Uganda

Country Operational Plan

COP21

Strategic Direction Summary

May 20, 2021

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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
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
DREAMS	Determined, Resilient, Empowered, AIDS Free, Mentored, and Safe
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
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 2021
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
OVC	Orphans and Vulnerable Children
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 = Untransmissible"
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

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1.0 Goal Statement

The 2021 PEPFAR Country Operational Plan (COP21) for Uganda will continue with 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 increase the COP21 cohort to 1,339,579 on treatment (ambitious target of 94% coverage) and will focus active case-finding to the index modality, especially where recency hotspots are identified
- Expanding client-centered approaches to care to address barriers to treatment continuity
- Strengthening community-led monitoring (CLM) as a routine part of program review, planning, and oversight
- Introducing 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 Kampala
- Scaling up PEPFAR-supported cervical cancer screening to decrease HIV-related mortality
- Intensifying programming in ten northeastern districts to close the clinical cascade gaps in testing, treatment, and treatment continuity
- Increasing funding for VMMC to achieve saturation while adapting program under COVID
- Improving civil society organizations' (CSO) engagement and community-led monitoring, especially toward strengthening treatment literacy and increasing multi-month dispensing
- Addressing issues of gender-based violence (GBV) and disclosure that prevent acceptance of multi-month dispensing

Under COP20 (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 2021 Planning Level Letters (PLL). These strategies and other promising approaches will be refined and intensified in the COP21 implementation period.

PEPFAR Uganda will execute a highly ambitious and targeted program under COP21, prioritizing client treatment continuity on antiretroviral therapy (ART) 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 continuity of treatment, 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 2020-2021) to identify areas for activity performance improvement critical to attaining our targets and objectives. COP21 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 COP21 priorities reflect this strategy and the PEPFAR 2021 County Operational Plan guidance. Our COP21 objectives fully align with and will contribute enormously 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); the Ministry of Gender, Labor & Social Development (MOGLSD); the Ministry of Education and Sports (MOES); the 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. PEPFAR Uganda has also enhanced its collaboration with CSOs, multilateral and bilateral partners, and other key stakeholders.

How will PEPFAR Uganda's COP21 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 COP21 goal is to initiate and retain 1,339,579 persons living with HIV (PLHIV) on treatment through September 30, 2022, and beyond. This represents 94% of the estimated 1,420,812 Ugandans living with HIV. PEPFAR Uganda will strive for 95% linkage of newly identified PLHIV and to support treatment continuity among 98% of this cohort. Intensive efforts to improve treatment continuity are currently underway. Our goals for COP21 will be accomplished through the priority strategies and interventions described here and by retaining these new enrollees through the end of FY21 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 COP21, PEPFAR Uganda's path to epidemic control will:

- Prioritize continuity of treatment of PLHIV in care and treatment by building on proven and promising platforms and initiatives, while adapting services in the context of COVID-19
- 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 treatment continuity 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
- Prioritize community-led treatment literacy programs to reach the last mile
- Mitigate harms to HIV treatment, prevention, and care caused by COVID-19

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

In addition, PEPFAR Uganda will:

- Support independent community monitoring and community linkages to assure robust advocacy and "watchdogging"
- Expand efforts in Point-of-Care Early Infant Diagnosis (EID) in line with new WHO guidelines while maximizing and optimizing testing platforms
- Simultaneously reduce the number of HIV tests conducted and increase case-finding effectiveness
- Expand community-based differentiated service delivery
- 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
- Advance the scale-up of 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

GOU engagement remained strong in COP20, with an increase in public funding for ARV medicines, incremental absorption of human resources across national and district levels, rapid adoption and dissemination of policies and guidelines, formalization of community health extension workers (CHEWs), expedited FDA approval of local ARV manufacturer Quality Chemicals, and rollout of the national E-Health policy to uniquely identify patients. The GOU has fulfilled its commitment to increase funding for HIV/AIDS commodities to $52 million, inclusive of both ARVs and laboratory commodities. The GOU also finalized plans to pilot the CHEWs program and has completed CHEW selection, curriculum development, and identification of pilot districts. PEPFAR will work in close collaboration with MoH to implement the phase one pilot in four PEPFAR supported districts in COP 21. The lessons from the pilot will inform national roll-out.

Strong engagement continues in COP21. Uganda's Minister of Health, Honorable Dr. Jane Ruth Aceng, has made assurances to the following GOU commitments for COP21:

- Sustained financing of $52 million for HIV commodities and human resources for health (HRH) transitions primarily in the public sector in FY22
- Use of Global Fund (GF) and GOU procured commodities for clients in the private-not-for-profit (PNFP) sector

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 the district level and below.

Based on lessons learned to date, in COP 21, PEPFAR Uganda will continue to leverage the RRH platform to meet its core care and treatment and prevention site-level targets. Historically, this was achieved through comprehensive implementing partner (IP) sub-grants. However, since COP 20 and onwards, service targets will be achieved through direct support to the majority of RRHs in a bid to advance PEPFAR's goal of working with and directly funding local entities. In addition to the service delivery targets, PEPFAR will provide above-site support to all 17 RRHs in order to increase local capacity for oversight, leadership, and coordination of regional efforts. RRHs will provide CQI for enhanced disease surveillance to support districts/health facilities to identify the few remaining PLHIV, enroll them on ART, and achieve suppression. This support will include: integrated support supervision; virtual training and mentoring through virtual platforms such as ECHO/Zoom via a hub and spoke model; conducting and providing leadership for regular region-specific quarterly performance reviews; addressing HRH productivity concerns; and coordination with CLM and highly impactful community systems. RRHs will feed valuable information generated through CLM and the national CQI platform (with representation from MoH, RRHs, and CSOs) into the broader supportive supervision and CQI efforts. This will ensure a linkage between community-level actions and facility-level efforts to improve program performance at all levels.

By the end of COP21, at least 70% of PEPFAR funds will be channeled through local institutions, strengthening their capacity while ensuring local ownership and sustainability. PEPFAR continues to engage with the GOU to advocate for increased domestic resources for HIV commodities. In COP20, two areas of the PEPFAR Uganda portfolio began phased transition to management by USAID/Uganda—procurement of HIV commodities and the orphans and vulnerable children (OVC) platform. These shifts 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).

Ugandan external stakeholders have noted that the COP21 budget presents an uptick in management costs. For example, under COP21, USAID's program management costs are projected to increase by 13.43% over COP20. This one-time management cost is the result of the deliberate shift away from international implementing partners in favor of investing in direct awards to local Ugandan non-governmental organizations, as well as in Government to Government (G2G) direct funding arrangements. This is the right direction for enhancing the sustainability of local host country partners; however, the "up-front" investment costs will have a short-term effect on program management costs. The costs associated with the necessary mentoring, oversight, and capacity- building interventions for first-time local Ugandan Prime

awardees are significant; however, this is an excellent long-term investment. PEPFAR is focused on financial risk management, enhancing local awardees' absorptive capacity, and strengthening the new local IPs' management and operations systems to meet NUPAS findings and other special award conditions. The investment under COP21 will lead to measurable cost savings in the near future, as these local Ugandan IPs will be far less costly than international IPs, while being more attuned and effective in-country.

COP21 will strive to balance resources strategically between supporting public sector health facilities and systems, while working with the private not-for-profit (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 and over 40% of other health services in Uganda. Besides service delivery, the PNFP sector also plays a critical role in training health workers, with 65% of the nursing and midwifery training institutions in Uganda owned by this sector. Sustained direct awards to local Ugandan implementing partners under COP21 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 engages with PEPFAR regularly to track progress and solve problems. COP21 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 Global Fund 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 Voice COP21 Principles, as discussed in Section 2.6.

Further information on new activities under COP21 may be found in Section 2.2.

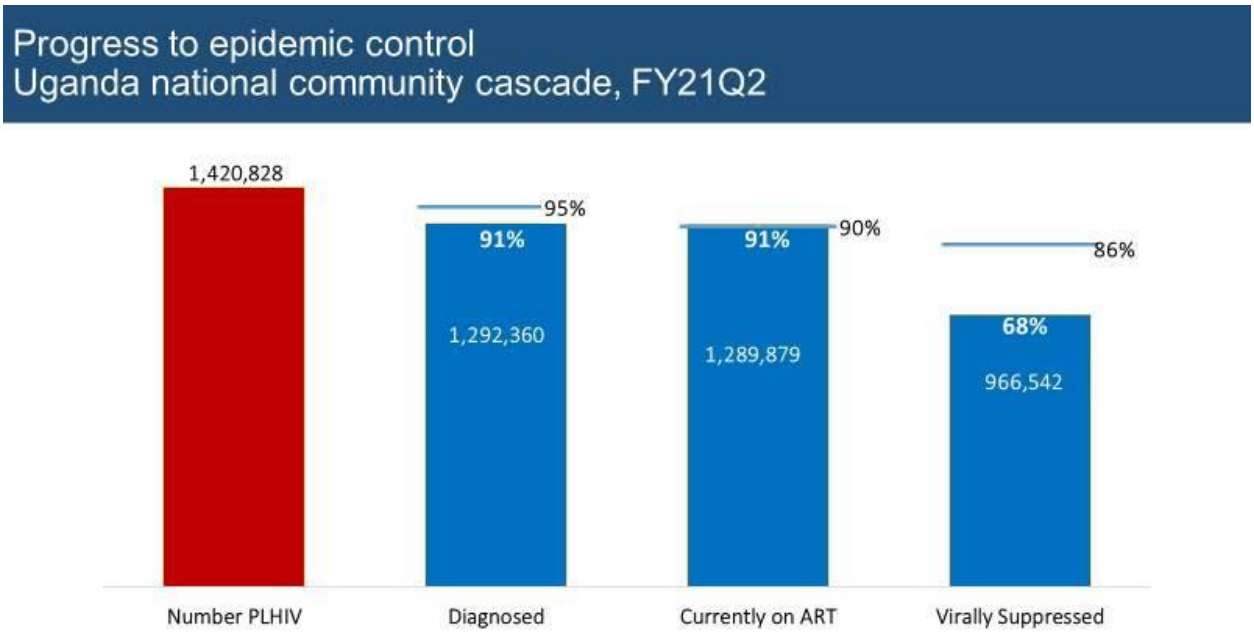
2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden, and country profile

In 2021, Uganda has a population of 43.7 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 under age 24.[4]

Uganda is on course to achieve the 95-95-95 UNAIDS global goals by the end of FY2030. By the end of March 2021, 91% of the people living with HIV (PLHIV) had been diagnosed, 91% of PLHIV were on treatment, and 68% of PLHIV were virally suppressed. The latest Spectrum projections indicate that in 2021, 1.420 million Ugandans are living with HIV, the majority of whom are women. The program's goal is to have 94% of these PLHIV on ART by the end of FY2022 – bringing us very close to achieving the global goal of 95% of PLHIV on ART by 2030.

[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)



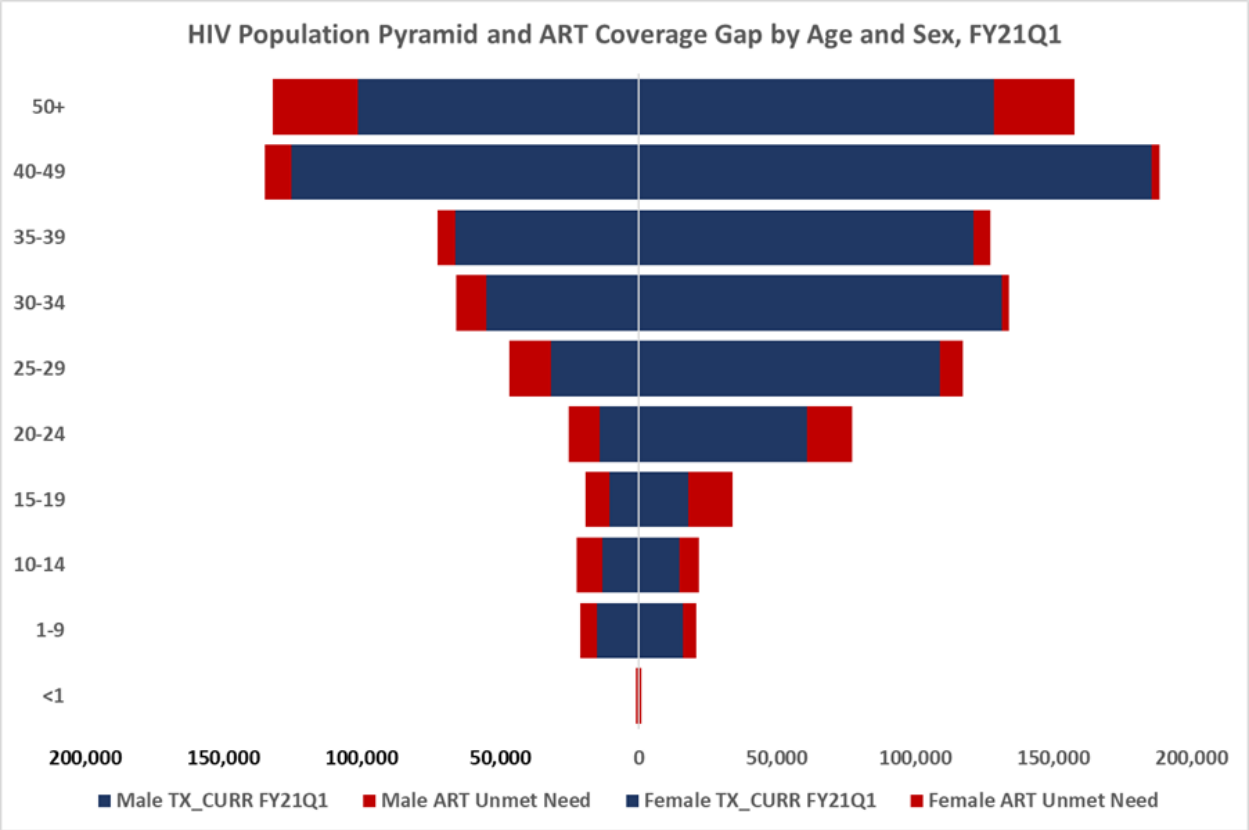
According to the Uganda population HIV Impact Assessment (UPHIA 2016-2017), HIV prevalence in Uganda is 6.2%. Findings from UPHIA showed an annual incidence of HIV among adults 15-64 to be 0.4%, with women having higher incidence rates (0.46%) compared to men (0.36%). This incidence rate translated to approximately 73,000 new cases of HIV annually in 2016-2017 among adults in Uganda. New spectrum incidence estimates have decreased with the 2021 estimate at 34,806 new cases of HIV annually. Although women have higher HIV prevalence and incidence compared to men, the proportion of women who are under care is much higher than men, as shown by the HIV population pyramid, and the ART coverage gap by sex and age. The older population, aged 50+ of both sexes, continue to have a treatment gap. At the same time, women show treament gaps in the younger age group 15-24, and the male population has treatment gaps in all age groups, particularly in 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 has completed data collection for UPHIA 2020, which will determine the progress towards achieving the UNAIDS 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 60% and AIDS-related death[5]s by 60%.

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. 1 HIV Population Pyramid and ART Coverage Gap by Age and Sex, FY21Q1



Based on FY20 results, Uganda achieved most treatment and prevention targets in COP19. Reports at FY21 Q1 indicate that the program is on course to achieve COP20 targets; however, a few program areas are lagging behind. Although index testing is on course, the number of HIV-positive persons identified through this testing modality was below the projected proportion. Following concerns raised by CSOs on index testing among KPs and the subsequent OGAC directive to suspend index testing services, PEPFAR Uganda confirms that absolutely all of the PEPFAR-supported Index Testing sites which failed the REDCap assessment were halted from offering Index Testing Services (ITS).

The MOH, working with PEPFAR and other stakeholders, including the civil society organizations, developed a framework for implementing index testing reforms. The framework included guidance on quality index testing assessments. The national, regional, and district task teams, which all have CSO representation, were trained on the guidance ahead of implementing index testing assessments.

Regarding index testing assessments, the national guidelines clearly stipulate that, sites that fail the index testing assessment should be halted from offering index testing services until gaps identified are addressed, and re-assessments are done with 100% pass. The guidance also recommended assessments to be done by a minimum of three individuals, representing the district, IPs and CSOs, and that no assessments should be conducted without CSO representation,

even if the district and IP representatives are available. IPs and assessment teams were all trained on the Ugandan MOH national guidance. According to information that PEPFAR Uganda representatives received from IPs during routine IP meetings, sites that failed baseline index testing assessments were halted from delivering index testing service until gaps identified were addressed and reassessments passed. However, there were some sites that failed assessments due to missing documents; these sites were able to resume service delivery within two weeks once the IPs provided the missing documents. We do not yet have documentation regarding halting index testing service delivery upon failing an assessment. We will work with IPs to provide this information. PEPFAR will also continue to support IPs to ensure the delivery of quality index testing services.

All PEPFAR Uganda USG agencies and implementing partners that support HIV testing services (HTS) engaged in remedial actions for sites failing to pass the REDCap assessments are working together with CSOs, the MOH, and other stakeholders. Mitigation efforts include building health provider competencies to ensure that safe and ethical index testing would be implemented without human rights violations. These efforts ensured that all counselors are certified to provide HTS according to PEPFAR and World Health Organization (WHO) standards. PEPFAR IPs shared the MOH circular with all facilities, reiterating the need to implement index testing according to WHO guidelines, i.e., emphasis on the 5Cs (Consent, Confidentiality, Counseling, Correct Results, and Connection) when implementing assisted partner notification (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.

The Ugandan National HTS policy and implementation guidelines are opposed to the use of monetary incentives for HIV testing services; this applies to all HIV testing approaches, including index testing. PEPFAR, in collaboration with the Ministry of Health and the National Index Testing task team, will work with implementing partners to ensure services are safe, ethical and that monetary incentives, either for service providers or index clients, are not used in the delivery of services.

HIV recency testing is below set targets mainly due to slow scale-up and human resources for health (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 FY21, all 400 facilities will be in a position to provide services. During FY20, training of trainers was conducted, and the trainers 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 and most recently to 2.3% in 2020. 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 follow up with mothers to bring their exposed children for HIV tests at six weeks. An 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, including implementing the MOH-led tailored "EID surge" interventions to improve overall coverage of EID 0-12 months to 100% with 90% targeted to receive the EID test within two months of age. These interventions will increase early initiation of ART for HIV-positive infants and improve linkage to ART initiation.

Uganda has continued to achieve VMMC targets over the years; currently, the VMMC coverage stands at 62% (this proportion has not changed due to low COP20 VMMC targets). The higher fertility rate and the significant youth bulge in Uganda slow down the VMMC coverage despite high circumcision rates in Uganda. In FY20, Uganda was successful in achieving targets 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 years and older through the integration of VMMC services into other health services where feasible, use of incentives, and the use of flexible VMMC services provided at the convenience of clients.

Key population (KP) programming in Uganda has faced tremendous challenges, but until May 2021, there had been significant improvements in the political environment. On May 3, 2021, Parliament passed the "Sexual Offences Bill, 2019," providing for the criminalization of a range of sexual offenses and sex acts between consenting adults. This further criminalizes people living with HIV, LGBTQI Ugandans, and sex workers and reintroduces a “ban” on homosexuality, as clause 11 of the bill criminalizes same-sex intercourse, with a sentence of five-years of imprisonment if convicted. In light of this bill, the environment remains unwelcoming for KP and this will affect PEPFAR's work.

During COP20, PEPFAR Uganda's Key and Priority Populations program put in place KP tracking systems that ensure that KP tested and found HIV positive are initiated into treatment and followed up to ensure treatment continuity. 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%. PEPFAR Uganda demonstrated positive outcomes from deploying KP peer navigators as linkage facilitators, and under COP20/COP21, the training and remuneration for these peer outreach workers will be standardized. KP peer navigators and PEPFAR IPs will collaborate 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 COP21 Guidance

Uganda is on course to achieve all the COP21 minimum program requirements (MPR) as identified in the PLL. (See MPRs and new site-level requirements in Appendix D). The few remaining MPRs from the COP20 PLL include the 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 was gained on solutions. Below is a brief status update on progress towards COP20 MPRs:

- In FY21, GOU has committed to providing $52 million and accelerating the transition of PEPFAR-supported HRH to the government.
- Commodity security continues to improve through aligned USG, GOU, and Global Fund investments; for the first time, beginning in COP 20, Uganda holds a six-month ARV buffer. Three- and six-month dispensing is occurring with plans for further scale-up of MMD to eligible clients.
- Current government guidelines allow for AGYW and pregnant and breastfeeding women (PBFW) to access PrEP, but some of the target populations are not accessing PrEP services for various reasons. HIV clinicians and primary care providers may lack training or be unfamiliar with PrEP and might, therefore, lack confidence in PrEP prescribing. Research findings from other countries suggest that some providers may have concerns that PrEP might cause unintended harms (such as toxicity in otherwise healthy individuals) and that clients might not adhere to the regimen or might use PrEP in a manner that could compromise effectiveness (e.g., intermittent dosing). In COP21, PEPFAR will continue to use root cause analyses to pinpoint the reasons underlying health providers reluctance to prescribe PrEP and reasons for clients' hesitation to uptake PrEP. That information will improve our approaches, and we 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 COP20 and to be implemented at scale in COP21. This approach, along with increased investment in the health information system (HIS) infrastructure, will allow for a better understanding of the epidemic and improved case management information, such as the numbers of individuals on treatment and which services each is receiving. This is expected to assure linkage and improve the continuity of treatment.

In partnership with GOU, PEPFAR Uganda has committed to promoting quality and client-centered services to achieve and sustain epidemic control. In COP21, USG will aim to attain 97% of clients diagnosed, 94% of all PLHIV 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 essential. 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, continuity of treatment, 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 the development and implementation of national dashboards accessible at all levels of the health systems, adapted SIMS/surge

assessments to address unique facility challenges, and the expansion of the Uganda CSO CLM program that was launched in June 2020.

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	43,713,629		9,825,605	23	10,004,810	23	4,645,695	11	4,662,046	11	7,676,013	18	6,899,460	16	Population projection for 2021 UBOS
HIV Prevalence (%)	*	6.2	*	0.7	*	0.4	*	3.3	*	0.8	*	10.7	*	7.7	UPHIA 2016
AIDS Deaths (per year)	17,245	*	2145	*	2200	*	1258	*	826	*	5449	*	5367	*	Spectrum estimates 2021
# PLHIV	1,420,812	*	v	*	44,648	*	111,252	*	44,333	*	724,149	*	452,747	*	Spectrum estimates 2021
Incidence Rate (Year)	*	88/ 100,000 popn.	*	*	*	*	*	*	*	*	*	*	*	*	Spectrum estimates 2021
New Infections (Yr)	34,806	*	*	*	*	*	*	*	*	*	*	*	*	*	Spectrum estimates 2021

Annual births	1,875,315	*	*	*	*	*	*	*	*	*		*	*	*	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	88,466	*	*	*	*	*	*	*	*	*	*	*	*	*	Spectrum Estimate 2021
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*	44,397	*	*	*	*	*	*	*	*	*	*	*	*	*	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	179,116	*	*	*	*	*	*	*	*	*	*	*	*	*	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	7,169	*	*	*	*	*	*	*	*	*	*	*	*	*	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	14.9–35	*	*	*	*	*	*	*	*	*	*	*	*	*	HIV Knowledge, Attitudes, and Practices and Population Size Estimates of Fisherfolk in 6 Districts

(Adults)															in Uganda. IOM 2013. https://www.iom.int/news/ugandan-fishing-communities-high-risk-hiv-aids-iom

**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.

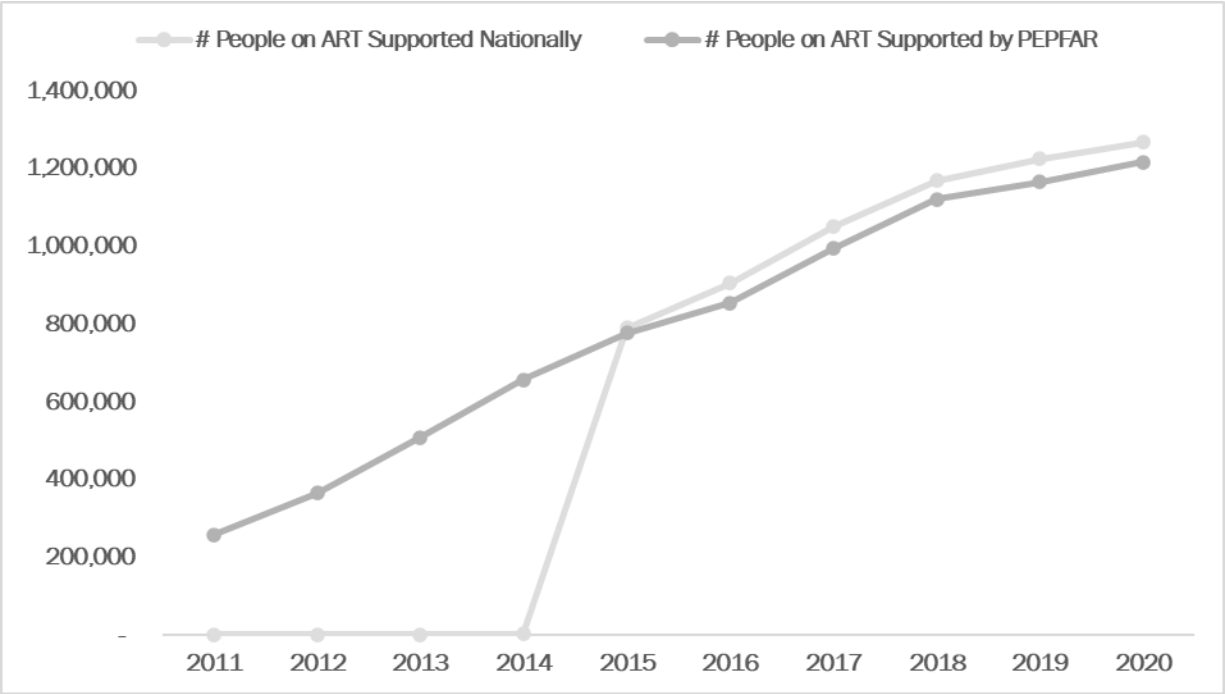
However, age disaggregation data is only available for the age groups < 15 Years and 15+. Data for Sub-disaggregation of 15-24 years and 25+ are not available. Therefore, the figures inserted under the 15 – 24 age categories are for cases aged 15+ years

* *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	43,713,629	3%	1,421,290	1,238,938	1,235,466	100%	79%	8,032,305	232,572	187,769	81%
Population <15 years	19830415	0.4%	93,901	64,904	64,843	100%	75%	606,960	7,263	7,869	108%
Men 15-24 years	4,662,046	0.9%	46,796	27,196	27,058	99%	58%	718,368	8,151	6,768	83%
Men 25+ years	6899460	6.6%	468,653	373,801	372,688	100%	77%	1,139,978	52,704	56,772	108%
Women 15-24 years	4645695	2.4%	112,082	88,054	87,306	99%	75%	1,421,502	36,513	35,947	98%
Women 25+ years	7676013	9.4%	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	44,397	12.7	5,625	*	*	*	*	11,771	389	141	30%
FSW	179,116	31.3	54,351	*	*	*	*	82,922	3,698	3,342	90%
PWID	7,169	16	1,148	*	*	*	*	4,510	171	233	136%
Incarcerated populations	157,350	15	23,603	*	*	*	*	77,383	2,636	2,561	97%

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

Figure 2. 2 Updated National and PEPFAR Trend for Individuals currently on Treatment



*Data from DHIS2 was only available starting 2015

Figure 2. 3 Updated Trend of New Infections and All-Cause Mortality Among PLHIV –

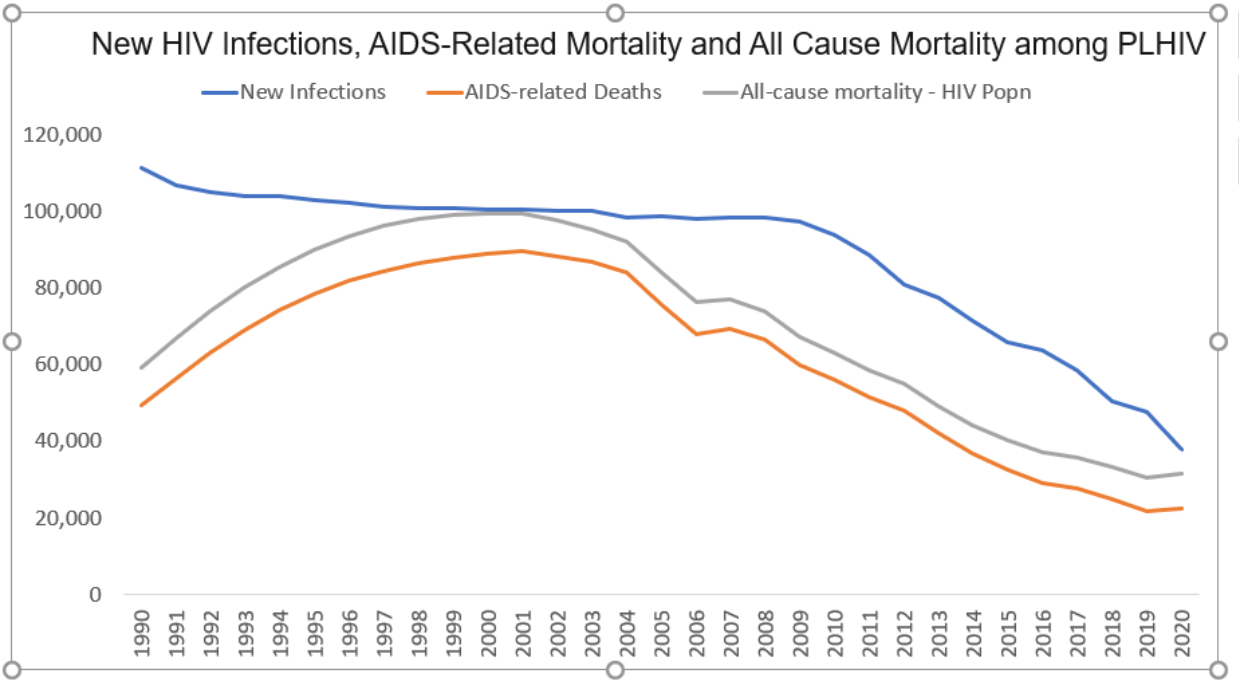


Figure 2. 4 Spectrum Estimates for the period of COP19 to COP 21

	COP19	COP20	COP21
CLHIV <15	96,742	88,547	88,331
PLHIV 15+ Male	511,795	520,358	497,081
PLHIV 15+ Female	784,909	822,648	835,400
Total PLHIV	**1,393,445**	**1,431,553**	**1,420,812**

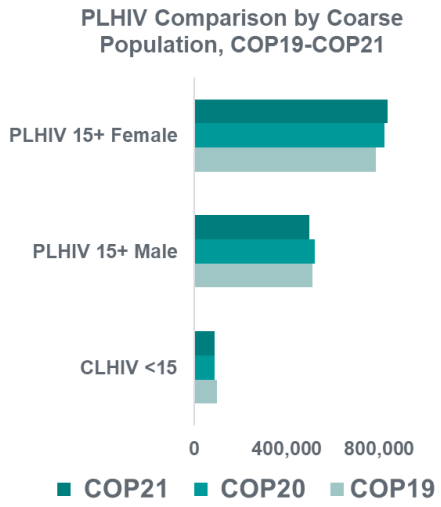


Figure 2. 5 Epidemiologic Trends and Program Response

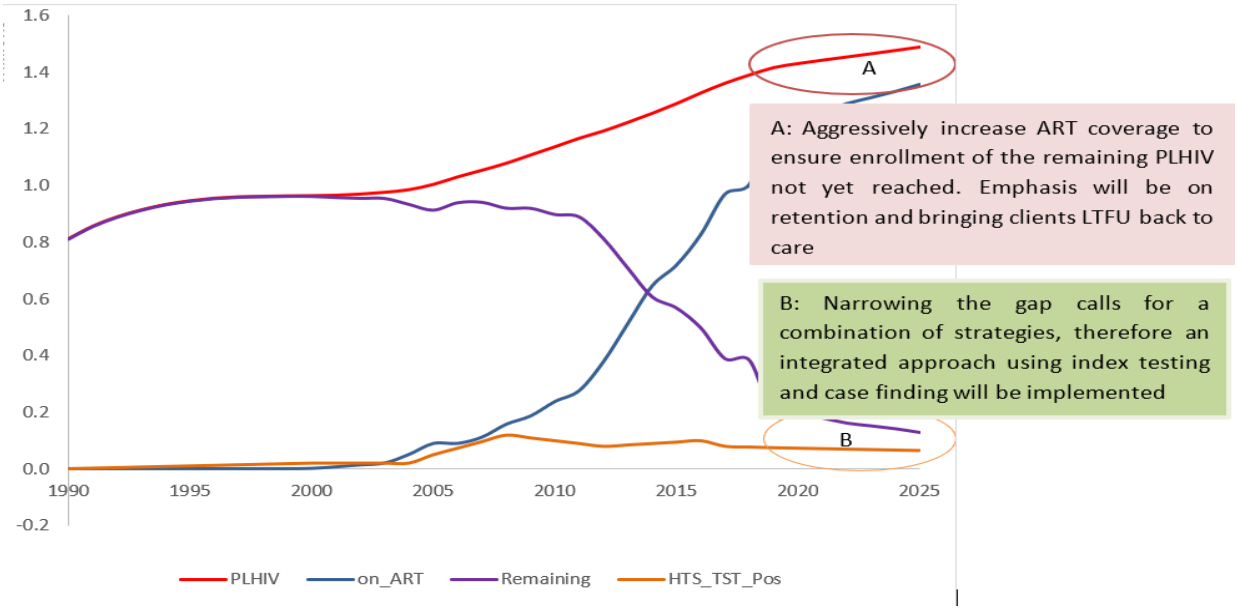
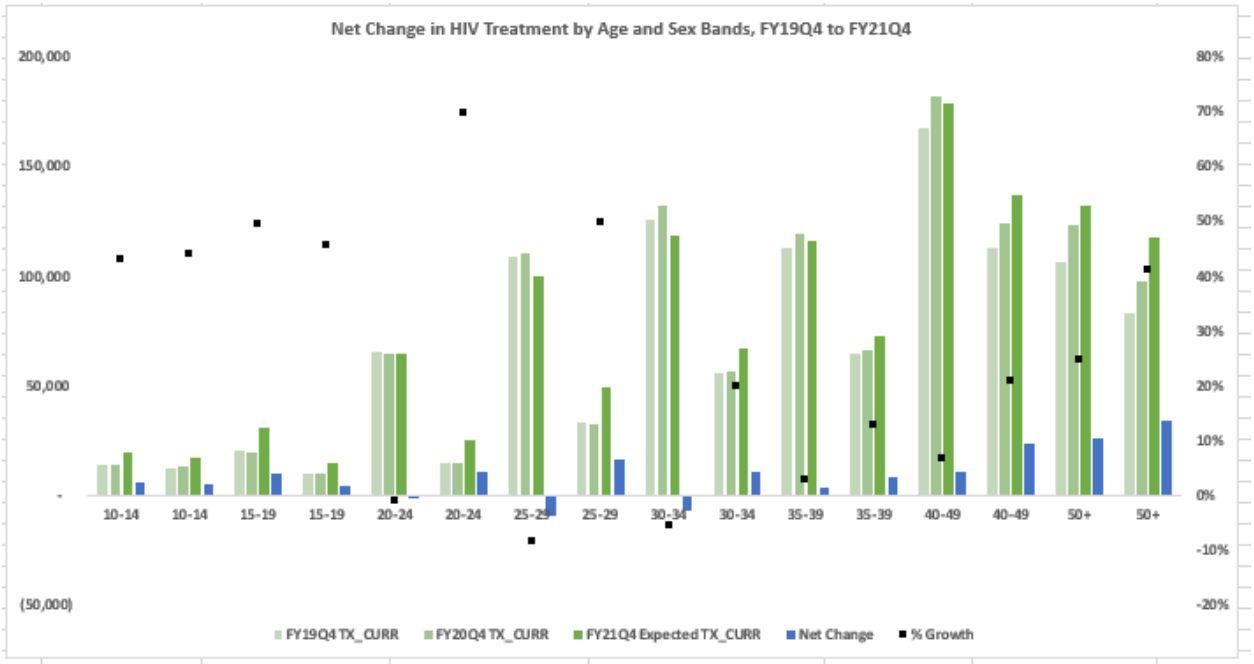


Figure 2. 6 Net change in HIV treatment by sex and age bands, FY18 Q4 to FY21 Q4



2.2 Key Activities and Areas of Focus for COP21

Consistent with COP21 guidance, and with S/GAC communications to Ambassador Brown and the wider PEPFAR Uganda team, no substantial changes in Uganda's program direction are called for under COP21. The S/GAC Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction letter dated January 13, 2021, did confirm that PEPFAR Uganda's fundamental challenges continue. Under COP21 PEPFAR Uganda will prioritize and intensify our efforts to achieve measurable progress towards the following issues:

- Continued efforts to reduce new HIV infections in adolescents and young women
- Ensuring men are diagnosed and treated early
- Ensuring 15-35-year-old asymptomatic clients are maintained on treatment and virally suppressed
- Ensuring that all children are diagnosed, receive optimal pediatric treatment regimens, and are virally suppressed
- Supporting key populations with prevention and treatment services

The above-specified fundamental challenges are common to many PEPFAR programs worldwide.

There are also key challenges specific to Uganda with which our PEPFAR program continues to grapple. Discussed below are some of the approaches we will take in COP$_{21}$ to mitigate each:

To address continued new HIV infections in adolescents and young women, the DREAMS program will expand, particularly in urban areas and select townships, and the platforms will also be used to implement social network HIV testing services in urban centers to locate adolescents at the highest risk of infection. In COP21, PEPFAR Uganda will explore whether it is feasible to begin supporting the implementation of comprehensive clinical care services for select eastern districts where AGYW are under-served to ensure that vulnerability and risk are reduced and new infections are averted. This approach must first be discussed and agreed upon by the PEPFAR Uganda agencies and S/GAC.

The MenStar findings and approaches, as well as the Faith and Community Initiative (FCI) "Messages of Hope," will be employed to engage men to manage their own health, starting in COP 21 and throughout COP22. PEPFAR's Strategic Behavior Change Communications activity 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.

A focus on client continuity of treatment will be our starting point to reduce Uganda's high levels of treatment interruption, particularly for those newly initiated on ART, and with a focus on treatment continuity among young men and adolescents. Core interventions to improve treatment continuity and VL suppression in adolescents, for example, will include peer support, OVC services, and differentiated service delivery.

To close significant gaps in both the pediatric and adolescent cascades, from weaknesses in EID coverage to viral load suppression of adolescents**,** PEPFAR Uganda 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. The MOH is leading an "HEI surge" to improve testing and case identification, and PEPFAR Uganda-supported health facilities will adopt the "HEI surge" approach. We will also continue to support pediatric regimen optimization. EID is critical for the timely initiation of ART in HIV-infected children who are at high risk of mortality. In COP20 and COP21, PEPFAR Uganda will improve the efficiency of EID testing platforms to improve early identification of HIV-exposed infants and timely ART initiation and treatment continuity for all eligible infants, including by expanding POC EID, consistent with the new WHO technical guidance.

Key population programming in Uganda has faced tremendous challenges due to the legal and cultural context. On May 3, 2021, Parliament passed a bill that targets the LGBTQI community and sex workers, and the environment has become more unwelcoming for KP. This could make our work more difficult. 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 KP peer outreach workers and in collaboration with CSOs to ensure that identified KPs are linked to care and are retained. Once the GOU has cleared on the use of unique identifier systems, our program's KP case management is anticipated to significantly improve, as will be our ability to track the various HIV-related health services that a KP client is receiving.

Implementation of interventions and mitigation measures to address Minimum Program Requirements and Directives of S/GAC

The S/GAC Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction letter dated January 13, 2021, confirmed the minimum program requirements and specific country directives for PEPFAR Uganda. The Minimum Program Requirements (MPRs) and the country directives are based on S/GAC's FY 2020 Analysis of PEPFAR Uganda's Performance as well as key implementation challenges noted.

All PEPFAR programs are expected to have the following minimum program requirements in place by the beginning of the COP22 implementation (FY2021). Adherence to policies and implementation practices as specified by S/GAG in the PEPFAR Planned Allocation and Strategic Direction letter will be essential to the success of PEPFAR Uganda's interventions during COP22 at national, subnational, and service delivery levels. S/GAC's rationale for the MPRs is that evidence demonstrates that the lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs.

Appendix C includes a table detailing the COP22 Minimum Program Requirements, and **Appendix D** includes a tracking matrix for documenting the progress towards meeting remediation plans proposed to meet and comply with the MPRs.

2.3. Investment Profile

While the GOU has a 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). According to the most recent National Health of Accounts (NHA), Uganda's THE in FY19 was $36.9, which is far less than $86 recommended by WHO. GOU health sector budget for FY 21/22 is 2.6 trillion UGX, a decrease of about 10% from last year. The health budget remains at around 6% of the national budget like last year. Out-Of-Pocket (OOP) expenditure remains extremely high at 38.6% in 2018/19, drawing families into deeper levels of poverty. According to the recent National AIDS Spending Assessment, in 2018/19, 83% of funding for the Ugandan national HIV response comes from external donors, mainly PEFAR and GF. Uganda has received a grant worth $602.5m from the Global Fund for the period 2021 to 2023. Of this, $339.5m will be allocated to supporting HIV/AIDS, for which about 80% will be for commodities. While this has helped advance the epidemic control efforts, the heavy dependence on donor assistance will compromise the long-term sustainability of the program.

The COVID-19 pandemic also had a negative impact on the economic situation in Uganda. In FY 20, the economy grew at 2.9%, far less than the projected 6.8% at the start of the financial year. In effect, this puts further strain on the economy in general and in the health sector in particular, where the expected government health sector budget is expected to be further reduced.
Whereas the government contribution to HIV/AIDS response has increased by about 48% from 2008 to 2018, this increment is not aligned to the current need for financial sustainability. Under the leadership of MOH and working with other development partners, PEPFAR is supporting the development of a health financing transition and harmonization plan.

In COP19, GOU increased funding for ARVs from $24 million in the past years to $39 million. In FY2021, the GOU provided $13 million in additional funding for ARVs and lab commodities, increasing the total GOU contribution to $52 million for HIV commodities. While this is commendable, more needs to be done to increase domestic resources for HIV/AIDS. The financing and harmonization plan that the USG is developing in close collaboration with the GOU and other stakeholders is expected to facilitate negotiations with the GOU in this regard and will lay the groundwork for the ultimate transition of the HIV program to the government.

A table showing GOU commitment to HIV/AIDS response for the next 5 years

	2020/21	2021/22	2022/23	2023/24	2024/25
	USD (millions)				
NSP annual estimates	**732.53**	**780.31**	**836.03**	**851.56**	**908.73**
GOU commitment	82	82.82	83.65	84.48	85.33
Development Partners' commitment	507.52	522.82	523.66	428.07	432.17
Total commitment	589.52	605.64	607.31	512.55	517.5
Funding gap	143.01	174.68	228.72	339	391.22
Proportion of GOU contribution to the response	**13.9%**	**13.7%**	**13.8%**	**16.5%**	**16.5%**

Source: The National HIV and AIDS Strategic Plan 2020/21 – 2024/25

Development Partners and CSOs continue to play an important advocacy role to ensure GOU financing for key interventions is gradually increased to attain and sustain epidemic control. Key areas for negotiation in the transition plan will include PEPFAR supported HRH and funding for commodities. PEPFAR Uganda is 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. Preliminary data from the analysis have been presented to the PEPFAR interagency team, and the national steering committee established to oversee the process. Analysis from the ABC/M exercise is expected to inform future resource allocation decisions by PEPFAR while improving program efficiency. However, more technical assistance will be needed to refine the data and methodology to institutionalize ABC/M as a routine costing approach in the local context.

The Ministry of Health continues to improve resource tracking in the health sector, including for HIV/AIDS. The Ministry of Health 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.

Figure 2. 7 Uganda Gross National Income per Capita (US $)

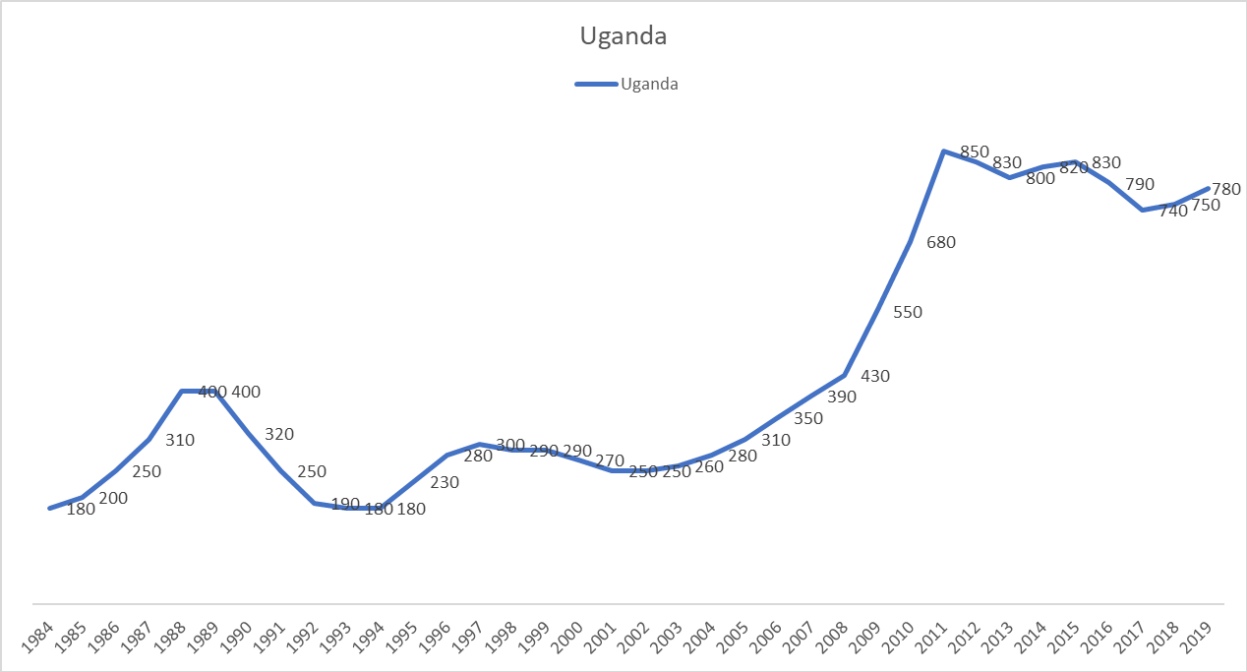


Table 2.3.1- Investment Profile by Program Area

Table 2.2.1 Annual Investment Profile by Program Area 2019/20					
Program Area	**Total Expenditure**	**PEPFAR**	**Global Fund**	**Host Country**	**% Other**
Clinical care, treatment and support	$ 321,772,066	$ 208,253,190	$ 75,624,139	$ 37,894,737	
Community-based care, treatment, and support	$ -				
PMTCT	$ -				
HTS	$ 27,358,608	$ 16,954,567	$ 10,404,041		
VMMC	$ 32,378,251	$ 32,378,251			
~~Priority population prevention~~					
~~AGYW~~ General Prevention		$ 19,216,358	$ 6,936,284		
~~KP prevention~~					
OVC	$ 23,686,878	$ 20,844,195	$ 2,842,683		
Laboratory	$ 2,209,658	$ 2,209,658			
SI, Surveys and Surveillance	$ 10,368,660	$ 10,368,660			
HSS*	$ 11,272,073	$ 8,921,073		$ 2,351,000	
Total	$ 455,198,836	**$ 319,145,952**	**$ 95,807,147**	**$ 40,245,737**	

Table 2.3.2 Annual Procurement Profile for Key Commodities					
Commodity Category	**Total Expenditure (USD)**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs	137,343,870	28.3%	43.0%	28.7%	0.0%
Rapid test kits	9,506,264	28%	58%	14%	-
Other drugs*	6,355,659	47.2%	46.9%	5.9%	-
Lab reagents**	18,505,791	49%	51%	-	-
Condoms	12,015,397	-	87.9%	-	12.1%
VL commodities	31,413,919	74%	11%	15%	-
VMMC kits	17,852,385	100%	-	-	-
MAT	-	-	-	-	-
Other commodities***	22,898,062	54%	35%	11%	-
Total	255,891,347	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	$15,000,000	$11,350,000	12	$55,101,898	Support programs to improve maternal, neonatal and child health
USAID TB	$7,000,000	$5,710,919	11	$52,526,929	Support programs to reduce TB related mortality and morbidity
USAID Malaria	$35,000,000	$4,074,800	10	$53,792,792	Support programs to reduce malaria associated mortality
Family Planning	$27,000,000	$14,420,000	16	$59,050,858	Support programs to increase contraceptive prevalence and birth spacing
USAID COVID 19	$3,350,000	$3,350,000	7	$43,528,772	COVID-19 support
USAID (Global Health Security Agenda)	$900,000	9	0	0	Risk Communication and Supply Chain Strengthening
NIH	N/A				
CDC (Global Health Security Agenda)	$30,348.000	$11,982000 5.05M	17	2 $480,692	Surveillance, Workforce Development, Emergency Response, Health Information Systems, Laboratory, Anti-Microbial Resistance (AMR), Ebola Response Surveillance, Workforce Development, Emergency Response, Health Information Systems, Laboratory, Anti-Microbial Resistance (AMR), Ebola Response
Peace Corps	N/A				Peace Corps Uganda receives only PEPFAR funding
DOD Influenza	$1,100,000				Supporting Influenza Surveillance and AMR prevention
MCC	N/A				
Other (specify)					
Total	**T/B/Confirmed**				**WILL CONFIRM WHEN USAID GHSA DATA ARE INCLUDED**

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, Global Fund 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 have also attained encouraging levels of sustainability. However, there is a 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 the supply chain for HIV services. Similarly, there is concern about the continued need for external support for human resources in order to mitigate the effects of the staffing gaps at subnational and national levels for service delivery, leadership, and oversight capabilities.

Table 2.4.1 Sustainability Domains and Elements

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

Sustainability Strengths:

- **Planning and Coordination:** The national-level strategic planning and coordination of the response are led by the UAC. The governance of the response is strong, and the active involvement of the private sector and civil society adds strength to the sustainability of this element. At the district level, there is a need to consolidate the planning function and improve coordination regarding 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 the 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.

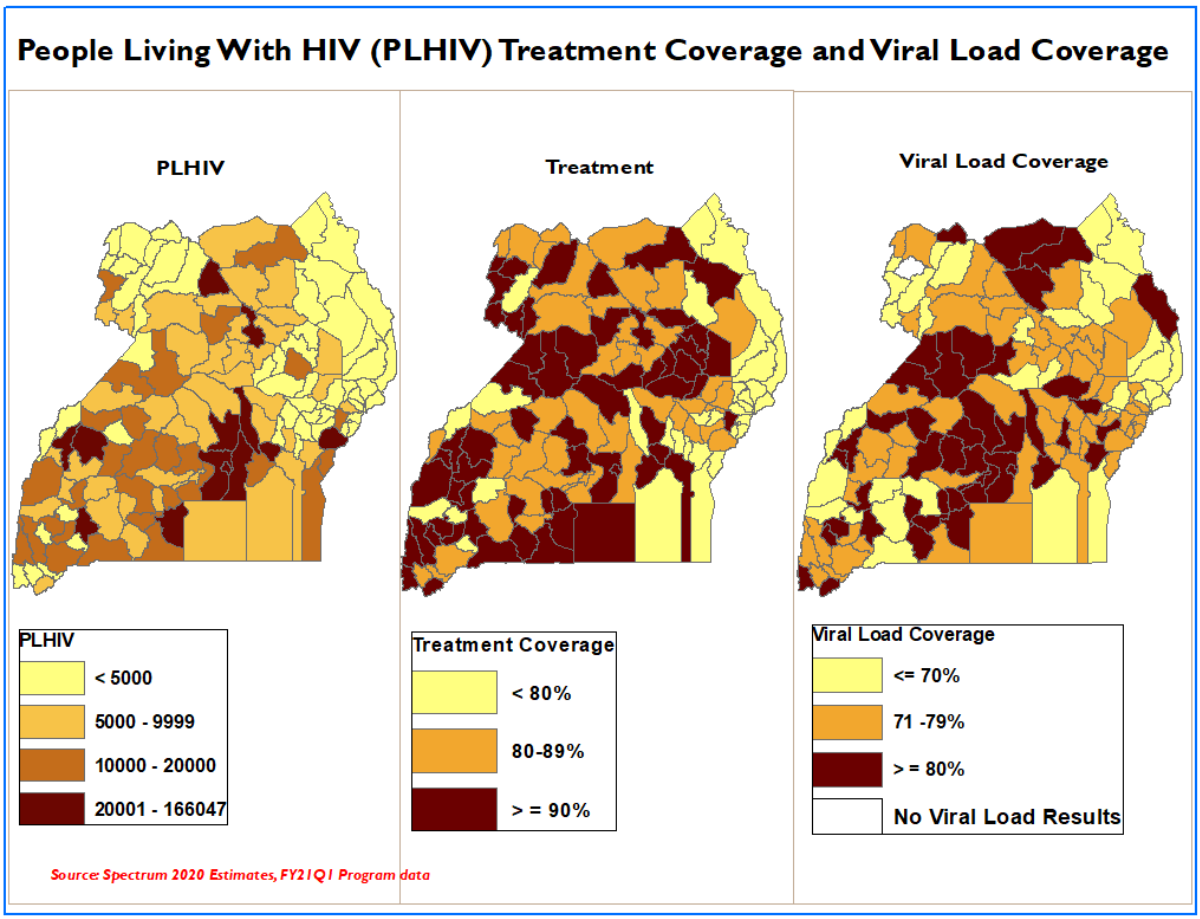
- Regarding Uganda's contribution to the HIV response, the GOU scored itself as having 'Primary Responsibility' in strategy formulation/planning and service delivery, with 'Secondary Responsibility' in many cases in non-service delivery arenas (Responsibility Matrix 2019). PEPFAR scored 'Secondary' in the strategy formulation and service delivery section, with 95% of the non-service delivery considered primary, as it is the GOU's 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/continuity of treatment, male circumcision, key and priority populations, and OVC. PEPFAR also provides significant commodities, training, and supervision. Global Fund 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 2016-2017 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. 8 Maps showing percent PLHIV by SNU, total PLHIV by SNU, coverage of total PLHIV with ART, and VL coverage by SNU.



2.6 Stakeholder Engagement

To achieve sustained control of the HIV/AIDS epidemic, it is essential that PEPFAR teams actively and routinely coordinate and communicate with stakeholders and partners who can provide valuable insights that improve the impact and accountability of programs. Key stakeholders include the Government of Uganda, multilateral organizations, other bilateral donors, the private sector, and civil society, including faith-based organizations. All these participated in the COP/ROP21 virtual Regional Planning Meeting of April 26 and 27, 2021.

For COP21 planning and implementation, PEPFAR maintained the active and expanded engagements of stakeholders in all aspects. PEPFAR will ***continue working closely with the Government of Uganda, partners and civil society to ensure alignment with in-country policies*** as we update and distribute the date-stamped Technical Guidance to inform PEPFAR implementation as COVID-19 developments continue to unfold across the world. At a planning

level, PEPFAR Uganda conducted an in-country strategic planning consultation with local stakeholders by the end of January 2021. The retreat introduced and discussed all COP21 tools, guidance, results, and targets, as well as the proposed trajectory and strategy for COP21. Even after COP21 submission, the engagements will continue. ***Table 1 in this section highlights how PEPFAR Uganda is expected to continue expanding the meaningful engagements.***

To ensure strengthened accountability and transparency even within the virtual COP21 planning process, PEPFAR Uganda joined the Community Led Monitoring regional and national level dialogues, National TWG platforms, and the various PEPFAR facilitated stakeholder forums that provided a basis for priority identification. Prior to COP submission, PEPFAR Uganda shared key documents, including the Strategic Direction Summary (SDS) and final targets, with key stakeholders for their final feedback.

At the release of the COP21 guidance, a COP21 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 Global Fund 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 Global Fund committees.

The chart below summarizes the different COP20 ongoing engagements to which stakeholders were involved and as well highlights planned engagement for COP21 implementation.

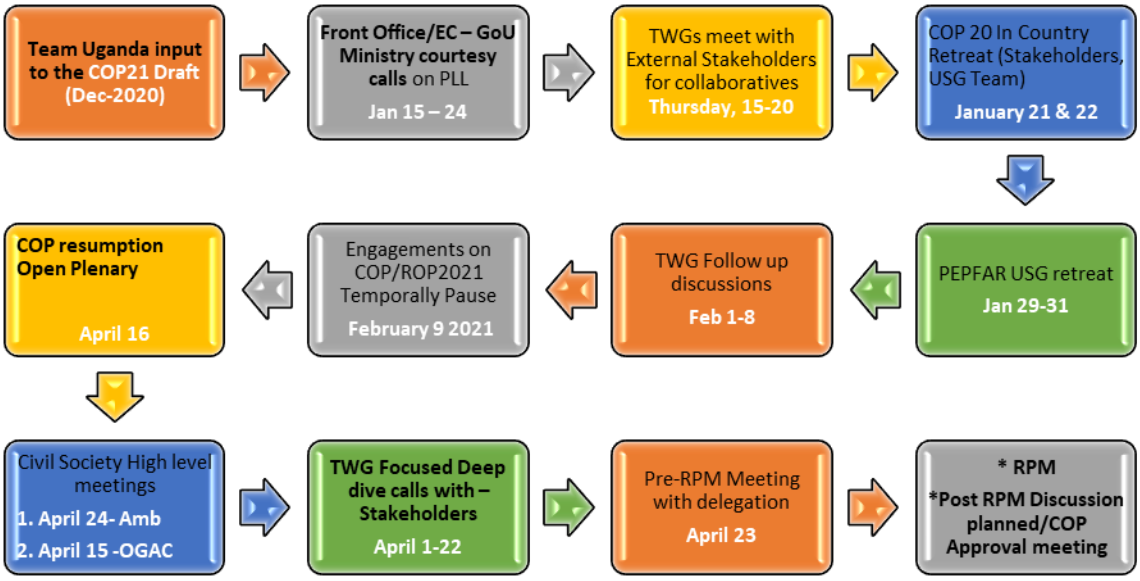


Table 2.6.1 summarizing the PEPFAR and CSOs agreed upon policy and programmatic actions and priorities for COP21

AREA	What does the evidence show (issues)?	PEOPLE'S COP21 PRIORITIES/ASKS	USG/PEPFAR Comment
COVID-19	Increased risk of new HIV infections (rape, sexual assault, physical violence, lack of schooling, loss of economic independence, shut down of DREAMS programs, lack of access to HIV prevention interventions such as VMMC and community programs) Increased risk of clinical progression particularly among children and women Human rights violations Some community adaptations out of necessity (e.g., door to door ART delivery)	PEPFAR should use COP20 and COP21 resources (including emergency COVID-19 funding) to put in place comprehensive programs to recover from the COVID-19 crisis, prioritizing the communities that experienced the most harm, such as targeted community cash transfers for the most vulnerable, access to justice for those who experienced violence. Communities must be consulted in developing and implementing this response. PEPFAR must carry out a surge in investment to direct IPs to find and support the return to care and treatment of the 62,871 people who experienced interruptions to treatment between Quarter 1 FY2020 and Q1 FY2021. PEPFAR should fund effective community COVID-19 adaptations so that they can be taken to scale nationally.	**Agree:** • COVID recovery interventions identified for ARPA funding include: additional support for child justice and violence response, community TB case finding, enhancement and expansion of DSD for PBFW, adolescents, and KPs; provision of PPE for PEPFAR-funded peers; and transport vouchers for vulnerable PLHIV in non-OVC supported districts. • PEPFAR continues to invest in intensified back to care efforts. Nearly 30,000 people returned to treatment during FY21Q1. The age- and sub-population tailored interventions to both retain clients and bring back those who are lost are detailed in the RPM slide decks which were shared. Data quality issues have also been identified and a data quality assessment (DQA) is underway to address "losses" that be an artifact of recording and reporting challenges. • $25M is being invested in community programming in COP21 through the C&T portfolio alone, $4.2M more than COP20 to support scale-up of interventions, including those demonstrated to be effective during the COVID epidemic.
VL Coverage	IDI Kampala and Mbarara RRH have very high VL coverage 97% IDI Kampala has a high proportion of patients on multi-month (6 months) dispensing. VL suppression poor among children and adolescents	These best practices should be identified and shared with all IMs	**Agree:** • PEPFAR will support MoH to establish regional QI collaboratives that will serve as learning platforms and address contextual challenges to VL coverage and other region-specific poorly performing program areas. • More point of care (POC) testing services for VL will be supported across the country
Interruptions to Treatment	Analysis for Q4 TX CURR presented a drastic drop because of interruptions to treatment (20,249), CLM community experiences indicate rude reception and punishment of clients returning to care by health facilities.	COP21 should invest in 'a friendly return to care' emergency medical and social support interventions to find people and bring them back to care, including treatment for advanced HIV disease ART/IPT optimization	**Agree:** • PEPFAR will continue to work with GOU to support CSO and health facilities to trace and bring back all clients who disengage from care. • COP21 includes funding to the national QI steering committee

			to prioritize review and incorporation of CLM findings into national and regional CQI collaborative activities, including the concern raised regarding reception of clients returning to care. • PEPFAR is closely tracking Return to Treatment/RTT as a key performance indicator and will continue to incorporate program adaptations as needs arise. Back to care efforts are on-going, with the involvement of peer supporters and community resource people with standardized compensation as agreed in COP20. • Treatment optimization will be finalized by Sept 2021. The global delay in production and distribution of the shorter regimens for TB Preventive Therapy (3HP three times weekly for three months instead of INH daily for six months) delayed COP20 implementation. Full 3HP implementation is included in COP21.
Client led Community Support groups	Some known client led Community Support groups are not functional; client led community groups like Mukono Girls Health Initiative (MUGHI), Community Health Livelihood Support Groups (CHLEGS) – this cross-cutting among most IPs.	Invest and leverage on client led support groups to fast track DSDM i.e., CLADDs in COP21.	**Agree:** • COVID-19 impacted group gatherings, including support groups. We encourage civil society to reconvene these groups following GoU COVID guidance now that restricts are being eased. • Expansion of Community Drug Distribution Points (CDDPs) and introduction of Community Retail Pharmacy Drug Distribution Points (CRPDDP) pharmacy refill are currently underway in COP20 and will continue in COP21.
Multi-Month Dispensing (MMD)	Multi-Month Dispensing (MMD) – continued low stocks and stock outs of ARVs affecting implementation of the MMD policy, still below average with very high rates of 1–3-month refills only central region performing better.	PEPFAR must scale up provision of 6-month ART refills, with a particular emphasis on vulnerable and/or mobile communities. MMD policy, still below average with very high rates of 1–3-month refills only central region performing better.	**Agree:** • Slow 3- and 6-month MMD expansion have been observed due to policy barriers, inadequate ARV stock at facility level as well as other implementation challenges. • PEPFAR is closely working with the National Medical Stores to improve facility level ARV stocks. • MoH disseminated a circular which addresses implementation barriers to treatment continuity and expands MMD eligibility. IPs are supporting facilities to implement this guidance.
Treatment Literacy	Health workers transit clients to TLD, without providing enough information and low levels of treatment and viral load literacy	PEPFAR must invest in a new, comprehensive treatment literacy program implemented by networks of people living with HIV in order to ensure people are	**Agree:** • PEPFAR continues to invest in treatment literacy in COP21 and appreciates the CSOs active

	Low levels of treatment literacy, low levels of demand for services (Viral load) Delays in test results	empowered and informed to demand quality services. PEPFAR should Invest more in Treatment literacy for COP21	involvement in the working group meetings and development of messaging and materials. • Delay in VL test results has been observed in Q1 and Q2 of FY21 due to inadequate VL test supplies caused by COVID-19; this has been largely resolved and we expect a quick turnaround of VL test results moving forward
Self-referrals	Self-referrals, facilities turning away clients with-out referral letters and eventually people drop-off treatment completely –	PEPFAR and GoU must actively facilitate inter-facility transfers and require all IPs to commit never to turn away a patient seeking care for lack of a transfer letter. PEPFAR must formally investigate and implement IP- and program-wide policy changes in response to the death of an 11-year-old patient seeking HIV and TB care at TASO Masaka, who was turned away from critical care because her caregiver had no transfer letter. Investigation results should be made available to the community. In COP21, responsibility for verification of client medical history be done by facility through improved inter-facility and inter-IP communication.	**Agree:** • PEPFAR has reiterated with partners the need to make patient transfers as seamless as possible, ensuring that no one is turned away from services. • As a critical component of client-centered care efforts, PEPFAR continues to collaborate with MoH on development of unique identifiers and a convenient client care registry which will be a centralized health information exchange that all facilities can access.
Community outreach programs	Community outreach programs not well resourced to conduct community case finding, linkage and referral. Found a disconnect between TB program from HIV program		**Agree:** • Integration of TB case finding, TB treatment, and TPT into DSD are already in the HIV guidelines; operationalization of the guidelines is a focus for COP20 and 21. Additional resources for this activity have been secured through COVID19 funding streams.
PrEP	Low awareness and coverage of PrEP services.	PrEP should be rolled out nationally as a core part of combination prevention in Uganda, with further expansion of targets beyond 95,000, and program adaptations such as same-day initiation. Adopt WHO guidelines for event driven PrEP for MSM, along with a communication strategy and demand creation activities. Accelerate roll out of the dapivirine ring and cabotegravir, along with a communication strategy and demand creation activities. Generate demand for PrEP services, particularly among at-risk AGYW and pregnant and breastfeeding women (PBFW). Integrate PrEP education in curricula that are used for parents and communities of AGYW. Scale PrEP as part of the combination prevention for pregnant in ANC	**Agree:** • PEPFAR will continue to work with SBCA our communication Partner and the Health Promotion department at the MOH to increase PrEP awareness not only for pregnant women in ANC but also among other eligible sub-populations like AGYW and PBFW. There has been a progressive increase in the PrEP targets and coverage since COP 16. The PrEP program expanded from 6 sites in 6 districts targeting 3,417 clients to 259 sites in 73 districts targeting over 90,000 clients in COP 20. We intend to increase the PrEP targets to 130,000 in COP 21. • PEPFAR will promote review and adoption of updated guidelines related to event-driven PrEP, and other evidenced-based prevention. This will pave the way for programmatic adoption and implementation.

Community Systems	COVID-19 left families and children in a dire situation, IPs provided minimal help beyond treatment, and in some cases, not even that. National assessment of 88 families shows virtual abandonment by clinical partners.	COP21 reprogramming is needed to extend support and to rectify that harm. invest in emergency funding grants needed for families.	**Agree:** • PEPFAR will continue to work with CSO, and GOU to review and implement the standardized remuneration approach across the various PEPFAR IPs and continue to work with GOU on a sustainable community staffing approach. • PEPFAR is exploring additional opportunities to support most vulnerable populations impacted by COVID19. • During the COVID19 lockdown PEPFAR Uganda intentionally redirected resources to prioritize continuity of treatment including for most vulnerable PLHIV. This included ensuring ongoing support for parasocial workers supported by the OVC program as well as food assistance and linkage to government assistance programs for the most vulnerable households. Due to these efforts, Uganda was able to maintain 98% program treatment continuity despite the challenging environment compounded by elections.
Continuity of Treatment:	Barriers to quality services are undermining PWDs treatment continuity ● Staff and staffing levels having major impact on treatment continuity and quality ● Facility-based support groups exist in name only	PEPFAR should continue CLM funding at COP20 levels (net $1.56 million for the CLS program) for independent, community and PLHIV-led monitoring of quality and accessibility of services at PEPFAR-funded sites. Increased funding should be explored for expanded coverage. Resilient community systems for improved treatment continuity in COP21 Invest in community and facility infrastructure that will enable people with disabilities to access services without any structural barriers: priority investments are community facility linkage designed for people with disabilities. Carry out an assessment of the needs of people with disabilities who are living with HIV in order to establish a baseline regarding gaps in service quality and accessibility, with a focus on establishing the unique needs of this community. HIV materials should be made accessible for people with disabilities, such as sign language captions on posters, and sign language interpreters and captions for videos.	**Agree:** • Though the recently concluded National QI collaborative on Retention & VLS (Feb. 2020) and the ongoing Ped. & Adol. National QI collaborative, MoH/PEPFAR has continued to intensify efforts of capacity building of Regional, district & site level technical staff across the country focusing on low performing sites. • PEPFAR will continue to work with GOU to support CSO and Health facilities to trace and bring back all clients who disengage from care. • COVID-19 impacted group gatherings, including facility-based groups. Facility-based group ANC and adolescent groups are restarting as COVID19 restrictions are lifted. Further, we are relying on CSOs to encourage uptake of community models to allow for social distancing at facilities and minimize the risk to clients
KP and PP	Robust and scaled up KP and PP HIV care and prevention programs	All community-based DICs must be accredited and equipped to provide on-site, 24-hour medical HIV treatment and prevention. DICs should be expanded beyond the current number, focusing on retaining current DICs while rolling out this approach in USAID	**Agree:** • The KP program has expanded over the years to the current 55 SNUs, whose selection was informed by triangulation of UNAIDS size estimation, incidence, KP category specific prevalence and program

		supported regions/sites. KPIF funding ($10 million for two years, implemented by CDC) should be retained in the COP21 budget—there must be no cuts to KP budgets even though the KPIF is ending. These resources should prioritize capacity building of key population-led organizations, and the tools should be nationalized so that USAID-funded regions/sites are not disadvantaged. Prevention for PP, KP, and Women and girls living with HIV Robust and scaled up KP and PP HIV care and prevention programs	performance. • The KP and PrEP programs have been aligned to improve access and retention in PrEP. • The program has set targets along the clinical cascades and is using the KP tracker to monitor and address patient level outcomes • In COP21, the program is expanding IBBS from Kampala to 6 (possibly 12) additional cities. Exact number of cities t/b/d • We are conducting a Legal environment assessment in COP20 and will address findings in COP21 • **CLARIFICATION: The KPIF funding was a one-time, one-off two-year grant from OGAC. It is not an ongoing source of funding**.

EID Access and Pediatric HIV	Low Point of Care testing coverage (POC). WHO has revised their guidelines; all <18-month-old children 'should' receive POC.	PEPFAR must dedicate a funding stream to returning pediatric clients and caregivers to treatment and provide direct cash transfers to address profound economic shocks that have undermined HIV treatment outcomes.
		
		All children living with HIV should be linked to comprehensive OVC services starting in FY20 and continuing to FY21. Functional family support groups should be established for all sites providing PMTCT services, along with 100% coverage of the Mother Baby Care Points and Mentor Mothers approaches, which have been shown to result in higher levels of viral load suppression and better retention in quality care.
		
		Introduce a transport voucher system for caregivers with children living with HIV to counter the impact of COVID-19.
		
		PEPFAR should budget and plan for providing universal POC EID testing for children exposed to HIV <18 months old.
		
		Urgently implement shift to new pediatric DTG formulation for children <10kgs.
		
		Implementation of the proposed "Children of KPs" program should meaningfully consult first with caregivers who are KPs, including mothers and fathers, on all aspects of design, implementation, budget and accountability.
			Agree:
			• PEPFARs goal is for universal access for EID testing and rapid linkage of HIV positive infants to HIV treatment.
			  • For COP 21, PEPFAR Uganda will support the MOH to scale up EID POC services.
			  • Program implementation will be strengthened to support optimal EID POC scale-up, ensure commodity availability and effective Laboratory Management Information systems for EID POC data at all supported sites.

Index Testing:	IPs are 'monetizing' Community Index Testing by paying CHWs/VHTs to go to the field for contact tracing. This is unethical; is induces CHWs/VHTs to do contact tracing in person so he/she can get funds, whether the client wants it or not Annual assessment is not fixing the lack	All sites that failed their 2020 assessment regarding IPV and/or adverse event reporting should be temporarily halted from carrying out index testing until appropriate standards are put in place at the site level. Site assessments for 2021 should be done by an independent entity.	• **Agree:** The national guidelines stipulate that sites that fail REDCap baseline assessment should be halted from offering index testing services until gaps identified are addressed and re-assessments are done with 100% pass. In line with

	of quality in the testing program High success rates signal something could be wrong Remediation plans are not transparent What did the evidence show? ● About 50% of 566 patients interviewed reported that they were not given reason asking for index names and contacts ● Sites had index testing assessment tools laminated and on display but unclear that counsellors understood them.	No monetary or other incentive should be provided as part of index testing services—instead all Community Health Workers should receive a standard level of remuneration, $50/month. IP-level testing sub targets should not be communicated. A formal mechanism for high level reporting of adverse events and IPV must be developed. CDC should stop carrying out index testing in UPS.	the guidance index testing was suspended at all the sites that failed baseline assessments. Throughout June 2021, PEPFAR Uganda will be working with IPs to discern the technical and capacity gaps in these sites and drawing up remedial plans. • At a meeting of May 5, 2021 between PEPFAR Uganda and the CSO community, it was agreed that site assessments should not be conducted by IPs only, as this raises concerns on the independence of the exercise and the subsequent results. Therefore, going forward, assessments will be conducted by a combined team of USG staff (at least one), district representative, IP staff and a CSO representative recommended by the Community Led Monitoring team. • PEPFAR Uganda does not pay monetary incentives for either staff or clients in its index testing program. In the May 5 2021 meeting, all agencies made a commitment to reassess current practices within index testing program to ensure that no monetary incentives are given. A provision was made in COP21 budget for payment of a monthly stipend of $50 for Community Health Workers, to support community level HIV services across the HIV prevention, care and treatment portfolio. • Index testing targets are disaggregated up to district level and IPs are discouraged from apportioning and communicating these targets down to facility level. • COP21 has no provision for index testing within the Prisons program. The national guidelines stipulate that disclosure of sex partners is purely voluntary and clients must be adequately counselled on this need and potential for IPV extensively assessed. This message will continue to be reinforced through site monitoring and capacity as

			well as manpower gaps filled where they exist.
Structural Drivers of New Infections and Poor Outcomes: GBV, Economic Empowerment, Stigma and Discrimination, and Criminalization	Community Led Monitoring has found that the following is a barrier to service uptake and is a driver of new infections: There was indication that service providers doing index testing have robust GBV programming, but all clients think they must provide sex partners' names	Provide funds through either its IPs or other appropriate channels funds to improve the economic status of targeted populations i.e., PWDs, AGYW, KPs, women living with HIV and other high risk groups. Scale up funding for comprehensive GBV programming and trauma-informed services across the program, focused on and platforms where more women seek health care services. PEPFAR should fund HIV-positive religious leaders who are active in the faith-based sector in Uganda to develop and implement evidence-based interventions to fight HIV stigma and discrimination and who espouse progressive principles and values. These interventions will first target other religious leaders and will become a robust and high-impact engagement of the faith-based sector in fighting against all forms of stigma and discrimination that harm people living with HIV and key and vulnerable populations. We restate our recommendation from COP20: 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. • GBV prevention and response among women and girls should be key in COP21 • Addressing social and structural barriers to access including GBV and stigma and discrimination	**Agree:** • OVC continues to support the child justice sector as well as the Child Health Line as part of GBV response efforts. GBV prevention program is focusing on both skill building and norms change interventions.
Supply Chain	No data on strategy for switching Large stocks of expiring TLD. Dated Dec 20 TX-CURR of 5000 e.g., Barapwo HCIII Stocked out of ART, STI treatment, NVP syrup Q2-Q3. Patients told to buy during COVID-19 restrictions	The practice of people being told they must buy HIV medicines from private clinics violates PEPFAR's Minimum Program Requirement (MPR) of "elimination of all formal and informal user fees." PEPFAR must increase funding to focus on ensuring medicines actually reach communities, on time and in full at 100% of its supported sites PEPFAR must at minimum double its funding for STI treating and tests in order to address chronic facility-level shortages (Cross reference: Prevention) A clear COP21 plan on Supply Chain.	**Agree:** • Regarding large stocks, PEPFAR will continue to work with GOU (MOH, NMS, JMS) and partners to ensure all patients receive medicines without any break in service. • PEPFAR has increased funding for STIs in COP 21 by about 50%. In addition, IPs will work closely with CSOs to leverage the STI drugs from the GoU health facilities that come in as part of the primary health care
HRH	Most of the health center IIIs and IVs were understaffed and the health workers were often over whelmed with the workload	Ensure all IPs pay CHWs a minimum of $50/month, with no per-client "incentives" permitted; a best practice for minimum concentration of CHWs for quality	**Agree:** • PEPFAR already passed a circular to all IPs in October

		programming should be rapidly established and IPs instructed to recruit and deploy staff accordingly. PEPFAR must develop a sufficient, standard CHW-to-client ratio and use that ratio to direct IPs to use their budgets to hire sufficient CHWs. Require IPs to increase their spending on staff providing clinical services in poorly performing clinics. Work with the Government of Uganda (GoU) to urgently revise outmoded staffing norms COP21 should prioritize on HRH coverage	2020 instructing them to pay the minimum $50 for CHW per month. Going forward, the USG team will monitor implementation of this guidance across all IPs to ensure it is being followed. • PEPFAR will continue to work with GOU to prioritize appropriate Health Sector HRH coverage, and staffing
DREAMS	DREAMS programs have stalled due to COVID-19; high default and low completion rates point to need for further overhaul beyond COP20 priorities	PEPFAR should commit to "dream bigger" with an overhaul of the DREAMS program, in order to address new HIV infection risks AGYW are experiencing as a result of COVID-19 restrictions, as well as chronic underperformance of the program. This overhaul should be guided by AGYW.	**Agree** • PEPFAR has expanded the geographical coverage for the DREAMS program from 10 to 24 districts since COP16 and will expand to Kampala in COP21. The first two years of DREAMS were a Proof of Concept and we demonstrated a reduction in HIV incidence in 8 of the 10 original DREAMS districts. Since then, we have continued to refine the Program to align with new implementation Guidance. Overall, AGYW_PREV progress over the last six months shows good program completion rates of primary and additional secondary services across all age bands and the performance will continue to improve as the safe spaces reopen following the COVID 19 restrictions
Prevention	73,000 new infections/year Majority among AGYW and key populations Men with unsuppressed viral load are key partners in prevention	PEPFAR and GOU start regulatory approvals for the dapivirine ring and, eventually, long acting cabotegravir for prevention while simultaneously preparing for roll out by developing program models, establishing training needs and civil society roles in leading communications and program design PEPFAR must at minimum double its funding for STI treating and tests in order to address chronic facility-level shortages (Cross reference: Supply Chain) All AGYW receiving prevention or treatment services must be offered FP with method mix on-site, including informed consent and client-centered counseling.	**Agree:** • discussions are already underway with the MoH to agree on a process for introducing the dapivirine ring and, eventually, long acting cabotegravir for HIV prevention into prevention programming • There has been a 32% (1,674,471 in COP20 to 2, 477,035) increase in funding allocated to STIs on both the KP and PrEP platforms where we expect to find the highest number of STI infections. • Family planning method mix is part of the interventions in the AGYW/DREAMS layering table and has been included as part of the unit cost for the secondary interventions as relevant for the age category
AHD/TB/other OIs	Mortality rates still too high 40% of people living with TB have HIV	PEPFAR should scale up cervical cancer screening and treatment for all women living with HIV rather than only the 25-49 age	**Agree:** • As agreed to during COP20,

	All women with HIV should benefit from cervical cancer screening and treatment	group, as was already agreed to during the COP20 Regional Planning Meeting in Johannesburg PEPFAR should close the funding gap for nutrition support and other essential supportive services for people living with TB and HIV. PEPFAR should dramatically increase funding to carry out integrated, community-led TB/HIV community support services in order to intensify case finding and save lives. Accelerate uptake of TB LAM and urgently increase supply of TB LAM commodities.	PEPFAR has included one-off cervical cancer screening with HPV testing for WLHIV>50 and treatment for those who screen positive. • Nutritional support for severely malnourished children continues to be included in the COP budget. • $2,550,000 are being requested to increase community case finding efforts for TB using dedicated community health workers/peers. • The MoH has already adopted the new TB LAM guidelines, PEPFAR partners are in process of sensitizing providers and the community, and the TB LAM commodity need for COP21 is fully funded.

1. GOU Engagements

PEPFAR Uganda's vision is to strengthen Uganda's MoH technical capacity and ensure the resiliency of its health care system for the delivery of client-centered services through community engagement, implementing adaptive approaches by level of care, and improving its capability to respond to HIV/AIDS and other public health threats; an example being COVID-19 and Ebola Virus disease in the years to come with dwindling donor/partner support for sustainability.

PEPFAR is committed to continually strengthening its partnership with host-country governments to ensure alignment between PEPFAR contributions and national priorities and investments. 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 COP21 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 (Index Testing, etc.,), Unique Identifier, Human Resources for Health, Commodity Security and TPT.*

Meaningful engagement will also continue during COP21 finalization, approval, and implementation. PEPFAR Uganda will share the final COP21 content and implementation strategy during the Q2 PEPFAR Stakeholders' Meeting in May 2021. 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.

COP21 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 the capacity of local civil society organizations to meet this challenge, better preparing them to play a leadership role now and in the future.

2. GF, private sector, and other external donors

Multilateral partners, including the Global Fund, UNAIDS, WHO, UNICEF, the World Bank, and others, play a critical role in supporting our mutual goal of HIV epidemic control. Often, these partners have core competencies that differ from PEPFAR and other donors and can play a significant role in influencing host government policy and program decisions, addressing implementation challenges, and coordinating and aligning efforts across the partners. OU teams must proactively engage multilateral stakeholders from the earliest phase of COP planning.

As in years past, PEPFAR in COP21 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. 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 COP21 planning, PEPFAR Uganda worked collaboratively with Global Fund to optimize synergies and leveraging of resources. Uganda received U.S. $602,501,930 for grants for the three diseases HIV, Tuberculosis and Malaria from 2021 to 2023 ($339,476,980 allocated to HIV & Tuberculosis and $263,024,950 allocated to Malaria). Through the C-19 Response Mechanism, Uganda received U.S. $61m in 2020 to mitigate the impact of COVID-19 on the implementation of the three disease programs and systems strengthening to respond to the COVID-19 pandemic. The country is currently developing another application amounting to U.S. $86, 850, 290 under the C-19 Response Mechanism. There is continued collaboration with PEPFAR to align resource allocation and service delivery to ensure efficiency gains for the three diseases and the COVID-19 response.

Despite the Global Pandemic, the USG continues to actively participate with the Global Fund to ensure close collaboration and coordination. The USG is a member of the Global Fund Country Coordinating Mechanism (CCM)'s executive committee and has served as a stabilizing force in the restructuring of new board membership this year. Additionally, all three subcommittees have US representatives to increase harmonization. Throughout COP21, the USG employed an American Liaison to the Global Fund who served as the principal coordinator in Global Fund related efforts and provided a mechanism to streamline communication with the CCM. PEPFAR Uganda continued engagement with the Geneva-based Country Portfolio Manager to align

priorities. The Portfolio Manager was able to give a brief presentation at the Regional Planning Meeting, which helped to solidify coordination efforts.

3. Civil Society/Community

PEPFAR values the perspective of community and civil society organizations at both the global and local levels. Community and CSO engagement with and observations of PEPFAR programming and response to COVID 19 can help us further refine our activities. If CSOs and communities have questions, comments, or observations about how PEPFAR is adjusting in the context of COVID 19, feedback shall be provided through the planned collaborative engagements. In addition, PEPFAR Uganda shall engage in virtual consultations with local, global civil society, and community organizations as teams make decisions about and adaptations to programming in the context of the COVID 19 pandemic. While it is understood that varying degrees of physical distancing measures may preclude in-person meetings, PEPFAR shall continue with making use of virtual technologies to convene or otherwise seek critical input from the communities and constituencies that we serve.

PEPFAR has 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.

Since 2012, communities of People living with HIV (PLHIV), Key and Vulnerable Populations (KVPs), and Civil Society Organizations (CSOs) under the leadership of the International Community of Women Living with HIV Eastern Africa (ICWEA), the Coalition for Health Promotion and Social Development (HEPS-Uganda), and Sexual Minorities Uganda (SMUG) in collaboration with global partners including Health GAP and AVAC have been monitoring and informing PEPFAR Country Operational Planning (COP) processes. At that time, there were no minimum standards for the meaningful engagement of PLHIV, KVPs, and CSOs and discussions with the U.S. government regarding Uganda's COP would take place only in meetings at the U.S. Embassy. PLHIV, KVP, and CSOs worked to ensure that the engagement processes became truly community-owned and community-led.

The People's Voice21 is the third edition, with the first published in 2019 and the second in 2020. Successes resulting from these efforts over the years include: introduction and scale-up of Pre-exposure Prophylaxis (PrEP); acknowledgment of the problems that come from poor implementation of index testing; development and implementation of policies and guidelines for harm reduction programs; establishment of a package of harm reduction services for people who use and inject drugs (including Medication-Assisted Therapy or MAT); commitment to standardize the package of services provided by community health workers (CHWs), and investment in the Community-Led Monitoring (CLM).

Like earlier editions, this edition outlines recommendations and priorities from PLHIV, KVPs, and CSOs. It is built from PEPFAR's existing promises from COP20 while introducing new recommendations. Communities and CSOs acknowledge PEPFAR for being responsive to the priority areas in The People's Voice. This version of The People's Voice was developed using the following process: Community-Led Monitoring (CLM) in 32 health facilities which are located in

28 districts during the CLM pilot phase (August-September 2020) and Focus Group Discussions (FGDs) with community representatives.

Communities also undertook a rapid fact-finding assessment on the theme of pediatric treatment access and COVID-19; held consultation and validation meetings with national-level CSOs; reviewed PEPFAR and Ministry of Health HIV and TB program performance data; and conducted interviews with key informants from the national government and local government. In addition, regional meetings with 13 PEPFAR Implementing Mechanisms (IMs) were convened and attended by CSOs, people living with and affected by HIV, respective Implementing Partners (IPs), and PEPFAR Uganda Team. Consultations with the Ministry of Health, Uganda AIDS Commission (UAC), PEPFAR, and AIDS Development Partners were held during the annual retreat. The People's Voice21 focuses on critical themes in the PEPFAR COP_{21}, as described below:

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 the International Community of Women Living with HIV Eastern Africa (ICWEA) and other development partners will be invited to attend these monthly/bi-monthly sessions to enrich results.

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. In COP21, 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.

The Stakeholder Engagement Calendar for COP21 (planning and implementation) can be found in Appendix E to this SDS

3.0 Geographic and Population Prioritization

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP21**	**# Current on ART (FY20)**	**# of SNU COP20 (FY21)**	**# of SNU COP21 (FY22)**
Attained	371,210 (26%)	326,835	32	35
Scale-up Saturation	583,957 (41%)	482,719	19	70
Scale-up Aggressive	465,661 (33%)	385,945	25	31
Sustained	0 (0%)	0	60	0
Central Support	0 (0%)	0	0	0
Total	**1,420,828** (100%)	**1,215,943***	**136**	**136**

*Total includes 20,444 TX_CURR attributable to Military

4.0 Client-Centered Program Activities for Epidemic Control

4.1 – 4.4 COP21 Programmatic Priorities for Epidemic Control

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

FY21Q1 Cascade by age

Age	Sex	PLHIV	Diagnosed	On Treatment	VL Suppressed	Diagnosed	On Treatment	VL Suppressed
<10	Female	21,714	17,368	17,335	12,037	80%	80%	55%
	Male	22,140	15,958	15,934	10,559	72%	72%	48%
10-19	Female	55,943	34,559	34,399	24,802	62%	61%	44%
	Male	41,725	24,212	24,152	18,114	58%	58%	43%
20-29	Female	194,571	182,345	181,414	129,670	94%	93%	67%
	Male	71,782	47,767	47,329	27,556	67%	66%	38%
30-39	Female	261,021	266,916	266,277	198,218	102%	102%	76%
	Male	138,518	128,558	127,917	84,042	93%	92%	61%
40-49	Female	188,321	192,547	192,320	143,076	102%	102%	76%
	Male	135,181	131,474	131,116	93,568	97%	97%	69%
50+	Female	157,521	132,597	132,462	105,226	84%	84%	67%
	Male	132,391	105,128	104,959	79,814	79%	79%	60%
Overall		**1,420,828**	**1,279,429**	**1,275,614**	**926,682**	**90%**	**90%**	**65%**

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

UNCLASSIFIED

Table 4.2. Cluster ART coverage (COP21)

CLUSTER	<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		OVERALL
	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	24%	23%	100%	100%	92%	90%	87%	81%	68%	87%	72%	82%	83%	83%	98%	100%	100%	100%	100%	100%	100%	100%	96%	84%	96%
JINJA CLUSTER	61%	59%	100%	100%	98%	92%	91%	84%	73%	89%	79%	89%	91%	87%	98%	89%	98%	96%	99%	98%	100%	100%	89%	93%	93%
KABALE CLUSTER	77%	77%	100%	100%	85%	88%	81%	84%	68%	84%	91%	82%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	80%	79%	95%
KABAROLE CLUSTER	41%	41%	99%	92%	92%	85%	83%	78%	67%	80%	98%	78%	100%	86%	100%	100%	100%	100%	97%	100%	99%	95%	70%	74%	95%
KAMPALA CLUSTER	31%	30%	83%	82%	85%	77%	99%	93%	73%	100%	76%	81%	79%	73%	85%	71%	91%	78%	100%	89%	100%	100%	100%	100%	90%
LIRA CLUSTER	64%	62%	100%	100%	97%	86%	90%	81%	73%	87%	76%	88%	93%	94%	100%	100%	100%	100%	100%	100%	100%	99%	85%	76%	96%
MASAKA CLUSTER	27%	27%	100%	100%	93%	90%	85%	83%	68%	79%	96%	87%	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%	83%	85%	98%
MBALE CLUSTER	38%	38%	100%	100%	100%	88%	100%	91%	82%	100%	76%	88%	75%	89%	88%	80%	86%	90%	99%	100%	100%	100%	100%	100%	94%
MBARARA CLUSTER	38%	36%	100%	100%	89%	87%	82%	83%	71%	81%	100%	85%	100%	99%	100%	100%	100%	100%	94%	100%	96%	91%	77%	77%	96%
SOROTI CLUSTER	100%	100%	100%	100%	100%	94%	88%	82%	74%	82%	71%	82%	76%	81%	94%	100%	100%	100%	100%	100%	100%	100%	100%	94%	99%
STANDALONE	96%	95%	100%	100%	95%	92%	85%	81%	75%	88%	100%	92%	100%	96%	100%	100%	97%	100%	92%	100%	91%	96%	75%	82%	95%
TORORO CLUSTER	94%	85%	100%	100%	94%	90%	86%	84%	76%	92%	75%	92%	78%	89%	91%	88%	91%	93%	99%	97%	100%	100%	96%	91%	92%
OVERALL	60%	59%	100%	100%	93%	88%	88%	84%	73%	89%	90%	87%	98%	90%	100%	97%	98%	100%	98%	100%	100%	99%	86%	86%	94%

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

Client-centered Program Activities for Epidemic Control

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

As of December 2020, 1,420,828 individuals were estimated to be living with HIV in Uganda. By March 2021, approximately 91% of thos individuals had been diagnosed, 91% were on treatment and 68% were virally suppressed. Reaching the remaining undiagnosed positives requires ingenuity and continued use of the most efficient approaches.

In COP21, HIV case finding will continue to be differentiated by age, sub-population. and geographic location based on antiretroviral (ARV) coverage. The HTS_TST_POS target increased from 37,372 in COP20 to 74,036 in COP21 and the average yield from 2.1% in COP20 to 2.6% in COP21. While the HTS_TST_POS target is projected to double in COP21, the HTS_TST target will only increase by 60%. Therefore, more positives are expected to be identified from fewer tests, hence requiring continued implementation of a highly targeted program to reach individuals at high risk for HIV infection and in the right places. The FY22 HTS_TST target was derived from the TX_NEW target of 71,527 needed to reach 94% treatment coverage at 95% linkage. Targets were allocated to different testing modalities following COP21 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 COP21 yields and proportion contribution to total HTS_TST_POS target, respective modality HTS_TST_POS targets were set with index testing contributing 58% of the target, PMTCT 7.4%, TB3.6%, and EID and VMMC each <1%. The remaining HTS_TST_POS target was distributed based on priority populations targeted with other community testing and community mobile testing contributing 8.6% and 0.65 of HTS_TST_POS target, respectively. Other testing modalities were allocated targets as follows: Other Provider-Initiated Counseling and Testing (PITC) (projected at around 17.8% % with an anticipated yield of 10%), In-patient (2.3% with a targeted yield of 10%), sexually transmitted infection (STI) clinics (1.5% with 10% yield).

Index testing, including assisted partner notification (APN), remains the main approach to the PEPFAR Uganda testing program and will account for 58% of the total positives to be identified with an average yield of 15%. This yield is achievable based on historical performance. We will

target partners of newly identified PLHIV, unsuppressed clients on ART, all children under the age of 19 years with an HIV positive biological parent 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 were missed in FY21. We will also continue to work with CSOs, MOH, and other stakeholders to build provider competencies to ensure sustained safe and ethical delivery of index testing.

In addition, the Uganda Ministry of Health (MOH) has established a system to reinforce the index testing reform agenda: a national task force was constituted in FY20 to steer and oversee the reform agenda; site level index testing assessments were launched in FY20 (the REDCap assessments). Sites failing the assessment were required to immediately stop index testing. Mitigation measures such as follow-up training, on-site mentoring, monitoring, and oversight were instituted. Only when a failed site was re-assessed and passed was it allowed to again offer index testing. Going forward, the MOH has incorporated a site and service provider requirement for certification; a dashboard is already in place to track assessments and certification of sites; and a monitoring system for negative events will be finalized in FY21. In order to address a few gaps that were identified in index testing implementation materials in FY20, the MOH has planned to revise the materials to align with Ugandan national testing implementation guidelines.

According to Uganda's National Implementation Guidelines for index testing, screening for IPV is mandatory for all index clients offered index testing services and is a key determinant for the partner notification model/approach that is selected for each of the partners elicited. The guidance strongly recommends IPV screening for each of the partners elicited by the index client. In addition, the guidance emphasizes the training of service providers in index testing delivery (including IPV screening and management) and careful formation and orientation of the APN task team before implementation starts in any site. Therefore, it is expected that 100% of sites implementing index testing will screen for IPV as a bare minimum, and also provide post GBV services within the facility and/or refer clients to other similarly-prepared and compliant facilities.

Other HTS interventions that will continue to be implemented in COP21 include social network testing and targeted community testing using the enhanced peer outreach approach (EPOA) to reach KPs and PP, including men, as well as self-testing targeted to partners of pregnant and lactating mothers, KP/PPs and adolescent girls and young women. Recency testing will be rolled out to all PEPFAR-supported sites and will help refocus testing to individuals and geographic locations with the greatest need for HTS. Public health guidance to standardize the use of recency findings to refocus testing for high-risk individuals will be finalized in FY21.

In COP21, PEPFAR Uganda will continue to improve testing efficiencies at outpatient departments (OPDs) by deploying designated, trained screeners at high-volume sites to consistently screen individuals for eligibility for HIV testing services. The target yield within OPD remains 10%. Eligibility screening will continue to be applied to KP and PPs; screening tools will be actively monitored in all facilities where screeners will be deployed in order to improve yield.

With support from Global Fund, HIV self-testing will be rolled out across the country.

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 FY21, there were 88,382 CLHIV in Uganda. Of these, 59,656were receiving ART (68%) and 49,719 (56%) 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.

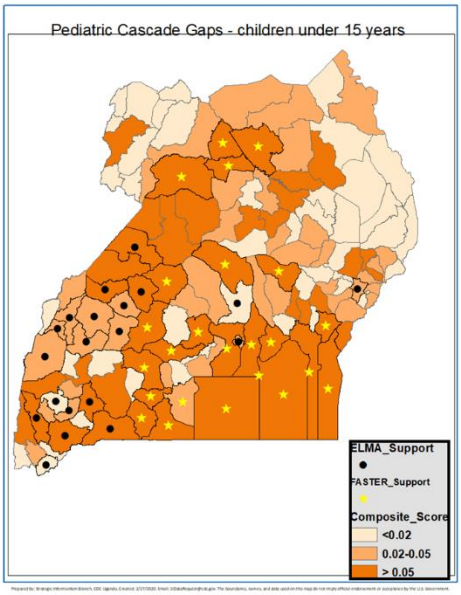
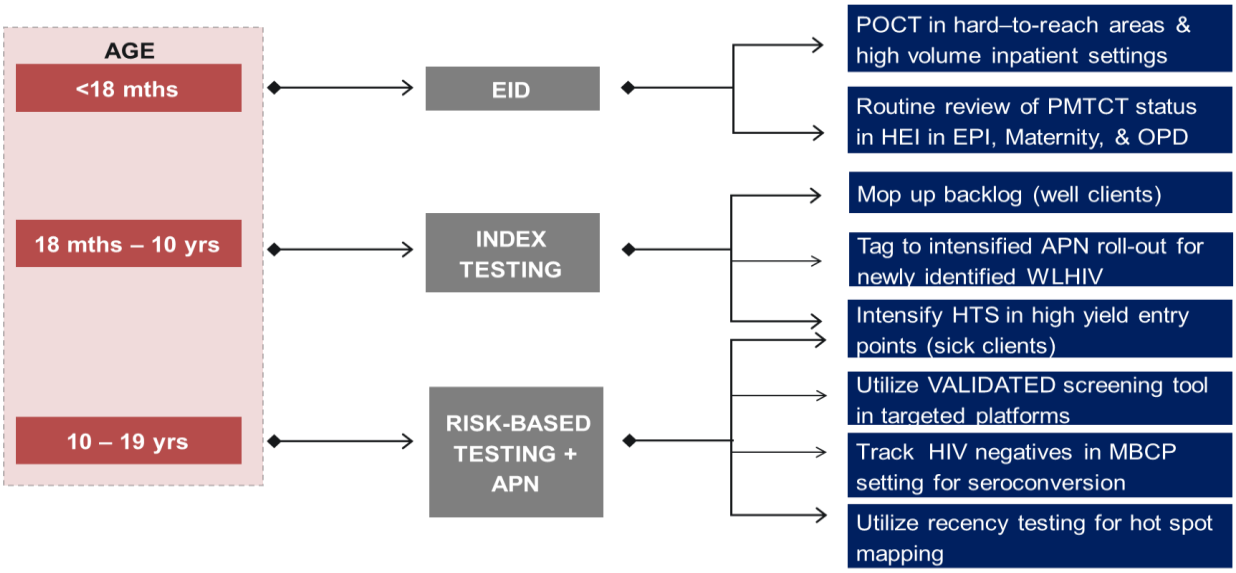


Figure 4.0.1 Pediatric cascage gaps - children under 15 years

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 Faith-Based Action for Scaling up Testing and Treatment for Epidemic Response (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 have seconded pediatric coaches to each of the priority district health teams to support sites in improving pediatric performance. Additionally, we developed pediatric care bundles for case identification, including EID, linkage and initiation, viral suppression, and treatment continuity that have been 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 are being 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 children 18 months to nine (9) years, PEPFAR Uganda will continue to support case identification through index testing of biological children of women living with HIV. In COP19 and COP20, Uganda is conducting "mop up" index testing for children of HIV-positive women in care within 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 developed a new pediatric HTS screening tool that is being used in outpatient departments (OPD) and community settings to determine children eligible for HIV testing, and only those who screen positive are 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. As a result of the

use of the new screening tool, the NNT in OPD settings has reduced from 70 in Q1 of FY 20 to 55 in Q1 of FY 21. We will continue supporting our sites to further reduce the NNT.

PEPFAR will continue to support the 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 sexually active adolescents. Due to overwhelming demand, Uganda has trained YAPS peers to provide pre- and post-test counseling and conduct rapid HIV tests for adolescents and young people. This has helped increase the uptake of testing among adolescents.

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 COP20, PEPFAR, through FASTER, is supporting the MOH to assess the feasibility of implementing HIV self-testing among adolescents 15-17 years in public health settings. This assessment is exploring 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 COP21.

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 the end of Q1 FY 21, linkage was 100% among children <15 years and 85% among adolescents 10-19 years. In COP21, 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 the 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 COP20, 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 in the facility and within the community. Uganda will also institutionalize Faith Communities Initiative (FCI) activities, 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, fisherfolk, truck drivers and men from centrally supported districts of Abim, Amudat, Bulambuli, Kaabong, Kapchorwa, Karenga, Kween, Nabilatuk, Nakapiripirit, and Napak.

HIV case finding 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, as well as 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 COP21. These interventions are being scaled up in COP21:

- 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 contact 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 scaled up in all PEPFAR supported regions in FY22.

- 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 COP21, community testing is expected to contribute 29% (6,764/23,126) of total HTS_TST_POS target allocated to men.

- HIV self-testing. In COP21, HIV self-testing for males will be implemented only for KPs and partners of pregnant and breastfeeding 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 in FY22, 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 streamlining 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 for men among presumed TB cases and in TB clinics.

In COP 21, the previously termed "ambition districts" have been absorbed within the COP budget and will be receiving the same level of facility and community-based support as other districts. PEPFAR Uganda will continue to intensify HIV case identification, ensure continuity of treatment, and access to essential HIV prevention and treatment services. The engagement of cultural/Manyata leaders and elders has been instrumental in stimulating demand for HTS and sensitization on stigma reduction. The program will continue to rely on these community platforms and PLHIV networks to bring essential services closer to people living with HIV.

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 what was formerly called 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.

Progress on MenStar adaptation as a targeted intervention for identification, continuity of treatment and suppression of Men 20+: In COP20, Uganda finalized the MenStar adaption using the "treatment journey" approach that was successful in South Africa and Nigeria. We have prioritized target audiences based on the HIV cascade: New on treatment, interruptions to treatment, and virally non-suppressed. This will be a mix of audio-visual literacy tools, interactive digital tools and narrative empathy through radio talk shows and television airings at audience peak times. We have also completed the review and adaptation of messages of hope with the faith-based stakeholders. The materials are with MOH and Uganda AIDS Commission for approval. The faith-based partners plan to disseminate messages in the coming month.

In COP21, 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+

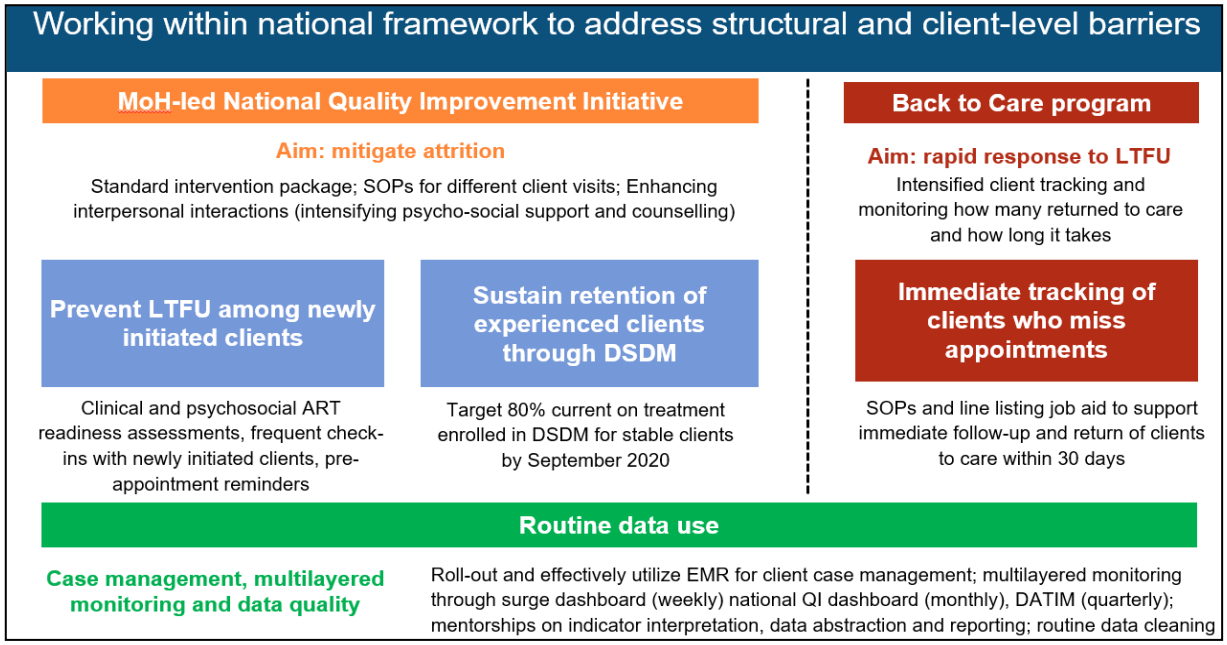
Achieving epidemic control in Uganda requires addressing gender gaps in HIV testing, linkage, ART access and achieving viral suppression. UPHIA 2016 data indicate that HIV prevalence among women aged 15–64 is 7.6% compared to 4.7% for men of the same age group. For women, HIV prevalence peaks at 12.9% 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. FY20 program data demonstrate that 44% of WLHIV were identified through "other PITC," followed by index testing, and the PMTCT platform.

FY21 Q1 program data demonstrated that 20,087 women aged 15+ were diagnosed HIV-positive. This constituted 61% of all positives identified during the same period. In COP21, a total of 22,798 women 15+ will be identified, the majority (74%) aged 40+ years, mainly through index testing.

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 23% of positive women will be identified through the PMTCT platform. The remaining approximately 7% of HIV-positive women will be identified through highly targeted and diagnostic PITC at critical service delivery points including STI, TB, in-patient and OPD. The screening tool will be used at the OPD. PEPFAR will leverage the DREAMS and OVC platforms, using validated screening tools to identify adolescents and young women. In FY22, 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 treatment continuity 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 treatment continuity 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 COP21, PEPFAR Uganda will utilize this platform to rapidly respond to findings from the community-led monitoring and will support districts and health facilities in implementing 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 having 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 COP21, the program will continuously utilize routine data to better understand who we are losing, why, from where, and how can we address their individual barriers to care.

FY21 Q1 data show that older women and men who are less than three months on treatment experience higher treatment interruptions, while young women and men (aged 24-29) are most at risk of treatment interruptions once in care (over three months on treatment). PEPFAR Uganda is intensifying efforts in supporting individual clients in overcoming barriers to HIV treatment, working in close collaboration with CSOs and PLHIV networks. In COP21, we will largely utilize feedback from the Client Led Monitoring reports, PLHIV feedback and client exit interviews to continuously refine our interventions.

Age and sex specific treatment continuity challenges and interventions

By the end of Q1 FY 21 proxy retention was 95.8% among children less than 15 years, slightly above the targeted retention level of 95%. PEPFAR Uganda will continue to utilize the national QI collaborative to strengthen treatment continuity efforts by rolling out a pediatric and adolescent treatment continuity care bundle across all PEPFAR sites supported by the pediatric-focused QI coaches as described in section 4.1. The treatment continuity care bundle will continuously be refined based on findings from quarterly root cause analyses and community monitoring.

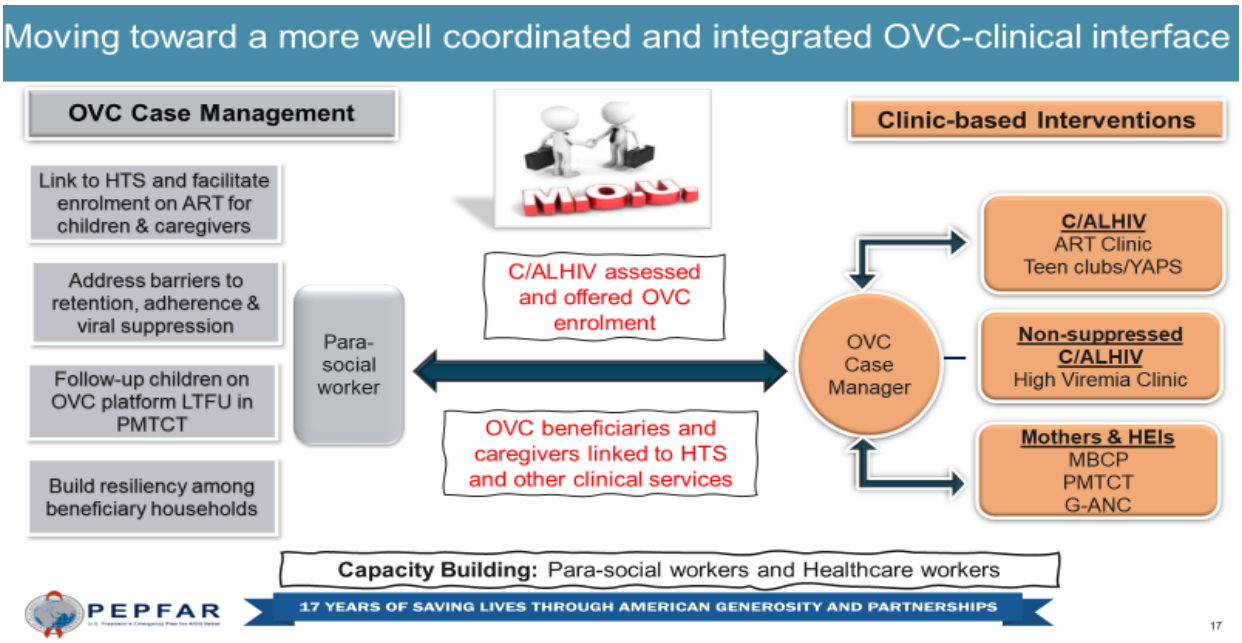
For infants Zero (0) to 18 months, we shall continue to strengthen preregistration for PBFW and their HIV-exposed or infected infants at MBCP, send out pre-appointment reminders, track mother-baby pairs who miss appointments and bring them back to care, and utilize peer mothers to provide psychosocial 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, treatment continuity 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 treatment continuity 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 67 to 90 districts in COP 21, and we shall integrate aspects of Operation Triple Zero into the YAPS program. 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 FY22.

For children and adolescents eligible for OVC programming - In COP21, and in line with OGAC guidance, PEPFAR Uganda will continue to strengthen the Clinical-OVC interface and leverage the OVC program to improve treatment continuity and viral suppression for infants and C/ALHIV. 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.



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 COP21, PEPFAR Uganda will build on the MenStar adaptation to the Ugandan context that the Social Behavior Change Activity (SBCA) developed to improve our reach to men. Uganda's MenStar adaptation used HIV cascade data to identify high-priority male audiences. The SBC activity then translated raw audience concepts into high fidelity prototypes, using human-centered design (HCD) processes to develop a package for health providers, a guide on the ideal facility setting for males, and approaches for scaling up health service branding.

In COP 21, 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. Furthermore, through Uganda's MOH-led QI platform, the activity will focus on addressing both extrinsic and intrinsic factors hindering men's consistent engagement in care, especially for men who are asymptomatic.

Interventions to engage men in managing their health will include:

- Increased interpersonal interaction through psychosocial support:

- Supporting patient self-management through the provision of tools and skills for clients to actively participate in their own health care;
- Increased focus on client literacy;
- Using digital solutions to disseminate male-focused messaging; and,
- Expansion of differentiated service delivery models and MMD.

Facilities will be supported to make it more convenient for men to access services, for example, through integrated wellness clinics for screening, diagnosis and treatment of non-communicable diseases (NCDs) and flexi-clinics with hours and services suitable for men. CBOs will be used to follow up lost clients. The faith-based network will be engaged in community mobilization for improved service uptake especially HTS, linkage, and treatment continuity.

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 treatment continuity. Root cause analyses have demonstrated that gender-based violence (GBV) is a significant contributing factor to poor adherence and interruptions to treatment among women. In COP21, 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 treatment continuity faced by women themselves, but also will improve the situation for their children whose adherence and treatment continuity is affected by GBV.

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

Program data Q1FY21, indicates that about 25% 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 treatment continuity 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 FY20 PEPFAR supported the scale-up of CD4 testing to 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. However, CD4 access among those eligible remained low at about 18% of new and non-suppressed clients receiving CD4 test, CrAg testing reduced to only 64%, and TB-LAM testing remained low at 45% mainly due to insufficient commodity availability. In FY21 (COP20), PEPFAR will continue to work 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 82,341 incident TB cases annually, 38% of which are TB/HIV co-infected. As result of COVID-19 restrictions, TB case finding has declined to 60,830 as compared to 67,874 in FY20. Despite the improved diagnostic coverage, quality TB screening, and the data quality yield of TB among PLHIV has reduced from 2% in FY19 to 1.7% in FY20. 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. In addition, PEPFAR will support MOH strategies to restore TB case finding to meet or exceed the numbers of new TB cases identified pre-COVID. This will be accomplished by implementing the integrated algorithm for COVID19 and TB screening and the new WHO TB screening guidelines. PEPFAR continues to invest additional resources toward intensified TB case finding efforts in prisons, given the higher burden of TB in this setting. In COP21, 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 Global Fund 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 FY20. 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, in COP21, will support MOH to develop guidelines, tools, and materials to guide phased pilots of the integration of NCD screening and treatment (specifically hypertension and mental health) within HIV clinics in select sites. Results from these initiatives will inform plans for national scale-up.

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

In FY20, a total of 279,806 PLHIV were enrolled on TPT; the completion rate was 88%, a slight decline from 89% in FY19. This has been achieved through implementation of a QI change package for TPT completion. PEPFAR Uganda has targeted an additional 320,863 PLHIV to receive TPT to reach 90% coverage of all eligible PLHIV with TPT by the end of FY21 (COP19). 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 88% in FY21Q1. Uganda has also registered improvement in VL suppression from 87% in 2017 to 93% in FY21 Q1. The lowest suppression rates are in males and females aged <24 years: 78% for <10 years and 82% for 10-19years. HIV drug resistance (HIVDR) is reported as the highest contributor to the non-suppression among children.

The transition of clients to more optimal regimens is nearly complete. As of March 2021, close to 940,000 PLHIV had transitioned to TLD, representing 77% of all eligible PLHIV on treatment. This is an improvement from 58% at FY20 Q4. Commodity stocks for TLD 30- and 90-packs are adequate to support the completion of the transition by the end of COP20.

Over the last 10 months, pediatric ART regimen optimization has increased from 59% to 96%. By the end of Feb 2021, PEPFAR had only 2,714 children and adolescents on NNRTI with the majority of these within MCH. Remaining adolescents in MCH will transition to optimized regimens when they become eligible after six months postpartum. As a final step of pediatric ART optimization, PEPFAR is preparing to introduce pediatric DTG. A transition plan has been developed together with the Ministry of Health and other stakeholders. Commodities are expected to arrive in the country by July 2021 and the transition will be complete by September 2022

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. As we establish regional CQI collaboratives led by each RRH in COP21, regions with the largest gaps in VL coverage and suppression will continue with these collaboratives, modifying the intervention package based on contextual issues unique to that region.

Furthermore, PEPFAR Uganda will continue to refine and disseminate communication messages as part of a larger comprehensive treatment literacy intervention that is under development. This treatment literacy plan will be fully led, designed, and implemented by Ugandan networks of people living with HIV. The comprehensive treatment literacy plan will encompass robust

campaigns on all aspects of the clinical cascade, including awareness of optimized regimens and HIV drug resistance.

In COP20, for adolescents and youth, the program is adapting and integrating Kenya's successful Operation Triple Zero program into the YAPS model to strengthen peer support for adherence, disclosure and stigma reduction. Utilization of social media and other digital platforms is also being explored per preferences identified during focus groups and market research. Dissemination of these messages will be incorporated into the treatment literacy plan for COP21. Additionally, for men, the MenStar adaptation was finalized using the "treatment journey" approach that was successful in South Africa and Nigeria, targeting audiences based on the HIV cascade: the men new on treatment, those with interrupted treatment, and the virally non-suppressed. This will be a mix of audio-visual literacy tools, interactive digital tools and narrative empathy through radio talk shows and television airings at audience peak times. Finally, we have completed review and adaptation of messages of hope with the faith-based stakeholders. The materials are with MOH and Uganda AIDS Commission for approval.

In COP21, PEPFAR will strengthen support to the 10 centrally supported districts to improve the low VL coverage and suppression through institutionalizing processes and systems that have worked in other regions.

As the country completes ART optimization, PEPFAR Uganda will continue supporting MOH to implement DTG safety and drug resistance monitoring. As a part of this process, the Uganda National Drug Authority (NDA) has intensified pharmacovigilance monitoring through the expansion of digital apps, toll-free lines and WhatsApp. Furthermore, PEPFAR is supporting a rapid assessment of data from 6 active pharmacovigilance sites to follow-up on concerns raised by CSO, health providers, and the National Drug Authority (NDA). Preliminary results from IDI and Mildmay COE indicate that 6.6% of clients who initiated or transitioned to TLD developed hyperglycemia. This is consistent with the NDA reports. The revised treatment guidelines incorporate management of these adverse events and PEPFAR partners will continue to provide mentorship at site level on the management of adverse events as we transition to TLD. 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 COP21, PEPFAR will continue to contribute to HIVDR testing on VL remnant samples (DBS and Plasma) for clients on optimal regimens who remain non-suppressed despite intensive adherence counseling.

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 COP21, Uganda will continue to implement an integrated AGYW strategy that is aligned to the National Health Sector HIV Prevention Strategy for AGYW (2020-2025)[6]. 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 most at risk AGYW for epidemic control.

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

The DREAMS program will expand from the current twenty-four (24) focus districts to targeted sub-counties in Kampala within selected AGYW hot spots, based on incidence and AGYW at-risk burden. Under COP21 Uganda proposes to reach 262,660 AGYW in the 24 DREAMS focus districts taking into consideration aging in and out of AGYW, and ensuring program completion for enrolled AGYW to reach district saturation.

In terms of DREAMS beneficiaries, the USG has served a total of 640,000 AGYW aged 9-24 over the past five years. Currently in COP20 we are following a cohort of about 160,000 AGYW ages 9-24 to support their completion of age-appropriate DREAMS services.

The DREAMS initiative will focus on continued program realignment to respond to emerging AGYW challenges due to COVID-19, such as addressing increases in teenage pregnancies, and increased GBV cases. Refurbishment and remodeling of safe spaces will comply with the new COVID-19 standard operating procedures. The initiative will also focus on the continuation of enhanced social economic strengthening approaches, scaling up PrEP, and increasing its urban coverage.

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. 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.

In response to sub-optimal completion and saturation rates across different age bands (particularly among 10-14-year-olds) and districts for DREAMS interventions, a root cause analysis was carried out. The findings showed lack of a community level HIV and violence prevention curriculum, relocation, school dropouts and long distance to safe spaces as the key barriers to program completion. To address these, Uganda conducted a consultative process to modify the school-based *Journeys Plus* curriculum and is in the process of finalizing the community-based *Journeys Plus* curriculum, pending OGAC approval. In addition, under COP21, the DREAMS initiative will invest in an enabling environment for intervention completion by enhancing education subsidies; improving AGYW tracking and referrals across SNU's; and using client centered service delivery models in safe spaces.

Uganda will continue to 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 based on findings from extensive market assessments that were done in COP 20 to identify scalable market-driven opportunities and guide intervention packages into male

dominated enterprises. We shall continue with the roll out of enhanced market-relevant trainings, bolstered start-up support (matching grants and start-up kits) and will leverage GOU structures like operation wealth creation. Ongoing mentorship and peer networking and adaptation of evidence-based models currently being used in Uganda's DREAMS initiative, such as *Empowerment & Livelihoods for Adolescents* by Building Resources Across Communities (BRAC) and *Women's Income Generating Support* (WINGS).

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.

Early learnings from implementing a DREAMS urban model show that initial key strategies for successful rollout included the formation of district steering committees and empowering AGYW peers to lead program startup. We are also learning that the AGYW are of varying urban categories, and there is a need to provide tailored approaches per urban category at flexible hours. Tailored approaches might include providing short-term social economic strengthening packages for the AGYW soon after enrollment, to enable them to start saving early as a retention strategy. Initial challenges identified with the urban DREAMS intervention include the high turnover of trained AGYW peer facilitators and challenges with identification of strategic safe space locations given the AGWY high mobility. PEPFAR Uganda implementing partners are working with the town council and municipal council leadership to designate strategic locations for the safe spaces. These lessons will inform expansion strategies of the urban model in COP 21.

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[7], 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 using a locally contextualized violence prevention early detection index for children living in households that are rated at most risk of experiencing violence. After piloting, the early warning index tool development was completed and validated under the leadership of the Ministry of Gender Labor and Social Development and the VACS multisectoral team. The early warning index tool will engage families and profile households where violence against children is reported. It will enable practitioners to design interventions that directly deal with factors perpetuating violence and to anticipate and immediately act on households identified

[7]Uganda Violence Against Children Survey, 2015

as most at risk of violence occurring. The Ministry of Gender Labor and Social Development will be championing the rollout of this tool during the COP21 implementation period, and PEPFAR Uganda will support this roll-out.

At the individual level: Interventions will aim to empower girls and boys and reduce risk. Girls aged 10-14 who are out of school will be offered a community-based curriculum (*Journeys Plus* curriculum for children). *No Means No* for girls and boys will be continued in COP21 to build protective skills against violence.

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 stage 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. The curriculum purpose is to inculcate HIV preventive sexual behaviors among adolescent girls and young women, targeting the age group 15-24.

SINOVUYO curriculum focuses 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.

Community-Based Journeys Plus curriculum (pending OGAC approval) is also an HIV and violence prevention specific curriculum, with content tailored to 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. It teaches boys resilience, to challenge rape culture, and to practice consent, as well as bystander intervention skills.

At family level: The program will continue to promote positive parenting and effective communication between girls and boys 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 and vulnerability 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, to foster normative 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

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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.

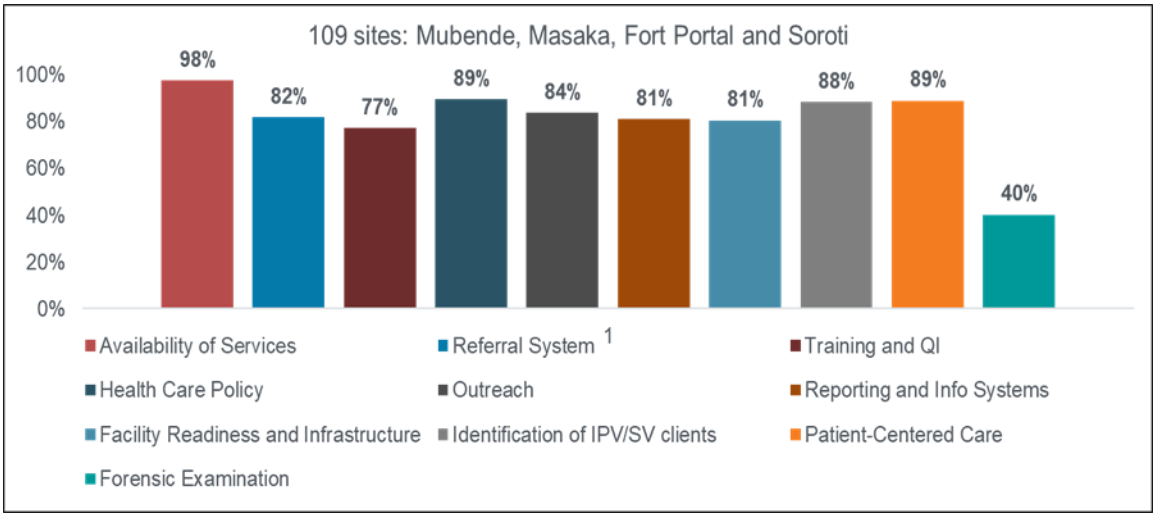
The program will ensure that male sexual partners receive core prevention interventions including HIV testing services, VMMC and ART. Additionally, men and boys will be engaged in interventions that address harmful gender norms, sexual coercion and violence. The program will continue to profile/characterize male sexual partners, using the male partner characterization approach and will use strategic information to map where recent infections are occurring in men.

Through the Peace Corps, Uganda rolled out the Grassroots Soccer Curriculum with 12 modules targeting 10-to-19 year old boys and young men. 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 COP20, a phased approach to scale up Grassroots Soccer to other high prevalence districts starting with DREAMS supported districts will be implemented in COP21.

During COP21, the program will build off of the second phase of the *No Means No* curriculum that targets boys which was introduced in COP20 to reduce their risk and future perpetration of violence. COP21 will leverage existing PEPFAR supported OVC and VMMC programs (and platforms) to reach boys and offer the curriculum.

Multi-level violence prevention and response interventions

In COP20, Uganda continued to triangulate multiple data sources to inform a multi-level robust violence response program. These sources include the FY20 GEND_GBV performance data, Root Cause Analysis, National GBV QA Tool assessment 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 we will continue to prioritize safety and access to services for all who need post-violence care.



In COP21, the program will address the following top three gaps identified from the GBV QA tool assessments in FY21: a) training and QI gaps to be addressed through ongoing mentorships; b) inadequate facility readiness and infrastructure to be addressed by investing in capacity at facility level; and c) lack of forensic kits at facilities. PEPFAR Uganda began procuring forensic kit supplies under COP20, and we intend to continue procuring under COP21. 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 survivors. 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 to non-viral suppression which impedes epidemic control. In COP21, 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 by collaborating with faith communities.

Uganda reached its 2020 Annual Program Result (APR) to reduce GBV. COP21 will refocus on reaching AGYW performance targets, especially for sexual violence. Uganda will further roll-out the "*Every Hour Matters*" campaign with communities, and will include 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, 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. Program success stories will be documented and disseminated to promote cross learning.

Figure 4. 1 AGYW Geography of Implementation

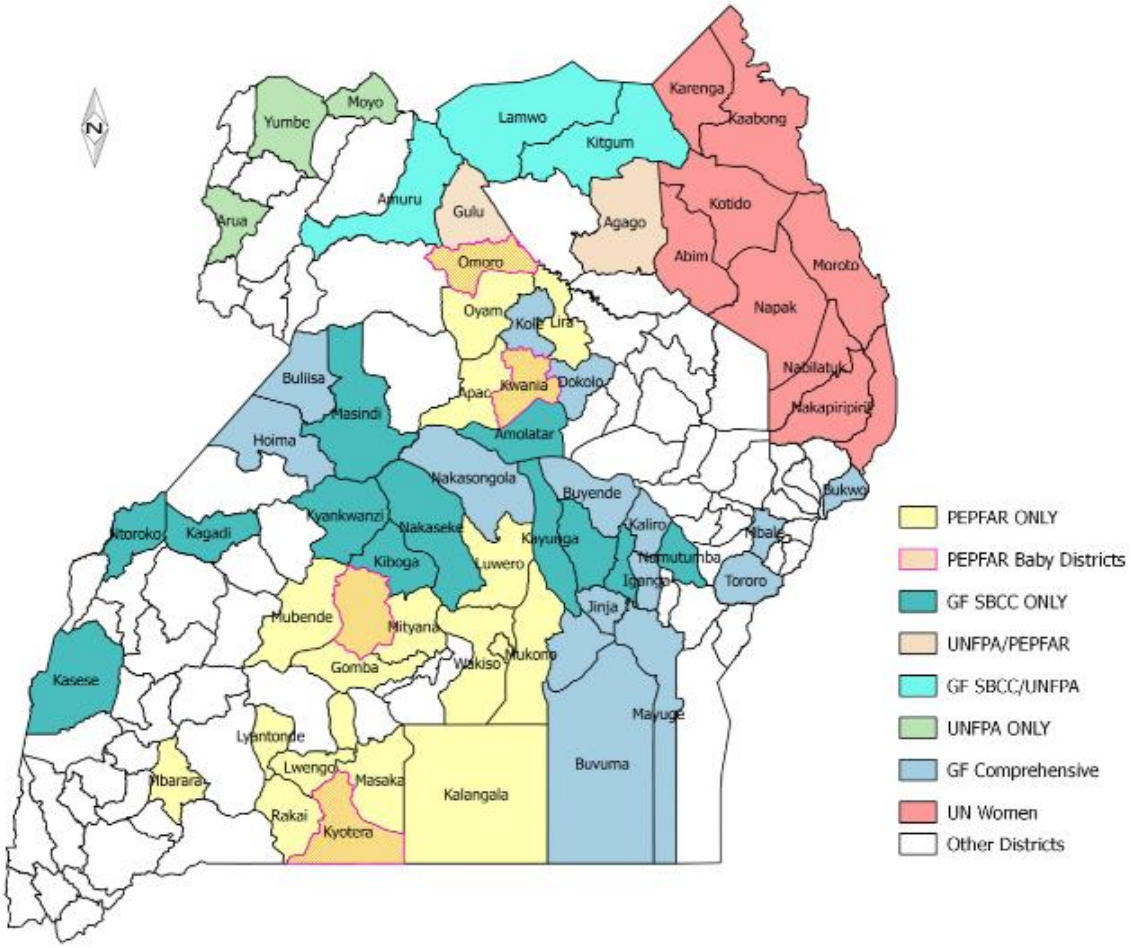
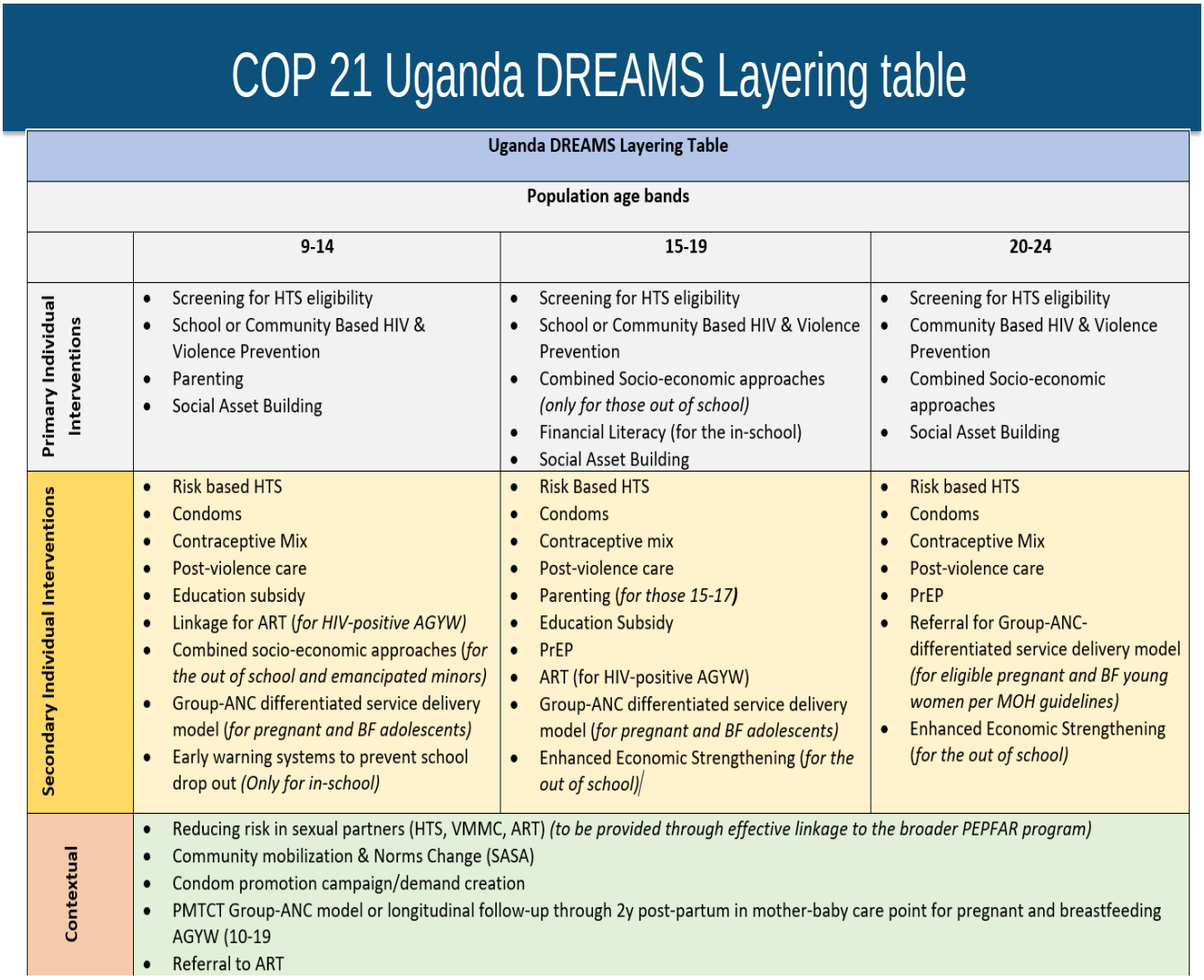


Figure 4. 2 DREAMS Layering Table



COP 21 Uganda DREAMS Layering table

Uganda DREAMS Layering Table			
	Population age bands		
	9-14	15-19	20-24
Primary Individual Interventions	• Screening for HTS eligibility • School or Community Based HIV & Violence Prevention • Parenting • Social Asset Building	• Screening for HTS eligibility • School or Community Based HIV & Violence Prevention • Combined Socio-economic approaches *(only for those out of school)* • Financial Literacy (for the in-school) • Social Asset Building	• Screening for HTS eligibility • Community Based HIV & Violence Prevention • Combined Socio-economic approaches • Social Asset Building
Secondary Individual Interventions	• Risk based HTS • Condoms • Contraceptive Mix • Post-violence care • Education subsidy • Linkage for ART (*for HIV-positive AGYW)* • Combined socio-economic approaches (*for the out of school and emancipated minors)* • Group-ANC differentiated service delivery model (*for pregnant and BF adolescents)* • Early warning systems to prevent school drop out *(Only for in-school)*	• Risk Based HTS • Condoms • Contraceptive mix • Post-violence care • Parenting (*for those 15-17)* • Education Subsidy • PrEP • ART (for HIV-positive AGYW) • Group-ANC differentiated service delivery model (*for pregnant and BF adolescents)* • Enhanced Economic Strengthening (*for the out of school)*	• Risk based HTS • Condoms • Contraceptive Mix • Post-violence care • PrEP • Referral for Group-ANC-differentiated service delivery model *(for eligible pregnant and BF young women per MOH guidelines)* • Enhanced Economic Strengthening *(for the out of school)*
Contextual	• Reducing risk in sexual partners (HTS, VMMC, ART) *(to be provided through effective linkage to the broader PEPFAR program)* • Community mobilization & Norms Change (SASA) • Condom promotion campaign/demand creation • PMTCT Group-ANC model or longitudinal follow-up through 2y post-partum in mother-baby care point for pregnant and breastfeeding AGYW (10-19 • Referral to ART		

Orphans and Vulnerable Children

The OVC program will target 423,761 children aged 0 to 17 and their caregivers, of which 371,700 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 11 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 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 COP20 and will continue and/or expand in COP21. Additionally, the *Journeys Plus* curriculum will be adapted for community-based implementation 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, continuity of treatment 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 100% (FY20). 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 FY20). 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 51% of the newly identified positives at 1st ANC visit (ANC1) in PMTCT supported PEPFAR sites (FY20). 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 FY21 Q1 was 1.3% among those infants tested, with 0-12 months EID coverage at 88%, an improvement from 83% at FY20 Q4. However, in FY20 and FY21 Q1, 0-2 months EID coverage was 67.1% and 74%, respectively. This gap in early diagnosis indicates missed opportunities for early intervention, that we will address in COP21.

COP21 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 COP21, we expect 1,501,498 pregnant women to attend ANC1 at PEPFAR supported sites. Of these, we targeted 100% to have known HIV status. Among the estimated 6% of pregnant women who are HIV-positive, 89,188 (99%) are targeted to receive ART among which 94% (83,853) are expected to already be on ART at ANC1 and 6% (5,335) will be new on ART. Additional COP21 targets include 95% treatment continuity and viral suppression among pregnant women initiating ART; 90% 0-2 months EID coverage; 99% 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 (>50%) 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 PMTCT & EID services, PEPFAR Uganda will work with MOH to improve functionality and 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). PEPFAR Implementing Partners (IPs) will 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. IPs will routinely review all the ANC, maternity registers, and postnatal registers to ensure adherence to guidelines and proper documentation.

Treatment, initiation, and continuity

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 treatment continuity 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 COP21 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 treatment continuity of mother-infant pairs in care until 18-months final outcome status post-partum.

In COP21, additional focus will be directed to support Health Centre IIs to address sub-optimal ART 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.

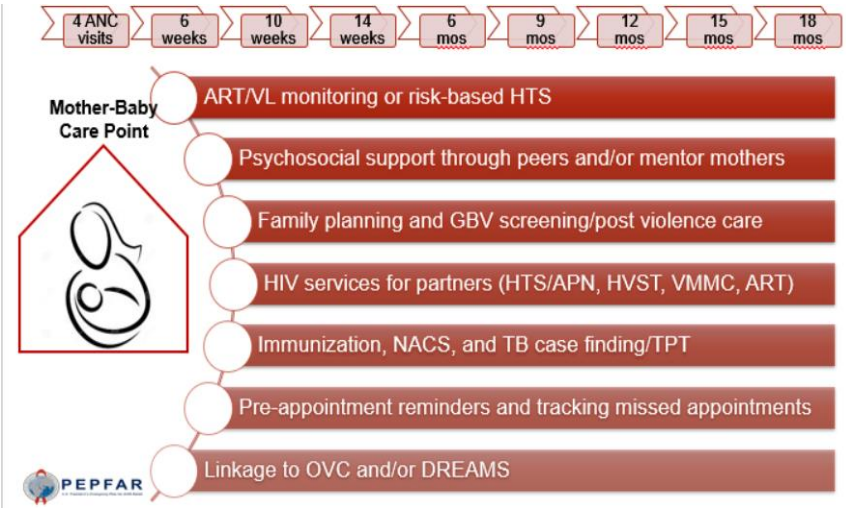
In COP21, PEPFAR Uganda and MOH will optimize the functionality of 250 high-volume ANC/MCH HCIIs through American Rescue Plan Act (ARPA) catalytic support to improve coverage of PMTCT/EID services, enhance continuity of treatment and follow-up of identified mother-infant pairs until 18-months final outcome status. This will be achieved through the following strategies:

- Establish Mother-Baby Care Points (MBCPs) at targeted high-volume ANC/MCH HCIIs to improve access and coverage of EID and PMTCT services for mother-infant pairs
- Support redistribution of essential HIV commodities including HIV rapid test kits, self-test kits, ART, EID bundles, and others enable operation as Community Drug Distribution Points (CDDPs) or satellite clinics for higher-level health facilities (HCIIIs and IVs)
- Strengthen M&E systems and reporting for program indicators
- Leverage the Regional Referral Hospital mentorship model to build the capacity of HCII staff and ensure quality assurance for PMTCT/EID results
- Utilize the Continuous Quality Improvement approaches to identify and address process gaps and challenges iteratively
- Recruit and retain mentor mothers and counsellors at the HCIIs to provide intensified peer support to minimize barriers for same-day ART, male partner case-finding and enhanced community-facility linkages

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 are linked 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 the same refill date for the mother and baby; pairing mother and baby charts; engaging peer mothers 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 treatment continuity for 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 experienced interruptions to treatment 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. 3 MBCP service delivery approach



Viral coverage and suppression for pregnant and breastfeeding women

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 updated WHO recommendations on HIV prevention, infant diagnosis, antiretroviral initiation, and monitoring guidelines (March, 2021), indicate that the addition of point-of-care viral load testing is a progressive step towards improving the use of viral load in a variety of settings, and may also be considered for use in specific populations critically needing more rapid test results, including pregnant and breastfeeding women and infants less than two years of age.

PEPFAR Uganda PMTCT program data, FY21Q1 shows 92% Viral Load (VL) suppression among pregnant & breastfeeding women (PBFW) despite low viral load coverage rates of 28% across PEPFAR IMs. The indicator definition and reporting for VL coverage among pregnant and breastfeeding women is a challenge across PEPFAR programs, Headquarter and Country SI & MCH teams are addressing this. Pockets of low VL coverage among PBFW at targeted sites and districts are being addressed through rollout of VL Point-of-Care testing in COP 21. Implementing Partners will adapt the VL change package from the National QI collaborative to

address gaps in VL coverage for PBFW. Additionally, ANC/PMTCT staff are included in the VL collaboratives as well as the multidisciplinary switch teams at the facilities to ensure that the 10-point VL change package is being implemented at all PMTCT/EID sites.

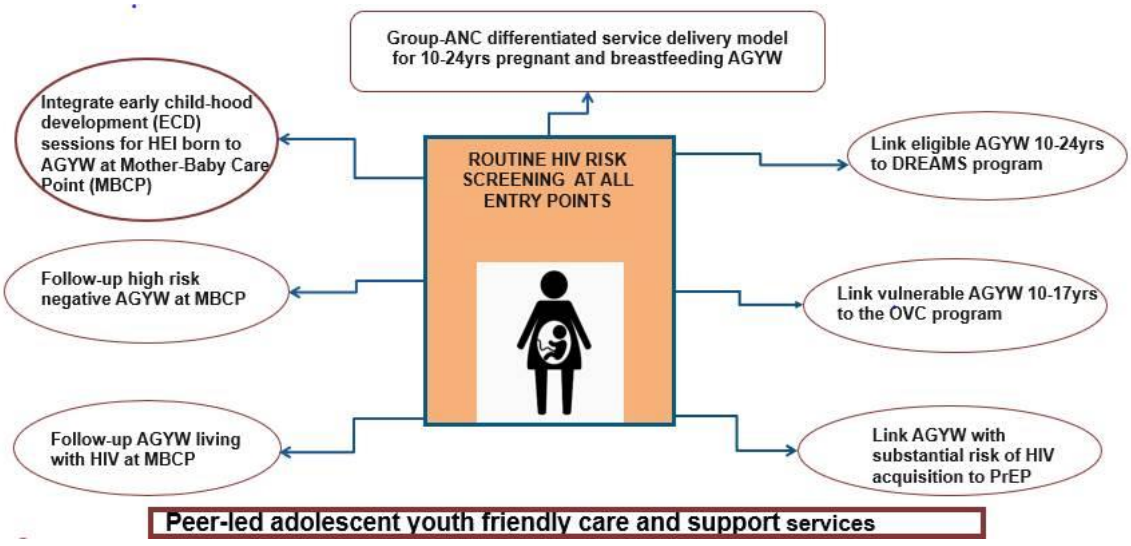
Preventing new infections among pregnant and breastfeeding AGYW

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 FY21 Q1, almost half (51%) 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 FY21Q1, only 24% of male partners were tested in ANC settings. COP21 will continue to strengthen male partner involvement in ANC/PMTCT activities including male partner index contact tracing and HIV self-testing services using the ANC/PMTCT platform.

In COP21, PMTCT programs will leverage existing DREAMS and OVC PEPFAR platforms for comprehensive service delivery targeting eligible pregnant and breastfeeding AGYW and their infants.

PEPFAR Uganda will implement integrated programming and cross-program linkages to address HIV risk, seroconversion, interruptions to treatment, and Gender-Based Violence (GBV) among vulnerable pregnant & breastfeeding AGYW using a Peer-led Adolescent Youth-friendly model.

Figure 4. 4 Leveraging DREAMS & OVC platforms for comprehensive service delivery for pregnant and breastfeeding AGYW at facility and community levels



Group ANC/PNC for Pregnant & Breastfeeding AGYW 10-24 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 a need to differentiate this sub-population group and provide evidence-based, tailor-made service packages that respond to their dynamic needs.

In COP20, Group ANC differentiated service delivery was rolled-out in 130 sites in 43 districts. Preliminary program data shows improving trends in treatment continuity among AGYW 10-24 years in supported districts. In COP21, the intervention will be scaled with fidelity to 155 sites to increase geographic coverage within high-volume ANC/PMTCT sites for improved maternal and infant health outcomes.

Electronic Medical Records (EMR) and Point of Services (POS) data capture to improve treatment continuity, tracking and follow-up of Pregnant and Breastfeeding women, and HIV Exposed Infants (HEIs

Program data for PMTCT/EID MER indicators is largely derived from numerous paper-based M&E tools at PEPFAR supported PMTCT sites. Coupled with clinical service delivery, midwives face a huge workload to correctly complete all these paper-based M&E tools hence compromising data quality of PMTCT/EID data. Some of these tools do not support longitudinal tracking of mother-infant pairs throughout the cascade of care and patient-level data is de-linked, i.e., from pregnancy, labor and delivery and the postnatal period. Currently, 50% of PMTCT MER indicators can be derived from EMR which affects the quality of data to inform programming.

Building off COP20 PMTCT/EID EMR and POS investments at high-volume mother-baby care points (MBCPs), PEPFAR Uganda in collaboration with MoH will scale-up and operationalize the use of EMR solutions and POS data capture to improve service delivery, PMTCT/EID clinical management, client follow up, treatment continuity, and data quality at HCIIIs and above.

Proposed strategies to achieve these milestones include:

- Support the utilization of server-based installations through the establishment of local area networks within health facilities
- Customize UgandaEMR to include all MCH/PMTCT data collection and reporting requirements
- Utilize a phased approach model of implementation starting with selected high-volume health facilities to enable learning and inform scale-up to other sites
- Build capacity of MNCH staff and data clerks in electronic data management and analysis
- Regular targeted support supervision and mentorship focused on improved functionality and use of Uganda EMR in MNCH/PMTCT

Care for the HIV Exposed Infant (HEI) and Early Infant Diagnosis

In COP20, PEPFAR Uganda in collaboration with MOH is implementing tailored EID surge interventions to improve overall coverage of EID 0-12 months to 95% with 90% targeted to receive the EID test within two months of age. These interventions will increase early initiation of ART for HIV-positive infants and improve linkage to ART initiation. The MoH EID surge interventions include:

- Placement and utilization of 100 EID POC m-Pima machines at 133 sites to improve 0-2 months coverage in hard-to-reach regions and sites
- Line-list all mother-infant pairs and HEIs due for DNAPCR testing for immediate follow-up
- Community EID sample collection & integrated CDDPs at high-volume MCH/PMTCT HCIIs
- Strengthen maternal literacy and peer-to-peer counseling support
- Leverage the OVC platforms to support transport needs for vulnerable, pregnant and breastfeeding AGYWs

In COP21, PEPFAR Uganda will institutionalize these interventions across all PMTCT/EID supported regions and sites.

Early Infant Diagnosis POC testing and scale-up for HIV Exposed Infants

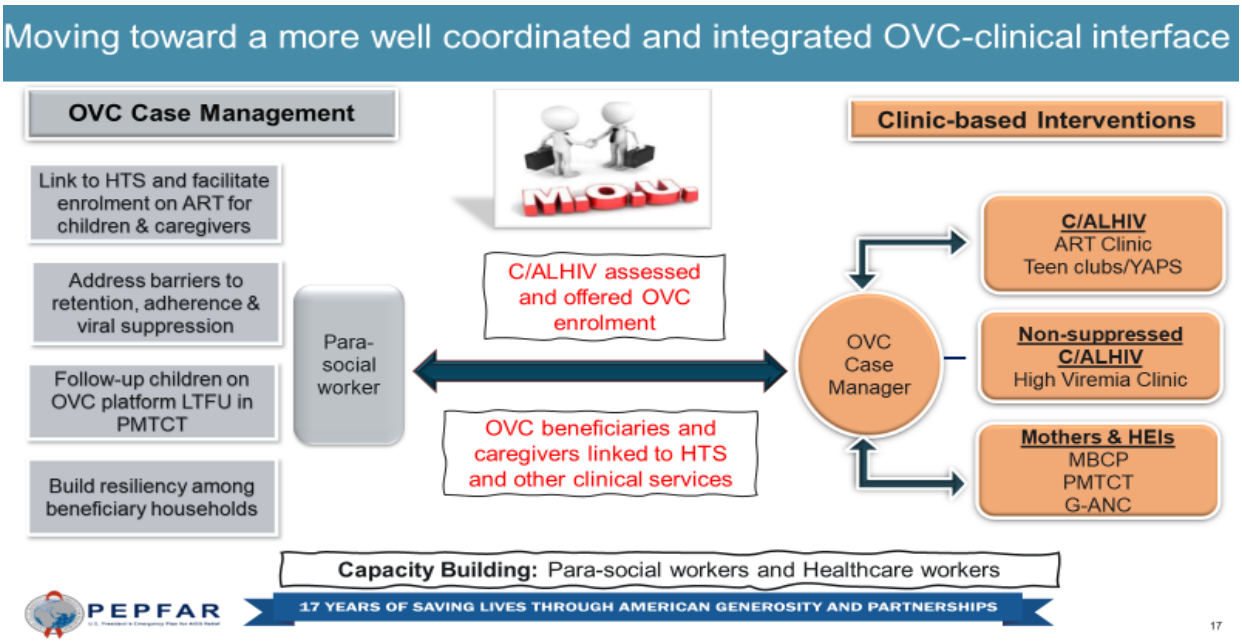
National EID POC testing volumes increased from 13.5% (FY21Q1) to 20.5% (FY21Q2), thus achieving the COP20 target of testing 20% of samples through POC testing platforms. Factors that led to this improvement include: placement of m-Pima POC machines at 133 sites; training, support supervision and mentorship of HCWs at POC sites; and weekly the Ministry of Health EID surge performance monitoring meetings. In COP21, PEPFAR in collaboration with the Ministry of Health will scale-up EID POC implementation to a 40/60 split, with 40% of EID tests done through the POC platform. EID POC will improve EID 0-2 months coverage, Turnaround time (TAT) and same-day linkage to ART for positive infants. Strategies to accelerate utilization and scale-up of EID POC testing include:

- Optimize referral for EID POC testing at all facility entry points: MCH/MBCP clinics, pediatric, nutrition, immunization, and TB wards
- Skill-based mentorships for health care workers and lay providers on proper sample collection
- Demand creation through treatment literacy for caregivers
- Expand EID POC sample collection from peripheral facilities and community outreach sites
- Multiplexing GeneXpert POC machines at targeted regional referral hospitals

Optimization of the conventional EID platforms and sample transport network will continue. The quality of EID/Expanded Program on Immunization (EPI) integration will 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 OVC services.

For children and adolescents eligible for OVC programming - In COP21, and in line with OGAC guidance, PEPFAR Uganda will continue to strengthen the Clinical-OVC interface and leverage the OVC program to improve treatment continuity and viral suppression for infants, C/ALHIV as per the figure below. An OVC case manager or focal person will be based within each high-volume 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. The OVC program focus on supporting the pediatric clinical cascade will continue to be built on a comprehensive package of OVC services including parenting and economic empowerment, that will be provided to all households enrolled in the comprehensive program.



This comprehensive OVC programming will be offered to 90% of C/ALHIV in the 78 districts where PEPFAR supports OVC programming (**73,448** of **88,142** TX_CURR 0-19) to cover an estimated 66,103 C/ALHIV and their households. As of Q1FY21, **37,390 (57%)** C/ALHIV were already enrolled in the OVC program, of which 77% had VL results available to the OVC provider, and 84.4% of those were virally suppressed. We anticipate enrolment of an additional 28,713 C/ALHIV into the OVC program by the end of COP20/FY21. 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. Children of Female sex workers on treatment will also be targeted for enrolment on the OVC

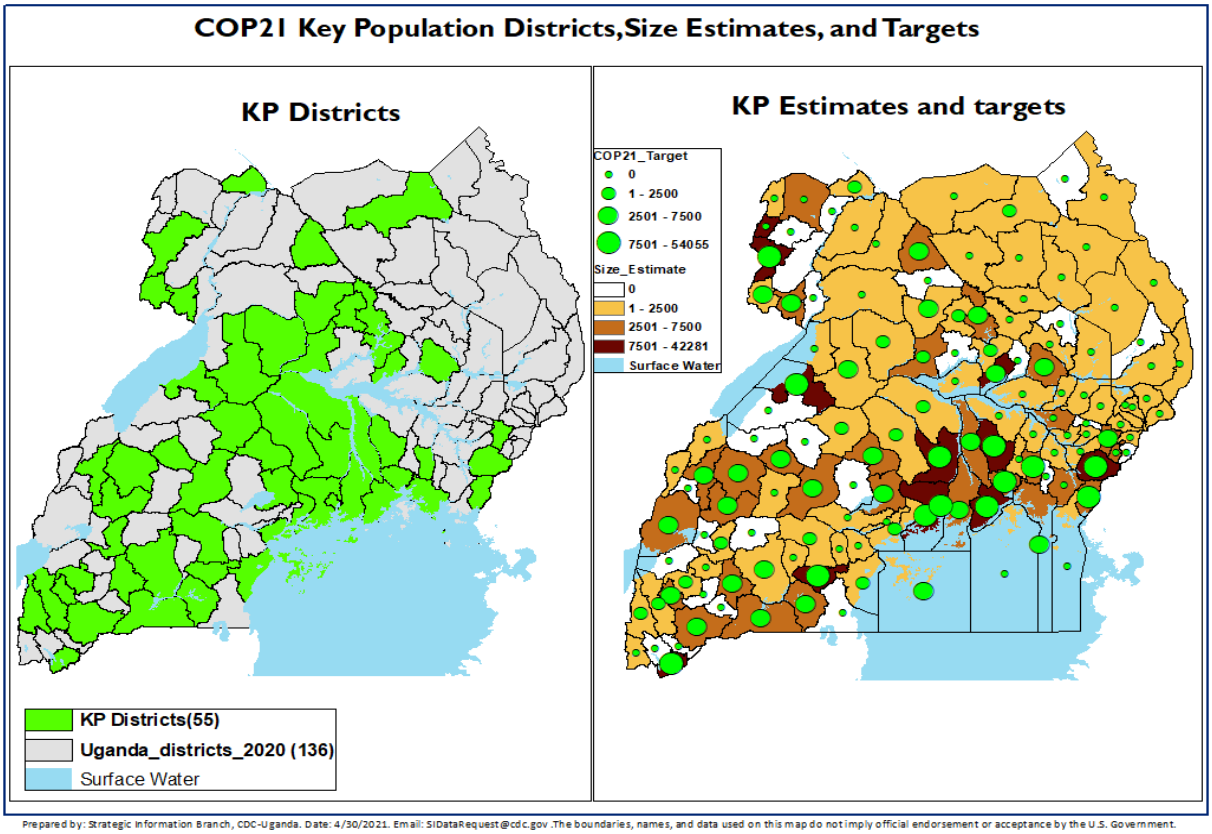
program while ensuring confidentiality and working with the clinical IPs. In addition, the program will purpose to enroll HEIs of adolescent mothers onto the OVC program to support treatment continuity for the mother and timely completion of the EID cascade. We are currently developing additional custom indicators to support the tracking of EID outcomes among OVC beneficiaries.

4.2.b. COP19 Key and Priority Populations, Pre-exposure Prophylaxis (PrEP)

PEPFAR Uganda identifies key and priority populations (KP/PP) as indicated in the graphic table below *"COP21 Key Population Districts, Size Estimates, and Targets,"* which also includes population size estimates, coverage goals and targets. Targeted KPs include female sex workers (FSW), men who have sex with men (MSM), transgender women (TG), prisoners, and people who inject drugs (PWID). In COP21, we have also targeted 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. 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. 5 COP21 KP Districts and KP Estimates and Targets



Our targeting was informed by UNAIDS, the UAC national harmonized size estimates study, UPHIA 2017, KP estimates, FY 20 program performance data and feedback from civil society organizations. The total COP21 KP_PREV target is 284,811 and PP_PREV is 108,122. In COP21, we will maintain the total number of KP/PP_Prev at 371,916 in 55 districts. We maintained the categorization of nine (9) SNUs with high incidence and high KP populations as high priority. Forty-six (46) SNUs now categorized as priority SNUs were "high to moderate" for both KP population and incidence.

PEPFAR Uganda's KP/PP program will implement the client-centered KP service package with fidelity, and will monitor and report the prevention and treatment cascades. The program will utilize Community Led Monitoring (CLM) and Community Score Cards as feedback mechanisms to improve accountability and service quality. The KP program will utilize other prevention platforms including VMMC, PMTCT and PrEP to reach KPs and ensure referral to other high impact prevention interventions, as well as working closely with the OVC program on getting children of KPs into care. In COP21, PEPFAR Uganda will use differentiated service delivery models to improve identification, linkage to and continuity on antiretroviral treatment (ART). In addition, the key populations program will ensure referrals to the DREAMS program particularly for FSW aged 10 – 19 years

The PEPFAR Uganda KP/PP program will continue to focus on violence prevention and response through the scale-up of community social norm changes, building capacity of CSOs for advocacy and leadership, training of health workers to screen and detect GBV cases, improve GBV case management, documentation, and reporting, as well as by continuing to support CSO-led Hotlines. Hotlines have been noted as a Best Practice for identifying, reporting, and acting upon human rights violations. The program will continue trainings in KP and PP Friendly Service Delivery, including Gender & Sexual Diversity (GSD) trainings to address stigma and discrimination at the facility level and community level.

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 Ugandan CSOs to enhance identification, enrollment, and treatment continuity of KPs in HIV services. We will leverage use of social media to improve HIV services, especially for MSM and TG. This includes use of WhatsApp, Facebook, and other CSO-driven applications/online groups to support adherence and viral suppression. We will offer and deliver 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 greatly improved from 71% in FY19 to 94% in FY20 and we will continue to implement population specific linkages and interventions in FY 21 to close the linkage gap further. The program will scale up KP-competent ART services to increase enrollment of more KPs on treatment. This will include same day ART initiation and fast track enrollment, community ART provision, physical peer escort and unique identifiers.

To enhance treatment literacy among KPs and their families, we will use educational, normative, and behavior change messaging, for example, "undetectable=untransmittable" or U=U messaging. We will continue strengthening peer navigation and monitoring systems and will increase efforts to reduce stigma and discrimination in both KP-specific ART sites and within the more mainstream clinical sites. The program will place pre-clinic appointment reminder phone calls and will perform weekly data reviews to identify missed appointments. Root Cause Analyses (RCA) will be used to design and improve interventions and will inform finalization of DSDM guidelines for KPs and PPs.

To further improve HIV treatment continuity and VL suppression among KPs/PPs, we will continue to implement intensified adherence counseling using peers, strengthen the community/facility framework, and ensure KP focal persons are present within facilities. And, for VL monitoring, the program will conduct file audits for VL uptake, line list all KPs eligible for VL testing and contact KP/PP clients through peer-to-peer approaches and text and telephone call reminders. The program will integrate VL activities (sample collection, result disbursement at community level/DIC) and target facilities with low VL coverage. These include peer-led defaulter tracking, monthly adherence support groups, multi month drug refills and intensified U=U messaging.

To improve the reach and quality of services offered to KP at DICs, PEPFAR Uganda and Ugandan Civil Society Organizations will standardize DIC service package and to strengthen reporting between the DIC and the health facilities. In addition, PEPFAR Uganda will support harmonized DIC data reporting processes.

In COP21 Uganda Prisons Service (UPS) will utilize a three-pronged approach to deliver comprehensive HIV services at the 56 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 will expand linkage and follow up through decentralized services, enhanced peer networks support, electronic medical records and use of the SMS linkage platform. To enhance prevention interventions, we will implement service layering with fidelity. Third, to further improve VL coverage (95%) and VLS (93%) we will implement VL POC testing for HIV and improve TB GeneXpert access by optimizing existing Xpert machines. In COP21 we will monitor the accredited facilities and ensure smooth operations, and this will inform expansion planning, scale up efforts to expand ART services to more prison facilities, and strengthening TB control efforts.

Uganda launched a Medication Assisted Treatment (MAT) program for PWIDs in COP20 using KPIF resources at Butabika Hospital, which already had an existing alcohol and drug unit. The challenges facing the MAT program include, low uptake, enrolment transport challenges, financial constraints, lack of client's family support, and the long screening process before the client PWIDs are initiated into the program. The activities for COP21 will include maintenance of the MAT program in Butabika with a COP21 target of 206 PWID and a formative assessment in Eastern Uganda to determine the need and feasibility of a possible MAT program in COP22.

The proposed remedial actions which will inform and improve MAT implementation in COP21 include:

- Recruitment of more highly networked peers;
- Training current MAT users to educate and refer PWID peers;
- Continue to line list clients from DICs and the PWID community;
- Developing demand creation messages by working with PWID communities:
- Using an incentivized coupon model to increase identification and enrolment;
- Extending services to community refill points through the mobile van services; and
- Partnering with CSOs to advocate for relevant organizations for social services support to MAT clients.

Promoting condom and lubricant last-mile distribution by improving risk perception among KP will be a major focus of COP21. Condom promotion and distribution channels will be strengthened through interpersonal communication and 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. The program will also procure Syphilis duo and STI drugs.

In COP21, the PEPFAR program will build the capacity of KP CSOs and enhance coordination efforts as part of the PEPFAR Uganda vision of strengthening country ownership and sustainability. Under COP20, two Legal Environment Assessments are underway, one focuses on Ugandan PLHIV, and the other focuses on Key Populations. We will utilize in COP21 the findings from the two Legal Environment Assessments to help shape and inform legal advocacy and policy reforms related to KP and PP. Moreover, PEPFAR Uganda will use the Legal Environment Assessment findings, together with the Stigma Index data, to explore options to improve the legal environment, which currently in Uganda is not conducive for some client groups to access quality care in health facilities and at the community level. Under COP21, PEPFAR Uganda will take concerted action to counter the persistent barriers to quality care that are posed by legislation such as the "Sexual Offences Bill" passed by the Ugandan Parliament in May 2021. To improve targeting and programming, we will expand the upcoming COP21 IBBS to six (6) additional districts beyond Kampala. PEPFAR Uganda will involve KP CSOs and KP and PP representatives in the planning and design of the new KP CSO capacity-building activity.

Stakeholders such as UNAIDS and Ugandan Civil Society have asked PEPFAR Uganda about the metrics and indicators that COP 21 would use to gauge progress against stigma, discrimination, and human rights violations. The Global Fund commissioned the preparation of Uganda's *National Human Rights Plan 2020- 2024*, and that plan has an M&E Framework which represent metrics that the GOU is considering. PEPFAR Uganda could align with those indicators as well as with the PEPFAR MER and COP21 guidance and technical considerations as related to planning, programming, and measuring the progress of interventions to reduce stigma, discrimination, and human rights violations.

In COP21, the program will scale up Assisted Computer Self Interview (ACASI) to improve HIV risk categorization. Working with CSOs, we will improve case finding by deploying lay screeners to increase HTS efficiency and targeting. To address low yield of HIV positives among KP/PP tested.

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[8] • 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)
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	• 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[9] • Post-violence care • Condoms[10] • 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

[8] 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.

[9] Need advocacy and policy change for this to be available

[10] Current Prisons policy does not allow condoms for prisoners

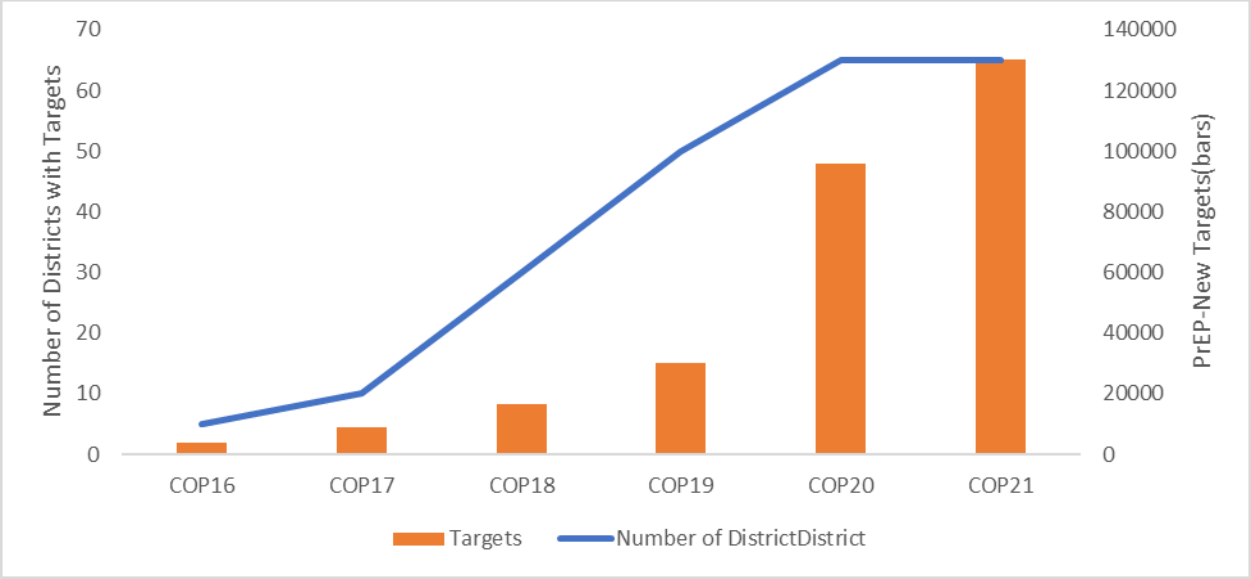
	• Lubricants • Curriculum based HIV prevention			(MAT) including buprenorphine, naloxone, naltrexone
CONTEXTUAL	• For partners: Referrals (HTS, VMMC, ART) • Community mobilization & Norms Change (SASA) • Condom promotion campaign/demand creation • OVC for children of sex workers • Stigma and discrimination reduction capacity building			

PrEP for Key and Priority Populations

Following CSOs' recommendations to scale-up PrEP in COP 19, Uganda PrEP targets have increased markedly to bridge the gap and to maintain sero-negativity among populations at substantial risk of HIV. PrEP targets increased from 30,001 in COP 19 and tripled to 95,833 in COP20. In COP21 PrEP targets will increase to 130,000, Figure (1) below shows significant, progressive scale up of PrEP since COP16.

PrEP targets, districts and sites

Figure 4. 6 **PrEP targets, districts and sites**

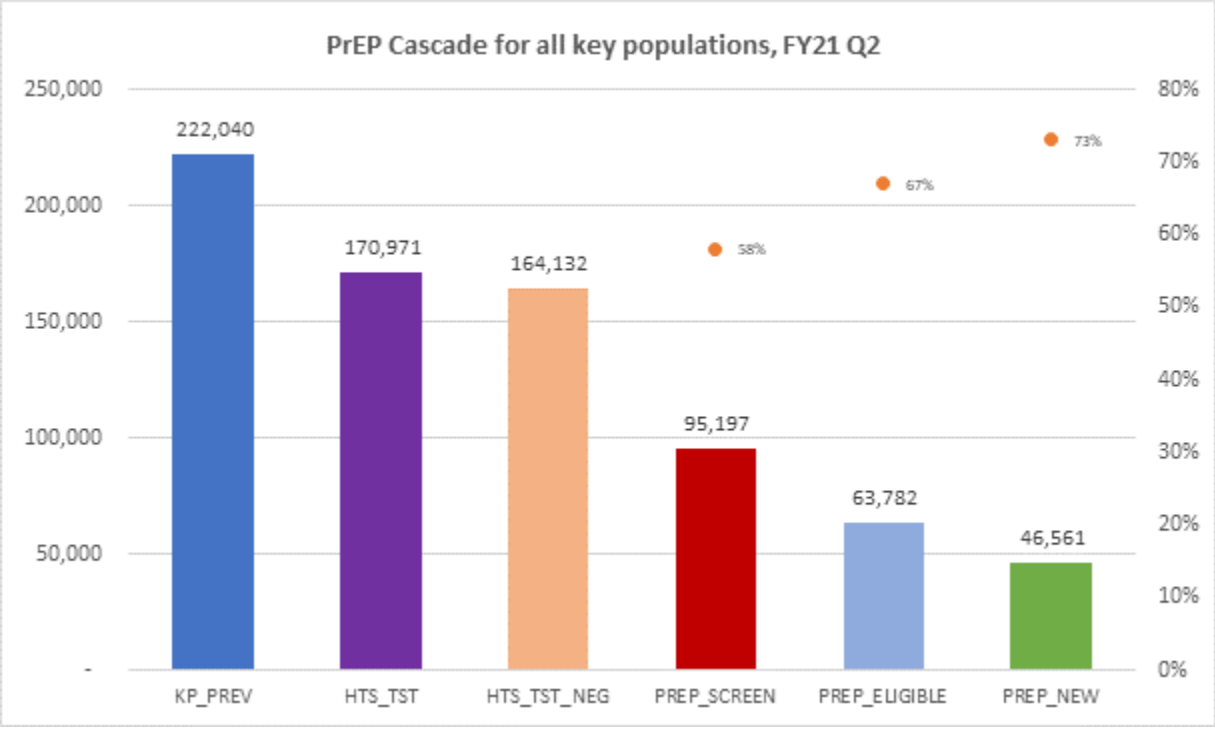


In COP21, overall, there is an increase in PrEP targeting for KPs, pregnant and breast-feeding women, and AGYW. About 36.3% (47,379/130,000) will be KPs, 29.8% (38,634/130,000) will be AGYW, 25.7% (33,483/130,000) will be pregnant and breast-feeding women, and the rest will be other priority populations including fisherfolks and sero-discordant couples.

COP21 PrEP Targets by Sub-populations

Sub-populations	Target	Percentage of Target
FSW	39,000	30.0%
MSM	7,418	5.7%
PWID	711	0.5%
TG	250	0.2%
Pregnant and breastfeeding women	33,483	25.8%
AGYW (15-19)	10,881	8.4%
AGYW (20-24)	27,753	21.3%
Fisher folks	4,231	3.3%
Sero-Discordant Couples	6,273	4.8%
Totals	130,000	100.0%

Uganda has had a progressive achievement against PrEP_NEW annual targets since FY17, with an overachievement of 126% (37,831/30,001) in FY20. Based on the FY21Q2 PrEP cascade, there have been improved efforts in linking PrEP - eligible persons to PrEP_NEW.



A PrEP Root Cause Analysis (RCA) conducted during FY21Q1 found that main barriers to PrEP initiation include: personal fears; adherence readiness; taking drugs every day; managing social relationships; preference for condoms to drugs; and stigma. In COP21, the program will enhance Pre-PrEP initiation counseling to address these barriers. The RCA also highlighted that transport to facility and forgetting refill dates were among the key barriers to PrEP continuity. The program will continue implementing targeted differentiated service delivery models and multi-month dispensing to address these identified barriers.

The MOH has updated the national PrEP guidelines to provide a favorable policy environment for PrEP service delivery among AGYW, pregnant and breast-feeding women. In COP21, the program will continue scaling-up PrEP for AGYW to reach 38,634 AGYW on PrEP, the majority of these (71.3%) being 20-24-year-olds. Client-centered approaches including pre-appointment reminders, peer 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. And it will reinforce and promote consistent condom use among AGYW PrEP users. Based on COP20 early lessons from JCRC-Kigezi subregion, timely orientation of staff and proper use of risk classification tools, as well as adopting peer-led outreaches to AGYW-dominated spots have been very helpful in improving PrEP uptake among AGYW. These approaches will scaled-up in other regions in COP21.

In COP21, 33,483 pregnant and breastfeeding HIV-negative women, who are at substantial risk will be counselled and offered PrEP. The program will continue leveraging 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 support PrEP uptake by 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 clients interested in 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 will be linkage and referrals to other programs providing structural interventions.

Based on COP20 early lessons from Mubende region, extending PrEP services to the Expanded Program on Immunization (EPI) outreaches and intensification of screening at MCH and ART clinics have improved PrEP uptake among HIV negative pregnant and breast-feeding women. This will be scaled-up in other regions in COP21 to enhance PrEP uptake among this beneficiary population. In addition, the program will work with the MOH to update the Ministry's tools and update the PrEP tracker to capture PrEP data for pregnant and breast-feeding women.

In COP21, the PrEP program is targeting a total of 47,379 KPs and 10,504 other Priority Populations. The Program will continue to work with KP-CSOs adopting peer deployment to improve PrEP continuation and strengthen messaging for PrEP continuation among KP peers. In addition, the program will utilize DICs as community PrEP dispensing points and will employ DSDM models for PrEP. Anecdotal data suggest 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, COP21 will target reaching 130,000 individuals at substantial risk of acquiring HIV in 72 districts. The program will strengthen community-based initiation and refills for PrEP to enhance service uptake. The program will work with Social Behavioral Change Activity (SBCA) - the PEPFAR communication partner, to implement PrEP demand generation focused on creating a supportive environment for PrEP uptake and continuity and leveraging digital health in social behavioral communications. We will continue to focus on targeted 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.

Future Directions of PrEP in Uganda: The issue of ambitious PrEP expansion was discussed during a meeting held May 5, 2021 amongst Civil Society Organizations, members of Key and Priority Populations, and representatives of the US government agencies that comprise PEPFAR Uganda. It was agreed that significant scale up of PrEP services is warranted in Uganda beyond the current target, which is only a 26% increase; however, given the current low retention on PrEP, as the COP20 program moves into COP21, the program should focus on improving quality, with the understanding that, if the PrEP program performs well during the COP 20 and first quarter of COP21 implementation period then, on the basis of target achievement, PEPFAR Uganda would request the PEPFAR Office of the Global AIDS Coordinator to allot additional funding to Uganda for further scale up PrEP programming.

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 2017-2020, indicate that by the end of FY21, the total number of male adolescents and men aged 15-29 years eligible for VMMC nationally was 5,098,153. Program data show that 4,231,346 VMMCs have been conducted to date among the 15-29-year-old age band, representing 74% 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 1,027,755 in the 15-29-year age group.

Scaling up VMMC is critical to Uganda achieving epidemic control. In FY2021, PEPFAR Uganda supported 311,927 circumcisions. Building on these efforts and to increase the immediacy of impact, the COP21 strategy is to maintain high coverage among the 15-29 year male age bands. 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.

VMMC outreaches were heavily impacted by the COVID-19 pandemic, which resulted in a significant decrease in performance in FY20Q3, with many VMMC services partially or completely suspended. COVID-19 mitigation measures are still affecting the VMMC outputs. However, services at most VMMC sites have resumed after essential risk mitigation interventions needed to comply with national standards were implemented. In order to address the challenges of COVID19, the program has implemented a multi-pronged strategy:

For demand creation:

- Implementing Partners have engaged in small group education, door to door IPC mobilization and village-to-village drives
- The number of volunteers transported per vehicle to circumcision sites was reduced as per GOU guidance
- Partners have adapted health communication to include COVD-19 risk communication and to address the fears of possible MC clients on possible acquisition of COVID19

For service delivery:

- Implementing partners have worked with the Ministry of Health to accredit lower Health Center III's that are closer to the communities to provide mini VMMC camps while observing COVID-19 standard operating procedures

In COP21 VMMC IPs will continue implementing 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, use of VMMC VIP card, engaging private providers to increase access to services, and reinforcing key VMMC demand generation messages using various channels including:

    - 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;
    - Two-way, longer-format radio programming to allow for dialogue with featured guests including providers; and
    - 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.

The COP21 targeting process triangulated data from Uganda Bureau of Statistics, 2020 population projections to estimate number of circumcised males 10-64 years and the 2020 circumcision

unmet need. The estimated district coverage of 2021 was calculated by estimating number of men circumcised from the 2011 AIS and 2016 UPHIA data in addition to 2020 VMMC program data. Distribution of targets focused on regions with high circumcision unmet need and high HIV burden including all KP and DREAMS districts in addition to partner performance in districts with more targets assigned to high performing districts. Eighty percent of the targets were allocated to the 15-29 age group, 19% to the 30+ and 1% in the 14-year-old boys to be implemented using ShangRing only. Six percent of the total MC targets will be implemented using ShangRing and 5% were allocated to fisherfolk and truckers.

Key shifts and considerations in COP21

- The Uganda VMMC program will support **decentralization of adverse events management from the capital city by establishing Severe Adverse Management Centers (SAMCs) in five Regional Referral Hospitals**. The SAMCs will serve as referral centers for managing SAEs plus other complex VMMC-related adverse events (AE) referred from lower levels of health care.
- **Investments in infection prevention (PPE)** for clients and health care workers within COVID-19 operating context.
- **Integrate violence intervention messaging on the VMMC platform** through an abridged INSPIRE messages package to build the capacity of communities to prevent violence against children.
- **Budgeting for STI medicines on the VMMC platform in COP21 to avoid over dependence on the GOU**, which occasionally has stockouts that have resulted in missed opportunities for circumcision of clients who are at high risk of HIV acquisition.
- As part of its sustainability agenda, PEPFAR Uganda **will increase the proportion of the reusable instruments from 50% in COP20 to 60% in COP21.** 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 resource, consistent supply of electricity and water to support proper functioning of the autoclaves have been budgeted.

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 performed. 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.

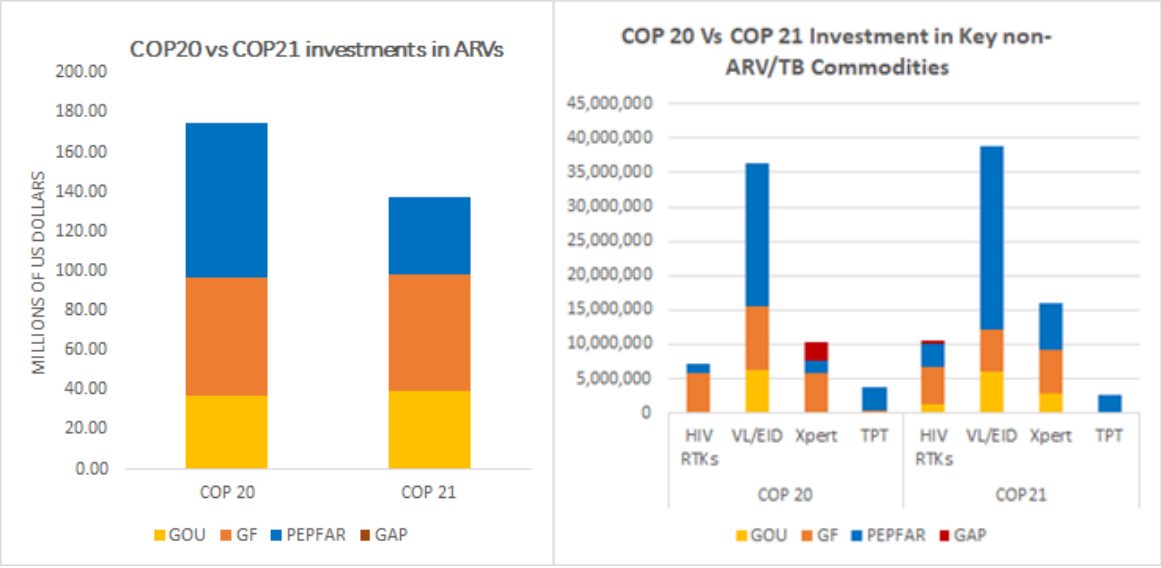
4.4 Additional country-specific priorities listed in the planning level letter

MOH revised the national HIV treatment guidelines in 2020, aligning to WHO guidance and adopting policy changes that facilitate improved treatment continuity 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 and recently issued a circular that expands MMD eligibility
- Toxicity monitoring: strengthened guidance on standardized process for drug toxicity monitoring.

4.5 Commodities

Uganda is committed to commodity security for HIV epidemic control. Notably, since 2018 there has been a 120% increase in GOU's earmarked annual HIV commodity funding from $23.7M in 2018 through $36.7M (2019) and $49.7M(2020) to $52.6M (2021). Joint forecasting and supply planning between GOU, GF, and PEPFAR has ensured full funding in COP21 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 of commodity shortages due to unavailability of funds and lengthy procurement timelines. The figure below provides a snapshot of the comparative investment between COP20 and COP21, as well as illustrating the increase in GOU funding and the diversification of funding sources.



ARVs

The GOU's commitment to increase funding for ARVs during COP20 was realized and ARVs are fully funded for both COP20 and COP21. In summary, for COP21, GOU has committed $39.4M, Global Fund $59M, and PEPFAR $38.9M. 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 2021, over 864,595 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 70% 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) as these are expected to be available during the COP21 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 Warehouse stock status reports, web-based ART Ordering System (WAOS), NMS ERP Customer self-service portal and Real Time ARV Stock Status (RASS) systems.

Whereas previously Global Fund 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 COP21, 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)

The commodity needs to test all HIV exposed infants nationally through December 2022 are fully covered through contributions from the GoU, GF, and PEPFAR. PEPFAR is contributing USD 3,363,120 to conduct ~285,605 tests in COP21, or nearly half of the national need. EID POC testing will continue to be prioritized for high throughput and hard to reach areas with a focus on optimal utilization of the 133 existing POC platforms and multiplex testing on both newly placed and underutilized GeneXpert POC machines at additional sites based on findings from a recent GeneXpert utilization assessment. The PMTCT program is aiming to double the proportion of EID tests conducted on POC platforms from 20% in COP20 to 40% in COP21. The national supply plan has conservatively budgeted for 35% POC commodities as a starting point in order to minimize risk of expiries, with planned adjustment based on monthly consumption rates as utilization of the POC platform increases. Sufficient funding is available to accommodate an increase to 50% EID POC testing or beyond, particularly in light of an expected global price reduction for EID POC cartridges. Please see the Section 4.9 for further details on POC plans.

TB Preventive Therapy (TPT)

By the end of COP20, over 1,049,529 PLHIV are expected to have received TPT with INH/B6. COP21 will cover the remaining 342,424 individuals with procurements by both Global Fund 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

Three hundred fifty thousand eight hundred and six (350,806) GenXpert tests were done in FY21 with a drastic drop in testing and cartridge utilization at the end of COP19 Q1 due to COVID_19 country lockdown and long turnaround times (TAT) for equipment maintenance. Gradual increase in testing and consumption has been noted since end of COP20 Q2. Uptake of TB LAM has been slower, but with the completion of the advanced disease implementation plan and intensified mentorship planned for COP21 implementation, utilization is expected to increase by 33% between CY20 and CY21. In response to this increase in utilization of improved TB diagnostic technologies, Uganda is planning for additional 523,500 Xpert cartridges and 565 TB LAM kits for CY22/COP21. In addition, the country team working with National TB Reference Lab has continued to monitor implementation of the GenXpert access care following the signed a Memorandum of Understanding (MOU) between MOH and Cepheid, where the supplier will ensure proper management of the GenXpert equipment and consider placement of 16 module platforms for TB high volume facilities.

During FY21 seven (7) 16 module GenXpert machines will be procured by Global Fund thus increasing access. In COP21 $6,374,452 (with $3,486,514 public sector gap fill) has been allocated from PEPFAR. With the commitment of $6,311,500 from Global Fund FY22 and proposed request of funding to GOU of $2,894,737 the COP21 GenXpert commodity requirement will be funded 100%.

Advanced disease and cervical cancer commodities

In order to address the contribution of advanced disease to client attrition, PEPFAR and Global Fund 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.

In COP21 $2,894,737 has been allocated for CD4 testing and for the first time PEPFAR will fund CD4 rapid testing (i.e., Omega Visitect CD4), at a value of $743,210. This is expected to increase access to CD4 testing. This is essential to determine eligibility for advanced disease diagnosis and management. PEPFAR is also investing $1,399,830 in commodities and equipment to diagnose and treat cervical cancer for the proportion (40%) of the targeted women living with HIV that will not be reached in COP20. These will include 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 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 523,810VMMC procedures during COP21 and currently fully funds the national program commodities requirement. Uganda will increase circumcisions carried out using reusable kits from 50% to 60% (314,285), while decreasing procedures carried out with disposable kits from 50% to 40%. In COP21, 5% of the procedures are targeted for the ShangRing approach for fishermen and truck drivers.

4.6 Collaboration, Integration and Monitoring

The United States (U.S.) American Rescue Plan (ARP) Act of 2021 contribution of $3,500,000,000 to the Global Fund is supporting the Global Fund COVID-19 Response Mechanism (C19RM) in a manner consistent with Board Decisions establishing and governing C19RM, including the Global Fund Board Decision approved March 30, 2021.

The U.S. ARP contribution to the Global Fund is intended for use in Global Fund to: Respond to COVID-19 and advance country preparedness for COVID-19; Mitigate the impact of COVID-19 on HIV, TB and Malaria Programs; Support recovery from the impact of COVID-19, strengthening health security and health security financing. The ARP contribution will support a continuum of actions, including:

- support for urgent, pure COVID-19 response needs;
- protection and scaling of HTM programs safely in the COVID-19 context; and
- investment in country health and community systems for advancing the COVID-19 response and simultaneously support preparedness for future health threats and support recovery.

Uganda received US $ 602,501,930 for grants for the three diseases HIV, Tuberculosis and Malaria from 2021 to 2023; of which $339,476,980 was allocated to HIV & Tuberculosis and $263,024,950 is allocated to Malaria. Through the C-19 Response Mechanism, Uganda received US $61m in 2020 to mitigate the impact of COVID-19 on the implementation of the three disease programs, and to perform systems strengthening to better respond to the COVID-19 pandemic.

The country is currently developing another application amounting to US $86, 850, 290 under the Global Fund C-19 Response Mechanism, with close involvement of USG subject matter experts. Relatedly, the USG team has submitted a proposal for US $19,925,000 million under the United States (U.S.) American Rescue Plan (ARP) Act of 2021. These funds are expected to complement available resources from Government of Uganda, Global Fund and other Development Partners to

respond to COVID-19 and mitigate the impact of COVID-19 on the three disease programs. There is continued collaboration with PEPFAR to align resource allocation and service delivery to ensure efficiency gains for the three diseases and COVID-19 response.

Close collaboration with the Global Fund has been instrumental with two separate COVID-19 funding mechanism grants amounting to 146 million USD. USG provided experts and consultants to help write the grants and worked closely with stakeholders to coordinate funding priorities. USG was also instrumental in assisting Global Fund Uganda virtual site visits, which were modeled after similar USG initiatives to maintain communication with the field. The USG continues to have a strong presence in CCM committees, with team members on every sub-committee to help facilitate coordination. 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 Global Fund to provide key programmatic and policy updates.

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 FY 2022, 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.

Collaboration with Host Country MOH Entities and Initiatives

PEPFAR will conduct root cause analysis for the Ugandan MOH-led national Quality Improvement Collaborative Initiative. Under COP21, PEPFAR would 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 Global Fund with other in-country financing mechanisms. PEPFAR Uganda 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 Global Fund counterparts and the MOH Quantification and Procurement Planning Unit (QPPU) to coordinate procurement schedules, distribution, and systems strengthening. PEPFAR Uganda and Global Fund 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 Global Fund 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 was 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 continuity 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.

For COP21, PEPFAR Uganda will actively engage and collaborate with stakeholders in all aspects of strategic planning. To this end, our team conducted an in-country strategic planning consultation with local stakeholders at the end of January 2021, where we introduced and discussed all COP21 tools, guidance, results, and targets, as well as the proposed trajectory and strategy for COP21. Even after the COP21 submission, we have planned for continued engagement with external stakeholders through routine sharing of data from the PEPFAR Oversight and Accountability Response Team (POART) (Details are in Section 2.6). The USG is represented on the CCM, across all participating PEPFAR Uganda agencies.

The 2021 round of the Global Fund grants making cycle coincided with the COP20 implementation season. The overlap in COP20 and Global Fund planning provided an opportunity for Uganda to consider all resources at one time and plan holistically using shared epidemiologic data, program results, outlays, and planning levels. Uganda continues to collaborate with the Global Fund and others to better align resources, avoid duplication, drive efficiency, and improve the cost data and resource estimations of HIV treatment and prevention programming. The multiyear Resource Alignment collaboration has provided harmonized financial data to better understand HIV investments across PEPFAR, Global Fund, and host country government, enhances strategic collaboration and coordination during program cycle planning, advances efforts around domestic responsibility and resource mobilization to ultimately ensure financial and programmatic sustainability of HIV programs. PEPFAR Uganda will actively continue engaging in consultations around the development of the Global Fund's next strategy, including soliciting input from all stakeholders to ensure informed PEPFAR priorities

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.

PEPFAR Faith & Community Initiative (FCI) Programming

PEPFAR Uganda's success has been built in partnership with community, including faith-based organizations (FBOs) and faith-based and traditional communities. Sixty to seventy percent (60-70%) of the Ugandan population attends religious services and participates in religious communities. These communities are well-structured and have deep, intimate networks into the community. The FCI in Uganda is designed to utilize those faith community structures and networks to accomplish two objectives: (1) to reach into the community in a very targeted fashion

and help find people at risk for HIV and bring them into care; and (2) to help address and prevent sexual violence against children.

In COP20, PEPFAR Uganda supported Faith & Community Initiative (FCI) programming through Uganda's four faith-based medical bureaus (Uganda Catholic Medical Bureau, Uganda Protestant Medical Bureau, Uganda Muslim Medical Bureau, and Uganda Orthodox Medical Bureau) as well as through local CSOs and FBOs, with support from the SBCA mechanism. These partners have provided direct HIV and TB service delivery at faith-based facilities and have engaged MoH, UAC, DHOs, and comprehensive partners to identify key areas where faith leaders and faith communities can address gaps in HIV and TB programming. In COP21, FCI partners will continue working with these stakeholders to identify critical needs and to engage faith and community leaders, including radio personalities, community change agents, bishops, priests, imams, sheikhs, youth leaders, and heads of marriage groups, men's and women's groups, youth groups, and choirs.

Ugandan Civil Society stakeholders have asked about the role that the faith based sector might play in addressing stigma and discrimination against PLHIV and other HIV-affected groups such as Key and Priority Populations. Below are some illustrative strategies and approaches that the FCI might consider to combat stigma:

- PEPFAR partners have been leading faith and community leader sensitization trainings and training-of-trainers. We welcome KP CSOs and other CSOs to review and suggest additions to these materials. We can facilitate that this quarter.
- We encourage our partners to sensitize and encourage faith leaders to respect confidentiality and employ other practices particularly necessary for PLHIV and KPs.
- We encourage our partners to convey to faith leaders the importance of destigmatizing approaches to demand creation. This might include access to the "safe faith spaces" during flex times, strengthening referrals to the health facilities, and stigma-free messaging. We can connect CSOs with funded partners to gather feedback on practices to suggest to faith leaders.
- The Ugandan Faith Based Medical bureaux have confirmed that they would like to be welcoming to all. We can encourage faith-based facilities to adopt and post non-discrimination statements in facilities so that KPs and others know they are welcome.
- The bureaux have proposed building capacity to ensure Community Scorecards are completed and used to improve services. We welcome CSOs to support FBOs and faith-based facilities in these efforts.

PEPFAR's global FCI is not providing additional funds in COP21, but the COP21 Guidance encourages allocation of core funding to support activities with evidence for success in increasing case-finding, linkage, and continuity of services amidst community transmission of COVID-19. PEPFAR Uganda is leveraging COP20 FCI investments to continue to engage faith leaders and faith communities. Key FCI interventions in COP21 will include:

- Direct HIV, TB, and psychosocial service delivery in faith-based PNFP facilities and affiliated community sites
- Establishment and operation of faith community sites for HIV and TB prevention, care, and treatment services

- Training of faith leaders on latest MoH guidance to support psychosocial needs of PLHIV and mobilization and demand creation for testing, linkage, VMMC, and other critical HIV and TB prevention, care, and treatment services
- Men's group interventions, including group dialogues, peer education, and disseminating FCI Messages of Hope in faith communities
- Participation of faith-based medical bureaus on national MoH and MoGLSD adolescent and young people's task forces
- Capacity building of religious counselors and other faith leaders in rapid GBV and VAC response and other HIV care and referral using both virtual and physical interfaces (e.g., referral to hotlines) through curriculum-based programs
- Capacity building of teachers to provide adherence counseling and psychosocial support to residential students living with HIV, including IEC with school peer health clubs

Approximately 40% of Uganda's healthcare service delivery occurs through faith-based PNFP facilities. PEPFAR Uganda will continue to support faith-based facilities for HIV and TB direct service delivery. In addition, COP21 will continue and build upon above-site FCI programs. In COP20, community champions were identified and trained in more than 100 churches and mosques for demand creation and distribution of HIV self-test kits in faith communities. Approximately 2,000 HIV self-test kits have already been distributed in Uganda through FCI in COP20; the majority were distributed to men, resulting in case identification and linkage to care. Some IEC and service delivery sites have been established in places of worship, including Catholic, Protestant, and Pentecostal churches and Muslim mosques. Pentecostal churches do not fall under umbrella medical bureaus, but influential Pentecostal leaders have been engaged in FCI programming. In COP21, these sites will be supported for IEC, demand creation, and service delivery where there are gaps to utilization of prevention, care, and treatment services and where faith and community leaders can impact healthcare-seeking behavior of faith community members.

In COP20, FCI partners including SBCA worked with MoH to gain approval for FCI Messages of Hope developed by the PEPFAR global FCI (https://www.faithandcommunityinitiative.org). Messages of Hope will continue to be disseminated to faith and community leaders and to faith communities through sermons (including Muslim *khutbas*) and subsidized radio programming (including IEC skits) for demand creation of critical HIV and TB prevention, care, and treatment services. COP21 programming will also include more targeted FCI activities with foci on engagement with men's group leaders and faith-based educational institutions where Messages of Hope will be delivered through peer leaders. FCI implementing partners will also engage women's groups, such as leveraging baby showers to improve PMTCT and EID programming.

GBV and VAC have increased during the COVID-19 pandemic. Faith leaders in Uganda have emphasized the need to confront increasing GBV and sexual violence against children. In COP20, FCI activities have been leveraged to train and sensitize faith and community leaders to respond to GBV and VAC through referrals to hotlines and healthcare services. In COP21, FCI partners will continue to fill gaps where MoH, DHOs, and other partners have expressed the need for faith leader and faith community engagement. Primary FCI activities addressing GBV and VAC will include curriculum-based programming and other capacity building for GBV and VAC response by faith and community leaders.

Finally, PEPFAR Uganda will continue to support CSOs through FCI. In COP20, this has occurred through funding PLHIV-led, KP-led, and other CSOs to reach people in faith communities through FCI activities. This will continue in COP21, and PEPFAR Uganda will integrate CQI into FCI programming to ensure that interventions are client-centered, impactful, and responsive to the needs of the community and gaps in PEPFAR programming. FCI implementing partners will support stakeholders in using the Community Scorecard to document feedback from clients to ensure high-quality client-centered healthcare services; critical feedback will be gathered through CLM and used to improve FCI programming if CLM teams set this as a priority.

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 for COP21**	**Expected current on ART (APR FY21)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY22) *TX_CURR***	**Newly initiated (APR FY22) *TX_NEW***	**ART Coverage (APR 22)**
Attained	371,210	365,555	0	347,483	12,129	94%
Scale-Up Saturation	583,957	512,700	0	543,466	34,081	93%
Scale-Up Aggressive	465,661	424,240	0	426,277	24,788	92%
Sustained	0	0	0	0	0	N/A
Military	N/A	24,302	N/A	22,353	528	N/A
Total	**1,420,828**	**1,326,829**	**0**	**1,339,579**	**71,526**	**94%**

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 FY22***	**Expected Coverage FY22**
Butambala District	33,492	51,809	59%	2,459	68%
Kalangala District	32,330	35,853	66%	1,184	70%
Lwengo District	89,926	136,733	61%	930	62%
Lyantonde District	37,148	54,654	78%	2,094	85%
Masaka District	113,998	159,770	70%	5,511	76%
Mpigi District	98,960	140,211	54%	4,428	60%
Rakai District	99,367	154,411	49%	3,560	53%
Kyotera District	87,296	125,962	70%	4,149	76%

Sembabule District	99,404	147,234	56%	3,772	61%
Wakiso District	992,849	1,375,126	58%	22,400	61%
Buvuma District	49,520	68,247	60%	2,500	66%
Kayunga District	127,111	195,879	78%	2,286	81%
Kiboga District	61,307	86,343	56%	2,409	61%
Kyankwanzi District	99,089	148,297	55%	3,632	60%
Luwero District	177,490	256,708	60%	4,000	63%
Mubende District	192,396	280,820	72%	4,000	74%
Kassanda District	102,924	159,018	48%	3,000	51%
Mukono District	240,220	328,999	69%	3,483	71%
Nakaseke District	89,269	125,751	63%	3,125	67%
Nakasongola District	76,451	110,021	58%	3,016	63%
Bugiri District	145,403	235,339	67%	5,484	72%
Buyende District	120,246	203,367	56%	4,842	61%
Iganga District	126,072	190,612	57%	5,244	63%
Bugweri District	56,952	90,368	47%	3,000	54%
Jinja District	166,183	241,472	70%	5,000	74%
Luuka District	78,996	124,933	47%	1,000	48%
Mayuge District	169,945	269,715	59%	4,148	63%
Namayingo District	72,534	114,981	64%	3,725	70%
Budaka District	78,553	123,443	60%	2,570	64%
Bududa District	92,793	138,689	58%	3,255	62%
Bukwo District	36,581	61,442	62%	1,341	66%
Bulambuli District	81,761	116,367	54%	2,000	57%
Busia District	124,287	185,997	70%	4,039	74%
Butaleja District	91,470	148,930	76%	1,587	79%
Kibuku District	75,351	121,635	63%	1,898	66%
Manafwa District	54,870	85,103	54%	1,738	59%
Namisindwa District	69,548	113,919	72%	2,500	77%
Pallisa District	111,216	174,396	50%	4,486	55%
Sironko District	92,503	135,749	64%	3,462	69%
Tororo District	183,060	287,018	80%	1,443	81%
Agago District	70,246	118,835	57%	3,607	64%
Alebtong District	86,936	128,907	31%	3,037	35%
Amolatar District	56,682	83,519	43%	1,915	47%
Apac District	72,018	110,729	62%	5,713	72%
Kwania District	66,903	104,623	27%	3,438	34%
Gulu District	106,556	154,363	56%	8,185	66%
Omoro District	65,039	96,413	35%	4,215	44%
Kitgum District	73,142	105,901	40%	2,392	45%
Lamwo District	43,961	66,030	31%	1,726	36%

Lira District	151,882	222,753	46%	6,768	51%
Nwoya District	77,802	125,955	28%	4,237	36%
Oyam District	136,601	217,863	38%	8,346	45%
Hoima District	123,825	183,207	76%	5,319	81%
Kikuube District	116,468	184,508	46%	9,781	57%
Kabarole District	117,297	162,090	82%	7,701	90%
Bunyangabu District	66,298	94,557	76%	6,675	89%
Kamwenge District	102,643	164,757	88%	1,885	90%
KITAGWENDA District	56,454	87,495	48%	1,336	51%
Kibaale District	61,792	102,431	77%	1,639	80%
Kagadi District	125,988	209,073	59%	2,453	62%
Kakumiro District	155,829	250,606	45%	5,856	50%
Kyegegwa District	143,673	230,516	50%	2,270	53%
Kyenjojo District	167,132	261,495	71%	3,545	73%
Masindi District	116,924	168,251	74%	3,438	78%
Ntoroko District	26,797	38,132	69%	1,200	74%
Amuria District	70,171	111,623	26%	4,717	34%
Kapelebyong District	32,217	51,604	16%	2,000	24%
Bukedea District	83,746	128,252	21%	5,547	30%
Katakwi District	67,369	95,644	57%	2,181	62%
Kumi District	93,424	139,457	28%	5,481	36%
Moroto District	38,518	53,961	43%	2,389	51%
Nakapiripirit District	39,441	53,861	19%	2,000	26%
Soroti District	122,312	177,546	44%	7,294	52%
Bushenyi District	83,592	116,619	41%	4,789	49%
Ibanda District	91,111	130,875	35%	4,915	42%
Isingiro District	182,584	288,443	53%	8,656	59%
Kabale District	85,162	114,501	57%	8,000	69%
Rubanda District	63,191	95,308	38%	2,400	43%
Rukiga District	35,530	48,604	58%	3,200	70%
Kanungu District	87,545	129,444	41%	5,332	49%
KAZO District	72,217	107,601	22%	2,000	25%
Kisoro District	90,859	136,711	53%	2,400	57%
Mbarara District	137,299	181,958	53%	5,000	57%
RWAMPARA District	46,394	68,576	45%	2,000	50%
Mitooma District	57,666	88,897	69%	1,867	73%
Ntungamo District	169,453	254,548	49%	6,703	54%
Rubirizi District	42,686	67,283	37%	2,280	43%
Rukungiri District	106,932	154,217	54%	5,917	61%
Sheema District	73,624	101,712	53%	3,573	59%
Arua District	157,925	243,128	95%	4,533	99%

Moyo District	36,398	53,364	49%	3,485	62%
Yumbe District	182,410	311,104	42%	4,763	45%
Zombo District	84,433	136,161	51%	3,320	57%

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	44,397	23,320	66%	29,120
FSW	179,116	124,387	70%	125,845
*Prisoners	157,350	95,164	65%	101,673
Clients of sex workers	1,664,957	1,048,923	6%	108,122
AGYW	2,733,554	2,230,675	9%	247,819
PrEP implementation (FSW, MSM, FF)	2,669,233	2,030,973	5%	130,000
TOTAL				742,579

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	4,880	2,524
Agago District	6,475	4,162	1,870
Apac District	5,985	3,702	1,881
Arua District	13,574	4,624	3,305
Bugiri District	12,751	2,460	1,758
Bugweri District	4,965	776	554
Buikwe District	12,350	7,671	5,054
Bukomansimbi District	3,989	2,372	1,252
Bunyangabu District	5,106	2,596	1,855
Bushenyi District	6,360	5,128	3,665
Busia District	10,148	3,004	2,075
Dokolo District	5,645	2,148	1,535
Gomba District	4,492	3,007	1,352
Gulu District	8,566	14,009	6,297

Hoima District	9,920	5,272	3,768
Ibanda District	7,184	3,004	2,147
Iganga District	10,552	2,796	1,926
Isingiro District	15,766	7,716	3,157
Jinja District	13,338	7,988	5,709
Kabale District	6,394	2,696	1,926
Kabarole District	8,783	9,384	6,707
Kagadi District	11,373	4,240	3,030
Kakumiro District	13,303	3,392	2,424
Kalangala District	1,814	3,509	1,577
Kalungu District	4,971	4,036	2,813
Kampala District	44,073	54,254	32,207
Kamuli District	14,515	3,384	2,347
Kamwenge District	8,894	4,464	1,904
Kanungu District	7,163	3,000	2,144
Kasese District	20,665	4,640	3,316
Kassanda District	8,163	6,806	3,058
Katakwi District	5,096	1,816	1,298
Kayunga District	10,487	4,324	3,090
Kazo District	5,755	1,336	954
Kibaale District	5,397	1,788	1,278
Kiboga District	4,505	2,808	2,007
Kikuube District	9,682	2,988	2,136
Kiruhura District	4,934	1,856	1,327
Kitagwenda District	4,724	1,476	1,055
Kitgum District	5,794	3,628	2,593
Kole District	7,453	2,728	1,950
Kotido District	5,378	300	214
Kwania District	5,675	3,480	1,564
Kyegegwa District	12,295	5,584	2,848
Kyenjojo District	13,917	6,824	4,878
Kyotera District	6,757	12,180	4,864
Lira District	12,559	11,116	5,989
Luwero District	13,721	10,623	5,272

Lwengo District	7,459	5,722	2,365
Lyantonde District	2,914	4,046	2,012
Madi Okollo District	4,305	680	486
Masaka District	8,786	17,170	7,871
Masindi District	8,948	4,448	3,179
Mayuge District	14,816	3,084	2,204
Mbale District	15,576	10,164	5,334
Mbarara District	10,202	16,069	7,222
Mitooma District	4,956	1,216	869
Mityana District	9,431	7,046	3,717
Mpigi District	7,506	4,168	2,979
Mubende District	15,062	9,672	5,683
Mukono District	18,528	14,084	6,813
Nakaseke District	6,181	2,877	1,985
Namayingo District	6,145	2,928	2,093
Nebbi District	7,404	2,296	1,641
Ntungamo District	14,009	4,536	3,242
Omoro District	5,216	3,189	1,433
Oyam District	11,886	6,088	3,577
Pakwach District	5,225	1,568	1,121
Rakai District	8,288	6,830	2,392
Rubanda District	5,336	1,008	721
Rukiga District	2,688	900	643
Rukungiri District	8,534	5,480	3,916
Rwampara District	3,752	2,184	1,561
Sembabule District	7,809	4,845	2,179
Sheema District	5,651	3,640	2,601
Soroti District	9,685	5,796	4,142
Tororo District	15,563	9,895	4,842
Wakiso District	80,572	45,072	18,400
Grand Total	**773,839**	**472,676**	**265,677**

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

Table 4.7.5: 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 reinitiated cervical cancer screening and treatment of pre-cancerous lesions among women living with HIV (WLHIV) in Uganda at 604 health facilities. To this effect several activities including revision of the national cervical cancer strategy, development of a training manual, job aides, standard operating protocols, IEC materials and M&E tools were accomplished in the first quarter of COP20. National and regional level training of trainers and the arrival of the first batch of commodities happened in quarter 2. A few health facilities have already started screening WLHIV for cervical cancer and treating those identified with precancerous lesions. The number of such facilities is expected to quickly rise in quarter 3 as last mile delivery of cervical cancer commodities is ramped up. All the 604 target health facilities are expected to be offering cervical cancer screening services by the end of quarter 3.

In COP21, PEPFAR Uganda was allocated $3M for the cervical cancer program and as such Uganda plans to expand the program to 225 new static health facilities and 947 outreach sites, this in addition to the 604 COP20 health facilities. With this investment we shall reach 282,559 WLHIV aged 25-49 years in COP21, accounting for 50% of HIV-positive women aged 25-49 years in HIV care and treatment. A one-off HPV screen will be offered to WLHIV aged above 50 years receiving care at the 23 health facilities offering HPV testing as the primary screening tool.

4.9 VL and EID Optimization

EID Point of Care (POC) testing POC is one component of a broader strategy to improve EID coverage, reduce rates of interruptions to treatment among HIV Exposed Infants (HEIs) and support early ART initiation for identified HIV-positive infants at all entry points. The FY21Q1, EID coverage stood at 74% and 88% for age bands 0-2 and 0-12 months respectively. The COP21 target is 72,664 80% and 8,070 95% for age bands 0-2 and 0-12 months respectively. Uganda will therefore strive to optimize EID testing.

Uganda has a centralized VL and mixture of centralized and POC 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. The country started implementing Point of Care (POC) testing for EID in FY20 (COP19) with a pilot at 33 sites to improve EID 0-2 months coverage, Turnaround time (TAT) and same-day linkage to ART for positive infants. In FY21 19 (COP20), the diagnostic network EID optimization focused on placement of m-Pima PEPFAR supported a scale up of the POC platforms to 13300 more sites with mPIMA devices targeting hard–to-reach areas (mountainous and/or on island communities) and high-volume inpatient, TB, and nutritional wards; training, support supervision & mentorship of Health Care Workers (HCW) at POC sites (lab personnel, midwives and data clerks); and integration of the POCs on to the Laboratory Information System. For FY22 (COP21), Uganda plans to maintain the EID POC at 133 sites and focus on optimal utilization of the existing POC platforms, timely screening and internal referral for EID POC testing from alternative entry points (pediatric, nutrition, immunization, TB wards, etc.), HCW re-training, multiplex testing on both

newly placed and underutilized GeneXpert POC machines at additional sites, and demand creation through treatment literacy. This will increase the proportion of tests conducted using EID POC platform from 20% in COP20 to 40% in COP21. Adequate laboratory commodity funding is available to cover both EID POC and Conventional for 100% of targets. The supply plan has conservatively budgeted for 35% POC: 65% conventional split in order to minimize risk of expiries. Consumption is tracked monthly and the supply plan will be adjusted as utilization increases. The current budget could easily accommodate an increase to 50% EID POC or beyond should the expected global price reduction for EID POC cartridges be realized. In addition, the country plans to prioritize connectivity of all EID POC devices to the central data system, conduct assessment of tester competency through Proficiency Testing (PT) for accurate & reliable test results, improve POC machine functionality through timely machine replacement, maintenance/repair, and commodity management.

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 Ministry of Health (MOH) to explore multiplexing for VL, EID, TB, HPV and Hepatitis B. As part of the lab optimization exercise PEPFAR Uganda will continue working in collaboration with the National Health Laboratory and Diagnostic Services (NHLDS) department of MOH and the National TB and Leprosy Program (NTLP) to enhance the efficiency of the conventional centralized and POC platforms to achieve optimal sample turnaround time, expansion of EID POC sample collection from peripheral facilities, community sites, and EID/EPI outreaches and timely utilization of results for patient management by program. Strategies to meet this POC scale up include implementing proficiency testing for all testing sites, ensure commodity availability, data connectivity of POC platforms to the central system, utilization of electronic results download at facility level, additional hub riders and an electronic sample tracking system to improve chain of custody. Regarding VL, PEPFAR Uganda supported to maintain a steady VL coverage of 88% in Q4FY20 (COP19) in Q1FY21 (COP20) but with an increment of suppression from 92% to 93%. 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 through health information exchange
- Sending of a preemptive system generated SMS alert to patients and health workers for intensive adherence counseling and for sample collection one month prior to VL due
- Explore the use of SMS/USSD systems for returning results to ART patients and health workers.

- Supporting district mentors to follow up high volume facilities for increased management of non-suppressed patients.
- Using lessons learnt from the already established EID POC testing platform, the same devices shall be multiplexed for VL POC testing targeting pregnant and breastfeeding women (PBFW) in line with WHO guidance for managing non suppression of this population category as a matter of urgency.

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, treatment continuity, 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. COP21 systems investments builds upon these successes and will promote a patient-centered approach that will improve HIV patient outcomes. In COP21, 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. COP21 priorities were identified through a rigorous process that engaged key players including GOU, civil society, and key donors including Global Fund (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:

- 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 treatment continuity for men, women and children in care.

- 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.

- HRH: There are still inadequately-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, treatment continuity, adherence, community care, and DSDM that compromises quality of care. In COP21, PEPFAR Uganda will continue the HRH optimization analysis, looking at the workload and HRH availability. Based on the analysis, PEPFAR will optimize its HRH investments, which will involve redeploying HRH resources to health facilities with the greatest needs.

  PEPFAR Uganda IPs are expected to ensure appropriate staffing is available at PEPFAR-supported sites, including an adequate community lay cohort to help deliver programs and improve client services. IPs are expected to provide appropriate compensation (aligned with standardized wage expectations) and to address HRH challenges by addressing staffing vacancies or adding additional staff, if necessary. This language will be standardized and reflected in IP workplans.

- 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.

- 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.

- Community Systems: In COP21 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.

- Empowerment of the RRH with a robust health information management system for coordination of laboratory, supply chain and HIS/strategic information. It will further improve performance reviews with a regional lens and the capabilities of drilling into individual district specific metrics. Additionally, RRH will roll out and coordinate virtual platforms through ECHO/Zoom model for tele-mentorship of health workers with improved skills for client centered services, enhanced disease surveillance, improving linkage to care & treatment, and ensuring treatment continuity and viral suppression. These improvements will enhance readiness to respond to other public health threats and will increase the impact within the decentralized health care delivery system as well as strengthen community systems. Finally empowering the RRH will prepare aspects of the program for transitioning and sustainability.

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 and approaches that PEPFAR will support in COP21.

Policy, Governance and Leadership

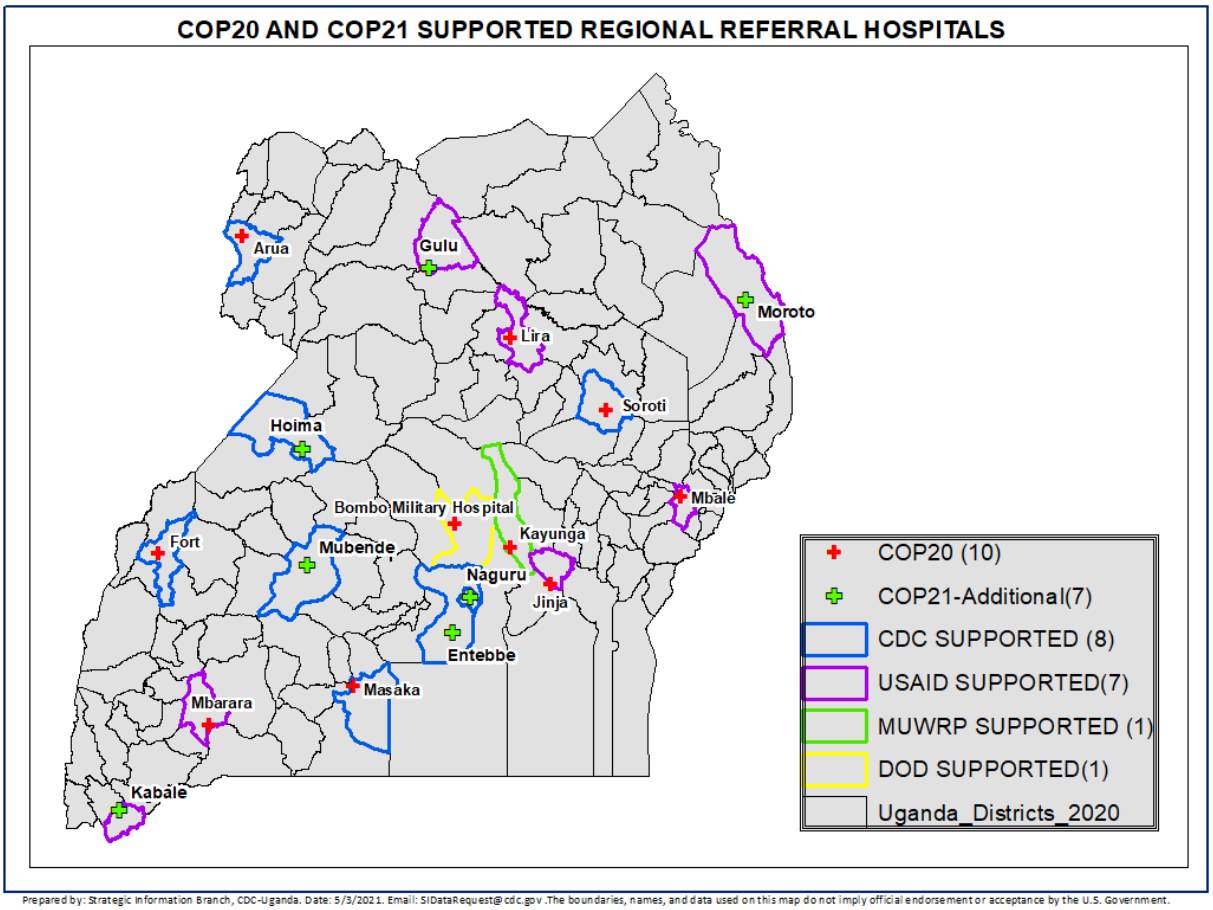
Cognizant of the public sector role to reach HIV epidemic control, USG will facilitate and empower the GOU entities to assume greater responsibility for increased leadership, ownership and sustainability of the HIV response. We will intensify our engagement with GOU at national and subnational levels, civil society organizations (CSOs) and leverage resources from other stakeholders (Global Fund, 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 continuity on treatment, 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), MOH's ability to effectively oversee districts and health facilities at the lower levels is severely constrained. As centralized supportive supervision has been ineffective, PEPFAR Uganda will support MOH's efforts and regional referral hospitals (RRHs) for enhanced support supervision of sub-national entities through a hub and spoke approach. This approach will strengthen MOH's oversight, accountability, and leadership of the decentralized HIV/TB response. In COP20, ten regional platforms including RRHs (as shown in the map below), will be supported to become centers of excellence to provide technical

assistance and support supervision, surveillance and specialized laboratory services, expand CQI at the regional level, performance monitoring, cost-effective capacity building approaches through tele-mentoring and effective community mobilization for client centered quality services. This approach expands to all the 17 RRH and will ensure that interventions within districts are standardized and institutionalized within existing GOU systems for sustainability.

Figure 5. 1 COP21 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.

PEPFAR Uganda is keen on ensuring citizen participation in policy review, formulation and program monitoring through civil society engagement. We will continue to build the capacity of civil society and facilitate CSOs to influence national policies and participate in client led

service delivery monitoring for improved accountability of health resources, including PEPFAR investments.

PEPFAR Uganda will continue to support the civil society to engage GOU and advocate for policy shifts and formulation using the findings from the client led monitoring evaluations and review of the PEPFAR program.

PEPFAR Uganda will continuously engage the MOH and MOFPED to work on the government roadmap for sustainability including, putting systems in place for increased accountability and transparency across programs. The goal is transitioning program aspects to the GOU. Transitioning will require us to harmonize approaches, institutionalize investments and provide a platform for leveraging and integration at operational level.

Human Resources for Health

PEPFAR Uganda continues provision of technical assistance to MOH to improve HRH management and optimization of available HRH for sustained epidemic control. The GOU is committed to further improvement in the health worker remuneration and coverage of the HRH in public health facilities However, the current HRH coverage of 76% still falls short of the Health Sector Development Plan target of 85% by 2021. 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 optimal treatment continuity, case finding, KP programming, quality counseling and community service support. In COP21 PEPFAR will provide focused HRH support particularly in the regional referral hospitals to strengthen program support in the area of continuous quality improvement , Laboratory and strategic information/HIS. At the same time, PEPFAR will continue to advocate for staff absorption for the existing seconded staff and work with MoH and the Ministry of Public Service to revise staffing norms to facilitate smooth transition of these staff. We have seen significant improvement in staff absorption in the public sector with over 1030 PEPFAR-seconded staff transitioned by April 2021. We will continue our advocacy efforts in collaboration with CSOs to increase funding for HRH, as well as work with local governments to develop recruitment plans that will facilitate the absorption. There are still looming gaps in the PNFP sector due to limited wage, and PEPFAR will continue to have dialogue with the Ministry of Finance and Health regarding increased HRH funding to the PNFP sector. Given the challenges from COVID, PEPFAR will expand its support for virtual training and mentorship using virtual platforms. This will help address concerns raised from the community led monitoring on how to manage stigma, improve treatment literacy, 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 is being reviewed to ensure alignment to burden, need and optimal cadre mix for maximum efficiency and impact. Emphasis is given to ensuring that HRH is aligned to address the sites with low VL suppression and treatment continuity rates. In the past year, GOU absorbed 69 health workers, and in COP20, PEPFAR will work with MOH to address the sites with low VL suppression and treatment continuity rates.

PEPFAR will work with MOH to ensure that HRH support for central and RRH level is aligned to TA needs and engage with stakeholders and line Ministries for increased wage allocation.

Relatedly, PEPFAR will engage GOU and PNFPs to develop a road map for the transition of 440 seconded staff in PNFP sites. PEPFAR will work with MOH to ensure that HRH support for central and RRH level is aligned to TA needs and engage with stakeholders and line Ministries for increased wage allocation.

PEPFAR Uganda is currently working on HRH optimization analysis, looking at the workload and HRH availability. Based on the analysis, PEPFAR will in COP 21 optimize its HRH investments which will involve redeploying HRH (including lay workers) resource to health facilities with the greatest needs. Based on the findings from HRH optimization, PEPFAR Uganda will work with the MoH, CSOs, WHO and key stakeholders to determine the appropriate ratio to harmonize the HRH deployment against needs at the community level. In addition, PEPFAR will continue to monitor IP implementation of the $50 enumeration that was agreed upon in COP 20 to ensure quality service delivery resulting from well-motivated community health workforce.

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 evidence-based HRH planning. In COP21, PEPFAR will support operationalization of a ten year HRH strategic plan to inform annual HRH planning, utilize efficient e-models for training/mentorship including ECHO/Zoom at RRH/districts and improve performance management for increased HW productivity. PEPFAR will continue support for targeted training of key cadres like dispensers and epidemiologists to strengthen supply chain management and public health leadership/stewardship of the HIV response. Additionally, TA will be provided to finalize the revision of the staffing norms at regional and district levels to increase the staffing establishment and advocate for introduction of key cadres – particularly laboratory 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 to GOU for the development of community health worker policy/guidelines and Community Health Extension Workers (CHEWS) strategy. PEPFAR worked with implementing partners, CSOs and other stakeholders to standardize the CHW remuneration, terms of employment, and clarification of roles and responsibilities for community workers, who constitute over 60% of the workforce at site level. Through this process, PEPFAR is monitoring the implementation of the guidance, including payment of a minimum monthly pay of $50 for fully employed CHW.

PEPFAR Uganda will continue to support community systems through its partners and health facilities and will link site level services with the community participation to ensure that communities have representatives who are included within the site level continuous quality

improvement work groups. This will assure that communities participate in quality assurance exercises. This will create small rings of mobilized communities within the catchment population of the supported health facilities that will grow with time for wider coverage in line with the ministry of health led community engagement strategy.

These efforts will provide lessons for the MOH as they embark on the institutionalization of the community health workers that will play a critical role in treatment continuity, case-finding, adherence counseling and treatment 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 transition full ARV regimen optimization for both adults and children, as well as MMD and delivery model (DSDM) whereby ARVs could be distributed through private pharmacies, community-based and non-clinical locations as Decentralized Drug Distribution points.

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 accredited 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 scaling up the use of the Enterprise Resource Planning (ERP) system from central level to service delivery points. The NMS ERP began active use of the ERP system "Live" in FY 21. By July 2021, about 250 high volume health facilities, including RRHs, & Hospitals, and HCIVs, will have begun to place their orders through the ERP ordering portal.

Once established, rollout of the ERP customer self-service portal will commence. The pace of rollout will be determined by health facilities' capacity (computers, training, and staff). To this end, USG and other development partners are having ongoing discussions on how to rollout to lower facilities. In COP21, we will reinforce information exchange between the various systems. A combination of these will serve to reduce both stock outs and over-stocking (maldistribution) at facilities.

In COP21, USG will provide above site TA to the national warehouses to streamline their procurement capacity. Given the increased financing from GoU for HIV commodities (ARVs and labs), USG will work in close collaboration with the GoU to ensure full utilization of the financial commitment for these commodities and provide TA to support procurement of the HIV lab products that will be procured through NMS for the first time. Finally, in FY21 USAID began

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.

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. 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 worked with QCIL in the preparation of an application to the US FDA to produce TLD. 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, in FY21 USAID began 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.

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. As part of this process, the USG is undertaking the consolidation of USG activities under one USG supply chain entity, in a phased manner to minimize interruption in commodity availability. In COP20, three regions that were served through CDC were 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. Further sustainability plans will include strengthening of national data systems for commodity management, absorption of USG seconded supply chain staff into the GOU staffing norms, providing government to government assistance to National Medical Stores, and finally a transition of USG supply chain support and commodity management to GOU.

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 COP21, 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

Amidst disruptions due to COVID-19, PEPFAR Uganda continues to focus on improving the quality, utility, and robustness of patient-level data systems for improved patient outcomes. Clinical and laboratory systems across all health facilities and focused in high-volume service centers are currently managing over 90% of PEPFAR supported ART clients. Through algorithmically based unique identification at every facility, health information exchanges for system interoperability, and service-based client registries, client mobility, unique identification, deduplication and improved patient outcomes is beginning to be realized on a national level.

Currently, supported patient level systems have been customized with workflows for point of service data capture at the various service delivery areas in HIV clinics, Maternal and Child Health

clinics, TB clinics and, recently, a module for COVID-19 case management. Targeted service data capture areas include registration to support client registry functionalization, triage, consultation rooms, dispensing and laboratory services. Roll out has reached 1337 facilities. The implementation strategy is a 3-tier approach (Tier I, II and III). Tier I being for sites that meet minimum requirements for point of service data capture operations, Tier II for small sites that can only manage data room-based operations and Tier III being support for mobile data capture and blends with both Tier I and II as an extension of the facility-based system for selected services offered in the community. When fully implemented at all 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 continuity of HIV and TB care. The EMRs will also support clinical decision making, timely delivery of client laboratory results to health care providers/systems, decentralized drug distribution, Community-based treatment initiation, interruptions in treatment and continuity resolution, 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 and roll out continues slowly with an average of 12,000 requests and resulting happening every quarter. Data hosting capabilities and internet connectivity at the national data center at the Central Public Health laboratory (CPHL) has been improved to be able to handle volume of requests. The primary challenge to large scale implementation is establishing a fixed, secure and reliable internet connection at all facilities. In COP20 a step has been taken to first equip all high volume sites with mesh Wi-Fi hardware through a centralized mechanism and guidance continues to be provided in preference for fixed internet connectivity over dongle based connections.

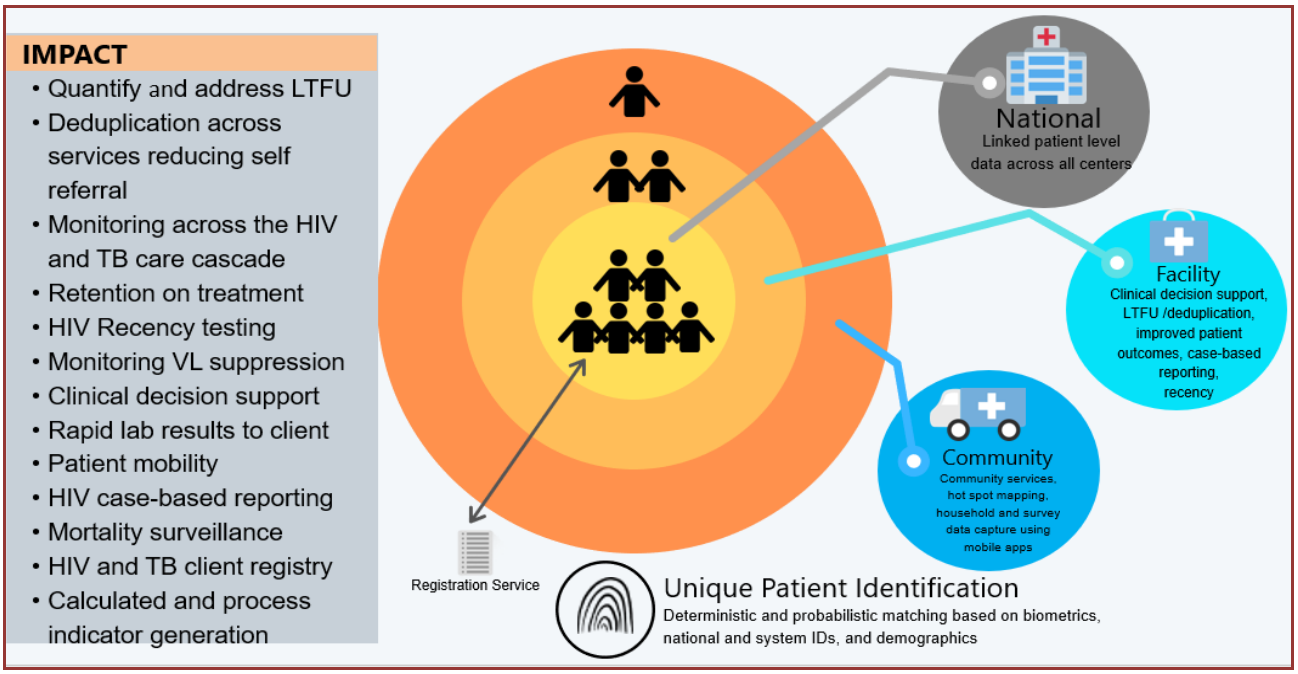
Implementation of patient Unique Identification (UI) has been achieved at the site level for all point of care EMR installations. Health information exchanges, service-based client registries and national data governance entities required for UID implementation on a national level has progress considerably in the last year as demonstrated and presented to the SGAC Informatics Technical Working Group. Efforts continue to bolster policy, legal requirements, and governance for protection of privacy, confidentiality, and security of personal health information. Specifically updating on key pieces of this architecture: 100% of supported sites have paper-based UI algorithms, 71% of ART sites (94% of ART clients) have algorithm-based UI that includes a combination of biometrics and National Identification Numbers (NINs) and currently a Client Registry (CR) is under development for national UI for patient mobility and deduplication.

Again, successful implementation of unique identification that will improve patient mobility as well the patient experience critical for their continuity of treatment 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:

- **Building HIS for epidemic control that provides client-centric data and improves individual client 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.

- **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.

- **Central hardware procurement and promotion of IT standards and pricing thresholds.**
  - Move hardware procurement function for the regional partners
  - Procure all required hardware for data capture, connectivity, and alternative power solutions through one mechanism
  - Increase footprint through recommendation of various computer form factors for both data capture devices and server options.

- **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.

- **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.

- **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.

- **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 and community 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. Implementing partners will be

required to conduct 100% follow up on all sites that have yellow and red scores and conduct a targeted SIMS assessment on sites while following the corrective action plan developed by the implementing mechanism in collaboration with the USG officials. The selection of the sites and the sets to be assessed at each visit 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. COVID-19 pandemic adaptations will be considered including the conduct of virtual SIMS and a hybrid of virtual/onsite SIMS. Adherence to the S/GAC guidance regarding USG participation and leadership of comprehensive SIMS will be observed.

CDC conducted 27 SIMS visits in FY20. For FY21, has planned to conduct 102 assessments of which all follow up SIMS assessments within the schedules SIMS assessments will be completed.

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. 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 continuity in treatment, ensure data quality, monitor ARV stock outs, plus enhance TB case finding and treatment completion. In COP21 assessment focus will be on strategies that improve treatment continuity among adult men and women, pregnant women, adolescents and children on HIV treatment, TB treatment, TB preventive therapy and continuity of treatment for people at risk of HIV infection such as the discordant couples and Key and priority populations on pre-exposure prophylaxis. Focus will also be placed on targeted HIV testing using index testing through Assisted Partner notification and HIV risk behavior screening to test those at high risk of HIV infection and improving access to prompt (<2 months) HIV testing among HIV Exposed infants through encouraging mothers to deliver in established health facilities under the supervision of trained midwives. HIV infected Orphans and vulnerable children will be identified through healthcare facilities and referred to community OVC programs for support.

The PCO/STATE with support from 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 treatment continuity.

In FY20, USAID conducted a total of 24 SIMS visits across the program portfolio. In response to COVID-19 pandemic adaptations, USAID piloted the conduct of virtual SIMS at two sites in the RHITES SW region. The lessons learned did not favor a full roll out of virtual SIMS as this would require a significant resource allocation in terms of staff time to assess a small number of facilities compared to what is feasible with on-site SIMS assessments. For FY21, as at Q2, USAID has been able to conduct 18 comprehensive SIMS assessments out a planned 72 assessments and 17 follow up SIMS assessments from the planned 27 follow-up assessments.

DOD/MUWRP conducted only two SIMS visits in FY20. For FY21, the 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, treatment continuity and linkages. In FY21, DOD/MUWRP plans to conduct intensive site level visitations and follow up to support improvement of key performance indicators in addition to planned SIMS visitations. Adherence to the COVID-19 pandemic safety guidelines will remain a key principle of SIMS implementation.

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 continues to be largely paper-based and lacking a universal format of unique identification for beneficiaries, making it difficult to de-duplicate program data. The Ministry of Health has made commitments to include KP indicators in the national HMIS (DHIS-2 instance) with all the required data safety and protection considerations, but until full devolution of the system to subnational levels, the USG will utilize the HIBRID system to collect KP data. In addition, PEPFAR will triangulate with other available KP data within the KP/PP tracker, dashboard and outside PEPFAR. In FY21, PEPFAR Uganda for the first time started providing cervical cancer screening and treatment services to HIV positive women aged 25-49 years. The HMIS tools to support the data collection, weekly reporting through a HIBRID dashboard and monthly reporting have been printed by the comprehensive implementing partners. Reporting through the DHIS2 will be completed by the Health Information Systems team in collaboration with the Ministry of Health Division of Health Information. The regional comprehensive Implementing Partners have supported the printing of the HMIS tools to support the monthly reporting expected to start by FY21. The USG Health information Systems team will be working with METS team to develop an electronic data capture module for inclusion in the EMR to facilitate site level electronic data capture for the cervical cancer screening and treatment services. A TPT census was conducted by ministry of health and found higher numbers of **751,379 compared to the DATIM number of 697,742** eligible TX_CURR clients had completed TPT. This adjustment was used in targets setting and SI has proposed to the care and treatment TWG to provide funds that can support the data quality assessment to validate the revised TPT census figures.

Generation of data, reporting and analysis of KP cascade data will be a priority in COP20 and will continue in COP21. 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 and meetings, and with mystery clients' surveys where necessary.

Following the more than 80% of the PEPFAR MER indicators' alignment with Uganda's 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 are reported. Comprehensive regional activities and districts will be supported to conduct periodic quantitative program data analysis. Results will be triangulated qualitatively using stakeholder feedback, targeted agency-specific and routine interagency data, and service quality assessments. Community led monitoring will utilize the community/clients' feedback to inform programs.

Data Quality Assessments

Interagency Data quality assessments such as the PMTCT DQA, OVC DQA/SQA and TPT DQA will be conducted to ensure quality data is utilized for evidence-based decision making. In FY20 and FY21 PEPFAR Uganda conducted the following DQAs and findings were used for program improvement as indicated below:

- USAID conducted a DREAMS DQA in April 2021 to ascertain the quality of Q1 DREAMS data and identify areas of remedial action for key performance gaps.
- 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.
- An interagency OVC SQA was conducted in FY20; and recommendations made to improve gaps in education and development, economic strengthening, and stability, health and survival, care and protection, Artisan Assessment Findings, Health Facility Verification Findings, and cross-cutting areas. OVC DQA/SQA will be conducted annually.
- An interagency PMTCT DQA was conducted in FY20 led by Ministry of Health.
- The 95-95-95 cascade DQA started April 6th 2021 and will continue till mid-May 2021 with the leadership of METS, SITES and the MOH and the participation of the Uganda National Laboratory Services to oversee the third 90. The results are expected in Q3 and will inform the corrective actions at the site level for the overall PEPFAR program across the entire 95-95-95 cascade.
- In COP21 we plan to conduct an interagency DQA for the PMTCT and EID services.

- A TPT DQA has been proposed following the TPT census completed in March 2021 that shows variation between the census and the HIBRID data. In the meantime, IPs have been encouraged to update the numbers in the TPT Register and the EMR in anticipation of the planned DQA to inform the TPT adjustment factor.

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. An M&E QI Dashboard is under development by the METS team and this will facilitate nationwide entry of QI projects all levels from facilities, district, regional referral, and National referral hospitals. This will improve data visualization and analytics for the data collected from the multiple streams of QI projects.

Surveillance, Research, and Evaluation: An Overview

Surveillance & Surveys: With the continued adoption of TLD, collecting crucial information on the possible effects of these medications remains key. The proposed activities will continue to 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 identify hotspots of HIV transmission to inform better prevention, care and treatment programming for special populations including 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: There are no research activities in Uganda's COP21 plan.

Evaluation: Proposed and ongoing evaluation activities will identify effective and cost-effective approaches in priority areas, both existing (HTC, linkage, treatment continuity, viral suppression, and incidence reduction) and new (PrEP, PWID, self-testing, adolescent SRH, CBS, and recency testing).

Specifically, COP21 will feature the following surveillance and evaluations.

COP21 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 ART 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 coverage to 80% of all testing sites for national coverage and maintain QA/QC activities	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, Data collection started
160699 – TBD, MUWRP Follow on	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 in order to inform program pivots and program improvements.	Ongoing- Data collection, real-time data analysis and dissemination to inform MOH and PEPFAR programming
160699 - 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. (multi-year cohort)	Ongoing- data collection Data analysis and dissemination to inform MOH and PEPFAR programming.
18566- HIV Drug Resistance (DR) sentinel surveillance for TLD and transmitted DR	HIV Drug Resistance (DR) sentinel surveillance for TLD and transmitted DR	The project will monitor DTG HIVDR rates in the population with an aim to check on epidemic control	Ongoing – protocol in clearance
81976- CBS/recency above-site support	Recency Testing and Case-based Surveillance	To establish surveillance system of newly-identified cases at the time of diagnosis to (1) monitor	Ongoing - Data collection

		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	

COP21 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

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

In COP21, projected Costs of Doing Business (CODB) increased by $2,225,930 between COP20 ($35,940,932) and COP21 ($38,166,862). The CODB budget represents 9.57% of the COP21 notional funding envelope for PEPFAR Uganda of $398,500,000. With the exception of State/PCO, which will use $361,166 in applied pipeline instead of receiving funding for M&O under COP21, the remaining PEPFAR Uganda USG agencies will have increases over their respective COP20 M&O baseline budget levels ranging from 4.8% (USAID) to 13.7% (Peace Corps), with the mid-range agencies being the CDC at 7.5% and the DOD at 10%.

The total CODB applied pipeline is US $16,351,919 with HHS/CDC applying the largest amount, US $11,559,323.

In COP20, PEPFAR will support 212.5 Full Time [staffing] Equivalents (FTEs). Thirty-six (36) of these FTEs are currently vacant, with USAID having the highest number at 22 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.

In COP21, USAID/Uganda has 75 PEPFAR-funded FTEs, a slight increase of eight PEPFAR-funded FTEs since COP20. USAID anticipates hiring most of the currently vacant positions during COP21/FY22. The vacant 22.5 positions still include 16 of the 18 new positions previously approved by Ambassador Malac in July 2018, such as the two positions embedded, respectively, in the MOH and National Medical Stores. Seven of the 22 vacant positions are currently in clearance or negotiation stage. Current USAID vacancies also include two existing Foreign Service Positions which were vacated over the course of the past year due to normal expected staff turnover, and five previously approved positions (the majority of which are only partially PEPFAR-funded).

Beyond the positions described 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 OGAC's local partner directive, as well as PEPFAR's requirements for high-frequency data reporting, and USAID's Journey to Self-Reliance. Given that there is no additional space to bring these new positions onto the Embassy compound (until the current Embassy construction is finalized), USAID/Uganda hired these positions through an institutional contractor. We intend to transition seven of these positions to Locally Engaged Staff during COP21.

USAID/Uganda significantly increased the proportion of PEPFAR resources being provided directly to public sector entities and to local non-governmental partners in COP20. Under COP21, USAID/Uganda will need to work closely with these Ugandan partner entities to ensure they responsibly manage USG resources and deliver planned results. USAID/Uganda staff continue to provide strong oversight and management of institutional contractors and grantees to ensure that programs operate efficiently and cost-effectively, while meeting PEPFAR targets. The seven new staff being transitioned to Locally Engaged Staff status under COP21 will continue giving support to USAID/Uganda by providing intensive engagement, mentoring and organizational management capacity building to the new local Ugandan USAID implementing partners, as well as to meet Site Improvement through Monitoring System (SIMS) requirements.

Combined, the above-described USAID staffing configuration will help meet the additional requirements associated with OGAC's local partner directive and data reporting requirements, as well as USAID's Journey to Self-Reliance. However, despite having successfully filled these positions, USAID/Uganda will remain understaffed by one-third (per USAID agency-wide staffing formulae and USAID "right-sizing" numbers) to fully meet the compliance, technical rigor, and fiduciary requirements commensurate with its budget.

HHS/CDC leadership is committed to the well-being and professional growth of all its staff, and health subject matter experts continue to directly support Uganda's HIV/AIDS response by providing a foundation of scientific methodology and data-driven evidence, and its business services staff support those efforts by ensuring accountability and protection of HHS/CDC's investments in Uganda.

HHS/CDC filled seven vacancies in COP20: Deputy PEPFAR Coordinator, Associate Director of Management and Operations, Health Systems Sustainability Advisor, Health Services Branch Chief, Prevention Deputy Branch Chief, Statistician, and Electrician. Several repurposed vacancies are under active recruitment: Executive Assistant, Cooperative Agreement Specialist, Human Resources Assistant, Care and Treatment Team Lead, Health Services Deputy Branch Chief, and Associate Director for Management and Operations. New in COP21, one existing supply chain position will shift 50% level of effort to the Global Health Security Agenda (GHSA) program, with 50% funding from non-PEPFAR sources. Including this addition, a total of four technical positions and all management and operations positions are cost-shared with non-PEPFAR funding sources. Total staffing for HHS/CDC is 117.1 FTES in COP21.

In FY22, upon completion of the new Embassy office complex, HHS/CDC will shift into an office space adequate for the staffing footprint. ICASS and related costs are projected to increase significantly due to the increase in square footage. HHS/CDC also projects wage and benefit increases as well as increases in relocation and shipping costs. Consequently, the CODB budget is projected to increase by $1.3 million. HHS/CDC's program management costs remain lean and efficient in order to maximize funding for program impact.

Peace Corps had three vacancies filled in FY20: A Driver, a Safety and Security Assistant, and an M&E Specialist. Currently, all Peace Corps' 16 FTEs are filled. In COP21, Peace Corps will maintain a flat budget and its entire COP21 budget of just under US $ 2.4 million will be under M&O.

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 filled two vacant LES positions to support management of the PEPFAR program at the current DoD/WRAIR/Uganda PEPFAR funding level, a Program Manager and a Strategic Information Specialist. Additionally, the program will hire a Management and Finance Specialist. This position has been approved and costed and will assist with the transition to a local partner.

The Department of Defense HIV/AIDS Prevention Program (DHAPP) is staffed by a Program Manager and a Program Assistant. The CODB budget has been maintained at the same planning level as COP20 with slight shifts to cater for locally employed staff wage increase. The staffing level has remained the same with no new staffing requests.

The U.S. Department of State (STATE) PEPFAR Uganda Coordination Office (PCO) COP20 budget has slightly decreased. PCO had a total of seven approved positions under COP20, and is currently staffed by five and a half (5.5) positions, four of which are FTEs. A half-time position is currently in recruitment for a part-time small grants manager. PCO filled two previously approved vacancies during COP20: a DREAMS Coordinator and a Global Fund Liaison. PCO otherwise remains lean, with a Deputy PEPFAR Coordinator filled (through a CDC secondment) in mid-2020. The other currently filled PCO positions are: one of the two part-time Small Grants positions, and three LES: a Program Assistant; a Program Outreach and External Engagements Advisor; and a Strategic Information Advisor. Three positions are filled through secondments: an SI liaison seconded from the CDC, and the Global Fund Liaison, an EFM/local hire, is seconded by USAID. A PEPFAR funded communications position, seconded to the Embassy Kampala Public Affairs Section by USAID, provides media and communications support to the overall PEPFAR program.

The PEPFAR Coordinator's Office (PCO) will continue to be the nexus for civil society engagement in COP21. OGAC will channel funds for the COP21 Community Led Monitoring (CLM) activities to viable Ugandan CSOs through a CDC headquarters agreement with UNAIDS headquarters.

With PEPFAR Home Operational Funds, USG Uganda also hosts a Resident Advisor from the U.S. Department of Treasury Office of Technical Assistance who is embedded in the Ministry of Finance, Planning and Economic Development (MOFPED) to support and advise on public financial management and administrative structures for Global Fund grants, financial processes, tracking of health sector resources to support enhanced allocation, and M&E.

APPENDIX A — SNU Prioritization to Reach Epidemic Control

Continuous Nature of SNU Prioritization to Reach Epidemic Control

See following pages for Table A.

Cluster	District	COP	Results Reports	Prioritization	<1	<1	1-4	1-4	5-9	5-9	10-14	10-14	15-19	15-19	20-24	20-24	25-29	25-29	30-34	30-34	35-39	35-39	40-44	40-44	45-49	45-49	50+	50+	Overal
					F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	ITE
GULU CLUSTER	Amuru District	COP 17	APR 18	Sustained	18%	69%	44%	33%	81%	70%	43%	44%	15%	118%	15%	107%	37%	165%	51%	156%	65%	123%	44%	109%	80%	102%	56%	88%	76%
		COP 18	APR 19	Sustained	116%	224%	103%	87%	63%	61%	170%	72%	51%	17%	70%	16%	65%	24%	82%	41%	70%	49%	61%	67%	79%	81%	70%	93%	65%
		COP 19	APR 20	Sustained	99%	190%	81%	74%	73%	75%	75%	74%	75%	74%	74%	74%	74%	74%	74%	74%	74%	74%	74%	74%	73%	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%
		COP 21	APR 22	Scale-up: Saturation	0%	0%	107%	133%	128%	108%	93%	81%	70%	90%	84%	71%	95%	99%	102%	130%	91%	134%	77%	87%	90%	109%	74%	76%	91%
	Gulu District	COP 17	APR 18	Attained	71%	61%	65%	68%	105%	109%	143%	160%	53%	215%	30%	299%	38%	256%	68%	260%	85%	247%	91%	238%	110%	253%	113%	211%	140%
		COP 18	APR 19	Attained	113%	101%	85%	84%	54%	52%	144%	61%	116%	40%	162%	38%	150%	61%	187%	101%	161%	119%	139%	164%	181%	199%	159%	124%	140%
		COP 19	APR 20	Attained	181%	161%	138%	142%	129%	129%	128%	128%	128%	127%	128%	127%	128%	127%	128%	127%	128%	127%	128%	127%	128%	127%	128%	127%	128%
		COP 20	APR 21	Attained	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
		COP 21	APR 22	Scale-up: Saturation	16%	15%	101%	84%	84%	84%	88%	81%	62%	88%	65%	78%	75%	66%	88%	79%	99%	92%	116%	89%	139%	96%	115%	87%	92%
	Lamwo District	COP 17	APR 18	Attained	0%	0%	71%	64%	101%	100%	108%	94%	25%	118%	29%	210%	42%	195%	75%	215%	98%	217%	81%	181%	75%	144%	95%	168%	114%
		COP 18	APR 19	Attained	1035%	0%	122%	113%	92%	90%	246%	104%	103%	33%	141%	32%	131%	49%	165%	83%	141%	98%	122%	134%	159%	162%	141%	107%	124%
		COP 19	APR 20	Attained	885%	0%	108%	105%	121%	122%	122%	122%	122%	121%	122%	121%	122%	121%	122%	120%	122%	121%	122%	120%	122%	121%	122%	120%	121%
		COP 20	APR 21	Scale-up: Saturation	87%	87%	84%	84%	85%	86%	85%	85%	85%	86%	85%	86%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
		COP 21	APR 22	Attained	50%	50%	153%	132%	97%	89%	81%	82%	70%	96%	63%	85%	91%	103%	107%	131%	108%	124%	115%	94%	116%	111%	86%	68%	96%
	Nwoya District	COP 17	APR 18	Sustained	60%	55%	63%	43%	58%	75%	35%	38%	12%	48%	17%	148%	24%	124%	34%	116%	42%	96%	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%	99%	50%	85%	59%	74%	81%	96%	93%	85%	65%	73%
		COP 19	APR 20	Sustained	103%	124%	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%
		COP 21	APR 22	Scale-up: Aggressive	50%	50%	122%	144%	83%	92%	83%	76%	73%	87%	74%	100%	80%	119%	98%	140%	95%	133%	84%	111%	86%	91%	70%	71%	90%
	Omoro District	COP 17	APR 18	Scale-up: Aggressive	0%	0%	21%	18%	44%	48%	42%	38%	24%	79%	16%	159%	23%	124%	36%	126%	54%	113%	56%	119%	67%	112%	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%
		COP 21	APR 22	Scale-up: Aggressive	25%	25%	170%	138%	101%	89%	82%	79%	77%	85%	85%	86%	91%	94%	116%	112%	100%	138%	94%	100%	87%	93%	67%	75%	92%
JINJA CLUSTER	Bugueri District	COP 17	APR 18	Scale-up: Saturation	38%	40%	44%	32%	61%	42%	52%	61%	115%	527%	44%	258%	24%	235%	27%	120%	31%	74%	26%	85%	33%	70%	32%	46%	67%
		COP 18	APR 19	Scale-up: Saturation	86%	98%	97%	88%	55%	54%	147%	62%	52%	16%	72%	19%	67%	25%	84%	43%	72%	50%	62%	69%	81%	83%	72%	54%	65%
		COP 19	APR 20	Scale-up: Saturation	90%	102%	84%	77%	69%	70%	70%	69%	69%	67%	69%	68%	69%	68%	69%	69%	69%	68%	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%
		COP 21	APR 22	Scale-up: Saturation	100%	100%	250%	122%	82%	106%	83%	81%	86%	93%	103%	92%	108%	90%	91%	101%	86%	96%	74%	94%	84%	83%	76%	81%	88%
	Buikwe District	COP 17	APR 18	Scale-up: Saturation	31%	99%	57%	51%	85%	94%	68%	74%	22%	108%	13%	232%	23%	214%	38%	188%	48%	155%	63%	132%	62%	112%	65%	95%	84%
		COP 18	APR 19	Scale-up: Saturation	108%	185%	47%	42%	32%	31%	86%	37%	90%	29%	124%	28%	115%	42%	144%	73%	123%	96%	107%	117%	139%	142%	124%	94%	105%
		COP 19	APR 20	Scale-up: Saturation	246%	419%	84%	77%	83%	83%	83%	83%	83%	82%	83%	82%	83%	82%	83%	82%	83%	82%	83%	82%	83%	82%	83%	82%	83%	82%	83%
		COP 20	APR 21	Attained	92%	92%	93%	94%	93%	94%	93%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%
		COP 21	APR 22	Scale-up: Saturation	62%	57%	140%	130%	116%	108%	106%	82%	62%	78%	79%	79%	95%	77%	102%	94%	105%	108%	96%	101%	97%	110%	79%	91%	94%
	Iganga District	COP 17	APR 18	Scale-up: Saturation	94%	112%	86%	71%	39%	93%	63%	71%	50%	251%	53%	236%	52%	214%	39%	202%	35%	177%	39%	158%	44%	94%	32%	94%	84%
		COP 18	APR 19	Scale-up: Saturation	248%	360%	117%	107%	80%	78%	214%	90%	75%	25%	103%	23%	96%	36%	120%	60%	103%	71%	89%	97%	116%	118%	103%	78%	94%
		COP 19	APR 20	Scale-up: Saturation	217%	314%	94%	78%	82%	82%	82%	82%	82%	81%	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%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%
		COP 21	APR 22	Scale-up: Saturation	57%	57%	155%	115%	85%	81%	71%	80%	77%	93%	83%	92%	90%	89%	96%	80%	86%	88%	81%	97%	84%	90%	73%	82%	85%
	Jinja District	COP 17	APR 18	Attained	122%	34%	53%	77%	67%	80%	109%	128%	123%	332%	63%	299%	50%	337%	50%	194%	65%	245%	95%	213%	111%	291%	111%	206%	140%
		COP 18	APR 19	Attained	155%	79%	79%	90%	53%	52%	143%	61%	124%	41%	171%	39%	159%	61%	199%	102%	170%	121%	147%	165%	192%	200%	170%	130%	147%
		COP 19	APR 20	Attained	247%	176%	142%	164%	138%	138%	137%	138%	137%	137%	137%	136%	138%	136%	137%	136%	138%	136%	138%	136%	137%	136%	138%	136%	138%
		COP 20	APR 21	Attained	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
		COP 21	APR 22	Scale-up: Saturation	71%	67%	113%	99%	98%	78%	90%	78%	70%	82%	64%	84%	77%	76%	90%	75%	102%	83%	112%	92%	153%	106%	123%	107%	98%
	Kamuli District	COP 17	APR 18	Attained	74%	67%	69%	72%	70%	96%	48%	59%	26%	141%	40%	315%	44%	264%	50%	196%	58%	159%	69%	150%	72%	146%	57%	94%	97%
		COP 18	APR 19	Attained	259%	236%	138%	134%	92%	90%	247%	105%	95%	31%	130%	30%	121%	45%	152%	77%	130%	90%	112%	123%	146%	149%	130%	99%	117%
		COP 19	APR 20	Attained	247%	225%	104%	104%	101%	101%	100%	101%	100%	99%	100%	99%	100%	99%	100%	99%	100%	99%	100%	99%	100%	99%	100%	99%	100%
		COP 20	APR 21	Scale-up: Aggressive	78%	96%	80%	80%	80%	81%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
		COP 21	APR 22	Scale-up: Aggressive	42%	43%	166%	191%	94%	95%	83%	76%	67%	79%	104%	78%	120%	103%	118%	110%	107%	116%	111%	117%	103%	92%	89%	81%	101%
	Kayunga District	COP 17	APR 18	Scale-up: Aggressive	74%	22%	40%	46%	67%	75%	59%	76%	28%	117%	12%	212%	19%	183%	35%	178%	47%	161%	62%	150%	81%	149%	90%	129%	90%
		COP 18	APR 19	Scale-up: Aggressive	262%	139%	66%	68%	48%	47%	128%	55%	92%	29%	126%	29%	117%	44%	147%	74%	126%	87%	109%	119%	142%	145%	126%	96%	109%
		COP 19	APR 20	Scale-up: Aggressive	419%	221%	84%	89%	88%	88%	88%	88%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%
		COP 20	APR 21	Scale-up: Aggressive	75%	72%	75%	76%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
		COP 21	APR 22	Scale-up: Saturation	42%	42%	103%	103%	99%	99%	95%	95%	85%	108%	77%	107%	77%	104%	80%	99%	81%	95%	82%	92%	79%	90%	66%	93%	85%
	Mayuge District	COP 17	APR 18	Scale-up: Aggressive	80%	66%	71%	80%	53%	63%	41%	36%	45%	142%	54%	225%	28%	161%	26%	140%	31%	110%	48%	100%	49%	103%	23%	35%	64%
		COP 18	APR 19	Scale-up: Aggressive	1523%	1261%	97%	94%	75%	72%	199%	85%	84%	27%	115%	26%	108%	40%	135%	68%	115%	90%	100%	109%	130%	133%	116%	88%	103%
		COP 19	APR 20	Scale-up: Aggressive	1220%	1008%	62%	61%	68%	69%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	67%	68%	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%
		COP 21	APR 22	Attained	83%	83%	173%	167%	87%	86%	83%	84%	70%	84%	90%	83%	123%	78%	124%	78%	105%	86%	112%	84%	108%	89%	86%	73%	95%

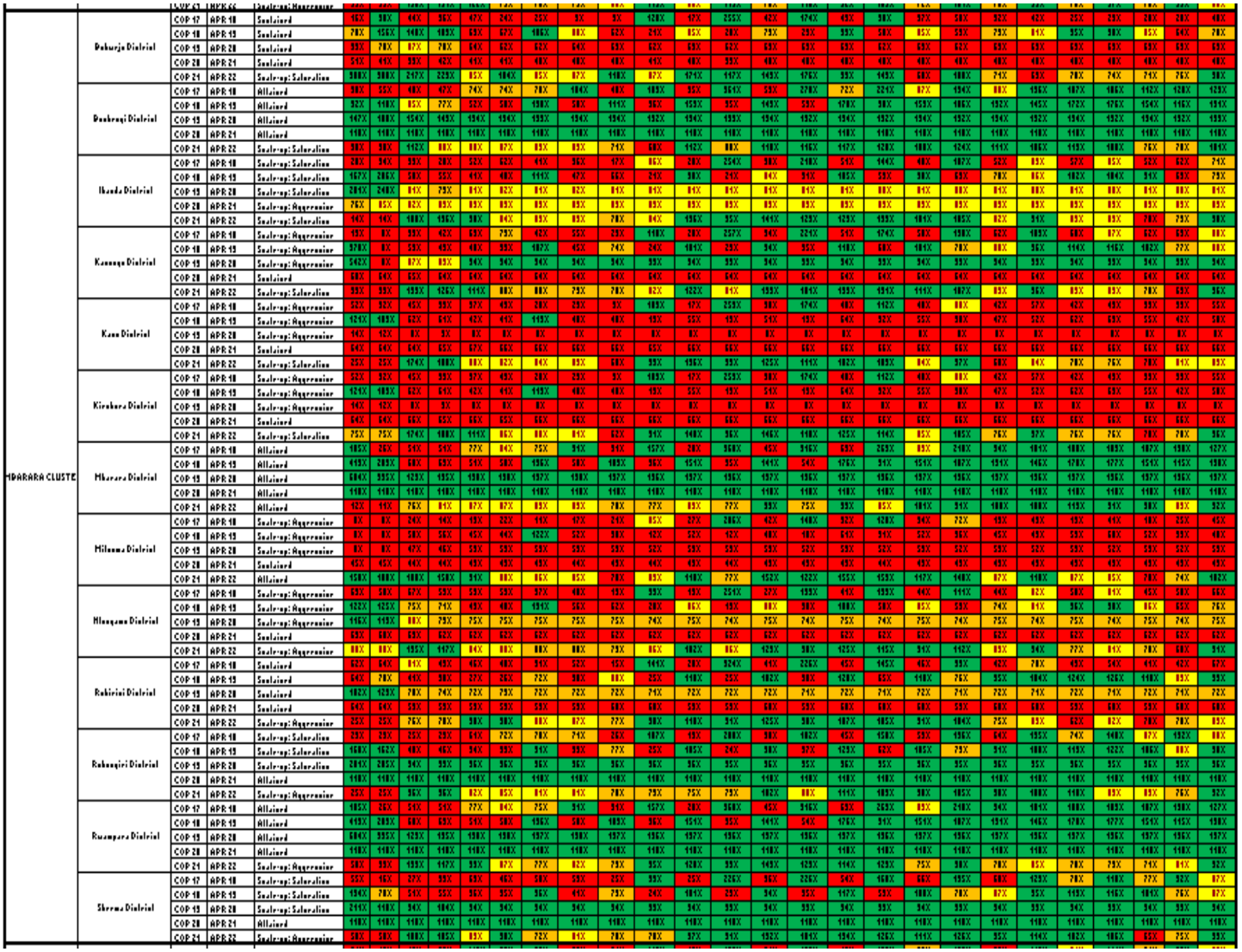
		COP 21	APR 22	Attained	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
KABALE CLUSTER	Kabale District	COP 17	APR 18	Attained	0%	0%	29%	36%	76%	80%	111%	117%	56%	173%	36%	315%	49%	275%	69%	259%	90%	241%	108%	218%	133%	243%	154%	207%	143%
		COP 18	APR 19	Attained	0%	228%	105%	118%	83%	80%	221%	93%	136%	43%	186%	42%	174%	65%	217%	110%	186%	129%	161%	177%	210%	214%	187%	141%	162%
		COP 19	APR 20	Attained	0%	531%	150%	165%	157%	158%	159%	159%	159%	158%	158%	157%	158%	157%	158%	157%	158%	156%	158%	157%	158%	157%	158%	156%	159%
		COP 20	APR 21	Attained	110%	92%	97%	98%	96%	97%	97%	97%	97%	97%	97%	98%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%
		COP 21	APR 22	Scale-up: Saturation	17%	17%	71%	79%	83%	89%	78%	85%	63%	84%	71%	77%	90%	92%	112%	88%	106%	104%	101%	95%	126%	106%	88%	90%	95%
	Kisoro District	COP 17	APR 18	Attained	16%	0%	28%	35%	64%	75%	60%	101%	28%	140%	13%	274%	36%	278%	49%	223%	60%	183%	63%	177%	80%	155%	89%	145%	105%
		COP 18	APR 19	Attained	299%	0%	180%	145%	118%	115%	319%	135%	93%	29%	127%	29%	118%	44%	148%	75%	126%	88%	110%	120%	143%	146%	127%	96%	118%
		COP 19	APR 20	Attained	366%	0%	141%	113%	126%	125%	126%	124%	126%	124%	125%	124%	124%	123%	124%	123%	124%	124%	124%	123%	125%	123%	124%	123%	125%
		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%
		COP 21	APR 22	Scale-up: Saturation	67%	67%	131%	115%	83%	87%	81%	82%	65%	80%	119%	82%	131%	123%	112%	124%	104%	124%	115%	112%	94%	105%	75%	66%	99%
	Rubanda District	COP 17	APR 18	Scale-up: Aggressive	0%	0%	43%	37%	39%	44%	38%	50%	16%	141%	16%	198%	30%	168%	36%	120%	47%	106%	53%	95%	60%	104%	67%	93%	70%
		COP 18	APR 19	Scale-up: Aggressive	0%	125%	43%	47%	34%	33%	91%	39%	76%	24%	104%	23%	97%	36%	121%	61%	104%	72%	90%	98%	117%	119%	104%	78%	89%
		COP 19	APR 20	Scale-up: Aggressive	0%	360%	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	110%	110%	83%	84%	84%	84%	84%	84%	84%	85%	84%	84%	84%	85%	85%	84%	85%	84%	84%	85%	85%	84%	85%	84%	84%
		COP 21	APR 22	Scale-up: Aggressive	300%	300%	113%	200%	86%	89%	83%	83%	64%	86%	112%	88%	118%	101%	101%	111%	112%	105%	91%	120%	92%	93%	76%	72%	95%
	Rukiga District	COP 17	APR 18	Attained	209%	22%	84%	75%	92%	89%	69%	101%	38%	217%	24%	385%	42%	236%	75%	211%	79%	158%	73%	134%	83%	148%	89%	98%	106%
		COP 18	APR 19	Attained	430%	135%	70%	76%	52%	51%	139%	60%	101%	33%	140%	32%	130%	49%	163%	82%	139%	97%	121%	132%	158%	161%	140%	106%	121%
		COP 19	APR 20	Attained	1222%	382%	122%	132%	122%	123%	122%	121%	121%	121%	121%	121%	121%	120%	121%	120%	121%	120%	121%	120%	121%	120%	121%	120%	122%
		COP 20	APR 21	Scale-up: Saturation	110%	110%	89%	90%	90%	88%	91%	91%	90%	89%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
		COP 21	APR 22	Scale-up: Aggressive	50%	50%	133%	111%	89%	84%	87%	82%	89%	86%	95%	89%	101%	94%	114%	103%	99%	101%	107%	99%	103%	101%	67%	71%	91%
KABAROLE CLUSTE	Bunyangabu District	COP 17	APR 18	Scale-up: Aggressive	0%	0%	22%	31%	72%	67%	59%	71%	21%	96%	23%	198%	28%	187%	45%	159%	56%	129%	58%	96%	56%	90%	53%	66%	73%
		COP 18	APR 19	Scale-up: Aggressive	392%	0%	34%	32%	26%	25%	70%	29%	63%	20%	87%	20%	81%	30%	101%	51%	86%	60%	75%	82%	98%	99%	87%	66%	74%
		COP 19	APR 20	Scale-up: Aggressive	703%	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%
		COP 21	APR 22	Scale-up: Saturation	20%	20%	109%	71%	93%	88%	90%	77%	70%	82%	95%	73%	125%	92%	130%	116%	113%	123%	103%	111%	103%	97%	66%	69%	98%
	Kabarole District	COP 17	APR 18	Attained	32%	24%	28%	29%	79%	82%	85%	88%	42%	148%	25%	280%	39%	258%	62%	224%	77%	172%	80%	145%	87%	121%	78%	94%	102%
		COP 18	APR 19	Attained	192%	160%	63%	62%	45%	44%	120%	51%	86%	28%	119%	27%	111%	42%	138%	71%	118%	84%	103%	115%	134%	139%	118%	90%	103%
		COP 19	APR 20	Attained	281%	234%	114%	115%	111%	111%	111%	111%	111%	110%	111%	110%	111%	110%	111%	110%	111%	110%	111%	110%	111%	110%	111%	110%	111%
		COP 20	APR 21	Attained	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
		COP 21	APR 22	Scale-up: Saturation	30%	30%	76%	72%	86%	86%	82%	80%	62%	75%	82%	72%	104%	78%	111%	88%	112%	95%	107%	101%	113%	100%	70%	79%	93%
	Kamwenge District	COP 17	APR 18	Scale-up: Saturation	20%	10%	49%	56%	59%	64%	41%	47%	20%	191%	27%	360%	49%	246%	62%	187%	63%	128%	65%	106%	62%	95%	55%	62%	87%
		COP 18	APR 19	Scale-up: Saturation	737%	366%	83%	83%	63%	61%	169%	72%	86%	28%	118%	27%	110%	41%	137%	69%	117%	82%	102%	112%	133%	135%	118%	89%	104%
		COP 19	APR 20	Scale-up: Saturation	644%	318%	91%	93%	94%	94%	94%	94%	94%	93%	94%	93%	94%	93%	94%	93%	94%	93%	94%	93%	94%	93%	94%	93%	94%
		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%
		COP 21	APR 22	Scale-up: Saturation	60%	60%	142%	154%	92%	86%	83%	82%	70%	82%	134%	82%	138%	108%	121%	122%	90%	117%	83%	103%	89%	87%	70%	64%	96%
	Kitagwenda District	COP 17	APR 18	Scale-up: Saturation	20%	10%	49%	56%	59%	64%	41%	47%	20%	191%	27%	360%	49%	246%	62%	187%	63%	128%	65%	106%	62%	95%	55%	62%	87%
		COP 18	APR 19	Scale-up: Saturation	737%	366%	83%	83%	63%	61%	169%	72%	86%	28%	118%	27%	110%	41%	137%	69%	117%	82%	102%	112%	133%	135%	118%	89%	104%
		COP 19	APR 20	Scale-up: Saturation	644%	318%	91%	93%	94%	94%	94%	94%	94%	93%	94%	93%	94%	93%	94%	93%	94%	93%	94%	93%	94%	93%	94%	93%	94%
		COP 20	APR 21	Scale-up: Saturation	110%	87%	86%	86%	87%	87%	87%	87%	87%	87%	87%	86%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%
		COP 21	APR 22	Scale-up: Saturation	67%	67%	100%	100%	106%	87%	85%	84%	64%	84%	128%	83%	146%	109%	125%	130%	107%	118%	89%	106%	91%	90%	70%	68%	98%
	Kyenjojo District	COP 17	APR 18	Scale-up: Saturation	26%	54%	38%	37%	68%	81%	59%	57%	15%	118%	19%	279%	31%	226%	50%	169%	57%	121%	60%	97%	62%	78%	54%	60%	77%
		COP 18	APR 19	Scale-up: Saturation	161%	221%	51%	48%	36%	35%	97%	41%	70%	23%	97%	22%	90%	34%	113%	57%	96%	67%	84%	91%	109%	111%	97%	73%	83%
		COP 19	APR 20	Scale-up: Saturation	225%	307%	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	86%	83%	82%	82%	83%	82%	83%	83%	83%	82%	82%	82%	82%	83%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%
		COP 21	APR 22	Attained	43%	43%	101%	96%	93%	80%	81%	73%	70%	83%	99%	83%	125%	83%	118%	99%	106%	108%	92%	99%	87%	91%	70%	74%	94%
	Ntoroko District	COP 17	APR 18	Sustained	53%	11%	19%	31%	73%	71%	24%	57%	22%	85%	10%	203%	24%	181%	43%	149%	48%	111%	43%	92%	53%	66%	35%	45%	63%
		COP 18	APR 19	Sustained	133%	56%	56%	66%	38%	37%	105%	45%	63%	20%	87%	20%	81%	30%	102%	52%	87%	61%	76%	83%	99%	100%	88%	66%	76%
		COP 19	APR 20	Sustained	134%	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%	70%	71%	71%	71%	70%	70%	71%	71%
		COP 21	APR 22	Scale-up: Aggressive	100%	100%	163%	138%	113%	94%	87%	81%	78%	97%	113%	96%	115%	97%	102%	104%	93%	112%	67%	78%	76%	72%	70%	83%	90%

KAMPALA CLUSTER	Kampala District	COP 17	APR 18	Attained	60%	48%	53%	54%	97%	106%	120%	133%	61%	190%	51%	365%	60%	378%	80%	344%	101%	290%	113%	241%	130%	223%	111%	154%	154%
		COP 18	APR 19	Attained	868%	750%	132%	124%	95%	92%	272%	148%	138%	87%	154%	52%	138%	55%	169%	87%	145%	102%	124%	140%	162%	170%	142%	109%	134%
		COP 19	APR 20	Attained	840%	723%	117%	112%	128%	129%	137%	138%	168%	166%	167%	166%	167%	166%	167%	166%	168%	166%	168%	166%	167%	166%	161%	150%	165%
		COP 20	APR 21	Attained	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
		COP 21	APR 22	Scale-up: Saturation	19%	18%	70%	70%	87%	77%	119%	107%	77%	132%	63%	73%	68%	70%	79%	68%	92%	78%	108%	98%	132%	118%	115%	121%	90%
	Mukono District	COP 17	APR 18	Scale-up: Saturation	28%	44%	31%	42%	51%	44%	36%	49%	18%	95%	13%	201%	20%	166%	31%	143%	37%	112%	45%	78%	45%	82%	45%	71%	62%
		COP 18	APR 19	Scale-up: Saturation	264%	222%	52%	52%	39%	38%	105%	44%	70%	22%	96%	22%	90%	34%	112%	57%	96%	67%	83%	91%	108%	111%	97%	73%	84%
		COP 19	APR 20	Scale-up: Saturation	478%	401%	64%	67%	38%	40%	47%	69%	129%	68%	97%	68%	87%	68%	84%	68%	84%	68%	87%	68%	92%	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%
		COP 21	APR 22	Attained	16%	16%	122%	91%	96%	94%	83%	77%	75%	83%	97%	83%	110%	81%	99%	104%	88%	99%	89%	95%	81%	93%	68%	73%	89%
	Wakiso District	COP 17	APR 18	Scale-up: Aggressive	15%	29%	23%	19%	33%	31%	41%	37%	21%	74%	13%	147%	16%	126%	21%	94%	25%	72%	29%	65%	36%	61%	37%	50%	45%
		COP 18	APR 19	Scale-up: Aggressive	68%	97%	40%	37%	27%	26%	71%	30%	42%	14%	59%	13%	55%	20%	68%	34%	58%	41%	51%	55%	66%	67%	59%	44%	51%
		COP 19	APR 20	Scale-up: Aggressive	129%	183%	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%	81%
		COP 21	APR 22	Scale-up: Saturation	63%	62%	96%	102%	79%	72%	76%	80%	65%	93%	95%	92%	96%	76%	91%	69%	86%	65%	97%	66%	122%	75%	120%	87%	88%
LIRA CLUSTER	Alebtong District	COP 17	APR 18	Scale-up: Saturation	22%	85%	29%	53%	80%	84%	33%	64%	24%	66%	17%	182%	34%	214%	61%	188%	67%	151%	71%	146%	82%	144%	79%	104%	92%
		COP 18	APR 19	Scale-up: Saturation	183%	287%	82%	75%	56%	55%	150%	63%	83%	27%	114%	26%	106%	40%	133%	67%	114%	79%	99%	108%	129%	131%	115%	87%	100%
		COP 19	APR 20	Scale-up: Saturation	222%	346%	99%	94%	95%	95%	95%	95%	94%	94%	94%	94%	94%	94%	94%	93%	95%	94%	94%	93%	94%	94%	94%	94%	94%
		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%
		COP 21	APR 22	Scale-up: Saturation	20%	20%	117%	109%	96%	95%	81%	79%	72%	88%	73%	86%	94%	81%	111%	109%	105%	119%	116%	115%	104%	94%	85%	73%	95%
	Amolatar District	COP 17	APR 18	Attained	30%	16%	68%	42%	97%	87%	99%	84%	30%	98%	15%	176%	32%	171%	61%	173%	70%	156%	84%	148%	90%	114%	94%	125%	95%
		COP 18	APR 19	Attained	192%	203%	70%	67%	49%	48%	131%	56%	95%	31%	131%	29%	122%	46%	152%	77%	130%	91%	113%	124%	147%	150%	131%	99%	113%
		COP 19	APR 20	Attained	265%	280%	102%	99%	98%	98%	98%	98%	98%	98%	98%	97%	98%	97%	98%	97%	98%	97%	98%	97%	98%	97%	98%	97%	98%
		COP 20	APR 21	Scale-up: Saturation	110%	87%	95%	95%	95%	95%	95%	95%	96%	95%	95%	96%	95%	95%	95%	95%	96%	95%	95%	95%	96%	96%	96%	95%	95%
		COP 21	APR 22	Scale-up: Saturation	100%	100%	171%	167%	74%	80%	69%	73%	71%	85%	68%	84%	78%	76%	98%	88%	101%	96%	108%	100%	107%	96%	115%	90%	93%
	Apac District	COP 17	APR 18	Attained	0%	0%	53%	42%	90%	72%	48%	66%	13%	105%	18%	237%	37%	186%	69%	190%	71%	147%	87%	117%	72%	93%	58%	73%	86%
		COP 18	APR 19	Attained	0%	0%	43%	41%	34%	33%	89%	38%	91%	29%	124%	28%	116%	44%	145%	73%	124%	86%	108%	118%	140%	143%	125%	94%	106%
		COP 19	APR 20	Attained	0%	0%	93%	91%	101%	101%	101%	101%	101%	99%	101%	100%	101%	100%	101%	100%	101%	100%	101%	100%	101%	100%	101%	100%	101%
		COP 20	APR 21	Scale-up: Aggressive	91%	81%	86%	87%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%
		COP 21	APR 22	Scale-up: Saturation	83%	83%	179%	145%	83%	84%	82%	80%	73%	87%	71%	87%	75%	76%	104%	92%	103%	108%	102%	97%	108%	98%	86%	79%	91%
	Dokolo District	COP 17	APR 18	Attained	37%	79%	64%	60%	34%	33%	19%	20%	12%	151%	50%	266%	44%	233%	51%	156%	69%	140%	79%	124%	65%	149%	54%	85%	88%
		COP 18	APR 19	Attained	684%	965%	169%	159%	123%	120%	330%	140%	71%	23%	98%	22%	91%	34%	114%	58%	98%	68%	85%	93%	110%	113%	98%	74%	94%
		COP 19	APR 20	Attained	356%	504%	95%	91%	96%	96%	95%	96%	96%	95%	95%	95%	95%	95%	95%	95%	95%	95%	96%	94%	95%	94%	95%	95%	95%
		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%
		COP 21	APR 22	Scale-up: Saturation	60%	60%	141%	95%	115%	102%	115%	85%	77%	83%	73%	83%	85%	82%	106%	107%	106%	125%	97%	120%	100%	107%	77%	75%	94%
	Kole District	COP 17	APR 18	Scale-up: Aggressive	78%	151%	105%	109%	64%	93%	38%	42%	11%	115%	17%	217%	36%	208%	54%	150%	54%	128%	57%	103%	59%	103%	44%	74%	77%
		COP 18	APR 19	Scale-up: Aggressive	84%	106%	63%	57%	39%	38%	107%	45%	81%	26%	111%	25%	104%	39%	130%	65%	111%	77%	96%	105%	125%	128%	112%	84%	96%
		COP 19	APR 20	Scale-up: Aggressive	114%	143%	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%	82%	81%	82%	82%	82%	82%
		COP 21	APR 22	Attained	17%	17%	283%	250%	128%	101%	99%	75%	76%	89%	84%	88%	93%	106%	106%	115%	98%	114%	90%	102%	97%	99%	79%	74%	94%
	Kwania District	COP 17	APR 18	Scale-up: Aggressive	0%	0%	77%	62%	72%	96%	63%	64%	16%	109%	17%	109%	27%	154%	41%	133%	40%	109%	61%	92%	53%	81%	52%	79%	68%
		COP 18	APR 19	Scale-up: Aggressive	495%	0%	29%	28%	22%	22%	61%	25%	61%	20%	84%	19%	78%	29%	93%	49%	84%	58%	73%	79%	95%	96%	84%	64%	71%
		COP 19	APR 20	Scale-up: Aggressive	882%	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%
		COP 21	APR 22	Attained	125%	125%	180%	135%	110%	80%	74%	85%	71%	91%	70%	142%	88%	148%	116%	127%	113%	118%	108%	109%	108%	118%	90%	69%	101%
	Lira District	COP 17	APR 18	Attained	95%	26%	34%	53%	76%	87%	90%	107%	36%	126%	21%	251%	37%	259%	60%	241%	71%	185%	71%	154%	76%	143%	64%	102%	102%
		COP 18	APR 19	Attained	261%	116%	51%	53%	28%	37%	101%	43%	93%	30%	128%	29%	119%	45%	149%	75%	128%	89%	111%	121%	144%	147%	128%	97%	109%
		COP 19	APR 20	Attained	503%	223%	104%	110%	106%	106%	106%	106%	105%	104%	105%	105%	105%	105%	105%	104%	105%	104%	105%	104%	105%	104%	105%	104%	105%
		COP 20	APR 21	Attained	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
		COP 21	APR 22	Attained	42%	42%	108%	89%	84%	71%	99%	87%	70%	85%	71%	74%	95%	86%	114%	100%	115%	109%	103%	100%	112%	95%	83%	76%	95%
	Otuke District	COP 17	APR 18	Attained	149%	43%	61%	115%	136%	136%	75%	99%	27%	168%	29%	247%	50%	243%	89%	205%	63%	149%	87%	141%	92%	139%	91%	115%	110%
		COP 18	APR 19	Attained	223%	97%	69%	76%	49%	48%	133%	54%	90%	30%	123%	28%	115%	43%	144%	73%	123%	86%	106%	117%	139%	142%	123%	93%	107%
		COP 19	APR 20	Attained	246%	151%	117%	122%	115%	116%	116%	116%	116%	115%	115%	115%	115%	114%	115%	114%	115%	114%	116%	114%	115%	114%	116%	114%	115%
		COP 20	APR 21	Attained	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
		COP 21	APR 22	Scale-up: Aggressive	125%	125%	300%	200%	113%	110%	72%	71%	72%	95%	93%	84%	113%	114%	124%	137%	105%	139%	94%	96%	84%	87%	72%	69%	97%

UNCLASSIFIED

		COP 21	APR 22	Scale-up: Aggressive	129%	129%	300%	200%	116%	116%	72%	71%	72%	95%	95%	94%	116%	114%	124%	131%	109%	139%	94%	95%	94%	97%	72%	69%	97%
MASAKA CLUSTER	Bukomansimbi Dirtrict	COP 17	APR 18	Scale-up: Aggressive	98%	17%	37%	46%	65%	61%	46%	58%	13%	75%	12%	185%	20%	125%	33%	100%	34%	78%	33%	65%	39%	64%	39%	54%	52%
		COP 18	APR 19	Scale-up: Aggressive	313%	130%	82%	89%	59%	58%	158%	67%	61%	20%	83%	19%	78%	29%	97%	49%	83%	58%	72%	79%	94%	96%	84%	63%	75%
		COP 19	APR 20	Scale-up: Aggressive	188%	78%	59%	67%	61%	61%	61%	61%	61%	61%	61%	60%	61%	61%	61%	60%	61%	60%	61%	60%	61%	60%	61%	60%	61%	60%	61%
		COP 20	APR 21	Sustained	64%	64%	64%	64%	64%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%
		COP 21	APR 22	Scale-up: Saturation	33%	33%	156%	181%	123%	103%	96%	75%	72%	84%	128%	76%	145%	101%	119%	134%	99%	108%	86%	106%	79%	95%	70%	68%	95%
	Kalungu Dirtrict	COP 17	APR 18	Attained	56%	41%	45%	59%	112%	122%	75%	83%	45%	204%	34%	294%	49%	230%	60%	206%	59%	148%	61%	141%	61%	113%	68%	99%	96%
		COP 18	APR 19	Attained	125%	92%	48%	48%	33%	32%	90%	38%	63%	21%	87%	20%	81%	30%	101%	51%	86%	60%	75%	82%	98%	100%	87%	66%	75%
		COP 19	APR 20	Attained	226%	166%	105%	111%	105%	105%	105%	105%	105%	104%	105%	104%	105%	104%	105%	104%	105%	104%	105%	104%	105%	104%	105%	104%	105%
		COP 20	APR 21	Attained	94%	95%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%
		COP 21	APR 22	Scale-up: Saturation	13%	13%	111%	118%	124%	107%	99%	83%	69%	67%	89%	61%	117%	94%	121%	121%	102%	131%	99%	120%	105%	114%	78%	95%	100%
	Kyotera Dirtrict	COP 17	APR 18	Scale-up: Saturation	60%	19%	29%	38%	45%	48%	54%	73%	23%	100%	21%	198%	32%	196%	51%	166%	63%	156%	68%	128%	75%	103%	54%	89%	94%
		COP 18	APR 19	Scale-up: Saturation	231%	115%	46%	47%	34%	33%	91%	38%	100%	32%	137%	31%	127%	48%	159%	80%	136%	95%	118%	129%	154%	157%	137%	104%	116%
		COP 19	APR 20	Scale-up: Saturation	363%	181%	88%	95%	93%	93%	93%	93%	93%	92%	93%	92%	93%	92%	93%	92%	93%	92%	93%	92%	93%	92%	93%	92%	93%	92%	93%
		COP 20	APR 21	Attained	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
		COP 21	APR 22	Attained	33%	33%	92%	85%	92%	93%	89%	89%	67%	77%	99%	100%	126%	126%	112%	107%	108%	118%	101%	110%	119%	100%	86%	71%	100%
	Luonga Dirtrict	COP 17	APR 18	Scale-up: Aggressive	31%	111%	62%	43%	48%	41%	33%	40%	12%	92%	10%	193%	21%	147%	28%	105%	32%	80%	38%	70%	32%	55%	33%	49%	51%
		COP 18	APR 19	Scale-up: Saturation	76%	150%	70%	58%	42%	41%	113%	48%	54%	17%	74%	17%	69%	26%	87%	44%	74%	52%	64%	70%	84%	85%	75%	56%	66%
		COP 19	APR 20	Scale-up: Saturation	60%	118%	63%	59%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%
		COP 20	APR 21	Sustained	57%	57%	56%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%
		COP 21	APR 22	Attained	24%	24%	131%	123%	86%	94%	81%	81%	77%	91%	96%	91%	121%	103%	115%	117%	88%	95%	77%	86%	72%	79%	70%	79%	88%
	Lyantonde Dirtrict	COP 17	APR 18	Attained	91%	65%	45%	25%	40%	49%	44%	86%	33%	143%	27%	231%	37%	198%	41%	192%	73%	283%	70%	144%	90%	145%	85%	106%	104%
		COP 18	APR 19	Attained	102%	102%	38%	36%	26%	26%	71%	30%	104%	33%	143%	32%	133%	50%	166%	84%	142%	99%	123%	135%	161%	164%	143%	108%	120%
		COP 19	APR 20	Attained	244%	243%	114%	115%	114%	115%	114%	114%	114%	113%	114%	113%	114%	113%	114%	113%	114%	113%	114%	113%	114%	113%	114%	113%	114%
		COP 20	APR 21	Attained	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
		COP 21	APR 22	Attained	20%	20%	156%	164%	89%	89%	86%	86%	70%	79%	114%	158%	126%	224%	119%	142%	109%	145%	101%	110%	109%	112%	69%	70%	109%
	Masaka Dirtrict	COP 17	APR 18	Attained	10%	138%	34%	40%	70%	61%	72%	88%	38%	153%	30%	245%	44%	212%	58%	186%	70%	170%	77%	161%	90%	164%	83%	147%	104%
		COP 18	APR 19	Attained	156%	464%	71%	62%	48%	47%	130%	55%	90%	18%	71%	16%	65%	28%	81%	46%	70%	54%	60%	75%	79%	91%	68%	54%	65%
		COP 19	APR 20	Attained	240%	712%	124%	123%	131%	131%	131%	131%	131%	130%	131%	130%	131%	130%	131%	130%	131%	130%	131%	130%	131%	129%	131%	130%	131%
		COP 20	APR 21	Attained	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
		COP 21	APR 22	Attained	9%	9%	77%	69%	81%	78%	82%	82%	62%	75%	78%	72%	96%	81%	100%	92%	100%	99%	103%	103%	132%	110%	99%	103%	97%
	Rakai Dirtrict	COP 17	APR 18	Scale-up: Saturation	120%	13%	40%	43%	42%	49%	36%	48%	18%	99%	13%	155%	18%	133%	27%	119%	35%	106%	45%	101%	53%	92%	52%	79%	61%
		COP 18	APR 19	Scale-up: Saturation	494%	164%	51%	53%	39%	38%	104%	44%	74%	24%	102%	23%	95%	36%	119%	60%	102%	71%	84%	97%	115%	117%	103%	77%	84%
		COP 19	APR 20	Scale-up: Saturation	511%	169%	65%	70%	71%	71%	71%	71%	71%	70%	71%	70%	71%	70%	71%	70%	71%	70%	71%	70%	71%	70%	71%	70%	71%	70%	71%
		COP 20	APR 21	Scale-up: Aggressive	85%	78%	82%	81%	82%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%
		COP 21	APR 22	Scale-up: Aggressive	100%	100%	127%	116%	83%	84%	79%	80%	70%	78%	104%	73%	120%	86%	113%	112%	106%	100%	109%	109%	114%	104%	95%	95%	102%
	Sembabule Dirtrict	COP 17	APR 18	Scale-up: Saturation	37%	68%	51%	51%	37%	46%	39%	43%	35%	135%	22%	244%	24%	172%	34%	131%	44%	104%	45%	68%	53%	71%	42%	53%	62%
		COP 18	APR 19	Scale-up: Saturation	144%	182%	69%	64%	47%	46%	126%	53%	60%	20%	83%	19%	77%	29%	97%	49%	83%	57%	72%	79%	93%	95%	83%	63%	73%
		COP 19	APR 20	Scale-up: Saturation	140%	177%	84%	82%	82%	82%	82%	82%	82%	81%	82%	81%	82%	81%	82%	81%	82%	81%	82%	81%	82%	81%	82%	81%	82%	81%	82%
		COP 20	APR 21	Scale-up: Saturation	83%	93%	90%	89%	90%	90%	90%	89%	90%	89%	90%	89%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
		COP 21	APR 22	Scale-up: Aggressive	29%	29%	143%	126%	101%	102%	71%	79%	75%	87%	114%	86%	121%	97%	111%	104%	91%	98%	82%	96%	79%	86%	62%	79%	90%
MBALE CLUSTER	Budaka Dirtrict	COP 17	APR 18	Sustained	0%	0%	58%	39%	58%	65%	54%	36%	18%	61%	23%	188%	49%	172%	45%	173%	37%	158%	38%	114%	55%	115%	55%	83%	76%
		COP 18	APR 19	Sustained	225%	0%	177%	136%	111%	108%	295%	125%	66%	20%	90%	20%	84%	32%	104%	53%	89%	62%	78%	85%	101%	103%	90%	68%	86%
		COP 19	APR 20	Sustained	191%	0%	90%	78%	88%	88%	87%	86%	86%	87%	86%	86%	87%	85%	86%	86%	87%	86%	86%	86%	86%	86%	87%	86%	87%
		COP 20	APR 21	Sustained	61%	61%	53%	55%	54%	53%	54%	54%	54%	53%	53%	54%	53%	54%	54%	54%	54%	54%	54%	54%	54%	53%	54%	54%	54%
		COP 21	APR 22	Scale-up: Saturation	0%	0%	175%	217%	92%	85%	83%	83%	82%	95%	82%	95%	86%	92%	107%	87%	78%	115%	90%	114%	70%	88%	71%	72%	86%
	Bududa Dirtrict	COP 17	APR 18	Sustained	90%	12%	20%	53%	92%	87%	63%	62%	22%	102%	14%	137%	8%	122%	14%	109%	34%	90%	37%	75%	57%	101%	40%	65%	55%
		COP 18	APR 19	Sustained	563%	163%	125%	144%	91%	89%	245%	104%	49%	16%	67%	16%	63%	23%	78%	40%	67%	47%	58%	64%	76%	78%	68%	51%	66%
		COP 19	APR 20	Sustained	409%	118%	55%	72%	60%	61%	60%	62%	60%	61%	60%	60%	60%	60%	60%	60%	61%	60%	61%	60%	61%	60%	61%	60%	61%
		COP 20	APR 21	Sustained	34%	34%	33%	36%	35%	35%	35%	35%	35%	34%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%
		COP 21	APR 22	Scale-up: Saturation	0%	0%	289%	144%	111%	91%	117%	74%	83%	106%	83%	106%	79%	102%	74%	97%	74%	93%	83%	85%	81%	86%	90%	91%	87%
	Mbale Dirtrict	COP 17	APR 18	Attained	25%	97%	48%	47%	48%	84%	100%	123%	41%	118%	16%	118%	17%	118%	25%	156%	43%	176%	28%	92%	126%	334%	108%	188%	96%
		COP 18	APR 19	Attained	174%	330%	78%	70%	54%	92%	144%	61%	85%	28%	117%	27%	109%	42%	137%	71%	117%	83%	101%	114%	132%	139%	117%	89%	103%
		COP 19	APR 20	Attained	373%	706%	108%	107%	110%	110%	110%	110%	110%	109%	110%	109%	110%	109%	110%	109%	110%	109%	110%	109%	110%	109%	110%	109%	110%
		COP 20	APR 21	Attained	110%	97%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
		COP 21	APR 22	Attained	50%	50%	134%	135%	110%	91%	115%	105%	79%	110%	70%	73%	72%	79%	86%	67%	92%	82%	109%	101%	133%	122%	117%	117%	98%
	Sironko Dirtrict	COP 17	APR 18	Sustained	32%	82%	100%	50%	66%	80%	68%	78%	20%	121%	8%	180%	9%	132%	15%	135%	24%	106%	33%	98%	38%	119%	54%	107%	63%
		COP 18	APR 19	Sustained	127%	214%	131%	111%	77%	75%	207%	87%	65%	21%	89%	20%	83%	31%	104%	52%	89%	62%	77%	85%	100%	103%	90%	68%	82%
		COP 19	APR 20	Sustained	123%	208%	79%	75%	69%	69%	69%	70%	69%	68%	69%	68%	69%	68%	69%	69%	69%	69%	69%	68%	69%	69%	69%	68%	69%
		COP 20	APR 21	Sustained	44%	44%	45%	45%	43%	44%	44%	44%	43%	44%	44%	44%	44%	44%	44%	44%	44%	44%	44%	44%	44%	44%	44%	44%	44%
		COP 21	APR 22	Scale-up: Aggressive	33%	33%	156%	131%	122%	79%	78%	73%	88%	113%	88%	113%	76%	110%	92%	105%	72%	101%	76%	99%	76%	97%	76%	99%	88%

UNCLASSIFIED



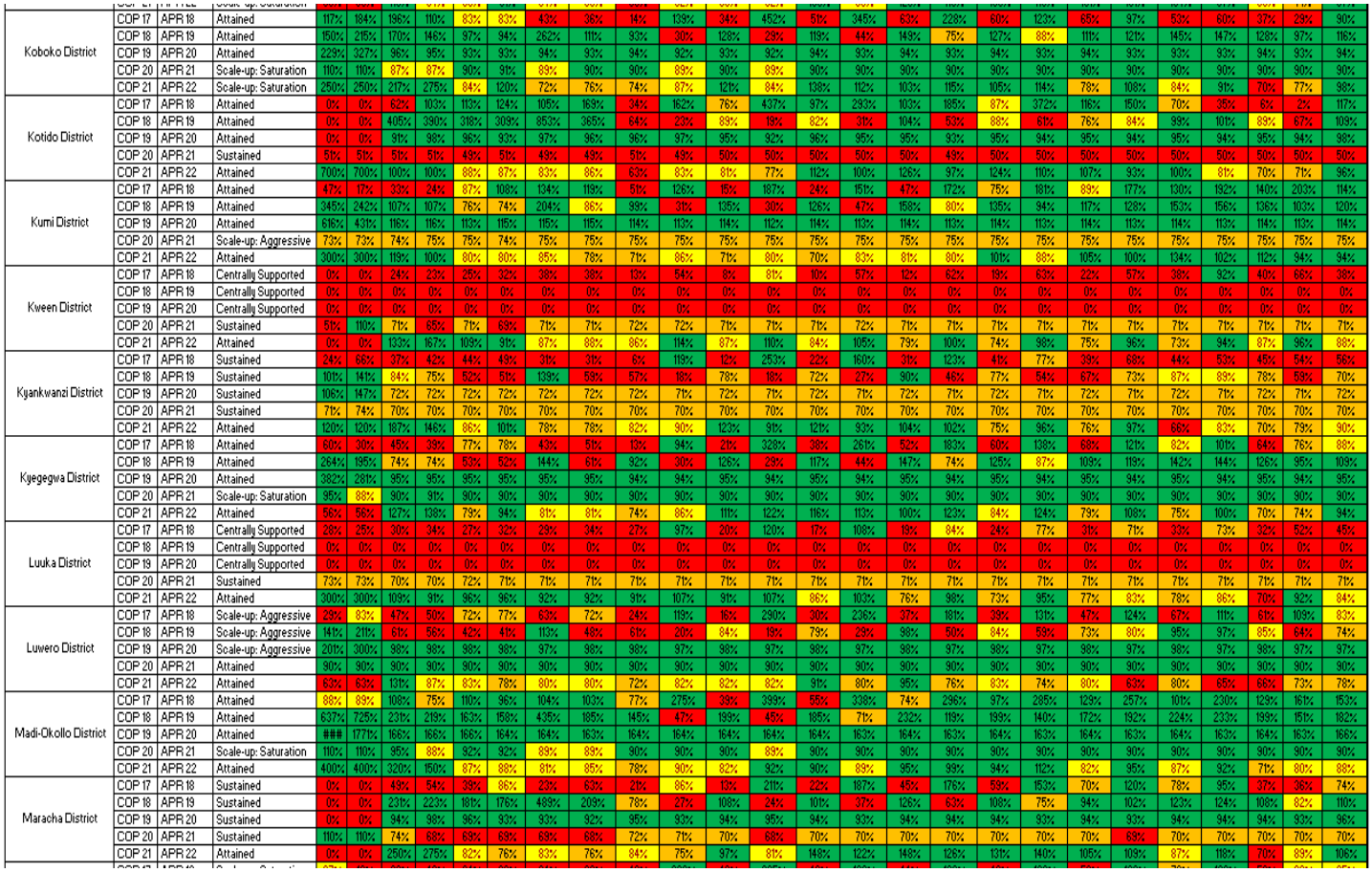
SOROTI CLUSTER	Amuria District	COP 17	APR 18	Sustained	64%	47%	49%	63%	112%	90%	99%	62%	24%	113%	16%	197%	24%	170%	48%	157%	79%	129%	66%	119%	94%	114%	74%	99%	85%
		COP 18	APR 19	Sustained	432%	319%	95%	94%	70%	68%	186%	80%	72%	22%	99%	23%	92%	34%	115%	58%	98%	69%	84%	93%	110%	113%	99%	74%	89%
		COP 19	APR 20	Sustained	1081%	797%	116%	120%	124%	124%	123%	124%	123%	122%	123%	121%	123%	122%	123%	122%	120%	122%	123%	122%	123%	122%	123%	122%	124%
		COP 20	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 21	APR 22	Scale-up: Saturation	200%	200%	125%	146%	91%	87%	73%	80%	70%	84%	69%	85%	99%	90%	117%	130%	105%	138%	109%	110%	98%	80%	86%	70%	95%
	Kaberamaido District	COP 17	APR 18	Attained	33%	133%	96%	62%	113%	128%	108%	109%	49%	120%	24%	224%	34%	213%	62%	188%	65%	159%	57%	112%	103%	120%	76%	108%	96%
		COP 18	APR 19	Attained	196%	397%	99%	88%	67%	65%	179%	76%	88%	29%	120%	27%	112%	42%	140%	71%	120%	84%	104%	114%	136%	138%	121%	91%	106%
		COP 19	APR 20	Attained	441%	887%	107%	102%	103%	104%	104%	104%	104%	103%	104%	103%	104%	103%	104%	103%	104%	103%	104%	103%	104%	103%	104%	103%	104%
		COP 20	APR 21	Attained	110%	110%	97%	97%	97%	97%	97%	98%	97%	96%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%
		COP 21	APR 22	Scale-up: Saturation	50%	50%	140%	140%	108%	120%	76%	104%	70%	82%	70%	83%	93%	78%	109%	101%	120%	110%	116%	103%	107%	107%	92%	88%	99%
	Kalaki District	COP 17	APR 18	Attained	33%	133%	96%	62%	113%	128%	108%	109%	49%	120%	24%	224%	34%	213%	62%	188%	65%	159%	57%	112%	103%	120%	76%	108%	96%
		COP 18	APR 19	Attained	196%	397%	99%	88%	67%	65%	179%	76%	88%	29%	120%	27%	112%	42%	140%	71%	120%	84%	104%	114%	136%	138%	121%	91%	106%
		COP 19	APR 20	Attained	441%	887%	107%	102%	103%	104%	104%	104%	104%	103%	104%	103%	104%	103%	104%	103%	104%	103%	104%	103%	104%	103%	104%	103%	104%
		COP 20	APR 21	Attained	110%	110%	110%	95%	95%	96%	97%	97%	99%	99%	97%	96%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%
		COP 21	APR 22	Scale-up: Saturation	50%	50%	250%	156%	176%	124%	96%	93%	81%	74%	77%	76%	110%	113%	139%	148%	128%	150%	118%	107%	122%	106%	75%	78%	107%
	Kapelebyong District	COP 17	APR 18	Attained	0%	0%	116%	123%	146%	194%	108%	151%	28%	148%	24%	346%	24%	240%	75%	254%	79%	191%	98%	191%	130%	171%	125%	173%	129%
		COP 18	APR 19	Attained	0%	314%	135%	151%	106%	103%	287%	123%	112%	42%	153%	33%	141%	53%	178%	90%	152%	106%	134%	145%	175%	176%	153%	116%	138%
		COP 19	APR 20	Attained	0%	46%	11%	13%	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	68%	68%	73%	80%	77%	77%	77%	78%	78%	79%	77%	77%	78%	78%	78%	78%	78%	78%	78%	77%	78%	77%	78%	78%	78%
		COP 21	APR 22	Scale-up: Saturation	50%	50%	128%	114%	103%	76%	88%	84%	71%	87%	71%	86%	89%	82%	114%	107%	118%	98%	109%	90%	117%	104%	102%	95%	99%
	Katakwi District	COP 17	APR 18	Attained	0%	0%	57%	39%	113%	123%	89%	116%	25%	96%	18%	171%	30%	145%	56%	158%	61%	142%	70%	137%	87%	146%	114%	168%	97%
		COP 18	APR 19	Attained	0%	0%	75%	73%	59%	58%	156%	67%	76%	24%	105%	24%	98%	37%	123%	63%	105%	74%	91%	101%	119%	123%	105%	80%	93%
		COP 19	APR 20	Attained	0%	0%	90%	94%	103%	102%	102%	102%	103%	100%	102%	101%	102%	101%	102%	101%	102%	101%	102%	101%	102%	101%	102%	101%	102%
		COP 20	APR 21	Sustained	57%	68%	65%	63%	64%	64%	64%	63%	64%	64%	63%	64%	64%	63%	64%	64%	64%	64%	64%	64%	64%	63%	64%	64%	64%
		COP 21	APR 22	Scale-up: Saturation	50%	50%	71%	111%	105%	100%	100%	77%	70%	84%	70%	84%	78%	82%	108%	142%	115%	107%	109%	118%	108%	103%	103%	84%	99%
	Ngora District	COP 17	APR 18	Scale-up: Aggressive	76%	91%	79%	91%	79%	83%	67%	88%	41%	145%	32%	194%	33%	133%	44%	114%	43%	122%	48%	88%	72%	108%	59%	82%	73%
		COP 18	APR 19	Scale-up: Aggressive	171%	170%	109%	104%	71%	69%	190%	81%	62%	20%	86%	20%	80%	30%	100%	50%	85%	59%	74%	91%	96%	98%	86%	65%	78%
		COP 19	APR 20	Scale-up: Aggressive	257%	254%	62%	83%	76%	77%	75%	77%	77%	77%	76%	75%	76%	76%	77%	76%	77%	76%	76%	76%	76%	76%	76%	77%	76%	77%
		COP 20	APR 21	Scale-up: Saturation	110%	110%	88%	83%	85%	85%	85%	85%	85%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%
		COP 21	APR 22	Scale-up: Aggressive	150%	150%	163%	136%	111%	122%	94%	78%	110%	102%	79%	108%	78%	79%	90%	96%	92%	96%	110%	109%	139%	120%	105%	89%	100%
	Serere District	COP 17	APR 18	Scale-up: Aggressive	0%	75%	63%	75%	94%	73%	52%	79%	33%	112%	19%	144%	35%	139%	43%	130%	61%	109%	72%	100%	94%	114%	87%	115%	81%
		COP 18	APR 19	Scale-up: Aggressive	371%	422%	138%	131%	97%	94%	258%	109%	69%	23%	95%	21%	88%	33%	110%	56%	94%	66%	82%	90%	107%	109%	95%	72%	89%
		COP 19	APR 20	Scale-up: Aggressive	494%	559%	67%	88%	89%	89%	89%	90%	89%	88%	88%	87%	88%	88%	88%	87%	88%	88%	88%	87%	88%	87%	88%	88%	89%
		COP 20	APR 21	Sustained	68%	68%	75%	72%	73%	73%	73%	73%	72%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%
		COP 21	APR 22	Scale-up: Aggressive	367%	367%	133%	133%	87%	75%	95%	90%	71%	83%	72%	83%	84%	80%	87%	89%	99%	115%	95%	112%	126%	132%	100%	91%	95%
	Soroti District	COP 17	APR 18	Attained	24%	186%	74%	61%	93%	97%	139%	161%	71%	205%	30%	271%	45%	216%	68%	237%	99%	228%	127%	255%	167%	291%	185%	294%	158%
		COP 18	APR 19	Attained	383%	993%	285%	239%	180%	175%	483%	204%	77%	25%	106%	24%	99%	37%	123%	62%	106%	74%	92%	100%	119%	122%	106%	80%	107%
		COP 19	APR 20	Attained	443%	1160%	164%	149%	150%	149%	149%	150%	150%	148%	149%	149%	149%	148%	149%	148%	149%	148%	150%	148%	149%	148%	150%	148%	150%
		COP 20	APR 21	Attained	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
		COP 21	APR 22	Scale-up: Aggressive	70%	70%	70%	83%	87%	87%	84%	76%	70%	76%	70%	75%	61%	74%	73%	77%	96%	92%	112%	101%	150%	123%	154%	114%	100%
	Abim District	COP 17	APR 18	Centrally Supported	26%	34%	33%	31%	49%	50%	52%	57%	22%	67%	12%	107%	17%	87%	29%	89%	37%	83%	42%	77%	56%	85%	57%	84%	54%
		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	61%	81%	69%	69%	71%	72%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%
		COP 21	APR 22	Scale-up: Saturation	0%	0%	150%	186%	80%	86%	84%	84%	84%	105%	85%	105%	80%	103%	74%	98%	74%	91%	77%	83%	82%	89%	78%	91%	84%
	Adjumani District	COP 17	APR 18	Attained	0%	0%	76%	68%	124%	120%	92%	100%	14%	145%	24%	253%	32%	243%	47%	219%	65%	184%	89%	115%	58%	121%	76%	117%	93%
		COP 18	APR 19	Attained	0%	0%	231%	223%	181%	176%	484%	206%	83%	26%	115%	27%	107%	40%	134%	68%	115%	80%	100%	109%	130%	132%	115%	87%	115%
		COP 19	APR 20	Attained	0%	0%	94%	94%	96%	96%	94%	95%	97%	96%	96%	95%	96%	95%	95%	95%	96%	95%	95%	95%	95%	95%	95%	94%	97%
		COP 20	APR 21	Scale-up: Aggressive	81%	110%	69%	90%	91%	89%	90%	89%	90%	89%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
		COP 21	APR 22	Scale-up: Saturation	450%	300%	233%	150%	115%	103%	77%	78%	71%	85%	76%	85%	103%	105%	122%	104%	113%	107%	104%	125%	100%	89%	78%	80%	98%

Agago District	COP 17	APR 18	Attained	75%	27%	47%	44%	102%	91%	84%	89%	20%	83%	19%	207%	28%	181%	55%	168%	63%	134%	74%	114%	71%	130%	64%	105%	85%
	COP 18	APR 19	Attained	318%	225%	72%	71%	53%	51%	142%	60%	107%	35%	147%	33%	137%	51%	171%	86%	146%	102%	127%	139%	165%	168%	147%	111%	126%
	COP 19	APR 20	Attained	463%	328%	96%	96%	97%	96%	96%	97%	97%	95%	96%	95%	96%	95%	96%	95%	96%	95%	96%	95%	96%	95%	96%	95%	96%
	COP 20	APR 21	Scale-up: Aggressive	74%	74%	75%	76%	75%	74%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
	COP 21	APR 22	Scale-up: Saturation	20%	20%	142%	150%	86%	89%	83%	83%	72%	86%	79%	86%	101%	86%	112%	122%	94%	113%	100%	100%	90%	85%	80%	68%	91%
Amudat District	COP 17	APR 18	Centrally Supported	0%	0%	23%	21%	48%	46%	44%	58%	17%	69%	12%	103%	16%	81%	26%	83%	35%	90%	39%	74%	52%	78%	55%	81%	51%
	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	110%	110%	68%	68%	68%	73%	70%	71%	72%	72%	71%	72%	71%	71%	71%	72%	71%	71%	72%	71%	71%	73%	71%	72%	71%
	COP 21	APR 22	Scale-up: Saturation	100%	100%	250%	200%	100%	89%	100%	100%	91%	115%	93%	118%	78%	114%	81%	111%	77%	107%	73%	105%	74%	103%	73%	103%	92%
Arua District	COP 17	APR 18	Attained	88%	99%	108%	75%	110%	96%	104%	103%	77%	275%	39%	399%	55%	338%	74%	296%	97%	285%	129%	257%	101%	230%	129%	161%	153%
	COP 18	APR 19	Attained	637%	725%	231%	219%	163%	158%	435%	185%	145%	47%	199%	45%	185%	71%	232%	113%	199%	140%	172%	192%	224%	233%	199%	151%	182%
	COP 19	APR 20	Attained	###	1771%	166%	166%	166%	164%	164%	163%	164%	164%	164%	164%	164%	163%	164%	163%	164%	163%	164%	163%	164%	163%	164%	163%	166%
	COP 20	APR 21	Scale-up: Saturation	87%	98%	90%	91%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	COP 21	APR 22	Scale-up: Saturation	125%	125%	128%	105%	93%	93%	89%	89%	66%	94%	77%	87%	107%	98%	105%	101%	117%	95%	118%	88%	136%	111%	79%	69%	96%
Bukedea District	COP 17	APR 18	Sustained	78%	32%	38%	65%	56%	38%	77%	60%	20%	89%	25%	104%	31%	86%	48%	104%	61%	106%	79%	98%	84%	113%	85%	116%	74%
	COP 18	APR 19	Sustained	230%	125%	126%	140%	84%	81%	223%	94%	68%	23%	95%	21%	88%	33%	110%	55%	94%	68%	82%	89%	106%	108%	94%	71%	87%
	COP 19	APR 20	Sustained	342%	185%	89%	85%	86%	86%	88%	87%	87%	86%	87%	86%	87%	86%	87%	86%	87%	86%	87%	86%	87%	86%	87%	86%	87%
	COP 20	APR 21	Sustained	51%	51%	51%	51%	50%	50%	50%	50%	50%	51%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
	COP 21	APR 22	Scale-up: Saturation	250%	250%	122%	111%	89%	88%	87%	87%	72%	90%	72%	90%	85%	86%	84%	83%	94%	90%	109%	89%	118%	109%	115%	93%	95%
Bukwo District	COP 17	APR 18	Sustained	0%	0%	17%	41%	74%	46%	99%	98%	82%	263%	36%	161%	23%	60%	21%	77%	25%	65%	40%	104%	32%	70%	19%	57%	52%
	COP 18	APR 19	Sustained	0%	0%	168%	162%	132%	128%	349%	145%	45%	14%	65%	14%	59%	22%	75%	38%	64%	45%	55%	60%	72%	73%	64%	49%	67%
	COP 19	APR 20	Sustained	0%	0%	97%	93%	99%	96%	98%	97%	95%	92%	95%	92%	95%	95%	95%	94%	95%	94%	95%	94%	96%	95%	95%	94%	96%
	COP 20	APR 21	Sustained	51%	51%	46%	56%	51%	49%	51%	49%	50%	49%	49%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
	COP 21	APR 22	Scale-up: Saturation	0%	0%	125%	400%	93%	107%	70%	81%	75%	100%	84%	96%	96%	98%	79%	91%	90%	87%	94%	105%	81%	87%	77%	86%	88%
Bulambuli District	COP 17	APR 18	Centrally Supported	13%	28%	24%	26%	28%	34%	35%	40%	14%	56%	8%	79%	9%	57%	12%	62%	18%	63%	21%	58%	38%	90%	39%	65%	38%
	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	Scale-up: Aggressive	76%	76%	71%	71%	71%	72%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%
	COP 21	APR 22	Scale-up: Saturation	50%	50%	190%	100%	131%	79%	104%	73%	85%	109%	86%	109%	81%	104%	73%	98%	80%	95%	76%	92%	82%	90%	73%	93%	85%
Bulisa District	COP 17	APR 18	Scale-up: Saturation	0%	0%	55%	61%	31%	62%	40%	46%	17%	155%	20%	342%	42%	248%	62%	199%	55%	95%	49%	89%	49%	63%	42%	47%	76%
	COP 18	APR 19	Scale-up: Saturation	445%	0%	57%	53%	43%	42%	116%	49%	74%	24%	102%	24%	95%	36%	119%	60%	102%	71%	89%	97%	115%	118%	103%	77%	89%
	COP 19	APR 20	Scale-up: Saturation	661%	0%	83%	82%	82%	82%	84%	83%	83%	83%	83%	82%	82%	82%	83%	82%	83%	82%	83%	82%	83%	82%	83%	82%	83%
	COP 20	APR 21	Sustained	76%	76%	70%	71%	73%	72%	73%	74%	73%	72%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%
	COP 21	APR 22	Scale-up: Saturation	100%	100%	213%	200%	97%	97%	72%	76%	133%	118%	153%	151%	134%	111%	146%	118%	93%	117%	105%	104%	89%	100%	70%	65%	107%
Bundibugyo District	COP 17	APR 18	Attained	0%	0%	58%	73%	107%	124%	56%	55%	17%	128%	16%	286%	32%	285%	59%	249%	56%	168%	53%	127%	44%	108%	32%	67%	89%
	COP 18	APR 19	Attained	318%	0%	149%	125%	102%	99%	272%	114%	84%	26%	115%	26%	107%	40%	134%	67%	115%	79%	99%	109%	129%	132%	115%	87%	106%
	COP 19	APR 20	Attained	481%	0%	95%	96%	95%	95%	96%	95%	94%	94%	95%	94%	94%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	93%	95%
	COP 20	APR 21	Scale-up: Aggressive	81%	81%	89%	89%	90%	90%	91%	89%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	COP 21	APR 22	Scale-up: Saturation	67%	67%	162%	108%	119%	117%	82%	75%	74%	90%	81%	89%	117%	91%	125%	122%	119%	119%	87%	95%	77%	73%	70%	77%	96%
Butambala District	COP 17	APR 18	Attained	21%	142%	52%	57%	85%	83%	90%	68%	23%	135%	19%	283%	25%	211%	35%	167%	44%	134%	61%	140%	77%	127%	93%	179%	94%
	COP 18	APR 19	Attained	243%	558%	71%	65%	51%	50%	137%	57%	77%	25%	106%	24%	93%	37%	124%	82%	106%	74%	92%	101%	120%	122%	107%	81%	93%
	COP 19	APR 20	Attained	395%	905%	118%	119%	120%	119%	119%	120%	119%	117%	119%	117%	119%	118%	119%	118%	119%	117%	119%	117%	119%	117%	119%	117%	119%
	COP 20	APR 21	Scale-up: Saturation	110%	95%	94%	95%	95%	96%	95%	95%	95%	94%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
	COP 21	APR 22	Scale-up: Saturation	25%	25%	133%	111%	87%	91%	91%	77%	72%	95%	145%	94%	114%	95%	95%	88%	93%	119%	108%	118%	103%	116%	61%	78%	96%
Butebo District	COP 17	APR 18	Scale-up: Saturation	127%	75%	74%	123%	116%	113%	43%	78%	8%	228%	11%	227%	22%	157%	35%	157%	43%	132%	56%	111%	47%	100%	66%	127%	80%
	COP 18	APR 19	Scale-up: Saturation	783%	464%	193%	196%	140%	136%	375%	154%	83%	33%	109%	27%	103%	39%	130%	66%	110%	75%	95%	106%	124%	128%	111%	83%	107%
	COP 19	APR 20	Scale-up: Saturation	###	765%	94%	96%	95%	92%	92%	98%	96%	90%	95%	95%	95%	95%	94%	95%	94%	95%	93%	95%	94%	95%	94%	96%
	COP 20	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%	60%
	COP 21	APR 22	Scale-up: Saturation	100%	100%	233%	200%	108%	108%	141%	78%	74%	93%	78%	95%	89%	86%	118%	89%	83%	88%	78%	114%	126%	142%	115%	94%	101%

Buvuma District	COP 17	APR 18	Scale-up: Saturation	28%	22%	22%	28%	35%	29%	25%	22%	9%	68%	15%	136%	27%	121%	52%	113%	57%	84%	70%	77%	66%	76%	58%	63%	61%
	COP 18	APR 19	Scale-up: Saturation	268%	210%	55%	54%	40%	39%	108%	45%	79%	26%	108%	25%	101%	37%	126%	63%	108%	75%	94%	102%	122%	124%	108%	82%	93%
	COP 19	APR 20	Scale-up: Saturation	358%	280%	96%	96%	94%	95%	95%	95%	95%	95%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%
	COP 20	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%
	COP 21	APR 22	Scale-up: Saturation	67%	50%	112%	88%	97%	97%	93%	94%	91%	107%	90%	107%	81%	103%	77%	98%	78%	94%	76%	82%	70%	89%	77%	91%	86%
Buyende District	COP 17	APR 18	Scale-up: Saturation	24%	97%	57%	41%	41%	41%	33%	33%	9%	87%	18%	159%	21%	121%	36%	134%	44%	103%	52%	106%	61%	99%	72%	116%	69%
	COP 18	APR 19	Scale-up: Saturation	172%	343%	144%	121%	69%	86%	237%	100%	73%	24%	101%	23%	94%	35%	118%	59%	101%	70%	88%	96%	114%	116%	102%	77%	93%
	COP 19	APR 20	Scale-up: Saturation	256%	511%	95%	94%	96%	95%	95%	95%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%
	COP 20	APR 21	Scale-up: Saturation	87%	67%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	COP 21	APR 22	Scale-up: Saturation	100%	100%	216%	217%	78%	86%	83%	83%	77%	85%	76%	84%	72%	81%	95%	87%	91%	93%	100%	107%	101%	100%	104%	91%	92%
Gomba District	COP 17	APR 18	Scale-up: Saturation	55%	12%	36%	28%	55%	55%	30%	53%	8%	80%	9%	148%	19%	120%	31%	118%	36%	84%	44%	77%	57%	80%	61%	83%	58%
	COP 18	APR 19	Scale-up: Saturation	159%	107%	75%	77%	51%	50%	136%	57%	48%	15%	66%	15%	62%	23%	77%	39%	66%	46%	57%	63%	74%	76%	66%	50%	60%
	COP 19	APR 20	Scale-up: Saturation	190%	127%	86%	86%	86%	86%	86%	86%	86%	85%	86%	85%	86%	85%	86%	85%	86%	85%	86%	85%	86%	85%	86%	85%	86%
	COP 20	APR 21	Sustained	64%	76%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
	COP 21	APR 22	Scale-up: Saturation	50%	50%	126%	153%	105%	101%	87%	78%	66%	85%	106%	85%	122%	91%	111%	107%	88%	102%	84%	100%	78%	91%	69%	87%	91%
Hoima District	COP 17	APR 18	Scale-up: Saturation	41%	47%	36%	53%	52%	44%	64%	57%	55%	214%	45%	300%	58%	276%	49%	193%	56%	147%	40%	128%	49%	89%	24%	31%	83%
	COP 18	APR 19	Scale-up: Saturation	159%	140%	77%	75%	52%	51%	140%	59%	86%	28%	119%	26%	111%	42%	138%	70%	118%	83%	103%	113%	134%	137%	119%	90%	103%
	COP 19	APR 20	Scale-up: Saturation	297%	260%	133%	133%	133%	133%	133%	133%	133%	132%	133%	131%	133%	131%	132%	131%	132%	131%	133%	131%	132%	131%	133%	131%	132%
	COP 20	APR 21	Attained	91%	91%	90%	91%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	COP 21	APR 22	Scale-up: Saturation	44%	44%	151%	117%	109%	74%	77%	77%	84%	86%	137%	94%	137%	112%	114%	112%	101%	101%	93%	87%	89%	87%	66%	70%	97%
Isingiro District	COP 17	APR 18	Scale-up: Aggressive	20%	190%	68%	63%	49%	40%	36%	34%	32%	163%	30%	306%	41%	198%	49%	146%	49%	100%	43%	79%	47%	84%	34%	42%	69%
	COP 18	APR 19	Scale-up: Aggressive	497%	1389%	80%	75%	60%	58%	160%	68%	72%	23%	99%	22%	92%	34%	115%	58%	98%	69%	85%	94%	111%	113%	99%	75%	88%
	COP 19	APR 20	Scale-up: Aggressive	631%	1761%	86%	88%	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	74%	74%	75%	76%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
	COP 21	APR 22	Scale-up: Saturation	56%	56%	167%	167%	94%	76%	79%	79%	63%	85%	133%	95%	137%	110%	120%	128%	95%	109%	88%	95%	69%	81%	70%	74%	95%
Kaabong District	COP 17	APR 18	Centrally Supported	170%	221%	193%	180%	269%	295%	295%	323%	125%	384%	70%	611%	97%	495%	161%	501%	206%	469%	236%	439%	314%	474%	320%	473%	306%
	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	110%	51%	73%	64%	68%	70%	71%	71%	71%	72%	72%	73%	71%	72%	71%	72%	71%	71%	71%	71%	71%	72%	71%	71%	71%
	COP 21	APR 22	Scale-up: Saturation	0%	0%	117%	117%	119%	123%	118%	119%	116%	127%	116%	124%	112%	124%	107%	122%	104%	119%	102%	117%	100%	116%	101%	118%	113%
Kagadi District	COP 17	APR 18	Scale-up: Saturation	51%	48%	50%	49%	50%	51%	38%	52%	20%	184%	25%	368%	43%	246%	58%	180%	48%	124%	60%	110%	57%	77%	54%	72%	83%
	COP 18	APR 19	Scale-up: Saturation	280%	262%	53%	51%	39%	38%	105%	45%	84%	27%	115%	26%	107%	40%	134%	67%	114%	80%	99%	109%	129%	132%	115%	87%	99%
	COP 19	APR 20	Scale-up: Saturation	435%	407%	94%	94%	94%	94%	94%	94%	94%	93%	94%	93%	94%	93%	94%	93%	94%	93%	94%	93%	94%	93%	94%	93%	94%
	COP 20	APR 21	Scale-up: Saturation	88%	95%	89%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	COP 21	APR 22	Scale-up: Saturation	25%	25%	148%	125%	89%	90%	86%	85%	61%	87%	139%	120%	134%	125%	127%	135%	90%	103%	82%	92%	76%	87%	64%	68%	97%
Kakumiro District	COP 17	APR 18	Scale-up: Saturation	30%	46%	30%	51%	58%	51%	34%	50%	13%	161%	20%	262%	33%	197%	40%	143%	48%	110%	54%	89%	56%	92%	59%	71%	72%
	COP 18	APR 19	Scale-up: Saturation	171%	156%	44%	42%	32%	31%	84%	36%	82%	27%	112%	26%	105%	39%	131%	68%	112%	78%	97%	106%	126%	129%	112%	85%	96%
	COP 19	APR 20	Scale-up: Saturation	298%	272%	91%	91%	91%	91%	91%	91%	91%	90%	91%	90%	91%	90%	91%	90%	91%	90%	91%	90%	91%	90%	91%	90%	91%
	COP 20	APR 21	Attained	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
	COP 21	APR 22	Scale-up: Saturation	67%	67%	130%	126%	89%	88%	85%	85%	78%	85%	141%	85%	145%	122%	122%	118%	110%	93%	99%	94%	106%	76%	93%	84%	104%
Kalangala District	COP 17	APR 18	Scale-up: Saturation	28%	2%	8%	8%	10%	11%	8%	14%	8%	31%	6%	47%	21%	79%	26%	60%	32%	52%	27%	26%	26%	14%	14%	9%	27%
	COP 18	APR 19	Scale-up: Saturation	51%	16%	10%	11%	7%	7%	20%	8%	29%	9%	39%	9%	37%	14%	46%	23%	38%	27%	34%	37%	44%	45%	40%	30%	33%
	COP 19	APR 20	Scale-up: Saturation	28%	9%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%
	COP 20	APR 21	Sustained	71%	74%	69%	70%	69%	70%	70%	70%	71%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
	COP 21	APR 22	Scale-up: Saturation	20%	20%	77%	109%	97%	73%	96%	75%	89%	83%	142%	91%	114%	100%	97%	103%	97%	109%	85%	90%	95%	82%	72%	73%	94%
Kaliro District	COP 17	APR 18	Attained	123%	31%	68%	69%	64%	55%	48%	57%	16%	70%	29%	215%	29%	159%	41%	177%	57%	156%	63%	137%	68%	147%	98%	115%	89%
	COP 18	APR 19	Attained	966%	490%	167%	169%	124%	121%	331%	142%	71%	22%	98%	23%	91%	34%	114%	57%	96%	68%	84%	93%	110%	112%	98%	74%	94%
	COP 19	APR 20	Attained	1410%	714%	96%	97%	95%	95%	94%	95%	96%	95%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	96%
	COP 20	APR 21	Sustained	81%	81%	69%	73%	70%	70%	70%	70%	69%	70%	70%	69%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
	COP 21	APR 22	Scale-up: Saturation	450%	450%	155%	127%	82%	98%	83%	82%	72%	86%	72%	86%	69%	85%	75%	85%	90%	87%	90%	103%	94%	90%	94%	89%	87%

Kapchorwa District	COP 17	APR 18	Centrally Supported	33%	36%	42%	44%	50%	59%	63%	69%	25%	97%	14%	139%	16%	101%	21%	110%	32%	112%	38%	102%	67%	158%	69%	115%	67%			
	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	68%	68%	71%	73%	73%	70%	72%	72%	71%	69%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%			
	COP 21	APR 22	Scale-up: Saturation	0%	0%	133%	167%	117%	105%	115%	93%	78%	104%	83%	100%	108%	95%	80%	89%	71%	92%	95%	83%	92%	74%	73%	84%	86%			
Karenga District	COP 17	APR 18	Centrally Supported	170%	221%	193%	180%	269%	295%	295%	323%	125%	384%	70%	611%	97%	495%	161%	501%	206%	469%	238%	439%	314%	474%	320%	473%	306%			
	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	110%	0%	51%	68%	76%	64%	71%	71%	73%	73%	70%	71%	71%	72%	71%	72%	72%	72%	71%	71%	72%	72%	71%	71%	71%			
	COP 21	APR 22	Scale-up: Saturation	100%	100%	100%	200%	129%	114%	110%	111%	106%	114%	103%	118%	98%	109%	90%	103%	89%	103%	89%	100%	85%	96%	88%	100%	98%			
Kasese District	COP 17	APR 18	Attained	80%	34%	48%	55%	87%	72%	69%	77%	33%	183%	26%	357%	33%	273%	49%	213%	59%	161%	62%	130%	66%	113%	65%	86%	95%			
	COP 18	APR 19	Attained	481%	328%	110%	110%	81%	79%	216%	91%	75%	24%	103%	23%	96%	36%	120%	60%	102%	71%	89%	97%	116%	118%	103%	78%	93%			
	COP 19	APR 20	Attained	699%	475%	95%	95%	95%	95%	95%	95%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%			
	COP 20	APR 21	Attained	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%			
	COP 21	APR 22	Scale-up: Saturation	82%	82%	112%	115%	84%	104%	90%	81%	85%	80%	113%	80%	118%	88%	113%	104%	107%	108%	93%	107%	88%	98%	65%	80%	96%			
Kassanda District	COP 17	APR 18	Scale-up: Saturation	30%	46%	42%	34%	48%	52%	33%	38%	10%	63%	10%	223%	22%	177%	28%	124%	33%	88%	37%	69%	41%	62%	40%	61%	56%			
	COP 18	APR 19	Scale-up: Saturation	149%	191%	58%	54%	40%	39%	108%	46%	59%	19%	82%	19%	76%	28%	95%	48%	81%	57%	70%	77%	91%	94%	82%	62%	71%			
	COP 19	APR 20	Scale-up: Saturation	165%	212%	79%	79%	79%	79%	78%	79%	79%	78%	79%	78%	79%	78%	79%	78%	79%	78%	79%	78%	78%	78%	79%	78%	78%			
	COP 20	APR 21	Scale-up: Aggressive	71%	78%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%			
	COP 21	APR 22	Scale-up: Saturation	129%	129%	134%	164%	112%	96%	77%	77%	76%	89%	103%	88%	115%	84%	108%	99%	89%	95%	73%	92%	71%	96%	70%	74%	88%			
Kibaale District	COP 17	APR 18	Scale-up: Saturation	0%	0%	36%	51%	43%	62%	49%	58%	13%	151%	22%	279%	37%	196%	52%	152%	49%	105%	62%	82%	46%	75%	65%	74%	73%			
	COP 18	APR 19	Scale-up: Saturation	0%	511%	91%	93%	71%	69%	192%	81%	89%	29%	122%	27%	114%	42%	142%	72%	122%	95%	106%	116%	138%	140%	122%	92%	108%			
	COP 19	APR 20	Scale-up: Saturation	0%	634%	82%	82%	81%	82%	81%	81%	82%	80%	81%	80%	81%	81%	81%	81%	81%	80%	81%	80%	81%	80%	81%	80%	81%			
	COP 20	APR 21	Scale-up: Aggressive	73%	73%	76%	75%	75%	76%	76%	75%	75%	74%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%			
	COP 21	APR 22	Scale-up: Saturation	67%	67%	221%	143%	91%	90%	86%	86%	69%	88%	124%	83%	124%	83%	110%	101%	103%	90%	82%	83%	89%	80%	80%	77%	93%			
Kiboga District	COP 17	APR 18	Scale-up: Saturation	37%	24%	24%	38%	77%	63%	47%	48%	18%	95%	17%	279%	28%	193%	44%	171%	49%	136%	53%	122%	56%	104%	52%	84%	78%			
	COP 18	APR 19	Scale-up: Saturation	115%	76%	41%	42%	29%	28%	77%	33%	68%	22%	93%	21%	87%	33%	109%	55%	93%	65%	81%	88%	105%	107%	94%	71%	80%			
	COP 19	APR 20	Scale-up: Saturation	153%	101%	87%	88%	88%	88%	88%	88%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	87%			
	COP 20	APR 21	Attained	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%			
	COP 21	APR 22	Scale-up: Saturation	83%	83%	86%	118%	115%	80%	87%	71%	70%	81%	100%	73%	124%	90%	113%	105%	100%	96%	89%	100%	92%	104%	70%	80%	94%			
Kibuku District	COP 17	APR 18	Sustained	36%	77%	41%	69%	73%	65%	53%	58%	29%	135%	6%	184%	18%	150%	31%	133%	49%	118%	56%	147%	72%	157%	81%	114%	79%			
	COP 18	APR 19	Sustained	526%	563%	200%	190%	139%	136%	372%	168%	70%	24%	97%	22%	91%	33%	113%	57%	97%	67%	84%	92%	109%	111%	97%	74%	95%			
	COP 19	APR 20	Sustained	735%	785%	98%	93%	94%	95%	96%	95%	96%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	96%			
	COP 20	APR 21	Sustained	76%	76%	58%	58%	60%	60%	60%	59%	60%	59%	60%	60%	60%	59%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%			
	COP 21	APR 22	Scale-up: Saturation	0%	0%	300%	125%	87%	92%	80%	82%	91%	107%	73%	96%	68%	93%	97%	86%	83%	104%	102%	97%	103%	101%	79%	89%	90%			
Kikuube District	COP 17	APR 18	Scale-up: Saturation	37%	45%	35%	48%	67%	77%	58%	55%	24%	153%	33%	313%	44%	262%	54%	196%	51%	137%	62%	93%	57%	71%	50%	49%	82%			
	COP 18	APR 19	Scale-up: Saturation	208%	189%	71%	68%	50%	49%	133%	57%	83%	26%	114%	27%	106%	40%	132%	67%	113%	79%	98%	107%	128%	130%	114%	86%	99%			
	COP 19	APR 20	Scale-up: Saturation	417%	378%	120%	120%	120%	119%	119%	120%	120%	119%	119%	118%	119%	118%	119%	118%	119%	118%	119%	118%	120%	118%	119%	118%	119%			
	COP 20	APR 21	Scale-up: Aggressive	71%	81%	76%	75%	75%	75%	74%	75%	75%	74%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%			
	COP 21	APR 22	Scale-up: Saturation	67%	67%	124%	128%	88%	87%	84%	84%	83%	89%	119%	84%	115%	94%	86%	90%	84%	86%	72%	80%	69%	71%	70%	77%	85%			
Kiryandongo District	COP 17	APR 18	Scale-up: Saturation	37%	74%	52%	54%	33%	33%	71%	78%	43%	364%	63%	362%	56%	228%	39%	123%	37%	124%	52%	123%	61%	163%	22%	48%	83%			
	COP 18	APR 19	Scale-up: Saturation	346%	457%	74%	70%	55%	53%	147%	62%	90%	29%	123%	28%	115%	43%	144%	73%	123%	96%	107%	117%	139%	142%	124%	93%	107%			
	COP 19	APR 20	Scale-up: Saturation	492%	648%	89%	90%	89%	89%	89%	89%	89%	89%	89%	89%	89%	88%	89%	88%	89%	88%	89%	88%	89%	88%	89%	88%	89%			
	COP 20	APR 21	Attained	91%	91%	92%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%			
	COP 21	APR 22	Scale-up: Saturation	120%	120%	177%	148%	95%	100%	75%	74%	70%	88%	112%	129%	119%	123%	120%	130%	107%	118%	105%	115%	101%	93%	76%	75%	103%			
Kitgum District	COP 17	APR 18	Attained	58%	0%	52%	36%	73%	95%	66%	70%	17%	137%	25%	290%	49%	228%	68%	233%	76%	147%	63%	110%	61%	102%	68%	81%	93%			
	COP 18	APR 19	Attained	904%	972%	81%	78%	62%	60%	166%	71%	70%	23%	96%	22%	90%	34%	112%	57%	96%	67%	83%	91%	108%	110%	96%	73%	86%			
	COP 19	APR 20	Attained	###	1339%	104%	105%	105%	104%	104%	105%	104%	103%	104%	103%	104%	103%	104%	103%	104%	103%	104%	103%	104%	103%	104%	103%	104%			
	COP 20	APR 21	Attained	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%			
	COP 21	APR 22	Scale-up: Saturation	38%	38%	119%	84%	99%	91%	84%	80%	63%	82%	89%	82%	106%	83%	123%	119%	109%	119%	101%	101%	104%	97%	86%	71%	97%			

UNCLASSIFIED



Koboko District	COP 17	APR 18	Attained	117%	184%	196%	110%	83%	83%	43%	36%	14%	139%	34%	452%	51%	345%	63%	228%	60%	123%	65%	97%	53%	60%	37%	29%	90%
	COP 18	APR 19	Attained	150%	215%	170%	146%	97%	94%	262%	111%	93%	30%	128%	29%	119%	44%	149%	75%	127%	88%	111%	121%	145%	147%	128%	97%	116%
	COP 19	APR 20	Attained	229%	327%	96%	95%	93%	93%	94%	93%	94%	92%	93%	92%	94%	93%	94%	93%	94%	93%	94%	93%	93%	93%	94%	93%	94%
	COP 20	APR 21	Scale-up: Saturation	110%	110%	87%	87%	90%	91%	89%	90%	90%	89%	90%	89%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	COP 21	APR 22	Scale-up: Saturation	250%	250%	217%	275%	84%	120%	72%	76%	74%	87%	121%	84%	138%	112%	103%	115%	105%	114%	78%	108%	84%	91%	70%	77%	98%
Kotido District	COP 17	APR 18	Attained	0%	0%	62%	103%	113%	124%	105%	169%	34%	162%	76%	437%	97%	293%	103%	185%	87%	372%	116%	150%	70%	35%	6%	2%	117%
	COP 18	APR 19	Attained	0%	0%	405%	390%	318%	309%	853%	365%	64%	23%	89%	19%	82%	31%	104%	53%	88%	61%	76%	84%	99%	101%	89%	67%	109%
	COP 19	APR 20	Attained	0%	0%	91%	98%	96%	93%	97%	96%	96%	97%	95%	92%	96%	95%	95%	93%	95%	94%	95%	94%	95%	94%	95%	94%	98%
	COP 20	APR 21	Sustained	51%	51%	51%	51%	49%	51%	49%	49%	51%	49%	50%	50%	50%	50%	50%	49%	50%	50%	50%	50%	50%	50%	50%	50%	50%
	COP 21	APR 22	Attained	700%	700%	100%	100%	98%	87%	83%	86%	63%	83%	81%	77%	112%	100%	126%	97%	124%	110%	107%	93%	100%	81%	70%	71%	96%
Kumi District	COP 17	APR 18	Attained	47%	17%	33%	24%	87%	108%	134%	119%	51%	126%	15%	187%	24%	151%	47%	172%	75%	181%	89%	177%	130%	192%	140%	203%	114%
	COP 18	APR 19	Attained	345%	242%	107%	107%	76%	74%	204%	96%	99%	31%	135%	30%	126%	47%	158%	80%	135%	94%	117%	128%	153%	156%	136%	103%	120%
	COP 19	APR 20	Attained	616%	431%	116%	116%	113%	115%	115%	115%	114%	113%	114%	112%	114%	113%	114%	113%	114%	113%	114%	113%	114%	113%	114%	113%	114%
	COP 20	APR 21	Scale-up: Aggressive	73%	73%	74%	75%	75%	74%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
	COP 21	APR 22	Attained	300%	300%	119%	100%	90%	80%	85%	78%	71%	86%	71%	80%	70%	83%	81%	90%	101%	88%	105%	100%	134%	102%	112%	94%	94%
Kween District	COP 17	APR 18	Centrally Supported	0%	0%	24%	23%	25%	32%	38%	38%	13%	54%	8%	81%	10%	57%	12%	62%	19%	63%	22%	57%	38%	92%	40%	66%	38%
	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	51%	110%	71%	65%	71%	69%	71%	71%	72%	72%	71%	71%	71%	72%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%
	COP 21	APR 22	Attained	0%	0%	133%	167%	109%	91%	87%	88%	86%	114%	87%	110%	84%	105%	79%	100%	74%	98%	75%	96%	73%	94%	87%	96%	88%
Kyankwanzi District	COP 17	APR 18	Sustained	24%	66%	37%	42%	44%	49%	31%	31%	6%	119%	12%	253%	22%	160%	31%	123%	41%	77%	39%	68%	44%	53%	45%	54%	56%
	COP 18	APR 19	Sustained	101%	141%	84%	75%	62%	51%	139%	58%	57%	18%	78%	18%	72%	27%	90%	46%	77%	54%	67%	73%	87%	89%	78%	59%	70%
	COP 19	APR 20	Sustained	106%	147%	72%	72%	72%	72%	72%	72%	72%	71%	72%	71%	72%	71%	72%	71%	72%	71%	72%	71%	72%	71%	72%	71%	72%
	COP 20	APR 21	Sustained	71%	74%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
	COP 21	APR 22	Attained	120%	120%	187%	146%	96%	101%	78%	78%	82%	90%	123%	91%	121%	93%	104%	102%	75%	96%	76%	97%	66%	83%	70%	79%	90%
Kyegegwa District	COP 17	APR 18	Attained	60%	30%	45%	39%	77%	78%	43%	51%	13%	94%	21%	328%	38%	261%	52%	183%	60%	138%	68%	121%	82%	101%	64%	76%	88%
	COP 18	APR 19	Attained	264%	195%	74%	74%	53%	52%	144%	61%	92%	30%	126%	29%	117%	44%	147%	74%	125%	87%	109%	119%	142%	144%	126%	95%	109%
	COP 19	APR 20	Attained	382%	281%	95%	95%	95%	95%	95%	95%	94%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%
	COP 20	APR 21	Scale-up: Saturation	95%	88%	90%	91%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	COP 21	APR 22	Attained	56%	56%	127%	138%	79%	94%	81%	81%	74%	86%	111%	122%	116%	113%	100%	123%	84%	124%	79%	108%	75%	100%	70%	74%	94%
Luuka District	COP 17	APR 18	Centrally Supported	28%	25%	30%	34%	27%	32%	29%	34%	27%	97%	20%	120%	17%	108%	19%	94%	24%	77%	31%	71%	33%	73%	32%	52%	45%
	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	73%	73%	70%	70%	72%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%
	COP 21	APR 22	Attained	300%	300%	109%	91%	96%	96%	92%	92%	91%	107%	91%	107%	86%	103%	76%	98%	73%	95%	77%	83%	78%	86%	70%	92%	84%
Luwero District	COP 17	APR 18	Scale-up: Aggressive	29%	83%	47%	50%	72%	77%	63%	72%	24%	119%	16%	290%	30%	236%	37%	181%	39%	131%	47%	124%	67%	111%	61%	109%	83%
	COP 18	APR 19	Scale-up: Aggressive	141%	211%	61%	56%	42%	41%	113%	48%	61%	20%	84%	19%	79%	29%	98%	50%	84%	59%	73%	80%	95%	97%	85%	64%	74%
	COP 19	APR 20	Scale-up: Aggressive	201%	300%	98%	98%	98%	98%	97%	98%	98%	97%	98%	97%	98%	97%	98%	97%	98%	97%	98%	97%	98%	97%	98%	97%	97%
	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%
	COP 21	APR 22	Attained	63%	63%	131%	87%	83%	78%	80%	80%	72%	82%	82%	82%	91%	80%	95%	76%	83%	74%	80%	63%	80%	65%	66%	73%	78%
Madi-Okollo District	COP 17	APR 18	Attained	88%	89%	108%	75%	110%	96%	104%	103%	77%	275%	39%	399%	55%	338%	74%	296%	97%	285%	123%	257%	101%	230%	129%	161%	153%
	COP 18	APR 19	Attained	637%	725%	231%	219%	163%	158%	435%	185%	145%	47%	199%	45%	185%	71%	232%	119%	199%	140%	172%	192%	224%	233%	199%	151%	182%
	COP 19	APR 20	Attained	###	1771%	166%	166%	166%	164%	164%	163%	164%	164%	164%	164%	164%	163%	164%	163%	164%	163%	164%	163%	164%	163%	164%	163%	166%
	COP 20	APR 21	Scale-up: Saturation	110%	110%	95%	88%	92%	92%	89%	89%	90%	90%	90%	89%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	COP 21	APR 22	Attained	400%	400%	320%	150%	87%	88%	81%	85%	78%	90%	82%	92%	90%	89%	95%	99%	94%	112%	82%	95%	67%	92%	71%	80%	88%
Maracha District	COP 17	APR 18	Sustained	0%	0%	49%	54%	99%	86%	23%	63%	21%	86%	13%	211%	22%	187%	45%	176%	59%	153%	70%	120%	78%	95%	37%	38%	74%
	COP 18	APR 19	Sustained	0%	0%	231%	223%	181%	176%	489%	209%	78%	27%	108%	24%	101%	37%	126%	63%	108%	75%	94%	102%	123%	124%	108%	82%	110%
	COP 19	APR 20	Sustained	0%	0%	94%	98%	96%	93%	93%	92%	95%	93%	94%	95%	94%	93%	94%	94%	94%	93%	94%	93%	94%	94%	94%	93%	96%
	COP 20	APR 21	Sustained	110%	110%	74%	68%	69%	69%	69%	68%	72%	71%	70%	68%	70%	70%	70%	70%	70%	70%	70%	69%	70%	70%	70%	70%	70%
	COP 21	APR 22	Attained	0%	0%	250%	275%	82%	76%	83%	76%	84%	75%	97%	81%	148%	122%	148%	126%	131%	140%	105%	109%	87%	118%	70%	89%	106%

UNCLASSIFIED

Masindi District	COP 17	APR 18	Scale-up: Saturation	87%	18%	38%	46%	34%	38%	64%	68%	48%	283%	48%	285%	43%	199%	44%	133%	46%	129%	56%	136%	72%	160%	52%	82%	85%
	COP 18	APR 19	Scale-up: Saturation	503%	210%	53%	53%	40%	39%	107%	46%	66%	22%	91%	21%	95%	33%	106%	55%	91%	65%	78%	89%	102%	106%	90%	69%	80%
	COP 19	APR 20	Scale-up: Saturation	720%	300%	95%	94%	95%	95%	94%	94%	94%	93%	94%	93%	94%	94%	94%	93%	94%	93%	94%	93%	94%	93%	94%	93%	94%
	COP 20	APR 21	Attained	93%	94%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
	COP 21	APR 22	Attained	13%	13%	165%	105%	81%	83%	78%	79%	66%	95%	113%	98%	109%	94%	105%	102%	92%	104%	91%	98%	107%	92%	77%	72%	93%
Mityana District	COP 17	APR 18	Scale-up: Saturation	124%	21%	45%	56%	47%	55%	49%	62%	18%	113%	17%	224%	24%	185%	35%	141%	41%	113%	51%	103%	58%	93%	63%	98%	72%
	COP 18	APR 19	Scale-up: Saturation	418%	156%	43%	44%	33%	32%	87%	37%	54%	18%	74%	17%	69%	26%	87%	44%	74%	52%	64%	70%	84%	86%	75%	56%	65%
	COP 19	APR 20	Scale-up: Saturation	504%	187%	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	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
	COP 21	APR 22	Attained	64%	64%	164%	127%	108%	101%	87%	71%	69%	81%	109%	80%	121%	81%	116%	106%	100%	99%	93%	107%	90%	105%	72%	81%	95%
Moroto District	COP 17	APR 18	Attained	0%	0%	0%	17%	107%	132%	85%	208%	15%	116%	59%	586%	43%	299%	71%	326%	78%	247%	91%	114%	43%	118%	84%	75%	120%
	COP 18	APR 19	Attained	0%	0%	191%	184%	150%	146%	409%	173%	72%	23%	102%	24%	95%	36%	118%	60%	101%	71%	88%	96%	114%	116%	101%	76%	100%
	COP 19	APR 20	Attained	0%	0%	91%	99%	96%	93%	97%	96%	96%	96%	95%	92%	95%	93%	95%	94%	95%	95%	94%	94%	95%	95%	95%	94%	96%
	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%
	COP 21	APR 22	Attained	0%	0%	125%	125%	100%	100%	97%	95%	79%	93%	93%	100%	105%	86%	80%	83%	94%	81%	80%	77%	64%	77%	71%	79%	84%
Moyo District	COP 17	APR 18	Attained	0%	0%	100%	79%	101%	123%	123%	99%	46%	137%	19%	225%	24%	154%	37%	181%	64%	193%	92%	199%	96%	227%	120%	147%	110%
	COP 18	APR 19	Attained	0%	0%	237%	228%	186%	181%	497%	212%	89%	27%	123%	27%	115%	43%	144%	72%	123%	86%	107%	117%	139%	142%	124%	94%	122%
	COP 19	APR 20	Attained	0%	0%	113%	115%	113%	115%	116%	115%	116%	116%	116%	114%	115%	115%	115%	115%	115%	115%	116%	114%	115%	114%	115%	114%	117%
	COP 20	APR 21	Sustained	68%	68%	76%	71%	75%	73%	74%	75%	76%	75%	75%	74%	75%	74%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
	COP 21	APR 22	Attained	200%	200%	140%	120%	83%	83%	89%	82%	72%	88%	73%	88%	85%	85%	83%	89%	85%	83%	100%	100%	116%	87%	87%	81%	88%
Mpigi District	COP 17	APR 18	Scale-up: Saturation	0%	39%	38%	27%	62%	63%	53%	63%	29%	130%	18%	334%	33%	222%	39%	150%	46%	115%	44%	79%	50%	83%	45%	59%	71%
	COP 18	APR 19	Scale-up: Saturation	336%	436%	41%	39%	31%	30%	84%	36%	73%	24%	100%	23%	93%	35%	116%	53%	99%	69%	86%	94%	112%	114%	100%	76%	85%
	COP 19	APR 20	Scale-up: Saturation	437%	565%	87%	87%	87%	87%	87%	87%	87%	86%	87%	86%	87%	86%	87%	86%	87%	86%	87%	86%	87%	86%	87%	86%	87%
	COP 20	APR 21	Sustained	74%	70%	69%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
	COP 21	APR 22	Attained	67%	60%	167%	91%	96%	83%	78%	78%	74%	87%	105%	87%	115%	90%	109%	93%	93%	94%	82%	98%	96%	101%	64%	72%	89%
Mubende District	COP 17	APR 18	Scale-up: Saturation	44%	29%	34%	33%	40%	57%	32%	36%	15%	96%	23%	263%	31%	191%	39%	138%	42%	108%	42%	86%	48%	83%	43%	57%	65%
	COP 18	APR 19	Scale-up: Saturation	328%	257%	60%	59%	44%	43%	119%	50%	66%	21%	90%	20%	84%	31%	105%	53%	90%	62%	78%	85%	102%	103%	90%	68%	79%
	COP 19	APR 20	Scale-up: Saturation	532%	415%	112%	112%	112%	112%	112%	112%	111%	110%	112%	111%	112%	110%	111%	110%	111%	110%	112%	110%	112%	110%	112%	110%	112%
	COP 20	APR 21	Sustained	68%	72%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
	COP 21	APR 22	Attained	108%	108%	114%	117%	82%	86%	83%	83%	74%	87%	103%	86%	98%	91%	89%	87%	78%	90%	74%	85%	78%	75%	63%	76%	83%
Nabilatuk District	COP 17	APR 18	Centrally Supported	0%	0%	136%	127%	190%	185%	175%	217%	76%	258%	46%	369%	62%	308%	99%	308%	128%	294%	145%	268%	191%	290%	195%	291%	189%
	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	0%	0%	110%	110%	81%	81%	73%	73%	68%	68%	72%	68%	71%	70%	71%	69%	70%	73%	70%	68%	72%	72%	71%	70%	71%
	COP 21	APR 22	Attained	100%	100%	100%	100%	200%	200%	100%	100%	100%	100%	90%	100%	83%	83%	73%	113%	138%	144%	122%	171%	129%	133%	72%	88%	109%
Nakapiripirit District	COP 17	APR 18	Centrally Supported	0%	0%	45%	41%	62%	60%	67%	76%	27%	90%	15%	134%	22%	113%	35%	114%	46%	105%	53%	99%	70%	108%	72%	107%	69%
	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	110%	110%	68%	68%	71%	76%	75%	75%	76%	76%	75%	73%	75%	75%	75%	76%	75%	76%	75%	76%	74%	75%	75%	75%	75%
	COP 21	APR 22	Attained	0%	0%	167%	100%	105%	106%	104%	100%	85%	90%	86%	92%	83%	87%	78%	84%	76%	90%	80%	79%	80%	76%	75%	79%	82%
Nakaseke District	COP 17	APR 18	Scale-up: Aggressive	22%	30%	35%	23%	46%	59%	35%	48%	17%	95%	10%	167%	16%	146%	28%	110%	35%	95%	47%	85%	48%	82%	56%	75%	59%
	COP 18	APR 19	Scale-up: Aggressive	170%	231%	42%	39%	30%	30%	81%	35%	58%	19%	79%	18%	74%	28%	92%	47%	79%	55%	69%	75%	89%	91%	80%	60%	69%
	COP 19	APR 20	Scale-up: Aggressive	207%	280%	76%	76%	76%	77%	76%	76%	77%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%
	COP 20	APR 21	Sustained	65%	68%	71%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
	COP 21	APR 22	Attained	67%	67%	134%	133%	128%	119%	94%	64%	79%	84%	91%	84%	102%	81%	98%	84%	80%	89%	76%	86%	79%	89%	70%	81%	85%
Nakasongola District	COP 17	APR 18	Scale-up: Aggressive	38%	29%	35%	43%	56%	62%	46%	55%	24%	100%	17%	181%	29%	156%	47%	129%	62%	104%	58%	101%	63%	74%	57%	68%	69%
	COP 18	APR 19	Scale-up: Aggressive	414%	312%	85%	83%	62%	61%	167%	70%	64%	20%	88%	20%	82%	31%	103%	52%	88%	61%	76%	83%	99%	101%	88%	67%	79%
	COP 19	APR 20	Scale-up: Aggressive	483%	363%	86%	86%	86%	87%	87%	87%	86%	86%	86%	86%	86%	86%	86%	85%	86%	85%	86%	85%	86%	85%	86%	85%	86%
	COP 20	APR 21	Scale-up: Aggressive	73%	76%	76%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
	COP 21	APR 22	Attained	75%	75%	174%	163%	84%	84%	81%	81%	70%	83%	83%	82%	100%	75%	96%	85%	90%	91%	87%	86%	75%	74%	72%	73%	83%

	COP 21	APR 22	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]
Namayingo District	COP 17	APR 18	Scale-up: Aggressive	46%	65%	54%	53%	35%	46%	40%	66%	25%	120%	18%	226%	27%	167%	51%	183%	58%	118%	86%	109%	41%	59%	48%	63%	74%
	COP 18	APR 19	Scale-up: Aggressive	187%	212%	66%	63%	47%	45%	125%	53%	105%	34%	143%	33%	133%	50%	167%	84%	143%	99%	124%	135%	161%	164%	144%	108%	123%
	COP 19	APR 20	Scale-up: Aggressive	278%	314%	95%	94%	95%	95%	95%	95%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%
	COP 20	APR 21	Sustained	54%	51%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
	COP 21	APR 22	Attained	43%	43%	150%	128%	89%	90%	86%	86%	82%	97%	82%	97%	84%	94%	90%	95%	85%	92%	83%	94%	81%	87%	72%	83%	86%
Namutumba District	COP 17	APR 18	Sustained	53%	109%	70%	83%	41%	40%	32%	36%	27%	126%	12%	146%	19%	117%	24%	108%	29%	84%	47%	82%	56%	96%	54%	92%	59%
	COP 18	APR 19	Sustained	99%	115%	159%	141%	83%	80%	220%	93%	64%	21%	89%	21%	82%	31%	103%	52%	88%	61%	77%	84%	100%	102%	89%	67%	82%
	COP 19	APR 20	Sustained	149%	174%	96%	95%	95%	94%	96%	95%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	93%	95%	94%	95%	94%	95%
	COP 20	APR 21	Sustained	68%	68%	75%	73%	75%	75%	74%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
	COP 21	APR 22	Scale-up: Aggressive	250%	167%	142%	250%	100%	85%	81%	81%	74%	89%	95%	88%	88%	82%	102%	84%	93%	103%	89%	105%	89%	92%	90%	85%	91%
Napak District	COP 17	APR 18	Centrally Supported	91%	119%	78%	72%	118%	123%	125%	141%	53%	167%	31%	270%	42%	216%	70%	220%	91%	206%	104%	191%	139%	208%	140%	207%	134%
	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	51%	51%	71%	71%	74%	73%	72%	71%	71%	73%	71%	69%	71%	71%	71%	71%	71%	71%	71%	71%	71%	70%	71%	71%	71%
	COP 21	APR 22	Scale-up: Aggressive	###	1600%	333%	167%	88%	88%	100%	87%	72%	128%	67%	85%	94%	82%	105%	94%	100%	100%	114%	104%	125%	123%	71%	80%	97%
Nebbi District	COP 17	APR 18	Attained	186%	110%	142%	143%	116%	117%	78%	72%	23%	322%	35%	534%	54%	355%	80%	272%	71%	181%	79%	141%	66%	118%	61%	77%	118%
	COP 18	APR 19	Attained	347%	264%	103%	102%	74%	72%	198%	84%	113%	37%	155%	35%	145%	54%	181%	91%	155%	108%	134%	147%	175%	178%	156%	118%	136%
	COP 19	APR 20	Attained	714%	540%	130%	128%	129%	130%	128%	129%	129%	128%	129%	128%	129%	128%	129%	127%	129%	127%	129%	127%	129%	127%	128%	127%	129%
	COP 20	APR 21	Attained	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
	COP 21	APR 22	Scale-up: Aggressive	140%	140%	182%	109%	96%	99%	77%	76%	72%	83%	104%	83%	117%	91%	118%	112%	108%	120%	96%	114%	91%	98%	71%	81%	96%
Obongi District	COP 17	APR 18	Attained	0%	0%	100%	79%	101%	123%	123%	99%	46%	137%	19%	225%	24%	154%	37%	181%	64%	183%	92%	199%	96%	227%	120%	147%	110%
	COP 18	APR 19	Attained	0%	0%	237%	228%	186%	181%	497%	212%	89%	27%	123%	27%	115%	43%	144%	72%	123%	86%	107%	117%	139%	142%	124%	94%	122%
	COP 19	APR 20	Attained	0%	0%	113%	115%	113%	115%	116%	115%	116%	116%	116%	114%	115%	115%	115%	115%	115%	115%	116%	114%	115%	114%	115%	114%	117%
	COP 20	APR 21	Scale-up: Aggressive	110%	110%	76%	76%	76%	79%	74%	76%	76%	71%	76%	75%	75%	75%	74%	76%	75%	73%	75%	74%	75%	76%	74%	75%	75%
	COP 21	APR 22	Scale-up: Aggressive	100%	100%	325%	200%	143%	113%	89%	100%	82%	106%	77%	92%	79%	83%	89%	75%	116%	116%	106%	121%	96%	105%	89%	94%	97%
Oyam District	COP 17	APR 18	Attained	97%	37%	56%	66%	74%	75%	57%	71%	33%	124%	22%	222%	36%	175%	53%	173%	58%	147%	61%	126%	69%	124%	66%	103%	86%
	COP 18	APR 19	Attained	427%	243%	58%	57%	43%	42%	116%	49%	96%	31%	131%	30%	123%	46%	153%	77%	131%	91%	114%	124%	148%	151%	132%	100%	113%
	COP 19	APR 20	Attained	640%	363%	95%	95%	95%	95%	95%	95%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%	94%	95%
	COP 20	APR 21	Attained	91%	91%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	COP 21	APR 22	Scale-up: Aggressive	50%	50%	155%	125%	95%	90%	76%	69%	70%	84%	74%	84%	100%	84%	117%	115%	115%	117%	105%	103%	106%	98%	83%	78%	96%
Pader District	COP 17	APR 18	Centrally Supported	32%	31%	31%	32%	45%	48%	40%	45%	15%	70%	13%	129%	20%	114%	32%	106%	37%	89%	39%	79%	42%	77%	39%	62%	52%
	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	Scale-up: Aggressive	81%	74%	76%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
	COP 21	APR 22	Scale-up: Aggressive	60%	60%	152%	160%	80%	84%	71%	80%	70%	84%	84%	84%	100%	89%	127%	109%	106%	103%	99%	83%	85%	63%	75%	73%	90%
Pakwach District	COP 17	APR 18	Scale-up: Saturation	146%	139%	143%	142%	59%	80%	30%	41%	15%	204%	28%	401%	40%	250%	58%	180%	57%	129%	51%	95%	59%	106%	52%	70%	87%
	COP 18	APR 19	Scale-up: Saturation	105%	100%	87%	84%	54%	52%	145%	61%	100%	33%	136%	31%	127%	47%	159%	80%	136%	94%	118%	129%	153%	157%	137%	103%	118%
	COP 19	APR 20	Scale-up: Saturation	183%	174%	109%	109%	108%	110%	109%	110%	109%	109%	109%	108%	109%	108%	109%	108%	109%	107%	109%	107%	109%	108%	109%	108%	109%
	COP 20	APR 21	Scale-up: Saturation	85%	85%	91%	91%	91%	90%	90%	91%	91%	91%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	COP 21	APR 22	Scale-up: Aggressive	67%	67%	157%	121%	112%	106%	100%	77%	71%	83%	128%	100%	114%	80%	131%	157%	98%	118%	103%	115%	83%	85%	78%	79%	101%
Pallisa District	COP 17	APR 18	Attained	63%	63%	46%	86%	81%	115%	50%	83%	21%	174%	16%	331%	28%	188%	44%	205%	58%	182%	66%	191%	119%	179%	103%	144%	108%
	COP 18	APR 19	Attained	433%	329%	299%	307%	192%	187%	514%	220%	83%	26%	117%	25%	109%	40%	136%	69%	117%	82%	101%	110%	131%	134%	117%	89%	118%
	COP 19	APR 20	Attained	638%	483%	94%	97%	96%	93%	94%	95%	94%	92%	95%	93%	94%	94%	95%	94%	94%	94%	95%	94%	95%	94%	95%	94%	96%
	COP 20	APR 21	Sustained	44%	44%	49%	51%	50%	51%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
	COP 21	APR 22	Scale-up: Aggressive	200%	200%	189%	133%	108%	79%	88%	79%	72%	85%	62%	84%	73%	83%	93%	77%	102%	109%	118%	98%	130%	106%	121%	109%	100%
Terego District (new)	COP 21	APR 22	Scale-up: Aggressive	0%	0%	260%	280%	90%	130%	79%	100%	69%	88%	142%	79%	131%	116%	145%	132%	116%	115%	83%	81%	92%	101%	66%	77%	102%
Yumbe District	COP 17	APR 18	Sustained	100%	75%	97%	78%	96%	91%	57%	65%	18%	114%	17%	293%	28%	193%	43%	197%	48%	120%	51%	97%	61%	68%	53%	53%	75%
	COP 18	APR 19	Sustained	###	1024%	562%	545%	379%	368%	1013%	430%	36%	12%	49%	11%	46%	17%	57%	29%	49%	34%	43%	47%	56%	57%	50%	37%	84%
	COP 19	APR 20	Sustained	1126%	1052%	72%	73%	73%	73%	72%	72%	74%	73%	74%	72%	74%	72%	74%	72%	74%	73%	73%	73%	73%	73%	73%	73%	76%
	COP 20	APR 21	Sustained	44%	44%	51%	51%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
	COP 21	APR 22	Scale-up: Aggressive	800%	800%	270%	290%	115%	98%	78%	74%	75%	93%	97%	92%	106%	96%	124%	120%	97%	111%	94%	89%	84%	81%	63%	80%	95%
	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 21	APR 22	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]
	Zombo District	COP 17	APR 18	Attained	44%	309%	98%	138%	128%	106%	65%	67%	16%	427%	38%	563%	61%	316%	79%	228%	76%	156%	73%	110%	74%	101%	58%	70%	111%
		COP 18	APR 19	Attained	318%	644%	132%	119%	91%	89%	244%	104%	118%	39%	162%	37%	151%	56%	189%	95%	162%	112%	140%	153%	182%	186%	162%	123%	143%
		COP 19	APR 20	Attained	544%	1098%	110%	110%	109%	108%	109%	109%	110%	108%	109%	109%	109%	108%	109%	108%	109%	108%	109%	108%	109%	107%	109%	108%	109%
		COP 20	APR 21	Sustained	58%	73%	70%	71%	71%	70%	71%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
		COP 21	APR 22	Scale-up: Aggressive	133%	133%	213%	147%	100%	79%	82%	83%	81%	87%	172%	112%	133%	134%	133%	130%	95%	117%	98%	95%	97%	66%	61%	69%	98%
ORORO CLUSTE	Bugiri District	COP 17	APR 18	Scale-up: Saturation	34%	12%	17%	23%	31%	33%	18%	24%	9%	35%	6%	92%	7%	81%	12%	73%	19%	66%	26%	74%	33%	72%	38%	61%	38%
		COP 18	APR 19	Scale-up: Saturation	367%	191%	64%	65%	48%	46%	127%	54%	29%	9%	41%	9%	38%	14%	47%	24%	40%	28%	35%	38%	46%	47%	41%	31%	39%
		COP 19	APR 20	Scale-up: Saturation	373%	194%	45%	46%	47%	47%	47%	47%	47%	47%	47%	47%	47%	46%	47%	46%	47%	46%	47%	46%	47%	46%	47%	46%	47%
		COP 20	APR 21	Scale-up: Saturation	89%	89%	91%	91%	90%	92%	91%	91%	91%	91%	91%	91%	91%	92%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%
		COP 21	APR 22	Scale-up: Saturation	320%	267%	162%	133%	87%	78%	83%	83%	78%	99%	69%	98%	79%	95%	94%	90%	93%	85%	90%	84%	102%	92%	84%	84%	88%
	Busia District	COP 17	APR 18	Scale-up: Aggressive	106%	45%	64%	77%	68%	71%	67%	64%	30%	124%	35%	270%	32%	118%	28%	116%	44%	112%	37%	98%	39%	108%	50%	71%	67%
		COP 18	APR 19	Scale-up: Aggressive	203%	129%	88%	92%	61%	59%	163%	69%	87%	28%	119%	27%	111%	41%	138%	70%	118%	82%	103%	112%	134%	136%	119%	90%	104%
		COP 19	APR 20	Scale-up: Aggressive	271%	172%	81%	86%	79%	78%	78%	78%	78%	77%	78%	78%	78%	77%	78%	77%	78%	77%	78%	77%	78%	77%	78%	77%	78%
		COP 20	APR 21	Sustained	45%	45%	49%	49%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%
		COP 21	APR 22	Scale-up: Saturation	14%	14%	133%	152%	98%	94%	79%	77%	80%	93%	81%	92%	93%	89%	108%	89%	90%	98%	86%	102%	77%	90%	71%	80%	88%
	Butaleja District	COP 17	APR 18	Attained	49%	175%	65%	108%	53%	71%	57%	74%	18%	128%	12%	219%	21%	195%	41%	212%	55%	143%	82%	139%	91%	132%	63%	103%	89%
		COP 18	APR 19	Attained	205%	267%	262%	228%	146%	142%	389%	165%	79%	27%	109%	25%	102%	39%	128%	64%	109%	76%	95%	103%	123%	125%	110%	83%	106%
		COP 19	APR 20	Attained	155%	202%	133%	121%	107%	107%	105%	107%	106%	104%	106%	105%	106%	104%	105%	104%	105%	104%	105%	104%	105%	104%	106%	104%	106%
		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%	63%
		COP 21	APR 22	Scale-up: Saturation	150%	150%	189%	122%	85%	85%	90%	81%	72%	88%	69%	90%	85%	87%	104%	81%	96%	96%	109%	124%	116%	125%	95%	89%	96%
	Manafwa District	COP 17	APR 18	Sustained	17%	192%	62%	53%	79%	95%	23%	76%	17%	106%	9%	112%	12%	99%	17%	85%	32%	107%	30%	83%	49%	143%	53%	124%	60%
		COP 18	APR 19	Sustained	172%	486%	198%	154%	114%	111%	302%	127%	69%	23%	94%	22%	88%	33%	110%	55%	94%	65%	80%	89%	105%	108%	94%	71%	90%
		COP 19	APR 20	Sustained	108%	305%	87%	73%	75%	73%	72%	72%	72%	72%	72%	73%	72%	72%	72%	72%	72%	72%	73%	72%	73%	71%	73%	72%	73%
		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%
		COP 21	APR 22	Attained	0%	0%	157%	171%	125%	118%	90%	80%	91%	114%	92%	110%	86%	108%	73%	103%	79%	99%	77%	97%	87%	93%	75%	97%	89%
	Namisindwa District	COP 17	APR 18	Sustained	16%	46%	47%	41%	48%	60%	60%	69%	25%	97%	14%	138%	16%	99%	21%	109%	32%	110%	38%	100%	66%	156%	69%	114%	66%
		COP 18	APR 19	Sustained	226%	640%	247%	192%	142%	138%	384%	164%	52%	18%	70%	16%	66%	25%	83%	42%	70%	49%	61%	67%	80%	82%	71%	54%	74%
		COP 19	APR 20	Sustained	144%	405%	112%	87%	88%	85%	87%	86%	87%	87%	87%	86%	87%	87%	87%	86%	87%	86%	87%	86%	87%	86%	87%	86%	87%
		COP 20	APR 21	Sustained	68%	68%	54%	54%	52%	52%	53%	52%	53%	52%	53%	52%	53%	53%	53%	53%	52%	53%	53%	53%	53%	53%	53%	53%	53%
		COP 21	APR 22	Scale-up: Aggressive	300%	300%	138%	125%	86%	93%	88%	84%	85%	109%	85%	109%	80%	107%	71%	100%	67%	96%	69%	93%	137%	102%	81%	94%	89%
	Tororo District	COP 17	APR 18	Attained	248%	13%	58%	62%	87%	92%	136%	135%	54%	188%	23%	224%	23%	176%	38%	190%	58%	216%	111%	288%	146%	320%	185%	301%	144%
		COP 18	APR 19	Attained	###	458%	79%	80%	61%	60%	164%	70%	125%	41%	171%	39%	160%	60%	200%	101%	171%	119%	148%	162%	193%	197%	172%	130%	148%
		COP 19	APR 20	Attained	###	1288%	155%	158%	169%	168%	168%	169%	168%	167%	168%	167%	168%	167%	168%	167%	168%	167%	168%	167%	168%	166%	168%	167%	169%
		COP 20	APR 21	Scale-up: Saturation	89%	89%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
		COP 21	APR 22	Scale-up: Aggressive	21%	20%	97%	99%	92%	92%	88%	88%	70%	85%	70%	84%	63%	82%	79%	78%	90%	85%	111%	93%	135%	105%	114%	94%	93%

APPENDIX B — Budget Profile and Resource Projections

B1. COP21 Planned Spending in alignment with planning level letter guidance

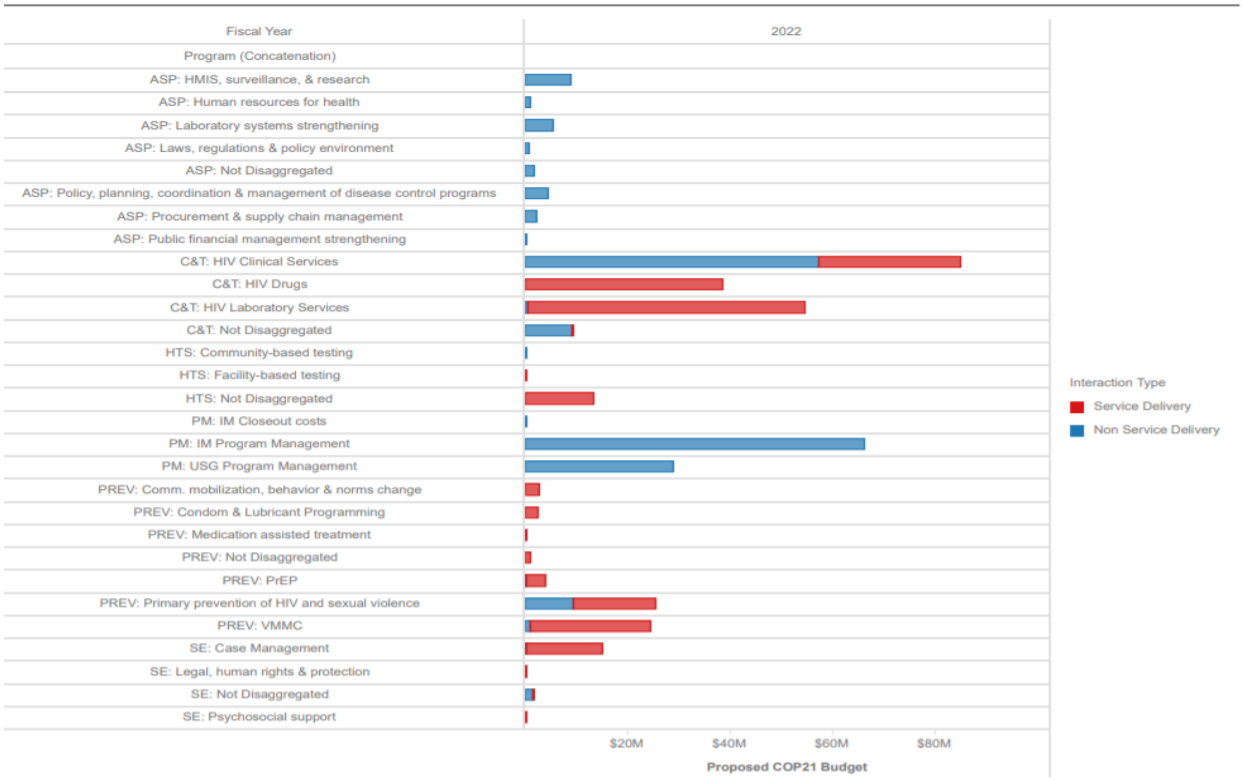


Table B.1.2 COP21 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$16,749,085	**$381,750,915**	**$398,500,000**

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

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

B.2 Resource Projections

Ending AIDS as a public health threat by 2030 requires prioritizing investments. PEPFAR Uganda must dedicate its investments and programmatic emphases across an array of urgent needs within the Ugandan health sector. Under COP21, PEPFAR Uganda will balance its investments amongst health systems strengthening, institutional capacity building of local Ugandan private health and public health sector entities, as well as essential direct service delivery.

Per the COP21 guidance and the budgeting tool for COP21—the Funding Allocation to Strategy Tool (FAST)—PEPFAR Uganda team used an incremental budgeting process to guide the apportionment of resources for COP21. 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 COP21 resources are allocated.

A secondary change driver was target linkage and treatment continuity rates, which—per headquarters guidance via the DataPack—are 95% for linkage and for treatment continuity (retention) 98% for those new and already on treatment. PEPFAR Uganda's FY21 Q1 results demonstrated progress over FY20 in increasing the rate at which the program links newly-identified PLHIV to treatment, from 89% linkage in FY20 Q4 to 92% linkage in FY21 Q1. PEPFAR Uganda will continue to intensify efforts to support continuity of treatment and community programming now and into COP21, working in close collaboration with CSOs and PLHIV networks. Accordingly, COP20 resource allocations factored the inputs needed to further these priorities; 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.

To illustrate another balancing challenge that PEPFAR Uganda faces: per the PEPFAR initiative's definition, clinical services that do not include direct interaction with the beneficiary must be labeled as "non-service delivery." The non-service delivery activities and budget contributions made under PEPFAR help support Ugandan districts, facilities, and health care workers to provide high quality services to HIV and TB program beneficiaries. These include supporting implementation of priority interventions through site level technical support for quality improvement interventions, training and mentoring of healthcare workers and lay workers in providing HIV clinical services, rolling out guidelines, site level commodity management, electronic medical record (EMR) expansion, and cervical cancer screening and treatment.

To provide some concrete examples of interventions funded through non-service delivery, these include the scale-up of the validated pediatric testing screening tool to improve pediatric case finding, mentorship to sites on EID POC implementation, introduction of pDTG 10mg and related mentorship, expansion of the community pharmacy alternative drug distribution model, and intensified mentorship for the integration of non-communicable disease and mental health screening and management (4th 95). These costs constitute 68% of the care and treatment budget and are comparable with COP20 (68% non-service delivery).

Other information relevant to how resources have been allocated in COP21 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: COP20 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 — Minimum Program Requirements

Excerpted from S/GAC COP22 Planning Letter dated January 13, 2021 pages 15 - 19

Table 1. COP/ROP 2021 (FY 2022) Minimum Program Requirements

Minimum Program Requirement	Status and Issues Hindering Implementation
Care and Treatment	
• Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Test and Start is national policy and implemented throughout the country. FY20 linkage proxy was 88%, but fails to account for a significant number of clients repeat testing. PEPFAR Uganda should continue to refine programs to ensure 95% linkage and better define the contribution of repeat testing.
• 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 who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV- based ART regimens.	By the end of FY20, 64% of the treatment cohort had been enrolled on TLD, with plans to reach 80% by the end of FY21 Q1. Issues hindering implementation include provider perception of the impact of DTG on women of reproductive age and adolescents; this challenge is being addressed through CQI activities, mentorship, education materials and training. 82% of sites have been trained on the revised HIV treatment guidelines, which have a particular focus on this issue. Global supply of LPV/R initially delayed the transition of pediatric patients off of NVP-based regimens, but is now resolved. 84% of pediatric clients were transitioned to optimized regimens by the end of FY20 and PEPFAR Uganda is on track to complete optimization by FY21 Q2.

• Adoption and implementation of differentiated service delivery models for all clients with HIV, including six- month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	Uganda treatment guidelines allow for 3-6 months prescriptions for stable patients. However, the guidelines require suppressed viral load prior to MMD. This challenge should be addressed through revised guidelines delinking VLS and MMD. The Ministry of Health approved alternative drug distribution points through pharmacies in 16 districts with high concentration of pharmacies and dense populations of PLHIV. This model decongests facilities and improves client access. Rapidly assessing lessons-learned and collaboration with MOH to endorse this model for scale should be a high priority. Commodity stock-outs are infrequent; however, provider perception of concerns continues to impact MMD.
• All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	TB preventive treatment was scaled rapidly through surge efforts in FY20. 568,950 patients were initiated on TPT, with an 88% completion rate. PEPFAR Uganda will increase use of 3HP in COP21. No issues hindering implementation are noted.
• 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 viral load testing and results delivered to caregiver within 4 weeks.	Viral load coverage for adults was impacted by COVID-19 restrictions, resulting in 86% VLC in FY20 Q4. EID 2- month testing coverage improved from 56% in FY19 Q4 to 68% in FY 20 Q4. In COP19, the EID Surge catch-up interventions improved EID coverage at 12 months and included 100 EID POC m-Pima machines to address systemic barriers. COP20 includes investments to expand EID coverage and quality.

Testing	
• Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	Index testing is scaled nationally though some gaps remain in site-level coverage. Self-testing is available and commodity shortages have been addressed. Index testing protocols include screening and treatment for IPV. PEPFAR Uganda has assessed 91% of applicable sites for Safe and Ethical Index Testing, and assessments and remediation effort are ongoing. Gains must be made in pediatric testing, especially pediatric index testing; this remains a priority. The new pediatric HIV screening tool has been incorporated into the 2020 National guidelines and disseminated through the CQI collaborative. 82% of ART sites have been trained.
Prevention and OVC	
• Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (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, key populations and adult men engaged in high-risk sex practices).	The updated PrEP policy guidelines include provision for AGYW and PBFW, and clarified that fewer labs are currently needed for screening. Challenges remain that only 50% of HIV-negative clients were screened for PrEP, and 56% of eligible clients were initiated. As broader policy issues are addressed, the focus should remain on demand creation, improving continuity and adherence through DSD models, and addressing stigma.

• 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, 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.	The alignment of OVC packages of services and focus on priority populations for enrollment continued to improve in FY20. The OVC programs meet requirements per COP20 Guidance.

Policy & Systems	
• 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.	There are no user fees levied to patients.
• OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.	MOH leads the national CQI Collaborative with strong support from PEPFAR Uganda technical experts. All IPs participate in these activities.
• Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS 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.	The national CQI Collaborative sub-groups actively updated and disseminated treatment guidelines and literacy materials, with ongoing mentoring and education efforts to improve practice. Updates to improve U=U messaging is a particular focus of the IEC partner and MOH. PEPFAR Uganda has engaged with the S/GAC Private Sector Engagement team to improve messaging.

• Clear evidence of agency progress toward local, indigenous partner direct funding.	PEPFAR Uganda is on track to meet minimum requirements. Local partner transitions will be slightly delayed as several contracts were not able to be awarded due to local partner capacity. In these cases, transition awards were developed to build capacity for transition over the next 2-3 years.
• Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	The Government of Uganda committed an additional $13M toward commodity procurement in COP20, and for the first time GOU has procured viral load lab reagents. Progress has been made to advance formal recognition of Community Health Extension Workers, however, legislation is not yet finalized.
• Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	PEPFAR Uganda reported on TX_ML in FY20 and investments in national systems will continue to support this MPR.
• Scale-up of case surveillance and unique identifiers for patients across all sites.	PEPFAR Uganda continued to scale the electronic medical record system, which now covers 93% of ART clients. In addition, PEPFAR Uganda continued to support development of a unique identifier, which has support from MOH. The policy requires approvals from ministries beyond MOH before it can be fully implemented and the plethora of identifiers will need to be harmonized and streamlined to ensure interoperability.

APPENDIX D — COP21 Stakeholder Engagement Calendar

Below is the Stakeholder engagement calendar for COP21 (planning and implementation)

COP21 Stakeholder Engagement Calendar:				
	PEPFAR Team Action	**Stakeholder Action**	**Dates**	**Status**
1	Distribute critical data and COP21 materials (links or hardcopy): • Draft and Final COP21 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 COP21 discussions at strategic planning retreat. Identify areas of successful performance that can be leveraged going into COP21 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 2-29, 2021	PCO Shared both the Draft and final COP21 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 bodies/CSOs/Development Partners on PLL	Harmonize COP20 priorities with GOU and Development Partners' plans Discussion on the Country Specific Minimum Program Requirements for COP21	Jan 15-Jan 24, 2021	PCO successfully coordinated these high-level discussions Similar discussions to continue throughout COP20 and COP21 implementation.

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3	Organize and facilitate TWG COP20 consultation meetings	TWG Co-Chairs identify and recommend their external guests to participate in COP20 consultation meeting	Jan 15-20, 2021	Consultative meeting successfully held with great participation from (GOU, Development partners, CSO/FBO and private sector) provided feedback and input into COP21 priorities
4	Meeting with MOH and MOFPED, MOD, MGLSD	FO and Agency Heads attend as GOU shares its projected plans and agreed upon priorities	January 15 -28, 2021	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 COP21 focus, based on analysis of Q4 results and observations of in-country performance.	January 21 & 21, 2021	Retreat held, (Smaller group discussions, panel discussions and presentations were made to cater for all targeted groups)
6	Arrange for stakeholder participation in the COP21 RPM	GOU, CSOs ad development partners actively participate in COP20 RPM, provide feedback on approaches, strategies and targets	April, 23, 2021	Completed
7	Agency specific IPs Meeting to consult on COP21 and share feedback on RPM	IPs actively participate in post RPM feedback meeting and provide feedback on technical and management approaches.	April 28-30, 2021	Completed virtually due to COVID19
8	Invite stakeholders to post COP21 Strategic Planning meeting to discuss outcomes and strategies for finalizing COP submission	Actively participate in Post COP21 strategic planning Meeting Consultation (Ask questions, seek clarification and make recommendations)	May 25, 2021	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 COP21 meeting agreements/strategies Global and regional/national CSOs request information as applicable	SDS to stakeholders for review April 29-May 3rd, 2021 Within a minimum of 48 hours of COP Submission to S/GAC. May 11, 2021	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	April 28 – May 11, 2021	Ongoing
11	Invite stakeholders to COP21 approval meetings, ensure that the final plan-inclusive of expected policy shifts,	Actively participate in COP20 approval meetings, and questions, seek clarification, raise areas of discrepancy or misalignment and	In country approval meting window is May 18, 2021	Likely a virtual meeting with S/GAC chair, PCO and Charge, and follow up virtual session convened

	targets and priority interventions- are understood and shared by all Arrange for GOU participation in COP approval meeting	continue communicating with PCO		by PCO on May 18, 201.
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	May-June 2021	Planned
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, 2021.	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 COP21 priorities		Completed
16	Development Partner meetings	USG share updates of COP20 and COP21 agreements	Monthly	CDC currently chairs the HDP; USG active in both HDP and ADPG meetings
17	Organize/Attend/facilitate Regional CLM Dialogue on CLM	GOU, USG and CSO share qualitative and quantitative findings and recommendations for program quality.	Quarterly/biannual	Led by CSO, GoU, PCO and Co-facilitated by the 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 & key policy TWG focused directions	Monthly	Continuous

PEPFAR/Uganda OVC Programming

FY20-FY24 Transition Roadmap Overview

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 goal

Maintaining Services through Beneficiary Transition

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.

Figure 1 below summarizes the anticipated timeline and notional magnitude of the planned transitions, including the two USAID mechanisms. COP19 targets are used for illustrative purposes only; actual numbers of districts and beneficiaries involved will vary based on annual COP planning and graduation rates achieved by each mechanism.

Subject to change based on future COP decisions related to geography and scope, Figure 2 on the following page summarizes the changes in agency geographic coverage (for OVC service delivery) that will result from these transitions.

USAID incorporated this timeline and the guiding principles into the scopes of the three follow-on mechanisms to ensure continuity of services. These follow-on mechanisms have aligned with existing clinical regions (led by different agencies) to facilitate continued close coordination with clinical services, regardless of the agency clinical lead. USAID hired a dedicated transition advisor to facilitate joint planning and active monitoring of transition processes.

Agreed actions and milestones are summarized in the Summary Roadmap.

Figure 2. Anticipated Timeline for Transitioning Districts/Beneficiaries to USA

Agency	Mechanism	COP 2019 Districts	COP 2019 Beneficiaries	FY 2020 Q1	FY 2020 Q2	FY 2020 Q3	FY 2020 Q4	FY 2021 Q1	FY 2021 Q2	FY 2021 Q3	FY 2021 Q4	FY 2022 Q1	FY 2022 Q2	FY 2022 Q3	FY 2022 Q4	FY 2023 Q1	FY 2023 Q2	FY 2023 Q3	FY 2023 Q4	FY 2024 Q1	FY 2024 Q2	FY 2024 Q3	FY 2024 Q4
CDC	IDI W/WN	4	6,858				●																
USAID	BOCY	21	108,983							●													
USAID	SOCY	25	138,921							●													
CDC	IDI Kampala	2	35,846								●												
CDC	Mildmay	5	16,841								●												
CDC	RHSP	8	21,767								●												
CDC	TASO	2	4,421								●												
CDC	Baylor	6	38,101																●				
DOD	MUWRP	3	21,263																●				
Total Districts (% of total):				0				50* (66%)				17* (22%)				0				9* (12%)			
Total Beneficiaries (% of total):				0				254,762* (65%)				78,875* (20%)				0				59,364* (15%)			

Legend: Prepare for transition Transition districts/beneficiaries to USAID USAID continues service delivery ● Mechanism ends

* *based on COP19 targets to illustrate scale; actual numbers will be based on annual COP targets and graduation rates*

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

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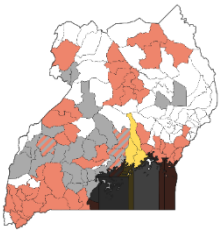
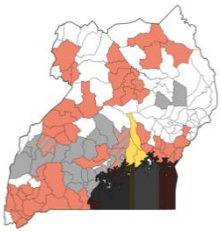
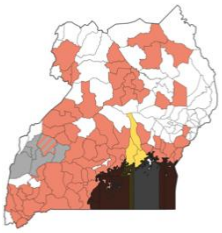
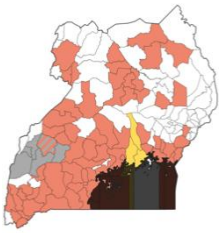
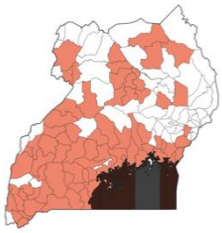
*Figure 2. Anticipated Changes in Agency Coverage for OVC Service Delivery**

FY 2020 / COP19	FY 2021 / COP20	FY 2022 / COP21	FY 2023 / COP22	FY 2024 / COP23
				
n CDC 27 districts n DOD 3 districts n USAID 46 districts	n CDC 23 districts n DOD 3 districts n USAID 50 districts	n CDC 6 districts n DOD 3 districts n USAID 67 districts	n CDC 6 districts n DOD 3 districts n USAID 67 districts	n CDC 0 districts n DOD 0 districts n USAID 76 districts

*Subject to change based on future COP decisions related to geography and scope.

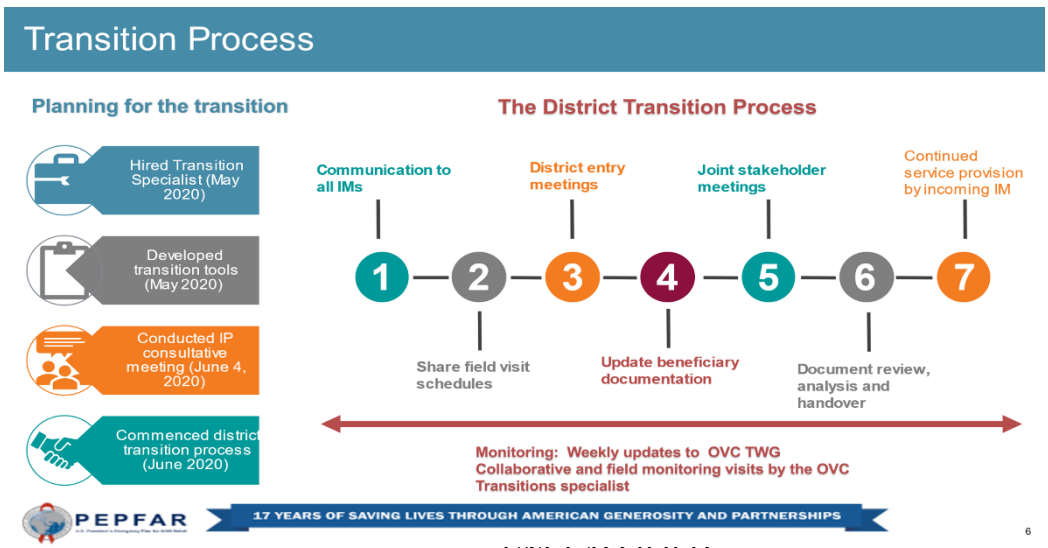
Transitions: July to December 2020

The OVC portfolio successfully transitioned 52 districts involving 63,250 beneficiaries to new USAID partners, including two local organizations, during the period July to December 2020. This included inter-agency transitions of four CDC districts in West and West Nile Regions, three districts that were shared between USAID and CDC, and 45 districts transitioned internally from legacy USAID programs. These transitions were carried out in line with a roadmap for PEPFAR OVC programming in Uganda, FY2020 – FY2024 and drawing lessons from the 2017 Uganda OVC transitions.

The process to transition 15 CDC districts to USAID commenced in Q3 of FY2021 with interagency and implementing partners' consultations and is scheduled to be completed by the end of this fiscal year.

Transition Process

Learning from the 2017 Uganda OVC transitions, the interagency OVC collaborative agreed to follow a similar process, adjusted based on lessons learned. The following diagram summarizes this transition process.



UNCLASSIFIED

APPENDIX F — PEPFAR Uganda Proposal for American Rescue Plan (ARP) Act of 2021 Funding

In 2020, as PEPFAR Uganda was making great strides to achieve the 95-95-95 goal of epidemic control of HIV, the threat of COVID-19 caused significant disruption throughout the Ugandan health system. Uganda, through support of PEPFAR and its implementing partners, developed innovative methods to reach patients despite the growing need to protect patients and health care workers amidst lock downs, and growing fears of COVID spreading in the facilities and communities where HIV patients accessed services. PEPFAR Uganda's proposal for $19,925,000 additional funding through the American Rescue Plan Act of 2021 was approved to prevent and mitigate the negative impacts of COVID-19 on PEPPFAR programs and beneficiaries. The interagency PEPFAR team has prepared this proposal to work in synergy with other COVID and health systems funding to reduce duplication of activities over the COP20 and COP21 implementation periods.

As of April 16, 2021, Uganda has reported 41,378 confirmed cases and 338 deaths due to COVID-19. While these relatively low numbers represent the success of prevention and response efforts, Uganda has confirmed the presence of several variants of concern and is monitoring disease resurgences in neighboring countries with concern. In addition, COVID-19 vaccination efforts have proceeded very slowly, and much work remains to be done to strengthen clinical and epidemiologic response capacity and to preserve the continuity of essential HIV, TB, malaria, maternal-child health and other services. Challenges identified by the Ministry of Health include slow uptake of the COVID-19 vaccines and hesitancy among some of the health workers to get vaccinated, declining response momentum (mainly attributed to lack of resources for district teams), slow uptake of digital tools implementation, and community complacency to COVID-19 preventive measures.

Prevent, prepare for, and respond to coronavirus in PEPFAR programs

A. Infection Prevention and Control Programming (IPC)

Soon after COVID-19 was identified in Uganda in March 2020, Ministry of Health (MOH) acted swiftly to intensify infection prevention and control procedures in all public places. These measures included enforcement of handwashing practices, wearing of face masks, introduction of temperature guns and hand sanitizers as well as reorganizing facilities to enhance social distance. These interventions were adopted by the general public at the peak of the epidemic. However, infection prevention and control practices have since lapsed as incidence of and mortality due COVID-19 began to decline. Ugandan scientists predict that another potentially more catastrophic phase of the epidemic is imminent in Uganda, reckoning the need to sustain and further strengthen infection control procedures.

While Global Fund and the MOH will procure personal protective equipment (PPE) for public facilities, PEPFAR will procure sufficient PPE (masks, hand sanitizer, limited gowns, limited temperature guns) for PEPFAR IP field staff and community resource persons/peers supporting PEPFAR activities. PEPFAR Uganda will also support continuing medical education among health workers, teachers, and other frontline workers. In addition, PEPFAR Uganda will build the

capacity of Ministry of Health to ensure stable supply of essential inputs in health facilities and will provide mentorship and education to sustain facility IPC standards.

Regional Referral Hospitals play a key role in providing oversight of clinical services and serving as technical and referral hubs for lower health facilities. Thus, RRHs are well placed to serve as coordination centers for COVID-19 infection control, providing routine technical assistance, knowledge upgrades and monitoring compliance to practices in lower facilities. PEPFAR Uganda will provide support to RRHs to coordinate IPC activities in their respective regions of jurisdiction, working in collaboration with District Local Governments, Cities, Municipalities and Divisions by providing two IPC specialists per RRH to link up with the MOH IPC team and District Health Teams (creating an IPC community) at the district level. Previous PEPFAR and other USG investments in ZOOM platforms at RRH will also facilitate this coordination role, including through the hosting of virtual trainings and consultations.

PEPFAR Uganda achieves more that 80% of its VMMC and HTS outputs through community outreaches. To demystify COVID-19 related myths at community level that impact prevention health outcomes, PEPFAR will increase behavior change communications to link the health facility IPC activities with their catchment populations.

In these outreach settings, health teams operate in small spaces within close proximity of each other and their clients. In addition to strengthening infection control and prevention at facility level, PEPFAR Uganda will extend similar practices to the community-based services. PEPFAR Uganda will expand training to raise community awareness with faith and community-based organizations, who will serve as resident community change agents and behavior monitors at household and community level. PEPFAR Uganda will also build on the Community-Led Monitoring (CLM) platform to ensure that quality and outputs of US government-supported WASH and IPC interventions will be scrutinized and improved through the findings and recommendations of the CLM process.

B. Services supporting COVID-19 vaccination access for staff at PEPFAR-supported sites and beneficiaries.

The Uganda MOH has received 864,000 doses of the AstraZeneca COVID-19 vaccine through the COVAX facility and procured another 100,000 doses from India. Uganda is expecting a total of 3,552,000 doses of the AstraZeneca vaccine for the period of January – June 2021. The remaining 2,688,000 doses are expected by June 2021. However, uptake of vaccines among priority populations has been modest, mainly due to fears and uncertainty about the vaccine efficacy and potential long term health effects and logistical challenges. To date, only 27% of available vaccine doses have been administered after almost 6 weeks, and 55 districts have reported using less than 10% of doses.

Therefore, as Uganda prepares to imminently expand COVID-19 vaccine coverage to the general population, it is essential that community literacy on the merits of vaccination is stepped up to address rumors and misconceptions, increase COVID-19 risk perception at individual and household level and ultimately improve demand and uptake. Through this activity, PEPFAR Uganda will leverage the community trust of key behavior influencers including cultural, political, and religious leaders as well as civil society organizations to increase community understanding of COVID-19, its health impact, and the importance of taking preventive measures including

vaccination. PEPFAR Uganda will increase vaccine demand creation, provide rumor monitoring, and clarify misconceptions among HCW and lay providers and PLHIV/TB at risk with funds for message development and to comprehensive IPs, CSOs, and FBOs for dissemination and advocacy.

Even with low uptake of vaccinations in Uganda, the MoH is still struggling to keep up with the required volume of data entry for this important activity. PEPFAR will develop COVID data systems training materials at the central level for dissemination and will train data entry staff at the district level. This activity will be complementary to existing support to cover the increased demand, with greater yield due to PEPFAR on the ground presence and capacity.

PEPFAR Uganda will build healthcare workforce resiliency through intentional COVID-19 vaccination status and outcomes monitoring through a central data warehouse. PEPFAR Uganda will build and deploy HIS at national and facility levels for health care worker (HCW) vaccination tracking and reporting linked to electronic medical records (EMR) and event reporting HIS. No new systems will be developed and this HCW occupational health promotion model could be expanded into other domains of individual health and nationally within the health system. A robust information system for the registration of healthcare workers for both vaccines doses and monitoring for adverse events following infection (AEFI) will contribute directly to the ongoing investments in a national vaccine delivery system and registry.

C. Testing PEPFAR-supported staff and beneficiaries for COVID-19 and to inform both IPC practices and epidemiologic surveillance.

Uganda faces a challenge of health care waste management and the expansion of COVID-19 has further contributed to this burden, with limited infrastructure to handle the health care waste that comes with it, including the disposal of used and toxic/carcinogenic materials from GeneXpert cartridges and PPE. This is in addition to the already existing waste from HIV programming from VMMC, lab reagents, testing, and expired or legacy ARVs. Currently, there are no high temperature incinerators in the public sector. Accumulated toxic waste remains a major detriment to the environment. The Global Fund conducted a situation analysis of the HCW in Uganda in late 2019 which recommended the procurement of high temperature incinerators to handle all health care ware and install them at regional referral level. The Global Fund through the HIV/TB grant and the additional COVID funding will only fund a small portion of the full need identified. PEPFAR will support the installation of one additional high temperature incinerator.

PEPFAR will ensure safe completion of data collection for the Uganda Refugee Population-based HIV Impact Assessment (RUPHIA) by providing baseline COVID-19 testing to all RUPHIA staff prior to field deployment and of symptomatic staff & contacts during survey implementation. PEPFAR will also add a COVID-19 survey coordinator and distribute IPC materials (including face masks) for survey staff and participants to ensure COVID-19 safety SOPs and risk mitigation plans are effectively implemented during fieldwork for the Refugee UPHIA survey.

Mitigate COVID-19 Impact on PEPFAR programs and beneficiaries and support PEPFAR program recovery from the impacts of coronavirus

A. Logistics and commodity costs to HIV programs associated with COVID-19.

COVID-19 commodities pile up in COVID centers/hubs limiting access by community and facility services. The inclusion of dispensing capabilities within EMR will link critical supply chain and clinical services data. To enable commodities traceability and accountability, PEPFAR will integrate eLMIS and EMR to improve PEPFAR's ability to deduplicate and align critical data for program monitoring and improve end-to-end visibility of commodity availability, accountability, and patient numbers. Enhancement of the eLMIS by adding a dispensing module will improve commodity traceability and streamline and support ordering and redistribution of COVID-19 commodities as well as ARV multi-month dispensing (MMD) packs.

B. Laboratory

In order to rapidly scale up COVID-19 testing, key lab partners deployed existing laboratory staff for this purpose, resulting in severe shortages of staff to perform routine HIV testing for HIV and EID. To address increased demand on laboratory services resulting from COVID-19 testing, PEPFAR will increase human resources for health using short-term contracts for COVID-19 centralized testing and rollout of decentralized testing to ensure minimal interruption of VL/EID, TB and advanced HIV disease (AHD) testing program. Investments in human resources will be time limited. PEPFAR will improve lab infrastructure for lab hubs and calibration centers to support biosafety for COVID-19, TB and HIV. PEPFAR will also strengthen the national sample transport system to support integrated sample transportation without interfering with the HIV/TB and COVID-19 turnaround times.

C. Repair of Program Injury

Since the start of the COVID-19 pandemic, PEPFAR has experienced reduced ANC visits, facility deliveries, infant services such as immunization, EID HIV-exposed infant (HEI) testing, maternal-infant treatment continuity, and final outcome coupled with lack of PPE & MCH staff infections. Community-based programming, such as for key populations (KP) through peer-based programs and drop-in centers have also been affected. Given the disproportionate impact of COVID on MCH, PEPFAR Uganda will improve access to and safety of populations most affected by COVID (pregnant and breastfeeding women (PBFW), children/adolescents, KPs, TB/HIV co-infected) by expanding services to health center level II (HCII) and to high-volume sites in districts severely affected by COVID-19 to improve utilization, demand creation, and strengthening of point-of-care (POC) services; HCII outreaches and community PMTCT programming. PEPFAR will support and improve EMR and reporting, demand creation, community literacy on MCH/ PMTCT/ IPC and education, and peer mother support. In some high-volume facilities PEPFAR will also support adapting waiting spaces to allow for social distancing, and handwashing points at all ANC, maternity, PNC and immunization points in the facilities. PEPFAR Uganda will also intensify support for treatment continuity for these populations to address high levels of treatment interruption.

PEPFAR will also increase the training of Youth, Adolescents and Peer Support (YAPS) and provide an additional 2 YAPS at each high-volume facility. PEPFAR will also provide additional airtime and data for YAPS to facilitate their efforts to track and bring back the high numbers of adolescents with treatment interruption.

COVID-19 has exacerbated TB case finding efforts, especially during COVID-19 lock downs. TB case finding in Uganda has not returned to pre-COVID levels in both general and HIV-positive population despite being above the global target in 2019. This is to be expected due to lack of access to facilities where most of case finding is done, in addition to shut down of community case finding activities and lack of availability of diagnostics (e.g., use of GeneXpert for COVID-19 testing rather than TB case finding). PEPFAR will implement a joint screening algorithm and surge the community TB activities through deployment of dedicated community health care workers for contact tracing, community TB screening and facility based intensified TB case finding. PEPFAR will revamp community case finding activities and improve HIS for TB point of service data capture to improve case finding and monitoring of treatment adherence.

Teenage pregnancies, and gender-based and sexual violence has increased during the COVID-19 pandemic. Through the OVC, DREAMS and prevention platforms, PEPFAR Uganda will increase sexual violence prevention to reaching more children with an evidence-based curriculum in districts with a high prevalence of violence. PEPFAR will provide additional funding to the Child Helpline to address increased demand and will increase efforts under Justice for Children. PEPFAR will also build the capacity of para-social workers to provide COVID-19 prevention messages and conduct a rapid assessment of the impact of COVID-19 on OVC beneficiary households. For gender-based violence (GBV) programming, PEPFAR will increase support to GBV shelters, Every Hour Matters campaign and respond to teenage pregnancy, supporting teenage mothers