Uganda

Country Operational Plan

COP20

Strategic Direction Summary

April 1, 2020

Table of Contents

List of Acronyms 3

Table of Figures 5

1.0 Goal Statement 7

2.0 Epidemic, Response, and Program Context 11

2.1 Summary statistics, disease burden and country profile 11

2.2 New Activities and Areas of Focus for COP20, Including Client Retention 23

2.3. Investment Profile 26

2.4 National Sustainability Profile Update 29

2.5 Alignment of PEPFAR investments geographically to disease burden 31

2.6 Stakeholder Engagement 32

3.0 Geographic and Population Prioritization 39

4.0 Client-Centered Program Activities for Epidemic Control 39

4.1 – 4.4 COP20 Programmatic Priorities for Epidemic Control 39

4.2 Retaining clients on treatment and ensuring viral suppression 48

4.3 Prevention, specifically detailing programs for priority programming: 55

4.4 Additional country-specific priorities listed in the planning level letter 79

4.5 Commodities 79

4.6 Collaboration, Integration and Monitoring 82

4.7 Targets by population 86

4.8 Cervical Cancer Program Plans 93

4.9 VL and EID Optimization 93

5.0 Program Support Necessary to Achieve Sustained Epidemic Control 96

6.0 USG Operations and Staffing Plan to Achieve Stated Goals 112

APPENDIX A — PRIORITIZATION REQUIRED 115

APPENDIX B — Budget Profile and Resource Projections 138

APPENDIX C —Tables and Systems Investments for Section 6.0 141

APPENDIX D — Minimum Program Requirements 144

APPENDIX E — Summary Actions/Progress by PEPFAR UGANDA in Meeting the Minimum Country Specific Program Requirements 147

APPENDIX F — The People's Voice Uganda and the Community Priorities 148

APPENDIX G — PEPFAR/Uganda OVC Programming 158

List of Acronyms

ACP	AIDS Control Program
AGYW	Adolescent girls and young women
ANC4	Antenatal clinic—4 Visits
APN	Assisted partner notification
ART	Anti-Retroviral Therapy
CBO	Community Based Organization
CCLAD	Community Client Led ARV Distribution
CCM	Global Fund Country Coordinating Mechanism
CHC	Communication for Healthy Communities
CDDP	Community Drug Distribution Point
C/ALHIV	Children and adolescents living with HIV
CLM	Community-led monitoring
COE	Centers of Excellence
CPHL	Central Public Health Laboratory
CSO	Civil society organizations
DHIS2	District Health Information System 2.0
DHT	District Health Teams
DQA	Data quality assessment
DR	Drug resistance
DRC	Democratic Republic of Congo
DSDM	Differentiated service delivery model
DTG	Dolutegravir
ECP	Emergency contraception
EID	Early infant diagnosis
EMR	Electronic medical records
EPI	Extended Program on Immunization
EQA	External quality assurance
ERP	Enterprise resource planning
FBO	Faith-based organizations
FCI	Faith and Community Initiative
FF	Fisher folk
FSW	Female sex workers
GBV	Gender-based violence
GDP	Gross Domestic Product
GF	Global Fund
GNI	Gross National Income
GOU	Government of Uganda
GSD	Gender and sexual diversity
G2G	Government-to-Government awards

HEI	HIV-exposed infants
HIS	Health Information System
HMIS	Health Management Information System
HRH	Human resources for health
HTC	HIV testing and counselling
HTS	HIV testing services
IP	Implementing partner
IRIS	Immune Reconstitution Inflammatory Syndrome
KP	Key populations
LPV/r	lopinavir/ritonavir pellets
LTFU	ART clients lost to follow up
MAT	Medically assisted treatment
M&E	Monitoring and evaluation
MBCP	Mother-baby care points
MC	Male circumcision
MGLSD	Ministry of Gender, Labour and Social Development
MMD	Multi-month dispensing (of ARVs and TB meds)
MNCH	Maternal, neonatal and child health
MOES	Ministry of Education and Sports
MOFPED	Ministry of Financing, Planning and Economic Development
MOH	Ministry of Health
MOLG	Ministry of Local Government
MOPS	Ministry of Public Service
MPR	Minimum Program Requirements under COP 2020
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
MUJHU	Makerere University-Johns Hopkins University
MUSPH	Makerere University School of Public Health
NASA	National AIDS Spending Assessments
NDA	National Drug Authority
NGO	Non-governmental organizations
NMS	National Medical Stores
NTLP	National TB and Leprosy Program
OOP	out-of-pocket expenditure
OPD	Outpatient department
OPM	Office of the Prime Minister
OVCMIS	OVC Management Information System
PBFW	Pregnant and/or Breas-feeding women
PITC	Provider-initiated testing and counseling
PLHIV	People living with HIV/AIDS
PLL	Planning Level Letters
PMTCT	Preventing mother-to-child transmission
PNFP	Private Not For Profit organization
PP	Priority populations
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
QA	Quality assurance

QI	Quality improvement
QPPU	Quantification Procurement Planning Unit
RCA	Root cause analyses
RPM	PEPFAR Regional Planning Meeting
RRH	Regional referral hospital
RTK	Rapid test kits
RTT	New treatment indicator - "return to treatment"
SBCC	Social and behavior change communication
SDG	Sustainable Development Goals
SID	Sustainability Index Dashboard
SIMS	Site Improvement through Monitoring System
SNU	Sub-national unit
SOP	Standard Operating Procedures
SRH	Sexual and reproductive health
STI	Sexually-transmitted infection
TB	Tuberculosis
3HP for TB	Once-weekly isoniazid-rifapentine for 12 weeks (3HP)
TGW	Transgender women
TLD	Tenofovir-lamivudine-dolutegravir
TPT	TB preventive therapy
TT	Tetanus toxoid
TWG	Technical working group
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UDTS	Uganda DREAMS Tracking System
UPHIA	Uganda Population-Based HIV Impact Assessment
U=U	"Undetectable = Untransmittable"
VACS	Violence Against Children Survey
VL	Viral load
VMMC	Voluntary medical male circumcision
WAOS	Web-Based ARV Ordering and Reporting System
WLHIV	Women living with HIV (target population for cervical cancer screening)
WRAIR	Department of Defense (DoD) Walter Reed Army Institute of Research
YAPS	Young People and Adolescent Peer Support model to scale up peer led index testing and APN for sexually-active adolescents

Table of Figures

HIV Population Pyramid and ART Coverage Gap by Age and Sex, FY20Q1 12
Uganda Gross National Income per Capita (US $) 15
Updated National and PEPFAR Trend for Individuals currently on Treatment 21

Updated Trend of New infections an All-Cause Mortality Among PLHIV - Updated 21
Spectrum Estimates for the period of 1990 to 2019 22
DREAMS data quality improvement example 25
Sustainability Domains and Elements ..... **Error! Bookmark not defined.**
PLHIV Treatment Coverage and Viral Load Coverage 32
Who is missing, finding them and getting them on treatment 39
Pediatric cascage gaps - children under 15 years 42
National Framework to Improve Retention 49
Moving toward a more well-coordinated and integrated OVC clinical interface 51
Monitoring the quality of GBV service delivery, FY19 58
AGYW Geography of Implementation 61
DREAMS Layering Table 62
MBCP service delivery approach ..... **Error! Bookmark not defined.**
Integrating DREAMS Interventions within PMTCT/MCH Platforms at Facility and Community Level 67
COP19 and COP20 KP Districts 68
PrEP targets, districts and sites 74
PReP Cascade for all Key Populations FY19 ..... **Error! Bookmark not defined.**
Investments in ARVs and commodities ..... **Error! Bookmark not defined.**
COP20 Scale Up of Regional Support Supervision Platforms 98
Linking Facilities for Patient Level Data for Epidemic Control 103

1.0 Goal Statement

The 2020 PEPFAR Country Operational Plan (COP20) for Uganda will make major tactical shifts to further Uganda's significant progress towards meeting Sustainable Development Goal (SDG) 3.3 by 2030 to end HIV as a public health threat, including:

- Shifting significantly from reaching epidemic control to sustaining epidemic control: PEPFAR Uganda will maintain the COP19 cohort on treatment (ambitious target of 98% retention) and will focus active case-finding to the index modality, especially where recency hotspots are identified
- Expanding client-centered approaches to care in order to address barriers to adherence and retention
- Launching community-led monitoring (CLM) as a routine part of program review, planning, and oversight
- Introduction of once-weekly isoniazid-rifapentine for 12 weeks (3HP) for tuberculosis (TB) preventive therapy
- Expanding pre-exposure prophylaxis (PrEP), especially among adolescent girls and young women (AGYW)
- Strengthening the DREAMS (Determined, Resilient, Empowered, AIDS Free, Mentored, and Safe) program to reduce HIV incidence among AGYW and expanding the program to four new districts
- Reintroducing PEPFAR-supported cervical cancer screening to decrease HIV-related mortality
- Discontinuing conventional surgical circumcision in the 10-14-year age group and focusing on the 15+ age group
- Intensifying programming in ten northeastern districts to close the clinical cascade gaps in testing, treatment, and retention
- Ensuring a six-month buffer of antiretroviral (ARV) medicines for the first time in the history of the response

Under COP19 (the current implementation year), PEPFAR Uganda has already adopted multiple strategies to address programmatic gaps identified by the Office of the Global AIDS Coordinator (OGAC) in its January 2020 Planning Level Letters (PLL). These strategies and other promising approaches will be refined and intensified in the COP20 implementation period.

PEPFAR Uganda will execute a highly ambitious and targeted program under COP20, prioritizing retention of clients on ARV treatment through high-quality, client-centered service delivery. Using advanced targeted strategies to reduce the number of HIV tests conducted while increasing efficiency and testing yield, our team will enhance case identification, particularly for pediatrics, adolescents, and men. Approaches proven to be effective in the Ugandan context will strengthen linkage to care and treatment services, improve retention, and ultimately achieve viral suppression. PEPFAR Uganda's program will remain nimble to improve performance, using site- and location-specific data (particularly from recency testing and UPHIA 2020) to identify areas for activity performance improvement critical to attainment of our targets and objectives. COP20 will target the most underserved age and sex bands while preventing HIV transmission among the most vulnerable populations.

PEPFAR's global 2017-2020 *Strategy for Accelerating HIV Epidemic Control* sets a bold course for achieving epidemic control.[1] Uganda's COP20 priorities reflect this Strategy and the PEPFAR 2020 County Operational Plan guidance. Our COP20 objectives fully align with and will contribute strongly to achieving the goals of Uganda's National AIDS Control Program and President Museveni's *The Presidential Fast-track Initiative on Ending HIV&AIDS in Uganda by 2030,* decreasing HIV infections and HIV-related deaths, and achieving epidemic control by 2030 in line with the UNAIDS 90-90-90 and Uganda's national 95-95-95 goals across sex and age bands. PEPFAR Uganda collaborates with the Government of Uganda (GOU) through the Uganda AIDS Commission (UAC); the Ministry of Health (MOH); Ministry of Gender, Labor & Social Development (MOGLSD); Ministry of Education and Sports (MOES); Ministry of Finance, Planning and Economic Development (MOFPED); and other key line ministries to increase national program impact by ensuring that all national HIV-related policies and circulars are known and implemented at site and community levels and that barriers to accessing services by the most vulnerable are minimized.

How will PEPFAR Uganda's COP20 strategic directions translate into targets?
Summary statistics and a full discussion of Uganda's HIV epidemic and disease burden trends are provided in Section 2.0. In brief, PEPFAR Uganda's overarching COP20 goal is to have initiated and retained 1,326,797 persons living with HIV (PLHIV) on treatment through September 30, 2021, and beyond. This represents 93% of the estimated 1,431,553 Ugandans living with HIV. PEPFAR Uganda will strive for 95% linkage of newly identified PLHIV and 98% retention in care and treatment. Intensive retention efforts are currently underway. Our goals for COP20 will be accomplished through the priority strategies and interventions described here, including reaching and treating additional PLHIV through focused scale-up in ten northeast "Ambition Fund" districts and retaining these new enrollees through the end of FY20 and beyond, which will reduce the number of annual incident cases of HIV to less than the number of deaths of PLHIV, bringing Uganda to epidemic control.

Under COP20, PEPFAR Uganda's path to epidemic control will:
- Prioritize retention of PLHIV in care and treatment by building on proven and promising platforms and initiatives
- Find and retain men through scale-up of MenStar approaches (e.g., male-focused messaging, innovations in technology, community-based differentiated service delivery)
- Close clinical cascade gaps among children and adolescents living with HIV (C/ALHIV) to improve treatment outcomes and assure retention and viral load (VL) suppression
- Refocus the PEPFAR-supported Key Populations (KP) program to expand safe spaces, increase reach, and improve quality and outcomes of services for Key & Priority Populations

In addition, PEPFAR Uganda will:

- Support independent community monitoring and community linkages to assure robust advocacy and "watchdogging"
- Simultaneously reduce the number of HIV tests conducted and increase case-finding effectiveness
- Expand community-based differentiated service delivery

[1] PEPFAR. *Strategy for Accelerating HIV Epidemic Control, 2017-2020.* (Washington, D.C.: Department of State, 2017).

- Intensify efforts in Point-of-Care Early Infant Diagnosis (EID) while maximizing and optimizing testing platforms
- Refine geographic targeting using recency assays to pinpoint hotspots of ongoing transmission
- Foster collaboration with faith networks and community-based organizations (CBOs) to test, link, and retain men and boys on treatment
- Enhance programming depth and breadth for AGYW
- Fully scale up health information systems (HIS) including client registry, taking electronic medical records and unique identifier systems to scale
- Continue engaging and expanding support for activities with indigenous Ugandan partners, including faith communities and faith-based organizations (FBOs), private not-for-profit (PNFP) organizations, CBOs, GOU, and parastatal and KP-led networks
- Continue partnering with GOU for quality improvement (QI) and client-centered services, including safe and confidential HIV testing services
- Continue efforts for sustainability by reinforcing GOU leadership for managing and financing the national HIV response

GOU Engagement

Strong GOU engagement was demonstrated in COP19 with an increase in public funding for ARV medicines to approximately $39 million, incremental absorption of human resources across national and district levels, and rapid adoption and dissemination of policies and guidance. This engagement continues in COP20. On Day One of the March 2-6, 2020 COP20 in-person planning meetings, Uganda's Minister of Health Honorable Dr. Jane Ruth Aceng and the Deputy Secretary for Treasury Mr. Patrick Ocailap announced four major GOU commitments for COP20:

- Formalize a cadre of community health workers
- Increase financing to ~$52 million for HIV commodities and human resources for health (HRH) in FY21, incrementally increasing this amount annually
- Expedite US FDA approval to optimize ARV procurement through the local manufacturer Quality Chemicals
- Certify and roll out the National E-Health Policy, together with MOH and MOFPED, allowing expansion of approaches to uniquely identify patients and reducing challenges with data quality and patient retention and "loss to follow up"

These commitments have been greatly desired by HIV stakeholders in Uganda. Taken together, these constitute a significant step towards greater GOU financing of the country's HIV response. Each will lead to fundamental improvements in the operational context and will accelerate the pace at which Uganda will reach epidemic control.

Approaches for Sustainability

Internally, the USG is streamlining implementation approaches, anticipating a post-epidemic-control scenario where resources will likely decline. To that end, under COP19, PEPFAR Uganda designed a series of new multi-year project activities that have been or are soon to be awarded to indigenous GOU entities and non-governmental organizations (NGOs) including FBOs and vendors. The new awards include Government-to-Government (G2G) arrangements to provide direct service delivery and to work directly with select Regional Referral Hospitals (RRH) towards quality assurance and strong program delivery at district level and below. By the end of COP20, 70% of PEPFAR funds will be channeled through local institutions to strengthen their capacity

while ensuring local ownership and sustainability. PEPFAR continues to engage with GOU to advocate for increased domestic resources for HIV commodities. In COP20, two areas of the PEPFAR Uganda portfolio will begin phased transition to management by USAID/Uganda—procurement of HIV commodities and the orphans and vulnerable children (OVC) platform. These shifts will lay the foundations for further transitions to GOU and other local partners over the next five to ten years. See summary Appendix F for the PEPFAR/Uganda OVC Programming (FY20-FY24 Transition Roadmap Overview).

Achieving epidemic control by 2020 requires prioritizing investments. COP19 will balance resources strategically between support of public sector health facilities and systems, as well as continuing to work with the PNFP health sector to deliver HIV services. The Ugandan public health sector accounts for roughly 75-80% of new PLHIV initiating ART, whereas the PNFP sector currently provides 20-25% of comprehensive HIV/AIDS services in the country. Direct awards to local Ugandan implementing partners under COP19 will enhance HIV service delivery by the PNFP sector.

The PEPFAR Uganda program is a team effort. “Team Uganda” comprises GOU counterparts, the USG including five PEPFAR implementing agencies, the Global Fund (GF) bi- and multi-lateral development partners, and many different civil society groups, each of which collectively engage with PEPFAR regularly to track progress and solve problems. COP20 is a product of substantial USG dialogue and partnership with the full array of Uganda's HIV sector stakeholders. This year PEPFAR Uganda closed gaps in technical programming through a series of “Technical Consultations,” harmonized programming for the next three years through active involvement in GF grants writing and planning sessions, and gained consensus with civil society well in advance of RPM on a number of pressing issues. To that end, PEPFAR Uganda concurs with the *Uganda People’s COP20 Principles,* as discussed in Section 2.6.

Further information on new activities under COP20 may be found in Section 2.2.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

In 2020, Uganda has a population of 42.3 million.[2] Uganda's annual population growth is 3.3 percent and its total fertility rate is 5.4, making it the third fastest-growing population in the world.[3] Additionally, the population pyramid demonstrates that Uganda has a large "youth bulge" with 47 percent of the population under age 15 and 68 percent is under age 24.[4] According to the Uganda population HIV Impact Assessment (UPHIA) HIV prevalence in Uganda is 6.2%. Findings from UPHIA showed and annual incidence of HIV among adults 15-64 to be 0.4% with women having higher incidence rates (0.46% compared to men 0.36%. This incidence rate translates to approximately 73,000 new cases of HIV anually in 2016-2017 among adults in Uganda. Although women have higher HIV prevalence and incidence compared to men, the proportion of women who are under care are much higher compared to men as shown by the HIV population pyramid, ART coverage gap by sex and age. Whereus the older population aged 50+ in both sex have a high treatment gap and women showing treament gaps in the younger age group 15-24, the male population have treatment gaps in all age groups but particularly in the older males aged 20 years and above. Key strategies have been put in place to address these gaps focusing on primary interventions to engage men in managing their own health: through developing and disseminating messages men can identify with; digitalized solutions for communicating messages, appointment reminders, and improving treatment literacy and establishing additional community based differentiated service delivery options, particularly for fishing communities.

Uganda is implementing UPHIA 2020, that will determine the progress towards the achievement of the UNAID global targets. Uganda has made tremendous progress in the fight against HIV; notably since 2010 there has been a decrease in new HIV Infections by 43% and AIDS-related deaths by 58%. Uganda is on course to the achievement of the 95-95-95 UNAIDS global goals by 2020, as of January 2020 89% of the people living with HIV (PLHIV) had been diagnosed of whom 89% are on treatment and 70% of these are virally suppressed. The latest spectrum projections indicate that in 2020, 1.43 million Ugandans are living with HIV, majority of whom are women. The goal of the program is to have 93% of these on ART by the end of FY2020, with the aim of achieving the global goal by end of FY21.

[2] UBOS. *Population Projections 2015-2020*. (Kampala: UBOS, 2014). http://www.ubos.org/onlinefiles/uploads/ubos/census_2014_regional_reports/Population percent20Projections_2015_2020.pdf (accessed 3/6/2018)

[3] UBOS. *Uganda Demographic and Health Survey 2016: Key Indicators Report*. (Kampala: UBOS, 2017). https://dhsprogram.com/pubs/pdf/PR80/PR80.pdf (accessed 3/6/2018)

[4] UBOS, 2014.

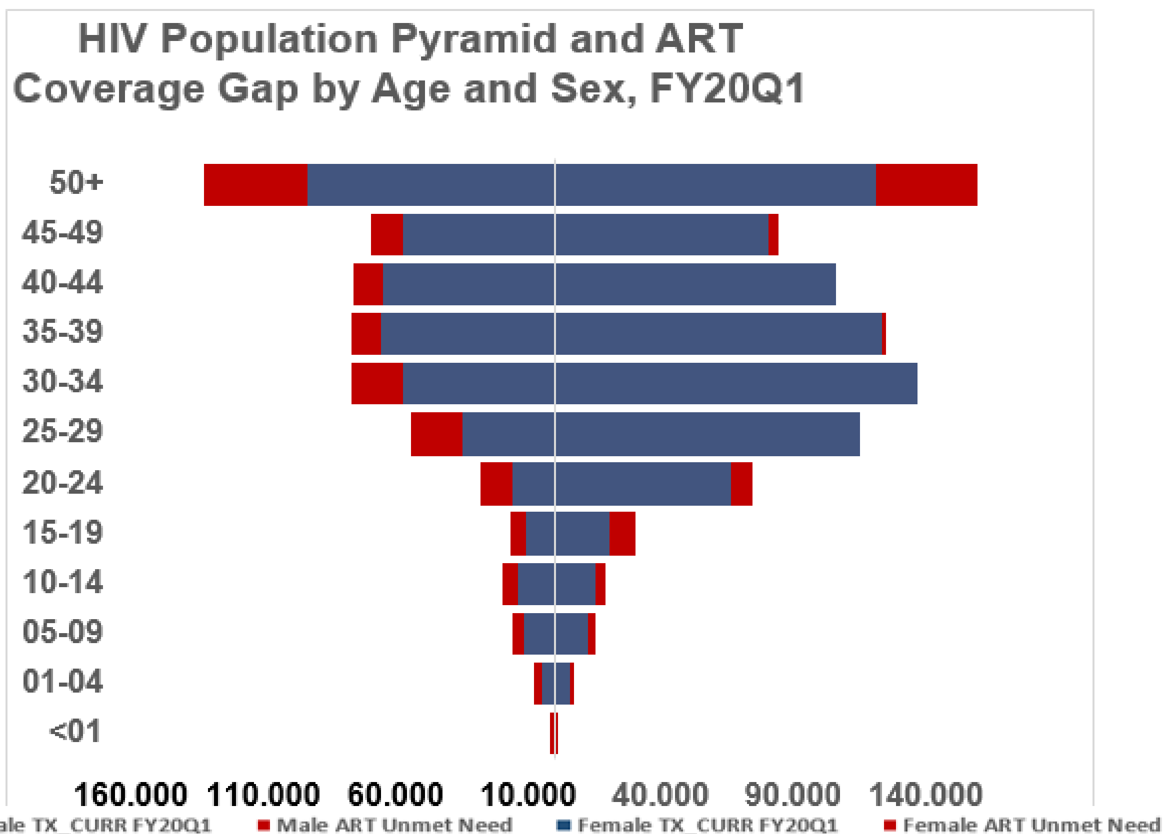


Figure 2.0.1 HIV Population Pyramid and ART Coverage Gap by Age and Sex, FY20Q1

Based on FY19 results, Uganda achieved most of her targets and outputs from FY20 Q1 indicate that the program is on course to achieve the set targets, however a few program areas are lagging behind. Although index testing is on course, the number of HIV positives identified through this testing modality was below the targeted number of positives, indicating a lower testing HIV yield than expected. HIV recency testing is below set targets mainly due to slow scale-up and HRH challenges at the facilities. Current services have been rolled out in the 184 high volume facilities out of 400, however by the end of FY20, all the 400 facilities will be in position to provide services. During FY20, training of trainers was conducted and the trainer are now training health workers at the facilities that provide these services, this will partially curb the HRH challenges being faced.

Progress has been made in the PMTCT program, the policy adopted in Uganda to initiate any HIV positive clients on treatment has facilitated the achievement of the PMTCT goal with HIV transmission from mother to child declining from over 5% in 2015 to 3.5% in 2019. Challenges remain on 2-month testing coverage among HIV exposed infants. Teams continuously track and monitor EID through the weekly surge dashboard to ensure that facilities are following up with mothers to bring their exposed children for HIV tests at 6 weeks. Additional challenge lies in the

suboptimal capacity HCII where mothers access care. This has been a significant structural barrier to eliminating MTCT. Strategies at various levels have been put in place to address this challenge.

Uganda has continued to achieve her VMMC targets over the years, currently the VMMC coverage stands at 62%. The higher fertility rate and the huge youth bulge in Uganda slows down the VMMC coverage despite high circumcision rates in Uganda. There have been challenges in achieving target in the pivot age 15-29. In this COP, the program will implement client-centered strategic approaches to improve uptake of VMMC among men aged 15-29 years through integration of VMMC services into other health services where feasible, use of incentives and the use of flexi VMMC services: provided at the convenience of clients.

Key population programming in Uganda has faced tremendous fall backs however there has been significant improvement in the political environment. The program has put in place KP tracking systems that ensures that KP tested and found HIV positive are initiated into treatment and followed up to ensure retention. Although there has been great improvement in ART coverage (83%) and VL suppression of KP clients initiated in care (91%), linking those identified positive into care has remained a challenge currently at only 47%. The program will work with CSOs to ensure that identified KPs are linked to care and are retained.

Implementation of key policies to address minimum program requirements as per COP20 Guidance

Uganda is on course to achieving all the minimum program requirements (MPR) as identified in the PLL. (See MPRs and new site level requirements in Appendix D). The few remaining MPRs include continued increase of resources for HIV from the host government; perception of ARV stock insecurity impacting the scale-up of the six-month multi-month dispensing (MMD), scale up of PrEP to additional individuals at risk, including AGYW, and the need for expanded use of unique patient identifiers. All these areas were discussed at the RPM and consensus gained on solutions.

- In FY21, GOU has committed to provide $52 million and accelerate the transition of PEPFAR-supported HRH to government.
- Commodity security continues to improve through aligned USG, GOU, and GF investments; for the first time ever, Uganda will hold a six-month ARV buffer throughout COP20. Three-month dispensing is occurring now with plans to scale up six-month MMD to eligible clients.
- Current government guidelines allow for AGYW and pregnant and breastfeeding women (PBFW to access PrEP, but these target populations are not accessing PrEP services for various reasons. In COP20, PEPFAR will build on existing PMTCT and DREAMS platforms to scale PrEP for these populations.
- The National E-Health policy is awaiting the final Certificate of Financial Compliance from MOFPED; thereafter, it is expected that the unique patient identifier program will be ready to expand during COP19 and to be implemented at scale in COP20. This approach, along with increased investment in the health information system (HIS) infrastructure, will allow

for a better understanding of the epidemic and how many individuals are on treatment, assuring improved linkage and retention in care.

In partnership with GOU, PEPFAR Uganda has committed to promoting quality and client-centered services to achieve and sustain epidemic control. In COP20, USG will aim to attain 97% of clients diagnosed, 92% of these on treatment and 86% virally suppressed. PEPFAR will address barriers that hinder patient access to care at both policy and individual levels. At the policy level, optimization of ART regimens, provision of client-centered service delivery models, and rapid incorporation of new evidence into HIV prevention, care, and treatment guidelines are key. Through the MOH Continuous Quality Improvement (CQI) program, PEPFAR will support the national system to take to scale intervention packages found to be effective, continuously review and refine interventions, and address quality issues in real-time. PEPFAR will also focus on addressing intrinsic barriers and client self-management, to increase access to HIV services and retain individuals in care. Service QI strategies will be integrated in national guidelines and job aids; robust collaboratives will continue to champion successes and address challenges to linkage, retention and suppression; teams will continue to carry out 'short-learning loops' and rapidly integrate best practices into programs. Several approaches to monitoring the quality of services will be used, including development and implementation of national dashboards accessible at all levels of the health systems, adapted SIMS/surge assessments to address unique facility challenges, and expansion of the Uganda CSO CLM program to be launched by June 2020.

Major programmatic and system gaps and barriers in achieving epidemic control (e.g., lost to follow-up, forecasted commodities shortfalls)

Though Uganda's GNI per capita growth fluctuated substantially in recent years, it tended to decrease through the 1999 - 2018 period, ending at 1.9 % in 2018. The GNI per capita for Uganda was UGX 1,396,752 in 2018 (The World Bank). Data showing the proportion of the GNI spent on HIV response and/or the health sector is not available. GNI per capita (formerly GNP per capita) is the gross national income, converted to U.S. dollars using the World Bank Atlas method, divided by the midyear population. GNI is the sum of value added by all resident producers plus any product taxes (less subsidies) not included in the valuation of output plus net receipts of primary income (compensation of employees and property income) from abroad.

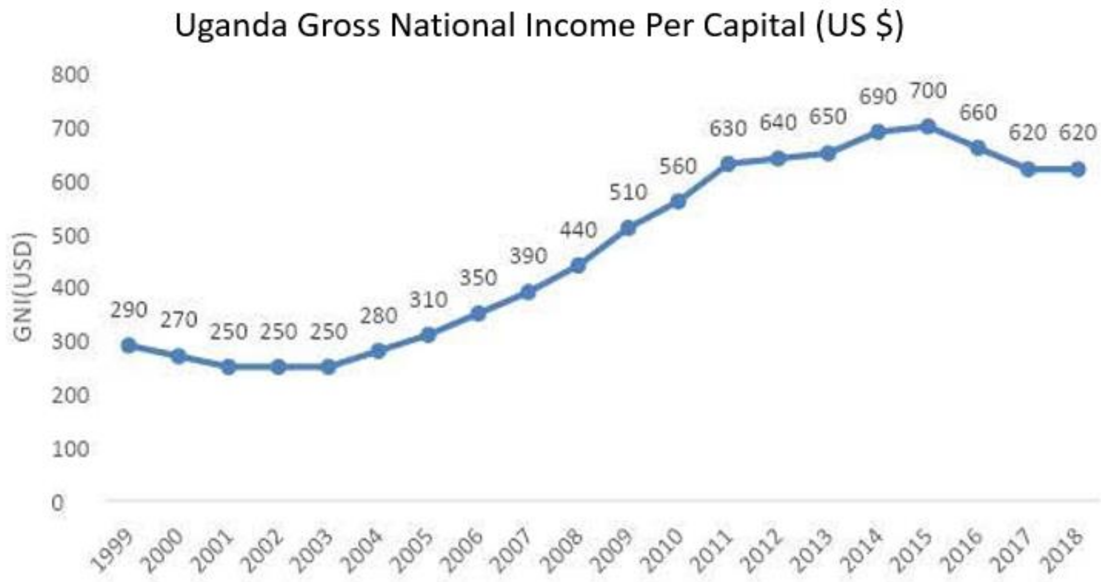


Figure 2.0.2 Uganda Gross National Income per Capita (US $)

Data Source: World Bank, Gross National Income for Uganda: https://www.macrotrends.net/countries/UGA/uganda/gni-per-capita'>Uganda GNI Per Capita 1984-2020. www.macrotrends.net. Retrieved 2020-03-16.

Table 2.1.1 Host Country Government Results

	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	42,259,429		9,561,662	23	9,736,159	23	4,473,836	11	4,475,116	11	7,402,106	18	6,610,550	16	Population projection for 2020 UBOS
HIV Prevalence (%)	*	6.2	*	0.7	*	0.4	*	3.3	*	0.8	*	10.7	*	7.7	UPHIA 2016
AIDS Deaths (per year)	19,186	*	2,031	*	2,118	*	1,363	*	1,019	*	5,120	*	7,536	*	Spectrum estimates 2020
# PLHIV	1,431,557	*	43,697	*	44,844	*	105,177	*	44,570	*	717,485	*	475,784	*	Spectrum estimates 2020
Incidence Rate (Year)	*	108/ 100,000 popn.	*	*	*	*	*	*	*	*	*	*	*	*	Spectrum estimates 2020
New Infections (Yr.)	43,436	*	*	*	*	*	*	*	*	*	*	*	*	*	Spectrum estimates 2020

Annual births	1,812,930														Applying birthrate of 42.9/1000 to UBOS estimated population of 42.3 million in 2020
% of Pregnant Women with at least One ANC Visit	97														Uganda Demographic and Health Survey 2016
Pregnant women needing ARVs	90,075														Spectrum Estimate 2020
Orphans (maternal, paternal, double) (*Data for ages 15-24 just reflect ages 15-17.)	2,635,721		1,062,256		1,156,137		205,526*		211,802*						Used UBOS population estimates for 2020, multiplied by UNICEF estimate of 11% children who are orphans
Notified TB cases (Yr.) **	67,874		4,125		4,508		3,812		3,942		17,794		33,693		Uganda MOH DHIS2: 2019:
% of TB cases that are HIV infected#	25,810	38%	991	24%	1,000	25%	9,967	46%	13,852	37%	NA	NA	NA	NA	Uganda MOH DHIS2: 2019
% of Males Circumcised	42.2														UPHIA Report 2017

Estimated Population Size of MSM*	44,288														UAC and UNAIDS; Key and Priority Population Size Estimation Numbers in Uganda Report 2019
MSM HIV Prevalence	13														UAC and UNAIDS; Key and Priority Population Size Estimation Numbers in Uganda Report 2019
Estimated Population Size of FSW	173,646														UAC and UNAIDS; Key and Priority Population Size Estimation Numbers in Uganda Report 2019
FSW HIV Prevalence	31														UAC and UNAIDS; Key and Priority Population Size Estimation Numbers in Uganda Report 2019
Estimated Population Size of PWID	7,174														UAC and UNAIDS; Key and Priority Population Size Estimation Numbers in Uganda Report 2019
PWID HIV Prevalence	16														UAC and UNAIDS; Key and Priority

															Population Size Estimation Numbers in Uganda Report 2019
Estimated Size of Fishing Community (All Ages) (Priority Populations)	1,611,769	*	*	*	*	*	*	*	*	*	*	*	*	*	Uganda Fisheries and Fish Conservation Association (UFFCA)
Fishing Community Prevalence (Adults)	14.9–35	*	*	*	*	*	*	*	*	*	*	*	*	*	HIV Knowledge, Attitudes, and Practices and Population Size Estimates of Fisherfolk in 6 Districts in Uganda. IOM 2013. https://www.iom.int/news/ugandan-fishing-communities-high-risk-hiv-aids-iom

Table 1 Host Country Government Results

**The available age disaggregated data for incident TB cases (that form 97% of total TB cases notified) was adjusted proportionately for retreatment cases and other data whose age disaggregation data was not available.

However, age disaggregation data is only available for the age groups < 15 Years and 15+. Data for Sub-disaggregation of 15-24 years and 25+ are not available. Therefore, the figures inserted under the 15 – 24 age categories are for cases aged 15+ years

* *There are currently no national data collection systems/sources of reliable data on the variable*

Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment, and viral suppression*												
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year				
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV-positive (#)	Initiated on ART (#)	Linkage to Treatment
Total population	42,259,429	3%	1,421,290	1,238,938	1,235,466	100%	79%	8,032,305	232,572	187,769	81%
Population <15 years	19,297,821	0.5%	93,901	64,904	64,843	100%	75%	606,960	7,263	7,869	108%
Men 15-24 years	4,475,116	1%	46,796	27,196	27,058	99%	58%	718,368	8,151	6,768	83%
Men 25+ years	6,610,550	7%	468,653	373,801	372,688	100%	77%	1,139,978	52,704	56,772	108%
Women 15-24 years	4,473,836	3%	112,082	88,054	87,306	99%	75%	1,421,502	36,513	35,947	98%
Women 25+ years	7,402,106	9%	699,858	684,983	683,571	100%	81%	1,592,796	64,374	70,675	110%
AGYW	4,575,863	3.3	114,052	*	*	*	*	172,971	1,634		
MSM	44,288	12.7	5,625	*	*	*	*	5,806	151	137	91%
FSW	173,646	31.3	54,351	*	*	*	*	35,359	2,429	1,852	76%
PWID	7,174	16	1,148	*	*	*	*	753	22	52	236%
Incarcerated populations	125,534	15	18,830	*	*	*	*	123,317	4,703	2,020	43%

Table 2 HIV diagnosis, treatment, and viral suppression

**There are currently no national data collection systems/sources of reliable data on the variable.*

Figure 2.1.3 Updated National and PEPFAR Trend for Individuals currently on Treatment_

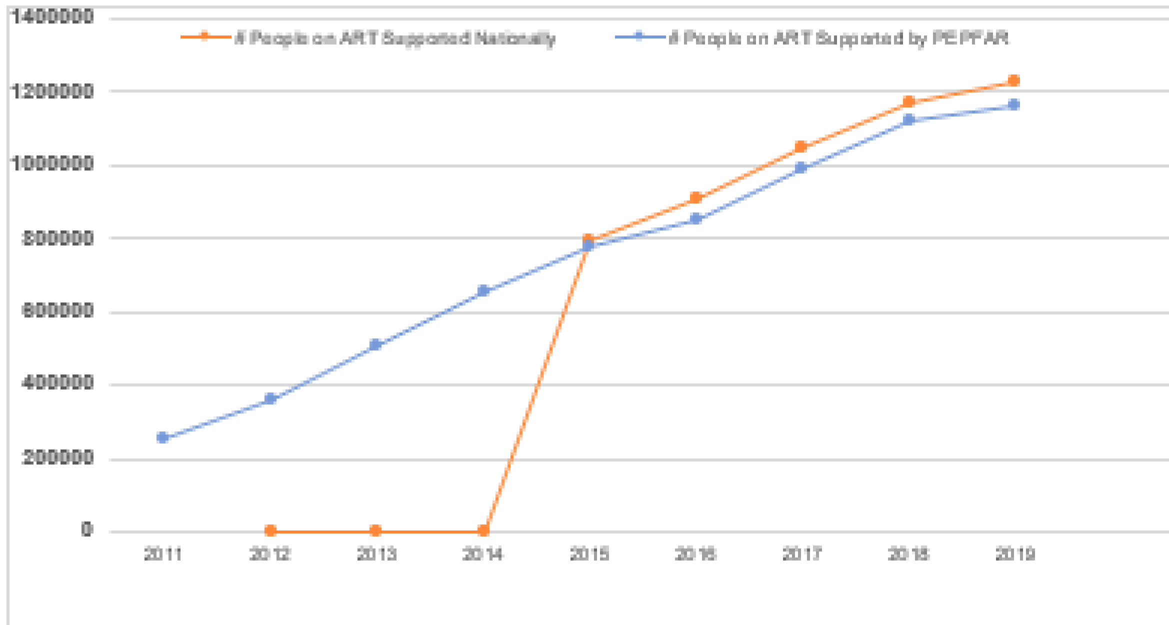


Figure 2.0.3 Updated National and PEPFAR Trend for Individuals currently on Treatment

*Data from DHIS2 was only available starting 2015

Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV – Updated

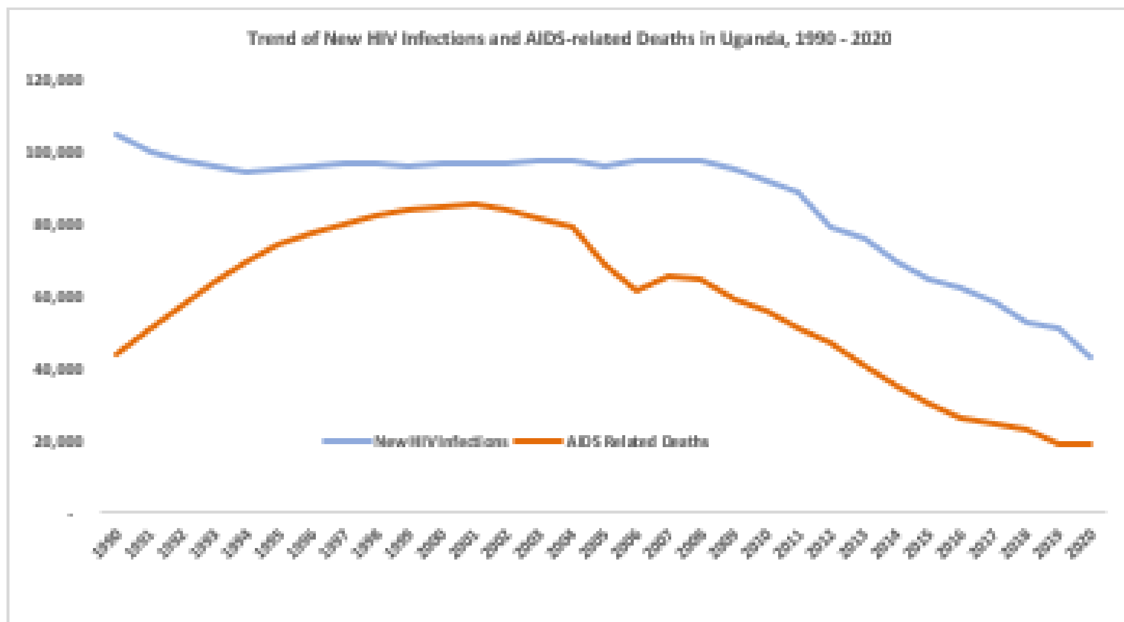


Figure 2. 0.4 Updated Trend of New infections an All-Cause Mortality Among PLHIV - Updated

Figures 2.1.5 and 2.1.6 Spectrum Estimates for the period of 1990 to 2019

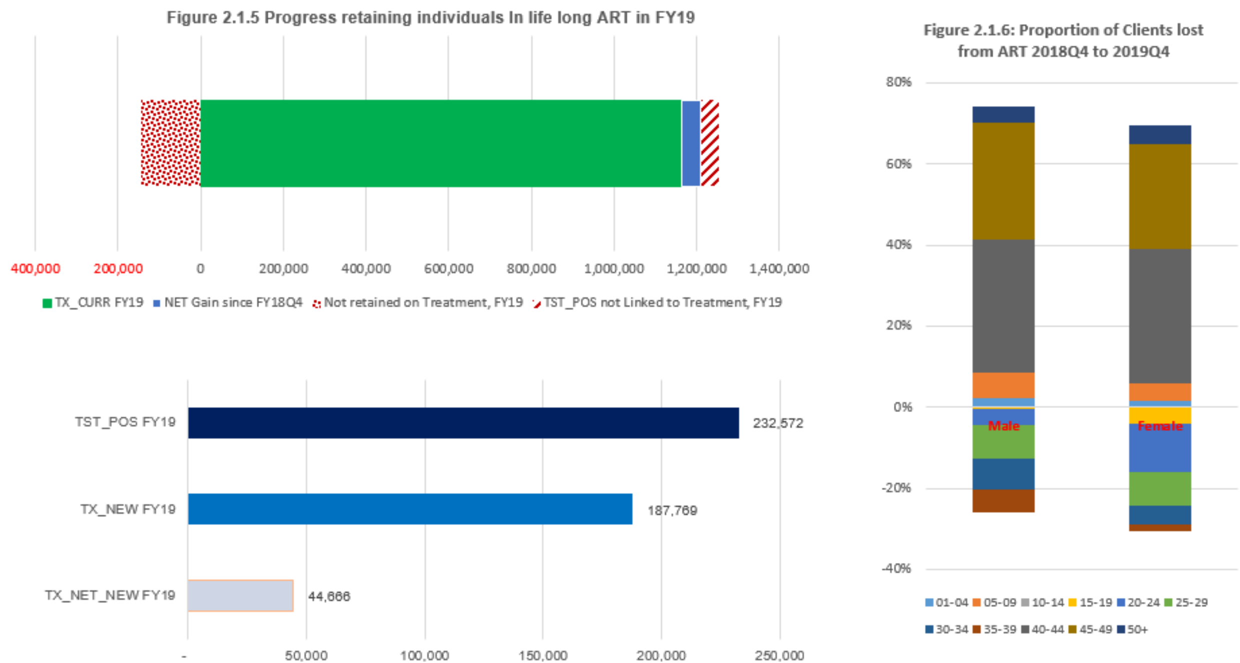


Figure 2. 0.5 Spectrum Estimates for the period of 1990 to 2019

Figure 2.1.7 Epidemiologic Trends and Program Response

(Figure 2.1.1.3 in COP20 Guidance)

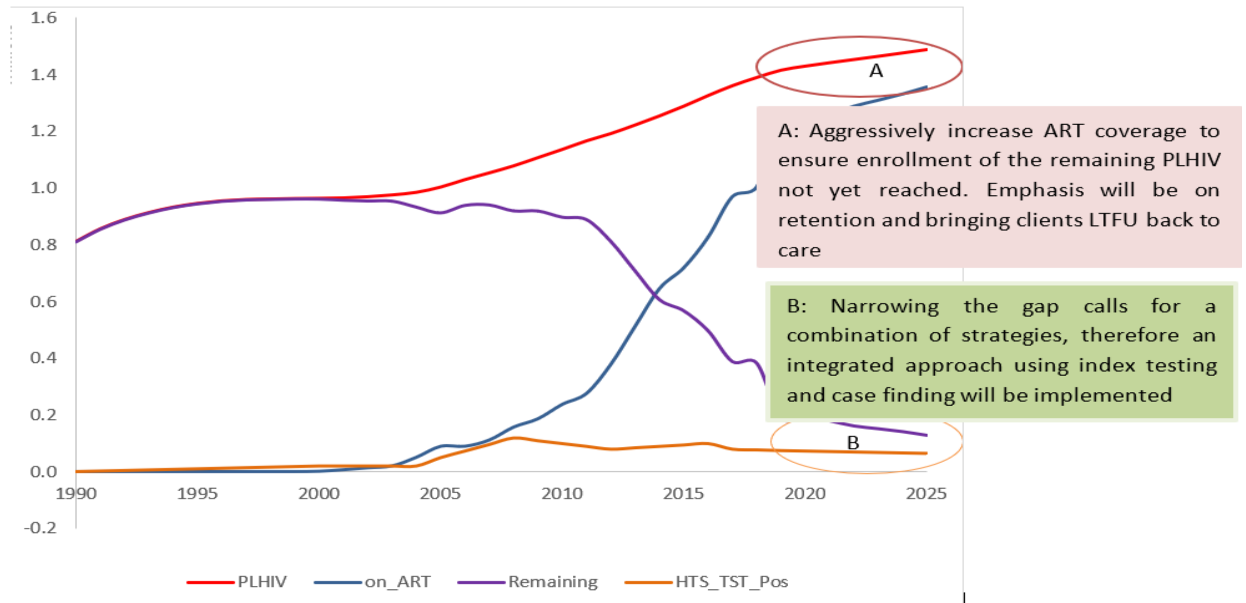


Figure 2.7 Epidemiologic Trends and Program Response

Figure 2.1.8 Net change in HIV treatment by sex and age bands, FY18 Q4 to FY19 Q4

Figure 2.1.8 shows the HIV treatment growth by age/sex to pinpoint where there are specific areas of intervention needed to maintain and grow the HIV treatment population.

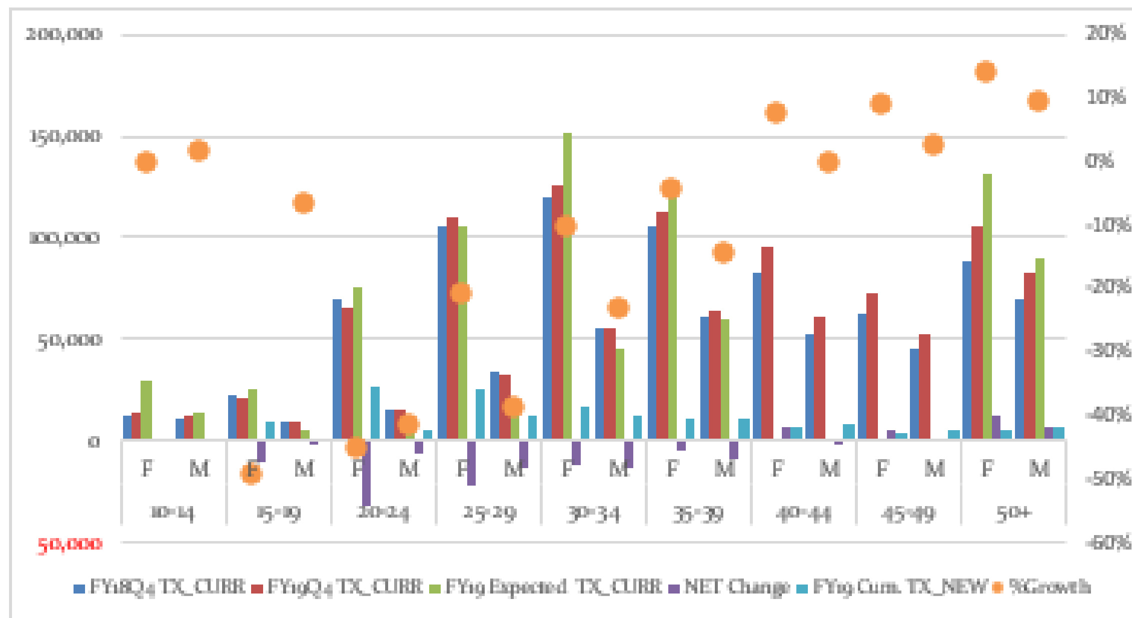


Figure 2.8 Net change in HIV treatment by sex and age bands, FY18 Q4 to FY19 Q4

2.2 New Activities and Areas of Focus for COP20, Including Client Retention

COP20 brings an array of new activities, opportunities, and interventions. The strategic shifts in COP20 are premised on reaching and sustaining epidemic control starting in calendar year (CY) 2020. To close remaining gaps in specific population groups including children, we will work with the national QI collaborative to provide support in areas where the need is greatest, using strategies for health facilities and the community. Core interventions to improve retention and VL suppression in adolescents, for example, will include peer support, OVC services, and differentiated service delivery. We will also continue to support pediatric regimen optimization.

EID is critical for timely initiation of ART in HIV-infected children who are at high risk of mortality. In COP20, PEPFAR Uganda will improve the efficiency of EID testing platforms to improve early identification of HIV-exposed infants and timely ART initiation and retention for all eligible infants.

The DREAMS program will expand strategically to four additional high-prevalence, high-incidence districts, and the platforms will additionally be used to implement social network HIV testing services in urban centers to locate adolescents at the highest risk of infection.

Circumcision for boys and men older than 15 years will minimize serious adverse events and increase the short-term contribution of VMMC to reduction of new infections.

In COP20, PEPFAR will support implementation of comprehensive clinical care services for ten northeastern districts to ensure that the current low viral suppression rates are reversed, and new infections reduced.

Renewal of support for cervical cancer screening and treatment of pre-cancerous lesions among women living with HIV (WLHIV) is a welcome opportunity for Uganda. We plan to screen 260,616 women living with HIV, accounting for 50% of the targeted HIV-positive women aged 25-49 years in HIV care and treatment.

The MenStar findings and approaches, as well as the new Faith and Community Initiative (FCI) "Messages of Hope," will be employed to engage men to manage their own health, starting now and throughout COP20. PEPFAR will use male-focused messaging, SMS messaging and other innovative technology, and differentiated service delivery models to bring services where men are in an appealing way.

During COP20 implementation, PEPFAR Uganda will identify effective and cost-effective approaches for the GOU to expand recency testing for all newly identified HIV-positive individuals, with a focus on quality assurance. PEPFAR and the GOU will stop over-testing and use safe HIV testing approaches to increase yield. Finally, PEPFAR will ensure that the COP19 cohort remains on treatment.

Now and in COP20, PEPFAR Uganda will support community monitoring initiatives to pinpoint and rapidly respond to a wide range of issues associated with effective and quality HIV service delivery.

PEPFAR investments in HIS will strengthen the health information exchange, expand unique identifiers, and amplify analytics at national, regional, facility and community levels to improve precision in targeted case-finding of men and children and reaching KPs, as well as retention of men, women, and children on treatment.

Focus on Client Retention

PEPFAR Uganda made marked progress towards epidemic control in 2019. In addition to achieving 80% ART coverage during 2019, we made marked improvements in retention of clients on antiretroviral treatment between FY 2018 and FY 2020 Quarter 1, and our goal now is to sustain this performance by reducing quarterly unexplained treatment loss to 1% over the next three quarters of FY 2020. Lessons learned in strengthening retention from the improvements made by our Implementing Partners in Uganda's northeastern region are already being disseminated throughout Uganda via the MOH-led national CQI initiative.

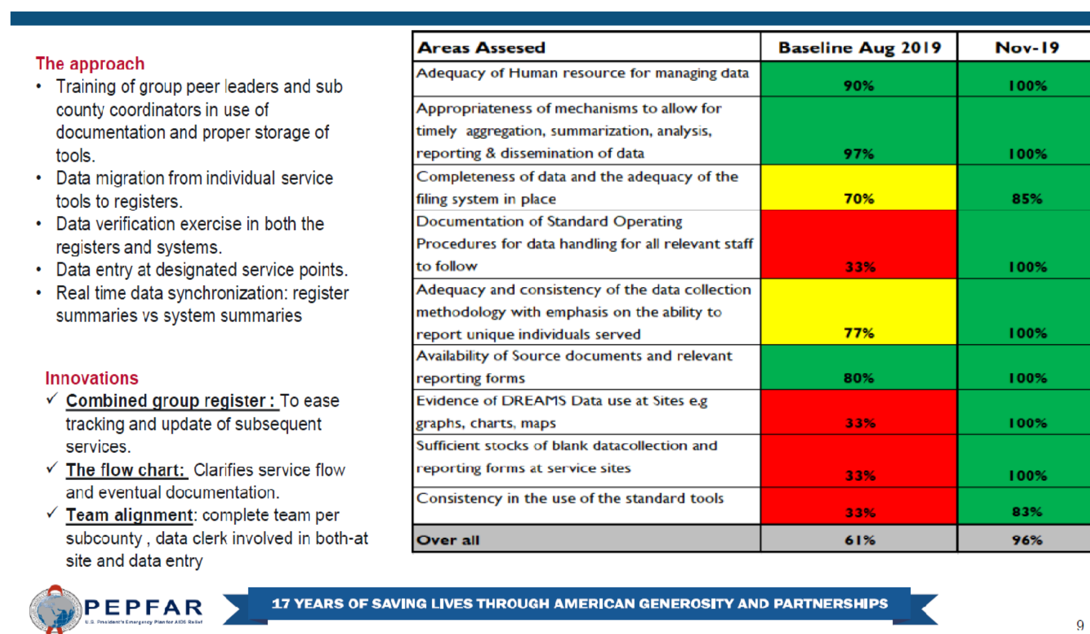
Despite these gains, Uganda is still grappling with persistent challenges to achieving epidemic control. Now and under COP20 PEPFAR Uganda must:

- Address ART treatment retention among young men
- Close the gaps in pediatric and adolescent care and treatment that persist at every step along the clinical cascade
- Improve our reach and strengthen our programming for the most vulnerable, including Uganda's KP, AGYW, and OVC

- Expand PrEP to all populations at elevated risk of HIV infections, including AGYW and PBFW

Starting now and under COP20, PEPFAR Uganda will continue to refine approaches through root cause analyses (RCA) and other program data analytics. As challenges are identified and change over time, PEPFAR will continue to expand use of differentiated approaches to treatment retention, including specific interventions aimed at sub-populations such as children and their caregivers, adolescents, and young men.

CQI has been used to strengthen DREAMS programming as can be seen below:



Areas Assesed	Baseline Aug 2019	Nov-19
Adequacy of Human resource for managing data	90%	100%
Appropriateness of mechanisms to allow for timely aggregation, summarization, analysis, reporting & dissemination of data	97%	100%
Completeness of data and the adequacy of the filing system in place	70%	85%
Documentation of Standard Operating Procedures for data handling for all relevant staff to follow	33%	100%
Adequacy and consistency of the data collection methodology with emphasis on the ability to report unique individuals served	77%	100%
Availability of Source documents and relevant reporting forms	80%	100%
Evidence of DREAMS Data use at Sites e.g graphs, charts, maps	33%	100%
Sufficient stocks of blank datacollection and reporting forms at service sites	33%	100%
Consistency in the use of the standard tools	33%	83%
Over all	61%	96%

Figure 2.0.6 DREAMS data quality improvement example

Specific site-level technical support is closing pediatric and adolescent cascade gaps. An estimated 40% of youth ART clients are pregnant or breastfeeding women (PBFW) who might be at risk of treatment default. To keep PBFW in care, retention is reinforced by expanding peer support through mentor mothers' groups and proactive mother-infant pair tracking. In adults, Uganda's focus is on addressing "extrinsic and intrinsic" client level barriers faced by men, such as patient self-management. PEPFAR Uganda works with Uganda's MOH-led national QI initiative to tackle client-level barriers as well as structural barriers.

Together with the GOU, we expect to have a positive impact by improving quality of care through patient-centered service delivery. The aim of the MOH's national CQI initiative is to mitigate attrition amongst ART clients through a standard intervention package that includes standard operating procedures for different client visits; enhancing interpersonal interactions between ART clients and providers through patient-centered psycho-social support; and improving providers' counseling skills.

The CQI is complemented by community-level approaches and outreach to prevent LTFU among newly initiated clients. PEPFAR implementing partners will continue to work with district leadership and the MOH to support ART accreditation of eligible health facilities, including in Kalangala. We are prioritizing non-facility-based outreaches and interventions to minimize LTFU in hard to reach areas such as Kalangala. A skilled workforce liaising between the facilities and the community plays a critical role in retention, case finding, adherence counseling and patient literacy. In COP20, PEPFAR Uganda will continue to support community, youth, KP, and other PLHIV organizations to provide quality peer-to-peer support services targeted to case-finding, addressing stigma and discrimination, adherence, treatment literacy, VL suppression, and amplifying key messages (e.g., U=U, FCI “New Messages of Hope”).

In COP20, PEPFAR will provide grants under the FCI to increase case-finding among men and disseminate messages of hope through faith community platforms to promote retention in care, positive living, and dignity, and ending gender-based violence (GBV). PLHIV, CSO, and faith institutions will play critical roles in mobilizing and decentralizing key messages to improve retention and VL suppression and address barriers to quality care.

Finally, a doubling of GOU investment in its HIV response over the past two years to 200 billion UGX demonstrates continued commitment and leadership of epidemic control efforts.

2.3. Investment Profile

While GOU has policy of free healthcare, budget constraints compromise the country’s ability to achieve its ambitious health goals. As a result, the health sector is heavily dependent on external donors who contribute almost 42% of Total Health Expenditure (THE). The GOU’s THE stands at around 16%, while another 42% comes through out-of-pocket (OOP) expenditure despite the free healthcare policy. High OOP is highly discouraged as it impacts service utilization and draws families into deeper levels of poverty. According to the recent National AIDS Spending Assessment, almost 90% of funding for the Ugandan national HIV response comes from external donors, mainly PEFAR and GF. While this has helped advance the epidemic control efforts, the heavy dependence on donor assistance will compromise long-term sustainability of the program.

PEPFAR has been working closely with host country counterparts and development partners to step up GOU’s contribution to the national response. In COP19, GOU increased funding for ARVs from $24 million in the past years to $39 million. The GOU will maintain this level in COP20, and the money will be ring-fenced for ARVs. In addition, MOFPED has committed to an additional $13 million for HIV commodities in COP20 beyond and above the $39 million already committed. These funds will procure needed HIV commodities including Viral Load (VL) and EID laboratory commodities, and first-line tuberculosis medicines for the entire country as well as provide support for needed human resources for health (HRH). While this is a step in the right direction, more needs to be done to increase domestic resources and ensure sustainability approaches for HIV. Over the years, GOU’s health budget has been increasing in nominal terms; however, the proportion of the health budget to the national budget averaged around 8% over the last several years, which is lower than the health sector development plan target of 10%. This nominal increase does not match with the needs of the rapidly growing population.

Uganda has submitted a joint TB and HIV grant application to the Global Fund for AIDS, TB and Malaria (GFATM) for the period 2021-2023. Most of the funds will be used to procure commodities.

Development Partners and CSOs continue to play an important advocacy role to ensure GOU financing for key interventions to attain and sustain epidemic control, including HRH and financing. The Health and AIDS Development Partners Groups, led by CDC and UN Women respectively in 2020, are working together with the Department for International Development (DFID), Irish AID, PEPFAR and US government (USG) agencies, World Bank, World Health Organization, UNAIDS, and all engaged bi- and multilateral donors to ensure that a health financing transition plan, fully owned by the GOU, will be completed in 2020. USG is providing technical support for plan development and will also be working with OGAC to carry out the first activity-based costing (ABC) exercise with MOFPED and the MOH to understand the true costs of interventions.

MOH continues to improve resource tracking in the health sector. MOH recently completed a comprehensive resource mapping to which PEPFAR contributed data. Information from the resource mapping will inform GOU budgeting as well as the development of the health financing transition and harmonization plan that is being supported by the USG and other health donors. Technical assistance will be needed to identify sustainable ways of raising additional funds from domestic sources while improving efficiency. The USG, through the Department of Treasury, seconds an advisor to MOFPED to improve e-health finance management systems while also engaging with MOH. The Activity Based Costing (ABC) exercise was planned to launch in February 2020 and is delayed due to the COVID-19 crisis, however the first round is still planned to be completed by end of September 2020.

Table 2.3.1- Investment Profile by Program Area

Table 2.2.1 Annual Investment Profile by Program Area 2018/19					
Program Area	Total Expenditure	PEPFAR	GF	Host Country	Other
Clinical care, treatment and support* (includes PMTCT)	330,987,667	189,076,345	71,445,491	70,465,831	
Community-based care, treatment, and support	-				
PMTCT	-	-	-		
HTS	28,983,113	20,861,225	8,121,888		
VMMC	41,690,514	41,690,514	-		
General population prevention	68,170,463	58,423,239	4,077,559	5,669,665	
AGYW Prevention	1,698,196		1,698,196		
KP prevention	1,955,859		1,955,859		
OVC	32,279,599	32,279,599	-		
Laboratory	4,994,144	4,994,144	-		
SI, Surveys and Surveillance	8,848,314	8,848,314			

HSS (includes program management)	27,327,541	21,235,687	1,232,141	4,859,713	
Total	**546,935,410**	**377,409,067**	**88,531,134**	**80,995,209**	**19,830,204** *

Table 3 Annual Investment Profile by Program Area 2018/19

**includes funding from the UN, CHAI, and Irish Aid*

Table 2.3.2 Annual Procurement Profile for Key Commodities					
Commodity Category	**Total Expenditure (USD)**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs	191,680,439	46.8%	32.6%	20.5%	0.1%
Rapid test kits	13,512,622	27%	73%	-	-
Other drugs*	6,355,659	47.2%	46.9%	5.9%	-
Lab reagents**	8,205,247	20%	80%	-	-
Condoms	12,015,397	-	87.9%	-	12.1%
VL commodities	21,245,497	100%	-	-	-
VMMC kits	17,852,385	100%	-	-	-
MAT	-	-	-	-	-
Other commodities***	6,838,236	53%	47%	-	-
Total	276,253,629	50.9%	30.8%	14.4%	0.1%

Table 4 Annual Procurement Profile for Key Commodities

**includes Cotrimoxazole, INH, STI/OI, B6*
***includes CD4, GeneXpert*
****includes EID, Syphilis-duo, RUTF, HIV Self-test kits, Serum, CrAg, TB Masks*

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	15,500,000	9,840,000	12	64,235,618	Support programs to improve maternal, neonatal and child health
USAID TB	6,000,000	6,000,000	11	40,716,443	Support programs to reduce TB related mortality and morbidity
USAID Malaria	33,000,000	6,625,600	9	58,093,632	Support programs to reduce malaria associated mortality
Family Planning	29,000,000	14,350,000	17	64,235,618	Support programs to increase contraceptive prevalence and birth spacing
NIH					
CDC (Global Health Security)		9,330,016.58	3	480,692	Surveillance, Workforce Development, Emergency Management, Laboratory, AMR, Ebola Response
	10,860,113				
Peace Corps					
DOD Ebola					
MCC					
Other (specify)					
Total					

Table 5 Annual USG Non-PEPFAR Funded Investments and Integration

2.4 National Sustainability Profile Update

PEPFAR Uganda and UNAIDS completed the 2019 Sustainability Index Dashboard (SID) and the first ever Responsibility Matrix (RM) in mid-2019, in full partnership with GOU, IPs and civil society. These two tools have provided the current status of the country regarding the sustainability profile. Since the mid-1990s, HIV has been among the leading causes of morbidity and mortality in Uganda. The national HIV response has been structured along the continuum of HIV prevention, testing linked to treatment and care and support. Uganda has consistently held consultative processes to develop policies and program design inclusive of public and private sector actors, including civil society. The PEPFAR Country Operational Plan, GF grant proposals and the National Strategic Plan for HIV are all developed with wide consultation and with the GOU taking a leadership role, thus underscoring sustainability in the planning and coordination functions of the response. The generation and use of financial and service delivery data has also attained encouraging levels of sustainability, although there is need to ensure that the budget documents such as the National AIDS Spending Assessments (NASA) and the National Health Accounts include funding for key and priority populations and are cross-related. On the other hand, despite the expanded access to ART and the rigorous monitoring of the results of HIV treatment, the delivery of HIV services in general, and domestic funding of the response, continue to fall short of the desired sustainability levels. The situation is compounded by low technical and allocative efficiencies, which impacts heavily on commodity security and supply chain for HIV services. Similarly, there is concern about the continued need for external support for human resources to

mitigate the effects of the staffing gaps at subnational and national levels for service delivery and leadership and oversight capabilities.

SUSTAINABILITY DOMAINS and ELEMENTS

	2015 (SID 2.0)	2017 (SID 3.0)	2019
Governance, Leadership, and Accountability			
1. Planning and Coordination	8.67	9.33	10.00
2. Policies and Governance	7.17	8.19	7.48
3. Civil Society Engagement	5.00	5.00	7.29
4. Private Sector Engagement	3.98	7.40	8.25
5. Public Access to Information	6.00	6.00	7.33
National Health System and Service Delivery			
6. Service Delivery	5.88	3.80	5.12
7. Human Resources for Health	6.92	6.20	6.71
8. Commodity Security and Supply Chain	4.54	3.80	4.24
9. Quality Management	6.24	6.52	8.33
10. Laboratory	5.69	5.25	4.61
Strategic Financing and Market Openness			
11. Domestic Resource Mobilization	2.78	5.36	4.84
12. Technical and Allocative Efficiencies	1.31	4.16	6.46
13. Market Openness	N/A	N/A	6.67
Strategic Information			
14. Epidemiological and Health Data	5.30	4.65	4.87
15. Financial/Expenditure Data	6.25	5.00	7.50
16. Performance Data	8.30	7.23	8.33
17. Data for Decision-Making Ecosystem	N/A	N/A	4.67

Figure 2.0.7 Sustainability Domains and Elements

Sustainability Strengths:

- **Planning and Coordination:** The national-level strategic planning and coordination of the response is led by the UAC. Governance of the response is strong and active involvement of the private sector, and civil society adds strength to the sustainability of this element. At the district level there is need to consolidate the planning function and to improve coordination in respect of the private-for-profit sector. In order to ensure program sustainability, Uganda's MOH needs to increase its visibility for coordination and leadership at the sub national level through empowerment of RRH technical teams. These teams will, among other functions, ensure that all technical capacity building platforms are managed at the regional level, enhance supervision, and provide on-the-job training to minimize disruption to service delivery.

- **Private Sector Engagement**: The private sector, dominated by the PNFP sector, continues to take maximum advantage of the available channels and opportunities to engage GOU institutions responsible for HIV at both the national and district levels.

- **Performance Data:** Government ownership of HIV data continues to register an upward trend. Collection, collation, reporting, and utilization of data for HIV management continues to improve significantly at both the facility and district levels. What remains is to focus the attention of service providers and managers on using the data for HIV disease control.

Sustainability Vulnerabilities

- **Commodity Security and Supply Chain:** There has been substantial improvement in ARV domestic financing, now at 25%, but critical supplies like HIV test kits, condoms, and laboratory supplies are virtually all donor funded. The PEPFAR country team supports ongoing ARV stock monitoring and management, using the Web-Based ARV Ordering and Reporting System (WAOS), Real Time ARV Stock Status Reporting (RASS), and other systems.

- **Technical and Allocative Efficiencies:** Whereas the country uses service delivery data for programmatic and performance monitoring, there remains a shortfall in triangulating economic and health data to optimize HIV outcomes within the available resource envelope. Spectrum and Naomi data models are used for programmatic planning and not for resource allocation.

- Regarding Uganda's contribution to the HIV response, the GOU scored itself as having 'Primary Responsibility' in strategy formulation/planning and service delivery, with 'Secondary Responsibility' in many cases in non-service delivery arenas (Responsibility Matrix 2019). PEPFAR scored 'Secondary' in the strategy formulation and service delivery section, with 95% of the non-service delivery considered primary, as it is the GOU responsibility to move policies and guidelines forward, and the program has significant technical assistance support. PEPFAR continued to score Primary in several other elements, including linkage/retention and adherence, male circumcision, key and priority populations, and OVC. PEPFAR also provides significant commodities, training and supervision. GF is considered to hold the "Primary Responsibility" now for most commodities except male circumcision and laboratory reagents and is considered to have secondary or nominal support in many programmatic areas.

2.5 Alignment of PEPFAR investments geographically to disease burden

Key data used to ensure PEPFAR investments are aligned with disease burden geographically (to district level) include the 2016 UPHIA and routine program data, as well as the historic Spectrum and new Naomi estimates. Below find a graphical display of PLHIV, treatment coverage and viral load suppression by district.

Figure 2.5.1 Maps showing percent PLHIV by SNU, total PLHIV by SNU, coverage of total PLHIV with ART, and VL coverage by SNU.

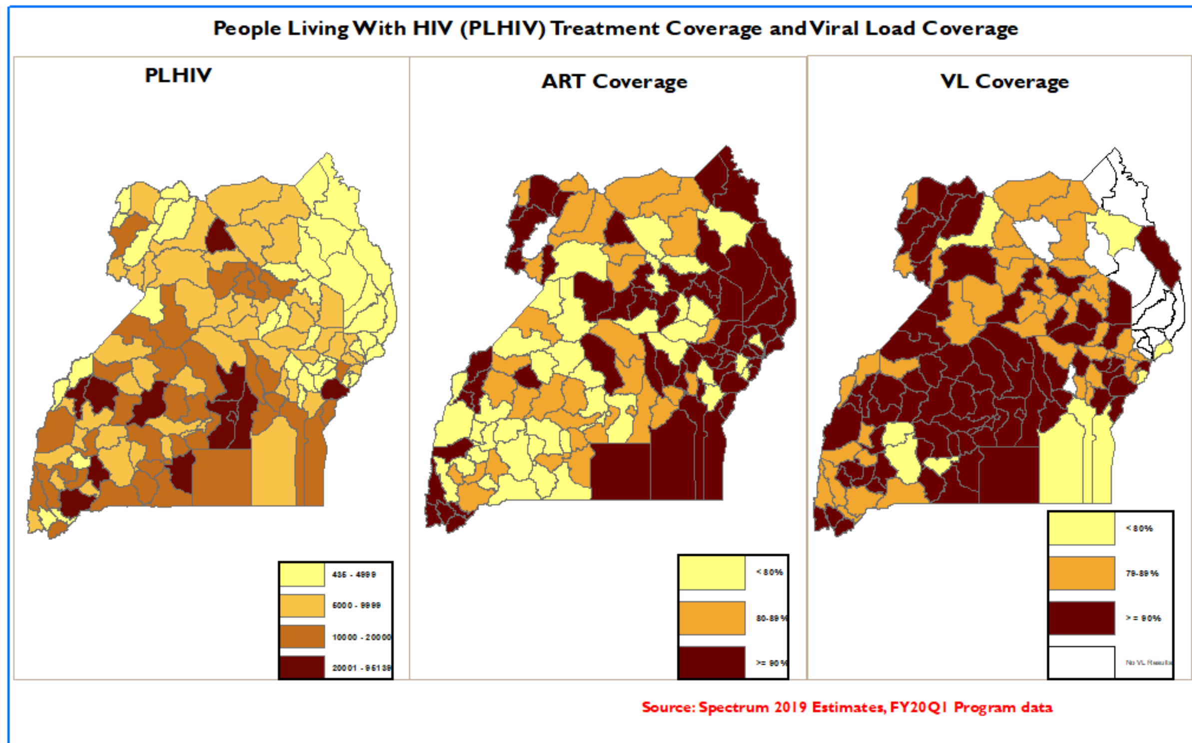


Figure 2.0.7 PLHIV Treatment Coverage and Viral Load Coverage

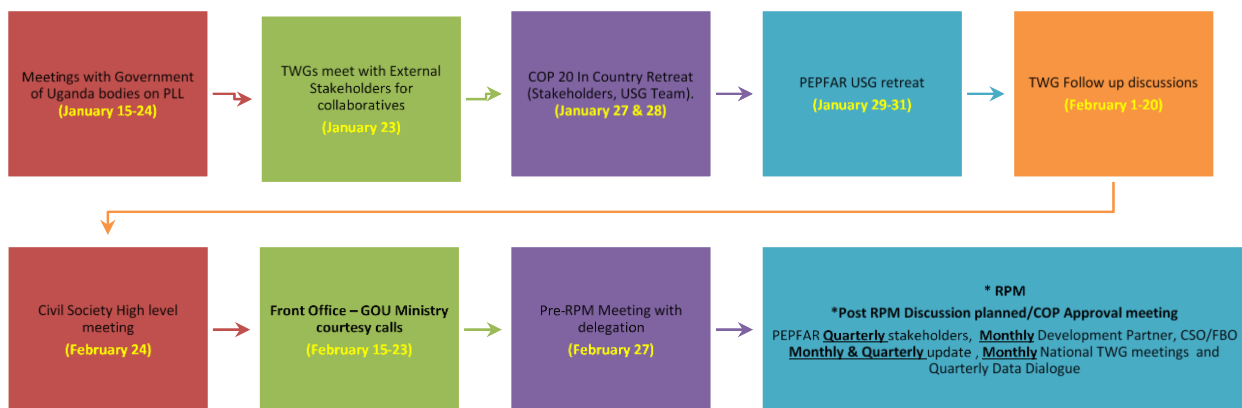
2.6 Stakeholder Engagement

The 2020 PEPFAR Country Operational Plan (COP20) for Uganda builds on COP19's bold moves toward epidemic control in line with both the UNAIDS 90-90-90 and the national 95-95-95 goals across sex and ten age bands. PEPFAR Uganda has intensively engaged stakeholders in COP20 development and review. To be specific, GOU, development partners, and national and international Ugandan CSOs participated in the COP national and RPM in Johannesburg. Priorities identified for Uganda during pre-COP consultative processes were presented in the RPM to OGAC and PEPFAR teams. Prior to COP submission, PEPFAR Uganda will share key documents including the Strategic Direction Summary (SDS) and final targets with key stakeholders for their final feedback.

Stakeholder engagement is critical as Ugandan entities assume greater ownership of the country's HIV response. Stakeholder engagement will continue throughout the COP20 implementation as highlighted in the engagement calendar.

At the release of the COP20 guidance, a COP20 introductory letter highlighting the key dates of the planning processes was shared with relevant stakeholders including the GOU, AIDS and health development partners, implementing partners (IPs) and a wide range of civil society actors. GOU participation included Office of the President and Office of the Prime Minister, MOH, MOFPED, MOES, MOGLSD, UAC, Uganda Bureau of Statistics (UBOS), the National Identification and Registration Authority (NIRA), Kampala Capital City Authority (KCCA), the Ministry of Defense, the Uganda People's Defense Forces (UPDF) and Ministry of Local Government (MOLG). PEPFAR maintains close relationships with WHO, UNAIDS and the UN family, Irish AID, DFID and other bilateral development partners through formal AIDS and Health Development Partner coordinating structures that meet monthly. USG also engaged closely with the GF through the Geneva-based portfolio manager and the local Country Coordinating Mechanism (CCM), where USG is a voting Executive Council member and sits on all three GF committees.

The chart below summarizes the different COP20 engagements to which stakeholders were involved and as well highlights planned engagement or COP20 implementation.



1. GF, private sector, and other external donors

As in years past, PEPFAR in COP20 will utilize other opportunities for broader engagement beyond civil society that exist through various fora in which PEPFAR Uganda regularly engages. These include national technical working groups, Uganda CCM Board for the GF, the Health and AIDS Development Partner Groups, the UAC Partnership Committee, and the Health Policy Advisory Committee. PEPFAR Uganda will continue to strengthen collaborations with the UNAIDS country office and other UN agencies especially in the areas of government to government (G2G) approaches, strategic information, health financing, civil society engagement, and human rights. From March 2020, the USG has facilitated informational, planning, and coordinating meetings regarding HIV support to the Karamoja Region, and the other northeastern districts the U.S. government will be intensifying efforts (10 districts altogether). In April 2020, MOH's AIDS Control Program convened an initial northeastern districts coordination meeting to lay the groundwork for increased USG presence for treatment expansion and viral suppression in the region.

In COP20 planning, PEPFAR Uganda worked collaboratively with Global Fund to optimize synergies and leveraging of resources. With regard to DREAMS, coverage for both programs was

harmonized to ensure that interventions are properly aligned to needs while mitigating duplication of efforts. For instance, Busia and Buikwe districts in Eastern Uganda, which met the PEPFAR criteria for comprehensive DREAMS interventions, were left for prioritization by Global Fund.

USG has maintained active representation on the Uganda GF CCM Board and is a voting Executive Council and CCM Board member. USG has maintained a strong presence on all committee meetings. Representatives for the resource mobilization and program development, finance and procurement, and the program oversight committees were submitted to and approved by the chair of the CCM. PEPFAR Uganda also collaborates closely with the Geneva-Based country portfolio manager. Multiple meetings were held in Uganda with the portfolio manager to align high level priorities throughout the grants writing process aligned with COP20 planning processes. Additionally, the Uganda Portfolio Manager presented at the COP20 Regional Planning Meeting (RPM) in South Africa to solidify efforts and ensure programs are harmonized and complementary.

2. **GOU COP20 Engagements**

At the higher political leadership level, PEPFAR Uganda will continue to engage with the Office of the President, Office of the Prime Minister (OPM), Office of the First Lady, MOFPED, MOH, Ministry of Public Service (MOPS), MGLSD, MOLG, MOES and UAC. Key areas of engagement at the political, policy and technical levels include: increasing domestic financing for health and the HIV response; rapid adoption and implementation of new policies; supply chain management; HRH absorption; community level cadre; strategic investments in data and laboratory systems, and leadership and governance of the HIV response, as well as protection of human rights.

PEPFAR held high level political and administrative level meetings as part of COP20 planning with the Minister of Health and Minister of Finance, Planning, and Economic Development, including representatives from the GOU agency UNHLS, and discussed five main areas: *Financing, Policy Guidelines, Unique Identifier, Human Resources for Health, Commodity Security.TPT*

PEPFAR Uganda will continue proactively to solicit input from the GOU at multiple levels regarding their goals, priorities, targets, and budgets while implementing the COP20. Meaningful engagement will also continue during COP20 finalization, approval and implementation. PEFPAR Uganda will share the final COP20 content and implementation strategy during the Q2 PEPFAR Stakeholders' Meeting in April 2020, in a virtual format given the COVID-19 pandemic. GOU, civil society, FBO development partners, and bilateral and multilateral donors will be engaged in quarterly pre-PEPFAR Oversight Accountability and Response Team (POART) review sessions to assess progress against targets and any policy or programmatic challenges.

COP20 implementation will increasingly strengthen approaches that transition leadership and financing of the national program to the GOU and local partners. External engagements will be more critical and meaningful as the Ugandan government assumes greater ownership of the HIV responses; the sustainability of this ownership will rely heavily on GOU investing in health, and civil society partners to advocate for the health needs of their constituents. PEPFAR will continue to support capacity of local civil society organizations to meet this challenge, better preparing them to play a leadership role now and in the future.

3. **Civil Society/Community**

During COP20 planning, PEPFAR engaged CSOs primarily through the self-organized civil society platform, represented by HEPS Uganda, ICWEA and SMUG. This platform consults with and

represents nearly 100 national CSOs, representing women, men and youths living with HIV, mainstream civil society organizations, and representatives of KP groups.

As in COP19, the civil society sector developed their own version of COP20 called "The People's Voice Uganda: Community Priorities" (Appendix E). Through pre- and post-RPM meetings, PEPFAR and CSOs agreed on a number of policy and programmatic actions and priorities including PEPFAR supported sites have sufficient funding invested in community-led retention and treatment program quality; investing in human rights work for KP using KP Investment Fund (KPIF) funding; human rights, justice and advocacy training for LGBTQI under a USAID human rights mechanism; expansion of high-impact prevention through COP20, focusing on AGYW, KP, pediatrics, and men; addressing consistent stock outs; persistent HRH barriers and PEPFAR small grants for people with disabilities among other areas.

Table 1 summarizing the PEPFAR and CSOs agreed upon policy and programmatic actions and priorities for COP20

S/N	PEOPLE'S COP20 PRIORITY/ASK	USG/PEPFAR Comment
1	COP20 to ensure 100% of PEPFAR supported sites have enough funding invested in community-led retention and treatment program quality	Agree: PEPFAR will work with CSO, and GOU to review and standardize the approach to remuneration across the various PEPFAR IPs and continue to work with GOU on a sustainable community staffing approach. To be completed by May 2020.
2	COP20 must fund a complete redesign of Key Population programs in Uganda being implemented through COP and KPIF support.	Agree. PEPFAR agrees the KP program needs reinvigoration and upgrading. We will work with GOU and CSO to develop standard approaches, expand DICs and expand the SPECTRUM toll free line, all in close collaboration with CSO representatives at local and national levels.
3	Immediately halt implementation of policies that violate human rights	Agree: PEPFAR, CSO and MOH will establish a 'Task Force' to revamp tools, consent language, testing adverse event reporting and follow up system beginning in COP19. Task force established March 2020.
4	High impact prevention must be expanded through COP19 and COP20, focusing on AGYW, KP, pediatrics and men	Agree: In COP20, PrEP will be offered to all people at substantial risk of HIV infection including AGYW, pregnant and breast-feeding women. MOH has a permissive policy, PEPFAR will support through implementation.
5	Expand pediatric HIV diagnosis and quality treatment access	Agree: PEPFAR's goal is for universal access for EID testing rapidly linked to services. POC is expanded to 146 sites. COP20 PEPFAR will scale up optimized pediatric ART regimens.
6	Stop stock outs	Agree: PEPFAR will continue to work with GOU (MOH, NMS, JMS) and partners to ensure all patients review medicines without any break in service. ERP goes 'live' June 2020.
7	Address persistent HRH barriers	Agree: PEPFAR will continue to work with GOU to prioritize appropriate Health Sector HRH coverage, and staffing.
8	TB/HIV service delivery	Agree: COP20 will ensure completion rates of at least 80% and PEPFAR will scale up Q1 package for TPT completion.
9	Community Led Monitoring for Advocacy	Agree. Monitoring will be led by communities; Uganda will anchor the existing work with other key

		stakeholders working in the wider consortium. CLM will respond to key considerations and themes including LTFU, access for KP, pregnant women, adolescents

Table 6 PEPFAR and CSOs agreed upon policy and programmatic actions and priorities for COP20

PEPFAR Uganda will continue to hold quarterly interagency stakeholder meetings, led by the US Ambassador or her/his delegate, and facilitated by the PEPFAR Coordination Office (PCO). The interagency team will continue to hold monthly or bi-monthly joint care and treatment, HTS, KP, and other technical area IP meetings—along with MOH—to review data, address challenges and policy issues, and scale up best practices across partners. CSO representatives through International Community of Women living with HIV Eastern Africa (ICWEA) and other development partners will be invited to attend these monthly/bimonthly sessions to enrich results. New in COP20 is even closer collaboration with independent CSOs for data dialogue discussions to inform program quality.

PEPFAR Uganda will continue to implement a multi-stakeholder engagement process to include state and non-state actors during and throughout COP20 implementation. Further, USG will continue holding pre-POART review sessions with stakeholders to review quarterly data and develop jointly owned solutions. New in COP20 is that PCO will coordinate and facilitate inter-agency quality assurance and monitoring visits based on discussions of crucial information and observations regarding HIV service delivery from and about KP and other underserved groups as may be presented as a result of CLM to guide program implementation.

Below is the Stakeholder engagement calendar for COP20 (planning and implementation)

COP20 Stakeholder Engagement Calendar:				
	PEPFAR Team Action	**Stakeholder Action**	**Dates**	**Status**
1	Distribute critical data and COP20 materials (links or hardcopy): • Draft and Final COP20 guidance. • PEPFAR Solutions Platform, • 2019 Sustainability Index and Dashboard Responsibility Matrix. • Q4 results via spotlight; Q4 POART overview slides. • SIMS Outcomes (Above PSNU level) • COP19 SDS and approval memo	• Analyze materials to prepare for COP20 discussions at strategic planning retreat. • Identify areas of successful performance that can be leveraged going into COP20 • Develop recommendations onsite level or site level or non-service delivery activities that should not continue. • Global and regional CSOs request information • Receive POART slides	January 2-31, 2020	PCO Shared both the Draft and final COP20 guidance; COP19 SDS; Q4 results and Q4 POART overview slides and the 2019 SID/RM. Completed successfully
2	• Organized and facilitated courtesy calls and Meetings with GOU	Harmonize COP20 priorities with GOU and Development Partners' plans	Jan 15-Feb 20, 2020	PCO successfully coordinated these high-level discussions

3	Organize and facilitate TWG COP20 consultation meetings	TWG Co-Chairs identify and recommend their external guests to participate in COP20 consultation meeting	Jan 23, 2020	great participation from (GOU, Development partners, CSO/FBO and private sector) provided feedback and input into COP20 priorities
4	Meeting with MOH and MOFPED, MOD, MGLSD	PCO and Agency Heads attend as GOU shares its projected plans and agreed upon priorities	Tuesday, January 22 and 28, 2020	Completed successfully and generated commitments of Domestic Financing, HRH absorption plan, Commodities and PrEP
5	USG invites and review materials with stakeholders at In-Country Strategic Planning Retreat	Attend in-country Strategic Planning retreat; provide PEPFAR Teams with recommendations for COP20 focus, based on analysis of Q4 results and observations of in-country performance.	Monday and Tuesday, January 27 & 28, 2020	Retreat held, (Smaller group discussions, panel discussions and presentations were made to cater for all targeted groups)
6	Arrange for stakeholder participation in the COP20 RPM	GOU, CSOs ad development partners actively participate in COP20 RPM, provide feedback on approaches, strategies and targets	March 1-8, 2020	Completed
7	Agency specific IPs Meeting to consult on COP20 and share feedback on RPM	IPs actively participate in post RPM feedback meeting and provide feedback on technical and management approaches.	March	Completed virtually due to COVID19
8	Invite stakeholders to post COP20 Strategic Planning meeting to discuss outcomes and strategies for finalizing COP submission	• Actively participate in Post COP20 strategic planning Meeting Consultation (Ask questions, seek clarification and make recommendations)	March, 2020	Completed virtually due to COVID19
9	Provide stakeholders with draft SDS 2-3 days prior to submitting to in-country ambassador	• Review materials and communicate to PEPFAR Coordination office is submitted materials are not aligned with COP20 meeting agreements/strategies • Global and regional/national CSOs request information as applicable	SDS to stakeholders for review March 16, 2020 Within a minimum of 48 hours of COP Submission to S/GAC. March 23-2020	Completed virtually due to COVID19 A/GAC will review, exchange and concur within a week of submission.
10	Provide SDS and final target data	Review all materials	March 2020	Completed
11	Invite stakeholders to COP20 approval meetings, ensure that the final plan-inclusive of expected policy shifts, targets and priority interventions- are understood and shared by all	Actively participate in COP20 approval meetings, and questions, seek clarification, raise areas of discrepancy or misalignment and continue communicating with PCO	In country approval meting window is March30-April 10, 2020	Likely a virtual meeting with S/GAC chair, PCO and Charge, and follow up virtual session convened by PCO week of April 6. No in person due to COVID19

	Arrange for GOU participation in COP approval meeting			
12	Host Follow up meeting with stakeholders to review approved COP and discuss which stakeholder recommendations were incorporated and which were not	Participate in follow up meeting	April 26, 2020	Completed virtually due to COVID19
13	Invite and engage stakeholders to meet prior to each quarterly POART call to engage their feedback and recommendations for program improvement	Participate in stakeholder meetings prior to POART calls; offer analysis and recommendations to remove barriers and bottlenecks.	Jun 30; Sept 30; Dec 20, 2020.	Planned POART calls dates in draft.
14	Organize and facilitate Quarterly Stakeholder and IP meetings- Performance reviews, conduct strategic direction changes, and share best practices	IPs to participate in the quarterly meetings, share best practices, and plan to adopt changes identified through the short learning loops. Possibly monthly care and treatment meetings to prioritize the surge, with MOH presence.	Quarterly, Dates to be set in advance of meetings	Ongoing
15	Sharing and receiving feedback to the CSO people's COP20 checklist	USG and CSO share inputs and COP20 agreements with reference to the CSO developed People's COP20 priorities		Completed
16	Development Partner meetings	USG share updates of COP19 and COP20 agreements	Monthly	CDC currently chairs the HDP; USG active in both HDP and ADPG meetings
17	Organize/Attend/facilitate Data Dialogue on CLM	GOU, USG and CSO share qualitative and quantitative findings and recommendations for program quality.	Quarterly/biannual	Led by PCO and Co-facilitated by the CSOs and UNAIDS
18	Inter-agency monitoring visits coordinated and organized by PCO to guide program implementation.	Reported observations and recommendations shall inform a basis and selection of sites as well scope for monitoring visits.	Quarterly	Led by PCO to guide program implementation
19	PEPFAR participates in National TWG meetings	GOU shares programmatic and key policy TWG focused directions	Monthly	Continuous

3.0 Geographic and Population Prioritization

Table 3.1 Current Status of ART saturation				
Prioritization Area	Total PLHIV/% of all PLHIV for COP20	# Current on ART (FY19)	# of SNU COP19 (FY20)	# of SNU COP20 (FY21)
Attained	525,068 (37%)	425,714	46	32
Scale-up Saturation	156,132 (11%)	131,505	34	18
Scale-up Aggressive	334,430 (23%)	268,417	26	25
Sustained	415,927 (29%)	390,712	18	60
Central Support	0 (0%)	0	11	0
Total	**1,431,557 (100%)**	**1,216,348**	**135**	**135**

Table 7 Current Status of ART saturation

4.0 Client-Centered Program Activities for Epidemic Control

4.1 – 4.4 COP20 Programmatic Priorities for Epidemic Control

Table 4.1: Who is missing, finding them and getting them on treatment.

FY20Q1 Cascade by age

Age	Sex	PLHIV	Diagnosed	On Treatment	VL Suppressed	Diagnosed	On Treatment	Proxy Retention	VL Suppressed
<10	Female	28,348	18,830	18,805	13,871	66%	66%	81%	49%
	Male	29,135	17,082	17,062	11,645	59%	59%	80%	40%
10-19	Female	52,161	36,390	36,201	26,611	70%	69%	76%	51%
	Male	35,498	24,644	24,622	17,626	69%	69%	99%	50%
20-29	Female	192,100	182,470	181,347	144,435	95%	94%	76%	75%
	Male	83,513	51,357	50,979	30,691	61%	61%	69%	37%
30-39	Female	251,329	261,205	260,614	212,721	104%	104%	94%	85%
	Male	145,054	123,342	122,838	92,422	85%	85%	83%	64%
40-49	Female	182,610	187,208	187,029	148,234	103%	102%	104%	81%
	Male	142,900	122,254	122,005	96,993	86%	85%	98%	68%
50+	Female	151,755	121,133	121,047	101,463	80%	80%	114%	67%
	Male	126,886	93,023	92,917	76,758	73%	73%	110%	60%
Overall		**1,421,290**	**1,238,938**	**1,235,466**	**973,470**	**87%**	**87%**	**92%**	**68%**

1_95	2_95/RET	3_95
>=95%	>=90%	>=85%
85%-94%	80%-89%	75%-84%
75%-84%	70%-79%	65%-75%
<75%	<70%	<65%

Figure 4.0.1 Who is missing, finding them and getting them on treatment

Table illustrating cluster ART coverage

	<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		OVERALL
CLUSTER	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
GULU CLUSTER	94%	94%	94%	95%	93%	93%	93%	93%	96%	94%	97%	96%	98%	97%	97%	98%	95%	97%	94%	95%	93%	94%	93%	92%	95%
JINJA CLUSTER	87%	88%	89%	89%	87%	87%	88%	87%	90%	88%	91%	90%	91%	92%	90%	93%	90%	92%	89%	92%	89%	91%	89%	89%	90%
KABALE CLUSTER	97%	93%	89%	89%	89%	89%	89%	90%	90%	90%	90%	90%	90%	91%	90%	91%	90%	91%	90%	91%	90%	90%	90%	90%	90%
KABAROLE CLUSTER	92%	90%	90%	90%	89%	89%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
KAMPALA CLUSTER	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+
LIRA CLUSTER	94%	96%	95%	95%	94%	94%	94%	93%	95%	93%	96%	95%	97%	96%	96%	97%	96%	96%	95%	96%	94%	94%	93%	93%	95%
MASAKA CLUSTER	96%	96%	95%	95%	94%	94%	94%	94%	95%	94%	96%	96%	97%	97%	97%	97%	96%	96%	95%	96%	93%	94%	93%	93%	95%
MBALE CLUSTER	74%	72%	72%	73%	71%	70%	71%	70%	72%	70%	74%	72%	76%	74%	76%	74%	75%	74%	74%	72%	73%	71%	72%	70%	73%
MBARARA CLUSTER	89%	89%	89%	89%	88%	88%	88%	88%	90%	89%	91%	91%	91%	92%	91%	91%	90%	91%	90%	90%	89%	90%	89%	89%	90%
SOROTI CLUSTER	95%	95%	96%	95%	94%	94%	93%	93%	95%	94%	96%	95%	97%	96%	96%	97%	95%	96%	95%	96%	95%	95%	93%	94%	95%
STANDALONE	80%	81%	80%	80%	80%	80%	80%	80%	80%	80%	81%	80%	81%	80%	80%	80%	80%	80%	80%	80%	80%	80%	81%	80%	80%
TORORO CLUSTER	71%	70%	70%	71%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	69%	70%	69%	70%	70%	71%	70%	70%	70%	70%

Legend
>=90%
80%-89%
70%-79%
<70%

Finding the missing, getting them on treatment, and retaining them to ensure viral suppression

As of December 2019, 1,385,653 individuals were estimated to be living with HIV in Uganda. Of these, approximately 1,238,938 (89%) had been diagnosed and 1,235,466 (89%) were on treatment. Of those on treatment, 973,470 (70% of all PLVHIV) had attained viral suppression. Reaching the remaining undiagnosed positives requires ingenuity and continued use of the most efficient approaches.

In COP20, testing will continue to be differentiated by age, sub-population and geographic location based on antiretroviral (ARV) coverage. The reduction in the HTS_TST_POS target from 189,777 in COP19 to 37,457 in COP20 and the average yield from 5.5% in COP19 to 2.1% in COP20 requires implementation of a highly targeted program to reach individuals at high risk for HIV infection and in right places. The FY21 HTS_TST_POS target was derived from the TX_NEW target of 36,005 needed to reach 98% treatment coverage at 96% linkage. Targets were allocated to different testing modalities following COP20 guidance. Index testing, Prevention of Mother to Children (PMTCT), tuberculosis (TB), early infant diagnosis (EID) and voluntary medical male circumcision (VMMC) were pre-determined in the DataPack for TX_NEW; and using the recommended COP20 yields and proportion contribution to total HTS_TST_POS target, respective modality HTS_TST_POS targets were set with index testing contributing 60% of the target, PMTCT 6%, TB 5%, and EID and VMMC each <1%. The remaining HTS_TST_POS target was distributed based on priority of the populations targeted with community testing with KPs and other priority groups contributing 23% of HTS_TST_POS target. Other testing modalities were allocated targets as follows: Other Provider-Initiated Counseling and Testing (PITC) (projected at around 2% with an anticipated yield of around 6%), In-patient (2% with a targeted yield of 9%), sexually transmitted infection (STI) clinics (2% with 9% yield).

Index testing, including assisted partner notification (APN), remains the main approach to the PEPFAR Uganda testing program and will account for 59% of the total positives to be identified with an average yield of 20%. This yield is achievable based on historical performance. We will target partners of newly identified PLHIV, unsuppressed clients on ART, and clients with new HIV risk (e.g., new sexual partners, newly diagnosed STIs). We will continue to mop up clients in care whose partners and eligible family members are missed in FY20. Following civil society concerns

regarding index testing implementation and the subsequent OGAC directive to suspend index testing among KPs, we will continue to work with CSOs, MOH, and other stakeholders to build provider competences to ensure that index testing is implemented without human rights violations. Uganda is already taking active steps to address concerns raised by CSOs and to implement OGAC recommendations to ensure index testing is implemented without any form of harm to index clients, partners, and healthcare workers. The MOH issued a circular to all facilities reiterating the need to implement index testing according to WHO guidelines. In addition, the PEPFAR team has reviewed all national index testing implementation standards and confirmed that the national guidelines align with WHO recommendations. For example, the policy emphasizes adherence to the World Health Organization (WHO) 5Cs (Consent, Confidentiality, Counseling, Correct Results and Connection) when implementing APN, screening for intimate partner violence (IPV) prior to and one month after APN, provision of post-GBV services, and IPV adverse event monitoring in the APN register. Uganda is committed to addressing any gaps and implementing OGAC recommendations with fidelity. We plan to assess and certify sites and service providers with the GBV QA tool and to reinstate index testing for KPs before the end of FY20. Beginning March 2020, Uganda will undertake the following actions:

- Assess quality of service according to WHO and national guidelines at different levels and with different key stakeholders. Key areas that will be assessed mainly at site level include index testing acceptance levels and documentation of refusal rates, availability of index testing implementation materials, minimum package for post-violence care, training of service providers in index testing and IPV, systematic documentation and reporting of APN-related IPV, and evidence of provision of post-IPV care
- Engage MOH to take leadership in implementing COP20 RPM agreements
- Establish a short-term index testing task force
- Communicate clear expectations with implementing partners to achieve HTS_TST and HTS_TST_POS targets rather than strictly focusing on achieving testing modalities' targets
- Review and revise (if deemed necessary) consent forms and other HTS implementation materials with MOH and other stakeholders
- Strengthen adverse event monitoring
- Assess and review the quality of overall counseling services
- Assess and certify index testing sites and index testing providers
- Assess and review the quality of overall counseling services

Other HTS interventions that will continue to be implemented in COP20 include social network testing, targeted community testing to reach KPs and PP including men, and self-testing targeted to partners of pregnant and lactating mothers and KP/PPs. Recency testing will be rolled out to all PEPFAR-supported sites and will help refocus testing to individuals and geographic locations with greatest needs for HTS.

In COP20, PEPFAR Uganda will continue to improve testing efficiencies at outpatient departments (OPDs) through eligibility screening for both adults and children with target yield of 6%. Eligibility screening will also be applied to KP and PPs; screening tools will be actively monitored in all facility-based services in order to improve yield.

Finding and reaching epidemic control among Children and Adolescents

The prevalence of HIV among children <15 years in Uganda stands at 0.5%. By the end of Q1 FY20, there were 96,742 CLHIV in Uganda. Of these, 61,355 were receiving ART (63%) and 49,255 (51%) were virally suppressed. In the same period, 87,659 adolescents 10-19 years were estimated to be living with HIV, with 60,823 (69%) receiving ART and 44,237 (50%) virally suppressed.

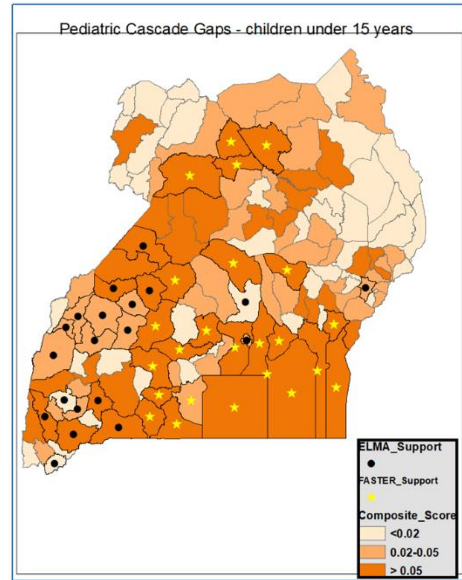
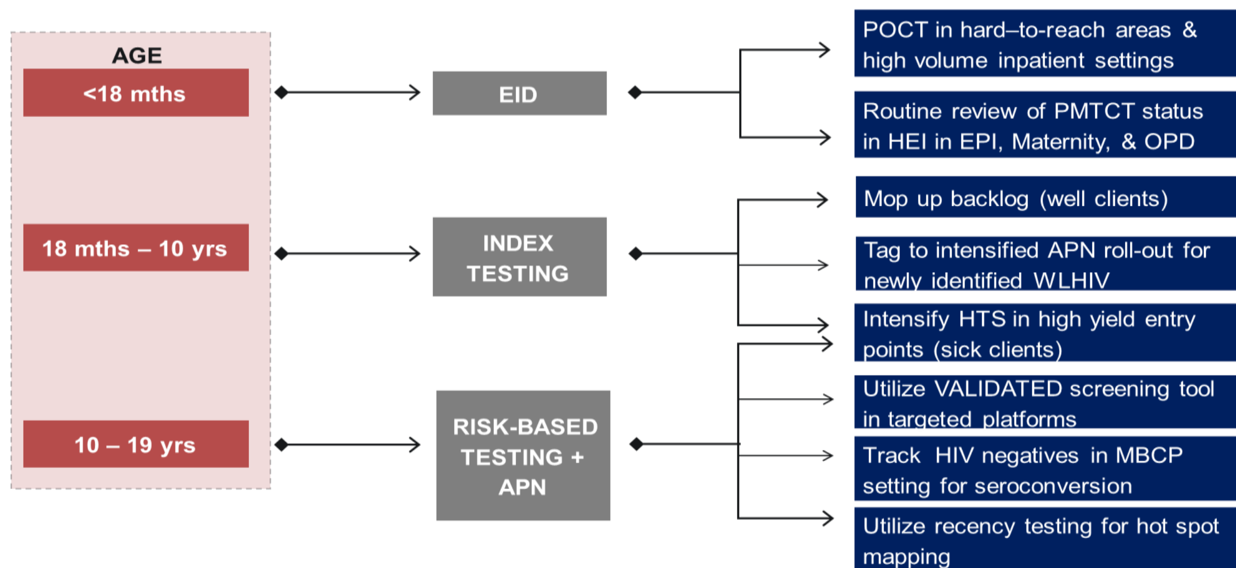


Figure 4.0.2 Pediatric cascage gaps - children under 15 years

As shown in the figure to the right, significant gaps remain across pediatric and adolescent clinical cascades. Efforts have already started in COP19 to address these gaps. Through the National Quality Improvement Collaborative, we have launched an initiative to strengthen the pediatric clinical cascade utilizing the already existing QI structures at national, regional, district and site levels. Through support from FASTER, an above-site pediatric TA mechanism, we identified 22 priority districts with the greatest unmet need and lowest viral suppression for additional support. We are seconding pediatric coaches to each of the priority district health teams to support sites in improving pediatric performance. Additionally, we have developed pediatric care bundles for case identification including EID, linkage and initiation, viral suppression and retention that will be rolled out across all PEPFAR supported sites with the support of the pediatric coaches. We are working with CHAI (ELMA philanthropies) to support an additional 25 priority districts with similar interventions; these efforts will be tracked through the national QI dashboard.

Identification of missing PLHIV in all age groups is the critical starting point to achieving these goals, and Uganda is focusing on age-specific case-finding interventions to improve pediatric ART coverage as summarized in the figure below.



For infants 0-18 months old, the primary strategy is reaching 95% EID coverage. In FY19, 71,668 HIV-exposed infants received an EID test within 12 months of age, translating to 80% EID coverage. By the end of Q1 FY20, this had improved to 89%. Similarly, the proportion within 0-2 months of age improved remarkably from 56% in FY19Q4 to 66% in FY20Q1.

In COP19, PEPFAR Uganda is supporting interventions to further improve the overall coverage of EID 0-12 months to 95% with 84% targeted to receive the EID test within 0-2 months. These interventions will also increase the opportunity for early initiation of ART for HIV-positive infants and improve linkage from EID to ART initiation. In COP20, PEPFAR will maintain the 20/80 split agreed in COP19 with 20% of EID done through the POC platform. Optimization of the conventional EID platforms and sample transport network will continue. EID POC will improve EID coverage especially for infants identified from alternative entry points (pediatric and nutrition wards) as well as improve linkage to ART for HIV-positive infants. Additionally, PEPFAR Uganda will continue to support implementation of pre-registration at mother-baby care points (MBCP) from ANC and maternity; pre-appointment reminders; fast tracking all identified HIV-positive infants for early receipt of results and same day linkage to ART; weekly tracking of infants that are LTFU; and monthly review of birth cohorts. The quality of EID/Expanded Program on Immunization (EPI) integration will also be improved through institutionalizing review of child health cards at every visit to assess for the child's HIV exposure status and actively link them (and/or their mother) to testing if indicated. We will leverage the OVC program to identify mothers of infants with unknown status, as well as malnourished infants, and link them to EID services.

For older children, PEPFAR Uganda will continue to support case identification through index testing of biological children of women living with HIV. In COP19 Uganda is conducting "mop up" index testing for children of HIV-positive women in care both with in ART and PMTCT settings. During this initiative Implementing Partners are supporting sites to line list all biological children of women in care using the family tracking tool, the HIV status or each child is indicated on the tool and all children with unknown HIV status are provided with HTS at the facility or in the community. This initiative will be completed in COP19 for all PEPFAR-supported sites; in COP20 we shall focus on index testing of children of newly identified HIV-positive women. It is expected that 90% of targeted HIV-positive children will be identified through index testing.

To further increase access to HIV testing services for children, Uganda is conducting a study to evaluate the acceptability, feasibility and effectiveness of caregiver assisted oral fluid-based HIV screening in children. Caregiver-assisted oral fluid-based screening presents a safe, convenient, and reliable way to identify children living with HIV and could potentially expand access to essential testing services for children in resource-limited settings such as Uganda. Evidence generated from this study will inform guideline revisions to allow caregivers to screen their children for HIV in the comfort of their homes without incurring transport costs and spending long hours in facilities waiting for HIV testing services. This study is expected to be completed by June 2021.

To identify sick children, PEPFAR will continue to support PITC at high-yield entry points including the malnutrition clinics, TB clinics, and inpatient pediatric wards. Uganda has developed a new pediatric HTS screening tool that will be used in outpatient departments (OPD) and community settings to determine children eligible for HIV testing and only those who screen positive will be

offered an HIV test. The new screening tool is shorter, simpler, markedly reduces the number needed to test to identify one positive child (NNT of 28 in OPD settings) and is expected to further improve efficiencies in testing within OPD and community settings.

PEPFAR will continue to support identification of HIV infected adolescents through a peer led approach. In order to increase access to HIV testing among adolescents, we are using the Young People and Adolescent Peer Support (YAPS) model to scale up peer led index testing and APN for the sexually active adolescents. Due to overwhelming demand, Uganda will train YAPS peers to provide pre- and post-test counseling and conduct rapid HIV tests for adolescents and young people.

We will continue to support the use of HIV self-testing to identify adolescents 18-19 years as recommended by the national HIV testing guidelines and use the YAPS peers to distribute the HIV self-test kits and link the positives back to facilities for confirmation. In COP19 PEPFAR through the Faith Based Action for Scaling up Testing and Treatment for Epidemic Response (FASTER) will support MOH to assess the feasibility of implementing HIV self-testing among adolescents 15-17 years in public health settings. This assessment will explore and propose appropriate distribution channels for HIVST among adolescents, the acceptability of these channels and the feasibility of their implementation within public health settings. Lessons learned will inform scale-up in COP20.

We shall continue to implement social network testing in urban centers to locate adolescents at the highest risk of infection and offer them HTS. In order to accommodate in-school adolescents, we will support sites to provide flexible HTS, including during weekends and holidays. Given the high rates of seroconversion among pregnant and breastfeeding adolescents, we shall follow up with pregnant and breastfeeding adolescents in ANC/MBCP to identify those who seroconvert and link them to treatment. We will use recency testing results for adolescents to map hot spots of transmission and to better target our HIV testing services. Adolescents on the OVC platform will be screened for HIV risk using the DREAMS/AGYW and the HTS screening tools. Those eligible for testing will be linked to HTS, counseled on the importance of partner testing, and supported to reach out to their partners for HTS.

PEPFAR will support demand creation for pediatric HIV testing services through the development and dissemination of messages targeting parents and caregivers to bring children, particularly well children, for HIV testing. We will take advantage of social media platforms to reach out to the adolescents with messages on HTS and will use faith-based platforms to promote messages on pediatric and adolescent HTS.

By end of Q1 FY 20, linkage was 98% among children <15 years and 81% among adolescents 10-19 years. In COP20, we will continue to support the scale-up of a package of linkage interventions, which has been proven to be effective. This package includes:

- Same-day ART initiation
- Phone calls and/or home visits to follow up clients who are not ready to initiate ART on the same day
- ARV starter packs for PLHIV identified outside the facility
- Client locator forms to track linkages and ensure successful referral
- Physical escort of clients by the linkage facilitators

- Supported disclosure

We will further strengthen linkage among adolescents by utilizing the YAPS peers to provide pre and post-test counseling for the adolescents and physically escort the newly identified HIV-positive adolescents from the testing point to the ART clinic.

Finding and Reaching Epidemic Control Among Men

The Uganda HTS program continues to be well aligned with the epidemic, with targets assigned based on ART coverage by geography and sub-population. Geographically, 86% of total positives will be identified in districts with 70% and above ART coverage, the majority of whom (61%) will be men. In addition, most of the positives will be identified in the high burden SNUs of Wakiso, Mukono, Namayingo, Ntungamo, Mayuge, Busia, Mubende, Lwengo, Luwero, Nakaseke, Kalangala, Mpigi, Bulambuli, Kyenjojo, Kyankwanzi, Kayunga, Kassanda, Hoima, Kanungu, Buikwe, Sironko, Isingiro, Aleptong, and Tororo.

UPHIA (2016) revealed that only 74.6% of the estimated HIV-positive men aged 35–49 have been diagnosed, 66.3% are on ART, and 55.9% are virally suppressed. Coverage was lower among younger men, with only 26.5% diagnosed, 22.2% initiated on ART, and 12.3% virally suppressed. UPHIA also reports that just over half, (54.7%) of men aged 25–34 know their HIV status, and that the highest numbers of new infections are occurring in men aged 35–39, while men aged 25–39 have the highest unmet need for ART. There is also evidence of an increase in unmet need for ART among men in Central Region. The Uganda Demographic and Health Survey (UDHS) 2016 further reports that younger men aged 20–29 are less likely to use condoms, most likely to have multiple partners, and have the lowest ART coverage.

PEPFAR Uganda program has been scaling up interventions to reach men with HIV testing since FY16 and individuals identified have steadily increased over the years. As of December 2019, 78% of HIV-infected men aged 20 years and above had been diagnosed, 76% of them were on treatment and 59% had attained viral suppression. Significant gaps remain in infants, children, and adolescents across the clinical cascade with 59% diagnosed, 59% on ART and 42% virally suppressed as of FY20 Q1. Reaching the remaining undiagnosed men will require skill to reach men with heightened risk for HIV and use of highly efficient testing approaches to identify those infected with HIV. Building on experience and practices in COP19, Uganda will continue to prioritize initiatives and testing approaches proven to reach huge numbers of high-risk men and identify high volumes of positives in the critical age group of 25-49 where HIV infections are high according to the UPHIA 2016. In order to maximize efficiencies, Uganda will leverage existing and different community networks such cultural institutions, and other community structures and systems to heighten the demand for HTS and support active linkage to testing sin the facility and within the community. Uganda will also participate in rolling out the FCI through which religious and faith-based structures will be optimized to reach men. Working through the different community networks, the program team, including PEPFAR implementing partners will intensify engagement and use of male champions and male peers to reach and link high risk men to testing. Emphasis will be on KP and PP groups including prisoners, policemen and private security guards, fisher folk, truck drivers and men from centrally supported districts of Abim, Amudat, Bulambuli, Kaabong, Kapchorwa, Karenga, Kween, Nabilatuk, Nakapiripirit, and Napak.

HIV testing services for men will be differentiated by age, population sub-groups (segments) and geographic location. In order to appropriately tailor services to the right sub-populations in the right places and at the right time, the program team will continue to: profile men in each district to determine the different male segments; conduct age-specific dialogues to understand age-specific risks, and the social dynamics within the segments; and align the testing strategies to the sub-population context.

The following key HTS interventions will be prioritized for reaching men in COP20. These interventions are being scaled up in COP19:

- Index client testing with assisted partner notification (APN). This intervention will continue to be prioritized to identify 59% (13,691/23,126) of the total HTS_TST_POS target allocated to men. Tracking of exposed men will be highly prioritized at PMTCT settings and ART clinics with women who are; newly identified with HIV, unsuppressed and those with new HIV risk.

- Social network testing. This intervention will be implemented alongside APN to reach social contacts of HIV-positive and high-risk HIV-negative men. Evidence from the regions that rolled-out social network testing starting COP19 indicates very high yields and HIV-positive volumes. This intervention will be rolled-out in all PEPFAR supported regions in FY20.

- Highly targeted risk-based facility testing. Within the facility, testing will be concentrated at critical service delivery points like TB, STI, malnutrition. Testing outside the critical delivery points will be done with screening for HIV test eligibility. The adult screening tool has been revised and the pediatric tool was validated. These tools have very few questions and are user-friendly. Facility testing contributes 15% (3,468/23,126) of the total HTS_TST_POS target allocated to men.

- Highly targeted community testing to reach KPs and PP including men. All community testing will be subjected to screening for HIV test eligibility for all populations, including KPs. MOH recommended screening for eligibility in all populations and a circular is already in place to support implementation of the guidance. Evidence from current implementation indicates targeted community testing with screening has high yields, and high HIV-positive volumes. In COP20, community testing is expected to contribute 29% (6,764/23,126) of total HTS_TST_POS target allocated to men.

- HIV self-testing. In COP20, HIV self-testing will be implemented for only KPs and partners of pregnant and lactating mothers. HIV test kits will be distributed in the facility and within the community using males' peers and male champions. Distribution of test kits will be accompanied by education on the use of test-kits and need for confirmatory testing for individuals with a reactive test result. Service providers working closely with PEPFAR implementing partners and peers will be required to track all individuals receiving test-kits for feedback on test results.

- Recency testing. Recency will be used to enhance targeting to reach high risk individuals, especially in the community.

HTS interventions for men aged 20+
According to UPHIA (2016), HIV prevalence among men steadily begins to rise from the age 20-24 and peaks at 40-49 years. Uganda will continue to maximize testing in this age through APN, social network testing, highly targeted facility-based testing especially in centrally supported ambition districts, HIV self-testing and targeted community testing. In addition, recency testing will be used to further re-focus testing to high risk male sub-populations in high burden geographic locations. Uganda already scaled-up index testing beyond the Surge sites in FY19 and starting in FY20, efforts will be directed at further minimizing missed opportunities for testing men. This is done through optimizing index testing in sites that rolled-out in FY19 while ensuring no missed opportunities through the PMTCT platform; rolling-out recency, and supporting sites to use recency to focus testing to high risk sub-populations; and streamline testing for adult men at all HTS entry points in the centrally supported districts. Screening for HIV test eligibility will continue to be done for all sub-populations including KP and PP in the facility as well as in the community. In addition, efforts will be made to enhance joint TB and HIV case finding among presumed TB cases and in TB clinics.

Community testing will continue to be implemented to reach men, including KPs, and clients of female sex workers (FSW) but alongside recency testing. Using recency results, IPs working together with the service providers will continuously profile men identified with HIV, especially the ones who are newly infected with HIV to understand the social dynamics and contexts within which they get infected; and work with them to reach their social contacts (outside of the sexual partners) for testing and linkage to appropriate services based on test results. IPs will also work with men who test HIV-negative but are high risk for HIV to link their social networks for testing and linkage to appropriate services. Community testing is a key intervention in reaching men in the ambition districts of Karamoja where community ties are still very strong and traditional/cultural leaders wield a lot of influence. Working through the traditional/cultural leaders and faith-based initiatives, HTS will be more easily accessed by men and boys. Continuous use of recency data will enable IPs to continuously assess the HIV burden up to the sub-county level and to prioritize for HIV testing those geographic locations with the highest need.

In the central "ambition fund" districts, IPs will routinely conduct assessments within the facility to determine service delivery points (HTS entry points) with missed opportunities for male testing and subsequently work with the facilities to ensure men presenting at all critical points are prioritized for testing and that no missed opportunities for linkage to treatment occur. Based on the assessments, IPs will support the sites to streamline HTS flow charts and institute systems within the facility that will raise demand for HTS, reduce waiting time for men undertaking HIV testing, and facilitate women testing HIV-positive to access APN services.

Multiple platforms will be leveraged to reach men aged 20+, including Uganda's Presidential Fast Track Initiative which seeks to reposition the role of country leadership in the HIV response. Increasing access to services for men is still a key priority of this initiative. At the community level, the program will continue to characterize men to allow for tailoring of HIV testing services to their appropriate contexts. We will continue to strengthen facility-community linkage systems and a referral framework, especially in the central ambition fund districts to improve clinical cascade performance on HIV-positive identification and linkage. These will be complemented by intensified community-level demand creation and approaches tailored for effectively reaching men aged 20+, including men from KP/PP, and the AGYW who are part of their sexual and social

networks. Testing in the community will continue to be risk-based using the adult screening tool. This will help to increase testing efficiency and yield especially in central ambition fund districts.

In COP20, we will continue to ensure that learning and adaptation are institutionalized for improving partner performance and achieving activity targets and goals. PEPFAR Uganda will continue to review data weekly to assess progress towards set targets and take timely corrective action or make modifications as needed. At the facility level, service providers will review data on identification and linkage daily and will share reports with IPs. Parallel reporting dashboards and portals established in COP17 and fully operationalized in COP19 will continue to be used to allow for real-time sharing of data, which PEPFAR Uganda will review together with IPs on a weekly basis.

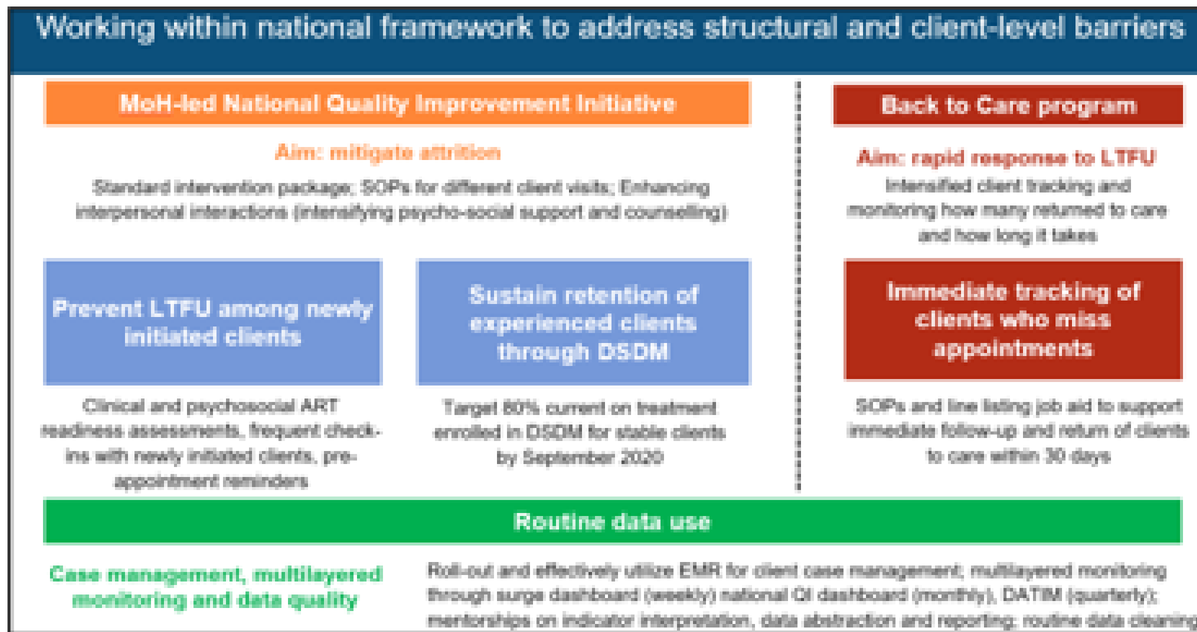
Finding and Reaching Epidemic Control among Women 15+
Achieving epidemic control in Uganda requires addressing gender gaps in HIV testing, linkage, ART access and achieving viral suppression. UPHIA 2016 data indicate that HIV prevalence among women aged 15–64 is 7.6% compared to 4.7% for men of the same age group. For women, HIV prevalence peaks at 12.9% among those aged 35–39 and is almost four times higher among the 15–24-year-olds than men of the same age group. Incident HIV infection is 2.5 times higher in women than men aged 15–19, with the highest incidence among women aged 25-34 (0.7%). Women aged 20–29 also have the greatest unmet need for ART. For women, the largest unmet need for ART falls geographically within four regions: Kampala, Central 1, Central 2, and Southwest. FY19 program data demonstrate that a third of WLHIV were identified through "other PITC," followed by index testing, and the PMTCT platform.

FY19 program data demonstrated that 23,185 women aged 15+ were diagnosed HIV-positive. This constituted 60% of all positives identified during the same period. In COP20, a total of 13,022 women 15+ will be identified, majority (67%) aged 40+ years mainly through index testing with men identified from all testing modalities as indices. Re-testing and active follow up of HIV-negative pregnant women in ANC/FP clinics will be done to identify those that could have seroconverted. Close to 20% of positive women will be identified through targeted community mobile VCT to women in high prevalence locations based on recency testing data. Less than 10% of HIV-positive women will be identified through highly targeted and diagnostic PITC at critical service delivery points including STI, TB, in-patient testing of symptomatic as well as individuals at high risk of HIV infection. PEPFAR will leverage the DREAMS and OVC platforms, using validated screening tools to identify adolescents and young women. In FY20, PEPFAR will support recency testing for all women who test HIV-positive and scale up self-testing. We will routinely inquire for IPV at all testing sites.

4.2 Retaining clients on treatment and ensuring viral suppression

PEPFAR Uganda's comprehensive retention strategy addresses both structural and client-level barriers through a government-led national QI collaborative and implementation framework, focused on client-centered care. This framework aims to mitigate attrition and rapidly bring back those who miss scheduled appointments and/or drug refills. The framework is underpinned by routine use of program data and intermittent collection of in-depth qualitative information to guide program adjustments. The national QI collaborative aims to improve early retention and ensure standard intervention packages are implemented at scale, with quality and fidelity. Within this

collaborative, routine root cause analyses to better understand and respond to needs of the clients are conducted at high volume sites across different regions. The findings are used to inform the refinement of intervention packages in real time.



In COP20, PEPFAR Uganda will utilize this platform to rapidly respond to findings from the community monitoring and will support districts and health facilities implement tailored QI interventions to address these findings and recommendations. In addition, the program continues to implement an intensive back to care/return to treatment initiative, line listing about 80% of clients reported to have missed appointments at the end of the reporting period. This activity will scale-back as we roll-out the new treatment indicator (return to treatment/RTT), strengthen the quality of reporting and implement activities to address performance gaps. In COP20, the program will implement this approach in targeted regions and districts where high losses from treatment are reported.

FY20 Q1 data showed geographic, age, and sex disparities in retention. Lower retention rates were reported among children (<10 years), adolescent and young women (15-24 years) and men (30-39 years). PEPFAR Uganda is implementing a differentiated retention approach described below to address age/sex specific retention challenges. This will be complemented by enhanced site-specific technical support and a blended approach (virtual and in-person) for mentorships and support supervision of QI initiatives to ensure scale of interventions with fidelity to all facilities.

Age and sex specific retention challenges and interventions

Figure 4.0.3 National Framework to Improve Retention

By the end of Q1 FY 20 proxy retention was 80% among children 0-9 years and 87% among adolescents 10-19 years compared to the targeted 95%. PEPFAR Uganda will utilize the national QI

collaborative to strengthen retention efforts by rolling out a pediatric and adolescent retention care bundle across all PEPFAR sites supported by the pediatric-focused QI coaches as described in section 4.1. The retention care bundle will continuously be refined based on findings from quarterly root cause analyses and community monitoring.

For infants 0-18 months, we shall continue to strengthen preregistration for PBFW and their HIV-exposed or infected infants at MBCP, send out pre-appointment reminders, track mother-baby pairs who miss appointments and bring them back to care, and utilize peer mothers to provide psychosocial support for adherence and disclosure. We will continue to support demand creation efforts through the "Bring Back Mother Campaign" and messaging through faith communities.

For children 18 months-9 years, retention will be further improved through adoption of appropriate service delivery models. We shall scale up family clinics which provide services for both children and their parents on the same day and ensure synchronization of appointments of children with those of their parents or caregivers. Stable children aged 2 years and above will benefit from 3 monthly ARV refills as well as enrollment into community DSDM models together with their families. Additionally, we are exploring ways to improve disclosure to children through counseling for parents on how to talk with their HIV-positive children about living with HIV.

For adolescents and youth 10-24 years, PEPFAR Uganda will utilize a four-pronged approach to improve retention which includes peer support, provision of adolescent-friendly services, differentiated services delivery, and provision of comprehensive OVC services. The YAPS model (modeled after the Zimbabwe Zvandiri program) will be expanded from 50 to 71 districts. Adolescent-friendly services are being standardized across facilities and include assigning an adolescent focal person at each facility, having dedicated space or a clinic day for adolescents, aligning clinic appointments to school holidays, and, where feasible, extending services to weekends and evenings. Stable adolescents will continue to benefit from multiple month refills, and we are expanding service delivery options in both facility and community-based models. Adolescents will be offered the option of receiving service together with their family members (at the facility or as part of a community drug dispensing points (CDDP), community led ARV drug distribution (CCLADD) or through adolescents-only clinics. Some of our partners are piloting school nurse programs through which school nurses and matrons are trained to provide adherence support for adolescents in boarding schools. Lessons learned from this intervention in FY20 will be utilized to explore opportunities for scale up in FY21.

For children and adolescents eligible for OVC programming - In COP20, and in line with OGAC guidance, PEPFAR Uganda will continue to strengthen the Clinical-OVC interface and leverage the OVC program to improve retention and viral suppression for infants, C/ALHIV as per the figure below. An OVC case manager or focal person will be based within each facility to support coordination and integrated programming between the clinic and the OVC provider. For example, para-social workers will assess households for violence against children and link affected children to post violence care, participate in the viral non-suppression clinics and switch meetings during which management of children and adolescents are being discussed, identify households that can

benefit from family centered DSDM models and refer them for enrollment, and support access and delivery of ARVs to critically vulnerable children and adolescents. Furthermore, we will explore inclusion of parenting and economic empowerment activities as part of adolescent and family support groups.

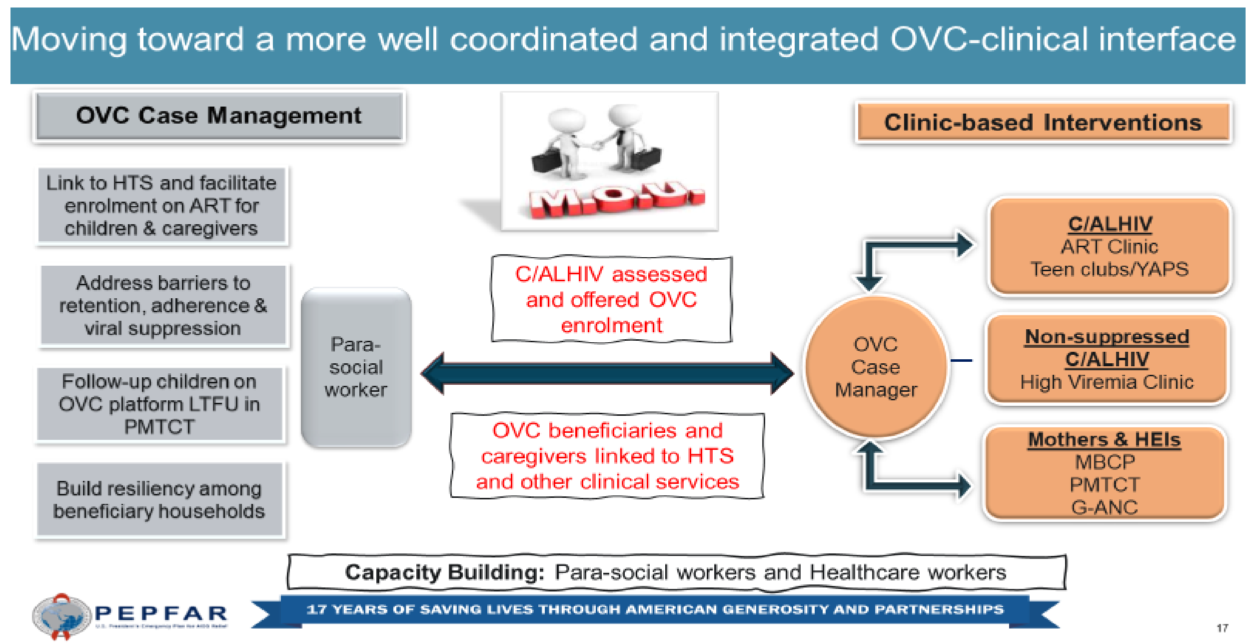


Figure 4.0.4 Moving toward a more well-coordinated and integrated OVC clinical interface

This comprehensive OVC programming will be offered to 90% of C/ALHIV in the 78 districts where PEPFAR supports OVC programming to cover an estimated 77,137 C/ALHIV and their households. As of Q1FY20, 27,483 C/ALHIV were already enrolled in the OVC program, of which 69% had VL results available to the OVC provider and 84% of those were virally suppressed. We anticipate enrolment of an additional 15,000 C/ALHIV into the OVC program by the end of COP19/FY20. The HMIS tools, including the client ART card, have been modified to allow for tracking of screening and enrolment of C/ALHIV into the OVC program, and PEPFAR has introduced quarterly custom indicators to track progress.

For men, guided by the MenStar client centered approach, we will be building on the national QI initiative to address their emotional and healthcare system needs. Specifically, in COP20, we plan to expand male-focused messaging, disseminate the messages using digital solutions, and make it more convenient for men to access services, including expansion of alternative drug distribution points. PEPFAR/Uganda will engage the MenStar team to provide technical support through the Social Behavior Communications for Transformation (SBC4T) activity to develop and disseminate male-focused messaging and potentially scaling up the health service branding approach. Furthermore, through the QI platform, the program will focus on addressing both extrinsic and intrinsic factors hindering consistent engagement in care, especially for men who are healthy.

Interventions to engage men in managing their health will include increased interpersonal interaction through psychosocial support; support patient self-management through provision tools and skills for clients to actively participate in their health care; increased focus on client literacy, expansion of differentiated service delivery models and MMD. Facilities will be supported to conduct integrated wellness clinics for diagnosis and treatment of non-communicable diseases (NCDs), implement flexi-clinics suitable for men, as well as use CBOs to follow up lost clients. The faith-based network will be engaged in community mobilization for improved service uptake especially HTS, linkage, and retention.

For women, as with other subpopulation groups, expansion of differentiated service delivery (DSDM), MMD, and additional peer support will help to address some of the barriers to retention. Root cause analyses have demonstrated that gender-based violence (GBV) is a significant contributing factor to poor adherence and retention among women. In COP20, PEPFAR plans to intensify support for GBV screening and provision of post violence care. This will not only address one of the obstacles to adherence and retention faced by women themselves, but also will improve the situation for their children whose adherence and retention is affected by GBV.

Addressing advanced HIV disease (AHD), TB and non-communicable diseases to reduce mortality and improve retention

Program data from a subset of PLHIV indicates that over 20% of newly diagnosed and virally non-suppressed PLHIV have advanced disease with CD4<200. TB continues to be a significant comorbidity with 38% of TB client coinfected with HIV, and over 15,000 TB cases remaining undiagnosed annually. Further, due to the aging cohort on ART, NCDs are becoming a larger contributor to morbidity and mortality. Available data indicates that among PLHIV, the prevalence of hypertension is 22% and of diabetes 2-4%. To improve retention and reduce mortality and morbidity among PLHIV in care, the country will continue to strengthen management of AHD and work toward integrated management of HIV and non-communicable diseases.

During FY19 PEPFAR supported the scale-up of CD4 testing to over 90% of eligible PLHIV on treatment, development of guidelines and screening tools, implementation of the AHD package, and strengthening end-user capacity in preventive maintenance of POC testing equipment. As a result, CD4 access increased from 67% to 95%, CrAg testing from 81% to 85% while TB-LAM testing reduced from 40% to 36% (mainly due to insufficient commodity availability). In FY20 (COP19), PPEPFAR is working with the MOH to strengthen AHD screening and management by providing refined tools, job aides and IEC materials, improving provider capacity at all ART sites through mentorships, and strengthening monitoring and evaluation (M&E) through roll out of the revised HMIS tools incorporating AHD reporting into DHIS2.

While there has been a marked improvement in TB case finding from 57,145 in FY 18 to 67,874 in FY 19 (MOH DHIS2), it is estimated that Uganda has 83,583 incident TB cases annually, 38% of which are TB/HIV co-infected. Improved diagnostic coverage, quality TB screening and data quality have contributed to the improvement in TB case finding from 1.4% of PLHIV in FY18 to 2%

in FY19. PEPFAR Uganda will continue to scale up effective approaches for finding TB among PLHIV by integrating TB screening into HIV index testing approaches, enhanced facility-based case finding through quality TB screening at all entry points, and optimize GeneXpert so that 100% of all PLHIV access GeneXpert as the primary test for TB diagnosis. PEPFAR also invested additional resources toward intensified TB case finding efforts within prisons given the higher burden of TB in this setting.

In COP20 PEPFAR will increase commodity support for AHD management to improve access to TB_LAM, CD4, and CrAg testing. GeneXpert will continue as the mainstay of TB diagnosis with an increase in commodity support through GF and GOU (see section 4.5). PEPFAR will continue supporting AHD management and sustain successful TB case finding interventions through CQI, mentorship and support supervision, as well as review and revise strategies to improve TB treatment success rates which stood at <75% at the end of FY19. For children with advanced disease, focus will continue to be placed on screening and management of severe malnutrition, using ready-to-use therapeutic foods (RUTF). The priority will be on 5% of children on ART below 10 years of age who annually require RUTF at high volume sites.

To address comorbidities related to NCDs, PEPFAR partners, in collaboration with other stakeholders, funders, and the MOH, are piloting integration of NCD screening and treatment (specifically Hepatitis B and hypertension) within HIV clinics in select sites. Results from these initiatives will inform plans for future scale-up.

Preventing TB through continued scale-up of TB Preventive Therapy (TPT):

In FY19, a total of 429,191 PLHIV were enrolled on TPT; the completion rate was 89%, an improvement from 68% in FY18. This has been achieved through implementation of a QI change package for TPT completion. PEPFAR Uganda has targeted an additional 400,000 PLHIV to receive TPT to reach 73% coverage of PLHIV with TPT by the end of FY20 (COP19). In COP20, PEPFAR Uganda is targeting the remaining ~355,419 PLHIV to ensure that 97% PLHIV have been offered TPT. Given concerns related to liver toxicity side effects, more robust monitoring through active and passive pharmacovigilance is being implemented as part of the revised HIV guidelines. Please see section on ARV and TPT toxicity monitoring below and in the commodities section for further details.

PEPFAR, in collaboration with MOH and other partners, will transition TPT from the use of a 6-months daily INH regimen to a more acceptable 3-month weekly course of 3HP that is likely to further improve TPT retention and completion rates. PEPFAR Uganda will support procurement, distribution, and management of TPT supplies, development of standard operating practices (SOPs), mentorship of health workers, and coordination of a systematic and transition to 3HP for TPT. The 3HP regimen is targeted to be available for site-level implementation beginning April 2021.

Ensuring viral suppression

Over the past three years, Uganda has improved VL coverage from 77% in 2017 to 94% in FY20Q1. Uganda has also registered improvement in VL suppression from 87% in 2017 to 91% in FY20 Q1. The lowest suppression rates are in males and females aged <24 years: 72% for <10 years, 78% for 10-19years and 89% for 20-24 years. HIV drug resistance (HIVDR) is reported as the highest contributor to the non-suppression among children.

Efforts are underway to transition clients to more optimal regimens. The ARV optimization process for children commenced August 2019. Due to global shortages of lopinavir tablets (125mg) and limited in-country DTG 50mg stocks, a phased roll out is implemented to ensure commodity security for children on or transitioned to optimal regimens. We are continuously monitoring stock levels at national and site level to guide optimization efforts and expect more drug deliveries in country by June 2020 when we will resume intensive optimization and plan to complete by Dec 2020 (see section 4.5). The optimization progress against set targets is tracked through the weekly PEPFAR surge dashboard.

Other interventions to improve VL suppression include scaling up an evidence-based refined intervention package to address structural and patient-level barriers to adherence; improving management of non-suppressed clients through dedicated clinic days, enhanced psychosocial support and addressing gaps along the non-suppressed cascade to ensure completion of three consecutive Intensive Adherence Counseling (IAC) sessions, timely repeat of second VL test and switching to an appropriate ARV regimen; and improving facility-community linkages, particularly the clinical-OVC interface as discussed above. The results from rapid CQI iterative cycles and routine RCAs implemented through the national QI collaborative informed the refinement process.

In order to intensify interventions in sites that will have the largest impact, we are focusing on absolute numbers of non-suppressed rather than simply percentage suppression. With support from PEPFAR/Uganda, the MOH has identified facilities with the highest non-suppressed volumes and will engage district health leadership to support sites to implement these interventions. Following the March COP20 in-person reviews, MOH provided each district leadership with a list of non-suppressed patients in their respective districts. The district leadership through the national QI platform will be required to actively track and report to MOH the outcomes of each non-suppressed patient. Should this approach, incorporating an element of accountability, lead to demonstrated improvements within the next quarter, the program will scale it up into COP20.

Furthermore, PEPFAR Uganda will refine and disseminate communication messages in COP19 into COP20. For instance, the program will utilize the YAPS model and adapt Kenya's successful Operation Triple Zero to strengthen peer support for adherence, disclosure and stigma reduction. As mentioned earlier, PEPFAR Uganda will work with the MenStar team to develop and disseminate male-focused messaging to encourage consistent engagement in care and adherence to treatment. In COP20, PEPFAR will also expand to 10 centrally supported districts to improve the low VL coverage and suppression through establishing processes and systems that have worked in other regions and implementing at the same level of intensity as other districts.

In addition, as the country transitions to TLD, PEPFAR Uganda is supporting MOH to implement DTG safety and drug resistance monitoring. Following reported adverse events signals and concerns raised by CSO, health providers, the National Drug Authority (NDA), PEPFAR Uganda is supporting MOH to put in place safety and toxicity monitoring as the country moves into the second phase of DTG transition. A harmonized and comprehensive guidance for DTG safety and toxicity monitoring is now included in national HIV treatment guidelines. PEPFAR Uganda also supports TLD drug resistance monitoring. Monitoring tools are in place and VL test request forms are revised to capture DTG-based regimens. In COP20, PEPFAR Uganda through Uganda Virus Research Institute (UVRI) will support HIVDR testing on all VL remnant samples (DBS and Plasma) for clients on TLD who are non-suppressed for at least 9 months on TLD.

4.3 Prevention, specifically detailing programs for priority programming:

4.3 a. HIV and violence prevention for Adolescent Girls and Young Women (AGYW) and Orphans and Vulnerable Children (OVC)

In COP20, Uganda will continue to implement an integrated AGYW strategy that is aligned to the National Health Sector HIV Prevention Strategy for AGYW (2020-2025)[5]. This will be implemented across multiple platforms including Prevention, OVC, PMTCT and Treatment. The program will provide comprehensive HIV and violence prevention and treatment services to the right beneficiaries for epidemic control. The DREAMS program will expand from the current fifteen focus districts to an additional four districts (Kalangala, Masaka, Wakiso, and Mbarara), based on incidence and AGYW at-risk burden. Uganda proposes to reach 187,809 AGYW in the 19 DREAMS focus districts taking into consideration aging in and out of AGYW and ensuring program completion for enrolled AGYW to reach district saturation.

Uganda will implement a robust client-centered quality AGYW program with fidelity aimed at reaching AGYW with the highest HIV risk, identified using a standardized risk screening and vulnerability to HIV screening tool. HIV-positive status is not an exclusion criterion for enrollment in the DREAMS program. The DREAMS program will track AGYW cascades for AGYW Reached, screened, eligible, enrolled and completed minimum required interventions. The program will continue to implement harmonized, age-appropriate core package of evidence-based primary and relevant secondary interventions for each target age band. (see DREAMS Layering table)

The program will continue to use a peer-led service delivery model with case management to ensure that every AGYW receives appropriate comprehensive interventions tailored to her needs. Primary interventions will include HTS, Stepping-Stones or another developmentally appropriate intervention and combined socio-economic services (financial literacy and Village Savings and Loan, asset building). Secondary services will include condom promotion and provision, parenting and caregiver program, and offering contraceptives mix. Post-GBV care for survivors will be offered when appropriate. We shall ensure optimal layering using a blended approach starting with line listing and targeted catch up peer driven service delivery models. DREAMS data QI will be done through multiple approaches including combined group registers to ease tracking.

[5] MOH, 2020. Health Sector HIV Prevention Strategy for Adolescent Girls and Young Women (2020-2025)

In response to sub-optimal completion and saturation rates across different age bands (particularly among 10-14-year-olds) and sub-national units (SNUs) for DREAMS interventions, a root cause analysis was carried out. The findings showed relocation, school dropouts and long distance to safe spaces as the key barriers to program completion. To address these in COP20, the program will invest in an enabling environment for intervention completion, enhancing education subsidies, improving AGYW tracking and referrals across SNU's and using client centered service delivery models in safe spaces.

Uganda will strengthen the social economic approach interventions to boost accelerated pathways to economic independence for AGYW by enhancing wage to employment with more emphasis on the entrepreneurship pathway. This will be done through a multi-pronged approach which will include extensive market assessments to identify scalable market-driven opportunities and guide intervention packages into male dominated enterprises. We shall roll out enhanced market-relevant trainings, bolstered start-up support (matching grants and start-up kits), and leverage GOU structures like operation wealth creation. Ongoing mentorship and peer networking and adaptation of evidence-based models used in Uganda, like Empowerment & Livelihoods for Adolescents by Building Resources Across Communities (BRAC) and Women's Income Generating Support (WINGS) will be adapted.

The program will continue to roll out strategies to identify sexual partners of the AGYW through male partner profiling/characterization. Community gatekeepers and opinion leaders will continue to be sensitized about the benefits of the DREAMS and will be involved in community QI teams and community interventions. The program has identified male champions who are now "DREAMS ambassadors" in the communities and will be critical in supporting their AGYW partners to complete the interventions.

The program approach prioritizes bringing services as close as possible to the AGYW and working with AGYW peer leaders, district, cultural, community and religious leaders for active referrals. District Action Centers (DACS) will continue to be supported to use a case management approach to follow-up survivors of violence, while garnering community support for violence prevention. Through systems strengthening, support, the Uganda Child Helpline will be supported to facilitate reporting and response to abuse cases. The program will continue implementing a child justice program targeting the district prosecutorial authorities and other stakeholders throughout the justice chain.

Learning from the Violence Against Children Survey (VACS) 2018[6], and INSPIRE, a global action tool with seven strategies on ending violence against children (Implementation and enforcement of laws; Norms, and values; Safe environments; Parent and caregiver support; Income and economic strengthening; Response and support services; and Education and life skills), Uganda piloted a project in Mityana which will roll out a locally contextualized violence prevention early detection index for children living in households that are rated as at most risk of experiencing violence. This tool is currently under development and validation in COP19. The index will engage families and profile households where violence against children is reported. The early detection index will enable practitioners to design interventions that directly deal with factors perpetuating violence and to anticipate and immediately act on such households identified as most at risk of violence occurring.

[6]Uganda Violence Against Children Survey, 2015

AGYW aged 9-14: Uganda will focus on primary prevention of HIV and violence among the 9-14-year-old through evidence-based interventions known to delay sexual debut, particularly we shall continue to advocate and support AGYW to stay in school, a key factor that delays sexual debut as well as reduces risk. We shall also provide education subsidies to vulnerable girls who would otherwise drop out if unable to meet school fees; and to prevent HIV infection and violence (Stepping-Stones or another developmentally appropriate intervention for children out of school). Uganda will increase participation of FBOs and communities to address violence among 9-14 young girls using the SASA! Faith and in addition to other curricula applied in the program. Community platforms will be used to offer these services. The program will implement interventions that enhance adolescent girls' ability to resist coerced sex and to seek support if they experience coerced sex (for example, building self-esteem and confidence as well as self-defense, developing life skills such as assertiveness, effective collaboration and improve social networks.

At the individual level: Interventions will aim to empower girls to avoid risk. Girls aged 10-14 who are out of school will be offered a community-based curriculum (Stepping-Stones curriculum for children or another development appropriate intervention). No Means No for girls will be continued in COP20 to build protective skills against violence.

At family level: The program will continue to promote positive parenting and effective communication between girls and their caregivers, as well as to empower families to keep their girls in school through timely education subsidies and household economic strengthening. Regular visits by case managers to monitor the home environment and to provide early intervention to address risks of violence in the home and ensure equitable investment in girls will be a critical component of the program

AGYW aged 15-19: The program will focus on risk reduction interventions including: violence and HIV prevention (Stepping-Stones), parenting skills (SINOVUYO) for HIV prevention, keeping girls in school and combined social economic interventions for AGYW who have dropped out of school.

AGYW aged 20-24: Risk reduction and asset building through combined socio- economic approaches that positively contribute to determinants of health as well as interventions for violence and HIV prevention (Stepping-Stones) will be supported.

Community (including parents): The program will continue scaling up SASA! for violence prevention, foster norms change and parenting interventions to support AGYW with a special focus on keeping girls in school while galvanizing the role of society as a key community resource.

Men, Boys and Sexual partners: The program will continue to aggressively reach more men aged 35-49 years, who have been identified as the highest-risk age bracket by Uganda Population HIV Impact Assessment (UPHIA), 2016. This will be achieved through male Priority Populations (PP) champions and male age-specific dialogues to optimize identification and linkage. Emphasis will be on KP and PP groups, including prisoners, police officers, private security guards, fisher folk, and truck drivers.

The program will ensure that male sexual partners receive core prevention interventions including HIV testing services, VMMC and ART. Additionally, men and boys will be engaged in interventions that address harmful gender norms, sexual coercion and violence. The program will continue to

profile/characterize male sexual partners, using the male partner characterization approach and will use strategic information to map where recent infections are occurring in men.

Uganda Curriculum-Based Interventions

Working with families, communities and faith-based organizations, Uganda will optimize curriculum-based interventions to address specific needs of AGYW tailored to their age. The prominent tools/curricula to be used include: SASA!, Stepping-Stones, SINOVUYO and Journeys Plus.

SASA! is a four staged curriculum with 16 modules aimed at addressing the core drivers of violence against women and HIV. It is meant to inspire, enable and structure effective community mobilization to prevent violence against women and addresses the imbalance of power between women and men as well as girls and boys. SASA! involves everyone, creating a critical mass of people across all levels of society in order to reshape social norms and behaviors related to gender-based violence within communities.

Stepping Stones is a 14-module curriculum designed to improve sexual health through building stronger, more gender-equitable relationships and better communication between partners. It is purposed inculcate HIV preventive sexual behaviors among adolescent girls and young women and targets girls in the age group 15-24. Uganda will also start the roll out of **Stepping Stones for HIV and violence prevention** among children aged 9-14 who are out of school or another development appropriate intervention.

SINOVUYO curriculum focusses on improving parenting skills among care givers. It is jointly offered to AGYW together with care givers to optimize opportunities for open discussions and debunking some of the myths that widen the gap between children and their parents.

Journeys Plus is also an HIV and violence prevention specific curriculum, with content tailored to school going young girls aged 9-14. It offers an opportunity to orient young girls on the risk of HIV and to enable begin perceiving their risk and vulnerability to infection.

No Means No is a worldwide sexual violence prevention program. The program uses the **'Impower'** curriculum to teach girls mental, verbal and physical skills to prevent sexual assault; and teaches boys resilience, challenging rape culture, and practice consent and bystander intervention skills.

Figure 4.0.5 Monitoring the quality of GBV service delivery, FY19

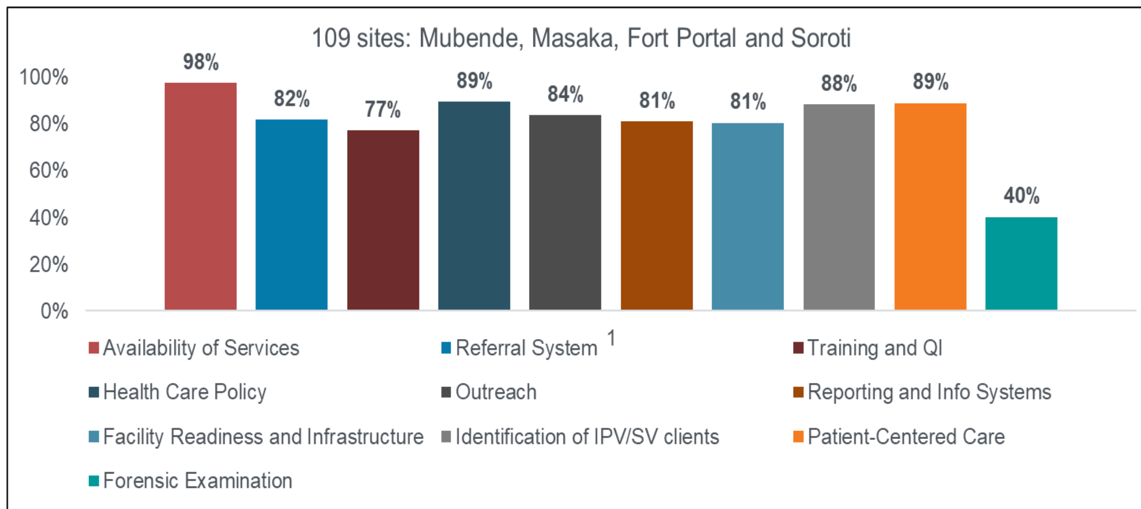
Through the Peace Corps, Uganda in COP19 is rolling out the Grassroots Soccer Curriculum with 12 modules targeting 10-19-year-old young boys. This intervention uses simple and powerful connections between soccer and life to teach young boys life skills focused on HIV and violence prevention. Taking lessons from COP19, a phased approach to scale up Grassroots Soccer to other high prevalence districts starting with DREAMS supported districts will be implemented in COP20. In COP20, a second phase of No Means No curriculum that targets boys is being introduced to reduce their risk and future perpetration of violence. This will leverage existing PEPFAR supported OVC and VMMC programs (and platform) to reach boys and offer the curriculum.

In COP 18, Peace Corps contributed to finding men through its pilot tripartite partnership with the Uganda Police and Uganda Red Cross through which the road traffic regulations training platform was used to identify and link PLHIV to prevention and treatment. At the end of the training, each boda (motorcycle) driver is provided with a toolkit that consists of a helmet, vest with HIV message, HIV sticker and first aid materials. Peace Corps will scale this up in COP20 in high HIV burden districts.

Multi-level violence prevention and response interventions

In COP20, Uganda continues to triangulate multiple data sources to inform a multi-level robust violence response program. These sources include the FY19 GEND_GBV performance data, Root cause analysis, National GBV QA Tool assessments data, VACS 2015, data from the Uganda National Child Helpline (SAUTI 116), and MOGLSD-supported District Action Centers data. We continue to support the government to complete key policy documents including GBV and VAC guidelines and the Comprehensive Children's Policy which

addresses violence against children. We shall continue rolling out the GBV QA tool to reach all sites offering post-violence care services and prioritize safety and access to services for all who need post-violence care.



In COP20, the program will address the following top three gaps identified from the GBV QA tool assessments in FY19: a) training & QI gaps to be addressed through ongoing mentorships; b) inadequate facility readiness & infrastructure to be addressed by investing in capacity at facility level, and c) lack of forensic kits at facilities which we plan to procure in COP20. Uganda has dedicated a GBV fellow through CDC to support the national efforts in monitoring GBV service quality including real-time remedial actions across the prevention and treatment cascade.

Through our DREAMS and OVC programming, PEPFAR will continue to support the government-led district action centers (DAC) through which community awareness on violence against children is improved and timely services are offered to victims. We shall continue joint investments in the justice, law and order (JLOS) sector to improve resolution of child cases by supporting and monitoring cases at the district level.

Our data indicate that GBV is associated with non-adherence to treatment leading non-viral suppression which impedes epidemic control, in COP20, we shall continuously profile survivors to support them with needed services and counseling We recognize that men's health seeking behaviors are often negatively affected by societal expectations about 'being strong', which keeps them from treatment, thus PEPFAR will deliberately support men to access services collaborating with faith communities.

Uganda reached its 2019 Annual Program Result (APR) to reduce GBV. COP20 will refocus on reaching AGYW performance targets especially for sexual violence. Uganda is building capacity to roll-out an "Every Hour Matters" campaign with communities including DREAMS ambassadors and YAPS to raise awareness about the 72 hours within which one should access services to avert HIV and pregnancy.

We shall employ an integrated approach to address GBV across the Prevention and Treatment cascade including LIVES. and continue monitoring Intimate Partner Violence (IPV) among AGYW, KPs, PMTCT, and index testing and PrEP recipients.

Monitoring of service provision: To monitor the quality of services provided to enrolled AGYW we shall continue to use the Uganda DREAMS Tracking System (UDTS) which efficiently tracks the layering of multiple interventions for each individual AGYW. Quality assurance and M&E IPs will verify the data in the UDTS and in source documents through quarterly data quality assurances (DQAs). Weekly district dashboards will be used to flag areas for immediate technical assistance and course correction. To ensure fidelity of curriculum-based interventions the program will use uniform SOPS for training quality checks. Facility and community DREAMS quality improvement/quality assurance (QI/QA) teams will be functionalized to monitor the quality of interventions at facility and community levels respectively.

The program will strengthen community monitoring and follow up to mitigate AGYW program drop out by using beneficiaries and community stakeholders including CSOs who to conduct independent monitoring of DREAMS interventions using standard benchmarks, tools and processes and render timely, objective and constructive feedback at various levels adapted Site Improvement through Monitoring Systems (SIMS) assessments and Program service delivery and impact data will continuously be reviewed to inform future scale-up plans. and program success stories will be documented and disseminated to promote cross learning.

Figure 4.2.2. AGYW Geography of Implementation

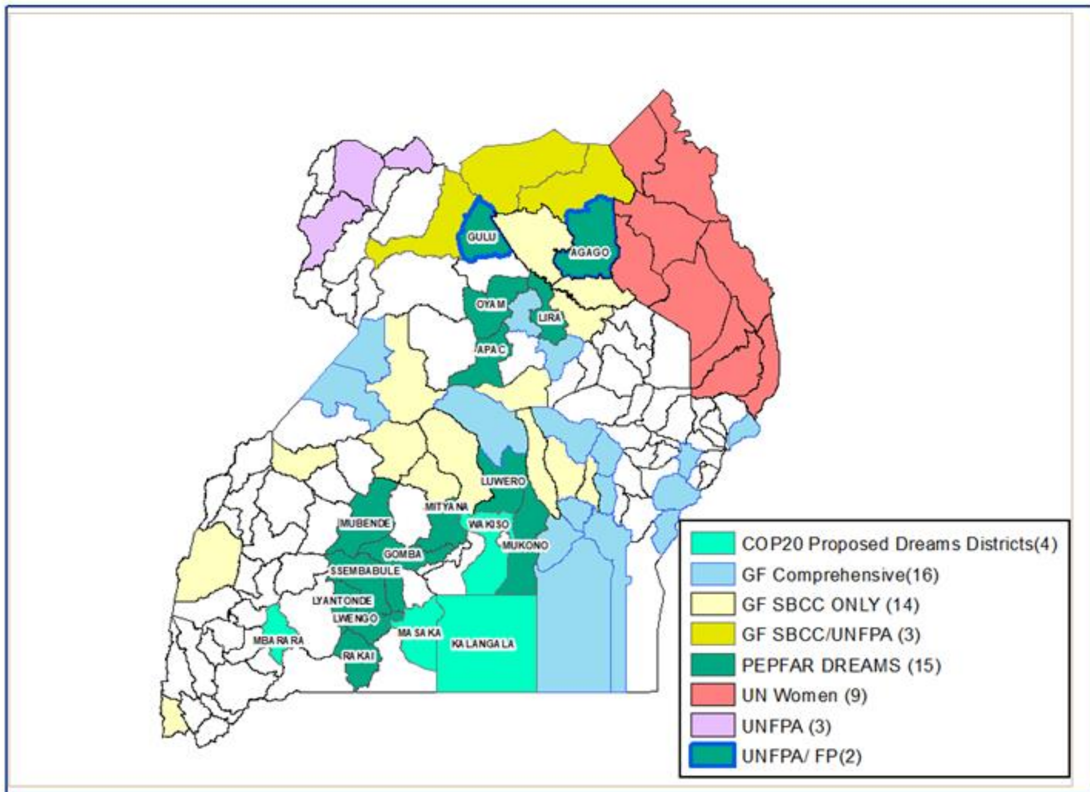


Figure 4.0.6 AGYW Geography of Implementation

Figure 4. DREAMS Layering Table

Uganda DREAMS Layering Table			
Population Segments			
	10-14	15-19	20-24
Primary Individual Interventions	• Screening for HTS eligibility • School or Community Based HIV & Violence Prevention • Parenting	• Screening for HTS eligibility • School or Community Based HIV & Violence Prevention • Combination Socio-economic approaches ***(only for those out of school)***	• Screening for HTS eligibility • Community Based HIV & Violence Prevention • Combination socio-economic approaches
Secondary Individual Interventions	• Risk based HTS • Condoms • Contraceptive Mix • Post-violence care • Education subsidy • ART (***for HIV-positive AGYW***) • Group-ANC model or longitudinal follow-up through 2y postpartum in PMTCT mother-baby care point (***for pregnant and BF AGYW***)	• Risk Based HTS • Condoms • Contraceptive mix • Post-violence care • Parenting (***for those 15-17 years***) • Education Subsidy • PrEP • ART (***for HIV-positive AGYW***) • Group-ANC model or longitudinal follow-up through 2y postpartum in PMTCT mother-baby care point (***for pregnant and BF AGYW***)	• Risk based HTS • Condoms • Contraceptive Mix • Post-violence care • PrEP • ART (***for HIV-positive AGYW***)

Figure 4.0.7 DREAMS Layering Table

Orphans and Vulnerable Children

The OVC program will target 480,167 children aged 0 to 17 and their caregivers, of which 371,728 will receive a comprehensive package, including HIV and violence prevention, using a family-centered case management approach. OVC beneficiaries will be targeted at multiple levels: individual empowerment, family strengthening, and community mobilization for change.

OVC prevention programming will be implemented in 12 districts with high rates of violence against children. A total of 108,439 boys and girls aged 9-14 in these districts will receive evidence-based primary prevention of HIV and sexual violence interventions through schools, faith communities and cultural platforms, leveraging the structural roles that these platforms play in changing community perceptions and behaviors.

At the individual level: Interventions will aim to empower girls and boys to reduce or avoid risk. Based on context, need, and opportunity, girls and boys will receive HIV and violence prevention in school through *Journeys Plus* or in their communities through *Grassroots Soccer, No Means No, Coaching Boys into Men*, and SINOVUYO. These curricula are being implemented in COP19 and will be continued and/or expanded in COP20, with the exception of *Stepping Stones* which is currently being adapted for 9-14-year olds.

At the family level: The program will continue to promote positive parenting and communication between children and their caregivers, as well as empower families to keep children in school through education subsidies and household economic strengthening. Regular visits from case managers will help in monitoring the home environment and providing early intervention to address risks of HIV and violence in the home.

At the community level: OVC programs will implement SASA! to mobilize communities and facilitate norms change among both community and faith leaders. The program will also strengthen child protection systems including District Action Centers and support the Uganda Child Helpline to facilitate reporting and response to abuse cases. The program will continue implementing a child justice program targeting law enforcement and justice sector authorities and stakeholders.

4.3 b. Children/Preventing Mother-to-Child Transmission (PMTCT)
Identification, linkage, ART initiation, retention and viral suppression for PBFW aged 15+.

Since the rollout of Option B+ in 2013, the proportion of HIV-positive pregnant women initiated on ART increased from 84% (FY13) to 98% (FY19). HIV-positive women on ART at the beginning of pregnancy increased from 33% (FY13) to 73% (FY19), although the proportion of pregnant women who are known positive and already on ART at the time of diagnosis has plateaued. The fertility rate has dropped from 6.2 in 2011 to 5.4 in 2016, but pregnancy among young women remains high: 53% of pregnant women are under age 24 (PEPFAR Program data FY19). In Uganda, 25% of adolescent girls aged 15-19 years have begun childbearing (UDHS, 2016). Furthermore, HIV-positive pregnant AGYW (aged 10-24 years) accounted for 48% of the newly identified positives at 1st ANC visit (ANC1) in PMTCT supported PEPFAR sites (FY19). High rates of sexual GBV (SGBV) against women (22%) persist in Uganda, predisposing vulnerable women to unwanted pregnancies and disproportionately more new HIV infections.

HIV transmission to infants in FY20 Q1 was 1.84% among those infants tested, with 0-12 months EID coverage at 89%, an improvement from 79% at FY19 Q4. However, in FY19 and FY20 Q1, 0-2 months EID coverage was 54% and 66%, respectively. This gap in early diagnosis indicates missed opportunities for early intervention, that we will address in COP20.

COP20 activities (detailed below) will strengthen existing strategies and introduce innovations where gaps have been identified, in order to provide high-quality care for pregnant women and mother-baby pairs. In COP20, we expect 1,484,687 pregnant women to attend ANC1 at PEPFAR supported sites. Of these, we targeted 100% to have known HIV status. Among the estimated 6% of individuals who are HIV-positive, 87,764 are targeted to receive ART among which 97% (85,531) are expected to already be on ART at ANC1 and 3% (2,233) will be new on ART. Additional COP20 targets include 95% retention and viral suppression among pregnant women initiating ART; 84% 0-2 months EID coverage; 98% ART linkage for identified mothers and HIV-infected infants; 100% final outcome infant status at 18 months; maintain <2% early MTCT rates; improved PMTCT data quality; and expansion of EMR (>40%) to high volume ANC/PMTCT PEPFAR supported sites.

Case Finding: All pregnant women attending ANC will continue to receive PITC as per national PMTCT guidelines utilizing dual HIV-Syphilis testing in ANC. The mothers who do not receive HTS at 1st ANC visit will be followed up to receive HTS in subsequent visits. In addition, given evidence of high rates of seroconversion and new pediatric HIV infections during pregnancy and breastfeeding periods, HIV-negative pregnant and breastfeeding women, and those with unknown HIV status presenting at MNCH/PMTCT entry points will be retested per national HIV prevention and treatment guidelines in ANC, maternity (labor & delivery), postnatal care (PNC) and young child/immunization clinics. Given that many women (21% ANC1 attendees) and their infants seek MNCH and Young Child Clinic(YCC) /Immunization services at HCIIs, yet HCIIs are not accredited to provide ART/Option B+ PMTCT & EID services, PEPFAR Uganda will work with MOH to improve service access for these mother-infant pairs in COP20.

At the community level, PEPFAR will work with CSOs/CBOs, Village Health Teams (VHTs), and peer mentor-mother networks to identify, register and refer all pregnant women in the communities to attend ANC and receive HIV testing services. In Uganda, DPT1 coverage is very high at 95% (UDHS 2016). We shall continue to use community outreach immunization platforms to identify mothers with unknown HIV status and offer HTS to them, especially those who do not attend ANC and who deliver at home. We will routinely review all the ANC, maternity registers, and postnatal registers to ensure adherence to guidelines and proper documentation.

Treatment, initiation and retention

Same-day ART initiation is provided at ANC, maternity and the mother-baby care point (MBCP). In addition to the standard package of linkage and retention interventions described above, peer mothers provide ongoing counseling and support through the pregnancy and postpartum period with a focus on disclosure, IPV screening and post-violence care, and linkage with OVC and DREAMS program activities including economic strengthening and training for Early Childhood Development. In many PMTCT settings, family support groups (FSGs) have been established though these need to be re-energized and functionalized in COP20 to provide intensive peer adherence support for vulnerable pregnant and breastfeeding mothers (e.g. newly identified PMTCT clients, Adolescents and Young mothers, SGBV victims and those with poor socio-economic status). FSGs offer the much needed additional PMTCT & EID services to mother-infant

pairs in supported PEPFAR programs using non-clinical trained personnel to encourage women to: i) seek and attend early ANC services, ii) ensure health facility delivery, iii) receive HTS/PITC services, iv) initiate timely ART for all identified positives and v) support adherence, follow-up and retention of mother-infant pairs in care until 18-months final outcome status post-partum.

In COP20, additional focus will be directed to support Health Centre IIs to address sub-optimal ART/Option B+ coverage among positive pregnant and breastfeeding PMTCT clients identified at this level of service delivery. While almost 21% of ANC attendance happens at Health Centre II level, traditionally these health facilities face a number of system challenges including : i) poor infrastructure at ANC/MNCH service delivery points, ii) lack critical staff (midwives, counsellors, laboratorians, M&E personnel, etc.) to support quality HIV/PMTCT service delivery, iii) lack of critical commodities e.g. HIV test kits (RTKs, dual-syphilis kits, EID bundles, etc.) and other multiple structural barriers for optimal service delivery of eligible mother-infant pairs in PEPFAR-supported PMTCT regions. In COP20, PEPFAR Uganda and MOH propose the following strategies to address poor ART/Option B+ linkage of identified mothers:

- Support districts to redistribute ART to HCIIs and operate Community Drug Distribution Points (CDDPs) or satellite clinics at sites offering ANC/MNCH services
- Ensure establishment of Mother-Baby Care Points (MBCPs) at high volume HCIIs and PNFP sites
- Recruit counsellors and peer mentor-mothers at HCIIS to provide intensified counselling to minimize barriers for same-day ART initiation
- Strengthen family support groups (FSGs) to provide psychosocial (PSS) support to vulnerable pregnant and breastfeeding mothers (refer to categories identified above)
- Conduct targeted technical support through onsite CMEs and mentorships to health workers at HCIIs on TLD transition in PMTCT/EID clinics
- Scale-up use of CQI approach to bridge identified program gaps and ensure data quality of PMTCT data
- Strengthen the PEPFAR linkage package of interventions and use evidence-based practices tailored for PMTCT/EID clients at the MBCP

The MBCP has proved to be an effective platform for follow-up of mothers and infants. The MBCP service delivery approach follows mother-infant pairs for 2 years post-delivery (visits track to the immunization schedule) utilizing a “One Stop Shop” approach as depicted in figure 4.1.4. Factors contributing to the success of this approach include giving one refill date for the mother and baby; pairing mother and baby charts; engaging linkage facilitators to follow up lost mothers of babies due for testing; placing stickers on charts of babies due for testing at 18 months; and immediate update of registers for children tested at 18 months. QI teams are being systematically established to strengthen retention of mother infant pairs and will be focusing on rapid follow-up of missed appointments and utilization of the site level birth cohort monitoring register and HEI cohort analysis (HCA) tools to bring back mother-infant pairs that had previously been LTFU within the PMTCT/HEI continuum of care. These teams will also promote expansion of the integration of support groups, socio-economic strengthening and early childhood development within the MBCPs

Figure 4.1.4. MBCP service delivery approach

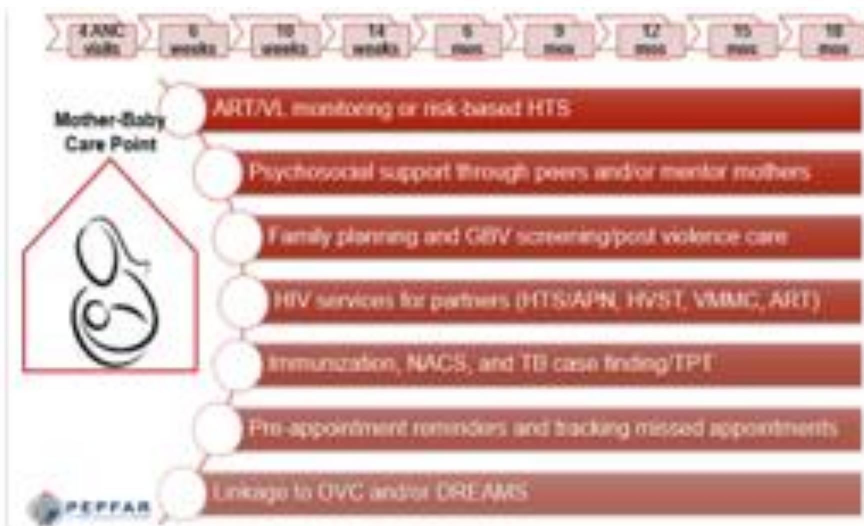


Figure 4.0.8 MBCP service delivery approach

Viral suppression

Given the increased MTCT risk for an infant whose mother is not virally suppressed, additional attention is being given to identify viral non-suppression early among pregnant and breastfeeding mothers, conduct appropriate clinical management of non-suppressed clients, and ensure optimal VL return to undetectable levels. The revised consolidated guidelines for prevention and treatment of HIV in Uganda (Sept.2018) include a more rigorous VL monitoring algorithm for PBFW recommending VL at first ANC for any woman who is already on treatment (regardless of timing of last VL test) and six monthly VL testing through the end of breastfeeding. Additionally, the ANC/PMTCT staff are being included in the VL collaboratives as well as the multidisciplinary switch teams at the facilities to ensure that the 10-point VL change package (described above in section 4.1) is being implemented in these settings. These new policy guidelines, along with the intensified mentorship and interventions through the QI collaboratives, will greatly support national efforts towards virtual elimination (<5%) of final MTCT by FY2022.

Preventing new infections among pregnant and breastfeeding AGYW

PMTCT services provide a platform to prevent HIV incident cases among AGYW. Of all the identified positives among pregnant women aged 10-24 years in FY20 Q1, almost half (49.5%) were newly identified positive clients. Although Uganda is making strides in improving contraceptive uptake and lowering fertility rates, increasing male partner testing and ART coverage among the partners of these women is necessary to decrease the relatively high rates of newly identified positives among pregnant women, particularly the Adolescent and Young Women age group (10-24 years). In FY19, only 32% of male partners were tested in ANC settings. COP20 will continue to strengthen male partner involvement in ANC/PMTCT activities including male partner index contact tracing, APN and HIV self-testing services using the ANC/PMTCT platform.

In DREAMS districts, the ANC/PMTCT platform has been used to actively identify and link AGYW to DREAMS services (see section 4.1 for DREAMS package). COP20 will support the more direct

integration of DREAMS services within the ANC/PMTCT platform by working with ANC/PMTCT sites in DREAMS districts to expand the MBCP services to HIV-negative AGYW mothers 15-24 years of age given that these young women are some of the most vulnerable and would greatly benefit from a more structured environment with strong linkages to additional services. As described above, the MBCP has systems in place to provide both support and active follow-up of HIV-positive mothers during the first two years post-delivery from which the youngest, at risk negative AGYW can also benefit. Figure 4.1.5 outlines the integration of DREAMS interventions within the PMTCT/MCH platform at facility and community levels.

Integrating DREAMS Interventions within PMTCT/MCH Platforms at Facility and Community Level

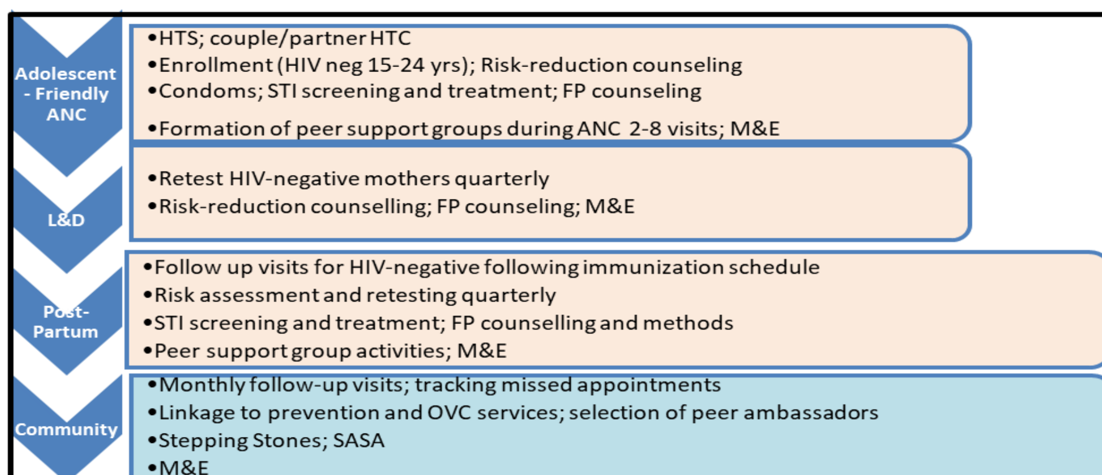


Figure 4.0.8 Integrating DREAMS Interventions within PMTCT/MCH Platforms at Facility and Community Level

Group ANC/PNC for Pregnant & Breastfeeding AGYW 15-24 years.

Adolescent pregnancies and childbearing are associated with risky behaviors such as early sexual debut, early marriages, trans-generational sex, transactional sex, multiple sexual partnerships, alcohol and drug abuse and unprotected sex. Most of these pregnancies are unintended and often result in negative sexual and reproductive health outcomes. In Uganda, pregnant AGYW receive ANC together with older mothers above 25 years of age, yet pregnant AGYW have unique biological, psychosocial and emotional needs.

Given these challenges, there is need to differentiate this sub-population group and provide evidence-based, tailor-made service packages that respond to their dynamic needs.

In FY 19, the Uganda MOH introduced Group-Antenatal (G-ANC) model of care in 33 PEPFAR supported sites targeting pregnant AGYW (HIV+ and HIV-negative) aged 10-24 years in high volume sites. The model was adapted from the HOPE project G-ANC model in Kenya and is based on “centering pregnancy” (Rising, 1998), a group model of prenatal care delivery that places all three components of prenatal care—risk assessment, education, and support—within a group setting. Pregnant AGYW in groups of 8-12 women, based on similar gestation periods or age groups, receive peer-led ANC sessions facilitated by a trained midwife following a standard curriculum. The Group

ANC model provides enhanced adolescent friendly services integrated into PMTCT and ANC/MCH platforms. Early results from Kenya demonstrate improvement in retention from 72% to 88% over a 6-month period.

4.2.b. COP19 Key and Priority Populations, PrEP

PEPFAR Uganda identifies key and priority populations (KP/PP) as indicated in Table 4.1.3 which also includes the size estimates, coverage goals and targets. Targeted KPs include female sex workers (FSW), men who have sex with men (MSM), transgender persons (TP), people who use or inject drugs (PWUID), and prisoners. In COP20, we shall also target clients of FSW as a priority population – including long-term partners, boyfriends/husbands of sex workers. PEPFAR will focus on community testing of clients of FSW, through FSW hotspots and where testing is occurring with the women, we will include men with a similar strategy of risk screening.

Key and Priority Population Size Estimates

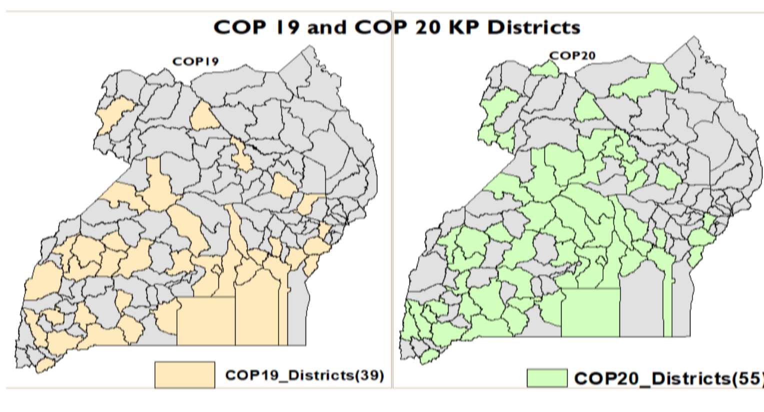


Figure 4.0.9 COP19 and COP20 KP Districts

Our targeting was informed by the UNAIDS, UAC national harmonized size estimates study, UPHIA 2017, KP estimates, FY 19 program performance and feedback from civil society organizations. The total COP20 KP_PREV target is 284,810 and PP_PREV is 116,915. Coverage was increased from 39 SNUs to 55 SNUs. We categorized 9 SNUs with high incidence and high KP population as high-priority and 46 SNUs categorized as priority SNUs were high to moderate for both population and incidence.

PEPFAR Uganda program will implement the client centered KP service package with fidelity, monitor and report the prevention and treatment cascades. Working with the community, we will provide feedback mechanisms by scaling up community scorecard, instituting community advisory groups and incorporate client feedback in service delivery for improved community prevention case management. The KP program will utilize other prevention platforms including VMMC and PMTCT and PrEP to reach KPs and ensure referral to other high impact prevention interventions. In COP20, PEPFAR Uganda will use specific strategies to improve identification, linkage to and retention on antiretroviral treatment (ART).

We will continue to work with CSOs to address low yield among KPs to implement risk-based testing with innovative testing approaches, expand social network strategy (SNS) and expanded peer outreach, self-testing. Hotspot mapping and profiling, attaching CSOs to KP facilities, and

information communication and technology services (ICTs) will facilitate the interventions. The program will utilize the peer referral app developed and managed by CSOs to enhance identification, enrollment and retention of KPs in HIV services. We will leverage use of social media to improve HIV services for especially MSM and TG; this includes use of WhatsApp, Facebook and other CSO driven applications/online groups to support adherence and viral suppression We will implement non-intrusive and non-judgmental services in safe locations. Our program will also promote male and youth friendly services as a platform to increase MSM service uptake.

PEPFAR Uganda KP linkage increased from 48% in FY 18 to 71% in FY19 and we will implement population specific linkages interventions in FY 20 to close the linkage gaps. The program will scale up of KP-competent ART services to increase enrollment of more KPs on treatment, same day ART initiation, community ART provision, and enhanced treatment literacy among KPs and their families ("undetectable=untransmittable" or U=U messaging), strengthening peer navigation and monitoring systems, reducing stigma and discrimination in both KP-specific ART sites and within the more mainstream clinical sites. The program will implement Pre clinic reminder phone calls, Root Cause Analysis (RCA) to inform interventions, weekly data reviews to identify missed appointments, finalize DSDM guidelines for KPs and fast track enrollment, physical peer escort and unique identifiers.

Improved HIV treatment, retention and VL suppression among KPs will require systematic implementation of intensified adherence counseling using peers. VL monitoring will be rapidly implemented and scaled up, while careful monitoring will assure suppression. Patients eligible for VL will be reminded by text and telephone calls. The program will expand VL appointments to DICs and target facilities with high testing gaps for tailored interventions. These include peer-led defaulter tracking, monthly adherence support groups, multi month drug refills and intensified U=U messaging.

In COP20 Uganda Prisons Service (UPS) will utilize a three-pronged approach to deliver comprehensive HIV services at the 55 high-volume sites and select mid-volume sites (103). First, the program will implement risk-based entry, routine and exit testing to improve yield. Second, UPS expand linkage and follow up through decentralized services, enhanced peer networks support, electronic medical records and use the SMS linkage platform. To enhance prevention interventions, we will implement service layering with fidelity. Third, to address low VL coverage (79%) and VLS (89%) we will expand POC testing for HIV (VL, EID) and TB via deployment of GeneXpert. In COP20 we will scale up efforts to expand ART services to more prison facilities and strengthen TB control efforts.

Promoting condom and lubricant last mile distribution by improving risk perception among KP will be a major focus of COP20. Condom promotion and distribution channels will be strengthened through interpersonal communication, peer led replenishment of condom dispensers in addition to male centered condom education. KP peers will be assigned to hotspots and dispensers to ensure

continuity of services. PEPFAR, along with the GF, will procure lubricants and work with CSOs to ensure effective distribution mechanisms.

KP Investment Fund (KPIF)

Uganda is a recipient of $10m as part of the KPIF central OGAC initiative to scale up KP-led community approaches to expand HIV services. The fund objectives are to scale up KP-led community approaches to expand and enhance HIV services to deepen reach to KPs with comprehensive HIV services, and to address structural barriers to service access through various civil servants (e.g. police, legal and judicial system, local political leaders, etc.) sensitization to reduce stigma and discrimination. Overall, 45 KP-led and leaning CSOs have received 77% of the KPIF funds.

The KPIF has supported the development of standard operating procedures for Drop-In Centers (DIC), developed KP Dashboard for real time performance monitoring, developed PWID specific tools for MAT implementation and supported duty bearer engagement for a supportive program environment. Uganda is currently in the process of launching Medication Assisted Treatment (MAT) services and in COP20 we will ensure integration of services for people who use or inject drugs (PWID) in a public health setting and strengthen engagement of PWID community organizations.

Table 4.2.1. Uganda KP Layering Table

Uganda KP Layering Table				
	Sex workers	**MSM**	**Prisoners**	**PWID**
Primary Individual Interventions	• Peer education • Condoms • Targeted HIV testing services • Routine STI screening[7] • Routine TB screening • Hepatitis Screening • SGBV screening	• Peer education • Condoms • Targeted HIV testing services • Routine STI screening • Routine TB screening • Hepatitis screening • SGBV screening	• Peer education • Targeted HTS (entry and exit testing) • Curriculum-based HIV prevention • GBV screening • Routine STI screening • Hepatitis screening • Routine TB screening	• Peer education • Condoms • Targeted HIV testing services • Routine STI screening • Routine TB screening • Hepatitis Screening • SGBV screening • Screening for Opioid Substitution Therapy (OST)

[7] Prevention and care of STIs, including the application of specific aspects of syndromic STI management: including standard testing procedures to detect asymptomatic bacterial anal and urethral infections, and vaccination against Hepatitis B.

Secondary Individual Interventions	• PrEP • RH services (contraceptive mix, ANC, Post Abortion Care-medical, counseling) • Alcohol/drug harm reduction • Partner testing for sexual partners • ART Adherence support • STI treatment • Hepatitis treatment • VL and other monitoring & investigative tests • TB treatment • Disclosure of status to steady sexual partners/spouses • Post-violence care • Lubricants • Curriculum based HIV prevention	• PrEP • Post-violence care • ART Adherence support • STI treatment • Alcohol/drug harm reduction • TB treatment • Partner testing for sexual partners • VL and other monitoring & investigative tests • Hepatitis treatment • Disclosure of status to steady sexual partners/spouses • Lubricants	• Contraceptive Mix[8] • Post-violence care • Condoms[9] • PrEP • GBV prevention • HIV care & treatment – through DSDM and on-site management • VL and other monitoring & investigative tests • Hepatitis treatment • STI treatment • Safe Male Circumcision (SMC)	• PrEP • Post-violence care • ART Adherence support • STI treatment • Alcohol/drug harm reduction • TB treatment • Partner testing for sexual partners • VL and other monitoring & investigative tests • Hepatitis treatment • Disclosure of status to steady sexual partners/spouses • Lubricants • Methadone and other medical-assisted therapies (MAT) including buprenorphine, naloxone, naltrexone

[8] Need advocacy and policy change for this to be available
[9] Current Prisons policy does not allow condoms for prisoners

CONTEXTUAL	• For partners: Referrals (HTS, VMMC, ART) • Community mobilization & Norms Change (SASA) • Condom promotion campaign/demand creation • OVC for children of sex workers • Stigma and discrimination reduction capacity building

Table 8 Uganda KP Layering Table

PrEP for Key and Priority Populations

Following CSO's recommendations to scale-up PrEP in COP 18, Uganda PrEP targets have increased gradually to bridge the gap and to maintain sero-negativity among populations at substantial risk of HIV. PrEP targets increased from 16,481 in COP 18 and doubled to 30,000 in COP19. In COP20, PrEP targets increased to 95,933, in addition, the number of districts and sites also increased. Figure (1) below shows significant scale up of PrEP in COP20.

PrEP targets, districts and sites

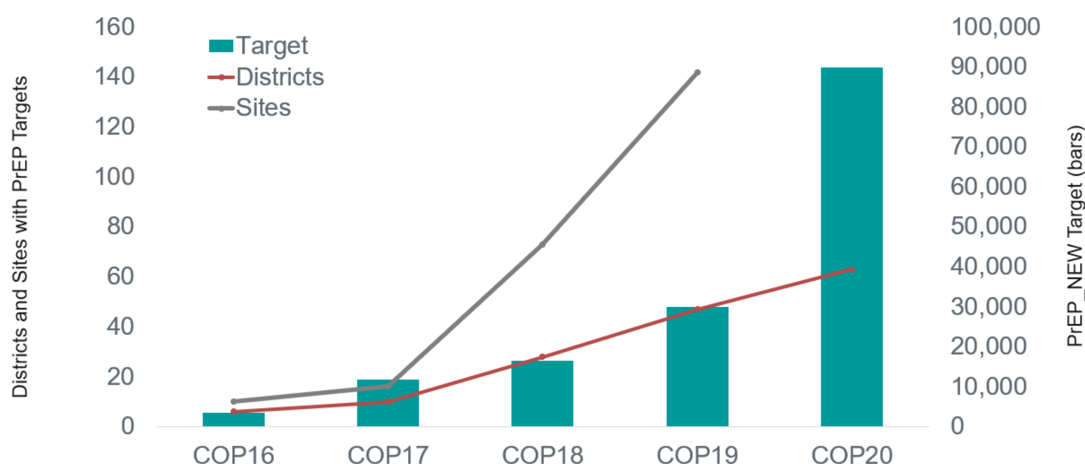


Figure 4.0.10 PrEP targets, districts and sites

In addition to an increase in the geographical footprint in the Table below, the number of sub population groups targeted for PrEP has expanded to include AGYW, (31.4%), Pregnant women (4.3%) and Breast-feeding Mothers (2.2%).

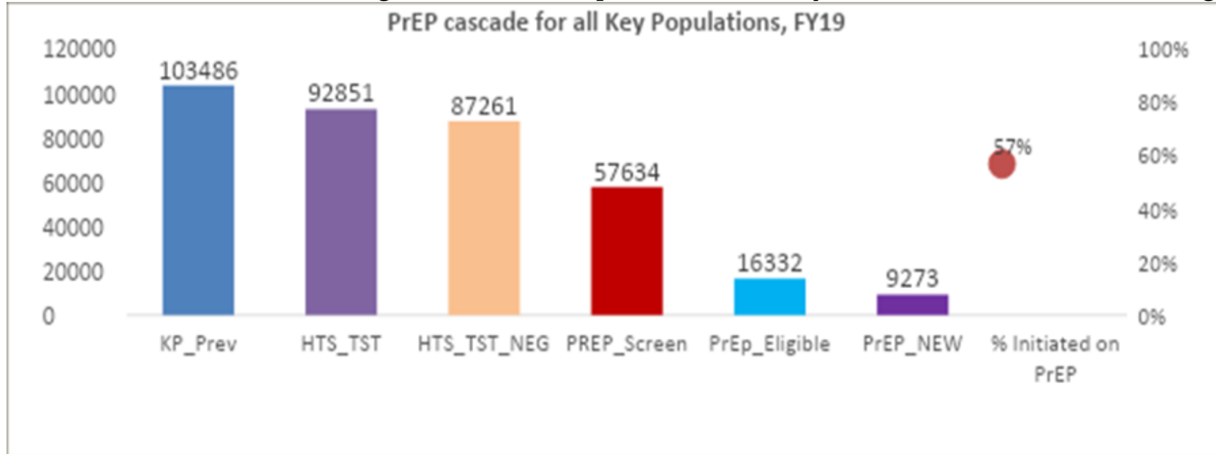
COP20 PrEP Targets by Sub-populations

Sub-populations	Target	Percentage of Target
FSW	30,183	31.50%
MSM	5,013	5.20%
PWID	563	0.60%
TG	471	0.50%
Pregnant women	4,156	4.30%
Breast-feeding Women	2,120	2.20%
AGYW (15-19)	10,400	10.90%
AGYW (20-24)	19,602	20.50%
Fisher folks	10,197	10.60%
Sero-Discordant Couples	13,128	13.70%
Totals	95,933	100%

Table 9 COP20 PrEP Targets by Sub-populations

Uganda has had a progressive achievement against PrEP_NEW annual targets since FY17, with an overachievement of 106% (17,825/16,841) in FY19. However, only 66% of the HIV-negative clients were screened for PrEP. This was essentially because KPs and PrEP targets were not aligned and as a result not all high risk KPs could access screening for PrEP eligibility. As part of the strategy to address this, KP and PrEP targets have been aligned in COP20. Also, only 57% of the eligible clients

were initiated on PrEP. This was partly because of lack of clear guidelines on which lab tests were required before initiating PrEP, long turnaround times for the lab results and stock out of the specific lab reagents at some sites. Moving forward, the national PrEP guidelines are being updated to clarify which labs are needed prior to initiation. Also, the program has adequately planned to minimize stock out of lab reagents and will implement same day PrEP initiation after screening.



As PrEP use is risk-based, retention on PrEP is a challenge for all KPs and priority populations at 3 months, 6 months and 9 months based on program data review in FY19Q2. The program will utilize community advisory groups and embed client satisfaction surveys to improve PrEP continuation in COP20.

A root cause analysis of the reasons for discontinuation PrEP during FY18Q4 and FY19Q1 highlighted that travel, being busy (including work/school), and stigma were among the main barriers highlighted. In COP20, the program will implement differentiated service delivery models including community PrEP initiation and PrEP refills as well as delivery of PrEP at more Drop-in-Centers (DICs) and fast-track options for PrEP refill at facilities to address these. Additionally, the program intends to improve patient level systems to enable tracking of KPs through deterministic and probabilistic algorithms. As part of the strategies to reduce stigma, the program will change the current PrEP drug (TDF/3TC) to generic TDF/FTC.

Based on the PrEP demonstration for AGYW in Mukono implemented by Makerere University Walter Reed Project (MUWRP), only 10% of health workers had perfect knowledge of PrEP (potential side effects being the least well known) among the service-related barriers. The client-related barriers include poor adherence in the first two months due to side effects and 13 social harm events (violence) mainly due to accidental discovery of pills by partners/guardians and mistaking them for ART. In COP20, the program will train and mentor ANC/MCH health workers and peers on PrEP to increase knowledge, update and dispel myths. Also, client centered approaches including pre-appointment reminders, peers support systems like PrEP buddies and use of differentiated service delivery models to dispense PrEP will be used to improve PrEP continuation and adherence among AGYW. The program will also monitor for violence and how it is addressed as well as reinforce and promote consistent condom use among AGYW PrEP users. The MOH is updating the current PrEP Policy to provide a favorable policy environment for PrEP service delivery among AGYW, pregnant and breast-feeding women. The program intends to initiate 30,002 AGYW on PrEP in COP20.

In COP20, 4,156 pregnant and 2,120 breastfeeding HIV-negative women, who are at substantial risk will be counselled and offered PrEP. The program will leverage on existing Integrated MCH/RH/PMTCT/HIV prevention interventions to provide routine PrEP education at ANC, carry out HIV risk screening to assess risk behaviors among Pregnant and Breast-Feeding Women (PBFW) and engage peer mothers to deliver PrEP among the approaches to deliver PrEP to eligible PBFW. PrEP messaging will be integrated as part of overall ANC education at the selected PrEP implementing sites. Individual PrEP counseling and screening will be provided to interested clients for enrolment. PrEP will be provided at mother-baby care points. Follow-up visits will be aligned with the PMTCT/ANC/PNC visit schedule. Ongoing adherence and continuation counseling will be provided as well as linkage and referrals to other programs providing structural interventions.

In COP20, the PrEP program is targeting a total of 36,230 KP and 10,197 among Priority Populations. The Program will continue to work KP-CSOs adopting peer deployment to improve PrEP continuation and strengthening messaging for PrEP continuation among KP peers. In addition, the program will consider DICs as community PrEP dispensing points and employing DSDM models for PrEP. Anecdotal data suggests negative perceived social norms and emphasizing the risk of STIs, in COP20, the program will provide syndromic treatment of STIs and strengthen positive PrEP messaging. In summary COP20 will target reaching 95,933 individuals at substantial risk of acquiring HIV in 63 districts, including MSM, FSW, TP, AGYW, and PBFW. The program will strengthen community-based initiation and refills for PrEP to enhance service uptake. The program will continue to focus on demand creation through targeted messaging to eligible sub-populations. Our program will continue to expand enhanced peer led approaches, support hot-spot mapping, and ensure more robust technical assistance to CSOs and districts to locally map and re-map hotspots. We will support peer support and pre-appointment reminders and expand community-based PrEP initiation and refills.

4.3 d. VMMC

According to the Uganda Population-Based HIV Impact Survey (UPHIA) 2016, 21.7% of men reported having been medically circumcised and 20.5% reported non-medical circumcision. This data demonstrates an increase in the proportion of circumcised men (both medical and non-medical) from 2011, when only 26% of men aged 15-49 years were circumcised (Uganda AIDS Indicator Survey, 2011). UPHIA data show geographic variation in Voluntary Medical Male Circumcision (VMMC), with higher coverage in urban areas (28%) compared to rural areas (20%). By region, coverage ranged from 13% in Mid-North to 32% in Kampala. National Bureau of Statistics Population estimates, UPHIA findings and program data for VMMCs conducted between 2017-2018, indicate that by the end of FY19, the total number of male adolescents and men aged 15-29 years eligible for VMMC nationally was 5,729,630. Program data show that 3,427,132 VMMCs have been conducted to date among the 15-29-year-old age band, representing 59% of the eligible male population. The unmet need for VMMC in all PEPFAR sub-national units (SNUs- 88 districts with the highest burden and unmet need) is 1,914,930 in the 15-29-year age group.

Scaling up VMMC is critical to Uganda achieving epidemic control. In FY2019, PEPFAR Uganda supported 727,548 circumcisions, and by end of FY 2020, an additional 800,000 MCs will be performed if all the targets are achieved. Building on these efforts, the COP20 strategy is to maintain high coverage among 15-29-year-age. Focus will be in districts where circumcision coverage is close to 80% in order to achieve saturation and in regions with low MC coverage and

high HIV prevalence, including all DREAMS districts. To increase the immediacy of impact, the program will continue to target the high priority age band of 15-29-year-old males.

In COP20 VMMC IPs will roll out proven, high-impact, client centered approaches to generate and sustain demand that will lead to a surge in the uptake of VMMC services among males aged 15-29 years. **These include**:

Incentives The cost per circumcision performed in Uganda varies with lowest cost being in static sites and highest in outreaches and camps. Approximately 80% of all MCs in Uganda are done in camps. As the country approaches saturation, demand creation to reach the late adopters will increase. The program will use non-coercive rewards such as transport refund and compensation for lost wages to reach the high-risk men including fisher folk and truckers. These have been demonstrated to improve uptake of VMMC (Kennedy CE, et al; A systematic review and meta-analysis-2020). Additionally, onsite VMMC services will be offered at factories, construction sites, security companies and plantations, in consultation with the respective management.

Offering potential clients, a VMMC VIP Card with a menu of adult-friendly services such as choosing the day/time of service and gender of the circumciser. This approach tailors VMMC services to overcome identified barriers, found particularly among older men. To refine the program focus, IPs will conduct regular client satisfaction surveys and group discussions to unpack key findings from utilization of the VIP cards.

Engaging private providers to expand access to VMMC addresses men's desire for privacy and their perception that private health services offer higher quality services. In addition, private providers can tap into their existing client base to raise awareness of the VMMC services they offer.

To **reinforce key VMMC demand generation messages** and enhance the likelihood that a message will be understood, accepted, and acted upon, particularly with the older priority age group, a blend of communication channels will foster dialogue and allow for follow-up with potential clients. These channels will include:

- a VMMC toll free hotline for men to anonymously ask and receive answers to their questions and concerns.
- WhatsApp and other messaging platforms to support individualized communication responsive to a man's specific needs. This channel will share short videos addressing specific barriers, such as fear of pain.
- Two-way, longer-format radio programming to allow for dialogue with featured guests including providers, counselors, satisfied VMMC clients, community leaders, and others with the background and training to promote VMMC. Bringing quality mobile VMMC units as close as possible to the workplace, for example, onsite at factories, construction sites, security companies and plantations, as well as incentives such as transport reimbursements will facilitate access to services.

Dedicated house-to-house mobilization teams will apply questionnaires tailored to identifying uncircumcised males in the target age group within homesteads. These mobilizers will be compensated with a daily transport allowance and monthly pay.

Women play a pivotal role in influencing partners' and sons' decisions, hence more **women will be trained and facilitated in VMMC demand creation,** to be stationed at maternity/antenatal centers, outpatient and HIV wards to educate the mothers and their partners to take up VMMC Offer differentiated service delivery including extended hours and moonlight services.

Additionally, we will focus on "older" men 30 years and above by addressing key barriers to seeking VMMC services through focused demand creation that addresses structural and accessibility challenges for this age group. In DREAMS districts multiple channels will be used to reach older men for VMMC; these will include, identifying them through male sex partner characterization, using DREAMS ambassadors, girl's engagement forums, and AGYW male partner champions. In addition, there will be active referrals of eligible HIV-negative adult men for VMMC services.

By the end of FY21, the saturation in the 15-29 years will increase from 12-37 districts. By the end of FY20, PEPFAR Uganda will have supported 5,754,796 circumcisions since inception of the program in 2010 and by end of FY20Q1, an estimated 269,726 HIV infections will have been averted.

The COP20 targeting process triangulated data from Uganda Bureau of Statistics' 2019 population projections, 2011 AIS, 2016 UPHIA, and FY19 VMMC program data to estimate 2019 district coverage and unmet need of males 10-64 years. Targets were focused in regions with high unmet circumcision need and high HIV burden including all DREAMS districts. High-performing partners received more targets in high-performing districts with unmet need. Sixty-two percent of targets were allocated to the 15-29 age group, 37% to the 30+, and 1% to 14-year-old boys using ShangRing only.

Key shifts and considerations in COP20

Based on Notifiable Adverse Event (NAE) review, severity of glans injuries and fistulas when they occur, and expected timing of pubertal development, PEPFAR is changing the lower age for VMMC to 15 years or below 15 only those who have reached Tanner stage 3 of sexual development to minimize risks. There will be need for messaging and other demand creation efforts. Early infant male circumcision has an NAE rate twelve times higher than VMMC in 10-14-year olds and 22x higher than VMMC in those age ≥15 years (PEPFAR Notifiable AE Reporting System (NAERS) hence there will be no infant circumcision activities supported in FY21. A total of 18,060 (6%) of MCs will be implemented using the ShangRing device in a program mode following the active surveillance which found the device safe and acceptable in the 6 regions where it was implemented. Seventeen percent (17%) of the ShangRing placements will be implemented in the 14year old boys.

As part of its sustainability agenda, PEPFAR Uganda will reduce the proportion of disposable kits and increase on the use of the reusable instruments from 25% in COP19 to 50% in COP20. To facilitate this transition, PEPFAR will support regional health facilities with infection prevention and control (IPC) training, sterilization equipment for appropriate sterilization in addition to purchasing the VMMC reusable kits for dorsal slit method. In addition, dedicated sterilization human resources, consistent supply of electricity and water to support proper functioning of the autoclaves have been budgeted for.

Implementing partners will be managed to improve performance through weekly performance review of results monthly inter-agency VMMC partner performance review meetings and quarterly DQAs led by the M&E partners. Routine site visits to the consistently underperforming sites to diagnose problems and institute course corrective actions will be done. CQI interventions will focus on scaling up proven approaches for Adverse Events prevention and management and active post

circumcision client follow up according to the national VMMC package of care. IPs' compliance with mandatory reporting of notifiable adverse events to S/GAC within 24 hours of learning of adverse events will continue to be emphasized.

4.4 Additional country-specific priorities listed in the planning level letter

MOH has recently revised the national HIV treatment guidelines, aligning to WHO guidance and adopting policy changes that would facilitate improved retention and viral suppression rates. Specifically, the guidelines include:

- ARV optimization: expansion of eligibility for DTG-based regimens to all PLHIV and inclusion of new formulations (4in1 and DTG 10mg).
- Differentiated Service Delivery Models (DSDM): inclusive for children and expanded eligibility to accommodate early enrolment (6 months after ART initiation).
- MMD: permissive for routine MMD eligibility for all subgroups and permits 6 months MMD
- Toxicity monitoring: strengthened guidance on standardized process for drug toxicity monitoring.

The adoption of these policy revisions meets the Minimum Program Requirements, including retention-related site level requirements for client centered services.

4.5 Commodities

Uganda is committed to commodity security for HIV epidemic control. Notably, the GOU doubled its earmarked annual HIV commodity funding from $23.7M in 2018 to $49.7M in 2020. Joint forecasting and supply planning between GOU, GF, and PEPFAR has ensured full funding in COP20 for all critical HIV commodities including ARVs, TPT, VL and EID. Additionally, the funding streams for all commodities have been diversified demonstrating shared responsibility as well as mitigating risk due to availability of funds and procurement timelines. The figure below provides a snapshot of the comparative investment between COP19 and COP20, as well as illustrates the diversification of funding sources.

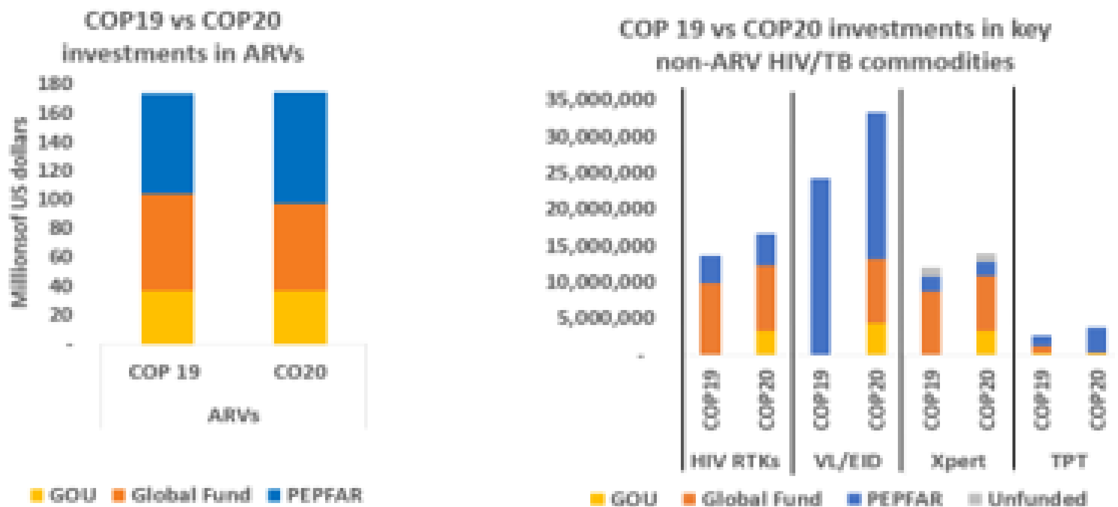


Figure 4.0.13 Investments in ARVs and commodities

ARVs

The GOU's commitment to increase funding for ARVs during COP19 was realized and ARVs are fully funded for both COP19 and COP20. In summary, for COP20, GOU has committed $37M, GF $60M, and PEPFAR $77.5M. The CY21/COP20 national supply plan has been developed to maintain between 3 and 6 months of stock in the central warehouses. These stock levels will facilitate the transition to longer (3-6m) refills for most clients.

At the end of January 2020, over 525,000 PLHIV were receiving TLD. The ARV supply plan assumes full ARV regimen optimization for both adults and children by Dec 2020, with TLD as the preferred first and second line for adults and children >20kg, and ABC/3TC + LPV/r as the preferred first line for children < 20kg. For TLD, over 75% of the procurement is planned for 90-packs to improve cost efficiency and facilitate MMD. The supply plan also incorporates the transition to new pediatric formulations (DTG 10mg and ABC/3TC/LPV/r 4-in-1 tablet) as these are expected to be available during the COP20 implementation period.

Throughout the remainder of the ARV regimen optimization process, PEPFAR will continue to monitor progress using the PEPFAR weekly surge dashboard. We will also work with the MOH Quantification and Procurement Planning Unit (QPPU) to minimize expiries and mitigate stock outs by monitoring central and facility-level stock status using the Web-based ART Ordering System (WAOS) and Real Time ARV Stock Status (RASS) systems.

Whereas previously GF and GOU have covered ARVs for the public sector and PEPFAR took responsibility for the PNFP sector, the diversification of funding across the portfolio has required a movement away from the sector split. As part of the preparation for COP20, policies and procedures will need to be reviewed and/or developed to ensure ability to seamlessly transfer ARVs across sectors.

Viral Load (VL) and Early Infant Diagnosis (EID)

Historically, the funding for VL/EID was provided exclusively by PEPFAR, but in FY21/COP20 has been diversified to include both GF and the GOU. PEPFAR Uganda has allocated USD 17,211,247 to conduct ~1.3 million VL tests during the COP20 implementation period. Uganda will benefit from reduced VL bundle pricing that the USG negotiated with Abbott, Roche and Hologic. Uganda will receive Roche VL reagents using Vendor Managed Inventory (VMI) solutions. Under VMI, the vendor is responsible for monitoring usage and ensuring that reagent stock levels remain adequate for testing without interruption (note that ancillary commodities needed for testing and sample collection are purchased outside the VMI agreement). This will enable the country to receive reagents for more tests, reduce interruption in services due to equipment downtime or stock outs, and decrease service contract costs. For EID, PEPFAR Uganda has allocated USD 2,651,058 to conduct ~154,640 tests in COP20. Uganda will continue to process most samples on conventional platforms (average unit cost of USD $15) while prioritizing EID POC (average unit cost of USD $26) to high throughput and hard to reach areas. The target for EID POC testing will increase from 20% to 35% in FY21, with POC machines available at 146 sites across the country. Please see the Section 4.9 for further details on POC plans.

TB Preventive Therapy (TPT)

By the end of COP19, over 900,000 PLHIV are expected to have received TPT with INH/B6. COP20 will cover the remaining 390,000 individuals with procurements by both GF and PEPFAR. The plan includes introduction of 3HP planned to begin in April 2021 which will allow enough time for preparations needed to support the regimen transition as well as lead time for procurements.

GeneXpert and TB LAM

FY19 and Q1 FY20 saw a rapid scale-up of the use of GeneXpert for TB diagnosis. Between FY18 and FY19, the percentage of TB cases diagnosed by GeneXpert doubled from ~35,000 to over 70,000. Uptake of TB LAM has been slower, but with the completion of the advanced disease implementation plan and intensified mentorship planned for COP19 implementation, utilization is expected to increase. In response to this increase in utilization of improved TB diagnostic technologies, Uganda is planning for additional Xpert cartridges and TB LAM kits for CY21/COP20. In addition, MOH signed a Memorandum of Understanding (MOU) with Cepheid, where the supplier will ensure proper management of the GeneXpert equipment and consider placement of the 12 and 16 module platforms for TB high volume facilities. PEPFAR's investment of $2.2M will continue and the GF investment from both the HIV and TB grants is expected to increase over the $6M invested in COP19. GOU is also expected to invest in GenXpert for the first time at ~$3.2M. To fully fund the anticipated need in CY21/COP20, an additional $3-5M may be needed.

Advanced disease and cervical cancer commodities

In order to address the contribution of advanced disease to client attrition, PEPFAR and GF are investing in commodities to diagnose and treat advanced disease and opportunistic infections including CD4 for newly identified or previously lost clients, Hepatitis B, Cryptococcal Antigen, cotrimoxazole, and fluconazole. As part of the reintroduction of a large-scale cervical cancer screening program, PEPFAR is also investing over $2.5M in commodities and equipment to diagnose and treat cervical cancer for over 250,000 women in COP20 including VIA kits, HPV cartridges, thermocoagulators, and LEEP machines.

ARV and TPT toxicity monitoring

With the rapid scale-up of both TLD and TPT, Uganda identified severe adverse events in a small subset of clients. The MOH and National Drug Authority are in the process of introducing a more rigorous pharmacovigilance system in anticipation of completing the ARV regimen optimization process in order to maximize client safety. Active pharmacovigilance with routine laboratory monitoring is planned for 18 high volume facilities while enhanced spontaneous pharmacovigilance with screening for potential risk factors will be implemented at the remainder of sites. Chemistry tests, including liver function, kidney, function, and blood glucose will be procured as part of the supply plan to support these efforts.

HIV RTKs

As per PEPFAR guidance, PEPFAR's procurement of HIV RTKs will be limited to higher risk populations including pregnant women, TB clients and suspects, KP, and partners of newly identified or virally non-suppressed PLHIV. Syphilis DUO is being procured for use in the ANC setting, and self-testing will be scaled up as part of the index testing approach. Recency testing has been planned for all newly identified positives.

VMMC commodities

PEPFAR will carry out 318,519 VMMC procedures during COP20 and currently fully funds the national program commodities requirement. Uganda will increase circumcisions carried out using reusable kits from 25% to 50% (170,386), while decreasing procedures carried out with disposable kits from 75% to 50%. In COP20, 1% of the procedures are targeted for the ShangRing approach for fishermen and truck drivers.

4.6 Collaboration, Integration and Monitoring

The GF is currently writing its three-year proposal for the 2020-2023 timeline. In January 2020, the Deputy Chief of Mission via the PEPFAR coordinator provided a list of technical experts composed of USAID and CDC employees to inform, draft and review sections of the current grant writing process. The subject matter experts have attended the writing process to answer questions and provide critical feedback throughout every step of the process. Additionally, PEPFAR hired a full time GF Liaison to engage in the development of the GF grants proposal to ensure harmonization and complementarity of resources and programming. Efforts will continue to maintain open lines of communication to minimize program and funding gaps. The monthly National TWG meetings led and hosted by and at the MOH headquarters are as well collaborative platforms that bring together technical HIV actors including UNAIDS, UAC, and GFATM to provide key programmatic and policy updates.

PEPFAR Uganda collaborates closely with MOH, UAC, the GF via the CCM the Geneva-based Country Manager as well as with other AIDS Development partners that include UNAIDS, Irish AID on development of the 2020/21- 2024/25 National HIV strategic plan, CHAI on the VL monitoring. The USG is represented on the CCM, across all agencies.

The CCM and PEPFAR Uganda actively share information on planning and progress in country, and PEPFAR Uganda technical staff have contributed to grant proposals and review meetings. In 2020, PEPFAR Uganda will continue to collaborate with MOH, other key line ministries, and the Health

and AIDS Development Partners to strengthen the one national monitoring and evaluation system and leverage costs for reporting.

PEPFAR will conduct root cause analysis for QI collaboratives and maintain its leadership of hybrid SIMS/Surge site evaluation visits, as well PEPFAR's ongoing participation in the National Stakeholders' meeting for harmonization and alignment of the GF with other in-country financing mechanisms. PEPFAR will carry on its role in reviewing program implementation frameworks, work plans, budgets and procurement and supply chain plans.

The PEPFAR Uganda commodity supply chain team regularly meets with GF counterparts and the MOH QPPU to coordinate procurement schedules, distribution, and systems strengthening. PEPFAR Uganda and GF are communicating regularly on new grants and the GF's "catalytic programs" for the TB and HIV cross-border refugee proposal from the Inter-Governmental Authority on Development; legal barriers to HIV service access; and a DREAMS-like program for AGYW. New grants are rolling out and teams will continue to link closely through CCM, PEPFAR Uganda stakeholders' meetings, and informal meetings.

In 2017, PEPFAR Uganda, together with the MOH and MOFPED, had very productive discussions with GF staff in connection with the negotiation of an Implementation Letter regarding improvement of the transparency, effectiveness, and efficiency of Uganda's health commodities supply chain system. The goal of the Implementation Letter is to ensure that there will be no national stock-outs of essential medicines and commodities, including ARVs, RTKs, and other HIV-related health commodities.

Partner Performance and Monitoring
Since COP17, PEPFAR Uganda has been implementing an intensive IP performance monitoring and improvement strategy that involves more frequent analysis of partner data and monthly meetings with IPs to address areas of poor performance, identify best practices, and work to ensure best practices are scaled up with fidelity. Recognizing that since COP18, all targets were formulated based on the assumption that PEPFAR Uganda would accomplish its COP19targets—and given the poor performance of the program in retaining clients on treatment and reaching men 15+ with VMMC services in the third quarter of FY19. In the second quarter of FY18 PEPFAR Uganda initiated a "surge" resulting in 71% achievement of the FY18 target and a 146% TX_NEW Achievement and 91% Achievement of the TX_CURR of the FY19 target. The surge, embraced by the MOH in a circular that went out to all Ugandan district health officials and health facilities, is now re-framed as the "surge for quality" and so far in FY2020 Q1 PEPFAR Uganda is solidly on track, with a 21% achievement of its annual TX_NEW target at the end of that initial quarter.

While in 2018, the surge focused on high volume sites yielding 80% of the targets, in 2019 and forward, there is a plan to scale up surge for quality to all PEPFAR –supported facilities and to their surrounding catchment areas. In COP19, the surge for quality will be integrated into the routine practice of PEPFAR Uganda IPs, and it is anticipated to spur IPs towards meeting ambitious COP19 targets. The surge for quality focuses primarily on key areas in which the program is performing most poorly, namely scaling up VMMC services among the men 15+, finding and identifying HIV-positive individuals (in particular men), reducing testing while improving testing efficiency and yield, ensuring high percentage of linkages to rapid treatment initiation, improving rates of retention on treatment, tracking VL suppression, and related issues of commodity security. The

technical activities meant to achieve specific outcomes, such as actions to improve index client partner and pediatric testing and APN, are noted in the strategy tables in SDS section 4.3.

Implementing partners are already using results tracking tools that capture site-level and community-level data, including new HIV cases identified, linked to care, initiated on ART and retained on ART. Data on key indicators including HTS, HTS_POSTX_NEW, VMMC_CIRC, EID, TB case finding, TLD enrolment rates, and IPT Initiation rates are reported on a weekly basis in the HIBRID data collection system. The data are disaggregated by age band, testing modality, sex, etc. IPs conduct joint weekly review meetings among their staff and key facility and outreach personnel such as ART in-charges, linkage facilitators, and counselors to review performance against targets and address challenges and areas of underperformance. IPs also conduct root cause analysis and use these opportunities to address key bottlenecks such as sub-partner performance.

IPs are using "real-time" HIV commodities tracking systems to avert stock-outs and maldistribution of supply. These tracker dashboards are updated on a weekly basis to monitor supply for HIV services carried out with district logistics persons, health facility stores managers and Medicines Management Supervisors. This tracking process will maintain HIV commodities stock levels and allow for inter facility commodity transfers to maximize identification of HIV-positive persons and enrollment of each on ART.

PEPFAR Uganda agencies have combined surge and SIMS assessments on priority topics, including retention strategies. On a quarterly basis, PEPFAR Uganda is also issuing surveys among all IPs to monitor the scale-up of key indicators, such as index client testing, same day initiation, and ART starter packs, Back to care updates. From a management perspective, agencies are monitoring burn rates with each IP, helping ensure partners' resources are focused on achieving targets within COP outlay authority and gaining efficiencies wherever possible. PEPFAR Uganda employs clear and regular communication with IPs and with IP headquarters' offices to facilitate efficient work plan approvals, sub-contracting, procurements, and evaluation protocol approvals. Technical staff review weekly surge performance data and provide immediate feedback if the data trends are of concern. Integrated technical and management teams travel to key underperforming sites and districts with partners and engage MOH counterparts and district health teams to facilitate more rapid improvement, verify actual practice, carry out data spot checks, assist in rolling out good practices, and consult with high-volume site leadership, district health officers and local government officials to promote ownership and collaboration with PEPFAR IPs.

PEPFAR recognizes the importance of engaging with communities in the development and implementation of its programming. New in COP20 is PEPFAR program will support an independent community led monitoring platform, working with leading CSOs across the country. The CLM must be truly independent, community-led and owned, building on approaches that are delivering impact and ensuring robust advocacy and watchdogging,

With leadership from the PEPFAR Coordination Office, PEPFAR Uganda will hold and co facilitate quarterly data review discussions using quantitative and qualitative indicators, and monthly community monitoring feedback sessions focused on improving HIV service delivery. These discussions are important for gathering crucial information and observations regarding HIV service delivery from and about KP and other underserved groups. Reported observations and recommendations shall inform a basis and selection of sites for the Inter-agency service QI monitoring visits coordinated and organized by PCO to guide program implementation.

Collaboration with community groups, civil society organizations, development partners and patients/beneficiaries will help diagnose and pinpoint persistent problems, challenges, and share successes to be scaled up widely.

Finally, on a quarterly basis, PEPFAR Uganda will continue broad stakeholder meetings, led by the U.S. Ambassador or Chargé d'Affaires, to share results and best practices, disseminate critical policy and programmatic issues, and host dialogues with partners to solve pressing challenges. In 2019 for example, we held a panel discussion on rolling out the unique identifiers, drawing in leadership from the National Identification and Registration Authority (NIRA) for the first-time to publicly discuss opportunities. Other panels were on key population and human rights, roll out of TLD, assisted partner notification approaches, scale up of electronic medical records and other pressing implementation issues.

Above site service delivery

The key outcomes expected from COP19 and COP20 above site service delivery activities include accurate commodity supply plans; ensuring zero stock out of ARVs and key HIV commodities; TLD transition completed by December 2019 to 90% of PLHIV on adult 1st line regimens; improved recording and reporting of commodities; and accountability and traceability of USG-procured commodities in the public sector.

Other outcomes include an increase in GOU-salaried health workers at site-level to support service delivery, laboratory (central and sub-national) and supply chain management. Additionally, there is an expectation of improved quality and timely data for program management to inform epidemic control, better CSO engagement in community led monitoring, finding men and mitigating stigma barriers, and increased engagement of national, district and CSO leadership in monitoring efforts to achieve epidemic control.

4.7 Targets by population

The targets for the following three tables have been generated from DATIM.

Standard Table 4.7. 1 ART Targets by Prioritization for Epidemic Control

Table 4.7.1 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	Total PLHIV	Expected current on ART (APR FY20)	Additional patients required for 80% ART coverage	Target current on ART (APR FY21) *TX_CURR*	Newly initiated (APR FY21) *TX_NEW*	ART Coverage (APR 21)
Attained	525,068	651,773	0	656,571	13,131	125%
Scale-Up Saturation	156,132	129,193	0	130,144	2,603	83%
Scale-Up Aggressive	334,430	262,784	4,760	264,718	9,468	79%
Sustained	415,927	249,260	83,482	251,096	10,350	60%
Military	N/A	24,122	N/A	24,300	486	N/A
Total	**1,431,557**	**1,317,132**	**0**	**1,326,829**	**36,038**	**93%**

Table 8 ART Targets by Prioritization for Epidemic Control

Table 4.7.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

Table 4.7.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	Target Populations (15+)	Population Size Estimate (SNUs)	Current Coverage (FY20)	*VMMC_CIRC* (in FY21)	Expected Coverage (in FY21)
Adjumani District	52,018	113,573	47%	2,219	52%
Agago District	57,247	122,909	57%	2,122	60%
Amolatar District	47,460	87,059	53%	1,526	56%
Apac District	59,480	114,260	74%	5,023	82%
Arua District	187,331	366,542	84%	4,579	86%
Bugiri District	117,590	238,913	67%	1,860	69%
Bundibugyo District	69,697	131,048	45%	2,445	48%
Bunyangabu District	54,055	99,410	79%	586	80%

Butambala District	27,165	54,210	37%	1,242	42%
Buyende District	97,573	206,770	61%	1,940	63%
Ibanda District	74,669	137,601	40%	1,000	41%
Iganga District	104,656	197,605	77%	4,164	81%
Isingiro District	148,031	295,562	46%	5,000	50%
Kagadi District	104,864	215,336	61%	2,754	63%
Kamuli District	140,413	277,891	64%	2,737	66%
Kamwenge District	84,400	169,764	113%	1,904	115%
Kayunga District	103,665	203,733	78%	1,792	80%
Kibaale District	51,367	103,688	77%	552	78%
Kisoro District	70,029	142,150	57%	677	58%
Koboko District	69,210	131,836	53%	1,885	55%
Kole District	71,647	142,637	47%	2,606	51%
Kumi District	74,401	142,948	27%	3,691	32%
Kyegegwa District	115,406	228,614	60%	2,593	62%
Kyenjojo District	137,248	269,901	70%	2,248	72%
Lamwo District	35,223	69,441	37%	1,833	42%
Mukono District	199,737	348,077	70%	2,769	71%
Nakasongola District	65,155	115,366	59%	1,823	62%
Ngora District	42,828	81,905	21%	2,360	27%
Pakwach District	49,178	98,344	67%	891	68%
Rakai District	81,032	159,878	49%	1,798	51%
Sembabule District	81,599	152,608	58%	1,905	60%
Tororo District	148,083	294,550	81%	1,457	81%
Wakiso District	839,097	1,434,253	60%	19,692	62%
Total	**3,661,554**	**6,948,382**	**60%**	**91,671**	**62%**

Table 11 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

Table 4.7.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Table 4.7.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control				
Target Populations	Population Size Estimate		Coverage Goal	FY21Target
	(All SNUs)	(scale-up SNUs)	(in FY21)	
MSM	34,340	5,553	85	29,120
FSW	139,822	50836	90	125,845
*Prisoners	125,534	42,044	81	101,673
Prison Officers	9446	3,679	93	8,787
Clients of sex workers	1,611,769	43,502	7	108,122
AGYW	529,459	263,057	20	103,554
PrEP implementation (FSW, MSM, FF)	455,329	130360	24	108798
TOTAL				**527,904**

Table 9 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Table 4.7.4 Targets for OVC and Linkages to HIV Services

Table 4.7.4 Targets for OVC and Linkages to HIV Services			
PSNU	Estimated # of OVC	Target # of active OVC (FY20Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files
_Military Uganda	0	5,532	4,649
Agago District	15,808	2,616	1,962
Apac District	14,343	2,792	2,134
Arua District	47,578	15,104	13,948
Bugiri District	30,441	2,460	1,845
Bugweri District	12,006	856	662
Buikwe District	30,001	7,392	5,624
Bukomansimbi District	9,835	1,828	1,391
Bunyangabu District	12,367	2,676	2,027

Bushenyi District	15,614	5,128	3,846
Busia District	24,427	3,224	2,498
Dokolo District	13,613	2,148	1,611
Gomba District	10,978	1,892	1,419
Gulu District	20,641	8,808	6,606
Hoima District	23,762	15,752	14,434
Ibanda District	17,505	3,004	2,253
Iganga District	25,404	3,016	2,342
Isingiro District	37,782	6,716	5,612
Jinja District	32,569	7,988	5,991
Kabale District	15,651	2,696	2,022
Kabarole District	21,330	9,384	7,038
Kagadi District	27,257	4,240	3,180
Kakumiro District	30,409	3,392	2,544
Kalangala District	4,334	2,208	1,656
Kalungu District	12,206	4,176	3,192
Kampala District	10,7106	55,776	44,511
Kamuli District	35,165	3,364	2,543
Kamwenge District	21,276	3,764	3,098
Kanungu District	17,484	3,000	2,250
Kasese District	50,074	4,640	3,480
Kassanda District	19,769	4,276	3,207
Katakwi District	12,313	1,816	1,362
Kayunga District	25,566	4,484	3,403
Kazo District	13,788	1,336	1,002
Kibaale District	12,631	1,788	1,341
Kiboga District	10,894	2,808	2,106
Kikuube District	22,849	2,988	2,241
Kiruhura District	11,808	1,856	1,392
Kitagwenda District	11,305	1,476	1,107

Kitgum District	14,147	3,628	2,721
Kole District	17,943	2,808	2,126
Kotido District	13,034	300	225
Kwania District	13,676	2,188	1,641
Kyegegwa District	28,248	5,084	4,088
Kyenjojo District	33,257	6,824	5,118
Kyotera District	16,506	8,814	7,113
Lira District	30,303	10,312	8,217
Luwero District	33,220	9,670	7,826
Lwengo District	18,326	3,708	2,881
Lyantonde District	7,025	2,896	2,192
Madi-Okollo District	10,399	680	510
Masaka District	21,312	13,145	10,391
Masindi District	21,599	4,528	3,416
Mayuge District	35,654	3,084	2,313
Mbale District	37,404	11,630	9,764
Mbarara District	24,755	10,108	7,581
Mitooma District	12,177	1,216	912
Mityana District	22,976	5,440	4,140
Mpigi District	18,174	4,248	3,206
Mubende District	35,464	8,032	6,044
Mukono District	44,629	12,069	9,686
Nakaseke District	14,874	2,856	2,162
Namayingo District	14,993	2,928	2,196
Nebbi District	17,848	2,296	1,722
Ntungamo District	34,105	4,536	3,402
Omoro District	12,495	2,004	1,503
Oyam District	28,650	5,324	4,073
Pakwach District	12,481	1,568	1,176
Rakai District	20,082	5,588	4,751

Rubanda District	13,113	1,008	756
Rukiga District	6,620	900	675
Rukungiri District	20,961	5,480	4,110
Rwampara District	9,115	2,184	1,638
Sembabule District	18,834	3,048	2,286
Sheema District	13,863	3,640	2,730
Soroti District	23,182	5,796	4,347
Tororo District	37,671	11,561	9,868
Wakiso District	187,135	70,638	64,201
Grand Total	1,874,140	480,167	387,236

Table 10 Targets for OVC and Linkages to HIV Services

Below is OVC Portion of Table 5.2.1: Expected Beneficiary Volume -Receiving Minimum Package of Services in Attained Support Districts

Table 5.2.1: Expected Beneficiary Volume Receiving Minimum Package of Services in Attained Support Districts*			
Attained Support Volume by Group		**Expected result APR 20**	**Expected result APR 21**
HIV testing (all populations)	*HTS_TST*	1,484,186	159,545
HIV-positives (all populations)	*HTS_TST_POS*	94,885	16,672
Treatment new	*TX_NEW*	81,978	13,115
Current on ART	*TX_CURR*	632,328	656,560
OVC	*OVC_SERV*	152,644	232,831
KP	*KP_PREV*	178,741	138,934
Table 5.2.2. Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts			
Sustained Support Volume by Group		**Expected result APR 19**	**Expected result APR 20**

HIV Testing (all populations)	HTS_TST	259,284	114,067
HIV-positives (all populations)	HTS_TST_POS	8,619	89,23
Treatment New	TX_New	92,31	10,312
Current on ART	TX_CURR	53,525	250,527

4.8 Cervical Cancer Program Plans

In COP20, PEPFAR Uganda was allocated $5M to reinitiate cervical cancer screening and treatment of pre-cancerous lesions among women living with HIV (WLHIV) in Uganda. As per PEPFAR guidance, Uganda plans to screen HIV-positive women aged 25-49 years every two years. During the COP20 implementation period, 260,619 WLHIV are being targeted for screening, accounting for 50% of the targeted HIV-positive women aged 25-49 years in HIV care and treatment.

In February 2020, a stakeholder consultative meeting was convened by MOH to facilitate COP20 cervical cancer planning. Under the leadership of MOH, and in collaboration with the Uganda Cancer Institute, a task team was formed to prepare for implementation of this initiative, building on the current cervical cancer screening and management activities occurring at the RRH. From April-September 2020, the task team will review and update of the national Cervical Cancer strategy, develop an implementation plan for systematic cervical screening and treatment among WLHIV (including development and adaptation of M&E tools, IEC materials, training materials and job aides), and develop the VIA quality assurance system and standards.

The first year of cervical cancer program expansion will focus on 640 of the largest volume health facilities covering the national referral hospital, all RRH, all general hospitals, all health center IVs, and 300 highest volume HCIIIs. HIV "centers of excellence" are included among these facilities. The program will operate using two models/algorithms based on the level of facility as described below:

- **At General Hospitals, Health Center IVs and Health Center IIIs,** Visual inspection of cervix with acetic acid (VIA) will be the primary screening tool. Eligible lesions will be treated using thermocoagulation at site. Patients with precancerous lesions needing Loop Electrosurgical Excision Procedure (LEEP) will be referred to Regional or National Referral Hospitals. Cancerous lesions will be referred to Uganda Cancer Institute for further management.
- **At National Referral and RRH,** an HPV test will be the primary screening tool, those with positive HPV tests will be screened with VIA. Eligible lesions will be treated using either thermocoagulation or Loop Electrosurgical Excision Procedure (LEEP). Cancerous lesions will be referred to Uganda Cancer Institute for further management.

The $5M investment is largely allocated to commodities (VIA kits and HPV tests), equipment (thermocoagulators and LEEP machines), materials adaptation and printing, demand creation/communication/community mobilization, training/mentorship and oversight of service delivery, and management of adverse events.

4.9 VL and EID Optimization

Uganda has a centralized VL and EID testing system using conventional PCR platforms for analysis of both plasma and dried blood spot (DBS) samples transported through the national specimen transportation network. In FY19, the lab optimization committee focused on development of the EID POC national implementation plan, outlining the criteria for site selection and integration of EID into existing GeneXpert equipment without disrupting the TB program, service delivery

models, training and the roll out schedule. Based on findings from a pilot of EID POC at 33 sites, and a TB laboratory network assessment, the committee identified EID coverage and health facility issues such as staffing, waste management, data connectivity, quality assurance and infrastructure as key considerations in site selection.

The expansion of EID POC to 146 sites in COP19 targeting hard–to-reach areas (mountainous and/or on island communities) and high-volume inpatient, TB, and nutritional wards, conforms to an agreed-upon national policy for the selection, evaluation, adaptation, implementation and evaluation of POC testing in Uganda. The majority of EID POC will be conducted on the mPIMA device. For sites that have a GeneXpert machine, addition of EID POC platforms will only be considered if the GeneXpert theoretical utilization rate is less than 80%. EID POC is one component of a broader strategy to improve EID coverage, reduce rates of LTFU among HIV Exposed Infants (HEIs) and support early ART initiation for identified HIV-positive infants at all entry points. The FY20Q1, EID coverage stood at 66% and 89% for age bands 0-2 and 0-12 months respectively. The COP20 target is 80% and 95% for age bands 0-2 and 0-12 months respectively.

For FY19 (COP20), Uganda plans to maintain the EID POC at 146 sites and focus on optimal utilization to increase the proportion of tests conducted using EID POC platform from 20% in COP19 to 35% in COP20. As part of the optimization exercise PEPFAR Uganda will continue working in collaboration with the Central Public Health Laboratory at Ministry of Health to enhance the efficiency of the conventional centralized and POC EID platforms to achieve optimal sample turnaround time and timely utilization of results for patient management, by program to inform policy. Strategies to meet this include utilization of electronic results download at facility level, additional hub riders and an electronic sample tracking system.

Regarding VL, PEPFAR Uganda supported improvement of VL coverage from 80% in Q4FY18 (COP19) Q4 to 94% by Q1FY20 (COP19). PEPFAR will continue to use a multifaceted strategy consisting of a surge approach using existing partners and MOH-led district-focused support to the centrally supported districts to improve VL coverage to over 95% across all regions and population groups including pregnant and breastfeeding women. These strategies will include

- Implementation of a bar-coded sample tracking systems for monitoring the movement of samples from collection to resulting delivery
- Expanding the electronic result transmission to all high-volume sites by real-time linkage of EMR with the VL dashboard
- Sending of a preemptive system generated alert to health workers for intensive adherence counseling and for sample collection one month prior to VL due

In addition, using lessons learnt from the already established EID POC testing platform, and as evidence on feasibility and scalability of VL POC becomes available, PEPFAR Uganda in collaboration with MOH and stakeholders, will explore VL POC for hard-to-reach locations or particular populations such as pregnant and breastfeeding women.

To maximize access, cost efficiency and impactful use of both conventional and point of care (POC) instruments for laboratory testing, PEPFAR Uganda is working with MOH to explore multiplexing for EID, TB, HPV and Hepatitis B.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

As Uganda nears epidemic control, it is critical to address the systems barriers to improve case finding especially among young men and children, retention, VL suppression, closing the gaps for key/priority programming, and maintaining clients enrolled on treatment. In COP19, PEPFAR has made significant progress in key aspects including increased uptake of TLD for all men, women and eligible children; enrolled over 50% of HIV patients on TB preventive therapy; scaled up optimized pediatric regimens, increased the number of patients who are enrolled unto DSDM, increased VL coverage to 91%, and reported improved VL suppression rates across most targeted populations. COP20 systems investments builds upon these successes and will promote a patient-centered approach that will improve HIV patient outcomes. In COP20, PEPFAR will continue to work with and through the GOU systems in order to get towards sustainability and increased responsibility by the host country.

The development of the systems support investments were mostly informed by the MER, SIMS, sustainability index dashboard-(SID 1, 2 and 3), the responsibility matrix, and pre-COP consultation meetings with key government and non-government stakeholders. COP20 priorities were identified through a rigorous process that engaged key players including GOU, civil society, and key donors including GF (for purposes of efficiency and harmonization). Multiple consultative meetings were held in order to take stock of progress to date, identify remaining systems bottlenecks and jointly design appropriate interventions to address these programmatic barriers. In addition to addressing these barriers, PEPFAR will continue to support the MOH to develop critical policies that will respond to the dynamics of HIV/TB, technical guidelines and standard operating procedures that will reinforce its oversight and leadership roles and responsibilities.

Key areas for systems intervention included: HRH, supply chain and commodity management, HIS, laboratory systems, sustainable financing, quality of services and community participation/ engagement.

Overall, the systems interventions will address the following barriers:

1. HIS: Data systems for health information exchange, unique identifiers, and analytics at national, regional, facility and community levels are not fully rolled out and/or utilized for precision in targeted case finding among men and children, reaching KP, and retention of men, women and children in care.
2. Supply Chain and Commodity Security: Uganda's health supply chain system has not reached its full maturity level to allow for commodity security and end-to-end visibility of commodity flow from the central level to the health facilities thereby compromising commodity availability for HIV and TB clients.
3. HRH: There are still inadequate skilled health workforce available both at facility and community levels to deliver quality HIV services to match the growing demand and needs for case finding, treatment and clinical monitoring, retention, adherence, community care, and DSDM that compromises quality of care.
4. Laboratory Systems: Uganda's laboratory capacity has increased substantially but there remain gaps in terms of coverage (affecting access), utilization and quality of lab tests

conducted, as well as closing the gap in turnaround time for lab results to allow for clinical case management and advise policy and program.

5. Financing for Sustainability: While the government has made efforts to increase financing for HIV commodities, increases in support for services, commodities including ARVs, and systems will need to increase to ensure epidemic control and sustainability.
6. Community Systems: In COP20 PEPFAR will build on the innovative indigenous model of "Community Led Monitoring" (CLM) developed by Ugandan CSOs. The CLM will be expanded and institutionalized with support first from COP19 PEPFAR Small Grants, and then through funding via UNAIDS Headquarters to Ugandan CSOs for COP20 CLM.

PEPFAR is cognizant of the fact that most of the systems support will have to transition fully to the GOU national systems over the coming years. In preparation for a seamless transition, PEPFAR will facilitate strategic and systematic capacity building efforts with GOU counterparts through phases with agreed benchmarks, so that systems investments are integrated, institutionalized, and sustained after PEPFAR support decreases over the years. PEPFAR will achieve the smooth transition to GOU by deliberately working with and through GOU established structures, that are led by GOU personnel. To effectively respond to system related barriers, strategic activities have been proposed with clear benchmarks set. These benchmarks will be closely monitored to establish progress and reported quarterly, through existing GOU and Health Development Partner coordination mechanisms, to enhance program accountability and assess their impact on site level indicators.

The subsections below will highlight the key systems investments from Table Six and approaches that PEPFAR will support in COP20.

Policy, Governance and Leadership

Cognizant of the public sector role to reach HIV epidemic control, USG will facilitate and empower the GOU entities to assume greater responsibility for increased leadership, ownership and sustainability of the HIV response. We will intensify our engagement with GOU at national and subnational levels, civil society organizations (CSOs) and leverage resources from other stakeholders (GFATM, other donors) to increase our efficiencies. There will be special focus on accountability for HIV performance at all levels especially in the area of patient retention, viral suppression and case identification in poorly performing districts and health facilities.

The public sector engagement process will focus on the national and sub-national entities that will enhance the public health response through delivery of comprehensive HIV/TB services within all high-volume sites and communities with greatest need. Key focus areas will include supporting the MOH to develop and disseminate critical policies that will respond to the dynamics of HIV/TB, technical guidelines and standard operating procedures that will reinforce its oversight and leadership roles and responsibilities. MOH is in the process of completing the development of several key HIV policy guidelines, including HIV testing for Key and Priority Populations, PrEP for AGYW and PBFW, and six-month multi-month scripting. More guidance will be sought regarding PrEP being part of a broader prevention package following comprehensive risk screening. The MOH, though in agreement to roll out MMD, has raised concerns about the ability for some individuals to be able to properly store the six-month bottles of pills given that the majority of HIV clients stay in rural areas where mold and extreme temperatures are common. During COP19 and through COP20 implementation, more engagements with MOH-ACP and the National Drug Authority around experience with medicine storage approaches will be conducted.

With the ever-increasing number of districts in Uganda (138), PEPFAR Uganda will support MOH's efforts for enhanced support supervision of sub-national entities through the regional referral hospital (RRH) approach (hub and spoke). This approach will strengthen MOH's oversight, accountability and leadership of the decentralized HIV/TB response through the RRHs. In COP20, ten regional platforms including RRHs (as shown in the map below), will be supported to become centers of excellence to expand central level technical support supervision, surveillance, specialized laboratory services, regional CQI, performance monitoring, cost-effective capacity building approaches through tele-mentoring and effective community mobilization for client centered quality services. This approach will ensure that interventions within districts are standardized and institutionalized within existing GOU systems for sustainability.

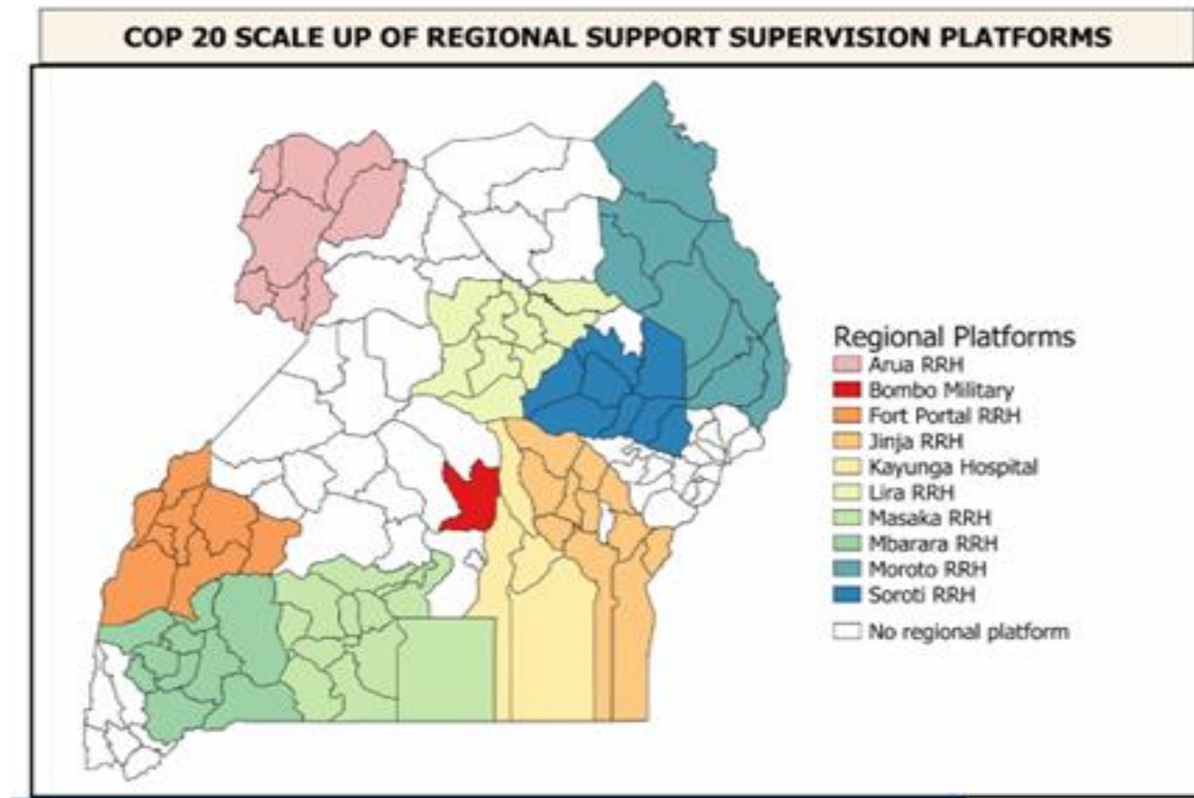


Figure 5.0.1 COP20 Scale Up of Regional Support Supervision Platforms

In COP20, the USG will support district-led programming, whereby district health leaders will be supported to coordinate and oversee HIV service delivery at lower levels for effective stewardship of the HIV response. New districts will be supported to develop costed HIV strategic and operational plans and their capacities built in data management and reporting, commodities security, management of district resources as well as performance monitoring and reporting. The poor performing districts will remain the focus of this support in order to bring them up on key programmatic aspects along the 95/95/95 cascade.

Human Resources for Health

PEPFAR Uganda will continue providing technical assistance to support the MOH to improve HRH management to optimize available HRH for sustained epidemic control. The GOU has made

notable improvements in health worker remuneration and overall coverage of the HRH in public health facilities, to current coverage of 76%. However, this still falls short of the Health Sector Development Plan target of 80% by 2020. Furthermore, Uganda's staffing norm is outdated, and the numbers and cadre range are not in sync with the current workload and service needs for retention, case finding, KP programming, quality counseling and community service support. PEPFAR will continue to provide focused HRH support at national, regional and district levels targeting priority cadres that contribute to improved client centered care and attainment of PEPFAR targets, however a five-year transition plan was agreed in COP19 and is being implemented. At sub national level health workers will receive continuous mentorship and training on issues around addressing stigma, minimizing risk of GBV related to PITC, and overall clinical management per national HIV guidelines.

As part of COP20, Uganda conducted a detailed inventory of the PEPFAR HRH across all implementing partners, Overall PEPFAR HRH support will be reviewed to ensure alignment to burden, need and optimal cadre mix for maximum efficiency and impact. Emphasis will be given to ensure that HRH is aligned to address the regions/IPs with low VL suppression and retention rates. In the past year, MOH absorbed over 100 health workers, and in COP20, PEPFAR will continue to work closely with GOU to facilitate absorption of seconded HRH in both private and public sector. The support for the absorption of seconded HRH at sub national levels will continue to ensure that the 816 non-absorbed health workers are progressively transitioned to GOU with specific focus on the 307 HWs in public facilities to be fully transitioned over the next 2 years. PEPFAR will work with MOH to review TA needs at central level, engage with stakeholders and line Ministries for increased wage allocation, and work with GOU and PNFPs to develop a road map for the transition of 509 PEPFAR seconded HRH in PNFP sites.

In order to build a strong and sustainable HRH system, PEPFAR will provide TA for the functionalization and optimal utilization of the national Human Resource Information System (HRIS) to support recruitment planning and deployment to areas with high vacancies and high disease burden. In COP20, PEPFAR will support HRH strategic and recruitment planning, utilize efficient e-models for training/mentorship including ECHO/Zoom at RRH, scale up performance management for increased HW productivity and provide targeted training of key cadres like skilled epidemiologists for public health leadership/stewardship and sustainability of the HIV response. Additionally, TA will be provided for the ongoing revision of the staffing norms at regional and sub-national levels to increase the staffing establishment and advocate for introduction of key cadres – particularly lab scientists, counselors and community workers.

Finally, the Ministry of Health announced the formation of the National Institute for Public Health (NIPH)in 2019, which will consolidate many departments for better operational clarity and sustainability. PEPFAR will continue to support the NIPH development.

Community systems support and service delivery

A dedicated community health workforce is critical for effective delivery of HIV/TB services at community level. PEPFAR will work with HDPs and provide technical assistance for the development of community health worker guidelines. A first step is unified U.S. government guidelines, to be completed on schedule by June 2020. PEPFAR will standardize enumeration and

clarify roles and responsibilities for community workers who constitute over 60% of the workforce at site level. Through this process, PEPFAR will ensure that CHWs receive a pay commensurate to their level of effort.

PEPFAR is working with implementing partners to standardize remuneration across CHWs and will align with GOU CHEWS policy. The remuneration rates will be determined in consultation with Government of Uganda and Civil Society. This effort will provide lessons for the MOH as they embark on getting a skilled workforce at community level that will play a critical role in retention, case-finding, adherence counseling and patient literacy.

National Supply Chain system

Overall, PEPFAR will continue to support the technical capacity of the MOH at the national, district, and health facility levels to provide oversight, leadership, and management of all facets of the HIV response, with the key guiding principle of ongoing support being a framework of mutual accountability for program results.

USG will continue to work to strengthen the national distribution system and ensure the availability of commodities needed to realize the DTG and pediatric optimization transitions, including MMD and differentiated service delivery model (DSDM) whereby ARVs could be distributed through private pharmacies, community-based and non-clinical locations.

We will work to improve data utilization and integration of commodity logistics systems to ensure visibility, transparency and availability of commodities. To date Uganda uses many systems throughout the supply chain. The service delivery points (SDP) use WAOS, and TWOS for ordering, and RASS (an SMS & Web Dashboard system) to inform redistribution at facilities. Many ARV credited SDPs use the Uganda EMR for patient-by-regimen data to inform accurate ordering of ARVs. At the national level, the USG will continue its efforts to improve efficiency and transparency at the National Medical Stores (NMS) through the installation of an Enterprise Resource Planning (ERP) system. The NMS ERP is planned to go "Live" (NMS begins using it) in July 2020. By December 2020, several health facilities (RRHs & Hospitals) will have begun to place their orders through the ERP ordering portal. Once established, rollout of the ERP client portal will continue gradually. The pace of rollout will be determined by health facilities capacity (computers, training, and staff). To this end, USG & other development partners are having ongoing discussions on how to rollout to lower facilities. In COP20, we will also focus on ensuring information exchange between the various systems. A combination of these will serve to reduce both stock outs and over-stocking (maldistribution) at facilities.

In COP20, USG will provide above site TA to the national warehouses to streamline their procurement capacity. The USG will continue its efforts to maximize the efficiency of commodity procurement and the role of the private sector for the sustainability of one national supply chain. Quality Chemical Industries Limited (QCIL) began to produce TLD in 2020. The USG is working with QCIL in the preparation of an application to the US FDA to produce TLD that could, thereafter, be procured by both PEPFAR and the GF. This expanded scale of production would not only allow QCIL to reduce its price for Uganda but make QCIL a major supplier of TLD for the African continent. We will also continue to work with VL reagent manufacturers to reduce prices

and provide commodities under Vendor Managed Inventory (VMI) solutions that will reduce interruptions and prices. Finally, USAID will begin to use local partners for the procurement, warehousing and distribution of HIV commodities for the PNFP sector. All these efforts will further the path to sustainability.

PEPFAR completed 26 medicine stores at high volume ART sites to ensure that these large facilities have enough and appropriate space to store and issue all health commodities, including HIV. Moving forward, the USG will focus attention on optimizing the use of space available in health facilities, while other donors may provide resources to build additional stores around the country.

To ensure longer-term sustainability, the USG will begin the process of transitioning full ownership and leadership of the national supply chain system toward the GOU. This process will begin with the strengthening of national data systems for commodity management, the consolidation of USG activities under one USG supply chain entity, absorption of USG seconded supply chain staff into the GOU staffing norms and finally a transition of USG supply chain support and commodity management to GOU. In COP20, three regions that are currently served through CDC will be transitioned to USAID and this consolidation will be complete (with all health facilities currently receiving commodities from CDC transitioned to USAID mechanisms) before September 2022.

Health financing and sustainability

As discussed in the investment profile section above, close to 90% of funding for the national HIV response comes from external donors, which is unsuitable. As we approach epidemic control, PEPFAR's efforts towards ensuring greater efficiency, financial sustainability and local ownership of the program will be critical to maintain the large number of patients on ART. Currently, PEPFAR/Uganda is working with Health Development Partners (HDP) and the Ministries of Health and Finance to develop a health financing transition and harmonization plan that covers a broad range of areas including commodities and HRH. However, such transition can only be possible if the country has the capacity to finance and effectively manage the response. PEPFAR will provide technical assistance to GOU to explore sustainable financing options including introducing a health insurance scheme that provides coverage for HIV services. In addition, capacity building technical assistance will be provided in budget planning and execution and public financial management (PFM) to MOH as they manage HIV funds from GOU and other donor partners. The USG is also working with OGAC in finalizing plans to pilot the Activity Based Costing and Management (ABC/M) methodology to determine the actual cost of the PEPFAR program both for direct service delivery and technical assistance. Information from the ABC/M exercise will be critical for improving efficiency within the program in addition to providing valuable information to the GOU on resource requirements to maintain epidemic control.

Laboratory systems

Uganda's laboratory capacity has increased substantially but there remain systems in place which are inadequate for efficient coordination, management, and continued quality assurance of laboratories required to inform program and policy to reach and sustain epidemic control.

PEPFAR will provide technical assistance to the newly created MOH department of National Health Laboratory Diagnostic Services (NHLDS) under which the Uganda National Health Laboratory

Services (UNHLS) and all other laboratory services fall, will support GOU to undertake service delivery management and routine surveillance for sustainability of investments and gains made. This technical assistance will ensure a consistent institutional capacity strengthening with the government taking increased ownership in providing quality laboratory services, optimizing multi-disease testing to meet the unmet diagnostic need.

In COP20, PEPFAR will support laboratory optimization including multiplex testing to ensure improved access, efficiency and reduce costs. This activity will focus primarily on VL, EID and TB for both conventional and POC platforms but consider inclusion of Hepatitis and HPV. Implementation of the CQI initiatives in 100 hubs and lower level facilities that are linked to the 100 hubs will provide timely accurate and reliable results. Activities will include implementation of Quality management systems (QMS), External Quality Assessment (EQA), ensuring workforce competence for Rapid HIV, VL, EID, CD4, TB, testing and advanced disease management. In addition, implementation of the National Laboratory Information Management Systems (LIMS) will assist in capturing, transmitting, analyzing and utilization of laboratory data to inform program and policy for the management of patients.

The goal is to have a government-owned resilient, quality assured, coordinated laboratory systems that meets program needs for diagnosis, prevention, treatment monitoring, surveillance, and disease control. Finally, PEPFAR will support GOU efforts to review the lab policy and the development of the laboratory strategic plan 2020/2025. The recent announcement by the GOU to establish a National Institute of Public Health (NIPH) is highly welcomed as the country moves towards sustainability, and PEPFAR will support the MOH in this process.

Building HIS for Epidemic Control

In the last months, PEPFAR Uganda has been focusing on improving the quality, utility, and the overall value proposition of patient- level data systems. These clinical and lab information systems are designed to support PEPFAR critical priorities and the MOH requirement of promoting systems that are designed for a range of public health priorities for patient level data use. Nationwide upgrades and roll out plans have been drawn out for all PEPFAR supported sites. When fully implemented at all high-volume ART sites, the improved Electronic Medical Records (EMRs) will be able to provide patient-level data for monitoring adherence to medications, document and track clients' transfers, and capture relevant data for monitoring retention on HIV and TB care. The EMRs will also support clinical decision making, timely delivery of client laboratory results to health care providers/systems, HIV recency testing, VL testing, reporting for program monitoring, and HIV case-based surveillance.

A functional standardized platform for health information exchange, linking patient level EMR systems with the national reference laboratory has been demonstrated. The primary challenge to large scale implementation is establishing a fixed, secure and reliable internet connection at all facilities.

Implementation of patient Unique Identification (UI) has continued at a slow and decentralized way as efforts continue to bolster policy, legal requirements, and governance for protection of privacy, confidentiality, and security of personal health information. However, this has not deterred efforts for working on sharable key architecture pieces to continue. A use-case to inform

the development of a prototypical client registry to support implementation of unique identification is being completed. Again, successful implementation of unique identification that will improve patient mobility as well the patient experience critical for their retention requires internet connectivity across sites from which clients get their care services.

In COP20, initiatives of building the national systems architecture including UI implementation from COP19 will continue. However, the emphasis will be put on the following:

1. **Building HIS for epidemic control that provide that the client-centric data and improve individual outcomes**
    - Meeting these priorities will require higher quality and accessible data, especially at the patient-level and uniquely identified at national scale. The information systems to achieve this will depend on internet connectivity across sites, and standards for information exchange between systems (interoperability). The resulting health information exchanges will include all priority data sources (aggregate and patient level) and must be secure, robust and well governed.
    - Detailed costs of implementation and maintenance of these systems will be required to determine data value, increase host government investments and health partner co-investments.
    - The most critical HIS strategy for COP2 centers around connecting the many instances of EMRs and laboratory systems through a central client registry for patient-centric data use for the following impact as indicated in the figure below.

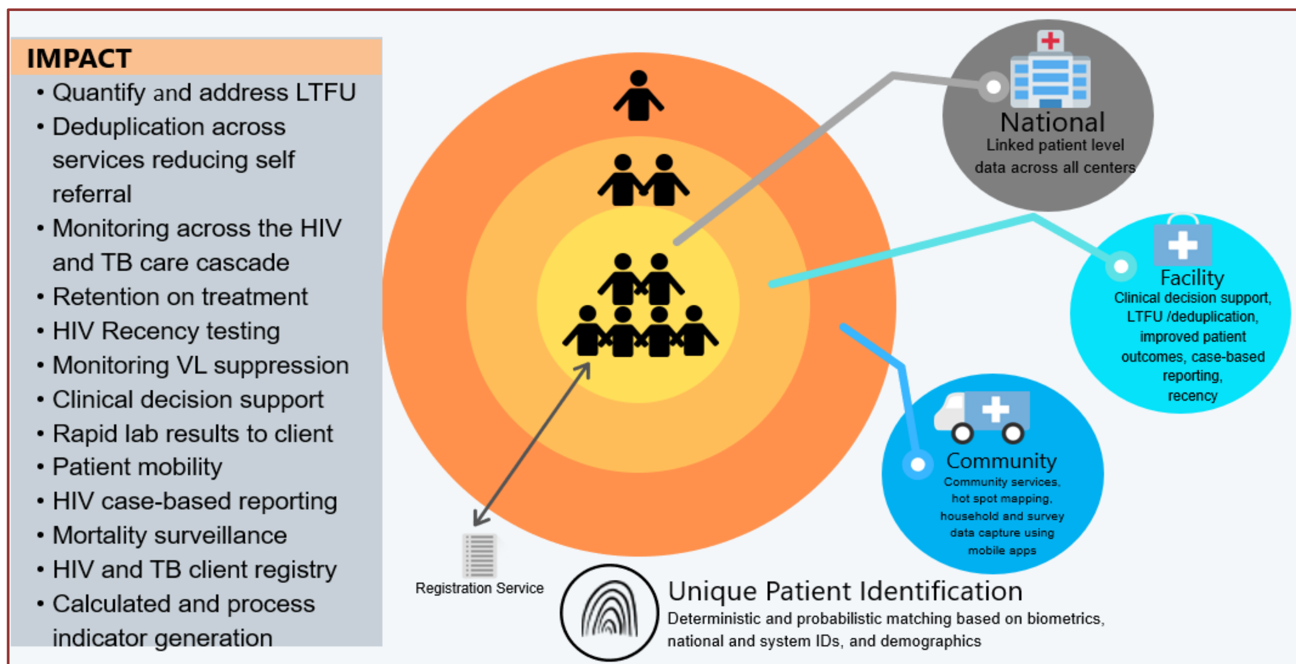


Figure 5.2 Linking Facilities for Patient Level Data for Epidemic Control

- At facility and community level of implementation, Uganda's strategy will focus on increasing availability, and use of patient -level data by ensuring that that facility-based patient level systems link to existing disparate facility solutions for testing, treatment, dispensing, and laboratory, especially VL monitoring, to provide better care to patients

both within single site systems and between systems at different sites. Achievement of this will be through the EMR Technical Working Group (TWG) governed and directed by MOH to ensure that these systems are based on standards and shared principles to enable data integration.

2. **PEPFAR Uganda will focus on internet connectivity for health facilities to enable linkage of individual records across services.**
   - HIS investments in an interconnected facility have higher value than stand-alone HIV investments that lack interconnection. Siloed, program specific investments in wireless connectivity for computers dedicated to specific programs will be minimized and avoided whenever possible. Following are key actions:
     - Move from dongle-based solutions in facilities to fixed internet solutions and mesh wi-fi to connect the entire facility/campus.
     - Mobile (Smart-first) and satellite solutions will be considered for community connectivity.
     - Specialized internet service providers will be contracted to implement best solution for uncapped bandwidth depending on location and available solutions at that site.
     - Continuous quality of service (QOS) monitoring and bandwidth management will be carried out.

3. **Initiating efforts towards next generation aggregate systems that support data integration and health information exchange.**
   - Move towards PEPFAR adoption of national HMIS data sources for its reporting needs as well as monitoring of program implementation and partner performance.
   - Integration of multiple aggregate monitoring systems into a single platform. PEPFAR Uganda will leverage initiatives like Palantir Technologies to achieve this through a bridge mechanism while HIE is functionalized to full scale in Uganda.
   - Explore the role/utility of DATIM4U for example by ensuring that patient level information systems support functionality for automated reporting directly to PEPFAR information systems (DATIM) to reduce burden on IPs for routine data submission.

4. **Continue working on establishing health information exchanges to enable integration of multiple disparate information systems in Uganda e.g. clinical, laboratory, pharmacy and supply chain**
   - Continue working on the client registry with a goal of linking records created for individual patients in different systems since HIE will help establish proper data governance, and controlled access to data and information systems. Through established exchanges, PEPFAR Uganda will work on establishing an integrated clinical data repository that supports de-deduplicated analytic data sets to identify gaps in the care cascade towards HIV epidemic control.

5. **Data Use Community Built Around PEPFAR Subject Matter Experts and the Broader Data Science Community**
   - While many who work in HIS have expertise in data science, there is a clear need to recognize that these are two distinct domains that should be coordinated with more engagement from data scientists from within and beyond PEPFAR.

6. **Collaboration and Coordination Across Host Country Governments and Global Public Health Stakeholder**
   - From a governance perspective, PEPFAR Uganda will continue to work with MOH and other health development partners to ensure that all system investments are coordinated. The strategy will be to clearly understand benefits and harm of short-term systems that only address short term needs, while distracting attention and resources away from initiatives that move wider health sector systems forward.
   - Building, maintaining, and governing a shared service with multiple partners using governed resources and support will allow the various stakeholders to share expertise and technology support, to create large-scale efficiencies, and to focus additional resources on data security and privacy
   - Coordinated and shared digitized systems can enable multiple disease surveillance which can strengthen the health security of Uganda

Unique Identifiers as part of HIS architecture
Unique identification (UI) continues to be ongoing work in Uganda with UI implemented at all sites where patient level data are collected. The goal of investing in infrastructure including internet connectivity is to support linkages across all sites for a nationally de-duplicated registry of uniquely identified clients. The strategy for implementing patient identification program initiatives in Uganda will continue to involve all relevant stakeholders including MOH, Ministry of ICT, Ministry of Internal Affairs, and the National Identification Regulatory Authority (NIRA). After piloting select UI strategies such as the National Identification Number and biometrics, PEPFAR Uganda in conjunction with MOH is moving towards algorithm-based unique identification that brings together multiple personally identifying data elements to ensure a higher probability of matches and more robust registries.

The following will be considered for the algorithms:

- Record matching algorithms, both deterministic and probabilistic, as well as machine learning techniques will be essential tools to implement the patient matching strategy.
- HIV program specific identification initiatives will not be fronted, as they remain coupled with possibility of stigma and discrimination.
- The use of a patient identification approach will be supported by implementing a client registry or master patient index. If this information system is integrated in a health information exchange, all patient level information systems can leverage the client registry for patient identification.
- Handling patient identifying information in any information must be explicitly supported by the implementation of information security and data privacy and confidentiality controls for those systems.

SIMS

The implementation of SIMS will continue with health facility sites selected based on **performance, program needs and program gaps, or if a new site, new partner, if scaling an activity and to ensure** fidelity of existing activity. The selection of the site will be agreed upon after review of the program data reported through any of the existing data streams that include DATIM, weekly reporting dashboards, quarterly activity reports and the HIBRID system used to collect data not captured in the national DHIS2 system.

A critical component of this approach is more frequent reporting and analyzing of results to make course adjustments and adapt program approaches, including fulfilling the Site Improvement through Monitoring System (SIMS) requirements.

CDC conducted 24 SIMS visits in FY19. Late FY18 going into FY19, the SIMS strategy changed to urgent partner performance monitoring using a “surge” approach to help achieve of TX_NEW targets and address specific program challenges. This surge has meant intensified site visits and meetings with district leadership, partners and staff at high volume sites. Surge for quality will continue in COP19 and COP20 advancing key interventions and focusing on core indicators to increase HIV-positive yield with fewer tests, improve linkage and retention in treatment, ensure data quality, monitor ARV stock outs, plus enhance TB case finding and treatment completion.

The PCO/STATE with support SITES carried out a SIMS visit in Q4 of COP18 and plans another in Q2 of COP20, depending on COVID-19 travel bans. PCO continues to meet monthly with UNHCR in Kampala to review the challenges facing the refugee population supported through PEPFAR funds, and to develop solutions, particularly around linkage and retention.

USAID conducted 4 SIMS visit in four out of the five RHITES regions. In total we conducted 23 site visits in FY 2019 to assess the quality of HIV service delivery in the supported regions. Our target for FY 2020 was to conduct 72% assessments of the required total assessments. This has been impeded with COVID-19 and the related restrictions imposed by GOU. To date, USAID in FY 2020 has completed 5 SIMS assessments and we hope to resume as soon as the restrictions have been lifted.

DOD/MUWRP conducted 13 SIMS visits in FY19. Ten (10) site visits were comprehensive while three (3) were follow up assessments. The FY19 SIMS strategy focused on partner performance monitoring implementation of “surge” beyond the initial surge indicators; for TX_New and to include tracking performance for indicators like TX_CURR, retention and linkages. DOD/MUWRP intensified site visitations to facilities and above site entities as part of efforts to track implementation of Surge across indicators. In COP19, DOD/MUWRP will continue with conduct intensive site level visitations and follow up to support improvement of key performance indicators in addition to planned SIMS visitations.

MER reporting

Uganda has progressively strengthened its data collection systems for the HIV/TB program and has subsequently moved to reporting more than 80% of the PEPFAR indicators in the national Health Management and Information System (HMIS) with the finer age disaggregates inclusive. However, this system has been largely paper-based and lacking a universal format of unique identification for beneficiaries, making it difficult to de-duplicate program data. In addition, KP indicators were excluded from the HMIS. USG will utilize the HIBRID system to collect KP data, while also advocating for its inclusion in the DHIS-2. In addition, PEPFAR will triangulate with other available KP data within the KP/PP Dashboard and outside PEPFAR.

Generation of data, reporting and analysis of KP cascade data will be a priority in COP19 and will continue in COP20. Partners will be supported to use customized hybrid KP data capture and technical assistance will improve reporting. In addition, the KP dashboard will continue to be supported to provide “real time” data. Continued quality management for KP will be tracked

through enhanced partner management for weekly and quarterly data quality reviews, KP/PP sub-national unit (SNU) level and site level analyses, monitoring implementation of the KP service package and using tailored KP/PP reporting tools. The KP-led community scorecard will contribute to community-led QI processes. Community led monitoring will be supported through the PEPFAR small grants office to enable the CSOs to assess the quality of service through the community score cards, client satisfaction surveys, regular dialogues meeting and with mystery clients' surveys were necessary.

Following the more than 80% of the PEPFAR MER indicators' alignment with national M&E framework into one national M&E system with the finer age disaggregates inclusive, there is need for continued mentorship of health facility staff to ensure quality data is reported. Comprehensive mechanisms and districts will be supported to conduct periodic quantitative program data analysis. Results will be triangulated qualitatively using stakeholder feedback. Community led monitoring will utilize the community/clients' feedback to inform programs.

Data Quality Assessments

Data quality assessments will be conducted to ensure quality data is utilized for evidence-based making. In FY19 PEPFAR Uganda conducted the following DQAs and findings were used for program improvement as indicated below:

- DREAMS DQAs were conducted in November 2019 to ascertain the quality of Q3 DREAMS data and identify areas of remedial action for poorly performing partners.
- TPT DQAs was conducted in December 2019 to validate the high uptake reported through the weekly dashboard
- VMMC DQAs conducted in March 2019 to investigate potential falsification of reported numbers and the findings confirmed accuracy of VMMC reporting
- KP DQA were conducted in November 2019 to investigate the quality of services provided to the client and provide onsite mentorship to service providers
- OVC SQAs conducted in September 2019 to ascertain the quality of services identified programming gaps that are being addressed. One of the major key finding was cases of false HIV positive status in some sites. This was fueled by the HIV_STAT indicator that required self-reporting. A decision was made to stop enrollment of CLHIV based on self-reporting but rather with evidence of ART number and focusing enrollment more at the facility level than community. Service providers inadequately supporting OVC for VL test uptake and limited follow-up of CLHIV on ART to ensure routine VL on schedule. OVC partners have developed MOUs with health facilities and agreed to place a social worker at high volume sites. The role of this social worker will be to identify children on ART who require additional community support and links them to the OVC platform. Track their VL and suppression and actively participate at the health facility SWITCH committee that discusses complicated cases of children not suppressing. The presence of a social worker in health facilities is improving VL testing and suppression.

Continuous Quality Improvement

PEPFAR, in collaboration with MOH, will provide technical support to districts to pilot, implement and scale up successful collaborative CQI interventions using short learning QI loops.

Surveillance, Research, and Evaluation: An Overview

Surveillance & Surveys: As the country shifts to the adoption of TLD, collecting crucial information on the possible effects of these medications is key, the proposed activities will further inform efforts in finding men, reaching KPs, preventing HIV in AGYW, approaching Epidemic Control by efficiently identifying undetected HIV cases including in children, and establishing the proportion of acquired HIV drug resistance (ADR) among HIV-positive adults on Dolutegravir containing regimens. Interim data analysis and dissemination from AFRICOS Surveillance which longitudinally assess the impact of clinical practices, biological factors and socio-behavioral issues on HIV infection and disease progression in an African context formed part of the body of evidence that is guiding MOH and PEPFAR program implementation especially TLD transition in light of reported severe adverse events attributed to dolutegravir. Proposed- ongoing research activities will inform better prevention, care and treatment services for the military, fishing, and nationwide populations, and will identify and seek to modify barriers to PrEP among AGYW sex workers, as well as demonstrate intensified efforts to promptly initiate ART in persons diagnosed with HIV

Research:

Evaluation: proposed and ongoing evaluation activities will identify effective and cost-effective approaches in priority areas, both existing (HTC, linkage, retention, viral suppression, and incidence reduction) and new (PrEP, PWID, self-testing, adolescent SRH, CBS, and recency testing). In a bid to support Uganda to consolidate its gains from PMTCT and Test and Start efforts and to drive through to epidemic control.

Specifically, COP20 will feature the following surveillance, research, and evaluations.

COP20 Surveillance Portfolio

IM Number	Short name of study	Objective	Status
SURVEILLANCE			
18567- Enhanced case-based surveillance and validation of TX_ML indicator	Case based surveillance and TX_ML validation	To better understand mortality for case-based surveillance and TX_ML	Ongoing, Protocol in clearance
17705- Hospital-based birth defects surveillance in Kampala, Uganda	Birth Defects study	This study will collect crucial information on the possible effects of these medications to the unborn babies in the PMTCT setting.	Ongoing - Data collection
18566- Scale up of Recency Testing specifically QA/QC activities	Recency Testing	To scale up recency testing specifically QA/QC activities (Next UPHIA in 2020)	Ongoing - Data collection
18565- Provision of comprehensive, friendly services for KPs and CRANE follow on for enhanced surveillance.	Provision of comprehensive, friendly services for KPs and CRANE follow on for enhanced surveillance	Primary focus: Sero-behavioral and recency surveys, size estimations, and mapping among KP/PP	Ongoing, Protocol in clearance
9043- Makerere University Walter Reed Project	Evaluation of Changing Guidelines, System and Practices on Prevention, Care, and Treatment in PEPFAR districts	This study provides ongoing routine assessment of program data aggregated from the facility level and up to inform program pivots and program improvements.	Ongoing- Data collection and real-time data analysis to inform MOH and PEPFAR programming
9043- MUWRP AFRICOS	African Cohort Study (AFRICOS)	The objective of this activity is to longitudinally assess the impact of clinical practices, biological factors, and socio-behavioral issues on HIV infection and disease progression in an African context.	Ongoing- data collection
18566-	HIV Drug Resistance (DR) sentinel	The project will monitor DTG HIVDR rates in the population with an aim to check on epidemic control	NEW

HIV Drug Resistance (DR) sentinel surveillance for TLD and transmitted DR	surveillance for TLD and transmitted DR		
81976- CBS/recency above-site support (TBD)	Recency Testing and Case-based Surveillance	To establish surveillance system of newly-identified cases at the time of diagnosis to (1) monitor epidemiological trends in newly-diagnosed HIV cases by demographics, behavior, mode of transmission, and recent HIV infection; (2) monitor trends of clinical status (World Health Organization (WHO) Stage, initial CD4 T-lymphocyte (CD4), other opportunistic infections) at the time of diagnosis; and (3) monitor trends in linkage to services (e.g. same-day antiretroviral therapy (ART)) at the time of diagnosis	Ongoing - Data collection

COP20 Evaluation Portfolio

EVALUATIONS			
18563- OVC Evaluation	OVC Evaluation	The evaluation will provide PEPFAR agencies and partners with actionable findings to transition OVC service delivery responsibility to a sustainable case management model delivered by local public and private institutions and improve service delivery layering (and its cost effectiveness) by rigorously examining the prominent causal pathways out of extreme vulnerability.	a) Final data collection and analytics of both qualitative and quantitative data. b) Dissemination and presentation of final evaluation findings to various stakeholders (USAID, implementing partners and GOU). c) Final report that incorporates the endline survey to

			deliver clear findings on the relative effect of OVC service delivery components on household vulnerability; and, d) Handover Mapping, including capacity analysis of local partners (including GOU) and potential access to alternative resources.
81975- No Means No Evaluations (Process and Outcomes)	No Means No Evaluation	1. To determine the feasibility and acceptability of NMN in Uganda by documenting inputs and outputs (i.e., attendance, disclosures, and referrals) and feedback from participants, Instructors, implementing partners and community stakeholders 2. To assess the fidelity of the Uganda training by measuring the outcomes of the training through pre- and post-tests of participants' knowledge, perceived behavioral capability, and self-efficacy to protect themselves from sexual assault 3. To analyze the cost of implementing NMN in Uganda by documenting costs related to the planning and implementation of NMN	Protocol in clearance
9043- Makerere University Walter Reed Project	Evaluation of Changing Guidelines, System and Practices on Prevention, Care, and Treatment in PEPFAR districts	This study provides ongoing routine assessment of program data aggregated from the facility level and up to inform program pivots and program improvements.	Ongoing- Data collection

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

REDACTED

In COP20, PEPFAR will support 212 Full Time [staffing] Equivalents (FTEs). Thirty-six (36) of these FTEs are currently vacant, with USAID having the highest number at 22.25 FTEs. All agencies are affected by a lengthy timeline for recruiting new staff, from position classification to clearances, which takes up to 240 days for both offshore and LES staff.

REDACTED

Beyond the positions listed above, during the COP19 RPM in Johannesburg in March 2019, USAID/Uganda received permission to hire an additional 13 staff to meet the increased requirements associated with the local partner directive and USAID's Journey to Self-Reliance. As there is no additional space to bring these new positions onto the Embassy compound (until the Embassy annex, currently under construction, is finalized), USAID/Uganda is hiring these positions through an institutional contractor. These positions will be on-board prior to the end of quarter three of FY20.

USAID/Uganda is significantly increasing the proportion of PEPFAR resources being provided directly to public sector entities and to local partners in COP20. As such, USAID/Uganda will need to work closely with these Ugandan institutions to ensure they responsibly manage USG resources and deliver results. USAID/Uganda also continues to provide strong oversight and management of contractors and grantees to ensure that programs operate more efficiently and cost-effectively and that they meet PEPFAR targets. The new USAID/Uganda staff will help provide this intensive engagement with partners as well as meet the Site Improvement through Monitoring System (SIMS) requirements in which USAID has been under-performing; of the 94 sites USAID prioritized for SIMS in FY2019, SIMS visits were only conducted at 23 sites, representing a quarter of the requirement, however intensive "surge" visits continued.

Combined, the new staffing positions which will be hired directly by USAID and the 13 which will be hired by an institutional contractor will help meet the additional requirements associated with the local partner directive and USAID's Journey to Self-Reliance. However, despite the addition of these positions, per USAID agency-wide staffing formulas, USAID/Uganda will remain understaffed (by a third per USAID right-sizing numbers) to fully meet the compliance, technical vigor, and fiduciary requirements commensurate with its budget.

For CDC, the CODB budget is maintained at the same planning level as COP19, with slight shifts between CODB cost categories to offset staff salaries and benefits for normal within grade increases and a mission wide locally employed staff wage increase.

CDC filled four vacancies in COP19: Senior Program Advisor, PMTCT Specialist, Strategic Information Deputy Branch Chief, and Epidemiologist. Three positions have been vacant less than one month and are expected to be filled during COP19 (Health Systems Strengthening Branch Chief, Chauffeur, and Electrician). Two have been vacant less than 6 months and will be filled in the next 6 months (Statistician and HIV Prevention Deputy Branch Chief, currently pending regional classification.) CDC is repurposing three positions to meet current organizational needs:

GF Liaison to Deputy PEPFAR Coordinator seconded to the PCO, Janitor to Cooperative Agreement Specialist, and Laboratory Quality Assurance Specialist to Executive Assistant. No new positions are planned.

The Department of Defense (DoD) Walter Reed Army Institute of Research (WRAIR) is staffed by one USDH responsible for programmatic oversight and supervision. DoD/WRAIR requires two LES to support management of the PEPFAR program at the current DoD/WRAIR/Uganda PEPFAR funding level. Recruitment of the LES positions is moving forward after lifting of a previous space restriction at the U.S. Embassy Kampala. DoD DHAPP conducted 8 SIMS visits in FY19 with full participation from IPs, UPDF clinic staff and UPDF HIV directorate and chieftaincy of medical services.

DoD/WRAIR is laser-focused on monitoring the current implementing partner to attain key clinical cascade indicators. DOD/WRAIR currently supports programming in four districts, with special emphasis on differentiated case finding, VL suppression especially for children and adolescents, and retention on treatment. In FY20 in the island district of Buvuma specifically, retention continues to be affected by government crackdown on the fishing community and the development of large palm oil farms. These developments continue to destabilize the economic livelihood of fishermen and farmers, causing many people to depart the district. To regain traction, in partnership with the IM DOD/WRAIR carried out intensified site visits to facilities, district health teams, and district administrative offices to document the major barriers and devise mechanisms to address bottlenecks. Additionally, SIMS visits will be conducted in FY20Q2 and beyond to further assess quality of services in Buvuma district. These efforts will be paired with CQI methods in COP20/FY21 as well as the ongoing Ugandan PEPFAR surge for quality in high volume and other strategic sites, to ensure maximal retention of the treatment cohort, and documentation of any transfers out.

The U.S. Department of State (STATE) PEPFAR Coordination Office (PCO) COP20 budget has slightly decreased. PCO will add one new position in COP19 - a DREAMS Coordinator. PCO otherwise remains lean, with two EFM job-sharing the Small Grants position, and three LES; a Program Assistant, a Program/Outreach Advisor, new Strategic Information Advisor, seconded SI liaison, and a Global Fund Liaison, all currently filled. The current USDH PEPFAR Country Coordinator will be wrapping up her assignment in May 2020, and it is expected that the next PEPFAR Country Coordinator will be hired through a USAID PSC mechanism. CDC has seconded the Strategic Information Officer and USAID the GF Liaison (EFM/local hire). The currently vacant Deputy Coordinator position will be filled (through a CDC secondment) in mid-2020. A PEPFAR funded communications position, seconded to the Public Affairs Section by USAID, provides media and communications support to the overall PEPFAR program.

The PEPFAR Coordinator's Office (PCO) will be the nexus for civil society engagement in COP20. OGAC will channel funds for the COP20 community monitoring activities to viable Ugandan CSOs either through a headquarters agreement with UNAIDS headquarters.

USG Uganda also hosts PEPFAR Home Operational Funds-supported Resident Advisor from the U.S. Department of Treasury Office of Technical Assistance who is embedded in the MOFPED to support and advise on public financial management and administrative structures for GFATM grants, financial processes, tracking of health sector resources to support enhanced allocation, and M&E.

Of its 15 FTEs, Peace Corps currently has three vacancies in various stages of recruitment - a Driver, a Safety and Security Assistant and an M&E Specialist. All positions will be filled by the end of FY20.

APPENDIX A — PRIORITIZATION REQUIRED

Continuous Nature of SNU Prioritization to Reach Epidemic Control

See following pages for Table A.1

Cluster	District	COP	Results reported	Prioritization	<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		Overall TX
					F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
GULU CLUSTER	Amuru District	COP 17	APR 18	Sustained	18%	69%	44%	33%	81%	70%	43%	44%	15%	90%+	15%	90%+	37%	90%+	51%	90%+	65%	90%+	44%	90%+	80%	90%+	56%	88%	70%
		COP 18	APR 19	Sustained	90%	90%	90%	87%	63%	61%	90%+	72%	51%	17%	70%	28%	65%	24%	82%	41%	70%	49%	61%	67%	79%	81%	70%	53%	65%
		COP 19	APR 20	Sustained	90%	90%	81%	74%	73%	75%	75%	74%	75%	74%	74%	74%	74%	74%	74%	74%	74%	74%	74%	73%	74%	74%	74%	74%	74%
		COP 20	APR 21	Sustained	58%	58%	61%	62%	61%	61%	61%	61%	61%	62%	61%	61%	61%	61%	61%	61%	61%	61%	61%	61%	61%	61%	61%	61%	61%
	Gulu District	COP 17	APR 18	Attained	71%	61%	65%	68%	90%+	90%+	90%+	90%+	53%	90%+	30%	90%+	38%	90%+	68%	90%+	85%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	85%	84%	54%	52%	90%+	61%	90%+	40%	90%+	38%	90%+	61%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Lamwo District	COP 17	APR 18	Attained	0%	0%	71%	64%	90%+	90%+	90%+	90%+	25%	90%+	29%	90%+	42%	90%+	75%	90%+	90%+	90%+	81%	90%+	75%	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	33%	90%+	32%	90%+	49%	90%+	83%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Scale-up: Saturation	87%	87%	84%	84%	85%	88%	85%	85%	88%	85%	85%	88%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
	Nwoya District	COP 17	APR 18	Sustained	60%	55%	63%	43%	58%	75%	35%	38%	12%	48%	17%	90%+	24%	90%+	39%	90%+	42%	90%+	41%	88%	45%	73%	41%	63%	57%
		COP 18	APR 19	Sustained	59%	72%	37%	35%	24%	24%	65%	27%	62%	20%	85%	19%	79%	30%	90%+	50%	85%	59%	74%	81%	90%+	90%+	85%	65%	73%
		COP 19	APR 20	Sustained	90%+	90%+	62%	61%	61%	61%	61%	61%	61%	60%	61%	60%	61%	61%	61%	60%	61%	60%	61%	60%	61%	60%	61%	60%	61%
		COP 20	APR 21	Sustained	73%	73%	70%	71%	70%	70%	70%	71%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
	Omoro District	COP 17	APR 18	Scale-up: Aggressive	0%	0%	21%	18%	44%	48%	42%	38%	24%	79%	16%	90%+	23%	90%+	36%	90%+	54%	90%+	56%	90%+	67%	90%+	53%	64%	67%
		COP 18	APR 19	Scale-up: Aggressive	0%	0%	26%	25%	20%	20%	54%	23%	53%	18%	73%	17%	68%	25%	85%	43%	73%	51%	63%	69%	82%	84%	73%	55%	62%
		COP 19	APR 20	Scale-up: Aggressive	0%	0%	62%	64%	73%	73%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	71%	72%	72%	72%	72%	72%	72%	72%
		COP 20	APR 21	Sustained	68%	68%	69%	69%	69%	70%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%
JINJA CLUSTER	Bugweri District	COP 17	APR 18	Scale-up: Saturation	35%	40%	44%	32%	61%	42%	52%	61%	90%+	90%+	44%	90%+	26%	90%+	27%	90%+	31%	74%	26%	85%	33%	70%	32%	46%	67%
		COP 18	APR 19	Scale-up: Saturation	88%	90%+	90%+	88%	55%	54%	90%+	61%	52%	18%	72%	19%	67%	25%	84%	43%	72%	50%	62%	69%	81%	83%	72%	54%	65%
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	84%	77%	69%	70%	70%	69%	69%	67%	69%	68%	69%	68%	69%	69%	69%	68%	69%	68%	69%	68%	69%	68%	69%
		COP 20	APR 21	Sustained	51%	51%	56%	53%	55%	54%	56%	57%	56%	55%	56%	56%	56%	55%	56%	56%	56%	55%	56%	56%	56%	55%	56%	56%	56%
	Buikwe District	COP 17	APR 18	Scale-up: Saturation	31%	90%+	57%	51%	85%	90%+	68%	74%	22%	90%+	13%	90%+	23%	90%+	38%	90%+	48%	90%+	63%	90%+	62%	90%+	65%	90%+	84%

		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	47%	42%	32%	31%	80%	37%	90%+	29%	90%+	28%	90%+	43%	90%+	73%	90%+	80%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	84%	77%	83%	83%	83%	83%	83%	82%	83%	82%	83%	82%	83%	82%	83%	82%	83%	82%	83%	82%	83%	82%	83%
		COP 20	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Iganga District	COP 17	APR 18	Scale-up: Saturation	54%	90%+	80%	71%	39%	53%	63%	71%	50%	90%+	53%	90%+	52%	90%+	39%	90%+	35%	90%+	39%	90%+	44%	90%+	32%	54%	84%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	90%+	90%+	80%	78%	90%+	90%+	75%	25%	90%+	23%	90%+	36%	90%+	60%	90%+	71%	85%	90%+	90%+	90%+	90%+	78%	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	84%	78%	82%	82%	82%	82%	82%	81%	82%	81%	82%	81%	82%	81%	82%	81%	82%	81%	82%	81%	82%	81%	82%
		COP 20	APR 21	Scale-up: Aggressive	81%	81%	87%	85%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Jinja District	COP 17	APR 18	Attained	90%+	34%	53%	77%	67%	80%	90%+	90%+	90%+	90%+	63%	90%+	50%	90%+	50%	90%+	65%	90%+	85%	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	79%	79%	90%+	53%	52%	90%+	61%	90%+	41%	90%+	39%	90%+	61%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kamuli District	COP 17	APR 18	Attained	74%	67%	69%	72%	70%	90%+	48%	59%	26%	90%+	40%	90%+	44%	90%+	50%	90%+	58%	90%+	69%	90%+	72%	90%+	57%	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	31%	90%+	30%	90%+	45%	90%+	77%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Scale-up: Aggressive	78%	80%	80%	80%	80%	81%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Kayunga District	COP 17	APR 18	Scale-up: Aggressive	74%	22%	40%	46%	67%	75%	59%	76%	28%	90%+	12%	90%+	19%	90%+	35%	90%+	47%	90%+	62%	90%+	81%	90%+	90%+	90%+	90%+
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	60%	68%	48%	47%	90%+	55%	90%+	29%	90%+	29%	90%+	44%	90%+	74%	90%+	87%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	84%	89%	88%	88%	88%	88%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%
		COP 20	APR 21	Scale-up: Aggressive	76%	72%	75%	76%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
	Mayuge District	COP 17	APR 18	Scale-up: Aggressive	80%	60%	71%	80%	53%	63%	41%	36%	45%	90%+	54%	90%+	28%	90%+	26%	90%+	31%	90%+	48%	90%+	49%	90%+	23%	35%	64%
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	90%+	90%+	75%	72%	90%+	85%	84%	27%	90%+	26%	90%+	40%	90%+	68%	90%+	80%	90%+	90%+	90%+	90%+	90%+	88%	90%+
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	62%	61%	68%	69%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	67%	68%	68%	68%
		COP 20	APR 21	Sustained	48%	48%	49%	47%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%
KABALE CLUSTER	Kabale District	COP 17	APR 18	Attained	0%	0%	29%	36%	76%	80%	90%+	90%+	56%	90%+	36%	90%+	49%	90%+	69%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	0%	90%+	90%+	90%+	83%	80%	90%+	90%+	90%+	43%	90%+	42%	90%+	65%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+

		COP 20	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kisoro District	COP 17	APR 18	Attained	16%	0%	28%	35%	64%	75%	60%	90%+	28%	90%+	17%	90%+	36%	90%+	49%	90%+	60%	90%+	63%	90%+	80%	90%+	89%	90%+	90%+
		COP 18	APR 19	Attained	90%+	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	29%	90%+	29%	90%+	44%	90%+	75%	90%+	88%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Scale-up: Aggressive	85%	85%	81%	78%	81%	79%	79%	80%	80%	81%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Rubanda District	COP 17	APR 18	Scale-up: Aggressive	0%	0%	43%	37%	39%	44%	38%	50%	16%	90%+	16%	90%+	30%	90%+	36%	90%+	47%	90%+	53%	90%+	60%	90%+	67%	90%+	70%
		COP 18	APR 19	Scale-up: Aggressive	0%	90%+	43%	47%	34%	33%	90%+	39%	76%	24%	90%+	23%	90%+	36%	90%+	61%	90%+	72%	90%+	90%+	90%+	90%+	90%+	78%	89%
		COP 19	APR 20	Scale-up: Aggressive	0%	90%+	83%	84%	84%	85%	86%	85%	84%	86%	85%	84%	85%	83%	85%	84%	85%	84%	85%	84%	85%	84%	85%	84%	85%
		COP 20	APR 21	Scale-up: Saturation	90%+	90%+	83%	84%	84%	84%	84%	84%	84%	85%	84%	84%	84%	85%	85%	84%	85%	84%	84%	85%	85%	84%	85%	84%	84%
	Rukiga District	COP 17	APR 18	Attained	90%+	22%	84%	75%	90%+	89%	69%	90%+	38%	90%+	24%	90%+	42%	90%+	75%	90%+	79%	90%+	73%	90%+	83%	90%+	89%	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	70%	76%	52%	51%	90%+	60%	90%+	33%	90%+	32%	90%+	49%	90%+	82%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Scale-up: Saturation	90%+	90%+	89%	90%+	90%+	88%	90%+	90%+	90%+	89%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
KABAROLE CLUSTER	Bunyangabu District	COP 17	APR 18	Scale-up: Aggressive	0%	0%	22%	31%	72%	67%	59%	71%	21%	90%+	23%	90%+	28%	90%+	45%	90%+	56%	90%+	58%	90%+	56%	90%+	53%	60%	73%
		COP 18	APR 19	Scale-up: Aggressive	90%+	0%	34%	32%	16%	15%	70%	19%	63%	10%	87%	10%	81%	30%	90%+	51%	86%	60%	75%	82%	90%+	90%+	87%	60%	74%
		COP 19	APR 20	Scale-up: Aggressive	90%+	0%	76%	74%	81%	80%	80%	81%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	81%	80%	80%	80%	80%
		COP 20	APR 21	Scale-up: Aggressive	71%	81%	75%	77%	76%	76%	77%	77%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	77%	76%	76%	76%	76%	76%
	Kabarole District	COP 17	APR 18	Attained	32%	24%	28%	29%	79%	82%	85%	88%	42%	90%+	25%	90%+	39%	90%+	62%	90%+	77%	90%+	80%	90%+	87%	90%+	78%	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	63%	62%	45%	44%	90%+	51%	86%	28%	90%+	27%	90%+	42%	90%+	71%	90%+	84%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kamwenge District	COP 17	APR 18	Scale-up: Saturation	20%	10%	49%	56%	59%	64%	41%	47%	20%	90%+	27%	90%+	49%	90%+	62%	90%+	63%	90%+	65%	90%+	62%	90%+	55%	62%	87%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	83%	83%	63%	61%	90%+	72%	86%	28%	90%+	27%	90%+	41%	90%+	69%	90%+	82%	90%+	90%+	90%+	90%+	90%+	89%	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Scale-up: Aggressive	89%	79%	87%	87%	86%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%
	Kitagwenda District	COP 17	APR 18	Scale-up: Saturation	20%	10%	49%	56%	59%	64%	41%	47%	20%	90%+	27%	90%+	49%	90%+	62%	90%+	63%	90%+	65%	90%+	62%	90%+	55%	62%	87%

		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	83%	83%	63%	61%	90%+	72%	80%	28%	90%+	27%	90%+	41%	90%+	69%	90%+	82%	90%+	90%+	90%+	90%+	90%+	89%	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Scale-up: Saturation	90%+	87%	80%	80%	87%	87%	87%	87%	87%	87%	87%	80%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%
	Kyenjojo District	COP 17	APR 18	Scale-up: Saturation	26%	54%	38%	37%	68%	81%	59%	57%	15%	90%+	19%	90%+	31%	90%+	50%	90%+	57%	90%+	60%	90%+	62%	78%	54%	60%	77%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	51%	48%	36%	35%	90%+	41%	70%	23%	90%+	22%	90%+	34%	90%+	57%	90%+	67%	84%	90%+	90%+	90%+	90%+	73%	83%
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	87%	84%	85%	85%	85%	85%	85%	84%	85%	84%	85%	84%	85%	84%	85%	84%	85%	84%	85%	84%	85%	84%	85%
		COP 20	APR 21	Scale-up: Saturation	80%	83%	82%	82%	83%	82%	83%	83%	83%	82%	82%	82%	82%	83%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%
	Ntoroko District	COP 17	APR 18	Sustained	53%	11%	19%	31%	73%	71%	24%	57%	22%	85%	10%	90%+	29%	90%+	43%	90%+	48%	90%+	43%	90%+	53%	60%	35%	45%	63%
		COP 18	APR 19	Sustained	90%+	56%	56%	66%	38%	37%	90%+	45%	63%	20%	87%	20%	81%	30%	90%+	52%	87%	61%	76%	83%	90%+	90%+	88%	66%	76%
		COP 19	APR 20	Sustained	90%+	56%	77%	90%+	70%	72%	72%	71%	72%	72%	71%	71%	71%	71%	71%	71%	72%	71%	72%	71%	72%	71%	72%	71%	72%
		COP 20	APR 21	Sustained	68%	68%	75%	70%	72%	73%	70%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	70%	71%	71%	71%	70%	70%	71%	71%
KAMPALA CLUSTER	Kampala District	COP 17	APR 18	Attained	60%	48%	53%	54%	90%+	90%+	90%+	90%+	61%	90%+	51%	90%+	60%	90%+	80%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	87%	90%+	52%	90%+	55%	90%+	87%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Mukono District	COP 17	APR 18	Scale-up: Saturation	28%	44%	31%	42%	51%	44%	36%	49%	18%	90%+	13%	90%+	20%	90%+	31%	90%+	37%	90%+	45%	78%	45%	82%	45%	71%	62%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	53%	52%	39%	38%	90%+	44%	70%	23%	90%+	22%	90%+	34%	90%+	57%	90%+	67%	83%	90%+	90%+	90%+	90%+	73%	84%
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	64%	67%	38%	40%	47%	69%	90%+	68%	90%+	68%	87%	68%	84%	68%	84%	68%	87%	68%	90%+	68%	83%	68%	79%
		COP 20	APR 21	Scale-up: Aggressive	80%	81%	78%	79%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%
	Wakiso District	COP 17	APR 18	Scale-up: Aggressive	15%	29%	23%	19%	33%	31%	41%	37%	21%	74%	13%	90%+	16%	90%+	21%	90%+	25%	72%	29%	65%	36%	61%	37%	50%	45%
		COP 18	APR 19	Scale-up: Aggressive	68%	90%+	40%	37%	27%	26%	71%	30%	43%	14%	59%	17%	55%	20%	68%	34%	58%	41%	51%	55%	66%	67%	59%	44%	51%
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	51%	49%	37%	37%	32%	32%	61%	48%	54%	48%	49%	48%	49%	48%	49%	48%	49%	48%	49%	48%	49%	48%	48%
		COP 20	APR 21	Scale-up: Aggressive	81%	81%	81%	81%	80%	81%	81%	80%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	82%
LIRA CLUSTER	Alebtong District	COP 17	APR 18	Scale-up: Saturation	22%	85%	39%	53%	80%	84%	33%	64%	24%	66%	17%	90%+	34%	90%+	61%	90%+	67%	90%+	71%	90%+	82%	90%+	79%	90%+	90%+
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	82%	75%	56%	55%	90%+	63%	87%	27%	90%+	26%	90%+	41%	90%+	67%	90%+	79%	90%+	90%+	90%+	90%+	90%+	87%	90%+

		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Sustained	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%
	Amolatar District	COP 17	APR 18	Attained	30%	16%	68%	42%	90%+	87%	90%+	84%	30%	90%+	15%	90%+	32%	90%+	61%	90%+	70%	90%+	84%	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	70%	67%	49%	48%	90%+	56%	90%+	31%	90%+	29%	90%+	46%	90%+	77%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Scale-up: Saturation	90%+	87%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Apac District	COP 17	APR 18	Attained	0%	0%	53%	42%	90%+	72%	48%	66%	17%	90%+	18%	90%+	37%	90%+	69%	90%+	71%	90%+	87%	90%+	72%	90%+	58%	73%	80%
		COP 18	APR 19	Attained	0%	0%	43%	41%	34%	33%	89%	38%	90%+	29%	90%+	28%	90%+	44%	90%+	73%	90%+	80%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Scale-up: Aggressive	90%+	81%	80%	87%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Dokolo District	COP 17	APR 18	Attained	37%	79%	64%	60%	34%	33%	19%	20%	12%	90%+	50%	90%+	44%	90%+	51%	90%+	69%	90%+	79%	90%+	65%	90%+	54%	85%	88%
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	71%	23%	90%+	22%	90%+	34%	90%+	58%	90%+	68%	85%	90%+	90%+	90%+	90%+	74%	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Sustained	68%	79%	72%	71%	72%	72%	72%	72%	72%	71%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%
	Kole District	COP 17	APR 18	Scale-up: Aggressive	78%	90%+	90%+	90%+	64%	90%+	38%	42%	11%	90%+	17%	90%+	36%	90%+	54%	90%+	54%	90%+	57%	90%+	59%	90%+	44%	74%	77%
		COP 18	APR 19	Scale-up: Aggressive	84%	90%+	63%	57%	39%	38%	90%+	45%	81%	26%	90%+	25%	90%+	39%	90%+	65%	90%+	77%	90%+	90%+	90%+	90%+	90%+	84%	90%+
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	90%+	84%	79%	79%	79%	79%	79%	78%	79%	78%	79%	78%	79%	78%	79%	78%	79%	78%	79%	78%	79%	78%	79%
		COP 20	APR 21	Scale-up: Aggressive	74%	83%	82%	83%	82%	81%	81%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	81%	82%	82%	82%	82%	82%
	Kwania District	COP 17	APR 18	Scale-up: Aggressive	0%	0%	77%	61%	72%	90%+	63%	64%	16%	90%+	17%	90%+	27%	90%+	41%	90%+	40%	90%+	61%	90%+	53%	81%	52%	79%	68%
		COP 18	APR 19	Scale-up: Aggressive	90%+	0%	29%	28%	22%	22%	61%	25%	61%	20%	84%	19%	78%	29%	90%+	49%	84%	58%	73%	79%	90%+	90%+	84%	64%	71%
		COP 19	APR 20	Scale-up: Aggressive	90%+	0%	53%	52%	58%	57%	57%	57%	57%	57%	57%	57%	57%	57%	57%	57%	57%	57%	57%	57%	57%	56%	57%	56%	57%
		COP 20	APR 21	Scale-up: Aggressive	79%	79%	78%	78%	77%	78%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%
	Lira District	COP 17	APR 18	Attained	90%+	26%	34%	53%	76%	87%	90%+	90%+	36%	90%+	21%	90%+	37%	90%+	60%	90%+	71%	90%+	71%	90%+	76%	90%+	64%	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	51%	53%	38%	37%	90%+	43%	90%+	30%	90%+	29%	90%+	45%	90%+	75%	90%+	89%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Otuke District	COP 17	APR 18	Attained	90%+	43%	61%	90%+	90%+	90%+	75%	90%+	27%	90%+	29%	90%+	50%	90%+	89%	90%+	63%	90%+	87%	90%+	90%+	90%+	90%+	90%+	90%+

		COP 18	APR 19	Attained	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 22	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
MASAKA CLUSTER	Bukomansimbi District	COP 17	APR 18	Scale-up Aggressive	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Aggressive	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	90%+	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Aggressive	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 22	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Kalungu District	COP 17	APR 18	Attained	[illegible]	[illegible]	[illegible]	[illegible]	90%+	90%+	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	90%+	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 22	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kyotera District	COP 17	APR 18	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Saturation	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Scale-up Saturation	90%+	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 22	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Lwengo District	COP 17	APR 18	Scale-up Aggressive	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Aggressive	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Aggressive	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 22	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Lyantonde District	COP 17	APR 18	Attained	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	[illegible]	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 22	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Masaka District	COP 17	APR 18	Attained	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	[illegible]	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 22	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+

Cluster	District	COP	APR	Status																									
	Rakai District	COP 17	APR 18	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Sembabule District	COP 17	APR 18	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
MBALE CLUSTER	Budaka District	COP 17	APR 18	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Bududa District	COP 17	APR 18	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Mbale District	COP 17	APR 18	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Sironko District	COP 17	APR 18	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
MBARARA CLUSTER	Buhweju District	COP 17	APR 18	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

	District	COP	APR	Status																									
	Bushenyi District	COP 17	APR 18	Attained	30%	55%	40%	47%	74%	74%	78%	90%+	48%	90%+	35%	90%+	53%	90%+	72%	90%+	83%	90%+	88%	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	83%	75%	52%	50%	90%+	58%	90%+	36%	90%+	35%	90%+	53%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Ibanda District	COP 17	APR 18	Scale-up Saturation	28%	34%	39%	28%	52%	62%	41%	36%	17%	88%	20%	90%+	38%	90%+	51%	90%+	48%	90%+	52%	85%	57%	85%	51%	62%	71%
		COP 18	APR 19	Scale-up Saturation	90%+	90%+	58%	55%	41%	40%	90%+	47%	60%	22%	90%+	22%	84%	31%	90%+	53%	90%+	63%	78%	86%	90%+	90%+	90%+	69%	79%
		COP 19	APR 20	Scale-up Saturation	90%+	90%+	81%	79%	81%	82%	81%	82%	81%	81%	81%	81%	81%	81%	81%	80%	81%	80%	81%	80%	81%	80%	81%	80%	81%
		COP 20	APR 21	Scale-up Aggressive	76%	83%	82%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%
	Kanungu District	COP 17	APR 18	Scale-up Aggressive	19%	0%	33%	41%	63%	75%	41%	55%	27%	90%+	20%	90%+	34%	90%+	52%	90%+	58%	90%+	64%	90%+	60%	85%	62%	60%	81%
		COP 18	APR 19	Scale-up Aggressive	90%+	0%	53%	40%	40%	39%	90%+	45%	74%	24%	90%+	23%	90%+	35%	90%+	60%	90%+	70%	88%	90%+	90%+	90%+	90%+	77%	88%
		COP 19	APR 20	Scale-up Aggressive	90%+	0%	85%	83%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Sustained	68%	64%	65%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%
	Kisoro District	COP 17	APR 18	Scale-up Aggressive	52%	32%	45%	39%	37%	43%	20%	27%	9%	90%+	17%	90%+	30%	90%+	40%	90%+	40%	80%	44%	57%	42%	49%	39%	39%	55%
		COP 18	APR 19	Scale-up Aggressive	90%+	90%+	62%	61%	42%	41%	90%+	48%	40%	13%	55%	13%	51%	19%	64%	32%	55%	38%	47%	52%	62%	63%	55%	42%	52%
		COP 19	APR 20	Scale-up Aggressive	14%	12%	8%	9%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%
		COP 20	APR 21	Sustained	64%	64%	64%	65%	65%	66%	66%	66%	66%	65%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%
	Kiruhura District	COP 17	APR 18	Scale-up Aggressive	52%	32%	45%	39%	37%	43%	20%	27%	9%	90%+	17%	90%+	30%	90%+	40%	90%+	40%	80%	44%	57%	42%	49%	39%	39%	55%
		COP 18	APR 19	Scale-up Aggressive	90%+	90%+	62%	61%	42%	41%	90%+	48%	40%	13%	55%	13%	51%	19%	64%	32%	55%	38%	47%	52%	62%	63%	55%	42%	52%
		COP 19	APR 20	Scale-up Aggressive	14%	12%	8%	9%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%
		COP 20	APR 21	Sustained	64%	64%	66%	65%	66%	65%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%
	Mbarara District	COP 17	APR 18	Attained	90%+	26%	52%	52%	77%	84%	79%	90%+	31%	90%+	28%	90%+	45%	90%+	69%	90%+	80%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	68%	69%	52%	50%	90%+	58%	90%+	36%	90%+	35%	90%+	54%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Mitooma District	COP 17	APR 18	Scale-up Aggressive	0%	0%	24%	14%	19%	22%	0%	17%	11%	85%	25%	90%+	42%	90%+	32%	90%+	34%	72%	19%	49%	14%	41%	18%	25%	45%
		COP 18	APR 19	Scale-up Aggressive	0%	0%	58%	56%	45%	44%	90%+	54%	38%	12%	54%	12%	48%	18%	60%	31%	54%	36%	45%	49%	55%	60%	54%	39%	48%

					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
		COP 19	APR 20	Scale-up Aggressive	0%	0%	-43%	-46%	53%	53%	53%	53%	53%	54%	53%	53%	53%	54%	53%	54%	53%	54%	53%	54%	53%	54%	53%	54%	52%
		COP 22	APR 21	Sustained	-45%	-45%	-44%	-44%	-43%	-43%	-43%	-44%	-43%	-44%	-43%	-44%	-43%	-43%	-43%	-44%	-43%	-43%	-43%	-43%	-43%	-43%	-43%	-43%	-43%
	Ntungamo District	COP 17	APR 18	Scale-up Aggressive	63%	58%	63%	53%	59%	53%	37%	-40%	13%	90%+	13%	90%+	27%	90%+	42%	90%+	-44%	90%+	-44%	82%	50%	81%	45%	58%	66%
		COP 18	APR 19	Scale-up Aggressive	90%+	90%+	75%	71%	49%	48%	90%+	56%	62%	20%	86%	19%	82%	30%	90%+	52%	83%	59%	74%	81%	90%+	90%+	86%	69%	76%
		COP 19	APR 20	Scale-up Aggressive	90%+	90%+	80%	79%	75%	75%	75%	75%	75%	74%	75%	74%	75%	74%	75%	74%	75%	74%	75%	74%	75%	74%	75%	74%	75%
		COP 22	APR 21	Sustained	63%	62%	63%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%
	Rubirizi District	COP 17	APR 18	Sustained	62%	64%	81%	49%	-46%	-48%	3%	52%	15%	90%+	20%	90%+	41%	90%+	-45%	90%+	-46%	90%+	-42%	78%	-43%	54%	41%	-42%	69%
		COP 18	APR 19	Sustained	64%	78%	4%	38%	27%	26%	52%	30%	80%	29%	90%+	29%	90%+	38%	90%+	69%	90%+	76%	90%+	90%+	90%+	90%+	90%+	83%	90%+
		COP 19	APR 20	Sustained	90%+	90%+	78%	74%	72%	73%	72%	72%	72%	73%	72%	72%	72%	73%	72%	73%	72%	73%	72%	73%	72%	73%	72%	73%	72%
		COP 22	APR 21	Sustained	64%	64%	59%	59%	59%	59%	59%	59%	60%	60%	59%	59%	60%	59%	60%	60%	60%	59%	60%	60%	59%	60%	59%	60%	62%
	Rukungiri District	COP 17	APR 18	Scale-up Saturation	29%	29%	25%	29%	61%	52%	70%	71%	26%	90%+	19%	90%+	30%	90%+	-45%	90%+	55%	90%+	64%	90%+	74%	90%+	87%	90%+	88%
		COP 18	APR 19	Scale-up Saturation	90%+	90%+	-48%	-48%	34%	33%	90%+	39%	77%	29%	90%+	24%	90%+	37%	90%+	62%	90%+	77%	90%+	90%+	90%+	90%+	90%+	82%	90%+
		COP 19	APR 20	Scale-up Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 22	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Rwampara District	COP 17	APR 18	Attained	90%+	26%	52%	52%	77%	84%	77%	90%+	3%	90%+	28%	90%+	-45%	90%+	69%	90%+	80%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	68%	69%	51%	52%	90%+	58%	90%+	36%	90%+	35%	90%+	54%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 22	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Sheema District	COP 17	APR 18	Scale-up Saturation	55%	16%	27%	37%	63%	-48%	50%	55%	27%	90%+	27%	90%+	36%	90%+	54%	90%+	66%	90%+	68%	90%+	78%	90%+	77%	90%+	80%
		COP 18	APR 19	Scale-up Saturation	90%+	70%	51%	55%	36%	35%	90%+	41%	77%	24%	90%+	23%	90%+	35%	90%+	59%	90%+	70%	87%	90%+	90%+	90%+	90%+	76%	80%
		COP 19	APR 20	Scale-up Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 22	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
SOROTI CLUSTER	Amuria District	COP 17	APR 18	Sustained	64%	-47%	-48%	63%	90%+	90%+	90%+	62%	24%	90%+	16%	90%+	24%	90%+	-48%	90%+	79%	90%+	66%	90%+	84%	90%+	74%	90%+	80%
		COP 18	APR 19	Sustained	90%+	90%+	90%+	90%+	70%	68%	90%+	80%	72%	22%	90%+	23%	90%+	34%	90%+	58%	90%+	69%	84%	90%+	90%+	90%+	90%+	74%	80%
		COP 19	APR 20	Sustained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 22	APR 21	Sustained	68%	68%	67%	70%	69%	68%	68%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%
		COP 17	APR 18	Attained	33%	90%+	90%+	62%	90%+	90%+	90%+	90%+	49%	90%+	24%	90%+	34%	90%+	62%	90%+	69%	90%+	55%	90%+	90%+	90%+	76%	90%+	90%+

	Kaberamaido District	COP 18	APR 19	Attained	95%+	95%+	95%+	[illegible]	[illegible]	[illegible]	95%+	[illegible]	[illegible]	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	95%+	95%+	95%+	95%+	95%+	90%+
		COP 19	APR 20	Attained	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	90%+
		COP 20	APR 21	Attained	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	90%+
	Kalaki District	COP 17	APR 18	Attained	[illegible]	95%+	95%+	[illegible]	95%+	95%+	95%+	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	95%+	95%+	[illegible]	95%+	90%+
		COP 18	APR 19	Attained	95%+	95%+	95%+	[illegible]	[illegible]	[illegible]	95%+	[illegible]	[illegible]	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	95%+	95%+	95%+	95%+	95%+	90%+
		COP 19	APR 20	Attained	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	90%+
		COP 20	APR 21	Attained	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	90%+
	Kapelebyong District	COP 17	APR 18	Attained	[illegible]	[illegible]	95%+	95%+	95%+	95%+	95%+	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	95%+	95%+	95%+	95%+	95%+	95%+	90%+
		COP 18	APR 19	Attained	[illegible]	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	90%+
		COP 19	APR 20	Attained	[illegible]	[illegible]	[illegible]	[illegible]	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Katakwi District	COP 17	APR 18	Attained	[illegible]	[illegible]	[illegible]	[illegible]	95%+	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	95%+	95%+	90%+
		COP 18	APR 19	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	95%+	[illegible]	[illegible]	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	95%+	95%+	95%+	95%+	[illegible]	90%+
		COP 19	APR 20	Attained	[illegible]	[illegible]	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	90%+
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Ngora District	COP 17	APR 18	Scale-up Aggressive	[illegible]	95%+	[illegible]	95%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	[illegible]	[illegible]	95%+	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Aggressive	95%+	95%+	95%+	95%+	[illegible]	[illegible]	95%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	95%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	95%+	95%+	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Aggressive	95%+	95%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Scale-up Saturation	95%+	95%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Serere District	COP 17	APR 18	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	95%+	[illegible]	[illegible]	[illegible]	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	95%+	95%+	[illegible]	95%+	[illegible]
		COP 18	APR 19	Scale-up Aggressive	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	[illegible]	[illegible]	95%+	[illegible]	[illegible]	[illegible]	95%+	[illegible]	95%+	[illegible]	[illegible]	95%+	95%+	95%+	95%+	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Aggressive	95%+	95%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	95%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Soroti District	COP 17	APR 18	Attained	[illegible]	95%+	[illegible]	[illegible]	95%+	95%+	95%+	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	90%+
		COP 18	APR 19	Attained	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	[illegible]	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	[illegible]	95%+	95%+	95%+	95%+	95%+	[illegible]	90%+
		COP 19	APR 20	Attained	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	90%+
		COP 20	APR 21	Attained	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	95%+	90%+
STANDALONE	Abim District	COP 17	APR 18	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	95%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

		COP 18	APR 19	Centrally Supported	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
		COP 19	APR 20	Centrally Supported	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Adjumani District	COP 17	APR 18	Attained	0%	0%	[illegible]	[illegible]	90%+	90%+	90%+	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+
		COP 18	APR 19	Attained	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	[illegible]	90%+
		COP 19	APR 20	Attained	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Scale-up Aggressive	[illegible]	90%+	[illegible]	90%+	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Agago District	COP 17	APR 18	Attained	[illegible]	[illegible]	[illegible]	[illegible]	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]
		COP 18	APR 19	Attained	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Amudat District	COP 17	APR 18	Centrally Supported	0%	0%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Centrally Supported	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
		COP 19	APR 20	Centrally Supported	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
		COP 20	APR 21	Sustained	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Arua District	COP 17	APR 18	Attained	[illegible]	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Scale-up Saturation	[illegible]	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Bukedea District	COP 17	APR 18	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]
		COP 18	APR 19	Sustained	90%+	90%+	90%+	90%+	[illegible]	[illegible]	90%+	90%+	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	[illegible]	90%+	90%+	90%+	[illegible]	[illegible]
		COP 19	APR 20	Sustained	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Bukwo District	COP 17	APR 18	Sustained	0%	0%	[illegible]	[illegible]	[illegible]	[illegible]	90%+	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Sustained	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Sustained	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Bulambuli District	COP 17	APR 18	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]

	COP 18	APR 19	Centrally Supported	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 19	APR 20	Centrally Supported	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 22	APR 21	Scale-up Aggressive	96%	96%	71%	71%	71%	72%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%
Bulisa District	COP 17	APR 18	Scale-up Saturation	0%	0%	55%	61%	31%	62%	40%	46%	17%	90%+	20%	90%+	42%	90%+	62%	90%+	55%	90%+	49%	80%	49%	63%	42%	43%	59%
	COP 18	APR 19	Scale-up Saturation	90%+	0%	53%	53%	43%	42%	90%+	49%	74%	24%	90%+	24%	90%+	36%	90%+	60%	90%+	71%	80%	90%+	90%+	90%+	90%+	77%	85%
	COP 19	APR 20	Scale-up Saturation	90%+	0%	83%	82%	82%	82%	84%	83%	83%	83%	83%	82%	82%	82%	83%	82%	83%	82%	83%	82%	83%	82%	83%	82%	85%
	COP 22	APR 21	Sustained	96%	96%	70%	71%	73%	72%	73%	74%	73%	72%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	77%
Bundibugyo District	COP 17	APR 18	Attained	0%	0%	58%	73%	90%+	90%+	56%	55%	17%	90%+	16%	90%+	34%	90%+	59%	90%+	56%	90%+	53%	90%+	44%	90%+	34%	63%	85%
	COP 18	APR 19	Attained	90%+	0%	90%+	90%+	90%+	90%+	90%+	90%+	84%	26%	90%+	26%	90%+	40%	90%+	63%	90%+	79%	90%+	90%+	90%+	90%+	90%+	83%	90%+
	COP 19	APR 20	Attained	90%+	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 22	APR 21	Scale-up Aggressive	80%	80%	80%	80%	90%+	90%+	90%+	80%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
Butambala District	COP 17	APR 18	Attained	22%	90%+	52%	57%	85%	83%	90%+	68%	29%	90%+	13%	90%+	25%	90%+	35%	90%+	44%	90%+	61%	90%+	77%	90%+	90%+	90%+	90%+
	COP 18	APR 19	Attained	90%+	90%+	71%	63%	51%	52%	90%+	57%	77%	25%	90%+	24%	90%+	37%	90%+	62%	90%+	74%	90%+	90%+	90%+	90%+	90%+	80%	90%+
	COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 22	APR 21	Scale-up Saturation	90%+	80%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
Butebo District	COP 17	APR 18	Scale-up Saturation	90%+	75%	74%	90%+	90%+	90%+	43%	78%	8%	90%+	0%	90%+	22%	90%+	35%	90%+	43%	90%+	56%	90%+	43%	90%+	66%	90%+	82%
	COP 18	APR 19	Scale-up Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	83%	33%	90%+	27%	90%+	39%	90%+	66%	90%+	75%	90%+	90%+	90%+	90%+	90%+	83%	90%+
	COP 19	APR 20	Scale-up Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 22	APR 21	Sustained	51%	51%	57%	57%	61%	61%	59%	59%	60%	60%	60%	59%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	62%
Buvuma District	COP 17	APR 18	Scale-up Saturation	28%	22%	22%	28%	35%	29%	29%	22%	9%	68%	15%	90%+	27%	90%+	52%	90%+	53%	84%	70%	75%	68%	76%	58%	63%	61%
	COP 18	APR 19	Scale-up Saturation	90%+	90%+	55%	54%	40%	39%	90%+	49%	79%	26%	90%+	29%	90%+	37%	90%+	63%	90%+	75%	90%+	90%+	90%+	90%+	90%+	82%	90%+
	COP 19	APR 20	Scale-up Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 22	APR 21	Sustained	51%	44%	53%	51%	51%	51%	52%	52%	52%	53%	52%	51%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%
Buyende District	COP 17	APR 18	Scale-up Saturation	24%	90%+	53%	41%	41%	41%	33%	33%	9%	87%	18%	90%+	22%	90%+	36%	90%+	44%	90%+	52%	90%+	61%	90%+	52%	90%+	69%
	COP 18	APR 19	Scale-up Saturation	90%+	90%+	90%+	90%+	80%	86%	90%+	90%+	73%	24%	90%+	23%	90%+	35%	90%+	59%	90%+	76%	100%	90%+	90%+	90%+	90%+	77%	90%+

		COP 19	APR 20	Scale-up Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 22	APR 21	Scale-up Saturation	[illegible]	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Gomba District	COP 17	APR 18	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Saturation	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Saturation	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 22	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Hoima District	COP 17	APR 18	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Saturation	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Scale-up Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 22	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Isingiro District	COP 17	APR 18	Scale-up Aggressive	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Aggressive	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	90%+	90%+	90%+	90%+	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Aggressive	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 22	APR 21	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Kaabong District	COP 17	APR 18	Centrally Supported	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 22	APR 21	Sustained	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Kagadi District	COP 17	APR 18	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Saturation	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	[illegible]	90%+
		COP 19	APR 20	Scale-up Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 22	APR 21	Scale-up Saturation	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kakumiro District	COP 17	APR 18	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Saturation	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	[illegible]	90%+

		COP 19	APR 20	Scale-up Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kalangala District	COP 17	APR 18	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Kaliro District	COP 17	APR 18	Attained	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	[illegible]
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	90%+	90%+	90%+	90%+	[illegible]	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Kapchorwa District	COP 17	APR 18	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]
		COP 18	APR 19	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Karenga District	COP 17	APR 18	Centrally Supported	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Sustained	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Kasese District	COP 17	APR 18	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	90%+
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	[illegible]	[illegible]	90%+	90%+	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	90%+	90%+	90%+	90%+	[illegible]	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kassanda District	COP 17	APR 18	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Saturation	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	90%+	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Saturation	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

	Kibaale District	COP 17	APR 18	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Kiboga District	COP 17	APR 18	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Kibuku District	COP 17	APR 18	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Kikuube District	COP 17	APR 18	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Kiryandongo District	COP 17	APR 18	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Kitgum District	COP 17	APR 18	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Koboko District	COP 17	APR 18	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Scale-up Saturation	90%+	90%+	[illegible]	[illegible]	90%+	90%+	[illegible]	90%+	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kotido District	COP 17	APR 18	Attained	0%	0%	[illegible]	90%+	90%+	90%+	90%+	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	[illegible]	90%+	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	90%+
		COP 18	APR 19	Attained	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	90%+	[illegible]	[illegible]	90%+
		COP 19	APR 20	Attained	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Kumi District	COP 17	APR 18	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	90%+	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Kween District	COP 17	APR 18	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Centrally Supported	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
		COP 19	APR 20	Centrally Supported	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
		COP 20	APR 21	Sustained	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Kyankwanzi District	COP 17	APR 18	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Sustained	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Sustained	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Kyegegwa District	COP 17	APR 18	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Attained	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Scale-up Saturation	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Luuka District	COP 17	APR 18	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Centrally Supported	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
		COP 19	APR 20	Centrally Supported	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Luwero District	COP 17	APR 18	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]

		COP 18	APR 19	Scale-up Aggressive	90%+	90%+	61%	56%	42%	42%	90%+	48%	61%	20%	84%	13%	75%	20%	90%+	52%	84%	59%	77%	80%	90%+	90%+	85%	64%	74%
		COP 19	APR 20	Scale-up Aggressive	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Madi-Okollo District	COP 17	APR 18	Attained	88%	85%	90%+	75%	90%+	90%+	90%+	90%+	77%	90%+	39%	90%+	55%	90%+	74%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	43%	90%+	40%	90%+	71%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Scale-up Saturation	90%+	90%+	90%+	88%	90%+	90%+	85%	85%	90%+	90%+	90%+	85%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Maracha District	COP 17	APR 18	Sustained	0%	0%	49%	54%	39%	86%	43%	63%	42%	86%	13%	90%+	44%	90%+	45%	90%+	59%	90%+	70%	90%+	78%	90%+	37%	36%	74%
		COP 18	APR 19	Sustained	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	78%	27%	90%+	24%	90%+	37%	90%+	63%	90%+	75%	90%+	90%+	90%+	90%+	90%+	82%	90%+
		COP 19	APR 20	Sustained	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Sustained	90%+	90%+	74%	68%	69%	69%	69%	68%	72%	71%	70%	68%	70%	70%	70%	70%	70%	70%	70%	69%	70%	70%	70%	70%	72%
	Masindi District	COP 17	APR 18	Scale-up Saturation	87%	18%	38%	40%	34%	38%	64%	68%	48%	90%+	48%	90%+	41%	90%+	44%	90%+	40%	90%+	50%	90%+	72%	90%+	52%	82%	85%
		COP 18	APR 19	Scale-up Saturation	90%+	90%+	57%	57%	40%	39%	90%+	40%	66%	22%	90%+	21%	85%	33%	90%+	55%	90%+	63%	78%	83%	90%+	90%+	90%+	63%	82%
		COP 19	APR 20	Scale-up Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Mityana District	COP 17	APR 18	Scale-up Saturation	90%+	22%	45%	56%	47%	55%	49%	62%	18%	90%+	17%	90%+	24%	90%+	35%	90%+	41%	90%+	51%	90%+	58%	90%+	63%	90%+	72%
		COP 18	APR 19	Scale-up Saturation	90%+	90%+	43%	44%	33%	34%	87%	37%	54%	18%	74%	17%	60%	26%	87%	44%	74%	51%	64%	70%	84%	86%	75%	56%	65%
		COP 19	APR 20	Scale-up Saturation	90%+	90%+	82%	83%	82%	83%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	81%	82%	81%	82%	81%	82%	82%	82%
		COP 20	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Moroto District	COP 17	APR 18	Attained	0%	0%	0%	17%	90%+	90%+	85%	90%+	15%	90%+	59%	90%+	41%	90%+	71%	90%+	78%	90%+	90%+	90%+	43%	90%+	84%	75%	90%+
		COP 18	APR 19	Attained	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	72%	23%	90%+	24%	90%+	36%	90%+	60%	90%+	71%	88%	90%+	90%+	90%+	90%+	76%	90%+
		COP 19	APR 20	Attained	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Sustained	51%	51%	68%	68%	71%	70%	71%	71%	71%	72%	71%	74%	71%	72%	71%	71%	72%	72%	72%	72%	71%	72%	72%	72%	71%
	Moyo District	COP 17	APR 18	Attained	0%	0%	90%+	75%	90%+	90%+	90%+	90%+	46%	90%+	19%	90%+	24%	90%+	35%	90%+	64%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	85%	25%	90%+	27%	90%+	41%	90%+	72%	90%+	86%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Sustained	68%	68%	76%	71%	75%	77%	74%	75%	76%	75%	75%	74%	75%	74%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%

	Mpigi District	COP 17	APR 18	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Mubende District	COP 17	APR 18	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Nabilatuk District	COP 17	APR 18	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Nakapiripirit District	COP 17	APR 18	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Nakaseke District	COP 17	APR 18	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Nakasongola District	COP 17	APR 18	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 20	APR 21	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

District	COP	APR	Category																									
Namayingo District	COP 17	APR 18	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	COP 18	APR 19	Scale-up Aggressive	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 19	APR 20	Scale-up Aggressive	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 22	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Namutumba District	COP 17	APR 18	Sustained	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]
	COP 18	APR 19	Sustained	90%+	90%+	90%+	90%+	[illegible]	[illegible]	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	90%+	[illegible]	[illegible]	[illegible]
	COP 19	APR 20	Sustained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 22	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Napak District	COP 17	APR 18	Centrally Supported	90%+	90%+	[illegible]	[illegible]	90%+	90%+	90%+	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 18	APR 19	Centrally Supported	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 19	APR 20	Centrally Supported	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 22	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Nebbi District	COP 17	APR 18	Attained	90%+	90%+	90%+	90%+	90%+	90%+	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	90%+
	COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 22	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
Obongi District	COP 17	APR 18	Attained	0%	0%	90%+	[illegible]	90%+	90%+	90%+	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 18	APR 19	Attained	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 19	APR 20	Attained	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 22	APR 21	Scale-up Aggressive	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Oyam District	COP 17	APR 18	Attained	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]
	COP 18	APR 19	Attained	90%+	90%+	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 22	APR 21	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
Pader District	COP 17	APR 18	Centrally Supported	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90%+	[illegible]	90%+	[illegible]	90%+	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	COP 18	APR 19	Centrally Supported	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 19	APR 20	Centrally Supported	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

		COP 22	APR 21	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Pakwach District	COP 17	APR 18	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 22	APR 21	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Pallisa District	COP 17	APR 18	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 22	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible] District	COP 17	APR 18	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 22	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Zombo District	COP 17	APR 18	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 22	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
TORORO CLUSTER	Bugiri District	COP 17	APR 18	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 22	APR 21	Scale-up Saturation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Busia District	COP 17	APR 18	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 19	APR 20	Scale-up Aggressive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 22	APR 21	Sustained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Butaleja District	COP 17	APR 18	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		COP 18	APR 19	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Sustained	76%	76%	61%	63%	63%	64%	64%	64%	64%	63%	63%	64%	63%	64%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	65%
	Manafwa District	COP 17	APR 18	Sustained	17%	90%+	62%	53%	79%	90%+	27%	76%	17%	90%+	9%	90%+	12%	90%+	17%	85%	32%	90%+	30%	87%	49%	90%+	53%	90%+	60%
		COP 18	APR 19	Sustained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	69%	23%	90%+	22%	100%	33%	90%+	55%	90%+	65%	80%	80%	90%+	90%+	90%+	71%	90%+
		COP 19	APR 20	Sustained	90%+	90%+	87%	55%	55%	55%	52%	52%	52%	52%	52%	55%	52%	52%	52%	52%	52%	52%	55%	52%	55%	51%	55%	52%	55%
		COP 20	APR 21	Sustained	34%	25%	36%	40%	38%	37%	38%	38%	38%	39%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%
	Namisindwa District	COP 17	APR 18	Sustained	10%	48%	47%	4%	48%	60%	60%	69%	25%	90%+	14%	90%+	18%	90%+	22%	90%+	32%	90%+	38%	90%+	68%	90%+	69%	90%+	66%
		COP 18	APR 19	Sustained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	54%	18%	70%	18%	68%	25%	83%	42%	70%	49%	61%	67%	80%	82%	71%	54%	74%
		COP 19	APR 20	Sustained	90%+	90%+	90%+	87%	88%	85%	87%	88%	87%	87%	87%	88%	87%	87%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	89%
		COP 20	APR 21	Sustained	68%	68%	54%	54%	54%	54%	57%	54%	57%	54%	57%	54%	57%	57%	57%	57%	54%	57%	57%	57%	57%	57%	57%	57%	52%
	Tororo District	COP 17	APR 18	Attained	90%+	13%	58%	62%	87%	90%+	90%+	90%+	54%	90%+	43%	90%+	43%	90%+	38%	90%+	58%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	79%	80%	61%	60%	90%+	79%	90%+	4%	90%+	39%	90%+	60%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 20	APR 21	Scale-up Saturation	89%	89%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%

Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall

SNU	COP	Prioritization	Results reported	Treatment Coverage at APR by Age and Sex: <1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		Overall TX Coverage
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
SNU 1	COP 15	Scale-Up: Saturation	APR 16	45%	49%	55%	57%	65%	77%	63%	64%	77%	74%	80%	65%	62%	49%	60%	58%	77%	60%	81%	73%	80%	58%	77%	75%	65%
	COP 16	Scale-Up: Saturation	APR 17	66%	69%	71%	72%	75%	91%	81%	78%	83%	80%	91%	75%	77%	67%	78%	75%	91%	72%	93%	76%	91%	75%	94%	79%	81%
	COP 17	Scale-Up: Saturation	APR 18	81%	81%	83%	82%	82%	95%	85%	81%	87%	83%	95%	82%	90%	81%	89%	86%	95%	82%	96%	84%	95%	86%	95%	86%	86%
	COP 18	Attained	APR 19	83%	82%	85%	84%	85%	95%	87%	85%	92%	87%	95%	85%	92%	85%	90%	84%	95%	87%	97%	91%	95%	84%	96%	90%	92%
	COP 19	Attained	APR 20	86%	84%	85%	89%	83%	94%	88%	87%	94%	89%	95%	88%	95%	87%	89%	86%	95%	89%	97%	91%	95%	83%	94%	90%	92%
SNU 2	COP 15	Scale-Up: Aggressive	APR 16	27%	33%	47%	46%	73%	68%	35%	48%	58%	43%	55%	40%	68%	44%	67%	43%	70%	61%	66%	73%	77%	74%	57%	71%	47%
	COP 16	Scale-Up: Aggressive	APR 17	51%	60%	53%	59%	75%	77%	60%	48%	66%	51%	64%	42%	77%	50%	73%	45%	83%	66%	78%	75%	83%	80%	76%	89%	63%
	COP 17	Scale-Up: Saturation	APR 18	72%	71%	81%	77%	89%	88%	81%	63%	82%	79%	89%	65%	88%	77%	87%	81%	92%	77%	89%	89%	87%	83%	91%	93%	84%
	COP 18	Attained	APR 19	81%	82%	84%	82%	95%	91%	90%	83%	87%	85%	94%	82%	91%	83%	92%	85%	94%	82%	94%	95%	92%	87%	93%	95%	90%
	COP 19	Attained	APR 20	81%	82%	86%	82%	95%	92%	90%	84%	87%	86%	94%	83%	91%	84%	92%	85%	94%	82%	94%	95%	92%	87%	93%	95%	91%
SNU 3	COP 15	Sustained	APR 16	22%	26%	20%	21%	71%	39%	35%	37%	53%	25%	50%	39%	59%	36%	71%	49%	77%	55%	71%	60%	71%	68%	72%	68%	39%
	COP 16	Scale-Up: Aggressive	APR 17	30%	33%	25%	34%	81%	48%	40%	44%	51%	37%	54%	48%	61%	43%	81%	53%	83%	66%	73%	59%	81%	77%	74%	74%	50%
	COP 17	Scale-Up: Saturation	APR 18	45%	44%	38%	42%	84%	56%	46%	55%	56%	45%	70%	56%	66%	71%	84%	72%	88%	75%	91%	70%	84%	88%	81%	76%	63%
	COP 18	Scale-Up: Saturation	APR 19	61%	70%	66%	59%	91%	79%	71%	67%	79%	71%	84%	79%	80%	84%	91%	89%	94%	77%	92%	76%	91%	91%	83%	80%	82%
	COP 18	Attained	APR 19	81%	82%	83%	81%	93%	82%	81%	83%	85%	81%	85%	83%	91%	94%	93%	91%	95%	81%	95%	82%	91%	91%	85%	83%	90%
SNU 4	COP 15	Sustained	APR 16	39%	41%	60%	44%	60%	49%	56%	37%	60%	40%	65%	32%	82%	26%	50%	35%	57%	50%	74%	63%	74%	63%	70%	55%	45%
	COP 16	Sustained	APR 17	40%	44%	61%	47%	59%	53%	59%	40%	64%	44%	70%	41%	84%	31%	63%	37%	61%	55%	74%	66%	74%	66%	72%	47%	50%
	COP 17	Scale-Up: Aggressive	APR 18	49%	53%	70%	55%	70%	72%	62%	50%	71%	60%	81%	49%	86%	45%	66%	44%	70%	63%	77%	72%	77%	72%	75%	66%	62%
	COP 18	Scale-Up: Saturation	APR 19	67%	60%	75%	61%	76%	89%	83%	59%	83%	70%	93%	72%	93%	62%	72%	59%	83%	71%	86%	79%	86%	79%	90%	73%	81%
	COP 19	Scale-Up: Saturation	APR 20	67%	63%	79%	70%	75%	90%	88%	65%	89%	75%	93%	79%	94%	65%	75%	64%	85%	74%	89%	81%	87%	82%	94%	80%	85%
SNU 5	COP 15	Central Support	APR 16	N/A: no target required																								55%
	COP 16	Central Support	APR 17	N/A: no target required																								58%
	COP 17	Central Support	APR 18	N/A: no target required																								59%
	COP 18	Central Support	APR 19	N/A: no target required																								61%
	COP 19	Central Support	APR 20	N/A: no target required																								72%

APPENDIX B — Budget Profile and Resource Projections

B1. COP20 Planned Spending in alignment with planning level letter guidance

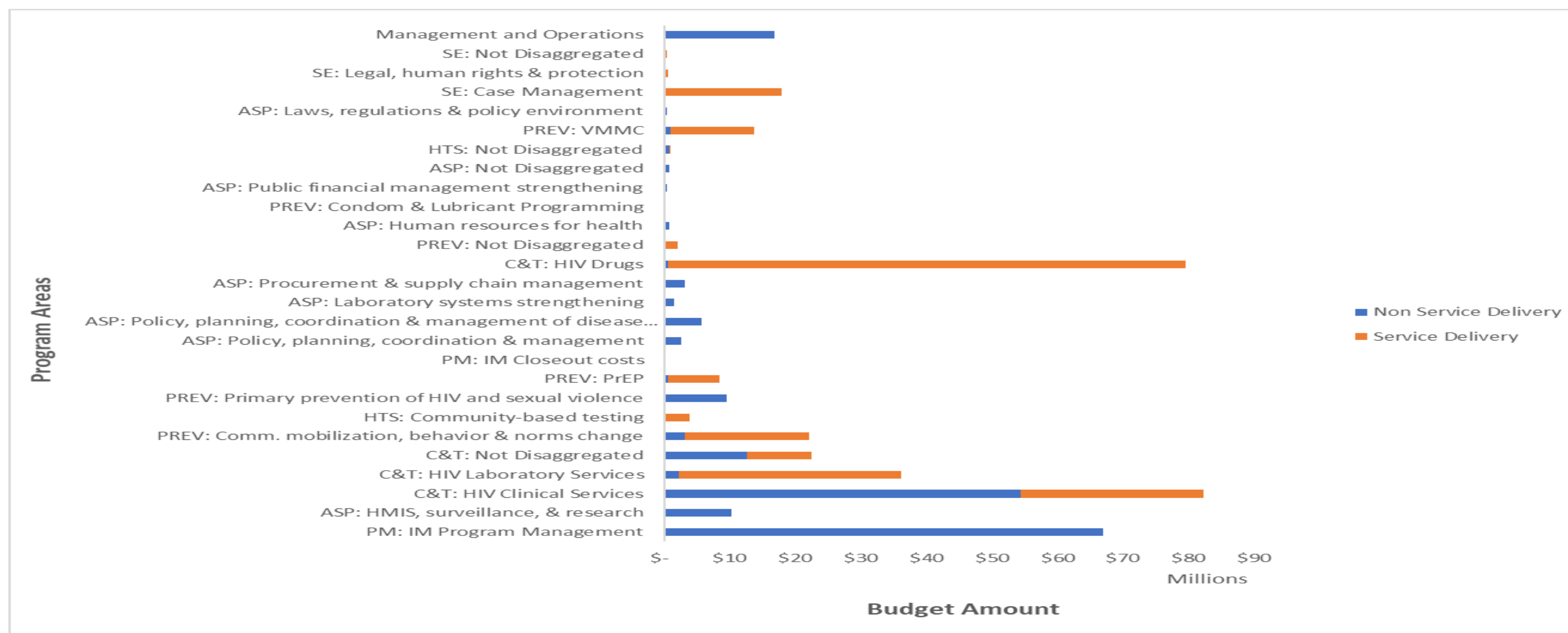


Table B.1.2 COP20 Total Planning Level		
Applied Pipeline	New Funding	Total Spend
$US 27,830,554	$US 381,119,446	$US 408,950,000

*Data included in Table B.1.2 should match FACTS Info records and total applied pipeline amount required in PLL guidance.

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	$293,877
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	$2,637,178
HVOP	Other Sexual Prevention	$30,842,960
IDUP	Injecting and Non-Injecting Drug Use	$0.00
HMBL	Blood Safety	$0.00
HMIN	Injection Safety	$0.00
CIRC	Male Circumcision	$11,663,799
HVCT	Counseling and Testing	$6,119,600
HBHC	Adult Care and Support	$17,618,222
PDCS	Pediatric Care and Support	$1,191,893
HKID	OVC	$24,850,079
HTXS	Adult Treatment	$146,949,878
HTXD	ARV Drugs	$58,435,800
PDTX	Pediatric Treatment	$33,381,348
HVTB	TB/HIV Care	$12,588,120
HLAB	Lab	$4,020,248
HVSI	Strategic Information	$4,310,917
OHSS	Health Systems Strengthening	$5,864,808
HVMS	Management and Operations	$20,350,719
TOTAL		**$381,119,446**

*Data included in Table B.2.2 should match FACTS Info records.

B.2 Resource Projections

Per the COP20 guidance and the budgeting tool for COP20—the Funding Allocation to Strategy Tool (FAST)—PEPFAR Uganda team used an incremental budgeting process to guide the apportionment of resources for COP19. Implementing mechanism budgets from COP19 were the point of departure; however, these budgets were adjusted in accordance with the PLL.
The primary change driver was the allocation of targets, which had shifted per UPHIA data and updated PLHIV estimates from Spectrum. PEPFAR's comprehensive health service delivery partners in Uganda are regionalized, so updated information on where undiagnosed Ugandan PLHIV are living is an important factor in determining how COP19 resources are allocated.

A secondary change driver was target linkage and retention rates, which—per headquarters guidance via the DataPack—are 95% for linkage and for retention 95% for those on treatment for greater than 12 months and 90% for those on treatment less than 12 months. PEPFAR Uganda's FY18 results demonstrated progress over FY17 in increasing the rate at which the program links newly-identified PLHIV to treatment, from 79% linkage in FY17 to 81% linkage in FY18, likely attributable to the "surge for quality improvement" which PEPFAR Uganda initiated in Quarter 2 of FY 2018. PEPFAR Uganda continues to wrestle with challenges in the rate at which new treatment enrollees are retained, having achieved 71% retention in FY18 and 76% retention in FY19. Accordingly, COP20 resource allocations factored the inputs needed to further improve linkage and to intensify efforts to increase retention: the human resources required to physically escort and follow-up on every newly diagnosed PLHIV and the systems-level resources needed to uniquely identify and track services delivered to all PLHIV.

Other information relevant to how resources have been allocated in COP2 include the mandate from headquarters to increase support to the public sector in Uganda where most PLHIV are being served, as well as the mandate from headquarters to increase the percentage of the PEPFAR Uganda budget that is directly awarded to Ugandan organizations and institutions as "prime" awardees.
Data sources used to calculate resource allocations include: COP19 budget allocations; expenditure analysis 2019; FY19 End of Fiscal Year (EOFY); information from GOU on national expenditures, including the National AIDS Spending Account (NASA) data; and market information on various goods and services.

APPENDIX C —Tables and Systems Investments for Section 6.0

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark
HHS/CDC	BAYLOR COLLEGE OF MEDICINE CHILDRENS FOUNDATION-UGANDA	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP19	COP21	1. 90% of PLHIV deaths and lost to follow up tracked
HHS/CDC	Population Council, Inc., The	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	Surveillance	Coordination and leadership of Uganda's HIV response in the decentralized approach as we move towards 95/95/95 still faces challenges of supervision, accountability, oversight/policy, HRH planning and management, quality assurance and information use for decision making at national, regional and district levels	COP18	COP21	90% of KP focussed sites trained in KP friendly services 80%IPs reporting KP cascade data
HHS/CDC	A Global Healthcare Public Foundation, Inc.	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Uganda's laboratory capacity has increased substantially but there remains inadequate systems in place for efficient coordination, management, and continued quality assurance of laboratories required to inform program and policy to reach and sustain epidemic control	COP19	COP21	Operationalization of the National lab waste management policy and implementation plan and monitoring compliance through Biorisk assessment
HHS/CDC	MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP16	COP21	10 PHFP trainees graduate from the program 20 HIV/AIDS related studies/projects/evaluation completed by the Fellows 90% of projects brought to scale to influence regional/district operational plans Number of policy, guidelines and technical documents converted into audio-visual
HHS/CDC	MUJHU CARE	ASP: HMIS, surveillance, & research-NSD	Pregnant & Breastfeeding Women: Not disaggregated	Surveillance	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP16	COP21	Percentage of major external birth defects of interest to the study delivered at each participating Hospital; Proportion of birth defects amongst babies born to HIV positive women, on cotrimoxazole, ARVs or other and other medications during early pregnancy; Number of other major birth defects both live and stillbirths delivered at each participating Hospital
HHS/CDC	UGANDA VIRUS RESEARCH INSTITU TE	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Uganda's laboratory capacity has increased substantially but there remains inadequate systems in place for efficient coordination, management, and continued quality assurance of laboratories required to inform program and policy to reach and sustain epidemic control	COP17	COP21	HIV serology EQA with 100% response and pass rate CD4 EQA with 100% response rate and 80% pass rate HIV/Syphillis DUO EQA with 100% response and pass rate
HHS/CDC	AFRICAN FIELD EPIDEMIOLOGY NETWORK	ASP: Policy, planning, coordination & management of disease control programs-NSD	Pregnant & Breastfeeding Women: Not disaggregated	Information and sensitization for public and government officials	Coordination and leadership of Uganda's HIV response in the decentralized approach as we move towards 95/95/95 still faces challenges of supervision, accountability, oversight/policy, HRH planning and management, quality assurance and information use for decision making at national, regional and district levels	COP19	COP20	85% coverage for testing babies 0-2 months
HHS/CDC	THE AIDS SUPPORT ORGANIZATION (TASO)	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP19	COP21	100% Full arm EMR system implementation in Regional, district hospitals and HC Ivs Regional Clients and provider registries established Centralised Case Based data respository established at regional level HIV health information exchange established in the region Mobile-based case reporting in communities single desktop EMR system in light volume facilities
HHS/CDC	RAKAI HEALTH SCIENCES PROGRAM	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP19	COP21	100% Full arm EMR system implementation in all high volume prisons HIV health information exchange established between prisons Mobile-based case reporting in small prisons Single desktop EMR system in light volume prisons
HHS/CDC	INFECTIOUS DISEASES INSTITUTE LIMITED	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP19	COP21	100% Full arm EMR system implementation in Regional, district hospitals and HC Ivs Regional Clients and provider registries established Centralised Case Based data respository established at regional level HIV health information exchange established in the region Mobile-based case reporting in commuties Single desktop EMR system in light volume facilities 40 districts Hotline is operational in 80% of PEPFAR supported with high GBV burden districts
HHS/CDC	UGANDA VIRUS RESEARCH INSTITU TE	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP20	COP22	Protocol develeopment and Implementation
DOD	DoD Mechanism	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Coordination and leadership of Uganda's HIV response in the decentralized approach as we move towards 95/95/95 still faces challenges of supervision, accountability, oversight/policy, HRH planning and management, quality assurance and information use for decision making at national, regional and district levels	COP20	COP21	40% coverage of military bases with pediatric and adolescent ART clinics
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Surveillance	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP16	COP22	6 monthly follow up of participants;Interim data analysis and dissemination of findings, Realise the target enrollment of 15-24 year old.

Table 6-E (Entry of Above Site Programs Activities)								
Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark
DOD	HenryM. Jackson Foundation For The Advancement Of MilitaryMedicine, Inc., The	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP19	COP22	Various HIS built and active based on robust facility and client registries supporting client-centered care, patient mobilities and public health priorities including HIV epidemic control, viral load suppression, addressing lost to follow-up and strategic programmatic shifts for epidemic control. National data analytics platform established.
HHS/CDC	Population Council, Inc., The	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	Coordination and leadership of Uganda's HIV response in the decentralized approach as we move towards 95/95/95 still faces challenges of supervision, accountability, oversight/policy, HRH planning and management, quality assurance and information use for decision making at national, regional and district levels	COP17	COP22	90% of DIC using new guidelines 80% of IPS using Alcohol and harm guidelines 100% of the NRH and RRH sites are providing KP friendly services.
DOD	University Research Co., LLC	ASP: Policy, planning, coordination & management of disease control programs-NSD	Priority Pops: Military & other uniformed services	Assessing impact of policies and regulations on HIV	Coordination and leadership of Uganda's HIV response in the decentralized approach as we move towards 95/95/95 still faces challenges of supervision, accountability, oversight/policy, HRH planning and management, quality assurance and information use for decision making at national, regional and district levels	COP20	COP22	1 regional Referrral Hospital awarded and conducting quarterly regional CQI meetings, mentorship and support supervision to facilities in their region
HHS/CDC	Regents of the University of California, San Francisco, The	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Uganda's laboratory capacity has increased substantially but there remains inadequate systems in place for efficient coordination, management, and continued quality assurance of laboratories required to inform program and policy to reach and sustain epidemic control	COP18	COP22	Institutionalise recency testing in all (1750) of PEPFAR supported facilities
HHS/CDC	MILDMAY UGANDA	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP19	COP22	100% Full arm EMR system implementation in Regional, district hospitals and HC IVs Regional Clients and provider registries established Centralised Case Based data respository established at regional level HIV health information exchange established in the region Mobile-based case reporting in communities single desktop EMR system in light volume facilities
HHS/CDC	MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Training in laboratory systems strengthening	Uganda's laboratory capacity has increased substantially but there remains inadequate systems in place for efficient coordination, management, and continued quality assurance of laboratories required to inform program and policy to reach and sustain epidemic control	COP17	COP21	100% of hubs linked to the CPHL LIMS 100% of instruments linked with the Logistic management system
HHS/CDC	MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	Coordination and leadership of Uganda's HIV response in the decentralized approach as we move towards 95/95/95 still faces challenges of supervision, accountability, oversight/policy, HRH planning and management, quality assurance and information use for decision making at national, regional and district levels	COP17	COP21	100% of RRH being able to implement 5-year strategic plans in line with their new role as regional support to decentralized response 100% of districts have M&E plans to monitor their strategic plans
HHS/CDC	MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	Coordination and leadership of Uganda's HIV response in the decentralized approach as we move towards 95/95/95 still faces challenges of supervision, accountability, oversight/policy, HRH planning and management, quality assurance and information use for decision making at national, regional and district levels	COP17	COP21	100% of CDC supported partners are reporting through the OVC tracker. 1 DQAs and 1 SQA to be conducted during the reporting period
HHS/CDC	MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	Uganda's health supply chain system has not reached its full maturity level to allow for commodity security and end-to-end visibility of the finance and commodity flow from the central level to the health facilities thereby compromising effective quantification, supply planning, ordering, stock management and accountability for HIV and TB commodities	COP17	COP20	100 % of sites are reporting timely through RASS. 10 % of districts reporting stock outs ARV and commodities.
HHS/CDC	MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP18	COP21	90% of the various MER indicator data elements mapped and reported through the national reporting system. 100 % PEPFAR critical HMIS tools printed.
USAID	SOCHA LLC	ASP: HMIS, surveillance, & research-NSD	OVC: Not disaggregated	Evaluations	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP18	COP20	a) Final data collection and analytics of both qualitative and quantitative data, b) Dissemination and presentation of final evaluation findings to various stakeholders (USAID, implementing partners and Government of Uganda). c) The final evaluation report will incorporate the Endline Survey to deliver clear findings on the relative effect of OVC service delivery components on household outcomes.
USAID	ICS Technologies, Inc.	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Uganda's health supply chain system has not reached its full maturity level to allow for commodity security and end-to-end visibility of the finance and commodity flow from the central level to the health facilities thereby compromising effective quantification, supply planning, ordering, stock management and accountability for HIV and TB commodities	COP18	COP20	ERP Hardware (Primary Data Center) migrated to new NMS Warehouse. ERP equipment installed at 230 high volume sites(RRHs,District hospitals,HCIVs). Hardware training for users in 230 High volume sites.
USAID	ICS Technologies, Inc.	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Uganda's health supply chain system has not reached its full maturity level to allow for commodity security and end-to-end visibility of the finance and commodity flow from the central level to the health facilities thereby compromising effective quantification, supply planning, ordering, stock management and accountability for HIV and TB commodities	COP18	COP20	ERP Hardware (Primary Data Center) migrated to new NMS Warehouse. ERP equipment installed at 230 high volume sites(RRHs,District hospitals,HCIVs). Hardware training for users in 230 High volume sites.
USAID	ICS Technologies, Inc.	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Uganda's health supply chain system has not reached its full maturity level to allow for commodity security and end-to-end visibility of the finance and commodity flow from the central level to the health facilities thereby compromising effective quantification, supply planning, ordering, stock management and accountability for HIV and TB commodities	COP18	COP20	30 NMS technical and health workers trained in 230 high volume ART health facilities

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark
USAID	BRUNSWICK GROUP ASSOCIATES, INC., THE	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	Uganda's health supply chain system has not reached its full maturity level to allow for commodity security and end-to-end visibility of the finance and commodity flow from the central level to the health facilities thereby compromising effective quantification, supply planning, ordering, stock management and accountability for HIV and TB commodities	COP19	COP20	LAB systems/eLMIS interfaced with the ERP
USAID	BRUNSWICK GROUP ASSOCIATES, INC., THE	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	Uganda's health supply chain system has not reached its full maturity level to allow for commodity security and end-to-end visibility of the finance and commodity flow from the central level to the health facilities thereby compromising effective quantification, supply planning, ordering, stock management and accountability for HIV and TB commodities	COP18	COP22	ERP software MVP modules in live production at NMS, 15 RRH, and linked to 230 public ART high volume health facilities
USAID	BRUNSWICK GROUP ASSOCIATES, INC., THE	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	Uganda's health supply chain system has not reached its full maturity level to allow for commodity security and end-to-end visibility of the finance and commodity flow from the central level to the health facilities thereby compromising effective quantification, supply planning, ordering, stock management and accountability for HIV and TB commodities	COP19	COP22	Additional new ERP software MVP components and modules in live production at NMS and linked to 230 high volume public ART health facilities
USAID	University Research Co., LLC	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP19	COP22	Scale up change packages in 85% of high volume ART accredited sites including those in central supported districts
USAID	University Research Co., LLC	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	The number of skilled health workforce available to deliver HIV/AIDS services in the public sector has not grown to match the growing demand and needs for HIV services provision, thus compromising Uganda's ability to further accelerate epidemic control	COP19	COP22	Implement HRH QI in 20 sites, document and disseminate lessons learned (HRH QI) to USG IPs
USAID	University Research Co., LLC	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Coordination and leadership of Uganda's HIV response in the decentralized approach as we move towards 95/95/95 still faces challenges of supervision, accountability, oversight/policy, HRH planning and management, quality assurance and information use for decision making at national, regional and district levels	COP16	COP21	90%
USAID	SOCIAL & SCIENTIFIC SYSTEMS, INC.	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce.	COP16	COP21	(1) 61 Districts complete their own analysis and presentations for quarterly performance reviews (2) HIBRID care & treatment data from 95% of USAID sites is within +/- 5% of DHIS2 (3) 32 analytical reports (8 per quarter) completed from quantitative and qualitative data each with recommendations for adjustments to enhance program performance (4) 200 sites visited (25 per quarter) and aided to complete reports, analyze and present performance to facility management (5) DHIS2 and HIBRID data transformation and exchange into DATIM4U, and quarterly reports completed on time for TWGs to use and prepare for OGAC POART
USAID	University Research Co., LLC	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP19	COP21	40 ART sites with Full arm EMR system implementation in Regional, district hospitals and HC IVs Regional Clients and provider registries established Centralised Case Based data respository established at regional level HIV health information exchange established in the region Mobile-based case reporting in commuties Single desktop EMR system in light volume facilities
USAID	INTRAHEALTH INTERNATIONAL, INC.	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP19	COP21	40 ART sites with Full arm EMR system implementation in Regional, district hospitals and HC IVs Regional Clients and provider registries established Centralised Case Based data respository established at regional level HIV health information exchange established in the region Mobile-based case reporting in commuties Single desktop EMR system in light volume facilities
USAID	Elizabeth Glaser Pediatric Aids Foundation	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP19	COP21	50 sites with Full arm EMR system implementation in Regional, district hospitals and HC Ivs Centralised Case Based data respository established at regional level HIV health information exchange established in the region Mobile-based case reporting in commuties Single desktop EMR system in light volume facilities
USAID	University Research Co., LLC	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP19	COP21	40 sites with Full arm EMR system implementation in Regional, district hospitals and HC Ivs Centralised Case Based data respository established at regional level HIV health information exchange established in the region Mobile-based case reporting in commuties Single desktop EMR system in light volume facilities
USAID	John Snow, Incorporated	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP19	COP21	40 sites with Full arm EMR system implementation in Regional, district hospitals and HC Ivs Centralised Case Based data respository established at regional level HIV health information exchange established in the region Mobile-based case reporting in commuties Single desktop EMR system in light volume facilities
USAID	SOCIAL & SCIENTIFIC SYSTEMS, INC.	ASP: HMIS, surveillance, & research-NSD	OVC: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP16	COP21	District level OVC analysis for quarterly performance review at expert level. This level of analysis includes: 1) Excel-based visual tools such as dashboards with graphical representation of data from OVCMIS and other secondary data; 2) key informant interviews and focus group discussions with thematic analysis of factors associated with enhanced or poor performance; 3) geo-spatial analysis identifying locations where more OVC with high risk factors; 4) action plans with timeline
USAID	SOCIAL & SCIENTIFIC SYSTEMS, INC.	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP19	COP22	Single desktop EMR system established in light volume facilities

APPENDIX D — Minimum Program Requirements

Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[10]	Program is meeting
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[11]	Program is meeting
	3. Adoption and implementation of differentiated service delivery models, including six-month MMD and delivery models to improve identification and ARV coverage of men and adolescents.[12]	Program is meeting
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of COP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[13]	Program is meeting
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual VL testing and results delivered to caregiver within 4 weeks.	Program is meeting
Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is	New Task Force established week after RPM, site certification and monitoring approach to be

[10] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

[11] Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

[12] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

[13] Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

	established. All children under age 19 with an HIV-positive biological parent must be tested for HIV.[14]	developed with CSO, GOU and IPs
Prevention and OVC	1. Direct and immediate assessment for and offer of prevention services, including PrEP, to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, KP and adult men engaged in high-risk sex practices)[15]	Program is meeting
	2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	Program is meeting
Policy & Public Health Systems Support	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[16]	Program is meeting
	2. OUs assure program and site standards are met by integrating effective quality assurance and CQI practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[17]	Program is meeting
	3. Evidence of treatment and VL literacy activities supported by Ministries of Health, National AIDS	Program is meeting

[14] Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/

[15] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en).

[16] The practice of charging user fees at the point of service delivery for HIV treatment and care. Geneva: World Health Organization, December 2005

[17] Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

	Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Program is meeting
	5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	Program is meeting
	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Program is meeting
	7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Under discussion with host government and other stakeholders to strategize – GOU committed to resolve at RPM

Site level MPRs related to linkage and retention: During FY 2020 (COP19 implementation), all OUs are expected to fully implement retention-related PEPFAR Minimum Program Requirements at every PEPFAR-supported site, as these have a known impact on continuity of ART. Site level implementation of these 4 elements must be assessed to inform COP20 planning. Below is a country specific actions highlighting progress in addition to an effective tracking and tracing system in place at each site.

Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.
Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.
Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services.
Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits.

APPENDIX E — Summary Actions/Progress by PEPFAR UGANDA in Meeting the Minimum Country Specific Program Requirements

Summary MPR	Issue	Action/Country Progress
TLD Transition	• Localized supply chain stockouts has slowed TLD scale up	• Improve commodity security through aligned investments • 1st time ever 6-month ARV buffer
PrEP	• Current government guidelines allow for AGYW and PBFW, but most are not accessing	• Build on existing PMTCT and DREAMS platforms to scale PrEP for these populations
Differentiated Service Delivery and MMS	• Perceived supply chain insecurity has slowed roll out of dispensing greater than three months	• ERP goes LIVE June 2020 • Planning with MOH to expand 6-month dispensing
Increased Host Government Resources	• Maintain GOU investment for ARV, and increase resources for ARV, HRH and other HIV commodities.	• GOU commitment to provide $52 million in CY 2021 • Working to accelerate HRH transitions
Unique Patient Identifiers	• "Unique enough" algorithm • Finalize unique identifier • Single USG strategy for investing in HIS infrastructure	• E-Health policy awaiting MOFPED Certificate of Financial Compliance • When final, Unique identifiers ready to go to scale in COP19

APPENDIX F — The People's Voice Uganda and the Community Priorities

Summary of People's COP Asks		
LANGUAGE TO INCLUDE IN COP20	COP20 TARGET	USG/PEPFAR Action
1. Walk the talk--put communities at the center		

COP20 will ensure 100% of PEPFAR supported sites have sufficient funding invested in community-led retention and treatment program quality improvement strategies, prioritizing treatment literacy, stigma reduction and U=U, to ensure access to quality treatment services for all HIV treatment sites and their corresponding communities.	**Target**: 100% of PEPFAR supported sites fund community-led retention strategies. **Target**: Increase the number of trained, supervised, equipped and adequately remunerated community health workers (community linkage facilitators, expert clients, peer leaders/educators, mentor mothers and peer buddies) supported to facilitate community-facility linkage and follow-up for improved retention and treatment outcomes. **Target**: Increased PEPFAR COP20 HRH budget outlay for community health worker recruitment should result in at least 1000 additional lay health workers in post by the end of COP20, with remuneration (non-taxed) of 350,000 UGX per month. **Target**: All PEPFAR-supported sites should increase funding for the three prongs of DSD so that all DSD options are available at all sites and CCLADs and CDDPs are fully functional. IPs must increase their budget allocation for DSD implementation in COP20. **Target**: COP20 should fund accreditation of all remaining HCs in Kalangala for integrated ART and aggressively manage the IP (Rakai Health Sciences Project) to improve retention in care and 100% access to client-friendly services, particularly for pediatrics and sex workers and their families.	All sites will have a strong community component through community-led retention strategies and community-facility linkage; PEPFAR Uganda will work with CSOs and GOU to develop guideline for minimum package by September 2020. Average remuneration for CHWs from the HRH inventory is approximately $55 per month (vs. CSO recommendation of $95). PEPFAR will standardize the approach to remuneration across the various PEPFAR IPs, taking into consideration differentiation by rural/urban. PEPFAR will continue advocating GOU for a formal cadre of CHWs. PEPFAR will shift increased funding for Community client Led ART Distribution model (CCLAD) and Community Drug Distribution Points (CDDP). All partners received an increment of funds allocated to both models. PEPFAR implementing partners will continue to work with district leadership and the MOH to support ART accreditation of eligible health facilities, including in Kalangala. We are prioritizing non-facility-based outreaches and interventions to minimize LTFU in hard to reach areas such as Kalangala.
2. Key populations programming		
COP20 must fund a complete redesign of Key Population programs in Uganda being implemented through COP and Key Population Investment Fund (KPIF) support. The programs are out of step with the needs of HIV positive and HIV negative Key Populations in Uganda.	**Target**: Across the country, Drop in Centers (DIC) must be subjected to "community audit" and should be replaced with community-designed interventions that respond to the priorities of key populations, including minimum components such as a: District-level key populations coordinator whose cell phone number is known to communities and can be available on a routine basis to address client needs; a center staffed by at least 3 paid, trained counselors, a professional clinician, and providing a minimum package of quality services including on site access to PrEP, STI screening and free treatment, counseling and support, viral load testing, and condoms and lubricant.	In COP20, an additional 9 Drop-in Centers (DICs) will be launched in high-priority districts; all FY19 DICs will be maintained. PEPFAR will introduce KP led DICs. The community scorecard developed in collaboration with CSOs will be used to monitor service delivery. Community Led Monitoring (CLM) will launch in COP19 and expand in COP20. PEPFAR will work with GOU and CSOs to ensure guidelines for DICs include access to healthcare services either on-site or through linkage to nearby facilities; DICs will be scaled up to include on-site peer counselors, refill points for PrEP and ART, and outreach testing services.

	Target: COP20 should fund continuous professional and community health workers to improve client satisfaction. The impact of training must be measured through anonymous surveys to determine whether health worker attitudes and high rates of stigma are improving. **Target:** COP20 should fund a pilot with Uganda Bureau of Prisons and other partners to implement an HIV prevention and treatment literacy program, modeled on the MAT/harm reduction program being implemented in partnership with Butabika. **Target:** PEPFAR should publicly and actively support decriminalization of HIV and of KPs in order to increase uptake of life-saving services, decrease new infections, and ensure evidence-based response in Uganda. PEPFAR should fund establishment of rapid-response mechanisms for violence elimination (either community or IPV) through phone-trees or WhatsApp links, with a protocol for how to support KPs who are in trouble. **Target:** Human rights interventions should involve some basic legal literacy, particularly referral mechanisms for legal assistance. Community health workers/peer navigators should be empowered to provide these services. Human rights interventions should also involve improving safety and security systems and processes, as well as sensitization work in local communities where services are located/provided.	PEPFAR in collaboration with MOH plans to support continuous professional and community health workers to ensure client satisfaction._PEPFAR will incorporate client satisfaction surveys into service delivery and root cause analysis, particularly for KPs. CDC has provided direct funding to Uganda Prison Services (UPS) since 2010 to implement HIV prevention and treatment services. PEPFAR will plan a briefing to ensure all UPS program information and data are shared and CSOs can provide input on areas of improvement. Inclusion of MAT in UPS may require higher-level advocacy, but PEPFAR has included this topic in discussions with CSOs and UPS Legal environment assessment is planned for COP19. This will provide all actors with data for advocacy. PEPFAR is committed to achieving health outcomes such as uptake of life-saving services and decrease of new infections. This will be achieved through various evidence-based interventions and client-centered services that are responsive to client needs as determined in surveys and root cause analysis. PEPFAR is also using insights from the HIV Stigma Index study, which included a large percentage of KP respondents, to ensure KP-friendly client-centered interventions. PEPFAR will expand the SPECTRUM toll-free line and set up regional response centers to support referral and linkages for various services including IPV, PrEP, etc. PEPFAR has begun assessing legal assistance mechanisms through the GBV QA Assessment tool. These data can be used to advocate for improvements in forensic and legal services.
3. Social enablers must be implemented		

3a. Immediately halt implementation of policies that violate human rights 3b. Resolve socioeconomic and legal structural barriers affecting women living with HIV 3c. Expand comprehensive services for women living with HIV	**Target:** PEPFAR and GOU must not fund implementing partners to restart index testing *anywhere* without a restructuring of the program to resolve fundamental barriers to quality - client centered testing - and to protect human rights. Our concerns must be resolved. **Target:** COP20 must invest in programs to reduce policy and legal barriers that worsen women's inequality and perpetuate violence that further impacts the HIV response. COP20 must improve access to quality and comprehensive SRHR services and information for women and girls living with HIV. All women and girls (irrespective of gender identity or sociocultural or economic status) should access, utilize, and enjoy quality SRHR. **Target:** COP20 should support interventions to address the needs of women living with HIV and disabilities with a priority focus in Year 1 on infrastructure and sign language interpreters.	OGAC issued a circular halting index testing for KPs until PEPFAR programs can ensure index testing programs are implemented with confidentiality, non-coercion, and informed consent. PEPFAR is developing site assessment tools and client satisfaction surveys to assure WHO and GOU guidelines are followed before index testing fully resumes. PEPFAR's Index Testing, Key Populations, Adolescent Girls and Young Women (AGYW) Communities of Practice have collaborated with CSOs, WLHIV, and KP representatives to develop materials to improve the quality of index testing, putting clients first. PEPFAR and MOH will share OGAC tools and index testing information with IPs to create an environment that is safer for index testing and safeguards the human rights of all populations we serve. As mentioned above, PEPFAR will expand the SPECTRUM toll-free line and set up regional response centers to support referral and linkages for various services including IPV, PrEP, etc. PEPFAR has begun assessing legal assistance mechanisms through the GBV QA Assessment tool. These data can be used to advocate for improvements in forensic and legal services. In COP19 PEPFAR funded four CSOs to address PWD and will expand this in COP20. PEPFAR will explore minor infrastructure modifications in COP20 and seek partnership with GOU and GF for broader systematic supports and sign language interpreter support.
4. High-impact prevention must be expanded through COP19 and COP20, focusing on adolescent girls and young women (AGYW), key populations, pediatrics, and men		

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4a. PEPFAR and GOU must prioritize programs that address socio-economic, legal, and structural barriers to increase service uptake by Adolescent Girls and Young Women

PEPFAR COP20 should prioritize interventions for reducing stigma and discrimination in schools targeting both boys and girls.

4b. PrEP scale up must be supported through COP20

4c. Expand quality harm reduction services

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<u>**Target**</u>: COP20 should invest in programs aimed at improving the quality of services delivered by and for young people, by rapid expansion of the YAPs model nationally. COP20 must ensure increased access to FP services and comprehensive sexuality education for young people.

<u>**Target**</u>: PrEP must be rolled out nationally, with public promotion of this high-impact prevention tool. COP19 and COP20 should fund a pivot away from geographic and population restriction, instead offer PrEP to all people at substantial risk of HIV infection, everywhere, including adolescent girls and young women (AGYW) and pregnant and breastfeeding women.

<u>**Target**</u>: Health workers must be trained to offer stigma-free screening for PrEP eligibility, and supply forecasting must be adjusted to ensure adequate PrEP supply and appropriate national coverage.

<u>**Target**</u>: COP20 must support expanded community-based harm reduction services including psychosocial interventions for MAT clients, scale-up of the hub-and-spoke model for PWID in prisons and other closed settings, stronger community models for referral and linkage to MAT and other HIV services, and education and training of health care providers, caretakers, families and PWID communities about harm reduction.

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YAPs were included in COP19 and is being scaled up in COP20 and will leverage family planning and sexuality education services from other sources. PEPFAR continues to advocate for completion and roll out of the National Sexuality Education program.

PEPFAR uses the "No Means No" program with both girls and boys to complement anti-GBV and sexuality education programs.

In COP20, PrEP will be offered to all people at substantial risk of HIV infections including AGYW and pregnant and breast-feeding women, with an increase in the PrEP targets from 30,000 in COP19 to 95,933 in COP20

<table>
<tr><th colspan="2">COP 19</th><th colspan="2">COP 20</th></tr>
<tr><th>Sub-populations</th><th>Targets</th><th>Sub-populations</th><th>Targets</th></tr>
<tr><td>FSW</td><td>21,075</td><td>FSW</td><td>30,183</td></tr>
<tr><td>SDCs</td><td>5,102</td><td>SDCs</td><td>13,128</td></tr>
<tr><td>MSM</td><td>1,172</td><td>MSM</td><td>5,013</td></tr>
<tr><td>PWID</td><td>182</td><td>PWID</td><td>563</td></tr>
<tr><td>Fisher folks</td><td>2,171</td><td>Fisherfolks</td><td>10,197</td></tr>
<tr><td>Truckers and others</td><td>301</td><td>TG</td><td>471</td></tr>
<tr><td></td><td></td><td>Pregnant Women</td><td>4,256</td></tr>
<tr><td></td><td></td><td>Breast feeding Women</td><td>2,120</td></tr>
<tr><td></td><td></td><td>AGYW (15-19)</td><td>10,400</td></tr>
<tr><td></td><td></td><td>AGYW (19-24)</td><td>19,602</td></tr>
<tr><td>Totals</td><td>30,001</td><td></td><td>95.933</td></tr>
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All health workers providing PrEP are trained to professionally offer PrEP services with stigma-free screening. PEPFAR will use client satisfaction surveys and root cause analysis to assess quality of counseling, including adherence to WHO and GOU

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		guidelines regarding provision of prevention services without comprehensive behavioral screening. The MAT program at Butabika is expected to start in June 2020 and lessons will inform scale up. In COP20, PWID programming will be expanded beyond Kampala to Wakiso, Arua, Kibale, Iganga, Mbale, Jinja and Tororo.

5. Expand pediatric HIV diagnosis and quality treatment access		
	Target: COP20 must expand Point-of-Care EID to cover *all* HIV-exposed infants to improve rapid case detection and linkage to treatment. **Target**: IPs must budget for service delivery models that increase pediatric treatment retention through treatment education and support for caregivers, HIV positive women, children, and adolescents. **Target**: Increasing new pediatric infections in Uganda must be tackled through better quality treatment and prevention programs that suppress the viral load of HIV-positive pregnant and breastfeeding women and provide PrEP and retesting services for HIV-negative pregnant and breastfeeding women.	PEPFARs goal is for universal access for EID testing rapidly linked to services. PEPFAR will use both conventional and Point-of-Care EID to maintain the COP19 implementation plan into COP20. Treatment will be provided for all CLHIV including infants following MOH Guidelines. PEPFAR will continue to scale up optimized pediatric ART regimens. As mentioned above, PrEP will be scaled up to include pregnant and breastfeeding women.

6. **Stop stock-outs**	**Target**: The government and PEPFAR must work towards eliminating treatment interruption resulting from stock-outs of ART for adults and children. Communities must be supported to monitor stock-outs at every step of the supply chain. **Target**: Pharmacovigilance systems must be put in place to track adverse events, including at Community Drug Distribution Points. Pharmacovigilance committees at district level should be put in place to monitor side effects of drug interactions and long-term use of ARVs.	PEPFAR participates in GF and GOU quantification discussions for ARVs and Non-ARV commodities with the Pharmacy division and Quantification Planning and Procurement Unit (QPPU) to ensure there are no stock outs in both public and private sectors. PEPFAR Uganda also works with OGAC and manufacturers to remain informed about global stocks and supply chains of multiple ARV medications to ensure there is equity of supplies across countries. PEPFAR will continue to support pharmacovigilance/safety monitoring of commodities in PNFPs and will continue to work with NMS to quantify and obtain commodities for the public sector. Currently, there is a global shortage of LPV/r due to low stocks of API; Uganda has worked with OGAC to advocate for the commodity. It is anticipated that by June 2020, Uganda will continue the Peds Optimization efforts to combat VLNS and HIVDR in children. In 2021, DTG 10-mg tablets will be FDA-approved and children <20 kg will be able to take it if Uganda is still experiencing LPV/r shortages. PEPFAR will improve HIS for real-time adverse event reporting; PEPFAR works with IDI to coordinate pharmacovigilance activities ensuring adverse event reporting at active spontaneous sites (RRHs, IDI and Mildmay CoEs) including clients in CDDPs supported by above-site mechanisms. PEPFAR will continue to engage on the pharmacovigilance task force working with MOH/ACP, NDA, and IPs on a safety monitoring implementation plan for all new ART products. Following the WHO mission recommendation, PEPFAR will conduct a safety monitoring evaluation, and results will be disseminated.
7. **Address persistent human resources for health barriers**		

	Target: COP20 must prioritize increased funding to deploy additional priority health workers in clinical sites with high volume, high vacancies and poor outcomes and patient satisfaction reported among PLHIV. **Target**: Government must increase its funding for the recruitment, equitable deployment, and increased remuneration of critical cadres of health workers as part of Global Fund and PEPFAR co-financing agreements, rather than only explore annual allocations for ART.	COP20 references the National Health Sector HRH coverage plan. PEPFAR provides Technical Assistance to MOH for quantifying investments and planning for funding and absorption of seconded staff. PEPFAR seconds critical cadres at the national level to improve MOH technical capacity to provide oversight, develop policies and technical guidelines, and institutionalize partner- and donor-supported activities such as through rapid adoption of new innovations for epidemic control. PEPFAR will strengthen GOU entities for increased oversight and leadership through a G2G mechanism with Regional Referral Hospitals. PEPFAR seconds staff to sites to rapidly implement health sector policies aimed and accelerating and sustaining epidemic control. PEPFAR builds District Health Team technical capacity for district-led programming by convening all players within the decentralized response system for joint planning, implementation, monitoring, and performance reviews that inform the national system. PEPFAR supports VHTs and CHWs for effective community mobilization to increase access to service points and address stigma and discrimination (especially among KPs). These initiatives are linked to existing GOU community-based programs to ensure sustainability.
8. TB/HIV service delivery		
	Target: COP20 must invest in expanded TB service delivery including ensuring TB symptom screening and urine-LAM and Xpert MTB/RIF Ultra testing are being implemented in all settings where PLHIV present for care, including outpatient settings. **Target**: COP20 must support universal access to TPT for all eligible PLHIV (those currently on treatment who have not previously received TPT in addition to those newly initiating treatment) and household contacts of PLHIV with TB disease, including children. The preferred TPT regimen for adults should be 3HP.	PEPFAR will scale up TB screening on clinic entry and will boost TB diagnostic capacity through placement of GeneXpert machines at six high-volume sites. To address high rates of TB in prisons, PEPFAR provide TB preventive therapy to 100% of all eligible prisons and prison staff. COP20 strives for 80% TPT completion; PEPFAR partners will achieve this through surge implementation and CQI. Limited access is caused by stockout of TB kits. PEPFAR plans to procure TBLAM kits to improve access.

9. Community-Led Monitoring for Advocacy		
COP20 should fund independent, community- and PLHIV-led monitoring of the state of service provision at PEPFAR-supported sites and escalate issues using advocacy interventions. Key areas to be monitored include poor performance, poor quality of services, poor health worker attitudes, health, and rights violations, and stockouts and/or shortages of diagnostics and treatment. The results of monitoring must be linked to a model of advocacy to ensure an accelerated response from all actors to address the issues identified to ensure they are rapidly rectified. The funding mechanism must foster independence and transparency.	**Target:** COP20 supports implementation of a routine, robust, independent community-led monitoring system led by monitors who are themselves service users.	PEPFAR has engaged CSOs and various community structures in critical stages of COP planning and delivery of services to PLHIV and those at high risk of acquiring HIV. PEPFAR has supported innovative initiatives to monitor the provision and quality of HIV services through use of the Community Scorecard. This has provided timely feedback to HCWs about the quantity, intensity and quality of services offered by HFs to PLHIV. This has improved access to high-quality HIV services. In COP 20, PEPFAR will engage CSOs to recommend feasible and efficient approaches/systems to monitor the access, quality, and quantity of care services. These systems will be led by independent community structures (e.g., CSOs, local CBOs, other organized groups or cadres that are not involved in service delivery). This will result in client-centered feedback for PEPFAR, MOH and service providers to improve access and quality of treatment and prevention services. PEPFAR Uganda is excited about this new, community led approach.

PEPFAR/Uganda OVC Programming

FY20-FY24 Transition Roadmap Overview

25 March 2020

Background and Rationale

PEPFAR Uganda developed a three to five-year vision for OVC programming based on assumptions that:

- HIV epidemic control is likely to be announced in 2020
- PEPFAR funds, including those for OVC programming, will likely decrease after 2020
- GOU is accountable for resourcing and sustaining OVC service delivery and can and should progressively take on more responsibility

This vision aims to maintain epidemic control and sustain services by shifting PEPFAR investments towards system strengthening while continuing service delivery for critical outcomes and sub-populations with a focus on children and adolescents living with HIV and/or in families struggling to maintain viral suppression, HIV-exposed infants living in severely vulnerable households, severely vulnerable AGYW at high risk of HIV, children exposed to sexual abuse, and children of key populations. Leveraging non-OVC funds and platforms to maintain caseloads and sustain broader service delivery must increase. In 5-10 years, epidemic control will continue to be maintained as national, district, and community-level structures and institutions lead in the financing and provision of critical services. Uganda's systems will be more self-reliant and will sustain past PEPFAR investments while at the same time vulnerable children and families at risk of poor outcomes due to HIV will have built greater resilience, reducing their demand for services.

In January 2019, after considering recommendations from different agencies, Ambassador Malac decided to move forward with USAID's proposed approach and leadership in the implementation of this vision. Accordingly, responsibility for service delivery will consolidate under USAID in a phased and deliberate manner. Specialized programming from Peace Corps, State Department, and DOD (for military populations) remain unaffected by this consolidation.

Overarching Assumptions and Guiding Principles

The interagency vision for PEPFAR OVC programming in Uganda over the next 3-5 years is based on the following assumptions:

- Epidemic control is likely to be announced in 2020; PEPFAR priorities will shift to consolidate and maintain epidemic control
- PEPFAR OVC priorities after 2020: children and adolescents living with HIV and/or in families struggling to maintain viral suppression, HIV-exposed infants living in severely vulnerable households, severely vulnerable AGYW at high risk of HIV, children exposed to sexual abuse, and children of key populations.
- GOU is accountable for resourcing and sustaining OVC service delivery and can and should progressively take on more responsibility with targeted support
- PEPFAR funds will likely decrease after 2020. Despite 10% earmark, HKID funds will therefore also decrease.
- Other sources of funding (both public and private) will be available for leverage but funding levels and total estimated gap are uncertain.

The OVC portfolio has matured in recent years to align with and support overall PEPFAR objectives in Uganda. Continued program evolution must sustain and advance these gains, even as PEPFAR priorities also shift to maintaining epidemic control. Likewise, the anticipated programmatic transitions must mitigate any adverse consequences for beneficiaries.

Further guiding principles include:

- Continue to emphasize the interests of children and families in all decisions and apply data-driven decision-making to drive targeting of beneficiaries and services.
- Continue to coordinate and leverage all aspects of the PEPFAR portfolio involving children, adolescents, and their caregivers regardless of agency lead, with a particular focus on community-clinic linkages
- Make difficult though strategic decisions to preserve PEPFAR investments in the most critical OVC program components while providing targeted technical assistance to progressively transition other components to GOU and other development partners
- Leverage synergies with other USG investments beyond PEPFAR
- Accommodate the fluid operating environment with continuous reflection, learning, and adaptation using all available data and experience

As the OVC portfolio progressively consolidates under USAID, there is a compelling need to preserve the interagency collaboration that has made the current program relevant, strong, and successful.

Ongoing coordination should be situated within the existing PEPFAR Uganda governance structure, comprising interagency Technical Working Groups for treatment and prevention. Oversight, collaboration, and alignment and integration of the USAID-led OVC portfolio within PEPFAR will continue either through the “collaboratives” established under each TWG or through alternative arrangements developed in the interagency and approved by PEPFAR Uganda leadership. As other USG investments are more intentionally leveraged, it will be important to periodically engage those entities within the “collaborative” for joint planning and coordination. Structured opportunities for senior PEPFAR leadership to engage with the OVC team will be regularly scheduled throughout the transition process to ensure that the OVC portfolio remains in-step with broader interagency PEPFAR priorities and goals

Maintaining Services through Beneficiary Transitions

Any transition of beneficiaries between mechanisms elevates the risk for interruption of critical services. While agencies are accustomed to transferring beneficiaries from a closing mechanism to a new mechanism, it is a rare event to do this between agencies.

PEPFAR Uganda previously navigated a complex transition of almost 60,000 beneficiaries among CDC, DOD, and USAID mechanisms during FY 2017 and FY 2018. Fortunately, the following robust lessons learned from this experience will guide future beneficiary transitions with the goal of minimizing any adverse consequences for beneficiaries, such as interruption of services:

- Start the process at least 6 months before mechanisms end
- Develop plans jointly with incoming and outgoing mechanisms, facilitated and monitored by a third party and consistent with SOPs to be established by the interagency
- Communicate early and often with beneficiaries and district-level stakeholders

- Adopt successful existing implementation modalities wherever possible (e.g., high-performing CSOs, support to district governments, arrangements with health facilities and other service providers)
- Ensure that required documentation (e.g., beneficiary case files) are up-to-date, available, and transferred to incoming mechanisms
- Maintain open communication, transparency, and accountability at the interagency level, with regular discussions on progress and challenges

Six CDC mechanisms and 1 DOD mechanism will transfer OVC programming in their districts to USAID mechanisms, including the transfer of any active OVC beneficiaries. Two USAID mechanisms will also end and make similar transitions to follow-on USAID mechanisms. Peace Corps, State Department, and DOD military-serving activities will continue, as determined in annual COP processes.

The timeline for all transitions is harmonized to coincide with the end dates of each mechanism. These end dates also align with USG fiscal years and COP cycles, which facilitates future planning and resource allocations. No premature transitions are planned.

While preparations must begin during FY 2020, the first wave of transitions will occur in FY 2021 and will need to be accounted for in COP20 planning. This timeline does not alter target and budget allocations already approved in COP19.

USAID will incorporate this timeline and the guiding principles into the scopes of follow-on mechanisms to ensure continuity of services. These follow-on mechanisms will align with existing clinical regions (led by different agencies) to facilitate continued close coordination with clinical services, regardless of the agency clinical lead. As with the prior interagency transition, USAID will deploy a dedicated transition advisor to facilitate joint planning and active monitoring of transition processes.

All agencies have critical roles to play in adhering to anticipated timelines, defining SOPs for transition, managing their respective mechanisms to carry out the agreed SOPs, and providing interagency oversight during each wave of transition.

Agreed actions and milestones are summarized in the Summary Roadmap on the following page.

Summary Roadmap Maintaining Services through Beneficiary Transitions	
FY 2020	**USAID** ensures that new service delivery mechanisms are in place to facilitate transitions and maintain continuity of services **USAID** brings on board a dedicated transition advisor to facilitate transition planning, monitoring, and troubleshooting **Interagency** develops SOPs for transition, led by **USAID** transition advisor
FY 2020 to FY 2024	**All agencies** ensure beneficiary records (e.g., case files) and reporting (e.g., OVC MIS, OVC Tracker) are aligned with national standards, complete, and up to date through ongoing DQAs and other actions **All agencies** prioritize household graduation and restrict new enrollments to most critical cases (e.g., non-suppressed CLHIV, HIV exposed infants in severely vulnerable households, children experiencing sexual abuse, and children of KPs) in the final year of their mechanisms **All agencies** comply with anticipated timelines and established SOPs to achieve smooth beneficiary transitions, with active support from the **USAID** Transition Advisor **USAID** mechanisms ensure continuity of services and clinical coordination for transferred beneficiaries