

Approved



# **Uganda**

## **Country Operational Plan**

### **FY 2014**

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.



## Operating Unit Overview

### OU Executive Summary

#### EPIDEMIOLOGY

UNAIDS estimates there were 1,500,000 Ugandans living with HIV in 2012; 1,390,000 were adults and 100,000 were children. The projected number of annual new infections was 140,000 in 2012 (86% estimated to be among adults, 14% are children under the age of 15 years), a decrease from 150,000 in 2011. Incidence declined from 0.92 in 2008 to 0.77 in 2012. In 2013, the number of persons initiated on antiretroviral therapy (ART) surpassed the number of annual new infections for the first time, thus reaching a programmatic tipping point. Uganda must build upon this success and scale up effective combination prevention quickly enough to have a transformative impact on the epidemic and make the national HIV response sustainable.

HIV/AIDS was second to malaria among the causes of death in 2010-11 and was responsible for 9.4% of all health center deaths reported in Uganda in 2010-11 (UBOS 2012 Statistical Abstract). An estimated 173 persons died of AIDS-related causes every day in 2012. However, there has been a sustained decline in HIV/AIDS mortality from 120,000 in 1998 to 63,000 in 2012 with 80.9% of such deaths in adults (15+ years of age).

According to the Uganda AIDS Indicator Survey (UAIS) 2011, HIV prevalence for 15-59 year olds increased from 6.4% in 2004-5 to 7.3% in 2011. Prevalence was higher among women (8.3%) than among men (6.1%). Compared to the 2004/5 UAIS survey, Central, Western, Southwestern, and Northern regions remain the worst-affected, while modest declines in prevalence were recorded in the East-Central and Mid-Eastern regions. Of particular concern was the rise in prevalence among Ugandans aged 15-24 years and in the West Nile, Central and North East regions that previously were least affected. Increases in the prevalence were most significant among women and uncircumcised men, key population (KP) groups such as fishing communities and sex workers (SWs).

HIV is predominantly heterosexually transmitted, accounting for 75-80% of new infections (18% vertical transmission; less than 1% blood borne and other modes). Those most affected, the risk factors, and drivers of HIV infections have evolved in recent years. Studies show an HIV prevalence of 1.2% in university students, 15-40% in fishing communities, 37% among SW, 18% in the partners of SWs, and 13% in the group of men with a history of having sex with men (MSM). Strikingly, 35% of new infections occur amongst self-reported monogamous individuals, raising concerns regarding rising multiple concurrent partnerships, extra-marital relations, and transactional, early, and cross-generational sex. HIV transmission involving SW networks bridging to the general population accounts for approximately 10% of



new HIV infections. As a result of these trends, the peak of the epidemic has shifted from unmarried younger individuals to 30 to 39-years-old individuals, who are more likely to be married or in long-term relationships (2011UAIS).

Uganda has the second highest birth rate in the world. The population is projected to double (from 37 to 60 million) in 20 years and reach 90 million by 2040. Uganda, as a result, is a strikingly youthful nation with over half the population under the age of 15. The surge in population will likely exceed the government's ability to provide basic health and education services or provide employment opportunities for many of its citizens. The rapidity of this growth, and the correspondingly ever-greater youth bulge, will likely complicate our HIV/AIDS efforts for years to come.

#### NATIONAL RESPONSE

The Ministry of Health (MoH) through its AIDS Control Program (ACP) and the Uganda AIDS Commission (UAC) under the office of the President lead the national HIV response. The MoH is responsible for coordination and technical guidance; the ACP coordinates service delivery in public and private facilities and other public health programs. The UAC provides oversight of nationwide HIV efforts, including coordination of policy development, planning, resource mobilization and allocation, as well as monitoring and reporting on progress. Over the last year, coordination between the UAC and MoH has improved under the leadership of the UAC Board Chairman and the new Minister of Health appointed in May 2013. However, internal conflicts within the MoH continue to persist.

The Government of Uganda (GoU) continues to increase investments in the health sector. Overall health sector spending increased between 2001 and 2013 but declined from 9% to 7.9% as a percentage of total national budget. The GoU's percentage contribution of total national HIV expenditures increased from 5% to 12%. Ugandan households contribute substantially towards the national response. Out-of-pocket spending by households on HIV/AIDS and related conditions not only accounts for more than one-fifth of annual expenditures but is also twice the amount contributed by the GoU.

In 2013, the GoU demonstrated increased leadership in the national HIV response. The UAC shepherded the national HIV investment case dialogue and the MoH and UAC jointly led development of the interim application to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GF). Through these processes, they have better coordinated national stakeholders; articulated national testing, treatment, care, and circumcision targets; and set the tone for increased collaboration in 2014.

#### U.S. GOVERNMENT AND OTHER STAKEHOLDERS ROLE

More than 80% of Uganda's national HIV response spending comes from development partners.

International donors contributed \$1.6b out of the \$1.7b spent on the national response between 2007 and



2013. The U.S. Government (USG) is the dominant donor as it contributed (i) 78% of the total national spending, (ii) 87% of the spending by international development partners, and (iii) 94% of all the funding from bilateral donors in that period.

Bilateral contributions accounted for 93% of external AIDS funding between 2007 and 2012 while multilateral sources accounted for about 7%. In addition to the GF and United Nations agencies, other donors include Denmark's DANIDA, Sweden's SIDA, and Irish Aid who all contribute to the Civil Society Fund. Britain's DFID is exploring a broader investment and partnership within the HIV sector; it contributed test kits and other laboratory (lab) supplies in 2013. The UNITAID Foundation's support for pediatric antiretroviral drugs (ARVs) through the Clinton Health Access Initiative (CHAI) will end in 2014. A World Bank grant for human resources and M&E systems is expected to directly benefit the HIV response. Following enactment of the Anti Homosexuality Act (AHA) many donor governments restricted or redistributed their aid. The impact on HIV programs was minimal; however, several governments have indicated that they plan to end their HIV support in Uganda in the near future.

In 2013, PEPFAR expanded its collaboration with multilateral partners through the AIDS Development Partner Group (ADPG) and other fora to ensure that activities fit synergistically within the national response, advance policies and partnerships, and minimize duplication and service and commodity gaps. The USG currently holds the ADP co-chair seat and will become chair for the period July 2014-June 2015. The USG also became chair of the broader Health Development Partners Group in January 2014 and will hold the seat through December 2014.

The GF is the second largest donor to the Uganda HIV response. Given prior scandals involving GF resources, current GF resources are 95% commodities. The remaining commodities under the Round 7 grant will be in country in 2014-15. An additional \$118m had been available through the GF interim application, submitted in September 2013, which was critical to planned treatment scale up in 2015; however, the Technical Review Panel (TRP) raised a number of concerns and ultimately approval was delayed due to transition to the New Funding Model (NFM). As result, the Country Coordinating Mechanism (CCM) opted to submit a costed extension of the approved Round 7 grant in April 2014 to avoid delays in disbursement of funding. The GF Board approved the extension in September 2014 and the associated commodities are expected in 2015. The total amount in new funding available for HIV under the NFM is less than expected and will constrain further plans to scale up treatment. During the GF interim application development, partners agreed to rationalize projected funding: the GoU, GF, and possibly DFID will cover the vast majority of public sector commodities while the USG will cover all private sector needs. PEPFAR's COP 14 plans for 2015 implementation were built on the assumptions outlined in the interim application. The PEPFAR team will honor the agreement to fund private sector commodities despite the application being shelved and will maintain a small buffer fund for public sector commodity



gap fill. PEPFAR was actively involved in the development of both the GF interim application and the national HIV investment case. In 2014, PEPFAR will actively support the creation of the NFM standard application.

PEPFAR coordinates with the GF Secretariat and participates in country as an ex officio member of the CCM. PEPFAR began holding monthly coordination calls with the GF on commodities issues in 2013 and meets with the Secretariat team during each in country visit. The team will continue to pursue common talking points and policy approaches with UNAIDS and GF. For example, UNAIDS and PEPFAR jointly advocated for creation of the investment case and have actively guided the process. The USG has collaborated with UNAIDS, the GF, and ADPG to coordinate response to and consultation with the GoU on the AHA and impact on public health and the HIV/AIDS response.

#### INCREASED DOMESTIC RESOURCES

The current reliance on external partners is clearly unsustainable. Additional resources are needed beyond the current funding envelope to continue treatment scale up and support the broader portfolio. One goal of the investment case is to make an evidence based case for additional domestic sources of funding, namely an HIV trust fund proposed by the UAC. The HIV Prevention and Control Act, signed by President Museveni on July 31, 2014, establishes an HIV trust fund. The Act appoints the Ministries of Finance and Health as co-managers and requires an implementation plan to be developed within 6 months. The U.S. Mission will continue to advocate for increased domestic resources with the GoU at all levels and transparent, accountable management of the fund.

#### PEPFAR 2014-15 FOCUS

The USG's top priorities for 2014-15 are to achieve full coverage to eliminate mother-to-child transmission; maintain the tipping point by scaling up ART and support the GoU in adopting the new WHO guidelines including raising initiation to CD4 500, and test and treat for all pediatric patients; improve outreach and service delivery to populations most at risk - MSM, SWs, and fisherfolk; continue VMMC implementation; and build health systems – labs, Human Resources for Health (HRH), and data. These priorities expand on those outlined in the 2012 13 COPs, which redirected the program toward evidence based, high impact interventions. In 2014 15, PEPFAR will support universal ART coverage of all pediatric patients under 15 years old.

PEPFAR continues to increase partnership with GF, UNAIDS, and the GoU to further align the HIV program to the most effective interventions based on science. The USG strengthened supply chain management through increased coordination with the GoU and other stakeholders and supported an in-depth supply chain assessment which will lend important findings critical for addressing system flaws and weaknesses. While there were a number of issues with post shipment testing of condoms that limited



increased condom distribution, these issues were largely resolved in late 2013.

PEPFAR is committed to reducing the HIV incidence rate and ensuring Uganda maintains the programmatic tipping point. As of September 30, 2013, PEPFAR supported more than 507,000 out of the approximately 577,000 Ugandans on ART. Increases in service delivery coverage rates in ART, PMTCT, and VMMC made this achievement possible. PEPFAR will continue these efforts in 2014-15 and support Uganda in initiating more patients on treatment at or below CD4 500 and target testing efforts to serodiscordant couples, most at risk populations (including orphans and vulnerable children (OVC), and key drivers of the epidemic.

Ensuring quality across all program areas is a key priority and TA visits in 2013 and early 2014 to support VMMC, PMTCT, labs, and pediatric treatment provided useful guidance for improving service delivery and quality. PEPFAR will continue to emphasize combination prevention approaches and demonstrate a “distinct shift away” from stand-alone AB programs as outlined in the 2012-13 COPs.

PEPFAR will target prevention efforts and HIV counseling and testing (HTC) to fisherfolk, SWs, uniformed services, their partners, and other Ugandan KPs, e.g. boda boda and truck drivers. However, two laws signed into law in February 2014 present challenges to addressing KPs fully. The Anti-Pornography Act may affect our outreach to SWs. The AHA directly challenged activities to reach lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons. While the Act was dismissed by the Court on August 1, 2014, the law’s chilling effect had already driven many in the LGBTI community even further underground during the months of its enactment, making them harder to reach with health programming, and impeding PEPFAR’s efforts to focus on these KPs. As of September 2014, Members of Parliament were actively working to re-introduce the legislation.

The U.S. Mission works with the GoU at diplomatic and technical levels to ensure that LGBTI and SWs can access the services they need and health workers can provide services without fear of retribution with or without the AHA. The AHA signed in February 2014 included language subjecting those who aid, abet, or counsel another to engage in acts of homosexuality to incarceration and was particularly troubling for its impact on PEPFAR implementing partners (IPs) and health workers. Non governmental organizations (NGOs) found to be aiding or abetting homosexuality would have their certificate of registration cancelled and their chief of party imprisoned for 7 years. Adjustments to planned activities may be required if the AHA is re introduced and enacted with similar language.

#### COUNTRY OWNERSHIP

While donors fund 80% of the national response, the GoU and civil society consider themselves “owners” of the national response and actively participate throughout the year in various fora. However, challenges



continue in building national capacity and effectively executing the national HIV response, e.g. poor leveraging of and advocating for resources and disjointed GoU partner coordination and national M&E structures. However, the GoU demonstrated increased leadership in 2013 through the investment case dialogue and GF interim application development, which resulted in on-time submission.

Further, as an outcome of the investment case, PEPFAR will support the revision of the National Strategic Plan (NSP) in 2014. An evidence based, costed NSP with clear targets and goals will be an important tool for measuring annual progress and holding stakeholders accountable. The PEPFAR team envisions the development of a Sustainability Plan in 2014 as part of the broader national dialogue and an opportunity to articulate shared goals and all partners' contributions over the next 5 years. PEPFAR will support the UAC in strengthening its coordination of the multi-sectoral response through active participation in the GF CCM, Partnership Committee, and investment case steering committee. Through its own transparency, PEPFAR will encourage other stakeholders to share information to harmonize and identify gaps. With plateaued funding, alignment and leveraging of all activities will be crucial to improve efficiencies for additional scale up. PEPFAR will continue to support civil society as strong advocates and catalysts for programmatic and policy improvement.

PEPFAR also is supporting broader country ownership through its management and technical support to the MoH through CDC, increasing harmonization of national data systems, a single M&E system, and capacity building for districts to support public health planning, management, and evaluation. PEPFAR expects to begin transitioning away from its parallel HIBRID data collection system and pulling data directly from the GoU's DHIS II following submission of the Semi-Annual Program Results in May 2014. Given that DHIS II does not collect all required PEPFAR indicators, some information will continue to be collected through HIBRID or other sources. To facilitate and support the transition, PEPFAR's monitoring and evaluation (M&E) partner will begin providing additional TA to the MoH's Resource Center.

At the district level, the USG and its IPs have made significant progress in working with local governments and administrative structures through the introduction of district based programs. The USG will continue to work with the GoU to promote good governance, coordination among partners, responsiveness to the district administration, mutual accountability for finances and performance, and a constructive relationship between IPs and district authorities. PEPFAR will focus on governance, capacity-building, and promoting the role of districts as the unit of implementation to strengthen the decentralized response and enhance engagement by local government, civil society, cultural and religious leadership, and community members.

There are opportunities to explore public-private partnerships (PPPs) and other private sector engagement to boost local buy-in and shared responsibility. In addition, ordinary Ugandans must see



themselves as key actors in addressing the HIV epidemic and feel empowered to take steps to protect themselves, their families, and their communities through prevention interventions, VMMC, and/or treatment. The U.S. Mission has focused on this need for shared responsibility at all levels of society during 2013 World AIDS Day and PEPFAR 10th Anniversary commemorations, in public remarks by senior leadership, and in social media campaigns. Boosting the capacity of districts and local communities to manage their HIV response is an area for continued emphasis in 2014-15. There is an opportunity while developing a Sustainability Plan to bring renewed focus on country ownership and its linkages with systems strengthening by articulating mutual accountabilities for attaining key benchmarks. However, the national country ownership dialogue will be challenged by the AHA and its aftermath.

## PREVENTION

Implementation of evidence based, combination HIV prevention approaches led to a decrease in incidence between 2011 and 2012; however, incidence remains high. The overall increase in prevalence can be attributed to previous interventions not being scaled up enough to make a significant impact; prevention interventions not being aligned to sources of new infections; and widespread risky sexual behavior with low levels of prevention knowledge and risk perception in the population.

PEPFAR has shifted its prevention activities away from stand-alone behavioral interventions to combination approaches, which integrate appropriate prevention messaging and condom promotion with biomedical interventions, e.g. PMTCT and VMMC. PEPFAR continues to refine its behavioral prevention portfolio to better target KPs and prioritize proven biomedical and structural interventions. In 2014-15, PEPFAR will prioritize continued VMMC scale up; ensuring a balanced portfolio that addresses prevention needs across generational subgroups; eliminating bottlenecks that impede condom access and use; and targeting KPs with tailored programs. PEPFAR will continue its support for blood safety, medical infection, post exposure prophylaxis (PEP), and sexually transmitted infection (STI) management.

The GoU implements the Safe Male Circumcision Strategic Plan (SMCSP) (2013-17) in the context of the National Safe Male Circumcision Policy and NSP. It provides a framework for increasing access and use of safe and sustainable VMMC services as an integral part of the country's HIV prevention strategy by contributing to reduction of HIV and other STIs through VMMC services. The national VMMC target is to circumcise 4.5 million men by 2015. Since June 2010, over 1.2 million men have been circumcised, offered HTC, and counseled with prevention messages. PEPFAR is currently the sole funder of VMMC. The SMCSP prioritizes scale up of VMMC in all regions of the country beginning with high HIV prevalence areas and populations. While the majority of circumcisions are conducted in outreach sites and camps, IPs work in collaboration with health facilities for VMMC community mobilization, client follow up, and management of adverse events. In 2013, WHO pre-qualified Uganda for use of the PrePex non surgical circumcision device and the GoU has adopted the method. In 2014, PEPFAR will support adverse effects



surveillance and plans to begin providing PrePex throughout the country in 2015.

In September 2012, Uganda launched treatment for life for HIV positive pregnant women (Option B+). In FY 13, over 1.5 million pregnant women tested for HIV (85% of annual target), 88,263 HIV positive pregnant women identified received ARVs, 22,630 infants received an HIV test, and 21,117 exposed infants were started on treatment within two months of birth. In 2014 15, PEPFAR will continue to scale-up Option B+ coverage and roll out the Mother Baby Care Point service delivery model to improve retention and linkage to pediatric care and treatment by better integrating services for HIV-positive mother and HIV exposed children, which has previously been fractured between antenatal clinics (ANC) and early infant diagnosis (EID) care points. PEPFAR will support universal Option B+ coverage by testing 80% of pregnant women for HIV, providing ARVs to 85% of identified HIV-positive pregnant women, and ensuring early testing to 65% of HIV-exposed infants.

The 2011 UAIS results indicate a reduction in condom use in those engaged in high-risk sex (47% to 29% for women; 53% to 38% for men). PEPFAR will support implementation of the MoH's Condom Strategy and coordination mechanisms to ensure comprehensive condom programming. Under the GF interim application, GF and UNFPA will provide male and female condoms; PEPFAR will support distribution and messaging. Key activities include increasing distribution outlets at facilities, community level, fishing landing sites, and hard to reach areas (primarily rural); strengthening national coordination through the MoH's Condom Coordinating Unit to plan condom procurement and monitor availability; undertaking diplomacy and advocacy activities to de-stigmatize condoms; social marketing of condoms in the private sector and tertiary institutions; engagement with the hospitality industry, bars, and hotels; and supporting advocacy efforts among religious and political leaders. Deliberate efforts will be made to promote condom use among KPs, serodiscordant couples, and multiple concurrent partnerships.

## TREATMENT

The GoU has set ambitious goals for treatment scale up and has revised its integrated national HIV treatment guidelines based on the 2013 WHO recommendations; it officially announced the new policy in late January 2014. The GF interim application outlined annual targets of more than 230,000 new patients annually through 2015 on top of the 566,046 on ART as of June 2013 (76.5% coverage at CD4 350). As of September 30, 2013, PEPFAR supported 507,663 PLHIV on ART. Uganda is expanding ART eligibility criteria to HIV positive individuals with CD4 =500, all HIV positive children less than 15 years of age, HIV positive individuals in serodiscordant relationships and KPs. The new annual initiation targets will improve ART coverage to 80% (at CD4 <500). PEPFAR is planning to support initiation of 334,684 HIV positive individuals on ART (36,197 children and 68,991 pregnant and breastfeeding mothers) by September 30, 2014, and 212,947 HIV-positive individuals by September 30, 2015 (15,438 children and 70,876 mothers). In 2013, Uganda achieved the tipping point for the first time (0.76) with 152,407 net new ART



enrollments compared to an estimated 142,000 annual new HIV infections; this is a significant improvement compared to 2004 whereby the ratio of net new enrollment compared to annual estimated HIV infections was 4.58. The targeted net new enrollment for FY 14 will result in a targeted tipping point of 0.8.

PEPFAR is supporting treatment scale up at technical and policy levels through its membership on the national technical committees and TA to strengthen the MoH's oversight capacity and coordination of the national HIV program. PEPFAR also contributes to district and facility support supervision and quality improvement (QI) visits. In addition, PEPFAR has expanded its coordination with the GoU to ensure better joint planning and target setting. PEPFAR is working with the MoH to recruit new health workers, ensure continued training and skills development, and increase the number of accredited sites to achieve a target of 1,500 ART sites by APR 2014.

The MoH, in collaboration with PEPFAR, assessed the national pediatric and adolescent HIV care and treatment programs. Preliminary findings show that only 12,695 (29%) of the estimated 43,333 eligible adolescents living with HIV were receiving ART; CD4 access among adolescents in care was only 48.4%. In FY 13, pediatric ART coverage increased from 30,641 (30%) in 2012 to 42,712 (41%); initiation of children less than 2 years was above 90%. The national target for new pediatric enrollments in 2014 is 35,000 of which PEPFAR plans to contribute 31,620. The number of accredited ART sites providing pediatric ART increased from 496 in June 2012 to 834 in September 2013. Of all PEPFAR supported accredited sites, about 56% offer pediatric and adolescent ART services.

Key priorities for pediatric and adolescent HIV treatment for next 2 years include support to the following national initiatives: initiation treatment of all Ugandans under 15 years irrespective of CD4 count; development and implementation of the national pediatric and adolescent scale up plans; and implementation of a new service delivery model aimed at improving the retention of HIV exposed and infected babies in care.

PEPFAR will strengthen identification of unknown HIV infected children by supporting: a) scale up of pediatric provider-initiated counseling and testing (PITC) through establishment of more testing points for children at targeted entry points within supported facilities; b) recruitment of HTC volunteers at these points; and c) improvements in pediatric linkages, referral, and retention including applying CQI approaches and scaling up evidence informed, promising approaches such as use of linkage facilitators and family support groups. PEPFAR, through its IPs, will continue to support use of "Initiate me" yellow stickers on patient records to identify children who need to be started on ART. PEPFAR, in collaboration with the MoH, will support scale up of adolescent friendly services and strengthen adolescent psychosocial support groups to improve adherence and retention based on the ongoing adolescent



review and stakeholder consultations. PEPFAR is supporting an ongoing evaluation to assess the national EID program and establish the HIV prevalence among HIV exposed infants and the proportion of HIV infected children started on ART.

In 2014-15, PEPFAR will continue to support the MoH/ACP to oversee, monitor, and coordinate the national HIV pediatric and adolescent response and provide technical support and resources for the development of national pediatric/adolescent scale up plans and strategic actions, joint technical support supervision with the MoH, and regional pediatric mentorship activities to support the roll out of the revised guidelines.

The NPS defines KPs as fishing communities, SWs, partners of SWs, MSM, uniformed services, internally displaced persons, mobile populations such as migrant workers, and persons living with disabilities. Uganda has prioritized some KPs for test and treat. PEPFAR IPs will work with the MoH to map out hot spots and provide targeted interventions to scale up treatment and support ART retention and adherence.

As PEPFAR supports treatment scale up and other evidence-based high impact interventions, quality is a priority to ensure achievement of results; obtain a greater value for investments made; and sustain the impact of our programs. In 2014-15, PEPFAR will support a national quality assessment, which will serve as a baseline for overall HIV QI efforts. As the USG expands its support into the private sector, it will prioritize quality of treatment services and support accreditation and regulatory mechanisms, including the development and adoption of agreed upon standards for the private sector.

## CARE

The roll out of the Option B+ program has led to increased enrollment of HIV positive pregnant women into care, 72% of the FY 13 target. Introduction of the Continuum of Care approach in applying targeted testing, use of linkage facilitators, and quality initiatives have contributed to improved linkages, retention, and integration of HIV care and support services. Quarterly program data indicates an average of 86% linkage from HTC into care and treatment programs. In particular, PEPFAR and the MoH's use of linkage facilitators that walk clients to points of enrollment has greatly influenced the increase in retention. Other successes include the increase in Cotrimoxazole prophylaxis coverage to 84% and in TB screening to 78%.

PEPFAR's 2014-15 care goals include 1) strengthening the referral and linkage system and expand the use of linkage facilitators; 2) improving prescription, dispensing, and availability of the commodities to enhance use of Cotrimoxazole prophylaxis; 3) and improving retention, with the goal of reaching a retention level of 90%. A priority is to improve systematic biannual clinical staging and/or CD4



measurement from 60% to 80%, with a focus on pre-ART clients and at district based facilities where there have been challenges. In 2014, PEPFAR will support the MoH to standardize a Standard Package of HIV Care (SPHC) to ensure equitable and quality care at all levels of health services in both public and private health facilities.

PEPFAR will continue to scale up the provision of the Basic Care Package (BCP) to all new clients in care and provide refills for existing clients who received the package more than 3 years ago. The BCP will be prioritized to improve quality of care through safe water systems, supportive counseling, provision of condoms, and malaria control. PEPFAR will continue to support treatment of opportunistic infections (OIs) through training and providing OI drugs. Further, PEPFAR will implement a combination of high impact TB/HIV interventions that includes ART, Isoniazid Preventive Therapy (IPT), infection control, and intensified case finding. PEPFAR also will strengthen essential prevention interventions for Positive Prevention, Health and Dignity (PHDP), including family planning (FP) integration, risk reduction counseling, condom use, and safe disclosure, and support roll out of Nutrition Assessment, Counseling and Support (NACS) in all supported health facilities. Treatment will be provided for moderate to severely malnourished children using the Ready to Use Therapeutic Foods (RUTF).

In 2014-15, PEPFAR will scale up pediatric care in all PMTCT sites and improve HTC for exposed infants and children; support new national pediatric care and treatment guideline roll out; and facilitate training and mentorship on the new guidelines at all care and treatment sites.

For TB/HIV, PEPFAR will strengthen and expand TB/HIV activities to increase coverage of HIV testing among TB patients from 80% to 90% and increase access to and uptake of ART in TB clinics from 61% to 80%. PEPFAR will strengthen TB/HIV integration through implementation of QI approaches to foster linkage and retention. PEPFAR will work to increase coverage of TB symptom screening among PLHIV from 78% to 90% and support IPT roll out in HIV settings, as well as to strengthen the implementation of TB infection control measures in health care and community settings. Programs will increase awareness among health care providers on the availability and use of Xpert MTB/RIF assay for early diagnosis and treatment of TB, MDR TB, and pediatric TB and build the capacity of health workers to diagnose and manage childhood TB.

In 2014-15, PEPFAR will further strengthen M&E of OVC projects through supporting the OVC Management Information System (MIS) and independent impact evaluation. The program will strengthen OVC programming within the Continuum of Response (CoR) to address the lifetime needs of the target populations through increased linkages to age appropriate prevention, care, and treatment services in accordance to the changing needs and circumstances of the target population. PEPFAR is supporting an OVC QI pilot in 4 districts covering 11 sub counties and 24 villages, which will provide lessons learned for



scale up in 2014-15. Furthermore, PEPFAR will focus on QI of OVC services through supporting review of the national OVC quality standards and the vulnerability index, as well as strengthening the Ministry of Labor, Gender, and Social Development's role in leading and coordinating implementation of the national standards and delivery of quality OVC services. PEPFAR also plans to undertake two impact evaluations to strengthen evidence-based programming.

## GOVERNANCE AND SYSTEMS

In 2013, PEPFAR had notable improvements in governance and systems strengthening, including stimulating GoU leadership, particularly for Option B+ and lab services expansion, as well as the recruitment of more than 1,500 health workers. In 2014-15, the USG will continue to shift from vertical emergency approaches to working through, and supporting, the Ugandan health system.

The USG will strengthen its efforts across institutions and individuals to build capacity for health sector leadership and improved governance. At the central level, USG TWGs will support key line ministries with strategic planning, policy and guideline development and standardization of tools and processes to assist in planning, monitoring, and QI. Strengthening governance, technical capacity, performance, and accountability to improve service delivery systems at the unit of implementation will have an impact on key HIV performance parameters and on health systems well beyond HIV/AIDS.

Through PEPFAR technical support, the HRH information system will be expanded to cover all 112 districts; staffing levels at districts will gradually increase; health training institutions and professional associations will receive resource inputs and capacity building to ensure that production of critical cadres through pre-service institutions remains on track, contributing 3,000 health workers to the 140,000 global target. PEPFAR will support the MoH and Ministry of Education to establish and complete their information system on in-service training and pre service training, which will improve forecasting and planning, as well as accreditation, coordination, and regulation of all in service training events in the country. PEPFAR will continue to build capacity within district and local governments and district health teams to strengthen work environments, performance, and management. In addition, PEPFAR will support the MoH and districts in implementing the retention and motivation plan and support staff motivation and accommodation in hard-to reach and remote districts with low staffing levels and high patient load.

PEPFAR will support pre-service training institutions to generate key cadres, enhance the quality of trainers/tutors, upgrade training facilities/equipment, and standardize national training curricula. PEPFAR will continue to support universities and health training institutions through 1) the Medical Education Partnership Initiative (MEPI) support to medical training, MPH and leadership fellowships, and scholarships for poor students from hard-to reach areas and 2) the Global Health Service Partnership



(GHSP), a PPP between SEED Global Health, Peace Corps, and PEPFAR, that will continue to provide valuable teaching and mentorship of medical school professors and students through the placement of American doctors and nurses in Ugandan schools.

The USG will remain an important TA provider to the MoH for supply chain system strengthening. PEPFAR builds capacity of local institutions to manage all components of the supply chain system effectively and will continue to focus on strengthening the national supply chain management system and building on past investments. In partnership with GF and other partners, and under the leadership of the GoU, the key short-term priorities are 1) increasing warehousing and distribution capacity to deliver the large volumes of condoms needed for effective prevention activities; 2) ensuring standardized logistics manual, paper based data collection tools are available at all levels for all health commodities; 3) developing standards for electronic logistics management information systems and ensuring they are interoperable with the national HMIS; 4) rolling out electronic inventory management systems for stock management at high volume facilities; 5) ensuring logistics management data are available for tracer HIV products to report on PEPFAR indicators; and 6) reinforcing lab logistics through capacity-building interventions.

Longer-term efforts include 1) advocacy for increasing GoU commitments for health commodities; 2) national coverage of district/facility-level pharmaceutical and lab commodity management capacity building interventions; 3) recruitment of adequate/additional supply chain workforce; 4) institutionalization of quality pre-service training on health commodity management for health workers; and 5) institutionalization of adequate internal controls and processes to ensure appropriate facility ordering relative to patient load/consumption and prevention of product leakage. The USG, in collaboration with the GF and the MoH, initiated a comprehensive survey of the health sector supply chain in January 2014. Outcomes of the assessment will inform strategic changes in 2014-15.

#### STRATEGIC INFORMATION

The four key priorities to guide PEPFAR funded SI activities in 2014-15 are: 1) align USG supported systems with DHIS II; 2) support robust M&E systems at service delivery points and districts; 3) increase use of data for evidence-based planning and decision making at all levels; and 4) promote technological innovations to track referrals, linkages, and retention of clients. In the short term, PEPFAR will work towards improving data quality (timeliness, completeness, accuracy, and reliability) at facility, district, and national levels to facilitate transition of PEPFAR reporting to the national systems. In the longer term, PEPFAR will support: 1) refining and scaling up successful technologies to track referrals, linkages and retention of patients 2) evaluating and disseminating findings on key programs such as Option B+ and VMMC; 3) complete key population studies and transmission hotspot mapping; 4) establishing best practices within districts for monitoring linkages within and across the COR through case-based



surveillance 5) assessing data quality and requirements for shifting ante-natal based surveillance to PMTCT programmatic surveillance, and 6) conducting an AIS. By continuing to support the GoU-owned SI system, and involving line ministries and district health teams in site, data, and service quality assessments, and in conducting surveillance and surveys, the USG will continue to build the GoU's capacity to manage and assess their own data systems to determine performance and make policy decisions.

#### GHI AND CENTRAL INITIATIVES

The U.S. Mission does not have a formal Global Health Initiative (GHI) strategy; however, the mission implements a GHI approach in several ways. First, the Ambassador heads the Interagency Health Team (IAHT) comprised of all health agency heads and program leads, political and public diplomacy section heads, and interagency communications officers. The IAHT harmonizes policy and programmatic efforts across health activities, ensures coordination in messaging to the GoU and other partners, and addresses hurdles affecting effective program implementation. Second, the U.S. Mission has expanded its leveraging and harmonization across PEPFAR; the President's Malaria Initiative (PMI); the Saving Mothers, Giving Life (SMGL) initiative and other maternal and child health (MCH) activities; as well as increased alignment between PEPFAR and FP and TB focused activities. For example, Uganda's PEPFAR and PMI programs are integrated by several jointly funded IPs and projects that integrate malaria treatment during pregnancy and bed net distribution into PMTCT activities. The dramatic successes under SMGL in reducing maternal deaths during pregnancy and childbirth and increasing ART uptake for pregnant women in the pilot districts have illustrated the power of leveraging PEPFAR and MCH programs to benefit Ugandans. Further, using the additional \$5 million received for FP/HIV integration in 2013, PEPFAR will support the MoH and partners to integrate FP services in all facilities providing MCH/PMTCT/ART services and all ART sites. The goal is to optimize efficient and effective utilization of FP/HIV and MCH services through smart integration, and maximize bi-directional FP/HIV reach with synergy from both programs as the same personnel provide antenatal care (where PMTCT begins), FP, and MCH at facility level. The acceleration funding will be used to overcome discrete barriers that hinder integration.