Uganda

Country Operational Plan

(COP) 2022

Strategic Direction Summary

April 27, 2022

PEPFAR

U.S. President's Emergency Plan for AIDS Relief

List of Acronyms

ACP	AIDS Control Program
AGYW	Adolescent Girls and Young Women
ANC4	Antenatal Clinic—4 Visits
APN	Assisted Partner Notification
ART	Antiretroviral 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	Expanded 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 to Fight AIDS, Tuberculosis and Malaria
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
MAT	Medication 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 Breast-Feeding Women
PITC	Provider-Initiated Testing and Counseling
PLHIV	People Living with HIV
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 Analysis
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 Adolescent Program Support

***Military PSNU data are non-public**

A portion of PEPFAR data relates to foreign military sites, such as bases, barracks, or military hospitals. Data originating at these sites are aggregated to each respective OU's Military PSNU and are non-public. When developing graphics for the SDS, do not include the Military PSNU, which you can find in PSNU dropdowns in Panorama. These services may be funded through a variety of implementing agencies or mechanisms, so the Military PSNU designation is not equivalent to DOD as an implementing agency.

1.0 Vision and Goal Statement

The President's Emergency Plan for AIDS Relief (PEPFAR) Country Operational Plan 2022 (COP22) vision is to (1) make progress toward reaching and maintaining epidemic control of HIV through evidenced-based, equitable, person-centered HIV prevention and treatment services; (2) build enduring capabilities across the health sector, and (3) build lasting partnerships by strengthening coordination and cooperation across the Government of Uganda (GOU), private sector, civil society organizations (CSOs), and faith-based organizations (FBOs). The vision for COP22 implementation focuses on reaching and sustaining HIV epidemic control and planning for long term sustainability towards PEPFAR investments in HIV across Uganda. The focus on equity, reducing stigma, discrimination, and violence, and promoting human rights are essential to sustain these gains. President Museveni's Presidential Fast-track Initiative on Ending HIV& AIDS in Uganda by 2030, and the Government of Uganda's 95-95-95 goals across sex and age bands contribute to the PEPFAR COP22 goals and strategy.

The PEPFAR Uganda Country Operational Plan 2022 (COP22) will continue to emphasize long-term sustainability and focus on significant progress towards the Sustainable Development Goal (SDG) 3.3 to end the HIV public health threat by 2025, including:

- Reach and sustain epidemic control by increasing the COP22 cohort on treatment to 1,361,632 through a focus on active HIV case finding, using targeted modalities such as index testing, and guided by Uganda Population-Based HIV Impact Assessment (UPHIA) 2020 findings and recency data.
- Provide life-long person-centered HIV services to ensure people remain on continuous antiretroviral therapy (ART). This includes antiretroviral (ARV) regimen optimization and removing all barriers to continuous HIV care, including stigma and discrimination, and maximizing convenience and responsiveness to individual needs and preferences.
- Intensify overall programming to close the clinical cascade gaps in testing, treatment, and treatment continuity with a focus on children and adolescents living with HIV.
- Strengthen community-led monitoring (CLM), civil society organization (CSO) and faith-based organization (FBO) engagement and fund key population (KP) led indigenous CSOs to provide KP-centered services.
- Expand pre-exposure prophylaxis (PrEP), especially among adolescent girls and young women (AGYW).
- Strengthen the Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) program to reduce HIV incidence among AGYW and expand the program including the urban model.
- Scale up PEPFAR-supported cervical cancer screening to decrease HIV-related mortality.
- Address issues of gender-based violence (GBV) and disclosure that impact services across the clinical cascade and acceptance of differentiated service delivery models (DSDM).

- Scale-up case-based surveillance (CBS) and unique identification across all sites with focus on health information exchange (HIE) and health information systems (HIS) interoperability.
- Increase GOU ownership through investments in HIS, laboratory and the regional referral hospital (RRH) strategy.

Under the current COP21 year, PEPFAR Uganda has already adopted multiple strategies to address the programmatic gaps identified by the Office of the Global AIDS Coordinator and Health Diplomacy (OGAC) in the January 2022 Planning Level Letter (PLL). These strategies will be continued throughout the COP22 implementation period.

Together with the MOH and partners, PEPFAR Uganda will execute a highly ambitious and targeted program under COP22, prioritizing client treatment continuity on ART through high-quality, person-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, AGYW, 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 HIV viral suppression. PEPFAR Uganda's program will remain nimble to improve performance, using site- and location-specific data (particularly from recency testing and UPHIA 2020) to identify areas for activity performance improvement critical to attaining our targets and objectives. COP22 will target the most underserved age and sex bands, while preventing HIV transmission among the most vulnerable populations.

PEPFAR's *Strategy: Vision 2025* sets a global course for achieving epidemic control. Uganda's COP22 priorities reflect this strategy and the PEPFAR 2022 Country Operational Plan guidance (2022 Country Operational Plan Guidance - United States Department of State). Our COP22 objectives fully align with and will contribute to President Museveni's *The Presidential Fast-track Initiative on Ending HIV & AIDS in Uganda by 2025*, decreasing HIV infections and HIV-related deaths, and achieving epidemic control by 2025 in line with the United Nations Program on HIV/AIDS (UNAIDS) and Uganda's national 95-95-95 goals across sex and age bands. PEFPAR Uganda collaborates with the 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 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 also established strong collaboration with CSOs, multilateral and bilateral partners, and other key stakeholders to intensify HIV epidemic control.

To achieve sustained control of the HIV epidemic, PEPFAR Uganda has actively and routinely coordinated and communicated with stakeholders and partners who provide valuable insights to improve the impact and accountability of programs. Key stakeholders include GOU (ministries and agencies), multilateral organizations, other bilateral donors, the private sector, and civil

society including KP-led, women-led, youth-led, and faith-based organizations. PEPFAR Uganda is aligned with the global PEPFAR strategy, which highlights the vital work of coordinating and communicating with partners to build lasting strategic partnerships to strengthen health services, improve resilient health systems, and institutionalize the work needed to sustain HIV epidemic control. Goal 3 of PEPFAR's *Strategy: Vision 2025* highlights the opportunity and imperative to continue the vital work of coordinating and communicating in ways that heighten impact, sustainability, and accountability, as well as build lasting strategic partnerships that strengthen the available services and add resilience to our efforts to institutionalize the work needed to sustain HIV epidemic control.

Throughout COP22, PEPFAR's routine engagement with all stakeholders has been viewed as an inclusive approach to understand the needs in country to achieve and sustain 95-95-95. This includes a reflection on shared work with PEPFAR while identifying technical and programmatic strengths, areas requiring additional discussion, and long-term approaches to reaching and sustaining epidemic control. Ensuring community voices are included is critical to ensure that systems evolve with person-centered services that engage all affected populations, especially those most marginalized. Community-Led Monitoring (CLM) findings generated from the community through PEPFAR reporting platforms inform decision making. Collaborative decision making will support the evolution of the HIV response to a mature epidemic as Uganda strives to reach and sustain epidemic control and end HIV as a public health threat by 2025.

To achieve our COP22 vision, the following areas require targeted efforts:

Gaps and Solutions for Achieving Viral Load Suppression: In FY22Q1, there were two regions with viral load suppression below 80% among PLHIV aged 0-9 and 10-19 years and this was mainly due to delays in rolling out pediatric dolutegravir (pDTG). Uganda rolled out pDTG using a phased approach, with first priority going toward those who were newly initiating and the non-suppressed. Health facilities in regions like West Nile received commodities including pDTG in FYQ22 Q2, hence the low suppression among the 0–9-year age group in FY22 Q1. It is anticipated that improvement in VLS among pediatric and adolescent populations will be observed toward the second half of COP21 and during COP22, when children in the affected regions are fully optimized.

Non-disclosure of HIV status to children and adolescents and relying on care givers to bring in the children for clinic visits and ART refills. PEPFAR supports the MOH guidelines on status disclosure and in COP22, implementing partners will support counsellors and peers (YAPS) to provide psychosocial support around ART adherence, benefits, importance of viral load monitoring and intensive adherence counseling for those with low- and high-level viremia. In addition, children and adolescents will be encouraged to pick up ART refills in the community models.

For the older adolescent who have been disclosed to, stigma is one of the reasons they are missing clinic visits and ART refills and hence low viral suppression rates eventually when tested. Adolescent friendly services and corners have been set up in most high-volume facilities

to support adolescents to cope with their status and life-long ART, in addition to the peer-peer twining strategy especially for the naïve newly starting ART.

Interpretation of data in settings with lower numbers of children and adolescents living with HIV (CALHIV): Rates (e.g., performance, VLS) need to be appropriately interpreted in areas with low number of CALHIV on treatment. For example, West Nile and Karamoja regions both have low numbers of CALHIV on treatment. As a result, some facilities and districts might appear to have very poor performance. However, when interpreted with the numerator and denominator in mind, the issue is skewed by small treatment cohorts.

Recency assays to define clusters of recent HIV acquisition (outbreaks) and planned response to these outbreaks: Recency data are captured electronically using Uganda electronic medical record (EMR) and summarized on a recency dashboard for implementing partners' and central level access. Recency data will be used to characterize clusters of recent HIV infections by geographic locations, demographics, and risk groups. These data will be used to identify ongoing transmission and monitor HIV epidemic trends over time at group level and as part of case surveillance. Furthermore, the data will be used to generate a public health response through focused counseling, prevention, and testing programs, that will identify PLHIV and link them to care. This approach should ensure implementation of tailored HIV prevention services to interrupt HIV transmission. The public health response strategy will be implemented with response teams at national and subnational levels including districts and facilities. The response will be focused on interrupting new infections and addressing late identification and linkage to HIV care.

High Interruption In Treatment (IIT): Adolescents and young people are noted to have high IIT: in FY22Q1, age groups 10-14 (3.5%) and 15-19 (5.7%), which might impact ART adherence and viral suppression rates. Clients in these age groups report they are less likely to return to treatment due to stigma. The ART program rolled out the Young Adolescent Program Support (YAPS) geared toward returning adolescents and young people to care, improving treatment continuity and ART adherence, and achieving viral suppression. In COP22, YAPS will be rolled out to the remaining districts. In addition, PEPFAR is supporting implementing partners (IPs) to implement multi-month dispensing (MMD) in order to prevent IIT as well as other differentiated service delivery models (DSDM), such as community ART delivery (e.g., community drug distribution points [CDDP], community retail pharmacy drug pick up points, client-led ART delivery [CLAD], home delivery). Scale up of these programs reduced IIT over the last 8 quarters and will continue expansion in COP22.

Need for strengthened treatment literacy: An improved appreciation for the importance and benefit of continued ART adherence and viral load monitoring especially among seemingly healthy adolescents and young people will improve continuity of treatment. In COP22, PEPFAR provided funding to the social behavioral change activity (SBCA) partner to engage CSOs, train them to mentor networks of people living with HIV (PLHIV) who will cascade the message down to the grass roots in order to sensitize the affected age groups, care givers and other sub-populations about the benefits and importance of ART adherence and VL monitoring, in addition to the U=U messaging.

Lack of food and poverty: Various age groups, including adult OVC caregivers, orphans and vulnerable children (OVC) programs in various regions are encouraging and empowering households to join village level saving associations (VLSA), maintain demonstration gardens with an aim of selling surplus food to generate an income, and save. The DREAMS and AGYW activities demonstrate innovative programs that empower young women.

To improve quality, person-centered care, PEPFAR will support the scale up and implementation of health facility and community continuous quality improvement collaboratives that will address gaps in care as highlighted in the People's Voice and feedback from the Community-Led Monitoring (CLM) partners. PEPFAR will expand the alternative drug distribution points of care to 200 new pharmacies across 90 districts, in addition to the community DSDM with a focus on quality and equity, bringing care closer to the communities. To ensure adequate reach for young people, PEPFAR will utilize a peer-led approach and expand our YAPS model to achieve national coverage. Treatment literacy was raised as a gap within the PEPFAR program and in COP22 PEPFAR will expand peer-led treatment literacy to

COP22 Human Resources for Health (HRH) investments will focus on supporting the institutionalization of the community health extension workers (CHEWs) cadre, completing staff restructuring to create more positions and cadres, increasing capacity of RRH to implement the delegated MOH public health functions and achieve service delivery targets, providing cost effective in-service training, and improving HRH data utilization for evidence-based decision making.

Continue to scale of VMMC: In COP22 the program will focus on demand generation approaches to increase VMMC coverage, safety, and quality, increasing the use of reusable kits from 60% in COP21 to 75% in COP22, scaling up ShangRing implementation from 18,000 to 30,000 and begin to plan for sustainability by integrating VMMC services into combined prevention programming. Among the key strategic shifts in COP22 implementation, PEPFAR will work with the MOH to revise the national VMMC guidelines to align with the 2020 WHO guidelines, including the need for PLHIV to have documented viral load suppression (VLS) before VMMC.

The Uganda VMMC program achieved 21% of the annual target at end of financial year 2022 quarter one with 89% of circumcisions in the 15–29-year age category. A majority of VMMCs were performed by the conventional surgical method, with ShangRing contributing about 4%. The program had over 90% post operation follow up rates within 14 days. The program has identified two main challenges during FY22Q1 implementation, and these include low uptake of ShangRing among 14-15-year-old boys and low performance in the 30+ men.

Focus on continuous quality improved aimed to reduce the occurrence of adverse events and post-operative follow-up. Findings from a root cause analysis done to understand the barriers to uptake of VMMC in the older men showed that timing of the service delivery and perception that VMMC was for young boys were key barriers. Targeted mobilization by peers and provision of services during flexi hours in 30 focus facilities resulted in a 20% increase in the uptake of VMMC among the older men. These interventions are being scaled to other regions to improve the VMMC reach in the older men.

Overall, Uganda has a safe VMMC program with an overall adverse event (AE) rate of 0.2%. Most AEs reported are excessive swelling, bleeding and infection after surgery. The PEPFAR program also reported 5 notifiable AEs in fiscal year (FY) 2021. The MOH is decentralizing the support supervision for VMMC services to the regional referral hospitals (RRH). The RRH's capacity is being built to attain center of excellence status that continuously mentors and coaches lower-level health facilities to provide quality VMMC services. A regional VMMC safety committee is being constituted at each regional referral hospital to provide oversight on the quality of services in the region.

Improved KP programming: KP programming in Uganda has improved with support from GOU; however, the country needs to address barriers preventing KPs from accessing HIV prevention and treatment services. The program instituted KP-specific data systems that ensure KPs tested and found HIV positive are initiated into treatment and receive follow-up to improve treatment continuity. Uganda has improved ART coverage (96%) and VL suppression of KP clients initiated in care (91%), while positive test yield has remained a challenge at only 4%. In COP22, the program will expand efforts to increase KP proportion reached and work with CSOs to ensure that identified KPs are linked to care and are retained.

2.0 Epidemic, Response, and Program Context

2.1 Summary Statistics, Disease Burden, and Country Profile

In 2022, Uganda has a population of 45.3 million. Uganda's annual population growth is 3.3 percent, and its total fertility rate is 4.7, making it one of the fastest-growing population in the world (Uganda is 15th). Additionally, the population pyramid demonstrates that Uganda has a large "youth bulge," with 44.5 percent of the population under age 15 and 66 percent under age 24. Uganda is also among the most rapidly urbanizing countries in the world.

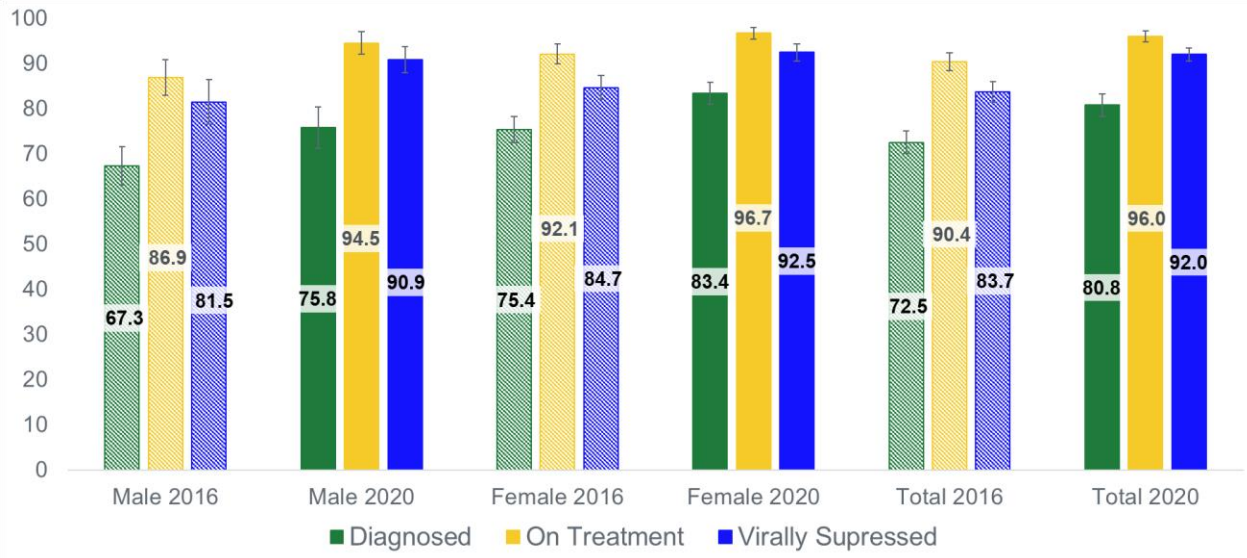
Findings from the UPHIA 2020, a nationwide, household-based survey conducted to provide estimates of HIV prevalence, viral load suppression, and other important HIV/AIDS program indicators, was used to inform COP22 planning. UPHIA 2020 estimated HIV prevalence at 5.5% (95% confidence interval [CI]): 5.0%-6.0%) for adults aged 15-49. For adults aged 15 and above, HIV prevalence was estimated at 5.8% (95% CI: 5.3%-6.3%), with a higher prevalence in women of 7.2% (95% CI: 6.6%-7.8%) than in men of 4.3% (95% CI: 3.8%-4.7%). No statistically significant difference in prevalence for men, women, or overall, between UPHIA 2020 and the previous UPHIA survey conducted in 2016-2017 were found.

UPHIA 2020 estimated viral load suppression for adults 15+ at 75% (95% CI: 73%–78%). Viral load suppression (VLS) estimates for men, women, and overall increased significantly compared to UPHIA 2016-2017, with VLS estimates increasing from 57% to 73% among adults aged 15 to 49 years.

Preliminary UPHIA 2020 survey data were incorporated into the COP22 subnational PLHIV estimates process. For the COP22 planning period there are approximately 1.453 million people estimated to be living with HIV, of whom 79,000 are children under 15 years (Spectrum 2022).

The updated UNAIDS targets aim for 95 percent of people living with HIV to know their status, 95 percent of those who know their status to be on treatment, and 95 percent of those on treatment to be virally suppressed. The preliminary results of the UPHIA 2020 survey show encouraging progress toward the achievement of the UNAIDS 95-95-95 targets, particularly among women. UPHIA 2020 conditional cascades for adults 15 years and above show improvements across three indicators, overall and by sex. Specifically, the survey showed that in adults 15 years and above: 81% of those living with HIV were aware of their status, 96% of those aware of their HIV status were on ART, and 92% of those on ART were virally suppressed. The high second and third conditional 95s suggest good performance, once individuals are in the program. For both males and females, all three 95s improved from UPHIA 2016-2017 to UPHIA 2020, with the largest increase in the third 95.

Figure 2.1.1 Conditional 90-90-90 adult (15-64 years) cascade, by sex [ARV-adjusted]



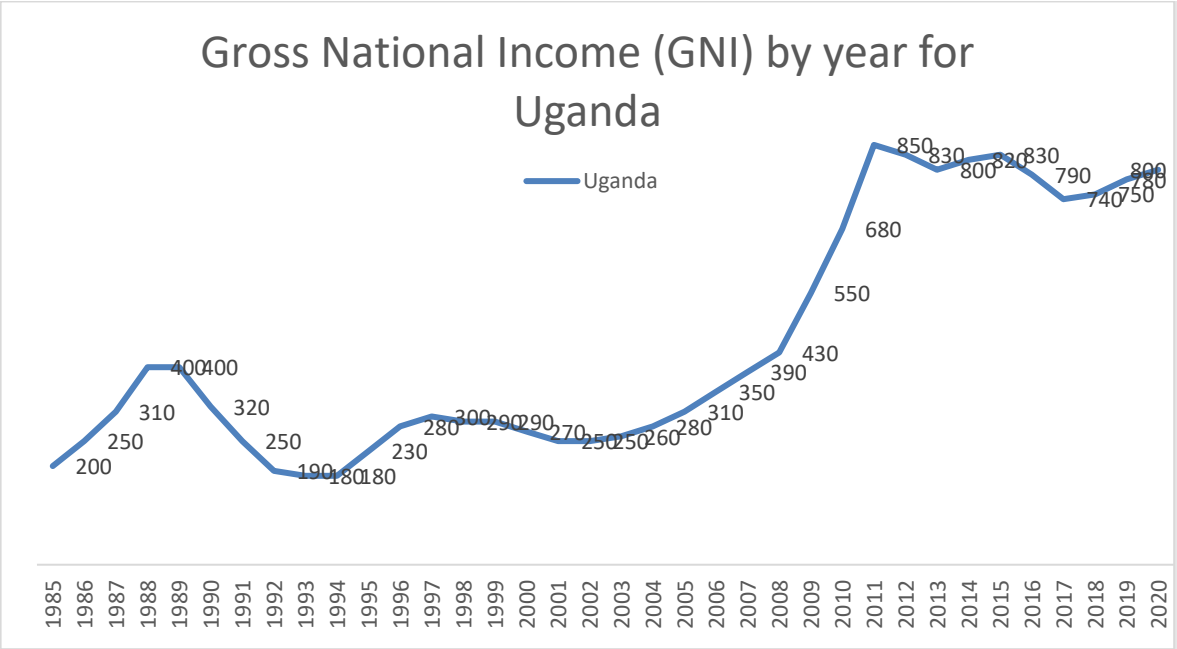
UPHIA 2020 showed an improved VMMC coverage of 54% from 43% in UPHIA 2016-2017. COP22 targets will further increase the national coverage to 63%. To align with the COP22 priorities, the VMMC program utilized UPHIA 2020 and Spectrum incidence data to identify and target high risk men especially the 30+ age range. In the targeting methodology, PEPFAR Uganda considered 2022 Spectrum incidence rates, KP size estimates, and DREAMS districts. Using UPHIA 2020 and program data – districts close to 90% saturation were allocated targets needed to reach saturation. Districts in regions with the lowest VMMC coverage (Teso at 23.6% and Mid-North at 24.1%) were allocated more aggressive targets.

Uganda is on course to achieve all the COP21 minimum program requirements (MPR) as identified in the PLL. The country is well positioned to identify and address the remaining

programmatic challenges and systems barriers to achieve the MPRs. Barriers to the country's ability to achieve its ambitious health goals are:

a) Inadequate national technical and financial capacity for effective quantification, supply planning, ordering, stock management, and accountability for HIV and TB commodities. PEPFAR is committed to support an improved supply chain system that allows for commodity security and end-to-end visibility of the finance and commodity flow from the central level to health facilities. PEPFAR is also committed to support the national supply chain to accommodate effective supply chain management processes from quantification to last mile delivery of commodities.
b) Lack of sufficient financial resources from GOU towards health promotion activities that provide behavior change communication packages for HIV prevention as well as care and treatment activities. In COP22, PEPFAR will continue to ensure collaborations with other partnerships including GOU to advocate for improved access to and utilization of HIV,TB, prevention and ANC services by adolescents and adults, which will eventually lead to improved health outcomes.
c) Suboptimal uptake and expansion of person-centered approaches, DSDMs and multi-month dispensing (MMD) with eventual impact on retention of PLHIV in care for children, adolescents, adults as well as special populations including KPs, priority populations (PPs), men and PLHIV from hard-to-reach areas like the Karamoja region. This is attributable to a multitude of factors, including insufficient literacy among PLHIV resulting in fear of uptake of DSDM & MMD, health care worker skepticism towards MMD and other DSDM as well as past unstable supply of commodities (shortages of commodities) to facilitate MMD. In COP22, PEPFAR has planned to continue to support MOH and partners integrate and expand MMD into all the DSDMs for improved retention and further minimization of interruption of ART.
d) Lack of sufficient human resources for health (HRH) to cover all the key and competing tasks/activities for an efficient provision of impactful care and treatment services. Certain health cadres such as counsellors are not available at many of the health facilities leading to a gap in provision of tailored services to the special needs of PLHIV. This also leads to missed opportunities for screening and identification of people with various conditions, including advanced HIV disease; non-communicable diseases (NCDs) such as mental health concerns, substance abuse, and psycho-social issues; toxicity to ARVs; and those at risk for poor adherence, interruption in treatment, missed appointments, and non-suppressed clients. In COP22, PEPFAR will continue to support lay workers, para-social workers, and other community resource persons who can contribute to mitigation of the staffing shortages, support client literacy, demand creation, client follow up and referrals as well as screening and identification of clients with various disease conditions with an aim to offer rapid relevant interventions.
e) Lack of relevant policy frameworks to support implementation of the novel and high impactful interventions for improved health outcomes. In COP22, PEPFAR will collaborate with other national and international partnerships to support Uganda conduct regular policy development and reviews to create an enabling environment for delivery of high impact interventions in key areas namely; TB/HIV (advocacy for policy change for concurrent

initiation of ART and TB medicines for newly diagnosed TB patients); Advanced HIV Disease (AHD) (policy change for inclusion of anti -fungal drugs on the essential medicines list and policies for inclusion of point-of-care platform for CD4 testing in public health settings); non-communicable diseases (NCDs) (Policy change for inclusion of newer anti-hypertensives in the essential medicines list); HIV viral load (VL) testing (Policy change on inclusion of low level viremia in the national VL algorithm); cervical cancer screening (finalization of policy changes on the cervical cancer screening algorithms) and DSDMs (policy changes for DSDM for children and pregnant women).



Source: World Bank national accounts data and OECD National accounts data files

Standard Table 2.1.1 Host Country Government Results

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	45,335,380		9,970,750	22%	10,481,090	23%	4,808,700	11 %	4,555,800	10 %	7,671,680	17 %	6,725,100	15%	Population projection UBOS 2022
HIV Prevalence (%)		5.50%		0.7%		0.4%		2. 9 %		0. 8 %		9.9 %		6.7%	UPHIA 2016 for age<15, UPHIA 2020
AIDS Deaths (per year)	17,788		2,170		2,228		1,221		766		5,350		6,053		Spectrum Estimates 2022
# PLHIV	1,453,891		39,002		39,879		134,708		46,219		735,613		458,174		Spectrum Projections 2022
Incidence Rate (Yr)				0.03		0.03		0. 31		0. 08		0.2 4		0.13	Spectrum Projections 2022
New Infections (Yr)	50,511														Spectrum Projections 2022
Annual births	1,944,888	0.043													UDHS 2016
% of Pregnant Women with at least one ANC visit	97														UDHS 2016
Pregnant women needing ARVs	87,368														Spectrum Projections 2022

Orphans (maternal, paternal, double)	4,986,892		1,096,783		1,152,920		528,957		501,138		843,885		739,761		
Notified TB cases (Yr)	69,748		4,219		4,364		3,360		3,536		19,277		34,993		
% of TB cases that are HIV infected	22,483		724		659		1,108		5050		8,418		11,024		
% of Males Circumcised	6,578,488	54.1%			328,924	5%			4,144,447	63 %			2,105,116	32%	
Estimated Population Size of MSM*	44,397														UAC and UNAIDS; key and priority populations size estimation 2019
MSM HIV Prevalence (%)	13%														UAC and UNAIDS; key and priority populations size estimation 2019
Estimated Population Size of FSW	179,116														UAC and UNAIDS; key and priority populations Size estimation 2019
FSW HIV Prevalence	31%														IBBS Kampala 2022 (preliminary data)

Estimated Population Size of PWID	7169														UAC and UNAIDS; key and priority populations Size estimation 2019
PWID HIV Prevalence (%)	16%														UAC and UNAIDS; key and priority populations Size estimation 2019
Estimated Size of Priority Populations (Fisher folks)	1,611,769														HIV Knowledge, Attitudes, and Practices and Population Size Estimates of Fisherfolk in 6 Districts
Fishing community prevalence	15-35%														HIV Knowledge, Attitudes, and Practices and Population Size Estimates of Fisherfolk in 6 Districts
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table. Cite sources*														

Standard Table 2.1.2

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 (#)
Total population	45,335,380	5.5	1,453,891	1,319,427	1,266,588	96%	88%	4,650,713	131,226	124,603
Population <15 years	20,255,392	0.39	79,185	61,812	59,825	97%	95%	240791	5,137	*5,631*
Men 15-24 years	4,869,434	0.95	46,166	25,587	24,287	95%	82%	468699	5,374	*4,211*
Men 25+ years	7,290,433	6.3	458,225	410,661	392,534	96%	85%	891674	40331	*38,236*
Women 15-24 years	4,835,754	2.79	134,682	86,392	82,125	95%	84%	1473318	28,131	*25,563*
Women 25+ years	8,084,367	9.1	735,633	734,974	707,817	96%	90%	1,576,214	52,253	*50,962*
MSM	44,397	12.70%	5,638		621	11%	53%	22,153	314	*310*
FSW	179,116	31.30%	56,063		11,514	21%	55%	188,503	7,313	*6,814*
PWID	7,169	16%	1,146		280	24%	31%	10,889	312	*275*
Priority Pop (fishing community)	157,350	15%	23,603		4,544	19%	74%	42,144	1000	*1030*

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

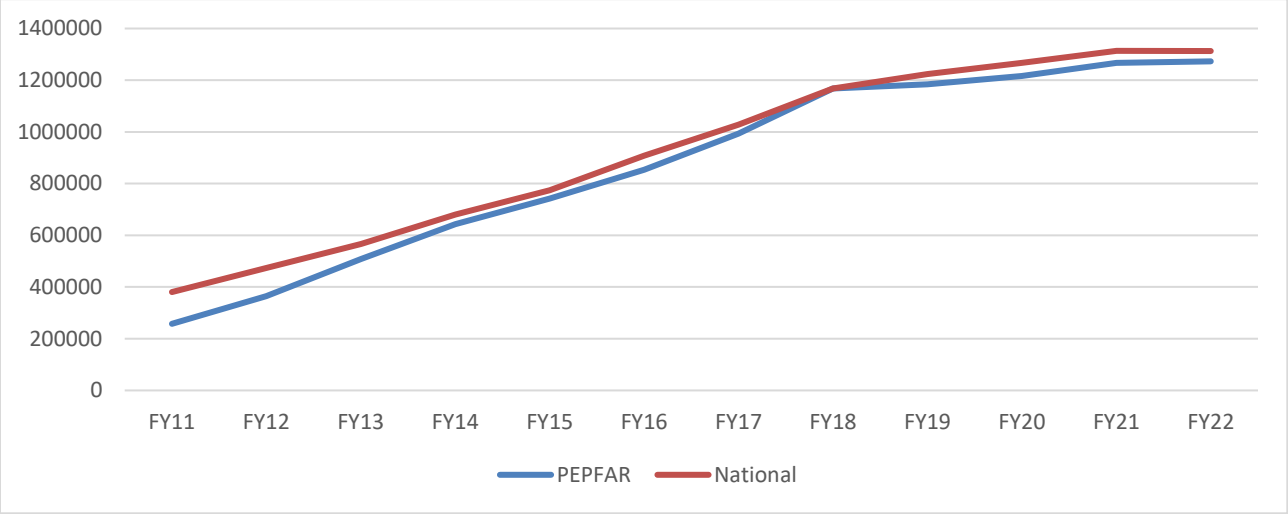


Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV

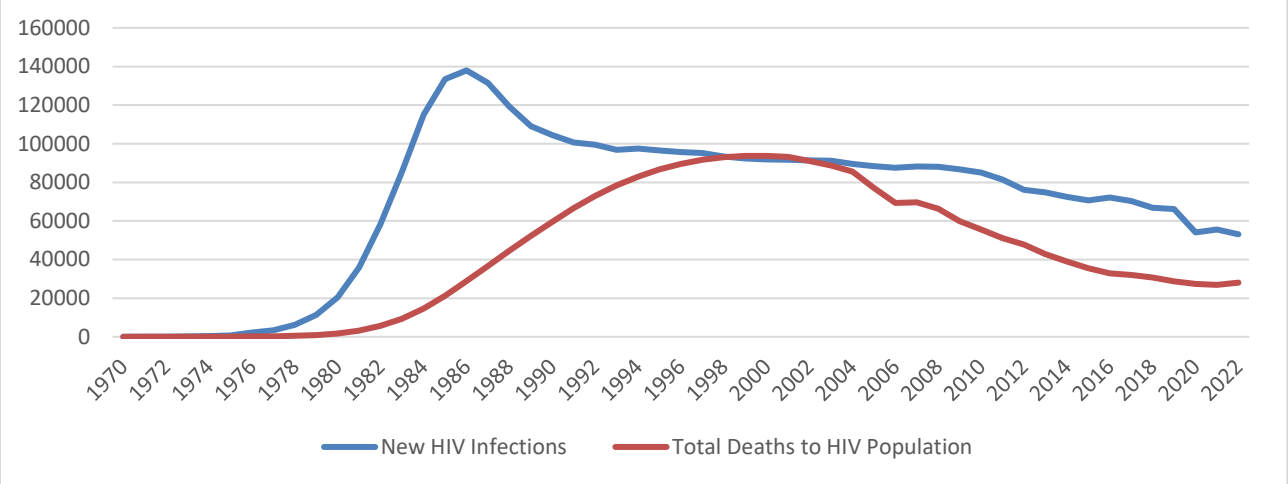


Figure 2.1.5 Assessment of ART program growth in FY21

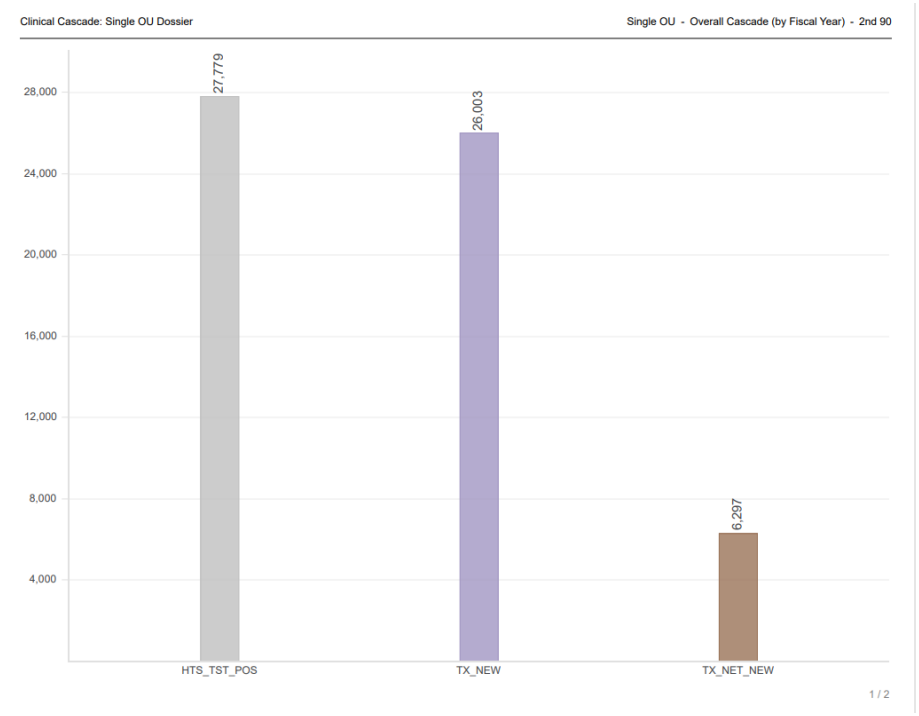


Figure 2.1.6.1 Clients Gained/Lost from ART by Age/Sex, FY21 Q4

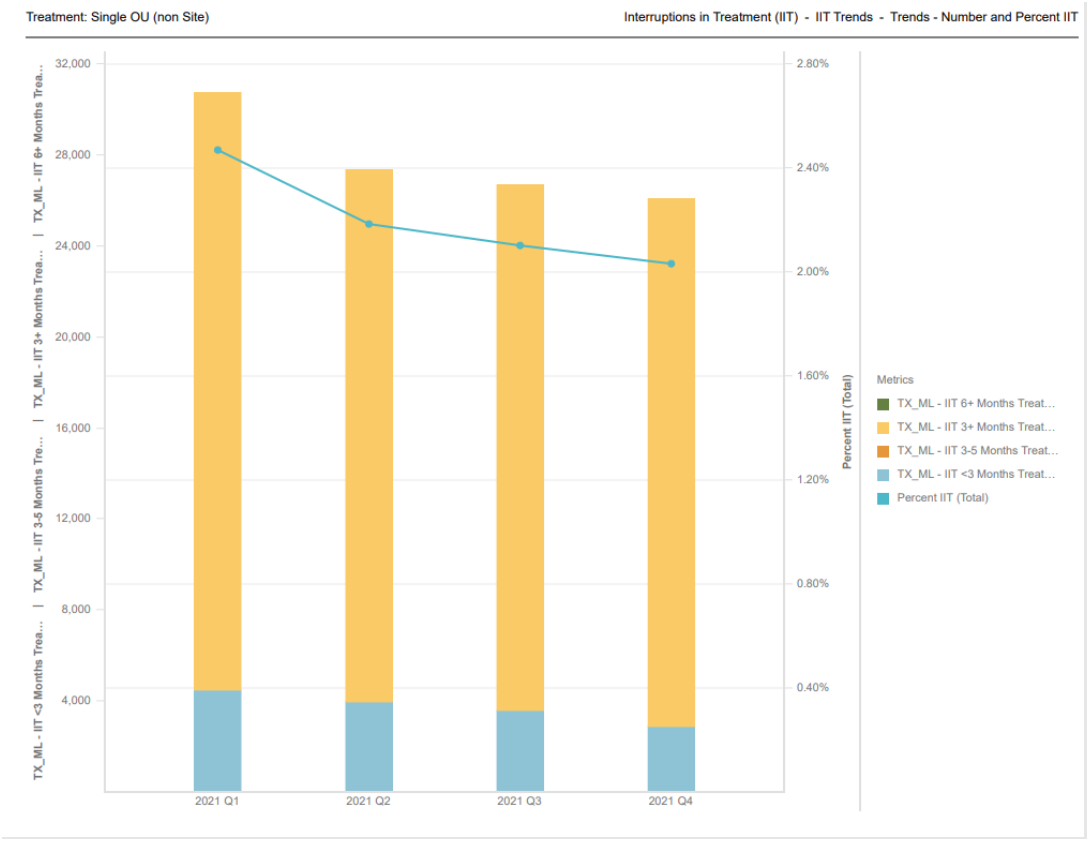


Figure 2.1.6.2 Clients Gained/Lost from ART by Age/Sex, FY21 Q4

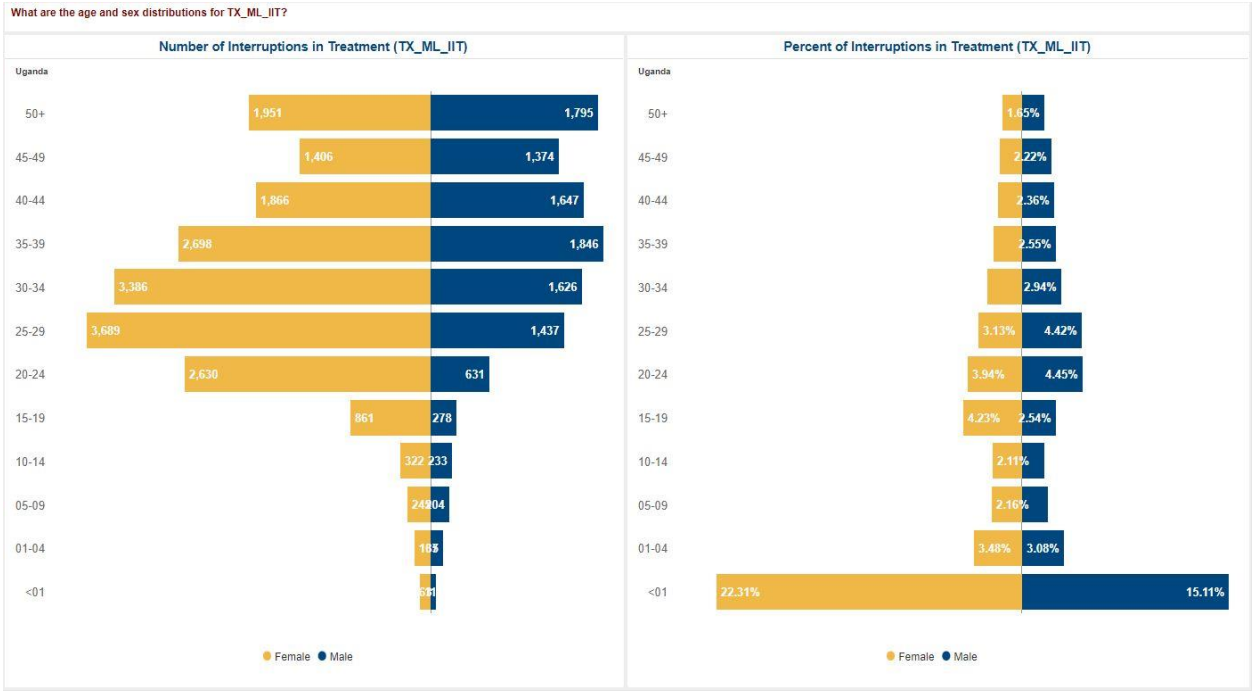


Figure 2.1.7 Epidemiologic Trends and Program Response for Uganda

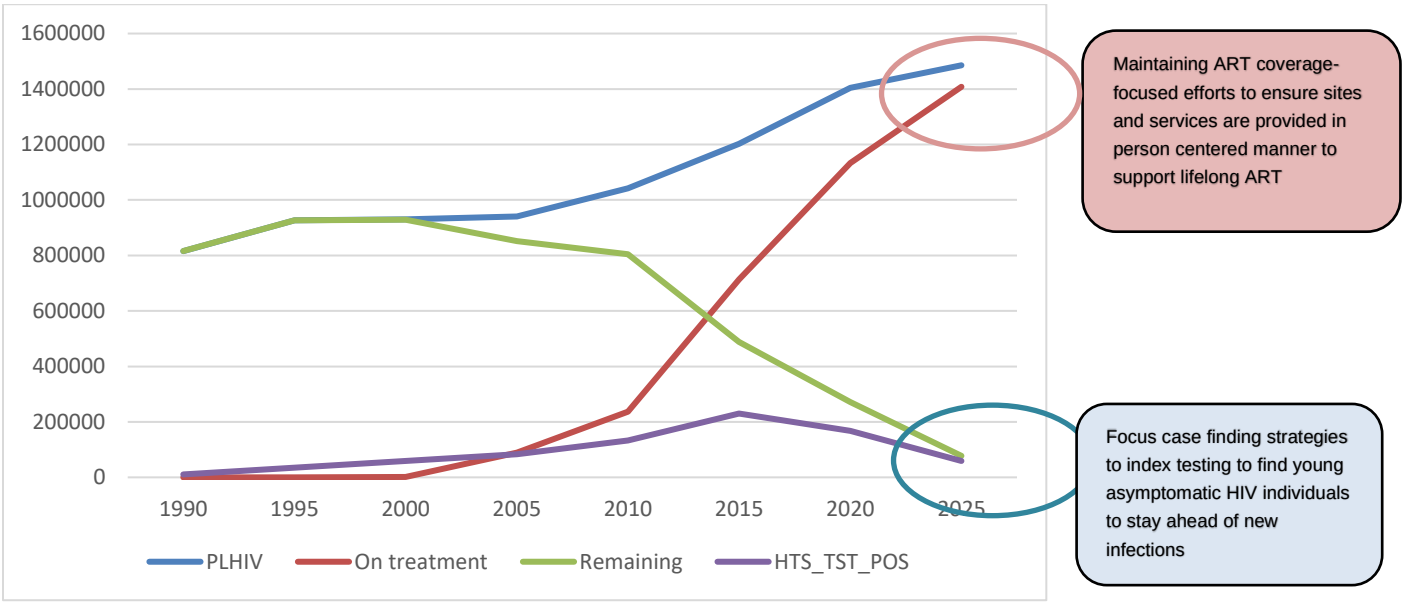
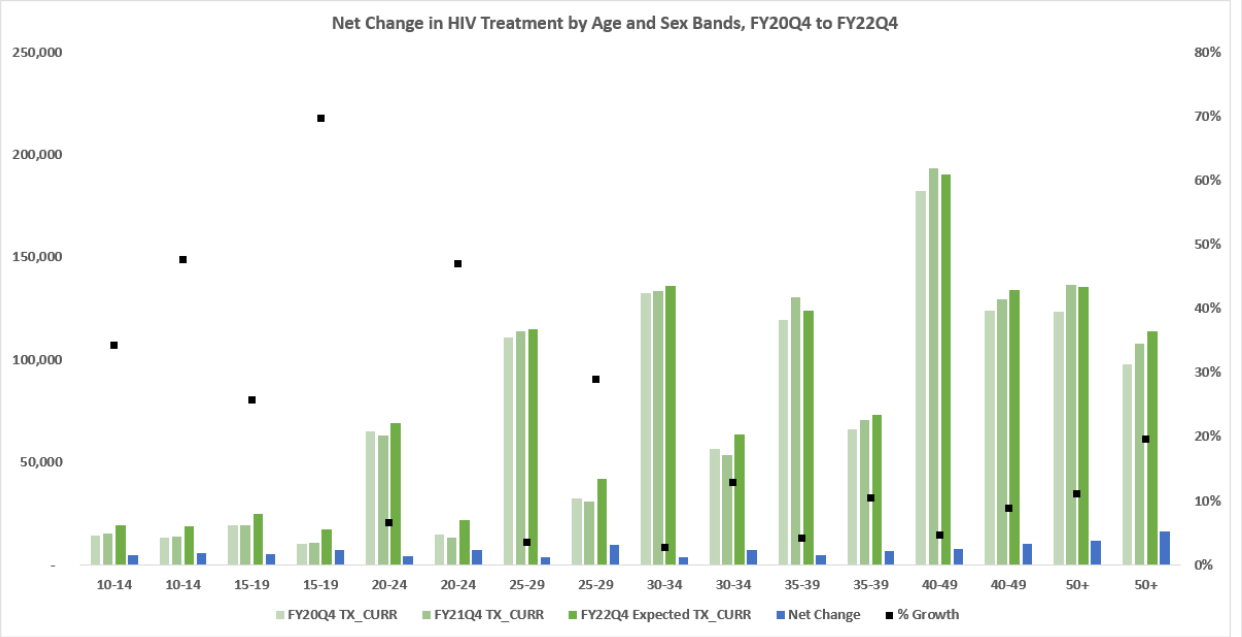


Figure 2.1.8 Net change in HIV treatment by sex and age bands 2020 Q4 to 2022 Q4



2.2 New Activities and Areas of Focus for COP22, Including Focus on Client ART Continuity

As of December 2021, PEPFAR Uganda supported 1.27 million HIV positive individuals on treatment. During FY22Q1, PEPFAR Uganda initiated 26,003 individuals on ART (TX_NEW) and supported 21,389 individuals to return to treatment. PEPFAR Uganda also supported the accreditation of additional ART sites which served 4,093 individuals on ART. Collectively, this resulted in a program growth of 51,485 individuals on treatment. However, the treatment interruptions (30,600), deaths (2,029), individuals making the choice to stop treatment (169), transfers out (5,838), sites dropped (220), and unexplained losses (6,332), the program experienced an overall program loss of 45,188. This represents a net growth (TX_NET_NEW) of 6,297 individuals on ART between FY21Q4 to FY22Q1. PEPFAR Uganda made some progress in reducing treatment interruptions for individuals who were less than 3 months on treatment from 18% in FY21Q4 to 13% in FY22Q1, although ITT remains a challenge that is being addressed. Unexplained loss also improved from -1.68% in FY21Q1 to -0.49% in FY22Q1. This improvement is attributed to our program focus on patient tracking and data quality.

New strategies for continuity of treatment and service integration

As PEPFAR Uganda scales up the alternative community differentiated service delivery models including the Community Retail Pharmacy Drug Distribution Point (CRPDDP), the program will integrate the following services: HIV self-test (HIVST) kits at the community pharmacies for case

finding, TB prevention, case finding/screening and treatment drugs as well as expanding eligibility to include adolescents, young adults, and caregivers of children living with HIV on ART. PEPFAR Uganda aims to enroll 66% of stable clients in 200 community retail pharmacies across 90 districts in COP22. The program will also expand the community-led drug distribution points to 10 districts experiencing high IIT and develop guidelines to include 10–19-year-olds and care givers in the CRPDDP.

PLHIV-led treatment literacy

In January 2022, PEPFAR Uganda awarded a sub-grant to NAFOPHANU (the national umbrella organization for PLHIV in Uganda) and partner PLHIV networks to pilot the PLHIV-led treatment literacy in 10 districts in mid-North and West Nile regions. The district and site selection were completed in consultation with MOH and PLHIV networks. The pilot will target four high-volume sites with a high IIT burden and their catchment sub-counties in each selected district. Peers will be trained and attached to the high-volume health facilities. The peers will use national approved treatment literacy materials, leverage the *Time up HIV* campaign, and document promising practices. NAFOPHANU will collaborate with MOH, PEPFAR Uganda communication partner, comprehensive partners, and CSO networks on this pilot. Lessons learned from the pilot will guide the scale-up and expansion of PLHIV-led treatment literacy initiative.

Tuberculosis (TB) and Tuberculosis Preventive Therapy (TPT)

While there has been a slight improvement in TB case finding from 67,874 in FY20 to 69,162 in FY21 (MOH DHIS2), this is an estimated 85% of the 81,352 targeted incident TB cases, 32% of which are HIV co-infected. This improvement from FY20 is a result of program adaptations to the COVID-19 restrictions that contributed to the slight increase in TB case finding. Despite the improved diagnostic coverage and data quality, the yield of TB screening among PLHIV remained low at 1.8% in FY21. To address this TB case finding gap, PEPFAR will invest in novel approaches of TB screening and testing for those found symptomatic. These will include the use of C-reactive protein (CRP) for TB screening in ART clinics and use of Truenat for TB testing at lower-level health facilities to ensure 100% access to a TB molecular test for PLHIV. In addition, PEPFAR will support efforts by MOH to implement TB screening using digital X-ray technology given the improvement in availability of mobile X-rays machines in the country. PEPFAR will sustain investment in TB-LAM commodities to reduce missed opportunities to find TB among PLHIV with advanced disease. To reduce missed opportunities of finding TB among patients who delay seeking care, PEPFAR will support lay workers to conduct TB contact investigation, hot-spot mapping and screening and collection of sputum samples in the community for testing at diagnostic facilities. In addition, PEPFAR will participate in the 6-monthly MOH-led Community Awareness, Screening and Testing (CAST) campaigns to bridge the case finding gap.

By end of FY21, 90% of PLHIV in care had enrolled on TB preventive therapy (TPT) and 92% of those enrolled had completed. In collaboration with MOH, PEPFAR will sustain efforts to enroll all eligible PLHIV pending TPT enrollment to ensure 100% coverage by end FY22. To ensure enrolment of the pending 10% of PLHIV in care on TPT, PEPFAR will intensify support aimed at reaching all pending patients through activities such as initiation of TPT in the community and calling back eligible patients on long MMD for ART to initiate TPT. To ensure high TPT

completion rates, PEPFAR has invested in procurement of 3HP (isoniazid plus rifapentine), a shorter TPT regimen, which is becoming available in FY22. During FY22, PEPFAR continues to work with MOH to transition TPT from an isoniazid (INH) to a 3HP based program among adult PLHIV through a phased approach beginning with regional referral hospitals, then centers of excellence and district hospitals, and finally health centers III and IV. To support TPT among HIV-negative adult and child TB contacts, PEPFAR will sustain support to TB contact tracing and ensure that eligible contacts are initiated on TPT with commodities procured through other funding streams, such as Global Fund and GOU.

For COP22, PEPFAR has allocated a total of $6,613,557 for TB clinical services, $4,900,079 to support TB services at health facilities and $ 1,713,478 for TB activities at community level.

Advanced HIV disease commodities and management

The burden of advanced HIV disease (AHD) among newly diagnosed is significant. Among 126,833 TX_NEW in FY21, 53,088 (42%) had a CD4 testing, of whom 24% (12,975/53,088) presented with CD4 less than 200 cells/mm3 at the time of HIV diagnosis. In order to address the potential contribution of AHD to PLHIV's interruption in treatment (IIT), PEPFAR and Global Fund are investing in commodities to diagnose and treat AHD and opportunistic infections including CD4 testing for newly identified or previously lost clients, testing for hepatitis B, cryptococcal antigen, and TB_LAM, and provision of cotrimoxazole and fluconazole for eligible PLHIV. At FY21 Q4, among 28,402 TX_NEW,13,152 (46%) and 2176 out of 3120 (70%) accessed CD4 testing and CrAg testing respectively. Over 80% (202/228) of those found positive for CrAg were linked to appropriate treatment with fluconazole and rapid initiation of ART as recommended by the national ART guidelines.

In COP22 PEPFAR is committed to eliminate the gap for CD4 testing. As such, $679,147 has been allocated for CD4 testing access, including expansion of the rapid point-of-care platforms for CD4 testing with an aim to further increase access for rapid AHD identification, linkage to treatment, and minimization of IIT; this will ensure 100% of people identified as HIV positive have access to CD4 screening.

PEPFAR, in collaboration with the Clinton Health Access Initiative (CHAI), will continue to leverage the UNITAID fund to treat cryptococcal meningitis in the 18 national and regional referral hospitals across the country by use of the newer potent, effective, and well-tolerated antifungal called AmBisome (Amphotericin B-Liposomal) and flucytosine, per current MOH guidelines. PEPFAR will support the roll out of single AmBisome, treatment of cryptococcal meningitis beyond the 18 regional referral hospitals that are currently supported by CHAI and UNITAID to improve access to better treatment options.

PEPFAR will continue to collaborate with the MOH and other partners to ensure the current guidelines are updated to accommodate the newer evidence-based protocol for use of AmBisome as a single high dose accompanied by Flucytosine for 2 weeks for the treatment of cryptococcal meningitis. In COP22, all other sites, including district hospitals and lower-level HFs, will continue to offer screening, identification, and referral of patients with cryptococcal meningitis to the 18 national and regional referral hospitals across the country for specialist

management, including toxicity monitoring with laboratory tests. In COP22, PEPFAR will intensify community-based follow-up through training and support CHWs to provide community-based AHD follow up care for patients on AHD treatment.

Non-Communicable Diseases Prevention and Management

Over time, the proportion of PLHIV 50 years and older has grown from 13% in FY 17 to the current estimated 19% in FY 21. While recognizing the potential susceptibility of this population to non-communicable diseases (NCDs), PEPFAR in COP21 planned to support integration of prevention, screening, and management of NCDs into the HIV program through a phased approach beginning in three PEPFAR regions (Kampala-Wakiso, Southwest, and Kayunga/Mukono) in a total of 106 selected health facilities where screening for hypertension, diabetes, and mental health is institutionalized and strengthened. In COP21, PEPFAR allocated $700,000 to these efforts, including national level coordination in development of the NCD integration operational guidelines, information, education and communication (IEC) materials, standard operating procedures (SOPs), job aides, and monitoring and evaluation (M&E) tools as well as advocacy for key policy changes for suitability of implementation of the newer NCD interventions. All these will be accomplished in FY22Q3. The three pilot regions have already initiated processes to build the capacity of the healthcare workers (HCWs) at the selected sites to screen for the NCDs and to link to appropriate treatment.

In COP22, we are more than doubling investments for NCD prevention and management, including mental health services and services for ageing PLHIV, and a total of $1,512,000 has been allocated by PEPFAR Uganda to NCD integration. Through partnerships and collaborations with Global Fund and other national and international level stakeholders, Uganda has planned to scale up the NCD integration services to a total of 1,800 sites through site level HCW capacity building, repurposing, and strengthening capacity of lay workers at each site to screen, identify, and link to the appropriate treatment as well as conducting support for monitoring and reporting for NCDs. PEPFAR Uganda will consult with PLHIV in the design and implementation of this program, and the program will proactively engage peer leadership in implementation of the community-based elements of this program.

Focus on Pediatrics and Adolescents/Peds Surge

Uganda has been selected as one of seven countries for the “Accelerating Progress in Peds/PMTCT” (AP3) initiative. According to spectrum estimates for 2022, Uganda will have an estimated 79,185 children less than 15 years of age living with HIV in COP22. By the end of FY22 Q1, 57,842 children were receiving treatment, translating to a treatment coverage of 73% and an unmet need for treatment of 21,343. To address this gap, Uganda will implement a Peds/PMTCT Surge in 579 priority sites that contribute 80% of our pediatric treatment volume to implement high impact interventions for case finding and linkage to treatment, address IIT, and improve viral load suppression, as shown in the figures below.

The program has put in place dedicated pediatric human resources at all levels from USG, MOH, implementing partner, facility and community level to support the surge. PEPFAR Uganda will build capacity of our teams to ensure that they provide quality pediatric services through a mixed model approach using both virtual and in person platforms. Facility staff and community health workers will be trained using the MOH approved modular case-based tool kit on pediatric

and adolescent HIV care and treatment. The program will utilize peds specific coaches at district level to provide ongoing mentorship and coaching for site level teams. Weekly virtual pediatric ECHO meetings will be held, led by the MOH, to discuss key pediatric strategies and interventions while providing a platform for cross learning and sharing of best practices.

PEPFAR Uganda wants to be able to hear from clients in the community on a regular basis so will leverage the existing CLM mechanism. The program will engage the CLM team to discuss CLM program priorities regarding pediatrics, adolescents, and PMTCT. PEPFAR Uganda will ensure that populations, including caregivers, adolescents, pregnant and breastfeeding women (PBFW), are included among the assessors and the assessed so that the program is able to receive feedback from the right voices in the community and tailor the programs accordingly.

To monitor the Peds/PMTCT Surge, PEPFAR Uganda will use the weekly PEPFAR dashboard, with additional investments to PEPFAR Uganda's strategic information implementing partner (IP) for dedicated support. This dashboard will be revised to capture age and sex disaggregation of interest to the Peds and PMTCT programs. The program will include additional indicators to capture viral load and continuity of treatment. The priority sites will report weekly in the Surge Dashboard and weekly IP data reviews led by the MOH will be held to review performance, address challenges, and share best practices.

A dedicated pediatric budget has been allocated to support the above surge activities. In COP 22, $11,696,339 has been allocated to strengthen the pediatric clinical cascade. This is an increase of 45% above our COP21 peds funds with $ 3,626,795 dedicated to surge activities covering case identification, data quality and reporting and caregiver literacy. PEPFAR Uganda has ensured that 42% of pediatric budget goes to support community interventions, toward strengthening continuity of treatment and viral load suppression and 9% of these peds care and treatment funds has been allocated to case finding, which is our biggest gap.

Given the major surge in funding, PEPFAR will strive to expand point-of-care (POC) coverage and community models for early infant diagnosis (EID) in COP22 to reach 100% of HIV-exposed infants with this essential service, in line with new WHO recommendations on the importance of POC EID.

PEPFAR will support MOH in accreditation of health center (HC) IIs to reach all pregnant and breastfeeding women, beyond the additional 125 sites in COP21. PEPFAR will reach 575 HCIIs in COP22.

National scale up of mentor mother approaches (led by trained, supervised HIV-infected women who are paid $50/month) will be a priority under the COP22 surge.

Using a mix of interventions to improve Pediatric Case finding

INFANTS

- POCT in hard–to-reach areas & high-volume inpatient settings
- Scale up community EID testing through integrated EPI/EID outreaches
- Maternal retesting in late pregnancy and post-partum periods
- Strengthen HEI screening for exposure at PMTCT/MBCPs & Immunization clinics

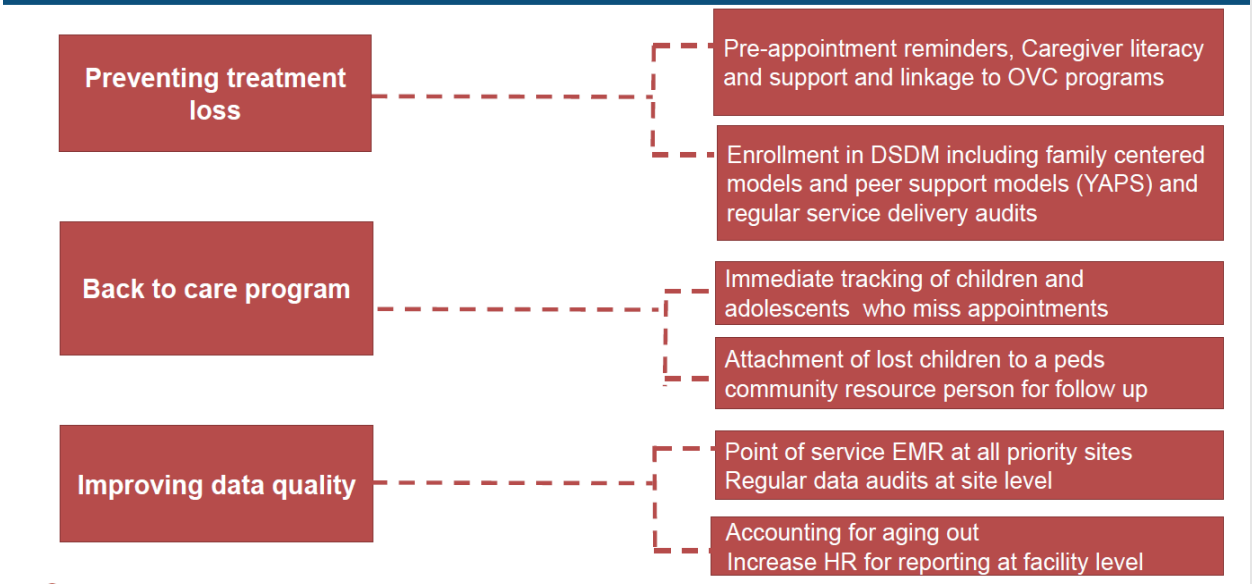
CHILDREN

- Strengthen Index testing for biological children of WLHIV
- Expand Caregiver assisted HIV self testing
- Use lay screeners to administer peds screening tool at 579 priority sites
- PITC at high yield entry points

ADOLESCENTS

- Strengthen index testing for biological children and adolescents of WLHIV & APN
- Expand adolescent HIV Self testing through the YAPS platform
- Expand Social net work testing
- PITC at high yield entry points

Using a multi pronged approach to address structural and patient level barriers to improve CoT in COP 22



VL package for children and adolescents

Infants and Children

- ARV regimen optimization
  - pDTG 10mg transition
- Psychosocial support for adherence
- Caregiver literacy and support
- Linkage to OVC program for psychosocial and economic support
- Attachment of unsuppressed children to community health worker for additional support
- Dedicated Non suppressed clinic days

Adolescents

- ARV regimen optimization
- Peer led psychosocial support for adherence, stigma and disclosure through YAPS model
- Caregiver engagement and support
- Peer led treatment literacy
- Linkage to OVC program for psychosocial and economic support
- Dedicated Non suppressed clinic days

2.3 Investment Profile

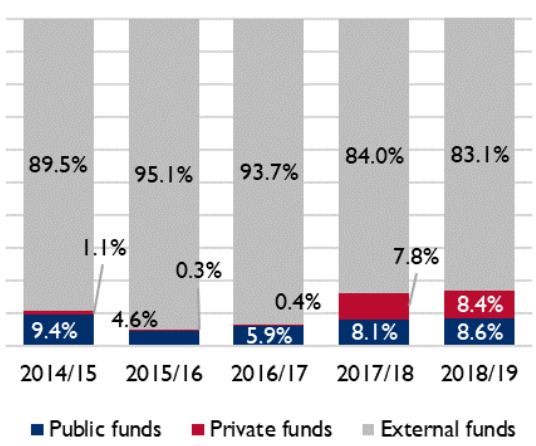
In FY2020/21, Uganda's health sector budget increased by 8% from 2.6 trillion Uganda Schillings (UGX) in FY2019/20 to 2.8 trillion UGX in FY 2020/21 (from about U.S. $739 million to $794 million). As a proportion of the national budget, there was a drop from 7.2% to 6.1% in the same period clearly indicating that the funding of the health sector is not only inadequate but also falling short of the Health Sector Strategic Investment Plan target of 10% and the Abuja target of 15%, to which targets that GOU has committed. This has led to high dependency on external funding not only for HIV/AIDS funding but all other aspects of health. PEPFAR and the Global Fund together accounted for about 97 percent of total HIV spending in FY 2018/19. PEPFAR contributions alone made up about 60 percent of total country HIV expenditure in FY 2018/19. The current HIV funding model, which heavily relies on external sources, is not sustainable. The country needs to explore alternative domestic financing options for HIV and health in general, especially now that overall donor contributions are declining. Stepping up domestic resource mobilization efforts requires concerted efforts by all stakeholders.

While Uganda is approaching HIV epidemic control, there are serious obstacles that may prevent the country from achieving the crucial goal of ending AIDS as a public health challenge. To be on course to end the pandemic by 2025, sustained effort by all stakeholders is required, which should include stepping up domestic resource mobilization efforts for HIV response to slowly fill some of the anticipated funding gaps. The available HIV funding should also be spent on interventions and services that are cost-effective, efficient, and targeted to the populations most in need. The Ministry of Finance, Planning, and Economic Development (MOFPED) introduced dedicated vote output for HIV mainstreaming, which instructs all Ministries, Departments and Agencies (MDAs) to allocate 0.1% of their budget (excluding pension) to the HIV response. This new development should be best used to increase and sustain HIV funding in Uganda.

The GOU has over the years progressively increased funding to the HIV response particularly towards HIV commodities and salaries for human resources for health. However, more needs to be done to use the existing resources effectively and mobilize additional domestic resources.

The graphs below are derived from datasets from the National AIDS Spending Account (NASA) studies undertaken in Uganda between 2014 and 2019 and indicate that external funding sources accounted for an average of about 89 percent of total HIV expenditure during this period.

Figure 1. HIV Expenditure by Financing Source (%) Figure 2. HIV Expenditure by Financing Source (US$ Million)



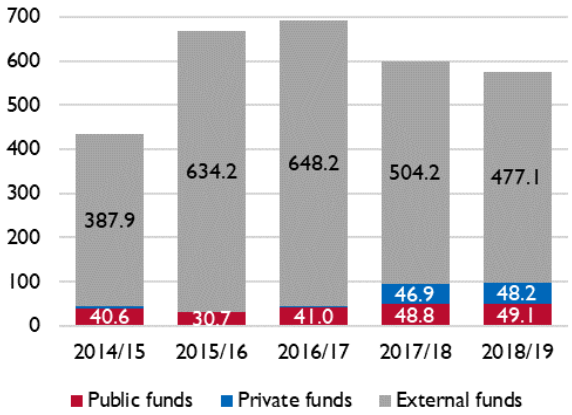
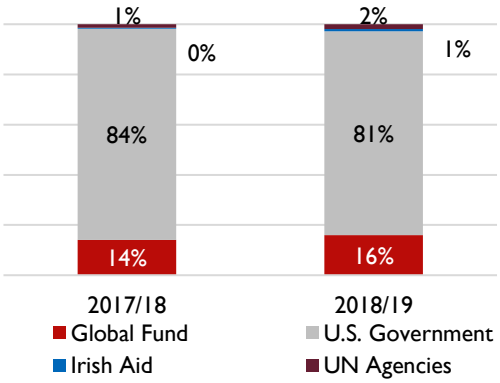


FIGURE 3. HIV Expenditure by International Donors (%)



The U.S. government, through PEPFAR, is the largest financing donor to the national HIV response in Uganda, accounting for about 84 percent and 81 percent of total external HIV resources mobilized in FYs 2017/18 and 2018/19, respectively. The Global Fund is also a critical player contributing 14 percent and 16 percent of total external resources mobilized in FYs 2017/18 and 2018/19, respectively. USG and GF work collaboratively to plan, allocate resources and support the national HIV response.

Standard Table 2.3.1 Investment Profile for HIV Programs, 2022

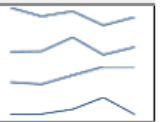
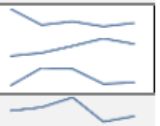
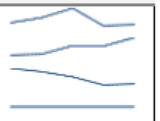
Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2022
Care and Treatment	$301,408,059	0%	34%	66%	0%	
HIV Care and Clinical Services	$235,170,717	0%	43%	57%	0%	
Laboratory Services incl. Treatment Monitoring	$56,572,395	0%	1%	99%	0%	
Care and Treatment (Not Disaggregated)	$9,664,947	0%	0%	100%	0%	
HIV Testing Services	$19,987,496	0%	32%	68%	0%	
Facility-Based Testing	$2,040,697	0%	89%	11%	0%	
Community-Based Testing	$836,511	0%	97%	3%	0%	
HIV Testing Services (Not Disaggregated)	$17,110,288	0%	22%	78%	0%	
Prevention	$68,601,612	0%	7%	93%	0%	
Community mobilization, behavior and norms change	$8,663,167	0%	56%	44%	0%	
Voluntary Medical Male Circumcision	$24,887,912	0%	0%	100%	0%	
Pre-Exposure Prophylaxis	$4,145,375	0%	1%	99%	0%	
Condom and Lubricant Programming	$2,577,822	0%	3%	97%	0%	
Opioid Substitution Therapy	$102,879	0%	0%	100%	0%	
Primary Prevention of HIV & Sexual Violence	$27,194,681	0%	0%	100%	0%	
Prevention (Not Disaggregated)	$1,029,776	0%	4%	96%	0%	
Socio-economic (incl. OVC)	$20,174,092	0%	11%	89%	0%	
Case Management	$15,140,748	0%	0%	100%	0%	
Economic Strengthening	$0					
Education Assistance	$0					
Psychosocial Support	$84,161	0%	50%	50%	0%	
Legal, Human Rights, and Protection	$2,762,511	0%	68%	32%	0%	
Socio-economic (Not Disaggregated)	$2,186,672	0%	14%	86%	0%	
Above Site Programs	$27,991,872	0%	4%	96%	0%	
HRH Systems	$1,463,798	0%	0%	100%	0%	
Institutional Prevention	$0					
Procurement and Supply Chain Management	$2,546,830	0%	0%	100%	0%	
Health Mgmt Info Systems, Surveillance, and Research	$10,265,275	0%	0%	100%	0%	
Laboratory Systems Strengthening	$5,452,553	0%	0%	100%	0%	
Public Financial Management Strengthening	$256,375	0%	0%	100%	0%	
Policy, Planning, Coordination and Management of Disease Ctrl Programs	$5,600,426	0%	21%	79%	0%	
Laws, Regulations and Policy Environment	$685,232	0%	0%	100%	0%	
Above Site Programs (Not Disaggregated)	$1,721,383	0%	0%	100%	0%	
Program Management	$70,038,262	0%	2%	98%	0%	
Implementation Level	$70,038,262	0%	2%	98%	0%	
Total (incl. Commodities)	**$591,152,293**	**14%**	**20%**	**66%**	**0%**	
Commodities Only	**$217,164,040**	**0%**	**50%**	**50%**	**0%**	
% of Total Budget	*37%*					

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Standard Table 2.3.2 Investment Profile for HIV Commodities, 2022

Table S2. Investment Profile (Budget Allocation) for HIV Commodities, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2022
Antiretroviral Drugs	$95,908,350	0%	67%	33%	0%	
Laboratory Supplies and Reagents	$45,993,574	0%	26%	74%	0%	
CD4	$1,946,919	0%	0%	100%	0%	
Viral Load	$21,139,809	0%	0%	100%	0%	
Other Laboratory Supplies and Reagents	$22,906,846	0%	52%	48%	0%	
Laboratory (Not Disaggregated)	$0					
Medicines	$9,661,006	0%	24%	76%	0%	
Essential Medicines	$2,449,773	0%	64%	36%	0%	
Tuberculosis Medicines	$1,892,801	0%	5%	95%	0%	
Other Medicines	$5,318,432	0%	12%	88%	0%	
Consumables	$27,699,583	0%	34%	66%	0%	
Condoms and Lubricants	$1,974,559	0%	1%	99%	0%	
Rapid Test Kits	$20,532,676	0%	45%	55%	0%	
VMMC Kits and Supplies	$5,192,348	0%	0%	100%	0%	
Other Consumables	$0					
Health Equipment	$850,274	0%	0%	100%	0%	
Health Equipment	$568,836	0%	0%	100%	0%	
Service and Maintenance	$281,438	0%	0%	100%	0%	
PSM Costs	$37,051,252	0%	54%	46%	0%	
Total Commodities Only	**$217,164,040**	**0%**	**50%**	**50%**	**0%**	

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Standard Table 2.3.3

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	$13,000,000	$11,000,000	15	$32,930,924	Support programs to improve maternal, neonatal and child health
USAID TB	$7,000,000	$5,190,000	9	$40,666,327	Support programs to reduce TB related mortality and morbidity
USAID Malaria	$34,000,000	$1,364,800	5	$12,529,447	Support programs to reduce malaria associated mortality
Family Planning	$27,000,000	$14,200,000	16	$31,120,467	Support programs to increase contraceptive prevalence and birth spacing
USAID Nutrition	$8,000,000	$5,080,000	9	$27,407,232	Support programs to improve nutrition
USAID COVID-19	$28,500,000	$30,728,221	9	$17,614,228	COVID-19 support
CDC (Global Health Security)	$4,703,318	$4,703,318	6	$60,542,055	Epidemic preparedness and response through support to international health regulations
CDC ARPA (non PEPFAR) planned to be obligated in FY22 + FY22 COVID/CARES	$11,641,532	$11,641,532	14	$88,583,798	COVID-19 support
DOD	$2,914,642	$2,914,642	1	$16,860,555	Supporting infectious diseases surveillance and AMR prevention
Total	**$136,759,492**	**$86,822,513**	**84**	**$328,255,033**	

2.4 National Sustainability Profile Update

1. *Progress addressing sustainability strengths and vulnerabilities previously identified through the Sustainability Index Dashboard (SID) process*

PEPFAR Uganda, jointly with UNAIDS, have been able to facilitate the SID/ responsibility matrix (RM) assessment process in Uganda. No single domain has had a red score over the years. However, out of the RM, Uganda/MOH continue to lag behind in fiscal and functional responsibility for most of the domains. This poses vulnerability risk for long-term sustainability. Out of sustainability concerns, PEPFAR Uganda continues to invest in areas that will address systems barriers particularly in areas of

policy reviews and development, activity-based financing and management that will provide information on unit costs that will make it possible for the MOH to hold budget discussions for increased financing and resource allocation to the health sector, including for HIV. Moreover, the Ministry of Finance Planning and Economic Development (MOFPED) has over the years provided budgetary allocations for the procurement of ARVs and other HIV-related commodities Together with the MOH, MOFPED has been able to mobilize other Ministries, Department and Agencies (MDAs) for the development of a ONE government led development process of a ten (10) year sustainability roadmap for ARVs, supply chain strengthening, and other commodities. It is this process that PEPFAR Uganda will explore as a model for the development of Uganda's sustainability roadmap. PEPFAR will consult widely with civil society, GOU, and other key stakeholders on establishing the process for developing a sustainability roadmap.

The other area in which Uganda/MOH has done very well, is to ensure that the PEPFAR-funded health staff have been absorbed into the GOU payroll systems as a sustainability plan These two areas create a viable entry point for the development of Uganda's sustainability roadmap. The other area/ element that illustrates this level of analysis is in the laboratory sector. The current laboratory program utilizes resources according to the national laboratory policy and strategic plan (SP) for sustainable quality-assured testing within 100 hubs and various levels of laboratory service delivery. Strategies such as HIV and TB diagnostic integration and use of the electronic results return have improved the HIV and TB results turnaround time and built efficiencies at various levels of the laboratory network using existing platform including those for point of care (POC) and conventional polymerase chain reaction (PCR) for multi-disease testing. Despite the highlighted achievements, gaps were identified through the SID 2021 review process. These gaps included inadequate institutional administrative authority and staff to oversee laboratory services, inadequate qualified laboratory personnel at all levels of laboratory service delivery to achieve sustained epidemic control, and limited domestic financing of laboratory diagnostics, among others.

2. *Among those SID elements identified as sustainability vulnerabilities, which will be prioritized in COP22? Is this a change from COP21? Of the elements of programming required to maintain epidemic control, what elements will domestic entities take responsibility for by the end of COP22?*

The laboratory system is one such element whose SID scores dropped across FY 19 (4.61) and FY21 (3.81). To safeguard gains made in laboratory systems strengthening, sustainability strategies are critical. Therefore, PEPFAR Uganda will continue to support the MOH strategy to consolidate laboratory resources through the department of National Health Laboratory and Diagnostic Services (NHLDS) & implementation of the Regional Referral Hospital (RRH) strategy for ownership, accountability, and sustainability.

3. *To date and since COP21, have PEPFAR and/or other donors (e.g., Global Fund) increased, decreased, or maintained their investment in these areas? If so, how? Country teams can refer to their HIV Resource Alignment country profile.*

   PEPFAR Uganda working with the MOH will support development and implementation of cost recovery strategies to sustain gains made in strengthening the laboratory network; and will advocate for increased GOU funding for laboratory services, laboratorians (both in skills and numbers), better infrastructure and adequate testing supplies and commodities, and thus address system barriers that were identified under the laboratory SID score. In addition, COP22 investments laboratory service investments will continue to address laboratory information system (LIS) interconnectivity with POC platforms; triangulation of data from the LIS, DHIS-2, and the Uganda national dashboard for real-time HIV and TB data capture, transmission, and analysis. An efficient integrated sample transport network and tracking system remains a major component for access to quality-assured HIV and TB testing services, which will fit into the country's national Diagnostic Network Optimization processes for epidemic control.

   PEPFAR HRH investments at the national level was generally maintained across most HRH priority areas including policy support for restructuring, HRH performance and data management systems, HR capacity building and e-learning roll out. Additional funding was allocated to support the CHEWS pilot to generate evidence to inform the institutionalization of community health worker cadre. At the sub-national level, the investment in PEPFAR seconded staff was maintained to continue supporting the priority cadres that provide HIV services at site level. The HRH investment by implementing partners slightly increased due to additional staff recruitment and alignment of remuneration of CHWs pay to minimum of $50 per month. The Global Fund HRH investment has remained minimal and focused at the national level.

4. *Transition to indigenous partners*

   Over the years, PEPFAR Uganda has empowered and developed local capacity for the implementation of its supported programs. For example, more than 75% partners in Uganda are indigenous (local) partners that will contribute to the improved local capacity to maintain and sustain the current program level of performance and quality assurance, engagement with district local teams that ensures harmonized implementation and a transition avenue for sustainability.

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 2020 UPHIA and routine program data, as well as the historic Spectrum and new estimates. Figure 2.5.1 displays PLHIV, treatment coverage, and viral load suppression by district.

Figure 2.5.1 Total PLHIV by SNU, Coverage of Total PLHIV with ART, and Viral Load Coverage by SNU.

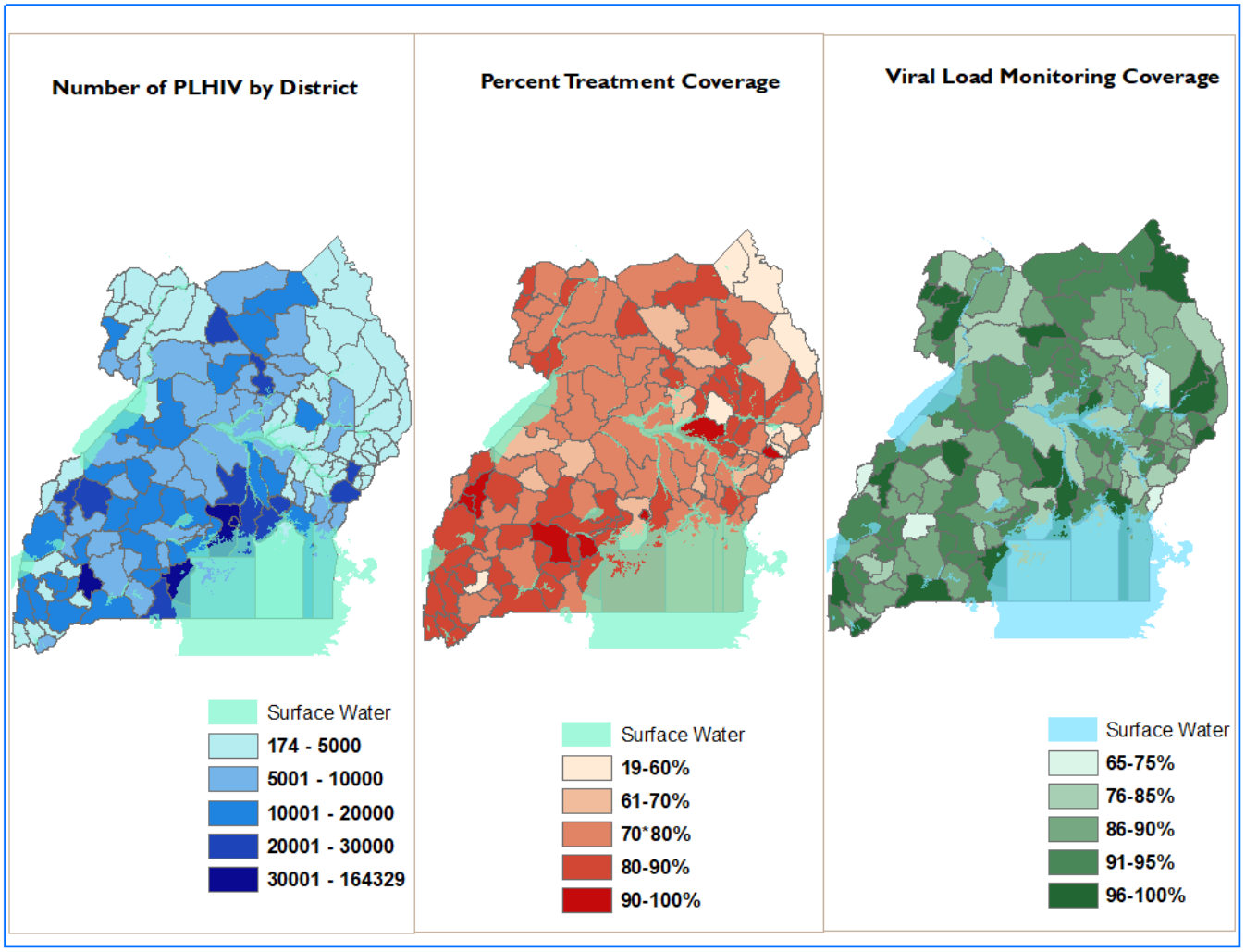
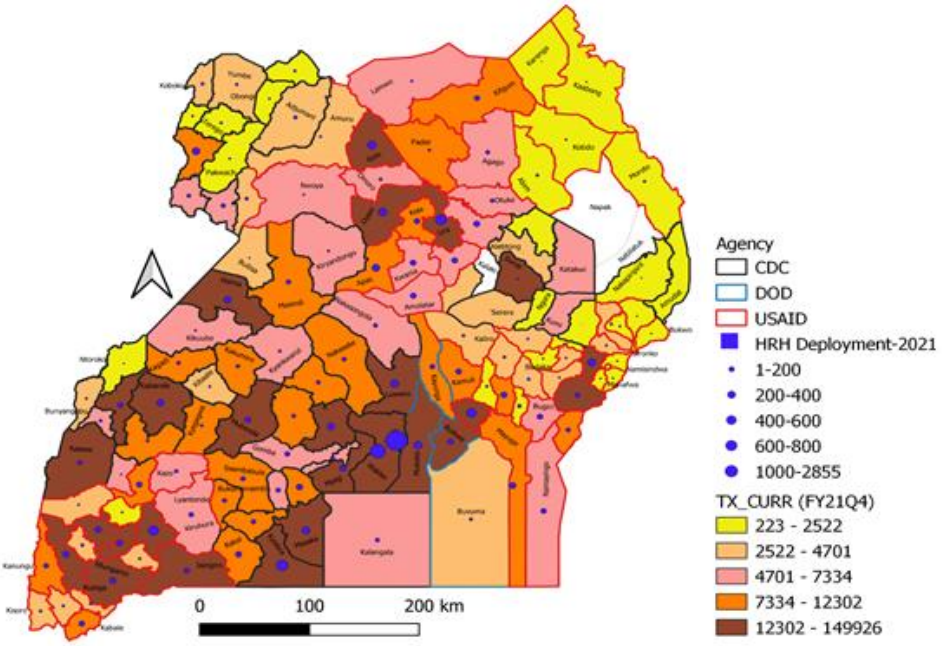


Figure 2.5.2; Alignment of HRH to disease burden



Generally, the HRH investment is aligned to the disease burden with high HRH deployment to areas of high HIV burden to ensure that PEPFAR targets are met, and clients receive comprehensive quality HIV/TB services.

2.6 Stakeholder Engagement

For an effective transformation of the program, PEPFAR Uganda teams have recognized the need to continue focusing on how systems work both formally and informally, working in concert with partner governments and communities. Understanding a diverse set of country context variables, like institutional culture, constitutional tradition, or civil service structures, as a necessity to consider in developing a sustainable response. The program is under Chief of Mission (COM) authority, but there are many layers.

Ambassador and the interagency team collaborate with multiple stakeholders across the GOU, civil society, and development partners. Across multiple ministries including Health, Gender, and Finance, PEPFAR works with the government to advance policies and implement programs. Civil society encompasses PLHIV-led, KP-led, faith-based, and other groups of affected persons and includes CLM partners. Global Fund, relevant UN partners, and other bilateral development partners are consulted to ensure HIV, TB and other health programs work in harmony without duplication of effort.

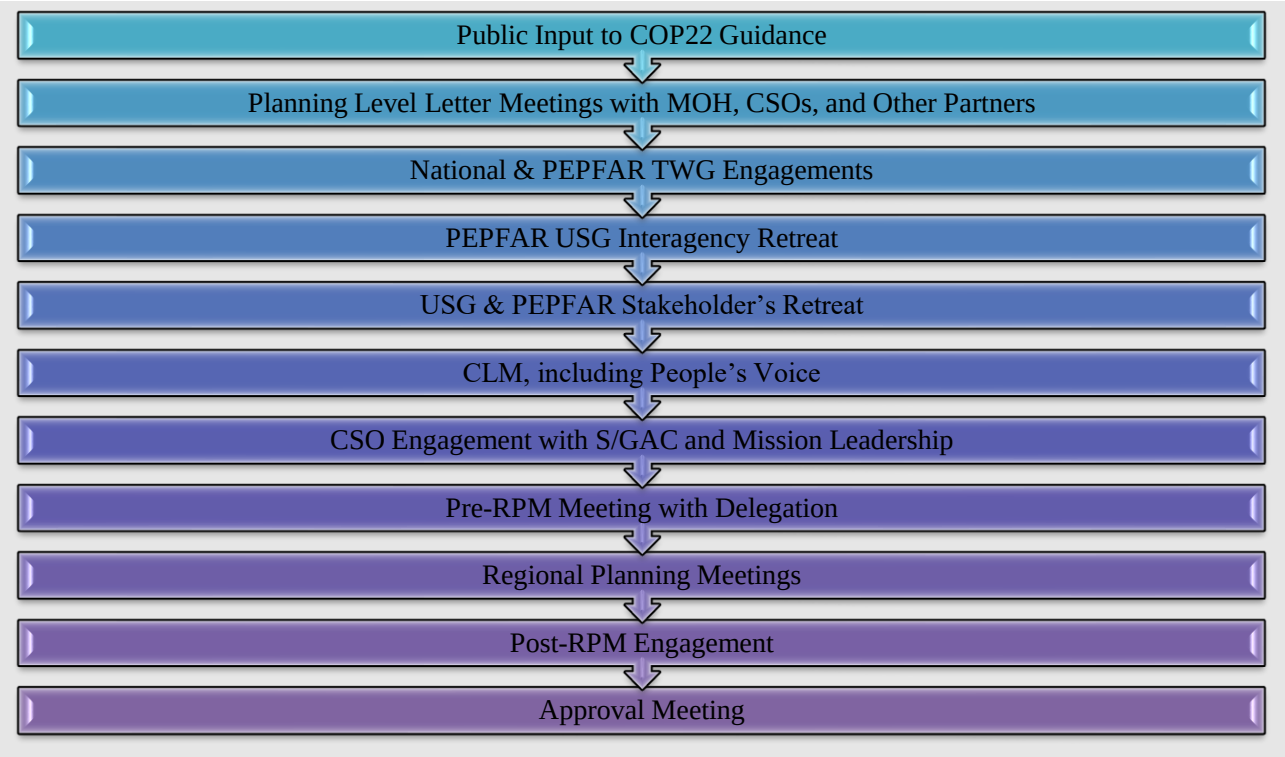
PEPFAR Uganda engages with a range of local, national, and international civil society organizations. CLM is an important aspect of stakeholder engagement and coordinated by civil society organizations. CLM has illuminated the experiences of people seeking prevention, care, and treatment services through qualitative data collection. The CLM team conducted quantitative and qualitative data collection activities based on data reported by implementing partners and shared by PEPFAR Uganda; this has confirmed areas needing improvement and supplemented PEPFAR data with additional information to identify root issues. CLM recommends priorities for PEPFAR Uganda and facility, district, regional, and other leaders have informed COP22 priorities to address gaps and improve person-centered care.

As PEPFAR initiated the inclusive COP process for 2022, OGAC hosted a Government-to-Government Leadership Consultation that involved six countries (Botswana, Eswatini, Kenya, Lesotho, Namibia, and Uganda) who have made tremendous progress and are poised to begin the journey of sustaining HIV impact. This consultation included PEPFAR HQ leaders, in-country PEPFAR USG leadership and main government interlocutors in the Chief Executive's Office, the MOH, Uganda AIDS Commission, MOFPED and other related ministries. The leadership consultation on sustaining HIV response impact was intended to develop a shared vision and expectations as PEPFAR begins developing a Roadmap for Sustaining Impact. Throughout COP22 discussions, PEPFAR systems and HRH support across the platform and at various working levels, including site-level and above-site activities at community and regional levels, were reviewed with a sustainability lens.

With consideration of the current COP priorities, PEPFAR Uganda has begun planning for inclusive discussions to develop a multi-year roadmap for achieving and sustaining epidemic control. Some of the considerations for discussion include definitions, stakeholders, roles and responsibilities, time horizon, goals and objectives, guiding principles and values, assumptions, disparities and challenges, and how to monitor and adjust course.

For COP22 planning and implementation, PEPFAR maintained the active and expanded engagements of stakeholders in all aspects. At a planning level, PEPFAR Uganda conducted an in-country strategic planning consultation with local stakeholders by the end of January 2022. The retreat introduced and discussed all COP22 tools, guidance, results, and targets, as well as the proposed trajectory and strategy for COP22. Even after COP22 submission, the engagements will continue. Figure 2.6.1 highlights how PEPFAR Uganda will continue to expand meaningful engagements with partners. The COP22 development process involved frequent engagements with multiple stakeholders, particularly the Government of Uganda and civil society. This included calls for public input to COP22 Guidance, internal and external stakeholder retreats, and frequent engagement with the CLM team and other civil society representatives. Table 2.6.2 below provides a summary of engagements and as well highlights planned engagement for COP22 implementation.

Figure 2.6.1 PEPFAR Uganda Partner Framework



1. GOU COP22 Engagements

PEPFAR Uganda's vision includes partnering with and providing technical assistance to Uganda's line ministries, implementing partners, and community stakeholders to ensure resiliency and sustainability of Uganda's healthcare system for the delivery of person-centered services towards sustainable control of HIV, TB, and other public health threats. PEPFAR is commitment to the: 1) Development of the multi-sectoral 10-year HIV sustainability roadmap; 2) Alignment of PEPFAR contributions and national priorities and investments; Regional approach linking facilities and districts to Regional Referral Hospitals; and strategic investments in data, laboratory systems, leadership and governance of the HIV response, as well as equity and protection of Key and Vulnerable Populations.

PEPFAR is committed to continually strengthening its partnership with host-country governments to ensure alignment between PEPFAR contributions and national priorities and investments. PEPFAR Uganda will continue to engage political leadership through the Office of the President, Office of the Prime Minister (OPM), Office of the First Lady (OFLA), Ministry of Finance Planning and Economic Development (MOFPED), MOH, Ministry of Public Service (MOPS), Ministry of Gender Labour and Social Development (MGLSD), Ministry of Local Government (MOLG), Ministry of Education and Sports (MOES) and Uganda AIDS Commission (UAC). Key areas of engagement at the political, policy, and technical levels include domestic financing for health and the HIV response, supply chain management, HRH (facility and community level cadres), data and laboratory systems, leadership and governance, and the protection of human rights.

Meaningful engagement continued during COP22 finalization, approval, and implementation. PEFPAR Uganda will share the final COP22 content and implementation strategy during the PEPFAR Stakeholder Meetings. 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.

COP22 implementation will increasingly strengthen approaches that transition leadership and financing of the national program to the GOU and local partners as a strategy to realize one of the COP Minimum Program Requirements (MPR). Undertaking greater financial responsibility for the HIV response is a core component of PEPFAR's Sustainability Framework. Diverse stakeholder engagements will be critical and meaningful as the GOU assumes greater functional leadership of the HIV response; the sustainability of which will rely heavily on GOU investment in health, and civil society partners to advocate for the health needs of their constituents. PEPFAR will continue to support capacity of local civil society organizations to meet this challenge, better preparing them to play a leadership role now and in the future.

2. Global Fund, private sector, and other external donors

Multilateral partners, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS, WHO, the United Nations Children's Fund (UNICEF), the World Bank, and others, play a critical role in supporting our mutual goal of HIV epidemic control. Often, they 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.

PEPFAR Uganda worked collaboratively with Global Fund to optimize synergies and leveraging of resources. Uganda received US $602,501,930 for grants for the 3 diseases HIV, Tuberculosis and Malaria from 2021 to 2023 ($339,476,980 allocated to HIV & Tuberculosis and $263,024,950 allocated to Malaria). In addition to the $184,587,547m C19RM grant that was received during COP21 planning, during COP22 planning period, Uganda received additional C19RM worth $28,950,097 through 2023. Additional funding is expected primarily for procurement of COVID-19 diagnostic tests and oxygen support (targeting gaps in oxygen health products identified by in-country assessments and operational plans).

There is continued collaboration with PEPFAR, President's Malaria Initiative (PMI), and other USG health programs to align resource allocations and service delivery to ensure efficiency gains for the HIV, TB, Malaria, and COVID-19 responses. As in years past, PEPFAR in COP22 will utilize other opportunities for broader engagement.

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 GF 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. In COP21, PEPFAR planned to shift the Global Fund Liaison to the PEPFAR Coordination Office, and this role has been filled. PEPFAR Uganda continued engagements with the Geneva based Fund Portfolio Manager to align priorities. The Portfolio Manager was actively engaged in planning efforts and provided an update on the GF grant at the Regional Planning Meeting, which helped to solidify coordination efforts.

3. Civil Society/Community

PEPFAR has engaged CSOs primarily through the self-organized civil society platform, represented by the Coalition of Health Promotion and Social Development (HEPS Uganda), International Community of Women Living with HIV—East Africa (ICWEA) and Sexual Minorities of Uganda (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.

Communities of people living with HIV (PLHIV), key and vulnerable populations, and CSOs and FBOs continue in 2022 their longstanding commitment to meaningfully engaging with PEPFAR's Country Operational Planning (COP) processes. This commitment started in 2012, a time when there were no minimum standards for the involvement of PLHIV, key and vulnearable populations (KVPs) and CSOs in COP planning. Under the leadership of Coalition Coordinators, 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), communities in Uganda have released this, the fourth edition of "The People's Voice (PV22)."

PEPFAR Uganda engages with a range of local, national, and international civil society organizations through the CSO engagement spaces and CLM purposed engagements. CLM is coordinated through the ICWEA, SMUG AND HEPS Uganda.

CLM illuminates the experiences of people seeking prevention, care, and treatment services through qualitative data collection, conducts quantitative and qualitative data collection activities based on data reported by implementing partners and shared by PEPFAR Uganda; this has confirmed areas needing improvement, recommends priorities for PEPFAR Uganda to address gaps and improve person-centered care and has enabled engagements of facility, district, regional, and other leaders to improve person-centered care. This shall continue through COP22.

As in earlier editions, the People's Voice 2022 (PV22) describes the recommendations and priorities from PLHIV, KVPs and CSOs. These recommendations are built on PEPFAR's existing promises from COP21 as well as areas where PEPFAR did not address community demands in COP21. The People's Voice was developed using the following process: CLM in

health facilities took place during Quarter 3 of 2021 and during Quarter 1 of 2022; data from monitoring informed the People's Voice priorities. (See Table below summarizing the PEPFAR and CSOs agreed upon policy and programmatic actions and priorities for COP22).

Table 2.6.1 PEPFAR and CSOs agreed upon policy and programmatic actions and priorities for COP22

AREA	What does the evidence show (issues)?	PEOPLE'S COP22 PRIORITIES/ASKS	USG/PEPFAR Comment
COP22 Guidance	**What's New in COP22** We do recognize PEPFAR's efforts towards epidemic control with the new areas listed below. • Emphasis being put on Completing the Mission (95/95/95), Building Enduring capabilities and Building Lasting Collaborations. COP22 shifts language from 'client-centred' to 'person-centred." • Quality Assurance (SIMS) updated to better translate Minimum Program Requirements into site standards Testing guidance is updated, • Technical Considerations updated to include (Approach to CD4 testing revised to allow identification and improve management of advanced HIV disease; Intensified TB case finding among PLHIV; Updated cervical cancer screening and treatment guidelines and algorithm; Key Populations Approach and Strategy consolidated and updated; New Gender Equality section and added guidance on clinical enquiry for Gender Based Violence and Violence Against Children and Behavioural health content reorganized into two sections (Mental Illness and Psychosocial Support))	• Equity being added to Accountability, Transparency, and Impact as a guiding pillar for PEPFAR and a key theme for COP22. • Minimum Program Requirements updated to demonstrate progress in equity, stigma, discrimination, and human rights, to add KP-led and women-led organizations among local partners, and to include infection prevention and control activities • highlighting the need for a strategic mix of testing modalities that adapts as countries approach treatment saturation and takes into account positivity rate, cost, number of positives, and epidemiologic impact. • Sustainability Guidance updated as more countries are at or near 95/95/95 benchmarks, underscoring PEPFAR's need to move toward a vision for sustained epidemic control.	**Agree:** • The COP 2022 vision is to advance sustainable epidemic control of HIV by supporting equitable health services and solutions, enduring national health systems and capability, and lasting collaborations. As stated, Equity has been added as a guiding pillar for PEPFAR and a key theme for COP22. • The COP22 updated minimum program requirements (MPRs) are a true reflection marking progress in stigma, discrimination, and human rights work; PEPFAR added KP-led and women-led organization among local partners; and includes infection prevention and control activities with QA and CQI functions. • Testing guidance is updated, highlighting the need for a strategic mix of testing modalities. This is especially important for Uganda in order to respond to UPHIA results. Case finding for undiagnosed children living with HIV is a high priority requiring specific planning and investment. **Additionally:** • PEPFAR Uganda will share this document with the Office of the Global AIDS Coordinator and Health Diplomacy for consideration in COP23 Guidance. • We encourage CSOs and Community Led Monitoring (CLM) colleagues to submit recommendations for the COP Guidance when the draft is available for public comment (ca. November 2022).

AREA	What does the evidence show (issues)?	PEOPLE'S COP22 PRIORITIES/ASKS	USG/PEPFAR Comment
COP22 PLL	**Our observations on the New Technical Areas/additions in COP22** • Whereas we resonate with the proposed new strategic shifts to reach epidemic control, we are concerned about the persistent treatment and viral load suppression gaps among children and young people.	• Preliminary UPHIA2020 analysis shows there is still a long way to go in reaching all people PLHIV • With an estimated 46% of the Ugandan population under the age of 15, there is need to ensure high coverage of HIV prevention interventions to sustain control of the epidemic. • Incidents of human rights violations, stigma, and discrimination, coupled with shrinking civil society space in political discourse are still of concern. • Focused programming to facilitate equitable access to health services for key and priority populations is essential to reaching and sustaining epidemic control.	**Agree:** • The planning level letter included several achievements and noted challenges as well. As we evolve the program to address the needs of a mature epidemic and sustainable epidemic control, several priorities were identified including prevention for the young population of Uganda will be essential; acknowledgement that the political and social environment, and incidents of human rights violations this year, impact equitable access to health services for key and priority populations; and Legal Environment Assessment findings should be used to address identified barriers. These priorities have guided our development of the COP22 budget and targets. • As mentioned in several places in this document, PEPFAR is providing funding for CLM and KP- and women- led CSOs to identify and address human rights violations, stigma, discrimination, and advocacy efforts and political discourse. • Throughout COP22 development, PEPFAR is utilizing the UPHIA 2020 incidence data to identify high risk groups and consider targeting tailored demand generation efforts.

AREA	What does the evidence show (issues)?	PEOPLE'S COP22 PRIORITIES/ASKS	USG/PEPFAR Comment
COVID-19 and access to HIV Services	**Key Issues:** • The COVID-19 pandemic and the 2- year long lockdown resulted in closure of schools and the economy which in effect brought about issues of teenage pregnancies and new HIV infections. • Many clients were lost to follow due to COVID-19 lockdown and closure of public transport. Investment in community network initiative to aid recovery of such clients would go a long in restoration of accessibility to HIV/TB services.	• PEPFAR should use COP21 and COP22 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 should fund effective community COVID-19 adaptations so that they can be taken to scale nationally. • PEPFAR to invest in community recovery initiatives from the effects of COVID-19 and community resilience to pandemics • Global VAX country plans for Uganda should be developed with meaningful community engagement and accountability, and ongoing PEPFAR coordination	**Agree:** • COVID recovery interventions identified for ARPA funding in COP21 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 work with the Ministry of Health to invest in intensified back-to-care efforts. 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.
Access to and Retention on PrEP	We agree that PEPFAR Uganda made significant strides in scaling up PrEP among high-risk populations, overachieving PrEP targets. CLM/CSOs have been involved in the PrEP mass communications preparation processes by SBCA programme. However, CLM data shows that the following gaps exist in access to and retention on PrEP: • PrEP packaging has not been embraced by KVPs and	**1)**PrEP should be rolled out across the country as a national program, using 250 existing PrEP facilities as a hub-and-spoke model linking to communities demanding services. Adaptations already tested in Uganda such as same-day PrEP initiation, outreach-based initiation, and use of HIV self-testing (HIVST) should be scaled up nationwide. **2)**Fund community-led PrEP demand creation, and service delivery outreach programs, that rely on community health workers building	**Agree:** • Provisions have been made for long-acting cabotegravir and event-driven PrEP in COP22, both as demonstration projects as the products become available. DICs are being expanded to increase PrEP community access. • The number of sites has increased from 250 in COP21 to 263 in COP 22 based on Geographical locations and populations with High Incidence • PEPFAR is supporting the MOH review and update of the PrEP Guidelines on PrEP, including use of HIV self-testing and new biomedical

AREA	What does the evidence show (issues)?	PEOPLE'S COP22 PRIORITIES/ASKS	USG/PEPFAR Comment
	AGYW and this affects uptake and retention. • PrEP has not been fully embraced for PBFMs and AGYW as was adopted by WHO recommendation. This is attributed to limited information given to PBFMs and AGYW.	PrEP literacy among communities and health workers, and immediately link people with screening and same-day initiation. 3)COP22 TARGET: PEPFAR should fast track implementation of new WHO Guidance on Simplified PrEP Implementation. COP22 TARGET: PrEP delivery should be AGWY- and KP-led, simplified, with minimal testing barriers. Fast track rollout of event driven PrEP and DSD for PrEP, using HIVST to ensure testing does not create a barrier to PrEP roll out. 4) 5)PEPFAR to make provision for the new WHO Simplified PrEP implementation guidance. 6)PEPFAR should support MOH to revise the guidelines 7)FastTrack rollout of event driven PrEP and new PrEP products and DSDM for PrEP 8)PrEP is only available at 250 sites nationwide; it must be a national program **Rationale:** PrEP remains one of women-controlled HIV prevention tools available in the country but access and retention among the intended population is low; amidst the ever-increasing new HIV infections	interventions such as cabotegravir, Dapivirine Vaginal Ring, and event-based PrEP.
Availability, Access to and Utilization of the Dipivefrine Ring & CAB LA	**Community evidence/voices** • The Dapivirine Vaginal Ring has not been rolled out as a National Program.	PEPFAR should support the development of guidelines, procurement of and roll out of DVR as part of a package of comprehensive primary prevention services. COP22 TARGET: PEPFAR	COP22 includes provision for demonstration projects of event driven PrEP and long acting cabotegravir, as the product becomes available.

AREA	What does the evidence show (issues)?	PEOPLE'S COP22 PRIORITIES/ASKS	USG/PEPFAR Comment
	• Long acting cabotegravir has superior protection compared with both oral PrEP and DVR • There are gaps in information dissemination and educating AGYW to make an informed choice about the benefits and potential risks when considering using the DVR. Access to the DVR ring has an age limit of 18 years and above, yet new HIV infections among those less than 18 years and the high teenage pregnancies among those less than 18 years shows there is an increased risk and the need to lower age limit to 15 years.	should support women's access to comprehensive information about the DVR in order to make an informed choice and to create demand. PEPFAR should invest in updating the current national guidelines to include the DVR as another HIV prevention option. PEPFAR should support Government of Uganda to accelerate the approval process and roll out of DVR and CAB LA as an HIV prevention tool targeting AGYW **Rationale:** The Dapivirine Vaginal Ring is included on the WHO's Prequalification list of medicines. The recommendations for the DVR are based on evidence that women are at a higher risk of HIV and equally lack HIV prevention tools	In COP21, a Dapivirine Vaginal Ring readiness project will be completed. In COP22, a Dapivirine Vaginal Ring pilot project in public health facilities is planned pending National Drug Authority approval and S/GAC concurrence.

AREA	What does the evidence show (issues)?	PEOPLE'S COP22 PRIORITIES/ASKS	USG/PEPFAR Comment
Early Infant Diagnosis, pediatrics, CLHIV <15, Treatment and prevention for pregnant and breastfeeding women	**Community voices:** • While EID (0-2mos) coverage improvement from 68% (FY20 Q4) to 86% (FY21 Q4) TAT is still extremely low and outcomes for HEI at the end of breastfeeding are still largely unknown. • In line with the PLL commitment on case finding for undiagnosed children living with HIV as a high priority requiring specific planning and investment. We ask PEPFAR to invest in community led (peer-mother) community bleeding sample for especially 2nd and 3rd PCR	• PEPFAR to further expand its PoC Coverage and Strengthen community models for the Early Infant Diagnosis (EID). 45:55 split proposed for COP22 should be reconsidered, given overwhelming evidence of benefit of PoC EID. Prioritize accreditation of HCIIs to provide ART refills as already committed to in COP20 and COP21 Further scale up of mentor mother program so all PEPFAR supported sites prioritize preventing interruptions in treatment for mother baby pairs	• We agree that there is overwhelming evidence on the benefit of POC EID. • Ten new GeneXpert machines procured by Global Fund will increase capacity for POC EID at RRHs. • We will also scale up POC EID to sites identified in a February 2021 assessment as suitable for multiplexing. • In COP22, PEPFAR and MOH goal is to increase EID testing to 45:55 split vs conventional testing. This is an increase from COP21 targets (40:60 split). In COP21, we are addressing the inherent implementation challenges around uptake, utilization, and data management. In addition, we will ensure commodity availability and effective Laboratory Management Information systems for EID POC data at all supported sites. • We will monitor the implementation progress, while striving to achieve a balance between expediency of viral load results for pregnant and breastfeeding women with the need for low level viremia monitoring and response. • In COP22, PEPFAR will continue to support the functionalization of high-volume ANC HCII to provide comprehensive, person-centered PMTCT/EID services; we will expand coverage from 250 HCIIs in COP21 to 575 HCIIs in COP22. • • PEPFAR will further scale up mentor mother program for all PEPFAR supported sites, including community PMTCT/EID service delivery.

AREA	What does the evidence show (issues)?	PEOPLE'S COP22 PRIORITIES/ASKS	USG/PEPFAR Comment
Retention in care and Loss to Follow up	**Community evidence:** ● Continued interruptions in care and treatment services due to unfavorable community level environment. ● The social support groups at community and health facility either are reduced or collapsed yet they had a great contribution on retention in care. ● Follow up is irregularly happening because either community linkage facilitators/CHWs are few or not well motivated - with some clients giving wrong contact information ● There are no clear mechanisms to track clients who relocate; mobile clients (especially traders, KPs and armed forces). ● CLM data shows that up to 68% of CHWs don't have tools to support them in follow up.	PEPFAR should support full (100%) functionality of support groups and other working models that promote retention in care. PEPFAR should expand and fully functionalize adherence support groups and all other community led DSD approaches that promote retention in care. Ensure all IPs are uniformly implementing the requirement that CHWs be paid a minimum of $50/month, in full for CHWs including YAPs and mentor mothers. PEPFAR should accelerate efforts to provide 6-month ART refills. **Rationale**: Retention in care for the general population has over the years improved and appreciate efforts by PEPFAR and its agencies; however, data for certain cohorts especially KVPs and young people is alarming! Whereas we have many new infections among AGYW and KPs, their retention in care is poor	**Agree:** • PEPFAR will continue to work with GOU to support CSO and health facilities to trace and bring back all clients who experience treatment interruption. • COP22 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. • We are closely tracking return to treatment (RTT) as a key performance indicator and will continue to incorporate program adaptations as needs arise. Return-to-care efforts are ongoing with the involvement of peer supporters and community human resources with standardized remuneration as agreed in COP20. • We will continue intensive partner management and oversight to ensure accountability and agreed interventions are implemented at scale. This focus on accountability and transparency will ensure 100% of PEPFAR-supported community resource persons and groups are functional and adequately supported.

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Assisted Partner Notification/Index Testing and the resulting challenges	**Findings from our monitoring** indicate that there was an improvement in APN practices during monitoring. For example, we saw an increase in the number of clients that mentioned that health workers clearly asked them for their partners' names and highlighted that they were meant to contact them to undertake an HIV test from 75% to 87% over a period of 6 months. **Issues identified** ● Forced Index testing is especially for pregnant mothers who are required to test alongside their partners. This affects uptake and quality of index testing since most partners are not willing to escort their wives and some pregnant mothers share false information, etc. for fear of disclosing status. ● Non-disclosure of status to partners by the HIV positive partner due to stigma which hinders the uptake and access to APN and index testing services ● Clients who have experienced violence from one or more of their partners do not share contact information for HIV testing.	Strengthen remedial service delivery for victims of violence	The GBV Quality Assessment tool has been rolled out and will support the strengthening of GBV services. District Action Centers have also been supported in DREAMS districts and will provide a minimum package of services including legal aid. In addition to existing systems, the MOH in collaboration with stakeholders is working on an expanded monitoring system to ensure negative outcomes from index testing including intimate partner violence are promptly identified, documented and victims provided appropriate support. This system once rolled out will strengthen remedial service delivery for victims of violence and other negative outcomes.

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Treatment Literacy	We appreciate PEPFAR for prioritizing treatment literacy in COP21 to receive support from USAID/CSSA, $272,000 (Feb 2022-Jan 2023) to Pilot in 10 districts; West Nile (Zombo, Nebbi, Yumbe, Moyo, Koboko) and Acholi (Amuru, Gulu, Kitgum, Lamwo and Agago), 4 facilities per district A multi-stakeholder designed program by CSSA, MOH, USAID/SBCA, USAID, PEPFAR, member networks and CSOs, Key approach is peer to peer support at facility and community level, target being children and young people, newly enrolled, unstable and those aging with HIV. ● CLM data shows that most PLHIV can neither explain which treatment regimens they are taking nor understand why they are switched to other lines which causes interruption in treatment.	PEPFAR should Roll out a national PLHIV led treatment literacy to reach all regions and at 100% of the ART centers PEPFAR to fully scale-up the PLHIV led progamme in the entire country. **Treatment illiteracy**: We agree with PEPFAR that the national CQI Collaborative sub-groups updated and disseminated treatment guidelines and literacy materials, with ongoing mentoring and education efforts to improve practice.	**Agree** PEPFAR continues to invest in treatment literacy in COP21 and appreciates the CSOs active involvement in the working group meetings and development of messaging and materials. The pilot in 10 districts implemented by member networks started in February 2022. Collectively, we will use the lessons learned to inform the scale-up and implementation coverage. In addition, all PEPFAR treatment partners will sustain ongoing support for treatment literacy through training and mentorship of the health service providers, community platforms and through supported peer networks. PEPFAR has committed to a level funding like COP21 for this initiative. Ten of the pilot districts fall within the 55 districts that contributed 80% of IIT burden at FY 22 Q1. Together with CSOs, PEPFAR will monitor the number of districts contributing 80% of IIT every quarter, with the aim to reduce this number as we scale up IIT mitigation measures and back to care initiatives. By end of September 2022, all stakeholders will participate in selection of the districts to target in COP22.

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TB Services Integration	**Key issues identified** • CLM findings show 61.3% of PLHIV knew they were screened for TB symptoms (15.7% - sometimes they are asked, 18.4% not asked – 4.6% don't know), furthermore, our findings show less than half (41%, 154/372) of the facilities had coughing corners, which increases the risk of TB transmission among clients attending facilities that do not have coughing corners. Additionally, the majority (43%, 159/372) of the clinics did not have any IEC materials for TB prevention; for example, those telling people to cover their mouths when coughing or sneezing. • TB management registers including TB contact tracing registers for most of Ankole and Kigezi Districts are not fully updated and health workers gave reasons for this scenario i.e., too many registers amidst fewer staff, limited knowledge on tools update and use of DHIS2 • Limited facilitation for health workers to conduct contact tracing – only initial visits are conducted for less than 30% of the targeted index clients and TB yield (case detection is very low compared to the national target) • Persistent IPT stockouts, clients give wrong contact	PEPFAR should allocate resources towards increasing human resources to manage TB; full rollout of 3HP & introduction of 1HP as TPT, 100% TB screening, testing and documentation and 100% contact tracing for all index clients **Rationale**: PLWHA are up to 21 times more likely to develop TB disease than HIV negative people. Children and adolescents are up to 10 times more likely to contract TB also. TB Preventive Therapy (TPT) reduces TB risk among PLWHA. WHO recommends that all PLWHA who do not have active TB disease receive TPT.	**Agree:** • PEPFAR will continue to work with GOU to prioritize appropriate health sector HRH coverage, staffing and capacity building for TB service delivery as well as proper documentation and reporting • PEPFAR will continue working with MOH to scale up 3HP, which started in COP21 • COP22 funds will be provided for contact tracing by both health care workers and Community Resource persons • PEPFAR continues to invest in treatment and TPT literacy in COP22 and appreciates the CSOs active involvement in the working group meetings and development of messaging and materials. **Disagree:** • The unmet need for TPT was 10.2% by Jan 2022. • The TPT completion from site level monitoring engagements show high TPT completion levels although there are still data gaps in some facilities. PEPFAR will focus efforts on TPT data accuracy and completeness to address these gaps. PEPFAR, in collaboration with MOH and partners, will focus on closing the remaining TPT gaps in 2022 through a surge approach and support integration of TPT in routine care. Key interventions will include line listing PLHIV that have not yet received TPT, CQI integration, ensuring commodity security and improving client TPT literacy as well as addressing stigma and discrimination

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	information because of rampant community level stigma and discrimination • Low completion rates for IPT because clients are given limited and/or no information on the importance of taking IPT, PEPFAR Planning Letter (pg. 10) indicates that 92% of PLHIV had completed TPT but this is not reflected in the TPT registers		

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ADVANCED HIV DISEASE (AHD)	**COP/ROP22 Guidance for All PEPFAR Supported Countries page 369;** PEPFAR does not envision immediate wide-spread scale up of CD4 testing, rather prioritization of testing in places that provide care for individuals with advanced HIV disease with a view to implementing a hub and spoke model of care. CLM data/information indicates that some clients with AHD are referred to private health service provide for the related services, but the economic status of some clients does not allow them to access the services. • Prioritization of testing in places that provide care for individuals with advanced HIV disease - might mean that clients will have to travel long distances before getting the necessary care - which in one way or the other might be unaffordable. **Rationale:** Despite expanded access to HIV testing and antiretroviral therapy (ART), a significant portion of people living with HIV and AIDS (PLWHA) are still suffering and dying of AIDS-related illnesses every year. **Tuberculosis (TB) & cryptococcal meningitis (CM)** are the other leading cause of HIV-related deaths, mainly driven by the lack of timely diagnosis and trea-	1. Strengthen Identification of people with advanced HIV disease through Increased coverage and utilization for AHD diagnostics specifically CD4 testing and PoC CRAG testing and introduce point-of-care platform for CD4 test kits. 2. Scale up use of recommended Cryptococci treatment regimen including Liposomal 3. amphotericin B, 5FC and Fluconazole beyond the 52 hospitals where it is currently rolled out 4. Recommend through COP22 ensure procurement, training and provision of L-AmB or amphotericin B deoxycholate (AmB) for all facilities that currently provide infusions and flucytosine and fluconazole for maintenance oral treatment. 5. Scale-up use of combination therapy of Liposomal Amphotericin B (L-AmB), flucytosine, fluconazole to treat cryptococcal meningitis: 6. Prioritize facilitation of CHWs to do follow-ups, For those with advanced HIV disease, more intensive follow-up and a package of interventions could reduce morbidity and mortality in this vulnerable group 7. Share detailed information on CM and TB disease burden and service coverage throughout the COP22 process 8. Provide ample support for the procurement and distribution of the following essential diagnostic and therapeutic tools and services in Uganda's Country Operational Plan (COP) for FY2022	**Agree:** •Since COP 18, PEPFAR has supported identification and management of AHD in clinics, including support for CD4 tests, Crag Tests and TB_LAM. In COP 21, PEPFAR has increased its support for AHD commodities, significantly reducing the gap in the public sector. **Focus for COP22:** •PEPFAR will continue to strengthen commodity security for the AHD equipment and commodities •Introduce point of care for CD4 tests to increase access to diagnosis. •PEPFAR will continue to advocate for inclusion of newer efficacious and palatable medicines for AHD (Liposomal AmBisome & Flycytosine) into the national essential medicines' lists. CHAI in collaboration with UNITAID is implementing a pilot in 52 health facilities using these expanded treatment regimens; PEPFAR will work with CHAI and UNITAID for a collective advocacy effort. **Demonstrable Successes:** •PEPFAR supported the revision of AHD guidelines, roll out and implementation. •Despite several implementation challenges, we have seen CD4 coverage improve from less than 10% to about 46% by the end of FY 21. Also, CrAg and TB_LAM access increased to above 70% and 55%, respectively. Once PLHIV are diagnosed with AHD conditions, the clinics leverage the GOU medicines for TB treatment and fluconazole for pre-emptive treatment; access to treatment has been sustained above 85%. •Through PEPFAR's CQI initiatives, health care workers' have enhanced their capacity to ensure timely and effective identification (CD4, Crag and TB_LAM), diagnosis, and linkage to appropriate treatment and completion of fluconazole and TB

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			treatment. Reports and data can now be collected from about 1879 health facilities. •Increasing treatment of OIs has proven expensive and logistically challenging over the years. Rather, it is important to maintain focused efforts for earlier case finding, successful linkage to care, and return to treatment quickly for those who interrupt. As such, PEPFAR is intensifying its efforts in case finding as described in the first bullet of this section. **Additional response:** •The PEPFAR Uganda team is preparing detailed analysis of Cryptococcal meningitis (CCM) and TB disease burden in Uganda and will share this information with all stakeholders once it is available. While the data on the TB disease burden is easily available, the national data on CCM is a challenge. - TB disease burden: •Over the past years, PEPFAR Uganda ramped up investment in TB Preventive Therapy for PLWHA with coverage levels reaching 90%. This, coupled with high levels of ART coverage, has reduced the TB co-infection among PLHIV from 40% in FY19 to 32% in FY21 (source: PEPFAR program data). Despite a significant increase in TB case findings in FY21, 30% of the TB cases are still missing. COP22 Planning Level Letter emphasizes TB case finding, and we have allocated additional investments for enhanced TB case finding at community and facility levels. •PEPFAR will support the roll out of a new diagnostic tool for TB point of care testing (Truenat) in COP21; we plan to scale-up this POC in COP22 and also introduce C-Reactive Protein (CRP) for TB screening. • Response: Since COP18, PEPFAR has contributed to the procurement and distribution of cryptococcal antigen (CrAg) Tests, CD4 tests, and TB_LAM commodities for the Advanced HIV Disease (AHD) program. In COP21, PEPFAR's

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			support eliminated the gap for AHD commodities. Similarly, in COP22, PEPFAR will continue to support procurement and distribution of commodities for the AHD program, closing the funding gap in both public and private-not-for-profit sectors.

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Aging with HIV and other associated challenges	**Key issues identified** • UPHIA data indicates that HIV prevalence among people aged 60-64 years has increased • HIV programming in the country does not pay special attention to those aged 50 years and above ● CLM data indicated that older PLHIV face challenges especially at health facilities while accessing care. They prefer to receive HIV services in seclusion from other persons of younger age brackets • Older PLHIV face adverse effects especially associated with other NCDs.	• PEPFAR should design an age specific program targeting older PLHIV including management of comorbid conditions **Rationale**: Comorbid conditions are common among older PLHIV. The needs of older adults are different from those of younger adults, and this group has a higher all-cause mortality. Provision of other medications needed in a fast track or with ART may protect these vulnerable clients and may be lifesaving.	**Agree:** • PEPFAR is integrating the use of data, person-centered and age specific approaches for provision of HIV services and as such, PEPFAR's data shows that currently about 20% of PLHIV are above 50years of age and are vulnerable to non-communicable diseases. In COP 21, PEPFAR is implementing a pilot in 106 health facilities across 3 regions to integrate NCDs management in HIV services, including differentiated service delivery models and multi-month dispensing. In collaboration with MOH, PEPFAR will apply lessons learned from a pilot to design and scale an age specific program targeting older PLHIV. • PEPFAR has forged partnerships with donors and stakeholders to support MOH review the national guidelines for NCDs integration; this revision is anticipated to conclude by end of FY22. • In COP 22, PEPFAR plans to roll-out an agreed model to about 1800 health facilities.
The DREAMS (Determined, Resilient, Empowered, AIDS Free, Mentored, and Safe) Program	**Key Issues**: • Low completion rates among those enrolled on the program and we concur with issues highlighted in the Planning Letters i.e., AGYW feeling that they could utilize their time doing other things, refusal by partner/parent, COVID-19, and delayed income generating activities **(Pg. 18).** • DREAMS beneficiaries feel that most of The skills gained are insufficient to create the much-needed economic strengthening capacity. Trainees have not managed to make changes at their	1. PEPFAR Program Implementers should create a platform for trainees to select their own enterprises. 2. PEPFAR should support those who complete to start viable economic venture 3. PEPFAR in COP22 should increase the targets on socio-economic empowerment and BCC of AGYW and the skills training to cater for the girls affected by the toll of teenage pregnancies during the COVID period in the affected districts.	• This was noted in COP20. Starting in COP21, PEPFAR Uganda is addressing this through enhanced socioeconomic strengthening (SES) models, ELA • (Empowerment and Livelihood for Adolescents, BRAC), and WINGS Plus (AVSI). • As part of the enhanced SES approach, the PEPFAR • DREAMS program has conducted DREAMS market assessments, and AGYW are given start-up kits based for viable economic ventures that are appropriate for particular geographic regions. • PEPFAR Uganda is focused on improving the quality of the social economic program. In COP22, we have budgeted to ensure that we maintain a high-quality SES program for different age bands and to reach the right number of at-risk AGYW.

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	respective household level as expected. This discourages others from completing the training • Predetermined courses don't answer the immediate needs of DREAMS' beneficiaries • With COVID-19 challenges, many AGYW got unwanted pregnancies - can't rule out the possibilities of contracting HIV - yet the DREAMS program is limited to few districts, fewer beneficiaries (only for HIV- AGYW).		
Community services / Differentiated Service Delivery Models (DSDM)	**Key Issues** Some of the DSDM are not fully functional due to the following issues: • Lack of commitment from some CCLAD group members • High levels of stigma, discrimination and gender bias in group formation • Some clients are not consulted before groups are formed • Challenges in the health systems including frequent drug stock outs limit efficiency of DSDM • CDDPs are challenged with transport for medicines to community distribution points • Inadequate psychosocial support and health education by health workers hence affecting adherence	• PEPFAR should address hindrances to facilitate sustainability and the realization of the full range of benefits that the model presents **Rationale:** We continue to see long queues at facilities even when the COP22 PLL-Uganda clearly shows that MMD steadily increased over FY21; at Q4, 49% of adult clients received 3-5-month and 26% received 6+ month MMD; however, MMD for children continues to lag behind, with only 51% receiving 3+ months.	**Agree:** • The uptake of community models of care (CCLADs and CDDPs) has been persistently below national targets at 15% and 10%, respectively. Routine root cause analyses report several implementation challenges raining from system barriers (e.g., attitudes of HCWs), differing patient preferences and commodity security/situations. MOH, with support from PEPFAR, is rolling out alternative ART drug distribution models such as the pharmacy refill model and the community-led drug distribution points, which are adaptations of the traditional community models. These new community models provide alternative options and additional benefits to complement traditional community models. We anticipate that the expansion of models/options will meet clients' needs and preferences. • So far, we have about 40 functional retail community pharmacies through which clients receive drugs in the community and by end of COP21, we aim to have an additional 100 pharmacies. This will bring the total number of pharmacies across the country to 200.

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			• We will also integrate additional services into the pharmacy refill model (e.g., TB drugs, NCD drugs, PrEP and HIV self-test kits). • We will focus on increasing CQI for DSDM at the HFs to improve efficiency and streamline access to the models. • We plan to tailor models to specific populations (e.g., TB_DSDM for TB clients, KP-specific models for ART and models specific for children above 2 years). • We plan to increase MMD through integration of MMD into all models of ART delivery, , and will reach 90% of children with 3MMD..
DiCs and location of community led clinics with DiCs	• **Accreditation for more DiCs:** since COP20, PEPFAR has funded additional community led DICs that are now accredited to provide a comprehensive package of services. However, most community DICs are still not accredited to provide the comprehensive package of clinical services that KPs require. • **Co-locate DiCs with community led clinics**: co-location facilitates convenience of dealing with just one landlord and bridges gap between community activities and programme services hence functioning as a one-stop shop. Such convenience helps in motivating and mobilizing KPs to access service	Accredit all remaining community DICs to provide clinical services PEPFAR should prioritize substantial increases in funding for indigenous, KP-led community organizations to deliver quality prevention, linkage and continuous treatment services for KPs. Improve KP size estimates by rolling out a BBS of key populations, in particular trans* people and men who have sex with men. The methodology should be developed in collaboration with communities, who should advise at each step: inception, research, and dissemination.	• DIC Accreditation: This was discussed with MOH at the PEPFAR stakeholder engagement retreat (February 2022), and commitment is being sought with clear timelines. •This has been taken into consideration in the COP22 budget with funding for community led CSOs included.

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Funding for KP Led organizations	• **Flexible funding for KPs programmes:** Engage funding agencies, IPs and other general CSOs in developing modus operandi for KP CSOs that is tailored to the specific needs of those KP CSOs. For example, many CSOs cannot follow standardized procedures because of the element of criminalization and social animosity that they have to deal with while executing their work. A good example is they may not be able to follow stringent venue procurement procedures because they need to only go venues where they do not feel threatened or where they are likely to be attacked or arbitrarily arrested. • **Unclear Funding landscape for KP programmes**; funding challenges have been gleaned that suggest there is a need to re-examine funding priorities, gaps, modalities, alternatives and avenues for KP programming and organizing. UKPC is conducting a study on this looking at the last five years and the findings will be shared by or after this COP22 planning document has been submitted. However, whatever challenges there are in funding such as over-concentration on funding strictly health-related interventions should be addressed	• Develop a funding basket following calls for the establishment of new DICs. • Support the establishment of more DICs that cater to KPs who are able to pay out of pocket for services and who are relatively wealthy. • Plan and budget to Carry out a rapid assessment of DICs to determine their baseline functionality. • Organizational capacity strengthening: KP community organizations need to be supported with not only funding for programmes or activities but also organizational capacity assistance such as for building governance structures, putting in place financial and other policies, registration and auditing.	• New DICs will be supported in COP22 – please see below • DIC have been expanded in COP22 to 85 from 75 in COP21. • This activity is planned in COP21. This can be supported by CQI activities or through CLM in COP21 or COP22 if needed. • Above-site investments are available for CSO organizational capacity assessments and capacity building.

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Commodity Security	**Community voices:** • 31% of facility staff reported shortages and stock outs of essential HIV/TB medicines specifically DTG (29%), FDC first-line (12%) and pediatric HIV medicines (18%) • Supply chain difficulties, especially bureaucratic procurement processes to delayed delivery of medicines to health facilities were reported • Utilization of available supplies is affected by the short life span of most essential HIV regimens and other STI treatment medicines. Drugs expire before they can be dispensed. • Store managers reported unfavorable requisition and approval processes during the procurement process • Excess supply of some commodities and at times delivering what is different from the original request	• PEPFAR should support supply chain managers and health facility teams making requisitions to ensure timely distribution of HIV Commodities **Rationale**: Availability of HIV commodities has a direct bearing on access to and utilization of HIV/TB services	**Support to facility supply chain managers** • To improve the capacity of the facility, supply chain managers, training and mentoring will be conducted by the regional implementing partners • Facility staff will be trained in the use of the NMS ERP ordering module **Supply chain data visibility and ordering process** • In the public sector, the roll out of the NMS ERP ordering module (up to HC IIIs) will improve visibility at all levels of the ordering process, identifying and addressing any delays in the system. • The ERP will improve visibility of commodities ordered and supplied to health facilities • Facility eLMIS will be linked to the central level and ERP to improve visibility and responsiveness in addressing stockouts **Commodity availability and stock monitoring** • At the national level, MOH/QPPU will continue to be supported to conduct national quantification, supply planning and stock status monitoring • Facility stock status reporting and monitoring through HMIS reporting, PIP and RASS will continue. This will guide any redistributions or emergency orders.

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Human Rights and the legal environment	We welcome legal assessment findings and look forward to a robust PEPFAR supported road map to address barriers from the assessment. • Continuing fear or experience of stigma at healthcare facilities, both the fear of and the lived experience of stigma for key populations and people living with HIV. • Insufficient access to information: Information on side-effects, how to take pills, and the importance of adherence needs to become more accessible and relevant to MSM and PWIDs. • Fears or perceptions of breaches in confidentiality by healthcare workers, this drives to perceiving a potential of stigma or criminal charges that could result in supporting PWID, MSM or LGBTI populations	• PEPFAR to invest in community-led efforts to address support for enabling environments against all inequalities and other human rights **Rationale:** Even when PEPFAR has a focus on programming to facilitate equitable access to health services for key and priority populations to reaching and sustaining epidemic control. HIV-related stigma, discrimination, and violence, reduce access to, and use of, essential health services, and undermine efforts toward effective responses to HIV/AIDS. The UNAIDS 10-10-10 targets require focus on removal of societal, including legal barriers that limit access to or utilization of HIV services.	• We are continuing to fund CLM in COP22. CLM can be used for identifying inequalities and advocating for enabling environments and human rights. • Additionally, we are funding the national KP CSO mechanisms and supplementing regional comprehensive mechanisms with funding for KP CSOs.
Human Resources for Health	• From national engagements the regional referral model is in advanced stages however operationalization of the model remains uncertain, i.e. need to support formation of a regional community-based working groups to spearhead community activities at the sub-national level. • CLM Data shows that transitioning of donor supported workers onto the	• Functionalization of the regional referral model to facilitate strengthening of treatment literacy and primary prevention activities at community level to sustain the gains so far made in the HIV response **Rationale:** Efficiently and effectively achieving and sustaining HIV epidemic control requires a data driven approach to health workforce decision-making and management. PEPFAR funds can be leveraged to support governments to coordinate with and report, including	A number of ongoing and planned investments address the concerns raised: • HRH investments at the RRHs includes the support for critical HRH secondments (4 technical staff per RRH) to increase capacity for supervision/ mentorship of facility and community level services and use of data and QI approaches for improved program performance • TA to all partners to ensure harmonization of community workers' remuneration • Support to districts to carry out recruitment planning including the transitioning of PEPFAR supported HRH to GOU

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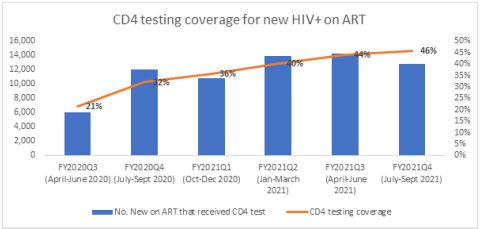
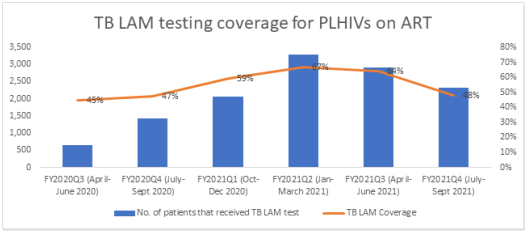
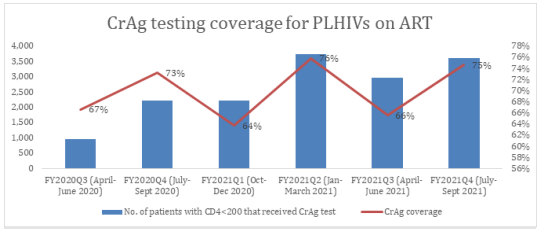
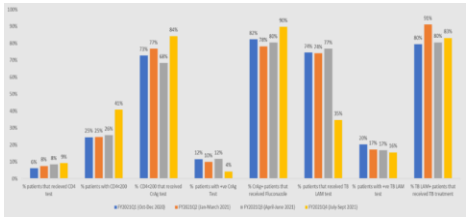
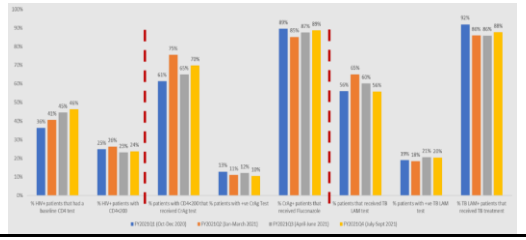
<tr><td></td><td>government payroll is not organized structurally.
• Facilities lacked capacity building strategy for the health workers.</td><td>investments in HMIS and critical human resource capacity. Alignment of HRH cadres and support (amount and type) to partner country government systems is key for facilitating absorption of workers required for sustained epidemic control</td><td>• Scaling of e-learning infrastructure for cost-effective in- service training /capacity building for health workers</td></tr>
<tr><td>Community Led Monitoring (CLM)</td><td>• In COP22 independent civil society organizations implementing the Community-Led Monitoring (CLM) program will continue to carry out CLM in order to improve the accessibility and quality of HIV services across the country.
CLM through COP22 will align itself in sustaining the community led HIV/TB response and the sustainability areas of focus will include
• Strengthening and supporting community structures for a sustained HIV response, throughout COP22 CLM will continue to ground the CSOs and CBOs into Subnational and national level Advocacy coalitions that continue to participate, engage and advocate for programmatic and policy shifts for improved PEPFAR HIV/TB program through the various platforms at the different levels including district level performance review meetings, budget</td><td>• Increase CLM budget to consolidate and Scale-up CLM programme/model/approach
<table><tr><th>Description</th><th>Cost</th></tr><tr><td>Personnel</td><td>$368,956</td></tr><tr><td>Fringe Benefits</td><td>$66,412</td></tr><tr><td>Travel</td><td>$0</td></tr><tr><td>Equipment</td><td>$0</td></tr><tr><td>Supplies</td><td>$6,377</td></tr><tr><td>Contractual</td><td>$44,130</td></tr><tr><td>Construction</td><td>$0</td></tr><tr><td>Other</td><td>$950,217</td></tr><tr><td>Total Direct Charges (sum of 6a-6h)</td><td>$1,436,092</td></tr></table></td><td>In COP22, we plan to strengthen and support independent community structures for a sustained HIV response in multiple ways:
• We will continue to dedicate PEPFAR staff time to providing technical assistance and other capacity strengthening to the CLM Team and other community structures if relevant.
• We plan to supplement funding to regional comprehensive mechanisms to be sub-awarded to strengthen civil society organizations (CSOs) to support HIV service delivery. This will have direct impacts on CSOs and on people receiving services.
• We plan to fund the national KP CSO mechanisms.
• We plan to continue funding CLM at a level of $1M and to continue working with the CLM Team to develop budgets and workplans that will have maximal impact on Ugandans, including key populations. The total PEPFAR budget has remained flat, so level funding of CLM plus the additional funds mentioned will result in an overall increase in the funding for supporting and strengthening community structures. Our funding approach seeks to have maximal impact on people seeking services through increasing funding for implementation while maintaining funding for other community-led activities like CLM.</td></tr>
</table>

AREA	What does the evidence show (issues)?	PEOPLE'S COP22 PRIORITIES/ASKS	USG/PEPFAR Comment
	advocacy meetings, District AIDS Committee meetings, regional level Implementing partner level performance and update meetings and at national level through the health assemblies, the annual joint AIDS reviews, PEPFAR POART meetings levels CLM identified and engaged.	<table><tr><td>Indirect Charges</td><td>$114,887</td></tr><tr><td>Totals</td><td>$1,550,979</td></tr></table> **Rationale:** PEPFAR COP planning level letter includes CLM as one of the critical progresses the PEPFAR program is taking towards in line with the direct local partner funding as a sustainability factor in the HIV/TB response.	

AREA	What does the evidence show (issues)?	PEOPLE'S COP22 PRIORITIES/ASKS	USG/PEPFAR Comment
Essential tools for preventing, detecting, and treating AHD/AIDS CD4 tests as a gateway into managed AHD and AIDS care	• Baseline CD4 count remains the best diagnostic tool to assess a person's immune and clinical status. Furthermore, CD4 can also help guide clinical decisions in PLWHAs virologically failing ART or who have disengaged from treatment for some time. The use of point-of-care semiquantitative CD4 tests that are available and affordable can identify PLWHA with advanced HIV disease (CD4<200) and therefore those in need of PEPFAR and WHO's recommended package of care that includes prevention and screening tools for cryptococcal meningitis and TB	In keeping with PEPFAR's COP22 revised guidance on the use of CD4 "to allow identification and improve management of advanced HIV disease," we urge you to ensure that in COP22, PEPFAR supports procurement of baseline CD4 testing for people entering or reentering ARV care and for those with virologic failure. Request: share information current coverage and planned support for universal free access to CD4 tests for people with AHD.	Response: There has been improved CD4 coverage from 21% in Q3 of FY20 to 46% by Q4 of FY21. In FY22, PEPFAR will support the introduction of the point of care CD4 test, targeting 33 high volume sites as a start. This test will minimize investment in equipment for CD4 testing and sample transportation while improving coverage. PEPFAR will also continue to work with NHLDS to reduce CD4 equipment breakdown, while increasing proportion of CD4 tested conducted with point-of-care platform for CD4 testing. Graph 1: Trend in CD4 testing coverage 

AREA	What does the evidence show (issues)?	PEOPLE'S COP22 PRIORITIES/ASKS	USG/PEPFAR Comment
TB lipoarabinomannan (TB LAM) tests to provide timely TB detection and treatment	• We recognize PEPFAR's commitment for full funding of TB LAM tests are rapid point-of-care tests for the detection of TB among PLWHA. The tests utilize urine and return results in just 25 minutes. TB LAM tests are affordable and lower the risk of mortality and lead to an increase of people that start TB treatment. Following a LAM-positive result, patients should immediately start TB treatment. However, we saw previously insufficient commodity availability affect access to TB LAM testing	Per PEPFAR and WHO's recommendations, we urge you to include in COP22 the impetus, goal, and support so that 1) every PLWHA, including children, in a hospital receives a TB LAM test; 2) all PLWHA, including children, with TB symptoms, or severely ill, or with AHD receives a rapid TB LAM test in outpatient settings; and 3) TB LAM tests are available in all inpatient and outpatient facilities.	Response: TB LAM coverage has increased steadily from 45% in Q3 of FY20 to 64% at Q3 of FY21. There was an observed drop in FY21 Q4 due to delayed distribution from National Medical Stores following a glitch in the new warehouse electronic commodity management system. The number of sites offering AHD clinical care and treatment services has gradually increased over the years, reaching 1,872 sites as of December 2021. PEPFAR will continue to support procurement of TB LAM in COP22 to close the commodity gap and ensure commodity security. Graph 2: Trend in TB LAM testing coverage 

AREA	What does the evidence show (issues)?	PEOPLE'S COP22 PRIORITIES/ASKS	USG/PEPFAR Comment
Cryptococcal antigen (CrAg) screening for cryptococcal meningitis	• The cryptococcal antigen (CrAg) can be found in the body weeks before symptoms of meningitis. Point-of-care rapid CrAg tests are easy to administer (via venous blood or finger-prick) and are affordable.[vi] Timely screening and provision of fluconazole after a positive test is essential given the median time to development of CM following a CraG positive test is just 22 days	Request: data on coverage and levels of the health care system provided and COP22 PEPFAR's planned expansion of CrAg screening and current baseline data.	**Response:** CrAg testing coverage has increased from 67% in Q3 of FY20 to 75% at Q4 of FY21. All levels of the health care system are covered with CrAg screening for CCM. PEPFAR will continue to support procurement of CrAg tests in COP22 to close the commodity gap and ensure commodity security. **Graph 3: Trend in CrAg testing coverage** 

AREA	What does the evidence show (issues)?	PEOPLE'S COP22 PRIORITIES/ASKS	USG/PEPFAR Comment
Fluconazole pre-emptive treatment of cryptococcal meningitis	Following a positive (CrAg) screening, PLWHA should receive pre-emptive fluconazole treatment to prevent the development of CM.	Request: Status update on access to fluconazole used as pre-emptive treatment of CM disease	Response: The linkage to treatment for non-suppressed patients with a positive CrAg by end of FY21 was 90%. The linkage to treatment for TX_NEW patients with a positive CrAg by end of FY21 was 89%. We will continue to focus on this area and ensure commodity security at facility level. **Graph 4: Linkage to treatment among non-suppressed patients with a positive CrAg test**  **Graph 5:** Linkage to treatment among TX_NEW patients with a positive CrAg test 

AREA	What does the evidence show (issues)?	PEOPLE'S COP22 PRIORITIES/ASKS	USG/PEPFAR Comment
Liposomal amphotericin B (L-AmB), flucytosine, fluconazole to treat cryptococcal meningitis	Currently, WHO recommends a combination of infusion and oral therapy to treat CM: seven days of infusion of Liposomal amphotericin B (LAmB) followed by 14 days of oral therapy (fluconazole and flucytosine). As the PEPFAR guidance states, future treatment guidelines may change to reduce the infusion time from seven days to a single one-day dose based on recent data. This helps to reduce the costs and complexity of administering L-AmB that has led to PLWHA only receiving oral therapy or fluconazole monotherapy. According to experts, the mortality among CM patients treated only with fluconazole is around 70% at 10 weeks after diagnosis. This drops to 24% mortality at 10 weeks after exposure with Amphotericin (the infusion) and flucytosine.	Request: Provide information on current coverage of L-AmB or amphotericin B deoxycholate (AmB) and flucytosine and fluconazole.	Response: PEPFAR will continue to advocate for inclusion of newer efficacious and palatable medicines for AHD (Liposomal AmBisome & flycytosine) into the national essential medicines' lists. CHAI in collaboration with UNITAID is implementing a pilot in 52 health facilities using this expanded treatment regimens; PEPFAR will work with CHAI and UNITAID for a collective advocacy effort.

PEPFAR Uganda will continue to hold quarterly interagency stakeholder meetings, led by the US Ambassador or her delegate, and facilitated by the PEPFAR Coordination Office (PCO). The interagency team will continue to hold monthly or bi-monthly joint care and treatment, HIV testing services (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 and other development partners will be invited to attend these monthly/bimonthly 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 COP22 implementation. Further, USG will continue holding pre-POART and POART sessions with stakeholders to review quarterly data and develop jointly owned solutions. In COP22, 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.

4. Private Sector

The GOU takes primary responsibility for strategy formulation and planning, with the donors coming secondary and private sector playing a nominal role. PEPFAR and the GOU share, almost equally, the primary and secondary responsibilities for the service delivery elements, with Global Fund secondary and private sector continuing to play a nominal role. In the Non-Service Delivery dimension, PEPFAR continues to take primary responsibility due to the significant technical assistance support to districts and service delivery sites. Global Fund plays a secondary role, and the private sector, though primary and secondary in a few elements, continues to play a predominantly nominal role (RM 2021).

Relevant private sector including private for-profit institutions, social enterprises, foundations, and private sector health delivery systems (for example, private pharmacy chains, private provider networks and clinics, or private hospitals), Private Sector Engagement (PSE) strategies and Public Private Partnerships (PPPs) are enablers that engage expertise, core competencies, skillsets, and/or encourage coordination of resources investments (in-kind, cash, or other) to seek to achieve epidemic control. As PEPFAR ensures sustainability of the impact, the success shall rely on building meaningful and wide-ranging partnerships with the private sector at global and local levels including strengthening the private sector initiatives (One Dollar Initiative). In addition, partnerships with the private sector provide opportunities to pursue innovative strategies that can be replicated if effective.

In COP22, the private sector engagement strategy may include leveraging the core business and/or competencies of the private sector to achieve the Ugandan people's and PEPFAR's goals, in addition to formal public private partnerships (PPPs). *PEPFAR defines formal PPPs as collaborative endeavors that coordinate technical expertise and contributions from the public sector with expertise, skillsets, and contributions from the private sector (financial or in-kind) to achieve epidemic control*. Areas of strength with the private sector that will be emphasized in COP22 include:

- Availability of formal channels for private sector engagement
- Systems and policies that allow private corporate contributions to HIV/AIDS programming
- Private health providers allowed to deliver HIV services
- Private sector has interest /expertise to contribute to HIV/AIDS services
- Private institutions in place to provide scientifically accurate information on HIV/AIDS

Table 2.6.2 PEPFAR Stakeholder engagement calendar for COP22 (planning and implementation)

	PEPFAR Team Action	Stakeholder Action	Dates	Status
1	Distribute critical data and COP22 materials (links or hardcopy): ● Draft and Finalize COP22 guidance. ● PEPFAR Solutions Platform, ● 2021 Sustainability Index and Dashboard Responsibility Matrix. ● Q4 results via spotlight; Q4 POART overview slides. ● SIMS Outcomes (Above PSNU level) ● COP21 SDS and approval memo ● CLM findings	● Analyze materials to prepare for COP22 discussions at strategic planning retreat. ● Identify areas of successful performance that can be leveraged by 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	December 2021 - January 2022	PCO Shared both the Draft and final COP22 guidance; COP21 SDS; Q4 results and Q4 POART overview slides and the 2021 SID/RM. Completed successfully
2	● Organized and facilitated courtesy calls and Meetings with GOU bodies/CSOs/Development Partners on PLL	Harmonize COP22 priorities with GOU and Development Partners' plans, policy and programmatic shifts Discussion on the Country Specific Minimum Program Requirements for COP22	February 15-March 24, 2022	PCO successfully coordinated these high-level discussions Similar discussions to continue throughout COP21 and COP22 implementation.
3	Organize and facilitate TWG COP22 consultation meetings	TWG Co-Chairs identify and recommend their external guests to participate in COP22 consultation meeting	Jan 15 to February 3, 2022	Consultative meeting successfully held with great participation from (GOU, Development partners, CSO/FBO and private sector) provided feedback and input into COP22 priorities
4	Meeting with MOH and MOFPED, MOD, MGLSD, Uganda AIDS Commission	FO and Agency Heads attend as GOU shares its projected plans and agreed upon priorities	February 15-March 24, 2022	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	Attending in-country Strategic Planning retreat; providing PEPFAR Teams with recommendations for COP22 focus, based on analysis of Q4 results and observations of in-country performance.	February 3-4, 2022	Retreat held, (Smaller group discussions, panel discussions and presentations were made to cater for all targeted groups)
6	Arrange for stakeholder participation in the COP22 RPM	GOU, CSOs ad development partners actively participate in COP22 RPM, provide feedback on approaches, strategies and targets	March 14 – 17, 2022	Completed
7	Agency specific IPs Meeting to consult on COP22 and share feedback on RPM	IPs actively participate in post RPM feedback meetings and provide feedback on technical and management approaches.	March 18-30, 2022	Planned as per agency/IP specific meetings
8	Invite stakeholders to post COP22 Strategic meeting to discuss outcomes and strategies for finalizing COP submission	Actively participate in Post COP22 strategic planning Meeting Consultation (ask questions, seek clarification and make recommendations)	April/May 2022 (TBD)	Planned for in person. Shall be merged with the PEPFAR periodic Stakeholder meetings
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 COP22 meeting agreements/strategies Global and regional/national CSOs request information as applicable	April 2022	OGAC will review, exchange and concur within a week of submission.

	PEPFAR Team Action	Stakeholder Action	Dates	Status
10	Provide SDS and final target data	Review all materials	March –April 2022	Ongoing
11	Invite stakeholders to COP22 approval meetings, ensure that the final plan- inclusive of expected policy shifts, targets and priority interventions- are understood and shared by all Arrange for GOU participation in COP approval meeting	Actively participate in COP22 approval meetings, and questions, seek clarification, raise areas of discrepancy or misalignment and continue communicating with PCO	Virtual approval meeting window is April 2022	The plan is to have this approval meeting in person with S/GAC chair, expect to have FO participation
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 2022	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 on POART calls; offer analysis and recommendations to remove barriers and bottlenecks.	Jun 30; Sept 30; Dec 20, 2022.	Planned POART calls dates TBC.
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	Planned
15	CLM coordination and feedback sharing meetings	CLM partner meetings, CLM budget update meeting,	Monthly/Bi-weekly	Ongoing
16	Development Partner meetings	USG share updates of COP22 and COP21 agreements	Monthly	Planned
17	Organize/Attend/facilitate Regional CLM Dialogue on CLM/SIMs	GOU, USG and CSO share qualitative and quantitative findings and recommendations for program quality.	Quarterly/Bi-annual	Led by CSO, GOU, PCO and co-facilitated by UNAIDS
18	Inter-agency site 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	Planned
19	PEPFAR participates in National TWG meetings	GOU shares programmatic and key policy TWG focused directions	Monthly/Weekly/ Bi-weekly	Continuous

2.7 Stigma and Discrimination

Leveraging GOU support on targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration on equity and reduction of stigma and discrimination, PEPFAR will work closely with stakeholders and IPs to advocate for stigma and discrimination free environment in all healthcare settings. In addition, the KP programming will incorporate the Legal Environment Assessment (LEA) findings as advocacy to protection of human rights and promote equitable access to health services. This would include adapting MOH training manuals for health care providers in provision of friendly, stigma- and discrimination-free services. PEPFAR and GOU will train and mentor law enforcements officers to explore underlying causes of stigma, discrimination, and violence against KPs. The training will support knowledge building and strengthen their response to all victims of violence, including members of KPs. Finally, PEPFAR will support measurement of KP and HIV-related stigma through the Stigma Index.

3.0 Geographic and Population Prioritization

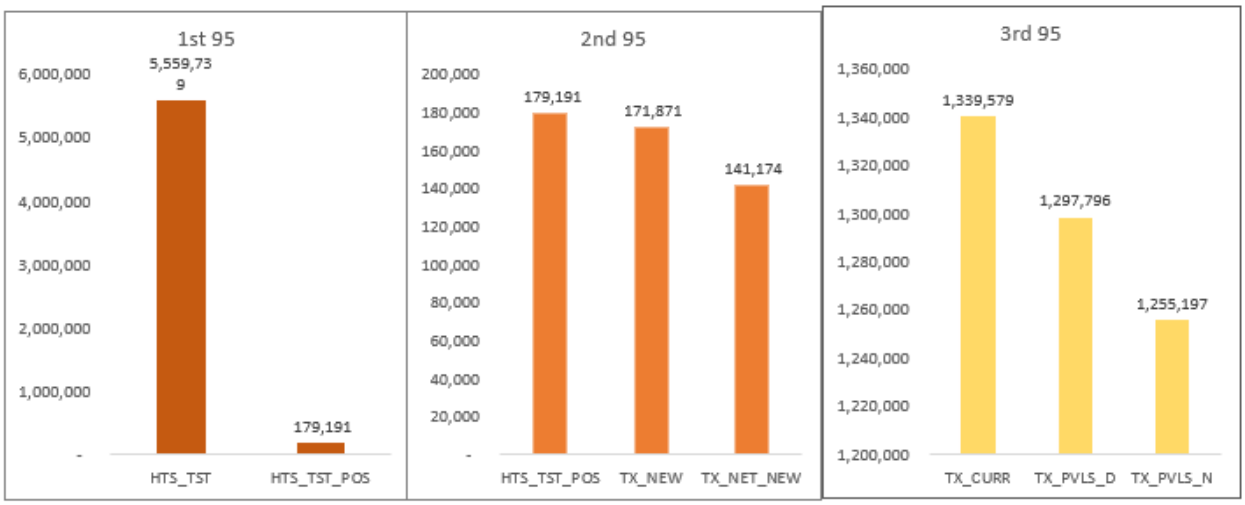
Table 3.1 Current Status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP22	# Current on ART (FY21)	# of SNU COP21 (FY22)	# of SNU COP22 (FY23)
Attained	374,479 (26%)	336,749	35	35
Scale-up Saturation	586,772 (40%)	506,097	70	70
Scale-up Aggressive	492,368 (34%)	402,088	31	31
Sustained				
Central Support Total	1,453,619	1,266,588*	136	136

*Total includes 21,654 TX_CURR attributable to Military

4.0 Person-Centered Program Activities for Epidemic Control

Figure 4.0.1 Overview of 95/95/95 Cascade, FY21



4.1 Finding People with Undiagnosed HIV and Getting Them Started on Treatment

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

According to Spectrum, Uganda is expected to have 1,453,891 individuals living with HIV by the end of September 2022; 87% of them will have been diagnosed. Reaching the remaining undiagnosed positives will require ingenuity and continued use of the most efficient approaches.

In COP22, HIV case finding will continue to be differentiated by age, sub-population and geographic location based on the gap to the first 95%. The HTS_TST_POS target more than doubled from 74,036 in COP21 to 179,191 in COP22 and the expected yield increased from 2.6% in COP21 to 3.2% in COP22. While COP22 targets substantially increased when compared to COP21, the increase in HTS_TST_POS target was more than two-fold. Therefore, more positives are expected to be identified with fewer tests; this requires the implementation of a highly targeted program to reach individuals at high risk for HIV infection and in the right places. The FY23 HTS_TST target was derived from the TX_NEW target of 171,812 needed to reach 95% treatment coverage at 95% linkage. Targets were allocated to different testing modalities based on past performance in identifying HIV positive individuals. In COP22, unlike in COP21, targets were not pre-determined in the data pack for TX_NEW. Using yields determined from FY21 performance and proportion contribution to total HTS_TST_POS annual achievement, respective HTS_TST_POS modality targets were derived with Other Provider-

Initiated Counseling and Testing (PITC) contributing 36% (with anticipated yield of 5%) of the target, index testing 27%, (with 14% yield), community mobile/SNS 14% (with average yield of 5.4%), PMTCT (ANC1 and Post ANC1) 12%, (with yield of 1.1%) and TB 3% (with 10.5% yield). Other PITC modalities combined (inpatient, malnutrition, pediatrics and STI) will contribute 7% of the HTS_TST_POS target while community other will be 1.4% at 3% yield. Yields for other PITC modalities were targeted as follows; in-patient 3.4%, malnutrition 1.6%, pediatrics 2%, STI 5.4% and VMMC 0.2%.

During the COP2022 planning, we conducted analysis for the period FY18 to FY22 Q1 to understand which modalities account for the highest volume of positives. The analysis showed that four testing modalities consistently contributed >80% of positives identified in each year; These modalities include Other PITC, PMTCT, Index testing and Community mobile with Other PITC. In COP2022, the Uganda testing program will prioritize and invest in these testing modalities which will contribute 89% of COP22 HTS_TST_POS target. Although PMTCT is typically not a case identification modality, it generates a substantial number of HIV positives. Social network strategies (SNS), targeting key populations and other priority populations will continue to be integrated into community testing. In FY21, Uganda rolled-out SNS and by end of FY22 Q1 all regions were implementing. Although site level coverage is still low, the results are promising with an 8% contribution to total positives at a yield of 11% in FY22 Q1. Social network strategies are integrated into the national HTS program, and we are working with the MOH to bring coverage to scale and optimize testing of elicited individuals by start of COP22. In addition, SNS is incorporated into our weekly dashboard as a priority intervention. We are also working with the MOH and IPs to refocus investments in other PITC, Index testing and targeted community starting FY22 Q3. Under the leadership of MOH, Uganda is developing a continuous quality improvement (CQI) project to enhance case identification. This will be rolled out in May 2022. To minimize missed opportunities for testing, and to enhance testing efficiency, PEPFAR Uganda will use validated screening tools for both adults and children/adolescents at outpatient departments (OPDs) as well as in the community for KP/PPs. Trained screeners will be deployed and designated to consistently screen individuals for eligibility for HIV testing services at high-volume sites. The target yield within OPD was reduced to 5% from 10% in COP21. Validated screening tools will continue to be actively monitored in all facilities where screeners will be deployed.

Index testing, including assisted partner notification (APN) will remain the mainstay for the PEPFAR Uganda testing program although its proportion contribution to the HTS_TST_POS target is only 27%. The focus in COP22 will be to sustain 100% coverage of PEPFAR supported sites and optimize testing of exposed individuals at >80%. By the end of FY21, 89% of PEPFAR supported sites implemented index testing. The implementation gap will be closed in FY22. We will continue to 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 FY22. This will be done through line listing index clients that were missed for index testing and prioritizing them for elicitation of exposed individuals including children and partners. We will also line-list exposed

individuals who were missed and prioritize them for testing. We will work with trained peers and linkage facilitators to strengthen tracking of index clients and elicited individuals for services. To improve reporting, we will work with the MOH and other stakeholders to roll-out EMR in all high-volume facilities.

Under the leadership of MOH, we will continue to ensure sustained safe and ethical delivery of index testing. In COP20, the materials for index testing were not aligned with Uganda national testing implementation guidelines but were aligned in the implementation materials revised in FY21. There is already a system in place for monitoring index testing services. The systems include routine site level index testing assessments (with certification of sites incorporated); and tracking, documentation, and response to intimate partner violence (IPV). Routine index testing assessment will continue in COP22 with remedial actions for sites that fail assessments. We will continue to work with MOH to ensure sites that fail assessments suspend services until gaps identified are addressed, and re-assessments are done with 100% pass. We will also continue to strengthen IPV tracking and response system in COP22. In addition, we are working with the MOH to expand the monitoring system to include other negative outcomes from index testing and HIVST. This system will be rolled out in COP22

Other HTS interventions that will continue to be implemented in COP22 include HIV self-testing (HIVST) and recency. PEPFAR Uganda supported the national roll-out of HIV self-testing in FY21 with procurement of 1,976,439 HIV self-tests. HIV self-testing was rolled out in all PEPFAR supported sites. In FY21, under the leadership of the MOH, Global Fund (GF) and other stakeholders supported the country to pilot different delivery models, including vending machines, online and other digital approaches, facility delivery, community pharmacies and the use of the private sector. In COP22, PEPFAR will sustain delivery of HIVST at all PEPFAR supported, and support roll-out of new and effective delivery models. HIVST has been fully integrated into community and index testing; we will ensure continued use of HIVST in this platform including for index testing among children and adolescents. We will also continue to target key populations and other priority groups like AGYWs and men. In addition, PEPFAR will work with the MOH to develop a system to track feedback for confirmatory testing for individuals who are reactive on the self-test.

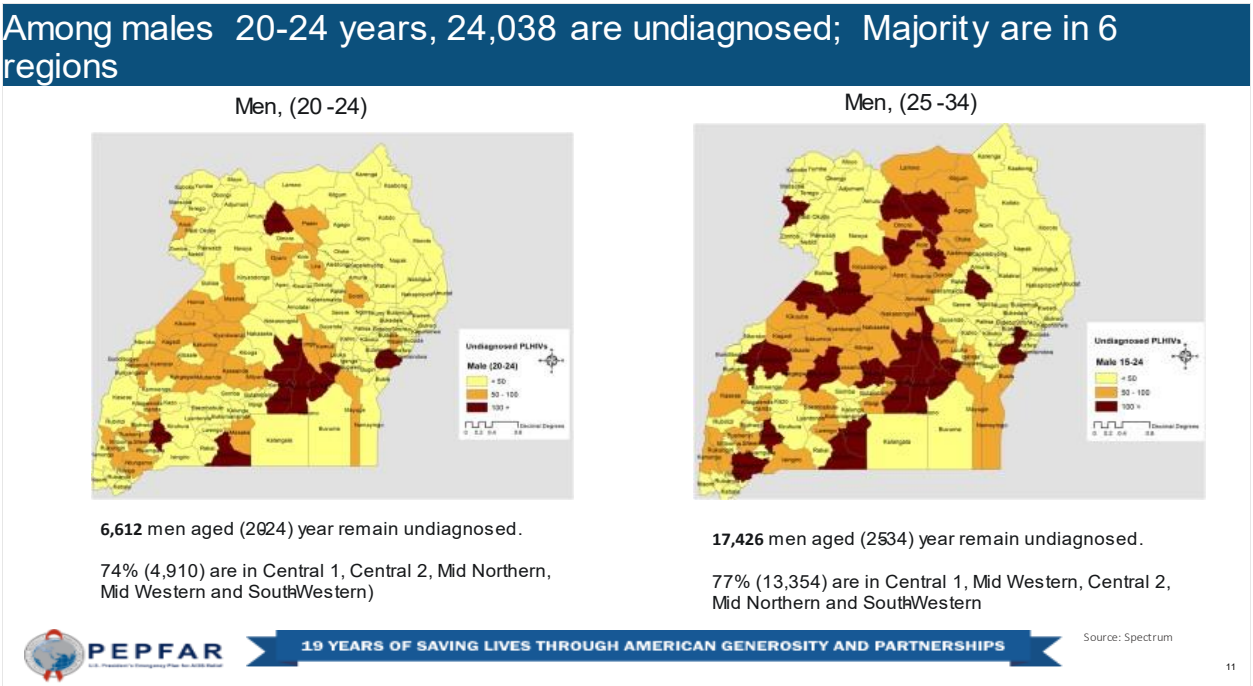
Recency testing will be rolled out to sites contributing 85% of HTS_TST_POS COP22 target. Roll-out to 100% of PEPFAR-supported sites will not be possible due to logistical challenges including the capacity of sites to conduct, report and use recency for public health response. Recency is one of several data sources which, through triangulation, provides an opportunity to target case finding and other prevention services. The MOH has drafted the public health response plan for using recency results; With this plan, we will geo-map recent infections, triangulate with other data sources including MER, characterize infection, and appropriately respond to prevention gaps by geography and subpopulations, including intensified case finding.

Finding and Reaching Epidemic Control Among Men 20+ years

The HTS program is well aligned with the HIV epidemic in Uganda. The COP22 targets were aligned to the case identification gap towards UNAIDS 1st 95 and the HTS_TST_POS target was derived backwards from TX New target by age, gender, and geolocation. The overall, the HTS_TST_POS target increased from 74,036 in COP21 to 151,831 in COP22 with 40.4% (61282/151,831) being men aged 20+ years. The TST_POS targets were aligned to high volume testing modalities including Other PITC, Index testing, Community Mobile and PMTCT that contributed 82% of positive identified including men and their respective yields based on past performance. Overall, there are 61,282 undiagnosed males aged 20+ years, 80% of these are in six regions of ten regions in Uganda including Central 1, Central 2, Mid-Western, Mid Northern, South-Western, and East Central. Central 1, Central 2 and Mid Northern alone host 51% of the undiagnosed individuals.

The UPHIA (2020) revealed that only 75.8% of the estimated HIV-positive men aged 15-64 have been diagnosed, 71.6% of those are on ART, and 65.1% are virally suppressed.

PEPFAR Uganda program has been scaling up HIV testing interventions to reach men since FY16, and individuals identified have steadily increased over the years. Reaching the remaining undiagnosed men will require person centered and efficient strategies to reach men at heightened risk for HIV. Building on experience and practices in COP21, Uganda will continue to prioritize initiatives and testing approaches proven to reach high numbers of high-risk men and identify high volumes of positives in the critical age group of 24-49. To maximize efficiencies, Uganda will leverage existing and different community networks such as CSOs, community-based organizations, cultural institutions, and other community structures and systems to increase the demand for HTS and support active linkage to testing in the facility and within the community. Uganda will also leverage the 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 the five regions with highest gap including Central 1, Central 2, Mid-Western, Mid Northern and South-Western.



UPHIA (2020) findings also showed the highest case identification gap is in men of the age group 15-24 with only 47.3% diagnosed, 47.3% of those are on ART, and 37.6% are virally suppressed. In addition, there is a significant case identification gap in men aged 25-34-years with 58.6%, diagnosed, 54.3% of those are on ART, and 47% are virally suppressed. HIV case finding services for men will be person centered 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.

Over the years, including FY21, over 80% of men 20+ years were diagnosed through Other PITC, Index testing TB clinic and Community Other testing modalities, with Other PITC alone contributing close to 50% of positives. In COP22, we shall leverage the success and prioritize key HTS interventions to identify men. The following interventions will be scaled up in COP22 including:

Other PITC: This is intervention will be prioritized to identify most men 20+ years in COP22, with increased focus on; working with men's peers to fast-track men for testing and making testing more flexible to allow men room to test when they are available. HIV self-testing will be integrated into facility testing and strengthening integration of TB and HIV screening will continue to be prioritized. The validated screening tool will be used to ensure efficiency.

Optimize index testing**:** Index testing remains a critical intervention for reaching men and will be prioritized to identify men 20+ years in the COP22. In COP21, HIVST was integrated into index testing, this will be intensified in COP22 and will be enhanced with more effective delivery

models including vending machines, online and other digital approaches, and Private sector delivery. We will leverage PMTCT platform to increase reach for men through working with mothers to ensure their partners are tested.

Refocus community-based testing**:** Within the community, we will support the scale-up of Social network testing (SNS) alongside APN to reach social contact of HIV-positive and high-risk HIV-negative men in 80% of PEPFAR supported sites. Evidence from the regions that implemented social network testing in COP21 indicates an average yield of 11% and high HIV-positive volumes. Highly targeted community testing will be intensified to reach KPs and PP including men aged 20+ years. All community testing will be subjected to screening for HIV test eligibility for all populations, including KPs. In COP22, community testing is expected to contribute over 30% of total HTS_TST_POS target allocated to men aged 20-34 years. Hot spot mapping will be key in reaching priority groups for HTS. We will continue to scale up HIV self-testing as an integral approach in community testing. Engagement of community initiatives including CSO, CBO, Faith and Community Initiatives (FCI), Peers will be intensified to enhance demand and linkage to HIV self-testing.

Highly targeted risk-based facility testing. Within the facility, testing will be concentrated at critical service delivery points like TB, STI, and malnutrition. Testing outside the critical delivery points will be done with screening for HIV test eligibility using the validated screening tool

Scale up recency testing and use findings to enhance case identification: In COP22, we will scale-up recency in 80% of PEPFAR supported sites. Recency data will be utilized to geo-map locations with high rates of recent infections especially in men aged 15-24 years that have showed high rates of recent infections in FY21 to inform targeted testing. In addition, recency data will be triangulated with other sources such as MER and UPHIA to ensure individuals infected are promptly identified and other prevention programs are optimized in areas of active transmission

In COP22, 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+

The UPHIA (2020) revealed that 83.4% of the estimated HIV-positive women aged 15-64 have been diagnosed, 80.6% of those are on ART, and 74.6% are virally suppressed. UPHIA (2020) findings also showed the highest case identification gap is in women of the age groups 15-24 with only 63.7% knowing their HIV status, 60.2% of those are on ART, and 53.3% are virally suppressed. Overall, there are 72,141 undiagnosed females aged 20+ years, 80% of these are six regions including Central 1, Central 2, Mid-Western, Mid Northern, South-Western, and East Central. There are 48,602 undiagnosed females aged 10-34 years (significantly more than the

males in the same age band), and of these 77% are in 6 regions. These regions are Central 1, Central 2, Mid-Western, Mid Northern, South-Western and Kampala

FY21 program data demonstrate that 39% of women living with HIV were identified through other PITC, 24% on PMTCT platform, followed by 18% on index testing, and5% o through other modality community testing.

In COP22, we shall leverage the success and prioritize key HTS interventions to identify women. These interventions are being scaled up in COP22 including:

Other PITC: Other PITC will be prioritized to identify majority of the COP22 women TST_POS target aged 20+ years with increased focus on using the validated screening tool will be used to ensure efficiency. Integration of HIV self-testing in facility testing will be prioritized. Strengthening of integration of TB and HIV screening will continue in COP22.

Optimize PMTCT testing: Over 40% of women of positive women will be identified through the PMTCT platform. 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. Integration of PMTCT/EID in EPI will be intensified. We will continue to build the capacity of MCH testers to ensure provision of quality HIV testing.

Optimize index testing**:** Index testing remains a critical intervention for reaching women and will be prioritized to identify women 20+ years in the COP22. In COP21, HIVST was integrated into index testing, this will continue in COP22 and will be enhanced with more effective delivery models including vending machines, online and other digital approaches, and Private sector delivery.

Refocus community-based testing**:** Within the community, we will support the scale-up of social network testing (SNS) alongside APN to reach social contact of HIV-positive and high-risk HIV-negative women in 80% of PEPFAR supported sites. Evidence from the regions that implemented social network testing in COP20 indicates an average of 11% and high HIV-positive volumes. Highly targeted community testing will be intensified to reach Female sex workers, their partners and other priority women aged 20+ years. All community testing will be subjected to screening for HIV test eligibility for all populations, including female sex workers. In COP22, community testing is expected to contribute over 25% of total HTS_TST_POS target allocated to women aged 20-34 years. Hot spot mapping will be key in reaching priority groups for HTS. We will continue to scale up HIV self-testing and HIVS will continue to be integrated in community testing. Engagement of community initiatives including CSO, CBO, Faith and Community Initiatives (FCI), Peers will be intensified to enhance demand and linkage to HIV self-testing.

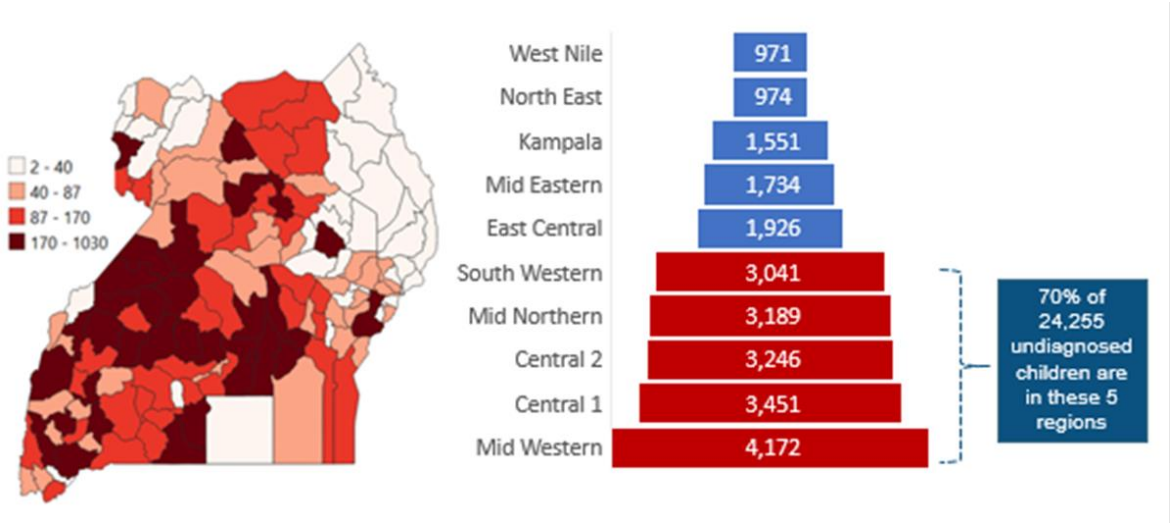
Scale up Recency and use findings to enhance case identification: In cop22, scale-up recency in 80% of PEPFAR supported sites is a priority. Recency data will be utilized to geo-map locations with high rates of recent infections in women aged 15-24 years that have showed high rates of recent infections in FY21 to inform targeted testing. In addition, recency data will be triangulated with other sources such as MER and UPHIA to ensure individuals infected are promptly identified and other prevention programs are optimized in areas of active transmission

The HTS program will leverage the DREAMS and OVC platforms, using validated screening tools to identify adolescents and young women.

Finding and Reaching Epidemic Control among Adolescents

HIV prevalence among children <15 years is estimated at 0.39% (Spectrum 2022); this translates into an estimated 79,185 children living with HIV in COP21. By FY21Q1, 57,842 children were receiving treatment while 21,343 children were not on treatment. It is projected that by COP22 60,777 will be diagnosed, and there will be 5,847 new infections.

Based on Spectrum data, there are 12,561 children living with HIV who are undiagnosed in Uganda. Mid-Western, Central 1, Central 2, Mid North and Southwestern contribute 70% of the undiagnosed children while Mid-Western has the highest number of undiagnosed children. Approximately 50% of all undiagnosed children are in 25 districts of Uganda.



In COP22, Uganda will surge case finding interventions to find the remaining undiagnosed children. We will focus our efforts in the districts highlighted above with the highest numbers of undiagnosed children. We will stratify our interventions by age, and we will refine these interventions based on lessons learned from the FASTER initiative and the national pediatric QI collaborative.

For children 18 months to 9 years, Uganda will continue to prioritize index testing for biological children of women living with HIV through use of the family tracking tool. We have received feedback from caregivers that there are challenges with lack of transport and time to bring the children to the facility for testing. At the facility level there are inadequate resources for teams to go out to the community to provide index testing. To bridge this gap in COP 22, we have included a dedicated budget to support pediatric community index testing to enable facility teams to go into the community to provide index testing. We shall utilize community resource people to identify households with HIV exposed children and link them to the testing teams. To

further increase access to HIV testing services for children, we will scale up caregiver assisted HIV self-testing for children using the index testing platforms for caregivers who prefer to have their children tested at home without the presence of a health worker. Caregiver assisted HIV self-testing has been proven to be highly feasible and acceptable through a study conducted here in Uganda and has been included in our national guidelines as an additional platform to reach more children with HIV testing services.

To identify sick children, Uganda will further optimize HIV testing services within the Outpatient Department (OPD) which consistently has been contributing the highest number of HIV positive children. We will continue to use our validated HIV risk screening tool to identify children who are eligible for HIV testing however based on lessons learned from the CRS FASTER initiative, we shall use lay screeners who will be deployed at the OPD to ensure correct and consistent use of the screening tool and reduce missed opportunities for testing. In addition to this we will continue to support PITC at high yield entry points including malnutrition clinics, TB clinics and inpatient pediatric wards.

In COP 22 we estimate to have 86,217 (Spectrum 2022) adolescents 10-19 years living with HIV. By Q1 of FY21, 27,897 were not on treatment. To address this gap, Uganda will use a peer-led approach to implement innovative case finding strategies tailored to the needs of the adolescents. We will scale up HIV self-testing among adolescents 15-19 years. This approach has been proven to be highly acceptable and feasible through a pilot conducted in Uganda and has been incorporated into our national guidelines. We will utilize our YAPS peers to distribute the HIV Self-Test kits to their peers and link positives to confirmatory testing.

Social Network Strategy (SNS) testing has proven to be a high yield case funding strategy for adolescents especially in the urban areas. The scale up of this approach has however been sluggish due to inadequate resources. In COP 22 we will prioritize SNS testing and utilize the YAPS peers to identify these networks of adolescents at risk of HIV and link them to treatment. In addition to these we will continue to provide PITC in OPD and other high yield entry points including STI clinics and TB clinics. Index testing has been expanded from 14-19 years and this will continue to be provided in COP 22.

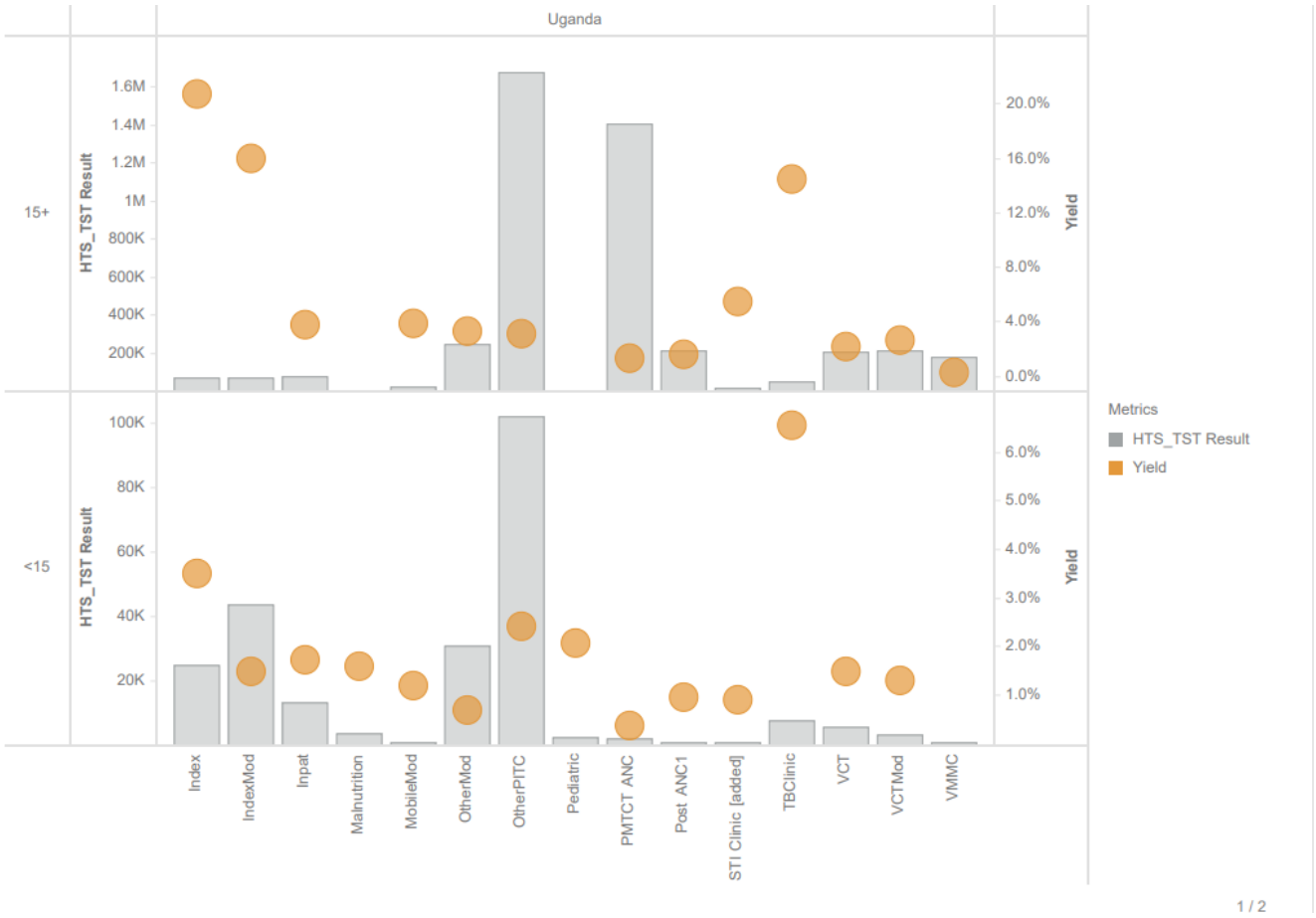
For young adolescents (10 years to 14 years), case finding will be optimized through four priority actions. The first is to strengthen index testing for biological children of women living with HIV (WLHIV). Biological children of WLHIV will be line listed, followed up and tested for HIV by service providers for and tested. Secondly, PEPFAR will expand HIVST using the YAPS platform; the YAPS will be oriented on HIVST and given HIVST kits to distribute to their contacts with appropriate guidance to ensure safe testing. Thirdly, SNS testing will be optimized among adolescents. The adolescents will be requested to identify their contacts who will also be followed up and tested. Fourthly, PITC will be optimized at facility entry points that generate high volumes of positives. This will ensure that no one is missed at these service points.

For children under 18 months, PEPAR will implement POC testing in hard-to-reach areas and high-volume inpatient settings. This will require health workers to provide in-patient testing services to avoid missed opportunities. IPs will also scale up community EID testing through integrated EPI/EID outreaches that will be held in locations that have the highest unmet need.

Additional interventions will be to enhance maternal retesting in late pregnancy and post-partum periods and strengthening HIV-exposed infants (HEI) screening at PMTCT, mother-baby care points (MBCPs) and immunization clinics. These interventions are intended to identify HEI early and ensure that they are actively followed up. Health workers will be oriented in these approaches to ensure effective implementation.

As part of the COP22 case identification surge, intensive data reviews will be conducted on a weekly basis to monitor progress and identify performance gaps. Solutions will be sought jointly with the IPs and implemented in a timely manner. In addition, a tiered partner management strategy will be implemented which is designed to provide tailored support to IPs in line with the needs of the program.

Figure 4.1.1 Testing Volume and Yield by Modality and Age/Sex, FY21



4.2 Ensuring Viral Suppression and ART Continuity

To improve HIV viral load (VL) coverage in FY21 Q4, PEPFAR Uganda embarked on a VL surge that involved data review to identify implementing partners with the highest VL coverage gap, identified and prioritized health facilities and districts contributing 80% of the gap. Successful interventions implemented at the priority facility include: 1) line lists and flagged

clients' charts due for VL test VL during the reporting period, including those with MMD, and contacted them on phone provided them with the option to come back to the clinic for a sample draw, 2) community sample collection for those who were unable to make it to the facilities due to transport fare challenges following the COVID-19 lockdown, 3) flexi-hour VL bleeding for busy working or corporate clients, 4) expert clients and YAPS were used to physically track and follow up age specific sub-populations in the communities as well as generate demand by offering health education talks on radio shows, 5) IPs reactivated facility based VL committees to ensure active identification of eligible clients and timely filing of results, and 6) PEPFAR conducted weekly IP performance review meetings to monitor partner progress against VL coverage targets. IPs improved their data quality and reporting to account for all clients including those who had died, transferred out, or lost to follow up.

The VL surge was implemented in collaboration with the district health teams. In addition, the PEPFAR team worked jointly with MOH and CPHL teams to ensure availability of commodities needed to support the above activities. The VL coverage improved from 85% in FY21 Q3 to 94% in FY21 Q4. In COP22 PEPFAR will conduct VL data reviews using a dashboard that captures monthly IP achievements in order to institute course correction measures in a timely manner.

For viral suppression, PEPFAR in collaboration with MOH supported IPs to roll out optimal regimens mainly TLD or DTG containing regimens for those on 1st and 2nd line respectively including adolescents >20kgs, adults and women of reproductive age. Overall, by the end of FY22 Q1, 79% of PLHIV had transitioned to TLD. PEPFAR will work with IPs to mop up the remaining PLHIV on non-nucleoside reverse transcriptase inhibitors (NNRTIs) that is; the pregnant and breastfeeding women at 6 months post-partum and transition them to TLD. We are also working collaboratively with MOH to transition PLHIV on protease inhibitors (PIs) as 2nd line to DTG based regimens (DBRs) and by end of February 2022, close to 75% of clients on PIs had transitioned to DBRs. Furthermore, PEPFAR will continue to support the roll out of pediatric Dolutegravir (pDTG) in line with the revised HIV treatment guidelines. IPs will be encouraged to utilize the VL change package and support 1) high viremia clinic days in order to address clients' adherence barriers 2) counsellors in facilities to offer psychosocial support for non-suppressed clients, 3) enrollment of eligible children on to OVC programs and 4) train VL result interpretation and clinical management of non-suppressed clients.

Low level viremia monitoring

The 2021 WHO guidelines define undetectable viral load as less than 50 copies/mL and recommend enhanced adherence counseling and repeat viral load testing for PLHIV with low level viremia (51-999 copies/mL). Research shows that low level viremia >50 copies/mL is a risk factor for poor individual and public health outcomes, including virologic non-suppression and virologic failure, HIV drug resistance, serious non-AIDS events (SNAEs), potential sexual transmission potential >200 copies/mL, and potential for mother-to-child transmission. In view of this evidence, the Uganda MOH is revising the HIV treatment guidelines to lower the viral load cut off threshold from the current cut off threshold of >1,000 copies/mL in order to address low level viremia and align with the U=U goal. Thus, low level viremia monitoring is intended to identify patients that

might need additional support to prevent poor individual and public health outcomes, as well as serving as an improve tool for patient empowerment through improved literacy around viral load. The PEPFAR communication partner, Social Behavioral Communication Activity (SBCA), will support MOH/ACP community department to engage CSOs and PLHIV networks with patient literacy information on the importance and benefits of early treatment initiation, ART adherence, and viral load monitoring, including U=U messaging. Implementing partners will support site teams to provide intensified adherence counseling for PLHIV with low level viremia.

In COP22, PEPFAR will support revision and roll out of the national guidelines including low level viremia monitoring and management at national, regional, district, facility, and community level. While guidelines are still under development, the anticipated changes are as follows: PLHIV with viral load 51-199 copies/mL will receive routine adherence messaging and will continue with their ART and get a repeat test after 1 year. Those with 200-999 copies/mL will receive three sessions of intensive adherence counseling (IAC) followed by a repeat VL after 6 months. PLHIV tested on the dried blood spot (DBS) platform will have plasma repeat VL test following completion of IAC. PEPFAR Uganda will continue to support MOH to expand plasma specimen management capacity and therefore increase the testing capacity using plasma from the current 60% plasma specimens with 40% DBS to 70%:30% in COP22 and will increase the proportions in subsequent COP years. Efforts will be made to ensure adequate commodities to support low level viremia monitoring. All these efforts are directed toward maintaining durability of dolutegravir for as long as possible while decreasing HIV transmission and HIV incidence to achieve epidemic control.

CONTINUITY OF TREATMENT (COT)

We will focus on three main strategies as we stay the course to ensure continuity of treatment and close gaps in the second 95: 1) REFINE interventions; 2) SUSTAIN and enhance our focus on data for impact; and 3) INTENSIFY partner management for accountability.

We are continuously refining what we are doing, regularly monitor program improvements, and adapt to the dynamic context and impact of COVID-19 as well as the evolving needs of the people we serve.

To mitigate treatment interruption, we continuously utilize data to identify who is most vulnerable to treatment interruption, who is less likely to return to treatment, where they are? and why? We will use this data to continuously refine and tailor our interventions as well as laser target for impact. As efforts to improve IIT reporting intensify we observe an increase in IIT reported. We will sustain these efforts with support from the HQ ICPI teams. Accurate and complete data is critical to correctly target our interventions and resources, to address the most in need in a timely manner.

We are partnering with local communities and PLHIV networks to increasingly lead the COT response, monitor the quality of services, and test innovative approaches.

With a flatline funding level, we are intensifying partner management approaches for accountability to ensure our investments are effectively utilized in the right place for the right service and for improved results.

All our work is underpinned by core principles of partnerships, amplifying crucial voices especially women and youth, equity and inclusion as well as evidence and innovation.

Aside from the basic core treatment services, we have increased our budget allocation for community services and early retention initiatives to ensure we provide the support and bring services closer to the persons we serve and implement interventions to mitigate early interruption in treatment for the newly initiated individuals.

Overall, 5% of all PLHIV had been experiencing a cycle of interruption and return to ART (CIRA), throughout FY21. However, we have seen a promising start to the year with a decline in overall program CIRA at 4% in FY22 Q1.

FY22 Q1 data shows that the populations at highest risk of treatment interruption were adolescents aged 15-19 and 20–34-year-old clients.
Continuity of treatment is a priority to sustain gains made in the second 90. In COP22, our focus is to maintain current cohort and intensify support for newly initiated PLHIV on ART as well as the sub-populations most at risk. We aim to reach 1.36million PLHIV with treatment services and initiate 171,000 newly identified HIV positive individuals on treatment. This will bring our population level ART coverage to 90.8%.

This should include incorporating findings from community-led monitoring and any relevant quality improvement and/or assurance efforts.

PEPFAR Uganda will continue with the test and treat strategy, with immediate linkage to treatment and ensure treatment continuity.

Despite this, we have more work to do to support adolescents and youth aged 15-29 years old who are most vulnerable to experience high treatment interruption and less likely to return to treatment. There is no notable variable between males and females. We will describe in detail what we are doing to address this issue later in the Pediatric and Adolescent session.

We observe geographical variations in IIT burden with more interruptions in the mid-north and central regions as well as a few pockets in the southwest. Notably, 3 cities Kampala, Gulu and Mbarara report a high IIT burden which calls for a review of our continuity of treatment interventions in urban versus rural communities.

We have identified 55 districts which account for 80% of the total IIT of which 4 districts account for about 30% of the IIT burden.

We will prioritize these districts in the upcoming national IIT QI collaborative.

In COP22, we continue to utilize our data to target districts and sites with high IIT burden to maximize impact.

Urban and semi-urban areas report a higher burden of IIT for PLHIV on ART less than 3 months, calling for a review of COT strategies to address these variations and early retention strategies.

PEPFAR Uganda will utilize the national and regional QI platforms, CLM feedback loops and PLHIV-led treatment literacy initiatives to implement a targeted and tailored approach

We are making substantial progress in MMD coverage following the MOH circular in March 2021 expanding eligibility for MMD and delinking VL testing as a pre-requisite for MMD. We achieved 77% MMD coverage at FY22 Q1 and to date, program monitoring data shows a sustained upward trajectory. Provision of MMD will be synched with VL bleeding at both facility and community levels to avoid missed opportunities. In COP22, we aim to reach and maintain>90% 3+ months MMD coverage, including scale up of MMD among all eligible children.

However, we do not see a similar trend in the uptake of community differentiated service delivery models. We are working with PLHIV networks and counselors to better understand the barriers. We will continue to enhance demand for these models through the recently launched Time Up HIV campaign and expand alternative DSDM.

Figure 4.2.1 Number and Percent Contribution of Clients Receiving MMD by Age/Sex, FY21Q4

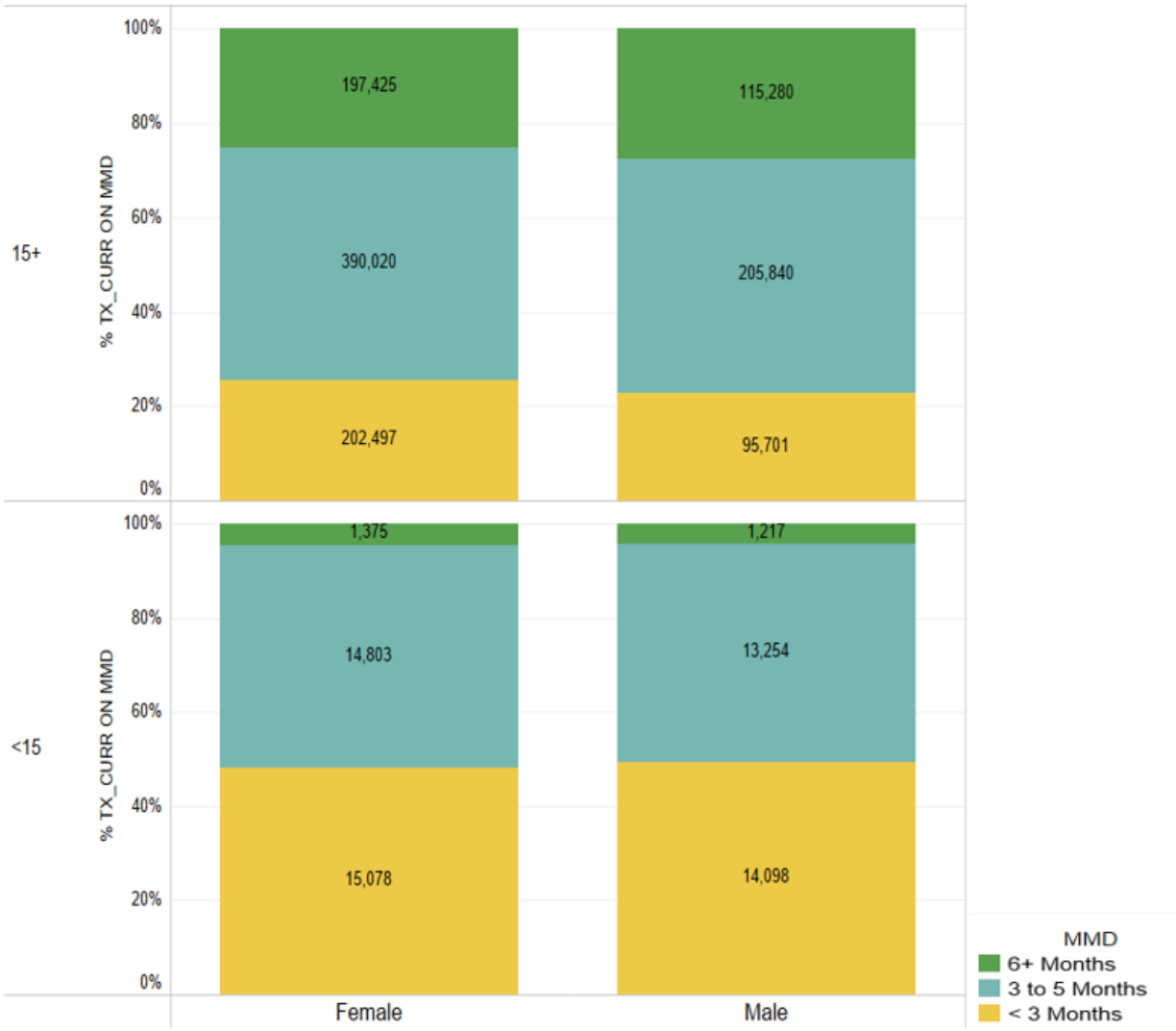
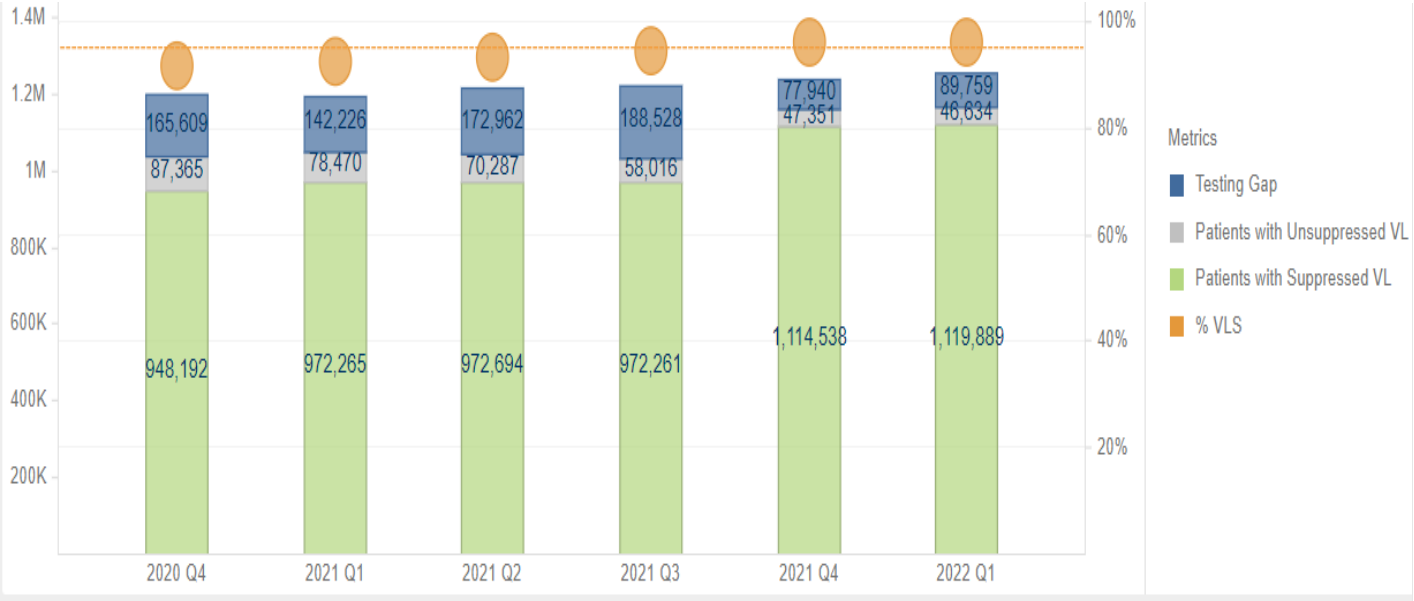


Figure 4.2.2 Viral Load Outcomes, FY21



This visual comes from: Treatment Single OU Dossier; Treatment Overview chapter; Multi-month Dispensing by Age/Sex page; current quarter, by sex

4.3 Prevention, Specifically Detailing Programs for Priority Programming

a. *HTS: Describe how the program will incorporate HIV Testing Services into prevention programming and prevention monitoring in alignment with Section 6.3.5 of COP22 guidance.*

Beyond case finding and linkage to treatment, testing for HIV prevention will be tracked to ensure enhanced comprehensive risk assessment and tracking linkage of high-risk individuals to the appropriate package of prevention services. In addition, testing for prevention will ensure continued risk assessment and repeat testing for early HIV case identification. We will focus implementation to the youth bulge across the mix of prevention interventions starting from case finding through to the DREAMS and VMMC programs. This entails working with youth groups including YAPS and Uganda Network of Young People Living with AIDS (UNYPA), including through Y+ Ambassadors. Testing for prevention will be implemented on the following prevention interventions:

HIV testing will be integrated in DREAMS program, for efficiency, will leverage AGYW platforms and the PMTCT Platform to address the Youth Budge. Male characterization, and risk screening for referral to VMMC, PrEP and case finding will be optimized.

Targeted HIV testing for prevention on the VMMC will be implemented with a focus on partners of AGYW, partners of PBFW- likely to be men aged 30+. We will track VMMC implementation among the Fishing community and Truck Drivers.

Routine testing of individuals receiving PrEP, is critical for monitoring the impact of interventions for preventing new infections and maintaining epidemic control. In addition,

HIV self-testing will be implemented on the PrEP program as part of repeat testing and screening for those who seroconvert.

b. *DREAMS: Describe how you will respond to all minimum requirements and program guidance in Section 6.2.2.2 of the COP22 Guidance; how you will scale up PrEP for AGYW in DREAMS SNUs, improve mentoring, and enhance economic strengthening approaches? Describe your progress and plans for saturation by SNU (including any maintenance plans), and any approved geographic expansion.*

In COP22, Uganda will continue to implement an integrated AGYW strategy that is aligned to the National Health Sector HIV Prevention Strategy for AGYW (2020-2025)[1]. This will be implemented across multiple platforms including HIV 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.

PEPFAR Uganda is targeting the highest risk AGYW in the 24 DREAMS districts, with lower targets for the 15-19-year-old age band in COP22 based on current saturation and maintenance calculations. The youth bulge, higher need for secondary package interventions due to school disruption and impacts of COVID-19 on AGYW and the economy have created a complex implementation and targeting environment. As the DREAMS program identifies the highest risk individuals and IPs continuously analyze program data, there is a need for precision around risk assessment and enrollment, and flexibility around age band targeting. Partners will be encouraged to actively assess the number of young women being screened and eligible, and if additional 15-19-year-olds are found eligible beyond the AGYW_PREV target PEPFAR will guide IPs on how to use available resources across the DREAMS portfolio to provide equitable services for eligible AGYW. This will be done within the total target and resources set for the program, while continuing to ensure adequate coverage of the 20-24 age band which is usually the most difficult to enroll and retain in the program.

The Uganda program assessed saturation reach to guide the targeting process by age band by district. In the districts close to saturation, targets that were provided focused on bridging the gaps to saturation. For districts that had saturated, we provided maintenance targets to cater for aging in and out of AGYW and ensuring program completion for enrolled AGYW to reach district saturation. The program considered saturation rates across age bands and SNUs which guided target allocation to facilitate saturation in age-bands and SNUs that were yet to saturate. To cater for the improvement in the quality-of-service provision as laid out in the layering table with most of the targets allocated to the urban districts of Wakiso, Mukono, Mbarara and Kampala to increase coverage given their huge numbers of AGYW at risk, the overall targets were reduced from 247,819 in COP21 to 159,665 in COP 22.

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

The USG has served a total of 735,000 AGYW aged 9-24 over the past five years. In COP21 we are following a cohort of 262,660 AGYW aged 9-24 to support their completion of age-appropriate DREAMS services. Uganda will implement a robust person-centered quality AGYW program with fidelity aimed at reaching AGYW with the highest HIV risk, identified using a standardized risk 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 a harmonized, age-appropriate core package of evidence-based primary and relevant secondary interventions for each target age band. (See DREAMS Layering table)
In COP 21, DREAMS ambassadors were hired across each DREAMS SNU to support district level coordination of DREAMS activities. The ambassadors improved engagement between the local government community department and DREAMS implementing partners, supported meaningful engagement of DREAMS peers and mentors in DREAMS activities and are advocates for improved AGYW programming in their respective districts. In COP 22, 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

The DREAMS initiative will continue realignment of the program 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 enable compliance with the COVID-19 standard operating procedures. To Improve its access, we plan to integrate PrEP, HTS and FP into the safe spaces to ensure a one stop center where AGYW can receive services and reduce losses along multidirectional -directional referrals, capacity building of AGYW mentors, peers and ambassadors will be critical to support scale up of these services. All PrEP sites will consult with young adults to ensure services are appropriate for this age group. The initiative will also focus on enhanced social economic strengthening approaches and increasing its urban coverage. In COP21, the program intends to reach 38, 634 AGYW with PrEP. However, in COP22 as per the PLL directive, the program plans to increase AGYW PrEP targets to 70,196. PrEP messaging will be part of the primary package for the 15–24-year-olds. Innovations like PrEP initiation and refills in AGYW safes paces will be adopted. The program will engage peers to be part of the PrEP service delivery and support the PrEP interpersonal literacy initiative for the AGYW. The peers will be mentored/trained on the benefits of PrEP to improve demand, uptake, adherence and continuation of PrEP.. The program will in addition, further expand social behavior change communication through SBCA communication IP to ensure continuous sensitization to clear PrEP myths and misconceptions among AGYW.

In response to sub-optimal completion for the 20-24 as highlighted in the PLL, the program will strengthen use of community gatekeepers and peer male champions to

help AGYW partners and spouses understand the value of the DREAMS program. PEPFAR will support the creation of a platform for trainees to select their own enterprises and support those who complete to start viable economic ventures. PEPFAR will also expand funding under DREAMS for socio-economic empowerment, behavior change communication, and skills training for AGYW to respond to skyrocketing teen pregnancy and violence as a result of COVID.
The program has also adapted enhanced social economic strengthening models, like the WINGS Plus and BRAC-Empowerment and Livelihood for Adolescents (ELA) models that support girls to learn as they earn, which is useful in retention. Such models will be scaled-up in COP22 to support retention, completion and promote sustainability among the AGYW after graduation. We will continue to utilize findings from extensive market assessments that were done in COP21 to identify scalable market-driven opportunities and guide intervention packages into male dominated and quick economic gains enterprises for AGYW.

In addition, under COP22 the DREAMS initiative will invest in an enabling environment for intervention completion by scaling up Journeys plus in the community for the girls 10-14, enhancing education subsidies to address school re-enrollment and retention; improving AGYW tracking and referrals across SNU's; and using person centered service delivery models in safe spaces.

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 roll out included formation of district steering committees and empowering AGYW peers to lead program start up. 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 will 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 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 22.

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,

Figure 4.0.1 Monitoring the quality of GBV service delivery, FY19

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 in COP 22.

In COP22 a third phase of No Means No curriculum that targets boys is being introduced to reduce their risk and future perpetration of violence. This will leverage existing PEPFAR supported OVC and VMMC programs (and platform) to reach boys and offer the curriculum.

Uganda Curriculum-Based Interventions

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

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

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

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

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

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

Multi-level violence prevention and response interventions

In COP22**,** Uganda continues to triangulate multiple data sources to inform a multi-level robust violence response program. These sources include the FY21 GEND_GBV performance data, Root cause analysis, National GBV QA Tool assessments data, VACS 2015, data from the Uganda National Child Helpline (SAUTI 116), and MOGLSD-supported District Action Centers data. We continue to support the government to complete key policy documents including GBV and VAC guidelines and the Comprehensive Children's Policy which addresses violence against children. We shall continue rolling out the GBV QA tool to reach all sites offering post-violence care services and prioritize safety and access to services for all who need post-violence care.

Through our DREAMS and OVC programming, PEPFAR will continue to support the government-led district action centers (DAC) through which community awareness on violence against children is improved and timely services are offered to victims. We shall continue joint

investments in the justice, law and order (JLOS) sector to improve resolution of child cases by supporting and monitoring cases at the district level.

Our data indicate that GBV is associated with non-adherence to treatment leading non-viral suppression which impedes epidemic control, in COP22, we shall continuously profile survivors to support them with needed services and counseling We recognize that men's health seeking behaviors are often negatively affected by societal expectations about 'being strong', which keeps them from treatment, thus PEPFAR will deliberately support men to access services collaborating with faith communities.

Uganda is continuing to build capacity to roll-out an "Every Hour Matters" campaign with communities including DREAMS ambassadors and YAPS to raise awareness about the 72 hours within which one should access services to avert HIV and pregnancy.

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

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

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

Figure 4.2.2. AGYW Geography of Implementation

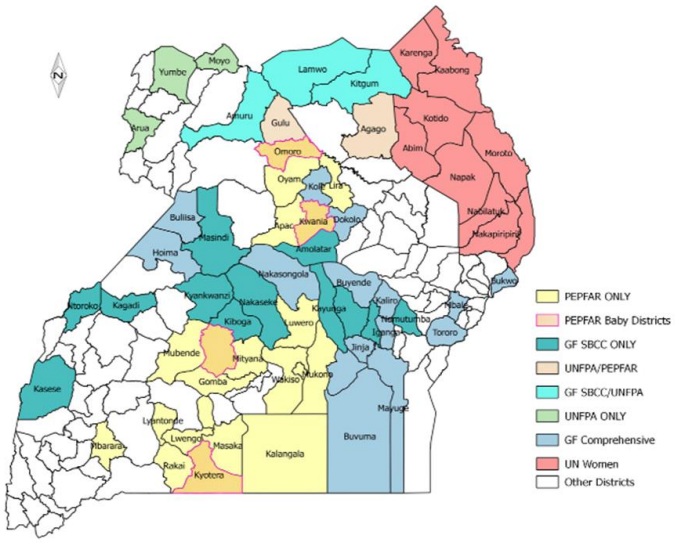


figure 4.0.2 AGYW Geography of Implementation

Figure 4. DREAMS Layering Table

COP 22 Uganda DREAMS Layering Table			
Population age bands			
	9-14	**15-19**	**20-24**
Primary Individual Interventions	• Screening for HTS eligibility • In community Based HIV & Violence Prevention • Parenting • Social Asset Building • Financial Literacy	• Screening for HTS eligibility • In community Based HIV & Violence Prevention • Basic social 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 • Basic 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)* • Basic 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 dropout *(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)* • *VSLA* • Enhanced SES components (*for the out of school)*	• Risk based HTS • Condoms • Contraceptive Mix • Post-violence care • PrEP • ART (for HIV-positive AGYW) • Group-ANC-differentiated service delivery model *(for pregnant and BF young women)* • *VSLA* • Enhanced SES components (for the out of school) • Education Subsidy
Contextual	• Reducing risk in sexual partners (HTS, VMMC, ART) *(to be provided through linkage with 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		

Figure 4.0.3 DREAMS Layering Table

c. *OVC: Describe the rationale for how your OVC_SERV target was divided across OVC Comprehensive, OVC Preventive, and DREAMS beneficiaries receiving OVC services. For OVC Comprehensive, describe your priority subpopulations and how you will ensure at least 90% of PEPFAR-supported C/ALHIV (<age 19) in high volume sites within high burden SNUs are offered enrollment in OVC programs.*

In COP22, the OVC_SERV target is 550,270 of which 406,845 is comprehensive (9% increase from COP21), 83,495 preventive (60% increase from COP21; boys = 40,134 [48%]; girls = 43,361[52%]) and 59,940 DREAMS (23% increase from COP21). For target setting, priority was given to the OVC Comprehensive program to ensure that at least 90% of PEPFAR-supported C/ALHIV (<age 19) in high volume sites within high HIV pediatric burden SNUs are offered enrollment. This target includes all active beneficiaries as reported at FY21Q4.

We conducted an analysis to determine district alignment with pediatric HIV/ PMTCT. The analysis shows that currently the OVC program aligns in 67 of the 77 districts. In order to further align for both impact and efficiency, we will: 1) Expand to 3 districts with a high burden and have a high proportion of high-volume facilities, and 2) Scale down in 10 districts where the OVC program is present but have a low burden and a low proportion of high-volume facilities. Scaling

down will be done responsibly to ensure continuity of services among beneficiaries. The priority subpopulations for the OVC Comprehensive program are C/ALHIV, HEIs, children of HIV-positive caregivers, survivors of sexual violence, children of female sex workers livingith HIV (FSWLHIV), and adolescent mothers.

For the OVC preventive program, we are targeting the same COP 21 SNUs with a high prevalence of violence against children and resuming in-school prevention which was suspended due to COVID-19 school closures. The OVC DREAMS program aims at serving 60% of 10-17-year-old AGYW who will have received OVC-like services.

The OVC program will contribute towards closing the pediatric/PMTCT/EID gap across the care and treatment and EID cascade. The program will expand to an additional 3 districts (Kiryandongo, Amolatar and Albetong) which have a high pediatric burden and a high proportion of high-volume facilities. The program will also intensify the household case management approach to provide targeted interventions across the pediatric and EID cascades to the priority OVC sub-populations.

Under the first 95, the OVC program continues to follow up on currently enrolled beneficiaries whose HIV status is unknown mainly due to missing results and refusal to disclose. We will further strengthen collaboration with the clinical program to facilitate index testing. The clinical partners will share line lists of C/ALHIV with the OVC partners to identify siblings and other household members with an unknown HIV status for HTS services. The OVC program will in addition support other pediatric case finding approaches by facilitating linkages of OVC households to service providers and ensuring timely follow-up. We will specifically explore using the OVC platform for caregiver-facilitated home-based self- testing to orient caregivers on using HST and support client confirmatory testing among others.

To support continuity of treatment, pediatric ART optimization and EID cascade completion, the OVC program will continue strengthening the collaboration with clinical partners through memoranda of understanding (MOUs) and OVC case workers placed in high volume facilities. Joint interventions will include training of para-social workers in HIV/TB using the MOH Community Actors Curriculum, linkage of OVC beneficiaries to DSD models, attaching a para-social worker to all children on treatment to reduce IIT, appointment monitoring by pre-appointment reminders, provision of person-centered support for pregnant/lactating adolescents at G-ANC, assessment of mother/child health status and link to HIV, nutrition, immunization, reproductive health (RH) services, safety, food/economic security, and education access, screen, and address violence at household level and, facilitate access to health facilities. In addition, the OVC CSOs will continue to have joint planning and review meetings with the clinical IPs to streamline operations across the board.

In supporting VLS, the program will scale up the following successful practices that have improved VLS results. At household and individual level, we will enhance caregiver literacy on the need for VL uptake and address barriers to VLS through the OVC package that includes nutrition support household socio- economic strengthening, violence screening and response, counseling, provision of transport to facilitate appointment keeping all provided through a case management approach. The program will collaborate with health facilities for case conferencing, joint household level IAC, home based VL bleeding, drug refills, and routine VL tracking and

participate in the Viral committee meetings at the health facilities. We will strengthen the social welfare workforce to conduct routine root cause analysis to identify and address barriers to VL uptake and suppression. Finally, the program will facilitate linkages for non-suppressed OVC to access community adherence clubs and treatment supporters including YAPS.

The OVC program will also collaborate with the TB program to integrate TB into OVC household case management to ensure positive treatment outcomes. This will include screening for case finding, linkage to TPT for enrolment and completion and adherence support to those enrolled on TB treatment and ensure completion of the dose.

d. *Primary prevention of HIV and sexual violence among 9–14-year-olds: Describe which intervention(s) will be used across different platforms (e.g. DREAMS, OVC).*

OVC prevention programming will be implemented in 12 districts with high rates of violence against children. A total of 83,495 boys and girls aged 10-14 (boys = 40,134 [48%]; girls = 43,361[52%]) in these districts will receive evidence-based primary prevention of HIV and sexual violence interventions through faith communities and cultural platforms, leveraging the structural roles that these platforms play in changing community perceptions and behaviors. We will also resume in-school activities that were suspended due to COVID-19-related school closures. Based on context, need, and opportunity, girls and boys will receive HIV and violence prevention in school using the Journeys and Plus or in their communities through Grassroots Soccer, No Means No, and SINOVUYO curricula.

The program will support strengthening of the response structures right from the national level through the Child helpline where cases of abuse are reported to the district level through district action centers. Follow-up is done to ensure linkage to the right services. The OVC program will continue supporting and engaging with the child justice sector to ensure that cases of violence against children are followed to logical conclusion.

Uganda will focus on primary prevention of HIV and violence among the 9-14-year-old age band through evidence-based interventions known to delay sexual debut. We shall continue to advocate and support the boys and girls to stay in school, a key factor that delays sexual debut as well as reduces risk. We shall also provide education subsidies to vulnerable girls in the comprehensive OVC program - who would otherwise drop out if unable to meet school fees - and to prevent HIV infection and violence, using the Journeys Plus community curriculum for children out of school. Uganda will increase participation of FBOs and communities to address violence among 9-14 young girls and boys. Community platforms will be used to offer these services. The program will implement interventions that enhance adolescent girls' and boys' ability to resist coerced sex and to seek support if they experience coerced sex (for example, building self-esteem and confidence as well as self-defense, developing life skills such as assertiveness, effective collaboration and improve social networks).

At the individual level: Interventions will aim to empower girls and boys to avoid 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 COP22 to build protective skills against violence. Also, the program will work with other stakeholders to enhance 10–14-year-old AGYW school re-enrollment and retention in schools following COVID-19 lock down effects.

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

e. PMTCT

Since the rollout of Option B+ in 2013, the proportion of HIV-positive pregnant women initiated on ART increased from 84% (FY13) to 100% (FY21). HIV-positive women on ART at the beginning of pregnancy increased from 33% (FY13) to 98.8% (FY21), 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 25 (PEPFAR Program data FY21Q4). 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 54% of the newly identified positives at 1st ANC visit (ANC1) in PMTCT supported PEPFAR sites (FY21Q4). 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 FY22Q1 was 1.4% among those infants tested, an improvement from 1.7% at FY21Q4. In FY21Q4 and FY22Q1, 0-2 months EID coverage improved from 86% to 93% respectively. Interventions to address missed opportunities for EID diagnosis and ensure timely 0-2 months testing will be scaled-up in COP22.

Below, we detail COP22 PMTCT activities, which 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 COP22, we expect 1,606,882 pregnant women to attend ANC1 at PEPFAR-supported sites. Of these, we targeted 100% to have known HIV status. Among the estimated 5% of pregnant women who are HIV-positive, 79,629(99%) are targeted to receive ART among which 61,810 (78%) are expected to already be on ART at ANC1 and 22% (17,819) will be new on ART. Additional COP22 targets include: 95% treatment continuity and viral load suppression among pregnant women initiating ART; 95% 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 electronic medical records (EMR) (>50%) to high-volume PEPFAR-supported ANC/PMTCT 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 MCH/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. The national PMTCT Impact evaluation study showed that 46% ANC 1 attendees) and their infants seek MCH, Young Child Clinic (YCC), and immunization services at HCIIs, yet HCIIs are not accredited to provide ART PMTCT and EID services, PEPFAR Uganda will work with MOH to improve functionality and service access for these mother-infant pairs in COP22.

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-funded 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 points (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 COP22, building off ongoing support 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.

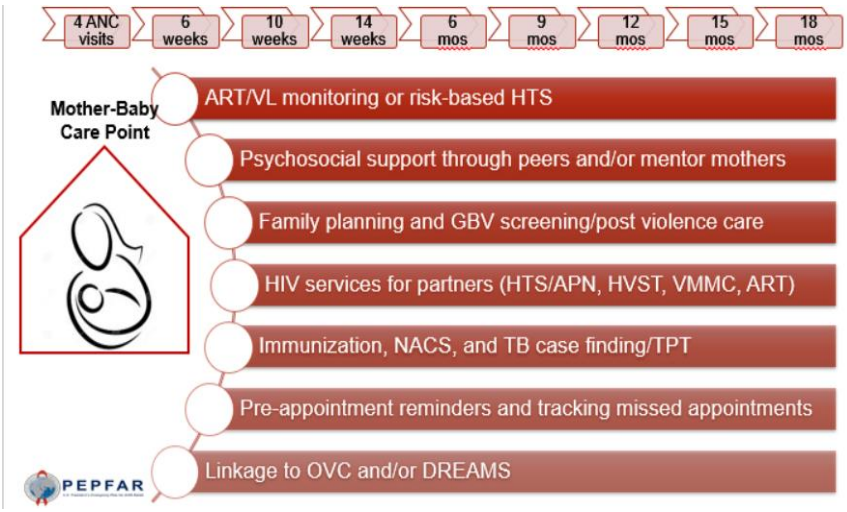
In COP22, additional focus will be directed to support health center IIs (HCII) to address sub-optimal ART coverage among positive pregnant and breastfeeding PMTCT clients identified at this level of service delivery. While almost 21% of ANC attendance happens at health center II level, traditionally 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 COP22, PEPFAR Uganda and MOH will optimize the functionality of 575 high-volume ANC/MCH HCIIs to improve access and utilization of comprehensive PMTCT/EID services, enhance continuity of treatment and follow-up of identified mother-infant pairs until 18-months final outcome status. PEPFAR Uganda received a one-time conditional plus up AP3 support an additional 200 HCIIs beyond the 375 that we have planned for within the COP22 budget. The Ministry of Health maintains the mandate to accredit HCIIs and CSOs, through their advocacy mechanisms will need to engage MOH for this consideration, including commitment to ensure high-volume HCIIs and those targeted for COP22 functionalization are supported to receive all the commodities (rapid HIV test kits (RTKs), HIV-syphilis duo test kits, hepatitis B test kits, opportunistic infection (OI) medicines, and ART etc.) to optimize care for mother-infant pairs. Specifically, PEPFAR will:

- 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 4.3. 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. 1 MBCP service delivery approach


4 ANC visits
6 weeks
10 weeks
14 weeks
6 mos
9 mos
12 mos
15 mos
18 mos
Mother-Baby Care Point
ART/VL monitoring or risk-based HTS
Psychosocial support through peers and/or mentor mothers
Family planning and GBV screening/post violence care
HIV services for partners (HTS/APN, HVST, VMMC, ART)
Immunization, NACS, and TB case finding/TPT
Pre-appointment reminders and tracking missed appointments
Linkage to OVC and/or DREAMS
PEPFAR

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 PBFW and infants less than 2 years of age.

PEPFAR Uganda PMTCT program data, FY22Q1 shows 93% viral load (VL) suppression among PBFW, although the national viral load coverage rate among PBFW is 56% according to the recent PMTCT Impact evaluation findings (2017-2019). 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. In COP22, PEPFAR in collaboration with the Ministry of Health will scale-up VL POC implementation to a 35/65 split, with 35% of VL tests done through the POC platform. VL POC will improve coverage among pregnant and breastfeeding women and timely clinical decision making to eliminate MTCT among unsuppressed mothers. Furthermore, the Ministry of Health policy guidelines have been updated to support VL POC for PBFW.

For additional information on the laboratory strategy to strengthen diagnostic optimization for viral and early infant diagnosis, please see 4.10 Viral Load and Early Infant Diagnosis Optimization.

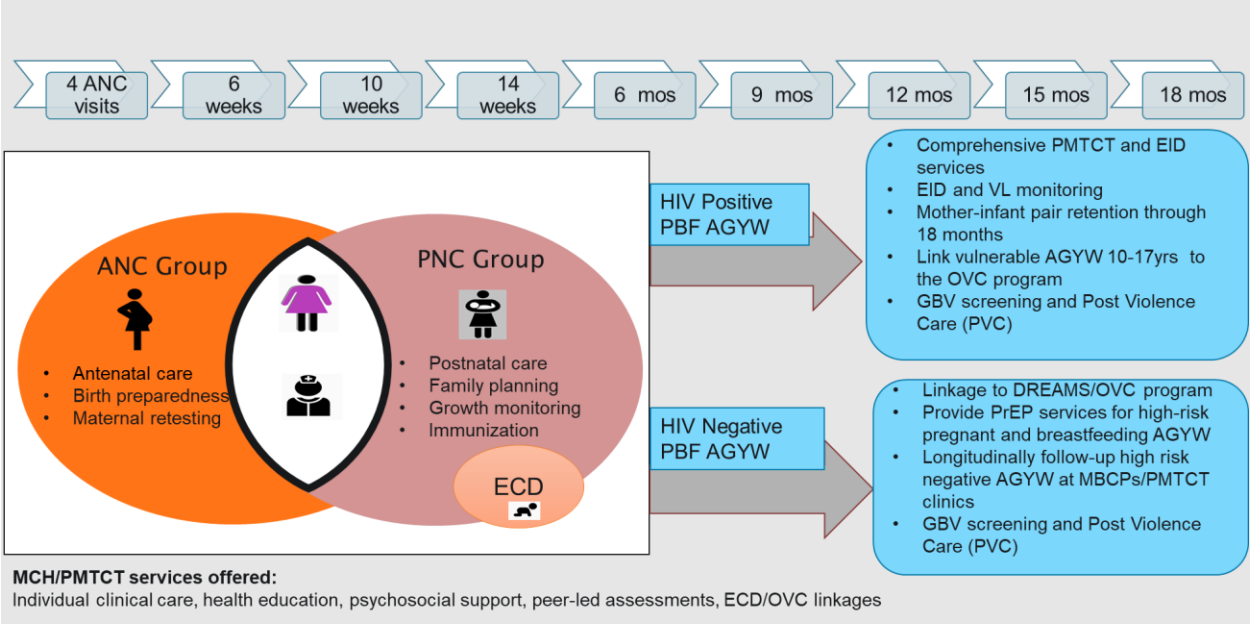
Preventing new infections among pregnant and breastfeeding AGYW

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 FY22Q1, almost half (48%) 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 AGYWs (10-24 years). In FY22Q1, only 21% of male partners were tested in ANC settings. During COP22, we 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 COP22, 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 and breastfeeding AGYW using a peer-led youth-friendly model.

Figure 4. 2 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

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 COP22, this intervention will be maintained and implemented with fidelity at 155 sites to increase geographic coverage within high-volume ANC/PMTCT sites for improved maternal and infant health outcomes.

EMR and point of services data capture to improve treatment continuity, tracking and follow-up of PBFW and 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 COP21 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 Uganda EMR 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 (EID)

In COP21, 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 COP22, PEPFAR Uganda will institutionalize these interventions across all PMTCT/EID supported regions and sites.

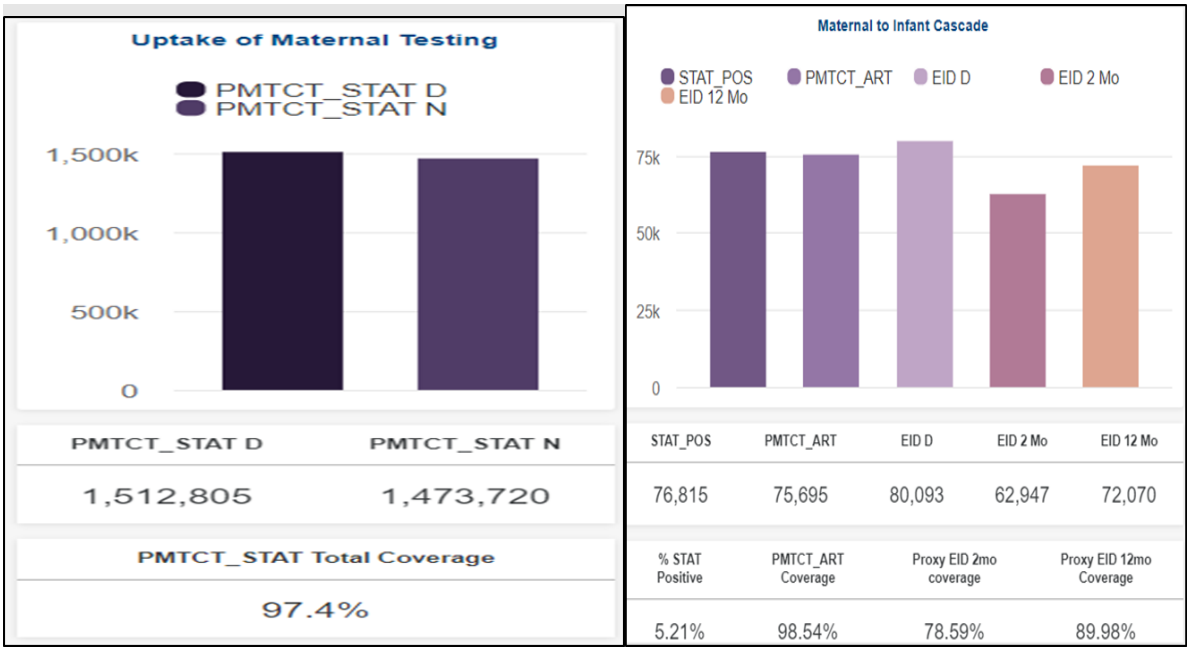
EID POC testing and scale-up for HEI

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 COP22, PEPFAR in collaboration with the Ministry of Health will scale-up EID POC implementation to a 45/55 split, with 55% 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.

Figure 4.3.1 PMTCT Cascade



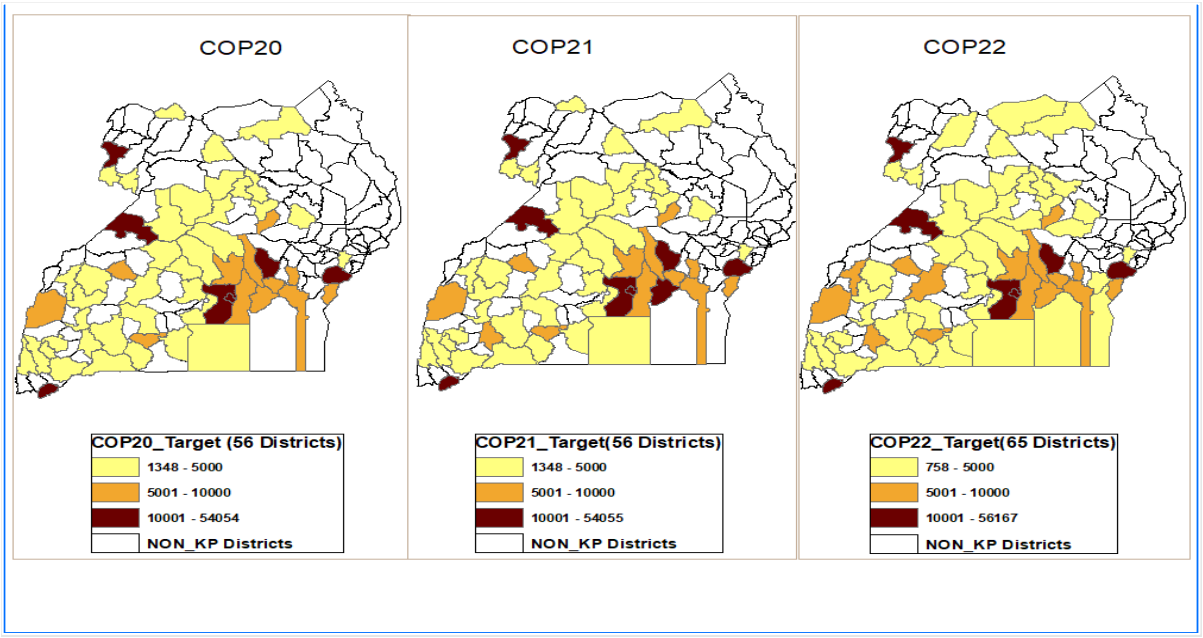
f. Key Populations

Key and Priority Populations

Key populations (KPs) continue to be disproportionately affected by HIV, contributing significantly to new annual HIV infections. Targeted KPs include female sex workers (FSW), men who have sex with men (MSM), transgender women (TGW), people who inject drugs (PWIDs), and people in prison (PIP).

Expansion of services for KPs

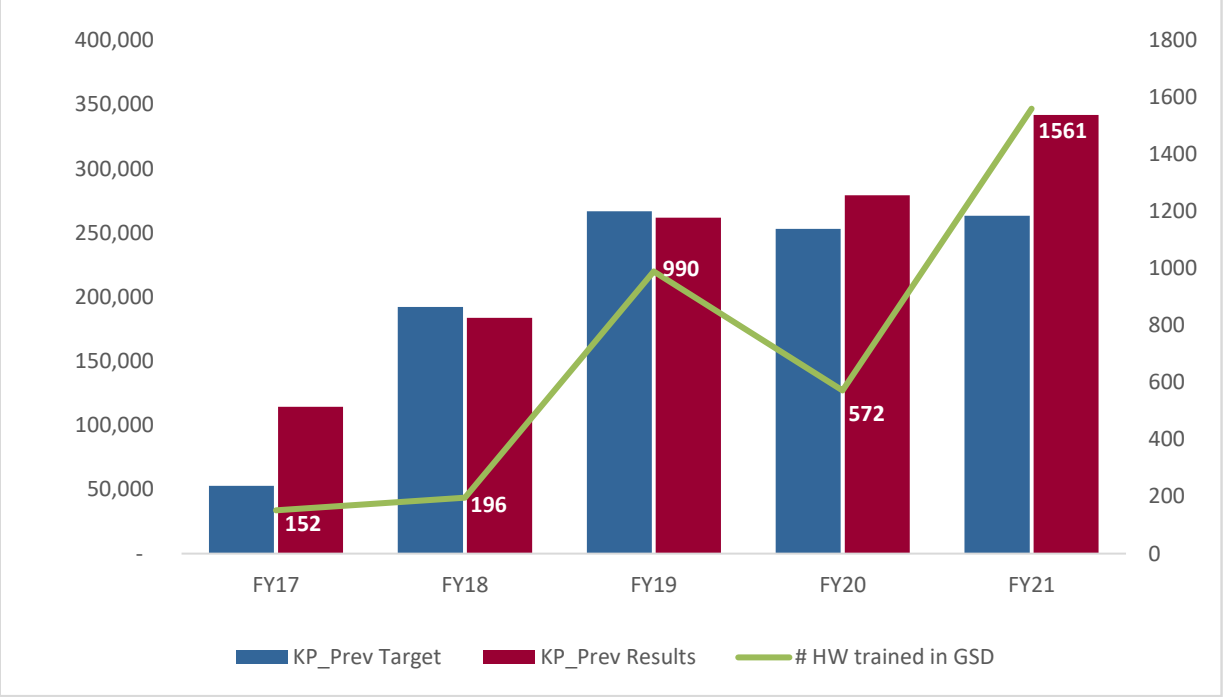
In COP22, we are expanding in targets and geography for KPs in alignment with the unmet need and people's COP voices. Our targeting was informed by the UNAIDS, the UAC national harmonized size estimates study 2019, Spectrum incidence rates 2022 and FY 21 district level KPs served (KP_Prev). Based on these variables, SNUs was categorized into five groups (very high risk, high risk, moderate risk, low risk and very low risk). All 27 very high risk and 25 high risk SNUs and an additional 13 (based on context) out of 30 moderate SNUs were allocated targets in COP22. This brings the total number of COP22 KP districts to 65 up from 55 in COP21 as shown in the figure below.



The total COP22 KP_PREV target is 306,083 and PP_PREV is 112,878, an increase in the overall KP/PP Prev target to 418,960 up from 371,916 in COP21. To improve targeting and programming, we will maintain 12 COP21 Integrated Biobehavioral Surveillance (IBBS) sites as sentinel surveillance sites in COP22 and work with the MOH to validate the utility of the "IBBS Lite" approach, which is an abridged version of IBBS to be piloted in Uganda during the COP21 implementation period through non-PEPFAR funds.

Addressing Stigma and Discrimination

We will implement a two-pronged approach that addresses stigma and discrimination at the facility level and enhance community level enablers. In the facilities we aim to continue training HCWs on Gender & Sexual Diversity and have designated KP Focal Persons at all HFs. We have maintained collaboration between healthcare providers and CSOs. The figure below shows an improved KP Prev achievement that was partly attributed to addressing stigma and discrimination through training health workers in Gender and Sexual Diversity



In the communities we will enhance our peer outreach approaches by reaching out to true KP peers through enhanced KP monitoring systems. We will leverage the KP hotline to support reporting on cases of violence, stigma, and discrimination among KP services and users. We will implement a person centered KP service package with fidelity, monitor and report the prevention and treatment cascades. Working with the community, the program will utilize feedback mechanisms like the Community Score Card (CSC), CLM, community advisory groups and client feedback in service delivery for improved community prevention case management.

Empowering the community to advocate for legal and policy reviews

We will continue to empower CSOs to advocate for legal reform and access to legal systems. To improve the capacity of KP CSOs with more focus on KP-Led and women-led CSOs as per the PLL requirement, PEPFAR Uganda has earmarked funds ($751,325) for sub granting KP CSOs through the regional mechanisms. In addition, the national KP CSO mechanism will continue to build the capacity of CSOs in Legal and policy review in addition to grants and HRH management among other priority program areas. PEPFAR will utilize the COP21 findings from

the two Legal Environment Assessments to help shape and inform legal advocacy and policy reforms related to KP and PP in addition to using, the Stigma Index data, to explore options to improve the legal environment. In COP22 PEPFAR will therefore provide $274,504 for the LEA follow-up.

Implementing DSD models and leveraging on other HIV prevention platforms

In COP22, PEPFAR Uganda will strengthen differentiated service delivery models for KPs to improve identification, linkage to and retention on antiretroviral treatment (ART). We will work with the MOH to expediate the accreditation of drop-in centers (DICs) to distribute ARVs, including for PrEP.

To improve the reach and quality of services offered to KP at DICs, we will increase funding to DICs to over $1.12M in COP22 up from $72,453 in COP21. This improved funding will see functional DICs increase from 77 in COP21 to 84 in COP22. The funds will also support integration of mental health services in DICs through supporting skilled nurses/counselors to offer screening for, detection of and referral for treatment of mental health conditions/diseases among KPs. PEPFAR Uganda and Ugandan CSOs will continue to ensure adherence to the standardized DIC service package and to strengthen collaboration between the DIC and the health facilities. In addition, we will leverage other prevention platforms including VMMC, PMTCT and PrEP to reach KPs and ensure bi-directional referral to other high impact prevention interventions as well as working closely with the OVC program on getting children of KPs to care. We will also leverage the DREAMS program to reach FSWs aged 10-19 years with high impact HIV prevention interventions.

Improving case finding for KPs

We will continue to work with CSOs to address low yield among KPs (which currently stands at 4%) through implementing risk-based testing and other innovative testing approaches like ethical and quality index client testing, social network strategy (SNS), enhanced peer outreach approach (EPOA) and confidential HIV self-testing. Hotspot mapping and profiling, attaching CSOs to KP facilities, and information communication and technology services (ICTs) will facilitate these interventions. The program will utilize the peer referral app developed and managed by CSOs to enhance identification, enrollment, and retention of KPs in HIV services. We will leverage use of social media to improve HIV services, especially MSM and TG; this includes use of WhatsApp, Facebook and other CSO driven applications/online groups to support adherence and viral suppression. We will implement non-intrusive and non-judgmental services in safe locations. Our program will also promote male and youth friendly services as a platform to increase MSM service uptake.

Improving linkage to and retention on ART and viral load suppression

PEPFAR Uganda KP linkage increased from 94% in FY 20 to (96%) in FY21. We will continue to implement population specific linkages interventions in FY 21 to close the linkage gaps. The program will scale up KP-competent ART services to increase enrollment of more KPs on

treatment. These will include same day ART initiation, community ART provision-including accreditation of DICs for ART provision and use of dedicated peers to physically escort the newly identified HIV positive KPs to ART provision points. To support adherence to treatments and improve viral suppression, we will implement enhanced treatment literacy among KPs and their families using educational, normative, and behavior change messaging like "undetectable=untransmittable" or U=U messaging. We will strengthen peer navigation and monitoring systems, reducing stigma and discrimination in both KP-specific ART sites and within the more mainstream clinical sites. The program will implement Pre clinic reminder phone calls, Root Cause Analysis (RCA) to inform interventions and weekly data reviews to identify missed appointments for prompt follow up and bring back to care interventions.

For improved retention on ART and VL suppression among KPs, we will continue to implement intensified adherence counseling using peers. We will also implement MMD and leverage on community pharmacies as DDPs We will rapidly scale up VL monitoring to ensure >95% coverage through integrating VL activities (sample collection and result disbursement) into DIC services, while ongoing psychosocial and adherence support will ensure suppression. Patients eligible for VL will be reminded by text and telephone calls. The program will expand VL appointments to DICs and target facilities with high testing gaps for tailored interventions. These will include peer-led defaulter tracking, monthly adherence support groups, multi month drug refills and intensified U=U messaging.

Improved Service Delivery for PIP

In COP22 Uganda Prisons Service (UPS) will utilize a three-pronged approach to deliver comprehensive HIV services at the 55 high-volume sites and select mid-volume sites (103). First, the program will implement risk-based testing on entry for new prisoners, three (3) monthly routine targeted testing (using HTS adult screening tool), as well as exit medical screening to detect TB and HIV among inmates as they exit the prison units to improve yield. Secondly, UPS will expand linkage and follow up through focused community and home-based testing & linkage efforts within the regions and facilities with high national prevalence and yield. In addition, there are accelerated efforts to expand ART services through a phased accreditation process of 26 additional prison facilities. Thirdly, we will support enhanced peer networks, electronic medical records, and use of the SMS linkage platform to address the low yield (2%) and suboptimal Viral load Suppression (VLS) at 93% by end FY22Q1.

MAT for PWIDs

In COP22 we will maintain the Medication Assisted Treatment (MAT) services at Butabika with a target of 300 PWIDs to be newly enrolled on MAT. We will continue to address challenges in enrollment and retention through; peer to peer coupon distribution and tracking, working with KP CSOs and home/hospital delivery of MAT for bed ridden or hospitalized PWIDs. Additionally, in response to the people's COP voices, we are extending MAT services to the Eastern Region of Uganda target of 100 in the first year. the MAT clinic in the eastern region will be under the mental health unit at Mbale Regional Referral Hospital. This will enhance government

ownership of the program and align well with the long-term PEPFAR sustainability plan. The Mbale MAT program will leverage the in-country capacity at Butabika and scale up best practices from the Butabika MAT program to ensure optimal enrollment and retention on MAT.

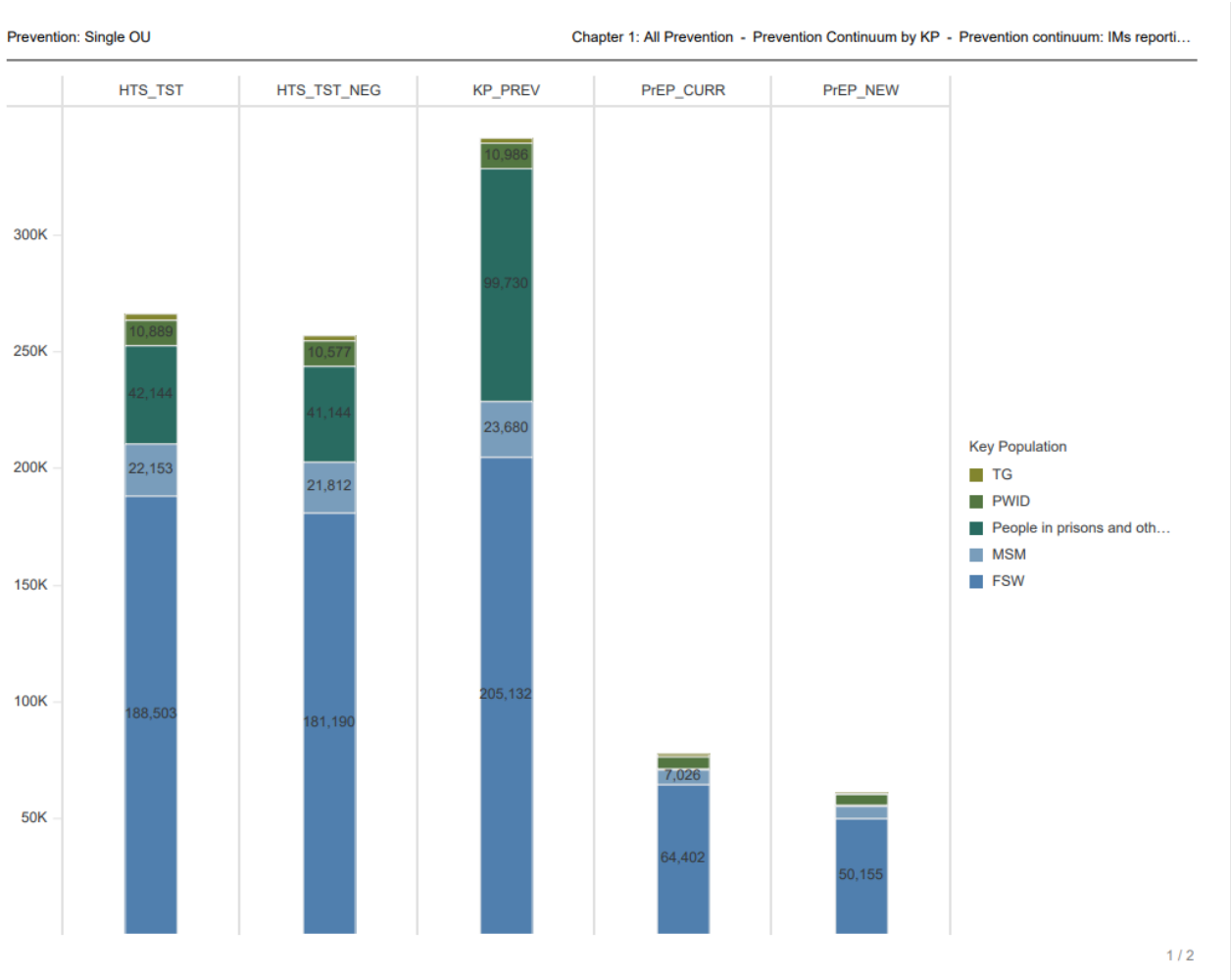
STI Screening, Diagnosis and Treatment

Sexually transmitted infections (STIs) continue to be a major burden for KPs increasing their risk for HIV. In COP22, the focus will be offering STI screening for all KPs seeking care, laboratory testing to confirm diagnosis for those with signs and symptoms and treatment of those with confirmed STIs. In COP22 the program will procure STI drugs and where feasible, will support laboratory tests for STI monitoring.

Condom and Lubricant Programing

Promoting condom and lubricant last mile distribution by improving risk perception among KP will continue to be a major focus of COP22. Condom promotion and distribution channels will be strengthened through interpersonal communication, peer led replenishment of condom dispensers in addition to male centered condom education. KP peers will be assigned to hotspots and dispensers to ensure continuity of services. PEPFAR, along with the GF, will procure lubricants and work with CSOs to ensure effective distribution mechanisms.

Figure 4.3.2 Prevention Continuum by Key Population Group



g. PrEP for Key and Priority Populations

With MOH and CSO recommendations to scale-up PrEP, Uganda PrEP targets have increased gradually to reach more populations at substantial risk of HIV. PrEP targets increased from 30,001 in COP 19, tripled to 95,833 in COP20, increased to 130,000 in COP21. In COP22, PrEP targets will increase to 180,000, in addition, the number of sites will increase. PrEP budgets have increased from $6.5 million in COP21 to 8.5 million in COP22. In addition to service delivery, the increased budget will support PrEP information and demand creation in high incidence and burden districts and development of a referral system for all health facilities near PrEP sites, so that people outside PrEP sites can still be reached with this essential service. With the increase in districts from 55 to 65, the PrEP sites have increased from 316 to over 400 sites. All the new sites will focus on youth friendly services for AGYW and KPs aged 15-19. In COP22, PEPFAR will expand the PrEP literacy program that is focused on addressing

myths and misconceptions and will include community based interpersonal exchanges targeting health workers, PPs and KPs.

Figure (1) below shows progressive scale-up of PrEP since COP16 and Figure 2) significant geographic expansion and coverage from COP 16 to COP 22

Figure 1: Trend of PrEP targets

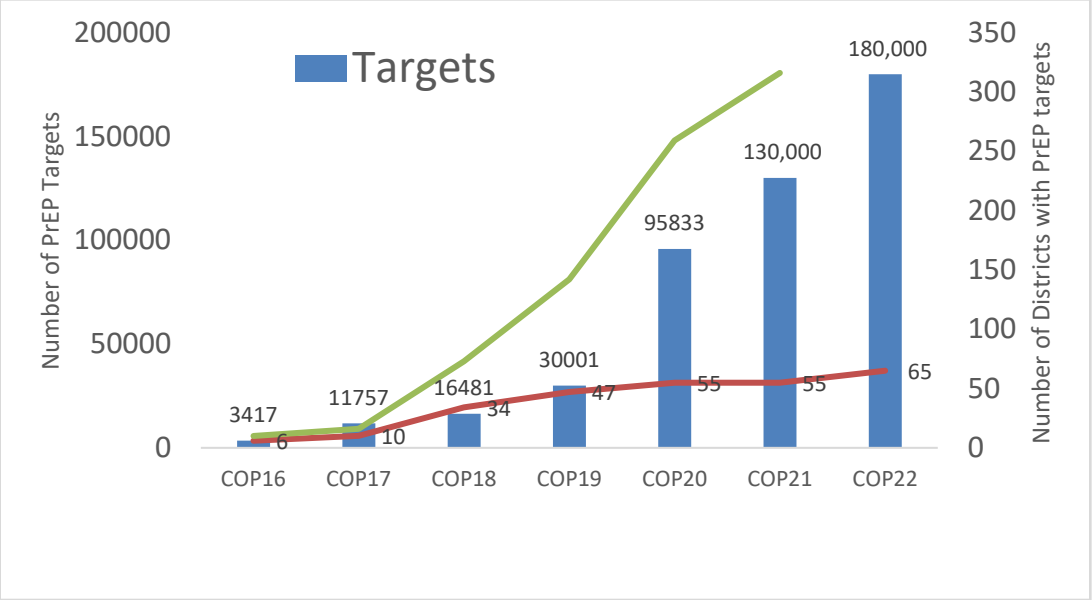
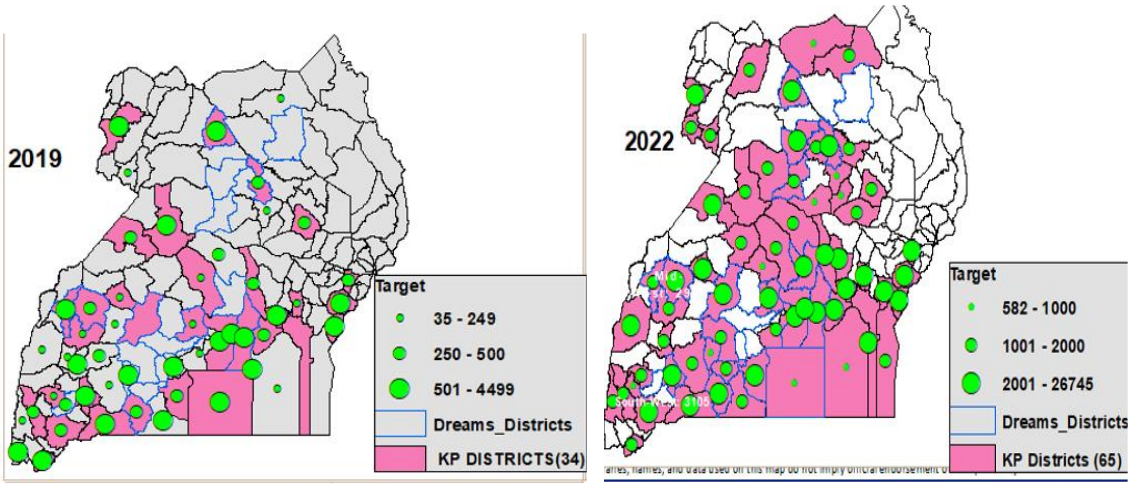


Figure 2 PrEP targets, districts and sites



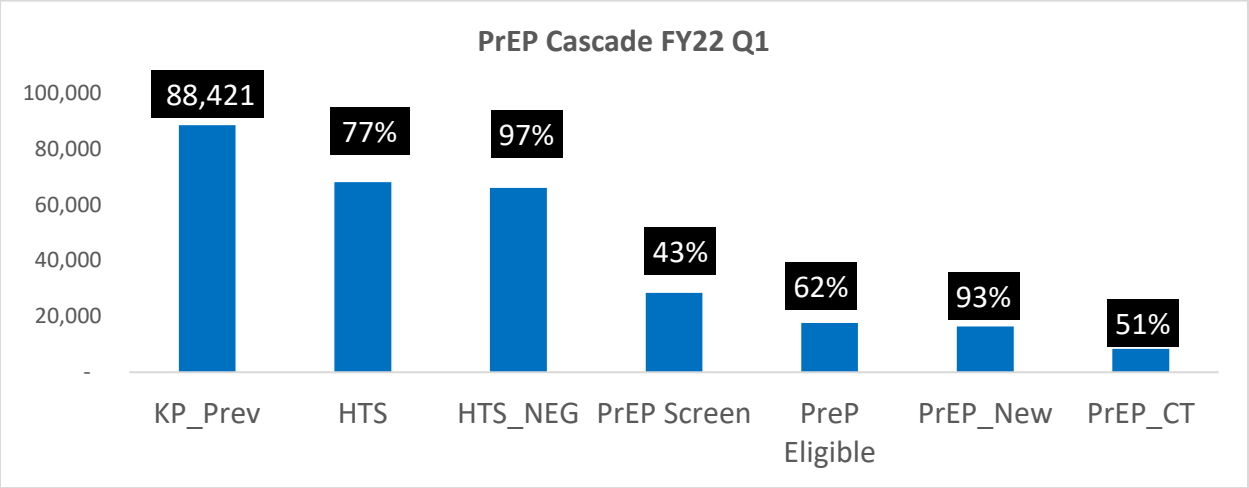
In COP 22, overall, there is an increase in PrEP targeting for KPs, Adolescent Girls and Young Women (AGYW) and Pregnant and Breast-feeding Women (PBFW). About 48% (86,397/180,000) will be KPs, 39% (70,196/180,000) will be AGYW, 25.7% (16,208/180,000) will be PBFW, and the rest will be other priority populations including fisherfolks and sero-discordant couples. The majority of the targeted AGYW 74% (52,118/70,196), will be 20-24-year-olds.

COP 21 Vis-à-vis COP22 PrEP Targets by Sub-populations

PrEP Category	COP21	COP22
FSW	39,000	70,620
MSM	7,418	11,551
PWID	711	3,412
TG	250	814
Pregnant women	33,483	10,003
Lactating and Breastfeeding women		6,204
AGYW	10,881	18,078
AGYW	27,753	52,118
Priority Populations	10,504	7,200
Totals	**130,000**	**180,000**

Uganda has had a progressive achievement against PrEP_NEW annual targets since FY17, with an overachievement of 127% (120,526/95,000) in FY20. Based on the FY22Q1 PrEP cascade, there has been improved efforts in linking PrEP eligible to PrEP_NEW. In addition, 32,207 have returned for their PrEP refills.

Figure 3 PrEP Cascade for all key populations FY22Q1



The MOH implemented a nationwide quality improvement assessment through bringing together PrEP implementing health facilities to address the gaps along the PrEP cascade. The main objectives were to increase the proportion of eligible high-risk HIV negative clients started on PrEP and to increase proportion of eligible high-risk HIV negative clients, continue PrEP use. The preliminary results have identified barriers to PrEP continuation including high mobility among KPs and failure to comply to medication routine and drug side effects. In COP22, the program will enhance tracking PrEP appointments using an appointment register, SMS /call reminders a day before the appointment dates, line listing missed clinic appointments for follow up and PrEP outreaches that are synchronised with expected PrEP refill dates for clients. 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 COP 22, the program will continue working with the MOH to update the PrEP guidelines to implement new biomedical PrEP interventions including injectable cabotegravir, Dapivirine Vaginal Ring as they become available, and Event-Driven (ED-PrEP) for MSM and cis-gender men.

In COP 22, the program will continue scaling-up PrEP for AGYW to reach 70,196 AGYW on PrEP, majority of these (74.2%) 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. PrEP messaging will be part of the DREAMS primary package and PrEP will be provided at safe spaces. The program will also monitor violence and how it is addressed as well as reinforce and promote consistent condom use among AGYW PrEP users. Based on COP 21 early lessons from Acholi, training of healthcare workers on the revised MOH PrEP guidelines, integrated PrEP delivery in FP, MCH, Adolescents Health friendly Clinics line-listing of all AGYW from UDTS under the segment- engaged in TS and integrated PrEP delivery into DREAMS service layering at safe spaces have been very helpful in improving PrEP uptake among AGYW. These will be scaled up in other regions in COP 22.

In COP22, 25,000 pregnant and breastfeeding HIV-negative women, who are at substantial risk will be counselled and offered PrEP. The program will continue leveraging on existing integrated MCH/RH/PMTCT/HIV prevention interventions to provide routine PrEP education at ANC, carry out HIV risk screening to assess risk behaviors among Pregnant and Breast-Feeding Women (PBFW) and engage peer mothers to deliver PrEP among the approaches to deliver PrEP to eligible PBFW. PrEP messaging will be integrated as part of overall ANC education at the selected PrEP implementing sites. Individual PrEP counseling and screening will be provided to interested clients for enrolment. PrEP will be provided at mother-baby care points. Follow-up visits will be aligned with the PMTCT/ANC/PNC visit schedule. Ongoing adherence and continuation counseling will be provided as well as linkage and referrals to other programs providing structural interventions. Based on COP20 early lessons from Mubende region, extending PrEP services to 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 COP22 to enhance PrEP uptake among pregnant and breastfeeding women. In addition, the program will work with the MOH to update MOH 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 70, 196 KPs and 7,200 other Priority Populations. The program will continue to work with KP-CSOs adopting peer deployment to improve PrEP continuation and strengthening messaging for PrEP continuation among KP peers. In addition, the program will consider DICs as community PrEP dispensing points and employing DSDM models for PrEP. Anecdotal data suggests negative perceived social norms and emphasizing the risk of STIs, in COP22, the program will provide syndromic treatment of STIs and strengthen positive PrEP messaging. In COP22, the PrEP program will expand access to PrEP and include policy and program changes, in alignment with WHO guidelines, to simplify PrEP service delivery, including minimize testing requirements, encourage implementation of Event-Driven (ED) PrEP for MSM, cisgender men and TG not on gender-affirming hormones.

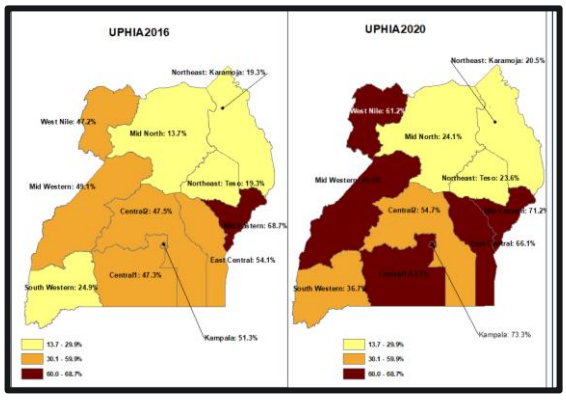
In summary, in COP22, the program will scale-up from 130,000 to 180,000 in COP22, with wider geographic expansion, implement a multipronged approach to enhance PrEP initiation and continuity, enhance DSD models of service delivery, DIC approach and multi-month dispensing and work with MOH to adopt WHO guidelines for event driven PrEP for eligible persons, and injectable CAB-LA. 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.

h. VMMC

Uganda has continued to achieve Voluntary Medical Male Circumcision (VMMC) targets over the years; currently, the VMMC coverage stands at 54% according to the Uganda Population-Based HIV Impact Survey (UPHIA) 2020, this is an improved coverage compared to 43% in UPHIA16**.**

This survey data demonstrates a doubling in the proportion of circumcised men from 2011, when only 26% of men aged 15-49 years were circumcised (Uganda AIDS Indicator Survey, 2011).



UPHIA2020 survey shows geographical variation in VMMC coverage, with highest coverage in the capital city of Kampala (73%). Some of the regions with the lowest MC coverage include Karamoja - 20.5%, Teso-23.6% and Mid-North-24.1%. The higher fertility rate and the significant youth bulge in Uganda slows down progress in VMMC coverage despite high circumcision rates in Uganda. In FY21, Uganda was successful in achieving targets (286,276 MCs) which was 152% in the pivot age of 15-29 years.

UPHIA2020 findings and program data for VMMCs conducted between 2020 and 2021, indicate that by the end of FY22, the total number of male adolescents and men aged circumcised would be 6,215,056. The eligible all age unmet need for VMMC in all PEPFAR sub-national units will be 3,111,410 MCs by the end of FY22.

Scaling up VMMC is critical to Uganda achieving epidemic control. In FY22, PEPFAR Uganda will support 523,810 circumcisions and the COP22 targets will further increase the national coverage to 63%. Building on these efforts and to increase the immediacy of impact, the COP22 strategy is to maintain high coverage among the 15-29-year-age. To achieve saturation, focus will be in districts where circumcision coverage is close to 90% and in regions with low MC coverage and high HIV prevalence, including all DREAMS districts.

Despite the challenges of COVID-19 mitigation measures which impacted the VMMC outreaches, the Uganda program made adjustments for the safe continuation of VMMC services

including changes in promotion and demand generation - partners have adapted health communication to include COVD-19 risk communication and address the fears of possible MC clients on possible acquisition of COVID19 and have engaged in small group education, door to door IPC mobilization and village to village drives. As part of service delivery innovations, the partners focused on providing flexi-hour services on weekends, recruiting private practitioners to beef up VMMC teams, procuring PPE for clients, mobilisers, and health care workers, deploying dedicated teams for post circumcision follow-up, and advocating for COVID19 vaccination especially for staff providing VMMC services. Services have also been brought closer to the communities in the lower health centers where mini-camps are been run in strict observance of the COVID-19 SOPs.

In COP21 VMMC IPs will continue implementing proven, high-impact, client centered and integrated comprehensive social-behavioural change 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

- Using insights from action media done with VMMC target populations to inform targeted demand generation approaches
- Using a toll-free hotline and a short SMS code for VMMC clients to get instant feedback from qualified health workers that address their fears, questions and concerns and link them to service availability.
- Engaging private providers to increase access to services,
- 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
- Extended hours and moonlight services.

Additionally, 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 bi-directional referrals of eligible HIV-negative adult men for VMMC services.

The COP22 targeting process triangulated data from Uganda Bureau of Statistics, 2021 population projections to estimate number of circumcised males 10-64 years and the 2021 circumcision unmet need. The estimated district coverage of 2022 was calculated by estimating number of men circumcised from the 2011 AIS and UPHIA 2020 data in addition to 2021 VMMC program data. In addition, we did take into consideration 2022 spectrum incidence rates, KP size estimates and DREAMS districts. 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. Sixty-two percent of the targets were allocated to the 15-29 age group, 37% to the 30+ and 1% in the 13-14-year-old boys to be implemented using ShangRing only. Six percent of the total MC targets will be implemented using ShangRing.

Key shifts and considerations in COP22

- According to the WHO2020 guidelines, clients who test positive for HIV should start treatment for their own health. Those who test positive and wish to be circumcised should delay circumcision until ART has lowered their viral load in recognition that VMMC provides them no HIV benefit. Starting in COP22, at a minimum, all clients known to be living with HIV must be adherent on ART for at least 3 months prior to being circumcised and should be virally suppressed. We will work with MOH to revise the VMMC guidelines to include this new guidance.

- 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. This will include offering non-coercive incentives, especially compensation for the lost wages which will also be used to target fisherfolks and truckers. PEPFAR-Uganda will continue implementing user-friendly VMMC services tailored to ensure privacy for adult men, allow for separation of older men from younger men, extend hours and moonlight services, and use of the VIP VMMC services model targeting. Finally, the program will focus on workplace interventions tailored to fishing communities, mining areas, prisons, and refugee camps to reach adult men for VMMC services

- The Uganda VMMC program will continue to support decentralization of adverse events management from the capital city by establishing Severe Adverse Management Centers (SAMCs) in six other Regional Referral Hospitals (RRHs). The SAMCs serve as referral centers for managing SAEs plus other complex VMMC-related adverse events (AE) referred from lower levels of health care.

- As part of its sustainability agenda, PEPFAR Uganda ensure integration of VMMC services in HIV prevention services and will increase the proportion of the reusable instruments from 60% in COP21 to 75% in COP22. To facilitate this transition, PEPFAR will support regional health facilities with infection prevention and control (IPC) training, sterilization equipment, in addition to purchasing the VMMC reusable kits for dorsal slit method. In addition, dedicated sterilization human resources, consistent supply of electricity and water to support proper functioning of the autoclaves have been budgeted for.

The Ugandan program will focus on strengthening the quality of VMMC services through MOH and RRHs coordinated supportive supervision and mentorship, external quality assurance programs for safety including adverse event monitoring, prevention, and management.

Implementing partners will be supported to improve performance through weekly performance review of results, monthly inter-agency VMMC partner performance review meetings and quarterly DQAs led by the M&E partners. Routine site visits to the consistently underperforming

sites to diagnose problems and institute course corrective actions will be done. CQI interventions will focus on scaling up proven approaches for Adverse Events prevention and management and active post circumcision client follow up according to the national VMMC package of care. IPs' compliance with mandatory reporting of notifiable adverse events to S/GAC within 24 hours of learning of adverse events will continue to be emphasized.

Figure 4.3.3 VMMC Quarterly Trends by Age is required. except for countries with no VMMC investments or targets.

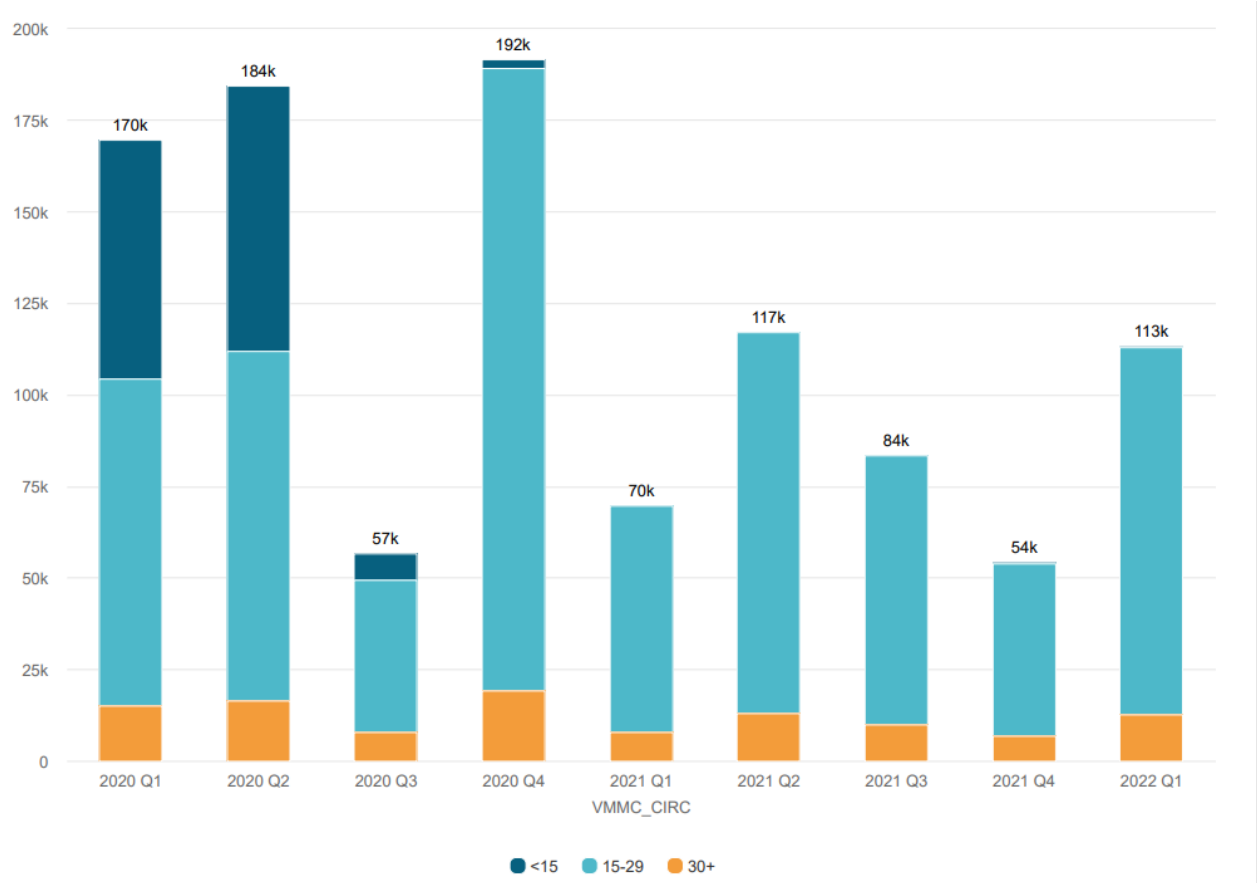
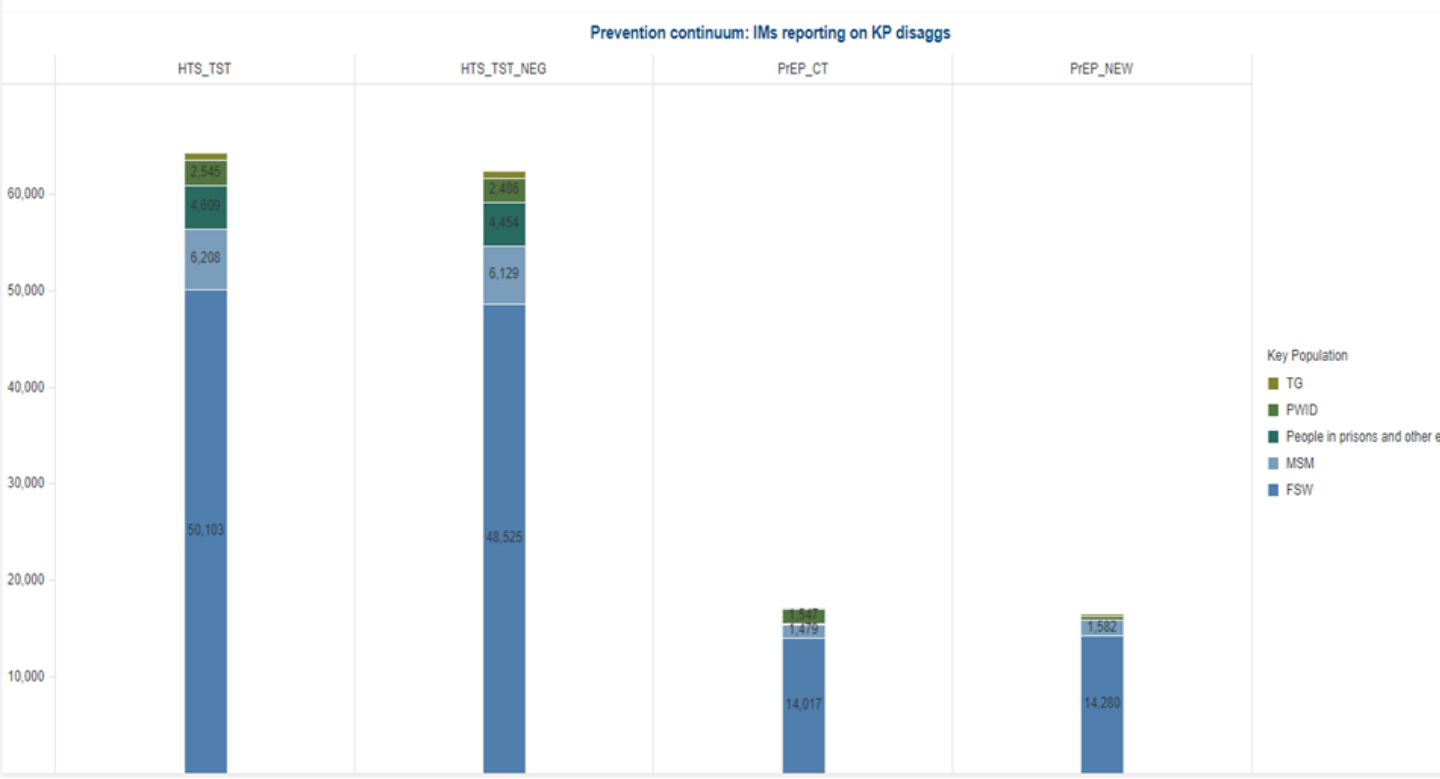


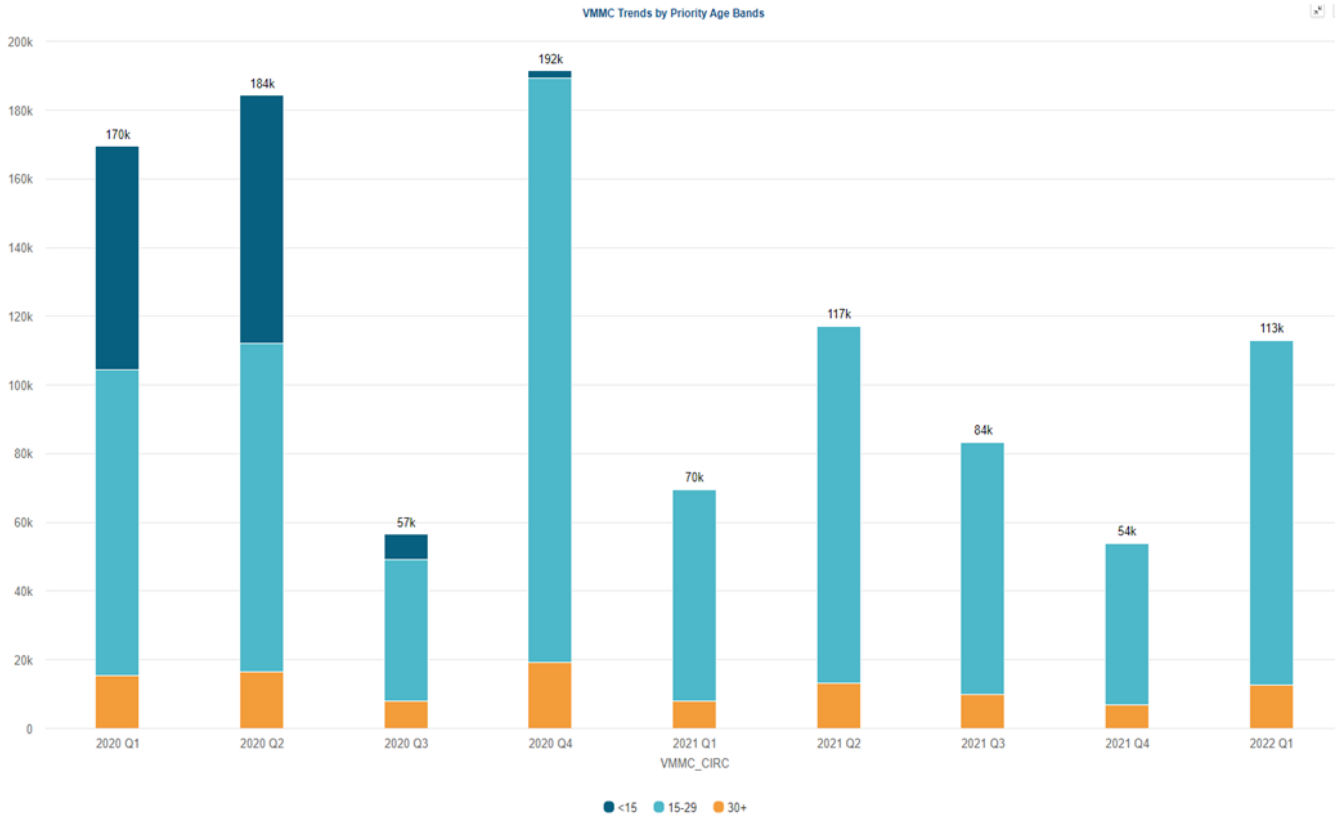
Figure 4.3.2 Prevention Continuum by Key Population Group



This visual comes from: Prevention: Singe OU dossier; All Prevention chapter; Prevention Continuum by KP page

i. VMMC

Figure 4.3.3 VMMC Quarterly Trends by Age



4.4 Additional Country-specific Priorities Listed in the Planning Level Letter and Emerging from Regional Planning Meeting

•*Preliminary UPHIA 2020 data suggest significant progress towards the UNAIDS 95-95-95 goals, however, gaps in known HIV-status remain, particularly among young people. Various data sources, including UPHIA, program data, recency, updated spectrum models, and other sources should be used to target case-finding investments to reach the first 95. Effective testing strategies, such as safe and ethical index testing and self-testing, should be prioritized.*

UPHIA 2020 data suggest significant progress towards the UNAIDS 95-95-95 goals. However, gaps in known HIV status remain, particularly among young people aged 15-24 years and 25-34; In COP2022, the focus of case identification will be closing the case gaps in these age groups. We have significantly increased HTS targets from 2,831,610 tests and 74,036 positives in COP21 to 5,559,739 tests and 179,191 positives in COP22 with 62% of COP22 positive target allocated to individuals aged 15-34 years. A review of testing modalities implemented in the country over the past five years revealed that over 80% of positives were identified through Other PITC, PMTCT, Index testing and Community mobile Uganda will therefore prioritize these modalities to reach the missing individuals. HIV self-testing will continue to be prioritized for the hidden and hard-to-reach individuals including key populations, AGYW, partners of index clients and men.

We will roll-out recency to 80% of PEPFAR supported sites and use the findings to geo-map and characterize infections to appropriately respond to prevention gaps by geography and sub-population, including intensified case finding.

•*Persistent treatment and viral load suppression gaps among children and young people. Treatment and VLS gaps persist among children and young people 0-19 years old and young men 20-29 years old. Pediatric VLS in FY21 was under 90% nationally, however, VLS among those supported by the orphans and vulnerable children (OVC) comprehensive program exceeded 90%. Person-centered services tailored for populations at high risk for treatment interruption should be expanded, including youth case management approaches.*

In COP 22, Uganda will make the following shifts to address gaps the persistent treatment and viral suppression gaps among children and adolescents. We will enhance pediatric and adolescent HIV case finding with a focus on strengthening index testing and scaling up HIV self-testing while maintaining an appropriate mix of other case finding interventions. We will leverage lessons learned from the CRS FASTER initiative and the pediatric and adolescent national quality improvement collaborative to optimize testing in OPD and scale up HIV self-testing among children and adolescents. We will continue to strengthen continuity of treatment particularly among adolescents and young people where we have the highest IIT rates through person centered and peer-led approaches, including expansion of the YAPS program to achieve national coverage to the remaining 46 Districts 46 districts, and close coverage gaps in peer-led supportive services for C/AWHIV and their families, focusing on programs designed and implemented by peers, to address stressors unique to C/ALHIV. YAPS should be paid a living wage, trained, supported and equipped with the tools to carry out their work, such as airtime. Viral load suppression will remain an area of focus through completion of completion of pediatric ART regimen optimization, including completion of transition to pediatric DTG 10mg for children <20kg while strengthening psychosocial and caregiver support to enhance adherence. Uganda will implement a Peds/PMTCT Surge at 579 priority sites that contribute 80% of our pediatric treatment cohort using a package of proven standardized interventions informed by lessons from the FASTER initiative and the pediatric and adolescent national QI collaborative to galvanize efforts to close the remaining gaps across the clinical cascade. Details of these interventions will be found the pediatric section of the SDS.

•*Close the remaining diagnosis and treatment gaps.*

PEPFAR Uganda supported the national roll-out of HIV self-testing in FY21 with procurement of 1,976,439 HIV self-tests. HIV self-testing was rolled out in all PEPFAR supported sites. In COP22, PEPFAR will sustain delivery of HIVST at all PEPFAR supported sites, and support roll-out of new and effective delivery models. HIVST has been fully integrated into community and index testing; we will ensure continued use of HIVST in these platforms including for index testing among children and adolescents. We will also continue to target key populations and other priority groups like AGYWs and men. In addition, PEPFAR will work with the MOH to

develop a system to track feedback for confirmatory testing for individuals who are reactive on the self-test.

Under the leadership of MOH, Uganda is developing a continuous quality improvement (CQI) project to enhance case identification. This will be rolled out in May 2022. This project will be rolled into COP22. To minimize missed opportunities for testing, and to enhance testing efficiency, PEPFAR Uganda will use validated screening tools for both adults and children/adolescents at outpatient departments (OPDs) as well as in the community for KP/PPs. Trained screeners will be deployed and designated to consistently screen individuals for eligibility for HIV testing services at high-volume sites and during targeted community out reaches

Recency testing will be rolled out to sites contributing 85% of HTS_TST_POS COP22 target. By end of FY22 Q1, 704 sites were implementing recency. Uganda plans to activate additional 300 sites, which will bring the total number of sites implementing recency to 1,000 by end of FY2022. Scale-up to 100% of PEPFAR-supported sites may not be possible due to logistical challenges including capacity of sites to conduct, report and use recency for public health response. However, the MOH working closing with PEPFAR, is doing assessments to determine sites that could use paper-based tools as EMR is being rolled out. The MOH is also working on integrating recency quality assurance/ quality control into overall HTS quality assurance program. The MOH has drafted the public health response plan for using recency results. With this plan, we will geo-map recent infections, triangulate with other data sources including MER, characterize infection, and appropriately respond to prevention gaps by geography and subpopulations, including intensified case finding.

- *National CQI efforts to address interruption in treatment, expand DSDM, strengthen person-centered services, and ARV regimen optimization for all people living with HIV should be prioritized.*

PEPFAR Uganda has a comprehensive treatment continuity strategy designed to address both client-level and structural barriers, using the MOH-led National Quality Improvement (QI) collaborative platform to rapidly scale up interventions with fidelity to address continuity of treatment. In COP21, the national collaborative was utilized to rapidly respond to CLM findings and recommendations and support districts and health facilities to implement QI interventions to address findings, gaps, and recommendations. In COP22, PEPFAR Uganda will leverage the National QI collaborative platform and support national-level efforts to specifically address interruption in treatment (IIT), close the gaps in the 1st 95, and focus on pediatric and adolescents. The national IIT improvement collaborative will focus on: improving data quality and utilization; identifying, addressing and scaling up interventions to prevent interruption in treatment; trace and return patients to care; and enable site teams to account for losses and transfers. The national IIT improvement collaborative will also ensure that eligible patients receive DSDM and track the impact on DSDM on IIT.

In COP21, PEPFAR Uganda supported the national-level strategy to functionalize the regional QI coordination structures, with regional referral hospitals taking a central role in implementing QI, supporting regional QI collaboratives and providing QI support to districts and health facilities. In COP 22, PEPFAR Uganda will continue to strengthen these regional coordination

structures. The regional coordination QI structures will provide contextual guidance to address areas such as ARV regimen optimization for all PLHIV, viral load coverage and suppression and any other region-specific gaps in the HIV care and treatment cascade. Person-centered services will be strengthened through the use of already known tools and best practices identified in previous years.

Quality improvement for the Pediatric and PMTCT/EID surge will be done at scale with districts leading improvement efforts including coaching and site-level performance. High-volume PMTCT and pediatric health facilities in all the districts will be engaged in PMTCT/ Pediatric Surge efforts to rapidly close the gaps in PMTCT/EID and pediatric case finding and care. The Surge will build upon the successes of the national pediatric, adolescent, and PMTCT improvement collaborative implemented in COP20 and COP21. Lessons learned will be scaled up and monitored. District-based teams will be supported to take the lead in quality improvement, monitoring, and accountability for results through regular engagement. PEPFAR will ensure consistent, mandatory implementation by IPs of the minimum remuneration of CHWs at $50/month, through a new requirement that IPs report to PEPFAR on their implementation of this requirement.

- *Recency testing was conducted in about 40% of planned sites in FY21, with plans to scale this year. Approximately 10-15% of the tests conducted during the period were recent infections (acquired within the past one year), with recent infections higher among females than males, and highest among 15–24-year-olds. Geographic and demographic differences, triangulated with program data, should be used to understand implications of recency results and correlations with rates of transmission. A performance monitoring framework that measures site level implementation of testing quality and capacity to deliver a public health response, including deployment of recency and follow-on public health interventions, should be implemented.*

Recency testing will be rolled out to sites contributing 85% of HTS_TST_POS COP22 target. By end of FY22 Q1, 704 sites were implementing recency. Uganda plans to activate additional 300 sites, which will bring the total number of sites implementing recency to 1,000 contributing to 85% of newly identified PLHIV by end of FY2022. Scale-up to 100% of PEPFAR-supported sites may not be possible due to logistical challenges including capacity of sites to conduct, report and use recency for public health response. However, the MOH working closing with PEPFAR, is doing assessments to determine sites that could use paper-based tools as EMR is being rolled out. Approximately 15-20% of the tests conducted through FY22 Q1 were recent infections (acquired within the past one year), with recent infections higher among females than males, and highest among 15–24-year-olds. However, on disaggregation by age and sex, HIV recency is higher among 15-24 in females and 40-45 among males. We will use geographic and demographic differences, triangulated with program data, to understand implications of recency results and correlations with rates of transmission. The MOH is also working on integrating recency quality assurance/ quality control into overall HTS quality assurance program. The MOH has drafted the public health response plan for using recency results. With this plan, we will geo-map recent infections, triangulate with other data sources including MER, characterize

infection, and appropriately respond to prevention gaps by geography and subpopulations, including intensified case finding. Recency Data-Use for public health response will be cascaded down to all sites through support by PEPFAR-funded IPs.

•Alignment of prevention interventions to meet areas of high HIV incidence/recent infections is essential. With an estimated 46% of the Ugandan population under the age of 15, there is need to ensure high coverage of HIV prevention interventions to sustain control of the epidemic, particularly in areas of higher incidence. This will include appropriately targeting DREAMS, VMMC, PrEP, and primary prevention interventions for key and priority populations.

PEPFAR/ Uganda's COP 22 targets for DERAMS, VMMC and PrEP are geo-focused to reach the most at risk in districts with high prevalence rates based on UPHIA 2020. We recognize the need for a paradigm shift from just monitoring linkage to treatment to enhancing comprehensive risk assessment and tracking linkage of high-risk individuals to the appropriate package of prevention services while ensuring continued risk assessment and repeat testing for early HIV case identification. This will allow us monitor not just the treatment cascades but also the prevention cascades, particularly for key and priority populations. We will focus implementation to the Youth Bulge across our comprehensive prevention interventions by using an integrated approach across DREAMS, OVC, PMTCT, Key Populations, VMMC and care and treatment platforms to support systematic case identification and linkage of most key and priority populations through bi-directional referrals and leveraging efficiencies. We will also work with youth groups including YAPS within service delivery for improved last mile reach.

- *Build capacity within the public health response such that Uganda is able to rapidly identify and address threats to sustaining epidemic control. Begin evolving the HIV response to one focused on sustaining epidemic control and building resilience within health systems to withstand future public health threats. PEPFAR Uganda should build upon resource alignment discussions to map out what sustainable epidemic control looks like with the Government of Uganda, civil society, Global Fund and other development partners, private sector and other stakeholders. COP22 resources should align with and support those goals. This will require increased transparency on how PEPFAR resources are spent and the support they provide.*

With U.S. government support, Uganda has built and will continue to build capacity within the public health response such that Uganda is able to rapidly identify and address threats to sustaining epidemic control. In Appendix E the plan to begin evolving the HIV response to one focused on sustaining epidemic control and building resilience within health systems to withstand future public health threats is described. PEPFAR Uganda should build upon resource alignment discussions to map out what sustainable epidemic control looks like with the Government of Uganda, civil society, Global Fund and other development partners, private sector and other stakeholders.

•Address barriers preventing key populations from accessing HIV prevention and treatment services. Incidents of human rights violations, stigma and discrimination, coupled with shrinking civil society space in political discourse are of concern. The Legal Environment Assessment (LEA) was conducted in 2021 and results should be used to address identified barriers. Focused

programming to facilitate equitable access to health services for key and priority populations is essential to reaching and sustaining epidemic control. Key populations programming should continue to scale effective interventions, such as community-based medication distribution and health and support services at drop-in centers

In COP22, PEPFAR will fund efforts to address findings from the Legal Environment Assessment (LEA). This will include advocacy to protection of human rights, legal reform monitoring and strategic litigation. PEPFAR will scale up funding of KP- and PLHIV-led efforts to advocate for laws and policies reform that will deliver more enabling environments, combat inequalities, and defend human rights.

Additional country-specific priorities identified during RPM to include in the SDS:

•*Plans to scale up peer-led treatment literacy, particularly to the 55 districts that contribute 80% of early*

Treatment literacy was raised as a gap within our program and in COP22 we will expand peer-led treatment literacy to districts that contribute 80% of treatment interruptions in treatment in addition to the nationwide "Time Up" HIV campaign, which is also addressing treatment literacy. We will continue capacity building efforts for health facility staff and community health workers to ensure service provision in accordance with the MOH guidelines, gaps identified will be addressed through mentorship.

•*Timeline on accreditation of DICs (will need to be provided by MOH, PEPFAR team to follow-up)*

The MOH is in the process of finalizing a tool for accreditation of DICs and other community DSD points. In FY22 the MOH will assess DICs which are in hot spots with high volumes of KP and AGYW population to certify them for accreditation. We anticipate that this will be done in FY22 Q3.

•*What is the transition plan to move the remaining patients to first line/TLD*

Overall, by the end of FY22 Q1, 79% of PLHIV had transitioned to TLD. PEPFAR will work with IPs to mop up the remaining PLHIV on non-nucleoside reverse transcriptase inhibitors (NNRTIs) that is; the pregnant and breastfeeding women at 6 months post-partum and transition them to TLD. We are also working collaboratively with MOH to transition PLHIV on protease inhibitors (PIs) as 2nd line to DTG based regimens (DBRs) and by end of February 2022, close to 75% of clients on PIs had transitioned to DBRs. Furthermore, PEPFAR will continue to support the roll out of pediatric Dolutegravir (pDTG) in line with the revised HIV treatment guidelines. IPs will be encouraged to utilize the VL change package and support 1) high viremia clinic days in order to address clients' adherence barriers 2) counsellors in facilities to offer psychosocial support for non-suppressed clients, 3) enrollment of eligible children on to OVC programs and 4) train VL result interpretation and clinical management of non-suppressed clients.

•Addressing commodity gaps around advanced HIV disease, specifically CD4 count.

The updated COP 22 commodities quantification and budget has fully covered the funding requirement in both the public and private not-for-profit (PNFP) sectors for an estimated 612,973 CD 4 tests based on a suppression rate of 81% (Viral load cut off 200 copies/mi). Testing will cover all unsuppressed clients, 80% reach for all new enrollments, 100% reach for all PLHIV returning to care after treatment interruptions and a repeat CD4 test for all CRAG positive clients during treatment monitoring.

•Low level viremia monitoring – is this costed, there are many benefits to the community

Phased implementation of low-level viremia monitoring has been incorporated into the COP 22 conventional viral load budget. A comprehensive costing based on the current proportion of 60% plasma and 40% DBS samples at a cut off of 200 copies per ml was done and the incremental cost of 95,386 tests moving from a cut off of 1000 copies/ml to 200 copies/ml for low level viremia monitoring has been incorporated into the budget.

Low level viremia monitoring

The 2021 WHO guidelines define undetectable viral load as less than 50 copies/mL and recommend enhanced adherence counseling and repeat viral load testing for PLHIV with low level viremia (51-999 copies/mL). Research shows that low level viremia >50 copies/mL is a risk factor for poor individual and public health outcomes, including virologic non-suppression and virologic failure, HIV drug resistance, serious non-AIDS events (SNAEs), potential sexual transmission potential >200 copies/mL, and potential for mother-to-child transmission. In view of this evidence, the Uganda Ministry of Health is revising the HIV treatment guidelines to lower the viral load cut off threshold from the current cut off threshold of >1,000 copies/mL in order to address low level viremia and align with the U=U goal. Thus, low level viremia monitoring is intended to identify patients that might need additional support to prevent poor individual and public health outcomes, as well as serving as an improve tool for patient empowerment through improved literacy around viral load. The PEPFAR communication partner, Social Behavioral Communication Activity (SBCA), will support MOH/ACP community department to engage CSOs and PLHIV networks with patient literacy information on the importance and benefits of early treatment initiation, ART adherence, and viral load monitoring, including U=U messaging. Implementing partners will support site teams to provide intensified adherence counseling for PLHIV with low level viremia.

In COP22, PEPFAR will support revision and roll out of the national guidelines including low level viremia monitoring and management at national, regional, district, facility and community level. While guidelines are still under development, the anticipated changes are as follows: PLHIV with viral load 51-199 copies/mL will receive routine adherence messaging and will continue with their ART and get a repeat test after 1 year. Those with 200-999 copies/mL will receive three sessions of intensive adherence counseling (IAC) followed by a repeat VL after 6 months. PLHIV tested on the DBS platform will have plasma repeat VL test following completion of IAC. PEPFAR Uganda will continue to support MOH to expand plasma specimen

management capacity and therefore increase the testing capacity using plasma from the current 60% plasma specimens with 40% DBS to 70%:30% in COP22 and will increase the proportions in subsequent COP years. Efforts will be made to ensure adequate commodities to support low level viremia monitoring. All these efforts are directed toward maintaining durability of dolutegravir for as long as possible while decreasing HIV transmission and HIV incidence to achieve epidemic control.

•Type of treatment, coverage, and scale up of sites offering cryptococcal treatment

PEPFAR, in collaboration with CHAI, will continue to leverage the UNITAID fund to treat cryptococcal meningitis in the 18 national and regional referral hospitals across the country by use of the newer potent, effective, and well tolerated antifungal called AmBisome (Amphotericin B-Liposomal) and Flucytosine, per current MOH guidelines. PEPFAR will continue to collaborate with the MOH and other partners to ensure the current guidelines are updated to accommodate the newer evidence-based protocol for use of AmBisome as a single high dose accompanied by Flucytosine for 2 weeks for the treatment of cryptococcal meningitis. In COP22, all other sites, including district hospitals and lower-level HFs, will continue to offer screening, identification and referral of patients with cryptococcal meningitis to the 18 national and regional referral hospitals across the country for specialist management, including toxicity monitoring with laboratory tests.

•Cervical Cancer: What are we doing to address concerns of coercion for cervical cancer screening; reports that screening has been made a requirement to receive medication

For PEPFAR, we stand firmly that all PEFPAR-supported services should be offered without coercion, including cervical cancer screening and treatment for women living with HIV. We look forward to hearing more from CSO on how to better understand and substantiate these claims, toward remediation action. Going forward, we'll lean on Community Led Monitoring to ensure claims of coercion are swiftly brought to our attention for immediate response and remediation. Please see section 4.9 Cervical Cancer Program Plans.

•MOH and PEPFAR to send out a circular on coercion?

To address the concerns of coercion that were raised by CSOs during the RPM, MOH will send a circular to all health facilities against any form of coercion or precondition to access ART services. Please see section 4.9 Cervical Cancer Program Plans.

•Information on screening women over 49 years

In the COP22 guidance PEPFAR revised the screening algorithm for cervical cancer and recommends screening either with HPV DNA or VIA once every 3 years instead of every 2 years, as it was previously. Refer to figure 6.4.4.1 on page 398 of the COP22 guidance for the new PEPFAR recommended algorithm. As the recommended algorithm aligns with Uganda's recently revised guidance, which also is in alignment with the WHO 2021 cervical cancer elimination targets.

At all HPV screen, triage, and treat sites, we have guided that all WLHIV aged 50 years and above are provided a one-off screening for cervical cancer using HPV DNA testing.

Please see section 4.9 Cervical Cancer Program Plans

•Specific commitments/plans to address findings from LEA

In Cop 22 PEPFAR Uganda has allocated funds (over $132,000) to the Civil Society Strengthening Activity (CSSA) to support the follow-on actions that will address the findings from the LEA in COP 21. With these funds, the activity will support building capacity of KP and PLHIV CSOs to advocate for human rights reforms and non-discriminatory service delivery.

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4.5 Additional Program Priorities

1. *Have there been recent policy/guideline changes that impact the program area? Please describe the policies and status of implementation. What is the intended impact of the policies on programmatic targets? Reference the Minimum Program Requirements, including ART continuity-related site level requirements for client-centered services*

   For care and treatment, there have been no new policy changes that impacted program changes and targets.

2. *What are the plans to ensure scale up of index testing in alignment with the PEPFAR Guidance on Implementing Safe and Ethical Index Testing? What are the plans for ongoing monitoring, action and accountability to ensure compliance with the above guidance?*

   As noted above, under the leadership the MOH, we will continue to ensure sustained safe and ethical delivery of index testing. In COP20, the materials for index testing were not aligned with Uganda national testing implementation guidelines but were aligned in the implementation materials revised in FY21. There is already a system in place for monitoring index testing services. The systems include routine site level index testing assessments (with certification of sites incorporated); and tracking, documentation, and response to intimate partner violence (IPV). Routine index testing assessment will continue in COP22 with remedial actions for sites that fail assessments. We will continue to work with MOH to ensure sites that fail assessments suspend services until gaps identified are addressed, and re-assessments are done with 100% pass. We will also continue to strengthen IPV tracking and response system in COP22. In addition, we are working with the MOH to expand the monitoring system to include other negative outcomes from index testing and HIVST. This system will be rolled out in COP22.

3. *What decisions were made on the program direction in COP22 based on the assessment of program performance reflected in COP20 Q1-Q4 POART findings and discussions and COP21 performance to date?*

   For care and Treatment, the key decisions that were made based on program performance assessment reflected in COP 20 included: focusing and intensifying the

continuity of ART interventions in the 10 high IIT burden districts and to focus on improving both quality and use of data in fostering the right IIT anti IIT interventions across board. Due to the suboptimal treatment coverage for children (73% by FY 22Q1), Uganda has made decision to implement a Peds/PMTCT Surge in 579 priority sites that contribute 80% of our pediatric treatment volume to implement high impact interventions for case finding and linkage to treatment, address interruptions in treatment (IIT), and improve viral load suppression. Based on program performance assessment in COP 20, the diagnostic coverage and yield of TB among PLHIV remained low at 1.8% in FY21. To address this TB case finding gap, PEPFAR made decisions to invest in novel approaches of TB screening and testing for those found symptomatic and these will include the use of CRP for TB screening in ART clinics and use of Truenat for TB testing at lower-level health facilities to ensure 100% access to a TB molecular test for PLHIV. To ensure enrolment of the pending 10% of PLHIV in care on TPT, PEPFAR has made decisions to change strategy on TPT in order to reach all pending patients through activities such as initiation of TPT in the community and calling back eligible patients on long MMD for ART to initiate TPT. To ensure high TPT completion rates, PEPFAR has invested in procurement of 3HP, a shorter TPT regimen, which is becoming available in FY22. Due to the demonstrable MDR risk associated Low viral copies in the patients' blood, MOH together with PEPFAR has made decisions to enhance low level viremia monitoring in order to identify patients that might need additional support to prevent poor individual and public health outcomes, as well as serving as an improved tool for patient empowerment through improved literacy around viral load.

4. *How are Implementing Partners managed to ensure alignment with PEPFAR program strategy and to improve partner performance in an ongoing and timely manner?*

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. 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."

While in 2018, the surge focused on high volume sites yielding 80% of the targets, in 2019 and forward, there was a scale up to surge for quality in all PEPFAR –supported facilities and to their surrounding catchment areas. The surge for quality focuses primarily on key areas in which the program is performing most poorly, finding and identifying HIV-positive individuals (in particular men), improving rates of continuity on treatment, tracking VL suppression, and related issues of commodity security.

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 PEPFAR in country reporting system (PIRS). 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 COP22, PEPFAR Uganda will continue to 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 2022, where we introduced and discussed all COP22 tools, guidance, results, and targets, as well as the proposed trajectory and strategy for COP22. Even after the COP22 submission, we have planned for continued engagement with external stakeholders through routine sharing of data from the PEPFAR Oversight and Accountability Response Team (POART). The USG is represented on the CCM, across all participating PEPFAR Uganda agencies.

5. *Describe the community-led monitoring plans and program, including focus on key populations, and how teams will ensure findings are utilized to drive program improvement.*

CLM has been guided to support community involvement and transparency of the PEPFAR program especially on community and stakeholder engagement as important roles of community-led efforts. Periodic community-led monitoring coordination meetings involving the CLM core team, UNAIDS, and PEPFAR interagency shall be maintained. In addition to the CLM data sharing sessions between the CLM team and PEPFAR Interagency Technical Teams, PCO shall start mobilizing Ministry of Health and other line ministries to participate in the periodic CLM meetings and dialogues.

KPs are part of the CLM structure, consortium and steering represented by Sexual Minorities Uganda, and ICE-Breakers Uganda respectively. These provide oversight on and

guides the CLM on the priorities and focus of KP populations. To support for enabling environments, address discriminatory policies, gender-based violence, and other inequities that stand in the way of progress and human rights that impact HIV services, PEPFAR has planned to continue with the robust support and refinement of CLM activities: 1) Prioritize review and incorporation of community-led monitoring findings into national and regional continuous quality improvement collaborative activities; 2) Continue collection of CLM data and tracking data comparisons between rounds (e.g., clients' knowledge about viral load).

And for COP21/22 focus, PEPFAR has worked with the CLM leadership to update a set of tools to include a DIC survey for assess services offered in DICs, KP personal interview tool. In COP22 there is a deliberate effort to focus these tools in the 65 KP districts in the recent RPM. All this shall lead to a continued community engagement through Community data triangulation and visualization with PEPFAR data streams. For COP22, PEPFAR has incorporated explicit quality management practices, including Quality Assurance (QA), Quality Improvement (QI), Continuous Quality Improvement (CQI), and CLM activities, into service delivery and partner management to ensure equity to attain epidemic control.

4.6 Commodities

The commodity quantification was redone based on UPHIA/Spectrum numbers. There is no ARV gap. The country shall close with 6 months' worth of stock at the end of the COP year. This buffer is specific for the TLD 90 pack as over 90% of patients are taking this regimen.

There is no funding gap for VMMC and EID commodities; the VL commodities are fully funded at a cut off of 1000 copies, the country requires an additional $4,032,968 to implement the cut off of 200 copies and $6,333,549 for the cut of 50 copies.

Service level agreements at country level are in place for the procurement of VL/EID reagents and plans are underway to implement Vendor Managed Inventories in the near future.

National quantification and supply planning is coordinated and done by the MOH Quantification and Procurement Planning Unit (QPPU). The condom quantification and funding analysis factors in all partner contributions, coordinated by QPPU.

To mitigate effects of COVID-19 pandemic, we shall scale up implementation of multi-months dispensing and community retail pharmacy drug distribution points (CRPDDP). We shall integrate facility level electronic logistics management information systems (eLMIS) with central level systems in order to improve commodity visibility across all levels of the supply chain.

Table 4.6 Commodities

COMMODITY CATEGORY	COP22 Propoded budget (April 12, 2022)
ARVs	$40,505,015
PREP ARVS	$1,127,864
VIRAL LOAD	$21,770,583
EID	$1,901,866
VMMC	$6,815,958
TB Pharma Prophylaxis	$3,455,930
HIV Tests/RTK	$7,458,686
HIV Self Testing	$0
Recency Testing	$1,167,530
HIVDR	$555,110
CD4	$3,120,857
OTHER LAB	$15,462,930
TB Reagents And Consumables (GeneXpert)	$4,835,618
Essential medicines and other pharma	$7,679,773
Instrument And Equipment Procurements	$1,257,000
Condoms and Lubricants	$2,250,000
MAUL Close out	$893,440
Total	**$120,258,160**

4.7 Collaboration, Integration and Monitoring

a. Strengthening cross-technical collaborations and implementation across agencies and with external stakeholders, including the GFATM and MOH;

PEPFAR is committed to continually strengthen its collaborative engagements and partnerships with MOH, Uganda AIDS Commission, other line ministries and key stakeholders to strengthen integration and alignment right from COP planning, to implementation, monitoring and evaluation. PEPFAR shall continue to support national priorities and investments through interagency participation in technical foras such as the National Technical Working Groups and strategic platforms such as the Health Policy Advisory Committee (HPAC), Development Partner platforms (A/HDPG). PEPFAR Uganda's interagency collaborative engagements will continue to feed into Technical Working Groups at PEPFAR's ITT and Executive Council level.

The PEPFAR interagency teams will continue to proactively engage MOH, key stakeholders and the private sector to support the national HIV/AIDS response and related health and community systems strengthening. Multilateral partners, including the Global Fund , UNAIDS, WHO, UNICEF, the World Bank, and others, shall be engaged to support mutual goal of HIV epidemic control. COP22 plan is for PEPFAR to work with other development partners to inform policy and program decisions, addressing implementation challenges, and coordinating and aligning efforts across the partners.

USG will remain a member of the Global Fund Country Coordinating Mechanism (CCM) Board and subcommittees. In COP21, PEPFAR planned to shift the Global Fund Liaison to the PEPFAR Coordination Office and this position has been filled.

b. *Strengthening IP management and monitoring and the implementation of innovative strategies across the cascade, with fidelity and at scale, to improve impact within shorter time periods.*

As noted earlier, 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 PEPFAR in country reporting system (PIRS). 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.

The various interagency teams also 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.

c. *Improving integration of key health system interventions, including HRH and laboratory (VL) activities across the cascade*

PEPFAR will work with MOH and line ministries, health development partners (HDPs) and key stakeholders to support improved HRH analytic tools (Human Resource Information System (HRIS) HRH needs and optimization solutions, Workload Indicator of

Staffing Need (WISN) utilization to inform optimization of available staff/ rational staff deployment (including community health workers) in relation to disease burden and need for efficient achievement of PEPFAR targets and epidemic control. Additionally, PEPFAR, MOH and other stakeholders will regularly monitor staff performance at all levels of care, in line with the MOH performance management guidelines and related tools, ensuring optimal productivity and provision of high-quality HIV/TB services across the cascade.

PEPFAR will continue supporting systems integration/linkage, ensuring HRIS interoperability with other HIS systems to facilitate quick gap identification, evidence-based planning, and real-time decision making.

In COP22, PEPFAR will enhance the collaboration with the CSOs and key stakeholders and utilize targeted initiatives including CLM to provide timely feedback and ensure mutual accountability for effective planning and implementation of priority interventions across the cascade.

d. Improving integration of quality and efficiencies in service delivery through improved models of care delivery across community and facility sites;

PEPFAR Uganda will scale up and strengthen the alternative community differentiated service delivery models including the Community Retail Pharmacy Drug Distribution Point (CRPDDP), in which we will integrate other services beyond ART in order to achieve efficiencies: The services to be integrated will include: HIVST kits at the community pharmacies for case finding, TB prevention, case finding/ screening and treatment drugs as well as expanding eligibility for community pharmacy refill model to include adolescents, young adults and caregivers of children living with HIV on ART. To further improve efficiencies of ART delivery and to reduce IIT, the program will expand the community-led drug distribution points to 10 high IIT burden districts and develop guidelines to include 10–19-year-olds and care givers in the CRPDDP.

e. Supporting community-led monitoring of treatment services with minimum quarterly meetings to review reported observations and recommendations with representatives and follow up as needed;

PEPFAR shall continue to collaborate with CSOs in maintaining or establishing community-led monitoring activities, whereby service beneficiaries, through local, independent civil society organizations, formally and routinely monitor the quality and accessibility of treatment services and the patient-provider experience at the facility level. PEPFAR shall work with the CLM team to ensure their engagement plan is more engaging and allows timely and meaningful feedback. CLM findings shall regularly be reviewed collaboratively with MOH, Development Partners and the PEPFAR teams with other PEPFAR data streams such as MER and SIMS, with the aim of informing and monitoring facility-level service delivery to ultimately make services more accessible and of higher quality to people.

Periodic (e.g., weekly, monthly) CLM data sharing and collaboration with community advocates, community groups, civil society organizations, and clients shall be treated with urgency and critical as PEPFAR continues to confront the challenges of assuring ART continuity in clients who may not view themselves as sick. The collaboration shall help PEPFAR-supported programs and facilities ensure they are providing quality services that clients want to utilize and pinpoint persistent problems, challenges, and barriers with service uptake at the site and facility level that PEPFAR can take on to improve health outcomes.

During COP22, PEPFAR shall purpose to integrate the CLM regional dialogues with the SIMs for subnational workable solutions that overcome these barriers and ensure persons have access to these services.

f. Ensuring above-site program activities are mapped to key barriers and measurable outcomes related to reaching epidemic control; and monitored in an ongoing manner;

Above site investments were informed by gaps and key barriers identified from stakeholder engagements (MOH and line Ministries, PEPFAR technical teams, CSOs peoples voice and other stakeholders,) and results from SID/RM 2021.

For the COP22, PEPFAR Uganda will strengthen systems for sustainability through focusing investments to interventions that address the SID elements with low scores including Commodity Security/ Supply Chain, Laboratory, Service Delivery, Data for Decision-Making Ecosystem and Domestic Resource Mobilization. The supported strategies and activities have been captured in table 6/SRE tool with clear benchmarks and indicators to guide regular monitoring of performance.

g. Use of unique identifiers across sites and programs in clinical settings for monitoring

Implementation of a Unique Identification (UI) strategy has continued to gain momentum with government of Uganda demonstrating significant leadership over the past year with work on a national health client registry (NHCR). This has further been evidenced by additional investments into the establishment of key enterprise architecture pieces, especially service registries such as the current work in progress on the national health facility registry (NHFR), among others. PEPFAR Uganda continues with a decentralized way of UI implementation as efforts continue to bolster policy, legal requirements, and governance for protection of privacy, confidentiality, and security of personal health information. However, this has not deterred efforts for working on key architecture pieces needed to implement the long-term vision of centralized unique identification as a service. A use-case to inform the development of a prototype client registry to support implementation of unique identification has been completed. Again, successful implementation of unique identification that will improve patient mobility as well as the patient experience critical for their retention will require connected devices and tools at the various points of service, across the HIV continuum of care - the reason PEFAR Uganda is focusing among others to greatly invest in the necessary IT infrastructure.

To meet the COP/ROP 2022 (FY 2023) Minimum Program Requirements for scale-up of case surveillance and unique identifiers for patients across all sites, both short term and medium to long term approaches are proposed.

4.8 Targets by Population

Table 4.8.1 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	Total PLHIV	**Expected current on ART**	**Additional patients required for 80% ART coverage**	**Target current on ART**	**Newly initiated (APR FY23)**	**ART Coverage (APR 23)**
		(APR FY22)		**(APR FY23)** ***TX_CURR***	***TX_NEW***	
Attained	374,479	347,483	0	357,643	34,050	96%
Scale-Up Saturation	586,772	543,466	0	537,119	72,169	92%
Scale-Up Aggressive	492,368	426,277	0	444,354	64,969	90%
Sustained		0	0			
Military		22,353	N/A	22,516	624	
Total	**1,453,619**	**1,339,579**	**0**	**1,361,632**	**171,812**	**94%**

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

District	Target population 15-29 2022	COP 21 Targets	Cumulative VMMC COP20	Coverage COP20 Q4	VMMC_CIRC (in FY23)	Cumulative Coverage COP22	Expected Coverage FY23
Total	6,100,480	386,573	3,854,835	63%	309,268	4,164,103	68%
Bukomansimbi District	20,050	880	13,416	67%	682	14,098	70%
Butambala District	14,550	1,967	11,382	78%	620	12,002	82%
Gomba District	25,390	2,113	18,491	73%	1,780	20,271	80%
Kalangala District	12,450	947	8,953	72%	1,354	10,307	83%
Kalungu District	25,810	1,277	17,971	70%	783	18,755	73%
Lwengo District	35,670	744	23,436	66%	577	24,013	67%
Lyantonde District	16,680	1,674	13,977	84%	2,790	16,767	101%
Masaka District	51,960	4,410	38,373	74%	4,650	43,023	83%
Mpigi District	43,880	3,398	32,185	73%	1,690	33,875	77%
Rakai District	41,320	2,849	28,624	69%	2,208	30,832	75%
Kyotera District	35,340	3,320	26,006	74%	2,480	28,486	81%
Sembabule District	41,860	2,878	29,615	71%	2,337	31,952	76%

District	Target population 15-29 2022	COP 21 Targets	Cumulative VMMC COP20	Coverage COP20 Q4	VMMC_CIRC (in FY23)	Cumulative Coverage COP22	Expected Coverage FY23
Wakiso District	481,190	17,920	318,497	66%	10,230	328,727	68%
Buikwe District	74,960	8,400	48,291	64%	6,510	54,801	73%
Buvuma District	20,420	1,987	13,589	67%	775	14,364	70%
Kayunga District	56,580	1,830	33,541	59%	2,836	36,377	64%
Kiboga District	28,280	1,927	18,261	65%	747	19,008	67%
Kyankwanzi District	44,910	2,906	28,224	63%	1,126	29,350	65%
Luwero District	83,060	3,036	53,356	64%	2,480	55,836	67%
Mityana District	56,500	2,930	35,031	62%	2,480	37,511	66%
Mubende District	95,230	3,200	59,180	62%	4,541	63,721	67%
Kassanda District	46,270	2,400	27,076	59%	1,860	28,936	63%
Mukono District	110,990	2,753	64,524	58%	6,200	70,724	64%
Nakaseke District	38,820	2,500	24,675	64%	968	25,643	66%
Nakasongola District	36,810	2,413	24,768	67%	935	25,703	70%
Bugiri District	67,590	4,387	50,160	74%	2,320	52,480	78%
Buyende District	56,730	3,874	41,340	73%	2,120	43,461	77%

District	Target population 15-29 2022	COP 21 Targets	Cumulative VMMC COP20	Coverage COP20 Q4	VMMC_CIRC (in FY23)	Cumulative Coverage COP22	Expected Coverage FY23
Iganga District	61,000	4,196	45,373	74%	2,246	47,619	78%
Bugweri District	25,730	2,400	18,895	73%	930	19,825	77%
Jinja District	77,730	8,000	62,283	80%	5,890	68,173	88%
Kaliro District	40,990	2,443	30,033	73%	2,187	32,220	79%
Kamuli District	80,350	4,115	59,021	73%	3,720	62,741	78%
Luuka District	36,510	800	24,366	67%	310	24,676	68%
Mayuge District	80,160	3,317	56,660	71%	1,596	58,256	73%
Namayingo District	32,730	2,980	25,514	78%	1,466	26,980	82%
Namutumba District	42,810	3,376	31,707	74%	1,419	33,126	77%
Kampala District	307,050	10,424	238,720	78%	25,047	263,767	86%
Budaka District	35,330	1,772	27,893	79%	2,294	30,187	85%
Bududa District	43,540	2,604	33,943	78%	1,550	35,493	82%
Bukwo District	16,930	1,073	13,350	79%	1,860	15,210	90%
Bulambuli District	35,190	1,600	25,359	72%	1,435	26,794	76%
Busia District	57,180	3,230	43,295	76%	1,562	44,856	78%

District	Target population 15-29 2022	COP 21 Targets	Cumulative VMMC COP20	Coverage COP20 Q4	VMMC_CIRC (in FY23)	Cumulative Coverage COP22	Expected Coverage FY23
Butaleja District	41,360	1,270	30,213	73%	1,688	31,900	77%
Kapchorwa District	17,530				1,860	1,860	11%
Kibuku District	34,570	1,519	25,488	74%	1,302	26,790	77%
Kween District	16,150						0%
Manafwa District	21,940	1,390	17,548	80%	1,580	19,128	87%
Namisindwa District	28,290	2,000	22,950	81%	1,324	24,274	86%
Mbale District	90,020	2,800	66,854	74%	3,003	69,857	78%
Pallisa District	52,490	3,590	39,828	76%	1,391	41,219	79%
Butebo District	16,370	476	12,827	78%	1,860	14,687	90%
Sironko District	35,920	2,770	30,795	86%	4,546	35,341	98%
Tororo District	77,800	1,141	60,054	77%	2,205	62,259	80%
Agago District	29,930	2,886	11,714	39%	1,674	13,388	45%
Alebtong District	38,790	2,190	13,526	35%	1,502	15,028	39%
Amolatar District	26,260	1,773	9,085	35%	1,373	10,458	40%
Amuru District	30,960	3,367	13,018	42%	1,925	14,943	48%

District	Target population 15-29 2022	COP 21 Targets	Cumulative VMMC COP20	Coverage COP20 Q4	VMMC_CIRC (in FY23)	Cumulative Coverage COP22	Expected Coverage FY23
Apac District	32,850	3,162	13,224	40%	2,235	15,459	47%
Kwania District	30,460	2,750	11,624	38%	1,867	13,491	44%
Dokolo District	29,230				1,109		
Gulu District	51,090	6,372	23,814	47%	6,005	29,819	58%
Omoro District	30,280	3,373	12,848	42%	1,928	14,776	49%
Kitgum District	33,090	1,913	11,240	34%	934	12,173	37%
Kole District	39,740	1,550	11,844	30%	787	12,631	32%
Lamwo District	18,600	1,380	7,396	40%	843	8,239	44%
Lira District	71,860	6,229	27,392	38%	6,473	33,865	47%
Nwoya District	35,730	3,390	13,922	39%	1,448	15,370	43%
Otuke District	17,900	1,384	6,550	37%	918	7,468	42%
Oyam District	61,580	6,251	26,092	42%	4,969	31,061	50%
Pader District	27,920	-	8,029	29%	586	8,615	31%
Buliisa District	25,290	5,600	22,693	90%	3,555	26,248	104%
Bundibugyo District	39,160	400	25,165	64%	620	25,785	66%

District	Target population 15-29 2022	COP 21 Targets	Cumulative VMMC COP20	Coverage COP20 Q4	VMMC_CIRC (in FY23)	Cumulative Coverage COP22	Expected Coverage FY23
Hoima District	55,850	4,087	43,972	79%	4,656	48,628	87%
Kikuube District	52,040	7,824	40,312	77%	4,334	44,646	86%
Kabarole District	51,650	4,978	42,923	83%	3,512	46,436	90%
Bunyangabu District	30,330	5,340	27,187	90%	2,279	29,466	97%
Kamwenge District	44,650	1,507	31,932	72%	1,888	33,820	76%
KITAGWENDA District	23,240	1,070	16,326	70%	1,335	17,662	76%
Kasese District	118,800	4,436	86,441	73%	2,306	88,747	75%
Kibaale District	29,760	1,310	20,466	69%	1,246	21,712	73%
Kagadi District	58,300	1,963	41,408	71%	1,395	42,803	73%
Kakumiro District	73,220	4,684	52,176	71%	2,530	54,706	75%
Kiryandongo District	49,880	3,200	37,498	75%	2,480	39,978	80%
Kyegegwa District	65,670	1,816	44,465	68%	1,633	46,099	70%
Kyenjojo District	76,060	2,836	52,640	69%	2,449	55,089	72%
Masindi District	53,650	2,750	40,527	76%	1,860	42,387	79%
Ntoroko District	12,360	960	8,902	72%	966	9,868	80%

District	Target population 15-29 2022	COP 21 Targets	Cumulative VMMC COP20	Coverage COP20 Q4	VMMC_CIRC (in FY23)	Cumulative Coverage COP22	Expected Coverage FY23
Abim District	25,220				964		
Amudat District	20,550						
Amuria District	33,400	3,773	16,159	48%	1,462	17,621	53%
Kapelebyong District	14,990	1,600	5,000	33%	1,240	6,240	42%
Bukedea District	36,760	4,437	15,895	43%	1,719	17,614	48%
Kaabong District	16,220				771		
Karenga District	9,670				578		
Kaberamaido District	20,570	4,097	12,033	58%	3,100	15,133	74%
KALAKI District	18,660	1,200	5,433	29%	1,860	7,293	39%
Katakwi District	29,660	1,744	11,050	37%	1,916	12,966	44%
Kotido District	31,430	2,303	10,080	32%	771	10,851	35%
Kumi District	41,200	4,384	16,117	39%	1,699	17,816	43%
Moroto District	16,860	1,911	7,311	43%	1,267	8,578	51%
Nakapiripirit District	17,600	1,600	6,398	36%	1,240	7,638	43%
Nabilatuk District	14,240						

District	Target population 15-29 2022	COP 21 Targets	Cumulative VMMC COP20	Coverage COP20 Q4	VMMC_CIRC (in FY23)	Cumulative Coverage COP22	Expected Coverage FY23
Napak District	20,190	1,600	5,653	28%	1,240	6,893	34%
Ngora District	24,050	2,803	10,218	42%	2,326	12,545	52%
Serere District	53,430	4,293	20,186	38%	1,663	21,850	41%
Soroti District	59,800	5,402	25,734	43%	4,030	29,764	50%
Buhweju District	19,620	2,016	9,807	50%	781	10,588	54%
Bushenyi District	36,370	3,830	17,947	49%	3,720	21,667	60%
Ibanda District	38,620	3,933	19,160	50%	3,720	22,880	59%
Isingiro District	75,020	6,885	43,293	58%	3,613	46,906	63%
Kabale District	35,120	6,400	26,709	76%	3,261	29,970	85%
Rubanda District	25,750	1,920	12,744	49%	744	13,488	52%
Rukiga District	13,680	2,560	9,268	68%	992	10,260	75%
Kanungu District	36,010	4,266	18,783	52%	2,690	21,474	60%
Kiruhura District	28,820	3,221	13,822	48%	3,720	17,542	61%
KAZO District	30,140	1,600	12,793	42%	620	13,413	45%
Kisoro District	38,090	1,920	16,012	42%	744	16,756	44%

District	Target population 15-29 2022	COP 21 Targets	Cumulative VMMC COP20	Coverage COP20 Q4	VMMC_CIRC (in FY23)	Cumulative Coverage COP22	Expected Coverage FY23
Mbarara District	62,260	3,748	32,293	52%	4,340	36,633	59%
RWAMPARA District	19,520	1,600	9,065	46%	620	9,685	50%
Mitooma District	23,440	440	13,144	56%	579	13,723	59%
Ntungamo District	70,080	5,363	36,432	52%	2,078	38,510	55%
Rubirizi District	17,350	1,824	9,024	52%	707	9,731	56%
Rukungiri District	42,920	4,733	22,464	52%	3,923	26,387	61%
Sheema District	30,240	841	13,297	44%	1,108	14,404	48%
Adjumani District	28,930	3,514	23,283	80%	3,461	26,744	92%
Arua District	70,101	3,535	48,753	70%	5,622	54,375	78%
Madi Okollo District	22,210						
Terego District	31,669	2,400	22,684	72%	3,100	25,784	81%
Koboko District	41,830	2,986	29,535	71%	1,778	31,312	75%
Maracha District	23,880	3,060	19,473	82%	1,185	20,658	87%
Moyo District	15,870	2,787	14,016	88%	1,640	15,655	99%
OBONGI District	7,550	800	5,288	70%	3,100	8,388	111%

District	Target population 15-29 2022	COP 21 Targets	Cumulative VMMC COP20	Coverage COP20 Q4	VMMC_CIRC (in FY23)	Cumulative Coverage COP22	Expected Coverage FY23
Nebbi District	36,240	960	23,735	65%	1,240	24,975	69%
Pakwach District	27,010	960	17,904	66%	1,240	19,144	71%
Yumbe District	87,870	3,730	58,459	67%	1,477	59,936	68%
Zombo District	24,620	2,657	23,542	96%	1,649	25,191	102%

Standard Table 4.8.3

Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control (PrEP)																	
	FSW			MSM			PWID			AGYW (15-24)			Pregnant, Lactating and Breastfeeding women			PP_Prev(Fisherfolk/S	PP_Prev(Fisherfol
District	FSW PSE	popn negative	COP22 Target	MSM PSE	popn negative	COP22 target	PWID PSE	popn negative	PrEP target	population	high risk	COP22 Targets	population	high risk	COP22 Targets	population	COP22 Targets
Lwengo District	890	643	**431**	295	234	97	30		-	26,730	683	566	66900	5,546	157	474	34
Masaka District	710	430	**296**	313	243	101	31	21	2	37,700	917	796	88740	7,357	208	378	27
Wakiso District	13,558	9,895	**6623**	880	627	259	252	174	21	466,250	11,975	11,070	976450	80,949	2,285	12,557	896
Buikwe District	2,590	1,811	**1219**	872	683	282	73	57	7	55,510	1,404	1,206	123580	10,245	290	2,408	172
Kayunga District	2,334	1,767	**1177**	393	311	129	58	45	5	40,830	1,039	861	93600	7,760	219	2,145	153
Luwero District	2,912	1,662	**1153**	472	362	150	69	20	3	58,760	1,488	1,270	131210	10,877	308	1,395	100
Mityana District	1,680	1,046	**715**	356	277	114	37		-	38,270	962	816	86700	7,188	203	805	57
Mubende District	3,094	1,931	**1321**	578	454	188	75		-	63,550	1,631	1,450	146560	12,150	343	1,482	106
Mukono District	3,754	2,696	**1808**	431	340	141	85		-	87,740	2,242	1,972	199360	16,527	467	3,450	246
Iganga District	3,373	2,567	**1709**	1,101	870	360	88	65	8	48,460	1,250	1,066	107110	8,880	251	2,700	193
Jinja District	2,722	2,062	**1374**	2,622	2,070	855	91	69	8	64,440	1,616	1,384	131410	10,894	308	2,269	162
Mayuge District	2,847	2,215	**1471**	736	583	241	76	58	7	61,870	1,605	1,392	141420	11,724	331	2,278	163
Kampala District	22,314	14,767	**10015**	14,019	10,820	4,471	2,774	2,085	244	282,040	6,872	6,530	575680	47,724	1,348	16,000	1142
Busia District	2,715	2,077	**1382**	252	198	82	53	29	4	44,140	1,139	954	97710	8,100	229	2,174	155
Tororo District	7,632	5,889	**3914**	362	272	112	88	55	7	65,860	1,678	1,381	138680	11,497	325	6,154	439
Gulu District	2,068	1,514	**1013**	237	185	76	59	40	5	41,840	1,021	871	86000	7,129	201	1,245	89
Lira District	1,612	1,182	**791**	376	295	122	61	44	5	61,490	1,541	1,302	126270	10,468	296	752	54
Hoima District	2,816	2,045	**1370**	356	279	115	68		-	44,970	1,141	992	95560	7,922	224	1,799	128
Kabarole District	1,743	1,113	**759**	504	375	155	53	41	5	38,950	957	825	82940	6,876	194	1,418	101
Kasese District	3,123	2,274	**1523**	434	339	140	77	60	7	88,710	2,301	1,998	202090	16,753	473	2,499	178
Kyenjojo District	1,752	1,329	**885**	344	265	110	47	34	4	56,100	1,425	1,231	120340	9,976	282	1,425	102
Masindi District	1,570	1,217	**809**	172	132	54	37		-	37,780	957	836	81870	6,787	191	1,003	72
Soroti District	887	519	**358**	223	175	72	44		-	44,360	1,127	941	95270	7,898	223	445	32
Ibanda District	1,217	926	**616**	154	122	50	27	20	2	30,640	780	660	67900	5,629	159	633	45
Kabale District	1,693	1,230	**824**	313	248	102	58		-	28,770	737	628	63420	5,258	149	881	63
Mbarara District	2,333	1,565	**1059**	445	325	134	51	32	4	50,470	1,233	1,106	109310	9,062	256	1,960	140
Arua District	4,128	3,204	**2128**	389	305	126	102	80	9	60,664	1,564	1,314	131494.767	10,901	308	4,367	312
Kyotera District	1,812	1,315	**881**	45	34	14	78	60	7	25,830	636	531	63180	5,238	148		
Lyantonde District	363	190	**134**	70	51	21	10		-	11,720	290	250	26880	2,228	63		
Mpigi District	1,054	777	**519**	300	238	98	26		-	30,220	764	661	69850	5,791	164	561	40
Rakai District	1,616	1,239	**824**	283	224	93	53	41	5	29,340	754	648	73980	6,133	173	859	61
Sembabule District	975	702	**471**	216	171	71	26		-	28,430	726	619	70260	5,825	165	519	37
Kiboga District	744	456	**313**	142	112	46	17		-	17,580	441	377	39810	3,300	94	357	25
Kyankwanzi District	1,000	616	**422**	184	146	60	25		-	29,230	749	662	63680	5,279	149	479	34
Nakaseke District	1,101	640	**442**	156	123	51	25		-	22,360	567	484	49060	4,067	115	527	38
Nakasongola District	877	589	**398**	190	150	62	25	19	2	22,630	582	490	50650	4,199	118	420	30
Bugiri District	3,111	2,455	**1627**	610	483	200	65		-	51,490	1,339	1,131	117500	9,741	275		
Kamuli District	2,952	2,305	**1530**	682	540	223	80	60	7	59,060	1,527	1,265	132110	10,952	309	2,363	169
Mbale District	721	417	**289**	1,313	1,018	421	106	75	9	75,540	1,932	1,661	165870	13,751	389	581	41
Apac District	1,775	1,404	**930**	242	192	79	51	39	5	26,350	667	560	54780	4,541	128	402	29
Lamwo District	555	440	**291**	68	54	22	17		-	14,250	359	301	34110	2,828	80		
Oyam District	1,874	1,333	**895**	60	48	20	53	32	4	51,330	1,308	1,076	107070	8,876	251	874	62
Kamwenge District	1,936	1,427	**954**	237	188	78	45		-	34,110	878	777	78860	6,538	185	1,574	112
Kibaale District	3,777	2,934	**1949**	513	406	168	90		-	21,640	557	489	46390	3,846	109	2,413	172
Kaberamaido	847	646	**430**	157	124	51	30		-	14,750	378	306	32430	2,688	76	424	30
Bushenyi District	1,011	701	**472**	185	135	56	26	19	2	29,370	733	603	62390	5,172	146	526	38
Isingiro District	1,973	1,517	**1009**	348	276	114	52		-	60,320	1,559	1,334	142850	11,842	335	1,026	73
Kanungu District	881	631	**423**	170	135	56	27		-	29,680	758	636	67030	5,557	157	458	33
Kiruhura District	1,462	1,157	**767**	197	156	64	33		-	19,420	496	427	45160	3,744	105	761	54
Ntungamo District	1,941	1,406	**942**	41	28	12	52	40	5	57,110	1,466	1,219	128430	10,647	301	1,011	72
Rukungiri District	1,244	893	**599**	84	67	27	35		-	36,150	912	740	80430	6,668	188	647	46
Nebbi District	2,052	1,593	**1058**	67	53	22	49		-	31,000	799	663	65790	5,454	154	1,311	94
Kalangala District	143	97	**64**	105	74	31	6		-	6,530	159	165	18820	1,560	44	4,205	300
Buvuma District	430	256	**173**	121	85	35	13		-	13,220	340	328	34180	2,834	80		
Namayingo District	1,170	823	**545**	306	215	89	-		-	23,970	612	527	56260	4,664	131		
Alebtong District	816	574	**381**	152	107	44	31		-	29,250	751	618	65090	5,396	152		
Amolatar District	701	308	**219**	110	77	32	20		-	18,790	477	398	42340	3,510	99		
Serere District	1,128	787	**522**	254	179	74	41		-	39,490	1,030	855	86550	7,175	203		
Adjumani District	1,271	892	**591**	78	55	23	30		-	24,250	630	526	55230	4,579	130		
Dokolo District	754	525	**348**	127	89	37	26		-	24,210	615	499	49990	4,144	117	352	25
Kitgum District	839	587	**389**	85	60	25	26		-	24,030	607	500	55030	4,562	129	505	36
Kole District	1,062	737	**489**	176	124	51	35		-	32,410	829	678	65710	5,447	154	495	35
Kiryandongo District	1,377	940	**625**	147	103	42	35		-	34,100	877	749	77170	6,397	181	880	63
Mitooma District	776	546	**362**	138	97	40	21		-	20,820	539	439	46370	3,844	109	403	29
Zombo District	1,328	901	**600**	216	152	63	30		-	27,350	709	590	27350	2,267	66	849	61
Total	**147,516**	**105,331**	**70,620**	**36,204**	**27,959**	**11,552**	**5,974**	**3,413**	**400**	**3,174,224**	**80,636**	**70,200**	**6,916,215**	**573,361**	**16,200**	**100,878**	**7,200**

Table 4.8.3.2 Target Populations for Prevention Interventions to Facilitate Epidemic Control KP and PP

District	FSW PSE	Targets	MSM PSE	Targets	PWID PSE	Targets	TG PSE	Targets	PIP_PSE	Targets	Truck Drivers, Fisherfolk,
Lwengo District	890	846	295	280	30	29		-	7,651	7,268	474
Masaka District	710	675	313	297	31	29		-	146	139	378
Wakiso District	13,558	12,880	880	836	252	239	167	159	4,246	4,034	12,557
Buikwe District	2,590	2,461	872	828	73	69		-	3,864	3,671	2,408
Kayunga District	2,334	2,217	393	373	58	55		-	1,441	1,369	2,145
Luwero District	2,912	2,766	472	448	69	66		-	5,030	4,779	1,395
Mityana District	1,680	1,596	356	338	37	35		-	1,535	1,458	805
District	3,094	2,939	578	549	75	71		-	187	178	1,482
Mukono District	3,754	3,566	431	409	85	81		-	-	-	3,450
Iganga District	3,373	3,204	1,101	1,046	88	84	209	199	1,875	1,781	2,700
Jinja District	2,722	2,586	2,622	2,491	91	86		-	688	654	2,269
Mayuge District	2,847	2,705	736	699	76	72	140	133	1,237	1,175	2,278
Kampala District	22,314	21,198	14,019	13,318	2,774	2,635	2,664	2,531	510	485	16,000
Busia District	2,715	2,579	252	239	53	50		-	3,467	3,294	2,174
Tororo District	7,632	7,250	362	344	88	84		-	3,736	3,549	6,154
Gulu District	2,068	1,965	237	225	59	56		-	408	388	1,245
Lira District	1,612	1,531	376	357	61	58		-	399	379	752
Hoima District	2,816	2,675	356	338	68	65		-	11,102	10,547	1,799
Kabarole District	1,743	1,656	504	479	53	50		-	1,567	1,489	1,418
Kasese District	3,123	2,967	434	412	77	73		-	-	-	2,499
Kyenjojo District	1,752	1,664	344	327	47	45		-	481	457	1,425
Masindi District	1,570	1,492	172	163	37	35		-	524	498	1,003
Soroti District	887	843	223	212	44	42		-	3,387	3,218	445
Ibanda District	1,217	1,156	154	146	27	26		-	759	721	633
Kabale District	1,693	1,608	313	297	58	55		-	10,861	10,318	881
Mbarara District	2,333	2,216	445	423	51	48		-	996	946	1,960
Arua District	4,128	3,922	389	370	102	97		-	6,834	6,492	4,367
Kyotera District	1,812	1,721	45	43	78	74		-	642	610	2,000
Lyantonde District	363	345	70	67	10	10		-	1,155	1,097	

Standard Table 4.8.4 Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY23 Target) OVC_SERV Comprehensive	Target # of OVC (FY23 Target) OVC_SERV Preventative	Target # of active OVC (FY23 Target) OVC_SERV DREAMS	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target) OVC*
_Military Uganda	-	5,304	1,348	-	4,124
Agago District	6,378	3,060	-	895	2,187
Alebtong District	6,956	1,958	-	-	1,400
Amolatar District	4,449	2,133	-	-	1,526
Apac District	6,005	2,689	300	1,215	2,065
Arua District	13,513	4,498	-	-	3,990
Bugiri District	12,838	3,207	7,064	-	2,293
Bugweri District	4,934	990	-	-	707
Buikwe District	12,216	6,255	340	-	4,610
Bukomansimbi District	3,891	1,769	-	1,910	1,264
Bunyangabu District	5,068	2,649	-	-	1,893
Bushenyi District	6,231	4,570	-	-	3,266
Busia District	10,134	3,174	600	-	2,298
Dokolo District	5,622	2,493	-	-	1,782
Gomba District	4,419	1,819	-	1,282	1,300
Gulu District	8,544	9,996	-	1,142	7,144
Hoima District	9,951	5,369	-	-	4,714

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY23 Target) OVC_SERV Comprehensive	Target # of OVC (FY23 Target) OVC_SERV Preventative	Target # of active OVC (FY23 Target) OVC_SERV DREAMS	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target) OVC*
Ibanda District	7,092	3,212	-	-	2,296
Iganga District	10,531	3,455	200	-	2,504
Isingiro District	15,816	6,853	3,300	-	5,735
Jinja District	13,126	7,622	-	-	5,447
Kabale District	6,281	2,814	7,064	-	2,011
Kabarole District	8,694	9,848	-	-	7,039
Kagadi District	11,401	4,797	-	-	3,428
Kakumiro District	13,983	3,604	-	-	2,576
Kalangala District	1,826	2,071	-	338	1,479
Kalungu District	4,868	3,778	-	-	2,727
Kampala District	43,552	43,998	9,192	4,712	32,705
Kamuli District	14,399	4,084	100	-	2,953
Kamwenge District	8,932	4,464	2,100	-	3,704
Kanungu District	7,059	3,149	-	-	2,251
Kasese District	20,490	4,460	-	-	3,188
Kassanda District	8,101	4,040	100	2,867	2,888
Katakwi District	5,075	2,572	-	-	1,839
Kayunga District	10,341	5,326	100	-	3,807
Kazo District	5,778	1,491	-	-	1,065
Kibaale District	5,538	2,017	-	-	1,441
Kiboga District	4,480	2,728	-	-	1,950
Kikuube District	9,859	3,234	-	-	2,312

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY23 Target) OVC_SERV Comprehensive	Target # of OVC (FY23 Target) OVC_SERV Preventative	Target # of active OVC (FY23 Target) OVC_SERV DREAMS	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target) OVC*
Kiruhura District	4,956	1,874	-	-	1,339
Kiryandongo District	8,253	2,367	-	-	1,693
Kitagwenda District	4,749	1,375	-	-	983
Kitgum District	5,706	4,051	-	-	2,895
Kole District	7,438	3,094	-	-	2,212
Kotido District	5,331	300	-	-	214
Kwania District	5,659	2,379	-	1,156	1,701
Kyegegwa District	12,857	5,205	1,740	-	4,146
Kyenjojo District	13,993	8,424	-	-	6,020
Kyotera District	6,653	7,370	1,355	1,113	5,617
Lira District	12,509	10,570	1,540	2,491	7,943
Luwero District	13,622	8,733	1,730	4,904	6,759
Lwengo District	7,301	3,653	200	2,776	2,813
Lyantonde District	2,905	3,369	200	1,681	2,457
Madi Okollo District	4,291	877	-	-	626
Masaka District	8,704	9,577	2,250	2,993	7,308
Masindi District	8,907	4,894	-	-	3,498
Mayuge District	14,793	4,144	-	-	2,962
Mbale District	15,592	8,155	2,700	-	6,446
Mbarara District	10,104	11,779	-	2,932	8,419

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY23 Target) OVC_SERV Comprehensive	Target # of OVC (FY23 Target) OVC_SERV Preventative	Target # of active OVC (FY23 Target) OVC_SERV DREAMS	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target) OVC*
Mitooma District	4,851	1,267	-	-	906
Mityana District	9,304	5,608	-	3,227	4,008
Mpigi District	7,449	4,297	-	-	3,072
Mubende District	15,366	8,460	160	2,638	6,134
Mukono District	18,488	10,190	2,650	4,302	7,952
Nakaseke District	6,172	2,601	200	-	1,884
Namayingo District	6,051	3,333	-	-	2,382
Nebbi District	7,386	2,369	-	-	1,694
Ntungamo District	13,838	4,638	-	-	3,314
Omoro District	5,233	2,262	-	923	1,617
Oyam District	11,852	5,669	300	1,501	4,112
Pakwach District	5,257	1,438	-	-	1,027
Rakai District	8,223	3,933	1,510	2,681	3,159
Rubanda District	5,222	982	-	-	702
Rukiga District	2,630	945	-	-	675
Rukungiri District	8,360	5,674	-	-	4,055
Rwampara District	3,718	2,341	-	-	1,673
Sembabule District	7,782	3,149	-	1,768	2,251
Sheema District	5,541	3,481	-	-	2,488

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY23 Target) OVC_SERV Comprehensive	Target # of OVC (FY23 Target) OVC_SERV Preventative	Target # of active OVC (FY23 Target) OVC_SERV DREAMS	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target) OVC*
Soroti District	9,725	5,265	-	-	3,763
Tororo District	15,461	7,933	3,119	-	6,383
Wakiso District	83,330	27,260	32,033	8,493	23,278
TOTAL	**793,932**	**406,835**	**83,495**	**59'940**	**304'488**

4.9 Cervical Cancer Program Plans

In COP21, PEPFAR Uganda scaled up cervical cancer screening of and treatment for precancerous lesions services from 604 static sites in COP20 to 225 additional static sites and 947 outreaches sites. This brings the total number of supported facilities to 1,776, covering all ART sites that have eligible WLHIV aged 25 to 49 years. In COP21, we target to screen 282,576 WLHIV aged 25-49 years, representing 50% of the WLHIV that are currently in care. By the end of FY22Q1, we had screened 23% of the COP21 target and are therefore on course to achieve the annual target.

Of the COP22 cervical cancer $3 million earmark, we have allocated $1.257 million to commodities and $1.743 million to services. In early 2022, Uganda's MOH revised its cervical cancer guidelines to align with the WHO 2021 guidance. The revised guidelines provide for four screening approaches: (i) HPV screen and treat; (ii) HPV screen, triage, and treat; (iii) VIA screen and treat; and (iv) screening with cytology. In addition, the revised guidelines specifies that screening should be done once every 3 years among WLHIV. Considering this revision and the COP22 guidance, for COP22 PEPFAR Uganda has revised the screening interval from once every 2 years to once every 3 years. In COP22, we have planned to scale HPV screen, triage, and treat from the current 23 sites to 61 sites. At all HPV screen, triage and treat sites, we have guided that all WLHIV aged 50 years and above are provided a one-off screening for cervical cancer using HPV DNA testing.

Treatment for invasive cervical cancer is currently centralized at the Cancer Institute in Kampala, and Government of Uganda is in the early stages of decentralizing cancer treatment services. We currently provide transport support to WLHIV identified with invasive cervical cancer to aid the referral process. As much as possible, we guide that screening and treatment of precancerous lesions is done on the same day, in situations when this is not possible tracking mechanisms are in place to bring back those identified with precancerous lesions for treatment. We are in the early phases of setting up VIA quality assurance regional teams and an HPV DNA testing quality assurance system.

To address the concerns of coercion that were raised by CSOs during the RPM, MOH will send a circular to all health facilities against any form of coercion or precondition to access ART services.

4.10 Viral Load and Early Infant Diagnosis Optimization

Uganda has a centralized early infant diagnosis (EID) and viral load (VL) testing system using conventional PCR platforms and several point of care (POC) platforms for EID and VL testing, including the m-PIMA and GeneXpert among others for analysis of both plasma and dried blood spot (DBS) samples transported through the national specimen transportation network. To ensure efficient and impactful use of POC platforms for laboratory testing, PEPFAR Uganda has worked with the National Health Laboratory and Diagnostic Services (NHLDS) department of MOH to

explore multiplexing for EID, TB, human papilloma virus (HPV), and hepatitis B for improved access, efficiency, and cost savings. Diagnostic Network Optimization (DNO) will guide how to use the conventional platform as well as the POCs, which will especially ensure the availability of efficient and impactful best practices to close remaining gaps in low VL testing coverage among certain populations, such as pregnant and breastfeeding women (PBFW), infants, children, and adolescents, and low EID at 2 months. The complementary use of POC and centralized instruments for analysis of both plasma and DBS samples will increase VL and EID testing coverage, ensuring that the available equipment have high throughout for increased testing capacity and appropriate cut off threshold that supports the national HIV/TB testing program.

PEPFAR Uganda will continue working in collaboration with NHLDS and the National TB & Leprosy Program (NTLP) to enhance the diagnostic efficiency through TB/HIV diagnostic integration and multiplexing for optimized VL, EID, TB, HPV and hepatitis B testing. For FY23 (COP22), Uganda plans: placement of 16 module GeneXpert platforms in all 16 Regional Referral Hospitals (RHHs); support the scale-up Laboratory Information Management System (LIMS) in all POC sites to improve results turnaround time; implement laboratory-based continuous quality improvement (CQI); proper waste management for safe disposal of guanidine thiocyanate (GTC) and other liquid laboratory waste; and scale-up POC testing coverage through demand creation, treatment literacy, and outreach efforts.

In COP22, based on scalability, country capacity, and the available budget, PEPFAR Uganda working with the MOH will support processes for improving the specimen transport process by tracking specimens from collection at the health care facility to the testing laboratory, through utilizing the existing hubs network optimization to develop a plan to track specimens from health care facility to hubs and the Central Public Health Laboratories (CPHL), and the use of data systems to include person-centered SMS to alert patients of the availability of their test results, targeting front line health workers and HIV patients to them access EID, VL, and COVID-19 results using a phone at any time.

PEPFAR Uganda is working with MOH to scale-up Enterprise Resource Planning (ERP) implementation in the 100 hubs to improve timely ordering and facility level commodity visibility. The country has already transitioned to all-inclusive pricing model for all procurement of VL and EID commodities. USG team will continue to build capacity for NHLDS to monitor supplier's performance against all-inclusive pricing key performance indicators (KPIs) of the different sales level agreement and coordinate quarterly meetings with suppliers to discuss the KPIs.

Due impact of COVID-19 on commodities and supply chain, we anticipate partial and delayed deliveries of some commodities. To address this, we will continue supporting NHLDS to monitor the supply plan fulfillment and flag potential delays early enough to allow for interventions and minimize testing interruptions. The NHLDS monthly VL/EID commodity security meetings will also be used to monitor and provide guidance on timely and full deliveries.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

1. *What was the process for determining which key systems barriers (those highlighted in the Key Systems Barriers-E tab) would be focused on in COP22?*

   PEPFAR Uganda's COP22 above site investments have been informed by the results of the SID and triangulated through the RM for fiscal and functional roles and responsibilities. Going forward, PEPFAR Uganda's investments will address systems barriers especially within domains/elements whose SID scores have been low, not picking up or declining over the past years. For elements for which the country has consistently scored well, dark/light green, PEPFAR Uganda's investments will focus on elements and components specifically to address the transition challenges. PEPFAR Uganda will ensure harmonization of approaches for institutionalization of such interventions that will facilitate transition into the public sector domain for enhanced country ownership for sustainability.

2. *If only sub-set of SID elements were selected, what was the rationale and process used for narrowing the focus?*

   From the SID scores, only 4/17 had dark green scores while 3/17 had light green scores. One of such domains whose scores have been dark green for the last three cycles is governance, leadership and accountability. This domain speaks to more of the Ministry of health central level mandates. In consideration of these SID scores, PEPFAR Uganda will remain light at the central level except for maintenance of senior advisor positions that will strengthen the MOH to develop key policies that are meant to address systems barriers for sustaining epidemic control targets. In the same vein, PEPFAR Uganda will strengthen the sub national entities especially the Regional Referral Hospital team that will provide oversight, leadership and coordination role from a central perspective that will ensure increased visibility of the MOH for country led processes for sustainability.

3. *What are the key systems gaps identified through SID, MER, SIMS, HRH inventory, and other sources? How do the Table 6 activities resolve these identified gaps?*

   PEPFAR Uganda continues to provide targeted technical assistance to MOH to improve HRH management and optimization to achieve sustained epidemic control. Over the last year, this support facilitated the approval of the 10-year HRH strategic plan; harmonized the monthly pay for lay health workers; transitioned 110 PEPFAR seconded staff to GOU, improved HRIS functionality and utilization; scaled up E-learning platforms to selected districts and high-volume facilities; trained public health managers; and recruited additional health workers for RRHs to improve the capacity to implement public health functions and achieve PEPFAR targets.

Despite achievements highlighted, outstanding gaps/concerns were identified through consultation with MOH and line ministries, CSOs, PEPFAR technical teams and review of SID 2021 results and the PLL. The gaps include lack of standardized community health workforce cadre in GOU health staff establishment, low staffing coverage in relation workload especially for laboratory, HRH productivity and absenteeism concerns; limited use of data to inform staff optimization and deployment; Inadequate alignment of IP compensation with GOU pay scales; inadequate funding for in-service training by GOU; and limited capacity of RRHs to implement delegated public health functions.

The COP22 investments focus on completion of the CHEWs pilot to inform institutionalization of the CHEWS by GOU, completion of staff restructuring to create more positions and cadres, capacity building for public health leaders to provide effective stewardship of the response, critical HRH support to increase the capacity of RRH to implement the delegated MOH public health functions and sustainability, achieve targets, scale up cost effective in-service training platforms (ECHO/Zoom) to an additional 30 districts/high volume sites, maintain up to date HRH inventory and improve HRIS utilization and functionality for generation of data for evidence-based decision making; recruitment planning and seconded staff transition to GOU and PNFP payrolls.

4. *How do Table 6 investments leverage systems investments by the host country government and other donor investments?*

   Systems investments are aligned to the country program gaps that are identified through rigorous program performance monitoring, stakeholder engagements by level including the SID and RM processes. This ensures that there is information sharing, efficiencies and complementarity with other health development partners.

5. *Are timelines, benchmarks, and outcomes adequately defined to support monitoring of progress towards addressing key systems barriers and Table 6 investments?*

   Yes, the table six investment and progress are data driven that are reviewed each funding year to ensure that program inputs are linked to process indictors that speak to the benchmarks and inform program outcomes.

6. *How do Digital Health Investments, both above-site in Table 6 and site-level, address key digital health gaps and strategically address key program needs?*

   The main goal of the Digital Health Investments (DHI) is to ensure that there is in-country capacity to develop, roll out, maintain secure and sustainable patient centric solutions to meet the critical program priorities where key service delivery data care captured to improve service, outcomes, and progress towards epidemic control. 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 do 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.

Investing in critical IT infrastructure is necessary to deliver a connected patient journey for the entire HIV continuum of response from HIV testing linkages to prevention services or care and treatment until clinical wellness or viral suppression. This way, care providers are enabled to have timely latest patient data to improve outcomes with personalized care. Additionally, Investing in the connectedness of the systems also lays a firm foundation for implementation of unique identification which is important for maintaining an accurate number of people on antiretroviral drugs, facilitate patient tracking within and across facilities, monitor transfers in or out of particular facilities and identify those who are lost to follow-up or who have died- potentially helping with deduplication and accurately supporting the measurement IIT and retention resolutions as well as viral suppression.

Finally, to unlock and act on this individual level data, requires not only investments in the right tools and platforms, but it also requires skilled workforces, as well proper data governance which requires techniques, policies, standards and procedures that allow all stakeholders to reliably securely and confidentially transmit sensitive and non-sensitive data collected. It is for this reason that COP22 HIS table 6 site level and AS investments plan to invest in technology to continue to build site level and above site systems support HIV care, TB as well as other diseases, the workforce required to use the systems and improve processes necessary for the establishment of the data governance environment as well as collaborate and coordinate across major in country players and global public health stakeholders.

7. *What is the ultimate goal of the systems investments and at the country level what are the indications that the system is adequately functioning?*
   Through the SID/RM assessment exercise, the Government of Uganda entities provide leadership specifically to ensure that these entities do internalize these scores, participate in the PEPFAR COP planning and budgeting process, jointly review systems barriers that inform subsequent budgeting processes, harmonize approaches for institutionalization within districts and health facilities for country ownership, transition and sustainability. One such example being the laboratory whose SID scores dropped from 4.61 (FY19) to 3.81 (FY21). The Ministry of health has since then directed that all Laboratory funding be consolidated into ONE government led mechanism through the National Health Laboratory and Diagnostic Services; a department within the MOH as part of the plan to prepare for country ownership and transition for sustainability.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

In COP22, USAID/Uganda has 79 PEPFAR-funded FTEs. USAID anticipates hiring most of the currently vacant positions during COP22/FY21. The 13 vacant positions still include new positions previously approved by Ambassador Malac in July 2018. All 13 of the vacant positions have been advertised and are in various stages of the clearance or negotiation stage.

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 COP22, USAID/Uganda will continue 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 COP22 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.

The Department of Defense HIV/AIDS Prevention Program (DHAPP) is staffed by two LES staff, one Program Manager and one Program Assistant. They participate in inter-agency meetings and provide both management and technical assistance to the implementing partner and Uganda Peoples' Defense Forces (UPDF) chieftaincy of medical services. The CODB budget has been maintained at the same planning level as COP21 with slight shifts to cater for locally employed staff wage increases. The staffing level has remained the same with no new staffing requests. DoD/DHAPP supports programming in military health facilities throughout the country, with special emphasis on differentiated case finding, viral load coverage and suppression, and retention on treatment especially for children, adolescents, and uniformed personnel. The DoD/DHAPP staff carry out SIMS visits and site supervision to the PEPFAR UPDF health facilities with full participation from IPs, UPDF clinic staff, UPDF HIV directorate and chieftaincy of medical services. Adherence to the COVID-19 pandemic safety guidelines will remain a key

principle of SIMS implementation. The Department of Defense Walter Reed Army Institute of Research (WRAIR) is staffed by one US Direct Hire - the DOD/WRAIR Country Director, and three LES – PEPFAR Program Manager, SI specialist, and Finance and Management specialist. The staffing level is the same as COP21 with a slight increase in the CODB budget to account for the LES wage increase and higher ICASS expenses.

The U.S. Department of State (STATE) PEPFAR Uganda Coordination Office (PCO) COP22 budget has decreased and will use its applied pipeline for the management and operations of the office. PCO had a total of six approved positions under COP21 and is currently staffed by five and a half (5.5) positions, five of which are FTEs. A part-time small grants manager position is currently under recruitment.

PCO remains lean with one of the two part-time Small Grants positions, and five LES: a Program Assistant; a Program Outreach and External Engagements Advisor; and a senior Strategic Information Advisor, a DREAMS Coordinator and a Global Fund Liaison. Three positions are filled through secondments: the PEPFAR Coordinator seconded through USAID, and the Deputy PEPFAR Coordinator and a Strategic Liaison seconded through CDC. A PEPFAR funded communications position, seconded to the Embassy Kampala Public Affairs Section through USAID, provides media and public communications support to the overall PEPFAR program. In COP 22, the PCO will request two new positions, which are an LES Small Grants Coordinator to provide continuity in the grants' office and an LES Communications Advisor for bilateral communication.

HHS/CDC's subject matter experts continue to directly support Uganda's HIV and TB 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 continuously and strategically repurposes vacant positions to meet both current and future needs and has been able to maintain a level staffing footprint with resources available. HHS/CDC filled 9 vacancies in COP21: Associate Director of Management and Operations, Associate Director of Partner Management, Budget Analyst, Statistician, Executive Assistant, Human Resources Assistant, Property Assistant, Key Populations Specialist, and Data Management Specialist. A total of 8 new vacancies are under active recruitment: Deputy PEPFAR Coordinator, Associate Director for Program, Care and Treatment Specialist, IT Team Lead, IT Analyst, two cooperative agreement specialists, and a PMTCT specialist. HHS/CDC has secured the Ambassador's concurrence to repurpose one USDH position previously funded by PEPFAR to a Project Officer. This position will provide specialized oversight for the accountability of awards to Ugandan institutions. 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 remains level at 117 FTES in COP22.

The HHS/CDC CODB budget slightly decreased in COP22 by finding efficiencies across budget line items through a detailed review and adjustment of budget assumptions based on prior year actual expenses and future projections. HHS/CDC was able to offset over $600,000 of expected budget increases (ICASS, CSCS, salary increases) within the existing resource envelope.

HHS/CDC's program management costs remain lean and efficient in order to maximize funding for program impact.

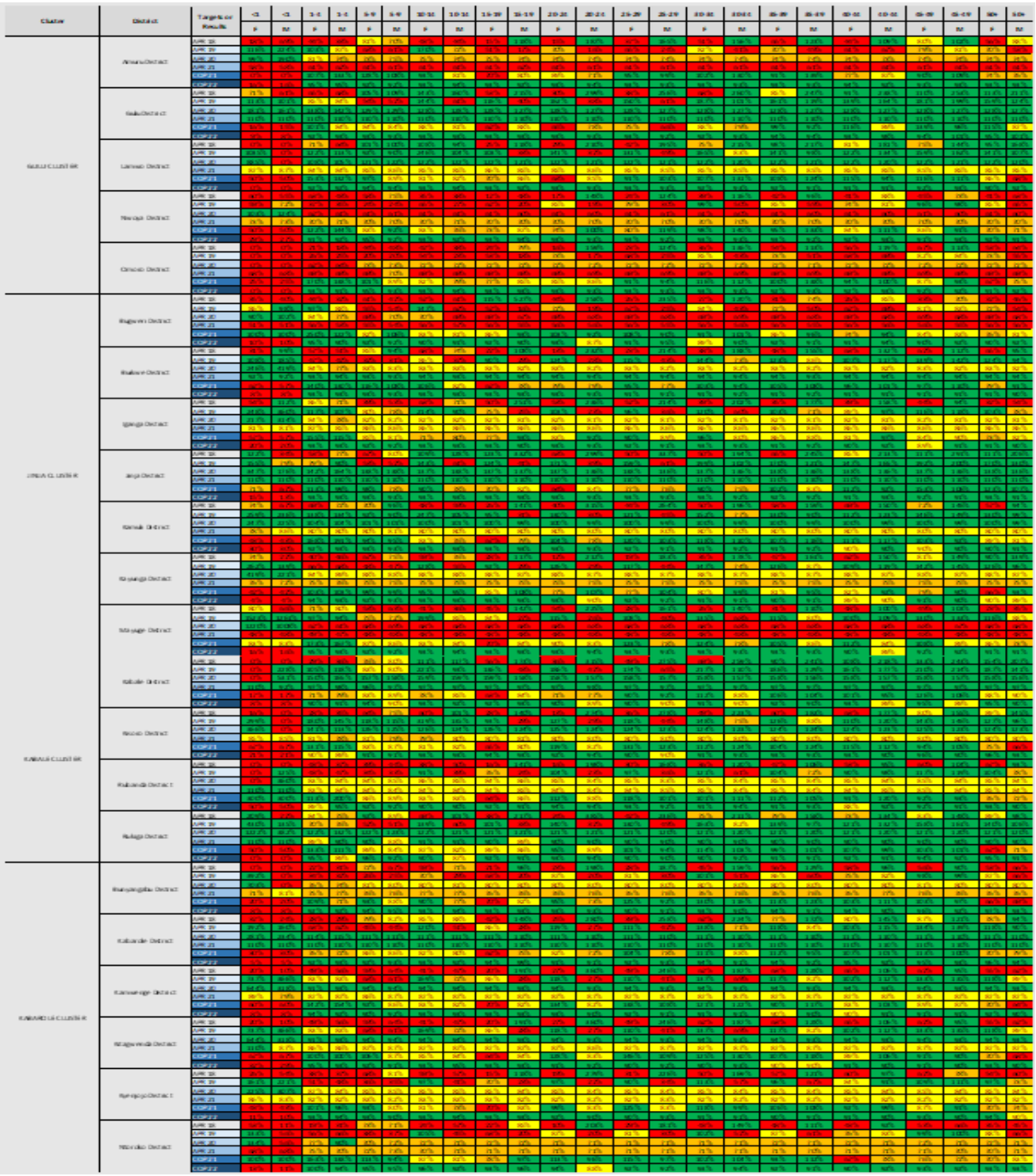
Peace Corps has 16 PEPFAR funded FTE positions and all are currently filled. In COP22, the entire Peace Corps Uganda PEPFAR budget of just under $2.2 million will be under M&O.

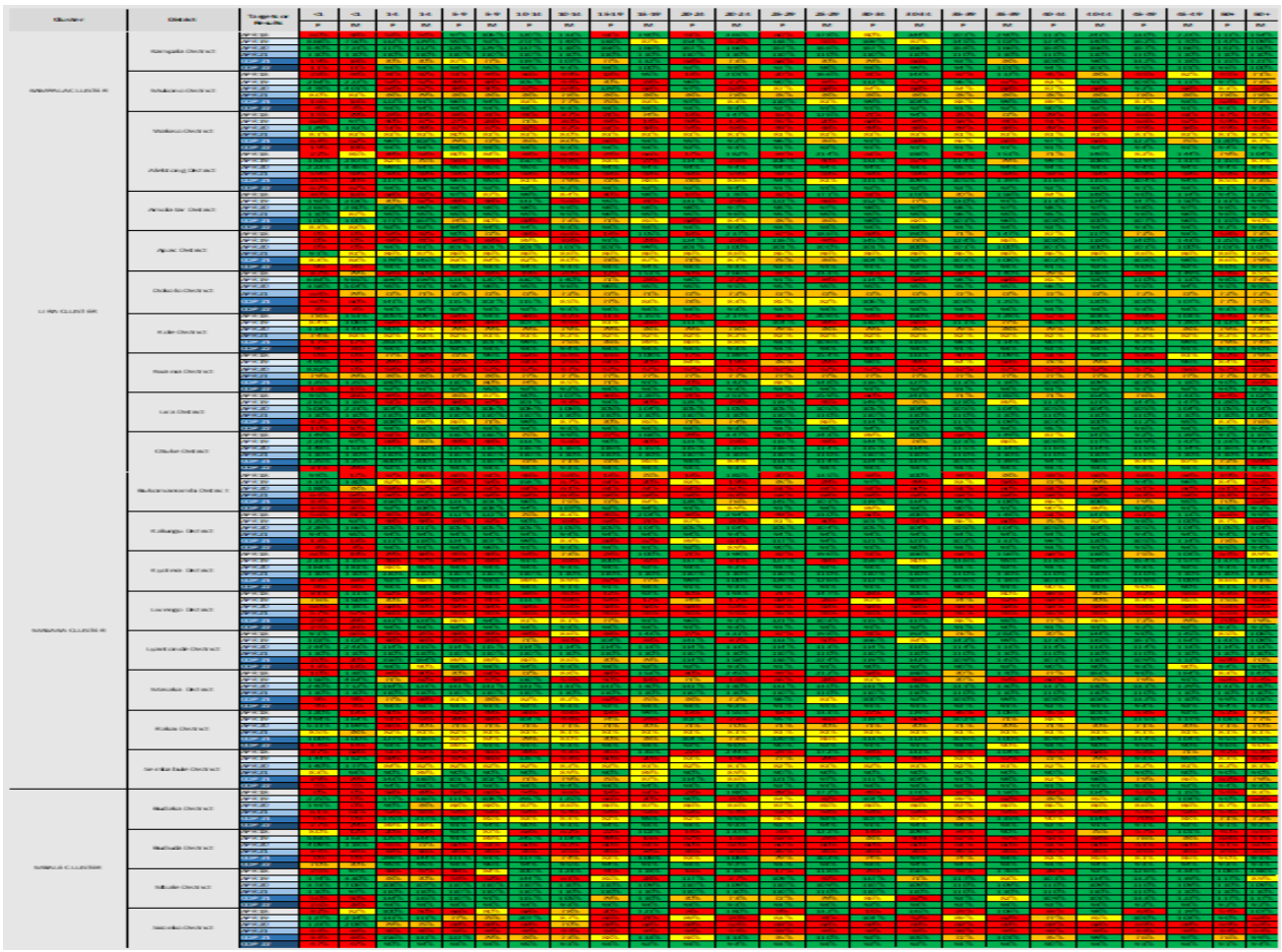
The PEPFAR Coordinator's Office (PCO) will continue to be the nexus for civil society engagement in COP22. OGAC will channel funds for the COP22 Community Led Monitoring (CLM) activities to Ugandan CSOs through a CDC headquarters agreement with UNAIDS headquarters.

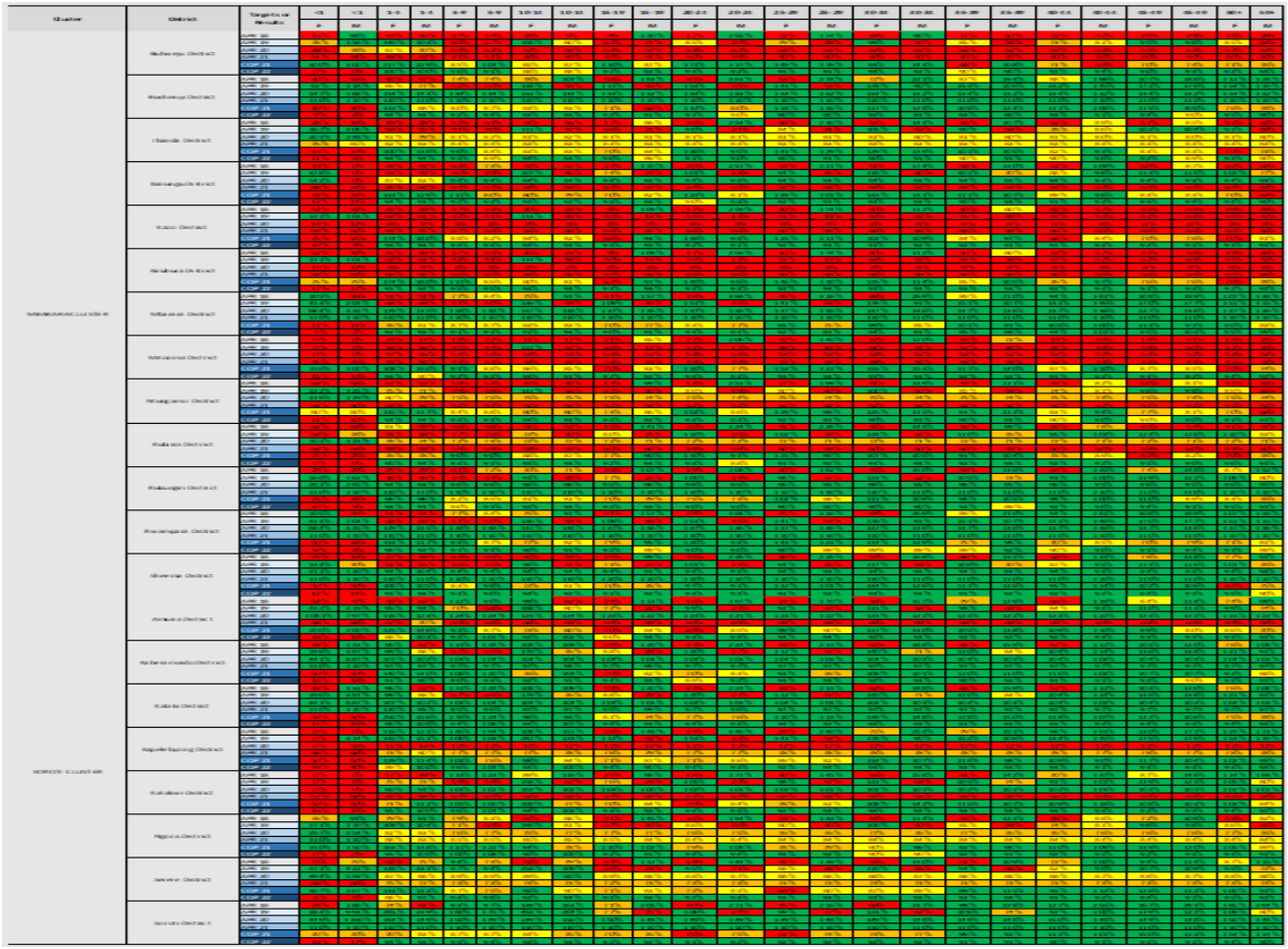
With PEPFAR Home Operational Funds, USG Uganda also hosts a Resident Advisor from the U.S. Department of Treasury Office of Technical Assistance who is embedded in the Ministry of Finance, Planning and Economic Development (MOFPED) to support and advise on public financial management and administrative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

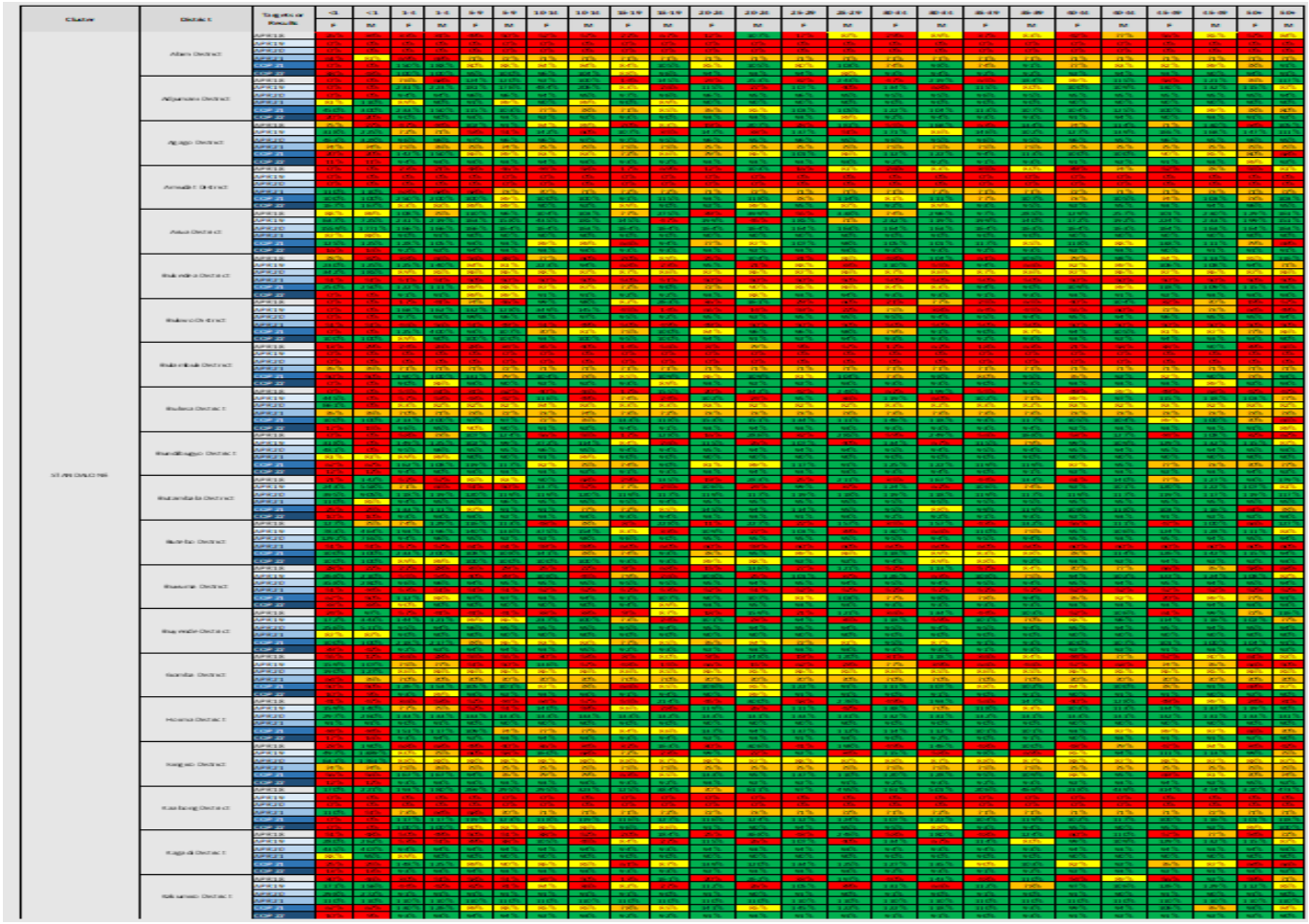
APPENDIX A -- PRIORITIZATION

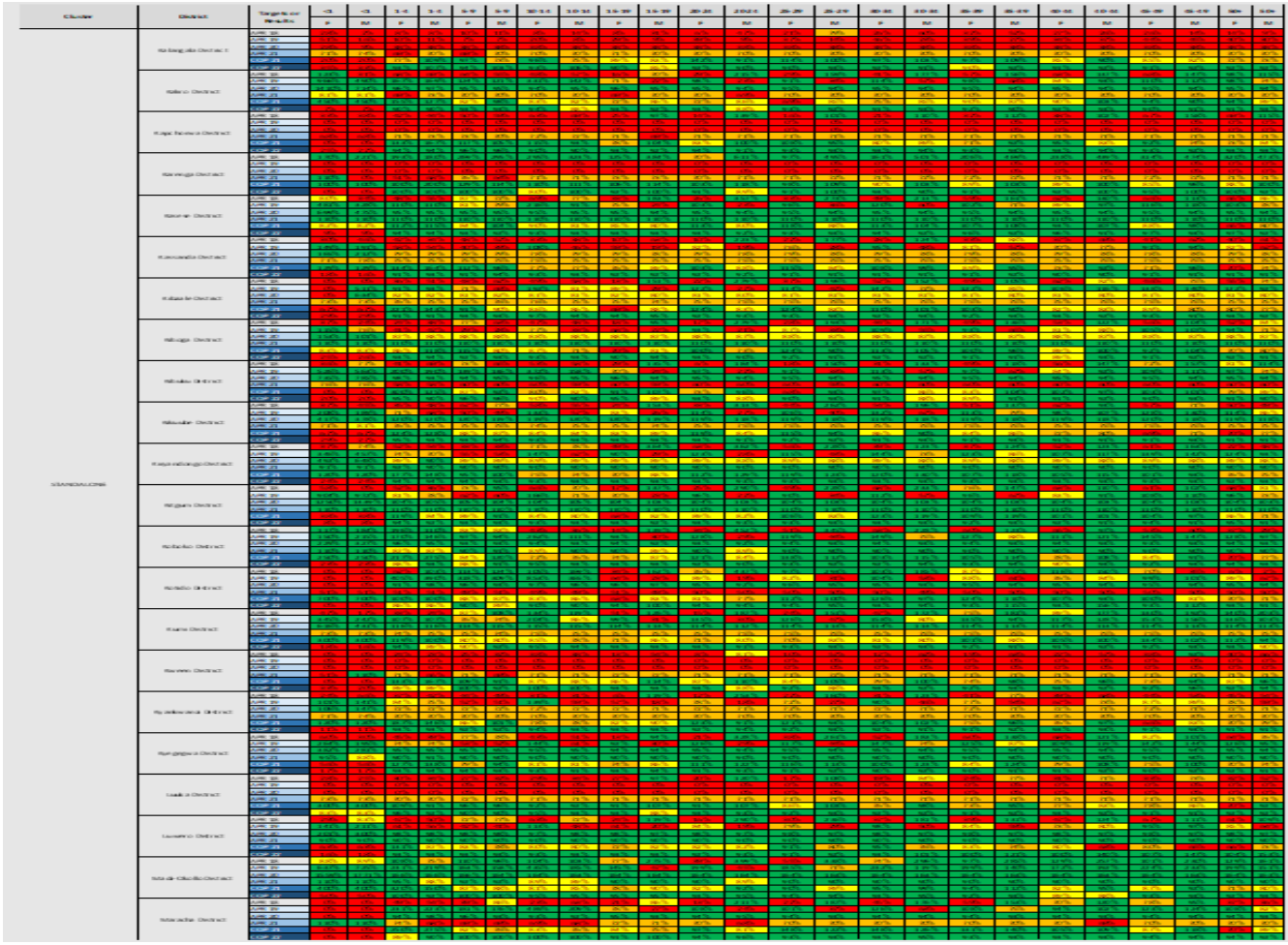
Table A.1 ART Coverage by Age, Sex, District, and Time

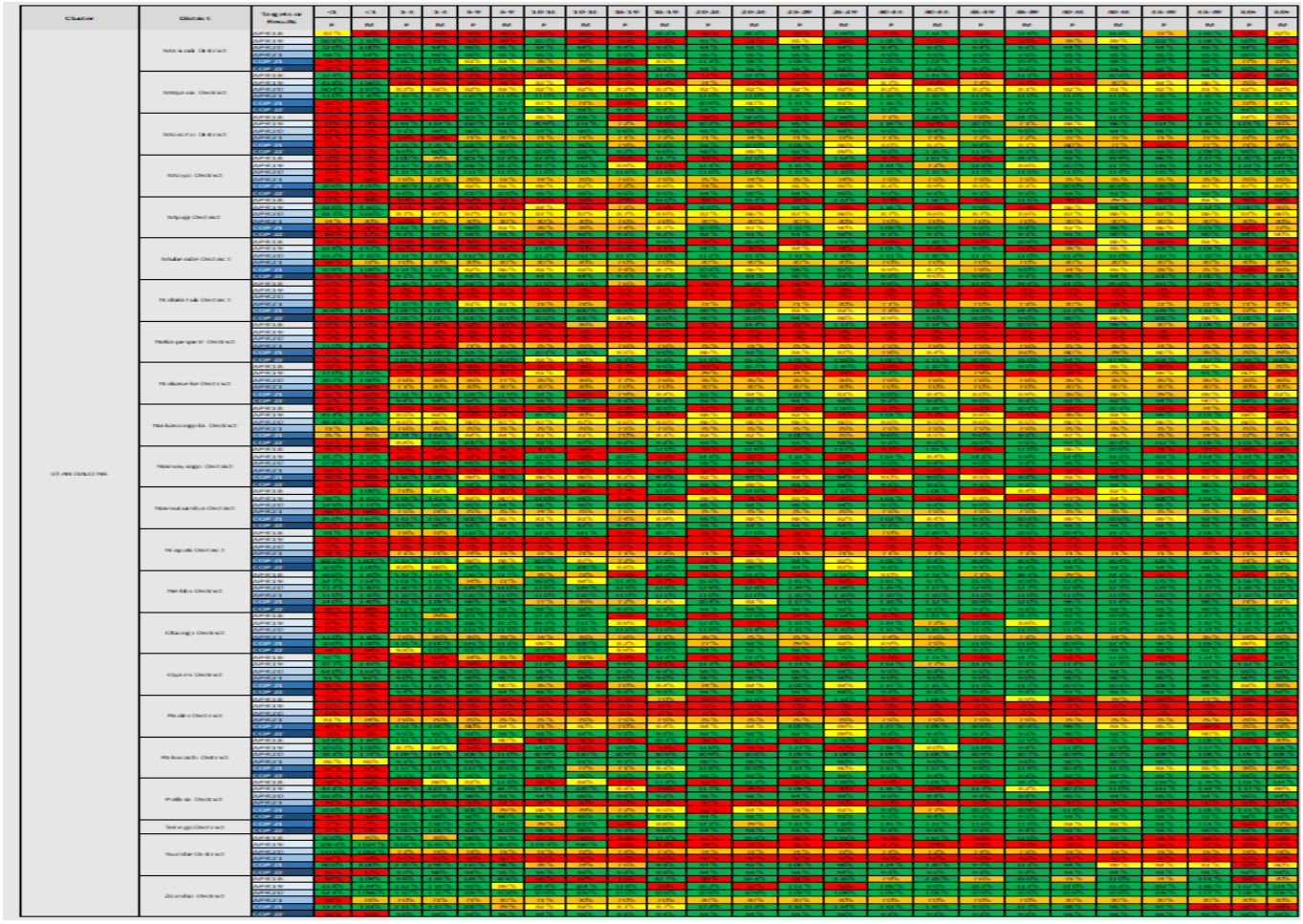


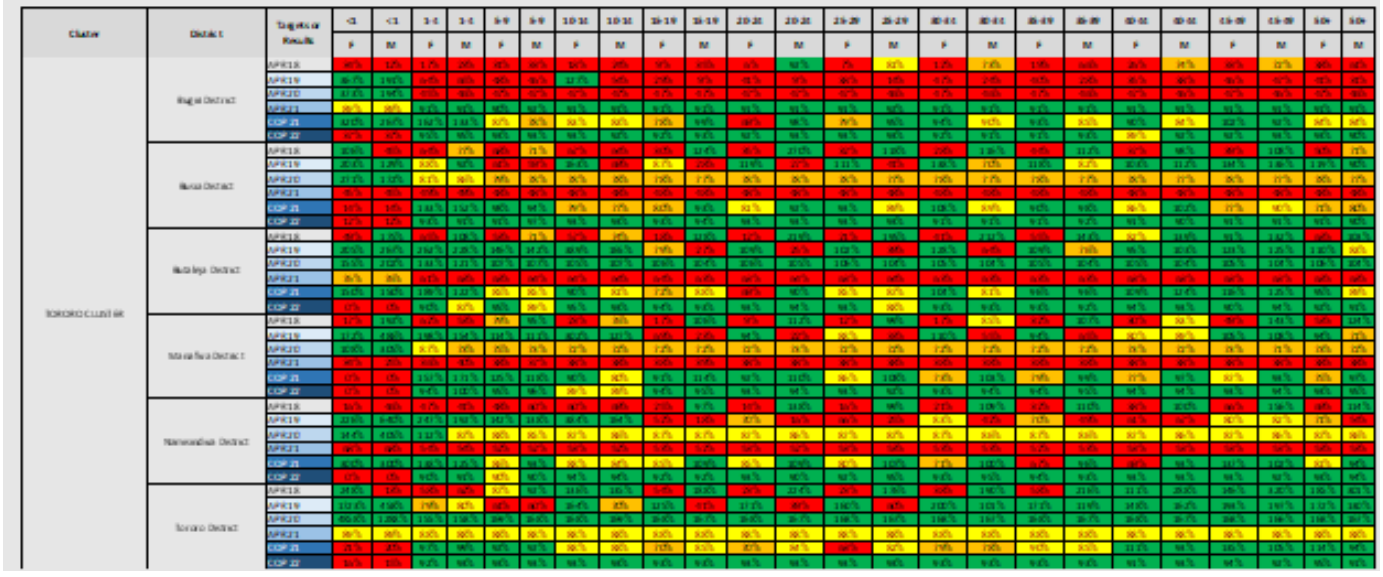












APPENDIX B – Budget Profile and Resource Projections

B1. COP22 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP22 Budget by Program Area

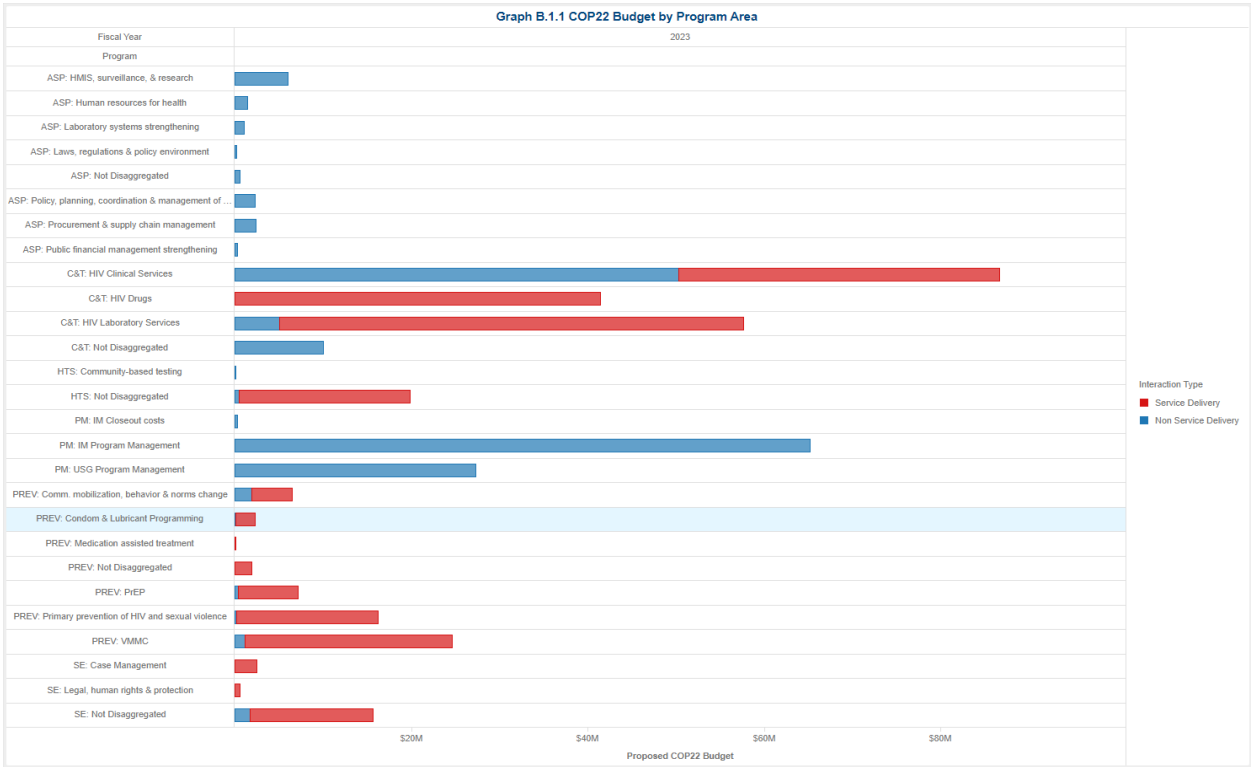


Table B.1.2 COP22 Budget by Program Area

Table B.1.2 COP22 Budget by Program Area

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		**$178,252,256**	**$221,947,744**	**$400,200,000**	45%	55%	100%
C&T	**Total**	**$65,411,946**	**$130,278,661**	**$195,690,607**	33%	67%	100%
	HIV Clinical Services	$50,265,425	$36,346,448	**$86,611,873**	58%	42%	100%
	HIV Drugs		$41,398,450	**$41,398,450**		100%	100%
	HIV Laboratory Services	$5,100,976	$52,533,763	**$57,634,739**	9%	91%	100%
	Not Disaggregated	$10,045,545		**$10,045,545**	100%		100%
HTS	**Total**	**$518,494**	**$19,376,153**	**$19,894,647**	3%	97%	100%
	Community-based testing	$76,095		**$76,095**	100%		100%
	Not Disaggregated	$442,399	$19,376,153	**$19,818,552**	2%	98%	100%
PREV	**Total**	**$3,637,909**	**$55,266,673**	**$58,904,582**	6%	94%	100%
	Comm. mobilization, behavior & norms change	$1,899,845	$4,608,518	**$6,508,363**	29%	71%	100%
	Condom & Lubricant Programming	$48,332	$2,250,000	**$2,298,332**	2%	98%	100%
	Medication assisted treatment		$123,200	**$123,200**		100%	100%
	Not Disaggregated		$1,900,866	**$1,900,866**		100%	100%
	PrEP	$341,971	$6,827,174	**$7,169,145**	5%	95%	100%
	Primary prevention of HIV and sexual violence	$177,298	$16,088,568	**$16,265,866**	1%	99%	100%
	VMMC	$1,170,463	$23,468,347	**$24,638,810**	5%	95%	100%
SE	**Total**	**$1,694,843**	**$17,026,257**	**$18,721,100**	9%	91%	100%
	Case Management		$2,470,508	**$2,470,508**		100%	100%
	Legal, human rights & protection		$591,262	**$591,262**		100%	100%
	Not Disaggregated	$1,694,843	$13,964,487	**$15,659,330**	11%	89%	100%
ASP	**Total**	**$14,267,116**		**$14,267,116**	100%		100%
	HMIS, surveillance, & research	$6,051,944		**$6,051,944**	100%		100%
	Human resources for health	$1,409,777		**$1,409,777**	100%		100%
	Laboratory systems strengthening	$1,057,718		**$1,057,718**	100%		100%
	Laws, regulations & policy environment	$215,041		**$215,041**	100%		100%
	Not Disaggregated	$561,733		**$561,733**	100%		100%
	Policy, planning, coordination & management of disease control programs	$2,245,711		**$2,245,711**	100%		100%
	Procurement & supply chain management	$2,421,969		**$2,421,969**	100%		100%
	Public financial management strengthening	$303,223		**$303,223**	100%		100%
PM	**Total**	**$92,721,948**		**$92,721,948**	100%		100%
	IM Closeout costs	$245,000		**$245,000**	100%		100%
	IM Program Management	$65,200,963		**$65,200,963**	100%		100%
	USG Program Management	$27,275,985		**$27,275,985**	100%		100%

Table B.1.3 COP22 Total Planning Level

Table B.1.3 COP22 Total Planning Level

Metrics	Proposed COP22 Budget		
Operating Unit	Applied Pipeline	New	Total
Total	$33,139,952	$367,060,048	$400,200,000
Uganda	$33,139,952	$367,060,048	$400,200,000

Table B.1.4 COP22 Resource Allocation by Program and Beneficiary

Table B.1.4: COP22 Resource Allocation by Program and Beneficiary

Operating Unit	Metrics	Proposed COP22 Budget							Percent to Total						
	Beneficiary	C&T	HTS	PREV	SE	ASP	PM	Total	C&T	HTS	PREV	SE	ASP	PM	Total
Uganda	Total	$195,690,607	$19,894,647	$58,904,582	$18,721,100	$14,267,116	$92,721,948	$400,200,000	100%	100%	100%	100%	100%	100%	100%
	Females	$2,536,417	$29,728	$18,952,890				$21,519,035	1%	0%	32%				5%
	Key Pops		$149,640	$11,764,720		$507,003		$12,421,363		1%	20%		4%		3%
	Males		$969,737	$24,638,810				$25,608,547		5%	42%				6%
	Non-Targeted Pop	$179,421,903	$8,836,494	$2,073,168		$12,575,825	$87,169,248	$290,076,638	92%	44%	4%		88%	94%	72%
	OVC				$18,721,100	$200,000	$5,552,700	$24,473,800				100%	1%	6%	6%
	Pregnant & Breastfeeding Women	$13,732,287	$7,588,545			$350,000		$21,670,832	7%	38%			2%		5%
	Priority Pops		$2,320,503	$1,474,994		$634,288		$4,429,785		12%	3%		4%		1%

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 COP22, 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 COP22 guidance and the budgeting tool for COP22—the Funding Allocation to Strategy Tool (FAST)—PEPFAR Uganda team used an incremental budgeting process to guide the apportionment of resources for COP22. Implementing mechanism budgets from COP21 were the point of departure; however, these budgets were adjusted in accordance with the PLL. The primary change driver was strategic alignment to UPHIA 2020 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 COP22 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 Q4 results show 95% linkage rate of newly-identified PLHIV to treatment which has been maintained at FY22Q1 with a slight drop to 94% linkage rate. PEPFAR Uganda will continue to intensify efforts to support continuity of treatment and community programming now and into COP22, working in close collaboration with CSOs and PLHIV networks. Accordingly, COP21 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, and EMR and HIS expansion.

Data sources used to calculate resource allocations include: COP21 budget allocations; expenditure analysis 2020; FY21 End of Fiscal Year (EOFY); information from GOU on national expenditures, including the National AIDS Spending Account (NASA) data; and market information on various goods and services.

APPENDIX C – Tables and Systems Investments for Section 6.0

Key Systems Barriers-E

Key Systems Barriers-E (Entry of Objectives, Related SID Elements, Barriers to Local Responsibility)						Uganda
Step 1: Select SID element	SID score (autopopulated)	Step 2 - What is the outcome expected from investing in this element? (may duplicate outcome to more than one row to allow capture of all barriers)	Step 3: What are the barriers to local responsibility for this outcome?	Step 4: Describe the barrier	Step 5: Timeline to Barrier Addressed	Comments
7. Human Resources for Health	7.1	A workforce with the right skills and	Lack of Financial Resources	The GoU allocation to wage for the health sector is	6-9 years	
7. Human Resources for Health	7.1	A workforce with the right skills and numbers, that is optimally productive, motivated and equitably distributed to support delivery of quality, client centered services for sustained HIV epidemic control	Lack of sufficient HRH	There is insufficient HRH to sustainably deliver quality service with only 74% of the approved MOH staffing positions filled and the gap being supported by staff recruited through PEPFAR IPs. PEPFAR is supporting close to 20,000 Health workers at facility and community level.	6-9 years	
7. Human Resources for Health	7.1	A workforce with the right skills and	Lack of technical capacity	Inadequate technical capacity in HRH data analysis	6-9 years	
7. Human Resources for Health	7.1	A workforce with the right skills and	Legal, policy or regulatory constraint	Restrictive/outdated staffing norms which limits	6-9 years	
8. Commodity Security and Supply Chain	4.7	End-to-end visibility of commodities including HIV and TB commodities at the central, district and facility levels	Physical infrastructure not complete/further investment needed by donors	National Medical Stores(NMS) has outdated, siloed and and largely manual supply chain processes, with no end-to-end System and primary data centre, to handle public health sector commodities efficiently.	2-3 years	
8. Commodity Security and Supply Chain	4.7	End-to-end visibility of commodities including HIV and TB commodities at the central, district and facility levels	Lack of technical capacity	Lack of local capacity and expertise to develop, set up,and implement the various modules of the supply chain ERP system	2-3 years	
8. Commodity Security and Supply Chain	4.7	A robust and strengthened supply	Lack of Financial Resources	The GOU financing for national supply chain is	2-3 years	
8. Commodity Security and Supply Chain	4.7	Improved supply chain system that	Physical infrastructure not	Lack of data visibility compromises effective	2-3 years	
8. Commodity Security and Supply Chain	4.7	Improved supply chain system that	Physical infrastructure not	Lack of data visibility compromises effective	2-3 years	
1. Planning and Coordination	9.8	A sustainable MOH led HIV/TB	Lack of technical capacity	The available work force at MOH and RRHs is	4-5 years	
2. Policies and Governance	7.4	Effective stewardship of the HIV/TB response and other health programs with enabling/updated policies and guidelines to guide provision of high	Legal, policy or regulatory constraint	The HIV/AIDS/TB is a rapidly changing field with need for regular policy development and reviews to create enabling environment for delivery of high impact interventions	4-5 years	
11. Domestic Resource Mobilization	5.7	A country that raises and spends sufficient own funds to procure	Lack of technical capacity	90% of funding for HIV/AIDS response comes from external donors. This is unsustainable	4-5 years	We will have and PFM TA, NHIS and HIV mainstreaming under this area
15. Financial/Expenditure Data	5.8	A GOU system that routinely collects,	Lack of technical capacity	Uganda does not have a system that routinely	4-5 years	We will have ABCM, NASA and NHA under this area
10. Laboratory	3.8	An optimized diagnostic network to maximize access to appropriate diagnostics services in a timely & cost effective way, and ensure testing	Lack of information on costs and program requirements	Inadequate coordination and fragmented data on lab diagnostic network has resulted into more imbalanced utilization of lab instruments	2-3 years	Anticipated increase in testing targets, and the need for the network to sustainably address long-term testing needs for HIV-VL, EID, TB, AHD as well as test priorities non-communicable diseases (NCDs), surveillance and
10. Laboratory	3.8	A country-led quality management systems in place including national Proficiency Testing (PT) panel production and distribution capacities that enable attainment of sustainable national and international standards for labs to provide timely, accurate and reliable test results for HIV, VL. EID, TB & advanced HIV disease management of patients and epidemic control.	Lack of Financial Resources	There is inadequate financial commitment from the Government of Uganda (GoU) and other donors outside PEPFAR to sustain lab quality management systems (LQMS) for continuous quality improvement & attainment of national and international standards for quality as a measure to provide accurate and reliable test results for HIV, TB, HIV/Syphilis DUO, recency and other advanced HIV disease (AHD) test needs for proper patient management.	6-9 years	The quality of HIV serology, VL, EID, TB, cervical cancer (CaCx) and Advance HIV Disease (AHD) test results is highly dependent on the national program for strengthening the quality of lab services by supporting implementation of quality management systems using the WHO "Strengthening Lab Management Towards Accreditation (SLMTA)" and "Stepwise Lab Improvement Towards Accreditation (SLIPTA) tools" including establishing institutional capacities for Proficiency Testing (PT) panel production and distribution to all labs for continuous quality improvement & competence of the testing personnel to conduct the tests correctly.
2. Policies and Governance	7.4	Effective stewardship of the VMMC	Lack of Financial Resources	Over 95% of VMMC program is supported by	1 year	All HIV+ men must have a VLS before getting a medical circumcision
10. Laboratory	3.8	Adequately financed laboratory network with 50-89% of laboratory service funded through domestic financial sources and completely implemented in accordance to the national health laboratory strategic	Lack of Financial Resources	The national quantification report indicated that laboratory network in Uganda is only financed at 63% commitment from government of Uganda (GoU) and donors (World Bank, PEPFAR, Global Fund, GHSA) of which only 8%	10+ years	Continue investing in the regionalisation approach to laboratory services delivery, implementation and revision of national health laboratory standards while effectively monitoring implementation of lab services in accordance to the approved National Health Laboratory Strategic Plan III.

Key Systems Barriers-E (continued)

Key Systems Barriers-E (Entry of Objectives, Related SID Elements, Barriers to Local Responsibility)						Uganda
Step 1: Select SID element	SID score (autopopulated)	Step 2 - What is the outcome expected from investing in this element? (may duplicate outcome to more than one row to allow capture of all barriers)	Step 3: What are the barriers to local responsibility for this outcome?	Step 4: Describe the barrier	Step 5: Timeline to Barrier Addressed	Comments
10. Laboratory	3.8	100% compliance to bio-risk management practices for all the 100 lab hubs to eliminate and/or reduce potential risks of staff	Lack of Financial Resources	Limited funding and inadequate technical capacity for bio risk management in the country	4-5 years	Need for routine monitoring of health workers environmental safety to minimize intentional and non-intentional exposure to biohazards through maintenance of recommended bio-risk standards.
6. Service Delivery	4.8	Improved leadership and technical capacity for effective HIV/TB Epidemic control	Lack of Financial Resources	Inadequate financial resources from GOU and inadequate technical capacity to effectively plan, coordinate, implement and monitor the National HIV/TB epidemic	6-9 years	USG will continue engage MOFPED, MOH, and the Parliment for resource allocation. A joint USG/GOU sustainability plan will ensure a phased transition
6. Service Delivery	4.8	Improved leadership and technical capacity for effective HIV/TB Epidemic control	Lack of technical capacity	The work force at national and subnational levels has insufficient technical skills and tools for implementing quality services	6-9 years	Adequate human resources in numbers and skills are need to effectively transition to GOU. Financial resources should be made available as well
6. Service Delivery	4.8	Improved disposal of biomedical waste and expired commodities	Physical infrastructure not complete/further investment needed	Inadequate infrastructure and capacity to dispose medical/toxic wastes that require	6-9 years	USG will continue engage MOFPED, MOH, and the Parliment to prioritize disposition of medical wastes
6. Service Delivery	4.8	Improved local Organization Capcity to effectively mobilize and manage resources	Lack of managerial capacity	Local organizations need technical support to improve their Governance and Financial Management systems to effectively manage	2-3 years	Short to Mid-term technical assistance is required as PEPFAR funding is transitioning to local partners
6. Service Delivery	4.8	Reduction in new HIV infections	Lack of technical capacity	The health promotion workforce at MOH	4-5 years	
6. Service Delivery	4.8	Improved access to and utilization	Lack of Financial Resources	There is inadequate gou funding towards	4-5 years	
17. Data for Decision-Making Ecosysten	4.7	National technical documets that	Legal, policy or regulatory constraint	There is no approved Unique Identification	2-3 years	
17. Data for Decision-Making Ecosysten	4.7	Critical infrastructure necessary to	Physical infrastructure not	No or limited internet connectivity at health	4-5 years	
17. Data for Decision-Making Ecosysten	4.7	Critical infrastructure necessary to	Physical infrastructure not	Reliabe grid or alternative power solutions	4-5 years	
17. Data for Decision-Making Ecosysten	4.7	Linkage of routine program data	Lack of technical capacity	There is no central integration of HIV/AIDS	4-5 years	
17. Data for Decision-Making Ecosysten	4.7	Fully integrated HIV/AIDS data and	Physical infrastructure not	Existing HIV/AIDS data management	4-5 years	
17. Data for Decision-Making Ecosysten	4.7	Fully integrated HIV/AIDS data and	Legal, policy or regulatory constraint	Lack approved national interoperability	1 year	
17. Data for Decision-Making Ecosysten	4.7	Alignment of national policies, legal	Legal, policy or regulatory constraint	Lack of national data security privacy and	1 year	
9. Quality Management	8.3	National led CQI to address	Lack of technical capacity	There is insufficient skills and capacity at	4-5 years	
6. Service Delivery	4.8	RRHs as centers of excellence to provide oversight and knowledge transfer to the Lower level facilities through the hub and spoke approach	Lack of Financial Resources	There is inadequate funding from GOU to RRHs to facilitate provision of comprehensive and effective oversight to districts,General hospitals and HCIVs as well as coordination of CQI activities	4-5 years	
14. Epidemiological and Health Data	5.7	Fully functional EMR that	Lack of Financial Resources	Rapid deployment of electronic medical	4-5 years	

Table 6-E tab

Expected Outcom	Primary Barrier t Local Responsibili	Barrier to Local Responsibility thi	Barrier to Local Responsibility thi	COP22 Activity Description	Interven	Inter	If ongoing from a previ year, please provide	Benchmark from COP21 activity existed in COP	Met benchmark past years?	COP22 Baseline	COP22 Benchmark	Indicator/Measuremen Tool	Will the activ be continue	Notes
MOH capacity for HRH planning and staff development enhanced	Lack of technical capacity	Lack of sufficient HRH	Lack of Financial Resources	Secondment of Technical Advisors to MOH HQ to provide support for HRH planning and development for sustainability. This activity will address staffing norms, restructuring and use of HRIS for HRH planning.	COP19	COP25	MOH HRM unit is still understaffed and lack the capacity to comprehensively plan and manage HRH functions; HRIS is not fully utilized at MoH and some	10 year HRH strategic plan approved	Yes	Approved 10 year strategic plan	Final national HRH revised documents developed and over 80% functional HRIS at MoH, and 95% at site level	Revised Staffing structure and schemes service	Yes	USAID will continue providing TA to MOH to implement the revised staffing structure and schemes of services
District led coordination and monitoring performance to attain HIV epidemic control. (Through implementing approved HIV strategic	Lack of technical capacity	Lack of Financial Resources	Lack of managerial capacity	-Strengthen district capacity to coordinate and monitor HIV /AIDS activities for sustained epidemic control. -CSO-District led performance reviews for poor performing districts. -USAID will build capacity of district local government health	COP19	COP25	New administrative structures have been created and there's staff turn over that requires on-going hands on support.	50 districts have approved strategic plans	Yes	50 districts have approved strategic plans	70 USAID supported districts have approved, costed strategic plans aligned to NDP III - "poor performer" districts performance improvements on the	Number of districts implementing HIV strategic plans aligned to the NDP III Number of poor performer districts that hold joint	Yes	USAID will continue to support the districts to coordinate, monitor , appropriately plan for, and align their resources to national strategic plans for sustained ownership of the HIV epidemic control efforts
Skilled health workforce developed at lower level health facilities , through continuous professional development.	Physical infrastructure not complete/further investment needed by donors	Lack of technical capacity	Lack of Financial Resources	-Echo zoom hub and spoke scale up to 7 RRH hubs and 21 spokes in high volume facilities (30K per RRH)	COP21	COP25	Echo-zoom model is being expanded from the RRH as a hub to lower level health facilities in a phased approach	4 RRH expanding echo-zoom to 3 Health Facilities in their catchment area	Not Applicable	4 RRH expanding echo-zoom to 3 Health Facilities in their catchment area	7 RRHs expanding Echo Zoom platform to 5 HFs in their catchment area	Number of echo-zoom spokes per RRH hub	No	
Strengthened RRH capacity to provide oversight and supervision of national policies and guidelines implemented at districts and	Lack of technical capacity	Lack of managerial capacity	Lack of Financial Resources	-Support MOH SCAPP department in standardization of supportive supervision, quality assurance, district and regional level planning and coordination and GOSPORTWG coordination. -TA to MOH, MOFPED and UAC to coordinate	COP20	Post COP25	USAID provides TA to MOH and 7 RRHs, to coordinate oversight and supervision public health functions through their community health departments, for improved	Regional Referral Hospital Strategy developed and disseminated by MOH	Yes	Regional Referral Hospital Strategy developed and disseminated by MOH Organizational capacity	7 RRH fully providing quarterly oversight and supervision of HIV epidemic control efforts to district hospitals and Health Centre IV in their regions	Number of RRHs conducting quarterly support supervision and performance review meetings (including CQI).	Yes	In the absence of a regional government structure in Uganda, RRHs offer a platform, to devolve MOH oversight and supervision functions to the 136 districts and 3 cities .
MOH and partners utilizing evidence -based financial data analytics and resource tracking methodologies for planning, resource	Lack of technical capacity	Lack of Financial Resources	Lack of information on costs and program requirements	Health Financing; -ABC/M Phase 2 (Stakeholder advocacy, training and capacity building, ABC/M toolkit development) - Finance Analytics (NASA/NHA), -NHIS TA (costing the minimum health care package, incorporating HIV) Support to Uganda AIDS commission to mobilize HIV	COP20	Post COP25	Resource tracking and financial data analytics is a new and under-resourced field that requires on-going technical support	ABC/M completed	Yes	ABC/M completed	ABC/M institutionalized within MOH	Report for revised ABC/M costing disseminated UAC HIV mainstreaming policy developed	Yes	
Community Health Worker Guidelines implemented to support the PEPFAR shift to DSD implementation and further strengthening of	Lack of technical capacity	Lack of managerial capacity	Lack of Financial Resources	Community Health policy, CHEWS pilot and policy support	COP20	Post COP25	There's a shift towards community service delivery of HIV service. The CHEWS pilot kick started in COP 21 and will take 18months to inform national rollout	1) National CHEWS pilot completed and results disseminated; (2) Draft community health policy	Partial	1) National CHEWS pilot completed and results disseminated; (2) Draft community health	1) National CHEWS pilot completed and results disseminated; (2) Community health guidelines completed and disseminated	Number and proportion of districts implementing the national community health worker guidelines	Yes	
Harmonized and efficient national Commodities and Supply Chain system in the laboratory	Lack of technical capacity	Lack of Financial Resources	Lack of sufficient HRH	TA for National quantification, supply planning and stock status monitoring (support to GPPU) for laboratory commodities - Supply chain data analytics to support improved site level ordering and stock management	COP20	COP25	Given MoH HRH constraints, it is critical that this activity is supported to continue building capacity in national quantification, supply planning and stock status	1. 3-year rolling National quantification of laboratory commodities 2. Continuous supply planning and stock status monitoring to inform	Partial	1. Review of the national quantification for laboratory commodities 2. Bimonthly stock status reporting and supply	1. Updated national quantification for laboratory commodities	National quantification output for laboratory commodities	Yes	
A robust and strengthened supply management system for ordering, tracking and reporting of HIV and TB commodities	Lack of technical capacity	Lack of sufficient HRH	Lack of Financial Resources	- Support advisors to MOH quantification unit for national quantification, supply planning and stock status monitoring of HIV commodities Care, treatment and prevention. - Scale up of CRPDDP - inclusion of more HIV commodities PrEP, TPT	COP20	COP25	Given the HR constraints in the MOH, this is a critical area to continue support . A supply chain transition roadmap has been developed to later on absorb	1. 3-year rolling National quantification of VMMC and PrEP commodities 2. Continuous supply planning and stock status monitoring to inform	Partial	1. Review of the national quantification for HIV prevention commodities 2. Bimonthly stock status reporting and supply	National bimonthly stock status reporting	National bimonthly stock status reporting	Yes	

Table 6-E tab (continued)

Expected Outcom	Primary Barrier t Local Responsibili	Barrier to Local Responsibility thi	Barrier to Local Responsibility thi	COP22 Activity Description	Interven	Inter	If ongoing from a previ year, please provide	Benchmark from COP21 activity existed in COP	Met benchmark past years?	COP22 Baseline	COP22 Benchmark	Indicator/Measurement Tool	Will the activ be continue	Notes
Robust and locally-led national supply chain system that is responsive to HIV care and treatment program needs at facility and community	Lack of Financial Resources	Lack of sufficient HRH	Lack of Financial Resources	· Supply chain data analytics to support improved site level ordering and stock management (WAOS (for PNFP) and ERP/CSSP data analysis) · ERP/CSSP rollout and implementation to HC IIIs · Support community systems - scale up of CRPDDP and	COP20	COP25	Given the HR constraints in the MOH, this is a critical area to continue support . A supply chain transition roadmap has been developed to later on absorb	1. 3-year rolling National quantification of HIV commodities 2. Continuous supply planning and stock status monitoring to inform action, ensuring availability	Partial	1. Review of the national quantification for HIV care and treatment commodities 2. Bimonthly stock status reporting and supply	Bimonthly facility stock status reports	Facility stock status reports	Yes	
Robust and locally-led national supply chain system that is responsive to HIV care and treatment program needs at facility and community	Lack of Financial Resources	Lack of technical capacity	Lack of sufficient HRH	· National quantification, supply planning and stock status monitoring of laboratory commodities · Supply chain data analytics to support improved site level ordering and stock management (WAOS (for PNFP) and ERP/CSSP data analysis)	COP20	COP25	There is insufficient capacity at MOH to support lab commodities quantification	70% of PEPFAR facilities reporting stock levels of lab commodities of 2-4 months	Yes	80% of PEPFAR facilities reporting stock levels of lab commodities of 2-4 months	90% of PEPFAR ART sites reporting stock levels for key lab commodities between 2-4 months;	Facility stock status reports	Yes	
A robust and strengthened supply management system for ordering, tracking and reporting of HIV and TB commodities	Lack of technical capacity	Lack of Financial Resources	Lack of technical capacity	· Implementation of the 10-year supply chain roadmap · SC self assessments, e-learning and support supervisions scaled up to all facilities · Track and monitor GOU funding for HIV Lab commodities · Provide TA to RRHs to transform them into centers of	COP20	COP25	Given the HR constraints in the MOH, this is a critical area to continue support . A supply chain transition roadmap has been developed to later on absorb	70% of PEPFAR facilities reporting stock levels of ARV commodities of 2-4 months	Yes	80% of PEPFAR facilities reporting stock levels of ARV commodities of 2-4 months	90% of PEPFAR ART sites reporting stock levels for key ARV drugs between 2-4 months;	Facility stock status reports	Yes	
End-to-end visibility of the stock status for all commodities including HIV and TB commodities at the central, district and facility	Physical infrastructure not complete/further investment needed by donors	Lack of Financial Resources	Lack of technical capacity	Improve the planning, ordering and receipt of laboratory commodities and supplies by public sector health facilities providing HIV services · Scaling up the ERP online ordering to the 100 hubs	COP18	COP22	Scale up of ERP to all the 100 laboratory hubs	ERP set up at NMS and UNHLS	Partial	ERP set up at NMS and UNHLS	100 hubs ordering lab commodities through the CSSP	Number of laboratory hubs ordering commodities through the CSSP	No	
End-to-end visibility of the stock status for all commodities including HIV and TB commodities at the central, district and facility	Physical infrastructure not complete/further investment needed by donors	Lack of Financial Resources	Lack of technical capacity	Finalize ERP system implementation at NMS, Provide helpdesk support, and stabilize utilization, Support rollout of the ERP online ordering module to planned HCs. Train stakeholders, and ensure knowledge transfer to NMS technical staff and users. Provide SC ASP support during	COP18	COP22	Continuation of phased implementation of ERP COVOD-19 restrictions impacted completion timelines	90% ERP software modules set up, and functional at NMS , Rollout ERP online ordering to all High volume sites	Partial	ERP software set up at NMS linked to High volume sites, and RRHs	RRHs and District Hospitals and HCIVs ordering through ERP/CSSP	Number of Health Facilities ordering commodities through the ERP/CSSP	Yes	Rollout of the ERP to HCIIIs, HCIIs will continue with assistance from GOU and USG SC IP, and Regions IPs
Improved GOU stewardship for commodity availability and security.	Lack of Financial Resources	Lack of technical capacity	Lack of information on costs and program requirements	Provide TA to NMS for stakeholder coordination, communication and supply chain data analytics for on-time-in-full delivery of commodities	COP21	Post COP25	N/A	Risk assessment for NMS conducted	Not Applicable	Risk assessment completed	>70% Order fill rate for selected HIV commodities	Order fill rate for selected HIV commodities	Yes	
Improved citizen empowerment; a more conducive legal environment that facilitates equitable access and utilization of HIV/	Legal, policy or regulatory constraint	Lack of technical capacity	Lack of managerial capacity	Implement Legal Environmental Assessment findings/recommendations to improve the lives of people living with HIV and reduce vulnerability to HIV infection	COP20	COP24	To promote meaningful engagement of civil society actors in the HIV response which is critical to a sustainable HIV response	Legal Environmental Assessment Conducted	Yes	National level dissemination of LEA findings	Regional and District level dissemination of LEA findings leveraging CSO and PHLIV networks	Report on LEA assessment findings disseminated at regional and district levels; proportion of regions and districts covered	Yes	Support will be provided to civil society organizations to address the barriers to equitable access of prevention and treatment services through a peer to peer approach.
Capacity built for PLHIV led CBOs and CSOs to lead advocacy efforts, participate in health governance and critical decision making.	Lack of technical capacity	Lack of Financial Resources	Lack of sufficient HRH	-Strengthen the capacity of national CSOs to mobilize peers and advocacy for PLHIV; promote human rights and combat stigma and discrimination; -Organizational capacity building technical assistance to PHLIV- led CSOs and CBOs to improve their financial, governance and management systems	COP20	COP24	GOU efforts towards CSO involvement in HIV programming is sub-optimal	Needs assessment completed	Partial	Civil society organizations receive capacity strengthening grant	Civil society organizations receive training on grant, financial management and administration.	Number and proportion of national PLHIV CBOs/CSOs trained on grant management, financial management and innovative community monitoring.	Yes	The capacity of civil society organizations will be built to prepare them to apply for and receive PEPFAR funds.
Improved resource base for CBOs/ CSOs to facilitate the integration of CLM findings into PLHIV networks and peers; -which will lead to	It is not included in local HIV response plans	Lack of technical capacity	Lack of Financial Resources	Sub-grants to national level CSOs targeting women and youth networks for oversight, mobilization, and advocacy efforts across regions	COP20	COP24	While GOU recognizes the contribution of CSOs to the HIV response, it has not prioritized funding to the CSOs to facilitate their work	Quarterly CSO stakeholder engagement meetings at regional level; CSOs participate in CLM	Partial	Quarterly CSO stakeholder engagement meetings; CSO national meetings	CSO coordination meetings at regional level including participating with districts/RRHs coordination meetings; stakeholder engagement meetings,	Number of CSO coordination meetings conducted, and engagement meetings held with RRHs/Districts; number of CSO's participating in CLM,	Yes	Civil society will be supported to mobilize and coordinate peer networks of PLHIV; and engaged in CLM
Improved management of HIV generated health care waste free of Human health and environmental hazardous threats	Lack of Financial Resources	Lack of managerial capacity	Lack of technical capacity	Safe disposal of infectious and toxic waste generated from POC GeneXpert	COP21	COP25	There's insufficient capacity to manage and safely dispose off toxic health care waste generated from GeneXpert Cartridges	Toxic waste generated from GeneXpert Cartridges collected and safely disposed off from targeted PEPFAR supported sites	Yes	Hazardous waste from GeneXpert collected and disposed off from targeted PEPFAR supported sites	Hazardous waste from GeneXpert collected and disposed off from targeted PEPFAR supported sites	Standard disposal methods for waste implemented	Yes	

Table 6-E tab (continued)

Expected Outcom	Primary Barrier t Local Responsibili	Barrier to Local Responsibility thi	Barrier to Local Responsibility thi	COP22 Activity Description	Interven	Inter	If ongoing from a previ year, please provide	Benchmark from COP21 activity existed in COP	Met benchmark past years?	COP22 Baseline	COP22 Benchmark	Indicator/Measurement Tool	Will the activ be continue	Notes
Improved access to and utilization of HIV/TB, prevention and ANC services by adolescents and adults, leading to improved health	Lack of technical capacity	Lack of Financial Resources		Support adolescent focused messaging on T&S, VL, SDM, EID, early ANC,TB case detection and GeneXpert utilization	COP20	COP25	There's insufficient capacity and resources towards SBCC	Completed SBCC messaging package and guidelines	Yes	Completed SBCC messaging package and guidelines	100% PLHIV have access to high quality HIV Prevention, care and treatment services	% PLHIV accessing high quality treatment literacy on ART initiation, adherence, disclosure, viral load suppression in different platforms	Yes	
RRH capacity to coordinate regional CQI activities enhanced	Lack of sufficient HRH	Lack of technical capacity	Lack of Financial Resources	HRH CQI support - Compensation for CQI experts at 7 USAID supported RRH supporting quality improvement activities within the Hospital and the region (lower level Health facilities)	COP21	COP25	Regional coordination of CQI activities is a priority for PEPFAR programs, with a spill over to other health activities, and yet not adequately supported by	7 CQI officers recruited and seconded to USAID supported RRHs	Yes	7 CQI officers recruited and seconded to USAID supported RRHs	7 CQI officers recruited and seconded to USAID supported RRHs	Number and proportion of USAID supported RRHs with regional CQI coordinators	Yes	
100% transition of PEPFAR programming from international to Local Partners	It is not included in local HIV response plans	Lack of information on costs and program requirements		Capacity strengthening(institutional, managerial, financial) of local partners in support of the MOH to country led development and sustainability of the HIV response. This includes the Government to Government results verification prior to pay for performance.	COP20	COP24	The transition from international to local partners requires on-going capacity building efforts	40% of USAID PEPFAR portfolio implemented through local partners as prime awardees	Partial	50% of USAID PEPFAR portfolio implemented through local partners as prime awardees	70% of USAID PEPFAR portfolio implemented through local partners as prime awardees	Number of awards in the PEPFAR portfolio implemented through local partners as Prime in Uganda. Proportion of USAID funds awarded to local partners as	No	
HIV/AIDS and TB data collection and use is institutionalized at the health facility, district, and national level with a focus on finer age	Lack of technical capacity	Lack of sufficient HRH	Other	(1) Support to USAID High Frequency Reporting and custom indicators for select PEPFAR indicators as part of USAID partner management and oversight through the Office of HIV/AIDS (OHA) as a benchmark for institution partner	Prior to COP 18	Post COP25	Monitoring, evaluation, reporting and learning support is of an ongoing nature to ensure program oversight, identify performance gaps, inform course corrective	While no benchmarks were set for COP21 for this activity, all USAID partners will submit on time standard PEPFAR reports including the quarterly report to	Yes	USAID service delivery partners including local partners prepare and submit quality (a) Weekly PEPFAR surge	USAID service delivery partners including local partners prepare and submit quality (a) Weekly PEPFAR surge reports through the PEPFAR	# of reports submitted by USAID partners as per the PEPFAR and USAID OHA reporting calendars % of submitted reports that are	Yes	
OVC, related child well-being and HIV/AIDS data collection and use is institutionalized at the community, district, and	Lack of technical capacity	Lack of Financial Resources	Lack of sufficient HRH	Improve country capacity for OVC data collection, analysis and management including working with MoGLSD , supporting OVMIS & DQA for OVC	COP18	COP25	While benchmarks were not set for COP21, the Ministry of Gender Labor and Social development is transitioning to a new policy environment with a new Child	Child wellbeing MIS designed by an international consultant through the MOGLSD. SITES provided support for the adoption of the OVCMIS modules into the new	Partial	Child wellbeing MIS fully developed to accommodate PEPFAR and other stakeholder reporting requirements	Child wellbeing MIS fully developed to accommodate PEPFAR and other stakeholder reporting requirements and devolved to the district local	Number of Local government units reporting OVC outputs in the Child well-being MIS Number of PEPFAR supported	Yes	OVC program reporting will continue in the post PEPFAR era as it remains critical in the post-epidemic control era
Strengthened organizational capacity gaps of four local organizations who will be first time prime implementing partners for care and	Lack of managerial capacity			Institutional strengthening of Local partners (providing care and treatment services) in managing USG resources	COP22	COP25	Not applicable	Not applicable	Not Applicable	Capacity gaps identified through pre-award assessments	100% Local partners have financial systems and institutional, managerial and financial policies to manage PEPFAR funds	Number of local partners with functional financial systems and policies in place	No	The local partners are currently sub-awardees of an international prime.
Strengthened organizational capacity gaps of four local organizations who will be first time prime implementing partners for OVC programs.	Lack of managerial capacity			Institutional strengthening of 4 Local partners (providing OVC services) in managing USG resources	COP22	COP25	Not applicable	Not applicable	Not Applicable	Capacity gaps identified through pre-award assessments	4 (100%) Local partners have financial systems and institutional, managerial and financial policies to manage PEPFAR funds	Number of local partners with functional financial systems and policies in place	No	The local partners are currently sub-awardees of an international prime.
Capacity built for Local partners including regional referral hospitals that receive G2G funds in developing and implementing activity	Lack of technical capacity	Lack of Financial Resources		Support the Monitoring, Evaluation, and Learning standards for the USAID Local Partner transition. Local partner M&E system capacity enhancement and improvements. The approach for COP20 will be aligned to the USAID Collaboration, Learning and Adaptation methodology	COP19	COP25	Ongoing support required	5 new local partners supported to develop and implement AMELPs	Yes	10 new local partners supported to develop and implement AMELPs	15 new local partners supported to develop and implement AMELPs including all the 7 RRHs	Number of Local Partners under USAID that are supported to successfully establish or improve M&E , systems for the Uganda Local partner transition.	Yes	Local partners receive continuous support
Fully functional EPR that supports data driven and real time commodities ordering all targeted facilities	Lack of technical capacity	Lack of technical capacity		Oversee ERP design and roll out and governance structure for ERP management.	COP20	Post COP25	Activity is implemented in a phased manner	ERP functional at NMS and all RRHs	Yes	ERP functional at NMS and all RRHs	ERP functional at all levels up to HC111s	No. of Facilities with functional ERP system	Yes	
National medical stores takes on more responsibilities in the supply chain system beyond warehousing and distribution	Lack of technical capacity	Lack of technical capacity		Support NMS in capacity and systems development, manage IL implementation, and ensure coordination among stakeholders.	COP20	Post COP25	NMS capacity to develop and implement robust and efficient supply chain systems is still suboptimal and needs more support	1) Annual supply plan developed; 2) joint coordination meetings held	Yes	(1) Annual HIV/AIDS commodities quantification completed, and quarterly updates performed in a timely manner and includes	Quarterly coordination mechanism established among NMS, MOH Pharmacy Division and the AIDS Control Program for joint supply planning and management of	Quarterly stakeholder coordination mechanism established at NMS	Yes	

Table 6-E tab (continued)

Expected Outcom	Primary Barrier t Local Responsibili	Barrier to Local Responsibility thi	Barrier to Local Responsibility thi	COP22 Activity Description	Interven	Inter	If ongoing from a previ year, please provide	Benchmark from COP21 activity existed in COP	Met benchmark past years?	COP22 Baseline	COP22 Benchmark	Indicator/Measurement Tool	Will the activ be continue	Notes
Technical and allocative efficiency of GOU and donor resources	Lack of technical capacity	Lack of technical capacity		Assist in implementation of Health Finance strategy. Identify efficiencies and raise domestic resources for health and HIV. Improve planning and budgeting (including Program Based Budgeting), procurement, accountability and resolution of audit findings at MoH. Coordinate ABC/M	COP20	Post COP25	Implementation is phased	MOH capacity in budgeting and health financing built	Partial	Draft health financing strategy	TA provided to MOH	Establishment of a system for tracking budget for MoH; and key donor funders 2) bottleneck analysis implemented	Yes	
Fully functional QI system at districts and health facilities generating information for quarterly performance reviews and programming	Lack of technical capacity	Lack of technical capacity		Work with QA Unit in MOH to establish and enforce QA standards for service delivery, and support QA policy development and oversight.	COP20	Post COP25	QI capacity at districts and facilities is still inadequate and needs further support	(1) Data driven QI dashboard created for use by health facilities and districts to improve case finding and retention in care.	Yes	QI fully functional at MOH	HIV/AIDS QI data reviewed on a quarterly basis with action items generated for implementation by IPs	# Quarterly QI coordination meetings held by MOH for all PEPFAR IPs	Yes	
Fully functional EMR that supports data driven decision making at all levels of the health care system	Lack of Financial Resources	Physical infrastructure not complete/further investment needed by donors		Support Enterprise Architecture development activities at regional level that will support implementation of full scale EMR systems with point of service data capture for all key health services as well as supporting case reporting with Unique Identification, Interoperability and Health Exchanges.	COP19	COP25	Activity implemented in a phased manner	50% of PEPFAR supported Health Facilities have established EMR systems in place	Partial	3 new high volume sites assessed for EMR systems at HIV clinics for with Point of service (PoS) implementation	3 new high volume sites implementing EMR systems at HIV clinics with Point of service (PoS) implementation	No. of sites with full EMR system with point of care data capture and capable of vertical interoperability.	Yes	
Fully functional EMR that supports data driven decision making at all levels of the health care system	Lack of Financial Resources	Physical infrastructure not complete/further investment needed by donors		Support Enterprise Architecture development activities at regional level that will support implementation of full scale EMR systems with point of service data capture for all key health services as well as supporting case reporting with Unique Identification, Interoperability and Health Exchanges.	COP19	COP25	Activity implemented in a phased manner	50% of PEPFAR supported Health Facilities have established EMR systems in place	Partial	3 new high volume sites assessed for EMR systems at HIV clinics for with Point of service (PoS) implementation	3 new high volume sites implementing EMR systems at HIV clinics with Point of service (PoS) implementation	No. of sites with full EMR system with point of care data capture and capable of vertical interoperability.	Yes	
Provision of observational data for PLHIV treatment outcomes which contributes to the body of evidence that guides the MoH and PEPFAR program	It is not included in local HIV response plans	Lack of Financial Resources		(AFRICOS) Longitudinally assess the impact of clinical practices, biological factors and socio-behavioral issues on HIV infection and disease progression in an African context	Prior to COP 18	Post COP25	The research study is important in achieving epidemic control and improving quality of services by providing evidence on effectiveness on interventions and approaches.	On going replacement, quarterly data analysis and results shared with MoH and USG and CDC to inform policy and PEPFAR programming	Yes	Generated publications and informed TLD transitions.	Follow up of participants; Interim data analysis and dissemination of findings to guide MOH and PEPFAR implementations	Viral load measurements; CD4 count; TB incidence cases; Rate of TB rifampicin and multi drug resistance; HIVDR mutations; Rates of cervical cancer; Incidence of opportunistic	Yes	
Improved KP data for programing. National IBBS data available	Lack of Financial Resources	Lack of technical capacity	Lack of sufficient HRH	Support implementation of a national IBBS strategy for KPs	COP22	Post COP25	Continuation of IBBS to cover additional populations of MSM and PWID not covered in COP21	Completion of site activation and IBBS in FSW in 12 regions	Yes	Sites set up with ACASI after completion of FSW IBBS in COP21	Completion of IBBS among MSM and PWID, with sentinel surveillance sites set up	number of sites with completed IBBS for MSM and PWID	Yes	strategy to have a continuous surveillance system for KPs to regularly update biomarker, and population size estimates
Improved identification, linkage, retention and viral load suppression among key populations	Lack of technical capacity	Legal, policy or regulatory constraint	Legal, policy or regulatory constraint	KP service oversight, technical assistance, and supervision to subnational levels	COP19	Post COP25	Above site stakeholder that provides oversight and capacity building for sub national level facility and community structures to provide KP HIV services.	25% of KP CSOs supported to improve service delivery at existing DICEs and scale up good practices	Partial	75% of KP CSOs supported to improve service delivery and scale up good practices	100% KP CSO with adequate organizational capacity and functional systems. Improved identification, linkage, retention and viral load suppression among	%of KP CSOs with adequate organizational capacity & functional systems	Yes	
Short learning loops/QI projects to inform the program implemented and disseminated at district, regional and national level.	Lack of sufficient HRH	Lack of managerial capacity		Funding supports fellows carry out projects that address program/service related gaps, generate solutions and use QII approaches to scale up best practices within and across districts/regions.	Prior to COP 18	Post COP25	The coverage of epidemiologists in the country is still suboptimal, coverage is 23% from 2020 MOH Audit Report. In order for Uganda to maintain the current program	13 QI projects completed by fellows 13 districts implementing projects supported by fellows 13 manuscripts submitted to peer	Yes	13 QI projects completed by fellows 13 districts implementing projects supported by fellows	13 QI projects completed by fellows 13 districts implementing projects supported by fellows 13 manuscripts submitted to peer	No of QI projects completed by fellows No of districts implementing projects supported by fellows No of manuscripts submitted to	Yes	
Data collected from 100% of all sites including community sites, private for profit and private not for profit health facilities	Lack of Financial Resources	Lack of sufficient HRH	Lack of sufficient HRH	Support PEPFAR supported community sites and health facilities to meet PEPFAR reporting requirements	COP22	Post COP25	This is an ongoing activity to support the site level activities for all agencies except USAID to meet the PEPFAR MER reporting requirements	100% of sites supported to meet the PEPFAR MER reporting requirements	Not applicable	All PEPFAR supported facilities able to report and meet the PEPFARMER reporting requirements	100% of PEPFAR sites supported to meet the MER reporting requirements	Quarterly, semi-annual and annual program performance reports	Yes	Site level support (CDC+DoD+WRAIR+PC+STATE)
Data from all sites comprehensively analyzed by age, gender, population type and used for evidence based decision making	Other	Other	It is not included in local HIV response plans	Data for AIDS related mortality and HIV recency is not collected from 100% of the sites limiting full scale analysis for these areas	COP22	Post COP25	This is an ongoing activity for coordination of reporting with all stakeholders including ministry of health, PCO, UNHLS and all above site SI mechanisms	Support the scale up of reporting of data on AIDS related mortality and HIV recency from all community sites, health facilities including private for profit and	Not applicable	All above site SI mechanisms coordinated and supported to meet the PEPFAR MER reporting and analysis requirements	100% of above site mechanisms and agencies supported to meet the PEPFAR MER reporting requirements and to analyse data for evidence based decision	Quarterly, semi-annual and annual program performance reports	Yes	SI Overall above site support +PCO activities (50k)

Table 6-E tab (continued)

Expected Outcom	Primary Barrier t Local Responsibili	Barrier to Local Responsibility thi	Barrier to Local Responsibility thi	COP22 Activity Description	Interven	Inter	If ongoing from a previ year, please provide	Benchmark from COP21 activity existed in COP	Met benchmark past years?	COP22 Baseline	COP22 Benchmark	Indicator/Measurement Tool	Will the activ be continue	Notes
100% of the sites reporting HIV recency data	Physical infrastructure not complete/further investment needed by donors	Physical infrastructure not complete/further investment needed by donors	Lack of Financial Resources	There will be scale up of IT physical infrastructure investments through HIS scale up that will enable the scale up of reporting on the HIV recency testing activities	COP22	Post COP25	This was recommended to scale up recency activities to more PEPFAR supported sites	N/A	Not applicable	Recency testing scaled up to more PEPFAR supported health Facilities and data collected	Recency testing scaled up to more PEPFAR supported health Facilities and data collected and used for evidence based decision making	Recency performance reports	Yes	Recency Budget (a recommended increase for more scale up)
UPHIA and RUPHIA reports completed and findings disseminated	Other	Other	Other	To support data collection, analysis, report writing and close out of the Uganda population HIV impact assessment and Refugee Population HIV impact assessment	COP22	COP23	To support data collection and close out of the Uganda population and Refugee Population HIV impact assessment	N/A	Not applicable	RUPHIA and UPHIA data analysed	RUPHIA and UPHIA reports completed and findings disseminated	UPHIA and RUPHIA reports available	No	Refugee RUPHIA (Close out and dissemination activities (UPHIA + RUPHIA)
Ministry of health with capacity to lead on SI activities	Lack of technical capacity	Lack of managerial capacity	Lack of sufficient HRH	To build the capacity for the MoH to lead on SI activities	COP22	Post COP25	For support of ministry of health coordination activities for program sustainability	MoH with financial and technical capacity to lead SI activities	Not applicable	Support Ministry of health to build capacity to take lead in SI activities	Ministry of health capacity to lead SI activities built	Sustainability report	Yes	For MoH SI Support and other national coordination activities for government ownership
Legal Environment Assessment finding addressed	Legal, policy or regulatory constraint			Address findings from legal environment assessments and address issues therein	COP21	COP25	The supported activities include revision of policies, which involves stakeholders engagements for buy and cannot be concluded in one year	Finalize the KP specific LEA and share the findings	Not applicable	KP specific LEA findings in place	Development of action plan to address the LEA findings Issue identification, Policy analysis and development of options Communication and consultation	1. Action plan to address the LEA findings in place 2. Issue identification, Policy analysis and development of options framework in place	Yes	
Data collected from all KCCA sites	Lack of Financial Resources	Lack of sufficient HRH		Support KCCA HFs to meet PEPFAR reporting requirements	COP21	Post COP25	This is an on-going to support KCCA facilities to meet the PEPFAR MER reporting requirements	100% of KCCA sites supported to meet the PEPFAR MER reporting requirements	Not Applicable	All KCC facilities able to report and meet the PEPFAR MER reporting requirements	100% of KCCA sites supported to meet the PEPFAR MER reporting requirements	proportion of KCCA facilities supported to meet the MER reporting requirements	Yes	Maintain support data systems and reporting and PoC EMR systems
Improved KP data for programing. National IBBS data available	Lack of Financial Resources	Lack of technical capacity		Support implementation of a national IBBS strategy for KPs	COP22	Post COP25	Continuation of IBBS to cover additional populations of MSM and PWID not covered in COP21	Completion of site activation and IBBS in FSW in 12 regions	Yes	Sites set up with ACASI after completion of FSW IBBS in COP21	Completion of IBBS among MSM and PWID, with sentinel surveillance sites set up	number of sites with completed IBBS for MSM and PWID	Yes	strategy to have a continuous surveillance system for KPs to regularly update biomarker, and population size estimates
Improved mortality data to improve TX-ML disaggregates and HIV programing	Lack of Financial Resources	Lack of technical capacity		Support development and validation of mortality in case base surveillance system and TX_ML indicator. Tracking will be done at facility and community level. In the community, Verbal Autopsy interviews will be done to ascertain the cause of death or obtain outcome for those who are lost to follow up	COP19	COP23	Mortality is an ongoing activity which is being progressively scaled up to more regions to and sites to generate data to inform programming	90% of PLHIV deaths and lost to follow up tracked	Yes	90% of PLHIV deaths and lost to follow up tracked	Mortality surveillance implemented in 7 CDC supported regions 90% of PLHIV deaths and lost to follow up tracked	No. of regions implementing mortality surveillance Proportion of PLHIV deaths and lost to follow up tracked	Yes	
Teams of competent epidemiologists with surveillance, data analytical and Public Health leadership skills to sustainably manage	Lack of sufficient HRH	Lack of technical capacity	Lack of Financial Resources	Funding supports 26 fellows for an on-the-job skills building and training through service in applied epidemiology, surveillance, outbreak investigations, public health leadership, program evaluations, and analysis of data for decision making. The fellows support the HIV/TB	Prior to COP 18	Post COP25	The coverage of epidemiologists in the country is still suboptimal, coverage is 29% from 2020 MOH Audit Report. This is below the WHO recommended standard of	26 fellows supported; 13 fellows graduate per year	Yes	26 Fellows supported, 13 fellows graduate from the program	26 Fellows supported, 13 fellows graduate from the program	Number of fellows graduating from the PHFP program Number of HIV/AIDS studies/projects that inform program execution completed	Yes	The program will be progressively transition into the MoH and other public sector entities for institutionalization of the approach; with mandate to coordinate disease epidemiology, surveillance, outbreak investigation/response and working
Strengthened RRH and district systems to use data and other evidence for effective planning, coordination, supervision and	Lack of technical capacity	Lack of Financial Resources		Strengthen the implementation of RRH approach to decentralized service delivery through building the capacity of RRH teams in governance, planning, coordination, data analysis and use, performance monitoring, support supervision and mentorship, quality assurance, efficient use	Prior to COP 18	Post COP25	The MOH has reviewed the role of RRHs in decentralized service delivery; the RRH still have capacity gaps to address for them to effectively deliver the	50% of RRHs implementing quarterly support supervision to districts and high volume sites 50% of RRHs implementing quarterly performance monitoring	Yes	50% of RRHs implementing quarterly support supervision to districts and high volume sites 50% of RRHs implementing	100% of RRHs & districts implementing 5-year HIV/AIDS strategic and integrated annual work plans 100% of RRHs providing direct	Proportion of RRHs & districts implementing 5-year HIV/AIDS strategic and integrated annual work plans with minimal support from IPs	Yes	Improved local capacity (RRHs/Districts) to use data for effective service delivery with spillover effects to other disease programs
Improved visibility and accountability for laboratory reagents and linkage with instrument utilization for improved supply planning,	Lack of technical capacity			To support the completion of a full Central Public Health Laboratory Inventory System that will link reagent to instrument utilization and patient samples in order to reduce misdiagnosis and misclassification and improve efficiencies. Additionally, this will improve supply planning for viral load	COP19	COP23	There is phased implementation of the activity; the program is shifting to more plasma samples that require centralized testing and thus the need for increased	70% of hubs linked to the CPHL LIMS 100% of instruments linked with the Logistic management system	Yes	70% of hubs linked to the CPHL LIMS 100% of instruments linked with the Logistic	100% of hubs linked to the CPHL LIMS 100% of instruments linked with the Logistic management system	Proportion of hubs linked to the CPHL LIMS Proportion of instruments linked with the Logistic management	Yes	

Table 6-E tab (continued)

Expected Outcom	Primary Barrier t Local Responsibili	Barrier to Local Responsibility thi	Barrier to Local Responsibility thi	COP22 Activity Description	Interven	Inter	If ongoing from a previ year, please provide	Benchmark from COP21 activity existed in COP	Met benchmark past years?	COP22 Baseline	COP22 Benchmark	Indicator/Measurement Tool	Will the activ be continue	Notes
Quality HIV/AIDS services delivered at all levels of care with minimal interruption due medicines and health supplies stock outs.	Lack of technical capacity			To strengthen the implementation of the RASS in all Uganda districts, increase coverage and site level reporting rates on ARVS and related commodities, improve internal re-distribution within districts and across region(s) in order to avert stock outs and expiries	COP19	COP24	The monitoring of ARV stock status at health facility level is an ongoing/ weekly activity, that informs planning for and redistribution of commodities to	95% health facility reporting rates in RASS ...stock out rates	Partial	65% health facility reporting rates in RASS ...stock out rates	95% health facility reporting rates in RASS ...stock out rates	Proportion of health facilities reporting in RASS dashboard Health facility stock out rates	No	
MOH led HIV/TB response and other health/disease programs with resilient health system and enabling/updated policies and guidelines for	Lack of technical capacity			This strategic partner will provide critical TA and coordination function for MOH and all other Health development partners to achieve; updated national level policies that reflect WHO/global recommendations; relevant HIV/TB and health related policies and guidelines (e.g.	COP19	COP24	To support the review/updating of relevant HIV/TB and health policies and guidelines, support conducting of annual NHA compilation, finalize the guidelines	Support MOH to revise NHI bill for presentation to parliament Supported review of TB screening and TB preventive therapy	Yes	Support MOH to revise NHI bill for presentation to parliament Supported review of TB screening and TB	Revision of key policies and guidelines for epidemic control; Finalization of guidelines for the regionalization of health service Completion of health sector	No of policies and guidelines developed / reviewed Health sector staffing norms completed NHA completed and report	Yes	
Institutionalized in-service training using efficient virtual training models supported using the hub and spoke approach and linked to health	Lack of technical capacity	Physical infrastructure not complete/further investment needed by donors		To support establishment of new and increase utilisation of virtual platforms for e-learning/tele-mentoring /teleconferencing for skills transfer and improved HW performance; expanding the coverage and access to in service training/ continuous medical education, increasing	COP19	COP24	The implementation and scale up of the virtual learning infrastructure has been phased using the hub and spoke approach, there is still need to	50 subnational spokes established	Yes	50 subnational spokes established	Roll out the implementation of e-platforms to 30 spokes Provide TA to stakeholders for standardization of the e- learning platform	Proportion of RRH implementing standardized e-learning sessions Number of spokes established Proportion of districts implementing e-training for HCW	Yes	
Key policies for epidemic control in place, fully capacitated regional teams taking on delegated MOH functions of effective	Lack of technical capacity	Lack of sufficient HRH		Development/revision of policies and guidelines in response to new evidence for sustained epidemic control e.g.: MOH accreditation of high volume HC II to provide ART and PMTCT/EID, VL POCT policy for pregnant/breast feeding women, finalize RRH Implementation guideline, Revise	COP19	COP24	As Uganda approaches epidemic control, MOH leadership, evidence based and responsive policies will be key. The RRH approach is still a new approach that needs to	Updated policies to meet the HIV dynamics and new innovations for sustained epidemic control, 57% (4/7) RRH meeting their	Yes	Updated policies to meet the HIV dynamics and new innovations for sustained epidemic control, 83% (8/9) RRHs meeting	1. Updated policies to meet the HIV dynamics and new innovations for sustained epidemic control 2. 57% (4/7) RRHs meeting their central level mandate under	Number of Policies, technical guidelines updated/developed and disseminated; Proportion of RRH carrying out quarterly support	Yes	*positions within various departments in the Ministry of Health including the AIDS Control Program, Division of Health Information and National TB/Leprosy*
Improve VL suppression among PLHIV on DTG regimens	Lack of Financial Resources	Lack of sufficient HRH		Trends of DTG associated HIV drug resistance	COP20	Post COP25	Annual monitoring from COP guidance	Protocol approval and commencement of data collection	Partial	Completed data collection	Completed analysis	Proportion of PLHIV on DTG with HIVDR mutations	Yes	This is an annual surveillance activity
100% compliance to bio risk management practices for all hubs	Lack of Financial Resources	Lack of technical capacity	Lack of managerial capacity	Implement bio risk assessment in 100 hubs	COP19	COP25	Need for routine monitoring of health workers environmental safety to minimize intentional and non-intentional exposure to biohazards through maintenance	Availability of the bio-risk policy and assessment tools.	Partial	Availability of the bio-risk policy and assessment tools.	1) Bio-risk report for 100 hub labs 2) Proportion of health facilities with waste management guidelines and IEC materials available.	100% compliance of 100 lab hubs to bio-risk management standards.	Yes	
•Fully functional high containment negative pressure facility for NTRL Butabika and Wandegeya •In-country capacity	Lack of Financial Resources	Lack of technical capacity	Limited partner government control to prioritize the allocation of PEPFAR resources or investments	Maintenance of high containment negative pressure facility for NTRL Butabika and Wandegeya through service contracts and repairs Build local capacity for maintenance of high containment negative pressure building maintenance systems (BMS)	COP22	Post COP25	Previously costs were covered by the Global Fund (GF) until a request made by GF, for own country to meet these costs.	TB negative pressure containment lab is serviced and repaired annually	Yes	TB negative pressure, high containment lab is serviced and repaired annually	Functional national supranational high containment lab for quality TB testing services and local capacity for BMS established	EQA panel production for TB and COVID-19 through the high containment lab	Yes	The facility building management system (BMS) outsourced (in Dubai) at $95,000, plus service maintenance of negative pressure at $65,000 and annual recurrent service maintenance cost at $8000. Contributions from HLAB-$53,816 and
An improved access to quality, and cost-effective laboratory services within the national diagnostic network	Lack of information on costs and program requirements	Lack of technical capacity	Lack of managerial capacity	Implementation of diagnostic network optimization following recommendations/scenarios from national assessments.	COP20	COP24	The activity is best implemented in a phase approach to ensure design of diagnostic network that better meet the country's needs. The first phase was baseline	Conducted the baseline network assessment, data analysis is ongoing.	Not applicable	Conducted the baseline network assessment, data analysis is ongoing.	Implementation of scenarios stemming from the baseline assessment.	Design the network to better meet the country diagnostic demand with efficiency & sustainability.	Yes	
Storage space for PEPFAR data which is not in government hosting space ensuring data availability to inform programming	Physical infrastructure not complete/further investment needed by donors			Funding will help improve an alternative backup/ redundancy data hosting services at the MOH HQ based one. The plan is to make sure we are able to provide continuity of HIE services no matter what happens	COP18	COP25	Government lacks infrastructure to host this data	KP tracker, SURGE dashboard and PEPFAR Reporting System hosted	Yes	KP tracker, SURGE dashboard and PEPFAR Reporting System hosted	KP tracker, SURGE dashboard and PEPFAR Reporting System hosted	KP tracker, SURGE dashboard and PEPFAR Reporting System hosted	Yes	
Interconnectivity between various facility and community systems (PEPFFAR and non PEPFAR), Improving tracking	Physical infrastructure not complete/further investment needed by donors	Legal, policy or regulatory constraint	Lack of technical capacity	Funds will support partner to take lead on the various required data integration, health information exchanges and data warehousing projects critical for the electronic data exchange across facilities, ensuring linkage of clients and services across the implementation space and services both	COP20	Post COP25	HIE projects started as a pilot, necessary infrastructure was not in place, been improving and scaling but have not carried out required. But also more integration project	EMR-Viral Load HIE set up in 200 sites , National Clinic Data Repository infrastructure set up. Integration between EMRs and Private pharmacy system set up,	Partial	EMR- Viral HIE scaled up to 200 high volume ART sites, Clinical Data Repository set up, EMR- ART Access integration in 64 sites	EMR-Viral HIE scaled to 400 high volume sites, one data deduplication project undertaken, EMR- Private pharmacy Integration extended to 200 sites,	No of HIE projects undertaken, No. of systems integrated	Yes	HIEs and data integrations will continue as long HIV programs run

Table 6-E tab (continued)

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Fully functional and integrated EMRs rolled out in supported facilities, improved Data use in supported sites	Physical infrastructure not complete/further investment needed by donors	Lack of technical capacity		Continued development and enhancement of patient-level systems for facility and community settings (HIV, TB, PMTCT, Lab, supply chain, cervical cancer etc.), including continuous monitoring and support as well as knowledge transfer	Prior to COP 18	Post COP25	Software customization continues as program needs changes, changing from data room to point of care implementation, EMR being improved beyond single	TB, PMTCT/EID Covid Modules and workflows for Point of care services added	Yes	POC EMR partially or fully being implemented in 200 facilities.	POC EMR scaled up to 400 high volume ART sites, EMR in 300 Mother Baby Care points, EMR in 100 TB clinics	No. of sites with POC EMR, No. of additional modules added in EMR	Yes	
Local technical expertise established and institutionalized at national, regional ,district and health facility levels for full and	Lack of technical capacity	Lack of sufficient HRH		Resources will be used to build capacity as well as pass on skills needed for delegation of systems operation across Ministry of health workforce for POC system functionality	COP21	Post COP25	Planned engaged did not get traction due to COVID-19 disruptions	training resources prepared, Critical staff in Regional Referral Hospitals trained, Development of eLearning platform started on	Partial	Key HIS human resources deployed in MOH using COVID- resources, skilling program established (Building Health Informatics	Key HIS human resources maintained in MOH HQ, Health care workers trained in EMR use and data use	No. of key HIE staff at MOH HQ, No. of HCWs trained in EMR use, POC EMR sites fully using GOU of staff	Yes	Government continues to recruit and deploy new staff from training institutions, staff are transferred periodically - quite common for non trained staff to be transferred to a critical site
Alignment of Unique Identifier Implementation with national policies, legal requirements, and governance for protection of privacy,	Legal, policy or regulatory constraint			Resources will used by partner to support government efforts to produce the various technical documents needed to support UI implementation	COP20	COP24	COVID-19 disruptions in travel to physical meetings, draft documents never cleared by MOH senior leadership, some lacking because government has been	Draft National Health Information and Digital Health Strategic Plan in place	Partial	National Health Information and Digital Health Strategic Plan finalised, UI implementation guidelines drafted	UI implementation guidelines finalised	HIV Clients registry in use	Yes	Guidelines are usually time bound continue to be revised to suit changing environment
Interoperability between the systems, data exchange and vocabulary standards as well have national policies, legal requirements, and governance	Legal, policy or regulatory constraint	Lack of Financial Resources		In order to implement a unique IDs, we need to optimize interoperability between the systems and use data exchange and vocabulary standards whenever possible and as well have national policies, legal requirements, and governance for protection of privacy, confidentiality, and	COP22	COP25	Not applicable	Not applicable	Not applicable	Key HIS human resources deployed in MOH using COVID- resources	HIE standards documents in place, 4 Registries fully functional, key positions regularised in MOH HR structure	Availability of national standards for HIE, UI guidelines and proper staffing at MOH to support National Enterprise Architecture	Yes	
Informatics workforce within relevant MOH Divisions (ACP, DHI, ICT) with needed public health informatics capabilities to lead the	Lack of technical capacity	Lack of sufficient HRH		Resources will support MOH Divisions (ACP, DHI, ICT) with needed public health informatics capabilities to lead the governance and coordination. In order to have national HIE Standards, HIS strategies and key documents for privacy, confidentiality, (cyber) security of personal identifying	COP22	Post COP25	Not applicable	Not applicable	Not applicable	Key HIS human resources deployed in MOH using COVID- resources, skilling program established (Building Health Informatics	Key HIS human resources with required skills in MOH (Projects manager, EMR Developer, HIE Architect , etc.)	Availability of national standards for HIE and UI guidelines in place	Yes	Guidelines are usually time bound continue to be revised to suit changing environment
National guidelines for HIE and UI implementations in place	Legal, policy or regulatory constraint	Lack of technical capacity		WHO will support MOH and other collaborating entities to ensure that required HIE and UI guidelines are in place . WHO will provide technical support to the National TB/Leprosy program to update national guidelines on TB screening diagnosis and treatment, quarterly and annual reporting	COP22	COP24	N/A	N/A	Not Applicable	National Health Information and Digital Health Strategic Plan finalised	Revised staffing norms in place; Advocate and streamline the implementation of the CHEWS; TB guidelines updated, quarterly and annual reporting done.	National HIE and Interoperability guidelines in place National Health UI guidelines in place	Yes	Guidelines undergo regular/period reviews
IT Infrastructure critical for Interoperability and HIE maintained, improved data hosting capabilities, optimum internet bandwidth available	Physical infrastructure not complete/further investment needed by donors			The is still further need for investment in IT Infrastructure critical for Interoperability and HIE. Continuous improvement and maintenance of the on- Premise data hosting center at CPHL including, data hosting capabilities to support future needs including data repositories and data warehouses and	COP20	Post COP25	Current data center at CPHL which support Viral load , EID and clinical data repository has not reached optimum storage capacity for all planned projects, not yet	Data hosting capacity improved by 28 terabytes , 2 internet service providers supported	Partial	Optimum data hosting capacity for Viral Load system, Viral Load HIE in 200 sites	Data Hosting capacity maintained, Viral load HIE in 400 sites	Data hosting capacity established	Yes	
100 hubs enrolled on interoperable LIMS with EMR LIM, VL/EID results delivery via SMS for 55% of HIM clients, An	Lack of Financial Resources	Lack of technical capacity	Physical infrastructure not complete/further investment needed by donors	LIS interoperability with EMR, LIS interconnectivity with POC devices, Coordination of monthly EID/VL demand creation, Sample tracking software implementation	Prior to COP 18	Post COP25	currently 133 sites implementing EID POC testing, about 68 hubs enrolled on LIMS and SMS results delivery software developed awaiting rollout	68 hubs enrolled on LIMS, interoperable LIMS with EMR in at least 5 sites, needs mapping completed and software developed enable VL/EID results	Yes	68 hubs on LIMS	VL, EID sample return by SMS, 100 interoperable LIMS, VL POC interface in 133 sites	VL/EID TAT within 24 hours of sample collection	No	
Above 70% of laboratory service delivery activities implemented in accordance with the approved and costed lab strategic plan	Lack of technical capacity	Legal, policy or regulatory constraint	Limited partner government control to prioritize the allocation of PEPFAR resources or investments	Lab standards, policies, and guidelines review, monitoring and implementation according to the lab strategic plan	Prior to COP 18	Post COP25	Focus on institutional collaboration, capacity monitoring and integration of services to rhyme the lab strategic plan by at least 70% as a means of	37% of lab services implemented according to lab strategic plan	Yes	37% of lab services implemented according to lab strategic plan	over 70% of lab services implemented according to lab strategic plan	Functional national lab M&E framework in line with lab policy and strategic plan	Yes	WHO is a strategic partner enabling translation of national lab standards to local context thus contributing to international health regulations
Improved KP data for programing. National IBBS data available	Lack of technical capacity	Lack of Financial Resources		Support implementation of a national IBBS strategy for KPs	COP19	Post COP25	Continuation of IBBS to cover additional populations of MSM and PWID not covered in COP21	Completion of site activation and IBBS in FSW in 12 regions	Yes	Sites set up with ACASI after completion of FSW IBBS in COP21	Completion of IBBS among MSM and PWID, with sentinel surveillance sites set up	number of sites with completed IBBS for MSM and PWID	Yes	strategy to have a continuous surveillance system for KPs to regularly update biomarker, and population size estimates

Table 6-E tab (continued)

Expected Outcom	Primary Barrier t Local Responsibili	Barrier to Local Responsibility thi	Barrier to Local Responsibility thi	COP22 Activity Description	Interver	Inter	If ongoing from a previ year, please provide	Benchmark from COP21 activity existed in COP	Met benchmark past years?	COP22 Baseline	COP22 Benchmark	Indicator/Measurement Tool	Will the activ be continue	Notes
Improved detection of birth defects and other related birth outcome reporting	Lack of Financial Resources	Lack of technical capacity		On-going detection and reporting of birth defects and other related birth outcomes	COP20	COP24	Annual monitoring for DTG related AES	Preliminary results	Partial	continued data collection	Dissemination of preliminary results	Number of deliveries witnessed Number of infants with external birth defects detected	Yes	The project is supports reports on birth defects and more in WLHIV on DTG and helps to monitor and report the outcomes to inform MOH policy
Eased reporting and improved data use at facilities with EMRs	Lack of technical capacity			Integrate Health stats an in-house reporting and data mining application with PEPFAR supported EMRs	COP22	COP24	Not applicable	Not applicable	Not applicable	Not applicable	Solution fully integrated in UgandaEMR and Clinicmaster and available at least 400 PEPFAR supported facilities	No of EMR sites using Health stats App for reporting and data mining.	No	
National data governance guidelines for person level data	Legal, policy or regulatory constraint	Lack of technical capacity		The funds will support the partner to coordinate and take lead on the production of the person level data governance critical documents	COP22	COP23	Not applicable	Not applicable	Not applicable	Not applicable	Draft personal level data governance framework	Draft personal level data governance framework in place	Yes	
Improved documentation of service access and delivery for community based interventions	Lack of USG-Government integration planning	Physical infrastructure not complete/further investment needed by donors		Support Integration of PEPFAR supported EMRs with a Ugandan customisation of the Community Health Toolkit (MOH preferred tool) as an HIS solution for community based services	COP22	COP25	Not applicable	Not applicable	Not applicable	Not applicable	Draft Data Governance Guidelines	Availability of National data Governance Guidelines for Person level data	Yes	Guidelines are usually time bound continue to be revised to suit changing environment
Availability of legal requirements for UI implementation, and governance for protection of privacy, confidentiality, and	Lack of technical capacity			Provide expert scientific advice, consultation, and leadership to the review, adoption, and implementation of internationally consistent data and information standards to facilitate data exchange and aggregation, data use, key guidelines and policy solutions to support in areas of security, data sharing	COP22	COP25	Not applicable	Not applicable	Not applicable	Not applicable	Partners to support Identified, understanding of technical needs around centralization through HIE advancement as well as development of national MOH	Centralization projects undertaken with TA partners, Data Integration uses developed, Data repository designed for CBS	Yes	
Local capacity built to support the various data centralisation projects planned	Lack of technical capacity	Physical infrastructure not complete/further investment needed by donors		Provide on-going hands-on technical expertise and mentorship in the design and implementation of the various data centralization projects that will be undertaken in the country so that there is local competency and capacity for managing and maintaining them	COP22	COP25	Not applicable	Not applicable	Not applicable	Not applicable	Partners to support Identified, understanding of technical needs around centralization through HIE advancement as well as development of national MOH	Centralization projects undertaken with TA partners, Data Integration uses developed, Data repository designed for CBS	Yes	
Local capacity built to support the various data centralisation projects planned	Lack of technical capacity	It is not included in local HIV response plans		On-going Capacity building for HCWs	COP22	COP23	continued roll out of HIV recency testing for surveillance	70% of targeted sites reached with recency testing	Not applicable	70% of targeted sites reached with recency testing	100% of target sites reached with HIV recency testing and quality improvement monitoring	Proportion of targeted sites reached with HIV recency testing and quality improvement monitoring	No	UCSF-TRACE mechanism supports HIV recency activities in multiple PEPFAR countries, making them well placed to provide TA with experiences from other countries.
Fully functional and integrated EMRs rolled out in supported facilities, improved Data use in	Physical infrastructure not complete/further investment needed by donors	Lack of technical capacity		Build capacity of health workforce and support roll out of PEPFAR systems and data Integration, HIE and data warehousing and POC EMR in the military facilities	COP21	COP25	Activity implemented in a phased manner	50% of PEPFAR supported Health Facilities have established EMR systems in place	Yes	50% of PEPFAR supported Health Facilities have established EMR systems in place	80% of PEPFAR supported Health Facilities have established EMR systems in place	No. of sites with full EMR system with point of care data capture and capable of vertical interoperability.	Yes	
Strengthened military HIV directorate systems to use data and other evidence for effective	Lack of technical capacity	Lack of managerial capacity	Lack of sufficient HRH	Strengthen the implementation of RRH approach to decentralized service delivery through building the capacity of RRH teams in governance, planning, coordination, data analysis and use, performance monitoring, support supervision and mentorship, quality assurance, efficient use	COP20	Post COP25	The MOH has reviewed the role of RRHs in decentralized service delivery; the RRH still have capacity gaps to address for them to effectively deliver the	UPDF HIV directorate implementing quarterly support supervision to high volume sites	Yes	UPDF HIV directorate implementing quarterly performance monitoring for the divisional hospitals UPDF HIV directorate with	25% of UPDF division hospitals implementing quarterly support supervision to high volume sites 50% of UPDF divisional hospitals implementing quarterly	Number of UPDF division hospitals implementing quarterly support supervision to high volume sites	Yes	

Table 6-E tab (continued)

Expected Outcom	Primary Barrier t Local Responsibili	Barrier to Local Responsibility thi	Barrier to Local Responsibility thi	COP22 Activity Description	Interven	Inter	If ongoing from a previ year, please provide	Benchmark from COP21 activity existed in COP	Met benchmark past years?	COP22 Baseline	COP22 Benchmark	Indicator/Measuremen Tool	Will the activ be continue	Notes
the various facility and community systems (PEPFAR and non PEPFAR), improving	Physical infrastructure not complete/further investment needed by donors	Legal, policy or regulatory constraint	Lack of technical capacity	required data integration , HIE and data warehousing projects critical for electronic data exchange across facilities , ensuring linkages of clients and services across the implementation space and services both	COP20	COP25	and necessary infrastructure was not in place but also more integrated projects do come up between PEPFAR	EMR viral load HIE scaled up to xxx facilities Some investments into Infrastructure	Partial	EMR viral HIE scaled up to 35 facilities	Viral load HIE scaled up to 35 Facilities . EMR - community pharmacy system integration set up to 10 sites Recency HIE for 35 facilities .All recency sites should participate in HIV	# of HIE projects undertaken # of systems integrated .	Yes	
integrated EMR rolled out in Walter reed supported facilities, improved data use in supported sites,	Lack of technical capacity	Physical infrastructure not complete/further investment needed by donors		patient level systems for community and facility settings (HIV, TB, PMTCT, Lab,), including continuous monitoring and support as well as knowledge transfer	Prior to COP 18	Post COP25	Need to develop more PEPFAR program modules and integrate them into Clinic Master EMR	HST module included into clinic Master	Partial	HIV modules integrated into clinic master	HIV and other clinical services modules integrated into clinic master	Number of HIV and other clinical service modules integrated into Clinic Master	Yes	HIV program is ever evolving and thus the need for continuous system development and evolution
established and institutionalised at the National, regional, district and health facility levels	Lack of technical capacity	Lack of sufficient HRH		Resources will be used to build capacity as well as pass on skills needed for delegation of system operations across MoH workforce for PoC system functionality.	COP21	Post COP25	Planned engagement did to get traction due to Covid -19 distraction	prepared Development of the E learning platform has been started on	Partial	Key HIS human resources have been deployed in MoH using Covid -19 resources . HIS skilling program established (building health informatics	Health care workers trained in EMR data use	# of key staff at MoH trained in EMR use	Yes	
Further build the capacity of the new local mechanism	It is not included in local HIV response plans	Lack of information on costs and program requirements		Capacity strengthening(institutional, managerial, financial) of local partners in support of the MOH/DOD-WRAIR region to country led development and sustainability of the HIV response.	COP21	COP24	The transition from international to local partners requires on-going capacity building efforts	50% transition of DOD /PEPFAR portfolio from international to local partners	Partial	50% of DOD/PEPFAR portfolio implemented through local partners as prime awardees	50% of DOD/ PEPFAR portfolio implemented through local partners as prime awardees	Number of awards in the PEPFAR portfolio implemented through local partners as Prime in Uganda.	No	
Operational lab equipment maintenance workshop	Lack of Financial Resources	Physical infrastructure not complete/further investment needed by donors	Lack of technical capacity	Procurement of the necessary tools and equipment , generation or drafting SOPs and schemes of service for the lab maintenance workshop	COP21	Post COP25	Insufficient funds in COP 21 to operationalise the equipment workshop	inform the equipment maintenance/repair needs, generate regional equipment inventory and capacity	Partial	20% of the regional equipment maintained	20% of the regional equipment maintained	Number of equipment maintained or repaired	Yes	
Improved citizen empowerment; a more conducive legal environment that facilitates equitable access and utilisation of HIV/	Legal, policy or regulatory constraint			Generate and /or update National policies/guidelines to ensure un-interrupted implementation of PEPFAR/MOH programs	COP19	Post COP25	Need for alignment of programming to evidence based policies guidelines	MOH guidelines aligned to current WHO/PEPFAR guidelines	Partial	Updated guidelines	100% of guidelines up to date		Yes	
Laws, policies, or regulations in place which mandate CSOs to be funded annually from a government budget through open and transparent	Legal, policy or regulatory constraint			Advocacy with national, regional, and/or district officials for instituting policy to mandate CSOs to be funded annually from a government budget through open and transparent competition	COP22	COP22			Not Applicable	CSOs receive funding from Government, but there is no specific mandate for Government to fund CSO HIV activities	Government to fund CSO HIV activities annually through open, transparent, and competitive process	SID response to "Are there laws, policies, or regulations in place which permit CSOs to be funded from a government	No	

SRE Tool-E tab of the Table 6

Prime Partner	Mech ID	COP22 Program Area	COP22 Beneficiary	Activity Description	Filter Here - Select Surveillance and Research	Activity Type	Country	Planned start date of data collection
Comprehensive HIV/AIDS Prevention, Care and Treatment in Central Uganda	160699	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	(AFRICOS) Longitudinally assess the impact of clinical	Surveillance	HIV case surveillance	Uganda	On going
Strengthening Civil Society organizations' capacity and coordination for accelerated HIV epidemic control in Uganda, through supporting the implementation of comprehensive HIV/AIDs prevention and treatment for Key Populations (KP) under the U.S President's Emergency Plan for AIDs Relief (PEPFAR)	81973	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	Support implementation of a national IBBS strategy for KPs	Surveillance	Bio-behavioral survey (BBS)	Uganda	10/1/2022
Accelerating Epidemic Control in Fort Portal region in the Republic of Uganda under the President's Emergency Plan for AIDS Relief	18567	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	KP service oversight, technical assistance,	Surveillance	Other	Uganda	10/1/2022
Strengthen Capacity of Uganda Ministry of Health and Sub-National	160702	ASP: HMIS, surveillance, &	Non-Targeted	Funding supports	Surveillance	Other	Uganda	10/1/2022
Strengthening Civil Society organizations' capacity and coordination for accelerated HIV epidemic control in Uganda, through supporting the implementation of comprehensive HIV/AIDs prevention and treatment for Key Populations (KP) under the U.S President's Emergency Plan for AIDs Relief (PEPFAR)	81973	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Support implementation of a national IBBS strategy for KPs	Surveillance	Bio-behavioral survey (BBS)	Uganda	Nov-22
Accelerating Epidemic Control in Fort Portal region in the Republic of Uganda under the President's Emergency Plan for AIDS Relief (PEPFAR)	18567	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Support development and validation of mortality in case base	Surveillance	Other	Uganda	1-Oct
Production, distribution and monitoring implementation of Rapid HIV PT, facility and site certification, HIVDR sentinel surveys, validation of emerging lab assays and lab equipment	18566	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Trends of DTG associated HIV drug resistance	Surveillance	HIV drug resistance surveillance	Uganda	1/15/2023
Strengthening Civil Society organizations' capacity and coordination for accelerated HIV epidemic control in Uganda, through supporting the implementation of comprehensive HIV/AIDs prevention and treatment for Key Populations (KP) under the U.S President's Emergency Plan for AIDs Relief (PEPFAR)	81973	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	Support implementation of a national IBBS strategy for KPs	Surveillance	Bio-behavioral survey (BBS)	Uganda	10/1/2022
Hospital Based Birth Defects Surveillance in Kampala, Uganda under the President's Emergency Plan for AIDS Relief (PEPFAR)	160701	ASP: HMIS, surveillance, & research-NSD	Pregnant & Breastfeeding Women: Not disaggregated	On-going detection and reporting of birth defects and other related birth outcomes	Surveillance	Other	Uganda	10/1/2022
Recency HQ Mechanism - UCSF	81976	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not	On-going Capacity building for HCWs	Surveillance	HIV recency surveillance	Uganda	10/1/2022

SRE Tool-E tab of the Table 6 (continued)

Prime Partner	Mech ID	Expected end date of data collection	Budget planned for the closeout year of the activit	Activity Title	Name of USG Agency POC for this activity	USG Agency POC Official email address (typically ending i	PI Name (s)	PI Official email address (typically associated with th
Comprehensive HIV/AIDS Prevention, Care and Treatment in Central Uganda	160699	Open ended	Not applicable	African Cohort study (AFRICOS)	Estella Birabwa	BirabwaEM@state.gov	Dr Hannah Kibuuka	hkibuuka@muwrp.org
Strengthening Civil Society organizations' capacity and coordination for accelerated HIV epidemic control in Uganda, through supporting the implementation of comprehensive HIV/AIDs prevention and treatment for Key Populations (KP) under the U.S President's Emergency Plan for AIDs Relief (PEPFAR)	81973	9/30/2023	On-going	KP surveillance	Herbert Kiyingi	inx1@cdc.gov	Herbert Kiyingi	inx1@cdc.gov
Accelerating Epidemic Control in Fort Portal region in the Republic of Uganda under the President's Emergency Plan for AIDS Relief	18567	9/30/2023	On-going	mortality surveillance	Herbert Kiyingi	inx1@cdc.gov	Herbert Kiyingi	inx1@cdc.gov
Strengthen Capacity of Uganda Ministry of Health and Sub-National	160702	9/30/2023	On-going	short learning loops FETP		inx1@cdc.gov	Herbert Kiyingi	inx1@cdc.gov
Strengthening Civil Society organizations' capacity and coordination for accelerated HIV epidemic control in Uganda, through supporting the implementation of comprehensive HIV/AIDs prevention and treatment for Key Populations (KP) under the U.S President's Emergency Plan for AIDs Relief (PEPFAR)	81973	30-Sep	Non	KP surveillance	Herbert Kiyingi	inx1@cdc.gov	Prof. Wanyenze Rhoda	rwanyenze@musph.ac.ug
Accelerating Epidemic Control in Fort Portal region in the Republic of Uganda under the President's Emergency Plan for AIDS Relief (PEPFAR)	18567	9/30/2023	On-going	mortality surveillance	Herbert Kiyingi	inx1@cdc.gov	Dr. Kekitiinwa	akekitiinwa@baylor-
Production, distribution and monitoring implementation of Rapid HIV PT, facility and site certification, HIVDR sentinel surveys, validation of emerging lab assays and lab equipment	18566	6/15/2023	On-going	Cyclical Acquired HIV Drug Resistance Surveillance: Focusing on Dolutegravir in Uganda	Grace Namayanja	uwo9@cdc.gov	Dr.Christine Watera	cwatera@uvri.or.go
Strengthening Civil Society organizations' capacity and coordination for accelerated HIV epidemic control in Uganda, through supporting the implementation of comprehensive HIV/AIDs prevention and treatment for Key Populations (KP) under the U.S President's Emergency Plan for AIDs Relief (PEPFAR)	81973	9/30/2023	Non	KP surveillance	Herbert Kiyingi	inx1@cdc.gov	Herbert Kiyingi	inx1@cdc.gov
Hospital Based Birth Defects Surveillance in Kampala, Uganda under the President's Emergency Plan for AIDS Relief (PEPFAR)	160701	9/30/2023	On-going	Hospital based Birth defect surveillance	Emilio Dirlikov	klt9@cdc.gov	Prof. Phillipa Musoke	pmusoke@mujhu.org
Recency HQ Mechanism - UCSF	81976	9/30/2023	On-going	Recency surveillance	Herbert Kiyingi	inx1@cdc.gov	Herbert Kiyingi	inx1@cdc.gov

SRE Tool-E tab of the Table 6 (continued)

Prime Partner	Mech ID	Primary evaluation or study questions	Activity objectives	Activity's primary study population
Comprehensive HIV/AIDS Prevention, Care and Treatment in Central Uganda	160699	To longitudinally assess the impact of clinical practices, biological factors and socio-behavioral issues on HIV infection and disease progression in an African context.	Describe, among PLWH and their families, stigmatizing events and social and economic harms attendant to HIV care and treatment; evaluate their impact on care seeking behaviors, HIV treatment response and disease progression. Identify attributes of HIV care and treatment programs associated with optimal	People living with HIV
Strengthening Civil Society organizations' capacity and coordination for accelerated HIV epidemic control in Uganda, through supporting the implementation of comprehensive HIV/AIDs prevention and treatment for Key Populations (KP) under the U.S President's Emergency Plan for AIDs Relief (PEPFAR)	81973	To estimate prevalence of HIV, viremia, select STI, progress towards the UANIDS 95|95|95 goals, HIV service uptake, stigma and abuse, and size estimation.	Identify attributes of HIV care and treatment programs associated with optimal clinical outcomes (including, but not limited to, organization, location, accessibility, logistic support, compliance with MOH guidelines, and drug distribution).	Key Pops: Not disaggregated
Accelerating Epidemic Control in Fort Portal region in the Republic of Uganda under the President's Emergency Plan for AIDS Relief	18567	To scale-up HIV-related mortality in all regions in Uganda	Describe HIV disease outcomes, including, but not limited to, mortality, progression to AIDS, event-free survival, and prevalence/incidence of HIV	Key Pops: Not disaggregated
Strengthen Capacity of Uganda Ministry of Health and Sub-National	160702	To be developed with program teams	To utilize FETP fellows to analyse already available program data to get	Non-Targeted Pop: Not disaggregated
Strengthening Civil Society organizations' capacity and coordination for accelerated HIV epidemic control in Uganda, through supporting the implementation of comprehensive HIV/AIDs prevention and treatment for Key Populations (KP) under the U.S President's Emergency Plan for AIDs Relief (PEPFAR)	81973	To estimate prevalence of HIV, viremia, select STI, progress towards the UANIDS 95|95|95 goals, HIV service uptake, stigma and abuse, and size estimation.	to estimate population size of FSW,MSM and PWID for national estimates; 2) To describe the risk characteristics and sero-prevalence of relevant biomarkers among KPs.	KP
Accelerating Epidemic Control in Fort Portal region in the Republic of Uganda under the President's Emergency Plan for AIDS Relief (PEPFAR)	18567	To scale-up HIV-related mortality in all regions in Uganda	improve vital statistics and death registration. 2) improve the mortality disagregation in the TX-ML indicator for PEPFAR programs	Non-Targeted Pop: Not disaggregated
Production, distribution and monitoring implementation of Rapid HIV PT, facility and site certification, HIVDR sentinel surveys, validation of emerging lab assays and lab equipment	18566	What is the prevalence of acquired HIVDR among PLHIV on Dolutegravir based regimens in Uganda	To estimate the prevalence of ADR among PLHIV receiving DTG for at least 12 months with VL non suppression,	Adults and children living with HIV receiving DTG b
Strengthening Civil Society organizations' capacity and coordination for accelerated HIV epidemic control in Uganda, through supporting the implementation of comprehensive HIV/AIDs prevention and treatment for Key Populations (KP) under the U.S President's Emergency Plan for AIDs Relief (PEPFAR)	81973	To estimate prevalence of HIV, viremia, select STI, progress towards the UANIDS 95|95|95 goals, HIV service uptake, stigma and abuse, and size estimation.	to estimate population size of FSW,MSM and PWID for national estimates; 2) To describe the risk characteristics and sero-prevalence of relevant biomarkers among KPs.	Key Pops: Not disaggregated
Hospital Based Birth Defects Surveillance in Kampala, Uganda under the President's Emergency Plan for AIDS Relief (PEPFAR)	160701	Is maternal use of dolutegravir, cotrimoxazole and other medications in early pregnancy associated with a higher risk of birth defects in newborns?	1. To conduct hospital-based surveillance of major external birth defects among all live and stillbirths delivered at four participating hospitals in Kampala 2. Identify factors associated with higher risk of major external birth defects, prematurity, and low birth weight in hospital deliveries	Pregnant women delivering in hospitals
Recency HQ Mechanism - UCSF	81976	To scale-up HIV Recency surveillance in all regions in Uganda	quality assurance for HIV recency surveillance activities	Non-Targeted Pop: Not disaggregated

SRE Tool-E tab of the Table 6 (continued)

Prime Partner	Mech ID	Additional populations studied	Planned activity sample size	Planned sampling methodology	HIV biomarkers to be assessed as part of protoc	COP or HOP funded?	Activity Start COP/FY Year	Activity End COP/FY Year	Current Stage of activity
Comprehensive HIV/AIDS Prevention, Care and Treatment in Central Uganda	160699	People without HIV	700	Participants identified among the PEPFAR clinic population, HIV negative recruited from the community	Not applicable	COP	COP16/FY17	COP26/FY27 or after	Confirmed in COP
Strengthening Civil Society organizations' capacity and coordination for accelerated HIV epidemic control in Uganda, through supporting the implementation of comprehensive HIV/AIDs prevention and treatment for Key Populations (KP) under the U.S President's Emergency Plan for AIDs Relief (PEPFAR)	81973	FSW biological children	1500	Respondent driven sampling	HIV,HPV, HVS, Syphillis	COP	COP22/FY23	COP22/FY23	Ongoing
Accelerating Epidemic Control in Fort Portal region in the Republic of Uganda under the President's Emergency Plan for AIDS Relief	18567	HIV positive children	600 health facilities, 1500 villages	Random sampling	None	COP	COP22/FY23	COP22/FY23	Proposed in COP
Strengthen Capacity of Uganda Ministry of Health and Sub-National	160702	None	NA	NA	None	COP	COP22/FY23	COP22/FY23	Proposed in COP
Strengthening Civil Society organizations' capacity and coordination for accelerated HIV epidemic control in Uganda, through supporting the implementation of comprehensive HIV/AIDs prevention and treatment for Key Populations (KP) under the U.S President's Emergency Plan for AIDs Relief (PEPFAR)	81973	FSW biological children	1500	Respondent driven sampling	HIV, HPV, Syphilis, HVS, Recer	COP	COP20/FY21	COP22/FY23	Ongoing
Accelerating Epidemic Control in Fort Portal region in the Republic of Uganda under the President's Emergency Plan for AIDS Relief (PEPFAR)	18567	HIV positive children	600 health facilities, 1500 villages	Random sampling	None	COP	COP22/FY23	COP22/FY23	Proposed in COP
Production, distribution and monitoring implementation of Rapid HIV PT, facility and site certification, HIVDR sentinel surveys, validation of emerging lab assays and lab equipment	18566	None	400	Random sampling	No	COP	COP21/FY22	COP26/FY27 or after	Ongoing
Strengthening Civil Society organizations' capacity and coordination for accelerated HIV epidemic control in Uganda, through supporting the implementation of comprehensive HIV/AIDs prevention and treatment for Key Populations (KP) under the U.S President's Emergency Plan for AIDs Relief (PEPFAR)	81973	FSW biological children	1500	Respondent driven sampling	HIV,HPV, HVS, Syphillis	COP	COP22/FY23	COP22/FY23	Ongoing
Hospital Based Birth Defects Surveillance in Kampala, Uganda under the President's Emergency Plan for AIDS Relief (PEPFAR)	160701	Infants born to women delivering in Hospitals	170,000 births	cross sectional	HIV test	COP	COP20/FY21	COP24/FY25	Ongoing
Recency HQ Mechanism - UCSF	81976	None	NA	NA	HIV test, HIV recency	COP	COP22/FY23	COP22/FY23	Ongoing

SRE Tool-E tab of the Table 6 (continued)

Prime Partner	Mech ID	COP22 Baseline Status (major)	COP22 Baseline Status (detail	How does this activity advance COP priorities?
Comprehensive HIV/AIDS Prevention, Care and Treatment in Central Uganda	160699	Data_collection	In progress	evaluate the prevalence and incidence of HIV related coinfections and comorbidities as well as the pathogenesis of these conditions
Strengthening Civil Society organizations' capacity and coordination for accelerated HIV epidemic control in Uganda, through supporting the implementation of comprehensive HIV/AIDs prevention and treatment for Key Populations (KP) under the U.S President's Emergency Plan for AIDs Relief (PEPFAR)	81973	Data_collection	In progress	improves epidemiological data for programinmg
Accelerating Epidemic Control in Fort Portal region in the Republic of Uganda under the President's Emergency Plan for AIDS Relief	18567	Data_collection	Not started	improves epidemiological data for programing and Case based surveillance
Strengthen Capacity of Uganda Ministry of Health and Sub-National	160702	Protocol_Scope	Not started	improves epidemiological data for programinmg
Strengthening Civil Society organizations' capacity and coordination for accelerated HIV epidemic control in Uganda, through supporting the implementation of comprehensive HIV/AIDs prevention and treatment for Key Populations (KP) under the U.S President's Emergency Plan for AIDs Relief (PEPFAR)	81973	Data_collection	In progress	improves epidemiological data for programinmg
Accelerating Epidemic Control in Fort Portal region in the Republic of Uganda under the President's Emergency Plan for AIDS Relief (PEPFAR)	18567	Data_collection	Not started	improves epidemiological data for programinmg and Case based surveillance
Production, distribution and monitoring implementation of Rapid HIV PT, facility and site certification, HIVDR sentinel surveys, validation of emerging lab assays and lab equipment	18566	Data_collection	In progress	Helps the program to monitor the effectiveness of DTG among PLHIV by decreasing, morbidity, mortality and HIV incidence
Strengthening Civil Society organizations' capacity and coordination for accelerated HIV epidemic control in Uganda, through supporting the implementation of comprehensive HIV/AIDs prevention and treatment for Key Populations (KP) under the U.S President's Emergency Plan for AIDs Relief (PEPFAR)	81973	Data_collection	In progress	improves epidemiological data for programinmg
Hospital Based Birth Defects Surveillance in Kampala, Uganda under the President's Emergency Plan for AIDS Relief (PEPFAR)	160701	Data_collection	In progress	Provides data on Birth defects for those on DTG compared to the general population in order to provide drug (DTG) safety data in pregnancy
Recency HQ Mechanism - UCSF	81976	Data_collection	In progress	TA mechanism provides TA to MOH to implement HIV recency testing with quality.

APPENDIX D– Minimum Program Requirements

Care and Treatment	
1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.	Completed: the 2016 version of the "Consolidated Guidelines for Prevention and Treatment of HIV in Uganda" expanded the HIV "test and start" policy to all adolescents and adults diagnosed with HIV. Uganda since then fully implemented the test and start with immediate and direct linkage of ART at community and facility level.
2) Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	In Progress: For adult care, we stay the course on ART optimization to improve viral load suppression outcomes and will improve person-centered community interventions to improve treatment continuity. We are rolling out Ped DTG currently at 12%. The plan is to optimize 100% of eligible by September 2022.
3) 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.	PEPFAR Uganda achieved 77% MMD coverage at FY22 Q1. Program monitoring data from indicate >80% MMD coverage in Q2. We are making substantial progress in MMD coverage following the MOH circular in March 2021 expanding eligibility for MMD and delinking VL testing as a pre-request for MMD. The graph on the left shows this positive trend – we achieved 77% MMD coverage at FY22 Q1 and to date, program monitoring data shows a sustained upward trajectory. In COP22, we aim to reach and maintain>90% 3+ months MMD coverage.
4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where	Completed: PEPFAR Uganda already met the Minimum requirement.

indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	The TB preventive therapy is fully integrated into HIV clinical care package at no cost to the patient. In FY2019 Uganda successfully implemented TPT campaign by reaching more than 300,000 in 90 days. The campaign helped to fully integrate TPT into HIV clinical care. Currently close to 90% PLHV on ART completed TPT, and currently the country is implementing rolling out 3HP for the remaining individuals eligible for TPT. In COP22 PEPFAR Uganda will provide 3HP for all TPT eligible clients.
5) Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	In Progress: The MOH has been leading DNO implementation, starting with designing country-specific objectives, with the aim of ensuring efficiency of the national diagnostic network. MOH, together with the different stakeholders developed the concept & conducted data collection. Data analysis for the core DNO and modeling of scenarios is currently ongoing. In COP22, we plan to pilot the developed scenarios, analyze the comprehensive DNO and implement the identified gaps in a phased approach
Case Finding	
6) 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.	The HTS program is steadily meeting the minimum program requirements: • 89% of PEPFAR supported sites implemented index testing in FY2021. PEPFAR team is working with IPs and the Ministry of health to scale implementation to 100% of PEPFAR supported sites. • There is a system in place for assessing safe and ethical delivery of index testing - 94% of sites assessed in FY21 adhered to standards for index testing delivery. • There is also a system in place for assessing IPV before and after index testing services. • System for monitoring negative outcomes from index testing and HIV self-testing is under development • Age group for index testing for exposed children was extended to under 19 years in the new policy currently under final review. • PEPFAR supported the National roll-out of HIVST in FY21. Overall, all PEPFAR

	supported sites were allocated HIVST targets. We are working with IPs to ensure sites that were not initially trained receive training and start implementation by beginning of FY22 Q3.
Prevention and OVC	
7) 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 PrEP program has had a progressive achievement against PrEP_new annual targets since FY17, with an overachievement of 127% (120,526/95,000) in FY20. •MOH updated the national PrEP guidelines to provide a favorable policy environment for PrEP service delivery among AGYW, pregnant and breast-feeding women •PrEP providers are trained to provide PrEP services according to national PrEP guidelines •In COP 22, the program will continue working with the MOH to adopt WHO guidelines for event driven PrEP for eligible persons, and injectable CAB-LA •The program will implement a multipronged approach to enhance PrEP initiation and continuity, enhance DSD models of service delivery, DIC approach and multi-month dispensing • 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
8) Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing	In progress: PEPFAR Uganda is on course with 99% of OVC beneficiaries having a known status reported to OVC partner. We are also on track with index testing for biological children of HIV+ mothers. In COP22, we periodically assess risk

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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	factors of HIV negative OVC beneficiaries and intensify index testing for biological children of HIV+ mothers and, siblings of C/ALHIV. 100% of OVC beneficiaries are linked to treatment, these effective strategies will continue to be implemented in COP22 57% of adolescent girls in high HIV-burden reached with primary prevention in FY21 Q4. In COP22, we continue using evidence-based prevention curricula for community and in-school activities
Policy & Public Health Systems Support	
9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, PEPFAR Uganda has conducted a Legal Environment Assessment (LEA) as root cause analysis to assess the extent to which the existing laws, regulations, and policies enable or constrain key protections and those affected by HIV in Uganda. With the support of MOH and CSOs PEPFAR Uganda will continue to advocate for improved KP friendly policies, legal reforms, and an enabling political environment. PEPFAR will leverage the MOH standardized curricular for training health workers in providing PLHIV/KP/PP/vulnerable populations with friendly services and integrate human rights, gender equality and stigma reduction into curriculum of institutions that train health workers, judicial officers, police officers and other relevant professionals.
10) 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.	In Uganda, there is no informal user fees within public health sector sites although within private wings of NRH/RRH and General Hospitals there is an agreed form of user fees for those clients who might not have time to go all the way in the ques. As a country there is a wider move through the Ministry of Health sector mobilization move for Universal health Coverage (leaving no one behind).

11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.	PEPFAR Uganda meets Minimum Program Requirements. MOH leads the national CQI Collaborative with strong support from PEPFAR Uganda technical experts. The country has quality improvement systems and structure in place from national level to all the way to site levels. All IPs participate in the national CQI activities.
12) Evidence of treatment literacy 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.	PEPFAR Uganda will continue to support a multipronged approach to treatment literacy through HIV messaging at all levels, the “Time Up” campaign, and through the PLHIV peer led treatment literacy program. In COP22, we will scale-up the PLHIV peer led treatment literacy program to additional districts that contribute 80 percent of the interruption in treatment burden and high viral load non-suppression rates. This program will complement the ongoing treatment literacy activities supported by implementing partners at facility and community level. We anticipate that the “Time Up” campaign will reinforce the person-centred messaging and address community stigma.
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses	PEPFAR Uganda KP program will Sub-grant $751,325 directly to KP led CSOs through Regional Mechanism to enhance KP Prevention & Clinical cascade through 3 arms of sub granting; direct funding, CSO consortiums and through program results based funding to: • KP-led indigenous civil society organizations to provide KP- centred services to improve access and utilization of services. • Conduct Organizational Capacity Assessment (OCA) to determine capacity building. • OCA will define capacity building priorities for the respective CSOs • Utilize OCA findings to determine the funding modalities.

14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	
15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	In Progress, IPs will implement lessons learnt from a community HIV Mortality Surveillance project completed in FY22 to strengthen reporting and monitoring of all-cause mortality and morbidity data at national and district levels. This is expected to improve on the performance of TX_ML indicator
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	See below detailed response.

16) Scale-up of case surveillance and unique identifiers for patients across all sites.

Since COP20, PEPFAR Uganda along with various partners including MOH, above site and site level partners have focused on a holistic, MOH-led Health Information Systems (HIS) implementation strategy leveraging the use of digital health to achieve HIV/TB epidemic control through sustainable HIS. The strategies have led to improvements in increasing the ability of various HIS solutions to support evolving program needs both at facility and community level. There has been an improvement in functionality of existing systems to support information exchange from linked systems. Examples include the EMR- viral load system, EMR- community pharmacy system, EMR- community Applications and tools among others. This is a critical step towards support for person-centered clinical services, use of data for monitoring and programmatic decision-making. This is enabled through investments in infrastructure for point of service data capture implementation, critical information technology (IT) infrastructure for network connectivity, power solutions and building a competent workforce.

Implementation of a Unique Identification (UI) strategy has continued to gain momentum with government of Uganda demonstrating significant leadership over the past year with work on a national health client registry (NHCR). This has further been evidenced by additional investments into the establishment of key enterprise architecture pieces, especially service registries such as the current work in progress on the national health facility registry (NHFR), among others. PEPFAR Uganda continues with a decentralized way of UI implementation as efforts continue to bolster policy, legal requirements, and governance for protection of privacy, confidentiality, and security of personal health information. However, this has not deterred efforts for working on key architecture pieces needed to implement the long-term vision of centralized unique identification as a service. A use-case to inform the development of a prototype client registry to support implementation of unique identification has been completed. Again, successful implementation of unique identification that will improve patient mobility as well as the patient experience critical for their retention will require connected devices and tools at the various points of service, across

the HIV continuum of care - the reason PEFAR Uganda is focusing among others to greatly invest in the necessary IT infrastructure.

To meet the COP/ROP 2022 (FY 2023) Minimum Program Requirements for scale-up of case surveillance and unique identifiers for patients across all sites, both short term and medium to long term approaches are proposed.

Short-term approach for UI implementation.

A simple, faster, reliable and secure transfer of critical data from EMR implementation sites to a central data repository on a quarterly basis (COP21 Q3 & Q4) will be undertaken so that demographic data for PLHIV in the EMR is pooled and used for deduplication. Deduplication will be carried out using fuzzy matching algorithms, indexing, blocking, algorithms, machine learning, and some strategic human input to review the results of the deduplicated database to ensure accuracy. The deduplicated database of HIV records will be used to provide an estimation of number of patients currently on treatment at PEPFAR sites with a functional EMR in Uganda. This information will be made available to program stakeholders at national, regional, district and facility levels. This activity will continue on quarterly basis until a long-term solution is finalized.

The medium to long term UI implementation approach

PEPFAR Uganda will continue towards a national, standardized registration practice for all clients within the health system with processes understood and valued by all health providers through a skilled workforce and good governance. This will require significant investment in infrastructure, including internet connectivity to support linkages across all sites for a nationally de-duplicated registry of uniquely identified PLHIV 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).

The following will be considered:

- The use of a patient identification approach will be supported by implementing a client registry or master patient index.
- Handling patient identifying information in any information system will be explicitly supported by the implementation of information security and data privacy and confidentiality controls for those systems.
- Record matching algorithms, both deterministic and probabilistic, as well as machine learning techniques will be essential tools to implement the patient matching strategy.

Overall, towards a successful HIS strategy that builds on earlier investments, the following will be prioritized, and most are a continuation of earlier COP investments.

Person-centered systems

The objective will be to increase the ability of health information systems (HIS) to support high-quality patient-centered services, data quality, and subsequent use at all levels to achieve current and emerging health sector objectives. Focus will be on continuing to improve information systems to support clinical, community, and prevention settings and a point of service data capture approach will be scaled further. Priority systems include, EMRs Community HIS, Lab systems, Logistics systems, HMIS among others. The digital solutions will be used to improve linkages, retention, and viral suppression through high quality patient centered care.

Investing in critical HIS infrastructure

Getting the right information at the right time for the right person in the right format, securely, critical IT and other infrastructure are very important. HIV care service mobility success depends on strong network connections. Connectedness of HIS solutions is critical for improved care experience but also for addressing non-documented self-referrals between care sites which is greatly responsible for duplications, IIT and retention issues.

- A centralized procurement approach will be used to acquire and equip participating health facilities.
- This will lower the overall cost of acquisition resulting from economies of scale and promotion of IT standards for more robust and resilient choices.
- This approach helps to define costing tiers for EMR systems with point of service data capture for all key health services
- Infrastructure to be considered will include data capture devices to support point of service data capture, network connectivity (WiFi or hardwired connections) and power solutions.

HIS Workforce

In order to support PEPFAR and MOH to implement various systems that are the building blocks of the national Enterprise Architecture, ranging from facility and community required across the entire HIV/AID and TB continuum of care and others expected to leverage such investments like the Global Health Security (GHS), COVID-19 systems, there is a need to have a strategy for a skilled and adequate staffing to support the demands of the various HIS and other health domains. Workforce development and continuous capacity building at all levels is a key focus. The MOH HIS Strategy 2021-2025 emphasizes this as an important strategic objective.

- Engage global technical partners/subject matter experts to provide technical assistance, mentorship, and support in the design, development, and implementation of key HIS components.
- Strengthen collaborations between experienced above site partners' critical HIS staff and other experts into MoH- DHI and RRHs to build the capacity of the MOH staff to provide continuous improvements moving forward

- Increase collaborations between much experienced above site HIS partners and site level partners/teams on various HIS solutions projects to create a pool of competent teams capable of designing and managing solutions
- Build capacity to maintain HIS infrastructure by establishing an Informatics lab to provide day-to-day testing of hardware solutions, expertise, and technical support to the implementation of digital health initiatives that will be positioned under MOH/School of Public Health
- Continue with the local MOH led- Building Uganda Health Informatics Capacity (BUHIC)initiative that uses both in house trainings as well virtual platforms for capacity building
- Work with MOH and partners to develop data use toolkits to provide step-by-step guidance to HCWs at all levels on how to utilize HIV data for decision-making.
- Develop and expand the cadre of data use mentors to boost data management capacity within site level partners and MOH staff.

Central Data Strategies

To address and break down inaccessibility silos and solve the “data all over the place” problem, as well as create a single authoritative source/system of record for all critical HIV/TB prevention, care and treatment data and make it available to all stakeholders, PEPFAR Uganda will focus on centralizing data. Much focus is going to be placed on centralized data infrastructure for collecting, processing, and storing data. The intention is to ensure that data from multiple sources like EMRs, LIS, Lab, and community HIS is made accessible to and usable for all critical partners through self-service assets like analytics and visualization tools. This will empower all decision makers to make informed decisions towards epidemic control. The planning will also cater for increased use of data from multiple health-related information systems to improve programmatic impact:

- Approaches will entail using best approaches for protection of personal identity
- Local data protection regulations and standards will be followed to minimize abuse and misuse of sensitive personal data
- Ensure data security, privacy, integrity, quality, regulatory compliance, and governance
- Flexible data centralization approaches like Extract, Load and Transform (ELT) will be used and will optimize data extraction, standardization, storage, and access
- Data hosting platforms will be MOH approved and governed
- HIE and data integration will be central.

Governance and policy.

All HIS activities will be aligned with the national digital health strategies in support of national health strategies. PEPFAR Uganda and its partners will work closely with the Health Information Management Division (DHI), the AIDS control program (ACP) and other relevant departments within MOH. Critical areas of success will include:

- Joint planning and development of areas of support with clear deliverables and timelines. Strengthen the collaboration and governance framework for HIS including the finalizations of critical governance documents, guideline and standardized terminologies and data exchange formats, operating procedures critical for implementation of the various PEPFAR supported systems as well as other system for COVID-19 and GHS that are expected to leverage PEPFAR investment.
- Engagement of the relevant divisions in MOH on the agreement of the implementation of HIS solutions
- Putting in place data access, use, and sharing guidelines
- Data and systems confidentiality, privacy, and security

Global Partnerships

PEPFAR Uganda will engage and collaborate with global HIS technical leaders and subject matter experts in the areas of data integration, centralization and technical document writing, as this is crucial for local capacity building and involves empowering Ugandan teams both within PEPFAR and MOH as well as other critical stakeholders. The focus will be on hands on skills, knowledge, tools, and other resources needed to reach their goals. This will strengthen skills in Uganda.

These partnerships will also create avenues and platforms for collaboration with various communities of practice to learn, share expertise, and work together on solving common HIS technical problems. Additionally, partnerships will promote local professionals to work together to identify and leverage best practices and standards, collaborative efforts and sharing of lessons learned in the community.

NEW APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

1. Misalignments between Investments and Outcomes

- ***Program Expenditures vs. SID Score Trends and Responsibility Ratings:***

In COP22, PEPFAR Uganda will continue to focus on implementing a sustainable approach to epidemic control and will work with the GOU to emphasize investments and interventions that address the SID domain/elements whose SID scores are low or not improving. Forging a sustainable approach will involve engagement with the GOU Ministries, Department and Agencies (MDAs) for harmonization of approaches and begin to discuss GOU fiscal/functional responsibilities for sustainability.

Uganda has not received a red score in any element, since SID collection began in 2015. Three elements have remained green over all SID years; 10 (59%) elements scored yellow in 2021; 4 elements have consistently scored yellow over all SID years; 6 elements declined from green to yellow in 2021, including service delivery, supply chain, and lab; and 1 element (10 - laboratory) was dark green in 2019 and declined to yellow in 2021.

Both the SID and RM provide insights in the fiscal and functional responsibilities readiness for the GOU entities in taking on the transition of the current program investments. These tools will continue to inform PEPFAR Uganda and other stakeholders that provide support to the HIV/AIDS program interventions for sustainability. To reach the remaining PLHIV, PEPFAR Uganda will maintain key senior advisor positions at the MOH to increase the MOH technical capacity to review and develop key policies to facilitate implementation of high impact interventions for the attainment of 95/95/95 targets.

Beginning with COP22, the above site investments will focus on the SID scores that are lagging including the lab systems, commodity security and supply chain and assure these areas are moving toward GOU having primary responsibility in most areas. Areas that have consistently scored dark green like governance/leadership will work toward building local capacity and transitioning primary responsibility. An example is the RRH strategy that will focus to strengthen local capacity for oversight and leadership and transition to greater ownership.

Figure E.1.2. Percent Primary Responsibility Ratings from Responsibility Matrix

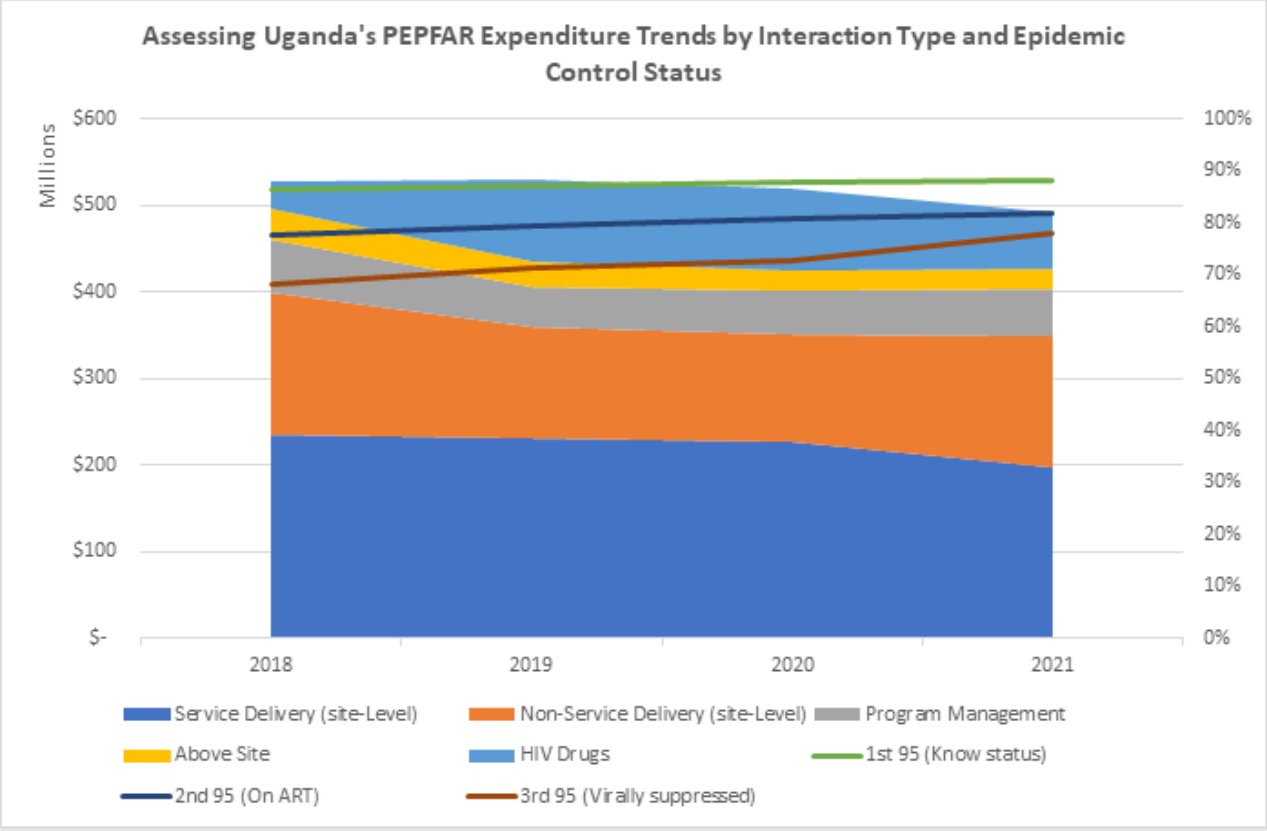
% Primary Responsibility Ratings from Responsibility Matrix			
Health Systems Area	**Host Country**	**PEPFAR**	**Global Fund**
HMIS	100%	40%	0%
Laboratory Systems	79%	50%	7%
Supply Chain	94%	100%	50%
HRH Systems	100%	0%	0%
Policy	100%	0%	0%
Health Financing	50%	50%	0%
Other Systems Support	100%	0%	0%
Health Workforce	69%	0%	0%

- ***Trajectory of Service Delivery, Commodities, Non-Service Delivery, Above Site Program, and Program Management Expenditures and Country's Status of Achieving HIV/AIDS Epidemic Control:***

Figure E.1.3 below demonstrates spending trends in service delivery, commodities, non-service delivery, above site program, and program management alongside Uganda's status of HIV/AIDS epidemic control (first, second and third 95) from 2018 to 2021. As Uganda moves toward epidemic control, we see efficiencies have been found in service delivery and currently savings from these efficiencies have been used to scale up investments in health information systems and other above site non-service delivery investments that will move the country toward sustainability. PEPFAR Uganda anticipates that in coming years as Uganda reaches epidemic control and response programs mature to a level needed to sustain their

achievements, the overall level of NSD spending (on activities such as training, supportive supervision, mentorship, etc.) will decrease. Uganda has invested in more efficient approaches to trainings and mentorship through ECHO zoom platform which should also realize savings in coming years.

Figure E.1.3. Assessing PEPFAR Uganda Expenditure Trends by Interaction Type and Epidemic Control Status



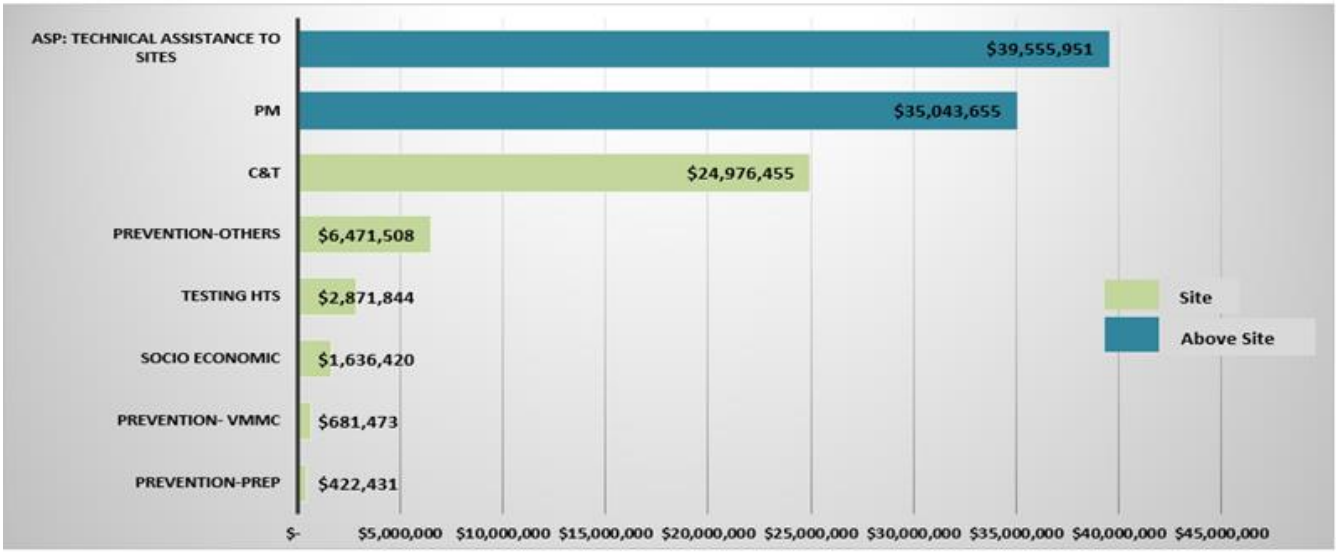
- ***HRH Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery:***

PEPFAR supports around 27,000 health workers through its implementing partners with 40% of the total footprint being lay community health workers. The health workforce is aligned to PEPFAR program areas and burden with 55% supporting care and treatment, 22% prevention, 11% above site 9% program management and 3% social economic activities.

In FY21, the PEPFAR HRH investment cost $112 million. Out of the total HRH investment, close to 70% supported direct service (SD) and non-service delivery (NSD)/Technical assistance (TA) activities at site level (see Figure E.1.4). The TA to sites involved IP staff at cluster and regional offices providing mentorship, supervision, quality assurance (QA)/quality

improvement (QI) and performance monitoring to improve program implementation and provision of quality HIV/TB services.

Figure E.1.4. Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery



Source: HRH inventory

For sustainability of HIV/AIDS programming, there is need for additional staff recruitment and transitioning key PEPFAR-supported HRH to GOU. However, limited wage allocation and restrictive staffing norms limit the number of positions and the cadre range for recruitment/transitioning PEPFAR HRH to manage the epidemic. PEPFAR is supporting advocacy for increased wage allocation and remuneration for the work force and the revision of staffing norms to ensure availability of adequate HCW numbers and skills mix to sustainably manage HIV and TB services. Focus will also be put on completion of the community health extension workers (CHEWS) pilot and supporting GOU to institutionalize the CHEWS cadre as an avenue for transitioning PEPFAR community health workforce for sustainable community HIV/AIDS service delivery.

2. Areas for Transition

Supply Chain

On January 20th, 2022 the GOU launched the 10-Year Health Supply Chain Road Map for the period 2021/22 to 2031/32. The roadmap seeks to strengthen the capacity of the GOU's ministries, departments, and agencies (MDAs) to plan, finance, and effectively manage the national health commodities supply chain priority areas independent of donor support. This is aligned with Government of Uganda's Vision 2040 and 3rd National Development Plan that both seek to make Uganda more self-reliant as the country progresses to a middle-income status. The road map articulates a plan, process, and transition as an exit strategy from donor reliance with more than 70% of public sector funding for essential medicines and health supplies in Uganda coming from donors. The road map presents the short-, medium- and long-term investment needs of Uganda's national health supply chain system over the next 10 years with the aim of ensuring sustainability of development outcomes of the health supply chain. Aligned

with the goal and objectives of the National Health Policy III (2021) and National Pharmaceutical Services Strategic Plan (2020/2021 – 2024/2025), the eight core thematic areas of the road map include (1) health commodities supply chain management; (2) human resources for health supply chain; (3) health commodities infrastructure, warehousing, storage, and distribution; (4) health commodities quality and waste management; (5) health supply chain information systems; (6) public-private partnerships for health supply chain; (7) resource mobilization and financing of the health supply chain; (8) health supply chain policy and governance.

The development of this 10-year health supply chain road map was coordinated by the Office of the Prime Minister under a *One-Government* approach. The MDAs involved included: Ministry of Health; Ministry of Finance, Planning, and Economic Development; Ministry of Local Government; Ministry of Information and Communications Technology and National Guidance; Ministry of Energy and Mineral Development; Ministry of Public Service; National Medical Stores (NMS); National Drug Authority; National Planning Authority; and the National Information Technology Authority-Uganda. Several development partners contributed including, United States Agency for International Development, CDC, UNICEF, United Nations Population Fund, United Nations Refugee Agency, Global Fund.

The developers of the road map propose and remain committed to follow through its implementation under the One-Government, multi-sectoral collaboration, leadership, and ownership, with each MDA taking specific roles and responsibilities in the road map implementation using resources appropriated by the GOU and with support from development partners, albeit in a decreasing manner. The road map envisages that the GOU will enhance its domestic resource mobilization as well as streamline private sector participation and financing as donor input reduces over the 10-year period and established specific line items in the GOU budget through which the transition would occur. In this spirit, private sector and civil society organizations are equally key in the implementation of this road map.

PEPFAR contributed to the key progress made in Uganda's health supply chain. HIV/AIDS and TB medicines are now ordered through web-enabled ordering systems that improve turn-around time as well as more accurate data transmission. Likewise, an automated notification system for deliveries is now in place to strengthen accountability. NMS has undertaken the development of an enterprise resource planning system (ERP) with joint GOU and U.S. government support. JMS is already receiving similar significant support for the same from the U.S. government to strengthen alternative channels and the PNFP sector.

Regional Referral Hospitals (RRH) and HRH

The MOH recognized that the number of local governments in Uganda were increasing each year and yet the MOH technical capabilities were not correspondingly changing to match their constitutional mandates of providing oversight, supportive supervision, and performance monitoring of the HIV/AIDS programs and other health related programs. From the public sector domain, the RRHs are mandated through the National Health Policy III, the amended 1995 constitution, and the Local Government Act to fill in this gap. The MOH's long-term vision for RRHs in this National Policy is to ensure that RRHs will not only be centers for tertiary and specialized care, but also hubs for skills transfer. In addition, the HIV program relies on RRHs to provide above-site functions for CQI, capacity building, and laboratory services, while using a hub-spoke approach. As indicated earlier, the joint assessment team identified key barriers that

need to be addressed to facilitate RRHs to fulfill their core mandate and reach the MOH vision. The barriers include insufficient financing to carry out their oversight roles, inadequate organizational technical capacity, finance and budget management, and inadequate HRH and infrastructure.

PEPFAR is working with MOH and MOFPED, and other key GOU entities to address some of these barriers so that RRHs can provide effective leadership for the public health response which will facilitate HIV and TB epidemic control.

Baseline assessments identified barriers and PEPFAR has supported MOH to develop policy guideline development around CQI, HRH, lab, and supervision. PEPFAR Uganda has seconded key HRH to the RRHs and are strengthening their financial and organizational management. In COP 22 we plan to work with all 17 RRHs, operating as centers of excellence and hubs for strengthening decentralized technical assistance for HIV services.

Our expectation is that by addressing these barriers and building capacity of the RRH in areas like CQI, lab, HIS, training infrastructure, and financial management, RRH will take up more technical assistance responsibility in their regions and the roles of IPs for wrap around technical assistance will decrease over the years.

Laboratory Systems

For greater domestic ownership and sustainability of the gains made in the laboratory sector, the National Health Laboratory and Diagnostic Services (NHLDS) department of the MOH will provide leadership and operationalize the RRH strategy for leadership and technical oversight. It will build the RRH capacity to implement the RRH strategy, which will strengthen the delegated MOH public health functions and service delivery. The NHLDS is responsible for leadership, coordination, and development of laboratory policies, strategic plans, guidelines, and to streamline institutional integration and monitor implementation of the laboratory strategic plan 2021-2025. It is required to provide oversight of the integrated sample transport network, optimize the diagnostic network for testing for viral load, early infant diagnosis and advanced HIV disease, oversee laboratory information management systems, the bio risk/biosafety management and equipment maintenance programs. PEPFAR Uganda will support the MOH strategy to raise domestic resources and consolidate laboratory related resources as applicable through NHLDS in a phased approach to strengthen laboratory services at national, sub-national, and district levels, and thus effectively utilize resources according to the National Health Laboratory Policy and Strategic Plan (SP 2021-2025). All PEPFAR implementing partners that support laboratory services will implement through the NHLDS for technical oversight and guidance while executing their funded priorities. This will ensure seamless provision of a country-led timely, accurate and reliable HIV and TB testing, to meet diagnostic, prevention treatment monitoring, surveillance, and disease control program needs with minimal duplication of resources.

The Sustainable Index Dashboard (SID) 2021, revealed that committed funding from GOU, GF and PEPFAR was at 63% out of which 8% was GOU contribution. About 37% of laboratory quantification was unfunded priorities, and there is an over reliance on partners for funding

laboratory network functions. PEPFAR Uganda will support implementation of laboratory schemes of service, advocate for increased funding for laboratory services, availability of adequate laboratorians (in both skill set and numbers), better infrastructure, and adequate testing supplies and commodities for HIV/TB to reach epidemic control. In addition, PEPFAR will provide support to NHLDS to build strong partnerships with the Global Fund, WHO, bilateral and multilateral partners. Plus, work to reduce resource duplication and ensure appropriate resource utilization and accountability. The NHLDS is working to roll out cost recovery measures for laboratory services utilizing established infrastructure for staff equipment calibration and biosafety cabinet servicing under mutually acceptable PEPFAR (USG) and GOU terms of reference.

Increasing the number of GOU's skilled laboratory healthcare workforce according to laboratory workload indicator needs assessment is critical to ensuring accessible and sustainable HIV/TB services. The SID 2021 health systems strengthening index attributed to staffing reduced from 4.61 to 3.81, due to the laboratory health care workforce not keeping pace with the increased demands and complexity of the testing landscape in Uganda. These challenges are as a result of the delayed laboratory restructuring to create additional positions commensurate with laboratory cadres' skill sets required for service delivery. This is anticipated to negatively impact the broader HIV/TB service delivery, especially at the RHHs which are not keeping a corresponding pace in increasing their staffing and technical capacities to match the yearly increase in newly constituted local government entities.

HRH

PEPFAR Uganda supports the establishment of iHRIS system with a central coordination unit at MOH, infrastructure, and trained staff to manage the system at all levels. GOU progressively increases responsibility for the management of the system. Over the next 2 -3 years, PEPFAR aims at supporting the system to become interoperable with other HI systems (e.g., DHIS2), and fully financed and managed by GOU.

Additionally, PEPFAR builds the capacity of institutions and districts to effectively manage performance and productivity of health workers. PEPFAR supported the development and roll of performance management guidelines, functionalization of rewards and sanctions committee, and staff attendance to duty tracking. Sufficient capacity is incorporated among the public health managers at all levels to progressively take over this role.

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

Throughout the consultation process for COP22, including the External Stakeholder Meeting, PEPFAR Uganda has engaged with GOU, civil society, and other development partners to define areas for potential sustainability of epidemic control discussions. While those discussions will continue across all TWGs in the coming years, PEPFAR Uganda identified specific activities to initiate sustainability strategic discussions.

PEPFAR Uganda used Table Six to program above site activities that will strengthen, and fill identified gaps and address barriers improving the capacity and quality of services provided by the GOU. However, according to the RM, there are remaining elements of the core program which PEPFAR has primary responsibility (strategic information, laboratory services, supply chain, human resources for health, health financing, etc.). In the upcoming year, the country will develop a transparent multi-staged plan established through an inclusive process with all stakeholders to effectively achieve epidemic control and pivot to a sustaining HIV impact.

PEPFAR will use lessons learned and best practices from the 10 Year Health Supply Chain Road Map 2022 process to build on the key activities and processes for the creation of the epidemic control sustainability road map.

Moving forward, PEPFAR Uganda is convening an interagency sustainability technical working group that will work through the PEPFAR Coordination Office. Critical first tasks of the group will be to identify appropriate secretariat and determining which GOU entity will serve to coordinate the inter-ministerial taskforce. The identified secretariat will rely heavily on the lessons learned from the development of the 10- Year Roadmap process for Government of Uganda's Health Supply Chain. Once the secretariat and coordinating unit are identified, additional considerations for discussion include consideration of definitions, identification of all stakeholders and their roles and responsibilities, time horizon, goal and objectives, guiding principles and values, assumptions, disparities and challenges and finally how we will monitor and adjust course. Stakeholders are a critical piece since donors, civil society, local partners, as well as private sector are essential alongside the national, sub national, and local government. Maintaining open and transparent communication with all stakeholders will be imperative to the process.

As noted in COP guidance, specific objectives for sustaining epidemic control will include increasing the capacity of GOU to assume greater functional and financial leadership of the HIV program; creating a transparent planning process with clear benchmarks to determine readiness for GOU to assume responsibility for both activities and eventually budgets; creating partnerships with other key stakeholders outlining responsibilities for transitions and establishing specific parameters for multi-year investments necessary to ensure a successful transition process and outcomes; creating a process to monitor progress as well as a contingency plan for unexpected challenges, barriers, or events so it acts as a safety net to protect against program corrosion. Updates on conversations and process will be provided during PEPFAR Uganda's quarterly POART calls.

4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting).

High data quality and improved data use at multiple levels of the health system is a key priority for PEFPAR Uganda currently, in COP22, and beyond. Significant progress was made in data alignment between PEPFAR and MOH data systems, including routine detailed indicator mapping, site list reconciliation, and harmonization of reporting processes. Many required

PEPFAR data elements are available in national health information systems including DHIS2 and serve as source data for PEPFAR reporting needs. Health information systems investments in interoperability and data integration will continue to streamline and improve data alignment goals and create efficiencies in Uganda. Focus on data visualization and data use for decision making through routine monitoring platforms and tools will continue to be prioritized in COP22. Data Quality Assessments (DQAs) are jointly conducted with the USG, MOH, and implementing partners to ensure data quality standards are met for priority indicators, results communicated to all stakeholders, and corrective action plans for issues identified collaboratively developed and implemented.

Beyond aggregate indicator reporting, partnerships at local levels have improved data use and will continue to be prioritized. District led programming aims to enhance capacities of district health management teams to more effectively and efficiently manage the decentralized HIV response. Routine data use at local levels is critical for reaching and sustaining epidemic control, as well as program ownership.

USG-funded surveys, surveillance, and program evaluation activities maintain strong MOH leadership. Technical working groups on subnational estimation, including the annual Spectrum process, recency surveillance, and the UPHIA 2020 survey, are chaired by the MOH. The MOH is critical to the development of the draft recency public health response plan, ensuring surveillance data is appropriately used and triangulated with other sources for rapid program response. Completion and dissemination of critical population-based surveys like UPHIA 2020 enabled the availability of rigorous data to inform program planning and strategic directions for epidemic control. MOH is critical in the implementation of key PEPFAR-funded cohort studies, such as the African Cohort Study (AFRICOS), which is a large, long-term cohort study at multiple African sites which evaluates HIV prevention, care, and treatment services. Uganda is one of the participating countries in AFRICOS and instrumental in studying long-term outcomes, such as time to progression to AIDS and mortality; clinical information on viral suppression, persistent low-level viremia, and drug resistance; and noninfectious comorbidities (NCDs), including cardiovascular risk factors, cognitive impairment, depression, and cervical cancer. AFRICOS findings impact HIV policy and PEPFAR programming, including evidence-based ART recommendations, multi-month dispensing, and overall clinical management guidelines.