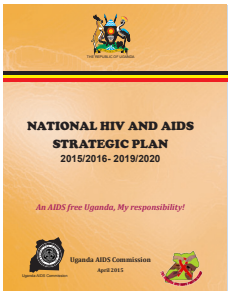
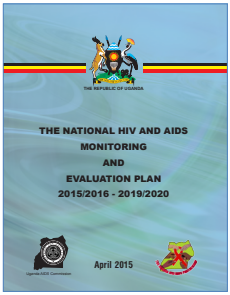
## An AIDS Free Uganda, My Responsibility: Documents For the National HIV and AIDS Response, 2015/2016 - 2019/2020



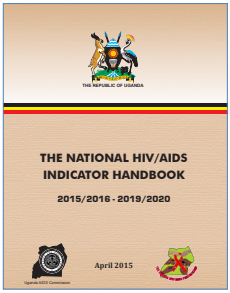

### NATIONAL HIV AND AIDS STRATEGIC PLAN 2015/2016 - 2019/2020

The guiding document for the Uganda National HIV and AIDS response during the coming five years. Developed in a participatory, consultative way, and intended for use by all stakeholders in Uganda's response to HIV and AIDS



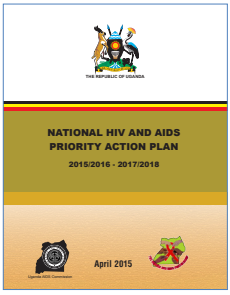

### NATIONAL HIV AND AIDS MONITORING AND EVALUATION PLAN 2015/2016 - 2019/2020

The guiding document for results and evidence based tracking and management of the Uganda National HIV and AIDS response during the coming five years. develop in a participatory, consultative way, and intended for use by all stakeholders in involved in producing, collecting, analyzing and using evidence about uganda's response to HIV and AIDS




### THE NATIONAL HIV AND AIDS INDICATOR HAND BOOK 2015/2016 - 2019/2020

A supporting document for results based tracking management of the Uganda National HIV and AIDS response during the coming five years. Developed for use by all stakeholders involved in producing, collecting, analyzing and using evidence about Uganda's response to HIV and AIDS.




### NATIONAL HIV AND AIDS PRIORITY ACTION PLAN 2015/2016 - 2017/2018

The National Priority Action Plan 2015/2016 - 2017/2018 (NPAP) is not a stand-alone document, but rather part and parcel of the National Strategic Plan 2015/2016 - 2019/2020 (NSP). The National Priority Action Plan details the implemention and priorities the activities within the first three years of the National Strategic Plan as part of guuidance for the different stakeholders.

This publication has been made possible by special support from the Government of Uganda , HIV and AIDS Partnership Fund and The Global Fund.

**Published by:** Uganda AIDS Commission



**Preferred Citation:** UAC (2015) National HIV and AIDS Strategic Plan 2015/2016- 2019/2020: An AIDS Free Uganda, My Responsibility! Uganda AIDS Commission, Republic of Uganda.

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# Acknowledgments

The Abridged Version of the National Strategic Plan 2015/2016—2019/2020(NSP) is a synthesis of the detailed National Strategic Plan for purposes of dissemination and quick reference. It particularly targets policy-makers at all levels to facilitate quick decision-making. Uganda AIDS Commission (UAC) would therefore like to take this opportunity to express its deep appreciation and sincere thanks to its key stakeholders including members of the Self Coordinating Entities (SCEs), UAC staff and all those who participated in the development of the National Strategic Plan and subsequently this Abridged Version.

The process of developing this National Strategic Plan was highly participatory involving key stakeholders and interest groups including communities of people living with HIV (PLHIV) at national and sub-national levels. The development process for the National Strategic Plan was mainly coordinated through the programmatic technical working groups (TWG) that met regularly in working sessions and workshops to provide their inputs and technical advice following the Mid-Term Review of the previous NSP 2011/2012-2014/2015. The TWGs were composed of representatives from all groups of stakeholders involved in the national HIV response: Civil Society Organizations (including People Living with HIV and AIDS), private sector partners, government agencies (Ministries, Departments and Agencies), decentralized units of government, Development Partners (UNAIDS, UNFPA, UNICEF, UN Women, WHO, US Government and the Global Fund) and last but not least the Ministry of Health.

Uganda AIDS Commission was the lead agency in coordinating the NSP 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 Limited 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 and support in the development of the new NSP, and above all for their invaluable and continuous contribution to the fight against HIV and AIDS.

**Dr. Christine J. D. Ondoa**
**DIRECTOR GENERAL**

# Acronyms

| | |
|---|---|
| AIS | AIDS Indicator Survey |
| ANC/PNC | Antenatal care / Post-natal care |
| ART | Antiretroviral Therapy |
| ARVs | Antiretroviral Drugs |
| CSOs | Civil Society Organisations |
| DDPs | District Development Plans |
| DOTS | Directly Observed Therapy, short course |
| EID | Early Infant Diagnosis |
| eMTCT | Elimination of Mother to Child Transmission |
| FBOs | Faith-Based Organisations |
| GBV | Gender-Based Violence |
| GBSV | Gender-Based & Sexual Violence |
| GOU | Government of Uganda |
| HC | Health Centre |
| HCT | HIV Counseling and Testing |
| IC | Investment Case |
| KP | Key Populations (at higher risk of HIV) |
| LG | Local Government |
| LTFU | Lost to Follow-Up |
| MDA | Ministries, Agencies and Departments |
| MARPs | Most At Risk Populations |
| M&E | Monitoring and Evaluation |
| MOH | Ministry of Health |
| MIS | Management Information System |
| MNCH | Maternal, Neonatal and Child Health |
| MSM | Men who have Sex with Men |
| MTCT | Mother to Child Transmission |
| NPA | National Planning Authority |
| NPAP | National Priority Action Plan |
| NPS | National HIV Prevention Strategy |

| | |
|---|---|
| NSP | National Strategic Plan |
| OVC | Orphans and other Vulnerable Children |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PHDP | Positive Health Dignity and Prevention |
| PIASCY | Presidential Initiative on AIDS Strategy for Communication to Youth |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of Mother to Child Transmission (of HIV) |
| PWDs | Persons with Disabilities |
| RUTF | Ready to Use Therapeutic Food |
| SCE | Self-Coordinating Entity |
| SRH | Sexual and Reproductive Health |
| STI | Sexually Transmitted Infection |
| TWG | Technical Working Group |
| UAC | Uganda AIDS Commission |
| WHO | World Health Organization |

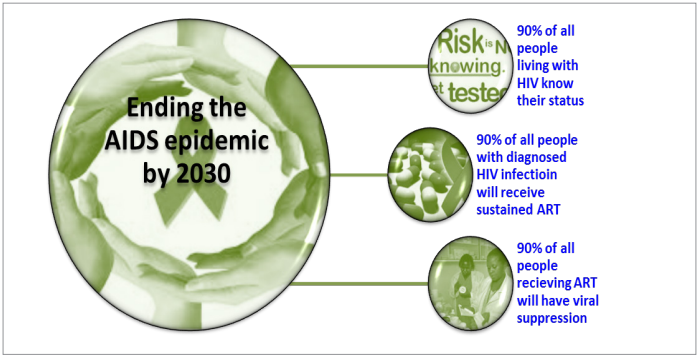
# Table of Contents

# 1.0 Introduction

The Uganda National Strategic Plan for HIV and AIDS (NSP) is the overarching document that guides all policy and program development for HIV and AIDS in the country. The current NSP replaces the NSP 2011/2012-2014/2015, during whose implementation a series of developments occurred in the HIV and AIDS response particularly in the area of prevention, care and treatment. A new NSP represents fresh thinking and innovative approaches all of which are necessary to stay ahead of the epidemic. Thus, the NSP represents Uganda's readiness in keeping up with the changing dynamics of the AIDS epidemic that require appropriate adjustments in the country's response. Additionally, new priority areas and focus shaped by the central agenda of the post 2015 Millennium Development Goals (MDGs) necessitate national re-alignment in policies and programs.

As part of its international commitment, Uganda is attuned to the global call to action that seeks Zero new HIV infections, Zero discrimination and Zero AIDS-related deaths. During the 69th United Nations General Assembly world leaders in collaboration with the Joint United Nations Programme on HIV and AIDS (UNAIDS) agreed that ending the AIDS epidemic by 2030 was possible.

### *The UNAIDS 2030 Goal*



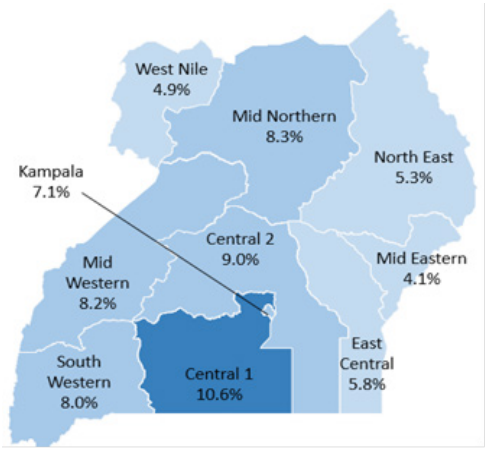
The NSP has, therefore, been aligned to contribute to global efforts to end the AIDS pandemic, particularly the United Nations post-2015 agenda that commits to ending the AIDS epidemic by 2030. This NSP represents Uganda's commitment to invest in impactful combination interventions to drastically reduce the number of new infections, in order to reach Zero new infections, Zero HIV and AIDS-related deaths and Zero discrimination.

Since the early 1990s, His Excellency the President of Uganda has spearheaded the national response to HIV through a multi-sectoral approach. This concerted effort reduced the prevalence of HIV from a national high of 18% between 1989 and 1992 to an average of 6.4% by 2005. In the course of implementation of NSP 2011/12—2014/15, the First Lady, Hon Janet Kataaha Museveni, became the national political champion for the Elimination of Mother to Child Transmission (eMTCT). The First Lady's involvement endeared the participation of other stakeholders including traditional and religious leaders. This new NSP ties up the achievements of the last NSP and drawing from lessons learnt provides a revised blue print for the country's HIV and AIDS response for NSP.

# 2.0 HIV and AIDS in Uganda: A Situational Analysis

*In Africa, Uganda is second to South Africa where 2363 get infected with HIV every week, compared to 468 for Kenya, 491 for Tanzania and only 25 for Rwanda, (UNAIDS 2013) Each week in Uganda, 570 young women aged 15-24 get infected with HIV.*

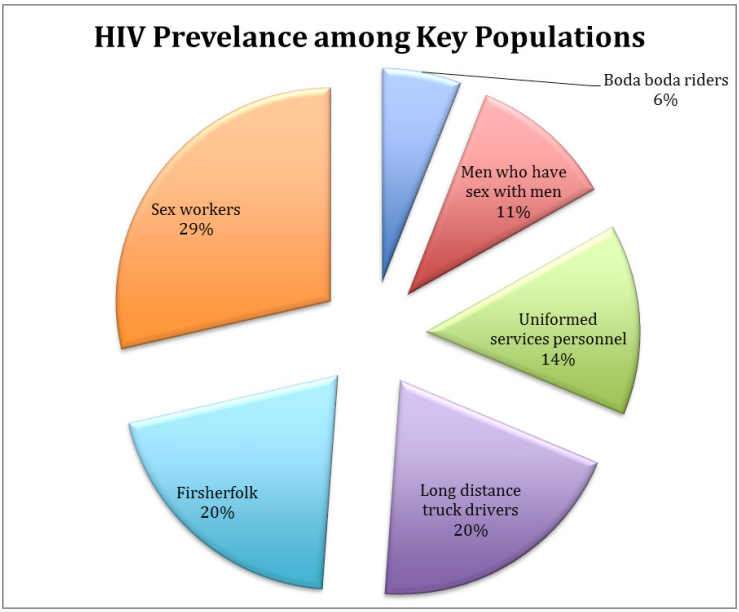
Although Uganda managed to reverse the high HIV prevalence rate from (18%) in the early 1990s, to 6.4% in 2005, the country has since 2011 witnessed a resurgence of the epidemic with HIV prevalence rising to 7.3% among adults aged 15-49 years (Uganda AIDS Indicator Survey 2011). HIV is predominantly higher in women (8.3%) and girls than men (6.1%). HIV prevalence is highest in the central region (10.4%) and lowest in West Nile region (4.3%)[1] (Map 1—**Uganda Sero-Survey, 2011**). Urban areas continue to post a higher prevalence rate (8.7%) than rural areas (7.0%).




Map 1: Prevalence of HIV by Regions in Uganda

HIV prevalence is especially higher among key populations (KPs) or Most at Risk Populations (MARPs).

[1] *MoH (2011). Uganda AIDS Indicator Survey 2011. Ministry of Health. Kampala.*




## Within the East African region Uganda has the highest HIV prevalence rate

### Table 1: HIV Prevalence in East Africa

| Country | Population (millions) | HIV Prevalence (%) |
|---|---|---|
| Burundi | 8.8 | 1.1 |
| Kenya | 41.0 | 6 |
| Rwanda | 11 | 2.9 |
| Tanzania | 47.1 | 5.3 |
| Uganda | 35.6 | 7.3 |
| EA | 143.5 | 4.5 |

## Key factors responsible for new HIV infections in Uganda

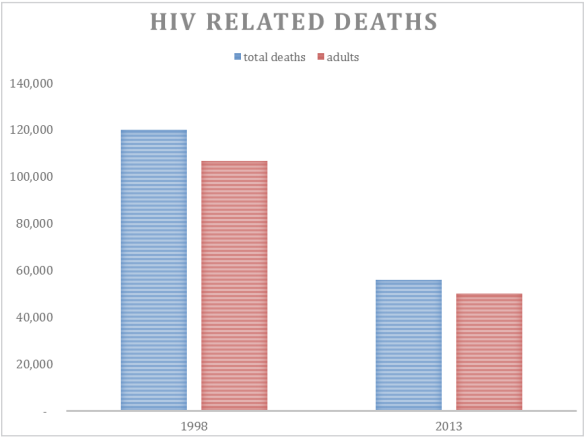
Drivers of HIV refer to factors that cause or explain the status of HIV incidence in a particular area. In Uganda, high HIV incidence is attributed to:

- High risk sexual behaviors including early sexual debut, multiple sexual relationships, limited and inconsistent condom use
- Transactional, cross-generational and sex work;
- Low individual level risk perception
- Limited awareness about personal and/or partner HIV status;
- High sexually transmitted infection (STI) prevalence;
- Low utilization of antenatal care (ANC) and delivery services;
- Low uptake of safe male circumcision (SMC) services;
- Sub-optimal scale-up of ART;
- Structural factors related to issues such as inequitable access to health services, governance, accountability, human rights, coordination, stigma and discrimination and,
- Gender inequalities including gender-based violence (GBV) exacerbated by alcohol drinking.

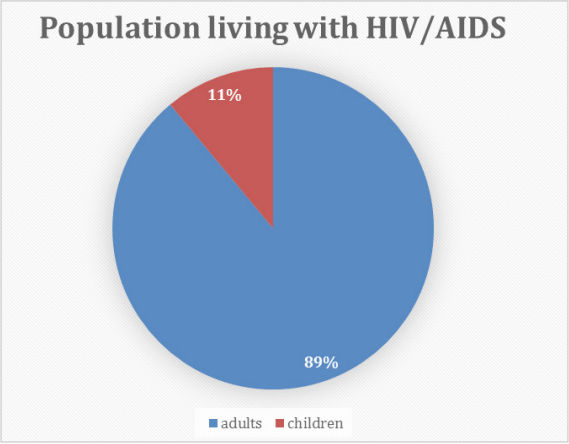
## HIV-related Mortality: Uganda has attained a Tipping Point

In Uganda, HIV-related mortality is declining, largely due to increased enrolment of eligible HIV-positive individuals on ART. In 2013, the number of people enrolled on ART exceeded the number of new infections, marking what epidemiologists refer to as a **"*Tipping Point*"** in the national treatment program. In Uganda, this ratio was 3.12 in 2011/12 and declined to 0.76 in 2012/13. Between 1990 and 2012, it is estimated that 1,973,000 people died of AIDS-related causes. However, there has been a sustained decline in HIV and AIDS deaths from 120,000 in 1998

to 56,000 in 2013 with 80.9% of such deaths occurring among adults (15+ years of age).




An estimated 1.6 million people in Uganda are living with HIV and AIDS, and of these, 176,948 are children (MOH 2014).




Although the country continues to experience a high rate of new HIV infections, the trend over the last three years shows a decline; from an estimated 162,294 in 2011 and 154,589 in 2012, to 137,000 in 2013. Declines in new HIV infections have

been more pronounced among children (<15 years); from 27,660 in 2011 to 15,411 in 2012; and further down to 8,000 in 2013. Overall, HIV incidence declined from 0.83% in 2009 to 0.77% in 2013. However,although pockets of high HIV incidence still exist among key populations such as the fisher-folk (UNAIDS 2013). High HIV incidence and prevalence among the key populations and the general population impact greatly on the socio-economic development of the country.

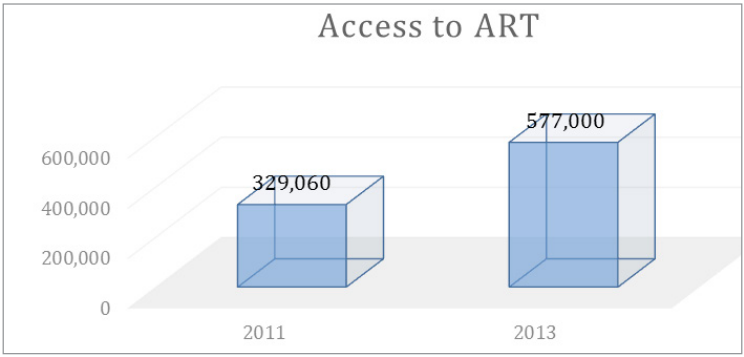
Thus, the impact of the HIV and AIDS epidemic on the country's economy and human development index is felt in many ways. Economic projections state that Uganda's Gross Domestic Product (GDP) would grow at an average rate of 6.5% per year between 2005 and 2025 if there were no AIDS, but this would be reduced to 5.3% under the "AIDS-without-ART" scenario, and by 2025 the economy will be 39% smaller than it would have been without AIDS, (UAC, Investment Case, 2014).

Without any interventions, Uganda's annual number of new HIV infections will rise from 140,000 in 2014 to 340,491 in 2025; resulting into a cumulative 2,890,569 new HIV infections by the year 2025 (UAC Investment Case, 2014). IC instead of UAC 2014

## Summary of Achievements in the Response

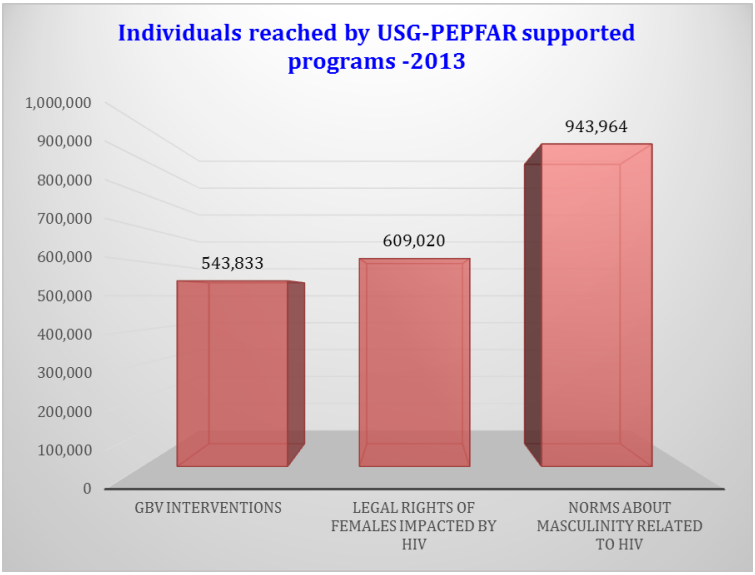
During the implementation of NSP 2011/12—2014/15 impressive strides were made in promoting Combination Prevention Interventions (CPI), which involves biomedical, behavioural and structural interventions. Specifically, there was increased comprehensive knowledge about HIV and AIDS, increase in SMC, and increased access to HCT to 66% and 45% for women and men respectively, initiation of moonlight HCT for sex workers, rolling out PMTCT Option B+ countrywide; thus more than half of the pregnant HIV positive women receive ARV treatment for life. Uganda reached a programmatic tipping point in the course of NSP 2011/2012—2014/2015 implementation.

**HIV related mortality started declining due to increased access to ART.**




Access to ART increased as the number of individuals accessing ART based on the 2010 WHO Treatment Guidelines, increased from 329,060 (57% coverage) to 577,000 (76.5%) between September 2011 and September 2013, with children comprising 8%. Treatment coverage among eligible children currently stands at 41% compared to 28,107 in June 2012 (28% eligible). Retention on ART is 86%, surpassing the target of 85% (HIV and AIDS Sector Issues Paper for the National Development Plan (NDP) II 2015/2016- 2019/2020)

By the 2014, there was a noticeable reduction in the proportion of PLHIV that reported cases of sexual gender-based violence (SGBV) from 39% to 25%. In 2013, USG- PEPFAR supported programs reached 543,833 individuals with interventions that explicitly addressed GBV; 609,020 individuals with interventions and services that addressed legal rights and protection of women and girls impacted by HIV; and 943,964 individuals with interventions that explicitly addressed norms about masculinity related to HIV.




The GOU demonstrated its commitment to fight against HIV and AIDS through increasing domestic budgetary allocations for HIV and AIDS. In the period between 2007/08 and 2011/12, GOU's contribution tripled from $14m to $53m. Bilateral contributions accounted for 93% of the AIDS external funding between 2007/08 and 2011/12 while multi-lateral sources accounted for about 7%. The response is also funded by private out-of-pocket sources estimated at 21% indicating that Ugandan households contribute a substantial amount towards the national response.

**Outstanding Challenges during the implementation of NSP 2011/12—2014/15, as identified in the NSP Mid-Term Review (UAC, 2014)**

| Prevention | Care and Treatment | Social Support and Protection | Infrastructure, Governance and Leadership | Monitoring and Evaluation | Financing and Costing |
|---|---|---|---|---|---|
| Prevention interventions were implemented separately and not in combination<br>Structural and environmental barriers undermine access to prevention services by key populations<br>Condom use is declining partly related to stock-outs.<br>Proportion of Ugandans with comprehensive knowledge of HIV remains low.<br>The vulnerability of young women is not improving.<br>Behavioral disinhibitions and fatigue | Persistent disparities in sex, age and geographical ART coverage. Only 41% of the estimated 107,000 children eligible for ART in 2013 have access to paediatric ART due to limited capacity in many facilities especially the peripheral units,in addition, to suffering from frequent stock-outs and loss to follow up. | High levels of stigma and discrimination among PLHIV and in the wider community.<br>Limited funding for nutrition and food security related activities for PLHIV and OVC.<br>Poor access to credit, loans or inputs by PLHIV and OVC due to stringent qualification procedures.<br>HIV Prevention and Control Act 2014 likely to undermine access to HIV prevention, treatment, care and support services due to the escalated stigma and fear to disclose status by those affected (HIV Prevention and Control Act, Clauses 13, 14, 18(e) and 41). | The capacity of UAC to coordinate the national multi-sectoral HIV and AIDS response is undermined by limited understanding and adoption of existing policy guidelines and legal instruments.<br>Management and coordination of the response was weak due to lack or limited capacity of functional HIV structures and systems to supervise the district HIV response | Lack of a comprehensive national reporting mechanism that captures biomedical and behavioral/ structural data (non-biomedical) on HIV and AIDS interventions from all actors.<br>Limited popularization of the M&E Plan due to little awareness about the reporting systems, tools and timelines.<br>Insufficient tracking of the National HIV and AIDS M&E Plan indicators with the indicator performance table not being routinely populated.<br>Limited gender-based analysis and reporting. | Late release of funds from central government to the local government, while at the same time the Treasury requires all accounts to cease operation at the end of the financial year.<br>External funding such as the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) had its challenges with predictability of inflow.<br>The shift to commoditisation has resulted into less resources for program activities. |

# 3.0 The Strategic Plan 2015/16-2019/20

In the next five years, Uganda seeks to accelerate scaling-up of combination prevention interventions to achieve the NSP targets, in particular:

- Combining the potential of ART to prevent new HIV infections with other proven HIV prevention methods such as male and female condoms,
- Sustaining voluntary medical male circumcision,
- Taking firm steps to reduce stigma and discrimination to zero,
- Pursuing non-discriminatory and criminalizing approaches to key populations,
- Increasing access to sexual and reproductive health services and innovative social support and protection measures.

The fruition of the targets will require more government commitment and tough decisions being made at multiple level—political, technical and operational. It also calls for innovative strategies to raise the financing required to fund the national response, which is currently underfunded and heavily donor dependent.

**Vision:** ***"A Healthy and Productive Population free of HIV and AIDS and its effects".*** The Vision of NSP 2015/16—2019/20 builds upon the Vision of NSP 2011/12—2014/15, 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".

**Goal of NSP 2015/16—2019/20: "*Towards zero new infections, zero HIV and AIDS-related mortality and morbidity and zero discrimination*"**

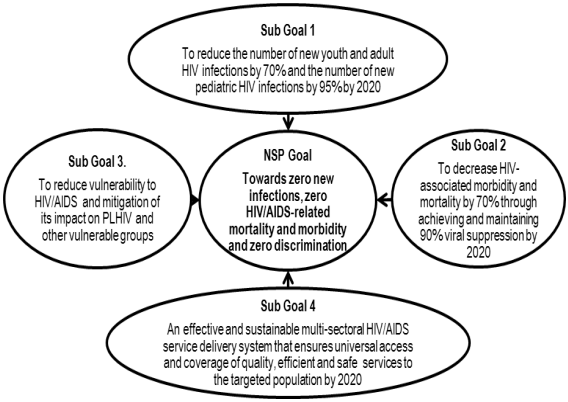
## NSP 2015/16—2019/20 Thematic Areas

The implementation of the NSP falls under four broad activity areas, also called thematic areas. All programming, funding, M&E focus on these four thematic areas.

- Prevention,
- Care and Treatment,
- Social Support and Protection, and
- Systems Strengthening[2].

[2]*The thematic area of Systems Strengthening includes governance, infrastructure, human resource, financing/resource mobilization, monitoring, evaluation and research.*

## Overall Goal and Sub-Goals of NSP 2015/16—2019/20




## General Outcomes of the NSP

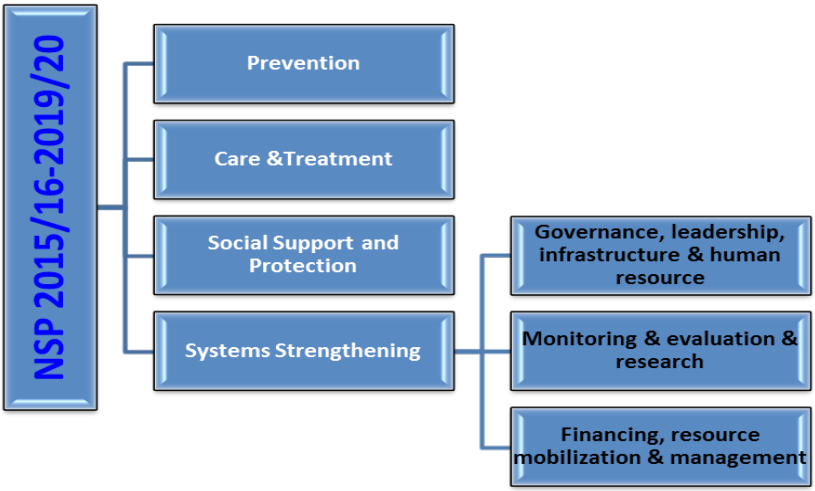
This NSP targets averting over 500,000 deaths and preventing 2 million infections by 2020.

General outcomes refer to the expected results that will be realized if the NSP meets its targets. Using the GOALS model in the Spectrum modeling system, it is projected that new annual infections will drop by 69% (from 134,562 in 2014 dropping to almost 60,000 by 2025). To achieve this, the NSP mid-term (2018) targets are 80% ART coverage, 50% HCT coverage, 50% condom coverage, 60% SMC coverage, 90% reduction in number of sexual partners and support for those infected. Roll out of the 2013 treatment will ensure the test and treat approach for all key populations, discordant couples, HIV positive pregnant women, TB/HIV co-infected, and HIV positive children below 15 years.

This NSP promotes scale-up of the combination prevention approach,strengthening health andcommunity systems and addressing critical enablers through strategic integration of HIV service with other health care and social programs, and enhancing rational resource allocation. The NSP advocates for reduced vulnerability of HIV and AIDS and sustainable multi-sectoral HIV delivery systems.

# 4.0 The NSP Thematic Areas, Strategic Objectives and Actions


## NSP Intervention Areas



## Prevention


The goal of the prevention thematic areas is to reduce the number of youth and adult infection by 70% and the number of new pediatric HIV infection by 95% by 2020. This target will be achievedby scaling up implementation of proven combination HIV prevention interventions over the next 5 years of the NSP.

**Prevention Thematic Goal**

Reduce the number of new youth and adult HIV infections by 70% and the number of new pediatric HIV infections by 95% by 2020

**Objective 1:**
To increase adoption of safer sexual behaviours and reduction in risky behaviours

**Objective 2**
To scale-up biomedical HIV prevention interventions delivered as part of integrated health care services

**Objective 3**
To mitigate underlying socio-cultural, gender and other factors that drive the HIV epidemic

## **Objective 1:** To Increase Adoption of Safer Sexual Behaviours and Reduction in Risky Behaviours

1. Scale-up age-and audience-appropriate social and behavioral change interventions including AB to reach all population groups with targeted HIV prevention messages
2. Strengthen policy guidance, quality assurance and capacity for effective IEC/social and behavioral change communication programming at all levels
3. Procure and distribute adequate numbers of male and female condoms (free and socially marketed condoms) and expand condom distribution across settings and at community level
4. Scale-up condom education (emphasizing correct and consistent use) to address complacency and fatigue associated to condom use
5. Integrate sexual and gender-based violence (SGBV) prevention and human rights into HIV prevention programming
6. Conduct mapping and size estimation for key populations to inform targeted and scaled-up interventions for key populations
7. Scale-up comprehensive sexual and reproductive health (SRH)/HIV programs targeting, adolescents (both in and out of school) and young people
8. Scale-up comprehensive interventions targeting key populations
9. Provide a comprehensive package of SRH, HIV prevention, care and treatment through harmonized programming and ensure access by vulnerable populations such as women and girls and persons with disability.
10. Expand programming for positive health, dignity and prevention (PHDP) interventions

11. Support and implement family centered approaches to prevent HIV infection

**Objective 2:** To Scale-Up Coverage and Utilization of Biomedical HIV Prevention Interventions Delivered as Part of Integrated Health Care Services

1. Expand coverage and uptake of biomedical priority HIV interventions (SMC, EMTCT, condom, ART) to optimal levels

2. Improve the quality of biomedical HIV prevention interventions through enhanced quality assurance (QA)/ quality control (QC) approaches

3. Scale-up coverage of HCT and increase linkage into HIV prevention care and treatment targeting the general population key populations and vulnerable groups especially in identified hotspot areas

4. Enhance test and treat programming for: pregnant women, HIV &TB co-infected persons, HIV-discordant couples, most-at-risk populations and children <15 years of age

5. Scale-up demand creation interventions to increase uptake of biomedical interventions

6. Expand targeted STI interventions for key populations and vulnerable groups

7. Integrate SRH; maternal, newborn and child health (MNCH) and TB services with HIV prevention

8. Expand standardized and targeted combination HIV prevention services for key populations

9. Adopt new HIV prevention technologies and services including Pre-Exposure Prophylaxis (PrEP)

10. Strengthen medical infection control and ensure universal precaution

11. Expand mechanisms to improve blood collection, storage and screening for HIV

12. Support research in primary prevention including microbicides and vaccines

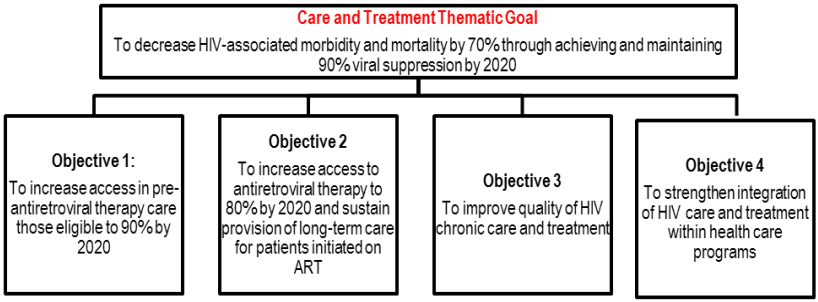
**Objective 3:** To mitigate underlying socio-cultural, gender and other factors that drive the HIV epidemic

1. Address socio-cultural and economic drivers of the epidemic through strategic engagement of the media, civil society organizations, religious, cultural, and political institutions in the HIV prevention effort
2. Strengthen legislative and policy framework for HIV prevention
3. Apply gender and human rights-based programming approaches for HIV prevention programs at national and lower levels
4. Strengthen capacity of health, legal and social service providers to manage SGBV cases
5. Promote male involvement in HIV prevention for their own health and the health of their partners and families
6. Strengthen efforts against stigma and discrimination
7. Utilize community extension work programs in the socio-economic sectors to deliver HIV programs

## Care and Treatment

Uganda seeks to decrease HIV associated morbidity and mortality by 70% through achieving and maintaining 90% viral suppression by 2020. To achieve this target, efforts will focus on increasing enrollment, early initiation, and better retention in chronic HIV care.

Below is a graphic representation of the specific objectives of the Care and Treatment thematic area.




## Strategic Objective 1: To Increase Access to Pre-Antiretroviral Therapy Care for those Eligible

### Strategic Actions

1. Strengthen mechanisms for linkage to care for all HI positive individuals
2. Increase HIV care entry points within health facilities, community, schools social/child protection and workplaces for HIV exposed infants, children, adolescents and men
3. Strengthen community level follow-up and treatment support mechanisms for pre-ART and ART individuals (adults and children)
4. Scale-up implementation of prevention and treatment of AIDS-related life threatening opportunistic infections including cryptococcal meningitis

5. Promote universal access to the basic care package

**Strategic Objective 2:** To Increase Access to Antiretroviral Therapy to 80% and Sustain Provision of Chronic-Term Care for Patients Initiated on ART

**Strategic Actions**

2.2.1. Strengthen care and treatment referral within decentralized ART services with inclusion of community and home-based HIV treatment

1. Expand and consolidate pediatric and adolescent ART in all accredited ART sites
2. Supporting transitions between child-adolescent -adult care
3. Roll out "Test and Treat" interventions for HIV positive pregnant women, key populations, HIV/TB co-infected persons, HIV discordant couples, and children <15 years.
4. Strengthening early initiation into ART and adherence support services
5. Streamline "Nurse Driven' Care plus 3-4 monthly drug refills for patients who are stable on ART.

**Strategic Objective 3:** To improve quality of chronic HIV care and treatment

**Strategic Actions.**

2.4.1. Establish quality assurance and quality improvement activities at all HIV care and treatment sites

1. Define and implement integrated guidelines on community-based care, basic care package, linkages with social support structures, lost to follow up(LTFU) management and private sector care

2. Strengthen monitoring of chronic HIV care and treatment including scale-up of viral load monitoring and surveillance for drug resistance
3. Strengthen treatment monitoring and evaluation of clinical complications and effects of long-term use of antiretroviral drugs.
4. Promote universal access to the basic care package.

**Strategic Objective 4:** To strengthen integration of HIV care and treatment within health care programs

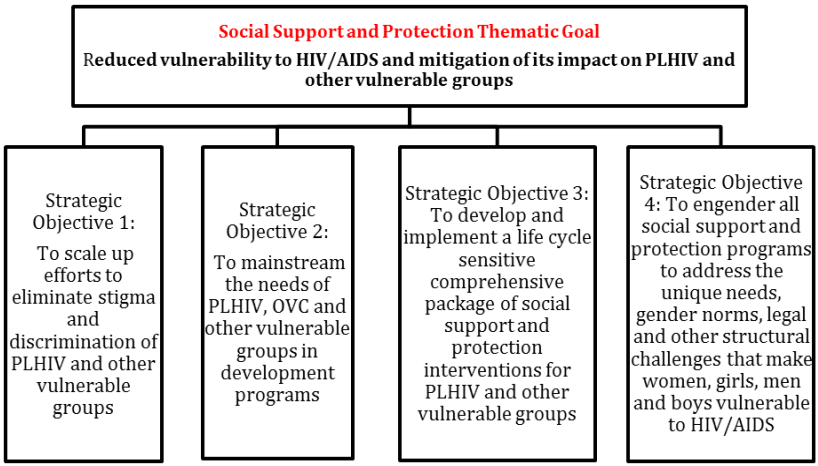
**Strategic Actions**

2.4.1 Fully integrate HIV/TB programming and services at all levels including community DOTS and home-based care

1. Integrate HIV care and treatment with maternal, newborn and child health, sexual and reproductive health and rights, mental health and non-communicable /chronic diseases
2. Provide prevention and management of OI, STIs and ART wrap around services in general outpatient and inpatient care
3. Integrate nutrition assessment, counseling and support in HIV care and treatment services including use of ready to use therapeutic food(RUTF) for severely malnourished, and linkages to increase food security.

## Social Support and Protection

In the next five years, the NSP will advocate for an increase in provision of promising interventions with the intention of reducing vulnerability to HIV and AIDS and mitigation of its impact on PLHIV and other vulnerable groups by, among others, scaling-up efforts to eliminate stigma and discrimination.




**Strategic Objective 1:** To scale up efforts to eliminate stigma and discrimination of PLHIV and other vulnerable groups

**Strategic Actions**.

1. Mobilize and strengthen cultural (including traditional healers) and religious institutions, community support systems and PLHIV Networks to address stigma
2. Strengthen interventions that empower PLHIV to deal with self-stigma
3. Conduct PLHIV Stigma Index assessment at least every two years

4. Implement campaigns to addresses stigma experienced in homes, communities and other institutions (schools, hospitals, workplaces and places of worship)

5. Design and implement interventions to eliminate discrimination against women and girls in the context of HIV and AIDS

6. Institute and strengthen anti-stigma and discrimination programs for key populations

**Strategic Objective 2:** To mainstream the needs of PLHIV, OVC and other vulnerable groups3 into other development programs

**3.2.0 Strategic Actions**.

1. Integrate PLHIV, OVC and other vulnerable groups' needs in development programming

2. Coordinate all sectors to fulfil and account for their mandate in relation to social support and social protection

3. Campaign for revision of harmful laws and policies that deter PLHIV, OVC, key populations and vulnerable groups from accessing social support and protection interventions

4. Integrate social support and protection issues in education sector programs (including school health and reading programs, PIASCY, curricular and extracurricular activities)

5. Implement targeted programmes that support PLHIV, OVC and other vulnerable groups to access livelihood opportunities, vocational skills training and informal education

[3]*Vulnerable persons include PWD, the elderly and key populations*

6. Expand social assistance grants to most vulnerable PLHIV, OVC and other vulnerable persons

7. Design and implement interventions that prioritize the key populations, elderly and PWDs in social support and protection services

**Strategic Objective 3:** To develop and implement a life cycle sensitive comprehensive package of social support and protection interventions for PLHIV and other vulnerable groups

**Strategic actions.**

3.3.1 Develop and promote a life cycle sensitive comprehensive package of social support and protection interventions for PLHIV,OVC, key populations and other vulnerable groups.

1. Develop and implement interventions to reduce the economic vulnerability of families and empower them to provide for the essential needs of children in their care

2. Develop and implement appropriate strategies to prevent and respond to child abuse and exploitation

3. Strengthen community-based structures to effectively respond to the needs of PLHIV, OVC and other vulnerable groups

4. Develop and implement interventions to strengthen the community facility linkage for responding to needs of PLHIV, OVC and other vulnerable groups

5. Build and scale- up capacity for quality counseling services for PLHIV, OVC, key populations and other vulnerable groups

**Strategic Objective 4:** To engender all social support and protection programs to address the unique needs, gender norms, legal and other structural challenges that make women, girls, men and boys vulnerable to HIV and AIDS

**Strategic Actions**

3.4.1 To support review, implementation and monitoring of legal and policy instruments that empowers women, girls, men and boys to access and utilize social support and protection services.

1. Strengthen institutions and sectors to implement laws and policies addressing SGBV and other rights violations among PLHIV, OVC, key populations and other vulnerable persons

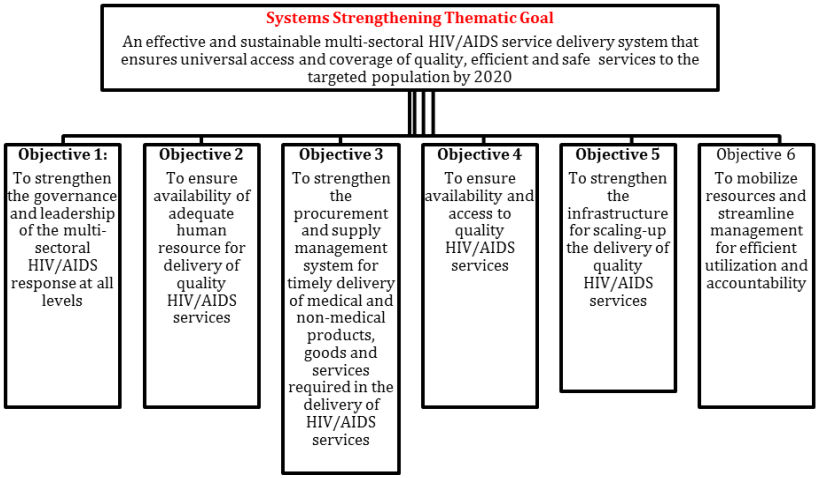
2. Enhance capacity of all actors engaged in the HIV and AIDS national response to adopt gender and rights-based HIV programming

3. Establish mechanisms for engaging men and boys in HIV/AIDS and SGBV programming

4. To build capacity of community groups and networks to address violence against women, girls, men and boys, and vulnerability to HIV and AIDS through social mobilization targeting cultural and religious structures.

## Systems Strengthening

In order to strengthen systems for timely and effective HIV prevention and AIDS care services, the NSP puts emphasis on an effective and sustainable multi-sector HIV and AIDS service delivery system. Such a system will ensure universal access and coverage of quality, efficient and safe service to targeted population by 2020.




## Objective 1: To strengthen the governance and leadership of the multi-sectoral HIV and AIDS response at all levels

### Strategic Actions

4.1.1 Strengthen the engagement of leaders (political, religious, cultural and technical) in the stewardship of the multi-sectoral response at all levels and key institutions, organizations, facilities and communities

1. Review, disseminate and monitor implementation of legal and policy related instruments for reducing structural barriers to national response
2. Strengthen the capacity of UAC and the partnership mechanism to carry out coordination of the multi-sector response.
3. Support the public and non-public sector coordinating structures to carry out their roles including gender and function better with improved linkages, networking and collaboration within and across sectors and at national, decentralized and community levels

4. Promote multi-sectoral planning at all levels with emphasis on target setting based on disease burden and continuum of response by geographical locations, facilities/institutions and key populations and that all plans are responsive and aligned to respective local government and/or sectoral plans
5. Ensure that gender, disability and human rights are mainstreamed in all major programmes in public and non-public sector.
6. Ensure implementation of EAC trans-boundary HIV and AIDS related legal and programmatic concerns as required by all partner states

**Objective 2:** To ensure availability of adequate human resource for delivery of quality HIV and AIDS services

**Strategic Action**

4.2.1 Review the policy and strategy for improving attraction, motivation and retention of staff involved in delivery of HIV and AIDS services in the health, non-health and community based services departments in both public and non-public sector

1. Harmonize pre- and in-service training of different cadres for HIV/ AIDS service provision
2. Ensure that HIV and AIDS is mainstreamed in the curriculum of Education Institutions at all levels
3. Advocate for revision of public service structures and institutionalize critical staff and positions at health facilities, line ministries, departments, agencies and districts
4. Build the leadership and management capacity of key workers and structures for enhancing implementation of the national and decentralized HIV and AIDS response.
5. Promote the implementation of the public private partnership in the delivery of HIV and AIDS services.

**Objective 3:** To strengthen the procurement and supply chain management system for timely delivery of medical and non-medical products, goods and services required in the delivery of HIV and AIDS services

**Strategic Action**

4.3.1 Institutionalize the QPPU and support capacity building in procurement and management of products, goods and supplies, particularly at lower level health facilities.

1. Strengthen the harmonization of procurement and supply chain management, and the expansion of operationalization of Web-based ARV ordering and Reporting System
2. Standardize the LMIS and build the requisite capacity in ICT and logistics management
3. Develop and implement a national comprehensive policy on storage, distribution of health commodities and supplies and waste management in public and non-public facilities
4. Build the capacity of CSOs and communities in procurement and supply chain management of both health and non-health goods and services that enhance uptake of HIV and AIDS services

**Objective 4:** To promote integrationand access to quality HIV and AIDS services

**Strategic Actions**

4.4.1 Promote integration of HIV and AIDS services in all settings and in major development programme service delivery

1. Build strong linkages between institutionalized facilities and community systems and ensure an effective referral system, greater adherence to treatment and improved monitoring of service delivery
2. Promote greater coordination, linkage, partnership and collaboration among public and non-public sectors

3. Strengthen capacity of CSOs and communities for increased advocacy and mobilization for demand and uptake of services, social participation, self-regulation and accountability in the multi-sectoral response.

**Objective 5:** To strengthen the infrastructure for scaling-up the delivery of quality HIV and AIDS services

**Strategic Actions**

4.5.1 Scale-up rehabilitation and building of new health and non-health infrastructure as well as improving management and maintenance of infrastructure for enhancing better HIV and AIDS related service delivery to different category of users


1. Expand availability and capacity of laboratories at different levels for delivery of HIV and AIDS services
2. Increase the accreditation of HC-IIIs and HC-IIs to provide comprehensive HIV and AIDS and TB services

**Objective 6:** To mobilize resources and streamline management for efficient utilization and accountability

**Strategic Actions**

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

1. Institutionalize a resource mobilization conference for facilitating advocacy for increased support by traditional and non-traditional bilateral and multilateral actors and the

private sector

2. Develop and disseminate appropriate tools for enhancing planning and resource allocation based on disease burden[4] at district/facility levels and continuum of response
3. Increase government allocation for HIV and AIDS
4. Strengthen the public sector budgeting tools for facilitating the mainstreaming of HIV and AIDS in public sector at national and local government levels and in major development programmes
5. Develop appropriate tools to strengthen harmonized financial (allocations, disbursements, expenditures) and programmatic accountability against set targets on a quarterly and annual basis by public and non-public partners
6. Establish a resource tracking mechanism and an annual cost effectiveness review to enhance monitoring the utilization and effectiveness of resources for HIV and AIDS in the country
7. Strengthen capacity of stakeholders at all levels for local and international resource mobilization and efficient management and accountability of resources for HIV and AIDS in the country

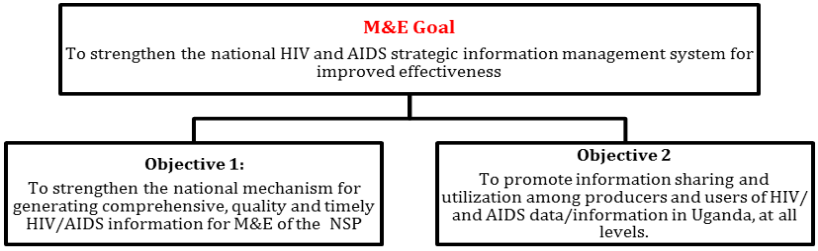
[4] *The disease burden parameters include prevalence, new infections, PLHIV, ART coverage, OVC, etc by district and/or facility and key populations*

## Resource Mobilization and Financing


The NSP provides for innovative ways of resource mobilization that seek to harness resources from the GOU, Development Partners and non-state actors including the private sector, civil society and local communities. Among the proposed options for increasing local financing for HIV and AIDS including budgetary support and innovative local financial resource mobilization. It is expected that the operationalization of the National AIDS Trust Fund and establishment of a National Health Insurance Scheme to operate concurrently with community and private commercial health insurance schemes will help bridge the financial gap in the response.

## Monitoring and Evaluation Plan for the NSP

The 2015/16-2019/20 NSP Monitoring and Evaluation (M&E) Plan will build on the NSP as part of the Three Ones to systematically track progress of implementation of priority initiatives and assess performance of stakeholders.



**Objective 1:** To strengthen the national mechanism for generating comprehensive, quality and timely HIV and AIDS information for M&E of the NSP

1. Operationalize of the HIV and AIDS M&E Plan.
2. Operationalize and roll out Knowlege platform/portal.
3. Improve mechanisms for capturing biomedical and non-biomedical HIV prevention data from all implementers
4. Enhance mechanisms for improving data quality.
5. Strengthen the M&E capacity of HIV and AIDS implementers.
6. Strengthen HIV and AIDS M&E coordination and networks.
7. Perform regular data analysis, aggregation and reporting

**Objective 2:** To promote information sharing and utilization among producers and users of HIV/ and AIDS data/information at all levels.

1. Produce and disseminate tailored HIV and AIDS information products.
2. Conduct and disseminate NSP reviews.
3. Conduct operations research guided by the national HIV and AIDS research agenda to improve programming.
4. Expand platforms for multi-sectoral program reviews and data utilisation at national, regional and district levels.

# 5.0 NSP Co-ordination and Implementation Arrangements

Spearheaded by the national HIV and AIDS secretariat i.e., UAC, implementation of the NSP is a multi-stakeholder activity. Effective implementation of the NSP therefore requires an efficient coordination mechanism that streamlines HIV and AIDS activities of Government Ministries, Departments and Agencies (MDAs), Districts and self-coordinating entities including civil society organisations (CSOs), the private sector, networks of PLHIV, development partners and the research community. In order to operationalize the NSP, under the stewardship of UAC, a National Priority Action Plan (NPAP) will be developed.

## Uganda AIDS Commission

UAC is responsible for overseeing the implementation of the 'Three Ones' principles in the coordination of a national response i.e. One National AIDS Coordinating Authority, One Action

Plan and One Monitoring and Evaluation Framework. Thus, UAC will disseminate the NSP including this Abridged Version, the NPAP and M&E Plan and mobilize resources required for implementation of the NSP. In addition, UAC will liaise with Sectors, Government Ministries, Departments and Agencies (MDAs), Districts SCEs to ensure their active involvement in the implementation of the NSP. Lastly, UAC will operationalize an effective information management system (IMS).

### Government Ministries, Departments and Agencies)


All sectors are important in the national HIV response. Hence, every MDA is mandated and required to mainstream HIV/ AIDS activities into their policies and programmes. The roles and responsibilities of each MDA will 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.

## CSOs and Communities of PLHIV

Civil Society Organizations are both providers and consumers of HIV prevention and AIDS care services. Their participation in HIV and AIDS services delivery and management will enhance acceptability and use by members. CSOs and networks of PLHIV will play a key role in ensuring access to prevention, and HIV care services for women and girls and key population groups.

## M&E of Implementation of the NSP

The NSP M&E Plan guides information sharing and utilization at various levels for effective programming. The NSP M&E Plan will ultimately aim at ensuring that quality and timely HIV and AIDS information is generated to guide decision-making. The NSP M&E Plan will provide a basis for continuous learning and improvement of the NSP strategies. The data generated by the M&E Plan will feed into the National HIV and AIDS database at UAC, which is linked, to other national line ministry databases such as NIMES, HMIS, OVC MIS, EMIS and LOGICS. All stakeholders will be able to access aggregate system generated reports for information and use.

# 6.0 Cost Estimates for Implementing NSP 2015/16-2019/20

- **US$3,786 Million** required to finance the period of the NSP (2015/16 to 2019/20)
- **US$2,868 million** projected resource inflow for the next five years (2019/20) expected from GOU and Partners
- **US $ 918 million** is the projected financing gap by the year 2019/20.
- **US $ 3.64bn** is the cumulative cost of cost for implementing the NSP by 2020; indicating an increase from US $ 546.9m in 2015/16 to US $ 918.9m.

## Financing of the NSP

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) donor support through the budget support. GOU has within the health sector budget ring-fenced funds, which are earmarked for the HIV medicines and supplies.