. To what extent did JUPSA address or meet the identified needs of targeted beneficiaries? *(Probe for institutions and end beneficiaries)*
18. What is the level of stakeholders' participation in the design and in the management/implementation of the JUPSA activities? *(Probe for the role of stakeholders in the design, implementation, progress review)*

Theme 2: Effectiveness – To examine the extent to which the Programme's stated objectives are achieved

10. To what extent did the JUPSA achieve its stated objectives? *(Tick as appropriate)*

Poor	Fair	Good	Excellent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. What do you consider to be the main achievements of JUPSA? *(Probe for HIV prevention, care and treatment, governance and human rights, as well as gender)*
12. What were the main constraints/challenges that were encountered during the implementation of JUPSA?
13. What major factors contributed to the achievement /non-achievement of JUPSA objectives?

Theme 3: Efficiency – To analyze the outputs in relation to the inputs, the financial management, and the implementing timetable

17. How has JUPSA enhanced efficiency in the operations of the HIV and AIDS response? *(Probe for avoidance of duplication, overlaps, and resource wastage,)*
18. What particular challenges constrain efficiency attainment in course of programme implementation?
19. Are there better (more efficient) ways of achieving the JUPSA objectives?

Theme 4: Sustainability – The extent to which benefits from the JUPSA will continue or are likely to continue

5. Has there been any capacity strengthening of local systems, structures and persons to continue operating after the JUPSA?
What are some of the examples in this respect?
6. In what ways are the interventions and benefits derived from JUPSA likely to continue beyond the lifetime of the programme? *(Probe for which aspects of JUPSA work and results are likely to continue; what factors are likely to influence this continuity)*

Which aspects are less likely to continue, why?

Theme 5: Impact – To determine the positive and negative, foreseen and unforeseen changes as result of JUPSA

11. What long-term changes are attributable to the JUPSA? *(Probe for positive and negative, foreseen and unforeseen changes in attitudes, behaviours, relationships or practices) among women, men, girls and boys?*
12. In what ways has JUPSA ensured gender equity (availing equal opportunities to both females and males) please explain?
13. How has the Uganda HIV and AIDS response situation changed over time and what, if any, has been the contribution of the JUPSA to those changes?
14. How has the JUPSA influenced the HIV and AIDS legal and policy environment in Uganda?

Theme 6: Lessons Learnt

9. What facilitated achievement of JUPSA results that should be incorporated into the design of related programmes in future?

10. What constrained achievement of JUPSA results that should be avoided when designing related programmes in the future?

11. What would you do differently to improve future related programs?

Theme 7: Best Practices – To highlight good practices and exemplary implementation experiences

3. What special techniques used by particular implementers or sectors proved to be effective and efficient that can be replicated in related programs?

Theme 8: Emerging issues

2. What are the emerging issues in the HIV and AIDS response that need to be taken into consideration in the next planning period?

Theme 9: Recommendations for Future Program Improvement

5. What recommendations would you give for improving future UN HIV and AIDS response in Uganda?

Theme 10: Priorities for Jan-Dec 2015 Bridging Work-plan

4. In view of the JUPSA achievements, gaps as well as International and National priorities for HIV and AIDS response, what should be the priority interventions for the January –December 2015 bridging work-plan

END

THANK YOU VERY MUCH

Annex 2 List of Respondents Interviewed

No.	Name of respondent	Designation	Institution
1.	Dr. Kaggwa Mugagga	Country Advisor	WHO
2.	Mr. Steve Okokwu	HIV/AIDs Specialist	UNICEF
3.	Ms. Sarah Nakku Kibuuka	Program Analyst (HIV/AIDS)	UNDP
4.	Ms. Rosemary Kidomunda	National Program Officer HIV/AIDs	UNFPA
5.	Dr. Musa Bungudu	Uganda Country Coordinator	UNAIDS
6.	Mr. Julius Kasozi	HIV/AIDS Coordinator	UNHCR
7.	Mr. Charles Draecabo	National Professional Officer HIV AIDS	
8.	Mr. Patience Bulage	Program Assistant	UNESCO
9.	Dr. Natalia Gitu	Chief Medical Officer	IOM
10.	Mr. David Mawejje	National HIV/AIDS Coordinator	ILO
11.	Dr. Shaban	Ag, ACP Manager	MOH
12.	Mr. Jackson Nsamba Kasozi	The Prime Minister	Bunyoro Kitara Kingdom
13.	Ms. Beat Bisangwa	Executive Director	OAFLA
14.	Ms. Nancy Nyinomujuni	HRO	Ministry of Finance
15.	Hon. Sarah Kayagi	Chair HIV Committee	Parliament
16.	Dr. Okello	Director Public Health HIV focal person	Public Health
17.	Ms. Caroline Kego Laker	Social Development Advisor	Embassy Ireland
18.	Dr. Albert Byamugisha	Commissioner M&E	OPM
19.	Dr. Zepher Karyabakabo	Director Policy, Research and Planning	UAC
20.	Ms. Enid Wamani	Director Partnerships	UAC
21.	Mr. Mulumba Moses	Executive Director	CERURD
22.	Mr. Noel Komunda	M&E Officer	
23.	Dr. Nsubuga	Director Health HIV /AIDs Coordinator	MOES
24.	Ms Stella Kentusi	Executive Director	NAFOPHANU
25.	Ms. Elizabeth Kyasimiimire	Commissioner Gender and Women Affairs	
26.	Dr. Donna Kabatesi	Director of Programmes	CDC
27.	Mr. Fred Taganalye	District Health Educator/HIV Focal Person	Mayugwe District
28.	Mr. Allan Mugisha	Advocacy and Partnership Manager	IRCU
29.	Dr. Zepher Karyabakabo	Director Policy, Research and Planning	UAC
30.	Mr. Moritz Magaall	Head OVC NIU	MGLSD
31.	Mr. Bagyenda Livingstone/Dr. Byaruhanga		Ministry of Internal Affairs
32.	Ms. Lisa Godwin	HIV Team Leader/Chair ADP	USAID
33.	Ms. Winnie Adoch	HIV Focal Person	Ministry of Works and Transport
34.	Dr. Geoffrey Mugisha	Chief Executive Director	MAARPS
35.	Mr. Tamale George	Private Sector Advisor on HIV/AIDS	Private Sector
36.	Mr. Opwona John	HIV /AIDS Focal Person	Gulu District
37.	Mr. Titus Twesigye	Executive Director	AMICAALL
38.	Dr. John Mugisa	Advisor	AMICAALL
39.	Mr. Jackson Saturday	Population Officer/HIV /AIDS Focal Person	Kanungu District
40.	Mr. Naluyati Nabiwande	Principal Labour Officer	MGLSD
41.	Ms. Joy Naiga	HIV Specialist	UNODC
42.	Professor Vinand Nantulya	Board Chair	UAC
43.	Mr. Jotham Mubangizi	Strategic Information Advisor	UNAIDS
44.	UN TWGs		

45.	Umbrella CSOs		
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Annex 3 Indicator-based Performance Assessment Matrix

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
Joint Programme Outcome 1.1: National Systems have increased capacity and deliver equitable and quality HIV prevention integrated services		
JP Output 1.1.1 Technical capacity for combination prevention programming service delivery strengthened (with priority focus on SMC, HCT & PMTCT and comprehensive condom programming)		
<p>Number of national guidance documents on HIV prevention programming and service delivery developed and implemented.</p> <p>Achievements More than 16 national guidance documents were developed, disseminated</p>	16 (2014)	<p>a. The National guidance documents supported for development were: 10 sector HIV strategic plans, SRH/HIV integration strategy, domestication of guidelines on addressing HIV in selected MARPS settings, National Comprehensive Condom Programming (CCP) strategy, RH/HIV Integration Strategy, Health Sector Plan on SRH/HIV and Sex Work, the Draft School Health Policy that integrates HIV/SRH, draft Sexuality Education Curriculum evaluation framework, systematic review of service delivery standards and tools for SRH/HIV linkages and integration including a review of IMAI/IMPAC , an abridged version of draft EMTCT Implementation Guideline, costed EMTCT Plan, SMC Policy and Communication Strategy, SMC SoPs, SMC Surgical Manuals, draft SMC Strategic Plan, SGBV integrated into the revised VHT Communication Tool, Draft Male Involvement Guidelines in SRH/HIV, Clinical mentoring guidelines to conduct support supervision and mentoring of service providers, National Capacity Building Plan HIV/AIDS 2010/1-2014/15, bottleneck analysis in service delivery SRH/HIV prevention sector (2011-2012)</p> <p>b. (1) 183m male condoms were procured, 129m and 5.4m female condoms all from UNFPA; (2) The male and female condom campaigns are on-going with materials cleared by the UAC Clearance Committee; (3) Discussions on post-shipment policy are on-going at different level including at ADPG/MoH/UAC meeting; (4) Branding for public sector condoms almost finalized (5) The National Condom Strategy approved by the relevant MoH technical working group (2013)</p> <p>c. (1) Rapid assessment done in 5 districts and district plans drafted (2) Work on indicators initiated with WHO leadership to be finalized through the Task Team (2013)</p> <p>d. 1) Draft MARPs mapping analysis report is in place, mapping for programme coverage is ongoing, development of MARPs Programming Framework and programme delivery tools on-going; (2) The ational MARPs Steering Committee approved by the NPC at UAC; (3) Learning site on comprehensive service delivery to MARPs established at STD Clinic MARPI; (4) MARPs studies done by AMICAAL for KCCA and MARPs Network; (5) Service delivery to MARPs in 10 (IOM/UNFPA) districts on-going (6) Action plan on SRH/HIV sex work settings printed and dissemination sessions held (2013)</p> <p>e. (1) The School Health Policy final draft was discussed and validated by the stakeholders. (2) The National Youth Policy approved by Ministry of Gender (2013)</p> <p>f. (1) Work was initiated on Adolescent Literacy toolkit for the out-of-school youths. Ministers of Education in East & Southern Africa signed the declaration on CSE in schools</p> <p>g. (1) Teachers and TAAG groups from 33 districts trained by MoES; (2) Aide memoire from national education stakeholders meeting in place; (3) Advocacy meetings with young positives, cultural, religious and political leaders held</p> <p>h. Materials were printed but funds were inadequate to support BCC activities; (1) Worked with key sectors to roll-out the toolkit; Trained 350 sex workers in Raka,</p>

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
		<p>Gulu and Lyantonde as Peer educators; (2) Supported Public- Private Partnerships in increasing linkage to HIV care services in Gulu, Kiryandongo, Rakai and Lyantonde; (3) 1600 MARPs linked to care and treatment</p> <p>i. (1) Policy and Minimum standards guidelines printed and disseminated; (2). Strategic plan printed but not disseminated. (3). Communication strategy developed; (4) Tools distributed to 40 HFs where surgical teams were trained; (5) Initiated process of development of SMC training curriculum based on the WHO/JIPHIEGO generic tool. (6) Finalised SMC M&E/data capture tools</p> <p>j. (1) HMIS indicator review done and relevant EMTCT indicators captured; (2) ACP revised the tools in line with the EMTCT option B+; tools now ready for printing</p> <p>k. (1) Finalized National Male involvement guidelines in place endorsed by MCHTWG. (2) Roll-out planned in SIDA/UNICEF supported districts</p> <p>l. (1) Training of 100 health workers in STAR EC districts done in collaboration with a USG implementing partner. 2) 66 TOT trained on the revised HIV/AIDS training curriculum</p> <p>m. (1) 300 SP trained on FC2 in selected districts -all HFs in the 17 target districts have at least one SP trained; (2) 50 SPs from HIV clinics in selected districts trained in comprehensive FP service delivery</p> <p>n. (1) Baseline survey done, findings verified through district meetings, dissemination concluded in all 6 districts and at national level; (2) District action plans (including M&E frameworks) with district partners developed, validated and adopted. Documents printed</p> <p>o. (1) Baseline survey done in Hoima district; (2) TA seconded to Hoima district to support implementation of programme. Following the completion of the baseline survey, the agreement was to prioritize safe male circumcision and HIV counseling and testing. SMC kits/supplies and HIV testing kits were procured</p> <p>p. 300 sets of re-useable SMC kits were procured and distributed in 30 health facilities where health workers have been trained on delivery of SMC services; tools for active surveillance of Adverse Events following SMC by the use of Prepex were generated; a report on AEs has been compiled. Introduction of Prepex method has been supported.</p> <p>q. Since Jan 108.8m male condoms (29m by UNFPA) have been received in the country. 117m expected by end of the year (87m from UNFPA). 1.5m FC2 expected from UNFPA</p> <p>r. Process for generating pronouncement of HIV/maternal health/GBV on-going in 9 cultural institutions that will inform expanded community action hinged on common messages. Expanded action for religious institutions on-going through trained leadership. A national teenage pregnancy campaign launched.</p> <p>s. Critical mass of 12 cultural institutions and religious (6 denominations) leaders were trained at national and community levels to support community engagement for social and behaviour change. Support provided to conduct community dialogues. Need for commonly agreed M&E tools for SBCC</p>
Number of districts supported to pilot delivery of the nationally agreed combination	6 (2014)	<p>a. JUPSA identified 9 focus districts of Arua, Gulu, Busia, Mayuge, Rakai, Kasese, Kayunga, Kabale and Hoima to support systematic implementation of the NPS. A process for conducting a programmatic baseline study, whose protocol was approved, was initiated at the end of 2012 to be concluded by March 2013 and this was to provide the basis for setting benchmarks against which changes would be measured. Support to the response in the districts of Rakai, Kabale, Mayuge, Arua, Kasese and Gulu was initiated in 2012 e.g. to enable the DHTs and HSDs to conduct EMTCT support supervision and orientation of health</p>

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
prevention package		<p>workers to offer Option B+; with 180 health workers trained in PMTCT logistics management in the six districts. Outreaches for delivery of SMC, HCT and other SRH services have been conducted in these 6 districts. 400 HWs in public and PNFP units were also trained as ToTs for female condom service delivery.</p> <ul style="list-style-type: none"> b. A draft M&E framework has been generated by ACP/MoH c. Technical and financial support provided for the KCCA launch on Feb 2014 and West Nile launch in Arua on 13 June d. Capacity of HWs in 38 out of 52 health facilities was built for Paediatric HIV/AIDS care and treatment in Karamoja region e. National SMC strategic plan in place with clear targets; modeling of annualised SMC targets for adults and adolescents done; f. Pre-pex methodology endorsed by the NTF; support for rollout plan in progress. g. Concept note on SMC documentation done; mentorship on data collecting tools completed h. Mentoring of health workers conducted in 6 districts i. Final MARPS mapping report in place. First draft of Framework discussed by stakeholders and proposals for desired tools made. j. Campaign activities initiated in January, campaign launched by the Speaker of Parliament in July 2014 in Butaleja. First consultation with 9 cultural institutions on early marriages conducted and pronouncements in draft form k. Selected teachers oriented on new curriculum, processes for procurement of textbooks initiated. l. Trained 150 teachers living with HIV and AIDS under the umbrella of the Teachers Anti AIDS Group (TAAG) in 3 regions (North, East and Western Uganda). DEOs and district HIV focal persons were part of the capacity building workshop. Education Sector Work place policies were disseminated and there were agreed 10 point action points to reduce stigma in schools through TAAG. m. Draft school health policy pending approval by Cabinet. Policy implementation however already initiated e.g. existence of draft guidelines on violence in schools
JP Output 1.1.2: Leadership and coordination for HIV prevention strengthened at national and district levels		
Number of sector and district development plans integrating prevention priorities	50% increase in baseline values by 2014	<ul style="list-style-type: none"> a. All the nine sector HIV prevention plans (Agriculture, Education, Prisons, Police, Local Government, Public Service, works and transport, Gender and Defense) were developed and agreed on their HIV prevention priorities to support integration into respective sector development plans. Two-year HIV action plans have been developed for 17 cultural institutions and 5 major faiths of RCC, COU, UMSC, SDA and Orthodox. A study on social cultural norms, values and practices that impact on HIV prevention, maternal health and GBV conducted in the same institutions. Hinging on developed national normative guidance documents, various advocacy initiatives have been launched and are being conducted at national and district level targeting among other aspects integration of HIV into development, planning and mobilization of local resources.

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
Number of HIV prevention coordination and management structures at national, sector and pilot district levels functional	50% increase in baseline values by 2014	<p>a. Most key national coordination structures have been supported and are functional: National Prevention Committee (NPC) that among other tasks spearheaded the development of the NPS and supported 2011 and 2012 annual review of the prevention response; the National PMTCT Advisory committee and Steering committee led processes for adoption of Option B+ policy and mobilization of funds for scaling up the EMTCT programme; the SMC Task force has overseen finalization of the SMC policy and communication strategy, development of SOPs and training of TOTs; the revived National Condom Coordination Committee that supported the 1st quantification exercise for condom needs 2012-2015; the National CT17 guided review of HCT policy and implementation guidelines; the HIV and AIDS Technical Working Group at MoE&S is supporting the department heads to mainstream HIV and AIDS programme in their work plans. A national technical working group on MARPs has been established and existing CSO coordination structures e.g. UNASO, IRCU are being utilized to harmonize action in those sectors. District level structures are however not yet fully conceptualized and established.</p> <p>b. NPC met quarterly as planned and even held extra-ordinary meetings. Issues addressed include: MARPs mapping, MoT, Fishing communities, NSP MTR, etc. NPC will reconstitute into an NSP/NSP MTR TWG on prevention</p> <p>c. Quarterly meetings of NPC held and action plan finalized. (2) Advocacy strategy endorsed, MARPs Steering Committee established, JAR 2013 prevention report generated</p> <p>d. Messages Clearing Committee (MCC) established at UAC (2) Condom Committee met twice (3) MARPs Steering Committee established and held several meeting</p> <p>e. EMTCT and ART national advisory committees have merged, several meetings held (2) National EMTCT campaign running and option B+ rolled to all the 112 districts</p> <p>f. Technical support provided in the SMC NTF, CT 17 meetings and its sub-committees (2) KCCA HCT Campaign on-going (3) His Excellency's Public testing. (4) Infection Control Committee not revitalized</p> <p>g. National Advocacy Leadership Strategy endorsed by NPC, awaiting UAC endorsement for printing (2) UAC prevention message done and disseminated to districts (3) The First Lady & the Nabagereka engaged in EMTCT campaign (4) National leadership on board on the national response</p> <p>h. So far there has been launches in South Western Northern, Eastern and the Karamoja regions</p> <p>i. The 2013 World AIDS Day (WAD) was held in Mbarara, and UNIADS provided technical and financial support for popularization of the day in media, and also engagement and uptake of HIV services through pre- WAD activities that included sports activities. Also support WAD in Lyantonde. Other pre- WAD activities included Candle Light Day and Philly Lutaya Day</p> <p>j. Functional programmes in 9 institutions; (2) Studies on-going in 4 institutions; (3) Existence of a functional Task Force on Culture and HIV. (Assessment report on progress of implementation of 2010 declaration in place; (5) Annual Forum held and actions for 2014 agreed on</p> <p>k. (1) Running programmes on SRH and for community mobilization through religious leadership in the 5 major denominations and association of Pentecostals</p> <p>l. As at Week 46, 26th November a) 1493/1692 (88%) facilities had provided reports on Option B+. b) 99% (22794) of ANC1 attendees tested for HIV; c) 80% of women initiated on Option B+(N=656). On coverage achievements, total</p>

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
		216,252 pregnant women (PW) attended ANC, 204,388 PW were tested (94.5%), 6983 tested positive (3.4%), 7805 cumulatively initiated on ART (100%) (1) EMTCT Campaign launched in KCCA (2) Uganda Global AIDS Report indicates significant progress against global EMTCT targets elevating Uganda to countries likely to achieve targets by 2015
JP Output 1.1.3: Strategic information generated and utilized for evidence-based HIV prevention programming		
Existence of national annual and 3-year prevention review reports (based NPS implementation)	1 annual report and 3-year report available by 2014	<ul style="list-style-type: none"> a. 2011 and 2012 Annual Joint AIDS review reports were developed, with each having a respective thematic report on prevention. Key HIV indicators have been incorporated in the national HIV M&E framework building on the M&E framework proposed in the NPS. JUPSA is on course to achieve this b. Finalized and disseminated findings of a rapid assessment on status of SMC services in the 6 focus districts c. Finalized, print and disseminate study report - KAP study for fishing communities in pilot districts d. Finalize a study on adolescent utilization of SRH/HIV integrated services and disseminate findings e. Finalize an operations study on condom use among male circumcised UPDF officers f. Study of cultural norms, values and practices that impact on HIV and AIDS in the cultural institutions of Alur and Banabasaba. The draft report for Banabasaba has been submitted, while report writing for Alur was on going. Final reports will be submitted by 30th April 2014. Final reports for Busoga, Bunyoro, and Rwenzururu in place. g. Based on the recommendations of the 2012 Mapping and population size estimation study conducted among the key populations around Kampala district <ul style="list-style-type: none"> • 150 sex workers, fisher folks, and 'bodaboda' cyclists received HCT services and information about ART, eMTCT and SMC. • Over 200 female sex workers were trained as peer educators and equipped to ensure fulltime access to HIV services and condoms in the HIV hotspots of Gulu, Rakai, Kiryandongo and Lyantonde.
Number of HIV Prevention Research Conducted and disseminated	50% increase in baseline values by 2014	<ul style="list-style-type: none"> a. Major gaps in evidence have been identified and studies conducted in the areas of MARPs, condom programming, adolescent health, socio-cultural drivers of the epidemic, establishing programmatic baselines, assessments of systems capacity to implement SRH/HIV integration at district levels, demographic surveys, AIDS indicator survey, Several others are on-going or planned including national MARPs mapping, PMTCT programme impact evaluation, 2nd Modes of transmission study and operational research on condom use among the circumcised males. A review of establishing evidence gaps for HIV prevention will be conducted to inform further action. JUPSA on course to achieve this target
Joint Programme Outcome: 1.2 Communities mobilised to demand for and utilise HIV prevention integrated services		
JP Output 1.2.1: capacity of community systems for social and behavior change strengthened.		

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
Number of districts with registered community driven mechanisms addressing prevention for MARPs priority prevention interventions	6 (2014)	<p>b. The UN made a strategic decision to expand beyond upstream focus and contribute to efforts to bridge gaps between the comprehensive national policy and programming efforts and the limited service uptake at community level. Programmes supported in a few focus districts are being documented to inform scaled-up actions. Key actions include development of skills for leadership and community member e.g. through peer education and supporting these resource persons to engage communities to identify own SRH/HIV related problems and design solutions and provide support for outreach services for those communities that cannot access them from static facilities. In addition to this, a BCC toolkit for MARPS in the transport sector was developed. Dialoguing approaches have also been utilized by different community resource persons including religious and cultural leaders, members of key population groups such as sex workers, young people, uniformed forces and mobile populations in 18 target districts, 9 cultural institutions and 5 religious faiths.</p> <ul style="list-style-type: none"> • Adolescents and young people in 13 selected districts. (2) About 1000 trained peer educators supported to conduct community dialogue sessions, distribute condoms and link peers to services at static sites and outreaches • 350 SWs trained in Gulu, Rakai and Lyantonde. Hold monthly review meetings. • VHTs and FSGs training in the Karamoja region and are supporting implementation of maternal health including option B+ • (1) A total of 90 TOTs trained in institutions of Tieng, Adhola, Toro, Bugisu, Alur and cascade training done for 120 cultural leaders from 9 institutions. • Various channels being utilized to reach the different population groups - peer educators, religious & cultural leaders, service providers thru outreaches, etc. About 3,500,000 reached • Development and utilization of communication materials (in local languages) for 3 religious institutions done for the Roman Catholic Church translating the leadership manual into Runyankole, Rukiga, Luganda, Langi, Iteso, Lugbara and Ngakarimajong. Unlikely to support other denominations to develop messages due to resource constraints • Draft policy briefs from 9 cultural institutions in place following the initial consultative meeting in each of institutions involving high-level leadership. Community dialogues on-going • Training of religious leaders done in 6 religious denominations, processes for developing SBCC materials initiated
JP Output 1.2.2: Capacity of districts for delivery of SRH/HIV integrated services expanded		
		<p>a. (1) About 500,000 people reached with services in Mubende, Katakwi, Moroto, Kotido, Kabing, Oyam, Yumbe, Kanungu for the general population and in Kampala, About 5000 SW and about 800MSM reached in Kalangala, Gulu, Arua, Pader for MAPRs through SW</p> <p>b. (1) Service delivery in selected districts including 35 youth corners in health facilities and schools; (2) About 300,000 young people reached with services</p> <p>c. (1) 126m male condoms & 5m female condoms procured and delivered to Uganda (2) Alternative arrangements for distribution at national and community level applied to get condoms nearer to users. Condom campaign estimated to have reached 2.7m Ugandans.</p> <p>d. All the 112 districts are now implementing EMTCT Option B+ with support from UNICEF and PEPFAR</p> <p>e. AMICALL contracted to support advocacy activities for women involvement through the urban and local leaders</p>

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
		<p>f. Service delivery conducted over the past 6 months. Over 70,000 new users on FP already also accessing HIV services</p> <p>g. Condom distribution done as part of service delivery at facility and outreach services. Condom distribution also happening through peer education systems for specific groups. 29m male condoms procured by UNFPA awaited before end Dec 2014. 1.5m FC2 expected from UNFPA</p> <p>h. Support to further roll out Option B+ in 27 districts including mentorship, supply logistics for care and treatment commodities; support for provision of quality M&E systems and support for VHTs and other community structures</p>
Joint Programme Outcome 2.1: Access to antiretroviral therapy for PLWA who are eligible increased to 80%		
JP Output 2.1.1 Guidance provided and capacity built for provision of standard ART care according to the WHO recommendations		
Number of the National Integrated ART guidelines updated and distributed	5000 (2014)	<p>a. National Integrated ART guidelines for adults, adolescents, children including young child feeding updated, with 10,000 printed and disseminated to guide patient management at all levels of care.</p> <p>b. Procured training materials for option B+ for the whole of Karamoja region</p> <p>c. PEP policy and implementation guidelines were reviewed and updated in 2012</p> <p>d. NCD screening guidelines were finalized, key information booklets on cancer, cardio-vascular and diabetes produced and widely disseminated</p> <ul style="list-style-type: none"> NCDs integrated in the comprehensive HIV/AIDS training curriculum. MPs and CSOs sensitized on NCDs, to advocate for NCD management in at least 50% of ART facilities
Number of copies of updated training materials/job aids distributed	20000 (2014)	Training materials/job aids updated and distributed. i.e SoPs updated, IMCI computer assisted training package adopted and finalized; IMAI/IMPAC tools revised into a comprehensive HIV curriculum
Number of districts with ART Quality Improvements (QI) Teams	80% (2014)	<p>a. Procured cabinets for record keeping 15; Procure PIMA 2 CD4 machines; Procured PIMA CD4 cartridges – 1000</p> <p>b. Facilities in Gulu, Rakai and Lyantonde hotspots identified. Oriented on migrant friendly care activities to stock medicines and initiate HIV care are ongoing. Referrals for HIV treatment at government health facilities ongoing.</p>
Percentage of ART sites providing both adult and pediatric treatment	80% (2014)	<p>a. 20 districts supported to initiate new EMTCT and EID sites. This has contributed to improvement in the national programme. The number of facilities providing EID increased from 550 in 2010 to 1447 facilities nationally by 2012. Since EMTCT sites are 1,800, this means 80% of EMTCT sites offer EID services. As for ART, 400 (84%) of the 475 adult sites provide Paediatric HIV treatment.</p> <p>b. Support for accreditation assessment of 27 HCIs in Karamoja for EMTCT services; improved EID services through integrated outreaches (11 outreaches by Baylor, and xxx by CUAMM); 120 HCWs and 223 VHTs trained on Paed HIV care and treatment</p> <p>c. Financial support for courier of DBS samples</p>
Number of regions with trained TOTs to operationalize new ART	8 (2014)	<p>a. Some regional trainings on catalytic (ToT) capacity building initiatives to operationalize the new ART guidelines were done.</p> <p>b. Through the national resources from PEPFAR and UNICEF. Now 1,521 facilities conducting EID in the country</p> <p>c. Direct support was provided to the Karamoja Region with all the 5 hospitals and the 4 HCIs functional as hubs. This is done in partnership between SUSTAIN &</p>

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
guidelines		CUAMM d. 66 TOTs trained to support scale up of comprehensive HIV/AIDS training
Percentage of ART facilities submitting timely quarterly reports	80% (2014)	a. There is improved quarterly reporting by ART facilities; the Open MRS system has been scaled up to 20 health facilities; a review of training materials for Open MRS is underway. b. TA Customizing and upgrading of the Open EMRS system to the revised ART/HIV reporting tools, 4 facilities supported
Percentage of ART facilities in which at least 80% of the clients keeping their medical appointments	80% (2014)	a. Disseminated the WHO tool for monitoring emerging HIV drug resistance and codes updated b. Early Warning Indicator (EWI) draft report c. 6 facilities oriented on open eMRS;
Number of districts with VHTs trained in Home-based care for HIV	20 (2014)	a. Baylor supported to initiate the integrated training and mentoring of staff to provide Paediatric AIDS services in 20 districts. 390 health workers were trained. In addition 297 VHTs were trained in community home based care. In addition 42 VHTs in Rwamwanja were trained and provided commodities (supplies, medicines, commodities) to 3 clinics in Kiryandango, Kaluma, Bweyale, Rwamwanja and Kigumba. Increased testing of HIV, referrals
JP Output 2.1.2: Enhanced programming for Pre-and Post-Exposure Prophylaxis		
Percentage of ART facilities providing Post-Exposure Prophylaxis for HIV	50% (2014)	b. PEP policy and implementation guidelines have been reviewed and updated, to inform full scale-up of interventions in the subsequent year.
Number of copies of Post - Exposure Prophylaxis implementation manual disseminated	5000 (2014)	a. Implementation plan has been integrated within the PEP policy guidelines b. 1000 copies of the PEP policy guidelines printed and disseminated in 3 regions of (), 3 regional meetings supported through MOH CDC support
JP Output 2.1.3: Capacity for screening and management of non communicable diseases associated with HIV strengthened in all ART centres		
Percentage of ART facilities screening and managing common NCDs according to national guidelines	50% ART facilities screening and managing common NCDs as per national guidelines (2014)	a. NCD screening guidelines were finalized; Parliamentarians and CSO groups sensitized; key information booklets on 3 conditions produced and NCDs have been integrated in the comprehensive HIV curriculum b. Draft NCD guidelines in place awaiting approval from MOH c. The revised HIV/AIDS curriculum incorporated HIV/ART related NCDs d. A national study risk factor assessment study on NCDs e. Two non communicable health clubs were established in Mukono and Kampala International University comprising of 150 members, 35 journalists sensitized so as to report positively on tobacco control in Uganda, A database for one way SMS for the university students in UCU and KIU has been established and over 10 SMS have been sent on the implications of smoking, alcohol consumption and bad diet.
JP Output 2.1.4: Procurement and supply chain management streamlined		

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
An updated PSM Plan for HIV commodities in place	PSM Plan for HIV commodities updated (one)	<ul style="list-style-type: none"> a. Periodical review of stock status of HIV related commodities and supplies have been done as part of improving the procurement and supply chain management; technical support provided during the rationalisation of HIV commodities b. There has been continued dialogue to address the overall supply chain issues in the country. There has also been joint mission to NMS
Joint Programme Outcome: 2.2 TB deaths among people living with HIV reduced		
JP Output 2.2.1: Accelerated and streamlined implementation of HIV/TB collaborative interventions		
Availability of updated TB/HIV management guidelines	Availability of an updated TB/HIV management guidelines	<ul style="list-style-type: none"> • TB/HIV policy guidelines were updated and disseminated with training materials integrated in comprehensive HIV curriculum. Also TB infection control guidance has been integrated in the comprehensive HIV curriculum. • 1000 copies of TB/HIV policy guidelines printed • National dissemination meeting organised, 1 quarterly meetings supported and implementation of TB/HIV interventions in the prisons on-going • Finalized assessment to establish trends in TB related deaths in HIV patients, including among refugees
Percentage of facilities fully implementing TB/HIV collaborative activities	(50%)Health facilities fully implementing TB/HIV collaborative activities	<ul style="list-style-type: none"> • Mentoring tools have been developed and intensified case finding forms developed; Training has been done in some facilities on TB-HIV integrated services; 4 zonal meetings have been facilitated as part of strengthening full integration of TB/HIV collaboration; Supported strengthening and full integration of TB/HIV collaborative activities at district and health facility levels through quarterly coordination meetings. Assessment to establish TB related deaths in HIV patients done as part of the ART temporal trends analysis of treatment outcome 2005 – 2010.
Joint Programme Outcome: 2.3 People living with HIV and households affected by HIV are addressed in all National Social protection strategies and have access to essential care and support		
JP Output 2.3.1: National social protection policy, strategy and programs integrate issues of People Living with HIV and their households		
No of LGs implementing social protection plans that integrate HIV response	50% increase in # of DLGs by 2014	<ul style="list-style-type: none"> • Supported a study on the analysis of HIV-sensitive social protection responses in Uganda that gave insight on how the various social protection strategies mitigate the socio-economic impact of HIV&AIDS in Uganda. The study will also be strategic in promoting inclusion of HIV in the development of a national social protection policy framework. In addition the National Action Plan on HIV-induced Child Labour dissemination tools were developed with the NAP on Child Labour disseminated and planning workshops in 4 regions of Uganda (60 districts) were supported. • Completed study analysis of HIV sensitive social protection responses and planning to develop guidelines for dissemination
JP Output: 2.3.2 Communities vulnerable to HIV have increased resilience and empowered to be food and nutrition secure		
Percentage of households with food sufficiency	50% increase above baseline in 4	<ul style="list-style-type: none"> • 6 comprehensive district livelihood profiles with clear recommendations for response were conducted; Consultative meetings with the District technical persons done including provision of skills and knowledge on vegetable production and nutrition to farmers groups and PHLAs with 10 groups mobilised and vegetable production demonstrations established. 30 NGO and

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
	districts by 2014?	<p>Government personnel in Kabaremaido district (production, health department staff including HIV and AIDS focal persons) have been trained and have set up gardens that are producing food as part of addressing nutrition among PLHIV. Furthermore, Mayuge district technical teams have been trained in the formulation of food and nutrition audiences- to re-in force the interrelationship between HIV/AIDS and Nutrition.</p> <ul style="list-style-type: none"> • Six fishing communities and 5 farmers trained on pond and cage fish farming for increased livelihood options, diversification from capture fisheries to fish farming and promote productivity for food/nutrition and improved incomes. Small scale irrigation • Aspects of food and nutrition policies/ordinances sensitisation covered under activity 3.2.2.3 • 3 districts to be covered - Rakai, Kasese, Kabale. 50 persons (technical, political and administrative) from district LGs and CSOs trained.
2.3.3 Strengthened capacity of government to implement OVC policy and Plans for vulnerable children operationalised		
Percentage of OVCs accessing social protection services	50% of OVCs accessing social protection services	<ul style="list-style-type: none"> • Formation and training of members of 40 child protection committees in 40 out of 78 parishes in Kabarole District with over 400 Child Protection Committee members who were trained. 113 parish child protection committees established and trained in Kabarole and Kyenjojo districts • MGLSD has developed a draft Program Plan of Intervention for Social Protection with a section that outlines specific interventions for strengthening social care and support for most vulnerable people including OVC. This will be submitted to Cabinet for approval together with the Social Protection Policy draft. • Number of OVC receiving Social care support under CPA2 Jan - Sept 2014: 16,908 (Males 7,803 and Females 9,105). Source - OVC-MIS - UNICEF: Besides the numbers, the following achievements have been realised: (a). 283,246 (Females 130,014 and Males 153,232) OVC identified using the 3 factor criteria have been linked to services. (b). DOVCCs and SOVCCs have been formed in all the 32 supported districts. (b). Regular coordination meetings have been conducted. (c). PSWO in all the 32 focus districts have been trained on OVC-MIS. (d). There has been regular (Quarterly) reporting on OVC work in the OVC-MIS. (e). Procured and delivered 32 Laptops with internet modems loaded with data bundles worth 4GB for 4 months to all 32 supported/focus districts. • Number OVC receiving sustainable livelihoods under CPA1 Jan - Sept 2014: 5,438 (Males 2,787 & Females 2,651) Source - OVC-MIS- UNICEF; • UNESCO in consultations with the department of Teacher Training at Ministry of Education have developed a module course on integration of ICT in teacher training institutions. This will increase the scope and range of courses and improve on teachers' skills that will be beneficial to the OVC/learners' livelihood. Evaluation of Life skills education in upper primary schools is ongoing. This will inform design and programming for Life skills education in upper primary schools

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
Percentage of districts where The National Action Plan (NAP) has been disseminated	50% (2014)	<ul style="list-style-type: none"> 32 new districts developed their OVC Action plans and integrated into their DDP. Districts such as Namutumba, Maracha, Kasese, Nebbi, Yumbe and Gulu, have allocated some funds for OVC; The National Association of Social Workers was supported to train 50 social workers in child protection (using the national curriculum approved by the MGLSD and the National Council for Higher education). UNICEF and MGLSD leveraged resources from SUNRISE OVC Project with which 1,300 other government social workers were trained in child protection. The NASWU trained its members on the professional code of conduct, and hold meetings of its members in Kabale, Arua and Kampala attracting 96 members who formed chapters in those regions. A half-day conference on Medical Social Work was held bringing together 57 medical Social Workers from all over the country. An annual General meeting was also held and all these have contributed to revitalization of the association increasing its contribution to strengthening of the OVC workforce. 23 out of 32 districts have been financially supported to map out and coordinate OVC service providers; dialogue with communities to prevent property grabbing from children and mothers who have lost bread winners; report OVC issues or data to OVC MIS; facilitate access to health education and protection services for OVC; As a result, each district has harmonized OVC coordination and meets quarterly; 15 out 32 districts have reported through the OVC MIS contributing significantly to a total of 21817 (11,476 boys; 10341 girls) OVC reported as served in the OVC MIS. Districts have also trained Child Protection Committee about 9 per sub-county in psychosocial counseling;
Child Labour indicators adopted for inclusion in the NSP for OVC	4 (2014)	<ul style="list-style-type: none"> The OVC M&E Framework and Plan with the data collection tools have been finalized, printed and with about 6000 copies disseminated in 112 districts. The OVC Management Information System has been revised to capture information on new indicators and to create new reports for managers. A vibrant M&E Technical Working Group is operational; utilized the sing Uganda 2002 census data to developed an evidence based criteria for identification and targeting of orphans and other vulnerable children at community level using a three- factor evidence based criteria namely; (orphan, child out of school, child engaged in child labor) that helped to identify 86% of OVC and an addition of a fourth factor (child with disability) one reaches 91% of OVC/OVC households, this was used to identify and register OVC in 32 new districts of Uganda. It is cheaper, faster and easy to use by communities. This study and approach was presented at the AIDS 2012 Conference in Washington D.C. in July 2012.
Joint Programme Outcome 3.1: National capacity to lead, plan, coordinate implement monitor and evaluate the national HIV response strengthened by 2014.		
JP Output 3.1.1: Capacity of national institutions to lead and coordinate the national HIV response strengthened		
Number of issues papers on pertinent issues developed and presented to relevant fora	20 by 2014	<ul style="list-style-type: none"> a. Supported CSOs to harmonize and articulate their position on the Anti-Homosexuality Bill, HIV Prevention and Control Bill and Anti-Counterfeiting Bill; 2) Conducted a meeting between the UNCT and LGBTI activists; 3) Supported 2 delegates to attend the High Level Mission on HIV in June 2011; and 6 delegates to attend the pre-HLM in Namibia; 4) Supported 11 delegates to attend the Africa Regional Dialogue of the Commission on HIV and the Law; supported 1 youth to attend the Bamako Youth Conference; Political leaders engage with High Level mission on HIV- Consensus reached among political leaders. Other advocacy papers have been made with Parliamentarians, Cultural and religious leaders, the First Lady, the Presidency and Queens, for their increased advocacy for HIV prevention. An advocacy paper for meaningful involvement in national decision making processes in the national response finalized and funding for

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
		<p>youth meeting to disseminate and develop action plan in progress</p> <p>b. Operational mechanisms for the functioning of the Zonal Coordination structures finalized. Phase1: Engagement with District leadership and consensus reached on establishment of 4ZC Offices- Wakiso/central; Mbarara/Western; Mbale/Eastern; Gulu/Northern. 15 districts per region- total 60; excluding the 57 covered by CDC & IA. Phase 2: District coordination guidelines finalized and disseminated & two Zonal coordinators posted to Gulu and Mbarara.</p> <p>c. HIV/AIDS Partnership Mechanism Review finalized, disseminated and results used to restructure the SCEs for the effective coordination of the AIDS response. Young People Self-Coordination Entity (YP-SCE) developed Action plan 2013/14 and undertook training in leadership, coordination and strategic planning with technical and financial support from UNAIDS</p> <p>d. Orientation & Induction of UAC staff members on the mandate, programme areas of UAC and Change management. Eleven core UAC Staff were trained and equipped with skills to effectively coordinate the national AIDS response in the following areas: Partnership, Collaboration and Networking; Advocacy, Negotiation and Communication; Resource mobilization, Gender Mainstreaming and managing meetings and Minutes writing.</p> <p>e. Over 200 urban leaders have been trained to integrate gender and HIV activities at the municipality level, A study on key populations in Kampala district has been launched and disseminated as a result of the study a two year action plan for KCCA has been developed to focus on MARPS interventions.</p> <p>f. 812 (429 males and 383 female) have been reached with HCT services and messages in the urban councilors of Kitgum, Ntugunamo, Masindi and Kampala districts, KCCA HIV committee revamped</p> <p>g. Supported two persons from People In Need Agency (PINA) to participate in the IAC, UNAIDS also advocated with UNICEF for another member & the Director of PINA that were supported by UNICEF to participate in the IAC in Melbourne</p>
Proportion of institutional review recommendations implemented	90% of Recommendations implemented by 2014.	Technical and financial support were provided for the implementation of restructuring of the institutional capacity of UAC with the creation of new directorates and filling major positions and normative guidance for the review process of the partnership structures; UAC reached a consensus on modalities for establishing Zonal Coordination offices. Funding is currently being transferred to AUC for strengthening AUC Partnership arrangement to re-engage strategic partners for effective coordination of the response at national and decentralized levels, including the zonal coordination structures.
Proportion of Health sector HIV response recommendations implemented	75% by 2014	Technical assistance provided to UAC to finalize the new NSP and develop a National Priority Action plan for 2012/2013. UAC supported to undertake JAR and Partnership Forum meetings to review performance of the implementation of the first year of the NSP 2011/12 – 2014/15 and agree on key strategic actions for the second year NPAP
Number of GFATM proposals developed and submitted in time.	2 Annually by 2014	High-level advocacy undertaken resolved the GF bottlenecks including review of and revitalization restructuring of the CCM. Uganda is now receiving funds from GF again. Successfully advocated for TASO to become 2nd PR for and from the civil society; provide TA that led to eventual agreement on alternative procurement methods for GF; including supporting the establishment of the database as part of conditions precedent for TASO Working in an environment in elements of abuse.
Number of agencies with evidence on	1 study conducted by 2014	A National Accountability scorecard established, Study on "Governance and Accountability mechanisms in Uganda" undertaken. The AAI shall be developed in 2013 based on the ensuing results. Additionally, CSOs' capacity shall be enhanced to

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
accountability and governance mechanisms for improved service delivery		play a watchdog role i.e. rights holders holding duty bearers accountable on the basis of the AAI;
HIV Partnership Tool developed and disseminated	1 by 2014	Not achieved
JP Output 3.1.2: Improved national and local government capacity to mainstream HIV/AIDS and gender issues in planning and policy processes		
Proportion of UN JPs that mainstream HIV	100% (2014)	<ul style="list-style-type: none"> a. HIV has been mainstreamed in the three Joint Programmes namely; JP on HIV, Gender and Population b. Conduct a study to review status of HIV and gender mainstreaming in key sectors (and identify bottlenecks and promising practices) and build capacity for LG to mainstream HIV and AIDS issues c. Over 320 urban and 120 district officer empowered with knowledge and skills to mainstream Gender and HIV in Urban leaders development plans as a result an issue paper has been development to guide the process of NSP d. National and district based Gender Reference group meetings held in the first and second quarter e. HIV has been integrated in the UN Joint Program on gender Equality and also in the UN gender convergence group, Youth and Maternal Health
Study report on bottlenecks to mainstreaming HIV and AIDS issues	1(2014)	<ul style="list-style-type: none"> a. Supported development of guidelines to integrate HIV into the collective bargaining agreement of workers organizations. And trained HIV coordination committee for the private sector in mainstreaming HIV in the planning, budgeting, monitoring and reporting functions aimed at enhancing coordination and mainstreaming HIV/AIDS in the formal and informal private sector b. Undertaking dialogue with UAC for a possible assessment exercise to identify sectoral capacity needs as basis for developing appropriate sectoral mainstreaming strategies c. HIV issues were integrated in the UNDAF 2014-16 action plan, HIV issues have been integrated in the UN convergence group on gender equality and women empowerment
HIV Mainstreaming Action Plans developed and disseminated	8 sectors 6 districts (2014)	Capacity of selected sectors & LG strengthened to mainstream HIV and AIDS issues; HIV has been mainstreamed in all the nine sector plans of Agriculture, Education, Prisons, Police, Local Government, Public Service, Works and Transport, Gender and Defense.
Number of HIV issues included in African Peer Review Mechanism	TBD (2014)	Not achieved
JP Output 3.1.3: The UAC and sector institutional capacity to plan, Monitor and Evaluate strengthened		

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
NSP and PMMP reviewed and aligned to NDP.	NSP and PMMP aligned to the NDP (2014)	<ul style="list-style-type: none"> a. The NSP, PMMP/National M&E plan and indicator handbook have been revised and aligned to the NDP, following a midterm review and an Annual Joint AIDS review that informed the development of National Action Plan. National M&E TWG has been revived and is functional with representation of key stakeholders and 15 members trained as TOT. Addition support was extended to strengthen Data Information System (NADIC) and the Customization of the ESAM&E Training Curriculum. Supported MOH Target/indicator setting exercise as part of support to health sector M&E framework, b. Uganda AIDS Commission continued to convene a national Multisectoral M&E technical working group. The group has continued to work as a clearing house for a number of reports including the HLM Midterm review report, Global AIDS report, the JAR report c. Provided technical support for the conceptualization, convening and finalization of the JAR report including finalization of the Aide memoire d. National Stakeholders Conference for ESS HIV and AIDS partners held from 21-24 October 2013 in Kampala. Total of 150 participants attended from DEOs and CSO e. IOM provided Technical and Financial support to MOWT to conduct and strengthen HIV Workplace programmes within the Transport Sector. Currently evaluation of the MOWT evaluation is under way and preliminary findings show signs of job well done. f. Currently over 10,000 people living in High at Risk areas such as fishing communities, Border points have been reached by over 300 Sex Workers trained as peer educators. This has been realised through effective mobilization and advocacy for HIV prevention and care services. g. a) UCO continued to provide technical and financial assistance for the convening of the national M&E TWG. h. B) In addition UCO as member of the United Nations M&ETWG has contributed to the development of UN M&E Calendar, review indicators for UNDAF and UN 3 convergence areas and compilation of UNDAF progress report and development of eMIS a tool used for tracking and reporting on UNDAF and Joint Programmes under DaO i. a) UCO provided technical assistance to MOH in the updating of the spectrum with programme data and surveillance data for subsequent generation of 2013 HIV estimates. j. a) UCO provided technical backstopping for the development of the concept note, road and budget for the review of the NSP and development of 2015/16 to 2019/2020. The UCO in addition provided technical guidance in the evaluation of the firms to undertake the midterm review of NSP/NPS. b) As part of informing the development of NDPII and subsequent re-alignment of NSPIII, an HIV key issues paper has been developed to inform NDPII development k. The country is in the process of updating and revising the 2008/09 Modes of Transmission study report. Three Local consultants and Futures Institute have been engaged. The concept note and inception report have been presented and approved by the National HIV Prevention Committee. A think tank was convened and provided critical review of the inputs and assumptions for the Incidence Modelling and subsequently a draft incidence modeling report has been produced. The team is now working on the component reports.

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
Number of staff trained on the PMMP	80% of District HIV Focal Points (2014)	<p>a. Supported UAC with funding to train 144 participants from 32 newly created Districts. The focused attention was to create a pool of resources in 32 new districts by training about 4-5 people per district than the planned one staff per district; 60 staff of the Education sector were trained and these facilitated the End of Decade assessment study that was conducted and informed the development of the indicators.</p> <p>b. Though UAC supported M&E capacity building for Mbale and Jinja districts with 60 records management staff trained in data management. In addition, Kasese was supported to train 23 DAT members, strengthen the office of Focal person, orientation of 25 records officers in data management, and holding of annual district forum. Retooling of district/zonal offices with systems and human capacity for effective coordination of M&E activities at the district levels. As part of facilitating time coordination role by the National Commission, 5 internet modems were procured for key staff and these have continued to be loaded with airtime to streamline timely communication and sharing of data. As part of strengthening districts capacity to management and report the procurement process for computers and printers has been concluded now at award level, the five districts will each receive one computer each.</p>
Number of LGs with functional AIDS Task Forces.	80% of District (2014)	No current data
Number of UAC and sectoral joint programme reviews conducted	Annual JPR and 8 regular sectoral programme reviews supported per year (2014)	Two Annual AIDS reviews have been held, this informed development of subsequent NPAPs. Respective sectors have also undertaken their Joint annual reviews.
JP Output 3.1.4: Institutional capacity for resources tracking supported		
Number of institutions that have institutionalised AIDS Spending Assessment	40% of Districts and 10 Sectoral institutions do NASA (2014)	<p>a. NASA study was concluded, report presented, discussed and shared widely with stakeholders. NASA TWG and Steering Committee have held regular meetings; Initial concept on institutionalisation being reviewed; to integrate ideas on how to incorporate key indicators under routine financial tracking systems of key sectors/MoFPED</p> <p>b. Supported a Technical Writers for the preparation of HIV Interim application and TB continuation Global fund proposals in the amount of \$119M and US\$10million respectively. In Addition the Regional office undertook a peer review and the proposal was submitted on time. In addition the UN provided technical and financial support for the Team Leader, the costing consultant and Futures Institute for the modeling. The draft investment cases has been presented and discussed by the Joint Steering Committee</p> <p>c. A draft investment case report is in place</p> <p>d. Supported work of the CCM Oversight Committee</p> <p>e. Financial gap analysis and suggestion of options incorporated in the Investment case. Inception mission facilitated with support of RST that identified funding landscape gap perception, and considerations of alternatives for further critical analysis of options for sustainable financing of the Investment case</p> <p>f. a) Investment case document completed b) the document was presented to the</p>

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
		<p>steering committee who made additional comments and approved for presentation at a validation meeting. c) UAC organized a validation meeting on 17 of June 2014 where the document was presented and feedback received. The document was endorsed by stakeholders d) Feedback from the validation meeting accommodated and final product submitted to UAC on July 9, 2014.e) Sustainability analysis inception mission conducted in June 2014 and preliminary report of mission completed.</p> <p>g. a) Provided support for development of TOR for the NSP and NPS review that will inform the TB/HIV joint proposal process including in the context of the HIV invest case b) facilitated discussion and planning process for harmonization of support of JUPSA for joint HIV/TB proposal .c) facilitated the and contributed to the mission of UNAIDS regional advisers to support TRP response to GF application, investment case roadmap, sustainability analysis , costed extension of GF application and NPS)</p> <p>h. National Accountability score card was disseminated as been used for the development of HIV issue paper and it will also form a basis for the NSP review</p>
JP Output 3.1.5: National capacity to gather and disseminate strategic information strengthened		
Number of analytical studies undertaken and disseminated	10 Studies Supported Yearly by 2014	<p>a. Final AIDS Indicator Survey report for 2011 was produced and disseminated, in addition to a brief. The findings were also widely disseminated at national and international conferences and influenced the 2012 JAR and high level discussions for improved HIV programming; 2012 Global AIDS report for Uganda was developed, validated and submitted. The report informed the development of the Global AIDS reports that was launched at 2012 World AIDS Day. Further support was extended for the finalization and dissemination of the UDHS, and 2012 HIV Estimation data; The 2011 Universal Access report was developed and submitted as part of the global commitment; Study conducted on the drivers of HIV and AIDS in education and sports sector has substantial information for analysis of HIV and AIDS in education sector.</p> <p>b. A National HIV Community Scorecard in place</p> <p>c. The GARP Report and Mid-Term Review report of the HLM developed and shared</p> <p>d. Ability to integrate most indicators within the routine HMIS.</p> <p>e. Findings of the "Mapping of Education sector HIV/AIDS partners was disseminated during National Stakeholders Conference in Kampala. High level Interstate Ministerial Conference on Education for All was conducted in Kampala, Uganda.</p> <p>f. a) UCO provided technical and financial support for the generation, validation and submission of 2013 country HIV progress report. b) UCO convened the in-country UN co-sponsors for the generation of 2012-2013 UBRAF/JPMS reporting. c) The UCO responded to the Monkey survey on MTR HLM: The main purpose of the survey was: - to assess the extent to which the mid-term review (MTR) has contributed or been instrumental in helping countries to make significant changes in national HIV and AIDS policies and programmes to accelerate progress against the Ten Targets.- to identify lessons learned and implications for the design of the 2015 country-level end-review.</p>
Number of forums for information sharing organized	5 Forums supported Annually by 2014.	<p>a. The information sharing forums included the Annual Joint review fora, the Pre and post ICASA fora, the 2012 International AIDS Conference, the NASA and UAIS dissemination fora; A successful conference was held with the theme: Towards Virtual Elimination of HIV and AIDS in children. Majority of stakeholders participated, with over 500 participants drawn from the city centre</p>

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
		<p>and districts.</p> <p>b. In collaboration with PEPFAR team, selected results were analysed and a small booklet produced towards the end of last year.</p>
JP Output 3.1.6 Engagement of the civil society including PLHIV, women and youth networks and the private sector in the national HIV response strengthened and streamlined		
Number of umbrella CSO organisations including networks of PLHIV and young people led CSOs support on key capacity areas	7 CSOs' capacity supported Annually by 2014	<p>a. Funds and TA provided to UNASO to develop its Strategic and Action Plan that are aligned to the NSP& NPS; NACWOLA Operational manuals finalized and Strategic Plan and AWP developed. AMICAALL carried out national consultations and orientation of Urban Local leadership and supported them to mobilize local communities to access SMC and EMTCT including SRH and FP in 6 districts. Funding disbursed to MGLSD to organize a Youth Forum to strengthen the YP-SCE was made. Documentation for the two cultural institutions of Toro and Inzuyabamasaba by Grand Consult Group limited is on going under the supervision of Ministry of Gender, Labour and Social Development. Supported the Inter Religious Council to coordinate religious sector leadership on prevention aspects through an annual session meeting; with two sessions held. HIV Strategic Plan for Forum of Kings approved and Action plans for 17 kingdoms shared with Leadership sensitization sessions held for each denomination, review of teachings done and leadership handbooks, communication messages and materials developed for CoU and UMSC, 5) Reviews of social service delivery systems and approaches done for RCC</p> <p>b. 1.NAFOPHANU MTR undertaken and new Strategic plan developed. 2. NACWOLA developed and implemented district action plan that advanced Community-Level Participation and re-engaged the Leadership of Women Living with HIV towards eMTCT. 3. UNASO trained 40 program/M&E staff of ASOs on RBM to promote delivery on results and value for money within the CS fraternity.</p> <p>c. Completed printing of the private sector HIV/AIDS strategy and conducted two regional dissemination workshops in central and eastern regions. Supported development of HIV workplace policies, training of HR structures and training of peer educators in three supermarkets (Uchumi, Tuskeys and Shoprite). Supported development of HIV/AIDS workplace policies and programmes in the hotels, catering and tourism sector targeting 92 hotels in Kampala, Mbale and Gulu</p> <p>d. YP-SCE proposal 2013/14 finalized and submitted for funding through PF. 2. YP-SCE Operational guidelines developed. 4. Youth Entrepreneurs Uganda supported to integrate HIV and FP into its Youth Go Green Campaign and undertook its first training workshop to train ToT on mechanisms of integrating HIV into the rollout Youth Go Green Campaign dubbed "I million Youth I Million Trees. Supported the Ugandan Youth Forum Conferences for 2012 and 2013 to re-engage Youth Leaders and Key Stakeholders to renew commitment in the HIV/AIDS prevention drive. Conference was held in the Karamoja, Gulu, Kumi and Fort Portal Districts culminating in over 4000 youth leaders sensitized.</p> <p>e. a) Increasing eMTCT community awareness and HIV and AIDS service uptake in Kampala undertaken by AMICAALL leading to Increased awareness on EMTCT and HIV and AIDS; increased uptake of eMTCT, HCT, SMC services; increased engagement of local leaders in promotion of eMTCT. b) Local communities and leaders participate in the eMTCT campaign. Provided technical assistance, to Giramatskio. Stigma index finalised. Provided TA to NACWOLA for the rollout of campaign to reduce male engagements. PINA to attend the Meridible Conference.</p>

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
		<p>f. c) Supported AMICAALL to sensitize 500 CAOS, LCV to be sensitized on the Post 2015 agenda. Contributed TA to Pan African Interreligious Leaders meeting. Made input into the development of NDP II.</p> <p>g. Supported 5 hotels in Mbale and 5 Hotels in Gulu to develop HIV/AIDS workplace responses. # Supported the development of sectoral HIV/AIDS workplace guidelines for the Hotel and Tourism sector (in collaboration with the Uganda Hotels Owners Association). Supported 4 fish factories in Entebbe through the Uganda Fish Exporters and Processors Association to conduct HIV prevention activities at their work places.</p>
Number of PR accesses, utilises and accounts for GFATM resources	2 PRs Annually by 2014	Provided technical and financial support to TASO as PR and SRs for the development of data base and website for reporting on GF related interventions under the CSOs
Number of RFAs aligned to available evidence on HIV	100 % by 2014	
Number of CSF grantees working closely with / in partnership with government institutions at national and decentralised levels	100 % by 2014	
Number of private sectors/CSO representatives meaningfully participating in the annual partnership forum	50% increase by 2014	<ul style="list-style-type: none"> The private Sector was supported to conduct the situation and response analysis of HIV&AIDS in the private sector. The outcome of the study informed the development of a strategic paper for the private sector HIV&AIDS response, that was validated, leading to the development of a final strategy; A coordination mechanism/structure for the Private Sector HIV/AIDS response established and ToRs for the committee developed and approved 2) Private sector representation on the CCM transparently attained, as guided by the recommendations for representation on the CCM.
JP Output 3.1.7: Capacity of the UN Joint Team strengthened to coordinate, plan, implement, monitor and evaluate the JP		
Proportion of UN HIV JT Annual Activities implemented	80% by 2014	<p>a. JUPSA 2011-2014 developed, costed aligned to NSP and NDP and disseminated 2) JSC constituted and 2 meetings held; 3) Mid-term and end of year reviews undertaken. JT oriented and trained in JUPSA eMIS; Partners and JT members trained in Results Based Managed and used the tool for 2013 planning; Annual work plans developed and implemented and also provided coordination to the forum of ADPG. Core management Group and Thematic working groups effective and operational.</p> <p>b. 3rd JSC convened, reviewed and approved the 2013 AWP and budget and 2012 annual report; 2012 annual consolidated report uploaded on MPTF, and shared</p>

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
		<p>with partners and Government; JT and CMG convened to review programme implementation; three agencies received UBRAF funding for HIC</p> <ul style="list-style-type: none"> c. ADPG has continued to be effective fora for harmonization and alignment development assistance to the GoU by minimizing duplication, and overlaps. Monthly ADPG meetings held, periodic dialogue with GF, HDPG and ADPG. The UN Coordinated the convening of annual ADPG that reviewed implementation of 2012/2013 AWP and developed the 2013/ 2014 AWP. d. Have held 11 monthly meetings. In addition to Ad hoc meetings for AHA, HIV prevention Act, and other key issues like GF e. Annual ADPG retreat held and the matrix populated quarterly. Technical and financial support extended for the JAR, JRM and sector reviews f. The UN as part of strengthening capacity for Government supported one staff from MoH, UAC and 2 staff from the UN to attend the HIV/AIDS Estimates and Projections Regional Training Workshop Johannesburg, South Africa. This resulted in the generation of 2013 HIV/AIDS estimates that were approved in July 2013 by Government of Uganda and have been used in informing planning and prioritization. Two staff were identified, recruited and coordinated JUPSA. g. a) The 2013 Annual report was shared with government and development partners and posted on to the Multi- Partner Trust Fund website. As a practice MPTF generates a financial annual report to be integrated into the narrative report. The report was reviewed and submitted to MPTF to inform the generation of the final narrative and final report that was uploaded on website and sent to Government and head of UN agencies by 31st May 2014 b) UCO convened an end of year review that brought together government partners, UN and bilateral development partners. This informed the development of JUPSA 2014 AWP that was approved at the 5th Joint Steering Committee. h. c) UCO intensified resource mobilisation for JUPSA and this resulted into a funding of about USD 15 million from UN agencies and USD1.6 million from Irish Aid towards JUPSA 2014 AWP. i. a) The 4th Joint Steering Committee was convened, received and approved the 2013 JUPSA Annual Report and 2014 AWP b) The Joint Steering Committee has continued to provide guidance and strategic direction for the operationalization of Joint Programme of Support in Uganda j. c) Core Management and JT meetings continued to be held to review programme implementation and address key emerging issues' k. d) UNAIDS has continued to be a secretariat for the AIDS Development Partners Group and timely monthly ADP meeting have been held to discuss and address key issues regarding the national HIV/AIDS response. As of mid-year 6 monthly scheduled meetings and 4 ad hoc meetings were held to discuss key HIV related harmonization and implementation issues l. e) UNAIDS supported convening of the 3rd Joint meeting between UAC, MoH, ADPG and HDPG to discuss progress on HIV and AIDS interventions and to also address some of the day-to-day challenges in the national HIV/AIDS response m. f) UCO provided technical support for the development of 2014 ADPG workplan n. g) UCO provided guidance for the generation of quarterly progress reports o. A) In collaboration with PEPFAR, a capacity building training in HIV estimation, modeling, and estimation of resource use was conducted benefiting staff from Uganda AIDS Commission, Ministry of Health, the private sector, CDC and USAID and UNAIDS. This is expected to contribute to improved data generation and estimation at country level. b) Supported a capacity building in Economics and costing to MoH, UAC, Makerere University School of Public Health, School of

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
		<p>Economics Makerere, and Private Sector. This was aimed at improving and creating a pool of economics and cost experts in the country. This initiative will be followed up with small project.</p> <ul style="list-style-type: none"> The development of a bridge one year plan will be developed in second half of the year
Joint Programme Outcome: 3.2 Laws, policies and practices improved to support an effective HIV response by 2014.		
JP Output 3.2.1: Relevant laws, policies and practices that undermine and support effective responses to AIDS identified and implemented.		
Evidence available on existing and proposed policies and laws which impact on the HIV response	Evidence available by 2014	<ol style="list-style-type: none"> A Legal audit was conducted with a focus on MSM and sex workers and report was used to inform the development of sector prevention plans The intellectual property rights bill of 2009 was passed by parliament with provisions of access to medicines, which enables Ugandans to continue accessing medicines at a cheaper cost. The anti -homosexuality bill was passed in December by parliament with clauses that have negative public health impact that may reverse the gains gained in the HIV response. There are efforts to engage with the President so that he does not assent to the bill. Advocacy is on going with selected members of parliament so that the HIV Prevention Bill is reformed to exclude clauses like mandatory testing and criminalisation of HIV people who pass on the various to their partners. Formal & informal group discussions on the bill have been done with hope for better and reformed laws. Conducted a high level seminar to strengthen capacity of judicial authorities and legal professional on HIVAIDS related stigma and discrimination; Developed a statutory instrument on Employment and HIV-Non discrimination regulations; Established a sectoral taskforce to develop strategies, content & methodologies for integrating HIV and AIDS into the Judicial Training Programmes for Judicial Officers and Legal Professionals Stigma index Survey Report finalized and disseminated among stakeholders in Uganda and at ICASA 2013 in Cape Town - South Africa Conducted a consultative meeting with the members of the national reference team, journalists, and held public debates about the punitive laws on HIV, laws and policies New version of the Anti-Counterfeit Bill 2014, was submitted to the Ministry of Trade for adoption and presentation to the parliament
Stigma index report produced	1 Report produced by 2014.	<ul style="list-style-type: none"> Funding has been mobilized and TA provided to the network of PLHIV in Uganda (NAFOPHANU) to develop a proposal to undertake a stigma index survey with 40 PLHIVs trained as interviews, an international learning experience visit was undertaken, a National Steering Committee established to oversee to implementation of the survey and data collection exercise concluded with report expected at the end of January 2013.
National Strategy for Reduction and /or Elimination of Stigma and Discrimination available	1 Report to be produced by 2014.	
Number of selected punitive laws identified and	TBD - (2014)	UGANET working collaboratively with UHRC has undertaken a study to analyze capacities of key institutions to engage in law reform - taking forward the ensuing recommendations from the above-mentioned legislative environment assessments. Also, supported Ministry of Trade, Industry and Cooperatives to undertake a

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
reformed		rigorous analysis of the Industrial Property Bill as well as the Anti-counterfeiting Bill to ensure access to medicines (largely through use of generics) is safeguarded and TRIPS flexibilities utilised. This analysis formed the basis for the UNDP/MTIC/URSB convened expert consultation in March 2012 to bring together MPs and key government and CSO actors to agree on amendments to the IP Bill; (1) Cabinet information paper on the recommendation concerning HIV/AIDS and the world of work developed and forwarded. Other bills supported include HIV/AIDS Control and prevention bill and the anti-homosexuality bill.
JP Output 3.2.2: National capacity to reform laws, policies and practices that block the effective AIDS response enhanced		
	UHRC and ULRC on HIV-sensitive legislative analysis and in place	<ul style="list-style-type: none"> a. Consultations held in March 2012 and public health sensitive language agreed for the Bill. These have been discussed with the Parliamentary and Legal Affairs Committee and have been included in the Bill to be re-tabled in the House; Disseminated to key actors and ZOPED pieces on the same published in the Ugandan media. Report to be formally launched early in 2013 as part of the proposed HIV, Human Rights and the Law symposium. b. A policy brief was developed on HIV and the law, A national reference team was formed on HIV and the Law, T.V and radio messages have been developed and passed on to create awareness, trainings have been conducted for parliamentarians, CSOs and law enforcement officers. HIV positive people whose rights have been abused and violated have been given legal support, so far 12 cases have been registered and taken to court for hearing c. Conducted a consultative meeting with the members of the Judicial Studies Institute to develop a strategy outline of integrating HIV&AIDS and labour rights into the Judicial training programme. d. Rules and regulation for implementation of AHA underway. Meantime UNAIDS with partners advocated at the highest level, and secured assurances from the government and concerned ministries Health, Internal Affairs., MOFA.to ensure that LGBT/ MSM are protected from violence and harassment; and have access to health and HIV-related services without any discrimination. The government issued statement on AHA 2014 reaffirming its commitment to the protection of the rights of all Ugandans & ensure that nobody takes laws into their hands: Basic services including Health/HIV are provided to all. e. Legal Aid given 16 girls in Masindi and Gulu district to enhance property inheritance rights
JP Output 3.2.3: Action framework on women, girls, gender equality and HIV/AIDS rolled out		
One National action plan developed	1 (2014)	<ul style="list-style-type: none"> a. MGLSD capacitated to develop a National Action Plan on women, girls, gender equality and HIV; MGLSD in collaboration with UNAIDS& WHO reviewed the WHO manual for adoption to country for TOT at national level & six districts. In addition a national training guide integrating gender in HIV and AIDS Programmes has been designed for use by MGLSD in TOT and rollout of action plan in the districts. b. Fund made available to MOGSD for the printing, launching/dissemination & training of the NAP-WGGE. CSOs - Capacity of cultural leaders, Costs enhanced through dissemination of the NAP and development of their own action plans. NAP-WGGE disseminated to clan leaders of Bunyero Kitara kingdom and 258 cultural religious and political leaders of Busoga kingdom & draft action plans being developed. Provided FA to the HIV Parliamentary Committee on HIV for Stop AIDS campaign and Active involvement of positive mothers and fathers in EMTCT supported through mama's club

Indicator baseline	Planned indicator target	Cumulative indicator performance 2011 and 2012
		<ul style="list-style-type: none"> c. Develop the gender scorecard and facilitate annual reporting on the same d. A gender and Women empowerment UN Convergence group has been established, Through the development of the Gender and HIV score card, A CSO technical working group on gender and HIV has been formed e. Continued support to CSO to implement intervention of NAP WGGEH: <ul style="list-style-type: none"> a) ICWEA and UGANET supported for increasing access to SRHR and EMTCT& during this reporting period, project activities implemented in two districts (Wakiso and Mukono). f. <ul style="list-style-type: none"> a) 5 forums were conducted for the National HIV reference committee , A national HIV and the law dialogue conducted, b) Discussion with UAC for placement of Gender focal person/Gender desk at UAC on-going by UNDP/UNAIDS, TOR developed, UNAIDS to supplement budget of UNDP for the gender desk

Annex 4 References

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