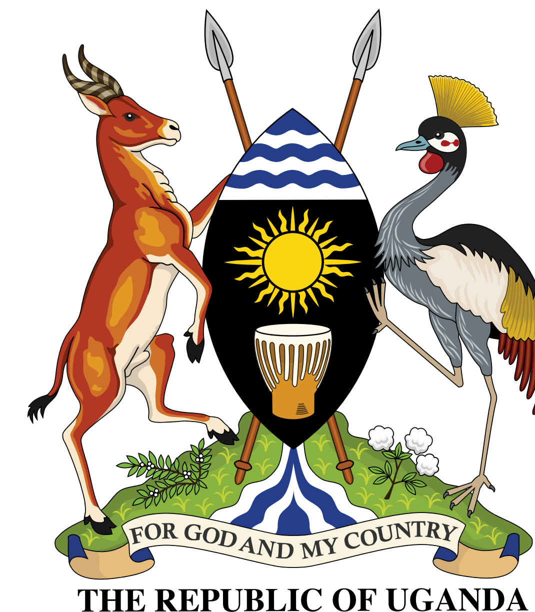

MITYANA
DISTRICT HIV AND AIDS
STRATEGIC PLAN
2020/2021- 2024/2025

JULY 2021

Disclaimer and citation

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Foreword

Many interventions have been put in place by the Government of Uganda to respond to the epidemic of HIV and AIDS. As key stakeholders in the delivery of services to the grassroots, Mityana district is charged with a major role of identifying the needs of people affected and infected with HIV and AIDS. This role requires the district to come up with strategies to address them, which entails systematic planning, implementation and monitoring of progress towards realization of the aspirations of the district and the people affected and infected with HIV and AIDS in the District.

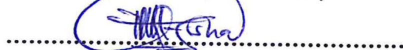
Over the past decade, the district has implemented activities on HIV and AIDS prevention, care and treatment, social support and systems strengthening but there is still a lot that need to be done to reduce HIV incidence and improve the lives of the people affected and infected with HIV and AIDS. HIV and AIDS remains a great contributor to the challenge of many orphans in the District. The new strategies for prevention like safe medical male circumcision, PITC, eMTCT, early initiation of ART to all HIV positive children under 15 years, discordant couples, and MARPs are being scaled up to reach the intended beneficiaries in the community.

There are very few CSOs providing active service to the community. These institutions do not have sufficient capacity and resources to care for the big number of clients and to give a holistic package. The work done by civil society organizations to improve the welfare of PLHIVs cannot be over emphasized because they are very few and have capacity gaps of finance and other logistics. Many families living with PLHIVs are in a very poor state, and lack resources to cater for the basic needs.

This plan will guide the implementation of HIV and AIDS activities for prevention, Care and treatment, Social Support for improved lives of the affected and infected people and Systems Strengthening to build capacity of the district for effective and efficient services delivery.

I appreciate the work done by the various departments and partners for developing this strategic plan notably the Health Department which has played the coordination role.

For God and My Country



Mugisha Patrick Nshimye

MITYANA DISTRICT CHAIRPERSON

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Acknowledgement

Mityana District Local Government wishes to acknowledge and thank the District HIV and AIDS Committee, for their efforts devoted to the development of this Five-Year District HIV and AIDS strategic plan 2020/21 - 2024/2025.

We wish to thank District Technical Planning Committee and representatives from Civil Society organizations for the technical assistance during the process of developing the plan. Finally, special thanks go to Makerere University School of Public Health Monitoring and Evaluation Technical Support (METS) Program for providing technical support and funding to the development of this strategic plan. We appreciate the guidance by Dr. Walusimbi Simon (METS) during the strategic planning process, and staff of Mildmay-Uganda for offering financial and technical support to the process of the strategic planning.

The District Local Council wishes to thank all the participants in the Committees who generated and analyzed issues that led to the development of the HIV and AIDS strategic plan, 2020/21 - 2024/2025.

Finally, special thanks go out to the following persons from the department of health Dr. Lwasampijja Fred, Dr Kawooya M Vincent Mr. Muwereza Peter, Ms. Justine S. Nampijja, Mr.Ivan Kasirye, Mr. Nyangale James, Nansubuga Jamiah, Enzaru Betty, Ms Nansubuga Martha, Mr. Ojuka Francis, Mr. Mono Denis and Ms Nakimbugwe Winnie from the department of Health; Muzira David and Ms Nabbosa Doreen from community services; Mr. Kyagera Albert from planning department; Mr. Golooba Isaac from administration and Mr. Ssenyonjo Raphael from MIFOPLA for working tirelessly to co-ordinate and come up with this strategic plan.

....

MS. Edith Mutabazi

Chief Administrative Officer

MITYANA DISTRICT LOCAL GOVERNMENT

Acronyms

ANC/PNC	Antenatal care / Post-natal care
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
CD4	cells T-lymphocyte cells with CD4 marker molecule
CSF	Civil Society Fund
CSOs	Civil Society Organizations
S/C	Sub County
DACs	District AIDS Committees
DLFP	District Laboratory Focal Person
DOTS	Directly Observed Therapy, Short course
EID	Early Infant Diagnosis
eMTCT	Elimination of Mother to Child Transmission
FBOs	Faith-Based Organizations
FP	Focal person
FSW	Female Sex Workers
GBSV	Gender-Based & Sexual Violence
GOU	Government of Uganda
HBC	Home-Based Care
HIV	Human Immune- Deficiency Virus
HMIS	Health Management Information System
HSD	Health Sub District
HC	Health Centre
HCT	HIV Counseling and Testing
KP	Key Populations (at higher risk of HIV)
LG	Local Government
LQAS	Lot Quality Assurance Survey
LTFU	Lost To Follow-Up
MARPs	Most At Risk Populations
MoH	Ministry of Health
MIS	Management Information System
MNCH	Maternal, Neonatal and Child Health

MTCT	Mother to Child HIV Transmission
NAFOPHANU	National Forum for PHA Networks in Uganda
MIFOPHLA	Mityana Forum for People Living with HIV/AIDS
DPS	District HIV Prevention Strategy
DSP	District HIV and AIDS Strategic Plan 2015/2016-2019/2020
NTLP	National TB and Leprosy Control Program
OI	Opportunistic Infection
OVC	Orphans and other Vulnerable Children
PIASCY	Presidential Initiative on AIDS Strategy for Communication to Youth
PITC	Provider Initiated (HIV) Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PNFP	Private Not for Profit
PWDs	Persons with Disabilities
RHU	Reproductive Health Uganda
RUTF	Ready to Use Therapeutic Food
SACCO	Savings and Credit Cooperative Organization
SBC	Sexual Behavioral Change
SMMC	Safe Male Medical Circumcision
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Disease
TASO	The AIDS Support Organization
TB	Tuberculosis
TBAs	Traditional Birth Attendants
TBD	To Be Determined
T/C	Town Council
TSR	Treatment Success Rate (for TB)
VHTs	Village Health Teams
TWG	Technical Working Group

Executive Summary

This five year District HIV Strategic Plan (DSP) 2020/2021–2024/2025 lays out strategies and actions to implement evidence-informed interventions and innovations through programme optimization. It builds on significant progress achieved during the last five years.
The process of developing this DSP involved key stakeholders to include the political will, departmental heads, communities of people living with HIV at the District level and civil society organizations. The DSP was developed in alignment with the National Strategic Plan (NSP) 2020/21 – 2024/25 that aims at achieving Equity in Access to HIV, TB and Malaria Services in Uganda.

Situational Analysis

The District prevalence rate for HIV is estimated at 6.1% which is higher than the national that is at 5.8%. Currently, the District positivity rate is estimated at 4% for the general population and that of the pregnant women is at 2% (District HMIS Annual Report, 2020/21).

Whereas all data sources indicate declining HIV prevalence and incidence over time, there are wide variations in some parts of the district especially in the urban, landing sites, tea estates and hard core mining areas where we find key populations (KPs). The positivity rates in these areas ranges from 11 – 15%. The male account for the lowest antiretroviral therapy (ART) coverage and poor health-seeking behaviours in all facilities for the district.

Vision and Goal of the National Strategic Plan

The overall goal for the DSP 2020/2021–2024/2025 is to "Increase productivity, inclusiveness and well-being of the population by ending HIV **and AIDS as an epidemic by 2030" and the vision is "**A society free from HIV and AIDS and its effects."

Prevention

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

- Breaking the HIV transmission cycle by identifying people who are HIV-positive, with particular attention on finding missing men, members of key populations and other HIV-exposed individuals likely to test positive for HIV and initiating them on treatment.
- Increasing coverage of comprehensive and innovative HIV prevention and Sexual and Reproductive Health (SRH) services that focus on adolescents and young people, especially AGYW and the male partners of AGYW.

- Improving and scaling up targeted HIV prevention programmes for key populations, such as sex workers, men who have sex with men, transgender persons and persons who inject drugs, including newer interventions, such as opioid substitution therapy and needle–syringe exchange programmes for people who inject drugs.
- Initiating a new generation of condom programming aimed at redirecting condom distribution towards a total market approach, with more distribution via social marketing, targeting non-traditional outlets and sex work settings, promoting female condom use while ensuring adequate supplies of all condoms.
- Reducing the risk of HIV acquisition by young males through targeted, high-quality circumcision by shifting VMMC from a vertical intervention to a more sustainable and integrated one, and by including information, education and communication (IEC) to women on how they benefit from VMMC for their male partners.
- Consolidating EMTCT gains by: (a) emphasizing the triple elimination of HIV, syphilis and hepatitis; (b) closing emerging gaps in the uptake of ART, and in retention and adherence; (c) monitoring mother–baby pairs; and (d) increasing testing and care of HIV-exposed infants.
- Promoting targeted use of PrEP for preventing new infections, based on geographical location, high level of risk and vulnerability.
- Increasing the quality of PEP for those who have been or are likely to have been exposed to HIV infection, such as health workers and victims of rape.
- Increasing access to sexually transmitted infection (STI) services that include diagnosis and management of STI symptoms and STI screening among key populations and to all pregnant women alongside the provision of EMTCT.
- Addressing the structural drivers of HIV infection and barriers to HIV prevention, such as stigma and discrimination, restrictive policies and laws, and inequitable gender and cultural norms.
- Building a locally led prevention response by strengthening the capacity of sectors and districts—and community-led groups, organizations and actors—to contribute effectively to the increased uptake of prevention interventions through social mobilization, advocacy and monitoring of provision of services.

Care and Treatment

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

Prioritizing high-impact HIV testing and counseling approaches, including assisted partner notification, index client testing, self-testing and the use of screening tools for provider-initiated testing and counseling (PITC).
Ensuring dolutegravir (DTG) transition for all people living with HIV linked to care and improving access to second line treatment.
Strengthening differentiated service delivery approaches for ART and other HIV-related services, including implementing the Youth and Adolescent Peer Support model, drop-in centres in urban areas, and community- and peer-led initiatives for key populations.
Strengthening community structures and systems for client tracing, care, referral, linkages and follow-up.

Social Support and Protection

Psychosocial, economic, legal and protection services are recognized as "social enablers" for HIV prevention and the uptake of care and treatment services. These will be given more attention compared to the past, with particular focus on the following:
Scaling-up efforts to eliminate HIV-related and other forms of stigma and discrimination against people living with HIV, key populations, persons with a disability (PWD), and other vulnerable groups.
Implementing the National Anti-HIV and AIDS Stigma and Discrimination Policy.
Mainstreaming social support for people living with HIV, affected populations and populations at high risk into national social development programmes.
Strengthening prevention and response to sexual and gender-based violence (SGBV) and discrimination, and mainstreaming gender and human rights programming into the HIV and AIDS response to address and remove barriers to access.
Strengthening legal and policy frameworks on HIV and AIDS to ensure the inclusion of all KPs, priority populations and vulnerable groups.
Increasing the coverage and delivery of services to meet the basic needs to households with OVC.
Building the capacity and coordination of community actors to prevent and respond to SGBV and the abuse of human rights, including sensitizing communities about laws related to HIV.

Systems Strengthening

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

Strengthening capacity to collect, analyze and use strategic information for decision-making.
Optimizing supply chain management of medical and pharmaceutical products for commodity security with minimal stock-outs of essential products.
Strengthening human resource capacity for relevant MDAs.
Strengthening health and social services infrastructure.
Improving financing for HIV-related services along priority interventions, including those relating to gender and human rights.
Improving efficiencies in HIV programme management and coordination, including engaging community actors.
Strengthening the capacity of community-led structures, organizations and networks to plan, implement, manage and coordinate accelerated epidemic control interventions, including the development and implementation of bylaws at decentralized levels.
Strengthening the national mechanism for generating comprehensive, quality and timely HIV and AIDS information for monitoring and evaluating the NSP.
Promoting information sharing and use among producers and users of HIV and AIDS data/information at all levels.

1.0 BACKGROUND

1.1 Introduction

HIV/AIDS remains one of the major health social-economic problems internationally, nationally and locally. Currently the national prevalence stand**s** at 5.8% with 4.3% among males and 7.1 among females between 15-49 years. Mityana District HIV prevalence is estimated at 6.1% (Ministry of Health 2020). The district positivity rate estimated at 4% (District HMIS Annual Report, 2020/21).

Mityana District has remained consistent in its pursuit of reduction of HIV transmission as the overriding priority for the District socio-economic development. Although the District has registered significant progress, HIV and AIDS prevalence continues to be high more especially among the urban population, youth, fisher folks, estate workers and the security personnel. The strategic plan has therefore been designed to address these challenges and to consolidate and extend the achievement that has been made.

The HIV and AIDS pandemic has led to far reaching social and economic consequences notably a decline in life expectancy and putting strain on the available resources.

The number of orphans is currently estimated at 28,526 as per the District OVC Strategic plan, 2014. Reducing the current HIV prevalence levels and mitigating any further impact of the epidemic requires more of the multisectoral efforts and scaling up interventions that positively impact on the epidemic. This therefore calls for further strengthening the District HIV/AIDS responses at all levels with special focus on prevention and strengthened care and treatment services.

1.2 Purpose of the District HIV/AIDS Strategic Plan

It is recognized that no single sector, department or organization can by itself able to address the HIV epidemic, which is emphasised by program based planning being championed by NDP III. This document is a broad District strategic plan designed to guide the District's response as a whole to the HIV and AIDS epidemic. It is not a plan for the directorate of health specifically, but a statement of intent for the district as a whole, both within and outside the Local Government. It is envisaged that all Government Departments, Organizations and stakeholders will use this document as the basis for program based planning so that, all District efforts can be harmonized to maximize efficiency and effectiveness.

4.0 JUSTIFICATION FOR DEVELOPING A DHSP

The DHSP 2020 -2025 portrays the needs and aspiration of Mityana district local government in HIV/AIDS response namely; prevention, care and treatment, social support and systems strengthening aimed at addressing the plight of people infected and affected by the scourge. The plan will help harmonize, coordinate and monitor the implementation of decentralized HIV/AIDS responses and

soliciting support from implementing partners. It is informed by the current situation in Mityana and the needs and priorities of the district that all stakeholders should support if the district is to realize good health outcomes in the fight against HIV.

The DSP 2020 – 2025 builds on the significant progress achieved in the last five years and it will respond to the gaps and challenges identified during the period. These include;

- A decline in social and behaviour change communication (SBCC) interventions and misinformation among the general public due uncensored messages issued by some faith- based and traditional healers.

- Inadequate programming for key populations (KPs).1

- Limited integration of sexual and gender-based violence (SGBV) prevention and human rights within HIV prevention programming.

- Limited adolescent-friendly sexual and reproductive health (SRH) and HIV information and services.

- Inadequate skills among health-care workers for the provision of adolescent-friendly SRH.

- And others

1.3 The HIV and AIDS Planning Environment in National and District Context

Compare with the national indicators

5.0 PROCESS OF DEVELOPING THE DHSP

The District HIV and AIDS strategic plan has been developed through an intensive and interactive process that involved all key stakeholders in the District. The process commenced in September 2020 with discussions in the DHT meeting and then an orientation workshop for the DAC and other District stakeholders. The meeting was attended by representatives of faith-based organizations, people living with HIV and AIDS, the civil service organizations, security organs, the media, women's organizations, youth organizations and departmental heads from Mityana District.

Later in June 2021, with support from Mild May-Uganda, a 5 day review meeting was held for all stake holders that led to development of a new 5 year HIV and AIDS strategic plan. The review meeting drew 15 participants from the following offices; CAO, DHO, Planner, DCDO, HIV FP, DTLS, Biostatistician, Secretary for Health, PLHIV Chairman, Condom FP, Assistant DHO Maternal Health and DHE leading to development of a draft District HIV and AIDS Strategic plan 2020 - 2025.

The preparatory work for HIV and AIDS strategic plan entailed an intensive process of SWOT(Strength, Weakness, Opportunities and Threats) analysis of the past interventions mainly in the different areas including; Behavioural change communication/Information Education and Communication(BBC), quality service delivery, treatment, care and support and governance, institutional capacity for planning implementation monitoring and evaluation accountability.

The review included analysis of data collected from HIV and AIDS service providers, the revised National Strategic Framework for HIV and AIDS, HIV and AIDS Monitoring and Evaluation Framework, data from the Health Management Information System, various monitoring and supervision reports and detailed discussions with in the working groups. This preparatory work led to the initial draft plan.

The draft was reviewed by the stakeholder's meeting, the District technical Planning Committee. The final document was forwarded to the District council for approval.

1.3 Guiding Principles

1. Strong linkage among prevention, treatment, care and social support
2. Shared responsibility, an AIDS-free population is everyone's responsibility.
3. Inclusion and non-discrimination, no person shall be discriminated from accessing HIV and AIDS services, no one shall be left behind.
4. Meaningful participation and inclusion of communities, people living with HIV and key and vulnerable populations
5. Respect for personal dignity and autonomy
6. Human rights and gender-based, people- centered approached to programming
7. Evidence-informed and result-driven planning and implementation
8. Adherence to the three ones principle by all stakeholders
9. Effective mainstreaming of HIV and AIDS in all programs
10. District ownership and accountability for results
11. Innovativeness to keep pace with evolving epidemics like COVID 19, Ebola, Cholera

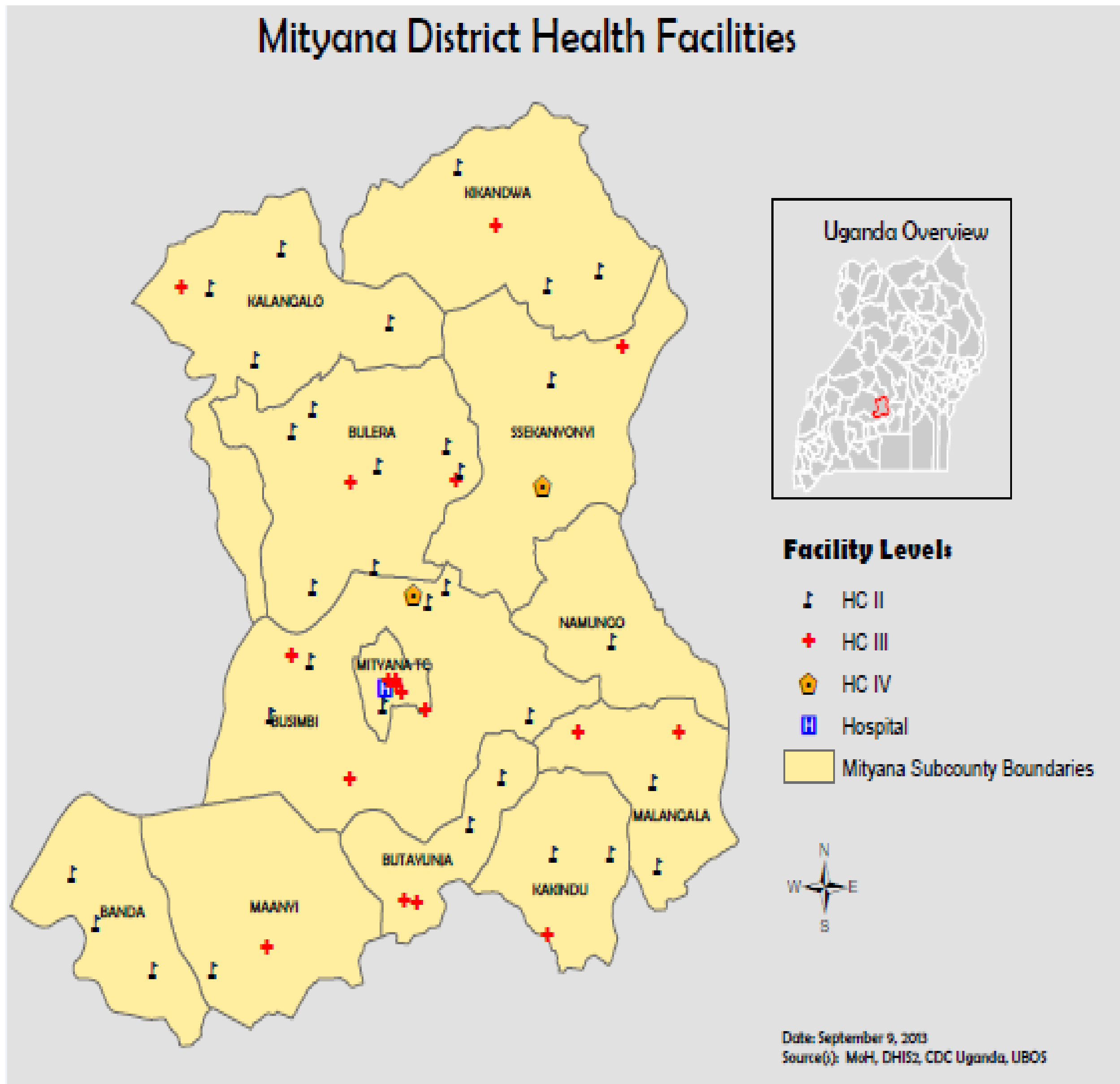
1.4 District Profile

1.4.1 Location

Mityana District lies in the Central region, bordering with Nakaseke and Wakiso Districts in the East, Kiboga in the North, Mubende in the West, Mpigi, Butambala and Gomba in the south. Mityana covers a total area of 1,550 square kilometres. The district headquarters is 74 Kms West of Kampala and located in Mityana Municipal council in Busimbi Division at Kunywa Village. The District is comprised of

one municipality with 3 Divisions, 10 sub-counties, 4 town councils, 93 parishes and 614 villages

Let's have a map of the district inserted here



1.4.2 Demographic and socio-Economic characteristics

1.4.2.1 District Population **Population indicators**	**Mityana (2021)**	**National values**
Total Population (Projected based on 2014 population and housing census)	383,226	40 M
Urban Population	14%	12%
Accessibility of HHs to safe water	78%	61%
Under five mortality	105/1000	97/1000

Source: Mityana District , 2014 Population projection

Characteristics

Population indicators	**Status**
Household	95,817
Infant population (aged under one year)	16,480
Children under five years	77,420
Children below 15 years	176,302
*Adolescents (10-14)	49,027
*Adolescents(15-24)years	54990
Adults (15-59)years	152,382
Life expectancy(Males)	50 years
Life expectancy(Females)	53.4 years
Paternal orphan hood	9.1%
Maternal orphan hood	4.2%
Double orphan hood	1.1%

Source: 2014 Population and housing Census projections*Refers to Females ONLY

1.4.2.7 Adoloscent Girls and Young Women/Men and the Elderly

Adolescent girls and Young women/men constitute the majority of the total special interest group population (59.3%). The youth comprises of 34.8%% and the elderly are only 4%. The district Teenage Pregnancy rate is at 17% (DHIS2, 2020/21.However, Ssekanyonyi S/C had the highest teenage Pregnancy rate (26.7%) as per the HMIS Annual report ,FY 2020/21, followed by Malangala S/C (23.6%), followed by Kalangaalo S/C (22.2%), followed by Banda S/C (21.4%) followed by Butayunja and Bulera Sub Counties at 19.5%). Zigoti Town Council indicated the lowest teenage pregnancy rates of 11.8%) for that period.

1.5. Current HI V/AIDS Situation in Mityana District

Table 3: Population estimates for the HIV services in the district

Details	Numbers 2014/15	Numbers 2019/20	Numbers 2020/21	Source of data
Women in child bearing age in the District	66,916	72,335	73,492	Planning unit
Estimated number of pregnancies of HIV positive mothers in the District per year	2,132	1,325	1,201	HMIS
Estimated number of PHAs (15-59) years	19,657	26,499	12,967	HMIS
Estimated number of orphans	28,526	20486	21386	Mityana OVC Plan, 2014
Cumulative number of PHAs getting ARVs	8,104	15, 684	17,130	HMIS
Estimated ART un met need based on the 95-95-95 target for adults only (1st 95)	10,804	6%	6%	HMIS
Estimated ART un met need based on the 95-95-95 target for adults only (2nd 95)		10%	10%	
Estimated ART un met need based on the 95-95-95 target for adults only (3rd 95)		12%	12%	
Number of clients assessed for TB	36245.	168,688	59538	HMIS Annual Report
Suspected Tuberculosis in the District	994	774	1091	HMIS Annual Report
Treated with Tuberculosis in the district	547	506	822	HMIS Annual Report
Patients co-infected TB/HIV/AIDS	281	242	220	HMIS Annual Report
Pregnant mothers counseled and tested	13925	6735	14,499	HMIS Annual Report
Pregnant mothers tested HIV positive	832	240	411	HMIS Annual Report
Pregnant women enrolled in care	647	180	373	
HIV positivity rate from PMTCT sites	6%	4%	4%	As calculated from above
ART sites	26	26	26	HMIS Annual Report
EMTCT SITES	26	26	26	HMIS Annual Report
HCT sites	32	26	26	HMIS Annual Report

Table 4: Shows the HIV services provided per health facility level

Level of facility	Number		Number providing the services1091						
	Gov't	Private/PNFPs	EMTCT	SMC	HCT	ART	Condom	STI	PEP
Hospital	1	0	1	1	1	1	1	1	1
HC IV	3	1	4	2	4	4	3	4	4
HC III	12	9	21	0	21	21	14	18	11
HC II	17	17	0	0	0	0	20	36	0
Total	**33**	**27**	**26**	**3**	**26**	**26**	**38**	**59**	**15**

1.6 Achievements for the last financial year in the following areas

1.6.1 Functionality of community structures

- PLHIV groups, FSG, Linkage facilitators in the district; There is a functional district forum of PLHIV which coordinates lower Networks in the district to ensure that the plight and services entitlement to clients are delivered effectively at facilities and community levels. Similarly Family Support Groups at EMTCT service points, Peer mothers and champion fathers also help HIV positive mother to assess ART services and remain in care.

- VHT functionality in the district; VHT coverage has increased from 30% to 75% and several orientations done on specific services like ICCM, Family planning, HIV, referral etc.

○

1.6.2 *Human Resource for Health*

Table 5: Public sector District staffing by health facility level[1]

District & Facility level	No of Units	Unit Norm	Total Norms	Filled	Vacant	% Filled	% Vacant
DHO's Office	1	11	11	10	1	91	9
General Hospital	1	190	190	177	11	93	7
HCIV	3	48	144	99	39	72	28
HCIII	12	19	190	130	54	68	32
HCII	10	9	90	40	75	36	64
District Total	**27**	**277**	**625**	**456**	**180**	**70**	**30**

The Health Sector Development Plan recommends 80% staffing levels across the levels of care but in the district is still below and the gaps are contributed to by lack of support staff especially at HCIIs. The critical cadres like anaesthetic officers, Enrolled Nurses, Theatre Assistants, Public health nurse also contribute to low staffing. The ban on recruitment of Nursing Assistants has left many unfilled posts hence contributing to low staffing levels.

For PNFP human resource staffing is below the recommended norms and there is a high staff turnover.

[1] Please refer to the annexes for the staffing norms

Table 6: Stakeholders Service Reporting

Name of Project/ Partner	Intervention Area (e.g HCT, eMTCT)	Duration of project	Coverage (Sub county, HF etc)	Target group/ Estimated pop'n.	Implementation mode (tick all applicable)			Estimated annual budget
					Direct Funding	Technical Assistance	In kind	
Mildmay	Comprehensive HIV treatment and care plus OVC Support	5	District wide	27,163	√	√		100m
	eMTCT	5 years	District wide	16,563	√	√		80m
	DREAMS	5years	District wide	Girl child 25,000		√	√	
	ELMA	5years	Mityana Hospital	500 children for ART		√	√	
	Safe motherhood	5 years	District wide	Safe motherhood and new born with disabilty		√	√	35m
Community Health Alliance	Advocacy for ART access	1 years	Bulera Namungo Bbanda Kalangalo Kikandwa	*1200*		√		-
SBCCA	BCC	5years	Butayunja	200,000		√		
Action 4 Health - Uganda	MCH/FP (Advocacy)	3 years	Maanyi, ,Kalangalo, Malangala, Bbanda, Bulera	150,000	√	√	√	50.0M
PACE	Positive living, community linkages	5years	District wide	20,000			√	
NAFOPHANU	Advocacy	5years	District wide	2000		√	√	
Hope Sharing Family (HOSFA)	Health, Education and OVC	Ongoing	Municipal and Busujju County				√	250.0m
New life/ Seed faith Ministries	Education, OVC and Health-Clinic	On going	Kikandwa Namutamba -Bulera S/C				√	
Nabagereka Foundati	DREAMS	On going	District wide			√	√	

on								
MARIE STOPES Ltd	Family Planning	On going	District wide			√	√	
Reproductive Health Uganda (RHU).	Family Planning Clinic	On going	Municipal council			√	√	
Living goods	Community access to medicines of malaria, diarrheal diseases and pneumonia and referral	3 years	Bulera, Kikandwa			√	√	
TEAM UP	Promoting Youth livelihoods., Advocacy and promotion of budgeting for allocation RH/FP funds	3 years	Bulera, Bbanda, Maanyi, kalangalo, Malangala,			√	√	
Partners for Community Transformation (PaCT)	Water, Sanitation and Health infra structure construction	3 years	District wide			√	√	
Rotary Club Mityana	Community empowerment and wellbeing	On going	District wide			√	√	
MUJHU	HIV and AIDS services operation research		District wide			√	√	
FOWODE	Advocacy on Human Rights	On going	District wide				√	
Mityana Diocese	Health services provision, advocacy for health, FP and social economic and spiritual wellbeing	On going	District wide			√	√	
Kiyinda Mityana Diocese	Health services provision, advocacy for health, FP and	On going	District wide			√	√	

	social economic and spiritual wellbeing							
UMSC Mityana	Health services provision, advocacy for health, FP and social economic and spiritual wellbeing	On going	District wide			√	√	
Wells of life	Promotes water and sanitation	5 years	District wide				√	

2.0 SWOT ANALYSIS

Thematic area	Strength	Weakness	Opportunity	Threat
Prevention				
HCT	▪ All HC IIIs and above provide HCT services; ▪ Presence of condom dispenser at public places, ▪ Functional theatres in Mityana Hospital and HC IVs providing SMC services; ▪ Presence of counsellors in the ART sites	▪ Inadequate Laboratory, personnel, & supplies. ▪ Inadequate infrastructure in the newly and old accredited ART sites; ▪ Limited training opportunities; Limited skilled staff, HWs and patient attitude, ▪ Lack of qualified Nutritionist in HFs; ▪ Limited resources for conducting refresher HCT training of HWs; ▪ Absenteeism of some staffs. ▪ Low male participation in HIV services. ▪ Inadequate	High Political Will in support to preventive services	Long distance to health facilities providing HCT services, limiting access; Regular stock out of HCT commodities, ▪ Short expiry products distributed to HFs; ▪ Constant changes in tools/regular update of tools by MoH; ▪ Therapeutic nutrition takes longer and leads to high loss to follow up; ▪ Social economic problems and hunger in some communities affecting ART adherence.

		data capturing tools in the health facilities. ▪ Stigma among PLHIV ▪ Increasing cases of GBV		
eMTCT	Some HC IIs have been accredited for provision of PMTCT services, Availability of VHTs, Peer mothers, champion fathers; expert clients and HWs supporting retention monitoring; Availability of a structured retention monitoring system (bicycles, airtime, funds) supported by an IP Political, community leaders and structures oriented/aware about PMTCT	Limited staffing; limited storage facilities for PMTCT records; Limited support supervision from HFs to community structures involved in retention monitoring; Too many PMTCT tools amidst limited staff, work load, stock out of some PMTCT commodities like Niverapine Syrup; limited follow up of HIV exposed infants for EID.	Presence of IPs; Good political environment ; Availability of radio stations that can be used to health educate the community;	Dependence on IPS to functionalize newly accredited PMTCT sites;, Limited male involvement in PMTCT services, , Existence of TBAs and private HFs which do not have mandatory testing of pregnant/lactating mothers; policy implementation not regulated and monitored;
VMMC	Availability of qualified VMMC staff; Documentation of VMMC data; Availability of equipments for VMMC; infrastructure at VMMC sites	Few facilities have VMMC equipment; Limited access VMMC data, limited resources AND Irregular supply of VMMC commodities	MoH integration of VMMC in HMIS; '	Training opportunities for VMMC are limited; IP driven, data not updated in the HMIS system; IPs discontinuing VMMC services in some accredited sites without engagement of the district;
Care and treatment				
Nutrition	Availability of Nutrition clinic at Mityana hospital and all HCIVs; all HFs have nutrition basic screening tools; at least one staff	Fewer opportunities to refresher trainings for nutrition ; Not all facilities have therapeutic	Presence of IPs supporting data manageme nt; Availability	Use of rudimentary food preparation techniques Stock out RTUF; food insecurity at community level

	trained in nutrition ; integration of nutrition in other services; Availability of trained mentors; Availability of district nutritional committee;	feeds	of nutritional policies and protocols ;	
ART (adolescent, adult and Pediatric)	All HC IIIs and above have been accredited for ART; Functional hub system; 85% staff have knowledge on ART service provision; Knowledge sharing during CMEs; Presence of Youth corners at public HC IIIs, IV and Hospital; Availability of motorcycles to transport samples and results between facilities and Hurb. Trained Staffs on adolescent friendly services;	limited number of well-trained HWs in ART, limited space and infrastructure, Some HFs did not receive mentorship, Inadequate space for youth friendly services, limited skills; Presence of mentors within district; Lack of knowledge on drug stores management	Presence of IPS supporting retention monitoring by procuring phones, airtime and home visits; hub functionality; Presence of IPs supporting youth friendly services; Availability of guidelines and policies from MOH and UAC	Home visits are entirely supported by IPs; Dependence on IPs for hub functionality; Stock out of DTG 10mg, lab and FP commodities; Lack of stores personnel in the staff structure at HC III and below; Long turnaround time for VL results from CPHL
Social support				
OVC, Youth, elderly, PWDs	Sustainable Livelihoods(Economic Strengthening); Availability of land, Availability of extension staff for technical and advisory services to OVCB HHs, Existence of Government Programs like WCP, Luwero, Rwenzori, Special grant for PWDs, CDD, YLP, Political stability and peaceful communities, Availability of ready market for commodities, Existence of Government	Inadequate extension staff, Inadequate agronomic skills among OVC caregivers, Limited ownership of land among OVC HHs which inhibits large scale commercial farming, Limited access to financial services due to lack of collateral security Inadequate focus of programs to	Existence of CBOs offering ES services, External support from development Partners; Availability of guidelines and policies from the centre;	High poverty levels among OVC caregivers, Negative attitude; Low demand for Vocational skills; Over dependency on external support by CBOS(un reliable funding), Limited acreage of land for meaningful food production(especially in Urban settings); Overwhelming numbers of OVC compared to the resources; Some OVC lack care takers that affect

	programs providing improved seeds and seedlings; Strong social family setting; Community structures like para social workers and VHTs	OVC HHs; Stigma in the society;		adherence;
	Presence of Government programs in education sector on HIV like PIASCY, YAPS,	Limited coverage of OVC due to overconcentration of CBOs in a few LLGs.		Contradicting Political pronouncements; Over dependence on external funding; Inadequacy of the education system in promoting skills for self-reliance. Limited coverage for the programs;
Systems strengthening				
Coordination of the HIV Response	Availability of Coordination Structure(DOVCC, DAC; SAC, PAC SOVCC);	Limited functionality of Coordination structures due to inadequate logistical and financial ; facilitation; Limited integration of OVC issues in other sectoral plans and budgets; Limited Technical Support Supervision to CDOs and CBOs by DCDO and PSWO	Technical and logistical support from IPS	Overdependence on external support – Unreliable
Linkages and Referrals for OVC and HIV services Presence of PHA networks, Family support groups.	Availability of an up-to-date OVC service provider inventory, Availability of Linkage facilitators and VHTs	Inflexible budgets of CBOs to cater for emergency referrals. Limited linkage between Clinical and non-clinical OVC service providers	Availability of networking and referral systems,	Stigma; Over reliance on external support from CBOs and IPs; Long distances between service points making accessibility quite costly; High poverty levels among OVC HHs limiting their capacity to access

				even the available services
HIV/AIDS Coordination	Availability and functionality of District coordination committee Presence of HIV focal person; Availability HMIS focal persons at HSD and District; HMIS	Low funding irregular meetings. limited functionality of the lower coordination committees; Data inconsistence, incompleteness and not updating data tools	political will; Availability of HMIS tools; Data cleaning and review meetings by IPs; Availability of HIV data systems like Dreams trucker, EMR, mTrac	Changing councils at all levels; Overdependence on external support – Unreliable; Many tools to be filled; Un integrated reporting tools like those for DREAMS
Procurement of medicines and supplies	Timely delivery of HCT and ART commodities to HFs; Availability of HMIS tools to all ART sites and computers to most of ART sites for WAOs, Presence of qualified personnel in charge of medical records. Presence of MMS	Inadequate supply of medicine and health supplies Poor quantification, poly-pharmacy, inadequate stores personnel, inadequate storage facilities	Presence of IPs(UHSC, Mild may Uganda, and CHAI) supporting mentorship and training of health workers in supply chain	Stock out of some HIV commodities and supplies at the central level, Inflation of prices, Push system leading to expiry of some items
Staffing	Availability of critical staff to offer HIV services (75%);	Insufficient staffing; The newly recruited staff not trained on offering HIV services;	Additional staff by IPs (counselors, data clerks, Nurses, Doctors etc)	Limited wage bill, staff attrition in PNFP facilities
Infrastructure and equipment	Availability of General Hospital, HC IVs in each HSD, HC IIIs in most lower local governments and HC II in some parishes;	Inadequate space for HIV services in some HFs; Inadequate equipments like X – Ray, U/S and Hospital beds;	Availability of IPs supporting the District with infrastructure and equipments	It is difficult to get spare for Some equipments procured

2.1 District HIV situation Analysis

2.1.1 Picture of the Epidemic

HIV has continued to be a leading cause of morbidity and mortality in Mityana District. According to the HMIS report 2019/2020, AIDS is ranked 6th among the 10 leading causes of morbidity in the District. It contributes greatly to MMR, IMR and crude mortality rates. HIV affects mainly the sexually active population and sexual activity is the main defining risk factor. Heterosexual contact with an infected person and Mother to child transmission remains the primary routes of infection in Mityana District. However sharing of non-sterile contaminated sharp instruments and men having sex with men are the other risky factors.

The main predisposing factors to HIV infection remain early, multiple and extra marital sexual relationships without correct and consistent use of condoms, low awareness and poor access to condom outlets, community myths and misconceptions on HIV and AIDS issues and inadequate/delayed treatment of STDs. Socio-economic factors such as poverty, migrant labour, commercial sex, the low status of women including over dependency on men, illiteracy and lack of formal education, stigma, discrimination and substance abuse especially alcoholism also have a big bearing to HIV infection. The other factors contributing to HIV infection include; urbanization, displacement of people, economic activities like fishing as is seen at landing sites and road construction.

Socio-Cultural factors which include; peer influence, inadequate family life education, insufficient life skills training and communication continue to be leading causes of HIV Infection due to lack of parental and community involvement. This leaves the vulnerable youths prone to dangers of sexuality including early pregnancy and HIV infection. The District HIV and AIDS strategic plan is therefore designed to address all these immediate determinants and underlying causes.

2.2 HIV Prevention

HIV/AIDS Pandemic is still a big problem to the district. The prevalence for the District is estimated at 6.1%. (Uganda AIDS Commission 2020) and prevention remains a key priority in its control.

As a District we been able to carry out; BCC, HCT, SMC, PreP, PEP, Condom promotion, screening and treatment of STIs, Infection Control/Blood Safety and eMTCT

Table 8: eMTCT Services

Financial Years	ANC attendance	No. of preg women tested for HIV	No. tested HIV Positive	No. initiated in care	Percentage initiation
Jul 2020-Jun2021	16741	15429	378	363	96%
Jul 2019-Jun 2020	16396	9096	201	180	89.5%
Jul 2018-Jun 2019	16106	18369	505	446	88.3%
Jul 2017-Jun 2018	14825	14668	528	486	92.04%

Source: Health sector DHIS2

There was a reduction in the trend of positivity rates among pregnant women testing for HIV over time, however, in 2020/21 the positivity increased. However the initiation of HIV pregnant women on ART improved. This could be attributed to inadequate counselling, support supervision, follow up, mentorship and coaching.

Table 9: Early Infant Diagnosis

Financial Year		Infants tested for HIV below 18 months (1st PCR)			Infants tested for HIV below18 months (2nd PCR)			Rapid Test
	Enrolled	Total Tested	Tested HIV +	Positivity Rate	Total Tested	Tested HIV +	Positivity Rate	Infants who had a rapid test at 18 months or older
FY 2020/2021	26	1209	24	2%	987	2	0.1%	32
FY 2019/2020	7	1759	7	0.4	646	0	0	307
FY 2018/2019	26	1154	25	2.2	905	1	0.1	627
FY 2017/2018	46	981	33	3.4	604	13	2.2	523

Source: Health sector DHIS2

There has been reduction in trends of positivity among HIV exposed infants and this may imply that the District is moving towards achieving the global target of elimination of mother to child transmission of HIV by 2030.

EID Cascade

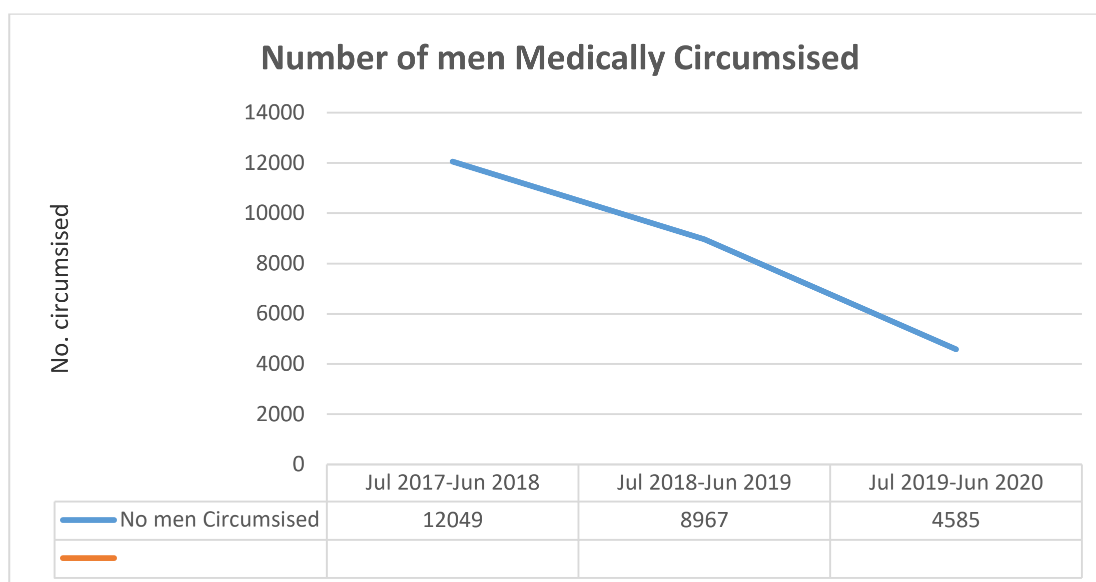
Year	No. of HIV+ Mothers	1st PCR	<2 Months	EID Coverage (%)	EID Timeliness (%)	No. of HIV+ Infants	No. of HIV+ started on ART	Linkage (%)
2020	1584	1158	1062	**73%**	**67%**	26	35	**135%**
2019	1527	1233	1010	**81%**	**66%**	31	30	**97%**
2018	1562	1019	687	**65%**	**44%**	33	29	**88%**
2017	1634	900	651	**55%**	**40%**	62	41	**66%**
2016	2138	792	430	**37%**	**20%**	47	58	**123%**

The coverage of DNA PCR has improved from 37% in 2016 to 67% in 2020. In addition, the timeliness of 1st DNA PCR has improve over the past five years from 20% in 2016 to 67% in 2020. To manage mothers' self-stigma, the facilities were supported to strengthen counselling of mothers on every visit and ensuring they receive consent before visiting the mothers. Mothers were also constantly sensitized on the availability of PMTCT/EID services at their lower level health facilities. Facilities were supported to come up with weekly line lists for infants due for EID tests and would benefit from home based sample collection. These lists were given to the BBMBs (Bring Back Mother Baby pairs community workers) to track. Furthermore, facilities were supported to offer services to clients visiting within their districts and ensure right documentation.

2.2.1 Safe Male Medical Circumcision trend

Safe male medical circumcision in Mityana exhibited an upward trend from 2013 to 2014 however this was short lived as a decline in the number of men circumcised dropped from 2014 to 2015 mainly due to reduced support from implementing partner (AMREF) as they prepared to pull out of the District. The performance has further reduced from 2016 - 2020 as the supporting implementing partner stopped offering support to some accredited VMMC sites. (see graph below)

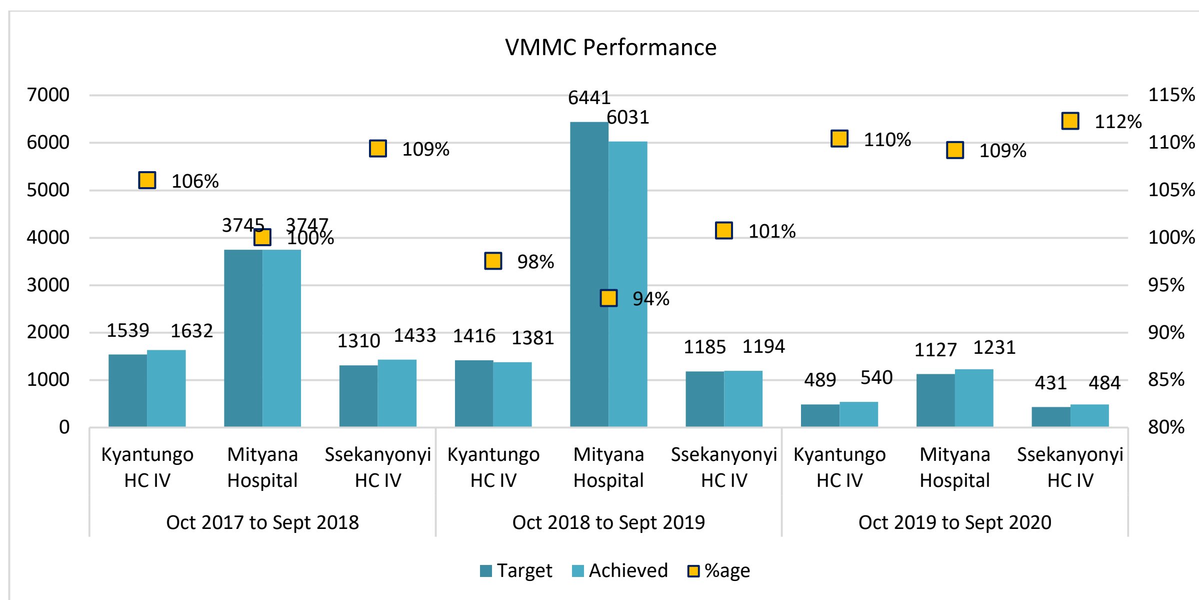
Fig 1: Graph Showing SMMC trend



Source: District HMIS reports

A total of 25,601 males were circumcised across the district during the previous implementation period (2017/18-2019/20, HMIS Annual Reports). The unmet need remains

high at 23,636 men that need to be circumcised if the district is to achieve the 80% national target of men aged (15-59) years.



Mityana district has effectively implemented safe male circumcision as a biomedical HIV preventive measure for men. The four VMMC sites in the district i.e. Kyantungo HC IV, Mityana Hospital and Bulera HC III have maintained a performance of over 90% against their annual targets. Over 80% of the men circumcised were within the pivot age of 15-29 years. Interventions implemented to reach the eligible men included House to house mobilisation to reach the 15-29-year-old males currently at home due to the closure of educational institutions, remote follow up especially for the 7th day and after continuous enhanced safety monitoring for SR amongst the 14 yrs and other men

2.2.2 Knowledge, Risk Perception and Behaviour Change

Whereas awareness on HIV/AIDS in most parts of the district is universal, behaviour change remains elusive. There is generally lack of IEC materials in local language and low levels of information about the HIV disease. This demonstrates the need for production and dissemination of IEC materials, drama shows, film shows, community dialogues and radio talk shows among others. Denial, stigma, discrimination and Domestic Violence continue to exist despite of efforts to fight the above over time, there has been a low attendance to HCT services among men in the district. There has been reduction trend of ART enrolment since 2017 as reflected in reduction of positivity rates.

According to a survey by Makerere school of public health in 2013, using PLACE methodology, it was found that the positivity rates at landing sites on Lake Wamala was 15%, Tea estates 12% and in Mityana Town council 10%. The low risk perception by individuals in particular the youth, fishermen and sexual workers, negatively affect the behaviour change, this therefore requires the integration of life skills building and other innovative aspects in the communication programs.

2.2.3 Sexually Transmitted Diseases

There is compelling evidence showing that STDs are a major determinant of HIV transmission. This is because STDs facilitate the transmission of HIV. Knowledge about the signs and symptoms of STDs is low and the knowledge about taking proper corrective action when infected with an STI is very low. This therefore poses a great risk of transmission of STDs/STIs including HIV and it calls for community education about the signs and symptoms, effects of STI, relationship between STI and HIV, and benefits of seeking early medical treatment (Source; LQAs 2015).

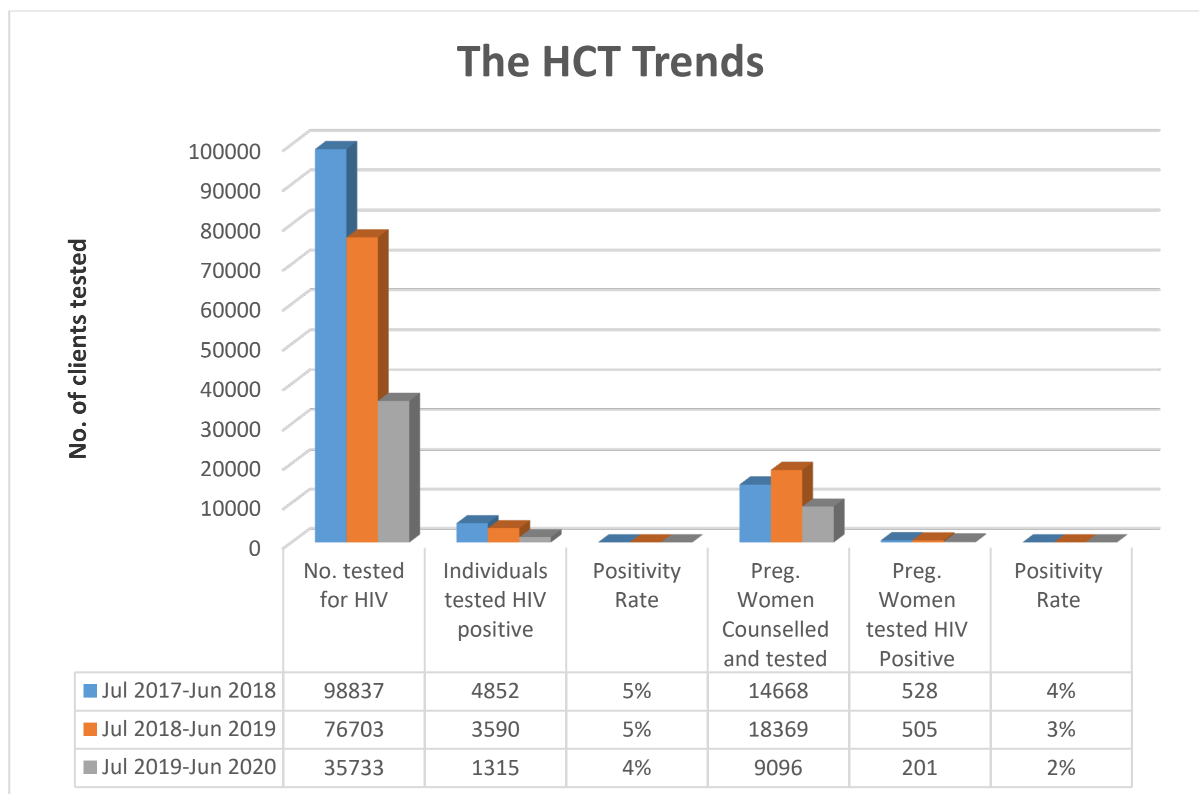
2.2.4 HIV Counselling and Testing Services

Mityana District has 9 laboratories that meet minimum standards out of the 26 ART sites that offer lab services and one laboratory hub at Mityana Hospital. Currently only 26 facilities out of 55 facilities are able to offer HCT service. Despite the additional staff provided by Mildmay, service delivery is constrained by inadequate space, supplies and staff both in terms of numbers and skills; especially the counselling cadre, laboratory personnel and clinicians.

The uptake of HCT is still low especially among males compared to females (See graph below). The proportion of people who have ever taken an HIV test is still low even to communities in close proximity to the HIV testing centres.

This district HIV/AIDS strategic plan will consider scaling up of the HCT services to the community through HTS optimization.

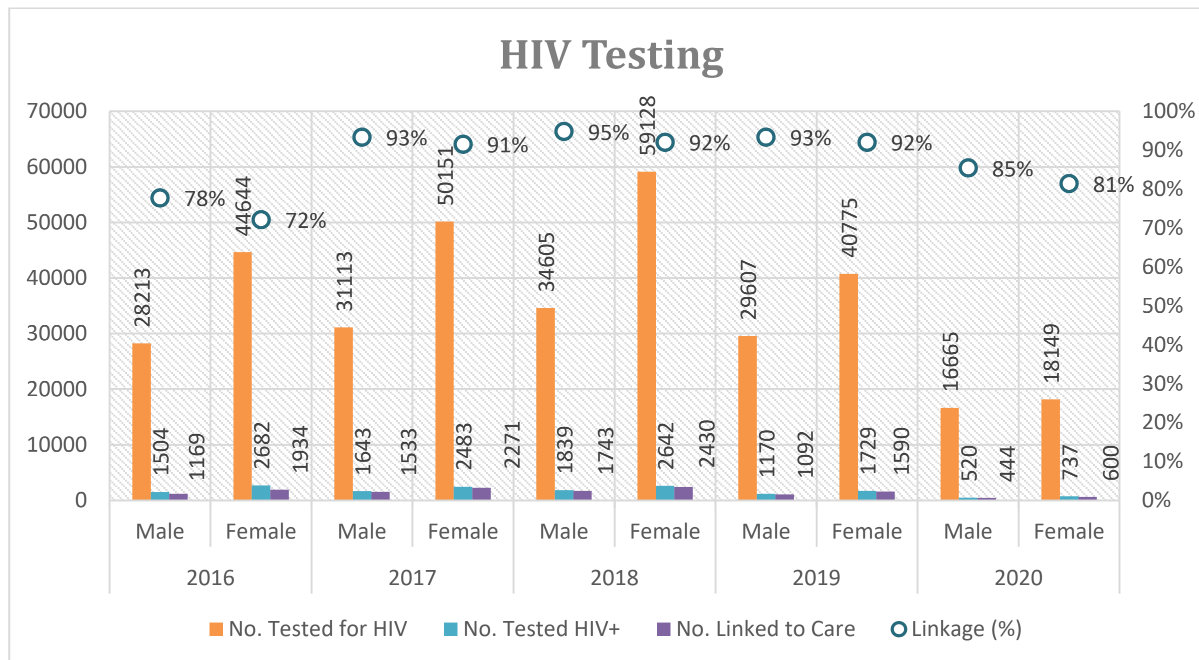
Fig 2: A Graph showing general HCT trends over time.



	No. tested for HIV	Individuals tested HIV positive	Positivity Rate	Preg. Women Counselled and tested	Preg. Women tested HIV Positive	Positivity Rate
Jul 2017-Jun 2018	98837	4852	5%	14668	528	4%
Jul 2018-Jun 2019	76703	3590	5%	18369	505	3%
Jul 2019-Jun 2020	35733	1315	4%	9096	201	2%

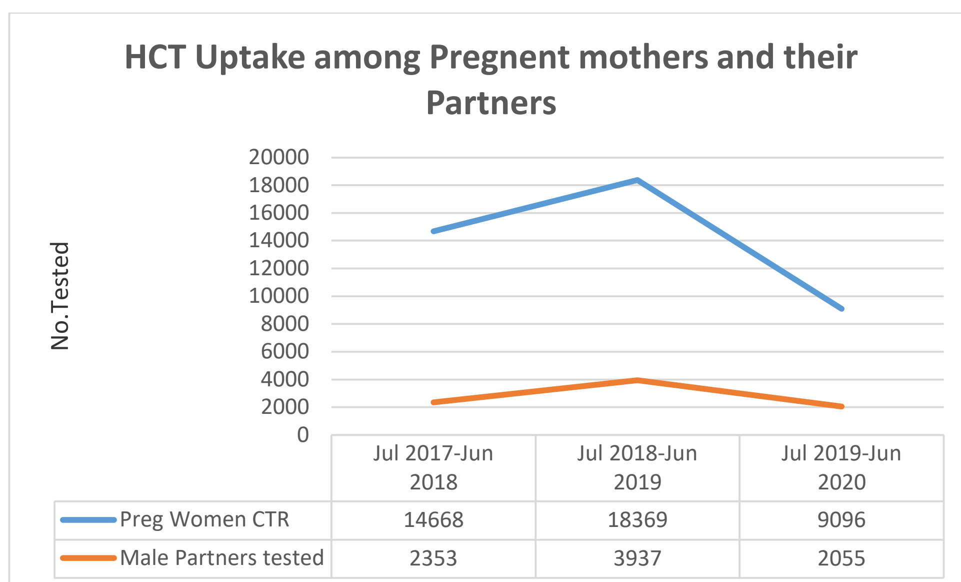
Source: District HMIS reports 2020/21 (NB there was loss of data of FY July 2015 – June 2016 and July 2016 – June 2017 due to upgrade of Uganda DHIS2)

There was a 4.6 percentage reduction in HIV positivity rate from 8.6 (Mityana District HIV Strategic Plan 2015/2016 -2019/2020)



Over the past five years, timely linkage of positive HIV patients has been supported in all facilities across the district. HTS screeners at facility outpatient departments supported testing of high risk groups for HIV resulting in identification of new positives and curbing re-testers. These were supported to initiate ART by physical escorting of the clients to ART clinics at the health facilities. Strengthened same day ART initiation of new positives with emphasis on client's optimization to their recommended first line regimens was also done. To ensure good stock/availability of ARVs, Real time ARV Stock Status (RASS) monitoring, mentorship by medicines supervisors and redistribution when necessary were done. In addition, monitoring of facility achievements against targets for linkage and basing on these to design weekly improvement strategies including follow-up by phone and by community resource persons (CORPS) to enhance linkage for the unlinked new positives also played a part in improving linkage. Line-listing of previously unlinked positives to direct follow –up efforts to ensure ART initiation for them was also helpful.

Fig 3: A Graph showing HCT up take among pregnant mother and their male sexual partners



Source: District HMIS reports

HIV male partner testing continues to be very low and this calls for urgent interventions to achieve the global target of HIV elimination by 2030.

EMTCT cascade

Year	Total ANC 1	No. Tested for HIV	Newly Tested HIV+	Yield (%)	Known HIV+	Total HIV+	Total on ART	Linkage (%)	Male Partners Tested	Partners Tested HIV+	Partner Testing (%)
2020	16723	14255	432	**3.0%**	1056	1488	1353	**91%**	4509	72	**27%**
2019	16099	14330	425	**3.0%**	1027	1452	1406	**97%**	4304	68	**27%**
2018	15375	13414	522	**3.9%**	903	1425	1373	**96%**	3452	90	**22%**
2017	15125	12715	551	**4.3%**	776	1327	1234	**93%**	1160	56	**8%**
2016	15315	12261	673	**5.5%**	934	1607	1190	**74%**	1080	71	**7%**

As per the MoH guideline, Mityana continued to support the testing of pregnant mothers at first ANC. The linkage of HIV positive mothers improved from 74% in 2016 to 91% in 2020. This achievement was attributed to continued using higher health facilities to support lower HCIIs as CDDP sites and hard to reach areas as EPI/PMTCT/EID outreach sites. This together with support from peer mothers, MCH CORPS and private midwives strengthened referrals and linkages for PMTCT/EID contributing to an increment of pregnant mothers referred from the community.

2.2.5 Infection Control/Blood Safety and Transfusion

Prevention of blood borne HIV transmission is being implemented in accordance with the established national guidelines. The district has ensured safe storage, distribution and supervision of blood usage in the hospital. Health workers have been sensitized on infection control, Injection safety measures and universal precautions while using and disposing of wastes. Facilities have established infection control committees.

There is greater need for improved infection control measures due to emergence of COVID – 19 pandemic.

2.2.6 Condom education and promotion

The community has been sensitized on proper and consistent use of condoms. 400 Condom dispensers have been put in strategic locations in rural and urban centres for easy accessibility and utilization.

2.2.7 Pre and Post exposure Prophylaxis

There are 7 facilities that provide Pre exposure prophylaxis to eligible clients. These facilities include; Buyambi HC III, Bulera HC III, Magala HC III, Naama HC III, Ssekanyonyi HC IV, Maanyi HC III and Mityana Hospital. There is need to scale up the service to some other facilities for easy accessibility. Currently 1629 access PrEP at the above facilities. On average each month 239 seek for PreP services and the number is projected to grow on account of making availability of the services known

All ART sites have the capability of providing PEP, however some health workers need to be mentored on proper prescription.

2.2.8 HIV/AIDS and Education Sector

The District has got a total of 299 both Government Aided and private primary and secondary schools.

Table 10: Distribution of Mityana Primary and Secondary schools in by Sub County

Name of Admin Unit	Primary		Secondary	
	Government	Private	Government	Private
Mityana MC	37	73	3	27
Malangala SC	12	04	1	03
Butayunja SC	10	02	1	2
Kikandwa SC	12	02	1	2
Kakindu SC	11	03	1	3
Maanyi SC	14	6	2	3
Ssekanyonyi SC	25	6	1	0
Bulera SC	30	2	1	2
Total	151	98	10	40

Source: District Education Office, 2020

Estimated 40% of primary schools have talking compound messages and only 4 secondary schools were reached with AB messages. There is need to orient head and senior women/men teachers on AB activities, Conducted meetings for out of schools youth groups on AB and carry out drama shows in schools and communities.

2.3 Care and Treatment

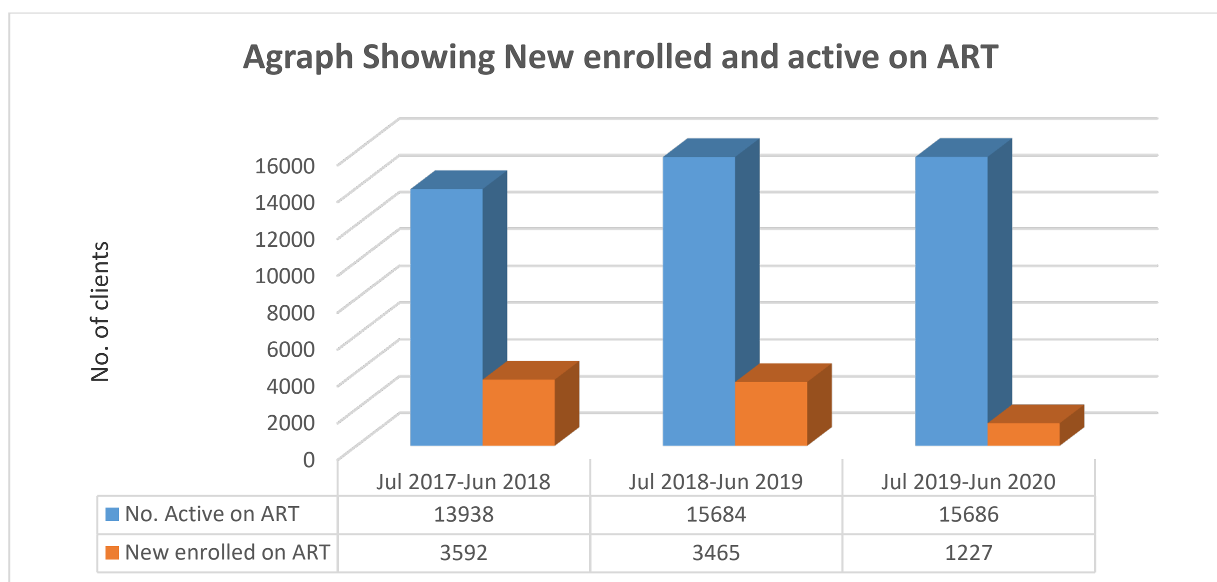
Mityana District started providing antiretroviral therapy in 2005. Currently 26 sites are accredited to offer ART to HIV/AIDS clients. This has brought a lot of hope to hundreds of patients. Today, the district has about 16,938 clients active on ART. This has been made possible due to the availability of ART centres that include; Mityana Hospital, Kyantungo HC IV, Mwera HC IV, St Padre Pio, Maanyi HC III, Malangala HC III, Kyamusisi HC III, Sekanyonyi HC IV, Kabule HC III, St. Francis HC IV,

Magala HC III, Naama HC III, Kikandwa HC III and Bulera HC III, UMSC HC III, Lulagala HC III, Namutamba HC III, St. Luke HC III, St. Jacinta HC III, Archbishop Kiwanuka HC III, Kitongo HC III and Kambaala HC III.

The other accredited ART sites are; Mpongo HC III, Busunju HC III, Namungo HC III, Kalangalo HC III and Kajoji HC II.

Show 90-90-90 performance

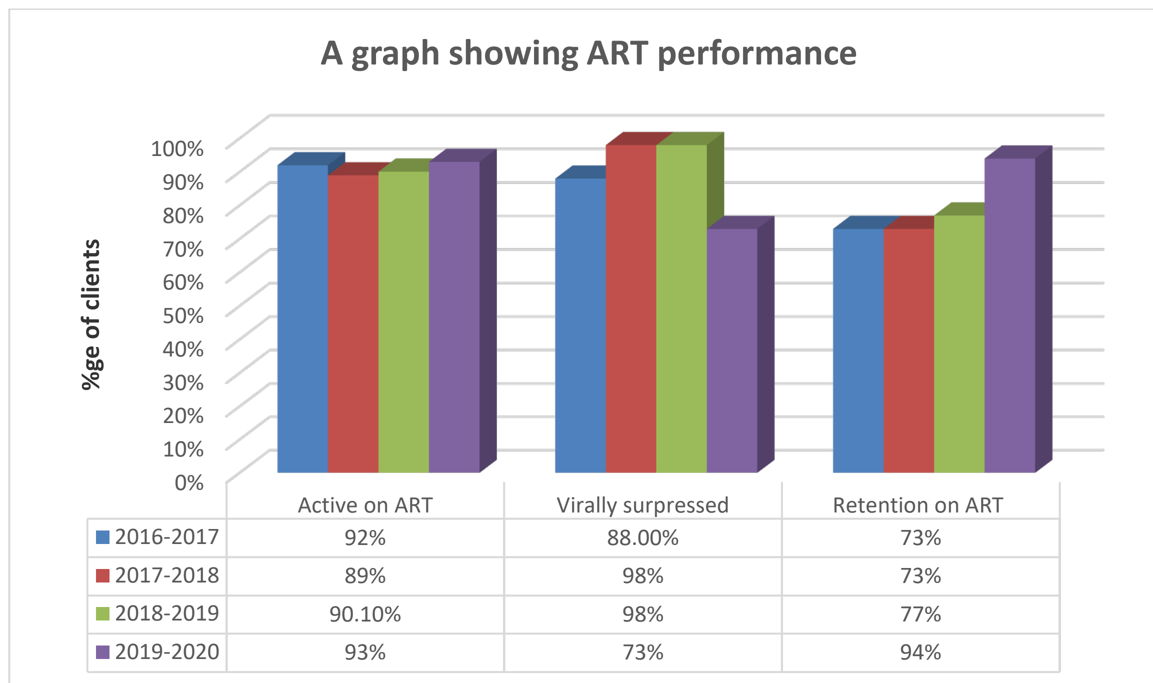
Figure 4: Graph showing new enrolment and Active on ART



Source: District HMIS reports

According to the graph, there had been reduced trends for the new enrolment and this could imply that the new infections are reducing and prevention strategies are working.

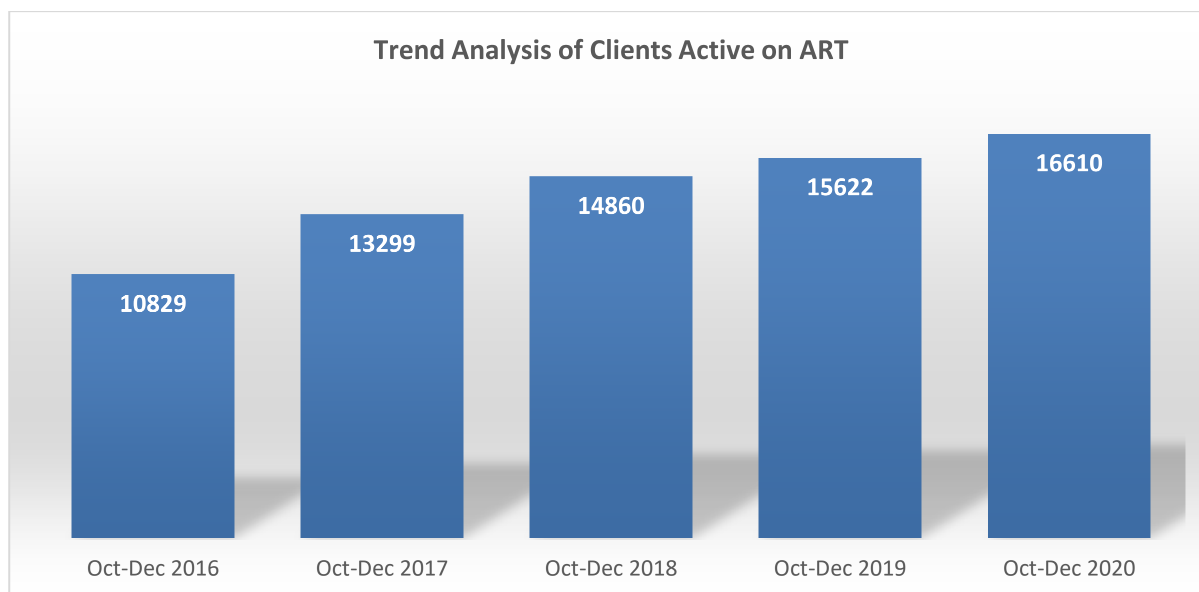
Figure 5: Graph showing ART performance

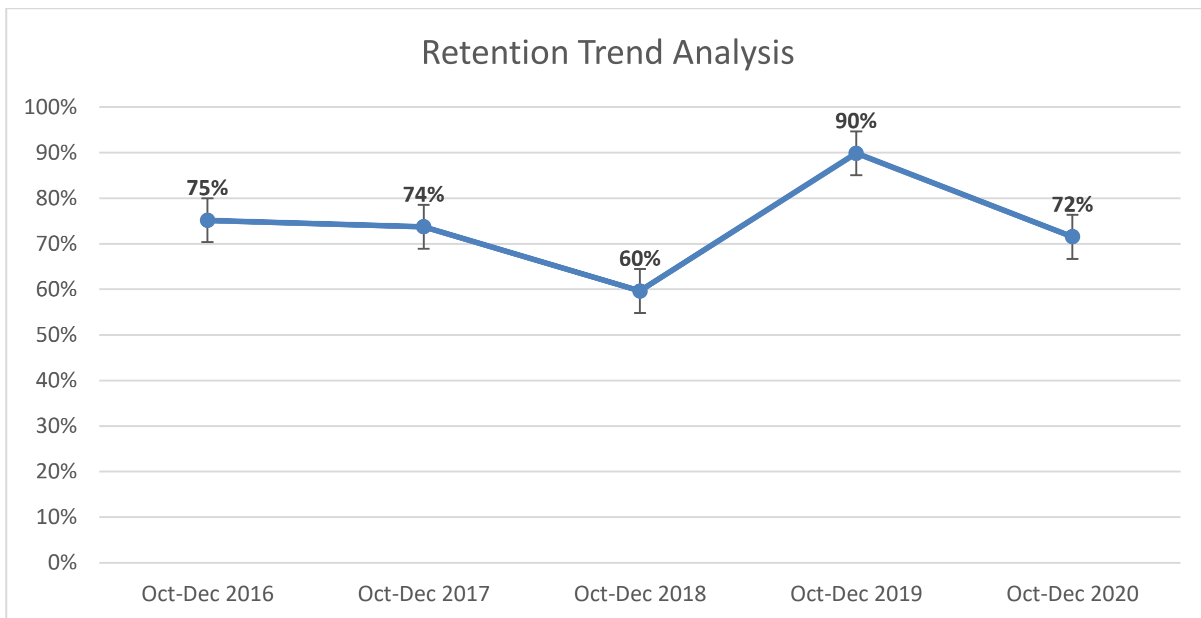


	Active on ART	Virally surpressed	Retention on ART
2016-2017	92%	88.00%	73%
2017-2018	89%	98%	73%
2018-2019	90.10%	98%	77%
2019-2020	93%	73%	94%

Source: District HMIS reports

Over the years as indicated above, there has been improvement on the category "active on ART and retention", however, the virally suppressed reduced markedly in the FY 2019/2020 on account of COVID- 19 pandemic.





Over the past 5 years, the number of clients active in care steadily increased every year. Continuity of treatment has therefore greatly improved. Strategies employed to improve client continuity of treatment included multi-month drug dispensing, leveraging on pediatric regimen optimization activity to retain children in care, timely line-listing and follow up of missed appointments by phone calls and physical home visits as well as conducting home ART delivery (using CORPS) and OVC integration to support children and adolescents on ART). Other interventions included weekly tracking of performance of second visit for newly initiated clients on ART (TX-SV) indicator to aid retention of new clients on the ART program, a shift of the DREAMS safe space from a collective ground to a home based activity catering for smaller numbers of AGYW at a time, implementation of Young People and Adolescent Peer Supporters (YAPS) program through use of peers to support retention in care for adolescents and linkage to health services in the community as well as delivery of ART to adolescents.

2.3.2 Laboratory Services

- HIV testing
- Complete Blood Count
- Multiple organ function testing (Renal, Liver)
- TB gnosis (Genexpert, TB LAM, ZN stain,)
- viral load testing and DNA PCR testing for infants
- Laboratory HUB services

2.3. **Achievements in the Last District HIV Strategic Planning Period During**

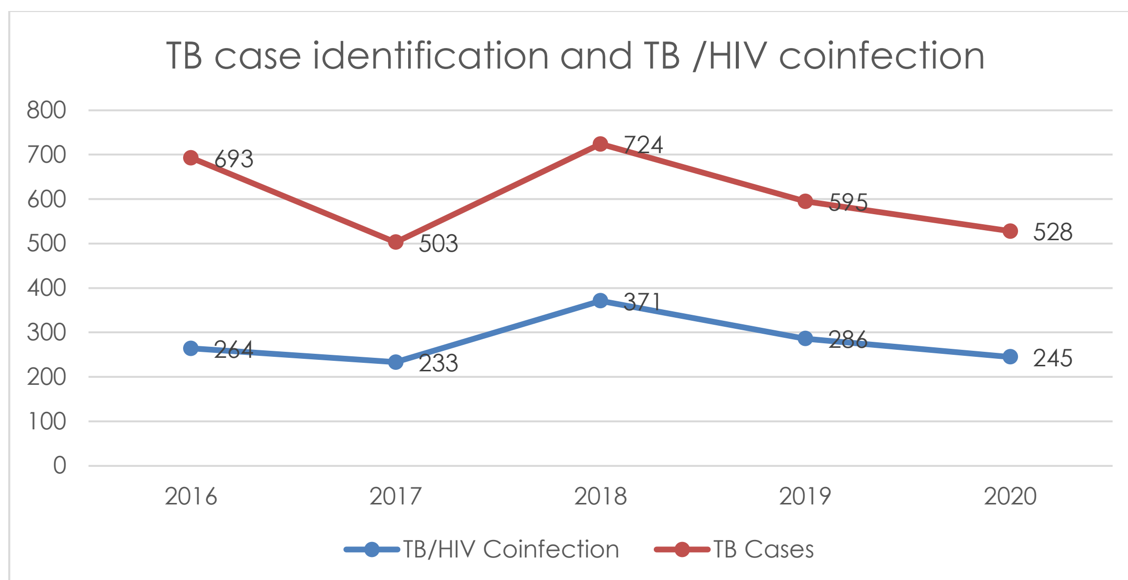
During the past five years a total of 16,407 have been maintained on ART, of who 2,842 are children between 0 – 14 and 3,593 are youth (15 – 24 years). The positivity rate reduced from 6.4% to 4%.

Under UNAIDS goal, 95:95:95, the district achieved 94:90:87 which is almost similar to that of the nation.

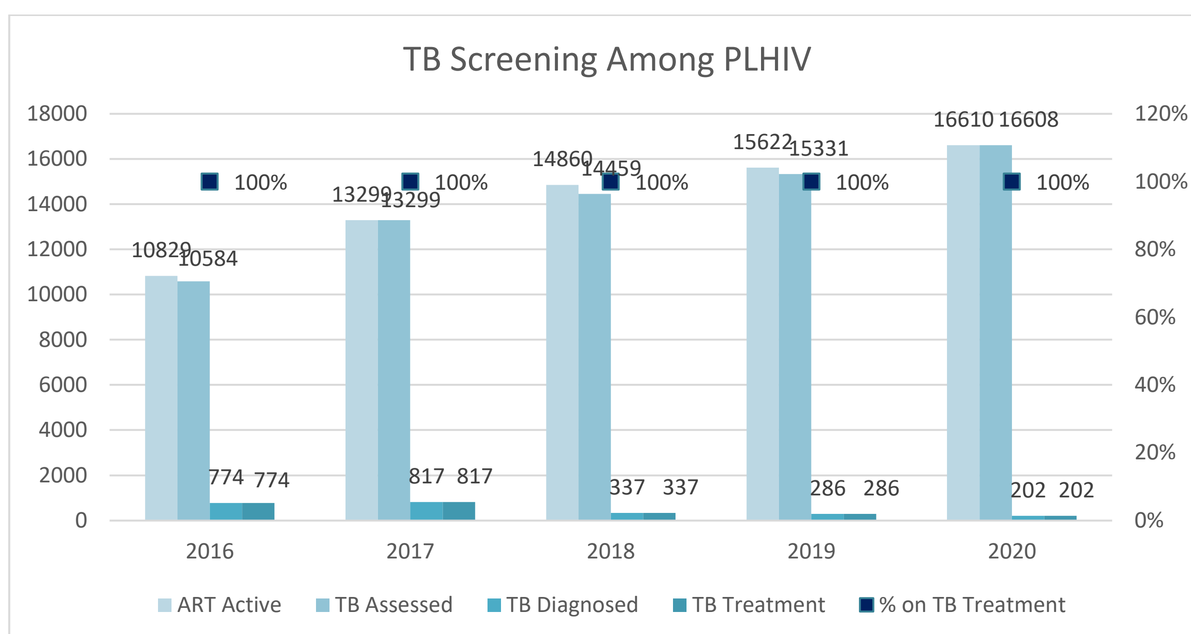
2.3.3 HIV/AIDS and Opportunistic Infections

Tuberculosis

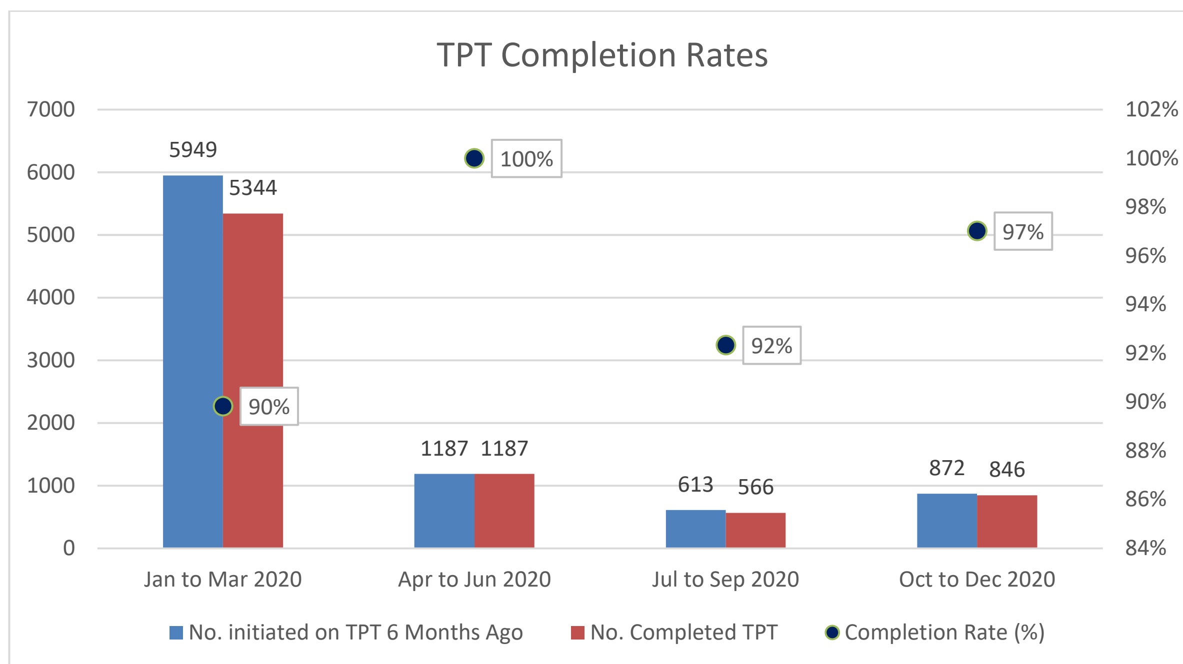
Out of the 73 health facilities, only 21 implement TB cases management. The rest do health education, counselling and refer TB suspects to diagnostic and treatment units. The TB case detection rate in Mityana district for the year 2019/20 was 75% while treatment success for patients started on TB treatment was 86% below the required standard of WHO that is 90%. TB- HIV co-infection is approximately 47% while TB – HIV co-management is 100%.



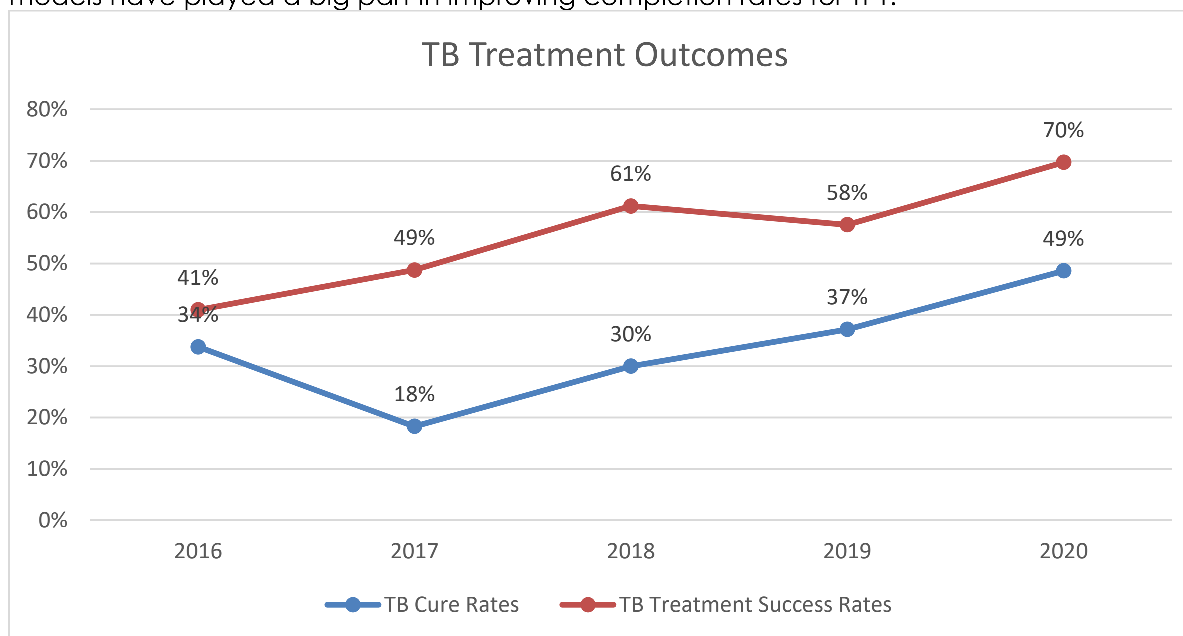
The number of TB cases of all forms identified in the district has been maintained above 500. And reached a peak at 724 in 2018. Some of the interventions that the district has employed to increase the number of cases identified include TB screening at all service points in all health facilities, contact tracing, targeted TB outreaches, CXR paid voucher system, DETECT paediatric TB strategy, CSO engagement strategy among others.



Over the past five years, Mityana has endeavored to have all her PLHIV screened for TB (100%) at every clinical encounter. Intensified Case Finding guides are available at all service points and health workers have been mentored to fully utilize them for all clients. Other interventions included use of cough monitors to support screening, Chest X- Ray (CXR) screening (routine) for new and current PLHIV and provision of paid vouchers to eligible children and adults to receive CXR services, tracking the TB diagnostic cascade, timely GeneXpert commodities to ensure full time functionality, conducting collaborative activities with MoH/ACP/National TB Reference Laboratory (NTRL) and health facilities to improve TB screening, improving sputum sample transportation among others.



During 2020, the completion rates for TPT among PLHIV ranged from 90% in Jan-March, 100% in April-June, 92% in July- Sept and 97% in October-December. Multi Month Drug Refills for TPT, synchronizing TPT and ART refills, home delivery of drugs and integration of TPT in the various DSD models have played a big part in improving completion rates for TPT.



From 2016 to 2020, the proportion of TB patients on treatment that cured and completed treatment have steadily improved. The TSR improved for 41% in 2016to 70% in 2020 and the cure rate from 34% to 49%. Some of the interventions employed to improve these indicators included multi Month Drug Refills (2 months & 4 Months with sputum monitoring), the DOT DAT strategy in selected sites,

physical follow up of patients who interrupt TB treatment and continuous mentorship of health workers on sputum monitoring.

2.4 Social Support and Protection

2.4.1 HIV/AIDS and Culture

Cultural practices such as, widow inheritance, extended family relationships, witch craft using razor blades, administration of traditional medicine through sex to have children, cultural functions that gather many people together such as, last funeral rights, introductions, weddings, burial among others remain potential areas for contracting HIV. This calls for increased massive awareness to the community.

2.4.2 Rape, Defilement and Gender-Based Violence

Gender based violence arises from discrimination and oppression particularly against women and children but also experienced by some men. It includes physical and psychological injury due to domestic violence, assault, rape and defilement. There is growing evidence linking the epidemics of HIV and violence against women. Women in Mityana District are still vulnerable to sexual violence and other forms of abuse that predispose them to HIV infection. The situation has escalated more with emergence of COVID 19 pandemic where family members are confined at home.

Many women are denied the knowledge and tools to protect themselves from HIV therefore they hesitate to take HIV test or fail to return for their results because they are afraid of exposing their HIV positive status to their spouses. This particular fear has constrained the prevention of mother to child transmission of HIV in the district. The capacity to handle defilement is very limited and the police is ill equipped to be able to successfully investigate and charge the offenders before the courts of law. In most situations defilement cases are settled by LCs and elders with simple non deterrent fines to the offenders such as a goat and local brew, without treatment and psycho-social support to the victims.

2.4.3 OVC STATUS IN THE DISTRICT

Table 11: Orphan hood status for Children(Less than 18 years Old) by Sub County for the population

County/Sub county	All Children				Orphan Children		
	Orphans	Non-Orphans	Unknown	Total	Father Deceased	Mother Deceased	Both Parents Deceased
Busujju	7,984	40271	74	48,329	6,117	3,647	1,780
Butayunja	1,106	5531	10	6,647	833	519	46
Kakindu	1,947	8,738	28	10713	1,494	910	458
Maanyi	2,988	15,935	23	18,946	2,313	1,310	635
Malangala	**1,944**	**10,066**	**13**	**12,023**	**1,477**	**864**	**441**
Mityana	18898	94623	217	13738	14600	8,646	4,348
Bulera	1885	26011	61	30956	3,711	2,289	1,115
Kikandwa	2,316	10,931	23	13,270	1,771	1,098	553

Mityana Municipality	7641	37019	75	44735	5968	3446	1710
Ssekanyonyi	4056	20663	58	24777	3,150	1,812	906
Mityana	27156	134894	291	162,066	20718	12292	6128

Source: Population census and Housing census (2014)

Factors responsible for increasing OVC in Mityana district include but not limited to HIV/AIDS, COVID 19, Domestic violence, Occupation migration among fishing communities, Child sacrifice, High mortality rate among mothers, Unemployment among parents, Disabilities, Early marriages, Excess consumption of alcohol, Low awareness on child rights and responsibilities in the communities, Land wrangles and evictions, Lack of life skills leading to cross generation and transactional sex and low ability to cope up with challenging situation by adolescent OVC, Chronic illness to some caregivers and parents, and the rude reception by health workers that affects seeking medical treatment of OVC by caregivers.

2.4.4 Substance Abuse and HIV/AIDS

Alcohol use by men has been found to have a strong association with risky behaviour that predispose to HIV acquisition more especially among the youth. Alcohol and other substances create a situational factor increasing the likelihood of engaging into risky and unhealthy behaviours, clouding judgment and impairing an individual's ability to interpret issues. Some people drink so as to get the courage to approach their intended partner. This may result into improper condom use hence acquiring HIV.

Alcohol and other drugs of addiction pose a threat on the achievement so far made on HIV prevention, adherence to treatment. There is therefore need to prioritize this problem as an effort toward the prevention of HIV transmission.

2.4.5 **Increasing perversion in communities**

There is increasing perversion in communities such as multiple partners, homosexual, lesbians, transactional sex, trans-generation sex which increases the risk of HIV transmission and this requires a social behavioural management response.

2.5 Systems strengthening

2.5.1 Transport Facility for HIV/AIDS Services

Majority of the facilities offering these services lack transport means like motorcycles which is a major hindrance in the provision of HIV/AIDS related services. The outreaches, home visiting/home based care, follow up of PLHIV including positive mothers and their families require some reliable transport means. The impact of COVID 19 has greatly affected the movement of health workers and clients to provide or receive service respectively.

2.5.2 Staffing Situation

Although the general staffing situation in the health facilities has improved from 62% (FY 2014/15) to 71% (FY 2020/21) there are still notable gaps related to

HIV/AIDS treatment, care and support. Deficiency of counsellors, laboratory, Stores, Anaesthetic and pharmacy staff still poses a big challenge to the provision of treatment, care and support to PLHIV. The available staffs are equally affected by the COVID 19 since some of them and their family members have been infected and as well stretched by extra care needed and follow up. The current situation of the trained staffs that are capable of providing quality HIV/AIDS services is shown in the table 12.

Table 12: showing Staffing Levels

District & Facility level	No of Units	Unit Norm	Total Norms	Filled	Vacant	% Filled	% Vacant
DHO's Office	1	12	12	10	2	83	17
General Hospital	1	190	190	155	35	82	18
HCIV	3	49	147	122	25	83	17
HCIII	9	19	171	118	53	69	31
HCII	20	9	180	85	95	47	53
District Total	34	279	700	490	210	70	30

Source: District Health Office

The numbers are still inadequate to match the high demand for the services. New health workers have been recruited in the last financial year however; they will require basic training in counselling, comprehensive HIV/AIDS care, Paediatric ART, SMC and STI management. The laboratory staff will also require training in HIV testing techniques and EID to Strengthen Institutional Capacity to Manage the HIV/AIDS Response.

2.5.3 HIV/AIDS Financing

Financial resources remain a key input for HIV/AIDS response. The sources of financing mainly include; the central Government, District, partners and households through pocket contributions to individual clients. Much has been done and attained with the support given but a lot remains to be done .This strategic plan is therefore aimed at addressing the funding gaps in view of the binding constraints.

3.0 BEST PRACTICES, LESSONS AND OPPORTUNITIES

Working with PLHIV Networks in advocacy and scaling up services at facilities and community.

Family Support Groups and expert clients have helped in reduction of stigma and increased adherence and follow up on clients.

Motorcycle rider strengthened collection of PCR, CD4 and Viral load samples to the testing laboratory.

Coordination and mapping of CSOs has helped in enhancing equitable service delivery.

The demand and dissemination of HMIS data has helped in identification of performance gaps and decision making to address them accordingly.

Supervising of PLHIV networks with a component of socio-economic empowerment has sustained ART clients in care.

6.0 VISION, MISSION AND CORE VALUES

This strategic plan is guided by the following Vision, Mission and Goal.

6.1 Vision

A society free from HIV and AIDS and its effects

6.2 Mission:

To provide quality and accessible HIV and AIDS services through coordinated service delivery.

6.3 Goal

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

6.4 Core Values

Respect, professionalism, confidentiality, transparency, accountability, and team work

7.0 RESOURCE MOBILIZATION AND FINANCING

The sources of funds for this plan are anticipated to come from the central Government transfers, donations from Global Fund, USAID/PEPFAR/CDC, other AIDS Development Partners; local CSOs, local government revenue, private organizations and well wishers.

8.0 CO-ORDINATION AND IMPLEMENTATION ARRANGEMENTS

Coordination and implementation will be based on the existing leadership, governance and management structures of local government. The District HIV and AIDS coordination committee will take the leadership roles of ensuring effective coordination and implementation. The district HIV Focal Person will head the secretariat and work hand in hand with public and private service providers in implementation of the strategic plan.

9.0 THEMATIC AREAS, GOALS, STRATEGIC OBJECTIVES AND ACTIONS

9.1 Prevention

Strategic Objective 1: To Increase adoption of safer sexual behaviour and reduced risky behaviours

***Strategic Action 1.1*: Scale-up age- & audience-appropriate SBC interventions**

Activities:

- Disseminate age sensitive IEC/BCC messages & materials to the population groups using a dynamic mix of channels (Cultural institutions, Religious institutions and community leaders)

- Conduct HIV education for in and out-school youth with focus on multiple partnerships, cross-generational, transactional and early sex
- Expand provision of life skills communication training, peer networks development, & youth friendly Sexual Reproductive Health Rights (SRHR) information & linkages to services for in and out of school youth
- Engage community structures and networks in design, and scale up innovative HIV prevention programmes to improve comprehensive HIV knowledge, impart life skills, reduce high-risk sexual behaviors, address SGBV, and improve sexual and reproductive health statuses among in and out-of-school children and youth
- Implement school-based interventions for all adolescents addressing gender equality, prevention of violence & sexuality education
- Conduct radio talk shows to raise awareness and build community level capacity to change negative gender norms, beliefs and practice
- Hold Sensitization counseling sessions and linkage to SRHR services to all education institutions
- Positive parenting and guidance

***Strategic Action 1.2*: Procure& distribute adequate numbers of male and female condoms and expand condom distribution.**

Activities:

- Develop & operationalize the condom procurement &distribution plan
- Map out condom distribution points.
- Expand condom distribution outlets including dispensers in strategic places for accessibility
- Expand promotion, procurement and distribution of female condoms
- Monitor condom distribution outlets to ensure constant availability

***Strategic Action 1.3*: Scale-up condom education (emphasizing correct & consiste**nt **use) to address complacency & fatigue.**

Activities:

- Conduct radio talk shows on correct & consistent use
- Carry out campaigns on condom use in post primary schools and the community
- Provide IEC materials

***Strategic Action 1.4*: Scale-up comprehensive interventions targeting MARP**

Activities:

- Map MARPs and services coverage HIV prevention services
- Provide tailor made integrated services targeting MARPs
- Set up outreach & dedicated clinics for MARPs e.g. moonlight clinics
- Train service providers in managing MARPs and their special needs
- Train MARPs network members for mobilization, sensitization & delivery of quality services

***Strategic Action 1.5*: Scale-up adolescent targeted comprehensive SRH/HIV programs**

Activities:

- Provide tailored adolescent friendly services
- Incorporate sex education in open talks targeting adolescent boys and girls
- Promote creation of adolescent peer networks & establish youth friendly corners at all major HIV care service outlets in the public and private sectors
- Engage boys as peer leaders for SRHR services
- Educate communities about HIV/STIs co-infection, how to negotiate safe sex, & where to seek treatment
- Conduct STI & Cancer of the cervix screening & treatment at friendly facilities and community- based satellite clinics
- Train health educators & care providers to improve their skills of dealing with adolescent mothers and others newly experiencing changes with their bodies
- Provide peer to peer psycho-social support
- Conduct parenting/caregiver programs
- Provide Pre and post-Exposure Prophylaxis

***Strategic Action 1.6*: Support & implement family centred approaches to prevent HIV infection**

Activities:

- Sensitize on the use and provide condoms to married individuals living in discordant relationships
- Train front-line care providers; women, the elderly, and orphaned children in coping strategies
- Provide couple HIV Counseling and Testing
- Improve community-based referral systems to support individuals living with HIV
- Support the affected HHs to provide food security for PLHIV thru training in modern farming practices, & basic nutrition counseling & support

Strategic Objective 2: To scale-up coverage and utilization of biomedical HIV prevention interventions delivered as part of integrated health care services.

***Strategic Action 2.1:* Expand coverage and uptake of HCT, eMTCT, PreP, PEP and SMC services to optimal levels**

Activities:

- Open more service points and increase uptake for HCT, eMTCT, PreP, PEP and SMC services
- Offer HCT and STI prevention information and Treatment services for mothers attending the MCH clinics
- Increase G ANC in adolescent and other age specific mothers.
- Provide ARV drugs & cotrimoxazole to HIV positive pregnant & breastfeeding women according to recommended guidelines
- Provide ARV drugs & cotrimoxazole for prophylaxis to HIV exposed infants (< 6wks)

- Raise awareness and provide ARV drugs for PreP and PEP services and scale up to other facilities.
- Provide nutritional assessment & counseling support to HIV positive pregnant & breastfeeding mothers & the exposed babies
- Provide EID services for all infants born to HIV positive mothers
- Scale up quality SMC services in HC IV onwards, augmented with outreaches to all HC IIIs, and dedicated mobile SMC teams

***Strategic Action 2.2*: Scale up coverage of HCT targeting MARPs and MSM**

Activities:

- Create demand for HCT through community mobilization and education
- Lobby for recruitment, training & retention of counselors throughout the health care system
- Conduct refresher trainings on counseling skills and customer care for counselors and other health workers.
- Streamline the use of expert clients in facility & non-facility based HCT
- Promote establishment of post-test clubs
- Expand provider-initiated HCT, couple HCT as well as targeted community based outreach HCT (APN, Index testing, moon light testing)
- Awareness creation and strengthen HIV self-testing

***Strategic Action 2.3:* Enhance test & treat for pregnant women, HIV/TB co-infected, discordant couples, MSM, MARPs, &children<15 years**

Activities:

- Provide ART for all MARPs testing HIV positive
- Provide ART for all pregnant women testing HIV positive
- Provide ART for all HIV positive individuals in HIV discordant r/ships
- Expand service outlets for HIV prevention & commodity distribution targeting MARPs, pregnant women, adolescents & discordant couples
- Improve referral & follow-up for all priority populations (Pregnant mothers, Men Having Sex with Men (MSM), MARPs, women and girls, children, & discordant couples)

***Strategic Action 2.4:* Expand targeted STI interventions for MSM, MARPs & vulnerable groups**

Activities:

- Improve STI case management in HF targeting MARPs and MSM
- Re-orient providers & intensify support supervision & mentorship for all service providers for improved STI case management
- Screen all mothers attending ANC for syphilis & Treatment for all reactive
- Conduct STI & Cancer screening for MARPs attending HIV care clinics

***Strategic Action 2.5:* Strengthen capacity of health, legal & social service providers to manage SGBV cases**

Activities:

- Train nurses and doctors to screen for SGBV and provide comprehensive SGBV related services and Post Violence Care
- Engage community leaders and law enforcement personnel to reduce SGBV and support processes towards justice for victims of SGBV

Strategic Action 2.6: **Promote male involvement in HIV prevention for own health & that of partners & families**

Activities:

- Enhance male-friendly services & mentor fathers for mobilization
- Engage men in HIV, S&RH programs & also offer them services
- Establish training networks of men through the workplace
- Conduct community & school-based interventions for boys at an early age to adopt safer behavior
- Conduct grassroots based community dialogue meetings to develop positive& respectful attitudes & behaviors towards Women and Girls.
- Identify socialization/ leisure areas for male engagement.
-

Strategic Action 2.7**: Strengthen efforts against HIV stigma & discrimination**

Activities:

- Conduct community dialogues on HIV-related stigma & discrimination.
- Sensitize community leaders to speak against HIV-related stigma & discrimination
- Provide psychosocial support services for affected individuals through training service providers & communities in counseling
- Sensitization of the community about stigma & discrimination

Strategic Action 2.8: **Utilize community extension work programs in the socio-economic sectors to deliver HIV programs**

Activities:

- Engage community health workers to strengthen linkages between communities & facilities
- Advocate for affirmative action in development & livelihood programs for vulnerable population
- Equip & engage peers, community workers with skills, tools & commodities to promote uptake of HIV services, deliver stigma free prevention & referral for services

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

Strategic Action 3.1: Address socio-cultural & economic drivers

Activities:

- Engage the media, CSOs, and religious, cultural, and political institutions in the HIV prevention efforts
- Conduct activities that promote male involvement in HIV prevention for their own health and the health of their partners and families, and address gender and cultural norms that perpetuate inequality and GBV through innovative community peer engagement models.
- Train CSOs and service providers in management of SGBV cases, delivery of integrated youth-friendly HIV and SRH services.
- Sensitize the community through the mass media on the dangers of alcohol and drug abuse as risk factor for HIV acquisition and care.
- Integrate SGBV prevention into HIV prevention programming and mitigation services for HIV, SRHR and violence (psychosocial, SGBV and violence against children).
- Train service providers in the delivery of KP-friendly services, address stigma among health-care workers for the effective utilization of health facility-based services, and scale up peer-led community outreaches.
- Conduct activities aimed at reducing stigma and discrimination by enhancing the knowledge, attitudes/actions and accountability of various actors—such as community leaders, health workers, people living with HIV and family members.
- Conduct community dialogues on factors that hinder behavior change and uptake of HIV prevention services in the district
- Implement school-based interventions for all adolescents addressing gender equality, prevention of GBV & comprehensive sexual education
- Increase access to comprehensive targeted information & services for vulnerable populations and MARPs groups

Strategic Action 3.2: Strengthen legislative & p/framework for HIV prevention

Activities:

- Create awareness of existing laws & institutions that address SGBV
- Establish and /or build the capacity of existing community-based structures and networks to advocate for their rights.

Strategic Action 3.3: Strengthen capacity of health, legal & social service providers to manage SGBV cases

Activities:

- Train health workers in the district to screen for SGBV and provide comprehensive SGBV related services
- Train and engage community leaders and law enforcement personnel to reduce SGBV and support processes towards justice for victims of SGBV

9.2 Care And Treatment

Objectives:

1) To increase HIV individuals diagnosed and started on ARVs who adhere to regimen and are retained on treatment to 95% by 2025
2) To increase HIV positive clients who are put on ART and are virally suppressed to 95% by 2025.
3) To strengthen integration of HIV care and treatment within Health care programs (OIs, STIs, depression) by 2025.

Strategic Objective 1: To increase HIV individuals diagnosed and started on ARVs who adhere to regimen and are retained on treatment to 95% by 2025

Strategic Action1.1: **Strengthen mechanisms for linkage to care for all HIV positive individuals**

Activities

1) Orient HWs, VHT and expert clients on intra facility referral and linkage to community and other HIV service providers in the district.
2) Conduct PITC in high yield service points like inpatient wards, TB patients, YCC
3) Conduct targeted community testing for high-risk/high prevalence groups especially tea plantations, landing sites, truckers, etc. and timely linkage to care
4) Conduct support supervision and mentorship of HWs on the ART guidelines and Viral load monitoring

Strategic Action 2. Increase the number of diagnosed HIV-positive persons who start antiretroviral therapy.

- Scale up HIV care entry points for HIV-exposed infants, children, adolescents and men in the facility and community.
- Increase the number of ART-accredited sites, especially in the private sector.
- Integrate HIV (services for HIV, TB, and reproductive, maternal, newborn, child, and adolescent health), share information and establish effective referrals across different levels of the health system
- Provide daily ART services in ART clinics
- Use of COVID-19 sensitive mechanisms in delivery of ART and related medicines to individual clients in the community.
- Conduct patient education on ART at all entry points.

Strategic Action.3. Strengthen community health and peer-led platforms to identify, support and link people living with HIV (including KPs who remain undiagnosed) to care.

Activities

- Scale up the (**"identify, reach, test, treat, and retain**") approach at the community level, and pursue community engagement (including but not limited to schools, social/child protection and workplaces) using community "in-reach" and task-sharing approaches.

- Train community actors (including CSOs and networks of people living with HIV) to link newly identified people living with HIV to ART.

Strategic Action.4. Implement adolescent-friendly health services in the community and health facilities

- Implement the eight global standards for quality health-care services for adolescents.
- Train providers to treat adolescents and provide them with ongoing mentorship and supportive guidance.
- Improve facility infrastructure to provide adolescent and youth friendly services
- Support peer to peer activities to encourage age-appropriate disclosure.
- Implement psychological support
- Start differentiated service delivery for adolescents, including facility-based adolescent group refill, community-based adolescent group refill, longer refilling for adolescents in boarding school.

Strategic Action.5. Quality treatment and care for key populations and other vulnerable groups to realize their health-related rights.

- Training health-care providers (including health unit management committees) on gender and human rights, medical ethics and culturally appropriate services for KPs and other vulnerable groups who are underserved and encounter significant access barriers.
- Monitoring the levels of discrimination in health-care settings, including the experiences of health-service users and the attitudes and practices of service providers.
- Review and reform HIV service delivery to ensure that it provides meaningful participation and involvement for people living with HIV, key and affected populations, and community-based organizations.

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

Strategic Action 2.1. Optimizing and rolling out ARV treatment regimens, including consolidation of the DTG transition plan, to enhance viral suppression, tolerability and sustainability.

- Continue to implement the test-and-treat approach policy within the Consolidated Guidelines for Prevention and Treatment of HIV in Uganda.

- Support continuous quality improvement (viral load, testing, retention and intimate partner testing) should be intensified.
- Early diagnosis and effective linkages to treatment for those who test HIV-positive to maximize treatment outcomes.
- Coordinate networks of people living with HIV and peers of key and priority populations, and empower families to provide adherence support to people living with HIV who are receiving ART.
- Provide a clinical package for children and adolescents with advanced HIV disease.
- Monitor drug resistance for all groups, including hyperglycemia in stable patients transitioning to DTG.

Strategic Action 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.

- Continued support to community structures (e.g., champions or linkage facilitators/peer-led models) and systems for client tracing, care, linkage referral, adherence support and follow-up.
- Implement models for men, adolescents, young adults and children to support identification, linkage, initiation, retention and viral suppression.
- Scale up community drug distribution points linked to health facilities for stable patients.
- Conduct treatment literacy using expert clients, networks of people living with HIV, VHTs, community structures and community sensitization to reduce stigma and GBV.
- Integrate eHealth info HIV-related disease self-management and service delivery; especially using short message service (SMS) interventions to enhance ART adherence and other related medications to encourage paternal involvement.

Strategic Action 2.3. Scale up of a differentiated service delivery model

- Supervise and mentor staff to scale up and sustain differentiated service delivery model within district and health facility.
- Support facility and community structures for service delivery through working with expert clients, VHTs, peer networks and lay counsellors to support HIV status disclosure, adherence, retention (tracking missing clients) and viral suppression.
- Work with other Districts and Implementing Partners to support cross-border collaboration on HIV and TB epidemic control.
- Work with CSOs, community-based organizations and networks to scale up the implementation of the differentiated model of care and service delivery.

***Strategic Objective 2.3:* To increase HIV positive clients who are put on ART and are virally suppressed to 95% by 2025.**

Strategic Action 2.3.1. Strengthen efforts to improve quality of care and patient safety.

- Increase the voice of users and participation of people living with HIV in care.
- Train health workers in the management of second- and third-line ART regimens.
- Conduct drug resistance testing to optimize and provide third-line ART regimens.

Strategic Action 2.3.2. Scale up the implementation of person-centred monitoring during ART.

- Conduct HIV pharmacovigilance for the effectiveness and safety of ART.
- continue using unique identifiers while taking care of patient confidentiality.
- Conduct monitoring and evaluation of clinical complications and effects of long-term use of antiretroviral drugs.
- Carry out psychosocial services with enhanced ART adherence support for men, young adults, children, older people and PWD.
- Support treatment monitoring in communities and household level by working with peers/ expert clients, community health workers, networks and KPs.

Strategic Action 2.3.3. Provide a comprehensive care package for the management of co-morbidities and advanced HIV disease.

- Integrate HIV and TB programming services at all levels, including community directly observed treatment strategy, home-based care, intensified case detection and TB preventive therapy, especially pyridoxine and isoniazid for eligible HIV-positive people.
- Provide prevention and management services for opportunistic infection, STIs and ART wrap-around services in general outpatient and inpatient care.
- Integrate nutrition assessment, counselling and support in HIV care and treatment services, including linkages to increase food security and the use of ready-to-use therapeutic foods (RUTF) for the severely malnourished.
- Integrate the management of advanced HIV disease and co-morbidities such as mental illness, diabetes mellitus, hypertension, viral hepatitis, heart disease, and malignancies within HIV care and treatment service delivery, as appropriate for each level.
- Scale up implementation of the prevention and treatment of AIDS-related life-threatening opportunistic infections, including cryptococcal meningitis.
- Scale up cervical cancer screening, hepatitis B vaccination and treatment.
- Scale up effective pain management, palliative care and end-of-life care.

Strategic Action 2.3.4. Offer quality, efficient laboratory and diagnostic services, HIV viral load testing, and specimen referral, and expand testing services and develop the health workforce.

- Scale up POC especially CD4 cell count, EID and viral load testing to all HC IVs and 5 high volume HC IIIs.
- Optimize the diagnostic network, encompassing both lab-based and decentralized testing.
- Integrate diagnostic services with other diseases to create efficiencies.
- Scale up printing of viral load results to reduce turn-around time
- Develop comprehensive HIV testing and waste management system
- Procure and provide personal protective equipment (PPE) to health workers.
- Procure and provide sample transportation and referral packing materials
- Facilitate transportation of samples and results from the facilities to analysis centres.
- Integrate platforms to support viral load testing for HIV and hepatitis B and C, testing

Strategic Action 1.2 - Increase HIV care entry points for HIV exposed infants, children, adolescents and men within communities, police (social/child protection) units and workplaces

Activities

Mobiles and sensitise public on appropriate HIV care and treatment that is age and population specific

1) Conduct targeted health education talks on adherence
2) Establish and conduct targeted HTC outreaches to landing sites, plantations and 'hot spots' for CSWs
3) strengthen linkages between police and HFs on cases of sexual abuse receiving HIV testing

Strategic Action 1.3: Strengthen community level follow-up and treatment support mechanisms for pre-ART and ART individuals

Activities

1) Facilitate community resource persons(expert clients, peer mothers and VHTs) for enrolment and retention in care
2) Conduct nutrition assessment, counselling and support for pre-ART patients

3) Scale up tested treatment and care program models for MARPs and vulnerable children
4) Facilitate FSG monthly facility meetings with HWs
5) Train VHTs and other client community support groups in reporting on client referral, linkage and follow up
6) Facilitate HF with airtime and transport for patient follow up

Strategic Action 1.4 - Scale-up implementation of prevention and treatment of AIDS-related life threatening opportunistic infections including Cryptococcal meningitis.

Activities

1) Mentor HW on supply chain management for OI diagnosis and medications
2) Build capacity of HWs for management of OIs and non-communicable diseases such as cervical cancer

Strategic Objective2: ***To increase access to antiretroviral therapy from 60%to 90% by 2020 and sustain provision of long-term care for patients initiated on ART***

Strategic Action 2.1: Strengthen care and treatment referral within decentralized ART services with inclusion of community and home-based HIV treatment

Priority Activities

1) Build capacity of health care providers in ART delivery.
2) Strengthen facility and community linkages
3) Establish friendly HIV care and treatment services for key populations
4) Scale-up stigma reduction interventions to increase access to care and treatment
5) Conduct targeted HCT and ART outreaches to underserved communities (Banda and Namungo sub-counties).

Strategic Action 2.2: Expand and consolidate paediatric and adolescent ART in all accredited ART sites

Priority Activities

1) Integrate and support referral between PMTCT and HIV care and treatment services
2) Utilize technology including social media for education, recruitment and retention in care
3) Provide care givers with HIV education, literacy and empowerment on pediatric and adolescent ART

4) Integrate HIV care treatment into youth and adolescent friendly services
5) Conduct KP campaigns and activities at all ART sites
6) Support plat forms for HIV positive children in schools

Strategic Action 2.3: Supporting transitions between child-adolescent -adult care

Priority Activities

1) Train more health care providers in pediatric and adolescent care
2) Scale up integrated youth and adolescent friendly services
3) Build capacity for all accredited facilities to provide comprehensive pediatric, adolescent and adult HIV care and treatment

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

Strategic Action 3.1- Establish quality assurance and quality improvement activities at all HIV care and treatment sites

Priority Activities

1) Train more health service providers at all levels in quality improvement.
2) Implement quality improvement initiatives including EQA, IQA and documentation.
3) Conduct continuous quality assurance routine support supervision and client feedback to meet the needs of clients
4) Conduct periodical district-led QI learning sessions
5) Mentor HWs on provision of quality ART services(prescription practices, support mechanisms for patient retention and adherence) to prevent emergence of drug resistance to ARVs

Strategic Action 3.2: Implement integrated guidelines on community-based care, basic care package, linkages with social support structures, lost to follow up (LTFU) management and private sector care

Priority Activities

1) Provide integrated guidelines on community-based care, basic care package, linkages with social support structures, LTFU management to all HF
2) Implement periodic monitoring for adherence and disclosure
3) Disseminate and support the implementation of the guidelines in (1) above.
4) Strengthen the capacity of PLHIV networks (FSGs, Peer mothers and expert clients) to follow up and link PLHIV to social support structures

Strategic Action 3.3: Strengthen treatment monitoring and evaluation of clinical outcomes of long-term use of antiretroviral drugs and other medications

Priority Activities

1) Mentor Health service providers on viral load monitoring
2) Adopt the standardized national tools for tracking HIV patients active in care
3) Implement and rollout the IPT and TB Intensified Case Finding (ICF) guidelines
4) Train and mentor health care workers in the use of Gene -Xpert to enhance TB diagnosis
5) Support sample transportation and referral system in the District

Objective 4: To strengthen integration of HIV care and treatment within healthcare programmes

Strategic Action 4.1: Fully integrate HIV/TB programming and services at all levels including community DOTS and home-based care

Priority Activities

1) Orient health care workers on linkages and referral between TB and HIV, care and treatment services to ensure early diagnosis and initiation of HIV treatment among TB patients
2) Conduct monthly technical support supervision to TB diagnostic and treatment units
3) Enhance coordination of TB/HIV collaborative services at the HSDs by supporting HSD focal persons to do quarterly support supervisions
4) Integrate TB and ART services to create one-stop-centres
5) Build capacity of district and facility teams to conduct periodic TB infection risk assessments and monitor implementation of the TB infection control plan
6) Orient District coordination structures (DHT, DAC, SAC ...) in the TB/HIV collaboration
7) Train health workers on TB, TB/HIV and MDR TB
8) Conduct on-site training and mentorship of health care providers to implement Isoniazid Preventive Treatment(IPT), targeting all HIV care clinics for PLHIV and TB clinics for HIV negative children under five years of age, who are eligible;
9) Support sub-county healthworkers/VHTs in monitoring of TB patients on treatment

Strategic Action 4.2: Integrate HIV care and treatment with maternal, newborn and child health, sexual and reproductive health rights, mental health and non-communicable /chronic diseases

Priority Activities

1) Integrate HIV testing, care and treatment services into maternal, neonatal and child health settings and services

2) Train health care providers in screening and diagnosis of TB, Non Communicable Diseases, malnutrition and Opportunistic infections in HIV care services.
3) Scale up prevention interventions for TB, OIs and other co-morbidities, water and sanitation-related diseases, vaccinations for preventable diseases (cervical cancer, hepatitis, pneumococcal)
4) Train health service providers in long-term and short-term family planning methods
5) Integrate family planning services in HIV care and treatment service points

Strategic Action 4.3: Integrate nutrition assessment, counseling and support in HIV care and treatment services including use of Ready to use Therapeutic Food (RUTF) for severely malnourished, and linkages to increase food security.

Priority Activities

1) Build capacity of HW in nutritional screening, assessment and management
2) Integrate nutritional education, assessment and therapeutic support into HIV care and treatment
3) Provide nutrition assessment tools and equipment to health facilities
4) Integrate nutritional care and support for pregnant and lactating women and HIV-exposed children at ANC and childcare points
5) Provide nutrition commodities especially therapeutic foods
6) Mentor HWs in RUTF supply chain management including reporting

9.3 Social Support and Protection

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

Strategic Action1.1: Mobilize and strengthen cultural (including traditional healers) and religious institutions, community support systems and PLHIV Networks to address stigma

Activities:

- Hold community dialogue meetings with traditional and religious leaders about HIV prevention and stigma at district and sub county level

- Support formation of more PLHIV networks and strengthen existing ones to address discrimination and stigma.
- Training expert clients in counseling and guidance for PLHIV

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

Activities:

- Support formation of peer mothers clubs, family support groups, and PLHIV Networks
- Hold quarterly dialogue meetings to share experiences

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

Activities:

- Support formation of drama groups among PLHIV
- Hold quarterly meetings with teachers association, PTAs about HIV/ AIDS
- Conduct training for Head teachers, Administrators, In-charges and church leaders in stigma and discrimination
- Sensitization and dissemination of the HIV workplace policy among institutional managers.

1.4 Design and implement interventions to eliminate discrimination against women and girls, Youths, Key priority population, in the context of HIV and AIDS

Activities:

- Sensitization of above categorized groups on health and reproductive rights.
- Organize girls into peer led clubs in schools.
- Build capacity of local CSO's that raise awareness to change norms that promote stigma and discrimination among Communities.

Strategic Objective 2: To mainstream the needs of PLHIV, OVC and other vulnerable groups into livelihood, Education and poverty alleviation programs.

Strategic Action 1: Integrate PLHIV, OVC and other vulnerable groups' needs in the livelihood and poverty alleviation programs.

Activities:

- Involve PLHIV, OVC and other vulnerable groups in the district planning and implementation process

- Advocate and create awareness for gender and rights based HIV programming at sub county level and CSO interventions
- Monitor and assess on involvement of the PLHIV, OVC and other vulnerable groups.
- Reserve and allocate empowerment resources to vulnerable categories.

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

Activities:

- Update and harmonize the HIV/ AIDS , OVC, Service providers inventory,
- Monitor, support supervise CSOs and AIDS Support Organizations interventions
- Hold bi-annual stakeholders meeting with HIV and OVC service providers

Strategic Action 3: Integrate social support and protection issues in education sector programs (including school health and reading programs, PIASCY, curricular and extracurricular activities)

Activities:

- Train senior women / men and teachers to be able to handle the special needs of children living with HIV /AIDS in schools.
- Train pupils and students in life skills education.
- Sensitize pupils and students on adolescent reproductive health issues
- Provide sanitary information and commodities for the girl child in Schools.
- Sensitize school leadership committees (SMCs, PTAs & SSCs) to integrate HIV/AIDS in their programming.

Strategic Action 4: Implement targeted programmes that support PLHIV, OVC and other vulnerable groups to access livelihood opportunities, vocational skills training and informal education

Activities:

- Advocate and lobby for the enrollment of OVC's and Youth vocational and apprenticeship programs
- Support OVC and youth to enroll into vocational and apprenticeship programs such as start-up kits, bursaries, placements.
- Link vocational graduates possible service/ product consumers/ markets

Strategic Action 6: Expand social assistance grants to PLHIV, OVC and other most vulnerable persons

Activities:

- Facilitate Community Development officers to map OVC, PLHIV, Key priority population and other most vulnerable person's households in order to link them to services.
- Ensure preferential treatment is accorded to OVC in the district education bursary scheme
- Provide social assistance grants such as CDD, Special grant for PWDs, UWEP, YLP, SAGE, Myooga, PCA and Parish model to enhance their livelihoods.

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

Strategic Action 3.1: Develop and implement interventions to reduce the economic vulnerability of families and empower them to provide for the essential needs of children in their care

Activities:

- Train and support community structures to promote food production , processing technologies, storage, utilization and hygiene by PLHIV and affected households
- Train teachers, school nurses and matrons in psycho social support for OVC, children and teachers living with HIV AIDS.
- Mobilize and train, PLHIV, OVC and vulnerable persons households in the Village saving and loan association's (VSLA) approaches.
- Support and train PLHIV, OVC and vulnerable person's households in Income generating activities.
- Link PLHIV, OVC and vulnerable person's households markets for their products.

Strategic Action 3.1: **Develop and implement appropriate strategies to prevent and respond to, Gender Based Violence, child abuse and exploitation**

Activities:

- Establish Para-social workers network and child protection committees in all sub counties.
- Train Para-social workers in all sub counties in child protection, legal and policy frameworks
- Conduct community out reaches on child protection in all sub counties.
- Popularize the child abuse & GBV help lines.

- Conduct radio talk shows on GBV & child protection issues by involving all stake holders.
- Support probation office and CDO's to carry out social inquiries
- Support the legal structures(medical, police, Court and Probation office) to deliver on their social protection mandate.

Strategic Action 3.1: **Build and scale- up capacity for quality counselling services for PLHIV, OVC, key populations and other vulnerable groups**

Activities:

- Train Health workers level in provision of psychosocial support and counseling
- Train PHA Groups, family support groups, Maama groups, adolescent peer groups in peer to peer counseling.

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

Strategic Action 4.1: **Enhance capacity of all actors engaged in the HIV and AIDS district response to adopt gender and rights-based HIV programming**

Activities:

- Train Community Development Officer, heads of departments, district and Sub county leadership in gender, human rights and disability mainstreaming.
- Monitor and assess gender, human rights, HIV and disability programs implementation in the district.

Strategic Action 4.2: **Establish mechanisms for engaging men and boys in HIV and AIDS and SGBV programming**

Activities:

- Conduct community dialogue sessions and drama on SGBV in schools and public place like trading centers and markets
- Conduct community sensitization on the role of men and boys in HIV/AIDS and SGBV prevention.
- Hold community advocacy campaign targeting, political, cultural, religious leaders as resource persons for the SGBV campaign.
- Conduct stake holders Community outreach clinics on GBV.

9.4 System Strengthening

Health systems strengthening is critical in ensuring an effective and sustainable multi-sectoral HIV and AIDS service delivery system that ensures universal access

and coverage of quality, efficient and safe services to the targeted population by 2025.

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

Strategic Action1: **Disseminate and monitor implementation of existing and new legal and policy related instruments for reducing structural barriers to the district response.**

Activities

1.1 Develop and disseminate an inventory of existing laws, policies and guidelines on the multi-sectoral AIDS response to the HFs, DACs, SACs, and other stakeholder.

1.2 Monitor and evaluate the implementation of the existing laws, policies & guidelines for multi-sectoral HIV/AIDS response.

Strategic Action 2: **Strengthen the capacity of DAC, SAC and the partnership mechanism to carry out coordination of the multi sectoral response.**

Activities

1.1 Conduct regular quarterly stakeholder review and planning meetings for all the stakeholders implementing HIV/AIDs service.

1.2 Equip SACs and DACs with adequate knowledge and skills to carry out monitoring & evaluation activities of the response at all levels of the district.

1.3 Provide technical and financial/facilitation support to the DACs & SACs during their quarterly review meetings.

Strategic Action 3: **Support the public and civil society sector coordinating structures to carry out their roles including gender to function better with improved linkages, networking and collaboration within the district**.

Activities

3.1 Develop and disseminate an inventory for all public and non-public HIV/AIDS service providers in the district.

3.2 Update the mapping of programs and stakeholders engaged in implementation of the District HIV strategic plan.

3.3 Support Lower Local Governments to enforce laws, national policies, standard procedures and guidelines on HIV/AIDS services.

3.4 Conduct regular stakeholder feedback meetings targeting CSOs, local leaders

Strategic Action 4: **Enhance multi-sectorial planning at the district and sub counties with emphasis on target setting based on disease burden and continuum of response by geographical locations, facilities/institutions and key populations**

Activities

4.1 Integration of HIV/ AIDS including gender into sectoral Annual work plans.

4.2 Develop and Support the development of a consolidated annual operational plan and budget for HIV/AIDS service delivery.

4.3 Build the human resource capacity at the district and HSD level in intensive data analysis, interpretation and presentation on HIV/AIDs indicators.

4.4 Conduct integrated multi-sectoral support supervision for HIV activities.

4.5 Conduct exchange visits to roll model Districts to share experience on HIV/AIDS management.

Strategic Action 5: **Ensure that gender, disability and human rights are mainstreamed in HIV/AIDS programmes in public and civil society sectors.**

5.1 Provide gender, disability, and HIV/AIDS mainstreaming guidelines to the public and non-public sector for inclusion in all programs.

5.2 Advocate for human and patient rights at all levels of service delivery through radio talk shows, drama and meetings such as LC meetings.

5.3 Monitor the implementation of the workplace HIV/AIDS policies in public and non-public sector

5.4 Sensitize and equip the local Institutions, public and non-public sector, Statutory bodies, and Civil Society Organizations on HIV /AIDS mainstreaming

5.5 Develop, disseminate and monitor utilization of self-assessment framework on HIV/AIDS mainstreaming

5.6 Come up with tools that have a disaggregation on disability

5.7 Orient the DHT and Health Facility in charges on financial and human resource management

Strategic Objective 5.2 To ensure availability of adequate human resource for delivery of quality HIV and AIDS services

Strategic Action 1: Build capacity of different cadres for HIV/ AIDS service provision

Activities

2.1.1 Carry out in service training for all critical cadres in HIV/AIDS service provision.

2.1.2 Conduct leadership and management training for health facility staff.

2.1.3 Conduct technical support supervision and mentorship to staffs.

2.1.4 Scale up Continuous Professional Development in the facilities.

2.1.5 Conduct recruitment, orientation and retention of HIV/AIDS service providers

2.1.6 Provide & disseminate Standard Operating Procedures to all facilities

***Strategic Action 2:* Promote the implementation of the public private partnership (PPP) in the delivery of HIV and AIDS services**

2.1.7 Design and implement an effective feedback mechanism for PPP policy in the delivery of HIV/AIDs services.

2.1.8 Disseminate and implement the operationalization of the public-Private Partnership Policy

2.1.9 Monitor the implementation process of the PPP policy

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

Strategic Action *1:* Establish proper mechanisms for Quantification and Procurement Planning, capacity building in procurement and management of products, goods and supplies, particularly at health facility level.

Activities

3.1.1 Conduct training of in charges and stores assistants in procurement and management of health products and medical supplies.

3.1.2 Rejuvenate and train therapeutic and medical supplies committees in the health facilities.

3.1.3 Provide appropriate procurement tools for timely and efficient forecasting, quantification and periodic HIV/AIDS logistics supply.

3.1.4 Train the DHT, facility and Stores in charges in forecasting, logistics management, procurement and disposal of health goods and services

3.1.5 Conduct regular and timely procurement of HIV/AIDs related commodities

3.1.6 Conduct HIV commodity management and supply chains monitoring and supervision

***Strategic Action 2:* Standardize the Logistics Management Information System and build the requisite capacity in ICT and logistics management**

Activities

3.2.1 Train health facility staff in logistics management to improve data for logistics in the district.

3.2.2 Develop a robust Logistics Management

3.2.3 Conduct Procurement of computers and other necessary infrastructure and equipment for ICT and logistics management in order to operationalise logistic management Information System.

3.2.4 Train the DHT, facility and Stores in charges in ICT and logistics management.

3.2.5 Conduct VHT training to roll out the community health management information system.

3.2.6 Expand the Web Based Ordering Systems (WAOs) currently only for ARVs to include coverage for all HC IIIs.

3.2.7 Support the implementation of weekly Real-time ARV Stock status (RASS)

Strategic Action 3: **Implement the national comprehensive policy on storage, distribution of health commodities and supplies and waste management in public and non-public facilities**

Activities

3.2.8 Conduct remodelling and renovation of storage facilities in the health facilities

3.2.9 Train Health workers on infection control and medical waste management at facility levels

3.2.10 Construct more incinerators for medical waste management to all HC IIIs

Strategic Objective 4: To ensure coordination and access to quality HIV and AIDS services

Strategic Action 1: **Promote integration of HIV and AIDS services in all settings and in major development programme service delivery**

Activities

4.1.1 Train stakeholders in HIV /AIDS mainstreaming

4.1.2 Provide technical support in integration of HIV / AIDS in departmental projects

4.1.3 Monitor and evaluate the integration of HIV/AIDs services in all departmental projects.

Strategic Action 2: **Build strong linkages between institutionalized facilities and community systems and ensure an effective referral system, greater adherence to treatment and improved monitoring of service delivery**

Activities

4.2.1Conduct training of CSOs, CBOs, FBOs, PLWHAs providers to strengthen linkages and referral systems to enhance availability, referral, access, utilization and quality of HIV/AIDs related services

4.2.2 Train VHTs and other grassroots structures including those of PLHIV for enhancing referrals and treatment adherence.

Strategic Action 3: **Promote greater coordination, linkage, partnership and collaboration among public and non-public sectors**

Activities

4.3.1 Carry out advocacy for memorandum of understanding between public and non-public institutions

4.3.2 Conduct community dialogues and meetings with active engagement of service providers, NGOs and CSOs

4.3.3 Support formation and orientation of Health Unit Management Committees

Strategic Action 4: **Strengthen capacity of CSOs and communities for increased advocacy and mobilization for demand and uptake of services, social participation, self-regulation and accountability in the multi-sectoral response.**

4.4.1 Train community structures i.e. VHTs, Health unit management committees, community leaders, etc in mobilization skills.

4.4.2 Conduct selection and training of VHTs to scale up the VHT coverage in the district to strengthen community linkage and referral systems.

4.4.3 Enhance the capacity of Civil Society to hold duty bearers responsible to the ordinary citizens to participate in demanding for accountability.

4.4.4 Conduct quarterly review meetings with CSOs and VHTs to share experiences

Strategic Action 5.1: Scale-up rehabilitation and building of new health and non-health infrastructure as well as improving management and maintenance of infrastructure

Priority Activities

5.1 Carry out rehabilitation and maintenance of the physical infrastructure, equipment and transport for provision of HIV/AIDS

5.2 Carry out infrastructure development to cater for the needs of MARPs and MSM including youth, PWDs, and the elderly related activities by the public sector

5.3 Plan and monitor the utilization and maintenance of the existence and new infrastructure, equipment, transport and supplies for HIV/AIDs related services.

5.4 Provide basic utilities at the health facilities i. e water, electricity, e .t. c

5.5 Develop a district monitoring frame work for storage and distribution of HIV/AIDS related commodities including those provided by donors.

***Strategic Action* 5.2 Expand availability and capacity of laboratories at different levels for delivery of HIV /AIDS services**

Activities

5.2.1 Review, disseminate and monitor the implementation of policies, procedures, laboratory protocols and Standard Operating Procedures by the health facility laboratories

5.2.2 Ensure timely ordering through Web-based and delivery of laboratory re-agents/commodities necessary for provision of HIV/AIDs related diagnostic services.

5.2.3 Train laboratory staff in the health facilities to provide quality HIV/AIDS diagnostic services, Bio-safety and Bio-security, Laboratory SPARS

5.2.4 Conduct laboratory targeted support supervision and monitoring to strengthen effective networking and diagnosis for ART and other HIV/AIDS related diagnostic services.

5.2. 4 Reduce turnaround time for results and feedback

5.2.5 Conduct regular maintenance of laboratory equipment for functional HIV/AIDS diagnostic services.

***Strategic Action 5.3:* Increase Accreditation of HC IIIs and HC IIs to provide comprehensive HIV/AIDS and TB services.**

Activities

5.3.1 Carry out HIV/AIDs integrated outreaches to high risk groups and underserved areas

5.3.2 Scale up comprehensive HIV / AIDS service provision to HC-III's and HC-IIs.

5.3.3 Conduct remodelling of facilities to enhance provision of services to special groups such as the youth, MARPS, disabled and elderly who may be affected.

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

***Strategic Action*6.1: Develop and disseminate appropriate tools for enhancing planning and resource allocation based on disease burdens at district/facility levels.**

Activities

6.1.1 Develop and disseminate the tools for resources allocation

6.1.2 Train district and health facility in charges in planning for HIV/AIDS service delivery

***Strategic Action6.2*: Develop and review the district budgeting tools to facilitate budgeting process and mainstreaming HIV/AIDS in the departmental and lower local government work plans.**

Activities

6.2.1 Prepare and provide the necessary data for enhancing planning for HIV/AIDS services at the lower local governments and health facilities

6.2.2 Scale up the participation of HIV/AIDS focal point persons in support of planning and budgeting for HIV/AIDS services at the lower local governments and health facilities

6.2.3 Integrate HIV/AIDS services into the health facility routine activities.

***Strategic Action* 6.3: Strengthen capacity of stakeholders at the district and community levels on resource mobilisation for HIV/AIDS services**.

6.3.1 Increase public awareness and accountability by sharing information about funds for HIV/AIDS at district and community levels via newspapers, radios, community notice boards and meetings

6.3.2 Enhance the capacity of the DACs and SACs to harmonise funding for HIV/AIDS services

6.3.3 Provide support to health facilities and other sectors to allocate funds for HIV/AIDS services.

***Strategic Action 7:* Support HIV/AIDS information management Systems**

Activities

- Conduct data collection, analysis and reporting
- Conduct Data Quality Assurance through mentorship and support supervisions
- Train/mentor Health workers on the use of HMIS tools
- Conduct data reviews and sharing through meetings

9.5 System Strengthening: Monitoring, Evaluation and Research

MONITORING AND EVALUATION MATRIX						
Outcomes	**Indicators**	**Baseline**	**Target**	Data Source	Frequency of collection	Responsible Person
Overall Goal:Increase productivity, inclusiveness and well-being of the population by ending HIV and AIDS as an epidemic by 2030						
Prevention: **Sub goal 1-To reduce the number of youth and adult HIV infections by 65% and pediatric HIV infections by 95% by 2021**						
1.1 Increased adoption of safer sexual behaviors and reduction in risky behaviors	Number of condoms dispensed per quarter	75000 000	150000 000	Stock cards	Quarterly	Condom Focal Person
	Number of males circumcised	500	600	HMIS reports	Monthly	Biostatistician
	Number of males and females who have abstained from sex by the age of 15 -24	20000	47,314	Survey Reports	Yearly	DHO
1.2 Increased coverage and utilization of biomedical HIV prevention interventions delivered as part of integrated health care services	Number of women and men (15-49 years) who tested for HIV in the last 12 months and know their results	10205	50000	HMIS reports	Monthly	Biostatistician
	Number of HIV exposed Infants	922	100%	HMIS reports	Monthly	Biostatistician

	receiving Niverapine Syrup					
	Percentage of infants born to HIV positive women receiving a virological test for HIV below 18 months of birth. **	95%	100%	HMIS reports	Monthly	Biostatistician
1.3 Underlying socio-cultural, gender and other structural factors that drive the HIV epidemic addressed	Number of women (15-49 years) who experience sexual and gender-based violence	**40**	**20**	HMIS reports	Monthly	Biostatistician
Care and treatment Outcomes and Indicators **Sub-Goal 2: To reduce AIDS-related morbidity and mortality by 2025**						
Outcomes	**Indicators**	**Baseline**	**Target**			
2.1 Increased linkage to ART to 95% by 2025	Number of Adults and Children enrolled in HIV care services	1858	500	HMIS reports	Monthly	Biostatistician
	Number of adults and children with HIV active on ART	17346	180000	HMIS reports	Monthly	Biostatistician

2.2 Increased ART retention rates to 95% by 2025	Number of estimated HIV-positive incident TB cases receiving both TB and HIV treatment	84	130	HMIS reports	Monthly	Biostatistician
	Percentage of people with diagnosed HIV infection on Isoniazid Preventive Therapy (IPT)	45%	100%	HMIS reports	Monthly	Biostatistician
2.3 Adherence on ART increased to 95% by 2025	Percenatge of clients with good adherence	65%	100%	HMIS reports	Monthly	Biostatistician
Social support and protection outcomes and indicators **Sub-Goal 3: 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, KPs and other vulnerable groups**						
3.1 Stigma and discrimination minimized		TBD	95%			
3.2 Reduced socio-economic vulnerability for PLHIV and other vulnerable groups programs.		37.90 %	90%			
3.3 Reduced gender-based violence/discrimination vulnerable groups		40	10	HMIS reports	Monthly	Biostatistician

developed and implemented						
Systems Strengthening Sub-Goal 4: A resilient multisectoral HIV and AIDS service delivery system that ensures sustainable access of efficientand safe services to all the targeted population						
Outcomes	**Indicators**	**Baseline**	**Target**			
4.1 Governance and leadership of the multi-sectoral HIV and AIDS response strengthened at all levels	4.1.1 Percentage of health facilities with the required staffing levels	75%	100%			
4.2 Ensured availability of adequate human resources for the delivery of quality HIV services						
4.3 Stock-outs of medicines and supplies in health facilities reduced	Number of facilities makingtimely orders					
	Number of drug deliveries made annualy	6	6			
4.4 Health infrastructure responsive to HIV service needs	Number of facilities offering ART services in the district	23	26			
4.5 Community systems strengthened	4.5.1 Percentage of HIV and AIDS funding	GoU: 11% ADPs: 89% (NASA	GoU:40%			

	from GOU	2012)				
4.6 Resources for HIV and AIDS mobilized and management streamlined for efficient utilization and accountability						
4.6 National mechanism for generating comprehensive, quality and timely HIV and AIDS information for monitoring and evaluation						
4.7 Information sharing and utilization among producers and users of HIV and AIDS data and information improved at all levels						

LIST OF REFERENCES

1. National Strategic Plan 2020/21 – 2024/25
2. District Strategic Plan (DSP) 2015 – 2020
3. HMIS/DHIS2 2020 – 2021
4. District 5 year Development Plan
5. District OVC Strategic Plan

Annex

Status of HIV services

HIV/AIDS service delivery mapping (Combination HIV Prevention Interventions)

COUNTY (HSD)	SUB-COUNTY	PARISH	HEALTH UNIT	OWNER	HC LEVEL	*Accreditation status*	*PMTCT*	*VMMC*	*HCT*	*ART*	*Condom promotion/distribution*	*STI screening and treatment (routine)*	*HIV testing and counselling specific to PEP*
Mityana North	Kikandwa	Kikandwa	Kikandwa	Govt	III	√	√	X	√	√	√	√	√
	Kalangaalo	Kiryokya	Kyantungo	Govt	IV	√	√	√	√	√	√	√	√
		Kyamusisi	Kyamusisi	Govt	III	√	√	X	√	√	√	√	√
	Bulera	Bulera	Bulera	Govt	III	√	√	X	√	√	√	√	√
		Namutamba	Namutamba	PNFP	III	√	√	X	√	√	√	√	√
Mityana South	Ssekanyonyi	Ssekanyonyi	Ssekanyonyi	Govt	IV	√	√	X	√	√	√	√	√
		Busunju	St. Padre Pio	Govt	III	√	√	X	√	√	√	√	√
	Mityana Municipal Council	Kabule	Kabule	Govt	III	√	√	X	√	√	√	√	√
		Naama	Naama	Govt	III	√	√	X	√	√	√	√	√
		Nakibanga	Lulagala	Govt	III	√	√	X	√	√	√	√	√
		Central ward	Mityana Hospital	Govt	Hosp	√	√	√	√	√	√	√	√
			St. Francis	PNFP	IV	√	√	X	√	√	√	√	√
			Mityana UMSC	PNFP	III	√	√	X	√	√	√	√	√
		East ward	St. Luke Kiyinda	PNFP	III	√	√	X	√	√	√	√	√
		South ward	Magala	Govt	III	√	√	X	√	√	√	√	√
	Namungo	Namungo	Namungo	Govt	II			X					
Busujju	Maanyi	Kivuuvu	Maanyi	Govt	III	√	√	X	√	√	√	√	√
		Serinya	Kambaala	PNFP	III	√	√	X	√	√	√	√	√
	Bbanda		Mpongo	Govt	III			X	X	X	X	X	X
	Butayunja	Kitongo	Kitongo	Govt	III	√	√	X	√	√	√	√	√
		Kitongo	Cardinal Nsubuga	PNFP	III	√	√	X	√	√	√	√	√
	Malangala	Kiwawu	Malangala	Govt	III	√	√	X	√	√	√	√	√
		Zigoti	St. Jacinta	PNFP	III	√	√	X	√	√	√	√	√
	Kakindu	Mwera	Mwera	Govt	III	√	√	√	√	√	√	√	√
		Ngugulo	Mayirye	PNFP	III	√	√	X	√	√	√	√	√

MITYANA DISTRICT HIV STRATEGIC PLAN – 5 YEAR IMPLEMENTATION WORK PLAN

No	Activity	Output indicator	Target	Time Frame in years					Budget ('000)	Resp. person/institution	Assumption
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
1.0	**PREVENTION**										
	Strategic Objective 1.1: To Increase adoption of safer sexual behaviour and reduced risky behaviours										
	***Strategic Action 1. 1.1*: Scale-up age- & audience-appropriate SBC interventions**										
1.1.1.1	Disseminate IEC/BCC materials to the population groups using a dynamic mix of channels	# HFs with IEC materials	26 facilities	30,000	0	0	0	0	30,000	DHE	To be implemented in year 1
1.1.1.2	Conduct HIV education for in and out-school youth with focus on multiple partnerships, cross-generational, transactional and early sex.	# of HE sessions conducted	120	10,000	10,200	10,250	11,500	11750	**53,700**	HIV FP	Schools adhere
1.1.1.3	Expand provision of life skills communication training, peer networks development, & youth friendly Sexual Reproductive Health Rights (SRHR) information & linkages to services for in and out of school youth	# Peer educators trained	300 peer educators	50,010	52,510	55,136	0	0	**157,656**	DHO	To be implemented in three years
1.1.1.4	Implement school-based interventions for all adolescents addressing gender equality, prevention of violence & sexuality education	# of schools reached with school based interventions addressing gender equality, prevention of violence & sexuality education	40 secondary schools targeted	29,120	30,576	32,104	33,710	35,395	160,906	DHO	Schools adhere

No	Activity	Output indicator	Target	Time Frame in years					Budget ('000)	Resp. person/institution	Assumption
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
1.1.1.5	Conduct radio talk shows to raise awareness and build community level capacity to change negative gender norms, beliefs and practice	# of radio talk shows conducted	60 radio talk shows	18,000	36,000	37,800	39,690	0	**131,490**	DCDO	Funds are available
1.1.1.6	Hold Sensitization counselling sessions and linkage to SRHR services to all education institutions	# of schools reached with SRHR services	320	0	0	0	0	0	**0**	HIV FP	No cost-to be integrated with other activities
	***Strategic Action 1.1.2*: Procure & distribute adequate numbers of male and female condoms and expand condom distribution**										
1.1.2.1	Map out condom distribution points.	# of S/Cs reached	12	1,398	0	0	0	0	**1,398**	Condom FP	Implementation to be in year1
1.1.2.2	Expand condom distribution outlets including dispensers in accessibility places to ease accessibility	# of condom distribution outlets established	150	0	8,012	8,412	0	0	**16,424**	Condom FP	Implementation to be in year 2 &3
1.1.2.3	Procurement and distribution of female condoms	# of female condoms procured and distributed	2,000,000	0	0	0	0	0	**0**	DHO	Hope to get donations
1.1.2.4	Monitor condom distribution outlets to ensure constant distribution	# of condom distribution outlets reached	200	0	2,048	2,150	2,257	2,370	**88,127**	Condom FP	Implementation to be in 4 years
	***Strategic Action 1.1.3*: Scale-up condom education (emphasizing correct & consistent use) to address complacency & fatigue.**										
1.1.3.1	Conduct radio talk shows on correct & consistent use	# of radio talk shows conducted	60	5,520	5,796	6,085	6,390	6,709	**30,501**	Condom FP	Will be conducted per year
1.1.3.2	Carry out campaigns on ABC strategy in Secondary schools / post primary schools	# of schools reached with campaigns on condom use	50	0	11,184	11,743	0	0	**22,927**	Condom FP	Schools comply
1.1.3.3	Provide IEC materials	# of facilities provided with IEC materials	59	0	0	0	0	0	**0**	DHE	To be integrated in activity 1.1.1.1

No	Activity	Output indicator	Target	Time Frame in years					Budget ('000)	Resp. person/institution	Assumption
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
	***Strategic Action 1.1.4*: Scale-up comprehensive interventions targeting MARPs**										
1.1.4.1	Map MARPs and services covering HIV prevention services	# of service providers mapped	12 sub counties	1,950	0	0	0	0	**1,950**	HIV FP	Service providers cooperate
1.1.4.2	Provide tailor made integrated services targeting MARPs	# sub counties provided with integrated services targeting MARPs	12 sub counties	0	0	0	0	0	**0**	HIV FP	To be integrated with other activities
1.1.4.3	Set up outreach & dedicated clinics for MARPs e.g. moonlight clinics	# of targeted outreaches conducted	240	0	7,450	7,822	8,213	8,624	**32,110**	DLFP	Funds are available
1.1.4.4	Train service providers in managing MARPs and their special needs	# of service providers trained	40	0	17,820	0	0	0	**17,820**	DHO	Through partners in year 2
1.1.4.5	Train MARPS network members for mobilization, sensitization & delivery of quality services	# of MARPs network members trained	40	0	6,470	6,793	0	0	**13,263**	DHO	
1.1.4.6	Lobby for recruitment, training & retention of more counsellors and health workers throughout the health care system	# of counsellors recruited and retained	65	80,641	84,673	0	0	0	**165,314**	DHO	
1.1.4.7	Facilitate expert clients in facility & non facility based HCT to mobilise the communities. (2 expert clients will be attached to a facility and facilitated monthly with 100,000/=)	# of expert clients facilitated	50	0	60,000	60,000	0	0	**12,000**	DLFP	
1.1.4.8	Promote establishment of post-test clubs. (Each high volume treatment site will	# of post-test clubs established	18	0	10,800	11,340	11,907	12,502	**46,549**	HIV FP	

No	Activity	Output indicator	Target	Time Frame in years					Budget ('000)	Resp. person/instituti on	Assumption
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
	have at least a post-test club. The clubs will be facilitated with a monthly refreshment of 50,000 during their meeting.										
	***Strategic Action 1.1.5*: Scale-up adolescent targeted comprehensive SRH/HIV programs**										
1.1.5.1	Provide tailored adolescent friendly services. (The district will procure and distribute indoor games & TV sets to each high volume facility)	# of health facilities with adolescent friendly services	15	0	12,000	12,600	0	0	**24,600**	HIV FP	To be integrated with other services
1.1.5.2	Incorporate sex education in open talks targeting adolescent boys and girls	# of open talks targeting adolescent boys and girls having sex education incorporated	250	0	7,000	87,350	7,717	0	**22,067**	HE	To be implemented in 4 years' time
1.1.5.3	Promote creation of adolescent peer networks and establish youth friendly corners at all major HIV care service outlets in the public and private sectors.	# of sub counties with peer networks	12	0	10,000	0	0	0	**10,000**	DHO	To be implemented in year 2 only
1.1.5.4	Engage boys as peer leaders for SRHR services	# of sub counties with boys as peer leaders in SRHR	12	7,506	0	0	0	0	7,506	RH FP	To be implemented in year 1
1.1.5.5	Integration of services: HCT,ANC,eMTCT to the in and out of school adolescents	# of adolescents reached with adolescent friendly	600	0	0	0	0	0	**No cost**	eMTCT FP	To be integrated in routine activities

No	Activity	Output indicator	Target	Time Frame in years					Budget ('000)	Resp. person/institution	Assumption
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
		services									
1.1.5.6	Educate communities about HIV/STIs co-infections, how to negotiate safer sex,& where to seek treatment	# of sub counties reached with education on HIV/STIs co-infection, how to negotiate safe sex, & where to seek treatment	14	0	10,000	10,500	0	0	**20,500**	DHO	Funds are available
1.1.5.7	Train health workers on STI & cancer screening and treatment	# of health workers trained in cancer screening & treatment	210	29,935	31,431	33,003	0	0	94,370	DHO	Train 7 0 people per year
1.1.5.8	Conduct STI & cancer screening & treatment at health facilities and community based satellite clinics	# of health facilities & clinics equipped with reagents for cancer screening	22	0	0	0	0	0	**No cost**	RH FP	To be integrated with other activities
1.1.5.9	Promote parenting & care giver programs	# of sub counties reached with parenting programs	14	0	7,000	7,350	7,717	8,103	**30,170**	RH FP	
1.1.5.10	Promote Pre- Exposure Prophylaxis (PEP) services in several facilities	# of facilities with Pre-Exposure Prophylaxis services	20	0	0	0	0		**No cost**	HIV FP	PEP is available all the time
	***Strategic Action 1.1.6*:Support & implement family centered approaches to prevent HIV infection**										
1.1.6.1	Provide and promote	# of condoms	1000	0	0	0	0	0	**No cost**	Condom FP	Donations from

No	Activity	Output indicator	Target	Time Frame in years					Budget ('000)	Resp. person/institution	Assumption
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
	condom use among married individuals living in discordant relationships	distributed									funders
1.1.6.2	Train front-line care providers; women, the elderly, and orphaned children in coping strategies	# of front-line care providers trained	70	0	29,935	31,431	0	0	**61,366**	DCDO	To be implemented in two years' time
1.1.6.3	Promote couple HIV Counselling and Testing through local radios and community gatherings.	# of radio talk shows conducted	60	18,000	18,900	19,845	20,837	21,879	**120,298**	HIV FP	Funds are available
1.1.6.4	Improve community based referral systems to support positive living	# of health facilities with proper community referral systems	65	12,900	13,545	14,222	14,933	15,680	**86,214**	HIV FP	Funds are available
1.1.6.5	Train HHs of PLHIV in modern farming practices, & basic nutrition counselling& support to provide food security for PLHIV	# of HH of PLHIV trained in modern farming practices, & basic nutrition counselling & support to provide food security for PLHIV	100	0	0	60,000	0	0	30,000	ADHO	To be implemented in one year-year 3
Strategic Objective 1. 2: To scale-up coverage and utilization of biomedical HIV prevention interventions delivered as part of integrated health care services. ***Strategic Action 1. 2.1:*** **Expand coverage and uptake of HTC, eMTCT and SMC services to optimal levels**											
1.2.1.1	Expand coverage and uptake of HCT, eMTCT and SMC services in all sub counties through community dialogues,	# of community dialogues , sensitization meetings conducted	12	9,960	10,458	10,980	11,529	12,106	**55,035**	HIV FP	Funds are available

No	Activity	Output indicator	Target	Time Frame in years					Budget ('000)	Resp. person/institution	Assumption
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
1.2.1.2	Offer HCT and STI prevention information and Treatment services for mothers attending the MCH clinics	% of mothers attending ANC receive HCT and STI prevention information and Treatment information	100%	0	0	0	0	0	**No cost**	eMTCT FP	To be integrated with other activities
1.2.1.3	Provide ARV drugs & cotrimoxazole to HIV positive pregnant & breastfeeding women according to recommended guidelines	% of HIV positive pregnant & breastfeeding women initiated on ART	100%	0	0	0	0	0	**No cost**	eMTCT FP	To be integrated with other activities
1.2.1.4	Provide ARV drugs & cotrimoxazole for prophylaxis to HIV exposed infants (< 6wks)	% of exposed infants (< 6wks)received ARV drugs &cotrimoxazole for prophylaxis	100%	0	0	0	0	0	**No cost**	eMTCT FP	To be integrated with other activities
1.2.1.5	Provide nutritional assessment & counselling support to HIV positive pregnant & breastfeeding mothers & the exposed babies	%ge of HIV positive pregnant & breastfeeding mothers & the exposed babies provided with nutritional assessment & counselling support	95%	0	0	0	0	0	**No cost**	eMTCT FP	To be integrated with other activities
1.2.1.6	Provide EID services for all infants born to HIV positive	% ge of infants born to HIV	100%	0	0	0	0	0	**No cost**	eMTCT FP	To be integrated with

No	Activity	Output indicator	Target	Time Frame in years					Budget ('000)	Resp. person/institution	Assumption
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
	mothers	positive mothers provided with EID services									other activities
1.2.1.7	Scale up quality SMC services in HC IV onwards, augmented with outreaches to all HC IIIs, and dedicated mobile SMC teams	# of facilities offering SMC services	5	10,000	10,000	10,000	10,000	10,000	**50,000**	SMC FP	Funds are available
	Strategic Action 1.2.2: **Enhance test & treat for pregnant women, HIV/TB co-infected, discordant couples, MARPs, &children<15 years**										
1.2.2.1	Provide ART for all MARPs testing HIV positive	%ge of MARPs testing HIV positive provided ART	80%							HIV FP	Mild may cost
1.2.2.2	Provide ART for all pregnant women testing HIV positive	%ge of pregnant women testing HIV positive provided ART	90%	0	0	0	0	0	**No cost**	eMTCT FP	Mild may cost
1.2.2.3	Provide ART for all HIV positive individuals in HIV discordant r/ships	%ge of HIV positive individuals in HIV discordant r/ships initiated on ART	100%	0	0	0	0	0	**No cost**	eMTCT FP	Mild may cost
1.2.2.4	Expand service outlets for HIV prevention & commodity distribution targeting MARPs, pregnant women, adolescents & discordant couples	# of service outlets for HIV prevention & commodity distribution targeting MARPs, pregnant	23	0	0	0	0	0	**No cost**	eMTCT FP	Mild may cost

No	Activity	Output indicator	Target	Time Frame in years					Budget ('000)	Resp. person/instituti on	Assumption
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
		women, adolescents & discordant couples established									
1.2.2.5	Facilitate VHTs to refer & follow-up all priority populations (Pregnant mothers, MARPs, women and girls, children, & discordant couples)	# of VHTs facilitated to refer & follow-up all priority populations (Pregnant mothers, MARPs, women and girls, children, & discordant couples)	120	28,800	30,240	31,752	33,339	35,006	**159,138**	HIV FP	Funds are available

	*Strategic Action 1.2.3:*Expand targeted STI interventions for MARPs & vulnerable groups										
1.2.3.1	Screening and treatment for STI in HFs targeting MARPs	%ge of MARPS screened and treated for STIs	90%	0	0	0	0	0	**No cost**	HIV FP	Mildmay Cost
1.2.3.2	Re-Orient providers & intensive support supervision & mentorship to all service providers for improved STI case management	# of facilities supervised & mentored	25	12,000	12,600	13,230	13,891	14,586	**66,307**	DHO	Funds are available
1.2.3.3.	Screen all mothers attending ANC for syphilis & treatment for all effects	# of mothers attending ANC screened and treated for syphilis	26000	5,000	5,000	5,000	5,000	5,000	**25,000**	RH FP	Outreaches are respected

No	Activity	Output indicator	Target	Time Frame in Years					Resp. person/institution	Budget ('000)	Remarks
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
2.0	**CARE AND TREATMENT**										
	Objective 2.1:To increase new enrolment into care to 95% by 2025										
	Strategic Action 2. 1.1:Strengthen mechanisms for linkage to care for all HIV positive individuals										
2.1.1.1	Orient HWs, VHT and expert clients on intra facility referral and linkage to community and other HIV service providers in the district	No. of health workers, VHTs and expert clients oriented	120 HWs,66 VHTS and 45 expert clients	6,920	0	0	0	0	**HIV FP**	**6,920**	To be implemented in year 1
2.1.1.2	Conduct PITC in high yield service points like in patient wards, TB patients, YCC	No. of HFs conducting PITC in high yield service points like inpatient wards, TB patients, YCC	24	0	0	0	0	0	DLP	**No cost**	Facilities cooperate
2.1.1.3	Conduct targeted community testing for high risk/high prevalence groups especially tea plantations, landing sites, truckers ,e.t.c and timely linkage to care	No. of targeted outreaches conducted	210	15,000	15,750	16,537	17,364	18,232	DLP	**64,651**	Funds are available
2.1.1.4	Orient HWs on the newly revised ART guidelines including eligibility assessment for adults and children, clinical assessments and viral load monitoring	No. of HWks oriented on the newly revised ART guidelines including eligibility assessment for adults and children, clinical assessments and viral load	250	10,000	10,000	0	0	0	HIV/eMTCT Focal persons	**20,000**	HIV FP
2.1.1.4	Mentor HWs, Counselors linkage facilitators on HTS	No. of facilities reached with mentorship on HTS screening tool	28	5,070	0	0	0	0	DLP	**5,070**	Funds are available

No	Activity	Output indicator	Target	Time Frame in Years					Resp. person/institution	Budget ('000)	Remarks
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
	screening tool for adults										
	Strategic Action 2.1.2: Increase HIV care entry points for HIV exposed infants, children, adolescents and men within communities, police (Social/child protection) units and workplaces										
2.1.2.1	Mobilise and sensitize the public on appropriate HIV care and treatment that is age and population specific	# of radio talk shows, announcements and spot messages made.	60 radio talk shows, 20 spot messages and announcements per month.	18,000	36,000	37,800	39,690	0	DHE	**131,490**	Funds are available
2.1.2.2	Conduct targeted health education talks on adherence	# HFs conducting health education talks on adherence	24	0	0	0	0	0	HIV FP	No cost	Education charts and materials are availed to every facility
2.1.2.3	Establish and conduct targeted HCT outreaches to landing sites, plantations and "hot spots" for CSWs	# targeted HTC outreaches to landing sites, plantations and "hot spots" for CSWs	210	7,500	7,875	8,268	8,682	9,116	DLP	41,442	All the necessary equipments are availed.
2.1.2.4	Strengthen linkages between police and HFs on cases of sexual abuse receiving HIV testing	# Meetings for the HWs and police conducted	25	6,130	6,436	6,758	7,096	7,451	ADHO	33,872	Will be conducted yearly

No	Activity	Output indicator	Target	Time Frame in Years					Resp. person/institution	Budget ('000)	Remarks
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
	Strategic Action 2.1.3: Strengthen Community level follow up and treatment support mechanisms for Pre-ART and ART individuals										
2.1.3.1	Facilitate community resource persons (Expert clients, peer mothers and VHTs) for enrolment and retention in care	# of community resource persons (Expert clients, peer mothers and VHTs) facilitated	50	60,000	60,000	60,000	60,000	60,000	HIV FP	300,000	Will be conducted yearly
2.1.3.2	Conduct nutrition assessment, counselling and support for pre-ART patients	# of ART sites conducting nutrition assessment, counselling and support for pre-ART patients	23	0	0	0	0	0	ART In charges in facilities	Cost free	IPs support the program
2.1.3.3	Scale up tested treatment and program models for MARPS and vulnerable children(Differentiated Service Delivery Model-DSDM)	# of ART sites implementing up tested treatment and care program models for MARPS and vulnerable children	23	6000	6000	6000	6000	6000	HIV FP	30,000	IPS support the program
2.1.3.4	Facilitate FSG monthly facility meetings with HWs	# of FSG monthly facility meetings with HWs facilitated	23	1,380	1,449	1,521	1,597	1,677	DHO	7,625	Funds are available

No	Activity	Output indicator	Target	Time Frame in Years					Resp. person/institution	Budget ('000)	Remarks
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
2.1.3.5	Train VHTs and other client community support groups in reporting on client referral ,linkage and follow up	# of VHTS trained	80	0	22,650	0	0	0	VHT FP	22,650	Funds are available
2.1.3.6	Facilitate HF with airtime and transport for patient follow up	# of HFs facilitated with airtime and transport for patient follow up	27	3,240	3,402	3,572	3,751	3,938	DHO	17,903	IPS support and also HWS cooperate
	Strategic Action 2.1.4: Scale up implementation of prevention and treatment of AIDS related life threatening opportunistic infections including Cryptococcal meningitis										
2.1.4.1	Mentor HW on supply chain management for OI diagnosis and medications	# of HWs mentored on supply chain management for OI diagnosis and medications	300	2,352	0	0	0	0	DMMS	2,352	Funds are available
2.1.4.2	Build capacity of HWs for management of OIs and non-communicable diseases such as cervical cancer	# of HWs trained in the management of OIs and non- communicable diseases such as cervical cancer trained	28	0	5,034	0	0	0	DHO	5,034	Facilities will be mentored on this
	Strategic Objective 2.2: To increase access to antiretroviral therapy from 86% to 95% by 2025 and sustain provision of long term care for patients initiated on ART										
	Strategic Action 2.2.1: Strengthen care and treatment referral within decentralised ART services with inclusion of community and home based HIV treatment										
2.2.1.1	Build capacity of health care providers in ART delivery	# of HWs trained in ART provision	60	0	55,664	55,664	0	0	HIV FP	111,328	Funds are available

No	Activity	Output indicator	Target	Time Frame in Years					Resp. person/institution	Budget ('000)	Remarks
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
2.2.1.2	Strengthen facility and community linkages	# of HFs and communities with strong linkages	27	5,034	0	0	0	0	HIV FP	5,034	Funds are available
2.2.1.3	Establish friendly HIV care and treatment services for key populations	# of facilities offering friendly HIV care and treatment services for key populations	10	2,000	0	0	0	0	HIV FP	2,000	The youth comply
2.2.1.4	Conduct targeted HCT and ART outreaches to underserved communities (Bbanda and Namungo Sub counties)	# of outreaches conducted	120	4,224	4,435	4,656	4,889	5,134	HIV FP	23,340	
	Strategic Action 2.2.2: Expand and consolidate paediatric and adolescent ART in all accredited ART sites										
2.2.2.1	Integrate and support referral between eMTCT and HIV care and treatment services	# of H/F with proper linkages between eMTCT and ART clinics	27	0	0	0	0	0	eMTCT FP	No cost	
2.2.2.2	Utilize technology including social media for education, recruitment and retention in care	# of radio talk shows conducted	60	18,000	36,000	37,800	39,690	41,675	DHO	173,165	Funds are available
2.2.2.3	Provide care givers with HIV education, literacy and empowerment on	# of HFs providing education to care givers and adolescents	23	0	0	0	0	0	In charges ART clinics	Cost free	Training materials are available

No	Activity	Output indicator	Target	Time Frame in Years					Resp. person/institution	Budget ('000)	Remarks
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
	paediatric and adolescent ART										
2.2.2.4	Integrate HIV care treatment into youth and adolescent friendly services	# HF providing HIV care treatment into youth and adolescent friendly services	18	0	0	0	0	0	HIV FP	No cost	Youth and adolescent friendly corners function well and the HIV FP ensures that the facilities provide those services
2.2.2.5	Conduct KP campaigns and activities at all ART sites	# of HFs conducting KP campaigns	23	0	0	0	0	0	In charges ART clinics	Cost free	The training materials are in place
2.2.2.6	Support plat forms for HIV positive children in schools	# of plat forms for HIV positive children in schools supported	100	2,000	2,000	2,000	2,000	2,000	HIV FP	10,000	School heads cooperate
	Strategic Action 2.2.3: Supporting transitions between child-adolescent -adult care										
2.2.3.1	Train more health care providers in paediatric and adolescent care	# of health care providers in paediatric and adolescent care	70	600	600	600	600	600	DHO	3,000	Funds are available
2.2.3.2	Scale up integrated youth and adolescent friendly services	# Facilities providing integrated youth and adolescent friendly services	18	2,000	2,000	2,000	2,000	2,000	DHE	10,000	Enabling equipment are acquired and the facilities are willing to take it on

No	Activity	Output indicator	Target	Time Frame in Years					Resp. person/institution	Budget ('000)	Remarks
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
2.2.3.3	Build capacity for all accredited facilities to provide comprehensive paediatric, adolescent and adult HIV care and treatment	# of Facilities with health workers trained on provision of comprehensive paediatric, adolescent and adult HIV care and treatment	28	0	4,000	0	0	0	DHO	4,000	Funds are available
	Strategic Objective 2.3:To improve quality of HIV chronic care and treatment										
	Strategic Action 2.3.1- Establish quality assurance and quality improvement activities at all HIV care and treatment sites										
2.3.1.1	Train more health service providers at all levels in quality improvement.	# of health workers trained	72	5,000	0	0	0	0	DHO	5,000	Funds are available
2.3.1.2	Implement quality improvement initiatives including EQA, IQA and documentation.	# of facilities implementing EQA and IQA	28	4,000	4,200	4,410	4,631	4,862	DLP	22,103	Funds are available
2.3.1.3	Conduct routine support supervision and client feedback to meet the needs of clients	# of support supervision and client feedback to meet the needs of clients conducted	60 supervisions 240 feedback meetings	2,400	2,520	2,646	2,778	2,917	DHO	13,261	Funds are available
2.3.1.4	Conduct periodical district-led QI learning sessions	# of periodical district-led QI learning sessions conducted	20	50,000	52,500	55,125	57,881	60,775	QI FP	276,281	Funds are available
2.3.1.5	Mentor HWs on provision of quality	# of HFs with HWs mentored on quality	28	5,000	5,250	5,512	5,788	6,078	HIV FP	27,628	H/Ws mentored

No	Activity	Output indicator	Target	Time Frame in Years					Resp. person/institution	Budget ('000)	Remarks
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
	ART services(prescription practices, support mechanisms for patient retention and adherence) to prevent emergence of drug resistance to ARVs	ART services(prescription practices, support mechanisms for patient retention and adherence) to prevent emergence of drug resistance to ARVs									once a year
	Strategic Action 2.3.2: Implement integrated guidelines on community-based care, basic care package, linkages with social support structures, lost to follow up (LTFU) management and private sector care										
2.3.2.1	Provide integrated guidelines on community-based care, basic care package, linkages with social support structures, LTFU management to all HF	# of HF with integrated guidelines on community-based care, basic care package, linkages with social support structures, LTFU management to all HF	23	0	0	0		0	HIV FP	Cost free	The guidelines are in place
2.3.2.2	Implement periodic monitoring for adherence and disclosure	# HF implementing periodic monitoring for adherence and disclosure	28	0	0	0	0	0	DHO	No cost	To be integrated
2.3.2.3	Disseminate and support the implementation of the guidelines in (1) above.	# Facilities with guidelines in (1) above.	28	2,000	0	0	0	0	DHO	2,000	To be implemented in year 1
2.3.2.4	Strengthen the capacity of PLHIV networks	# of PLHIV networks (FSGs, Peer mothers	50	60,000	63,000	66,150	69,458	72,930	HIV FP	33,154	Will be conducted

No	Activity	Output indicator	Target	Time Frame in Years					Resp. person/institution	Budget ('000)	Remarks
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
	(FSGs, Peer mothers and expert clients) to follow up and link PLHIV to social support structures	and expert clients)trained and supported to follow up and link PLHIV to social support structures									yearly
	Strategic Action 2.3.3: Strengthen treatment monitoring and evaluation of clinical outcomes of long-term use of antiretroviral drugs and other medications										
2.3.3.1	Mentor Health service providers on viral load monitoring	# of HFs with Health service providers mentored on viral load monitoring	28	5,070	0	0	0		HIV FP	5,070	Funds are available
2.3.3.2	Adopt the standardized national tools for tracking HIV patients active in care	# of HFs with standardized national tools for tracking HIV patients active in care	28	0	0	0	0	0	Biostatistician	Cost Free	Partners avail the tools
2.3.3.3.	Implement and rollout the IPT and TB Intensified Case Finding (ICF) guidelines	# of HFs with trained staff and implementing IPT and TB Intensified Case Finding (ICF) guidelines	28	7,318	0	0	0	0	TB FP	7318	To be in year 1
2.3.3.4	Train and mentor health care workers in the use of Gene -Xpert to enhance TB diagnosis	# of HW trained and mentored in the use of Gene -Xpert to enhance TB diagnosis	80	0	2,352	0	0	0	DLP	2,352	Funds are available
2.3.3.5	Support sample transportation and referral system in the District	# of functional motor bike riders supported in sample transportation and referral system in the District	2	10,000	10,000	10,000	10,000	10,000	DLP	100,000	Funds are available

No	Activity	Output indicator	Target	Time Frame in Years					Resp. person/institution	Budget ('000)	Remarks
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
	Objective 2.4: To strengthen integration of HIV care and treatment within healthcare programmes										
	Strategic Action 2.4.1: Fully integrate HIV/TB programming and services at all levels including community DOTS and home-based care										
2.4.1.1	Orient health care workers on linkages and referral between TB and HIV, care and treatment services to ensure early diagnosis and initiation of HIV treatment among TB patients	# of HWs oriented on linkages and referral between TB and HIV, care and treatment services to ensure early diagnosis and initiation of HIV treatment among TB patients	105	5,070	0	0	0	0	DTLS	5,070	
2.4.1.2	Conduct monthly technical support supervision to TB diagnostic and treatment units	# of HFs visited for monthly technical support supervision to TB diagnostic and treatment	17	6,240	6,552	6,880	7,224	7,585	DTLS	34,480	
2.4.1.3	Enhance coordination of TB/HIV collaborative services at the HSDs by supporting HSD focal persons to do quarterly support supervisions	# of HSD FPs supported to conduct quarterly support supervisions	3	2,304	2,419	2,540	2,667	2,801	DTLS	12,731	Funds are available
2.4.1.4	Integrate TB and ART services to create one-stop-centres	# of HFs integrating TB and ART services to create one-stop-centres	17	0	0	0	0	0	Facility In charges	Cost Free	Provided In charges are well oriented
2.4.1.5	Build capacity of district and facility	# of DHT members and facility teams trained in periodic TB infection	45	0	43,795	0	0	0	DTLS	43,795	Funds are available

No	Activity	Output indicator	Target	Time Frame in Years					Resp. person/institution	Budget ('000)	Remarks
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
	teams to conduct periodic TB infection risk assessments and monitor implementation of the TB infection control plan	risk assessments and monitor implementation of the TB infection control plan									
2.4.1.6	Orient District coordination structures (DHT, DAC, SAC ...) in the TB/HIV collaboration	# of District coordination structures (DHT, DAC, SAC ...)oriented in the TB/HIV collaboration	1 DHT 1 DAC 12 SAC	0	4,202	4,412	0	0	HIV FP	8,614	One training per year
2.4.1.7	Train health workers on TB, TB/HIV and MDR TB	# of HWs trained on TB, TB/HIV and MDR TB	84	0	21,954	0	0	0	DTLS	21,954	On site training will be done for 3 days
2.4.1.8	Conduct on-site training and mentorship of health care providers to implement Isoniazine Preventive Treatment(IPT), targeting all HIV care clinics for PLHIV and TB clinics for HIV negative children under five years of age, who are eligible;	# of HFs with HWs trained and mentored to implement Isoniazine Preventive Treatment(IPT), targeting all HIV care clinics for PLHIV and TB clinics for HIV negative children under five years of age, who are eligible;	28	0	21,954	0	0	0	DTLS	21,954	Funds are available

No	Activity	Output indicator	Target	Time Frame in Years					Resp. person/institution	Budget ('000)	Remarks
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
2.4.1.9	Support sub-county health workers/VHTs in monitoring of TB patients on treatment	# sub- county HWs/VHTs supported in monitoring of TB patients on treatment	46	19,008	19,958	20,956	22,004	23,104	DTLS	105,031	Monitoring to be carried out on a quarterly basis
	Strategic Action 2.4.2: Integrate HIV care and treatment with maternal, newborn and child health, sexual and reproductive health rights, mental health and non-communicable /chronic diseases										
2.4.2.1	Integrate HIV testing, care and treatment services into maternal, neonatal and child health settings and services	# of HFs with integrated HIV testing, care and treatment services into maternal, neonatal and child health settings and services	27	0	0	0	0	0	Health Facility In charges	Cost free	Funds are available
2.4.2.2	Train health care providers in screening and diagnosis of TB, Non Communicable Diseases, malnutrition and Opportunistic infections in HIV care services.	# of HWs trained in screening and diagnosis of TB, Non Communicable Diseases, malnutrition and Opportunistic infections in HIV care services.	70	0	2,450	0	0	0	DHO	2,450	Funds are available
2.4.2.3	Scale up prevention interventions for TB, OIs and other co-morbidities, water and sanitation-related diseases, vaccinations for preventable diseases (cervical	# HFs implementing prevention interventions for TB, OIs and other co-morbidities, water and sanitation-related diseases, vaccinations for preventable diseases (cervical cancer, hepatitis, pneumococcal)	36		0	0	0	0	Facility in charges	Cost free	Facility in charges cooperate

No	Activity	Output indicator	Target	Time Frame in Years					Resp. person/institution	Budget ('000)	Remarks
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
	cancer, hepatitis, pneumococcal)										
2.4.2.4	Train health service providers in long-term and short-term family planning methods	# of HWs trained in long-term and short-term family planning methods	80	0	66,000	66,000	0	0	RH FP Focal person	132,000	Funds are available
2.4.2.5	Integrate family planning services in HIV care and treatment service points	# of HFs with integrated family planning services in HIV care and treatment service points	28	0	0	0	0	0	Health facility In charges	Cost free	In charges cooperate
	Strategic Action 2.4.3: Integrate nutrition assessment, counseling and support in HIV care and treatment services including use of Ready to use Therapeutic Food (RUTF) for severely malnourished, and linkages to increase food security.										
2.4.3.1	Build capacity of HW in nutritional screening, assessment and management	# of HWs trained and mentored in nutritional screening, assessment and management	300	5,042	0	0	0	0	Nutrition FP	7,000	Funds are available
2.4.3.2	Integrate nutritional education, assessment and therapeutic support into HIV care and treatment	# of HF integrating nutritional education, assessment and therapeutic support into HIV care and treatment	28	0	0	0	0	0	Nutrition FP	Cost free	Facility in charges cooperate
2.4.3.3	Provide nutrition assessment tools and equipment to health facilities	# of HFs with nutrition assessment tools and equipment	28	0	0	0	0	0	Nutrition FP	Cost free	Partners avail the tools
2.4.3.4	Integrate nutritional care and support for	# of HFs integrating nutritional care and	28	0	0	0	0	0	Health Facility in	Cost free	To be implemented all

No	Activity	Output indicator	Target	Time Frame in Years					Resp. person/institution	Budget ('000)	Remarks
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
	pregnant and lactating women and HIV-exposed children at ANC and childcare points	support for pregnant and lactating women and HIV-exposed children at ANC and childcare points							charges		through
2.4.3.5	Provide nutrition commodities especially therapeutic foods	# of HFs with regular stocks of nutrition commodities especially therapeutic foods	27	0	0	0	0	0	Nutrition FP	Cost free	Provided the therapeutic foods are available

	Activity	Output indicator	Target	Time Frame in Years					Budget ('000)	Resp. person/ institution	Assumptions
				Yr1	Yr2	Yr3	Yr4	Yr5			
3.0	**SOCIAL SUPPORT**										
	Strategic Objective 3.1: To scale up efforts to eliminate stigma and discrimination of PLHIV and other vulnerable groups										
	Strategic Action 3.1.1 Mobilize and strengthen cultural (including traditional healers) and religious institutions, community support systems and PLHIV Networks to address stigma										
3.1.1.1	Hold community dialogue meetings with traditional and religious leaders about HIV prevention and stigma at district and sub county level	Number of community dialogue meetings conducted	48	10,240	10,240	0	0	0	20,480	DCDO	Funds are available
3.1.1.2	Support formation of more PLHIV networks and strengthen existing ones to address discrimination and stigma.	Number new networks formed	30	4,632	4,864	0	0	0	9,496	HIV FP	Funds are available
3.1.1.3	Training expert clients in counselling and guidance skills for PLHIV	Number of expert clients trained	82	0	0	55,056	0	0	55,056	DHO	Funds are available
***Strategic Action 3.1.2*: Strengthen interventions that empower PLHIV to deal with self-**											
3.1.2.1	Support formation of peer mothers clubs, family support groups, and PLHIV Networks	Number of peer mothers clubs, family support groups formed	24	0	8,600	0	0	0	8,600	HIV FP	Funds are available
3.1.2.2	Hold quarterly platform meetings to share experiences	Number of platform meetings conducted	20	10,000	10,000	10,000	10,000	10,000	50,000	HIV FP	Funds are available
	***Strategic Action 3.1.3:* Implement campaigns to addresses stigma experienced in homes, communities and other institutions (schools, hospitals, workplaces and places of worship)**										
3.1.3.1	Support formation of equipped drama groups among PLHIV	Number of equipped drama groups among PLHIV	12	0	3,000	0	0	0	3,000	DHE	Funds are available

	Activity	Output indicator	Target	Time Frame in Years					Budget ('000)	Resp. person/ institution	Assumptions
				Yr1	Yr2	Yr3	Yr4	Yr5			
		formed									
3.1.3.2	Hold quarterly meetings with teachers association, PTAs about HIV/ AIDS in 10 sub counties and 3 divisions	Number of meetings held with teachers association, PTAs	52	10,000	10,500	11,025	11,576	12,155	55,256	DHO	Funds are available
3.1.3.3	Conduct training for Head teachers, Administrators, In-charges and church leaders in stigma and discrimination	Number of trainings conducted for Head teachers, Administrators, In-charges and church leaders	5	0	41,460	0	0	0	41,460	DCDO	Funds are available
3.1.3.4	Sensitization and dissemination of the HIV workplace policy among institutional managers.	Number of dissemination meetings held	2	0	12,304	0	0	0	12,304	DHO	Funds are available
***Strategic Action 3.1.4*: Design and implement interventions to eliminate discrimination against women and girls in the context of HIV and AIDS**											
3.1.4.1	Sensitization of women, girls and men, on women and girls health and reproductive rights.	Number of meetings, talk shows, Drama shows	-48 radio talk shows - one drama show per sub county in a quarter	5,056	5,309	5,574	5,853	6,146	27,938	Gender FP	Funds are availa ble
3.1.4.2	Organize girls into peer to peer clubs in schools	Number of peer clubs organised in schools	50	0	3,120	0	0	0	3,120	DHE	Funds are available
3.1.4.3	Train local CSO's that raise awareness to change norms that promote stigma and discrimination among	Number of CSO.s whose capacity is enhanced	40	0	56,070	0	0	0	56,070	DHO	Funds are available

	Activity	Output indicator	Target	Time Frame in Years					Budget ('000)	Resp. person/ institution	Assumptions
				Yr1	Yr2	Yr3	Yr4	Yr5			
	women and girls										
Strategic Objective 3.2: To mainstream the needs of PLHIV, OVC and other vulnerable groups into livelihood, Education and poverty alleviation programs.											
Strategic Action 3.2.1 Integrate PLHIV, OVC and other vulnerable groups' needs in the livelihood and poverty alleviation programs.											
3.2.1.1	Involve PLHIV, OVC and other vulnerable groups in the district planning and implementation process	Number of PLHIV, OVC and other vulnerable groups involved	50	0	**0**	**0**	**0**	**0**	No cost	**DCDO**	To be integrated in other activities
3.2.1.2	Advocate and create awareness for gender and rights based HIV programming at sub county level and CSO interventions	Number of awareness raising meetings held for gender and rights based HIV programming at sub county level and CSO interventions	14	0	125,000	0	0	0	125,000	Gender FP	Funds are available
3.2.1.3	Monitor and assess on involvement of the PLHIV, OVC and other vulnerable groups in livelihood, Education and poverty alleviation programs.	Number of PLHIV, OVC and other vulnerable groups assessed to have been involved in livelihood, Education and poverty alleviation programs.	80	8,000	8,400	8,820	9,261	9,724	44,205	DCDO	Funds are available
Strategic Action 3.2.2: Coordinate all sectors to fulfill and account for their mandate in relation to social support and social protection											
3.2.2.1	Update and harmonize the HIV/ AIDS , OVC, Service providers inventory,	Number of copies of Updated Service providers inventory printed	100	5,000	0	0	0	0	5,000	DCDO	Funds are available
3.2.2.2	Monitor, support supervise	Number of support supervision visits	20	4,800	5,040	5,292	5,557	5,834	26,523	DCDO	Once a quarter

	Activity	Output indicator	Target	Time Frame in Years					Budget (‘000)	Resp. person/ institution	Assumptions
				Yr1	Yr2	Yr3	Yr4	Yr5			
	CSOs and AIDS Support Organizations interventions	conducted									
3.2.2.3	Hold bi-annual stakeholders meeting with HIV and OVC service providers	Number of meetings held	10	4,200	4,410	4,631	4,862	5,105	23,208	DCDO	Twice a year
Strategic Action 3.2.3 Integrate social support and protection issues in education sector programs (including school health and reading programs, PIASCY, curricular and extracurricular activities)											
3.2.3.1	Train senior women / men and teachers to be able to handle the special needs of children living with HIV /AIDS in schools.	Number of trainings held in targeted schools	100 schools	0	55,000	55,000	0	0	110,000	DCDO	Twenty schools per year
3.2.3.2	Train school pupils and students in life skills education	Number of pupils and students trained in targeted schools	100 primary schools 27 secondary schools	40,000	42,000	44,100	46,305	48,620	221,025	DCDO	Twenty schools per year
3.2.3.3	Provide sanitary information and commodities for the girl child in Schools.	Number girls that received sanitary commodities	10000 commodit y packs	50,000	50,000	50,000	50,000	50,000	250,000	DCDO	Also hope for a donation
Strategic Action 3.2.4 Implement targeted programmes that support PLHIV, OVC and other vulnerable groups to access livelihood opportunities, vocational skills training and informal education											

	Activity	Output indicator	Target	Time Frame in Years					Budget ('000)	Resp. person/ institution	Assumptions
				Yr1	Yr2	Yr3	Yr4	Yr5			
3.2.4.1	Advocate and lobby for the enrollment of OVC's and Youth in vocational and apprenticeship programs	Number of OVC and youth that enrolled into vocational and apprenticeship programs	500	0	0	3,000	0	0	3,000	DCDO	100 per year
3.2.4.2	Support OVC and youth to enroll into vocational and apprenticeship programs such as start up kits, bursaries, placements.	Number of OVC and youth supported with start-up kits, bursaries, placements	500	0	0	30,000	0	0	30,000	DCO	100 per year
3.2.4.3	Link vocational graduates to possible service/ product consumers/ markets	Number of graduated linked to prospective service/ product consumers / markets	500	500	525	551	578	607	2,762	DCDO	Funds are available
Strategic Action3.2. 5 Expand social assistance grants to PLHIV, OVC and other most vulnerable persons											
3.2.5.1	Facilitate Community Development officers to map OVC, PLHIV and other most vulnerable person's households in order to link them to services.	Number of OVC and PLHIV most vulnerable H/H mapped	890	1,500	0	0	0	0	1,500	DCDO	

	Activity	Output indicator	Target	Time Frame in Years					Budget ('000)	Resp. person/ institution	Assumptions
				Yr1	Yr2	Yr3	Yr4	Yr5			
3.2.5.2	Mobilize PHLAs , OVC care givers and key population to form groups in order to access social assistance grants	Number of PHLAs, OVC Caregiver and key populations groups formed	480 groups	0	0	3,000	0	0	3,000	DCDO	At least 10 groups per sub-county per year
3.2.5.3	Ensure preferential treatment is accorded to OVC in the district education b298ursary scheme	Number of OVC receiving district bursary schemes	1000	0	0	0	0	0	No cost	DEO	At least 200 per year
3.2.5.4	Provide social assistance grants such as CDD, Special grant for PWDs to enhance their livelihoods to key population groups	Number of key population s groups supported with grants	250	0	0	0	0	0	No cost	DCDO	Gov't programs
Strategic Action 3.2. 6 Design and implement interventions that prioritize the key populations, elderly and PWDs in social support and protection services											
3.2.6.1	Collect, analyze ,document and disseminate data on the needs, support systems in place wellness and access to services and district programs by OVC,PHLAs and Key populations.	Data base and developed printed	100 copies	1,500	1,575	1,653	1,736	1,823	8,288	DCDO	Funds are available

	Activity	Output indicator	Target	Time Frame in Years					Budget ('000)	Resp. person/ institution	Assumptions
				Yr1	Yr2	Yr3	Yr4	Yr5			
3.2.6.2	Establish an engendered community-managed data base for vulnerable groups and house holds	Data base developed	1	0	0	0	0	0	No cost	DCDO	
3.2.6.3	Mobilize community support groups and facilitate them to provide basic social needs to chronically ill PLHIV, OVC and care givers.	Number groups mobilised and supported	720	0	20,000	20,000	20,000	20,000	80,000	DCDO	At least 20 groups per sub-county per year
3.2.6.4	Provide emergency care support (safety nets) to PLHIV, OVC and other vulnerable person's households.	Number of PLHIV, OVC and key populations receiving emergency support	400	0	0	0	0	0	No cost	DCDO	Hope for a donation
Strategic Objective 3.3: To develop and implement a life cycle sensitive comprehensive package of social support and protection interventions for PLHIV and other vulnerable groups											
Strategic Action 3.3.1 Develop and implement interventions to reduce the economic vulnerability of families and empower them to provide for the essential needs of children in their care											
3.3.1.1	Train and support community structures to promote food production	Number of community structures trained	120	0	4,200	4,410	0	0	8,610	DCDO	At least 10 per sub-county

	Activity	Output indicator	Target	Time Frame in Years					Budget ('000)	Resp. person/ institution	Assumptions
				Yr1	Yr2	Yr3	Yr4	Yr5			
3.3.1.2	Train teachers, school nurses and matrons in psycho social support for OVC, children and teachers living with HIV AIDS.	Number of teacher, school nurses and matrons trained	300	0	60,000	0	0	0	60,000	DCDO	Target 100 schools with 3ppts each
3.3.1.3	Mobilize and train, PLHIV, OVC and vulnerable persons households in the Village saving and loan association's (VSLA)	Number of VSLA formed	445 VSLAs	4,000	4,000	4,000	4,000	4,000	20,000	DCDO	At least 5 VSLAs in each parish
3.3.1.4	Support and train PLHIV, OVC and vulnerable person's households with Income generating activities.	Number of PLHIV, OVC and Vulnerable households supported with income generating activities	4450 H/Hs	0	0	0	0	0	No cost	DCDO	To be integrated
3.3.1.5	Link PLHIV, OVC and vulnerable person's households to markets for their products.	Number of markets identified and linked too	40	0	2,000	2100	2205	2315	8,620	DCDO	At Least 10 per year, coordination air time
Strategic Action 3.3. 2 Develop and implement appropriate strategies to prevent and respond to child abuse and exploitation											
3.3.2.1	Establish Para-social workers network and child protection committees in all sub counties.	Number of Para social workers networks and child protection committees (CPCs)established	14 Para social workers. 89 CPCs established	0	6,000	63,00	6,615	6,946	25,861	DCDO	One network per sub-county and one district level net work One CPC per parish

	Activity	Output indicator	Target	Time Frame in Years					Budget ('000)	Resp. person/ institution	Assumptions
				Yr1	Yr2	Yr3	Yr4	Yr5			
3.3.2.2	Train Para-social workers in all sub counties in child protection, legal and policy frameworks	Number of para-social workers trained in target sub-counties	Seven sub-county	0	68,000	71,400	0	0	139,400	DCDO	30 Para social workers per sub-county
3.3.2.3	Conduct community out reaches on child protection in all sub counties.	Number of community out reaches conducted	1080	86,142	90449	94,972	99,720	104,706	475,988	DCDO	At least 3 outreaches per quarter per sub-county
3.3.2.4	Popularize the child abuse help line	Number of cases reported using child abuse help line per quarter	200	6,000	6,000	6,000	6,000	6,000	30,000	DCDO	At least 10 per quarter
3.3.2.5	Conduct radio talk shows on child protection issues.	No of radio talks shows conducted	60	5,520	5,796	6,085	6,390	6,709	30,509	DCDO	One radio talk show per month
3.3.2.6	Support probation office and CDO's to carry out social inquiries.	No of social inquires carried out	300	5,000	5,250	5,512	5,780	6,077	27,628	DCDO	At least 5 per quarter in 12 sub-counties
Strategic Objective 4: To engender all social support and protection programs to address the unique needs, gender norms, legal and other structural challenges that make women, girls, men and boys vulnerable to HIV and AIDS.											
Strategic Actions:3.4.1 Enhance capacity of all actors engaged in the HIV and AIDS district response to adopt gender and rights-based HIV programming											

	Activity	Output indicator	Target	Time Frame in Years					Budget (‘000)	Resp. person/ institution	Assumptions
				Yr1	Yr2	Yr3	Yr4	Yr5			
3.4.1.1	Train Community Development Officer, heads of departments, district and Sub county leadership in gender, human rights and disability mainstreaming.	Number of trainings conducted	8	0	20,000	20,000	20,000	20,000	80,000	DCDO	Two trainings per year
3.4.1.2	Monitor and assess gender, human rights, HIV and disability programs implementation in the district.	Number of district programs addressing the target crosscutting issues	All	0	0	3,000	3,150	3,308	9,458	DCDO	Once a year
Strategic Actions:3.4.2Establish mechanisms for engaging men and boys in HIV and AIDS and SGBV programming											
3.4.2.1	Conduct community dialogue sessions and drama on SGBV in schools and public place like trading centers and markets	Number of community dialogue sessions conducted	780	0	3,250	3,413	3,583	3,762	14,008	DCDO	At least three session per quarter per sub-county
3.4.2.2	Conduct community sensitization on the role of men and boys in HIV/AIDS and SGBV prevention.	Number of community sensitization meetings held	192	0	7,500	7,500	7,500	7,500	30,000	DCDO	One per quarter per sub-county
3.4.2.3	Conduct community sensitization on the causes, magnitude and	Number of community sensitization	192	0	0	0	0	0	No cost	Gender FP	To be integrated

	Activity	Output indicator	Target	Time Frame in Years					Budget ('000)	Resp. person/ institution	Assumptions
				Yr1	Yr2	Yr3	Yr4	Yr5			
	consequences of SGBV to both men/boys and women/ girls.	meetings									
3.4.2.4	Hold community advocacy campaign targeting, political, cultural, religious leaders as resource persons for the SGBV campaign.	Number of community campaigns held	192	0	3,000	3,000	3,000	3,000	120,000	Gender FP	One per quarter per sub-county
Strategic Action: 3.4.3 Build capacity of community based organizations and other CSOs to address violence against women and girls, men and boys in the context of HIV /AIDS through social mobilization.											
3.4.3.1	Train and support local leaders to carry out community education campaigns on human rights, legal and ethical needs of PLHIV, OVC and other HIV and AIDS affected people.	Number of trainings held	8	0	10,000	10,500	11,025	11,576	43,101	Probation Officer	Two trainings per sub-county

No	Activity	Indicator	Output/ Target	Time Frame in Years					Budget ('000)	Responsible Person	Assumptions
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5			
4.0	**SYSTEMS STRENGTHENING**										
	Objective 4.1: To strengthen the governance and leadership of the multi-sectoral HIV and AIDS response in the district.										
	Strategic Action 4.1.1: Disseminate and monitor implementation of existing and new legal policy instruments for reducing structural barriers to the district response										
4.1.1.1	Disseminate existing policies and guidelines on the multi-sectoral AIDS response to the HFs, DAC, SACs and CSOs	Proportion of HFs, SACs, and CSOs receiving all policies and guide lines	100%	0	23,000	0	0	0	23,000		
4.1.1.2	Conduct quarterly monitoring of implementation for existing policies & guidelines for multi sectoral HIV/AIDS response	Number of monitoring visits conducted	16	0	22,200	23,310	24,475	25,699	95,684	DHO	
		Strategic Action 4.1.2 : Strengthen the capacity of SACs to coordinate HIV/AIDS activities in the district and sub counties									
4.1.2.1	Facilitate the DAC and SACs to hold quarterly review and planning meetings for HIV/AIDs activities.	Number of quarterly DAC and SACs meetings held	20 DACS 240 SACs	11,840	12,432	13,053	13,706	14,391	65,423	HIV FP	Funds are available
4.1.2.2	Conduct training of DAC and SACs on monitoring and coordination of HIV/AIDs response in the community	Number of DAC and SACs trained	1 DAC 12 SACs	0	17,390	0	0	0	17,390	HIV FP	To be in year 2
4.1.2.3	Conduct quarterly support supervision of the SACs' activities	Number of supervision visits conducted	20	0	29,600	31,080	32,634	34,265	127,579	HIV FP	Funds are available

	in the sub counties										
4.1.2.4	Conduct regular quarterly stakeholder review and planning meetings for all the stakeholders implementing HIV/AIDs service.	Number of quarterly stakeholder review and planning meetings held	20	0	8,000	8,400	8,820	9,261	34,481	HIV FP	Funds are available
4.1.2.5	Develop and disseminate an inventory for all public and non-public HIV/AIDS service providers in the district.	Number of the inventory copies distributed.	500	0	5,000	0	0	0	5,000	DHO	Funds are available
	Objective 4.2: To ensure availability of adequate human resource for delivery of quality HIV and AIDS services										
	Strategic Action 4.2.1 : Build capacity of different cadres for HIV/ AIDS service provision										
4.2.1.1	Carry out in service training for all critical cadres in HIV/AIDS service provision	Number of critical cadres trained	200	50,000	52,50 0	55,125	57,881	60,775	276,281	DHO	The critical cadres include Doctor, Nursing Officer, clinical officers, midwives, dispenser, laboratory staff, pharmacists, and theatre assistants
4.2.1.2	Conduct leadership and management training for health	Number of health facility staffs trained	75	0	5,550	0	0	0	5,550	DHO	60 in charges, 15 DHT members, 5

	facility staff.										
4.2.1.3	Conduct quarterly Integrated technical support supervision and mentorship to staffs.	Number of support supervisions and mentorship visits conducted	20	2,960	3,108	3,263	3,426	3,597	16,355	Ass. DHO	Funds are available
4.2.1.4	Scale up Continuous Professional Development (CPD) in the facilities.	Number of CPD sessions conducted in the facilities	1,500	0	10,00 0	10,500	11,025	11,025	55,256	DHE	At least 1 CPD in a month in the 25 ART facilities
4.2.1.5	Conduct recruitment, orientation and retention of HIV/AIDS service providers	Percentage increase in the number of service providers recruited	20%	0	60,00 0	0	0	0	60,000	DHO	Current staffing level is at 70%. Hope to increase by 20% in five years
4.2.1.6	Provide & disseminate Standard Operating Procedures(SOPs) to all facilities	Number of copies provided and disseminated	200	0	0	5,000	0	5,500	10,500	DHO	The SOPs are available
Strategic Action 4.2.2: Promote the implementation of the public private partnership (PPP) in the delivery of HIV and AIDS services											
4.2.2.1	Disseminate and implement the operationalization of the public-Private Partnership Policy	Number of PPP copies disseminated	75	0	20,00 0	21,000	22,050	23,153	86,203	DHO	Disseminated to all in charges and the DHT

Objective 4.3: To strengthen the procurement and supply chain management system for timely delivery of medical and non-medical products, goods and services required in the delivery of HIV and AIDS services										
Strategic Action 4.3.1: **Establish proper mechanisms for Quantification and Procurement Planning, capacity building in procurement and management of products, goods and supplies, particularly at health facility level**										
4.3.1.1	Conduct training of the DHT, in charges and stores assistants in procurement, management and disposal of health products, infection control and medical supplies.	Number of in charges and stores assistants trained	**65**	**0**	60,000	**63,000**	**0**	**0**	123,000	District Drug Inspector	Train the DHT, all the in charges and stores assistants in the ART sites
4.3.1.2	Rejuvenate and train therapeutic and medical supplies committees in the health facilities	Number of committees rejuvenated and trained	26	**0**	**0**	20,000	0	0	20,000	District Drug Inspector	1 District committee and 25 committees in the ART facilities
4.3.1.3	Provide appropriate procurement tools for timely and efficient forecasting, quantification and periodic HIV/AIDS logistics supply.	Number of procurement tools ordered and supplied to facilities	-135 reams of stock cards. -3000 booklets of order forms	8,000	8,400	8,820	9,261	9,724	44,205	District Stores' personnel	1 ream of stock cards in 24 ART facilities per year and 3 reams for the hospital 4 booklets of order forms per order in five years in the 25 ART facilities
4.3.1.4	Conduct regular and	Proportion of regular and	100%	**0**	**0**	**0**	**0**	**0**	No cost	DHO	Mild may cost

	timely procurement and supply of HIV/AIDs related commodities	timely procurements and supplies made									
4.3.1.5	Conduct quarterly HIV commodity management and supply chains monitoring and supervision	Number of facilities supervised and monitored	25	**14,800**	**15,540**	**16,317**	**17,132**	**17,990**	81,779	District stores person	The DHT, CAO & political team to conduct the exercise
	Strategic Action 4.3.2: **Standardize the Logistics Management Information System and build the requisite capacity in ICT and logistics management**										
4.3.2.1	Conduct Procurement of computer supplies for ICT and logistics management in order to operationalize logistic management Information System.	Number of computer supplies procured for the district and targeted Health facilities	26	**0**	**74,300**	**0**	**0**	**0**	**74,300**	DHO	Computer supplies include a computer set, modem, storage disks and printer
4.3.2.2	Train the DHT, facility and Stores in charges in ICT and logistics management.	Number of the DHT members, facility and stores in charges trained	75	**0**	**0**	**80,000**	**0**	**0**	**80,000**	DHO	members, 25 in and n charges 25 stores personnel
4.3.2.3	Conduct VHT training to roll out the community health management	Percentage increase in the number of VHTs trained	26%	10,000	10,000	10,000	10,000	10,000	50,000	DHE	The current VHT trained status is 24%.

	information system										
	Strategic Action 4.3.3: Implement the national comprehensive policy on storage, distribution of health commodities and supplies and waste management in public and non-public facilities										
4.3.3.1	Conduct Re-remodelling and renovation of storage facilities in the health facilities	Number of health unit storage facilities remodelled/renovated	15	0	30,000	31,500	0	0	61,500	DHO	3 HC IVs, 9 gov't, HC IIIs and 3 PNFP facilities
	Objective 4.4: **To ensure coordination and access to quality HIV and AIDS services**										
	Strategic Action 4.4.1: **Promote integration of HIV and AIDS services in all settings and in major development programme service delivery**										
4..4.1.1	Train stakeholders in HIV /AIDS mainstreaming	Number of HIV/AIDS Mainstreaming training conducted	10 sessions	0	73,200	76,860	80,703	0	230,763	HIV FP,DHO	Two trainings per year
4.4.1.2	Provide technical support and monitor integration of HIV / AIDS in departmental projects	Number of departments integrating HIV/AIDs in their projects	9	4,000	4,200	4,410	4,631	4,862	22,102	DHO	All departments
	Strategic Action 4.4.2: Build strong linkages between institutionalized facilities and community systems and ensure an effective referral system, greater adherence to treatment and improved monitoring of service delivery										
4.4.2.1	Conduct training of CSOs, CBOs, FBOs, PLWHAs providers to strengthen linkages and referral systems to enhance availability, referral, access, utilization	Number of trainings conducted	8	0	8,200	8,610	9,041	9,492	35,343	DHE	Two trainings per year

	and quality of HIV/AIDs related services										
4.4.2.2	Train VHTs and other grassroots structures including those of PLHIV for enhancing referrals and treatment adherence.	Number of training held	8	0	0	**0**	**0**	**0**	No cost	DHE	To be integrated in activity 2.1.3.5
	Strategic Action4.4. 3: Promote greater coordination, linkage, partnership and collaboration among public and non-public sectors										
4.4.3.1	Conduct quarterly community dialogues and meetings with active engagement of service providers, NGOs and CSOs	Number of meetings held	20	7,000	7,350	7,717	8,103	8,508	38,679	HIV FP	One meeting per quarter
4.4.3.2	Support rejuvenation of Health Unit Management Committees (HUMC)	Number of HUMCs functional	60	0	50,00 0	0	50,000	0	100,000	DHO	All HC in the district
	Strategic Action4.4. 4: Strengthen capacity of CSOs and communities for increased advocacy and mobilization for demand and uptake of services, social participation, self-regulation and accountability in the multi-sectoral response.										
4.4.4.1	Train community structures i.e. VHTs, Health unit management committees, community leaders' e.t.c in mobilization	Number of trainings conducted	8	0	52,00 0	54,600	57,330	60,197	22,127	DHE	Two trainings per year

	skills.										
	Objective 4.5: To strengthen the infrastructure for scaling-up the delivery of quality HIV and AIDS services										
	Strategic Action 4.5.1: Scale-up rehabilitation and building of new health and non-health infrastructure as well as improving management and maintenance of infrastructure										
4.5.1.1	Carry out rehabilitation and maintenance of the physical infrastructure, equipment and transport for provision of HIV/AIDS Services	Number of health infrastructure rehabilitated ,maintained and equipped	**25**	15,000	15,75 0	16,538	17,364	18,232	82,884	DHO	
4.5.1.2	Carry out infrastructure development to cater for the needs of MARPs including youth, PWDs, and the elderly related activities by the public sector	Number of Health facilities with appropriate infrastructure for MARPS	**25**	**0**	45,00 0	47,250	0	0	92,250	DHO	All ART sites in the district according to priority
4.5.1.3	Provide basic utilities at the health facilities i. e water, electricity, e .t. c	Number of health facilities with basic utilities	25	0	**35,00 0**	**0**	**38,500**	**0**	73,500	DHO	Funds are available
Strategic Action 4.5. 2: Expand availability and capacity of laboratories at different levels for delivery of HIV /AIDS services											
4.5.2.1	Ensure timely ordering and delivery of laboratory re-	Number of laboratories with with adequate laboratory reagents	25	8,000	8,400	8,820	9,261	9,724	44,205	Lab FP	Funds are available

	agents/commodities necessary for provision of HIV/AIDs related diagnostic services.										
4.5.2.2	Train laboratory staff in the health facilities to provide quality HIV/AIDS diagnostic services.	Number of staff strained	40	0	10,000	0	0	0	10,000	Lab FP	1 lab Technologist, 14 Lab. technicians and 25 Lab. assistants
4.5.2.3	Conduct quarterly laboratory targeted support supervision and monitoring to strengthen effective networking and diagnosis for ART and other HIV/AIDS related diagnostic services.	Number of targeted support supervision visits conducted	20	8,100	8,505	8,930	9,377	9,846	44,758	Lab FP	4 Visits per year
4.5.2.4	Conduct regular maintenance of laboratory equipments for functional HIV/AIDS diagnostic services.	Number of facilities with functional laboratory equipments	25	5,000	5,250	5,513	5,788	6,078	27,628	Lab FP	Funds are available
	Strategic Action 4.5.3: Increase Accreditation of HC IIIs and HC IIs to provide comprehensive HIV/AIDS and TB services.										
4.5.3.1	Carry out HIV/AIDs integrated	Number of integrated outreaches carried out	20	12,000	12,600	13,230	13,892	14,586	66,308	HIV FP	At least one outreach per

	outreaches to high risk groups and underserved areas										month
4.5.3.2	Expand the accreditation for comprehensive HIV / AIDS service provision to HC-III's and HC-IIs	Percentage increase in number of facilities accredited	**5%**	**0**	**0**	**0**	**0**	**0**	No cost	DHO	To write to the MOH to accredit the facilities
	Objective 4.6: To mobilize resources and streamline management for efficient utilization and accountability.										
	Strategic Action 4.6.1: Develop and disseminate appropriate tools for enhancing planning and resource allocation based on disease burdens at district/facility levels.										
4.6.1.1	Train district and health facility in charges in planning and resource allocation for HIV/AIDS service delivery	Number of Trainings conducted	**8**	**0**	**5,000**	**5,250**	**5,513**	5,788	21,551	DHO	2 trainings per year
	Strategic Action 4.6.2: Develop the district budgeting tools to facilitate budgeting process and mainstreaming HIV/AIDS in the departmental and lower local government work plans.										
4.6.2.1	Prepare and provide the necessary data for enhancing planning for HIV/AIDS services at the lower local governments (LLGs)and health facilities	Number of LLGs and facilities able to prepare evidence based work plans and budgets	14 LLGs 60 Health facilities	**14,000**	**14,70 0**	**14,773**	**15,512**	16,287	75,272	DHO	HMIS dissemination meetings at the facilities
4.6.2.2	Train HIV/AIDS focal point persons	Number of trainings held	**4**	**0**	**4,000**	**0**	4,000	0	8,000	HIV FP	Two per year

	to support planning and budgeting for HIV/AIDS services at the lower local governments and health facilities										
4.6.2.3	Integrate HIV/AIDS services into the health facility routine activities.	No of facilities integrating HIV/AIDS services into routine activities	**60**	**0**	**0**	0	0	0	Cost free	HIV FP	All health facilities in the district comply
Strategic Action 4.6.3: Strengthen capacity of stakeholders at the district and community levels on resource mobilisation for HIV/AIDS services.											
4.6.3.1	Increase public awareness and accountability by sharing information about funds for HIV/AIDS at district and community levels via newspapers, radios, community notice boards and meetings	No times information is shared	**20**	**3,600**	**3,780**	**3,969**	**4,167**	4,376	19,892	DHE	Funds are available
4.6.3.3	Train the DAC and SACs in resource mobilisation skills for HIV/AIDS services	Number of SACS trained	1 DAC 12 SAC	0	4,000	4,200	0	0	8,200	HIV FP	Funds are available

4.6.3.4	Train health facility staffs and other sector staffs to allocate funds for HIV/AIDS services.	Number of health facility staffs trained in resource mobilisation skills per sub county	At least 3 staffs per sub county	0	6,000	0	6,600	0	12,600	HIV FP	Funds are available

No	**Activity**	**indicator**	**Output/ Target**	**Time Frame**					**Budget ('000)**	**Resp. person /institution**	**Assumptions**
				Yr1	Yr2	Yr3	Yr4	Yr5			
5.0	**MONITORING AND EVALUATION**										
	Objective 5.1: To strengthen the district's mechanism for generating comprehensive quality and timely HIV/AIDS information for Monitoring and HIV/AIDS information for monitoring and Evaluating the district strategic Plan 2020/21 to 2024/2025										
	Strategic Action 5.1.1: Operationalize the District HIV and AIDS M&E Plan										
5.1.1.1	Hold **HIV and AIDS** stakeholders' Planning and coordination meetings	Number of planning and coordination meetings held	4 meetings held in a year	0	0	0	0	0	No cost	DHO	To be integrated in activity 4.1.2.4
Strategic Action 5. 1. 2: Strengthen the M&E capacity of HIV and AIDS service providers in the mechanisms for capturing bio medical and non bio-medical HIV prevention data from all implementers											
5.1.2.1	Conducting data quality assessment(DQA)	Number of DQAs conducted per year	20	146,520	146,520	161,538	169,615	178,096	809,615	Biostatistician	Quarterly DQAs in all the 59 facilities, 11

No	Activity	indicator	Output/ Target	Time Frame					Budget ('000)	Resp. person /institution	Assumptions
				Yr1	Yr2	Yr3	Yr4	Yr5			
											people to conduct it quarterly
5.1.2.2	Provision of Health Information Management tools	-Proportion of Health facilities provided updated tools	100%	4,000	4,200	4,410	4,631	4,862	22,103	Biostatistici an	Tools are available
5.1.2.3	Training health workers on data capturing, compilation, reporting and analysis.	Proportion of targeted health facilities with trained health workers in data capturing, compilation, reporting and analysis.	60%	0	62,000	0	65,100	0	127,100	Biostatistici an	Funds are available
5.1.2.4	Conduct quarterly HMIS data review meetings	Number of data review meetings conducted	20	0	2,220	2,331	2,448	2,570	9,568	Biostatistici an	75 people to be invited per meeting
5.1.2.5	Equip high volume HC III facilities with computer sets (Kyamusisi, Maanyi, Bulera, Magala, & Kabule)	Number of high volume HC IIIs provided with computers	5	0	60,000	0	0	0	60,000	DHO	Funds are available
5.1.2.6	Conduct support supervisions	Number of health facilities visited	20	0	0	0	0	0	No cost	Biostatistici an	To be integrated in activity 5.1.2.1
Strategic Action 5.1.3: Strengthen HIV and AIDS M&E coordination and networks											
5.1.3.1	Formation of SACs	Proportion of sub counties with functional SACs	14 sub counties	0	3,000	0	0	0	3,000	HIV FP	Funds are available
5.1.3.2	Training of SACs and DAC	Proportion of SACs trained	100%	0	0	0	0	0	No cost	HIV FP	To be integrated

No	Activity	indicator	Output/ Target	Time Frame					Budget ('000)	Resp. person /institution	Assumptions
				Yr1	Yr2	Yr3	Yr4	Yr5			
5.1.3.3	Conducting SAC and DAC meetings	Number of meetings conducted	4	0	0	0	0	0	No cost	HIV FP	To be integrated

Care & Treatment	Year 1	Year 2	Year 3	Year 4	Year 5	Total
	(000 Ushs)					
Prevention	360,740	551,648	596,898	238,630	199,710	1,947,626
Care & Treatment	358,832	608,401	487,807	375,790	339,759	2,170,589
Social Support and protection	264,090	805,962	516,699	344,806	362,218	2,029,685
Health Systems strengthening and M&E	283,720	924,945	876,251	562427	509629	0
Total	1,267,382	2,890,956	2,477,655	1,521,653	1,411,316	6,147,900
	21%	47%	40%	25%	23%	100%