THE REPUBLIC OF UGANDA

NATIONAL MULTI-SECTORAL HIV AND AIDS RESOURCE MOBILIZATION STRATEGY

2024/25-2029/30

Uganda AIDS Commission 2024

UGANDA AIDS COMMISSION

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FOREWORD

Uganda has made significant progress in the fight against HIV and AIDS over the last three decades. The progress and achievements made are attributed to the multisectoral approach including the resource mobilization efforts by Government. Financing of the HIV response is very key in effectively managing and sustaining the gains made. The Presidential Fast Track Initiative clearly spells out the need to scale up domestic resource mobilization for the response to sustain the gains made. The resources outlook indicates that HIV funding levels will flat-line and perhaps decline over the foreseeable future. As such the role of prioritisation, efficiency, and increase in domestic financing becomes an important pre-requisite given that this is a seven-year implementation plan. It is in the best interest of Uganda to consolidate the gains made in the HIV response while covering ground for areas still lagging behind.

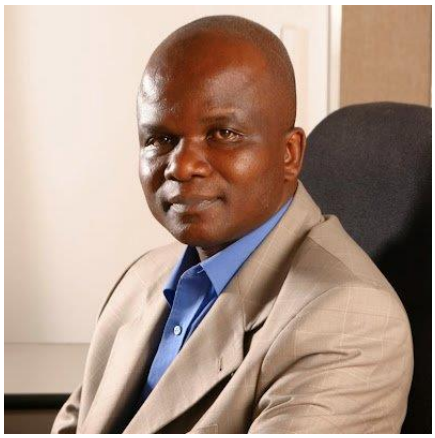
The overall objective of the National Multi-Sectoral HIV and AIDS Resource Mobilization Strategy 2024/25–2029/30 is to ensure that there are adequate resources for a sustainable HIV and AIDS response. The strategy focuses on expanding the resource base to ensure resources are available for implementation of priority interventions that will lead the country to achieving the goal of ending AIDS as a public health threat by 2030.

It is my sincere hope that by implementing the resource mobilization approaches highlighted in this strategy, HIV financing in the country will be more focused and that our common aspiration of zero new infections, zero deaths, and zero stigma and discrimination will be achieved. The failure to realise adequate revenue or persistence of the funding gap hinders the full implementation of impactful interventions in the fight against HIV and AIDS, which could result in the reversal of the gains the country has made against the HIV epidemic.

I therefore call upon key stakeholders and our valued partners to take ownership of this document and use it as a guide towards financing the HIV and AIDS response in the next seven years. HIV remains a priority on the national development agenda, and through the multi-sectoral approach, all government sectors are urged to effectively mainstream and scale-up HIV and AIDS programs in their respective strategic and annual work plans.

Dr. Ruth Senyonyi
CHAIRPERSON
UGANDA AIDS COMMISSION

ACKNOWLEDGEMENT



The National Multi-Sectoral HIV and AIDS Resource Mobilization Strategy has been developed to provide guidance on the resource mobilization opportunities and options for optimizing available resources. It guides the stakeholders (Government, AIDS Development Partners, Non-State actors) to work together to avoid duplication of efforts and wastage of resources. The process of developing the National Multi-Sectoral HIV and AIDS Resource Mobilization Strategy 2024/25–2029/30 was highly participatory. While the Uganda AIDS Commission was leading, various stakeholders including individuals and organizations played an important and active role.

I would like to recognize and congratulate all staff of the Uganda AIDS Commission who took on this task with great courage and enthusiasm. Especially, I would like to appreciate the excellent coordination and support of the Directorate of Planning and Strategic Information headed by Dr. Vincent Bagambe for their commitment and dedication, and Dr. Sarah Khanakwa Bwayo for coordinating the process of developing this resource mobilization strategy.

Uganda AIDS Commission acknowledges the significant contribution and technical guidance of key sectors such as the Ministry of Health, Ministry of Finance, Makerere School of Public Health, the Private Sector and the technical working group members (listed in Annex I).

We would also like to thank the U.S. Government through the USAID/Uganda Health Systems Strengthening (UHSS) Activity, UNAIDS and UNICEF for their technical and financial assistance towards the development of this strategy.

In addition, we wish to acknowledge the input of all individuals, organizations, and development partners (listed in Annex I) that were consulted as key informants for this Resource Mobilization Strategy.

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Dr. Nelson Musoba
DIRECTOR GENERAL
UGANDA AIDS COMMISSION

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ABBREVIATIONS AND ACRONYMS

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
CHAI	Clinton Health Access Initiative
CSO	Civil Society Organization
DAC	District AIDS Committee
EAC	East African Community
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GGE	General Government Expenditure
GoU	Government of Uganda
HIV	Human Immune Virus
JAR	Joint AIDS Review
JICA	Japan International Cooperation Agency
KOICA	Korean International Cooperation Agency
MDA	Government Ministries Departments and Agencies
MoFPED	Ministry of Finance, Planning and Economic Development
MoGLSD	Ministry of Gender, Labour, and Social Development
MoH	Ministry of Health
NASA	National AIDS Spending Assessments
NGO	Non-governmental Organisation
NMS	National Medical Stores
NSP	National Strategic Plan
ODI	One Dollar Initiative
OOP	Out of Pocket Funds
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PrEP	Pre-exposure Prophylaxis
RMS	Resource Mobilization Strategy
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UGX	Uganda Shillings
UHC	Universal Health Coverage
UHHC	Universal Health and HIV Coverage
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UPHIA	Uganda Population-based HIV Impact Assessment
USAID	United State Agency for International Development

EXECUTIVE SUMMARY

Global leaders have declared a commitment to accelerate progress in ending AIDS as a public health threat by 2030. The life-saving and social and economic dividends of achieving this goal should provide the impetus to dedicate adequate resources towards the HIV response. Investments made to respond to the HIV epidemic contribute to broader social and economic priorities, both through the knock-on effects of reduced mortality and morbidity and by freeing up resources to put towards broader national priorities.

However, progress in advancing achievement of the goal to end AIDS by 2030 is under threat. Multiple recent global crises, including the recent COVID-19 Pandemic, continue to have significant threats and place strong pressure on financing for the HIV response. Simultaneously, the Government of Uganda, like governments in many other HIV high burden low-income countries, has been forced by economic conditions and burgeoning debt levels to make limited increments in domestic funding for HIV and AIDS programs, and other health related interventions. Without bold political commitment and action on sustainable HIV financing, these fiscal constraints and competing global priorities will push targets to end the AIDS epidemic as a public health threat increasingly out of reach for Uganda.

This document presents the multi-sectoral resource mobilization strategies for the Uganda's national HIV and AIDS response. The document highlights specific strategies that will be deployed to generate additional resources needed to effectively implement The Uganda HIV Investment Case Framework 2021–2030 and the remaining period for the National Strategic Plan (NSP) FY 2021/22–2024/25. The HIV Investment Case Framework specifies the optimal package of services to be scaled up, with ambitious targets to enable Uganda to not only attain epidemic control, but also to end AIDS as a public health threat (the maximum feasible coverage of a comprehensive set of critical interventions for impact, i.e., HIV testing, treatment, condoms, safe male circumcision, prevention of mother to child transmission, early infant diagnosis, adolescent girls and young women, and programmes for key populations/priority populations). The investment case framework further clarifies on the incremental costs for implementing the optimal package, attaining national targets and returns on investments which includes averting up to 130,000 new HIV infections, and 51,000 AIDS-related deaths, with a favourable economic return on each dollar of approximately USD 5.6 by the year 2030.

The NSP specifically aims at bridging the funding gap identified for the response for the period 2020/21–2024/25; leading up to 2030, and the HIV Investment Case Framework 2021–2030 aims to sustain the gains. According to the NSP 2020/21–2024/25, Uganda will require USD 4.1 billion (UGX 15 trillion) against total commitments of USD 2.8 billion (UGX 10.4 trillion) to attain its set targets, leaving a huge gap of USD 1.3 billion (UGX 5 trillion) as of 2025. The 10-year Uganda HIV Investment Case Framework (2020/21–2029/30) estimates a funding need at USD 8.375 billion (31 trillion) to implement the priority scenario. The Investment Case framework prioritized scenario estimates resource needs of USD 6.375 billion (UGX 24.2 trillion) over the targeted 7 years of this strategy — 2023/24 up to 2029/30 — against total commitments of USD 3.411 billion (UGX 12.9 trillion), leaving a wide gap of USD 2.971 billion (UGX 11.3 trillion), as of 2030.

This strategy presents the urgent and collaborative actions needed to re-prioritize financing towards the HIV response and health more broadly in the national development agenda. Without these commitments and decisive actions, the current gains of the HIV response will retract, threatening to widen the health and socio-economic inequalities — where young women, children, and other vulnerable populations will pay the highest price. The human costs are striking in themselves, and a loud call for action is critically needed.

Failing to mobilise the required funding to achieve the HIV epidemic control targets and sustain the impact leads to not only health, but also social and economic costs. Applying the investment thinking for maximum impact on HIV epidemic will give rise to economic gains which can be modelled through a human capital impact pathway that estimates the productivity impacts on current and future generations.

Broad health budget prioritization needs explicit focus to increase domestic resource mobilization for the HIV and AIDS response. With the reality that Uganda has failed to hit the 15% target as budgetary allocation to health as a proportion of general government expenditure — (GGE), this strategy proposes that if the budget for health is prioritized to aim for at least 10% of GGE, it is likely to generate the additional resources needed for universal health coverage (UHC), and thus for HIV and AIDS. This means, that Uganda will have to double its allocations, from current 6.1% of GGE to 10% and more of GGE by 2030.

However, while budget prioritization is the most effective way to increase domestic resources for health and the HIV response, it will not substantially generate the additional resources required, as a low-income country. Therefore, this strategy emphasizes that external financing will have to still play a critical role in financing HIV and AIDS needs, in addition to resources from the private sector, efficiency gains as well as innovative revenue collection and effective resource management mechanisms.

Resources can be released through gains from efficiency. According to the World Health Organization (2015), 20–40% of the general government health expenditure can be saved through efficiency gains. However, not only is Uganda's government health spending on GGE low (at 6.1% in 2020/21), but the country also presents several areas of inefficiency: infrequent or inconsistent funds flow, weak public financial management, vertical programs, allocative inefficiencies, and fragmented pools and funds flow. Thus, addressing inefficiency is critical.

The Government of Uganda developed a health financing strategy in 2015 to provide a framework through which Uganda would finance its health sector to achieve its stated goals of UHC. The Ministry of Health (MoH) is currently conducting a mid-term review of the health financing strategy, but the strategy does not provide details on HIV and AIDS financing. It is therefore necessary to have a specific HIV and AIDS resource mobilization strategy to ensure focused targeting of HIV and AIDS priorities as well as complementing the broader health financing strategy.

This strategy has proposed broad financing strategic actions which aim to: **i) Accelerate** the budgetary allocation from the Government of Uganda towards supporting the HIV national response; **ii) Deepen** mobilization of resources from existing and potential funders; **iii) Optimize** utilization of the available resources; **iv) Diversify and explore** new and innovative domestic

funding options; and **v) Strengthen capacity** for resource mobilization across the sector for sustainable mobilization of resources for the national resource. For each of the strategic actions above, the resource mobilization strategy outlines the objectives and targets to be achieved along with specific actions and measures to help attain those goals. In addition, the strategy presents a detail on the social and economic returns on HIV investment. Each stream has specific targets — as indicated in the table below, strategies and key performance indicators for the next seven years.

Table 1: Targets by proposed funding stream (in USD million)

	2023	2024	2025	2026	2027	2028	2029	2030	Totals
Resources Needed	679.97	722	756.46	785.64	814.16	843.91	874.71	906.97	6,383.82
Domestic Financing									
Public Financing (budget allocations)	96.48	99.33	101.32	103.34	129.34	155.34	181.34	207.34	1,073.83
Public financing (HIV Mainstreaming)	5.69	6.96	7.03	7.1	16	16	16	16	90.78
Public Financing (through the proposed NHIS)	0	0	0	0	92.38	108.57	130.56	167.18	498.69
Total Public Sector Financing	**102.17**	**106.29**	**108.35**	**110.44**	**237.72**	**279.91**	**327.9**	**390.52**	**1663.3**
Domestic Private sector financing	0.1	0.18	0.18	0.18	101	100.55	101	100.55	402.84
External donor funding	551	551.17	547.12	548.12	88.02	88.02	88.02	88.02	2,549.39
Resource Optimization (efficiency gains)	0	252.61	252.61	252.61	253	252.61	253	252.61	1,768.27
Total	**653**	**910**	**908**	**911**	**679**	**721**	**769**	**832**	**6,384**
Proportion of contribution per source of funding									
Public Sector Financing	**15.64%**	**11.68%**	**11.93 %**	**12.12%**	**35.01 %**	**38.82%**	**42.64%**	**46.95%**	
Private sector financing	**0.01%**	**0.02%**	**0.02%**	**0.02%**	**14.81 %**	**13.94%**	**13.07%**	**12.09%**	
External donor funding	**84.35%**	**60.55%**	**60.24 %**	**60.14%**	**12.97 %**	**12.21%**	**11.44%**	**10.58%**	
Resource Optimization	**0**	**27.75%**	**27.81 %**	**27.72%**	**37.21 %**	**35.03%**	**32.85%**	**30.37%**	

Note: Refer to section 6 for a detail on the funding assumptions

Furthermore, the RMS contains an implementation plan clearly indicating the necessary capacities, coordination, and institutional alignment needed to effectively execute the strategies as well as the monitoring and evaluation framework with a set of indicators to help assess progress and impact of the strategy.

INTRODUCTION

About This Document

This Resource Mobilization Strategy (RMS) presents a multi-sectoral approach for the Uganda's national HIV and AIDS response for the period up to 2030. The RMS highlights the specific approaches that will be deployed to generate the additional resources needed as indicated in the National Strategic Plan (NSP) FY 2021/22–2024/25 and the HIV and AIDS Investment Case Framework 2021–2030. The HIV Investment Case Framework indicates the optimal package of services to be scaled up, with ambitious targets to enable Uganda not only to attain epidemic control, but also to end AIDS as a public health threat by 2030. The investment framework further clarifies on the incremental costs for implementing the optimal package, attaining the national targets and the returns on investments which includes averting up to 130,000 new HIV infections and 51,000 AIDS-related deaths, with a positive economic return on each dollar at USD 5.6 by the year 2030.

The strategy outlines the rationale, the challenges, and objectives for resource mobilization for the HIV and AIDS national response. In a special way, the strategy provides a detail on the social and economic return on HIV investment — a key advocacy tool for investing in HIV and AIDS. It analyses the current situation with particular focus on financing of the national resource and projected resource outlook both at the national and international scale. Further stated in the strategy is the estimated resource need, the resource mobilization framework, strategies, and target revenues from identified streams. Finally, the strategy presents the implementation, monitoring, and evaluation plan for financing the HIV response. The document further highlights to the stakeholders, the need to go beyond raising funds to aspects that include building relationships, networks, valuable contacts, and garnering the interest, support, and in-kind contributions from a wide section of parties. It looks at the value chain for resources including resource mobilization, pooling, channelling allocation, implementation, and accountabilities.

Strategy Development Process and Methodology

In recognition of the challenges of financing the national response, Uganda AIDS Commission (UAC) engaged services of a team of experts to develop an inception report, conduct a desk and literature review, undertake stakeholder consultations, identify and cost priority resource mobilization approaches, and develop a multi-sectoral RMS for the HIV and AIDS national response.

The process of developing the HIV and AIDS RMS was consultative and participatory with key stakeholders. It involved a series of interconnected tasks: identifying a minimum HIV and AIDS basic care package for universal coverage, analyzing current and anticipated funding needs, and determining sustainable financial strategies and actions to meet those needs — with estimated gap at USD 2.97 billion for the next seven years up to 2030. The team carried out stakeholder classification and mapping to ensure proper targeting of stakeholders. The strategy draws on insights gathered from a literature review, expert interviews — a cross and purposeful selection of stakeholders were interviewed representing different categories such as policy makers, funders, program implementers, and the public — indicated in Annex 1.

A review of literature and documents was conducted with a focus on resource management. The documents reviewed included:

- NSP 2015/16–2019/20.
- NSP 2021–2025.
- National Priority Action Plan (2017/18–2019/20).
- The HIV Investment Case Framework 2021–30.
- Annual Joint AIDS review (JAR) reports for 2015/16–2021/22.
- NSP MTR reports (2015/16–2021/22).
- The Country Progress Reports (2017–2019).
- National AIDS Spending Assessment (NASA) Reports (2014–2020).
- U.S. Government Country Operational Plans (2016–20).
- Developments and Agency annual country plans.
- Annual Government of Uganda (GoU) budget framework papers and funding reports.
- Online documents and reports provided vital information for this report.

Stakeholder engagement included an entry meeting with UAC, and key informant interviews with officials from the Ministry of Health (MoH); Ministry of Gender, Labour, and Social Development (MoGLSD); Ministry of Finance, Planning, and Economic Development (MoFPED); UAC; health development partners; and civil society organisations. Consultative workshops were conducted with a wide spectrum of participants. A mix of data-collection methods was used to obtain primary financial data, including desk review of existing resource documents and other secondary data, and technical briefings from UAC, MoH, and other stakeholders.

A technical working group (TWG) was formed which held meetings to solicit their input by way of validating the proposed strategies, the facts, and figures presented in the strategy. Prior to approval, the strategy was further subjected to review and quality assurance by relevant structures established under the national partnership mechanism. The proposed strategic actions were prioritized and those that were specific, measurable, realistic, and feasible with the time span of seven years were selected and costed.

Historical Context of HIV and AIDS

Uganda has made significant progress in the HIV and AIDS response, with the prevalence of the HIV reducing from as high as the 18% in the 1980s to 5.5% in 2022. The number of new HIV infections has decreased steadily from 83,000 in 2015 to 53,000 in 2022, with AIDS-related deaths decreasing from 28,000 to 17,000 in the same period. As of 2022, 90% of the people living with HIV in Uganda know their HIV status, 94% are receiving antiretroviral therapy (ART), and 94% are virologically suppressed. These accomplishments have been possible with significant investment in HIV and AIDS by the Government of Uganda, development partners, and the private sector, including out to pocket from households. These contributed resources that increased exponentially from around USD 460 million in 2015/16 to around USD 636 million in 2019/20[1]. However, it has since plateaued at an average of USD 836 million. Non-financial resource contributions have also been realised in many instances. The current resource base is

[1] The HIV Investment Case Framework for Uganda 2021–30; Investing Now To Save For The Future.

inadequate to support the HIV response needs and the country's universal access, equity, and sustainability agenda.

The progress made by Uganda in the fight against HIV and AIDS since the mid-1980s has largely been due to political commitment at the highest level, the president, as well as effective management of partnership at the local, national, and global levels. The country has been at the forefront of championing innovative ideas, research, and practices that have seen death and despair among communities turn into life and hope.

During the past three decades, the national response to the HIV and AIDS epidemic has been guided by multi-sectoral and sectoral strategic plans. UAC leads in developing and guiding the multi-sectoral plans, whilst the MoH and some line Ministries have developed sectoral plans. The current National HIV and AIDS Strategic Plan 2020/21–2024/25, the five-year blueprint for implementation was developed to increase productivity, inclusiveness, and wellbeing of the population through ending HIV and AIDS by 2030. The plan underscores the fact that the attainment of the overall goal is contingent on achieving the following outcomes by 2025: i) New HIV infections amongst adults and adolescents and young people reduced by 65%; ii) Mother-to-child HIV transmission reduced to less than 5%; iii) High-quality services optimized to achieve 95% linkage to treatment; iv) Viral load suppression in at least 95% of persons living with HIV and AIDS enrolled on ART; and v) Capacity of health and other service delivery systems optimized with maximum efficiencies for HIV services delivery.

According to the National HIV and AIDS Strategy Plan 2020/21–2024/25, Uganda will require USD 4.1 billion against total commitments of USD 2.8 billion to attain its set targets, leaving a huge gap of USD 1.3 billion. And at the same time, Uganda embarked on fast-tracking the HIV and AIDS response with the goal of ending AIDS by 2030, which estimated a resource need of USD 8.375 billion (UGX 31 trillion) to implement the priority interventions with maximum impact using an investment thinking. And for the targeted seven years of this strategy (2023/24–2029/30), the Investment Case Framework prioritized scenario estimates resource needs of USD 6.4 billion. To sustain the impactful interventions and the new prevention technologies like pre-exposure prophylaxis (PrEP) will require additional investments and focused efforts. This will require a sustained resource mobilization for the period of this plan.

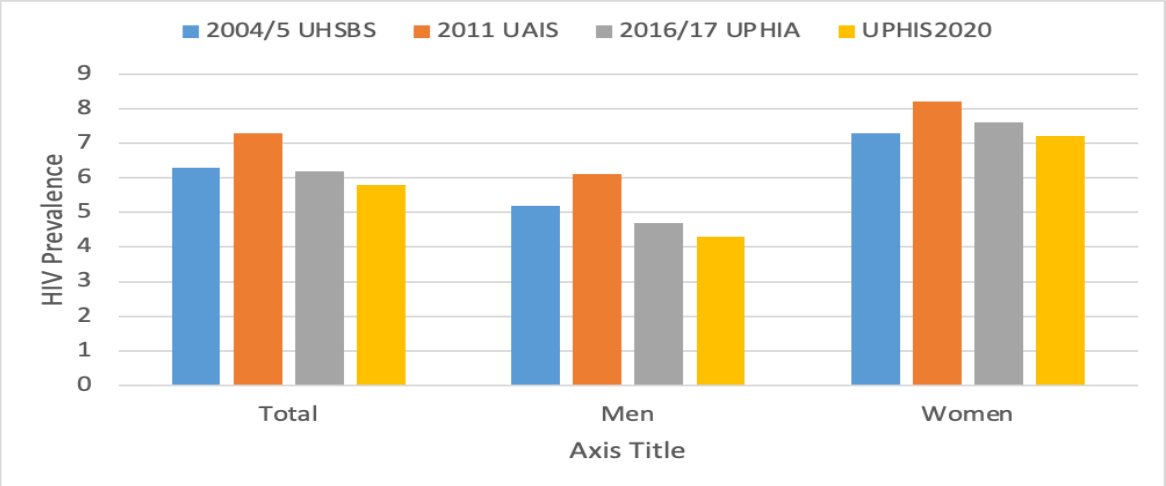
It is based on this background that UAC and partners developed this strategy to ensure increased investment for the national HIV and AIDS response as its contributions to the Human Capital Development Programme for the sustained development, as stipulated in the Third National Development Plan, the goal of the plan is to increase Household Incomes and Improved Quality of Life of Ugandans.

The Current Context of HIV and AIDS

The Uganda epidemic is now mature and has taken on all the characteristics of a long-standing chronic condition. The number of people estimated to be living with HIV has cumulatively increased to 1.4 million partly due to increasing survival on ART and persistent new infections. New infections are mainly among adolescents and young women, key populations, and adult males. The prevalence of HIV in the general population has progressively reduced to 5.3% as of 2022 from 18% in the 1990. AIDS-related mortality has equally reduced to less than 17,000 in the same period due to increased

coverage of efficacious antiretroviral (ARV) regimens, and implementation interventions for advanced HIV diseases which has averted further death. There is increased demand on the resources to maintain the increasing population on ART and the increasing non-communicable diseases.

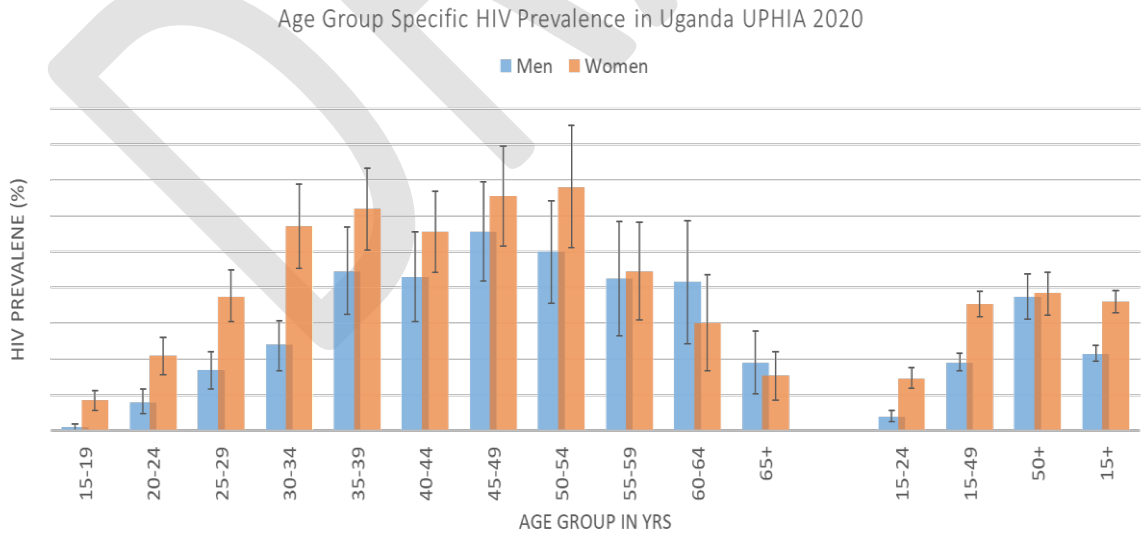
Figure 1: Trends in HIV prevalence in Uganda based on four previous population-based surveys



Source: UPHIA 2020

HIV prevalence appears to have been stagnated for most of the past decade. The HIV burden has continued to grow in parts with high population growth. Figure 2 indicates that there is an overall higher burden of HIV among the women.

Figure 2: Age group specific HIV prevalence



Source: Uganda Population-based HIV Impact Assessment (UPHIA) 2020

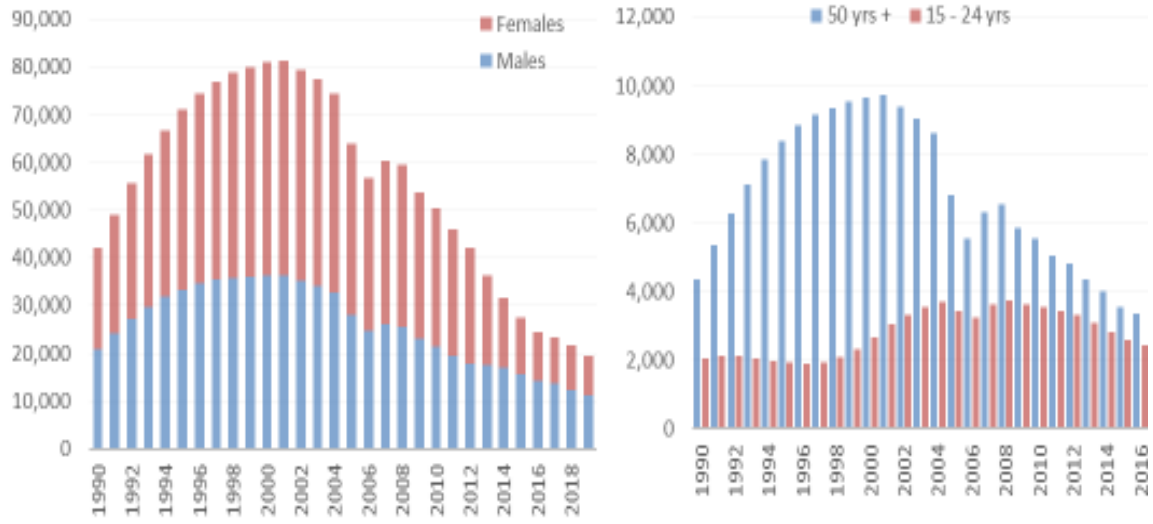
The above figure shows that all age groups are affected by HIV and that HIV is highest within the 45–54 age range for all people living with HIV and AIDS.

The country has prioritised HIV combination prevention interventions in populations and geographies with high HIV transmission rates. Figure 3 shows HIV incidence trend declining since 2010 but stagnated between 2015–2016 and declining again. The figure further presents HIV prevalence still high among females.

Overall, there has been significant progress in coverage and quality of the HIV response with reduction in new infection and AIDS-related mortality. The progress includes reduction in the rates of new infections and incidences as well as provision of ART to almost 1.4 million people. New HIV infections and AIDS-related mortality have declined by 52% and 60% respectively since 2010. By the end of 2020, Uganda was among the eight countries in the world that had fully achieved the 90:90:90 targets[2]. These positive trends have been sustained across many other parameters. The number of people living with HIV increased from 1.2 million to 1.4 million largely due to improved access and utilization of HIV services like testing, care, and treatment[3]. The reduction in AIDS-related deaths has resulted in a decline in the number of AIDS-related orphans, which has increased the general welfare of many families.

Despite these successes, several challenges still exist more so among the key populations and other groups. For example, there are some significant variations across gender that are biased against women. Although mortality rates have declined continuously since 2002, the pace has been slower for the age bracket of 15–24 years as well as the women. (See Figure 3 below.)

Figure 3: AIDS related mortality is falling but with variations in gender and age

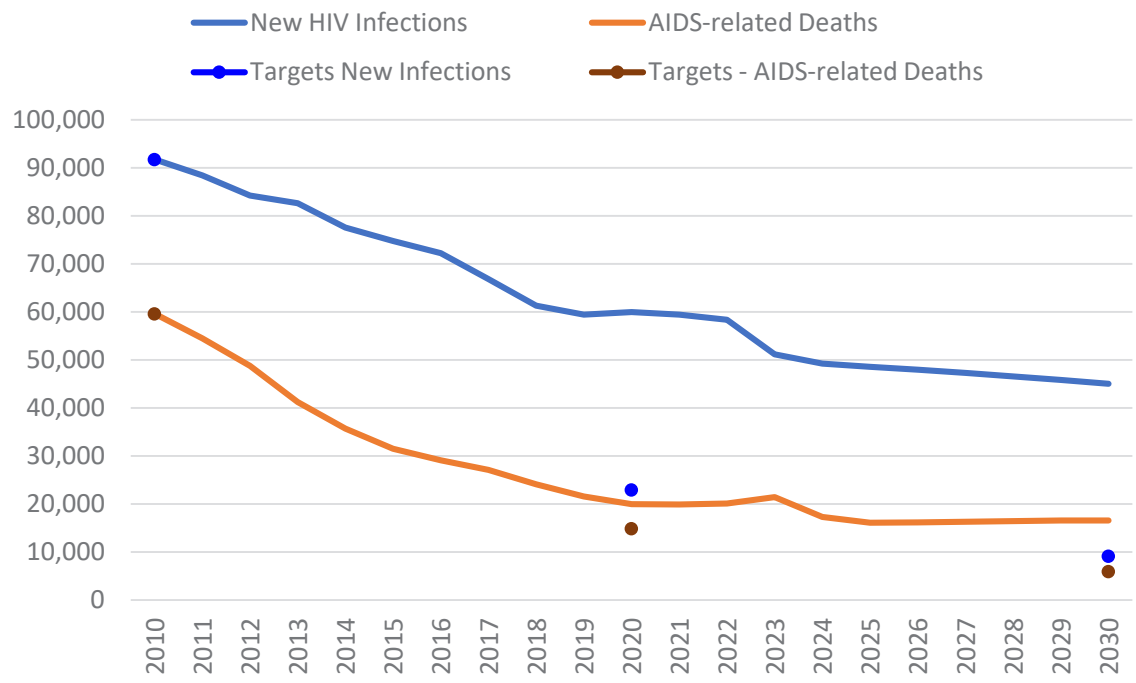


Source: The Investment Case Report

[2] The others are: Eswatin, Switzerland, Rwanda, Qatar, Botswana, Slovenia, and Malawi.
[3] UAC, Fact Sheet for the year ending December 2020.

The decline in new HIV infections and AIDS-related mortality will slow considerably if the current program effort remains constant (i.e., constant coverage of ART, safe male circumcision, condoms, etc.) at 2022 levels. Figure 4 shows the trend of new HIV infections and AIDS-related mortality during 2010–2022, and projections for 2023–2030 under the assumption of constant coverage of all interventions at the coverage levels of 2022.

Figure 4: Trends in New HIV infections and AIDS deaths 2010–2022 and projections to 2030 under assumption of constant coverage of services at 2022 levels



It should be noted that constant coverage of services at 2022 level would still require new enrolments into HIV services. However, the new enrolments would be low, sufficient only to cater for attrition arising from mortality, defaulting or loss to follow up, and for population growth.

Progress Still Shows Vulnerabilities

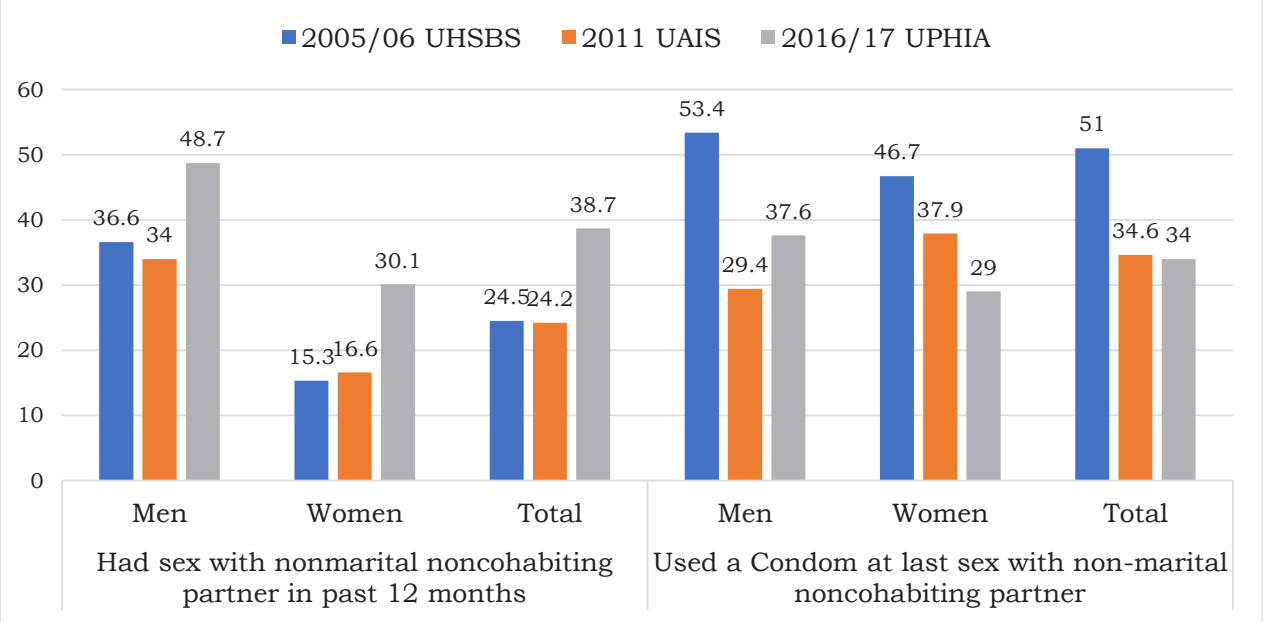
The HIV and AIDS epidemic remains a severe threat as its generalised and heterogeneous across geographical, socio-economic, and demographic subgroups of the population. The downward trends are yet to reach sustainable levels as shown by some key indicators. For example, vertical HIV infections in the country are still high partly due to the following:

i. About half of the new infections occurred among children born to women who dropped off ART during pregnancy or breast feeding.
ii. Several women still acquire HIV during pregnancy or breast feeding.
iii. There is a substantial numbers of vertical infection among children of women who do not start ART either due to lack of attending antenatal care or not taking up ART during antenatal care.

iv. Furthermore, the six-weeks indicator of mother-to-child transmission rates shows a slow pace of decline (Figure 4) and hence reflects potential increases in future treatments costs.

The slow progress in behavioural change continues to drive transmission upwards and reflects a great risk to both the historical gains and future goals. The slowing pace of change in sexual behaviour across the various genders (Figure 5) requires sustained investments in preventive measures such as sexual education to avoid future increase in treatment costs.

Figure 5: Behavioural change from various surveys



Source: Investment Case Report

These new developments of prevalence and mortality presented render it necessary to review and update the national HIV and AIDS RMS to facilitate the achievement of 95-95-95 targets by mobilizing adequate and required domestic and non-domestic resources with efficient allocation and targeted tracking of the resources.

The Problem and Rationale for Continued Investments in HIV Programs

Financing for HIV and AIDs and Universal Health Coverage

The efforts to end the AIDS epidemic by 2030 and to achieve UHC are both at critical junctures. And with only seven years until that deadline, their prospects for success — or failure — are increasingly intertwined. The fight against HIV and AIDS has long been at the centre of many programs in lower-income countries and international donor funding for health. More recently, particularly with the advent of the Sustainable Development Goals, health practitioners, policymakers, and funders are emphasizing an integrated approach to health services, with a focus on universal access within each country to a set of critical health services as part of a Minimum Health Benefits Package.

Despite substantial progress in the national and global response to HIV, persistent challenges remain and by 2030, HIV is expected to be one of the most common cause of death in Sub-Saharan Africa (it is fourth now)[4]. In this environment, UHC cannot be achieved without tackling HIV. Similarly, as practitioners and funders increasingly move to an integrated approach to health services and separate funding streams for HIV stagnate or decline, those involved in HIV will have to find more opportunities by being cognizant of this trend, while working to integrate HIV programming into the broader effort.

Fiscal Space and Its Implications of HIV and AIDS

The concept of fiscal space is closely associated with the ability of the government to maintain debt sustainability. Large shocks to the economy (such as wars or natural disasters) could trigger a fiscal crisis and lead to an unsustainable public debt position. One major shock that is often overlooked is the debt burden associated with treating infectious diseases like AIDS, particularly in developing countries.

Several reports that include the report on Prospects for New Domestic funding for HIV and AIDS in Uganda, by the Health Policy Project (2016); and a study on the future of financing for HIV services in Uganda and sub-Saharan Africa region, by Tom Kakaire (2016), have raised the issue of growing fiscal risks in Uganda as with other countries with high HIV burden in Sub-Saharan Africa due to the fiscal implications of HIV and AIDS treatment. They identify the risks as a "potential fiscal calamity." The authors make two important points about the treatment of HIV in Sub-Saharan Africa. First, because "the decision to start treatment locks in the need to finance future provision, that future liability needs to be known in advance." Therefore, understanding the costs and developing a practical, sustainable financing strategy for HIV and AIDS is a core requirement for Uganda (the third highest HIV burden country in Sub-Saharan Africa) to successfully achieve the HIV and UHC goals. Increasing domestic funding for HIV in Uganda will require increasing fiscal space for public spending in general.

Second, the reports note that "because the continuing spread of infection creates large future liabilities, there is a new rationale for prevention policies. While no longer medically essential to prevent death, prevention becomes more financially valuable. It is worth expanding spending on prevention at least until an extra dollar averts a dollar of liability from new infections".

Challenges in Increasing allocations from Taxes

There are two major challenge to increased funding by GoU out of the Consolidate Fund option. First, is the competition with other increasing demands for financial resources due to payment of interest on debt, security, general salaries and wages, as well as public administration. The policy is to give first priority to debt management (including provisions for interest payment) during the resource allocation process. This has resulted in reductions in resources available for other causes despite increases in the overall budget.

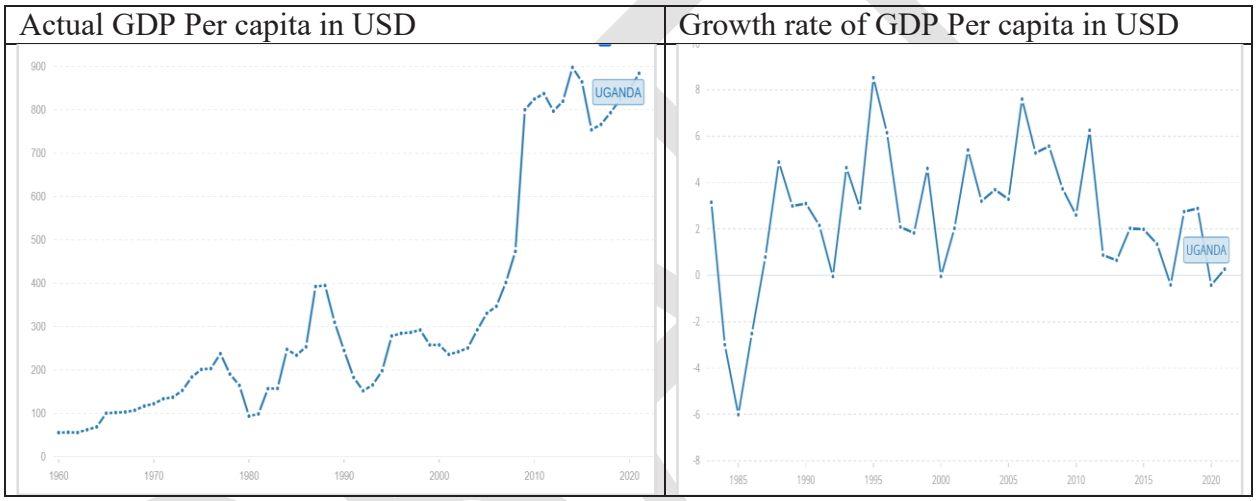
In fact, during the process of developing the FY 2023/24 budget, the government noted "whereas the overall budget had increased from UGX 47.328 trillion in FY 2022/23 to UGX 50.871 trillion in FY 2023/24, the discretionary resource has reduced by UGX 3,370

[4] WHO Analytical Fact Sheet, 2023

billion." Accordingly, "No entity shall receive an increase in the budget …"[5] This was largely due to increases in allocations for debt servicing that are expected to take 30% of the national budget in FY 2023/24 and in the outer years.

The other challenge is slow growth of the economy including delayed transition to lower-middle-income country status. The anticipated transition, which was projected for 2017 and later in 2020 is yet to be realised. This is partly due to delayed production of oil and gas, which is likely to go beyond the current set target of FY 2024/25 given delays of prior activities such as construction of more roads, the oil rigs and pipeline. In fact, historical trends show that the pace towards lower-middle-income status has slowed or stagnated, over the last decade, at less than USD 900 per capita compared to the required USD 1,035 or more. Figure 6 shows that the growth rate of gross domestic product (GDP) per capita has continued to decline since 2005.

Figure 6: Uganda GDP per capita (current USD)



Source: https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=UG

The implication of delayed transition to the lower-middle-income is that local resources based on increased tax and non-tax revenues will not be easily realized at the pace required to increase domestic financing to 46% of the response.

Dominance and Overdependence on International Funding for the HIV Response

There has been consistent dominance and overdependence on international development partners to scale up of HIV services in Uganda, with the bulk of the funding (over 80%) coming from international sources — whereas the GoU and out of pocket (OOP) contributes about 13.3% and 6.3% respectively (NASA, 2024) — Table 2.

Table 2: Actual and percentage contribution (UGX) by source

[5] MoFPED, Medium Term Expenditure Framework on the 2nd Budget Call Circular, February 15, 2023.

FINANCING ENTITIES (UGX)	YEAR OF ASSESSEMENT		% SHARE	
	2019/20	2020/21	2019/20	2020/21
Public Entities	248,684,274,278	256,573,761,644	12.9%	13.3%
Domestic Private Entitites	105,241,957,677	121,636,516,957	5.5%	6.3%
International Entities	1,570,677,522,169	1,554,924,081,237	82%	80%
Grand Total	1,924,603,754,124	1,933,134,359,838	100%	100%

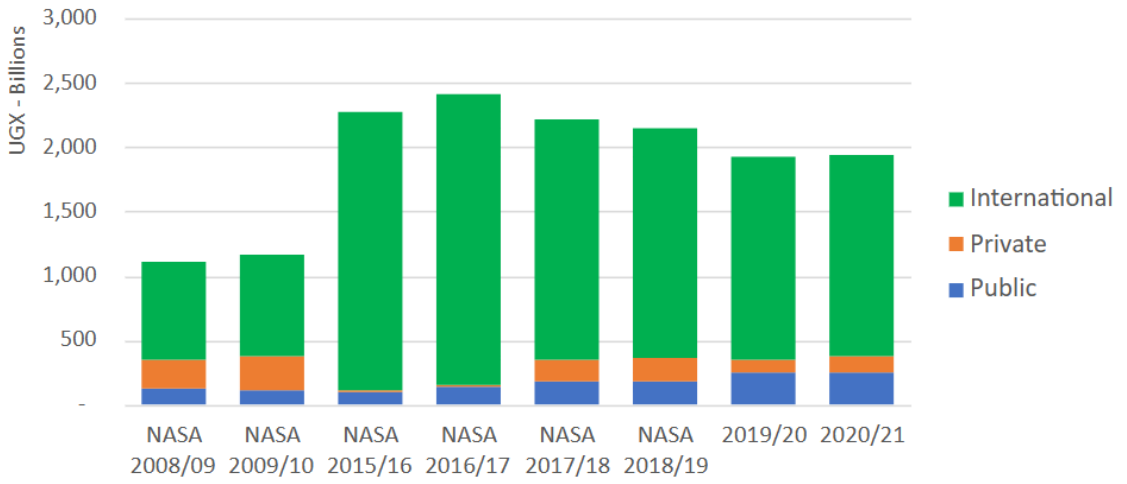
Source: NASA Report 2024

Figure 7 emphasizes the fact that the dominance of funding by external sources has been in the trend for more than a decade.

The HIV response in Uganda has been largely supported by external partners. The recent NASA produced 2024 indicates that 80% of the resources for the response come from external partners. Among the external partners U.S. President's Emergency Plan for AIDS Relief (PEPFAR) contributed 83% and 80 % of the external resources in 2019/20 and 2020/21, while the Global Fund contributed 12% and 15% in the same periods.

However, Figure 7 below, illustrates a declining trend (annually) for international financing entities since 2017/18. It is therefore important to identify new sources of revenue. These sources could include philanthropists who provide funding directly or through initiatives such as the Bill & Melinda Gates Foundation, Elma Foundation, Clinton Health Access Initiative, etc. Furthermore, the World Bank Group and other development banks can also be leveraged to support health system components that are critical for HIV services (service delivery, Human Resources for Health, health information systems, etc.). Although they may not provide funding specifically for HIV and AIDS, they can provide funding for non-health issues that are critical for a population-based approach and for improved human capital development. For example, the World Bank projects in Uganda on education and sexual and reproductive health for adolescent girls and young women (AGYW). The United Nations system also has potential to provide additional funding for example through, the Unified Budget, Results and Accountability Framework that allocates some funds across United Nations (UN) agencies specifically for HIV and AIDS while UNICEF, the United Nations Population Fund, or United Nations Development Programme, can be an important source of funding especially around AGYW, paediatric, or human rights. Lastly, the UN Refugee Agency and Unitaid which is an important actor for introducing new health products should also be considered.

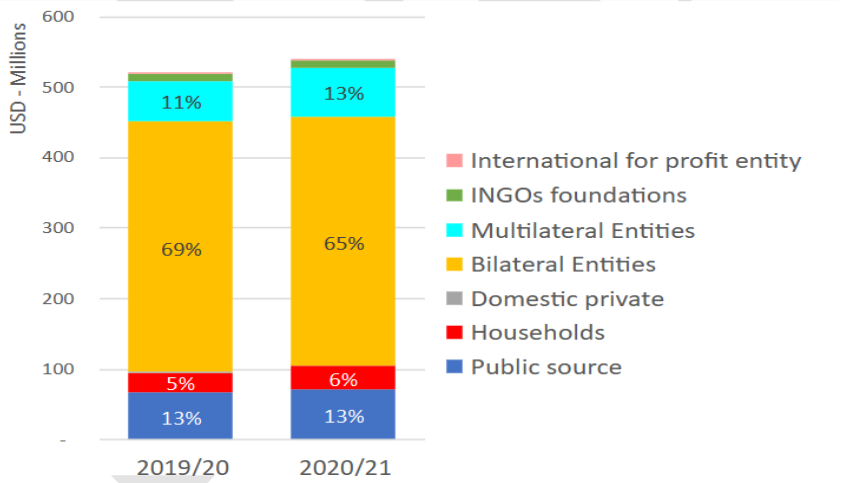
Figure 7: Funding for HIV in Uganda — trends over time (UGX, 2009/10–2020/21)



Source: NASA 2024

A breakdown of the funding by sources (Figure 8) shows that the U.S. Government is the biggest single source of funding followed by the Global Fund. The dominancy of the contributions by the U.S. Government and Global Fund highlights both a need to increase domestic resources for sustainability as well as a strategy to ensure smooth transition to avoid a shock to the system that will lead to loss of previous gains and derailment of traction.

Figure 8: Contributions from major funding entities



Source: NASA Report 2024

Financial Sustainability Challenges

The key question of consideration is whether the system will be financially sustainable to attain the goal of ending AIDS as public health threat in Uganda by 2030. For the purposes of strategy, financial sustainability is defined as the ability to financially sustain the implementation of comprehensive interventions for the prevention and management of HIV and AIDS up to 2030 and beyond.

Rationale for Continued Investments in HIV Programs

The slow progress and associated vulnerabilities observed in the previous section highlight a compelling case for scaling up tailored interventions across all aspects of the response. The following examples are worth noting:

1) Vertical infections require continuity of services for the prevention of mother to child transmission in the following areas: i) The four-pronged strategy that includes family planning by HIV-infected women (including use of condoms); ii) Primary prevention of HIV among women of reproductive age; iii) Enhanced case finding; iv) ART linkage and adherence; iv) Retention of HIV-infected pregnant and breast feeding women; and v) Maintaining PrEP in HIV pregnant women.
2) Despite the high ART enrolment, the viral load suppression remains low among men, children, and adolescents, and effectiveness of HIV prevention services such as safe male circumcision remains low. The men, children, adolescent, and key populations/priority populations did not meet the 2020 targets and are also lagging in the overall HIV testing and treatment. Efforts to exploit the potential of these services in further reduction of new HIV infections are necessary since 95-95-95 may not assure universal viral load suppression.
3) The high levels of HIV drug resistance, prevalence of cases of advanced HIV disease, and comorbidities (especially tuberculosis, non-communicable diseases, and other infectious diseases) still represent a potential threat to the response. These amplify the need for continued strengthening of health systems and integration with other disease management programmes.
4) The data for monitoring and evaluation of the response is still not comprehensively compiled and analysed to continuously give a clear concrete basis for decision-making. There is need to improve the management of data related to the response including costs on each component of the response (human resources, commodities, prevention, etc.) and HIV epidemiological trends among some population groups that likely have high HIV incidence and prevalence.

Strategic Direction of the Resource Mobilization Strategy

Vision

A population free of HIV and its effects.

Mission

To provide effective leadership to the HIV and AIDS multi-sectoral response.

Strategic Goal

To mobilize adequate resources for sustainable financing of the HIV and AIDS national response.

Objectives of the Strategy

- Quantify the existing funding streams and identify new funding mechanisms to meet USD 3 billion (53%) funding gap of attaining universal access to HIV and AIDS by 2030.
- Identify domestic resources (both existing and new) that can be realistically mobilized (and used) to end AIDS by 2030.
- Identify efficiency gains that can help contribute to financing and meeting the goals of ending AIDS.
- Prioritise and create an action plan to operationalize prioritized resource mobilization opportunities, and to strengthen relationships with partners.

Key Outputs of the Strategy

a) An action plan to guide the country in sustainably mobilizing resources and efficiently allocating and utilizing them to implement HIV and AIDS plans to national and sub-national levels.
b) Framework through which all stakeholders including the GoU, development partners, non-state actors, and the private sector will finance its health sector to achieves its stated goals.
c) Framework to address the current fragmented financing efforts by emphasizing and guiding the alignment resources to HIV and AIDS priorities and proposing opportunities for the efficiency savings in the response.

Guiding Principles of the RMS

This strategy is founded on a set of principles, which, not only aim at generating additional resources but also build sustainable capacity to mobilize resources for future.

Harmonization with international development strategies. The strategy will harmonize with Sustainable Development Goals 3.8, Africa Agenda 63, Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that low- and middle-income countries will need investments of USD 29 billion annually to meet targets of ending AIDS as a public health threat by 2030. Funding levels in 2020 fell almost 30% below targets, making subsequent resource needs harder to achieve and putting upcoming targets further out of reach. UNAIDS projects more than 7 million AIDS-related deaths by 2030, but half of those can be averted if the HIV response is fully financed and policies are rightly oriented.

Harmonization with Africa Regional Health strategies. The African Union Agenda 2063 places the objective of realising "healthy and well-nourished citizens." Africa's health frameworks for the next fifteen years that include the overarching Africa Health Strategy and the Catalytic Framework, to end AIDS, tuberculosis, and malaria in Africa by 2030 translate this objective into concrete actions plans and business models Harmonization with the East African Community (EAC) Universal Health and HIV Coverage (UHHC) Strategy 2018–2023 and its EAC Framework of Action.

Consistence with the five principles of aid delivery mechanism. These are ownership, alignment, harmonization, managing for results and mutual accountability) as agreed under

different accords such as Paris Declaration (1999), Accra Agenda of Action (2001), and the Windhoek Declaration (2006).

Alignment with the national development strategies. These are the Uganda Vision 2040, the Third National Development Plan and the HIV and AIDS NSP 2021–2025.

Conformity with financing mechanisms and modalities. The strategies will conform with financing mechanism for the GoU and UAC partners.

Alignment with Uganda's Health Financing Strategy. The main objective of health financing strategy is to facilitate attainment of UHC through making available the required resources for delivery of the essential package of services for Uganda in an efficient and equitable manner[6]. It also strives toward increasing the public spending towards meeting the 15% Abuja Declaration. The strategic interventions mentioned are revenue collection, risk pooling, and strategic purchasing to address risks of accessing healthcare.

Value for money. The strategy will focus on initiatives that have been proven to be cost effective and that can provide value for money.

Feasibility of implementation. The strategy will consider the feasibility of implementing different initiatives by assessing political and social acceptability of the initiatives proposed as well as technical feasibility with regard to the availability of the resources that will be required to implement the strategy in the short, medium and long term.

SITUATIONAL ANALYSIS: THE NATIONAL HIV AND AIDS FINANCING CONTEXT

Introduction

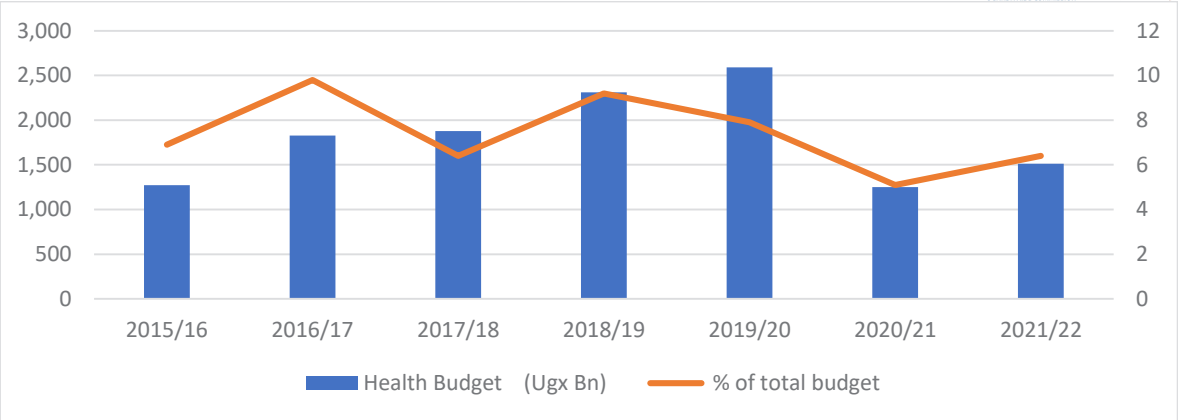
This section analyses the state of funding of the national HIV and AIDS for Uganda. It analyses the major sources of funding and their contribution overtime, and the mechanisms in place to enhance coordination and effective management of the funds. The section also presents analysis of key trends and uncertainties, which influence HIV and AIDS financing globally and nationally. Other aspects covered under this plan include the general outlook on resource envelope both internationally and nationally. At the national scene, an assessment of resources allocated to the health sector and HIV and AIDS was completed.

Financing for the Health Sector

The GoU funds the HIV response as part of the overall healthcare provision to the population. In the last decade, Uganda witnessed a tremendous economic growth, posting an average economic growth of 6% to 7.9%. Following the COVID-19 pandemic, the economic growth was reported at 2.9% in 2020/21 and was expected to remain low for the next two years. Prior to the pandemic, the GoU contribution to the health sectors grew in nominal terms from UGX 1.27 trillion in 2015/16 to UGX 2.585 trillion in 2019/20. This nominal increase however is reflective of an annual average of 7.2% as a proportion of health sector funding to the total national budget.

Figure 9: Trends in GoU allocations to the health sector

[6] MoH, 2016. Health Financing Strategy 2015/16–2024/25.



Overall, the Uganda budget allocation to health has not met the aspirations as set by the Abuja Declaration in April 2001, which recommended the member countries to allocate at least 15% of the national budgets to health. As such funding to the HIV response is similarly affected and has been perpetually low.

The National HIV and AIDS Strategic Plan (2020/21–2024/25) and the 10-year Uganda HIV Investment Case Framework (2020/21–2029/30) were developed and provided indicative resource estimates for the prioritized interventions. According to the national HIV and AIDS Strategy Plan (Table 1), Uganda will require USD 4.1 billion (UGX 15 trillion) from 2020 to 2025 to attain its set targets, leaving a huge gap of USD 1.3 billion (UGX 5 trillion) as of 2025. The HIV Investment Case Framework estimates a funding need at USD 8.375 billion (UGX 31 trillion) to implement the priority scenario from 2020–2030. And for the targeted seven years of this strategy (2023/24–2029/30), the Investment Case framework prioritized scenario estimates resource needs of USD 6.4 billion – Table 6 below.

Challenges of the Past Resource Mobilization efforts

Despite the combined efforts to mobilize funds and implement effective impactful interventions indicated in the NSP and ICF, there were a number of challenges and barriers. These included among others the following:

- Domestic initiatives that did not become operational affecting the resource planning. These initiatives include the AIDS Trust Fund, long-awaited National Health Insurance which are still under parliamentary reviews, and the One Dollar Initiative (ODI).
- The response has suffered low allocations from the GoU budget.
- There have been low technical ad allocative efficiencies of the HIV resources during the operational period which affects performance.
- The COVID-19 pandemic affected the resource mobilization and management due to the global and national economy lockdowns as well as disruption in the service delivery due to reprioritization.
- The COVID-19 pandemic affected program implementation as well as resource reallocation, utilization, and replenishments.
- Low absorption of mobilized resource results into low replenishments particularly for performance-based and results-based funding.

- The contributions from the non-public sector have not been adequately catered for due to lack of recent studies that would provide evidence of the extents of contributions to the HIV response.

Sources of Funding for HIV in Uganda

A review of recent trends in funds and their sources based on both the Investment Case report and the NASA indicate that the major component of domestic funding is by GoU and OOP by households.

Domestic Financing

The major sources of domestic funding take the following forms:

i.) Allocations to the mainstream health sub-program budget through the MoH for purposes of strengthening the systems for delivery of all healthcare programme. This includes salaries, wages, and other operational and capital development costs that are often leveraged by the response through its regular operations within the general healthcare system.

ii.) Additional resources are directed through the National Medical Stores and UAC. These funds are often leveraged by HIV and AIDS interventions.

iii.) To mobilize additional resources and address funding gaps, GoU developed a strategy to mainstream HIV and AIDS interventions which requires each Government Ministry, Department, and Agency (MDA) to allocate 0.1% of their budgets (excluding pension, gratuity, and transfers) to specific activities related to the response. The guidelines for this initiative were designed in 2018. A review progress of this initiative that was conducted by UAC in 2019 revealed that allocation of the 0.1% had been realized with an estimated UGX 60 billion (USD 16 million) mobilized from all MDAs and local governments. However, there were gaps in prioritization, documentation, and tracking of the funding.

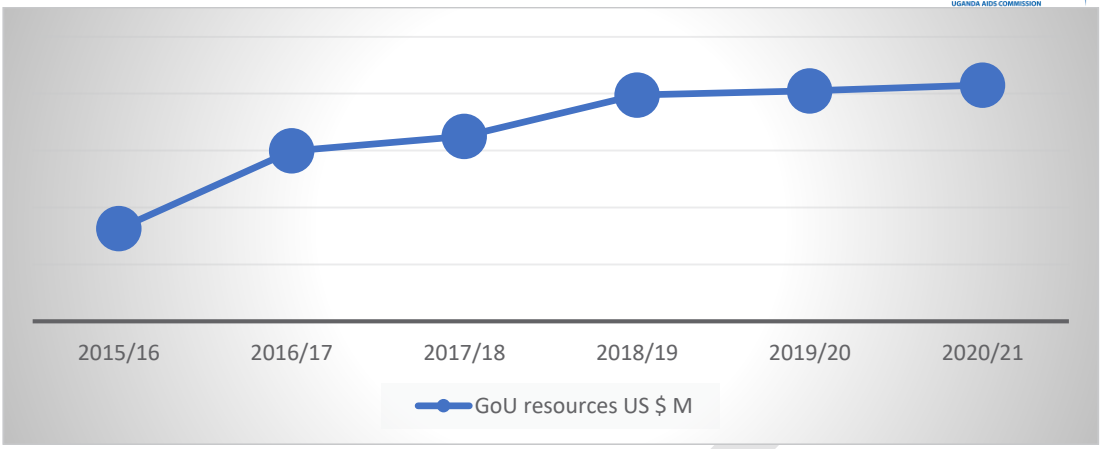
iv.) Provision of an annual increment of UGX 50 billion starting with 2018/2019. This allocation had been suspended in 2020 following an escalation of domestic costs and decline in revenues due to the COVID-19 pandemic. The GoU has committed to resume the funding in FY 2023/24.

v.) Finally, additional domestic resources are obtained from households through the OOP arrangements which entails catastrophic expenditure for most communities in Uganda.

Public Domestic Resources Mobilization

The key milestone in the public domestic resource mobilization were seen in terms of growth in the domestic resources from about USD 32 million in 2015/16 to about USD 83 million in 2020/21. This represents a 155% growth in public domestic resources.

Figure 10: GoU funding trends 2015/16–2020/21



Source: JAR Reports 2022

While GoU resources fell short of the planned resources by about 65%, GoU is still commended for the initiatives that were set in place to generate the additional resources. The initiatives included:

i.) With the aspiration to meet the then 90-90-90 targets by 2020 and the call to implement the "Test and Start treatment" initiative, GoU took a deliberate effort to ensure availability of ART services for all who need them. The aspiration saw GoU increase and ring-fence finances to the National Medical Stores for procurement of ARVs and the HIV test kits. During this period, the ART funds to the National Medical Stores grew from USD 25 million in 2015 to USD 65 in 2020/21.

ii.) In 2018, GoU through UAC rolled out the revised HIV and AIDS mainstreaming guidelines for all MDAs as one of the sustainable measures to deploy domestic funds to address the multifaceted drivers and effects of the HIV epidemic. The guideline required all the MDAs to allocate 0.1% of their budgets net of the wages bill towards the HIV and AIDs interventions. Preliminary assessments estimated about USD 39 million to have been availed through this initiative. However, the actual utilization of the said funds was yet to be fully analysed at the time of writing this report.

iii.) In addition, GoU requires large infrastructure projects to commit resources and implement HIV response activities of Uganda.

iv.) GoU rolled out the Presidential Fast-Track Initiative as one of the strategies to ending HIV and AIDS by 2030. The focus for the fast track was on:

- Engage men in HIV prevention and close the tap on new infections particularly among adolescent girls and young women.
- Accelerate implementation of Test and Treat and attainment of the then 90-90-90 targets particularly among men and young people.
- Consolidate progress on eliminating mother-to-child transmission of HIV.
- Ensure financial sustainability for the HIV response.
- Ensure institutional effectiveness for a well-coordinated multi-sectoral response.

The initiative was a rallying tool for mobilizing additional resources as it proved an opportunity campaign to renew the country's historic strides in combating the HIV and AIDS.

GoU strengthened measures to ensure efficient use of the limited resources in the HIV response. Some of the efficiency measures include the operationalization of the Commodity Security committees, whose roles among others was to ensure effective and efficient management of the HIV commodities. The committee was charged with undertaking the country's quantifications, monitoring procurements, distribution of the commodities, as well as warehouse managements of the commodities. This was one of the initiatives to minimise wastes, overstocking, and understocking, which not only affect the service delivery but also financial management. The country has embarked on building capacity of central and decentralized staff in areas of resource mobilization and utilizations as a precursor for sustainability and resource management.

Table 3: Sources of public domestic funding

	2020/21	2021/22	2022/23
On budget support to health sector	USD		
Ringfenced commodity allocation	41,186,022	38,446,296	52,144,926
Support to HIV multi-sectoral coordination	3,038,884	3,986,601	3,291,532
Support to research agencies	2,673,819	4,461,807	3,101,401
Support to decentralized response	9,358,863	10,987,585	14,015,928
HIV mainstreaming budget (or other source)	24,358,863	24,358,863	24,358,863
Total estimates	80,616,450	82,241,151	96,912,649

Source: UAC JAR Report 2021/22

Domestic Private Sector Resource Mobilization

At the advent of the HIV and AIDS epidemic in Uganda, the private sector (organizations) through the Federation of Uganda Employers were very instrumental in the fight against HIV and AIDS, within the workplace reaching out to high numbers of employees/workers with HIV and AIDS prevention and education programs.

Workplace Health Initiatives

The multi-sectoral approach guidance on HIV mainstreaming also mandated the private sector to integrate the HIV response in their program. The integration naturally resulted into resources being allocated by the private sector players.

The private sector engagement, through the Federation of Uganda Employers and the Uganda Business Coalition on AIDS, in 1988, initiated workplace health programs —with support from the United Nations Development Programme, ILO and the U.S. Agency for International Development (USAID) — to address the high levels of HIV and AIDS-related stigma and discrimination and abuse of rights of employees/workers living with HIV and AIDS. They were able to advocate for non-discrimination at the workplace by influencing the Employment Act (2006) provision No. 5 on the prohibition of Discrimination in Employment and the International Convention 101 on Non-Discrimination in the world of work. Private sector enterprises were also brought on board to raise resources for their work force.

Most big corporations have in addition developed health schemes for their staff at their facilities and as health insurance schemes that provide for HIV services. Many of these service contributions to HIV response have not yet been quantified.

One Dollar Initiative

The private sector through the One Dollar Initiative (ODI) joined hands to support the GoU efforts to raise resources for the HIV response. The ODI, concept on build on a call for every adult individual to raise and contribute one dollar or its equivalent to the HIV response. With an estimated 21 million adults the initiative initial objective was to target at least one million adults and gradually grow to a point where not less than 50% of the adults would be active on the scheme.

Civil Society Organisation Initiatives

Civil society organisations (CSOs) have played a significant role in financing components of the HIV response. These have continued to provide HIV services particularly for the social support and community mobilization which are not within the public domain. Of interest is the fact that most of the CSOs have own sourced the funds from both internal and external sources. An estimate of resources sourced through the CSOs is yet to be fully established as the majority of such resources are off budget in nature.

OOP Expenditure

The Uganda NASA 2020 indicated that OOP expenditure contributes significantly to overall financing of the national HIV and AIDS response in Uganda. OOP expenditure survey findings for 2020 show that about 8% of the financing that pays for HIV and AIDS-related care and treatment activities comes from private sources in form of OOP payments.

External Donor Funding

The resources from the external funding are comprised of support from the bilateral and multilateral agencies, global health initiatives, international research collaborations, and private philanthropies and foundations. Funding from the external sources has supported the GoU in areas procurement of health commodities, health systems strengthening, laboratory services, improvements in the equipment, and infrastructure. Other support has been directed to human resources and capacity building. The HIV financing landscape is dominated by funding provided from the U.S. Government, the Global Fund, the European Union, and UN agencies. Overall funding from these players accounted for over 80% of the HIV resources, but this has since been declining to the current 60% of the response save for the Global Fund which have general increased it contribution from 7% to 25%.

Funding from the external sources during the of the NSP mobilized for HIV and related services as indicated in the table below.

Table 4: External fund contributions for the HIV response

	2020/21	2021/22	2022/23
Development partners	**USD millions**		
The U.S. Government-PEPFAR	402.2	405.2	426.22
Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM)	89.65	99.89	99.65

Royal Netherlands	1.603	1.603	1.619
UN Agencies	14.5	16.5	19.5
Clinton Health Access Initiative (CHAI)	1.17	1.22	1.29
Korean International Cooperation Agency (KOICA)		0.80	0.88
Japan International Cooperation Agency (JICA)		2.61	2.74

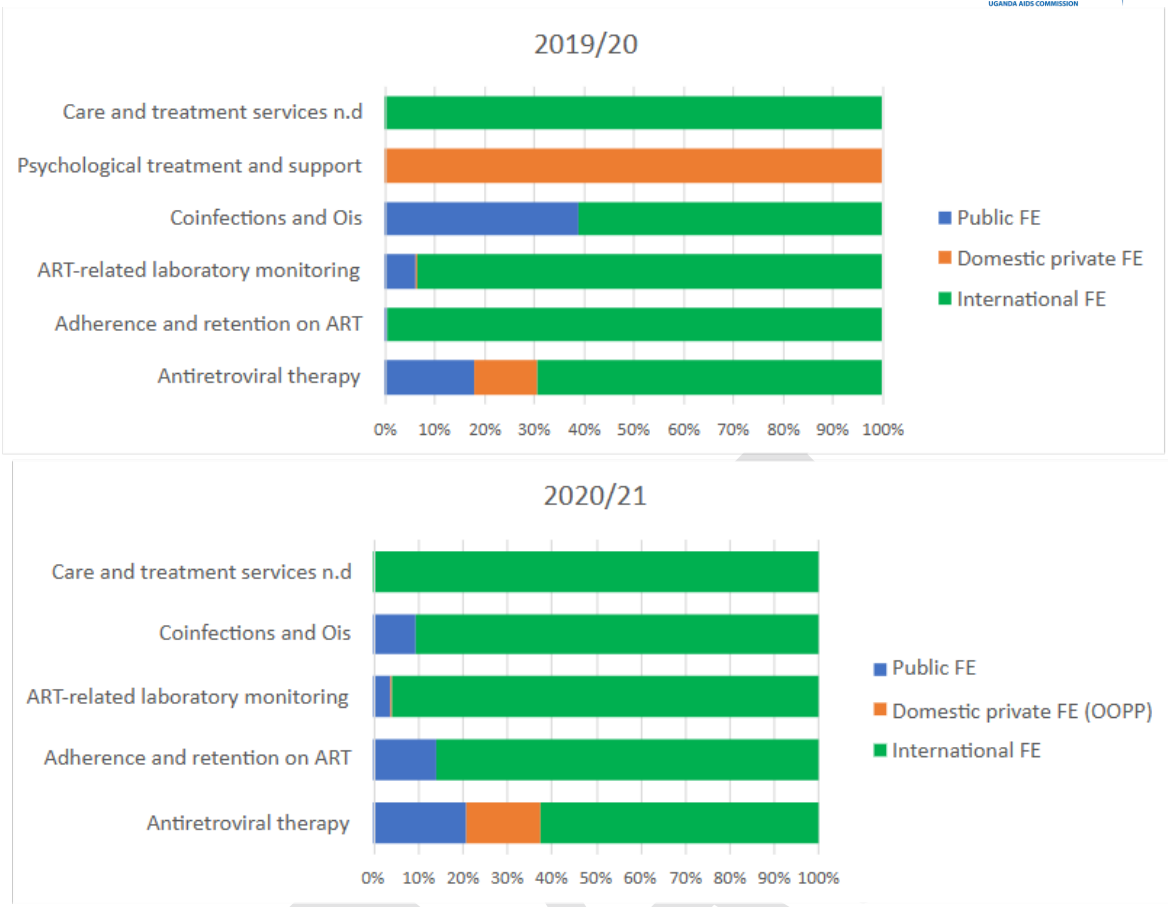
Source UAC JAR Report 2021/22

The conclusion from the current sources of funding show that the bilateral entities contribute the bulk (more than 60%) of the resources, followed by multilaterals, and finally GoU as well as OOP. Specifically, the U.S. Government is the biggest contributor – directly through PEPFAR and indirectly through the Global Fund.

Funding for Specific Activities

The bulk of care and treatment was funded by international entities (Figure 11) although domestic sources (mainly OOP) covered almost all costs associated with psychological treatment and support services as well as nutrition. The public entities dominated spending on adherence and retention on ARTs.

Figure 11: Care and treatment by funding entity

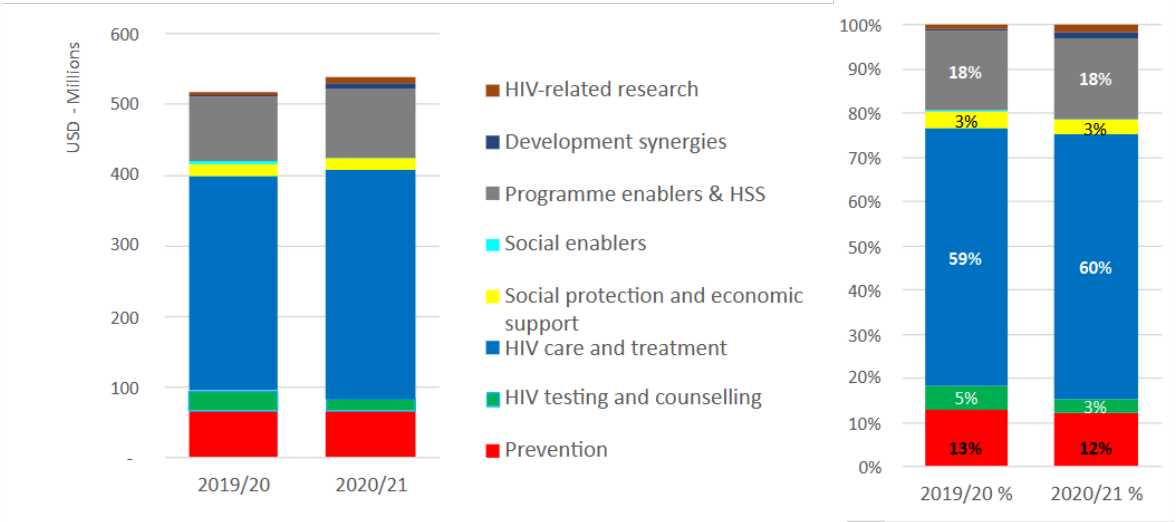


Source: NASA Report 2024

Programme Spending Areas

The spending per programme (Figure 12) highlights the critical role played by the international agencies/entities that fund the critical aspects of the response. These include HIV care and treatment, programme enablers and systems strengthening, prevention, and HIV testing and counselling. Specifically, prevention is not highly prioritised by domestic sources both public and private, yet it is critical for lowering infection rates among all categories including discordant partners — reducing deaths and increasing better wellbeing of people living with HIV and AIDS.

Figure 12: Programme area spending by providers



Source: NASA Report 2024

Cost Drivers for HIV Interventions

The section provides a background on structure of spending, which can inform potential sources of domestic funding given the amounts involved and the possibility of leveraging existing resources allocated to complementary activities. According to Table 5, the biggest cost drivers of the response for by international agencies, GoU, and households include medical products including drugs and supplies, operational and programme management costs, and recurrent expenditure and personnel costs.

Table 5: Major spending items by the international entities and households, 2028/19

Expenditure Item	International Agencies	GoU/Public Entities	Households (OOP)
Medical products & supplies	41%	51%	50%
Operational and Programme Management expenditures	32%	11%	-
Transportation related to BP	-	-	29%
Personnel costs	14	13%	-
Recurrent Expenditure	6%	21%	21%
Buildings, renovation & other Capital investments	-	4%	-

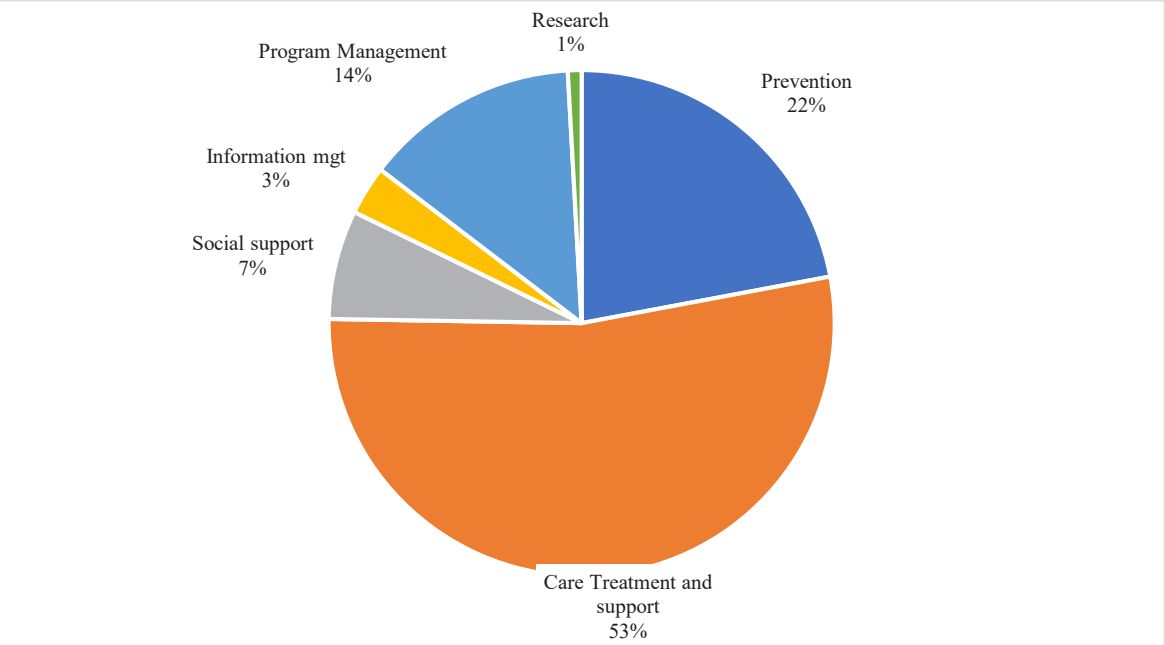
Source: Investment Case Report 2020/21

The table reflects an emphasis on recurrent costs of treatment, personnel, and supplies. The information on spending by GoU reveals potential underfunding on capital development and systems strengthening especially of infrastructure that is critical for the mainstreaming component of the transition. The report indicates that, in 2018/19, GoU committed only 4% to building, renovation, and other capital development. This is quite a small figure considering the expenditure by GoU on strengthening of the health system and the various human resources. There is need to adequately capture the public sector contribution that seems to be understated.

Resource Utilisation

Resources are alloacated to thematic areas as illustrated in Figure 13. The care and treatment thematic areas had the largest share of about 53% of the resources. The key cost driver under these thematic areas are the ART services. The prevention thematic area utilises 22% of the resource while program management utilised 14% of the resources Other allocations went to social support with 7%, information management with 3%, and research with about 1% of the total resources.

Figure 13: Resource utilization across the thematic areas



Source: JAR 2018/19

RESOURCE NEED FOR THE HIV RESPONSE

Resource Estimates for the HIV Investment 2023/24–2029/30

The Investment Case framework prioritized scenario estimates resource needs of USD 6.375 billion over the targeted seven years of this strategy (2023/24 to 2029/30). The section provides a background for the required resources based on the Investment Case, which was the most recent study on the possible investments.

Table 6: Estimates of the seven-year revised Investment Case priorities 2023/24–2029/30

Service	Estimated Annual Costs (in USD millions)								
	2023	2024	2025	2026	2027	2028	2029	2030	Totals
Testing services	11.85	9.56	7.10	7.33	7.58	7.83	8.08	8.35	67.69
Treatment	314.80	307.52	304.11	298.99	293.81	288.75	283.65	279.07	2,370.71

General population 25+	19.89	22.42	25.01	27.99	31.15	34.49	38.02	41.72	240.68
Key populations	6.08	7.55	9.13	11.00	12.99	15.11	17.34	19.70	98.91
Programs for AGYW	53.93	68.62	84.08	96.64	107.75	119.29	131.19	143.39	804.91
Programs for ABYM	36.79	35.53	38.53	40.37	42.28	44.08	45.82	47.43	330.84
Programs to reduce stigma and discrimination	24.67	32.51	40.15	46.04	51.82	57.51	63.09	68.56	384.38
Prevention of gender-based violence	25.04	34.39	44.38	53.31	62.82	72.90	83.57	94.80	471.23
Mitigation and support	203.94	203.94	203.94	203.94	203.94	203.94	203.94	203.94	1,631.56
TOTAL	**697.00**	**722.05**	**756.46**	**785.64**	**814.16**	**843.91**	**874.71**	**906,974,950**	**6,383.87**

Source: Investment Case Framework (2020/21-2029/30)

Recent development such as COVID-19 and Ebola disrupted the funding sources to the extent that the response was unable to realise some of the prioritised scale up activities that were forecasted to control the HIV epidemic by 2024. The lapse implies that activities intended to trigger a decline in the HIV burden along with the number of people in need of ART and the associated costs did not happen leading to loss of anticipated savings. The COVID-19 pandemic did not only increase the need for additional investments in other areas but also disrupted the trends as some of the patients could not easily access treatment during the lockdowns. Specifically, the commitment to incrementally provide UGX 50 billion per year to the HIV and AIDS response was halted due to a need for more resources to address the COVID-19 pandemic.

In view of the foregoing the changed landscape makes it necessary to make a new analysis and update the Investment Case to guide strategic choices for HIV programme planning, resource mobilization, and investment. The planned interventions, which reflect the ambitious targets, need to be revised to get a clear picture of the required funding and the associated gap.

Identifying Critical Interventions for the Response

The review of the interventions to be prioritised to sustain and enhance impact provides insights into possible alternative and/or additional ways of financing them since some may partly be funded through leveraging existing budgetary resources. The major aspects to be funded include HIV treatment, HIV testing, condoms for high-risk groups, safe male

circumcision, prevention of mother-to-child transmission, early infant diagnosis, PrEP, programmes for key populations, and social enablers (e.g., social and behaviour change communication, AGYW, and stigma and violence prevention).

The Investment Case identifies critical areas to be prioritized since they offer multiple gains. For example, prevention and treatment will reduce the number of new infections and results into savings due to reduced cost of treatment. The annual cost of treatment is projected to decline by USD 13 million in 2025 because of transition to Differentiated Service Delivery Model while the annual testing costs will decline by USD 14 million as testing volumes decrease. In addition, the cost for safe medical circumcision is expected to decline by USD 15 million annually once the program reaches its coverage target and switches to the maintenance phase. Finally, the savings due from the anticipated productivity gains are estimated at USD 140 million, for the priority scale up scenario over the 10-year period.

Significant increases in resource needs are projected for programs for AGYW, stigma reduction, and prevention of violence. Annual expenditures for AGYW increase to USD 87 million by 2025 in the NSP. The largest amounts would be needed for PrEP (USD 30 million), economic empowerment (USD 21 million), and education subsidy (USD 15 million). PrEP costs could be reduced by limiting the use of PrEP to the areas and populations with the highest risk. The other programs all have benefits beyond the HIV prevention so the costs might be shared with other sectors. Large increases in funding would also be required to expand programs to reduce stigma (USD 40 million in 2030) and programs to reduce violence against women (USD 70 million).

An outlook of the funding of the Investment framework would not be adequately estimated given the fact that, GoU runs a three-year Medium-Term Expenditure Framework, and most external funders run a two-to-three-year funding cycles. A funding gap analysis has been adapted from the HIV and AIDS Investment Case framework 2020/21–2029/30 and adjusted with recent performances of the NSP and current commitments from GoU as baseline information as shown in the table below.

Table 7: The funding gap analysis 2023/24–2029/30 (in USD millions)

	2023	2024	2025	2026	2027	2028	2029	2030	Totals
Resource estimates	679.97	722	756.46	785.64	814.16	843.91	874.71	906.97	**6,383.87**
Projected commitments									
GoU*	96.48	99.33	101.32	103.34	129.34	155.34	181.34	207.34	**1,073.83**
Development partners									**0.00**
The U.S. Government-PEPFAR	426.22	426.22	426.22	426.22	-	-	-	-	**1,704.88**
Global Fund to Fight AIDS, Tuberculosis, and Malaria	100.4	100.4	98	99	-	-	-	-	**397.80**
Royal Netherlands	1.64	1.65			-	-	-	-	**3.29**
UN Agencies	16.5	16.5	16.5	16.5	-	-	-	-	**66.00**
CHAI	1.29	1.29	1.29	1.29	-	-	-	-	**5.16**
KOICA	0.97	1.07	1.07	1.07	-	-	-	-	**4.18**
JICA	2.87	3.02	3.02	3.02	-	-	-	-	**11.93**
New strategies									
Mainstreaming for HIV	5.69	6.96	7.03	7.1	16	16	16	16	**90.78**
Philanthropic Contributions	1.01	1.02	1.02	1.02	-	-	-	-	**4.07**
HIV Research funds	11.73	12.32	12.32	12.32	-	-	-	-	**48.69**
ODI	0.1	0.18	0.18	0.18	-	-	-	-	**0.64**
Total commitments	**664.9**	**669.96**	**667.97**	**671.06**	**145.34**	**171.34**	**197.34**	**223.34**	**3,411.25**
Funding Gaps	**15.07**	**52.09**	**88.49**	**114.58**	**668.82**	**672.57**	**677.37**	**683.63**	**2,972.62**

Source: Investment Case Report 2020-30, NSP 2020/21-2024/25, JAR Report 2022/23

Key Assumptions for financial gap analysis:

- The resource estimates were based on the indicative costs for most impactful evidence-based interventions in the HIV Investments Case framework.
- The funding commitments — particularly by development partners — have been projected up to 2026. Beyond 2026, the funding mechanism would not ably project and commit on the resources available for the HIV response.
- Projected resources from GoU are based on the Medium-Term Expenditure Framework, actual allocations with a baseline of 2023/24, and adjusted to the MoFPED projected commitment of annual increment by UGX 100 billion.
- Projected resources from the U.S. Government have been based on the 2021 funding levels. The U.S. Government has adopted a two-year funding cycle, and the targeted funding is yet to be known.
- The Global Fund funding is based on the funding cycle (Global Fund Grant Cycle 7) running from 2024 to 2026.

- UN agencies funding based on the projections in the Joint UN annual work plans.
- Funding from CHAI has been flat lined.
- Funding from KOICA and JICA were projected from the 2022/23 funding levels with minimal scale ups.
- Funding from HIV mainstreaming are projected to increase as GoU plans to enforce the allocations and utilizations of 0.1% MDA allocations over and above the wage bills. Projections were based on the actual allocations for 2023/24, as a baseline.
- The RMS will be updated as the implementations of the national policies and guidelines are reviewed.

Projected Program Impact

The proposed resource mobilization strategies discussed in this strategy are geared towards contributing to efforts to attain the HIV results as illustrated in the Uganda HIV Investment Case 2020–2030. The Investment Case recommended HIV reprograming based on the prioritised scale-up scenario. This scenario proposed a rapid scale up to attain maximum feasible coverages of a comprehensive set of interventions. The critical interventions for impact were: testing, treatment, condoms, safe male circumcision, prevention of mother to child transmission, early infant diagnosis, programmes for AGYW, and programmes for key populations. In addition, set of enablers were considered a these had the profound effect of influencing uptake of key services, as well as services uptake among the key and vulnerable populations. The set of enablers include social and behaviour change communications, stigma, and discriminations reduction, prevention of violence (including gender-based violence). The prioritized scale-up scenario also assumed aggressive targets for the AGYW, adolescent boys and young men, violence prevention, and stigma in order to illustrate the impact and cost of achieving high coverage in these areas. In the final analysis, these targets may be scaled back or implemented with co-funding from other sectors.

Table 8: Coverage targets for prioritized scale-up

Intervention	2019	2025	2030
Testing (% adults tested annually)[7]	15%	5%	5%
Percent of population diagnosed	87%	90%	95%
Percentage of tests by type			
-Provider initiated	70%	40%	40%
-Index partner testing (APN)	10%	30%	30%

[7] Testing coverage declines as knowledge of status reaches very high levels as fewer tests are needed to sustain knowledge than in the catch-up phase.

-Community-based testing	15%	5%	5%
-Self-Tests	5%	25%	25%
Treatment			
Adult women	93%	95%	95%
Adult men	81%	95%	95%
Children	74%	95%	95%
Viral load suppression	86%	95%	95%
Prevention of mother to child transmission	95%	95%	95%
General population aged 25+			
Condom use with non-regular partner	32%	50%	70%
Programs for key populations			
Female sex workers (FSW)	77%	90%	90%
Men who have sex with men (MSM)	35%	90%	90%
People who inject drugs (PWID)	8%	90%	90%
PrEP for serodiscordant couples	0%	100%	100%
Programs for adolescent girls and young women (AGYW)			
Family planning	8%	16%	22%
Parenting/care giver programs	8%	16%	22%
Educational subsidies	8%	16%	22%
Economic empowerment	0%	16%	22%
Comprehensive sexuality education	8%	16%	22%
Community activities to change norms	8%	16%	22%
PrEP	1%	4%	7%
Programs for adolescent boys and young men (ABYM)			

Safe medical circumcision	68%	90%	90%
Condom use with non-regular partners	41%	60%	80%
Comprehensive sexuality education	8%	16%	20%
Programs to reduce stigma and discrimination			
Community norms change	0%	50%	90%
Workshops to PLHIV to address internalized stigma	0%	50%	90%
Prevention of gender-based violence			
Community activities to change norms	0%	45%	90%
Outreach to male youth	0%	45%	90%
Economic empowerment for women	0%	45%	90%
Treatment for rape victims	20%	55%	90%

The Social and Economic Return on HIV Investment

Uganda, as in many developing countries with high HIV burden, now finds itself in a challenging situation where it faces a highly constrained fiscal environment with rising debt obligations, a dwindling health budget, and various competing priorities, as well as a growing HIV burden that still needs to be urgently addressed to meet ambitious targets. Several reports demonstrate that enhancing financing towards the HIV response has direct implications for the spread of new HIV infections, and therefore contributes towards the goal of ending AIDS as a public health threat. Thus, quantifying the potential gains that could be made by making adequate investments in the response to HIV was a key consideration in this strategy document. This strategy adopts findings of an analytical study, by UNAIDS (2023), on the health, social, and economic gains from financing the HIV response in Africa:

- **Increasing investments towards the HIV response could significantly curb growth in new infections.** A study by Avenir Health (The Lancet HIV, 2023) demonstrates that meeting HIV funding targets could reduce the number of new HIV infections by 40% to up to 90% in 2030 depending on the country, compared to business-as-usual funding levels. The impacts are more pronounced in high-burden countries.
- **Increasing investments towards the HIV response could reduce the spread of new HIV infections among vulnerable populations, including girls who are**

particularly at risk of contracting HIV. In Uganda, girls aged 15–19 are four times more likely to become infected with HIV compared to boys. Directing increased investment towards the HIV response could substantially benefit this vulnerable group. For example, if the full funding targets for HIV are met in a high HIV burden country like Uganda, the female population aged 15–19 could account for almost 15% of the total reduction in new HIV infections between 2022 and 2030. This demonstrates how investments in the HIV response could address existing gender disparities.

- **Increasing investments towards the HIV response could improve educational outcomes among children and adolescents and subsequently give rise to spill-over effects for current and future generations.** Reduced mortality rates among adults — resulting from higher levels of investment in the HIV response — reduce the number of children orphaned by AIDS. For example, a reduction of approximately 722,000 orphans relative to business as usual was estimated in Mozambique in 2030 when full funding targets for HIV are met. Combined with a reduction in new HIV infections in children and adolescents themselves, this leads to higher school enrolment rates and reduced school absenteeism.
- **Increasing investments towards the HIV response could contribute towards reducing gender inequalities in access to education.** In South Africa, for example, achieving full funding targets for HIV could increase the number of boys enrolled in secondary school in 2030 by 23,000 (or 0.8%), compared with an increase of 27,000 (or 0.9%) for girls of the same age. By allowing more girls to stay in or return to school, the response to HIV could help to narrow the gender gap in education.
- **Increasing investments towards the HIV response could enable a shift in the demographic profile of countries, avoiding large losses to the working age population.** Under a fully funded HIV response scenario, a decline in mortality rates could significantly contribute to a larger population, compared with business-as-usual funding levels.
- **Increasing investments towards the HIV response could contribute to wider and sustained economic gains in the long term, beyond the human lives saved.** The improved health and education outcomes from increased HIV investment contribute to human capital development. This, coupled with growth in the size of the working-age population, can drive economic growth. An analysis on the economic impact of HIV investment in South Africa (UNAIDS, 2023), found that the GDP of South Africa — which has the highest burden of disease — could be 2.8% higher (equivalent to USD 17 billion) than business-as-usual funding levels in 2030 if HIV funding targets are met.
- **Increasing investments towards the HIV response could contribute towards health systems strengthening and enhancing pandemic preparedness and response.** In addition to the economic gains estimated, the global response to HIV can serve multiple purposes in strengthening health systems and supporting preparedness for and response to future pandemics. Evidence of existing health system infrastructure developed for the response to HIV being re-deployed during the COVID-19 pandemic in low- and middle-income countries sheds light on the contribution of the response to HIV to health system strengthening. Data from the World Bank Group (2022) indicates that more than one-third of the budget

allocated towards HIV, AIDS, tuberculosis and malaria, equivalent to a budget of more than USD 2.5 billion, has synergistically supported health security efforts. These findings offer further support for the need to ensure adequate investments in the response to HIV, not only to meet AIDS-related targets, but also to ultimately free up resources within health budgets to address other health priorities.

- **Increasing investments towards the HIV response could result in substantial overall health, social, and economic gains.** However, ensuring a sustainable response will require a range of strategies to enhance financing for the health sector more broadly and maximize the use of existing resources and partnerships. Introducing pro-health taxes to generate revenue for healthcare spending, earmarking allocations to health from government revenue and implementing measures to address tax evasion are some of the possible approaches to enhance overall financing for the HIV response and health more broadly. However, the adoption of policies aimed at enhancing financing alone is not enough to ensure a sustainable response to the HIV epidemic. Strategies aimed at maximising the use of existing resources and partnerships will also need to be considered. For instance, a closer integration of HIV and relevant health services holds the potential to enhance the accessibility and uptake of services while offering a more people-centred approach to care. Moreover, integrating HIV services and community-led responses into national health financing policies can also support the sustainability of the broader response to HIV.

As the GoU budget becomes increasingly constrained and the need to address immediate economic and fiscal priorities takes over, there is a risk that the HIV epidemic is relegated lower on political agendas. However, the analysis above suggests that the long-term consequences of this course of action are far from trivial. By failing to meet the AIDS targets set in the Political Declaration, countries — particularly those with a high burden of disease — are at risk of higher death tolls from AIDS and related co-morbidities, increasing pressures on health systems, growing inequalities among vulnerable populations, and lost economic opportunities. Government budgets will continue to be burdened by the need to manage and treat the HIV epidemic, creating less fiscal space for other priorities that enable social development and economic growth.

Resource Mobilization Approaches

The funding options for the response over the coming years will partly be informed by the historical trends that anchor the capabilities and willingness to support the interventions. Additional insights are derived from analyzing the feasibility of the ongoing discussions regarding increasing domestic financing as well as ownership of the response.

Pillar 1: Domestic Resource Mobilization Strategies

The section reviews assumptions and possibilities of the transition to domestic sources, which will be a gradual process that requires backup of sustained contributions from foreign sources. The analysis of the possible sources of domestic funds is based on the following aspects:

i.) The policy decisions with potential to increase the current sources.

ii.) The possible sources of alternative funds with significant potential to support the response. These include investments for strengthening health systems, leveraging other existing budgets, and mainstreaming processes.
iii.) The cost savings arising from efficiencies as the systems get better and expenditures are rationalized and harmonized through integration.
iv.) Additional sources from the private sector.

Possible sources of domestic financing:

Public Sector Funding Streams

In total, this strategy targets to raise USD 1.66 billion (raising from 15% in 2023/24 to 47% in 2029/30 of total HIV and AIDS resource needs) from the public sector, including central and local governments during 2023/24–2029/30. The main propositions for domestic financing from the public sector streams include the following three categories:

i.) Financing from new sources (on budget allocations) by government.
ii.) Leveraging existing resources in public sectors and activities that are complementary to the HIV and AIDS response.
iii.) Efficiency gains from better implementation of current interventions.

The main source of public sector financing is expected from the Consolidated Fund, which is mainly financed through tax and non-tax revenues — whose current effort is 13% (NASA Preliminary findings 2023). The proposals, therefore, consider possible increase in the size of the Consolidated Fund as well as increased prioritization of the response compared to demands from other sectors/commitments by government. An increase in the Consolidated Fund would largely depend on growth of the size of the economy including transition into middle-income status. While economic growth would automatically increase tax and non-tax revenues, the government could also introduce new taxes including those with specific contributions earmarked for the HIV response. Finally, proposals to manage the competing priorities from other programs include 'ring-fencing' certain revenues and creation of a special funding mechanism for the HIV response.

Additionally, institutions shall mobilize additional resources from other sources to address funding gaps. This resource mobilization strategy is cognizant of other existing structural interventions which could be tapped into for HIV resourcing in these sectors, including poverty eradication interventions at the MoGLSD and interventions to delay girls at schools by the Ministry of Education and Sports. The strategy also aims at conducting purposive resource mobilization from strategic government institutions, for example, the Ministry of Tourism, Wildlife and Antiquities; Uganda Investment Authority; and Ministry of Science

The key strategies to achieve these targets are as follows:

Approach 1: Advocacy for increasing the national budget allocations for the Human Capital Development program particularly for health and HIV.

Strategic Objective

Increase the annual proportion of government allocations to HIV and AIDS from 13% in financial year 2022/23 to 47% by 2029/30.

Strategic Actions

a. Stakeholder engagement with relevant agencies to lobby for additional resources to cover evidenced funding gaps in the HIV response.
b. Support budgetary allocation decisions aligned with geographical needs as prioritized in the Uganda Essential Health Care Package.
c. Identify health sector budgeting reforms for allocative efficiency.
d. Undertake an economic study on the impact of HIV and AIDS to facilitate evidence-based policy shifts for the HIV response.

Approach 2: Consolidate HIV mainstreaming contribution.

As part of the efforts for the country strengthen the HIV response, GoU has mainstreamed funding in key sectors to implement specific activities for HIV response. Allocate 0.1% of the institution's total budget (excluding Pensions & Transfers) to HIV and AIDS response activities.

Strategic Objectives

1. Increase the mainstreaming contribution from MDAs and large infrastructure projects from USD 30 million to USD 50 million by 2030.
2. Systems strengthening and leveraging budgets of MDAs and local governments that offer support to the response.

Strategic Actions

a. Enforce compliance of the HIV mainstreaming compliance by using MoFPED directives to MDAs.
b. Advocate for increased compliance with allocation of funds for HIV from large infrastructure projects.
c. Advocate for sectors to mobilize and reflect the additions resources for HIV.

Approach 3: Increase funds for HIV and AIDS through the National Health Insurance Scheme (NHIS).

Strategic Objective

Advocacy for inclusion of HIV and AIDS services in the NHIS benefit package.

Strategic Actions

a. UAC in collaboration with MoH and her partners will identify the HIV and AIDS services that should be included in the NHIS.
b. UAC and MoH hold periodic engagements to advocate for increasing enrolment of contributors for NHIS.

Approach 4: Include HIV services in the Uganda National Essential Health Care Package.

Strategic Objective

Advocate for inclusion of the comprehensive package of HIV services (including testing and treatment) in the Uganda National Essential Health Care Package**.**

Strategic Action

UAC in collaboration with MoH and her partners will identify the HIV and AIDS services that should be included in the Uganda National Essential Health Care Package.

Approach 5: Strengthening of health sector systems.

Strategic Objective

Mobilize additional funding through systems strengthening and leveraging budgets of MDAs and local governments.

Strategic Actions

a. Leverage activities in the health sector through areas that complement the HIV and AIDS response.
b. Increase the capacity of MDAs to plan, finance, and effectively manage the health commodities supply chain.

Approach 6: Mobilize additional resources from existing structural interventions particularly poverty eradication interventions at the MoGLSD and interventions to delay girls at schools by the Ministry of Education and Sports.

Strategic Objective
Increase contributions to funding the HIV/AIDS response from non-traditional GoU health budget spending.

Strategic Action
Influence policy decisions and budgets to include HIV within government development priorities.

Approach 7: Mobilize HIV/AIDS response resources from strategically placed government institutions, for example, the Ministry of Tourism, Wildlife and Antiquities; Uganda Investment Authority; Ministry of Science, Technology, and Innovation; and Ministry of Trade, Industry, and Cooperatives

Strategic Objective
Increase contributions to the HIV/AIDS response by strategically placed GoU institutions.

Strategic Actions

a. Strong partner intelligence within government sectors.

b. Regular and effective communication regarding the burden of HIV on the economy.
c. Clear advocacy for HIV needs and priorities and strengthened political and policy advocacy for HIV-related Sustainable Development Goals.
d. Consistent and vital government partner visibility and recognition.

Private Sector Financing Strategies

This resource mobilization strategy targets to mobilize USD 402.84 million from the private sector for the period 2023/24 to 2029/30. The private sector in Uganda has played a key role in the financing and resourcing of the health systems. With regards to the HIV pandemic, the private sector has contributed significantly to ensuring that workers have access to care and treatment. Local funding through the private sector (excluding OOP expenditure) has been growing and has potential to increase beyond the current 1% of the total contributions. The following are worth noting:

a. The contribution of health insurance and private sector health facilities has grown significantly and remains on an upward trajectory.
b. In the future, the private sector corporates can be mobilized to allocate a portion of their corporate social responsibility budget to the response. They can also organize regular fundraising events such marathons (MTN, Rotary, Kingdoms, etc.), in-kind contributions, music launces by celebrity musicians, and deliberate fundraisings events with a view of contributing the entire or a portion of the proceeds to the response or specified aspects of it.

Approach 8: Strengthen Private sector participation in the HIV response.

Strategic Objective

Harnessing the Private sector potential for the HIV response.

Strategic Actions

a. Promote the private sector in the planning for the HIV response.
b. Promote and scale up private sector funding initiatives.
    i. Revitalize and the ODI as one of the blueprints for HIV sustainability financing.
    ii. Scale up private medical covers/schemes to include HIV services.
c. Advocate and rally the private sector to include the HIV response interventions in their corporate social responsibility effort.
d. Promote and scale up community health insurance initiatives to include HIV response interventions in their benefit packages.

Approach 9: Promote public-private partnerships for HIV and AIDS response.

Strategic Objective

To harness opportunities for in public-private partnerships.

Strategic Actions

a. Undertake an analysis of existing and potential public-private initiatives.
b. Strengthen existing collaborations with the private sector in health services including HIV programming and implementation.
c. Popularize the benefits of public-private partnerships through mass media and sensitizing the general population. These partnerships are collaborative endeavours that includes monetary and in-kind resources contributed by the public and private sector to for HIV and AIDS prevention, care, and treatment goals.
d. Identify and establish new public private partnerships that can be implemented in the short, medium, and long term.
e. Map out private companies to leverage and transfer their respective expertise in areas including supply chain, marketing skills, and business competencies to reach the "last mile" to those that are left behind in achieving the triple 95 global targets of ending AIDS by 2030. The targeted private companies include telecommunication, aviation, banking, construction, automotive industry, logistics, manufacturing, media and entertainment, printing and publishing media, bottling companies, and breweries.

Approach 10: Implement sustainable financing innovations.

Strategic Objective

Pursue strategic innovations to sustainably finance the HIV response and optimize other domestic initiatives.

Strategic Actions

In-kind contributions

Well-developed, in-kind contribution strategies can greatly strengthen the overall financial health of the HIV response at both national and sub-national levels. In-kind contributions consist of goods, materials, or services required to achieve organizational goals. In-kind contributions include the donation of equipment, materials, services, volunteer time, buildings, and land, among others. Private companies, government entities, and external development partners will be targeted for in-kind contributions/donations. In-kind contributions ensure that organizations can target specific needs to achieve greater efficiency. Several benefits of in-kind contributions have been documented, including:

- The expansion of services offered by organizations.
- In-kind donations help create awareness of an organization's work. In addition, get more people involved in supporting their cause.
- In-kind donations can be especially beneficial for small organizations that may need the means to purchase equipment, supplies, or services.
- In-kind donations provide organizations with flexibility regarding how they use their resources.

- In-kind donations can also help build partnerships between organizations and donors.

Activity 1: Build a comprehensive approach to incorporating gifts of in-kind products and services into the funding structure of the HIV response.

Activity 2: Map out viable goods, services, and materials, as well as organizations (including private corporations/companies, nongovernmental organisations (NGOs), religious and faith-based institutions, public sector, and international partners) for in-kind contribution.

Activity 3: Develop a policy on in-kind contributions for the national HIV response.

Social contracting

This is a mechanism where CSOs are directly funded to perform specified interventions and activities where they have distinct competences in. The Government develop policies and guidelines to detail the engagement including: reviewing and understanding legal and regulatory needs for social contracting mechanisms, developing /adapting regulatory process for selecting CSOs for contracting, ensuring domestic finances are available for social contracting mechanisms and providing quality Implementation and monitoring of publicly-financed services.

Social impact bonds for HIV response

Social impact bonds are a 'pay-for-success' or results-based payment mechanism pioneered in the United Kingdom prisoner rehabilitation program in 2010. Under this innovative financing model, the outcome funder (government agency or donor) pays a private sector service provider for delivering a social benefit. The preference for using a private sector entity or NGO as a service provider is the realisation of efficiency gains expected from a private operator, compared to a public one.

Basket funding for HIV response

During the development of this strategy, preliminary discussions with key stakeholders particularly MoFPED, development partners, and the private sectors, and an analytical study were conducted where a funding mechanism (basket funding) is proposed for re-operationalization and streamlined for better coordinate activities in the areas of HIV and AIDS prevention. This basket funding will be managed under and governed by a multi-sectoral arrangement with functions of: financial management, technical management and monitoring, and evaluation delegate to a commitment team(s). The basket funding would support the implementation of specified core interventions that may best be managed through the funds, to ensure effective and efficient management of the programs and resources.

Engage local philanthropies

- Private sector corporations can be mobilised to allocate a portion of their corporate social responsibility budget to the response.

- Organize regular fundraising event marathons: MTN, Rotary, Kingdoms, etc.
- Music launces by celebrity musicians. In the past, HIV and AIDS benefited a lot from linkages with music, art, & drama.

Pillar 2: External Support

Global economic conditions, including those resulting from the COVID-19 pandemic, have led to the redeployment of finances to address immediate economic and health priorities. As a result, financing for the HIV response has suffered a double hit, with declines in both international and domestic investments. Many major international donors have reduced assistance. In fact, international resources targeted towards tackling the HIV epidemic were 6% lower in 2021 than they were in 2010[8]. This is partly explained by a decline in bilateral donor funding—official development assistance for HIV from bilateral donors (other than the United States) have fallen by almost 60% over the past decade.

However, there is a new ray of hope in addressing the HIV epidemic. United Nations member countries adopted a new political declaration on HIV and AIDS (replacing a 2016 declaration) at the High-Level Meeting on AIDS held June 8–10, 2021[9]. Within this, member states affirmed commitments to reach the goal of ending AIDS as a public health threat by 2030, in line with Sustainable Development Goal 3 (target 3.3). Targets were set to reduce the number of annual new HIV infections to under 370,000 and annual AIDS-related deaths to under 250,000 by 2025. Furthermore, world leaders committed to reinforcing global, regional, national, and sub-national responses to the HIV epidemic through enhanced engagement with a broad range of stakeholders—including regional and sub-regional organisations and people living with, at risk of, and affected by HIV and AIDS.

This strategy aims to ensure current partners are still major players in the HIV response, while identifying new partners as well. Potential funders for HIV include multilateral global health financing initiatives, bilateral government financing schemes, philanthropic organisations/individuals, and international NGOs, as well as financial support provided by financial institutions such as the world bank and the International Monetary Fund.

In a special approach this strategy will map out other major development investments of current global interest, where HIV and AIDS programming can tap into the resources. These include climate change, gender programming, education, non-communicable diseases, poverty eradication, etc., to ensure continued service provision as one of the measures for scale up and sustain the gains achieved.

Approach 1: Consolidate and deepen relationship with existing partners.

Strategic Objective

Engage partnerships with country external donors to support the HIV response.

[8] In Danger: UNAIDS Global AIDS Update 2022. Geneva: Joint United Nations Programme on HIV/AIDS; 2022.

[9] Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030. United Nations General Assembly; 2021.

Strategic Actions

a. Advocate for additional funding from external partners.
b. Advocate for realigning of external resources to national priorities.
c. Ensure external funding are inclusive of a sustainability and transition plan.
d. Institute or revitalize a platform for regular engagement with development partners — (focused performance of RMS) and identification of unfunded priorities.

Approach 2: Establish and court new partners.

Uganda realised that the current funding from the current partnerships for the response is not fast enough to realize the national and global HIV targets.

Strategic Objective

To enhance the donor funding from new partners to fast track the achievement of the national targets.

Strategic Actions

a. Engage potential new funders and philanthropists and their potential interests.
b. Hold donor and funding conference at global, national, and sub-national levels.
c. Leverage resources earmarked for other development priorities particularly in areas of gender programming, education, poverty eradication, and climate change strategies.

Pillar 3: Resource Optimization

Alongside policies aimed at tapping into new resources, it will be equally important to consider approaches that maximize the effective utility of existing funds, resources, and partnerships for high-priority health sector activities, including the response to HIV. A cross-programmatic efficiency analysis that was implemented in Uganda indicated that the country loses a significant amount of resources through fragmentation in financing. Although the country's health financing strategy included a basket fund for funds from development health partners, this did not materialize. Furthermore, these fragmented financing pools lead to inefficiencies through duplicate procurement and implementation systems[10]. Resources such as human resources are often directly recruited and remunerated by partners to support specific programs instead of supporting all the programs in the facility[11]. Such inefficiencies could be minimized through more harmonization and alignment of human resource and procurement systems and joint planning and budgeting and implementation.

Another strategy that has been proposed to boost the sustainability of the response to HIV is moving towards an integrated service delivery model. Closer integration of HIV and

[10] World Health Organization. Cross-Programmatic Efficiency assessment for selected Health Programs in Uganda (2015: 2020).

[11] World Health Organization. Cross-Programmatic Efficiency assessment for selected Health Programs in Uganda (2015: 2020).

relevant health services holds the potential to enhance the accessibility and uptake of services in a way that is equitable and enables stigma free access to key populations, while offering a more people-centred approach to care. Furthermore, integrated health service models have consistently been found to be more cost-effective.

Another strategy to maximize efficiency and bolster sustainability is through alignment between key stakeholders involved in the response to HIV — both within the country and between governments and international donors using a multi-sectoral financing approach. One way in which key stakeholders can build synergies that ultimately allow for the country to meet national goals is through the implementation of co-financing arrangements using a multi-sectoral approach.

The NASAs implemented in Uganda indicate that more funding is usually allocated for care and treatment rather than prevention. This has contributed to the stagnation observed in the number of new HIV cases registered in the country in addition to an ever-increasing funding gap. Reduction in new cases will eventually lower the cost of care and treatment, therefore resources for HIV prevention services should be prioritized. Furthermore, efforts to ensure that all HIV positive patients start treatment and achieve viral suppression are also central to the success of this strategy.

Local manufacture of HIV related products has several potential benefits including faster access to products and hence reduced stock outs especially during global crises and conflicts, as well as increased generation of local revenue. However currently local manufacture is undermined by the high cost of production and lack of incentives for promoting local manufacture.

The current mode of delivery involves some aspects that can be conducted at less cost but with the same or even better results. This mainly relates to certain categories operations such as outreach for community sensitization that can easily be leveraged and mainstreamed into the teams that are already engaged in doing similar or related work as part of the public health activities. Additional gains can be realized through streamlining the production, procurement, and distribution of commodities. Detailed savings and hence contributions to the response require computations based on the respective staff numbers and operational costs of outreaches and in-house/facility treatment (both out-patients and in-patients) as well as possible reduction from manufacturing of key commodities within the region.

Approach 1: Promote integrated delivery of HIV and AIDS services.

HIV epidemic control has been predicted with provision of integrated service provision and reduction of financing health services in silos.

Strategic Objective

Integration of the delivery of HIV and AIDS services with other primary healthcare services.

Strategic Actions

a. Implement integrated service delivery models that are high impact.
b. Conduct research to identify innovative, effective, and efficient integrated service delivery models.

Approach 2: Rationalization of the supply chain management.

Strategic Objective

To improve efficiencies in supply chain management through reduction of duplicated efforts.

Strategic Actions

a. Strengthen and harmonize the national and sub-national quantification and procurement planning processes.
b. Strengthen data-driven rationalization of the health supply chain to identify opportunities to improve efficiencies.
c. Streamline the health supply chain to eliminate duplications and parallel programming.

Approach 3: Advocate for increased local manufacture of HIV service pharmaceutical and non-pharmaceutical products.

Over 90% of funds for the HIV response is spent on procurement of HIV commodities and moreover procured from donor funds and outside Uganda. Local manufacturing of HIV commodities is one of the key drivers for domestic sustainable HIV financing.

Strategic Objective

Create policy and regulatory environment to promote local production and consumption of HIV and AIDS products.

Strategic Actions

a. Engage with the manufacturing associations to priorities local manufacturing of HIV products.
b. Work with regional bodies to lobby for the expansion of regional markets for locally produced products.

Approach 4: Efficiency gains from procurement of commodities.

The other aspect of efficiency gains is associated with the procurement of commodities, mainly drugs from sources outside the EAC region. The ability to realize reduction in the price of ARVs will largely depend on the production costs that are driven by the, active pharmaceutical ingredients, associated patents, profit margins put by the manufacturers, and mode of purchase whereby bulk quantities lower the cost. This has critical implications for sustainable treatment for HIV and AIDS in Uganda and neighbouring countries within the EAC region.

Despite the reduction in the prices of ARVs based on the evolving reduced process for the price of API, the literature shows that further reductions are possible if the partners can address indirect costs and profits added by suppliers over the direct production costs. The study recommends that Uganda works with the current API patent holders in the United States to engage in local manufacturing within the country and, preferably, supply the whole region. The results are yet to establish the exact possible savings from such an initiative of manufacturing within the region. However, given the fact that commodities account for a significant cost of the response, the savings arising from local production would be quite substantial. For example, a reduction of 10% would amount to over USD 20 million.

During the development of this strategy, preliminary discussions show that the United States and other western countries need assurances that the system will be fair to ensure competition among the producers. UAC and Office of the President should work with partners including member states of the EAC, to further discussions with the U.S. government and the private sector in the United States and other potential areas.

Other options as best practices from the region.

A review of the situation with the neighbouring countries revealed that:

i. The national HIV response for Kenya is heavily funded from international donors up to 69% of HIV expenditure in 2018/19 and the government contribution of 24%, households 5%, and corporations 3%.
ii. Similar trends exist in Tanzania where the largest expenditure for HIV response is mainly driven by international donors. With an increase in total expenditure from USD 466.8 million in 2015 to USD 612.0 million in 2017., 90% of which is from PEPFER and the Global Fund, these big funders indicated that there will be a reduction or flattening in funding in the next funding cycles.

An analysis of the EAC financing for UHHC suggest six strategic result-based programs, including:

- Enhanced fiscal space for UHHC.
- Sustainable UHHC financing mechanisms developed by each partner state.
- Improved efficiencies and financial investments in UHHC from less than 70% to at least 90% by 2023.
- Increased UHHC funding through public-private partnerships.
- Strengthened structures at national and regional level to support and enable UHHC policy, governance, regulation, and resource mobilization.
- Enhanced cross-sectoral collaboration for UHHC resource mobilization.

Pillar 4: Non-Financial Resources and Enlist the Strategies and Targets

The HIV response has arrangements with private and voluntary actors to provide non-financial resources and enlist the strategies and targets.

Strategic Objective

To develop sustainable mechanisms to mobilize non-financial resources.

Strategic Actions

a. Establish forums to engage potential agents and organisations to emphasise the importance of non-financial resources.
b. Map out the agencies with the potential to provide non-financial resources.
c. Develop a pool of these resources and design allocations as needed.

Funding Targets by Proposed Funding Streams

Table 9: Projected revenues from proposed funding streams

	2023	2024	2025	2026	2027	2028	2029	2030	Totals
	USD millions								
Resources Needed	679.97	722	756.46	785.64	814.16	843.91	874.71	906.97	6,383.82
Domestic Financing									
Public Financing (budget allocations)*	96.48	99.33	101.32	103.34	129.34	155.34	181.34	207.34	1,073.83
Public financing (HIV Mainstreaming)	5.69	6.96	7.03	7.1	16	16	16	16	90.78
Public Financing (through the proposed NHIS)**	0	0	0	0	92.38	108.57	130.56	167.18	498.69
Total Public Sector Financing	**102.17**	**106.29**	**108.35**	**110.44**	**237.72**	**279.91**	**327.9**	**390.52**	**1663.3**
Domestic Private sector financing***	0.1	0.18	0.18	0.18	101	100.55	101	100.55	402.84
External donor funding****	551	551.17	547.12	548.12	88.02	88.02	88.02	88.02	2,549.39
Resource Optimizatio	0	252.61	252.61	252.61	253	252.61	253	252.61	1,768.27

	2023	2024	2025	2026	2027	2028	2029	2030	Totals
n (efficiency gains)*****									
Total	**653**	**910**	**908**	**911**	**679**	**721**	**769**	**832**	**6,384**
Proportion of contribution per source of funding									
Public Sector Financing	**15.64%**	**11.68%**	**11.93%**	**12.12%**	**35.01%**	**38.82%**	**42.64%**	**46.95%**	
Private sector financing	**0.01%**	**0.02%**	**0.02%**	**0.02%**	**14.81%**	**13.94%**	**13.07%**	**12.09%**	
External donor funding	**84.35%**	**60.55%**	**60.24%**	**60.14%**	**12.97%**	**12.21%**	**11.44%**	**10.58%**	
Resource Optimization	**0**	**27.75%**	**27.81%**	**27.72%**	**37.21%**	**35.03%**	**32.85%**	**30.37%**	

Assumptions:

*Estimates based on current commitments and projected annual increments by GoU on budget allocations.

**Based on estimated share for HIV response in the proposed NHIS.

***Estimates based on currents private sector revenues for HIV through various streams: ODI, in-kind contributions, fundraising events and OOP expenditure (whereby OOP expenditure will be minimized by 50% of the current OOP expenditure spending to HIV).

****Based on traditional partners' current commitments up to 2026, then adjusted to the gap after allocating estimates to domestic sources and efficiency gains. Partners to be targeted include PEPFAR, GFATM, Royal Netherlands, UN agencies, CHAI, KOICA, JICA, and philanthropies, as well as non-traditional partners.

*****Based on a recent high-profile systematic review by Nabyonga-Orem et al., 2023, that analysed 39 efficiency studies for health systems in Africa, where approximately 23% of the inefficiency were observed, with a conclusion that improving efficiency alone will yield an average of 34% improvement in resource availability.

Management, Implementation, and Monitoring

Improvement in Governance of the HIV Response at all Levels

Increased domestic financing of the HIV response will require improved governance and oversight at the national, regional, and local levels, with adequate coordination among stakeholders in key public and private institutions. Strong institutional and governance arrangements are synonymous with effective and efficient resource mobilization and utilization. In addition, multi-sectoral collaboration is crucial to drive national domestic resource mobilization activities.

Key Interventions for Strengthening Implementation, Governance, and Accountability

Strengthen the institutional capacity of national and sub-national leadership to drive domestic resource mobilization efforts, support resource mobilization TWGs, and encourage multi-sectoral collaboration by undertaking the following actions:

a. Revitalize and strengthen the governance and institutional arrangements that enable proper mobilization, coordination, transparency, and accountability for HIV resources at all levels.
b. Build capacity of the workforce at national and sub-national to engage in evidence-based budget advocacy with key stakeholders, to efficiently manage and account for mobilised resources, and to track and report on progress of domestic resource mobilization activities.
c. Consolidate governance, accountability, leadership, and management practices of key state and non-state implementing partners.
d. Introduce the UAC accreditation and certification program as a form of monitoring mechanism.

Strengthen accountability mechanisms for mobilized funds by undertaking the following actions.

a. Leverage the experience of key CSOs and implementing partners to strengthen the capacity of HIV-focused CSOs to carry out resource mobilization tasks.
b. Include budget tracking and monitoring of the use of funds among the indicators of community-led monitoring tasks.
c. Build the capacity of government and non-public HIV actors in collaboration in public financial management.
d. Institutionalize routine budget tracking, transparency, and accountability mechanisms at the national and state level.
e. Conduct periodic Value-for-Money assessments for the national HIV response.

Management Arrangement

UAC will be responsible for overall leadership, coordination, implementation, and monitoring and evaluation of the RMS. The resource mobilization TWG at UAC will continue to serve as the technical arm of the board. These structures will be replicated at the district level.

Roles and responsibilities of key stakeholders will be as follows:

UAC

- Lead, coordinate, monitor, and evaluate implementation of the RMS.
- Advocate and communicate the RMS to all stakeholders at all levels.
- Track collection, allocation, and use of domestic resources in accordance with the RMS.
- Build capacity for effective implementation of the RMS at all levels.
- Request, negotiate, and secure budget funds from the government treasury at the national level, in coordination with the MoH.
- Lead development of the legal framework and guidelines needed to support resource mobilization mechanisms in the RMS.
- Serve as the secretariat of the national consultative board.
- Produce quarterly reports on performance of RMS initiatives.

MoH

- Oversee and support implementation of the RMS.
- Ensure efficiency in the allocation of domestic resources through alignment with the HIV and AIDS Strategic Plan.
- Advocate to participate in tracking, collection, allocation, and use of domestic resources per the RMS.

Ministry of Finance and District Chief Finance Offices

- Support UAC and the Attorney General in developing a legal framework and guidelines for the implementation of resource mobilization mechanisms.
- Support tracking, collection, allocation, and use of domestic resources as per the RMS.
- Support requests and negotiation of budgets from the government treasury.

Sector Ministries and Local Governments

- Create an appropriate structure and assign staff and budget to implement targeted mainstreaming.
- Plan, budget, implement, and monitor and evaluate targeted mainstreaming as per the revised guideline.
- Document and report performance of targeted mainstreaming on a quarterly basis.

Private Companies and Public Enterprises

- Advocate for the promotion and ensure participation in the private sector initiatives like the ODI.

Development Partners and Donors

- Participate in and provide strategic guidance through the consultative board.

- Provide technical and financial support in implementation of the RMS.
- Support the development of regular HIV funding landscapes to identify and close.
- Address HIV program funding gaps.

Implementation Road Map

Table 10: Increase the national budget allocation for health and HIV (6.0)

Activity	Outputs	Implementation Year							Responsibility	Collaborators
		1	2	3	4	5	6	7		
6.0.1 Undertake an economic study on the impact of HIV and AIDS.	Report on impact of HIV and AIDS		X						UAC	MKSPH, HDP's
6.0.2 Conduct a consultative workshop on the need to increase govt funding for HIV with theMOH; MOFPED; Women forum, and other MDAs, the Prime Minister'sOffice; the Council of Ministers; and District governments.	Consensus on the responsibility of the government to increase budget allocation for the HIV program		X						UAC	MoH
6.0.3 Develop annual costed action plans andfunding landscapes.	Action plan and funding landscape developed	X	X	X	X	X	X		UAC, DHO, and subcounty healthoffices	MOH, DRMS TWG
6.0.4 Hold targeted high level meetings to Lobby MoFPED to allocate more money to health.	Meeting report		X		X		X	X	MoH, UAC	MOFPED, HDP's
6.0.5 Conduct an annual review and report on budget allocation and use at National, District,and subcounty levels.	Domestic budget allocation report produced anddistributed		X	X	X	X	X		UAC, MOH, Regional District Health Office	DRMSTWG
6.0.6 Conduct an annual audit of budget allocation and use at National and District levels.	Annual audit report		X	X	X	X	X		UAC, MOH, Regional District Health Office, MoFPED	Auditor General

Table 11: Increase the HIV mainstreaming contribution from MDAS and large infrastructure projects (6.1)

Activity	Outputs	Implementation Year							Responsibility	Collaborators
		1	2	3	4	5	6	7		
6.2.1 Develop mainstreaming guidelines for the infrastructuresector and a supportive legal framework to mandate and standardize the practice.	Mainstreaming proclamation approved, guidelines revised,legal framework developed	X							UAC, MoFPED, Attorney General	
6.2.2 Assign an account code and expenditure title for HIV mainstreaming within the infrastructure sector.	Account code and expenditure title created		X						UAC, MoFPED	
6.2.3 Conduct planning meetings with districts and program managers of large infrastructure projects to ensure proper allocation and budgeting for mainstreaming funds by infrastructure projects and MDAS.	Planning meetings held with MDAs and large infrastructure projects	X	X	X	X	X	X	X	UAC, District AIDS Committee	Local governments, Local government association, MOFPED
6.2.4 Ensure that mainstreaming of funds for HIV is considered among documents required for issuing of certificate of compliance by the equal opportunities commission.	Documentation that includes allocation of 0.1% of MDA budgets to HIV AND AIDS as a requirement for getting a certificate of compliance	X							UAC, Equal opportunities commission	
6.2.5 Track the allocation of mainstreamed funds by MDAs and large infrastructure projects.	Report on mainstreamed fund allocation and use of the funds	X	X	X	X	X	X	X	UAC, District AIDS Committees	Local governments

Table 12: Increase funds for HIV through the NHIS (6.3)

Activity	Outputs	Implementation Year							Responsibility	Collaborators
		1	2	3	4	5	6	7		
6.3.1 Estimate the long-term costs to the NHIS of integration of HIV services based on a range of possible HIV benefits packages (e.g.,treatment, counselling, and testing) and reimbursement rates, considering service utilization rates, enrolment trends, and beneficiary population characteristics.	Report on cost of HIV benefit packages		X						UAC, MoH,	Academic institutions
6.3.2 Conduct stakeholder dialogue based on results of the feasibility on the inclusion of HIV services within the NHIS benefit package.	Consensus developed on need for HIV insurance integration		X						UAC, National Forum of People Living with HIV/AIDS Networks Uganda (NAFOPHANU)	MoH
6.3.3 Define an HIV benefits package and reimbursement rates basedon results of the feasibility analysis.	Benefits package and reimbursement rates defined		X						UAC	Clinton Health Access Initiative, Health FinancingImprovement Program, DRMS TWG
6.3.4 Hold targeted meetings to lobby for the inclusion of HIV and AIDS within the NHIS benefit package.	HIV included within the NHIS benefit package	X	X	X	X	X	X	X	UAC, MoH, NAFOPHANU, HDP Forum	Clinton Health Access Initiative, Health Financing Improvement Program, DRMS TWG

Table 13: Increase the contribution of the private sector through ODI and other private sector initiatives (6.4)

Activity	Outputs	Implementation Year							Responsibility	Collaborators
		1	2	3	4	5	6	7		
6.4.1 Conduct a review of the ODI governance structures and implementation structures.	ODI review report	X							UAC, HAAC	ILO, FUE
6.4.2 Revise operational manual and implementation structures for ODI.	Revised operational manual for ODI		X						UAC, HAAC	ILO, FUE
6. 4.3 Track and monitor use of funds by ODI.	Report on mobilization and use of funds generated through the ODI initiative		X	X	X	X	X	X	UAC, HAAC	MoH
6.4.4 Revise the private sector engagement strategy and identify resource mobilization strategies.	Private sector engagement strategy revised Strategy's for mobilizing resources for HIV identified	X	X						HAAC	ILO
6.4.5 Revive the HACC and review/update the ToRs.	HAAC revitalized. Regular HAAC meetings	X	X	X	X	X	X	X	UAC, FUE	

Activity	Outputs	Implementation Year							Responsibility	Collaborators
		1	2	3	4	5	6	7		
6.4.6 Build capacity of the private sector to mobilize resources by facilitating / recruitment of personnel responsible for resource mobilization, conducting skills building workshops, providing resources and tools.	Personnel for resource mobilization identified and facilitated. Skills building workshops conducted, resources for implementing RMS obtained		X	X					UAC, HAAC	ODI Board
6.4.7 Update, mapping, and profiling of the Private Sector Associations – to understand operational and coordination systems and HIV and AIDS issues/concerns in the respective sectors.	Mapping of private sector associations		X						HAAC	FUE
6.4.8 Hold advocacy meetings about the importance of funding HIV and AIDS and benefits of engaging in resource mobilization efforts.	Advocacy meetings held		X	X	X	X	X		MoH, HAAC, UAC	NAFOPHANU
6.4.9Develop incentives that can encourage companies to contribute towards HIV and AIDS.	Incentives that encourage contribution towards HIV AND AIDS identified		X	X						URA
6.4.10 Track and monitor use of funds by ODI and other private initiatives.	Report on mobilization and use of funds generated through the ODI initiative		X	X	X	X	X		UAC, HAAC	

Table 14: Promote public private initiatives for health (6.5)

Activity	Outputs	Implementation Year							Responsibility	Collaborators
		1	2	3	4	5	6	7		
6.5.1 Undertake an analysis of existing and potential private public initiatives.	Analysis of public private initiatives undertaken		X						UAC, HDP's	MoH
6.5.2 Identify and establish new public private partnerships that can be implemented in the short, medium and long term and strengthen existing initiatives.	Existing public private initiatives strengthened New public private initiatives identified	X	X	X	X	X	X	X	MoH, UAC	
6.5.3 Improve resource targeting and promote strategic purchasing through the implementationof social contracting within the MOH's public- private partnership framework.	Public-private partnership guidelines for social contractingof NGOs for HIV service provision developed	X	X	X	X	X	X	X	UAC, MoH	

Table 15: Increase external resources from current multilateral and bilateral partners and new partners (6.6)

Activity	Outputs	Implementation Year							Responsibility	Collaborators
		1	2	3	4	5	6	7		
6.6.1 Conduct meetings to lobby for continued investment in HIV and AIDS through the returns on investment on HIV and AIDS.	Report of advocacy meetings		X	X	X	X	X	X	UAC, NHI	Clinton Health Access Initiative, Health Financing Improvement Program, DRMS TWG
6.6.2 Update e mapping data base of existing partners and new funders and philanthropists and their potential interests.	Funders data base updated	X	X	X	X	X	X	X	UAC MOH	
6.6.3 Develop an Aids development partner portfolio spelling out engagement conditions for different partner categories and preferential treatment for the top 10 partners.	AIDS development partner portfolio developed and updated regularly		X	X	X	X	X	X	UAC	MoH
6.6.4 Develop an implementation plan for collaboratively working with MDA's CSO's/NGO's, academic and research institutions to mobilize additional resources for HIV from new funding sources.	Implementation plan developed	X							UAC	CSOs, NGOs, and academic institutions
6.6.5 Re-establish regular quarterly HIV Donor Coordination Working Group meetings to develop a coordinated long-term strategy for HIV financing.	Donor coordination meetings held quarterly	X	X	X	X	X	X		UAC	HDP's, MoH

Activity	Outputs	Implementation Year							Responsibility	Collaborators
		1	2	3	4	5	6	7		
6.6.6 Develop a transition and harmonization Plan to set out how partners and GoU will collaborate to map out financing of the HIV response.	Transition and harmonization plan developed		X						UAC, MoH, HDPs	
6.6.7 Monitor and track the utilization of resources generated from external sources.	Annual NASAs undertaken	X	X	X	X	X	X	X	UAC, MoH	MAKSPH, academic institutions, HDP's
6.6.8 Monitor track progress in achieving the sustainability plan actions.	Progress report	X	X	X	X	X	X	X	UAC, MoH	HDP's

Table 16: Ensure optimal use of HIV resources (6.7)

Activity	Outputs	Implementation Year							Responsibility	Collaborators
		1	2	3	4	5	6	7		
6.7.1 Review the cross efficiency programmatic study conducted by WHO and identify actions that can be implemented in relation to HIV and AIDS. These should include among others HR and procurement harmonization.	Action points identified from the cross programmatic efficiency study Harmonization of procurement systems undertaken Alignment and harmonization of Human Resources for HIV		X						MoH, UAC	HIV implementing partners, civil society, development partners
6.7.2 Develop guidelines for the integration of HIV and AIDS services into primary healthcare services.	Guidelines developed		X						MoH	UAC
6.7.3 Review and revise guidelines for health prevention to ensure that they are comprehensive and include HIV and AIDS.	Guidelines revised		X						MoH	UAC
6.7.4 Review prioritize criterion for HIV commodity and funding allocations.	Methodology/approach developed and integrated into annual workplan guidelines		X						MOH PCD and Policy and Planning Directorate	UAC, MOH

Activity	Outputs	Implementation Year							Responsibility	Collaborators
		1	2	3	4	5	6	7		
6.7.5 Train UAC, MOH, RHAPCO/RHB, and strategic sector staff on results-based planning, high-impact interventions, national HIV AND AIDS Strategic Plan priorities, and resource tracking toimprove allocative efficiency and effective use ofresources.	Key stakeholders trained inhigh-impact practices		X						UAC	DRMS TWG
6.7.6 Enforce joint budgeting, planning and implementation of HIV and AIDS programs at national and sub-national levels.			X	X	X	X	X		UAC, MOH, RHAPCO/DHO	
6.7.7 Conduct a study to identify factors that constrain local production and identify strategies for promoting local production.	Study on local manufacturing Done and action plan developed	X							UAC	
6.7.8 Lobby ministry of trade and tourism to put in place incentives for promoting local manufacture.	Incentives for promoting local manufacture in place			X	X				Min of trade tourism and industry Uganda investment authority	URA
6.7.9 Work with regional bodies to lobby for bulk procurement and expansion of regional markers for locally produced goods.	High level meetings held and agreements for bulk purchase and regional markets developed					X	X	X	Min of trade tourism and industry Uganda investment authority	URA

Table 17: Strengthen government stewardship to effectively implement the DRMS Strategy by building capacity for coordination, advocacy, and transparent management (6.8)

Activity	Outputs	Implementation Year							Responsibility	Collaborators
		1	2	3	4	5	6	7		
6.8.1 Facilitate endorsement, approval, and dissemination of the HIV RMS.	HIV RMS approvedby the Minister	X							UAC	MOH
6.8.2 Develop an advocacy and communications strategy, materials (flyers and posters), and media campaigns with key information on the HIV DRMS Strategy.	Strategy developed and communicated to the publicand stakeholders	X							UAC	RMS TWG, Broadcasting Corporation
6.8.3 Conduct sensitization and advocacy workshopswith key National and District stakeholders on the HIV DRMS Strategy; develop District targets and workplans for cascading.	Consensus created on the role of stakeholders in strategy implementation	X	X						UAC, DAC	
6.8.4 Assign/ recruit staffat UAC and district level to support the implementation of the HIV RMS Strategy.	Staff to support implementation of RMS identified and facilitated	X	X						UAC	RMS TWG
6.8.5 Build skills of resource mobilization staff at national and sub-national level to engage in evidence-based budget advocacy, financial management to efficiently manage and account for mobilized resources, and to track and report on progress of DRMS activities.	Skills in resource mobilization and use, transparency and accountability enhanced		X						UAC	HDP's

Activity	Outputs	Implementation Year							Responsibility	Collaborators
		1	2	3	4	5	6	7		
6.8.6 Strengthen governance, accountability, leadership and management practices of key state and non-state implementing partners.	Skills in governance, leadership and management enhanced		X	X	X	X	X	X	UAC, DAC	MoH
6.8.7 Revitalize National and sub national HIV AND AIDS coordination structures to enable proper mobilization, coordination, transparency and accountability for HIV resources at all levels.	Regular convening of Districtand subcounty AIDS councils	X	X	X	X	X	X	X	UAC, DAC	
6.8.8 Meet to review and monitor progress on the HIVRMS Strategy, including updating and revising theHIV Sustainability Road Map at least annually.	HIV DRMS Strategy progress monitored, and HIV Sustainability Road Map reviewed and revised.	X	X	X	X	X	X	X	UAC	HDP's
6.8.9 Institutionalize routine budget tracking for HIV and AIDS.	Routine tracking of HIV AND AIDS budget undertaken at national and sub-national level	X	X	X	X	X	X	X	UAC	
6.8.10 Work with CSOs to conduct community budget tracking of HIV and AIDS resources	Structured functional system for community budget tracking of HIV funds								UAC, NAFOPHANU, DAC	
6.8.11 Develop a value for money framework for the use of HIV and AIDS funds	Value for money framework			X					UAC	MoH
Resource harmonization and Alignment as part of Sound Partnership Forum.				X					UAC	MoH

Activity	Outputs	Implementation Year							Responsibility	Collaborators
		1	2	3	4	5	6	7		
The Partnership Forum is important for Health and HIV response to ensure that spending is in keeping with budget ceilings, that budget resources are aligned with government priorities and deliver good value for money for the public.										
Outlined an iterative process to support budgetary allocation decisions aligned with regional populations and needs as prioritized in the essential health services package.										

Monitoring Framework

A monitoring and evaluation framework is required to monitor the implementation of the RMS with particular indicators to be tracked by the UAC Resource Mobilization Desk and the Resource Mobilization TWG. The national Resource Mobilization TWGs will serve as an advisory body that reviews RMS implementation progress, including amounts mobilised, allocation criteria, and use of the funds. The RMS will be reviewed at the midterm in 2026 and evaluated in the first quarter of 2030.

Monitoring and Evaluation Framework for the RMS Implementation

Table 18: Selected indicators for tracking progress on the RMS

Strategy	Objectives	Indicators
Increase public sector budgetary allocation for the HIV response.	• Increase the budget allocation for the HIV response by at least 11% by 2030. • Introduce and improve HIV budgetaryallocation at the local government area level.	• The annual HIV budget at the national level. • Yearly increase (percentage) in the national HIVbudget using 2023 as the baseline. • The annual HIV expenditure from public sources.
Increase public sector budgetary execution for the HIV response.	• Ensure at least 95% execution of HIV budgets at the national and state level by 2025.	• Proportion of the approved HIV budget that was spent (yearly). • Percentage increase in HIV expenditure from 2024–2030

Table 19: Resource needs for implementation of the RMS (USD)

		Year 1	2	3	4	5	6	7	Total
	PILLAR 1: Domestic Resource Mobilization Strategic Actions								
1.1	Increase the national budget allocation for health and HIV								
1.1.1	Undertake an economic study on the impact of HIV AND AIDS	-	53,100	-	-	-	-	-	53,100
1.1.2	Conduct a consultative workshop on the need to increase government funding for HIV		17,500						17,500
1.1.3	Develop annual costed action plans and funding landscapes	8,550	8,806.50	9,070.70	9,342.82	9,623.10	9,911.79		55,305
1.1.4	Hold targeted high-level meetings to Lobby MoFPED to allocate more money to health		6,910	7,117.30	7,330.82	-	7,550.74	7,777.27	36,686
1.1.5	Conduct an annual review and report on budget allocation and use		8,595	8,852.43	9,118.01	9,391.55	9,673.29	9,963.49	55,593
1.1.6	Conduct an annual audit of budget allocation and use at National and District levels		3,730	3,841.62	3,956.87	4,075.58	4,197.84	4,323.78	24,125
1.2	Increase the HIV mainstreaming contribution								
1.2.1	Develop mainstreaming guidelines for the infrastructure sector	9,800							9,800
1.2.2	Expenditure for HIV mainstreaming within the infrastructure sector		1,800						1,800
1.2.3	Conduct planning meetings with districts and program managers of large infrastructure projects	126,900	130,707	134,628	138,667	142,827	147,112	151,525	972,366
1.2.4	Ensure that mainstreaming of funds for HIV is considered	2,780							2,780
1.2.5	Track the allocation of mainstreamed funds by MDAs and large infrastructure projects	9,800	10,094	10,397	10,709	11,030	11,361	11,702	75,092
1.3	Increase funds for HIV through the NHIS								

1.3.1	Estimate the long-term costs to the NHIS of integration of HIV services		9,800						9,800
1.3.2	Conduct stakeholder dialogue based on results of the feasibility on the inclusion of HIV services within the NHIS benefit package		2,780						2,780
1.3.3	Define an HIV benefits package and reimbursement rates based on results of the feasibility analysis		4,170						4,170
1.3.4	Hold targeted meetings to lobby for the inclusion of HIV /AIDS within the NHIS benefit package	4,170	4,295.10	4,423.95	4,556.67	4,693.37	4,834.17	4,979.20	31,952
1.4	Increase the contribution of the private sector through ODI and other private sector initiatives								
1.4.1	Conduct a review of the ODI governance structures and implementation structures	17,200							17,200
1.4.2	Revise operational manual and implementation structures for ODI		17,200						17,200
1.4.3	Track and monitor use of funds by ODI	5,043	5,194.54	5,350.38	5,510.89	5,676.21	5,846.50	6,021.90	38,644
1.4.4	Revise the private sector engagement strategy and identify resource mobilization strategies	17,200	17,716						34,916
1.4.5	Revive the HACC and review/update the ToRs	12,278							12,278
1.4.6	Build capacity of the private sector to mobilize resources		9,035	9,305.91					18,341
1.4.7	Update, mapping, and profiling of the Private Sector Associations		17,200						17,200
1.4.8	Hold advocacy meetings about the importance of funding HIV AND AIDS		7,413	7,635.64	7,864.71	8,100.65	8,343.67		39,358
1.4.9	Develop incentives that can encourage companies to contribute towards HIV AND AIDS		7,413	7,635.64					15,049
1.4.10	Track and monitor use of funds by ODI and other private initiatives		3,363	3,464.14	3,568.06	3,675.11	3,785.36		17,856
1.5	Promote public private initiatives for health								-
1.5.1	Undertake an analysis of existing and potential private public initiatives		17,200						17,200

1.5.2	Identify and establish new public private partnerships	7,413	7,635.64	7,864.71	8,100.65	8,343.67	8,593.98	8,851.80	56,804
1.5.3	Improve resource targeting and promote strategic purchasing through the implementation of social contracting	7,413	7,635.64	7,864.71	8,100.65	8,343.67	8,593.98	8,851.80	56,804
	PILLAR 2: External support								
2.1	**Increase external resources from current multilateral and bilateral partners and new partners-**								
2.1.1	Conduct meetings to lobby for continued investment in HIV AND AIDS through the returns on investment on HIV AND AIDS		5,560	5,726.80	5,898.60	6,075.56	6,257.83	6,445.56	35,964
2.1.2	Update e mapping data base of existing partners and new funders and philanthropists and their potential interests	17,200	17,716	18,247	18,795	19,359	19,940	20,538	131,794
2.1.3	Develop an Aids development partner portfolio spelling out engagement conditions for diff partner categories and preferential treatment for the top 10 partners.	9,035	9,306	9,585	9,873	10,169	10,474	10,788	69,229
2.1.4	Develop an implementation plan for collaboratively working with MDA's CSO's/NGO's,	9,035							9,035
2.1.5	Re-establish regular quarterly HIV Donor Coordination Working Group meetings	5,560	5,727	5,899	6,076	6,258	6,446		35,964
2.1.6	Develop a transition and harmonization Plan to set out how partners and GoU will collaborate to map out financing of the HIV response.		17,200						17,200
2.1.7	Monitor and track the utilization of resources generated from external sources	5,792	5,965.37	6,144.33	6,328.66	6,518.52	6,714.08	6,915.50	44,378
2.1.8	Monitor track progress in achieving the sustainability plan actions	5,792	5,965.37	6,144.33	6,328.66	6,518.52	6,714.08	6,915.50	44,378
	PILLAR 3: Resource Optimization								-
3.1	**Ensure optimal use of HIV resources**								-
3.1.1	Review the cross efficiency programmatic study conducted by WHO		7,413						7,413

3.1.2	Develop guidelines for the integration of HIV AND AIDS services into primary healthcare services		12,600						12,600
3.1.3	Review and revise guidelines for health prevention		12,600						12,600
3.1.4	Review prioritize criterion for HIV commodity and funding allocations		5,792						5,792
3.1.5	Train UAC, MOH, RHAPCO/RHB, and strategic sector staff on results-based planning,		7,413						7,413
3.1.6	Enforce joint budgeting, planning and implementation of HIV AND AIDS programs at national and sub-national levels	e	5,792	5,965.37	6,144.33	6,328.66	6,518.52		30,749
3.1.7	Conduct a study to identify factors that constrain local production and identify strategies for promoting local production	14,600			-		-		14,600
3.1.8	Lobby ministry of trade and tourism to put in place incentives for promoting local Manufacture	e		4,170	4,295.10		-		8,465
3.1.9	Work with regional bodies to lobby for bulk procurement and expansion of regional markers for locally produced goods.					14,169	14,593.71	15,031.52	43,794
3.2	**Strengthen government stewardship to effectively implement the DRMS Strategy by building capacity for coordination, advocacy, and transparent management**								
3.2.1	Facilitate endorsement, approval and dissemination of the HIV RMS	5,520							5,520
3,2,2	Develop an advocacy and communications strategy,	18,493							18,493
3.2.3	Conduct sensitization and advocacy workshops	48,723	50,184.66						98,908
3.2.4	Assign/ recruit staff at UAC and district level to support the implementation of the HIV RMS Strategy	79,278	81,656.17						160,934
	Admin costs								-
3.2.5	Build skills of resource mobilization staff at national and sub-national level to engage in evidence-based budget advocacy		27,892						27,892

3.2.6	Strengthen governance, accountability, leadership and management practices of key state and non-state implementing partners		27,892	28,728.65	29,590.51	30,478.22	31,392.57	32,334.35	180,416
3.2.7	Revitalize National and sub national HIV AND AIDS coordination structures	245,400	252,762	260,345	268,155	276,200	284,486	293,020	1,880,368
3.2.8	Meet to review and monitor progress on the HIV RMS Strategy	8000.00	8,240	8,487	8,742	9,004	9,274	9,552	61,300
3.2.9	Institutionalize routine budget tracking for HIV AND AIDS	20,000	20,600	21,218	21,855	22,510	23,185	23,881	153,249
3.2.10	Work with CSOs to conduct community budget tracking of HIV AND AIDS resources	8,000	8,240	8,487	8,742	9,004	9,274	9,552	61,300
3.2.11	Develop a value for money framework for the use of HIV AND AIDS funds	-		7,622					7,622
	Total	**728,975**	**975,809**	**624,222**	**617,648**	**638,372**	**665,074**	**648,971**	**4,899,070**

Annexes: Key Assumptions

Mainstreaming Across 19 sectors

The report on HIV and AIDS Mainstreaming for Uganda, by the different sectors of government estimated the .001 share for HIV and AIDS from 19 sectors. This amount is calculated after deducting the pension gratuity and transfers as per the budget call circulars for FY 2019/20.

	2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**Key Assumptions**
GoU projections in billions	15,891	17,561	19,662	21,579	23,620	25,629	GoU Medium Term Expenditure Framework projections
Percentage	0.10%	0.10%	0.10%	0.10%	0.10%	0.10%	
Expected compliance	25%	31%	40%	48%	57%	60%	Proportion of funds projected to be realised through the Mainstreaming requirements
UGX in billions	3.973	5.415	7.783	10.430	13.483	15.377	UGX Equivalents
Amount (USD)	**1,088,425**	**1,483,425**	**2,132,295**	**2,857,554**	**3,693,930**	**4,212,993**	**USD equivalents**

*Amount for years 2022–2025 are subject to change depending on the mainstreaming amount.

**Source: Report on HIV and AIDS mainstreaming for Uganda, by the different sectors of government (UGX 27.066 billion allocated in 2019/20).

Proposed Outline for the Communication and Engagement Framework for HIV Financing

The Communication and Engagement Framework ("The Framework") should outline how GoU will communicate and engage with national and international HIV response agents and stakeholders and indicate the major innovations and actions that will take to improve communication and engagement between GoU and stakeholders for the HIV financing and sustainability. This will ensure continuous flow of information between GoU and the HIV financing stakeholders, to ensure transparency and a two-way communication, to achieve timely, clear, and easily understood communications by all of our financing stakeholders.

1. Introduction
2. Community Engagement Overview
3. Context
4. Key Communication and Engagement Objectives
5. Principles That Guide the Way We Communicate and Engage
6. Communications and Engagement Framework
7. Why we communicate and engage?
8. Who we communicate and engage with?
9. How We Communicate and Engage
10. Evaluation
11. Report
12. The Action Plan

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for every child

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