National Strategic Plan to Reduce Human Rights-Related Barriers to HIV, TB and Malaria Services:

Uganda

2020-2024

DECEMBER 2019

The Republic of Uganda

LEAVING NO ONE BEHIND: A NATIONAL PLAN FOR ACHIEVING EQUITY IN ACCESS TO HIV, TB AND MALARIA SERVICES IN UGANDA
2020-2024

FINAL VERSION
DECEMBER 2019

ABBREVIATIONS AND ACRONYMS

AAAQ	Available, accessible, acceptable and quality
AIDS	Acquired immune deficiency syndrome
ART	Anti-retroviral therapy
CHEW	Community Health Education Worker
HIV	Human immuno-deficiency virus
KVP	Key and vulnerable population
MDR	Multi-drug resistant
MoES	Ministry of Education and Sports
MoGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
MoIA	Ministry of Internal Affairs
MoJCA	Ministry of Justice and Constitutional Affairs
MoLG	Ministry of Local Government
MSM	Men-having-sex-with-men
ODPP	Office of the Director of Public Prosecutions
PLHIV	People living with HIV
PWIUD	People who inject or use drugs
TB	Tuberculosis
UAC	Uganda AIDS Commission
UHRC	Uganda Human Rights Commission
UPF	Uganda Police Force
UPS	Uganda Prison Service
VHT	Village Health Team
WHO	World Health Organisation
XDR	Extremely drug resistant

FOREWORD

The Government of Uganda, through the Ministry of Health and the Ministry of Justice and Constitutional Affairs, is committed to promoting and protecting the right of all Ugandans to attain the highest attainable standard of health. To achieve this, in 2017, the government, with support from the Global Fund to Fight HIV, Tuberculosis and Malaria, undertook a baseline assessment to identify human rights and equity-related barriers to HIV, tuberculosis and malaria services. The assessment was a landmark achievement that provided important evidence on barriers impeding access to HIV, tuberculosis and malaria services for individual and communities with high vulnerabilities to one or more of the three diseases. It also provided guidance for specific actions necessary to remove these barriers so that all Ugandans can secure their rights and responsibilities for health as committed to them under the 1995 Constitution of the Republic of Uganda as well as the many regional and international treaties, conventions and declaration to which the country is a signatory.

The findings of the baseline assessment led to the development of this comprehensive response plan to remove human rights and equity barriers to HIV, TB and malaria services for all Ugandans. The plan is the outcome of a series of consultative meetings with a broad range of stakeholders, including representatives of key and vulnerable populations, civil society organizations, ministries, agencies and departments of government, development partners, media and academia. It sets out all of the necessary interventions to address stigma and discrimination in communities and healthcare settings; gender inequality and gender-based violence, including those gender norms that put both men and women at risk; punitive practices, policies and laws that drive people away from services; and poverty and other forms of social marginalization that negatively affect health.

It is my belief that the implementation of the plan will in no small way enable Uganda's response to the three diseases contribute to the realization of Sustainable Development Goal 3 – ensure healthy lives and promote wellbeing for all at all ages and in particular end the epidemics of AIDS, tuberculosis and malaria by 2030.

PREFACE

The need for a national plan of action on the removal of human rights and equity-related barriers to national response to HIV, tuberculosis and malaria cannot be over-emphasized. With higher rates of infection among specific groups within the general population, there can be no better time for a focused plan of action. As evidence of this need, the prevalence of HIV among adults aged 15 to 64 in Uganda is 6.2%: 7.6% among females and 4.7% among males, corresponding to approximately 1.2 million people aged 15 to 64 living with HIV in Uganda. Prevalence is higher among women living in urban areas (9.8%) than those in rural areas (6.7%). HIV prevalence peaks at 14.0% among men aged 45 to 49 and 12.9% among women aged 35 to 39. Among young adults, there is a disparity in HIV prevalence by sex and prevalence is nearly four times higher among females than males aged 15 to 19 and 20 to 24. HIV prevalence is also nearly three times higher in men and women aged 20-24 compared to those aged 15 – 19.

With regard to tuberculosis, the first national population based tuberculosis disease prevalence in 2014-15 indicated that tuberculosis disease prevalence stood at 253/100,000; and the disease was found to be four times more common in men than in women and in urban centres than the rural. Additionally in 2018/19 financial year, the country only registered 52,458 (65%) out of an expected 80,000 tuberculosis cases, leaving a significant percentage of tuberculosis cases unaccounted for. HIV and tuberculosis have a strong co-relation; with people living with HIV being 16-27 times more likely to develop tuberculosis than persons without. Malaria on the other hand, is endemic in 95% of the country and accounts for 30 – 50% of outpatient visits and 15 – 20% of hospital admissions. Efforts at ending the epidemics of AIDS, tuberculosis and malaria by 2030 may be achievable if current equity barriers are removed.

The completion of a comprehensive baseline assessment in 2017 provided the impetus for the development of this plan of action. The assessment identified a number of human rights and equity barrier to access to services for people affected by HIV, tuberculosis and malaria, key and vulnerable groups as well as underserved populations. This plan is therefore designed to strengthen the national framework to address challenges. It is aimed at facilitating the elimination of health-related stigma and discrimination, in communities and in health care settings; improvements in laws, regulations and policies that protect and promote health equity; strengthening of access to legal services and legal literacy of stakeholders and key and vulnerable populations; and addressing the needs of underserved populations by reason of geography, culture, language, disability, age or other equity related needs.

The government remains committed to the removal of all barriers that hinder the equitable attainment of the highest standard of health for all Ugandans. This is demonstrated in the concrete and bold actions highlighted in the plan. We all share a common aspiration for a successful national response, which can be accomplished with our resolve and commitment to further improve upon our existing strengths. Success is possible through systematic sensitization for ending discriminatory practices, gender inequality and respect for fundamental human rights of all to access services.

ACKNOWLEDGEMENTS

The development of this comprehensive response plan for of the removal of equity barriers to HIV, TB and malaria services is a result of immeasurable support and contributions by several organizations and individuals. Our sincere appreciation go to the Technical Working Group (TWG) consisting of individuals, representatives of Ministries, Agencies and Departments of government, Civil Society Organizations (CSOs); people living with and affected by HIV/AIDS, tuberculosis and malaria, key and vulnerable populations; development partners, implementing partners, media and the academia. We are particularly grateful to the Global Fund to fight HIV, Tuberculosis and Malaria as well as Frontline AIDS for the financial and technical support for the processes that led to the development and launch of this plan.

We equally appreciate the Ministry of Justice and Constitutional Affairs and the Ministry of Presidency for the inter-ministerial cooperation. Special thanks to Dr Shaban Mugerwa and Dr Hudson Balidawa for leading the process and last but not least the Technical Working Group that worked diligently to ensure the development of the comprehensive response plan to address equity barriers to HIV/AIDS, tuberculosis and malaria including the consultation with different key stakeholders and validation of the final report.

KEY TERMS AND DEFINITIONS

Barriers: A barrier refers to a person or thing that hinders one's ability to realize his or her rights. It is the direct or indirect denial of service or health benefit to an individual or group of individuals for unfair, unjust but remediable reasons including challenges in the environment that are unfair, unjust but remediable.

Discrimination: Discrimination is the unjust or prejudicial treatment of different categories of people especially on the grounds of race, age or sex. It is mostly exhibited in form of gender discrimination.

Equity: Equity refers to fairness and justice. It is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification.

Health equity: Health equity is the notion that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.

Gender: the socially constructed characteristics of women and men. Gender equality is the act of treating men and women equally in as far as access to opportunities, rights and responsibilities within all areas of life.

Gender discrimination: Gender discrimination is unequal or disadvantageous treatment of an individual or group of individuals based on gender. It includes distinctions, exclusions or restrictions based on the biological characteristics and functions that differentiate women from men. Gender discrimination typically disadvantages women more than men. Discrimination against women has the "effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on the basis of equality, of human rights and fundamental freedoms in the political, economic, social, cultural civil or any other field".

Stigma: Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others. Within particular cultures or settings, certain attributes are seized upon and defined by others as discreditable or unworthy.

Key Population: Those who are most likely to be exposed to HIV or to transmit HIV and whose engagement is critical to a successful HIV response i.e. they are key to the epidemic and key to the response. In Uganda, key and vulnerable populations include people living with HIV, men who have sex with men, sex workers, fisher folk, long distance truck drivers.

EXECUTIVE SUMMARY

Uganda remains committed to ensuring that all Ugandans in their diversity have a fair opportunity to attain their full health potential and that no one is left behind. In this spirit, the Government of Uganda, through the Ministry of Health, set up a multi-sectoral Technical Working group to develop a five year comprehensive response plan to address human rights and equity barriers to HIV, TB and malaria services. **Leaving No One Behind: A National Plan for Achieving Equity in Access to HIV, TB and Malaria Services in Uganda (2020-2024)** is intended to contribute to achieving an HIV, TB and malaria free Uganda through improved health equity and increased respect for, protection and promotion of human rights and gender equality for all Ugandans, in all their diversity. It was developed through a consultative process with a broad spectrum of stakeholders, including representatives of key and vulnerable populations, civil society organizations, ministries, agencies and departments of government, development partners, media and academia.

The Plan reinforces commitments under the national, regional and international legal and policy frameworks to end AIDS, TB and malaria as public health threats to all Ugandans by 2030. At the national level, it strengthens the commitment under the national strategic plans for HIV, TB and malaria to follow human rights based and gender sensitive principles and to leave no one behind in benefiting from the collective efforts to address the three disease. It further contributes to Uganda's commitment to health equity and guides the country towards fulfilling its commitments under the *2016 United Nations Political Declaration on ending AIDS*; the *2018 United Nations Political Declaration on the Fight against TB*; the *WHO's Global High Burden to High Impact Malaria Response Initiative* and the *Global Technical Strategy for Malaria 2016 – 2030*; the *African Union's Catalytic Framework to End AIDS, TB and Eliminate Malaria by 2030*; and the *Sustainable Development Goals* and Africa's *Agenda 2063*.

The plan is well aligned with Uganda's national, regional and international commitments and obligations to protect and promote human rights, and to achieve general equality for all Ugandans that are expressed in the *1995 Constitution of the Republic of Uganda*, the *African Charter on Human and People's Rights*, the *Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa*, the *African Charter on the Rights and Welfare of the Child*, the *Universal Declaration of Human Rights*, the *Covenant on Civil and Political Rights*, the *Covenant on Economic, Social and Cultural Rights*, the *Covenant on the Rights of the Child*, and the *Covenant on the Elimination of All Forms of Discrimination Against Women*, amongst other regional and international instruments to which Uganda is a State Party.

The plan is informed by a baseline assessment, carried out in 2017, that identified a number of human rights and equity barriers to HIV, TB and malaria that primarily affect population groups that are most vulnerable to one or more of the three diseases but continue to have the least access to programmes and services for unfair, unjust and resolvable reasons. These barriers ranged from stigma and discrimination in the community and at health facilities; gender inequalities and power dynamics, as well as violence, that lessen the ability of women and girls to leave a healthier life; punitive practices, policies and laws that

drive key and vulnerable populations away from services and make it difficult to estimate population sizes; health facility level barriers including discriminatory practices or stigmatizing attitudes at the hands of health workers and other patients, poor quality services for some key populations, frequent commodity stock-outs, and inconsistent opening times; TB-related barriers in prisons, women including pregnant women, may have less access to malaria prevention and treatment services due to gender inequality, including lack of decision-making power, and gendered preferences in care seeking behaviour; and the voices and concerns of some affected populations including prisoners, refugees and mobile populations are not heard and accounted for in programme decision-making and insufficient information about services.

To address and remove these equity barriers, the plan has one overall goal and nine key result areas as shown below:

Goal	An HIV, TB, and malaria-free Uganda through protecting human rights, achieving gender equality, and improving health equity for all Ugandans in all their diversity.
Result Area 1	There is zero stigma, discrimination and violence in the context of HIV, TB and malaria.
Result Area 2	Health care services are non-discriminatory and respect, protect and promote the health and safety of all patients and staff.
Result Area 3	Law makers and law enforcement agents understand and fulfil their role to respect, protect and promote human rights and health.
Result Area 4	Individuals and communities are knowledgeable about and can secure their rights and responsibilities for health.
Result Area 5	Legal information and services are available and responsive to individuals and groups) who seek redress.
Result Area 6	Laws, regulations and policies promote and protect health equity.
Result Area 7	Gender-related health inequities in HIV, TB and malaria services are resolved, particularly gender-based stigma, discrimination and violence.
Result Area 8	Equity barriers for specific key and vulnerable populations in the context of HIV, TB and malaria are addressed and reduced.
Result Area 9	The public health response to removing equity barriers is comprehensive, sustainable, and well-coordinated.

The Plan includes a comprehensive Monitoring and Evaluation Framework. A National Technical Working Group, with share leadership from the different sectors involved in the implementation of the Plan, will monitor and routinely report on progress towards reducing and removing human rights and equity barriers. The Plan will be financed through the integration of its interventions across national disease programmes that are supported through both domestic and external funding sources, including the Government of Uganda; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the United States Government partners; the UN family; and other multi-lateral and bi-lateral donors and partners that are committed to achieving health equity for all Ugandans.

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1. BACKGROUND AND CONTEXT

1.1. Progress in Addressing HIV, TB and Malaria in Uganda

In 2019, for the approximately 43 million children and adults living in Uganda, the on-going epidemics of HIV, tuberculosis (TB), and malaria remain critical public health concerns. While, under the leadership of the Ministry of Health (MoH), the country continues to make progress on all three fronts, there is still some distance to go to achieve the 2030 goal of eliminating HIV, TB and malaria as public health threats to the population.

With regard to HIV, by the end of 2018, there were approximately 1.3 million adults (15-49 years) living with HIV in Uganda, 60% of which were adolescent girls and young women. At the same time, there were approximately 100,000 children (0-14) years living with HIV. Adult HIV prevalence remains at 5.7% but with significant differences by age, sex, location and population. HIV prevalence for adult females is 7.3% as compare to 4.7% for males. Amongst older adolescents and young people, prevalence is almost four times higher among females than males. HIV prevalence is highest in Central 1, 2 and South-West Regions (8%, 7.6% and 7.9%) and lowest in the North-East and West Nile Regions (3.7% and 3.1%). Although not all data are current or comprehensive, for certain population groups, particularly key populations, HIV prevalence has been found to be significant higher, ranging from 13.7% to as high as 37%.[1]

In 2018, there were approximately 53,000 new HIV infections (all ages) and 23,000 AIDS-related deaths, figures that represented reductions of 43% and 58% respectively since 2010. Part of the reason for this progress has been the continuing expansion and increasing uptake of HIV programmes to the point that approximately 84% of all people living with HIV (PLHIV) know their HIV status of which 83% are enrolled on anti-retroviral treatment (ART), and of those approximately 88% are virally suppressed. In addition, by 2018, PMTCT coverage had reached 93% of women in need of ART prophylaxis and prevented an estimated 17,000 new HIV infections amongst infants. However, significant differences remain particularly for ART uptake and viral suppression. For example, viral suppression is lower amongst males than females; it lowest amongst adolescents and young people compared to older HIV-positive populations. Amongst HIV-positive 15-24-year-olds, only 44.9% of females and 32.5% of males are virally suppressed as compared to approximately 75% of 35-44-year-old females and 60% of similarly aged males. Detailed, disaggregated data on HIV testing, ART uptake and viral suppression for key and vulnerable populations are not available.

In 2018, Uganda had a TB incidence rate of 200 per 100,000 population or 85,000 new infection of which only approximately 67% were notified. Of notified cases, 57% were amongst males and 12% amongst children (0-14 years). TB treatment success reached 72%. The country registered 525 cases of MDR/XDR TB in 2018 of which 510 (97%) were started

[1] According to the National HIV and AIDS Strategic Plan 2015-2020, these HIV prevalence rates included sex workers (35-37%), fisher folk (22-29%), long distance truck drivers (25%), uniformed services personnel (18.2%), men who have sex with men (13.7%), and boda-boda taxi-men (7.5%). However, such results come from different times periods and were measured using different methods meaning that they are not necessarily comparable amongst each other.

on treatment. Almost all (98%) newly diagnosed TB patients knew their HIV-status and 40% were co-infected with HIV of which 97% were on ART. A recently completed national survey to determine the direct and indirect costs borne by TB patients and their households found that 53% of TB patients and their households spend at least 20% of their household expenditure, categorized as catastrophic expenditure, on accessing TB treatment. TB prevalence in prison settings is triple that of the general population and this is attributed to overcrowding, poor ventilation and hygiene, irregular and limited diet, indoor confinement and poor access to healthcare services.

Malaria remains an important public health priority for Uganda and accounts for 30% to 50% of outpatient visits, and 15% to 20% of hospital admissions. It is endemic in 95% of the country and its high incidence is attributable to stable, year round transmission. Uganda continues to be one of the 11 countries globally where 70% of the world's malaria is concentrated. People living in poverty are affected more than those in better socio-economic positions. Economic and social barriers often prevent marginalized populations including vulnerable and underserved populations from participating in malaria prevention, treatment and control programmes.

Evidently, then, sustained collective commitment is still needed across all sectors to protect gains in HIV, TB and malaria prevention, treatment and control, and to accelerate progress towards the country's commitments to end these epidemics and the negative impacts they bring to the health and well-being of the population.

1.2. Importance of Achieving Health Equity in the Context of HIV, TB and Malaria

Uganda's commitment to health equity is reflected in the Health Sector Development Plan 2015-2020, as well as other related health and social policy instruments. This commitment is informed by the World Health Organisation (WHO) guidance where equity is, "the **absence of avoidable, unfair, or remediable differences"** amongst different groups in the population, regardless of distinctions based on sex, gender, age, socio-economic status, physical ability, geographic location or other characteristics. **Health equity** is achieved when all Ugandans, in all their diversity, have **"a fair opportunity to attain their full health potential"** and no one is left behind. In the context of HIV, TB and malaria, health equity means that all individuals have fair opportunities to avoid infection or to live with their disease in full health and dignity in the absence of barriers or other limits based on avoidable, unfair or remediable differences. The importance of health equity is clear: **to the extent that health inequities are present for avoidable or unfair reasons (that individual and groups remain 'left behind') the national HIV, TB and malaria responses cannot achieve their full potential and individuals and communities remain vulnerable to one or more of these diseases. This in turn affects the health of all Ugandans so long as HIV, TB and malaria continue to remain as public health challenges**. For this reason, in order to avoid this situation and to continue to achieve progress towards addressing and ending these public health challenges, it has become important to identify and resolve equity barriers within the context of HIV, TB and malaria.

1.3. Equity Barriers to HIV, TB and Malaria Services

In 2017, with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria through its Breaking Down Barriers Initiative, a baseline assessment of equity barriers (including those linked to human rights and gender concerns) to HIV, TB and malaria services was carried out.[2] Arising from the assessment, the following barriers were identified that, if addressed and resolved, would contribute towards improving the sustainability and impact of Uganda's national responses to HIV, TB and malaria while improving health equity for all.

Equity barriers to **HIV services** include:

- On-going challenges of HIV-related stigma and discrimination in family and community settings negatively affecting the motivation of some PLHIV to seek out and remain in HIV programmes.

- High levels of stigma, discrimination and violence against key and vulnerable populations, including stigmatising attitudes and practices amongst some health care workers in facilities, that prevent those at highest risk of HIV infection from accessing health services, including for HIV prevention, treatment, care and support.

- Problematic laws, regulations and policies, and strongly held socio-cultural and religious values that, from a public health perspective, limit the reach and effectiveness of HIV services through their contribution to stigma, discrimination and violence against certain key and vulnerable populations most-at-risk of HIV infection and least able to access HIV services.

- Complex challenges within prisons and other places of detention that prevent inmates and other detainees from accessing and fully benefitting from HIV, TB, malaria and other health services due to overcrowding, poor nutrition and poor levels of basic infection control and prevention.

- On-going challenges for gender equality and the elimination of gender-based violence that place girls and women at greater risk of HIV infection and prevent them from seeking assistance due to stigma and inadequate responses for survivors across the health and justice sectors. The harmful gender norms that drive these trends also affect of members of key and vulnerable populations who also experience violence and exclusion and, frequently, denial of health, legal or other services to recover form such traumas. Gender norms also influence the health seeking motivations of men and boys who continue to be under-representing in HIV testing, treatment and care programmes.

[2] In addition to its support for the baseline assessment, the Global Fund's Breaking Down Barriers Initiative is also providing Uganda with additional catalytic funding support and technical assistance to further strengthen its ability to address and resolve equity barriers to HIV, TB and malaria services. More information about the Breaking Down Barrier's Initiative is available at:

- On-going challenges of poverty, other forms of social exclusion and the limited reach and adaptability of health services for key and vulnerable populations due to cultural, geographic and other reasons.

Equity barriers to **TB services** include:

- On-going challenges of TB-related stigma and discrimination in communities, particularly self-stigma, largely as a result of low levels of basic knowledge about TB and the persistence of cultural myths and other problematic attitudes and practices about the disease.

- The lack of patient-centre approaches for making TB services accessible and reliable for all population groups, but particularly for key and vulnerable populations, including young children, men, prisoners and other detainees, mobile populations and those in very remote and inaccessible regions of the country.

- Complex challenges of gender whereby males have a higher burden of TB but low levels of participation in TB services with consequent poorer outcomes for treatment success and other related health outcomes.

Equity barriers to **malaria services** include:

- On-going challenges of socio-economically and culturally sustained inequalities for women and girls that limit access to malaria prevention and control interventions, including those provided in homes and through health services.

- Challenges to provide and sustain effective malaria prevention and control interventions for migrant and mobile populations, including nomads, refugees and asylum seekers, as well as for socially excluded populations such as people with disability and the elderly.

- Challenges to provide and sustain effective malaria prevention and control interventions in prisons and other places of detention and closed settings, including barracks, hostels, school dormitories and some health facilities.

- The limited technical and operational ability of the National Malaria Control Programme to offer differentiated approaches to malaria prevention and control in order to address and resolve equity barriers.

1.4. Current Efforts to Address and Remove Equity Barriers

In addition to identifying equity barriers, the baseline assessment also undertook an analysis of current efforts across HIV, TB and malaria to address and resolve equity barriers. In the context of HIV, there were a number non-governmental and community-based organizations, as well as governmental entities, working to address human rights-related barriers to HIV. However, these actions were typically of insufficient scale and

duration, largely due to inadequate investment of financial and technical resources, to yield sustainable change.

With regard to the national TB response, most stakeholders across all sectors had insufficient understanding of the human rights and health equity dimension of the TB epidemic resulting in a lower level of engagement in policy-rated or programmatic response to equity barriers. Similarly, although the country's malaria stakeholders aim to ensure equitable access to services and commodities few comprehensive or sustained interventions were in place to address and resolve equity challenges. Finally, across all three diseases.

Finally, the assessment found that although many stakeholders were very concern and motivate to improve their efforts to address and remove equity barriers, there was an overall gap in comprehensive data and needed technical capacities to more clearly identify these challenges and to design and implement effective, impact-level interventions to address them.

1.5. Strengthening the Multi-sectoral Commitment to Achieving Equity

In order to move from results to action in relation to the baseline assessment, the Ministry of Health convened a multi-sectoral Technical Working Group to develop a comprehensive plan to addressing and removing equity barriers. The results is **Leaving No One Behind: A National Plan for Achieving Equity in Access to HIV, TB and Malaria Services in Uganda (2020-2024).** The plan was developed through a number of stages that included consultations with representatives across all sectors. It was presented for validation at a meeting convened by the MOH on November 30, 2019. The plan was subsequently launched on December 10, 2019 as part of Uganda's commemoration of World Human Right Day. The plan will contribute to achieving an HIV, TB and malaria-free Uganda through improved health equity and increased respect for, protection and promotion of human rights and gender equality for all Ugandans in all their diversity.

2. Leaving No One Behind: A National Plan for Achieving Equity in Access to HIV, TB and Malaria Services in Uganda

2.1. Purpose

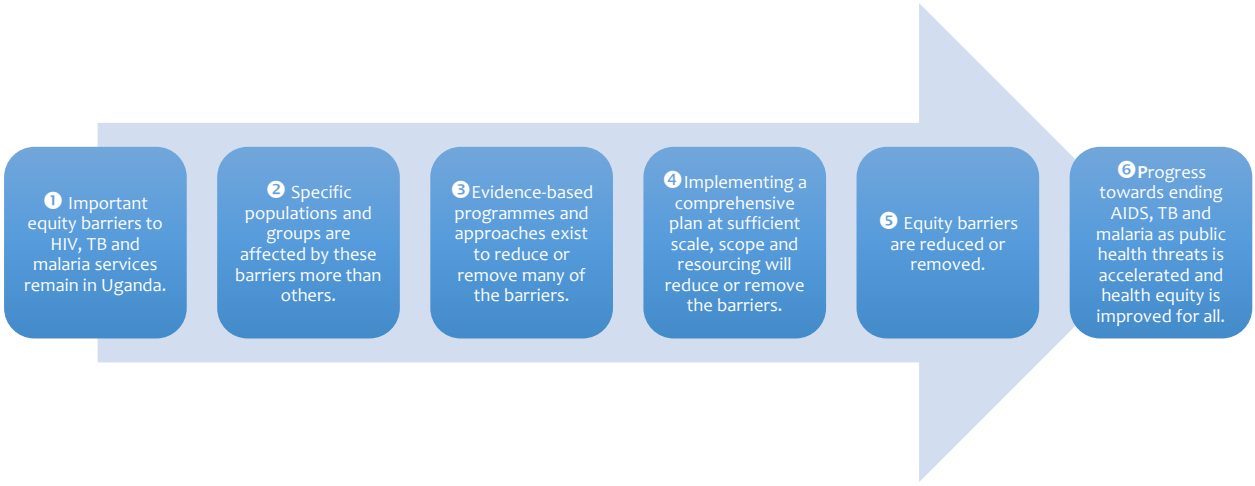
The Plan sets out a comprehensive response to human rights and equity related barriers to HIV, TB and malaria services in Uganda for people living with or affected by HIV, TB and malaria. The Plan reinforces and complements commitments under Uganda's *National Strategic Plans for HIV, TB and Malaria* to follow human-rights-based and gender sensitive principles and approaches that leave no one behind. It further reinforces the country's commitments under *2016 Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight Against HIV and to Ending the AIDS Epidemic by 2030*; the *2018 Political Declaration of the United Nations High-Level Meeting on TB*; the WHO's *Global High Burden to High Impact Malaria Response Initiative* and *Global Technical Strategy for Malaria 2016–2030*; and the African Union's *Catalytic Framework to End AIDS, TB and Eliminate Malaria by 2030*.

The implementation of the Plan will also contribute to the national effort, under the *Sustainable Development Goals* and Africa's *Agenda 2063*, to end AIDS, TB and malaria as public health threats by 2030 in the context of achieving universal health coverage, health equity, gender equality, and a prosperous, peaceful and just society for all Ugandans. The plan is further aligned with Uganda's national, regional and international commitments and obligations to protect and promote human rights, and to achieve general equality for all Ugandans, that are expressed in the *Constitution of Uganda*, the *African Charter on Human and People's Rights*, *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, the *African Charter on the Rights and Welfare of the Child*, the *Universal Declaration of Human Rights*, the *Covenant on Civil and Political Rights*, and the *Covenant on Economic, Social and Cultural Rights*, the *Convention on the Rights of the Child*, and the *Convention on the Elimination of All Forms of Discrimination Against Women*, amongst other regional and international instruments.

2.2. Theory of Change

The Plan has been developed around a theory of change shown below (**Figure 1**):

Figure 1: Theory of change for removing equity barriers



The Plan recognises that important equity barriers to HIV, TB and malaria services remain in Uganda ❶. These barriers affect all people living with or affected by one or more of the three diseases, and members of key and vulnerable groups, as identified in national strategic plans of HIV, TB and malaria and other relevant documents ❷. The populations and groups addressed by the Plan have greater vulnerability to infection or to a higher burden or prevalence of disease, while having least access to the continuum of services to prevent infection or to obtain needed treatment, care or other curative services for one or more of the .

At the time this plan was developed, the following key and vulnerable populations were prioritised based on evidence from a baseline assessment, global guidance documents, and the unique context of Uganda **(Table 1):**

Table 1: Key and vulnerable populations included in the Plan

HIV	TB	Malaria
▪ People living with HIV ▪ Key and vulnerable populations ▪ Uniformed services personnel ▪ Inmates and other detainees ▪ Adolescent girls and young women ▪ People with disabilities ▪ People affected by ethnic, geographic, religious or cultural barriers ▪ Older persons	▪ People living with HIV ▪ People living with/affected by TB ▪ Inmates and other detainees ▪ People in closed/congregate settings ▪ Slum dwellers ▪ Health care workers ▪ People with disabilities ▪ Internally Displaced Populations ▪ Refugees and asylum seekers ▪ Migrant/mobile populations ▪ People affected by ethnic, geographic or cultural barriers ▪ Older persons	▪ Children <5 years ▪ Pregnant women ▪ People living with HIV ▪ People with disabilities ▪ Inmates and other detainees ▪ People in closed/congregate settings ▪ Migrant/mobile populations ▪ Internally Displaced Populations ▪ Refugees and asylum seekers ▪ People affected by ethnic, geographic or cultural barriers ▪ Older persons

Moving forward, these many not be the only individuals or groups most affected by equity barriers to access to HIV, TB and malaria services. As the country context evolves and progress in reducing barriers is achieved, the groups to be included as priorities within the plan will be continually reviewed.

The Plan further recognises that, although equity barriers to HIV, TB and malaria services remain, evidence-based, best-practice approaches and interventions have been identified nationally, regionally and globally [3] that if implemented in a comprehensive manner [4] will contribute towards reducing or removing the barriers [5]. Comprehensiveness means that interventions are:

- Internationally recognised as effective in reducing equity-related barriers to HIV, TB and malaria services.

- Are available, accessible, affordable and acceptable and are offered at sufficient standards of quality to ensure maximum levels of uptake and retention for all population groups.

- Are aligned with and fully integrated within national strategic plans for HIV, TB and malaria; and,

- Are adequately resourced, technical and financially, to move from one-off or small-scale activities to a level of implementation likely to significantly reduce barriers to services (a sustained, mutually-reinforcing, broadly protective set of scaled-up programmes).

Finally, through scaling-up and sustaining human-rights informed, gender-sensitive public health responses to HIV, TB and malaria, health equity will be improved not only for those

key and vulnerable populations most affected by the three diseases but for all people in Uganda, in all their diversity ❻.

2.3. Guiding Principles

The Plan embodies the following guiding principles for all human-rights informed, gender-sensitive public health responses to HIV, TB and malaria:

The Plan embodies the following guiding principles for all human-rights informed, gender-sensitive public health responses to HIV, TB and malaria:

Equality & non-discrimination-- Healthcare providers and institutions must serve all people based on the principles of medical ethics and the right to health. No person should be denied needed health care services on the basis of diversity, professional status, or geographic location.

Do-no-harm-- No individuals or groups must be put at risk of avoidable harm as a direct or indirect result of the development and implementation of this plan.

Privacy and confidentiality-- All health service users, in all their diversity, have the right to privacy and full confidentiality of their health information. Health professionals have a duty to respect the essential human dignity of all persons and to protect the privacy and confidentiality of their patients.

Meaningful participation and inclusion of people living with the diseases and key and vulnerable populations--Members of key and vulnerable populations as well as groups living with or most affected by HIV, TB and malaria should be fully involved in of the development and implementation of this plan.

Respect for personal dignity and autonomy-- *All* persons have the following fundamental rights guaranteed under international, regional and national laws: right to be free from discrimination; right to equality; right to be free from torture and cruel, inhuman and degrading treatment; right to dignity; right to security of the person; right to information; and, the right, including in prisons and other closed settings, to the highest attainable standard of health.

2.4. Results Framework

Overall Goal							
An HIV, TB, and malaria-free Uganda through protecting human rights, achieving gender equality, and improving health equity for all Ugandans in all their diversity.							
1.0	**Result Area 1 : THERE IS ZERO STIGMA, DISCRIMINATION AND VIOLENCE IN THE CONTEXT OF HIV, TB AND MALARIA.**						
	OUTCOME INDICATORS: a) % of of women and men aged 15–49 who report discriminatory attitudes towards people living with HIV b) % of people living with HIV who report experiences of HIV-related discrimination c) % of key and vulnerable populations who reported physical violence in the last 12 months because someone believed they are members of a key population group. d) Number of people with TB who experienced self-stigma due to their TB status that inhibited them from seeking and accessing TB services in the last 12 months. e) Number of people with TB who experienced stigma in community settings due to their TB status that inhibited them from seeking and accessing TB services in the last 12 months.						
REF	**INTERVENTION**	**COVERAGE**	**FOCUS POPULATIONS**	**LEAD SECTOR/ INSTITUTION**	**EXPECTED RESULTS**	**INDICATORS**	**DURATION**
1.1	Finalise, launch and widely disseminate the National Anti-Stigma and Discrimination Policy. Ensure that the policy addresses HIV, TB and malaria, as well as priorities for key and vulnerable populations.	National	All stakeholders in the HIV and TB responses, including national and local level structures and networks.	UAC	National guidance and standards on stigma, discrimination and violence reduction interventions.	Policy document approved and disseminated.	2020
1.2	Develop, implement and sustain a country-wide, multi-media programme to address HIV, TB and malaria-related stigma, discrimination and violence, including specific components for key and vulnerable populations.	National	General population	All sectors	Decreased levels of stigma, discrimination and violence, including self-stigma. Improved uptake and retention in HIV, TB and malaria services for all populations.	# and coverage of stigma, discrimination and violence reduction campaigns.	2020-2024
1.3	Strengthen the capacity of community level structures to integrate stigma, discrimination and violence reduction	National	Community level structures	Government and civil	Reduced levels of stigma, discrimination and violence in communities.	% of community level structures that have integrated stigma,	2020-2024

	messages and activities across their routine health-related activities.[3]			society sectors		discrimination and violence reduction content based on the national policy.	
1.4	Create and sustain focussed HIV, TB and malaria-related stigma, discrimination and violence reduction interventions for adolescents and young people (15-24 years) in all their diversity, including those addressing priorities for adolescents and young people living with HIV.	National	Adolescents and young people, including those living with HIV.	Government and civil society sectors	Reduced stigma and discrimination (including self-stigma) regarding HIV, TB and malaria amongst young people. Improved uptake and retention in HIV, TB and malaria services.	# and coverage of HIV, TB and malaria stigma and discrimination reduction interventions for adolescents and young people.	2020-2024
1.5	Capacitate and engage religious, cultural and community leaders to address and reduce HIV and TB related stigma, discrimination and violence in communities and to improve uptake and retention in services.	National	Religious, cultural and local leaders in communities.	Government and civil society sectors	Community leaders (religious, cultural, others) are fully engaged in reducing stigma, discrimination and violence in their communities.	% of leaders with improved knowledge/capacity (based on pre- and post- intervention assessments). % of capacitated leaders undertaking interventions in communities.	2020-2024
1.6	Scale-up and sustain work in communities led by PLHIV, TB survivors, malaria champions, and members of key and vulnerable populations to address and reduce HIV, TB and malaria related stigma, discrimination and violence.	National	All communities	Civil society sector	HIV, TB and malaria affected individuals fully engaged in communities to reduce stigma, discrimination and violence.	# of PLHIV, TB survivors, and malaria champions working in communities.	2020-2024
1.7	Scale up and sustain quality assured drop-in centres (DICs) for KVPs in communities that provide 'safe spaces'	National	KVPs in communities	Government and civil	KVPs can understand and claim their health related	# of DICs (by focus population/location).	2020 - 2024

[3] Community structures include: local CSOs, Village Health Teams (VHTs) and Community Health Education Workers (CHEWs), structured and non structured faith-based organisations (FBOs), and cultural institutions among other entities.

	for health and rights literacy and function as entry points for HIV and TB services.			society sectors	rights and responsibilities in safe environments.	# and % of DIC users who know their health related human rights.	
1.8	Empower DICs to form and strengthen partnerships with local stakeholders for the creation and maintenance of safe and enabling environments for their beneficiaries in communities.	National	KVPs in communities	Government and civil society sector	KVPs can access services in safe environments that protect and promote their health-related rights and responsibilities.	# and % of DICs who establish and maintain partnerships.	2020-2024
1.9	Scale-up interventions addressing self-stigma for PLHIV, TB survivors and members of key and vulnerable populations, including integration of mental health support into HIV and TB services at health facilities and in communities.	National	PLHIV, TB patients/survivors, members of KVPs.	Government and civil society sector	Reduced self-stigma and mental distress. Improved uptake and retention in HIV and TB services. Improved mental health and quality of life.	# and coverage of interventions. # and % of service users benefiting from mental health support.	2020-2024
1.10	Scale-up collaborative interventions in communities to: improve general knowledge and awareness regarding TB; increase uptake of services; and to reduce TB-related stigma and discrimination.	National	All populations	Government and civil society sector	Increase knowledge and acceptance of TB in communities. Increased uptake and retention in TB services.	# and coverage of interventions.	2020-2024
1.11	Incorporate components on TB stigma and discrimination reduction (all forms) and promotion of health equity in all national policy and guidelines for TB service provision.	National	TB policy makers and service providers.	MoH	All opportunities to address stigma and discrimination reduction in TB service provision are identified and utilised.	# and % of TB policy/guidelines incorporating a clear focus on reducing TB stigma.	2021
1.12	Routinely measure HIV, TB and malaria-related stigma, discrimination and violence (in all their forms). Widely disseminate and popularise findings.	National	All stakeholders in the HIV, TB and malaria responses, including national and local level	Government and civil society sectors	Improved knowledge, awareness, and collective action on reducing/removing stigma, discrimination and violence.	# of assessment completed/repeated at routine intervals. # and coverage of dissemination activities.	2020-2024

			structures and networks.				
2.0	**Result Area 2 : HEALTH CARE SERVICES ARE INCLUSIVE, NON-DISCRIMINATORY AND PROMOTE AND PROTECT THE HEALTH AND SAFETY OF ALL PATIENTS AND STAFF.**						
	OUTCOME INDICATORS: a) % of people living with HIV who report experiences of HIV-related discrimination in health-care settings b) % of individuals from key and vulnerable populations who report experiences of HIV-related discrimination in health-care settings c) % of individuals from key and vulnerable populations who avoid health care because of stigma and discrimination d) Number of people with TB who experienced stigma in health care settings due to their TB status that inhibited them from seeking and accessing TB services in the last 12 months.						
REF	**INTERVENTION**	**LOCATION**	**FOCUS POPULATIONS**	**LEAD SECTORS/ INSTITUTIONS**	**EXPECTED RESULTS**	**INDICATORS**	**DURATION**
2.1	Re-enforce pre-service training for all health workers on patient and health worker rights and responsibilities, as laid out in the Patient's Charter. Emphasise topics on HIV, TB, malaria and KVP in the curriculum.	National	All health worker training institutions (including all cadres) whether public or private.	Health worker training institutions and professional bodies.	Health workers in all facilities provide services aligned to the requirements of the Patient's Charter.	# and % of students trained in patient and health worker rights.	2020-2024
2.2	Require all cadres of deployed health workers and auxiliary/support staff to undertake annual training/refresher courses (using different modalities such as e-learning) on patient and health worker rights and responsibilities.	National	All health workers and health facilities.	Government and health worker professional bodies.	Health workers in all facilities provide services aligned to the requirements of the Patient's Charter.	# and % of health workers completed annual refresher training.	2020-2024
2.3	Capacitate and mandate health facility managers/supervisors to train non-clinical and community health worker staff at health facilities on patient and health worker rights and responsibilities as laid out in the Patient's Charter.	National	Village health teams, community health education workers, receptionists, data entrants and gatekeepers of health care facilities	MoH	Non-clinical and community health worker staff provided services aligned to the requirements of the Patient's Charter.	# and % of non-clinical and community health workers trained in the observance of patient's rights.	2020-2024

2.4	Equip and obligate health facility managers/supervisors to routinely monitor and resolve problematic attitudes and behaviours of all staff that are not aligned to the requirements of the Patient's Charter.	National	Health facility mangers and supervisors.	MoH	Health workers in all facilities provide services aligned to the requirements of the Patient's Charter.	# and % of health facilities meeting minimum AAAQ standards as defined in the Patient's Charter.	2020-2024
2.5	Widely disseminate and popularise the Patient's Charter using different formats/modalities for different audiences and ensure that it is visible and available in all health facilities.	National	All health system users.	MoH, private sector, and civil society.	Improved understanding by patients and health workers of rights and responsibilities for health.	# and % of health facilities where the Patient's Charter is visible and available.	2020-2024
2.6	Engage central level managers and decision-makers to promote the principles of equity, human rights and gender equality in all aspects of their work.	National	Central level staff (programme officers, managers, decision-makers, policy makers)	MoH	Central level managers to promote the principle of human rights, equity and gender equality. Programmes and policies integrate and apply principles of equity, human rights and gender equality.	# and % of central level managers capacitated to apply principles of equity, human rights and gender equality.	2020, 2022, 2024
2.7	Enhance the knowledge and capacity of all health workers to monitor and demand for safe and equitable workplaces in the context of HIV, TB and malaria programmes.	National	All cadres of health workers in all sectors	MoH	Health care workers provide and patients receive services in healthy and safe environments.	# and % of health workers knowledgeable about their health and safety rights and responsibilities.	2020-2024
2.8	Strengthen and maintain responsive and confidential systems for health workers and patients to claim redress in the event of violations of workplace health and safety laws, policies and standards, including in the context of HIV, TB and malaria programmes.	National	All cadres of health workers in all sectors	MoH	Health care workers provide and patients receive services in healthy and safe environments.	A system is established and functional. # of successfully resolved claims where health worker/patients rights are restored.	2020-2024
2.9	Implement community-led monitoring/feedback mechanisms	National	'Sentinel' group of health facilities.	PLHIV, TB, KVP and	Improved AAAQ of health services.	% of facilities covered by functional	2020-2024

	(including the Community Score Card) on accessibility, acceptability, availability and quality (AAAQ) of HIV, TB and malaria services.			malaria networks in communities.	Increased capacity of PLHV and KVP to demand for access to equitable and quality health services	community-led monitoring/feedback mechanisms. # and % of health facilities meeting minimum AAAQ standards.	
2.10	Carry out routine assessments of knowledge, attitudes and practices of all cadres of health care workers and non-clinical staff to measure and sustain progress in providing AAAQ health services to all population groups.	National	All staff in sampled group of health facilities (in all sectors)	MoH Academic partners	Evidence to inform interventions to improve and maintain the AAAQ of HIV, TB and malaria services for all population groups.	# of assessments completed and disseminated.	2020, 2022, 2024
3.0	**Result Area 3 : LAW MAKERS AND LAW ENFORCEMENT AGENTS UNDERSTAND AND FULFIL THEIR ROLE TO RESPECT, PROTECT AND PROMOTE HEALTH AND RIGHTS.**						
	a) % of law makers, law enforcement agents with knowledge and capacity to apply human rights related standards and guidelines in the context of HIV, TB or malaria. b) % of key and vulnerable populations who reported physical violence in the last 12 months because someone believed they are members of a key population group						
	INTERVENTION	**LOCATION**	**FOCUS POPULATIONS**	**LEAD SECTORS/ INSTITUTIONS**	**EXPECTED RESULTS**	**INDICATORS**	**DURATION**
3.1	Strengthen the capacity of senior level policy-makers across the justice sector on their role to promote human-rights-informed and gender-sensitive public health responses to HIV, TB and malaria.	Central-level	Senior level managers and policy-makers across the justice sector	UAC	Senior level leadership in the justice sector can promote and reinforce human-rights-based public health responses to HIV, TB and malaria.	# of senior level managers and policy makers who publicly promote health equity.	2020-2024
3.2	Support the Uganda Police Force (UPF) and the Uganda Prisons Service (UPS) to provide pre-service training in academies on the role of law	National	Police and correctional recruits in academies	UPF and UPS	Police officer and correctional officers, upon deployment, can fulfil their role while	% of UPF/UPS recruits participating in pre-service training.	2020-2024

	enforcement agents and correctional officers to respect and protect the health and rights of all Ugandans, including in the context of HIV, TB and malaria programmes.				promoting and protecting health.	% changes in attitudes through pre- and post-training assessments.	
3.3	Scale up and sustain UPF and UPS training and sensitisation of deployed police officers and correctional officers, in collaboration with affected communities, on their role t to respect and protect the health of all Ugandans (including themselves), in the context of HIV, TB and malaria programmes.	National	Deployed police officers and correctional officers	UPF and UPS Government and civil society sectors	Deployed police officers and correctional offices can fulfil their role while promoting and protecting health.	% of police/correctional officers who receive UPF/UPS & sensitization training. % changes in attitudes through pre- and post-training assessments.	2020-2024
3.4	Engage the judiciary to promote human-rights-based public health responses to HIV and TB in the administration of justice.	National	Members of the judiciary	MoJCA Judicial Service Commission	The administration of justice supports human-rights-based public health responses to HIV and TB.	# of judgements related to HIV and TB passed by trained judges that promote health equity.	2020-2024
3.5	Scale-up and sustain training and sensitisation activities for all stakeholders in the criminal justice system on their role to promote and apply human-rights-based, public health approaches to HIV and TB in the administration of criminal justice	National	Criminal justice stakeholders	MoJCA UAC	Stakeholders across the criminal justice support and reinforce human-rights-based public health responses to HIV and TB.	# and % of stakeholder groups trained.	2020-2024
3.6	Scale-up and sustain activities led by CSOs in communities to create and sustain partnerships with local law enforcement agencies on their role to promote access, uptake and retention in HIV, TB and malaria services.	National	Police and other law enforcement stakeholders in communities.	Government and civil society sectors	Police in communities participate in promoting access, uptake and retention in HIV, TB and malaria services.	# of districts where CSOs support local law enforcement agencies to promote access, uptake and retention in HIV, TB and malaria services.	2020-2024
3.7	Equip cultural leaders, herbalists, champions, ambassadors and religious leaders to advocate for health-related	National	Cultural leaders, religious leaders, herbalists, champions,	Government, civil society, cultural and	Spiritual mentors, cultural custodians and gatekeepers, youth educators, and community leaders	# of faith-based organisations, cultural institutions and youth focused interventions	2020-2024

	rights and responsibilities in the context of HIV, TB and malaria.		ambassadors, school based educators, chaplains, and Imams.	religious institutions	promoting health related rights, duties and responsibilities in the context of HIV, TB and malaria.	with health rights and responsibilities compliant policies, plans, programmes and partnerships in the context of HIV, TB and malaria.	
4.0	**Result Area 4 : INDIVIDUALS AND COMMUNITIES ARE KNOWLEDGEABLE ABOUT AND CAN SECURE THEIR RIGHTS AND RESPONSIBILITIES FOR HEALTH**						
	OUTCOME INDICATORS: a) Knowledge of HIV-related rights among people living with HIV and key populations. b) Knowledge of TB-related rights and responsibilities among with TB and key populations.						
	INTERVENTION	**LOCATION**	**FOCUS POPULATIONS**	**LEAD SECTORS/ INSTITUTIONS**	**EXPECTED RESULTS**	**INDICATORS**	**DURATION**
4.1	Strengthen and sustain the capacity of networks and CSOs led by/working with PLHIV, KVPs, and TB- and malaria-affected individuals in communities to build movements and to integrate human rights awareness and community mobilisation activities within all of their programmes.	National	PLHIV, KVPs, and TB- and malaria-affected individuals	Civil society sector	Civil-society-led interventions for HIV, TB and malaria integrate human rights awareness in all of their activities.	Numbers of networks and CSOs with capacity to integrate human rights awareness and community mobilisation activities.	2020-2024
4.2	Scale-up and sustain the capacity of CSOs to lead interventions in regarding health-related rights and responsibilities.	National	KVPs, HIV, TB and malaria affected individuals and communities.	Civil society sector	Empowered KVPs, HIV, TB and malaria affected individuals and communities secure their rights and responsibilities for health.	Number of CSOs with capacity to lead interventions around health related rights.	2020-2024
4.3	Develop shared standards for human rights literacy materials and community sensitisation and mobilisation interventions.	National	CSOs working with/led by PLHIV, KVPs and TB-affected	UAC and civil society sector	Available, accessible and acceptable standards for human rights literacy materials.	Standards for human rights literacy developed.	2020, 2022, 2024

			individuals in communities		Quality assured health and human rights literacy interventions in communities.		
4.4	Develop/maintain a comprehensive, country-wide web-based system to document and report on health-related human rights violations in communities and to refer to individuals to legal services and redress mechanisms. Widely disseminate reports on a routine basis for awareness-raising and advocacy.	National	All stakeholders	Government and civil society sectors	A comprehensive, country wide web-based reporting and referral system is in place. Trends in health-related human rights violations are routinely monitored and addressed.	Systems is in place and operational. # of routine reports prepared and disseminated.	2020-2024
4.5	Develop, roll out and maintain community level reporting tools and processes for documenting health-related human rights violations of KVPs, PLHIV, TB- and malaria-affected individuals in communities.	National	CSOs working with/led by PLHIV, KVPs and TB-affected individuals in communities	Civil society sector	Tools are in place and used on a continuous basis. Trends in health-related human rights violations are routinely monitored and addressed.	# of individuals reporting human rights violations.	2020-2024
4.6	Increase and sustain the technical and operational capacity of networks and CSOs led by/working with PLHIV, KVP, and legal services providers to ensure the safety and security of their information, staff, members and volunteers.	National	CSOs working with/led by PLHIV, KVPs and TB-affected individuals in communities	Civil society sector	Staff, volunteers and members deliver health and human rights literacy programmes in environments where safety and security is assured.	# of CSOs and with operational protocols and tools for ensuring safety and security.	2020-2024
4.7	Scale-up and sustain networks of people affected by TB in communities to strengthen knowledge and capacity in communities regarding TB-related health rights and responsibilities.	National	TB-affected individuals in communities.	Civil society sector	Increased knowledge of TB-related human rights among people affected by TB and TB advocates	# and coverage of community networks.	2020-2024
4.8	Strengthen and sustain the capacity of malaria stakeholders (government and civil society sector) to identify and	National	Malaria stakeholders	MOH and civil society sector	Increase knowledge and capacity across all malaria stakeholders to identify and	# and % of malaria stakeholders with	2020-2024

	address human rights and gender related barriers to malaria prevention and control.				address human rights and gender-related barriers.	strengthened capacity.	
5.0	**Result Area 5 : LEGAL INFORMATION AND SERVICES ARE AVAILABLE, ACCESSIBLE, ACCEPTABLE AND RESPONSIVE TO INDIVIDUALS AND GROUPS**						
	OUTCOME INDICATORS: a) % PLHIV whose rights were violated and who sought redress. b) % of key and vulnerable populations who reported physical violence in the last 12 months because someone believed they are members of a key population group and who sought redress.						
	INTERVENTION	**LOCATION**	**FOCUS POPULATIONS**	**LEAD SECTORS/ INSTITUTIONS**	**EXPECTED RESULTS**	**INDICATORS**	**DURATION**
5.1	Scale-up CSO-led legal information and services interventions to reach (through different modalities, including community paralegals) all KVPs, PLHIV and TB-affected individuals and their communities.	National	KVPs, PLHIV and TB-affected individuals in communities.	Civil society sector	Increased access to justice for rights violations among affected populations in communities.	# and % of districts with access to legal information and services for affected communities.	2020-2024
5.2	Develop minimum standards and supervision/quality assurance tools for continuous monitoring of community-based HIV, TB and KVP-related legal information and services interventions	National	CSOs working on KVP, HIV, malaria and TB-related legal information and services.	Government and civil society sector	Quality-assured legal services and paralegal support available to individuals in communities.	Tools in place and utilised.	2020, 2022, 2024
5.3	Scale-up and sustain a national network of lawyers with knowledge and capacity to support the legal information and services needs of KVPs, PLHIV , TB- and malaria-affected individuals in communities.	National	Lawyers	Civil society sector	Affected individuals in communities have access to affordable, responsive and quality assured legal information and services.	# and coverage of legal services providers	2020-2024
5.4	Ensure that all accredited legal aid service providers have capacity to respond to legal information and services needs of all KVPs, PLHIV, TB- and malaria-affected individuals, who are eligible for this support.	National	Legal aid services providers	Uganda Law Council and civil society sector	KVPs, PLHIV and TB- and malaria-affected individuals in communities have access to informed and responsive legal aid services.	# and coverage of legal aid service providers working with affected individuals in communities.	2020-2024

5.5	Set up and maintain a national partnership and coordination mechanism (including a privacy-protected case registry) for routine monitoring and improvement of the quality, utilisation and outcomes of the provision of HIV, malaria and TB-related legal information and services.	Central level	All stakeholders in the provision of HIV, malaria and TB-related legal information and services.	UAC Uganda Law Council	A functional coordination mechanism in place. KVPs, PLHIV and TB- and malaria-affected individuals in communities have access to informed and responsive legal aid services.	National coordination mechanism in place and functioning.	2020-2024
5.6	Create and sustain a country-wide mechanism (hot-line and web-based directory) for individuals in communities to know about and quickly access HIV, malaria and TB-related legal information and services (linked to activity 4.4 above).	National	KVPs, PLHIV, malaria and TB-affected individuals in communities.	UAC and civil society sector	KVPs, PLHIV and TB- and malaria-affected individuals in communities have access to informed and responsive legal aid services.	Information and referral mechanism in place. # of calls/cases received and completed (by disposition).	2020-2024
5.7	Equip institutions and organisations working with KVPs, PLHIV, TB- and malaria-affected individuals in communities with information materials and tools (referral pathways) for timely referral to legal information and service providers.	National wide	Institutions and organisations working with KVPs, PLHIV, TB- and malaria-affected individuals	Government and civil society sector	KVPs, PLHIV and TB- and malaria-affected individuals in communities have access to informed and responsive legal aid services.	Pathways in place and utilised.	2020-2024
5.8	Scale up and sustain crisis response mechanisms for KVPs, PLHIV and TB-affected individuals in communities.	National	KVPs, PLHIV and TB-affected individuals in communities at high-risk for or having experienced stigma, discrimination, violence or abuse.	Civil society sector	A strong and effective safety and security response mechanism in place responding to security emergencies experienced by KVPs, PLHIV and TB-affected individuals in communities.	# of individuals receiving crisis response services.	2020-2024

5.9	Develop and scale up measures in the administration of criminal justice to protect the privacy and confidentiality of the health status of all individuals.	National	KVPs, PLHIV, TB- and malaria-affected individuals involved in criminal justice processes.	Criminal justice stakeholders and civil society sector	The privacy and confidentiality of the health status of individuals is respected and protected to avoid stigma, discrimination and violence in the administration of justice.	Mechanism to protect privacy and confidentiality of individuals in conflict with the law in place # of individuals whose privacy and confidentiality is protected	2020
5.10	Create and maintain a collaborative rapid-response mechanism to address and, where possible, resolve urgent cases involving HIV, malaria or TB-related health concerns.	National	KVPs, PLHIV, TB- and malaria-affected individuals involved in criminal justice processes.	KVPs, PLHIV, TB- and malaria-affected individuals	Collaborative rapid response mechanism in place for HIV, malaria or TB-related health concerns.	# of cases dealt with/completed using a rapid response approach.	2020-2024
6.0	**Result Area 6 : LAWS, REGULATIONS AND POLICIES PROMOTE AND PROTECT HEALTH EQUITY**						
	OUTCOME INDICATORS: a) Existence of laws, regulations, policies that specify protections for KVP, PLHIV, TB or vulnerable and underserved populations in the context of malaria. b) Existence of laws, regulations, policies that present barriers to HIV, TB or malaria services.						
	INTERVENTION	**LOCATION**	**FOCUS POPULATIONS**	**LEAD SECTORS/ INSTITUTIONS**	**EXPECTED RESULTS**	**INDICATORS**	**DURATION**
6.1	Undertake routine assessments of laws, regulations, and policies. Ensure that they promote and protect health equity while and removing barriers to HIV, TB and malaria services.	National	KVPs, PLHIV, people with TB and vulnerable and underserved for malaria.	Government and civil society sectors	Laws, regulations and policies create an enabling environment to remove barriers and to promote health equity in the context of HIV, TB and malaria.	# of assessments conducted. # of recommendations addressed.	2020, 2022, 2024
6.2	Strengthen and sustain the capacity of key stakeholders within relevant Ministries, Departments and Agencies (MDAs) to understand and apply the principles of human rights informed, gender sensitive public health	National	Key stakeholders in MDAs involved or having influence on HIV, TB and malaria responses.	Government and civil society sectors	Laws, regulations and policies create an enabling environment to remove barriers and to promote health equity in the	# of trained policy makers who are competent in human rights and gender sensitive issues in the	2020-2024

	responses at all stages of the development of laws, regulation and policies in the context of HIV, TB and malaria.				context of HIV, TB and malaria.	context of HIV, TB and malaria.	
6.3	Strengthen and sustain the capacity of CSOs to participate in health governance structures (including undertaking leadership roles) in order to influence the development and application of laws, regulations and policies in the context of HIV, TB and malaria services.	National	CSOs and networks of KVPs, PLHIV, people with TB, vulnerable and underserved populations in the context of HIV.	Civil society sector	Civil society participates in and/or leads health governance structures.	# of health governance structures with meaningful civil society participation.	2020-2024
7.0	**Result Area 7: GENDER-RELATED HEALTH INEQUITIES IN HIV, TB AND MALARIA PROGRAMMES ARE RESOLVED.**						
	OUTCOME INDICATORS: a) % of women and girls reporting physical/sexual violence (disaggregated by gender, age, location) b) % of women and girls reporting physical/sexual violence who sought redress (disaggregated by gender, age, location) c) Ration of males/females accessing HIV, TB or malaria services (disaggregated by age, sex, health status, location, etc.) d) # of members of key and vulnerable populations experiencing sexual violence. e) % of members of key and vulnerable populations experiencing sexual violence who sought redress.						
	INTERVENTION	**LOCATION**	**FOCUS POPULATIONS**	**LEAD SECTORS/ INSTITUTIONS**	**EXPECTED RESULTS**	**INDICATORS**	**DURATION**
7.1	Strengthen and sustain the capacity of networks and CSOs led-by or working with girls and women (women and girls living with HIV and those who are members of KVPs) to sensitise and empower communities to mobilise for ending gender-based violence.	National	Women and girls, especially women and girls living with HIV and those who are member of KVPs	Government and civil society sectors	Gender-based violence is eliminated from communities.	# and coverage of community-led programmes addressing gender-based violence.	2020-2024
7.2	Scale-up and sustain comprehensive, collaborative responses for survivors of gender-based violence in communities.	National	Survivors of gender-based violence, including women and girls living with HIV and those who are member of KVPs.	All sectors	Survivors of gender-based violence receive comprehensive care and support, including access to HIV and TB services.	# and coverage of community-led programmes addressing gender-based violence.	2020-2024

7.3	Ensure that interventions in communities to sensitise individuals on health-related rights and responsibilities in the context of HIV, TB and malaria include content on identifying, preventing and eliminating gender-based violence.	National	All communities	Government and civil society sectors	Individual in communities are knowledgeable about and contribute to identifying, preventing and eliminating gender-based violence.	# and coverage of interventions in communities addressing gender-based violence.	2020-2024
7.4	Scale up and sustain community based responses that inform and empower survivors of gender-based violence to report these crimes and to seek redress.	National	All communities	All sectors	Survivors of gender-based violence demand for and receive legal redress.	Number of GBV survivors who report violations Number of GBV survivors accessing justice	2020-2024
7.5	Scale-up CSO-led legal information and advocacy interventions responding to gender-based violence to reach (through different modalities, including community paralegals) all communities.	National	Women and girls, especially women and girls living with HIV and those who are member of KVPs, in communities	Government and civil society sectors	Increased access to justice for survivors of gender-based violence.	# and % of survivors of GBV seeking redress	2020-2024
7.6	Strengthen and sustain the capacity of all legal services providers to respond quickly and effectively to all cases of gender-based violence.	National	All legal information and service providers, including legal aid providers.	Government and civil society sectors	Increased access to justice for survivors of gender-based violence.	# and % of survivors of GBV seeking redress	2020-2024
7.7	Strengthen and sustain the capacity of KVP, HIV, TB or malaria service providers to recognise and address gender-based violence, including for timely referral and support from legal services providers.	National	HIV, TB and malaria service providers in all sectors.	All sectors	Increased access to justice, health (including PEP) and other support services for survivors of gender-based violence.	# and % of survivors of GBV seeking redress	2020-2024
7.8	Ensure that community monitoring and reporting mechanisms for human rights violations (4.5 above) are inclusive of all forms of gender-based violence.	National	All communities	Civil society sector	Trends in all forms of gender-based violence are routinely monitored and addressed.	# and % of survivors of GBV seeking redress	

7.9	Scale up and sustain age-appropriate campaigns and dialogues in educational settings to promote gender equality, change harmful gender norms and reduce or eliminate gender based violence.	National	Students, pupils, teachers and school staff, HIV related clubs in schools, inspectors of schools.	Government, civil society and faith-based sectors	Reduction of harmful gender norms, gender based violence and other human rights violations against women and girls.	# and % of educational settings where campaigns were conducted. # and % learners/students reached with gender equality messages.	2020-2024
7.10	Scale up and sustain community level campaigns and dialogues to promote gender equality, change harmful gender norms and reduce gender-based violence.	National	Community members including women and adolescent girls living with HIV, key and vulnerable populations, and parents, local leaders (local council, religious leaders, cultural leaders including clan leaders.	All sectors.	Reduction of harmful gender norms, gender based violence and other human rights violations against women and girls.	# and % of districts/parishes where campaigns were conducted. # and % of people reached with gender equality messages.	2020-2024
7.11	End stigma, discrimination and all other forms of exclusion in all settings against pregnant adolescents and young mothers to ensure their access and retention in health services.	National	All communities All stakeholders in the health and education sectors	All sectors	Pregnant adolescents and young mothers protect and promote their right to health.	# and % of pregnant adolescents/young mothers (10-19 years) attending health facilities. # and % of pregnant adolescents/ young mother assisted to remain in school.	2020-2024
7.12	Undertake an equity analysis of TB services and develop/implement a comprehensive, multi-sectoral action plan to address the findings.	National	All TB stakeholders	All sectors	Evidence-informed action plan to address and remove gender-related barriers.	Findings report produced and disseminated. Action plan finalised and disseminated.	2020-2024

7.13	Advocate with MOH to reorganize the delivery of TB services to ensure that services are sensitive to gender issues to maximize health outcomes.	National	All TB stakeholders	Government and civil society sectors	Gender-responsive TB services.	NA	2021-2024
7.14	Undertake an analysis of gender-related equity barriers to malaria, develop and implement a comprehensive, multi-sectoral action plan to address the findings.	National	All malaria stakeholders	All sectors	Gender-responsive malaria services.	Findings report produced and disseminated. Action plan finalised and disseminated.	2020-2024
7.15	Strengthen and sustain the capacity of key malaria stakeholders to understand, prioritize and act on gender-related inequities across the national malaria programme.	National	National, regional, district and community level stakeholders.	All sectors	Gender-responsive malaria services	# and % of key malaria stakeholders that are on knowledgeable on gender-related inequities.	2020-2024
7.16	Engage young people, through participatory approaches, in promoting malaria prevention and control, and in broader advocacy and education around the gender-related vulnerabilities to malaria.	National	Young people in communities	Government and civil society sectors	Young men and women participate in identifying and removing gender-related barriers.	# and coverage of participatory interventions.	2020-2024
8.0	**Result Area 8 : HEALTH-RELATED EQUITY BARRIERS FOR <u>SPECIFIC KEY AND VULNERABLE POPULATIONS</u> ARE ADDRESSED AND REMOVED IN THE CONTEXT OF HIV, TB AND MALARIA**						
	OUTCOME INDICATORS a) % of specific KVPs who report discriminating attitude towards them (disaggregated by gender, age, population and location) b) % of specific KVPs whose rights are violated and sought redress (disaggregated by gender, age, population and location) c) % of specific KVPs who report experiences of discrimination in health-care settings (disaggregated by gender, age, population and location) d) % of specific KVPs who avoid health care because of stigma and discrimination (disaggregated by gender, age, population and location)						
REF	**INTERVENTION**	**LOCATION**	**FOCUS POPULATIONS**	**LEAD SECTOR/ INSTITUTION**	**EXPECTED RESULTS**	**INDICATORS**	**DURATION**
8.1	**PRIORITIES FOR PEOPLE WITH DISABILITIES (PWDs) IN THE CONTEXT OF HIV, TB AND MALARIA[4]**						

[4] In this plan, people with disabilities includes someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.

8.1.1	Scale up and strengthen interventions by networks of PWDs to conduct sensitizations with all stakeholders on human rights for PWDs in the context of HIV, TB and malaria.	National	All HIV, TB and malaria stakeholders in all sectors	Networks of PWDs	Increased awareness, promotion and protection of the health and human rights of PWDs in the context of HIV, TB and malaria programmes.	# of CSOs and networks sensitised on PWDs op health and rights.	2020-2024
8.1.2	Equip and sustain networks of PWDs to mobilise against stigma, discrimination and gender-based violence in communities and in health care settings.	National	All communities and health facilities.	Government and civil society sectors	PWDs lead communities to mobilise against stigma, discrimination and violence and to ensure access to HIV, TB and malaria services.	# and coverage of programmes in communities addressing stigma and discrimination reduction.	2020-2024
8.1.3	Provide legal information and services that are available, accessible and responsive to the health and human rights-related needs and concerns of all PWDs.	National	All legal information and service providers.	Government and civil society sectors	Access to justice for PWDs seeking redress for human rights violations in the context of HIV, TB and malaria.	# and % of PWDs whose rights were violated that seek redress.	2020-2024
8.1.4	Equip all institutions and organisations working with PWDs in the context of HIV, TB and malaria with information materials and tools (referral pathways) for timely referral to legal information and service providers.	National	PWDs living with HIV or affected by TB, vulnerable and underserved populations in the context of malaria, and all other PWDs in communities	Government and civil society sectors	Access to justice for PWDs seeking redress for human rights violations in the context of HIV, TB and malaria.	# and % of PWDs whose rights were violated that seek redress.	2020-2024
8.1.5	Equip the health sectors with tools and capacities to provide AAAQ HIV, TB and malaria services to *all* PWDs.	National	Health sector	Government and civil society sectors	Community level structures promote and protect the health and rights of PWDs, including for	# and % of HIV, TB and malaria service points accessible to PWDs. .	2020-2024

					access to HIV, TB and malaria services.		
8.2	**PEOPLE (ADULTS, ADOLESCENTS AND CHILDREN) IN CLOSED SETTINGS INCLUDING PRISONS, PLACES OF DETENTION, HEALTH AND EDUCATIONAL INSTITUTIONS**						
8.2.1	Routinely assess the AAAQ of HIV, TB and malaria services in prisons to monitoring and ensure equity.	National	Prisons	Government and civil society sectors	All prisoners and detainees benefit from HIV, TB and malaria services at the same level as the general population.	# and % of prisons offering AAAQ of HIV, TB and malaria services according to national standards.	2020, 2022, 2024
8.2.2	Scale up and sustain partnerships between CSO and prisons for ensuring the AAAQ of HIV, TB and malaria services for all prisoners and detainees.	National	CBOs and CSOs working on prisoners' rights.	Government and civil society sectors	All prisoners and detainees benefit from HIV, TB and malaria services at the same level as the general population.	# and % of prisons supported with partnerships. # and % of prisoners and detainees benefiting from AAAQ of HIV, TB and malaria services.	2020-2024
8.2.3	Build and sustain the capacity of all cadres of prison workers to protect and promote the rights and responsibilities of all prisoners to access and benefit from HIV, TB and malaria services.	National	All cadres of prison workers.	MoIA MoH	All prisoners and detainees benefit from HIV, TB and malaria services at the same level as the general population.	# of prison workers whose capacity to protect rights of inmates has been built. # and % of prisoners and detainees benefiting from AAAQ of HIV, TB and malaria services.	2020-2024
8.2.4	Integrate content on health-related human rights and responsibilities into peer-led education programmes and other interventions addressing HIV, TB and malaria in prisons.	National	All prisoners and detainees	Government and civil society sectors	All prisoners and detains understand their health-related rights and responsibilities and can demand for HIV, TB and malaria services.	# and coverage of peer led programmes integrated human rights content.	2020-2024

8.2.5	Build and sustain the capacity of relevant MDAs to understand, implement and fully comply with minimum standards for infection control and prevention, including for HIV, TB and malaria, in training academies, barracks and other close settings across the law, justice and internal security sectors.	National	Police officers, prison workers, military personnel and others living in hostels, barracks and other closed settings.	MoH MoIA	Police officers, prison workers, military personnel and others live in environments that protect and promote health.	# and % of hostels, barracks, and other closed settings that comply within minimum standards for infection control and prevention.	2020-2024
8.2.6	Build the knowledge and capacity of individuals living in hostels, barracks and other closed settings to monitor and demand for compliance with minimum standards for infection control and prevention, including for HIV, TB and malaria.	National	Police officers, prison workers, military personnel and others living in hostels, barracks and other closed settings.	Government and civil society sectors	Police officers, prison workers, military personnel and others living in closed settings can protect and promote their health.	# and % of hostels, barracks, and other closed settings that comply with minimum standards for infection control and prevention.	2020-2024
8.2.7	Equip police units and courts with knowledge, skills and equipment for maintaining compliance with minimum standards for infection control and prevention in holding cells and other closed settings for the prevention and management of HIV, TB and malaria.	National	Inmates and other detainees placed in holding cells and other closed settings	MoJCA MoH	Inmates and other detainees in holding cells and other closed settings can protect their health.	# and % of police units and courts that comply with minimum standards for infection control and prevention.	2020-2024
8.2.8	Improve, implement and monitor policies and procedures for the management of detainees with HIV, TB or malaria in holding cells and other closed settings that respect and	National	Inmates and other detainees placed in holding cells and other closed settings	MoIA MoH	Inmates and other detainees in holding cells and other closed settings with HIV, TB or malaria can protect their health.	% reduction of human rights violations in prisons and other detention facilities	2020-2024

	protect their rights to health, including for privacy and confidentiality of their health status.						
8.2.9	Improve, implement and closely monitor compliance with minimum standards for infection control and prevention for HIV, TB and malaria in all institutional settings for children and adolescents in education, health, justice and social support sectors.		Children and adolescents in health facilities, dormitories, orphanages, shelters, rehabilitation facilities and other closed settings.	Government and civil society sectors	Children and adolescents in closed settings can protect and promote their health.	# and % of facilities and other closed settings for children and adolescents that comply with minimum standards for infection control and prevention.	2020-2024
8.3	**REFUGEES, ASYLUM SEEKERS AND OTHER DISPLACED POPULATIONS**						
8.3.1	Scale up and sustain interventions to inform and empower refugees and asylum seekers regarding the health-related rights and responsibilities in the context of HIV, TB and malaria.	National	Refugees, asylum seekers and other displaced persons in camps and in rural and urban settings	Government, civil society and humanitarian sectors	Refugees and asylum seekers understand and claim their rights and responsibilities for health.	# and coverage of interventions.	2020-2024
8.3.2	Ensure that laws, regulations and policies for refugees and asylum seekers protect and promote their health-related rights and responsibilities in the context of HIV, TB and malaria.	National	Refugees, asylum seekers and other displaced persons in camps and in rural and urban settings	Government, civil society and humanitarian sectors	The health-related rights and responsibilities of refugees and asylum seekers are respected, promoted and protected in all settings.	Laws, regulations and policies that promote and protect health for refugees and asylum seekers.	2020-2024
8.3.3	Empower settlement and community leadership structures on health-related human rights interventions so as to promote and protect the health of refugees, asylum	National	Settlement and community leadership structures	Government, civil society and humanitarian sectors	Leadership empowered and is able to protect and promote human rights .	# and % of structures capacitated on health-related rights and responsibilities.	2020-2024

	seekers and displaced persons.						
8.4	**SPECIFIC KEY AND VULNERABLE POPULATIONS FOR MALARIA**						
8.4.1	Create a system for mapping, identifying and engaging hard to reach, minority and socially disadvantaged populations affected by malaria especially on the islands, mountainous areas and Karamoja sub-region.	National	The islands, mountainous areas and Karamoja sub-region.	Government and civil society sectors	Mechanism in place for engaging hard to reach, minority and socially disadvantaged populations	System in place and functioning.	2020
8.4.2	Sensitize the local religious or cultural structures within islands, hard to reach areas and Karamoja sub-region on their role to promote malaria prevention and control services.	National	Islands, mountainous areas and Karamoja sub-region.	Government and civil society sectors	Remote/hard-to-reach communities are engaged in malaria elimination.	# of religious/cultural leaders trained/equipped to lead community engagement activities.	2020- 2024
8.4.3	Roll out and implement community scorecards to assess the AAAQ of malaria services at the health facility level and in communities.	National	All communities	Government and civil society sectors	Evidence to inform advocacy for service improvement. Evidence to monitor reduction in equity barriers.	# and % of health facilities monitored through score cards.	2020 – 2014
8.4.4	Develop guidelines for integrated service delivery for non-discriminatory equitable access for vulnerable populations seeking malaria services.	National	Country-wide	MoH	Guidelines that are all inclusive of the vulnerable populations.	Guidelines developed, adopted and rolled out.	2020-2021
8.4.5	Expand the scope of community malaria services to identify and include the disabled, older persons, and	Country-wide	Socially excluded populations for malaria.	Government and civil society sectors	All individuals in communities benefit from malaria interventions.	# and coverage of community programmes reaching vulnerable populations.	2020-2024

	other vulnerable groups who may not have access to services in health facilities.						
8.4.6	Equip VHTs to identify PWDs, the elderly and other vulnerable individuals for malaria commodities like LLINs and to deliver to them directly.	Community	Socially excluded populations for malaria	Government and civil society sectors	All individuals in communities benefit from malaria interventions.	# and % of VHTs identifying PWDs, elderly and vulnerable marginalised groups for malaria commodities.	2020-2024
9.0	**Result Area 9: THE PUBLIC HEALTH RESPONSE TO EQUITY BARRIERS TO HIV, TB AND MALARIA SERVICES IS SUSTAINABLE, RESPONSIVE, INCLUSIVE AND WELL-COORDINATED.**						
	OUTCOME INDICATORS NA						
REF	**INTERVENTION**	**LOCATION**	**FOCUS POPULATIONS**	**LEAD SECTOR/ INSTITUTION**	**EXPECTED RESULTS**	**INDICATORS**	**DURATION**
9.1	Strengthen and sustain the technical and operational capacity of the Gender and Human Rights desk at the MOH to design, coordinate, and implement interventions that address human rights and gender-related barriers across the public health sector.	National	Health sector stakeholders	MoH	Improved capacity of the Gender and Human Rights Desk to perform its mandate.	NA	2020-2024
9.2	Maintain, through technical and operational support, the TWG to lead, coordinate and continuously monitor the implementation of the 5-year plan.	National	TWG members	MoH, Development partners	Leadership and coordination for impact in addressing and removing barriers.	NA	2020-2024
9.3	Hold an annual multi-sectoral platform to assess progress on removing equity barriers and to address emerging issues.	National	All human rights/equity stakeholders	Government and civil society sectors	Leadership and coordination for impact in addressing and removing barriers.	# of platforms convened.	2020-2024

9.4	Routinely monitor, evaluate and adjust the plan using routine reporting, programme evaluations, further assessments and operational research.	National	All human rights/equity stakeholders	MoH	Evidence-based interventions to address and remove barriers.	# of reports produced and disseminated.	2020-2024

3. Implementation Arrangements

The Plan will not be implemented as a stand-alone venture but is meant to inform the multi-sectoral implementation of the three disease programmes as well as complementary plans and strategies influencing the programme environment. As national plans and strategies for HIV, TB and malaria are reviewed, revised and implemented they will incorporate relevant interventions from this equity plan. Where that is not the case, the Technical Working Group (see below) will look for opportunities across the health and social development sectors to implement relevant interventions.

4. Oversight and Monitoring Arrangements

Following the launch of the plan, a Technical Working Group will be convened to oversee and monitor progress in the implementation of the plan. The Technical Working Group will be jointly comprised of and led by representatives from the Government of Uganda (Ministry of Health; Ministry of Gender, Labour and Social Development; and Uganda AIDS Commission); national human rights entities, including the Uganda Human Rights Commission; and representatives from civil society, particularly representatives from people living with or affected by one or more of the three diseases.

5. Resource Needs and Resource Mobilisation

Implementation of the plan and the achievement of its outcome and impact level aspirations will require investment, significantly more investment than is currently available to support interventions to address human rights and equity barriers. Opportunities exist through current and planned investments in HIV, TB and malaria programmes to integrate interventions into current or planned interventions. Under the leadership of the Technical Working Group, a resource needs analysis will be completed and a resource mobilisation planned developed to support the full implementation of the plan.

6. Monitoring and Evaluation Framework

Ref	Outcome Indicators	Definition (Source)	Numerator	Denominator	Data Sources	Baseline Value	Date	Measure-ment Frequency
1	**Result Area One : There is zero stigma, discrimination and violence in the context of HIV, TB and malaria.**							
1 a)	Percentage of women and men aged 15–49 who report discriminatory attitudes towards people living with HIV.	Composite indicator measures key manifestations of HIV-related stigma and the potential for HIV-related discrimination within the general population (GAMS).	Number of respondents (15–49 years old) who respond no to either of the two questions (disaggregated).	Number of all respondents (15–49 years old) who have heard of HIV (disaggregated).	DHS			Every 3 -5 years.
1 b)	Percentage of people living with HIV reporting experiences of stigma and discrimination.	Indicator monitors progress towards reducing HIV-related stigma and discrimination (GAMS).	Number of respondents who answer yes to questions regarding specific experiences of stigma and discrimination in the last 12 months (disaggregated).	Number of respondents (disaggregated).	PLHIV Stigma Index.			Every 3 years.
1 c)	Percentage of key and vulnerable populations who reported physical violence in the last 12 months because someone believed they are members of a key population group.	Indicator monitors progress towards reducing human rights violations and improving access to justice.	Number of respondents who answer yes to questions regarding acts of violence in the last 12 months (disaggregated).	Number of respondents (disaggregated).	PLHIV Stigma Index, IBBS surveys, specific surveys/studies , data from intervention 4.5.			Annually.
1 d)	Number of people with TB who experienced self-stigma due to their TB status that inhibited them from seeking and accessing TB services in the last 12 months.	Indicator monitors effects of self-stigma on TB-related health seeking behaviour (Stop TB Partnership)	Number of respondents who answer yes to questions regarding avoid health care in the last 12 months due to different types of self-stigma (disaggregated).	Number of respondents (disaggregated).	New TB stigma index tool (Stop TB Partnership).	NA	NA	Every 3 years.
1 e)	Number of people with TB who experienced stigma in community settings due to	Indicator monitors effects of stigma and discrimination in communities on TB-related	Number of respondents who answer yes to question regarding	Number of respondents (disaggregated).	New TB stigma index tool	NA	NA	Every 3 years.

	their TB status that inhibited them from seeking and accessing TB services in the last 12 months.	health seeking behaviour (Stop TB Partnership)	experiences of stigma and discrimination in communities in the last 12 months disaggregated).		(Stop TB Partnership).			
2	**Result Area Two : Health care services are non-discriminatory and respect, protect and promote the health and safety of all patients and staff.**							
2 a)	Percentage of people living with HIV who report experiences of HIV-related discrimination in health-care settings.	Indicator monitors progress towards reducing discriminatory attitudes and support for discriminatory policies in health-care settings(GAMS).	Number of respondents who answer yes to questions regarding experiences of stigma and discrimination in health services in the last 12 months (disaggregated).	Number of respondents (disaggregated).	PLHIV Stigma Index; data from intervention 4.5.		2019	Every 3 years.
2 b)	Percentage of people from key and vulnerable populations who report experiences of discrimination in health-care settings.	Indicator monitors progress towards reducing discriminatory attitudes and support for discriminatory policies in health-care settings(GAMS).	Number of respondents who answer yes to questions regarding experiences of stigma and discrimination in health services in the last 12 months (disaggregated).	Number of respondents (disaggregated).	IBBS surveys, specific surveys/studies , data from intervention 4.5.			Annually.
2 c)	Percentage of individuals from key and vulnerable populations who avoid health care because of stigma and discrimination.	Indicator monitors progress towards reducing discriminatory attitudes and support for discriminatory policies in health-care settings (GAMS)	Number of respondents who answer yes to questions regarding avoiding services in the last 12 months due to different types of actual or anticipated stigma or discrimination (disaggregated).	Number of respondents (disaggregated).	PLHIV Stigma Index, IBBS surveys, specific surveys/studies .			Every 3 years.
2 d)	Number of people with TB who experienced stigma in health care settings due to their TB status that inhibited them from seeking and accessing TB services in the last 12 months.	Indicator monitors effects of stigma and discrimination on TB-related health seeking behaviour (Stop TB Partnership)	Number of respondents who answer yes to questions regarding avoiding health care in the last 12 months (disaggregated).	Number of respondents (disaggregated).	New TB stigma index tool (Stop TB Partnership), data from intervention 1.12.	NA	NA	Every 3 years.
3	**Result Area Three : Law makers and law enforcement agents understand and fulfil their role to respect, protect and promote human rights and health.**							

3 a)	Percentage of law makers, law enforcement agents with knowledge and capacity to apply human rights related standards and guidelines in the context of HIV, TB or malaria.	Indicator monitors changes in capacity of law makers/law enforcement agents to apply human rights standards.	Definitions and measurement modalities to be developed in first year of implementation.		Surveys and programme data (pre- post-test measures, for example)	NA	NA	TBD
3 b)	Percentage of key and vulnerable populations who reported physical violence in the last 12 months because someone believed they are members of a key population group	Indicator monitors progress towards reducing human rights violations and improving access to justice.	Number of respondents who answer yes to questions regarding acts of violence in the last 12 months (disaggregated).	Number of respondents (disaggregated).	PLHIV Stigma Index, IBBS surveys, specific surveys/studies, data from intervention 4.5.			Annually.
4	**Result Area Four : Individuals and communities are knowledgeable about and can secure their rights and responsibilities for health.**							
4 a)	Knowledge of HIV-related rights and responsibilities among people living with HIV and key populations	Indicator monitors knowledge and agency regarding HIV-related legal and human rights literacy.	Number of respondents responding correctly to specific questions regarding legal and human rights (disaggregated).	Number of respondents (disaggregated).	PLHIV Stigma Index, IBBS surveys, specific surveys/studies, programme data (pre- post-test measures, for example).		2019 (PLHIV)	Every 3 years.
4 b)	Knowledge of TB-related rights and responsibilities among with TB and key populations.	Indicator monitors knowledge and agency regarding TB-related legal and human rights literacy.	Number of respondents responding correctly to specific questions regarding legal and human rights (disaggregated).	Number of respondents (disaggregated).	TB Stigma Index, specific surveys/studies, programme data (pre- post-test measures, for example).	NA	NA	Every 3 years.
5	**Results Area Five : Legal information and services are available and responsive to individuals and groups) who seek redress.**							
5 a)	Percentage of PLHIV whose rights were violated and who sought redress.	Indicator monitors progress towards reducing human rights violations and improving access to justice.	Number of respondents who answer yes to questions regarding human rights violations and who sought redress in the last 12 months (disaggregated).	Number of respondents who answer yes to questions regarding human rights violations in the last 12	PLHIV Stigma Index, data from intervention 4.5.		2019	Annually.

				months (disaggregated).				
5 b)	Percentage of key and vulnerable populations who reported physical violence in the last 12 months because someone believed they are members of a key population group and who sought redress.	Indicator monitors progress towards reducing human rights violations and improving access to justice.	Number of respondents who answer yes to questions regarding acts of violence in the last 12 months and who sought redress (disaggregated).	Number of respondents who answer yes to questions regarding acts of violence in the last 12 months (disaggregated).	PLHIV Stigma Index, IBBS surveys, specific surveys/studies , data from intervention 4.5.			Every 3 years.
6	**Result Area Six : Laws, regulations and policies promote and protect health equity.**							
6 a)	Existence of laws, regulations, policies that specify protections for KVP, PLHIV, TB or vulnerable and underserved populations in the context of malaria.	Indicator monitors progress through laws and policies to improve health equity protections for HIV, TB and malaria affected populations.	NA	NA	NCPI, Legal environmental assessments for HIV, TB and malaria; other specific studies and reviews.			Every 2-3 years.
6 b)	Existence of laws, regulations, policies that present barriers to HIV, TB or malaria services.	Indicator monitors progress through laws and policies to improve health equity protections for HIV, TB and malaria affected populations.	NA	NA	NCPI, Legal environmental assessments for HIV, TB and malaria; other specific studies and reviews.			Every 2-3 years.
7	**Result Area Seven : Gender-related health inequities in HIV, TB and malaria services are resolved, particularly gender-based stigma, discrimination and violence.**							
7 a)	Percentage of women and girls reporting physical/sexual violence (disaggregated by gender, age, location)	Indicator monitors progress towards eliminating gender-based violence against women and girls.	Number of respondents who answer yes to questions regarding experiences of physical or sexual violence in the last 12 months (disaggregated).	Number of respondents (disaggregated).	DHS			Every 3 years.
7 b)	Percentage of women and girls reporting physical/sexual violence who sought redress (disaggregated by gender, age, location)	Indicator monitors progress towards increasing access to justice for survivors of gender-based violence.	Number of respondents who answer yes to questions regarding experiences of physical or sexual violence in the last 12 months who sought redress (disaggregated).	Number of respondents who answer yes to questions regarding experiences of physical or sexual violence in the last 12	Data from intervention 4.5. New monitoring tools to be developed.			Annually.

				months (disaggregated).				
7 c)	Ration of males/females accessing HIV, TB or malaria services (disaggregated by age, sex, health status, location, etc.)	Indicators monitors equity in access, uptake and retention in HIV, TB and malaria services.	Number of individuals accessing services by gender.	Total number people accessing services.	Secondary analysis of programme data; Malaria Match Box results.			Annually.
7 d)	Number of members of key and vulnerable populations experiencing sexual violence.	Indicator monitors progress towards eliminating gender-based violence amongst key and vulnerable populations.	Number of respondents who answer yes to questions regarding experiences of physical or sexual violence in the last 12 months (disaggregated).	Number of respondents (disaggregated).	PLHIV Stigma Index, IBBS surveys, specific surveys/studies , data from intervention 4.5.			Annually.
7 e)	Percentage of members of key and vulnerable populations experiencing sexual violence who sought redress.	Indicator monitors progress towards increasing access to justice for survivors of gender-based violence.	Number of respondents who answer yes to questions regarding experiences of physical or sexual violence in the last 12 months who sought redress (disaggregated).	Number of respondents who answer yes to questions regarding experiences of physical or sexual violence in the last 12 months (disaggregated).	PLHIV Stigma Index, IBBS surveys, specific surveys/studies , data from intervention 4.5.			Annually.
8	**Result Area Eight : Equity barriers for specific key and vulnerable populations in the context of HIV, TB and malaria are addressed and reduced.**							
8 a)	Percentage of specific KVPs who report discriminating attitude towards them (disaggregated by gender, age, population and location)	Indicator monitors progress towards reducing health-related stigma and discrimination according to specific prioritised groups as set out in this Result Area.	Number of respondents who answer yes to questions regarding specific experiences of stigma and discrimination in the last 12 months (disaggregated).	Number of respondents (disaggregated).	Population specific tools to be developed under intervention 1.12.	NA	NA	TBD
8 b)	Percentage of specific KVPs whose rights are violated and sought redress (disaggregated by gender, age, population and location)	Indicator monitors progress towards reducing human rights violations and improving access to justice for specific prioritised groups as set out in this Result Area.	Number of respondents who answer yes to questions regarding acts of violence in the last 12 months who south redress (disaggregated).	Number of respondents who answer yes to questions regarding acts of violence in the last 12 months (disaggregated).	Population specific tools to be developed under intervention 1.12, data from intervention 4.5.	NA	NA	TBD

8 c)	Percentage of specific KVPs who report experiences of discrimination in health-care settings (disaggregated by gender, age, population and location)	Indicator monitors progress towards reducing discriminatory attitudes and support for discriminatory policies in health-care settings for specific prioritised groups as set out in this result area.	Number of respondents who answer yes to questions regarding experiences of stigma and discrimination in health services in the last 12 months (disaggregated).	Number of respondents (disaggregated).	Population specific tools to be developed under intervention 1.12.	NA	NA	TBD
8 d)	Percentage of specific KVPs who avoid health care because of stigma and discrimination (disaggregated by gender, age, population and location)	Indicator monitors effects of stigma and discrimination on health seeking behaviour in the context of HIV, TB and malaria for specific populations as identified this Result Area.	Number of respondents who answer yes to questions regarding avoiding services in the last 12 months due to different types of actual or anticipated stigma or discrimination (disaggregated).	Number of respondents (disaggregated).	Population specific tools to be developed under intervention 1.12.	NA	NA	TBD