THE REPUBLIC OF UGANDA

NATIONAL HIV AND AIDS STRATEGIC PLAN

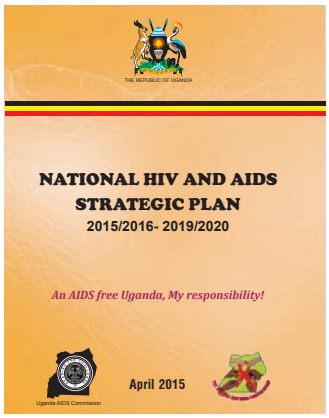
2015/2016- 2019/2020

An AIDS free Uganda, My responsibility!

Uganda AIDS Commission

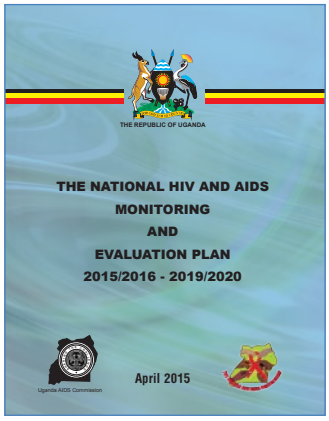
April 2015

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

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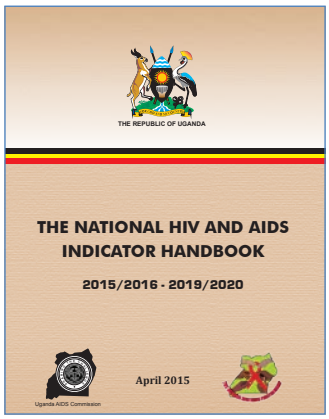
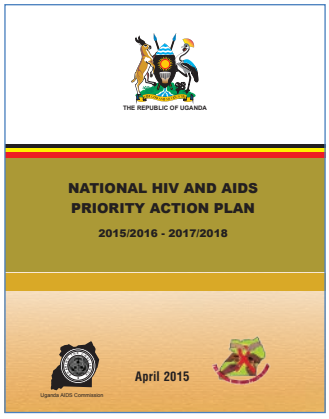


THE NATIONAL HIV AND AIDS INDICATOR HAND BOOK 2015/2016 - 2019/2020

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.

Available from:
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FOREWORD

In the early phase of the HIV epidemic, Uganda was hailed for successfully reducing the very high HIV prevalence rate (18%) in the 1990s down to 6.4% by 2005. These earlier gains in rapidly reducing new infections were, however, not sustained and HIV and AIDS remains a major public health challenge. Recently, the Government of Uganda took steps to re-invigorate the national HIV and AIDS response efforts through renewed engagement of the political leadership at all levels and strengthening the multi-sectoral efforts to curb the impact of the epidemic.

As part of its international commitment, Uganda is implementing several decisions and resolutions including the 2011 United Nations High Level Meeting on AIDS, where Member States adopted a Political Declaration on AIDS, providing a roadmap towards achieving the vision of 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 as a public threat by 2030 was possible and that member states must commit themselves to make this possible.

The HIV and AIDS epidemic in our country is now at crossroads with the number of new infections having appreciably declined as enrollment of patients on antiretroviral treatment increased. In 2013, Uganda reached a programmatic tipping point in the course of National HIV and AIDS Strategic Plan 2010/2011 - 2014/2015 implementation, whereby the number of new infections per year was less than the number beginning to receive Anti-Retroviral Therapy (ART). There are persistent disparities for example in ART coverage by sex, age and geographical reach and high levels of stigma and discrimination among people living with HIV and AIDS and in the wider community.

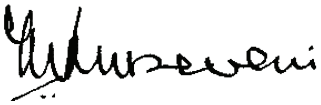
The impact of the HIV and AIDS epidemic on the country's economy and human development index is felt in many ways: on its Gross Domestic Product, its labor supply, productivity and savings/investment. Economic projections state Uganda's Gross Domestic Product would grow at an average rate of 6.5% per 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.

The overall goal of the National Strategic Plan is towards Zero new infections, Zero HIV and AIDS related mortality and morbidity, and Zero discrimination. The Plan has four sub goals: 1) reduce the number of new youth and adult HIV infections, 2) decrease HIV-associated morbidity and mortality, 3) reduce vulnerability to HIV and AIDS and mitigation of its impact on people living with HIV (PLHIV) and other vulnerable groups, 4) ensure an effective and sustainable multi-sectoral HIV and AIDS service delivery system that ensures universal access and coverage of quality, efficient and safe services. To accomplish these goals, we must commit to undertake a more coordinated national response to the epidemic.

Consequently the government will work towards a well-resourced multi-sectoral national response at all levels including private sector, communities, faith-based organizations, scientific community, People Living with HIV and others.

The government of Uganda leadership is dedicated to a strengthened response to HIV and AIDS and will increase the required resources to meet this goal. We look forward to working with development partners, communities and other stakeholders to support implementation of this innovative strategy that is grounded in scientific evidence, focuses on current priorities, and provides a clear direction for moving forward.

For God and My Country.



YOWERI K. MUSEVENI

PRESIDENT OF THE REPUBLIC OF UGANDA

PREFACE

The implementation of the National HIV and AIDS Strategic Plan 2010/11–2014/15 enabled the country to continue its progress towards universal access to HIV and AIDS services. The National HIV and AIDS Strategic Plan 2015/2016 –2019/2020 (NSP) will build on the previous efforts, pursuing the same objective, with inspiration from the global targets of "Zero new HIV infections, Zero HIV-related deaths and Zero stigma and discrimination due to HIV".

This National Strategic Plan has been aligned to the national laws and development frameworks. Uganda views HIV and AIDS and will continue to address it as a cross-cutting national development priority. The available national and international data has been used to ensure that this NSP is based on the most up to date understanding of the HIV and AIDS epidemic and the strategies proposed are based on proven evidence based interventions for Uganda and elsewhere.

The development of the National Strategic Plan was based on participation of all of the actors involved in addressing HIV and AIDS in Uganda: People Living with HIV and AIDS, communities, civil society organizations, government entities and development partners. As a result, we are confident that the strategies identified in the plan are those that are the most likely to achieve the results.

Cognizant of the current financial environment, we have prioritized the strategies and interventions presented in this National Strategic Plan based on estimated impact and cost effectiveness. This prioritization exercise required making pragmatic choices during the NSP development process and will undoubtedly continue to do so during the implementation period.

Government of Uganda will continue to prioritize and increase funding for HIV and AIDS interventions. I call upon every one of us to make HIV and AIDS a personal responsibility and rise to the challenge to combine the necessary individual and collective decisions in our drive towards universal access to HIV services

PROF. VINAND NANTULYA
CHAIRMAN, UGANDA AIDS COMMISSION

ACKNOWLEDGMENTS

Uganda AIDS Commission would like to take this opportunity to express its deep appreciation and sincere thanks to all who participated in the development of the National Strategic Plan.

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 NSP development process 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 National HIV and AIDS Strategic Plan 2010/11-2014/15. The TWGs were composed of representatives from all groups of stakeholders involved in the national HIV response: Civil Society Organizations (including PLHIV), private sector partners, government agencies (Ministries, Departments and Agencies), decentralized units of government, development partners (UNAIDS, UNFPA, UN Women, UNICEF, 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 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 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 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. CHRISTINE J.D ONDOA
DIRECTOR GENERAL

ACRONYMS

AHA	Anti-Homosexuality Act (2014)
ANC/PNC	Antenatal care / Post natal care
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
CD4 cells	T-lymphocyte cells with CD4 marker molecule
CSF	Civil Society Fund
CSOs	Civil Society Organisations
DACs	District AIDS Committees
DOTS	Directly Observed Therapy, Short course
DPs	Development Partners
EAC	East African Community
EID	Early Infant Diagnosis
eMTCT	Elimination of Mother to Child Transmission
FBOs	Faith-Based Organisations
FSW	Female Sex Workers
GBSV	Gender-Based & Sexual Violence
GOU	Government of Uganda
HBC	Home-Based Care
HCT	HIV Counseling and Testing
IC	Investment Case
KP	Key Populations (at higher risk of HIV)
LG	Local Government
LQAS	Lot Quality Assurance Survey
LTFU	Lost To Follow-Up
MDA	Ministries, Departments and Agencies
MARPs	Most At Risk Populations
MoGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
MoESTS	Ministry of Education, Science, Technology and Sports
MIS	Management Information System
MNCH	Maternal, Neonatal and Child Health
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
MTR	Mid-Term Review

NAFOPHANU	National Forum for PHA Networks in Uganda
NPAP	National Priority Action Plan
NPS	National HIV Prevention Strategy
NSP	National HIV and AIDS Strategic Plan 2015/2016-2019/2020
NTRL	National TB Reference Laboratory
NTLP	National TB and Leprosy Control Program
NUSAF	Northern Uganda Social Action Fund
OI	Opportunistic Infection
OPM	Office of the Prime Minister
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
PITC	Provider Initiated (HIV) Testing and Counseling
PLHIV	People Living with HIV
PM	artnership Mechanism
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PNFP	Private Not for Profit
PWDs	Persons with Disabilities
QPPU	Quantification and Procurement Planning Unit
RHU	Reproductive Health Uganda
RUTF	Ready to Use Therapeutic Food
SACCO	Savings and Credit Cooperative Organization
SALT	The Support on AIDS and Life through the Telephone
SCE	Self-Coordinating Entity
SEDC	Socio-Economic Data Centre
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Disease
TASO	The AIDS Support Organization
TB	Tuberculosis
TBD	To be Determined
TSR	Treatment Success Rate (for TB)
TWG	Technical Working Group

UAC	Uganda AIDS Commission
UBTS	Uganda Blood Transfusion Service
UHSBS	Uganda HIV and AIDS Sero-Behavioural Survey
UNAIDS	The Joint United Nations Program on HIV and AIDS
UNASO	Uganda Network of AIDS Service Organizations
UPDF	Uganda People's Defense Force
URCS	Uganda Red Cross Society
UVRI	Uganda Virus Research Institute
VHT	Village Health Team
WHO	World Health Organization
XDR-TB	Extremely Drug Resistant Tuberculosis

Executive Summary

Background and Approach

The National HIV and AIDS Strategic Plan 2011/12- 2014/15 was reviewed at Midterm—August/September 2014. Findings from the Mid-Term Review (MTR) were used to develop the National HIV and AIDS Strategic Plan (NSP) 2015/2016-2019/2020. Prioritization and costing for the new NSP was premised on similar assumptions as the Investment Case (IC) for HIV and AIDS 2015-2025. Both the NSP and the IC put emphasis on the need for priorities that are grounded in a solid understanding of country epidemiology as well as context. The process of developing this NSP was highly participatory involving key stakeholders and interest groups including communities of people living with HIV (PLHIV) at national and sub-national levels.

A Situational Analysis

In 2011, Uganda witnessed a resurgence of the HIV epidemic to a prevalence of 7.3% among the adult population implying a total sum of 1.6 million people who are living with HIV; 176,948 of these are children (MOH 2014). HIV is predominantly higher in women (8.3%) than men (6.1%). Three percent of adolescent girls 15-19 years live with HIV and prevalence doubles by the time they are 24 years. HIV prevalence among key populations (KPs) is comparatively higher than the general population. The trajectory of new infections stood at 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 has declined from 0.83% in 2009 to 0.77% in 2013, although pockets of high HIV incidence still exist among key populations. HIV-related mortality is declining, largely due to increased enrolment of eligible HIV-positive individuals on Anti-Retroviral Therapy (ART). The key drivers of HIV incidence in Uganda continue to revolve around: a) high risk sexual behaviors including early sexual debut, multiple sexual relationships, inconsistent condom use; and transactional sex b) low individual level risk perception c) high Sexually Transmitted Infections (STI) prevalence; d) low utilization of antenatal care (ANC) and delivery services; e) low uptake of Safe Male Circumcision (SMC) services; f) sub-optimal scale-up of ART; g) gender inequalities including Gender Based Violence.

Vision and Goal of NSP 2015/16—2019/20

The Vision of this NSP is "***A Healthy and Productive Population free of HIV and AIDS and its effects"*** while the Goal is "***Towards Zero new infections, Zero HIV and AIDS-related mortality and morbidity and Zero discrimination".*** To attain the goal of this NSP, it will be implemented under four thematic areas, namely, (i) Prevention, (ii) Care and Treatment, (iii) Social Support and Protection, and (iv) Systems Strengthening. The thematic area of Systems Strengthening includes governance, infrastructure, human resource, financing/ resource mobilization, monitoring, evaluation and research.

Strategic Objectives and Actions

Prevention: The Uganda IC makes a profound justification for scaling up coverage and utilization of critical HIV prevention interventions to reduce new HIV infections over the next ten years under a "feasible maximum scenario". To achieve the desired level of success, Uganda will need to scale up implementation of proven combination HIV prevention (biomedical, behavioral and structural with known efficacy in a geographical area at a scale, quality, and intensity to impact the epidemic) interventions to critical levels over the next 5 years of this NSP. 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.

Care and Treatment: The NSP in the next five years will target to increase enrollment, early initiation, and better retention in chronic HIV care. This is aimed to decrease HIV associated morbidity and mortality by 70% through achieving and maintaining 90% viral suppression by 2020.

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.

Systems Strengthening: In order to strengthen systems for timely and effective HIV prevention and AIDS care services, the NSP puts emphasis on having in place an effective and sustainable multi-sector service HIV and AIDS service delivery system that will ensure universal access and coverage of quality, efficient and safe service to targeted population by 2020. The National HIV and AIDS Monitoring and Evaluation (M&E) Plan 2015/2016-2019/2020 will build on the NSP as part of the three ones principle.

Resource Mobilization and Financing

GOU shoulders the responsibility of financing this NSP with contributions from Development Partners and non-state actors including the private sector, civil society and local communities. The Uganda Investment Case proposes options for increasing local financing for HIV and AIDS including budgetary support and innovative local financial resource mobilization. Operationalization of a National AIDS Trust Fund and establishment of a National Health Insurance Scheme to operate concurrently with community and private commercial health insurance schemes can help in bridging the financial gap in the response.

Co-ordination and Implementation Arrangements

In liaison with Government Ministries, Departments and Agencies (MDAs), Districts and self-coordinating entities including CSOs, the private sector, networks of PLHIV, development partners and the research community, UAC will ensure effective implementation of the NSP; and operationalize an effective monitoring and evaluation system to facilitate tracking and performance reporting. Every MDA is obligated to mainstream HIV and AIDS activities

into their policies and development programmes. Each sector and local government will also ensure that there is an HIV and AIDS Focal Person and an HIV and AIDS coordinating committee at institutional level.

Cost Estimates for Implementing NSP 2015/2016—2019/2020

The Cost for implementing the NSP will continue to grow in the next five years from US $ 546.9m in 2015/2016 to US $ 918.9m in 2019/2020. The period of the NSP (2015/2016 to 2019/2020) is projected to require a total of US $ 3,647.9 Million. Care and Treatment will accounts for 55% of the NSP resources, Prevention interventions will account for 23% while Social Support and System Strengthening will account for 4% and 18% respectively. This cost of NSP for the next five years is against a projected resource inflow of US 2,868 million from GOU and Partners, which leaves a projected financing gap amounting to US $ 918 million by the year 2019/2020.

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1.0 INTRODUCTION

1.1 Background

In 2011, Uganda AIDS Commission (UAC) developed the National Strategic Plan 2011/2012-2014/2015 to guide implementation of the multi-sectoral response and align key HIV and AIDS interventions to the key drivers of the epidemic and other key national development plans. The National HIV and AIDS Strategic Plan 2011/2012- 2014/2015, which was aligned to the National Development Plan (NDP) 2010/2011—2014/2015 provided the overall strategic direction for the national response under four broad thematic areas. The thematic areas included; (i) prevention, (ii) care and treatment, (iii) social support and protection, and (iv) systems strengthening.

To operationalize the National Strategic Plan 2011/2012- 2014/2015, UAC and partners developed a National Priority Action Plan (NPAP) 2011/2012—2012/2013 that articulated the key activities to be implemented by stakeholders for each of the strategic actions. The NPAP spells out output results, time frame for implementation and lead line sectors in the implementation of the strategic actions. The M&E plan for the NSP lays out a framework for tracking and evaluating the interventions that have been outlined in the National Strategic Plan while the M&E handbook is a guide for the user on the HIV and AIDS data management processes.

During the course of implementation, UAC developed Uganda Investment Case (IC) for HIV and AIDS 2015-2025 focusing on high-impact and high-value strategies. The Investment Case lays emphasis on the need for priorities that are grounded in a solid understanding of country epidemiology as well as context. It therefore calls for scaling up of evidence-informed activities among specific populations to reduce HIV transmission, morbidity and mortality. This NSP will, therefore, guide the national response in the first five years of the Investment Case whose lifespan is 10 years.

1.2 Justification for Developing New NSP

During the implementation of the National Strategic Plan 2011/2012- 2014/2015, a series of developments occurred in the HIV and AIDS response particularly in the area of prevention, care and treatment that were not envisaged in the NSP. The comprehensive Mid-Term Review (MTR) of the NSP carried out in August 2014 revealed noticeable progress in the implementation of the NSP, but also brought to the fore a number of gaps and challenges that required fresh thinking and planning. Thus, during the implementation of the National Strategic Plan 2011/2012- 2014/2015, the dynamics of the AIDS epidemic and its response needs kept on changing requiring reprogramming in the thematic areas. Additionally, new priority areas and focus shaped by the central agenda of the post 2015 Millennium Development Goals (MDGs) necessitate national replanning.

Thus, as part of its international commitment, Uganda as member of the international community is committed to implement several decisions and resolutions including the 2011 United Nations High Level Meeting on AIDS, where Member States adopted a Political Declaration on AIDS, providing a roadmap towards achieving the vision of 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 as a public threat by 2030 was possible and that member states must commit themselves to make this possible.

Looking ahead, there is an urgent need to invest in impactful combination interventions to drastically reduce the number of new infections, in order to reach Zero new infections, Zero discrimination and Zero HIV and AIDS-related deaths. This will require more governmental commitment and tough decisions being made at multiple levels - political, technical and operational. This includes funding the national response which is currently underfunded and heavily donor dependent. This is against a background that the total burden of HIV in Uganda has continued to increase due to the on-going spread of HIV, and increased longevity among PLHIV. Between 2007 and 2013, the estimated number of PLHIV increased from 1.2 million to 1.6 million. It is projected that annual new infections will grow from 140,000 in 2014 to 340,491 in 2025 resulting in a cumulative 2,890,569 new infections by 2025. Importantly, there is an urgent need to scale-up interventions to reduce new infections. The Investment Framework for which this NSP operationalizes offers a roadmap to maximizing the benefits of the HIV response through rational resource allocation for prioritized interventions, increased effectiveness and efficiencies in implementation of HIV prevention, treatment, care and support.

His Excellency the President of Uganda spearheaded the national response to HIV through a multi-sectoral approach adopted in 1993. As a result, the country was able to bring down the prevalence of HIV from a national peak of 18% between 1989 and 1992 to an average of 6.4% by 2005; which achievements have either stagnated or threatened to be reversed. In the course of implementation of National Strategic Plan 2011/2012- 2014/2015, the First Lady, Hon. Janet Kataaha Museveni, became the national political champion for the Elimination of Mother to Child Transmission (eMTCT). During the same period, the commitments of other stakeholders including traditional and religious leaders came to the fore. With this reinvigorated commitment, there is need to re-plan and build on what has been achieved to-date.

1.3 The National HIV and AIDS Strategic Plan 2015/2016-2019/2020 Development Process

The process of developing the NSP was highly consultative and participatory. The process entailed wider involvement of key stakeholders playing key roles in the national response. At national level, stakeholders were drawn from Parliament, MDAs, AIDS Development Partners (ADPs), private sector, PLHIV and civil society organizations (CSOs). Sixteen districts were selected for in-depth study from the ten operational regions used in the National AIDS Indicator Survey (NAIS) 2011 with each region being represented. Apart from regional representation, selection of districts took into consideration presence of referral hospitals, presence of partners, distinct characteristics such as status (new/old), fishing communities, on-going key programme support (e.g. PEPFAR,) those that are least served by HIV and AIDS actors; and districts with high prevalence of HIV and those with a low prevalence. *See Annex 1 for districts selected.*

Data for NSP was informed by both secondary and primary data that were collected for the Mid-Term Review of National HIV and AIDS Strategic Plan 2011/2012- 2014/2015 as elaborated below:

Desk review: Desk review of secondary data focused on key documents related to the national HIV and AIDS response. Some of the key documents consulted included the Uganda Investment Case (2014), Uganda Country AIDS Progress Report (2014), documents from line sectors such as Ministry of Health (MOH), Ministry of Gender, Labor and Social Development (MoGLSD), Ministry of Education, Science, Technology and Sports (MoESTS), program review reports, annual assessments conducted by Development Partners and other civil society organizations (CSOs) operating at the national level.

Meetings with technical working groups (TWGs): TWGs for each thematic area were constituted by UAC and comprised members from organizations involved in the implementation of the NSP. The terms of reference for TWGs included making technical input into the process, guiding the thematic consultants, and providing data on their respective organizations. This was in relation to the contribution they made to the national response, including achievements, challenges and shared their priorities for this NSP. The TWGs were constituted according to the Thematic Areas of the NSP including gender. The thematic areas were (i) HIV Prevention, (ii) Care and Treatment, (iii) Social Support and Protection, (iv) Gender, (v) Systems Strengthening focusing on Governance, Infrastructure, Human Resource and Financing, (vi) Monitoring and evaluation, and research, and (vii) Costing and Financing. Each Thematic MTR report has an annex on the members of TWG.

National level key informant interviews: Individual thematic consultants and their TWGs identified key informants at the national level who shared their experience regarding implementation of the NSP. Key informants were selected from key MDAs, representatives of ADPs supporting the national response, networks of PLHIV, young people, women activists, and key populations, non-governmental organizations (NGOs), CSOs, faith-based organizations (FBOs), cultural institutions and actors in the private sector.

District consultative meetings: UAC in liaison with District HIV and AIDS Focal Persons mobilized participants in district consultative meetings. These included Heads of Departments at district level and other key stakeholders involved in the implementation of NSP at sub-national level. The consultative meetings run for a half-day and were facilitated by the thematic Consultants.

Community and site visits: During the district meetings, thematic consultants with the help of district officials identified communities, health centres and other sites to assess achievements, gaps and challenges at a local level with regard to NSP implementation so as to inform priority areas for this NSP. Further, the aim of these meetings was to collect real life case stories including good practices and innovations in the national response at the lower level.

1.4 Management of the National HIV and AIDS Strategic Plan 2015/2016 - 2019/2020 Development Process

The development of this NSP followed the approval of the MTR Report by the 7th Annual Joint AIDS Review (JAR) of September 11th - 12th, 2014. The JAR discussed and refined, among others, the priority areas for this NSP 2015/2016—2019/2020, which are presented in Section 4.0. Further, the findings of the MTR together with the priority areas for this NSP were presented to the HIV and AIDS Parliamentary Standing Committee.

The process of developing this NSP was supervised and co-ordinated by UAC in close collaboration with the Partnership Committee (PC), which is constituted of representatives from Self-Coordinating Entities (SCEs). A Steering Committee (SC) was constituted to oversee the overall exercise and reported to the Partnership Committee (PC). The PC made input and provided guidance on the development process. TWGs that were constituted to provide input and guidance to the Consultants undertaking the MTR were retained to play the same role in the development of this NSP. Thus, TWGs provided technical input and reviewed the thematic area goal, strategic objectives and actions. The Draft NSP was validated by the Partnership Forum of October 14th-15th, 2014.

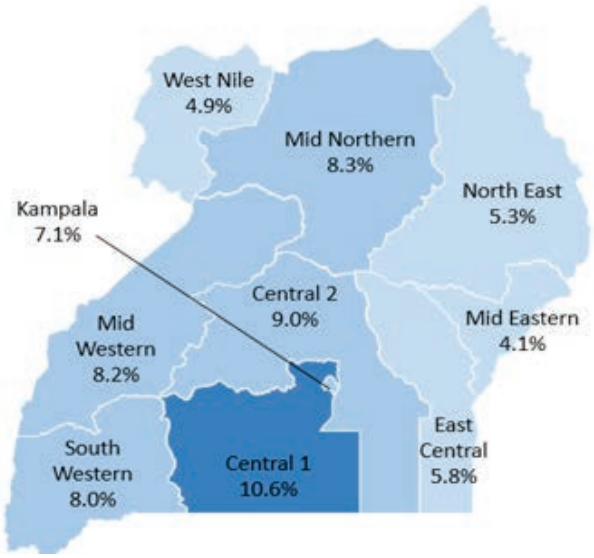
2.0 HIV AND AIDS SITUATION ANALYSIS

2.1 The HIV and AIDS Problem in Uganda

With a high HIV prevalence rate (18%) in the early 1990s, Uganda was one of the countries worst hit by the HIV and AIDS epidemic. Concerted effort underscored by spirited political commitment and a multi-sectoral approach successfully brought down the HIV prevalence to 6.4% by 2005. In the following years, adult HIV prevalence stabilized at 6-7% between 2005 and 2011. In 2011, the country witnessed a resurgence of the epidemic with the HIV prevalence rising to 7.3% among adults aged 15-49 years (Uganda AIDS Indicator Survey 2011).

HIV prevalence is especially higher in key populations (KPs) particularly sex workers (35-37%) [Vandepitte et al. 2011; MoH & UAC 2014], fisher folk (22-29%) [MoH & UAC 2014; Asiki et al. 2013], long distance truck drivers (25%) [MoH & UAC 2014], uniformed services personnel (18.2%) [MoH & UAC 2014], men who have sex with men (MSM) (13.7%) [Crane Survey 2010] and *boda-boda* taxi-men (7.5%), [Lindan et al., 2014]. Women and girls constitute the largest proportion of PLHIV - 8.3% compared to men at 6.1% (UAIS 2011). Recent UNAIDS data shows that each week in Uganda, 570 young women aged 15-24 get infected with HIV. 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 as cited by PEPFAR, June, 2014). UNAIDS further reports that one in every four new infections among women 15-49 years in Uganda occurred in adolescents and young women aged 15-24 years (GAP Report 2014). Young women who have experienced intimate partner violence (IPV) were 50% more likely to have acquired HIV than women who had not experienced violence. In Uganda 3% of adolescent girls 15-19 years live with HIV and prevalence doubles [7.1%] by the time they are 24 years (UAIS, 2011). HIV is much more common among women and men who are widowed, divorced, or separated than among those who are married or never married. Up to 6% of co-habiting couples in Uganda are discordant, i.e., one partner is HIV-positive and the other is HIV-negative. By age, prevalence shifted to the older age groups (35+ years) between the 2004/2005 and 2011 surveys.

Using the Uganda AIDS Indicator Survey regional demarcations, HIV prevalence is highest in the central region (10.4%) and lowest in West Nile region (4.3%). Urban areas continue to post a higher prevalence rate (8.7%) than rural areas (7.0%). (Map 1: Uganda AIDS Indicator Survey 2011) Source: MoH 2011.

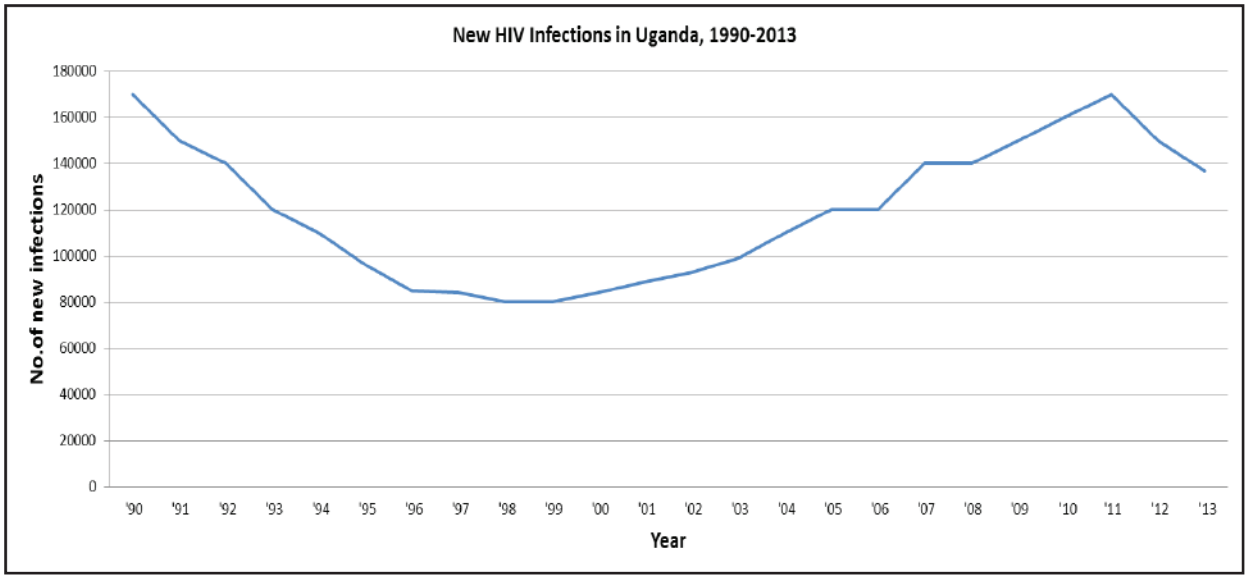


Map1: Prevalence of HIV by Regions in Uganda

Uganda's burden of HIV and AIDS stands at an estimated 1.6 million people who 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 (Figure 1). 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 has declined from 0.83% in 2009 to 0.77% in 2013 although pockets of high HIV incidence still exist among key populations such as the fisher-folk (UNAIDS 2013)

Figure 1: Trends in HIV incidence in Uganda: 1990 - 2013



Source: UNAIDS 2013

HIV-related mortality is declining, largely due to increased enrolment of eligible HIV-positive individuals on ART. For the first time, in Uganda's HIV and AIDS response, 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. A tipping point is a situation where the ratio of new infections to the net increase in ART enrolment is less than 1. In Uganda, this ratio was 3.12 in 2011/2012 and declined to 0.76 in 2012/2013. 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 63,000 in 2012 with 80.9% of such deaths occurring among adults (15+ years of age).

Despite this level of progress, the number of new HIV infections in Uganda remains unacceptably high. Modeled estimates from the UAC Investment Case (UAC 2014) suggest that, without any interventions, the annual number of new HIV infections will rise from 140,000 in 2014 to 340,491 in 2025; resulting in a cumulative 2,890,569 new HIV infections by the year 2025. Although there is a high level of political commitment and concerted effort by partners, the tide of the epidemic continues to outpace the national efforts to control it. The prevalence of HIV in the general population is 7.3%.

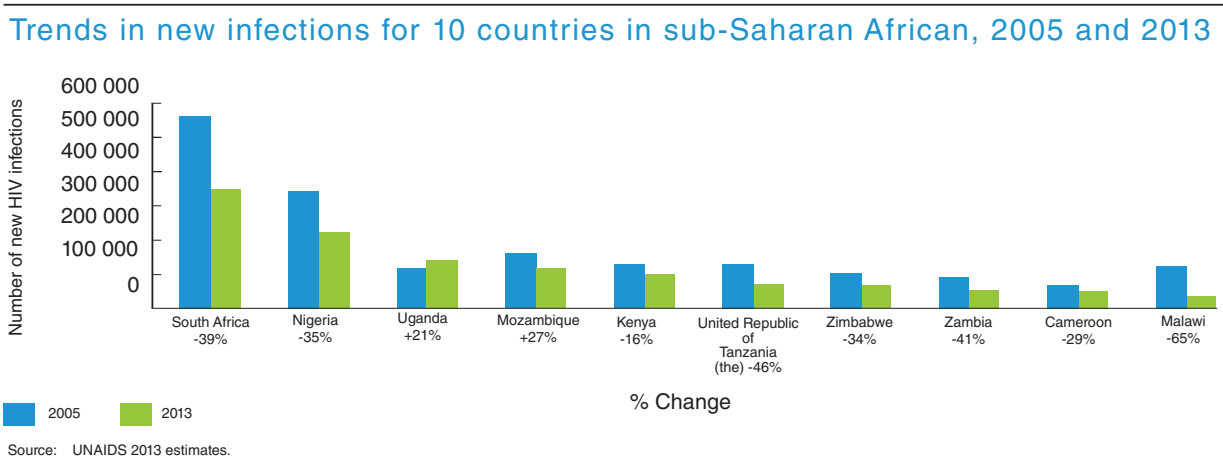
The impact of the HIV and AIDS epidemic on the country's economy and human development index is felt in many ways. Economic projections state Uganda's Gross Domestic Product would grow at an average rate of 6.5% per year between 2005 and 2025 if there were no AIDS, but this would be reduced to 5.3% under 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).

2.2 Uganda's Response in the Regional and Global Context

According to UNAIDS (GAP Report 2014), an estimated 24.7 million people in sub-Saharan Africa representing nearly 71% of the global total, are living with HIV. Ten countries, including Uganda, account for 81% of all people living with HIV in the region. Uganda is one of two countries (the second one is Angola) where the number of new HIV infections increased between 2005 and 2013. The number of new HIV infections in Uganda increased by 21% between 2005 and 2013 (Figure 2).

Figure 2: Trends in new HIV infections for 10 top sub-Saharan African countries: 2005-2013



Source: UNAIDS 2013

Further, Uganda is one of three countries – the others being Nigeria and South Africa– that represented almost 48% of the new HIV infections in sub-Saharan Africa in 2013. The number of new HIV infections that occurred in Uganda in 2013 accounted for 10% of the overall number of new HIV infections that occurred in sub-Saharan Africa in that year (GAP Report 2014). Within the East African region, Uganda has the highest HIV prevalence. See Table 1.

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

Source: East African Community (2014)

Uganda's response for the next five years is anchored in the global attempts to realize a 90 percent reduction in new adult HIV infections, zero new infections among children, 90 percent reduction in stigma and discrimination faced by people living with HIV, and 90 percent reduction in AIDS related deaths. In the just concluded 69th United Nations General Assembly, which Uganda's President attended; a high-level panel emphasized a fragile five-year window for rapid and massive acceleration of HIV treatment and prevention services. This panel proposed a new fast-track strategy, which seeks rapid and massive acceleration of HIV prevention, and treatment programmes with a people-centred approach for ending the AIDS epidemic by 2030. This call is not entirely new. Kenya has a similar target of zero infections by 2030, while the Uganda Health sector already seeks to have an AIDS free population by 2040. Therefore, Uganda's post 2015 NSP mission, which seeks to have an AIDS free population, fits squarely in the global and regional aspirations.

2.3 Factors Fueling HIV Infections

The drivers of the HIV epidemic in Uganda include behavioral, socio-economic and structural factors like gender norms and constructs of masculinity, gender relations, gender-based violence, and stigma and discrimination. The key drivers of HIV incidence in Uganda continue to revolve around: a) high risk sexual behaviors including early sexual debut, multiple sexual relationships, limited and inconsistent condom use; and transactional, cross-generational and sex worker; b) limited awareness about personal and/or partner HIV status; c) high STI prevalence; d) low utilization of antenatal care (ANC) and delivery services; e) low uptake of SMC services; f) sub-optimal scale-up of ART; g) structural factors related to issues such as inequitable access to health services, governance, accountability, human rights, coordination, stigma and discrimination and, h) gender inequalities including Gender Based Violence (GBV) exacerbated by alcohol drinking. Gender inequality refers to the norms and roles, cultural practices, policies and laws, economic factors, and institutional practices that collectively contribute to and perpetuate unequal power relations between women and men, boys and girls.

This inequality disproportionately disadvantages women in most societies. Many women lack access to and control over economic and other resources such as land, property and

have limited access to education, health and credit services. Their decision-making power in sexual relations, health care, spending household resources and choices about marriage are very limited. The lack of power makes it difficult for women to negotiate within, or leave abusive relationships including those they are aware could increase the risk of contracting HIV or other STIs. Additionally, the weak legislation and policies that perpetuate women's low status in society serve as underlying determinants for violence against women and increased risk of HIV infection.

A recent study shows that gender norms including *"something for something love",* age disparity, acceptance of sexual coercion, marital rape and widow inheritance greatly limit women's ability to negotiate safer sex (DANIDA, 2014). The same study showed that economic factors associated with vulnerability to HIV infection in Uganda are geographic mobility, migrant work, poverty and wealth. These are framed in society and on a structural level with policy related issues including: inequitable access to health services, governance, accountability, coordination, and stigma and discrimination that further worsen the situation or hamper initiatives for prevention, treatment and care.

2.4 HIV and AIDS Evidence-Based Response

The UNAIDS (September 2014) notes that in countries with a high prevalence, Uganda inclusive, the epidemic is often concentrated in large cities, few districts and localized areas. And in each setting, the affected populations vary. A concerted push to reach the specific populations most at risk in these countries and local areas will maximize the gains in preventing new HIV infections and stopping AIDS-related deaths.

To address the current drivers of HIV, the NSP emphasizes the need for scaling-up evidence-based effective interventions through the combination HIV prevention approach. This involves implementing multiple (biomedical, behavioral, and structural) interventions with known efficacy in a geographical area at a scale, quality, and intensity to impact the epidemic. These interventions are expected to contribute to reductions in HIV incidence through; (i) increasing knowledge of HIV status among the general population; (ii) reducing risk of HIV transmission from PLHIV; and (iii) reducing HIV acquisition among persons at risk. Similarly, PEPFAR recommends focus on high impact interventions, for instance, safe male circumcision (SMC), condoms, HCT and demand creation for clinical services; Most at Risk Populations (MARPS) and high impact locations.

2.5 Achievements in the Implementation of National HIV and AIDS Strategic Plan 2011/2012—2014/2015

During the implementation of National HIV and AIDS Strategic Plan 2011/2012—2014/2015 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 ART for life.

Uganda reached a programmatic tipping point in the course of National HIV and AIDS Strategic Plan 2011/2012—2014/2015 implementation, whereby for the first time, ART enrollment exceeded the number of new infections. As a result, HIV related mortality started declining due to increased access to ART. Thus, there has been a sustained decline in HIV and AIDS mortality from 120,000 in 1998 to 63,000 in 2012 with 80.9% of such deaths in adults (15+ years of age).

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%. (Ref: HIV and AIDS Sector Issues Paper for the NDP II 2015/2016- 2019/2020).

During the planning period there was a noticeable reduction in the proportion of PLHIV that reported cases of 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 Government of Uganda demonstrated its commitment to fight against HIV and AIDS through increased domestic budgetary allocations for HIV and AIDS. In the period between 2007/2008 and 2011/2012, GOU's contribution tripled from $14m to $53m. Bilateral contributions accounted for 93% of the AIDS external funding between 2007/2008 and 2011/2012 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. (UAC: 2012).

2.6 Challenges in the Implementation of National HIV and AIDS Strategic Plan 2011/2012—2014/2015

Prevention

A combination of challenges beset Uganda's HIV prevention efforts. Condom use is declining partly due to stock-outs and 'condom fatigue'. Secondly, there is no population reporting declining incidence except in newborns. The vulnerability of young women is getting worse. The proportion of Ugandans with comprehensive knowledge of HIV remains low (38% in women and 43% in men–UDHS 2011), and in some areas, there are still misconceptions about the causes of AIDS.

Reaching key and vulnerable populations with services is still a challenge due to structural and environmental barriers,. In addition, there are fewer interventions addressing vulnerable and key populations (sex workers, fisher folk, truckers, uniformed services, prisoners and men who have sex with men -MSM).

None of the intervention in combination prevention was implemented to the critical scale to

significantly impact on the epidemic. Further, most of the interventions were implemented separately and not in combination. Other prevention challenges included:

- Loss to follow-up of mother baby pairs
- Test kit and commodity stock-outs
- Limited behavioral studies to inform the response
- Lack of effective and embraced female controlled method of prevention

Care and Treatment

Despite improvements in geographical coverage for ART, there are still persistent disparities in sex, age and districts ART coverage. Paediatric ART coverage covers only 41% of the estimated 107,000 children eligible for ART in 2013. This is due to limited capacity in many facilities especially the peripheral units for Paediatric care and treatment, frequent stock outs and loss to follow up.

Social Support and Protection

There are still high levels of stigma and discrimination among PLHIV and in the wider community. Moreover, majority of the PLHIV especially orphans and vulnerable children (OVC), women living with HIV (WLHIV) have limited knowledge on their rights e.g., property rights, health rights.

There is limited funding for nutrition and food security related activities. Similarly, there is poor access to credit or inputs since there exist stringent qualification procedures.

Some sections of the recently enacted HIV Prevention and Control Act 2014 can be potential barrier to accessing 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 increasing accepting attitudes of GBV among communities, high rates of defilement and early marriages and child labor undermined enrollment and retention in health and social services leading to powerlessness and increased vulnerability for women and girls living with and /or affected by HIV/TB.

Infrastructure, Governance and Leadership

The capacity of UAC to coordinate the national multi-sectoral HIV and AIDS response was undermined by other players' limited understanding and adoption of existing policy guidelines and legal instruments.

Management and coordination of the response in some sectors and decentralized levels was weak. i.e weak or non-functional sector and district HIV coordination structures.

The level of HIV and gender responsiveness of sector investment plans and district development plans (DDPs) varied widely across sectors and districts respectively.

Monitoring and Evaluation

Lack of a comprehensive national reporting mechanism that captures biomedical and behavioral/ structural data (non-biomedical) on HIV and AIDS interventions from all actors.

Limited popularization of the M&E plan: There was limited awareness about the reporting systems, tools and timelines.

Insufficient tracking of the National HIV and AIDS M&E plan indicators: The indicator performance table was not routinely populated.

Limited gender based analysis and reporting: The districts reported having gender mainstreaming sections in district plans as a requirement by MoLG, but it was hardly traced during implementation and in reporting.

Financing and Costing

Late release of funds from central government to the local government, but at the same time the treasury requires all accounts to cease operation at the end of the financial year.

External funding such as the GFATM had its challenges with unpredictability of inflow.

The shift to commoditisation has resulted into a less resource for Program activities and unfortunately GOU and partners have not been able to fully fill the gap.

2.7 Best Practices, Lessons and Opportunities

Best Practices and lessons learned

Prevention

Innovative approaches especially to target KPs: The moonlight HIV testing strategy has improved HCT uptake particularly among key populations.

Demand creation through engagement of champions: Involvement of all leaders including cultural, religious and political leads to better results.

Involvement of communities/PLHIV: There are several interventions related to community systems strengthening to support mobilization, retention, adherence and psycho-social support. These have contributed to the success of the program.

Care and Treatment: The test and treat approach will increase the number on life-long medication. The adherence, disclosure and frequent clinic visits for clinical monitoring, laboratory tests, and counselling will demand patient and provider commitment. For many patients, the indirect costs including transport, missed employment days, and out-of-pocket expenses are major causes for loss to follow-up (LTFU).

The number of HIV infected persons accessing ART in Uganda is increasing rapidly and, particularly, the earlier start of ART using the Test and Treat approach has consequences for the emergence and spread of drug resistance.

Social Support and Protection: Reducing gender inequality in all its facets and manifestations and transforming gender stereotypes and relations is possibly the most effective strategy in enhancing the capabilities of individuals, households and communities to cope with the consequences of HIV and AIDS (UNAIDS 2005:8). NAFOPHANU's SALT program a best practice of gender and rights-based driven program.

Infrastructure, Governance and Leadership: Establishing public-private referral partnerships with the local private health service providers like drug shops, medical clinics, pharmacies and maternity centers can be an effective means of increasing the number of PLHIV who enroll and access care, support and treatment services

Monitoring and Evaluation

The SCEs provide an opportune forum for coordinating the national response and have potential for achieving even greater results.

The multi-sectoral M&E TWG is a great resource to provide M&E technical support and quality assurance functions.

The Lot Quality Assurance Sampling (LQAS) approach provided Local governments with district and sub-county specific parameters, which enhanced data use.

The harmonization of PEPFAR and DHIS2 reporting systems has strengthened the national reporting system.

Missed Opportunities

Community HCT including home-based HCT remains one of the best approaches to reach men, children and youth who do not come to the health facilities (Over 95% HCT uptake UAIS 2011) where provider initiated HIV counseling and testing (PICT) is provided, yet there is almost no funding for this approach.

Use of Village Health Teams (VHTs) to mobilize and sensitize the communities is minimal or not done at all yet, if supported and facilitated, VHTs can improve uptake, and linkage to care and treatment services

Access and utilization of eMTCT services is not yet at a level to achieve virtual elimination of MTCT. Data from the EID database indicates that only 28% of the infants tested through the EID program received the full eMTCT cascade in 2012/13. An estimated 56% of all exposed infants were tested in 2012/13. It is hoped that roll out of option B+, coupled with availability of HCT kits, plus additional staffing will address these gaps to a great extent.

Despite the roll out of Option B+, many HCIIs and private facilities have not yet been considered for Option B+ implementation. This, together with poor linkages and referrals, has affected access to eMTCT services.

Existing missed opportunities for ARV initiation due to factors such as stock-outs of HIV test kits and ARVs, non-disclosure and poor counseling skills. Between October 2012 and March 2013, it was noted that 12% of those eligible to receive ARVs missed them due to these factors. Relatedly, the lack of syphilis test kits in the facilities is a missed opportunity for elimination of neonatal syphilis.

Utilizing all forms of media and youth groups as vehicles of behavioral change communication to the public was missed opportunity during the NSP implementation period. More than ever there was a willing constituency of the media youth groups and church leaders under their different umbrella organizations of IRCU and UCAN for Pentecostals churches in Uganda.

Unmet family planning needs for women living with HIV constituted a missed opportunity.

There is a big missed opportunity in schools where a fair proportion of young boys and girls spend majority of their time and could be reached with HIV and AIDS messages through civic education. Schools have very organized systems for information flow and shape the behavior of young children.

There is a missed opportunity in the mass campaign for voluntary SMC to address norms about male masculinity and sexual violence.

The GBV assessment, family planning, good conception counseling and support are not provided as an integral component of the routine HIV care clinics. Men and women living with HIV should be supported to make safe conception and contraception choices.

Poor service integration and linkages to address GBV. Post Exposure prophylaxis (PEP), post trauma and risk reduction counseling and cancer screening are not yet integrated into existing HIV/TB services.

2.8 HIV and AIDS Policy and Planning Environment

The NSP shall be implemented within the existing planning, policy and legal framework in Uganda using the public health approach. The public health approach requires evidence based interventions that will be implemented to sufficiently impact on the epidemic to achieve critical levels sufficient for epidemic control. The National HIV and AIDS Policy (2011) provides a broader framework for delivering HIV and AIDS services in the country and inspires national action at all policy formulation, planning, programming and service delivery levels. It also promotes a human rights-based; gender-sensitive legal and policy environment to address HIV and AIDS in Uganda. The goal of the policy is "to prevent new HIV infections and eliminate the social economic impact of HIV and AIDS on the country and all categories of the population". All these subscribe to the outgoing National Development Plan (NDP) 2010/11—2014/15 and the Second NDP 2015/16—2019/20 (NDP II).

The Parliament of Uganda passed the HIV Control and Prevention Act which provides for positive attributes like reasonable care to avoid transmission, counseling and testing and medical practitioners mandated to take tests. However, this law has some controversial clauses with the most contentious being the criminalization of HIV transmission and mandatory HIV status disclosure.

The key contextual legal issues concern the repealed Anti-Homosexuality Act, 2014, The HIV Prevention and Control Act, 2014 and the continuing debate on the need to operationalize the HIV and AIDS Trust Fund. These laws were made with good intentions, however, some sections in them, may undermine gains made in the HIV and AIDS response in terms of potential creation of stigma and discrimination, access to HIV services, violation of human

rights and breach of fundamental medical code of practice of confidentiality. Fortunately, GOU issued a statement guaranteeing universal access to HIV services, which falls under the general health service provision with freedom from any form of discrimination, independent of sex, gender, sexual orientation, age, race, ethnic origin, social class, religion, and mental or physical disabilities. The affected populations by the Law will be treated like other clients. Furthermore, to avoid stigma and discrimination, data collected shall not specify sex orientation, which if breached by health professionals is criminalized. The confidence building with service providers may eventually lead to enrolment into other services like counseling and information sharing for health promotion.

Significantly and on a positive note, the HIV Control and Prevention Act,2014, establishes the AIDS Trust Fund under the Ministry of Health, which requires the government to make quarterly allocations for purchase of anti-retroviral drugs. The fund guarantees the availability of funding for HIV and AIDS activities, which are majorly dependent on donor funding. With the much-anticipated reduction in donor funds, this would ensure narrowing of the funding gap, ensuring universal access to HIV and AIDS services and sustainability of the national response.

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

3.1 The National HIV and AIDS Strategic Plan 2015/2016— 2019/2020 in the Context of the Investment Case

Globally, an investment approach has been increasingly recognized as a strategy that can lead the world towards ending the AIDS epidemic by 2025. The investment approach is a tool for evaluation and reallocation of funds to evidence-based activities that can specifically address the epidemic challenges and to get more effective and efficient long-term results. The framework is built on four pillars: Understanding the HIV and AIDS situation, Designing efficient programs, Delivering at scale, and sustaining it for impact with adequate funding.

According to the Investment Case for Uganda, the approach aims to rapidly scale up selected combination interventions over the first three years between 2015 and 2018 and thereafter, to be maintained at the targeted level of implementation. These combinations include ART coverage (80%) with test and treat for MARPs, PMTCT (95%), SMC and condoms (80%), HCT (50%) and Behavior Communication Intervention (BCI) with focus on most affected population particularly young women and girls. The Investment Case also provides recommendations for increased integration of HIV with TB and other programs including maternal and child health (MCH), Sexual and Gender Based Violence (SGBV), etc. The implementation also requires system strengthening that is critical in the enhancement of the prevention, treatment and support services for HIV at all levels of the health system including the community.

Globally, UNAIDS is spearheading the call to scale up the response against HIV and AIDS in the next five years, (effective 2015). This UN agenda seeks to reduce new HIV infections, discrimination and AIDS-related deaths to 10% of 2010 levels such that AIDS no longer represents a major threat to any population or country. Specifically, this agenda seeks to realize a 90% reduction in new adult HIV infections, zero new infections among children, 90% reduction in stigma and discrimination faced by PLHIV, and 90% reduction in AIDS related deaths. 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.

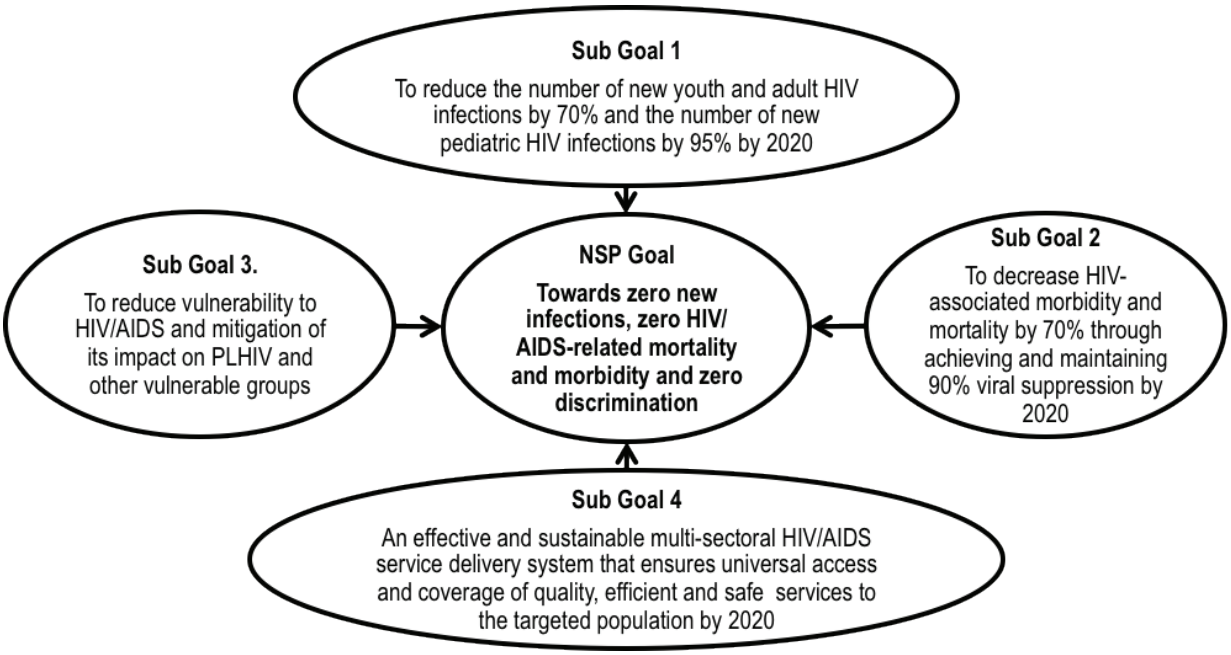
Uganda is aware that the UNAIDS target is overly ambitious, and the country needs to frame its own targets. In the next five years, Uganda will seek to halve the current burden of the AIDS pandemic. In this respect, the NSP seeks to accelerate scaling-up of interventions to achieve targets, particularly combining the potential of ART to prevent new HIV infections with other proven HIV prevention methods such as male and female condoms, firm steps to reduce stigma and discrimination to zero, non discriminatory and criminalizing approach to MARPs, SMC, sexual and reproductive health services and innovative social support and protection measures. This will require more governmental commitment and tough decisions being made at multiple levels- 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.

3.2 Vision

The Vision of this NSP builds upon the Vision of National HIV and AIDS Strategic Plan 2011/2012—2014/2015, 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".

The Vision of this NSP is *"A Healthy and Productive Population free of HIV and AIDS and its effects".*

3.3 Overall Goal and Sub-Goals

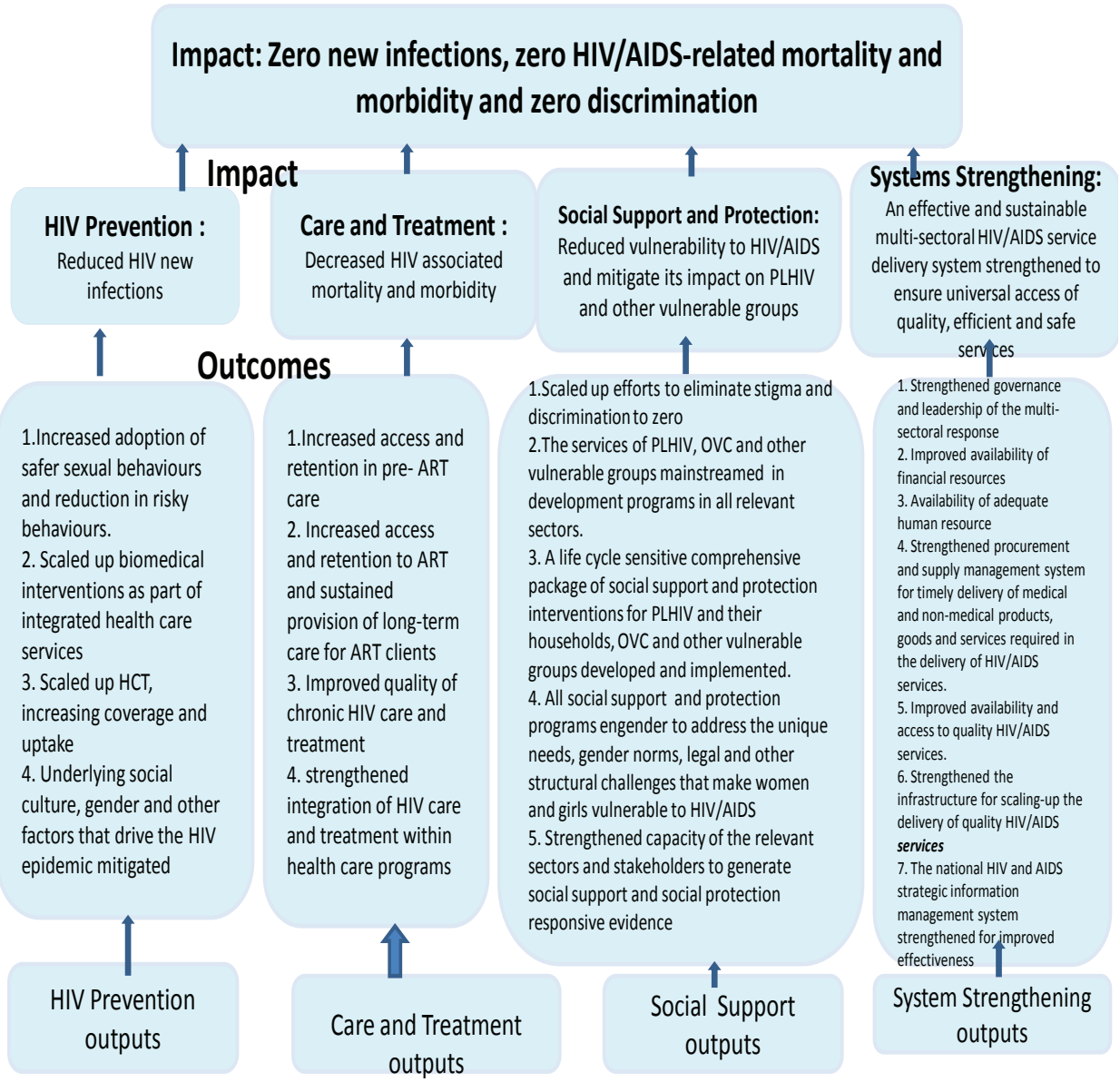


3.4 General Outcomes of the NSP

The NSP targets averting over 500,000 deaths and preventing 2 million infections by 2020. 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 50% HCT coverage, 50% condom coverage, 60% SMC coverage, 95% eMTCT coverage, 80% ART coverage and 24% reduction in number of sexual partners. The NSP also aims at providing social support for those infected. The roll out of the WHO 2013 treatment guidelines 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 involving strengthening health systems including community and household levels, addressing critical enablers through strategic integration of HIV service with other care and prevention programs, and enhancing rational resource allocation. The NSP advocates for reduced vulnerability of the population to HIV and AIDS and sustainable multi-sectoral HIV delivery systems.

Figure 3: Overall NSP results framework



3.5 Assumptions

- Effective mainstreaming of HIV and AIDS in all sectors and plans
- Country ownership and accountability for results
- Increased internal resource mobilization including sustained GOU budgetary support
- Complementary ADP financing aligned to national priorities
- Reinvigorated and sustained leadership commitment at all levels; Sustained economic
- Adequate absorptive capacity of available allocated and released resources by implementing agencies and organizations.

3.6 Guiding Principles

- **Shared responsibility:** an AIDS free population is everyone's responsibility, individually and collectively as a family, community.
- **Non-discrimination:** no person shall be discriminated from accessing HIV and AIDS services.
- Meaningful involvement of PLHIV
- Human rights and gender-based approach to programming.
- Evidence based and result-driven planning and implementation.
- Adherence to the three Ones Principle by all stakeholders.
- Effective mainstreaming of HIV and AIDS in all sectors.
- Country ownership and accountability for results.
- Strategic investments.
- Innovation is needed to keep pace with an evolving epidemic.

4.0 THE NATIONAL HIV AND AIDS STRATEGIC PLAN THEMATIC AREAS, STRATEGIC OBJECTIVES AND ACTIONS

4.1 Introduction

The NSP is a five-year guiding framework for implementation of the multi-sectoral response in support of the second National Development Plan (NDP II) contributing to the Uganda Vision 2040 aspirations. This NSP is informed by the findings of the MTR of the National HIV and AIDS Strategic Plan 2011/2012- 2014/2015 which was conducted in 2014. The review and NSP development processes were participatory with the involvement of key stakeholders. The NSP preparation operates within the context of unfolding foremost global, regional and country opportunities, challenges and the on-going discussions enshrined in the Post 2015 Development Agenda, Call and Commitment to ending AIDS Epidemic by 2030, and the United Nations Development Assistance Framework 2016-2020. The NSP informs the planning and implementation processes of all HIV and AIDS stakeholders, development partners, the private sector and other non-state actors in the country.

The NSP thematic areas and the planned strategic interventions have been developed cognizant of the global and national commitment to end the AIDS epidemic by 2030. It is in this regard that the "UN September 2014 Fast Track Response and Strategy proposes rapid and massive acceleration of HIV prevention and treatment programmes with a people-centred approach. The Strategy calls on countries particularly those with high burden of HIV to prioritise lifesaving HIV treatment and prevention services to people most at risk of HIV infection. The UNAIDS target of 90-90-90 would enable 90% of people to know their HIV status, 90% of people who know their HIV status to access HIV treatment and 90% of people on HIV treatment to achieve viral suppression by 2020. The call is relevant given that Uganda is one of 15 countries that account for more than 75% of the 2.1 million new HIV infections that occurred in 2013 at Global level and is one of the three countries in sub-Saharan Africa that account for 48% of all new HIV infections, others being Nigeria and South Africa.

This NSP is aligned to the UN September 2014 Fast Track Response and Strategy which is aimed at closing the access gaps to HIV prevention and treatment. Additionally, the commitment enshrined in the NSP is to ensure that no newborn child is infected with HIV during pregnancy, at birth and lactation period and generally reducing new adult infections by combining the potential of ART to prevent new infections with other proven HIV prevention interventions.

The overall goal of this NSP, which is further operationalized by the thematic specific goals, strategic objectives and actions is aimed at redefining the national response in the three (3) direct areas of intervention or service areas, namely, (i) prevention, (ii)care and treatment, and (iii) social support and protection. The service areas are supported by the strengthened systems of delivery that specifically fall under three components in this NSP. These are (i) governance, leadership, infrastructure and human resource, (ii) monitoring and evaluation, and research, and (ii) financing, resource mobilization and management.

4.2 Prevention

The Uganda Investment Case makes a profound justification for scaling up coverage and utilization of critical HIV prevention interventions to reduce new HIV infections over the next ten years under a "feasible maximum scenario". Implementation of this scenario calls for scaling up coverage to between 50-80% of biomedical HIV prevention interventions coupled with a 24% reduction in multiple sexual partnerships and targeted primary HIV prevention approaches for key and vulnerable populations. This is projected to reduce new HIV infections from 137,000 in 2014 to 39,774 by 2025. These reductions would translate into a cumulative 642,000 new HIV infections by 2025, down from an estimated 2.8 million new HIV infections that would occur if the current coverage levels are maintained. In effect, this would avert 2,160,000 new infections between 2014 and 2025 – a 77% reduction in new HIV infections over this period. To achieve this level of success, Uganda will need to scale up implementation of proven combination HIV prevention[1] interventions to critical levels over the next 5 years. The NSP targets are aligned to the Uganda HIV and AIDS Investment Case 2015-2025.

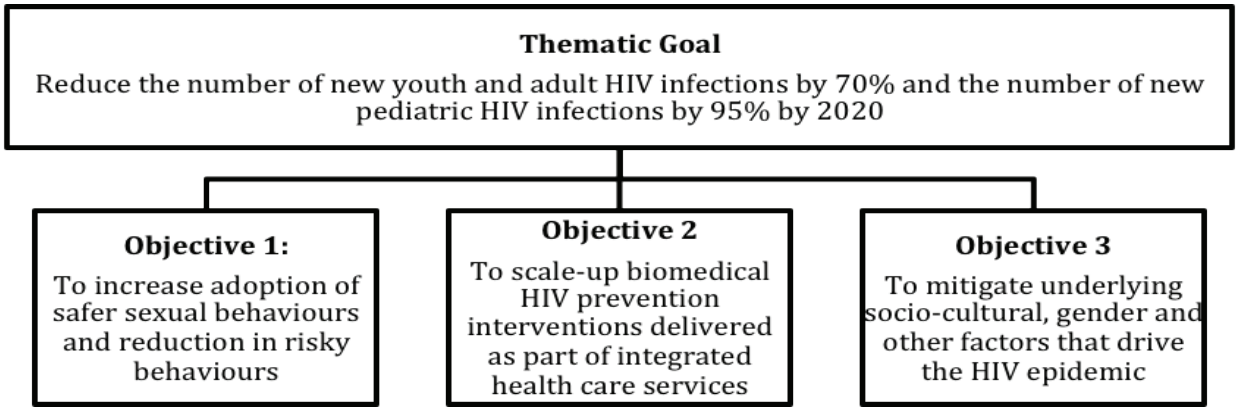
During the next five years, there is need for intensified implementation of combination HIV prevention interventions that are targeted to the local HIV epidemiology guided by the heterogeneity of Uganda's HIV prevalence. There will be need for targeted biomedical and behavior change interventions for *existing*[2] and *emerging*[3] *key populations as well as vulnerable*[4] groups in addition to the general population. There will also be need for more targeted social and behavioral change communication interventions targeting population groups and 'hotspots' that are associated with a higher risk of HIV transmission. Evidence from mathematical modeling suggests that through prioritization of the people at, contexts and locations associated with greatest risk of infections, and adaption of the interventions to reflect the local epidemiology context, the focused approach could substantially increase the efficiency and effectiveness in investments in HIV prevention. It is projected that the implementation of these interventions, together with targeted social support and protection will result in significant reductions in HIV incidence over the next 5 years.

Prevention was a national priority in the National HIV and AIDS Strategic Plan 2011/2012-2014/2015, which provided impetus for increased leadership commitment and expanded programming. Challenges to coordination and management of the prevention response, however, still exist including inadequate funding, fragmented programming, lack of programming standards for interventions targeting behavioral and structural drivers of the epidemic, low coverage of biomedical prevention services and inadequate coordination of actors especially at decentralized levels. This NSP provides priority focus on enhanced management and coordination of the prevention response at national, sector, district and community level to promote focus on common goals, synergetic programming for scaled coverage and efficient resource use.

1 *Implementing multiple (biomedical, behavioral and structural) prevention interventions with known efficacy in a geographical area at a scale, quality, and intensity to impact the epidemic*
2 *Sex workers, truckers, MSM, fisher-folk, and uniformed services personnel*
3 *Prisoners, miners, plantation workers, boda-boda taxi-men, brick-layers, and salt-extractors*
4 *Migrant and mobile populations, young women, adolescents, HIV-discordant couples, pregnant women, PWDs*

The following section summarizes the thematic goal, objectives and strategic actions per objective.

Figure 4.1: Prevention thematic goal and objectives



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

Strategic Actions

1.1.1 Scale-up age- and audience-appropriate social and behavioral change interventions including AB to reach all population groups with targeted HIV prevention messages

1.1.2 Strengthen policy guidance, quality assurance and capacity for effective IEC/ social and behavioral change communication programming at all levels

1.1.3. 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.

1.1.4. Scale-up condom education (emphasizing correct and consistent use) to address complacency and fatigue associated to condom use

1.1.5. Integrate sexual and gender-based violence (SGBV) prevention and human rights into HIV prevention programming

1.1.6. Conduct mapping and size estimation for key populations to inform targeted and scaled-up interventions for key populations

1.1.7. Scale up comprehensive interventions targeting MARPs

1.1.8. Scale-up comprehensive sexual and reproductive health (SRH)/HIV programs targeting, adolescents (both in and out of school) and young people

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

1.1.10 Expand programming for positive health, dignity and prevention (PHDP) interventions

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

Strategic Actions

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

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

1.2.3 Scale-up coverage of HCT for HIV prevention targeting the general population,key populations and vulnerable groups especially in identified hotspot areas

1.2.4 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

1.2.5 Expand targeted STI interventions for key populations and vulnerable groups

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

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

1.2.8. Strengthen medical infection control and ensure universal precaution

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

1.2.10 Support research in primary prevention including microbicides and vaccines

1.2.11 Expand standardized and targeted combination HIV prevention services for key populations

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

Strategic Actions

1.3.1 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

1.3.2 Strengthen legislative and policy framework for HIV prevention

1.3.3 Strengthen capacity of health, legal and social service providers to manage SGBV cases

1.3.4 Promote male involvement in HIV prevention for their own health and the health of their partners and families

1.3.5 Strengthen efforts against stigma and discrimination

1.3.6 Utilize community extension work programs in the socio-economic sectors to deliver HIV programs

1.3.7 Apply gender and human rights-based programming approaches for HIV prevention programs at national and lower levels

Table 2: HIV Prevention Outcomes and Indicators

Outcomes	Indicators	Baseline	Target
1. Increased adoption of safer sexual behaviours and reduction in risky behaviours	1.1 Percentage of adults (15-49) who have had sexual intercourse with more than one partner in the last 12 months***	Men 18.7%	14.2 *(24%reduction)*
		Females 3% UAIS 2011	2.28 *(24% reduction)*
	1.2 Percentage of young women and men aged 15-24 years who correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission***	Male: 39.3%	70%
		Female: 38.6% UAIS 2011	70%
	1.3 Percentage of adults aged 15-49 who use a condom at the last high risk sex (sex with non-marital partner)	35%	75%
	1.4 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.	M=11.9% (2011)	7%
		F=13.1% (2011)	8%
2. Coverage and utilization of biomedical HIV prevention interventions delivered as part of integrated health care services scaled-up.	2.1 Percentage of males and females 15-49 years reporting consistent condom use at last higher risk sex	Males: 37.9% (UDHS 2011)	90%
		Females: 29.4% (UDHS 2011)	85%
	2.2 Percentage of MARPs 15-49 yrs reporting consistent condom use	SW: TBD	50%
		Uniformed services: TBD	50%
		Fishermen: TBD	50%
		MSM: TBD	50%
		Truckers: TBD	50%
	2.1 Percentage of women and men (15-49 years) who tested for HIV in the last 12 months and know their results	63% 7,512,048 (MOH 2013)	80%
	2.2 Percentage of most-at-risk populations who have received an HIV test and know their results	SW: 49.2% (2010)	80%
		Uniformed services: TBD	80%
	2.3 Percentage of HIV-positive pregnant women who receive antiretroviral drugs to reduce risk of mother-to-child transmission of HIV	75% (midyear 2014)	85%
	2.4 Percentage of exposed infants who have received ARV prophylaxis to reduce risk of mother-to-child transmission of HIV	36.7% (37,423/101,907) Source: Spectrum estimates	80%
	2.5 Percentage of infants born to HIV positive women receiving a virological test for HIV within 2 months of birth. **	1st PCR =44% 2nd PCR= 10% (2013) Source: PMTCT and Paediatric HIV/AIDS Care program annual report	1st PCR-75%, 2nd PCR-70%
	2.6 Percentage of males (15-49 years) that are circumcised	25% (MOH 2013) AIS Survey	80%
	2.7 Percentage of donated blood units in the country that have been adequately screened for HIV according to national or WHO guidelines during the past 12 months	100% (UBTS Reports 2013)	100%

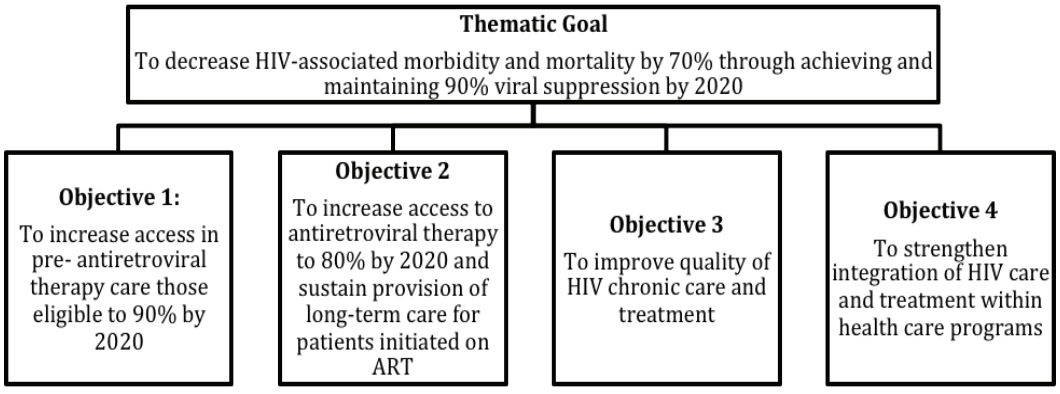
Outcomes	Indicators	Baseline	Target
3. Mitigated underlying socio-cultural, gender and other factors that drive the HIV epidemic	3.1 Percentage of women (15-49 years) who experience sexual and gender-based violence	Women: 27% (UDHS 2011)	Women: 23%
	3.2 Percentage of adults that believe that a woman is justified to refuse sex or demand condom use if she knows that her husband has a STI	Males: 90% Females: 84% (AIS 2011)	Male: 95% Female: 90%

4.3 Care and Treatment

Evidence adduced by the MTR of the National HIV and AIDS Strategic Plan 2011/2012—2014/2015 points to a situation where the country is within reach of providing universal ART by 2020. To-date, gains have been made in expanding and decentralizing treatment services to HC III and selected HC II levels. Despite this promising trend, concerted efforts to reach universal treatment access still face significant challenges especially in reaching increased number of eligible individuals coupled with longer treatment schedules. Reaching the increased number of eligible individuals requires rapidly getting people with HIV into care early after infection, maintaining them in care and ensuring adherence to treatment. As more people get on treatment, disparities may be magnified especially for key populations, men, children and adolescents. Though accelerated decentralization of services has brought services closer to the community, less trained staff and facilities with less capacity will have rapidly increasing patient loads. This magnifies existing health system gaps that have to be tackled to ensure effective and quality care and treatment.

This NSP puts primary emphasis on efforts that rapidly increase enrollment, better retention in chronic care, and early initiation of ART, effective HIV treatment, and greater adherence to HIV treatment. Comprehensive HIV Care Services based on a coherent continuum of care and standardized protocols will thus remain the foundation for the ART scale-up over the next 5 years but with intensified quality assurance, strengthened community linkages and institutionalizing treatment and drug resistance monitoring. The NSP further focuses on overcoming the unique delivery and demand barriers especially for key populations, children, adolescents and men in each component within the overall care continuum. To improve quality and ensure sustainability, efforts started in the previous strategic period towards full integration of HIV care and treatment will be strengthened.

The following section summarizes the thematic goal, objectives and strategic actions per objective.



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

Strategic Actions

1.1.1. Strengthen mechanisms for linkage to care for all HIV positive individuals

1.1.2 Increase HIV care entry points within health facilities, community, schools, social/ child protection and workplaces for HIV exposed infants, children, adolescents and men

1.1.3 Strengthen community level follow-up and treatment support mechanisms for pre-ART and ART individuals (adults and children) Scale-up implementation of prevention and treatment of AIDS-related life threatening opportunistic infections including cryptococcal meningitis

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

2.2.2 Expand and consolidate pediatric and adolescent ART in all accredited ART sites

2.2.3 Supporting transitions between child-adolescent -adult care

2.2.4 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.

2.2.5 Strengthening early initiation into ART and adherence support services

2.2.6 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

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

3.3.2 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.

3.3.3 Strengthen monitoring of chronic HIV care and treatment including scale-up of viral load monitoring and surveillance for drug resistance.

3.3.4 Strengthen treatment monitoring and evaluation of clinical complications and effects of long-term use of antiretroviral drugs.

3.3.5 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

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

4.4.2. Integrate HIV care and treatment with maternal, newborn and child health, sexual and reproductive health and rights, mental health and non-communicable /chronic diseases

4.4.3 Provide prevention and management of OI, STIs and ART wrap around services in general outpatient and inpatient care

4.4.4 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.

Table 3: Care and treatment Outcomes and Indicators

Outcomes	Indicators	Baseline	Target
1. Increased access in pre-antiretroviral therapy care to those eligible to 90% by 2020	1.1 Proportion of Adults and Children enrolled in HIV care services	70% (June 2014) Source: HMIS	80%
2. Increased access to antiretroviral therapy and sustained provision of chronic care for patients initiated on ART	2.1 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	83% 140,457/166,095): ART Quarterly reports,2013 (MOH)	90%
	2.2 Proportion MARPs living with HIV maintained in on ART for 12 months by category (disaggregated by different MARPs categories)	Not available	95%
3. Improved quality of chronic HIV care and treatment	3.1 Percentage of estimated HIV-positive incident TB cases receiving both TB and HIV treatment	60% Jan –June 2013, NTLP report (MOH)	70%
	3.3 Percentage of people with diagnosed HIV infection on Isoniazid Preventive Therapy (IPT)	TBD	80%
4. Strengthened integration of HIV care and treatment within health care programs	4.1 Unmet need for FP among PLHIV	34% 2011 in general population. No data among PLHIV.	25%
	4.2 Proportion of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	60%	100%
	4.3 Proportion of HIV positive acutely malnourished clients in care who received nutrition therapy	TBD	50%

4.4 Social Support and Protection

The National HIV and AIDS Strategic Plan 2011/2012-2014/2015 implemented a number of interventions that contributed to the psychosocial support and social protection needs of PLHIV, OVC and other vulnerable groups (People With Disability-PWD, the elderly and key populations). Despite the achievements attained under social support and protection, some challenges still exist that need to be addressed. These include but not limited to: a decline in the quality of counseling; decline in direct livelihood support services; inadequate gender mainstreaming in psychosocial support and social protection services; limited success of interventions addressing gender norms that increase vulnerability to HIV; low reporting and follow up of GBV cases as well as weak mainstreaming of disability issues in social support. Additionally, lack of a defined psychosocial support package for PLHIV; limited or no life cycle sensitive social support and social protection packages of PLHIV and other vulnerable persons; limited coordination and monitoring of sectors to ensure that they fulfil their mandates; legal provisions e.g. the HIV and AIDS Prevention and Control Act that includes provisions that derail the fight against AIDS are evident gaps in the area of social support and protection (UAC, 2014).

In the next five years, the NSP will advocate for addressing the identified gaps and an increase in provision of promising interventions aimed to improve the quality of life of PLHIV, OVC and other vulnerable groups. The Social Protection Life Cycle Approach will guide the social support and social protection interventions**.** This model guides in the analysis of risk and vulnerability across the life-cycle. It identifies different life cycle stages, with each associated with certain risks and vulnerabilities that if not addressed, one's graduation to an acceptable state of wellbeing remains unattainable.

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

Strategic Action

3.1.1. Mobilize and strengthen cultural (including traditional healers) and religious institutions, community support systems and PLHIV Networks to address stigma

3.1.2 Strengthen interventions that empower PLHIV to deal with self-stigma

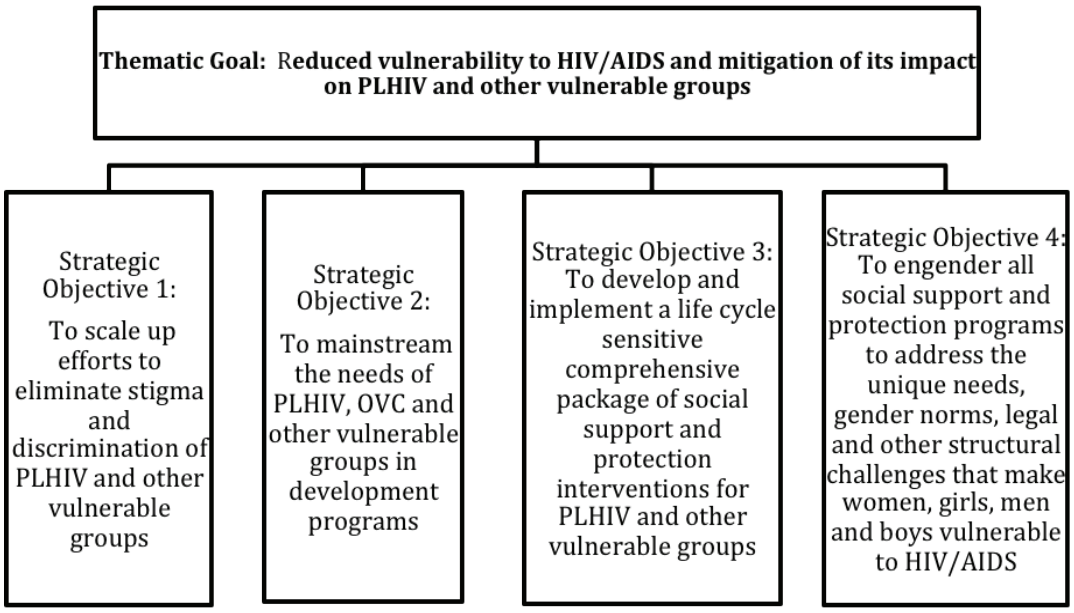
3.1.3 Conduct PLHIV Stigma Index assessment at least every two years

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

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

3.1.6 Institute and strengthen anti-stigma and discrimination programs for key populations

The following section summarizes the thematic goal, objectives and strategic actions per objective.



Strategic Objective 2: To mainstream the needs of PLHIV, OVC and other vulnerable groups[1] into other development programs

Strategic Action

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

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

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

3.2.4 Integrate social support and protection issues in education sector programs (including school health and reading programs, Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY), curricular and extracurricular activities)

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

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

3.2.7 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

3.3.2 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

3.3.3 Develop and implement appropriate strategies to prevent and respond to child abuse and exploitation

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

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

3.3.6 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 Action

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.

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

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

3.4.4 Establish mechanisms for engaging men and boys in HIV and AIDS and SGBV programming

3.4.5 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

Table 4: Social support and protection outcomes and indicators

Outcomes	Indicators	Baseline	Target
Enhanced efforts to eliminate stigma and discrimination of PLHIV and other vulnerable groups	1.1 Percentage of individuals (15-49 years) with accepting attitudes towards PLHIV	34% (AIS 2011)	70%
Scaled up mainstreaming of services for meeting the needs of PLHIV, OVC and other vulnerable groups in development programs	2.1 Percentage of OVC households that are food secure	45.2% (LQAS 2013)	60%
	2.2 Percentage OVC aged 5-17 years that have atleast 3 basic needs met.	24.8% (UDHS 2011)	70%
A life cycle sensitive comprehensive package of social support and protection interventions for PLHIV and other vulnerable groups developed and implemented	3.1 percentage of districts with Life cycle sensitive comprehensive package of social support and protection	TBD	100%
	3.2 Percentage of vulnerable individuals receiving a life cycle sensitive comprehensive package	TBD	65%
Engendered social support and protection programs addressing the unique needs, gender norms, legal and other structural challenges that make women, girls, men and boys vulnerable to HIV and AIDS	4.1 Percentage of married women participate in all three decisions pertaining to their own health care, major household purchases, and visits to their family or relatives.	38% (UDHS 2011)	70%
	4.2 Percentage of men and women who believe that wife beating is justified for at least one of the specified reasons (denying a husband sex; neglecting the children; arguing with a spouse; goes out without telling husband; and burning food)	Women: 58 % (UDHS 2011) Men: 43% (UDHS 2011)	20% (both men and women)
	4.3 Percentage of women who do not own land alone or jointly with their spouses	61% (UDHS 2011)	40%

4.5 Systems Strengthening

The system for the delivery of this NSP which is operationalizing the multi-sectoral HIV and AIDS Control Approach (MACA) adapted by Uganda in 1992 has six components, namely, governance and leadership, human resource, procurement and distribution of goods and services, financing, strategic information and actual service delivery. As indicated in the Investment Case for smarter investment, a strong multi-sectoral HIV and AIDS system is a cardinal requirement for deriving and maximizing the benefits from implementation of priority HIV prevention, treatment and care, and social support and protection interventions.

4.5.1 Governance, Infrastructure, Human Resource and Financing

Governance and leadership are critical in guiding the national response. During the planning period the country has witnessed reinvigorated national leadership in the response that need to be sustained. Thus, under governance and leadership component, the country will support greater involvement of leaders as champions and role models in the multi-sectoral HIV and AIDS response. Deliberate efforts to remove structural barriers at the national and sub-national levels will be carried out so that a conducive environment is provided. The UAC is mandated to coordinate the national HIV and AIDS response hence during the next five years; its capacity will be re-enforced so that coordination is improved. Coordination

structures in the various sectors, districts and in non-public institutions will be revamped.

The strengthening of the system will also address the issue of human resource from three perspectives, namely, provision of adequate number of resource persons to carry out the activities, training of more people and retaining different cadres of human resource required for the response. Procurement and distribution of goods and services has been a major challenge in the national response because of the large number of stakeholders and institutions involved in procurement and supplies chain management. During the period covered by the NSP, requisite policies and capacity will be put in place. There are numerous categories of services covered under the NSP. Therefore, integration of services, linkage between the various components of the continuum of response and referral mechanisms will be strengthened. The role of the CSOs is also clearly defined in this component of the NSP in relation to service delivery and accountability from duty bearers and rights holders. In order to ensure greater access and coverage of services, the systems component of the NSP will advocate for better infrastructure (health and non-health facilities[5], equipment, transport etc) required to deliver the services. The infrastructure will be at public and non-public sector institutions and community level.

The NSP will be implemented in a resource constrained but a growing service needs environment. This requires an aggressive resource mobilization and an efficient use of the resources available. The AIDS Trust Fund will be operationalized to ensure that the country mobilizes local resources as much as possible. In addition to this, both current and non-traditional development partners will be mobilized to support the multi-sectoral response. A key aspect of the NSP is the use of evidence- based resource allocation, utilization and accountability. This will be guided by periodically (a) linking and reviewing the projection of the epidemic in the NSP and Investment Case to resource allocation based on disease burden (b) assessing the effectiveness in resource utilization (c) promoting transparency, reporting and accountability.

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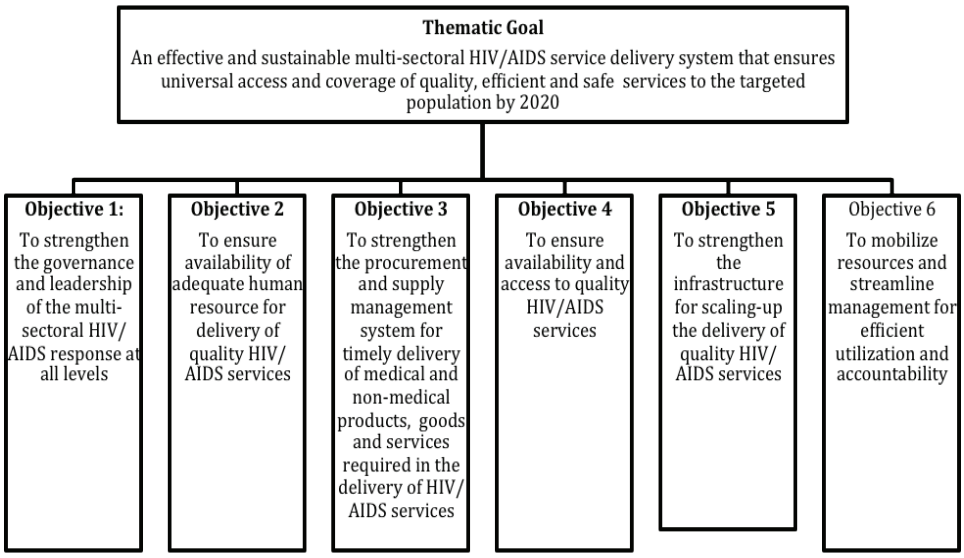


5 *Health facilities in the islands where the fisher folks live will also include aid posts as there are few formal health facilities and professional health workers serving these communities.*

Objective 4.1: 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

4.1.2. Review, disseminate and monitor implementation of legal and policy related instruments for reducing structural barriers to national response

4.1.3 Strengthen the capacity of UAC and the partnership mechanism to carry out their mandates.

4.1.4 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

4.1.5 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

4.1.6 Ensure that gender, disability and human rights are mainstreamed in all major programmes in public and non-public sector.

4.1.7 Ensure implementation of EAC trans-boundary HIV and AIDS related legal and programmatic concerns as required by all partner states

Objective 4. 2: To ensure availability of adequate human resource for delivery of quality HIV and AIDS services

Strategic Actions

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

4.3.2 Harmonize pre- and in-service training of different cadres for HIV and AIDS service provision

4.3.3 Ensure that HIV and AIDS is mainstreamed in the curriculum of Education Institutions at all levels

4.3.4 Advocate for revision of public service structures and institutionalize critical staff and positions at health facilities, line ministries, departments, agencies and districts

4.3.5 Build the leadership and management capacity of key workers and structures for enhancing implementation of the national and decentralized HIV and AIDS response.

4.3.6 Promote the implementation of the public private partnership in the delivery of HIV and AIDS services.

Objective 4. 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 Actions

4.3.1. Institutionalize the Quantification and Procurement Planning Unit (QPPU) and support capacity building in procurement and management of products, goods and supplies, particularly at lower level health facilities.

4.3.2. Strengthen the harmonization of procurement and supply chain management, and the expansion of operationalization of Web-based ARV ordering and Reporting System

4.3.3. Standardize the Logistics Management Information System (LMIS) abuild requisite capacity in ICT and logistics management

4.3.4. Develop and implement a national comprehensive policy onst distribution of healt commodities and supplies and waste management in public and non-public facilities

4.3.5. Build the capacity of CSOs and commchain management of both health and non-health goods and services that enhance uptake of HIV and AIDS services

Objective 4.4: To ensure coordination and 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

4.4.2. 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

4.4.3. Promote greater coordination, linkage, partnership and collaboration among public and non-public sectors

4.4.4. 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 4.5: *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

4.5.2. Expand availability and capacity of laboratories at different levels for delivery of HIV and AIDS services

4.5.3. Increase the accreditation of HC-IIIs and HC-IIs to provide comprehensive HIV and AIDS and TB services

Objective 4.6: *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

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

4.6.3. Develop and disseminate appropriate tools for enhancing planning and resource allocation based on disease burden6 at district/facility levels and continuum of response

4.6.4. Increase government allocation for HIV and AIDS

4.6.5. 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

4.6.6. 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

4.6.7. 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

4.6.8. 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

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

Table 5: Systems Strengthening outcomes and indicators

Outcomes	Indicators		Baseline	Target
1. Strengthen the governance and leadership of the multi-sectoral HIV and AIDS response at all levels	1.1 National Commitments and Policy Instrument (NCPI) Index score		54.6% (CPR 2013)	95%
2. Availability of human resources for delivery of quality HIV and AIDS services ensured	2.2 Percentage of health facilities with the required staffing levels		TBD	80%
3. The procurement and supply management system for timely delivery of medical and non-medical products, goods and services required in the delivery of HIV and AIDS services strengthened	1.1 Percentage of health facilities with no stock outs of essential commodities of STI drugs, HIV test kits and condoms for >1 month within last 12 months	STI drugs	TBD	100%
		HIV test kits	TBD	90%
		Condoms	TBD	90%
	1.2 Proportion of health facilities providing ART services with no drug stock outs of > 2 months in the last 12 months		TBD	90%
4. Availability and access to quality HIV and AIDS services ensured	Indicators for this outcome are covered under various thematic areas			
5. To strengthen the infrastructure for scaling-up the delivery of quality HIV and AIDS services	1.1 Percent of laboratories with capacity to perform clinical lab tests according to national standards		TBD (HMIS)	TBD
	1.2 Proportion of health facilities offering ARV and eMTCT services		TBD (HMIS)	TBD
6. Resources mobilized and resource management streamlined for efficient utilization and accountability	1.1 Percentage of HIV and AIDS funding from GOU		GoU: 11% ADPs: 89% (NASA 2012)	Government: 40% ADPs: 60%
	1.2 Percentage of districts with HIV and AIDS costed strategic plans		TBD (LOGICs)	100%

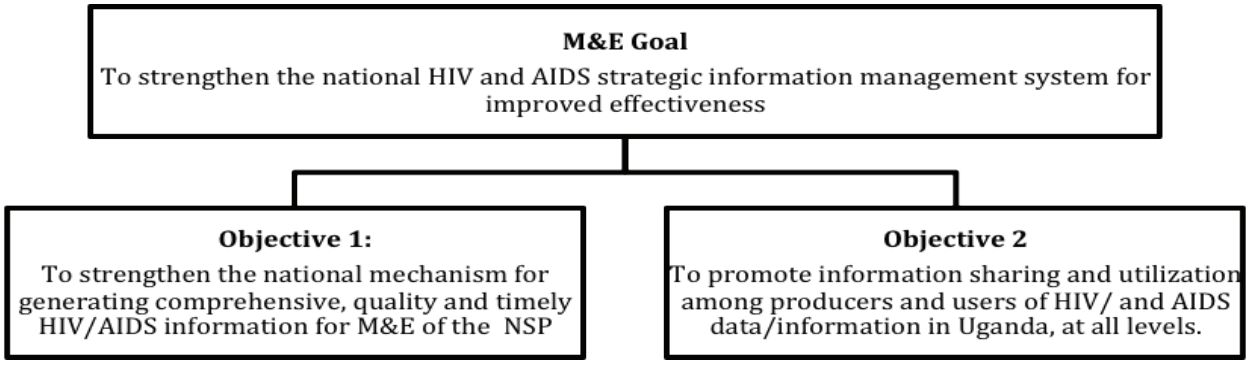
TBD: *These values will be collected by UAC in collaboration with respective sector Line Ministry.*

4.5.2 Monitoring, Evaluation and Research

The review of the National HIV and AIDS Strategic Plan 2011/2012- 2014/2015 pointed out the M&E component to be the weakest link of the NSP thematic areas. The M&E Plan 2015/2016-2019/2020 will therefore be developed, building on the NSP as part of the three ones to address the weakest link of the thematic areas. This M&E strategy is designed to coordinate and support all stakeholders to regularly and systematically track progress of implementation of priority initiatives of NSP and assess performance of stakeholders in accordance with the agreed objectives and performance indicators over the NSP period. It

will portray prioritized NSP objectives, as well as the performance tracking and measurement indicators that will enable stakeholders to assess progress towards achieving the desired results.

The following section summarizes the thematic goal, objectives and strategic actions per objective.



Objective 4.7.1: *To strengthen the national mechanism for generating comprehensive, quality and timely HIV and AIDS information for the National HIV and AIDS M&E 2015/2016-2019/2020*

Strategic Actions

4.7.1.1. Operationalization of the HIV and AIDS M&E Plan

4.7.1.2. Operationalize and roll out the National HIV and AIDS knowledge management platform/portal.

4.7.1.3. Improve mechanisms for capturing biomedical and non-biomedical HIV prevention data from all implementers.

4.7.1.4. Enhance mechanisms for improving data quality.

4.7.1.5. Strengthen the M&E capacity of HIV and AIDS implementers.

4.7.1.6. Strengthen HIV and AIDS M&E coordination and networks

4.7.1.7. Perform regular data analysis, aggregation and reporting.

Objective 4.7.2: *To promote information sharing and utilization among producers and users of HIV/ and AIDS data/information at all levels.*

Strategic Actions

4.7.2.1. Produce and disseminate tailored HIV and AIDS information products Conduct and disseminate NSP reviews.

4.7.2.3. Conduct operations research guided by the national HIV and AIDS research agenda to improve programming.

4.7.2.4. Expand platforms for multi-sectoral program reviews and data utilisation at national, regional and district levels

Table 6: Monitoring, evaluation and research outcome and indicators

Outcome	Performance Indicator	Baseline	Target	Data Sources
1. The national mechanism for generating comprehensive, quality and timely HIV and AIDS information for monitoring and evaluating the NSP 2014/15-2019/20 To strengthened.	1.1 Percentage of sectors with costed work plans reflecting HIV and AIDS M&E activities	TBD	50%	Sector Databases
	1.2 Percentage of key sectors submitting timely and complete reports	TBD	100%	UAC Database
	1.3 Proportion of complete reports submitted on community data for structural and behavioural indicators.	0%	80%	UAC E-mapping Database
2. Information sharing and utilization among producers and users of HIV and AIDS data/information promoted, at all levels.	2.1 Number of information dissemination products produced and disseminated by the NADIC	TBD	25 (5 per year)	UAC Databases
	2.2 Percentage of Implementing partners conducting HIV and AIDS operations Research based on the National Research Agenda.	0	100%	UAC Databases
	2.3 Number of NSP reviews conducted	1 End term evaluation 5 Annual reviews (UAC database)	1MTR 1 End term evaluation 5 Annual reviews	UAC Databases
	2.4 Global AIDS Response Progress Reports (GARPR) submitted on time	1 (UAC database)	5 (1 per year)	UAC Databases
	2.5 Number of information sharing events at sub - national level	4 events	20 sub-national meetings	UAC Databases

5.0 THE NATIONAL HIV AND AIDS STRATEGIC PLAN 2015/2016 - 2019/2020 CO-ORDINATION AND IMPLEMENTATION ARRANGEMENTS

5.1 Introduction

The UAC has the mandate to lead, coordinate and monitor the national multi-sectoral response to the HIV and AIDS epidemic in Uganda. During the implementation of the NSP, UAC will co-ordinate the response and provide guidance to the stakeholders; including public, civil society and private sector partners. Sectors, districts and lower local government structures will be responsible for (a) managing the response in their areas of jurisdiction (b) integrating HIV and AIDS in their core business and implementation agendas to achieve the set output and outcome targets.

Operationalizing and implementing the NSP will involve UAC, in continuous consultation with stakeholders, turning the strategic actions into annual priority action plans, delegating to stakeholders and assigning measurable outputs to the actions. The ever-changing landscape of the HIV epidemic will call for flexibility during programming, while still keeping focus on the set of core strategic actions in the NSP. The NSP was developed in line with the second NDP ational and overall post 2015 development agenda.

5.2 Institutional Arrangements for coordinating HIV and AIDS Response

5.2.1 Uganda AIDS Commission

The UAC is mandated to co-ordinate the national response. Hence, 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 operationalize an effective information management system (IMS) to facilitate implementation. In addition, and where possible, UAC will offer technical guidance to sectors, local governments and civil society actors.

Further, UAC will identify challenges in the implementation of the multi-sectoral response to the epidemic and ensure attainment of the NSP strategic actions and targets. It will also monitor the implementation of the NSP including resource utilization and accordingly consolidate and disseminate the information on the epidemic to national, regional, local and international partners.

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. Based on the HIV sero prevalence, the establishment started with two Zonal Coordination offices, one in Gulu to coordinate

northern Uganda and another in Mbarara to coordinate the Western region. The ZCUs are an extension of UAC to ensure closer HIV and AIDS planning, coordination and monitoring of the response. Thus, the ZCUs:

1. Provide technical guidance and support to scale-up the response; and advocate for improved Local Government commitment and effective coordination.
2. Coordinate, supervise, build capacity and monitor clusters of districts
3. Promote communication and collaboration between partners within the local governments on matters related to HIV and AIDS
4. Gather and scrutinize HIV and AIDS reports/data from all LGs for action.
5. Support LGs in a region/zone on planning and budgeting for HIV and AIDS activities
6. Provide capacity building to local governments HIV and AIDS coordination structures and key stakeholders regarding HIV and AIDS issues
7. Undertake regular support supervision to the LGs
8. Monitor and evaluate the HIV and AIDS response within the region/zone
9. Coordinate regional HIV and AIDS fora and events including regional HIV and AIDS advocacy and communication initiatives

5.2.2 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, Partnership Committee (PC), Self-coordinating Entities (SCEs) and Partnership Fund, with each structure playing a complementary and facilitating role to the others. The PM has since been reviewed and recommendations made for improving the functionality of the four structures.

The *Partnership Forum* is the overall body / General Assembly that comprises of stakeholders including the political, technical, policy level and civil society. The Forum brings together these stakeholders from the central and local government levels. Following the review of the Partnership Mechanism, the Forum is convened once every two years. The Forum reviews progress in the response and sets priorities for the next planning year paying keen interest to available resources in country.

The *Partnership Committee* (PC) is the central feature of the National HIV /AIDS Partnership. The PC plays a policy and technical advisory role to UAC and provides a platform for collective oversight over the management of the national response. PC also plays a technical advisory role to the UAC Board. The PC comprises of representatives from ten (10) Self-Coordinating Entities (SCEs), UNAIDS, the Ministries of; Health, Finance, Planning and Economic Development, Gender Labour and Social Development have permanent seats to the PC acknowledging their central role in the management of the multi-sectoral response.

The PC convenes quarterly to appraise members on progress made in implementation of the NSP, facilitate harmonisation of HIV and AIDS policies and steer mobilisation of resources to fill resource gaps in the national response. Further, PC sets the agenda for updating, implementation and monitoring of the national strategic framework for the AIDS response; review annual action plans and indicators to ensure that priority areas are adequately addressed; develop resource mobilization strategies for implementation of NSP; review budgets and financial reports from various constituencies and actors relevant to NSP; prepare for, organize, moderate and follow up on outcomes of the Partnership Fora; mobilize resources for the Partnership Fund, monitor and evaluate its outputs; approve budgets and activities of the Partnership Fund; identify and nominate outstanding achievements in HIV and AIDS work in Uganda for special recognition and award; and support HIV and AIDS Coordination in districts and lower level.

The *Self-coordinating entities (SCEs)* are clusters of stakeholders with similar areas of interest, come together in a coordinated way to contribute to the national HIV and AIDS response. These SCEs represent and coordinate the HIV and AIDS response on behalf of UAC within their constituencies. They come together regularly for joint planning, mutual support, consultation and complementarity on how to support implementation of national priorities as identified in the NSP. Currently, there are 10 *SCEs* namely, Parliament; Line Ministries; AIDS Development Partners (ADPs), Civil Society, Faith-Based Organisations (FBOs), PLHIV Networks, Private sector, Research Academia Science and Professionals; Media and Culture. SCEs are representatives of constituencies that exist in the national response.

During the implementation of this NSP, SCEs will be responsible for the performing roles that include 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 best practices amongst other SCEs; documentation and dissemination of best practices. It is a requirement that the AIDS Development Partners (ADPs) SCE will ensure that they fund implementers who align their plans to the NSP.

The *Partnership Fund* is a pooled source of funds from AIDS development partners 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, DFiD, Italian Cooperation, French Government, Norwegian Cooperation and the Joint UN Programme Support for HIV and AIDS (JUPSA). The system of pooling funds has set a positive precedence for common ownership of strategic responses, increased transparency and accountability of resources. The Partnership Fund will be used to support the coordination activities of the SCEs and UAC based on an agreed integrated work plan developed by the SCEs and consolidated by UAC Secretariat.

5.2.3 Government Ministries, Departments and Agencies (MDAs)

All sectors are important in the national HIV response. Hence, every MDA is mandated to mainstream HIV and AIDS activities into their policies and programmes. 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 also ensures that that there is a committed and capable HIV and AIDS Focal Person and a vibrant HIV and AIDS coordinating committee.

Table 7: MDAs and roles

Line Ministry, Department / Agency	Envisaged Role
Office of the Prime Minister	• Supervise and ensure that all government ministries, departments, agencies and local governments have mainstreamed HIV and AIDS in their core functions and integrated the NSP priorities in their investment plans and report accordingly
Ministry of Presidency	• Be the line ministry for Uganda AIDS Commission in government
Ministry of Justice and Constitutional Affairs	• Ensure appropriate legislations and policies in support of the national response are reviewed, implemented and monitored • Address rights violation-related drivers of HIV infection • Enforce regulations against SGBV, stigma and discrimination, good governance and accountability
Ministry of Health	• Ensure all health facility related interventions at national and decentralized levels are implemented • Ensure that health related goods and services are procured and distributed in time • Rationalize and monitor HIV and AIDS implementing partners
Ministry of Gender, Labour and Social Development	• Support implementation of interventions relating to socio-economic impact, promoters and barriers • Engage young people including youth and adolescents • Support mainstreaming of gender in HIV related policies, programmes, and budgets in public and private entities, • Enhance engagement cultural and religious institutions, workplaces, and special populations and OVC in the implementation of NSP
Ministry of Finance, Planning and Economic Development	• Ensure that central and local governments, ministries, departments and institutions mobilize adequate financial resources for implementation the NSP • Ensure that MDAs provide for, and disburse funds for NSP implementation • Oversee prudent financial management, procurement and accountability, and periodic tracking of HIV related resources. • Ensure that all national development initiatives integrate HIV as envisaged in the NSP. • Ensure that the AIDS Trust Fund is operationalized

Ministry of Public Service	• Ensure that all ministries, departments and agencies have HIV and AIDS related work place programmes that prioritize relevant NSP interventions
Ministry of Education, Science, Technology and Sports	• Ensure that all education institutions/schools design, plan and implement appropriate NSP activities targeting learners, educators and school communities. • Ensure that the pre-service curriculum in training and learning institutions integrate HIV and AIDS
Ministry of Agriculture, Animal Industry and Fisheries	• Ensure that HIV and AIDS activities are mainstreamed in the agriculture sector activities including fisheries • Ensure that appropriate interventions addressing the HIV and AIDS disease burden and vulnerability among fishing communities are included in major programmes within the sector • provide leadership in integration of HIV and AIDS in livelihood programmes, agricultural research and extension services
Ministry of Defence	• Ensure implementation of the NSP at all levels in the Ministry of Defence and Security
Ministry of Internal Affairs	• Ensure that NSP activities are implemented at all levels in the Police, Prisons and other departments of the ministry
Ministry of Works and Transport	• Ensure implementation of relevant NSP activities transport and communication sector
Ministry of Local Government	• Ensure implementation of relevant NSP activities are implemented at all levels in the ministry and in all local governments • Oversee the roles of DACs and lower local government AIDS committees, ensure NSP priorities are provided for in plans and budget of all departments, • Ensure that all PLHIV networks, CSOs, and FBOs align with the NSP and with district plans, appraise performance of officers against targets, and ensure that disbursement of funds is tied to progress in meeting targets.
All other ministries	• Ensure that they mainstream HIV and AIDS into their plans, programmes and policies • Disseminate HIV and AIDS Messages • Develop, align and Implement HIV and AIDS workplace policies • Mainstream and fund HIV and AIDS interventions

In general, MDAs will also be 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.

5.2.4 Local Government Level

The 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 LG
- 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 LG

5.2.5 CSOs and Communities of PLHIV

Civil society participation in the national response to HIV is dual track. CSOs are both providers and consumers of HIV prevention and AIDS care services. Their participation in HIV and AIDS services delivery and management enhances acceptability and use by members of the community because they can easily identify with the services that are being provided. In Uganda, Civil society networks and networks of persons living or affected by HIV play a key role in ensuring access to disease prevention, and HIV care services for women and girls and key population groups in whom HIV prevalence, and the likelihood of new infections and risk of transmission is particularly high. It is anticipated that civil society will play a leading role to:

- Participate in the processes of establishing HIV and AIDS policies and performance and other factors that are relevant to HIV prevention, AIDS care and support services, financing of programs, and of other structural challenges such as stigma and discrimination and gender-based inequalities that constitute barriers to an effective response to HIV and AIDS.
- Conduct advocacy at local and national levels aimed with an intention to hold accountable duty bearers for HIV prevention services, AIDS treatment, social support and protection for the most vulnerable communities such as persons with disability, key populations, women and girls among others.
- Strengthen collaboration and networking for effective linkages with other actors in the public and private sectors.
- 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

5.3 Implementation Arrangements for the NSP

5.3.1 Operationalization of the NSP

n order to operationalize the NSP, under the stewardship of UAC, HIV stakeholders 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. The development of the NPAP was guided by (a) disease burden disaggregated by districts, (b) overall and disaggregated output targets in the NSP and derived through computer simulation/modeling. 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.

5.3.2 Monitoring and Evaluation of Plan Implementation

A National M&E Plan provides 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 NSPM&E plan provides a platform for the establishment of a community data management system that has hitherto been absent. The Plan will be a core component of the national M&E system for the HIV and AIDS response which is strategically designed to utilise existing stakeholder sub-systems as building blocks. These building blocks comprise of sector management information systems. Given the multi-sectoral nature of the HIV and AIDS response and hence varied data sources for various indicators, the NSP M&E Plan clarifies the roles and responsibilities of various stakeholders in gathering, aggregating, and disseminating (including reporting) of HIV and AIDS data. The plan further spells out the required partnerships for generating data and performing data quality assurance interventions.

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.

6.0 COST ESTIMATES FOR NSP

6.1 Introduction

The finances to implement the NSP have been estimated with the view of achieving the best within a resource constrained setting. This has been guided by an analysis of a series of modeling aided by the Goals Model. The Goals model; a module implemented within the Spectrum Modeling System estimates the impact of future prevention and treatment interventions. The model calculates new HIV infections by sex and risk group as a function of behaviors and epidemiological factors such as prevalence among partners and stage of infection. The risk of transmission is determined by behaviors (number of partners, contacts per partners, condom use) and biomedical factors (ART use, male circumcision, prevalence of other STIs). Interventions can change any of these factors and, thus, affect the future course of the epidemic. The Goals Model is linked to the AIM module in Spectrum that calculates the effects on children (0-14) and those above the age of 49. The AIM module also includes the effects of programs to prevent mother-to-child transmission on pediatric infections.

6.2 Data and Assumptions

Epidemiological data used in the model are from the latest national estimates for Uganda prepared using Spectrum. This includes surveillance and survey data on HIV prevalence as well as program data on coverage of PMTCT and ART programs. International studies were used to set values of the epidemiological parameters such as the risk of HIV transmission per act and the variation in the risk of transmission by stage of infection, type of sex act, presence of other STIs, use of condoms, etc. See Annex 4.

Behavioral data are drawn primarily from the AIDS Indicator Survey (2011) and the Modes of Transmission (MoT) analysis. The inputs are presented in Annex 2. Unit cost data (Annex 2) are based on Uganda-specific sources or international averages[7]. Units' costs derived through a concerted process that included: reviews of relevant literatures on program expenditures, from the funding agencies and key implementing partners, costing studies and reports, as well as consultations with key implementing agencies. Where possible we have calculated expenditure per beneficiary using the latest estimates of expenditure by program component and the Goals estimates of the number of beneficiaries.

6.3 Modelling the Epidemic

The modeling for the NSP was done based on two key assumptions.

Base Case: – This assumes that HIV interventions will be carried out and maintained at the December 2013 levels.

NSP Scenario:- This is where interventions will be scaled up to attain the level set in the NSP.

7 *Financial Resources Required to Achieve National Goals for HIV Prevention, Treatment, Care and Support, Futures Institute, June 2010*

6.4 Model Based on Key Interventions Targets

The key interventions targets in the next five years for the NSP are shown in the Table below.

Table 8: Modeled key NSP interventions targets

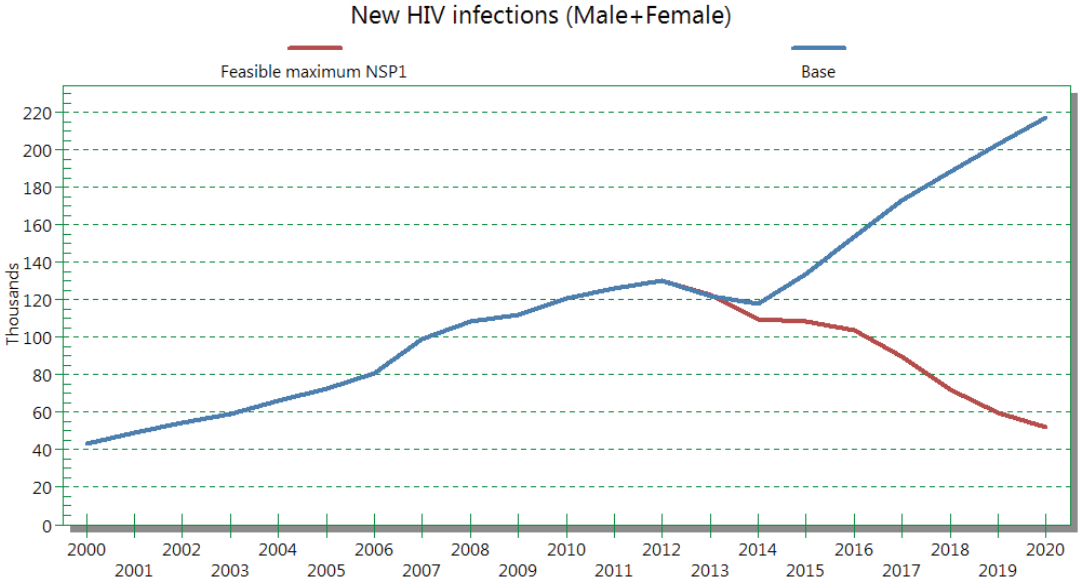
Indicator	Baseline (2013)	Target (2019/2020)
Adults tested for HIV in last 12 months and know results*	25%	35%*
HIV+ pregnant women receiving PMTCT**	76%	95%
High risk populations reporting consistent condom use	49% (AIS)	80%
Adult males that are circumcised	25%	40%
STI patients managed according to national guidelines	38%	50%
Blood screened	100%	100%
ART among eligible adults***	48%	80%
ART among eligible children***	32%	80%

** The NSP target is 80%. We assume that is 80% of the need. We interpret that to be 35% of the adult population tested each year.*

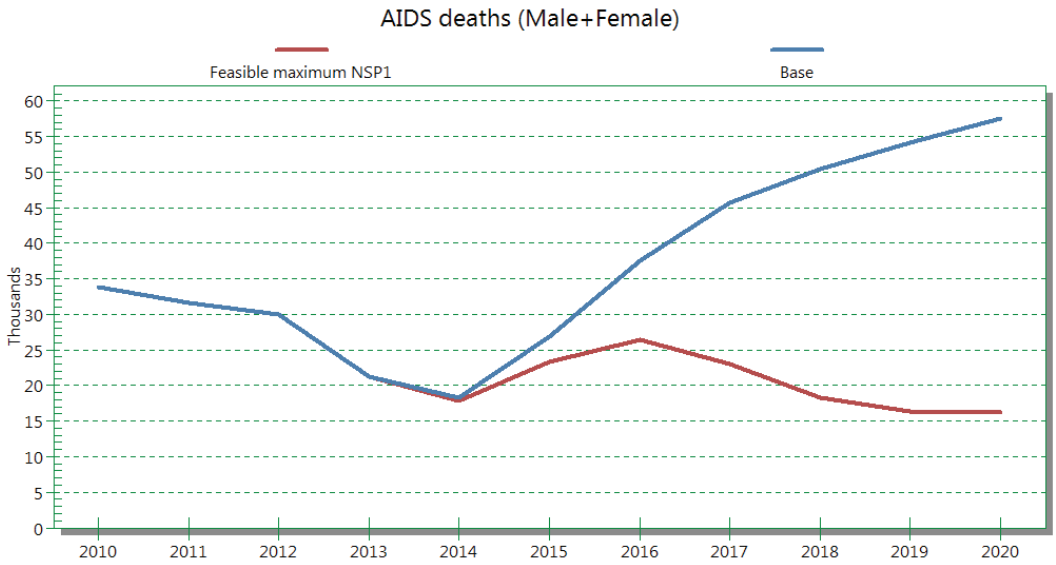
*** From 2013 onwards Option B+ is used.*

****Eligibility for ART for both adults and children changes in 2014 to the new WHO guideline recommendations. For adults that means eligibility at CD4 count < 500 cells/µl plus all HIV+ pregnant women, serodiscordant couples, HIV/TB co-infected, and HIV/HBV co-infected. For children the guidelines are modified to include eligibility for all HIV+ children below the age of 15.*

The results show that under the base case scenario new infections would continue to rise from 122,129 infections in 2013 to 217,056 new infections in 2020, (1,308,000 cumulative new infections). With the scale-up of the key interventions to attain the set targets by the 2020, new infections will drop from 122,129 as of 2013 to 48,300 new infections resulting into 607,698 new infections averted (46% reduction in new infections).



With increased scale-up of ART and improved quality of care, 149,000 AIDS deaths would be averted by the year 2020.



6.5 Projected Costs of the NSP.

The resource estimates for the NSP will be categorized annually based on the NSP thematic and a section for the program and other-cross cutting support overheads.

Table 9: Resources required for the NSP in US $ Millions

	2014	2015-16	2016/17	2017/18	2018/19	2019/20	2015-16 2019/20
Prevention	96.4	124.2	146.9	170.5	193.2	217.1	851.7
Care and treatment services	282.0	296.8	325.7	394.1	467.9	509.1	1,993.7
Social Support	28.0	29.0	30.0	31.0	32.0	33.0	155.0
System strengthening	87.1	96.9	108.7	129.9	152.1	159.8	647.5
Total Millions of USD	**493.5**	**546.9**	**611.3**	**725.5**	**845.2**	**918.9**	**3,647.9**

The cost for implementing the NSP will continue to grow in the next five years from US $ 546.9m in 2015/2016 to US $ 918.9m (cumulative cost of US $ 3647.9m by 2020). Care and treatment thematic area accounts for 55% of the NSP resources. Prevention interventions will account for 23% while Social Support and System Strengthening will account for 4% and 18% respectively.

6.6 Finance Gap Analysis.

The period of the NSP (2015/16 to 2019/20) is projected to require a total of US $ 3,786 Million. This is against a projected resource inflow of US 2,868 million from GOU and Partners. Thus, the financing gap is projected at US $ 918 million by the year 2019/20. This is largely on the account that most of the Development Partners have not yet indicated their projected commitments. See Table 10. The financing gap analysis also assumes that the GOU will increase its funding to the HIV and AIDS response to a level where it funds at least 40% of the NSP requirements from the current 11% (2013/14)

Table 10: Total commitment and funding gap

Agency	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Totals
Amounts in US $M.							
NSP estimates	526	568.5	632.6	752.4	876.2	957	3,786.70
Projected Inflow							
GoU	50.5	76	114	170	256	383	998.95
Bilateral	0						-
Irish Aid	8.58	8.58	TBC	TBC	TBC	TBC	8.58
DFID	4.84	8.23	TBC	TBC	TBC	TBC	8.23
DANIDA	7.1	7.1	TBC	TBC	TBC	TBC	7.10
SIDA	2.6	2	TBC	TBC	TBC	TBC	2.00
PEPFAR	323.39	323.39	323.39	323.39	323.39	323.39	1,616.94
Multilaterals	0						-
UNITAID / Clinton Health Access Initiative	5.48	2.9	TBC	TBC	TBC	TBC	2.90
UN Agencies	14.1	14.1	14.1	14.1	14.1	14.1	70.50
GFATM	70.2	72.1	81	TBC	TBC	TBC	153.10
Total Projected inflows	**486.79**	**514.15**	**532.11**	**507.93**	**593.14**	**720.97**	**2,868.30**
Funding Gap	**39.212**	**54.352**	**100.487**	**244.474**	**283.055**	**236.027**	**918.40**

6.7 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. These are the main sources of funding for the health sector from which the NSP drawn 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.

Increases in contributions by the GOU are essential and needed to fund the HIV and AIDS response. The rapid scale-up of the key priorities requires additional resources for the HIV and AIDS response. Thus,

Uganda needs to grow its HIV budget in tandem with the GDP expansion. The macro-economic prospects for Uganda are positive and this is consistent with the vision of the country to move from a low income developing country to a middle income country with the possibility of having a gross national income of between US $996 and US $3,945. With increasing GNI, GoU should increase its budgetary allocation to HIV and AIDS. It is important for the GoU to allocate more resources to the health sector to at least 12% of the total budget by 2018 and further to 15% by the year 2020 (in line with the Abuja Declaration of 2005). Increasing allocations to the health sector will be a key step, among others, toward improving the health infrastructure and human resource gaps which are vital for improved service delivery.

In 2011, Uganda embarked on the establishment and operationalization of a National AIDS Trust Fund and this has been included in HIV Control and Prevention Act, 2014. The purpose is (a) to mobilize resources for funding the national response to HIV and AIDS in the country and (b) to disburse funds and monitor the utilization of the funds according to the national priorities set out in the National Strategic Plan (NSP) and National Priority Action Plan (NPAP). The AIDS Trust Fund proposes modest tax on (a) direct incomes (including Income and Profits, Corporate Tax, With Holding Tax on Goods & Services and Bank Interest), (b) services (phones/internet services, international and domestic air tickets) and (c) manufactured goods (beers, soft drinks and cigarettes). This is expected to rise conservatively on an annual basis a total of US $100-250m (Shs 250-630bn)[8].

Further, a Bill was presented to Parliament with the objective to establish a National Health Insurance Scheme (NHIS)[9] to operate concurrently with community and private commercial health insurance schemes. Enactment of this Bill would significantly improve financial access to health care for many through a pooled financial risk mechanism. Funds from the NHIS would directly support access to clinical services associated with AIDS-related conditions and for treatment of STIs. Access to eMTCT services and treatment of other conditions such as malaria that adversely affects PLHIV would also improve. Estimates suggest that 30-35% (equivalent of up to US $24m) of this resource would be related to activities within the Investment Case to support all the community mobilization or all blood safety, PEP, universal precaution and safe injections activities.

8 *Uganda Investment case situation analysis*

9 *Ministry of Health (2007). The National Health Insurance Bill.*

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ANNEX 1: SELECTED DISTRICTS FOR IN-DEPTH CONSULTATION

NAIS Regions	District
Central 1	Kalangala
	Masaka
Central 2	Kiboga
Kampala	Kampala
East-Central	Namutumba
	Jinja
Mid-Eastern	Mbale
North-East	Amudat
	Soroti
West Nile	Arua
Mid Northern	Lira
	Gulu
South-Western	Bushenyi
	Kiruhura
Mid-Western	Kabarole
	Hoima

ANNEX 2: KEY UNIT COST ASSUMPTIONS

Intervention	Unit Cost	Source
BASIC PROGRAMMES		
ART	$420 per patient per year	MOH
Care and support		
Condoms	$0.039 per condom distributed	MOH, 2010
Male circumcision	$49 per circumcision	MUSPH, 2011
Prevention for sex workers and clients	$9.48 per person per year	NSP, 2011/12-14/15
Fishing Communities	$ 12 per Person	NSP
Blood safety (Additional cost of screening for HIV)	$ 4.8 per unit	NSP
ENABLING ENVIRONMENT		
Provider initiated testing and counseling	$7.56 per person	MOH Global Fund 2012
Workplace prevention	$6.67 per covered employee	RNM
Community mobilization	$1.07 per population	NSP
Mass media	$0.04 per person reached	MUSPH Costing Study
School-based programs	$181 per teacher trained	NSP
Out-of-school youth	$0.48 per youth reached	NSP
Program management	18% of direct costs	NSP

ANNEX 3: RESOURCE ESTIMATES FOR NATIONAL HIV AND AIDS STRATEGIC PLAN 2015/2016 TO 2019/2020

	2014	2015-16	2016/17	2017/18	2018/19	2019/20	2015-16 2019/20
	AMOUNTS IN US $ Millions						
Prevention	**96.4**	**124.2**	**146.9**	**170.5**	**193.2**	**217.1**	**851.7**
Priority populations							-
Youth focused interventions	5.1	5.2	5.4	5.6	5.8	6.0	28.1
Female sex workers and clien	0.2	0.2	0.2	0.3	0.3	0.3	1.3
Workplace	2.7	2.8	2.9	3.0	3.1	3.2	14.9
Men who have sex with men	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Community mobilization	5.9	6.6	7.3	8.1	8.9	9.8	40.8
Fishing Communities	6.0	7.4	8.8	10.2	11.6	13.0	51.0
Uniformed Services	3.3	3.5	3.8	4.1	4.4	4.6	20.4
Women and girls	2.6	3.4	4.1	4.9	5.6	6.4	24.3
Service delivery							-
Condom provision	3.3	4.0	4.7	5.5	6.4	7.3	27.9
STI management	15.5	16.7	18.0	19.3	20.7	22.2	96.9
Voluntary counseling and test	32.1	45.5	59.9	75.3	91.7	109.4	381.8
Male circumcision	1.2	7.8	8.3	8.6	9.0	9.4	43.1
PMTCT	16.5	18.9	21.2	23.4	23.3	23.0	109.8
Mass media	0.1	0.1	0.1	0.1	0.1	0.1	0.4
Health care							-
Blood safety	1.0	1.0	1.1	1.1	1.1	1.2	5.5
Post-exposure prophylaxis	0.3	0.3	0.3	0.3	0.3	0.3	1.6
Safe injection	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Universal precautions	0.6	0.7	0.7	0.7	0.7	0.7	3.5
							-
Care and treatment services	**282.0**	**296.8**	**325.7**	**394.1**	**467.9**	**509.1**	**1,993.7**
ARV therapy	282.0	296.8	325.7	394.1	467.9	509.1	1,993.7
							-
Social Support	**28.0**	**29.0**	**30.0**	**31.0**	**32.0**	**33.0**	**155.0**
OVC	28.0	29.0	30.0	31.0	32.0	33.0	155.0
							-
Program support	**87.1**	**96.9**	**108.7**	**129.9**	**152.1**	**159.8**	**647.5**
Enabling environment	3.8	4.2	4.7	5.6	6.6	7.3	28.5
Program management	1.9	2.1	2.4	2.8	3.3	3.6	14.2
Research	7.6	8.4	9.5	11.3	13.2	14.5	56.9
Monitoring and evaluation	18.9	21.1	23.6	28.2	33.1	36.3	142.3
Strategic communication	1.9	2.1	2.4	2.8	3.3	3.6	14.2
Logistics	11.4	12.6	14.2	16.9	19.8	21.8	85.4
Program-level HR	15.1	16.8	18.9	22.6	26.4	29.0	113.8
Training	3.8	4.2	4.7	5.6	6.6	7.3	28.5
Laboratory equipment	11.4	12.6	14.2	16.9	19.8	14.5	78.1
PVAW	0.0	0.0	0.0	0.1	0.1	0.1	0.3
Infrastructure	11.4	12.6	14.2	16.9	19.8	21.8	85.4
Total Millions of USD	**493.5**	**546.9**	**611.3**	**725.5**	**845.2**	**918.9**	**3,647.9**

ANNEX 4: EPIDEMIOLOGICAL PARAMETERS

Parameter	Value	Source
Transmission of HIV per act (female to male)	0.0011	Baggeley *et al*[i]., Gray *et al.*
Multiplier on transmission per act for		
- Male to female	1.0	
- Presence of STI	8	Galvin and Cohen[ii], 2.2-11.3 Powers *et a.l*[iii]. 5.1-8.2
- MSM contacts	2.6	Vittinghoff *et al*[iv].
Relative infectiousness by stage of infection		Boily *et a.l*[v]. 9.17 (4.47-18.81) Pinkerton[vi]
- Primary infection	9 – 40	Reference stage Boily *et al*[6]. 7.27 (4.45-11.88)
- Asymptomatic	1	Cohen *et al.*[vii]
- Symptomatic	7	Attia *et al.*[viii]
- On ART	0.04 – 0.08	
Efficacy in reducing HIV transmission		Weller and Davis[ix]
- Condom use	0.8	Auvert *et al*[x], Gray *et al*. (2007)[xi], Bailey *et al.*[xii]
- Male circumcision	0.6	Grant *et al.*[xiii]
- PrEP	0.55 – 0.73	Partners PrEP Study
- Microbicide	0.6	Abdool Karim *et al.*[xiv]

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Vulnerable persons include PWD, the elderly and key populations

ANNEX 5: LIST OF STEERING COMMITTEE MEMBERS

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35.	Margaret Happy	ICWEA
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3. Social Support and Protection Technical Working Group

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4.	Ms. Dorah K Musinguzi	UGANET
5.	Ms. Flavia Kyomukama	HRAPF
6.	Ms. Enid Wamani/Convener	UAC
7.	Mr. Mwesigwa Martin	NUDIPU
8.	Ms. Agnes Naluko	UAC
9.	Ms. Grace Muhuruzi	UAC
10.	Ms. Aidah Nakanjako	AMICAAL
11.	Ms. Kezia Mukasa	URAA
12.	Mr. Luwangula Richard	MUK
13.	Chimulwa Teddy	TASO/Chairperson
14.	Serwadda Christine	UAC
15.	Mworeko Lillian	ICWEA
16.	Mwesigwa Martin	NUDIPU
17.	Candiru Susan	UAC
18.	Akullu Harriet	UNICEF
19.	Wilbroad Ngambi	UNICEF
20.	Watya Stella	UAC
21.	Anne Kaddu	Mama's Club
22.	Alesi Jacquelyne	UNYPA
23.	Tumwine N. Apophia	MoGLSD
24.	Kabarungi Annet	MoGLSD
25.	Egesa John Joseph	TASO/GMU
26.	Ngobi Charles	TASO/GMU

4. Systems Strengthening Technical Working Group

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5.	Ndizihwe Assay	CDC
6.	Nuwagaba Gerald	MoLG
7.	Owembabazi Wilberforce	USAID
8.	Rose Okot-Ochono	USAID
9.	Ruyoka Raymond	UYAF/RHU – NAFOPHANU
10.	Tanzani Zephyr Kibenge	UAC
11.	Twesige Titus	AMICAALL
12.	Namakula Proscovia	NAFOPHANU
13.	Dr. Proscovia Namuwenge	CSF
14.	Namaganda Syson	CCM
15.	Kaboine Martin	UAC
16.	Mulungi Faith	UAC
17.	Arinaitwe Loyce	UAC
18.	Etii Tom	UAC
19.	Tatwebwa Lillian	UAC
20.	Dr. Wakooba Peter	UAC/Convener
21.	Candiru Susan	UAC
22.	Tumusiime Jennifer	UAC
23.	Odunge Josephine	UAC
24.	Kyeyune Daniel	UAC
25.	Okiiso Mary Christine	UAC
26.	Baguma Stephen	RAS
27.	Kulu Kenneth	MARPS Network
28.	Wanda Martin	AMICAALL

5. National Monitoring and Evaluation Technical Working Group

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3.	Magomu Steven	Uganda Young Positives
4.	Katungi Brian	MUK
5.	Denis Busobozi	UAC/Convener
6.	December Walter	MARPS Network
7.	Dr. Hudson Balidawa	MOH
8.	Dr. Wakooba Peter	UAC
9.	Dr. Zepher Karyabakabo	UAC
10.	Edward Mukooyo	MOH
11.	Esther Sempiira	MSH
12.	Adoch Gena Anna Winnifred	SSEO - MOWT
13.	Jotham Mubangizi	UNAIDS
14.	Dr. Kyokusingura Sarah	MEEPP
15.	Mark Tumwine	CDC
16.	Mugabi Emmanuel	MOES
17.	Mwangi Joseph	USAID
18.	Nakamya Phellister	CCM Secretariat of GF
19.	Nalukwago Judith	Family Health International
20.	Dr. Nelson Musoba	UAC
21.	Dr. Nkoyooyo Abdallah	AIC
22.	Dr. Norah Namuwenge	MOH
23.	Ocen Sam	Uganda Young Positives
24.	Kulu Kenneth	MARPS Network
25.	Senyonga Paul	MOGLSD
26.	Dr. Vincent Bagambe	MOH/FCO
27.	Walter Obiero	CDC
28.	Wandera Ibrahim	Office of the Prime Minister

29.	Dr. Mugerwa Shaban	MOH
30.	Kamoga Joseph	PEPFAR
31.	Mwesigwa Joshua	IRCU M&E
32.	Kashemeira Obadiah	MoGLSD
33.	Kyeyune Dan	UAC
34.	Ssenyonga Paul	S.E/MoGLD
35.	Bufumbo Leonard	Research Associate
36.	Bizimana David	Inter Aid Uganda

6. Resources and Costing Technical Working Group

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9.	Dr. Wakooba Peter	UAC
10.	Achom Agatha Mutenyo	UAC/Convener
11.	Mark Tumwine	CDC
12.	Kyomuhendo Sophia	UAC
13.	Busobozi Denis	UAC
14.	Katwesigye Elizabeth	UAC
15.	Amoit Sharon	UAC
16.	Bayigga Margie	UAC
17.	Swizin .K. Mugyema	MoLG
18.	Namanya Bhram	UNASO
19.	Owembabazi .W	USAID
20.	Raymond Ruyoka	NAFOPHANU
21.	Dr. Nakkazi Carol	UAC
22.	Assay Ndizihirwe	CDC
23.	Nakku Sarah	UNDP
24.	Namakula Prossy	NAFOPHANU
25.	Twesige Titus	AMICAALL

7. Gender Technical Working Group

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4.	Emebet Admassu	UNAIDS
5.	Mutavati Anna	UN Women
6.	Kabarungi Annette	MoGLSD
7.	Kiconco Dora	UGANET
8.	Makumbi Richard	CEDOVIP
9.	Minsi Monja Menengage	Mama's Club
10.	Mulindwa William	Positive Men's Union
11.	Mworeko Lillian	ICEAW
12.	Nakku Sarah	UNDP
13.	Senganda Jaffer	Muslim Centre for Justice and Law
14.	Tatwebwa Lillian	UAC
15.	Wamani Enid	UAC
16.	Watya Stella	UAC
17.	Odunge Josephine	UAC
18.	Okiiso Mary Christine	UAC
19.	Dr. Zepher Karyabakabo	UAC
20.	Nabaasa Samalie	Mama's Club
21.	Muhuruzi Grace	UAC
22.	Candiru Susan	UAC
23.	Bayigga Margie	UAC
24.	Mushabe Elizabeth	UN Women/SEDC Consultant
25.	Tumwesigye Eric	UN Women
26.	Magara Cornelius	PWIDO/MOGLSD
27.	Anne Kaddu	Mam's Club
28.	Dr. Wakooba Peter	UAC

29.	Dr. Mudiope Peter	UAC
30.	Prof. Vinand Nantulya	UAC
31.	Dr. Nakazzi Carol	UAC