Delivering as One UN

The Joint UN Programme of Support on AIDS in Uganda 2016-JULY 2021

The Joint UN Programme of Support on AIDS in Uganda (JUPSA) was due to end by 31st December 2020 but due to COVID19 interruptions, some of the UN agencies namely WHO, UNAIDS, UNESCO could not conclude implementation by December 2020 and UNFPA had some savings. Balances and savings will be spent in 2021. At its 14th JUPSA Joint Steering Committee meeting held on 27th January 2021 members approved the extension of JUPSA to 31st July 2021 to allow conclusion of implementation, closure out processes, reporting and documentation.

Towards Ending AIDS in Uganda

February, 2021

COUNTRY: UGANDA

Programme Title: The Joint UN Programme of Support on AIDS in Uganda 2016-JULY 2021

Joint Program Outcomes

1. Increased adoption of safer sexual behaviours among adolescents, young people and MARPS
2. Coverage and utilization of biomedical HIV prevention interventions delivered as part of integrated health care services scaled-up
3. Utilization of antiretroviral therapy increased towards universal access
4. Quality of HIV care and treatment improved
5. Programs to reduce vulnerability to HIV/AIDS and mitigation of its impact on PLHIV and other vulnerable communities enhanced
6. A well-coordinated, inclusive, gender and rights based multi-sectoral HIV and AIDS response that is sustainably financed to reverse the current trend of the epidemic
7. Capacity to implement and coordinate the JUPSA interventions enhanced

Program Duration:	**5 Years**
Start Date:	**January 2016**
End Date :	**JULY 2021**
Administrative Agent:	**UNDP**

Program Costs	**US $**
Estimated Budget	**104,548,715.2**
Funded Budget	**80,228,365.0**
Unfunded Budget	**24,320,350.2**

Funding Source	**US $**
FAO	**1,500,000.0**
ILO	**500,000.0**
IOM	**1,800,000.0**
UNAIDS	**3,380,000.0**
UNDP	**2,100,000.0**
UNESCO	**3,104,671.0**
UNFPA	**35,000,000.0**
UNHCR	**1,822,399.0**
UNICEF	**17,159,200.0**
UNWOMEN	**1,537,095.0**
WHO	**2,325,000.0**
Irish Aid	**10,000,000.0**
Totals	**80,228,365.0**

ACRONYMS AND ABBREVIATIONS

AA	Administrative Agency
AIDS	Acquired Immunodeficiency Syndrome
AIS	AIDS Indicator Survey
AMICAALL	The Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
ART	Anti-retroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health
ATF	AIDS Trust Fund
CP	Core Packages
CSE	Comprehensive Package on Sexuality Education
CSOs	Civil Society Organisations
DaO	Delivering as One
DoL	Division of Labour
ECC	Equal Opportunities Commission
EID	Early Infant Diagnosis
eMTCT	Elimination of mother-to-child HIV transmission
EWI	Early Warning Indicators
FAO	Food and Agricultural Organization of the United Nations
FGM	Female Genital Mutilation
GOU	Government of Uganda
HIV	Human Immunodeficiency Virus
HIVDR	HIV Drug resistance
HTC	HIV Testing and Counselling
HCD	Human Capital Development
HoAs	Heads of Agencies
HLO	High Level Outputs
IC	Investment Case
ILO	International Labour Organization
IOM	International Organization for Migration
JLOS	Justice Law and Order Sector
JUPSA	Joint UN Programme of Support on AIDS
JSC	Joint Steering Committee
KCCA	Kampala Capital City Authority
KMCC	Knowledge Management and Communications Capacity Building Initiative
KPs	Key Populations
LMIS	Logistics management information system
MARPs	Most-at-risk Populations
MISP	Minimum Initial Service Package
MoFPED	Ministry of Finance Planning and Economic Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
MSM	Men who have Sex with Men
MTR	Mid-Term Review
NASA	National AIDS Spending Assessment
NDP	National Development Plan
NSP	National HIV and AIDS Strategic Plan
OVC	Orphans and vulnerable children

PIASCY	Presidential Initiative on AIDS Strategy for Communication to Youth
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child HIV transmission
PUNOS	Participating UN Organizations
RC	Resident Coordinator
SBCC	Social and Behavioural Change Communication
SDG	Sustainable Development Goal
SMC	Safe Male Circumcision
SOPs	Standard Operating Procedures
SRHR	Sexual and Reproductive Health and Rights
SRMNCAH	Sexual Reproductive Maternal Neonatal Child Adolescent Health
TB	Tuberculosis
TWG	Thematic Working Group
UAC	Uganda AIDS Commission
UBRAF	Unified Budget, Results and Accountability Framework
UCD	UNAIDS Country Director
UHRC	Uganda Human Rights Commission
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNESCO	The United Nations Educational, Scientific and Cultural Organization
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commission for Refugees
UNDAF	United Nations Development Assistance Framework
UN	United Nations
UN WOMEN	United Nations Entity for Gender Equality and Empowerment of Women
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

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MEMORANDUM OF UNDERSTANDING

Since the establishment of the "Delivering as One" approach in Uganda in 2007, the United Nations (UN) in Uganda has jointly implemented HIV and AIDS programs through the Joint UN Programme of Support on AIDS (JUPSA). The Joint UN Team on AIDS was established to oversee and monitor JUPSA implementation. To date, two JUPSA programs have been implemented: the first generation JUPSA was implemented in 2007-2012 and the second generation JUPSA in 2011-2014 (extended to end of 2015 to align to national development plans).

Following an evaluation of the second generation JUPSA in December 2014, a comprehensive stakeholder consultative process was undertaken to develop the third generation JUPSA for the period 2016-2020. The JUPSA is aligned to key national documents including the United Nations Development Assistance Framework (UNDAF) 2016-2020, the National Development Plan II, the National HIV Strategic Plan (NSP) 2016-2020, and the HIV Investment Case 2015-2025. The JUPSA is also aligned to the international declarations for accelerated HIV response including: Getting to zero and the Unified Budget, Results, and Accountability Framework (UBRAF). The JUPSA interventions are also aligned to the UN core functions and mandate, largely focusing on upstream support and playing a catalytic role for implementation and scale-up of selected service delivery interventions.

The JUPSA 2016-JULY 2021 outcomes and high-level outputs (HLO) fall under the three thematic areas of HIV Prevention; HIV Treatment, Care and Social Support; and Governance and Human Rights. The prioritisation of high impact targeted interventions is aimed at achieving rapid acceleration of the national response towards elimination of HIV, in line with the Global movement.

The Joint Steering Committee (JSC) chaired by the UN Resident Coordinator and Co- Chaired by the Director General of Uganda AIDS Commission with attendance of the Embassy of Ireland representing the Donor at its 14th JUPSA Joint Steering Committee meeting held on 27th January 2021 approved the extension of JUPSA to 31st July 2021.

Her Excellency Rosa Malango
UN Resident Coordinator and
Designated Official for Security

Dr Nelson Musoba
Director General,
Uganda AIDS Commission

SIGNATURES OF PARTICIPATING UN ORGANIZATIONS AND NATIONAL COUNTERPARTS

The Joint UN Programme of Support on AIDS in Uganda (JUPSA) was due to end by 31st December 2020 but due to COVID19 interruptions, some of the UN agencies namely WHO, UNAIDS, UNESCO could not conclude implementation by December 2020 and UNFPA had some savings as per attached in appendix 1. Balances and savings will be spent in 2021. At its 14th JUPSA Joint Steering Committee meeting held on 27th January 2021 members approved the extension of JUPSA to 31st July 2021 to allow conclusion of implementation, closure out processes, reporting and documentation.

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ALAIN SIBENALER
UNFPA Representative

18 Feb 2021

YONAS TEGEGN WOLDEMARIAM
WHO Representative

JOTHAM MUBANGIZI
UNAIDS Country Director (OIC)

Charles Draecabo
UNESCO Uganda

EXECUTIVE SUMMARY

The Joint UN Programme of Support on AIDS in Uganda (JUPSA) was due to end by 31st December 2020 but due to COVID19 interruptions, some of the UN agencies namely WHO, UNAIDS, UNESCO could not conclude implementation by December 2020 and had balances to expend in 2021. UNFPA had some savings that JUPSA will utilize in 2021. At its 14th JUPSA Joint Steering Committee meeting held on 27th January 2021 members approved the extension of JUPSA to 31st July 2021 to allow conclusion of implementation, closure out processes, reporting and documentation.

Uganda continues to experience a high rate of new HIV infections, estimated at 99,000 at the end of 2014. However, HIV prevalence and incidence is much higher in some populations, including the most at risk populations such as fishing communities, sex workers, truck drivers, men who have sex with men (MSM), uniformed forces, and vulnerable populations such as young women and adolescent girls aged 15-24 years, among others. Uganda has made significant progress towards increasing access to several HIV interventions including HIV counselling and testing, expanding coverage of antiretroviral therapy for prevention of mother-to-child transmission and treatment, and safe male circumcision. However, inequities persist and limit access to services especially among children, adolescents, most at risk and vulnerable populations.

The third generation Joint UN Programme of Support on AIDS (JUPSA) 2016-2020 builds on the achievements of the second JUPSA (2011-2014) and the first JUPSA) 2007-2012). The second JUPSA which was evaluated in December 2014 to inform the development of the third JUPSA, made tremendous contributions to the HIV response in Uganda through support for generation of evidence, policy development, implementation capacity, coordination, resource mobilization and advocacy, among others. JUPSA 2016-2020 builds on these achievements to address the remaining gaps in policy and implementation, evidence generation and resource mobilization as well as expanding support for community level programming for an equitable and sustained response. The third JUPSA also aims at consolidating and accelerating partnerships in the HIV response towards ambitious global and national goals, to reach the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths in the post-2015 era.

The JUPSA 2016-2020 that is aligned to the United Nations Development Assistance Framework (UNDAF) 2016-2020, the National Development Plan II, the National HIV Strategic Plan 2016-2020, and the HIV Investment Case 2015-2025, has three thematic areas of: i) HIV Prevention, ii) HIV Treatment, Care and Social Support, and iii) Governance and Human Rights. The three thematic areas contribute to the UNDAF Strategic Intent 2 (Human Capital Development) and specifically the UNDAF Outcomes 2.2 on Health, 2.3 on Social protection, and 2.5 on the HIV and AIDS Response. Overall the JUPSA includes seven outcomes (two for Prevention, three for Treatment, Care and Support, two for Governance) and 23 high level outputs (HLO) (six for Prevention; eight for Treatment, Care and Support; nine for Governance). The seven JUPSA outcomes include:

1. Increased adoption of safer sexual behaviours among adolescents, young people and MARPS
2. Coverage and utilization of biomedical HIV prevention interventions delivered as part of integrated health care services scaled-up
3. Utilization of antiretroviral therapy increased towards universal access
4. Quality of HIV care and treatment improved

5. Programs to reduce vulnerability to HIV/AIDS and mitigation of its impact on PLHIV and other vulnerable communities enhanced
6. A well-coordinated, inclusive, gender and rights based multi-sectoral HIV and AIDS response that is sustainably financed to reverse the current trend of the epidemic
7. Capacity to implement and coordinate the JUPSA interventions enhanced

The cost of implementation of the JUPSA 2016-2020 is estimated at $104,548,715.2. Table 1 below presents a summary of the JUPSA five-year cost per outcome.

Table 1: Cost of Implementing JUPSA 2016-2020 per Outcome

JUPSA 2016-2020 Outcomes		AMOUNT (US$)	%
Outcome 1.1	Increased adoption of safer sexual behaviors among adolescents, young people and MARPS	20,227,655.85	19%
Outcome 1.2	Coverage and utilization of biomedical HIV prevention interventions delivered as part of integrated health care services scaled-up	40,412,454.36	39%
Outcome 2.1	Utilization of antiretroviral therapy increased towards universal access	4,182,790.16	4%
Outcome 2.2	Quality of HIV care and treatment improved	10,827,372.64	10%
Outcome 2.3	Programs to reduce vulnerability to HIV/AIDS and mitigation of its impact on PLHIV and other vulnerable communities enhanced	6,599,598.00	6%
Outcome 3.1	A well-coordinated, inclusive and rights based multi-sectoral HIV and AIDS response that is sustainably financed to reverse the current trend of the epidemic	19,430,482.75	19%
Outcome 3.2	Capacity to implement and coordinate the JUPSA interventions enhanced	2,868,361.45	3%
Totals		**104,548,715.20**	**100%**

The interventions for JUPSA 2016-2020 will be funded largely from the respective agency budgets (the core and extra non-core committed budgets) and from the commonly mobilized JUPSA resources. Agency core and non-core resources will be managed through the respective agency mechanisms while the commonly mobilized JUPSA resources will be channelled through the pooled funding approach with a pass through mechanism by a commonly agreed Administrative Agent (United Nations Development Programme).

Resource mobilisation strategies will be implemented to finance a funding gap of approximately 24,320,350.2 US Dollars that is required for implementation of this Joint Program.

A results matrix premised on the principles of results-based management will be used to monitor and track the progress of the plan.

1.0 SITUATIONAL ANALYSIS

1.1.Introduction

The Joint United Nations Programme on HIV/AIDS (UNAIDS) was introduced to ensure coordinated programming among the UN agencies in the support for national HIV/AIDS interventions and to improve efficiency in resource utilization, accountability for results and impact at country level. To date, these joint programs have been introduced in 79 countries. The first UN Joint Programme of Support on AIDS (JUPSA) was established in Uganda for the period 2007-2012 and a Joint UN Team on AIDS was set up to oversee and monitor its implementation. The JUPSA programs are implemented within the larger UN Delivering as One (DaO) framework. In October 2010 the Government of Uganda formally requested that Uganda adopts the DaO initiative and the UN Country Team launched the DaO in 2012. The DaO initiative is aimed at making the UN better coordinated and more efficient and effective, through having one leader, one programme, one budget framework, one voice, and shared common services. This is achieved through development of common national development assistance frameworks like the United Nations Development Assistance Framework (UNDAF).

1.2 The Uganda Country Development Context

Over the past 50 years, Uganda has experienced considerable and consistent growth. In the past 13 years, the economy grew by an average of 6.4% annually. The Government has developed a 30-year Vision, to develop from a predominantly peasant and low-income country to a competitive upper middle-income country by 2040. However, the country faces several challenges, among them, a rapidly increasing population. Rapid population growth can inhibit a country's ability to raise the standard of living when the need for food, health care, education, housing, land, jobs, and energy increases, especially if revenues do not increase at the same rate. Uganda has had a rapid population growth, estimated at 3.2% per annum between 1960 and 2002 and has remained fairly stagnant. Provisional results from the 2014 National Population and Housing Census indicated a growth rate of 3.03% per annum; the population increased by
10.7 million from 2002 to 34.9 million in 2014. Continued high population growth in Uganda may undermine the gains achieved by the current economic growth and is thus one of the Government's priorities for achieving Vision 2040.

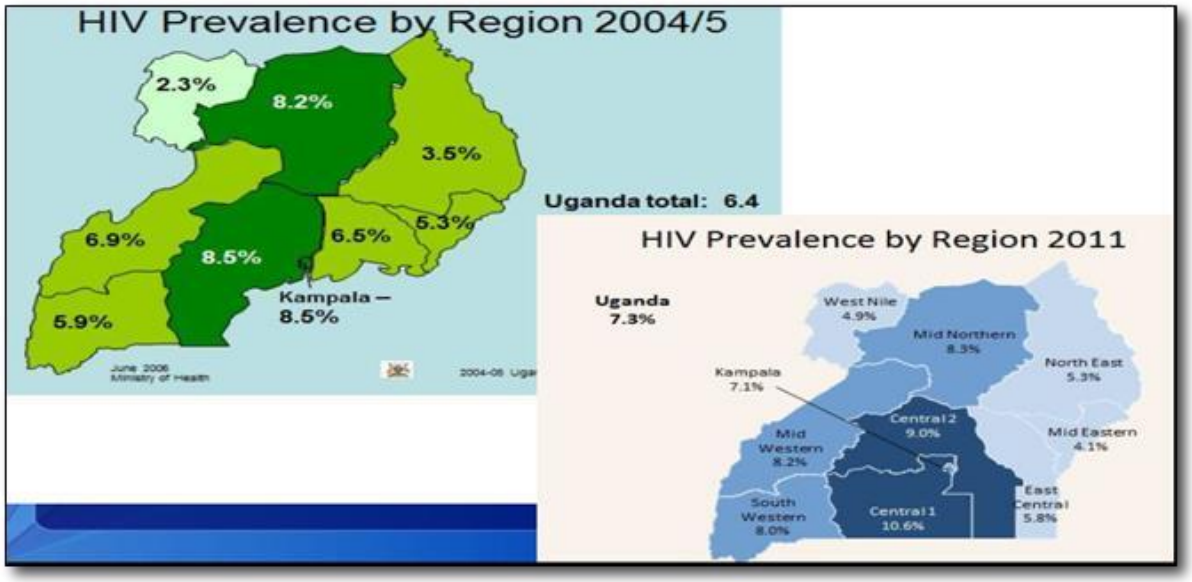
Under the first National Development Plan (NDP) for the period 2011-2015, Government of Uganda with support from the UN Agencies and Development Partners reduced absolute poverty from 24.5% in 2009/10 to 19.7% in 2012/13 and increased per-capita income from US $665 in 2009/10 to US$ 788 in 2013/14. Uganda's second NDP prioritizes investment in three key growth opportunities including Agriculture, Tourism and Minerals, Oil and Gas as well as two fundamentals: Infrastructure and Human Capital Development. One of the objectives of the NDP is to increase access to quality social services and, ultimately, the social status of the population as reflected in increased literacy levels, life expectancy at birth, safe water coverage and sanitation levels, and reduction in infant mortality rate, maternal mortality ratio, and incidence of communicable diseases including HIV. The NDP also aims to promote sustainable population and use of the environment and natural resources whose outcomes will be measured through the health status of the population, among other indicators.

1.3 The Country HIV Context

Uganda has had a generalised HIV epidemic for three decades, since identification of the first AIDS cases in the early 1980s. The HIV prevalence initially declined from approximately 15% in the late 1980s to 6.3% in the early 2000s but stabilised in 2000-2010, with a tendency towards increased prevalence starting 2010 onwards. HIV prevalence among adults aged 15-49 years, increased from 6.4% in 2004/05 to 7.3% in 2011, due to incident HIV infections and improved survival due to increased access to HIV care and treatment (Figure 1 below). Young women and adolescent girls form the majority of people living with HIV. HIV prevalence among adolescent girls 15-19 years is over 3% and rises to more than double [7.1%] by the time

they are 24 years. Thus, the country continues to experience a high rate of new HIV infections amongst her young population aged 15-24 years. According to the UNAIDS 2014 HIV Estimates for Uganda, the number of new infections among the general population was estimated at 99,000 at the end of 2014. Uganda alone contributed 10% of the total new infections in sub-Saharan Africa, with an estimated 570 adolescent girls and young women aged 15-24 years getting infected with HIV each week. The number of new HIV infections was consistently higher than that of individuals initiated on treatment until 2013 when the tipping point was reached (ratio of new HIV infections to the net increase in ART was <1).

Figure 1: HIV prevalence by Region 2004/5 and 2011 (AIS 2004/5 and AIS 2011)



Despite the generalised epidemic, HIV prevalence and incidence is much higher in some populations. Based on the 2011 AIDS Indicator Survey (AIS), women are disproportionately more affected than men with an overall HIV prevalence of 8.3% among women versus 6.1% among men. HIV prevalence is also higher among the urban residents (8.7%) than their rural counterparts (7%), and among high risk populations commonly referred to as most-at-risk populations (MARPs). The MARPs, as defined in the National HIV Strategic Plan, include fishing communities, sex workers, truck drivers, men who have sex with men (MSM), uniformed forces, among others. Fishing communities have a much higher prevalence ranging from 14% in the Lake Kyoga region to 20-42% in the districts surrounding Lake Victoria. HIV prevalence among other MARPs is also high, estimated at 33% among sex workers; 25-32% among truckers; 10-18% among uniformed personnel; and 13.7% among MSM. Despite the high HIV burden, HIV service uptake among MARPs is low due to various challenges including mobility, inability to tailor the models of service delivery to the special needs of these populations, and is partly constrained by the prevailing legal restrictions especially for sex workers and MSM. The high mobility also makes it difficult to link and retain MARPs in long-term care.

HIV prevalence among young people is lower than the general population; however, there is a trend towards increasing prevalence. For example, among men 15-19 years, HIV prevalence increased about 5 fold from 0.3% in 2004/5 to 1.7% in 2011. HIV prevalence among the female adolescents is more than twice that among their male counterparts, partly exacerbated by gender based violence and the girl child's inability to negotiate safe sex. In Uganda, 27% of girls aged 15-24 have experienced violence and 19% had their first sexual encounter against their will. There is generally low comprehensive HIV knowledge and an increased tendency towards risk taking among adolescents and young people including, alcohol and substance abuse before sex especially among men 15-24 years.

2. 0 THE NATIONAL AIDS STRATEGY, LESSONS LEARNED, AND PROPOSED INTERVENTIONS

2.1 Overview of the National AIDS Strategy

Government of Uganda (GOU) developed new strategies and plans to accelerate the momentum towards global HIV/AIDS targets and is committed to the 90-90-90 targets plus reaching zero new infections, zero AIDS related deaths and zero stigma and discrimination by 2030. In 2014, Uganda developed the HIV Investment Case to guide investments and improve efficiency and effectiveness of the HIV response for the period 2015-2025. The Investment Case aims to rapidly scale-up selected combination prevention interventions over the first three years (2015-2018) and maintain them at the targeted level of implementation. These include: increasing antiretroviral therapy (ART) coverage to 80%, prevention of mother-to-child HIV transmission (PMTCT) to 95%; safe male circumcision (SMC) and condoms to 80%; HIV testing and counseling (HTC) to 50%, and social and behavioral change communication (SBCC) with focus on MARPs and vulnerable populations particularly young women. The Investment Case also recommends increased integration of HIV with tuberculosis (TB) and other programs including maternal child health, among others, and system strengthening to enhance delivery of HIV services at all levels of the health system, including the community.

In 2014, the Government of Uganda developed a new National HIV/AIDS Strategic Plan (NSP) 2015/2016-2019/2020 with a vision of ***"A Healthy and Productive Population free of HIV and its effects".*** *The overall goal is* ***"Towards Zero new infections, Zero HIV related mortality and morbidity and Zero discrimination".*** This goal will be achieved through four sub-goals including: 1) To reduce the number of new youth and adult HIV infections by 70% and the number of new pediatric HIV infections by 95% by 2020; 2) To decrease HIV-associated morbidity and mortality by 70% through achieving and maintaining 90% viral suppression by 2020; 3) To reduce vulnerability to HIV/AIDS and mitigation of its impact on PLHIV and other vulnerable groups; and 4) An effective and sustainable multi-sectoral HIV/AIDS service delivery system that ensures universal access and coverage of quality, efficient and safe services to the targeted population by 2020.

The NSP guiding principles include: Shared responsibility towards an AIDS free population (individuals, families, communities, private and public sectors); Non-discrimination in service delivery; adherence to the multi-sectoral response, and effective partnership at all levels; engagement and involvement of people living with HIV (PLHIV); human rights and gender-based approach to programming; Evidence-based and result-driven planning and implementation; Adherence to the "Three Ones Principle" by all stakeholders; Effective mainstreaming of HIV/AIDS in all sectors and Plans; Country ownership and Accountability for results; and Strategic investments.

2.2 Lessons Learned

Uganda adopted combination HIV prevention interventions in 2010 following the development of the 2010-2015 National HIV Prevention Strategy, and the NSP 2009/10-2014/2015. Combination HIV prevention involves simultaneous implementation of a package of effective HIV prevention interventions including biomedical, behavioural and structural interventions. Major HIV combination prevention interventions include SBCC, condom programming, SMC, elimination of mother-to-child HIV transmission (eMTCT), HIV care and ART for HIV infected individuals, HTC as an entry point to various HIV prevention and care/treatment interventions, among others. There are also a number of structural interventions targeting the underlying sociocultural drivers of the HIV epidemic, including engagement of cultural and religious leaders to address negative socio-cultural practices that increase the risk of HIV transmission and acquisition. These interventions are largely targeted at the general population while focused interventions for certain populations groups such as adolescents and young people, MARPs, and others are also increasingly being scaled up.

Progress with implementation of major interventions

Uganda has registered significant progress towards achieving some of the Investment Case and NSP targets including HTC, expanding ARV coverage for PMTCT and ART for adults (including adolescents) and children (<14 years). Access to ART has increased steadily since 2003, and in 2013 Uganda reached a programmatic tipping point when for the first time, ART enrollment (193,000) exceeded the number of new infections (137,000). The number of ART facilities increased from 475 in 2011 to 1603 by June 2014; 100% public hospitals and 91% of Health Center (HC)-IVs (188) are providing ART. According to the NSP review of 2014, HIV treatment coverage among eligible children in 2013 reached 41% compared to 28% in 2012. Retention on ART was 86%, surpassing the target of 85%. However, there is need to enhance tracking and retention as the CD4 threshold for ART initiation increases; the number of individuals initiating ART at CD4 <250 reduced from 80% in 2008 to 48.7% in June 2014, a trend that is likely to be maintained with the adoption of the new WHO treatment guidelines. Laboratory infrastructure has also improved with 100% of HC IVs and HC IIIs performing or linked to CD4 and full blood count for patient monitoring. However, the reach of viral load testing is grossly limited and will affect tracking towards the 90% viral suppression target.

Access to HIV testing by the general population increased from 25% of women and 23% of men in 2006 to 66% among women and 45% among men in 2011. A total of 5,524,327 adults (≥15 years) out of an estimated 15,152,308 were tested and received results in 2011 (36.4%). This proportion increased to 58.2% in 2013 (6,982,715 of 12,000,450). The volume of male condoms coming into the country increased from 87 million in 2011 to 230 million by end of 2013. Programming for the female condom re-introduced in 2010 has expanded up to 5 million pieces distributed in a year. SMC interventions were slow at the beginning but have improved. In 2012/2013, 400,000 out of the targeted 1,000,000 annual circumcisions were done (40%) compared to 1,023,357 in 2013/2014. However, the funding allocation to SMC by PEPFAR has declined in 2015 while GOU commitment has not changed, which may affect the continued SMC scale- up. The PMTCT facility coverage increased significantly from 2,138 in 2013 to 3248 facilities by June 2014. Coverage of early infant diagnosis (EID) services (first DNA PCR) in 2013 was 60,437 (51%), a significant increase from 7% in 2007.

Pending challenges and obstacles to achieving the global and national HIV targets

Despite these tremendous achievements, coverage of interventions is still sub-optimal. There is overreliance on external funding which threatens sustainability of interventions and has contributed to slackening of some areas of programming such as male circumcision coverage which remains very low; the national coverage for male circumcision remained unchanged in the 2011 AIS (25% in 2004/05 and 26% in 2011). Condom programming also continues to experience challenges despite recent improvements; notable gaps include: inadequate condom quantities and distribution channels especially for high risk groups and young people; limited coverage of community engagement for demand creation and addressing of underlying myths and misconceptions; and inadequate attention to condom efficacy to ensure correct condom use.

Implementation of SBCC programs is fragmented, with limited segmentation of populations for relevant and effective messaging. The Knowledge Management and Communications Capacity building initiative (KMCC) SBCC review of 2013 indicated that the abstinence, be faithful and condom use “ABC” campaign although initially successful overlooked the influence of power relations between men, women and others, coercion and socioeconomics of decision-making dynamics and did not appropriately target MARPs such as sex workers and fishermen as well as the risk compensation due to new interventions like SMC and ART. Further, there are persistent disparities in the reach of several biomedical interventions including ART, SMC, and PMTCT services. HIV testing is also suboptimal for the attainment of the global 90-90-90 targets, especially among MARPs while paediatric HIV care and treatment has continued to lag behind compared to adult treatment. High levels of stigma and discrimination among PLHIV and in the wider community still persist, and some sections of the recently enacted HIV Prevention and Control Act 2014 could be a potential barrier to accessing HIV services. The factors that explain the disparities in response and access for both males and females across age groups were not fully addressed for the period of the ending JUPSA.

Such factors include power relations between men/boys and women/girls, tendencies of male masculinity and its hindrance to participation in HIV services uptake, violence against women and girls, limited access to and restrictions in use of household resources as well as low social status of women and girls.

2.3 The UN'S Role in the Country

The United Nations Country Team (UNCT) in Uganda, including 22 resident and non-resident UN agencies, has established effective working structures for driving joint UN results at the central and field levels with convergence result areas for the UN agencies. Through these structures, the UN has supported GOU to achieve its development goals. Some of the recent achievements include: 1) Support to humanitarian crisis, recovery and peace building e.g. the recovery programs in northern Uganda and Karamoja and handling of refugees from South Sudan; 2) Strengthening GoU capacity to formulate and implement its socio-economic policies in line with key crosscutting principles (gender, HIV and AIDS, population, environment and human rights); and 3) Strengthening national capacity in human-rights and evidence-based planning, including development of the second NDP II.

The UNCT developed the UNDAF 2016-2020, which focuses on upstream work and is aligned to the medium and long term NDP II and Vision 2040. In order to address the three structural issues that were identified as potential risks towards Vision 2040 and sustainable development goal targets, the UNDAF focuses on three priority areas of Governance, Human Capital Development and Sustainable and Inclusive Economic Development. These areas are aligned with the three "Strategic Intents" of the NDP and are aimed at contributing towards Uganda's Vision 2040-- A transformed Ugandan society from a peasant to a modern and prosperous country within 30 years. The UNDAF contributes to twelve outcomes under the three pillars, which provide a framework for interventions by the UN agencies, including the JUPSA. The JUPSA contributions are largely towards the human capital pillar (UNDAF Outcomes 2.2 on health, 2.3 on social protection, and 2.5 on HIV and AIDS Response).

2.4 The Joint UN Team on AIDS

The Joint UN Team on AIDS includes fulltime and part-time resident and non-resident UN programme staff working on HIV in Uganda (Annex 1). The UNAIDS Country Director (UCD) is the convenor and Chair of the Team and can contribute to any team member's performance appraisal. The Joint UN Team meets quarterly and its roles include:

1. Support Uganda AIDS Commission (UAC) and other bodies in their efforts to implement the national HIV response and resolve impediments to implementation;
2. Constitute entry points for national stakeholders to access HIV-related technical assistance from the UN;
3. Develop, facilitate and monitor the JUPSA based on the UNDAF and promote harmonisation with monitoring and evaluation systems;
4. Provide technical advice to the UNCT and follow up on decisions made;
5. Provide technical advice and review national progress in advance of annual JAR, sector; and
6. National Development Plan (NDP) reviews or other national processes.

The functions of the Joint UN Team on AIDS are to plan, set long-term and annual priorities, monitor implementation, and evaluate the programme, based on the outcomes, outputs, and the key deliverables agreed under JUPSA. Individual members are accountable to fulfil their roles and responsibilities within the team structure. Using existing agency accountability frameworks and individual organization processes, Heads of Agencies (HoAs) ensure that individual performance assessments take into account time and technical contribution to the team. The accountability and implementation modalities are further described under section 6.0 (Implementation Arrangements).

2.5 The Division of Labour

The global UNAIDS Division of Labour (DoL) provides guidance for lead organizations and participating organizations in the 15 areas that are clustered within the three JUPSA thematic areas of HIV Prevention,

Treatment, Care and Social Support, and Governance and Human rights (Table 2). However, the Committee of Cosponsoring Organizations allows for adaptation of the DoL to individual country circumstances, based on: (i) the comparative advantage and core mandates of the different Cosponsors; (ii) in-country presence of Secretariat or agencies; (iii) existing national capacities; and (iv) availability of funding for different functions and priorities at the country level. To avoid duplication between the Secretariat and Cosponsors, the Secretariat will not convene or co-convene any of the 15 Division of Labour areas but will facilitate and promote cooperation and achievement of goals, as stated in the Strategy, in all DoL areas.

The DoL in the JUPSA 2016-2020 is aligned to the global DoL in the UNAIDS guidelines and strategic vision of getting to zero but adapted to national context as agreed by the UNCT. UNAIDS has the overall responsibility for ensuring the functioning and accountability across all areas on matters of Leadership and Advocacy; Coordination; Coherence and Partnerships; and supporting mutual accountability of the Secretariat and Cosponsors.

The Technical Support DoL operates through Lead and Supporting Partners. Lead Agencies spearhead strategic and programmatic planning and serve as single entry points for government and other stakeholders that require support in a particular technical area. Lead Agencies then mobilise assistance from Supporting Partners, i.e. any other UN agency with relevant technical expertise or capacity in the area of need. The supporting partners are comprised of all agencies of the UN family in Uganda with institutional expertise and mandates to provide support in that thematic technical area. Supporting partners are not exclusive and additional partners can be co-opted as needed. Once particular areas of technical expertise are commonly known, requests for such support can enter the UN system at any point and the relevant UN Partners will liaise with the appropriate Lead Organization to coordinate support.

Table 2: The Uganda JUPSA 2016-2020 Division of Labour

No.	Thematic Area	Lead	Participating UN Organizations
1.	Reduce sexual transmission of HIV	UNFPA World Bank	UNDP, IOM, UNFPA, ILO UNICEF, WHO, UNESCO, UNHCR
2.	Prevent mothers from dying and babies from becoming infected with HIV	WHO UNICEF	IOM, UNFPA, WHO, UNICEF, UN WOMEN
3.	Ensure that people leaving with HIV receive treatment	WHO	UNDP, UNICEF, UNHCR, ILO, WHO, UNFPA
4.	Prevent people living with HIV from dying of TB	WHO	UNICEF, WHO, ILO, UN WOMEN
5.	Protect drug users from becoming infected with HIV and ensure access to comprehensive HIV services for people in prisons and other closed settings	WHO UNODC	UNDP, UNODC, WHO, UNESCO, UNFPA, UNICEF
6.	Empower men who have sex with men, sex workers and transgender people to protect themselves from HIV infection and to fully access antiretroviral therapy	UNDP UNFPA	UNESCO, WHO UNDP, UNFPA
7.	Remove punitive laws, policies, practices, stigma and discrimination that block the effective response to AIDS	UNDP	UNESCO, UNDP, UNICEF, ILO, UNFPA, WHO, UNHCR, UN WOMEN
8.	Meet the HIV needs of women and girls and stop sexual and gender based violence	UNDP UNFPA	UNICEF, UNDP, UNFPA, WHO, ILO, UNESCO, UNHCR, UN WOMEN
9.	Empower young people to protect themselves from HIV	UNICEF UNFPA	UNESCO, UNICEF, UNFPA UNHCR, ILO, WHO, FAO
10.	Enhance social protection of people affected by HIV	UNICEF	ILO, UNICEF, WB, UNDP, WHO, UNCHR, IOM, UN WOMEN, FAO
11.	Address HIV in humanitarian emergencies	UNHCR IOM	IOM, UNDP, UNDP, UNICEF, WHO, UNFPA, UNHCR
12.	Integrate food and nutrition within the HIV response	FAO	UNICEF, WHO, UNHCR, IOM, FAO
13.	Scale up HIV workplace policies and programs and mobilize the private sector	ILO	UNESCO, WHO, ILO
14	Ensure good quality education for a more effective HIV response	UNESCO	UNFPA, UNESCO, WHO, ILO, UNICEF
15.	Support strategic prioritized and costed multi-sectoral National AIDS Plans	UNDP	WB, ILO, UNHCR, WHO, UNDP, UNODC, UNICEF, UNESCO, UNFPA

Note: In the absence of UNODC, WHO will lead activity number 5

2.6 Achievements of the second generation JUPSA (2010-2014)

In November 2010 the first JUPSA mid-term assessment was conducted to review progress for 2007-2010 and the findings informed development of a second JUPSA (2011-2014). An evaluation of the second JUPSA was also conducted in December 2014 to inform development of the JUPSA 2016-2020. The evaluation revealed that JUPSA had made tremendous achievements in terms of realising its intended objective of improving synergies, effectiveness, and efficiencies through the DaO initiative; improved resources available for the Joint Program, enhanced engagement of key stakeholders in the HIV response including GOU, AIDS Development Partners, and communities including PLHIV; increased visibility and maintaining HIV/AIDS on the agenda of key stakeholders.

Overall, JUPSA was deemed as a very relevant program given its alignment to the national and international HIV and AIDS strategic plans; generating critical evidence for decision making; focus on the drivers of the epidemic and meeting the needs of those infected and affected by HIV and AIDS through evidence based interventions. The JUPSA implementation approach had a strong element of continuity through investment in institutional and capacity enhancement, and working with and through existing service delivery, political, religious and cultural structures to ensure sustainability of services. The program largely achieved its objectives and outcomes, in areas of HIV Prevention, Care and treatment, as well as governance and human rights. JUPSA made commendable contribution in terms of the impact on the HIV and AIDS response in all the thematic areas.

Under the HIV prevention thematic area, JUPSA supported HIV prevention strategy development and planning for implementation of combination HIV prevention at national, sector and district levels. JUPSA implemented focused campaigns for eMTCT, comprehensive condom programming, and SMC nationally. JUPSA played a catalytic role in systematic programming for MARPs at national and sub-national levels, supported delivery of integrated friendly sexual and reproductive health (SRH)/HIV services in selected districts and initiation of the regional hubs network model in Kampala, Mbarara, Gulu, Hoima, and Mbale districts by Ministry of Health. Through UN support, the Ministry of Education concluded processes for integration of sexuality education into the secondary school curriculum and there was delivery of SRH/HIV services to adolescents and young people through 40 youth friendly corners. Additionally, reinvigorated interventions focusing on structural drivers of the epidemic through support to cultural and religious institutions to generate evidence and develop systematic SRH/HIV leadership and community mobilization programmes were supported. JUPSA developed and operationalised several guidance documents for ART, EID, eMTCT, SRHR and Gender.

Care, treatment and social support achievements included support for increased access to ART through adaptation of WHO ART and post-exposure prophylaxis (PEP) guidelines and enhancing capacity for ART service delivery and providing targeted support to further scale up of paediatric HIV care. This support contributed to increased PEP and ART coverage. 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 paediatric 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.

Under governance, JUPSA supported resource mobilization and management including the Global Fund grants, increased commitments by ADPs, increased allocation of funds to HIV/AIDS in the districts through AMICAALL and Ministry of Local Government (MOLG), strengthened private sector engagement and contribution, and strengthened institutional and technical capacity for implementers through adaptation of the National AIDS Spending Assessment (NASA) methodology, among others. High-level re-engagements with government, religious and cultural institutions, and civil society organisations (CSOs) increased access to services. JUPSA supported improved coordination and monitoring and evaluation (M&E) by strengthening coordination of the UN agencies and supporting UAC to plan, develop and evaluate the NSP. A gender assessment for the national HIV response was also undertaken to generate evidence for future

planning and guidance for addressing the gender related disparities in the epidemic and the response at various levels.

Despite these achievements, there is still high unmet need for HIV and AIDS services within JUPSA supported districts and nationally, and disparities still remain in the spread of the epidemic and response patterns. The coverage of critical HIV care and prevention services is suboptimal and the number of new infections is way above the desired national and global targets. Funding for and sustainability of the HIV response also remains a concern with limited domestic financing and overreliance on a small donor base for HIV interventions. Further, the JUPSA II evaluation highlighted a need to enhance some JUPSA systems including M&E and documentation of best practices, rebranding and visibility for JUPSA. JUPSA III (2016- 2020) will build on previous successes to address these remaining gaps.

2.7 Development of JUPSA 2016-2020

The JUPSA 2016-2020 was developed in line with the global guidelines for JUPSA development which were updated in 2014 to support JUPSA Teams as they work towards the global AIDS targets and to accelerate progress towards reaching the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths in the post-2015 era. Further, the JUPSA 2016-2020 was developed in line with the 2016–2020 UNDAF for Uganda, the NDP II 2016-2020 and the national HIV/AIDS investment case 2015-2025 as well as the 2015/16-2019/2020 National HIV and AIDS Strategic Plan.

The JUPSA 2016-2020 development was preceded by a review of the second generation JUPSA. A national stakeholder's workshop was organised to review findings of the previous program and their implications for the new JUPSA. Further, extensive internal UN agency and stakeholder consultations were conducted to define JUPSA contribution to the national HIV response, with reference to the new NSP and the Investment Case. This was intended to ensure an efficient approach towards supporting GoU to achieve the new NSP and Investment Case targets in a relevant, harmonized, and efficient manner, and ultimately achieve the goal of ending the AIDS epidemic as a public health threat by 2030.

During the consultative workshop, a review of the national gaps was done through a recap of the 2014 NSP review findings. The new NSP priorities were presented to form the basis for analysis and identification of critical gaps for the JUPSA focus. Teams were formed in three thematic areas: i) Governance and Human Rights; ii) Prevention; iii) Care, Treatment and Social Support. Each thematic group generated a list of gaps and priorities for JUPSA 2016-2020. The priority list was extensively discussed with involvement of key national stakeholders including the GoU, NGOs, PLHIV, Private Sector, and ADPs, among others. The teams discussed the criteria for prioritization of focus areas and agreed to put emphasis on the upstream interventions, and a few downstream (implementation activities i.e. support for service delivery and programme acceleration). The selection of upstream interventions was based on the UNDAF core functions of: 1) Leadership, Policy guidance and Advocacy; 2) Strategic information to guide national strategies and programmes; 3) Tracking, monitoring and analysis of the epidemic and response; 4) Resource mobilization and investment optimization; and 5) Engaging political leadership, supporting civil society participation and brokering new partnerships. Prioritization of interventions was also done based on the in country support from other partners such as PEPFAR and the Global Fund to ensure synergies and efficiency and addressing of the most critical gaps within the national response, based on the mandate and comparative advantage of the UN agencies.

In summary the guiding documents and principles for the JUPSA 2016-2020 included: 1) The NDP II and the UNDAF 2016-2020; 2) The NSP 2015/16-2019/20 and Uganda's HIV Investment Case 2015-2025; 3) The international declarations for accelerated HIV response including: Getting to zero and the UBRAF and Intensifying efforts to eliminate HIV and AIDS; 4) the JUPSA II program review findings; and 5) Other in country support for the HIV response to ensure synergies.

2.8 Strategic priorities and critical gaps to be addressed by JUPSA 2016-2020

The JUPSA outcomes and High Level Outputs (HLO) were carefully selected to address the most effective and efficient interventions that will complement existing national efforts to accelerate attainment of the national goals. Overall JUPSA includes 7 outcomes and 23 HLO. Table 3 below shows the alignment between the JUPSA 2016-2020 and the key national and UNAIDS goals.

Table 3: Linkages between UNDAF, NSP and UNAIDS Vision and JUPSA (2016-2020)

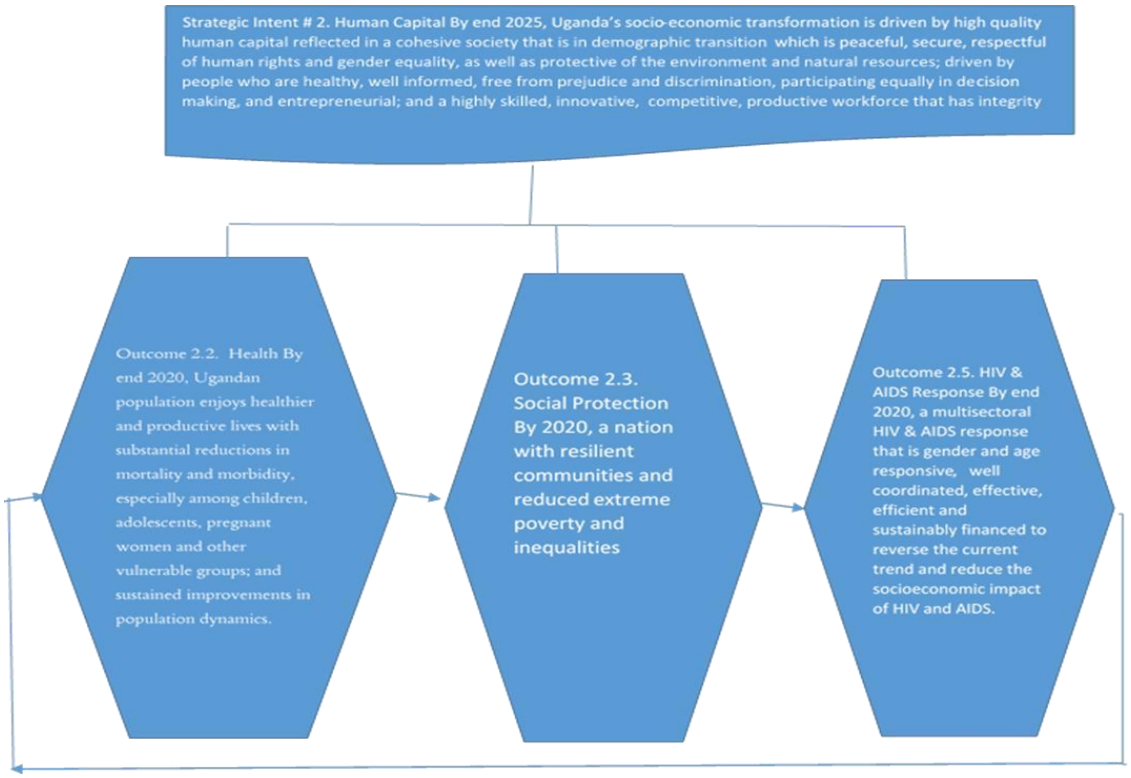
Thematic Area	NSP Goals	UNAIDS Vision	UNDAF outcome	JUPSA Outcome
HIV Prevention	Sub-goal 1: To reduce the number of new youth and adult HIV infections by 70% and the number of new paediatric HIV infections by 95% by 2020 Sub-goal 3: To reduce vulnerability to HIV/AIDS and mitigation of its impact on PLHIV and other vulnerable groups)	• Zero new Infections • UNAIDS 90-90-90 targets	UNDAF Outcome 2.5: By end 2020, a multi-sectoral HIV & AIDS response that is gender and age-responsive, well-coordinated, effective, efficient and sustainably financed to reverse the current trend and reduce the socio-economic impact of HIV and AIDS UNDAF Outcome 2.2: By end 2020, strengthened national capacity to deliver improved health outcome and nutrition through delivering preventive, promotive, curative and rehabilitative services that are contributing to: reduced mortality and morbidity, especially among children, adolescents, pregnant women and other vulnerable groups, and sustained improvements in population dynamics	• Increased adoption of safer sexual behaviours among adolescents, young people and MARPS • Coverage and utilization of biomedical HIV prevention interventions delivered as part of integrated health care services scaled-up
HIV Treatment, Care and Social Support	Sub Goal 2 To decrease HIV-associated morbidity and mortality by 70% through achieving and maintaining 90% viral suppression by 2020 Sub-goal 3: To reduce vulnerability to HIV/AIDS and mitigation of its impact on PLHIV and other vulnerable groups)	• Zero AIDS related Deaths • UNAIDS 90-90-90 targets	UNDAF Outcome 2.2: By end of 2020, Ugandan population enjoys healthier and productive lives with substantial reductions in mortality and morbidity, especially among children, adolescents, pregnant women and other vulnerable groups; and sustained improvements in population dynamics UNDAF Outcome 2.3: By 2020, a nation with resilient communities and reduced extreme poverty and inequalities UNDAF Outcome 2.5: By end 2020, a multi-sectoral HIV & AIDS response that is gender and age-responsive, well-coordinated, effective, efficient and sustainably financed to reverse the current trend and reduce the socio-economic impact of HIV and AIDS	• Utilization of antiretroviral therapy increased towards universal access • Quality of HIV care and treatment improved • Programs to reduce vulnerability to HIV/AIDS and mitigation of its impact on PLHIV and other vulnerable communities enhanced
Governance and Human Rights	Sub-Goal 4: An effective and sustainable multi-sectoral HIV/AIDS service delivery system that ensures universal access and coverage of quality, efficient and safe services to the targeted population by 2020	Zero discrimination	UNDAF Outcome 2.3: By 2020, a nation with resilient communities and reduced extreme poverty and inequalities UNDAF Outcome 2.5: By end 2020, a multi-sectoral HIV & AIDS response that is gender and age-responsive, well-coordinated, effective, efficient and sustainably financed to reverse the current trend and reduce the socio-economic impact of HIV and AIDS	• A well-coordinated, inclusive, gender and rights based multi-sectoral HIV and AIDS response that is sustainably financed to reverse the current trend of the epidemic • Capacity to implement and coordinate the JUPSA interventions enhanced

3. 0 THE JOINT UN PROGRAMME OF SUPPORT ON AIDS 2016-2020

The UN support encompasses provision of technical backstopping, partnership building, catalytic financing, advocacy and strategic guidance for the realization of commonly agreed targets for the national response in the short and medium term, guided by the Paris declaration on aid effectiveness. The JUPSA interventions are aligned to the core functions and UN mandate and address core functions of the Joint Programme including: Leadership, policy guidance and advocacy; Strategic information to guide national strategies and programmes; Tracking, monitoring and analysis of the epidemic and response; Resource mobilization and investment optimization; Engaging civil society and brokering new partnerships; and catalytic support for service delivery and programme acceleration in identified priority areas for an expanded and effective response at national and community level.

The presentation of the JUPSA 2016-2020 outcomes and high-level outputs (HLO) is based on the three thematic areas of HIV Prevention; HIV Treatment, Care and Social Support; and Governance and Human Rights. This presentation is intended to align with the Joint Team implementation arrangements and working groups. The three thematic areas contribute to the UNDAF Strategic Intent 2 (Human Capital Development) and specifically the UNDAF Outcomes 2.2 on Health, 2.3 on Social protection, and 2.5 on the HIV and AIDS Response (Figure 2).

Figure 2: UNDAF Outcome 2.5 and related Outputs



3.1.1 JUPSA 2016-2020 Strategic Direction-HIV Prevention

The new NSP highlights the need to intensify implementation of combination HIV prevention interventions including targeted biomedical, structural and behaviour change interventions targeting key populations and vulnerable groups such as adolescent girls and young women 15-24 years and couples in addition to the general population. The NSP also emphasizes the need to target 'hotspots' that are associated with a higher risk of HIV transmission.

JUPSA 2011-2014 focused more on the systems for delivery of biomedical interventions as well as social and behaviour change. However major gaps remain in terms of individual risk behaviours exacerbated by low HIV comprehensive knowledge, coverage for biomedical HIV prevention is still sub-optimal and there is

still inadequate targeting of the high risk and vulnerable groups. JUPSA supported all religious and 13 out of the 17 cultural institutions to generate evidence on the socio-cultural norms that fuel the HIV epidemic and findings were used to build the capacity of the institutions and leadership for expanded programming. These institutions however need resource support from various sources to undertake expanded and systematic community interventions for optimal coverage. Further, JUPSA supported key sectors to develop HIV sector strategic and operational plans that guided implementation in the last 5 years. These programmatic guidance tools need review and updating particularly to address gaps in integration of HIV prevention into sector development plans and budgets to ensure sustainable programming and focus on HIV as a development issue. Thus, the previous JUPSA largely supported evidence generation, development of strategic and thematic prevention frameworks and systems capacity building for prevention. The new JUPSA will consolidate these capacities and catalyse implementation for wide coverage and strengthen systems for strategic HIV prevention information management. JUPSA 2016-2020 will focus on targeted high risk and vulnerable individuals for prevention while maintaining systems strengthening for the key sectors (through integration of plans into these sectors). JUPSA 2016-2020 will maintain support for biomedical interventions to contribute to bringing interventions to scale and especially among the most at risk, adolescents, young people and vulnerable populations. Support for integration into sectors will go beyond plans to step up advocacy for ensuring budget allocation and implementation of the plans by respective sectors. JUPSA will continue to support religious and cultural institutions and other existing community structures to build on the systems developed and implement interventions to address the remaining gaps.

The JUPSA 2016-2020 HIV prevention thematic area will contribute to two NSP sub-goals as shown in Table 3 above. The HIV prevention interventions will target adolescents and more especially girls 10-19 years, young people 15-24 years, couples and MARPs to increase comprehensive knowledge of HIV prevention, increase the age at sexual debut among adolescents (reduce the proportion of adolescents having sex by age 15 years), reduce risky sexual behaviours (reduce multiple sexual partnerships and increase condom use at high risk sexual encounters, and promote consistent condom use especially among MARPs), life skills development for adolescent boys and girls, increase awareness about gender based violence (GBV) with special effort to reduce sexual gender based violence, support to GBV community level response mechanisms working with cultural and religious leaders and reduce vertical transmission of HIV. The HIV prevention strategic direction includes two outcomes and six HLO (Table 4).

Table 4: Summary of the JUPSA 2016-2020 HIV Prevention Outcomes and HLO

JUPSA Outcomes	JUPSA High Level Outputs (HLO)
Outcome 1.1: Increased adoption of safer sexual behaviours among adolescents, young people and MARPS	**Output 1.1.1:** HIV integrated into investment, annual and financing plans of key sectors that address identified structural drivers of the HIV epidemic
	Output 1.1.2: Programmes addressing underlying socio-cultural and economic drivers of the HIV epidemic expanded
	Output 1.1.3: Social and behaviour change communication focusing on adolescents, young people and key populations expanded
Outcome 1.2: Coverage and utilization of biomedical HIV prevention interventions delivered as part of integrated health care services scaled-up	**Output 1.2.1:** Availability of stocks of HIV prevention commodities at service delivery points
	Output 1.2.2: Biomedical HIV prevention interventions delivered to optimal coverage levels
	Output 1.2.3: SRHR/HIV interventions for adolescents and young people delivered at optimal coverage levels

JUPSA HIV Prevention Outcome 1.1

Output 1.1.1: HIV integrated into investment, annual and financing plans of key sectors that address identified structural drivers of the HIV epidemic: In order to increase focus on socio-cultural and economic causes of vulnerability to HIV infection and barriers to adoption of safer sexual behaviours among adolescents, young people, couples and MARPS, JUPSA will strengthen the capacity of UAC and support the

integration of HIV into plans of key sectors that address the structural drivers of the HIV epidemic especially health, education, gender/social development, and agriculture. This will be done by supporting the targeted sectors to operationalise the NSP, by developing and/or revising their sector HIV plans, integrating HIV priorities into sector development plans, translating them into annual plans and budgets, tracking implementation of programmes and resource expenditures, as well as establishing impact of HIV on sector development and impact of sector programmes on HIV outcomes.

Output 1.1.2: Programmes addressing underlying socio-cultural and economic drivers of the HIV epidemic expanded: JUPSA will support programs directly addressing the socio-cultural and socio-economic drivers of the HIV epidemic, with priority focus on support to strengthen community level mechanisms to monitor human rights violations and facilitate resolution at that level as well as build capacities of cultural and religious leaders and institutions to raise awareness of the key factors fuelling the epidemic. This will be done through supporting relevant sectors such as the Social Development Sector, cultural and religious institutions to develop and/or revise their plans linked to the NSP priorities, implement and track their programs. The selected cultural and religious institutions will be supported to deliver programs addressing underlying sociocultural drivers of the HIV epidemic. JUPSA will also strengthen prevention programming in urban areas targeting promoting awareness on vulnerability to HIV in urban settings so as to reduce new HIV infections among adolescents, young people, and MARPs. The selected municipalities will be supported to implement programs for priority population groups, through existing structures working with urban leaders, celebrities, and the media industry. These urban centres will be supported to generate context specific evidence on the epidemic, develop/review plans, mobilise resources for expanded implementation and track implementation.

JUPSA will support processes for policy enforcement and regulation in relevant areas to establish enabling environments for prevention of HIV transmission. Support will be provided for the development and implementation of policies to address issues fuelling the spread of HIV including alcohol and substance abuse, low socio-economic status among young people especially girls and MARPs. Interventions will include generating evidence for advocacy and programming (including evidence on gender related factors affecting access to HIV services) and advocating for the necessary legal frameworks including support and or linkage to other partners focusing on strengthening community level access to justice response mechanisms and actions against stigma and discrimination. Further, young people from selected districts will be equipped with life and livelihood skills and facilitated to serve as community role models. Support will specifically be provided for the development and implementation of SRHR/HIV programmes that improve the socio-economic status of adolescent and young girls that are affected and/or vulnerable to HIV infection in the Karamoja region. Entrepreneurship training and business development skilling for adolescent girls and young women as an alternative source of livelihood and linkage to economic opportunities i.e. assisting women and girls living with HIV to gain essential economic skills to be able to cope with the impact of HIV at individual and household level will be prioritised. This prioritization acknowledges the poor socio-economic status indicators for women, adolescents and young people in the region, the high increase in new HIV infections and the opportunity of the UN convergence in the region to support development generally. Supported programmes in the region will include focus on socio-cultural factors that promote HIV infection and sexual reproductive ill-health, promotion of school enrolment and retention, provision of SRHR/HIV information and services, access to life, livelihood and leadership skills building and training and linkage to opportunities for economic advancement for young people and women.

Output 1.1.3: Coverage of social and behaviour change communication (SBCC) interventions with focus on adolescents, young people and key populations expanded to optimal levels: This output acknowledges the low comprehensive knowledge about HIV in the general population and specifically for adolescents and young people as a major driver of the low risk perception and vulnerability to HIV infection. This will be done through strengthening coordination structures at relevant sectors including MOH, UAC, and MoGLSD to deliver harmonized and standardized SBCC with a focus on systematic targeted campaigns linked to integrated SRHR/HIV services, strengthening delivery of a comprehensive package on sexuality education (CSE) to reach at least 50% of the primary, secondary and tertiary institutions; supporting implementation

of the school health policy including revitalizing good practices such as the Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY) programme; exploitation of the sports structures to reach people with information for example expanding the reach of "Protect the Goal" campaigns to all regions of the country; and exploitation of other mechanisms to reach the out of school adolescents and young people including development of guidelines for delivery of CSE.

JUPSA HIV Prevention Outcome 1.2

This outcome is aligned to the UNDAF Outcome 2.2 on Health; Output 2.2.4 on SRMNCAH partnerships, coordination and good practices scale-up and Output 2.2.5 on dual burden of communicable and non-communicable diseases.

This JUPSA outcome targets to increase the coverage and utilization of biomedical HIV prevention interventions delivered as part of integrated health care services. This outcome area prioritizes focus on male circumcision, condom use, PMTCT promoting option B+ hinged on the maternal and neonatal health platform and focusing on family planning services to reduce unmet need for FP among HIV infected persons, HIV testing including the test and treat approach linked to ART services. JUPSA will support the country through advocacy for resources, evidence generation, thematic strategic planning, human resource capacity building, commodity and drug procurement and management, provision of technical guidance and demand creation to contribute to achievement of optimal coverage levels. JUPSA will also continue to support delivery of the Minimum Initial Service Package (MISP) of SRHR/HIV services for people in humanitarian settings.

Output 1.2.1: Availability of stocks of HIV prevention commodities at service delivery points: Stock outs of prevention commodities and supplies such as condoms and test kits have been a major barrier to sustainable HIV prevention programming. JUPSA will support strengthening of the procurement supply chain management including capacity building of managers and health workers to reduce stock out of supplies for biomedical prevention intervention; advocacy for and contribution to procurement of adequate quantities; streamlining distribution mechanisms to allow for easy stock tracking and quality management; and support to demand creation for prevention services. JUPSA will specifically support promotion of male and female condoms, tracking utilization of condoms by supporting functionality of the national condom logistics management information system (LMIS) at national, district levels, and facility and community levels; and provide support for procurement of SMC reusable kits. JUPSA will also support PMTCT scale-up including procurement of option B+ drugs and supplies.

Output 1.2.2: Biomedical HIV prevention interventions delivered to optimal coverage levels: JUPSA will provide support to expand the coverage of biomedical HIV prevention services (SMC, HTC, PMTCT) through systems strengthening interventions including revision of policies, development of standard operating procedures (SOPs), provider training in selected facilities, support to ensure functional national coordination structures, and also production of tools to integrate HIV with SRHR services including FP. There will be specific focus on strengthening community support groups to enhance service uptake and adherence to treatment. JUPSA will support expanded programming for MARPs with specific focus on the Ministry of Health five identified regional hubs including Kampala Capital City Authority (KCCA) to provide comprehensive SRHR/HIV services for MARPs utilizing tested community engagement models and working through designated MARPs coordination structures at UAC, sector and regional levels. Further, JUPSA will support improved coverage of comprehensive SRHR/HIV services for fishing communities in 5 districts.

Output 1.2.3: SRHR/HIV interventions for adolescents and young people delivered at optimal coverage levels: Adolescents and young people access to SRHR and HIV services is constrained by the inadequately packaged and delivered services at public health facilities. Issues of limited capacity and poor health worker attitudes, inconvenient opening hours, lack of incentives to attract adolescents and young people who are often seeking for information and preventive services have been documented. Under this output, JUPSA will support Ministry of Health and Faith Based Institutions to expand sustainable and evidence informed friendly adolescent SRHR/HIV programming through evidence generation, advocacy for resources and replication of tested models, human resource capacity building, equipping of facilities and contribution to

service delivery in 15 selected districts. JUPSA will enhance systems for reaching adolescents and young people with information and support community engagement processes e.g. through think tanks, community dialogue platforms and peer-to-peer support networks. JUPSA will support Ministry of Education, Science, Technology and Sports to implement the school health programmes in order to ensure that learners have access to quality ASRH services as stipulated in the school health policy.

3.1.2 JUPSA 2016-2020 Strategic Direction-HIV Treatment, Care and Support

Despite successes in scaling up HIV care and treatment in Uganda, the mid-term review of the 2011/2012—2014/2015 NSP highlights several inequities in accessing HIV care and treatment and emphasizes the need for concerted efforts to reach universal treatment access. Major disparities exist and some groups especially key populations, men, children and adolescents still have limited access to HIV care and treatment. There are efforts to scale-up testing and linkage to HIV care and the HIV prevention JUPSA thematic area includes support to further scale this up especially among the under-served groups. However, there is need to support other components of the continuum of care including ensuring availability of care and treatment commodities, maintaining HIV infected people in care and ensuring quality care including adherence support and treatment monitoring with support for expanded access to viral load monitoring for treatment outcomes, monitoring of drug toxicities as well as prevention and monitoring of HIV drug resistance.

JUPSA previously supported supply chain rationalization but there is still limited capacity for quantification beyond the national level and actualization of the web based ordering system for ARVs. Capacity for early warning indicators for HIV drug resistance (EWI) was built for 400 facilities (out of >1,000 sites) using the open MRS system. However, there is need to scale up beyond the 400 facilities and utilize the data generated as a source for EWI survey reports and cohort analysis for treatment outcome monitoring. There is also inadequate attention to integration of services in reducing HIV related comorbidities and ensuring continuous quality improvement across various HIV care and treatment programs, including PMTCT. JUPSA 2016-2020 Treatment, Care and Social Support thematic interventions will thus build on previous JUPSA support to further enhance the NSP efforts towards access to universal quality care and treatment.

For the social support and protection component, JUPSA has previously supported several interventions to address the psychosocial and social protection needs of PLHIV, OVC and other vulnerable groups. However, the NSP mid-term review (MTR) highlighted several gaps including decline in direct livelihood support services; inadequate gender mainstreaming in psychosocial support and social protection services; limited success of interventions addressing gender norms that increase vulnerability to HIV; lack of a defined psychosocial support package for PLHIV and limited or no life cycle sensitive social support and social protection packages of PLHIV and other vulnerable persons; among others. JUPSA will build on these efforts to address some of the remaining gaps, specifically in defining and implementing a psychosocial support and social protection package for PLHIV and other vulnerable persons.

The JUPSA HIV Treatment, Care and Social Support thematic area will include three outcomes and eight HLO that will contribute to two of the NSP care and treatment Strategic Objectives: NSP Care and Treatment Strategic Objective 2—To increase access to ART and sustain provision of chronic care for patients on ART; and NSP Care and Treatment Strategic Objective 3—To improved quality of chronic HIV care and treatment. The Treatment, Care and Support interventions will focus largely on upstream interventions including adaptation of new WHO guidelines, provide capacity building, program monitoring, quality improvement, and laboratory capacity strengthening. The JUPSA support and social protection interventions will contribute to the NSP Social Support Strategic Objective 1--To mainstream the needs of PLHIV, OVC and other vulnerable groups into other development programs and Strategic Objective 3--To develop and implement a life cycle sensitive comprehensive package of social support and protection interventions for PLHIV and other vulnerable groups. The social support and protection interventions including economic empowerment, nutrition and livelihood will focus on piloting, testing, and disseminating models of support and protection as well as advocacy for their scale-up.

Table 5: Summary of the JUPSA 2016-2020 HIV Treatment, Care, and Support Outcomes and HLO

JUPSA Outcomes	JUPSA High Level Outputs (HLO)
Outcome 2.1: Utilization of antiretroviral therapy increased towards universal access	**Output 2.1.1:** Guidance provided and capacity built for provision of ART according to the new WHO recommendations, to reach 90% of PLHIV
	Output 2.1.2: Institutional capacity for procurement and supply chain management systems enhanced
	Output 2.1.3: Institutional capacity for tracking, retention and adherence monitoring of PLHIV on treatment strengthened
Outcome 2.2: Quality of HIV care and treatment improved	**Output 2.2.1:** Institutional capacity for HIV care and treatment monitoring including scale-up of viral load monitoring and surveillance for drug resistance and toxicity enhanced
	Output 2.2.2: Accelerated and streamlined implementation of interventions to reduce HIV related comorbidities
	Output 2.2.3: Institutional capacity for HIV treatment and care quality improvement enhanced
Outcome 2.3: Programs to reduce vulnerability to HIV/AIDS and mitigation of its impact on PLHIV and other vulnerable communities enhanced	**Output 2.3.1:** Enhanced capacity of government and communities to mainstream the needs of PLHIV, OVC, adolescents and other vulnerable groups into other development programs
	Output 2.3.2: Strengthened community capacity for food security, nutrition, and economic livelihood to mitigate the socio-economic impact of HIV/AIDS

Output 2.1.1: Guidance provided and capacity built for provision of ART according to the new WHO recommendations, to reach 90% of PLHIV: This will be achieved through support for MoH to ensure revision (adaptation of the new WHO guidelines) and dissemination of the national policy and guidelines for eligibility and initiation on ART as well as training of trainers at the national and regional levels, to support rollout of implementation of the new guidelines, including enhanced treatment and models of care for under-served populations such as children and adolescents, key and vulnerable populations. To enhance access and retention in care for migrant communities such as sex workers and fishing communities, JUPSA will pilot a community referral mechanism using existing community structures in five districts.

Output 2.1.2: Institutional capacity for procurement and supply chain management systems enhanced: JUPSA will enhance logistics and commodity security for HIV care and treatment. Health facilities providing HIV treatment will be supported to initiate and/or strengthen web based ARV ordering through training of health workers and support for PSM plans at the national level. JUPSA will also support national systems for commodity tracking and partner coordination meetings for commodity security.

Output 2.1.3: Institutional capacity for tracking, retention and adherence monitoring of PLHIV on treatment strengthened: This will be achieved through support for MoH to strengthen patient tracking and monitoring of retention and treatment adherence. JUPSA will support MoH to improve patient ART monitoring. JUPSA will support development/enhancement of open MRS for 200 health facilities to improve patient tracking and monitoring. Further, JUPSA will pilot the use of a unique identifier (using the national ID card) for key/migrant populations to track and improve their access to HIV care and treatment. This could, in future, set the stage for expansion of unique ID tracking across countries within the region.

Output 2.2.1: Institutional capacity for HIV care and treatment monitoring including scale-up of viral load monitoring and surveillance for drug resistance and toxicity enhanced: JUPSA will support generation of data for HIV drug resistance (HIVDR) early warning indicators (EWI) and compilation of annual EWI reports; support for toxicity monitoring especially during pregnancy and breastfeeding, and compilation of annual toxicity reports. Further, JUPSA will support development of the HIVDR strategic plan and coordination structures for HIVDR monitoring including quarterly committee meetings. JUPSA will also support implementation of annual cross-sectional Viral Load measurements to support patient and ART program monitoring.

Output 2.2.2: Accelerated and streamlined implementation of interventions to reduce HIV related comorbidities: JUPSA will support integration of SRHR and interventions to reduce the effect of HIV related co-morbidities including non-communicable diseases such as cancers (Karposi sarcoma and cervical cancer screening); infectious diseases such as tuberculosis; leishmaniasis; hepatitis B, and malaria. JUPSA will support adaptation and rolling out of the WHO TB-HIV guidelines including guidelines for TB prophylaxis. JUPSA will also support capacity building for national and regional staff in TB/HIV integration; quarterly TB/HIV coordination meetings, and enhance capacity for TB data analysis and research to generate evidence to accelerate TB/HIV interventions as well as high level TB/HIV advocacy.

Output 2.2.3: Institutional capacity for HIV treatment and care quality improvement enhanced: JUPSA will support MoH in the quality of care improvement and management through review and updating of the national quality of care tools, and dissemination. JUPSA will also support capacity building for national, regional and district implementation of the revised standards and annual quality improvement performance review meetings.

Output 2.3.1: Enhanced capacity of government and communities to mainstream the needs of PLHIV, OVC, adolescents and other vulnerable groups into other development programs: This HLO will be achieved through a number of interventions including: Revision, dissemination, and implementation of national social protection policy, strategy and programs that are child sensitive and integrate issues of PLHIV, OVCs, adolescents and their households. Capacity of key actors engaged in the HIV and AIDS response will be strengthened to ensure adoption of gender and rights-based HIV programming. Support will be provided to government, local governments, and other stakeholders to ensure that they have improved capacity and are able to implement social protection programs to reduce vulnerability to HIV and AIDS and mitigation of its impact on PLHIV, OVCs, women and girls, adolescents, informal sector workers, and other vulnerable groups. Strategies will include direct provision of legal and child protection services for OVC and establishment of mechanisms to report and respond to cases of violence against children; direct psychosocial support services to OVC, caregivers, service providers and other stakeholders; capacity development to strengthen national institutions and systems to improve coverage, quality and sustainability of basic services for adolescent girls; establishment of mechanisms for engaging men and boys in HIV and AIDS and SGBV programming through mobilization of cultural and religious structures.

Output 2.3.2: Strengthened community capacity for food security, nutrition, and economic livelihood to mitigate the socio-economic impact of HIV/AIDS: This HLO will include interventions on food security and nutrition, capacity development and skilling for improved economic livelihood especially for adolescent girls and young women 15-24yrs, Orphans and Vulnerable Children (OVC) especially those in the informal work sectors. Due to their unequal access to household economic assets and resources, these groups of people are particularly vulnerable to economic insecurity and financial dependency. For instance, helping women gain essential economic skills has shown credible results towards addressing intrinsic stigma while at the same time promoting participation and leadership in economic ventures that liberate households and the larger community from absolute poverty. JUPSA will provide support to ensure that communities that are vulnerable to HIV and AIDS are food and nutrition secure and are economically resilient. HIV service providers shall also receive support to integrate nutrition assessment, counselling and support into HIV care and treatment services. Effort will be put to improve perceptions and practices of communities on gender norms and relations that impact on women's and children's participation in modern farming and business development working with cultural, religious leaders, through increasing awareness among target communities. Under this output, emphasis will be put on training to strengthen capacities of OVCs, adolescent girls and young women entrepreneurs to run their enterprises profitably through Enterprise Development Assistance and those in farming to learn and apply high yield less labour intensive modern farming methods. Other interventions will include building technical and business competencies around specific value chains, and linkage to market opportunities in Government and the private sectors; and ensuring linkages to agriculture extension workers at district level for continued technical assistance. JUPSA will also develop and test models for interventions targeting these groups and advocate for their scale-up.

3.1.3 JUPSA 2016-2020 Strategic Direction-Governance and Human Rights

A strong effective and efficient multi-sectoral HIV and AIDS system is critical to achieving the NSP goals and global HIV/AIDS targets as well as a robust and sustainable HIV response in Uganda. The Uganda AIDS Commission (UAC) is mandated to coordinate the national HIV and AIDS response. Thus, the NSP targets to enhance the UAC coordination capacity especially at decentralised levels where major gaps exist. JUPSA has previously supported UAC and several improvements have been realised. However, gaps remain in the functionality of regional coordination offices and committees at the national and lower levels. JUPSA 2011-2014 also supported development of the Investment Case, however, there is need for continued advocacy and support for establishment of sustainable funding for its implementation, including the AIDS Trust Fund, and to enhance strategic partnerships. The M&E and reporting has improved including meeting the international and global reporting indicators and national level surveys to inform planning; and integration of the national M&E. However, there is need to consolidate and support remaining gaps including data quality assessments, aggregation and dissemination of the data. Further, the NSP highlights stigma among the persistent challenges. Further, the legal provisions in the HIV and AIDS Prevention and Control Act 2014 potentially derail prevention efforts.

The JUPSA governance and human rights thematic area will contribute to the NSP sub-goal 4--An effective and sustainable multi-sectoral HIV/AIDS service delivery system that ensures universal access and coverage of quality, efficient and safe services to the targeted population by 2020. This thematic area will also contribute to the NSP Sub-goal 3--To reduce vulnerability to HIV/AIDS and mitigation of its impact on PLHIV and other vulnerable groups; and Sub-goal4, through interventions targeted at human rights (including stigma reduction) and gender equality.

The Governance Strategic Direction includes two outcomes: 1) "By end 2020, UAC supported by line ministries have technical and institutional capacity to coordinate, develop, implement and monitor a human rights & gender-focused national AIDS strategic plan supported by increased, sustainable and accountable domestic financing and informed by the investment framework for HIV and mechanism for efficient resource management"; and 2) **Capacity to implement and coordinate the JUPSA interventions enhanced**. These outcomes will be achieved through nine HLO (Table 6).

Table 6: Summary of the JUPSA 2016-2020 Governance and Human Rights Outcomes and HLO

JUPSA Outcomes	JUPSA High Level Outputs (HLO)
Outcome 3.1: A well-coordinated, inclusive and rights based multi-sectoral HIV and AIDS response that is sustainably financed to reverse the current trend of the epidemic	**Output 3.1.1:** Functional capacity of HIV and AIDS coordination structures at national and subnational levels strengthened
	Output 3.1.2: Sustainable financing mechanisms for the HIV Response in Uganda strengthened
	Output 3.1.3: A harmonized monitoring and evaluation system for the HIV and AIDS response built at national and sub national levels
	Output: 3.1.4: Strategic alliances and Partnerships enhanced for the multi-sectoral HIV response
	Output: 3.1.5: Reforms in national and sub-national laws, policies and strategies for better alignment to international standards
	Output 3.1.6: Capacity of key government and non-government institutions in gender responsive and human rights sensitive HIV programming strengthened
Outcome 3.2: Capacity to implement and coordinate the JUPSA interventions enhanced	**Output: 3.2.1:** Administrative and technical capacity for JUPSA implementation enhanced
	Output: 3.2.2: JUPSA monitoring and evaluation and performance tracking strengthened
	Output: 3.2.3: Enhanced advocacy and resource mobilisation to support JUPSA implementation

Output 3.1.1: Functional capacity of coordination structures at national and subnational levels strengthened:
This HLO will be achieved through supporting UAC, selected government and non- government institutions to ensure harmonized and functional coordination structures at national, sector, regional and district levels and scale up UAC zonal structure strategy. JUPSA will also support UAC to improve functionality of the

partnership mechanism and its working committees (Partnership Committee,

Prevention, M&E, Gender, SBCC, and RMS committees) and to revitalize the civil society inter-constituency coordination team (CICC) at national and regional levels.

Output 3.1.2: Sustainable Financing Mechanism for the HIV Response in Uganda strengthened: Governance interventions will also support UAC, MoH and Ministry of Finance Economic Planning and Development (MoFPED) and the office of the Prime Minister to develop the operational framework for the AIDS Trust Fund and implement the policy on AIDS Trust Fund. The private sector, music dance and comedian industry will also be engaged in domestic resource mobilization. External initiatives for resource mobilization will be enhanced and JUPSA will support initiatives on resource tracking, transparency and accountability. Specifically, JUPSA will provide technical and financial support to the Country Coordinating Mechanism (CCM) for national planning, effective mobilization and utilization of Global Fund resources.

Output 3.1.3: A harmonized monitoring and evaluation system for the HIV and AIDS response built at national and sub national levels: Under this HLO, JUPSA will strengthen institutional capacity of key sectors for effective knowledge management and information systems. This will include technical and financial support for strengthening of integrated and comprehensive information systems that align to the national and international information requirements, provision of strategic information, support for compilation of national AIDS reports and annual joint AIDS reviews. JUPSA will also support national and sub national capacity for data generation, dissemination and utilization. The key sectors of Health, Education, Gender and Labor and UAC will be supported to ensure functionally linked information systems. Support will be provided to ensure that timely annual country HIV progress reports are generated and shared, annual Joint AIDS review reports are compiled and shared; and NSP midterm and end of term evaluation reports as well as Modes of Transmission Study reports. Support will also be provided to establish national and regional projection and estimation teams and annual community score cards and citizens reports on selected topical issues about the national HIV response.

Output: 3.1.4: Strategic alliances and Partnerships enhanced for the multi-sectoral HIV response: This HLO will include interventions to enhance strategic alliances and partnerships with a focus on integration, implementation, increasing resource allocation and commitment to HIV/AIDS from development partners, private sector, telecommunication companies, banks, media and academia. JUPSA will focus on enhancing strategic collaborations and new partnerships for an effective HIV response and promoting civil society and private sector innovations to re-energize the HIV response. Support will be provided to expand the "protect the goal" campaign, the Uganda Olympic Committee and Schools Sports league, Textile Industries as mechanisms for reaching adolescents and young people. JUPSA will also mobilize and promote private sector corporate social responsibility initiatives for the HIV AIDS response. JUPSA will further advocate and offer technical support to UAC, MOH and CSO's to work with key development priority sectors (Tourism, Transport, Energy and Mineral Development, and Agriculture) to integrate and implement strategies, plans and budgets that address HIV. JUPSA will also focus on advocacy for regional partnerships in key aspects such as laws on HIV Prevention, resource mobilization, Pharmaceutical industries and use of information technology in the HIV response.

Output: 3.1.5: Reforms in national and sub-national laws, policies and strategies for better alignment to international standards: JUPSA will support MARPS, PLHIV and civil society advocacy and other initiatives for review and amendments in existing national laws and policies that hinder effective HIV prevention. These will include amendments in the 2014 AIDS Act, the intellectual properties Rights Act to protect the production of cheap and accessible HIV medicines, capacity of the legislative leadership to participate in the promotion of human rights and gender equality initiatives, and support for partners in the Justice Law and Order Sector (JLOS) including Police, Prisons, Judiciary, Community paralegals, to promote human rights and gender equality in the context of HIV. Further, JUPSA will provide support to government and non-governmental initiatives to ensure improved legal policy framework for an effective response among cross-border migrants and refugee populations. Support will be provided to guide, conduct and finance implementation of the Stigma Index report and Gender Assessment studies and innovations to address stigma and discrimination. JUPSA will also strengthen the capacity of cultural and religious institutions as well as the media to promote equality and respect for human rights. The capacity of JUPSA participating

agencies and the national working group for Gender Equality shall be strengthened to ensure gender responsive HIV reporting using the Global compendium of gender responsive indicators.

Output 3.1.6: Capacity of key government and non-government institutions in gender responsive and human rights sensitive HIV programming strengthened: Key government sectors and non-government institutions including cultural and religious institutions, the private sector, PLHIV, CSOs will be supported to ensure that they have the knowledge and tools to formulate, execute and monitor gender responsive HIV policies, plans and budgets. This will include technical and financial assistance to the UAC and MoGLSD to steer implementation, monitoring and progress reporting (including regular gender assessments). Coalitions and networks of CSOs shall also be provided with training and guidance to develop tools for holding duty bearers accountable in delivering a gender responsive and rights based HIV response. Technical and financial support will be provided for advocacy and resource mobilization for special programs for sustainable social and economic empowerment, and entrepreneurship capacity for adolescents and young women living with HIV in selected high prevalence areas.

JUPSA Outcome 3.2: Capacity to implement and coordinate the JUPSA interventions enhanced: The evaluation of the second generation JUPSA identified some areas for improvement in the JUPSA implementation notably the M&E and performance tracking, coordination, and visibility of JUPSA. This JUPSA outcome includes three HLOs that will improve functionality of the JUPSA governance and coordination structures to ensure an effective and efficient JUPSA. This outcome will include support for planning, monitoring and reporting on JUPSA implementation in Uganda, and ensuring functionality of JUPSA governance and coordination structures. This outcome will also include enhancing functionality of the secretariat, visibility, increased advocacy, monitoring, and resource mobilization (including ensuring increased allocation of core PUNOs and extra-budgetary resources for HIV and AIDS), JUPSA tracking and periodic program reviews, as well as functionality of the Steering committee, Core Management team and JUPSA technical working groups.

Output: 3.2.1: Administrative and technical capacity for JUPSA implementation enhanced: Under this HLO, JUPSA will support critical human resources for the JUPSA program and will convene regular JUPSA steering Committee meetings as well as periodic JUPSA Core Management Group and UN Joint Team meetings to review program performance.

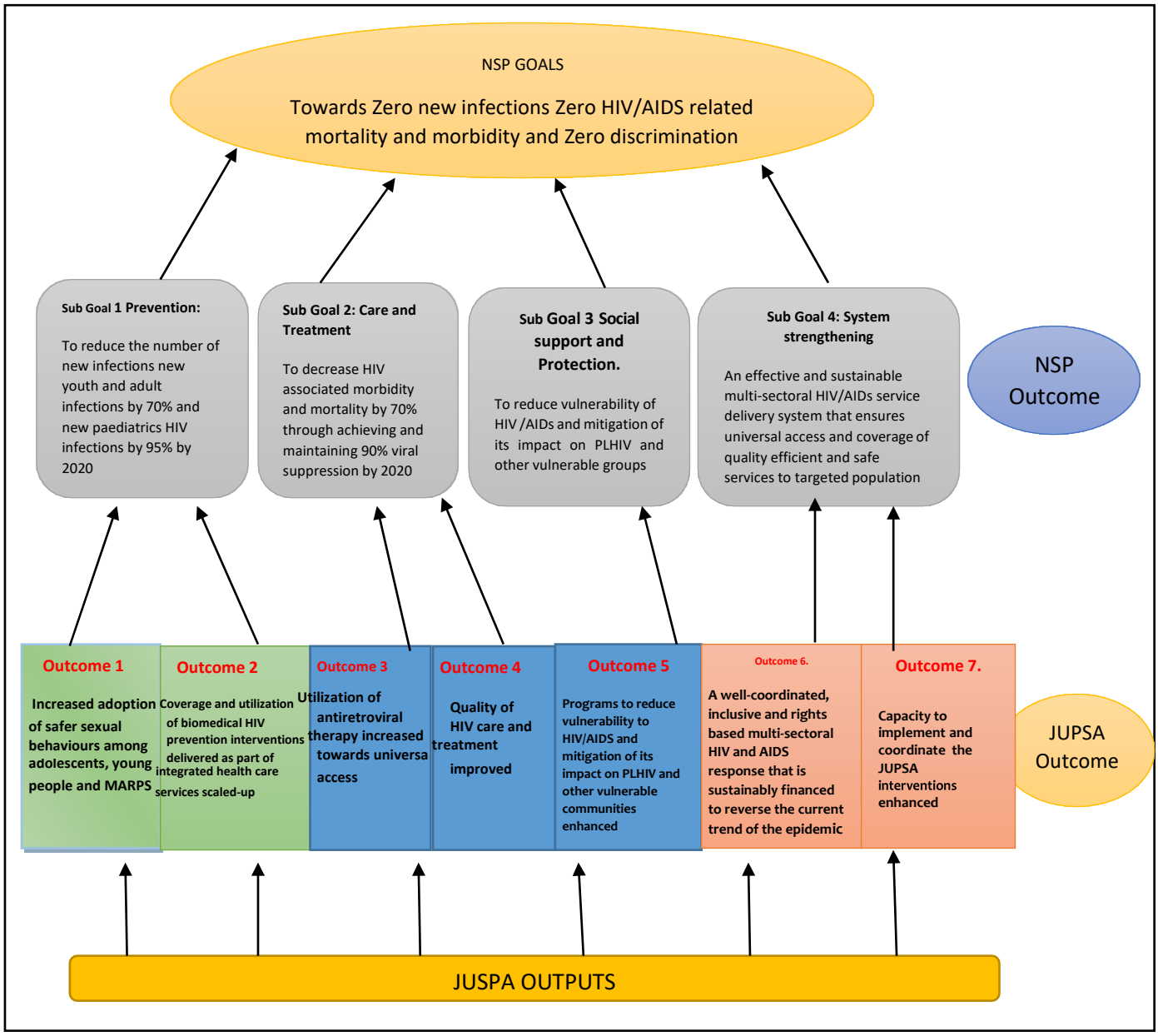
Output: 3.2.2: JUPSA monitoring and evaluation and performance tracking strengthened: This HLO includes activities aimed at building the capacity for JUPSA and national M&E and will ensure gender responsive HIV reporting using the WHO/UNW compendium of indicators. JUPSA will also coordinate annual planning for JUPSA stakeholders, conduct global and in-country UN wide related reporting functions, and provide technical support for the UNDAF planning, monitoring and reporting. Other activities will include bi-annual data quality reviews and validation.

Output: 3.2.3: Enhanced advocacy and resource mobilisation to support JUPSA implementation: Under the advocacy HLO, JUPSA public engagements including media campaigns will be supported to enhance its visibility. The JUPSA communication and advocacy strategy and resource mobilization strategy will be developed and operationalised.

3.3 Results framework

The results framework for JUPSA III has been developed to illustrate the extent to which JUPSA activities contribute to the outcomes of the NSP. While majority of JUPSA interventions are mostly upstream, these will contribute to outcomes of the NSP through strengthening of the national policy frameworks, advocacy and resource mobilization, leadership, coordination, strategic information, among others. JUPSA contributes to the achievement of the identified JUPSA outcomes as linked to the NSP Goals. JUPSA is however held accountable for achievement of the proposed outputs and lower level results. The Framework below shows the NSP outcomes to which the JUPSA interventions will directly contribute to (Figure 3). The results framework is attached (Appendix 2).

Figure 3: Link between the JUPSA outcomes and the NSP outcomes

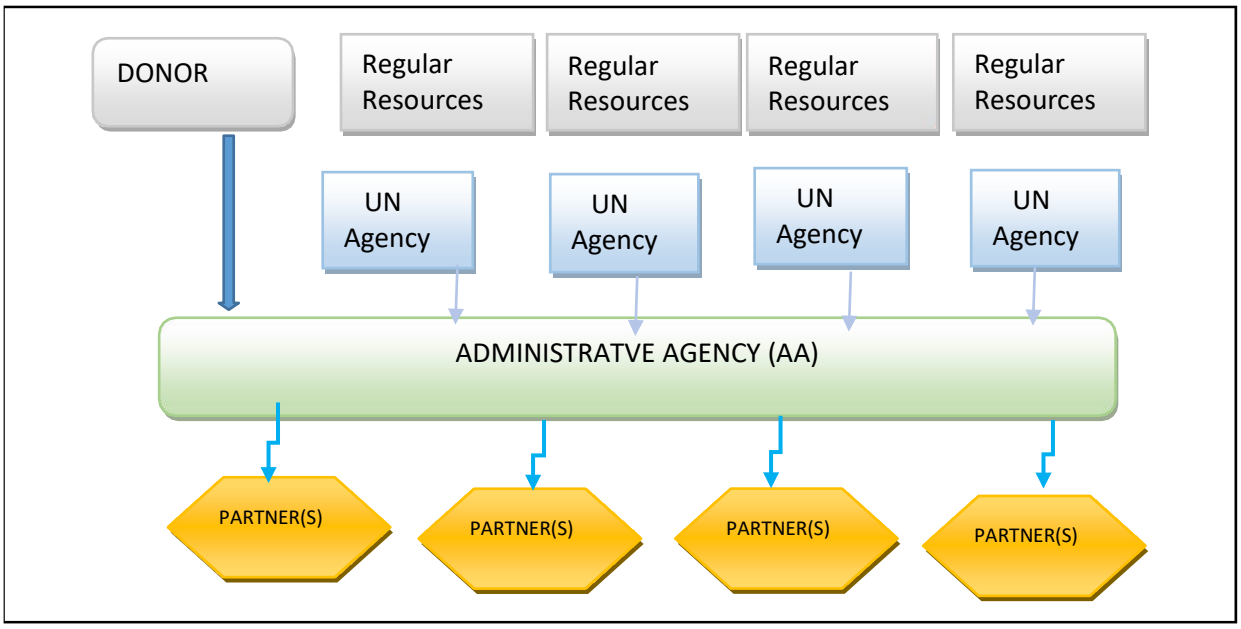


4.0 FUND MANAGEMENT ARRANGEMENTS

JUPSA will operate a Pooled funding arrangement as well as the Pass through funds management arrangements in line with the 2014 UNDG Guidance Notes on Joint Programming. This will enable smooth management of resources from the Core Agency fund and the UBRAF. Agencies operating at country level will undertake joint planning for all services to be delivered in the country. This is in the spirit of delivering as one - to have a joint planning: identifying and prioritizing critical gaps in service delivery and allowing the agencies take lead in the response in areas where they have comparative advantage. The joint activities for the JUPSA agencies will be consolidated with the JUPSA joint budget. The funds for this arrangement will be drawn from the current agency budgets through core and none core funds.

An Agency will be selected to serve as the Administrative Agency (AA) for this JUPSA program (UNDP). UNDP will be accountable for effective and impartial fiduciary management and financial reporting for the joint program. The pooled funds arrangement is used where JUPSA mobilizes resources jointly and are managed through one commonly agreed AA to support implementation of commonly agreed activities (Figure 4). In the pooled fund management arrangement, the Managing Agent (MA) is responsible for programmatic and financial accountability, narrative and financial reporting, supporting PUNOs in managing the JP, monitoring annual targets, and disbursing funds.

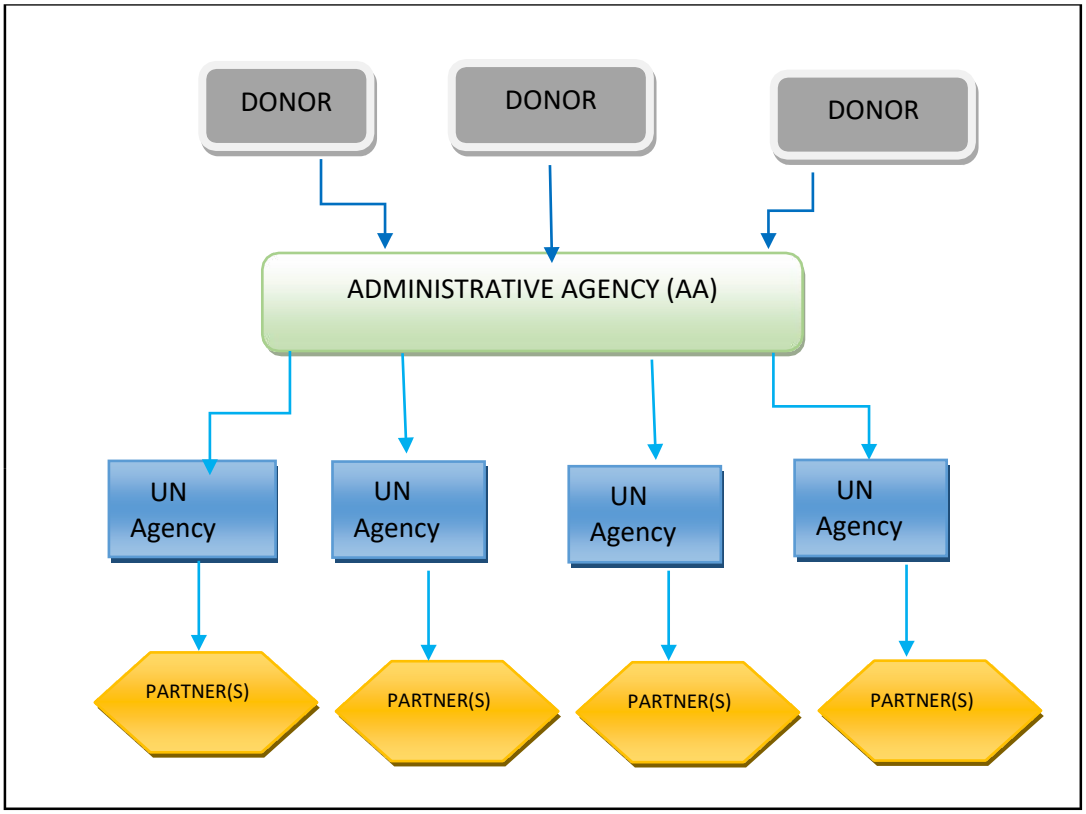
Figure 4: A Graphic presentation of the Pooled Funding arrangement.



The funds are received and disbursed through this agent to PUNOs. PUNOs will then request for funds from the AA for implementation directly or through national implementing partners and account for it separately. The AA is entitled to charge a fee to cover the costs of managing the fund. The AA signs an agreement with the funding partners, and a memorandum of understanding with the PUNOS for implementation.

A steering committee will provide strategic direction, oversight and has the authority to make decisions for the Joint program. The Administrative Agent is responsible for financial management, while each participating UN organization retains the programmatic and financial responsibility for the funds disbursed to it.

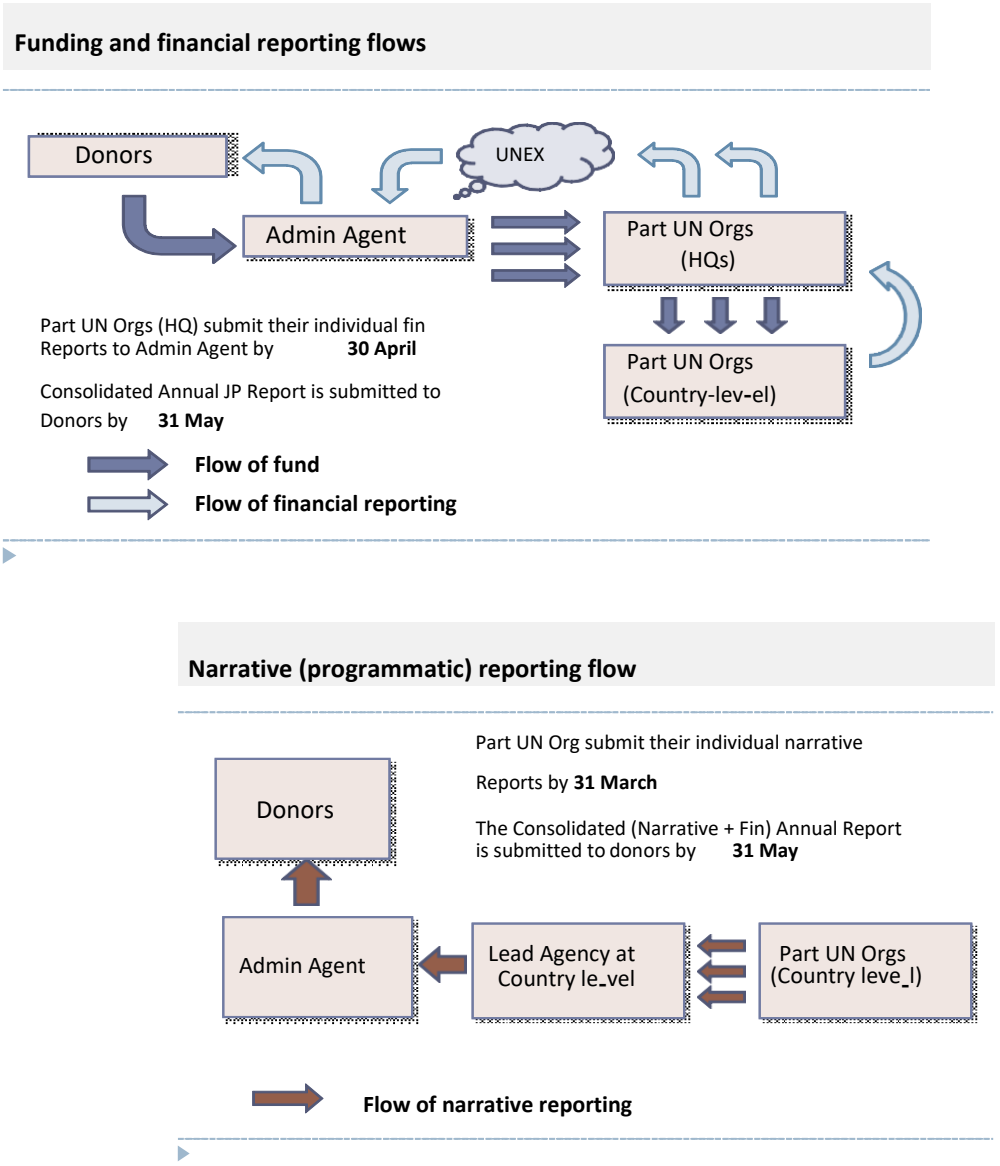
Figure 5: A Graphic presentation of the Pass through Funding arrangement



4.1 Transfer of Cash to National Implementing Partners

The implementing partners will undertake the JUSPA interventions. This requires formalising a framework between the PUNOS and the Implementing partners. The framework provides guidance on the transaction initiation, scope and size of disbursements and their frequencies. It also provides for the accountability, the funds retirements and reporting procedures. Other aspects governed by the framework include: monitoring, audits, quality assurance and the program review during the period of implementation.

Figure 6: JUPSA Funding and Reporting Flows



4.2 Financial Reporting

The AA for extra budgetary funds consolidates the financial reports of PUNOs and any disbursements of additional donor funds to the organizations over the reporting period. The Program coordination unit housed in the UNAIDS Secretariat will then aggregate the reports, highlighting key issues, achievements, lessons learned and recommendations for future action. The report undergoes a technical review by a Joint UN Team before it is forwarded to the UCD, which then submits to the CMG. The CMG will forward the reports for further review and analysis to the UNCT before they are presented for approvals to the JSC. The internal reviews have the participation of the Uganda AIDS Commission Secretariat and the Development Partners to appraise programme progress.

To ensure sound financial controls and monitoring of the program, the annual work plans and budgets are developed thorough a consultative and transparent process which ensure non-duplication of services, hence efficient deployment of, and accountability for the program resources.

4.3 Resources

4.3.1 Resource allocation/budget

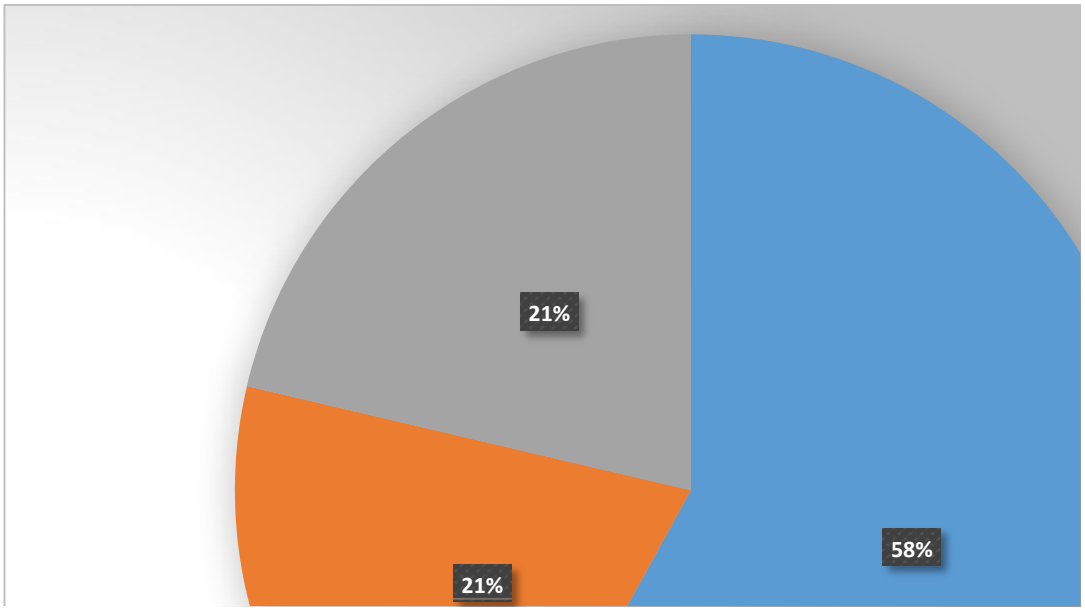
The costing for the JUPSA was developed using the ingredients approach. This approach identifies the inputs necessary for an activity or service. Once the inputs are identified, the quantities of the inputs are determined. Unit costs for each input are imputed to the inputs and a total cost for the input is determined according to the equation:

$$cost\ of\ services = number\ of\ service * unit\ cost\ of\ the\ service.$$

The units cost were guide by the UN rate guidelines for most of the personnel related activities while the programmatic supplies were informed by the supplier's current prices (2014/15 for procurements) along with GoU procurements and disposal guidelines (2014/15). These cost were adjusted for inflation.

The total cost of the five-year JUPSA is estimated at US $104.548 million. This will be allocated across the three thematic areas in proportions of 58% for Prevention, 21% for Care, Treatment, and Support, and 21% for Governance. These resources will be raised from the agencies core and non-core/extra-budgetary funds and also through the pooled funding mechanisms from the joint JUPSA resource mobilization efforts.

Figure 7: JUPSA Resource Allocation – 2016-2020



The Prevention inventions have been allocated a large share to ensure that prevention interventions are reinvigorated and scaled up. This is in line with the HIV Investment Case 2015-2025, which called for a rapid scale up of the key priority interventions in the first three years of implementation to reverse the rate of the new HIV infections. This allocation is also intended to complement other funding streams within the country. Table 7 below gives the detail breaks down of the high level output interventions that will be financed by the JUPSA.

Table 7: Summary of resource estimates for implementing the JUPSA 2016-2020

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Totals
	US $ in '000'					
Prevention						
Output 1.1.1: HIV integrated into investment, annual and financing plans of key sectors that address identified structural drivers of the HIV epidemic	105.7	94.8	58.4	94.9	36.5	390.2
Output 1.1.2: Programs addressing underlying socio-cultural and economic drivers of the HIV epidemic expanded	3,816.8	1,945.1	2,887.0	1,947.1	3,031.9	13,627.9
Output 1.1.3: Coverage of social and behavior change communication (SBCC) interventions with focus on adolescents, young people and key populations expanded to optimal levels	1,602.8	1,195.3	1,339.8	990.6	1,081.1	6,209.6
Output 1.2.1: Availability of stocks of HIV prevention commodities at service delivery points	3,524.6	3,645.3	3,550.0	3,508.7	3,507.5	17,736.1
Output 1.2.2: Biomedical HIV prevention interventions delivered to optimal coverage levels	3,770.5	3,405.9	2,776.2	2,210.7	2,458.2	14,621.5
Output 1.2.3: SRH/HIV interventions for adolescents and young people delivered at optimal coverage levels	1,881.7	1,621.0	1,428.4	1,595.3	1,528.5	8,054.8
Treatment, Care and Support						
Output 2.1.1: Guidance provided and capacity built for provision of standard ART care according to the new WHO recommendations	364.6	122.5	163.4	89.1	122.5	862.0
Output 2.1.2 : Institutional capacity for procurement and supply chain management systems enhanced	751.5	266.3	606.1	50.5	206.2	1,880.7
Output 2.1.3: Institutional capacity for tracking, retention and adherence monitoring of PLHIV on treatment strengthened.	260.3	229.9	229.9	169.9	550.0	1,440.1
Output: 2.2.1: Institutional capacity for HIV care and treatment monitoring including scaling up of viral load monitoring and surveillance of drug resistance and toxicity enhanced.	262.0	232.0	272.0	137.0	62.0	965.0
Output 2.2.2: Accelerated and streamlined implementation of HIV Co morbidities interventions	1,805.3	1,438.0	1,125.9	1,274.4	1,169.3	6,812.8
Output 2.2.3: Institutional capacity for HIV treatment and care quality improvement enhanced	625.4	656.7	623.1	537.5	606.8	3,049.5
Output 2.3.1: Enhanced capacity of government and communities to mainstream the needs of PLHIV, OVC, adolescents and other vulnerable groups into other development programs.	718.0	650.0	700.7	650.7	698.7	3,418.0
Output 2.3.2: Strengthened community capacities for food security, nutrition, and economic livelihood to mitigate the socio-economic impact of HIV/AIDS	930.0	720.0	775.8	435.4	320.3	3,181.6
Governance						
Output 3.1.1: Functional capacity of coordination structures at national and subnational levels strengthened	103.1	103.1	103.2	103.2	103.2	516.0

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Totals
	US $ in '000'					
Output 3.1.2: Sustainable Financing Mechanism for the HIV Response in Uganda strengthened.	799.4	30.1	661.8	113.5	661.8	2,266.5
Output 3.1.3 :A harmonized monitoring and evaluation system for the HIV and AIDS response built at national and sub national levels	1,666.7	4,394.1	1,690.0	4,312.4	1,668.3	13,731.5
Output 3.1.4: Strategic alliances and Partnerships enhanced for the multi-sectoral HIV response	125.9	125.9	126.0	126.0	126.0	629.8
Output 3.1.5: Reforms in national and sub-national laws, policies and strategies for better alignment to international standards	358.5	270.3	199.4	257.5	194.7	1,280.3
Output 3.1.6: Capacity of UAC, MOH, and other line ministries in gender responsive and Human Rights sensitive HIV Policy and Programming strengthened.	242.6	172.6	175.9	172.6	242.6	1,006.4
Output: 3.2.1: Administrative and technical capacity for JUPSA implementation enhanced	403.5	429.6	377.8	430.0	377.8	2,018.8
Output: 3.2.2: JUPSA monitoring and evaluation and performance tracking strengthened	53.2	21.0	24.0	21.0	30.0	149.3
Output: 3.2.3: Advocacy enhanced for JUPSA visibility	172.9	118.0	118.2	118.2	173.1	700.3
	24,345.0	**21,887.4**	**20,013.1**	**19,346.1**	**18,957.1**	**104,548.7**

4.3.2 Funds Gap Analysis

The agencies have indicated the future funding estimates for the period of the JUPSA 2016 to 2020. Table 8 below shows the projected resources from the agencies for the period 2016 -2020.

Table 8: Agency resource projections 2016-2020

Agency	2016	2017	2018	2019	2020	Total (us$)
FAO	*300,000*	*300,000*	*300,000*	*300,000*	*300,000*	*1,500,000*
ILO	100,000	100,000	100,000	100,000	100,000	500,000
IOM	600,000	300,000	300,000	300,000	300,000	1,800,000
UNAIDS	700,000	700,000	670,000	650,000	660,000	3,380,000
UNDP	*400,000*	*400,000*	*400,000*	*400,000*	*500,000*	*2,100,000*
UNESCO	487,486	545,774	612,030	686,933	772,448	3,104,671
UNFPA	7,000,000	7,000,000	7,000,000	7,000,000	7,000,000	35,000,000
UNHCR	493,503	414,802	351,442	301,473	261,179	1,822,399
UNICEF	4,774,800	3,841,600	3,291,300	2,586,800	2,664,700	17,159,200
UNWOMEN	297,819	297,819	322,819	297,819	320,819	1,537,095
WHO	465,000	465,000	465,000	465,000	465,000	2,325,000
Totals	15,618,608	14,364,995	13,812,591	13,088,025	13,344,146	70,228,365

An analysis of the anticipated resources against the estimated resource requirements resulted into a funding gap amounting to US 24,320,350 for the period 2016-2020. The table below shows the annual funding status for the JUPSA.

Table 9: Funding Gap Analysis- JUPSA 2016-2020

	2016	2017	2018	2019	2020	Totals
	US $ "000"					
Annual Resource Estimates	24,345.03	21,887.43	20,013.09	19,346.09	18,957.07	104,548.72
Pledges.						
CORE/UBRAF	15,618.61	14,365.00	13,812.59	13,088.03	13,344.15	70,228.37
Donors (Irish Aid)	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	10,000.00
Projected Commitments and pledges	17,618.61	16,365.00	15,812.59	15,088.03	15,344.15	80,228.37
Funding Gap	**6,726.42**	**5,522.44**	**4,200.49**	**4,258.07**	**3,612.92**	**24,320.35**

Assumptions in the Gap Analysis

i) Implementation arrangements are assumed to go as planned with no major operational changes.
ii) All pledges will be realised as projected.

4.4. Resource mobilization strategies

The success of the JUPSA programming rests on the assumption, that adequate resources will be available both at national and the sub national levels from the JUPSA agencies, Government of Uganda and bilateral partners. Resources for JUPSA implementation need to be viewed from the broader perspective, to include the human resources, logistics, infrastructure and equipment and finances necessary for program implementation. The UN Joint Team will leverage on available resources such as the Infrastructure, equipment and logistics from the GoU.

The resources estimates for the Program outstripped the projected available resources. This calls for a mechanism to bridge the funding gap during the period of implementation. The Joint UN team will explore the following to raise additional resources for the program.

Develop a Resource Mobilisation Strategy
The resource mobilisation strategy will provide guidance on how resources for the program will be raised. The strategy is critical as it complements efforts of the individual agencies in meeting objectives of the JUPSA.

The Joint UN team in Uganda operates the DaO frameworks, with the UN agencies delivering a joint program. The UNDAF seeks to among others meet the target of the sustainable development goals (SDGs). This requires a more sustained funding approach as opposed to the project or strategic outcome based funding mechanism. This therefore calls for an orderly, effective and efficient mobilization of resources on a sustainable basis. A functional resource mobilisation strategy should focus on promoting the following: Efficiency and effectiveness; Support creativity and innovative resource mobilisation strategies, while building on synergies with the GOU, Development partners and the Domestic resources; raise awareness of the HIV funding requirements; Strengthen capacity of the domestic stakeholders; take into account gender and socio-economic perspectives as well as the aspect of program ownership.

The strategy will highlight potential sources of funding, both domestic and foreign sources, when to raise the resources, who raises the resources, and will also highlight the expected outputs from such resources.

The other fund raising strategies that may be undertaken include:

i) Funding from the core agencies (agency specific core funding).

Advocacy will be done at various UNCT meetings to lobby for allocation of core resources by the agencies to support implementation of the JUPSA 2016-2020 strategy. The individual agencies may lobby for additional resources from their core budgets at the regional and head quarter level to target those critical and cost effective interventions that need to be scaled up or sustained in order to contribute to the realisation of the NSP goals. Furthermore, the agencies will advocate for more resources from bilateral agencies at their head quarter or regional level.

ii) Engagement of Global Ambassadors.

The Joint UN Team will explore ways of partnering with Global ambassadors in raising funds for some of its activities. The Ambassadors will be drawn from a pool of respectable and globally recognised personalities with the zeal to ending the HIV AIDS scourge. The personalities may be eminent academicians, politicians' diplomats, sports personalities, actors and actresses etc. Global ambassadors have the potential to raise resources through charities and appearances as guest to functions. They too will engage other stakeholders to create awareness on the activities of the UN agencies locally and regionally.

iii) National conferences.

The Joint UN team may hold a national conference(s) where donors (domestic and foreign) meet for among other issues, to raise funds for the JUPSA program, providing a venue for advocacy and lobbing for key strategic directions for the country. This may also be a venue to tap into new donors and partners for the HIV response in the country. Key participants would include the Foundations, philanthropist and the emerging economies in Asian and the Far East, who have traditionally not been very active in supporting the HIV response in Uganda. Such conferences will also discuss alternative funding mechanisms for the response including in kind contributions such as equipment and medicines, and sponsoring some in country activities.

iv) The Private sector and other domestic players.

These are some of the untapped recourse that would support some of the interventions for the HIV responses. In addition to providing in-house HIV services to the clients and their families, the Private sector will be courted to support the HIV response through their Social Corporate Responsibility. Many of the engagements such as dissemination of HIV messages and information, big meetings, Olympic activities, music and drama events and workshops could be sponsored by the private sector, where they are free to advertise and market their services. Resources realised from the meetings and events will be reallocated to fund the response.

VI) Ministries integrating HIV related budgets into their sectors

Integration of HIV activities into the sector or ministry budgets and implementation of those activities will provide an opportunity for the GoU to reprogram some of the vertical project interventions into the national budgeting process. This will ensure continuity of other interventions in the event of such projects coming to an end.

The above mechanisms in addition to improving on the efficiencies in implementation, minimising wastage, and ensuring proper use of resources and accountability will go a long way in attracting additional resources and sustainability of the programs.

5. PLANNING, MONITORING AND EVALUATION

One of the primary aims of the JUPSA is to consolidate planning and reporting. Following the national joint annual AIDS review (JAR), priority areas for the following year are identified and consultations are held with stakeholders to agree on areas to be supported by the UN. TWGs are convened to agree on annual results. Using the technical support, the DoL activities that work to achieve those results are selected along with

the agencies involved. The JUPSA budget is developed in the same way as reporting on the JUPSA. The JUPSA still uses the standard UN annual planning cycle (January- December). However, in order to ensure alignment with the GoU planning cycle (July-June), JUPSA planning and reporting are managed in two blocks of six months each, every 12 months.

5.1 Monitoring and evaluation arrangements

Monitoring of the JUPSA will be done throughout the duration of the programme. M&E of the programme of support is integrated with the Joint UN Team's annual work plan development to ensure that work of the UN builds on the achievements of the previous year(s) and is responsive to emerging needs. Progress will be tracked in a collaborative manner as a formal exercise through reporting systems agreed by the UNCT and informally during regular meetings of the Joint UN Team. Efforts will be made to engage external stakeholders for their input and feedback into the quarterly, mid-year and end of year review processes.

The MA is responsible for monitoring in accordance its regulations, rules and procedures applicable. A monitoring plan should include roles and responsibilities for monitoring, timing and methodology. Evaluation will aim to determine the relevance and fulfilment of objectives as well as the efficiency, effectiveness, sustainability and impact of JUPSA

Mid-year and Annual Review

The Joint UN Team will assess outcomes twice a year as mid-year and end-of-year internal reviews which are key accountability mechanisms for individual agencies and the Joint UN Team. The key steps in mid- year and annual review processes are:

- Thematic team members in each UN agency, in collaboration with the convenors of the thematic groups, will complete the monitoring tool matrix which will be prepared and shared by the UNAIDS Secretariat;
- The conveners of thematic groups will consolidate and submit their completed monitoring tool matrix to UNAIDS Secretariat biannually on agreed dates;
- The Joint UN Team on AIDS in collaboration with the UNAIDS Secretariat will review the results in relation to the expected outputs and assess whether the intended outcomes have been achieved.
- The mid-year and end-of-year review will have participation of key government partners and other partners. The reviews will also be used to determine future priorities;
- The UNAIDS Secretariat will produce a mid-year and annual report in consultation with the Joint UN Team on AIDS, consolidating results of all activities in relation to expected outputs and intended outcomes; and
- The mid-year and annual reports will be reviewed by the Joint UN Team on AIDS and will form the basis for reviewing the annual work plan and development of work plans for the next period.

5.2 Monitoring and evaluation plan

The M&E plan of the JUPSA is a management and policy guidance tool for tracking implementation of the JUPSA work plan, assessing achievement of its outcomes and channelling the resulting evidence to appropriate venues for application. It will enable monitoring and self-assessment of progress towards results and facilitate reporting on performance. The plan covers both the work plan and functioning of the Joint UN Team on AIDS. Further, the JUPSA M&E will be done within the new UNDAF framework and the Outcome Results Groups, and will align to the UNDAF planning and reporting templates and procedures. The specific objectives of JUPSA M&E plan are to: Ensure efficiency, quality control, completion of activities, clarity of roles and responsibilities and engagement of all partners; and Compare planned versus actual activities and outcomes.

The M&E plan will be used to generate data and enable:

- Analysis of outcomes in priority areas to which the JUPSA contributes;
- Assessment of key output results;
- Assessment of implementation of activities by agencies and UNAIDS Secretariat;

- Assessment and tracking of expenditures incurred against outputs and broad activities;
- Identification of lessons learned based on reviews and make recommendations on way forward; and
- Proposition of structures, mechanisms and methodological guidance for assessments and evaluations.

Working closely with UAC and other key government and CSO partners, the Joint UN Team on AIDS will use the following mechanisms to monitor performance of the JUPSA and ensure it supports the national M&E system and process:

- Rolling Annual Work plan and Budget;
- Six-monthly Financial and Programme Implementation Progress Reports;
- Full Annual Progress Report, linked to UAC JAR process; and
- Mid-Term Review (MTR) after three years of implementing JUPSA.

The M&E plan will enable and strengthen accountability of the Joint UN Team on AIDS through the following mechanisms:

- Team members receive official and formal notification on their roles and responsibilities from their HoAs;
- Individuals are expected to report regularly to their HoAs, demonstrating participation and contribution towards results; and

Indicators of participation in support to and contribution towards achieved results are part of each individuals regular annual performance review.

Indicators for the JUPSA

For this plan, indicators have been developed at outcome and output level. Further work needs to be done to develop activities and activity level indicators. For each output indicator, the UNCT will agree on targets and develop baseline information against which to measure progress.

Evaluation of the Joint UN Team on AIDS

Evaluation of the Joint UN Team and JUPSA will be conducted every two to three years. The assessment of performance of the Joint UN Team will focus on indicators of the successful establishment of the team and its effective functioning.

6. IMPLEMENTATION ARRANGEMENTS

6.1 Accountability mechanisms

Accountability is fostered through a results-based management approach within the Joint UN team on AIDS and each agency to ensure that processes, products and services contribute to achievement of planned outcomes and outputs. The Joint UN Team and its component agencies ensure good accountability for their involvement and performance in the national response with relevant systems, including a Monitoring and evaluation plan. The team reports to partners throughout the cycle of programme of support. There are two reports per year, the mid-year and annual review report of the JUPSA, which the UCD consolidates on behalf of participating UN agencies and submits to the Joint Steering Committee. The UNAIDS Secretariat has the overall responsibility to ensure accountability across all areas in the Division of Labour (DoL) on matters of leadership and advocacy, coordination, coherence and partnerships. UNAIDS also supports mutual accountability of the secretariat and cosponsors to enhance programme efficiency and effectiveness and to optimally deliver on the shared JUPSA outcomes.

Thematic Working Groups

JUPSA 2016-2020 has three thematic working groups (TWGs), which are aligned to the NSP thematic groups. The three groups include: Governance and Human Rights, HIV Prevention, and HIV Treatment, Care and Support (Table 9). The Prevention TWG focuses on interventions towards the NSP Sub-goal 1 (Reduced HIV new infections); The Treatment, Care and Support TWG focuses on support to NSP sub-goal 2 (Decreased HIV associated mortality and morbidity); and the Governance and Human Rights focuses on NSP sub-goal 4 (An effective and sustainable multi-sectoral HIV/AIDS service delivery system strengthened to ensure universal access of quality, efficient and safe services). Both the Prevention and Governance/Human Rights TWGs contribute to the NSP sub-goal 3 (Reduced vulnerability to HIV/AIDS and mitigate its impact on PLHIV and other vulnerable groups). The TWGs meet monthly.

Table 10: Thematic Working Group Chairs and Co-Chairs

Thematic Working Group (TWG)	Chair	Co-Chair
HIV Prevention	UNFPA	IOM
HIV Treatment, Care and Support	WHO	UNICEF
Governance and Human Rights	UNDP	ILO

The Terms of Reference for the TWGs include:

1. Set priorities for the UN action in the technical area based on national needs and gaps;
2. Develop and implement specific components of the JUPSA and its annual work plan;
3. Agree on technical support priorities for national response in the given technical area and how to deliver on them (operationalise technical support division of labour);
4. Discuss evidence and strategic issues in the key thematic area as they emerge and reach consensus/UN position;
5. Take lead in policy discussions regarding particular areas and keep abreast of developments, opportunities, challenges and bottlenecks in the national agenda;
6. In addressing bottlenecks, agree on any UN action required (i.e. ART stock outs, national rethink on HIV prevention and others);
7. Agree on linkages and representation at key national processes (such as National Prevention Committee, Education sector reviews, ART committee, AIDS decentralised response initiative) and agree on process for reporting back; and
8. Contribute with inputs to annual work plan and reports.

The Core Management Group (CMG)

UNAIDS is the lead agency, chairs and provides the secretariat for the core management group (CMG), prepares the agenda for discussion and follows up on implementation of recommendations. The CMG

meets every two months and reports to the Joint Steering Committee through the UCD. The CMG consists of Chairs and Co-Chairs (who are from non-convening agencies) of the TWGs and is chaired by the UCD. This group consists of senior HIV programme staff or deputies who work on behalf of the UN system bringing the system together to deliver on mandate of the TWGs.

Membership of this core group is extended to HIV focal points or technical officers of stakeholders participating in the JSC - UAC, MoH and key Government Ministries, Donors, Representatives of PLHIV, CSOs and the Private Sector. This ensures that JSC stakeholders, who are outside the UN family are updated and briefed on technical issues related to the functioning Joint Team and management of the Joint Programme.

The TOR for the CMG include:

1. Identify priorities for UN action on the AIDS response in future and identify key gaps that are relevant to the UN system;
2. Consolidate inputs from the TWGs and develop the JUPSA and annual work plan;
3. Negotiate agreement across the UN agencies on priorities;
4. Ensure implementation, oversight and monitoring of JUPSA within UNDAF and NSP;
5. Agree to operational and pooled funding modalities, including priority actions for use of extra-budgetary resources through pooled finance mechanism for approval by the Joint Steering Committee;
6. Oversee development and operationalisation of approaches to joint UN M&E of the UN response to AIDS ensuring alignment with national systems;
7. Review functioning of the Joint UN Team on AIDS and Uganda UN Technical Support DoL;
8. Address key issues of national importance in the national response as they emerge and propose recommendations for consideration by the UNCT;
9. Prepare agendas for Joint UN Team on AIDS and Joint Steering Committee (JSC) meetings on AIDS and follows up decisions/recommendations from the JSC; and
10. Ensure progress on UN learning/workplace action on AIDS.

The Joint Steering Committee

The Joint Steering Committee (JSC) provides overall oversight and governance for JUPSA through review of reports and other documents prepared by the CMG to solicit guidance and decision-making from JSC. The JSC is constituted by representatives from the UN Country Team (UN Agencies participating in the JUPSA, designated by the UNRC); GoU represented by UAC, MoH and other key line Ministries; Chair of AIDS Development Partners (ADP); Donors; Representatives of PLHIV, the umbrella CSO (UNASO), a representative of the private sector, MARPs networks, and academia. The Chairperson of JSC is the UN Resident Coordinator and the Co-chairperson is the Director General of UAC. UNAIDS provides the Secretariat for the JSC, prepares the agenda, and tracks implementation of recommendations. The Chairperson of CMG, in consultation with the Chairperson of JSC, calls for meetings of the JSC. The JSC meets twice a year.

Terms of Reference of the JSC

1. Discuss JUPSA requirements and priorities concerning, programme management, consistent and common approaches to programme costing, cost recovery, implementation modalities, results-based reporting and impact assessment, information management including appropriate GoU/UN and donor visibility; among others.
2. Review funds earmarked by donors to thematic areas, specific activities or agencies and prioritized or allocated within thematic clusters and ensure alignment of the allocations with the strategic development framework of the country and approved national priorities, and performance within the TWGs and if agencies do not deliver, such funds are reallocated;
3. For un-earmarked funds, to review and approve criteria for allocation of available JUPSA resources and to allocate available resources to thematic areas, making sure that the allocations are aligned with the strategic development framework of the country and approved national priorities. The

TWGs are responsible for prioritization within thematic areas and the CMG is to ensure that results are achieved;

4. Review and approve allocation of funds and ensure their conformity with requirements of the Standard Administrative Arrangement (SAA) between the Donor and Administrative Agency (AA) and MoUs;
5. Make decisions on allocation of un-earmarked funds. This is decided on the basis of prioritization, results based management and performance;
6. Ensure appropriate consultative processes take place with key stakeholders at country level in order to avoid duplication or overlap between the JUPSA and other funding mechanisms;
7. Review and approve periodic progress reports (programmatic and financial) and assess progress in achieving outcomes consolidated by the AA based on progress reports submitted by participating agencies.
8. Ensure consistency in reporting between outcomes;
9. Ensure annual review and appraisal of JUPSA in the context of wider joint programming;
10. Review reports and recommendations of CMG and make decisions on the governance of the JUPSA; and
11. Approve Terms of Reference and composition of CMG or other similar review bodies.

6.2 Heads of Agencies

The UN Head of Agencies in Uganda and their signatures are presented on page ix.

7. ANNEXES

Appendix 1: The JUPSA 2016-2020 Results Framework

	Key progress indicators,	Baselines	Targets	Means of verification	· Partners
<u>Outcome 1.1:</u> Increased adoption of safer sexual behaviours among adolescents, young people and MARPS					
Outcome Indicators	% of young people 15-24 years who correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission (strategic)	Total 38.9% Women 38.6% Men 39.3% (UAIS 2011)	Women 70% Men 70%	AIS Report	UBOS, MGLSD, MoH, MoESTS and partners
	Proportion of young women and men aged 15–24 who have had sexual intercourse before the age of 15 years.	Total 12.6% Female 13.1% Male 11.9% (UAIS 2011)	Female 7% Male 7%	AIS Report	UBOS, MGLSD, MoH, MoESTS and partners
	% of adults 15-48 who use a condom at the last high risk sex (sex with a non-marital partner) increased from 35% to 75%	35%	75%	AIS Report	UBOS, MGLSD, MoH, MoESTS and partners
	% of women 15-49 yrs who experience sexual and gender-based violence reduced from 28% to 23%	28%	23%	AIS Report	UBOS, MGLSD, MoH, MoESTS and partners
Output 1.1.1: HIV integrated into investment, annual and financing plans of key sectors that address identified structural drivers of the HIV epidemic	# of sectors budgets with HIV reflected in budget papers, sector HIV budget lines and expenditure reports	3 (2013)	9 (2020)	Sector Reports	UNAIDS, UNICEF UNFPA, IOM, FAO
Output 1.1.2: Programmes addressing underlying socio-cultural and economic drivers of the HIV epidemic expanded	# of cultural institutions with structured programs addressing structural and behavioural drivers of the HIV epidemic.	TBD	9	Annual Partner Reports and UDHS	UNICEF, UNAIDS, WHO, UNFPA
	# of adolescents and girls reached with SRH services.	TBD	50%	Annual Partner Reports and UDHS	UNFPA
	# of municipalities implementing Cities Fast Track HIV programmes targeting priority population groups	0	6	Annual Partner Reports and UDHS	UNFPA

	Key progress indicators,	Baselines	Targets	Means of verification	· Partners
Output 1.1.3: Social and behaviour change communication focusing on adolescents, young people and key populations	# of adolescents and young people out of school reached with HIV information annually	TBD	3,000,000	Annual Partner Reports and UDHS	UNICEF, UNDP, UNAIDS, UNFPA,FAO, IOM, WHO, UN WOMEN UNESCO
	# of regions that have implemented the Protect the Goal project.	0	12	Annual Partner Reports and UDHS	UNDP, UNAIDS, UNFPA,FAO, WHO UN WOMEN UNESCO
	# of peers trained in MARPS Programming to support community engagement initiates.	TBD	80%	Annual Partner Reports and UDHS	UNDP, UNAIDS, UNFPA,FAO, IOM, WHO, UN WOMEN UNESCO
<u>Outcome 1.2</u>: Coverage and utilization of biomedical HIV prevention interventions delivered as part of integrated health care services scaled-up					
Outcome Indicators	Proportion of HIV-positive pregnant women who receive anti-retroviral therapy (ART) to reduce risk of mother to child transmission.	92% HIV estimates 2014	98%	HMIS/ Projection estimate reports.	MoH, UAC, ACP WHO, UNFPA
	Estimated percentage of Child HIV infections from HIV positive women delivering in the past 12 months.	37%	80%	DHS/HMIS	MoH, UAC, ACP WHO, UNFPA
	Number of males circumcised per year.	878, 109 (2014 DHIS 2)	1,000,000 annually	DHS/HMIS	MoH, UAC, ACP WHO, UNFPA
	Percentage of adults aged 15-49 yrs. who tested for HIV in the last 12 months and know their results.	47% (2013)	80% (2020)	HMIS	MoH, UAC, ACP WHO
Output 1.2.1: Availability of stocks of HIV prevention commodities at service delivery points	# of Health workers trained in Procurement Supply Chain Management	50	600	Program Training Reports	MoH, UAC, WHO, UNFPA
	% unmet need for FP among people living with HIV	TBD	10% (2020)	Population-based survey	MoH, UNFPA, Global Fund

	Key progress indicators,	Baselines	Targets	Means of verification	· Partners
	# of additional districts supported to establish the e-ordering system	40	200	Program Installation reports	MoH, UAC, WHO, UNFPA
	% of designated community condom distribution points with stocks of female and male condoms	TBD	80%	DHIS/CLMIS	MoH, UNFPA
	# of Male condoms procured	60,000,000	100,000,000	Program procurement reports	MoH, UAC, WHO, UNFPA
Output 1.2.2: Biomedical HIV prevention interventions delivered to optimal coverage levels	# of district Health workers trained in SMC for sustainable service delivery.	TBD	160	Program Training Reports	MoH, UAC, WHO, UNFPA
	# of adults reached with HCT services in selected districts annually	0	1,000,000	Program Reports	MoH, UAC, WHO, UNFPA, IOM
	% of all people living with enrolled HIV treatment centres receiving SRH services including FP	TBD	60%		MoH, UNFPA, WHO
	% of MARPs in 6 regional hotspots reached with SRH/HIV services	TBD	60%		MoH, UNFPA, IOM
	# of MTCT community engagements conducted in targeted districts.	TBD	TBD	Program Reports	MoH, UAC, WHO, UNFPA
Output 1.2.3: SRH/HIV interventions for adolescents and young people delivered at optimal coverage levels	# of refugees supported with SRH/HIV, at all stages of humanitarian programming	TBD	300,000	Program reports	MoH, UAC, WHO, UNFPA, IOM
	# of health workers trained in delivery of friendly SRH services to adolescents and young people.	TBD	600	Program Training Reports	MoH, UAC, WHO, UNFPA
	% of HCs in selected 15 districts providing AYFSRH/HIV services	TBD	50%	MOH Program Reports	MoH, UAC, WHO, UNFPA
Outcome 2.1: Utilization of antiretroviral therapy increased towards universal access.					
Outcome 2.1: Utilization of antiretroviral therapy increased towards universal access.	% of adults and children with HIV infection receiving antiretroviral	50.1% (DHIS 2 2014)	80% (2020)	MOH Program Reports	MoH, UAC, WHO,
Output 2.1.1: Guidance provided and capacity built for provision of standard ART care according to the new WHO recommendations	# of health workers trained in revised WHO policies and guidelines.	**0**	480 (2020)	Program Training Reports	MoH,WHO,

	Key progress indicators,	Baselines	Targets	Means of verification	· Partners
Output 2.1.2: Institutional capacity for procurement and supply chain management systems enhanced	# of health workers trained in commodity quantification;	TBD	480 (2020)	Program Training Reports	MoH,WHO,
	# of additional health facilities with functional Web based ordering systems	0	200 (2020)	MOH Programme Reports	MoH,WHO,
Output 2.1.3: Institutional capacity for tracking, retention and adherence monitoring of PLHIV on treatment strengthened.	# of additional Health facilities using Open eMRS;	0	200 (2020)	Program Installation reports	MoH,WHO,
Outcome 2.2: Quality of HIV care and treatment improved.					
Output 2.2.1: Institutional capacity for HIV care and treatment monitoring including scaling up of viral load monitoring and surveillance of drug resistance and toxicity enhanced.	# of survey reports generated and disseminated for PDR and ADRS	0	2 PDR survey report (Yrs. 1 $ 4), 2 ADR survey reports (Yrs. 3 and 5)	MOH Program Reports	MoH,WHO,
Output 2.2.2 Accelerated and streamlined implementation of HIV Co morbidities interventions	# of Health workers trained on screening and management of co morbidities.	TBD	300 in Hepatitis, 200 trained in Visceral Leishmanaisis,	Program Training Reports	MoH,WHO,
Joint Programme Outcome 2. 3: Programs to reduce vulnerability to HIV /AIDS and mitigation of its impact on PLHIV and other vulnerable communities enhanced.					
Outcome indicators	% of care, protection and support to orphans and other vulnerable children (disaggregated by sex) and their families through case management.	TBD	90%	OVC MIS, Child Help Line Reports	UNICEF, MGLSD
	Ratio of Orphans to non-orphans (10-14yrs attending school)	0.9	0.96	EMIS	UNICEF, MoESTS MOLGs
	% of households receiving social assistance	4.50%	6%	Social Protection Sector Review Reports Digital platforms	UNICEF, MGLSD MOLGs

	Key progress indicators,	Baselines	Targets	Means of verification	· Partners
	Proportion of girls aged 15–19 who have experienced sexual violence	18.90%	At least 5% reduction	DHS, The National VAC Survey Report	UNICEF, MGLSD MOLGs
Output 2.3.1: Enhanced capacity of government and communities to mainstream the needs of PLHIV, OVC, adolescents and other vulnerable groups into other development programs.	# of social welfare workers trained in basic skills and practices of child protection.	_	500 (2020)	Program Training Reports	FAO, UNICEF,IOM
	Household dietary diversity score among targeted households	North 5.7, Karamoja 3.8	6.5 (2020)	Program Reports	FAO, UNICEF,
Output 2.3.2: Strengthened community capacities for food security, nutrition, and economic livelihood to mitigate the socio-economic impact of HIV/AIDS	Assessment and guidelines for integrating FNS in HIV counselling, care and treatment services developed	TBD	TBD (2020)	Program Reports	FAO, UNICEF, UN W
	# of households/communities trained on good agricultural practices, basic nutrition in context of mitigation of impact of HIV and AIDS.	TBD	TBD (2020)	Program Training Reports	FAO, UNW UNICEF,
GOVERNANCE AND HUMAN RIGHTS					
Outcome 3.1: A well-coordinated, inclusive and rights based multi-sectoral HIV and AIDS response that is sustainably financed to reverse the current trend of the epidemic*					
Outcome indicators	HIV national policy composite index scores	0.546	95%	NCPI surveys	UAC, MOH
	%age of domestic and international AIDS Spending categories and financing sources	GOU 11.2 External 68 Out of pocket 20.8	GOU 40 External 50 Out of pocket 10	NASA	UAC, MOH MOFPED
Output 3.1.1: Functional capacity of HIV and AIDS coordination structures at national and subnational levels strengthened	# of LGs with functional AIDS Task Forces.	TBD	90%	UAC Annual reports	UAC, MOLGS,
	# of Committee meeting conducted.	-	24.00	Meeting Minutes	UNAIDS, UNICEF UNFPA, FAO
Output 3.1.2:Sustainable financing mechanisms for the HIV Response in Uganda strengthened	Existence of functional HIV trust fund	None (2015)	One	UAC Annual reports	UAC UNAIDS, MOFPED
	# of AIDs funds tracking surveys conducted.	0	3 (2020)	NASA Reports	UAC UNAIDS,

	Key progress indicators,	Baselines	Targets	Means of verification	· Partners
	# of GFATM proposals developed and submitted in time	0	6 Proposals 2020	UAC Annual reports	UAC UNAIDS, UNFPA, WHO, UNICEF
Output 3.1.3: A harmonized monitoring and evaluation system for the HIV and AIDS response built at national and sub national levels	# of UAC and sectoral joint programme reviews conducted	1 Annual JAR Conducted (2015) 3 Sectoral Review Conducted (2015)	Annual JAR, Annual HIV Country reports, NSP Midterm, and end term evaluations, HIV gender Assessments by	NSP and Sectoral Joint Review Reports; UAC Programme Reports	UAC UNAIDS, UNFPA, WHO, UNICEF
	Estistance of a fully functional and centralized tracking and reporting system	None (2015)	One	One Annual review report	UAC UNAIDS, UNFPA, WHO, UNICEF
	# of National, regional and Districts HIV estimates and projections	One National and Nine regional	One national, 10 regional and 112 district HIV estimates	One Annual review report	UAC UNAIDS, UNFPA, WHO, UNICEF
Output 3.1.4: Strategic alliances and Partnerships enhanced for the multi-sectoral HIV response	# JUPSA program reviews conducted	0	1	One Annual review report	UAC UNAIDS, UNFPA, WHO, UNICEF
	# of non-traditional partnership promoted for social responsibility	2	6 (2020)	UAC Annual reports	ALL PUNOs
Output 3.1.5: Reforms in national and sub-national laws, policies and strategies for better alignment to international standards	Second Stigma index report produced	1st Stigma index report Produced (2013)	2nd Report produced by 2020.	NAPHOPANO , UAC Programme Reports	UAC UNAIDS, UNFPA, WHO, UNICEF
	% of PLHIV and CSO coalitions to with gender responsive and human rights included in their HIV plans and budgets	0	60#	NAPHOPANO , UAC Programme Reports	UAC UNAIDS, UNFPA, WHO, UNICEF, IOM

Appendix 2: The JUPSA 2016-2020 annual rolling work plan

Key Actions/ Interventions.	Yr. 1	Yr.2	Yr.3	Yr. 4	Yr. 5
JUPSA Outcome 1.1 Increased adoption of safer sexual behaviours among adolescents, young people and MARPS	**Activity Schedule**				
Output 1.1.1: HIV integrated into investment, annual and financing plans of key sectors that address identified structural drivers of the HIV epidemic					
1.1.1.1 Enhance sector leadership advocacy for integration of priorities and coordination of government, sector and civil society partners to contribute to sector targets					
1.1.1.2 Support capacity building for sector technical and policy leadership in HIV integration					
Output 1.1.2: Programmes addressing underlying socio-cultural and economic drivers of the HIV epidemic expanded					
1.1.2.1 Support to systematic programming and mobilization of resources for sustained and intensified community interventions by cultural and religious leaders.					
1.1.2.2 Support institutions to develop/review and implement institutional action plans through existing structures					
1.1.2.3 Support Capacity building of leaders and technical people of religious and cultural institutions in SRHR/HIV programming					
1.1.2.4 Support to tracking of implementation against set targets by cultural and religious institutions					
1.1.2.5 Support Capacity building of MoGLSD as lead agency for cultural institutions responses and IRCU for FBOs					
1.1.2.6 Support the development of common guidance on tracking and tools for urban centre HIV responses targeting underlying drivers of the epidemic and behavior change					
1.1.2.7 Support urban centres to develop, mobilize resources and implement HIV/SRHR campaigns in collaboration with celebrities, private sector, etc. to promote HIV prevention					
1.1.2.8 Support generate of evidence on alcohol and substance abuse and utilize to inform advocacy and programming including capacity building of service providers					
1.1.2.10 Support the develop capacities in sustainable livelihood skills for young people and MARPs					
1.1.2.11 Generate evidence on the situation responses and utilize it to shape programming (including baseline programming data) for Karamoja					
1.1.2.12 Support leadership programmes in Karamoja region for a supportive programming environment targeting adolescents and young people for SRHR/HIV (including cultural and religious leaders serving as champions for the girl child empowerment)					
1.1.2.13 Support programmes for addressing socio-cultural and economic factors that affect school HIV infection, sexual and reproductive health, self-empowerment and schooling					
1.1.2.14 Support programmes for enrolment and retention of HIV/AIDS affected girls in primary, secondary and tertiary institutions in Karamoja region					
1.1.2.15 Support programmes for delivery of SRHR/HIV services to young girls in Karamoja region					
1.1.2.16 Support programmes for livelihood skills building and linkages to economic development initiatives for HIV/AIDS affected girls in Karamoja					
Output 1.1.3: Coverage of social and behaviour change communication (SBCC) interventions with focus on adolescents, young people and key populations expanded to optimal levels					
1.1.3.1 Strengthen SBCC coordination structures at national, sector and local government levels					
1.1.3.2 Develop common guidance and tracking tools for SBCC programmes					

Key Actions/ Interventions.	Yr. 1	Yr.2	Yr.3	Yr. 4	Yr. 5
1.1.3.3 Support capacity building in SBCC program delivery at national, sector and local government levels					
1.1.3.4 Review, revitalize, institutionalize PIASCY and mobilize resources for implementation					
1.1.3.5 Support application of the new secondary school curriculum that integrates sexuality education					
1.1.3.6 Develop comprehensive sex education protocols for out of school young people and utilize different channels including sports, entertainment, and livelihood programmes to expand coverage of HIV programmes					
1.1.3.7 Support programming for HIV positive adolescents in the school setting					
1.1.3.8 Expand programming for Protect the Goal Campaign utilizing different channels					
1.1.3.9 Work with the arts and media industry to expand HIV communication programmes					
1.1.3.10 Support social media innovations in delivery of SRH/HIV information to adolescents and young people					
1.1.3.11 Support CSE initiatives and life skills training for out of school HIV/AIDS infected and affected young people					
1.1.3.12 Support capacity enhancement for partners in SBCC programming for MARPs					
1.1.3.13 Build capacity of peers among MARPs groups and support community engagement initiatives					
1.1.3.14 Generate evidence on sizes and profiles of MARPs to support targeted programming					
JUPSA Outcome 1.2 Coverage and utilization of biomedical HIV prevention interventions delivered as part of integrated health care services scaled-up					
Output 1.2.1: Availability of stocks of HIV prevention commodities at service delivery points					
1.2.1.1 Support the training of selected programme managers and health workers in PSCM and provide with appropriate tools and guidelines					
1.2.1.2 Support selected districts to establish the e-ordering systems beginning with option B+ accredited facilities					
1.2.1.3 Support establishment and functionality of a logistics management system for condom distribution at community level					
1.2.1.4 Procure male and female condoms					
1.2.1.5 Promote condom awareness, education and use with special focus on the female condom					
1.2.1.6 Sustain advocacy for mobilization of local resources for condom programming and removing programming bottlenecks including capacity for commodity handling and quality assurance					
1.2.1.7 Support procurement of SMC surgical tools with special focus on re-usable surgical kits for sustainable service delivery					
Output 1.2.2: Biomedical HIV prevention interventions delivered to optimal coverage levels					
1.2.2.1 Support adaptation and implementation of new WHO guidelines and technologies					
1.2.2.2 Support training of Surgical Medical Circumcision teams in all Regional Referral Hospitals and HCIVs					

Key Actions/ Interventions.	Yr. 1	Yr.2	Yr.3	Yr. 4	Yr. 5
1.2.2.3 Support SMC surgical camp for 5 prisons					
1.2.2.4 Support adverse event monitoring and mitigation					
1.2.2.5 Support SMC advocacy and community education (including use of champions)					
1.2.2.6 Support review and revision of the SMC policy and standard operating procedures (SoPs) to capture infant SMC					
1.2.2.7 Support adaptation and implementation of new WHO HCT guidelines					
1.2.2.8 Support functionality of HCT coordination structures					
1.2.2.9 Support HCT programming for adolescents, young people and couples e.g. thru campaign approaches with cultural and religious institutions, integration into SRHR programmes					
1.2.2.10 Conduct a programme review and revise eMTCT strategy and operational plan					
1.2.2.11 Sustain advocacy for eMTCT including review/document the campaign at regional and national levels					
1.2.2.12 Conduct the eMTCT impact assessment					
1.2.2.13 Support interventions for addressing unmet need for FP among people living with HIV - HW training in LTPM FP; SRH service delivery through HIV treatment centres					
1.2.2.14 Support HW mentorships to improve quality HIV service delivery: update mentorship tool; train and support regional mentorship teams					
1.2.2.15 Support delivery of eMTCT services in selected districts					
1.2.2.16 Support community engagement in delivery of biomedical HIV interventions including peer support mechanisms and organized groups of people living with HIV in selected					
1.2.2.17 Support functionality of coordination mechanisms for eMTCT					
1.2.2.18 Develop and support application of common MARPS service delivery and reporting tools					
1.2.2.19 Support the MoH MARPs hubs network programming (mainly linked to sex work in urban settings):					
1.2.2.20 Support MARPs programme delivery in selected fishing communities					
1.2.2.21 Support for functionality of MARPs coordination structures at national and sub-national levels					
1.2.2.22 Develop contingency plans for delivery of SRH/HIV services in emergency settings, mobilize resources, coordinate partners and support service delivery in displaced communities.					
1.2.2.23 Support expanded programming on universal infection control and post exposure prophylaxis					
Output 1.2.3: SRH/HIV interventions for adolescents and young people delivered at optimal coverage levels					
1.2.3.1 Build capacity of HWs for delivery of friendly SRHR services to adolescents and young people					

Key Actions/ Interventions.	Yr. 1	Yr.2	Yr.3	Yr. 4	Yr. 5
1.2.3.2 Support national resource mobilization strategies for AYF/SRHR from among others the CSF and AIDS Trust Fund					
1.2.3.3 Advocate for innovations in AYFSRHR/HIV service delivery within the public health system including establishment of model health/social facilities and youth friendly windows at health facilities					
1.2.3.4 Support delivery of comprehensive AYFSRHR in selected districts					
1.2.3.5 Support community engagement and support mechanisms including peer networks and young people/adult partnerships					
1.2.3.6 Review and support implementation of the National SRHR/HIV strategy					
1.2.3.7 Support coordination of the multisectoral adolescent and young people programs to enhance harmonization and optimal resource mobilization and engagement of the target populations					
Outcome 2.1: Utilization of antiretroviral therapy increased towards universal access					
Output 2.1.1: Guidance provided and capacity built for provision of standard ART care according to the new WHO recommendations					
2.1.1.1 Provide TA for adaptation of the global guidelines					
2.1.1.2 Updating, printing, reproduction and dissemination of the updated guidelines and related tools					
2.1.1.3 Support TOTs for national and regional trainers on Implementation of revised guidelines					
2.1.1.4 Conduct training for district health workers in high burden and priority districts (including refugee settlements) for district implementation of the revised guidance.					
Output 2.1.2 : Institutional capacity for procurement and supply chain management systems enhanced					
2.1.2.1 Support training for 600 health workers in commodity quantification					
2.1.2.2 Support the generation of the annual quantification report					
2.1.2.3 Support the roll out the Web based ordering system to 200 additional health facilities					
2.1.2.4 Support the training of additional 600 Health workers trained in commodity tracking					
2.1.2.5 Support the development of the PSM plans at national level					
2.1.2.6 Support the Quarterly commodity security meetings					
Output 2.1.3: Institutional capacity for tracking, retention and adherence monitoring of PLHIV on treatment strengthened.					
2.1.3.1 TA for development of the system-based patient tracking					
2.1.3.2 Procure Computer equipment					
2.1.3.3 TA for design and development of the EWI system					

Key Actions/ Interventions.	Yr. 1	Yr.2	Yr.3	Yr. 4	Yr. 5
2.1.3.4 Support monthly mentorship visits					
2.1.3.5 Support conducting of survey in EMRS facilities and report writing					
Outcome 2.2: Quality of HIV care and treatment improved					
Output: 2.2.1: Institutional capacity for HIV care and treatment monitoring including scaling up of viral load monitoring and surveillance of drug resistance and toxicity enhanced					
2.2.1.1 Procure TA for the designing and development of the EWI system for drug resistance					
2.2.1.2 Facilitate Drug resistance monitoring (tools development; and field sample collection)					
2.2.1.3 Support report generation and dissemination meetings					
2.2.1.4 Support monitoring of toxicity in pregnant mothers					
2.2.1.5 Support quarterly meeting for Partner coordination					
Output 2.2.2: Accelerated and streamlined implementation of HIV Comorbidities interventions					
2.2.2.1 Support the training of health workers in management of Viral Hepatitis					
2.2.2.2 Support supervision to facilities and Focal areas for hepatitis management					
2.2.2.3 Procure and distribute basic diagnostic kits for Viral Hepatitis					
2.2.2.4 Support training of health workers in management of Visceral Leishmaniasis					
2.2.2.5 Support supervision to facilities and Focal areas for management of Visceral Leishmaniasis					
2.2.2.6 Support training of Health workers in Management of NCDs among ART patients					
2.2.2.7 Support supervision to facilities and Focal areas for management of NCDs in ART patients					
2.2.2.8 Procure and distribute basic kit for management of NCDs					
2.2.2.9 Development of guidelines for TB /HIV integrations.					
2.2.2.10 Support training for TB/HIV; and supervision on DHIS2:					
2.2.2.11 Support capacity building of Health worker capacity to screen prison entrants for TB and HIV including health workers in Remand homes					
2.2.2.12 Support orientation of 80 prison personnel on TB/HIV screening and management among inmates					
2.2.2.13 Reproduction/printing of TB/HIV IEC Materials and work aids as well as the recording and reporting forms;					
2.2.2.14 Support annual Prison Stakeholders meetings to raise the profile of the TB/HIV issue in the prisons					
2.2.2.15 Support Quarterly meetings					
2.2.2.16 Conduct operational research in relevant TB /HIV interventions					

Key Actions/ Interventions.	Yr. 1	Yr.2	Yr.3	Yr. 4	Yr. 5
Output 2.2.3: Institutional capacity for HIV treatment and care quality improvement enhanced					
2.2.3.1 Facilitate review and updating of existing national quality of care tools					
2.2.3.2 Support printing, reproduction and dissemination of the updated tools					
2.2.3.3 Support capacity building for national and regional TOT for implementation of the revised standards on quality of care improvements					
2.2.3.4 Support capacity building at district for implementation of the revised standards					
2.2.3.5 Support partner coordination and engagement for Quality of care Improvement					
2.2.3.6 Support the mentorship in lab techniques for collection, packaging and transportation for VL, EID samples in health facilities with high samples rejection rates					
2.2.3.7 Support central team to conduct 4 annual national stakeholders' hub coordination meetings					
2.2.3.8 Support the review and production of the integrated national lab hub guidelines					
2.2.3.9 Strengthening the 14 regional lab quality coordination committee's capacity to supervise, monitor and report performance of HIV lab activities (sample referral, EQA, quality audit)					
Outcome 2.3: Programs to reduce vulnerability to HIV /AIDS and mitigation of its impact on PLHIV and other vulnerable communities enhanced.					
Output 2.3.1: Enhanced capacity of government and communities to mainstream the needs of PLHIV, OVC, adolescents and other vulnerable groups into other development programs					
2.3.1.1 Provide technical and financial assistance for the development of the national policy and costed strategy on child protection involving review of OVC policy and NSPPI 2					
2.3.1.2 Provide technical and financial support to GOU and partners to identify existing training needs of formal and informal social welfare workers including OVC households and caregivers and train them on CP core modules, including in protection and care for Vulnerable children					
2.3.1.3 Provide technical and financial support to GOU and the national social workers association to institutionalize, accredits, classify and implement standards and code of conduct for social welfare workforce at all levels					
2.3.1.4 Provide technical and financial support to DGLS to deliver effective services for prevention and response to violence, abuse, neglect, and exploitation of all vulnerable children including cases of FGM/C, Child marriage, teenage pregnancy and children with disabilities					
2.3.1.5 Provide technical and financial support the GOU to implement the harmonized coordination mechanism at national and sub-national level, including supporting regular coordination meetings, standardized reporting on data and trends, and follow up of agreed actions to protect all vulnerable children					
Output 2.3.2: Strengthened community capacities for food security, nutrition, and economic livelihood to mitigate the socio-economic impact of HIV/AIDS					
2.3.2.1 Develop criteria for assessment and guidelines for integrating FNS in HIV counselling, care and treatment services					
2.3.2.2 Demonstrate to communities/households technologies and better practices for prioritised commodities that are nutrient dense, marketable /profitable					

Key Actions/ Interventions.	Yr. 1	Yr.2	Yr.3	Yr. 4	Yr. 5
2.3.2.3 Training of affected households/communities on good agricultural practices, basic nutrition in context of mitigation of impact of HIV and AIDS					
2.3.2.4 Promote access to production and processing technologies that are labour saving and enhance production for PLHIV in the affected households					
2.3.2.5 Develop and disseminate food and nutrition information and education materials					
2.3.2.6 Train agriculture extension workers on food and nutrition in context of addressing HIV and AIDS impact for PLHIV					
2.3.2.7 Facilitate engagement of agricultural extension workers with other service providers for HIV and AIDS treatment and care					
2.3.2.8 Develop and promote social protection community-based models for enhancing economic livelihoods for households affected by HIV&AIDS					
2.3.2.9 Promote advocacy for Convention 202 on social protection floors, for the establishment of social security responses for persons with chronic sickness, including HIV&AIDS					
JUPSA Outcome 3.1: A well-coordinated, inclusive and rights based multi-sectoral HIV and AIDS response that is sustainably financed to reverse the current trend of the epidemic					
Output 3.1.1: Functional capacity of coordination structures at national and subnational levels strengthened					
3.1.1.1 Provide technical and financial support to UAC for the review, strengthening and harmonization of HIV and AIDS Coordination structures at national, sector, regional and district level					
Output 3.1.2: Sustainable Financing Mechanism for the HIV Response in Uganda strengthened					
3.1.2.1 Provide funding and technical guidance to UAC to develop a multi-sectoral financing strategy for the national response					
3.1.2.2 Support processes for the establishment of the ATF regulations, including development of an operations framework and implementation structures of the Trust fund					
3.1.2.3 Provide support to civil society and private sector to engage in the promotion and mobilization of resources towards the national response, including the ATF					
3.1.2.4 Provide technical and financial support to identify and re-invest efficiency saving in the national response					
3.1.2.5 Provide funding for the Civil Society Advocacy group and GEHTT in generating evidence for and advocating for gender integration in the AIDS Trust Fund					
3.1.2.6 Provide technical and financial assistance to UAC for tracking AIDS spending by sector (NASA)					
3.1.2.7 Provide technical and financial support for national planning , effective mobilization, utilization and accountability of Global Fund resources					
Output 3.1.3 :A harmonized monitoring and evaluation system for the HIV and AIDS response built at national and sub national levels					
3.1.3.1 Provide technical and financial assistance to UAC to establish a functional system for tracking, analysing and regular reporting on all structural and behavioural response indicators as indicated in the national M&E plan					
3.1.3.2 Provide technical guidance and financial support to compile the Annual country HIV progress reports, Quarterly reports, ANC and ART reports					
3.1.3.3 Provide technical guidance and financial support to conduct the Annual Joint AIDS review					

Key Actions/ Interventions.	Yr. 1	Yr.2	Yr.3	Yr. 4	Yr. 5
3.1.3.4 Strengthen capacity of key government actors and CSOs to conduct gender responsive and transformative HIV/AIDS evaluation and reporting					
3.1.3.5 Provide technical and financial assistance for regular decentralized level data validation / Support improved reporting through DHIS 2					
3.1.3.6 Provide technical assistance to strengthen capacity of Government and CSOs in HIV projection and estimation.					
3.1.3.7 Provide technical guidance and financial assistance for population based surveys and routine surveillance process (AIDS Indicator surveys, Annual Surveillance surveys)					
3.1.3.8 Conduct the annual gender assessment of the national HIV response using the gender and HIV Score card					
3.1.3.9 Support a comprehensive HIV/AIDS program review and develop a new HIV/AIDS 5-year strategic plan					
3.1.3.10 Review/ develop sector HIV strategies, plans, guidelines and popularize among government and civil society partners.					
Output 3.1.4: Strategic alliances and Partnerships enhanced for the multi-sectoral HIV response					
3.1.4.1 Provide Secretariat support for effective coordination of the ADP Group					
3.1.4.2 Provide technical guidance and financial support to adopt and translate the HIV/AIDS guidelines for the International Olympic Committee as a platform for engaging Adolescents and young people					
3.1.4.3 Mobilise and Promote private sector initiatives like Stanbic and Barclays bank, Oscar Industries, MTN, UTL, water companies, Hotels and tourism sites that demonstrate corporate social responsibility for the HIV AIDS response					
Output 3.1.5: Reforms in national and sub-national laws, policies and strategies for better alignment to international standards					
3.1.5.1 Support the Uganda law reform to draft appeals for amendments in the legislations					
3.1.5.2 Support CSOs to advocate for passing of the substance and drug abuse bill					
3.1.5.3 Support advocacy initiatives of civil society, UWOPA, Human Rights Forum, PLHIV networks for review and amendments in oppressive laws including the AIDS Act 2014.					
3.1.5.4 Build capacity of the legislative leadership to participate in the promotion of human rights and gender equality initiatives					
3.1.5.5 Provide support for partners in the JLOS sector (Police, Prisons, Judiciary, Community paralegals) to promote human rights and gender equality in the context of HIV					
3.1.5.6 Provide technical guidance and financing for CSO to implement and monitor anti stigma guidelines					
3.1.5.7 Support development and implementation of simplified guidelines for Media on gender responsive and Human rights sensitive reporting					
3.1.5.8 Provide training for media to understand and correctly apply existing laws and policies in their media work for reforms in regressive laws and policies as well as advocacy for better services					
3.1.5.9 Support adoption of global and regional policy guidelines for increased access of HIV prevention, treatment, care and support among refugees and cross-border migrants					
3.1.5.10 Support institutional capacity of OPM, Immigration, and International NGOs to integrate HIV prevention and care services for refugees and cross-broader migrants					

Key Actions/ Interventions.	Yr. 1	Yr.2	Yr.3	Yr. 4	Yr. 5
3.1.5.11 Harmonize the draft statutory instrument on HIV Non-discrimination with the HACPA, for cabinet approval					
3.1.5.12 Develop a communication strategy for popularising the statutory instrument on HIV Non Discrimination in selected sectors of Education, Internal Affairs and Private sector organizations					
Output 3.1.6: Capacity of key government and non-government institioins in gender responsive and human rights sensitive HIV policy and programming strengthened					
3.1.6.1 Provide enterprise development assistance and training to women's associations and women's entrepreneurs including WLHIV					
3.1.6.2 Advocate for and mobilise resources for special programmes for sustainable social and economic empowerment for adolescents living in high HIV prevalence regions					
3.1.6.3 Develop individual and group level capacities in entrepreneurship and business development for adolescents living with HIV high prevalence areas					
3.1.6.4 Provide technical support, tools and training for cultural and religious leaders and selected organizations and networks of women living with HIV to advocate for reforms and change in gender biased religious and cultural practices that impact on decisions to access and use of HIV prevention and AIDS treatment services.					
3.1.6.5 Provide training and tools to PLHIV and CSO coalitions to monitor gender responsive and human rights sensitiveness in HIV plans and budgets					
Outcome 3.2: Capacity to implement and coordinate the JUPSA interventions enhanced					
Output: 3.2.1: Administrative and technical capacity for JUPSA implementation enhanced					
3.2.1.1 Support the HR for the JUPSA program					
3.2.1.4 Convene Regular JUPSA steering Committee meetings					
3.2.1.3 Convene periodic JUPSA Core Management Group and UN Joint Team meetings					
Output: 3.2.2: JUPSA monitoring and evaluation and performance tracking strengthened					
3.2.2.1 Coordinate Annual planning process for JUPSA stakeholders					
3.2.2.2 Capacity building for JUPSA and national M&E					
3.2.2.3. Provide training for JUPSA and the National M&E Technical Working Group in Gender responsive HIV reporting using the WHO/UNW compendium of Indicators					
3.2.2.4 Conduct global and in-country UN wide related reporting functions					
3.2.2.5 Provide technical support for the UNDAF planning, monitoring and reporting					
Output: 3.2.3: Advocacy enhanced for JUPSA visibility					
3.2.3.1 Support JUPSA public engagements					
3.2.3.2 Support JUPSA media campaigns					
3.2.3.3 Support development and implementation of JUPSA communication and advocacy strategy					
3.2.3.4 Develop a resource mobilization strategy, including leveraging UN resources for the HIV response					