United States Department of State

Washington, D.C. 20520

FY 2015 Uganda Country Operational Plan (COP)

The following elements included in this document, in addition to "Budget and Target Reports" posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Uganda.

1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

   Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the "COP 15 Targets by Subnational Unit" sheets that follow for final approved targets.

2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the "FY 2015 Country Operational Plan Budget and Target Report."

UGANDA

Country Operational Plan

(COP) 2015

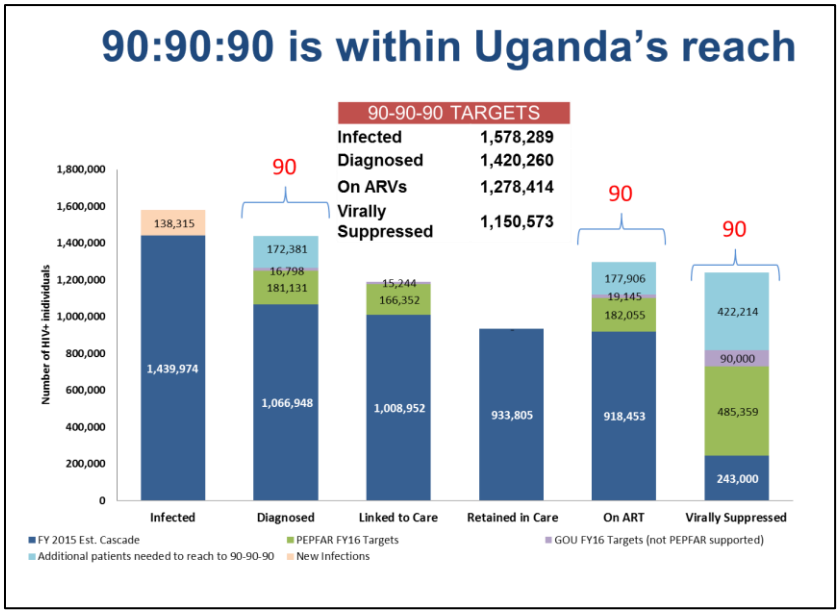
Strategic Direction Summary

September 1, 2015

Table of Contents

Goal Statement

Based on successful implementation of pivots made in the 2012 Country Operational Plan (COP), Uganda will be at 64% anti-retroviral treatment (ART) coverage by the end of U.S. fiscal year (FY) 15. With this foundation, PEPFAR Uganda, in collaboration with the Government of Uganda (GoU) and external stakeholders, developed a COP that will achieve and sustain ART saturation (≥80% ART coverage by 2017) in 61 Scale-Up districts, accounting for 80% of the HIV burden in Uganda. Achieving these geographic targets will move national ART coverage to 71%, placing Uganda within reach of achieving the UNAIDS 90-90-90 by 2020 goals. The strategy builds on and refines the programmatic overhaul made in COP 12 that shifted the focus to the highest impact combination prevention interventions (CPI) while simultaneously investing in health systems strengthening (HSS).



The 61 Scale-Up Districts include 15 districts that were already at 80% ART coverage by September 30, 2014 (see Section 3). In the Scale-Up Districts, the goals of 90% of PLHIV identified and 90% of identified PLHIV on ART will be achieved through active HIV counseling and testing (HTC) and innovative interventions to identify, link, and retain key and priority populations (KP/PPs), pregnant women, and children into HIV programs. These actions will improve ART coverage, time-to-initiation, and minimize loss-to-follow-up (LTFU). The goal of achieving 90% sustained viral suppression will be addressed through viral load (VL) scale-up and increased investment in adherence and retention interventions including additional investments in facility-community linkages. Prevention interventions, e.g. voluntary medical male circumcision (VMMC), condom use, and behavior change among KP/PPs, including adolescent girls and young women (AGYW) will be directed toward the 61 Scale-Up Districts, which will be complemented by the Determined. Resilient. Empowered. AIDS Free. Mentored. and Safe. (DREAMS) Initiative.

PEPFAR Uganda is able to make these shifts through an additional $30 million for treatment scale-up, further streamlining of the COP 12 core package of services, transitioning out of low burden/low yield districts and sites, rationalization of implementing partners (IPs), and exploration of more efficient service delivery models. Specifically, PEPFAR will completely transition 10 districts (with 96 sites) to the GoU and will transition out of 638 sites within Scale-Up and Sustained districts by the end of FY 16 (see Section 5.2). Portfolio and management reviews led to rationalizing responsibilities by region by agency and maintaining a minimum number of above site mechanisms. At the regional level, implementing mechanisms will be consolidated to improve management oversight, achieve efficiencies, and better focus on district-level operations, quality, reporting, and linkages along the cascade of care by the end of FY 16; some districts will be moved between agencies in COP 15 to facilitate the transition.

A planned Population HIV Impact Assessment (PHIA) will obtain more accurate prevalence and incidence data for future program adjustments. Additionally, a prevention of mother-to-child HIV transmission (PMTCT) effectiveness evaluation and KP size estimations will inform program investments and help better target interventions. Finally, PEPFAR and the Ministry of Health (MoH) will establish formal dialogue on critical issues affecting program implementation including HIV testing policies, human resources for health (HRH) at the district level, and operation and controls at National Medical Stores (NMS).

1.0Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

The total population of Uganda is 34,844,095[1], which represents a reduction of 3 million over modeled projections. PEPFAR Uganda, using a burden table analysis, estimates that 1,439,974 Ugandans will be living with HIV by September 30, 2015; by September 30, 2016, this will rise to 1,578,289. These estimates use the population counted in the September 2014 Uganda Census. The national HIV prevalence is estimated at 7.3%[2]. The HIV epidemic is heterogeneous and geographically dispersed. Compared to the 2004 Uganda AIDS Indicator Survey (UAIS), 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. There is wide geographical variation in adult HIV burden, ranging from 7,994 in Bugiri district to 99,527 in Wakiso district. HIV is predominantly heterosexually transmitted, accounting for 75-80% of new infections. Strikingly, 35% of new infections occur amongst self-reported monogamous individuals, indicating multiple concurrent partnerships, extra-marital relations, and transactional, early, and cross-generational sex. Prevalence is higher among women (8.3%) than among men (6.1%). The peak of the epidemic has shifted from unmarried younger individuals to those 30-to-39 years old, who are more likely to be married or in long-term relationships[3]. HIV prevalence among pregnant mothers in ANC care ranged from just above 1% to 32% in 2014, and is particularly high in districts in the Central 1, Central 2, and mid-Northern regions targeted by DREAMS.

The GoU recently revised its National Strategic Plan (NSP) to better target KP/PPs that have significantly higher than average prevalence rates. KP/PPs including female sex workers (FSWs), men who have sex with men (MSM), fisherfolk, truckers, uniformed officers, and prisoners, are particularly at risk:

- FSW HIV prevalence is estimated between 33% and 37%[4]. The number of FSW in Uganda is conservatively estimated at 192,000 with significant regional variations, e.g. 7,576 FSWs in the Kampala district and 120 in Moyo district. An estimated 16% of new infections are attributed to FSW, their clients, and their clients' partners[5]. Sex work is illegal in Uganda, thus creating challenges in providing appropriate services.

- MSM in the 18-64 age group in Kampala are estimated at 5,428 with an HIV prevalence of 13%[6]. Modeled size estimates for 4 major urban centers in the Eastern, Northern and Western Uganda regions range from 810 to 3,579 MSMs.[7] MSMs are highly stigmatized within a legal and policy environment that inhibits non-discriminatory service delivery.

[1] Ugandan Bureau of Statistics (UBOS) 2014 Census
[2]UAIS, 2011
[3]UAIS, 2011
[4]Crane Survey 2013, Vandepitte J, 2014
[5] Modes of Transmission Study, 2014
[6]Crane Survey, 2013
[7] Caceras et al (2008), Crane Survey, 2013, Ugandan Bureau of Statistics (UBOS) 2014 Census

Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	34,844,095	100%	8,778,378	25.2%	8,295,229	23.8%	9,136,678	26.2%	8,633,810	24.8%	Census 2014, DHS 2011
Prevalence (%)		7.3%		N/A		N/A		8.2%		6.1%	AIS 2011 (15+ - 15-59 was used)
AIDS Deaths (per year)	31,000		N/A		N/A		N/A		N/A		UNAIDS Spectrum Projections, May 2015
PLHIV	1,439,974										Burden tables: MOH DHIS2, AIS 2011, 2014 Census
Incidence Rate (Yr)		~0.8%		N/A		N/A		N/A		N/A	UAIS 2011 preliminary (Unweighted)
New Infections (Yr)	140,000										Burden tables: UNAIDS 2013, AIS 2011, Census 2014
Annual births	1,590,900										2012, UNICEF
% >= 1 ANC visit	1,565,005										MOH DHIS2, FY2014
Pregnant women needing ARVs	70,936										Treatment cascade
Orphans (maternal, paternal, double)	2,430,000										UNHS (2009/2010)
TB cases (Yr)	47,650										WHO, 2013
TB/HIV Co-infection	20,648										WHO, 2013
Males Circumcised	806,418	100%			209,335	26%			597,083	74%	MOH DHIS2, FY2014

Table 1.1.1 Key National Demographic and Epidemiological Data: Key and Priority Populations			
	N	%	***Source, Year***
Total MSM*	11,573		**See estimation method below. (Kampala, Wakiso, Mbarara, Mbale, Gulu
MSM HIV Prevalence		13.7%	Crane Study, 2013
Total FSW	192,233		UAIS and Crane data. ***See estimation method below
FSW HIV Prevalence		33%	Crane Study 2013
Total PWID	N/A	N/A	
PWID HIV Prevalence	N/A	N/A	
Priority Populations Prisoners	37,520		Uganda Prisons Service (UPS) 2015
Fisher folk	1.6 million	14%-20%	Uganda Fisheries and Conservation Association, 2014; Makerere School of Public Health, MOH
Uniformed police officers	44,760		SPEAR (2015)
Military	64,400		MOD (2014)
Priority Populations Prevalence Prisoners		12%	UPS 2015
Uniformed police officers		10%	SPEAR (2015)

MSM: Used the 2014 provisional census for the denominator, and applied percentages of the population from DHS to get an age band of 18-64. Used the proportion of men who are MSM from Crane for Kampala District (2%). For the other 111 districts, a 1% lifetime prevalence of same sex behavior was estimated. This figure was selected partly on a systematic review by Caceras et al (2008), who also found a 2% lifetime prevalence of same sex behavior in southern/eastern Africa males. However, since Kampala, the capital and largest city in Uganda, had only 2% lifetime prevalence, it was estimated that the proportion of males engaging in same sex behavior would likely be lower (~1%, or half that of Kampala) in more rural areas. Little data is available on differences between rural and urban rates of same sex behavior (Caceras et al 2006) but anecdotal information from Uganda field staff and qualitative research (Berry et al. 2013) indicate that rural areas tend to have a lower proportion of MSM than large cities.

FSW: Used Census/DHS combination to estimate the number of women in the 15-44 age group as UAIS data indicated that 94% of women who engaged in sex work in the last year are in the 15-44 age group. The Crane lower estimate for number of sex workers in Kampala was 2.5%, compared to 0.88% from AIS. The AIS is likely an underestimate because people tend to underreport illegal behaviors in a household survey. Under this reasoning, we calculated the percentage difference from 0.88% to 2.5%, and reasoned the Crane estimate was more accurate and was also 2.84 times higher than the AIS estimate. Assuming that the proportion of women underreporting sex work is consistent from region to region, we multiplied every AIS regional estimate for sex work by 2.84, and multiplied those numbers by the census estimate for population to estimate the number of FSW in the district.

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate	HIV Prevalence	Total PLHIV	In Care	On ART	Retained on ART 12 Months	Viral Suppression	Tested for HIV	Diagnosed HIV Positive	Initiated on ART
	(#)	(%)	(#)	(#)	(#)	(#)	12 Months	(#)	(#)	(#)
Total population	34,844,095	7.30%	1,301,084	834,964	643,458	187,135	NA	8,694,724	304,035	194,749
Population less than 15 years	17,770,488	0.80%	125,553	59,356	51,297	NA	NA	859,650	14,602	17,817
Pregnant Women	1,742,205	7.30%	127,775	88,060	88,060	NA	NA	1,574,512	50,868	50,597
MSM	11,573 (national)	13-70%								
FSW	192,233	33%								
PWID	NA	NA								
Fisherfolk	1,600,000	14-20%								
Truckers	3,838,000	27%								
Uniformed forces	44,760	10%								
Military	64,400	ND	ND	18,576	10,942	9,847	No data	36,124	No data	No data

- The estimated number of uncircumcised men aged 15-59 years in Uganda is 2,594,948[8]; the overall HIV prevalence in uncircumcised men was 6.7%, as compared with 4.5% in those circumcised[9].

- HIV prevalence ranges between 14.9% to 35%[10] in fishing community populations around the shores of Lake Victoria, other lake systems throughout the country, and on the border with the Democratic Republic of the Congo. Most of the estimated 200,000 fisherfolk are mobile or migratory, often staying away from their families, and therefore social structures that constrain sexual behavior in home communities may not apply in the context of fishing camps or ports. Their vulnerability stems from the amount of time spent away from home, disposable income, alcohol use, low education, ready availability of commercial sex in fishing ports, and sub-cultures of risk-taking and hyper-masculinity.

[8]COP 15 Burden Tables
[9]UAIS, 2011
[10]Bio-behavioral survey in Lake Kyoga Study 2014, Asiki et al 2011, Seleey et al 2012, Sigirenda et al 2013, Opio et al, 2011

- Truck drivers are clients of sex workers, which makes them a high risk "bridging population" and are included as a priority population in Uganda's National HIV prevention strategy 2011-2015. High-risk factors include long time spans spent away from family and primary sexual partners, poor health seeking behaviors, drug and substance abuse, MSM behavior among the truck driver community, high presence of commercial sex along the transport corridor hot spots, and multiple concurrent relationships with women in different hot spots along the transport corridor.

- There are an estimated 109,160 uniformed personnel (military forces) and family members as well as communities living with them. These individuals are classified as a high-risk and vulnerable population as they are often deployed away from their families in high-stress environments. HIV prevalence is estimated at 10%; however, accurate estimates on prevalence are not available due to the sensitive nature of testing in these populations.

- HIV prevalence among the 42,000 prison inmates who reside in 233 prisons nationally is 15%[11]. The most commonly reported HIV-related risk behavior was MSM activity (consensual and coerced) and sharing of razors. While some prison institutions have at least one health care provider and offer HIV care, prisons are not able to distribute condoms, lubricants, or sterile equipment in prisons, which conflict with existing laws and policies.

- HIV prevalence is significantly higher among young women than young men aged 20-24 years (7.1% vs. 2.8%); prevalence among 15-19 year old AGYW is 3% and more than doubles in ages 20-24[12].

Uganda has made substantial progress towards epidemic control through the provision of ART, nationwide coverage of Option B+, and rapid scale up of VMMC. However, there remain major gaps, especially data to understand the epidemic below the sub-national unit level, e.g. size estimation for KP/PPs and coverage for pediatric and adolescent PLHIV. These data gaps inhibit improving programming for these groups. Linkage and retention into care also requires more research and improvement to achieve epidemic control.

Uganda is a low-income country with Gross National Income (GNI) of $550 per capita (2013).[13] The percentage of GNI spent on health was 8.93% (proportion of Total Health Expenditure to GDP), including 3.35% for the HIV response (proportion of total HIV/AIDS response expenditure to GDP).[14]

1.2 Investment Profile

There is limited domestic investment in HIV and health. Total general health expenditure as a percentage of total government expenditure has ranged from 7%-9%, which still falls below the Abuja target of 15%. The situation is not anticipated to change in the near future given the renewed emphasis on infrastructure development in the National Development Plan over health and other areas. Efforts to establish and implement the AIDS Trust Fund, codified in the HIV Prevention and Control Act (2014), have recently been re-invigorated, but are not anticipated to produce meaningful resources in the near future.

More than 80% of Uganda's national HIV response spending comes from development partners. International donors contributed $1.6 billion out of the $1.7 billion spent on the national response between 2007 and 2013. Bilateral contributions accounted for 93% of external AIDS funding between 2007 and 2012 while multilateral sources accounted for about 7%. However, many bilateral partners have reduced or eliminated their HIV-related activities over the last year. PEPFAR and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GF) are the largest donors. Between 2007 and 2012, PEPFAR contributed (i) 78% of the total national spending, (ii) 87% of the spending by international development partners, and (iii)

[11]Preliminary findings from Uganda Prison Service (UPS) Survey, 2014
[12]UAIS, 2011
[13] http://data.worldbank.org/country/uganda?display=default
[14]National Health Accounts 2012

94% of all the funding from bilateral donors in that period. PEPFAR base funding has been relatively flat since FY11 with some additional central initiatives or scale up resources. Currently, 95% of GF grants are allocated to public sector commodities; PEPFAR provides commodities for private-not-for-profit (PNFP) and private-for-profit facilities (PFP) and service delivery support in the public and private sectors. Under the GF New Funding Model, the resources available for HIV in Uganda are insufficient. It is estimated that the gap for HIV commodities will be $11.4 million ($9.1 million for CD4 and viral load commodities, $1.6 million for ARVs, and $1.7 million for cotrimoxazole). PEPFAR has allocated $11 million to the commodity budget to ensure sufficient commodities for VL monitoring and at least a 3-month national ART supply, thereby mitigating the risk of stock outs. The GoU's reliance on external partners to fund its national HIV program remains a concern, especially with reduced GF resources. *[REDACTED]*

The GoU has not institutionalized collection of HIV expenditures. The most recent National AIDS Spending Assessment (NASA) only covers up to mid-2010 and does not allocate across sources of funding. A new NASA is pending but will only provide figures through mid-2013.

Table 1.2.1 Investment Profile by Program Area[15]

Program Area	Total Expenditure (2009/10) USD in Millions	% PEPFAR	% GF	% GRP	% Other
Prevention	93.91	N/A	N/A	N/A	N/A
Care and treatment	264.24	N/A	N/A	N/A	N/A
OVC support	24.85	N/A	N/A	N/A	N/A
Program management and admin	105.30	N/A	N/A	N/A	N/A
Human resources	20.24	N/A	N/A	N/A	N/A
Social protection and social services (excluding OVC)	3.23	N/A	N/A	N/A	N/A
Enabling environment	3.9	N/A	N/A	N/A	N/A
HIV/AIDS research	1.28	N/A	N/A	N/A	N/A
Total	516.96				

Table 1.2.2 Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GOU	% Other
ARVs	111,731,222	42	34	24	
Rapid test kits	13,104,298	31	69		
Other drugs	3,867,174	67	33		
Lab reagents	29,232,431	62	38		
Condoms	19,075,175	10	51		39
VMMC kits	9,297,059	100	0		
Other commodities	2,466,153	100	0		
Total	188,773,512				

The data in Table 1.2.2 are derived from PEPFAR Uganda's COP 13 commodity procurement expenditures, the Global Fund Round 7 phase 2 Grant (UGD-708-G07-H) covering the COP 13 period, and the GoU's

[15](GRP, National AIDS Spending Assessment, 2012), all amounts in 2012 USD

expenditures on ARV's recorded in the GF interim application gap analysis. The U.S. Government Fiscal Year runs from October-September, the GOU fiscal year covers July-June, and GF is a combination of GF fiscal year and calendar year.

Table 1.2.3 Non-PEPFAR Funded Investments and Integration with PEPFAR Central Initiatives

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	$14,900,000	$10,180,000	16	$89,532,040	Support programs to improve maternal, neonatal and child health
USAID TB	$5,000,000	$5,000,000	11	$52,616,364	Support programs to reduce TB related mortality and morbidity
USAID Malaria	$33,000,000	$12,168,000	11	$55,066,421	Support programs to reduce malaria associated mortality
Family Planning	$25,900,000	$9,800,000	16	$89,912,000	Support programs to increase contraceptive prevalence
Private Sector	$251,000	$251,000	1	$199,000	Provide integrated package of services (PPP model)
USAID/Green Label PPP	$600,000	$600,000	1	$600,000	Provide health care waste management generated from VMMC, HIV and TB laboratory testing services
CDC Saving Mothers Giving Life (SMGL)	$2,690,644	$1,200,000	2	$200,000	Support Programs to reduce maternal and neonatal morbidity and mortality
CDC GHS	$425,000	$230,000	1	$0	Achieve Improvement on all 11 Action package of the of the GHS program
CDC GID	$525,000	$200,000	HQ	$0	Support National Immunization Programs in Uganda
CDC Plague Study	$725,000	$300,000	1	$0	Epidemiology and Ecology of Plague and other AFI diseases
CDC FELTP	$600,000	$740,000	1	$300,000	Develop health work capacity to address epidemics of public health Importance (increased funding with GHS)
CDC DVBD Arbo Study	$395,000	$50,000	1	$0	Epidemiology and Ecology of Arboviral diseases
CDC NZVED	$600,000	$100,000	1	$0	Surveillance for dangerous pathogens including Increased Investments in FY16
Total	**$85,611,644**	**$40,819,000**	**63**	**$1,299,000**	

1.3 National Sustainability Profile

[REDACTED]. PEPFAR Uganda will focus investment to improve sustainability outcomes on:

- Supply Chain: reliance on development partners for almost all HIV commodities; management controls in the public sector; weaknesses in stock management, accountability and oversight at national and facility levels;
- Domestic Financing: reliance on development partners for approximately 90% of national HIV spending, domestic resource mobilization; and
- Governance: support for civil society organizations (CSOs) to advocate for improvements in the national response, increased domestic investment, and an enabling legal and policy environment.

With regard to commodity security, PEPFAR has primarily invested in private sector procurement, warehousing, and distribution systems capacity. The USG previously provided technical assistance (TA) to NMS. Both the USG and the GF are committed to a robust, sustainable national supply chain and to strengthening the capacity and accountability of NMS. Resources have been targeted in the GF HSS Concept Note (CN) to increase storage space at national and sub-national levels (NMS, Joint Medical Stores (JMS), and Uganda Health Marketing Group (UHMG); improve Logistics Management Information System (LMIS) capacity; and strengthen coordination of national procurement and supply chain management (PSM) functions. In addition, the Clinton Health Access Initiative (CHAI) works with public- and private-sector supply chain actors to improve capacity and accountability.

Neither PEPFAR nor the GF have focused on domestic financing. Despite increases in the overall amount going to the health sector in the annual budgets, Uganda is not close to meeting the Abuja Declaration commitment of 15%.

1.4 Alignment of PEPFAR investments geographically to disease burden

Figures 1.4.1 a-c and Figure 1.4.2 compare PEPFAR Uganda expenditures in FY 14 to burden of disease by district ("percent of PLHIV per SNU" refers to the proportion contributed by each SNU (district) to the national HIV burden). At district level, unit expenditure per PLHIV averaged $127 with variations across districts ranging from $15 to $1,560 (Figure 1.4.2). In 2014, PEPFAR spent on average $58 per person on treatment across all districts with a range from $6 to $740. Some of this variation can be explained by different service delivery models. The four districts with the highest unit expenditures (Nakapiripirit, Amudat, Abim and Napak) are low prevalence, low burden districts and are planned for transition. Kampala had the highest expenditure per person in care and treatment because it hosts majority of the Centers of Excellence (COEs) and the IP headquarters whose costs for supporting district programs were allocated to patient volume within the district. Some districts with significantly low expenditure per person in care and treatment had high HIV prevalence, including Mubende, Wakiso, Mityana, and Bukomansimbi.

PEPFAR Uganda previously focused on national programmatic scale up with little emphasis on geographical prevalence, disease burden, or evidence of presence of KP/PPs. During COP 15 preparation, attention was paid to aligning district budgets and associated targets to burden and population.

Figure 1.4.1.a Priority: 2014 PEPFAR Expenditure Per PLHIV and Percent of PLHIV by SNU

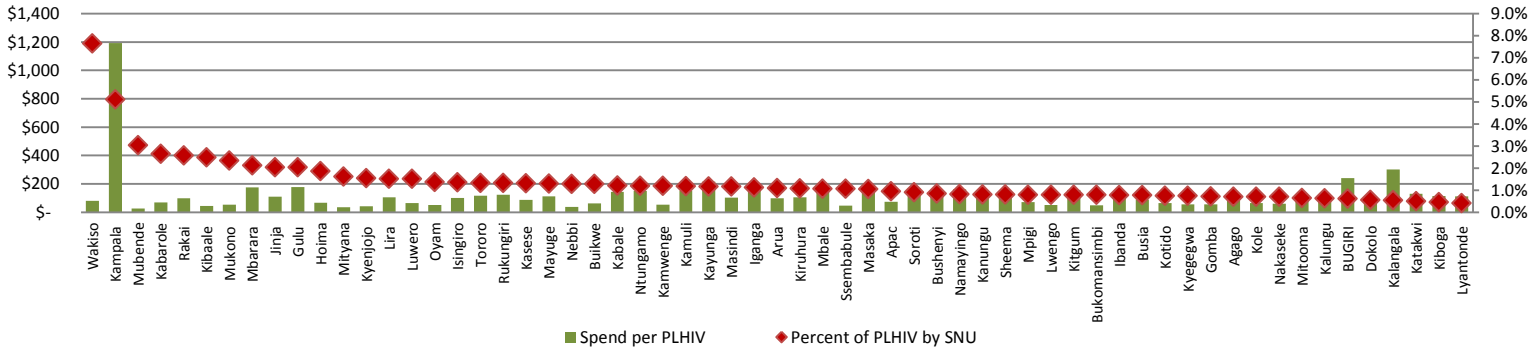


Figure 1.4.1.b Maintenance/Sustained Support districts: 2014 PEPFAR Expenditure Per PLHIV and Percent of PLHIV by SNU

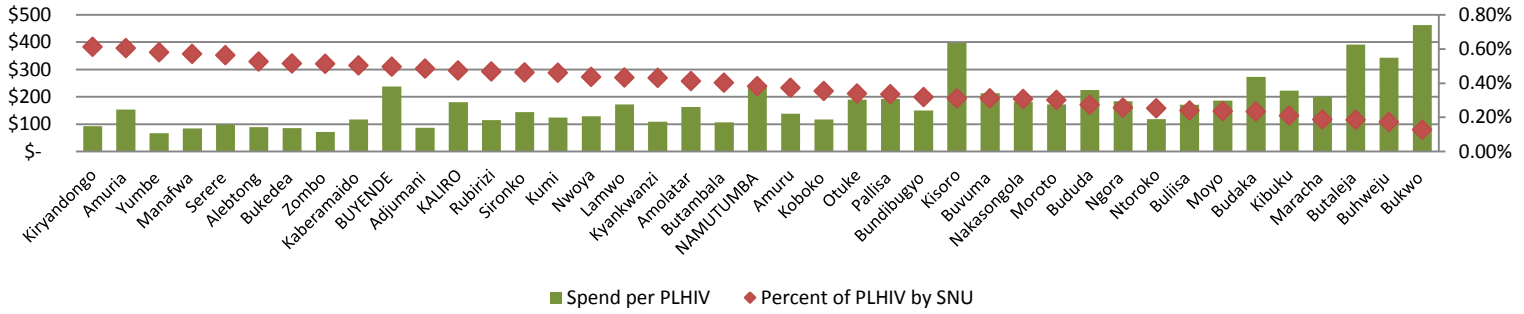


Figure 1.4.1.c Transition Districts: 2014 PEPFAR Expenditure Per PLHIV and Percent of PLHIV by SNU

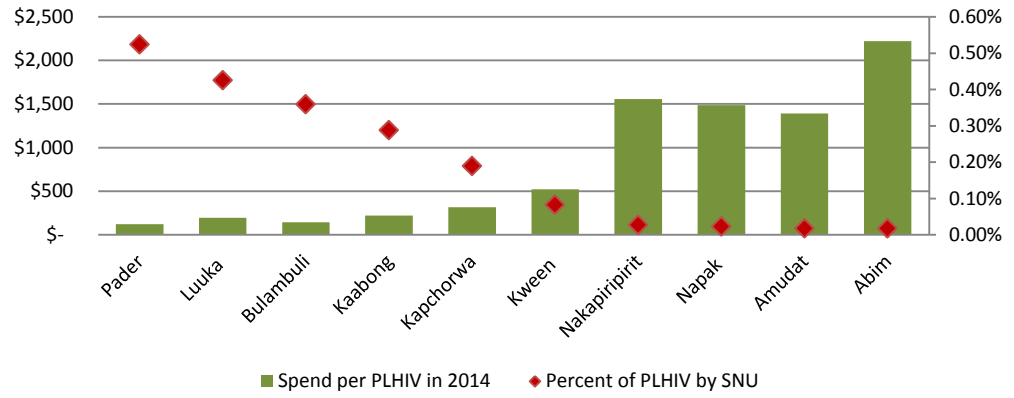
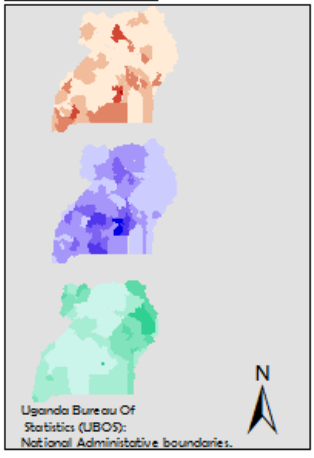
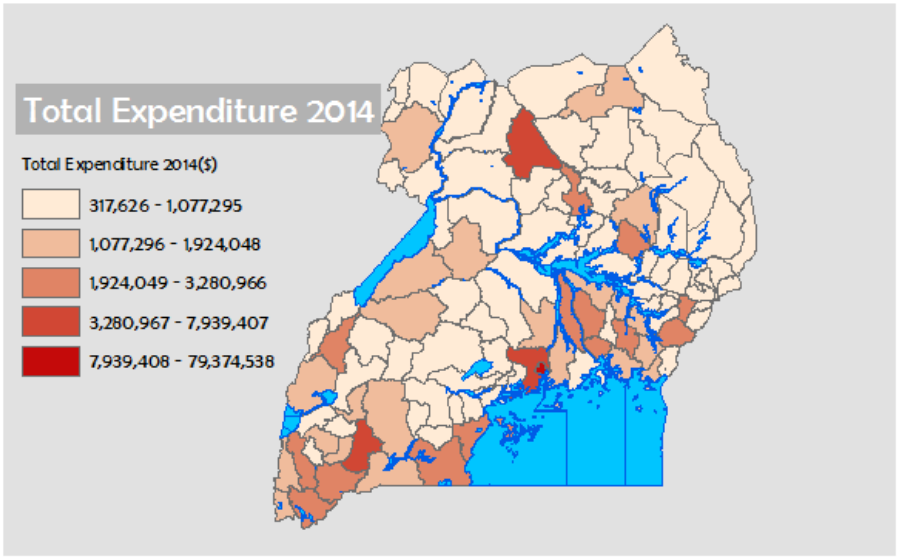


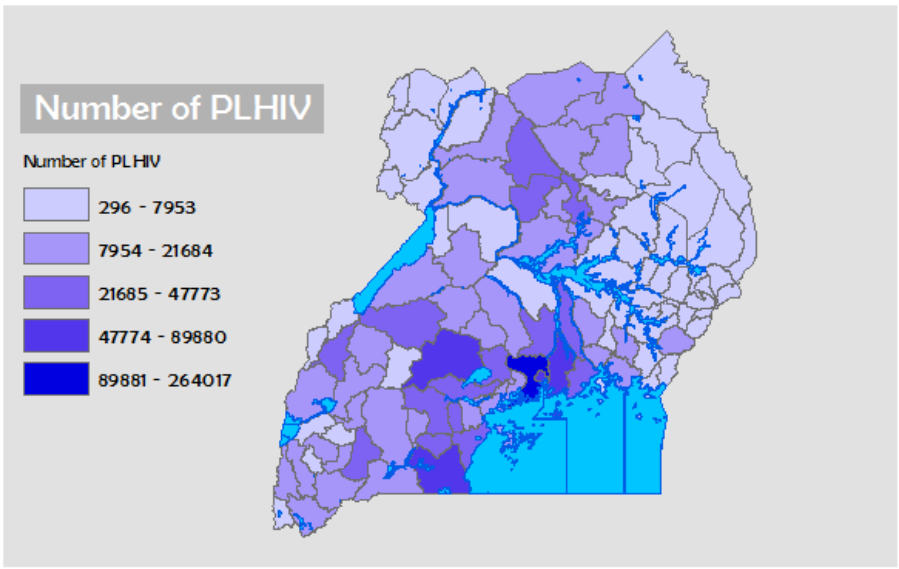
Figure 1.4.2

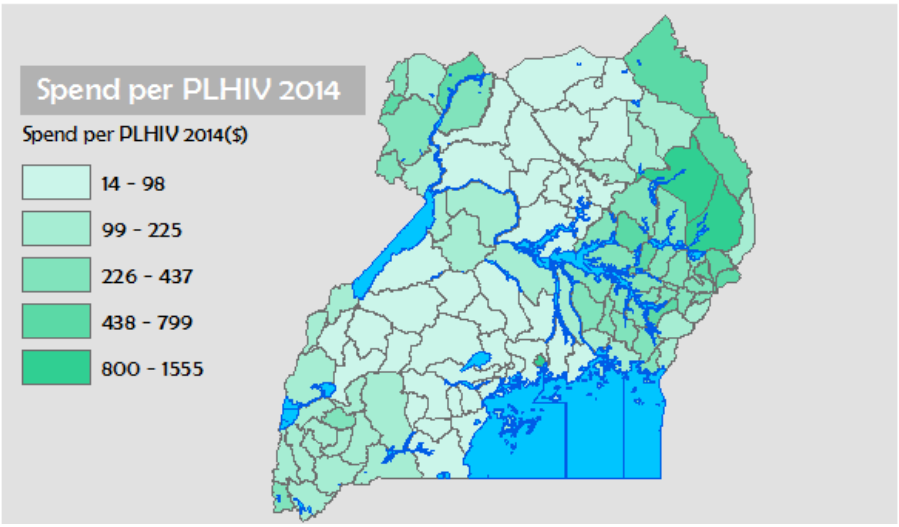
Operating Unit: Total Expenditures 2014, Total PLHIV and Spend per PLHIV

District	PLHIV	District	PLHIV
Abim	2881	Koboko	1331
Adjumani	1810	Kole	16044
Agago	16160	Kotido	3288
Alebtong	11960	Kumi	2228
Amolatar	9465	Kween	698
Amudat	2953	Kyankwanzi	9361
Amuria	2838	Kyegegwa	7912
Amuru	8338	Kyenjojo	16377
Apac	21684	Lamwo	10002
Arua	4143	Lira	35120
Budaka	1898	Luuka	3524
Bududa	2167	Luwero	33810
Bugiri	5189	Lwengo	26672
Buhweju	2070	Lyantonde	14119
Bukwekwe	28228	Manafa	4403
Bukedea	2353	Nyadri	730
Bukomansimbi	27459	Masaka	35767
Bukwo	997	Masindi	12247
Bulambuli	2701	Mayuge	10076
Bullisa	2562	Mbale	7953
Bundibugyo	3434	Mbarara	25239
Bushenyi	10003	Mitooma	7574
Busia	5674	Mityana	36693
Butaleja	1612	Moroto	1371
Butambala	13934	Moyo	891
Buvuma	6910	Mpigi	10281
Buyende	4205	Mubende	68734
Dokolo	12846	Mukono	52441
Gomba	24925	Nakapiripirit	346
Gulu	47773	Nakaseke	15521
Hoima	19727	Nakasongola	6566
Ibanda	9211	Namayingo	6158
Iganga	8918	Namutumba	3244
Isingiro	16116	Napak	296
Jinja	15245	Nebbi	4710
Kaabong	1408	Ngora	1243
Kabale	14433	Ntoroko	2685
Kabarole	27900	Ntungamo	14262
Kaberamaido	2342	Nwoya	10142
Kalangala	19418	Otuke	7833
Kaliro	3845	Oyam	31833
Kalungu	21440	Pader	12069
Kampala	66531	Pallisa	2845
Kamuli	9316	Rakai	89880
Kamwenge	12655	Rubirizi	5576
Kanungu	9583	Rukungiri	15745
Kapchorwa	1441	Serere	2688
Kasese	13979	Sheema	9545
Katakwi	2220	Sironko	3508
Kayunga	25644	Soroti	4049
Kibaale	26448	Ssembabule	36580
Kiboga	9986	Tororo	9773
Kibuku	1713	Wakiso	264017
Kiruhura	12782	Yumbe	2242
Kiryandongo	6552	Zombo	1910
Kisoro	3753		
Kitgum	18389		









1.5 Stakeholder Engagement

PEPFAR Uganda actively briefed and consulted with the MoH, Uganda AIDS Commission (UAC), AIDS Development Partners (ADPs), GF Secretariat, and CSOs throughout the COP development process. In addition, PEPFAR briefed the UAC Partnership Committee and GF Country Coordinating Mechanism (CCM), which include private sector and academic representatives. In August 2014, PEPFAR began briefing stakeholders on changes in overall strategic direction and to sensitize them on possible shifts in COP 15. PEPFAR convened regular meetings starting in December 2014 at the technical and ministerial levels to share data on burden, geographic prioritization, and site yield; consult on investment for commodities in 2016; discuss the target-setting methodology; and solicit feedback on changes to core programming.

Formal engagement on a Country Health Partnership (CHP) should begin in FY 17 after Presidential and Parliamentary elections in 2016. However, action will be taken in FY 16 to build on achievements gained during COP 15 development, i.e. greater data sharing and transparency, and more routine engagement on COP planning and decision making. One area of opportunity is the development of an annual operational plan for the national-level response to outline prioritized activities by geography to be conducted by various stakeholders with associated targets based on the available resource envelope. Both PEPFAR and UNAIDS have advocated for the creation of such a plan, which would better hold stakeholders accountable during the Joint Annual AIDS Review (JAR). The U.S. Mission will continue to advocate for a more enabling environment for non-discriminatory service provision to all Ugandans in need and investment of increased domestic financing.

2.0 Core, Near-Core and Non-Core Activities

The increase in ART coverage and high annual results in VMMC are attributable to PEPFAR Uganda overhauling its program to shift toward core Combination Prevention Interventions (CPI) in COP 12. COP 15 does not represent a significant shift from COP 12 pivots; however, the program has been refined to target highest impact interventions to KP/PPs and Scale-Up locations for epidemic control.

PEPFAR Uganda is the largest funder of biomedical CPI, especially PMTCT, VMMC, ART, and Care, and the only donor substantively working in service delivery support and TA in the public and private sectors. Therefore, all aspects of CPI will continue to be core. While some GF resources will go to service delivery support and TA in the GF HIV/TB and HSS grants in 2016, CPI HSS, e.g. training and mentorship, laboratory support, supply chain management, and program monitoring and evaluation (M&E), will remain core for PEPFAR in COP 15. PEPFAR support for public and private sector laboratory commodities for ART monitoring is core. Procurement of TB care commodities are near core for Scale-Up sites, with a plan to transition to GF. PEPFAR also made changes within the OVC portfolio for greater sustainability.

PEPFAR will not provide salary supplements, higher base salaries than government scale, or "top up" GoU salaries; pay per diem payments for GoU employees to attend functions within the geographical range of their normal duty station; or pay for GoU employee communication expenses. Support for the printing of HMIS tools will be transitioned by early FY 16 in consultation with GoU. See Appendix A for full list of core, near-core, and non-core activities and transition plans.

3.0 Geographic and Population Prioritization

Based on epidemiologic data, 80% of all current PLHIV are in half (56 of 112) of Uganda's districts. PEPFAR has supported direct service delivery (DSD), including commodities provision, to patients in PNFP and PFP facilities and provided TA in public facilities in 103 districts; PEPFAR also provided TA to 5 districts without any PNFPs. As of September 30, 2014, 55%, or 713,744 out of 1,301,084, PLHIV were on ART nationally; by September 30, 2015, the projected national coverage rate will be 64% (918,453 out of 1,439,974). In order to

reach national saturation of 80% PLHIV on ART, the net new needed is 230,881[16]. In COP 15 PEPFAR plans to reach a net new of 182,055 representing 79% of the net new needed for national saturation.

Given nationwide scale up of ART and Option B+ over the last 3 years, there are few districts with low ART patient numbers or new enrollment in FY 14. Focusing new ART enrollment in only 56 districts does not yield enough new patients to reach the 90-90-90 goals. Therefore, PEPFAR Uganda compared burden and prevalence rates across the 112 districts and looked at unmet need (see Figure 3.1.1) to determine how many districts need to be targeted. A total of 38 districts were categorized as having high burden (falling within the half of districts with 80% of the burden) and high prevalence (>= 7.3% prevalence national average). However, because focusing only on these 38 districts would not provide enough new enrollment by FY 17, the team analyzed how many additional districts would need to be targeted and how many could be supported within the planned spending level.

Figure 3.1.1 Summary of Districts by Burden/Prevalence

	HIV Disease Burden (Total PLHIV)		
HIV Prevalence **(Weighted HIV District Prevalence)**		**HIGH (in 80%)**	**LOW (in 20%)**
	HIGH (>= 7.3%)	**HIGH/HIGH (H/H)** 38 districts	**LOW/HIGH (L/H)** 13 districts
	LOW (<= 7.3%)	**HIGH/LOW (H/L)** 18 districts	**LOW/LOW (L/L)** 43 districts

Per Figure 3.1.2, PEPFAR Uganda classified districts as

- Scale-Up: 61 districts, of which 46 districts have a goal of reaching 80% ART coverage within 2 years, and 15 districts which will sustain >80% ART coverage
- Sustained: 41 districts which will sustain current ART expansion rates
- Central Support: 10 districts

The Scale-Up Districts include all 56 high-burden districts (H/H and H/L) and 5 low burden/high prevalence districts. The L/H districts were selected for Scale-Up based on characteristics including presence of KP/PPs and proximity to high-burden districts that had regional referral hospitals/centers of excellence or an artificial coverage of >100%. The remaining 8 L/H districts and 33 L/L districts became Sustained districts. The 10 L/L districts where PEPFAR provided only district-level support or minimal technical assistance were designated as Central Support.

Figure 3.1.2 COP 15 District Classification

Category	Districts	Criteria
Scale-Up	61	All H/H (38) and H/L (13) districts, plus 10 L/H districts that had significant KP/PPs or were near high burden districts with regional referral hospitals/centers of excellence
Sustained	41	8 L/H districts and 33 L/L districts
Central Support	10	L/L districts where PEPFAR provided only district-level support (4) or minimal technical assistance (6)

In Scale-Up Districts, PEPFAR will accelerate targeted and systematic HTC activities using innovative strategies to identify HIV-positive individuals and link them to care and treatment. Special emphasis will be given to KP/PPs and pediatrics. PEPFAR Uganda continued the COP 14 funding level for VMMC in COP 15 to ensure sufficient resources for focused HTC, improved linkage support, and enhanced efforts to support

[16] This figure derived from summing district net new needed for saturation and therefore differs slightly from the 233,526 national figure.

adherence, retention, and viral suppression. The VMMC program will be targeted to 58 Scale-Up Districts. In Sustained districts, provider-initiated counseling and testing (PITC) in high-yield entry points will continue. In Central Support districts, PEPFAR will maintain support for lab hubs that lie within the district.

Through rigorous unit cost analysis of treatment service delivery and commodities, PEPFAR Uganda has enough resources to support new enrollment in FY 16 of 182,055 net new patients for a total of 1,011,610 Ugandans current on ART, contributing towards a nationwide coverage of 71% by September 30, 2016. PEPFAR Uganda's focus on the 61 highest burden and/or prevalence districts is expected to result in these districts achieving 80% ART coverage by end of FY 17.

4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations

4.1 Targets for Scale-Up locations and populations

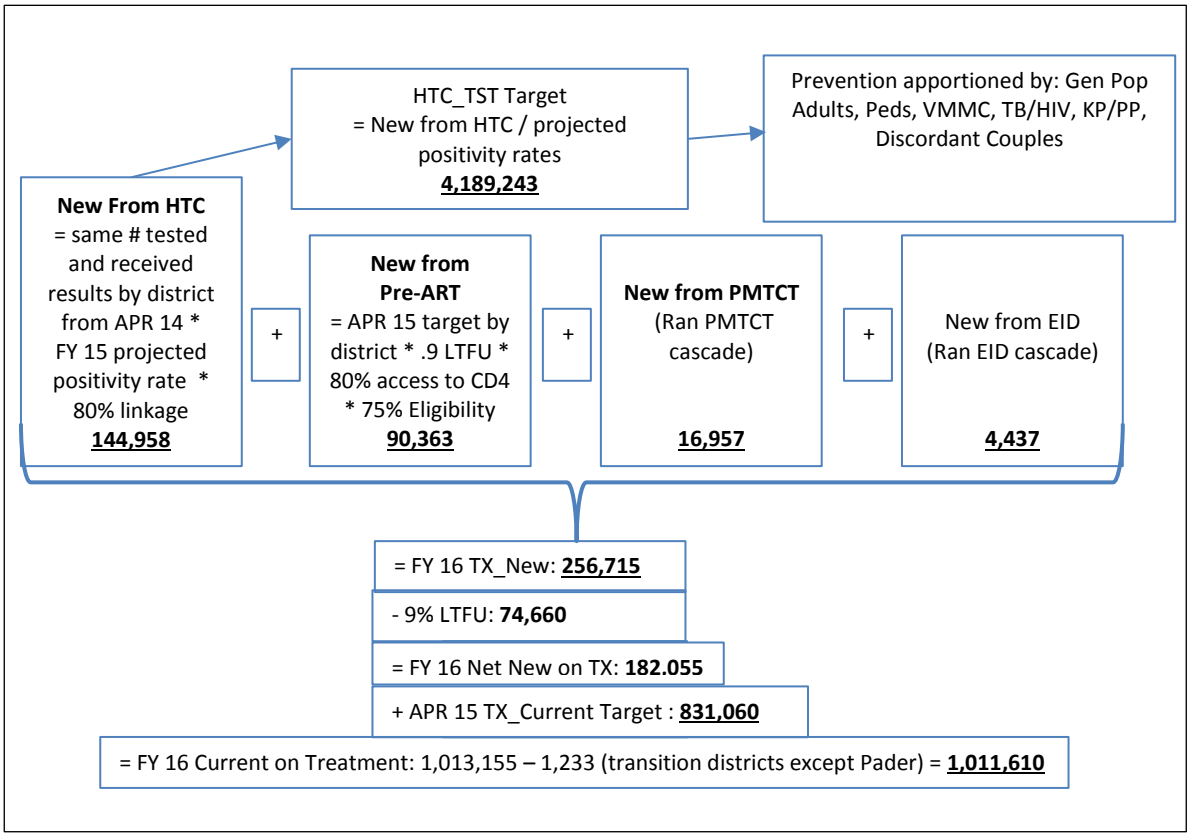
The FY 16 current on ART targets are derived from: 1) estimated current on ART at APR 15 (64% national coverage), adjusted for a loss to follow up (LTFU) of 9%; and 2) new on ART from pre-ART and HTC (includes PMTCT, EID, VMMC, HTC general). A clinical cascade approach was used to estimate the contribution of the various entry points as follows:

New from pre-ART: The new from pre-ART targets are derived from: 1) current in pre-ART from the previous APR who are eligible for treatment at a CD4 count of <500; 2) newly eligible for treatment at CD4 <500 from HTC (includes PMTCT, EID, VMMC, HTC general). It is estimated that 75% will be eligible for ART, of which 80% of will have CD4 access.

New from PMTCT: The PMTCT cascade was determined by using a population-based need/burden approach based on UBOS's district mid-year population estimates. A 5% pregnancy rate was applied to the districts' total population to generate the estimated number of expected pregnancies for each district. A 94% ANC attendance rate was applied to generate the number of pregnant women who are expected to attend ANC at least once of whom 95% already know or will learn their status at ANC (taking into account refusals and logistical challenges). District HIV weighted prevalence rates were then applied to establish the estimated total number of HIV-positive pregnant women identified. Of these women, 90% are expected to already know their status and be on ART at the first antenatal care visit (ANC1) given the recent intensive Option B+ scale up and anticipating increased overall ART coverage over the course of FY 15 and FY 16. All pregnant women living with HIV are targeted to receive ART.

New from EID: An estimated 80% of HIV-exposed infants are expected to be retained in the PMTCT program in FY 16 (double the number retained in FY 14), of whom 5% are estimated to be HIV-positive based on program data.

Figure 4.1.1 Contribution to New on ART by Entry Point



PEPFAR Uganda set district targets according to the priority classification system described in section 3.0. However, some Ugandan districts have more than 100% ART coverage, because many patients travel across district boundaries to attend national or regional referral hospitals. However, those patients are still included in their home district for district estimates of PLHIV. Thus, when calculating ART coverage, an individual who is in the numerator (i.e. ART patients) in one district could be in the denominator (i.e. PLHIV) of another district (see Table 4.1.1). To account for this overestimation of ART coverage in some districts and underestimation in others, PEPFAR Uganda created 8 clusters of districts, each of which had a national/regional referral hospital; 45 districts were assigned to one of the 8 clusters, based on the catchment areas of the major ART facilities. Regardless of the individual district classifications, aggregated targets were set by cluster. Within each cluster, targets were allocated to districts based on percent contribution to the cluster's total current on treatment.

FY 16 district level ART targets were assigned according to district categorization and clustering.

- In Scale-Up Districts that have not reached saturation (i.e. <80% coverage) and all clusters, the net new targets on treatment were set to reach district or cluster saturation by the end of FY 17. The targets were split 50/50 between FY 16 and FY 17. The clinical cascade was used to determine the contributions from pre-ART, PMTCT, and EID. The remaining gap to reach the total new on ART target was then assigned to new from HTC.
- For Sustained Districts not in clusters and districts already at 80% saturation, new on ART targets were calculated through a two-step process. First, the clinical cascade was used to determine the new from pre-ART, new from PMTCT, and new from EID. The new from HTC was then determined by using the number of those who were tested and received results by district from APR 14 multiplied by the projected FY 15 positivity (applying an adjustment of 0.5% increased yield due to more targeted testing) and assuming 80% linkage.

- For the six Central Support Districts that have current site-level support, FY 16 targets were allocated to allow for minimal new enrollment during the transition period. The target for the one district (Pader) that sits within a cluster was calculated using Scale-Up district approach. The other five districts were apportioned targets equal to 50% of estimated new on ART using the same approach as used in Sustained Districts. The remaining four Central Support districts with only above site-level support were given no targets.

Overall, 256,715 individuals are targeted to initiate ART in FY 16 contributing to a total of 1,011,610 adults and children on ART by September 30, 2016 (Figure 4.1.1). This represents 70% of national ART need at CD4 <500 and a 57% increase from the FY 14 achievement (643,458). If targets are reached, 79 districts will have achieved saturation by the end of FY 17.

For prevention interventions, PEPFAR Uganda focused on selected populations and districts, to set targets, which was a major shift from previous COPs. District-level prevention coverage targets were set using KP/PP population-level estimates and HIV prevalence for specific sub-populations. The coverage for sex workers, police personnel, and sero-discordant couples is 80%; while long-distance truck drivers is 50%; MSM is 40%; and fisher folk and army personnel are 25%. See Table 4.1-4. Possible challenges in meeting these targets are the closing out of comprehensive mechanisms and potential delays in start-up of follow-on mechanisms. In the absence of unique identifiers or a specific system to report and track KPs, access to reliable data will continue to be a challenge.

Table 4.1.1 ART Targets in Scale-Up Sub-national Units for Epidemic Control

District (SNU)	Total Est. PLHIV at Sept. 30, 2016	PEPFAR Est. FY 15 current on ART (Sept. 30, 2015)	Target PEPFAR Contribution to Net New Saturation[1]	FY 16 TX_CURR (adults & children)	FY 16 TX_NEW	FY 16 Net New Targets
Wakiso District	115,296	54,397	29,849	66,612	17,110	12,215
Kampala District	78,512	109,257	-78,391	132,543	33,119	23,286
Mukono District	35,176	13,481	4,898	20,514	8,246	7,033
Mbarara District	31,219	30,603	-8,786	33,061	5,212	2,458
Kiruhura District	16,519	6,935	5,242	7,493	1,181	557
Sheema District	12,067	7,411	740	8,006	1,262	595
Ibanda District	11,996	5,986	2,825	6,467	1,020	481
Ntungamo District	19,418	9,256	4,083	9,999	1,576	743
Bushenyi District	12,755	13,711	-4,248	14,812	2,335	1101
Mitooma District	9,716	2,739	4,449	2,959	466	220
Rukungiri District	19,674	12,519	1,664	13,524	2,132	1005
Kanungu District	12,431	6,390	2,758	6,903	1,088	513
Kabarole District	37,957	23,300	-1,280	26,932	5,730	3,633
Kyenjojo District	23,396	10,100	7,284	11,674	2,484	1,575
Kamwenge District	18,797	6,387	7,312	7,382	1,571	996
Gulu District	29,900	25,755	-4,638	26,976	3,539	1,221
Masaka District	15,888	11,096	-11,793	12,484	2,386	1,388
Rakai District	37,453	17,969	10,394	20,217	3,865	2,247
Lwengo District	12,437	5,293	3,781	5,955	1,138	662

Lyantonde District	6,027	1,636	-343	1,841	352	205
Sembabule District	15,701	4,211	7,561	4,737	906	526.58
Bukomansimbi District	11,364	1,948	6,679	2,191	419	244
Kalungu District	9,592	6,123	-1,169	6,889	1,317	765.77
Kabale District	19,963	11,759	1,117	12,698	1,997	939
Soroti District	13,984	8,497	-2,289	9,710	1,978	1,213
Katakwi District	7,678	3,760	1,858	4,296	875	537
Lira District	22,835	15,056	1,689	17,979	4,279	2,924
Kole District	10,983	3,773	2,841	4,506	1,072	733
Dokolo District	8,682	3,880	259	4,633	1,103	753
Apac District	15,269	7,734	3,305	9,236	2,198	1,502
Kitgum District	11,846	8,196	-126	9,290	1,831	1,094
Kalangala District	7,456	11,452	-6,775	17,936	7,514	6,484
Mbale District	17,787	13,113	-486	16,118	4,185	3,005
Mpigi District	12,275	8,090	-169	10,809	3,447	2,719
Busia District	12,546	8,513	-342	11,896	4,149	3,383
Kiboga District	6,993	5,063	60	6,252	1,644	1,189
Mubende District	44,772	13,643	19,844	23,565	11,150	9,922
Kibaale District	38,579	10,733	17,635	19,550	9,783	8,818
Jinja District	30,168	18,345	4,332	20,511	3,817	2,166
Hoima District	28,665	11,363	9,755	16,240	5,900	4,878
Mityana District	23,534	8,394	7,784	12,286	4,648	3,892
Luwero District	23,224	9,302	1,834	10,403	1,938	1,100
Oyam District	20,860	8,027	7,440	11,747	4,442	3,720
Isingiro District	21,453	7,133	3,006	8,936	2,445	1,803
Tororo District	21,422	14,583	875	15,021	1,750	438
Kasese District	22,574	9,972	4,339	12,142	3,067	2,169
Mayuge District	20,590	8,801	6,145	11,874	3,865	3,073
Nebbi District	19,739	6,333	8,242	10,454	4,691	4,121
Buikwe District	20,129	11,993	1,922	12,954	2,041	961
Kamuli District	19,217	6,852	6,955	10,329	4,094	3,478
Kayunga District	18,010	8,927	4,310	11,082	2,958	2,155
Masindi District	17,311	7,425	3,991	9,421	2,664	1,996
Iganga District	18,538	7,406	5,459	10,135	3,396	2,729
Arua District	20,453	11,791	1,443	12,513	1,783	722
Namayingo District	12,317	7,717	1,435	11,260	4,237	3,543
Kotido District	11,116	950	586	1,478	613	527.55
Kyegegwa District	11,858	5,046	3,557	6,825	2,233	1,779
Gomba District	10,565	2,441	4,130	4,506	2,285	2,065
Agago District	10,899	4,865	3,134	6,432	2,005	1,567
Nakaseke District	10,535	4,384	3,087	5,927	1,938	1,544

Bugiri District	11,151	5,348	2,313	6,504	1,638	1,156
Total	**1,269,267**	**707,163**	**123,366**	**867,625**	**224,108**	**160,463**

[1] 14 districts have negative net new targets because some ART clients receive ART in the district but do not reside in the district. These clients are not counted in the estimate of PLHIV for the district. To ensure that targets are assigned accurately in districts where clients are actually receiving HIV services, these districts were clustered for target setting as described in Section 4.1.

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Scale-Up Districts (FY 16)

Entry Streams for ART Enrollment	Tested for HIV (in FY 16)	Identified Positive (in FY 16)	Enrolled on ART (in FY 16)
Clinical care patients not on ART	-	136,484	74,520
TB-HIV Patients not on ART	11,853	5,097	5,097
HIV-positive Pregnant Women	1,032,022	15,155[1]	15,155
General, priority, and key populations[2]	3,377,950	136,477	123,382
Total	**4,621,825**	**268,414**	**209,321**

[1] These are pregnant women newly initiating ART. The pregnant women who are already on ART (current on ART) in Scale-Up Districts are 98,959.
[2] General population targets were merged with priority and key populations due to a lack of reliable data on key/priority population sizes

Table 4.1.3 VMMC Coverage and Targets by Age Bracket

Target Populations 15-to-59 years	Population Size Estimate (Scale-up SNUs)	Current Coverage - 2014	VMMC_CIRC (in FY 16)	Expected Coverage (in FY 16)
Scale-Up Districts	2,631, 050	24%	218,130	52%
Sustained Districts	174,990	46%	29,988	62%
Central Support Districts	31,887	12%	500	80%
Total/Average	**2,837,927**		**248,618**	

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate (Scale-Up SNUs)**	**Coverage Goal (in FY 16)**	**FY 16 Target**
Female Sex Workers	80,236[1]	80%	64,189
Fisher folk	568,356	22%	124,567
MSM	9,115[2]	40%	3,646
Army personnel	200,000	25%	50,000
Police personnel	45,000[3]	80%	36,000
Sero-discordant couples	93,328[4]	80%	74662

[1] Estimates modeled using UAIS 2011 data, Crane Survey, and National Population and Housing Census 2014; included in estimate are 27 districts that will be targeted for SW programming.
[2] Estimates modeled using UAIS 2011 data, Crane Survey, and National Population and Housing Census 2014; only five major urban districts included: Kampala, Wakiso, Gulu, Mbale, Mbarara
[3] 45,000 police estimated in PEPFAR-supported districts
[4] UAIS 2014, 6.2% of all married co-habiting couples

4.2 Priority and key population prevention

HIV services reached less than a third (326,345) of approximately 2.5 million KP/PPs in FY 1417. PEPFAR Uganda has refined national and district KP/PP hot-spot mapping in Scale-Up and Sustained Districts and geographically narrowed down the area of focus for better epidemic control. In COP 15, the program will target FSWs in 26 of the 61 Scale-Up Districts, and 1 of 41 Sustained Districts. PEPFAR Uganda will focus support for MSM programming in five urban centers across the country (Kampala, Wakiso, Gulu, Mbale, and Mbarara districts) and provide intensive prevention programing for fishing communities in 12 districts around Lake Victoria. Deliberate efforts will be made to strengthen the cascade of HIV diagnosis, care and treatment of the fisher folk and their sexual partners who in many cases are sex workers.

Among the targeted KP/PPs, PEPFAR will ensure that the standard package of services is provided in a continuum of prevention, which includes aggressive distribution and promotion of male and female condoms; support for comprehensive risk reduction programs for both HIV-negative and HIV-positive individuals; improved linkage of HIV-positive clients to PMTCT, care, and treatment programs; actions to address stigma and discrimination, and development of service delivery models tailored to these populations. PEPFAR will target hard-to-reach KP/PPs and mobilize them to access services through non-stigmatizing outreach, community empowerment and engagement, peer mobilization, and relationship and trust building. PEPFAR will engage affected communities and other stakeholders in all stages of program implementation and in preventing human rights violations targeting these groups. School and faith-based "abstinence and be faithful" programming focusing on youth will be transitioned to the GoU and other partners by the end of FY 16. See Appendix A for a full list of core, near core, and non-core activities.

As part of DREAMS, PEPFAR will include Pre-exposure Prophalaxsis (PrEP) provision for 1,000 18-24 year-old women for a two-year period as a demonstration project for one district proposed. It is anticipated that lessons learned from this project will inform the MoH on whether and how to allow future Scale-Up outside demonstration mode currently permitted.

PEPFAR also will integrate gender across all HIV program platforms by employing the norms change and violence prevention approaches from the Stepping Stones[18] and the SASA! Activist Kit[19] to address gender

[17] 2014 Uganda PEPFAR Annual Progress Report (APR)
[18] Jewkes R et al –Tropical Medicine and international Health, 2006 January; 11(1):3-16
[19] Michau L: The SASA! Activist Kit for Preventing Violence against Women and HIV. Kampala: Raising Voices; 2008.

and behavioral change for epidemic control. In Scale-Up Districts, PEPFAR will target AGYW ages 15-24, (i.e. HIV-negative pregnant girls, married adolescent girls, young women who had given birth by age 15, and those reporting sex work and transactional sex20). Efforts will be focused on the 10 DREAMS Initiative districts. Sexual partners of these AGYW will be targeted through the COP for high-impact services, including circumcision and ART provision as appropriate.

Consistent condom supply remains a challenge. For FY 16, the GF will supply 240 million condoms and PEPFAR will supply 36 million, leaving a gap against Uganda's annual need of 376,117,046 condoms[21]. However, despite the supply issues, SIMS data indicate that male condoms are consistently available at different facility departments and community levels. Community peer groups from selected KPs also report being well stocked with male condoms.

The *HIV and AIDS Prevention and Control Act, 2014,* prohibits discrimination in health institutions; however, the Act discriminates against PLHIV by criminalizing attempted, willful, or intentional HIV transmission, allows health workers to conduct an HIV test without the client's permission, and authorizes disclosure of the HIV test results to individuals other than the client. The Act was gazetted in February 2015; however, it is unclear how rigorously it is being enforced.

Blood Safety

In COP 15, PEPFAR funding to Uganda Blood Transfusion Services (UBTS) will focus on ensuring that PEPFAR investment is maximized in preparation for sustainability and handover of blood safety services to the GoU. Key areas of investment will include quality assurance of blood and blood products through a vein-to-vein model; installation of a Blood Safety Information System (BSIS); and establishment of a cost recovery system to ensure sustainability of blood services.

4.3 Voluntary medical male circumcision (VMMC)

Since 2010, more than 2 million eligible males have been circumcised, increasing from less than 10,000 to 906,615 in 2014. However, Uganda continues to have a large unmet need for VMMC services: 4.2 million 15-to-49 year-old men based on the Decision Makers' Program Planning Tool (DMPPT) 1.0/modeling (2010) or 6.3 million, including 10-to-14 year olds, based on the DMMPT 2.0 (2014).

Central resources to compliment COP funds have been essential to VMMC achievements. In order to invest more heavily in other programmatic areas for epidemic control, PEPFAR level-funded VMMC in COP 15. PEPFAR will target VMMC services in 58 districts with the highest HIV burden and low male circumcision prevalence to maximize impact through CPI saturation: 48 Scale-Up Districts, 9 Sustained Districts, and 1 Central Support district. PEPFAR has been the sole provider of VMMC kits and service delivery; however, the GF HIV/TB grant includes 42,000 VMMC kits in FY 16.

PEPFAR will focus VMMC demand creation on age groups most immediately at risk of acquiring HIV heterosexually to maximize the possibility of epidemic control. Focusing on the 20-to-34 year age group will have the fastest impact on HIV incidence and will require the lowest number of circumcisions for each infection averted. While the 10-to-19 year old age group has the greatest long-term impact on HIV incidence, targeting 20-to-29 year olds will have the most immediate impact on incidence. Focusing broadly on the 15-to-34 year old age group provides the most cost effective strategy over the long term.

PEPFAR will provide a minimum of HTC, clinical, and prevention services in VMMC and link HIV-positive patients into care and treatment, and conduct QA/continuous quality improvement (CQI)/external quality assurance (EQA) regularly, support infection prevention and control activities, and provide VMMC

[20] PEPFAR Uganda selected these sub-populations after analyzing UAIS 2011 data to identify predictors of HIV infection
[21] National Condom Programming Strategy 2013-2015 report

commodities and consumables, including emergency kits. Based on SIMS quarterly visits, documentation and referral of identified HIV-positive clients are continuing challenges, which will be addressed through the introduction of the MoH's triplicate referral forms that will confirm the completion of the referral loop. PEPFAR will transition several activities, including provision of Information Education Communication (IEC) materials, to the GoU and GF over time.

Following three tetanus-related deaths in 2014, tetanus infection risk mitigation is a critical concern. PEPFAR will work with the MoH to address WHO's recommendations to strengthen the "clean care approach" and determine effective and practical strategies for providing tetanus vaccination in the context of VMMC for HIV prevention programs. Following guidance from WHO and PEPFAR in close consultation with MoH, all VMMC clients will require two tetanus toxoid containing vaccine (TTCV) doses, which will be supported by PEPFAR central resources, not COP funding. PEPFAR has fostered improved infection prevention and control for all circumcision procedures; personal cleanliness before any surgical procedure; and adherence to standard surgical protocols on skin preparation. Clients are counselled on attention to clean wound care after circumcision, including provision of clear and understandable care and genital hygiene instructions, and community education about the dangers of applying potentially Clostridium *tetani* containing substances.

See Appendix A for a full list of core, near core, and non-core activities.

4.4 Preventing mother-to-child transmission (PMTCT)

In 2016, an estimated 1,715,419 pregnancies will occur in Uganda[22]. Uganda completed national roll-out of Option B+ in 2013. In FY 14, 1,647,018 pregnant women attending ANC received HTC services, of which 101,183 (6.14%) tested HIV-positive. Of pregnant women found to be HIV-positive, 88,058 (87%) were provided with lifelong ART of whom 42.5% were already on ART. Given national ART coverage, an estimated 90% of pregnant HIV-positive women in Scale-Up and Sustained Districts will already be on ART by FY 16.

Two hallmarks of the national Option B+ implementation strategy were the introduction of facility-level mother-baby care points (MBCP) and strengthened M&E consistent with the Option B+ M&E Framework. The MBCPs were aimed at improving adherence and retention of the mother-baby pairs across the continuum of PMTCT and early infant diagnosis (EID) cascade as described in the 2013 Uganda National Integrated ART Treatment guidelines. The aforementioned shifts resulted in major achievements including improved access to services through decentralization and improved service coverage from 1,596 health facilities in 2012 to 3,248 in 2015; improved PMTCT impact as shown by increased maternal ART coverage (65% in 2012 to 87% in 2014); and declining HIV infections among exposed infants (9.5% in 2012 to 5.3% in 2014)[23].

In 2013, PEPFAR and MoH launched a national real-time reporting platform that generates weekly reports through the Emergency Operations Center (EOC). Weekly reporting and SIMS both demonstrate successes in meeting standards in ARV provision to mothers and infants as well as supply chain management. However, timely provision of EID services and mother-infant follow-up are ongoing challenges. September-December 2014 SIMS data showed deficiencies in timely provision of EID (50% red/yellow) and cotrimoxazole (CTX) for HIV exposed infants (42% red/yellow), and lack of adequate mother- and infant-tracking systems for PMTCT services (45.4% red/yellow).

PMTCT/ART integration (central) funds will be used to further develop aspects of the Option B+ M&E framework e.g. improving data quality and utilization using a QI approach led by district health management teams, as well as establish cohort monitoring systems for maternal ART retention and HIV

[22] 5% of population estimates based on 2014 Census
[23] MoH PMTCT Annual Report 2013/14

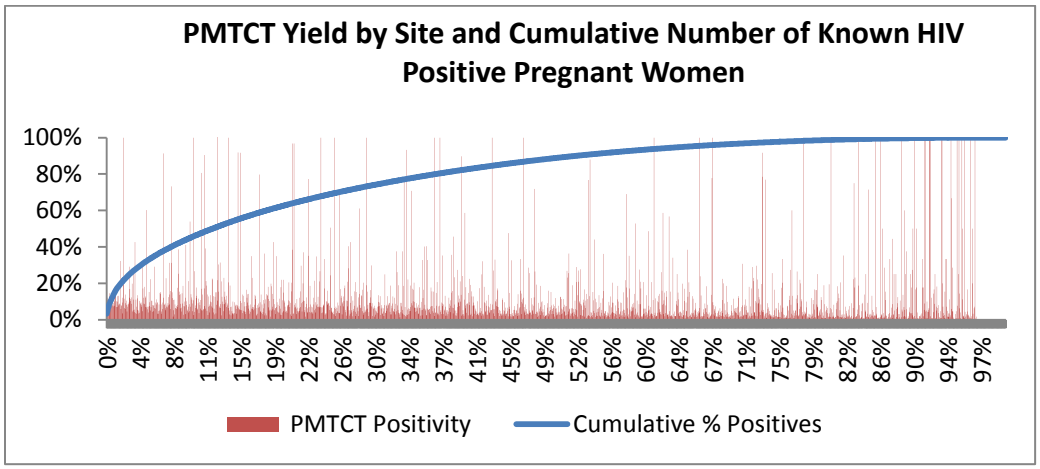
Exposed Infants (HEI) final outcome. PEPFAR has prioritized these funds to implement activities that will minimize commodity stock outs, improve integration of TB services within the MCH platform, strengthen sample transportation and result return systems, and improve ART access for highly migratory populations (e.g. fisher folk).

Through DREAMS, the expansion of primary prevention and targeted interventions toward HIV-negative pregnant AGYW will result in fewer new HIV positive mothers. FP/HIV integration funds are aimed at expanding contraceptive access for women living with HIV in PMTCT and ART programs. Saving Mothers, Giving Life (SMGL) Initiative interventions that improve service quality and access for ANC, maternity, and RH services will continue to be leveraged to reduce maternal and infant mortality.

In Scale-Up and Sustained Districts, PEPFAR and the MoH will focus on improving quality of PMTCT/EID services, building upon the work started with COP 14 and PMTCT/ART integration funds. Best practices like the use of mentor mothers/peer mothers, family support groups (FSGs), linkage facilitators, and QI initiatives will be more heavily supported to further strengthen retention, mother-infant tracking, adherence support, and good health outcomes for the pregnant and lactating mothers and their HEIs. PEPFAR Uganda is targeting 80% EID coverage and that at least 95% of pregnant women know their HIV status and 90% of HIV-positive pregnant women receive ART.

The PMTCT program falls within PEPFAR's overall clinical service approach of providing Technical Assistance-Service Delivery Improvement (TA-SDI) to public sector facilities, and DSD in PNFP, PFP, and public sector facilities where PEPFAR supports HRH. TA-SDI support includes training and mentorship on new guidelines and cohort monitoring, quarterly supportive supervision, M&E, QI, and patient tracking support. DSD support includes all the aforementioned components in addition to salary support for midwives and commodities deemed critical for PMTCT. See Appendix A for a full list of core, near core, and non-core activities.

Efficiency Analysis



Of the 2,138 PEPFAR-supported PMTCT sites, 36.5% (781) of sites identified 80% of HIV-positive pregnant women. The number of HIV-positives identified from the remaining sites ranged from 0 to 37 individuals. In FY 14, a total of 314 sites reported fewer than 4 HIV-positive pregnant women, including 70 that did not identify a single HIV-positive pregnant woman; 52 were health center IIs. The majority of these sites were identified to transition.

4.5 HIV testing and counseling (HTC)

PEPFAR supports PITC with targeted outreaches to KP/PPs. However, HTC is still offered universally in both facility settings and in the community, per the GoU HTC policy. Going forward, HTC interventions will be aligned to geographic areas and populations with comparatively higher HIV prevalence and low coverage of services. The MoH has committed to reviewing the policy, guidelines, and other implementation materials to allow for targeting of populations with increased risk of HIV infection.

To identify new patients for ART enrollment in Scale-Up Districts, PEPFAR will focus on intensive mobilization and HTC outreaches to KP/PPs in hot spots, e.g. lakeshores, urban centers, and truck stops. HTC within facilities will be targeted to individuals clinically determined to need it. Building upon the PLACE methodology, and working in collaboration with KP/PP networks and CSOs, PEPFAR will map hot spots for KP/PPs. In non-Scale-Up Districts, community outreach will not be conducted. HTC within facilities will be passive, targeting individuals who need it based on clinical or other symptoms, and prioritized in clinical settings that have a higher yield such as ANC, in-patient wards, TB clinics, STI clinics, and malnutrition and other child health centers. HTC will be offered to family members of individuals already in care through holistic family HTC education in ART clinics. Individuals diagnosed with HIV will be actively linked into care and treatment, while those testing HIV-negative will be linked to other prevention services.

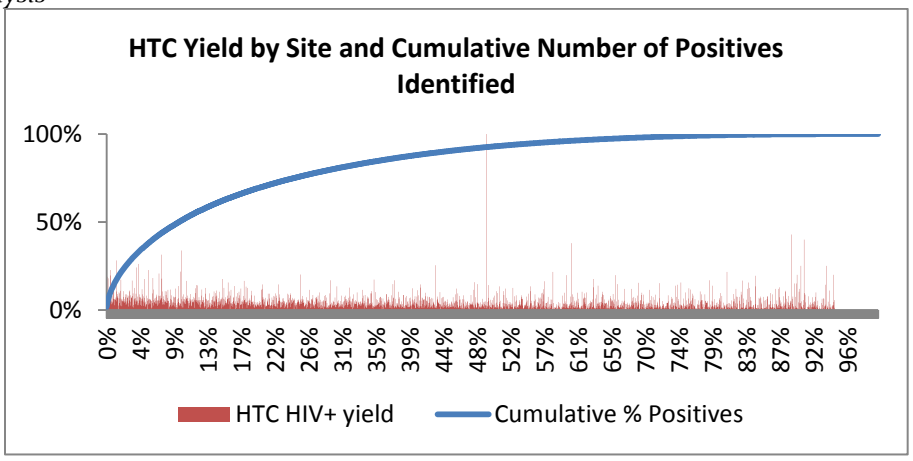
PEPFAR will support provision of quality services by ensuring that sites adhere to the testing protocol; conduct internal quality control for test kits; participate in EQA program; provide basic counseling before and after the test; and collect, manage, and routinely use data to improve on service delivery. PEPFAR will mentor service providers to adapt to the new approach of passive HTC in clinical settings. In addition, training and mentorships on how to deliver services for KP/PP will continue to be given to service providers.

There are challenges with monitoring service uptake of KP/PPs, as the national HMIS tools do not disaggregate by group. IPs have improvised parallel tools for capturing KP/PP data; however, PEPFAR will continue to work with the MoH to address this challenge.

The MoH has committed to revisiting the national HTC policy. Any delays may present challenges to PEPFAR HTC targets and test kit stocks. PEPFAR and GF are planning to bring in 10 million test kits in FY 16 based on targeted testing and analysis of previous annual consumption. However, any mass testing could result in stock outs particularly at lower-level public sites.

See Appendix A for a full list of core, near core, and non-core activities.

Efficiency Analysis



The efficiency analysis for PMTCT HTC sites is described in the PMTCT section. The number of HIV-positives identified from non-PMTCT sites ranged from 0 to 97 individuals. The number of sites accounting for 90% of results was 1,029 (45%), with 56 HIV-positives identified at this cut off, which highlights the efficiency of Uganda's HTC program due, in part, to strategic shifts made in COP 12. In FY 14, a total of 566 sites reported fewer than 11 HIV-positives, the chosen threshold for transition, including 135 that did not identify a single HIV-positive. The majority (70%) of these sites are government sites in which PEPFAR mainly provides TA support. These 566 sites were compared to low-volume ART and PMTCT sites and those that met the low yield/volume cut-offs in all program areas were identified for transition. (See Section 5.2)

4.6 Facility and community-based care and support

In 2014, Uganda developed an Integrated Health Care Services package for HIV prevention, treatment, and care services that standardizes interventions at all service delivery points to improve quality of care for adults, adolescents, and children. PEPFAR Uganda will prioritize prevention and management of common opportunistic infections (OIs) among clients accessing care through PNFP facilities, regular clinical assessment and, biannual CD4 testing for pre-ART clients for ART eligibility, annual VL for clients on ART, Cryptococcal infection screening for clients with CD4 counts less than 100 cells/mm3, cotrimoxazole prophylaxis for those who are eligible according to the national guidelines, provision of Prevention with Positives (PHDP) interventions, patient adherence support and counselling, as well as patient tracking and retention. Upon assessment, all clients identified or suspected to have TB, STI, or malnutrition will be appropriately linked to the relevant treatment services including ART and therapeutic feeds for severe malnutrition. Provision of the basic care kit is non-core as the President's Malaria Initiative (PMI), GF, and the United Nations Populations Fund (UNFPA) provide most components as part of routine care.

PEPFAR will support recruitment of additional health care workers (HCWs) in the Scale-Up Districts to support the Ugandans expected to be in care by APR 16. The HCWs will be transitioned to the GoU over 3 years.

September-December 2014 SIMS data revealed gaps in community-facility linkage with 90% of the sites scoring red or yellow for adults and 75% for children. Other weak areas were CD4 monitoring, patient tracking, and pediatric HIV testing. PEPFAR will improve facility linkage to community care and support services for adults and children to strengthen retention and patient tracking. PEPFAR also prioritized community-based adherence support and counselling since the 2014 Uganda ART guidelines emphasize "test and treat" for KPs, children under 15 years, TB/HIV patients, and HIV-positive individuals in sero-discordant relationships. PEPFAR will support these community-based care and support services through use of linkage facilitators and various existing community-based PLHIV networks and groups, which will be effectively utilized to provide the interventions at community level. Furthermore, in collaboration with the MoH, PEPFAR will increase focus on addressing the data quality issues (accuracy, completeness and reliability) and reporting tools between facility-community and vise-versa. PEPFAR will apply QI approaches to support linkages, adherence, and retention along the continuum of care. See Appendix A for a full list of core, near core, and non-core activities.

4.7 TB/HIV

As of APR 14, 95% (138,789) of TB clients received HTC, while 76% were initiated on ART. Within HIV clinics, 90% were screened for TB. To improve integration, Uganda recommends the one-stop-center model for TB/HIV care delivery, i.e. the same health worker provides both TB and HIV services in either the TB or the HIV clinic. Integration improves HTC among TB patients and presumptive TB clients and promotes early detection and initiation of TB/ART co-treatment among those co-infected. Early treatment for TB and HIV and improved retention and adherence will contribute to viral suppression among co-infected clients as well as reduce morbidity and mortality.

In Scale-Up Districts, PEPFAR will support the integrated model for TB/HIV services inclusive of these core services:

- TB screening at every visit for clients attending HIV clinics to ensure that those with presumptive TB are followed up for proper diagnosis and all clients without active TB are started on Isoniazid Preventive Therapy (IPT).
- Ensure that all TB patients and those with presumptive TB are provided with HIV testing and, if found HIV positive, are linked to HIV care and put on ART.

PEPFAR will continue to support the MoH's efforts to increase access and utilization of Gene Xpert MTB/Rif for diagnosis of TB among HIV-positive clients, including strengthening transport referral system, quality assurance, and operations research for Gene Xpert. PEPFAR will redistribute the existing 74 Xpert machines to the lab hubs to increase access.

In FY 16, PMTCT/ART integration (central) funds will continue to improve capacity for pediatric TB diagnosis, care, and treatment; innovatively integrate TB into existing PMTCT/ART services; increase coverage of TB laboratory EQA; increase utilization of Gene Xpert for the diagnosis of TB among TB/HIV co-infected in the routine PMTCT/ART service provision; and strengthen of the sputum referral system.

TB/HIV data quality is poor with incomplete reporting; TB data was only recently introduced into the Uganda District Health Information System (DHIS2). PEPFAR will leverage GF support for capacity building and mentorship at facility and district levels and provide support for data quality assessments. The GF provides all TB drugs. PEPFAR classified TB sputum microscopy supplies and GeneXpert cartridges as near core and will transition them to the GoU by FY 17.

Uganda is implementing new IPT guidelines for HIV co-infected clients. IPT roll-out will require capacity building for health care providers in TB intensified case finding (ICF), logistics management for isoniazid and program reporting; TB incidence among PLHIV will decline as IPT coverage improves. SIMS visits revealed that IPT had started in only a few of facilities visited (>80% of sites had red or yellow scores due to delays in IPT roll-out) and that there was lack of facility-specific TB infection plans in close to 50% of facilities. PEPFAR will support IPT roll-out through capacity building of the health facility staff, QI initiatives, and development of facility-specific TB ICF plans. See Appendix A for a full list of core, near core, and non-core activities.

4.8 Adult Treatment

In 2014, Uganda adopted the 2013 WHO recommendations and implemented revised treatment guidelines, expanding ART eligibility to include adults with CD4 ≤500 cells/mm3 and "test and treat" for priority populations i.e. HIV-infected pregnant and lactating women; HIV/TB and HIV/HBV co-infected individuals; fishing communities, long-distance truck drivers; HIV-positive individuals in sero-discordant relationships; and HIV-positive KPs, e.g. MSM and sex workers, irrespective of CD4 cell counts. Based on the new guidelines, adult ART coverage is at 55% with 12-month cohort retention estimated at 85%[24].

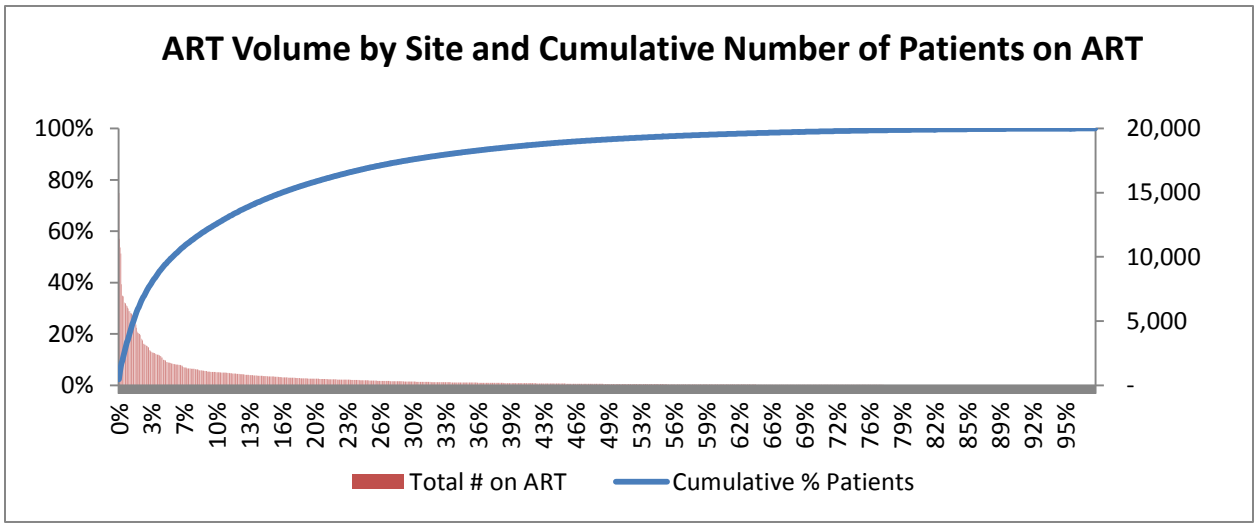
PEPFAR will initiate 256,715 new clients on ART in FY 16 and support 1,011,610 on ART by APR 16, an increase of 13.2% from APR 15, which includes 224,108 in Scale-Up Districts and 32,607 in Sustained and Central Support districts assuming passive enrollment. PEPFAR will focus on improving PITC and linkage to ART in the 61 Scale-Up Districts with special focus on increasing ART coverage among children, adolescents, TB/HIV co-infected, and KPs and support continued provision of quality care in Sustained Districts.

[24] MoH, June 2014

PEPFAR will support rapid assessment to determine gaps in HIV services delivery for hard-to-reach populations and identify potential opportunities to scale-up services. PMTCT/ART integration and DREAMS funds will establish adolescent-friendly services and identify more adolescents living with HIV, respectively, and link them to care and treatment.

PEPFAR will support DSD in all PNFP and PFP sites and TA-SDI in public sites. The service delivery package in DSD sites will include provision of ARVs; ongoing full or partial salary support for permanent site-level staff deemed critical for treatment including; as well as quarterly supportive supervision, including M&E reporting, mentorship and QI, and patient tracking support. PEPFAR will conduct quarterly supportive supervision visits jointly with District Health Teams (DHT). TA-SDI support will include quarterly supportive supervision conducted jointly with DHT, support for M&E reporting, mentorship and quality improvement, and patient tracking support. See Appendix A for a full list of core, near core, and non-core activities.

Efficiency Analysis



In FY 14, 80% of ART patients were seen in 20% (293) of the 1,461 PEPFAR-supported ART sites. In the remaining sites, patient volume ranged between 0 and 503, with 268 sites reporting fewer than 20 patients - the threshold for transition. By APR 15, there will be an estimated 3,267 clients served in 117 sites that are either no/low yield and/or in low prevalence/burden geographic areas to be transitioned by the end of FY 16 to the GoU. PEPFAR will work with the GoU to coordinate the transition process. See Appendix A for the services to be transitioned. Continued emphasis on quality will necessitate focus on adherence and retention, roll-out of VL for ART monitoring, and program M&E including regular site monitoring through SIMS and QI initiatives.

PEPFAR is working with the MoH to revise the national scale-up plan targeting 80% coverage of VL for monitoring patients on treatment by 2017 to enable earlier detection of treatment failure. PEPFAR will 1) support training and mentorship of HCWs to interpret VL results and make appropriate clinical decisions, 2) procure VL reagents, and 3) support sample transportation and lab testing through the already established laboratory hub system. Preliminary results on 25,012 samples estimate viral suppression (VS) at 88%[25]. Per the WHO HIV Drug Resistance (HIVDR) strategy, Uganda plans four national HIVDR surveys for 2016 and an Early Warning Indicator survey. See Appendix A for a full list of core, near core, and non-core activities.

[25] CPHL Viral load report, January 2015

4.9 Pediatric care and treatment

In 2014, Uganda expanded ART eligibility to all HIV-infected children below 15 years old. Despite the increase in number of children receiving ART (from 41,520 in June 2013 to 51,305 in June 2014), national coverage reduced from 41% to 28% as a result of expanded eligibility. Children are still underserved accounting for only 8% of PLHIV on ART.

Through central funding, PEPFAR has improved adolescent HIV care services, built capacity building for TB diagnosis among children, and evaluated the "test and treat" and PITC models. PEPFAR has improved access to quality HTC, and linkage to care and treatment through a pilot at 20 sites countrywide, which is expected to result in a package of interventions for improving pediatric case finding to be scaled up nationally. The increase in case finding anticipated through the central initiatives will not significantly impact the COP 15 set targets given the limited geographical focus.

To improve ART coverage among children, PEPFAR will prioritize strategies to improve access and uptake of HTC by providing PITC at key entry points such as OVC service outlets, TB clinics, malnutrition and in patient wards; improve uptake of EID among HIV-exposed infants; improve linkage to and retention in care; ensure all ART-accredited sites provide pediatric treatment; and improve adolescent HIV care and treatment. PEPFAR will include ensuring access to and timely provision of cotrimoxazole prophylaxis to all HIV-exposed and -infected children; screening and management of common OIs; NACS and management of moderate to severe malnutrition using ready-to-use therapeutic food (RUTF); TB screening, diagnosis, and management, including IPT; strengthening retention in care; psychosocial support of children and adolescents including disclosure, adherence counselling and support; and transition support from infant to adolescents to adult care services. PEPFAR will support facility-community linkages for appropriate services and referrals to and from communities and provision of a standardized adolescent package of care and adolescent friendly services. Central funds for pediatric TA and PMTCT/ART integration will contribute to reducing gaps in pediatric HTC and adolescent services.

PEPFAR will provide pediatric first- and second-line ARVs. Approximately 7% of children are on second-line ART. Uganda will continue to use Nevirapine-based regimens instead of PI-based regimens for children <3 years due to the challenges of maintaining a cold chain associated with LPV/r use. The need for pediatric third-line ARVs is increasing (215 children); the MoH is developing a proposal for third-line ARV funding. As VL testing is rolled out, children on ART will be prioritized for VL monitoring given their high risk for treatment failure. A planned infant HIVDR survey in 2016 will further inform the pediatric program.

PEPFAR will support data collection for the pediatric and adolescent program through the DHIS2 and through support supervision. One persistent challenge is lack of appropriate pediatric and adolescent age bands in the HMIS tools. See Appendix A for a full list of core, near core, and non-core activities.

4.10 Orphans and Vulnerable Children

The Uganda OVC program will target a total 404,211 children in 85 districts with a renewed focus on epidemic control. Based on district designation, the program will target 334,493 OVC in 58 Scale-Up Districts, graduate 64,852 OVC in 25 Sustained Districts within two years, and accelerate graduation of 4,866 OVC in 2 Central Support districts within one year. Of these children, 135,187 newly recruited children will be receiving comprehensive services and 269,020 existing beneficiaries will be supported until their households have stabilized and are no longer in need of direct project support. The program will specifically target girls for interventions aimed at minimizing risk of gender-based violence and HIV. In Scale-Up Districts, OVC programs will promote testing of children and adults in household and community settings that are beyond the reach of clinics. OVC partners employ a comprehensive family-based approach that results in benefits (i.e. improved food security) across all household members including adults living with HIV. OVC activities also support adherence and retention among both HIV-positive children, patient tracking, intensive case management and counseling, and connect OVC with services to help overcome a

range of barriers to adherence - including economic barriers, child care, physical disability, and stigma. PEPFAR Uganda will conduct an interagency study to better understand the cost-effectiveness of OVC interventions and program resources since no such data currently exists for Uganda. See Appendix A for a full list of core, near core, and non-core activities.

5.0 Program Activities to Sustain Support for Other Locations and Populations

5.1 Sustained package of services in other locations and populations

In order to sustain the ART coverage gains, PEPFAR will provide a core package of services to geographic areas outside of Scale-Up areas and populations in compliance with the GoU's national HIV care package that guides HIV prevention and care for adults, adolescents, and children. There will be no demand generation for HTC; however, HTC will be offered if requested, passive ART enrollment will continue, and women will be enrolled as needed on Option B+ in Sustained Districts. Where possible, and in collaboration with the GoU, lower volume sites in Scale-Up Districts will be transitioned to higher volume facilities.

Patients in Sustained Districts will be provided a minimum package of care including clinical HIV staging; adherence and retention; support for VL monitoring and CD_4 testing through the lab sample referral network; PHDP services; OI prevention and treatment including screening cryptococcal infection screening and CTX prophylaxis; and NACS and RUTF if needed. Pediatric clients will have their growth and development monitored and adolescents will be provided friendly services including provision of sexual and reproductive health services. In addition, PEPFAR will provide HIV/TB services, e.g. provision of TB diagnostic services by microscopy and GeneXpert and support for referral and linkage of HIV/TB co-infected patients to treatment.

The PMTCT sustained package will include routine HTC; PITC of family members with linkage to care, support, and treatment services; ART services and infant and young child feeding (IYCF) counseling; assessment for OVC program eligibility; retention monitoring and adherence support for mother-baby pairs until 18 months; Nevirapine and CTX prophylaxis for HEI (PNFP); 1st, 2nd DNA PCR and Rapid test at 18 months; cohort monitoring for mother retention and HEI final outcome. PEPFAR also will support district-based rapid response teams to address issues identified through Option B+ weekly reporting.

The OVC sustained package only includes those activities that continue to facilitate families toward graduation and not those that could promote dependency. PEPFAR also will continue to support cross-cutting activities such as M&E as well as reporting at site-, district-, and national-levels; continuous QI; and training, mentorship and technical support supervision.

The team defined a sustained package of services categorizing component services as core, near core, or non-core; compared the package to what was previously provided in COP 14, using SIMS findings to further understand quality of care; and reviewed the PEPFAR FY 14 unit expenditures to establish the cost of providing the sustained package. Where new elements were added to the previous package such as routine VL monitoring, a mark-up of the unit cost was done for that particular element using published data (where available). The team applied new unit costs for COP 15.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Non-Scale-Up Districts

Maintenance Volume by Group	Expected result APR 15	Expected result APR 16	Percent increase (decrease)
HIV testing in PMTCT sites	360,532†	364,110	1%
HTC (only sustained ART sites in FY 16)	1,675,562†	806,933*	-52%

Current on care (not yet initiated on ART)	9,686‡	4,452	-54%
Current on ART	69,923‡	64,892	-3%
OVC (Sustained and Central Support)	336,582‡	296,489	-21.90%

† Estimated using extrapolation from SAPR 15 results
‡ Estimated using PEPFAR Uganda clinical cascade
* Including EID, Peds, TB, and other (gen pop and KP) tests performed

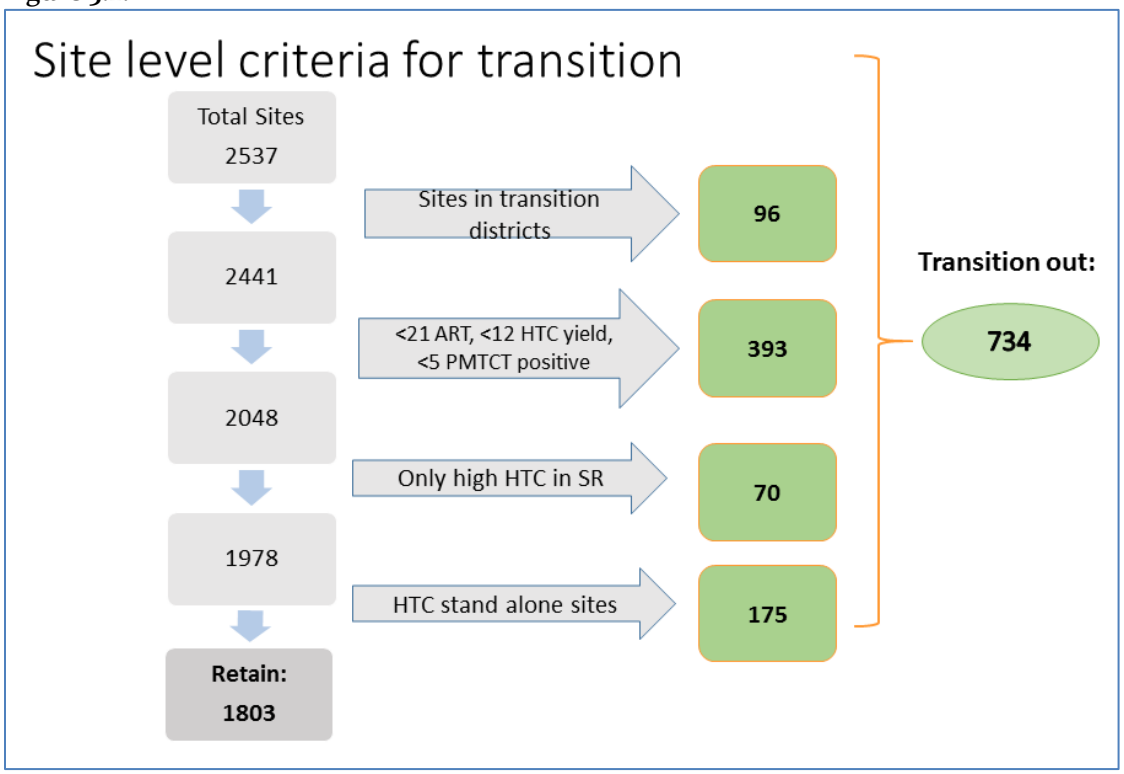
5.2 Transition plans for redirecting PEPFAR support to Scale-Up locations and populations

PEPFAR will work with the GoU and district leaders to transition support from sites that meet any of the following criteria as depicted in Figure 5.2.1:

1) Transition out of all sites in the 10 districts where PEPFAR provided only district-level support or minimal technical assistance (i.e. Central Support districts).
2) In both Scale-Up and Sustained Districts, Central Support sites below thresholds on each of three indicators in APR 14: HTC (<12 HIV-positives), PMTCT (<5 HIV-positive PMTCT clients) and ART (<21 ART clients current on treatment);
3) In Sustained Districts, transition sites below thresholds for ART (<21 ART clients current on treatment) and PMTCT (<5 HIV-positive PMTCT clients), regardless of HTC yield;
4) In both Scale-Up and Sustained Districts, Central Support sites that only provided HTC services.

Using these criteria, 734 sites of 2,537 FY 15 PEPFAR-supported sites, will be transitioned.

Figure 5.2.1



6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

PEPFAR laboratory activities are focused on identifying new cases and increasing access to virology monitoring for epidemic control. PEPFAR will build on the existing National Laboratory sample transportation, testing, and result transmission network that is supported through the hub system. PEPFAR team also will work with GoU to ensure optimal utilization of VL and EID results to monitor epidemic control and influence program and policy decisions.

In Scale-Up Districts, an increased number of testing sites, e.g. OPD, wards, ANC, child clinics, STI, TB units and selected hot spots, is anticipated to reach KP/PPs and detect new infections. PEPFAR laboratory support in Central Support districts will be phased out between 2015 and 2016. However, because laboratory hubs serve more than a single facility or district, the facilities whose laboratories serve as hubs will continue to receive PEPFAR support. In Sustained Districts or sites, PEPFAR will not increase the number of clinical laboratories or Point of Care (POC) testing sites supported.

CQI for laboratory tests (rapid HIV testing, CD4, VL, EID, TB and cryptococcal identification (CRAG)) remains core with special emphasis on monitoring Rapid HIV testing quality. PEPFAR will engage district lab focal persons and the hub systems to significantly increase the response rate from 60% to 100% and improve the competence of individual testers in the testing sites.

PEPFAR will invest in all laboratory hubs and reference laboratories; 77 of the hubs (up from 21) are expected to achieve the minimum acceptable level towards accreditation as an indicator for improved access to quality testing. In line with the Central Support from low-burden districts, the total number of PEPFAR-supported laboratories will reduce from 1,423 to 1,344. To enhance HIV detection and enrollment into care and treatment in high-burden districts, PEPFAR will support (POC) testing sites providing HIV rapid testing and CD4; the number will increase from 766 recorded in FY 14 to a minimum of 3,168.

PEPFAR will continue to support the GoU in establishing a functional National Health Laboratory Services with adequate capacity to coordinate and carry out critical laboratory services needed for epidemic control in a sustainable manner. Part of this support includes laboratory information and quality management systems to facilitate efficient and reliable laboratory results, data capture, transmission and analysis to inform program and policy on the HIV epidemic control.

Challenges include potential stock-outs at NMS-supplied public health facilities, the funding gap for lab commodities, and an inadequate skilled human resource capacity. Hematology and chemistry reagents are classified as noncore.

Table 6.1 Laboratory Strengthening

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Laboratory Data Capture, Transmission, and Analysis to inform program and policy regarding Epidemic Control	Develop and Implement National Lab Information Management Systems (LIMS) Strategy to capture, transmit, analyze and use laboratory data. Configure software, Enroll 10 facilities on LIMS	Enroll additional 90 hubs into LMIS	100,000	$400,000	17704	x	x	x	x	x	x
Improve Quality of HIV testing to achieve epidemic control, Scale up EQA by Dry Tube Testing for HIV Rapid testing to all testers Implement National EQA for laboratory Testing (Rapid HIV, CD4, TB/Expert, automated equipment)	HIV Rapid test Response rate was 66.7% and pass rate 99.6% CD4. Response rate was 47% and pass rate was 88%.	100% successful passing for all the responding sites that participate in EQA for HIV rapid test and EID; and at least 80% pass on PT for , CD4, Viral load, and TB 100% response rate for all PT panels	$842,000	1,000,000	12981	x	x	x	x	x	x

Capacity Building for Equipment maintenance and biosafety workshops – central and regional levels	Functional regional and central equipment maintenance workshops,	Training of biomedical engineers and technicians at 8 regional workshops and equipment users in first, second and third-line laboratory equipment maintenance. Uninterrupted service delivery due to equipment downtime	$400,000	$900,000	13136; 10326; 17977,	x	x	x	x		x
Technical Assistance to operationalize the National Health Laboratory Services. (NHLS) EQA for Cryptococcal Antigen Test (CRAG)	National Health Laboratory Services undergoing construction– end date October 2015	National Health Laboratory Services Coordinating laboratory-based epidemic response, the specimen transportation, testing and result transmission network, improved coordination of the national lab system	$0	$400,000	17976 Association of Public Health Laboratories -	x		x			
Centralized EID and VL testing at CPHL	130,000 EID tests and 270,000 VL tests	136,324 EID tests and 706, 602 VL tests And VL validation study	$750,000	$3,688,315	13047	x	x	x	x	x	x

Lab services and continuous quality improvement	Provision of CD4 and VL tests, and SLMTA mentorship	CD4 tests and SLMTA mentorship	700,000	500,000	13317	x	x	x	x	x	x
Access to quality laboratory services by improving laboratory management systems. Provide TA to MoH for implementing Laboratory Quality Management Systems – supplies and Logistics Management, Biosafety and waste management, SPARS, training	Implementation of Laboratory Quality Management Systems for continuous quality improvement. Deployment of quality auditors, assessors, and mentors for all HIV related tests	Increase the total number of labs and POC sites that attain a minimum level to show improvement in quality testing from 21 –to 100	$2,600,000	2,000,000	18003	x	x	x	x	x	x
WHO-CDC collaboration for QA strategy and policy (NPO)	WHO Technical Assistance to the Ministry of Health in Laboratory services	WHO Technical Assistance to the Ministry of Health in Laboratory services guidelines	$80,000	$80,000	13841		x	x	x		x
Support to National Laboratory Network, through 100 hubs, sample referral, transport	Provision of quality CD4, HIV test, VL, TB, EID tests and services in 100 hubs and lower levels facilities that are linked to the 100 hubs. Effective sample transportation and result transmission.	Provision of quality CD4, HIV test, VL, TB, EID tests and services in 100 hubs and lower levels facilities that are linked to the 100 hubs. Effective sample transportation and result transmission.	7,368,025	$9,819,931	9301,1304,13880,9183,12801,17078,9167, 13717, 13466,10326, 12981, 9043,17649, 17651,17654	x	x	x	x	x	x
Expansion of NHLS Viral Load Section - RIPSO		Completed NHLS building including the VL section	$0	$500,000	13029	x					x

6.2 Strategic Information (SI)

PEPFAR is working with the GoU and other development partners to improve both programmatic and population-based data to evaluate the state of the epidemic, and our contribution to the national effort, and to inform programming. PEPFAR is strengthening the HMIS to utilize a single national HMIS system (DHIS2). PEPFAR's M&E partner will export all data associated with PEPFAR indicators available in DHIS2 into PEPFAR's DATIM system. IPs will upload other indicator data directly into DATIM. PEPFAR will work with partners to ensure that district-level data is accurate, timely, and used for decision-making by building capacity at the district, regional, and national levels. PEPFAR is developing an evaluation of the utility of PMTCT data in comparison to ANC sentinel surveillance. DHIS2 reporting will be rolled out to an additional 100 high-volume facilities in 2015 and 200 in 2016.

Uganda requires updated population-based information on HIV prevalence, incidence, risk factors, and service delivery uptake at the national and, where possible, regional level to demonstrate impact and plan for future programming. The PHIA, to be completed in 2016, will provide such information and regional-level KP size estimates, which is necessary to inform sub-national interventions targeting these populations. It may include children 0-14. In addition, more information is needed on various KPs, in terms of prevalence, risk factors, and service-delivery update and barriers to health-seeking behavior. While it is not feasible to obtain national- and regional-level KP data, there will be small population-based studies of KPs in strategic locations; in one study PEPFAR will assess linkage to care for HIV-positive KPs and in some locations conduct KP/PP hotspot mapping. PEPFAR continues to conduct research other PPs to assess their burden of disease and access to resources. PEPFAR is heavily engaged in implementation science, including studies to determine the effectiveness of various service delivery concepts such as mentorship for mid-level providers and task shifting for ART delivery. PEPFAR is proposing a formative assessment to inform the design and implementation of anticipated integrated biological and behavioral surveillance study on HIV prevalence and risk behaviors around the Lake Victoria Basin fishing communities, which will inform planning for service delivery strategies for this vulnerable population.

PEPFAR is strengthening 1) M&E capacity at district level by ensuring that district-based M&E plans exist and are operationalized and 2) ongoing program evaluations within different technical areas and at district-level by including indicators that have outcome and impact measures.

Table 6.2 Strategic Information (SI)

1. Brief Activity Description	Deliverables		Budget codes and allocation ($) *SI TWG FY 2015 COP total=$15,572,908*		6. IM ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016 (Tentative funding levels)			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
HIS											

Roll out of EMR	Roll out EMR to 100 high volume sites	Roll out EMR to 200 high volume sites.	HVSI ~ $450,000	HVSI ~ $450,000	TBD (new mechanism)	3 14	X	X	X	X	X
Roll out of EMR	Roll out the EMR to high volume districts sites in Kayunga, Mokono, and Buvuma district, and completion to the Koome islands	Roll out the EMR to high volume districts sites in Kayunga, Mokono, and Buvuma district, and completion to the Koome islands	HVSI $400,000	HVSI $400,000	9043	3 14	X	X	X	X	X
Roll out of EMR	Roll out EMR to all sites Procure back up equipment Mop up training for new staff transferred in. Maintenance of the EMR system and offer ongoing TA support to facilities. Upgrade internet connectivity to sites, where possible connect to the National Backbone	Roll out EMR to all sites Procure back up equipment Mop up training for new staff transferred in. Maintenance of the EMR system and offer ongoing TA support to facilities. Upgrade internet connectivity to sites, where possible connect to the National Backbone	HVSI $200,000	HVSI $200,000	9303	3 14	X	X	X	X	X
Roll out of EMR	Coordination of the implementation of EMRs for all Agencies. The objective is to have one platform for all USG agencies	Coordination of the Implementation of EMRs for all Agencies. The objective is to have one platform for all USG agencies	HVSI $500,000	HVSI $500,000	17703	3 14	X	X	X	X	X
Strengthening national HMIS	Printing and rolling out of HMIS tools at	Printing and rolling out of HMIS tools at	HVSI $1 M	HVSI $ 1 M	17703	3 14					

	decentralized levels. Trained and competent staff to collect data at decentralized levels.	decentralized levels. Trained and competent staff to collect data at decentralized levels.	Cross cutting in the USG mechanisms	Cross cutting in the USG mechanisms		3 14					
Strengthening the DHIS II	Rolling out of revised DHIS II at decentralized and national levels. Trained and competent staff using DHIS II at national and decentralized levels.	Functional revised DHIS II at decentralized and national levels. Trained and competent staff using DHIS II at national and decentralized levels.	HVSI Cross cutting in the USG mechanisms	HVSI Cross cutting in the USG mechanisms		3 14 3 14					
Roll out of DHIS2	Roll out DHIS2 to 100 high-volume sites	Roll out DHIS2 to 200 high-volume sites	HVSI $450,000	HVSI $450,000	TBD (new mechanism)	3 14	X	X	X	X	X
Surveys and Surveillance											
PHIA – national survey for HIV Impact Assessment		Data collection complete	HVSI $0	HVSI $0	?	1 9.4	X	X	X	X	X

Uganda Prisons services	Strengthening HIV Prevention, Care and Treatment among Prisoner and Staff of the Prisons Service	Strengthening HIV Prevention, Care and Treatment among Prisoner and Staff of the Prisons Service	HVSI $150,000	HVSI $150,000	17698		X	X	X	X	X
Uganda Virus Research Institute	Strengthening capacity through improved management and coordination of laboratory, surveillance, and epidemiology activities, public health evaluations and training in Uganda – Lab Quality Assurance	Strengthening capacity through improved management and coordination of laboratory, surveillance, and epidemiology activities, public health evaluations and training in Uganda – Lab Quality Assurance	HVSI $980,000	HVSI $980,000	12981		X	X	X	X	X
Makerere University School of Public Health	-Slum dwellers survey complete -Know your Sero status (KYSS) -FSW linkage	-Slum dwellers survey complete -Know your Sero status (KYSS) -FSW linkage	HVSI $800,000	HVSI $800,000	13170	1 9.4	X	X	X	X	X
Makerere University School of Public Health	Combination prevention impact evaluation	Combination prevention impact evaluation	HVSI $650,000	HVSI $650,000	13880	1 9.4	X	X	X	X	X

Makerere University School of Public Health	Case based surveillance	Case based surveillance	HVSI $500,000	HVSI $500,000	17703	1 9.4	X	X	X	X	X
Uganda Virus Research Institute	FSW enhanced prevention	FSW enhanced prevention	HVSI $100,000	HVSI $100,000	13161	1 9.4	X	X	X	X	X
Priorities for Local AIDS Control Efforts (PLACE)	Improved prevention programs among KP/PPs	Strengthened national policy on KP/PPs	HVSI $750,000	HVSI $750,000	16594	1 9.4	X	X	X	X	X
M&E											
M&E capacity building	Technical Assistance to support Uganda Ministry of Health Capacity to Address HIV and Other Health Priority Conditions through Strengthening Health Systems	Technical Assistance to support Uganda Ministry of Health Capacity to Address HIV and Other Health Priority Conditions through Strengthening Health Systems	HVSI $730,000	HVSI $730,000	TBD	12 15	X	X	X	X	12 15
M&E training	Training manuals for M&E and clinical quality improvement revised. M&E district frameworks completed.	53 district-level biostatisticians and 106 records assistants will be trained in M&E.	HVSI $280,000	HVSI $280,000	TBD (new mechanism)	12 15	X	X	X	X	X
M&E capacity building	Strengthened national M&E systems that support domestic and international reporting requirements	Strengthened national and decentralized level M&E systems that support domestic and international reporting requirements	HVSI $1,500,000	HVSI $0	12496	12 15	X	X	X	X	X
M&E capacity building		Strengthened national and decentralized level	HVSI $2,100,000	HVSI $2,100,000	TBD	12 15	X	X	X	X	X

		M&E systems that support domestic and international reporting requirements									

M&E	Sustaining HRH at decentralized levels	Sustaining HRH at decentralized levels	HVSI $350,000	HVSI $350,000	12801	12 15	X	X	X	X	X
M&E	Collaboration, Learning & Adapting	Collaboration, Learning & Adapting	HVSI $1,312,908	HVSI $1,312,908	13837	12 15	X	X	X	X	X
M&E capacity building	Evaluation for Impact	Evaluation for Impact	HVSI $100,000	HVSI $100,000	17682	12 15	X	X	X	X	X
M&E capacity building	Evaluation for Impact	Evaluation for Impact	HVSI $100,000	HVSI $100,000	17686	12 15	X	X	X	X	X
M&E capacity building	Prospective assessment of behavior, adherence and clinical outcomes among HIV-infected adolescents	Prospective assessment of behavior, adherence and clinical outcomes among HIV-infected adolescents	HVSI $100,000	HVSI $100,000	13416	12 15	X	X	X	X	X
M&E capacity building	Impact evaluation on the Koome Island entitled: Improving retention in HIV services through the development of a network of ART clinics within the fishing communities on Koome Island, Uganda.	Impact evaluation on the Koome Island entitled: Improving retention in HIV services through the development of a network of ART clinics within the fishing communities on Koome Island, Uganda.	HVSI $1,350,000	HVSI $1,350,000	9043	12 15	X	X	X	X	X
M&E activities	M&E activities (DQA, CQI, technical support, and program evaluations)	M&E activities (DQA, CQI, technical support, and program evaluations)	HVSI $1,300,000	HVSI $1,300,000	17703	12 15	X	X	X	X	X

M&E capacity building	Technical Assistance for Public Health work force development	Technical Assistance for Public Health work force development	HVSI $600,000	HVSI $600,000	13897	12 15	X	X	X	X	X

6.3 Health System Strengthening (HSS)

PEPFAR's core HSS efforts in support of sustained epidemic control, derived from the SID, SIMS, and root-cause analysis, are captured within four pillars: (1) HRH; (2) Supply Chain System Strengthening; (3) Health Financing; and, (4) Leadership and Governance.

HRH: Despite recent improvements in HRH, the Scale-Up Districts still have a 31% overall vacancy gap against the MoH staffing norms. Performance management, attraction and retention, and shortage of HCWs with the right skills remain the major HRH challenges. To meet these challenges, PEPFAR will continue its investments in PEPFAR-seconded staff, targeting Scale-Up Districts, and high-volume ART sites. PEPFAR also will support the GoU with policy development on task-shifting, revision of staffing norms, and enhancing schemes of service. There will be additional focus on Scale-Up Districts through targeted reinforcement of performance management schemes, Human Resources Information System (HRIS) deployment and utilization, district-specific recruitment and retention TA, and targeted training and enhanced supervision for high-volume health facilities.

Supply Chain: PEPFAR support to strengthen national supply chain activities will be conducted through a Health Supply Chain TA mechanism. NMS has received minimal support, which has affected constant stock availability at facility-level. PEPFAR will reinforce its assistance to the private and public sectors through NMS and other health facilities by enhancing the LMIS and processes to assure commodity security, transparency, accountability, and timely distribution of essential health supplies.

Health Financing: GoU health sector budget support continues to decline; PEPFAR and GF resources are flat-lined. Efforts are required to revamp national systems and policies for health financing and resource mobilization and to identify internal efficiencies through costing studies and standardized management of IP planning, budgeting, and financial tracking processes to inform more robust annual expenditure analyses.

Leadership and Governance: A competent workforce in lab systems, applied epidemiology, and prevention effectiveness/health economics, providing leadership at national and sub-national levels, is critical to achieve epidemic control. Through a 2-year public health fellowship program, cadres of future public health leaders will establish these competencies, while simultaneously providing services and leadership in core aspects of epidemic control at national and sub-national levels.

New ART enrollment will occur largely in the public sector; therefore, it is critical that district-based programs adhere to established performance standards. PEPFAR will support the MoH, Ministry of Local Government, District Health Services, and IPs to establish and monitor standards for performance of the decentralized response, including support for development of micro-plans for epidemic control and deployment of standardized approaches and tools for performance monitoring.

Furthermore, findings from the SID, SIMS and CSO engagement clearly indicate that community participation and CSO engagement in HIV advocacy and service delivery sites is limited and ad hoc, in most cases. PEPFAR will support capacity building of CSOs in advocacy, involve them in assessing and developing approaches to facilitate access to quality HIV services in a non-discriminatory manner to all HIV-affected populations, and reinforce linkages between communities, CSOs, and facilities to ensure that all PLHIV are detected and linked to services.

Table 6.3 Health System Strengthening (HSS)

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		46. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
SUPPLY CHAIN MANAGEMENT											
Strengthen the availability and accessibility of HIV commodities	Commodity availability at central and health facility level improved by 70%	Commodity availability at central and health facility level improved by 80%	OHSS: 1,920,000	OHSS: 1,920,000	UHSC	Commodity security and supply chain Score: 5.1	X – Increased due to availability of commodities	X – Increased due to availability of commodities	X – Increased due to availability of commodities	X – Increased due to availability of commodities	X – Increased due to availability of commodities
Improve national information management systems and country capacity in supply chain performance	Increase the use of information management systems at central and district facilities	Increase the use of information management systems at central and district facilities	OHSS: 960,000	OHSS: 960,000	UHSC	Commodity security and supply chain Score: 5.1	X- Increased efficiency in commodity management	X- Increased efficiency in commodity management	X- Increased efficiency in commodity management	X- Increased efficiency in commodity management	X- Increased efficiency in commodity management
Support measures and policies aimed at enhancing national funding for HIV commodities	Increase in budgetary allocation by GoU towards HIV procured commodities	Increase in budgetary allocation by GoU towards HIV procured commodities	OHSS: 20,000	OHSS: 20,000	UHSC	Commodity security and supply chain Score: 5.1	X – Increased because of sustained funding levels	X – Increased because of sustained funding levels	X – Increased because of sustained funding levels	X – Increased because of sustained funding levels	X – Increased because of sustained funding levels
	Increasing alternative funding mechanisms towards HIV commodities	Increasing alternative funding mechanisms towards HIV commodities	OHSS: 20,000	OHSS: 20,000	UHSC	Commodity security and supply chain Score: 5.1	X – Increased because of sustained funding levels		X – Increased because of sustained funding levels	X – Increased because of sustained funding levels	X – Increased because of sustained funding levels
	100% of ARVs /lab orders placed through	100% of ARVs /lab orders placed	OHSS:	OHSS:	UHSC	Commodity security and supply chain	Increased due to availability of	Increased due to availability of	Increased due to availability of	Increased due to availability of	Increased due to availability of

	WAOS	through WAOS	280,000	280,000		Score: 5.1	commodities	commodities	commoditie	commodities	commodities
HUMAN RESOURCES FOR HEALTH											
HRH policy, Planning, recruitment and retention to support high volume sites and high burden areas.	HRH capacity needs analyzed; Transition plans for PEPFAR seconded staff developed; HWs recruited and posted; HRIS installed in all 112 districts Improved Use of HRIS; HR retention plans reviewed and implemented; and HRH policies on Task-shifting developed and staffing norms reviewed	Annual HRH capacity analysis conducted; Transition plans for PEPFAR seconded staff implemented; HWs recruited and posted; HRIS operationalized in all districts and transitioned to host systems; HR retention plans implemented; Schemes of service developed	OHSS 1,059,550	OHSS 1,059,550	17690, SHRH	Domestic Program and Service delivery-HRH; 9.1	Increased health workforce improves HIV testing	Increased health workforce improves LTC	Increased ART uptake	Increased	Increased
Health worker Performance Management improvement at moderate and high volume sites	Performance management plans implemented; Professional councils strengthened; Quality support supervision conducted; and National IST framework implemented	Performance management plans implemented; Professional councils strengthened; Quality support supervision conducted; and National IST framework implemented	OHSS 529,775	OHSS 529,775	17690, SHRH	Domestic Program and Service delivery-HRH; 9.1	Improved quality and targeting	Increased due to HW productivity	Increased ART uptake	Increased due to HW productivity	Increased due to HW productivity

Pre-service training support for adequate supply and appropriate skills mix of HWs to high volume sites and high burden areas	Increased quality of critical cadres; Curricula for critical cadres reviewed; and quality of training increased.	Increased quality of critical cadres; Curricula for critical cadres reviewed; and quality of training increased.	OHSS 1,059,550	OHSS 1,059,550	17690, SHRH	Domestic Program and Service delivery-HRH; Pre-service- 0	Improved quality and targeting	Increased	Increased ART uptake	Increased	Increased
LEADERSHIP AND GOVERNANCE:											
Support national and sub-national institutions to monitor implementation and performance towards epidemic control	National technical tools, score cards for district planning and monitoring for HIV developed (MoH) CSO engagement in legislative and regulatory frameworks to improve access for HIV services MoH/USG transition plans developed for transition districts/sites Annual district plans and targets developed in Scale-Up, Sustained, and Central Support districts District quarterly coordination/performance reviews conducted for HIV services (includes site level analysis) in Scale-Up, sustained, and Central Support districts Capacity building for regional support teams to monitor performance in all 12 health regions Districts with a competent, substantive disease control officer (targeting the ADHO)	Transition plans developed and implemented within Central Support districts Annual district plans and targets developed in Scale-Up and Sustained Districts District quarterly performance reviews conducted for HIV services (includes site-level analysis) in Scale-Up and sustained districts Bi-annual reviews of program performance Support supervision conducted at district/site levels	OHSS 800,000 1,058,000 1,242,000 200,000	OHSS 800,000 1,058,000 1,242,000 200,000	MoH ; METS (COP14 TBD), SDS ABH	6.0 (policies, laws and regulations) Performance data (score 15.0)	Increased use of data to determine sites for targeted testing	Increased data use with improved retention	Increased linkage from care to treatment; and increased uptake on treatment	Increased uptake of combination prevention services	Increased use of viral load

Uganda Public Health Fellowship Program: Field Epidemiology Track, Laboratory Leadership and health economics track	HIV/AIDS performance monitoring reports Public health evaluations, morbidity/mortality studies, operations research, and other investigations conducted and disseminated Epidemiologic leadership for national control program and Scale-Up Districts for achieving 90-90-90 targets provided by dedicated officers at MoH and SNUs. Client-based information systems for longitudinal patient monitoring established, monitored and evaluated Laboratory systems reinforced through performance monitoring and quality improvement projects HIV/AIDS-related epidemic control modules taught to local public health officials	HIV/AIDS performance monitoring reports Public health evaluations, morbidity/mortality studies, operations research, and other investigations conducted and disseminated Epidemiologic leadership for national control program and Scale-Up Districts for achieving 90-90-90 targets provided by dedicated officers at MoH and SNUs. Client-based information systems for longitudinal patient monitoring established, monitored and evaluated Laboratory systems reinforced through performance monitoring and quality improvement projects HIV/AIDS-related epidemic control modules taught to local public health officials	OHSS 1,500,000	OHSS 1,500,000	MakSPH (13880), Public Health Workforce Development (COP15 TBD)	Epidemiological and Health Data and Performance data (score 15.0) Financial/ Expenditure data: Performance Data: Human Resources for Health: Quality Management: Allocative Efficiency: Technical Efficiency: Public	Analysis of surveillance and program monitoring data will identify gaps in HIV testing. These results will inform actions to improve HIV testing.	Officers will routinely analyze program data to find performance gaps across the continuum of response Projects will identify risk factors for poor LTC, which will inform public health actions.	Officers will routinely analyze program data to find performance gaps across the continuum of response Through investigations, factors affecting ART uptake will be identified, which will inform public health actions	Officers will identify risk factors for HIV transmission in general and key populations, which will inform public health actions for preventing this transmission	Officers will be placed in central-level key departments and districts to reinforce client-based information systems for monitoring and evaluating ART adherence and VL suppression to inform public health actions; operations research will be conducted to evaluate service delivery models/ systems supportive of ART adherence and VL suppression

						Transparency: Oversight and Stewardship: Enabling policy and legal environment: Technical and Political leadership:					
HEALTHCARE FINANCING: Total Budget											
Strengthen systems to conduct Efficiency analysis and measurement	Unit costs of respective HIV/AIDS service elements determined; Improved Expenditure Analysis (EA) reporting and data use; and national health expenditures (NHAs, NASAs) tracked	Unit costs of respective HIV/AIDS service elements used; Improved EA reporting and data use; and national health expenditures (NHAs, NASAs) tracked	OHSS $200,000	OHSS $200,000	QED	Health Financing and Strategic Investments-Allocative efficiency 8; and Technical efficiency 7.3	Increased due to efficiency gains	Increased due to efficiency gains	Increased due to efficiency gains	Increased due to efficiency gains	Increased due to efficiency gains
Strengthen National, district management capacity and financing systems for sustainable epidemic response	USG Health financing Strategy developed; and Prioritized districts provided grants to support service delivery for HIV and OVC	National Health financing Strategy developed; Increased domestic resources for sustainable financing of HIV epidemic response; and Prioritized districts provided grants to support service delivery for HIV and OVC	OHSS $200,000	OHSS $200,000	WHO	Health Financing and Strategic Investments-Resource generation 7; Resource commitments 2	Increased due to better resource commitments	Increased due to better resource commitments	Increased due to better resource commitments	Increased due to better resource commitments	Increased due to better resource commitments

7.0 Staffing Plan

PEPFAR Uganda team structure was reviewed as part of the COP 12 overhaul to align with new programmatic pivots aimed at rapid scale up of CPIs. For COP 15, the team reviewed USG management and operations (M&O) through the lens of increased efficiency to manage the program while simultaneously taking on additional capacity for SIMS visits. The U.S. Mission is "tight-sized"; in late 2014, the Ambassador approved allocation of the remaining few desks to agencies to fill either vacancies or new hires. The PEPFAR Coordination Office was approved to hire two vacant positions; USAID received approval for 10 PEPFAR-related positions. CDC will move some staff from its main offices in Entebbe to the Embassy in Kampala for interagency coordination. Therefore, additional staff positions are not an option and each agency reviewed its vacancies carefully to ensure alignment with epidemic control goals.

PEPFAR staff will continue to focus on core activities within each of the budget codes. CDC eliminated the Blood Safety Advisor position and is moving quickly to hire the HIV Care and Treatment (Health Services) Branch Chief, Associate Director for Science (ADS), TB/HIV Specialist, and Care and Support Advisor. In 2014, USAID created a new office of Education, Youth, and Child Development, which addresses needs of in-school youth, OVC, and adolescents, separate from the health team.

Costs of Doing Business (CODB) are increasing for most agencies in 2016 due to increased ICASS costs and SIMS implementation. For CDC, CODB has increased as CDC will not yet see efficiency gains in moving staff to Kampala given higher ICASS charges, and costs in Entebbe cannot yet be reduced while the majority of staff remain there. In addition, CDC needs to replace 3 older motorpool vehicles and will install teleconference capability in Entebbe to reduce transportation costs and improve communication and coordination over time. For USAID, its ability to conduct SIMS is extremely limited given current staff size and prohibition on new hiring.

All agencies are mobilizing for SIMS. CDC technical advisors in each branch, SI staff, and CoAg management staff have been trained and are implementing SIMS activities with CDC motorpool drivers and vehicles; staff are trained in database use and SI is coordinating SIMS report input. Occasional overtime for beginning or end of travel outside normal work hours is budgeted. Wear and tear on vehicles may require additional replacement next year. IT and property management support tablet availability and maintenance, plus commodities management for paper and toner to print summary sheets and other tools for SIMS site level reporting. Peace Corps will integrate SIMS into site visits once the tool is adopted. Regularly, staff visit Volunteers at their sites of placement as part of program support and SIMS will be included as part of the process. DoD is leveraging its small staff and resources from other program budgets to support SIMS implementation. Roles and responsibilities of staff have been modified to include SIMS-related activities.

Agencies also reviewed existing vacancies and made adjustments to better align with PEPFAR's new strategic direction. Peace Corps converted a vacancy to have another driver to support increased field visits. USAID did not alter the scope of existing, unfilled positions; however, it re-allocated job responsibilities among current staff to ensure coverage and accessed headquarters TA to fill gaps until new staff are identified. CDC is conscious of cost containment priorities while also ensuring appropriate oversight of funds and expertise to support PEPFAR technical priorities. The previously approved voucher examiner position description is being revised to require more auditing experience for financial assessments and follow up with IPs on risk management. The biomedical prevention team lead will absorb the blood safety advisor duties as that position is abolished. The technical advisors in treatment, PMTCT, and sexual transmission areas will increase focus on HTC to complement the HTC advisor's role and the second HTC advisor position is eliminated. Separate M&E positions have been merged into one M&E advisor position and one vacant surveillance officer and one epidemiologist were eliminated since the Field Epidemiology Training Program co-funded by PEPFAR and Global Health Security (GHS) is contributing well to this area. Due to strong locally employed staff performance and coverage, the U.S. Direct Hire (USDH) M&E Advisor

position has been abolished for PEPFAR funding and will convert to a GHS position, leaving two USDH positions on the SI team. CDC staff has reduced from 136 in COP 14 to 125 positions in COP 15, gaining efficiencies while orienting to PEPFAR priorities.

APPENDIX A

Table A.1 VMMC Program Area Specific Core, Near-core, and Non-core Activities for COP 15

Core Activities	Near-core Activities	Non-core Activities
• Provide a minimum of clinical and prevention services of VMMC services including: routine offer of HTC, Tetanus Toxoid vaccination, active exclusion of STIs, surgery, counseling (risk reduction, wound care, follow-up counseling), condom provision. Client follow-up and AE management and documentation. • Linkage of identified HIV+ clients into care and treatment • Ensure QA/CQI/EQA are conducted regularly for VMMC at national and district levels • SMC training and mentorship • Supporting infection prevention and control activities including biomedical waste management • Demand Creation for priority age groups (15-to-29 years) at sub-national level • Provision of VMMC commodities and consumables including emergency kits.	• Provision of IEC materials • Support for program coordination at national and regional levels through GF • Hiring of dedicated staff/roving teams at high volume sites • Operation research for assessing the tetanus in male clients • Costing study to assess and identify efficiencies to maximize resources	• Formation of post VMMC clubs • Printing and distributing SMC HMIS tools

Table A.1 Care and Treatment Program Area Specific Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	**Package of Services in Sustained Districts** • Support clinical evaluation and HIV staging • Support interventions to optimize ART adherence and retention (including patient tracking) • Procurement and provision of ARVs (including for Option B+) • Facility community linkage & referral for OVC, TB, care and ART. • Facilitate ART patient monitoring and sample transportation to lab hubs (for CD4 and Viral load) • Provision of Prevention with Positives (PHDP) services such as risk reduction counseling, partner testing, adherence counseling, condoms, STI care and family planning etc. • Opportunistic Infection prevention and management • Growth and development monitoring for pediatric clients • Nutritional Assessment Counselling and Support (NACS) and provision of Ready to use food for eligible patients • Adolescent friendly services including provision of sexual and reproductive health services • HIV/TB services including Integration of HIV services in TB clinics (HTC in TB & ART for TB/HIV); Supporting the 3I's in TB care settings (Intensified Case Finding, TB Infection Control, Isoniazid Preventive Treatment); provision of TB diagnostic services by microscopy and GeneXpert; and support for referral and linkage of HIV/TB co-infected patients to	• Procurement of laboratory Diagnostics for TB including GeneXpert commodities • Facilitating TB/HIV collaborative reviews (coordination meetings; performance reviews - integration; triangulating and updating ART and TB registers; support Quality Improvement • Support facilities carry out EQA for TB microscopy (transportation of review slides) • Family Planning (technical assistance on integration) • Provision of MDR –TB treatment • Training /mentorship, and support supervision in non-Scale-Up Districts/regions • Human Resource Support at public sites in non-Scale-Up Districts /regions	• Facilitate ART patient monitoring using serum chemistries and hematology • Provision of palliative Care (Pain and symptom management: end of life) • Cervical cancer screening at HIV clinics and referral to treatment centers • Procurement and distribution of Basic Care Package Kit (mosquito net, safe water vessel, Water guard disinfectant tablet) • Home-Based care • Provision of mental health services • Procurement of reagents for TB microscopy and culture • Procurement of anti-TB first line and MDR drugs • MDR- TB treatment support (food support, hospitalization) • Community-based DOTS

treatment services

- Facilitate TB diagnosis (including sample collection and transportation for Gene Xpert testing)
- TB sputum microscopy and TB culture (including supporting facilities carry out EQA for TB tests - transport of slides for review)
- Facilitate MDR –TB diagnosis and treatment (support referral and linkage of patients to treatment facilities)
- Provide technical Assistance for Implementation of the revised ART guidelines (training, coaching and mentoring) in Scale-Up Districts/ regions
- Facilitate training, provision of tools and provide technical assistance for M&E data management and routine data quality assessments (including establishment of electronic medical records)
- Human Resource recruitment and retention
- Technical assistance in supply chain management
- Infrastructure (minor renovations for increasing space; laboratory renovation, storage, waste management)
- Support HIV drug resistance monitoring activities (technical assistance, provision of tools and training)
- Facilitate and provide technical assistance quality management and quality improvement (QI/QM) of care and treatment services
- Data management, QI, and Monitoring and Evaluation (HMIS reporting and data management)

Package for Scale-Up Districts

	Same package of services as above and; Procurement of additional ARVs for Scale-Up Districts in public sites Human resource support Minor Infrastructural improvements if needed (space, Lab, waiting area)	
Sub-national level	• Technical assistance, training coaching and mentorship on implementation of national guidelines – ART and IPT, including facilitating district Training of Trainers; planning meetings; TA on supply chain) • Joint PEPFAR/MoH support supervision with the District Health Team (DHT) Support quality management and quality improvement • Support for laboratory hubs: for CD4 testing and viral load	• Training and mentorship in public sector in non-Scale-Up Districts / regions • Planning and coordination (coordination, surveillance, oversight and management) • M&E (HMIS reporting, data management and quality) Technical assistance in data management and data quality • TB and MDR-TB coordination activities
National level	• Policy support (TA in policy development and reviews; training – ART, IPT, VL) • Planning and Coordination for Care and treatment programming • Joint PEPFAR/MoH Support Supervision • Quality improvement (oversight, coordination and management) • Technical assistance, training coaching and mentorship on implementation of national guidelines – ART & IPT , including facilitating Training of Trainers • Facilitate Viral load roll out planning, implementation and oversight • Supply chain management for commodities (100% private sector & part contribution for public, as needed (ARVs, COTRIM,OI drugs and CD4) • HIV Behavior Change Communication - adherence and retention messaging • Nutrition activities (technical assistance, coordination and oversight) • Supply chain management for	• Supply chain management for TB commodities (TB Lab reagents for sputum microscopy ZN culture, Gene Xpert cartridges) • External quality assurance for TB – HR support, supervision, results' return • Support for national technical conferences and review meetings (Pediatric; QI; TB; Treatment, Care and support) • Facilitate M& E data management and reviews (Care & TX reporting, data, retention measurement and surveys) • Support for TB prevalence survey

	commodities such as ARVs, cotrimoxazole, Opportunistic Infection drugs, lab reagents for VL and CD4)	

Table A.1 HTC Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	• Targeted HTC to KP/PPs • Facility-based PITC to target individuals with signs and symptoms indicative of HIV infection • Appropriate linkage and/or referral for individuals with HIV negative result. • Manage and coordinate HTC commodities (forecasting, requisition, and reporting) • Quality assurance and improvement for both HIV testing and HIV counseling		
Sub-national level	• HTC demand creation for KP/PPs • Manage and coordinate HTC commodities (forecasting, requisition, distribution and reporting) • Quality assurance and improvement for both HIV testing and HIV counseling	• Routine support supervision • Capacity building for logistics, service delivery, data collection, management and reporting	• Dissemination of HMIS tools, HTC policy and guidelines, SOPs and IEC materials
National level	• Quality assurance and improvement for HIV testing and HIV counseling	• Procure and distribute HTC commodities for the private sector (PNFP and PFP) sites • Support supervision for logistics (forecast, requisition, report), service delivery, data management and reporting • Capacity building for logistics, service delivery, data collection, management and reporting	• Print and disseminate HMIS tools, HTC policy and guidelines, SOPs and IEC materials

Table A.1 OVC Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	**Case Management** • Identification of vulnerable children and adolescent by or to HIV and AIDS • Assess child, adolescent & family socio-economic status and risk • Develop/Update case management plans, ensure monitoring of referral completion case closure • Reducing loss to follow up and ensuring continuity of care across community and clinic-based service providers		
	OVC Healthy • Promotion of HIV testing among OVC households including EID, & confirmatory HIV testing • Referral- keeping HIV negative adolescent girls free from HIV • Coordination with commodity and counseling providers to ensure dual protection is accessible to adolescent OVC • Integrate ART adherence assessment, counseling and support into routine household support to OVC households • Facilitate uptake of & monitoring completion of referrals		• Providing households supplies (i.e. blankets • Home visits solely for purpose of clinical linkages • Providing food packages
	OVC Safe • Supporting child protection/GBV prevention and response activities, & referral to other services • Supporting clinic-based child abuse & GBV response services (emergency medical/PRC) • Addressing psycho-social health among children & their caregivers • Succession planning and permanency support Promoting Positive Parenting Skills (discipline, communication on adolescent risk, HIV disclosure)	• Professional development of community volunteers in child protection, GBV & permanency	• Supporting placements in long-term residential care facilities
	OVC Stable • Facilitating group-based Household Economic Strengthening (HES) activities, such as saving	• Targeted food security initiatives	

	groups • Limited and temporary emergency cash (generally required for <10% of cases) • Supporting market linked vocational training & other individual HES activities		• Establishing or supporting business cooperatives • Providing Micro-credit • Providing housing • Covering vocational training/IGAs without established markets
	OVC Schooled • Identify key at risk groups for support • Facilitate access to primary and sec. education through temporary and targeted support • Supporting school-based psychosocial support and safety from violence • Supporting ECD in coordination with PMTCT & Pediatric HIV) • Integrating ECD into HIV care & treatment for children under 5 years	• Facilitating access to primary & Sec. education for girls through long-term or open ended subsidies • Providing long-term or open-ended school block grants or support for ECD centers • Improving education quality, making classroom environments gender and HIV sensitive • Supporting community education councils & PTAs to provide support to OVC	• Supporting tertiary education (including university subsidies and scholarships)
Sub-national level			
	Case Management	• Mapping services & develop directories (GOU) • Training in case management (districts)	
	OVC Safe • Support to "Safe spaces" approach for adolescents at high risk esp. girls (street children, domestic workers	• Strengthening structures for community-based mediation of child abuse cases	• Strengthening birth registration systems • Dissemination of Child protection laws
	OVC Stable • Supporting access to and uptake of social protection efforts (social grants, cash transfer programs, bursaries, etc.) • Linking business/agricultural projects to markets /value chain development	• Carry out market assessments for IGAs	
National level			
	Case Management • Implementing special studies to identify gaps in programing impact	• Support development of national MIS (GOU)	
	OVC Safe	• Strengthening government managed and case management systems to prevent and respond to child abuse and support family placement &	• Carrying out large-scale child rights awareness campaigns

		permanency for children • M&E systems for National child protection/social welfare effort • Supporting advocacy and policy efforts to improve safety of children from violence	

Table A.1 SI Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	• Implementation of technological innovations (EMR, finger printing technology) • Quality improvement (SIMS, DQAs, SQAs, CQI) • Supporting MER reporting and data use	• Printing of HMIS tools • M&E capacity building at site level	
Sub-national level	• Strengthening of national reporting systems (DHIS2) including spatial data collection and sharing platform • Training of district M&E staff, Biostatistician to inform program progress		
National level	• Surveys and surveillances –HIA, DHS, Key populations surveillance, ANC • Evaluations for impact –Systematic embedment of impact evaluations in all PEPFAR program designs • Implementation and operation science studies that improve programs • TOT at national level to strengthen the M&E capacity	• E-policy development • Piloting other innovations	• Research and evaluation activities that do not contribute to planning and program improvement • Development of the proposed pilot innovations

Table A.1 PMTCT Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	**HIV testing and counseling** • HTC for all pregnant and BF women • HTC for partners and children (woman as index case) • Retesting of HIV negative pregnant & BF women as per national guidelines • HTC for HIV-exposed infants (see HEI services below) • Active linkage of HIV-positive partners and family members to care, support and treatment services • RTQII (EQA for eMTCT services for all PMTCT sites) **Primary prevention** • Risk reduction counseling for HIV-negative pregnant and lactating mothers and their partners • Active linkage of negative partners to VMMC • Identification & management of discordance as per 2014 National ART guidelines **Family Planning** • Integrated FP service provision within ART/PMTCT (including as part of mentorship) - Core activity but currently funded with one-time central funds **Facility based Integrated mother-baby care point services for 18 months** *ART for HIV-positive pregnant and BF women (ANC, L&D, postnatal)* *Care & Support services for mothers(as per care and treatment package)* • STI screening • TB/HIV services • OI screening and treatment • Lab monitoring (including baseline CD4 and VL monitoring) • NACS (including procurement of	• Screening of SGBV pregnant & lactating women & linkage to existing services	• FP commodities – leveraging funds from USAID and UNFPA • FP compliance training (US regulatory requirement) – leveraging funds from USAID • Cervical cancer & breast cancer screening in eMTCT settings

	RUTF) ***HIV-exposed infant (HEI) services*** • NVP prophylaxis • DNA PCR for Early infant diagnosis • Rapid testing for final infant status • Provide care & support services (TB/HIV services, CTX, infant and young child feeding/NACS/RUTF, growth & development monitoring etc.) • Adherence and retention support through mentor mothers and enhanced client tracking systems • Adherence and retention support through mentor mothers and enhanced client tracking systems • Minor facility improvements and equipment necessary to support quality service provision and ensure compliance with infection control standards **Intra & Inter-health facility linkages and referral between PMTCT and ART** • Pregnant women already on ART to PMTCT • Postpartum women in PMTCT to ART after 18 months • HIV-positive infants to ART • Linkage to lifelong care and ART for HIV positive infants and mothers **HR/Training/ Mentoring** • Recruitment and retention of midwives (recruitment focused on Scale-Up Districts) • Mentorship for health workers to improve competence for delivery of quality integrated eMTCT/MNCH/RH services. • Build capacity of HCWs to order for PMTCT commodities through WAOS. **M&E** • Quarterly supportive supervision, including follow-up on sites identified during SIMS visits • Quarterly DQAs/SQAs • Implementation of Option B+ M&E	• Immunization, Vit A, etc. provided by GOU •

	framework Activities • Support HCWs to provide quality data for the longitudinal registers, HMIS tools & Cohort monitoring. • Support HCWs to provide weekly data to the Option B+ Real time reporting platform. • Implementation of cohort monitoring, analysis, and data use focused on maternal ART retention and HEI final outcome • CQI activities related to eMTCT		
Sub-national level	• Technical assistance to DHMTs for data management, quality, and use, including action planning and QI using the weekly B+ and routine HMIS reports	• Implement male involvement strategy (through Couple Counselling and testing, and family support groups in Scale-Up and Sustained districts)	• Community mobilization and sensitization by political and cultural leaders as part of demand creation (core for Scale-Up Districts)
National level	• Coordination of the national roll-out plan for the Option B+ M&E framework • Routine Monitoring (HMIS/DHIS2) • Enhanced monitoring (including EOC B+ weekly reporting and cohort monitoring for maternal retention and HEI final outcome) • Evaluation (Impact/effectiveness evaluation of eMTCT program and birth defects surveillance) • Quality improvement and supportive supervision for eMTCT (oversight, coordination and management) • IEC/BCC materials development and dissemination related to eMTCT	• Conduct annual eMTCT national stakeholders meeting for monitoring progress • Policy support (technical assistance in development, reviews and assessments)	• Support the Office of the First Lady (OAFLA) to implement high level advocacy and mobilization for eMTCT Global Plan

Table A.1 Prevention Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	**Distribution and promotion of condoms** • Aggressive condom promotion includes through social marketing and other models • Monitor distribution of condoms to rural and urban hotspots prioritizing priority populations	• Leverage existing platforms for primary & secondary prevention 40% • Offer prevention package for priority populations	

	Targeting Key and Priority Populations: • Target, monitor, track KPs and OVPs to ensure they are targeted and receive HIV services **Minimum Package (tailored to specific population)** • Peer education and community-based outreach • Sexually Transmitted Infection (STI) prevention, screening and treatment • Condoms and condom-compatible lubricants • HIV Testing and Counseling (HTC) • Antiretroviral Therapy (test & treat • Map hotspots to guide strategic condom distribution • Support tracking of KP to ensure linkage and retention • Intensify Inter personal communication including risk reduction counselling	GBV: • Ensure programs are screening for GBV and offering post-GBV care • Make PEP available for all who need it (victims of GBV) • Address harmful social-cultural and gender norms, beliefs and practices	
National level	• Support MoH to forecasting the national condom need in collaboration with the supply chain TWG **Strengthening QA and capacity to implement and monitor minimum prevention package** • Improving the quality, consistency and availability of HIV prevention materials across all platforms • Support monitoring and evaluation for minimum package offered • Standardizing reporting		

Table A.1 HSS Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
	Human Resources ***Workforce policy and planning***		

	• Provide TA for recruitment and retention of staff • Support policy development on HRH • Policy on staffing norms, schemes of services and task shifting	• Recruitment and secondment of HWs matching workload. • Strengthen HRIS	
	Performance Management • Reinforce support supervision to improve the quality of HIV services. • Performance management plans: rewards and sanctions • Work with GoU to design standardized/institutionalized training in HF & performance management for clinical officers	• Support Health Professional Councils	
	Training • Improve quality and efficiency of health training institutions • Service-based 2-year and 6-month fellowships at MoH and districts for technical public health leadership in applied epidemiology, management, lab systems, M&E/CQI and health economics	• Implement quality and efficient in-service training programs & councils • Targeted scholarships for training • Standardize in-service programs	• Infrastructure for training institutions
	Health Financing ***Resource mobilization and pooling*** • National systems and policies for health financing • National and private sector systems for innovative health financing and domestic resource mobilization	• Grants to districts to fill the financing gaps in direct service delivery for HIV and OVC	• District revenue enhancement plans
	Resource allocation • Studies: Costing and efficiency (models of care) • Track national expenditure and resources • Planning, managing, reporting for HIV/AIDS activities	• Review and use of financial data to plan and prioritize investments	
	Governance **District Programming for Effective Epidemic Control** • National technical tools, score cards for district planning &monitoring for HIV developed (MoH) • Civil society engagement in legislative and regulatory frameworks to improve access for HIV services;	• Work with MOH to define a minimum set of health systems capabilities that every district should have for sustained epidemic control, and ensure that each IP supports attainment of these	

	• Support district quarterly coordination and performance reviews conducted for HIV services (includes site level analysis) in Scale-Up, Sustained , and Central Support districts; **Leadership and program management (fellowship)** • HIV/AIDS-related surveillance and performance monitoring data analyzed by districts officers • Capacity building for district health teams, regional teams to monitor performance in all districts and 12 health regions **Civil society: Advocacy; community systems/ accountability** • Support NGO/CSOs advocacy efforts at national / district level on health finance issues (domestic financing for HIV; accountability of HIV resources; CSO follow up of the investment case and HIV trust fund) supporting access to HIV care and treatment services for priority populations • Work with Ministry of Health to establish a standardized and institutionalized system for strengthening COR linkages and retention using community and facility-level assets and information systems **Supply Chain Strengthening** ***Commodity Procurement, warehousing &Distribution*** • Procure, warehouse & distribute commodities for PNFP/PFPs and public sector gap fill Core commodities: (Key first line ARVs, VMMC OIs, Lab). • Support information management and operations at central warehouse level ***Support national policies, programs, and***	<u>minimum</u> district performance standards • Epidemiologic projects – including surveys, public health evaluations, and morbidity/mortality studies • Provide evidence to advocate for critical policies affecting access to HIV care and treatment services (e.g. upgrade of key H/C IIs at MARPS communities) HRH; supplies; HF • Support CSOs to act as watchdogs for access to services for all persons, service quality, and patient satisfaction at high volume and burden districts	Technical support for: • Efficient procurement and pricing of EMHS in private wings and PNFPs • Revise allocation formula for GOU pharmaceutical & health supplies funds to improve equity

systems to ensure optimal and transparent use of financial resources for medicines and other health commodities • Commodity Tracking System interoperable with DHIS 2 and GOU financial management systems. • Strengthen country capacity and performance in supply chain management	• Support pharmaceutical component of national health insurance scheme/AIDS trust fund	
Central Level • Strengthen Pharmacy Division and Laboratory Services /QPPU to improve forecasting and supply planning for HIV related commodities • Expand and integrate logistics management information systems to national e-health architecture • Improve performance of procurement, warehousing and distribution operations • Train Supply Chain personnel professionals in supply chain management at PEPFAR supported facilities • Supplement technical programs with logistics management support (PD, ACP, CPHL, NTLP) • Support NDA to: Increase capacity and efficiency of quality testing of condoms	• Support NDA to: – Implement WHO Good Distribution Practice accreditation for wholesalers – Continue Good Pharmaceutical Practice certification of public and PNFP facilities • Support institutionalization of pre-service training in EMHS management for health worker cadres • procurement, warehousing and distribution operations	

Table A.2 VMMC Program Area Specific Core, Near-core, and Non-core Activities for COP 15

	Core Activities	Near-core Activities	Non-core Activities
VMMC **Scale-Up sites**	• Through outreach and mobile SMC services, provision of VMMC services (routine offer of HTC, active exclusion of STIs, surgery, counseling (risk reduction, wound care, follow-up counseling), condom provision. Client follow-up and AE documentation • QA for VMMC at national and district levels, plus Scale-Up sites • SMC training and mentorship • Printing SMC HMIS tools • SMC reporting • Supporting IC activities including biomedical waste management • Demand Creation for priority age groups (15-to-29 years) at sub-national level • Provision of additional VMMC commodities at Scale-Up sites	• Provision of SMC services at static sites • Provision of SMC commodities in Sustained and Central Support sites (through GF support 42,000 SMC kits). Provision of HTC RTKs • Site-level QA at Sustained and Central Support sites • Provision of IEC materials • Support for program coordination at national and regional levels through GF • Hiring of dedicated staff/roving teams at high volume sites	• Formation of post-VMMC clubs • Demand creation for non-priority age groups (below 15 years and above 29 years)
Sustained sites	• Through outreach and mobile SMC services, provision of VMMC services (routine offer of HTC, active exclusion of STIs, surgery, counseling (risk reduction, wound care, follow-up counseling), condom provision. Client follow-up and AE documentation • QA for VMMC at national and district levels, plus Scale-Up sites • SMC training and mentorship • SMC reporting • Supporting IC activities including biomedical waste management	• Provision of SMC services at static sites • Provision of SMC commodities in Sustained and Central Support sites (through GF support 42,000 SMC kits). Provision of HTC RTKs • Site level QA at non-scale-up sites • Provision of IEC materials • Support for program coordination at national and regional levels through GF	

Table A.2 Care and Treatment Program Area Specific Core, Near-core, and Non-core Activities for COP 15

National Level	**Core Activities** • Policy support (TA in development, reviews and assessments) • Planning and coordination for Care and treatment programming • Facilitate joint PEPFAR/MoH Support Supervision • Quality improvement (oversight, coordination and management) • Technical assistance, training coaching and mentorship on implementation of national guidelines – ART & IPT, including facilitating Training of Trainers • Facilitate Viral load roll out planning, implementation and oversight • Supply chain management for commodities (100% private sector and part contribution for public, as needed (ARVs, COTRIM,OI drugs and CD_4) • HIV Behavior Change Communication - adherence and retention messaging • Nutrition activities (technical assistance, coordination and oversight)	**Near-core Activities** • TB external quality assurance – HR support, supervision, returning results • MDR TB activities (coordination, surveillance, oversight and management) • National technical conferences and review meetings (Pediatric; QI; TB; Treatment, Care and support) • Facilitate M& E data management and reviews (Care & TX reporting, data, retention measurement and surveys) • Supply chain management for TB commodities (TB Lab reagents for sputum microscopy ZN culture, Gene Xpert cartridges)	**Non-core Activities** • TB prevalence survey
Sub- National Level	**Core Activities** • Technical assistance, training coaching and mentorship on implementation of national guidelines – ART & IPT, including facilitating district Training of Trainers; planning meetings; TA on supply chain) • Joint PEPFAR/MoH support supervision with the District Health Team (DHT) • Support Quality Improvement and QA	**Near-core Activities** • Planning & coordination (coordination, surveillance, oversight and management) • M&E (HMIS reporting, data management and quality) Technical assistance in data management and data quality	**Non-core Activities**
Site Level	**Core Activities** • Support clinical evaluation and HIV staging • Support interventions to optimize ART adherence and retention (including patient tracking) • Procurement and provision of ARVs	**Near-core Activities** • Human Resource recruitment and retention (In sustained sites) • Facilitate TB/HIV collaborative reviews (coordination meetings;	**Non-core Activities** • Basic care kit • Mental Health • Home Based care • Cervical cancer screening at HIV clinics and referral to

	(including for Option B+); Cotrimoxazole and OI drugs • Facility community linkage and referral for PLHIV, OVC, TB, key and priority populations etc. • Facilitate ART patient monitoring and sample transportation to Hubs (CD4 & Viral load) • Provision of Prevention with Positives (PHDP) services such as risk reduction counseling, partner testing, adherence counseling, condoms, STI care and family planning etc. • Opportunistic Infection prevention and management • Growth and development monitoring for pediatric clients • Nutritional Assessment Counselling and Support (NACS) and provision of Ready to use food for eligible patients • Adolescent friendly services including provision of sexual and reproductive health services • Facilitate TB diagnosis (sample collection and transportation for Gene Xpert testing) • TB sputum microscopy and TB culture (including supporting facilities carry out EQA for TB tests - transport of slides for review) • Facilitate MDR –TB diagnosis and treatment (support referral and linkage of patients to treatment facilities) • Provide technical Assistance for Implementation of the revised ART guidelines (training, coaching and mentoring) in Scale-Up Districts/ regions • Facilitate training, provision of tools and provide technical assistance for M&E data management and routine data quality assessments (including establishment of electronic medical records)	performance reviews - integration; triangulating and updating ART and TB registers; support Quality Improvement) • Facilitate TB/HIV collaborative reviews (coordination meetings; performance reviews - integration; triangulating and updating ART and TB registers; support Quality Improvement)	treatment centers • Palliative Care (Pain and symptom management: end of life) • Facilitate ART patient monitoring (chemistries and hematology)

	• Human Resource recruitment and retention (for PNFP and PS in Scale-Up sites) • HIV/TB services including Integration of HIV services in TB clinics (HTC in TB & ART for TB/HIV); Supporting the 3I's in TB care settings (Intensified Case Finding, TB Infection Control, Isoniazid Preventive Treatment); provision of TB diagnostic services by microscopy and GeneXpert; and support for referral and linkage of HIV/TB co-infected patients to treatment services • Technical assistance in supply chain management • Infrastructure (minor renovations for increasing space; laboratory renovation, storage, waste management) • Support HIV drug resistance monitoring activities (technical assistance, provision of tools and training) • Facilitate and provide technical assistance quality management and quality improvement (QI/QM) of care and treatment services	

Table A.2 HTC Program Area Specific Core, Near-core, and Non-core Activities for COP 15

	Core Activities	Near-core Activities	Non-core Activities
Service Package Maintenance Services Standard of care	• Passive HTC: PITC for clinical signs and at clinical places: TB, STI, ANC, ART (family of index client), in-patient wards for both adults and pediatrics, pediatric malnutrition entry points. • Linkage into care and treatment, and other prevention services for all identified HIV+ • QA/QI for both HIV testing and counseling, • Active facility-based HTC: PITC for all in clinical places such as: TB, STI, ANC, ART (family of index client), and inpatient wards for adults and pediatrics, OPD (with clinical signs and symptoms indicative of HIV infection), malnutrition, OVC, and EPI/YCC sites. • Targeted HTC to key, priority, and hard-to-reach populations. • Appropriate linkage and/or referral for all individuals testing for HIV. • Demand creation for HTC, especially for pediatrics and couples • QA/QI for both HIV testing and counseling, • Additional HR (HTC counselors, linkage facilitators)	• Active facility-based HTC: PITC for all in clinical places such as: TB, STI, ANC, ART (family of index client), and inpatient wards for adults and pediatrics, OPD (with clinical signs and symptoms indicative of HIV infection), malnutrition, OVC, and EPI/YCC sites. • Targeted HTC to key, priority and hard-to-reach populations. • Appropriate linkage and/or referral for all individuals testing for HIV. • Demand creation for HTC, especially for pediatrics and couples • QA/QI for both HIV testing and counseling, • Additional HR (HTC counselors, linkage facilitators)	• Print and disseminate HMIS tools, HTC policy and guidelines, SOPs and IEC materials • Outreach HTC for general population
In Scale-Up sites			• Print and disseminate HMIS tools, HTC policy and guidelines, SOPs and IEC materials • Outreach HTC for general population

Table A.2 OVC Program Area Specific Core, Near-core, and Non-core Activities for COP 15

Case Management	Core Activities	Near-core Activities	Non-core Activities
	• Identification of vulnerable children and adolescent by or to HIV/AIDS • Assess child, adolescent & family socio-economic status and risk • Develop/Update case management plans, ensure monitoring of referral completion case closure • Reducing loss to follow up and ensuring continuity of care across community and clinic-based service providers • Implementing special studies to identify gaps in programing impact	• Mapping services & develop directories (GOU) • Support development of national MIS (GOU) • Training in case management (districts)	
OVC Healthy (Access to Health/HIV Services)	• Promotion of HIV testing among OVC households including EID, & confirmatory HIV testing • Referral- keeping HIV-negative adolescent girls free from HIV • Coordination with commodity and counseling providers to ensure dual protection is accessible to adolescent OVC • Integrate ART adherence assessment, counseling and support into routine household support to OVC households • Coordination with NACS by referring suspected malnourished OVC • Facilitate uptake of and monitoring completion of referrals	• Establish and strengthening referral mechanisms and other systems to ensure cross referrals between clinical and social services (Cross referrals)	• Providing household supplies such as blankets • Carrying out home visits solely for the purpose of clinical linkages • Providing food packages
OVC Safe (Protection & Psychosocial Support)	• Supporting child protection/GBV prevention and response activities, and referral to other services • Supporting clinic-based child abuse and GBV response services (emergency medical/PRC) • Addressing psycho-social health among children and their caregivers • Succession planning and permanency support • Promoting Positive Parenting Skills (discipline, communication on adolescent	• Strengthening government managed and case management systems to prevent and respond to child abuse and support family placement & permanency for children • Strengthening structures for community-based mediation of child abuse cases • Professional development of community volunteers in child protection, GBV and permanency • M&E systems for National child	• Strengthening birth registration systems • Supporting placements in long-term residential care facilities • Carrying out large-scale child rights awareness campaigns • Dissemination of Child protection laws

	risk, HIV disclosure) • Support to "Safe spaces" approach for adolescents at high risk esp. girls (street children, domestic workers)	protection/social welfare efforts Supporting advocacy and policy efforts to improve safety of children from violence	
OVC Stable (Econ. Strengthening and Social Protection Support)	• Facilitating group-based Household Economic Strengthening (HES) activities, such as saving groups • Supporting access to and uptake of social protection efforts (social grants, cash transfer programs, bursaries, etc.) • Limited and temporary emergency cash (generally required for <10% of cases) • Supporting market linked vocational training & other individual HES activities • Linking business/agricultural projects to markets /value chain development	• Carry out market assessments for IGAs • Targeted food security initiatives	• Establishing or supporting business cooperatives • Providing Micro-credit • Providing housing • Covering vocational training/IGAs without established markets
Schooled (Education)	• Identify key at risk groups for support • Facilitate access to primary and sec. education through temporary and targeted support • Supporting school-based psychosocial support and safety from violence • Supporting ECD in coordination with PMTCT and Pediatric HIV) • Integrating ECD into HIV care and treatment for children under 5 years	• Facilitating access to primary and secondary education for girls through long-term or open ended subsidies • Providing long-term or open-ended school block grants or support for ECD centers • Improving education quality, making classroom environments gender and HIV sensitive • Supporting community education councils and PTAs to provide support to OVC	• Supporting tertiary education (including university subsidies and scholarships)

Table A.2 SI Program Area Specific Core, Near-core, and Non-core Activities for COP 15

	Core Activities	Near-core Activities	Non-core Activities
Health Information Systems	• Strengthening of national reporting systems (DHIS2) including spatial data collection and sharing platform • Strengthening of PEPFAR reporting systems (DATIM)	• E-policy development • Printing of HMIS tools	
Surveys and Surveillance	• Surveys and surveillances –HIA, DHS, Key populations surveillance, ANC • Training of district M&E staff, Biostatistician to inform program progress • Evaluations for impact –Systematic embedment of impact evaluations in all PEPFAR program designs • Implementation and operation science studies that improve programs		
Monitoring and Evaluation	• TOT at national level to strengthen the M&E capacity • Quality improvement (SIMS, DQAs, SQAs) • Implementation of technological innovations (EMR, finger printing technology)	• M&E capacity building at site level • Provision of computer systems and internet connectivity • Piloting other innovations	• Research and evaluation activities that do not contribute to planning and program improvement
Technological Innovations			• Development of the Innovations

Table A.2 PMTCT Program Area Specific Core, Near-core, and Non-core Activities for COP 15

	Core Activities	Near-core Activities	Non-core Activities
Site Level	**HIV testing and counseling** • HTC for all pregnant and BF women • HTC for partners and children (woman as index case) • Retesting of HIV-negative pregnant & BF women as per national guidelines • HTC for HIV-exposed infants (see HEI services below) • Active linkage of HIV-positive partners & family members to care, support and treatment services • RTQII (EQA for eMTCT services for all PMTCT sites) **Primary prevention** • Risk reduction counseling for HIV-negative pregnant and lactating mothers and their partners • Active linkage of negative partners to VMMC • Identification & management of discordance as per 2014 National ART guidelines **Family Planning** • Integrated FP service provision within ART/PMTCT (including as part of mentorship) - Core activity but currently funded with one-time central funds **Facility based Integrated mother-baby care point services for 18 months** *ART for HIV-positive pregnant and BF women (ANC, L&D, postnatal)* *Care & Support services for mothers (as per care and treatment package)* • STI screening • TB/HIV services • OI screening and treatment • Lab monitoring (including baseline CD4 and VL monitoring) • NACS (including procurement of RUTF) *HIV-exposed infant (HEI) service***s**	• Screening of SGBV pregnant & lactating women & linkage to existing services	• Commodities (NVP, EID, RTK) for PS • FP compliance training (US regulatory requirement) – leveraging funds from USAID • FP commodities – leveraging funds from USAID and UNFPA • Cervical cancer & breast cancer screening in eMTCT settings

	• NVP prophylaxis • DNA PCR for Early infant diagnosis • Rapid testing for final infant status • Provide care & support services (TB/HIV services, CTX, infant and young child feeding/NACS/RUTF, growth and development monitoring etc.) • Adherence and retention support through mentor mothers and enhanced client tracking systems • Community based care and support services focusing on community based intensive adherence support (focus on KP/PP and those failing 1st/2nd line) and active re-engagement of those LTFU. • Minor facility improvements and equipment necessary to support quality service provision and ensure compliance with infection control standards **Intra & Inter-health facility linkages and referral between PMTCT and ART** • Pregnant women already on ART to PMTCT • Postpartum women in PMTCT to ART after 18 months • HIV-positive infants to ART • Linkage to lifelong care and ART for HIV positive infants and mothers **HR/Training/ Mentoring** • Recruitment and retention of midwives (recruitment prioritized for Scale-Up Districts) • Mentorship for health workers to improve competence for delivery of quality integrated eMTCT/MNCH/RH services. • Build capacity of HCWs to order for PMTCT commodities through the Web-based ordering system (WAOS). **M&E** • Quarterly supportive supervision, including follow-up on issues identified during SIMS visits • eMTCT Quarterly DQAs/SQAs	• Minor facility improvements and equipment necessary to support quality service provision and ensure compliance with infection control standards	• Immunization, Vit A, etc provided by GOU

	• Implementation of Option B+ M&E framework Activities • Support HCWs to provide quality data for the longitudinal registers, HMIS tools & Cohort monitoring. • Support HCWs to provide weekly data to the Option B+ Real time reporting platform. • Implementation of cohort monitoring, analysis, and data use focused on maternal ART retention and HEI final outcome CQI activities related to eMTCT		
Sub- National Level	• Technical assistance to DHMTs for data management, quality, and use, including action planning and QI using the weekly B+ and routine HMIS reports	• Implement male involvement strategy (through Couple Counselling and testing, and family support groups in Scale-Up and Sustained districts)	• Community mobilization and sensitization by political and cultural leaders as part of demand creation
National Level	• Coordination of the national roll-out plan for the Option B+ M&E framework • Routine Monitoring (HMIS/DHIS2) • Enhanced monitoring (including EOC B+ weekly reporting and cohort monitoring for maternal retention and HEI final outcome) • Evaluation (Impact/effectiveness evaluation of eMTCT program and birth defects surveillance) • Quality improvement and supportive supervision for eMTCT (oversight, coordination and management) • IEC/BCC materials development and dissemination related to eMTCT • Conduct annual eMTCT national stakeholders meeting for monitoring progress • Policy support (technical assistance in development, reviews and assessments)		• Support the Office of the First Lady (OAFLA) to implement high level advocacy and mobilization for eMTCT Global Plan

Table A.2 Prevention Program Area Specific Core, Near-core, and Non-core Activities for COP 15

Core Activities

Distribution and promotion of condoms

- Support MoH to forecasting the national condom need in collaboration with the supply chain TWG
- Map hotspots to guide strategic condom distribution
- Aggressive condom promotion includes through social marketing and other models
- Monitor distribution of condoms to rural and urban hotspots prioritizing priority populations

Targeting Priority Populations:

- Target, monitor, track KPs and OVPs to ensure they are targeted and receive HIV services
- Map hotspots to guide strategic condom distribution
- Support tracking of KP/OVP to ensure linkage and retention
- Work with peer groups at community level as part of program planning, implementation and M&E
- Intensify Inter personal communication including risk reduction counseling

Strengthening QA and capacity to implement and monitor minimum prevention package

- Improving the quality, consistency and availability of HIV prevention materials across all platforms
- Support monitoring and evaluation for minimum package offered
- Standardizing reporting

Near-core Activities

- Leverage existing platforms for primary & secondary prevention 40%
- Offer prevention package for priority populations
  - GBV: Ensure programs are screening for GBV and offering post-GBV care
  - Make PEP available for all who need it (victims of GBV)
  - Address harmful social-cultural and gender norms, beliefs and practices
  - Facilitate MOH's Health Promotion & Education Department to provide ongoing monitoring, QA and a clearing house for IEC/BCC messages and materials

Non-core Activities

- General population prevention

Table A.3 Transition Plans for Non-core Activities

Table A.3 VMMC Transition Plans for Non-core Activities						
Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
Formation of Post VMMC Clubs	Phasing Out	$10,000	$0	8	2016	There has been few Post VMMC activities and will be phased out
Printing and distributing SMC HMIS tools	Transition to GoU/GF	$300,000	$0	6	2016	GoU will continue the printing of all the SMC HMIS tools
Totals						

Table A.3 Care and Treatment Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
Mental Health	GOU	$0	$0	TASO	End of FY15	GOU has a mental health program at MoH
Home Based care	CSF	$0	$0	TASO	End of FY15	
Management of non-Communicable diseases	GOU	$0	$0	All	End of FY15	To transition to CBOs funded by CSF.
Cancer of the cervix Screening	GOU	$0	$0	All	End of FY15	GOU will support this activity as part of routine care
Provision of the basic care Kit	GOU	$0	$0	PACE	End of FY15	GOU will support this activity as part of routine care
Palliative end of life care	GOU	$0	$0	All	End of FY15	GOU will support this activity as part of routine care
ART patient monitoring using serum chemistries and hematology	GOU	$0	$0	All	End of FY15	
Totals						

Table A.3 HTC Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
HTC outreaches to the general population	HTC outreaches to the general population were transitioned to government in COP12	$0	$0			HTC outreaches to the general population were transitioned to government in COP 12. Currently Global fund and other stakeholders such as Uganda Cares, UNICEF are funding this activity.
Print and disseminate HMIS tools, HTC guidelines, SOPs and IEC materials	Printing and dissemination of HTC tools, SOPs and other implementation materials to sites will be transitioned to government	$0	$0		Transition already happened	PEPFAR has provided one-off printing of HMIS tools in FY 15. Government and/or other stakeholders will assume this role effective October 2015.
Totals						

Table A.3 OVC Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
OVC Case Management	N/A	$ 0	$0	N/A		N/A
OVC Healthy (Access to Health/ HIV Services) • Providing household supplies • Providing food packages	Transitioned to local government and informal structure Phased out	$ 0	$0		September 2014	
OVC Safe (Protection & PPS) • Dissemination of child protection laws	• Transition to UNICEF	$ 0	$ 0	1	June 2015	
OVC Stable (HES, Social Protection) • Providing Housing	• Transitioning to community					

• Direct funding of IGAs • Establishing/ Support business cooperatives	• structures • Phasing out • Transition to local government	$0	$ 0	3	September 2015	Community structures, mobilize the community to build housing for the family in emergency need of shelter	
				3	September 2015	All OVC households in the program in VSLA groups	
				1	September 2015	Farmer groups already registered at district level to access other government programs	
Schooled (Education) Supporting tertiary education	Phased Out			1	September 2014	All OVC caregivers in the program joined VSLA groups. They are sensitized to prioritize education of their children.	
		$0	$0				
Totals							

Table A.3 SI Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
Research and evaluation activities that do not contribute to planning and program improvement						
Development of the innovations					Ended	This development of the fingerprint and SMS modules of the Electronic Medical Record under Walter Reed was funded in COP 14 and completed in March 2015. No further development envisaged.
Totals						

Table A.3 PMTCT Transition Plans for Non-core Activities						
Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
Cervical cancer and breast cancer screening in eMTCT settings	GOU	$0	$0		Sept 2015	
Community mobilization and sensitization by political and cultural leaders for demand creation in Sustained districts	GOU, UNAIDS	$0	$0		Sept 2015	
Support the Office of the First Lady (OAFLA) to implement high level advocacy and mobilization for eMTCT Global Plan, as well as accelerated service delivery during the district campaigns	GOU, Possibly UN family	$0	$0		Sept 2015	
Totals						

Table A.3 Prevention Transition Plans for Non-core Activities						
Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
General Population Prevention		$0	$0			
Totals						

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$15,806,551	$337,581,821	$353,388,372

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$16,137,538
HVAB	Abstinence/Be Faithful Prevention	$1,145,137
HVOP	Other Sexual Prevention	$12,409,761
IDUP	Injecting and Non-Injecting Drug Use	$0
HMBL	Blood Safety	$1,007,420
HMIN	Injection Safety	$1,246,981
CIRC	Male Circumcision	$18,641,533
HVCT	Counseling and Testing	$14,939,345
HBHC	Adult Care and Support	$51,978,193
PDCS	Pediatric Care and Support	$12,780,671
HKID	Orphans and Vulnerable Children	$25,282,008

HTXS	Adult Treatment	$64,714,974
HTXD	ARV Drugs	$63,900,966
PDTX	Pediatric Treatment	$4,815,442
HVTB	TB/HIV Care	$8,065,991
HLAB	Lab	$8,579,864
HVSI	Strategic Information	$17,189,061
OHSS	Health Systems Strengthening	$12,420,204
HVMS	Management and Operations	$18,133,283
TOTAL		**$353,388,372**

B.2 Resource Projections

CLINICAL SERVICES: Adult and pediatric care and treatment, TB/HIV, and PMTCT

PEPFAR clinical services technical area (adult and pediatric care and treatment, HIV/TB, and PMTCT) costs were derived from the 2014 Expenditure Analysis (EA) and COP 12 unit costs, which had been based on the 2010 EA; costing studies, including DREAMS Malawi and the PEPFAR ART Costing Model (PACM); and the National Strategic Plan (2011/12 to 2014/15). The program area costs were a combination of per patient unit costs for a streamlined package of core clinical services, non-ART commodities, lab service costs, new investment in community support for adherence and retention, and costs to support HRH. Costs for each of these components were apportioned across HTXS, HBHC, PDTX, PDCS, HVTB, and MTCT budget codes based on COP Budget Code Guidance.

Core clinical services and operational costs

For COP 15, PEPFAR Uganda built per patient unit costs for six mutually exclusive groups of clients for which targets were available in the clinical care cascade: Adult ART, Adult pre-ART, Pediatric ART, Pregnant women, HIV+ pregnant and breastfeeding women, and HIV-exposed infants. Given that Uganda has a test-and-treat policy for all HIV-positive children <15 years, no targets or costs were apportioned for pediatric pre-ART. The clinical service unit cost includes services that PEPFAR supports across public, PNFP, and PFP sectors. Services for which unit costs were determined are listed in the table below.

Core clinical and operational cost categories
• Clinical care visits including clinical follow-up, job aids, education sessions, M&E, and site-level QI • Linkage and retention: expert clients/mentor mothers/linkage facilitators, SMS messaging, client tracking • Enhanced facility-based adherence counseling and support given increased ART initiation among KP/PPs and identification of clients

with unsuppressed VL.
- Training and mentorship for anticipated 2015 guidelines, VL scale-up, adolescent and KP/PP friendly services
- Implementation of the Option B+ M&E Framework
- Quarterly supportive supervision with district health management team using a QI approach
- Minor facility improvements and equipment/furniture necessary to support quality service provision
- Clinical services program management by the implementing partner

Costs were calculated for each of six groups of clients to obtain the core clinical service and operational unit costs found in the table below. Non-ART commodity, lab services, HRH, and community care and support costs are *not* included; methodology for calculating these components is described in subsequent sub-sections.

Client group	Core clinical service unit cost (excluding commodities, lab, HRH, community)
Adult ART	$71.22
Adult pre-ART	$45.19
Pediatric ART	$76.35
Pregnant women	$2.80
Pregnant and BF HIV+ women	$71.87
HIV-exposed infants	$68.37

Cost savings found through elimination of non-core clinical services were utilized to increase investments in linkage, retention, and adherence support, QI, and supportive supervision.

Non-ART commodity cost

Non-ART commodity costs necessary to support core care services and OI prophylaxis and treatment were budgeted outside of the per client unit cost based on the proportion of clients for whom PEPFAR is purchasing the commodities as detailed in the table below:

Commodity	Unit cost per client per year	Proportion of clients for whom PEPFAR is purchasing commodities
Cotrimoxazole	$8.40 (adult) $4.20 (child)	The 38% of clients attending PEPFAR-supported PNFP/PFPs
OI/STI treatment	$22	65% of clients attending PEPFAR-supported PNFP/PFPs
RUTF	$88	8% of all estimated HIV-positive malnourished clients
Masks for TB suspects	$0.40	20% of all HIV-positive clients in care

PEPFAR identified cost savings by leveraging other sources for components of the basic care kit (previously a $25 per new client and $15 per existing client cost) and providing more accurate targets for clients needing PEPFAR-funded OI/STI treatment and TB masks.

Lab service cost

Clinical lab service provision is coordinated and managed through 100 hubs running extensive sample transportation and result transmission network. PEPFAR based the cost of hub operation ($87,284 for each of 87 standard hubs and $113,469 for each of 13 regional referral hospital hubs) on the estimated number of samples processed (CD4, VL, EID, Crag, and GenXpert) plus oversight, sample transport, result return, training, and lab-related QA/QI to facilities in their catchment areas. Costs to support EID and VL operations at the central public health lab were also included in the clinical service budget. This year, additional funding was included to support scale-up of VL, roll out of the rapid test QI/EQA initiative, improving the sample transport system for TB sputum samples, and EQA for GenXpert. These costs were proportionately distributed across the clinical services budget codes.

HRH costs

The HRH budget of $10,133,876 will to support 1,740 positions within the medical officer, clinical officer, pharmacist, dispenser, nurse, midwife, laboratory technologist, laboratory technician, laboratory assistant, and biostatistician cadres. Of these, 819 positions ($5,639,727) are currently in post and 921 positions ($4,494,149) are new positions that will be recruited and allocated to sites in scale-up and Sustained Districts depending on vacancy rates, gap to saturation, and projected work load. The HRH costs were determined considering annual base salary, National Social Security Fund contributions, and IP M&O. Given the cross-cutting nature of HRH to all program elements, various budget codes contributed to the total and were allocated to the eight HRH IMs depending on the number and cadre of HCWs allocated to the districts they support.

Community care and support costs

September-December 2014 SIMS data showed that 78% of sites assessed lacked systems to track facility-community linkages in large part due to a gap in available community-based services to support adherence, retention, and quality of care. In order to address these gaps, PEPFAR Uganda has invested $12.70 per client in Scale-Up and Sustained Districts. These funds are intended to expand community support groups and services, provide intensive adherence support for KP/PPs, adolescents, and those failing first- or second-line ARVs, and strengthen community based client tracking systems. Funding came from savings found in eliminating non-core clinical services and more precise budgeting for commodities based on EA 14 and non-ART commodity targets.

Other activities to support clinical service delivery

PEPFAR budgeted for national-level core and near core activities outside of unit costs. These activities include support to the MoH (AIDS Control Program, National TB program, the Quality Assurance Department, and the private sector supervisory bodies) for program coordination and oversight, messaging focused on ART retention and adherence, a PMTCT effectiveness evaluation, TA for the Option B+ real-time monitoring system, and implementation of cohort monitoring to assess maternal ART retention and infant final outcomes.

Commodities (ARVs, lab reagents, CTX, OI/STI treatment, and VMMC)

PEPFAR developed the COP 15 commodity budget using a zero-based budgeting approach. Targets for each program area were derived from the care and treatment cascade with HTC and pre-ART as the entry points into care and treatment. Target program coverage was applied to this baseline; combined with the projected APR 15 achievements and the required HIV-positive case finding (yield), line-by-line commodity budgets were developed.

PEPFAR developed ART projections using the QuantiMed software, taking into consideration key factors including regimen mix/proportions, scale up, patient months on treatment, switch rates, and loss to follow up. For other commodities (VL, CD4, EID, CRAG, cotrimoxazole, PEPFAR applied the national standard of care guidelines to the target number of patients in care and treatment. For VMMC and STI/OI treatment/prophylaxis, program targets and epidemiological data were applied to arrive at the commodity requirements. All unit costs utilized to calculate budget estimates were based on multiple data sources including the GF price quality reporting mechanisms, SCMS pricing data, and current market prices from program procurement in COP 14. PEPFAR has allocated $11 million to the commodity budget to ensure sufficient commodities for VL monitoring and at least a 3-month national ART supply thereby mitigating the risk of stock outs.

Sexual Prevention and Other Prevention

The Prevention budget derives from COP 12 implementation expenditure costs, cost evaluation from South Africa, and the 2014 EA. PEPFAR Uganda will adopt modules from Stepping Stones and Community Conversation for community interventions. Only modules that address mobilization for HTC, stigma reduction, adherence or tracking, for example, will be implemented. The $21 unit cost is the cost per unit when all the 30 modules of the curriculum are implemented, and is derived from program evaluation of the Stepping Stones done in South Africa. PEPFAR will only implement aspects of the Stepping Stones and Community Conversation modules that lead to epidemic control in Uganda, hence the varying unit costs across different KP categories. For example, among discordant couples only half of the modules will be implemented at a unit cost of $14; only 10 modules will be implemented for the army and police at a unit cost of $7. For truckers, PEPFAR will support one knowledge room per year at key truck stops at a cost of $20,000 per room, which was derived from an IP's actual program cost for a similar activity. The knowledge rooms are mainly utilized for mobilization and other programs such as HTC and follow up will be funded from those program areas. The condom unit cost is the actual cost from last year's cost per unit. The $2 follow-up cost is estimated from COP 12 program data reported on the extra effort required to ensure effective follow up of KP/PPs. Other costs under condom distribution, gender analysis, and QA/QI are above-site interventions that support all program across the country and were based on previous program data and funding availability. AB is flat-funded.

Prevention Services Cost by Population and Activity			
Budget Line	**Target**	**Unit Cost ($)**	**Total Cost**
Sex workers	65,202	$21	
Fishing folks	250,000	$10.88	
Truck Stops	6	$20,000	
Discordant Couples	74,662	$14	
MSM	3,346	$21	
Police	30,000	$7	
Army	50,000	$7	
KPs follow-up	660,800	$2	
Condom procurement	36,000,000	$0.01	
Condom distribution and promotion			$1,500,000
Development of materials			$500,000
Gender analysis			$100,000
KP Linkage, retention Study			$100,000
QA/QI for prevention programming			$330,000
Coordination and support supervision and support to standardize prevention			$100,000
AB –In school, FBO			$1,000,000

APPENDIX C *[REDACTED]*

Uganda COP15 Targets by District: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Abim District	-	-	-	-	-
Adjumani District	32,225	430	2,844	596	2,673
Agago District	50,283	1,441	7,008	2,005	6,432
Alebtong District	24,096	637	3,998	872	3,663
Amolatar District	17,088	577	6,721	1,465	6,158
Amudat District	-	-	-	-	-
Amuria District	72,391	790	5,441	1,052	5,164
Amuru District	9,687	4	2,187	270	2,056
Apac District	33,954	910	10,080	2,198	9,236
Arua District	86,111	1,012	13,169	1,783	12,513
Budaka District	31,456	492	3,365	775	3,105
Bududa District	28,672	495	3,247	631	3,085
Bugiri District	75,289	1,033	7,058	1,638	6,504
Buhweju District	7,646	56	888	132	835
Buikwe District	48,074	1,160	13,681	2,040	12,953
Bukedea District	26,884	268	2,102	309	2,039
Bukomansimbi District	12,527	281	2,315	419	2,191
Bukwo District	14,804	276	951	303	893
Bulambuli District	18,110	364	2,279	425	2,190
Buliisa District	12,367	329	2,807	825	2,429
Bundibugyo District	38,402	453	3,263	699	3,035
Bushenyi District	33,143	1,014	15,743	2,334	14,812
Busia District	54,920	2,232	13,503	4,149	11,896
Butaleja District	41,054	549	3,126	876	2,827
Butambala District	27,604	920	3,940	992	3,761
Buvuma District	5,315	149	3,591	749	3,177
Buyende District	64,692	1,145	5,159	1,574	4,702
Dokolo District	14,411	39	5,057	1,103	4,633
Gomba District	39,621	2,148	4,887	2,285	4,506
Gulu District	29,863	1,069	25,379	3,322	23,861
Hoima District	135,771	4,756	17,702	5,900	16,239
Ibanda District	18,866	241	6,874	1,020	6,467
Iganga District	238,833	3,013	10,841	3,398	10,136
Isingiro District	32,170	938	9,986	2,446	8,936
Jinja District	69,478	2,393	21,271	3,756	20,037
Kaabong District	17,092	137	1,528	242	1,449
Kabale District	57,231	859	13,571	1,997	12,697
Kabarole District	142,272	4,708	28,412	5,730	26,933
Kaberamaido District	60,567	689	4,874	942	4,626
Kalangala District	27,284	2,542	21,629	7,514	17,936
Kaliro District	40,137	662	3,578	938	3,299
Kalungu District	24,634	1,045	7,276	1,318	6,889
Kampala District	517,323	25,483	139,811	32,881	131,300
Kamuli District	201,870	3,861	11,065	4,094	10,329
Kamwenge District	48,809	926	7,788	1,571	7,382
Kanungu District	22,723	257	7,337	1,088	6,903
Kapchorwa District	11,827	229	2,326	339	2,221
Kasese District	131,836	2,367	12,950	3,067	12,142
Katakwi District	53,108	654	4,527	875	4,296
Kayunga District	52,297	1,942	12,027	2,958	11,082
Kibaale District	181,156	8,900	21,142	9,579	19,334
Kiboga District	24,670	1,200	6,723	1,644	6,252
Kibuku District	27,395	412	2,256	587	2,079
Kiruhura District	22,182	262	7,964	1,181	7,493
Kiryandongo District	26,738	882	5,394	1,492	4,862
Kisoro District	18,276	184	3,211	473	3,005
Kitgum District	26,323	1,139	9,904	1,832	9,291
Koboko District	27,976	328	3,056	493	2,900
Kole District	20,382	612	4,918	1,072	4,506
Kotido District	8,293	451	1,587	613	1,478
Kumi District	44,736	369	4,348	653	4,107
Kween District	7,824	87	564	121	531
Kyankwanzi District	19,479	632	3,602	934	3,313
Kyegegwa District	59,306	1,940	7,306	2,233	6,825
Kyenjojo District	58,840	1,860	12,315	2,484	11,674
Lamwo District	8,876	253	3,961	489	3,725
Lira District	55,704	2,837	19,623	4,279	17,979
Luuka District	27,868	559	3,336	845	3,065

Uganda COP15 Targets by District: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Luwero District	23,549	1,119	10,979	1,938	10,403
Lwengo District	21,118	501	6,291	1,138	5,955
Lyantonde District	8,189	221	1,945	353	1,841
Manafwa District	53,350	778	3,635	973	3,398
Maracha District	22,865	164	1,262	216	1,207
Masaka District	32,386	1,336	13,187	2,385	12,483
Masindi District	46,144	1,929	9,872	2,577	9,170
Mayuge District	89,086	2,135	13,337	3,865	11,874
Mbale District	144,798	3,750	16,964	4,186	16,118
Mbarara District	56,903	3,182	34,269	5,166	32,241
Mitooma District	13,866	45	3,145	466	2,959
Mityana District	50,664	3,835	13,373	4,648	12,286
Moroto District	5,246	64	1,041	345	936
Moyo District	23,285	276	2,443	419	2,308
Mpigi District	42,816	2,515	11,773	3,446	10,810
Mubende District	236,198	9,458	23,147	10,370	21,321
Mukono District	107,877	6,472	22,520	8,246	20,513
Nakapiripirit District	-	-	-	-	-
Nakaseke District	35,334	1,314	5,839	1,661	5,421
Nakasongola District	23,439	788	3,714	1,396	3,317
Namayingo District	82,244	2,370	12,859	4,237	11,260
Namutumba District	51,676	838	3,783	1,019	3,560
Napak District	-	-	-	-	-
Nebbi District	227,605	4,550	11,238	4,691	10,454
Ngora District	39,647	396	2,491	482	2,364
Ntoroko District	9,951	187	1,563	315	1,482
Ntungamo District	44,999	1,035	10,628	1,576	9,999
Nwoya District	7,992	208	3,443	425	3,237
Otuke District	11,009	416	3,108	678	2,848
Oyam District	107,047	3,692	12,771	4,440	11,746
Pader District	9,669	58	4,624	587	4,347
Pallisa District	56,197	795	4,719	1,156	4,361
Rakai District	55,708	2,809	21,357	3,865	20,217
Rubirizi District	8,255	71	1,741	258	1,638
Rukungiri District	34,414	1,195	14,375	2,132	13,524
Sembabule District	17,287	519	5,004	906	4,737
Serere District	33,288	550	4,776	923	4,533
Sheema District	18,177	781	8,509	1,262	8,006
Sironko District	29,406	434	3,798	750	3,530
Soroti District	92,703	1,716	10,230	1,978	9,710
Tororo District	61,672	1,077	15,097	1,659	14,548
Wakiso District	268,411	13,239	68,065	16,375	64,125
Yumbe District	35,328	160	2,609	293	2,502
Zombo District	36,801	738	3,833	965	3,574
Total	**5,897,440**	**178,598**	**1,069,729**	**253,665**	**995,910**

Uganda COP15 Targets by District: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Abim District	-	-	-
Adjumani District	14,147	-	-
Agago District	18,689	-	-
Alebtong District	7,356	-	2,673
Amolatar District	6,908	-	500
Amudat District	-	-	-
Amuria District	35,969	-	2,409
Amuru District	1,662	-	2,569
Apac District	11,413	-	-
Arua District	36,697	571	865
Budaka District	10,362	-	4,308
Bududa District	9,151	-	5,196
Bugiri District	26,297	-	5,700
Buhweju District	1,182	-	4,524
Buikwe District	35,593	2,036	9,349
Bukedea District	11,825	-	3,148
Bukomansimbi District	3,681	-	2,151
Bukwo District	4,750	-	-
Bulambuli District	5,153	-	2,183
Buliisa District	3,918	-	-
Bundibugyo District	13,147	-	3,665
Bushenyi District	14,000	-	12,064
Busia District	22,307	3,700	5,494
Butaleja District	13,469	-	2,540
Butambala District	10,815	-	1,056
Buvuma District	5,394	682	4,671
Buyende District	22,319	-	5,888
Dokolo District	4,729	-	-
Gomba District	29,284	-	1,597
Gulu District	61,657	1,184	8,858
Hoima District	51,800	4,287	4,243
Ibanda District	6,677	-	778
Iganga District	89,970	-	5,787
Isingiro District	7,587	-	10,921
Jinja District	37,885	585	6,330
Kaabong District	7,341	-	-
Kabale District	22,058	-	4,398
Kabarole District	93,227	3,572	8,127
Kaberamaido District	30,439	-	2,391
Kalangala District	30,173	128	47
Kaliro District	13,002	-	-
Kalungu District	11,830	-	1,985
Kampala District	240,296	12,664	23,695
Kamuli District	75,100	-	5,157
Kamwenge District	16,245	-	10,687
Kanungu District	7,454	-	2,244
Kapchorwa District	3,882	-	-
Kasese District	47,493	5,422	17,269
Katakwi District	28,287	-	2,711
Kayunga District	19,280	-	4,902
Kibaale District	68,281	-	8,292
Kiboga District	9,429	-	-
Kibuku District	8,424	-	-
Kiruhura District	6,326	-	2,244
Kiryandongo District	7,733	-	-
Kisoro District	3,402	-	-
Kitgum District	10,781	-	3,739
Koboko District	12,426	-	-
Kole District	5,922	-	-
Kotido District	1,022	-	-
Kumi District	20,272	-	3,517
Kween District	1,610	-	-
Kyankwanzi District	5,179	-	-
Kyegegwa District	21,750	-	4,483
Kyenjojo District	21,561	-	12,559
Lamwo District	2,871	-	4,541
Lira District	72,300	927	4,995
Luuka District	7,958	-	2,432

Uganda COP15 Targets by District: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Luwero District	7,789	-	7,813
Lwengo District	6,886	-	1,752
Lyantonde District	2,483	270	1,039
Manafwa District	16,213	-	-
Maracha District	9,407	-	-
Masaka District	30,904	860	2,077
Masindi District	18,583	2,160	1,262
Mayuge District	32,242	-	3,486
Mbale District	58,744	5,884	-
Mbarara District	28,746	1,903	2,519
Mitooma District	3,501	-	2,016
Mityana District	23,225	2,160	6,887
Moroto District	2,436	-	-
Moyo District	10,777	-	-
Mpigi District	21,186	-	2,349
Mubende District	91,292	-	1,031
Mukono District	42,637	6,614	9,638
Nakapiripirit District	-	-	-
Nakaseke District	12,915	-	1,042
Nakasongola District	7,800	-	2,779
Namayingo District	33,226	-	1,436
Namutumba District	16,774	-	-
Napak District	-	-	-
Nebbi District	117,680	-	2,008
Ngora District	19,616	-	1,524
Ntoroko District	3,549	-	882
Ntungamo District	13,519	-	4,150
Nwoya District	2,427	-	3,578
Otuke District	3,776	-	5,086
Oyam District	41,049	-	-
Pader District	2,825	-	-
Pallisa District	17,803	-	-
Rakai District	22,412	-	5,046
Rubirizi District	1,681	-	2,213
Rukungiri District	16,900	-	13,207
Sembabule District	5,381	-	1,404
Serere District	14,516	-	3,633
Sheema District	7,688	-	4,001
Sironko District	9,132	-	2,064
Soroti District	42,767	411	3,312
Tororo District	24,059	6,059	2,745
Wakiso District	166,970	6,610	33,548
Yumbe District	11,392	-	-
Zombo District	16,078	-	-
Total	**2,608,133**	**68,689**	**385,409**

Uganda COP15 Targets by District: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Abim District	-	-
Adjumani District	10,395	274
Agago District	10,157	1,049
Alebtong District	10,061	760
Amolatar District	6,559	610
Amudat District	-	-
Amuria District	12,082	362
Amuru District	8,507	520
Apac District	16,466	1,389
Arua District	35,059	607
Budaka District	9,307	222
Bududa District	9,452	268
Bugiri District	17,417	403
Buhweju District	5,539	160
Buikwe District	19,487	1,584
Bukedea District	8,435	310
Bukomansimbi District	6,745	1,079
Bukwo District	3,985	128
Bulambuli District	7,917	380
Buliisa District	5,071	210
Bundibugyo District	10,008	264
Bushenyi District	10,521	857
Busia District	14,535	824
Butaleja District	10,978	151
Butambala District	4,486	543
Buvuma District	4,017	393
Buyende District	14,309	323
Dokolo District	8,152	833
Gomba District	7,149	976
Gulu District	19,654	3,140
Hoima District	25,624	1,684
Ibanda District	11,077	782
Iganga District	22,610	797
Isingiro District	21,973	1,355
Jinja District	20,815	1,613
Kaabong District	7,558	165
Kabale District	23,850	1,192
Kabarole District	21,174	2,461
Kaberamaido District	9,527	296
Kalangala District	2,385	772
Kaliro District	10,579	332
Kalungu District	8,221	832
Kampala District	67,535	7,603
Kamuli District	21,890	859
Kamwenge District	18,819	1,068
Kanungu District	11,255	816
Kapchorwa District	4,669	198
Kasese District	31,344	1,123
Katakwi District	7,392	291
Kayunga District	16,530	1,447
Kibaale District	33,806	2,164
Kiboga District	6,846	591
Kibuku District	9,048	192
Kiruhura District	14,669	1,089
Kiryandongo District	11,975	541
Kisoro District	12,823	276
Kitgum District	9,109	1,209
Koboko District	9,294	199
Kole District	10,800	1,036
Kotido District	7,991	452
Kumi District	11,522	263
Kween District	4,270	72
Kyankwanzi District	9,558	517
Kyegegwa District	12,385	664
Kyenjojo District	18,926	1,410
Lamwo District	5,985	651
Lira District	18,330	2,303

Uganda COP15 Targets by District: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Luuka District	10,781	289
Luwero District	18,785	1,786
Lwengo District	12,299	1,027
Lyantonde District	4,223	553
Manafwa District	15,755	584
Maracha District	8,313	103
Masaka District	13,246	1,389
Masindi District	12,939	1,048
Mayuge District	21,394	962
Mbale District	22,002	1,136
Mbarara District	20,746	2,147
Mitooma District	8,283	648
Mityana District	14,792	2,151
Moroto District	4,319	166
Moyo District	6,139	134
Mpigi District	11,230	1,450
Mubende District	29,619	3,868
Mukono District	26,782	3,009
Nakapiripirit District	-	-
Nakaseke District	8,708	884
Nakasongola District	7,824	342
Namayingo District	9,967	632
Namutumba District	12,718	336
Napak District	-	-
Nebbi District	17,200	732
Ngora District	6,362	149
Ntoroko District	2,966	232
Ntungamo District	21,848	1,187
Nwoya District	5,719	662
Otuke District	4,716	510
Oyam District	17,325	2,082
Pader District	7,956	756
Pallisa District	17,238	293
Rakai District	23,129	3,529
Rubirizi District	5,772	478
Rukungiri District	14,315	1,361
Sembabule District	11,297	1,428
Serere District	12,664	325
Sheema District	9,454	822
Sironko District	11,012	486
Soroti District	13,268	532
Tororo District	22,699	1,390
Wakiso District	88,225	10,122
Yumbe District	21,681	323
Zombo District	10,733	291
Total	**1,525,057**	**110,268**

Uganda COP15 Targets by District: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Abim District	-	-
Adjumani District	483	166
Agago District	488	168
Alebtong District	394	135
Amolatar District	517	177
Amudat District	-	-
Amuria District	213	73
Amuru District	517	178
Apac District	587	202
Arua District	420	145
Budaka District	137	47
Bududa District	207	71
Bugiri District	346	119
Buhweju District	190	65
Buikwe District	512	174
Bukedea District	113	39
Bukomansimbi District	278	96
Bukwo District	282	97
Bulambuli District	291	100
Buliisa District	229	79
Bundibugyo District	604	208
Bushenyi District	639	220
Busia District	378	130
Butaleja District	223	77
Butambala District	563	194
Buvuma District	188	65
Buyende District	107	37
Dokolo District	578	199
Gomba District	250	86
Gulu District	1,370	472
Hoima District	620	214
Ibanda District	621	213
Iganga District	322	111
Isingiro District	263	90
Jinja District	1,051	358
Kaabong District	336	116
Kabale District	336	115
Kabarole District	628	217
Kaberamaido District	265	91
Kalangala District	1,669	574
Kaliro District	235	81
Kalungu District	748	257
Kampala District	1,751	602
Kamuli District	214	73
Kamwenge District	307	106
Kanungu District	502	173
Kapchorwa District	450	155
Kasese District	351	121
Katakwi District	229	79
Kayunga District	326	112
Kibaale District	361	126
Kiboga District	575	198
Kibuku District	110	38
Kiruhura District	389	134
Kiryandongo District	279	96
Kisoro District	422	146
Kitgum District	1,066	366
Koboko District	333	115
Kole District	407	140
Kotido District	332	114
Kumi District	137	47
Kween District	78	27
Kyankwanzi District	237	81
Kyegegwa District	316	109
Kyenjojo District	274	94
Lamwo District	320	110
Lira District	815	279
Luuka District	196	68

Uganda COP15 Targets by District: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Luwero District	512	176
Lwengo District	338	116
Lyantonde District	581	199
Manafwa District	197	68
Maracha District	237	81
Masaka District	1,700	583
Masindi District	303	104
Mayuge District	323	111
Mbale District	646	221
Mbarara District	808	279
Mitooma District	220	76
Mityana District	722	250
Moroto District	542	187
Moyo District	528	182
Mpigi District	612	211
Mubende District	305	105
Mukono District	325	112
Nakapiripirit District	-	-
Nakaseke District	285	98
Nakasongola District	163	56
Namayingo District	280	96
Namutumba District	258	87
Napak District	-	-
Nebbi District	563	194
Ngora District	118	41
Ntoroko District	198	68
Ntungamo District	320	110
Nwoya District	396	136
Otuke District	606	208
Oyam District	670	230
Pader District	428	147
Pallisa District	162	56
Rakai District	519	178
Rubirizi District	201	69
Rukungiri District	462	158
Sembabule District	358	123
Serere District	179	62
Sheema District	481	167
Sironko District	296	102
Soroti District	567	196
Tororo District	494	170
Wakiso District	256	89
Yumbe District	85	29
Zombo District	232	80
Total	**46,451**	**15,976**

Uganda COP15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Abim District	-
Adjumani District	-
Agago District	3,570
Alebtong District	-
Amolatar District	-
Amudat District	-
Amuria District	-
Amuru District	-
Apac District	-
Arua District	-
Budaka District	-
Bududa District	-
Bugiri District	3,000
Buhweju District	-
Buikwe District	-
Bukedea District	-
Bukomansimbi District	2,340
Bukwo District	-
Bulambuli District	-
Buliisa District	8,129
Bundibugyo District	-
Bushenyi District	1,850
Busia District	-
Butaleja District	-
Butambala District	1,743
Buvuma District	1,209
Buyende District	-
Dokolo District	2,708
Gomba District	2,174
Gulu District	4,645
Hoima District	4,884
Ibanda District	3,412
Iganga District	-
Isingiro District	-
Jinja District	5,647
Kaabong District	-
Kabale District	-
Kabarole District	3,452
Kaberamaido District	-
Kalangala District	-
Kaliro District	-
Kalungu District	1,465
Kampala District	7,809
Kamuli District	-
Kamwenge District	8,057
Kanungu District	3,436
Kapchorwa District	-
Kasese District	1,536
Katakwi District	3,117
Kayunga District	4,389
Kibaale District	10,804
Kiboga District	1,256
Kibuku District	-
Kiruhura District	5,121
Kiryandongo District	-
Kisoro District	-
Kitgum District	2,000
Koboko District	-
Kole District	2,830
Kotido District	-
Kumi District	-
Kween District	-
Kyankwanzi District	-
Kyegegwa District	-
Kyenjojo District	7,508
Lamwo District	1,828
Lira District	5,689

Uganda COP15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Luuka District	-
Luwero District	3,774
Lwengo District	-
Lyantonde District	534
Manafwa District	-
Maracha District	-
Masaka District	4,381
Masindi District	4,036
Mayuge District	-
Mbale District	-
Mbarara District	6,851
Mitooma District	1,716
Mityana District	2,571
Moroto District	1,000
Moyo District	-
Mpigi District	5,474
Mubende District	7,393
Mukono District	7,291
Nakapiripirit District	-
Nakaseke District	1,677
Nakasongola District	6,795
Namayingo District	-
Namutumba District	1,500
Napak District	-
Nebbi District	4,282
Ngora District	-
Ntoroko District	544
Ntungamo District	-
Nwoya District	2,599
Otuke District	1,479
Oyam District	3,571
Pader District	-
Pallisa District	-
Rakai District	4,076
Rubirizi District	1,297
Rukungiri District	4,183
Sembabule District	3,872
Serere District	-
Sheema District	1,825
Sironko District	5,578
Soroti District	5,601
Tororo District	-
Wakiso District	20,199
Yumbe District	-
Zombo District	-
Total	**229,707**