AFRICA HEALTH ORGANISATION

AHO POLICY BRIEF ON HIV/AIDS IN UGANDA

PREVENTING HIV/AIDS IN UGANDA

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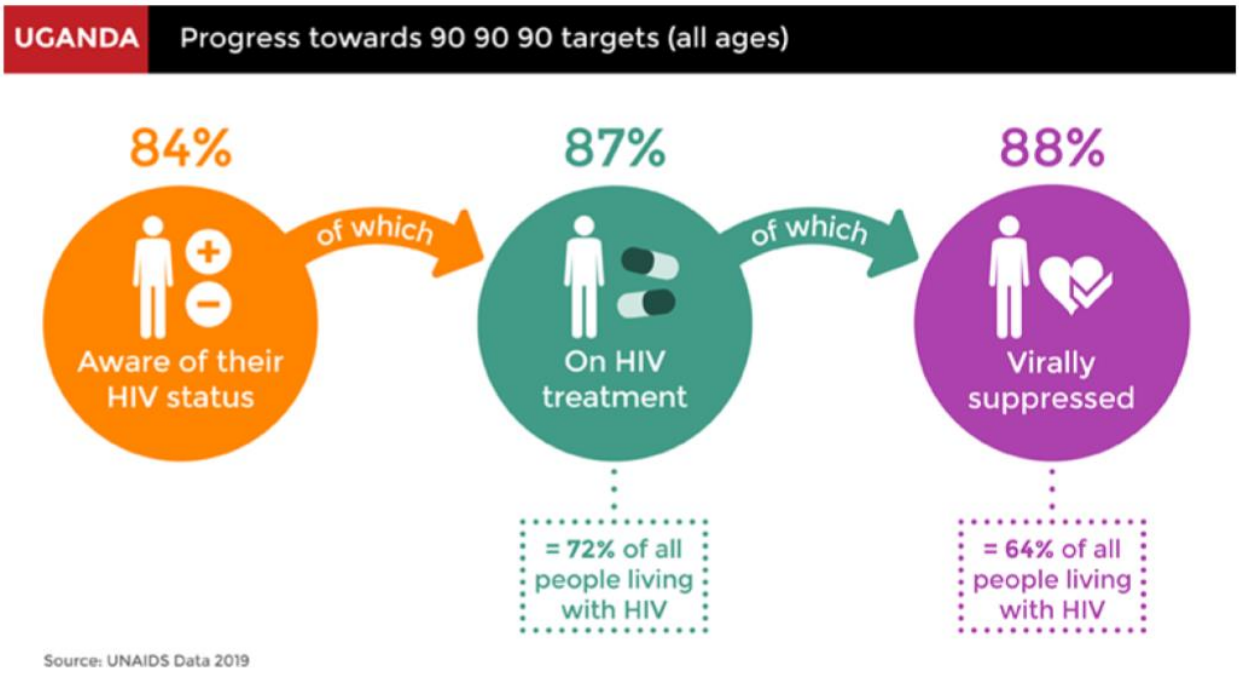
Introduction

With a high Human Immunodeficiency Virus (HIV) prevalence rate (18%) in the early 1990s, and Uganda was among the worst hit countries by the HIV and Acquired Immunodeficiency Syndrome (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 (UNAIDS, 2019).

HIV prevalence is especially higher in key populations (KPs) particularly sex workers (35-37%), fisher folk (22-29), long distance truck drivers (25%), uniformed services personnel (18.2%), men who have sex with men (MSM) (13.7%) and boda-boda taxi-men (7.5%). Women and girls constitute the largest proportion of People Living with HIV (PLHIV) - 8.3% compared to men at 6.1%. According to UNAIDS, 570 young women aged 15-24 get infected with HIV weekly in Uganda. 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 2017). The Joint United Nations Programme on HIV/AIDS (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. 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. 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 (UNAIDS, 2019).

FIGURE 1: UNAIDS 2030 GOAL

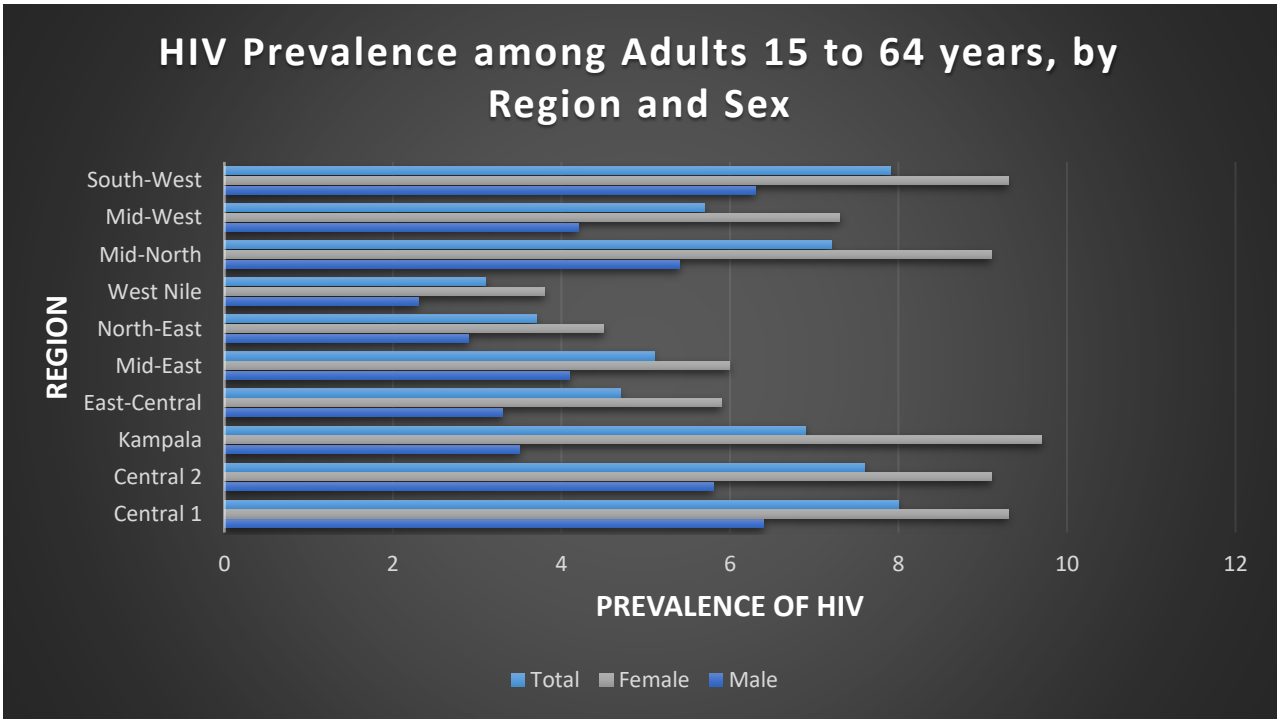


Analysis of the current situation

Globally, UNAIDS spearheads the call to scale up the response against HIV and AIDS and 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. Uganda has 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 (Ministry of Health, 2019).

Uganda seeks to halve the current burden of the AIDS pandemic and the country is scaling-up interventions, particularly combining the potential of Antiretroviral treatment (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, safe male circumcision (SMC), sexual and reproductive health services and innovative social support and protection measures. More governmental commitment and tough decisions are made at multiple levels- political, technical, and operational. In addition, innovative strategies to raise the resources are required to fund the HIV/AIDS response, which is currently underfunded and heavily donor dependent (Ministry of Health, 2019).

FIGURE 2: HIV PREVALENCE AMONG ADULTS 15 TO 64 YEARS, BY REGION AND SEX

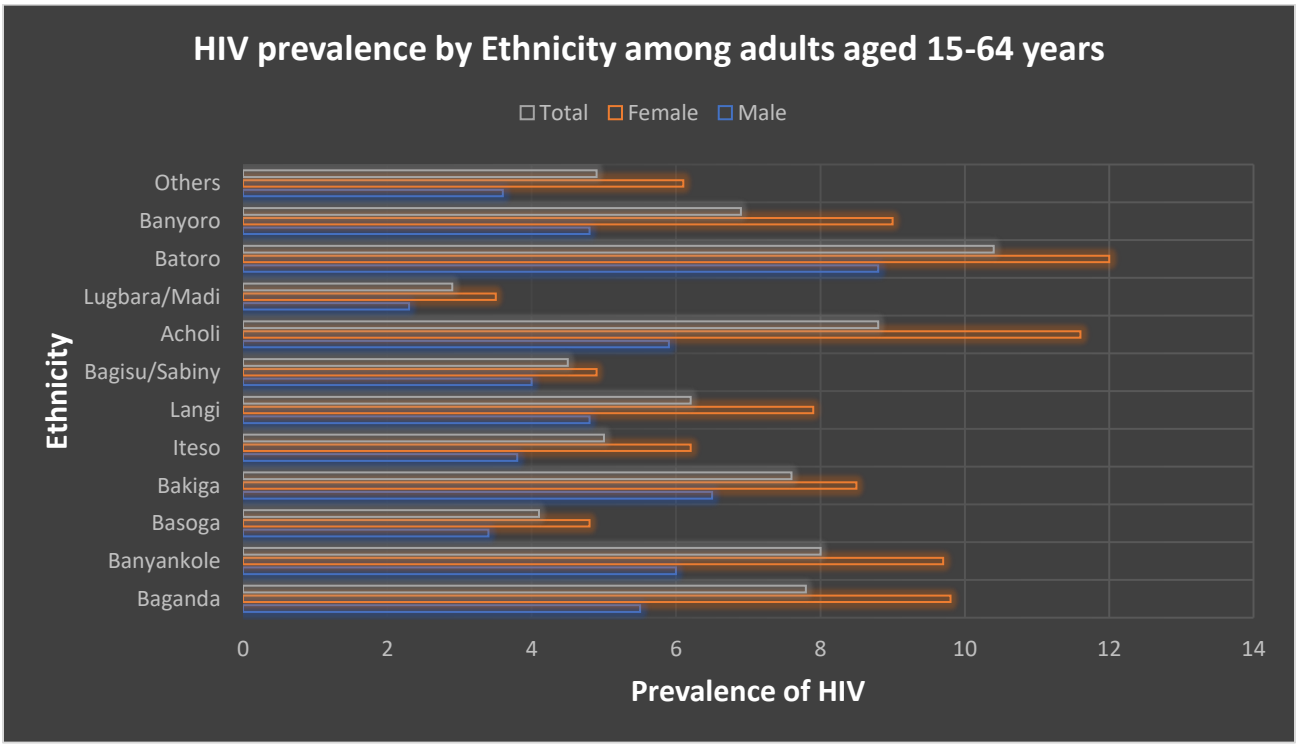


The impact of the HIV and AIDS epidemic on the country's economy and human development index is felt in many ways. Economic projections state that Uganda's Gross

Domestic Product (GDP) would grow at an average rate of 6.5% per year by 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 (Ministry of Health, 2019).

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 have higher prevalence rate (8.7%) than rural areas (7.0%), as shown below (UAC, 2015).

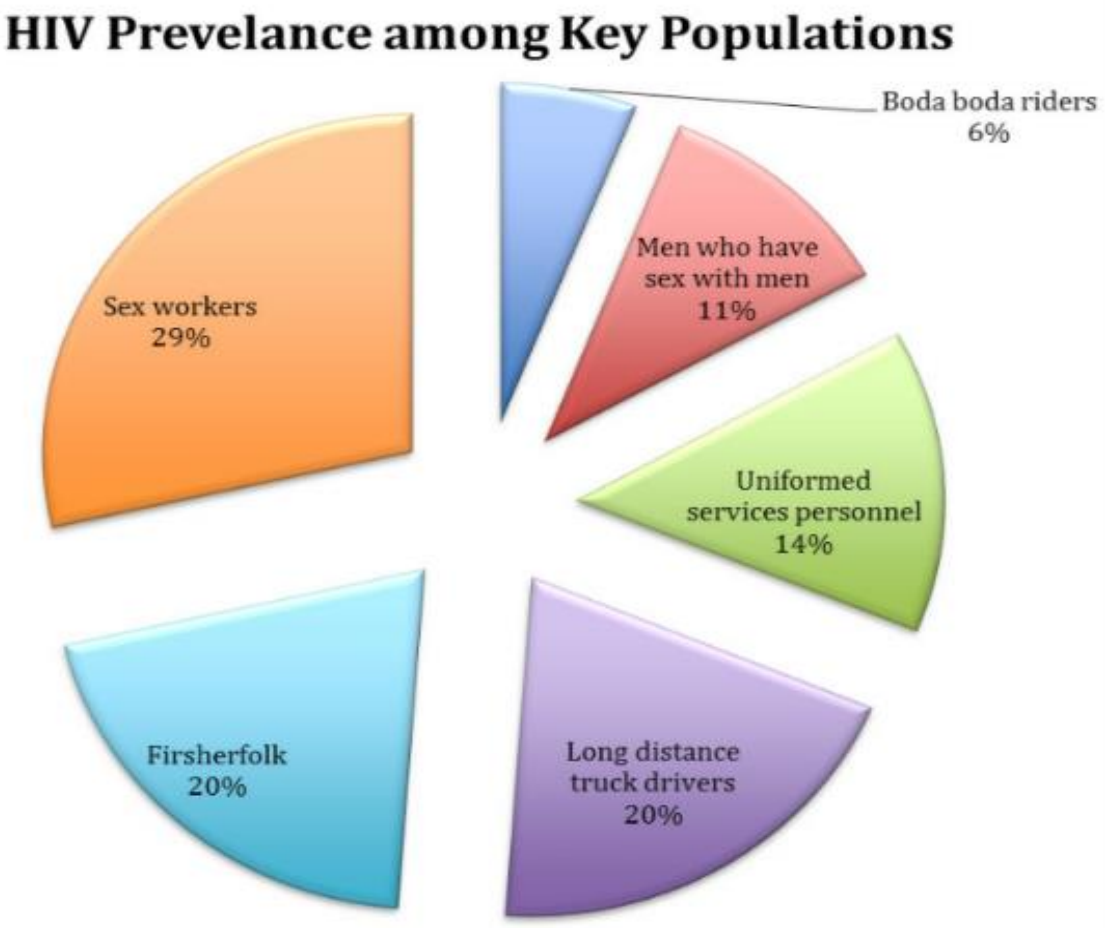
Figure 3: HIV prevalence by Ethnicity among adults aged 15-64 years



Affected population

In 2018, an estimated 1.4 million people were living with HIV, and an estimated 23,000 Ugandans died of AIDS-related illnesses. The epidemic is firmly established in the general population. As of 2018, the estimated HIV prevalence among adults (aged 15 to 49) stood at 5.7%. Women are disproportionately affected, with 8.8% of adult women living with HIV compared to 4.3% of men. Other groups particularly affected by HIV in Uganda are sex workers, young girls and adolescent women, men who have sex with men, people who inject drugs and people from Uganda's transient fishing communities (Ministry of Health, 2019).

FIGURE 4: MOST AT RISK POPULATIONS



Key factors responsible for new HIV infections in Uganda

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

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

Uganda is committed towards zero new infections, zero HIV and AIDS-related mortality and morbidity and zero discrimination. To achieve this, prevention, care and treatment, social support and protection, and systems strengthening are essential. Further, to reduce the prevalence of HIV/AIDS, Uganda needs to accelerate the scaling-up of prevention interventions such as: taking firm steps to reduce stigma and discrimination to zero; pursuing non-discriminatory and criminalizing approaches to key populations; combining the potential of ART to prevent new HIV infections with other proven HIV prevention

methods such as male and female condoms; increasing access to sexual and reproductive health services; and sustaining voluntary medical male circumcision (Ministry of Health, 2019).

HIV prevention programmes in Uganda

There were 50,000 new HIV infections in Uganda in 2017, mainly among adolescents and young people, women and girls, and key populations. The key prevention strategy may include, increasing the adoption of safer sexual behaviours and reduction in risk behaviours, scaling up coverage and use of biomedical HIV prevention interventions [such as voluntary medical male circumcision and (pre-exposure prophylaxis (PrEP)], and delivering as part of integrated health care services to mitigate underlying socio-cultural, gender and other factors that drive the HIV epidemic (UNAIDS, 2019).

- Condom availability and use

Data reported by UNAIDS in 2017 suggest 55.5% of men and 41.2% of women used a condom the last time they had higher-risk sex (defined as being with a non-marital, non-cohabiting partner). The number of male condoms distributed by the government rose from 87 million in 2012 to around 240 million by the end of 2015. However, this is far below the number of condoms required, given the population size. Strengthening the supply chain for both male and female condoms, and a coordinated approach to consistent condom promotion is an integral element in preventing the transmission of HIV in Uganda.

FIGURE 5: USE OF CONDOMS

- HIV education and approach to sex education

In 2015/16, more than 2 million people were reached with prevention information through religious congregations and cultural institutions programmes. Millions more were reached with HIV prevention messages through mass media channels including billboards, radio, television, and print media. Modules for life learning, with focus on sexuality education, were developed as part of the curriculum review process for lower secondary school classes. In addition, outreach to over 800 primary and secondary schools were conducted to provide HIV prevention information, with a focus on the risks of multiple partnerships, cross-generational, transactional, and early sex. In total, just under 360,000 children were reached with 1hour HIV and health education sessions in 2015/16.37

- Prevention of mother-to-child transmission (PMTCT)

In 2017, more than 97% of HIV-positive pregnant women received antiretroviral drugs to reduce the risk of mother-to-child transmission (MTCT), equating to over 115,000 women.

In 2016, around 3,637 health facilities were providing antiretroviral treatment for pregnant women, new mothers and breastfeeding women living with HIV. The positive strides Uganda has made towards PMTCT is evident by the 86% reduction in new infections among children between 2010 and 2016.41 However, the proportion of HIV-exposed infants tested for HIV remains low at 38% due to low retention of mother-and-baby pairs in PMTCT programmes.

- Voluntary medical male circumcision (VMMC)

Voluntary medical male circumcision (VMMC) is a proven bio-medical HIV-prevention intervention, reducing female-to-male sexual transmission of HIV by 60%. In 2011, the most recent data available, HIV prevalence stood at 4.5% among circumcised men and 6.7% among uncircumcised men. Although the percentage of eligible men receiving VMMC has risen to 40% in 2014 from 26.4% in 2011, problems with coverage and funding are hampering access. As a result, annual circumcisions declined in 2015 and 2016. While traditional and religious circumcisions continue, they are far too limited in their coverage and safety to contribute to the success of this intervention. In 2017, 847,633 male circumcisions were performed, falling short of the country's projected annual coverage target of 1 million.

- Access to PrEP

There are currently only an estimated 400-500 user of PrEP in Uganda. However, through a combination of clinical trials, demonstration projects, and implementation initiatives, this number could increase to 12,000-14,000.

Antiretroviral treatment (ART) availability in Uganda

In 2016, around 1,730 health facilities in operation in Uganda were offering antiretroviral treatment (ART). In the same year, nearly 898,200 people living with HIV were enrolled on treatment. In 2015, Uganda introduced World Health Organization treatment guidelines, which state that all people testing positive for HIV should be enrolled on ART regardless of their CD4+ T-Cell (CD4) count (which indicates the level of damage to the body's immune system). However, in 2016 only 67% of adults and 47% of children eligible for access were enrolled on ART (UNAIDS, 2019).

Just under 60% of adults living with HIV on treatment are virally suppressed. Increasing this percentage is a key target for the HIV response, as people who remain virally suppressed are unable to pass HIV on to others. Ugandan men on treatment are less likely to be virally suppressed than their female counterparts, with viral suppression rates standing at 53.6% and 62.9%, respectively. Children (aged 0-14 years) fare the worst in this respect, with just 39.3% virally suppressed. Staying on treatment is difficult for certain groups. Young people aged 15–19 in Uganda are more likely to drop out of HIV care, both before and after starting antiretroviral treatment, than are those aged 10–14 years or those older than 20 years. Studies suggest that stigma, discrimination, and disclosure issues, as well as travel and waiting times at clinics, are among the reasons (UNAIDS, 2019).

Civil society's role in Uganda

Civil society organizations (CSOs) play an active role in Uganda and many are dedicated to the protection of rights. The legal framework for civil society in Uganda is supportive of CSOs but only if their sphere of activity is politically and socially acceptable to the

government. In January 2016, the President assented to the Non-Governmental Organizations Act, 2016 which is a threat to the right to freedom of association. It prohibits CSOs and non-governmental organizations from carrying out activities in any part of the country unless they have approval from the government. The Prohibition of Promotion of Unnatural Sexual Practices Bill, which was introduced in October 2014 poses grave threats to NGOs engaging in any advocacy work with men who have sex with men or others from the LGBT community (UNAIDS, 2019).

HIV and tuberculosis (TB) in Uganda

Tuberculosis (TB) remains a major issue for people living with HIV in Uganda. HIV is the leading risk factor for development of TB, and TB is the leading cause of death among people with HIV. In 2016, HIV prevalence in Uganda was estimated at 7.3%, and 24% of people with TB were co-infected with HIV. As a result, a focus on delivering integrated TB/HIV services began in 2010. Between 2011 and 2017, the USAID-funded programme Strengthening Uganda's Systems for Treating AIDS Nationally (SUSTAIN) has resulted in a 13% increase (from 85% to 98%) for HIV testing and counselling for TB patients, and a 41% increase (50% to 91%) in initiation onto ART for people with TB who test positive (UNAIDS, 2019).

Barriers to the HIV response in Uganda

Social stigma and discrimination

Prejudices and social discrimination are some of the leading causes for certain groups of Uganda's population, such as sex workers and men who have sex with men, to avoid seeking health care or HIV testing. However, even the general population of people living with HIV are subjected to social stigma and negative judgement (UNAIDS, 2019).

Gender barriers

Since the Domestic Violence Act and the Prohibition of Female Genital Mutilation Act were both enacted in 2010, there has been a promising decline in rates of gender-based violence (GBV). Nevertheless, the 2011 Uganda Demographic and Health Survey, the most recent available, shows 50.5% of ever-married women reporting physical or sexual violence from a spouse in the preceding 12 months. Women aged 20-24 are worst affected, with 40% experiencing recent intimate partner violence, compared to 31% of women aged 15-19 and 30% of women aged 25-49 (UNAIDS, 2019).

Legal barriers

In Uganda, a number of laws and policies exist that constrain HIV and AIDS responses. However, the capacity to challenge these laws has been enhanced through the training of government officials and law enforcement officers on HIV, stigma and discrimination. This process contributed to major revisions to the Anti-Homosexuality Bill – reflected in the Act that was initially passed in 2013. Although the Anti-Homosexuality Act is thought to have resulted in increased anti-gay sentiment, the training scheme also led to Ugandan authorities implementing effective policies prohibiting the spread of GBV (UNAIDS, 2019).

The passing of the HIV Prevention and Control Act in 2014 has been a cause for concern. The bill includes mandatory HIV testing for pregnant women and their partners and allows medical providers to disclose a patient's HIV status to others. UNAIDS and other international agencies have discouraged such laws, which can disproportionately target women, who because of health care during pregnancy may be more likely to know their HIV status. The bill also criminalises HIV transmission, attempted transmission, and behaviour that might result in transmission by those who know their HIV status. Human

Rights Watch, HEALTH Global Advocacy Project, and Uganda Network on Law, Ethics & HIV/AIDS have criticised the act. They point to the fact that mandatory HIV testing and the disclosure of medical information without consent are contrary to international best practices and violate fundamental human rights. They also described the criminalisation of HIV transmission, attempted transmission, and behaviour that might result in transmission by those who know their HIV status as overly broad, and difficult to enforce (UNAIDS, 2019).

Structural and resource barriers

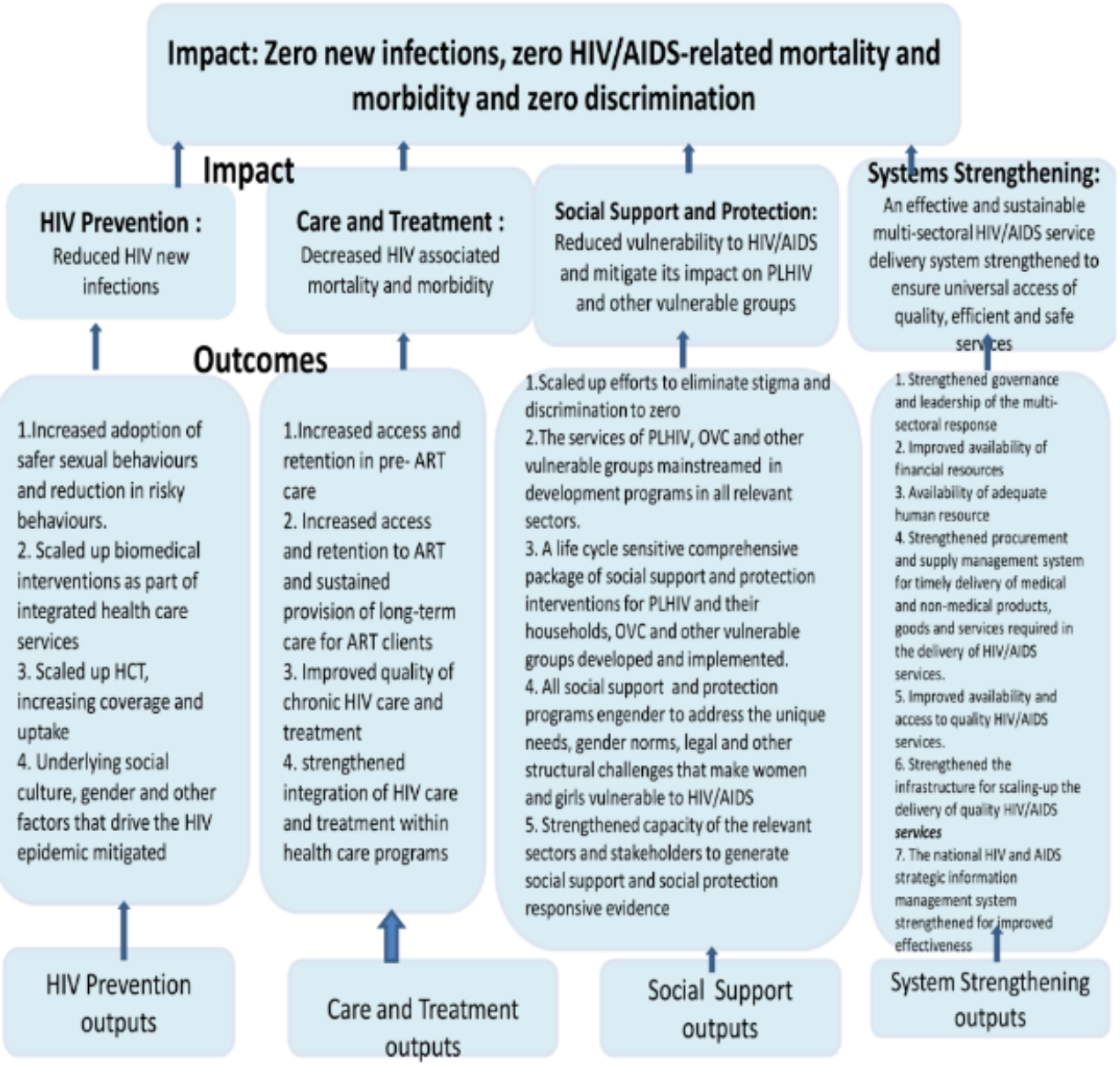
All Ugandan districts report frequent stock outs of HIV testing kits and inadequate human resource to offer comprehensive testing and treatment services. This is despite the presence of implementing partners that provide buffers stocks. Other prevention interventions such as VMMC and PMTCT services have been disrupted by a lack of drugs, medical supplies, and staff. In general, the supply chain for antiretroviral drugs is good. However, at times some health facilities will run out of specific formulations (UNAIDS, 2019).

Strategic Objectives and Actions to reduce the burden of HIV/AIDS in Uganda.

There is a need for Uganda to accelerate the scaling-up of prevention interventions, such as: combining the potential of ART to prevent new HIV infections with other proven HIV prevention methods such as male and female condoms; sustaining voluntary medical male circumcision; taking firm steps to reduce stigma and discrimination to zero; pursuing non-discriminatory and criminalizing approaches to key populations; increasing access to sexual and reproductive health services and innovative social support and protection measures. To achieve the goal of zero new infections, zero HIV and AIDS-related

mortality and morbidity and zero discrimination, implementation of interventions should focus four broad activity areas, namely: Prevention, Care and Treatment, Social Support and Protection, and Systems Strengthening (UAC, 2015).

FIGURE 6: STRATEGIC PLAN AND OBJECTIVES FRAMEWORK



Prevention

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

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

Strategic actions

- Scale-up age-and audience-appropriate social and behavioral change interventions including AB to reach all population groups with targeted HIV prevention messages
- Strengthen policy guidance, quality assurance and capacity for effective IEC/social and behavioral change communication programming at all levels
- 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
- Scale-up condom education (emphasizing correct and consistent use) to address complacency and fatigue associated to condom use
- Integrate sexual and gender-based violence (SGBV) prevention and human rights into HIV prevention programming
- Conduct mapping and size estimation for key populations to inform targeted and scaled-up interventions for key populations

- Scale-up comprehensive sexual and reproductive health (SRH)/HIV programs targeting, adolescents (both in and out of school) and young people
- Scale-up comprehensive interventions targeting key populations
- Provide a comprehensive package of SRH, HIV prevention, care and treatment through harmonized programming and ensure access by vulnerable populations such as women and girls and persons with disability.
- Expand programming for positive health, dignity, and prevention (PHDP) interventions
- Support and implement family centered approaches to prevent HIV infection

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

Strategic actions

- Expand coverage and uptake of biomedical priority HIV interventions (SMC, EMTCT, condom, ART) to optimal levels
- Improve the quality of biomedical HIV prevention interventions through enhanced quality assurance (QA)/ quality control (QC) approaches
- Scale-up coverage of HCT and increase linkage into HIV prevention care and treatment targeting the general population key populations and vulnerable groups especially in identified hotspot areas
- Scale-up demand creation interventions to increase uptake of biomedical interventions

- 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
- Expand targeted STI interventions for key populations and vulnerable groups
- Integrate SRH; maternal, newborn and child health (MNCH) and TB services with HIV prevention
- Expand standardized and targeted combination HIV prevention services for key populations
- Adopt new HIV prevention technologies and services including Pre-Exposure Prophylaxis (PrEP)
- Strengthen medical infection control and ensure universal precaution
- Expand mechanisms to improve blood collection, storage, and screening for HIV
- Support research in primary prevention including microbicides and vaccines

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

Strategic actions

- 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
- Strengthen legislative and policy framework for HIV prevention
- Apply gender and human rights-based programming approaches for HIV prevention programs at national and lower levels

- Strengthen capacity of health, legal and social service providers to manage SGBV cases
- Promote male involvement in HIV prevention for their own health and the health of their partners and families
- Strengthen efforts against stigma and discrimination
- Utilize community extension work programs in the socioeconomic sectors to deliver HIV programs

Care and Treatment

To reduce HIV associated morbidity and mortality, achieving, and maintaining 90% viral suppression, efforts should focus on increasing enrollment, early initiation, and better retention in chronic HIV care.

FIGURE 7: CARE AND TREATMENT

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

Strategic Actions

- Strengthen mechanisms for linkage to care for all HIV positive individuals
- Increase HIV care entry points within health facilities, community, schools social/child protection and workplaces for HIV exposed infants, children, adolescents and men
- 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
- Promote universal access to the basic care package

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

Strategic Actions

- Strengthen care and treatment referral within decentralized ART services with inclusion of community and home-based HIV treatment
- Expand and consolidate pediatric and adolescent ART in all accredited ART sites
- Supporting transitions between child-adolescent -adult care
- 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.
- Strengthening early initiation into ART and adherence support services
- Streamline “Nurse Driven’ Care plus 3-4 monthly drug refills for patients who are stable on ART.

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

Strategic Actions.

- Establish quality assurance and quality improvement activities at all HIV care and treatment sites
- 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
- Strengthen monitoring of chronic HIV care and treatment including scale-up of viral load monitoring and surveillance for drug resistance
- Strengthen treatment monitoring and evaluation of clinical complications and effects of long-term use of antiretroviral drugs.
- Promote universal access to the basic care package.

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

Strategic Actions

- Fully integrate HIV/TB programming and services at all levels including community DOTS and home-based care
- Integrate HIV care and treatment with maternal, newborn and child health, sexual and reproductive health and rights, mental health, and non-communicable /chronic diseases
- Provide prevention and management of OI, STIs and ART wrap around services in general outpatient and inpatient care

- Integrate nutrition assessment, counseling and support in HIV care and treatment services including use of ready to use therapeutic food (RUTF) for severely malnourished, and linkages to increase food security

Social Support and Protection

There is an need to 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.

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

vulnerable groups

Strategic Actions.

- Mobilize and strengthen cultural (including traditional healers) and religious institutions, community support systems and PLHIV Networks to address stigma
- Strengthen interventions that empower PLHIV to deal with self-stigma
- Conduct PLHIV Stigma Index assessment at least every two years
- Implement campaigns to addresses stigma experienced in homes, communities and other institutions (schools, hospitals, workplaces and places of worship)
- Design and implement interventions to eliminate discrimination against women and girls in the context of HIV and AIDS
- Institute and strengthen anti-stigma and discrimination programs for key populations

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

Strategic Actions.

- Integrate PLHIV, OVC and other vulnerable groups' needs in development programming
- Coordinate all sectors to fulfil and account for their mandate in relation to social support and social protection
- Campaign for revision of harmful laws and policies that deter PLHIV, OVC, key populations and vulnerable groups from accessing social support and protection interventions
- Integrate social support and protection issues in education sector programs (including school health and reading programs, PIASCY, curricular and extracurricular activities)
- Implement targeted programmes that support PLHIV, OVC and other vulnerable groups to access livelihood opportunities, vocational skills training, and informal education
- Expand social assistance grants to most vulnerable PLHIV, OVC and other vulnerable persons
- Design and implement interventions that prioritize the key populations, elderly and PWDs in social support and protection services

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.

- Develop and promote a life cycle sensitive comprehensive package of social support and protection interventions for PLHIV, OVC, key populations and other vulnerable groups.
- 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
- Develop and implement appropriate strategies to prevent and respond to child abuse and exploitation
- Strengthen community-based structures to effectively respond to the needs of PLHIV, OVC and other vulnerable groups
- Develop and implement interventions to strengthen the community facility linkage for responding to needs of PLHIV, OVC and other vulnerable groups
- Build and scale- up capacity for quality counseling services for PLHIV, OVC, key populations and other vulnerable groups

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

Strategic Actions

- 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.

- Strengthen institutions and sectors to implement laws and policies addressing SGBV and other rights violations among PLHIV, OVC, key populations and other vulnerable persons
- Enhance capacity of all actors engaged in the HIV and AIDS national response to adopt gender and rights-based HIV programming
- Establish mechanisms for engaging men and boys in HIV/ AIDS and SGBV programming
- To build capacity of community groups and networks to address violence against women, girls, men and boys, and vulnerability to HIV and AIDS through social mobilization targeting cultural and religious structures.

Systems Strengthening

To strengthen systems for timely and effective HIV prevention and AIDS care services, there is a need to puts emphasis on an effective and sustainable multi-sector HIV and AIDS service delivery system. Such a system will ensure universal access and coverage of quality, efficient and safe service to targeted population.

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

Strategic Actions

- 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

- Review, disseminate and monitor implementation of legal and policy related instruments for reducing structural barriers to national response
- Strengthen the capacity of interventions and the partnership mechanism to carry out coordination of the multi-sector response.
- 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
- 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
- Ensure that gender, disability and human rights are mainstreamed in all major programmes in public and nonpublic sector.
- Ensure implementation of trans-boundary HIV and AIDS related legal and programmatic concerns as required by all partner states

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

Strategic Action

- 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

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

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

Strategic Action

- Institutionalize the programs and support capacity building in procurement and management of products, goods, and supplies, particularly at lower level health facilities.
- Strengthen the harmonization of procurement and supply chain management, and the expansion of operationalization of Web-based Antiretroviral (ARV) ordering and Reporting System

- Develop and implement a national comprehensive policy on storage, distribution of health commodities and supplies and waste management in public and non-public facilities
- Standardize the interventions and build the requisite capacity in ICT and logistics management
- Build the capacity of CSOs and communities in procurement and supply chain management of both health and non-health goods and services that enhance uptake of HIV and AIDS services

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

Strategic Actions

- Promote integration of HIV and AIDS services in all settings and in major development programme service delivery
- 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
- Promote greater coordination, linkage, partnership, and collaboration among public and non-public sectors
- Strengthen capacity of CSOs and communities for increased advocacy and mobilization for demand and uptake of services, social participation, self-regulation, and accountability in the multi-sectoral response.

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

Strategic Actions

- 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

- Expand availability and capacity of laboratories at different levels for delivery of HIV and AIDS services
- Increase the accreditation of health centers to provide comprehensive HIV and AIDS and TB services

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

accountability

Strategic Actions

- Expedite the implementation of the AIDS Trust Fund for enhancing local resource mobilization
- Institutionalize a resource mobilization conference for facilitating advocacy for increased support by traditional and non-traditional bilateral and multilateral actors and the private sector
- Develop and disseminate appropriate tools for enhancing planning and resource allocation based on disease burden at district/facility levels and continuum of response
- Increase government allocation for HIV and AIDS

- 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
- 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
- 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
- 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

Objective 7: To strengthen the national mechanism for generating comprehensive, quality, and timely HIV and AIDS information for Monitoring and Evaluation of interventions.

Strategic objectives

- Operationalize of the HIV and AIDS Monitoring and Evaluation Plan.
- Operationalize and roll out Knowledge platform/portal.
- Improve mechanisms for capturing biomedical and nonbiomedical HIV prevention data from all implementers
- Enhance mechanisms for improving data quality.
- Strengthen the Monitoring and Evaluation capacity of HIV and AIDS implementers.

- Strengthen HIV and AIDS Monitoring and Evaluation coordination and networks.
- Perform regular data analysis, aggregation, and reporting

Objective 8: To promote information sharing and utilization among producers and users of HIV/ and AIDS data/information at all levels.

Strategic objectives

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

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