THE REPUBLIC OF UGANDA

THE NATIONAL HIV AND AIDS STRATEGIC PLAN 2020/21/2024/25

"Ending the HIV and AIDS epidemic: Communities at the forefront"

UGANDA AIDS COMMISSION

Abridged Version

April 27, 2020

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The process of developing this National Strategic Plan was highly participatory involving key stakeholders and interest groups including communities of PLHIV at national and sub-national levels. The process was mainly supported through the programmatic Technical Working Groups (TWG) that met regularly with respective thematic consultants in working sessions and workshops to provide their inputs and technical advice. The TWGs were composed of representatives from all groups of stakeholders involved in the national HIV response: Ministry of Health and government entities (Ministries, Departments and Agencies), Civil Society Organizations (including PLHIV), private sector partners, decentralized units of government, development partners (UNAIDS, UNFPA, UN Women, WHO, US Government and the Global Fund).

Uganda AIDS Commission was the lead agency in coordinating the National Strategic Plan development process, but all partners and stakeholders participated actively in all the steps of NSP development ensuring comprehensive consultation and fully inclusive consensus on the final document. The facilitation by the consultants from Socio-Economic Data Centre (SEDC) Limited under the leadership of Prof. Narathius Asingwire is appreciated. The conveners at the Uganda AIDS Commission and all the staff played a critical role.

I wish to congratulate all partners for their active participation in the development of the new National Strategic Plan, and above all for their invaluable and continuous contribution to the fight against HIV and AIDS.

Dr. Nelson Musoba
DIRECTOR GENERAL

ACRONYMS AND ABBREVIATIONS

ABYM	Adolescent Boys and Young Men
ACP	AIDS Control Programme
AGYW	Adolescent Girls and Young Women
AIS	AIDS Indicatory Survey
AIDS	Indicatory Survey
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral Medicines
CSO	Civil Society Organizations
DAC	District HIV/AIDS Committees
DREAMS	Determined, Resilient, Empowered, AIDS Free, Mentored and Safe Initiative
DTG	Dolutegravir
EOC	Equal Opportunities Commission
EID	Early Infant Diagnosis
EMTCT	Elimination of Mother-to-Child Transmission
FBO	Faith-Based Organization
FY	Fiscal Year
GBV	Gender-Based Violence
GHI	United States of America Government's Global Health Initiative
HCW	Health Care Waste
HMIS	Health Management Information System
HPV	Human Papillomavirus
IGAD	Inter-Governmental Authority on Development
IRCU	Inter-Religious Council of Uganda
JAR	Joint Annual Review
KPs	Key Populations
LMIS	Logistics Management Information Systems
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MARPI	Most at Risk Populations Initiative
MDAs	Ministries, Departments and Agencies
MIS	Management Information System
MNCHN	Maternal, Newborn and Child Health and Nutrition
MoES	Ministry of Education and Sports
MoFPED	Ministry of Finance, Planning and Economic Development
MoH-ACP	Ministry of Health–AIDS Control Programme

MTR	Mid-Term Review
NADIC	National AIDS Documentation and Information Centre
NAFOPHANU	National Forum of People Living With HIV/AIDS Networks in Uganda
NAIS	National AIDS Indicatory Survey
NASA	National AIDS Spending Assessment
NBF	National Budget Framework
NDP III	National Development Plan III 2020/21– 2024/25
NPAP	National HIV and AIDS Priority Action Plan
NSP	National Strategic Plan
NUSAF	Third Northern Uganda Social Action Fund
OVC	Orphans and Vulnerable Children
OWC	Operation Wealth Creation
PCR	Polymerase Chain Reaction
P EP	Post-Exposure Prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PWD	Persons with A Disability
RUTF	Ready-To-Use Therapeutic Foods
SAGE	Social Assistance Grants for Employment
SBCC	Social and Behaviour Change Communication
SCE	Self-Coordinating Entities
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-Based Violence
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SVAC	Sexual Violence Against Children
TWG	Technical Working Groups
UAC	Uganda Aids Commission
UDHS	Uganda Demographic and Health Survey
UNYPA	Uganda Network of Young People Living with HIV & AIDS
UPHIA	Uganda Population-Based HIV Impact Assessment
UWEP	Uganda Women Entrepreneur Programme
VHTs	Village Health Teams
VMMC	Voluntary Medical Male Circumcision
YAPs	Youth and Adolescent Peer Support
YLP	Youth Livelihood Programme
ZCU	Zonal Control Units

TABLE OF CONTENTS

ACKNOWLEDGEMENTS ii

ACRONYMS iii

1.0 INTRODUCTION AND BACKGROUND 1

2.0 HIV AND AIDS SITUATION ANALYSIS 2

3.0 STRATEGIC DIRECTION OF NSP 2020/21-2024/25- 6

3.1 Evidence-Based Response and Scenario adopted 6

3.2 Theory of change for attaining outcomes and goal of NSP 7

3.3 Major Strategic Shifts under NSP 2020/2021—2024/2025 9

4.0 THE NATIONAL HIV AND AIDS STRATEGIC PLAN 2020/2021-2024/2025 12

4.1 Vision 12

4.2 Overall Goal 12

4.3. Objectives of NSP 2020/2021—2024/2025 13

5.0 NSP 2020/2021-2024/2025 STRATEGIC OBJECTIVES AND ACTIONS 15

5.1 Prevention 15

5.2 Care and Treatment 19

5.3 Social Support and Protection 25

5.4 Systems Strengthening 30

5.5 Monitoring, Evaluation and Research 33

6.0 NSP 2020/2021-2024/2025 CO-ORDINATION AND IMPLEMENTATION 37

6.1 Institutional Arrangements for Coordinating the Response 37

6.2 Implementation Arrangements for the NSP 40

7.0 COST ESTIMATES AND ACCOUNTABILITY 42

1.0 INTRODUCTION AND BACKGROUND

Uganda prioritizes control of HIV and AIDS within the country's 3rd National Development Plan (NDP) 2020/21- 2024/25 and other national and international commitments such as the Sustainable Development Goals (SDGs). The country is implementing the Presidential Fast Track Initiative (PFTI) on Ending the AIDS Epidemic by 2030, launched by H.E Y.K. Museveni in June 2017. This National Strategic Plan for HIV and AIDS (NSP) 2020/2021-2024/2025) lays out strategies and actions to implement high impact evidence-based interventions and innovations, with program optimization. The Plan builds on significant progress achieved during the past five years and responds to gaps identified as laid out in the Mid-Term Review (MTR) and Joint Annual Reviews (JARs) of previous plans.

The process of developing this Plan extensively involved key stakeholders and interest groups including communities of people living with HIV (PLHIV) at national and sub-national levels. Technical Working Groups (TWGs) constituted from a wide spectrum of development partners, AIDS service organizations, government ministries, departments and agencies (MDAs) offered technical input in each thematic area of the NSP. For purposes of alignment with inset sectoral and other national plans, this NSP builds on the Health Sector HIV and AIDS Strategic Plan 2018/19 – 2022/23; National Plan for Achieving Equity in Access to HIV, TB and Malaria Services in Uganda 2020-2024; Acceleration of HIV Prevention Roadmap, Towards Zero New HIV Infections by 2030; and Presidential Fast-Track Initiative on Ending AIDS in Uganda 201

The NSP 2020/2021 – 2024/2025 builds on the significant progress achieved to- date and responds to the gaps identified from the past five years. The ultimate aim is to trigger catalytic action to end AIDS as a public health threat in the country. A comprehensive Mid-Term Review

MTR) of the NSP 2014/15 – 2019/20[1] and Joint Annual Review (JAR) during the 4th year of its implementation[2] revealed specific noticeable progress in the implementation of the NSP, but also brought to the fore a number of glaring gaps and challenges that require fresh planning. These include among others, decline in socio-behavioral change communication (SBCC) interventions coupled by misinformation of the general public by uncensored messages; limited condom supplies characterized by stock-outs for both male and female condoms in some districts; inadequate programming for key populations (KPs); limited integration of sexual and gender based violence (SGBV) prevention and human rights with HIV prevention programming; limited adolescent SRH/HIV information and services; inadequate skills in provision of adolescent friendly SRH among health workers and discriminatory provisions in the HIV control law. Noticeable also is the decline in linkage to care; low uptake of HIV testing services among men; and low early infant diagnosis (EID) coverage and retention.

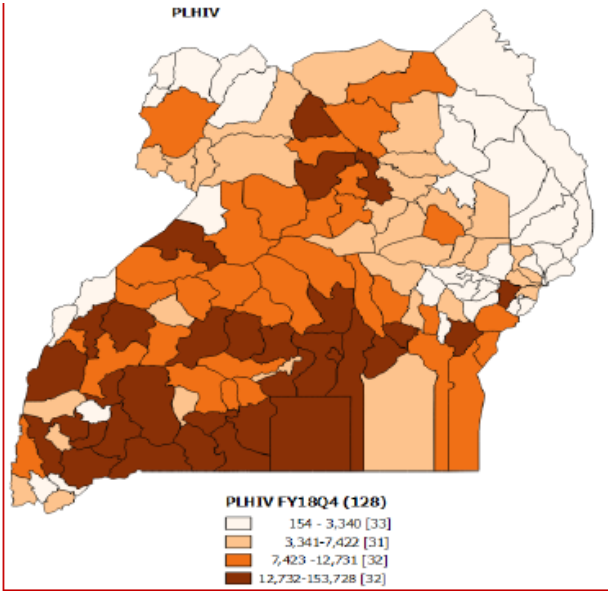
2.0 HIV AND AIDS SITUATION ANALYSIS

The National HIV estimates show that in 2019, people living with HIV were 1,461,370; HIV incidence per 1,000 uninfected among all ages was 1.4, but substantially higher in specific sub-populations and locations. The national estimates put HIV prevalence at 7.1% for women and 4.3% for men; 2.8% among young women and 1.1% among young men, and also indicate that 53,000 people were newly infected with HIV (5,700 children 0-14yrs; 48,000 adults 15+yrs, among them 28,000 were women 15+yrs). Amongst older adolescents and young people, prevalence is almost four times higher among females than males. Whereas all data sources indicate declining HIV prevalence and incidence for more than a decade, there are wide variations by region and district; most parts of Central, West and South-western of the country report higher rates. Same with urban and rural variations. Not all data are current or comprehensive for certain population groups, particularly key populations (KPs); still, HIV prevalence has been found to be significantly higher among these categories, ranging from 13.7% to as high as 37%.

1 UAC (2018). Mid-term Review of the National HIV and AIDS Strategic Plan (NSP) 2015/2016-2019/2020, Uganda AIDS Commission, Republic of Uganda.

2 UAC (2019). 12th Annual Joint AIDS Review (JAR) Final Report July 2019-June 2019, Empowering Young people to Champion the End of New HIV Infections, Sept. 2019. Uganda AIDS Commission, Republic of Uganda.

Proportion of people living with HIV (all ages) in Uganda per district



The HIV burden in Uganda is heterogeneously distributed by population, socio-economic, socio-demographic characteristics, and geographical areas (See Figure 1). There are wide variations by region and district; most parts of central, west and south-western of the country report higher prevalence rates; districts with least prevalence are mainly in far east, north-east, and West Nile regions. A national, population- based survey (UPHIA 2017) shows that HIV prevalence not only varies across the ten regions, ranging from 3.1% in West Nile to 8.0% in Central 1 region, but is also higher in those residing in urban areas (7.5%) compared to those living in rural areas.

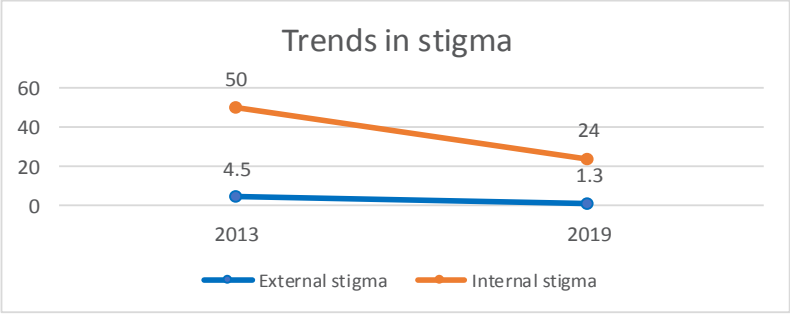
Although AIDS-related deaths have declined over the past decade, males, on account of their lower antiretroviral therapy (ART) coverage and health seeking behaviour are more disproportionately affected in mortality statistics (61%). Regarding 90-90-90 target by 2020, country performance data indicate that, as at March 2020, 89% of all adults (93% of the women; 86% of the men) living with HIV knew their HIV status, 84% (91% of the women; 77% of the men) were on treatment,

among them 75% (83% of the women; 68% of the men) with viral load suppression (VLS). Rates were 65-65-48 among children. About 93% of pregnant women living with HIV were on ART.

The second 90 targeted that 90% of those who know their status are on treatment translating into 81% of all PLHIV. This target was surpassed in 2019 with 84% of all estimated PLHIV being on ART. The third 90 targeted that 90% of the people on treatment are virally suppressed translating into 73% of all PLHIV. This also was surpassed with 75% of estimated PLHIV being virally suppressed.

Uganda has also witnessed a general reduction in stigma and discrimination against PLHIV and other vulnerable groups: Proportion of individuals aged 15-49 with accepting attitudes towards PLHIV increased from 34% in 2011 to about 66.8% by 2017[3]. Progress has also been registered in other specific measures of discrimination.

Trends in social and internal stigma towards people living with HIV



A reduction in some of the external forms of stigma, such as exclusion from social gatherings reduced from 4.5% in 2013 to 1.3% in 2019; internal forms of stigma such as feeling guilty of being HIV positive reduced from 50% in 2013 to 24% in 2019.
NAFOPHANU Second National Stigma Index Study (August 2019)

However, while there have been improvements in access to services in

3 NAFOPHANU Second National Stigma Index Study (August 2019) conducted with 1,398 respondents living with HIV, in 21 districts and 9 in sub regions of Uganda,

health settings particularly where there are specialized service delivery points such as at the MARPI[4] clinic, stigma directed at key populations persists. The legal environment in general has continued to engender stigma and discrimination based on other existing legislations such as the Penal Code Act Sections 139 and 145 which criminalize sex work and same sex acts respectively.

There are many factors driving the HIV epidemic that are behavioral, socio cultural and biomedical including concurrent sexual partnerships, discordance and non-disclosure, transactional and sex work, low and inconsistent condom use, low male circumcision, alcohol and drug abuse. Structural, socio-cultural and economic aspects include poverty, gender inequalities, as well as gaps in access to prevention, care and treatment services[5]. Outstandingactors include low male participation in HIV programming, limited reach and adaptability of health services for key and vulnerable populations and high levels of stigma, discrimination and violence against key populations.

Behavior change efforts (such as age-appropriate sex education, community-based behavioral prevention, and condom use and prevention programs among populations at greater risk of HIV exposure) also have not been sufficiently implemented to scale to result in sustainable declines in new HIV infections.

3.0 STRATEGIC DIRECTION OF NSP 2020/21-2024/25

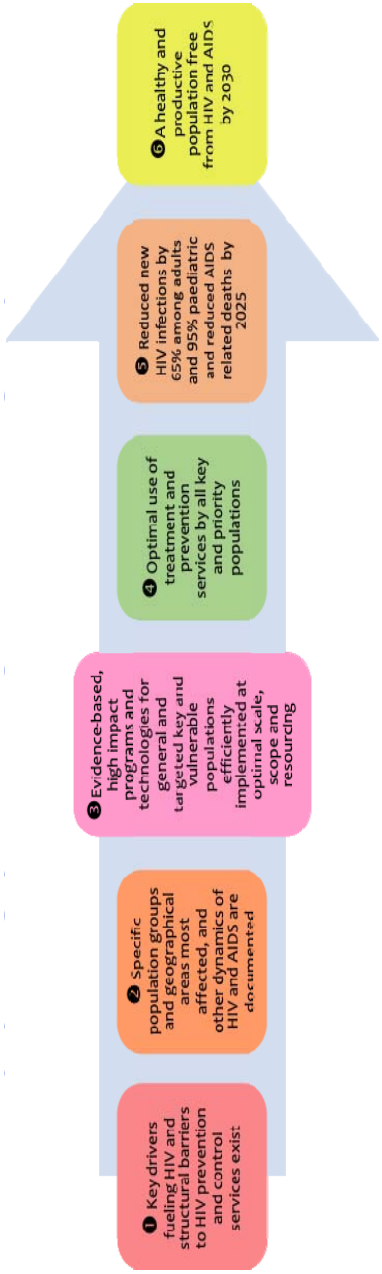
3.1 Evidence-Based Response and Scenario adopted

This NSP has adopted a Prioritized Scale-Up Scenario which envisions rapid scale-up to maximum feasible coverage of a comprehensive set of interventions. The critical interventions which have proven effectiveness for impact are HIV testing services (HTS), antiretroviral treatment, condoms especially male condoms, safe male circumcision (SMC), Elimination of Mother-to-Child HIV Transmission (EMTCT), Early Infant Diagnosis (EID) and programs for key populations (KPs). Other programs such as Socio-Behavioural Change Communication (SBCC), stigma and violence prevention, and interventions targeting adolescent girls and young women (AGYW) are social enablers that are expected to influence uptake of key services and provide non-HIV benefits as well.

With Prioritized Scale-Up, new HIV infections are projected to decline by 71% between 2019 and 2025 reaching 15,000 in 2025, averting 72,000 new HIV infections during this period, about 43% of the infections that would have otherwise occurred. For AGYW, new infections decline by almost 85% from 2019 to 2025 to about 2,000 per year. The proportion of people living with HIV under age 25 drop from 19% in 2019 to 12% by 2025. AIDS-related deaths also decline by 71% averting 42,000 deaths during this period. Overall, HIV incidence rates (15-49yrs) are projected to decline from 0.4% to 0.2%, annual HIV related deaths from 21,000 to 10,800, HIV mortality rate (15-49yrs) from 66 to 33/100,000.

4. The Most at Risk Populations Initiative of the Ministry of Health runs a specialized clinic at Mulago Hospital in Kampala for key populations. A number of other clinics modeled on the original clinic have been opened up in about 10 Regional Referral Hospitals.
5. Uganda AIDS Commission (2018): Acceleration of HIV Prevention: A Roadmap Towards zero new HIV infections by 2030. Kampala

3.2 Theory of change for attaining outcomes and goal of NSP



Building from a model developed for Equity Plan 2019[6], this NSP 2020/2021 – 2024/2025, there are key drivers fuelling the HIV epidemic and it is evident that major barriers to HIV related services remain in Uganda[1]. In a country facing a mature, generalized epidemic, these drivers and barriers affect all people living with or affected by HIV and AIDS.

However, there are members of key populations and vulnerable groups, as identified in the national HIV and AIDS surveillance system, surveys, routine reports other reports[2]. The populations and groups in the plan have greater vulnerability to infection and yet low access to the continuum of services to prevent infection or to obtain needed treatment. The Plan further recognises that evidence-based, best-practice approaches and interventions have been identified nationally, regionally and globally[3]. If implemented in a prioritized scale up mode with maximum efficiencies and differentiated according to populations at risk[4], it will contribute towards the desired goal – zero new HIV infections, zero AIDS related mortality and morbidity and zero discrimination. Ultimately, this will halt drivers and remove barriers by reducing HIV incidence and AIDS related mortality by 65%[5].

Priority interventions should be effective in stemming HIV spread, are available, accessible, affordable and acceptable and are offered at sufficient standards of quality to ensure maximum levels of uptake and retention for all population groups, including key and priority populations. The interventions should also be adequately resourced, technically and financially, to an optimal scale of implementation likely to significantly impact on the course of HIV to meet global targets. Ultimately, through scaling-up and sustaining the HIV response, a healthy and productive population, including key and vulnerable subpopulations most affected will be AIDS free by 2030[6].

6 Most concepts and variables plotted in this Theory of Change are specific to the NSP 2020/2021 – 2024/2025 while the theoretical framework is drawn extensively from Russell Armstrong's ideas in the National Plan for Achieving Equity in Access to HIV, TB and malaria services in Uganda 2020-2024, Kampala, Uganda

3.3 Major Strategic Shifts under NSP 2020/2021—2024/2025

This NSP presents a concise framework that identifies a set of priority strategic shifts that will serve as game-changers for the attainment of the above measurable outcomes. These shifts are conceived under each thematic:

Prevention

A package of combination HIV prevention interventions will be rolled out to achieve saturation levels with particular focus on:

- Breaking the HIV transmission cycle through identification of people who are HIV positive with particular attention to finding missing men, members of key populations and other exposed individuals likely to test positive for HIV and initiating them into treatment
- Increasing coverage of comprehensive and innovative HIV prevention and SRH targeting adolescents and young people, especially adolescent girls and young women (AGYW) and male partners of AGYW
- Improving and scaling up targeted HIV prevention programs for key populations, such as sex workers (SW), men who have sex with men (MSM), transgender persons and persons who inject drugs (PWID) - including newer interventions such as Opioid substitution therapy and needle exchange programs for PWID.
- A new generation of condom programming aimed to redirect condom distribution towards a Total Market Approach with more distribution via social marketing, and targeting non-traditional outlets and sex work settings; Promotion of female condom use and ensuring adequate supplies.
- Reducing risk of HIV acquisition by young males through targeted, high quality circumcision by shifting SMC from a vertical intervention to a more sustainable, integrated one; to include IEC to women on how they benefit from SMC of their male partners.
- Consolidating EMTCT gains through emphasis of triple elimination of HIV, syphilis and hepatitis, and closing emerging gaps in uptake of ART, retention and adherence, monitoring of mother-baby pairs, and testing and care of HIV exposed infants;
- Promoting targeted use of pre-exposure prophylaxis (PrEP) for prevention of new infections, based on geographical location, high level of risk and vulnerability

- Increasing the quality of post-exposure prophylaxis (PEP) targeting those who have been or likely to have been exposed to HIV infection such as health workers and victims of coerced sex;
- Increasing access to sexually transmitted infections (STI) services that include diagnosis and management of STI symptoms and STI screening among key populations and to all pregnant women alongside EMTCT
- Addressing the structural drivers of HIV infection and barriers to HIV prevention such as stigma and discrimination, restrictive policies and laws, and inequitable gender and cultural norms.
- Building a locally led prevention response through strengthening the capacity of sectors, districts and community led groups, organisations and actors to effectively contribute to increased uptake of prevention interventions through social mobilization, advocacy, and monitoring of provision of services.

Care and Treatment:

The triple 95-95-95 will provide the cornerstone for further reduction of HIV infection and AIDS related deaths by 2025, with deliberate programmatic emphasis on achieving high (above 90%) coverage among sex workers and other key populations. The game-changers in this NSP will comprise of:

- Prioritizing high impact HCT approaches including assisted partner notification (APN), index client testing, self-testing, and use of screening tools for provider-initiated counselling and testing (PICT)
- Ensuring Dolutegravir (DGT) transition for all people living with HIV linked to care and improvement of access to 2nd and 3rd line regimens
- Scaling-up differentiated service delivery approaches for ART and other HIV related services, including implementation of Youth and Adolescent Peer Support (YAPs) model, Drop-in Centers (DICs) in urban areas and community and peer-led initiatives for key populations
- Strengthening community structures and systems for client tracing, care, referral, linkage and follow-up.

Social Support and Protection

Psychosocial, economic, legal and protection services are recognized as "social enablers" for HIV prevention, and uptake of care and treatment services. These will be given more attention, compared to the past and will focus on:

- Scaling-up efforts to eliminate HIV related and other forms of stigma and discrimination against people living with HIV, key populations, persons with disabilities (PWDs), and other vulnerable groups; roll out and implement the National Anti- stigma Policy
- Mainstreaming social support for people living with HIV, affected population and at high risk population into national social development programs
- Strengthening prevention and response to sexual and gender-based discrimination and violence (SGBV), and mainstreaming of gender and human rights programming into the HIV and AIDS response to address and remove barriers to access
- Strengthening legal and policy framework on HIV and AIDS to ensure inclusion of all key populations, priority populations and vulnerable groups
- Increasing coverage and delivery of services to meet the basic needs to households of orphans and other vulnerable children (OVC)
- Building the capacity and coordination of community actors to prevent and respond to SGBV and abuse of human rights; includes sensitization of communities about laws related to HIV.

Systems Strengthening

Optimal service delivery will be possible with a bigger and diversified resource basket, efficient systems and infrastructure with sufficient capacity to achieve sustained outcomes through continuous quality improvement of services of evidential impact. Attention will thus be placed on:

- Strengthening capacity to collect, analyze and use strategic information for decision making
- Optimizing supply chain management of medical and pharmaceutical products for commodity security with minimal stockouts of essential products

- Strengthening human resource capacity for relevant ministries, agencies and departments
- Strengthening health and social services infrastructure
- Improving financing for HIV-related services along priority interventions, including those relating to gender and human rights
- Improving efficiencies in HIV program management and coordination including engagement of community actors.
- Strengthening capacity of community-led structures, organisations, and networks to plan, implement, manage and coordinate accelerated epidemic control interventions; including development and implementation of ordinances at decentralized response.
- Strengthening the national mechanism for generating comprehensive, quality and timely HIV and AIDS information for M&E of the NSP
- Promoting information sharing and utilization among producers and users of HIV/ and AIDS data/information at all levels

4.0 THE NATIONAL HIV AND AIDS STRATEGIC PLAN 2020/2021-2024/2025

4.1 Vision

The Vision of this NSP builds upon the Vision of National HIV and AIDS Strategic Plan 2014/2015—2019/2020, subscribes to Uganda's Vision Statement contained in Uganda Vision 2040 "a Transformed Uganda Society from a Peasant to a Modern and Prosperous Country within 30 years" and the goals and aspirations in the 3rd National Development Plan 2020/2021 – 2024/2025.

A Healthy and Productive Population free of HIV/AIDS and its effects

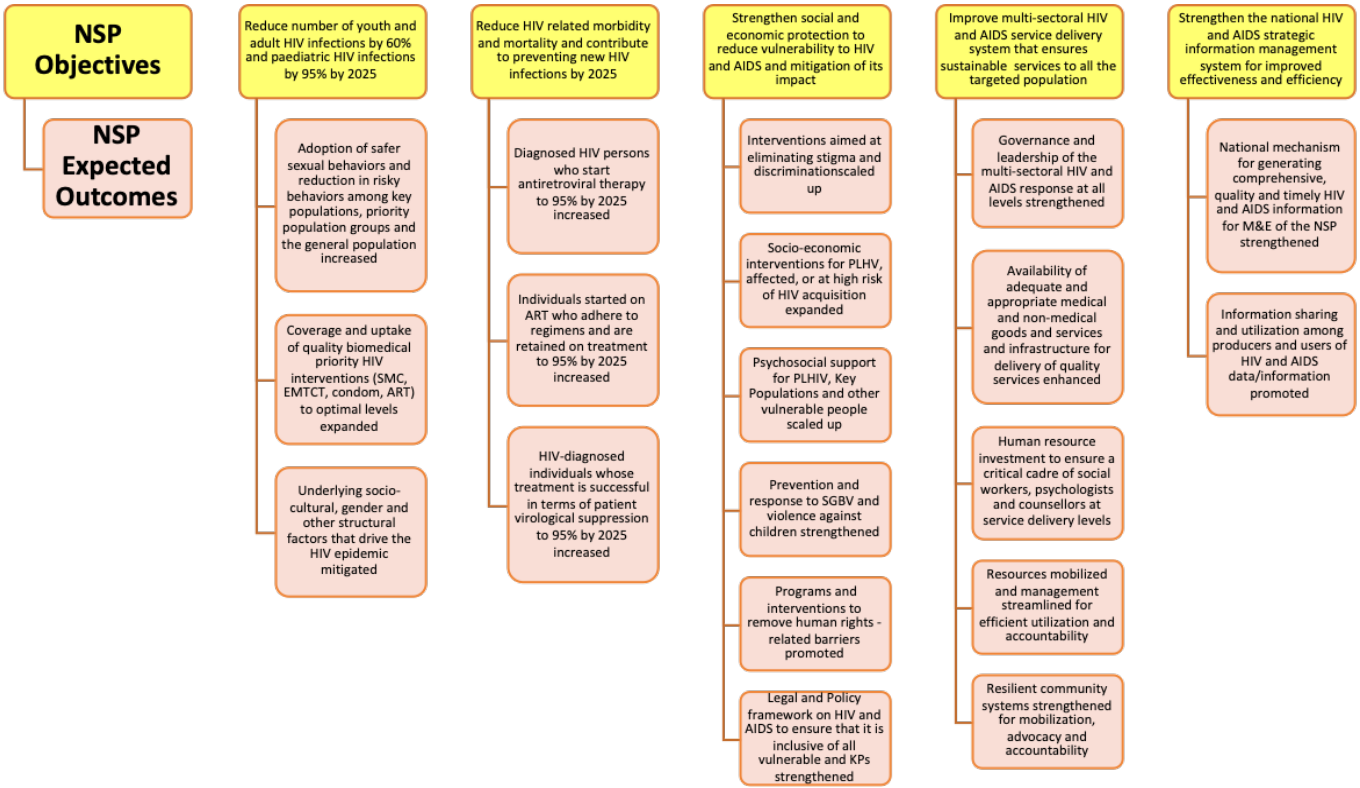
4.2 Overall Goal

Increase productivity, inclusiveness and wellbeing of the population through ending HIV and AIDS as an epidemic by 2030

4.3. Objectives of NSP 2020/2021—2024/2025

- To reduce new HIV infections by 65% among adults and youth and paediatric new HIV infections to less than 5% by 2025
- To reduce HIV related morbidity and mortality by 2025
- To strengthen social and economic protection to reduce vulnerability to HIV and AIDS and mitigation of its impact on people living with HIV, OVC, key populations and other vulnerable groups
- To strengthen the multi-sectoral HIV and AIDS service delivery and coordination system that ensures sustainable access to efficient and quality services for all targeted populations
- To strengthen the national HIV and AIDS strategic information management system for improved effectiveness and efficiency

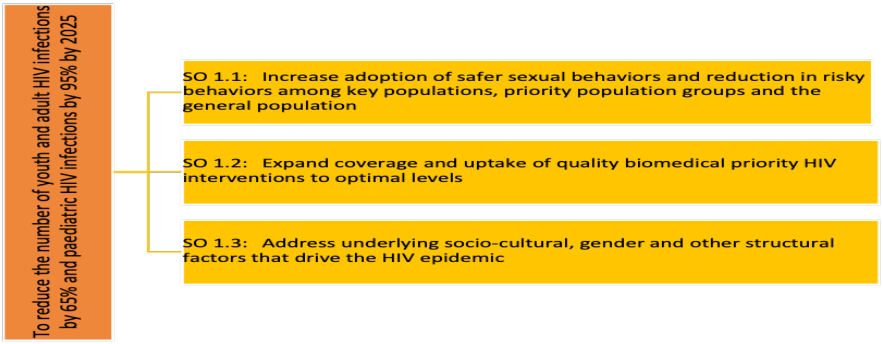
NSP results framework



5.0 NSP 2020/2021-2024/2025 STRATEGIC OBJECTIVES AND ACTIONS

5.1 Prevention

Sub-Goal and Strategic objectives



Strategic Actions for each Objective under HIV Prevention:

SO 1.1 Increase adoption of safer sexual behaviors and reduction in risky behaviors among v key populations, priority population groups and the general population

1.1.1 Scale-up age- and audience-specific social and behavioural change interventions including abstinence and be faithful interventions to reach all population groups

1.1.2 Design and implement youth-led HIV prevention programs utilizing innovative approaches such as adaptive leadership7 and human centered design8 and diversify SBCC channels to predominantly include media-based outreach platforms and other technology based-approaches

1.1.3 Engage community structures and networks in design and scale up innovative HIV prevention programs to improve comprehensive HIV knowledge, impart life skills, reduce risky sexual behaviours, address sexual and gender-based violence and improve SRH.

1.1.4 Implement interventions that can help to keep adolescent girls and young women in school by scaling up training for menstrual hygiene management among in-school AGYW, ending gender-based violence, providing sanitary pads for needy AGYW at school and cash transfers, among other interventions.

1.1.5 Increase availability of and access to quality condoms through targeted distribution of free condoms, improved social marketing approaches, and adoption of the Total Market Approach9.

1.1.6 Scale-up condom demand creation through evidence-based social mobilization and social marketing approaches to address complacency and fatigue associated with condom use.

1.1.7 Introduce and scale up harm reduction programs for people who inject drugs

1.1.8 Integrate SGBV prevention and human rights into HIV prevention programming and strengthen linkage to respective community and facility- based services.

1.1.9 Conduct comprehensive mapping and size estimation and determine HIV prevalence among all key populations and scale-up targeted comprehensive interventions including drop-in centers in regional referral and general hospitals as well as outside hospital settings

1.1.10 Support and implement family-centered approaches to prevent HIV infection10

1.1.11 Expand programming for positive health, dignity and prevention (PHDP) interventions among PLHIV[11]

SO1.2 Expand coverage and uptake of quality biomedical priority HIV interventions to optimal levels

7 Adaptive leadership a practical leadership framework that helps individuals and organizations adapt and thrive in challenging environments, where there are absolutely no trained experts to deal with the problems at hand.

8 Human-centered design is an approach to problem solving, commonly used in design and management frameworks that develops solutions to problems by involving the human perspective in all steps of the problem-solving process. It's a process that starts with the people you're designing for and ends with new solutions that are tailor made to suit their needs.

1.1.1 Scale-up coverage of differentiated HIV testing services to high-risk groups to identify HIV infected individuals and enroll them on ART to lower their viral load and reduce the ability to transmit HIV to other people.

1.1.2 Expand the coverage and accessibility of targeted biomedical interventions for key and priority populations, including STI services, HIV testing, VMMC, PrEP, PEP, EMTCT and harm-reduction interventions.

1.1.3 Expand coverage and eliminate all barriers to accessing PrEP and PEP for those at high risk of exposure to HIV infection; including engagement of KPs and priority population peers as distribution agents.

1.1.4 Expand coverage and access to quality voluntary medical male circumcision targeting males of all age groups, with priority given to adolescents and adults; and move towards a systems approach to sustain VMMC services.

1.1.5 Strengthen medical infection control and ensure universal precaution and consolidate mechanisms for improved blood collection, screening and storage, to support HIV prevention

1.1.6 Support implementation of high-quality research in promising HIV prevention interventions, including microbicides and vaccines

1.1.7 Integrate SRHR, especially family planning, maternal, newborn and child health and nutrition (MNCHN) and TB services into HIV prevention programming

SO1.3 Address underlying socio-cultural, gender and other structural factors that drive the HIV epidemic

1.1.1 Address socio-cultural drivers of HIV through strategic engagement of media, CSOs, religious, cultural, and political institutions in the HIV prevention effort

1.1.2 Promote male involvement in HIV prevention for their own health, the health of their partners and families through innovative community peer engagement models.

1.1.3 Build capacity of service providers to manage SGBV cases, deliver integrated youth-friendly HIV, SRH services that include prevention

of SGBV and address health worker-stigma

1.1.4 Create male-friendly interventions (e.g. work-place programs; mobile HIV testing, etc.) to attract men to use HIV prevention and care services.

1.1.5 Address alcohol and drug abuse as risk factors for HIV acquisition.

1.1.6 Integrate SGBV prevention into HIV prevention programming and build the capacity of service providers to deliver integrated HIV, SRHR. psycho-social and SGBV services

1.1.7 Apply a human rights-based approach to HIV programming through leveraging civil society for local advocacy to address HIV service barriers among key and priority populations.

1.1.8 Build capacity of service providers in delivery of KP-friendly services and address health worker-stigma for effective utilization of health facility-based services and scale out peer-led community outreaches

1.1.9 Enhance knowledge, attitudes, actions and accountability of various actors such as community leaders, health workers, PLHIV and family members for non-discriminatory and inclusive HIV prevention response.

9. The Total Market Approach (TMA) for condom distribution entails distribution of free condoms targeting to the poor and disadvantaged population segments, while the wealthier population segments either buy subsidized condoms from social marketing or full priced condoms from the commercial sector

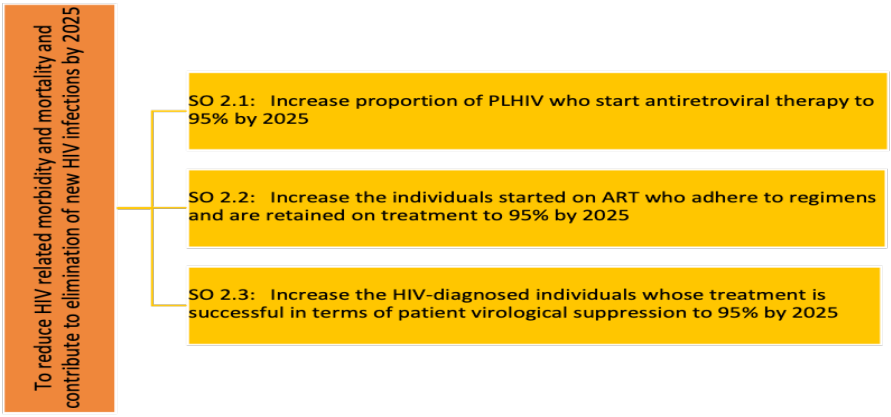
10. A family-centred approach acknowledges that an individual's quality of life is interwoven with the life and experience of the family in which they live. Family-centred services in the context of HIV/AIDS acknowledge a broad view of a "family system" and consists of a comprehensive coordinated care approach that addresses the needs of both adults and children in a family and attempts to meet their health and social care needs, either directly or indirectly, through collaboration and linkages with other service providers. A family-centred approach helps families to care for individuals living with HIV within the family. It provides services in a way that is 'family friendly' and recognises the relationships between family members.

11. Positive health, dignity and prevention (PHDP) engages people who know they are living with HIV in prevention. It involves supporting HIV-positive people to learn and practice how to live healthily and minimize the risks of spreading the virus to others.

12. The four prongs of eMTCT are: primary prevention of HIV infection for women of child-bearing age, prevention of unintended pregnancies among HIV-positive women, prevention of HIV transmission from HIV-positive mothers to infants, and provision of continuous care and treatment for infected mothers, partners and their children

5.2 Care and Treatment

Sub-goal and strategic objectives



Strategic Actions for each Objective under Care and Treatment:

SO 2.1 Increase the diagnosed HIV persons who start antiretroviral therapy to 95% by 2025

2.1.1. Increase HIV care entry points for HIV exposed infants, children, adolescents and men

- Increase the number of ART accredited sites especially in the private sector
- Integrate HIV services (HIV, RMNCAH, TB, Child Health services), share information and establish effective referrals across different levels of the health system.
- Provide daily ART services in ART clinics.
- Implement harm reduction strategy to scale
- Strengthen patient education on ART at all entry points
-

2.1.2. Strengthen community health and peer-led platforms to identify, support and link people living with HIV including key populations that remain undiagnosed to care

- Expand "identify, reach, test, treat and retain" at community level, community engagement (including schools, social/child

protection and workplaces) using community 'in-reach" and task sharing approaches
- Build capacity of community actors (including CSOs and networks of PLHIV) to effectively link newly identified PLHIV to ART.
- Build competence of Traditional and Complementary Medical practitioners (TCMPs) in expanding case finding, and linkage as an innovative way of mobilizing their intrinsic skills, reach and competencies

2.1.3. Implement adolescent-friendly health services (AFHS) in the community and health facilities
- Implement the eight global standards for quality health-care services for adolescents.
- Train providers who are competent to treat adolescents with appropriate skills and provide them with ongoing mentorship and supportive guidance
- Modifying facility characteristics towards adolescent-focused service times and waiting lines
- Institute age-appropriate disclosure process
- Implement psychological support (other examples of DSD for adolescents including facility-based adolescent group refill, community-based adolescent group refill, longer refilling for adolescent in boarding school, fast track).

2.1.4. Quality treatment and care for key populations and other vulnerable groups to realize their health-related rights.
- Training and other capacity building for health care providers (including health unit management committees) on gender and human rights, medical ethics and culturally appropriate services especially in addressing health care needs of KPs and other vulnerable groups who are underserved and encounter significant access barriers
- Monitoring the levels of discrimination in health-care settings, including the experiences of health service users, as well as the attitudes and practices of service providers.
- Review and reform HIV service delivery to ensure that they provide meaningful participation and involvement of people

living with HIV, key and affected populations, as well as of community-based organizations

SO 2.2 Increase HIV-diagnosed individuals started on ART who adhere to regimens and are retained on treatment to 95% by 2025

2.2.1. Optimizing and rolling out ARV treatment regimens including consolidation of the DTG transition plan to enhance sustained viral suppression, tolerability and sustainability

- Continue to implement the "Test and Treat" policy within the Consolidated HIV prevention and treatment guidelines. Interventions for Continuous Quality Improvement (National CQI initiative; VL, Retention, IPT) should be intensified.
- Early diagnosis and effective linkages to treatment for those testing HIV positive to maximize treatment outcomes.
- Leverage PLHIV networks, peers of key and priority populations; and empower families to provide adherence support to PLHIV on ART
- Provide a clinical package for children and adolescents with Advanced HIV Disease
- Increase access to drug resistance monitoring for all groups, including for severe AEs such as hyperglycemia in stable patients transitioning to DTG
- Conduct Operational Research in new care and treatment technologies and adopt to scale evidence-based innovations

2.2.2. Community empowerment to keep people engaged in care and help them access treatment, adhere to their medications and prevent the transmission of HIV

- Engagement of community structures (e.g. champions, linkage-facilitator/peer-led models) and systems for client tracing, care, linkage referral, adherence support and follow-up
- Design models for men, adolescents, young adults and children to support identification, linkage, initiation, retention, and viral suppression
- Scale up community drug distribution points (CDDP) for

stable patients linked to health facilities

- Community empowerment including community ownership, community management, and community monitoring
- Strengthen treatment literacy using expert clients, networks of people living with HIV, VHTs, community structures as well as Community sensitization to reduce stigma, Gender Based Violence (GBV)
- Integrating eHealth into HIV-related disease self-management and service delivery especially using short message service (SMS) interventions to enhance ART adherence encourage paternal involvement in child care
- Functionalize linkage to programs such as housing, SACCOS and food security programs that tackle structural barriers to engagement in HIV care and treatment for poor HIV positive patients and their families to meet financial-specific needs associated transportation to clinic appointments, and food and nutritional supplements

2.2.3. Scale-up of Differentiated service delivery model (DSDM)

- Expansion of DSDM within district and health facility routine planning and supervision systems
- Expanding scope of DSDM delivery for the older people and PWDs
- Strengthening both facility and community structures for service delivery using expert clients, peer networks, lay counselors to support HIV status disclosure, adherence, retention (tracking missing clients) and viral suppression.
- Strengthening cross-border collaboration on HIV and TB epidemic control.
- Strengthen CSO/CBO/networks capacity to scale-up the implementation of differentiated model of care and service delivery in the community and to reduce stigma and discrimination
- Continuity in care especially across different incarceration points

SO 2.3 Increase the prevalence of VLS among HIV-diagnosed individuals on treatment to 95% by 2025

- Strengthen efforts to improve quality of care and patient safety
- Increasing the voice of users, and promote more governance inclusive of people living with HIV and accountability in ART delivery at district, facility and community levels
- Strengthening professional associations and regulatory councils to address private sector ART accreditation and service constraints
- Build skills and competence among health workers in management of 2nd and 3rd line ART
- Conduct drug resistance testing to optimize and provide 3rd line ART

2.3.1. Scale up the implementation of person-centred monitoring during ART

- Institute HIV pharmacovigilance for effectiveness and safety of ART
- Roll out unique identifiers while taking care of patient confidentiality
- Strengthen treatment monitoring and evaluation of clinical complications and effects of long-term use of antiretroviral drugs
- Screening and management of side effects of ART
- Expand psychosocial services with enhanced ART adherence support for men, young adults, children, older people and PWDs
- Strengthen treatment monitoring in communities at household level through peers/expert clients, community health workers (CHWs), networks and KPs.

2.3.2. Provide a comprehensive care package for management of co-morbidities and advanced HIV disease

- Integrate HIV and TB programming services at all levels including community DOTS, home-based care, intensified case detection and TB preventive therapy especially pyridoxine and isoniazid for eligible HIV positive people.

- Provide prevention and management services for OI, STIs and ART wrap around services in general outpatient and inpatient care
- Integrate nutrition assessment, counseling and support in HIV care and treatment services including use of Ready-to-use Therapeutic Foods (RUTF) for severely malnourished, and linkages to increase food security
- Integrate the management of advanced HIV disease, and co-morbidities such as mental illness, diabetes mellitus, hypertension, viral hepatitis, heart disease, malignancies etc. within HIV care and treatment service delivery appropriate for each level.
- Scale up implementation of service packages such as nutrition, sexual and reproductive health (SRH) and GBV in HIV care.
- Scale-up implementation of prevention and treatment of AIDS-related life-threatening opportunistic infections including cryptococcal meningitis.
- Scale up cervical cancer screening, HBV vaccination and treatment.
- Scale up effective pain management, palliative care and end-of-life care

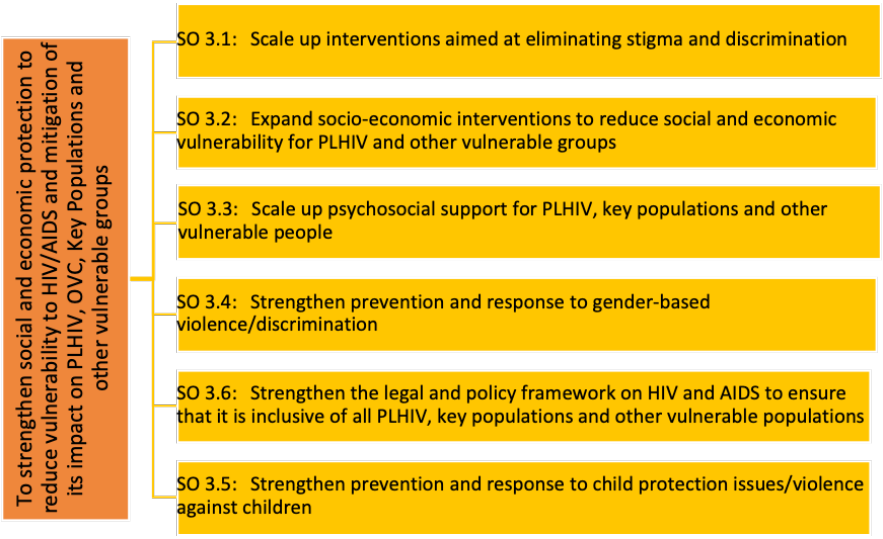
2.3.3. Strengthen quality and efficient laboratory and diagnostic services, HIV viral load testing, specimen referral expanding testing services and developing the health workforce

- Expand availability of POC especially CD4 cell count, EID and viral load testing
- Optimization of diagnostic network, encompassing both lab-based and decentralized testing
- Increase access to drug resistance monitoring
- Integration of diagnostic services with other diseases to create efficiencies
- Innovate technologies to improve turn-around time for viral load results
- Develop comprehensive HIV treatment and care, and waste management systems within the national medical waste

management
- Integrated platforms to support viral load testing for HIV and hepatitis B and C viruses starting with key populations

5.3 Social Support and Protection

Sub-goal and strategic objectives



Strategic Actions for each Objective under Social Support and Protection:

SO 3.1 Scale up interventions aimed at eliminating stigma and discrimination

3.1.1. Prioritize approval, operationalization and dissemination of the National Anti-HIV and AIDS Stigma and Discrimination Policy.

3.1.2. Scale up targeted messages and community education to engender comprehensive knowledge of HIV and AIDS-related stigma and to transform norms and values in order to eliminate social stigma and discrimination against people living with HIV, including PWDs, KPs and other vulnerable groups

3.1.3. Systematic implementation and monitoring of policies and interventions to address workplace and institutional stigma

and discrimination

3.1.4. Prioritize empowerment programs to reduce internal stigma for people living with HIV, Key Populations and other vulnerable populations and promote positive health living including life skills training

3.1.5. Develop, implement and sustain a country-wide, multi-media programme to address HIV-related stigma, discrimination and violence, including specific components for KP and KVP

3.1.6. Prioritise implementation of the recommendations of the 2019 HIV-stigma index survey and conduct a follow up National Stigma Index Survey in 2022 to inform policy, response mechanism and practice change

3.1.7. Build the capacity and engage religious, cultural and community leaders to address and reduce HIV related stigma, discrimination and violence in communities and to improve uptake and retention in services. This should include reviewing,evaluating and disseminating, existing guidelines for engagement of religious, cultural and community leaders in addressing HIV related stigma and discrimination in all its forms.

3.1.8. Strengthen engagement with school going children, teachers and other education stakeholders to address stigma and discrimination in schools and other education settings.

3.1.9. Strengnthen community led structures, organisations and networks to effectively engage out of school youth and young people to address stigma.

3.1.10. Sustain efforts to train health and social service workers in adoption of anti-oppressive, gender responsive human rights based service delivery approaches that addresses anti-stigma and anti-discriminatory practices, behaviours and attitudes and enforce strict mechanisms for monitoring and reporting of stigma and discrimination

SO 3.2 Expand socio-economic interventions aimed at reducing social and economic vulnerability for people living with HIV and other vulnerable groups

3.2.1. Prioritise interventions that enhance the socio-economic status

of households and individuals infected, affected, or at high risk of HIV acquisition

3.2.2. Institutionalize specific forms of affirmative action, including direct targeting approaches that assure access to existing social protection/ social assistance programmes for people at high risk of and those living with HIV including women, AGYW, PWDs and OVC.

3.2.3. Scale up targeted interventions to improve nutrition and household food safety for people living with HIV, children aged under 5, AGYW, pregnant, PWDs and lactating women and other vulnerable households

3.2.4. Mainstream social support for people living with HIV, HIV-affected populations and at high risk population into existing government social development programmes

3.2.5. Address socio-cultural, socio-religious and institutional barriers that deter people living with HIV, OVC, PWDs, KPs, priority populations and young people from accessing services in health and other development programmes

3.2.6. Support community led structures, organisations and networks to structural barriers that deter PLHIV and other vulnerable groups from accessing services.

3.2.7. Prioritize gender responsive interventions at community level by identifying gender-specific needs for women, girls, boys, men and PWDs that address their vulnerability to HIV and AIDS

3.2.8. Prioritise interventions that increase access to affordable and inclusive formal and non-formal education in order to reduce young people's socio-economic vulnerability

SO 3.3 Scale up psychosocial support for people living with HIV, PWDs, key and priority populations and other vulnerable people

3.3.1. Strengthen mechanisms and structures to enhance social capital and networks for social support at the community levels.

3.3.2. Scale-up interventions that integrate mental health support into HIV services at health facilities and especially in communities.

3.3.3. Expand both facility and community based counseling services for people living with HIV and other vulnerable groups

3.3.4. Re-define and monitor the implementation of a comprehensive package for psychosocial support and protection of people living with HIV, KP, PWD, youths and OVC (ensure context, age & gender sensitivity)

3.3.5. Strengthen networks, groups and associations of people living with HIV at all levels

3.3.6. Scale up and sustain psycho-social and socio-economic interventions among PWD, OVC, key and priority populations and other vulnerable groups.

3.3.7. Expand the network of quality drop in centres for key and priority populations to provide safe spaces for psycho social support and other critical services

SO 3.4 Strengthen prevention and response to sexual and gender-based discrimination and violence

3.4.1. Address discriminatory harmful gender norms and expand programs that reduce HIV-related gender discrimination, PWDs, violence against women and girls, KPs and other vulnerable people in all their diversity

3.4.2. Mobilize communities, policy-makers and other stakeholders on the importance of male participation / involvement in attaining positive outcomes in gender equality and addressing harmful gender norms

3.4.3. Strengthen and deepen community and social support systems in order to increase the scope of community based interventions that promote gender and social norm transformation and respond to structural drivers of SGBV and gender inequality, discrimination and violence against women and girls

3.4.4. Promote integration of GBV prevention interventions into exist at are inclusive of all forms of GBV and violence against children

SO 3.5 Strengthen prevention and response to child protection issues and Violence Against Children (VAC)

3.5.1. Strengthen community level child protection systems and structures to engender early identification, response and referral for child protection cases

3.5.2. Develop the capacity of child protection workers at the community and sub-national levels to prevent and appropriately respond to sexual violence against children

3.5.3. Develop and implement a national curriculum on case management in the context of HIV and sexual violence against children

3.5.4. Strengthen interventions to address child marriage and teenage pregnancies that increase vulneberability to HIV and AIDS in the community

Develop and adopt protocols and SOPs to strengthen interagency co-ordination between the health sector, the social work services, JLOS as well as the education sector for a more effective case management system for child protection

SO3.6 Strengthen the legal and policy framework on HIV and AIDS to ensure that it is inclusive of all PLHIV, PWDs, key and priority populations and other vulnerable groups

3.6.1. Support advocacy initiatves to revisit or repeal laws promoting mandatory HIV disclosure to make all health facilities stigma and discrimination free settings

3.6.2. Facilitate access to justice in relation to rights violations of people living with HIV, PWDs, KPs, priority populations and OVCs through strategic litigation and expansion of legal services.

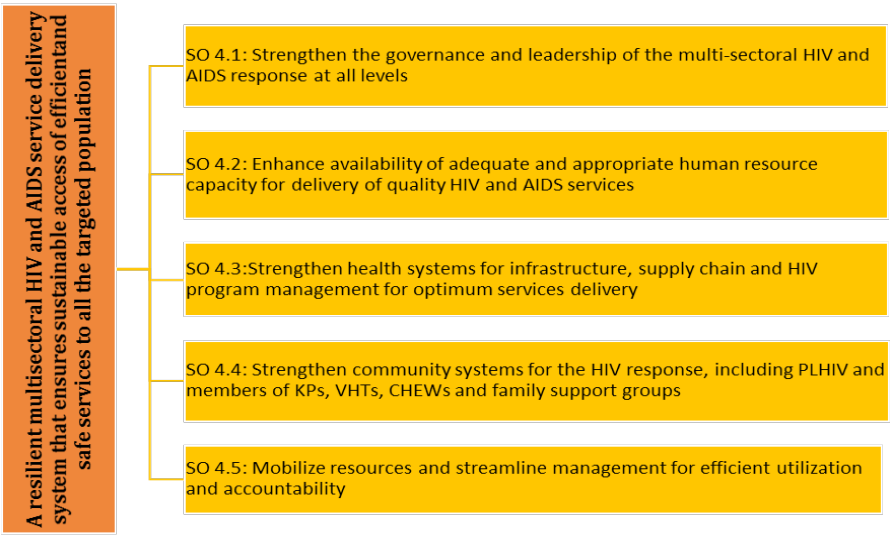
3.6.3. Expand provision of legal literacy, "Know your rights" campaigns among KPs, OVCs, PWDs and PLHIV through a cadre of peer human rights educators and paralegals.

3.6.4. Advocacy for reforms in laws and policies to decriminalize key populations to eliminate stigma and discrimination and other oppressive practices that impact access to services by key populations.

3.6.5. Scale up human rights education; legal support and protection of persons living with HIV and affected by it.

5.4 Systems Strengthening

Sub-goal and strategic objectives



Strategic Actions for each Objective under Systems Strengthening:

SO 4.1: Strengthen the governance and leadership of the multi-sectoral HIV and AIDS response at all levels

4.1.1. Build the capacity of political, cultural, religious and private sector leaders for more effective governance, leadership and participation in the multi-sectoral response to HIV and AIDS

4.1.2. Support key institutions, organizations, facilities and communities to develop strategic and operational plans aligned to the national multi-sectoral HIV and AIDS strategic plans

4.1.3. Mainstream HIV and AIDS, gender and human rights and the needs of people living with HIV, KPs and OVCs in socio-economic development programs of all MDAs, DLGs and the private sector

4.1.4. Review, amend or repeal existing laws, regulations, policies, byelaws, ordinances and guidelines relevant to HIV and AIDS, enact new ones and monitor their implementation

4.1.5. Strengthen the capacity of UAC, partnership mechanism and decentralized coordination structures to support the multi-sectoral HIV and AIDS response

4.1.6. Strengthen community[12] health and non-health systems in the multi-sectoral response to HIV and AIDS

SO 4.2: Enhance availability of adequate and appropriate human resource for delivery of quality HIV and AIDS services

4.2.1. Build the capacity of health facility staff and health workers at national, regional, district and lower levels for delivery and monitoring gender responsive quality HIV related services

4.2.2. Stregthen performance management of human resources for health at national, regional, district and community levels for quality HIV services

4.2.3. Enhance the human resource capacity of institutional and community led structures and networks at national, sub-national and lower levels.

SO 4.3: Strengthen health systems for infrastructure, supply chain and HIV program management for optimum service delivery

4.3.1. Procure new and and maintain existing equipment and all health infrastructure for optimal utilization and delivery of HIV services

4.3.2. Promote adherence to standards for medical waste management and disposal

4.3.3. Enhance national and sub-national capacity for the supply chain, with emphasis on quantification, procurement, storage and distribution of health commodities, cold chain infrastructures and waste management

4.3.4. Expand the roll out of e-LIMIS (LICS) from RRHs to lower level health facilities

4.3.5. Strengthen and expand digital infrastructure for telemedicine linkages between specialized HIV Care Centers and district hospitals and regional referral hospitals

SO 4.4 Strengthen community systems to support population groups including PLHIV and members of KPs for HIV services uptake

4.4.1. Expand community dialogues, outreaches, clubs, and other innovative platforms among priority and key populations for demand creation and mobilization for HIV services uptake

4.4.2. Strengthen capacity of cultural institutions to empower their communities to change negative social norms and address socio-cultural barriers to HIV services uptake

4.4.3. Support community-facility linkages for enhancing HIV services uptake through peer to peer initiatives and other community based/social networks among PLHIV and KPs

4.4.4. Support community led outreach campaigns targeting men and boys to address social cultural harmful gender norms and stereotypes and other human rights-related barriers to HIV services uptake

SO 4.5: Mobilize resources and streamline management for efficient utilization and accountability

4.5.1. Expedite the implementation of the AIDS Trust Fund for enhancing local resource mobilization

4.5.2. Support implementation of "One Dollar Initiative" with the private sector

4.5.3. Develop and disseminate appropriate tools for enhancing planning and resource allocation based on disease burden[13] at district/facility levels and continuum of response

4.5.4. Strengthen the public sector budgeting tools for facilitating the mainstreaming of HIV and AIDS at national and LG levels and in major development programs

4.5.5. Strengthen harmonized financial and programmatic accountability against set targets on a quarterly and annual basis by public and non-public partners

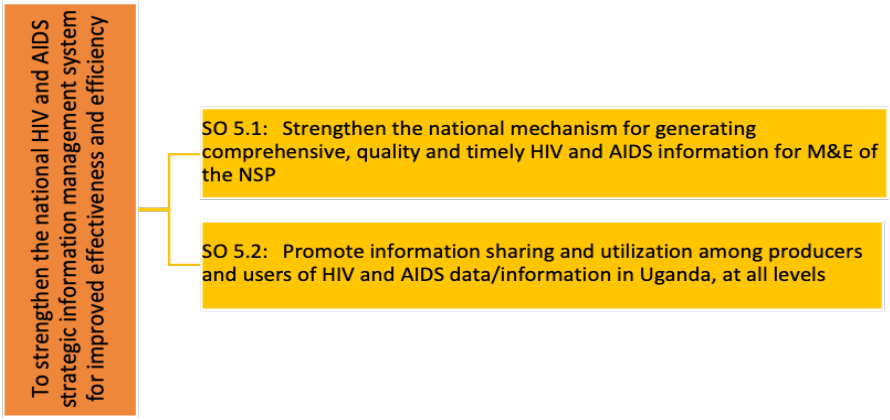
13 Community is a group, club, organization, association or network of people sharing common territories, interests and/or responsibility.

4.5.6. Support resource tracking mechanisms, including PFMA commitments and compliance for gender equity planning and annual cost effectiveness reviews to enhance monitoring the utilization and effectiveness of resources for HIV and AIDS in the country

4.5.7. Strengthen capacity of stakeholders at all levels, including community led organisations, for local and international resource mobilization and efficient management and accountability of resources for HIV and AIDS in the country

5.5 Monitoring, Evaluation and Research

Sub-goal and strategic objectives



Strategic Actions for each Objective under Monitoring, Evaluation and Research:

SO 5.1: Strengthen the national mechanism for generating comprehensive, quality and timely HIV and AIDS information for M&E of the NSP

5.1.1. Strengthen operationalization of NSP M&E Framework

- Institute a mechanism for monitoring MDAs with regard to the 0.1% budget allocation for HIV and AIDS mainstreaming as

per the MoFPED directive in the Budget Call Circular for FY 2018/19 to ensure effective integration and implementation of HIV and AIDS in their work plans.

- Institute a mechanism for monitoring the use of HIV and AIDS mainstreaming funds, AIDS Trust Fund and other funds allocated to HIV and AIDS.

5.1.2. Scale up the development of MDA and district HIV and AIDS Strategic Plans and M&E frameworks

- Expand capacity strengthening interventions in M&E for HIV and AIDS to more districts and CSOs in need of training
- Provide technical support to ministries to fully integrate the HIV and AIDS indicators in the performance monitoring tools for regular tracking of performance.
- Fast track finalization and rolling out of the situation room at a national and sub-national level. The situation room is an interactive software platform that pools data from different datasets and provides real time visual presentation of HIV data to the user for monitoring the multi sectoral response to the HIV epidemic.

5.1.3. Reinforce Routine M&E Activities

- Strengthen monitoring implementation of the developed MDA and district HIV and AIDS Strategic plans.
- Institute a sustainable mechanism to foster regular and timely reporting by ministries and SCEs. Consider reporting through OPM.
- Strengthen digital data capture mechanism for community led structures and networks for timely reporting.
- Institute a centralized data capture for all HIV and AIDS thematic areas beyond just care and treatment for easy to access data. UAC should develop centralized data management systems including developing tools for HIV and AIDS data collection and disseminating these tools to ADPs and local governments.
- Conduct regular multi-sectoral program reviews progress review meetings and national and district level focusing on achievements, challenges, lessons learnt and actions for

improvement.

- Perform regular data analysis, aggregation and reporting on NSP and SDG indicators.
- Produce the annual Joint AIDS Review Report and annually populate the NSP indicator tracking table.

5.1.4. Institutionalize multi-sectoral Regular Data Quality Assurance and Assessments

- Conduct regular data validation meetings at different levels; monthly at service provision point, quarterly at district, regional and national levels.
- Conduct quarterly participatory data quality assessments on sampled indicators and map trends of data quality to determine improvement.
- Develop national SOPs for HIV and AIDS data quality assessments and data validation for use all stakeholders involved.

SO 5.2: Promote information sharing and utilization among producers and users of HIV/ and AIDS data/information at all levels

5.2.1. Leverage digital technologies to expand data utilization at all levels

- Support electronic reporting of community HCT and patient tracking to improve real-time reporting
- Promote utilization of national KPI dashboards and granular data analysis to drive quality improvement
- Set up a national community score card monitoring dashboard to promote incorporation of community feedback in program design
- Strengthen point-of-care electronic reporting at all health facilities

5.2.2. Scale-up Data Use and Learning Events

- Expand the use of data dash boards for key NSP and SDG indicators including gender specific indicators and provide hands on capacity strengthening within Health Sector and across sectors and districts to visualize and share information.
- Institutionalize learning events at all levels and track

implementation of action points.

- Produce, translate and disseminate information dissemination products, customized for various life cycle categories and generate deeper discussions on the disseminated materials to allow asking of questions, raising fears and internalization of the content.

5.2.1. Undertake evaluative/periodic assessments and special studies

- Develop and disseminate the national research agenda to guide research for HIV response and commission operations research guided by the agenda to improve programming.
- Consolidate and synthesize conducted HIV and AIDS researches to make them more comprehensively informative and useful
- Institute a sustainable mechanism for regularly updating the National HIV dataset for research products
- Support implementation of in HIV research studies to inform evidence – based policies in areas social support and systems strengthening thematic which were least covered by HIV research studies conducted during the first half of the outgoing NSP
- As part of enhancing aggregation and centralized repository of HIV and AIDS research, NADIC should establish MoU with UNCST on sharing all HIV related researches and datasets conducted in the country. This involves MoUs with Uganda National Research Organization (UNRO) and Uganda Virus Research Institute (UVRI)
- Conduct NSP mid-term review and end-term evaluation and disseminate findings.
- Coordinate national and regional scientific fora to disseminate research findings including the 21st edition of the International Conference on AIDS and Sexually Transmitted Infections (ICASA 2021) planned for Dec 2021

6.0 NSP 2020/2021-2024/2025 CO-ORDINATION AND IMPLEMENTATION

6.1 Institutional Arrangements for Coordinating the Response

Uganda AIDS Commission

UAC is responsible for overseeing the implementation of the 'Three Ones' principle in the coordination of the national response i.e. One National AIDS Coordinating Authority, One Action Plan and One Monitoring and Evaluation Framework. Thus, UAC will disseminate the NSP and its accompanying documents (National M&E Plan, National Priority Action Plan, the Abridged Version of NSP and National Indicator Handbook); mobilize resources required for implementation; liaise with Sectors, Government Ministries, Departments and Agencies (MDAs), Local Governments and SCEs to ensure their active involvement in the implementation of the NSP; and oversee an effective management information system (MIS) to facilitate implementation. Where possible, UAC will offer technical guidance to sectors, local governments and civil society actors.

The UAC will expand and strengthen the established Zonal Coordination Units (ZCUs) that are responsible for coordination of the response at sub-national level. A zone is a cluster of districts located within a geographical area. The ZCUs are an extension of UAC to ensure closer HIV and AIDS planning, coordination and monitoring of the response.

HIV and AIDS Partnership Mechanism

In supporting the UAC in coordination, the HIV and AIDS Partnership Mechanism (PM) was established to minimize duplication; maximize potential for synergies, harmonization, learning and peer support; and pool efforts for scaling-up the response. The mechanism has four main components, namely, the Partnership Forum, Committee of Technical Experts (CTE), Self-coordinating Entities (SCEs) and Partnership Fund, with each structure playing a complementary and facilitating role to the others.

Currently, there are 10 SCEs namely, Parliament; Line Ministries; AIDS Development Partners (ADPs), Civil Society, Faith-Based

Organizations (FBOs), Networks of people living with HIV, Private sector, Research Academia Science and Professionals; Media and Culture. SCEs are representatives of constituencies that exist in the national response. These will be responsible for consultation of their constituencies for input into national policy development and strategic planning; representation of the members on national level for a; dissemination of national documents to their constituencies; monitoring and reporting about implementation by, members; capacity building for members; promoting, documentation and dissemination of best practices amongst other SCEs.

The Partnership Fund is a pooled source of funds from ADPs to support the operations of the PM. It is also supposed to reinforce the coordination capacity of UAC and SCEs in organizational development in addition to planning, monitoring and evaluating information and resources. It is envisaged that during the implementation of this NSP, the Partnership Fund will transition into a financing mechanism for mobilizing domestic resources for the response. Since inception of the PF, the contributors included; Irish Aid, DANIDA, PEPFAR, SIDA, UKaid, Italian Cooperation, French Government, Norwegian Cooperation and the Joint UN Programme Support for HIV and AIDS (JUPSA).

Government Ministries, Departments and Agencies (MDAs)

All sectors are important in the national HIV response. In general, MDAs are responsible for providing guidelines, setting standards and ensuring quality of service delivery, providing technical support, capacity building, resource mobilization, monitoring and evaluation of overall respective sector and MDA performance. Hence, every MDA is mandated to mainstream HIV and AIDS activities into their policies and programs. Therefore, the roles and responsibilities of each MDA include developing appropriate HIV and AIDS priority action plans with clear objectives, indicators and targets and integrating them into their annual investment plans and performance reporting system; allocating resources for implementation of the priority action plan, implementing and collecting information and reporting on their activities at the national, regional and/or district forum as may be

appropriate. Each sector, MDA and LG will also ensure that that there is a committed and capable HIV and AIDS Focal Person and a vibrant HIV and AIDS coordinating committee.

Local Governments

Local Governments (LGs) are responsible for provision of services, including HIV and AIDS related services. The LGs play the following roles but not limited to:

- Providing overall leadership, formulation of policies and guidelines to guide HIV and AIDS response
- Supervising and coordinating all implementing partners in the local governments
- Establishing and supporting the HIV and AIDS coordination structures in the local governments
- Planning, budgeting, coordinating and monitoring all HIV and AIDS activities in the local government
- Guiding HIV and AIDS mainstreaming in the LG programs ensuring that all NSP priorities are integrated appropriately
- Ensuring that resources are mobilized, allocated, utilized and accounted for in addressing LG HIV and AIDS activities
- Building strategic partnerships and networks for effective HIV response at the local level
- Appraising community HIV and AIDS programs and projects for quality assurance
- Ensuring that there is information documentation, reporting and dissemination
- Drawing bye-laws and ordinances to regulate activities that promote the prevention of HIV
- Promoting social support services in the local government

Civil Society Organizations and Communities

Civil society will play a leading role to:

- Participate in the processes of establishing and reviewing HIV and AIDS policies that are relevant to HIV prevention, AIDS care and support services, financing of programs, and of other structural challenges that constitute barriers to an effective response to HIV and AIDS.

- Apply digital technologies to enhance utilization of data from community score cards for quality improvement
- Conduct evidence-based advocacy at local and national levels aimed at holding accountable duty bearers for HIV prevention services, AIDS treatment, social support and protection for the most vulnerable communities.
- Strengthen collaboration and networking for effective linkages with other actors in the public and private sectors.
- Collaborate with stakeholders to conduct social mobilization for improved service uptake
- Strengthen collaboration and networking for effective linkages with other actors in the public and private sectors in reducing vulnerabilities and equity promotion.
- Spearhead efforts to build capacity of lower level community-based organizations to fulfill their roles in social mobilization, education and resources mobilization
- Complement government in the implementation of the NSP
- Self-regulation amongst members of civil society
- Regular reporting of HIV&AIDS activities undertaken

6.2 Implementation Arrangements for the NSP

UAC and HIV stakeholders have developed a National Priority Action Plan (NPAP). The NPAP articulates the priority activities that should be implemented by stakeholders for each of the strategic actions, spelling output results and timeframe for implementation. To the extent possible, the cascading of planning will go from national/sector level to the district, facility and MDA levels. Resource allocation will also be carried out up-front based on the output expected from each level of implementation. This performance-based planning will be reviewed at the annual Joint AIDS Review meeting.

The projections from the models will be revised annually based on the outcomes of the previous year. In this way, the iteration of planning, resource allocation and implementation will be carried out in order to ensure that the country is constantly checking its potential of achieving

the goals envisaged in the NSP and Investment Case.

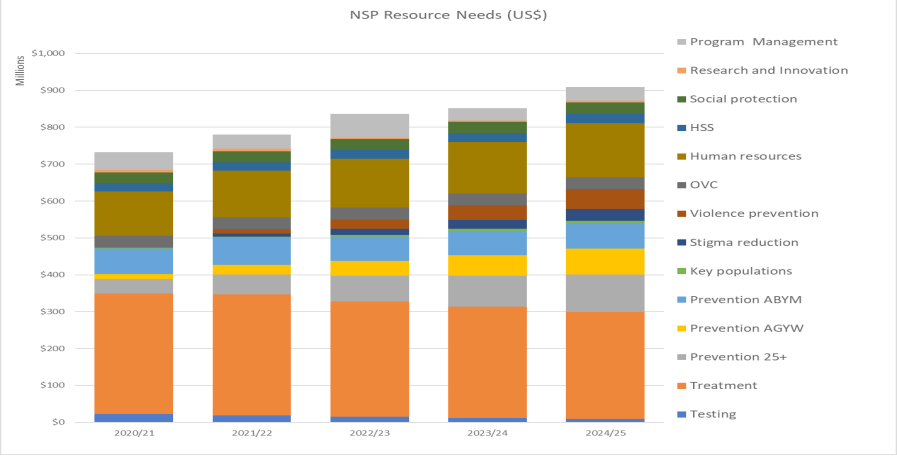
A National M&E Plan is in place to provide a framework for comprehensive data collection, aggregation, storage, reporting and dissemination. It also provides for data quality assurance for the generated data; routine monitoring and M&E technical support interventions; M&E capacity strengthening; operations research for program improvement as well as essential reviews and evaluations to gauge the achievement of NSP hierarchy of results (outputs, outcomes and impact). The NSP M&E plan provides guidance for enhanced information sharing and utilization at various levels for effective programming. The NSP M&E plan ultimately aims at ensuring that quality and timely HIV and AIDS information is generated to guide evidence-based decision making on programming, policy making and implementation to achieve better results. The NSP M&E Plan provides a basis for continuous learning and improvement of the NSP strategies. Furthermore, the NSP M&E plan provides a platform for the establishment of a community data management system that has hitherto been absent.

The data generated will feed into the National HIV and AIDS database at UAC which is linked to other national line ministry databases such as Prime Ministers Integrated Management Information System (PM - IMIS), HMIS, OVC MIS, EMIS and LOGICS. All stakeholders will be able to access aggregate system generated reports for information and use. The data generated will further enable Uganda as a country to meet her national and international reporting obligations. At the national level, UAC will use the M&E plan data to produce the Annual Uganda AIDS Status Report, Sector Annual Joint Review Reports, and Quarterly reports as well as HIV and AIDS statistical abstracts. The UAC will generate data for the Country Progress Reports as well as submit program performance reports to the OPM.

7.0 COST ESTIMATES AND ACCOUNTABILITY

The costs for each intervention are estimated as a product of the population in need of the service, the coverage of the services (the percentage actually using the service) and the unit costs of service. The unit cost of the services was assumed to remain fairly constant except for inflation.

Resources required for the NSP at Prioritized Scenario in US $ millions



The cost of the NSP raises from approximately US $ 735 million to US $ 908 million by the year 2024/25. Interventions under Care and Treatment account for a large proportion of the NSP with 40% followed by the Prevention for 25+ with 9%, and then interventions for the ABYM and AGYW estimated at 8% and 5% respectively. Large increases in funding will be required to expand programs to reduce stigma and violence against women.

The NSP resource requirement is estimated at US $ 4,109.7 million over the planned period.

Resource estimates for NSP 2020/2021 - 2024/2025

	2020/21	2021/22	2022/23	2023/24	2024/25	Totals
Violence prevention	0.326	12.443	25.398	39.214	53.945	131.327
OVC	32.000	32.000	32.000	32.000	32.000	160.000
Human resources	120.200	126.210	132.521	139.147	146.104	664.181
HSS	21.314	22.380	23.499	24.674	25.908	117.775
Social protection	30.430	30.430	30.430	30.430	30.430	152.152
Research and Innovation	6.890	7.114	3.407	3.922	5.185	26.517
Program Management	47.716	38.238	64.302	32.921	36.282	219.459
Totals	**732.534**	**780.314**	**836.033**	**851.559**	**908.726**	**4,109.165**

Financing of the NSP is primarily the responsibility of the GoU with support from the Development Partners. Matching the projected commitments with the NSP resource estimates will result into an overall funding deficit of 30% over the planned period.

Total commitment and funding gap

	2020/21	2021/22	2022/23	2023/24	2024/25	Totals
	US $ Millions					
NSP Annual estimates	732.53	780.31	836.03	851.56	908.73	4,109.16
Projected Commitments						
GoU	82.00	82.82	83.65	84.48	85.33	418.28
Development Partners						-
The USG- PEPFAR	402.20	405.20	406.22	410.28	414.39	2,038.29
Global Fund for ATM	89.65	99.89	99.65			289.20
DFID	TBD	TBD	TBD	TBD	TBD	-
UN Agencies	14.50	16.50	16.50	16.50	16.50	80.50
CHAI	1.17	1.22	1.29	1.29	1.29	6.25

	2020/21	2021/22	2022/23	2023/24	2024/25	Totals
KOICA	TBD	TBD	TBD	TBD	TBD	-
JICA	TBD	TBD	TBD	TBD	TBD	-
Total Commitments	589.52	605.64	607.31	512.55	517.50	2,832.53
Funding gap	143.01	174.68	228.72	339.00	391.22	1,276.64

Responsibility for financing this NSP requires contributions from GoU, Development Partners and non-state actors including the private sector, civil society and local communities. Hence, the principles of shared responsibility and global solidarity need to be upheld if the funding gap is to be narrowed and financial sustainability ensured. Thus, the NSP will be funded through two funding mechanism, namely, (i) GoU funding from both domestic revenues and, (ii) development partner support through the budget support. These are the main sources of funding for the health sector from which the NSP draws its resources. GoU has within the health sector budget, ring-fenced funds which are earmarked for the HIV medicines and supplies. The Uganda Investment Case proposes options for increasing local financing for HIV and AIDS including budgetary support and innovative local financial resource mobilization.

A major goal running through the NSP 2020/21-2025/2025 will be to emphasize transparency and accountability. All budgets across sectors and Government MDAs shall be presented with basic assumptions and unit costs clearly spelled out. Consortiums of government MDAs, CSO and local governments will be brought together from time to time depending on thematic areas for the national HIV response they handle to make workplans/proposals to be financed by monies raised against the plan utilizing the same level of detail and transparency. Under oversight of UAC, the MoH/ACP and other coordination focal points within sectors and MDAs will be available to support with monitoring, evaluation and accountability of all funds provided.

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