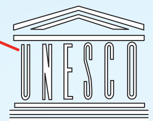
Delivering as One UN on AIDS in Uganda



The Joint UN Programme of Support for AIDS in Uganda 2007-2012

Delivering as One UN on AIDS in Uganda:

The Joint UN Programme of Support for AIDS in Uganda 2007-2012

prepared by
The Joint UN Team on AIDS

Produced by: Joint United Nations Programme on HIV/AIDS (UNAIDS) 2009

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of UNAIDS concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

Any part of this document may be reproduced without permission but the copy or extract must include an acknowledgement of the **Joint United Nations Programme on HIV/AIDS (UNAIDS)**. Commercial use of these materials is prohibited without the prior written permission of the UNAIDS Secretariat in Uganda.

To order more copies of this publication please contact:

The Secretariat
Joint UN Team on AIDS (UNAIDS)
P.O. Box 24578
Kampala, Uganda
Fax: +256-414-340113

Webpage for RC Uganda:
http://www.undg.org/unct.cfm?CountryID=UGA&fuseaction=Resident%20Coordinator%20Office&module=Rco&page=CountryRCO

Webpage for UNAIDS
http://www.unaids.org

Acknowledgements

This document on the Joint UN Programme of Support on AIDS for Uganda has been produced through the efforts of the members the Joint UN Team on AIDS. On behalf of the Resident Coordinator, the UNAIDS Secretariat is responsible for consolidating this effort.

The Joint UN Team on AIDS is grateful to the Government of Uganda and the Partnership Committee of Uganda AIDS Commission for the useful feedback that has been provided during the various stages of developing the Programme. They are equally grateful for the support and feedback provided by the AIDS Development Partners.

The Joint UN Team acknowledges the support of Tom Barton for document editing and design.

The United Nations system in Uganda is committed to supporting the Government and the people of Uganda in their efforts in implementing the National Strategic Plan for HIV and AIDS 2007/2008 – 2011/2012.

Table of Contents

Table of Contents i
Foreword by the Resident Coordinator iii
Executive Summary v
List of Acronyms vii
1. Supporting an Effective National Response 1
1.1 The HIV Epidemic in Uganda 1
1.2 UN reform & improving aid effectiveness 6
2. Joint Support – Maximising Value 9
2.1 The contribution of the UN system 9
2.2 How the UN works 9
2.3 Funding the Joint UN Programme 12
3. Programming for Strategic Results 13
3.1 Developing the Joint UN Programme 13
3.2 Contents of the Joint Programme 14
3.3 Mainstreaming and rights 15
3.4 Multisectoral HIV prevention & education 19
3.5 Care, treatment and social support 23
3.6 M&E, surveillance & strategic information 27
4. Managing the Joint UN Programme 29
4.1 Technical support division of labour 29
4.2 Structures and relationships 29
4.3 Administering the Joint UN Programme 33
4.4 Risk analysis 34
5. Accountability – M&E of Joint UN Programme 37
5.1 Annual Joint UN planning/reporting cycle 37
5.2 Performance monitoring & evaluation 39
5.3 Monitoring 41
5.4 Evaluation 43
References 45
ANNEXES 47
Annex 1: HIV Epidemic & MDGs in Uganda 47
Annex 2: Development of the Joint Team and Joint Programme (summary) 51
Annex 3: Joint Agreement 52
Annex 4: UN Division of Labour, Uganda 55
Annex 5: 5-year plan for Joint UN Programme on AIDS (results matrix) 57
Annex 6: Indicator matrix for monitoring Joint UN Programme 63
Annex 7: Framework for measuring performance of joint programme management 66
Annex 8: National HIV & AIDS PMM System 67

Foreword by the Resident Coordinator

Millennium Development Goal 6 calls on the UN to support countries to halt and begin to reverse the spread of HIV. In the 1990s, Uganda was one of the few countries globally to have made progress toward this MDG and thereby reduce the human suffering associated with AIDS. The complex evolution of the epidemic has, however, meant that there is now a worrying reversal of past gains. The number of new infections in Uganda continues to grow year on year and there is substantial evidence of far reaching social and economic impacts of the epidemic.

National stakeholders have responded to this context by developing a National HIV and AIDS Strategic Plan that places a renewed focus on HIV prevention. This focus is essential if Uganda is to make progress toward their commitment to the goal of Universal Access to HIV prevention, treatment, care and support that was endorsed by UN member states at the UN General Assembly High Level meeting on AIDS in 2006.

The UN in Uganda is a central player in supporting the national HIV and AIDS response. With over 20 full time and 30 part time staff and a wide breadth of technical expertise, the UN assists government and non-governmental stakeholders to deliver a truly multi-sectoral response.

The UN system is committed to improving the effectiveness of its response to HIV and AIDS in Uganda through the establishment of a Joint UN Team on AIDS and a Joint UN Program of Support. These changes are part of the wider UN reforms occurring globally.

In light of these commitments, it is my pleasure to present this 5 year Joint UN Program of Support on AIDS, which for the first time unites the HIV and AIDS work of all UN agencies under a common results framework. These results respond directly to the priorities laid out in the National HIV and AIDS Strategic Plan for 2007/8 – 2011/12.

The Joint Program of Support is delivered through a Joint UN Team on AIDS that brings together 14 UN Agencies, Funds and Programmes working under an agreed upon Division of Labour. This way of working reflects UN reform globally and I sincerely believe will lead to an accelerated, more effective and highly accountable UN response to HIV and AIDS in Uganda.

At the time of printing of this document, the Joint team has been operational for two years and is in the sixth quarter of implementing the Joint programme. This represents two years of reform on Delivering as One UN on HIV[1]. There have been achievements, challenges and many lessons learned. These experiences will be of great value for other UN reform processes here in Uganda and elsewhere.

Theophane Nikyema
UN Resident Coordinator

[1] See 2008 Report for details on progress

Signatories to the Joint Agreement[2]

The undersigned, duly authorised representatives of the respective Participating UN Organisations, have signed this Memorandum of Understanding in the English.

For UNAIDS Secretariat
Signature: (signed)
Name: Mai Harper
Title: Country Coordinator

For UNICEF
Signature: (signed)
Name: Keith Mckenzie
Title: Representative
Place: Kampala
Date: 7 December 2007

For UNDP
Signature: (signed)
Name: Theophane Nikyema
Title: Representative

For UNFPA
Signature: (signed)
Name: Hassan Mohtashami
Title: Representative a.i.

For ILO
Signature: (signed)
Name: Jurgen Schwettman
Title: Director

For UNOHCR
Signature: (signed)
Name: Kyle Ward
Title: Chief Programme Support
And Management Services

For WFP
Signature: (signed)
Name: Tesema Negash
Title: Representative

For WHO
Signature: (signed)
Name: Melville George
Title: Representative

For UNODC
Signature: (signed)
Name: Sandeep Chawla
Title: Officer-in-Charge

For IOM
Signature: (signed)
Name: Jeremy Haslam
Title: Head of mission

For UNESCO
Signature: (signed)
Name: Augustine Omare Okurut
Title: Secretary General

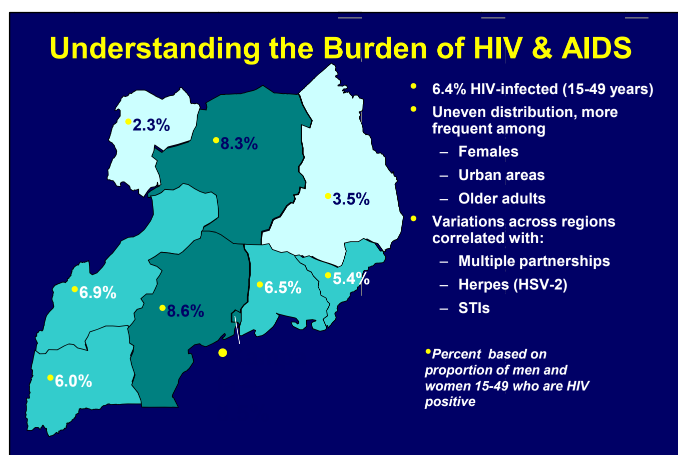
These were the signatories as of 31st December 2007. We have subsequently been pleased to welcome FAO and WB/IDA as full members of the team.

[2] See Annex 3: Joint Agreement - Memorandum of Understanding between The Participating UN Organizations and The United Nations Development Programme regarding The Operational Aspects of a Joint Programme on AIDS in Uganda.

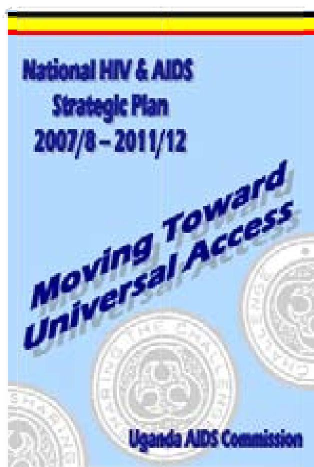
Executive Summary

HIV and AIDS in Uganda

The HIV epidemic in Uganda is big – and the national response is big – but the epidemic continues to expand faster than the response. This trend is very worrying to all observers. The Government of Uganda and all its partners, including the UN, need to rethink and redouble our efforts if Uganda is to make significant progress on our shared commitments to halting the spread of HIV and guaranteeing universal access to HIV and AIDS treatment for all who need it. Simply put, these are the core targets of the Millennium Development Goal (MDG) 6, to which most countries in the world, including Uganda, have endorsed.



To address the increasing gap, the Government of Uganda and a wide range of stakeholders developed a new National HIV & AIDS Strategic Plan (NSP 2007/8-2011/12): "Moving toward Universal Access". The NSP made a bold, strategic choice to focus on reducing the number of new infections. Without this focus, the numbers in need of treatment and social support will continue to rise each year – along with human suffering. The central aim of reducing HIV incidence is to be achieved by realigning prevention efforts to where new infections are now occurring, focusing on rolling out cost-effective interventions first, and ensuring proven new approaches are widely accepted (e.g., promoting medical male circumcision, addressing discordance).



UN reform

Globally, the UN system is being reformed to improve its effectiveness and relevance at country level. In the area of HIV and AIDS, the UN reforms emphasise more resources, more efficient use of resources, and enhanced ownership by national governments as the best ways to support an effective national AIDS response. In Uganda, the reform process led to developing a **Joint UN Team on AIDS** (Joint Team) with a **Joint UN Programme of Support on AIDS** (Joint Programme). The main objective of this approach is to improve the coherence and effectiveness of UN support and to position the UN as a **strategic partner** to the national AIDS response.

The Joint UN Team on AIDS

The Joint Team has embraced a number of key principles, including harmonisation, alignment, simplification, accountability and achieving impact. These principles reinforce a single UN team speaking with one voice and collaborating on a consolidated Joint Programme aimed at having real impact for people in Uganda. The Joint Programme builds on the comparative advantages of each Agency, as well as maximising their collective influence in supporting the national response to HIV and AIDS. In implementing its key principles, the Joint Team will concentrate on the following roles:

- Up-stream work: contributing to the national and international evidence base, best practices, policy dialogue, planning and strategies, & strengthening systems;
- Consistency: consistent & sustained presence in a coherent framework of support;
- 'Honest broker': unbiased contribution to communicating, facilitating, & convening.

Joint UN Programme of Support for AIDS

The UN Development Assistance Framework (UNDAF) is the platform for the Joint UN Programme on AIDS. It was updated in 2007 to reflect shifts in the epidemic in Uganda and the priorities of the new National HIV and AIDS Strategic Plan 2007/8-2011/12. The 5 year Joint UN Programme of Support on AIDS is the operational plan for the UNDAF strategy on HIV and AIDS. It outlines the 'unity of purpose', the collective influence and responsibility of all the UN agencies toward the national HIV response. The Joint Programme has one overarching outcome linked to the UNDAF and four strategic country programme outcomes with respective outputs.

The UNAIDS Secretariat, and the Thematic Working Group on Monitoring and Evaluation of the Joint UN Team on AIDS will be responsible for joint programme monitoring, evaluation and reporting to the UNCT, Resident Coordinator, and the annual Joint AIDS Programme Review (JAR) led by the Uganda AIDS Commission (UAC). Working closely with the UAC and other key government and CSO partners, the Joint Team will track performance of the Joint Programme and ensure that it supports the National HIV and AIDS Strategic Plan.

UNDAF outcome 4: Reduction of HIV incidence by 40% during the period of the NSP with a strategic focus on addressing the social, cultural, & economic causes of vulnerability & better targeting of high risk groups

Country Programme Outcome 4.1: AIDS response is mainstreamed & sustained across government with improved planning, programming, budgeting, coordination, systems integration & a stronger policy & legislative environment (which is human rights based & gender sensitive).

Country Programme Outcome 4.2: Universal access to evidence based, quality assured HIV prevention services that lead to improved service uptake, sustained behaviour change & a reduction in the number of new infections.

Country Programme Outcome 4.3: Quality of life of people infected & affected by AIDS improved & their vulnerability reduced.

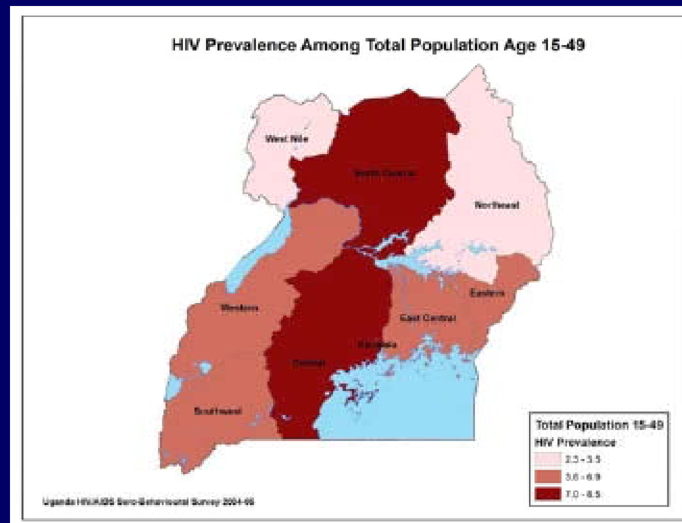
Country Programme Outcome 4.4: Effective management of response to HIV/AIDS pandemic by all actors, is being guided by generation & use of strategic information & a comprehensive system of results based measurement & surveillance.

List of Acronyms

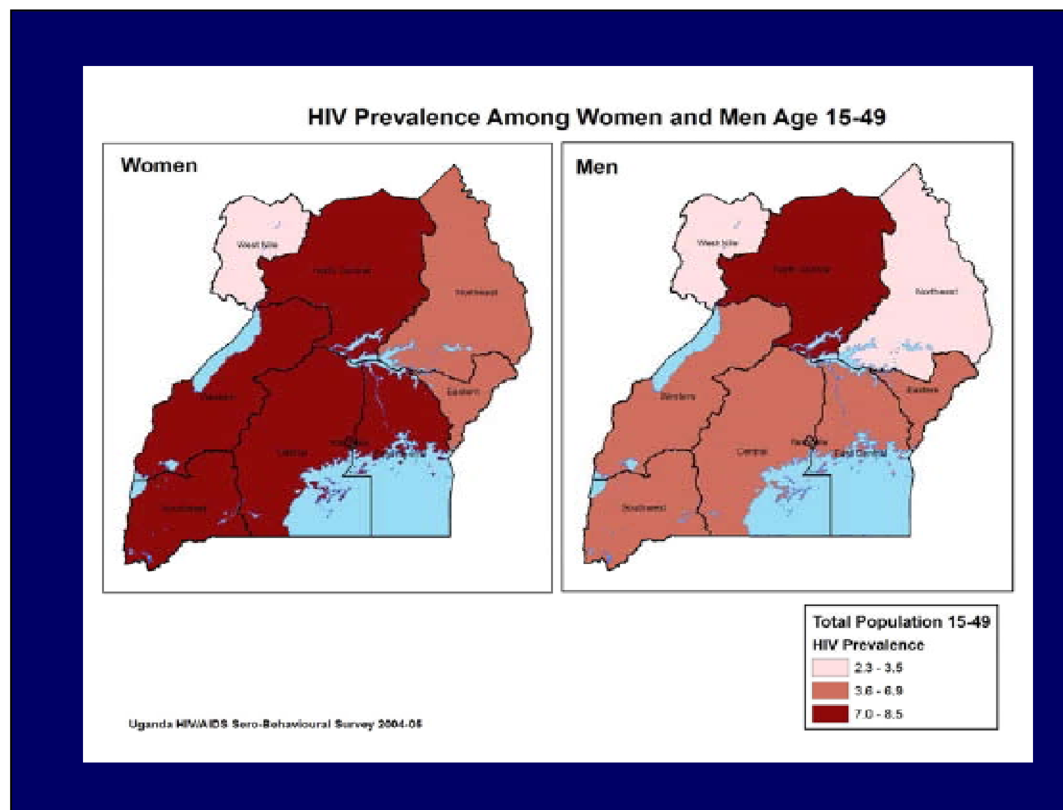
AA ....Administrative Agent
ADPs..........AIDS Development Partners
AIDS..........Acquired Immune Deficiency Syndrome
ANC ....Ante-natal care
ART ....Anti-Retroviral Therapy
ARVs ....Anti-retroviral drugs
BCC ....Behaviour Change Communication
CBOs..........Community Based Organizations
CP ....Country Programme
CSOs..........Civil Society Organizations
GFATM ....Global Fund to Fight AIDS, Tuberculosis, and Malaria
GoU ....Government of Uganda
GTT ....Global Task Team
HBC ....Home Based Care
HC ....Health Centre
HCT ....HIV Counselling & Testing
HIV............Human Immunodeficiency Virus
HoA ....Heads of Agencies
IDPs...........Internally Displaced Persons
IEC ....Information, Education & Communication
IGA............Income Generating Activities
ILO ....International Labour Organization
IOM ....International Office on Migration
JAR............Joint AIDS Review
JP ....Joint Programme
JUPSA ....Joint UN Programme of Support on AIDS
M&E...........Monitoring & Evaluation
MARPs........Most At Risk Populations
MDGs.........Millennium Development Goals
MoGLSD .....Ministry of Gender Labour and Social Development
MoH...........Ministry of Health
MoLG ....Ministry of Local Government
MTCT ....Mother-to-Child Transmission
NAFOPHANU...National Forum for PHA/PLHIV Networks in Uganda
NGOs ....Non-Governmental Organizations
NSP ....National Strategic Plan
OHCHR.......Office for the Coordinator of Humanitarian Affairs
OVCs..........Orphans & Vulnerable Children
PEAP..........Poverty Eradication Action Plan
PEPFAR ......President's Emergency Plan for AIDS Relief
PHA ....Persons living with HIV (see PLHIV)
PLHIV ....People Living with HIV (preferred term)
PMMP.........Performance Measurement & Management Plan
PMT ....Programme Management Team
PMTCT ....Prevention of Mother to Child Transmission
PO.............Participating Organization
STIs...........Sexually Transmitted Infections
TB ....Tuberculosis
ToRs..........Terms of Reference
TWGs.........Technical Working Groups
UAC...........Uganda AIDS Commission
UACP ....Uganda Aids Control Project
UACS ....Uganda Aids Control Secretariat
UCC...........UNAIDS Country Coordinator
UN.............United Nations
UNAIDS......United Nations Joint Programme on AIDS
UNASO.......Uganda Network of Aids Service Organizations
UNCT ....United Nations Country Team
UNDAF ....UN Development Assistance Framework
UNDGO .....United Nations Development Group Office
UNDP.........United Nations Development Programme
UNFPA ....United Nations Populations Fund
UNGASS.....United Nations General Assembly Special Session
UNICEF ......United Nations International Children's Education Fund
UNODC ......United Nations Office on Drugs and Crime
UNTWG ......UN Technical Working Groups
USAID........United States Agency for International Development
WFP...........World Food Programme
WHO ....World Health Organization

Understanding the Burden of Disease

Magnitude and Heterogeneity of Risk



- 6.4% HIV-infected (15-49 years)
- But Heterogeneous distribution, more frequent among
  - Females
  - Urban areas
  - Older adults
- Disparities across regions correlated with:
  - Multiple partnerships
  - HSV-2
  - STIs



1. Supporting an Effective National Response

1.1 The HIV Epidemic in Uganda

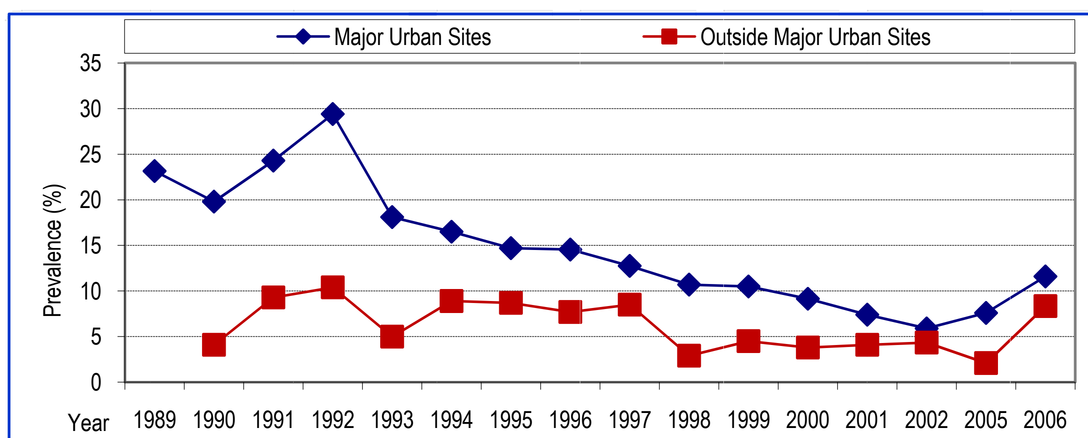
1.1.1 Epidemic update

The HIV epidemic in Uganda continues to be severe – currently, 6.4% of adults and 0.7% of children are infected with HIV, i.e., about one million people countrywide. While the epidemic is considered mature, it is not evenly distributed - women, residents of urban areas, and people in the central and mid-northern regions are more affected. [See maps on previous page]

The first AIDS cases in Uganda were identified in 1982 in the southern district of Rakai. After an initial rise in prevalence to 18%, Uganda experienced a sharp fall in the 1990s. The reduction in prevalence in the 1990s was, to a large extent, attributable to a decrease in the number of new infections (though mortality also played a role). Changes in sexual behaviour, especially reduction in the number of sexual partners, had the greatest effect on reducing new infections. This was followed by increased use of condoms and delayed age of first sexual activity (especially for girls) which pushed new infections down further.

Despite earlier prevention successes, there is now increasing evidence of stagnation and, in some cases, worsening trends in HIV indicators, beginning in about 2000.

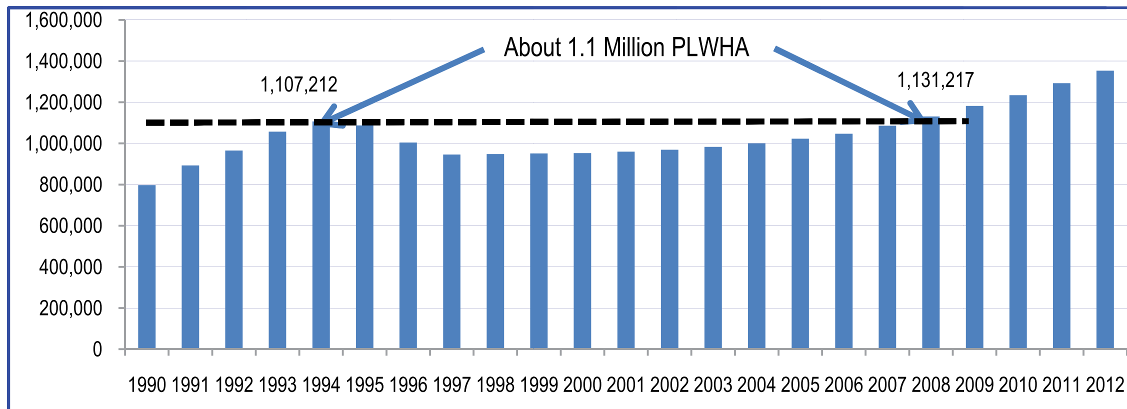
Figure 1: ANC HIV prevalence, by rural/urban distribution



Several longitudinal studies and indirect estimates show rising numbers of new infections. The estimated 132,500 new cases in 2005 is a substantial increase from the 1994 estimate of 85,000 new infections. High population growth over the last 20 years has influenced the rising tide of new infections and impeded efforts to keep ahead of the epidemic. Uganda's population growth is among the highest in the world, at 3.2% per annum and a

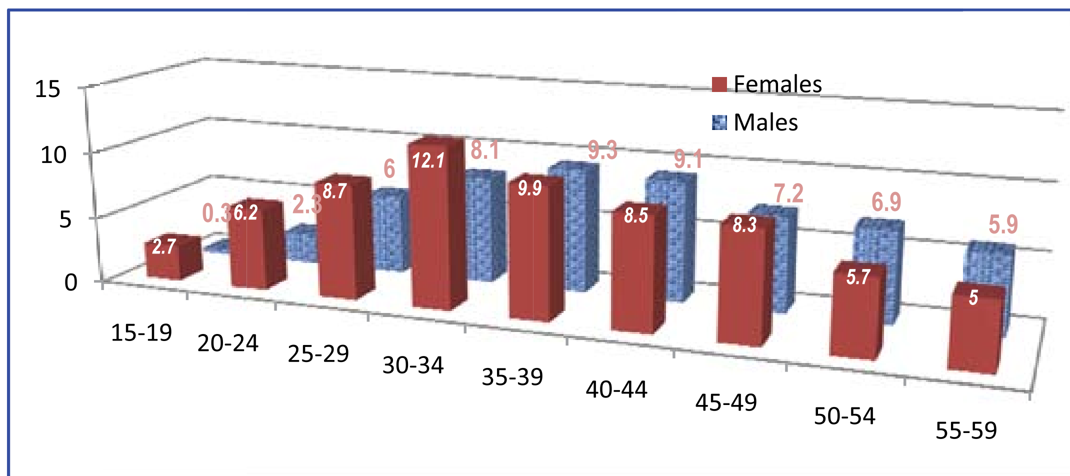
Total Fertility Rate (TFR) of 6.7 births per woman. There are now an estimated 1.1 million people living with HIV in Uganda, similar to estimates at the height of the epidemic in the mid-1990s. With current trends, this is likely to rise to 1.3 million people by 2012.

Figure 2: Annual burden of HIV in Uganda



The dynamics of the epidemic changed considerably since the 1990s. HIV prevalence now peaks among women at 30-34 years and men at 40-44 years, i.e., 5 to 10 years later than in the early 1990s. The greatest difference by gender is between young men and women aged 15-19 (see figure 3 below).

Figure 3: Gender, age and HIV infection



The gender impacts of HIV and AIDS are significant. Women are infected more than men across all ages from birth to the end of the reproductive years. Recent analyses, including secondary analysis of the Uganda HIV Sero-Behavioural Survey (UHSBS 2005) estimate that the biggest proportion of new infections is occurring among married and cohabitating partners, primarily because of multiple concurrent relationships (see table below). There are high numbers of discordant couples (where one is HIV positive and the other HIV negative). In addition, some children born with HIV have survived into adolescents and are reaching the age of sexual activity, though the exact numbers are not known.

HIV incidence, Uganda 2008, by mode of transmission (estimates)[3]	Percentage
Multiple sexual partnerships (including regular partners)	37.3%
Mutually monogamous partnerships (past 12 months)	35.1%
Mother-to-child	18.1%
Sex work (Including partners, clients and partners of clients)	8.7%
Medical injections	< 1%
Blood transfusion	< 1%
IDU (intravenous drug user) and MSM (men who have sex with men)	< 1%

The UNAIDS supported Modes of Transmission study (MoT study, 2008) looked at the distribution of new HIV infections and found that sexual transmission is still the most important source of new infections – accounting for about three-quarters of new HIV infections (see table at right). Approximately 37% new HIV infections were attributable to multiple sexual partnerships, including infections of their regular partners. Couples in discordant monogamous partnerships accounted for about 35% of the new HIV infections while mother to child transmission accounted for 18%. Commercial sex work (including partners of sex workers, their clients and partners of clients) was responsible for almost 9% of the new infections. There is substantial evidence of high rates of infection in certain Most-At-Risk-Populations (MARPs), such as IDPs, transport workers, commercial sex workers and fishing communities – groups that have often not been sufficiently targeted for prevention interventions because of their mobility or because of national laws.

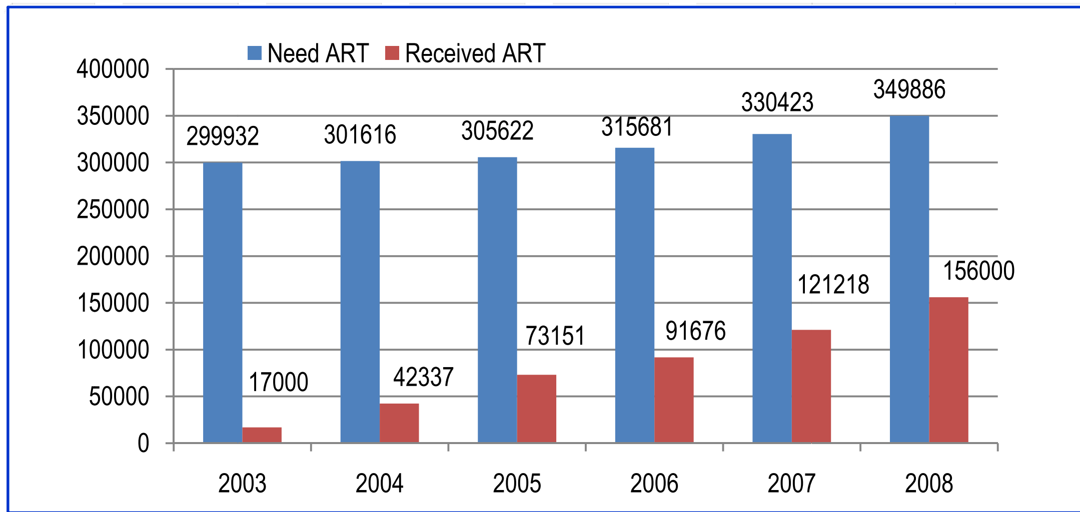
Very importantly, the MoT study also determined that most HIV/AIDS resources for prevention were not being allocated for activities targeting where the new infections are occurring. The study concluded that the ABC+ strategy needs to be modified to take into account the risk of infection in faithful relationships due to discordance and multiple concurrent partnerships. Preventive interventions such as couple counselling, testing and disclosure, identification of risks in all forms of concurrent relationships and condom use in risky relationships are key activities that need to be promoted more intensively. These findings are critical for the national HIV prevention strategies, as the core focus of NSP is the prevention of new HIV infections, including mother-to-child transmission.

There have been massive efforts to scale up ART in Uganda. In 2008, 156,000 persons were receiving ART, up from only 17,000 in 2003. This is a big achievement for any country, however, the number of those in need of ART continues to grow each year. At the end of 2008, despite more than 150,000 persons on ART, the numbers of PLHIVs in need of treatment but not yet getting ARVs was close to 200,000 persons (See Figure 4, next page). Moreover, the annual number of new infections far outstrips the numbers of PLHIVs being newly enrolled on treatment, e.g., the ratio of new infections to persons newly enrolled on ART was about 3:1, which will lead to an ever widening gap. It is anticipated that the numbers needing ART by 2012 will continue to greatly outstrip the available system capacity and resources – unless there is a concerted effort by all partners

[3] Table shows latest information available at the time of printing. Source: Wabwire-Mangen, F. (2009) Modes of Transmission Study: Analysis of HIV Prevention Response and Modes of HIV Transmission. The Uganda Country Synthesis Report. UAC, UNAIDS. February

to remove barriers to resource allocation and use (i.e., GFATM) and improve efficiency and capacity of current systems.

Figure 4: ART - Coverage compared to need 2003-2008



1.1.2 Epidemic impacts

Analysis of the macroeconomic impact of HIV/AIDS shows that AIDS is having and will continue to have a negative impact on the rate of economic growth in Uganda. The resultant downturn is projected to cause GDP growth to drop from a projected 6.5 percent a year without AIDS to an estimated 5.3 percent if no ART was available. By 2025 the economy will be 39 percent smaller than it would have been without AIDS.

In the same time period, it has been estimated that HIV/AIDS in Uganda will raise the overall households in poverty by 1.4 percentage points. The impact will be greater in rural areas, where poverty will rise by 1.6 percentage points compared to 0.9 percentage points in urban areas.

The impact of HIV is very different than other causes of illness and death (e.g., malaria, road traffic deaths). The poverty and vulnerability effects are multi-generational as Ugandan households sell off assets to fund long term health seeking by the HIV infected individual (often the breadwinner, or responsible for the care of children). This is not often the case of other illnesses that affect younger age groups, are short in duration, or lead to quick mortality. On the death of the individual, interim analysis suggests that a significant number of urban based families move back to rural areas and HIV thus can also delay national goals for the transformation of agriculture.

The drivers of the HIV epidemic are also more social and culturally complex than most other causes of ill health making it more difficult to reverse the epidemic. The central drivers of the epidemic are identified as:

- socio-cultural and political factors
- poverty, wealth and economic factors
- low status of women and girls
- stigma and discrimination and other human rights issues that drive HIV positive individuals underground
- inequity in access to HIV prevention, treatment and care services for most at risk populations and in some geographic areas.

1.1.3 A refocus on HIV Prevention

In the early days of this Millennium, UN member countries around the globe endorsed the Millennium Development Goals (MDGs), including MDG 6 to combat HIV/AIDS, malaria and other diseases. The two targets of MDG 6 are: 1) By 2015, have halted HIV/AIDS and begun to reverse its spread; and 2) By 2010, achieve universal access to treatment for HIV/AIDS for all who need it. Reaching MDG 6 requires far greater access to effective HIV prevention services and AIDS treatment, care and support than is currently available.

While considerable progress has been made in recent years in specific areas, the epidemic continues to expand faster than the response. This worrying trend confirms the need for Government and partners, including the UN, to rethink and redouble our efforts in the national response if Universal Access to prevention, treatment and care is to be reached.

In June 2006, a UN General Assembly high level meeting on AIDS acknowledged this widening gap between services and needs, and called for all countries to rededicate their efforts to reaching as close as possible to the 2010 target of universal access to prevention, treatment, care and support. Countries around the world used this commitment as a starting point for scaling up their AIDS responses towards the aim of Universal Access.

The Government of Uganda has recently worked with a wide range of stakeholders to develop a new National HIV & AIDS Strategic Plan 2007/8-2011/12: 'Moving toward Universal Access'. Significant data has become available in Uganda over recent years as well as programmatic analyses of the data generated. As a result, the development of this NSP has been exceptionally well informed. The NSP starting point was 'Know Your Epidemic' and then using the knowledge to gain consensus on the future response.

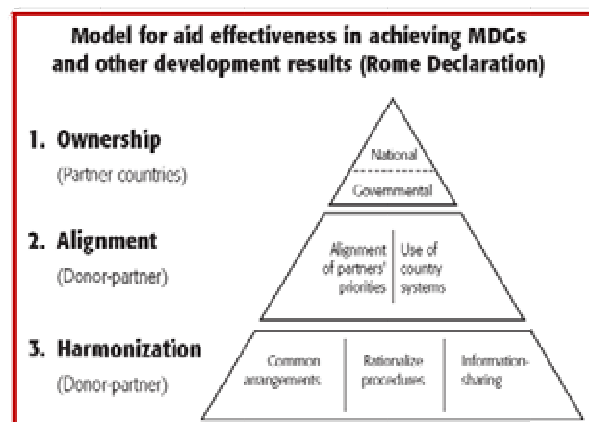
The stakeholders planning the NSP recognised that Uganda is at a crossroads in responding to the epidemic. The central dilemma at this juncture was whether to further scale up treatment in the face of an accelerating epidemic. The planners realised, however, that without a strategic choice to place more emphasis on reducing the number of new infections, the number of people in need of treatment and social support would continue to rise every year. **To address this gap, the cornerstone of the new NSP**

became the aim to reduce HIV incidence by 40%. This is to be achieved by ensuring that HIV prevention interventions are re-aligned to where new infections are occurring, focussing on rolling out the most cost-effective measures first, and working with national stakeholders to take up proven new interventions and respond to new priorities (e.g., HIV discordance).

Other key elements of the plan include consolidating the gains of ART access and continuing to scale up and much improved coverage of social support, particularly for orphans and vulnerable children. While recognising that HIV and AIDS is a generalised epidemic, the new NSP provides a focus for the first time on addressing the social, cultural, and economic causes of vulnerability. It proposes better targeting of interventions to groups where the highest proportions of new infections are occurring.

1.2 UN reform & improving aid effectiveness

The UN system in Uganda has reformed how it supports Government and Partners in the national HIV response. The key elements are establishing the *Joint UN Team on AIDS* and developing the *Joint UN Programme of Support on AIDS*. This reform process has taken place within the larger context of both UN reform[4] and international efforts to improve aid effectiveness. These include the Rome and Paris Declarations on AID effectiveness[5] and the Global Task Team (GTT) Recommendations on Improving AIDS Coordination (June 2005)[6]. The efforts emphasise more resources, more efficient use of resources and enhanced ownership by national government of the response as the key elements for an effective national AIDS response. The Joint UN Team on AIDS and Joint Programme of Support embraces the key Paris Declaration principles, including national ownership, harmonisation, alignment, simplification, accountability and achieving impact on the lives of people.



In expanded form, these principles are:

Ownership: is the first thematic heading in the Paris Declaration. External assistance is most effective when it supports countries' own development efforts and policies to which leaders, officials and citizens of the country are truly committed. The eventual status envisaged by the Paris Declaration is where partner countries

4 Report of the Secretary-General: An agenda for further change (9 September, 2002).
5 OECD-World Bank (2005). Paris Declaration on Aid Effectiveness, in: Harmonization, Alignment, Results: Joint Progress toward Enhanced Aid Effectiveness. Report of the High Level Forum, 28 February-2 March. Paris: OECD. OECD (2003) Rome Declaration on harmonization, Rome, 24-25 February 2003; In: Harmonising Donor Practices for Effective Aid Delivery. Good Practice Papers, A DAC Reference Document. DAC Guidelines and Reference Series. Organization for Economic Co-operation and Development
6 UNAIDS (2005) Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors; Final Report. 14 June

exercise effective leadership over their own development policies and strategies, and co-ordinate the efforts of development actors working in the country.

***Harmonisation*:** one UN team, one flag, one voice and one programme at country level.

***Alignment*:** more unified and optimal joint action of UN agencies in support of a scaled-up national response based on the "Three Ones" principle. Unification and integration of UN support on AIDS in national frameworks. It also implies that the UN works within government processes and systems and not outside.

***Simplification*:** a common entry point for all stakeholders at the country level to more easily access the full range of AIDS-related UN services, based on agency technical comparative advantages.

***Accountability*:** refers to support of agreed common outcomes and outputs of the national/sector plans, through the Joint UN AIDS Programme of Support. Promotes a more unified UN way of working and functions under the Resident Coordinator (RC) system. In the UN system, accountability for the overall response to HIV is vested in the Resident Coordinator and the UN Country Team consisting of the Heads of Agencies.

***Impact on lives*:** refers to expanded prevention, treatment, care and support, and reduced HIV infection levels and vulnerabilities. Clarity achieved on roles and responsibilities, division of labour regarding technical support and strengthened joint programming.

The Joint Programme of Support positions the UN as a more strategic partner for Uganda and is embedded in the principle of national ownership. The Joint UN Team and the Programme of Support adopt the international principle of the "Three Ones", wherein it was agreed that a comprehensive response to the HIV epidemic will be best achieved if there is only one national HIV strategic plan, one national HIV coordinating authority and one national HIV monitoring and evaluation (M&E) system.[7] The objectives and activities of the Joint UN Programme of Support on AIDS are fully aligned with Uganda's National HIV & AIDS Strategic Plan (2007/8-2011/12), as coordinated by the Uganda AIDS Commission and implemented by the key sector ministries and CSOs. The objective of the Joint Programme is to identify the comparative advantage and mandate of the UN system, and then mobilise the UN's technical and other resources in line with the NSP goals and targets, i.e., to facilitate achievements as close as possible to universal access to prevention, care and treatment, and social support.

7 UNAIDS (2004) "Three Ones: Key Principles," Geneva, Switzerland; April.

2. Joint Support – Maximising Value

2.1 The contribution of the UN system

2.1.1 The comparative advantage of the UN

In any country, the expected roles of the UN include:

a) *providing conceptual coherence**:* drawing on evidence-based policy and best practices for involvement in all aspects of policy dialogue with government and other partners;

b) *convening*: supporting national partners to ensure sector-based programmes are effectively accessible to all; and

c) *developing capacity*: enabling various kinds of capacity building to improve the national HIV response; includes active participation in ongoing technical dialogue, strengthening systems, and supporting national planning;

d) *providing a challenge function*: working to address issues of rights, stigma and discrimination and promoting action for marginalised or vulnerable groups.

2.1.2 Strategic Partner

The UN has committed itself as a **strategic partner** in accelerating prevention, care and treatment, and social support to reach sustainable universal access. Analysis of UN comparative advantages, the government programme, and other partners' contributions, suggests that the UN programme should concentrate on:

Up-stream work: support policy dialogue, strategic planning, systems strengthening, identifying best practices, links to international knowledge base;

Consistency: long-term, consistent, sustained presence providing support through a coherent framework; and

The 'honest broker' role: having no political, social, financial, or nationalistic bias; and providing support in bridging, communicating, facilitating, and convening.

2.2 How the UN works

2.2.1 Up-stream work

The heart of the UN activity is up-stream, normative work supporting capacity development and linking countries to the global professional and political community. This takes various forms:

Policy work: working with stakeholders to develop and build consensus for appropriate policies and strategies. The key UN role is facilitating consensus, both technical and political, in support of policy development, and providing technical assistance.

Advocacy for political commitment: advocacy for appropriate attention, commitment, and allocation of resources and recognition for specific challenges. The UN role includes the global human rights perspective that it is mandated to bring, as well as building on the wide range of advocacy opportunities that it can mobilise through the different agencies, fora and technical contexts in which it operates.

Building enabling environment: Because of the range of issues and sectors that UN agencies cover, the UN is well-placed to address issues in the wider environment that help or hinder achievement in specific sectors.

Establishing normative knowledge base: the UN brings international credibility and consensus to the development dialogue. This is a fundamental role for the UN system that all partners acknowledge.

Informing national strategy: through the wide technical experience of its staff, the UN can make a major contribution towards the better use of strategic information and the technical details for the formulation of specific national strategies, etc.

2.2.2 Consistency

The consistent presence of the UN as a permanent partner in the development dialogue gives it great influence and credibility. This is particularly useful in the kind of up-stream work described below.

UN advice, policies, and approaches are global and not bound by individuals, national politics or governments. The UN system provides consistent, internationally approved advice and recommendations as its fundamental mandate. While national politics or ideologies play a strong part in determining the design of HIV-related programmes and support, all can rely upon the consistent non-partisan advice of the UN.

UN technical staff members have the specific mandate to work with national partners, and they are 'obligatory' members of many committees, task forces, etc. They are thus in influential situations, providing consistency of advice, a sense of continuity and coherence; and a constant source of 'good-will' to all of the national efforts.

Focused and quality attention - The UN has the technical staff and resources able to give full, professional attention in support of partners and stakeholders, especially government. An assessment by UNAIDS in 2006 found 77 full-and part-time staff of UN agencies working on HIV in Uganda.[8] With refinement of the division of labour and 'speaking with one voice', the UN can ensure that it is well represented in all important fora. The Joint UN Team on AIDS in Uganda has been in existence for over a year now and currently has 22 full time HIV focal points and 39 part time staff members from 14 agencies/funds/programmes.

[8] A rapid headcount in early 2008 finds 21 staff working full-time on HIV-related posts, and 50 working part-time on HIV issues.

2.2.3 The 'honest broker' role

One of the most important contributions of the UN is its role as the 'honest broker', i.e., non-partisan bridging, communicating and facilitating between partners and stakeholders. Supportive brokering is particularly important and needed at the interface between government, donors and civil society. The Joint UN Programme has a crucial role in building engagement between government and civil society and facilitating capacity building. Greater involvement with civil society will lead to addressing challenges to bringing about change, such as:

- raising the level of civil society participation in planning, coordinating and monitoring within the national response;
- strengthening the capacity of civil society organizations to access and use globally sourced funds, and helping to ensure the rapid uptake and effective utilisation of available and promised funding; and
- improved accountability by encouraging civil society as a constant monitor to ensure that the current impetus and focus at national level is translated into real results for the people who are infected and affected.

Areas where the Joint UN Programme will be able to build on previous support to civil society include:

- Support to a forum that bring together representatives of various civil society organizations (CSOs) and AIDS-related constituencies on national level for developing consensus and a common voice as CSOs. This forum feeds a harmonised input into national processes such as the Partnership Committee.
- Strengthen the AIDS Partnership structure. The purpose of this structure is to provide formal and representative coordination for all stakeholders (with an emphasis on civil society participation) in the national response.
- Strengthen networks of/for persons living with HIV (PLHIV) in Uganda and facilitate a process to ensure that there is a more effective support of the PLHIV movement.

2.2.4 Downstream work and direct engagement

During the development of the Joint UN Programme of Support on AIDS (Joint Programme), the team noted that many UN agencies are, in fact, also engaged in service delivery ('downstream') work. A review of the downstream work revealed that agencies did so for a number of reasons: in response to emergencies, in direct response to government requests, to accomplish and meet donor commitments, and to access resources from donors interested in direct implementation. Agencies also added that they engaged in this kind of work when no other partners were available to undertake the specific requirements. Finally, in some cases it is a directive and corporate position of some agencies and a demand from the agencies' regional and headquarters offices.

The Joint UN Team has recommended the following as the way forward:

- Ensure maximum effectiveness of the UN by moving toward geographical convergence of services for the period that agencies are engaged in service delivery; and ensuring that the division of labour is operational even at the downstream level.
- Agencies to complete their current commitments and progressively move away from downstream work to more upstream work.
- All agencies to prioritise upstream work as part of their contribution to the national response.
- As far as possible, no new downstream activities will be initiated in the period of the implementation of the Joint UN Programme of Support.
- For a foreseeable period of the NSP implementation, however, UNICEF will continue to engage in service delivery for the PMTCT programme.

2.3 Funding the Joint UN Programme

The UN system in Uganda spent an estimated $25 million on HIV and AIDS support in 2006. The estimated programme for the next three years is in the range of $20 million per annum. Currently, most of the budget for UN support for HIV comes from agency budgets via headquarters or from their regional offices. Some agencies also mobilise funds locally through bilateral development partners at country level. Information on the resources available to the UN is usually available on an annual and/or biannual basis.

The management of agency funds within the Joint UN Programme will remain with the agencies themselves. However, some local bilateral partners have agreed to pool extra-budgetary funding for the Joint UN Programme to reduce their transaction costs and to provide an incentive for a strategic, prioritised Joint UN Programme. The establishment of a pooled funding mechanism for multiple donor support has thus been put into place (see section 4.2, page 29). The mechanism follows UN Development Group (UNDG) guidelines on pooled funding.

3. Programming for Strategic Results

3.1 Developing the Joint UN Programme

The following steps were taken to develop the 5-year Joint UN Programme of Support on AIDS (Joint Programme) for Uganda:

1. International stimulus

In May 2005, the Global Task Team (GTT) recommended the formation of joint UN teams on AIDS and a division of labour to streamline, simplify and harmonise UN support to national responses while building on existing frameworks and processes. In December 2005, the UN Secretary General sent a letter to all Resident Coordinators directing the establishment of Joint Teams and Joint Programs on AIDS.

2. Stakeholder analysis

In 2006, the Uganda UNCT commissioned an extensive in-house review of UN agencies, staff, programs, activities and financial resources in the area of HIV and AIDS[9]. This review led to the realisation that, from a financial perspective, the UN was an important medium size player in the national AIDS response. It also led to the realisation that, despite having one of the largest pools of human resources in the country devoted to working on HIV and AIDS, overall, in the UN system, technical support and engagement in policy and strategy dialogue were piece-meal. Harmonisation was low; in many cases, Agencies were working outside their mandate and there was fragmentation, duplication and competition. Staff seemed to be primarily engaged in oversight functions of multiple, separate projects. In mid-2006, based on the review recommendations, the Global UN Technical Support Division of Labour (DoL) was adapted to improve the coherence and responsiveness of UN support in Uganda (see Annex 4, DoL).

3. Engagement with NSP planning

During 2006-7, the UN applied the division of labour to collaborate in the development of a new National Strategic Plan (NSP) for HIV and AIDS (2007/8 – 2010/11). In Uganda, the National Strategic Planning began in August 2006 and by end of 2007, a new 5 year National Strategic Plan (NSP) for HIV and AIDS was finalised. The plan recognized that Uganda is at a crossroads in responding to the epidemic. The NSP sets the national 5-year vision for HIV and AIDS, which the UN's action must respond to and be aligned with.

4. Review and updating the UNDAF

In the process of contributing to NSP planning, the UN team saw that substantial changes had happened in Uganda's HIV and AIDS context and evidence base since the UN's

[9] The "Mapping Report" - UN System in Uganda: Repositioning the UN for a more effective response to AIDS; Final, UNAIDS Secretariat, June 2006

Development Assistance Framework (UNDAF) was developed in 2004. The UNCT agreed to revise the UNDAF Outcome 4 on HIV & AIDS "from the bottom up". In September 2006, the UNCT reviewed the existing UNDAF Outcome 4 on HIV & AIDS and the UN's Guidance on Joint Team and Program Structures[10]. This timing enabled the revision to reflect the strategic priorities being outlined in the emerging NSP (Annex 5). The UNDAF Outcome 4 was eventually revised substantially to be consistent with the new NSP. The revised UNDAF Outcome 4 outlines where UN agencies will focus in supporting the NSP.

5. Establishing the Joint UN Team on AIDS

In a series of meetings in 2006, the UNCT discussed and agreed on the structural and operational modalities for the Joint UN Team on AIDS[11]. The Joint UN Team on AIDS was established by late 2006. Joint Team members receive a formal letter of appointment signed by the Resident Coordinator (RC) and their Head of Agency.

6. Developing a Joint UN Programme of Support for AIDS

The revised UNDAF Outcome 4 became the strategic framework for the Joint UN Program of Support on AIDS (Joint Programme). The overall prioritisation of activities for the UN was based on the national priorities, as articulated in the NSP. The division of the priorities for the UN was based on:

- Agency mandate, capacity and record of results
- UN comparative advantages - Is it appropriate within the Joint UN Team; how does it reflect the Joint UN Team's comprehensive approach
- Partner analysis - assessing the extent to which we are harmonized and building on existing work; considering what other partners are doing to determine if the UN's work complements the other partners (e.g., GoU, PEPFAR, etc.)
- Assessing alignment – checking programme alignment to national priorities and processes; does it relate to the National Priority Action Plan (NPAP) and the National Strategic Plan? Is it working through national systems to deliver? Is it helping to strength the system - if so how? Is this good use of UN resources, or should this be something funded from the national budget…is the UN substituting?
- Ongoing consultations - with government counterparts, AIDS Development Partners (ADPs) and Civil Society.

3.2 Contents of the Joint Programme

The 5-year Joint UN Programme of Support on AIDS (Joint Programme) is the operational plan for UNDAF Outcome 4 on HIV and AIDS. It outlines the 'unity of purpose', the collective influence and responsibility of all the UN agencies toward the national HIV response. It therefore comprises the entirety of the UN contribution (technical and financial) to the HIV and AIDS response in Uganda.

[10] Three day cross-UN retreat in Jinja for more than 30 staff, September 2006

[11] July & November Theme Group Meeting 2006

The Joint Programme has one overarching outcome, identical to UNDAF Outcome 4, and four strategic country programme outcomes with respective outputs, as detailed below. (See Annex 5 for results matrix)

UNDAF outcome 4: Reduction of HIV incidence by 40% during the period of the NSP with a strategic focus on addressing the social, cultural, and economic causes of vulnerability and better targeting of high risk groups

Country Programme Outcome 4.1: AIDS response is mainstreamed and sustained across government with improved planning, programming, budgeting, coordination, systems integration and a stronger policy and legislative environment (which is human rights based & gender sensitive).

Country Programme Outcome 4.2: Universal access to evidence based, quality assured HIV prevention services that lead to improved service uptake, sustained behaviour change and a reduction in the number of new infections.

Country Programme Outcome 4.3: Quality of life of people infected and affected by AIDS improved and their vulnerability reduced.

Country Programme Outcome 4.4: Effective management of response to HIV/AIDS pandemic by all actors, is being guided by generation and use of strategic information and a comprehensive system of results based measurement and surveillance.

The Country Programme Outcomes are 5-year results, aligned with the NSP, which the UN collectively commits to contributing toward their attainment. The following section summarises the rationale for UN involvement in each issue, and the special nature of potential UN contributions to the results. It also articulates the roles of the UN agencies responsible, in accordance with the agreed UN Division of Labour.

3.3 Mainstreaming and rights

Country Programme Outcome 4.1[12]	**AIDS response is mainstreamed & sustained across government with improved planning, programming, budgeting, coordination, systems integration & a stronger policy & legislative environment (which is human rights based & gender sensitive)**

CP Output 4.1.1	***By 2012, evidence of socio-economic impact of HIV and AIDS available for selected sectors to support effective policy formulation, annual programme planning and resource allocation***

Rationale: Although there is general acknowledgement of the socioeconomic impact of HIV and AIDS in Uganda, little is done to quantify these impacts. This has hindered macro-economic planning and the formulation of an appropriate AIDS

[12] Numbering of programmatic outcomes in this JUPSA document is consistent with the numbering pertaining to UNDAF Outcome 4 in the current Uganda UNDAF document 2006-2010.

response; and perpetuated uncertainty over the level of investment that should be made in responding to AIDS in Uganda.

While the considerable focus on accelerating universal access to treatment and prevention services is very appropriate, the efforts to source funding for sustained universal access have often been relegated to a secondary status. Insecurity about sustainable financing of AIDS, particularly by the GoU, is a big threat facing the long-term future of the sector. Currently, the national AIDS response is 97% foreign financed, with the expenditure by the GoU accounting for less than 3% of the total cost of AIDS activities and interventions.

Role of the UN: UN leadership in this area will primarily be through the **UNDP** and **World Bank** with support from the **UNAIDS Secretariat** and collaboration with other UN agencies as appropriate. The UN will provide financial support and technical guidance to the Ministry of Finance, Planning and Economic Development, the UAC and the Ministry of Local Government, and to other relevant line Ministries to assess the macro-economic impact of HIV and AIDS. The UN will strengthen capacity to articulate AIDS issues and integrate them into plans and programmes; and engage in policy dialogue for resource allocation to AIDS. Integrating HIV and AIDS will help to ensure that macroeconomic and public expenditure frameworks support and appropriately prioritise the implementation of national HIV and AIDS action frameworks and annual priority action plans. The World Bank will do peer reviews and provide quality assurance, in addition to engaging key government institutions tasked with fiduciary responsibilities.

CP Output 4.1.2	***By 2012, improved national and district capacity to plan, budget, implement and coordinate the AIDS response and manage multiple finance channels (including GFATM)***

Rationale: Mainstreaming to mobilise the contribution of key actors and sectors is an important way to help scale up, deepen and sustain an effective national HIV response. HIV and AIDS needs to be fully integrated into national and decentralised development planning, policy making, priority setting and budgeting. Under the 'Three Ones' principle, a key success element for a multi-sectoral national AIDS response is leadership and coordination by the national AIDS programme for developing effective systems and partnerships at country level. Guided by global recommendations on improving aid effectiveness and harmonising support to national AIDS responses, the UN system is well placed to assist in facilitating development of structures and modalities that will enhance government's effectiveness of programme delivery, utilisation of resources, and monitoring and evaluation mechanisms for the national AIDS response in Uganda.

Role of the UN: UN leadership in the area of mainstreaming will be primarily through the **UNDP** and **World Bank**. The **UNAIDS Secretariat** will also collaborate with

other UN agencies to work closely with counterpart ministries. The UN will assume the same roles as described under CP Output 4.1.1 above and will focus on developing capacity of government and national counterparts. The UN will maximise technical support available through AIDS Development Partners (ADPs) and other providers both in and out of the country to help build leadership and coordination capacities. The UN will assist the UAC and key sectors and departments directly through active and ongoing participation in their planning and coordination mechanisms; and various long term and ad hoc taskforces and technical groups. The UN will also provide direct technical assistance to the UAC, key sectors and departmental secretariat staff to build and strengthen their capacity and systems as well as assist in mobilising resources, and broker and strengthen partnerships and provision of strategic information.

CP Output 4.1.3	***By 2012, relevant Government institutions operationalise human rights based and gender responsive legislation and policies that address vulnerability to HIV and AIDS in line with relevant international standards***

Rationale: There is need for a Human Rights Based Approach (HRBA) and concomitant principles to be applied in both the development and implementation of policies. Uganda has a national overarching AIDS Policy but it remains in draft form and has yet to be formally adopted and operationalised. Passing this bill would positively influence other relevant policies that have an impact on access to services and the rights of PLHIV. It is important for Government to identify and respond to factors likely to increase the vulnerability of employees and community members, and then to develop appropriate workplace programmes and policies. The national AIDS policy sets out fundamental principles and practical guidelines from which concrete responses to AIDS can be developed at enterprise, community and national policy levels. To date, however, workplace interventions have mainly focused on raising awareness with less attention to strengthening linkages to service provision sectors.

Within the UN, there are glaring gaps in HIV competence among staff not primarily involved in AIDS work[13]. E.g., there is low awareness about UN staff policy on HIV in the workplace where benefits, entitlements and job security in relation to HIV and AIDS are stipulated. In response, the UN has developed a learning strategy to build the competence of UN staff and families about HIV in the workplace. These efforts, however, have been scattered and agency specific.

Role of the UN: The UN leadership for the human rights area will be **OHCHR** in collaboration with the **UNAIDS Secretariat, UNICEF, UNDP, WHO, UNFPA** and **IOM**. The UN will provide technical and financial support to key legal and policy

[13] Global UN survey 2002

development organs to ensure the integration of human rights based approach into laws and policies that are responding to HIV and AIDS. The UN will also provide technical guidance through participation in key dialogue opportunities, processes and task forces - including the review of key documents. These entities include the Uganda Law Reform Commission, Equal Opportunities Commission, Uganda AIDS Commission, Uganda Human Rights Commission, Parliamentary Committee on Social Services, and the Parliamentary Committee on Legal Affairs.

The UN leadership in the area of workplace response will be through the **ILO**. The UN will provide technical guidance to priority public sector Ministries that include MoGLSD, Public Service, MoLG, MoH, Tourism, Trade and Industries, and the Ministry of Agriculture. Work will also be done with employers, worker organizations and private sector[14] to develop and implement sectoral workplace interventions related to HIV and AIDS. The UN, through an **ILO** partnership with the GoU, has developed a policy framework on HIV and the world of work that is recognised by its constituencies and other stakeholders as the basis for national, sectoral and workplace interventions.

For the UN workplace programme, leadership will be provided through the **Resident Coordinator** system in close collaboration with the **UNAIDS Secretariat** and managed through the multi-agency working group established to coordinate the UN workplace programme.

CP Output 4.1.4	***By 2012, civil society organizations & networks of Persons Living with HIV (PLHIV) participating effectively in national AIDS response***

Rationale: Civil society plays a critical role in the national response, and ensuring an appropriate and ongoing meaningful participation at all levels is crucial. The NSP for Uganda urges greater involvement of PLHIV, which is consistent with the UN mandate to promote underutilised resources, including PLHIV, in addressing HIV. Most development partners provide some resources for implementation of interventions by CSO and PLHIV organizations and networks. However, their capacity to deliver quality programmes is often limited and their ability to coordinate and adequately represent national and decentralised levels is weak.

Role of the UN: UNAIDS Secretariat will lead in this area and work closely with **UNDP.** Technical support will be provided to the UAC and the Partnership Committee to coordinate the CSO and PLHIV agendas. The Secretariat will also offer technical support and guidance to key national umbrella organizations[15] and self coordinating entities of the Partnership Committee to strengthen their engagement

[14] This will include key organizations like the Federation of Uganda Employers, Uganda Manufacturers Association, and affiliates of the National Organization of Trade Unions of Uganda. There will also be attention to the Alliance of Mayors and Municipal Leaders, RTI, Business PART (USAID), Market Vendors AIDS Project, Uganda Coalition of Business on HIV/AIDS, American Chamber of Commerce in East Africa, PANOS Uganda and Stop AIDS NOW.
15 E.g., the CICC, NAFOPHANU, UNASO, Civil Society Basket Fund

and participation in relevant decision making mechanisms and improve their institutional capacity to deliver on their mandates.

3.4 Multisectoral HIV prevention & education

Country Programme Outcome 4.2	**Universal access to evidence based, quality assured HIV prevention services that lead to improved service uptake, sustained behaviour change and a reduction in the number of new infections**

CP Output 4.2.1	***By 2012, prevention policies and action plans developed and implemented with better alignment of finance to priority areas***

Rationale: The fundamentals of HIV prevention need to be agreed upon and programmed for, funded, implemented, measured, and achieved. Half of all new infections projected before 2015 can be averted if the right HIV prevention efforts are focused on the right people and delivered at the right scale. The NSP calls for ADPs to support simultaneous scaling-up of HIV prevention and treatment by closing the prevention resource gap. GoU sectors and ADPs are implementing HIV prevention – but the interventions need better coordination and monitoring. GoU also needs support to maintain prevention as a national priority. Uganda needs to realign HIV prevention programmes through new understanding how the most recent HIV infections were transmitted, and understanding the reasons why they occurred. This helps in preventing new infections and in resource allocation and distribution. It also helps put forward a long term and sustainable AIDS response.

Role of the UN: **UNFPA** will lead in this area with the **UNAIDS Secretariat**, **WHO** and **UNICEF**. The UN will provide technical assistance to the National Prevention Committee (NPC)[16] to realise its mandate and ensure representation of relevant stakeholders in key strategic meetings from national to global levels. The UN will also help to ensure the provision of up-to-date strategic analyses and prevention information is disseminated and available to guide programming and associated policy and guideline preparation.

CP Output 4.2.2	***By 2012, BCC/IEC and life skills interventions are well coordinated, evidence informed and targeted at the national level***

Rationale: Reductions in HIV transmission need widespread and sustained efforts, and a mix of communication channels to disseminate messages to motivate people to engage in a range of options to reduce risk. The effect of behavioural strategies will be increased by aiming for many goals (e.g., delay in onset of first intercourse, reduction in number of sexual partners, increases in condom use, etc.) that are

16 The NPC is comprised of MoH, UAC and partners.

achieved by use of multilevel approaches (e.g., couples, families, social and sexual networks, institutions, and entire communities) with populations both uninfected and infected with HIV.

Interventions derived from behavioural science have a role in overall HIV-prevention efforts, but they are insufficient by themselves to produce substantial and lasting reductions in HIV transmission between individuals or in entire communities. For example, Behaviour Change Communication (BCC) programming is a key component of effective HIV prevention. Many IEC/BCC interventions exist but the messaging is inconsistent, targeting is fragmented, and access to strategic information to support evidence informed BCC programming is limited. In addition, the capacity of Government to coordinate and provide quality control for BCC is limited.

Role of the UN: **UNFPA** will lead, with **WHO, UNICEF** and **UNAIDS Secretariat**. The UN will provide technical support through the National Prevention Working Group (PWG) and focal points at the UAC and MoH and other important sectors such as education and the Ministry of Gender, Labour and Social Development (MoGLSD). The UN will also have a significant role in providing strategic information for planning programmes and developing guidelines for implementation.

CP Output 4.2.3	***By 2012, coordinated prevention programmes for Most at Risk Populations (MARPs) advocated for and developed***

Rationale: in many countries, even with high HIV prevalence among the general population, substantial numbers of new infections are also likely to be occurring in certain populations at higher risk of exposure to HIV, including IDPs, transport workers, commercial sex workers and fishing communities. These groups have rarely been selected or sufficiently targeted for prevention initiatives due to technical and logistical challenges arising from their mobility or because of national laws. Currently, prevention programmes in Uganda usually target only the general population and fail to adequately reach the Most at Risk Populations (MARPs). There is need to balance the mass approaches with sensitive highly specific targeting. The UN is well positioned to help as it upholds human rights principles and is able to play a key role in ensuring equal access.

Role of the UN: The UN will support the GoU (MoH, UAC, MoGLSD) and the National Prevention Committee (NPC) to:

- Develop the evidence base and programme strategies for reaching MARPs;
- Advocate & support for GoU and others to scale up targeted prevention for MARPs;
- Build capacity of GoU & service providers to effectively intervene for MARPs;
- Support collaboration between GoU & civil society for more action among MARPs;
- Mobilise resources for prevention directed to MARPs and vulnerable groups; and
- Build capacity to reach MARPs through opportunities to learn from other countries.

CP Output 4.2.4	***By 2012, improved capacity for expansion and delivery of HIV prevention services in the health sector (e.g., comprehensive PMTCT, condoms, blood safety, STI)***

Rationale: Mother-To-Child-Transmission (MTCT) plus breastfeeding accounted for 18.1% of new infections – making it one of the leading drivers of the epidemic in Uganda. HIV infection has increased child mortality, as only a third of children born with HIV survive beyond their second birthday. The number of women enrolling for PMTCT is low, which is attributable to socio-cultural and economic factors that deter women's use of PMTCT services and deter their return to health facilities for deliveries as recommended under PMTCT. According to the Uganda AIDS Control Project (UACP), half or more of HCIVs and HCIIIs are not providing PMTCT services, and there are low levels of community awareness and mobilisation for PMTCT. Even if available, PMTCT service quality is affected by staffing levels and the quality of counselling in health facilities.

Condom programming - The male condom, if used correctly and consistently, has been proven in observational studies to be very effective in blocking HIV transmission during sexual intercourse. Condom programming is a key component of cost-effective strategies for scaling up prevention, but Uganda faces serious gaps in condom programming. There are weaknesses in need identification and forecasting, e.g., populations that need condoms are not mapped and the supply-chain management system seems to leave out key MARPs. The current procurement systems are weak, with grossly inadequate numbers procured and frequent stock-outs, which further contribute to the inconsistent use of condoms.

Sexually Transmitted Infections (STIs) - Prevention and treatment of Sexually Transmitted Infections (STIs) are key components for the prevention of HIV transmission, due to the established linkages between STI and HIV infection. Treatment of sexually transmitted infections, which is a public health intervention in its own right, has had mixed results, depending in part on the epidemic context in which the approach was assessed.

Blood safety, infection control & universal precautions scaled up - WHO estimates that in Uganda the proportion of Hep C, Hep B and HIV due to unsafe injections is 30.8%, 22.4%, and 2.5% respectively. Despite training 60% of health workers, many health units continue to operate below acceptable standards. This is a result of poor infrastructure, attrition and limited human resource capacity, and lack of basic support for infection prevention such as protective gear, sterilisation equipment, waste segregation bins and medical pits for disposal of sharps. Effective performance of the blood bank is hindered by financial constraints and few voluntary blood donors. Considering the increasing shift of PLHIV care from

health facilities to community, there is also a need to improve local knowledge and skills for preventing blood borne infection transmission in the home.

Although some progress has been made with biomedical interventions, difficulties with product adherence and the possibility of sexual disinhibition are important concerns. Biomedical interventions therefore need to be part of an integrative package that includes biomedical, behavioural, and structural interventions.

Role of the UN: PMTCT **- UNICEF** will lead in this area, with **WHO** and **UNFPA**. They will provide technical support to MoH on the policy environment and management for ensuring coordinated delivery of PMTCT services. The UN will continue to advocate for integrating PMTCT into Reproductive Health services and provide technical support for the development, review and operationalisation of systems, procedures and normative guidelines, as well as the mobilisation of resources for rolling these out. Provision of PMTCT services for underserved areas in Northern, Eastern and Western Uganda is a priority.

Condoms - **UNFPA** will lead on condoms; ADPs and GoU have requested the UN through UNFPA to provide coordination and management leadership of the national condom programme. Technical support will be provided to MoH through the UACP, Directorate of Reproductive Health, and Essential Medicines and Supplies Board.

STI - **UNFPA** will lead together with **WHO**; they will support MoH /STI programme

Blood safety, infection control & universal precautions **- WHO** will lead in this area. They will provide technical guidance to ensure standard monitoring, accelerating prevention in the health sector; norms and standards; work closely with MoH

CP Output 4.2.5	***By 2012, new strategies and innovation in prevention advocated for, adopted and rolled out (e.g., medical male circumcision, prevention with positives, discordance)***

Rationale: Intensive research efforts for more than two decades have not yet resulted in an HIV vaccine of even moderate effectiveness. Scientists are currently testing many substances to see whether they help protect against HIV and/or other STIs, but no safe and effective microbicide is currently available to the public. Investments in vaccines are still very important and must expand dramatically -- and quickly-- if the promise of microbial control is to be realised. Findings from countries that have conducted studies on the modes of transmission and developed incidence estimates have highlighted three broad trends:

Discordant couples - Patterns of epidemics can change over time and therefore analyses must be undertaken at regular intervals and programmes adopted regularly. In Uganda, as in much of sub-Saharan Africa, new infections occur mainly as a result of having multiple sex partners and among discordant couples.

Medical male circumcision - Trials conducted in South Africa, Kenya and Uganda have proven beyond reasonable doubt that male circumcision can reduce female-to-male HIV transmission by more than half. Based on the evidence, an international consultation in March 2008 recommended that male circumcision be recognised as an important prevention measure, and countries with high prevalence and generalised heterosexual HIV epidemics should urgently scale up access to male circumcision services. Challenges to scale up include inadequate preparedness, low capacity of health system to provide quality services, divergent community perceptions, and information gaps (research needed on gender issues, challenges in access to high quality affordable circumcision services, and efficacy of circumcision in common service settings).

Positive prevention - The expanding provision of antiretroviral (ARV) treatment has brought a return to good health and new hope to many people throughout the world who are living with HIV. Meanwhile, this ongoing achievement, coupled with the increasing numbers of people accessing HIV testing, brings a new challenge: meeting the HIV prevention needs of people living with HIV. Positive prevention requires the meaningful involvement and participation of people living with HIV. This means not only giving support and information to individuals and groups of people living with HIV, but also ensuring their participation in planning how best to apply the strategies to their local context.

Role of UN: **WHO** and **UNFPA** are the technical leads, with contributions from **UNAIDS Secretariat** and **UNICEF**. They will work closely with UAC and MoH and will participate in ongoing technical dialogue, strengthen dissemination of research, and facilitate exchange visits for policy and programme managers. UN will work closely and complement the role of other partners working in this area. The lead in other areas will depend on the nature of the innovation.

3.5 Care, treatment and social support

Country Programme Outcome 4.3	Quality of life of people infected and affected by AIDS improved and their vulnerability reduced

CP Output 4.3.1	***By 2012, capacity of Ministry of Health to develop key policies and guidelines for HIV care and treatment strengthened***

Rationale: There are rapidly developing changes in treatment, care, and support for HIV and AIDS that call for new guidelines or the revision of existing national policies and guidelines, and ensuring that health providers know and apply these policies.

Role of the UN: With the leadership of **WHO** and **UNICEF**, the UN will work with the MoH and other partners, especially those providing technical assistance to AIDS-

related service-appropriate committees. They will provide support, relevant Technical Assistance and catalytic funding if needed, for country review and adaptation of care and treatment policies and guidelines, including development, field testing, dissemination and implementation stages.

CP Output 4.3.2	***By 2012, capacity of health care teams to provide quality HIV care & treatment services strengthened in all hospitals & HCIVs***

Rationale: It is estimated that there are more than 1,100,000 individuals living with HIV in Uganda today. Of these, about 250,000 are in need of ART but only 103,000 people (42%) of those needing ARVs are currently accessing them. The main barrier to ARV access is insufficient number of service points and trained health workers; currently only 40% of HCIVs provide ART. To improve access, the MoH intends to have ART services available at HCIV and higher level units, while HCIIIs will provide HCT, cotrimoxazole prophylaxis, and some chronic care.

MoH requires support to coordinate and manage the programme and to strengthen systems for delivery of care and treatment services. Laboratory support for diagnosis and clinical monitoring of treatment are also essential aspects. Post-training supervision and mentoring are needed by Regional Referral hospitals and the national level to maintain quality of service.

Role of the UN: UN leadership in this area is by **WHO**. UN support is technical and financial directly to appropriate departments and through active participation in the various technical working groups. Support will be targeted at development, adaptation and review of training manuals, training and post training support of service providers; and to development and dissemination of job aids, service manuals and guidelines. The UN will also provide support to the MoH to manage and coordinate the programme and to execute its Quality Assurance mandate.

CP Output 4.3.3	***By 2012, capacity of health care workers from district hospitals, HCIV and HCIIIs to provide standard HCT services strengthened***

Rationale: HCT remains central to all epidemic mitigation efforts. The Health Sector Strategic Plan (HSSP II) target for 2010 is that HCT services should be available at all HCIIIs; the NSP aims for routine HCT in all (102) hospitals and 214 HCIVs by 2012. Currently, there are about 450 HCT sites, representing about 40% coverage. The greatest challenge for the HCT intervention is capacity to meet the high demand. Both UDHS (2005) and the UHSBS (2004/5) indicate 70% of the population want to know their HIV status. To date, 21% of Ugandan adults have accessed HCT services, but only 11% have received their results (UHSBS, 2004/5). This is compounded by difficulty in assessing coverage, need to carry out regular reviews of the testing algorithm, inadequate test kits and supplies, low child counselling capacity and inadequate coordination of partners.

Role of the UN: **WHO** will lead in this area with **UNICEF** support to assist in coordinating HCT efforts. They will provide technical and financial support to the country stakeholders, facilitate UAC to support coordinators meetings at district level and ensure that annual performance reports on HCT are generated. **UNICEF** will support MoH and UAC to develop the HCT commodity security plan. **WHO** will give guidance on reviewing the testing algorithm, support development of counselling guidelines for children; and provide financial support for HCT scale up.

CP Output 4.3.4	***By 2012, procurement & supply chain management systems to provide timely delivery of medicines, condoms & supplies are coordinated & strengthened***

Rationale: Efficient procurement and supply management of HIV-related commodities are essential for an effective AIDS response. With enhanced experience in treatment access, countries are increasingly overcoming the difficulties associated with procuring ARVs. The next big obstacle emerging is weak ability to manage supplies in country programmes. In addition, it is clear that ART alone does not constitute quality of care for PLHIV. There is increasing demand for opportunistic infection drugs, antibiotics, topical drugs and drugs for palliative care. There is also rising demand for HIV tests and reagents to monitor HIV treatment and to diagnose opportunistic infections, plus gloves, injection equipment and condoms. The case for ARV integration in the mainstream supply chain for essential drugs and health commodities is becoming stronger and stronger. Supply systems for health sector commodities need to be strengthened and resources and skilled people are required to deliver.

Role of the UN: UN leadership in this area is through **UNICEF**, with close support by **WHO**, **World Bank** and **UNFPA**. They will provide technical and financial support to MoH and relevant stakeholders to strengthen the national system for HIV related commodities management, including forecasting, quantification and standardized delivery mechanisms. This is to be achieved through:

- Identifying gaps in service provision;
- Support to development and/or strengthening of effective public/private sector partnerships;
- Preparing guidelines and technical documents;
- Procuring commodities on behalf of the government (upon request); and
- Supporting the recruitment of external expertise and building capacity of nationals.

CP Output 4.3.5	***By 2012, nutritional support integrated into HIV and AIDS programming***

Rationale: Food and nutritional support for PLHIVs has proven to be an important means of saving lives, mitigating the negative nutritional impacts of HIV on PLHIVs as well as their households, and enhancing drug adherence.

Role of the UN: Under lead of **WFP**, and in close collaboration with **WHO** and **UNICEF**, the UN will provide NGOs, HIV treatment sites, and health units in food insecure areas with nutritional support. Collaboration between all partners is necessary to reach affected clients with a comprehensive care package that includes nutritional support. They will work closely with Ministries of Health and Agriculture to strengthen systems and strategies of monitoring of food security and support.

CP Output 4.3.6	***By 2012, improved systems for monitoring and supporting the quality of life of OVCs[17] and their families***

Rationale: The social, economic and health needs of vulnerable families in Uganda far exceed the current capacity of government and NGOs to provide. Nationally, there are over 2 million orphans and most are due to AIDS. The majority of Uganda's vulnerable children are cared for within households; an estimated 25% of all households host at least one orphan. Most families who care for orphans (70%) are headed by poor, often elderly widows (mothers, grandmothers, aunts).[18] These households struggle with limited resources to meet the increasing financial, psychological, educational and health needs of a larger number of dependents. Overall, host households have at least two more dependents than the average household, and the added cost of providing basic support of one extra child amounts to about 15% of an average Ugandan household's income.[19]

Role of the UN: The UN will be led by **UNICEF** working closely with the **ILO**. They will provide technical support to the MoGLSD to strengthen national systems and policies for the creation of a more protective environment for OVC. The UN will:

- support strengthening GoU coordination and management systems to provide leadership and oversight for effective and efficient implementation of OVC programmes by all stakeholders;
- build capacity of national & decentralised offices to coordinate and manage OVC programmes;
- assist GoU to develop and/or review relevant policies and guidelines;
- support the roll out of the national plan of action for OVCs;
- review and update the situational analysis for OVC; and
- develop and monitor national standards.

Through a pre-existing joint programme for HIV, Nutrition and Health in the North, the UN will continue to provide material, technical and financial support to the Government at district and local government levels; as well as material/financial support to institutions providing services in the areas of education, livelihoods, psychosocial counselling, nutrition and food security.

[17] OVC = orphans and vulnerable children
[18] MoGLSD, 2004. Rapid Country Response Analysis: Uganda, 2004.
[19] MoGLSD, 2002. OVC Situation Analysis

3.6 M&E, surveillance & strategic information

Country Programme Outcome 4.4	Effective management of response to HIV/AIDS pandemic by all actors, is being guided by generation & use of strategic information & a comprehensive system of results based measurement & surveillance

Rationale[20]: Effective, efficient and comprehensive M&E of the national AIDS response are crucial. Successive reviews have seen that HIV management information systems are weak. Knowledge management systems are underdeveloped or informal, and confusion exists in mandates among key GoU actors at all levels leading to multiple databanks instead of one central data warehouse. Data dispersion seriously impedes its use by planners and policy makers. The UAC needs critical strengthening for the M&E of its own programmes and performance; as well as enhancing its ability to monitor activities carried out by implementing agencies at local, regional and national levels. There is need for greater cooperation, coordination and harmonisation of key review functions such as the annual Joint AIDS Programme Review. There are currently significant differences in planning, monitoring and reporting formats among ADPs and other key agencies like large CSOs. To achieve a strong sustainable national M&E system, more coherence and standardisation is required of a Joint UN programme.

Role of the UN: the Joint Team will be led by the **UNAIDS Secretariat** working closely with **WHO**. **UNAIDS** will provide technical assistance to the M&E unit within UAC. They will also actively participate in M&E standing committee. Through **UNAIDS**, the UN will support mechanisms for M&E collection and consolidation, joint review process strengthening, provide technical and financial support towards effective use of information, and facilitate progress reviews against Universal Access targets. **WHO** works primarily with MoH and UAC but also collaborates with other national partners and research institutions. **WHO** support includes technical assistance for surveillance of the epidemic (estimates, modelling and projections), operations research, health sector performance reviews, producing health related statistics for HIV and AIDS; and supporting the development and dissemination of policies, guidelines and standard operating procedures.

Specifically, in this area, the UN will:

- Facilitate analytical synthesis reports on HIV epidemic & national response;
- Provide strategic, high-quality technical inputs;
- Engage with partners/stakeholders to provide coherent, consistent and objective support for institutionalisation of the process;
- Solicit support from development partners/stakeholders and provide financial support as appropriate.

[20] The text below covers common features of country outputs 4.4.1 - 4.4.3

CP Output 4.4.1	*By 2012, a comprehensive performance measurement & management system for all interventions responding to the challenge of the AIDS epidemic is funded & operational at national & district levels*

CP Output 4.4.2	*By 2012, strategic Information generated & used by National & district authorities for strategic & operational planning of all interventions responding to the AIDS epidemic*

CP Output 4.4.3	*By 2012, national systems for projections, estimations, surveillance and research are fully functional*

CP Output 4.4.4	*By 2012, all UN Agencies are using harmonized planning, performance management & measurement, reporting & evaluation systems for HIV/AIDS*

Rationale: The primary aim of the Joint UN Programme is to ensure that the UN's collective actions in response to HIV and AIDS are coherent and effective. UN approaches and interventions (including technical support arrangements) should be harmonised and directly aligned and responsive to national priorities. The Joint UN Programme will show how UN action is working towards universal access to AIDS services. In addition, the pattern of the epidemic can change over time, and periodic analyses are needed to update the evidence and understanding.

Role of the UN: Once operational, it is envisioned that the Joint UN Programme of support will save staff time, minimise transaction costs and reduce duplication for national partners, while maximising synergies and complementarities among the various UN agencies and national counterparts. UN programming on AIDS will be progressively harmonized and aligned over the life of the programme, working through a clear division of roles and areas of responsibility of the different UN entities in relation to partners in the national response, and setting up joint monitoring mechanisms involving national stakeholders. Joint UN Team arrangements have been agreed to that cover management of the Joint Programme as well as management and operational issues essential to define and detail clear agreements among UN agencies, between UN agencies and National Stakeholders, and between UN agencies and interested bilateral donors. Success will be measured by a combination of the following: UNDAF Outcome 4 M&E parameters, alignment with national systems and processes, how strategic the programme is and how well the UN delivers according to its mandate and UN reform imperatives

4. Managing the Joint UN Programme

This section describes the governance of the Joint Programme. It presents the UN's technical division of labour and how the Joint UN Team on AIDS (Joint Team) is structured.

4.1 Technical support division of labour

To improve accountability and harmonisation, the UN has adapted the global Technical Support Division of Labour for the Uganda setting. The Technical Support Division of Labour (DoL) was agreed in the UN system in Uganda in June 2006 and reviewed and updated in September 2007 (see Annex 4, DoL). The Technical Support Division of Labour operates through Lead and Supporting Partners.

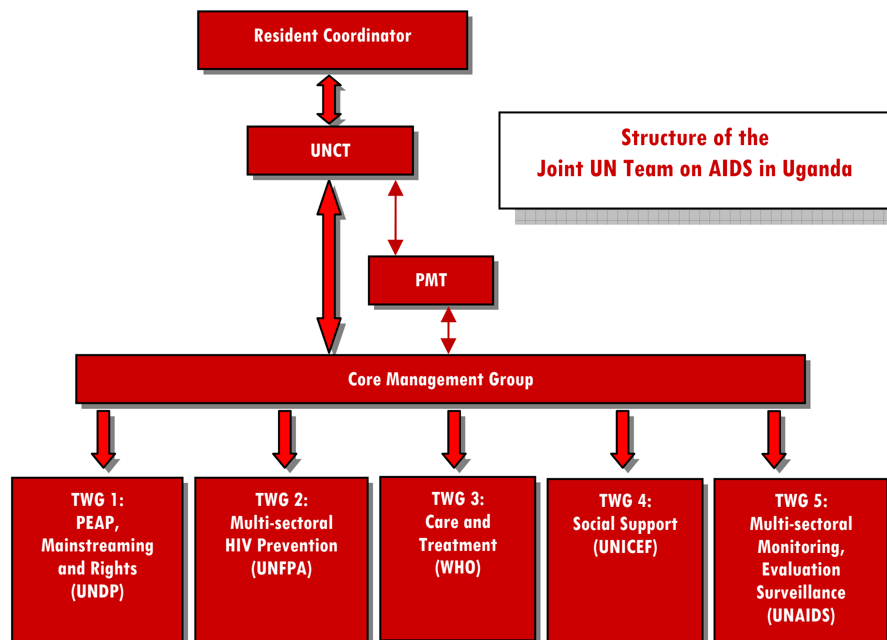
Within the 17 areas of the Division of Labour, Lead Agencies serve as single entry points for government and other stakeholders that require support within a particular technical area. Lead Agencies then mobilise assistance from Supporting Partners, i.e., any other UN agency with relevant technical expertise or capacity in the needed area.

The supporting partners within any given area of technical support are comprised of all agencies of the UN family in Uganda with institutional expertise and mandates for providing support in that thematic technical area. The 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 be responsible to liaise with the appropriate Lead Organization for coordinating the support.

4.2 Structures and relationships

4.2.1 The Resident Coordinator and the UN Country Team

Accountability for HIV in the UN system is vested in the Resident Coordinator (RC) with support from the UNAIDS Secretariat. This replaces the previous structure of a rotating Theme Group chair. The UN Country Team (UNCT) consists of all the heads of agencies/funds/programmes and is chaired by the RC. In managing the Joint Programme, the UNCT is responsible for ensuring accountability and harmonisation in its strategic policy and priority setting. Structurally, lines of authority and accountability span the levels between the Resident Coordinator and Thematic Working Groups.



4.2.2 Joint UN Team on AIDS in Uganda

The membership of the Joint UN Team on AIDS in Uganda is comprised of all full time and part time UN programme staff working on HIV and AIDS based in Kampala and the districts. The convenor is the UNAIDS Country Coordinator (UCC), who reports to the Resident Coordinator and the UNCT. The full Joint Team meets for planning, priority setting for the coming year and for evaluation functions. These meetings are based on the UNDAF annual planning timetable and the national Joint AIDS Review (JAR). UN Staff are formally nominated to the Joint Team in a letter jointly signed by their Heads of Agency and the Resident Coordinator.

Terms of Reference for the Joint Team are:

- Support the Uganda AIDS Commission and other bodies in their efforts to implement an accelerated national response, and resolve impediments to implementation;
- *C*onstitute entry points for national stakeholders to access HIV-related technical assistance from the UN system;
- Develop, facilitate and monitor the Joint Programme based on the UNDAF, and promote harmonisation with national systems of monitoring and evaluation;
- Provide technical advice to the UNCT and follow up on decisions made; and
- Provide technical advice and review national progress in advance of annual Joint AIDS Review, Sector and PEAP reviews or other national processes.

Individual members will be accountable for fulfilling their assigned roles and responsibility within the Joint Team structure. Key deliverables are agreed under the Joint Programme and the Rolling Annual Work Plan. Heads of Agencies (using existing agency accountability frameworks and individual organization processes) will ensure that individual performance

assessments take into account time and technical contribution to the Joint Team. The UCC can be asked to contribute to any Joint Team member's performance appraisal.

4.2.2 Thematic Working Groups of the Joint Team

The Joint Team has established five Thematic Working Groups (TWGs) to provide technical advice and leadership on implementation of the Joint Programme. The five TWGs of the Joint Team mirror the Country Programme Outcomes of the UNDAF Outcome 4 (on HIV and AIDS). TWGs 3 and 4 are responding to one outcome but are split for operational purposes. The TWGs directly correspond to priorities within the National Strategic Plan.

The TWGs are:

1. Mainstreaming and Rights (convener - UNDP)
2. Multi-sector HIV Prevention & Education (convener - UNFPA)
3. Treatment & Care (convener - WHO)
4. Social Support (convener - UNICEF)
5. Multisectoral, M&E, surveillance & strategic information (convener - UNAIDS)

Each TWG will focus on one of the Priority Areas described in the Joint Programme. Within each TWG, there will be Participating Organizations for the component activities of the Priority Area. Team Leaders of various UN agencies are convenors of the TWGs, dependent on their mandate and the Uganda Division of Labour. All UN program staff directly concerned with the thematic/technical area are members. The TWGs meet once per month, or as needed.

The **Terms of Reference** of the Thematic Working Groups are:

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

4.2.3 Convenors of Thematic Working Groups

Based on an agreement among the Heads of Agencies, the convening agencies of the TWGs are based on the agreed technical support division of labour and the mandate of

agencies in the UN system. Convenors are senior AIDS programme staff or deputies who work on behalf of the UN system (well beyond the specific mandate of their home agency) bringing the UN system together to deliver on the mandate of the TWGs.

Their **Terms of Reference** are:

- Responsible for convening and chairing meetings of their thematic/technical working group.
- Work through their Thematic Working Group to set priorities and ensure the development and implementation of their component of the Joint Programme.
- Sit on the Core Management Group that finalizes the Joint Programme and position for approval by UNCT
- Draw on and delegate to working group members as needed.
- Draft TWG group components

4.2.4 Core Management Group

The Core Management Group consists of the convenors of the Thematic working groups, heads of agencies, HIV programmes and HIV focal point programme staff in none convening agencies. This group makes decisions for which are forwarded for information to the UN Country Team through the PMT about how the Joint Programme funds should be spent and which partners should be allocated additional funds for implementation. The Core Management Group meets at least once every two months or on a need basis.

Terms of reference for the Core Management Group are:

- Identifies priorities for UN action on the AIDS response in future years and identifies key gaps in the national response (relevant for the UN system);
- Consolidates inputs from thematic working groups and develops the Joint UN Programme of Support on AIDS and Rolling Annual Work Plan;
- Negotiates agreement across UN agencies on priorities;
- Ensures implementation, oversight and monitoring of the Joint Programme within the UNDAF and NSP;
- Agrees to operational modalities and pooled funding modalities, including priority actions for use of extra-budgetary resources through the pooled finance mechanism for approval by UNCT;
- Oversees development and operationalisation of approaches to Joint UN M&E of the UN response to AIDS ensuring alignment with national systems;
- Reviews functioning of the Joint Team and Uganda UN Technical Support DoL;
- Addresses key issues of national importance on the AIDS response as they emerge and proposes recommendations for consideration by the UNCT;
- Prepares agendas for Joint Team meetings and UNCT meetings on AIDS and follow up decisions/recommendations from the UNCT; and
- Ensures progress on UN learning/workplace action on AIDS.

4.2.5 Extended Programme Management Team (PMT)

The extended PMT consists of deputy heads of agencies and the heads of HIV programmes for those agencies that are not ordinarily members of the PMT. The extended PMT will meet prior to the UNCT meeting on AIDS to review the recommendations of the Core Management Group in relation to the Joint Programme and Joint Team.

4.3 Administering the Joint UN Programme

4.3.1 Managing Agencies' own resources

The Joint UN Programme is funded from existing agency budgets and through pooled, non-earmarked extra-budgetary funds. Agencies are responsible for managing their own funds, and must indicate budgets and expenditure for the Joint UN Programme.

4.3.2 Managing extra-budgetary pooled funding

Additional funding for the Joint Programme is managed under a "Pass Through" arrangement, as per UNDG rules. UN agencies in the Joint Programme are required to select from among themselves an Administrative Agent (AA), taking into consideration: i) country presence; ii) financial and administrative capacity to interface between donors and POs, iii) thematic and functional expertise in HIV, iv) on-the-ground experience with AA functions, and v) competitive AA fees.

Based on these considerations, the UNCT in Uganda selected the UNDP to serve as the AA for the Joint UN Programme. This means that funds from donors will be channelled to UNDP as the AA, and then UNDP in turn will disburse to Participating UN Organizations (including itself), based on a common Annual Work Plan and budget as approved by the UNCT. This is known as a Pass-Through Fund Management mechanism (see illustration above), and applies where several UN organizations develop a joint proposal, identify funding gaps and submit a Joint UN Programme document to donors.

Via the AA, the UNCT will be accountable to donors for funds received. Acting as the AA authorised by the UNCT, UNDP will negotiate and sign a Letter of Agreement with donors in respect of the Joint UN Programme (see Annex 3). UNDP will also sign a Memorandum of Understanding with POs (see Annex 3). Under the MoU, each UN organization participating in the Joint UN Programme will be responsible to programme and manage the

allocated funds in line with its own established regulations and rules. In other words, both programmatic and financial accountability will rest with the Participating UN Organizations.

Funds received from donors will be recorded by the AA (UNDP) in a Joint UN Programme account. The AA (UNDP) will not record funds channelled to other POs as own income. The UNDP will only record as income those funds for which it is programmatically and financially accountable (i.e., for its part of the Joint UN Programme as a PO)[21].

Given the nature of the AA functions envisaged, UNDP as AA will be authorised by the UNCT to allocate 1% of the amount contributed by the donors (with no ceiling) for its costs of performing the AA functions. The anticipated work load of the AA will entail passing funds at least twice a year to executing UN organizations (i.e., excluding the UNAIDS Secretariat and possibly other smaller UN organizations, which currently operate a multiple transaction-based cost recovery arrangement with UNDP).

Additional to this AA fee, each PO will be expected to recover its own indirect costs in accordance with its financial regulations and rules, and as documented in the MoU signed with the AA. In the past, because of the differing nature of mandates and expertise required, rates for cost recovery varied between UN organizations. However, the UN Development Group (representing UNDP, UNICEF, WFP and UNFPA) recently agreed to levy their administrative fee for such joint activities at 7% across the board. In an unprecedented move, the WHO office in-country has agreed to this 7% levy. The UNCT's expectation is that others – UNHCR, UNODC and UNAIDS Secretariat – will follow suit.

Hence, in total and including the administrative costs of the AA, a UN system administrative cost of 8% can be expected to apply to donor contributions. This is a highly competitive overhead cost by any standard, and translates to a potential net savings for programme activities, as compared to using traditional parallel funding mechanisms.

4.4 Risk analysis

There are a number of possible risks associated with the Joint UN Programme. These are elaborated below, along with mitigation strategies.

Inadequate commitment of the UN agency heads, and the UN Resident Coordinator, to joint programming *(low probability, high impact)* - Commitment of all HoA officially sought, and approval of UNCT given, prior to development of the programme; commitment and full support of the UN Resident Coordinator established.

Choice of an AA and percentage of individual UN organization administrative fee are potential sources of misunderstanding and conflict in donor-funded Joint UN

[21] See Annex 3 for a detailed description of the Financial Management Procedures for donor funds, based the UNDG Guidance.

Programme activities *(low probability, medium impact).* Standardized rates and ceilings have been negotiated with all participating agencies beforehand; explicit instructions from UN Development Group to ExCom agencies (UNICEF, UNFPA, UNDP and WFP) to apply agreed ceilings for joint programming at country level prior to implementation of the Joint UN Programme in Uganda.

Inability of UN participating organizations to work together, communicate effectively, and deliver in a timely manner against the Joint UN Programme *(medium probability, high impact).* Process for the development of the team, and explicit ways of working together stressed during the development of the programme; M&E, accountability and systematic consultation mechanisms (Core Management Group/PMT) put in place for early identification of problems; involvement of the Regional Directors Team (RDT) in accelerating translation of the agency commitments to joint programming into action at country level; Global Implementation Support Team (GIST) in place and on stand-by to support problem solving at country level.

Lack of critical human resources or official presence, especially within certain UN organizations, to drive the joint programming agenda across agencies, and to implement the programme *(medium probability, high impact).* HoA willingness to make staff available for Joint UN Team work continuously monitored by UCC; possibility of donor funding to be used in a 'matching' mechanism to strengthen capacity in the short term; continuous performance monitoring system and programmatic M&E in place.

Resistance by agencies due to restriction of their current programmes as well as changes in current mind-sets for working *(medium probability, high impact).* Continuous focus on progressive harmonisation and increased pooling of resources within the UN system; incentives for joint programming need to be visible for individual agencies. Recognition of Joint UN Programme approaches necessary in agency reviews, planning, reporting, etc; and continuous involvement and peer review by Agencies (HoA) through the UNCT, Core Management Group/PMT, and technical staff through the Joint UN Team on AIDS.

5. Accountability – M&E of Joint UN Programme

5.1 Annual Joint UN planning/reporting cycle

5.1.1 Annual planning processes

One of the primary aims of the Joint UN Programme is to consolidate planning and reporting. Following the national Joint Annual Review (JAR), priority areas for the coming year are identified. After this, consultations are held with stakeholders to agree on areas that can best be supported by the UN. The Joint Team TWGs meet collectively to agree the annual results. Using the technical support, the Division of Labour activities that work to achieve those results are selected along with the agencies involved. The Joint UN Programme budget is developed in the same way as well as reporting on the Joint UN Programme. The new programme goes into effect on 1st January of the period.

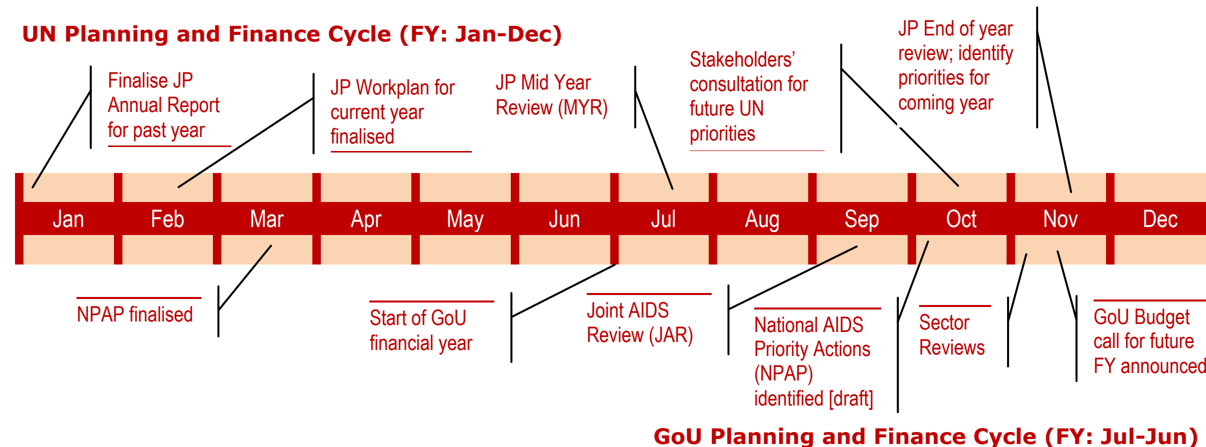
For extra-budgetary funds, the UNDP, acting as AA, will consolidate the financial reports of participating UN organizations and show disbursements of any additional donor funds to the participating organizations over the reporting period. These different reports and inputs will then be aggregated by the UNAIDS Secretariat and the Joint UN Team to highlight key issues, achievements, lessons learned and recommendations for future action. Following a subsequent technical review by the Joint UN Team on AIDS, the UNAIDS Country Coordinator will present the final report to the Core Management Group, for submission to the UNCT for final review and approval, and onward transmission to UAC, Partnership Committee, and AIDS Development Partners (and via UNDP, also to concerned donors on behalf of the UNCT). UAC and donors may be invited to internal UN reviews to appraise programme progress. If requested, the final consolidated report may annex individual reports from all agencies.

The UNAIDS Secretariat, and TWG 5 (on M&E) of the Joint UN Team on AIDS carry out the programme monitoring, evaluation and reporting to the UNCT that will feed into the annual Joint AIDS Programme Review (JAR) led by the Uganda AIDS Commission (UAC). Working closely with the UAC and other key government and CSO partners, the Joint UN Team on AIDS will use the following mechanisms to monitor performance of the Joint UN Programme and ensure it supports the national M&E system and process:

- Rolling Annual Work plan and Budget
- Six-monthly Financial and Programme Implementation Progress Report
- Full Annual Progress Report – linked to UAC JAR process
- Mid-Term Review (MTR) after three years implementing the Joint UN Programme

The Joint UN Programme still uses the standard UN annual planning cycle (January-December). But to ensure that this links to, and aligns with the Government of Uganda planning cycle (July-June), Joint UN Programme planning and reporting will be managed in two blocks of six months each within every 12 months [see Annual Calendar below].

Annual calendar of planning, M&E and reporting events



5.1.2 Reporting

The Joint Team will report to partners throughout the cycle of the programme of support. There will be two reports per year:

- The UCC will make the Mid-year report to the UNCT and the report will include information on the Joint Team and Programme of Support;
- The Resident Coordinator will make the Joint Programme annual report on behalf of the UNCT and will describe the progress and achievements of the Joint Team;
- The Resident Coordinator will make the annual report of the UNCT work plan;
- UNAIDS will make quarterly reports to the ADPs;
- JAR – fora for Technical Working Groups collectively reporting on annual accountability to PC, government and other stakeholders
- Annual reports will be disseminated to PC/UAC, line ministries, ADPs, and CSOs.

5.1.3 Calendar of important M&E events

The annual calendar of important M&E events include the mid-year review in July, the end year review in November, Development of the Annual Work plan in November. During the year 2009 there will be a Mid-Term Evaluation of the Joint Program and an end evaluation in the year 2011. Every First Day of December, the World's AIDS Day is observed. [For details of annual cycle, see section 5.1 and annual calendar above]

5.2 Performance monitoring & evaluation

5.2.1 Results based approach

The overall UN Joint Programme objective is to contribute to the achievement of change through four levels of results:

- Goal - refers to the impact, i.e., the highest level aimed at by the UNDAF;
- Country programme outcome - refers to the significant change from programme outputs aligned with the NSP;
- Country programme outputs - refers to the 5 year results, i.e., the totality of the UN results; and
- Annual results – refers to individual outputs of activities in the annual work plan.

The Joint Team and its component agencies can best ensure good accountability for their involvement and performance in the national HIV response if relevant systems, including a Monitoring and Evaluation framework, are in place. The M&E Framework of the Joint UN Programme on AIDS (Joint Programme) is a management and policy guidance tool for tracking implementation of the Joint Programme work plan, assessing achievement of its objectives, and channelling the resulting evidence to appropriate venues for application.

The specific objectives of the M&E framework for the Joint Programme are to:

1. Ensure efficiency, quality control, completion of activities, clarity of roles and responsibilities and engagement of all partners
2. Compare planned versus actual activities and outcomes

The M&E Framework will be used to generate data and enable structured analyses of:

- Outcomes in priority areas to which the UN Joint Program contributes
- Delivery of key output results
- Implementation of activities by UN Agencies and the UNAIDS Secretariat
- Expenditures incurred against outputs and broad activities
- Lessons learned, and
- Assessments and evaluations.

5.2.2 Accountability

Accountability will be fostered through a results based management approach with the Joint Team and each agency to ensure that processes, products and services contribute to the achievement of the targeted results (outputs, outcomes and impacts). The M&E framework will enable monitoring and self-assessment of progress towards results and facilitate reporting on performance. The M&E framework covers both the work plan and functioning of the UN Joint Team.

The M&E framework will enable and strengthen the 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 Heads of Agency;
- Individuals are expected to report regularly to their Heads of Agency, 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.

5.2.3 Monitoring and evaluation

The Joint UN Team on AIDS (Joint Team) will monitor progress in a collaborative manner. The Joint Team will track progress as a formal exercise through reporting systems agreed by the UN Country Team and informally during regular meetings of the Joint Team. The Joint Team will also assess outcomes twice a year as mid-year and end-of-year internal reviews. The ongoing monitoring will focus on providing information about the annual work plan progress, identifying shortcomings in time to correct them. Monitoring the annual work plan will include:

- whether or not the annual work plan has been created;
- whether it is aligned with the HIV component of National Priority Action Plan/UNDAF;
- whether targets have been reached; and
- at what rate programmes are being implemented

The Joint Team will carry out quality assurance on the programme progress as well as the M&E activities with a checklist aimed at ensuring impact. The checklist will, however, also look for any unintended or unexpected outcomes, either positive or negative, that may arise from the programme of support.

5.2.4 Indicators for the Joint UN Programme

The indicators that have been selected for both monitoring and evaluation look at the Joint Team establishment and functioning, as well as progress made towards development and implementation of the programme of support. The indicators for monitoring and assessment of the Joint Programme and Team have kept in mind their overall purpose which is: improved coherence, efficiency, effectiveness and relevance of the joint UN response to AIDS.

The selection of indicators for tracking annual work plan implementation has considered alignment to various national review processes so that they can be used to improve practice. In particular, they are aligned to the national HIV/AIDS monitoring and evaluation framework [National Performance Measurement and Management Plan (PMMP) for HIV/AIDS 2007/08 to 2011/12 – see Annex 8]. Moreover, the indicators are also aligned to the UNDAF monitoring and evaluation processes.

In selecting indicators, the Joint Team has also considered relevance, feasibility of collection and simplicity of measurement. The Joint Team plans that performance assessments will result in the formulation of recommendations, commitments and a plan of action for improving the quality of the joint UN response to AIDS.

5.3 Monitoring

5.3.1 Monitoring the annual work plan

5-year Country Output indicators have been identified and will be used to annually track progress on results expected to lead to the Joint Programme outcomes (see Annex 6). In addition, specific outputs for activities agreed in the annual work plans will be identified and tracked. For each of the country output indicators, the Uganda UN Joint Team will agree on targets. Progress in achieving these annual outputs and the 5-year country output targets will form the basis of monitoring the annual work plan.

There are 43 5-year country output indicators. Of these, 11 are for mainstreaming, 6 are for prevention, 14 are for care and treatment and social support and 12 for monitoring and evaluation. The important question at this level is whether activities are being implemented on time and within their budget lines. The other important question is whether the expected outputs of the activities are being achieved.

5.3.2 Mid-year and Annual Review of Progress

The mid-year and annual reviews of progress are key accountability mechanisms for the individual agencies and the Joint Team. Monitoring and Evaluation of the programme of support is integrated with the Joint Team's annual work plan development to ensure that the work of the UN builds on the achievements of the previous year(s) and is responsive to emerging needs.

A monitoring matrix (see Annex 6) that is based on the Annual Work plan will be the tool used to report progress on the work plan. The monitoring tool matrix collects the following information:

- Thematic area;
- Activities and Status of activities (not started, on-going completed);
- Expected annual outputs and Expected 5 year country output (i.e., means of verification);
- Achievements towards the 5 year country output and Joint Programme outcome,
- Joint Programme Outcome;
- Challenges/emerging issues; and

- Priority activities for the remaining period in the mid-year review and for the next year for the end year review.

As part of the thematic reports, a summary of number and proportion of activities completed, on-going and not started will be made to assess the implementation rate of the Annual Work plan.

The key steps in the mid-year and annual review processes are:

- Thematic team members in each UN agency in collaboration with the Convenors of the thematic groups and complete the monitoring tool matrix (Annex 6) for the activities for which they are responsible;
- The Thematic Group Convenors will submit their completed monitoring tool matrix to the UNAIDS office biannually on agreed dates;
- The Joint Team in collaboration with the UNAIDS office will review the results in relation to the expected outputs and assess whether the intended outcomes have been achieved. The mid-year and end year review will have participation of key government partners and will be used to determine future priorities;
- The UNAIDS Secretariat will produce a mid-year and annual report in consultation with the Joint Team consolidating the results of all activities in relation to expected outputs and intended outcomes.
- The mid-year and annual reports will be reviewed by the Joint UN Team on AIDS and will be used as the basis for reviewing the team's annual AIDS work plan and development of the work plan for the next period.

A questionnaire to determine satisfaction of government partners will be administered at the end of the year and the results will form part of the annual report. The questionnaire will obtain the following information:

1) Were you satisfied with the UN's contribution (TA/Financial) to the country output? Explain
2) If no, how else would you like the UN to assist in contributing to the country output?

5.3.3 Measuring Joint Programme Management

The Joint Programme management will also be assessed for effectiveness and efficiency. Aspects to be examined will include financial management, administration, governance, foundation, external relations and resource mobilization (see Annex 7). A report will be made by UNAIDS using the indicators in Annexes 6 and 7 as part of the annual report. In addition, for each activity budget line, planned budget will be compared with the actual amount spent.

All agencies will report six monthly on programmatic and financial expenditure. The report will be based on achievements made against work plans and budgets and across the UN Joint Programme for AIDS (JP) indicators. The Agency will use the UN Joint Programme provided report format (Annex 6). All reports should reach the Joint Programme Secretariat by 4th week of the following month after the end of the mid-year or end-year period. The report will be accompanied with sufficient supporting documents, e.g., face

formats. This report will enable active planning for the Joint Programme and assessment of value for money as might be necessary.

5.4 Evaluation

5.4.1 Evaluation of the UN Joint Team

Evaluation of the Joint Team and the Joint Programme of support will be conducted every two to three years. The assessment of performance of the UN Joint Team will focus on indicators of the successful establishment of the team and its effective functioning. A management performance matrix and detailed indicators are described in Annex 7.

5.4.2 Evaluation of the Joint Programme of support

Every 2 to 3 years, there will be an assessment of improvements in UN support to the national response, i.e., whether there are increases over time in key activities or competencies that are attributable to the Joint Team and its programme of support.

The following performance indicators will be used to assess the Joint Program:

- Number of joint program activities;
- Number of joint consultations with the Uganda AIDS Commission and key ministries of its partnership;
- Number of unified UN positions released on key issues;
- Number of meetings of the UNCT where HIV/AIDS is discussed:
- Percentage of resources (from donors, from headquarters) going through joint UN activities as articulated in the programme of support;
- Number of joint assessments;
- Capacity of joint team members;
- Implementation rate of main sources of funding; and
- Degree of harmonization and alignment with the national response by the Joint Programme and Joint Team will be determined by UAC with assistance of UNAIDS by using the Country Harmonization and Alignment Tool (CHAT). The tool will be applied every 2 years and will involve the UN and other AIDS Development Partners. The tool examines:
  a) The participation and degree of engagement of country-based partners in the national response, and
  b) The degree of harmonization and alignment among HIV international partners.

The indicators for harmonization and alignment are adapted from the Paris Declaration of AIDS effectiveness and include ownership (1 indicator); alignment (8 indicators); harmonisation (2 indicators); accountability (1 indicator); and mutual assessment (1 indicator).

5.4.3 Independent mid- and end-term evaluations

Independent mid-term and end-term evaluations using qualitative and quantitative methods will be carried out as part of the evaluation of the programme of support.

The evaluation will include whether the programme for support:

- is aligned to the national priorities;
- is strategic and evidence-informed;
- provides clarity on roles and responsibilities of individual agencies; and
- includes individual as well as joint or collaborative activities.

Other questions to be addressed during the mid-term review will be:

- What is the contribution of the Joint Programme to achieving NSP targets?
- Is the government holding the UN accountable for the commitments outlined in the Programme of support?
- How has the joint nature of the programme contributed to positive outcomes in each area?

The indicators for the evaluations are listed as outcome indicators in Annex 6. At the outcome level, the Joint Programme will use national targets for evaluating achievements.

Individual agencies will remain responsible for evaluating the performance of the activities/programmes that make up their programme of support, and that are assigned to them as the lead agency.

References

ADPs (2007) ADP meeting (minutes). 1st June

Adupa, R.L. and Mugerwa, C.G. (2006) Report on Review of the Performance and Contribution of Development Assistance and Major Funding Mechanism of the National AIDS Response. For UAC, February

Ainsworth, M.; Vaillancourt, D.A.; Gaubatz, J.H. (2005) Committing to results: improving the effectiveness of HIV/AIDS assistance: an OED evaluation of the World Bank's assistance for HIV/AIDS control. Operations Evaluation Department, World Bank.

Akol, A. (2007) The Uganda AIDS Commission should reconsider its decision to halt distribution of the female condom. Letter to Editor, Daily Monitor. 8 June.

Attawell, K. and Dickinson, C. (2007) 'An Independent Assessment of Progress on the Implementation of the Global Task Team Recommendations in Support of National AIDS Responses'. HLSP, May

DfID and UAC (2003) Mainstreaming HIV/AIDS issues into the PEAP. July

DfID, Irish AID and UAC (2007) The Civil Society Fund: A fund to increase civil society participation in the national response to HIV/AIDS, OVC, TB & malaria in Uganda; an Information Note', DFID, Irish Aid, UAC, March

Hudson, C.P. (1996) AIDS in rural Africa: a paradigm for HIV-1 prevention; Editorial review. International Journal of STD & AIDS 7:236-43

IASC (2006) Joint Inter-Agency Emergency Health, Nutrition and HIV/AIDS Response in IDP Camps in Northern Uganda 1 Jan-31 March 2006, Project Document

IASC (2007) 'HIV in Humanitarian Situations – Global and Country-level Coordination Arrangements', Inter-Agency Standing Committee 68th Working Group Meeting 13-15 June

ILO (2007) Uganda Decent Work Programme; final text. ILO Office for the United Republic of Tanzania, Kenya, Somalia and Uganda. May.

Irish Aid (2007) Letter of understanding between Irish Aid and the United Nations Development Programme (UNDP). December

Johnson, R. (2006) Report of the 2006 Annual Review of the Uganda UN Development Assistance Framework (UNDAF); Final Report. Prepared for the UN Resident Coordinator (Uganda). 15 December

Joint UN Team (2007) The Joint UN Programme of Support for AIDS (JUPSA) in Uganda, 2007-2012 (draft)

Joint UN Team (2007) Working meeting, Kabira hotel (minutes). 27th June

Lake, S. And Mwijuka, B. (2006) Sector based assessment of AIDS spending, Uganda. Final Report. European Commission. November.

MoAIF (2005) Strategy for Reducing the Impact of HIV/AIDS on Fishing Communities', Third Draft for Consultations. Dept.of Fisheries Resources; Ministry of Agriculture, Animal Industry and Fisheries; Republic of Uganda

MoFPED and UAC (2007) Inception Report for Developing Guidelines for integration of HIV and AIDS in planning and budgeting process at national and district levels. Ministry of Finance, Planning & Economic Development and UAC, April

MoGLSD (2004) Rapid Country Response Analysis: Uganda, 2004. Ministry of Gender, Labour and Social Development

MoGLSD (2006) National Child Labour Policy. Ministry of Gender, Labour and Social Development; November

MoH and ORC Macro (2006) Uganda HIV/AIDS Sero-Behavioural Survey 2004/2005 (UHSBS). March. MoH and ORC Macro

Munene, J. and Nansubuga, F. (2006) A Report on UN Reform in HIV/AIDS and Joint Programming and Readiness among UN Agencies in Uganda. Final draft, November. For UNAIDS

Secretary-General (2007) Remarks at the General Assembly, Review of Declaration of Commitment on HIV/AIDS. May

Slutkin, G.; Okware, S.; Naamara, W.; Sutherland, D.; Flanagan, D.; Carael, M.; Blas, E.; Delay, P.; Tarantola, D. (2006) How Uganda reversed its HIV epidemic. AIDS Behaviour 10:351-361.

Straker, M. (2006) Reviewing and streamlining long and short term technical assistance and support. Uganda AIDS Commission. April.

UAC (1993) The Multi-sectoral Approach to AIDS Control in Uganda – Executive Summary. UAC (from the UAC website)

UAC (2005) Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS) – Uganda Country Report, January 2003-December 2005. Uganda AIDS Commission

UAC (2005) National HIV/AIDS Stakeholders & Service Mapping Atlas. UAC, Uganda HIV/AIDS Partnership. December.

UAC (2006) Accelerating HIV Prevention: The Road Map towards Universal Access to HIV Prevention in Uganda. Uganda HIV/AIDS Partnership Committee; Uganda AIDS Commission. August

UAC (2006) Reviewing and Streamlining Long and Short Term Technical Assistance Support. Uganda AIDS Commission, April

UAC (2007) 'NSP 2007/8-2011/12 Draft 2nd Outline', 23 March

UAC (2007) An Operational Handbook for the HIV/AIDS National Performance Measurement and Management System. Zero draft copy, May. Uganda AIDS Commission

UAC (2007) The National Performance Measurement and Management Plan for the National Strategic plan for HIV/AIDS Uganda 2007/8 – 2011/12. Zero draft copy, May. Uganda AIDS Commission

UAC (2008) National Strategic Plan 2007/8-2011/12. March

UNAIDS (2005) Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors; Final Report. 14 June

UNAIDS (2005) The "Three Ones" in action: where we are and where we go from here. May

UNAIDS (2005) The Global Task Team, a pathway to implement the "Three Ones": Opportunities for scaling up the response to HIV at country level. Guidance Note. UNAIDS, December.

UNAIDS (2005) UNAIDS Technical Support Division of Labour: Summary & Rationale

UNAIDS (2006) UN System in Uganda: Repositioning the UN for a more effective response to AIDS. Final, UNAIDS secretariat, June

UNAIDS (2007) Country Performance and Analysis: Frequently asked questions on Joint UN teams and programmes. February

UNAIDS (2007) Second guidance paper: Joint UN programmes and teams on AIDS: Practical guidelines on implementing effective and sustainable joint teams and programmes of support. Joint United Nations Programme on HIV/AIDS (UNAIDS)

UNAIDS (2008) UNAIDS' Terminology Guidelines. February

UNAIDS Uganda (2007) Joint UN Programme of Support for AIDS: Performance measurement and management framework; draft. 22nd July

UNAIDS Zambia (2006) Joint United Nations Programme of Support on AIDS 2007-2010. Government of the Republic of Zambia; United Nations Country Team Zambia; UNAIDS Zambia.

UNESCO (2007) Ten-Year Strategic Plan (2007-2016). Uganda National Commission for UNESCO

Wabwire-Mangen, F. (2008) Modes of Transmission Study: Uganda, A Review of the Epidemiology of the HIV/AIDS Epidemic in Uganda. UAC, UNAIDS. August

Wabwire, F.; Tumwesigye, N.M.; and Opio, A. (2006) Accelerating HIV Prevention in Uganda: The Road towards Universal Access: I. A Review of the Trends and Projections of HIV/AIDS Prevalence and Incidence in Uganda. For UAC, June.

Wilson, D. (2007) Understanding AIDS in Asia: the role of development partners. Global HIV/AIDS Program, World Bank.

ANNEXES

Annex 1: HIV Epidemic & MDGs in Uganda[22]

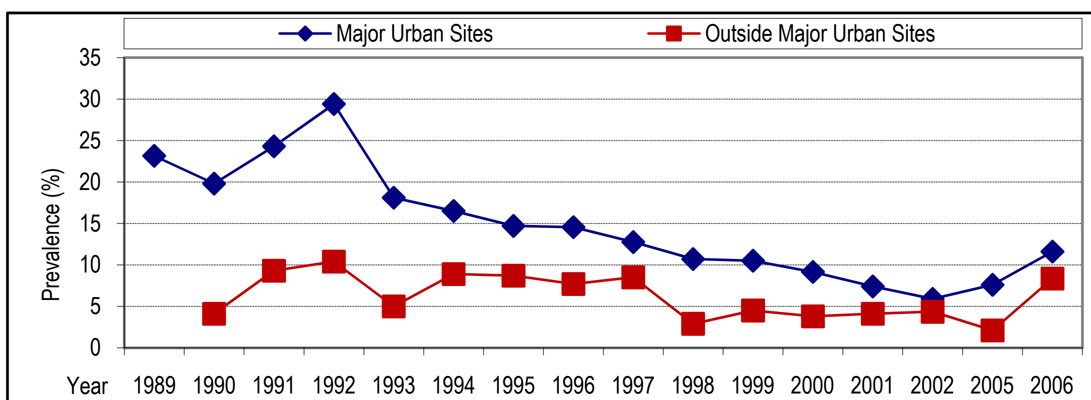
The Millennium Development Goal (MDG) number 6 is to combat HIV/AIDS, Malaria and other diseases. There are two targets for the MDG 6:

- Target 1: By 2015, have halted HIV/AIDS and begun to reverse its spread
- Target 2: By 2010, achieve universal access to HIV/AIDS treatment for all who need it

MDG 6 Target 1

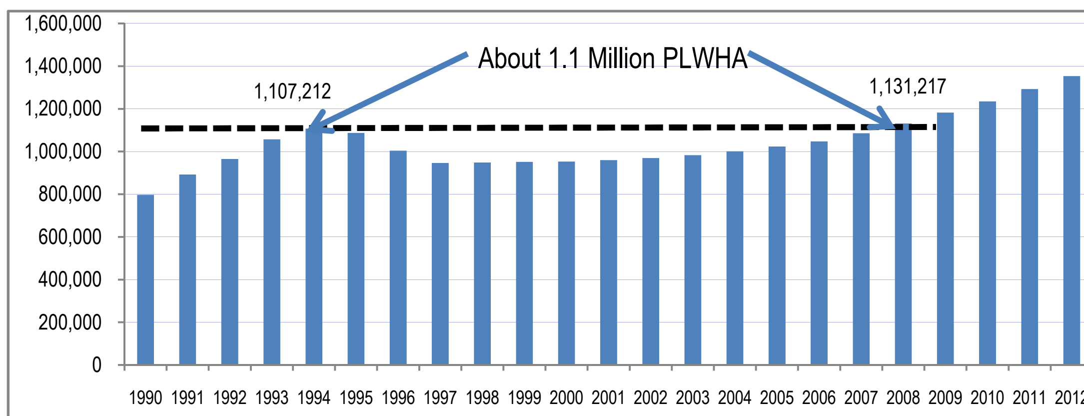
Figure A1.1 shows Uganda is not on track for Target 1; HIV prevalence is rising and the rural/urban gap is reducing.

Figure A1.1: ANC HIV prevalence, by rural/urban distribution



The numbers of PLWHAs have now exceeded the peak levels of 1994 despite just slight changes in prevalence; this is largely attributable to high population growth.

Figure A1.2: Annual burden of HIV in Uganda



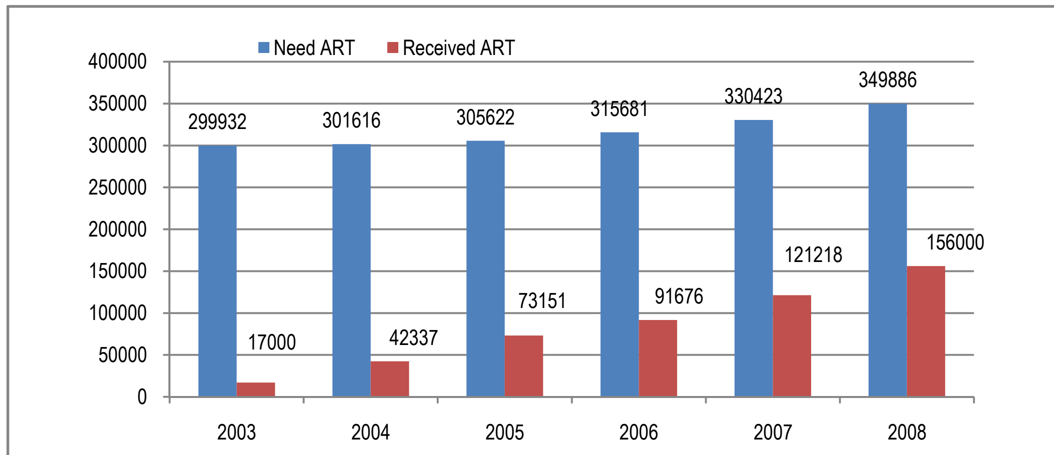
[22] The text in this annex shows latest information available at the time of printing.

The number of new infections in Uganda is outstripping the number of estimated deaths and new recipients of antiretrovirals (ARVs). During 2005, there were approximately 132,500 new infections, 72,000 deaths among persons living with HIV and 32,000 new ART recipients. Rapid population growth is an important contributing factor. By this scenario, the burden of HIV/AIDS on the systems for service delivery in Uganda is increasing and is liable to overwhelm efforts, resources and commitment.

MDG 6 Target 2

Despite increasing numbers on ART, Target 2 is also unlikely to be achieved, considering the rate of increase in numbers of those who need ART (Fig A1.2). There is still a wide gap between the need for treatment and levels of ART service achieved.

Figure A1.3: ART Coverage Compared to Need 2003-2008



Orphans and vulnerable children – 2007/08

Service coverage for OVCs is very low. About 21% of all children aged 0-17 years in Uganda are orphans or vulnerable (OVCs). About 2.3 million children (14.9%) have lost one or both parents. Close to half of all orphans (one million, 45.7%) are due to AIDS and among these are the most vulnerable – 10% of orphans aged 0-14 are themselves HIV positive. It is estimated that 17,000 orphan children are heading households, which are home to 32,000 orphans; and about 33% of children living in IDPs camps are OVCs. Of all the OVCs, only 308,000 (4%) were supported during 2007, mainly by PEPFAR.

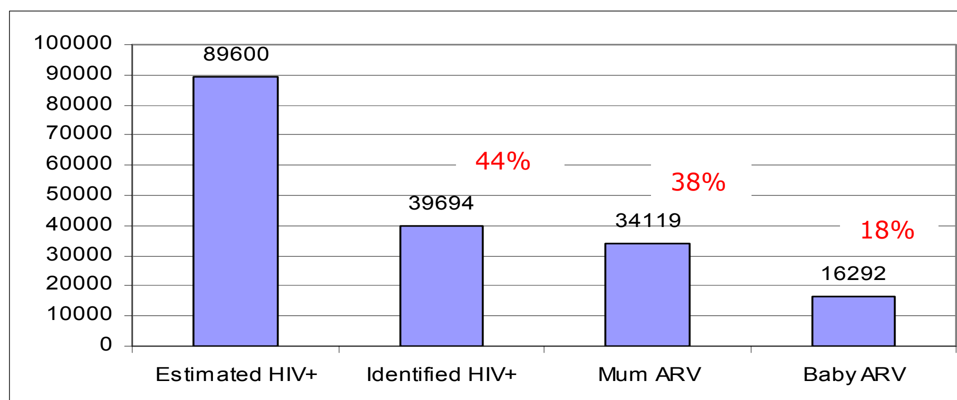
Coverage of HIV Counselling and Testing (HCT)

HCT coverage is very low. About 1.06 million persons were tested in 2007 and yet there were approximately 13,000,000 adults aged 15-49 years, i.e., less than 10% of adults know their status within the last 12 months. Without HCT, it is not possible to identify those in need of PMTCT, ART, or care, social support, and positive living interventions.

Prevention of Mother to Child Transmission (PMTCT) of HIV/AIDS

Out of an estimated 89,900 HIV positive pregnant women during the period July 2007 to June 2008, less than half (39,694 women, 44%) were identified as HIV positive, 38% received ARVs and 18% of their babies were given ARVs (Fig A1.3). Based on this analysis, one could say that a principal barrier to PMTCT is low levels of testing and identification of the pregnant women in need of ARVs (only 44% identification, but 86% coverage achieved for those identified).

Figure A1.3 HIV+ pregnant women getting ARVs for PMTCT (07–08)



Modes of Transmission of HIV

An epidemiological review was part of a Modes of Transmission study identified the following risk factors for HIV:

- Risky sex: Multiple concurrent sexual partners, Transactional sex, Cross-generational sex, Lack of consistent condom use
- Biological enhancing factors: HSV-2 infection, Intact penile foreskin
- Factors affecting decisions: Alcohol and drug use; behavioural disinhibition due to ART
- HIV Discordance

The latest estimates of HIV incidence by modes of transmission in Uganda were in 2008, using the MOT study for adults and Spectrum data for MTCT (Table A1.1).

Table A1.1. HIV incidence by mode of transmission (estimates)[23]

Mode of Transmission	Percentage
Multiple sexual partnerships (including partners)	37.3%
Mutually monogamous partnerships (past 12 months)	35.1%
Mother-to-child	18.1%
Sex work (Including partners, clients and partners of clients)	8.7%
Medical injections	< 1%
Blood transfusion	< 1%
IDU (intravenous drug user) and MSM (men who have sex with men)	< 1%

[23] Source: Wabwire-Mangen, F. (2008) Modes of Transmission Study: Uganda, A Review of the Epidemiology of the HIV/AIDS Epidemic in Uganda. UAC, UNAIDS. August

The MOT study also acknowledges the existence of contextual factors that are driving the epidemic and these include:

- Socio-cultural factors, including poverty and wealth, low status of women and girls
- Human rights factors, including stigma and discrimination
- Inequity and difficulty with access to prevention, care and treatment

Meanwhile, prevention programmes have not focussed on multiple partnerships and discordant couples, yet they are responsible for 72.4% of new infections.

Table A1.2: HIV-related MDG indicator values & Uganda national targets

MDG Indicator	2001	2002	2005	National Target 2011/12	Comments
HIV incidence (Spectrum)			132,500/ 0.85% (2005)	100,000/ 0.51%	
Adult HIV prevalence 15-49 years			6.4% (2004/05)	7.1%	Expected slight increase because of reduced mortality
HIV prevalence among pregnant women attending ANC	Major urban: 8.8% Outside major urban: 4.2% (2001)	Major urban: 7.2% Outside major urban: 4.6% (2002)	Major urban: 7.1% Outside major urban: 5.5% (2005)	Major urban: 7.8% Outside major urban: 6.6%	Stagnating by 2005. Expected slight increase because of reduced mortality
PMM indicator	**UDHS 2000/01**	**AIS 2004/05**	**UDHS 2006**	**Target 2011/12**	**Comments**
Condom use at last high risk sex for men 15-24 years		55.1%	54.1%		Low and no change
Condom use at last high risk sex for men 15-49 years	58.9%	53.4%	57.4%	73%	No significant change
Condom use at last high risk sex for women 15-24 years		52.9%	38.4%		Low and reducing
Condom use at last high risk sex for women 15-49 years	37.8%	46.7%	34.9%	70%	Low and reducing
Proportion of men aged 15-24 years with comprehensive correct knowledge of HIV/AIDS		35.3%	38.2%	64%	Low and no change
Proportion of women aged 15-24 years with comprehensive correct knowledge of HIV/AIDS		29.3%	31.9%	52%	Low and no change
Ratio of attendance of orphans to school attendance of non-orphans aged 10-14 years		0.9	0.96	1	High and no change perhaps because of UPE programme
Proportion of population with advanced infection having access to antiretroviral drugs		111,232/ 35.7% (Sep 2007)	141,000/42%	67%	Less than 50%

References

1. UDHS 2000/1, UBOS
2. Ministry of Health HIV surveillance reports of 2001, 2002 and 2003
3. AIS 2004/05, MoH
4. UDHS 2006, UBOS
5. Shafer LA et al. 2008. HIV prevalence and incidence are no longer falling in southwest Uganda: Evidence from a rural population cohort 1989-2005. *AIDS* 2008, 22:1641-1649
6. Ministry of Health. Universal Access Report for 2007.

Annex 2: Development of the Joint Team and Joint Programme (summary)

Programme design	Process	Partnerships	Time frame
Identify what is currently being done in the UN	Mapping of: Current UN human & financial resources for HIV; Program areas; How UN works - Report signed off by UNCT	Internal UN	May 2006
Identify National Agenda	Support development of National Strategic Plan for AIDS & review PEAP	Work with UAC & TWGs	July 2006 - 2007
Identify UN Agenda (with support by consultant): • What are the priority problems/issues? • What is already being done & by whom? • What should the UN do – maximizing comparative advantage & valued added of UN? • Which Agency(s) can do this?	1. Identify Leadership for Joint Programme (RC's office working through UNAIDS) - approved by UNCT 2. Establish Division of Labour (DoL); internal discussions with all Agencies - approved by UNCT 3. Identify Joint UN Team on AIDS – all those staff in all agencies working 20% or more; Write ToRs - approved by UNCT	1. Team interrogates Common Country Assessment (CCA) 2. Team interrogates UNDAF 3. Team consults with: DPs; CS; Other arms of Govt	July 2006 – July 2007
Determine Results Matrix 2009-2013 • Joint Programme Outcomes (5 years) • Joint Programme Outputs – results spread over 5 years • Joint programme Outputs – Yr 1 • Joint Programme Activities – Yr 1 • M&E Plan - Approved by UNCT	4. Appoint Joint UN Team on AIDS – nominate by HoA, Letter of Appointment from Resident Coordinator, include work as member of AIDS Team as part of performance appraisal 5. Revise UNDAF Outcome on AIDS 6. Establish AIDS Team Management Mechanism; prepare ToRs - approved by UNCT 7. Team designs programme (left-hand column) with help of consultant; draw on Joint Programming experience within UN Uganda	Team validates Results Matrix with all partners – Validation Workshop	September 2007
Determine Joint Programme Annual Work Plan – starts in 2007 (then annually) • Activities & Outputs for each year • Partners/Beneficiaries • Available resources & budget • Allocation of external resources (DFID) • Indicators of achievement of results - Approved by UNCT	8. Annual Workplans prepared following Joint AIDS Review	Management Group validates Annual Work Plan with all partners	September 2007
	1. Funding for Joint Programme identified/negotiated – approved by UNCT 2. Funding mechanisms identified (Pass Through? Selection of AA) – approved by UNCT 3. MoUs/LoAs signed 4. Funds mobilised	Resource Mobilization – Management Group/UNCT negotiates with potential donors: establish priorities, requirements, imperatives, constraints	
Implement	1. Team identifies implementation mechanisms, challenges 2. Team completes Joint Programme Performance Self Assessment (see tool); identify capacity-building needs 3. Management Group prepares Capacity-building Plan for Team – approved by UNCT	Team identifies & establishes coordination & oversight mechanisms; – approved by UNCT	
	Team Reports on Progress to UNCT		

Annex 3: Joint Agreement

Memorandum of Understanding between The Participating UN Organizations and The United Nations Development Programme regarding The Operational Aspects of a Joint Programme on AIDS in Uganda[24]

WHEREAS, the **Participating UN Organizations that have signed this Memorandum of Understanding** (hereinafter referred to collectively as the "Participating UN Organizations") have developed a joint programme (hereinafter referred to as the "Joint Programme") as part of their respective support to the National Strategic Plan on HIV & AIDS of the Government of Uganda, as more fully described in the detailed Joint Programme of Support for AIDS (JUPSA) dated **(insert date)** document no.**(insert number)** (hereinafter referred to as the "Joint Programme Document"), and have agreed to establish a coordination mechanism (hereinafter referred to as the "Joint Programme Core Management Group" of the Joint UN Team on AIDS) to facilitate the effective and efficient collaboration between the Participating UN Organizations and the host Government for the implementation of the Joint Programme;

WHEREAS, the Participating UN Organizations have agreed that they should adopt a coordinated approach to collaboration with donors who wish to support the implementation of the Joint Programme and have developed a Joint Programme Document to use as the basis for mobilising resources for the Joint Programme, and have further agreed that they should offer donors the opportunity to fund the Joint Programme and receive reports on the Joint Programme through a single channel; and

WHEREAS, the Participating UN Organizations have further agreed that the United Nations Development Programme (which is also a Participating UN Organization in connection with this Joint Programme) should be asked to serve as their administrative interface between donors and the Participating UN Organizations for these purposes and the United Nations Development Programme has agreed to do so in accordance with this Memorandum of Understanding.

NOW, THEREFORE, the United Nations Development Programme and the Participating UN Organizations (hereinafter referred to collectively as the "Parties") hereby agree as follows:

Article I - Appointment of Administrative Agent: its Status, Duties and Fee

1. The Participating UN Organizations hereby appoint the United Nations Development Programme (hereinafter referred to as the "Administrative Agent" or the "AA") to serve as their Administrative Agent in connection with the Joint Programme, in accordance with the terms and conditions set out in this Memorandum of Understanding. The Administrative Agent accepts this appointment on the understanding that the Participating UN Organizations assume full programmatic and financial accountability for the funds disbursed to them by the Administrative Agent. This appointment shall continue until it terminates, or is terminated, in accordance with Article VII below.

2. On behalf of the Participating UN Organizations, the Administrative Agent shall:
   a) Receive contributions from donors that wish to provide financial support to the Joint Programme through the Administrative Agent;
   b) Administer such funds received, in accordance with this Memorandum of Understanding including the provisions relating to winding up the Joint Programme Account and related matters;
   c) Subject to availability of funds, disburse such funds to each of the Participating UN Organizations in accordance with instructions from the Joint Programme Core Management Group, taking into account the budget set out in the Joint Programme Document, a copy of which is attached hereto as ANNEX A, as amended in writing from time to time by the Joint Programme Core Management Group;
   d) Review financial reports produced by each of the Participating UN Organizations and consolidated by UNAIDS into a consolidated report, and distribute such financial reports together with consolidated programme reports produced by the Participating UN Organizations, as further described in the Joint Programme Document, to each donor that has contributed to the Joint Programme Account, and to the Joint Programme Core Management Group.
   e) Provide final reporting, including notification that the Joint Programme has been operationally completed, in accordance with Article IV below;
   f) Perform such other activities as the Participating UN Organizations and the Administrative Agent may agree in writing.

3. The Administrative Agent shall enter into a letter of agreement, in the form attached hereto as ANNEX B (hereinafter referred to as a "Letter of Agreement"), with each donor that wishes to provide financial support to the Joint Programme through the Administrative Agent. The Administrative Agent shall not amend the terms of Annex B without prior written agreement of the Participating UN Organizations. The Administrative Agent shall provide the Participating UN Organizations with a copy of each Letter of Agreement it enters into.

4. Should there be a donor committee or other donor consultative mechanism established at any time in respect of the Joint Programme, the Participating UN Organizations will decide on the appropriate manner in which the Participating UN Organizations (including the Administrative Agent) will engage with such committee.

5. None of the Participating UN Organizations shall be liable for the acts or omissions of the Administrative Agent or its personnel, or of persons performing services on its behalf, except in regard to any contributory acts or omissions of other Participating UN Organizations. With respect to such contributory acts or omissions of the Participating UN Organizations, the resulting liability shall be apportioned among them or any one of them to the extent of such contributory acts or omissions, or as may otherwise be agreed.

6. The Administrative Agent shall be entitled to allocate an administrative fee of one percent (1 %) of the amount contributed by each donor, to meet the Administrative Agent's costs of performing the Administrative Agent's functions described in this Memorandum of Understanding. Notwithstanding the foregoing, in cases the contribution is less than $2 million, the fee will be subject to a minimum floor of $20,000; if the contribution is above $10 million, the fee will be subject to a maximum ceiling of $100,000.

[24] The font has been changed and reduced for minimizing space in the document, but all of the content in this document has been maintained.

Article II - Financial Matters

The Administrative Agent

1. The Administrative Agent shall establish a separate ledger account under its financial regulations and rules for the receipt and administration of the funds received pursuant to Letters of Agreement (hereinafter, the "Joint Programme Account"). The Joint Programme Account shall be administered by the Administrative Agent in accordance with the regulations, rules, directives and procedures applicable to it, including those relating to interest. The Joint Programme Account shall be subject exclusively to the internal and external auditing procedures laid down in the financial regulations, rules, directives and procedures applicable to the Administrative Agent.

2. The Administrative Agent will not absorb gains or losses on currency exchanges. Such amounts will increase or decrease the funds available for disbursements to Participating UN Organizations

3. The Administrative Agent shall make disbursements from the Joint Programme Account based on instructions from the Joint Programme Core Management Group, in line with the budget set forth in the Joint Programme Document, as amended from time to time by the Joint Programme Core Management Group. The disbursements shall consist of direct and indirect costs as set out in the budget.

4. Subject to the availability of funds, the Administrative Agent shall normally make each disbursement within seven (7) to ten (10) business days after receipt, in accordance with the instructions received from the Joint Programme Core Management Group in line with the Joint Programme Document. The Administrative Agent shall transfer funds to each Participating UN Organization through wire transfer. Each Participating UN Organization shall advise the Administrative Agent in writing of the bank account for transfers pursuant to this Memorandum of Understanding. When making a transfer to a Participating UN Organization, the Administrative Agent will notify that Participating UN Organization's Treasury Operations of the following: (a) the amount transferred, (b) the value date of the transfer; and (c) that the transfer is from the United Nations Development Programme as Administrative Agent in respect of the joint programme in Uganda pursuant to this Memorandum of Understanding.

5. Where the balance in the Joint Programme Account on the date of a scheduled disbursement is insufficient to make that disbursement, the Administrative Agent shall consult with the Core Management Group and make a disbursement, if any, in accordance with the Core Management Group's instructions.

The Participating UN Organizations

1. Each Participating UN Organization shall establish a separate ledger account under its financial regulations and rules for the receipt and administration of the funds disbursed to it by the Administrative Agent from the Joint Programme Account. That separate ledger account shall be administered by each Participating UN Organization in accordance with its own regulations, rules, directives and procedures, including those relating to interest. That separate ledger account shall be subject exclusively to the internal and external auditing procedures laid down in the financial regulations, rules, directives and procedures applicable to the Participating UN Organization concerned.

2. Each Participating UN Organization shall use the funds disbursed to it by the Administrative Agent from the Joint Programme Account to carry out the activities for which it is responsible as set out in the Joint Programme Document, as well as for its indirect costs. Each Participating UN Organization will recover indirect costs in accordance with its financial regulations and rules subject to a ceiling of 7% of funds disbursed. The Participating UN Organizations shall commence and continue to conduct operations for the Joint Programme only upon receipt of disbursements as instructed by the Joint Programme Core Management Group. The Participating UN Organizations shall not make any commitments above the approved budget in Annex A, as amended from time to time by the Joint Programme Core Management Group. If there is a need to exceed the budgeted amount, the Participating UN Organization concerned shall submit a supplementary budget request to the Joint Programme Core Management Group.

Article III - Activities of the Participating UN Organizations

1. Each of the Participating UN Organizations shall carry out its activities contemplated in the Joint Programme Document in accordance with the regulations, rules, directives and procedures applicable to it. Accordingly, personnel shall be engaged and administered, equipment, supplies and services purchased, and contracts entered into in accordance with the provisions of such regulations, rules, directives and procedures. On the termination or expiration of this Agreement, the matter of ownership shall be determined in accordance with the regulations, rules, directives and procedures applicable to such Participating UN Organizations, including, where applicable, its basic agreement with the Government of Uganda.

2. Any modifications to the activities set out in the Joint Programme Document, including as to their nature, content, sequencing or the duration thereof shall be subject to mutual agreement in writing between the relevant Participating UN Organization and the Joint Programme Core Management Group. The Participating UN Organization shall promptly notify the Administrative Agent through the Joint Programme Core Management Group, of any change in the budget as set out in the Joint Programme Document.

3. Where a Participating UN Organization wishes to carry out its Joint Programme activities through or in collaboration with a third party, it shall be responsible for discharging all commitments and obligations with such third parties, and no other Participating UN Organization, nor the Administrative Agent, shall be responsible for doing so.

4. In carrying out their Joint Programme activities, none of the Participating UN Organizations shall be considered as an agent of any of the others and, thus, the personnel of one shall not be considered as staff members, personnel or agents of any of the others. Without restricting the generality of the preceding sentence, none of the Participating UN Organizations shall be liable for the acts or omissions of the others or their personnel, or of persons performing services on their behalf.

5. Each Participating UN Organization shall advise the Administrative Agent in writing when all activities for which it is responsible under the Joint Programme have been completed.

Article IV - Reporting

1. Each Participating UN Organization through UNAIDS Secretariat shall provide the Core Management Group and the Administrative Agent with the following statements and reports prepared in accordance with the accounting and reporting procedures applicable to the Participating UN Organization concerned, as set forth in the Joint Programme Document. The Participating UN Organizations will endeavour to harmonize their reporting formats to the extent possible:

a) Six-monthly Financial and Programme Implementation Progress Report
b) Narrative progress reports for each twelve-month period, to be provided no later than one month after the end of the applicable reporting period;
c) Annual financial reports as of 31 December each year with respect to the funds disbursed to it from the Joint Programme Account, to be provided no later than four months after the end of the applicable reporting period;
d) A final narrative report and financial report, after the completion of the Joint Programme and including the final year of the Programme, to be provided no later than 30 April of the year following the financial closing of the Programme;
e) A final certified financial statement, to be provided no later than 30 June of the year following the financial closing of the Programme.

3. The Administrative Agent shall review consolidated narrative progress and financial reports prepared by UNAIDS from the reports referred to in paragraph 1 (a) to (d) above submitted by each Participating UN Organization, and shall provide those consolidated reports to each donor that has contributed to the Joint Programme Account, in accordance with the timetable established in the Letter of Agreement, and to the Joint Programme Core Management Group.

4. The Administrative Agent shall also provide a financial report and a final certified financial statement to Donors and Participating UN Organizations, on its activities as Administrative Agent, to be provided no later than 30 June of the year following the financial closing of the Joint Programme.

Article V - Monitoring and Evaluation

Monitoring and evaluation of the Joint Programme shall be undertaken in accordance with the provisions contained in the Joint Programme Document, which are consistent with the respective regulations, rules and procedures of the Participating UN Organizations.

Article VI - Joint Communication

Each Participating UN Organization shall take appropriate measures to publicize the Joint Programme and to give due credit to the other Participating UN Organizations. Information given to the press, to the beneficiaries of the Joint Programme, all related publicity material, official notices, reports and publications, shall acknowledge the role of **Uganda Government**, the donors, the Participating UN Organizations, the Administrative Agent and any other relevant parties. In particular, the Administrative Agent will include and ensure due recognition of the role of each Participating UN Organization and national partner in all external communications relating to the Joint Programme.

Article VII - Expiration, modification and termination of the Agreement

1. This Memorandum of Understanding shall expire upon completion of the Joint Programme, subject to the continuance in force of paragraph 5 below for the purposes therein stated.

2. This Memorandum of Understanding may be modified only by written agreement between the Parties.

3. Any of the Participating UN Organizations may withdraw from this Memorandum of Understanding upon giving thirty (30) days' written notice to all other parties to this Memorandum of Understanding stating that it has given notice, in accordance with the Joint Programme Document, of its withdrawal from the Joint Programme, subject to the continuance in force of paragraph 5 below for the purpose therein stated.

4. The Administrative Agent's appointment may be terminated by the Administrative Agent (on the one hand) or by the mutual agreement of all Participating UN Organizations (on the other hand) on thirty (30) days' written notice to the other party, subject to the continuance in force of paragraph 5 below for the purpose therein stated. In the event of such termination, the Parties shall agree on measures to bring all activities to an orderly and prompt conclusion so as to minimize costs and expense.

5. Obligations assumed by the withdrawing or terminating Parties under this Memorandum of Understanding shall survive the expiration or termination of this Memorandum of Understanding or the termination of the Administrative Agent or withdrawal of a Participating UN Organization to the extent necessary to permit the orderly conclusion of the activities and the completion of final reports, the withdrawal of personnel, funds and property, the settlement of accounts between the Parties hereto and the settlement of contractual liabilities that are required in respect of any subcontractors, consultants or suppliers. Any balance remaining in the Joint Programme Account or in the individual Participating UN Organizations' separate ledger accounts shall be used for a purpose mutually agreed upon by the Administrative Agent, the donor and the Joint Programme Core Management Group.

Article VIII - Notices

1. Any action required or permitted to be taken under this Memorandum of Understanding may be taken on behalf of the Administrative Agent by the Executive Coordinator of the Multi-Donor Trust Fund Office, Partnerships Bureau, UNDP, or his or her designated representative and on behalf of a Participating UN Organization by the Head of Office in Uganda or his or her designated representative respectively.

2. Any notice or request required or permitted to be given or made in this Memorandum of Understanding shall be in writing. Such notice or request shall be deemed to be duly given or made when it shall have been delivered by hand, mail, cable or telex to the party to which it is required to be given or made, at such party's address specified in ANNEX C to this Memorandum of Understanding or at such other address as the party shall have specified in writing to the party giving such notice or making such request.

Article IX - Entry into force

This Memorandum of Understanding shall enter into force upon signature by authorized officials of the Parties and shall continue in full force and effect until it is expired or terminated.

Article X - Settlement of disputes

The Parties shall use their best efforts to promptly settle through direct negotiations any dispute, controversy or claim arising out of or in connection with this Memorandum of Understanding or any breach thereof. Any such dispute, controversy or claim which is not settled within sixty (60) days from the date either party has notified the other party of the nature of the dispute, controversy or claim and of the measures which should be taken to rectify it, shall be resolved through consultation between the Executive Heads of each of the Participating UN Organizations and of the Administrative Agent.

Annex 4: UN Division of Labour, Uganda

UN Division of Labour for Technical Support to AIDS Response

#	Thematic and Technical Support Areas	Lead Agency[25]	Supporting Partners
1	HIV development, governance and mainstreaming, AIDS in PEAP, and enabling legislation, human rights and gender	UNDP	UNDP OHCHR UNAIDS UNESCO UNFPA UNICEF UNIFEM WFP WHO WB/IDA
2	Support to strategic, prioritised & costed national plans; human resources; macro-economic environment; impact alleviation & sectoral work; financial management; capacity & infrastructure development	UNDP	UNDP UNAIDS UNICEF WHO WB/IDA
3	Procurement and supply management, including training	UNICEF	UNICEF UNDP UNFPA WHO WB/IDA
4	HIV workplace policy and programmes, private-sector mobilization	ILO	ILO UNAIDS Sec UNFPA WFP WHO
5	Policy and prevention of HIV transmission in healthcare settings, blood safety, counselling and testing, sexually transmitted infection diagnosis and treatment, and linkage of HIV prevention with AIDS treatment services	WHO	WHO UNFPA UNICEF IOM
6	Provision of information and education, condom programming, prevention for young people outside schools, sexual and gender based violence and HIV, and prevention efforts targeting vulnerable groups including CSW	UNFPA	UNFPA ILO IOM WFP WHO
7	Prevention of mother to child transmission (PMTCT)	UNICEF	UNICEF UNFPA WFP WHO
8	Prevention for young people in education institutions	UNESCO	UNESCO UNFPA UNICEF WFP WHO
9	Prevention of transmission of HIV among injecting drug users, substance abuse, alcohol. Also among MSM, in prisons, and among uniformed services	UNFPA	UNAIDS IOM UNODC WHO

[25] The Lead Agency serves as an entry point to the Joint UN Team on AIDS for any government and other stakeholders requiring support within a particular technical area. The Lead Agency is primarily responsible for coordinating the provision and/or facilitation of this technical support, and involving the concerned main UN partners as per this chart for the division of labour.

#	Thematic and Technical Support Areas	Lead Agency[25]	Supporting Partners
10	Overall multi-sectoral prevention policy, monitoring and coordination	UNAIDS Secretariat	UNAIDS IOM UNHCR UNICEF UNESCO UNFPA WFP WHO WB/IDA
11	Antiretroviral treatment; monitoring; prophylaxis & treatment for opportunistic infections (adults and children)	WHO	WHO UNICEF
12	Care & support for people living with HIV, orphans & vulnerable children, & affected households (include agricultural households)	UNICEF	UNICEF ILO UNFPA WFP WHO
13	Dietary / nutrition support	WFP	WFP UNICEF WHO
14	Strengthening HIV response in context of insecurity and humanitarian	WHO	WHO IOM OCHA OHCHR UNAIDS UNFPA UNHCR UNICEF WFP
15	Addressing HIV among displaced populations (refugees and IDPs) and in migrant populations	UNHCR	UNHCR IOM UNAIDS UNFPA UNICEF WFP WHO
16	Coordination of national efforts, strategic information sharing, knowledge management, accountability, partnership building, and advocacy	UNAIDS Secretariat	UNAIDS IOM UNDP UNFPA UNICEF WFP WHO WB/IDA
17	Monitoring, evaluation, strategic data management & reporting; includes establishing systems & supporting implementation of surveillance for HIV; estimating / projecting national prevalence, socio-economic & demographic impact.	UNAIDS	UNAIDS UNDP UNFPA WHO WB/IDA

Annex 5: 5-year plan for Joint UN Programme on AIDS (results matrix)

UNDAF Outcome 4: *Reduction of HIV incidence by 40% during the period of the NSP with a strategic focus on addressing the social, cultural, and economic causes of vulnerability and better targeting of high risk groups*

Mainstreaming & Rights			
NSP Objective:	Mobilize adequate resources & streamline management for efficient utilization		
UN Joint Programme on AIDS Country Programme Outcome 4.1	AIDS response is mainstreamed & sustained across government with improved planning, programming, budgeting, coordination, systems integration & a stronger policy & legislative environment (which is human rights based & gender sensitive)		Convenor: UNDP
Joint Programme Outputs	Projected results to 2012 (Intermediate outputs[26])		
4.1.1: By 2012, evidence on socio-economic impact of HIV & AIDS available for selected sectors to support effective policy formulation, annual programme planning & resource allocation	By 2007	• Study design available for assessment of the socio-economic cost of accessing HIV treatment • Sector assessments completed	
	By 2008	• Empirical evidence on impact of HIV & AIDS for selected priority sectors & recommendations for policy & programming available	
	By 2009	• Key sectors (Education, Agriculture, Health, Labour) using the macroeconomic findings to inform their planning	
	By 2010	• Institutional capacity of selected sectors to conduct regular macro & socio-economic impact studies of HIV & AIDS established & institutionalized	
4.1.2: By 2012, improved national & district capacity to plan, budget, implement & coordinate the AIDS response & manage multiple finance channels (including GFATM)	By 2007	• The national guidelines on integrating HIV in plans & budgets developed & disseminated	
	By 2008	• HIV mainstreaming guidance available to relevant government sectors & ministries • HIV & AIDS strongly articulated in National Development Plan/ Poverty Eradication Action Plan/Post Recovery Development Strategy (PRDP) • National Annual operational plan for NSP developed disseminated & HIV annualisation process endorsed by partners • Capacity of MOH to take lead in coordination of health sector response to HIV, in prevention & treatment increased • Education Sector policies & guidelines on HIV & AIDS popularized among stakeholders • Capacity of MOGL to take mainstream HIV into its programmes enhanced • A national system & process for tracking HIV resources established • UAC institutional capacity to coordinate & plan improved • Technical assistance for implementing Long Term Institutional Arrangement (LTIA) in Uganda & other GFTAM needs is available in timely way • Mechanisms & systems for harmonizing technical support by all ADPs the NSP strengthened • .Partnerships for HIV strengthened for better advocacy	
	By 2009	• HIV/AIDS strongly articulated in National Development Plan • Mechanisms for resource tracking & National AIDS Spending Assessment (NASA) system adopted; • Capacities of the selected public sectors(Agric., Works, Internal Affairs, Local Government, Health, Gender) to articulate HIV/AIDS in their investment & annual plans strengthened • HIV Partnership Committee ability to plan & manage the national multisectoral response enhanced; • HIV/AIDS financing & management mechanisms adopted & operationalised; • Capacity of 21 districts to plan, budget & implement & monitor HIV/AIDS activities enhanced	

[26] The years associated with these milestones/intermediate outputs are indicative of the point by which the planned results will be achieved in the 5-year programme. They do not represent annualized activities, as many of the results that are listed for the middle to later years in the programme will actually require multi-year efforts to reach that level of achievement

		• Institutional assessment of the HIV in the UN workplace in Uganda disseminated & utilized for planning • National action plan on HIV & the world of work finalized
	By 2010	• Alternative financing for HIV/AIDS responses in Uganda established, based on study of fiscal space
	By 2012	• Sectoral & local Government plans & budgets incorporating HIV & AIDS priorities in place.
4.1.3: By 2012, relevant Government institutions operationalising Rights based & Gender responsive legislation & policies that address vulnerability to HIV & AIDS in line with relevant international standards	By 2007	• Study design on laws & policies completed • Advocacy framework for Gender, HIV & Food Security in place • Key HIV policies (National AIDS Policy & AIDS Bill) reviewed • National guidelines on gender & human rights programming in the AIDS response finalized
	By 2008	• key HIV related policies & laws reviewed & updated • Guidance on how to respond to linkages between HIV/AIDS & gender developed
	By 2009	• Stakeholders inputs into rights based & gender responsive HIV/AIDS Prevention Bill articulated & considered; • Enhanced knowledge of the Rights-based Approach to AIDS among legislators & policy makers
	By 2012	• Relevant non-discrimination & protective legislation & policies on HIV identified, reviewed & disseminated
4.1.4: By 2012, civil society organizations & networks of Persons Living with HIV (PLHIV) participating effectively in the national HIV response	By 2007	• Enhanced institutional linkages between NAFOPHANU, district Networks & other stakeholders involved in the national response
	By 2008	• National guidance & strategy for effective CSO /PLHIV engagement in the current status of the epidemic defined
	By 2009	• System for non-public sector support for HIV/AIDS activities reviewed
	By 2010	• Mechanism for CSO/PLHIV engagement functioning effectively
Prevention		
NSP Objective:	The incidence of HIV & AIDS is reduced by 40% by the year 2012	
UN Joint Programme on AIDS Country Programme Outcome 4.2	Universal access to evidence based, quality assured HIV prevention services that lead to improved service uptake, sustained behaviour change & a reduction in the number of new infections	Convenor: UNFPA
Joint Programme Outputs	Projected results to 2012 (Intermediate outputs)	
4.2.1: By 2012, prevention policies & action plans developed & implemented with better alignment of finance to priorities	By 2007	• National agenda finalized & adopted to accelerate HIV prevention interventions in context of universal access to prevention, treatment & care
	By 2008	• Coherent National Prevention Plan that mobilizes national & international partners & articulates strategic Joint UN program on HIV prevention • Modes of Transmission study (know your epidemic, know your response) finalized
	By 2009	• Systems for HIV coordination strengthened to support joint definition of supportive policies, strategic guidance & promote equitable delivery of quality services • Systems for establishing the evidence base available & functional • Increased capacity of HIV Prevention Working Group & Joint Team to support the national prevention response
	By 2010	• Systems for establishing the evidence base available & functioning effectively • Efficacy & effectiveness of prevention interventions reviewed
	By 2011	• Progress of the implementation of the prevention road map reviewed
	By 2012	• National prevention targets for 2012 -2017 developed
4.2.2: By 2012, BCC/IEC & life skills interventions are well coordinated, evidence informed & targeted at the national level	By 2007	• Key gap analysis on alignment of BCC interventions with evidence completed & available to inform policy & programming direction
	By 2008	• A national evidence based comprehensive Communication strategy developed • Standards monitoring tools for BCC/IEC interventions in place • BCC/IEC interventions scaled up
	By 2009	• Evidence base available for effective programming in targeted health promotion, IEC, BCC, life skills & social change intervention

	By 2010	• National standard setting instruments on BCC/IEC developed & disseminated. • A system to coordinate, track & document evidence in behaviour change (BCC/IEC) programmes established
	By 2012	• National ability to assess & address key issues in BCC in the national AIDS response Improved.
4.2.3: By 2012, national prevention programmes for Most at Risk populations (MARPS) advocated for & developed	By 2007	• Evidence & baseline data available on MARPs to inform programme planning & prioritization
	By 2008	• Prevention needs of the MARPS defined • Comprehensive coordinated prevention programmes for priority MARPS are developed
	2009	• Evidence & baseline data available on MARPs to inform programme planning & prioritization • Minimum packages to address the prevention needs of MARPs defined • Prevention needs of prioritized/selected MARPs articulated & addressed adequately in national sector & district plans
	By 2010	• Mechanisms in place for improved access to effective HIV prevention services for MARPS
	By 2011	• Evidence available about the efficacy & effectiveness of MARPS prevention programmes
4.2.4: By 2012, Improved capacity for expansion & delivery of HIV Prevention Services in the health sector (e.g., comprehensive PMTCT, Condoms, Blood Safety, STI)	By 2007	• Recommendations for improving the national PMTCT programme tabled
	By 2008	• Functioning of the PMTCT Technical Working Group strengthened • M&E of national PMTCT programme by MOH/ACP strengthened • Budgeted PMTCT scale up plan available • PMTCT programme scaled up in 16 CAP district • National policy, technical norms & training materials on STIs prevention & treatment developed & updated
	By 2009	• Operational research on-going & institutionalised for improved programming on comprehensive PMTCT services • National PMTCT programme scaled up & delivered in a coordinated manner • STI/RH/ASRH policy guidelines & standards in place • Human resource capacity developed for integrated HIV/RH/STI/infection control service delivery
	By 2011	• Capacity enhanced for health system delivery & expansion of integrated PMTCT & SRH services • Strengthened advocacy on integrated service delivery
	By 2012	• Service guidelines updated & operationalised
4.2.5: By 2012, new strategies & innovation in prevention advocated for, adopted & rolled out (e.g., medical male circumcision, prevention with positives, discordance)	By 2008	• Based on national consensus, medical male circumcision adopted as a key prevention strategy & country roll-out plan developed • Gaps in addressing medical male circumcision defined & quantified • Medical male circumcision advocacy strategy developed & effected. • Health facility capacity to provide quality male circumcision assessed • Tools available for programming & monitoring of male circumcision services • Consensus that MMC as a key prevention strategy by the Uganda society built service guidelines on medical male circumcision in place & disseminated
	By 2009	• A national policy & service guidelines on medical male circumcision in place & disseminated. • A national policy, scale-up plan & service guidelines on medical male circumcision in place & disseminated. • Minimum package of HIV/AIDS interventions for discordant couples available & utilized • Common guidance on context-specific communication for young positives & affected OVCs available • HIV/AIDS integrated into gender & GBV programming & service delivery
	By 2010	• HIV/AIDS interventions for discordant couples • Common guidance on context-specific communication for young positives & affected OVCs
Quality of Life (Treatment, Care & Support)		
NSP Objective:	A) The health effects of HIV & AIDS are mitigated, improving the quality of life of people living with the disease	

<table>
<tr><td></td><td colspan="3">B) The social, cultural & economic effects of HIV & AIDS are mitigated at individual household & community levels</td></tr>
<tr><td>UN Joint Programme on AIDS
Country Programme Outcome 4.3</td><td colspan="2">Quality of life of people infected & affected by AIDS improved & their vulnerability reduced</td><td>Convenor: WHO</td></tr>
<tr><td>Joint Programme Outputs</td><td colspan="3">Projected results to 2012 (Intermediate outputs)</td></tr>
<tr><td rowspan="4">4.3.1 By 2012, capacity of Ministry of Health to develop key policies & guidelines for HIV care & treatment strengthened</td><td>By 2007</td><td colspan="2">• HIV Drug Resistance prevention, monitoring & surveillance plan disseminated.</td></tr>
<tr><td>By 2008</td><td colspan="2">• Revised adult & paediatric treatment guidelines in use
• Home based care policy guidelines developed, disseminated
• ART literacy campaign guidelines adapted & disseminated
• Mentorship & supervision guidelines & standards adapted & disseminated</td></tr>
<tr><td>By 2009</td><td colspan="2">• National ART policy revised</td></tr>
<tr><td>By 2012</td><td colspan="2">• Standard operations procedures for HIV/AIDS care & treatment developed & operationalised in all hospitals & HC IVs
• National TB/HIV policy guideline revised</td></tr>
<tr><td rowspan="2">4.3.2 By 2012, capacity of health care teams to provide standard HIV care & treatment services strengthened in all hospitals & HCIVs</td><td>By 2008</td><td colspan="2">• Increased HIV care & treatment skills of health worker teams in hospitals & HC IVs in seven districts
• Increased skills of health workers teams in hospitals, HCIVs & HC IIIs to provide quality HIV care & treatment services
• Enhanced capacity of health workers in referral & district hospitals to provide paediatric & adolescent HIV care & treatment
• Enhanced skills of all regional supervision teams to support clinical teams providing HIV care in district hospitals, HCIVs & HCIIIs
• Comprehensive HIV Care & Treatment services including ART are scaled up in Northern Uganda & Karamoja
• Improved ART knowledge of people on ARVs & their caretakers
• TB/HIV collaborative activities strengthened at health service delivery level
• Enhanced capacity of VHTs to provide home based care</td></tr>
<tr><td>By 2012</td><td colspan="2">• Improved skills of health worker teams in hospitals/HCIVs to provide HIV care & treatment.
• Enhanced skills of supervision teams at regional & district level to support clinical HIV care
• Improved UAC & MoH district manager skills to manage & coordinate HIV care services</td></tr>
<tr><td rowspan="4">4.3.3 By 2012, capacity of health care workers from district hospitals, HCIV & HCIIIs to provide standard HCT services strengthened</td><td>By 2007</td><td colspan="2">• Increased skills of health worker teams up to HCIIIs to provide quality HCT services
• Skilled personnel available & ready for deployment to provide quality HCT in refugees camps</td></tr>
<tr><td>By 2008</td><td colspan="2">• Appropriate promotional packages for HCT developed & resources mobilized (see 4.2.2 on BCC)</td></tr>
<tr><td>By 2009</td><td colspan="2">• Standards for HCT including children counselling guidelines developed & disseminated</td></tr>
<tr><td>By 2012</td><td colspan="2">• Strengthened capacity of MoH to procure HCT supplies & commodities & distribute them to HCIIIs
• Increased capacity of MoH to supervise & conduct Quality Assurance (Q&A) for HCT</td></tr>
<tr><td rowspan="4">4.3.4. By 2012, procurement & supply chain management systems to provide timely delivery of medicines, condoms & supplies are coordinated & strengthened</td><td>By 2007</td><td colspan="2">• Commodities & supplies financed by the Global Fund round 3 phase II & III procured</td></tr>
<tr><td>By 2008</td><td colspan="2">• Procurement & Supplies Management Working Group (PSM) functional
• Strengthened human capacity for HIV procurement & supply chain management
• Procurement plan for Global Fund Round 7 developed
• HIV commodities security plan integrated into the national PSM plan.
• The status of PSM available & agreed action plan developed</td></tr>
<tr><td>By 2010</td><td colspan="2">• Capacity of NMS developed to store & distribute HIV commodities & supplies to hospitals & HC IVs</td></tr>
<tr><td>By 2012</td><td colspan="2">• Harmonised procurement systems for HIV commodities & supplies</td></tr>
<tr><td>4.3.5 By 2012, nutritional support</td><td>By 2007</td><td colspan="2">• Pilot study that tracks nutritional impact of food support among HIV malnourished clients with BMI approach is finalised & with lessons learnt & way forward</td></tr>
</table>

integrated into HIV & AIDS programming		drafted. • Evidence on the impact of food support among the HIV malnourished clients using the BMI approach finalised
	By 2008	• Tools for tracking nutritional impact of food support to malnourished HIV clients using BMI approach adopted/operationalised in all ART accredited sites. • 34,600 vulnerable PLHIV provided with nutritional support at HCs/communities in 24 districts • Evaluation of HIV related activities in WFP conducted & report drafted • HIV-related nutrition education operationalised at HCs & communities in 24 districts
	By 2009	• National Guidelines on Nutrition intervention among HIV clients are disseminated;
4.3.6 By 2012, improved systems for monitoring & supporting the quality of life of OVCs & their families	By 2007	• National plan of action for child labour finalized • Available national OVC support reviewed • TORs reviewed for NOSC (National OVC Steering Committee) & TRC (Technical Resource Committee) • Saving schemes for HIV affected households established at community level • HIV affected families engage in IGA activities.
	By 2008	• Strengthened ability of MoGLSD to effectively coordinate & monitor the utilization of the OVC component of Global Fund Round 3
	By 2009	• Institutional capacity of MGLSD to plan, coordinate & monitor the national OVC response strengthened 2) Field & life skills schools responding to the needs of HIV & AIDS affected households established
	By 2010	• Livelihood improvement programmes supported for HIV affected families, households & communities developed
	By 2012	• Saving schemes for HIV affected households in selected communities established • Livelihood improvement programmes supported for HIV affected families, households & communities • Community level saving schemes established for HIV affected households • HIV affected families engage in IGA activities; • Improved nutritional status of PLHIV & their households
Monitoring & Evaluation		
NSP Objective:	Coordinated the efficient collection, analysis, use, & provision of information that will enable tracking progress made in the national response to HIV/AIDS	
UN Joint Programme on AIDS Country Programme Outcome 4.4	Effective management of response to HIV/AIDS pandemic by all actors, is being guided by generation & use of strategic information & a comprehensive system of results based measurement & surveillance	Convenor: UNAIDS
Joint Programme Outputs	Projected results to 2012 (Intermediate outputs)	
4.4.1: By 2012, a comprehensive performance measurement & management system for all interventions responding to the challenge of the AIDS epidemic is funded & operational at national & district levels	By 2007	• Technical support provided to finalize PMMP by UAC & partners • UNGASS consultation conducted & report produced • National M&E Standing Committee appointed & formalized & functional
	By 2008	• Enhanced skills of central govt AIDS Focal Points to use standardized reporting formats against the agreed PMMP • A comprehensive Joint Annual AIDS Review (JAR) is held & report disseminated • Status of harmonization & alignment by AIDS development partners understood • The PMMP has been disseminated understanding of its application understood by relevant stakeholders
	By 2009	• Improved ability of central level AIDS Focal Points to carry out PMM P • Mid-term review of the roadmap to achieve Universal Access targets by 2010 is available • First annual consolidated & comprehensive HIV response document is developed & published
	By 2011	• The comprehensive analysis of Universal Access achievement is published
	By 2012	• All ADPs have adopted a common indicator system for their reporting

Output	Timeframe	Indicators
4.4.2: By 2012, strategic information generated & used by National & district authorities for strategic & operational planning of all interventions responding to the AIDS epidemic	By 2007	• Capacity developed/established at central level to use Uganda HIV & AIDS information
		• Evidence to inform programming across various thematic areas by various stakeholders available
	By 2009	• District partnership fora institutionalized • An up to date database for the multisectoral HIV response is available at UAC) • Key results periodic reports available to inform programming • Costed technical plan available for an integrated IT system • Sero-behavioural data for CSWs, refugees, pastoral communities available
	By 2011	• MIS of the MoH & UAC able to support the production of accurate timely data products & to maintain a data warehouse
	By 2012	• Evidence informed HIV priorities in national & district plan in place
4.4.3: By 2012, national systems for projections, estimations, surveillance & research are fully functional	By 2007	• Up -to-date 2007 data on the epidemic available
	By 2009	• A vulnerability assessment & analysis of data from high risk groups is completed • A Comprehensive AIDS Status Report is produced • UAC has prioritized national AIDS research agenda
	By 2010	• HIV surveillance is being undertaken in 10 sentinel sites for TB attendees • National institutions & AIDS partners are supported to conduct Operations research • UAC is supported to regularly organize regular dissemination fora for research findings & best practices
	By 2011	• Regional Teams for surveillance, projections & estimations established
4.4.4: By 2012, all UN Agencies are using harmonized planning, performance management & measurement, reporting & evaluation systems for HIV/AIDS	By 2007	• Joint UN programme of support on HIV disseminated & endorsed by the government & ADPs
	By 2008	• Joint UN programme of support completed & disseminated • The Joint Team on AIDS is operating effectively • M&E indicators for UN Joint Programme established • Planning & reporting for Joint Programme established; • Operations & management modalities of the joint programme of established & operational
	By 2009	• UNDAF articulates HIV/AIDS across all its outcomes • All the JP & JT systems are operational • UN mechanisms for planning for HIV in emergencies coordinated • Taskforce on HIV in the UN workplace is established & operational
	By 2010	• Effectiveness of the Joint UN Programme of support assessed
	By 2012	• Joint programme of support assessed for effectiveness • New Joint programme established

Annex 6: Indicator matrix for monitoring Joint UN Programme

Indicator	Data Source	Frequency	Baseline (Year)	Targets (2011/12)
UNDAF Outcome 4: Reduce HIV incidence by 40% during period of NSP with a strategic focus on addressing social, cultural, & economic causes of vulnerability & better targeting of high risk groups				
Annual number of new infections/incidence rate per 100 person years (PMMP Indicator No.1)	Spectrum estimates of MoH	Annual	132,500 new infections/ 0.85 (2005)	100,000 new infections/ 0.51
JP Outcome 4.1: AIDS response is mainstreamed & sustained across government with improved planning, programming, budgeting, coordination, systems integration & a stronger policy & legislative environment (which is human rights based & gender sensitive)				
Availability of an up to date National Strategic Plan for HIV/AIDS	UAC	5 years	1	1
Availability of a National Priority Action Plan	UAC	2 years	1	1
Amount/% of total annual budget (including donor budget support) for line ministries & districts committed to HIV/AIDS programmes in last financial year (PMMP Indicator No.56)	Ministry & district budgets	Annual	3%	5%
CP output 4.1.1: By 2012, evidence on socio-economic impact of HIV & AIDS available for selected sectors to support effective policy formulation, annual programme planning & resource allocation				
Num. of socioeconomic studies, assessments of AIDS impact at national, sector & community levels supported by UN	Agency, JP reports	Annual	2	4
Number of government ministries/institutions supported to conduct socioeconomic studies, assessments of AIDS impact at national sector & community levels	Ministry/ institution reports	Annual	0	4
CP output 4.1.2: By 2012, improved national & district capacity to plan, budget, implement & coordinate the AIDS response & manage multiple finance channels (including GFATM)				
Num. of gov't Ministries/institutions receiving institutional capacity building assistance to improve national & district capacity to plan, budget, implement & coordinate the AIDS response & manage multiple finance channels	Ministry/ institution reports	Annual	0	5
Number of workers of government Ministries/institutions trained in planning, budgeting, implementing & coordinating the AIDS response & managing multiple finance channels	Ministry/ institution reports	Annual	0	15
CP output 4.1.3: By 2012, relevant government institutions operationalising rights based & gender responsive legislation & policies that address vulnerability to HIV & AIDS in line with relevant international standards				
Num. of gov't Ministries/institutions receiving institutional capacity building assistance to operationalise rights based & gender responsive legislation/policies addressing vulnerability to HIV/AIDS per relevant international standards	Ministry/ institution reports	Annual	0	5
Num. of legislators & policy makers trained to apply Rights-based Approach & gender responsiveness in their legal & policy work	Ministry/ institution reports	Annual	0	15
Number of relevant non-discrimination & protective legislation & policies on HIV identified, reviewed & disseminated	Ministry/ institution reports	Annual	0	5
CP output 4.1.4: By 2012, Civil society organizations & networks of Persons Living with HIV (PLHIV) participating effectively in the HIV national response				
Number of staff of NAFOPHANU trained in coordination, networking & M&E	NAFOPHANU repts	Annual	0	4
Number of staff of UNASO trained in coordination, networking & M&E	UNASO reports	Annual	0	4
Capacity building plan for NAFOPHANU & its district branches	NAFOPHANU repts	Annual	0	1
Capacity building plan for UNASO & its district branches	UNASO reports	Annual	0	1
JP Outcome 4.2: Universal access to evidence based, quality assured HIV prevention services that lead to improved service uptake, sustained behaviour change & a reduction in the number of new infections				
% of pregnant women aged 15-49 years attending ANC clinics who are HIV infected (PMMP Indicator No.2)	MoH	Annual	Urban:7.1% Rural 5.5% (2005)	Urban:7.8% Rural 6.2%

Indicator	Data Source	Frequency	Baseline (Year)	Targets (2011/12)
Number/% of HIV positive pregnant women who receive a complete course of ARV prophylaxis to reduce the risk of MTCT in the last 12 months. (PMMP indicator No.18)	MoH	Annual	12% (2005)	80%
% of men & women aged 15-49 years who have had sex with a non-marital, non cohabiting partner in the last 12 months & report using a condom during the last high risk sex (PMMP indicator No.10)	UDHS, AIS	2 to 3 years	(2006) Males: 57.4% Females: 34.9%	Males: 73% Females: 70%
% of young women & men aged 15-24 years who have had sex before the age of 15 years (PMMP indicator No.7)	UDHS, AIS	2 to 3 years	(2006) Males: 12.2% Females: 15.5%	Males: 7% Females: 7%
% of schools that provided life skills based HIV/AIDS education within the last academic year (PMMP indicator No.16)	EMIS	Annual		95%
CP output 4.2.1: By 2012, prevention policies & action plans developed & implemented with better alignment of finance to priorities				
Number of government ministries/institutions supported to strengthen their HIV prevention roles	Agency, JP reports	Annual	0	4
Num. of policies/guidelines developed or adapted with UN support to improve access & use of HIV prevention services	Agency, JP reports	Annual	0	10
CP output 4.2.2: By 2012, BCC/IEC & life skills interventions are well coordinated, evidence informed & targeted at the national level				
Number of National standard setting instruments on BCC/IEC developed/revised & disseminated.	UAC & MoH reports	Annual	0	4
CP output 4.2.3: By 2012, national prevention programmes for Most at Risk populations (MARPS) advocated for & developed				
Number of National prevention programmes for MARPs developed	UAC & MoH reports	Annual	0	6
CP output 4.2.4: By 2012, improved capacity for expansion & delivery of HIV prevention services in the health sector (e.g., comprehensive PMTCT, condoms, blood safety, STI)				
Number of PMTCT, Condoms, Blood safety, STI guidelines that have been updated	MoH reports	Annual	0	4
CP output 4.2.5: By 2012, new strategies & innovation in prevention advocated for, adopted & rolled out (e.g., medical male circumcision, prevention with positives, discordance)				
Number of guidelines for medical male circumcision, prevention with positives & discordance developed	UAC & MoH reports	Annual	0	3
JP Outcome 4.3: Quality of life of people infected & affected by AIDS improved & their vulnerability reduced				
% of adults & children with HIV known to be on treatment 12 months after starting antiretrovirals (PMMP indic. No.27)	MoH	Annual	81% (2007)	90%
Current number/% of adults & children with advanced HIV infection receiving antiretrovirals (PMMP indicator No.28)	MoH	Annual	91,500/39% (2006)	240,000/67%
% of women & men aged 15-49 who were counselled & received an HIV test in last 12 months & know their results (PMMP indicator No.32)	UDHS, AIS	2 to 3 years	(2004/05) Men: 3.9% Women: 4%	Men: 15% Women: 15%
% of PLHIVs receiving cotrimoxazole (PMMP indicator No.29)	MoH	Annual	15% (2007)	60%
% of TB confirmed patients screened for HIV	MoH	Annual	TBD	70%
% of orphans & vulnerable children under 18, whose households received free basic external support in caring for the children in the last 12 months (PMMP indicator No.43)	UDHS	5 years	10.7% (2006)	30%
% of PLHIVs whose households received food support in the past 12 months (PMMP indicator No.37)	Survey PLHIV HHs	2 to 3 years	26.9% PLHIVs in past 3 months (UAC-LQAS)	60%
% of households of people living with HIV/AIDS that have benefited from IGAs in last year (PMMP indicator No.42)	Survey PLHIV HHs	2 years	41.2% (2006)	80%
% of randomly selected retail outlets & service delivery points that have condoms in stock at the time of the survey	Condom avail. surv.	2 years	TBD	90%
CP output 4.3.1: By 2012, capacity of Ministry of Health to develop key policies & guidelines for HIV care & treatment strengthened				
Number of policies, plans or guidelines for care & treatment developed or revised	MoH reports	Annual	0	8
CP output 4.3.2: By 2012, capacity of health care teams to provide quality HIV care & treatment services strengthened in all hospitals & HCIVs				
Number of health care teams trained to provide quality HIV care & treatment services in all hospitals & HCIVs	MoH reports	Annual	0	At least 1/district
No.regional supervision teams trained to support clinical teams providing HIV care in district hospitals, HCIVs & HCIIIs	MoH reports	Annual	0	All regions
CP output 4.3.3: By 2012, capacity of health care workers from district hospitals, HCIV & HCIIIs to provide standard HCT services strengthened				

Indicator	Data Source	Frequency	Baseline (Year)	Targets (2011/12)
Number of health workers trained to supervise & conduct Quality Assurance (QA) for HCT	MoH reports	Annual	0	At least 1/region
CP output 4.3.4: By 2012, procurement & supply chain management systems to provide timely delivery of medicines, condoms & supplies are coordinated & strengthened				
3-year integrated procurement plan for health commodities including HIV/AIDS supplies available & updated annually	MoH reports	Annual	1	1
Capacity strengthening plan for NMS available	MoH reports	Annual	0	1
CP output 4.3.5: By 2012, nutritional support integrated into HIV & AIDS programming				
Number of impact assessments/evaluation/studies of nutrition support & HIV & AIDS programming supported	UAC, MoH reports	Annual	0	2
Number of tools & guidelines for integration of nutritional support into AIDS programming developed	UAC, MoH reports	Annual	0	2
Number of peace recovery districts where vulnerable PLHIV have been provided nutritional support	OPM, WFP	Annual	0	24
Number of vulnerable PLHIV provided with nutritional support in the peace recovery districts	OPM, WFP	Annual	0	24
Number of homesteads of vulnerable PLHIV supported with IGA activities in the peace recovery districts	OPM, WFP, FAO	Annual	0	450
CP output 4.3.6: By 2012, improved systems for monitoring & supporting the quality of life of OVCs & their families				
Number of staff of MoGLSD trained to plan, coordinate & monitor the OVC programme	MoGLSD	Annual	0	4
Number of OVC guidelines developed/revised	MoGLSD	Annual	0	2
Number of homesteads of OVCs supported with IGA activities in the peace recovery districts	OPM, WFP, FAO	Annual	0	450
JP Outcome 4.4: Effective management of response to HIV/AIDS pandemic by all actors, is being guided by generation & use of strategic information & a comprehensive system of results based measurement & surveillance				
Availability of an up to date M&E Plan for the NSP of HIV/AIDS	UAC	5 years	1	1
UAC Management Index	UAC	Annual	TBD	95%
CP output 4.4.1: By 2012, a comprehensive performance measurement & management system for all AIDS interventions is funded & operational at national & district levels				
Complete & timely annual National HIV/AIDS status report	UAC	Annual	0	1
Complete & timely annual health sector performance reports that have up to date HIV/AIDS data	MoH	Annual	0	1
Complete & timely annual GLSD sector performance reports that have up to date OVC & other HIV/AIDS data	MoGLSD	Annual	0	1
CP output 4.4.2: By 2012, strategic Information generated & used by national & district authorities for strategic & operational planning of all interventions responding to the AIDS epidemic				
Number of Most at Risk Population Surveys supported	UAC & MoH reports	Annual	0	6
CP output 4.4.3: By 2012, national systems for projections, estimations, surveillance & research are fully functional				
Up-to-date ANC HIV seroprevalence reports available	MoH	Annual	0	1
Up-to-date HIV serobehavioural survey report of general population	MoH	Every 4 to 5 years	0	1
Up-to-date Demographic & Health Services report including HIV AIDS	MoH	5 years	0	1
Annual HIV incidence estimates report	MoH	Annual	0	1
CP output 4.4.4: By 2012, all UN Agencies are using harmonized planning, performance management & measurement, reporting & evaluation systems for HIV/AIDS				
Availability of a mid year & annual report of the Joint Programme of Support including financial expenditure	UNAIDS	Annual	2	2
Availability of evaluation report of Joint Team & JP	UNAIDS	Every 2 to 3 years	1	1
Availability of a 5 year Joint Programme workplan for HIV/AIDS	UNAIDS	Every 5 years	1	1
Availability of Annual Workplans for HIV/AIDS	UNAIDS	Annual	1	1

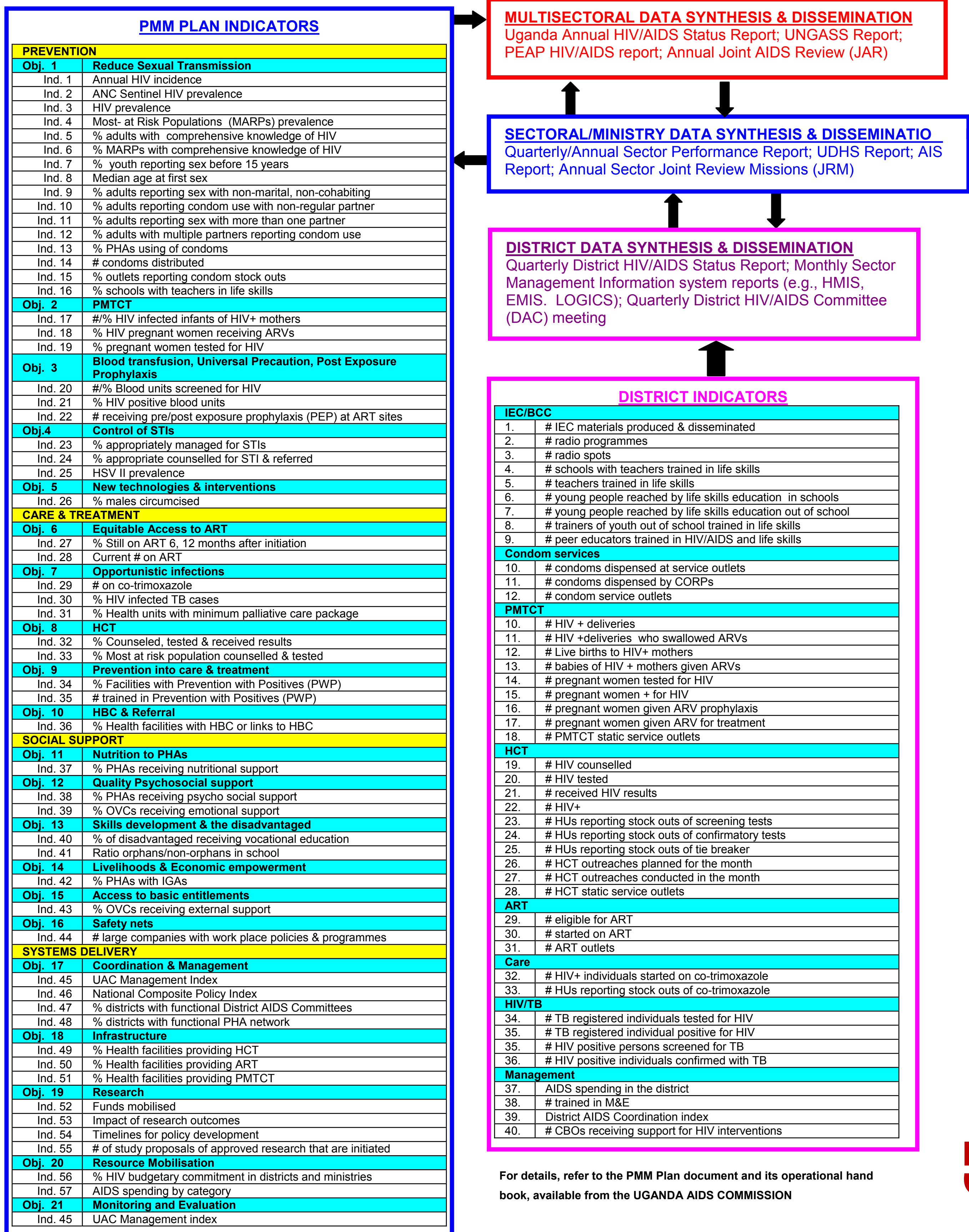
Annex 7: Framework for measuring performance of joint programme management

No	Management focus	Targets	Means of verification	Frequency
Financial				
F1	Disbursement-Expenditure ratio	1	Financial survey	Annual
F2	Mean requisition-disbursement time	7-10 days	Records	Annual
F3	Timely financial reports	Zero days overdue	Records	Annual
Administration and management				
A1	Annual programme reviews conducted	Zero days overdue	Records	Annual
A2	Report to UNCT on time	Zero days overdue	Records	Annual
A3	Annual skills update	Implemented	Attendance note	Annual
A4	Partners' satisfaction survey	Implemented	Management response	Annual
Governance and foundation				
G1	Attendance at meetings	100%	Records	Annual
G2	Convenors' reports to Core Management Group	Zero days overdue	Records	Quarterly
G3	Number of Joint Team members with JP in their Performance Eval Review (PER)	100%	Agency personnel records	Annual
External relations and resource mobilisation				
E1	Budget support for JP (Absolute/%)	Upwards trend	Financial reports	Annual
E2	Extra-budget for JP (Absolute/%)	Upwards trend	Financial reports	Annual
E3	Total budget for JP	Upwards trend	Financial reports	Annual

Detailed indicators for Joint Team management performance evaluations:

- The team has clear terms of reference, endorsed by the UN country team;
- Subgroups have been created to provide leadership in specific thematic areas;
- The Joint Team meets, and subsequently reports to through the Programme Management Team (PMT) to the UN Country Team (UNCT) on a regular basis;
- The UNCT meets quarterly;
- Members of the team have their own job profile reviewed to reflect participation in the joint team as a responsibility that will influence their performance evaluation;
- A mutual self assessment by the team members on key competencies, and appraisal of progress in addressing weaknesses is in place;
- The Division of Labour has been adopted to the local context and endorsed;
- The Joint Team is recognized by partners and used as the entry point for technical support to the national response;
- The Joint Team articulates a common position on key issues;
- The Joint Team represents the UN's position on AIDS in important fora;
- The Joint Team develops elements for the UNDAF;
- A programme of support has been produced, which articulates the combined efforts of all UN agencies present to address the HIV elements of the UNDAF;
- An annual report is produced; and
- Harmonised financial and legal mechanisms have been identified for joint programming and are stated in the Memorandum of Understanding.

Annex 8: National HIV & AIDS PMM System



PMM PLAN INDICATORS

PREVENTION	
Obj. 1	**Reduce Sexual Transmission**
Ind. 1	Annual HIV incidence
Ind. 2	ANC Sentinel HIV prevalence
Ind. 3	HIV prevalence
Ind. 4	Most- at Risk Populations (MARPs) prevalence
Ind. 5	% adults with comprehensive knowledge of HIV
Ind. 6	% MARPs with comprehensive knowledge of HIV
Ind. 7	% youth reporting sex before 15 years
Ind. 8	Median age at first sex
Ind. 9	% adults reporting sex with non-marital, non-cohabiting
Ind. 10	% adults reporting condom use with non-regular partner
Ind. 11	% adults reporting sex with more than one partner
Ind. 12	% adults with multiple partners reporting condom use
Ind. 13	% PHAs using of condoms
Ind. 14	# condoms distributed
Ind. 15	% outlets reporting condom stock outs
Ind. 16	% schools with teachers in life skills
Obj. 2	**PMTCT**
Ind. 17	#/% HIV infected infants of HIV+ mothers
Ind. 18	% HIV pregnant women receiving ARVs
Ind. 19	% pregnant women tested for HIV
Obj. 3	**Blood transfusion, Universal Precaution, Post Exposure Prophylaxis**
Ind. 20	#/% Blood units screened for HIV
Ind. 21	% HIV positive blood units
Ind. 22	# receiving pre/post exposure prophylaxis (PEP) at ART sites
Obj.4	**Control of STIs**
Ind. 23	% appropriately managed for STIs
Ind. 24	% appropriate counselled for STI & referred
Ind. 25	HSV II prevalence
Obj. 5	**New technologies & interventions**
Ind. 26	% males circumcised
CARE & TREATMENT	
Obj. 6	**Equitable Access to ART**
Ind. 27	% Still on ART 6, 12 months after initiation
Ind. 28	Current # on ART
Obj. 7	**Opportunistic infections**
Ind. 29	# on co-trimoxazole
Ind. 30	% HIV infected TB cases
Ind. 31	% Health units with minimum palliative care package
Obj. 8	**HCT**
Ind. 32	% Counseled, tested & received results
Ind. 33	% Most at risk population counselled & tested
Obj. 9	**Prevention into care & treatment**
Ind. 34	% Facilities with Prevention with Positives (PWP)
Ind. 35	# trained in Prevention with Positives (PWP)
Obj. 10	**HBC & Referral**
Ind. 36	% Health facilities with HBC or links to HBC
SOCIAL SUPPORT	
Obj. 11	**Nutrition to PHAs**
Ind. 37	% PHAs receiving nutritional support
Obj. 12	**Quality Psychosocial support**
Ind. 38	% PHAs receiving psycho social support
Ind. 39	% OVCs receiving emotional support
Obj. 13	**Skills development & the disadvantaged**
Ind. 40	% of disadvantaged receiving vocational education
Ind. 41	Ratio orphans/non-orphans in school
Obj. 14	**Livelihoods & Economic empowerment**
Ind. 42	% PHAs with IGAs
Obj. 15	**Access to basic entitlements**
Ind. 43	% OVCs receiving external support
Obj. 16	**Safety nets**
Ind. 44	# large companies with work place policies & programmes
SYSTEMS DELIVERY	
Obj. 17	**Coordination & Management**
Ind. 45	UAC Management Index
Ind. 46	National Composite Policy Index
Ind. 47	% districts with functional District AIDS Committees
Ind. 48	% districts with functional PHA network
Obj. 18	**Infrastructure**
Ind. 49	% Health facilities providing HCT
Ind. 50	% Health facilities providing ART
Ind. 51	% Health facilities providing PMTCT
Obj. 19	**Research**
Ind. 52	Funds mobilised
Ind. 53	Impact of research outcomes
Ind. 54	Timelines for policy development
Ind. 55	# of study proposals of approved research that are initiated
Obj. 20	**Resource Mobilisation**
Ind. 56	% HIV budgetary commitment in districts and ministries
Ind. 57	AIDS spending by category
Obj. 21	**Monitoring and Evaluation**
Ind. 45	UAC Management index

MULTISECTORAL DATA SYNTHESIS & DISSEMINATION
Uganda Annual HIV/AIDS Status Report; UNGASS Report; PEAP HIV/AIDS report; Annual Joint AIDS Review (JAR)

SECTORAL/MINISTRY DATA SYNTHESIS & DISSEMINATION
Quarterly/Annual Sector Performance Report; UDHS Report; AIS Report; Annual Sector Joint Review Missions (JRM)

DISTRICT DATA SYNTHESIS & DISSEMINATION
Quarterly District HIV/AIDS Status Report; Monthly Sector Management Information system reports (e.g., HMIS, EMIS. LOGICS); Quarterly District HIV/AIDS Committee (DAC) meeting

DISTRICT INDICATORS

IEC/BCC	
1.	# IEC materials produced & disseminated
2.	# radio programmes
3.	# radio spots
4.	# schools with teachers trained in life skills
5.	# teachers trained in life skills
6.	# young people reached by life skills education in schools
7.	# young people reached by life skills education out of school
8.	# trainers of youth out of school trained in life skills
9.	# peer educators trained in HIV/AIDS and life skills
Condom services	
10.	# condoms dispensed at service outlets
11.	# condoms dispensed by CORPs
12.	# condom service outlets
PMTCT	
10.	# HIV + deliveries
11.	# HIV +deliveries who swallowed ARVs
12.	# Live births to HIV+ mothers
13.	# babies of HIV + mothers given ARVs
14.	# pregnant women tested for HIV
15.	# pregnant women + for HIV
16.	# pregnant women given ARV prophylaxis
17.	# pregnant women given ARV for treatment
18.	# PMTCT static service outlets
HCT	
19.	# HIV counselled
20.	# HIV tested
21.	# received HIV results
22.	# HIV+
23.	# HUs reporting stock outs of screening tests
24.	# HUs reporting stock outs of confirmatory tests
25.	# HUs reporting stock outs of tie breaker
26.	# HCT outreaches planned for the month
27.	# HCT outreaches conducted in the month
28.	# HCT static service outlets
ART	
29.	# eligible for ART
30.	# started on ART
31.	# ART outlets
Care	
32.	# HIV+ individuals started on co-trimoxazole
33.	# HUs reporting stock outs of co-trimoxazole
HIV/TB	
34.	# TB registered individuals tested for HIV
35.	# TB registered individual positive for HIV
35.	# HIV positive persons screened for TB
36.	# HIV positive individuals confirmed with TB
Management	
37.	AIDS spending in the district
38.	# trained in M&E
39.	District AIDS Coordination index
40.	# CBOs receiving support for HIV interventions

For details, refer to the PMM Plan document and its operational hand book, available from the UGANDA AIDS COMMISSION