

UGANDA

COUNTRY/REGIONAL OPERATIONAL PLAN 2016 STRATEGIC DIRECTION SUMMARY



January 18, 2017

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Goal Statement

The PEPFAR Uganda program has evolved considerably since the 2012 pivot, placing Uganda on a positive trajectory towards the 90-90-90 goals and epidemic control. By the end of FY16, PEPFAR Uganda will have identified 82% of PLHIV, reached 77% Anti-Retroviral Therapy (ART) coverage, and achieved an estimated 90% viral suppression of PLHIV receiving a viral load test.

Given these already high percentages, Test and Start will be applied to reach the “last mile”: targeting hard-to-reach patients with high-impact combination prevention interventions, while simultaneously strengthening the health system by investing in human resources and health financing.

The Government of Uganda (GOU) has provided verbal commitment to begin Test and Start in October, 2016. Implementation will commence once PEPFAR and the Ministry of Health (MOH) have instituted supply chain reforms to improve procurement, warehousing, and distribution systems; provided verification/internal controls on PEPFAR-funded commodities; and, identified a plan to reduce waste and ensure the availability of high-quality drugs to all patients.

To increase care efficiency and maximize resources, PEPFAR will focus on new service delivery models that reduce the number of clinical and lab visits, and provide patients with additional months of ARVs. These changes will allow healthcare workers to focus more attention on patients who are ill or newly initiated on ART. They will also reduce the amount of time stable patients will need for traveling to health facilities.

In COP15, PEPFAR shifted focus to the highest-burden and highest-yield districts. In COP16, PEPFAR will initiate 310,364 new ART clients with 82% falling in scale-up districts. Of these, 113,197 will be pre-ART patients who will be initiated on treatment under Test and Start. In FY17, with this increase in PLHIV on treatment, Uganda will achieve a national coverage of 81%.

In the scale-up districts, initiating a facility-based HIV counseling and testing approach will increase numbers of PLHIV on ART. Additionally, PEPFAR will apply innovative interventions to identify and link the following populations to services: pregnant women, adolescent girls, discordant couples, key and priority populations (KP/PP), and HIV/TB, and HIV/HBV co-infected. New tools to target men will be tested, scaled-up, and tailored to specific social and economic circumstances.

The goal of achieving 90% sustained viral suppression will be addressed through aggressive scale-up of viral load testing and additional facility and community investments in adherence and retention. These activities will improve time-to-initiation and minimize patient loss-to-follow-up.

PEPFAR has dramatically increased the number of voluntary medical male circumcisions since COP13. However, 4.1 million men above the age of 15 years and additionally, 10 to 14 year old boys remain uncircumcised. PEPFAR will support an additional 657,382 circumcisions in COP16 contributing to national circumcision coverage of 49%.

For KP/PP, condom promotion and access will be enhanced through increased numbers of dispensers in hotspots and areas of high-risk sexual activities. PEPFAR will continue to support training that addresses stigma and discrimination against LGBT. Peer networks will also be strengthened to identify PLHIV for Test and Start while protecting privacy.

The OVC program will target 430,464 beneficiaries. Because adolescent girls account for 66% of new HIV infections in Uganda, OVC and prevention interventions will give special attention to this population in all 61 scale-up districts. DREAMS remains focused in the 10 selected districts. Lessons learned and evidence based programming informed by DREAMS implementation will be used to improve prevention programming targeting Adolescents Girls and Young Women (AGYW) in non-DREAMS districts.

This COP was developed in consultation with the Government of Uganda, Global Fund, AIDS development partners, and civil society organizations. Areas of engagement are at the political, policy, and technical levels.

The COP16 activities lay the groundwork for achieving the 90-90-90 goals in COP17.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden, and country or regional profile

The population of Uganda is 35,660,500 (Census 2014). Population growth is 3%/year, one of the fastest in the world. The median age will be 15 by 2017. Uganda's GNI per capita is US\$670 (World Bank). The percentage of GNI spent on HIV response and/or the health sector is not available.

Uganda has an estimated 1,502,885 PLHIV, and expected to increase to 1,602,389 in 2017. In 2015, the estimated CLHIV ≤ 14 years-old was 147,394, approximately 10% of all PLHIV. The estimated incidence rate is 0.3% and HIV prevalence is 7.3% (AIS survey, 2011). Half of Uganda's 112 districts have prevalence above the national average. The prevalence in the highest district is approximately 29%. Wide geographic variation exists in adult HIV burden due to population density and social norms.

Prevalence is higher in women (8.3%) than men (6.1%). Heterosexual transmission is predominant, accounting for 75-80% of new infections. Strikingly, 35% of new infections occur among self-reported monogamous individuals, indicating concurrent partnerships, extra-marital relations, and transactional, early, and cross-generational sex.

AIDS is the major cause of death among adolescents. Prevalence is higher among young women aged 20-24 than young men (7.1% vs. 2.8%). Prevalence among 15-19 year old AGYW is 3%. One in four girls 15-19 has begun child bearing, 31% of girls drop out of primary school to marry, and 21% drop out of due to pregnancy. Only five out of 100 girls who start primary school are able to complete secondary education.

Prevalence for all forms of TB is 253 cases per 100,000 population (TB prevalence survey, 2015). Bacteriologically confirmed TB was more prevalent in men than women (76.2% vs. 23.8%). TB prevalence among children is 7.8 % (national program data). The TB/HIV co-infection prevalence is 48% (national program data). Approximately 95% of TB patients know their HIV status.

Twenty-seven districts have identified hotspots of key and priority populations, including MSM, fishing communities, and sex workers. No national estimate for MSM exists. MSM in Kampala are estimated at 5,428 with 13.7% HIV prevalence. MSMs are highly stigmatized within a legal and policy environment that inhibits non-discriminatory service delivery.

In fishing communities around Lake Victoria and other lake systems, HIV prevalence ranges between 14.9% and 35%. Most of the estimated 200,000 fisher folk are mobile or migratory. Social structures that constrain sexual behavior in home communities may not apply in the context of fishing camps or ports.

The number of Ugandan female sex workers (FSW) is estimated at 192,000, with significant regional variations. HIV prevalence is estimated between 33% and 37%. An estimated 16% of new infections are attributed to FSW, their clients, and clients' partners. Sex work is illegal in Uganda therefore creating challenges in providing services.

Uganda has an estimated 109,160 uniformed military personnel. HIV prevalence is estimated at 10% in the police. Programmatic data estimates the HIV prevalence to be up to three times the national prevalence in the military. Accurate prevalence estimates are not available, however there are efforts being made to conduct a sexual behavior and prevalence study to obtain this data. The military are a

mobile population with deployment away from their homes, and this population sometimes engages in high-risk sexual behavior. With such a high estimated prevalence, they are a significant driver of the HIV epidemic.

HIV prevalence among the 42,000 prison inmates is 15%. The most commonly reported HIV-related risk behavior was MSM activity (consensual and coerced) and sharing of razors. While some prison institutions have at least one health care provider and offer HIV care, prisons are not permitted to distribute condoms, lubricants, or sterile equipment.

Uganda is on course to achieve the 90-90-90 goals. In FY16, PEPFAR estimates 82% of PLHIV will have been diagnosed and 77% will be on ART. By FY17, national ART coverage should rise to 80%, assuming achievement of FY16 and FY17 treatment targets. However, the GOU will need to implement Test and Start policy, and the current commodities shortage will need to be resolved.

Pediatric ART coverage has improved from 22% (2013) to 41% (2015). Coverage for HIV+ pregnant mothers identified at ante-natal care (ANC) clinics receiving ARVs increased from 67% (FY12) to 92% (FY15).

Uganda has circumcised more than 2.5 million males as of APR15. However, 6.3 million men and boys 10+-14 years old remain to be circumcised.

In FY16, PEPFAR Uganda supported a PrEP demonstration project in a DREAMS district among AGYW aged 18-24 engaged in sex work. In FY17, Uganda will expand PrEP as part of combination prevention at three additional sites. PrEP will be implemented in a phased approach and rolled out based on lessons learned. See PrEP annex for more details.

Increasingly, PEPFAR partners are successfully targeting KPs using the peer model in community outreach and hotspots. Partners are implementing Test and Start with KPs.

HIV epidemiological data in Uganda dated with the 2011 AIS based on samples obtained in 2010. Unpublished evidence indicates that pooled Enzyme Immunoassay (EIA) prevalence estimates have overestimated the number of PLHIV by at least 0.5%, contributing to the difficulty in finding new PLHIVs. Actual achievements towards 90-90-90 goals may have been underestimated. An HIV Population Impact Survey (PHIA) is being conducted this year. Data will be available in early 2017.

Table 1.1.1 Key National Demographic and Epidemiological Data

	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	35,660,500		9,452,697	26.2	8,955,039	24.8	9,082,003	25.2	8,603,861	23.8	Population projection 2 UBOS, 2015
Prevalence (%)		7.3		N/A		N/A		8.2		6.1	AIS, 2011 (15+ 15-59 was used)
AIDS Deaths (per year)	33,000		N/A		N/A		N/A		N/A		Spectrum projections 2014
PLHIV	1,502,885										Burden tables: MOH DHIS2, AIS 2011, 2014 Census
Incidence Rate (Yr.)		0.3		N/A		N/A		N/A		N/A	Burden tables
New Infections (Yr.)	100,000										Spectrum projections, 2014
Annual Births	1,804,680										MOH, UNICEF
% >= 1 ANC Visit	1,696,399										MOH DHIS2, FY2015
Pregnant Women Needing ARVs	110,268										Treatment cascade
Orphans (maternal, paternal, and double)	2,700,000										UNICEF, 2013
TB Cases (Yr.)	43,883										WHO, 2014
TB/HIV Co-infection	19,612										WHO, 2014
Males Circumcised	740,079	66.5			259,664	35.0			480,415	65.0	MOH DHIS2, FY2015

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment, and viral suppression (12 months)									
			HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART			
	Total Population Size Estimate	HIV Prevalence	Total PLHIV	On ART	Retained on ART 12 Months	Viral Suppression 12 Months	Tested for HIV	Diagnosed HIV Positive	Initiated on ART
	(#)	(%)	(#)	(#)	(#)		(#)	(#)	(#)
Total population	35,660,500	7.30%	1,403,103	742,537	153,293	135,769	8,511,752	260,706	167,721
Population less than 15 years	18,186,855	0.71%	138,435	56,837	12,032	11,156	927,568	12,068	13,124
Pregnant women	1,783,025	7.35%	131,325	83,150	18,616	2,878	1,626,134	41,701	4,608
MSM	11,573	13.7%							
FSW	192,233	33.0%							
PWID	N/A	N/A							
Prisoners	37,520	12%							
Fisher folk	1,600,000	14 – 20%							
Military	75,000	ND	ND	8,217	ND	ND	ND	ND	ND
Uniformed Police	44,760	10.0%							

Source data: UAIS, 2011; PEPFAR APR 15 (DHIS2 and DATIIM)

Populate the population size estimate; prevalence and total PLHIV using the data pack

For HIV treatment and suppression plus testing and linkage use APR 15

Crane Study, 2013

Uganda Prisons Service, 2015

Uganda Fisheries and Conservation Association, 2014; Makerere School of Public Health, MOH

SPEAR, 2015

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

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

1.2 Investment Profile

Uganda continues to depend on external donors to finance basic social services. While the health sector budget has increased nominally, the percentage of the budget for health has decreased from 9.6% in 2009/10 to 8.7% in 2013/14 - below the Abuja Declaration target of 15%.¹ Nearly 90% of funding for Uganda's HIV response came from AIDS Development Partners (ADP) between 2007 and 2013. During this period, PEPFAR was the single largest contributor providing:

- 78% of the total national spending;
- 87% of the spending by international development partners; and
- 94% of funding from bilateral donors to the national response.²

Many bilateral partners have reduced or eliminated support to the HIV response, preferring to contribute to the Global Fund (GF). The COP16 SID highlighted domestic financing as “unsustainable.” Donors, including the U.S., will be working more closely with the Government of Uganda to advocate for increased health financing in their annual budget for its national HIV/AIDS response. Greater domestic health financing, in light of reduction in bilateral partners, will benefit the country's ability to sustain the impressive progress made over the years towards epidemic control.

In the public sector, the HIV response is largely funded by Government of Uganda (GOU) and GF. More than 90% of funding from GF is to procure HIV/AIDS commodities. In 2015, low ARV stock levels were observed in the public sector, leading GF to front load Year 2 ARV stocks into Year 1. GOU has estimated a commodity funding gap for ARVs in the public sector of \$55 million from Jul 2016 - Jun 2017 and an additional \$58 million gap from Jul 2017 - Dec 2017. Despite an increase in the GOU commitment for ARV procurement from \$10 million in FY 15/16 to \$28.5 million in FY 16/17, the domestic resource base is insufficient to fill commodity funding gaps in the immediate future. In addition, GOU procures anti-retroviral drugs at significantly higher prices on the local market compared to international price benchmarks further decreasing effective availability of supplies and value for money.

PEPFAR has commenced discussions to initiate short-term procurement of ARV commodities worth \$8.6 million for July 2016 to December 2016 in order to avert potential stock outs in the public sector, and an additional \$11.5 million in COP16 to contribute to the gap fill. An application for a Global Fund cost extension covering Jul-Dec 2017 is expected to be approved to cover \$26 million of the ARV gap. GF investments in ARVs can be improved by negotiating down the high PSM rates requested by GOU in the application. Despite these investments, the commodity gap will remain at \$67 million for Jul 16-Dec 17. See table below.

GOU Projected Public Sector Gap								
	Jul-16	Oct-16	Jan-17	Apr-17	Jul-17	Oct-17	Jan-18	TOTAL
Total Need (adjusted for stock on hand)		\$83,735,980			\$72,592,565			\$156,328,545
GOU Commitment		\$28,486,551			\$14,243,275			\$42,729,826
Total GAP		\$55,249,429			\$32,325,311			\$113,598,719
GF Costed Extension					\$26,023,979			\$26,023,979
PEPFAR (COP15)	\$8,633,814							\$8,633,814
PEPFAR (COP16)		\$11,496,318						\$11,496,318
GAP after GF & PEPFAR contribution		\$35,119,297			\$32,325,311			\$67,444,608

GOU, AIDS Development Partners (ADPs), and others conducted the first comprehensive National AIDS Spending Assessment (NASA) in 2011, covering FY 2008/09 and 2009/10. National capacity to track allocation and expenditure of resources for HIV/AIDS remains weak and uncoordinated. Work has commenced to institutionalize tracking of HIV/AIDS spending to inform decision-making and advocacy. PEPFAR is now supporting a comprehensive NASA covering FYs 2010/2011 to 2013/2014. Additionally, the MOH has institutionalized the National Health Accounts (NHA) to track health sector resources.

PEPFAR will continue to advocate for increased domestic health financing. PEPFAR will support GOU to leverage resources and initiatives such as the Sustainable Financing Initiative (SFI) and the Global Financing Facility (GFF) for HIV/AIDS financing. Uganda is a phase-II SFI country and is currently

¹Health Sector Development Plan 2015/16-2019/20, Uganda Ministry of Health, September 2015.

² A Case for more Strategic and Increased Investment in HIV/AIDS Program for Uganda 2015- 2025, Uganda AIDS Commission, May 2014.

exploring strategies to increase domestic resource mobilization and improve efficiency in order to implement Test and Start and achieve the 90-90-90 target.

Table 1.2.1 Investment Profile by Program Area (2009/10)¹⁵

Program Area	Total Expenditure USD in Millions	%PEPFAR	% GF	% GRP	%Other
Prevention	93,910,000	N/A	N/A	N/A	N/A
Care and treatment	264,240,000	N/A	N/A	N/A	N/A
OVC support	24,850,000	N/A	N/A	N/A	N/A
Program management and admin	105,300,000	N/A	N/A	N/A	N/A
Human resources	20,240,000	N/A	N/A	N/A	N/A
Social protection and social services (excluding OVC)	3,230,000	N/A	N/A	N/A	N/A
Enabling environment	3,900,000	N/A	N/A	N/A	N/A
HIV/AIDS research	1,280,000	N/A	N/A	N/A	N/A
Total	516,950,000				

Table 1.2.2 Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GOU	% Other
ARVs	110,094,697	44	34	22	
Rapid test kits	12,217,760	26	74		
Other drugs	2,682,198	53	47		
Lab reagents	28,080,744	61	39		
Condoms	11,529,462	0	84		16
VMMC kits	6,953,575	100	0		
Other commodities	1,442,373	100	0		
Total	173,000,809				

Table 1.2.3 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	14,900,000	10,050,000	16	67,063,378	Support programs to improve maternal, neonatal, and child health
USAID TB	5,000,000	5,000,000	9	47,061,160	Support programs to reduce TB related mortality and morbidity
USAID Malaria	33,000,000	13,125,500	11	45,298,282	Support programs to reduce malaria associated mortality
Family Planning	25,900,000	8,400,000	16	67,967,523	Support programs to increase contraceptive prevalence
NIH					
CDC NCD					
Peace Corps					
DOD Ebola					
MCC					
Total	78,800,000	36,575,500	52	227,390,343	

Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP						
Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP co-Funding PEPFAR IMs	#Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
ACT		1,750,839	1,750,839	3		Although Uganda has not received ACT funding, three partners solicited non-PEPFAR resources to increase identification of HIV-infected pediatric clients and link them to ART.
DREAMS	25,685,758		25,685,758	14	20,930,936	The partners will implement a broad range of activities to prevent new HIV infections in young women and adolescents including: structural prevention interventions, early identification and linkage to HIV treatment, and economic empowerment of vulnerable adolescents.
VMMC	17,795,975		17,795,975	23	34,598,430	Scaling up of VMMC activities including tetanus vaccination in priority districts and age groups.
Viral Load	2,192,296		2,192,296	18	46,654,511	The partners will support training of health workers and other activities to advance scaling up of viral load monitoring for all patients on ART.
SMGL	5,632,883		5,632,883	8	18,867,175	These funds will support activities to improve outcomes for infants and their mothers during and soon after delivery and promote safe delivery in target districts.
PPP		4,013,367	4,013,367	3		The funds will support early diagnosis of HIV infection in children and adolescents, linkage, and retention on treatment. Research activities on adherence, optimization of retention on first line ARV regimens, and use of mobile phone technology for adherence.
Total	51,306,912	5,764,206	57,071,118	69	121,051,052	

1.3 National Sustainability Profile

In 2016, PEPFAR invited GOU senior staff members, other donors, and CSOs to provide input and insight into the Sustainability Index Dashboard (SID). This presentation covered the domains and elements as well as the process of populating the index and dashboard. Participants were organized into sub-groups comprised of individuals knowledgeable about each of the domains:

- Governance, leadership, and accountability;
- National health system and service delivery;
- Strategic investment, efficiency, and sustainable financing; and,
- Strategic information

Prior to stakeholder involvement, the PEPFAR Team populated the SID template using existing data and knowledge of the program. This was followed by a multi-stakeholder review to critically evaluate each element and come up with a unified sustainability analysis.

Planning and coordination, policies and governance, and performance data were identified as sustainability strengths. Opinions on the SID sustainability vulnerabilities varied. After discussion with both groups, PEPFAR identified the following priorities:

- Commodity security and supply chain;
- Service delivery;
- Laboratory; and,
- Domestic resource mobilization.

Specific aspects to be addressed during COP16 include:

- **Commodity security and supply chain:** ARV domestic funding, supply chain financing, stock management, supply chain assessments, and public sector supply chain reform.
- **Service delivery:** Responsiveness of facility and community-based HIV/AIDS services; and national and sub-national service delivery.
- **Laboratory:** VL infrastructure, capacity for lab workforce, regulations to monitor quality of labs, and POCT sites, and lab strategic plan.
- **Domestic resource mobilization:** Domestic spending on HIV response, domestic budget alignment to annual targets, and tax policy reforms.

PEPFAR and the GF have been investing in these areas. To date, PEPFAR has supported service delivery (albeit with a focus on facility-based services), commodity security and supply chain systems, lab capacity at service delivery points and recently, domestic resource mobilization. GF has supported commodity security and supply chain for HIV (TB and malaria.)

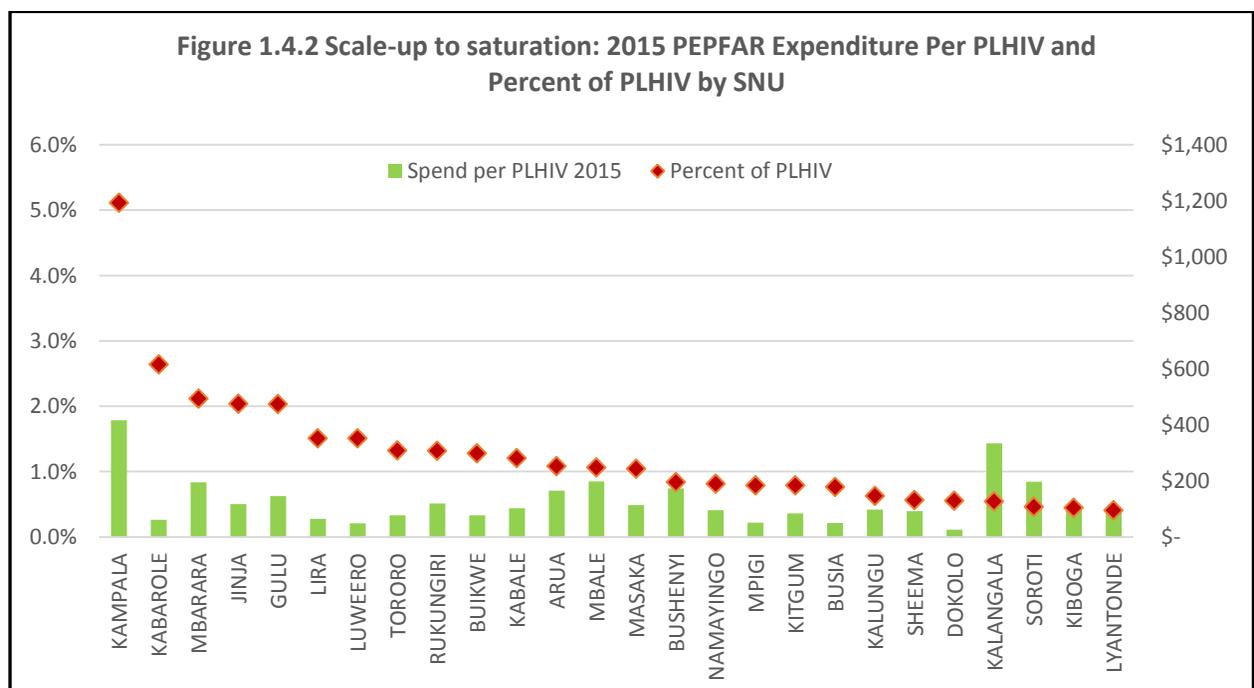
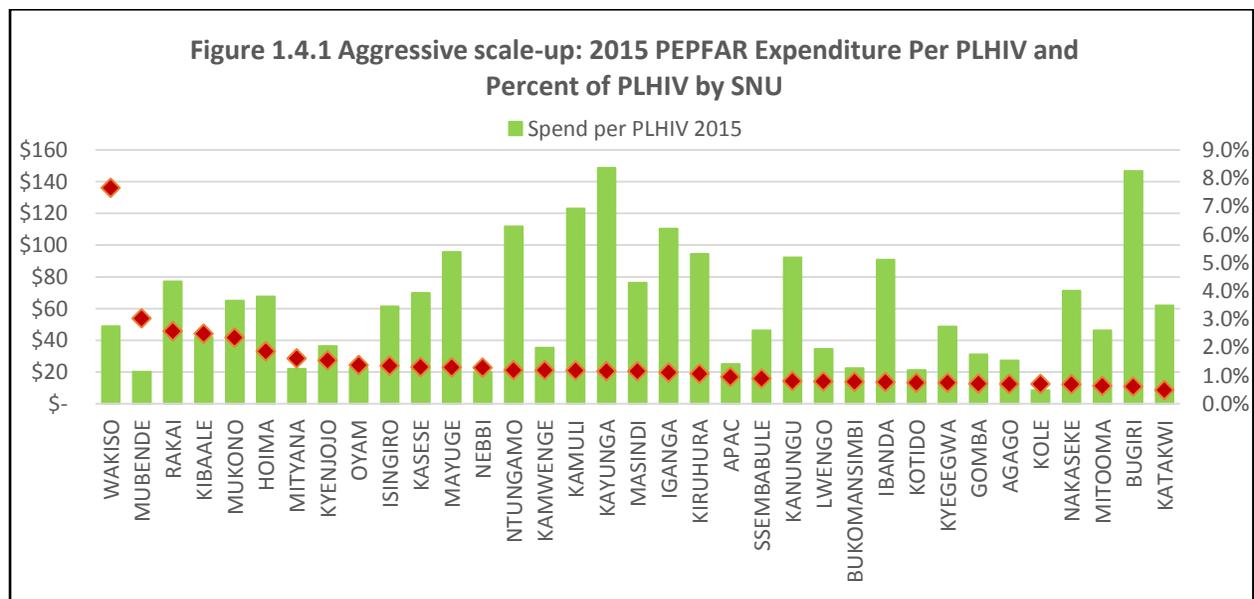
1.4 Alignment of PEPFAR Investments Geographically to Disease Burden

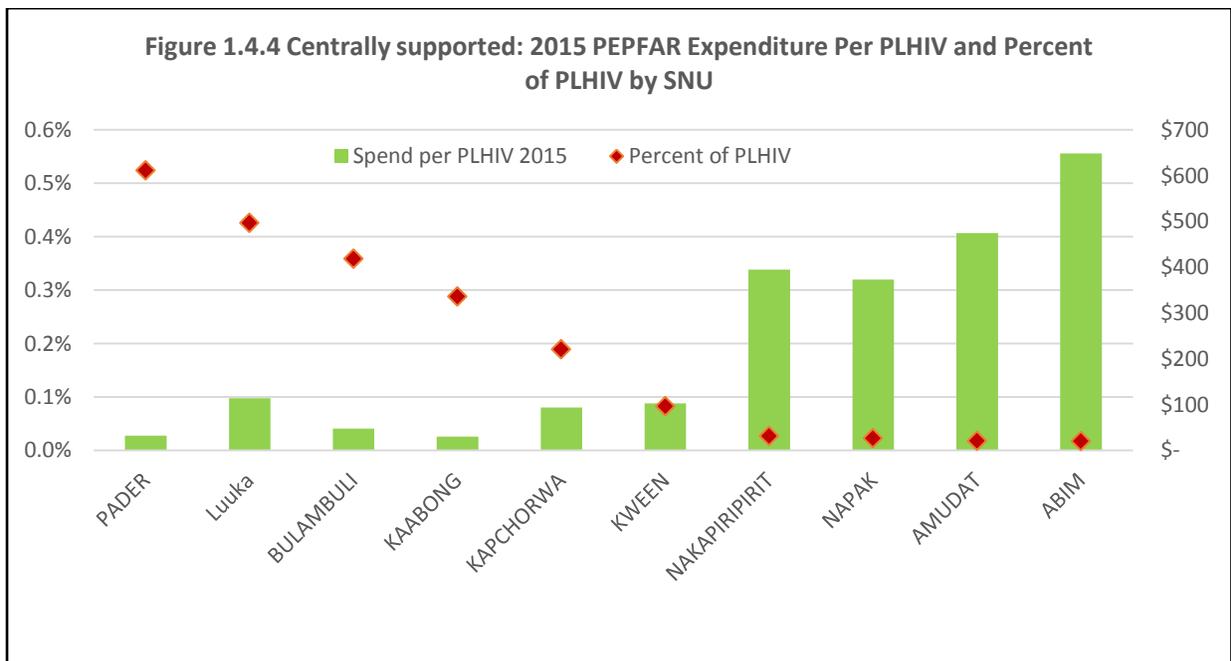
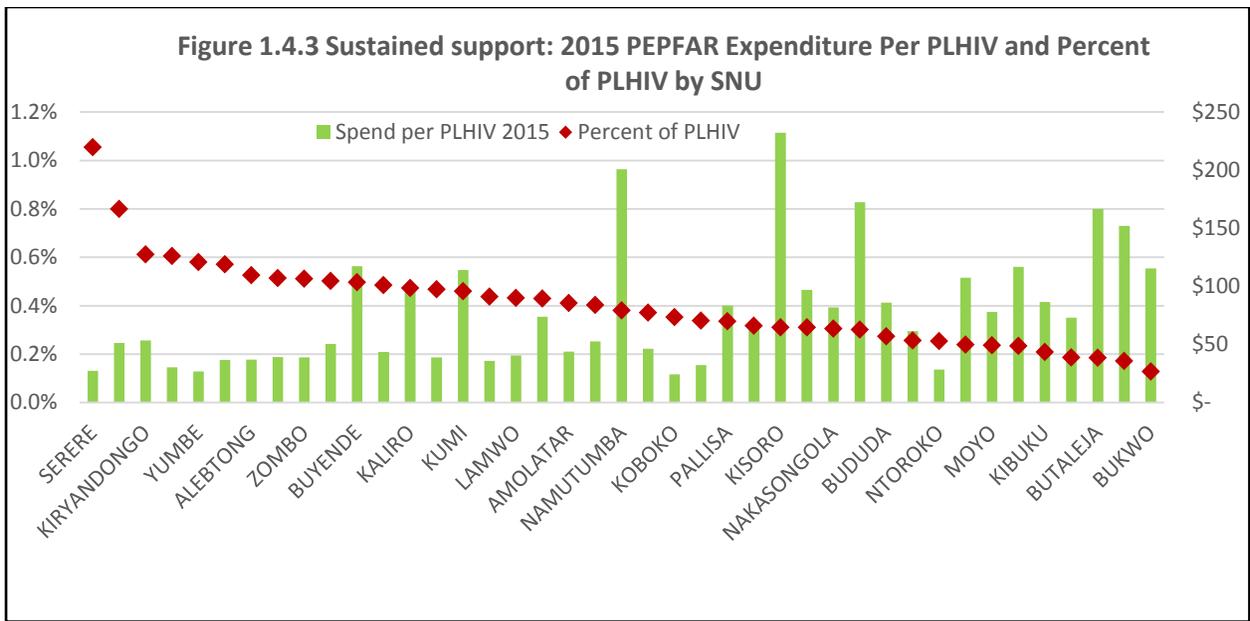
PEPFAR has tracked expenditures to burden of disease by district, spending on average \$171/PLHIV in FY14 and \$195 in FY15. The FY15 estimate was based on population projections using the 2014 census as the base year. The FY14 number was derived from the 2002 census.

In FY15, significant variation in expenditure per person existed, ranging from \$11 to \$285 (excluding outliers). This variation could be explained by partners operating in hard-to-reach areas, serving low client volumes, and differences in period of service delivery in different mechanisms. PEPFAR has seen an improvement in partner reporting, although data quality issues associated with the self-reporting of district expenditures still exist. Continued improvements will be made in FY 16.

Excluding military sites, the largest proportion of PLHIV spending was in scale-up-to-saturation districts (55.1%) and aggressive-scale-up districts (29.6%). A reduction in PLHIV spending in centrally supported districts from \$6.5m to \$2m was a result of shifts in district prioritization adopted in COP15. Scale-up-to-saturation districts reduced from \$94m to \$68m. The same trend was observed in aggressive-scale-up districts from \$52m to \$37m in 2015. At district level, PEPFAR observed a downward shift in expenses per PLHIV, which is attributed to increased efficiencies. More than half of the high-priority districts in aggressive-scale-up category (18 out of 35 districts) had lower expenses per PLHIV. In scale-up-to-saturation districts, only 4 of 26 had expenses below average.

In COP16, PEPFAR will place more emphasis on the strategic shifts to ensure resources follow prevalence and disease burden, or evidence of presence of KP/PPs.

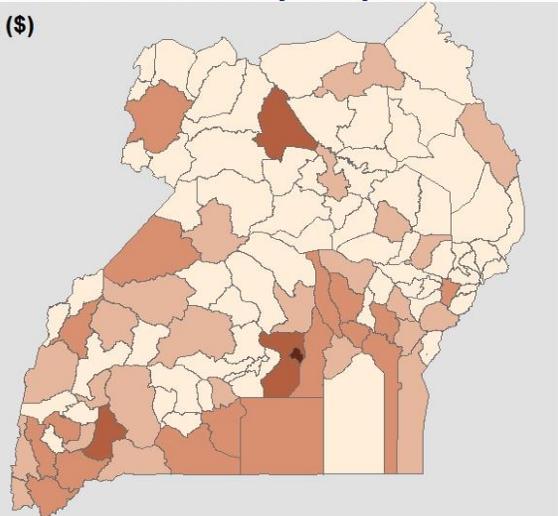
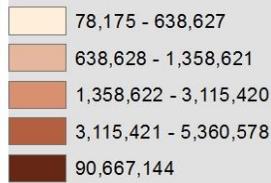




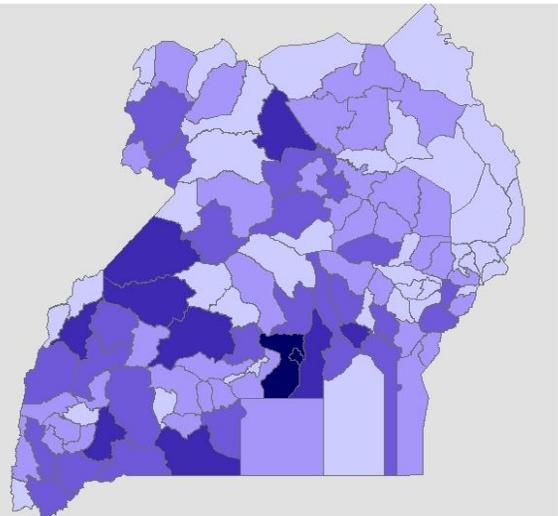
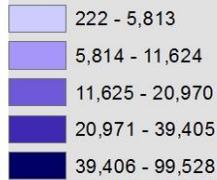
Operating Unit: Total Expenditures 2015, Total PLHIV and Spend per PLHIV

District	PLHIV	District	PLHIV
Abim	222	Kitgum	10244
Adjumani	6301	Koboko	4584
Agago	9094	Kole	9059
Alebtong	6838	Kotido	9718
Amolatar	5352	Kumi	5974
Amudat	228	Kween	1069
Amuria	7869	Kyankwanzi	5584
Amuru	4831	Kyegegwa	9645
Apac	12323	Kyenjojo	20057
Arua	14080	Lamwo	5616
Budaka	3046	Lira	19605
Bududa	3553	Luuka	5535
Bugiri	7993	Luweero	19600
Buhweju	2236	Lwengo	10245
Buikwe	16660	Lyantonde	5289
Bukedea	6683	Manafwa	7433
Bukomansimbi	10199	Maracha	2416
Bukwo	1656	Masaka	13548
Bulambuli	4668	Masindi	15015
Bulisa	3109	Mayuge	16769
Bundibugyo	4123	Mbale	13828
Bushenyi	10898	Mbarara	27528
Busia	9938	Mitooma	8251
Butaleja	2396	Mityana	20970
Butambala	5238	Moroto	3918
Buvuma	4040	Moyo	3069
Buyende	6458	Mpigi	10281
Dokolo	7233	Mubende	39405
Gomba	9319	Mukono	30471
Gulu	26451	Nakapiripirit	346
Hoima	24121	Nakaseke	8975
Ibanda	10029	Nakasongola	3975
Iganga	14473	Namayingo	10560
Isingiro	17531	Namutumba	4956
Jinja	26518	Napak	296
Kaabong	3746	Nebbi	16693
Kabale	15678	Ngora	3338
Kabarole	34322	Ntoroko	3290
Kaberamaido	6538	Ntungamo	15502
Kalangala	7073	Nwoya	5680
Kaliro	6156	Otuke	4399
Kalungu	8137	Oyam	17800
Kampala	66531	Pader	6818
Kamuli	15292	Pallisa	4362
Kamwenge	15442	Rakai	33448
Kanungu	10524	Rubirizi	6076
Kapchorwa	2463	Rukungiri	17168
Kasese	16912	Serere	13723
Katakwi	6363	Sheema	7329
Kayunga	15075	Sironko	10403
Kibaale	32328	Soroti	6018
Kiboga	5813	Ssembabule	11624
Kibuku	2709	Tororo	17215
Kiruhura	13919	Wakiso	99528
Kiryandongo	7964	Yumbe	7537
Kisoro	4040	Zombo	6656

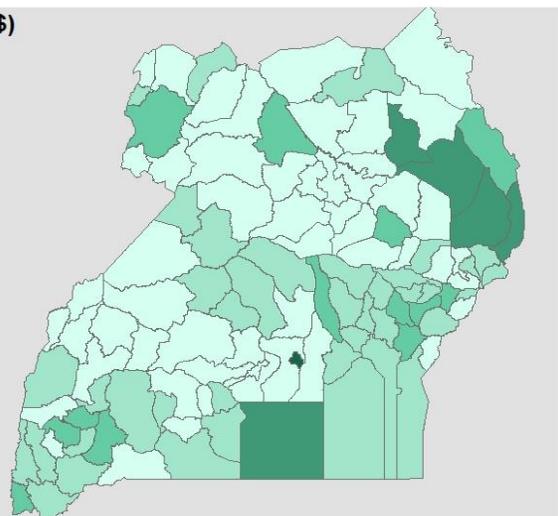
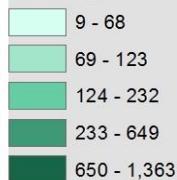
Total Expenditures 2015 (\$)



Number of PLHIV



Spend per PLHIV 2015 (\$)



Source(s): CDC-Uganda, UBOS
Date: 3/21/2016

1.5 Stakeholder Engagement

Multi-stakeholder engagement has been used during COP16 development and will continue throughout implementation. GOU, GF, AIDS Development Partners (ADP), and CSOs are the key entities PEPFAR engages. Areas of engagement are at the political, policy, and technical levels and include HIV response financing, commodities/supply chain management, HRH, and governance. At the higher GOU political and leadership level, PEPFAR engages the Office of the Prime Minister; Ministry of Finance, Planning and Economic Development (MOFPED), and the MOH.

PEPFAR established regular conference calls with GF and in-person meetings during their missions to Uganda. This engagement focuses on HIV commodities, as GF grants are mostly commoditized. Since 2015, the challenge of impending ARV stock outs has dominated PEPFAR, GOU, and GF discussions. In late 2010, MOFPED established a national ARV task force to analyze the stock situation. This group will work with MOH, QPPU and other stakeholders to regularly review the stock situation, identify causes and levels of the funding gaps, and determine possible available funding options to address these.

A high-level political and technical delegation from MOH participated in the DC Management Meeting as part of the COP16 development process. The MOH and PEPFAR continue to have in-depth interactions related to key strategies in the COP, including Test and Start, differentiated models of care, and transition planning related to PEPFAR support of scale-up locations and populations. PEPFAR and the MOH, with technical assistance from EQUIP, are analyzing the cost implications of Test and Start. Preliminary findings are being disseminated and discussed among stakeholders, including WHO, UNAIDS, and UNICEF. PEPFAR is providing technical assistance to the MOH to review ART subpopulations, differentiated models of care, related programmatic implications, and efficiency gains of the various models. MOH has since established a multi-stakeholder team to provide guidance on the process of adapting differentiated models of care.

In COP15, PEPFAR, the GOU, implementing partners, and district leaders initiated a plan to transition PEPFAR support to sites based on the volume of patients in an effort to improve efficiencies and to align resources. Timelines for this transition process were made based on patient volumes and facility type. This plan engages the districts, CSOs, and affected communities to ensure service delivery is not disrupted. Two levels of transition, district and site, emerged. Ten districts with 96 sites qualified for transition. All sites will be transitioned from PEPFAR support to the GOU by September 2016. PEPFAR will not transition additional sites in COP16.

For COP16, PEPFAR will continue to support 1,695 health workers with a plan to transition them to the GOU within three years. PEPFAR support for HRH dates back to COP14. Meetings are held quarterly with MOFPED, MOH, and the Ministry of Public Service to discuss vacancy rates, pre-service training for critical cadres, HRH support from development partners, and transition planning to the GOU.

A multi-stakeholder engagement process was used to complete the COP16 SID. In a meeting co-convened with UNAIDS, the SID was completed and findings from the Legal Environment Assessment and Stigma Assessment were discussed. Participants were drawn from GOU ministries, Uganda AIDS Commission, CSOs, Development Partners, GF Country Coordinating Mechanism Secretariat, academia, and PEPFAR. A separate PEPFAR and CSO engagement occurred, to report back from the DCMM a review of the results of the SID and map CSO areas of focus and key constituents. PEPFAR is committed to quarterly engagement meetings with CSOs and other stakeholders during the COP implementation period to discuss reports and updates.

PEPFAR regularly engages with stakeholders through technical working groups, GF CCM, Uganda AIDS Commission working groups, Health Development Partner Group, and ADP.

2.0 Core, Near-Core, and Non-Core Activities

PEPFAR will maintain most core activities identified in COP15.

PEPFAR will support Test and Start, differentiated models of service delivery, serum CrAg screening, community-based care and support services, and unique patient identifiers. PEPFAR will support HR at the national level to improve program coordination and leadership, at CPHL and district lab hubs to ensure sufficient staffing, and at site level to support quality HIV care and treatment. Commodity and supply chain management investments will be expanded to the public sector to support ART scale-up to address commodity gaps and strengthen the National Medical Stores (NMS) procurement, commodity management, and distribution systems.

Baseline CD4 testing, newly identified PLHIV will move from core to near-core. CD4 monitoring for ART clients will become non-core. VL will remain as the only core lab test for ART monitoring. Chemistry and hematology testing will move from non-core to near-core to allow for testing a limited number of clients

suspected of ARV toxicities. Support for chemistry and hematology lab equipment maintenance will remain near-core to allow adequate preparation for transition to GOU. Other care and treatment programs remaining as core include:

- District and site-level technical assistance
- Supportive supervision and mentorship for provision of quality ART and TB services
- Client tracking
- Adolescent and KP-friendly services
- Facility-community linkages
- Community-based care and support services
- Data quality and reporting

PEPFAR will continue to support efforts to eliminate MTCT through core support of the mother-baby care point service delivery approach to improve ART initiation, adherence, retention, and viral suppression among mothers. Coverage will continue for EID among HEI, and follow-up of mother-infant pairs through 18 months post-partum (infant final outcome). Mentorship, supportive supervision, data review, and QI interventions will emphasize use of the maternal ART and HEI birth cohort monitoring tools. The goal will be accounting for more than 80% of mother-infant pairs through final infant outcome. Option B+ weekly reporting and review will continue as core, given its success in improving outcomes. As short-term near-core activities, PEPFAR will provide resources to complete the birth defect surveillance and PMTCT impact/effectiveness evaluations. The latter is anticipated to provide national estimates of early and late MTCT and maternal HIV incidence and will inform the Uganda PMTCT program of gaps in current programming that program data are not capturing. Support for eMTCT mobilization campaigns has become non-core.

The USG OVC portfolio has shifted two activities from near-core to core at a sub-national level. These include training in case management and strengthening structures for community-based mediation of child abuse. This decision was informed by SIMS and inter-agency evaluation reports that revealed inadequate case management implemented by many OVC implementing partners, yet it is a major tool used in household improvements to inform graduation. Child protection services are dependent on community development officers and volunteers, who are poorly supervised. With no strengthening of the social welfare workforce, case management services, and child protection structures, the systems are at risk of collapse. The shift of these activities to core will attain the intended outcomes of the OVC program.

Condom promotion and availability is a core activity. The condom program will provide combination prevention to key and selected priority populations, and improve quality through training at the service delivery level. Evidence-based training curricula will be utilized to increase capacity and enhance community involvement. Support for VMMC and services for AGYW, particularly for DREAMS-supported districts, also remain a priority.

PEPFAR classifies other general population prevention interventions as non-core.

3.0 Geographic and Population Prioritization

During COP15, PEPFAR aligned district budgets and targets to geographical prevalence, disease burden, or evidence of presence of significant KP/PPs. Using a burden table analysis, which relies on regional prevalence estimates from the 2011 AIS weighted with district perinatal HIV prevalence, estimates were calculated for disease burden in each district. Half of Uganda's 112 districts have prevalence above the national average of 7.3%.

To prioritize for scale-up, PEPFAR compared burden and prevalence rates to determine how many districts needed to be targeted. Thirty-eight districts were categorized as having high burden (accounting for 80% of the burden) and high prevalence ($\geq 7.3\%$). The team analyzed how many additional districts could be scaled-up to the planned spending level.

Sixty-one districts were classified as scale-up for COP15 and continue as such for COP16. These districts included all 56 high-burden districts, and 5 low-burden/high-prevalence districts selected based on the presence of KP/PPs and proximity to high-burden districts.

Multiple districts have artificially high coverage rates sometimes $>100\%$. These districts have national referral hospitals/centers of excellence and clients come from surrounding districts to these facilities to obtain treatment. For targeting purposes, clusters were formed with referral hospital district and surrounding districts for which evidence existed that clients preferred to go to the national referral hospital (see also section 4.0).

The 61 scale-up districts were disaggregated into two categories:

1. Scale-Up to Saturation, receiving intensive PEPFAR support with a target of reaching 80% of PLHIV on ART by 2017 (26 districts)

2. Aggressive Scale-Up, receiving intensive PEPFAR support with a goal reaching 80% of PLHIV by 2018/9 (35 districts).

In the 41 sustained districts PEPFAR continues to support a minimum package of services, including HTC and ART enrolment. These districts require more time to reach ART saturation, but cannot be easily transitioned due to a large number of patients on ART. These districts have no KP/PPs considerations. The 10 low burden/low prevalence districts where PEPFAR provided only district-level support were designated as centrally supported.

For COP 2016, projected population statistics were updated (UBOS 2015) and an applied revised incidence of 0.30% (SPECTRUM 2014; new infection estimate 100,000) was used to calculate district burden. New population-based data were not available. In COP16, PEPFAR will continue to use the geographically narrowed focus to target KK/PPs in 26 of the 61 scale-up districts, and 1 of 41 sustained districts. PEPFAR will focus support for MSM programing in 5 urban centers across the country including the districts of Kampala, Wakiso, Gulu, Mbale, and Mbarara. Intense prevention programing for fishing communities will cover 12 districts around Lake Victoria. Through surveillance and data monitoring, if new hot spots are detected, these areas will be prioritized.

Uganda is on course to achieving national epidemic control (81% national ART coverage at FY17) with achievement of 100% of FY16 and FY17 treatment-current targets. Twenty of the 26 scale-up to saturation districts will have achieved epidemic control by end of FY17, along with 1 of 35 aggressive scale-up and 4 of 41 sustained districts. The number of districts that have reached saturation is probably higher due clients receiving treatment from facilities outside their district (see clustering discussion above). Some of these clusters will have reached saturation by end of FY17 even though individual districts within the cluster have not reached saturation. However, in order for FY16 and FY17 achievements to be met, implementation of GOU Test and Start policy will need to be fast tracked and the commodities shortage in the public sector will need to be resolved.

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

4.1 Targets for scale-up locations and populations

SNU classifications remained unchanged from COP15. The target setting process was based on the SNU classification. For the 15 scale-up-to-saturation districts that did not reach 80% coverage by end of FY 16; new-on-treatment targets were derived by calculating the net new needed to reach saturation by end of FY 17.

For the 35 aggressive-scale-up districts, PEPFAR began with APR₁₅ district achievement and increased by 20% to reach an increased rate of 'new on ART'. For the 41 sustained districts, new targets were assigned at the same rate as APR₁₅ achievements. Finally, in the 11 scale-up districts that had reached saturation, replacement targets for those lost to attrition were given.

Cluster targets were calculated in the same manner as stand-alone districts. Targets for the clusters were distributed to districts based on APR₁₅ achievement. Kampala was a unique case, as the cluster was already saturated. Targets were calculated to achieve 80% in two other districts in the cluster and distributed across the three districts.

Following the determination of ART coverage scale-up rates for the different SNU classifications, a clinical cascade approach was applied to derive targets across program areas. Current on ART targets were derived from:

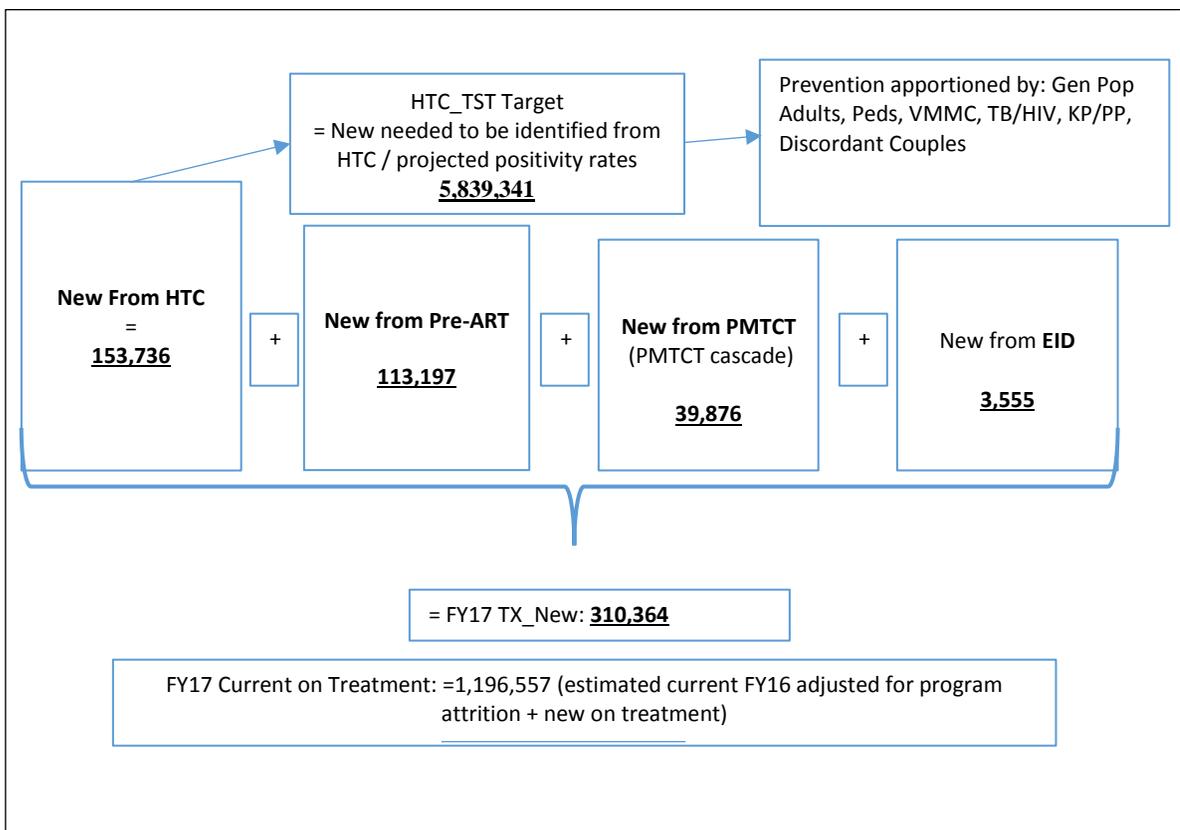
- 1) Estimated current on ART at APR₁₆ (77% national coverage), adjusted for a program attrition of 11.5%; and
- 2) New-on-ART from pre-ART and HTC (includes PMTCT, EID, VMMC, and HTC general).

The following served as the basis for these assumptions:

- With the presumed initiation of Test and Start in October 2016, all pre-ART clients have been included as new ART initiators.
- New from PMTCT were derived from a PMTCT cascade. The number of HIV-positive women expected to attend ANC at least once was based on population estimates and district level ANC program HIV prevalence 98% already know or will learn their status at ANC. 95% of pregnant women living with HIV are targeted to receive ART. 56% of these women are expected to already know their status and be on ART at ANC₁.
- New from EID is based on an estimated 80% of HIV-exposed infants expected to be tested through PMTCT. 5% are estimated to be HIV-positive. 95% of identified HIV-positive infants are expected to be linked to ART.
- For scale-up districts, HTC targets were set per SNU to achieve the total needing to be identified to reach the desired new treatment targets. The algorithm for setting HTC district targets included

the anticipated yield based on the FY15 yield, the undiagnosed prevalence rate of the district, and the HTC service delivery site (e.g., TB clinics were anticipated to have greater yield than out-patient department). Targeting was completed by assigning the largest proportion of targets to those service delivery sites where yield was anticipated to be highest (e.g., TB clinics, index client testing both in homes and HIV care and treatment clinics, inpatient departments and outreaches to KPs). Targets at highest yield sites were limited to the number of clients at those sites (e.g., although we anticipated very high yield at TB sites, we could not set targets above anticipated number of TB clients, the same held true for STI clinics, partners of HIV+ individuals and in patient departments). For 27 SNU known to have a high concentration of KPs, mobile testing was included. Once high-yield sites were exhausted, remaining targets were distributed to out-patient wards. The same approach was used for sustained districts, but no mobile or HBTC targets were given.

Figure 4.1.1 Contribution to new on ART by entry point



- VMMC targets prioritize the 10 DREAMS districts, the scale-up districts and a few sustained districts with a high VMMC unmet need.

The target levels will result in 80% national coverage. For scale-up-to-saturation districts, 23 of 26 have targets $\geq 80\%$. The three districts with target coverage below 80% were part of clusters with target coverage of 76%. Thirty-one out of 35 aggressive-scale-up districts have target levels $\geq 50\%$. Three of four districts with target coverage $< 50\%$ are part of clusters for which the cluster target is $\geq 75\%$. COP16 targets for treatment and current targets are 20% above the achievements in FY15.

Table 4.1.1 Targets in scale-up subnational units for epidemic control

District	SNU Priority	Estimated Number of PLHIV, end of FY16	Estimated Number of PLHIV, end of FY17	Estimated Current on ART, end of FY16	Remaining Needed for Saturation (end of FY17)	FY17 Target TX_CU RR	FY17 Target TX_NEW	FY17 Coverage
Arua	ScaleUp Sat	18,715	21,000	17,061	0	19,807	4,849	106%
Buikwe	ScaleUp Sat	19,173	20,412	13,020	1,153	14,901	3,417	78%
Bushenyi	ScaleUp Sat	12,229	12,886	14,812	0	16,500	3,190	135%
Busia	ScaleUp Sat	11,839	12,776	11,896	0	13,989	3,314	118%
Dokolo	ScaleUp Sat	8,287	8,807	7,128	0	6,119	2,245	74%
Gulu	ScaleUp Sat	25,223	26,466	23,861	0	25,105	5,792	100%
Jinja	ScaleUp Sat	29,145	30,441	24,256	0	25,341	2,566	87%
Kabale	ScaleUp Sat	18,754	20,270	12,895	0	15,894	4,966	85%
Kabarole	ScaleUp Sat	36,959	38,258	26,933	0	36,534	12,088	99%
Kalangala	ScaleUp Sat	7,354	7,492	17,936	0	18,994	2,690	258%
Kalungu	ScaleUp Sat	9,181	9,695	6,914	0	7,983	1,395	87%
Kampala	ScaleUp Sat	75,192	79,461	154,709	0	148,274	20,248	197%
Kiboga	ScaleUp Sat	6,670	7,092	6,252	0	6,611	466	99%
Kitgum	ScaleUp Sat	11,398	11,966	9,291	0	15,033	2,740	132%
Lira	ScaleUp Sat	21,957	23,117	18,234	0	21,905	6,258	100%
Luwero	ScaleUp Sat	18,479	19,775	22,043	0	12,910	888	70%
Lyantonde	ScaleUp Sat	5,826	6,091	1,841	2,606	2,161	272	37%
Masaka	ScaleUp Sat	15,241	16,076	28,136	0	16,295	4,391	107%
Mbale	ScaleUp Sat	16,718	18,143	16,258	0	17,057	2,075	102%
Mbarara	ScaleUp Sat	26,451	27,769	34,344	0	31,828	2,309	120%
Mpigi	ScaleUp Sat	11,727	12,439	11,206	0	11,407	879	97%
Namayingo	ScaleUp Sat	11,829	12,456	11,260	0	11,899	1,676	101%
Rukungiri	ScaleUp Sat	18,967	19,854	13,552	823	15,115	2,658	80%
Sheema	ScaleUp Sat	11,598	12,188	8,021	748	8,977	1,846	77%
Soroti	ScaleUp Sat	13,353	14,205	13,911	0	11,619	2,398	87%
Tororo	ScaleUp Sat	16,523	18,031	14,571	0	13,173	1,847	80%
	Total ScaleUp Sat	478,788	507,166	540,341	5330	545,431	97,463	114%
Agago	ScaleUpAgg	10,395	11,037	6,432	797	7,937	2,320	76%
Apac	ScaleUpAgg	14,474	15,535	9,236	1,431	10,710	2,561	74%
Bugiri	ScaleUpAgg	10,316	11,461	6,608	409	8,169	2,532	79%

Bukomansi mbi	ScaleUpAgg	11,031	11,441	2,204	6,312	2,622	355	24%
Gomba	ScaleUpAgg	10,215	10,658	4,506	2,664	5,810	984	57%
Hoima	ScaleUpAgg	27,469	29,120	16,239	2,152	20,922	6,964	76%
Ibanda	ScaleUpAgg	11,448	12,148	6,467	2,327	7,185	1,420	63%
Iganga	ScaleUpAgg	17,433	18,893	10,136	2,084	12,522	3,757	72%
Isingiro	ScaleUpAgg	20,407	21,825	13,748	0	14,004	6,849	69%
Kamuli	ScaleUpAgg	18,140	19,544	10,329	2,429	12,754	3,819	70%
Kamwenge	ScaleUpAgg	17,906	19,121	7,382	5,262	9,564	3,288	53%
Kanungu	ScaleUpAgg	11,874	12,583	6,903	2,226	7,670	1,501	65%
Kasese	ScaleUpAgg	21,017	23,041	12,142	2,144	15,485	5,072	74%
Katakwi	ScaleUpAgg	7,319	7,791	4,296	1,110	5,008	590	68%
Kayunga	ScaleUpAgg	17,194	18,238	11,082	703	13,923	4,227	81%
Kibaale	ScaleUpAgg	36,985	39,282	19,550	5,953	24,949	8,192	67%
Kiruhura	ScaleUpAgg	15,824	16,764	7,536	4,765	8,242	1,556	52%
Kole	ScaleUpAgg	10,463	11,155	4,506	3,244	5,411	1,477	52%
Kotido	ScaleUpAgg	10,173	10,398	1,707	6,258	1,720	431	17%
Kyegegwa	ScaleUpAgg	11,324	12,152	7,184	336	8,831	2,948	78%
Kyenjojo	ScaleUpAgg	22,509	23,718	11,719	3,122	15,645	5,859	70%
Lwengo	ScaleUpAgg	11,815	12,590	6,082	2,880	6,789	754	57%
Masindi	ScaleUpAgg	16,687	17,511	9,170	2,708	11,232	3,284	67%
Mayuge	ScaleUpAgg	19,559	20,935	11,874	2,112	14,287	3,885	73%
Mitooma	ScaleUpAgg	9,301	9,819	2,959	4,355	3,240	594	35%
Mityana	ScaleUpAgg	22,820	23,732	11,330	4,306	14,457	2,514	63%
Mubende	ScaleUpAgg	39,605	41,553	21,321	3,961	27,133	7,112	69%
Mukono	ScaleUpAgg	33,898	35,587	20,513	4,954	23,390	5,175	69%
Nakaseke	ScaleUpAgg	10,112	10,673	5,421	1,561	6,890	1,432	68%
Nebbi	ScaleUpAgg	18,915	20,010	10,454	2,611	13,212	4,251	70%
Ntungamo	ScaleUpAgg	18,333	19,729	9,999	4,107	11,143	2,153	61%
Oyam	ScaleUpAgg	20,031	21,132	11,746	2,140	14,657	4,455	73%
Rakai	ScaleUpAgg	36,344	37,772	20,269	6,129	24,157	6,445	66%
Sembabule	ScaleUpAgg	15,163	15,873	7,825	3,680	5,628	748	37%
Wakiso	ScaleUpAgg	111,395	117,246	64,887	18,099	74,189	11,210	67%
	Total ScaleUpAgg	717,894	760,067	393,762	119,331	469,487	120,714	65%

Entry Streams for ART Enrollment	Tested for HIV	Identified Positive	Newly initiated (APR FY 17)
	(APR FY17)	(APR FY17)	<i>TX_NEW</i>
Adults			
Clinical care patients not on ART			
HIV+ TB Patients not on ART	46,600	1,851	1,851
HIV-positive Pregnant Women	1,568,213	39,876	37,797
Other priority and key populations	154,524	6,333	6,017
Pediatrics			
Clinical care pediatrics not on ART	479,000	15,207	15,207
HIV Exposed Infants	74,871	3,555	3,372
Orphans and Vulnerable Children			
Provider Initiated Testing			
Total	2,323,208	66,822	64,244

Table 4.1.3 VMMC Coverage and Targets by Age brackets

Target Populations 15 to 29 years	Population Size Estimate (priority SNUs)	Current Coverage (2015)	VMMC_CIRC (in FY17)
Scale-up Aggressive districts	3,223,710*	4%	308,773
Scale-up Saturation districts	2,107,215*	6%	223,398
Sustained districts	1,864,953*	7.2 %	108,364
Military Districts	30,315*	40%	16,847
Total/Average	7,226,193		657,254

*Program Data indicates 15-29 year age group contributes to 43% of circumcision outputs

Target Populations	Population Size Estimate (priority SNUs)	Coverage Goal (in FY17)	FY17 Target
Sex Workers	81,502 ⁴	80%	67,843
Fisher folk	2,000,000 ⁵	25%	124,567
MSM	9115 ⁶	40%	3,645
Army personnel	75,000	67%	50,000
Police personnel	45,000 ⁷	80%	30,000
Sero-discordant couples	3,328 ⁸	0%	74662
PrEP implementation(SW,MSM,FF)	243,783	5.8%	3417

³For KP/PP the methodology applied in COP15 will be maintained, with PrEP being added as an additional service at select sites. PEPFAR set an outreach coverage target of 80% for FSW and 40% for MSM and TG. For FF, uniformed forces and SDC, the outreach coverage target is 80%.

⁴ Estimates modelled by CDC Epidemiologists using UAIS 2011 data and National Population and Housing Census 2014: Included in estimate from 25 COP scale-up districts (major towns), 5 maintenance districts including Wakiso, Mukono and Kampala

⁵ UAC, Multi-sectoral programming for MARPs report, 2014

⁶ Estimates modelled by CDC Epidemiologists using UAIS 2011 data and National Population and Housing Census 2014- Population: Only urban regional districts included: Kampala, Wakiso, Gulu, Mbale, Mbarara

⁷ 45,000 police estimated in PEPFAR supported districts

⁸ UAIS 2014, 6.2% of all married co-habiting couples

Table 4.1.5 Targets for OVC and Linkages to HIV Services

District	District Classification	Estimated # of Orphans and Vulnerable Children	OVC_SERV (N, DSD)Target: Beneficiaries (validated)	DREAMS Target	Overall Target
Military	Military		3,960	1,958	5,918
	Total Military		3,960	1,958	5,918
Apac District	Scale Up: Agg	7,621	1,516	-	1,516
Bugiri District	Scale Up: Agg	6,420	3,461	-	3,461
Bukomansi mbi District	Scale Up: Agg	2,558	2,366	3,518	5,884
Gomba District	Scale Up: Agg	2,730	2,971	3,396	6,367
Hoima District	Scale Up: Agg	10,848	4,322	-	4,322
Ibanda District	Scale Up: Agg	4,595	855	-	855
Iganga District	Scale Up: Agg	8,252	8,899	-	8,899
Isingiro District	Scale Up: Agg	9,258	11,290	-	11,290
Kamuli District	Scale Up: Agg	7,961	3,311	-	3,311
Kamwenge District	Scale Up: Agg	7,943	8,285	-	8,285
Kanungu District	Scale Up: Agg	4,665	3,780	-	3,780
Kasese District	Scale Up: Agg	13,068	11,583	-	11,583
Katakwi District	Scale Up: Agg	2,693	2,465	-	2,465
Kibaale District	Scale Up: Agg	15,067	5,970	-	5,970
Kiruhura District	Scale Up: Agg	6,176	3,951	-	3,951
Kyegegwa District	Scale Up: Agg	5,393	2,206	-	2,206
Kyenjojo District	Scale Up: Agg	7,987	8,895	-	8,895
Lwengo District	Scale Up: Agg	4,678	3,653	-	3,653
Masindi District	Scale Up: Agg	5,471	925	-	925
Mayuge District	Scale Up: Agg	7,829	3,455	-	3,455
Mitooma District	Scale Up: Agg	3,416	1,997	-	1,997
Mityana District	Scale Up: Agg	5,662	7,954	4,296	12,250
Mubende District	Scale Up: Agg	11,997	2,243	7,632	9,875
Mukono District	Scale Up: Agg	10,346	9,121	8,130	17,251
Nakaseke District	Scale Up: Agg	3,414	1,146	-	1,146
Nebbi District	Scale Up: Agg	7,764	2,652	-	2,652
Ntungamo District	Scale Up: Agg	9,083	6,327	-	6,327
Oyam District	Scale Up: Agg	8,005	6,818	10,603	17,421
Rakai District	Scale Up: Agg	8,873	5,550	12,536	18,086

Sembabule District	Scale Up: Agg	4,662	1,544	6,870	8,414
Wakiso District	Scale Up: Agg	35,728	26,105	-	26,105
	Total ScaleUp Agg		165,616	56,981	222,597
Arua District	Scale Up: Sat	15,792	3,379	-	3,379
Buikwe District	Scale Up: Sat	7,492	5,007	-	5,007
Bushenyi District	Scale Up: Sat	4,338	9,817	-	9,817
Busia District	Scale Up: Sat	5,310	3,587	-	3,587
Gulu District	Scale Up: Sat	9,173	9,014	9,999	19,013
Jinja District	Scale Up: Sat	7,543	6,090	-	6,090
Kabale District	Scale Up: Sat	9,846	5,043	-	5,043
Kabarole District	Scale Up: Sat	8,822	7,087	-	7,087
Kalangala District	Scale Up: Sat	925	200	-	200
Kalungu District	Scale Up: Sat	3,129	1,762	-	1,762
Kampala District	Scale Up: Sat	22,362	28,272	-	28,272
Kayunga District	Scale Up: Sat	6,333	4,687	-	4,687
Kitgum District	Scale Up: Sat	4,159	8,910	-	8,910
Lira District	Scale Up: Sat	8,456	7,050	7,609	14,659
Luwero District	Scale Up: Sat	7,873	11,954	-	11,954
Lyantonde District	Scale Up: Sat	1,631	1,142	-	1,142
Masaka District	Scale Up: Sat	5,086	5,247	-	5,247
Mbale District	Scale Up: Sat	8,052	1,584	-	1,584
Mbarara District	Scale Up: Sat	8,812	4,555	-	4,555
Mpigi District	Scale Up: Sat	4,321	1,954	-	1,954
Namayingo District	Scale Up: Sat	3,610	2,125	-	2,125
Rukungiri District	Scale Up: Sat	5,908	13,175	-	13,175
Sheema District	Scale Up: Sat	4,000	2,748	-	2,748
Soroti District	Scale Up: Sat	4,361	1,346	-	1,346
Tororo District	Scale Up: Sat	8,561	4,457	-	4,457
	Total ScaleUp Sat		150,192	17,608	167,800
Adjumani District	Sustained	4,616	343	-	343
Alebtong District	Sustained	4,634	3,094	-	3,094
Amolatar District	Sustained	3,041	520	-	520
Amuria District	Sustained	4,426	551	-	551
Amuru District	Sustained	3,923	2,570	-	2,570
Budaka	Sustained	3,414	1,358	-	1,358

District					
Bududa District	Sustained	3,495	1,761	-	1,761
Buhweju District	Sustained	2,326	1,575	-	1,575
Bukedea District	Sustained	3,096	1,637	-	1,637
Bundibugyo District	Sustained	4,188	265	-	265
Butaleja District	Sustained	4,033	1,620	-	1,620
Butambala District	Sustained	1,709	331	-	331
Buvuma District	Sustained	1,596	1,657	-	1,657
Buyende District	Sustained	5,282	2,182	-	2,182
Kaberamaindo District	Sustained	3,508	627	-	627
Koboko District	Sustained	4,227	742	-	742
Kumi District	Sustained	4,232	1,025	-	1,025
Lamwo District	Sustained	2,723	3,178	-	3,178
Maracha District	Sustained	3,720	-	-	-
Moyo District	Sustained	2,753	577	-	577
Nakasongola District	Sustained	3,138	1,308	-	1,308
Ngora District	Sustained	2,319	224	-	224
Ntoroko District	Sustained	1,234	173	-	173
Nwoya District	Sustained	2,790	1,432	-	1,432
Otuke District	Sustained	2,204	1,697	-	1,697
Pallisa District	Sustained	6,317	438	-	438
Rubirizi District	Sustained	2,397	1,550	-	1,550
Serere District	Sustained	3,905	373	-	373
Sironko District	Sustained	4,869	1,190	-	1,190
Yumbe District	Sustained	9,986	151	-	151
Zombo District	Sustained	4,839	-	-	-
	Total Sustained		34,149	-	34,149

Summary of Targets for OVC and Linkages to Services

	OVC_SER TARGET	OVC_SERV_DRE AMS TGT	Overall Target
Military	3,960	1958	5,918
Scale Up: Agg	165,616	56981	222,597
Scale Up: Sat	150,192	17608	167,800
Sustained	34,149	0	34,149
Total Target	353,917	76547	430,464

4.2 Priority Population Prevention

PEPFAR will focus on KP (key populations) and PPs (priority populations). The MOH requires KP data to be disaggregated by type for improved tracking of each group, linkages to services, and following up across the continuum of response.

HIV prevention messaging services reached 942,474 individuals in FY15. In COP16, PEPFAR will continue delivering services to KPs/PPs based on minimum standards. PEPFAR will build capacity of regional and district hospitals in KP-friendly service delivery to enhance access to quality combination prevention services.

SIMS data show improved quality of services. The main challenge is documenting activities, given the lack of standard indicators, especially for KP. PEPFAR has provided guidance on a standard minimum package of services. SIMS data highlights inadequate capacity to implement and document GBV services at sites. However, there are improvements in selection of gender focal points.

Condom promotion, access, and availability will be enhanced through increasing the number of dispensers in hotspots and areas of high-risk sexual activities. Additionally, PEPFAR will continue to support social marketing programs to access condoms through the private sector. PEPFAR will leverage GF and UNFPA efforts to ensure that duplication is minimized.

PEPFAR provided capacity building to its partners on gender integration and will review their quarterly performance. PEPFAR's gender analysis is under way. Program data indicate that only 35% of patients in care are men, highlighting the need for novel HTC strategies to reach them.

Working with community peer networks, the priority prevention program will support hot-spot mapping and will engage peers in program planning, mobilization, implementation and monitoring. PEPFAR will continue to support Gender and Sexual Diversity (GSD) training to address stigma and discrimination against LGBT. Sensitization trainings will address non-discriminatory service provision for KP and PLHIV. In COP16, PEPFAR will enhance service integration and leverage the Local Capacity Initiative, and Advocacy for Better Health to empower civil society to advocate for better services for marginalized populations. PEPFAR will support the cascade of the GSD training for IP and other key stakeholders. PEPFAR will continue to assist the MOH in harmonizing the KP health service providers training curriculum.

The DREAMS initiative provides an opportunity for Uganda to implement high-quality combination prevention to AGYW aged 15-24 in the 10 PEPFAR priority districts. The DREAMS program strategically targets AGYW in COP priority districts, and is integrated into COP activities.

DREAMS offers select, high-impact HIV services through a layered approach to negative AGYW 15-24 years old. This will be targeted to scale in the 10 priority districts by 2017. In addition, through the program, AGYW's partners are expected to be identified and offered appropriate services, such as VMMC for HIV-negative men and Test & Start for HIV-positive men, therefore contributing to a reduction in new infections. Through an enhanced facility-community linkage approach, DREAMS will support COP16 activities by improving the tracking of patients in the selected districts. This community linkage approach will improve the service delivery framework while supporting high-quality prevention services to AGYW aged 15-24. DREAMS will also seek to improve linking AGYW male sexual partners to HIV testing, and if diagnosed HIV+, to Test & Start. DREAMS wraps around COP16 activities to expand the layering effect for both AGYW and their sexual partners-such as ART and VMMC. DREAMS will continue to work closely with communities empowering them to identify practical solutions moving forward for an ingrown prevention approach.

Table 4.2.1 Indicator Targets in DREAMS SNUs

PREP_NE W	GEND_GBV	HTC_TS T	OVC_SERV(DREAMS+C OP)	OVC_SERV_DREA MS ONLY	PP_PRE V	PrEP_NE W
0	507	19,356	5,884	3,518	5,756	0
0	839	35,517	8,414	6,870	6,858	0
0	1,834	124,839	18,086	12,536	55,215	898
0	1,540	63,752	19,013	9,999	216,239	0
0	1,370	94,016	17,421	10,603	10,788	0
0	1,487	122,746	14,659	7,609	213,032	0
0	1,967	151,871	9,875	7,632	15,376	0
0	1,004	71,454	12,250	4,296	5,777	0
600	1,890	87,049	17,251	8,130	28,500	600
0	522	34,540	6,367	3,396	80,987	0
600	12,960	805,140	129,220	74,589	638,528	1,498

4.3 VMMC

From 2010 to 2015, the total number of men circumcised in Uganda rose from 10,000 to more than 2.5 million. However, 6.3 million men and boys 10+-14 years old remain to be circumcised.

Central funds used with COP funds have dramatically increased the number of circumcisions since COP13. However, even without central funds, VMMC partners in FY15 provided 492,019 circumcisions, 198% of the annual target. This number was obtained through use of dedicated VMMC teams, camps/outreach activities, and static facilities. PEPFAR contributed 66.5% of the total FY15 VMMC outputs. GF and AIDS Healthcare Foundation provide the balance.

PEPFAR is targeting 343,341 male circumcisions (MCs) with COP funding and anticipates central funding to yield an additional 313,913 MCs in FY16, for a total of 657,254 circumcisions for FY17. This will contribute to 49% national circumcision coverage. In COP 16, VMMC services will target 58 districts with the highest HIV burden and lowest MC prevalence: 26 scale-up aggressive districts, 18 scale-up saturated districts, and 14 sustained response districts (including the 10 DREAMS districts).

Focusing VMMC demand creation on the 15 to 29-year-old age group will have the greatest impact on new infections. Interventions to improve VMMC coverage in the 15-29-year old age group will include offering separate waiting and education areas at sites, extended hours/days, and mobile services at workplaces and marketplaces.

PEPFAR will provide a minimum of HTC, clinical, and prevention services. PEPFAR will also link HIV+ individuals to care and treatment, conduct QA/CQI activities, support infection prevention, and provide commodities/consumables, including emergency kits and tetanus toxoid.

SIMS data indicates that documentation and referral of identified HIV-positive clients remains a challenge. New referral forms will address this issue by confirming the completion of the referral loop, offering same-day enrollment in care, documenting referred clients, tracking clients, and documenting LTFU. The number of circumcised clients by HIV status was reported in the MOH-DHIS2 for the first time in Q4 of FY15. Of the 143,403 males circumcised, 1.3% tested HIV+ and were referred into care.

The MOH directed all districts to implement a two-dose tetanus immunization strategy for VMMC clients. This guidance was preceded by meetings in which the TT training curriculum, implementation guidelines, a facility assessment readiness tool, and the SMC HMIS tools were finalized. PEPFAR will procure 1.6 million doses of TT to complement the national TT stocks for VMMC. PEPFAR has fostered improved infection control for circumcision procedures, including personal cleanliness before the procedure and adherence to skin preparation surgical protocols. Clients are counselled on wound care after circumcision, including genital hygiene instructions and the dangers of tetanus.

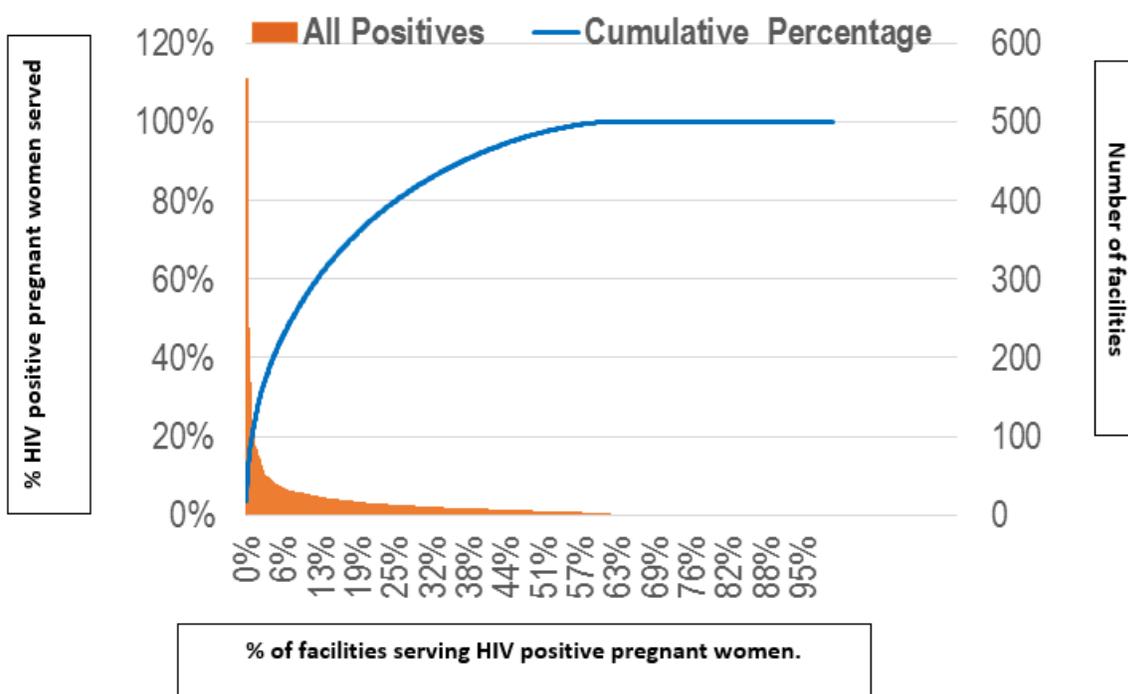
The return rates for men for the second TT dose and MC range from 27%-72% for the general population and up to 90% for students. Program challenges include unreliable TT stocks at districts and facilities, beliefs that TT vaccination causes impotence, injection pain, and the perceived need to be circumcised immediately after the first TT. Travel distances and time spent for the TT injections and MC discourage clients from seeking circumcision. The mobility of some populations (e.g. fisher folks, military, and truckers) creates challenges with the integration of TT in circumcision program.

Interventions to address these challenges include community sensitization about the benefits of TT vaccination, follow-up of clients after the first TT dose (e.g. telephone and SMS visit reminders), and working with the DHOs to ensure forecasting and reliable stocks of TT. PEPFAR will continue to monitor the impact of TT return rates on VMMC.

4.4 Preventing mother-to-child transmission (PMTCT)

The mother-baby care point (MBCP), part of Option B+, has provided a structure to provide high-quality care in a “one-stop-shop” approach. PMTCT-ART funds are being used for TB case finding, TB infection control, and INH therapy within MCH settings. COP16 funds will maintain these activities. A combination of FP/HIV integration central funds and COP15 funds have expanded contraceptive access for HIV+ women in PMTCT-ART programs, SMGL interventions, and RH services. In FY16, the MBCP platform and tracking structures will target HIV prevention and parenting interventions to negative pregnant and breastfeeding AGYW in DREAMS districts. COP16 funds will maintain TB case finding, TB infection control, and INH therapy within MCH settings. FP/HIV integration central funds and COP15 have expanded contraceptive access for HIV+ women in PMTCT-ART programs, SMGL interventions and RH services. In FY16, the MBCP platform and tracking structures will target HIV prevention and parenting interventions to negative pregnant and breastfeeding AGYW in DREAMS districts. COP16 will explore options to improve integration of PMTCT and OVC services.

2016 Q1 PMTCT Efficiency Analysis



Uganda completed the roll-out of Option B+ in 2013, increasing the proportion of pregnant women initiated on ART from 84% (FY13) to 92% (FY15). Women on ART at the beginning of pregnancy increased from 33% (FY13) to 51% (FY15). In FY17, 89,726 (95%) of HIV-positive pregnant women will receive ART (51% expected to already be on ART).

Twenty-five percent of the 1,537 PEPFAR-supported PMTCT sites served 80% of HIV-positive pregnant women in Q1 of FY16. PEPFAR will continue to support DSD in high-risk-high-volume NGO and PFP sites and expand DSD in public sector to include commodity support. At the same time, PEPFAR will continue transitioning out of low-volume facilities.

Two challenges remain to achieve eMTCT goals: maternal ART retention and HEI follow-up. Retention among women initiating ART during pregnancy or breastfeeding is only 65% at 6 months and 69% at 12 months, compared to more than 79% among other ART clients. A project to monitor and address 1-3 month

retention demonstrated that the biggest loss point (21%) was at month 1, and with a LTFU of 27% at 3 months.

While EID testing coverage has increased from 46% (FY13) to 60% (FY15), these results are short of the 80% target. The timing of EID testing remains suboptimal, with only 21% of HEI receiving the test by 8 weeks. Only 48% of sites met the EID testing standard. A review of EID registers demonstrated that only 27% of enrolled HEI had final outcome documentation.

PMTCT-ART integration and COP15 funds are being used to roll-out of maternal ART and HEI birth-cohort monitoring. These systems help HCW account for MIP, facilitate QI interventions, address LTFU, and improve the quality of PMTCT program data. COP15 is investing in facility-based linkage facilitators, mentor mothers, and family support groups to support retention and track LTFU. COP15 also invested in programs to strengthen community care and support to provide a continuum of responses for adherence and retention issues. COP16 will continue to invest in improving ANC-MBCP linkages, strengthening facility and community-based retention monitoring and support, providing mentorship, supportive supervision, and QI. COP16 will also explore alternative service delivery models for MIP follow-up, including integrating PMTCT services into immunization programs.

PEPFAR expects all sites will conduct ART monitoring using VL by the end of FY16. Roll-out of VL testing includes clinical mentorship, adherence counseling, and decision-making for switching to second-line drugs. PEPFAR is evaluating whether an additional VL test on ART-experienced pregnant women at ANC 1, followed by intensive adherence counseling for those who are non-suppressed, improves viral suppression by delivery. Results will inform the national VL algorithm for pregnant and breastfeeding women.

In COP16, PEPFAR shall continue promoting male partner involvement in PMTCT activities, including male partner testing, linkage to SMC services, and participation in family support groups.

Routine and enhanced data are being collected and utilized for program improvement. In FY15 (ongoing in COP16) a number of data quality initiatives were initiated, included revision/dissemination of the national HMIS tools, alignment of DHIS2 with these new tools, and piloting a longitudinal ANC register. Data review and use at facility, district, and national levels are expected to improve reporting of PMTCT.

In COP16, PEPFAR, in partnership with MOH, UNICEF, and WHO will support the implementation of a PMTCT impact/effectiveness evaluation. This evaluation will measure early and late MTCT rates, estimate HEI HIV-free survival, determine HIV-incident infections among pregnant and postpartum women, and determine the EID coverage gap. The evaluation (planned for FY16) will provide surveillance data that cannot be ascertained in the PHIA design and guide program planning.

PEPFAR is investing COP16 funds to complete a birth defect surveillance study initiated in FY15. This study will provide data on the rate of baseline birth defects in the region and whether ARV carries a risk of birth defects.

4.5 HTC

Of an estimated 1.5 million people living with HIV in Uganda, approximately 1.13 million (75%) have been diagnosed, and 1,081,206 are on treatment. With progressively fewer individuals remaining undiagnosed, the HTC yield has been declining over the past three years. The current yield is between 3% and 3.5%. However, in scale-up to saturation districts the yield is close 4%, demonstrating success in investments in targeted testing. More focused approaches are still needed for direct services to geographic areas and sub-populations considered at elevated risk of HIV infection.

The national focus is on identification and enrollment in treatment of those remaining undiagnosed. HTC is pivotal to the national response. The national HTC policy is undergoing revision, with the goal of enhancing targeted testing and quality of services in line with the WHO guidance. Uganda will discontinue low-yield HTS activities and concentrate on high-yield activities.

COP16 builds on the shifts of COP15, which focused on targeting HTC to the right populations and geographical locations. The HTC program has been re-defined to target the few remaining undiagnosed individuals. The following strategies will define the HTC program:

- Targeted PITC for individuals likely to have been exposed to HIV. PITC will be offered at HTC entry points such as: adult and pediatric in-patient wards; TB, STI, and ANC clinics; child health and

malnutrition centers; and ART clinics for purpose of reaching spouses, children, and/or siblings of index clients.

- Based on APR15 data, yield is higher at these testing points than others. Targets have been apportioned based on the estimated yields at these testing points. Services will be monitored to assess yield and progress towards set targets.
- Within geographical areas prioritized for HTS based on yield analysis (27 out of 112 districts), special attention will be paid to identifying and reaching out to KP/PP. Working with peers and other community platforms, PEPFAR Uganda will identify locations (hot spots) where populations (KP/PP) converge for targeted HTC. In line with the COP15 geographic prioritization, the bulk of HTC will be delivered in scale-up districts, which account for 79% of the overall “HTC other” target. Building on the previous initiatives with KP/PP, peer-to-peer approaches will be used for mobilization, referral, and post-testing support; particularly for reaching marginalized and discrete populations such as MSM and sex workers. In COP16, gender and sexual diversity training will be cascaded to all health facilities providing KP services. In addition, the development of a health workers curriculum focused on KPs will be completed and trainings rolled out.
- Prioritized index testing activities for families of individuals already accessing HIV care and treatment, as well as those newly diagnosed, will be put into place. This initiative will necessitate intensive mobilization of existing and new partners and the re-training of providers in counseling skills as well as addressing HR constraints public sites.
- In COP16, efforts will be made to target men in districts where their service uptake is traditionally lower than women. Efforts will be taken to increase men’s access to HTC services, including the prioritization of couple testing at HTC entry points such as ANC, PNC, VMMC, in-patient wards, and care and treatment settings. This will involve the use of systematic index client tracking whereby partners will review client charts to identify clients with male partners who are not tested. Other efforts will include the implementation of specific clinic stratifications to allow for integration of other services for men, such as BMI/weight measurement, blood pressure check-ups, STI screening and treatment, and prostate cancer screening. Existing family-centered and snow balling approaches will be expanded upon to access partners of existing clients. In addition, efforts will take place to reach more men thorough increased contact tracing of partners to HIV index clients in order to provide them with partner services from disease intervention specialists. Intensified counseling services will enhance partner disclosure while ensuring that women are not put at risk because of HIV status disclosure and partner notification services. In COP16, community/facility linkages will be strengthened and will serve as a platform to strengthen partner services, including referral for HTC. Existing regional performance monitoring teams will be used to review data to ensure that partners of index clients are offered partner services.
- Delivering HTC services in male-dominated professions, including truck drivers, boda boda riders, and uniformed forces: PEPFAR Uganda will intensify work place programs to enhance access to services by working men, especially civil servants and those in mobile occupations. Additionally, social marketing of male HIV/AIDS services through the use of male champions (spokespersons) at both facility and community levels will be emphasized. This is anticipated to further strengthen the peer-to-peer approach for mobilization and referral of men for services. The male champions will serve as linkage facilitators and conduct dialogues with men. Additionally, male involvement programs, which consist of peer-to-peer approaches and the use of role models, will be utilized. Some examples of these types of programs include the “stylish man” and “real man” campaigns aimed at motivating men to take a more active role in HIV prevention and treatment. In COP16, de-medicalized approaches, which repackage the practices and services to enable men to achieve what they want through health-seeking behavior, will be explored.
- PEPFAR partners will be monitored on the basis of new positives identified, rather than individuals counseled, tested, and given results.

There will be a continuation of scaling-up interventions in high-burden and high-prevalence districts, categorized as either “aggressive scale-up” or “scale up to saturation”, which constitute 34% of the country. In the “sustained” districts, passive engagement will continue, with services limited to facilities and prioritizing HTC to individuals clinically assessed likely to be HIV positive. With the Test and Start policy, all individuals diagnosed with HIV will be immediately linked into care and treatment, while those testing HIV-negative will be linked to other prevention services. Test and Start is anticipated to help address the challenge of repeat testing, which has been occurring more among HIV-positive individuals. Although efforts are being made to strengthen the national commodity supply chain system, PEPFAR anticipates HIV test kit stock outs.

HTC data will continue to be collected and reported using the National HMIS tools. Sites no longer supported by PEPFAR will be filtered out so that they are no longer included in PEPFAR results.

4.6 Facility and community-based care and support

As Uganda nears ART saturation and newly identified PLHIV are healthier, the care and support approach has shifted. OIs have decreased, reflecting the healthier population. Core care activities focused on provision of cotrimoxazole, NACS, TB/HIV interventions, STI/OI screening and treatment, family planning integration, and other PHDP interventions. PEPFAR increased investments in community-based care and support services to improve facility-community linkages including adherence, retention, and client-centered service delivery models. Peer counselors and educators living with HIV and from key populations (supported by PLHIV networks and key population organizations) will have a key role to play in these efforts.

COP16 maintains COP15 care and support with a few modifications. Because of Uganda's adoption of Test and Start in FY17, CD4 will only be used for newly initiated PLHIV to ascertain risk for immune reconstitution syndrome and determine need for serum CrAg screening. In COP15, the CrAg screening guidelines were finalized and LFA kits were introduced at select facilities.

COP16 will continue to screen asymptomatic, newly-diagnosed PLHIV with a baseline CD4<100, as well as diagnosed symptomatic cryptococcal meningitis. Cryptococcal meningitis treatment is provided by GOU and a corporate donor.

FY14 and FY15 investment in NACS scale-up with PMTCT/ART integration central funds has improved nutrition among clients. In APR15, 65% of clients in care were nutritionally assessed for malnutrition via anthropometric measurements. 18,393 individuals with moderate to severe malnutrition were provided Ready to Use Therapeutic Foods (RUTF). PEPFAR will continue to support NACS through routine mentoring and supportive supervision, and will contribute to the procurement of RUTF for moderate to severely malnourished HIV-infected and exposed children.

Family planning (FP) integration with HIV services was enhanced with investments from HIV/Family Planning integration central funds. PEPFAR supported the MOH to develop and disseminate policy guidance, coordinate FP/HIV integrated programs, and develop training materials, as well as build the capacity of HCWs to deliver quality FP integration services. COP16 funds will continue to provide mentorship, supportive supervision, and quality improvement for FP/HIV integration as a core component of site-level support. All IPs receive the required USG FP compliance training.

FY16 SIMS data revealed that 83% of facilities scored red in the core elements relating to facility-community linkages. In COP16, PEPFAR will improve facility-community linkages through development of a community-based care and support strategy with a focus on District Community Development Offices (DCDOs) and community-based organizations (CBOs). The DCDO will be supported to coordinate the community component of the continuum of response for PLHIV and will guide implementation of differentiated service delivery models that require formation of client-led groups to decongest facilities and streamline ART refills. IPs will help build capacity to provide economic strengthening and psychosocial interventions, update mapping of community services, address data quality issues, and support development and use of monitoring tools. The community based care and support strategy will align with and leverage the OVC program. By end of FY16, PEPFAR Uganda will have rolled out the community-based care and support services strategy.

4.7 TB/HIV

Results from the TB Prevalence survey conducted in 2015 indicated prevalence for all forms of TB at 253 cases per 100,000, higher than the 2015 WHO estimate of 159 cases per 100,000. The survey showed a 23% HIV co-infection rate, compared to 48% of clinical cases reported in the national program data. This difference could be the result of sampling from the general population as opposed to those seeking treatment. While women sought care more often than men (67% vs. 53.9%), bacteriologically confirmed TB was more prevalent among men (76.2% vs. 23.8%).

As of APR15, 67% of new and relapsed TB clients had a documented HIV status, and 88% of TB/HIV co-infected patients were using ART. Within HIV clinics, 80% of PLHIVs were screened for TB at the last clinical visit. Although this coverage seems low, TB data was only recently introduced into the Uganda District Health Information System (DHIS2). When comparing DHIS2 reporting with SIMS data, we find complete and accurate data on TB/HIV indicators at the facility level and incomplete data capture in the DHIS2. PEPFAR programs will work with facilities to improve TB/HIV data reporting and provide mentorship and support for data quality assessments.

The national model recommends an integrated model for TB/HIV service delivery. Integration improves HTC among known and presumptive TB clients, promotes early detection and initiation of TB/ART co-treatment, and facilitates follow-up by consolidating clients' clinical checks and refills into one appointment. Early identification and treatment for TB and HIV and improved retention and adherence will contribute to HIV viral suppression among co-infected clients. In FY17, PEPFAR will continue to support these core services:

- Provide TB screening at every visit to HIV clinics to ensure presumptive TB clients are diagnosed and clients without active TB are started on IPT.
- Ensure all known and presumptive TB patients are provided with HIV testing and, if positive, linked to HIV care.

PEPFAR will continue investments in the sample transport network, expand Xpert MTB/Rif EQA activities, and introduce real-time reporting using GX Alert. PEPFAR will also support national-level program coordinators to identify program gaps; drive necessary policy and implementation changes; and ensure coordination among partners, the National TB and Leprosy Program (NTLP) and the AIDS Control Program. Operations research for Xpert MTB/Rif will assess the effectiveness of the GXAlert system to improve case detection, early treatment initiation and monitoring of the Xpert MTB/Rif network. The 40 laboratory hubs lacking Xpert MTB/Rif machines will be prioritized for new machines. PEPFAR classified TB sputum microscopy supplies and Xpert MTB/Rif cartridges as near core and will transition to the GOU/GF in subsequent years.

Children contribute 7.5% of the notified TB cases, yet 15% of people with TB are estimated to be children (NTLP). FY15 SIMS findings reveal that 38% of sites scored red for provision of ART to HIV+ pediatric TB cases. To address this gap in FY15, a Pediatric TB curriculum was developed that included modules on screening, diagnosis, treatment, and prophylaxis of children, as well as a module focused on integrating intensive case finding, infection control, and IPT into PMTCT/MNCH settings. COP16 funding will continue to support CXR diagnosis in children who cannot produce sputum and provide ongoing mentorship, supportive supervision, and QI for pediatric TB.

Additionally, to assist in addressing the low coverage of identified pediatric TB cases, HOP funding is being used to evaluate whether a household-based approach to intensified TB and HIV case finding using index TB clients will improve identification and treatment coverage of children. SIMS visits revealed that 90% of sites assessed in FY15 for appropriate provision of IPT scored red due to erratic supplies and stock-outs. The GF provides all TB drugs, including Isoniazid. PEPFAR will continue to support IPT roll-out through capacity building and mentorship of health care providers and provide support to the NMS supply chain challenges.

4.8 Adult treatment

Uganda will expand Test and Start to all populations. The policy and implementation plan is awaiting cost estimates, procurement, and modification of commodity distribution arrangements to ensure ARV availability in public sector facilities, where 75% of newly-identified PLHIV are seen.

By APR15, treatment coverage was 62% (804,555/ 1,301,084), or 77% of the 1,040,867 needed for saturation. Program retention at 12 months is estimated at 91%, while 12-month cohort retention is estimated at 79%. This difference is likely due to silent transfers, mobile populations, and documentation challenges. By the end of FY17, we anticipate 1,196,557 to be currently on treatment, translating into a national coverage rate of 81%. PEPFAR will initiate 310,364 new ART clients, 113,197 (36%) of whom are expected to come from the current pre-ART pool.

Differentiated service delivery models (SDM) will allow the adoption of Test and Start. In collaboration with the MOH, stakeholders, and implementing partners, guidance is being developed to shift stable clients from six clinical assessments and refill visits (both with a nurse or clinical officer) to two clinical assessment (with nurse or clinical officer) and two refill visits (with expert client, dispenser, and/or client-led groups). Differentiated SDM will streamline ART distribution by using community models such as peer group pick-ups. Additionally, decongestion at clinics will permit providers more time for newly initiating, children, pregnant women, KP, and ill/virally non-suppressed PLHIV.

In addition, PEPFAR will continue to focus on improving the quality of Uganda's treatment program with an emphasis on improving bidirectional community-facility linkage, retention in care, treatment literacy, adherence support, and viral suppression through activities such as deploying increased numbers of peer counsellors and educators from KP and PLHIV networks and strengthening community-based organizations and government and community structures. Relevant tools and strategies under development will help guide and better monitor this effort.

PEPFAR is gaining efficiencies by transitioning low-volume sites. In FY15, 80% of ART patients were at 15% of the 1,461 PEPFAR-supported sites. Sites with less than 21 ART patients will transition to GOU support by the end of FY16.

GOU has an estimated ARV funding gap of \$55 million through FY17. To enable scale-up, PEPFAR will use existing pipeline to mitigate the stock out projected for January 2017. Also, the GOU/PEPFAR modified commodity arrangement will allow public-private stock transfers. Support will be provided to the National Medical Stores to improve financial and distribution tracking systems. PEPFAR will assist the GOU in

accessing better pricing, improving procurement transparency, and using financial and service data for new service delivery models.

PEPFAR will support MOH's transition to VL testing for ART monitoring. COP15 VL scale-up catalytic central funds, and remaining PMTCT/ART integration central funds are being used to strengthen the sample referral and results delivery system, improve VL coverage, ensure staffing at the Central Public Health Laboratory, and enhance VL program data systems. The goal is to achieve 80% coverage of VL monitoring by APR16.

In COP16 PEPFAR will:

1. Support training and mentorship of HCWs to interpret VL results and make appropriate clinical decisions
2. Procure VL reagents for public and NGO/FBO/for-profit sectors
3. Work with MOH to establish an adult 3rd line treatment program
4. Modify commodity forecasts to accommodate increased numbers of PLHIV switching to second and third line regimens
5. Strengthen VL M&E
6. Maintain sample transportation and lab testing through the laboratory hub system
7. Ensure sufficient staffing at the CPHL.

While the overall VL suppression is 90.7%, pediatric suppression (<18) is only 75.4%. Retention and adherence are critical to maintain adult suppression and address poor pediatric suppression. PEPFAR will also support infant and HIV drug resistance (HIVDR) surveys in COP16.

SIMS data reveal the weakest domain is patient tracking: 43% of sites scored red or yellow. This is attributed to incomplete tracking systems (or poor documentation) that do not confirm when lost clients return to care. PEPFAR will expand the use of EMRs and electronic adherence reminders, engage community cadres, and strengthen CBOs.

National-level support will focus on policy, planning, coordination, monitoring, supervision, supply chain, MOH technical capacity, laboratory systems, and QI. PEPFAR will continue to support DSD in remaining high-volume NGO/FBO/for-profit sites and expand DSD in the public sector. Supportive supervision, including M&E reporting, mentorship and QI at site and district levels will ensure quality HIV services.

4.9 Pediatric treatment

Uganda began implementing Test and Start for children <15 years in 2014, with treatment coverage growing from 22% (2013) to 41% by the end FY15. There is no longer a pool of pre-ART children. Further enrollment depends on identifying new CLHIV.

SIMS data suggest that routine HIV testing for children is not provided at many facilities. PEPFAR plans to address testing barriers for the different age groups. For children <18 months, EID coverage will be improved by following-up with children who do return for EID testing, providing EID during immunization outreaches, and improving EID messaging to pregnant and breastfeeding women. Tracking of mother-baby pairs using the birth cohort monitoring will enhance the program's ability to monitor HEI through final outcome and ensure that mother and infant are receiving interventions necessary to minimize MTCT during breastfeeding.

The proposal to begin HIV rapid testing at 9 months (followed by DNA PCR for those testing positive) to coincide with the measles vaccination will help identify HEI who may have seroconverted after the initial DNA PCR test. For older children, strategies will target PITC entry points including in-patient wards, TB clinics, malnutrition clinics, and OVC programs. To better estimate entry point yields, an HTC yield evaluation will be conducted in FY16. Linkages between entry points and ART initiation will continue to be emphasized.

There are 87,236 adolescents living with HIV in Uganda. Girls contribute to 67% of new infections, while boys have the majority of HIV-related deaths. Access to HTS remains low among adolescents. Only 64% of girls and 28% of boys aged 15-19 have ever tested for HIV. Barriers to adolescent testing are being addressed in the revised National HTC policy, which will remove the parental consent requirement for adolescents 12+ years. DREAMS will help identify and link AGYW to HTS. Additionally, PEPFAR shall ensure integration of HTS within sexual and reproductive health service points. All identified HIV-positive adolescents will be linked to care and treatment through linkage facilitators.

Care and treatment services for HIV-positive children and adolescents will remain facility-based, given the need for trained HCWs to change dosing and monitor for viral non-suppression. Additionally, the potential for caregiver changes that could lead to adherence and retention challenges necessitate that children stay in a facility until an assessment can be made. PEPFAR will continue focusing on strengthening adherence and retention among children and adolescents through CQI.

Given the lack of adolescent-friendly HIV services at the majority of facilities (55% of sites scored red), PEPFAR is using COP15 funding to provide TOT trainings, TA, and mentorship. PEPFAR will continue

focusing on access to testing, disclosure, peer support for adherence and retention, and transition to adult services.

SIMS data indicate referrals from facility to community are poor. PEPFAR is linking pediatric and OVC programs to ensure HIV-positive OVC are identified and linked to care and treatment, and eligible HIV-positive children and adolescents in care and treatment are linked to OVC programs.

Viral non-suppression rates among children and adolescents range between 20-25%. The primary cause for these high numbers is ongoing use of NNRTI-based first line ART regimen for <3 children. Viral non-suppression is being addressed by emphasizing the use of LPV/r-based regimens in three ways:

1. Dissemination of a MOH circular on preferred first-line regimen for <3 children
2. Procurement and introduction of LPV/r pellets to remove the need for cold chain
3. Intensive mentorship of district health teams, IP, and health workers

Other causes of non-suppression include incorrect ARV dosing due to representation of children by their caregivers at clinic visits and adherence challenges among adolescents. PEPFAR will emphasize the use of peer support groups among adolescents to improve adherence and retention.

PEPFAR is testing all children <15 for VL suppression so as to quickly identify those who are not suppressed and provide interventions to achieve viral suppression.

4.10 OVC

According to the State of the Ugandan Children report, 11.3% of children are orphaned (46% HIV-related), 70% drop out of school before completing primary grades, 62% live in poverty, teenage pregnancy is 24.8%, adolescent girls account for 66% of new HIV infections. The number of CLHIV is 138,435, with only 41% on treatment.

In order to mitigate the impact of HIV and other vulnerabilities that increase of HIV infection, new OVC programs will be aligned to the 61 scale-up districts. The program will target 390,397 total beneficiaries in the scale-up and the sustained districts. It will graduate or transition 34,149 in sustained districts that will still have active beneficiaries at the end of FY16. In the scale-up districts, 28,650 OVCs will graduate from the program and 28,650 new OVCs will be enrolled during FY17. By the end of FY17, PEPFAR Uganda will target 353,917 active OVCs (based on the MER 2.0 definition of OVC_SERV), of whom 218,005 (75%) will be children <18. In addition, 76,574 OVCs will be served through the DREAMS initiative.

In scale-up districts, OVC will support efforts to:

1. Prevent HIV infection among children (focusing on AGYW) and caregivers;
2. Promote testing of OVCs and caregivers with unknown status, and ensuring linkage to treatment for all identified as HIV+;
3. Assess all HIV+ children, HEI, children with HIV+ siblings, and caregivers and enroll those eligible into the OVC program; and,
4. Enable OVC households to reach a degree of self-sufficiency and graduate from direct project support so children and caregivers will remain HIV free or on treatment without ongoing direct PEPFAR support.

Partners will continue employing a family-based approach. In DREAMS districts, interventions targeting AGYW will be coordinated and complementary to ensure higher-risk beneficiaries receive OVC services. Partners will replicate elements of DREAMS in the non-DREAMS districts. Partners will also strengthen the community-facility linkages aimed at scaling up HTC, adherence support, and retention of HIV-positive OVC household members.

A two-pronged approach to identify and link OVC to services will be strengthened. At the community level, households with members of unknown status will be linked to health facilities for HIV services using community structures (VHTs and Para-social workers). At facility level, linkage facilitators will assess all HIV identified clients and link them to the community structures for OVC services.

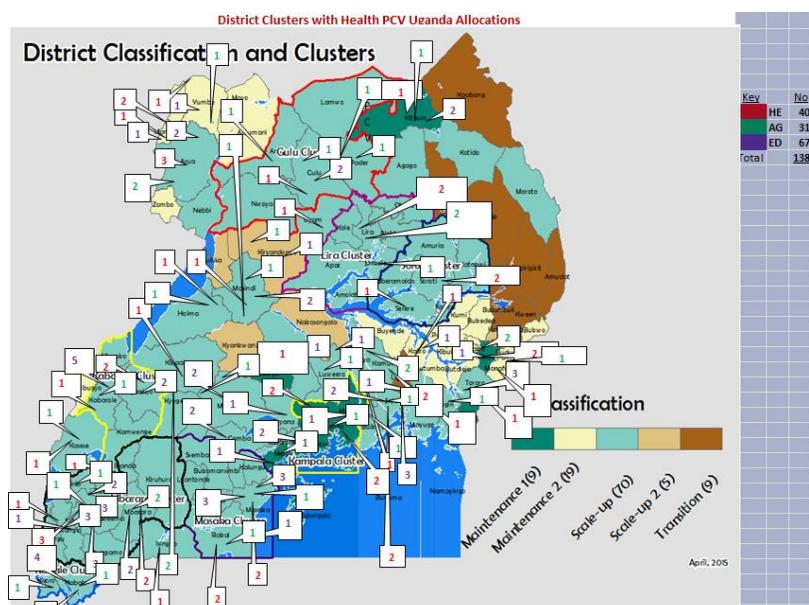
Case management was identified as a key gap during an OVC portfolio review (Q1 2016). Emphasis will be placed on strengthening case management skills and practices at community and district levels. To strengthen district-level child protection systems, PEPFAR will continue supporting capacity building of formal and informal community structures through child protection training, advocacy for filling vacant child protection positions, mentorship on data collection and reporting, and operationalizing coordination structures to enhance quality child protection and health services.

At the national level PEPFAR will continue to support implementation of the OVC MIS system; refine and standardize tools for OVC assessment, graduation, case management, and data collection; and encourage coordination between child welfare and health sectors.

4.11 Peace Corps

Nearly all of the 150 Peace Corps Volunteers (PCV) in Uganda are partially or fully funded by PEPFAR. Forty PCVs work in health, 67 in education, and 31 in agribusiness. Eleven doctors and nurses under the Global

Health Service Partnership Volunteers (100% PEPFAR funded) support training of medical practitioners at health institutions in Uganda.



HIV/AIDS implementation in PC Uganda is cross-sectoral, which means volunteers in all the sectors are trained and engaged in HIV/AIDS-related activities. Health volunteers are placed in PEPFAR priority districts, supporting the following technical areas:

HIV/AIDS Prevention

Volunteers are engaged in social mobilization of priority populations for HTC, PMTCT, VMMC, and condom education and distribution. Volunteers support development and distribution of HIV/AIDS-related materials to key stakeholders and the community. Through camps, youth clubs, and peer groups, Volunteers organize and provide life skills training to ensure young people aged 14-18 grow to be responsible members of their communities and remain HIV negative. Volunteers also engage in girl-centered empowerment program, where AGYW are trained in life skills and leadership, gender equitable practices, gender equality and women's empowerment.

OVC

With PEPFAR support, PC provides funds for PCVs-generated small grants projects that serve community needs. These projects target OVC and their families to improve household income and food security. PC supports income generating projects such as poultry, bee-keeping, animal rearing, village loans and saving schemes. Volunteers also help link OVCs to partners that offer child protection, education, and HIV services.

Supply Chain

Starting in 2015, PC rolled out a supply chain initiative to help minimize drug stock outs at health centers. The initiative assists health centers with drug labelling, stock cards, dispensing logs, forecasting, ordering/recording and reporting.

Other Prevention

Volunteers help with capacity building of village health teams, peer educators, and community resource persons to support community-based service delivery that includes home visits for those on treatment to improve adherence, data collection, and reporting.

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of services and expected volume in sustained support locations and populations

The package of services to be provided by PEPFAR in geographic areas outside of priority areas and populations is similar to that provided with COP15 funding. PEPFAR will not conduct demand generation

for HTC; however, HTC will be offered if requested, passive ART enrollment will continue, and women will be enrolled as needed on Option B. Once identified, PLHIV in sustained districts will receive the same package of PEPFAR-supported services as those in scale-up districts. District level support for lab hubs, supportive supervision, training, and data collection, reporting and use will also continue in these districts. Please see Appendix A for a detailed list of interventions included in the core package for adult, pediatric, TB/HIV, and PMTCT clients. Given that there is no difference in the package of services for PLHIV between scale-up districts and sustained districts, the unit cost for ART and PMTCT is applied equally across both categories of districts.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts

Sustained Support Volume by Group	Expected result APR 16	Expected result APR 17	Percent increase (decrease)
HIV testing in PMTCT sites (<i>PMTCT_STAT</i>)	377,433	419,180	11%
HTS (only maintenance ART sites in FY 17) (<i>HTC_TST</i>)	1,176,298	152,8,448	(30%)
Current on ART (<i>TX_CURR</i>)	130,873	159439	22%
OVC (<i>OVC_SERV</i>)	34,593	34592	0%

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

As part of COP15, PEPFAR, the GOU, and district leadership transitioning PEPFAR support from sites meeting the transition criteria, including patient numbers and type of support (DSD or TA). Transition timelines were based on patient volume and facility type. The transition plan included engagement with the districts, CSOs and affected communities to prevent service delivery interruptions.

Using the transition criteria, ten districts with a total of 96 sites qualified for transition. By December 2015, PEPFAR had transitioned out of all of these sites. PEPFAR previously provided support or minimal TA to these districts.

Additionally, 543 sites in scale-up and maintenance districts will be transitioned to GOU by September 2016. Of these sites, 126 were stand-alone HTCs, accredited to scale-up elimination of MTCT (EMTCT) activities and mostly designated as “lower health centers” (HCII.) PEPFAR transitioned out of these sites in November 2015. The remaining sites are either DSD public facilities with HR support or private not-for-profit (PNFP) sites previously receiving HR and commodity support. Public and PNFP sites will both be transitioned by June 2016, allowing the GOU time to absorb these staff. PEPFAR will not transition out of any sites in COP16. PEPFAR will continue providing support to the transitioned districts/facilities, including:

- M&E and CQI
- Laboratory hub support
- TA for data management and reporting
- HMIS in transition sites & districts
- Quarterly checks on data to identify any epidemic spikes.

PEPFAR has begun discussions with the Ministry of Gender Labor and Social Development in preparation for the exit from the sustained districts providing OVC services. The process will ensure that by the end of FY17 the districts are prepared for transition. The main strategy to support OVC households in these districts will be aggressive economic empowerment leading to sustainable graduation. An anticipated 15% of participants will graduate by the end of FY17. Those who have not graduated within the allotted time will be transitioned. The transition action plan will include strengthening existing formal and informal child protection structures, community-facility linkages to access health care including HIV services, strengthening OVC coordination structures, identifying local partners that can provide OVC services and advocating for more government funds to support OVC activities.

Table 6.1.1 Key Programmatic Gap #1: Low identification of PLHIV in Scale-up districts						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP ¹⁶	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Current HTS policy and guidelines are not aligned to current WHO guidelines	1.HTS policy and guidelines aligned to current WHO guidelines 2.Full implementation of revised HTS policy and guidelines	Support development and roll-out of the new national testing algorithm and revised HTS policy	HVCT,	\$120,000	MOH	HRH, 6.92
TOTAL				\$120,000		

¹ Comprehensives: (CDC Regional Mechanisms Kampala, Hoima, Arua, Soroti, Masaka, Mubende and Fortportal – TBDs) (USAID RHITES SW, and RHITES E, EC, Lango & Acholi _TBDs)

Table 6.1.2 Key Programmatic Gap #2: Low ART coverage in aggressive scale up districts

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Inadequate HRH at MOH, district, community and facility level	1. Increase critical cadre staffing from 69% to 75% in scale up districts 2. 50% increase in number of community health workers to support TS and SDM in priority & scale up districts 3. Wage bill increased to meet the 6% increase in staffing 4. 70% of PEPFAR funded staff transitioned to GOU	Support 1692 PEPFAR seconded HRH	HBHC, PDCS PDTX, HTXS	\$4,272,752 \$291,713 \$290,692 \$2,964,843	SDS, Seven COMPREHENSIVES	HRH, 6.92
		Recruit and second technical advisors to increase the technical capacity of MOH to plan and coordinate one national health sector response to HIV/AIDS for coordination, planning and oversight of Pediatric ART, PMTCT, TB, ART, SI, HTS, VMMC, care, Key population, including the pediatric call center.	HBHC MTCT PDCS PDTX HTXS HVTB HTC OHSS OHSS	\$150,000 \$100,000 \$914,802 \$100,000 \$250,000 \$1,355,761 \$150,000 \$500,000 \$400,000	DOD, TRACK TB, Kampala regional TBD MOH AFENET	HRH, 6.92
		Advocate for increased wage bill for HCW from GOU using the platforms of CSO budget advocacy groups; working with parliamentary budget committees, media campaigns (radio and TV), analytics on	OHSS HBHC HTXS	\$200,000 \$100,000 \$100,000	SHRH, ABH	HRH, 6.92
		Support MOH in policy to revise staffing norms to align	OHSS	\$298,876	SHRH	HRH, 6.92
		Continue support to lay HRH (linkage facilitators, case managers, Peer Supporters) to complement critical health workforce at	HBHC, PDCS OHSS	\$1,111,035 \$86,000 \$100,000	MOH, COMPREHENSIVES, WHO	HRH, 6.92
		Support districts to plan and distribute critical HRH among scale up/high volume sites	OHSS	\$220,000	SDS, seven COMPREHENSIVES	HRH, 6.92
		Provide TA for recruitment of	OHSS	1,050,000	SHRH	HRH, 6.92

Table 6.1.2 Key Programmatic Gap #2: Low ART coverage in aggressive scale up districts

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
		more skilled and critical HRH including absorption of PEPFAR seconded staff (midwives, clinical officers, doctors, nurses, lab personnel under the planned new GOU recruitment of 5,000 HW in FY16-17) who offer quality HTS and HIV services (care, treatment, lab); and Support HRIS system used for HRH recruitment, planning and management				
		Provide TA to health professional councils to regulate , coordinate and provide oversight, to private	HBHC,	\$200,000	PHS	HRH, 6.92
Inadequate stocks (supplies) and weak logistics system to manage the HIV commodities	<ol style="list-style-type: none"> No ARV stock-outs at national and site levels Increased GOU funding for HIV commodities from 20% to 30% of the national need. A robust and strengthened logistics system for managing HIV commodities 	Strengthen national capacity to effectively and routinely plan for HIV commodity resources through timely updates to commodity forecast (including monitoring supply plans, TA)	OHSS	\$850,000	UHSC,	Tech. & allocative efficiency 1.31
		Provide TA for pricing and efficiency analysis to GOU to	SFI	Non-COP Funds-		DRM, 2.78
		Scale up the electronic Logistics Management Information Systems which will include the Web-based ARV Ordering System (WAOS), Lab supplies ordering system, TB	OHSS	\$1,200,000	UHSC	Commodity security and supply chain, 4.54
		Support the rollout and implementation of supply chain logistics management adjustments as a result of	OHSS	\$550,000	UHSC	Commodity security and supply chain, 4.54

Table 6.1.2 Key Programmatic Gap #2: Low ART coverage in aggressive scale up districts

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
		Establish a robust system of capturing supply chain data at MOH and pro-actively provide	OHSS	\$394,258	METS	Commodity security and supply chain, 4-54
		Support reforms for Supply Chain Management at the National Medical Stores to facilitate transparent management of HIV medicines and other supplies within the public sector (This activity will include instituting a Fiduciary Agent at NMS, embedding TA at NMS, and increasing and expanding the roles of district/facility medicines management supervisors-MMS in tracking commodities, and building capacity of additional100 MMS in high volume sites)	OHSS	\$1,700,000	UHSC	Commodity security and supply chain, 4-54
			HTXS	\$3,600,000		
		Support CSOs advocacy efforts with MOFPED, MOH, NMS, GF, USG, Parliament to assure increased domestic funding for ART.	HTXS	\$150,000	ABH	DRM, 2.78; CS engagement, 5 and public access to info., 6.0
		Provide technical support to the Emergency Operating Centre for real-time monitoring and reporting across program areas including Early Infant Diagnosis and Viral Load testing	HTXS MTCT	187,450 187,450	METS	Performance data, 8.3
Facilitate district medicine management supervisors with tools to track HIV commodities	OHSS	\$450,000	UHSC	Commodity security and supply chain 4-54		

Table 6.1.2 Key Programmatic Gap #2: Low ART coverage in aggressive scale up districts						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
		at ART sites across the public and private sectors				
Quality for ART program management		Provide technical support and oversight for Quality Management/ Quality Improvements (QM/QI) including provision of relevant policies and implementation guidelines for data quality and utilization.	HBHC, PDSC PDTX, HTXS,	\$50,000 \$50,000 \$50,000 \$50,000	ASSIST/METS	Quality Management, 6.24
			OHSS OHSS	\$255,702 \$250,000	METS SDS	Quality Management, 6.24
						Performance data, 8.3
			PMTCT impact/effectiveness	MTCT	\$850,000	MUSPH
TOTAL				\$ 26,931,334		

By APR15, national treatment coverage was estimated at 57%, of which 46% was in aggressive scale-up districts. PEPFAR aims to achieve 81% ART saturation in all scale-up districts by APR17. Barriers to scale-up include HR constraints, supply chain challenges, and data management. Vacancy rates for critical cadres (medical and clinical officers, midwives, etc.) are over 36%. Uninterrupted availability of ARVs at sites requires support for supply chain management capacity. As Uganda implements Test and Start, funds for commodity procurement are required. The restrictions on inter-warehouse transfer of ARVs between the private and the public sector needs to be addressed. Data quality has been hampered by incomplete reporting in DHIS2 as a result of inadequate personnel, shortage of reporting tools, and limited use of EMR.

Table 6.1.3 Key Programmatic Gap #3: low viral load coverage and sub-optimal viral load suppression in certain sub-groups						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Inadequate HRH to support VL testing (numbers and skills at CPHL/UNHLS and facility level)	<ol style="list-style-type: none"> Increased VL tests from about 600,000 tests to 1.2 million tests per year Establishment of Uganda national health lab services with 40% of HRH supported by GOU reduction in the sample rejection rate from 14% to <5% 	Recruit and second technical advisors and officers for	HLAB	\$1,189,920	AFENET	Laboratory, 5.69
		Provide TA for revising staffing norms and advocacy to expedite the enactment of the	HLAB	\$200,000	SHRH	Laboratory, 5.69
		Build health workers capacity for sample management, clinical monitoring, supply chain and equipment	HLAB	\$950,000	AIHA, COMPREHENSIVES	Laboratory, 5.69
Interruption in the sample transportation system and results transmission schedule	<ol style="list-style-type: none"> 100% facilities submitting samples to hubs as per national hub guidelines VL turnaround time for results from CPHL to 100 hubs – is within two weeks 	Recruit one additional hub rider for each of the 100 hubs	HLAB,	\$600,000	COMPREHENSIVES	Laboratory, 5.69
		Implement lab quality management systems (SLMTA/SLIPTA) at UNHLS/CPHL, 100 hubs and 6 military facilities		\$560,624	AGHPF, MUWRP	
		Revise the Lab hub policy and implementation guidelines	HLAB	\$120,000	WHO	Laboratory, 5.69
		Implement national LIMS strategy to capture, transmit and use lab data in all 100 hubs	HLAB	\$300,000	APHL, METS	Laboratory, 5.69
Inadequate quality of HIV care	<ol style="list-style-type: none"> Reduction in OIs among PLHIV from 45% to less than 20% In increased retention of HIV patients from 80 to 95% Increase VL suppression rates to 95% Accurate and reliable VL results for patient management 	Support roll-out and implementation of the National minimum care package to all supported sites	HBHC	\$ 1,197,035	MOH, COMPREHENSIVES	Service delivery, 5.88
		Provide mentoring for comprehensive interventions and QI at facility level	HVTB HBHC	\$ 100,000	MOH, COMPREHENSIVES	Service delivery, 5.88
		Procure commodities for identification, management and treatment of co-morbidities	HLAB HBHC	\$200,000 \$ 4,585, 508	SCMS MAUL/SCMS	Commodity security and supply chain, 4.54

Table 6.1.3 Key Programmatic Gap #3: low viral load coverage and sub-optimal viral load suppression in certain sub-groups						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
	Reduced stock out of lab supplies and logistics	Functionalize GXAlert and support EQA for GeneXpert, AFB microscopy, sputum culture, CD4, HIV Drug Resistance, CRAG and Viral Load	HVTB HLAB	\$900,000 \$389,583	MUWRP UVRI	Laboratory, 5.69
		Procure food supplements for malnourished patients	HBHC	\$2,570,480	PIN	Service delivery, 5.88
		Support demand creation uptake of services including Test& Start, VL, differentiated service delivery models, TB case detection, targeted HIV testing for partners and children of PLHA. Promote key behaviours including adherence; retention; partner testing; consistent condom use etc.; and standardize job aides, SBCC messages to reach out to both primary and secondary audiences.	HTXS MTCT	\$367,999 \$300,000	CHC	Service delivery, 5.88
		Provide TA to the UNHLS/CPHL for laboratory logistics and supply chain to support VL	OHSS	\$450,000	AFENET	
		Conduct viral load DBS validation study to standardize in country cut-off points	HLAB	\$100,000	TBD regional Kampala	Laboratory, 5.69
		TOTAL				\$ 15,191,773

VL monitoring is essential for treatment to minimize the risk of HIVDR, to maximize the long-term effectiveness of first-line ART, and to ensure program sustainability. At APR15, only 21% of ART patients received VL tests. The COP16 target is 100% of all ART clients. System barriers include HR constraints, inadequate laboratory capacity, weaknesses in sample referral and result-delivery systems, and poor data management. The Central Public Health Laboratory (CHPL), where centralized VL testing is conducted, is not yet fully established with GOU-allocated budget and staffing. As of APR15, approximately 90% of VL personnel were supported outside GOU. While efforts are ongoing to increase the current CPHL capacity, VL suppression also requires that critical gaps be addressed in equipment maintenance, staffing, commodities management, and CQI to ensure uninterrupted service.

Table 6.2.1 Test and Start						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Lack of data on cost implication to support Test and Start policy adoption	1. Costed national test and start plan developed using evidence 2. Test and treat policy adopted	Support MOH to develop and disseminate national policy on	OHSS	\$100,000	MOH	Policies and governance, 7.17
		Conduct costing studies to inform HIV programming Support with pricing analysis and supply chain efficiency	NA	Non-COP Funds-Centrally Funded \$	SFI/EQUIP	Technical & allocative efficiency, 1.31
		Support the institutionalization of HIV/AIDS spending accounts	NA	Non-COP Funds-Centrally	SFI	Financial/expenditure data, 6.25
Inadequate funding	1. Increased GOU funding allocation for HIV/AIDS commodities from current 16% to 30% of national need	Support civil society efforts to track GOU commitments towards ARV funding and increase transparency/accountability of HIV resources;	HTXS	\$150,000	ABH	DRM, 2.78
Lack of updated and accurate data on HIV burden	1. PHIA data available and used by all stakeholders for annual planning and resource allocation	Conduct PHIA (see first 90)	HVSI	Non-COP Funds-Centrally Funded	CDC Central Mechanism	Epidemiological and Health data, 5.3
TOTAL				\$250,000		

Table 6.2.2 New and efficient service delivery models						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Lack of national policy and guidelines – on new service delivery models	<ol style="list-style-type: none"> Differentiated service delivery model policy in place 50% of districts implementing new service delivery model 	Develop and disseminate new HIV/AIDS service delivery policy and operational guidelines	OHSS	\$100,000	MOH	Service delivery, 5.88
		Develop M/E framework and print and disseminate tools for new service delivery models	HVSI	\$400,000	METS/SITES (TBD)	Performance data, 8.3
		Develop (pre-test) and implement communication strategy for the differentiated HIV care service delivery	HBHC	\$80,000	CHC	Service delivery, 5.88
		Support the coordination and national roll out the service delivery models policy, guidelines	HBHC, HTXS PDTX,	\$ 150,000 \$ 150,000 \$ 150,000	EGPAF /TA	Service delivery, 5.88
Weak community health system	<ol style="list-style-type: none"> Improved and strengthened linkages between facilities and communities All districts developed and implement new SDM and T/S plans Improved technical capacity by level to plan and coordinate implementation of new models 	Strengthen district and site level oversight to community structures involved in differentiated service delivery model	HBHC, PDCS	\$ 1,220,000	Comprehensives	Service delivery, 5.88
			OHSS	\$250,000	SHRH	
		Build capacity of selected client groups, CBOs and umbrella PLHIV networks to support community based HIV/AIDS services including sub-granting to CSOs for SDM at national and district level	HTXS	\$300,000	ABH	Service delivery, 5.88
		Dissemination and implementation of the HIV/AIDS community based care strategy	OHSS	\$150,000		
Lack of information on effectiveness and efficiency of the models	Publications on the evidence of efficiency and effectiveness of the models	Evaluate service delivery models	HVSI	\$100,000	WHO	Service delivery, 5.88
		Support community data information systems (including M&E)	OHSS	\$300,000	METS/SITES (TBD)	Tech. and allocative efficiency, 1.31
		Support community data information systems (including M&E)	HVSI	\$300,000	METS/SITES (TBD), Comprehensives, MOH	Performance data, 8.3
TOTAL				\$3,650,000		

PEPFAR will support the MOH in filling positions and facilitate policy development, QI, technical support supervision, strategic and resource planning, and performance reviews to monitor progress towards 90/90/90.

PEPFAR will continue to support local government structures to implement the HIV response through technical capacity of the DHTs, lower-level facility managers, health workers and community systems to coordinate, plan and implement the new strategic direction. PEPFAR will provide TA to support districts reorganize resources to address changes and accountability.

Weak capacity to produce HCW with the skills to scale-up HIV services hinders results. In COP 16 PEPFAR will strengthen health training institutions to increase the number and competencies of HCW in line with the innovative service delivery models. PEPFAR will support community health workers training. PEPFAR supports Public Health Workforce Development through offering the Master of Public Health, two year and eight month fellowship programs to health managers drawn from national, districts and private sector.

With Test and Start and differentiated-care models, facilities and medicine warehouses will need to store larger quantities of commodities. Regional hub warehouses with a minimum 6-month capacity are needed to allow frequent deliveries. Warehouses will need adequate delivery trucks and staffing.

*Reference Appendix C for a list of activity types that fit in each category.

Table 6.3 Other Proposed Systems Investments							
Systems Category* (only complete for categories relevant to country context)	Activity	For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Finance							
	Provide TA to GOU to finalize and implement new health care financing strategy and adopt a national health insurance program that covers HIV/AIDS	All the 90s and sustained epidemic control	<ol style="list-style-type: none"> 1. Health financing strategy adopted and implemented 2. National Health insurance adopted and implemented 	Non-COP Funds-Centrally Funded	Central Mechanism	SFI	Domestic resource mobilization (2.78)
	<ol style="list-style-type: none"> 1. Facilitate loan guarantees to private health sector to invest in HIV/AIDS 2. Provide TA for implementation of tax reforms to increase domestic resource mobilization for HIV/AIDS 3. Develop and implement expenditure tracking system for HIV/AIDS 	Sustained epidemic control	<ol style="list-style-type: none"> 1. Increased private sector investment from current 30% to 50% 2. Increase allocation to health sector from 8.9 % to 10% of national budget 3. National AIDS spending monitoring system institutionalized 	Non-COP Funds-Centrally Funded	SFI Central mechanism	PHS	Domestic resource mobilization (2.78)
Governance							
	Establish a project Implementation unit within the MOH to improve accountability, financial and reporting oversight functions for	1) First 90; 2) Second 90; 3) Third 90;	Accountability and reporting systems for PEPFAR funds established at MOH	\$600,000	OHSS	MOH	policy and governance, 7,17

	PEPFAR funding under the MOH CoAg.						
	Increase the technical capacity of the DHTs, health facility managers and local governments to coordinate HIV activities, hold monthly performance reviews, and develop plan for HIV/AIDS (includes accountability plans for results related to PEPFAR resources, progress on implementation of the SDM and T/S plans)	Sustained Epidemic Control.	1. All PEPFAR supported districts implement annual work plans aligned to 90-90-90, SDM and T&S	\$818,258 \$376,599	OHSS OHSS	METS/ SDS	Planning and coordination, 8.67
HRH - Systems/Institutional Investments							
	Support HIV/AIDS fellowship program for District health managers	Sustained Epidemic control	400 district health managers graduate from fellowship program	\$1,500,000	OHSS	MAKSPH	Human Resources for Health, 6.92
	Strengthen institutional production capacity of pre-service education to increase the number HCWs competent in HIV/AIDS services	1) First 90; 2) Second 90; 3) Third 90 and 4) Sustained Epi Control.	Increased number of graduates with competences to manage HIV/AIDS	\$100,000	OHSS	SHRH	Human Resources for Health, 6.92
	Provide TA for HRH performance management and formalizing	1) First 90; 2) Second 90; 3) Third 90 and 4) Sustained Epi Control.	Absenteeism reduced from 50% to 25%	\$350,000	OHSS	SHRH	Human Resources for Health, 6.92

	community health workforce.						
	Support pre-service training for critical cadre in hard to reach, hard to stay priority districts	1) First 90; 2) Second 90; 3) Third 90 and 4) Sustained Epi Control.	Improved retention of HRH in priority districts	\$400,000	OHSS	SHRH	Human Resources for Health, 6.92
Institutional & Organizational Development							
	Support planning, management and reporting for health/ HIV/ AIDS activities within private sector	Second 90 and sustained epidemic control	Strengthened capacity and oversight function of regulatory bodies in public and private sector facilities.	\$50,000	PDCS	PHS	Civil Society Engagement 5.00
Laboratory							
	Support IQA/EQA for HTS	First 90	All facilities pass the quantitative EQA with score of 80%	\$1,000,000	HLAB	UVRI, MOH, PHS, COMPREHENSIVES	Laboratory, 5.69
Strategic Information							
	Availability of quality data	First 90	Strengthen quality improvement processes at district and facility level	\$155,702	OHSS	METS	Epidemiological and health data 5.30
	Support sites and districts to submit timely reports into DHIS2; conduct district quarterly performance reviews and DQAs (nationally)	1) First 90; 2) Second 90; 3) Third 90 and 4) Sustained Epi Control.	1. Improved reporting rates from 70% to 95% resulting in more accurate data for evidence-based planning including private facilities. 2. Population-based HIV Impact Assessment (PHIA) data available every two years for planning and programming	\$84,080 \$138,000 \$201,000 \$88,500 \$201,000 \$201,000	OHSS, MTCT HBHC PDCS HTXS, PDTX	METS COMPREHENSIVES ASSIST	Performance data, 8.3 Epidemiological and health data 5.30
	Strengthen quality improvement processes at district and facility level			\$300,000	HVSI	METS METS/SITES (TBD)	Performance data, 8.3 Performance data, 8.3
	Increase coverage and capacity to use electronic systems for						

	<p>high volume sites. Equip 100% of high volume facilities with basic IT infrastructure to have a functional EMR by end of Q1.</p> <p>Support and fast track patient unique identifiers and integration in the national EMR Strengthen functionality and coordination of national M/E systems.</p>						
	<p>Provide technical support to the Emergency Operating Centre for real-time monitoring and reporting across program areas including Early Infant Diagnosis and Viral Load testing</p>			<p>\$125,000 \$37,450 \$187,450</p>	<p>HVSI HTXS MTCT</p>	<p>METS/SITES (TBD)</p>	<p>Performance data, 8.3</p>
	<p>Continue support in printing and distribution of HMIS tools. Priority to the PEPFAR reporting tools and registers</p>			<p>\$1,700,000</p>	<p>HVSI</p>	<p>METS/SITES (TBD)</p>	<p>Performance data, 8.3</p>
	<p>Roll out EMR systems, train and hire staff to support PEPFAR reporting. Currently 60% of high volume sites have new versions of OpenMRS. Target to have 100% of the sites with upgraded versions by Q1 reporting. Over 50% of targeted facilities require additional human</p>	<p>1) First 90; 2) Second 90; 3) Third 90 and 4) Sustained Epi Control.</p>	<p>Increased coverage for OpenMRS records from 60%-100%</p>	<p>\$1,600,000</p>	<p>HVSI</p>	<p>METS/SITES (TBD)</p>	<p>Performance data, 8.3</p>

	resources such as a records assistant to effectively run OpenMRS						
	Train district and facility site staff in M&E to increase capacity to plan and use data for evidence based decision making	1) First 90; 2) Second 90; 3) Third 90 and 4) Sustained Epi Control.	Improved reporting rates from 70% to 95% resulting in more accurate data for evidence-based planning including private facilities.	\$500,000	HVSI	METS/SITES (TBD)	Performance data, 8.3
	Strengthen national HMIS Standardizing HMIS tool and support the MOH to develop a national level HMIS tools specifications document for unified printing and version control Training and orientation and mentorship to new carders of staff as well as refresher trainings; Support the revision of national HMIS tools			\$1,500,000	HVSI	METS/SITES (TBD)	Performance data, 8.3
	Strengthen DHIS2 by cascading the DHIS2 trainings to all lower level facilities leveraging on the EMR IT infrastructure support. Data use workshops using district based platforms Deploy other advanced DHIS2 functionalities to improve data quality such as data approvals, locking and validation.			\$600,000	HVSI	METS/SITES (TBD)	Performance data, 8.3

	Developing web portals to improve data access and visualization						
Surveys and Surveillance activities	Conduct the Uganda Prisons Survey	All the 90s and sustained epidemic control	New data available for prison population programming	\$150,000	HVSI	Uganda Prisons Services	Epidemiological and health data 5-30
Surveys and Surveillance activities	Build capacity of UVRI to conduct surveillance, health informatics and operational research	3rd 90	UVRI generating periodic surveillance and survey report independently	\$100,000	HVSI	Uganda Virus Research Institute	Epidemiological and health data 5-30
Surveys and Surveillance activities	Birth Defects Surveillance for TDF among pregnant women	2nd 90	Study completed and evidence documented	\$500,000	MTCT	Implementation Science-Birth Defects Surveillance Study	Epidemiological and health data 5-30
Surveys and Surveillance activities	Conduct an evaluation of the combination prevention interventions implemented in Uganda	3rd 90	Impact of combination prevention on HIV transmission Uganda determined	\$200,000	HVSI	Makerere University School of Public Health	Epidemiological and health data 5-30
Surveys and Surveillance activities	Generate data for KP programming- Female sex worker linkage, Know your Sero status	All the 90s and sustained epidemic control	MARPS study report findings used for KP programming	\$1,000,000	HVSI	Uganda Virus Research Institute Priorities for Local Control Efforts (PLACE)	Epidemiological and health data 5-30
Surveys and Surveillance activities	Conduct evaluation of the PMTCT ANC Surveillance	first 90	Evidence available on validity of PMTCT data in comparison to ANC HIV surveillance data	\$50,000	HVSI	UVRI	Epidemiological and health data 5-30
Data quality for HTC	Print revised HMIS tools for HTC Support routine DQA and facilitate monthly reviews of HTS data at district and site level	First 90	Improved HTC data consistency between site and DHIS reports to acceptable levels of +/- 5%	\$200,000 \$126,792 \$250,000	HVSI HVCT	METS/SITES (TBD) Comprehensives, METS/ASSIST METS/SITES/TBD	Epidemiological and health data 5-30

	to improve HTS programming.							
Systems Development								
Strengthen the availability and accessibility of HIV commodities	Procure and install prefabricated warehouses in 33 scale up priority districts with high volume sites in response to differentiated service delivery model	These activities address 1) First 90; 2) Second 90; 3) Third 90; and 4) sustained epidemic control.	Increased warehousing capacity in 33 priority districts	\$2,000,000	OHSS	UHSC	Commodity security and supply chain 4.54	
TOTAL				\$ 16,590,831				

As Uganda adopts Test and Start and new service delivery models, strengthened governance becomes critical. PEPFAR will support the MOH in the following ways:

- HR
- Policy development
- QI
- Technical support supervision
- Strategic and resource planning
- Performance reviews to monitor progress towards 90/90/90.

At the district level, PEPFAR will continue to support government structures to implement the HIV response by supporting the

- Technical capacity of the DHTs, lower-level facility managers and HCW
- Community systems to coordinate, plan, and implement the strategic direction.

Health financing continues to be a challenge in Uganda. PEPFAR will continue to engage GOU on domestic resource mobilization and support the health financing strategy to establish a national health insurance scheme, which includes HIV/AIDS services. PEPFAR will explore other health financing options, such as community insurance and promote Performance-Based Financing to overcome current inefficiencies.

Access to quality laboratory services will ensure real-time results in for patient management.

Bushenyi HCIV laboratory hub, Mbarara, and Apac Hospital laboratory hubs are among the 100 hubs that ensure an effective sample transportation and result transmission network. These hubs were enrolled into the Strengthening Laboratory Management Toward Accreditation (SLMTA) program, which will allow them to meet their testing needs through improved infrastructure efforts. USG support to the GOU for the construction of the Mbarara Regional Referral Hospital Laboratory hub and refurbishment of Bushenyi HCIV and Apac Hospital laboratory hubs will expand laboratory space to accommodate increased demand for HIV diagnosis and disease monitoring in two high-burden and scale-up regions.

The refurbishments will improve existing space and not increase footprints. The new construction will build a laboratory infrastructure that will support testing for the entire South-Western region. It will serve as a center for specialized testing of samples from lower facilities, coordinator of laboratory services in the region, and a satellite for the National Health Laboratory (NHL).

PEPFAR supports GOU in conducting the population-based HIV-impact assessment to evaluate the state of the epidemic. PEPFAR is strengthening the national Health Management Information System to utilize the single national District Health Information System (DHIS2). PEPFAR works with partners and districts to ensure data are accurate, timely, and used for decision making by building capacity at the facility, district, regional, and national levels. PEPFAR has developed a protocol for the evaluation of PMTCT data in comparison to ANC sentinel surveillance.

PEPFAR plans to use an IT infrastructure assessment conducted in FY15 to guide the MOH in the rollout of an EMR to high-volume facilities. This advancement will improve the quality and timeliness of data submission and clinical care. PEPFAR will use this platform to upgrade the EMR system and link it to DHIS2 enabling reporting on age disaggregation. PEPFAR is assisting the MOH to determine a patient unique identifier.

PEPFAR will focus on building capacity of the supported national, districts, implementing partners and facilities in M&E, clinical quality improvement, and data quality assessments. Capacity for the facilities to do data validation will be built. A number of surveillance, survey and implementation science activities are being implemented that include the Uganda prisons survey, surveillance and training activities in laboratory quality assurance, population-based HIV case-based surveillance in 2 districts, a slum dwellers survey, FSW linkage study and a linkage to care study.

7.0 USG Management, Operations, and Staffing Plan to Achieve Stated Goals

For COP 16, the team reviewed USG management and operations (M&O) through the lens of increased efficiency to manage the program while simultaneously looking at innovative options to ensure capacity for SIMS visits. The U.S. Mission continues to be “tight-sized” with few remaining desks and/or office space. This challenge continues to impede the ability of agencies to fill the entire number of total vacancies, which are presently eighteen existing vacancies and six planned positions. PEPFAR Uganda looked closely at these positions and determined that at least sixteen of these positions will be filled in COP16 to respond to OGAC requirements and enrich our program. The planned positions include: an HIV Generalist, an Epidemiologist, a Senior PEPFAR Advisor, an OVC Supervisory Technical Lead, and an Administrative Assistant.

In order to fill a gap in strategic information activities and to respond to the increased data needs of OGAC, specifically the POART/APR/SAPR/COP processes, the interagency PEPFAR team is in the process of recruiting a third-party contractor to take over setting up the logistics and other administrative aspects of SIMS 2.0, as well as carry out the visits. Without this third-party contractor on board, PEPFAR will not be able to conduct the expected number of SIMS visits per year (see SAP and SIMS third-party contractor justification). Mobilizing to carry out the required number of SIMS visits has been a challenge due to extreme staffing constraints.

Costs of Doing Business (CODB) are increasing for most agencies in due to increased ICASS costs and SIMS implementation. For CDC, this increase is primarily due to the anticipated increase of \$1,942,279 in Capital Security Cost Sharing (CSCS), as FY17 is required start date to begin paying CSCS as desk space for the new Embassy Annex (NOX) construction project. CDC has changes in ICASS costs due to increased workload counts caused by Furniture and Appliances Pool (FAP) buy in and start-up costs for the new ICASS ISO position and a reduction in workload for two agencies (USAID Gulu office & INL withdrawals) leading to an increase in cost share for the other agencies including CDC. In addition, CDC needs to replace 3 older motor pool vehicles. These vehicles will soon begin posing a potential safety risk if not replaced in a timely manner. The new vehicles will be used for PEPFAR meeting transport, SIMS visits, and program support. For USAID, the ability to conduct SIMS is extremely limited given current staff size and prohibition on new hiring. To implement SIMS successfully, USAID has requested authorization to utilize a third-party contract to conduct the visits, with support from direct hire and local Mission staff, which will increase USAID's overall costs to implement PEPFAR. USAID's Strategic Information staffing gap and move to becoming data-centric led to a need to have several medium to long term consultants/fellows coupled with several medium to long term TDYers to cover the PEPFAR section staffing gap during the transition period has led to an increase the USAID's costs. Furthermore, with the planned implementation of Test and Start, USAID is hiring a fiduciary agent and audit firm to support/ strengthen existing tracking systems for accountability of commodities including ARVs and essential meds. The audit firm will identify existing gaps and system challenges. PEPFAR/STATE will see in an increase in its CODB due to the transition of the coordinator's position from a Personal Services Contractor (PSC) position to a Limited Non-Career Appointment (LNA) hiring mechanism. As a result of this change, the salary and other remunerations will now be included in the STATE M&O budget instead of USAID's M&O budget.

Appendix A- Core, Near-core and Non-core Matrix

Table A.1.1 Program Core, Near-core, and Non-core Activities for COP 16: Care and Treatment			
Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	<p>TA for implementation of Test and Start</p> <p>Mentorship for VL and CrAg result interpretation and utilization</p> <p>Strengthening facility-community linkages</p> <p>HIV/TB services</p> <p>HR Recruitment</p> <p>QA/QI for lab, care and treatment</p> <p>Adolescent friendly services</p> <p>Interventions to optimize adherence</p>	<p>HR recruitment and retention (in maintenance districts)</p> <p>TB/HIV collaborative reviews</p> <p>ART patient monitoring</p> <p>CD4 testing</p>	
Sub-national level	<p>TA on implementing national guidelines</p> <p>Joint PEPFAR IP/MOH planning, support supervision, data reviews and QI</p> <p>M&E and technical assistance in data management and data quality</p> <p>Viral Load, EID, CD4, TB and CrAg sample transport, processing, return and EQA through district hubs</p>	<p>Support maintenance of the chemistry and hematology machines at the lab hubs</p>	
National level	<p>Policy support and TA for implementation of test and treat, Differentiated models of service delivery, viral load scale-up, CrAg screening, nutrition monitoring, community care and support, and unique patient identifiers</p> <p>TA and mentorship implementing national guidelines</p> <p>Support crucial government positions to coordinate HIV and TB programs</p>	<p>TB external quality assurance: HR support, supervision, returning results</p> <p>MDR TB activities: Coordination, surveillance, oversight and management</p> <p>National technical conferences and review meetings</p> <p>Supply chain management for TB commodities</p> <p>Support the National EQA for laboratory Testing for CD4</p>	

Table A.1.2 Program Core, Near-core, and Non-core Activities for COP 15: Prevention

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
<p style="text-align: center;">Site level</p>	<p>Distribution and promotion of condoms: Aggressive condom promotion in scale up districts</p> <p>Prevention packages: Offer a comprehensive HIV prevention package for KPs and PPs.</p> <p>Intensified focus in DREAMS districts on prevention for AYGW</p> <p>Support tracking of KP/PP to ensure linkage to appropriate HIV/AIDS services.</p> <p>GBV: Ensure programs are screening for GBV and offering post-GBV care using the MCH, OPD as entry points for screening</p> <p>PrEP: Offer PrEP to eligible at-risk populations</p> <p>QA/QI for PrEP provision</p> <p>Supply chain: Ensure availability of ARVs</p> <p>Support HIV testing every 3 months aligned to refill dates</p> <p>PMTCT: Support HTS for all pregnant & BF women, partners, HEI & family members of HIV + women including active linkage to care and support services</p> <p>Implement RTQII (EQA for HTS at all PMTCT sites)</p> <p>Support risk reduction counselling, active linkage of negative partners to care and support services and management of discordance</p> <p>Support family planning services</p> <p>Implement integrated mother-baby care point services</p>	<p>Prevention packages: Leverage existing platforms for primary & secondary prevention</p> <p>Offer prevention package for priority populations</p> <p>Make PEP available for all eligible clients</p> <p>Address harmful gender norms, beliefs and practices</p>	

	Support PMTCT related HR/ training/Mentoring		
Sub-national level	<p>Prevention package: Standardize curriculum for service delivery for key and priority groups</p> <p>Distribution and promotion of condoms: Manage and coordinate condom distribution</p> <p>Strengthen PSM for condoms</p> <p>Prevention packages: Quality improvement of HIV prevention interventions</p>	<p>Sustainability: Routine supportive supervision</p> <p>Capacity building: Capacity building for logistics, service delivery, data collection, management and reporting</p>	Dissemination of HMIS tools, condom policy and guidelines, SOPs and IEC materials
National level	<p>Distribution and promotion of condoms: Support MOH with forecasting of national condom needs</p> <p>Capacity building: Strengthening QA and capacity to implement and monitor minimum prevention package</p> <p>Prevention packages : Improving the quality, consistency and availability of HIV prevention materials across all platforms</p> <p>Support monitoring and evaluation for minimum package offered</p> <p>Standardizing reporting</p> <p>PrEP: Use existing WHO guidelines to work with MOH on technical guidelines on PrEP Provide technical assistance to guide PrEP program planning and implementation</p>		<p>Dissemination of tools, policy and guidelines</p> <p>Support supervision</p>

Table A.1.3 Program Core, Near-Core, and Non-Core Activities for COP 16: OVC

Level of Implementation	Core Activities	Near-Core Activities	Non-Core Activities
Site level	<p>Case Management: Strengthen case management to ensure access to a continuum of prevention, mitigation, care and treatment</p> <p>OVC Healthy: Re-enforce community facility linkages of to HIV prevention, care and treatment services</p> <p>Contribute to community case finding, enrollment and retention for HIV+ children and family members Build on DREAMS platform for adolescent girls in non-DREAMS districts</p> <p>OVC Safe: Support to prevent and mitigate maltreatment of children and adolescents including GBV</p> <p>OVC Stable: Build family resiliency to achieve prevention, treatment & care outcomes</p> <p>Schooled: Support interventions to overcome barriers to accessing education</p>	<p>OVC Healthy: Provide HIV care and prevention services to Exposed and infected OVC household members.</p> <p>OVC Safe: Professional development of community volunteers in child protection, GBV & permanency</p> <p>OVC Stable: Support households to carry out market assessments and link business/agricultural projects to markets /value chain development</p> <p>Schooled: Improving education quality, making classroom environments gender and HIV sensitive</p>	
Subnational level	<p>Case Management: Strengthen community structures towards sustainable case management</p> <p>OVC Safe: Strengthen community structures for prevention, early identification, response and referral of child abuse cases</p>	<p>Case Management: Mapping OVC services & develop directories (GOU)</p> <p>OVC Safe: Strengthen government managed and case management systems</p>	
National level	<p>Case Management: Support development of child-related policies, guidelines and strategies.</p> <p>Conduct operational research to inform policy and programming</p> <p>Maintain a functional OVC MIS system</p> <p>OVC Safe: Strengthen GOU and civil society capacity to support affected and at-risk children and adults Support development of the VACS National Response plan</p>	<p>Case Management: Support M&E systems for national child protection/social welfare efforts</p> <p>OVC Safe: Support advocacy and policy efforts to improve safety of children from violence</p>	

Table A.1.4 Program Core, Near-Core, and Non-Core Activities for COP 16: Laboratory

Level of Implementation	Core Activities	Near-Core Activities	Non-Core Activities
Site Level	<p>Lab information system support for data capture, transmission and utilization.</p> <p>Sample transportation and results transmission network support for National Laboratory through 100 hubs for VL, EQA and OIs</p> <p>Continuous quality improvement for laboratory services</p> <p>External Quality Assurance (EQA) support for core HIV tests</p> <p>Uninterrupted VL/EID/CD4 service delivery</p>	<p>Preventive equipment maintenance (chemistry and hematology)</p> <p>CD4 POCT quality management support</p>	
Subnational Level	<p>Support hubs to improve capacity for testing and referral services</p> <p>Monitoring quality improvement through implementation of EQA schemes (rapid HIV, TB, CRAG, VL, EID and CD4) for correct diagnosis.</p>		
National Level	<p>Support the National Laboratory sample transportation system and results transmission</p> <p>Network coordination of core tests Lab information systems for data capture and utilization</p> <p>Lab accreditation and Lab Quality Management Systems for provision of quality lab services</p> <p>Support coordination of the National EQA scheme</p> <p>Strengthening the newly formed National Health Lab Services (NHLS) to coordinate lab services</p> <p>Advocacy with Ministries of Finance and Public Services on budget and staffing norms for NHLS, hubs and the equipment maintenance workshops.</p>	<p>Development/review and implementation of the national laboratory guidelines and the national health laboratory strategy (NHLS) to align with 90-90-90 strategy for epidemic control.</p> <p>TOT and coordination of mentorship of facilities enrolled on laboratory QI to support epidemic control.</p>	

Table A.1.5 Program Core, Near-Core, and Non-Core Activities for COP 16: SI

Level of Implementation	Core Activities	Near-Core Activities	Non-Core Activities
Site Level	<p>Implementation of technological innovations: Support and scale up EMR, finger printing technology, and ability to upload to a sharing platform DHIS2</p> <p>Quality improvement: Support implementation of SIMS visits, DQAs, SQAs, CQI</p> <p>MER reporting and data use: Train and support facility in MER reporting and use of data</p>	<p>HMIS tools: reproduction and distribution of revised national HMIS tools</p> <p>M&E capacity building: training and mentoring health workers in their use to ensure quality data is available for PEPFAR programming and reporting</p>	
Subnational Level	<p>National Reporting Systems: Strengthen MOH capacity to manage HMIS, DHIS2 and other reporting systems, sharing platform including Open ?MRS</p> <p>M&E reporting and data use: train biostatisticians and M&E managers to improve data quality and inform program progress</p>		
National Level	<p>M&E capacity: conduct national TOTs to strengthen M&E capacity and support compilation of national HIV/AIDS M&E report</p> <p>Surveys and Surveillance: implement key population mapping and size estimates, population-based HIV Impact Assessment, Pretreatment HIV DR surveillance, acquired HIVDR surveillance and infant HIVDR</p> <p>Evaluations: implement process and outcome evaluations to measure program implementation, fidelity, and outcomes</p> <p>Implementation and operation science studies: Improving programs through implementation science to determine outcomes of different interventions</p>	<p>E-policy development: support MOH to develop e-policy guidance to gain efficiencies and quality to promote health and improve service delivery</p>	

Table A.1.6 Program Core, Near-Core, and Non-Core Activities for COP 16: HRH and Supply Chain

Level of Implementation	Core Activities	Near-Core Activities	Non-Core Activities
<p>Site level and Sub-national level</p>	<p>Supply Chain: Improve commodity supply chain management at site and district levels</p> <p>Human Resources for Health (HRH): Improve the availability, skills, and performance of health workers at health facility and community levels.</p> <p>Leadership and Governance: Strengthen civil society and community engagement for sustainable HIV/AIDS response at the local level Improve coordination, supervision planning, managing, and reporting for HIV/AIDS activities at district level</p>	<p>HRH: Strengthen Human Resources Information System (HRIS) Governance</p> <p>Support CSOs to act as watch dogs for access to services for all persons, service quality, and patient satisfaction at high volume and in high burden districts</p>	
<p>National level</p>	<p>HRH: Support HRH planning, policy and strategy development and implementation</p> <p>Health Care Financing (HCF): Support finalization of the draft national health financing strategy Advocate for increased domestic resource allocation by GOU</p> <p>Governance Strengthen MOH capacity to oversee and coordinate the national HIV/AIDS</p> <p>Strengthen civil society engagement in legislative, regulatory, and service delivery to improve access to HIV services</p> <p>Support national policies, programs, and systems to ensure optimal and transparent use of financial resources for medicines and other health commodities</p>	<p>HRH: Improve quality and efficiency of health training institutions</p> <p>Support Health Professional Councils and regulatory bodies</p> <p>Provide targeted scholarships for training Standardize in-service training</p> <p>Supply Chain Support NDA to a) implement WHO Good Distribution Practice accreditation for wholesalers and b) continue Good Pharmaceutical Practice certification of public and private facilities</p>	

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

Program Area	Core Activities	Near-core Activities	Non-core Activities
HTS	<p>Support tracking of KP/PP to ensure linkage to appropriate HIV/AIDS services</p> <p>Standardize curricula for service delivery</p>	<p>Leverage existing platforms for primary & secondary prevention</p>	
Care and Treatment	<p>TA for policy development, reviews and assessments</p> <p>TA for program implementation in Test and Start, differentiated models of service delivery, viral load scale-up, cryptococcal Ag screening and nutrition monitoring</p> <p>Training, coaching and mentoring for implementation of Test and Start as per revised ART guidelines</p> <p>HIV services in TB clinics, strengthening the 3I's, provision of TB diagnostic services, support for referral and linkage of HIV/TB co-infected patients and reporting data into GX Alert system.</p> <p>Facilitate and provide technical assistance quality management and quality improvement (QI/QM) of lab, care and treatment services</p> <p>Ensuring HIV care and treatment quality standards are being met across all SIMS domains, including OI treatment, PHDP, nutrition, pediatric growth and development, TB/HIV and family planning</p>	<p>Human resource recruitment and retention in maintenance districts</p> <p>Supply chain management for TB commodities</p> <p>TB/HIV collaboration, including performance reviews, triangulation of ART and TB registers, EQA and QI</p> <p>ART patient monitoring for ART toxicities</p> <p>CD4 testing for ART eligibility assessment in pre-ART clients</p> <p>Support maintenance of chemistry and hematology machines at lab hubs</p>	<p>Support for enablers for MDR TB patients</p>
Prevention	<p>Aggressive condom promotion in scale up districts</p> <p>Offer a comprehensive HIV prevention package for KPs and PPs.</p> <p>Intensified focus in DREAMS districts on prevention for AYGW</p> <p>Support tracking of KP/PP to ensure linkage to appropriate HIV/AIDS services.</p>	<p>Routine supportive supervision</p> <p>Capacity building for logistics, service delivery, data collection, management and reporting</p> <p>Leverage existing platforms for primary & secondary</p>	<p>Dissemination of HMIS tools, condom policy and guidelines, SOPs and IEC materials</p>

	<p>Offer PrEP to eligible at-risk populations</p> <p>QA/QI for PrEP provision</p> <p>Ensure availability of ARVs</p> <p>Support HIV testing every 3 months aligned to refill dates</p> <p>Support HTS for all pregnant & BF women, partners, HEI & family members of HIV + women including active linkage to care and support services</p> <p>Implement RTQII (EQA for HTS at all PMTCT sites)</p> <p>Support risk reduction counselling, active linkage of negative partners to care and support services and management of discordance</p> <p>Ensure programs are screening for GBV and offering post-GBV care using the MCH, OPD as entry points for screening</p> <p>Support family planning services</p> <p>Implement integrated mother-baby care point services</p> <p>Support PMTCT related HR/ training/Mentoring</p>	<p>prevention</p> <p>Offer prevention package for priority populations</p> <p>Make PEP available for all eligible clients</p> <p>Address harmful gender norms, beliefs and practices</p>	
OVC	<p>Identify children and adolescents vulnerable to HIV</p> <p>Develop/update case management plans, ensure monitoring of referral completion case closure</p> <p>Promote HIV testing among OVC households including EID, & confirmatory HIV testing</p> <p>Implement DREAMS to keep HIV negative AGYW free from HIV</p> <p>Facilitate uptake and monitor completion of referrals</p> <p>Conduct integrated home visits (NACs, adherence assessment, counseling and support, malnutrition, education)</p> <p>Establish and strengthen referral mechanism to ensure cross referral between clinic and social services</p> <p>Support child protection/GBV prevention and response activities</p>	<p>Professional development of community volunteers in child protection, GBV & permanency</p> <p>Support targeted food security initiatives</p> <p>Link business/agricultural projects to markets /value chain development</p> <p>Facilitate access to primary & Sec. education for girls through long-term or open ended subsidies</p> <p>Provide long-term or open-ended school block grants or</p>	<p>Dissemination of tools, policy and guidelines</p> <p>Support supervision</p>

	<p>& referral to other services</p> <p>Address psycho-social health among children and caregivers</p> <p>Facilitate group-based HES activities and vocational training</p> <p>Facilitate access to primary and sec. education through temporary and targeted support</p> <p>Support and integrate ECD in coordination with PMTCT & Pediatric HIV</p> <p>Support “Safe spaces” approach for adolescents at high risk esp. girls (street children, domestic workers)</p> <p>Support development of the Violence Against Children (VACS) National Response plan</p>	<p>support for ECD centers</p> <p>Improve education quality and make classroom environments gender and HIV sensitive</p> <p>Support community education councils & PTAs to provide support to OVC</p> <p>Map services and develop directories (GOU)</p> <p>Strengthen government management and case management systems to prevent and respond to child abuse and support family placement & permanency for children</p> <p>M&E systems for National child protection/social welfare efforts</p>	
<p>Program/System Support</p>	<p>Support the MOH, Ministry of Public Service , and Districts to recruit new Health workers</p> <p>Strengthen training, mentorship, and support supervision of providers by level.</p> <p>Revise guidelines and training curricula and other implementation materials to align to test and treat.</p> <p>Advocate for increased domestic resource allocation for HIV commodities.</p> <p>Improve data management on commodities through improved LMIS</p> <p>Identify, engage and facilitate CSOs, CBOs working with PPs and KPs to improve service uptake</p> <p>Support district quarterly coordination and performance reviews for HIV services</p> <p>Strengthen systems for data capturing and transmission through</p>	<p>Work with MOH to define a minimum set of health systems capabilities that every district should have for sustained epidemic control, and ensure that each IP supports attainment of these minimum district performance standards in priority PEPFAR districts</p>	

	<p>the national HMIS system.</p> <p>Build the capacity of districts to analyze HIV/AIDS-related surveillance and performance monitoring data Improve Domestic Resource mobilization through advocacy and increase efficiency in the utilization of available resources</p> <p>Improve MOH capacity in budgeting and financial analysis</p> <p>Coordination of the sample transportation and results transmission network</p> <p>Build Health workers capacity for sample management, clinical monitoring, supply chain and equipment management related to viral load</p>		
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Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP16	Estimated Funding in COP17	# of IMs	Transition End date	Notes
CD4 monitoring	none	\$0	\$0	All clinical service IMs	FY15 – ART clients FY17 – pre-ART clients	CD4 monitoring of ART clients transitioned to VL monitoring in COP15. CD4 monitoring of pre-ART clients will end when test & start commences in FY17.

Appendix B – Budget Profile and Resource Projections

B.1 Planned Spending in 2016		
Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
\$12,230,156	\$371,158,216	\$383,388,372
Table B.1.2 Resource Allocation by PEPFAR Budget Code		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
CIRC	Male Circumcision	\$25,729,204
HBHC	Adult Care and Support	\$42,448,841
HKID	Orphans and Vulnerable Children	\$25,786,212
HLAB	Lab	\$6,888,079
HMBL	Blood Safety	\$3,579
HMIN	Injection Safety	\$1,788
HTXS	Adult Treatment	\$86,267,857
HTXD	ARV Drugs	\$59,993,858
HVAB	Abstinence/Be Faithful Prevention	\$15,226
HVCT	Counseling and Testing	\$18,605,085
HVMS	Management & Operations	\$19,650,448
HVOP	Other Sexual Prevention	\$11,432,438
HVSI	Strategic Information	\$14,744,842
HVTB	TB/HIV Care	\$9,034,804
IDUP	Injecting and Non-Injecting Drug Use	\$0
MTCT	Mother to Child Transmission	\$14,461,962
OHSS	Health Systems Strengthening	\$17,129,341
PDCS	Pediatric Care and Support	\$13,481,727
PDTX	Pediatric Treatment	\$5,482,925
TOTAL		\$371,158,216