Delivering as One UN

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

SEPTEMBER 2011

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United Nations
UGANDA

THE REPUBLIC OF UGANDA

'Delivering as One UN'

THE JOINT UN PROGRAMME OF SUPPORT ON AIDS

2011-2014

SEPTEMBER 2011

ACKNOWLEDGEMENTS

This document describes the Joint UN Programme of Support on AIDS (JUPSA) in Uganda for the period 2011-2014. It has been produced by the UN system in Uganda through efforts of the members of the Joint UN Team on AIDS. The Joint Team is grateful to the government of Uganda, donors and all stakeholders for the useful feedback they provided during the various stages of developing this JUPSA.

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FOREWORD

In 2007, the United Nations (UN) in Uganda adopted guidelines and principles of the Global Task Team on improving coordination of the UN and Multilateral Systems on AIDS. This led to the development of a Joint UN Programme of Support on AIDS (JUPSA 2007-2012) and the establishment of a Joint UN Team on AIDS to oversee and monitor its implementation.

2010 marked the mid-term for the implementation of the joint programme. A midterm review took stock of progress made and planned for the remaining years of the programme. This work resulted in the proposal of a second generation JUPSA (2011- 2014).

The JUPSA 2011-2014 is aligned to the current United Nations Development Assistance Framework (UNDAF) and the three priority areas in the UNAIDS vision of getting to *Zero: New HIV Infections*, *AIDS-related Deaths* and *Discrimination*. This vision resonates with Uganda's aspirations expressed in the National HIV and AIDS Strategic Plan, i.e:

- Achieving universal access to HIV prevention, treatment, care and support; and
- Halting and reversing the spread of HIV and contribute to achievement of other MDGs.

The UN system in Uganda is a key player in supporting the national HIV and AIDS response. The development of the JUPSA (2011-2014) is part of the UN's continuous commitment to support the Government of Uganda to fulfil its national and global obligations to combat HIV and AIDS. The UN system in Uganda aspires to promote and strengthen national leadership and ownership of the HIV response.

The second generation JUPSA was developed through a consultative approach with key stakeholders and close interaction with the Government of Uganda. The new JUPSA has a new management structure that includes the Government of Uganda, donors, civil society, Persons Living with HIV (PLHIV) and the private sector. The Steering Committee will be chaired by the UN Resident Coordinator and Co-chaired by the Director General of the Uganda AIDS Commission.

Through the JUPSA (2011-2014), we sincerely believe that the UN support and partnership with the Government of Uganda will lead to accelerated, integrated, more effective and highly accountable UN response to HIV and AIDS in the country.

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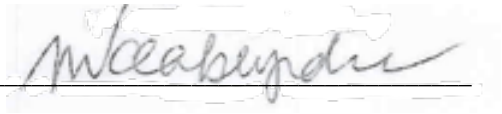

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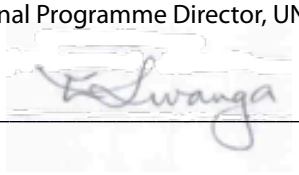

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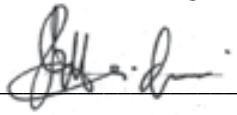

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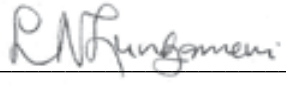


Acronyms and abbreviations

AA	Administrative Agency
ADP	AIDS Development Partners
AIDS	Acquired Immune Deficiency Syndrome
AIS	AIDS Indicator Survey
ART	Anti-Retroviral Therapy
ARVs	Anti-Retroviral drugs
CCM	Country Coordinating Mechanism
CHD	Congenital Heart Disease
CMG	Core Management Group
CP	Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CSF	Civil Society Fund
CSO	Civil Society Organizations
DoL	Division of Labour
EID	Early Infant Diagnosis
FMA	Financial Management Agent
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIST	Global Implementation Support Team
GoU	Government of Uganda
GTT	Global Task Team
HACT	Harmonised Approach to Cash Transfers
HIV	Human Immune Deficiency Virus
HoA	Heads of Agencies
HSSIP	Health Sector Strategic and Investment Plan
HSSP	Health Sector Strategic Plan
IDU	Injecting Drug Users
IMPAC	Intersegmental Major Preparation Ariculated Curriculum
IOM	International Organization for Migration
ILO	International Labour Organization
JAR	Joint AIDS Review
JSC	Joint Steering Committee
JPO	Junior Profession Officer
JT	Joint Team
JUPSA	Joint UN Programme of Support on AIDS
LG	Local Government
M&E	Monitoring and Evaluation
MACA	Multi-sectoral Approach to Control of AIDS
MO	Medical Officer
MDG	Millennium Development Goals
MDTF	Multi Donor Trust Fund
MIS	Management Information System
MoGLSD	Ministry of Gender Labour and Social Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
MoHT	Modes of HIV Transmission
MoU	Memorandum of Understanding

MTR	Mid Term Review
NAFOPHANU	National Forum of People Living with HIV/AIDS Network in Uganda
NASA	National AIDS Spending Assessment
NDP	National Development Plan
NPO	National Proffession Officer
NSP	National HIV/AIDS Strategic Plan
OHCHR	Office of the High Commissioner for Human Rights
OVC	Ophans and Vulunerable Children
PAF	Programme Acceleration Fund
PEAP	Poverty Eradication Action Plan
PLHIV	People Living with HIV and AIDS
PMMP	Performance Measurement and Management Plan
PMT	Programme Management Team
PMTCT	Prevention of Mother to Child Transmission
PR	Principle Recipient
PUNOs	Participating UN Organizations
RH	Reproductive Health
RC	Resident Coordinator
RDT	Regional Directors Team
SMC	Safe Male Circumcision
SNPO	Senior National Programme Officer
STI	Sexually Transmitted Infections
TB	Tuberculosis
TSF	Technical Support Facility
TWG	Technical Working Group
UA	Universal Access
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UBRAF	Unified Budget, Results and Accountability Framework
UCC	UNAIDS Country Coordinator
UDHS	Uganda Demographic Health Survey
UHSBS	Uganda HIV/AIDS Sero-Behavioural Survey
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNASO	Uganda National AIDS Service Organization
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNESCO	United Nations Education, Scientific and Cultural Organization
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children Fund
UNODC	United Nations Organizations Office against Drugs and Crime
UNTWG	United Nations Technical Working Group
WFP	World Food Programme
WHO	World Health Organization

Executive Summary

Uganda is experiencing a generalized HIV epidemic with a prevalence of 6.4 percent in adults and 0.7 percent in children. As of December 2009, approximately 1.2 million people were HIV-infected with; 124,261 new HIV infections and 64,016 AIDS-related deaths annually, out of a total population of 32 million. The current HIV incidence by far outstrips AIDS related mortality and number of clients enrolling into chronic AIDS care. Notably, the face of the epidemic in the country has evolved over the years, with a higher prevalence in women compared to men and a shift of the infection from young unmarried individuals, driven mainly by unprotected casual sex to older individuals in long standing relationships. Currently, incidence modelling shows that 43 percent of new infections are among monogamous relationships while 46 percent occur among people with multiple sexual partners. There is also growing recognition that HIV risk and vulnerability is shaped by a combination of biological and behavioural risk factors, social and health seeking behaviour has also been attributed to social-cultural, economic and structural drivers.

In responding to the HIV epidemic, Uganda adopted a Multi-sectoral Approach to Control of AIDS (MACA) as the overall framework to guide national policy and programmatic interventions. Using relevant national programming frameworks, the approach calls for involvement of all government institutions, non government organisations and the general public to respond to the epidemic at all levels.

Over the years, Uganda registered remarkable success in the national HIV response, at some point becoming the World's best practice country in responding to the epidemic. This success was essentially on account of strong commitment at political, operational and community leadership levels. However, recent trends show that Uganda is facing new challenges that are undermining progress in the national response. These include complacency in political leadership; poor financial sustainability, weak systems and limited human resource capacity to deliver on HIV and AIDS programmes. There are also programmatic challenges which include declining decentralized response, persistent discrimination and stigmatization of people living with and affected by HIV, and fragmentation of the response, with many implementers not adhering to commonly agreed framworks and plans at national, district and community levels.

The UN system in Uganda has been providing strategic support to the national response. Following the expiry of first generation JUPSA (2007-2012) and emerging dynamics in the national response, the system and national partners formulated the second generation JUPSA (2011-2014). The JUPSA (2011-2014) is informed by performance of the first generation JUPSA, aligned to the current UNDAF and guided by the UNAIDS Global Strategy (2011-2015) of getting to *Zero New Infections*, *Zero AIDS- related Deaths* and *Zero Discrimination*.

This JUPSA (2011-2014) was developed through extensive consultative processes with key stakeholders. The Programme has seven (7) outcomes and twenty-one (21) Higher Level Outputs (HLO). In developing the outcomes and HLOs, the Joint UN Team on AIDS reviewed national strategic guidance against UNAIDS global strategic guidance articulated in the ten (10) milestones of UNAIDS Strategy. This process enabled the Team to formulate outcomes and HLOs for each thematic area. The 7 JUPSA (2011-2014) outcomes are:

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

This JUPSA is managed through a new 3-tier structural arrangement which was developed in consideration of findings from the first generation JUPSA MTR, guidance from the UNAIDS Strategy (2011-2015) and the national context of managing joint programmes. The management structure comprises Thematic Working Groups (TWGs), Core Management Group (CMG) and to Joint Steering Committee (JSC). With clearly defined terms of reference and membership composition, these structures are intended to facilitate effective delivery of UN support on HIV and AIDS in the national response. In an unprecedented move, the JSC has broad-based membership drawing representatives from the UN Country Team, Uganda AIDS Commission, Ministry of Health and other key Government Ministries, Partnership Committee, AIDS Development Partners (ADP), donors, representatives of PLHIV, relevant Civil Society Organisations (CSOs) and the private sector.

The cost of implementing this JUPSA is estimated at US$ 31,217,367 over four years. The proportional cost breakdown expressed as percentages across the JUPSA outcomes are:

Table 1: Cost of Implementing the JUPSA per outcome

JUPSA (2011-2014) Outcome	Cost (US$)	%
1. National systems have increased capacity to deliver equitable and quality HIV prevention integrated services	13,626,625	43.65
2. Communities mobilized to demand for and utilize prevention integrated services	3,159,908	10.12
3. Access to antiretroviral therapy for PLHIV who are eligible increased to 80%	4,930,442	15.79
4. Tuberculosis deaths (TB) among PLHIV reduced	905,044	2.90
5. People Living with HIV and AIDS and households affected by HIV are covered in all national social protection strategies and have access to essential care and support	4,064,312	13.02
6. National capacity to lead, plan, coordinate, implement, monitor and evaluate the national HIV response strengthened	4,072,752	13.05
7. Laws, policies and practices improved to support gender equality and reduce human rights abuses, stigma and discrimination.	458,284	1.47
TOTAL COST (US$) AND PERCENTAGE	**31,217,367**	**100**

The JUPSA is funded from existing agency budgets through pooled and non-earmarked extra-budgetary funds. Of the estimated budget of US$31.2 million, US$24 million (77%) is total commitments leaving a gap of US$7.2 million (23%). The committed funds are expected from UN participating agencies, DFID, Irish Aid and UBRAF.

As per the traditional joint programme funding mechanisms, agencies will be responsible for managing their own funds but will be required to indicate budgets and expenditure in the JUPSA budget. Additional funding for the JUPSA will be managed under a Pass-Through Fund Management (PTFM) arrangement, with United Nations Development Programme (UNDP) as the Administrative Agent (AA).

Achievements of JUPSA (2011-2014) will be tracked through a robust results matrix which has been developed to provide accurate evidence of programme progress. The results matrix is guided by principles of Results-Based Management (RBM).

CHAPTER ONE: Introduction

1.1 Background

In 2007, the United Nations (UN) in Uganda adopted guidelines of the Global Task Team (GTT) on improving coordination of the UN and the Multilateral system on AIDS (UNAIDS 2005). The guidelines were intended to achieve efficient use of resources and enhance ownership of the response by national governments as key players in building an effective national HIV response. The adoption of these guidelines and principles culminated into the first generation of JUPSA (2007-2012) and the Joint UN Team on AIDS to oversee its implementation.

The main objective of the JUPSA (2007-2012) was to position the UN as a strategic partner in acceleration of prevention, care and treatment and social support to reach sustainable Universal Access (UA). The formation and development of the JUPSA was guided by the Paris Declaration on Aid Effectiveness that enshrined the following principles:

- *Harmonization:* One UN team, one flag, one voice and one country programme;
- *Alignment:* more unified and optimal joint action of UN agencies in support of a scaled up national response based on the "Three Ones" principles, unification and integration of UN support on AIDS in national frameworks;
- *Simplification:* a common entry point for all stakeholders at the country level to easily access the full range of AIDS related UN services, based on agency technical comparative advantage;
- *Accountability:* a collective performance instrument in support of agreed common outcomes and outputs of the national or sector plans, through joint programming. This promotes more unified UN ways of working and functions under the joint programme management hierarchy.
- *Impact on lives:* expanded prevention, treatment, care and support and reduced HIV infection levels and vulnerabilities, clarity on roles and responsibilities, technical support, division of labour and strengthening of joint programming

The first generation of JUPSA (2007-2012) was developed in concert with the previous UNDAF which had a stand-alone outcome on HIV and AIDS (UNDAF Outcome 4[1]). To facilitate implementation of the JUPSA, the Joint UN Team on AIDS established five Thematic Working Groups (TWGs) to focus on each priority area which included: Mainstreaming and Rights; Multisectoral HIV Prevention and Education; Treatment and Care; Social Support; Monitoring and Evaluation; and Surveillance and Strategic Information. Each TWG mirrored the country programme UNDAF outcomes on HIV and AIDS.

[1]Reduction of HIV incidence by 40 percent during the period of the NSP with a strategic focus on addressing the social, cultural and economic cause of vulnerability and better targeting of high risk groups

1.2 JUPSA (2011-2014) PLANNING Process

The development of JUPSA (2011-2014) was a two-staged process that included a Mid-Term Review (MTR) of the JUPSA (2007-2012) in November 2010 and subsequent development of the new JUPSA. The MTR assessed implementation progress of JUPSA (2007-2012) whose findings were used to inform alignment of the new JUPSA to the UNDAF (2010-2014), UNAIDS Strategy (2011-2015), National Development Plan (2010/11–2014/15) and other emerging national and global priorities. The development of this JUPSA included review of key documents; key informant interviews with Government of Uganda (GoU), donors and UN agencies; consultative meetings and workshops; data synthesis and validation. The Government of Uganda stakeholders interviewed included Ministry of Health (MoH); Ministry of Education and Sports; Ministry of Gender, Labour and Social Development (MoGLSD); Ministry of Finance Planning and Economic Development; and Uganda AIDS Commission (UAC). Donors consulted included the President's Emergency Plan for AIDS Relief (PEPFAR)/United States Aid for International Development (USAID), Irish Aid and Department for International Development (DFID).

CHAPTER TWO: HIV Context in UGANDA

2.1 The HIV Epidemic

2.1.1 Epidemiological Situation and Trends

The HIV epidemic in Uganda is generalized. National adult prevalence is 6.4 percent while prevalence in children is 0.7 percent (UAC, 2005). At its peak in the 1980s and 90s, HIV disproportionately affected young people, with peak HIV prevalence in men (25-30 years) and women (20-24 years). The majority of new HIV infections during the same period predominantly occurred among young unmarried individuals and was driven mainly by unprotected casual sex. However, HIV transmission now occurs predominantly among older people in stable relationships.

As of December 2009, approximately 1.2 million people were HIV-infected with; 124,261 new HIV infections and 64,016 AIDS-related deaths annually out of Uganda's total population of 32 million. The current HIV incidence by far outstrips AIDS related mortality and the number of clients enrolling into chronic AIDS care.

Table 2: Selected HIV and AIDS Indicators (2005-2009)

Indicator	Population	December 2005	December 2007	December 2009
Number of people living with HIV	Adults	880,978	991,191	1,042,711
	Women	516,723	577,562	606,154
	Children	152,747	149,549	149,661
	Total	**1,550,448**	**1,718,302**	**1,798,526**
People newly infected with HIV	Adults	80,140	94,380	99,712
	Women	45,122	53,089	56,078
	Children	25,825	24,878	24,548
	Total	**151,087**	**172,347**	**180,338**
AIDS deaths	Adults	58,658	50,718	48,296
	Women	33,243	28,732	27,422
	Children	19,122	16,556	15,721
	Total	**111,023**	**96,006**	**91,439**

The AIDS Indicator Survey (2004-05) showed that 57 percent of HIV-infected individuals had uninfected partners. This supports previous studies which also show that non-infected people in HIV-discordant relationships have a 10-12 times increased risk of HIV acquisition than other people in the general population. About 25,000 babies are estimated to be born with HIV every year in Uganda and in 2009 only 50 percent of the estimated 91,500 HIV infected pregnant women received ART, far below the target of 80 percent by 2015.

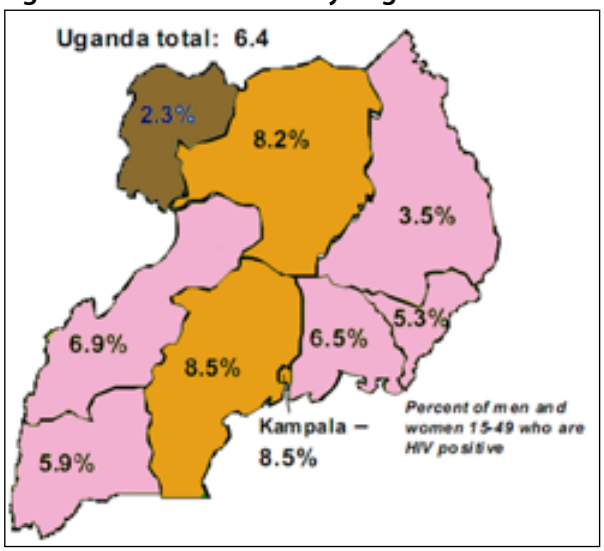
2.1.2 Sources of New HIV Infections

Sexual transmission continues to contribute four-fifths (76-80 percent) of new HIV infections followed by mother to child transmission (MTCT) at 18 percent. Incidence modelling shows that 43 percent of new HIV infections in Uganda are among monogamous relationships while 46 percent occur among people with multiple sexual partners. Sex workers, their clients and partners of clients contribute 10 percent of new infections while Men who-have-Sex with Men (MSM) and Injecting Drug Users (IDUs) combined contribute less than 1 percent.

2.1.3 Spatial Heterogeneity

The HIV epidemic in Uganda is heterogeneous with intra-regional variations. Central Kampala and North Central Regions have HIV prevalence above 8 percent while West Nile and North Eastern regions have the lowest prevalence rates at 2 percent and 4 percent, respectively (MoH and ORC Macro, 2005).

Figure 1: HIV Prevelence by Region



2.1.4 Sex Heterogeneity

The 2005 Uganda HIV/AIDS Sero-Behavioural Survey found that HIV prevalence was higher in women compared to men and increased with age until it reached the peak. For women, the peak is attained at ages 30-34 (12 percent) while for men at ages 35-44 (9 percent).

2.1.5 HIV Risks and Vulnerability

There is growing recognition that HIV risk and vulnerability is shaped by a combination of biological, and behavioural risk factors. Structural drivers have also been found to shape social and health seeking behaviours (Barnet and Whiteside 2002; Gupta *et. al* 2008; Auerbach *et. al* 2009).

Table 3: HIV Risk Factors and Structural Drivers in Uganda

Risk Factors	Structural Drivers
1. Multiple concurrent partnerships 2. High risk unprotected sex (low condom use) 3. Transactional and cross-generational sex 4. Discordance and non-disclosure 5. Presence of STIs especially HSV-2 6. Intact foreskin (uncircumcised males)	1. Socio-cultural factors including marriage and family values 2. Gender inequality and low status of women and girls 3. Sexual and gender-based violence 4. Human rights, stigma and discrimination 5. Income inequality, poverty and wealth 6. Governance and civil unrest

2.2 Country Response to the Epidemic

The national HIV response in Uganda currently aims at significantly reducing new infections and AIDS related deaths, while striving to achieve Universal Access (UA) to prevention, care, treatment and support.

2.2.1 The Multi-sectoral Approach to Control of AIDS

Uganda adopted a Multi-sectoral Approach to Control of AIDS (MACA) in 1992 as the overall framework to guide national policy and programmatic response to the epidemic. The approach calls for involvement of all government institutions, non government organisations, and the general public to respond to the epidemic at all levels within their mandates and capacities. In line with MACA; GoU, UN, donors, civil society and the private sector are playing key roles in the national response. The UN and the donors established a forum known as the AIDS Development Partners Group (ADPG) whose secretariat is UNAIDS. The civil society is coordinated by Uganda National AIDS Service Organization (UNASO) while PLHIV are coordinated by National Forum of People Living with HIV and AIDS Network in Uganda (NAFOPHANU). A Civil Society Fund (CSF) has also been established to harmonise and align the civil society response to HIV to the national response and ensure coordination of funding from development partners to civil society organizations in Uganda.

2.2.2 National Programming Frameworks

Within the MACA Framework, the GoU drafted a National Overarching AIDS Policy, various inset policies and national guidelines that support the national response. These include among others; the HIV Testing and Counselling (HTC) Policy, Anti-Retroviral Therapy (ART) Guidelines, Guidelines for Mainstreaming HIV and AIDS in Planning and Budgeting Processes, and the Orphans and Other Vulnerable Children (OVC) Policy.

At programmatic level, the country has a National HIV and AIDS Strategic Plan (NSP) 2007/08-2011/12 which provides direction of the programmatic response under four main themes; prevention, care and treatment, social support and systems strengthening. Uganda National HIV and AIDS Strategic Plan (NSP) 2007/08-2011/12) and the second Health Sector Strategic Plan 2005-2010 (HSSP-II) spell out country HIV prevention priorities (UAC 2008). Programmes such as the Universal Primary Education (UPE) and Universal Secondary Education (USE) directly or indirectly respond to the impact of HIV and AIDS in the education sector. The country plans to implement these plans on a scale commensurate with the current HIV transmission dynamics to meet the targets for UA and United Nations General Assembly Special Session on HIV and AIDS (UNGASS). A new national HIV multi-sectoral prevention strategy has been developed to better focus national HIV prevention efforts.

In order to advance the national response towards UA to effective PMTCT services and achieve the virtual elimination of new HIV infection in infants and young children, Uganda has developed a strategy and action plan in support of the global commitment to elimination of Mother-To-Child Transmission (MTCT) of HIV by 2015. The overall goal of the plan is to achieve virtual elimination of HIV transmission from infected mothers to their children through enhanced provision of integrated comprehensive Prevention of Mother to Child Transmission (PMTCT) services and to reduce morbidity and mortality among the HIV-exposed infants.

2.2.3 Challenges and Emerging Issues

Uganda was once a best practice country in the World in responding to HIV owing to strong commitment at political, operational and community leadership levels. Since 2002, GoU has been complacent in providing continuous leadership at all levels of the national response. Besides complacency in leadership, other challenges that have negatively impacted the national HIV response include:

Funding Challenges:

- High dependence on external funding, fragmented funding mechanisms largely supporting vertical programmes, declining volumes of resources and resource unpredictability with implications for sustainability; and
- Financial unsustainability of the national response, especially with respect of treatment, social support programmes and community coping mechanisms.

Capacity and Systemic Issues:

- Limited human resource capacity to deliver on HIV and AIDS programmes, aggravated by poorly coordinated HIV activities and weak partnerships at policy and service delivery levels;
- Inadequate operationalization of one Monitoring and Evaluation (M&E) system for the national response;
- Low absorption of and weak accountability for HIV and AIDS funding particularly in the public sector, leading to creation of alternative funding mechanisms that do not necessarily promote resource efficiency; and
- Chronic delays in procurement and distribution of health commodities leading to persistent stock outs.

Programmatic Challenges:

- Declining decentralized response which is the cornerstone for service delivery and implementation of the national response;
- Low progress in mainstreaming HIV across all sectors;
- Persistent discrimination and stigmatization of people living with and affected by HIV and AIDS which affects the roll out of HIV programmes such as HIV Testing and Counseling (HTC);
- Limited gender responsive HIV programming despite the evidence showing higher new infections among women and girls;
- Fragmentation of the national response with many implementers failing to adhere to commonly agreed frameworks at national, district and community levels; and
- Behavioural dis-inhibition and limited individual risk perception leading to complacency as many people perceive ARVs to be a cure for AIDS.

CHAPTER THREE: Review of UN support to Uganda National HIV Response (2007-2012)

In December 2010, the UN in Uganda commissioned a Mid-Term Review (MTR) of JUPSA (2007-2012) to assess progress made and plan for the remaining years of the Programme. The mid-term review was expected to inform the development of a second generation JUPSA (2011-2014) that is aligned to the new UNDAF and the UNAIDS Strategy (2011-2015) with clearly defined new priority areas.

3.1 Key Achievements of JUPSA (2007-2012)

3.1.1 Broad Achievements

The UN in Uganda continues to provide support towards strengthening national institutions and systems to ensure ownership and leadership for effective coordination and management of the national response. The UN has supported development of multi-sectoral HIV Prevention Strategy and is currently supporting its implementation and other support processes such as institutionalization of National AIDS Spending Assessment (NASA), the institutional review of UAC, the Joint AIDS Review (JAR) and the development of the new NSP. Other achievements include:

- Re-positioning the UN as a strategic partner with the GoU in the acceleration of prevention, care and treatment and social support. The unified voice of the UN has led government to understand key coordination, leadership and service delivery challenges and plans are underway to address these challenges;
- Improved understanding of the concept of "harmonization and alignment" the role and comparative advantage of the participating UN agencies, for a more unified and optimal joint action on AIDS which has led to alignment and efficient use of UN resources;
- Provided a common entry point for all stakeholders at country level and a collective performance instrument in support of agreed common outcomes and outputs of the national HIV response. This has led to a more streamlined relationship with other development partners and unified support to the national response; and
- Increased advocacy at all levels against legislation and policy that would adversely affect the national response. This led to the President's intervention calling on stakeholders and Parliament to consider implications of the legislation and ultimately the expiry of Bills under the 8th Parliament. The increased media coverage on subjects considered taboos such as sexual orientation inadvertently created an atmosphere of tolerance amongst some members of the community.

3.1.2 Specific Achievements

3.1.2.1 Mainstreaming and Rights

Through the Mainstreaming and Rights TWG, the Joint UN Team raised awareness on the need to review the national HIV response, supported the revitalisation of leadership for the national response at all levels and successfully brokered dialogue on unblocking Global Fund (GF) resources to the national response. These efforts have resulted in a national dialogue on HIV and AIDS where pertinent issues were identified and a way forward agreed by stakeholders. There was also unblocking of over US$100 million of GF resources; GoU allocation to the national HIV response increased by about 50 percent mainly for treatment and GoU decision to undertake an institutional review of UAC and the national HIV response.

The UN in Uganda also supported strengthening of civil society and PLHIV coordination bodies such as Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level (AMICAALL), UNASO, NAFOPHANU and other self coordinating entities of UAC partnership. Support was also provided to enhance the engagement of religious and cultural institutions in the national HIV response. As a result, the cohesive voice of the civil society is now stronger as evidenced by the common position on such issues as the need for a second Principal Recipient (PR). More attention is now given to socio-cultural drivers of HIV infection and more donors are allocating funds to cultural institutions to respond to HIV and AIDS in Uganda.

In terms of human rights and legal issues, the UN facilitated extensive national consultations with various constituencies. As a result, the Prevention and HIV Control Bill is more acceptable and harmonised; there is increased media coverage around the Anti- Homosexuality Bill. Preparations for request for continued funding under GF round 7 included a representative of MSM on the drafting team and at least 20 sex workers participated at the national launch of the action framework on women, girls, gender equality and HIV.

3.1.2.2 Multi-sectoral Prevention and Education

In light of new evidence on HIV transmission in Uganda and guided by proven HIV prevention interventions and the need for combination prevention as an HIV prevention strategy, the UN successfully advocated for a new country focus on HIV prevention. The subsequent development of a new NSP and sectoral strategies and plans, has led to the re-engagement of key sectors in the national response as well as provided a platform for increased resource mobilisation and scaling up proven HIV prevention interventions such as Safe Male Circumcision (SMC), PMTCT and condom use. The UN has supported continued advocacy and provided technical guidance on expanding access to prevention services through expanded integration of services for reproductive health and HIV.

The UN has also supported generation and dissemination of strategic information through the Uganda Modes of HIV Transmission (MoHT) Study; sex work profiling; mapping, response analysis of HIV programming and health service availability mapping for key populations; Reproductive Health (RH) choices for people living with HIV and AIDS; situational analysis and piloting of the female condom.

As a sustainability measure, the UN has facilitated revitalisation of the national coordination, guidance and policy support structures for HIV prevention in order to promote national leadership and ownership of the prevention response, improve coordination, share lessons and best practices among partners. This has resulted in re-establishment of a high level multi sectoral National Prevention Committee (NPC) and a functional National Behaviour Change Communication/Information Education Communication (BCC/IEC) Team.

The UN advocacy efforts have also contributed to establishment of the United Nations Education, Scientific and Cultural Organization (UNESCO) focal point to support the education sector prevention response in the country and placement of personnel in the HIV Prevention Unit at UAC. These efforts have strengthened UAC in coordinating the national prevention response at the respective levels and reinvigorated roles of the Ministry of Education and Sports as a key sector in the national response.

Communication strategies and plans were also developed for key populations. With regards to PMTCT, the national coordination was strengthened through a functional national TWG and the PMTCT scale up plan developed based on the new WHO (2010) PMTCT, ART IYC. Paediatric guidelines on provision of comprehensive HIV and AIDS care were adapted and PMTCT services scaled up to 23 districts using IMAI/ IMPAC tools.

The SMC Policy and Communication Strategy were launched and a situational analysis conducted. A national SMC Task Force was established by MoH with an action plan and resources availed for SMC roll out. Further, support was rendered for resource mobilisation to support rapid scale up through media briefings and training, orientation of district leaders and mayors, supporting partnership strengthening and coordination among MoH, Centres for Disease Control (CDC) and other partners. The UN has also provided technical guidance for the finalisation of the decisions makers' tool to support costing of SMC roll out, finalisation of the legal and regulatory framework assessment and finalisation of the national roll out strategy. As a result, increased funding has been committed to SMC; leadership support for SMC has increased and roll out is ongoing.

Regarding the UN workplace programme, the UN Cares Programme institutional assessment report was finalized and disseminated. Recommendations were made and consensus reached on scaling up the UN workplace programme on HIV/AIDS and a programme to institutionalise UN cares is being implemented.

3.1.2.3 Treatment and Care

A national scale up of Tuberculosis-HIV (TB-HIV) services was achieved through the development of policy, materials, tools and administration of mentoring and supervision. Infant and Young Child Feeding Guidelines were adapted and disseminated to 23 districts. The Joint UN Team on AIDS also supported training of 90 Health Workers (HWs) in the provision of adult, adolescent and paediatric care services. The Baylor College in Kilembe was designated a regional centre of excellence and MoH was supported to roll out Early Infant Diagnosis (EID) through Congenital Heart Disease (CHD).

The UN supported a Training of Trainers (ToT) workshop for Early Infant Diagnostics (EID), coordination of quarterly TB/HIV meetings, scaling up of Open Electronic Medical Records and dissemination of Early Warning Report (EWNI). The UN also provided technical assistance to MoH towards patient monitoring and collaborated with partners to support mentoring and supervision of health workers for quality ART that included TB/HIV supervision of health workers.

United Nation's contribution towards strengthening procurement and supply chain management systems to deliver timely medicines, condoms and supplies in a coordinated manner included support to development of draft female condom scale up plan; mapping exercise in 15 districts on condom promotion, procurement of Reproductive Health (RH) commodities and technical assistance to MoH. The UN also supported capacity building for effective management of HIV medicines and logistics in 45 districts and a ToT on laboratory quality assurance.

3.1.2.4 Social Support

The Joint UN Team on AIDS made significant progress in supporting the development of National Nutritional Guidelines, accomplishment of studies on the Impact of Food and Nutritional Support in the context of HIV and longitudinal impact of HIV on the agricultural sector. The Team also supported development of Child Labour Policy, a national plan of action on child labour, formulation of a national Strategic Plan on OVC for the period 2011-2016 and operationalization of OVC Management Information System (MIS) in 65 districts to provide information on services being provided. These were developed through support to the Ministry of Gender, Labour and Social Development (MoGLSD). Support of the UN also contributed to improved coordination of stakeholders across government ministries, districts and improved reporting by CSOs to the MoGLSD. Notably, the strengthening of public-private and target community partnerships also improved the coordination of OVC programming in the national response.

3.1.2.5 Monitoring and Evaluation, Surveillance and Strategic Information

The UN supported revitalisation of National Monitoring and Evaluation Technical Working Group, which oversaw production of 2010 UNGASS Uganda Report, UA report and the periodic epidemiological surveillance reports. These have provided the country with updated strategic information for HIV programming. UN in Uganda also supported the AIDS Indicator Survey (AIS) and conceptualisation and resource mobilisation for NASA and NSP MTR exercises.

3.2 Summary of Key Lessons from JUPSA (2007-2012) Review

The following are key issues from the MTR of JUPSA (2007-2012) to inform the development of JUPSA (2011-2014):

a. Effective Organisation, Coordination and Management of the Programme:

- UNAIDS needs to clearly lead by example by championing the concept of Delivering as One UN and discourage bilateral operations because some UN agencies still operate on bilateral level rather than through UN joint programming and action. UN support to target beneficiaries is fragmented because different agencies offer support to parallel programmes run by the same partners;
- UNAIDS Secretariat needs to have a calendar of TWG meetings in order to provide technical support to each of them. The calendar should be circulated in advance to enable members prepare and avoid concurrence in meetings of the different groups;
- The adaptation of global division of labour (DoL) at country level should not only be guided by mandates and capacities of the UN agencies but specific needs of the national stakeholders; and
- The JUPSA (2011-2014) should be developed through a more participatory process involving government and partners in order to identify distinct priorities for joint programming in addition to ongoing agency specific activities. Joint programming and joint prioritisation during planning is necessary to foster collective results.

b. Suitability of the Thematic Structure and the DoL

- There is need to review relevance of the five thematic groups particularly the role of Monitoring Evaluation as a thematic working group. This group should inform planning and operation of other thematic groups.

c. Participation of UN Agencies

- In Uganda, JUPSA comprises 14 UN agencies. However, there was lack of consistent and active

involvement by members, probably due to lack of clear guidelines to regulate and motivate their participation;

- Uncertainty over roles of participating agencies *vis-à-vis* the role of the lead agency, exacerbated by inadequate guidance on number of meetings and reporting mechanisms. Besides, meetings are not result-oriented leading to loss of interest among participants; and
- Lack of funding for programme implementation demoralised some members, particularly agencies without budget lines for jointly programmed activities.

d. Stakeholder Perception of the JUPSA

- Stakeholders (especially line ministries) appreciated current efforts of the UN and the support they received. However, it was clear that each ministry had a more familiar working relationship with specific agencies rather than the UN as a whole, with the general perception being that the UN's 'Delivering as One' was struggling; and
- It was felt that the UN was more effective in upstream roles and should only go downstream in piloting implementation of those policies for a limited duration while building and strengthening capacity at the lower level.

e. Sustainability of Programme and Programme Results and Benefits

- There has been capacity building of various institutions to sustain implementation of the national response. Furthermore, the UN has invested heavily in institutional and technical capacity building of government sectors and its partners which can be developed and tapped into for years to come. However, the national coordinating mechanism needs further support to effectively carry out its mandate. Financially, the programme is too dependent on donors particularly the GF. The Government of Uganda needs to be encouraged to allocate its own resources to address the epidemic.

f. Cost- Effectiveness

- The programme was considered cost effective because it minimised duplication and double funding both in terms of financial and human resources particularly in working with UAC. However, the focus at upstream level missed linkages with actual service delivery at the lower levels. There was no meaningful transfer of interventions at national level to the communities and grass roots. This diminished the relevance, presence and effectiveness of the programme at lower levels;
- The current work plan is said to be overambitious and should be simplified to make the targets more attainable. There is also need for agencies to better understand the concept of 'Delivering as One' since many still operate individualistically; and
- The UN should improve follow up on the support provided in order to ensure that it is used according to planned activities.

g. Financial Management and Operations

- The Multi-Donor Trust Fund (MDTF) faced challenges particularly around PUNOs' inadequate understanding of processes and procedures and roles of different parties involved in the processes. Other critical challenges included delays in disbursement of funding because the Administrative Agent (AA) lacked information of some PUNO contact persons at headquarters leading to late submission of PUNOs mid-term financial reports. There is therefore need for further training of PUNOs on new procedures, use of the MDTF Gateway and appeal to all of them to submit mid-year financial accountability and progress reports in time.

CHAPTER FOUR: Joint UN Programme of Support on AIDS in Uganda (2011-2014)

4.1 Linkages and Alignment

This JUPSA (2011-2014) is informed by performance of the first generation JUPSA and is aligned to the current UNDAF, guided by the UNAIDS Global Strategy (2011-2015). The Global Strategy defines three strategic directions that are necessary to achieve UNAIDS long-term agenda of getting to *Zero New Infections*, *Zero AIDS- related Deaths* and *Zero Discrimination*. The Strategy also sets out ten milestones, based on the vision of getting to zero, that will enable UNAIDS to fulfil its global commitments to:

- Achieve universal access to HIV prevention, treatment, care and support; and
- Halt and reverse the spread of HIV and contribute to the achievement of other MDGs.

Unlike JUPSA (2007-2012) which was developed based on one overarching UNDAF Outcome for HIV with five thematic areas, the new JUPSA (2011-2014) is premised on all the three UNDAF outcomes and aligned to the three priority areas in the UNAIDS vision of getting to zero.

4.2 Outcomes and higher level results

In developing outcomes and HLO, the Joint UN Team on AIDS reviewed national strategic guidance against UNAIDS global strategic guidance and 10 goals articulated in the UNAIDS Strategy. This process enabled the Team to formulate outcomes and HLOs for each thematic area that are underpinned by UNDAF outcomes, NSP goals and the global UNAIDS vision. The new JUPSA (2011-2014) has seven (7) outcomes and twenty-one (21) HLOs. The seven outcomes are:

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

Table 4: Linkages between UNDAF, NSP and UNAIDS Vision and JUPSA (2011-2014)

Thematic Area	UNDAF outcome	NSP Goal	UNAIDS Vision	Strategic Guidance	JUPSA Outcome
1. HIV Prevention	***Outcome 2***: Vulnerable segments of the population increasingly benefit from sustainable livelihoods and in particular improved agricultural systems and employment opportunities to cope with the population dynamics, increasing economic disparities, economic impact of HIV and AIDS, environment shocks and recovery challenges by 2014 ***Outcome 3:*** Vulnerable populations in Uganda, especially in the north, increasingly benefit from sustainable and quality social services by 2014	To reduce the incidence rate of HIV by 40% by the year 2012	Zero new infection	Revolutionize HIV prevention	▸ National Systems have increased capacity to deliver equitable and quality HIV prevention integrated services ▸ Communities mobilized to demand for and utilize prevention integrated services
2. Treatment, Care and Support	***Outcome 2:*** Vulnerable segments of the population increasingly benefit from sustainable livelihoods and in particular improved agricultural systems and employment opportunities to cope with the population dynamics, increasing economic disparities, economic impact of HIV and AIDS, environment shocks and recovery challenges by 2014 ***Outcome 3:*** Vulnerable populations in Uganda, especially in the north, increasingly benefit from sustainable and quality social services by 2014	To improve the quality of life of PHIVs by mitigating the health effects of HIV/ AIDS by 2012; To mitigate social, cultural and economic effects of HIV and AIDS at individual, household and community level	Zero AIDS-related death	Catalyze the next phase of treatment, care and support	▸ Access to antiretroviral therapy for PLHIV who are eligible increased to 80% ▸ TB deaths among PLHIV HIV reduced ▸ People Living with HIV and households affected by HIV are addressed in all National Social protection strategies and have access to essential care and support
3. Governance and Human Rights	***Outcome 1.*** Capacity of selected Government Institutions and the Civil Society improved to bring about good governance and realization of human rights that lead to reducing geographic, socio- economic and demographic disparities in attainment of Millennium Declaration and Goals by 2014	To build an effective system that ensures quality, equitable and timely service delivery	Zero discrimination	To advance human rights and gender equality for the HIV response	▸ National capacity to lead, plan, coordinate, implement, monitor and evaluate the national HIV response strengthened. ▸ Laws, policies and practices improved to support gender equality and reduce human rights abuses, stigma and discrimination

4.2.1 The Case for HIV Prevention

The Government of Uganda has highlighted HIV prevention as a major priority in the National Development Plan (2010-15) and set a target of 40 percent reduction in new infections by 2015. Although the country has experienced stable national HIV prevalence of between 6-7 percent among adults during the past decade, the estimated number of new HIV infections annually (over 124,000 new infections in 2009) is unacceptably high. This is in part attributed to low comprehensive knowledge and widespread risky sexual behaviours. Overall, an estimated 56 percent of new infections occur among women and girls while about 24 percent

of new infections occur among babies through MTCT. Factors responsible for the gender differentials in the epidemic have been documented and are well articulated in the Modes of HIV Transmission (MoHT) study report.

The UN in Uganda supported a high level national launch of action framework for women, girls, gender equality and HIV which will anchor the development and implementation of a national plan that addresses key challenges faced by women and girls in accessing and consistently using HIV prevention services. This will contribute to changing the tide of the epidemic in Uganda.

Despite implementation of HIV prevention interventions for over 25 years, UA to HIV prevention services has not yet been attained and some of the HIV prevention interventions are not aligned to sources of new infections. The new National HIV Prevention Strategy largely supports prioritisation of interventions where the best impact will be attained in the next five years. It also calls for increased focus, enhanced coordination and collaboration to comprehensively scale-up and align HIV prevention efforts with the drivers of the epidemic, strategically shift towards combination HIV prevention and promote resource effectiveness and efficiency in the prevention response. Other areas of emphasis include strengthened and sustainable enabling environment that mitigates underlying drivers of the epidemic, expansion and improvement in the quality and uptake of HIV prevention services, achieving a well coordinated HIV prevention response and strengthened information systems for HIV prevention at all levels.

While scaling up HIV and AIDS care and treatment services provide relief to HIV-infected individuals, long-term sustainability of the national response requires increased effectiveness of HIV prevention initiatives. HIV prevention is now the primary focus of the Uganda national HIV response and plans to galvanize all stakeholders to refocus on HIV prevention have been developed. The National HIV Prevention Strategy aims at guiding re-invigoration of HIV prevention in the country in order to contain and reduce the escalating rate and number of new HIV infections by 30 percent by 2015 and avert about 200,000 new infections over the next five years.

The Joint UN Team on AIDS was instrumental in the MoHT study that provided evidence on the epidemiology and drivers of the HIV epidemic in Uganda and thereafter provided technical expertise and mobilised resources for the development of the HIV Prevention Strategy and Action Plan. It is therefore not a coincidence that HIV prevention is a critical thematic area of support within the JUPSA (2011 -2014). Consequently, two JUPSA outcomes with corresponding JUPSA outputs have been defined.

Table 5: HIV Prevention JUPSA (2011-2014) Outcomes and Outputs

Thematic Area	JUPSA outcome	JUPSA output
HIV Prevention	National systems have increased capacity to deliver equitable and quality HIV prevention integrated services	Technical capacity for combination prevention programming and service delivery strengthened (with priority focus on SMC, HCT, PMTCT and comprehensive condom programming)
		Leadership and coordination for HIV prevention strengthened at national and district levels
		Strategic information generated and utilized for evidence-based HIV prevention programming
	Communities mobilised to demand for and utilise prevention integrated services	Capacity of community systems for social and behaviour change strengthened.

4.2.2 The Case for Treatment, Care and Support

Uganda is rolling out ART services in the public and private sector following the emergency phase of rapid roll out that was characterised by involvement of multiple partners. By June 2010, there were 237,070 (89 percent adults 15 years and older) ART clients on treatment out of 343,809 clients ever started on ART representing 69 percent enrolment rate.

While progress has been made in the national ART service delivery programme, the programme is currently at crossroads. Recently revised ART treatment guidelines where ART eligibility criteria was aligned with WHO recommendations means that the number of HIV-infected people eligible for ART treatment has markedly increased. At the same time, ART services in the country are experiencing low level funding. This situation calls for increased coordination among the multiple ART implementing partners in the country, increased government ownership and efficiency in the service delivery. The planned harmonization and rationalization of ART service delivery is anticipated to contribute to Zero AIDS related deaths. The recent breakthrough on treatment for prevention also implies that treatment will contribute to zero new infections.

People living with HIV and their households continue to experience enormous social and economic challenges such as increasing levels of poverty forcing them to sell off household assets such as land to meet the cost of care. HIV and AIDS continues to be a major driver of child vulnerability and contributes 48 percent of 2.4 million orphans (UNAIDS *et.al* 2004). Over 32,130 children between the ages of 10-17 are household heads and about 63 percent (1,530,900) of the orphans live with caregivers other than a natural parent. An estimated 32 percent of all children aged 5-17 in Uganda are involved in work that negatively impacts on their health, social and moral development while overall, more than half of children aged 5-17 are economically active (UNHS 2010). The most recent OVC situation analysis indicates that 43 percent of OVC are moderately vulnerable, while eight percent are considered critically vulnerable and in need of immediate protection and support (Kalibala and Lynne 2010). Households affected by HIV and AIDS continue to hardly afford adequate food and nutrition and education for children and many of these households are labour constrained. The emerging intentions of government to develop social protection interventions for vulnerable and poor families provides an opportunity to address concerns of households affected by HIV and AIDS but this will only happen if their issues are integrated in the forthcoming social protection policy frameworks and interventions. The UN provides a strong partner to support articulation and inclusion of families affected by HIV and AIDS in the forthcoming social protection policies. With the conclusion of the National Action Plan on Child Labour and the second strategic plan on OVC, the government expects the UN to provide support to the Government of Uganda to ensure effective implementation to enhance realisation of planned outcomes for vulnerable children.

Table 6: Treatment, Care and Support JUPSA (2011-2014) Outcomes and Outputs

Thematic Area	JUPSA outcome	JUPSA output
Treatment, Care and Support	Access to antiretroviral therapy for PLHIV who are eligible increased to 80 percent	Guidance provided and capacity built for provision of standard ART care according to the WHO recommendations
		Enhanced programming for Pre- and Post-exposure prophylaxis
		Capacity for screening and management of non communicable diseases associated with HIV strengthened in all ART centres
		Support relevant institutional capacity for procurement and supply chain management systems
	TB deaths among people living with HIV reduced	Accelerated and streamlined implementation of HIV/TB collaborative interventions
	People Living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support	National social protection policy, strategy and programs integrate issues of PLHIV and their households
		Communities vulnerable to HIV have increased resilience and empowered to be food and nutrition secure.
		Strengthened capacity of government to implement OVC policy and plans for vulnerable children operationalised

4.2.3 The Case for Governance and Human Rights

The UN in Uganda has a unique opportunity to galvanize multilateral, bilateral and national stakeholders in the effort to halt the reversal of progress that has been achieved. Since 2002, there has been gradual complacency in government to provide continuous leadership and ownership at political, operational and community levels. The Uganda AIDS Commission has been affected by a forensic audit and consequent series of capacity issues that have undermined the governance, coordination and management of the national multisectoral and decentralized response. The UN in Uganda would need to strengthen and support government capacity to carry out high level advocacy to revitalize and strengthen government's leadership role and systems.

Although 50 percent of Uganda HIV response is implemented by the civil society, there has been inadequate engagement of critical entities such as cultural institutions and religious leaders. These entities have a key role in addressing socio-cultural drivers of HIV. The private sector is also not playing its expected role in the national response. Working with networks of PLHIV has also not been as strategic as it should be. Furthermore, critical roles played by the civil society as advocates and watchdogs over AIDS resources and services, have declined as most civil society partners now focus more on direct services delivery. This is further compounded by the low capacity and fragmentation within the civil society and disconnect between civil society and government.

Gender inequality and challenges of women and girls rooted in the socio-cultural set up are key derivers of the HIV epidemic in Uganda as in many other countries. Available evidence shows that women are more vulnerable to HIV infection than men in Uganda. National HIV prevalence among men is 5 percent and 8 percent in women (UHSBS 2004). In response to this challenge, UNAIDS has developed an action framework on women, girls, gender equality and HIV which has been launched in Uganda. The JUPSA will provide technical support for the country towards domestication and roll out of the action framework.

Strengthening the capacity of government and supporting governance (including coordination mechanism, planning and monitoring and evaluation systems) and human rights systems are imperatives if Uganda is to effectively coordinate the multi-sectoral effort, execute and implement high level advocacy, provide expert technical support and broker volatile legal and legislative initiatives within the country. The UN has a strategic role to play in strengthening and supporting collection and utilization of strategic information to inform policy and programming decisions both at national and sub-national levels.

In addition to weak systems, many ADPs have expressed concern regarding governance and accountability for HIV resources in some government institutions. These challenges have forced many ADPs to channel resources for HIV through alternative mechanisms such as the Financial Management Agent (FMA). The UN is well positioned to provide technical backstopping when such mechanisms are employed. Considering that these alternative funding mechanisms disadvantage the national HIV response due to high costs associated with such measures, the UN should spend considerable time and human resources to broker normalization of relations between the ADPs and government institutions.

Legislative Bills tabled in the 8th Parliament such as the HIV/AIDS Prevention and Control Bill, Anti-Homosexuality Bill and Sexual Offences Bill if passed in their current state would undermine progress in the national response. Non-conducive legislative environment has created a turbulent legal and environmental situation and placed responsibility on the UN to strengthen national capacities to respond to these challenges through advocacy and lobbying. Male same-sex behaviour and sex work is a criminal offence in Uganda with male same-sex behaviour being punishable by a maximum penalty of life imprisonment. Stigma is severe and MSM are not accepted or recognised by the majority of Ugandan society.

Table 7: Governance and Human Rights JUPSA (2011-2014) Outcomes and Outputs

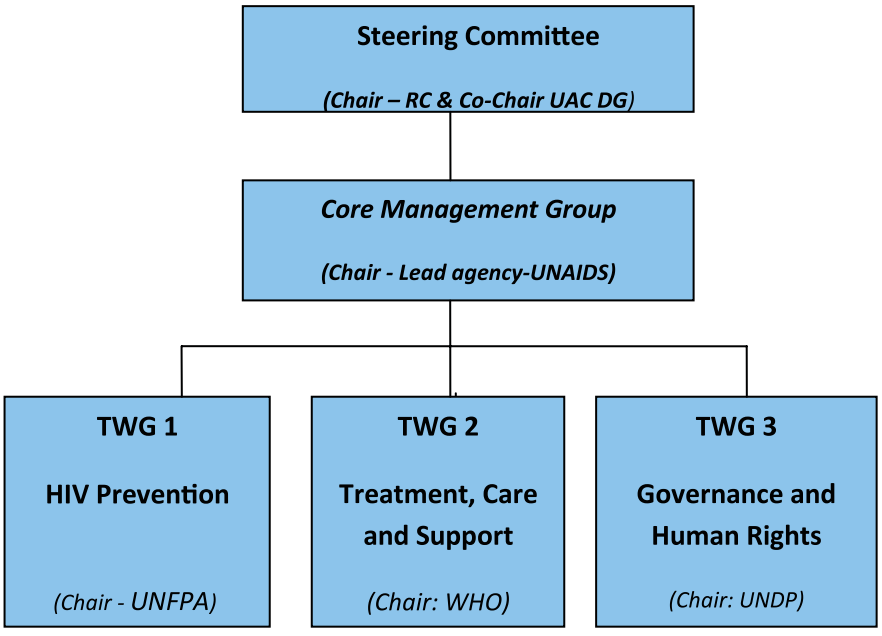
Thematic area	JUPSA outcome	JUPSA output
Governance and Human Rights	National capacity to lead, plan, coordinate, implement, monitor, and evaluate the national HIV response strengthened	Capacity of national institutions to lead and coordinate the national HIV response strengthened
		National and local government capacity to mainstream HIV and AIDS in planning and policy processes improved
		The UAC and sector institutional capacity to plan supported
		Engagement of the civil society including PLHIV and young people in the national HIV response strengthened and streamlined
		Institutional capacity for resources tracking supported
		National capacity to gather and disseminate strategic information strengthened
		Capacity of the UN JT to plan, implement, monitor and evaluate the JUPSA strengthened
	Laws, policies and practices improved to support gender equality and reduce human rights abuses, stigma and discrimination	Capacity of national institutions to identify and implement relevant laws, policies and practices that undermine and support effective responses to HIV and AIDS strengthened
		Technical capacity provided and resources mobilized to domesticate and implement the accelerated plan of action on women, girls, and gender equality in response to HIV

CHAPTER FIVE: Management and Funding Arrangements

5.1 Management Arrangements

The structural management arrangement of JUPSA (2011 -2014) was developed in the context of findings from the MTR of the first generation JUPSA (2007-2012), guidance from the UNAIDS Strategy 2011-2015 and the national context of managing joint programmes. The JUPSA management structure comprises three lines of communication and reporting; namely, the Thematic Working Groups (TWGs); Core Management Group (CMG) and the Joint Steering Committee (JSC).

Figure 2: Management Structure of JUPSA (2011-2014)



5.1.1 The Joint UN Team on AIDS

The Joint UN Team on AIDS comprises full time and part time resident and non-resident UN programme staff working on HIV in Uganda (Annex I). The UN staff are formally nominated to the team through a letter jointly signed by their Heads of Agency (HoA) and the UN Resident Coordinator. The UNAIDS Country Coordinator (UCC) is the convenor and Chair of the Team and can contribute to any team member's performance appraisal. Roles of the Joint UN Team on AIDS are to:

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

The functions of the Joint UN Team on AIDS are to plan, set priorities for the year and evaluation of the programme. These meetings are based on the UNDAF annual planning timetable and the national JAR. Individual team members are accountable to fulfill their roles and responsibilities within the team structure. Key deliverables are agreed under JUPSA. Using existing agency accountability frameworks and individual organization processes, HoAs ensure that individual performance assessments take into account time and technical contribution to the team.

Accountability is fostered through a results-based management approach within the Joint UN team on AIDS and each agency to ensure that processes, products and services contribute to achievement of planned outcomes and outputs. The team and its component agencies ensure good accountability for their involvement and performance in the national response with relevant systems, including a Monitoring and evaluation framework. The team reports to partners throughout the cycle of programme of support. There are two reports per year, the mid-year and annual review report of the JUPSA which the UCC consolidates on behalf of participating UN agencies and submits to the Joint Steering Committee.

Within UNAIDS (2011-2015) DoL (Annex II), UNAIDS Secretariat has the overall responsibility to ensure accountability across all areas in the DoL on matters of leadership and advocacy, coordination, coherence and partnerships. UNAIDS also supports mutual accountability of the secretariat and cosponsors to enhance programme efficiency and effectiveness and to optimally deliver on the shared JUPSA outcomes.

5.1.2 Thematic Working Groups (TWGs)

The JUPSA (2011-2014) has three TWGs. These working groups are linked to the national aspiration of turning off the tap of new HIV infections and AIDS related deaths in concert with the UNAIDS vision of Zero New Infections, Zero related-Deaths, and Zero Discrimination. Based on the above premises, the Joint UN Team on AIDS agreed to establish the following three TWGs:

1. Prevention Thematic Working Group which focuses on work towards achieving the "Zero New Infections" vision;
2. Treatment, Care and Support Thematic Working Group focuses on work towards achieving the Zero related-Deaths vision; and
3. Governance and Human Rights Thematic Working Group works towards achieving the Zero Discrimination vision.

The TWGs are chaired by UNFPA, WHO and UNDP respectively. Within each TWG, there are Participating UN Organizations (PUNOs) for component activities of the priority area. All UN program staff directly concerned with the thematic area are members. TWGs meet once a month or as need arises. Each TWG keeps records of its discussions for follow up.

Terms of Reference for Thematic Working Groups are:

1. Set priorities for UN system action in the technical area based on national needs and gaps;
2. Develop and implement specific components of the JUPSA and its annual work plan;

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

5.1.3 The Core Management Group (CMG)

The CMG consists of Chairs and Co-Chairs (who are from non-convening agencies) of the TWGs and is chaired by the UCC. This group (also referred to as Conveners of TWGs) consists of senior HIV programme staff or deputies who work on behalf of the UN system bringing the system together to deliver on mandate of the TWGs.

UNAIDS is the lead agency and chair of CMG. The CMG meets at least once every two months or as need arises and reports to the Joint Steering Committee through the lead agency, in this case the UCC.

Terms of reference for the CMG:

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

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

UNAIDS provides the Secretariat for the JSC and prepares agenda for discussion and follows up on implementation of recommendations. The CMG meets bi-monthly or when need arises.

5.1.4 The Joint Steering Committee

The Joint Steering Committee (JSC) provides overall oversight and governance for the JUPSA through review of reports and other documents prepared by the Core Management Group (CMG) to solicit guidance and decision-making from JSC.

5.1.4.1 The Composition of the JSC

The JSC is constituted by representatives from the UN Country Team (UN Agencies participating in the JUPSA, designated by the UNRC); GoU represented by UAC, MoH and other key line Ministries; Chair of AIDS Development Partners (ADP); Donors; Representatives of PLHIV, the CSOs and the private sector.

5.1.4.2 Chairperson and Co-Chair

The Chairperson of JSC is the UN Resident Coordinator and the Co-chairperson is the Director General of UAC. Joint Steering Committee members can propose convening of the JSC meeting through the Chairperson. This applies if there is a need for an extra-ordinary session of the JSC to discuss matters that are time sensitive.

5.1.4.3 Secretariat and Frequency of meetings

UNAIDS provides the secretariat for the JSC, prepares issues for discussion and ensures implementation of its recommendations. The Chairperson of CMG, in consultation with the Chairperson of JSC, calls for meetings of the JSC. The JSC meets twice a year.

5.1.4.4 Terms of Reference of the JSC

1. Discuss the JUPSA requirements and priorities concerning, *inter alia*, programme management, including consistent and common approaches to programme costing, cost recovery, implementation modalities, results-based reporting and impact assessment, information management including appropriate GoU/UN and donor visibility;
2. Review funds earmarked by donors to thematic areas, specific activities or agencies and prioritized or allocated within thematic clusters and ensure alignment of the allocations with the strategic development framework of the country and approved national priorities and performance within the TWGs and if agencies do not deliver, such funds are reallocated;
3. For un-earmarked funds, to review and approve criteria for allocation of available JUPSA resources and to allocate available resources to thematic areas, making sure that the allocations are aligned with the strategic development framework of the country and approved national priorities. The TWGs are responsible for prioritization within thematic areas and the CMG is to ensure that results are achieved;
4. Review and approve allocation of funds and ensure their conformity with requirements of the Standard Administrative Arrangement (SAA) between the Donor and Administrative Agency and MoUs;
5. Make decisions on allocation of un-earmarked funds. This is decided on the basis of prioritization, results based management and performance;
6. Ensure appropriate consultative processes take place with key stakeholders at country level in order to avoid duplication or overlap between the JUPSA and other funding mechanisms;
7. Review and approve periodic progress reports (programmatic and financial) and assess progress in achieving outcomes consolidated by the AA based on progress reports submitted by participating agencies.
8. Ensure consistency in reporting between outcomes;
9. Review findings of summary audit reports consolidated by the internal audit service of the AA;
10. Ensure annual review and appraisal of JUPSA in the context of wider joint programming;

11. Review reports and recommendations of CMG and make decisions on the governance of the JUPSA; and
12. Approve Terms of Reference and composition of CMG or other similar review bodies.

5.2 Fund Management Arrangements

The cost of implementing planned programme interventions under this JUPSA is estimated at US$ 31,217,367 over four years. The proportional cost breakdown expressed as percentage across the JUPSA outcomes are:

Table 8: Proportional cost of implementing JUSPA Outcome

JUPSA (2011-2014) Outcome	Cost (US$)	%
1. National systems have increased capacity to deliver equitable and quality HIV prevention integrated services	13,626,625	43.65
2. Communities mobilized to demand for and utilize prevention integrated services	3,159,908	10.12
3. Access to antiretroviral therapy for PLHIV who are eligible increased to 80 percent	4,930,442	15.79
4. Tuberculosis deaths among PLHIV reduced	905,044	2.90
5. People Living with HIV and AIDS and households affected by HIV are covered in all national social protection strategies and have access to essential care and support	4,064,312	13.02
6. National capacity to lead, plan, coordinate, implement, monitor and evaluate the national HIV response strengthened	4,072,752	13.05
7. Laws, policies and practices improved to support gender equality and reduce human rights abuses, stigma and discrimination	458,284	1.47
Total Proportional cost of implementing JUSPA Outcome	**31,217367**	**100**

The JUPSA is funded from existing agency budgets through pooled and non-earmarked extra-budgetary funds. Of the estimated budget of US$31.2 million, US$24 million (77%) is total commitments leaving a gap of US$7.2 million (23%). The committed funds are expected from the following sources: UN participating agencies, DFID, Irish Aid and UBRAF as depicted in the table below:

Table 9: Projected Available UN Resources 2011-2014

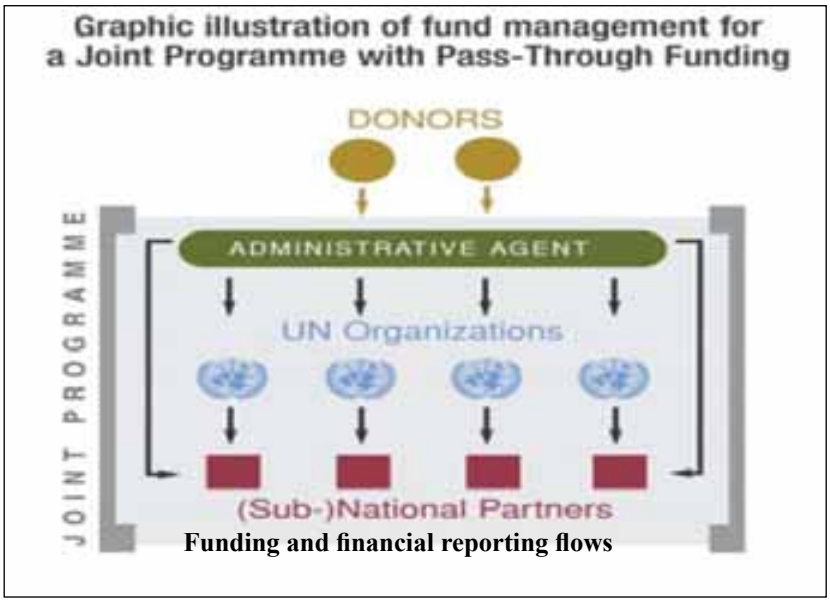
Source	Amount (US$)
UN Agencies- contribution to JUPSA	10,479,520
Irish	6,480,000
DFID	5,803,200
UBRAF	1,230,000
TOTAL	**23,992,720**

5.2.1 Disbursement Modalities

Agencies are responsible for managing their own funds but are required to indicate budgets and expenditure in the JUPSA budget. Additional funding for JUPSA is managed under a Pass-Through Fund Management (PTFM) arrangement, as per UNDG rules. Under this arrangement, UN agencies in JUPSA are required to select from among themselves an Administrative Agent (AA)[2].

[2]This is done 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.

Figure 3: Fund Management for JUPSA



Based on relevant considerations, the UNCT in Uganda selected UNDP to serve as the AA for JUPSA. At the headquarters level, UNDP's MDTF has as its primary role to manage such functions according to existing UNDG rules and regulations. This means that funds from donors are channelled to UNDP as the AA, and UNDP in turn disburses to PUNOs (including itself), based on a common Annual Work Plan and budget as approved by the UNCT. Through the AA, PUNOs are accountable to donors for funds received. As AA, UNDP negotiates and sign a Letter of Agreement with donors in respect of JUPSA and a Memorandum of Understanding (MoU) with PUNOs. Under the MoU, each PUNO is 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 rests with the PUNOs.

Funding received from donors are recorded by the AA in a JUPSA account. UNDP only records as income, those funds for which it is programmatically and financially accountable. Given the nature of AA functions, UNDP as AA is authorised by the UNCT to allocate 1 percent of the amount contributed by the donors (with no ceiling) for costs of performing the AA functions. The anticipated work load of the AA entails passing funds at least twice a year to executing UN organizations (excluding UNAIDS Secretariat and possibly other UN organizations, which currently operate a multiple transaction-based cost recovery arrangement with UNDP). Additional to this AA fee, each participating organisation is 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, due to different nature of mandates and expertise required, rates for cost recovery varied between UN organizations. However, the UN Development Group (UNDG) recently agreed to levy their administrative fee for such joint activities at 7 percent across the board. In an unprecedented move, the WHO office in Uganda has agreed to this 7 percent levy. The UNCT's expectation is that other agencies such as United Nations High Commission for Refugees (UNHCR), United Nations Office against Drugs and Crime (UNODC) and UNAIDS Secretariat will follow suit.

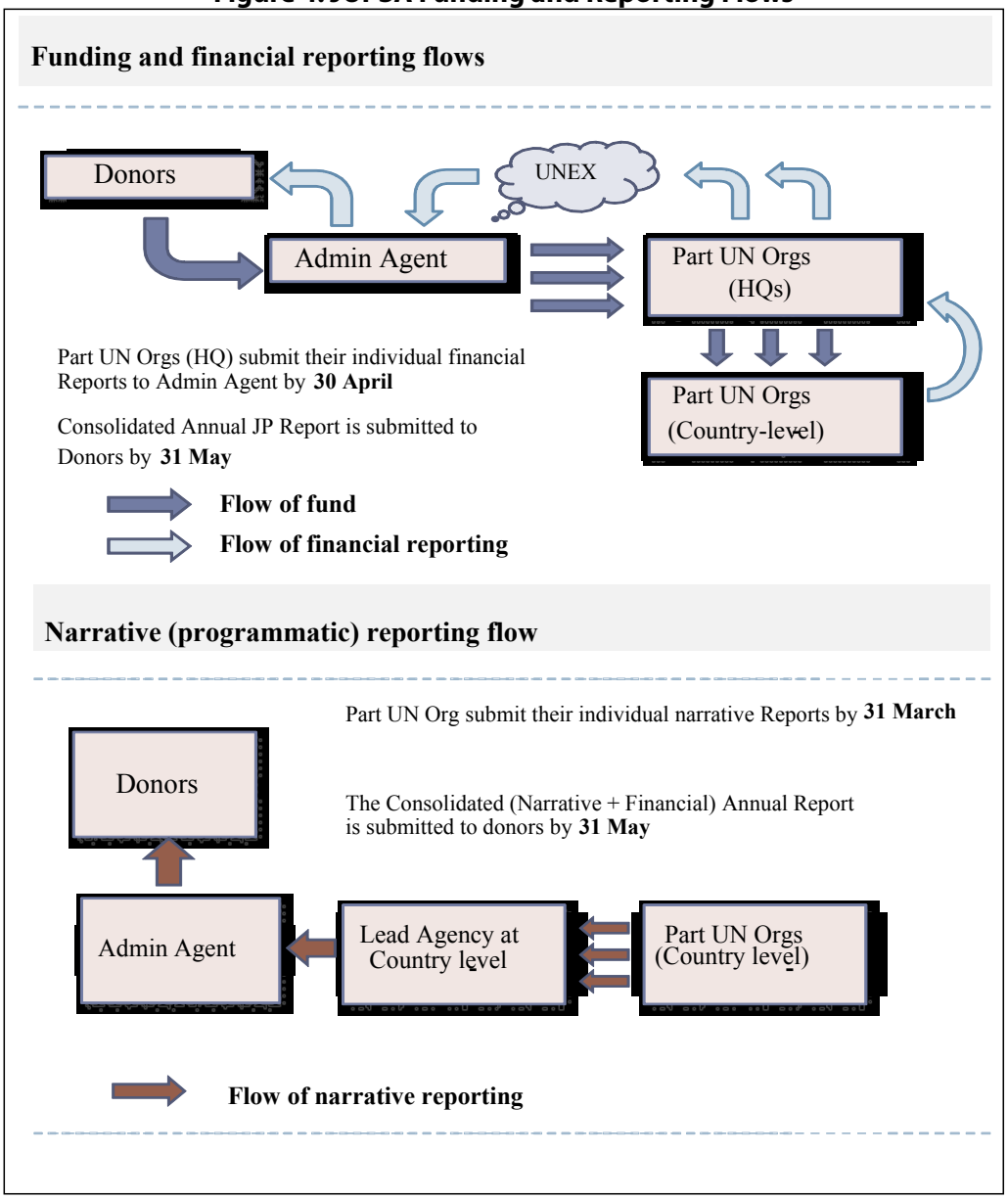
In total, a UN system administrative cost of 8 percent will apply to donor contributions. This is a highly competitive overhead cost by any standard and translates to potential net savings for programme activities, as compared to using traditional parallel funding mechanisms. In this JUPSA, PUNOs need to adhere to agreed modalities to offset the observations in the MTR where this was not working. Going forward, the catalytic funds which are accessed for instance Project Accelerated Funds (PAF) by UNAIDS Secretariat

should be made available to the Joint UN Team to facilitate the timely initiation and implementation of activities.

5.2.2 Transfer of Cash to National Implementing Partners

Implementation of this JUPSA entails transferring cash to implementing partners. In light of this, cash transfer modalities, size and frequency of disbursements and scope and frequency of monitoring, reporting, assurance and audit are agreed between respective lead PUNOs and implementing partners prior to programme implementation. The cash transfer arrangements are done taking into consideration the capacity of implementing partners and are subject to review during the course of implementation in accordance with applicable policies, processes and procedures of PUNOs. For ExCom agencies, the provisions required under the Harmonised Approach to Cash Transfers (HACT) as detailed in Country Programme Action Plans (CPAPs) or in other agreements covering cash transfers applies.

Figure 4: JUPSA Funding and Reporting Flows



5.2.3 Financial Reporting

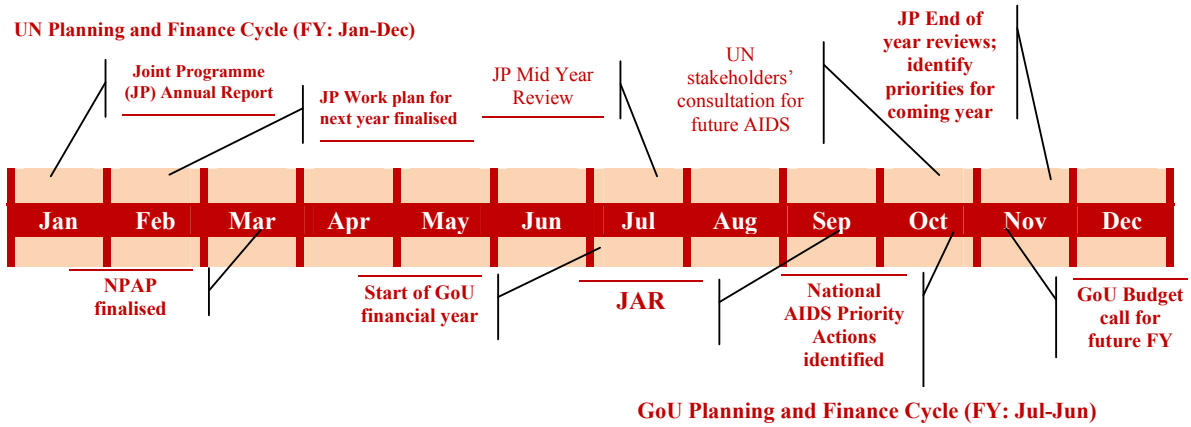
For extra-budgetary funds, UNDP, as AA, consolidates financial reports of PUNOs and shows disbursements of any additional donor funds to the organizations over the reporting period. These reports and inputs are then aggregated by UNAIDS Secretariat and the Joint UN Team to highlight key issues, achievements, lessons learned and recommendations for future action. Following subsequent technical review by the Joint UN Team, the UCC presents the final report to the CMG, for submission to the UNCT for final review and approval and presentation to the JSC. The Uganda AIDS Commission and donors as part of the JSC participates in internal UN reviews to appraise programme progress. If requested, the final consolidated report may annex individual reports from all agencies. Financial monitoring as a major consideration for donor funding is a critical component when costing the annual work plan and therefore a system is developed to monitor and track funding within JUPSA in order to avoid relying exclusively on the AA.

CHAPTER SIX: Planning, Monitoring and Evaluation

6.1 Annual Planning

One of the primary aims of the JUPSA is to consolidate planning and reporting. Following the national JAR, priority areas for the coming year are identified and consultations are held with stakeholders to agree on areas that can best be supported by the UN. Technical Working Groups meet collectively to agree on annual results. Using the technical support, the DoL activities that work to achieve those results are selected along with the agencies involved. The JUPSA budget is developed in the same way as reporting on the JUPSA. The JUPSA still uses the standard UN annual planning cycle (January- December). However, in order to ensure alignment with the GoU planning cycle (July-June), JUPSA planning and reporting are managed in two blocks of six months each, every 12 months.

Figure 5: Annual calendar of planning, Monitoring and Evaluation and reporting events



6.2 Mid-year and Annual Review

The Joint UN Team will assess outcomes twice a year as mid-year and end-of-year internal reviews which are key accountability mechanisms for individual agencies and the Joint UN Team. Monitoring and evaluation of the programme of support is integrated with the Joint UN Team's annual work plan development to ensure that work of the UN builds on the achievements of the previous year(s) and is responsive to emerging needs. Progress will be tracked in a collaborative manner as a formal exercise through reporting systems agreed by the UNCT and informally during regular meetings of the Joint UN Team. Efforts will be made to engage external stakeholders for their input and feedback into the quarterly, mid-year and end of year review processes.

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

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

6.3 Monitoring and Evaluation

6.3.1 Monitoring the Annual Work Plan

Ongoing monitoring of the annual work plan will be led by UNAIDS Secretariat, so that impediments to implementation can be quickly identified and resolved. The Joint UN Team will also self-asses their planning and programming process, in time to make recommendations for the next cycle of annual work planning or long term strategic planning. The Joint UN Team will be held accountable for the achievements of planned outputs.

An effective and sustainable M&E system is key for effective UN support to the national response. To effectively monitor progress towards achievement of the targets outlined in the M&E Matrix (Annex III) and in relation to the third principle of "Three Ones", the UCC with support from the UNAIDS M&E Advisor will develop and strengthen the overall capacity of the team to plan, monitor and evaluate annual program activities.

The UNAIDS Secretariat together with the Governance and Human Rights TWG will carry out programme monitoring, evaluation and report to the UNCT,which will eventually feed into the annual JAR led by UAC. The Joint UN Team on AIDS will monitor progress in a collaborative manner. It will track progress as a formal exercise through reporting systems agreed by the UNCT and informally during its regular meetings. The 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.

6.3.2 The Monitoring and Evaluation Framework

The M&E Framework of the JUPSA is a management and policy guidance tool for tracking implementation of the JUPSA work plan, assessing achievement of its objectives and channelling the resulting evidence to appropriate venues for application. It will enable monitoring and self-assessment of progress towards results and facilitate reporting on performance. The framework covers both the work plan and functioning of the Joint UN Team on AIDS.

The specific objectives of JUPSA M&E Framework are to:

- Ensure efficiency, quality control, completion of activities, clarity of roles and responsibilities and

engagement of all partners; and
- Compare planned versus actual activities and outcomes.

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

- Analysis of outcomes in priority areas to which the JUPSA contributes;
- Assessment of key output results;
- Assessment of implementation of activities by agencies and UNAIDS Secretariat;
- Assessment and tracking of expenditures incurred against outputs and broad activities;
- Identification of lessons learned based on reviews and make recommendations on way forward; and
- Proposition of structures, mechanisms and methodological guidance for assessments and evaluations.

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

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

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

- Team members receive official and formal notification on their roles and responsibilities from their HoAs;
- Individuals are expected to report regularly to their HoAs, demonstrating participation and contribution towards results; and
- Indicators of participation in support to and contribution towards achieved results are part of each individuals regular annual performance review;

6.3.3 Indicators for the JUPSA

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

6.3.4 Evaluation of the Joint UN Team on AIDS

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

6.4 Risk Analysis

In the first generation of the JUPSA, the Joint UN Team on AIDS analysed five possible risks that could negatively impact on the success of the programme. These are still valid and are presented in Table 10 below.

Table 10: Potential JUPSA Risks and Mitigation

Potential Risk	Risk Mitigation
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 also 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 Programme activities *(low probability, medium impact)*	Standardized rates and ceilings have been negotiated with all participating agencies before hand; explicit instructions from UNDG to ExCom agencies (UNICEF, UNFPA, UNDP and WFP) to apply agreed ceilings for joint programming at country level prior to implementation of the JUPSA in Uganda. All the staff members involved in the financial accountability processes will undergo further training in the use of the MDTF gateway so that they are fully knowledgeable about the operation of the MDTF processes and requirements
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 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 the 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. Since staff in the JUPSA are appointed by the UNRC and their HoAs, their roles in JUPSA form part of their work plan and appraisal. However, some staff members overlooked the need to indicate this particular work in their annual work plan and appraisal forms especially if no specific funding was provided by their agency for the JUPSA activities. They were therefore not appraised on it. There seems to be no clarity on the work of the full time staff on HIV and AIDS within agencies and its linkage with TWG including other responsibilities they have within the agencies that seem to overburden them leading to lack of participation in the TWG. It is desirable to indicate which staff are fulltime or part time from each agency
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 JUPSA approaches necessary in agency reviews, planning, reporting, etc; and continuous involvement and peer review by Agencies (HoA) through the UNCT, CMT/PMT, and technical staff through the UNJT

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Annexes

Annex I: UN staff dedicated to the JUPSA

A total of 21 full time members and 28 part time members and 3 vacant positions. Agency membership: 13 agencies namely WHO, UNDP, UNFPA, UNICEF, UN WOMEN, IOM, ILO, UNDOC, UNAIDS, UNHCR, UNESCO, World Bank (WB), FAO, (OHCHR and WFP are not official members of the JUPSA but will participate when there is a need)

Members of Joint UN Team

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52	World BANK	(vacant)	Senior Health Specialist		

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Annex II: Technical Support Division of Labour

The global Division of Labour provides guidance for lead organizations and participating organizations within the 3 thematic areas of HIV Prevention, Treatment, care and support, and Governance and Human rights.

UNAIDS GLOBAL DIVISION OF LABOUR

Division of Labour Area	Convener(s)	Agency Partners			
Reduce sexual transmission of HIV	World Bank UNFPA	UNDP UNICEF WFP	WHO UNFPA	World Bank UNESCO	ILO UNHCR
Prevent mothers from dying and babies from becoming infected with HIV	WHO UNICEF	UNICEF WFP	UNFPA WHO		
Ensure that people living with HIV receive treatment	WHO	UNDP UNICEF	UNHCR WHO	UNHCR ILO	WFP
Prevent people living with HIV from dying of TB	WHO	UNICEF WFP	WHO ILO	UNODC	
Protect drugs users from becoming infected with HIV and ensure access to comprehensive HIV services for people in prisons and other closed settings	UNODC	UNDP UNODC	WHO World Bank	UNESCO UNFPA	UNICEF
Empower men who have sex with men, sex workers and transgender people to protect themselves from HIV infection and to fully access antiretroviral therapy	UNDP UNFPA	UNDP UNESCO	UNFPA	World Bank	WHO
Remove punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS	UNDP	UNDP UNESCO UNICEF	UNFPA WHO	UNODC ILO	UNHCR
Meet the HIV needs of women and girls and stop sexual and gender-based violence	UNDP UNFPA	UNDP UNICEF UNODC	UNFPA WHO ILO	UNESCO UNHCR	WFP
Empower young people to protect themselves from HIV	UNICEF UNFPA	UNICEF UNESCO	WFP UNFPA	UNHCR ILO	WHO
Enhance social protection for people affected by HIV	UNICEF World Bank	ILO UNDP	WFP WHO	World Bank UNHCR	UNICEF
Address HIV in humanitarian emergencies	UNHCR WFP	UNDP UNICEF	WHO UNODC	UNFPA UNHCR	WFP
Integrate food and nutrition within the HIV response	WFP	UNICEF WFP	WHO UNHCR		
Scale up HIV workplace policies and programmes and mobilize the private sector	ILO	UNESCO	WHO	ILO	
Ensure good quality education for a more effective HIV response	UNESCO	UNESCO UNFPA	WHO ILO	UNICEF	
Support to strategic, prioritised and costed multisectoral national AIDS Plans	World Bank	ILO UNHCR WHO	UNDP World Bank UNODC	WFP UNICEF	UNFPA UNESCO

Source: UNAIDS Strategic Plan 2011-2015

The Committee of Cosponsoring Organizations allows for flexibility for the Division of Labour to be adapted to individual country circumstances, based on (i) the comparative advantage and core mandates of different Cosponsors; (ii) in-country presence of Secretariat or agencies; (iii) existing national capacities; (iv) availability of funding for different functions and priorities at the country level. Agencies that do not have in-country presence would not lead at country level. The UNCT would select an alternative convening agency or agencies from among the main partners in the DoL area. For co-sponsors that do not have country presence, it is advised that regional offices define their intervention strategies.

To avoid duplication between the Secretariat and the Cosponsors, the Secretariat will not convene or co-convene any of the 15 Division of Labour areas but will facilitate and promote cooperation and achievement of goals, as stated in the Strategy, in all Division of Labour areas.

The DoL in the current JUPSA has not departed much from the Global DoL articulated in the UNAIDS Strategy 2011-2015 and strategic vision of getting to zero. The new DoL informed the revision process of the 2007 DoL, wherein UNAIDS is not expected to lead on any of the thematic areas but has the overall responsibility for ensuring the functioning and accountability across all areas on matters of Leadership and Advocacy; Coordination; Coherence and Partnerships; and supporting Mutual accountability of the Secretariat and Cosponsors.

The Technical Support DoL operates through Lead and Supporting Partners. Within the areas of the DOL, 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 to provide support in that thematic technical area. Supporting partners are not exclusive and additional partners can be co-opted as needed. Once particular areas of technical expertise are commonly known, requests for such support can enter the UN system at any point and the relevant UN Partners will be responsible to liaise with the appropriate Lead Organization to coordinate support.

UGANDA DIVISON OF LABOUR

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

Annex III: Logical Framework: Strategic Level

Outcome/Output	Indicator	Baseline & Year	Target & Year	Means of Verification (MoV)	Assumptions and Risks
PREVENTION					
Joint Programme Outcome 1.1: National Systems have increased capacity to deliver equitable and quality HIV prevention integrated services	% ANC sites providing comprehensive PMTCT services	1,589 out of the estimated 4, 000 health facilities (June 2011)	HCIIIs and above target is 100%, HCIIs target is 80% by 2015	Surveillance reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities
	% HCIVs and above providing SMC services as part of a comprehensive SRH/ HIV package	To be determined (TBD) from Baseline Survey (2011)	TBD (2014) *Target to be determined in New NSP still under development	Surveillance reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities
	% of health units with monthly stockout of (6 tracer drugs) test kits & supplies, condoms, STI drugs, ARVs)	TBD from Baseline Survey (2011)	TBD (2014) *Target to be determined in New NSP still under development	Annual Health sector performance report	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Changing priorities of the international community, weakening efforts to address HIV and AIDS
Output 1.1.1: Technical capacity for combination prevention programming and service delivery strengthened (with priority focus on SMC, HCT & PMTCT, SRH/HIV integration)	# of national guidance documents on HIV prevention programming and service delivery developed and implemented	9 (2010)	16 (2014)	NSP and Sectoral Joint Review Reports; Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities
	# of districts supported to pilot delivery of the nationally agreed combination prevention package	0 (2010)	6 (2014)	JUPSA, NSP and Sectoral Joint Review Reports; Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation: Availability of technical and financial resource to support this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities
Output 1.1 2: Leadership and coordination for HIV prevention strengthened at national and district levels	# of sector and district development plans integrating prevention priorities	TBD by the baseline - 2011)	50% increase in baseline values by 2014	NSP and Sectoral Joint Review Reports; Programme Reports	**Assumptions:** UAC, MOH and Development Partners contribute to this area of cooperation **Risks**: Changing political environments and national priorities, undermining or compromising JUPSA implementation efforts

Outcome/Output	Indicator	Baseline & Year	Target & Year	Means of Verification (MoV)	Assumptions and Risks
	# of HIV prevention coordination and management structures at national, sector and pilot district levels functional	TBD by the baseline - 2011)	50% increase in baseline values by 2014	NSP and Sectoral Joint Review Reports; Programme Reports	**Assumptions:** UAC, MOH and Development Partners contribute to this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities
Output 1.1.3: Strategic Information generated and utilized for evidence-based HIV prevention programming	Existence of national annual and 3-year prevention review reports (based on implementation of NPS)	N/A (2010)	1 annual report and one 3-year report available by 2014	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** UAC and Development Partners contribute to this area of cooperation **Risks**: Uganda's mixed record of implementing policy documents
	# of HIV Prevention Research Conducted and disseminated	TBD by the baseline - 2011)	50% increase in baseline values by 2014	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Uganda's mixed record of implementing policy documents
Joint Programme Outcome 1.2: Communities mobilised to demand for and utilise HIV prevention integrated services	% of Eligible women enrolled in PMTCT	51.6% (2010)	Proportion of HIV positive pregnant women receiving ARV's for PMTCT increased to 90% by 2015	Surveillance reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation: Availability of technical and financial resource to support this area of cooperation. **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities
	% Condom use at last high risk sex	TBD from AIS (2010)	80% - by 2014	Surveillance reports; AIS Report	Assumptions: GoU and Development Partners contribute to this area of cooperation; Availability of technical and financial resources to support this area of cooperation. **Risks**: Changing priorities of the international community, weakening efforts to address HIV and AIDS
	HIV prevalence among 15-24 year old pregnant women	6.4% (2010)	TBD (2014) *Target to be determined in New NSP still under development	AIS report	**Assumptions**: GoU and Development Partners contribute to this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities

Outcome/Output	Indicator	Baseline & Year	Target & Year	Means of Verification (MoV)	Assumptions and Risks
Output 1.2.1: capacity of community Systems for social and BCC strengthened	# of districts with registered community driven mechanisms addressing prevention for key population groups and priority prevention interventions (PMTCT, SMC, MCP, Condom, HCT)	TBD by the baseline - 2011)	6 (2014)	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** Availability of technical and financial resource to support this area of cooperation: GoU and Development Partners contribute to this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities
TREATMENT, CARE AND SUPPORT					
Joint Programme Outcome 2.1: Access to antiretroviral therapy for PLHIV who are eligible increased to 80%	% of adults and children with advanced HIV infection receiving antiretrovirals	47.5% (274,208/577,027) March 2011	60% - by 2014	UNGASS/ Annual Health sector performance report; ART quarterly reports & Service provision surveys	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Changing political environments and national priorities, undermining or compromising efforts
	% of children in need of ART receiving them	23% (2010)	50% (2014)	UNGASS/ Annual Health sector performance report; ART quarterly reports & Service provision surveys	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks:** Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities
Output 2.1.1: Guidance provided and capacity built for provision of standard ART care according to the WHO recommendations	Copies of the National Integrated ART guidelines updated and distributed	**0 (2010)**	5000 **(2014)**	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** UAC, MOH and Development Partners contribute to this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities
	# of copies of updated training materials/job aids distributed	0 (2010)	20000 (2014)	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions**: UAC, MOH and Development Partners contribute to this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities
	# of districts with ART Quality Improvements (QI) Teams	50 out of 112 (2010)	80 (2014)	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** UAC, MOH and Development Partners contribute to this area of cooperation **Risks:** Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities
	% of ART sites providing both adult and paediatric treatment	322/423 = 76% - (2010)	80% (2014)	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** UAC, MOH and Development Partners contribute to this area of cooperation **Risks:** Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities

Outcome/Output	Indicator	Baseline & Year	Target & Year	Means of Verification (MoV)	Assumptions and Risks
	# of regions with trained TOTs to operationalize new ART guidelines	0 (2010) {Guideline not yet launched, thus no TOTs trained. This should be done (launched) by end of this year (2011)}	8 (2014)	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** UAC, MOH and Development Partners contribute to this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities
	% of ART facilities submitting timely quarterly reports	50% (2010)	80% (2014)	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** UAC, MOH and Development Partners contribute to this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities
	% of ART facilities in which at least 80% of the clients keep their medical appointments	14.1% (2008)	80% (2014)	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** UAC, MOH and Development Partners contribute to this area of cooperation **Risks:** Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities
	# of districts with VHTs trained in Home-based care for HIV	85 out of 112 current districts (2010)	20 (2014)	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities
Output 2.1.2: Enhanced programming for Pre- and Post-exposure prophylaxis	% of ART facilities providing Post-Exposure Prophylaxis for HIV	6% (2008)	50% (2014)	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities
	# of copies of post - exposure prophylaxis implementation manual disseminated	0 (2010)	5000 (2014)	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities
Output 2.1.3: Capacity for screening and management of Non Communicable Diseases associated with HIV strengthened in all ART centres	% of ART facilities screening and managing common NCDs according to national guidelines	0 (2010)	50% (2014)	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation of JUPSA activities

Outcome/Output	Indicator	Baseline & Year	Target & Year	Means of Verification (MoV)	Assumptions and Risks
Output 2.1.4: Procurement and supply chain management streamlined	An updated PSM Plan for HIV commodities in place	0 (2010)	1 by 2014	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation
Joint Programme Outcome 2.2: TB deaths among people living with HIV reduced	% TB associated deaths among people living with HIV	30% (2010)	20% (2014)	Annual Health sector performance reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Changing priorities of the international community, weakening efforts to address TB
	% of estimated HIV positive incident TB cases that received treatment for TB and HIV	10% (2010)	50% 2014	UNGASS reports, Universal Access reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Changing priorities of the international community, weakening efforts to address TB
JP Output 2.2.1: Accelerated and streamlined implementation of HIV/TB collaborative interventions	Availability of updated TB/HIV management guidelines	0 (2010)	1 (2014)	Annual Health sector performance reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Changing priorities of the international community, weakening efforts to address TB
	% of facilities fully implementing TB/HIV collaborative activities	30% (2010)	50% (2014)	Annual Health sector performance reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Changing political environments and national priorities
Joint Programme Outcome 2. 3: People Living with HIV and households affected by HIV are addressed in all National Social Protection Strategies and have access to essential care and support	% of care, protection and support to orphans and other vulnerable children and their families through case management	4.1% 2010	50% by 2014	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Changing political environments and national priorities
	% of PLHIV and OVC households with sustainable livelihood interventions.	To be developed out of the livelihood profiling in 4 districts (2011)	50% increase on the baseline by 2014	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** GoU, CSO and Development Partners contribute to this area of cooperation **Risks**: Changing political environments and national priorities
Output 2.3.1: National social protection policy, strategy and programs integrate issues of People Living with HIV and their households	# of LGs implementing social protection plans that integrate HIV response	TBD: to be determined by baseline (2011)	50% increase in # of DLGs by 2014	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation

Outcome/Output	Indicator	Baseline & Year	Target & Year	Means of Verification (MoV)	Assumptions and Risks
Output 2.3.2: Communities vulnerable to HIV have increased resilience and empowered to be food and nutrition secure	% of households with food sufficiency	To be determined by the baseline - (2011)	50% increase above baseline in 4 districts by 2014	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks:** Livelihood interventions may be affected by unfavourable weather and natural calamities
Output 2.3.3: Strengthened capacity of government to implement OVC policy and Plans for vulnerable children operationalised	% of OVCs accessing social protection services	.1 % (OVC accessing social protection services) - 2010	50% of OVCs accessing social protection services by 2014	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation
	% of districts where The NAP has been disseminated	0 (2012)	50% (2014)	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Limited political will and support
	Child Labour indicators adopted for inclusion in the NSP for OVC	0 (2010)	4 (2014)	NSP and Sectoral Joint Review Reports; UAC, Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Limited political will and support
GOVERNANCE AND HUMAN RIGHTS					
Joint Programme Outcome 3.1: National capacity to lead, plan, coordinate, implement, monitor and evaluate the national HIV response strengthened by 2014	HIV national policy composite index scores	70 out of 100 points (2010)	85 by 2014	UNGASS 2012 & 2014	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Limited political will and support
	% of districts with institutional capacity for M&E including harmonized resource tracking, database and information systems in place	N/A	112 by 2014	Joint Annual reviews and assessments	**Assumptions:** UAC and Development Partners contribute to this area of cooperation **Risks**: 5. Insufficient staff in national, civil society and local government institutions to facilitate effective implementation
Output 3.1.1: Capacity of national institutions to lead and coordinate the national HIV response strengthened	# issues papers on pertinent issues developed and presented to relevant fora	3 (2011)	20 by 2014	NSP and Sectoral Joint Review Reports; UAC, MOH Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Changing priorities of the international community, weakening efforts
	Proportion of institutional review recommendations implemented	N/A	90% of Recommendations implemented by 2014	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** UAC and Development Partners contributes to this area of cooperation **Risks:** Uganda's mixed record of implementing policy/review documents. Limited political will and support

Outcome/Output	Indicator	Baseline & Year	Target & Year	Means of Verification (MoV)	Assumptions and Risks
	Proportion of Health sector HIV response recommendations implemented	N/A	75% by 2014	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** MOH and Development Partners contribute to this area of cooperation Risks: Uganda's mixed record of implementing policy/review documents. Limited political will and support
	# of GFATM proposals developed and submitted in time	1 (2010)	2 Annually by 2014	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Lack operational and technical capacities in some PUNOs
	# of agencies with evidence on accountability and governance mechanisms for improved service delivery	N/A	1 study conducted by 2014	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Changing political environments and national priorities
	HIV Partnership Tool developed and disseminated	0 (2010)	1 by 2014	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: 3. Changing political environments and national priorities
Output 3.1.2: National and local government capacity to mainstream HIV and AIDS and gender issues in planning and policy processes improved	Proportion of UN JPs that mainstream HIV in their programmes	N/A (2010)	100% (2014)	JUPSA, UNDAF Review Report	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Lack operational and technical capacities in some PUNOs
	Study report on bottlenecks to mainstreaming HIV and AIDS issues	0 (2010)	1 (2014)	Study Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Changing political environments and national priorities
	HIV Mainstreaming Action Plans developed and disseminated	1 (2010)	8 sectors 6 districts (2014)	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Changing political environments and national priorities
	Country Action Framework for women, girls, gender equality and HIV developed and disseminated.	2 (2010)	1 (2014)	NSP and Sectoral Joint Review Reports; UAC, Ministry of Gender Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Changing political environments and national priorities

Outcome/Output	Indicator	Baseline & Year	Target & Year	Means of Verification (MoV)	Assumptions and Risks
	# of HIV issues included in African Peer Review Mechanism	TBD (2010)	TBD (2014)	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Changing political environments and national priorities
Output 3.1.3: Institutional capacity of UAC and sectors to plan, M&E strengthened	NSP and PMMP reviewed and aligned to NDP	NSP not aligned to NDP / PMMP not harmonized to NSP (2010)	NSP and PMMP aligned to the NDP (2014)	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** UAC and Development Partners contribute to this area of cooperation **Risks**: Capacity of UAC at national, regional and local levels
	# of staff trained on the PMMP	N/A	80% of District HIV Focal Points (2014)	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** UAC and Development Partners contribute to this area of cooperation **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation
	# of LGs with functional AIDS Task Forces	N/A	80% of District (2014)	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation. Reduced fluctuation in creation of New Districts **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation
	# of UAC and sectoral joint programme reviews conducted	1 Annual JPR Conducted (2011) 0 Sectoral Review Conducted (2011)	Annual JPR and 8 regular sectoral programme reviews supported per year (2014)	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** UAC and Development Partners contribute to this area of cooperation **Risks**: Changing priorities of the international community, weakening efforts to address this activity
Output 3.1.4: Institutional capacity for resource tracking strengthened	# of institutions that have institutionalised AIDS Spending Assessment	0 Institutions with Tracking Systems (2011)	40% of Districts and 10 Sectoral institutions have institutionalised NASA (2014)	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** UAC and Development Partners contribute to this area of cooperation. Requests for technical assistance by LG and CSOs will continue to increase, given the strengthened capacity of JT to support this process **Risks:** Changing priorities of the international community, weakening efforts to address this activity
Output 3.1.5: National capacity to gather and disseminate strategic information strengthened	# of analytical studies undertaken and disseminated	N/A	10 Analytical Studies Supported Yearly by 2014	same comment as above	**Assumptions:** UAC and Development Partners contribute to this area of cooperation **Risks**: Changing priorities of the international community, weakening efforts to address this activity

Outcome/Output	Indicator	Baseline & Year	Target & Year	Means of Verification (MoV)	Assumptions and Risks
	# of forums for information sharing organized	N/A	5 Forums supported Annually by 2014	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** UAC and Development Partners contribute to this area of cooperation **Risks**: Changing priorities of the international community, weakening efforts to address this activity
Output 3.1.6: Engagement of the civil society including PLHIV and young people and private sector in the national HIV response strengthened and streamlined	# of umbrella CSO organisations including networks of PLHIV and young people led CSOs supported on key capacity areas	N/A	7 CSOs' capacity supported Annually by 2014	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation. Requests for technical assistance by the Uganda Government and CSOs will continue to increase, given the strengthened capacity of PUNOs on HIV assistance **Risks**: Insufficient staff in national, civil society and local government institutions to facilitate effective implementation
	# of PR accesses, utilises and accounts for GFATM resources	N/A	2 PRs Annually by 2014	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Inadequate response to resource mobilization efforts, hampering capacity to respond to the increasing demand from partners
	Number of RFAs aligned to available evidence on HIV	N/A	100 % by 2014	NSP and Sectoral Joint Review Reports; UAC Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Inadequate response to resource mobilization efforts, hampering capacity to respond to the increasing demand from partners
	Number of CSF grantees working closely with / in partnership with government institutions at national and decentralised levels	N/A	100 % by 2014	NSP and Sectoral Joint Review Reports; UAC, CSO Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks:** Inadequate response to resource mobilization efforts, hampering capacity to respond to the increasing demand from partners
	# of private sectors/ CSO representatives meaningfully participating in the annual partnership forum	12 (2010)	50% increase by 2014	NSP and Sectoral Joint Review Reports; UAC, CSO Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Insufficient technical staff in private sector and civil society to facilitate effective implementation
Output 3.1.7: Capacity of the UN HIV JT to plan, implement, monitor and evaluate the JUPSA strengthened	Proportion of UN HIV JT Annual Activities implemented	N/A	80% by 2014	JUPSA, UNDAF Programme Reports	**Assumptions:** UN Agencies contribute to this area of cooperation **Risks**: Lack operational and technical capacities in some PUNOs

Outcome/Output	Indicator	Baseline & Year	Target & Year	Means of Verification (MoV)	Assumptions and Risks
Joint Programme Outcome 3.2: Laws, policies and practices improved to support an effective HIV response by 2014	National composite policy index score	4.6 (2010)	80% (2014)	UNGASS Reports, Universal Access reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks:** Limited political will and support
JP Output 3.2.1: Capacity of national institutions to identify and implement relevant laws, policies and practices that undermine and support effective responses to HIV and AIDS strengthened	Evidence available on existing and proposed policies and laws which impact on the HIV response	Inadequate research evidence (2010)	Evidence available by 2014	NSP and Sectoral Joint Review Reports; UAC, CSO Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks:** Limited political will and support
	Action Plan developed	0 (2010)	1 (2014	NSP and Sectoral Joint Review Reports; UAC, CSO Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Limited political will and support
	Stigma index report produced	Stigma index report not Produced (2010)	1 Report produced by 2014	NAPHOPANO Programme Report, UAC Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks:** Limited political will and support
	National Strategy for Reduction and /or Elimination of Stigma and Discrimination available	Report not available as of 2010	1 Report to be produced by 2014	UAC Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks**: Limited political will and support
	# of selected punitive laws identified and reformed	TBD -(2010)	TBD - (2014)	NSP and Sectoral Joint Review Reports; UAC, CSO Programme Reports	**Assumptions:** GoU and Development Partners contribute to this area of cooperation **Risks:** Limited political will and support
JP Output 3.2.2: Technical capacity provided and resources mobilized to domesticate and implement the accelerated plan of action on women, girls and gender equality in response to HIV and AIDS	National Action Plan developed	0 (2010)	1 (2014)	Accelerated country action plan report	**Assumptions:** GoU and Development Partners contributes to this area of cooperation **Risks:** Limited political will and support

Annex iv: JUPSA 2011-2014 Implementation Level Logframe

Activity (under each Output)	Lead UN organization	Participating Lead UN organization	Implementing Partner	Resource allocation and indicative time frame (USD)				
				2011	2012	2013	2014	Total
PREVENTION THEMATIC WORKING GROUP								
Joint Programme Outcome 1.1: National Systems have increased capacity to deliver equaitable and quality HIV prevention integrated services								
JP Output 1.1.1 Technical capacity for combination prevention programming and service delivery strengthened (with priority focus on SMC, HCT & PMTCT, SRH/HIV integration)								
Support development and delivery of combination prevention programmes for selected population groups, sectors and districts through human resource capcity assessments and skills development in programming and management	UNFPA	UNICEF,WHO, UNESCO	MoH,MoLG,civil society, UAC	809,500	559,760	259,497	334,268	**1,963,025**
Provide guidance and standards for SRH/HIV linkages & integration (PMTC/MNCH/STI/HCT(PITC)/ASRH/GBV) for national, sector, district and community levels	WHO	UNFPA, UNICEF	MoH, civil society,UAC	1,109,000	-	-	-	**1,109,000**
Provide standard guidance and service protocols on Virtual Elimination of MTCT at all levels of service delivery	WHO	UNICEF, UNFPA	MoH, MoLG, CSO	92,160	193,536	101,376	-	**387,072**
Provide guidance and standards for male circumcision implementation and scale up at national level	WHO	UNAIDS		-	21,350	22,418	23,485	**67,253**
Support scale up of IMAI/IMPAC/IMCI training package (linked to HIV chronic care and working with community resource persons e.g. mentor mothers)	WHO	UNICEF	MoH	75,000	48,000	50,400	52,800	**226,200**
Support capacity development for health workers to deliver SMC services	WHO	UNICEF	MoH	50,000	21,350	22,418	23,485	**117,253**
Support capacity building for targeted and integrated service delivery for key populations and special settings and priority sectors, including in epidemic hotspots	UNFPA	IOM, UNAIDS, WHO, UNDP	MoH, MoW&T, MoD, MoIA, MAIF	-	6,210	6,521	6,831	**19,562**
Support development and dissemination of national guidance on positive health dignity and prevention(PLA)	WHO	UNICEF	MOH	-	42,900	-	-	**42,900**
Support and Strengthen the school health programme including sexuality education curriculum development and implementation	UNESCO	UNFPA, UNIICEF	MoES, NCCD	-	78,000	81,900	-	**159,900**

Activity (under each Output)	Lead UN organization	Participating Lead UN organization	Implementing Partner	Resource allocation and indicative time frame (USD)				
				2011	2012	2013	2014	Total
Support UNJP pilot districts to deliver the agreed package of prevention combination services districts	UNFPA/UNAIDS	WHO, UNICEF, IOM, UNHCR	UAC, MoLG, MoH, Districts	176,500	36,000	37,800	39,600	**289,900**
Support review/development of national policy and planning frameworks on SRH/HIV linkages & integration (PMTC/MNCH/ STI/HCT (PITC) /ASRH/GBV)	UNFPA/WHO	UNICEF	MoH, UAC	-	110,670	116,204	121,737	**348,611**
Support MoH to develop and implement a comprehensive condom programming strategy in the context of RH commodity security	UNFPA	WHO	MoH, UAC	-	145500	-	-	**145,500**
JP output 1.1 2: Leadership and coordination for HIV prevention strengthened at national and district levels								
Support political, civic, religious and cultural leadership mobilization and capcity building for an expanded and sustainable HIV prevention response.	UNAIDS	UNFPA, WHO, IOM, UNICEF, UNDP	UAC, all sectors	1,761,455	516,744	542,582	568,419	**3,389,200**
Support functionality of HIV prevention coordination structures at national, sector and district (NPC, BCC TEAM, CT17, PMTCT Steering Committee, SMC Task Force, SRH/HIV Integration Task Team)	UNDP	WHO,UNICEF	UAC, MoLG	190,500	415,440	436,212	779,944	**1,822,096**
Support review/development of strategic and operational planning frameworks for HIV prevention at national, sector and selected districts	UNAIDS	UNFPA		376,518	257,400	-	-	**633,918**
JP output 1.1.3 Strategic information generated and utilized for evidence-based HIV prevention programming								
Support development and operationalization of an HIV Prevention Impact Evaluation Plan	UNDP	UNFPA, WHO	MoH,UAC	20,000	-	-	-	**20,000**
Evidence generation on epidemic and the prevention response at various levels	UNDP	WHO, UNICEF,ILO, UNSECO, IOM	UAC, MoH, CSO, other Sectors	936,000	348,080	147,189	154,198	**1,585,467**
Facilitate the process of identification of key prevention indicators and their integration into respective MISes	UNFPA	WHO,UNDP	UAC,Other sectoral ministries	-	42,900	-	-	**42,900**

Activity (under each Output)	Lead UN organization	Participating Lead UN organization	Implementing Partner	Resource allocation and indicative time frame (USD)				
				2011	2012	2013	2014	Total
Conduct PMTCT Impact Study every three years to establish the MTCT rates	UNICEF	WHO, UNFPA	MOH, UAC	82,500		86625		**169,125**
Facilitate the process of identifying research gaps in the areas of RH/HIV integration, MARPS, PMTCT, epidemiological and behavioral and social cultural trends	WHO	UNAIDS, UNICEF, UNESCO	UAC,	-	18,240	19,152	20,064	**57,456**
Generate strategic information on the impact of HIV on selected sectors	UNFPA	IOM	MOH/UAC	114,152	-	-	-	**114,152**
Subtotal JP Outcome 1.1: National Systems have increased capacity to deliver equaitable and quality HIV prevention integrated services				**5,793,285**	**2,862,080**	**1,930,292**	**2,124,831**	**12,710,488**
Joint Programme Outcome 1.2: Communities mobilised to demand for and utilise HIV prevention intergrated services								
JP output 1.2.1 capacity of community Systems for social and BCC strengthened								
Build technical capacity for social and behaviour change communication programming at national, district and lower levels (devt of tools, standards, TOTs, training)	UNFPA	WHO,UNAIDS, UNICEF, UNESCO, UNFPA, IOM	UAC, MOH, NAFOPHANU, CSOs	299,000	151,805	151,788	159,016	**761,609**
Support sustained and targeted communication programmes focused on priority prevention interventions	UNFPA	WHO,UNAIDS, UNICEF, UNESCO, UNFPA, IOM	UAC,	1,066,516	142,740	149,877	157,014	**1,516,147**
Support development and implementation of innovative approaches for involving targeted population groups in community mobilization (MARPs, girls, women, PLHIV, couples) for combination prevention (peer educators,)	UNFPA	WHO,UNAIDS, UNICEF, UNESCO, UNFPA, IOM	UAC,	-	212,664	223,297	233,930	**669,892**
Subtotal JP Outcome 1.2: Communities mobilised to demand for and utilise HIV prevention intergrated services				**1,365,516**	**507,209**	**524,962**	**549,960**	**2,947,648**
TREATMENT, CARE AND SUPPORT THEMATIC WORKING GROUP								
Joint Programme Outcome 2.1 : Access to antiretroviral therapy for PLWA who are eligible increased to 80%								
JP Output 2.1.1 Guidance provided and capacity built for provision of standard ART care according to the WHO recommendations							-	-

Activity (under each Output)	Lead UN organization	Participating Lead UN organization	Implementing Partner	Resource allocation and indicative time frame (USD)				
				2011	2012	2013	2014	Total
Update Integrated ART guidelines for adults, adolescents, children including infant and young child feeding in context to HIV in line with WHO recommendations	WHO	UNICEF, UNFPA, UNAIDS, UNHCR	MOH	100,000	50,000	52,500	55,000	**257,500**
Update, print and distribute training materials and job aids to enable health workers perform according to the guidelines	WHO	UNICEF, UNFPA, UNAIDS, UNHCR	MOH	50,000	30,000	31,500	33,000	**144,500**
Support ART quality improvement for refugee hosting districts	UNHCR	WHO	MOH, OPM	30,000	30,000	94,500	33,000	**187,500**
Support the National EID Coordination Unit to increase the number of new health facilities providing both EIC/EID and PMTCT services	UNICEF; WHO	UNICEF, UNFPA,	MOH	40,000	30,000	31,500	33,000	**134,500**
Support specific training and mentoring of staff to provide integrated paediatric HIV/AIDS care in sites currently not offering joint (Immunization/PMTCT)	UNICEF	UNICEF, UNFPA,	MOH	150,000	100,000	105,000	110,000	**465,000**
Support scale up of peaditric IMAI/IMCI ART services, including among in-service and pre-service training institutions	WHO	UNICEF	MOH	150,000	100,000	105,000	110,000	**465,000**
Support MOH to procure courier services for transportation of DBS samples	UNICEF	UNICEF, UNFPA,	MOH	120,000	120,000	126,000	132,000	**498,000**
Support catalytic (TOT) capacity building initiatives at rgeional level to operationalize new ART guidelines	WHO	UNICEF, UNFPA, UNHCR	MOH	80,000	100,000	105,000	110,000	**395,000**
Support patient tracking and quality of care monitoring initiatives	WHO	UNICEF, UNFPA	MOH	60,000	40,000	84,000	44,000	**228,000**
Support implemention of HIV Drug Resistance (HIVDR) prevention and monitoring surveys and other strategies	WHO	UNICEF, UNIADS, UNFPA	MOH, UVRI	75,000	60,000	63,000	66,000	**264,000**
Support implementation of HBC policy	WHO	UNICEF, UNFPA	MOH	60,000	50,000	105,000	55,000	**270,000**
Support care and treatment for mobile populations at epidemic hotspots	IOM	WHO, UNHCR	MOH	50,000	50,000	105,000	55,000	**260,000**
Provide national guidance for migrant sensitive HIV care and treatment services	IOM	WHO, UNHCR	MOH	20,000	10,000	10,500	11,000	**51,500**
JP output 2.1.2 Enhanced programming for Pre- and Post-exposure prophylaxis								
Support policy guidelines review and dissemination / support PEP and Pre- policy guidelines and review and dissemination	WHO	UNFPA, UNAIDS, UNICEF	MOH, UAC	40,000	40,000	42,000	44,000	**166,000**

Activity (under each Output)	Lead UN organization	Participating Lead UN organization	Implementing Partner	Resource allocation and indicative time frame (USD)				
				2011	2012	2013	2014	Total
Provide support for the development of a pre-and post-exposure prophylaxis implementation manuals	WHO	UNICEF, UNFPA	MOH, UAC	40,000	30,000	31,500	33,000	**134,500**
Advocate for availability of Pre- and Post- exposure prophylaxis drugs	WHO		MOH, UAC	10,000	5,000	5,250	5,500	**25,750**
JP output 2.1.3 Capacity for screening and management of non communicable diseases associated with HIV strengthened in all ART centres								
Support finalization, dissemination and use of NCD screening guidelines	WHO	UNICEF, UNFPA	MOH	60,000	50,000	52,500	55,000	**217,500**
Conduct advocacy and awareness sessions for NCD in HIV service delivery outlets	WHO	UNICEF, UNFPA	MOH	30,000	30,000	31,500	33,000	**124,500**
Support catalytic capacity building initiatives for the screening and management of NCD among HIV clients	WHO	UNICEF, UNFPA	MOH	50,000	40,000	42,000	44,000	**176,000**
JP output 2.1.4 Procurement and supply chain management streamlined								
Support evidence-based advocacy for improvement of procurement and supply chain management of HIV commodities	WHO	UNICEF, UNFPA	MOH, NMS, UAC	30,000	20,000	21,000	22,000	**93,000**
Broker high level dialogue for making local ARV production and procurement a viable option	WHO	UNAIDS, UNICEF	MOH, UAC, NDA	10,000	10,000	10,500	11,000	**41,500**
Subtotal JP Outcome 2.1 : Access to antiretroviral therapy for PLWA who are eligible increased to 80%				**1,255,000**	**995,000**	**1,254,750**	**1,094,500**	**4,599,250**
Joint Programme Outcome 2.2: TB deaths among people living with HIV reduced								
JP Output 2.2.1 Accelerated and streamlined implementation of HIV/TB collaborative interventions								
Support the review, update and dissemination of policy guidelines, training materials and tools to improve management of TB among people living with HIV	WHO	UNICEF, UNHCR	MOH	30,000	20,000	21,000	22,000	**93,000**
Support improvement of HIV/TB infection control practices in health care settings and other public areas of risk (workplaces).- Target health workers	WHO	UNICEF, UNHCR	MOH	40,000	25,000	26,250	27,500	**118,750**
Support training, mentoring and supervision initiatives to accelerate implementation of TB-HIV integrated services (ART, and HIV support services in TB clinics & ICF, in HIV Clinics)	WHO	UNICEF, UNHCR	MOH	30,000	30,000	31,500	33,000	**124,500**

Activity (under each Output)	Lead UN organization	Participating Lead UN organization	Implementing Partner	Resource allocation and indicative time frame (USD)				
				2011	2012	2013	2014	Total
Support strengthening and full integration of TB/HIV collaborative activities at district and health facility levels	WHO	UNICEF, UNHCR	MOH, Districts	50,000	50,000	52,500	55,000	**207,500**
Conduct an operational study on the integration of TB and HIV management	WHO	UNICEF,	MOH	60,000	20,000	21,000	22,000	**123,000**
Conduct assessment to establish trends in TB related deaths in HIV patients, including among refugees	WHO	UNICEF, UNHCR	MOH, OPM	20,000	50,000	52,500	55,000	**177,500**
Subtotal JP Outcome 2.2: TB deaths among people living with HIV reduced				**230,000**	**195,000**	**204,750**	**214,500**	**844,250**
Joint Programme Outcome 2. 3: People Living with HIV and households affected by HIV are addressed in all National Social protection strategies and have access to essential care and support								
JP Output 2.3.1: National social protection policy, strategy and programs integrate issues of People Living with HIV and their households								
Conduct an assessment on the formal and informal social protection strategies in relation to HIV	ILO	UNICEF	MoGLSD, CSOs	20,000	-	-	-	**20,000**
Develop and dessimnate guidelines for integrating HIV in existing social protection policy/strategy, NSP and DDPs conduct stakeholders workshop to validate and map out social protection strategies respsives to HIV	ILO	UNICEF	MoGLSD, CSOs	5,000	10,000	-	-	**15,000**
Build capacity of social protection unit in MoGLSD to advocate, supervise, and monitor HIV/AIDS related activities in the social protection programmes - disseminate HIV responsiveness social protection strategies for adoption	ILO	UNICEF	MoGLSD, CSOs	25,000	30,000	31,500	33,000	**119,500**
JP Output: 2.3.2 Communities vulnerable to HIV have increased resilience and empowered to be food and nutrition secure								
Conduct livelhoods profiling in selected districts	FAO	UNAIDS, WFP	CSOs, UAC,MAAIF	70,000	-	-	-	**70,000**

Activity (under each Output)	Lead UN organization	Participating Lead UN organization	Implementing Partner	Resource allocation and indicative time frame (USD)				
				2011	2012	2013	2014	Total
Build capacity of LGs to develop and disseminate appropriate food security and nutrition subsidiary laws to prevent and mitigate the impact of HIV and AIDS on households/communities	FAO	OHCHR, UNAIDS, WFP	CSOs, UAC,MAAIF, MoJCA. MoLG	20,000	10,000	10,500	11,000	**30,000**
Build capacity of national and LG institutions to integrate and implement social economic enhancement interventions for PLHIV	FAO		MAAIF, UAC	20,000	20,000	21,000	22,000	**83,000**
Build capacity of households affected by HIV to diversify their livelihood means along the agricultural value chain and enhance asset growth and savings (4 districts)	FAO	UNHCR	MAAIF, MGLSD, LGs, CSOs	800,000	800,000	840,000	74,800	**2,514,800**
JP output 2.3.3 Strengthened capacity of government to implement OVC policy and Plans for vulnerable children operationalised								
Contribute funds to DLGs to implement OVC plans	UNICEF	ILO	MoGLSD, MoLG, LGs, CSOs	10,000	50,000	52,500	55,000	**167,500**
National Action Plan on HIV- induced Child Labour disseminated and integrated into DLGs plans	ILO	UNICEF	MoLG, CSOs, DLGs	10,000	70,000	73,500	77,000	**230,500**
Finalise and disseminate the National Strategic Plan for OVCs to DLGs	UNICEF		MoGLSD	20,000	-	-	-	**20,000**
Revitilise and scale up OVC MIS in all districts	UNICEF		Line ministries, local govts	50,000	40,000	42,000	44,000	**176,000**
Provide technical assistance for specialised training and regulation of social welfare workers on Child Protection and case management for children	UNICEF	ILO	MoGLSD	30,000	100,000	105,000	110,000	**345,000**
Subtotal JP Outcome 2. 3: People Living with HIV and households affected by HIV are addressed in all National Social protection strategies and have access to essential care and support				**1,080,000**	**1,130,000**	**1,176,000**	**426,800**	**3,791,300**

Activity (under each Output)	Lead UN organization	Participating Lead UN organization	Implementing Partner	Resource allocation and indicative time frame (USD)				
				2011	2012	2013	2014	Total
GOVERNANCE AND HUMAN RIGHTS THEMATIC WORKING GROUP								
Joint Programme Outcome 3.1: National capacity to lead, plan, coordinate implement monitor and evaluate the national HIV response strengthened by 2014.								
JP output 3.1.1 Capacity of national institutions to lead and coordinate the national HIV response strengthened								
Engage in high level advocacy with the leadership and other relevant stakeholders on HIV to adress weak leadership on the HIV national response; and adress Low absorption of resources, delay in proposal development and grant implementation and weak governance. Advocate at high political level for the buy-in and ownership of the UAC Institutional Review findings and recommendations; health sector HIV response review recommendations, and resource allocation to the LGs	UNAIDS	All Co-sponsors	UAC, President's , OPM, Parliament, civil society	66,000	25,337	26,604	27,870	**145,811**
Provide technical and financial support to the Institutional Review of the UAC and implementation of the recommendations.	UNAIDS	WHO	UAC, President's Office	7,500	-	-	-	**7,500**
Provide technical and financial support for implementation of the health sector HIV /AIDS response review recommendations	WHO	WHO	MoH, UAC	-	68,000	-	-	**68,000**
Provide technical and financial support to in-country GFATM processes, including timely grant application, CSO involvement, implementation and the strengthening of the CCM	UNAIDS	UNDP, WHO, UNFPA, UNICEF	MoH MoFPED, UAC, CCM, CSO	80,000	24,920	26,166	27,412	**158,498**
Study on accountability and governance mechanisms for improved service delivery (in the context of HIV)	UNAIDS	All Co-sponsors	UAC	-	82,500	-	-	**82,500**
Provide technical and financial support for the development and dissemination of a Partnership Tool, in line with Public Private Partnership Policy (in the context of HIV)	UNDP	UNAIDS	MoH, UAC, CSOs, MoFPED, Private Sector	-	54,380	-	-	**54,380**

Activity (under each Output)	Lead UN organization	Participating Lead UN organization	Implementing Partner	Resource allocation and indicative time frame (USD)				
				2011	2012	2013	2014	Total
JP output 3.1.2 National and local government capacity to mainstream HIV/ AIDS and gender issues in planning and policy processes improved								
Provide technical support for the mainstreaming of HIV /AIDS issues in other UN JPs	UNDP	All Co-sponsors	UAC, CSOs	135,000	-	138,180	-	**273,180**
Provide technical and financial suppoort to conduct a study to identify bottlenecks in mainstreaming HIV in sectors	UNDP	WHO,UNAIDS	UAC, MoFPED, Line ministries, local govts	35,000	82,500	-	-	**117,500**
Technical and financial support provided to the development and implementation of an action plan to address the bottlenecks in mainstreaming HIV/AIDS in selected sectors and local governments	UNDP	All Co-sponsors	Line ministries, local govts	25,000	54,380	57,099	59,818	**196,297**
Provide technical and financial support for the development and implementation of the National Action Framework for women, girls, gender equality and HIV	UNAIDS	UNDP, UNFPA, UN Women, UAC	MoGLSD, CSOs	40,000	-	-	-	**40,000**
Provide technical support to the National Planning Authority (NPA) to include HIV/AIDS issues in the African Peer Review Mechanism	UNDP	UNDP	NPA	30,000	34,000	-	-	**64,000**
JP output 3. 1.3: Institutional capacity of UAC and sectors to plan, M&E strengthened								
Provide technical and financial support to UAC and sectors to revise and align the National Strategic Plan to the NDP and the ensuing PMMP and annual work plans	UNAIDS	All Co-sponsors	UAC	10,000	34,430	36,152	37,873	**118,455**
Capacity building of selected UAC and sector staff	UNAIDS	All Co-sponsors	UAC	10,000	28,980	30,429	31,878	**101,287**
Provide technical and financial support to the Decentralised SCE to plan and access funding from the Partnership Fund, develop strategic plan in line with the revised NSP	UNDP	UNAIDS, WHO, ILO, UNESCO	MoLG, AMICAALL	-	17,160	18,018	18,876	**54,054**

Activity (under each Output)	Lead UN organization	Participating Lead UN organization	Implementing Partner	Resource allocation and indicative time frame (USD)				
				2011	2012	2013	2014	Total
Provide technical and financial support to UAC and sectors to conduct Annual Joint Programme Reviews	UNAIDS	ILO, UNFPA, FAO, UNESCO, WHO	SCES	-	70,000	73,500	77,000	**220,500**
JP output 3.1.4: Institutional capacity for resources tracking strengthened								
Provide technical and financial resources for the implementation and institutionalisation of NASA	UNAIDS	UNAIDS UNDP, WHO	UAC, MoFPED, SCEs	70,000	107,790	113,180	118,569	**409,539**
JP output 3.1.5: National capacity to gather and disseminate strategic information strengthened								
Provide technical and financial support to AIS, other surveys and other forms of evidence generation including UNGASS, UA, Surveiilance reports	UNAIDS	UNAIDS	UAC, MoH, UBOS, CSOs, Academia	30,000	82,500	86,625	90,750	**289,875**
Provide TA and funding for the organisation of national fora for information sharing	UNAIDS	All Co-sponsors	UAC, MoH, UNRHO	25,000	49,500	51,975	54,450	**180,925**
JP output 3.1.6 Engagement of the civil society including PLHIV and young people and private secror in the national HIV response strengthened and streamlined								
Provide technical and financial resources to strenghthen the capacity of umbrella CSOs and PLHIV networks	UNAIDS	UNDP, UNICEF, UNFPA	UAC, UNASO, NACWOLA, NAFOPHANU, IRCU, AMICAALL, Forum of Kings, 1 Youth-led CSO	50,000	30,000	31,500	33,000	**144,500**
Provide technical and financial support to more effectively engage the private sector in the national HIV response	ILO	UNAIDS, UNDP		-	60,000	31,500	66,000	**157,500**
Provide technical and financial support to TASO to execute its role as 2nd Principle Recipient (PR)	UNAIDS	UNDP	UAC, MOLG, LOCAL GOVTS,	-	-	-	-	**-**
Provide technical support to the CSF to align to available evidence on HIV and the "Three Ones"				-	-	-	-	**-**
Provide technical and financial support to communities to demand services and accountability from duty bearers	UNDP	UNAIDS, UNDP		-	28,800	30,240	31,680	**90,720**

Activity (under each Output)	Lead UN organization	Participating Lead UN organization	Implementing Partner	Resource allocation and indicative time frame (USD)				
				2011	2012	2013	2014	Total
Provide technical and financial support to CSOs and private sector to undertake evidence informed advocacy on pertinent issues	UNAIDS		MoH, UAC, CSOs, Private Sector	242,000	20,000	15,000	33,000	**310,000**
JP output 3.1.7 Capacity of the UN HIV JT to plan, implement, monitor and evaluate the JUPSA strengthened								
Orientation of the Joint Team on management of JP; Develop of a costed new JP aligned to the UNDAF and UNAIDS strategic plan 2011-2014; Develop JP AWP, undertake MYR and annual report of the JP; Build capacity of JP on specific identified technical area; and support experince learning missions	UNAIDS	All Co-sponsors		290,000	53,370	112,077	58,707	**514,154**
Subtotal JP Outcome 3.1: National capacity to lead, plan, coordinate, implement ,monitor and evaluate the national HIV response strengthened by 2014				**1,145,500**	**1,008,547**	**878,244**	**766,883**	**3,799,174**
Joint Programme Outcome: 3.2 Laws, policies and practices improved to support an effective HIV response by 2014.								
JP Output 3.2.1: Capacity of national institutions to identify and implement relevant laws, policies and practices that undermine and support effective responses to HIV and AIDS strengthened								
Provide technical and financial support to relevant government institution to undertake a study to identify and analyze selected laws, policies and practices that impede or support effective responses to AIDS	UNDP	UNDP	ULRC, Min. of Justice, UHRC	30000	-	-	-	**30,000**
Provide technical and financial support to UHRC to develop and implement action plan on recommendations from the study on laws, policies and practices that impede or support effective responses to AIDS	UNDP	UNDP, UNAIDS, OHCHR	ULRC, Min. of Justice, Parliament	-	34,000	71,400	37,400	**142,800**
Technical and financial support provided to the relevant institutions to roll out the Stigma Index for and by PLHIV	UNAIDS	UNAIDS	NAFOPHANU, UAC, Academia	-	30,000	31,500	33,000	**94,500**

Activity (under each Output)	Lead UN organization	Participating Lead UN organization	Implementing Partner	Resource allocation and indicative time frame (USD)				
				2011	2012	2013	2014	Total
Provide technical and financial support for the development and implementation of a National Strategy for Reduction and /or Elimination of Stigma and Discrimination	UNAIDS	All Co-sponsors	NAFOPHANU, UAC	30,000	30,000	31,500	33,000	**124,500**
Technical and financial resoureces provioded to the ULRC to support legal reform of selected punitive laws, policies and practices	UNDP	All Co-sponsors	ULRC, Parliament, Min. of Justice, UGANET	-	-	35,700	-	**35,700**
JP Output 3.2.2: Technical capacity provided and resources mobilized to domesticate and implement the accelerated plan of action on women, girls, and gender equality in response to HIV and AIDS								
Provide technical and financial support to the MoGLSD for the development of the National Action Plan on women, girls, gender equality and HIV/AIDS			UNDP, UNAIDS, UNFPA	-	34,000	-	-	**34,000**
Subtotal JP Outcome: 3.2 Laws, policies and practices improved to support an effective HIV response by 2014				**60,000**	**128,000**	**170,100**	**103,400**	**427,500**
Total Program Funds				10,929,301	6,825,836	6,139,097	5,280,875	29,175,109
Operational costs (7%)				765,051	477,809	429,737	369,661	2,042,258
Total				11,694,352	7,303,645	6,568,834	5,650,536	31,217,367

Summary of estimates by Joint Programme Outcome

SUMMARY BY JP OUTCOME	2011	2012	2013	2014	Total- Program	Total- Program and Admin
Subtotal JP Outcome 1.1: National Systems have increased capacity to deliver equaitable and quality HIV prevention integrated services	5,793,285	2,862,080	1,930,292	2,124,831	12,710,488	13,626,625
Subtotal JP Outcome 1.2: Communities mobilised to demand for and utilise HIV prevention intergrated services	1,365,516	507,209	524,962	549,960	2,947,648	3,159,908
Subtotal JP Outcome 2.1 : Access to antiretroviral therapy for PLWA who are eligible increased to 80%	1,255,000	995,000	1,254,750	1,094,500	4,599,250	4,930,442
Subtotal JP Outcome 2.2: TB deaths among people living with HIV reduced	230,000	195,000	204,750	214,500	844,250	905,044
Subtotal JP Outcome 2. 3: People Living with HIV and households affected by HIV are addressed in all National Social protection strategies and have access to essential care and support	1,080,000	1,130,000	1,176,000	426,800	3,791,300	4,064,312
Subtotal JP Outcome 3.1: National capacity to lead, plan, coordinate, implement, monitor and evaluate the national HIV response strengthened by 2014	1,145,500	1,008,547	878,244	766,883	3,799,174	4,072,752
Subtotal JP Outcome: 3.2 Laws, policies and practices improved to support an effective HIV response by 2014	60,000	128,000	170,100	103,400	427,500	458,284
Total - Program and Admin						**31,217,367**

Sources of funds/commitments

Agency	2011		2012		2013		2014		Total Resources	
	Agency contribution to National HIV response	JUPSA Contribution	Agency contribution to National HIV response	JUPSA Contribution	Agency contribution to National HIV response	JUPSA Contribution	Agency contribution to National HIV response	JUPSA Contribution	**Total National response**	**Total JUPSA**
WHO	250,000	250,000	250,000	250,000	250,000	250,000	250,000	250,000	**1,000,000**	**1,000,000**
UNFPA	4,900,000	605,516	4,400,000	474,578	4,400,000	341,626	4,400,000	0	**18,100,000**	**1,421,720**
UNICEF	5,000,000	1,000,000	5,000,000	1,000,000	5,000,000	1,000,000	5,000,000	1,000,000	**20,000,000**	**4,000,000**
UNESCO	167,000	35,000	202,000	0	250,000	0	0	0	**619,000**	**35,000**
ILO	2,172,985	70,000	824,623	0	0	0	0	0	**2,997,608**	**70,000**
FAO	0	170,240		0	0	0	0	0	**0**	**170,240**
IOM	54,000	0	50,000	0	50,000	0	50,000	0	**204,000**	**0**
UNAIDS	870,000	600,000	870,000	600,000	870,000	600,000	870,000	600,000	**3,480,000**	**2,400,000**
UNHCR	283,345	0	283,345	0	0	0	0	0	**566,690**	**0**
UNDP	135,000	22,000	675,000	417,880	177,500	471,340	671,340	471,340	**1,658,840**	**1,382,560**
UN PNUS	13,832,330	2,752,756	12,554,968	2,742,458	10,997,500	2,662,966	11,241,340	2,321,340	**48,626,138**	**10,479,520**
Irish	1Euro=1.35US$	1,620,000		1,620,000		1,620,000		1,620,000		6,480,000
	6.4M euros for 4 yrs									-
DFID	1pound=1.56US$	1,934,400		1,934,400		1,934,400				5,803,200
	3.72Mpounds 3 yrs									-
UBRAF	1.23M for 4yrs	307,500		307,500		307,500		307,500		1,230,000
GRAND TOTAL		6,614,656		6,604,358		6,524,866		4,248,840		**23,992,720**

Analysis of JUPSA estimates and commitments

	2011	2012	2013	2014	Total
Total JUPSA 2011-2014 Estimates	**11,694,352**	**7,303,645**	**6,568,834**	**5,650,536**	**31,217,367**
Total commitments	**6,614,656**	**6,604,358**	**6,524,866**	**4,248,840**	**23,992,720**
Funding gap	**5,079,696**	**699,287**	**43,968**	**1,401,696**	**7,224,647**


UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR
UNICEF
WFP
UNDP
UNFPA
UNODC
ILO
UNESCO
WHO
WORLD BANK

World Health Organization



United Nations
Human Rights


UNITED NATIONS
Office on Drugs and Crime


UNHCR

UNFPA

unicef

UNPD
UN
DP
UNOPS

UN
WOMEN