The Republic Of Uganda

KANUNGU DISTRICT HIV AND AIDS STRATEGIC PLAN 2020/2021- 2024/2025

APRIL 2021

This publication has been made possible by special support from the Government of Uganda through Uganda AIDS Commission and HIV and AIDS Development Partners

Published by: KANUNGU District Local Government

Preferred Citation: Kanungu (2021) District HIV and AIDS Strategic Plan 2020/2021-2024/2025:

Available Copies from: ***Kanungu Health Department***

TABLE OF CONTENTS

Foreword

HIV/AIDS is a development problem in Kanungu. The high HIV sero prevalence rate of 7.3% among the general population and, the increasing number of orphans, the declining productivity and the food scarcity among the affected families is very challenging. The District AIDS Committee (DAC) has continued to spearhead the strengthening, expansion and coordination of the District response towards the scourge at all levels.

Over the years, strides in the fight against HIV/AIDS have been made to; prevent further HIV infections, mitigate its impact and build capacity to manage the implementation of HIV/AIDS activities. The district has tirelessly worked with its development agencies, implementing partners, communities and the PLHAs to make some difference, which must be expanded, strengthened and sustained.

In the recent past, the District has been able to improve on infrastructure for HIV/AIDS implementation in terms of financing, medicines and supplies, human resources in collaboration with HIV/AIDS partners. However, there are still numerous challenges in service delivery with regard to mainstreaming, coverage, accessibility, quality and not forgetting the emerging challenges that have come along with refugees and clients from South Sudan and the Democratic Republic of Congo.

Basing on the key mainstreaming principles, there is need for line budgets for implementing HIV/AIDS activities in the District in preventing the spread of HIV as per Presidential directives on ending HIV/AIDS by 2030. Government should undertake the flexibility of 0.1% funding to HIVAIDS response in the District

The District priorities in the next five years are fully elaborated in this 5-year HIV/AIDS Strategic Plan 2020/2021-2024/2025. It is my sincere hope that all the stakeholders shall support and utilize this strategic plan. The district pledges continued commitment and support and shall greatly appreciate contributions from other support partners towards achieving our goal.

For God and My Country

Eng. Arineitwe Sam Kajojo
DISTRICT CHAIRPERSON
KANUNGU DISTRICT LOCAL GOVERNMENT

ACKNOWLEDGMENTS

I wish to acknowledge the invaluable contributions from Departments that successfully participated in reviewing its second District HIV/AIDS strategic plan 2020/21-2024/25. Special tribute goes to Uganda AIDS commission and HIV and AIDS Development Partners for the technical backstopping during the review process without which this document would not have been a reality. Equally, I wish to express my appreciation to the USAID Uganda Health Systems Strengthening (UHSS) Activity and the RHITES-E for technical and financial assistance.

The District HIV/AIDS strategic plan 2020/21-2024/25 (HIV Plan) was reviewed through an inclusive and cooperative process that included input and feedback from stakeholders across public health, health care, research, and related fields. Partners throughout the Local Government that work in HIV and related fields have helped shape the goals, objectives, and strategies in this Plan.

I am equally indebted to the District council and Lower Local Government stakeholders plus the representatives of the civil society organizations for providing data which was analysed and interpreted to give meaning of this plan.

Indeed, all data in this plan should be able to inform all decision makers in resource allocation and location of service delivery points in this district.

I am grateful to the District technical working group (TWG) and more particularly the District Planning Unit spearheaded by District Population Officer/HIV Focal person and District Health Officer for ably consolidating the departmental responses into meaningful workable document.

To our stakeholders, I believe you will find this report very useful in guiding on benchmarks when designing programmes as the plan provides the district HIV/AIDS situation at glance and a more detailed and HIV/AIDS subject oriented analysis.

I am hopeful that the Strategic Plan once implemented well, will make significant improvements in reducing HIV/AIDS prevalence in Kanungu District.

Abenaitwe Robert
CHIEF ADMINISTRATIVE OFFICER
KANUNGU DISTRICT LOCAL GOVERNMENT

Acronyms

AIC	**AIDS Information Centre**
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
BCC	Behavior Change Communication
CB DOT	Community Based Directly Observed Treatment
CBOs	Community Based Organizations
DHAC	District HIV/AIDS Committee
DOT	Directly observed Treatment
DRC	Democratic Republic of Congo
GBV	Gender Based Violence
HBC	Home Based Care
JCRC	Joint clinical research Centre
HCT	HIV Counseling and Testing
HIV	Human Immune Deficiency Virus
HMIS	Health Management Information System
HSD	Health Sub District
HSSP	Health Sector Strategic Plan
IEC	Information Education Communication
IGA	Income Generating Activities
IMR	Infant Mortality Ratio
IPT	Intermittent Presumptive Treatment
LB	Live Birth
LC	Local Council
MCH	Maternal and Child Health
MDD	Music Dance and Drama
MMR	Maternal Mortality Rate
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHP	National Health Policy
OVC	Orphans and Vulnerable Children
PHC	Primary Health Care
PHP	Private Health Practitioner
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
PNFP	Private Not for Profit
SDS	Strengthening Decentralization for Sustainability
SSW	Star South West
STDs	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
SWOT	Strength Weakness Opportunity and Threats
TASO	The AIDS Support Organization
TB	Tuberculosis
UAC	Uganda AIDS Commission

DEFINITION OF KEY TERMS

Antiretroviral therapy (ART): Treatment with antiretroviral (ARV) drugs that inhibit the ability of HIV to multiply in the body, leading to improved health and survival in HIV-positive persons.

Combination HIV prevention: Refers to a focused combination of different HIV prevention tools or approaches that cut across behavioural, biomedical, and structural dimensions (either at the same time or in sequence) to offer high-impact packages of HIV prevention interventions to specific groups. Combination prevention is based on the recognition that no single HIV prevention approach can act alone to stop the HIV epidemic.

Community-led: Community-led organizations, groups and networks are entities for which most governance, leadership, staff, spokespeople, membership, and volunteers reflect and represent the experiences, perspectives, and voices of their constituencies—the communities— and that have transparent mechanisms of accountability to their constituencies.

Comprehensive knowledge of HIV: Persons able to: (a) recall having seen or heard messages on HIV and AIDS, (b) name the three recommended behaviours of HIV prevention and (c) reject two misconceptions about HIV transmission.

Discrimination: Refers to the unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age, disability or sex. It also may be exhibited against persons (known or suspected to be) living with HIV or suffering from AIDS.

Gender equality: Refers to the equal treatment of men and women in the access to—and allocation of—resources, opportunities, freedoms, services and benefits in families, communities and society at large. Men and women should enjoy equal status, recognition and consideration in all aspects of life.

Gender-responsive: Refers to awareness of gender concerns, disparities and their causes, and takes action to address and overcome gender-based inequalities.

Harm reduction: Refers to a comprehensive package of policies, programmes and approaches that seeks to reduce the harmful health, social and economic consequences associated with the use of psychoactive substances. The elements in the package include:

- Needle–syringe programmes.
- Opioid substitution therapy.
- HIV testing and counselling.
- HIV care and ART for people who inject drugs.
- Prevention of sexual transmitted infections.
- Outreach (information, education and communication for people who inject drugs and their sexual partners).
- Viral hepatitis diagnosis, treatment, and vaccination (where applicable).
- Tuberculosis prevention, diagnosis, and treatment.

HIV incidence: New HIV infections per population at risk in a specified period.

HIV mainstreaming: This refers to the process by which sectors and institutions address the causes and effects of HIV and AIDS in an effective and sustained manner, both through their usual work and within their workplaces.

HIV prevalence: The proportion of persons in a population who are living with HIV at a specific point in time.

Human rights: These are indivisible, inalienable fundamental freedoms to which a person is inherently entitled simply because she or he is a human being. Human rights are conceived as universal (applicable everywhere), egalitarian (the same for everyone) and interdependent, as recognized in both national and international law. Human rights are based on shared values like dignity, fairness, equality, respect and independence. These values are defined and protected by law.

Key populations (KP): Refers to people who are most likely to be exposed to HIV or to transmit HIV, and whose engagement is critical to a successful HIV response (i.e., they are key to both the epidemic and the response). UNAIDS considers gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs, and prisoners and other incarcerated people as the main KP groups. This categorization also applies to Uganda.

Multi-sectoral approach: A policy programming strategy that involves all sectors and sections of society in a holistic response to the HIV and AIDS epidemic.

Polymerase chain reaction (PCR) tests: Tests to directly detect the genetic material of HIV (not the immune response to HIV).

Post-exposure prophylaxis (PEP): Medicines that are taken after exposure (or possible exposure) to HIV. The exposure may be occupational or non-occupational.

Pre-exposure prophylaxis (PrEP): Refers to antiretroviral medicines prescribed before exposure (or possible exposure) to HIV.

Priority Populations: Populations that by virtue of socio-demographic factors (age, gender, ethnicity, disability, income level, education attainment or grade level, or marital status), behavioural factors or health-care coverage status or geography are at increased risk of HIV. In Uganda, they mainly include uniformed personnel, fisher folk and long-distance truck drivers.

Psychosocial support: Refers to all actions and processes that enable people living with HIV and those affected by HIV and AIDS—including the elderly, persons with a disability (PWD), orphans and other vulnerable children (OVC), and their families or communities—to cope with stressors in their own environment and to develop resilience and reach their full potential.

Risk: Risk of exposure to HIV or the likelihood that a person may acquire HIV. Behaviours, not membership in a group, place individuals in situations in which they may be exposed to HIV, and certain behaviours create, increase, or perpetuate risk.

Sex worker: Refers to a person who receives money or goods in exchange for sexual services, and who consciously defines those activities as income-generating, even if they may not consider sex work to be their occupation.

Sexual and gender-based violence (SGBV): Any sexual act or unwanted sexual comments or advances using coercion, threats of harm or physical force, by any person, regardless of their relationship to the survivor, in any setting. SGBV is usually driven by power differences and perceived gender norms. It includes forced sex, sexual coercion, rape of adult and adolescent men and women, and child sexual abuse.

Social change communication: The strategic use of advocacy, communication, and social mobilization to facilitate and accelerate systematic change in the underlying determinants of HIV risk, vulnerability and impact.

Social protection: Interventions by public, private and/or voluntary organizations—as well as informal networks—that support communities, households and individuals in their efforts to prevent, manage and overcome risks and vulnerabilities.

Social support: This includes a broad range of responses to deal with vulnerabilities at the intrafamily level (including high socioeconomic dependency, intra-household inequality, household and/or family break-up, and family violence). It also encompasses all efforts against gender discrimination, such as unequal access to productive assets, information and capacity–building opportunities. It may also include support to access to education, information and literacy.

Stigma: A dynamic process of devaluation that significantly discredits an individual in the eyes of others. It refers to attitudes or practices that define an individual's status as discreditable or unworthy within a particular group, culture or settings.

Transgender: An umbrella term used to describe people whose gender identity and gender expression does not conform to the norms and expectations associated with their sex at birth. Transgender people include individuals who have received gender reassignment surgery, individuals who have received gender-related medical interventions other than surgery (e.g., hormone therapy) and individuals who identify as having no gender, multiple genders or alternative genders.

Vulnerable populations: Groups of people exposed to a high-risk of HIV infection or greater effects of HIV due to their lifestyle, low incomes and living/working environments. They include OVC, PWD, migrant populations, mining workers, persons aged 50 years and older, and other mobile men and women

Antiretroviral Therapy (ART): Treatment with antiretroviral (ARV) drugs that inhibit the ability of HIV to multiply in the body, leading to improved health and survival among HIV-positive persons.

Community–led: Community-led organizations, groups, and networks are entities for which the majority of governance, leadership, staff, spokespeople, membership and volunteers, reflect and represent the experiences, perspectives, and voices of their constituencies – the communities - and who have transparent mechanisms of accountability to their constituencies.

Comprehensive Knowledge of HIV: Persons able to recall having seen or heard messages on HIV and AIDS, can name the 3 recommended behaviours of HIV prevention and reject 2 misconceptions about HIV transmission (UDHS 2011).

Discrimination: Refers to unjust or prejudicial treatment of different categories of people especially on the grounds of race, age, disability or sex. It may also be exhibited against persons (known or suspected to be) living with HIV or suffering from AIDS.

Harm Reduction: Refers to a comprehensive package of policies, programs and approaches that seeks to reduce the harmful health, social and economic consequences associated with the use of psychoactive substances.

HIV Incidence: New HIV infections per population at risk in a specified period of time.

HIV Prevalence: The proportion of persons in a population living with HIV at a specific point in time.

HIV Mainstreaming: This refers to the process by which sectors and institutions address the causes and effects of HIV and AIDS in an effective and sustained manner, both through their usual work and within their workplaces.

Key Populations: Refers to people who are most likely to be exposed to HIV or to transmit HIV and whose engagement is critical to a successful HIV response i.e. they are key to the epidemic and key to the response. UNAIDS considers gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs (PWID) and prisoners and other incarcerated people as the main key population groups. This categorization also applies to Uganda.

Multi-sectoral Approach: A policy programming strategy, which involves all sectors and sections of society in a holistic response to the HIV and AIDS epidemic.

PCR tests: Tests to directly detect the genetic material of HIV (not the immune response to HIV)

Post-Exposure Prophylaxis (**PEP**): refers to medicines that are taken after exposure (or possible exposure) to HIV. The exposure may be occupational or non-occupational.

Pre-Exposure Prophylaxis (**PrEP**): Refers to antiretroviral medicines prescribed before exposure (or possible exposure) to HIV.

Priority Populations: Populations which by virtue of demographic factors (age, gender, ethnicity, disability, income level, education attainment or grade level, marital status) or behavioural factors or health care coverage status or geography are at increased risk of HIV. In Uganda, they mainly include uniformed personnel, fisherfolk, and long-distance truck drivers.

Psychosocial Support: Refers to all actions and processes that enable people living with HIV, other HIV and AIDS affected persons including elderly, PWDs, OVC and their families or communities to cope with stressors in their own environment and to develop resilience and reach their full potential.

PWID: A person who injects drugs or takes in psychoactive drugs intravenously for non-medical purposes. Note that the term intravenous drug users is incorrect because subcutaneous and intramuscular routes may be involved.

Risk: Risk of exposure to HIV or the likelihood that a person may acquire HIV. Behaviours, not membership of a group, place individuals in situations in which they may be exposed to HIV, and certain behaviours create, increase or perpetuate risk.

Sex Worker: Refers to a person who receive money or goods in exchange for sexual services, and who consciously define those activities as income generating even if they may not consider sex work as their occupation.

Social Protection: These are interventions by public, private and/or voluntary organizations as well as informal networks which support communities, households and individuals in their efforts to prevent, manage and overcome risks and vulnerabilities.

Social Support: This includes a broad range of responses to deal with vulnerabilities at intra-family level (high dependency, intra-household inequality, household breakup, family violence, family break-up). It also encompasses all efforts against gender discrimination (unequal access to productive assets, access to information, capacity building opportunities). It may also include support to access to education/ information/literacy

Stigma: Refers to a dynamic process of devaluation that significantly discredits an individual in the eyes of others. It refers to attitudes of practices that define an individual's status as discreditable or unworthy within particular cultures or settings.

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Vulnerability: Refers to unequal opportunities, social exclusion, unemployment or precarious employment and other sociocultural, socioreligious, political and economic factors that make a person more susceptible to HIV infection and developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk, and they may be outside the control of individuals.

Vulnerable Populations: Groups of people exposed to a high-risk of HIV infection or greater effects of HIV due to their lifestyle, low incomes, and living/working environments. They include OVC, PWDs, migrant populations, mining workers, persons aged 50+ years, and other mobile men and women

EXECUTIVE SUMMARY

Building on lessons learned and progress made in the country for the past 40 years, Kanungu DLG has the opportunity to end the HIV epidemic as per the country progress reports. This opportunity has been made possible by tireless advocacy, determined research, and dedicated delivery of diagnostic, prevention, care, treatment, and supportive services. The National HIV/AIDS prevention Strategy of 2015 and the subsequent 2017 Presidential fast-track initiative on ending HIV and AIDS in Uganda changed the way Ugandan people talk about HIV and the ways stakeholders prioritize and coordinate resources towards HIV and AIDS

Kanungu District prioritizes control of HIV and AIDS within the District's Development Plan 2020/21–2024/25 (NDP III) and other national and international commitments, such as the Sustainable Development Goals (SDGs).

This District HIV Strategic Plan (DSP) 2020/2021–2024/2025 lays out strategies and actions to implement high-impact, evidence-informed interventions, and innovations through programme optimization. It builds on significant progress achieved during the past five years and responds to gaps identified in the Mid-term Review (MTR).

The process of developing this five-year HIV/AIDS strategic plan was participatory involving key stakeholders and interest groups including the communities of people living with HIV (PLHIV) and partners supporting HIV/AIDS activities within the district and other Departments within the District such as Community Development.

Kanungu District has HIV prevalence of 4.5% (HMIS 2021) giving an estimated 14,063 people living with HIV (using the projected population figures). This is not very far from the findings of the Uganda HIV/AIDS indicator survey conducted in 2011, Regardless of HIV status, the entire population needs prevention, care and treatment, social support and protection and health system strengthening which form the basis of this strategic plan.

The overall goal of this plan is to "**Increase productivity, inclusiveness, and well-being of the population by ending HIV and AIDS as an epidemic by 2030**". To achieve the goal of this strategic plan, the implementation will cover four thematic areas: Prevention; Care and Treatment; Social Support and Protection and Health Systems Strengthening. The District strategic plan is a broad overarching planning framework, which details priority activities to be implemented by all stakeholders in the fore mentioned thematic areas.

This strategic plan will be implemented with an oversight coordination of the District AIDS committee that is mandated with mobilizing resources, coordination, monitoring and evaluation of the HIV response results among other roles.

Implementation of the strategic plan is estimated to cost UGX **7,524,296,633** in the next five years. However, for the FY 2021/2022, the district shall need an estimated amount of UGX 1,447,900,000. Adjustments of 8% have been made to the subsequent annual estimates to cater for the national inflation and other likely global financial challenges.

The district shall mobilize these funds from local sources, development partners, Central Government and well-wishers who intend to support the district. The district will work in collaboration with departments, CSOs, private sector, networks of PLHIV, development and implementing partners to ensure effective implementation of the District HIV Strategic Plan and operationalize the monitoring and evaluation system to track performance.

1.0 Introduction

1.1 Background

Provide basic information about the HIV and AIDS situation in the district including the impact it has had in a paragraph.

In Kanungu HIV prevalence has progressively declined from 18.4% in 2007 to 4.5% in 2014. This reduction is as result of interventions by various development partners (STAR SW, MoH, Bwindi community hospital, UAC, AIC, RHU and UNFPA).

Further analysis shows that women are more disproportionately affected by the epidemic than men. The HIV pandemic is profound heterogeneous by Gender, Geographical area, Socio-demographic and economic characteristics.

Women and urban residents are more disproportionately affected, with a national prevalence estimates among women being 7.5% relative to 5.0% among men. 10.2% among urban resident's relative to 5.7% among rural residents.

Despite a sharp decline in the prevalence rate of HIV/AIDS in the district to 4.5% from 7.1, HIV still remains a challenge contributing significantly to the district's morbidity and mortality. In FY 2012/2013, only 157 pregnant women were on ARV's out of 451 women eligible for ART. Overall, only 86 % of the eligible people for ART were receiving treatment compared to target 90%people.

In Kanungu the drivers for the epidemic include poverty, limited knowledge about the epidemic, risk perceptions, and poor access to health care, culture (widow inheritance) gender inequality, stigma discrimination and violation of human rights. GBV cases are more rampant and has been among the top most driver of HIV.

In light of the above situation and where at the moment there is little evidence of real large scale sexual behavioral change in response to HIV Education or other interventions, the district will take up measures geared towards scaling up prevention and informing the population of the facts about HIV, also attention must be paid in designing mitigation measures against the impacts of the epidemic. This requires more than doubling the current efforts and scaling up interventions that positively impact on the epidemic through HIV mainstreaming and strengthening District and lower level responses to the HIV/AIDS.

Despite a sharp decline in the prevalence rate of HIV/AIDS, HIV still remains a challenge contributing significantly to the morbidity and mortality. As more people become infected, with HIV, many will die of AIDS. Prevention efforts must be scaled up and intensified as part of a comprehensive response that simultaneously expands access and care.

1.2 Justification of developing the district HIV and AIDS strategic plan

Strengthening strategic plan thinking and planning is one of the capacity building needs at the district level that will facilitate scaling up and stimulates local response to the HIV/AIDS epidemic. This Strategic plan will help the district to define the responsibility and design the appropriate responses and promote ownership and sustainability of HIV/AIDS interventions.

It has been recognized that no single sector, department or organization is by itself responsible for addressing the HIV epidemic alone. It is envisaged that all government departments, organizations and stakeholders will use this document as the basis to develop their own operational plans so that

all our initiatives as a district can be harmonized to maximize efficiency and effectiveness. It will provide a mechanism for coordination and harmonization of both planning, monitoring and evaluation of HIV/AIDS activities

This District strategic HIV/AIDS plan will define the district priorities and intervention packages and will provide strategic direction for the HIV/AIDS response to all stakeholders. This District Strategic Plan will operationalize the National Strategic plan and other national and Sectoral HIV/AIDS policies in addition to being a mechanism for mobilization of resources for the District response to the epidemic, which is one of the tasks of the coordinating structure as defined in the District coordination guidelines.

This District HIV/AIDS Multi-Sectoral Strategic plan has been developed in line with overall District Development Plan, NSP and other relevant national and Sectoral policies, to serve the following purposes:

- Provide forum for the participatory review and appraisal of the HIV/AIDS epidemic and socio-economic development situation in the district.
- Provide a platform for consensus building on priorities and implementation strategies.
- To integrate new packages of HIV/AIDS priority interventions for which the district can mobilize resources including new innovations/interventions.
- Mobilize the participation and commitment of key stakeholders and to promote district ownership of the planning interventions.
- Serve as a mechanism for mobilization of resources for HIV/AIDS.
- To support the plan and other development programmes, for effective utilization of existing capacity and available resources.
- Promote coordination, harmonization of planning, monitoring and evaluation of the HIV/AIDS a response at the district level.
- Strengthening HIV/AIDS strategic thinking and planning capacity; promotion of innovation and development of the initiatives targeting HIV/AIDS at the district level

1.3 The process of developing the district HIV and AID Strategic Plan

The HIV/AIDS strategic plan has been developed to provide a common strategic framework for guiding all interventions by all parties at all levels within the district. The scope of the strategic plan is therefore a district owned plan.

Specifically, this District HIV/AIDS strategic plan forms the basis for:

- Developing the annual budget and the district multi-Sectoral work plan
- Guiding investment by the district development partners, including project support
- Developing and implementing the respective operational plans of the departments of the District and Health Sub-District, Hospitals (including PNFP and related PHP interventions), Sub County and Community health action plans.
- Guiding participation of all stakeholders in health development in the district.

Therefore, the district HIV/AIDS strategic plan has been developed through an intensive and interactive process that involved all key stakeholders in the district. The process commenced with

a briefing of the district health officer, Chief administrative officer, RDC on the technical support provided by UAC, MoH, RHITES, JCRC and USAID UHSS. Data mining on HIV/AIDs related indicators together with the District HIV Focal Person, Biostatician and Health Management Information System Focal Person preceded stakeholder engagement for the actual planning.

The district planning team was then instituted to take over the entire planning process. The Team comprised of; the District Planner, The District Population Officer/ HIV/AIDS focal officer, District Education officer, Gender officer from Community services, production, works and engineering and Health. The development of the DSP 2020/21–2024/25 utilized predominantly qualitative methods that were highly consultative and participatory. The process extensively involved key stakeholders and interest groups, including communities of people living with HIV, at the District and Health sub district levels. While the Uganda AIDS Commission (UAC) facilitated the process of developing the DSP, the entire effort was led and coordinated by DHO's office. The processes included the following steps (among several others that are not listed).

Review of documents: Desk review of secondary data focused on key documents that are relevant to the District HIV and AIDS response. For purposes of alignment with sectoral and District plans, key documents were reviewed, including (among others): The National HIV and AIDS Strategic Plan 2020/21–2024/25, the Health Sector HIV and AIDS Strategic Plan 2018/19–2022/23; Leaving No One Behind: A National Plan for Achieving Equity in Access to HIV, TB and Malaria Services in Uganda, 2020–2024; the Acceleration of HIV Prevention: A Roadmap towards Zero New HIV Infections by 2030; and the PFTI.

District-level consultation: At the District level, stakeholders were drawn from key departments (Health, Community Development, and Planning), development partners including the USAID Uganda Health Systems Strengthening Activity and RHITES-EC, community groups including people living with HIV and AIDS and other Key Populations (KPs), cultural institutions and organizations, faith-based organizations (FBOs), and private sector and other agencies operating at the District level.

Thematic-level consultation: Technical working groups (TWGs) were constituted from a wide spectrum of District Health Team, departments, development partners, AIDS service organizations in the District to provide expertise input and review the DSP and related documents. The TWGs were constituted as follows: (a) Prevention, (b) Care and Treatment, (c) Social Support and Protection, (d) Systems Strengthening (focusing on governance, infrastructure, human resource, and financing, (e) M&E and Research, (f) Costing and Financing, and (g) a Cross-cutting TWG handling Gender and Human Rights.

Sub-District level consultations: In liaison with District HIV Focal Persons, the District mobilized participants from sub-district and sub-county level for consultative meetings. Participants in the consultations included HIV Focal Persons from the health sub district, facility in-charges and other key stakeholders involved in HIV control programmes at the sub-county level.

The planning team carried out their work in four days since they were building on the previous strategic plan. The team presented the situation analysis to the stakeholders and this provided a framework for the SWOT analysis, definition of key priority action, costing of the strategic interventions and developing of the monitoring and evaluation framework for the district. All these followed responses to each thematic program area (Prevention of HIV transmission, care and treatment, support and social protection and Health systems strengthening. Drafts of each thematic areas were compiled and fit into the structural framework of the strategic plan provided by UAC.UHSS took lead in compiling the drafts and shared among the team members for input. Draft

zero of the strategic plan will undergo review by the technical support team and finally with district health office for district consensus and then will approval by the district.

2.0 DISTRICT PROFILE

Geographical location

Kanungu District is located in southwestern Uganda between 29^0 50'E and $0^0$45'S of the Equator, bordering the Districts of Rukungiri in the north and east, Kabale in southeast, Kanungu in the south and the Democratic Republic of Congo in the west. It lies in the fringes of the western rift valley with the Northern part forms part of the Rift valley with undulating plains with the middle part (sub-counties of Rugyeyo, Kirima and parts of Kanyantorogo) comprising of flat toped hills with gentle sloping sides and broad valleys. These hills gradually increase in height to the highlands of Rutenga with Burimbi peak of Mafuga being the highest at 82222ft (2503m) above sea level with some parts of Kihihi Sub-County lying in the fringes of the western Eastern African rift valley. Kanungu District has a total population of 277300 people as per UBOS projections of which 11163 PLHIV at a prevalence rate 7.3%

2.1 Administrative units

Kanungu District was created by the sixth Parliament of Uganda in July 2001.The district was curved out of Rukungiri and comprises one county with 14 sub-counties of Kihihi, Kambuga, Nyamirama, Rugyeyo, Rutenga, Kayonza, Mpungu, Kinaaba, Katete, Nyakinoni, Nyanga, and Kanyantorogo, and the four town councils of Kanungu, Kihihi, Butogota, and Kambuga. The district is composed of 4 Town councils, 14 Sub counties

Figure 1: Map of Kanungu showing its administrative units and health facilities

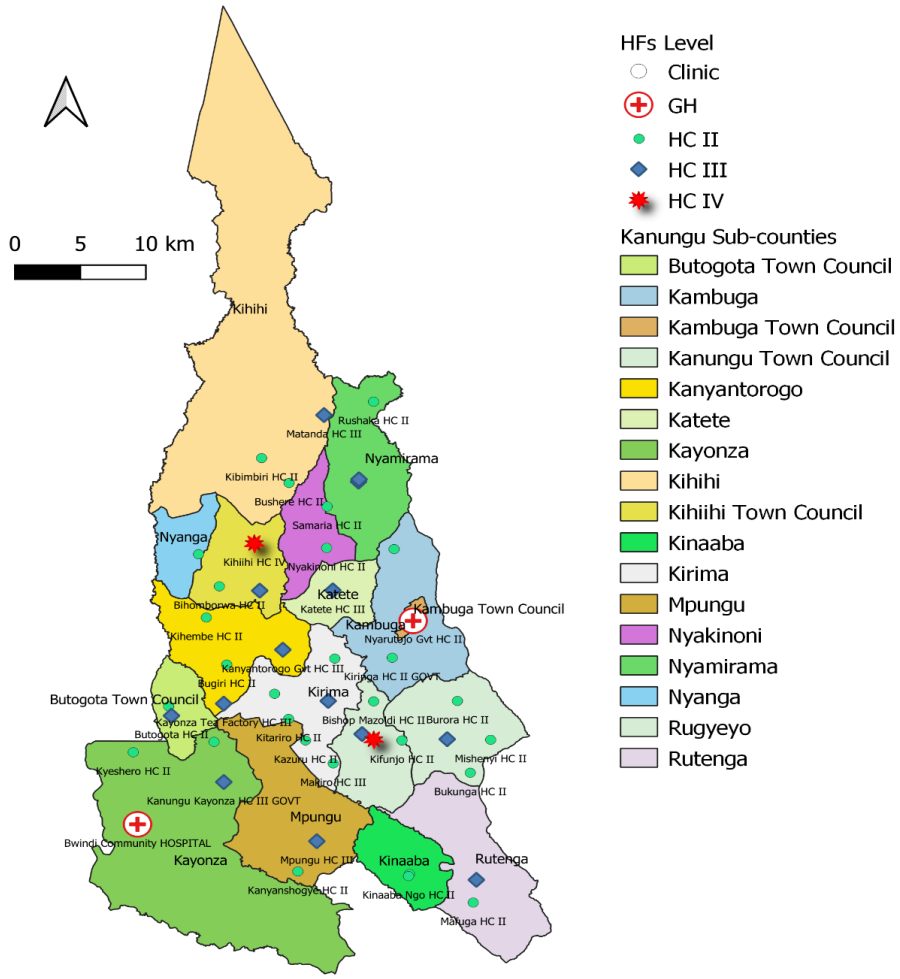


Table 1: Implementing partners supporting district HIV and AIDS services

Partners	Areas of Operation	Focus	Type of support provided
USAID JCRC	All Sub-Counties	HIV/TB	Financial and Technical support
MTI	KIHIHI S/C	IPC	Financial Support Transport support
UNICEF	District	Nutrition	Financial Support
Compassion International	District	OVC	Financial and Material support Education Support Psychosocial support
Raising the Village	3 Sub-Counties, Kayonza, Kirima, Nyamirama	Nutrition, Sanitation, Income generation	Raising the Village
UPMB	PNFP's	HIV /AIDs services	UPMB Technical Support
mariestopes	District	Family Planning and Circumcision	Mariestopes
MARPI	Kihihi TC, Butogota and Kanungu		MARPI
Japheigo	District	**IPC**	
CAFOMI &Save the children		Nutrition and teenage pregnancies, **R**efugees	

Table 2: Health service delivery infrastructures in the district by level and ownership

Facility name	Level	Owner ship	ART	PMTCT	SMC
Kambuga	Hospital	Gov't	Accredited	Accredited	Accredited
Bwindi	Hospital	PNFP	Accredited	Accredited	Accredited
Kihihi HCIV	HCIV	Gov't	Accredited	Accredited	Accredited
Kanungu	HCIV	Gov't	Accredited	Accredited	Accredited
Rugyeyo	HCIII	Gov't	Accredited	Accredited	
Rutenga	HCIII	Gov't	Accredited	Accredited	
Katete	HCIII	Gov't	Accredited	Accredited	
Nyamirama	HCIII	Gov't	Accredited	Accredited	
Matanda	HCIII	Gov't	Accredited	Accredited	
Nyamwegabira	HCIII	PNFP	Accredited	Accredited	
Kanyantorogo	HCIII	Gov't	Accredited	Accredited	
Nyakatare	HCIII	PNFP	Accredited	Accredited	
Makiro	HCIII	PNFP	Accredited	Accredited	
Kirima	HCIII	Gov't	Accredited	Accredited	
Kayonza	HCIII	Gov't	Accredited	Accredited	
Mpungu	HCIII	Gov't	Accredited	Accredited	
Bugiri	HCII	PNFP	Accredited	Accredited	
Butogota	HCII	PNFP			
Mburamizi	HCIII	Gov't	Accredited		
Nyakashozi	HCII	PNFP		Accredited	

Table 3: The distribution of the key population in Kanungu District

Parameter	Result
Total Population	277,300
District HIV Prevalence	7.3%
Estimated # of PLHIV	11,163
Estimated # of HIV+ Children <15 Years	827
Estimated # of HIV+ 15 – 49 Years	8,322
Expected # of HIV+ Pregnancies	558
Expected # of HIV+ Adolescents (10 – 19 Years)	741
List all known Key Populations and any estimates of size, HIV prevalence	Female sex workers, Bar Maids and Attendants. None-IDU, Truck Drivers, Fisher mongers, Male Sex Workers, MSM
Number of Health Facility Reported Maternal Deaths (from Previous Year)	13 MD's Bwindi Community Hospital 2, Kambuga Hospital 5, Kanungu HCIV, Kihihi 4
Number of Orphans and Vulnerable Children	36,630
Expected Number of TB Cases	643
Expected Number of TB Cases	643
Total Fertility Rate	5.2
Life Expectancy	66.0

2.3: Best Practices, Lessons and Opportunities

One of the lessons learnt from implementing the ***DSP 20015/2016-2019/20,*** was that by enabling easy access of care and treatment services in the district has reduced HIV and AIDs death

incidences among PLWAs. There has been more acceleration of prevention actions by; 1) improving quality, access to and utilization of a core package of HIV prevention services, care and treatment in the District by accrediting more health facilities as well as adopting safer sexual behaviours reducing HIV incidence. Also providing more service points for HIV/AIDS clients, more PLWAs have lived more years positively. The District review also pointed to more opportunities including reliable actors in the HIV and Aids service organizations like RHITES SW and JCRC –Kigezi, Bwindi community hospital being one of the HFs providing excellent HIV/AIDS services in the region. Besides over 80% of children come into contact with the healthcare system through immunization. The review revealed how protection issues were weakly articulated in the district planning framework.

3.0 Strengths, Weaknesses Opportunities and Threats (SWOT) Analysis.

3.1 Introduction

This section describes both internal and external factors that will determine the success of the district HIV response in Kanungu district. During the workshop, the team identified the strengths, weaknesses, opportunities and threats (SWOT) that have the potential to affect the HIV response in the district. This was in the context of four thematic areas of prevention, care and treatment, social support and protection and health systems strengthening. The strengths are the positive attributes of Kanungu District, weaknesses are negative factors that detract from the strengths, opportunities are external factors in the district HIV response that are likely to contribute to better outcomes, and threats are external factors that district has no control over.

Table 4: The SWOT analysis

THEMATIC AREAS			
1.0: HIV PREVENTION			
Strength	**Weakness**	**Opportunities**	**Threats**
• Provision of Prep services both at static and outreaches. • Condom distribution • Community dialogues and sensitization • Provision of e-MTCT services • Guiding policy on adolescent • Guiding policy on HIV prevention • Availability of medicine for HIV prevention • Established people living with HIV net work • Positive attitude of religious and political leaders • Availability of local radio stations • Provision of voluntary safe male circumcision	• Reduced accessibility to services due to stigma • Most health workers are not trained in handling key populations • Key populations do not know their rights • Inadequate information by HIV clients • Few sites are accredited for prep services • Absence of key peers	• Support from implementing partners like most at risk population initiative (MARPI) • Community social organisations like Nyaka Aids Foundation (Vulnerable groups) • Available guidelines for HIV prevention	• Key population not legalised by government • Illegalised condom distribution in primary schools • KP/PP behaviours are not socially acceptable
2.0: HIV CARE AND TREATMENT			
• Well distributes accredited health facilities • Qualified health personnel with adequate to provide HIV services • Functional supply chain system • Client centered service delivery models (DSD) rolled out in the district • Improved linkage to care and treatment. • Good follow up mechanisms in place • Good hub system supporting access to testing services (CD4,Viral load, Gene expert, CBC) • Well distributes accredited health facilities • Qualified health personnel with adequate to provide HIV services • Functional supply chain system • Client centre service delivery models (DSD) rolled out in the district	• Limited space for HIV activities • Staff absenteeism • Occasional poor ordering by some facilities • Community DSD models have not been widely implemented leaving the facilities still congested • Low linkage to care in some facilities • Low retention into care for PLHIV • Some gaps in viral load suppression • Some clients still have poor adherence to HAART • TB case identification still low. • High mother to child transmission • KP/PP treatment services not yet differentiated • No treatment centres for management of advanced HIV diseases like CCM • Challenges in third line management • Weak PLHIV network	• Very committed IPs • HIV policies and guidelines in place and routinely revised • Testing systems in place • Functional transport systems in place (Hub) • Functional HMIS and DHS12 systems • Very committed IPs • HIV policies and guidelines in place and routinely revised • Testing systems in place • Functional transport systems in place (Hub) • Functional HMIS and DHS12 systems	• Stock outs at some points in ware houses • Few accredited sites • Some PLHIV are not responsive to services availed to them • Some facilities are not supported for the follow up mechanisms • Lack of unique identifiers for PLHIV. • Stock outs at some points in ware houses • Few accredited sites • Some PLHIV are not responsive to services availed to them • Some facilities are not supported for the follow up mechanisms • Lack of unique identifiers for PLHIV.

3.0: SUPPORT AND SOCIAL PROTECTION			
Strength	**Weakness**	**Opportunities**	**Threats**
• Existence of networks such as PLWHIV and NGOs such as Uganda debt network (UDN) • Existence of media for information dissemination • Stakeholders Collaboration with civil servants especially the community development officers and production officers • Availability of data /information on support and social protection • Presence of technical officers who support social protection services • Availability of Government funding for youth empowerment programme (YEP) and Uganda women empowerment program (UWEP)	• Inadequate information on stigma and discrimination at all levels • Limited funding to social groups eg PLWHIV, KPS networks and young women and adolescent groups • No specific funding targeting the above groups • Weak laws on GBV • Corruption by police on GBV Issues	• Established work force on payroll • Existence of implementing partners such as Mend the broken hearts, RHITES SW, Uganda Debt Network, Kick corruption out of Uganda, Uganda Anti-Corruption Coalition • Supportive political leadership • Existing policy guidelines, books and manuals. • Trained staff in the district.	• Un predictable funding from the implementing partners • Budget allocations are limited in scope for impact • District competing priorities • Un predictable calamities such as floods, epidemics/outbreaks
4.0: HEALTH SYSTEMS STRENGTHENING			
• Existence of Coordination between district and development partners • HIV/AIDS coordination committees (DAC and SAC) • Staffing levels improved from 68%-78% • Continuous and timely capacity building activities (trainings, mentorships) on HIV care and treatment.	• Some departments have not fully elaborated mainstreaming e.g Education sector has not incorporated vmmc programme, IEC and behavior change prevention messages in school curriculum. • DACs quarterly coordination meetings have not been happening at all • Non- functional of SAC in all Sub counties. • HIV/AIDS not fully integrated in departmental reports to DTPC and council committees.	• Existence of HIV/AIDS policy • Budget call circular that gives guidance on mainstreaming HIV/AIDS in budgets and work plans. • Development partners for technical backstopping in HIV/AIDS programming • Availability of wage provision for recruitment of additional health workers. • Availability of retention policy/allowances for doctors • Availability of wage provision for recruitment of additional health workers.	• Over dependency on Development partners • Minimal participation of PLWHA in programming. • The Ministry of health structure that is unrealistic for the number of workers in a facility. • Delayed restructuring of health workers which limits their morale to work

• Limited space for HIV/AIDS care and treatment in health facilities. • Availability of CD4 machines (pima) • Availability of Genexpert machines • Availability of ARV drug stocks • Political support in resource mobilization for HIV/AIDS • Existence of governance structures such internal audit controls baraaza meeting and Public accounts committee. • District level development partners forum for resource mobilization.	• Inadequate time contact by trainers with staff during facility trainings • Inadequate frequency of trainings • Limited time allocated to HIV/AIDS interventions by health workers in health • Non alignment of logistic to support current needs esp. mult-month drug refills and CDDP- community drug distribution points and CCLAD • Weak mobilization of development partners to participate in the development forum. • Poor community sensitization on reporting of abuse of funds • Poor clients grievance handling mechanism	• Availability of retention policy/allowances for doctors especially at health centre iv. • Availability of health institutions such as nursing schools and paramedical school in the District. • Health sector expansion program. • Development partners for health infrastructure development. • Existence of development partners in resource mobilization for HIV/AIDS such as UAC, EGPAF, global funds etc	• Some health centre 111s are not accredited to offer HIV services. • Inadequate supply e.g. pima cartridges, • Covid 19 that may affect the internal bodies funding for HIV/AIDS • Non funding of the HIV/AIDS

4.0 SITUATION ANALYSIS

4.1 Introduction

The HIV epidemic in Kanungu continues to be severe, mature and generalized and heterogeneous. The Kanungu district crude HIV prevalence is estimated at 7.3 % (UPHIA 2019) which brings the district to an estimate of 11,163 basing on the Kanungu district projection of 2019. According to the UPHIA estimates on district prevalence, In Kanungu the prevalence is high among women 8.58 % while among men it is estimated to be 5.96%. HIV prevalence was rampant among the female sex workers, bar maids and attendants, Truck Drivers, Fisher mongers, Male Sex Workers, MSM. The estimated number of HIV+ Children below 15 Years of 827, HIV+ 15 – 49 Years of 8322, HIV+ Pregnancies of 558 and HIV+ Adolescents (10 – 19 Years) of 741. The total number of the estimated orphans and vulnerable children in Kanungu district stands at 36630 and expected number of TB cases in HIV is 643.

2.4 Status of Health services (2015/16- 2029/20) based on the Annual Health Sector performance report.

The Table below Shows the performance of indicators HIV/AIDS based on 2015/16- 2029/20) Annual Health Sector performance reports.

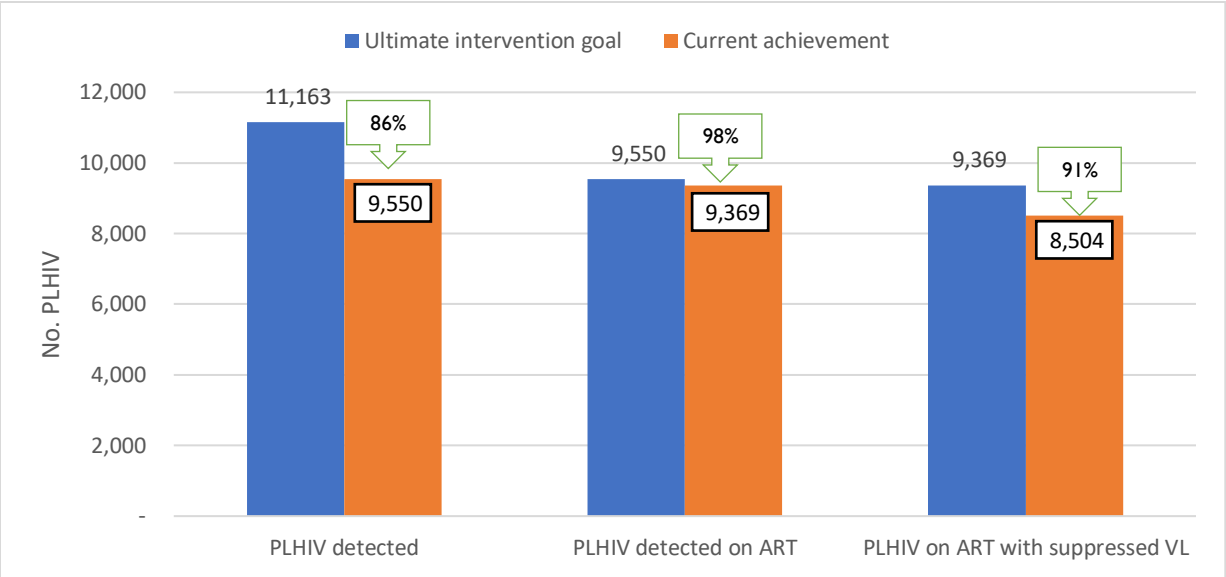
Table…… Showing the performance of indicators HIV/AIDS

Goal	Objective	Indicator achieved	Target 2020	Achieved 2020
Goal 1: To reduce HIV incidence from 4.5 to 3.6%	Prevention of Mother to Child Transmission	Proportion of facilities above HCIII providing PMTCT services	80%	89%
		To increase the %age of HIV+ women accessing EMTCT package	80%	100%
	To accelerate prevention of Sexual HIV transmission by 25%	To reduce on the %age of Youth 15-24 years who have had sexual intercourse before the age of 15	14%	2.7%
		To increase KAP by 80%	28% among women & 36% among men (32%)	46%
		To reduce high risk sex by 50%	18% among women and 8% among men	
		To promote HIV counselling and testing and disclosure	From 4% to 20%	
		To increase the %age of HCIIIs providing comprehensive HCT services in the district	50% to 80%	100%

	Objective: To control Sexually transmitted Infections	Decrease prevalence of tracer STI's for Antenatal mothers	2.7% to 2.0%	1.9%
Goal	**Objective**	**Indicator achieved**	**Target 2020**	**Achieved 2020**
Goal 2. To improve the quality of PLHIV by mitigating the health effects of HIV/AIDS	Integrate HIV Prevention into all care and treatment programs	To increase by 80% the proportion of care and treatment programs	Initiation	98%
		Increase by 70% the PLHIV networks with active prevention, care and support programs.	58.8%	12%
Goal 3. To improve the level of access of services for PLHIV, OVC's and other Vulnerable populations		To increase by 80% the percentage of schools trained in life saving skills based in HIV/AIDS		
		Increase by 80% the percentage of households with OVC's that received free based external support in caring for Children	From 22.6% to 41%	4.21%
Goal 4: To build an effective and efficient system that ensures quality, equitable timely services	Objective: To monitor trends of HIV epidemic/infection	To carry out LQAS annually	From 0% to 100%	100%
		To reduce HIV new infections	From 1300 to less than 1200	786
		To reduce new HIV infections among young men and women aged 15-24	From 23% to 15%	35%
		HIV Prevalence	From 7.3% to 7.4%	7.3%

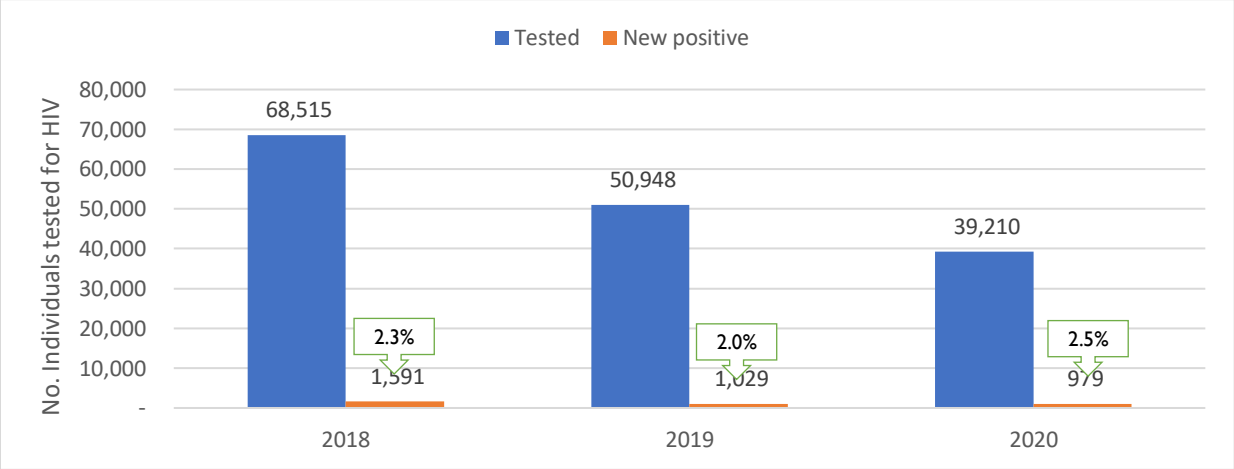
4.2 Performance against 90-90-90 targets

Figure 2: performance agaisnt the 90-90-90 global targets



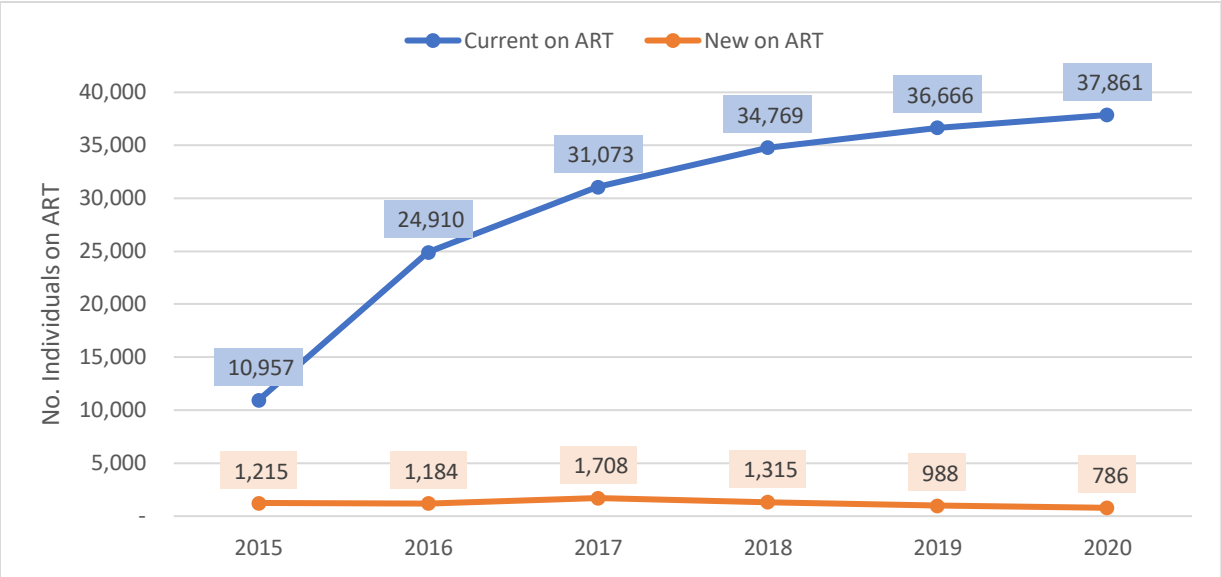
4.3 HIV testing services (HTS)

Figure 3: HTS trends (Tested, New positive and positivity rate) 2018-2020

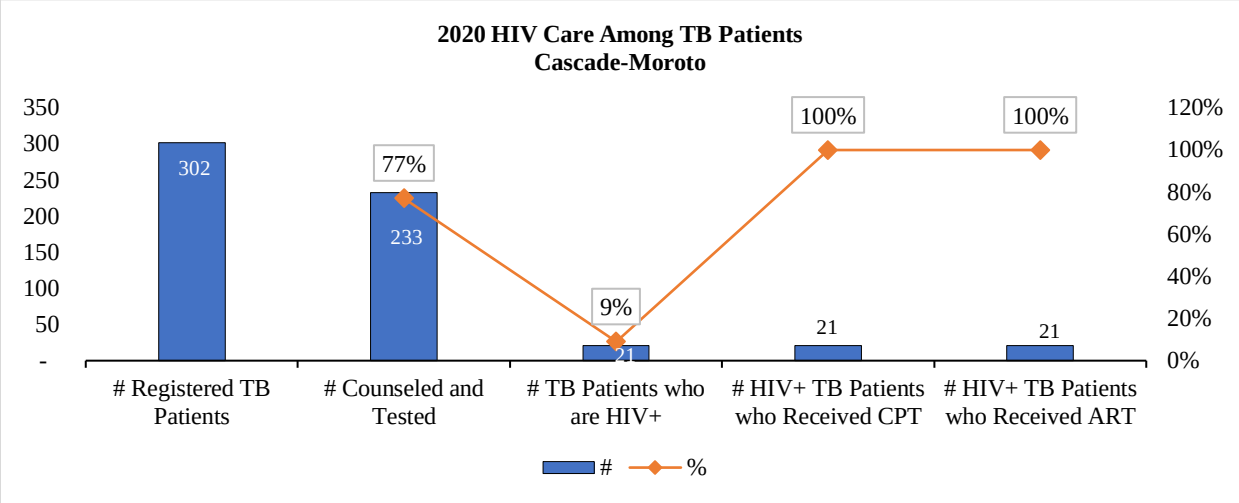


4.4. Current and new on treatment

Figure 4: ART trends (current and new) 2015-2020

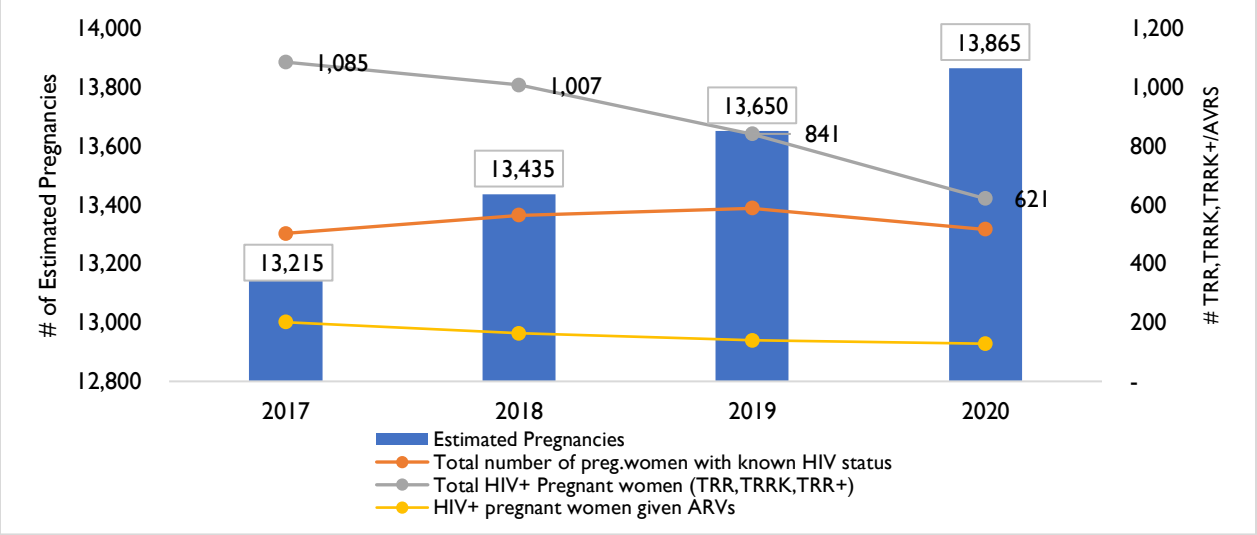


4.5 HIV/TB care and treatment-2020

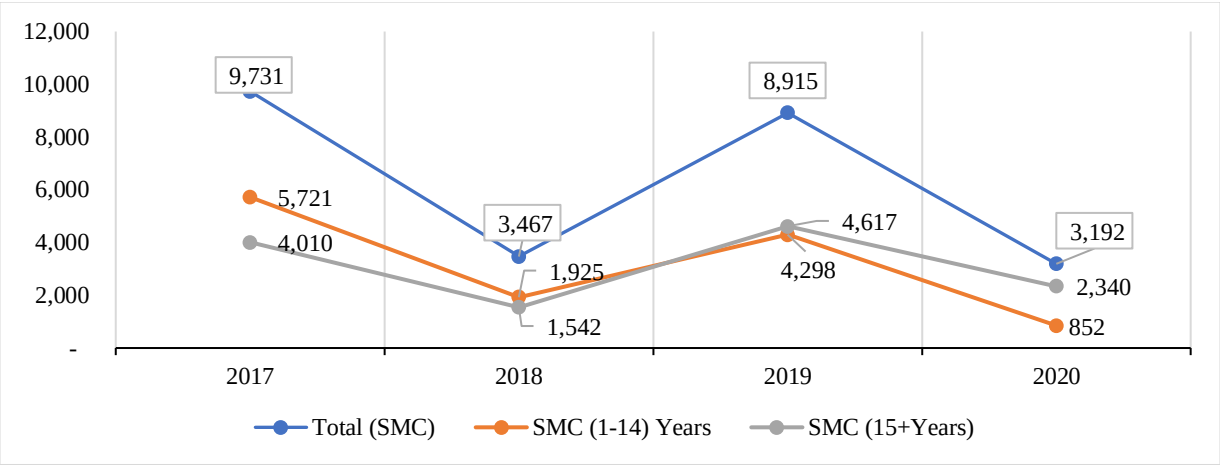


4.6 PMTCT Cascade

Figure PMTCT Cascade



4.7 Voluntary medical male circumcision (VMMC)



5.0 OVERALL STRATEGIC DESIGN

5.1 Vision

The Vision of this District HIV Strategic Plan (DSP) builds upon the Vision of NSP 2020/2021—2024/20205, and it subscribes to the Vision Statement in Uganda Vision 2040: “a Transformed Uganda Society from a Peasant to a Modern and Prosperous Country within 30 years.” It also reflects the goals and aspirations in the District Development Plan which is aligned to then NDP III.

A healthy and productive population, free of HIV/AIDS and its effects

5.2 Goal:

Increase productivity, inclusiveness, and well-being of the population by ending HIV and AIDS as an epidemic by 2030

5.3 Objectives

The following are the objectives of the District HIV and AIDS Strategic Plan 2020/2021–2024/2025.

- To reduce new HIV infections by 65% among adults and youth, and to reduce new paediatric HIV infections to less than 5% by 2025.
- To reduce AIDS-related morbidity and mortality in the district by 2025.
- To strengthen social and economic protection to reduce vulnerability to HIV and AIDS and to mitigate their impact on people living with HIV, orphans and other vulnerable children (OVC), KPs and other vulnerable groups in the district.
- To strengthen the multi-sectoral HIV and AIDS service delivery and coordination system that ensures sustainable access to efficient and quality services for all focus populations.
- To strengthen the district HIV and AIDS strategic information management system for improved effectiveness and efficiency.

5.4 Assumptions

- Effective mainstreaming of HIV and AIDS in all programs and district plans.
- District ownership and accountability for results.
- Increased internal resource mobilization, including sustained Government of Uganda budgetary support.
- Complementary AIDS Development Partner financing aligned to national priorities.
- Reinvigorated and sustained leadership commitment at all levels.
- Sustained economic development.
- Adequate absorptive capacity of resources by implementing agencies and organizations.

5.5. Guiding Principles

- Shared responsibility: an AIDS-free population is everyone's responsibility.
- Inclusion and non-discrimination: no person shall be discriminated from accessing HIV and AIDS services. No one shall be left behind.
- Meaningful participation and inclusion of communities, people living with HIV, and key and vulnerable populations.
- Respect for personal dignity and autonomy.
- Human rights and gender-based, people-centred approach to programming.
- Evidence-informed and result-driven planning and implementation.

- Adherence to the Three Ones principle by all stakeholders.
- Effective mainstreaming of HIV and AIDS in all sectors.
- District ownership and accountability for results.
- Strategic investments.
- Innovation to keep pace with an evolving epidemic.

6.0 STRATEGIC PLAN 2020/2021-2024/25:

6.1 Thematic Area 1: Prevention

During the next five years, there is a need for intensified implementation of combination HIV prevention interventions that are targeted to the local HIV epidemiology (10). Evidence from mathematical modelling suggests that by prioritizing the people in contexts and locations that are associated with the greatest risk of infections—and by adapting interventions to reflect the local epidemiological context—the Prioritized Scale-up Scenario could substantially increase the efficiency and effectiveness of investments in HIV prevention.

Half of the population of Uganda is under the age of 15 years. The large cohort of young people yet to commence their sexual and reproductive experiences means that intensive primary prevention of HIV is essential. Other age groups, however, also have their own age-specific needs. This NSP will include a life cycle approach to HIV prevention, in which age-specific interventions will be encouraged, recognizing that different prevention packages are needed for different age groups. Similarly, pockets of key and priority populations exist mainly in urban areas, fish landing sites, and refugee settlements, and these need to be identified, targeted and reached with services. The NSP thus provides for differentiated models of HIV prevention service delivery in order to reach different socio-demographic and geographically differentiated groups in an appropriate way.

The revised Uganda HIV Investment Case (2020–2030) makes a profound justification for the Prioritized Scale-up Scenario to maximize HIV prevention impact targeting key and general populations (e.g., up to 90% coverage for programmes for key and priority populations and 95% coverage of HIV treatment programmes for key and general populations), AGYW, adolescent boys and young men (ABYM); interventions to reduce stigma and discrimination and programmes for the prevention of SGBV. Modelling indicates that if consistent condom use were to be scaled up in Uganda to 80% of high-risk sexual encounters, it would independently avert about 140,000 new infections over a period of five years (about 10% of all new infections during this period). Close to 10% of people living with HIV are not virally suppressed, so the country might not be fully benefiting from treatment as prevention.

Taken together, the implementation of the Prioritized Scale-up Scenario will reduce new HIV infections by 65% among youth and adults of all ages—reaching 18,200 in 2025, thereby averting 46,000 new HIV infections during this period, or about 20% of the infections that would have otherwise occurred. It also will reduce new HIV infections among children by 95%. This scenario would also reduce new HIV infections among AGYW by almost 85% between 2019 and 2025 (to about 3,000 new HIV infections per year).

This NSP defines a package of high-impact HIV prevention interventions that have to be implemented for the country to end AIDS by 2030. These include condoms (when used correctly and consistently), targeted HIV testing services, HIV treatment as prevention, VMMC, EMTCT, PrEP, PEP, harm reduction for people who inject drugs, and other programmes for KPs. These all have proven effectiveness. Other programmes (SBCC, interventions for AGYW, and anti-stigma and SGBV programmes) are enablers that may influence the uptake of key HIV services and

provide non-HIV benefits as well. In addition, social mobilization of communities for the uptake of prevention interventions shall be emphasized.

The HIV prevention targets in this NSP have been aligned to the Uganda HIV Prevention Road Map (2018–2030) and they draw on inspirational targets for ending the epidemic by 2030, as spelled out in the revised Uganda HIV Investment Case (2020–2030).

Strategic Action 1: Scale-up age- and audience-specific social and behavioural change interventions including abstinence and be faithful interventions to reach all population groups with targeted HIV prevention messages

Key activities

1.1 Coordinate the IPs in the District to target the Social Behaviour Change Communication (SBCC) strategy aligned to the drivers of the HIV epidemic paying special attention to key populations, priority populations and adolescent girls and young women:

1.2 Expand provision of HIV education in-school youth with focus on abstinence, multiple partnerships, cross-generational, transactional and early sex, as well as life skills

Strategic Action 2: Design and implement youth-led HIV prevention programs utilizing innovative approaches such as adaptive leadership and human centred design and diversify SBCC channels to predominantly include media-based outreach platforms and other technology based-approaches to reach young people with HIV prevention messages

Key activities

2.1 Provide tailored adolescent friendly services including STI management, HCT, condom use and family planning information

Strategic action 3: Engage community structures and networks in design and scale up innovative HIV prevention programs to improve comprehensive HIV knowledge, impart life skills, reduce risky sexual behaviors, address gender-based violence and improve sexual and reproductive health status among in and out-of-school children and youth

Key activities

3.1 Promote the creation of adolescent peer networks for psychosocial support through use of adolescent friendly and provision of Information education material

Strategic Action 4: Implement interventions that can help to keep adolescent girls and young women in school by scaling up training for menstrual hygiene management among in-school AGYW, ending gender-based violence, providing sanitary pads for needy AGYW at school and cash transfers, among other interventions

Key activities

4.1 Train school girls in life skills and how to respond to SGBV and report incidents of abuse through Radio talks, Matrons, Religious leaders, Councilors and CDOs

Strategic Action 5: Increase availability of and access to quality condoms through targeted distribution of free condoms, improved social marketing approaches, and adoption of the total market approach. This will also include the operationalization of the condom logistics management information systems (LMIS) for improved efficiency

Key activities

5.1 promote social marketing of condoms by IPs and private sector companies through Meetings with drug shop owners, Bar shop owners Radio talks

5.2 Utilize non-traditional condom distribution outlets for free condoms to the general population and special groups including salons, barber shops, health clubs, road side kiosks, washing bays and related outlets through use of dispensers in strategic positions, engaging Priority population and key population

5.3 Expand condom distribution to key populations using the peer network and outreach models

5.4 Operationalize condom logistics management information systems (LMIS) to enable monitoring and tracking of condom procurements and supply through provision of condom registration registers, holding training meetings with condom distributors and regular submission of reports

5.5 Promote condom education programs to address misconceptions and other barriers to male and female condom use through radio talks, Counseling sessions and condom use demonstrations

Strategic action 8: Conduct comprehensive mapping and size estimation and determine HIV prevalence among all key populations and scale-up comprehensive interventions targeting key populations including drop-in centers in regional referral and general hospitals as well as outside hospital settings

Key activities

1. Scale up the coverage of specialized clinics and drop-in centres targeting key populations like conducting moonlight
   clinics, surge campaigns
2. Set up outreach services for key populations including moonlight services and integrated outreach clinics, different key
   population groups by identification of new places/sites
3. Set up DICs in health facilities and Hospitals
4. Build the capacity of facility and community-based service providers for quality service delivery to key populations by conducting CMEs and Internal mentorship
5. Conduct periodic evaluation of HIV prevention interventions by holding review meetings

Strategic action 9: Support and implement family-centered approaches to prevent HIV infection

1. Carry out couple counseling and HIV testing as well male involvement in care seeking for antenatal care, STI services,

2. Family planning, and eMTCT services through health education, provision of rewards, integration of services, provision of services specific for men.
3. Provide condom use among married individuals living in discordant relationships and other services like PrEP and Counseling
4. Orientation of affected households to provide food security for PLHIV through training in modern farming practices, and basic nutrition counselling and support through Nutrition assessment and counselling and setting up demonstration gardens.

Strategic Objective 2 Expand coverage and uptake of quality biomedical priority HIV interventions to optimal levels

Strategic Action 1: Scale-up coverage of differentiated HIV testing services to high-risk groups (such as pregnant women, HIV&TB co-infected persons, HIV-discordant couples, most-at-risk populations and children <15 years of age) to identify HIV infected individuals and enroll them on ART to lower their viral load and reduce the ability to transmit HIV to other people

Key activities

1. Implement differentiated HIV testing models such as Assisted partner Notification (APN), Index Client Testing, Self-Testing, use of screening tools to improve efficiency of Provider-Initiated Counselling and Testing (PICT), and recency testing by training community leaders and CMEs
2. Implement same day enrolment of all clients who test positive on ART, and strengthen linkage to treatment on newly diagnosed PLHIV through Counselling
3. Design and implement initiatives to link HIV negative individuals to customized preventive packages for each target population (STI screening and treatment, Family Planning, psychosocial support services, and PrEP) by counselling and referring for other services
4. Improve referral and follow-up for all priority populations (Pregnant mothers, MARPs, women and girls, children <15 years, and discordant couples) by making follow up schedules and working with VHTs

Strategic Action 2:

Key activities

1. Provide HCT services for all pregnant and breastfeeding women and their partners within the health care setting by counselling, HIV testing and Referring
2. Provide primary prevention services with a focus on young pregnant and breastfeeding women through providing biomedical prevention methods, counselling, STI screening, TB screening

Strategic Action 3:

Key activities

1. Implement strategies to increase demand for condoms among different population groups including discordant couples key populations, adolescent and young people through Radio talk shows taking the service near at-risk groups

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

Strategic Action 1: Address socio-cultural drivers of the epidemic through strategic engagement of the media, civil society organizations, religious, cultural, and political institutions in the HIV prevention effort

Key activities

1. Conduct community dialogue on factors that hinder behavior change and uptake of prevention services in the District
2. Engage cultural and religious leaders for HIV prevention campaigns and services uptake at all levels through meetings

Strategic Action 2: Promote male involvement in HIV prevention for their own health, the health of their partners and families, and address gender and cultural norms that perpetuate inequality and gender-based violence through innovative community peer engagement models

Key activities

1. Enhance Male-friendly HIV and AIDS services and use of mentor fathers for mobilization through training meetings
2. Establish and train networks of men through the workplace.

Strategic Action 3

Key activities

1. Conduct community and school-based interventions for boys at an early age to adopt safer behaviours through meeting radio talk shows and Peer meetings.

Strategic Action 4:

Key activities

1. Improve the identification of male spouses living with HIV through innovative approaches such as assisted partner notification and self-testing using HIV positive mothers as the index client through counselling sessions

6.2 Thematic area 2: Care and Treatment

Uganda has made significant progress in increasing access to HIV care and ART. Since 2017, the country has expanded its test-and-treat approach to include all people living with HIV, irrespective of CD4 count or clinical stage. It has also adopted routine viral load monitoring of patients on ART and started PEP and PrEP for individuals at higher risk of acquiring HIV. New infections, however, are twice the number of AIDS-related deaths, implying that there is still a net increase in new HIV infections, which poses a threat to the attainment of HIV epidemic control.

Among individuals who are put on treatment, about 90% received viral load testing in 2019, of whom 88.2% had a suppressed viral load (i.e., they had less than 1,000 HIV plasma RNA copies per ml of blood). Viral load suppression was higher among adults aged 15 years and older than among children aged 0 to 14 years (70.3%). The number of HIV-exposed infants who receive ART

prophylaxis has stagnated at around 42%, largely due to low health facility deliveries. While TB screening is reported at 95% of all people living with HIV in care, the quality of TB screening is sub-optimal, with low case-finding. As of December 2019, 554,000 people living with HIV (42%) had been initiated on TB preventative therapy, working towards the Ministry of Health target of 80% by 2023. Differentiated services delivery model implementation has improved adherence, retention and viral suppression, but they are not yet at optimal levels.

By December 2019, the proportion of ART facilities offering at least two differentiated service delivery approaches for care and treatment was 68% (1254 of 1832) against the Ministry of Health 2023 target of 95%. A total of 1,169,066 (94.7 %) adults and 65,536 (5.3%) children were active on ART by the end of 2019. Majority (93.3%) of the 1,151,979 people living with HIV are still on first-line regimens, with approximately 6.6% of those on treatment receiving second-line regimens. Uganda has adopted and rolled out use of DTG-based regimens as part of its first-line regimens, with 570,000 patients on DTG as of Dec 2019. The national programme for optimizing ART regimens aims to attain 95% of identified people living with HIV (children, adolescents and adults) initiated on or switched to an optimal ART regimen. The NSP aims for at least 95% of individuals who test positive for HIV to be on treatment and at least 95% of all people living with HIV on treatment to have a suppressed viral load by 2025.

Viral load monitoring for people living with HIV on ART has increased from coverage of 36.8% at the inception of viral load monitoring in FY15/16 to 95.5% by the end of 2019. Despite this, only 71.7% of HIV-positive children received at least one viral load test (compared to 96.8% of the adults). Viral suppression for people living with HIV has steadily increased, reaching 89.9% by the end of 2019, but it remains low among children on treatment (54%). It is necessary to address viral replication, improve immunological and clinical outcomes, decrease the risk of developing ARV drug resistance, and reduce the risk of transmitting HIV.

While there have been improvements in ART coverage, comorbidities among people living with HIV remain a major challenge, as do health issues experienced by the growing number of older people living with HIV and the increasing occurrence of non-communicable disease. Particular emphasis will be needed to manage advanced HIV disease, early screening for non-communicable diseases (especially cervical cancer) and viral hepatitis. Focus will be required for managing the increasing burden of comorbidities among people living with HIV, including mental ill health, diabetes, hypertension, cardiovascular disease and malignancies. Extra efforts will be needed to reach KPs with tailored interventions that include comprehensive harm reduction for people who use and inject drugs.

Key activities

1. Increase the number of ART accredited sited especially the private not for profit through conducting baseline assessment for non-accredited sites.
2. Integrate HIV services (HIV, RMNCAH, TB, Child health services), share information and establish effective referrals across entry points
3. Provide daily ART services in ART clinics
4. Implement harm reduction strategy to scale
5. Strengthen patient education on ART at all entry points and use mass media

Strategic Action 1.2: Strategic action: Strengthen community health platform to identify, support and link PLHIV including KP that remain undiagnosed to care.

Key activities

1 Expand "identify, reach, test, treat and retain" at community level, community engagement (including schools, social/child protection and work places) using community "in reach and task sharing approaches"

2 Build capacity of community actors (including CSOs and PLHIV network) to effectively link newly identified PLHIV to ART.

Strategic Action 1.3 Implement adolescent friendly health services (AFHS)

Key activities

1. Train providers who are competent to treat adolescents with appropriate skills and provide them with on-going mentorship and supportive guidance

2. Scale up Young people and adolescent peer support (YAPS)

3. Implement psychological support and DSD for adolescents like facility based adolescent group refill, community-based adolescent group refill, MMD for adolescents in boarding schools and fast track drug refill.

Strategic Action 1.4: Strategic action: Quality treatment and care for key populations and other vulnerable groups realizing their health-related rights.

Key activities

1.4 Training for health care providers on human rights, medical ethics and culturally appropriate services especially in addressing health care needs of KPs and other vulnerable groups.

1. Review and reform HIV service delivery to ensure that they provide meaningful participation and involvement of PLHIV, Key and affected populations of CBOs.

Strategic Objective 2 Increase HIV-diagnosed individuals started on ART who adhere to regimens and are retained on treatment to 95% by 2025

Strategic Action 2.1: Strategic action: optimizing and rolling out ARV therapy treatment regimens including consolidation of the DTG transition plan to enhance sustained viral suppression, tolerability and sustainability

Key activities

1. Continue to implement "test and treat" policy within the consolidated HIV prevention and treatment guidelines and intensify interventions for continuous quality improvement (Viral load, retention and TPT)
2. Early diagnosis and effective linkage to treatment to maximize treatment outcomes by reducing new PLHIV with AHD (CD4<200).

3. Leverage PLHIV networks, peers of key and priority populations and empower families to provide adherence support to PLHIV on ART
4. Provide a clinical package for children and adolescents with advanced HIV disease
5. Increase access to drug resistance monitoring for all groups including for severe AEs eg hypoglycemia in stable clients transitioning to DTG.

Strategic Action 3 **Community empowerment to keep people engaged in care and helps them access treatment and adhere to medications and prevent the transmission of HIV.**
Key activities

1. Engagement of community structures e.g. Champions, linkage facilitators/peer-led models and systems for client tracing, linkage referrals, adherence and follow up.
2. Bring up to scale the differentiated peer-to-peer service models for men, adolescents, young adults and children to support identification, linkage, initiation, retention and viral suppression
3. Strengthen treatment literacy using expert clients, PLHIV network, VHTs, community structures as well as community sensitization to reduce stigma, GBV
4. Functionalize linkage to programs such as housing, SACCOs and food security programs that tackle structural barriers to engagement in HIV care and treatment for poor HIV positive clients and their families to meet financial specific needs associated with transportation to clinic appointments and food and nutrition supplements

Strategic Objective 3 Increase the prevalence of VLS among HIV-diagnosed individuals on treatment to 95%

Strategic Action 3.1 Strengthen efforts to improve quality of care and patient safety
Key activities

1. Increasing the voice of users and promote more governance inclusive of PLHIV and accountability in ART deliver at facilities and community levels
2. Build skills and competence among health workers in management of 2nd and 3rd line ART
3. Streamline drug resistance testing to optimize and provide 3rd line drugs

Strategic Action 3.2: Scale up the implementation of person-centered monitoring during ART.
Key activities

1. Institute HIV pharmacovigilance for effective and safety of ART
2. Roll out unique identifiers while taking care of patient confidentiality
3. Strengthen treatment monitoring and evaluation of clinical complications and effects of long term use of ARVs.
4. Scale up screening and management of side effects of ART at all ART sites
5. Expand psychosocial services with enhanced ART adherence support for all clients in facilities with a low viral load suppression.
6. Strengthen treatment monitoring in communities at house hold level through peer/expert clients, CHW, networks and KPs.

Strategic Action 3.3: Provide a comprehensive care package for management of co-morbidities and advanced HIV disease.

Key activities

1. Integrate HIV & TB programming services at all levels including community DOTS, home-based care, intensified case detection and TB preventative therapy especially pyridoxine and Isoniazid for eligible HIV positive people.
2. Provide prevention and management services for O.I, STIs and AART wrap around services in general outpatient and in-patient care.
3. Integrate nutrition assessment, counselling and support in HIV care and treatment services including use of Ready-to-use Therapeutic foods (RUTF) for severely malnourished, and linkage to increase food security.
4. Integrate management of advanced HIV disease, and co-morbidities such as mental illnesses, diabetes mellitus, Hypertension, viral hepatitis, heart diseases, malignancies etc. within HIV care and treatment service delivery appropriate for each facility.
5. Scale up implementation of service package such as nutrition, SRH and GBV in HIV care
6. Scale-up implementation of prevention and treatment of AIDS-related life-threatening opportunistic infections including cryptococcal meningitis
7. Scale up cervical cancer screening, HBV vaccination and treatment
8. Scale up effective pain management, palliative care and end-of-life care

Strategic Action 3.4: **Strategic action: Strengthen quality and efficient laboratory and diagnostic services, HIV viral load testing, specimen referral expanding testing services and developing the health work force.**

Key activities

1. Expand availability of POC especially CD4 cell count, EID and viral load testing
2. Optimization of diagnostic network, encompassing both lab-based and decentralized testing
3. Increase access to drug resistance monitoring through ordering of necessary materials.
4. Integration of diagnostic services with other diseases to create efficiencies
5. Innovate technologies to improve turn-around-time for various testing services
6. Develop comprehensive HIV treatment and care, and waste management protocols within the district
7. Integrate platforms to support viral load testing for HIV and Hepatitis B & C viruses starting with KPs.

6.3 Thematic area 3 Social Support &Protection

Context and Rationale

Social support consists of material and psychological resources that people often access through social networks. It involves both psychological support and more instrumental support consisting of material and financial resources. Interventions that increase and strengthen existing social connections to peers at the time of HIV diagnosis may increase ART initiation among HIV-infected youth (26), disclosure and social support have a strong influence on care engagement (27), and social support interventions (such as counselling) increase linkage to care among HIV-positive persons (28). Reports have also shown how critical social support from strong family relationships

is in addressing ART adherence challenges among adolescents (29). Some studies have been more emphatic about the role of interventions designed to strengthen family relationships and social support in offsetting children's psychological well-being in communities that are highly impacted by HIV (30).

Despite the acknowledged role of social support and protection, significant gaps remain in realizing meaningful support and protection for people living with HIV, PWD, OVC, key and priority populations, and other vulnerable groups. This is predicated upon stigma and discrimination, gender-based discrimination and violence, and structural challenges related to equity and human rights.

In Uganda, both internal and external stigma are still prevalent, although they are reducing in varying magnitudes. A stigma index survey conducted among HIV-positive sex workers showed that 38.5% experienced self-blame, 17.9% blamed others, 5.3% felt they wanted to kill themselves and 0.8% felt guilty about their HIV status (31). Also, due to their HIV-positive status, 28% had stopped working, 16.3% avoided going to hospital, 11.4% chose not to attend social gatherings, and 10.6% avoided having children. None of them had avoided having sex, but they were very fearful of sexual rejection, and 48% feared being gossiped about. Overall, HIV discrimination continues to fuel stigma for people living with HIV and KPs, such as people who use or inject drugs, sex workers, men who have sex with men, prisoners and incarcerated people, and lesbians, gay, bisexual and transgender people (LGBT) (32). These population categories are also subject to human rights violations, including structural legal and institutional barriers that affect access to and utilization of HIV-related services (16).

The MTR and the 12th Annual Joint AIDS Review show that significant initiatives have been undertaken under the stewardship of the Ministry of Gender, Labour and Social Development, the Ministry of Agriculture, and the Office of the Prime Minister to integrate the needs of people living with HIV, OVC and other vulnerable groups in government programmes (1, 2). In particular, this includes the Uganda Women Entrepreneur Programme (UWEP), the Youth Livelihood Programme (YLP), and Social Assistance Grants for Empowerment (SAGE) and Operation Wealth Creation (OWC) However, only about 2.5% of the youths living with HIV benefited from YLP against an increase of 22.3% of other beneficiaries between 2017/18 and July 2019. Also, the life cycle-sensitive package for social support is vaguely defined or not properly popularized among key stakeholders, and more than 50% of people living with HIV still do not have adequate knowledge of the laws that protect their rights.

Goal: To strengthen social and economic protection to reduce vulnerability to HIV and AIDS and mitigation of its impact on PLHIV, OVC, KPs & other vulnerable groups

Strategic Objective. 3.1: Scale up interventions aimed at eliminating stigma and discrimination

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

Strategic Objective. 3.3: Scale up psychosocial support for people living with HIV, PWDs, key and priority populations and other vulnerable people

Strategic Objective. 3.4: Strengthen prevention and response to sexual and gender-based discrimination and violence

Strategic Objective. 3.5: Strengthen prevention and response to child protection issues and Violence Against Children (VAC)

Strategic Objective. 3.6: Strengthen the legal and policy framework on HIV and AIDS to ensure that it is inclusive of all PLHIV, PWDs, key and priority populations and other vulnerable groups

Strategic Action 1.1: Disseminate the National Anti-HIV and AIDS Stigma and Discrimination Policy 2019 and ensure the policy addresses priorities for key and vulnerable populations

Key activities

- Roll out and disseminate the National Anti-HIV and AIDS Stigma and Discrimination Policy 2019 at sub county level

Strategic Action 1.2: Scale up targeted messages and community education to engender comprehensive knowledge of HIV and AIDS-related stigma and to transform norms and values in order to eliminate social stigma and discrimination against people living with HIV, including PWDs, KPs and other vulnerable groups

Key activities

- Conduct dialogue meetings against stigma, discrimination and violence at the subcounty level to sensitize communities on stigma and discrimination
- Conduct dialogue meetings with religious, cultural and community leaders at district level for meaningful engagement in addressing HIV related stigma, discrimination and violence in communities
- Identify individuals who hold influence to provide leadership and championing of the anti-stigma message in work places

Strategic Action 2.1 Support and establish interventions in the work place that promote the wellbeing of individuals living with HIV in the organizations

Key activities

- Conduct training on skills building and experience sharing targeting CDOs, PLHIV (Coordinators and C/Ps),
- Promote opportunities for people living with HIV to speak as a community in challenging stigma and discrimination
- Conducting a training in advocacy skills involving, CDOs and PLHIV coordinators and chairpersons

Strategic Action 2.2 Support networks of PLHIV

Key activities

- Empower networks of PLHIV to provide psychosocial support for members to reduce self-stigmatization

- Training PLHIVs in psycho-social support at County level involving seventy-five members in each of the two counties with two facilitators.
- Empower PLHIV forums to reach out to their peers and promote positive living
- District PLHIV executives (02) reaching out to their peers in the Sub Counties for support supervision.

Strategic Objective 3: Expand socio-economic interventions aimed at reducing social and economic vulnerability for people living with HIV and other vulnerable groups

Strategic Action 3.1 Conduct financial literacy training of PLHIV at district level, two from each of the twenty five sub counties on informed investment decisions for households and individuals infected, affected, or at high risk of HIV acquisition

Key activities

- Promote apprenticeship support through provision of planting materials and livestock for households and individuals infected, affected, or at high risk of HIV acquisition with 10kg of seed (rice, beans and maize) and a goat targeting ten members per sub county.

Key activities

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

Strategic action 1.2:

Key activities

- Training of the most vulnerable households experiencing chronic food shortage on how to access seedlings and other resources (capacity building), involving two member from 10 households per sub count in the district

Strategic Action 1.3:

Key activities

- Prioritise interventions that increase access to affordable and inclusive formal and non-formal education in order to reduce young people's socio-economic vulnerability
- Conduct short term courses in life skills for out of school youth at sub county level targetin50 members

Strategic Action 1.4: Address harmful gender norms and expand programs that reduce HIV-related gender discrimination, PWDs, violence against women and girls, KPs and other vulnerable people in all their diversity

Key activities

- Sensitization aimed at promoting human rights awareness on gender and sexual reproductive health rights as a strategy to counter GBV and discrimination

Strategic Action 1.5: Conduct community dialogue meeting on SGBV involving male action group leaders

Key activities

- Disseminate the legal laws and penalties in regard to SGBV

Strategic Action 2.1: Conduct refresher training for community level service providers, including (para social workers, paralegal workers, Community Health Extension Workers and community activists) on GBV prevention, referral, care and post care management

1. Prioritize operationalization and dissemination of the National HIV and AIDS Stigma and Discrimination reduction Policy guidelines at the district level.

- District stakeholders meeting to disseminate the guidelines.
- Hold radio talk shows to disseminate the guidelines to communities.
- Distribute copies of the guidelines to stakeholders. (Police, health workers, religious leaders, cultural leaders and local council leaders).

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

- Community outreaches
- Targeted champions (male, KP, youth, women, adolescent)
- Design and disseminate messages on stigma and discrimination reduction through different channels such as radios, VHTs, schools, health workers, spiritual and cultural leaders.

3. Prioritize implementation and monitoring of policies and interventions to address workplace and institutional stigma and discrimination.

- Review HR manual to incorporate HIV workplace policy.
- Operationalize workplace policies. (routine staff orientation meetings, provide HTC services to district staff)
- Provide counselling services to the affected personnel.
- Conduct review meetings to assess the level of performance of the policies.

4. Prioritize empowerment programmes to reduce internal stigma for people living with HIV, KPs and other vulnerable populations, and promote positive and healthy living, including life skills training.

- Reconstitute and functionalize the eight PLHIV groups in the district.
- Support linkage to sustainable livelihood programmes.
- Support Life skill training for PLHIV, PWDs, OVCs and KPs

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

- Work with religious leaders through places of worship to promote the anti-stigma campaign.
- Orient community leaders through the emiryango systems to create awareness against stigma and discrimination.

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

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- Training of one health science teacher per school in stigma and discrimination reduction.
- Identify student champions, orient and use them to sensitise schools on stigma and discrimination reduction.

7. Strengthen community-led structures, organizations and networks to engage out-of school youth and young people to address stigma.

- Integrate HIV services into CSOs programmes that are related to out of school youth and young people.
- Work with youth champions to reach out of school youth and young people.
- Reactivate the PLHIV network to reach out 0f school youth and young people.

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

- Train social workers to handle stigma and discrimination.
- Introduce a communication line for reporting stigma and discrimination at facilities and other places of work.
- Design and disseminate IEC materials (talking walls) to health facilities and other work places.

Strategic Objective 3.2: Expand socioeconomic interventions aimed at reducing social and economic vulnerability for people living with HIV and other vulnerable groups.

1. Prioritize interventions that enhance the socioeconomic status of households and individuals infected or affected by HIV, or those at high risk of HIV acquisition.
    - Integration of PLHIV into government programmes such as EMYOGA, Operation Wealth Creation and others.
    - Advocate to CSOs and other IPs implementing livelihood programmes to support PLHIV, KPs and PWDs.

2. Institutionalize specific forms of affirmative action, including direct targeting approaches that assure access to existing social protection and social assistance programmes for people at high risk of HIV and those living with HIV, including women, AGYW, PWD and OVC.
    - Review and functionalize the existing system under gender department.
    - Strengthen information sharing among stakeholders.
    - Strengthen coordination mechanism with all actors to ensure case identification and referral pathways to support social protection.
    - Community follow up by the probation officer.
    - General sensitization on legal redress of the affected.

3. Scale up targeted interventions to improve nutrition and household food safety for people living with HIV, children under the age of 5 years, AGYW, pregnant women, PWD, lactating women and other vulnerable households.

- Updated a district nutrition action plan aligned to national plan.
- Support and scale up food demonstration gardens in all health centre IIIs and roll down to house levels.
- Review and strengthen nutritional assessment tools.
- Equip office of the district nutrition focal person. (computer, modem and others)
- Conduct mentorship sessions to AGYW and support supervision.

4. Address sociocultural, socioreligious and institutional barriers that deter people living with HIV, OVC, PWD, KPs, priority populations and young people from accessing services in health and other development programmes.
   - Support CDOs conduct Community sensitization meetings regularly.
   - Disseminate and monitor adherence to policy and policy guidelines. (parenting guidelines)
   - Support male engagement sessions that will enable males to support their families to participate in social support programmes.

5. Support community-led structures, organizations and networks to address structural barriers that deter people living with HIV and other vulnerable groups from accessing services.
- Mobilize and coordinate community structures (cult religious groups, traditional birth attendants and spiritual leaders) to promote utilization of HIV services.

6. Prioritize gender-responsive interventions at the community level by identifying gender specific needs for women, girls, boys, men and PWD that address their vulnerability to HIV and AIDS.
- Conduct a gender needs assessment targeting the PPs.
- Conduct dissemination of gender needs assessment findings.
- Conduct a gender mainstreaming meeting with stakeholders
- Identify and support community self-support groups (Nigina, women, girls, boys, men and PWD)

7. Prioritize interventions that increase access to affordable and inclusive formal and nonformal education in order to reduce young people's socioeconomic vulnerability.
- Formulate a bylaw to enforce the implementation of child labour.
- Develop guidelines to support enforcement of the bylaw.
- Build capacity of relevant officers to enforce the bylaw.
- Monitor and evaluate of the enforcement of the law.
- Increase on awareness campaigns

Strategic Objective 3.3: Scale up psychosocial support for people living with HIV, people with a disability, key and priority populations, and other vulnerable people

1. Create mechanisms and structures to enhance social capital and networks for social support at the community level.
- Building capacity of PLHIV, KP/ PP and CSOs networks to increase service demand and uptake of services such as adherence.

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

- Build capacity of POC staff in screening diagnosis and management of mental health conditions.
- Integrate mental health services in the different points of care in facilities.

3. Expand both facility- and community-based counselling services for people living with HIV and other vulnerable groups.

- Implement homebased care for PLHIV and other vulnerable groups.

4. Establish safe spaces for psychosocial support and other critical services for key and priority populations.

- Set up a district action canter to respond to victims of violence.
- Establish community-level child protection systems and structures to engender early identification, response and referral for child protection cases.

Strategic Objective 3.4: Strengthen prevention and response to sexual and gender-based discrimination and violence

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

- Engagement meeting of community leaders on discriminatory harmful gender norms through community dialogues, sensitization meetings and media.
- Roll out violence and HIV prevention programmes for girls, boys, women and men.
- Develop and implement a national curriculum on case management in the context of HIV and sexual violence against children.
- Conduct awareness session on parenting guidelines.
- Mobilize communities, policymakers and other stakeholders on the importance of male participation/involvement in attaining positive outcomes in gender equality and addressing harmful gender norms.

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

- Build skills of vulnerable groups in vocational programmes, resource mobilization and link them to govt programmes and other sources of funding.
- Build their skills in entrepreneurship.
- Strengthen systems to address practices on the age of consent, spousal consent, domestic violence, sexual consent, sexual exploitation and child marriage.
- Intensify interventions that promote human rights awareness on gender and SRHR as a strategy to counter GBV and discrimination.

- Mobilize and sensitize the providers and beneficiaries on human rights and link them to the CSOs providing those services.

- Conduct mass campaign to address child marriage and teenage pregnancies, which increase vulnerability to HIV and AIDS in the community.

- Increase the coverage and delivery of services to meet basic needs for OVC households.

Strategic Objective 3.6: Strengthen the legal and policy framework on HIV and AIDS to ensure that it is inclusive of all people living with HIV, people with a disability, key and priority populations, and other vulnerable groups

1. Facilitate access to justice in relation to the rights violations of people living with HIV, PWD, KPs, priority populations and OVC through strategic litigation and the expansion of legal services.
    - Sensitization and engagement of stakeholders on the available services.
    - Build capacity of health workers on examination of victims of violence.
2. Expand provision of legal literacy "Know Your Rights" campaigns and rights and responsibilities education among KPs, priority populations, OVC, PWD and people living with HIV through a cadre of peer human rights educators and paralegals.
    - Create client awareness on their rights and responsibilities.

3. Scale up human rights education, legal support and protection of persons living with and affected by HIV.

- Translate and disseminate the client charter targeting different population groups.
- Audio recording and brail materials.
- Train health workers in sign language.

4. Strengthen and sustain the capacity of networks and CSOs of people living with HIV, KPs and other vulnerable persons in order to build progressive movements that integrate human rights awareness, community mobilization and monitoring of health service provision.
    - Engage networks and CSOs of people living with HIV, KPs and other vulnerable persons in planning, implementation and evaluating during Quarterly coordination meetings with CSOs and PLHIV networks
    - Empower networks and CSOs of people living with HIV, KPs and other vulnerable persons in monitoring HIV programmes using the community score cards.

6.4 Thematic area 4 System Strengthening

Kanungu District is running the multi-sectoral response with up-to-date and evidence-informed policies, guidelines, protocols and related standards for HIV services to guide priority HIV interventions. Although a lot of gains have been made in strengthening systems for policy, planning and delivery of HIV services during the past decade, challenges cut across human resources, infrastructure, financing, information systems and laboratory services. There are human resource gaps, too: more than one quarter of health staff positions in the public sector are not filled and HIV counsellors are not yet included in the structure. While the logistical and supply chain management system for HIV and AIDS goods and services has improved, work is still required to fill stock-out gaps for ARVs and other essential drugs and supplies.

As part of coordination and oversight, UAC established the HIV and AIDS E-Mapping and Monitoring System to map the activities of HIV and AIDS stakeholders continuously, and the National AIDS Documentation and Information Centre (NADIC) was set up to manage HIV and AIDS data resources. In place is a situation room for harmonizing the sector databases (e,g. DHIS 2, DREAMS, PTCT dashboard, CPHL dashboard, OVC and MIS) that has yet to be rolled out at the national level (or lower). A gender-tracking dashboard for the NSP indicators also has been established. Training for capacity-building is thus necessary across the board.

In Kanungu districts DACs is functional and have established networks or forums of people living with HIV. However, increased stakeholder capacity for local and international resource mobilization needs to be built at all levels. Similarly, standard budget formats and nomenclatures for implementing partners need to be developed to streamline the District AIDS Spending Assessment (DASA) process.

Success in achieving service-related objectives under the DSP (such as prevention, care, treatment and social support) is contingent on the governance and leadership of the District HIV response, and on increasing the efficiency and effectiveness of systems for planning and delivering HIV services.[1] The implementation of the DSP requires increased focus, coordination and collaboration among stakeholders. The service delivery targets set for each thematic area hold institutions and stakeholders accountable for outcomes and results, and its implementation requires all sectors to build partnerships to provide the minimum set of complementary services. It also requires collaboration, close coordination and engagement among stakeholders at all levels for programme planning and implementation.

Taking into consideration circumstances and changes in the HIV and AIDS landscape—and in line with the NDP III—it is necessary for sectors to develop new HIV and AIDS strategic plans that are aligned with this DSP. The development of local government plans should cascade down to lower local government levels, too. Furthermore, MoFPED has instructed all accounting officers in the MDAs to allocate 0.1% of their annual budget for mainstreaming HIV and AIDS, gender equity planning and budgeting. Hence, UAC will scale up its advocacy role on mainstreaming HIV and AIDS in programmes and plans by preparing guidelines on how to budget and use the 0.1% of the allocation. As a sector, local government needs guidance on how to convert the strategic plan into annual results and performance-based outputs that can be used to hold partner agencies and local governments accountable. The DSP will pursue a three-level accountability framework to ensure that accountability is a more explicit strategic planning element. The levels are: (1) mutual accountability, (2) institutional accountability, and (3) programme or performance

[1] Governance focuses on the manner in which political, economic and administrative authority is exercised in the management of the multi-sectoral HIV/AIDS response. Leadership entails the generation and implementation of a shared vision in the national response. Governance addresses political commitment, transforming political will into ownership of the policy and implementation processes, and the ability and authority to make evidence-informed decisions and follow up on decisions.

accountability. UAC will play the leadership role of spearheading implementation of the accountability framework.

Below are the key legal and policy areas to be prioritised by the district.

Operationalize the HIV Prevention and Control Regulations.

- Enforce sexual and gender-based violence laws and amendments of discriminatory provisions in the Succession Act (1906).
- Participate in reviewing non-enabling policy and legal environments faced by key populations and other most-at risk groups.
- Support Departments and agencies to develop workplace policies.
- Participate in reviewing national technical policies and guidelines, such as the Consolidated Guidelines for Prevention and Treatment of HIV in Uganda, HIV testing services policy and guidelines, guidelines for HIV case-based surveillance, and circumcision policy and guidelines.
- Address cultural/religious impediments to the use of condoms and sexuality education for young people.
- Address harmful cultural practices, including early marriage, female genital mutilation and sexual violence

Goal

***To strengthen the multi-sectoral HIV and AIDS service delivery and coordination system that ensure sustainable access to efficient and quality services for all targeted populations*.**

SO. 4.1: Strengthen the governance and leadership of the multisectoral HIV and AIDS response at the district.

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

SO. 4.3: Strengthen health systems for infrastructure, supply chain and HIV program management to enable optimum services delivery.

SO. 4.4: Strengthen community systems for the HIV response, including PLHIV and members of KPs, VHTs, CHEWs and family support groups.

SO. 4.5: Mobilise resources and streamline management for efficient utilisation and accountability

SO. 4.6: Strengthen the national mechanism for generating comprehensive, quality and timely HIV and AIDS information for M&E of the NSP.

SO. 4.7: Promote information sharing and utilization among producers and users of HIV and AIDS data/information at all levels.

Under each strategic objective above, are strategic actions, below are activities the district will implement under each strategic action.

Strategic Objective 1 Strengthen the governance and leadership of the multi-sectoral HIV and AIDS response at all levels

Strategic Action1.1: Build the capacity of political, cultural, religious and private sector leaders for more effective governance, leadership and participation in the multi-sectoral response to HIV and AIDS

Key activities

4.1.1 Orientation of the DAC on the new coordination guidelines and structures

4.1.2 Orientation of SAC on the new coordination guidelines and Structures

Strategic Action 4.2: Mainstreaming HIV/AIDS activities into Departmental Work plans

Key activities

4.1.1 Orientation Heads of Department on the new HIV and Strategic Plan
4.1.2 Organizing an HIV and AIDS strategic Planning workshop
4.1.3 Organizing an HIV and AIDS strategic Planning workshop for Heads of Department
4.1.4 Organizing an HIV and AIDS strategic Planning workshop for Lower Local Government

Strategic action 3: Organizing Partner meetings for a Strong networks in the HIV/AIDS response programs

Key activities

4.3.1 Orientation Implementing Partners on the new HIV and Strategic Plan.

4.3.2. Organizing an HIV and AIDS strategic Planning workshop with Implementing Partners

4.3.3. Organizing an HIV and AIDS strategic Planning workshop for the Local Community Based Organizations

4.3.4. Organizing an HIV and AIDS strategic Planning workshop for Religious Leaders, Traditional Healers and Opinion Leaders

4.4.1 Orientation PLHIV Members on the new HIV and Strategic Plan

4.4.2 Organizing an HIV and AIDS strategic Planning workshop with PLHIV

Organizing coordination meetings

Strategic Action 4.4: Orient all Health workers and Extension staffs (CDO, SAS, GISO, Vet staffs towards providing universal access through task shifting.

Key activities

4.4.1 Orientation of Health Workers
4.4.2 Orientation of teachers in Pre-Primary, Primary, Secondary and Tertiary
4.4.3 Orientation of Lower Local Governments Extension Workers (CDO, Vet, SAS, GISO, SAA, Parish Chiefs, Agri,)

7.0: MONITORING & EVALUATION MATRIX

7.1 Introduction

The M&E framework is part of the three in ones ie one coordinating body, one strategic plan and one M&E framework. The 2019/2020 review of the outgoing National HIV /AIDS M&E evaluation of the 2015/2016-2019/2020 indicated strengths which informed the design of the ongoing M&E plan for the next strategic period 2020/2021-2024/2025

7.2 Outcome and Indicator matrix

Table 1: Outcomes and Indicators

PREVENTION							
Outcomes	**Indicators**	**Baseline**	**Target**	**Data Source**	**Freq.**	**Responsible centre**	**Outcomes**
Strategic Objective 1*: Increase adoption of safer sexual behaviors and reduction in risky behaviors among key populations, priority population groups and the general population*							
1.1	Increased adoption of safer sexual behaviors and reduction in risky behaviors among key populations, priority population groups and the general population	Percentage of men, women, young people who have had sexual intercourse with more than one sexual partner	LQAs	20.36	15.36%	Annual	District/IP
		Percentage of individuals who know two or more benefits of HCT	LQAS	78.47	95%	Annual	District/IP
Strategic Objective 2*: Expand coverage and uptake of quality biomedical priority HIV interventions (SMC, EMTCT, condom, ART) to optimal levels.*							
2.1	Increased coverage and use of biomedical HIV prevention interventions	Proportion of PLHIV who know their HIV status- 1st 95	DHIS2	69%	95%	Annual	District/IP
2.3	Increased VMMC coverage	Percentage of male youths 15-24 yrs who are circumcised	LQAS	57.14%	85%	Annual	District/IP

	Increased Emtct Coverage	%of HIV^+ pregnant/ breast feeding women on ART to reduce the risk of HIV transmission	DHIS2	96	100%	Quarterly	District/IP
	Reduction in Number of HIV positive infants	HEIs Tested HIV positive on any DNA/PCR or rapid test - Total	DHIS2	3.20%	0%	Quarterly	District/IP
		Percentage of mothers of children 0-11 months who were counseled for PMTCT services during last pregnancy	LQAS	75.19%	95%	Annual	
Strategic objective 3: Address underlying sociocultural, gender and other structural factors that drive the HIV epidemic							
	Reduction in GBV cases among AGYW, PWDs, children and KPs	Percentage of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	LQAS	33.66%	15%	Annual	District/IP
CARE AND TREATMENT							
Strategic objective1: Increase proportion of HIV positive persons who start antiretroviral therapy to 95% by 2025.							
1.1	Improved linkage to ART	Number of HIV positive persons (Children, women, men, KP, adolescents) enrolled on lifelong ART	DHIS2	87.50%	95%	Monthly	District/IP
Strategic objective 2: Increase individuals who start on ART who adhere to regimens and are retained on treatment to 95% by 2025.							
2.1	Improved retention on ART	Proportion of children, women, men, adolescents, KP retained on ART at 12 months after initiation	DHIS2	79%	95%	Quarterly	District/IP
Strategic Objective 3: Increase the HIV-diagnosed individuals whose treatment is successful in terms of patient virological suppression to 95% by 2025.							
	Improved viral suppression	Viral load suppression rate of clients on Art	Viral load dash board	91%	95%	Quarterly	District/IP
		The viral load test coverage	DHIS2	79%	95%		
	Integration of HIV care and treatment	Proportion of PLHIV active on ART screened for advanced HIV disease (TB)	DHIS2	88.30%	95%	Quarterly	District/IP
		Proportion of PLHIV who received nutrition assessment at last clinic visit	DHIS2	88.20%	95%	Quarterly	District/IP

SOCIAL SUPPORT AND PROTECTION							
Strategic objective 1: Scale up interventions aimed at eliminating stigma and discrimination							
	Stigma and discrimination minimized	Number of dissemination meetings conducted	District reports			Annually	District/IP
		Number of radio talk shows conducted	District reports		24	Monthly	District/IP
		Percentage of men and women who report HIV related discrimination disaggregated by community, health setting and work place	District reports			Annually	District/IP
SO. 3.2: Expand socio-economic interventions aimed at reducing social and economic vulnerability for people living with HIV and other vulnerable groups							
	Reduced socioeconomic vulnerability	Number of PLHIV who have benefited from livelihood programs	District reports			Annually	District/IP
SO. 3.3: Scale up psychosocial support for people living with HIV, PWDs, key and priority populations and other vulnerable people							
	Improved child protection and reduced VAC	Percentage of OVCs who 3 basic needs have at least met	District reports			Annually	District/IP
SO. 3.6: Strengthen the legal and policy framework on HIV and AIDS to ensure that it is inclusive of all PLHIV, PWDs, key and priority populations and other vulnerable groups							
	Legal and policy framework improved to ensure improved access by all vulnerable groups	Number of PLHIV, KPs who access legal services	District reports			Monthly	District/IP
		Number of PLHIV, KPs and other vulnerable groups who report rights violation	District reports			Monthly	District/IP

SYSTEMS STRENGTHENING							
Strategic Objective 1: Strengthen the governance and leadership of the multisectoral HIV and AIDS response at the district.							
	Governance and leadership structures for multisectoral HIV response strengthened	Number of functional HIV/AIDS coordination structures in place	District reports			Annually	District/IP
		Number of departments with HIV/AIDS activities integrated in their departmental plans	District reports			Annually	District/IP
		HIV workplace policy developed and implemented.	District reports			Annually	District/IP
		PLHIV network constituted and functionalized	District reports			Annually	District/IP
Strategic Objective 2: Enhance availability of adequate and appropriate human resource capacity for delivery of quality HIV and AIDS services.							
	Availability of adequate HRH for delivery of quality HIV services	Percentage of health facilities with adequate staffing levels	HRIS	60%	90%	Quarterly	District/IP
Strategic Objective 3: Strengthen health systems for infrastructure, supply chain and HIV program management to enable optimum services delivery.							
	Health infrastructure responsive to HIV service needs	Percentage of HCIIIs accredited and offering ART, PMTCT and HTS	District reports	56.10%	70%	Annually	District/IP

7.3 Coordination and implementation arrangements

The district carried out a stakeholder analysis including mapping out a coordination structure for the district. Stakeholders were idented and these, alongside other key sectors and other agencies, will work with the DAC and other lower-level structures such as the sub-county AIDS committees (SACs) to coordinate the implementation of this plan. Detailed roles of stakeholders will be generated during the initial planning meeting with all stakeholders.

7.4 Monitoring and Evaluation of the implementation

The DSP M&E plan ultimately aims to ensure that quality and timely HIV and AIDS information is generated to guide evidence-informed decision-making on programming, other stakeholders and district implementing partners to achieve better results. The DSP M&E Plan provides a basis for continuous learning and improvement of HIV interventions and strategies indicated in this DSP. The M&E Plan for the DSP will be a core component of National HIV and AIDS Monitoring and Evaluation Plan.

The data generated will feed into DHIS2 and HMIS accessible to several stakeholders. The data generated will further enable the district to meet its quarterly and annual reporting requirements and progress reports. The district will organize periodic meetings and midterm review to assess progress in the implementation of this plan.

8.0 COORDINATION AND IMPLEMENTATION

8.1 Justification for budget

The finances to implement the Kanungu District HIV/AIDS Strategic Plan 2020/2021-2024/2025 have been estimated with view of achieving the best within a resource constrained setting. A 10% progressive projection was applied to estimate the cost of implementation for each year based on expected future prevention and treatment interventions including financial inflation as well as cater for national inflation rates/global financial situations. The cost of the Kanungu DLG HIV and AIDS strategic plan estimated at Ugx, **10,304,665,463** for next five years as reflected in the table below

Table showing the five years' DSP Budget estimates

Five Year Kanungu DSP Budget Estimate in (000.UGX)							
Thematic area	Year 1	Year 2	Year 3	Year 4	Year 5	Total	%
Prevention	368,040,000	435,306,570	505,240,097	572,506,667	643,329,179	2,156,382,512	21%
Care & Treatment	416,640,000	457,209,057	553,227,170	656,825,660	714,661,132	2,381,923,019	23%
Social Support and protection	717,856,000	742,609,655	767,363,310	792,116,966	816,870,621	3,118,960,552	30%
Health Systems strengthening and M&E	466,000,000	522,747,162	624,699,690	731,461,300	768,491,228	2,647,399,381	26%
Total	**1,968,536,000**	**2,157,872,444**	**2,450,530,267**	**2,752,910,593**	**2,943,352,160**	**10,304,665,463**	**100%**
%	19%	21%	24%	27%	29%	100%	

Table 5. Costed plan for all the thematic areas

PREVENTION						
Item	**Qty**	**Unit Cost**	**Days**	**Frequency**	**Amount**	**Source of funding**
Strategic Objective 1.1: Increase adoption of safer sexual behaviors and reduction in risky behaviors among key populations, priority population groups and the general population						
Strategic Action 1.1.1: Scale-up age- and audience-specific social and behavioral change interventions including abstinence and be faithful interventions to reach all population groups with targeted HIV prevention messages						
Activity 1: Disseminate/distribute IEC/BCC messages and materials to key populations including Uniformed personnel, Trucker and Trader in the open market						
Perdiem for Radio talk show	3	161,000	1	20	9,660,000	
Fuel for Radio Talk show	20	4,000	1	20	1,600,000	
Radio Airtime	1	600,000	1	20	12,000,000	
Airtime for mobilisation	1	50,000	1	20	1,000,000	
Fuel for Distribution of IEC materials	20	4,000	1	5	400,000	
SDA	1	20,000	1	5	100,000	
Sub Total					**24,760,000**	**DLG/Donor**
Activity 2: Disseminate and distribute IEC/BCC messages and materials to the general population including social venues						
Hall Hire	1	300,000	1	5	1,500,000	
Meals and Refreshment	50	25000	1	5	6,250,000	
Transport Refund	50	30000	1	5	7,500,000	
Facilitators	3	81,000	1	5	1,215,000	
Sub Total					**16,465,000**	**DLG**
Activity3: Develop and implement District Advocacy Campaign targeting political, cultural and religious leaders to support and prioritize transformation of social-cultural and gender norms and practices that contribute to the spread of HIV or limit HIV prevention efforts						
Hall Hire	1	200000	1	5	1,000,000	
Meals and Refreshment	50	25000	1	5	6,250,000	
Transport Refund	50	30000	1	5	7,500,000	
Facilitators	3	81000	1	5	1,215,000	
Assorted Stationary	1	200,000	1	5	1,000,000	
Sub Total					**16,965,000**	**IP**
Activity 4: Expand provision of HIV education for in-school youth with focus on abstinence, multiple partnerships, cross-generational, transactional and early sex, as well as life skills						
Facilitators	4	81,000	1	50	16,200,000	
Fuel	20	4,000	1	50	4,000,000	
Assorted Stationary	1	200,000	1	50	10,000,000	
Sub Total					30,200,000	DLG/IP
Activity 5:Scale up awareness raising and build community level capacity to change negative gender norms, beliefs and practices through tailored audience specific messaging and lobbying						
Hall Hire	1	300,000	1	5	1,500,000	
Meals and Refreshment	50	25000	1	5	6,250,000	
Transport Refund	50	30000	1	5	7,500,000	
Facilitators	3	81000	1	5	1,215,000	
Assorted Stationary	1	200,000	1	5	1,000,000	

Sub Total					**17,465,000**	**DLG**
Activity 6: Expand provision of HIV prevention education, counselling and linkage to SRHR services to all tertiary education institutions						
Facilitators	4	81000	1	20	6,480,000	
Fuel	20	4000	1	20	1,600,000	
Assorted Stationary	1	200000	1	20	4,000,000	
Sub Total					**12,080,000**	**IP**
Strategic Action 1.1.2: Design and implement youth-led HIV prevention programs utilizing innovative approaches such as adaptive leadership and human centred design and diversify SBCC channels to predominantly include media-based outreach platforms and other technology based-approaches to reach young people with HIV prevention messages						
Activity 1: Disseminate/distribute IEC/BCC messages and materials to key populations including Uniformed personnel, Trucker and Trader in the open market						
Fuel	20	4,000	34	30	81,600,000	
SDA	3	20,000	34	30	61,200,000	
Sub Total					**142,800,000**	**IP**
Activity 2: Provide tailored adolescent friendly services targeting STI management, HCT, condom use and family planning information and commodities						
Fuel	20	4,000	1	200	16,000,000	
SDA	3	20,000	1	200	12,000,000	
Sub Total					**28,000,000**	**IP**
Activity 3: Train health educators (VHTs) and service providers [in the public and private sector] to improve their skills of dealing with adolescents and young people						
Facilitators Perdiem	4	161,000	5	10	32,200,000	
Perdiem for Participants	20	161,000	5	10	161,000,000	
Transport Refund (Facilitator	4	45,000	2	10	3,600,000	
Transport Refund (participant	20	45,000	2	10	18,000,000	
Hall Hire	1	300,000	5	10	15,000,000	
Assorted Stationary	1	200,000	1	10	2,000,000	
Sub Total					**231,800,000**	**IP**
Strategic Action 1.1.3: Engage community structures and networks in design and scale up innovative HIV prevention programs to improve comprehensive HIV knowledge, impart life skills, reduce risky sexual behaviours, address gender-based violence and improve sexual and reproductive health status among in and out-of-school children and youth						
Activity 1: Engage the existing champions on family planning and GBV to disseminate HIV messages						
SDA for champions	40	20,000	5	20	80000000	
Facilitation for supervisor	4	81,000	5	20	32400000	
Sub Total					**112,400,000**	**IP**
Activity 2: Conduct community dialogues on factors that hinder behaviour change and uptake of HIV prevention services						
Transport Refund participants	20	20,000	1	17	6800000	
SDA for participants	20	25,000	1	17	8500000	
Ffacilitator's'allowance	5	81,000	1	17	6885000	
Assorted Stationary	1	200,000	1	17	3400000	
Sub Total					**25,585,000**	**DLG**
Activity 3: Engage men in HIV, sexual and reproductive health programs and interventions and also offer them services						
Transport Refund participants	20	20000	1	17	6800000	
SDA for participants	20	25000	1	17	8500000	
Facilitators allowance	5	81000	1	17	6885000	
Assorted Stationary	1	200000	1	17	3400000	

Sub Total					**25,585,000**	**IP**
strategic Action 1.1.4: Implement interventions that can help to keep adolescent girls and young women in school by scaling up training for menstrual hygiene management among in-school AGYW, ending gender-based violence, providing sanitary pads for needy AGYW at school and cash transfers, among other interventions						
Activity 1Train In-school girls in menstrual hygiene including how to make reusable sanitary pads						
Facilitator allowance	6	81,000	1	50	24300000	
Purchase of Demonstration materials for reusable pads	1	300,000	1	250	75000000	
Sub Total					**99,300,000**	**IP**
Activity 2: Train in-school girls in life skills including how to respond to SGBV and report incidents of abuse						
Facilitator allowance	6	81000	1	50	24300000	
Sub Total					24300000	DLG
Activity 3: Engage education institutions to include HIV thematic messages in Music, dance and drama programs						
Facilitator allowance	6	81,000	1	1	486000	
SDA for participants	50	20,000	1	1	1000000	
Transport Refund for participants	50	25,000	1	1	1250000	
Sub Total					**2736000**	**DLG**
Strategic Action 1.1.5: Increase availability of and access to quality condoms through targeted distribution of free condoms, improved social marketing approaches, and adoption of the total market approach. This will also include the operationalization of the condom logistics management information systems (LMIS) for improved efficiency						
Activity 1:Utilise non-traditional condom distribution outlets for free condoms to the general population and special groups including salons, barber shops, health clubs, road side kiosks, washing bays and related outlets						
Fuel	20	4,000	1	17	1360000	
SDA for Driver	1	20,000	1	17	340000	
SDA for officer	1	20,000	1	17	340000	
Sub Total					**2040000**	**IP**
Activity 2: Expand condom distribution to key populations using the peer network						
Fuel	20	4000	1	17	1360000	
SDA for Driver	1	20000	1	17	340000	
SDA for officer	1	20000	1	17	340000	
Sub Total					**2040000**	**IP**
Activity 3: Design condom education programs to address misconceptions and other barriers to male and female condom use						
Facilitator allowance	6	81000	1	17	8262000	
SDA for participants	50	20000	1	17	17000000	
Transport Refund participants	50	25000	1	17	21250000	
Sub Total					**46512000**	**IP**
Strategic Objective 1.2: Expand coverage and uptake of quality biomedical priority HIV interventions to optimal levels						
1.2.1 Scale-up coverage of differentiated HIV testing services to high-risk groups (such as pregnant women, HIV&TB co-infected persons, HIV-discordant couples, most-at-risk populations and children <15 years of age) to identify HIV infected individuals and enrol them on ART to lower their viral load and reduce the ability to transmit HIV to other people						
Supervision Allowances	6	81,000	1	2	972,000	
Sub total					**972,000**	
Activity 2: Build the capacity of service providers to improve the quality of HIV testing and pass rates for external quality assessment (EQA)						
Facilitator allowance	3	81,000	1	50	12,150,000	

SDA for participants	3	20,000	1	5	300,000	
Sub Total					**12,450,000**	**DLG**
Activity 3: Increase coordination role for HIV testing services at district levels, and involve the private sector						
Facilitator allowance	3	81,000	1	1	243,000	
SDA for participants	30	20,000	1	1	600,000	
Transport Refund	30	25,000	1	1	750,000	
Assorted Stationary	1	200,000	1	1	200,000	
Sub Total					**1,793,000**	**DLG**
Activity 4: Provide youth friendly services at health centre III and above						
Supervision Allowances	2	81,000	1	100	16,200,000	
Space	1	10,000,000	1	10	100,000,000	
Sub total					**116,200,000**	**IP**
Strategic Action 1.2.2: Revitalize the four-pronged EMTCT approach and optimize EMTCT services by addressing EMTCT program coverage and quality of services, retention of Mother-Baby pairs, access of HIV-exposed infants to PCR and final diagnosis at 18 months						
Activity 1: Provide HCT services for all pregnant and breastfeeding women and their partners within the health care setting						
Meetings	10	20,000	1	20	4,000,000	
Sub Total					**4,000,000**	**DLG**
Activity 2: Provide primary prevention services with a focus on young pregnant and breastfeeding women						
Meetings	10	20,000	1	60	12,000,000	
Sub Total					**12,000,000**	**DLG**
Activity 3: Implement measures that target the underlying drivers of poor retention in EMTCT services including stigma and disclosure challenges with interventions such as assisted disclosure and psychosocial support						
Meetings	10	20,000	1	60	12,000,000	
Sub Total					**12,000,000**	**DLG**
Activity 4: Re-orient providers and intensify support supervision and mentorship for all service providers for improved STI case management						
Facilitator allowance	2	81,000	2	5	1,620,000	
SDA for participants	3	20,000	2	5	600,000	
Sub Total					**2,220,000**	**DLG**
Strategic 1.2.3: Implement condom distribution strategies for increased access, equity and sustainability, achieved through targeted distribution of free condoms, improved social marketing approaches into non-traditional outlets, with the commercial sector serving urban outlets to adopt the Total Market Approach						
Activity 1: Implement strategies to increase demand for condoms among different population groups including discordant couples, key populations, and adolescents and young people						
Meetings	6	81,000	1	5	2,430,000	
Sub Total					**2,430,000**	
Activity 2: Undertake targeted distribution of free condoms to low income and vulnerable groups						
Fuel	20	4,000	5	20	8,000,000	
SDA	3	20,000	5	20	6,000,000	
Sub Total					**14,000,000**	**DLG**
Strategic Action 1.2.4: Expand the coverage and accessibility of targeted biomedical interventions for key and priority populations, including STI services, HIV testing, VMMC, PrEP, PEP, EMTCT and harm-reduction interventions						
Activity 1: Expand provider-initiated HCT, couple counselling and testing as well as targeted community-based outreach HCT						
Allowances	12	20,000	1	20	4800000	
Sub Total					**4800000**	**DLG**

Activity 2: Create demand for HCT among key populations through community and network driven mobilization and education						
Meetings	100	45,000	1	5	22500000	
Sub Total					**22500000**	
Activity 3: Streamline the use of expert clients in facility and non-facility-based counselling pre and post HIV testing						
Meetings	100	45,000	1	5	22500000	
Sub Total					**22,500,000**	**DLG**
Activity 3: Improve STI case management in public and private health facilities targeting MARPs						
Facilitators allowance	2	81,000	1	5	810000	
SDA for participants	12	20,000	1	5	1200000	
Assorted Stationary	1	200,000	1	5	1000000	
Sub Total					**3,010,000**	**DLG**
Strategic Action 1.2.5: Expand coverage and eliminate all barriers to accessing PrEP and PEP for those at high risk of exposure to HIV infection; including engagement of KPs and priority population peers as distribution agents						
Activity 1: Disseminate policy and technical guidelines and training materials on new HIV prevention technologies including PrEP and PEP						
Fuel	20	4,000	1	1	80000	
SDA	4	20,000	1	1	80000	
Sub total					**160000**	**DLG**
Activity 2: Develop IEC/BCC messages and materials on new HIV prevention technologies						
SDA	5	20,000	1	5	500000	
Transport Refund	5	25,000	1	5	625000	
Sub total					**1125000**	**DLG**
Activity 3: Build capacity of service providers and service outlets to roll out new HIV prevention technologies, including the training of Peer workers to dispense PrEP						
Facilitator allowance	3	81,000	1	5	1215000	
SDA for participants	50	20,000	1	5	5000000	
Sub Total					**6215000**	**DLG**
Strategic Action 1.3.1: Address socio-cultural drivers of the epidemic through strategic engagement of the media, civil society organizations, religious, cultural, and political institutions in the HIV prevention effort						
Activity 1: Conduct community dialogues on factors that hinder behaviour change and uptake of HIV prevention services in the District						
Facilitator's allowance	3	81,000	1	5	1215000	
SDA for participants	50	20,000	1	5	5000000	
Sub Total					**6215000**	**DLG**
Activity 2: Build capacity of cultural and community leaders to mobilize for change of harmful socio-cultural norms and practices						
Facilitator allowance	3	81,000	1	5	1215000	
SDA for participants	50	20,000	1	5	5000000	
Transport Refund participants	50	25,000	1	5	6250000	
Sub Total					**12,465,000**	**DLG**
Activity 3 Implement school-based interventions for all adolescents addressing gender equality, prevention of GBV & comprehensive sexual education						
Facilitator allowance	4	81,000	1	50	16200000	
Sub Total					**16200000**	**DLG**
Activity 4: Improve affirmative action for promoting meaningful participation of girls and women, PWDs and other vulnerable groups in decisions about their own health						
Facilitator allowance	4	81000	1	50	16200000	

Sub Total					**16200000**	
Activity 5 Design and implement deliberate programs targeting to empower young boys and girls aged 15-24years with life skills						
Facilitator allowance	4	81000	1	50	16200000	
Sub Total					**16200000**	**DLG**
Strategic Action 1.3.2: Promote male involvement in HIV prevention for their own health, the health of their partners and families, and address gender and cultural norms that perpetuate inequality and gender-based violence through innovative community peer engagement models						
Activity 1: Enhance male-friendly HIV and AIDS services and use of mentor fathers for mobilization						
Meetings	12	20,000	1	20	4800000	
Sub Total					**4800000**	**DLG**
Activity 2: Engage men in HIV, sexual and reproductive health programs and interventions and also offer them services						
Meetings	12	20,000	1	20	4800000	
Sub Total					**4800000**	**IP**
Activity 3: Implement BCC/IEC interventions to empower men and boys to resist peer pressure of norms of masculinity, e.g. having many sexual partners						
Facilitator allowance	4	81,000	1	17	5508000	
SDA for participants	50	20,000	1	17	17000000	
Transport Refund participants	50	25,000	1	17	21250000	
Sub total					**43758000**	**IP**
Activity 4: Develop and disseminate HIV prevention messages delivered in context specific activities/events that are popular with men e.g. sports, workplaces, entertainment						
Fuel	20	4,000	3	5	1200000	
SDA	2	20,000	3	5	600000	
Sub Total					1800000	IP
Activity 5 Design and implement deliberate programs targeting to empower young boys and girls aged 15-24years with life skills						
Facilitator allowance	3	81,000	1	185	44955000	
Sub Total					44955000	IP
Strategic Action 1.3.3: Create male-friendly interventions (e.g. work-place programs; mobile HIV testing, etc.) to attract men to use HIV prevention and care services						
Activity 1: Improve the identification of male spouses living with HIV through innovative approaches such as Assisted Partner Notification and self-testing using the HIV positive mother as the index client						
SDA	4	20,000	5	20	8000000	
Transport Refund	4	25,000	5	20	10000000	
Sub Total					**18,000,000**	**IP**
Activity 2: Improve mobilisation of males through the scale up of male action groups, peer networks, and targeting of male places such as bars and health clubs						
Hall Hire	1	300,000	1	1	300000	
SDA	50	20,000	1	1	1000000	
Transport Refund	50	25,000	1	1	1250000	
Assorted Stationary	1	200,000	1	1	200000	
Sub Total					**2750000**	**IP**
Activity 3: Increase access to male-partner friendly services within the MNCH platform, including screening and treatment for syphilis and chronic non-communicable Diseases, SMC, condoms, all provided at flexible hours to suit male preferences						
Meetings	50	45,000	1	5	11250000	
Sub Total					**11250000**	**DLG**

Strategic Action 1.3. 4: Integrate sexual and gender-based violence (SGBV) prevention into HIV prevention programming and build the capacity of service providers to deliver integrated HIV, SRHR. Psycho-social, SGBV and violence against children (VAC) prevention and mitigation services						
Activity 1: Create awareness of existing laws and institutions that address SGBV among community leaders						
Meetings	50	45,000	1	5	11250000	
Sub Total					**11250000**	
Activity 2: Train HIV service providers to observe the principles of consent and confidentiality, as well as assessment of risk of violence in order to minimize risk of violence to female clients disclose HIV status to male partners or participate in APN						
Hall Hire	1	300,000	5	1	1500000	
Facilitator allowance	2	81,000	5	1	810000	
SDA for participants	14	20,000	5	1	1400000	
Transport Refund participants	14	25,000	5	1	1750000	
Sub Total					**5460000**	**DLG**
Activity 3: Train voluntary 62 ccounselling and testing providers [62 ccounselling both medical and social workers] to ask questions about partner violence and develop safe disclosure plans for individual clients						
Hall Hire	1	300000	5	1	1500000	
Facilitator allowance	2	81000	5	1	810000	
SDA for participants	14	20000	5	1	1400000	
Transport Refund participants	14	25000	5	1	1750000	
Sub Total					**5460000**	**IP**
TOTAL					**406,000,000**	

SOCIAL SUPPORT AND PROTECTION

Item	Qty	Unit Cost	Days	Freq	Amount	
Strategic Action1. 3.1.1. Prioritize approval, operationalization and dissemination of the National Anti-HIV and AIDS Stigma and Discrimination Policy						
Strategic Objective 3.1 Scale up interventions aimed at eliminating stigma and discrimination						
Activity 1: Disseminate the National Anti-HIV and AIDS Stigma and Discrimination Policy 2019						
Transport refund	170	20000	1	1	3,400,000	
Facilitator allowances	2	81000	17	1	2,754,000	
Sub Total					**6,154,000**	**IP**
Activity 2: Build capacity of stakeholders in stigma reduction						
Meals	50	20000	1	1	1,000,000	
SDA Allowances	50	20000	1	1	1,000,000	
Assorted allowances	LPSM	200000	1	1	200,000	
Facilitation allowance	2	81000	1	1	162,000	
Sub Total					**2,362,000**	**IP**
Activity 3: Conduct Community dialogue and awareness on the national Anti-HIV AIDS stigma policy						
SDA Allowances	10	20000	5	2	2,000,000	
Fuel	100	4000	Liters	2	800,000	
Sub Total					**2,800,000**	**IP**
Sttrategic Action2: 3.1.2. Scale up targeted messages and community education to engender comprehensive knowledge of HIV and AIDS-related stigma and to transform norms and values in order to eliminate social stigma and discrimination against people living with HIV, including PWDs, KPs and other vulnerable groups						
Activity 1: Conduct dialogue meetings against stigma, discrimination and violence at the district level to sensitise communities on stigma and discrimination						
SDA Participants	60	20000	1	2	2,400,000	
Meals	60	20000	1	2	2,400,000	
Assorted Stationery	200000	1	1	2	400,000	
Hall hire	1	100000	1	2	200,000	
Sub Total					**5,400,000**	**IP**
Activity 2: Conduct dialogue meetings with religious, cultural and community leaders at national and district level for meaningful engagement in addressing HIV related stigma, discrimination and violence in communities						
Meals	100	20000	1	1	2,000,000	
Facilitator Allowances	4	81000	1	1	324,000	
Assorted Stationery	1	300000	1	1	300,000	
Sub Total					**2,624,000**	**DLG/IP**
Activity 3: Integrate education on HIV-related stigma and discrimination into existing government programs such as Youth Livelihoods Program						
Facilitator Allowances	2	81000	2	4	1,296,000	
Transport Refund	34	20000	2	4	5,440,000	
Hall Hire	1	100000	1	4	400,000	
Sub Total					**7,136,000**	**IP/DLG**
Activity 4 Scale-up and sustain work in communities led by PLHIV and members of key and vulnerable populations to address and reduce HIV related stigma, discrimination and violence						

Fuel	300	4000	5	2	12,000,000	
Sub Total					**12,000,000**	**IP**

Strategic Action3: 3.1.3. Systematic implementation and monitoring of policies and interventions to address workplace and institutional stigma and discrimination.						
Activity 1: Review and evaluate current workplace policies to ensure that they do not reinforce negative attitudes towards people living with HIV and those at increased risk in workplaces						
Hall Hire	1	100000	1	1	100,000	**DLG**
Meals	20	20000	1	1	400,000	
Participant Transport Refund	20	20000	1	1	400,000	
Assorted Stationery	1	150000	1	1	150,000	
Sub Total					**1,050,000**	
Activity 2: Develop and deliver group-based workshops/programmes where information is combined with skills-building activities in the organisation						
Facilitator Allowances	4	81000	2	4	2,592,000	**IP**
Transport refund	40	20000	2	4	6,400,000	
Sub Total					**8,992,000**	
Activity 3: Involve staff across the organisation in the programme design and implementation, not only senior staff						
Participant Transport Refund	50	20000	1	2	2,000,000	**IP**
Meals	50	20000	1	2	2,000,000	
Hall hire	1	100000	1	2	200,000	
Sub Total					**4,200,000**	
Activity 4: Identify individuals who hold influence to provide leadership and championing of the anti-stigma message in work places						
Meal	30	20000	1	1	600,000	**DLG**
Transport refund	30	20000	1	1	600,000	
Sub Total					**1,200,000**	
Activity 5: Develop strong organizational policies that promote safe working and zero tolerance to discrimination						
ICT materials	100	50000	1	1	5,000,000	**IP**
Data Collection Allowance	20	20000	2	2	1,600,000	
Sub Total					**6,600,000**	
Activity 6: Support and establish interventions in the work place that promote the wellbeing of individuals living with HIV in the organization						
HIV FPP Facilitation	4	200000	1	4	3,200,000	DLG
Sub Total					3,200,000	

Activity 7: Oversee implementation of policies related to employment and workplace in regard to HIV						
HIV FPP Facilitation	4	200000	1	4	3,200,000	**DLG**
Sub Total					**3,200,000**	
Strategic Objective 3.2: Expand socio-economic interventions aimed at reducing social and economic vulnerability for people living with HIV and other vulnerable groups						
Strategic Action 3.2.1: Prioritise interventions that enhance the socio-economic status of households and individuals infected, affected, or at high risk of HIV acquisition						
Activity 1: Conduct financial literacy on informed investment decisions for households and individuals infected, affected, or at high risk of HIV acquisition						
Assorted Stationery	1	200000	2	2	800,000	**IP**
Facilitator Allowances	2	81000	2	2	648,000	
Participants SDA	80	20000	2	2	6,400,000	
Hall Hire	1	100000	2	2	400,000	
Meals	82	20000	2	2	6,560,000	
Sub Total					14,808,000	
Activity 2: Promote IGAs and market linkages households and individuals infected, affected, or at high risk of HIV acquisition						
Provide IGAs to PLWHIV Groups/ Households	10	5000000		1	50,000,000	**IP**
Sub Total					**50,000,000**	
Activity 3: Promote the Village Savings and Loans Associations (VSLA) model for PLHIV and households affected by HIV as a model to enhance socio-economic empowerment						
Facilitator allowance	2	81000	5	2	1,620,000	**DLG**
Fuel	20L	4000	5	2	800,000	
Assorted Stationery	1	150000	1.00	2	300,000	
Sub Total					**2,752,000**	
Activity 4: Expand apprenticeship support for households and individuals infected, affected, or at high risk of HIV acquisition						
Procurement of machinery	3	10,000,000		1	30,000,000	**IP**
Sub Total					**30,000,000**	
Strategic Action3: 3.2.2 Institutionalize specific forms of affirmative action, including direct targeting approaches that assure access to existing social protection/ social assistance programmes for people at high risk of and those living with HIV including women, AGYW, PWDs and OVC						
Activity 1: Strengthen the PLHIV network to increase access to social protection and social assistance programs for the members						
Facilitate to FPP	4	200000	2	2	3,200,000	**IP**
Sub Total					**3,200,000**	
Activity 2: Support most at risk 14-25 years AGYW to start up small scale business enterprises and mentorship						
Enterprise Fund	10	50,000,000		1	50,000,000	**IP**
Sub Total					**50,000,000**	

Activity 3:Ensure preferential treatment is accorded to OVC (esp. due to HIV) in the national education bursary scheme to include tuition and non-tuition dues for primary, secondary and tertiary institutions						
Facilitate HIV FPP	1	200000	5	4	4,000,000	**IP**
Sub Total					**4,000,000**	
Activity 4: Facilitate community, agriculture and veterinary extension workers to register households whose economic livelihoods have been devastated by HIV and AIDS in each sub-county						
SDA Allowances	17	20000	5	2	3,400,000	**IP**
Fuel	600	4000		1	2,400,000	
Sub Total					**5,800,000**	
Activity 5: Mobilize community support groups and facilitate them to provide basic social needs (such as shelter, food, firewood, bedding, clothing, ITN and soap, etc) to households with chronically ill PHA, OVC and caregivers						
Fuel	500	**400**	**3**	**2**	**1,200,000**	**DLG/IP**
SDA Allowances	30	20000	3	2	3,600,000	
Sub Total					**3,720,000**	
Strategic Objective 3.3: Scale up psychosocial support for people living with HIV, PWDs, key and priority populations and other vulnerable people						
Strategic Action 3.3.1: Strengthen mechanisms and structures to enhance social capital and networks for social support at the community levels.						
Activity 1: Train the different stake holders in psychosocial support.						
Assorted Stationery	1	200000	1	2	400,000	**DLG**
Transport Refund	30	20000	3	2	3,600,000	
Meals	35	20000	3	2	4,200,000	
Facilitation	2	81000	3	2	**972,000**	
Sub Total					**9,172,000**	
Activity 2: Conduct family visits and follow up to offer psychosocial support						
Facilitate HIV FPP	2	100000	3	4	2,400,000	
Sub Total					**2,400,000**	**DLG**
Activity 3: Identify peers and train them on psychosocial support including KPs PWDs, OVCs and PLHWA						
Transport Refund	50	20000	1	2	2,000,000	**DLG**
Facilitation Allow	2	81000	1	2	324,000	
Sub Total					**2,324,000**	
Strategic Objective 3.4: Strengthen prevention and response to gender-based violence/discrimination						
Strategic Action 3.4.1: Address harmful gender norms and expand programs that reduce HIV-related gender discrimination, PWDs, violence against women and girls, KPs and other vulnerable people in all their diversity						
Activity 1: Identify and disseminate innovative approaches and interventions that address harmful gender norms across high-risk communities						
Facilitate Gender FPP	1	400000	1	4	1,200,000	**DLG**
Sub Total					1,200,000	
Activity 2: Address social, cultural, and religious barriers that escalate violence against women and girls, PWDs, KPs and other vulnerable populations						
Facilitate DCDO and Gender FPP	2	500000	2	2	4,000,000	**DLG**
Sub Total					**4,000,000**	
Activity 3: Intensify interventions that promote human rights awareness on gender and sexual reproductive health rights as a strategy to counter GBV and discrimination						

Facilitation of DCDO	1	1000000	1	3	3,000,000	**DLG**
Sub Total					**3,000,000**	
Activity 4: Sensitize communities on existing legal laws and penalties for Sexual and Gender Based Violence (SGBV						
Facilitation of DCDO	1	1500000	1	3	4,500,000	**DLG**
Sub Total					**4,500,000**	
Strategic Objective 3.5: Strengthen prevention and response to child protection issues and Violence Against Children (VAC)						
Strategic Action 3.5.1: Strengthen community level child protection systems and structures to engender early identification, response and referral for child protection cases						
Activity 1: Strengthen coordination and collaboration along the child protection referral pathway amongst different stakeholders within the district.						
Facilitate PWO	2	200000	1	4	1,600,000	**DLG**
Sub Total					**1,600,000**	
Activity 4: Provide a minimum package of services for survivors of violence against children						
Facilitation	1	500000	1	4	2,000,000	**DLG**
Sub Total					**2,000,000**	
Activity 5: Disseminate and display an algorithm for responding to specific cases of child protection reported at the PSWO (since it does appear that the police and health facilities have existent procedures)						
Perdiem	2	160000	2	4	2,560,000	**DLG**
Transport Refund	2	81000	2	4	1,296,000	
Sub Total					**3,856,000**	
Strategic Objective 3.6: Strengthen the legal and policy framework on HIV and AIDS to ensure that it is inclusive of all PLHIV, PWDs, key and priority populations and other vulnerable groups						
Strategic Action 3.6.1: Support advocacy to revisit or repeal laws promoting mandatory HIV disclosure to make all health facilities stigma and discrimination free settings						
Activity 1 Print and launch the Patients' Charter led by the MOH in collaboration with CSOs and other stakeholders						
Facilitate of DCDO	1	2000000	1	2	4,000,000	**DLG**
Sub Total					**4,000,000**	
Activity 2:Capacitate and mandate health facility managers/supervisors to train nonclinical and community health worker staff at health facilities on patient and health worker rights and responsibilities as laid out in the Patient's Charter						
Facilitate DHO	1	3000000	1	1	3,000,000	**DLG**
Sub Total					**3,000,000**	
Activity 3: Widely disseminate and popularise the Patient's Charter using different formats/modalities for different audiences and ensure that it is visible and available in all health facilities in the country						
Facilitate DCDO	1	500000	1	4	2,000,000	**DLG**
Sub Total					**2,000,000**	
Activity 4Support health facilities to reduce waiting period for PLHIV that seek care and treatment services through effective engagement and support to expert clients						
Facilitation	1	500000	1	4	2,000,000	**IP**
Sub Total					**2,000,000**	
Grand Total					**453,500,000**	

Thematic Area: Care and Treatment

	Item	Qty	Unit cost	Days	Frequency	Amount	
Sub Objective 2.1: Increase the diagnosed HIV persons who start antiretroviral therapy to 95% by 2025							
Strategic Action 2.1.1: Increase HIV care entry points for HIV exposed infants, children, adolescents and men							
Activity 2.1.1.1	Integrate HIV services (HIV, RMNCAH, TB, Child Health services), share information and establish effective referrals across different levels of the health system - *2 HWs will take part in the ICHDs of October and April for 10 days each month to enhance the child package in 10 schools in each month. This is in addition to the PHC planned activities*.						
	SDA	2	20000	10	2	800,000	
	Transport	2	10000	10	2	400,000	
	Sub Total					**1,200,000**	**DLG**
Activity 2.1.1.2	Strengthen patient education on ART at all entry points - Availing and distributing IEC materials in the local language, Radio talk shows, provide audio visuals at entry points, empowering post-test clubs to perform dramas. *IEC Materials will be distributed at any given opportunity. Radio talkshows by 3 DHT members 2 times per month.*						
	SDA	3	20000	2	12	1,440,000	
	Transport	3	15000	2	12	1,080,000	
	Airtime for talkshow	1	500000	2	12	12,000,000	
	Sub Total					**14,520,000**	**IP**
Strategic Action 2.1.2*: *Strengthen community health platform to identify, support and link people living with HIV including key populations that remain undiagnosed to care							
Activity 2.1.2.1	Build capacity of community actors (including CSOs and networks of PLHIV) to effectively link newly identified PLHIV to ART - *Train PLHIV leaders at parishes, SC and District level. 1 representative from 4 KP sites, 2 representatives of Adolescents and 1 for males from 10 facilities (ART sites) at District venue. Peer leaders will also be identified. (The training content and materials will also address activity 2.2.2.2)*						
	SDA	34	20000	2	4	5,440,000	
	Transport	34	40000	2	4	10,880,000	
	Meals and refreshments	34	30000	2	4	8,160,000	
	Photocopying and stationary	34	4000	2	4	1,088,000	
	Sub Total					**25,568,000**	**IP**
Strategic Action 2.1.3: Implement adolescent-friendly health services (AFHS)							
Activity 2.1.3.1	Train providers who are competent to treat adolescents with appropriate skills and provide them with ongoing mentorship and supportive guidance. *Retraining HWs to treat adolescents with appropriate skills. Last trained in 2016. 3 HWs from 3 high volume facilities, 2 HWs from 7 low volume sites. District based training. 3 days per year. (Includes 2.1.3.5, 2.3.2.1, 2.3.2.3 and 2.3.4.3)*						
	SDA	23	20000	5	1	2,300,000	
	Transport	23	40000	5	1	4,600,000	
	Meals	23	30000	5	1	3,450,000	
	Photocopying and stationary	23	4000	5	1	460,000	

	Sub Total					**10,810,000**	**IP**
Activity 2.1.3.2	Modifying facility characteristics towards adolescent-focused service times and waiting lines. Drop-in centres for PLHIV at facilities. Allocate space and time at facilities for adolescents. 1 furnished Drop in container for 3 high volume facilities (Structural support).						
	Drop in containers	3	4000000	1	1	12,000,000	
	Sub Total					**12,000,000**	**IP**
Strategic Action 2.1.4: Quality treatment and care for key populations and other vulnerable groups realizing their health-related rights							
Activity 2.1.4.1	Training for health care providers (including health unit management committees) on human rights, medical ethics and culturally appropriate services especially in addressing health care needs of key populations and other vulnerable groups who are underserved and encounter significant access barriers. *Orientation of the HUMCs from 10 ART sites on client rights of vulnerable groups. 3 DHT members will join 1 HUMC meeting per facility per year. Population specific Rights charters will also be disseminated.*						
	SDA	3	20000	10	1	600,000	
	Transport	3	40000	10	1	1,200,000	
	Sub Total					**1,800,000**	**DLG**
Sub Objective 2.2: Increase HIV-diagnosed individuals started on ART who adhere to regimens and are retained on treatment to 95% by 2025							
Strategic Action 2.2.1: Optimizing and rolling out ARV treatment regimens including consolidation of the DTG transition plan to enhance sustained viral suppression, tolerability and sustainability							
Activity 2.2.1.1	Continue to implement the "Test and Treat" policy within the Consolidated HIV prevention and treatment guidelines. **Interventions** for Continuous Quality Improvement (National CQI initiative; VL, Retention, IPT) should be intensified to ensure that an extra 500,000 PLHIV are enrolled into a stable model of care. *Conduct Supportive supervision at facility level - Priority indicators and adherence to the test and treat policy/ guidelines. Guidelines will also be disseminated. 3 DHT members conduct 2 days supportive supervision per each of the 10 ART sites per quarter.*						
	SDA	3	20000	20	4	4,800,000	
	Transport	3	40000	20	4	9,600,000	
	Photocopying and stationary	3	4000	20	4	960,000	
	Sub Total					**15,360,000**	**DLG**
Activity 2.2.1.2	Leverage PLHIV networks, peers of key and priority populations; and empower families to provide adherence support to PLHIV on ART. 3 PLHIV to c*onduct targeted home-based care and counselling. Carry out 4 home visits per month per* each *of the 8 sub counties (Also addresses activity 2.3.3.1)*						
	SDA	3	20000	32	12	23,040,000	
	Transport	3	15000	32	12	17,280,000	
	Sub Total					**40,320,000**	**IP**
Strategic Action 2.2.2: Community empowerment to keep people engaged in care and help them access treatment, adhere to their medications and prevent the transmission of HIV							
Activity 2.2.2.1	Integrating eHealth into HIV-related disease self-management and service delivery especially using short message service (SMS) interventions to enhance ART adherence encourage paternal involvement in child care. *Bulk SMS for 7000 clients - 1 SMS per week.*						

	SMS reminder per each of the 7000 clients	7000	60	1	52	21,840,000	
	Sub Total					**21,840,000**	**IP**
Strategic Action 2.2.3: Scale-up of Differentiated service delivery model (DSDM)							
Activity 2.2.3.1	Expansion of DSDM within district and health facility routine planning and supervision systems. Identify and train group leaders for CLAD (Community Client Led ART Distribution). 3-day training at the 10 ART facilities will target 300 groups/ group leaders.						
	SDA	300	20000	3	1	18,000,000	
	Transport	300	20000	3	1	18,000,000	
	Meals and refreshments	300	30000	3	1	27,000,000	
	Photocopying and stationary	300	4000	3	1	3,600,000	
	Sub Total					**66,600,000**	**IP**
Activity 2.2.3.2	Strengthen CSO/CBO/networks' capacity to scale-up the implementation of differentiated model of care and service delivery in the community and to reduce stigma and discrimination. *Map and orient the CSO/ CBO/ Networks. Hold CSO stakeholder engagement meeting at the District. The CSOs will meet their own costs. The meeting will be a pre-budget consultative meeting.*						
Sub Objective 2.3: Increase the prevalence of VLS among HIV-diagnosed individuals on treatment to 95% by 2025							
Strategic Action 2.3.3: Provide a comprehensive care package for management of co-morbidities and advanced HIV disease							
Activity 2.3.3.1	Scale up cervical cancer screening, HBV vaccination and treatment. 2-day training for 2 HWs from each of the 3 High volumes ART sites and 1 HWs from each of the 7 low volume ART sites in screening cervical cancer, HBV vaccination and treatment.						
	SDA	13	20000	2	12	6,240,000	
	Transport	13	40000	2	12	12,480,000	
	Meals and refreshments	13	30000	2	12	9,360,000	
	Photocopying and stationary	13	4000	2	12	1,248,000	
	Sub Total					**29,328,000**	**IP**
Grand Total						**239,346,000**	

Thematic Area: Social Support and Protection

	Item	Qty	Unit cost	Days	Frequency	Amount	Source of funding
Sub Objective 3.1: Scale up interventions aimed at eliminating stigma and discrimination							
Strategic Action 3.1.1: Prioritize approval, operationalization and dissemination of the National Anti-HIV and AIDS Stigma and Discrimination Policy							
Activity 3.1.1.1	***Disseminate the anti-HIV stigma and discrimination policy 2019***						
	SDA	180	1	1	20,000	3,600,000	
	Transport refund	180	1	1	20,000	3,600,000	
	Printing costs	1	1	1	500,000	500,000	
	Mobilisation costs	1	1	1	1,000,000	1,000,000	
	Sub Total					**8,700,000**	**IP**
Activity 3.1.1.2	***Map out and disseminate the policy on PWDs focusing on the blind & deaf***						
	Mobilisation	1	1	1	1,000,000	1,000,000	
	Transport	160	4	1	20,000	12,800,000	
	stationary	1	1	1	1000000	1,000,000	
	Sub Total					**14,800,000**	**IPS**
Strategic Action 3.1.2: Scale up targeted messages and community education to engender comprehensive knowledge of HIV and AIDS-related stigma and to transform norms and values in order to eliminate social stigma and discrimination against people living with HIV, including PWDs, KPs and other vulnerable groups							
Activity 3.1.2.1	**Conduct dialogue meetings against stigma, discrimination and violence at the district level to sensitize communities on stigma and discrimination**						
	Fuel	25	4	16	4,000	680,000	
	Refreshment	25	4	16	10,000	16,000,000	
	SDA	5	4	16	20,000	6,400,000	
	Sub Total					**23,080,000**	**IP**
Activity 3.1.2.2	**Conduct dialogue meetings with religious, cultural and community leaders at national and district level for meaningful engagement**						
	SDA	25	4	1	20000	2,000,000	
	Transport Refund	25	4	1	20000	2,000,000	
	Refreshment	25	4	1	5000	500,000	
	Sub Total					**4,500,000**	**DLG**
Strategic Action 3.1.3: Systematic implementation and monitoring of policies and interventions to address workplace and institutional stigma and discrimination							
Activity 3.1.3.1	**Review and evaluate current workplace policies to ensure that they do not reinforce negative attitudes towards people living with HIV and those at increased risk in work places**						
	Fuel	20	2	16	4000	2,560,000	
	SDA	5	2	16	20000	3,200,000	
	Stationary	1	2	1	250000	500,000	
	Sub Total					**6,200,000**	**DLG**

	Item	Qty	Unit cost	Days	Frequency	Amount	Source of funding
Activity 3.1.3.2	**Develop and deliver group-based workshops/programs where information is combined with skills-building activities in the organization**						
	SDA	30	4	10	20000	24,000,000	
	Transport	30	4	10	20000	24,000,000	
	Stationary	1	4	1	200000	800,000	
	mobilization	1	4	1	250000	1,000,000	
	Sub Total					**49,800,000**	**IP**
Activity 3.1.3.3	**Hold multisectoral meeting in planning and execution of anti- discriminatory policies.**						
	SDA	20	1	4	20000	1600000	
	Transport refund	20	1	4	20000	1600000	
	Meals	20	1	4	20000	1600000	
	Sub Total					**4,800,000**	**DLG**
Strategic Action 3.1.4: Prioritize empowerment programs to reduce internal stigma for people living with HIV, Key Populations and other vulnerable populations and promote positive health living including life skills training							
Activity 3.1.4.1	**Create platforms e.g radio talk shows, baraaza, talent search events, dialogue meeting that promote the voice of PLWH against stigma**						
	SDA	50	1	4	20000	4,000,000	
	Transport	50	1	4	20000	4,000,000	
	refreshment (talent search)	200	1	1	2000	400,000	
	Sub Total					**8,400,000**	**IP**
Activity 3.1.4.2	**Orient PLHIV and peers on psychosocial support for members to reduce self -stigma. Reinvigorate post-test clubs**						
	Transport	40	1	1	20000	800000	
	SDA	40	1	1	20000	800000	
	Sub Total					**16,000,000**	**IP**
Strategic Action 3.1.5: Develop, implement and sustain a country-wide, multi-media programme to address HIV-related stigma, discrimination and violence, including specific components for KP and KVP							
Activity 3.1.5.1	**Facilitate media houses and journalists to profile and document issues against stigma, discrimination and violence**						
	Transport refund	3	5	4	50000	3000000	
	Hire of Camera and other accessories	1	5	4	500000	10000000	
	SDA	3	5	4	20000	1200000	
	Sub Total					**14,200,000**	**IP**
Strategic Action 3.1.9: Strengthen community led structures, organizations and networks to effectively engage out of school youth and young people to address stigma							
	Identify and support the out of school youth and adolescents and young people with anti-stigma materials						
	Fuel	20	2	4	4000	640,000	

	Item	Qty	Unit cost	Days	Frequency	Amount	Source of funding
Activity 3.1.9.1	SDA	4	2	4	20000	640000	
	Sub Total					**1,280,000**	**DLG**
Activity 3.1.9.2	**Orient religious leaders, PLHIV leaders & Political leaders to support the youths during the youth events like Youth conferences, talent search, sport events**						
	Fuel	20	4	4	4000	1,280,000	
	SDA	4	4	4	20000	1280000	
	Assorted materials	4	4	4	500000	32000000	
	Meals and refreshments	20	4	4	20000	6400000	
	Sub Total					**41,600,000**	**DLG**
Strategic Action 3.1.10: Sustain efforts to train health and social service workers in adoption of anti-oppressive, human rights-based service delivery approaches that addresses anti-stigma and anti-discriminatory practices, behaviors and attitudes and enforce strict mechanisms for monitoring and reporting of stigma and discrimination							
Activity 3.1.10.1	Conduct targeted workshops to orient health workers, police and para social workers on Human Rights Based Approach to HIV response						
	Meals	20	4	2	20000	3200000	
	Perdiem for experts	2	4	2	161000	2576000	
	Fuel	30	4	2	4000	960000	
	SDA	4	4	2	20000	640000	
	Assorted stationary/materials	1	4	2	200000	1600000	
	Sub Total					**8,976,000**	**IP**
Sub Objective 3.2: Expand socio-economic interventions aimed at reducing social and economic vulnerability for people living with HIV and other vulnerable groups							
Strategic Action 3.2.1: Prioritize interventions that enhance the socio-economic status of households and individuals infected, affected, or at high risk of HIV acquisition							
Activity 3.2.1.1	Conduct financial literacy workshops for the affected or at high risk of HIV acquisition.						
	Fuel	30	4	2	4000	960000	
	Meals and refreshments	20	4	2	20000	3200000	
	SDA	4	4	2	20000	640000	
	Assorted stationery/ materials	1	4	2	100000	800000	
	Sub Total					**5,600,000**	**DLG**
Activity 3.2.1.2	Establish IGAs and market linkages households and individuals infected, affected or at high risk of HIV acquisition						
	Seed materials	80	5	1	200000	80000000	
	Transport of materials	30	5	1	4000	600000	

	Item	Qty	Unit cost	Days	Frequency	Amount	Source of funding
	SDA	2	5	1	20000	200000	
	Sub Total					**80,800,000**	**IP**
Activity 3.2.1.3	Establish the village savings and loans association model for PLHIV and HHs affected by HIV						
	Fuel	30	3	1	4000	360000	
	SDA	16	3	1	20000	960000	
	Refreshments/ meals	20	3	1	20000	1200000	
	Sub Total					**2,520,000**	**DLG**
Strategic Action 3.2.2: Institutionalize specific forms of affirmative action, including direct targeting approaches that assure access to existing social protection/ social assistance programs for people at high risk of and those living with HIV including women, AGYW, PWDs and OVC							
Activity 3.2.2.1	Carryout social mobilization and orientation for PLHIV networks to increase access to social protection						
	Radio Airtime	1	4	2	1000000	8000000	
	SDA	2	4	2	20000	320000	
	Sub Total					**8,320,000**	**DLG**
Activity 3.2.2.2	Support Most at risk 14-24 yrs AGYW to start up small scale business enterprises & mentorships						
	Course fees	30	90	4	4000	46,080,000	
	Meals	30	90	4	25000	288,000,000	
	Accommodation	30	90	4	5000	57,600,000	
	Venue hire	2	90	4	3000	2,160,000	
	Monitoring and mentoring of the activity (fuel and SDA)	20	16	4	4000	6,80,000	
		4	16	4	20000	5,120,000	
	Learning materials	32	1	4	10000	1,280,000	
	Sub Total					**400,640,000**	**IP**
Activity 3.2.2.3	Facilitate community agricultural and Veterinary extension workers to register households whose economic livelihoods have been devastated by HIV in each sub county						
	Fuel	20	3	16	4000	3,840,000	
	SDA	10	3	16	20000	9,600,000	
	Sub Total					**13,440,000**	**DLG**
Sub Objective 3.3: Scale up psychosocial support for people living with HIV, PWDs, key and priority populations and other vulnerable people							
Strategic Action 3.3.2: Expand both facility and community-based counseling services for people living with HIV and other vulnerable groups							
Activity 3.3.2.1	Initiate and follow up income generating activities for HIV+ women in HIV/ AIDS projects						
	Fuel	30	2	16	4000	3840000	
	SDA	4	2	16	20000	2560000	
	Sub Total					**6,400,000**	**DLG**
	Conduct bi-annual performance review and quality improvement learning sessions targeting provision of counselling and psychosocial support within high burden districts						

	Item	Qty	Unit cost	Days	Frequency	Amount	Source of funding
Activity 3.3.2.2	Meals	30	1	2	20000	1200000	
	SDA	5	1	2	20000	200000	
	Transport refund	30	1	2	20000	1200000	
	Sub Total					**2,600,000**	**DLG**
GRAND TOTAL						**717,856,000**	

THEMATIC AREA: SYSTEM STRENGTHENING

	Item	Qty	Unit cost	Days	Frequency	Amount	
Objective 1: Governance and leadership of multisectoral HIV/AIDS							
Strategic Action 1: Cascading the new coordination guidelines as well as the coordination structures in the District							
Activity 1	**Orientation of DAC on the new coordination guidelines and Structures**						
	SDA members	40	20000	2	5	8,000,000	
	Transport refund	40	50,000	4	5	40,000,000	
	Stationary assorted	40	5,000	2	5	2,000,000	
	Communication	4	10,000	4	5	800,000	
	Sub Total					**50,800,000**	**IP**
Activity 2	**Orientation of SAC on the new coordination guidelines and Structures**						
	SDA members	20	20000	5	24	48,000,000	
	Transport refund	20	50,000	10	24	240,000,000	
	Stationary assorted	20	5,000	5	24	12,000,000	
	Communication	4	10,000	120	24	115,200,000	
	Sub Total					**415,200,000**	**IP**
Strategic action 2: Mainstreaming HIV/AIDS activities into Departmental Work plans							
Activity 1	**Orientation Heads of Department on the new HIV and AIDS Strategic Plan**						
	SDA members	40	20000	1	5	4,000,000	
	Transport refund	40	50,000	4	5	40,000,000	
	Stationary assorted	40	5,000	2	5	2,000,000	
	Communication	4	10,000	4	5	800,000	
	Sub Total					**46,800,000**	**DLG**
Activity 2	**Organising an HIV and AIDS strategic Planning workshop**						
	SDA members	80	20000	5	5	40,000,000	
	Transport refund	80	50,000	20	5	400,000,000	
	Stationary	80	5,000	10	5	20,000,000	
	Communication	4	10,000	20	5	4,000,000	
	Sub Total					**464,000,000**	**IP**
Activity 3	**organizing an HIV and AIDS strategic Planning workshop for Heads of Department**						
	SDA members	80	20000	5	5	40,000,000	
	Transport refund	80	50,000	20	5	400,000,000	
	Stationary	80	5,000	10	5	20,000,000	
	Communication	4	10,000	20	5	4,000,000	
	Sub Total					**464,000,000**	**IP**
Activity 4	**Organising an HIV and AIDS strategic Planning workshop for Lower Local Governments**						
	SDA members	20	20000	24	5	48,000,000	
	Transport refund	20	20,000	24	5	48,000,000	
	Facilitator SDA	3	50,000	24	5	18,000,000	
	Fuel	20	4,000	24	5	9,600,000	
	Driver SDA	1	20,000	24	5	2,400,000	
	Stationary	20	5,000	24	5	12,000,000	
	Communication	4	10,000	24	5	4,800,000	
	Sub Total					**142,800,000**	**IP**

	Item	Qty	Unit cost	Days	Frequency	Amount	
Strategic action 3: Organising Partner meetings for a strong networks in the HIV/AIDS response programs							
Activity 1	**Orientation Implementing Partners on the new HIV and Strategic Plan**						
	SDA members	40	20000	1	5	4,000,000	
	Transport refund	40	50,000	4	5	40,000,000	
	Stationary	40	5,000	2	5	2,000,000	
	Communication	4	10,000	4	5	800,000	
	Sub Total					**46,800,000**	**DLG**
Activity 2	**Organising an HIV and AIDS strategic Planning workshop with Implementing Partners**						
	SDA members	80	20000	5	5	40,000,000	
	Transport refund	80	50,000	20	5	400,000,000	
	Stationary	80	5,000	10	5	20,000,000	
	Communication	4	10,000	20	5	4,000,000	
	Sub Total					**464,000,000**	**IP**
Activity 3	**Organising an HIV and AIDS strategic Planning workshop for the Local CBOs**						
	SDA members	80	20000	5	5	40,000,000	
	Transport refund	80	50,000	20	5	400,000,000	
	Stationary assorted	80	5,000	10	5	20,000,000	
	Communication	4	10,000	20	5	4,000,000	
	Sub Total					**464,000,000**	**IP**
Activity 4	**Organizing an HIV and AIDS strategic Planning workshop for Religious Leaders, Traditional Healers and Opinion Leaders**						
	SDA members	100	20000	1	5	10,000,000	
	Transport refund	100	50,000	2	5	50,000,000	
	Stationary	100	5,000	1	5	2,500,000	
	Communication	4	10,000	1	5	200,000	
	Sub Total					**62,700,000**	**DLG**
Strategic action 3: Functionalizing PLHIV Structures							
Activity 1	**Orientation PLHIV Members on the new HIV and Strategic Plan**						
	SDA members	40	20000	1	5	4,000,000	
	Transport refund	40	50,000	4	5	40,000,000	
	Stationary	40	5,000	2	5	2,000,000	
	Communication	4	10,000	4	5	800,000	
	Sub Total					**46,800,000**	**DLG**
Activity 2	**Organizing an HIV and AIDS strategic Planning workshop with PLHIV**						
	SDA members	80	20000	5	5	40,000,000	
	Transport refund	80	20,000	20	5	160,000,000	
	Facilitators	3	50,000	5	5	3,750,000	
	Stationary	80	5,000	10	5	20,000,000	
	Communication	4	10,000	20	5	4,000,000	
	Sub Total					**227,750,000**	**IP**
Activity 3	**Organising coordination meetings**						
	SDA members	80	20000	20	5	160,000,000	
	Transport refund	80	20,000	40	5	320,000,000	

	Stationary assorted	80	5,000	20	5	40,000,000	
	Communication	4	10,000	20	5	4,000,000	
	Sub Total					**524,000,000**	**DLG**

	Item	**Qty**	**Unit cost**	**Days**	**Frequency**	**Amount**	
Strategic action 4: Strengthening the capacity of DHT and Heads of Department to effectively provide oversight leadership and supervision of lower health facilities.							
Activity 1	**Training DHT and Heads of department in the New Coordination guidelines and Strategic Planning for HIV and AIDS**						
	SDA members	20	20000	5	5	10,000,000	
	Transport refund	20	20,000	5	5	10,000,000	
	Facilitator SDA	3	50,000	5	5	3,750,000	
	Fuel	20	4,000	5	5	2,000,000	
	Driver SDA	1	20,000	5	5	500,000	
	Stationary	20	5,000	5	5	2,500,000	
	Communication	4	10,000	5	5	1,000,000	
	Sub Total					**29,750,000**	**DLG**
Activity 2	Training Sub County Health Teams and Heads of department in the New Coordination guidelines and Strategic Planning for HIV and AIDS						
	SDA members	20	20000	5	24	48,000,000	
	Tranport refund	20	20,000	5	24	48,000,000	
	Facilitator SDA	3	50,000	5	24	18,000,000	
	Fuel	20	4,000	5	24	9,600,000	
	Driver SDA	1	20,000	5	24	2,400,000	
	Stationary	20	5,000	5	24	12,000,000	
	Communication	4	10,000	5	24	4,800,000	
	Sub Total					**142,800,000**	**IP**
Objective 3: Improvement in Human Resource Capacity in providing comprehensive HIV and AIDS Care							
Strategic Action 1: Orient all Health workers and Extension staffs (CDO, SAS, GISO, Vet staffs towards providing universal access through task shifting.							
Activity 1 Orientation of Health Workers							
	SDA members	465	20000	2	1	18,600,000	
	Transport refund	465	20,000	2	1	18,600,000	
	Facilitator SDA	3	50,000	5	1	750,000	
	Fuel	20	4,000	5	1	400,000	
	Driver SDA	1	20,000	5	1	100,000	
	Stationary	465	5,000	1	1	2,325,000	
	Communication	1	10,000	5	1	50,000	
	Sub Total					**40,825,000**	**DLG**
Activity 2 Orientation of teachers in Pre-Primary, Primary, Secondary and Tertially							
	SDA members	1500	20000	2	1	60,000,000	
	Transport refund	1500	20,000	2	1	60,000,000	
	Facilitator SDA	3	50,000	5	1	750,000	
	Fuel	20	4,000	5	1	400,000	
	Driver SDA	1	20,000	5	1	100,000	
	Stationary	1500	5,000	1	1	7,500,000	
	Communication	1	10,000	5	1	50,000	
	Sub Total					**128,800,000**	**DLG/IP**
Activity 3 Orientation of Lower Local Governments Extension Workers (CDO, Vet, SAS, GISO, SAA, Parish Chiefs, Agri,) Community Based HIV and AIDS Data collection tools							
	SDA members	250	20000	2	1	10,000,000	

	Transport refund	250	20,000	2	1	10,000,000	
	Facilitator SDA	3	50,000	5	1	750,000	
	Fuel	20	4,000	5	1	400,000	
	Driver SDA	1	20,000	5	1	100,000	
	Stationary	2000	5,000	1	1	10,000,000	
	Communication	1	10,000	5	1	50,000	
	Sub Total					**31,300,000**	**DLG**
Activity 4 Conducting CPD in Health Units							
	SDA members	465	20000	1	1	9,300,000	
	Transport refund	465	20,000	1	1	9,300,000	
	Facilitator SDA	3	50,000	1	52	7,800,000	
	Fuel	20	4,000	1	25	2,000,000	
	Driver SDA	1	20,000	1	52	1,040,000	
	Stationary assorted	2000	5,000	1	1	10,000,000	
	Communication	1	10,000	5	1	50,000	
	Sub Total					**39,490,000**	**DLG**
Activity 5 Conducting CPD Schools and Institutions							
	SDA members	1500	20000	1	1	30,000,000	
	Transport refund	1500	20,000	1	1	30,000,000	
	Facilitator SDA	3	50,000	1	270	40,500,000	
	Fuel	20	4,000	1	25	2,000,000	
	Driver SDA	1	20,000	1	270	5,400,000	
	Stationary assorted	1500	5,000	1	1	7,500,000	
	Communication	1	10,000	5	1	50,000	
	Sub Total					**115,450,000**	**DLG/IP**
Strategic Action 2: Securing enough Data collection tools							
Activity 1 Quarterly assessment of the Data collection tools							
	SDA members	4	20000	5	20	8,000,000	
	Fuel	20	4,000	5	20	8,000,000	
	Driver SDA	1	20,000	5	20	2,000,000	
	Sub Total					**18,000,000**	**DLG**
Activity 2: Procuring data collection tools from the Implementing Partners							
	SDA members	2	140000	5	20	28,000,000	
	Fuel	20	4,000	5	20	8,000,000	
	Driver SDA	1	55,000	5	20	5,500,000	
	Sub Total					**41,500,000**	**DLG**
Strategic Action 3: Data Quality Management							
Activity 1: Organizing Data Quality Management Workshops							
	SDA members	60	20000	5	20	120,000,000	DLG/IP
	Transport refund	60	20,000	5	20	120,000,000	DLG/IP
	Facilitator SDA	3	50,000	5	20	15,000,000	
	Fuel	20	4,000	5	20	8,000,000	
	Driver SDA	1	20,000	5	20	2,000,000	
	Stationary assorted	2000	5,000	1	20	200,000,000	IP
	Communication	1	10,000	5	20	1,000,000	DLG
	Sub Total					**466,000,000**	

WRITING TEAM MEMBERS

NO.	NAME	Title	ORGANISATION
1.	Saturday Jackson	DPO/District HIV FP	District Planning Unit
2.	Namara Patience	Biostatistician	Health Department
3.	Emmanuel Nzeirwenawe	HMIS FP	Health Department

PARTICIPATING TEAM MEMBERS

NO.	NAME	Title	ORGANISATION
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	Saturday Jackson	HIV FP	Kanungu DLG
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	Ezra Ndizeye	DCDO	Kanungu DLG
	Besisira Moses Katto	ADHO-EH	Kanungu DLG
	Mashemerwerwa Diana	N/O	Kanungu DLG
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	Musinguzi Philip	Inventory supervisor	Kanungu DLG