



UGANDANS AND AMERICANS
IN PARTNERSHIP TO FIGHT HIV/AIDS

UGANDA

Country Operational Plan 2017

Strategic Direction Summary

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Table of Contents

1.0	Goal Statement	3
2.0	Epidemic, Response, and Program Context	5
	2.1 Summary statistics, disease burden, and country profile	5
	2.2 Investment Profile	11
	2.3 National Sustainability Profile Update	14
	2.4 Alignment of PEPFAR/UG Investments Geographically to Disease Burden	15
	2.5 Stakeholder Engagement	17
3.0	Geographic and Population Prioritization	19
4.0	Program Activities for Epidemic Control in Scale-up Locations and Populations	20
	4.2 Voluntary Male Medical Circumcision (VMMC)	22
	4.3 Prevention Programs for Key and Priority Populations	24
	4.4 Preventing Mother-to-Child Transmission (PMTCT)	26
	4.5 HTC	29
	4.6 Facility and Community-Based Care and Support	30
	4.7 TB/HIV	31
	4.8 Adult Treatment	33
	4.9 Pediatric Treatment	35
	4.10 Orphans and Vulnerable Children	36
	4.11 Peace Corps	40
	4.11 Addressing COP17 Technical Considerations	41
	4.12 Commodities	41
	4.13 Collaboration, Integration, and Monitoring	42
5.0	Program Activities for Epidemic Control in Attained and Sustained Locations and Populations	42
	Program Area Summaries 5.2-5.10	43
6.0	Program Support Necessary to Achieve Sustained Epidemic Control	
	6.1 Proposed System Investments Outside of Programmatic Gaps and Priority Policies	43
7.0	Staffing Plan	44
	APPENDIX A Table A.1 SNU Prioritization	46
	APPENDIX B Planned Spending in 2017	52
	APPENDIX C Section 6.0 Tables: Program Support Necessary to Achieve Sustained Epidemic Control	54
	Appendix D Acronyms	55

1.0 Goal Statement

Despite being a country that was devastated by the HIV/AIDS epidemic, Uganda is on course to achieve the 90-90-90 goals. National treatment coverage was 68% as of December 2016. With a COP17 goal of initiating 314,366 clients on antiretroviral treatment (ART), treatment coverage will be 95% by September 2018, with a total of 1.3 million people will be receiving ART. These targets will build on gains from the roll-out of the Test and Start policy in January 2017. Additionally, to capitalize on combination prevention to maximize impact in reducing new infections, PEPFAR/UG will focus efforts in the 10 DREAMS districts, their surrounding clusters, the three additional districts into which DREAMS will expand, and in the scale-up-aggressive districts. By FY18¹, 40 (36%) out of 112 districts that constitute 52% of the disease burden will have reached epidemic control.

Uganda has already met the global milestone for the elimination of mother-to-child transmission with a coverage of HIV-positive pregnant and breastfeeding women on ART of 98%, and an early mother-to-child HIV transmission rate of <5%. The success of the PMTCT program resulted in Uganda achieving the first and second 90 in children <15 years, with 91% of children diagnosed and 82% on treatment. The first 90 has also been achieved in women, with 90% being diagnosed; of these, 79% are on treatment, making the achievement of the second 90 among women likely by the end of FY17.

However, for the country to achieve HIV epidemic control, more men must be diagnosed and initiated on treatment, a major thrust of COP17. As of FY17 quarter one (FY17 Q1), only 61% of estimated HIV+ men had been diagnosed and only 54% had been initiated on antiretroviral treatment (ART). A targeted testing strategy, including increasing the demand for HIV testing among men and decreasing stigma around seeking HIV services, will be required. Uganda will optimize case finding through index case testing; additionally, within health facilities, there will be a focus on critical entry points, with eligibility screening to improve yield. Because men are less likely to come to health facilities, the strategy focusses on finding men in places where they congregate. Hotspot testing, including informal and formal workplaces, and demand creation through social networks will focus especially on men between 15-29 years of age. The Ugandan HIV testing guidelines will be revised to allow for self-testing, pending the results of two ongoing in-county evaluations. This strategy will be pursued particularly among male partners of HIV-positive women attending ANC and key populations (KP). COP17 will ensure that, once diagnosed, men are linked to ART. Concerted efforts to create an enabling environment for them to seek testing and treatment will include extended clinic hours, same day ART initiation, and tailoring differentiated service delivery models (DSDM) to address barriers for men accessing HIV services.

We will continue to encourage uncircumcised men between 15-29 years to undergo voluntary male circumcision (VMMC). The two doses of tetanus toxoid (TT) policy, which started in 2016, for male circumcision clients, resulted in a sharp decline in the number of men being circumcised. In March 2017, this policy was changed to align with WHO guidance and only require one dose of TT at the time of circumcision. To catch up on the decline in 2016, we will make aggressive efforts during 2017 and into FY18 to circumcise over 1.6 million men.

Viral suppression among those tested in the last year is >91.3% (FY17Q1 data). Uganda is able to closely monitor progress of the third 90 through the Ministry of Health's Central Public Health Laboratory's (CPHL) online Viral Load Dashboard. Therefore, replicating change packages that have been demonstrated to increase viral load (VL) testing, improving the quality of samples to reduce sample rejection rates, implementing innovative approaches for timely results transmission to both health facilities and clients, and intensifying mentorship on management of clients with non-suppressed VL will further move the country towards achieving the third 90. The VL/Early Infant Diagnosis (EID) laboratory within CPHL recently received ISO accreditation, a significant achievement towards quality VL and EID.

Pervasive cultural practices and limited opportunities for education have contributed to gender inequalities. Adolescent girls and young women (AGYW) are exposed to risk, reflected in HIV prevalence rates at least twice as high in females

¹ FY18 reflects the U.S. government fiscal year which is from October 1, 2017 to September 30 2018

aged 10-24 years than in young men of similar age. It will remain critical to intervene and keep AGYW HIV negative and empowered towards a better future. DREAMS interventions will reach 136,410 AGYW in the identified 10 COP15 districts and an additional 83,152 both by another three DREAMS districts and by incorporating more intensive HIV prevention activities within PMTCT platforms in an additional four districts. The OVC program will reach 436,944 moderately or critically vulnerable beneficiaries with a package of case management, improved food security, educational support, household economic strengthening, improved parenting skills, measures to address gender based violence (GBV) prevention, and linkage to health services as needed.

Key and priority populations (KP/PP) include female sex workers, men having sex with men (MSM), fisher folk, uniformed services, and prison inmates; prevalence among these groups range from 15%-37%. Targeted programs will address the special needs of these groups, including stigma reduction and the expansion of pre-exposure prophylaxis (PrEP). PEPFAR/UG will partner with civil society and community based organizations whose links to communities enable them to deliver support services. The rapid development and use of unique identifiers will improve patient management and decrease loss to follow-up in this highly mobile KP/PP population.

With Uganda's implementing partners providing services along the entire continuum of response, and with increased use of unique identifiers, we have opportunities to establish and demonstrate better linkages. However, achieving Uganda's ambitious goals for COP17 and beyond also brings challenges to implementing partner performance. Our new business model will require more frequent results reporting, a shortened time span to implement corrective measures, and closer supervision and oversight to generate both greater results accountability and improved efficiencies. The VL dashboard, which has allowed for continuous improvements in VL testing, will be linked with other data sources and real-time reporting systems through a central portal to allow for monitoring of the clinical cascades and rapid action for improved results.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden, and country profile

Uganda has a population projection for 2017 of 39.6 million and an annual population growth of 3.3% - with a total fertility rate of 5.4² making it the third fastest growing population in the world. Forty-eight percent of the population is <15 years (above 43.2% for sub-Saharan Africa), and 69% is <24 years. The contraceptive prevalence rate is 39% among married women and 51% in unmarried sexually active women; unmet need has declined from 34% in 2011 to 28% in 2016. 97% of pregnant women seek antenatal care at least once, and 73% deliver in a health facility. Over the past decade child mortality has decreased from 61 to 22 per 100,000 live births, and infant mortality has decreased from 71 to 43 per 100,000 live births.² While Uganda has been successful in reducing poverty over the last 20 years, poverty reduction has slowed since 2006; more than a third of Ugandans still lived on < \$1.90/day, a poverty threshold set over 20 years ago, which is now too low. Because poverty reduction in Uganda has been based mainly on agricultural income growth and favorable climatic conditions, economic vulnerability remains high. Uganda's GNI per capita is US \$700 with an annual GDP growth of 4.7% in 2016. For Uganda to attain the ambitious goals set out in its 2040 Vision, a fundamental shift in production from low-investment, informal activities to higher-capital, more productive employment is required, as is a more rapid reduction in fertility rates. Effective public investment in services such as education, health, agricultural extension, and social and economic safety nets will be crucial³.

The health budget comprises 7% of the total 2017/18 budget. Uganda ranks 160th out of 196 countries in per capita health expenditure, with a per capita per annum expenditure on health of \$27, far below the recommended \$44 per capita⁴. GOU has more-over decreased the 2017/2018 health budget by 37.5% from its 2016/2017 budget. Ravaged by the HIV/AIDS epidemic, Ugandan life expectancy was 44.3 years in 2000. Major gains in addressing the HIV epidemic have seen life expectancy increase now to 63.2⁵ years. Since the Uganda Population-Based HIV Impact Assessment (UPHIA) had not yet concluded by the time plans for COP17/FY18 were developed, the GOU and PEPFAR/UG used PMTCT program data, among other sources, to provide an estimate of the country's HIV burden. Using this methodology, the number of PLHIV is now estimated at 1.35 million, a decrease of 150,000 people. Heterosexual transmission accounts for 75%-80% of new infections. Evidence from Rakai presented at the Conference on Retroviruses and Opportunistic Infections (CROI) in February 2017, shows a declining incidence in that area which, although not generalizable nationally, is a hopeful sign of the impact of scaling up combination prevention.

The recent Violence Against Children Survey (VACS) indicates an unacceptably high level of physical, sexual, and emotional violence against children. Of females and males aged 18 to 24 years, 59% and 68% respectively reported experiencing physical violence before the age of 18. Twice as many girls (35%) than boys (17%) had experienced sexual violence, and one third of both girls and boys had experienced emotional violence. In two regions (central 1 and 2), 42% of girls had experienced sexual violence before the age of 18 years, the highest figure so far recorded in Africa. Among females aged 18 to 24 years, 10% of girls and 2% of boys stated that they experienced forced or pressured sex before age 18⁶. Unnegotiable early sexual encounters can force children out of homes and ultimately expose them to HIV risk. Although among 25-49 year olds, the yield in FY17Q1 was roughly the same when comparing men and women (4.0%), in adolescents, gender disparity is notable. PEPFAR/UG FY17Q1 data indicates that the HIV yield among 15-19 year olds was three and a half times greater among girls than boys (2.0% vs. 0.6%) and 38% greater among females aged 20 to 24 years old than males (3.3% vs. 2.4%). One in four girls aged 15 to 19 has begun childbearing. Among girls aged 6-15 years

² 2016 Uganda Demographic and Health Survey, Uganda Bureau of Statistics, 2017

³ Uganda Poverty Assessment 2016, World Bank 2016

⁴ WHO Country Profile 2014

⁵ National Population and Housing Census 2014, Uganda Bureau of Statistics

⁶ Uganda Violence Against Children Survey 2016

who drop out of primary school, 31% do so to marry, and 21% do so due to pregnancy; secondary school completion rates remain extremely low - only 34% of girls complete secondary school compared to 45% of boys.⁷

A national TB prevalence survey conducted in 2015 (not officially released) estimated the prevalence of all forms of TB to be 253 cases/100,000 (88,550 TB cases per year), higher than the 2015 WHO estimate of 159 cases per 100,000 (60,000 TB cases per year). Estimates from the survey showed a total burden of 33,670 TB/HIV cases, of which 16,028 were missed annually. Total notified new and relapse TB cases per year was 41,912, of which 17,642 were TB/HIV co-infected – giving a TB/HIV co-infection rate of 42%⁸. However, estimates from the survey showed a total burden of 33,670 TB/HIV cases, which is 38% of the 88,550 TB cases per year. Therefore, since 17,642 TB/HIV cases were notified, as a country, 16,028 (33,670-17,642) TB/HIV cases may be missed annually. While women sought care more often than men (67% vs. 53.9%), bacteriologically confirmed TB was more commonly diagnosed among men (76.2% vs. 23.8%)⁹.

Twenty-seven districts have identified hotspots of key (KP) and priority populations (PP). Population size estimates for MSM were conducted in Kampala, resulting in 7,000-13,000 MSM with 13.7% HIV prevalence. National estimates for the total number of MSM were calculated using the Kenya AIDS Indicator Survey figures.¹⁰ MSM are highly stigmatized within a legal and policy environment that inhibits non-discriminatory service delivery. The number of female sex workers (FSW) is estimated at 195,623, with an HIV prevalence between 33% - 37%. An estimated 16% of new infections are attributed to FSW¹¹, their clients, and clients' partners. Sex work is illegal in Uganda creating challenges in providing services.

In fishing communities around Lake Victoria and other lake systems, HIV prevalence ranges between 14.9% - 35% and was highest among women who had their first sex before the age of 15 years.¹² Most of the estimated 2,000,000 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.

Uganda has an estimated 109,160 uniformed 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. HIV prevalence among the 42,000 prison inmates is 15%¹³. The most commonly reported HIV-related risk behavior among prisoners 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.

Since January 2017, there has been a major influx of South Sudanese refugees into Northern Uganda. It is estimated that these refugees may reach 1.2 million. PEPFAR/UG is in discussion with PEPFAR/South Sudan to define a means of collaboration by which the refugees can be maintained on ART or started on ART, if newly diagnosed.

As of December 2016, 77% of PLHIV have been diagnosed, and 68% are on ART. With the roll-out of the Test and Start policy in January 2016, national ART coverage is expected to reach 95% by September 2018. Uganda has already met the global milestone for the elimination of mother-to-child transmission achieving 98% of HIV-positive pregnant and

⁷ The State of the Ugandan Child, 2015.

⁸ WHO Global TB report Country Profile, 2016

⁹ Report on the Population-based Survey of Prevalence of Tuberculosis Disease in Uganda 2014-15

¹⁰ CRANE, 2013

¹¹ MOT Uganda 2014

¹² Makere University School of Public Health HIV Bio-behavioural survey among fishing communities in the Lake Kyoga Region, Uganda, 2016; Opio, A.; Muyonga, M & Mulumba, N. HIV Sero-behavioral survey in fishing communities of the Lake Victoria Basin of Uganda

¹³ Uganda Prisons Service, Uganda Prisons Service Sero-Behavioral Survey (2013), 2016

breastfeeding women on antiretroviral treatment, and an early transmission rate to infants of <5%. The success of the PMTCT program has resulted in Uganda achieving the first and second 90 in children <15 years, with 91% of children being diagnosed and 82% on treatment. The first 90 has also been achieved in women, with 90% being diagnosed; of these 79% are on treatment, making the achievement of the second 90 among women likely by the end of FY17. Revised policies for HIV testing and care, rolled out in January 2017, are aligned to the WHO guidelines, emphasizing targeted testing to identify the undiagnosed positive; similarly, PrEP implementation guidelines allow for expansion of services among key and priority populations.

The 2016 policy of requiring two doses of TT for male circumcision clients resulted in a sharp decline in the number of men being circumcised. In March 2017, the policy was changed to align with WHO guidance requiring one dose of TT at the time of circumcision. Therefore, aggressive efforts will be made at the end of FY17 and into FY18 to circumcise over 1.6 million men.

The Ugandan health system remains weak with poor infrastructure, inadequate accountability, and many human resource challenges. PEPFAR/UG provides support for key clinical cadres within health facilities (HFs) and technical assistance at national and district levels, which is essential to supporting the goal of epidemic control. However, a clear commitment and plan from the GOU to absorb these critical personnel into their public service is essential. Major weaknesses in supply chain and commodity security remain a concern. PEPFAR/UG has been able to fill a gap in public sector ARV outages in the short-term. Our primary goal is to ensure that Ugandans on ART are not faced with disruptions in their drug supply through public sector stock-outs and inadequate service provision at the facility level. With COP17 funding, we will support supply chain reform within the public sector as part of a longer-term process to strengthen the supply chain from the national level to health facilities.

Table 2.1.1 Host Country Government Results

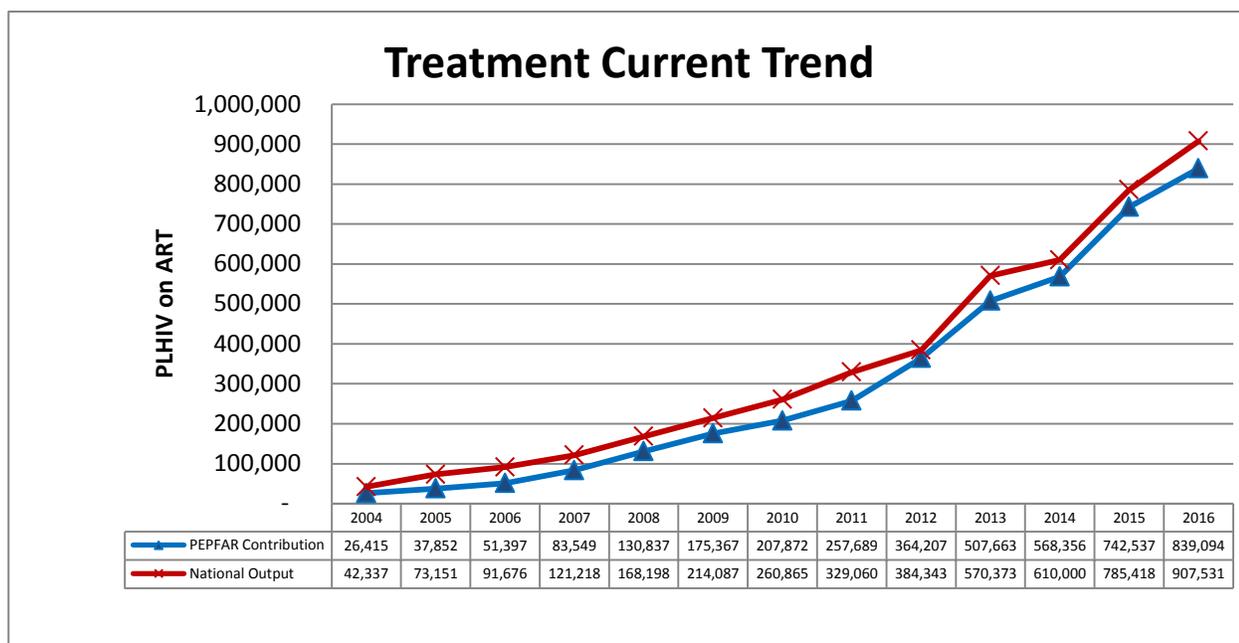
	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	39,688,689		9,310,973	23.4	9,704,276	24.4	4,250,662	10.7	3,928,386	9.9	6,679,601	16.8	5,814,791	14.6	Population projection for 2017 UBOS
HIV Prevalence (%)		6.4%		NA		NA		NA		NA		NA		NA	PMTCT program prevalence estimate MEEPP 2015
AIDS Deaths (per year)	10,000														
# PLHIV	1,411,218		38,660		38,660		121,137		25,954		635,979		550,828		FY17 PLHIV estimate
Incidence Rate (Yr)		169/ 100,000 pop.													
New Infections (Yr)	65,000														
Annual births	1,804,680														
% of Pregnant Women with at least One ANC Visit	97%														Uganda Demographic and Health Survey
Pregnant Women Needing ARVs	93,442														
Orphans (Maternal, Paternal, Double)	1,530,637		682,448		718,766		63,582		65,841						
Notified TB Cases (Yr)	43,736		1,302		1,699		2,831		3,463		11,623		22,818		WHO Global TB Report, 2016 and the NTLP Report 2016

Number and % of TB cases that are HIV Infected	17,642	100%	365	2%	445	3%	1,351	8%	1,317	7%	5,019	28%	9,145	52%	WHO Global TB report, 2016 and the NTLP report 2016
% of Males Circumcised	49%														
Estimated Population Size of MSM*	41,948														Calculated estimate using Kenya AIDS Indicator Survey estimate since no national estimate exists for Uganda
MSM HIV Prevalence	13.7%														
Estimated Population Size of FSW	195,623														
FSW HIV Prevalence	33%-37%														
Estimated Population Size of PWID	NA														
PWID HIV Prevalence	NA														
Estimated Size of Fishing community (Priority Population)	2,000,000														
Fishing community Prevalence	14.9%-35%														
<i>*If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.</i>															

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*

Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year			
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV Diagnosed (#) as of FY17Q1	On ART (#) As of FY17Q1	ART Coverage (%) as of FY17Q1	Viral Suppression (%) as of FY17Q1	Tested for HIV (#) APR16	Diagnosed HIV-positive (#) APR16	Initiated on ART (#) APR16
Total population	39,688,689	6.4%*	1,411,217	1,049,900	922,904	68%	45%	8,093,270	242,877	149,725
Population less than 15 years	19,019,892	0.4%	77,321	70,043	63,316	82%	51%	934,314	10,539	8,542
15-24 year olds	8,175,869	1.8%	149,762	132,519	120,343	80%	44%	NA	NA	NA
25+ year olds	12,492,928	9.4%	1,184,135	847,338	739,250	62%	44%	7,166,492 (all 15+)	232,672 (all 15+)	141,183 (all 15+)
MSM	41,951	13%	5,454	NA	NA	NA	NA			
FSW	195,629	33%	64,558	NA	NA	NA	NA			
PWID#				NA	NA	NA	NA			
Priority Pop (Fisherfolk)	2,000,000	14.9%	298,000	NA	NA	NA	NA			
Military (mil+civ)	NA	NA	26,711	19,138	18,046	68%	29%	56,565	2,870	2,182

Figure 2.1.3 National and PEPFAR/UG Trend for Individuals currently on Treatment¹⁴



2.2. Investment Profile

Uganda continues to depend on external donors to finance basic social services. The 2017/18 health sector budget has declined by 37.5% over the 2016/2017 budget. The percentage of the budget for health has steadily declined from 9.6% in 2009/10 to 8.7% in 2013/14 and even further in 2017/18 to 7%, well below the Abuja Declaration target of 15%.¹⁵ The COP16 Sustainability Index Dashboard (SID) highlighted domestic financing as “unsustainable.” Despite donors, including the USG, advocating for increased health financing in Uganda’s annual budget for its national HIV/AIDS response, the declining proportion of the health budget leaves little room for optimism. Public sector ARVs and other commodities are largely funded by Government of Uganda (GOU) and GFATM; additionally, Uganda is heavily donor-dependent. with 90% of HIV commodities historically provided through PEPFAR/UG and GFATM. Despite an increase in the GOU commitment for ARV procurement from \$10 million in 2015/16 to \$28.5 million in FY 16/17, the domestic resource base is insufficient to fill commodity funding gaps in the immediate future, and is also subject to foreign exchange fluctuations. In addition, GOU procures anti-retroviral drugs (ARVs) at significantly higher prices on the local market, compared to international price benchmarks limiting both availability of supplies and value for money. In the 2018-2020 GFATM application for HIV, about 93% of the \$255 million will procure HIV/AIDS commodities.

¹⁴ Public sector Commodities are principally purchased through GFATM resources and the government of Uganda; PEPFAR considers the technical assistance to the public sector as part of the contribution towards the current treatment trend.

¹⁵Health Sector Development Plan 2015/16-2019/20, Uganda Ministry of Health, September 2015.

PEPFAR/UG and the MOH, with technical assistance from EQUIP, have analyzed the cost implications of Test and Start. Preliminary findings are being disseminated and discussed among stakeholders, including WHO, UNAIDS, UNFPA, and UNICEF.

With the recent signing of an Implementation Letter Agreement (ILA) with the GOU, the USG has reduced the gap in public sector ARV outages in the short term through a total contribution of \$20.1 million. However, commodity security remains fragile. An impending gap of about \$31million (ex-works) for ARVs between July 2017- March 2018 has been likely averted through negotiations between GOU, GFATM, and PEPFAR, and will be covered by a redistribution under the current GFATM grant. Furthermore, there is a need for further advocacy with the GOU for targeted HIV testing, as there is also a potential gap for rapid test kits. The signing of the ILA opens a way by which the USG can support supply chain reform within the public sector. This will be part of a longer-term process to strengthen the supply chain from the national level to HFs.

National capacity to track the allocation and expenditure of HIV/AIDS resources remains weak and uncoordinated. The USG’s Sustainable Financing Initiative is working with the GOU on mobilizing additional domestic resources for the health sector; however, the goals of this program are long-term. The last National AIDS Spending Assessment was conducted in 2010; efforts are in place to institutionalize the process to ensure regular assessments take place.

Program Area	Total Expenditure (US\$)	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment, and support	238,908,867	52	38	10	
Community-based care, treatment, and support	14,934,506	71	30	0	
PMTCT	18,460,753	97	3	0	
HTS	18,834,289	64	36	0	
VMMC	29,447,321	98	2	0	
Priority population prevention	2,910,001	91	9	0	
Key population prevention	7,976,732	47	53	0	
OVC	13,813,249	100	0	0	
Laboratory	16,029,493	73	27	0	
SI, surveys, and surveillance	7,981,332	80	6	14	
HSS	16,455,731	71	1	28	
Total	399,152,274	62	28	7	3

Assumption-PEPFAR, GFATM, and GOU comprise over 90% of the funding for HIV and therefore the total expenditure.

¹⁶ GRP, National AIDS Spending Assessment, 2012, all amounts in 2012 USD

¹⁷ There is no current NASA report, therefore data obtained from USG 2016 UG Expenditure Analysis Report, Ministries of Finance and Health finance reports.

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	\$123,135,004	29.5%	59.9%	10.6%	
Rapid test kits	\$19,036,923	25.4%	74.6%	--	
Other drugs					
Lab reagents	\$8,466,939	39.0%	61.0%	--	
Condoms	\$6,187,192	9.9%	84.2%	--	5.9%
Viral Load commodities	\$17,537,670	72.6%	27.4%	--	--
VMMC kits	\$5,903,206	90.8%	9.2%		
Other commodities					
Total	180,266,934				

Assumption-Total expenditure = PEPFAR, GFATM and GOU resources comprise over 50% of the funding for the HIV response.

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution*	Objectives
USAID MCH	15,250,000	11,050,000	16	73,694,018	Support programs to improve maternal, neonatal, and child health
USAID TB	5,000,000	5,000,000	7	33,539,375	Support programs to reduce TB related mortality and morbidity
USAID Malaria	34,000,000	12,143,126	12	110,071,959	Support programs to reduce malaria associated mortality
USAID Family Planning	27,500,000	12,500,000	16	73,694,018	Support programs to increase contraceptive prevalence
USAID Nutrition	8,500,000	5,350,000	17	76,478,495	Support programs to improve nutrition
USAID WASH	6,000,000	400,000	1	1,821,639	Support programs to improve water and sanitation
USAID Basic Education	11,500,000	11,500,000	2	0	Support programs to promote basic education
NIH					
CDC (Global Health Security)	\$2,000,000	\$2,000,000	2	\$15,210,449	Support global health security initiatives
Peace Corps					
DOD Ebola					
MCC					
Total	96,250,000	46,443,126			

Note: As Implementing Partners have a comprehensive program, the same partner is funded through the various funding channels identified above.

¹⁸ Data obtained from USG UG 2016 Expenditure Analysis Report and Ministry of Health.

Table 1.2.4 Annual 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
DREAMS Innovation	3,927,058		3,927,058	2	18,409,027	Support primary HIV prevention among adolescent girls and young women
VMMC – Central Funds	21,247,715		21,247,715	15	188,159,639	Support programs in HIV prevention for epidemic control
SMGL	5,312,307	5,550,000	10,862,307	4	46,166,908	Support programs to reduce maternal and neonatal morbidity and mortality
LCI	600,884		600,884	1	0	Advocacy support for access to quality KP HIV services
Other PEPFAR Central Initiatives (OVC PLUS UP)	14,694,436		14,694,436	16	93,917,623	Support to OVC initiatives
Other Public Private Partnership						
Total	45,782,400	5,550,000	51,332,400			

Note: DREAMS, Viral Load, and some of VMMC and SMGL funds were reported in COP 16 for USAID so have not been included in this table.

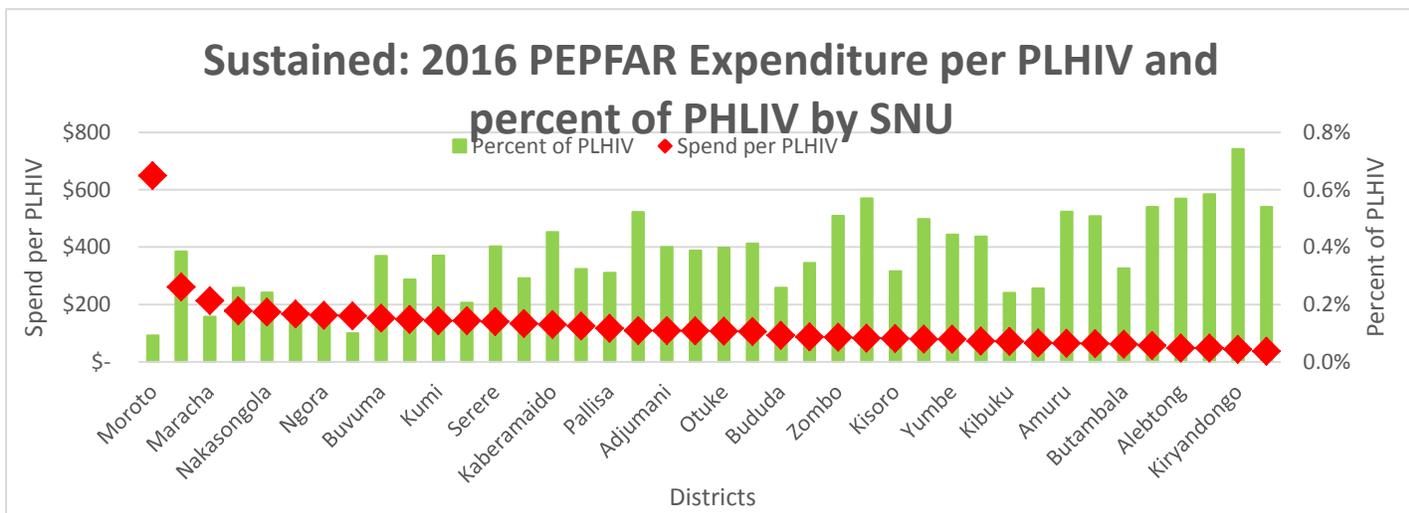
2.3 National Sustainability Profile Update

Since the Sustainability Index Dashboard (SID) consultation in 2016, there has been little progress on identified vulnerabilities in commodity and supply chain security, inadequate accountability, and domestic resource mobilization. The policy environment has improved with the roll-out launch in January 2017 of the Test and Start policy and guidelines, the revised HIV testing policy and guidelines, and the roll-out of implementation guidelines and training for PrEP. Moving towards financial sustainability needs to utilize a more nuanced approach, which includes resource mobilization from domestic resources beyond the treasury. For example, UNAIDS is working with the Ugandan AIDS Commission and the UK Oxford Policy Group to look for ways to harness the potential of the private sector.

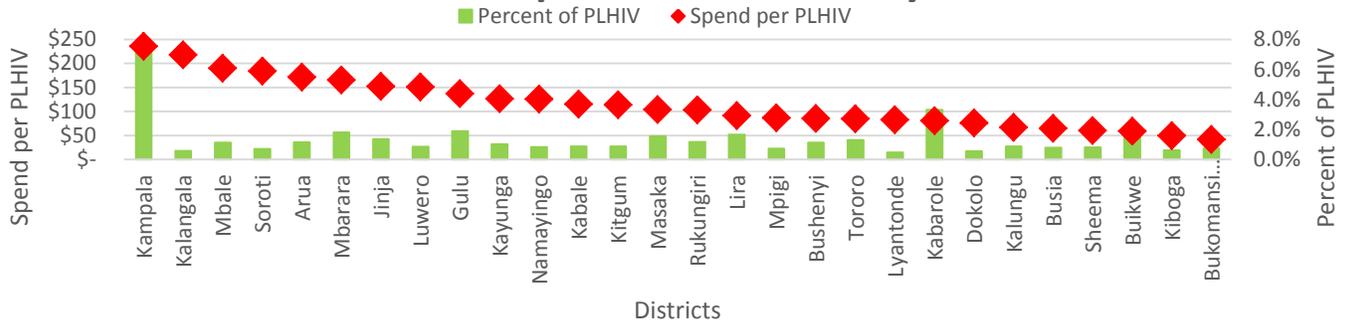
2.4 Alignment of PEPFAR/UG Investments Geographically to Disease Burden

PEPFAR/UG tracked expenditures to burden of disease by district based on population projections (2016/17) and the 2015 PMTCT burden estimate. In FY16, PEPFAR/UG spent \$103/PLHIV, 33% less than in FY15 (\$171/PLHIV) underscoring ongoing efforts to realize efficiencies.

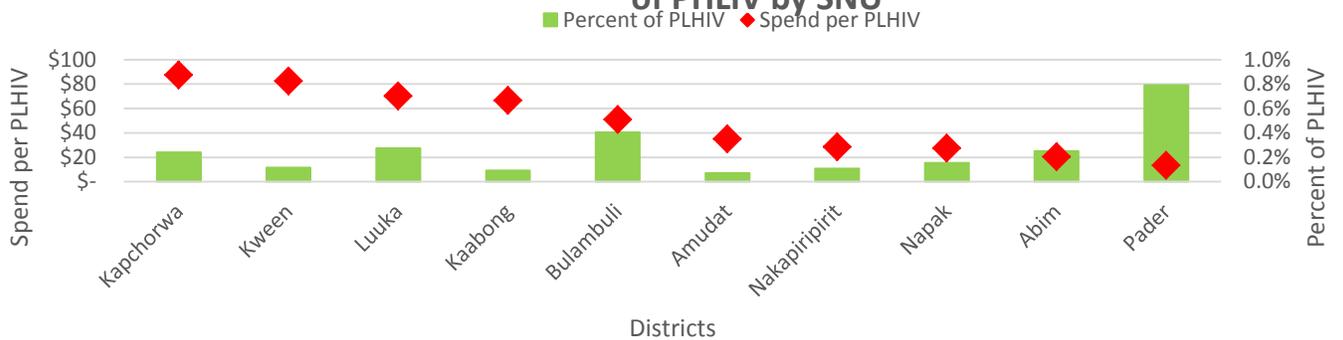
There is need for better alignment of expenditures. Aggressive scale-up districts, with 46% of all PLHIV, accounted for \$ 48.7 million (35% of total spend), while Scale-up-to saturation districts, with 37% of all PLHIV, accounted for \$68.9 million (49% of total spend). This discrepancy is thought to be due to IPs mistakenly reporting more costs as headquarter overhead costs, rather than district costs in Kampala and Wakiso. Expenditures in sustained and centrally supported districts decreased by about 30%.



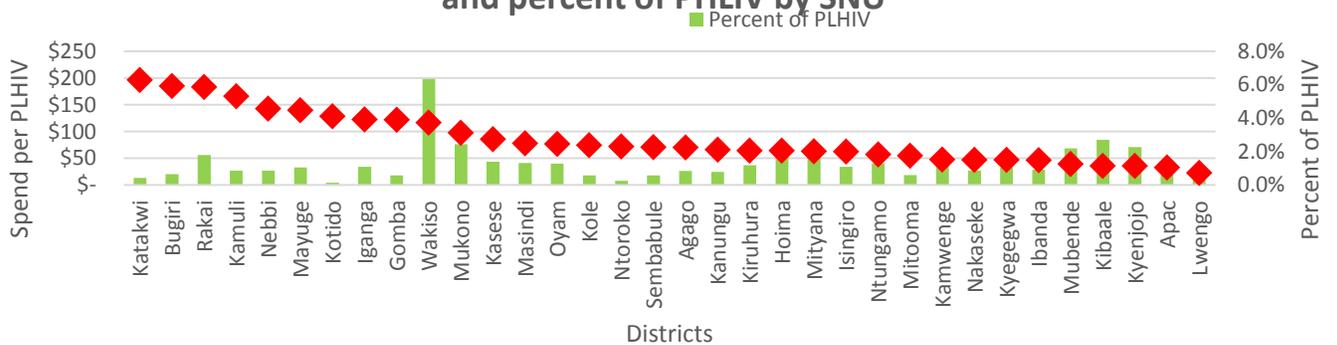
Scaleup to Saturation: 2016 PEPFAR Expenditure per PLHIV and percent of PHLIV by SNU



Centrally Supported: 2016 PEPFAR Expenditure per PLHIV and percent of PHLIV by SNU

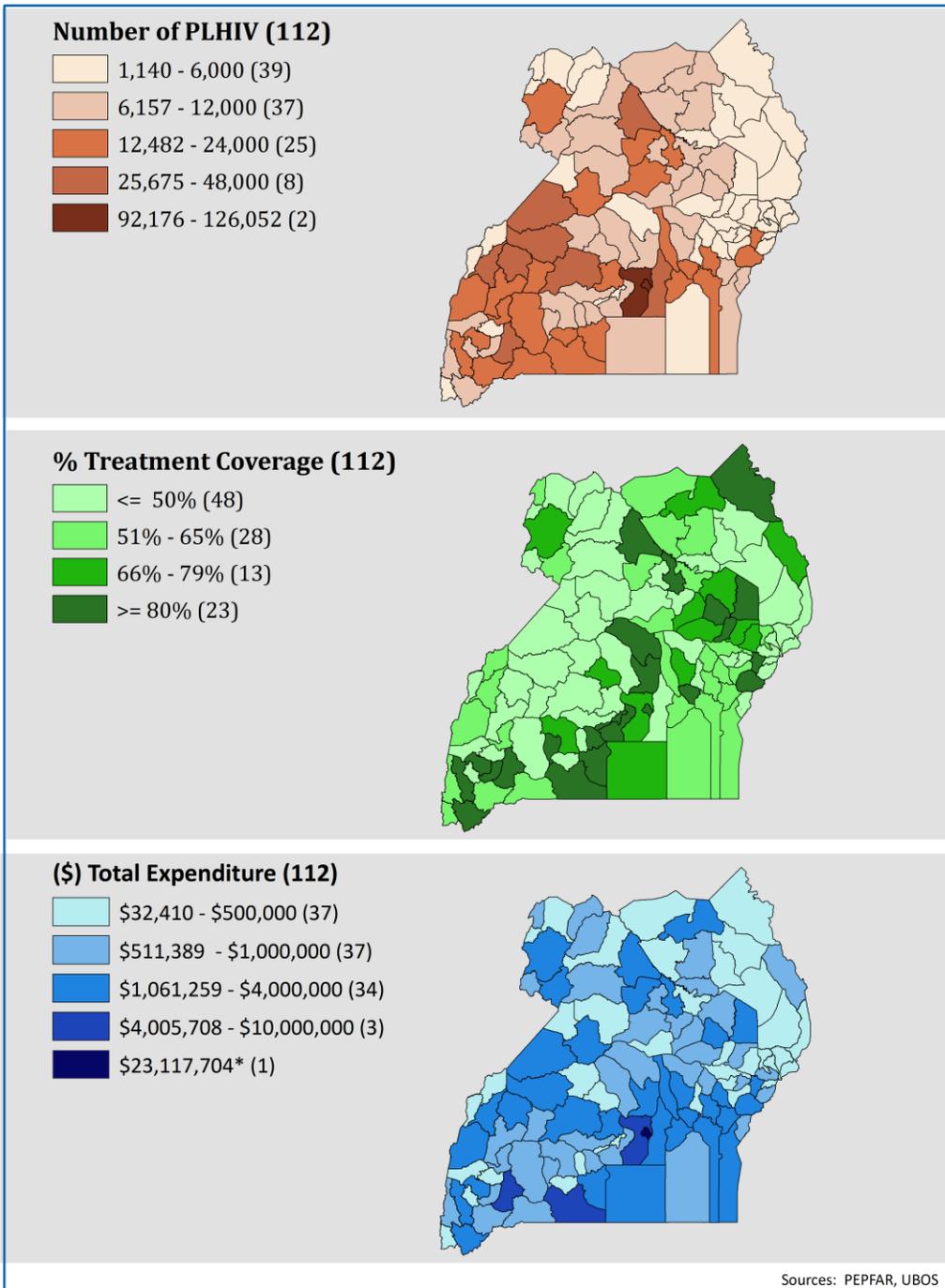


Aggressive scale-up: 2016 PEPFAR Expenditure per PLHIV and percent of PHLIV by SNU



Operating Unit 2016: Number of PLHIV, Treatment Coverage and Spend per PLHIV
UGANDA

Fig 2.4.1.



2.5 Stakeholder Engagement

Multi-stakeholder engagement comprising GOU, GFATM, AIDS Development Partners (ADP), and civil society organizations (CSOs) continued during the COP 2016 implementation period. At the highest political level, PEPFAR/UG engages the Office of the Prime Minister; the Ministry of Finance, Planning, and Economic

Development (MOFPED); the Ministry of Health (MOH); the Ministry of Gender, Labor and Social Development (MGLSD); and the Ministry of Local Government.

PEPFAR/UG holds regular conference calls with GFATM staff as well as in-person meetings during their missions to Uganda. This engagement has been dominated by supply chain issues and the challenge of impending ARV stock-outs. The parallel process of the COP development and Uganda's application for the next GFATM grant cycle provides opportunities for synergy. In February 2017, PEPFAR/UG had productive discussions with the GFATM staff to see how to work more closely together to both ensure that all parties remain firm in their commitments under their GFATM grant and to ensure that there are no stock-outs of both ARVs and rapid test kits.

PEPFAR/UG holds regular stakeholder meetings, including sharing quarterly results. A multi-stakeholder strategic planning meeting took place in February 2017 which was attended by senior technical representatives from the MOH, PEPFAR/UG implementing partners, multilateral and bilateral donors, and CSOs. Both the Minister of Health and the Permanent Secretary for Health attended both the DC Management Meeting and the COP Approval Meeting in Johannesburg as part of the COP17 development process. A follow-up meeting, hosted by civil society organizations and attended by PEPFAR/UG, and multilateral organizations was held in March 2017.

PEPFAR/UG regularly engages with stakeholders through technical working groups (TWGs), GFATM Country Coordinating Mechanism (CCM), Uganda AIDS Commission (UAC) working groups, UNAIDS, the Health Development Partner Group (which is currently co-chaired by USAID) and the AIDS Development Partners Group (to be chaired by the USG in July 2017). PEPFAR/UG is providing technical assistance to the MOH to support policy and coordination activities.

PEPFAR/UG's interagency team meets quarterly with CSOs to disseminate program results and information, obtain input on beneficiary populations (including KP and PP, youth, and people with disabilities), promote human rights including combating stigma and discrimination; help identify challenges and gaps in health care delivery and promote transparency. Civil society participates fully in every stage of PEPFAR/UG programming and planning. Civil society participation is critical to the success and sustainability of PEPFAR/UG efforts to combat HIV in Uganda and their feedback has informed the COP17 submission, including responses received from civil society review of the SDS.

Private Sector

The private health sector (faith-based and private for-profit providers) provides over 47 percent of primary and secondary health care in Uganda. Faith-based and private for-profit providers have created alternative supply chains to mitigate stock-out of medicines and established laboratory networks that augment inadequate diagnostic equipment in public facilities. In FY16, faith-based and private for-profit providers accounted for 14% of the total PEPFAR HIV/AIDS care and treatment result. Despite of its significance in Uganda's health system, the private sector remains uncoordinated and under-resourced and operates under a fragile health system. PEPFAR/UG works with national-level supervisory and regulatory bodies to improve stewardship and oversight of the private health sector and build the institutional capacity of faith-based and private for-profit providers, with the aim of helping them consolidate their role as an alternative channel for health care in Uganda. PEPFAR/UG also works with large workplaces to reach critical captive populations, including young men, with HIV services.

3.0 Geographic and Population Prioritization

During COP15, PEPFAR/UG aligned district budgets and targets to geographical prevalence, disease burden, and 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, disease burden estimates were calculated for each district. At that time, half of Uganda’s 112 districts had a prevalence above the national average at that time of 7.3%. Also introduced in COP15 was the concept of “clusters,” where districts had coverage above the national rate, often of >100%. These districts were identified if they had ART coverage of >77% and had a referral or large private not-for-profit or private-for-profit facility that served to draw in clients from other districts. Eight clusters were identified, covering a total of 36 districts. In COP17 a ninth cluster, covering an additional five districts, has been added utilizing the same criteria. Based on high burden (collectively accounting for 80% of the national HIV burden) and high prevalence ($\geq 7.3\%$), 61 districts were classified as scale-up for COP15 and continued 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 and PPs and proximity to high-burden districts.

For COP17, due to prevalence estimates coming out of PMTCT program data, GOU and PEPFAR/UG agreed to a revised FY16 PLHIV burden estimate of 1,356,217, representing a decrease of 146,668. The FY17 burden estimate was calculated to be 1,411,218. Geographic prioritization remained the same as COP15 and COP16 (see SDS 2015 and 2016 for methodology) other than 40 districts that, with COP17 targeting, will reach attained status by end of FY18.

Table 3.1 Current Status of ART saturation*				
Prioritization	Total PLHIV/% of all PLHIV for COP17	# Current on ART (FY16)	# of SNU COP16 (FY17)	# of SNU COP17 (FY18)
Attained	705,198/50%	565,544	0	40
Scale-up Saturation	137,153/9.7%	96,752	26	7
Scale-up Aggressive	323,329/23%	145,910	35	20
Sustained	184,150/13%	83,643	41	35
Central Support	34,677/2.5%	15,702	10	10

*PLHIV totals above do not include 26,711 military. Total PLHIV for FY17 is 1,411,218

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

4.1 Targets for Scale-up Locations and Populations

Targeting was calculated to achieve the attained level in the 10 original and the three new DREAMS districts, as well as in the seven scale-up districts that formed clusters with the DREAMS districts. Attained is defined as achievement of >80% treatment coverage across both male and female in three age bands <15, 15-24 and 25+ by end of FY18. In these 20 districts (13 DREAMS and 7 clustered districts), FY18 TX_NEW was calculated based on the unmet need to reach >80% ART coverage from projected APR17 achievement of TX_CURR in the above age bands for both male and female. In the remaining 82 districts, COP17 targets were set to achieve the attained level in as many districts as possible. Targets were calculated by first calculating net new needed for saturation for both males and females across two age bands, 15-24 and 25+. Due to focus on high targets of DREAMS districts for men and high net new needed for other districts for males 25+ targets, a high but feasible target was set for remaining districts by applying a series of decision rules: a) if net new needed to reach 80% saturation of sub-national units (SNU) was \leq APR 16 TX_NEW then FY18 target = net new needed; b) if the net new needed to reach 80% saturation was $>$ APR16 TX_NEW then 155% of APR16 TX_NEW for males; c) if the district was already at saturation, TX_NEW targets were set at replacement value (9% of TX_CURR for FY17). The ceiling of 155% was placed to push the partner beyond what they had accomplished in past years. The 155% for decision rule for men 25+ needed to be applied to 54 districts, 20 of which were in clusters with the major district of cluster having a greater proportion of targets. Of those districts that were not in clusters, the majority are sustained districts. Pediatrics was targeted to reach 95% coverage across both males and females in all districts.

This approach resulted in a total of 40 attained districts with a total TX_NEW of 188,385 to reach a TX_CURR of 734,966 by APR18. There are 7 scale up to saturation districts with a total TX_NEW of 24,421 to reach a TX_CURR of 109,733 by APR18; 20 aggressive scale up districts with a total TX_NEW of 59,687 to reach a TX_CURR of 210,967 by APR 18 and 35 sustained districts with a total TX_NEW of 35,142 to reach a TX_CURR of 121,003 by APR 18.

In COP17, PEPFAR/UG will continue to use the geographically focused approach to target KPs and PPs. Overall FSW prevention interventions are implemented in 31 districts, and MSM prevention interventions are focused in 5 districts with urban centers (Kampala, Wakiso, Gulu, Mbale, and Mbarara). These 31 districts include 20 attained, 3 scale-up-to-saturation, and 8 scale-up aggressive districts. For PP_PREV, the majority of the activities will be implemented in the 40 attained, 7 scale-up-to-saturation, and 20 aggressive scale-up districts. In addition, sero-discordant couples will be reached with a prevention package of services in the 35 sustained districts. Intense prevention programming for fisher folk will cover 12 districts around Lake Victoria. If new hot spots are detected through surveillance and data monitoring, , these areas will be prioritized.

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 population on ART at APR16 (77% national coverage), adjusted for a program attrition of 9%; 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 initiation of Test and Start in January 2017 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 estimated based on APR16 results. Based on the last three years of program data, 100% already know or will learn their status at ANC. Ninety-five percent of pregnant women living with HIV are targeted to receive ART. The proportion of newly initiating on ART was derived from the district proportion of newly initiating vs. already on ART at APR16, and aggregated to national level.
- New from EID is based on an estimated 80% of HIV-exposed infants expected to be tested through PMTCT. 3.9% are estimated to be HIV-positive based on APR16 EID positivity. Ninety-five percent 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 FY16 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 departments). 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 KP/PP). Targets at highest yield sites were limited to the number of clients at those sites (e.g., although there is an anticipated very high yield at TB sites, targets could not be set above anticipated number of TB clients; the same held true for STI clinics, partners of HIV+ individuals, and inpatient departments). For 27 SNUs known to have a high concentration of KPs, mobile testing was included. Once high-yield sites were exhausted, remaining targets were distributed to OPD. A screening tool for OPD will be developed to better target for increased yield. The same approach was used for sustained districts, but no mobile or HTC targets were assigned.

Entry Streams for ART Enrolment	Tested for HIV (APR FY18) HTS TST	Newly Identified Positive (APR FY18) HTS TST POS	Newly Initiated on ART (APR FY 18) TX_NEW
Adult			
TB Patients	2,821	806	806
Pregnant Women	433,548	10,463	10,008
VMMC Clients	497,258	3,426	3,186
Key Populations	19,774	1,976	1,838
Priority Populations	78,688	28,315	26,344
Other Testing	1,076,178	44,626	41,935
Previously Diagnosed and/or In Care	0	0	-
Total Adult	2,108,267	89,612	84,107
Pediatric (<15 years)			
HIV Exposed Infants	20,359	769	769
Other Pediatric Testing	89,199	934	934
Previously Diagnosed and/or In Care	0	0	0
Total Pediatric	109,558	1,703	1,703

SNU	Target Populations	Population Size Estimate	Current Coverage	VMMC_CIRC	Expected Coverage
		(SNUs)	2016	(in FY17)	(in FY18)
	[15 to 29 years]				
Attained	2,354,519	8,720,441	48%	405,794	52%
Scale-up districts: Aggressive	1,156,628	4,128,807	43%	183,887	47%
Scale-up districts: Saturation	351,567	1,302,098	62%	54,016	57%
Sustained districts	1,076,841	3,988,299	43%	35,504	43%
Military Districts				17,723	
Total/Average	4,939,555	18,139,645	49%	696,924	50%

4.2 Voluntary Male Medical Circumcision (VMMC)

From 2010 to 2016, the total number of VMMCs performed in Uganda increased from 9,052 to more than 3.4 million. However, 4.2 million men and boys between the ages of 10-49 years remain uncircumcised. PEPFAR continues to be the principal donor for VMMC, having supported 85% of all circumcisions during this period. GOU and other VMMC partners -such as AIDS Healthcare Foundation, Uganda Cares, and UNICEF - have gradually increased their contributions, although involvement outside of PEPFAR declined in 2016.

A 2016 MOH policy stipulating that two doses of tetanus toxoid (TT) must be administered prior to male circumcision resulted in a sharp decline in the number of men being circumcised. By APR16, 329,294 VMMCs had been performed, and only 26 districts had achieved a saturation of >80% - well below the anticipated target of >80% saturation in 58 districts. Based on FY16 Q4 data, men between 15 - 29 years contributed to 49% of all circumcisions. In March 2017 the tetanus policy was revised to require only one TT at the time of circumcision. With aggressive efforts in the last half of FY17 and FY18 1.6 million men will be circumcised.

In COP17, PEPFAR will perform 696,924 MCs with both COP and central funds. VMMC services will target 67 districts with the highest HIV burden and lowest MC prevalence. These districts include 40 attained districts, 20 scale-up aggressive districts, and 7 scale-up saturated districts; 5% of MCs will be carried out in the 35 sustained response districts in order to maintain VMMC coverage. Attained districts will account for 58% of the targeted MCs and include the 13 DREAMS districts. The DREAMS platform will be used for VMMC demand creation among 15-29 year olds, through the male sexual partner characterization assessment approach and the use of DREAMS Ambassadors, Girls Engagement Forums, and AGYW male partner champions. Others at high risk, such as STI clients and partners of sero-discordant couples, will also be encouraged to undergo MC. Interventions to improve VMMC coverage among 15-29 year old will include: 1) mobilization at schools and tertiary education institutions; 2) health education at ANC; 3) separate waiting and education areas at VMMC sites; 4) extended hours/days; 5) and, incentives such as the provision of transport and mobile services at workplaces and marketplaces. The military, through PEPFAR/UG support, plans to perform 17,723 circumcisions.

VMMC will be offered as part of a comprehensive HIV prevention package, which includes HTC, screening and treatment of STIs, and referral of HIV+ identified men to appropriate care and treatment. HIV testing services will be offered only upon request, and not routinely, to boys and adolescents who have not yet had sexual debut, given low rates of HIV infection in this age group. PEPFAR will conduct quality assurance (QA) and continuous quality improvement (CQI) activities, and provide commodities and consumables, including emergency kits and TT.

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, given genital hygiene instructions, and educated in the dangers of tetanus.

Site Improvement through Monitoring Systems (SIMS) data indicates that documentation and referral of identified HIV-positive clients remains a challenge. MOH triplicate referral forms will address the issues by: 1) confirming the completion of the referral loop; 2) offering same-day enrollment in care; 3) documenting referred clients; 4) tracking clients, and 5) documenting lost to follow up. In FY16Q4, of 329,294 men circumcised, 2.7% tested HIV+ and were referred into treatment.

In COP17, PEPFAR/UG will invest in online data tools to provide for better monitoring and real-time data:

- Uganda's Decision-Makers' Program Planning Toolkit (DMPPT 2.0) Online Tool will be updated to model VMMC targets for each age group at the SNU level;
- The Site Utilization/Online Site Capacity Tool will allow Implementing Partners (IPs) to maximize their site utilization capacity by assessing the capacity of a site to efficiently utilize all available resources. For those sites, which are operating at <80%, IPs will be able to initiate a tool kit that uses CQI approaches to improve and maximize their site utilization capacity;

- The GIS Mapping Tool will map results from the District Health Information Systems 2.0 (DHIS2), DATIM, DMPPT and the Site Utilization Tool. This will foster easy performance monitoring and allow IPs to provide focused TA for performance scale up.

4.3 Prevention Programs for Key and Priority Populations

PEPFAR/UG identifies key and priority populations as indicated in Table 4.1.3. The MOH requires KP data to be disaggregated by type for improved tracking of each group, linkages to services, and cascade monitoring. The reports may be underestimates because they are dependent on self-identification at service delivery points (SDP). The KP classification tool will enhance identification, linkage and tracking of KP across the cascade. The tool will be adapted to Uganda’s KP context based on preliminary feedback from one site, which participated in the pilot and showed that the tool needs to be revised in light of the potential stigma and homophobia for KP in general population settings.

In COP17, PEPFAR/UG will continue with service integration and leverage the Local Capacity Initiative and Advocacy for Better Health to empower civil society to advocate for better services for KP and PP. The KP-led score card process will be rolled out for CQI, and will, along with SIMS and partner risk assessment, contribute to an enabling KP/PP programming environment. Working with civil society groups and community peer networks, and utilizing inclusive and joint programming, the KP and PP program will support routine hot-spot mapping and will engage peers in program planning, mobilization, implementation, monitoring and reporting. Attention will be given to peer linkages and peer led prevention activities in prison settings. PEPFAR/UG will continue to support Gender and Sexual Diversity (GSD) KP sensitivity trainings to address stigma and discrimination against LGBT at IP level and among new team members. Sensitization trainings will address non-discriminatory service provision for KP and PLHIV. PEPFAR/UG will continue to assist the MOH to harmonize the KP and PP data capture and reporting and contribute towards building the capacity of regional and district hospitals in KP-friendly service delivery to enhance access to quality combination prevention services.

In COP17, PEPFAR/UG will maintain its geographical focus to maximize prevention and identification of KP undiagnosed positives by working in 5 regional urban districts where there is an MSM presence; three additional districts will target FSWs to reach a total 30 districts. In line with the major thrust of COP17, there will be a focus on reaching men in the KP/PP category (MSM, Uniformed, and Fisher Folk) aged 15-29 years with prevention interventions. Regular gender analyses will be conducted to inform program decisions. The HIV testing services guidelines will be revised to provide opportunities for HIV self-testing and this will be promoted among FSWs and MSM. There will be routine analysis of KP and PP data for program improvement and strategic roll out of the KP referral directory. Targets for MSM and FSW programs have all been increased in COP17, although there is some concern among the CSO community that these still remain low. Through quarterly program reviews, KP performance results will be assessed allowing for an increase in service delivery targets based on demonstrable progress. Efforts will be made to obtain better size estimations for KP populations using PLACE and CRANE methodologies.

Although SIMS data indicates improved quality of services for KP, the main challenge is documenting activities, given the lack of standard indicators for KP. PEPFAR/UG will continue to scale-up high impact prevention using evidence based curricula like “Stepping Stones,” as well as known GBV response models like “SASA!” from Raising Voices. PEPFAR will prioritize a VACS response plan with the GOU and utilize VACS data for GBV target setting, focusing on post violence care services using the maternal and child health (MCH)/PMTCT platform as a main entry point. PEPFAR will support translation and scale-up of GBV service

quality standards. SASA! is currently implemented in the DREAMS districts and will be implemented in other districts where there are high VAC/GBV rates. We plan to use a phased approach to implement SASA! in other districts beyond DREAMS districts.

Condom promotion, access, and availability will be enhanced through increasing the number of dispensers in hotspots and areas of high-risk sexual activities. When available, lubricant access and utilization will be promoted either through the MOH or through partner initiated supply options. PEPFAR/UG, will support social marketing to improve condom access through the private sector. A total market approach will be utilized to ensure equitable access to services and products through market segmentation and targeted geographic coverage. PEPFAR will leverage GFATM and UNFPA efforts to ensure maximum complementarity.

To coordinate and oversee the implementation of the revised National HIV Prevention Strategy, condom strategy, and related prevention policies and guidelines, as well as the National Quality Improvement (QI) Framework and Strategy, joint routine assessments of community prevention interventions will be undertaken with the MOH Quality Assurance Department (QAD). A USAID implementing partner will support all USG prevention mechanisms to develop/scale-up tailored health communication and behavior change strategies and tools for reaching specific audiences with effective interventions for improved uptake of services.

With the development by the MOH of PrEP guidelines, site readiness assessments, training and job aides, COP17 will also see an increase in PrEP to reach a target of 11,757 with KP and PP (Table 4.1.3). This will build on implementation in quarter 3 and quarter 4 of FY 17. The plan is to roll out the program to other sites with high KP and PP presence based on the lessons learnt from the pilot implementation in the second half of FY17. During COP 17, the program will work with CSOs to enhance demand creation among the targeted populations including FSWs, MSMs, IDUs and fisher folks across the sites. PrEP will be delivered as an integrated package within accredited health facilities with the COP17 scale up being informed by results from pilot interventions in COP16. Should excellent progress be seen through the quarterly program results reviews, targets, and services may be expanded.

The DREAMS initiative provides an opportunity for Uganda to implement high-quality combination prevention to AGYW aged 15-24 years. DREAMS offers select high-impact HIV services through a layered approach to HIV negative AGYW. DREAMS wraps around COP17 activities to expand the layering effect, such as ART and VMMC, for both AGYW and their sexual partners. This approach will be targeted to scale in the 13 priority districts in COP17. The Uganda DREAMS Tracking System will be used to track effective layering of interventions. Using an enhanced facility-community linkage approach, DREAMS will support COP17 activities by improving the tracking of patients. DREAMS will also improve linking AGYW male sexual partners to VMMC and HIV testing, and if diagnosed HIV+, to Test and Start. DREAMS will continue to work closely with communities empowering them to identify their own practical solutions. Uganda will prioritize strategic information to evaluate the cost of prevention packages, to select an optimal intervention mix, and to track and explain trends in new HIV infections.

Target Populations	Population Size Estimate (scale-up SNU)	Coverage Goal (in FY17)	FY18 Target
MSM	32,340 ¹⁹	17%	5,409
FSW	149,799 ²⁰	60%	88,869
Prisoners	140,956 ²¹	70%	98,150
Prison Officers	56,000	63%	35,400
Police ²²	60,000	65%	40,000
Fisher Folk	2,000,000 ²³	6%	124,567
Military	200,000 ²⁴	25%	50,000
SDC	22,709	50%	11,290
AGYW	318,038	20% (10 original districts) 100% (3 new districts) 50% (4 PMTCT districts)	82,490
PrEP Implementation (SW, MSM, and FF)	78,690 ²⁵	15%	11,757
TOTAL	3,738,216		547,932

4.4 Preventing mother-to-child transmission (PMTCT)

Since the roll-out of Option B+ in 2013, the proportion of HIV+ pregnant women initiated on ART increased from 84% (FY13) to 98% (FY16). HIV+ women on ART at the beginning of pregnancy increased from 33% (FY13) to 55% (APR16). In FY18, 79,849 (95%) HIV-positive pregnant women are targeted to receive ART of which 55% (43,697) are expected to already be on ART at 1st ANC visit. HIV transmission to infants in FY17Q1 was 3.1% among those infants tested, with EID coverage improving from 64.5% at APR16 to 76% in FY17Q1 through the use of an EID package implemented by IPs. The mother-baby care point (MBCP) has provided an effective platform for follow-up of mothers and infants. This service delivery model builds on a “one-stop-shop” approach and includes: 1) giving one refill date for the mother and baby; 2) pairing mother and baby charts; 3) engaging linkage facilitators to follow up lost mothers of babies due for testing; 4) placing stickers on charts of babies due for testing at 18 months; and, 5) immediate update of registers for children tested at 18 months.

The PMTCT platform provides an opportunity to access men through their partners. There are several promising practices: family support groups, letters to partners, male champions, integrating men into VSLA, male action groups, and community mobilization. The 2016 Annual Program Report indicated that 11,000 HIV+ men had been identified through the PMTCT platform, giving a yield of 2.2%. However regional

¹⁹ Figures from modelling by CDC Epidemiologists, using UAIS 2011 data and UBOS Statistics

²⁰ Figures from modelling by CDC Epidemiologists, using PMTCT Weight prevalence 2015 data and census 2014 population of women), and PLACE study 2016

²¹ UPS Report, 2016

²² Uniformed forces (army 20% and police 11%)

²³ UAC report on multi-sectoral program for MARPs, 2014

²⁴ DOD

²⁵ The base population of SDC, MSM, and SW in selected PrEP districts (all Scale-up districts), considering the prevalence in the difference populations

variations were also noted; for example in Central 1 and 2 regions, yields of 6.3% and 5.1% had been achieved. PEPFAR/UGAs part of increased partner monitoring and using more real-time information to foster change, PEPFAR/UG will share promising practices which have utilized a change basket of options, among IPs to increase the pace at which more men can be tested and linked to care and treatment.

COP16 supported the roll out maternal retention and birth cohort monitoring through outcomes, strengthening HIV exposed infants (HEI) cohort analysis, and CQI interventions for mother-infant pairs (MIP) throughout the pregnancy and 18 months post-partum. Additional emphasis is being placed on strengthening maternal retention through reporting, appointment tracking and active follow up of MIP across the continuum of care. Scaling up integration of EID services with immunization programs will improve early identification and linkage of HEI to the MBCP. Linkage from PMTCT to OVC programming will also ensure that vulnerable MIP can be provided with additional support services, including early childhood development. COP17 activities will continue to focus on strengthening these strategies to provide high quality care for the mother and baby pair with the goal of achieving 90% retention and viral suppression among pregnant women initiating ART and over 80% known final infant outcome at 18 months.

PEPFAR/UG expects all sites to conduct ART monitoring using VL by the end of FY17. VL implementation within the MBCP was introduced in COP16 and will aim for full integration of sample collection, result provision, enhanced adherence counseling, and decision-making for switching to second-line regimens. This will be achieved through using VL stickers to identify eligible clients, CQI interventions, and roll out of a VL non-suppressed register that will longitudinally track management of non-suppressed HIV-positive pregnant and breastfeeding women. At national and subnational level, regular VL data review meetings based on the VL dashboard will be conducted. The modification of the national HIV guidelines to include VL testing at ANC1 for all pregnant women already on ART will help to further reduce MTCT by identifying non-suppression early in pregnancy with time to intervene to return VL to undetectable levels.

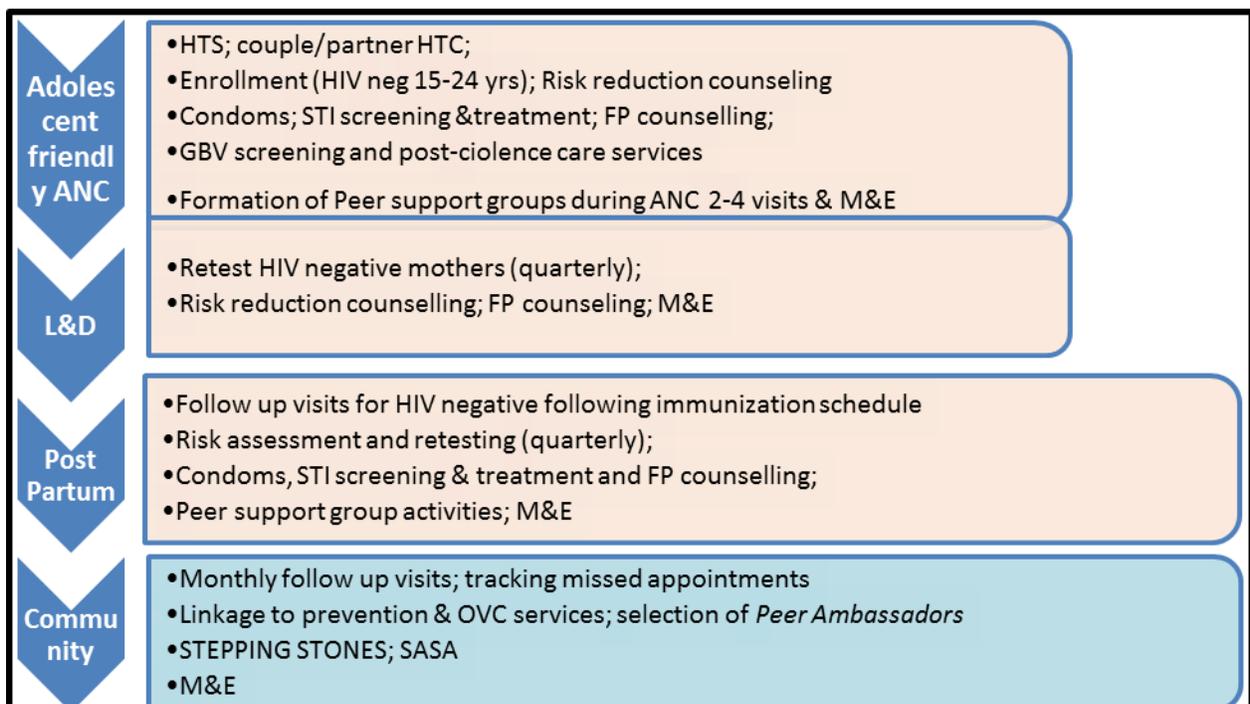
In this COP, funding has also been included for incidence testing in the PMTCT impact evaluation. Most available incidence testing has generally been shown to overestimate HIV incidence, particularly in epidemics with predominance of subtypes A and D, like Uganda. However, of these, LAg avidity testing has been demonstrated to have the lowest rate of misclassification for these sub-types. Given the above, Uganda has planned to incorporate the LAg avidity testing within its national PMTCT impact evaluation, which is also focused in the districts implementing DREAMS. This would allow us to have a baseline measurement of incidence (especially for DREAMS districts) and to compare the measured estimate with the observed incidence to determine an appropriate correction factor.²⁶

PMTCT services also provide a platform to prevent HIV-incident infection in AGYW. Over 90% of HIV-positive pregnant women aged 15-24 years are newly identified and account for 52% of all newly identified HIV-positive pregnant women (FY17 Q1 data). In DREAMS districts, support will provide active linkage of HIV-negative pregnant and breastfeeding AGYW and their infants to HIV prevention services and follow-up through facility visits, family support groups, peer mothers within MCH settings, and community. Key

²⁶ Longosz Andrew F., Serwadda David, Nalugoda Fred, et al. Impact of HIV subtype on performance of the limiting antigen avidity EIA, Bio-Rad avidity assay and the BED capture immunoassay in Rakai, Uganda. *AIDS Research and Human Retroviruses*. April 2014, 30(4): 339-344. doi:10.1089/aid.2013.0169.

interventions will include: 1) health education; 2), HIV testing and counseling and regular retesting for those with continuous exposure; 3), couple counselling and partner testing; 4) safer sexual practices including dual protection (condom promotion), risk reduction counseling; 5) family planning (FP); 6) GBV and post violence services; and, 7) linking their HIV negative male partners to the VMMC program. In FY17 Q1 only 28% of HIV+ male partners were tested in ANC settings. Subsequently, there is a clear need to continue to strengthen male partner involvement in PMTCT activities, including male partner index contact tracing.

Figure 4.4 Integrating DREAMS Interventions within PMTCT/MCH platforms at HF and community



4.5 HTC

Of an estimated 1,356,217 million PLHIV in Uganda in FY 2017, approximately 1.05 million (77%) have been diagnosed, and 950,000 (68%) are on treatment (FY17 Q1 data). The HTC program has been aligned with the epidemic to ensure that the bulk of testing (75%) and positives identified (90%) are in priority SNUs. Over 90% of HIV+ women and children have been diagnosed and 79% and 82% respectively are on ART. The key then to achieve HIV epidemic control is to diagnose more men and initiate ART. As of the FY17Q1, only 61% of men had been diagnosed and 54% initiated on ART. FY17Q1 data also suggests that AGYW remain at high risk of getting infected. The yield among the 15-19 year olds is three times higher in females (2.0%) than males (0.6%) and one and a half times higher in females aged 20-24 years than males. Between 25-49 years female and male yields are the same (4%) but men >50 years had a higher yield than women.

The DHS 2016 report indicates that risk practices start rapidly increasing in men over the age of 20 years, with over 25% of men having more than one sexual partner as well as low condom use²⁷. Further analysis by disaggregated age groups and of yield at different entry points provides a basis for a much more targeted HTS strategy in COP17 focusing on testing more men. This requires not only increasing the demand for testing among men but also a better understanding of where and when men prefer being tested for HIV. COP17 will have a differentiated HTS by age bands both at facility and within communities. At facility level, case finding will be optimized through the tracking and testing of family members, including sexual partners of index clients to reach 100% index case testing for all newly diagnosed clients and 50% of those currently in care across all age bands. There is low prevalence among males 15-19 so HIV testing will utilize a risk based testing approach building on the VMMC platform. Preliminary information also indicates a higher yield for this age group through client initiated HIV testing point.

COP17 will focus strategically on men above 20 years of age. Information from the HMIS shows that there are many missed opportunities to test men above the age of 20 who come to OPD; of the one third that were tested, yield was 3.8% were found to be HIV+ (HMIS FY16). Therefore, testing at critical entry points (TB, ANC, in patient wards and OPD) and the use of eligibility screening in OPD to increase yield will take place. At the facility, men will be tracked and given priority for HIV testing at all entry points. COP17 will also ensure that, once diagnosed, men are linked to ART. An enabling environment for them to seek services will be created including extended clinic hours and same day initiation. Several differentiated care models are being rolled out and these will be followed closely to adjust them accordingly for men. Existing regional performance monitoring teams will be used to review data to ensure that partners of index clients are offered partner services.

Men are less likely to come to health facilities than women. Outreach activities will include mobile testing in hotspots, informal (e.g. among boda boda riders) and formal work places (e.g. among civil servants), and to those in mobile occupations (truck drivers and uniformed services). Demand creation will be generated through social networks and will focus especially on men above 20 years of age. Demand creation for those men between 20-24 will use infotainment and social media whereas for the older men, the social marketing of male HIV/AIDS services through the use of male champions and opinion leaders at both facility and community levels will be emphasized. For example, UNAIDS has involved the King of Buganda for mobilization. This is also 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

²⁷ 2016 Uganda Demographic and Health Survey, Uganda Bureau of Statistics, 2017

men. Given that self-testing alongside partner services has the potential of increasing HIV testing uptake among men, the Uganda HIV testing guidelines will be revised to allow for self-testing among partners of HIV-positive women attending ANC and in social and sexual networkers of key and priority populations. Counselling services will be intensified to enhance partner disclosure while ensuring that, women who disclose their HIV status are protected from GBV.

COP17 HTC targets have been set using the data pack to achieve TX_NEW needed to reach targeted coverage. The SDP with the highest yield were prioritized (facility based index client, community based index client, TB clinic) and targets at these high yield SDPs were set as high as the volume of the SDP would allow: for TB clinics the number of tests was set at 100% of the TB clients from the prior year that was pulled from DHIS2; index client testing was set at 1.5 times the number of newly identified PLHIV in the prior year; mobile testing was set at two times the number of KP in the district. After targets were set at all the highest yield SDPs, the remaining targets needed to find the new positive PLHIV were given to the OPD. A screening tool will be developed for OPDs that will result in higher yield with less testing than in than prior years.

Starting now in COP16 implementation, there is a change in the way of doing business, with much closer partner monitoring of results and analysis of real-time data through more frequent meetings. This provides opportunities to better understand, share, and roll out good practices. Real-time data also provides earlier indications of poorly performing partners so that remedial action can be swiftly made.

Although efforts are being made to strengthen the national commodity supply chain system, PEPFAR/UG anticipates HIV test kit stock-outs. PEPFAR/UG will continue to lobby the GOU for more targeted HIV testing for higher yields.

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

4.6 Facility and Community-based Care and Support

As Uganda nears ART saturation, newly identified PLHIV are healthier. From program data, partners report median CD4 of 460 cells/mm³ at initiation on ART (FY2016 IP program reports) and available PIMA testing data shows approximately 10% of PLHIV care have CD4 <100 (access to CD4 is over 85%) compared to an estimated 20% in 2014²⁸.

Core care activities comprise: 1) provision of cotrimoxazole; 2) nutrition, assessment, counseling and support (NACS); 3) TB/HIV interventions; 4) STI/OI screening and treatment; 5) FP integration, and 6) other Positive Health, Dignity and Prevention (DHDP) interventions. PEPFAR/UG 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 especially those from KP with the support of PLHIV networks and KP organizations, will continue to support these efforts.

Following adoption of Test and Start in January 2017, CD4 will only be used for newly initiated PLHIV to ascertain risk for immune reconstitution syndrome and determine the need for serum Cryptococcal Antigen (CrAg) screening. In COP15, the CrAg screening guidelines were finalized and lateral flow assay (LFA) kits were

²⁸ ABCE Study and Sendagire et al, 2014 (IDI KCCA sites)

introduced at select facilities. The revised national HIV guidelines incorporate screening asymptomatic, newly-diagnosed PLHIV with a baseline CD4<100 and treatment algorithms for those with asymptomatic cryptococcal antigenemia and those diagnosed with cryptococcal meningitis. PEPFAR/UG will support the screening and GoU and a corporate donor (Pfizer) will support treatment. Screening should also be considered for those who are treatment experienced but present to care with advanced HIV.

In APR16, 73% of clients in care were evaluated using NACS; 12,968 individuals with moderate to severe malnutrition were provided Ready to Use Therapeutic Foods (RUTF). PEPFAR/UG will continue to support NACS, through routine mentoring and supportive supervision, and will contribute to the procurement of RUTF for severely malnourished HIV+ adults and children.

Family planning (FP) integration with HIV services was enhanced with investments from HIV/FP integration central funds. PEPFAR/UG supported the MOH to develop and disseminate policy guidance, coordinate HIV/FP integrated programs, develop training materials, as well as build the capacity of health care workers (HCW)s. COP17 funds will continue to provide mentorship, supportive supervision, and QI for FP/HIV integration as a core component of site-level support. All IPs either have or will receive the required USG FP compliance training.

Both program data and SIMS results on linkage of adults and children to community-based HIV services have shown marked improvement over FY16 - from 80% of facilities visited needing urgent remedial action to less than 5%. This has been achieved by: 1) piloting the PEPFAR/UG facility-community linkages framework for supporting health facilities to identify, map, and engage registered CSOs/CBOs and informal community platforms/groups in service delivery; 2) supporting successful referral processes; 3) involving facility based linkage facilitators; 4) using duplicate referral forms to track referral completion; 5) institutionalizing a referral focal desk to coordinate linkage facilitators with village health teams (VHTs); and, 6) integrating bi-directional referrals as part of HWs routine service delivery practice. At the community level, PEPFAR/UG has supported VHTs and engaged them in monthly data review meetings.

4.7 TB/HIV

With the increased TB prevalence (253 cases per 100,000), an estimated 45,000 cases of TB are missed. Of these, 16,028 HIV/TB con-infected cases are missed annually; the TB/HIV co-infection rate is 42%. There is a high 50% mortality rate among those that do not seek treatment. In Uganda, women sought care more often than men (67% vs. 53.9%), but bacteriologically confirmed TB was more prevalent among men (76.2% vs. 23.8%).²⁹

As of APR16, 75% of new and relapsed TB clients had a documented HIV status, and 86% of TB/HIV co-infected patients were on ART. Based FY16 SIMS data, 98% of sites demonstrate >90% documented HIV status among TB cases compared to 75% found in DHIS2. PEPFAR/UG programs will continue working with facilities to improve TB/HIV data reporting.

²⁹ Report on the Population-based Survey of Prevalence of Tuberculosis Disease in Uganda 2014-15

PEPFAR will support the MOH national guidelines for an integrated management of TB/HIV co-infection in one clinic, by the same health worker, and strengthening linkages and referrals between TB and ART clinics. In Uganda, a policy for provision of TB Preventive Therapy (TPT) for PLHIV was adopted in 2013, which recommends use of isoniazid for 6 months for all PLHIV (including children 12 months and older, or less than 12 months with a known TB contact) in whom active TB has been excluded. Due to resource constraints, the MoH has taken the decision to target these higher risk groups. Given that IPT will be prioritized to PLHIV newly initiated on ART, and these patients within the DSD care models are classified as “unstable” patients and will receive INH at the health facility level. Between the GFATM and PEPFAR, 85% of the INH will be covered through COP17 and the new Global Fund grant.

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 FY18, PEPFAR/UG will continue to support these core services:

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

Children contribute 7.5% of the notified TB cases annually, yet 15% of people with TB are estimated to be children²⁴. This discrepancy is largely due to limited implementation of contact and reverse contact tracing, sub-optimal linkage of TB and presumptive TB patients to HIV testing services (75%) and ART (86% APR 16), sub-optimal hub coverage of GeneXpert machines (77%) and delayed results return after GeneXpert testing³⁰. In order to find the missing TB/HIV and childhood TB cases, PEPFAR/UG will support the following activities: 1) household contact tracing and investigation through the community care strategy including DSDM; 2) the specimen referral and results transport system; 3) CXR diagnosis in children; 4) procure 16 GenXpert machines; 5) implement the revised diagnostic testing algorithm to use GenXpert for improved sensitivity and TB/HIV yield; 6) implement QI for TB/HIV; 7) optimize GxAlert platform to improve the turnaround time of results; and, 8) support reporting for TB_PREV by printing and distributing IPT registers for ART sites coupled with mentorship of health facility staff on recording and reporting for IPT. PEPFAR IPs will support the national reporting system both at the facility and sub-national level.

FY 16 SIMS visits indicated that 90% of sites were not providing adequate IPT due to erratic supplies and stock-outs. PEPFAR IPs will continue to mentor facility staff on IPT SCM to ensure timely and adequate ordering, forecasting, quantification, documentation and timely reporting for patients on INH prophylaxis. The GFATM provides all TB drugs, including isoniazid. PEPFAR/UG 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.

³⁰ PEPFAR Uganda Annual Progress Report 2016

4.8 Adult treatment

By FY17Q1, treatment coverage was 68% (922,909/1,356,217). The program retention at 12 months is estimated at 91%, while 12-month cohort retention is estimated at 77%. This difference is likely due to silent transfers, mobile populations, and documentation challenges. A 2013 study of program retention in Uganda demonstrated that at 2.5 years, retention among patients who had enrolled with a CD4 >350 was 88.2%. Of a randomly selected subset of those lost to follow-up, over 50% of were found to have reported to another site, thereby remaining in the program but lost to a cohort³¹. Given variability over time, the standard for measurement for attrition is annual. Historically, PEPFAR has used an annual program attrition of 9%. The target setting this year required a more granular approach, separating attrition within the first 12m after initiation and attrition for those on ART > 12m. The attrition for newly initiating varied by SNU and was based on the attrition reported at APR16. For attrition of those who have been on ART for >12months, 10% was used which is the average annual attrition over the past 3 years

By the end of FY18, an anticipated 1,200,326 will be receiving treatment, translating into a national coverage rate of 95%. PEPFAR/UG will initiate 314,369 new ART clients. It is expected that the estimated 86,000 patients currently in pre-ART care (at APR2016) will be started on ART during FY17 as Test and Start is rapidly rolled out. Subsequent new treatment enrolments will depend entirely on identification of HIV-positive clients through HTS. In COP 17, PEPFAR/UG will focus on enrolment of men, adolescents and young adults under 35 years into treatment with the aim to improve treatment coverage among these populations and reduce incidence of HIV infection. To achieve maximum benefits from Test and Start, same day ART initiation for newly identified PLHIV is highlighted in the guidelines and training materials. Specifically, 'If a client is ready, ART should be initiated on the same day. If a client is not ready or opts out of same day initiation, a timely ART preparation plan should be agreed upon with the aim of initiating ART within seven days for children and pregnant women, and within one month for adults.' Given that Uganda has already been doing same day initiation for pregnant women, children, discordant couples, and key populations, acceptance among health care workers is high. Similar to what was seen when Option B+ was rolled out, the program anticipates potential challenges such as commodity management and early retention. These are being addressed as part of the training to mitigate stock-outs and early lost to follow-up.

Uganda national ART guidelines provide for DSDM to promote needs-based client-centred HIV care and treatment services, while reducing unnecessary burdens on the health system. Uganda offers 5 models of ART service delivery, three of which are facility based (intensive clinical follow-up, fast track refills, or group refills, and two of which are community driven (community drug distribution points and client-led ART refills conducted through peer groups). This approach hinges on effective bidirectional facility-community linkages. The DSDM are tailored to the unique needs of the following populations: 1) Stable clients on ART (healthy PLHIV on ART for at least 12 months who have a VL<1000); 2) complex clients (newly diagnosed/new initiators, virally unsuppressed, ill clients and or TB patients, poor adherers and those who are lost to follow up); 3) KP and PP; 4) mothers in PMTCT programs and their HEI; 5) and HIV positive children and adolescents. Models tailored to improve initiation and access of men on ART will also be explored. Through these models stable ART clients will receive two clinical visits at the facility and two refill visits either at the pharmacy or in

³¹ Namusobya J et al. High Retention in Care among HIV-infected Patients Entering Care with CD4 levels \geq 350 under Routine Program Condition in Uganda. *Clinical Infectious Disease* 57(9): 1343-50. Nov 2013.

the community (through dispensers, expert clients or client led groups) annually. Multiple month prescribing is incorporated in selected DSDM – clients will receive three months prescriptions.

COP 17 funds will support an intensive monitoring of the roll-out of this approach and implications on the quality of patient care. PEPFAR/UG will support district health teams to oversee, monitor and coordinate the roll-out of the national differentiated service delivery implementation framework. HF staff will be provided with technical assistance through mentorships and coaching to ensure adequate commodity supply, required monitoring tools are effectively utilized, retention of patients served in the community remains high, and quality of patient care is not undermined.

PEPFAR/UG will improve program efficiencies by focusing on effective partner management to ensure that partners achieve their targets. This will be done through monthly performance reviews looking at the clinical cascades and in depth data analysis, using a QI based approach to address identified challenges. Further improvements will be gained through cross-learning between high and low performing partners, utilizing SIMS data to continually improve the program activities (for example, deploying increased numbers of peer counsellors and educators from KP and PLHIV networks) and strengthening community-based organizations, government, and community structures.

PEPFAR/UG will continue to support the national VL testing program for ART monitoring. From APR 15 to APR 16, VL coverage was expanded from 21% to 65%. Although coverage remains below target, viral suppression rates are high at 91%. Ongoing efforts in FY17 will: 1) continue to expand coverage; 2) maintain sample transportation and lab testing through the laboratory hub system; 3) roll out a laboratory information system (LIS) to hubs; and, 4) improve quality assurance to decrease viral sample rejections from 4.3% to 2%. Uganda's ability to monitor both coverage and viral suppression through its real-time Viral dashboard allows for close supervision of site performance and targeted TA. Further improvements will be achieved through: 1) scale-up of promising approaches such as monthly audits of client charts and use of VL stickers to identify clients who are due for testing; 2) expansion of the LIS from hubs to high volume sites; and, 3) use of innovative and promising approaches to improve result turn around to both health facilities and clients. Results turn-around is easier in HF with electronic medical registers (EMR); in other HF the availability of a VL focal person to file results and send SMS test results directly to patients will be explored. Community education through community cadres and CBOs will address client demand for both viral load assessment and quicker results. PEPFAR/UG will procure VL reagents for the public and private not-for-profit sectors and continue to support sufficient staffing at the Central Public Health Laboratory (CPHL)

While the overall VL suppression is 91%, pediatric and adolescent suppression rates are much lower (72%-82%). Retention and adherence are critical to maintain suppression and address poor pediatric suppression. PEPFAR implementing partners are rolling out promising models tailored to address the specific barriers to adherence through, for example, utilizing the OVC platform to address any social, economic and cultural barriers (program data has shown that children linked to OVC programs have better suppression rates than those not linked). Mentorship will be provided to health workers to switch failing patients to second line regimens. PEPFAR will continue to support infant and HIV drug resistance (HIVDR) surveys in COP17.

National-level support will focus on policy, planning, coordination, monitoring, supervision, supply chain, MOH technical capacity, laboratory systems, and QI. PEPFAR/UG will continue to support service delivery in remaining high-volume private-for-profit and private not-for-profit sites, and expand support in the public sector, including supportive supervision, M&E reporting, and mentorship and QI at site and district levels to ensure quality HIV services.

4.9 Pediatric Treatment

Uganda has achieved the second 90 for children <15 years with treatment coverage at 82% by FY17Q1 and improved EID coverage (76%). This has been largely attributed to the early adoption of Test and Start for children in 2014, intensified pediatric case identification and linkage to treatment, reduction in MTCT rates (3.1%) due to early implementation of option B, the establishment of MCBP and effective change packages to promote EID (see Section 4.4).

In COP17, PEPFAR will enroll 11,492 newly identified HIV positive children <15 years into treatment. COP17 will consolidate gains made in COP16 through continued support to the EID national program. The focus will be on tracking all HEIs at MBCPs, immunization clinics and outreaches as well as pre-booking mothers attending ANC to ensure they bring their babies back for EID. PEPFAR/UG will continue to support provision of PITC at all high yield entry points and ensure all identified HIV infected children are linked to care and treatment.

Treatment coverage among adolescents has improved from 29% in 2013 to 67% (52,223/78,295) by FY17Q1 and it is expected to further increase as the Test and Start policy is implemented among the older adolescents (15-19 yrs). Girls contribute to 67% of new infections, while boys have the majority of HIV-related deaths. Knowledge and access to HTS remains low among adolescents. Comprehensive knowledge of HIV prevention among 15-19 year olds is low at 40.7% among females and 40.2% among males³². Only 64% of girls and 28% of boys aged 15-19 have ever tested for HIV.

In COP17, PEPFAR will support scale up of HTS among adolescents through implementation of promising approaches tested through QI programs. These include: 1) adapting testing services to meet the needs and convenience of the adolescents such as evening testing; 2) testing within OVC programs; 3) partner testing for the older adolescents; and, 4) increasing demand for HTS among high risk adolescents through a peer led approach. PEPFAR/UG will continue to leverage DREAMS to identify and link AGYW to HTS; linkage to care and treatment will be ensured through the standard community facility linkage and referral systems.

The coverage of adolescent-friendly services remains suboptimal at 44%, as of the most recent program review in June 2016. PEPFAR/UG will continue to support scale up of adolescent-friendly services including: 1) peer support groups; 2) trained providers; 3) adolescent clinics or clinic days; and, 4) psychosocial support for disclosure, adherence, retention and the eventual transition to adult services. PEPFAR/UG will continue to support linkages between the care treatment and OVC programs for eligible HIV+ OVC.

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. Support to some IPs to pilot DSDMs for adolescents will provide opportunities to learn and inform scale up. Furthermore, linkage to the OVC program will provide for additional psychosocial, economic, and other community-level support, which program data has shown to lead to improved viral suppression among enrolled in the OVC program as compared to those who were not enrolled.

Viral suppression among children and adolescents remains a big challenge ranging from 71-82% across the different age bands. For children <3 years changing to a LPV/r pellet based first line ART regimen has been incorporated in the roll-out of the Uganda 2016 guidelines on adherence counseling and using peer support

³² Uganda Demographic and Health Survey 2016 Uganda Bureau of Statistics

groups to provide support for adherence and retention should also help address better outcomes. It is essential that non-suppressed children and adolescents are identified and receive intensive adherence support as well as other psychosocial or economic support and when indicated, rapidly switched to second line regimens. DSD models for stable school-aged children who have been disclosed are being explored by a number of IPs. Given that many IPs are supporting adolescent support groups, one promising model incorporates ART refills into the quarterly support group which is scheduled during school breaks.

4.10 Orphans and Vulnerable Children

There are 2.7 million orphans and vulnerable children, or 11.3% of children who are orphaned³³ (46% HIV-related). Seventy percent drop out of school before completing primary grades, and 62% live in poverty. Teenage pregnancy is 24.8%, and adolescent girls account for 66% of new HIV infections.

COP16 saw the alignment of the OVC program to scale-up districts; OVCs in the 30 sustained districts are in the process of transition or graduation. In COP17, 436,944 orphans and caregivers will be reached in attained (70%), scale up to saturation (9%) and scale up aggressive (21%) districts. The USG worked closely with the Ministry of Gender, Labor and Social Development (MGLSD) to calculate OVC burden estimates by district and, in combination with pediatric HIV burden and population of AGYW vulnerable to HIV, ranked districts for OVC prioritization to reach the OVC_SERV targets for COP17 (436,944). Targets were adjusted from APR16 results based on expected graduation and the prioritization matrix. DREAMS districts were assigned additional targets of 10 to 17 year-olds AGYW who will be receiving support.

In COP17, USG will strategically target children infected or directly affected by HIV (including HEI), children of KP, and in- and out-of-school adolescent girls at risk of HIV infection. Promising interventions from the DREAMS package will be replicated in the non-DREAMS districts as core elements of OVC program support to adolescent girls. Partners will also strengthen the community-facility linkages aimed at scaling up HTC, adherence support, and retention of HIV-positive OVC household members. Through a household-focused approach, the OVC program will:

- Prevent HIV infection among children (focusing on AGYW) and caregivers;
- Implement a standardized case management model to improve layering of services and linkage to quality interventions that will support and track a transition to graduation from vulnerability;
- Promote testing of OVCs and caregivers with unknown status, and ensure linkage to treatment for all identified as HIV+ using the community facility linkage framework;
- Assess all HIV+ children, HEI, children with HIV+ siblings, and caregivers and enroll those eligible into the OVC program;
- Support disclosure, adherence and viral suppression among to children and adolescents living with HIV through family counseling and peer groups;
- Provide early child development interventions for HIV infected and exposed children;
- Foster positive parenting;
- Support household economic strengthening through interventions that include Village Savings and Loans Associations, apprenticeships and household food security initiatives;
- Provide education support to ensure retention, transition and completion targeting highly vulnerable adolescent girls (both HIV infected and affected) at risk of dropping out of school;

³³ Household Survey 2015, Uganda Bureau of Statistics

- Provide targeted assistance to children and caregivers that have been victims of GBV including identification and notification of GBV cases, linkage to health and psychosocial services, and follow-up through the legal redress process;
- Roll out evidence based child protection interventions targeting GBV prevention at community level; and,
- Provide technical support to MGLSD, building capacity to plan, lead, manage, monitor, and coordinate the multi-sectoral response for children - ensuring the social welfare workforce cadres meet the needs of children efficiently and effectively, and improving evidence-based policy and program decision making.

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. The layering of OVC services that beneficiaries receive will be based on the development of comprehensive case management plans.

Preliminary data from a VACS survey carried out in 2016 show alarmingly high rates of physical, sexual and emotional abuse among children (see Section 2.1). Girls were more likely to experience sexual abuse. Of the 36% of females aged 18-24 years who had experienced sexual abuse, less than half told anyone, only 14% sought help and only 8% received any services. These high levels of abuse and the lack of access to services demand a response. In 2016, the GOU developed a National Action Plan for Gender Based Violence. To strengthen district-level child protection systems, PEPFAR/UG will continue supporting capacity building of formal and informal community structures through: 1) child protection training; 2) advocacy for filling vacant child protection positions; 3) mentorship on data collection and reporting; and, 4) operationalizing coordination structures to enhance quality child protection and health services. Under both the OVC programs and DREAMS interventions, school and community based interventions are addressing GBV prevention, including the provision of “safe places.” At household level, positive parenting interventions (SINOVUYO) will promote positive behaviors parents and their adolescents.

The OVC program is closely aligned to the DREAMS interventions, especially for adolescent girls and young women. The Core DREAMS package includes: 1) HTC; 2) condom promotion and provision; 3) community mobilization and norms change; 4) parenting and caregiver programs; and, 5) combination socio economic strengthening and education support. Partners will continue employing a family-based approach. In DREAMS districts, interventions targeting AGYW will be coordinated and complementary to ensure that moderately or critically vulnerable DREAMS beneficiaries receive OVC services, and that 10-17-year-old female OVC beneficiaries who are in DREAMS risk groups receive additional HIV-prevention interventions. In COP17, DREAMS will reach the remaining 20% of AGYW in the original 10 DREAMS districts and further expand to three districts reaching 100% (214,300) at-risk AGYW between 10-24 years of age. This will result in 100% coverage of DREAMS-eligible AGYW in these 13 attained districts by FY18.

At the national level PEPFAR/UG 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 the child welfare, education, and health sectors. The DREAMS passport model will be expanded to all OVC programming to facilitate more accurate tracking of service layering as well as beneficiary status as active, transferred, graduated, or exited without graduating.

Standard Table 4.1.4.

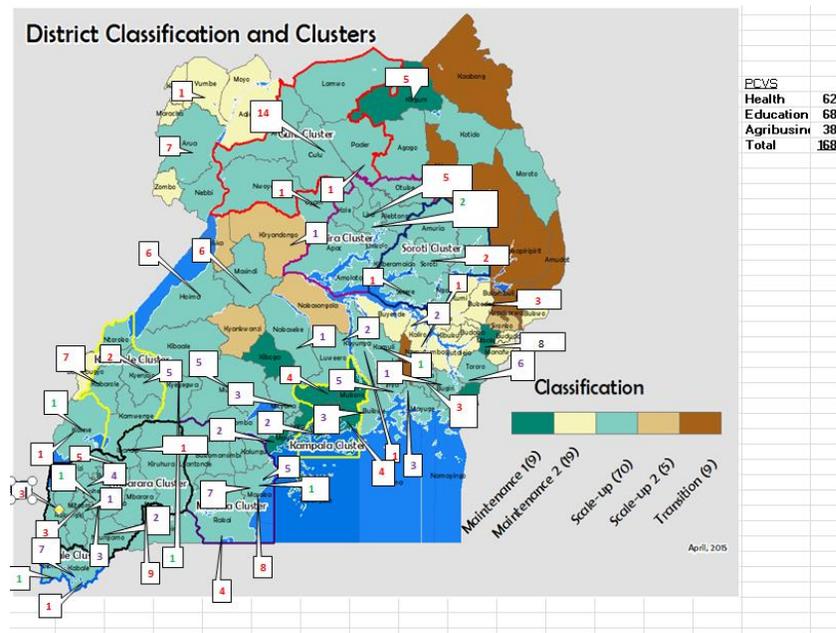
SNU	Estimated # of Orphans and Vulnerable Children (moderately or critically vulnerable)	Target # of active OVC (FY18Target)	Target # of active beneficiaries receiving support from PEPFAR/UG OVC programs whose HIV status is known in program files (FY18 Target)
		OVC_SERV	OVC*
Wakiso District	165,352	28,460	21,345
Tororo District	55,346	5,503	4,127
Soroti District	43,707	2,077	1,558
Sheema District	10,384	2,654	1,991
Sembabule District	27,348	4,076	3,057
Rukungiri District	17,605	6,267	4,700
Rakai District	36,091	25,392	19,044
Oyam District	60,527	14,538	10,904
Ntungamo District	31,695	2,944	2,208
Nebbi District	56,808	3,240	2,430
Namayingo District	25,227	957	718
Nakaseke District	12,425	977	733
Mukono District	36,362	11,747	8,810
Mubende District	46,873	5,789	4,342
Mpigi District	13,155	2,368	1,776
Mityana District	21,635	8,927	6,695
Mitooma District	11,803	1,497	1,123
Mbarara District	29,973	7,446	5,585
Mbale District	25,896	3,250	2,438
Mayuge District	37,490	5,151	3,863
Masindi District	25,116	1,108	831
Masaka District	19,104	4,122	3,092
Lyantonde District	7,496	4,216	3,162
Lwengo District	18,158	10,779	8,084
Luwero District	29,082	8,519	6,389
Lira District	49,446	21,395	16,046
Kyenjojo District	30,382	15,662	11,747
Kyegegwa District	23,402	3,637	2,728
Kotido District	26,050	400	300
Kole District	35,149	500	375
Kitgum District	28,157	9,299	6,974
Kiruhura District	25,887	2,358	1,769
Kiboga District	9,188	400	300
Kibaale District	12,322	7,645	5,734
Kayunga District	28,492	3,798	2,848

Katakwi District	29,157	2,696	2,022
Kasese District	49,007	9,416	7,062
Kanungu District	16,519	2,418	1,814
Kamwenge District	37,120	7,304	5,478
Kamuli District	29,418	4,037	3,028
Kampala District	134,724	32,703	24,527
Kalungu District	16,940	2,352	1,764
Kalangala District	1,535	397	298
Kabarole District	28,526	11,613	8,710
Kabale District	18,566	6,129	4,597
Jinja District	22,907	8,796	6,597
Isingiro District	34,042	4,074	3,056
Iganga District	29,324	13,544	10,158
Ibanda District	15,902	1,282	962
Hoima District	52,701	9,500	7,125
Gulu District	31,359	22,832	17,124
Gomba District	8,803	9,892	7,419
Dokolo District	31,284	1,000	750
Busia District	35,459	1,662	1,247
Bushenyi District	13,589	2,062	1,547
Bukomansimbi District	9,120	2,990	2,243
Buikwe District	25,664	6,039	4,529
Bugiri District	36,672	4,000	3,000
Arua District	97,534	13,827	10,370
Apac District	55,382	7,131	5,348
Agago District	41,359	8,190	6,143
Military Uganda	11,250	3,960	2,970
TOTAL	2,035,746	436,944	327,708

4.11 Peace Corps

The majority of the 168 Peace Corps Volunteers (PCVs) in Uganda carry out activities under the PEPFAR/UG program. These include 20 volunteers under the Global Health Service Partnership (GHSP) and 76 regular two-year volunteers.

The map showing distribution of PCVs by district



HIV/AIDS implementation in Peace Corps/Uganda is cross-sectoral, and volunteers in all the three sectors (health, education and agribusiness) are trained and engage in HIV/AIDS-related activities. Health volunteers' placements are aligned to PEPFAR/UG priority districts.

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. They also help in linking and referring those who have tested positive to health facilities. Linking with DREAMS districts through residential camps GLOW, girls aged 14-18 years are taught leadership and life skills around gender equality, sexual reproductive health and HIV prevention, and other economic empowerment programs, such as village saving and loan associations (VSLAs) and income generating activities (IGAs) like bead-making. PCVs set up clubs and drama groups in schools as a model for dissemination of HIV prevention messages.

With PEPFAR/UG support, Peace Corps provides funds for PCV-generated small grants that serve community needs, targeting OVC and their families to improve household income and food security. Peace Corps supports IGAs (such as poultry, bee-keeping, and animal rearing) and VSLAs. Volunteers also help link OVCs to partners that offer child protection, education, and other HIV services. 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 ART to improve adherence, data collection, and reporting.

4.11 Addressing COP17 Technical Considerations

COP17 can be characterized by greater geographical prioritization, DREAMS core package interventions for AGWY, VMMC, Test and Start, targeted approaches to diagnose and treat men <30 years and expanded VL coverage creating demand for HIV testing and initiation into treatment of those identified as HIV positive, particularly focusses on men between the age of 15-29 years. As such, the testing strategy homes in on approaches to reach men which include index testing and PICT at critical entry points within HF utilizing an eligibility screening tool to maximize yield. Outreach testing will include mobile units at hotspots, demand creation through social networks with special focus on KP, and informal and formal worksite testing. Men who test HIV negative, will be referred to VMMC services. The GOU HTS guidelines will be revised to include the roll out of HIV self-testing which will be encouraged among partners of pregnant women attending ANC and KPs. Men who test HIV positive will be linked to same day ART initiation. For those men that test HIV negative, they will be encouraged to undergo circumcision as well as use risk reduction strategies. In order for health facilities to become more “male-friendly”, working hours will be extended. There are a number of DSDM being rolled out, some based in communities, some at facilities. Not only will these decongest health facilities but they will also make it more convenient for patients to choose where to pick up their drugs. As these models are rolled out, special attention will be paid to those models that men prefer.

Uganda is unique in that it offers a real-time VL dashboard to follow program performance. Although viral suppression is high, VL coverage needs to be expanded. Additional efforts will be made in COP17 to get results back faster to both the HF and patients. Special efforts are needed to improve viral suppression in children and adolescents through creating adolescent responsive clinic environments and improving adherence. Regimens in younger children who are not virally suppressed need to be altered appropriately.

Geographical prioritization in COP17 builds upon success shown through DREAMS interventions districts - which focuses on the 10 original DREAMS districts, surrounding clusters, and three additional districts. This strategic approach means that 40 districts will reach attained status by FY18.

The Uganda health system is underfunded, has poor infrastructure, lack of accountability and several human resource challenges. Health system reform and inputs into strengthening the public-sector supply chain will improve commodity security. PEPFAR/UG will continue to support key health worker cadres but this strategy can only become sustainable if the GOU provides a commitment and a plan to absorb these staff into public service.

4.12 Commodities

There are serious concerns regarding HIV commodity security because of systemic issues resulting from a generally weak supply chain, flawed forecasting and quantification, poor GOU procurement practices, and forward funding of commodities through the GFATM. It is currently estimated that between October 2017-March 2018, there will be a potential ARV gap of \$31 million (ex-works price). There are ongoing discussions with GFATM to address this. Poorly targeted HIV testing not only results in low yield but Rapid Test Kits (RTKs) stock-outs, currently estimated at \$9 million. PEPFAR/UG procures all EID and VL commodities.

4.13 Collaboration, Integration and Monitoring

The parallel process of the COP development and Uganda’s application for the next GFATM grant cycle provides opportunities for synergy. PEPFAR/UG has had very productive discussions with GFATM staff to see how to work closely together to both ensure that all parties are held accountable for their commitments under their GFATM grant and that there are no national stock-outs of both ARVs and rapid test kits. Discussions have also reviewed potential GFATM and PEPFAR/UG support for health systems to ensure complementarity.

To achieve greater efficiencies and improve outcomes, there will be a change in the business model for management of partner performance. This will require regular meetings with IPs over shorter time periods to review their results across the clinical cascade using increased data granularity (by sex, age disaggregation, and SNU). As DSDM are rolled out, it will be critical to identify improved efficiencies both in terms of patient outcomes as well as in the efficiency of service delivery within health facilities.

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Attained Support Districts*			
Attained Support Volume by Group		Expected result APR 17	Expected result APR 18
HIV testing (all populations)	HTS	4,466,411	3,380,218
HIV positives (all populations)	HTS_POS	151,858	202,154
Treatment new	TX_NEW	141,228	188,385
Current on ART	TX_CURR	629,171	732,667
OVC	OVC_SERV	252,342	299,034
Key populations	KP_PREV	51,805	65,598

*Calculations for targets for clinical services based on maintaining 80% ART coverage levels in the attained districts. [Current Retention + (Passive HTC_POS * Linkage)]/PLHIV = 80% ART Coverage

Table 5.1.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts			
Sustained Support Volume by Group		Expected result APR 17	Expected result APR 18
HIV testing in PMTCT sites	PMTCT_STAT	401,046	289,865
HTS (only sustained ART sites in FY 17)	HTC_TST/HTS_POS	873,821/26,467	1,114,565/32,997
Current on ART	TX_CURR	109,661	121,003
OVC	OVC_SERV	29,260	0

Program Area Summaries 5.1-5.10

Program Area 5.11: Establishing service packages to meet targets in attained and sustained districts.

Prioritized activities for Attained SNUs: There are currently no districts which have reached attained status.

Prioritized activities for Sustained SNUs: The package of services to be provided by PEPFAR/UG in geographic areas outside of priority areas and populations is similar to that provided with COP16 funding. PEPFAR/UG 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/UG-supported services as those in scale-up districts. District-level support for lab hubs, supportive supervision, training, as well as data collection, reporting, and use will also continue in these districts. 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.

Program Area 5.12: Commodities (addressed under 4.12)

Program Area 5.13 Collaboration, Integration and Monitoring (addressed under 4.13)

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

Table 6 (Appendix C) outlines the above site systems investments considered critical to achieve epidemic control. Within the context of an underfunded and weak health sector, there are key systems interventions addressing human resource gaps, supply chain reform, and sample transport and laboratory capacity which must be addressed to move forward towards achieving epidemic control. There are also systems activities for improving data capture and analysis and surveillance and evaluations which are required to validate results.

Uganda is one of 57 countries in which the WHO has identified a health worker crisis. PEPFAR/UG will continue to hire senior technical advisors at national level to support the MOH in policy development and coordination. At the district level, TA and training for district health teams for improved coordination and accountability as well as fellowships for district health managers will contribute towards strengthening this important level within the health system. At the site level, 1,575 health workers will remain seconded to support service delivery in both public and private facilities. Critical to achieving the third 90, support will continue to the Central Public Health Laboratory, both in terms of personnel as well as external quality assurance systems. In the longer term PEPFAR/UG is supporting pre-service education for nurses, midwives and clinical tutors.

6.1 Proposed system investments outside of programmatic gaps and priority policies.

A national unique Identifier is critical to accurately identify how many people are re-tested for HIV, linked into treatment, transferred, or actually being lost to follow-up. In COP17 every effort will be made to roll this out at least as a pilot; EMR will be rolled out to 100% of high volume sites. To improve program results, there is a need for further inputs into strengthening the national HMIS and DHIS2 by standardizing the HMIS tool. Uganda is also a pilot country for DATUM4U, which will be rolled out during COP17 requiring additional personnel user training and development of country specific indicators.

Surveillance and evaluation activities include birth defects surveillance for tenofavir (TDF) among pregnant women, ARV drug resistance, sample estimations for KPs, evaluation of PMTCT ANC surveillance, the Africa Cohort study which is an open enrolment cohort study at multiple African sites to evaluate HIV prevention, care and treatment services supported through local facilities.

7.0 Staffing Plan

The U.S. Mission continues to be “tight-sized” with few remaining desks and/or office space. This impedes the ability of agencies to fill the total vacancies, presently at twenty-eight. In COP17 at least eighteen of these positions will be filled to ensure that there are no large gaps in staffing. There are no new positions being planned for COP17.

Staffing constraints continue to pose challenges in terms of meeting the SIMS requirement. Mobilizing to carry out the required number of SIMS visits and other competing reporting and planning priorities, such as POART/APR/SAPR and COP has been a challenge. To help meet the additional strategic information requirements of these processes, particularly for USAID which has a skeleton SI staff, PEPFAR/UG utilizes the data verification, cleaning, analytics and quality assessment services of implementing partners such as MEEPP and METS.

Costs of Doing Business (CODB) is holding steady or decreasing for most agencies. For CDC, CODB budget was reduced and \$367,191 pipeline was applied in COP17. The pipeline was available because of delays in hiring an international contractor position, a favorable exchange rate for FSN salaries and benefits, plus a 17% reduction in ICASS to match actual FY16 invoices. This was partially offset by a 6% increase in CSCS based on actual FMC computation, costs of onboarding new DH staff, cost-sharing update as two CDC non-PEPFAR programs phased out a country presence in FY16, and required update of three vehicles that conduct SIMS and other essential transportation for the CDC PEPFAR program.

USAID’s CODB budget decreased by almost \$200,000, of which \$4.45M (~37%) is applied pipeline. There is variance among individual line items when compared with COP16. For instance, the budget for the “Locally recruited staff salaries and benefits” line item has decreased over that for COP 16, despite an LES wage increase that was approved in July 2016, in part because of the hiring freeze, but also because of ongoing space constraints: six (6) of the 16 currently vacant positions will not be filled until sometime during FY18, if at all. As such, a portion of salaries for those positions has been moved to the “Institutional Contractors (Non-PSC/non- PSA)” line item in order to fill staffing needs with short to medium term technical staff and consultants. The increase in this line item is also attributed to the additional need to fill the SI-related staffing needs described above (not represented among the approved, vacant positions) and the continued need to support a fiduciary agent/audit firm to monitor and increase accountability for USG-funded commodities supplied to the public sector. It is also anticipated that ICASS will increase in COP17 due to an anticipated Mission-wide increase of 24% in ICASS costs over last years. The total number of positions included in the Staffing Database for USAID has increased based on COP guidance, to reflect all LOE on PEPFAR, though the

total number of FTEs supported with PEPFAR funding has remained the same over prior years. No new positions are requested.

The U.S. Department of State (STATE) will see in a slight 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 are included in the STATE M&O budget instead of USAID's M&O budget.

No changes are planned for Peace Corps and the U.S. Department of Defense.

APPENDIX A Table A.1 SNU Prioritization (revised)

SNU	COP 15 prioritization	APR 16 achievement of ART coverage	COP 16 prioritization	Expected achievement of ART coverage APR17	COP 2017 prioritization	ART coverage with COP 2017 APR18	ART coverage with COP 2017 APR18 age and sex bands					
							Female <15	Female 15-24	Female 25+	Males <15	Males 15-24	Males 25+
Zombo District	Sustained	46%	Sustained	56%	Sustained	60%	84%	105%	71%	74%	66%	52%
Yumbe District	Sustained	24%	Sustained	43%	Sustained	49%	102%	51%	53%	90%	27%	36%
Wakiso District	ScaleUp Agg	68%	ScaleUp Agg	75%	Attained	89%	98%	104%	101%	87%	167%	92%
Tororo District	ScaleUp Sat	94%	ScaleUp Sat	64%	ScaleUp Sat	103%	74%	98%	140%	66%	140%	95%
Soroti District	ScaleUp Sat	146%	ScaleUp Sat	104%	Attained	106%	363%	80%	124%	323%	84%	80%
Sironko District	Sustained	36%	Sustained	66%	Sustained	85%	87%	108%	108%	78%	108%	76%
Sheema District	ScaleUp Sat	80%	ScaleUp Sat	89%	ScaleUp Sat	80%	142%	117%	93%	125%	210%	67%
Serere District	Sustained	77%	Sustained	82%	Sustained	91%	107%	89%	121%	95%	134%	80%
Sembabule District	ScaleUp Agg	66%	ScaleUp Agg	63%	Attained	80%	145%	85%	85%	128%	85%	85%
Rukungiri District	ScaleUp Sat	85%	ScaleUp Sat	83%	ScaleUp Sat	86%	121%	89%	111%	107%	90%	77%
Rubirizi District	Sustained	29%	Sustained	22%	Sustained	27%	74%	60%	27%	68%	45%	22%
Rakai District	ScaleUp Agg	98%	ScaleUp Agg	104%	Attained	110%	120%	250%	99%	106%	628%	99%
Pallisa District	Sustained	60%	Sustained	104%	Attained	125%	94%	151%	180%	83%	210%	115%
Pader District	Ctrl Supported	NA	Ctrl Supported	NA	Ctrl Supported	NA	0%	0%	0%	0%	0%	0%
Oyam District	ScaleUp Agg	62%	ScaleUp Agg	74%	Attained	86%	93%	89%	104%	82%	89%	89%
Otuke District	Sustained	50%	Sustained	52%	Sustained	59%	113%	86%	70%	99%	96%	51%
Nwoya District	Sustained	43%	Sustained	48%	Sustained	52%	79%	78%	63%	71%	88%	44%
Ntungamo District	ScaleUp Agg	54%	ScaleUp Agg	55%	ScaleUp Agg	62%	80%	88%	74%	72%	88%	55%
Ntoroko District	Sustained	53%	Sustained	54%	Sustained	63%	100%	87%	76%	90%	85%	56%

Ngora District	Sustained	90%	Sustained	98%	Attained	108%	106%	90%	156%	96%	119%	91%
Nebbi District	ScaleUp Agg	64%	ScaleUp Agg	100%	Attained	103%	91%	155%	133%	82%	90%	91%
Napak District	Ctrl Supported	NA	Ctrl Supported	NA	Ctrl Supported	NA	0%	0%	0%	0%	0%	0%
Namutumba District	Sustained	53%	Sustained	67%	Sustained	73%	91%	101%	88%	80%	118%	65%
Namayingo District	ScaleUp Sat	51%	ScaleUp Sat	91%	Attained	98%	82%	135%	121%	80%	187%	90%
Nakasongola District	Sustained	126%	Sustained	248%	Attained	279%	130%	245%	416%	114%	177%	269%
Nakaseke District	ScaleUp Agg	42%	ScaleUp Agg	51%	ScaleUp Agg	63%	103%	100%	76%	93%	96%	53%
Nakapiripirit District	Ctrl Supported	NA	Ctrl Supported	NA	Ctrl Supported	NA	0%	0%	0%	0%	0%	0%
Mukono District	ScaleUp Agg	41%	ScaleUp Agg	61%	Attained	80%	99%	88%	88%	87%	119%	88%
Mubende District	ScaleUp Agg	50%	ScaleUp Agg	79%	Attained	89%	112%	117%	101%	100%	111%	89%
Mpigi District	ScaleUp Sat	83%	ScaleUp Sat	99%	Attained	128%	121%	165%	164%	109%	165%	113%
Moyo District	Sustained	37%	Sustained	66%	Sustained	68%	77%	64%	89%	71%	78%	62%
Moroto District	Sustained	68%	Sustained	79%	Sustained	90%	90%	92%	124%	82%	45%	85%
Mityana District	ScaleUp Agg	46%	ScaleUp Agg	57%	Attained	79%	125%	87%	87%	112%	87%	87%
Mitooma District	ScaleUp Agg	29%	ScaleUp Agg	36%	ScaleUp Agg	37%	102%	52%	42%	93%	67%	28%
Mbarara District	ScaleUp Sat	142%	ScaleUp Sat	142%	Attained	144%	204%	196%	181%	180%	320%	116%
Mbale District	ScaleUp Sat	85%	ScaleUp Sat	96%	Attained	105%	112%	92%	144%	100%	181%	90%
Mayuge District	ScaleUp Agg	56%	ScaleUp Agg	88%	ScaleUp Agg	95%	73%	175%	111%	65%	418%	77%
Masindi District	ScaleUp Agg	49%	ScaleUp Agg	55%	ScaleUp Agg	60%	94%	57%	79%	84%	102%	51%
Masaka District	ScaleUp Sat	124%	ScaleUp Sat	127%	Attained	132%	278%	147%	141%	248%	186%	142%
Maracha District	Sustained	41%	Sustained	60%	Sustained	76%	89%	88%	88%	80%	126%	77%
Manafwa District	Sustained	33%	Sustained	69%	Sustained	39%	93%	64%	38%	82%	57%	27%
Lyantonde District	ScaleUp Sat	88%	ScaleUp Sat	103%	Attained	84%	110%	93%	93%	96%	93%	93%

Lwengo District	ScaleUp Agg	43%	ScaleUp Agg	43%	Attained	72%	96%	79%	79%	85%	79%	79%	Masaka cluster attained
Luwero District	ScaleUp Sat	121%	ScaleUp Sat	96%	Attained	99%	128%	155%	117%	113%	131%	89%	
Luuka District	Ctrl Supported	NA	Ctrl Supported	NA	Ctrl Supported	NA	0%	0%	0%	0%	0%	0%	
Lira District	ScaleUp Sat	80%	ScaleUp Sat	84%	Attained	97%	135%	92%	122%	120%	92%	92%	
Lamwo District	Sustained	53%	Sustained	60%	Sustained	65%	75%	62%	86%	68%	68%	59%	
Kyenjojo District	ScaleUp Agg	42%	ScaleUp Agg	44%	ScaleUp Agg	48%	115%	77%	56%	103%	78%	40%	
Kyegegwa District	ScaleUp Agg	46%	ScaleUp Agg	55%	ScaleUp Agg	60%	79%	88%	74%	70%	88%	51%	
Kyankwanzi District	Sustained	36%	Sustained	48%	Sustained	55%	85%	88%	66%	75%	79%	46%	
Kween District	Ctrl Supported	NA	Ctrl Supported	NA	Ctrl Supported	NA	0%	0%	0%	0%	0%	0%	
Kumi District	Sustained	77%	Sustained	89%	Sustained	98%	77%	80%	139%	68%	93%	91%	
Kotido District	ScaleUp Agg	40%	ScaleUp Agg	83%	ScaleUp Agg	77%	105%	105%	94%	93%	146%	59%	Lira cluster attained
Kole District	ScaleUp Agg	41%	ScaleUp Agg	61%	Attained	79%	78%	89%	89%	68%	89%	89%	
Koboko District	Sustained	59%	Sustained	79%	Attained	92%	89%	90%	120%	80%	90%	91%	
Kitgum District	ScaleUp Sat	75%	ScaleUp Sat	109%	Attained	96%	210%	130%	119%	187%	81%	80%	
Kisoro District	Sustained	60%	Sustained	76%	Sustained	63%	81%	63%	79%	88%	182%	49%	
Kiryandongo District	Sustained	41%	Sustained	56%	Sustained	64%	80%	201%	60%	72%	122%	53%	
Kiruhura District	ScaleUp Agg	34%	ScaleUp Agg	45%	ScaleUp Agg	43%	133%	74%	46%	119%	74%	34%	
Kibuku District	Sustained	36%	Sustained	67%	Sustained	99%	105%	119%	132%	78%	109%	90%	
Kiboga District	ScaleUp Sat	66%	ScaleUp Sat	67%	ScaleUp Sat	72%	111%	88%	88%	100%	88%	67%	
Kibaale District	ScaleUp Agg	35%	ScaleUp Agg	59%	ScaleUp Agg	63%	75%	89%	78%	67%	105%	53%	
Kayunga District	ScaleUp Agg	53%	ScaleUp Agg	87%	ScaleUp Agg	93%	76%	193%	105%	67%	308%	76%	
Katakwi District	ScaleUp Agg	82%	ScaleUp Agg	79%	ScaleUp Agg	83%	120%	88%	107%	106%	87%	74%	
Kasese District	ScaleUp Agg	55%	ScaleUp Agg	71%	ScaleUp Agg	74%	83%	110%	89%	74%	107%	68%	

Kapchorwa District	Ctrl Supported	NA	Ctrl Supported	NA	Ctrl Supported	NA	0%	0%	0%	0%	0%	0%	
Kanungu District	ScaleUp Agg	63%	ScaleUp Agg	63%	ScaleUp Agg	67%	88%	88%	85%	79%	88%	58%	
Kamwenge District	ScaleUp Agg	42%	ScaleUp Agg	42%	ScaleUp Agg	49%	76%	72%	58%	67%	87%	42%	
Kamuli District	ScaleUp Agg	71%	ScaleUp Agg	96%	Attained	103%	77%	149%	133%	69%	206%	92%	Jinja cluster attained
Kampala District	ScaleUp Sat	134%	ScaleUp Sat	128%	Attained	128%	357%	113%	163%	330%	254%	101%	
Kalungu District	ScaleUp Sat	85%	ScaleUp Sat	88%	Attained	102%	133%	112%	112%	119%	113%	112%	
Kaliro District	Sustained	55%	Sustained	77%	Sustained	85%	90%	121%	108%	80%	132%	75%	
Kalangala District	ScaleUp Sat	78%	ScaleUp Sat	210%	Attained	218%	190%	460%	248%	164%	846%	162%	
Kaberamaido District	Sustained	78%	Sustained	76%	Sustained	82%	114%	88%	102%	102%	88%	76%	
Kabarole District	ScaleUp Sat	61%	ScaleUp Sat	70%	ScaleUp Sat	71%	184%	87%	86%	163%	117%	60%	
Kabale District	ScaleUp Sat	91%	ScaleUp Sat	115%	Attained	108%	79%	117%	150%	79%	159%	96%	Kabale cluster attained
Kaabong District	Ctrl Supported	NA	Ctrl Supported	NA	Ctrl Supported	NA	0%	0%	0%	0%	0%	0%	
Jinja District	ScaleUp Sat	105%	ScaleUp Sat	119%	Attained	124%	123%	102%	170%	109%	226%	107%	
Isingiro District	ScaleUp Agg	54%	ScaleUp Agg	83%	ScaleUp Agg	86%	88%	145%	102%	68%	124%	78%	
Iganga District	ScaleUp Agg	51%	ScaleUp Agg	74%	ScaleUp Agg	82%	69%	80%	110%	74%	103%	74%	
Ibanda District	ScaleUp Agg	53%	ScaleUp Agg	50%	ScaleUp Agg	57%	132%	85%	66%	118%	85%	48%	
Hoima District	ScaleUp Agg	43%	ScaleUp Agg	60%	ScaleUp Agg	65%	88%	99%	79%	78%	88%	56%	
Gulu District	ScaleUp Sat	109%	ScaleUp Sat	85%	Attained	105%	168%	113%	115%	149%	480%	97%	
Gomba District	ScaleUp Agg	43%	ScaleUp Agg	66%	Attained	82%	152%	100%	87%	133%	114%	87%	
Dokolo District	ScaleUp Sat	42%	ScaleUp Sat	70%	Attained	80%	269%	79%	79%	239%	79%	79%	Lira cluster attained
Buyende District	Sustained	41%	Sustained	74%	Sustained	84%	89%	83%	112%	79%	127%	75%	
Buvuma District	Sustained	53%	Sustained	77%	Attained	87%	117%	88%	105%	100%	88%	88%	
Butambala	Sustained	87%	Sustained	92%	Sustained	98%	157%	88%	128%	142%	77%	87%	

District												
Butaleja District	Sustained	64%	Sustained	112%	Sustained	74%	93%	154%	83%	83%	110%	62%
Busia District	ScaleUp Sat	43%	ScaleUp Sat	114%	Attained	118%	104%	179%	150%	93%	144%	104%
Bushenyi District	ScaleUp Sat	92%	ScaleUp Sat	94%	ScaleUp Sat	95%	177%	132%	116%	158%	140%	82%
Bundibugyo District	Sustained	44%	Sustained	57%	Sustained	63%	91%	73%	81%	80%	73%	53%
Buliisa District	Sustained	33%	Sustained	59%	Sustained	65%	75%	110%	78%	69%	89%	57%
Bulambuli District	Ctrl Supported	NA	Ctrl Supported	NA	Ctrl Supported	NA	0%	0%	0%	0%	0%	0%
Bukwo District	Sustained	45%	Sustained	70%	Sustained	98%	107%	109%	130%	76%	165%	88%
Bukomansimbi District	ScaleUp Agg	34%	ScaleUp Agg	23%	Attained	63%	163%	67%	67%	145%	67%	67%
Bukedea District	Sustained	67%	Sustained	78%	Sustained	87%	84%	86%	120%	76%	87%	81%
Buikwe District	ScaleUp Sat	60%	ScaleUp Sat	61%	ScaleUp Sat	68%	72%	88%	87%	99%	129%	57%
Buhweju District	Sustained	25%	Sustained	23%	Sustained	31%	102%	33%	33%	89%	62%	23%
Bugiri District	ScaleUp Agg	58%	ScaleUp Agg	80%	ScaleUp Agg	90%	85%	91%	122%	74%	111%	82%
Bududa District	Sustained	46%	Sustained	88%	Sustained	73%	90%	250%	65%	78%	90%	62%
Budaka District	Sustained	36%	Sustained	79%	Sustained	69%	88%	68%	90%	79%	68%	60%
Arua District	ScaleUp Sat	72%	ScaleUp Sat	109%	Attained	118%	80%	96%	173%	80%	145%	108%
Apac District	ScaleUp Agg	44%	ScaleUp Agg	50%	Attained	74%	73%	82%	82%	65%	126%	82%
Amuru District	Sustained	24%	Sustained	32%	Sustained	29%	92%	39%	32%	83%	53%	22%
Amuria District	Sustained	66%	Sustained	72%	Sustained	80%	104%	88%	101%	91%	80%	73%
Amudat District	Ctrl Supported	NA	Ctrl Supported	NA	Ctrl Supported	NA	0%	0%	0%	0%	0%	0%
Amolatar District	Sustained	55%	Sustained	89%	Attained	96%	118%	89%	125%	105%	89%	89%
Alebtong District	Sustained	54%	Sustained	48%	Sustained	57%	82%	69%	72%	71%	85%	50%
Agago District	ScaleUp Agg	60%	ScaleUp Agg	61%	Attained	79%	84%	88%	88%	81%	88%	88%
Adjumani District	Sustained	35%	Sustained	52%	Sustained	60%	91%	54%	77%	80%	81%	50%
Abim District	Ctrl Supported	NA	Ctrl Supported	NA	Ctrl Supported	NA	0%	0%	0%	0%	0%	0%

Masaka cluster attained

Lira cluster attained

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	Total PLHIV	Expected current on ART National (APR FY 17)	Additional patients required for 80% ART coverage End FY16	Target current on ART (APR FY18) TX_CURR	Newly initiated (APR FY 18) TX_NEW	ART Coverage (APR 18)
Attained	705,198	699,079	-134,922	734,966	188,384	104%
Scale-Up Saturation	137,153	100,473	9,249	109,733	24,421	80%
Scale-Up Aggressive	323,329	196,262	62,400	210,967	59,687	65%
Sustained	184,150	121,846	25,473	121,003	35,142	66%
Central Support	34,677	15,702	12,039	0	0	0%
Military	26,711	20836	533	23,609	6,732	88%
Commodities (if not included in previous categories)						
Total	1,411,218	1,154,198	-25,228	1,200,278	314,366	85%

APPENDIX B: B.1 Planned Spending in 2017

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
\$US 129,468,369	\$US 249,637,406	\$US 379,105,775

Table B.1.2 Resource Allocation by PEPFAR/UG Budget Code (new funds only)		
PEPFAR/UG Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$6,305,144
HVAB	Abstinence/Be Faithful Prevention	\$1,732,438
HVOP	Other Sexual Prevention	\$17,613,934
IDUP	Injecting and Non-Injecting Drug Use	-
HMBL	Blood Safety	\$3,715
HMIN	Injection Safety	\$1,857
CIRC	Male Circumcision	\$9,744,305
HVCT	Counseling and Testing	\$14,664,517
HBHC	Adult Care and Support	\$27,898,647
PDCS	Pediatric Care and Support	\$4,776,090
HKID	Orphans and Vulnerable Children	\$27,974,724
HTXS	Adult Treatment	\$60,360,382
HTXD	ARV Drugs	\$32,360,398
PDTX	Pediatric Treatment	\$1,833,920
HVTB	TB/HIV Care	\$7,656,345
HLAB	Lab	\$3,479,541
HVSI	Strategic Information	\$6,300,331
OHSS	Health Systems Strengthening	\$8,486,834
HVMS	Management and Operations	\$18,444,284
TOTAL		\$249,637,406

Note: This does not include \$23,285,980 in central Voluntary Medical Male Circumcision funding.

B.2 Resource Projections

Each program area reviewed the unit costs from previous years and correlated with UE as well as investments required for intended program shifts. Inputs in the four PBAC categories of target based budgeting, commodities, above site, and PM/SI were then calculated and aggregated to determine the required resources. Details can be found in the PBAC.

Program area	COP17 Unit cost
Adult Care and Treatment	\$74.14
Pediatric care and treatment	\$81.75
HIV Exposed Infants	\$67.37
HTS	\$3.27
PMTCT HTC	\$2.8
VMMC	\$34.94
HKID	\$56
KP-FSW	\$21
KP-MSMTG	\$21
Priority population	\$16.65

APPENDIX C: Section 6.0 Tables: Program Support Necessary to Achieve Sustained Epidemic Control

Appendix D Acronyms

ADP	AIDS Development Partners
AIDS	Acquired Immune Deficiency Syndrome
AIS	AIDS Impact Survey
AGYW	Adolescent girls and young women
ANC	antenatal clinic
APR	Annual Program Results
ART	antiretroviral therapy
ARV	Antiretroviral
CBO	community-based organization
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention (part of HHS)
CODB	Costs of Doing the U.S. government’s PEPFAR Business
COP	Country Operational Plan
CPHL	Central Public Health Laboratory
CQI	Continuous Quality Improvement
CrAg	Cryptococcal Antigen
CROI	Conference on Retroviruses and Opportunistic Infections
CSO	civil society organization
CSW/SW	Commercial Sex Worker
DHIS2	District Health Information Systems 2.0
DOD	U.S. Department of Defense
DOS	U.S. Department of State
DMPPT	Decision-Makers’ Program Planning Toolkit
DSDM	differentiated service delivery models
EID	Early-Infant Diagnosis
EMR	Electronic Medical Register
F	The Office of U.S. Foreign Assistance Resources
FBO	Faith-Based Organization
FP	Family Planning
FSW	Female Sex Workers
FTE	Full-Time Equivalent
FY	Fiscal Year
GBV	Gender Based Violence
GDP	Gross domestic product
GF	Global Fund
GFATM	The Global Fund to Fight AIDS, Tuberculosis, and Malaria (also “Global Fund”)
GHSP	Global Health Service Partnership
GIS	Geographic Information System
GNI	Gross National Income
GOU	Government of Uganda
GSD	Gender and Sexual Diversity
HCW	Health Care Workers

HEI	HIV exposed infants
HHS	U.S. Department of Health and Human Services
HIS	health information systems
HIV	Human Immunodeficiency Virus
HIVDR	HIV drug resistance
HMIS	Health Management Information System
HQ	headquarters
HR	Human Resources
HRH	Human Resources for Health
HTC	HIV Testing and Counseling
HTS	HIV Testing Services (formerly HIV Testing and Counseling – HTC)
ICASS	International Cooperative Administrative Support Services
IGA	Income Generating activity
ILA	Implementation Letter Agreement
IM	Implementing Mechanism
IP	Implementing Partner
IPT	isoniazid preventive therapy
KP	Key populations
LES	Locally Employed Staff
LCI	Local Capacity Initiative
LGBT	Lesbian, Gay, Bisexual, and Transgender
LNA	Limited Non-Career Appointment
MBCP	mother-baby care point
MC	Male Circumcision
MCH	Maternal and Child Health
M&E	monitoring and evaluation
MGLSD	Ministry of Gender, Labor and Social Development
NGO	Non-governmental organization
MIP	mother-infant pairs
MIS	Management information system
M&O	Management and Operations
MOH	Ministry of Health
MOFPED	Ministry of Finance, Planning, and Economic Development
MSM	Men who have sex with men
NACS	Nutrition Assessment Counseling and Support
NIH	National Institutes of Health (part of HHS)
NMS	National Medical Stores
NTP	National Tuberculosis and Leprosy Program
OI	Opportunistic infection
OPD	Out patient department
OVC	orphans and vulnerable children
PCVs	Peace Corps Volunteers
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider initiated testing
PLHIV/ PLWHA/PLWA	People Living with HIV/AIDS or People Living with AIDS
PMTCT	prevention of mother-to-child HIV transmission

POART	PEPFAR Oversight and Accountability Response
POC	Point of Contact
PP	Priority populations
PPP	Public-Private Partnership
PrEP	Pre=exposure prophylaxis
PSC	Personal Services Contract
PWID	People who inject drugs
QA	quality assurance
QAD	Quality Assurance Department
QI	Quality Improvement
RTK	Rapid Test Kit
RUTF	Ready to Use Therapeutic Foods
SAPR	Semi-Annual Program Results
SDS	Strategic Direction Summary
SI	Strategic Information
SID	Sustainability Index Dashboard
SIMS	Site Improvement through Monitoring System
SMGL	Saving Mothers Giving Life
STI	Sexually Transmitted Infection
SMS	Short Message Service
SNU	Smallest national unit
TA	Technical assistance
TB	Tuberculosis
TT	tetanus toxoid
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UG	Uganda
UPHIA	Uganda Population-based HIV Impact Assessment
USAID	U.S. Agency for International Development
VACS	Violence Against Children Survey
VHT	village health teams
VL	viral load
VSLAs	village saving and loan associations
VMMC	Voluntary male medical circumcision
WASH	Water, Sanitation and hygiene
WHO	World Health Organization

Appendix E: Additional Central Funding for South Sudanese Refugees:

Out of the 3.4 million South Sudanese who have been forced to flee their homes due to conflict, 1.6 million are refugees. More than 50% (823,528) of these refugees have sought refuge in Uganda. An estimated 1.25M South Sudanese refugees may be displaced to Uganda by September 2018, making it the fastest growing refugee crisis in the world. The HIV epidemic in South Sudan is geographically concentrated in Western, Eastern, and Central Equatoria. Two of these three states (Central Equatoria, prevalence of 2.6% and Eastern Equatoria, prevalence of 3.4%) share a border with Uganda.

In order to provide HIV services to those refugees most in need, PEPFAR Uganda will receive an extra \$4,963,804 in central funding in COP 2017. Specifically, PEPFAR Uganda will use the refugee plus-up funding to improve access to HIV services by focusing on identification of already known and new PLHIV, linkage to HIV and GBV support services, quality HIV care through differentiated service delivery, expansion of laboratory hub and sample transport to support ART sites, additional ART access points, ARVs, and human resource support. An estimated 15,705 South Sudanese refugees in Uganda are living with HIV and in need of ART. PEPFAR Uganda aims to identify 7,562 (48%) and treat 5,696 (36%) of the South Sudanese refugees living with HIV in Uganda, including 1,814 (95%) of the HIV-positive pregnant women attending ANC, by the end of FY18.

South Sudanese refugees in Uganda are accommodated in 13 settlements across 6 districts. The refugee plus-up funding will be provided to two PEPFAR Uganda implementing partners who already provide technical assistance in the geographical scope of the settlements: Infectious Diseases Institute (IDI), supported by CDC, and URC-ASSIST, supported by USAID. IDI is currently supporting 22 ART facilities, and URC-ASSIST (will be RHITES-N follow-on in COP17) is supporting 3. With the additional funding to support refugees, these implementing partners will provide increased support to these 22 sites, and expand support to 5 additional sites. Table 1 below summarizes the central funding breakout among the implementing partners.

Table 1 Central Funding Breakout:

Funding Agency	Mechanism Identifier	Prime Partner	Mechanism Name	Budget Code								Total Mechanism Budget
				HBHC	HVCT	HVTB	HTXD	HTXS	MTCT	PDCS	PDTX	
HHS/CDC	17706	Infectious Disease Institute (IDI)	Scaling up HIV services in Western and West Nile Regions of Uganda	179,439	1,654,522	49,589	0	459,676	186,312	177,561	71,523	2,778,622
USAID	18273	TBD	Regional Health Integration to Enhance Services - North, Acholi (Rhites-N, Acholi) (ASSIST Follow-on)	32,739	323,232	9,049	0	77,943	39,105	34,744	13,162	529,974
USAID	18369	Global Health Supply Chain Program	Global Health Supply Chain – Procurement and Supply Management (GHSC-PSM) - HIV/AIDS Task Order	8,895	111,111	0	115,928	19,001	10,989	1,243	5,387	272,554
HHS/CDC	17979	Medical Access Uganda Limited (MAUL)	To support the centralized procurement; warehousing and distribution of HIV/AIDS related commodities for CDC funded programs in Uganda	45,130	568,742	0	588,014	96,405	50,807	6,292	27,264	1,382,654
Budget Code Total:				266,203	2,657,607	58,638	703,942	653,025	287,213	219,840	117,336	4,963,804
TOTAL BUDGET											4,963,804	

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	Year one COP16 Annual benchmark	Year Two COP17 Annual benchmark	Relevant Indicator/ Measurement Tool	Proposed COP 17 Activities	Budget Code(s)	REVISED ACTIVITY BUDGET	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Current HTS policy and guidelines are not aligned to current WHO guidelines	1. Done. HTS policy and guidelines aligned to current WHO guidelines.	Benchmark Achieved:- Support development and roll-out of the new national testing algorithm and revised HTS policy. Revised policy and implementation guidelines and recently launched. Production of materials underway.	Achieved	N/A	Accomplished in COP16. HTS policy and guidelines aligned to current WHO guidelines.	N/A		MOH	HRH, 6.92
	2.Full implementation of the new HTS policy and guidelines		1) Revision of the HTS policy based on the results from self testing pilots 2) Systematic mentorship and supervision of service providers to enhance knowledge and increase understanding of implementation requirements. 3)Costing of KP service delivery models 4) 30 % of the facilities that implement self testing are supervised		Support MOH to fully implement the new HTS policy and guidelines. 1) Develop national mentorship and supervision framework for HTS policy (\$17,124) 2) Revise HTS policy to incorporate HIV self-testing and partner services (\$16,784) 3) Roll out revised policy in 1,194 sites in 20 selected attained districts, focusing on increasing HTS uptake for men, KP, and other priority populations (\$177,896) 4) Mentorships on the new policy and roll out of self-testing and partners services in selected attained districts (\$159,996) 5) MOH supervision of at least 30% of 1,194 implementing self-testing and partner services (\$6,200)	HVCT	\$378,000	AFENET	HRH, 6.92
TOTAL							\$378,000		

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	Year one COP16 Annual benchmark	Year Two COP17 Annual benchmark	Relevant Indicator/ Measurement Tool	COP 17 Activities	Budget Code(s)		Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Inadequate HRH at MOH, district, community, and facility level	1.Increased critical cadres (doctors, clinical officers, midwives, nurses, lab, dispersers) staffing from 69% to 75% 80% in scale up districts.	Critical cadre staffing increased to 75%. Current status: Evidence based advocacy and TA increased staffing to 71% and 73% for general and critical cadres respectively.	Critical cadre staffing increased to 80%.	1.Total wage allocation by GOU 2.Percent of approved posts filled by qualified health workers (critical cadres) in scale up districts	Support 1,575 PEPFAR seconded HRH at an average annual pay of \$4,509 (includes fringe benefits per Uganda labor laws and staff accommodation support) both to public and private not for profit facilities (Lab professionals: 288; Midwives: 392; Nurses: 561; Medical doctors: 66; Clinical Officers: 202; Pharmacists/Dispensers: 32; Records officers: 32)	HBHC PDCS PDTX HTXS	\$3,689, 846 \$261,580 \$260,644 \$2,788,655	Comprehensive IPs	HRH, 6.92
	2.Increased the technical capacity of MOH to plan and coordinate one national health sector response to HIV/AIDS	20 Technical Advisors recruited and seconded to MOH	20 Technical Advisors supported	Number of Technical Advisors supported at MOH	Activities include: 1) Provide short term (2-3yrs) technical assistance through recruitment of 20 senior technical advisors who will work side-by-side with MOH counterparts for policy reviews at an average monthly cost of \$3,155 (inclusive of fringe benefits); 2) Support subnational mentorship, stakeholder coordination, quality assurance, upgrading of electronic medical records; 3) Conduct national level annual technical review of the health sector response; and 4) Strengthen the decentralized response through supportive supervision.	CIRC HBHC HTXS HVCT HVSI HVTB MTCT OHSS PDCS PDTX		MOH	HRH, 6.92
		15 Technical Officers recruited	15 Technical Officers 2 HIV performance measurements done 2 Stakeholders meetings held	Number of Technical Officers supported No. of new facilities accredited No. of national level performance reviews held	1) Support 15 short term (2-3yrs) technical officers at a monthly rate of \$2,579 (inclusive of fringe benefits) and increase the capacity of the MOH. 2) Develop a five year health sector HIV/AIDS strategic plan and supervise the roll out and implementation of the new HIV/AIDS integrated guidelines in the 112 districts 3) Support the accreditation of new health facilities 4) Hold biannual HIV performance measurements in 50 sites and biannual national stakeholder planning and coordination meetings 5) Provide targeted mentorships to different technical areas including key populations, DREAMS, community systems, VL suppression, adolescent care and treatment	CIRC OHSS	\$42,000 \$302,400	AFENET	
	3. 50% increase in number of community health workers to support TS and SDM in priority and scale up districts				1) Continue support to lay HRH (linkage facilitators, case managers, peer supporters) to complement critical health workforce at facility/community level in scale up districts to align with SDM and Test and Start needs. This is integrated in the community care unit cost	HBHC, PDCS PDTX, HTXS			HRH, 6.92

	4. Wage bill increased to meet the 6% 80% increase in staffing	Wage bill available to meet 75% critical cadre positions filled. Current status: GOU allocated 50 billion UGX additional wage for recruitment of approximately 1,500 health workers	Wage bill available to meet 80% critical cadre positions filled	% of approved positions filled disaggregated by cadre	1) Evidence based advocacy for increased wage bill for health care workers from GOU using the platforms of CSO budget advocacy groups and working with parliamentary budget committees, media campaigns (radio and TV), and stakeholder advocacy meetings; 2) Conduct annual HRH staffing analysis/audit This includes: Gathering evidence for advocacy (\$80,000); Budget advocacy group meetings/each month (\$77,000); Working with parliamentary committees (\$60,000); Media Campaigns - Radio talkshows, TV adverts, print media (\$52,000); Stakeholder advocacy meetings (\$72,000); and HRH staffing analysis (\$41,200)	OHSS	\$252,000 \$130,200	SHRH ABH	HRH, 6.92
	5. 70% of PEPFAR funded staff in public sector transitioned to GOU	45% of PEPFAR funded staff transitioned to GOU	55% of PEPFAR funded staff transitioned to GOU	% of PEPFAR funded positions transitioned to GOU	Continue to support MOH in policy implementation and revise staffing norms aligned to workload indicator staffing norms (WISN). Includes: Holding interministerial task review meetings every month (\$74,192); Consultancy STTA to develop schemes of service and scopes of practice for all cadres (\$60,000); National level stakeholder review meetings (\$109,600); Dissemination and printing of tools (\$2,804).	OHSS	\$190,996	SHRH	HRH, 6.92
					1) Provide TA for GoU recruitment of 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) to support HIV services. This includes: a) Facilitating data collection (\$104,400); b) Recruitment planning workshops at central and district level, including district service commission support for the recruitment (\$495,640);c) Joint advertising (\$48,472);d) Interviews, selection and staff onboarding (\$7,900)	OHSS	\$659,494	SHRH	HRH, 6.92
		Increase district HRIS data use for HRH planning from 23%-50%	HRIS data use for HRH planning from 50%-75%	% districts using HRIS for recruitment plans	1) Support HRIS system used for HRH recruitment, planning and management. This includes: a) On-site support supervision (\$60,000); b) Targeted follow up visits (\$16,060); c) Capacity building of district based partners and regional resource persons (\$26,000)	OHSS	\$102,060	SHRH	HRH, 6.92
		Finalize private sector assessment; Set up web based application for licensing; Develop standards on quality of care practice in the private sector	Roll out the QI standards in 100% of private sector facilities	Quality improvement	1) Roll out the QI standards. This includes: TA to 4 medical bureaus (\$48,000), 4 medical professional councils (\$48,000) and private sector umbrella association (\$32,000) and conducting supportive supervision (\$40,000) (TA support covers staffing, systems development, networking support, supervision, policy reviews and development service contracts).	HTXS	\$168,000	PHS	HRH, 6.92

Inadequate stocks (supplies) and weak logistics system to manage the HIV commodities	1. No ARV stock-outs at national and site levels	No ARV stock-outs at national level 75% of the time, and at site level 100% of the time	No ARV stock-outs at national level 85% of the time, and at site level 100% of the time	Stock status level at national and site level	1) Strengthen national capacity on commodity management by TA to MOH, QPPU, and regions to do assorted supply chain strengthening activities. 2) Seconding 18 short term advisors @\$917/mth at regional level to support districts; 3) Supporting 24 core central level supply chain (NMS, JMS, NTLP, QPPU, ACP) @\$917/mth; 3) Maintaining PIP and RxSolutions at MOH and regional level for 10 officers, @\$917/month; 4) Supporting cross-cutting management activities with 16 technical staff @\$763/mth; 5) Quantification/biannual reviews (3 meetings); 6) Monitor new guidelines roll out at 20 sites, includes travel expenses to the sites, per diems, other logistics 40 visits (@visit\$500); 7) Bimonthly status reports includes trips to the 3 warehouses, coordination meetings and production of actual status report(6 reports per year); 8) Coordinating monthly security group meetings (12 group meetings in a year (@\$500)	OHSS	\$840,000	UHSC	Tech. & allocative efficiency 1.31
	2. Increased GOU funding for HIV commodities from 20% to 25 30 % of the national ARVs need.	GOU funding meeting 21% of HIV/AIDS ARVs commodities need;	GOU funding 23% of HIV/AIDS ARVs commodities need	% of HIV/AIDS-ARVs commodities funded by GOU	Continue to support civil society and PLHIV national networks efforts to track GOU commitments towards ARV funding and increase transparency/accountability of HIV resources. 6 national level HIV focused CSOs to continue monitoring and tracking government of Uganda commitments to commodity security and availability especially ARV. Each CSO will be supported with approximately \$ 300 for tracking GOU commitments and ensuring accountability at the Local government level (\$60,000) Capacity building of CSOs to carry out HIV/AIDS related budget advocacy including analysis and monitoring; ensuring integration of HIV/TB issues in local government plans and budgets. 14 CSOs to build strong coalitions for budget analysis, tracking and utilization monitoring to ensure integration of HIV/ TB issues in local government plans and budgets (24,000)	HBHC	\$84,000	ABH	

3. A robust and strengthened logistics system for tracking and managing HIV commodities	Over 75% of health facilities ordering using WAOS. Increase in use of RXSolutions (inventory system) from 150 to 220 high volume sites. Current status: 60% reporting on WAOS	85% of high volume facilities ordering using WAOS. Increase in use of RXSolutions from 220 to 300 high volume sites	% of high volume facilities ordering using electronic WAOS and RXSolutions	1) Scale up the electronic Logistics Management Information Systems which will include the web-based ARV Ordering System (WAOS), RxSolutions, lab supplies ordering system, and TB commodity management system. 2) Provide related TA to key actors across national, sub-national and all PEPFAR site levels. RX equipment and software for 253 sites@3500/site (\$745,500 up to HC IV); Installation (\$140,000); Rx training and travel costs (\$50,000); WAOS refresher training for 12 regions for 40 participants/training (\$204,000); Technical advisors travel and per diem for support supervision in 12 regions/month (\$153,700)	OHSS	\$1,243,200	UHSC	Commodity security and supply chain, 4.54
	Tool for monitoring ARVs at community level designed, piloted in selected sites per DSDM	Tool for monitoring ARVs at community level DSDM		1) Continue to facilitate oversight/mentorship roles of medicines management supervisors (525 MMS) in tracking commodities and implementation of supply chain logistics to 1620 ART sites/mth/qtr. Includes 3 visits/mth/MMS in 12 month total of 30 at \$19/visit. Visits per year (*525*15,750*19 \$300,000); Travel expenses and coordination for UHSC staff (\$21,000); Computer training (4 days) : 25 refresher training at \$5,000/ training (\$15,000) .	OHSS	\$336,000	UHSC	Commodity security and supply chain, 4.54
4. Functional real time monitoring platform for ARV commodities, VL results tracking through EOC in all HIV clinics	1. Pilot a real time reporting system on site level stocks of ARVs that links QPPU, MOH/ACP and warehouses for timely remedial actions by level. 2. Piloted national system for VL real time monitoring in 50% HIV facilities	1. 75% of health facilities able to submit SMS weekly reports on the ARVs stock status 2. A fully established real time monitoring VL through the emergency Operating Centre in 75% HIV facilities	1. Number of Health facilities submitting weekly reports on site level SC ARVs stock data 2. % of HIV sites reporting real time on VL through EOC	1) Provide technical assistance to the Emergency Operating Centre for real-time monitoring on ARVs stocks to the MOH in 75% of high volume sites; 2) Printing of training manuals, job aids, TOT training manuals and end user manuals for 1,620 ART sites (\$ 50,914); 3) Technical review meetings will be held each quarter to better understand/synthesize ARV data generated, analyzed and utilized for decision making (\$24,000); 4) Services internet connectivity for MoH program offices sites and health regions (\$ 12,857 per year); 5) mobile phone SMS at a cost of (\$28,882); 6) Equipment procurement of screens for MoH program (ACP, PD, RC) office sites and health regions to see the dashboard in real time (\$45,395); 7) Regional Refresher trainings for HF treatment teams, DHTs and IPs (\$29,714); 8) Data Validation Bi-annual Data validation and verification exercise by central METS/PEPFAR/MoH teams at 25% of all facilities offering ART (\$60,109).	SI HTXS MTCT	\$252,000 \$131,208 \$131,208	METS	Commodity security and supply chain, 4.54

	Trained 230 additional MMS in all districts.	Trained 75 additional MMS in all districts.	Number of MMS trained, deployed and supported	1) Train last batch of new MMS (75) to track and monitor ARVs; Currently 450 MMS trained since 2013 (but coverage is sub-optimal for 1,620 ART sites). Includes equipment and 75 bikes and accessories: \$ 3,500 per bike*75: (\$262,500); MMS training: (\$37,500); Computers: \$1,600 per person *75: (\$120,000)	HTXS	\$420,000	UHSC	Commodity security and supply chain 4.54
				1) Support phase one of ERP; 2) TA on NMS needs assessments; 3) Modular trainings; 4) Software procurement and configuration at NMS/RRH. This is a KEMSA-like stock management system, but with off-the-shelf software	HTXS	\$1,680,000	PSM	
				1) 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 Fiduciary Agent at NMS/sites, embedding TA at NMS. Includes travels for ARV verification in 61 district in 150 targeted sites@6 cycles/10 units @ \$8,000-(\$480,000); 2) Labor for consultants to do document verification, validate bi-monthly stock status report for all warehouses and GoU procurements and embed TA to NMS (\$150,000) (10 local @\$1,000/mth and 2 @\$5,000 international consultants @ \$/mth)	OHSS	\$630,000	UHSC	Commodity security and supply chain, 4.54

Quality for ART program management		1) A national QI frame work for HIV was developed and launched 2) Planned roll out of QI for HIV services at 100% supported districts and facilities.	Effective coordination of QI activities at national and 100% district levels	100% supported districts reporting regularly on QI activities	1) Support district health teams and district QI teams to address the performance gaps along the individual district 90-90-90 cascades using a QI approach for monthly district performance review and targeted TA to poorly performing facilities 2) Support to the MOH to oversee, coordinate and monitor the quality of HIV programs in the country; 3) Roll out of revised policies nationally. 4) Monitor and track progress of scale-up of identified promising practices, including QI change packages to improve the clinical cascade; 5) Maintain gains in sustained districts. These QI IMs will support districts and implementing partners in the implementation of the revised guidelines, compliance with standards and new protocols. This above-site support to districts will be prioritized based on district classification: <u>Attained and scale-up districts</u> (\$870,800) - on average \$15,200 per district per year for attained (40 districts) and average of \$9,600 per district per year for scale-up (27 districts). <u>Sustained districts</u> \$200,000 - on average \$5,700 per district per year (35 districts) for routine oversight and quality of services maintained.	HBHC HTXS MTCT PDCS PDTX HVTB HVCT	\$168,840 \$210,840 \$133,140 \$116,340 \$168,840 \$105,000 \$168,000	ASSIST; DOD METS	Quality Management, 6.24
		Protocols for PMTCT impact study developed	PMTCT Impact evaluation conducted and results disseminated		1) Support Participant screening and enrollment including travel costs (\$55,000); 2) National steering committee support supervision and technical oversight (\$61,160); 3) Quarterly regional and district stakeholder information sharing, learning & feedback sessions (\$77,404); 4) Bi-monthly high level stakeholder meetings (\$7,504); Audio Computer Assisted Self-Interviewing (*Training & conference costs) (\$51,132)		\$252,200	MUSPH	Data, 8.3
TOTAL							\$15,918,491		

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	Year one COP16 Annual benchmark	Year Two COP17 Annual benchmark	Relevant Indicator/ Measurement Tool	COP 17 Activities	Budget Code(s)		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)	1. Increased VL tests from about 600,000 tests to 1.2 million tests per year	900,000 VL tests conducted. Jan 2017, over 835,091 VL tests done.	1.1 million VL tests conducted.	Total number of viral load tests disaggregated by gender and age	<p>1) Setting up an equipment calibration center to ensure reduced equipment downtime due to broken or uncalibrated auxiliary VL equipment</p> <p>2. Capacity building for VL lab staff and biomedical engineers in first and second line equipment maintenance (VL, EID, GeneXpert, CD4 and chemistry analyzers), including training and placements of 14 VL lab staffs and Biomed, procurement of maintenance and training tool kits, development of national lab equipment maintenance guidelines and training curriculum for automated equipment</p> <p>3. Capacity building for biomedical engineers in biosafety cabinet maintenance and certification for VL and EID laboratories, including procurement of 2 tool kits, international trainer costs, and facilitation of trainees and fieldwork. Total AIHA (\$338,175)</p> <p>1. Equipment maintenance workshops at regional and national level, and procurement of spare parts for equipment that have broken down, as well as facilitation of support supervision visits to the 100 hubs and lower facilities in each regions.</p> <p>2. Capacity building of equipment end-users at hub level who will provide mentorship to health workers in 1,400 sites to ensure improved equipment management. Total Regional Comprehensives (\$450,700)</p>	HLAB	\$798,000	AIHA, COMPREHENSIV ES	Laboratory, 5.69
	2. Establishment of Uganda national health lab services with 40% of HRH supported by GOU	Recruit and second 84 staff to Uganda national health lab services and an Act of Parliament passed for the UNHLS.	20% of PEPFAR seconded UNHLS supported by GoU	Uganda national health lab services established; % of UNHLS HRH supported by GOU	<p>1) Seconding of 84 staff at the VL EID reference labs is critical for the 1st 90 (EID) and 3rd 90 (VL), including recruitment of 84 technical staff to ensure quality VL and EID testing. For 11 lab assistants (for sample reception, QC) and 15 data clerks; each on average earns \$900 per month) (\$281,232). For 35 lab technicians and 5 ICT technicians (each on average earns \$1,124 per month) (\$471,744). For 10 highly technical staffs (ICT, Operations, M&E, Biomed engineer), reduced to average \$1,130) (\$135,547). For 5 strategic level managers (VL/EID lab manager, VL/EID lab safety officer, VL/EID lab quality officer, VL/EID lab logistics manager & VL/EID national coordinator) meaning average \$1,176 per month) (\$70,560). For 3 senior lab technologists (responsible for lab management for all VL and EID labs). Average monthly pay of \$1,125 for each (\$40,480).NB: All staff position costs are inclusive of benefits and tax.</p>	HLAB	\$999,563	AFENET	Laboratory, 5.69

3. Reduction in the sample rejection rate from 14% to <5%2%	Sample rejection rate less than 5%. Current status: APR 16: 4.3%	Sample rejection rate less than 2%	Sample rejection rate	1) Conducting 2 national stakeholders consultative workshops each at \$20,000 (total \$40,000); 2) Conducting 3 rounds of benchmarking trips (15 days) in Kenya, Rwanda and Tanzania by key MOH officials and institutional heads (road transport will be used); 3) Staffing norms to meet current need at all levels of lab service delivery, and generate adequate evidence for revision of staffing norms for 100 hubs and sample transport system, in alignment with the revision of the National Health Sector Development Plan that will be revised during F 18 (\$80,000); 4) Advocacy and stakeholders engagement (LTC engagement for uptake of the higher lab cadres into the MOH scheme of service to meet the smooth transition of VL seconded staff, and staff supporting labs and sample transportation system in 100 hubs) (\$68,000)	HLAB	\$168,000	SHRH	Laboratory, 5.69
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Interruption in the sample transportation system and results transmission schedule	1. 100% facilities submitting samples to hubs as per national hub guidelines	85% facilities submitting samples to hubs as per national hub guidelines Current status APR 16: 70.5%	95% facilities submitting samples to hubs as per national hub guidelines	% facilities submitting samples to hubs as per national hub guidelines	1) Support hard to reach labs so that each hub conducts at least one outreach that last 4 days to the different islands in its catchment area. CDC district (Kalangala- scale-up to saturation district) --\$42,000 for 96 trips a year; USAID districts(Namaingo - scale up saturation and Mayuge scale-up aggressive)--\$ 42,000 for 96 trips per year MUWRP districts (Mukono - scale up aggressive and Buikwe scale up saturation)--\$42,000 for 96 trips 2) Provide technical assistance to CPHL as the institution transforms into the Uganda national health laboratory services (UNHLS) by strengthening organizational capacity of the national laboratory network. and building capacity of senior and mid-level managers at the central and regional	HLAB,	\$504,000	COMPREHENSIV ES	Laboratory, 5.69
	2. VL turnaround time for results from CPHL to 100 hubs – is within two weeks	85% of VL results from CPHL to 100 hubs – is within two weeks.	95% of VL results from CPHL to 100 hubs – is within two weeks	% of VL results with a turnaround time of within two weeks from CPHL to hubs		HLAB,	\$126,000	APHL	
	3. 100% (125) labs on SLMPPTA/SLIPTA achieving minimum level of accreditation	75% labs achieving minimum level of accreditation	85% achieving minimum level of accreditation	# of labs that meet minimum accreditation status	Technical assistance in support of laboratory CQI activities at 100 hubs, 19 high volume sites and maintenance of international accreditation status for the EID/VL lab. Six (6) other labs will be fast tracked for international accreditation. Activities include: 1. Conduct three (3) SLMTA workshops and LQMS within the 4 National SLMTA zones (4 trainings x 4 zones x \$20,000 per training = \$320,000 each training taking 5 days). 2. Internal auditor’s training (4 zones x \$20,000 = \$80,000) 3. Two rounds of lab audits per year (119 labs x \$350 unit audit cost x 2 rounds = \$83,300) 4. Mentorships of 119 labs per quarter to address gaps identified during audit (119 mentors x 15 days x \$41 per diem = \$73,185), transportation of mentors to & fro (\$250 x 4days per driver x 4 SLMTA zone x 6 drivers per zone = \$24,000) 5. Support for accreditation (training, light lifting, assessment, accreditation fees) for the 6 labs to be fast tracked for international accreditation (\$268,000) 6. Develop standard guidelines to initiate and operationalize a national accreditation process (\$10,000) through the national accreditation steering committee and also stakeholders engagement 7. Establishment of national EQA monitoring structures to oversee panel development, distribution and responses to EQA activities (\$10,000) through the national EQA committee and deployment of mentors 8. Maintenance of the international accreditation status for the EID-VL lab (\$10,000) 9. Root cause analysis, corrective action and preventive action training (\$42,439)	HLAB,	\$890,924	AGHPF, RTI	
		Revise the Lab policies and implementation guidelines (continued) Hub guidelines revised and await MOH top management approval	WHO Technical Assistance to the Ministry of Health in strengthening Laboratory services in line with its standards, policy and guidelines	Number of lab policies and guidelines aligned with WHO standards	1) Technical assistance to the MOH in Laboratory services guidelines, policies and standards to ensure coordinated National Laboratory Services as per WHO International recommendations.(\$60,000); 2) Technical Assistance to the MOH and stakeholders engagement in development and revision of Laboratory services guidelines including the National Laboratory quality manual, National External Quality Assurance scheme, National Health Laboratory Standards and Regulations (\$24,000)	HLAB	\$84,000	WHO	Laboratory, 5.69

		40% of hubs are able to access and print VL results from CPHL dashboards	100% of hubs and are able to access and print VL results from CPHL dashboards	%of facilities and hubs receiving and printing real-time VL results from CPHL dashboards	1) Support MOH (ACP & CPHL) to monitor the roll out of VL across the country providing feedback to districts and implementing partners via four quarterly performance review meetings for districts and regions (\$60,000) and bi-monthly strategic meetings with implementing partner (\$12,000) to lead to customization and roll out of facility level EMRs (OpenMRS) ; 2. Expand the coverage of the electronic results dispatch system for VL from the 100 hubs to at least 50% of all OpenMRS supporting sites, including site level visits to update and implement secure OpenMRS for patient tracking, results downloading and monthly reporting estimated at 96,000 for national coverage by 15 traveling teams.	HLAB	\$168,000	METS	Laboratory, 5.69
Inadequate quality of HIV care	1. Reduction in OIs among PLHIV from 45% to less than 20% In increased retention of HIV patients from 80 to 95%	OIs among PLHIV below 35% and increase retention of HIV patients to 80% . Current retention is 75%	OIs among PLHIV below 25% and increase retention of HIV patients to 90%		Support roll-out and implementation of the National minimum care package to all supported sites. Expand OI medicines package and rollout in the recently revised prevention, care and treatment guidelines since these have been integrated to all supported sites by FY17	HBHC		MOH, COMPREHENSIV ES	Service delivery, 5.88
	2. Increase VL suppression rates to 95%	VL suppression rate increased to 92%	VL suppression rate increased to 95%	VL suppression rate disaggregated by gender and age	Provide mentoring for comprehensive interventions and QI at facility level;	HVTB/ HBHC		MOH, COMPREHENSIV ES	Service delivery, 5.88
	3. Accurate and reliable VL results for patient management	At least 80% successful passing for all the responding sites that participate in EQA for CD4, CRAG, AFB microscopy, GeneXpert and TB culture 100% response rate for all EQA panels	At least 85% successful passing for all the responding sites that participate in EQA for CD4, CRAG, AFB microscopy, GeneXpert and TB culture	% of sites reporting successful passing EQA for CD4, CRAG, AFB, Gene pert and TB culture	1) Functionalize GXAlert and support EQA for GeneXpert, AFB microscopy, sputum culture, CD4, , CRAG and Viral Load. 2) Training of SRL staff in PT Preparation and mentorship to facilitate technology transfer, involving training facilitation for participants (SDA) from 110 facilities with 4 participants per facility (\$300,000); 3) Operations support, including remodeling /upgrading of infrastructure for PT preparation, packaging, storage and dispatch (\$162,000) 4) Accreditation Process for ISO 17043, including assessments and accreditation fees. 5) Procurement of GeneXpert supplies and materials, including PT preparation and calibration. 5) Installation and training on GX Alert system; 6) Quarterly review meetings and Gene Xpert EQA site visits for corrective actions and technical assistance, as well as internet support to enable GeneXpert EQA Result reporting; 7) Support to sputum smear microscopy EQA network	HVTB HVSI	\$462,000 \$46,200	MUWRP	Laboratory, 5.69
				HIV drug resistance monitoring (is this new activity)	1) Conducting HIV drug resistance surveillance for monitoring of patients (adults and children) failing on first and second line ART to inform the national program in designing the right interventions to ensure epidemic control. This will include human resource (\$69,000), supplies (\$40,000), field sample collection, transportation, storage and data analysis (\$80,000) (Total: \$189,000)	HLAB	\$189,000	UVRI-TBD FOLLOW ON	

				<p>1. # clients access & utilization Test and Start and HTS, VL monitoring, DSDM services</p> <p>2. % rate of PMTCT/HEI cascade/continuum of care services with 18 months post-partum for mother-baby pairs</p> <p>3. # of TB suspects screened and fully complete TB treatment</p>	<p>1. Translate new HTS, Test and Start and DSDM policy guidelines into illustrative and easy-to-read guides and tools to harmonize rollout across IPs and districts.</p> <p>2. Develop/update standardized client & provider communication materials on HTS, Test and Start, DSDM, VL and TB as part of the national umbrella communication campaign</p> <p>3. Generate demand for HTS, Test and Start, ART, VL and TB services through audience-centered and age-appropriate demand generation activities using Men-Only, AGYW-Only, Women-Only, FSW-Only, Pregnant Couple-Only interventions including seminars, dialogue sessions, Radio, TV programs, print materials and social media. Leverage communications campaigns supported by other development funding, including maternal and child health and family planning.</p> <p>4. Develop and implement evidence-based demand creation and stigma reduction communications campaign targeted at men aged 20-49; address issues of HIV testing (including self-testing as this is rolled out nationally, index client testing, hotspot testing, same day initiation), HIV care and treatment services, VMMC, etc.</p> <p>5. As part of CQI, monitor and document interventions to inform the learning agenda.</p> <p>6. Empower advocacy forums and communities to facilitate targeted strategies for men 20-49, and scaling index client testing in 169 sub counties (Total: \$462,000)</p>	<p>HTXS</p> <p>HVTB</p> <p>MTCT</p> <p>HVCT</p>	<p>\$210,000</p> <p>\$130,869</p> <p>\$210,000</p> <p>\$462,000</p>	<p>CHC</p> <p>ABH</p>	<p>Service delivery, 5.88</p>
	4. 23 GeneXpert machines procured to improve TB diagnosis	New COP 17 activity	23 machines procured	# of GeneXpert and cartridges procured	<p>1) Procurement of 16 Gene Xpert machines (GXIV-4-D)- (\$272,000); 2) Purchase of Gene Xpert Warranty(2-3 years); (\$ 109,440); 3) Freight charges (weight variant)(\$6,960); 4) UNOPS PSC (3% of cost of cost of machines) (\$ 11,443); 5) Cartridges (sold as boxes of 50 at \$499 @box- plan to buy 41,00 cartridges)(\$410,000)</p>	HVTB	\$993,279	Global Drug Facility(GDF) AID mechanism	

	5. 1)National and subnational leadership TB capacity increased from 20%-70% 2)Increased National and subnational TB program oversight and coordination 3)Increased HRH allocation at the NTLP	1) Support development and roll out of the new guidelines in relation to TB/HIV 2)National and subnational TB capacity strengthened to monitor and improve national TB/HIV data	1)Support development and roll out of the new guidelines in relation to TB/HIV 2)National and subnational TB capacity strengthened to monitor and improve national TB/HIV data	50% increase in national and subnational TB program oversight and coordination	1) Staff seconded to the NTLP to support oversight, coordination and policy development/revision (5 staff-QI advisor, pediatric TB, capacity building officer, 3Is for TB, M and E) (\$220,000); 2) Support health facilities to report into DHIS2 and support the SI unit for the NTLP to utilize data for improved TB programming(\$80,000); 3) Support quarterly national TB performance review meetings and the national coordination committee for TB/HIV (\$70,000); 4) Build the capacity of the NTLP staff to improve utilization of available resources like the GF (\$20,000); 5) Support quarterly national mentorship and support supervision activities (\$120,000); 6) Installation of Gene Xpert machines (\$4000 per machine with power back up systems and internet support for GXAlert reporting, training of HCWs/Laboratory staff on utilization)-16machines to be procured in FY 18 (\$64,000); 7) Support contact investigation for all TB/HIV patients through the Community Linkage facilitators/VHTs, and integrate into DSD models (\$200,000); 8) Support the decentralized TB microscopy EQA at RRHs-\$77,030; 9) QI mentorship at site level and national QI framework for the NTLP (\$30,800)	HVTB	\$1,081,242	DEFEAT TB	
	6. Reduced stock out of lab supplies and logistics for HIV care	Reduced stock out of lab supplies and logistics for HIV care at site level by 85%	Reduced stock out of lab supplies and logistics for HIV care at site level by 95%	% of facilities reporting stock outs of HIV lab commodities	1) Provide TA to the CPHL/UNHLS for monitoring of laboratory logistics and supply chains to support VL commodities at central level with direct visibility into selected laboratory hubs; 2) Functionalize the inventory system at national level (UNHLS) linking it to selected hubs with client numbers for commodity security at the hub. This system is linked to DHIS-2, the VL dashboard and lab information systems at the hubs (Basic Lab Information System).	OHSS		AFENET	Laboratory, 5.69
					Conduct viral load DBS validation study to standardize in-country cut-off points	HLAB (DONE)		Kampala Regional	Laboratory, 5.69
	7. Capacity built among health care workers across the country for management of pediatric and adolescent HIV and TB	Established and functional call in center at national level to support pediatric and adolescent HIV and TB management		# health care workers calling in for support of pediatric and adolescent care	Build capacity of health workers across the country through a national call in center to support care and treatment for pediatrics and adolescent care and TB/HIV. The call center has 4 different service providers (we do not have a one national service provider). These are MTN, AIRTEL, MANGO and AFRICELL. 1. Support 4 personnel who run the center for 12 months which is inclusive of salaries, medical insurance and statutory tax (\$60,988) 2. Call center maintenance including compliant management CRM software, TAPI premium server including 10 client software license, toll free facility for call in with 4 different providers \$36,969) 3. On going call center marketing for health care providers to use the facility using SMS platform, TV and radio spots, news letter and social media at (\$40,477).	PDCS	\$138,434	Kampala Regional	
TOTAL							\$7,661,511		

Table 6.2.1 Test and Start

Key Systems Barrier	Outcomes expected after 3 years of investment	Year one COP16 Annual benchmark	Year Two COP17 Annual benchmark	Relevant Indicator/ Measurement Tool	COP 17 Activities	Budget Code(s)		Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Lack of data on cost implications to support Test and Start policy adoption	1. Costed national Test and Start plan developed using evidence	Conduct costing study for Test and start	Conducting costing	Report available	1) Carry out modeling and economic evaluation as to the impact of implementing the new Test and Treat and DSDM Guidelines by identifying further cost savings that could be realized if new models of care are scaled up, as well as the actual cost and additional benefits of these models, such as improved adherence, reduced costs for patients, and easing of the burden on facilities. International consultants (\$80,000); 2) Local consultants (\$40,000); 3) Finalizing protocol, tools, stakeholder engagement (\$40,000); 4) Data collection, field monitoring (\$50,000)	HTXS HVTB MTCT PDCS PDTX	\$42,000 \$42,000 \$42,000 \$42,000 \$42,000	SFI/EQUIP	Technical & allocative efficiency, 1.31
	2. Test and treat policy adopted	Test and Treat policy adopted; Disseminate and print policy guidelines. Support for site level training should be completed by APR17.		# Proportion of ART & PMTCT sites implementing Test and Start.	NA	OHSS		MOH	Policies and governance, 7.17
Inadequate funding	1. Increased GOU funding allocation for HIV/AIDS commodities from current 16% to 30% of national need	GOU funding 25% of HIV/AIDS commodities	GOU funding 30% of HIV/AIDS commodities	% of HIV/AIDS commodities funded by GOU	1) Support civil society efforts to track GOU commitments towards ARV funding and increase transparency and accountability of HIV resources.	HTXS (integrated in community activity See gap 2 above)		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	Preliminary report PHIA. Currently PHIA data collection due to be completed in March 2017. Data cleaning and report writing to start in FY17	Final PHIA report and validation of existing models and development of new ones for estimating prevalence and incidence using program data.	Availability of PHIA report, Program data models for estimating prevalence and incidence	PHIA data available and used by all stakeholders for annual planning and resource allocation. Once off activity, to be accomplished by end of COP16	HVSI		CDC Central Mechanism	Epidemiological and Health data, 5.3
TOTAL							\$210,000		

Table 6.2.2 New and efficient service delivery models

Key Systems Barrier	Outcomes expected after 3 years of investment	Year one COP16 Annual benchmark	Year Two COP17 Annual benchmark	Relevant Indicator/ Measurement Tool	COP 17 Activities	Budget Code(s)		Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Lack of national policy and guidelines on new service delivery models	1. Differentiated service delivery model policy in place	DSDM policy and operational guidelines developed/ disseminated (including implementation manuals, job aids, SOPs etc.) training on course for national level, 75% of districts and 30% of high volume sites	100% districts trained, 75% of high volume sites trained	% of high volume sites implementing DSDM	<p>1) Support salary contributions of WHO technical personnel to strengthen MOH capacity for coordination of Regional Performance Monitoring Teams and their institutionalization within the community health departments of the Regional Referral Hospitals/MOH structure (\$40,000 per year per person)</p> <p>2) Support WHO/MOH field activities within regional referral hospitals to coordinate policy implementation for community health workers that integrate HIV services , including staff per diem, fuel cost to cover 14 regional referral hospital at \$5,085/district (\$ 71,200).</p> <p>3) Support EGPAF with 2 technical specialists to support the coordination and implementation of the service delivery models policy and guidelines, including phased roll out to facilities and on-going pilots, including salaries, medical insurance and statutory tax (\$51000)</p> <p>2) Support EGPAF in the roll out of the DSDM guidelines to the remaining estimated 25% facilities for operational costs including travel in country (\$40,000),</p> <p>3) Continue to support EGPAF in the coordination of the national TWG with quarterly meetings at national level (\$20,000)</p> <p>4) Support EGPAF in quarterly country-wide DSDM learning sessions and Harvest meetings at regional, district and IP levels (\$54,000).</p> <p>5) Support EGPAF to support MOH to conduct support supervision and mentorships, and arrange feedback meetings.(\$100,000).</p> <p>6) Support local EGPAF staff salaries and allowances including salaries, health insurance and statutory tax. (\$71000)</p>	OHSS HBHC, HTXS PDCS	\$151,200 \$84,000 \$126,000 \$126,000	WHO EGPAF	Service delivery, 5.88
	2. 50% 100% of districts implementing new service delivery model	75% districts implementing and reporting on DSDM	100% districts implementing and reporting on DSDM	% of districts reporting DSDM indicators	<p>1) Roll out M/E framework and disseminate tools for new service delivery models. Support orientation of implementing partners to track the indicators in HIBRID.</p> <p>2) Support printing of tools including the printing of the facility-community linkage and DSDM M&E framework. The unit cost for printing tools for each facility is \$850 at 593 PEPFAR supported facilities implementing the DSDM M&E framework, tools and facility linkage framework (\$504,000).Global fund will support printing for the rest of the tools.</p>	HVSI HBHC HTXS PDTX HVCT	\$336,000 \$21,000 \$21,000 \$42,000 \$84,000	\$400,000 \$25,000 \$25,000 \$50,000 \$100,000	METS/SITES (TBD)
		Communication materials for DSDM designed	Communication materials for DSDM printed and disseminated		Develop (pre-test) and implement communication strategy for the differentiated HIV care service delivery models	HBHC		CHC	Service delivery, 5.88

Weak community health system	1.Improved and strengthened linkages between facilities and communities	50% of facilities with community-based structures to support services across 90-90-90. Currently at about 10%	75% of facilities with community-based structures to support services across 90-90-90	% of facilities with community-based structures to support services across 90-90-90	1) Strengthen district and site level oversight to community structures involved in differentiated service delivery models (DSDM). a) Develop CHW supervision guidelines (\$30,000); b) Dissemination of supervision guidelines (\$70,000); c) capacity building on self-assessment tools (54,000); and c) Data registry for CHEWs (\$56,000) 2) Small grants to strengthen community resilience to enhance linkages, adherence and retention for HIV programs through sub-grants to CBOs supporting innovative PHA groups for economic sustainability activities (\$210,000)	HTXS HVOP HVTB MTCT OHSS	\$42,000 \$105,000 \$21,000 \$42,000 \$210,000	State Department(sm all grants) SHRH	Service delivery, 5.88
	2. All districts developed and implement new SDM and T/S plans. 3. Improved technical capacity by level to plan and coordinate implementation of new models	75% of scale up districts implementing new SDM and T/S plans; Disseminated the HIV facility-community linkage strategy at district level	100% of scale up districts implementing new SDM and T/S plans	% of districts implementing new SDMs and T/S plans	Support selected national CBOs and umbrella PLHIV networks to coordinate with community-based HIV/AIDS services at district level through sub-granting, and CSOs for DSDM at national and district level. 14 CSOs will be granted each \$15,000 to facilitate DSDMs within PLHIV networks and CBOs for service uptake	OHSS	\$210,000	ABH	Service delivery,
					Once off activity. Dissemination and implementation of the HIV/AIDS community-based care strategy.	OHSS		WHO	Service delivery, 5.88
Lack of information on effectiveness and efficiency of the models	1. Publications on the evidence of efficiency and effectiveness of the models	Develop and obtain ADS protocol approval to conduct an evaluation of DSDM	Disseminated the final report for differentiated service delivery models	Final report disseminated at National level	One off activity. Evaluate service delivery models-	HVSI		METS/SITES (TBD)	Tech. and allocative efficiency, 1.31
		10% of community level indicators reported through the National CIS (needs refining).Tools and community information systems developed and tested for DSDM/T&T.	75% of community level indicators reported through the National CIS (needs refining). Roll out the community management information system to scale up districts and increase the reporting from community sites in the district.	% PEPFAR supported districts reporting through the National CIS	The community management information system will be supported to standardize and regulate how health data are collected through METS and SITES. The \$300,000 indicated for this activity is allocated towards the following activities: 1) Conducting ToT at national level, and district level, and training the community information assistants (\$ 150,000 for 112 districts); 2) Supplementation of the purchase of computer equipment, internet connectivity devices, and power backup to run the system (\$40,000 to cover the gaps in terms of hardware and power solutions). 2) Conducting quarterly DQA and data use workshops to improve on reporting rates and data quality in the systems (\$70,000); 3) Revision and printing of the community HMIS tools for data collection (\$40,000)	HVSI	\$252,000	METS/SITES (TBD), Comprehensives , MOH	Performan ce data, 8.3
TOTAL							\$1,873,200		
GRAND TOTAL							\$26,041,202		

Table 6.3 Other Proposed Systems Investments									
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	Year One (COP/ROP16) Annual Benchmark	Year Two (COP/ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Budget Code(s)	REVISED ACTIVITY BUDGET	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Finance									
Providing 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 Epi control	Health financing strategy adopted and implemented	Health financing strategy finalized	Implementation plan for health financing strategy developed		Non-COP Funds-Centrally Funded		SFI	Domestic resource mobilization (2.78)
		National Health insurance adopted and implemented	Roadmap for national health insurance program developed	Roadmap for national health insurance program developed					Domestic resource mobilization (2.78)
Facilitate loan guarantees to private health sector to invest in HIV/AIDS.	Sustained Epi control	Increased private sector investment from current 30% to 50%				Non-COP Funds-Centrally Funded		SFI	Domestic resource mobilization (2.78)
Providing TA for implementation of tax reforms to increase domestic resource mobilization for HIV/AIDS.	Sustained Epi control	Increase efficiency and allocation to health sector from 8.9 % to 10% of national budget	DRM baseline assessment completed; Plan for budget; Current status workplan for pilot project in draft; Program based budgeting ToT conducted to MOH; Bottleneck analysis and budget execution	Pilot project design for DRM		Non-COP Funds-Centrally Funded		SFI	Domestic resource mobilization (2.78)
Developing and implementing expenditure tracking system for HIV/AIDS.	Sustained Epi control	National AIDS spending monitoring system institutionalized	NASA will be completed	NASA will be completed through GOU systems		Non-COP Funds-Centrally Funded		SFI	Domestic resource mobilization (2.78)
Governance									
Establishing a Project Implementation unit (PIU) within the MOH to improve accountability, financial and reporting oversight functions for PEPFAR funding under the MOH CoAg.	(1) First 90; 2) Second 90; 3) Third 90; 4) sustained Epi control	Accountability and reporting systems for PEPFAR funds established at MOH	Recruitment of PIU staff; Operational costs met and programmatic activities and set up of electronic accounts system; Develop a project operation manual (POM); Financial management guidelines for effective implementation and financial management of the CoAg	Recruitment of PIU staff (Management and Accounts), their operating costs, and electronic accounts system; Develop a project operation manual (POM); Financial management guidelines for effective implementation and financial management of the COAG	# of quarterly financial and programming submitted to USG on time	OHSS		MOH	policy and governance, 7.17
Supporting district level planning, operationalization of 5 year strategic plans, and coordination of district based partners for conducting performance management and regional technical reviews	4) Sustained Epi Control.	All PEPFAR supported districts implement annual work plans aligned to 90-90-90, SDM and T&S	Develop five year strategic and annual plans for all districts 105 District strategic and annual plans developed	All 105 district annual workplans developed and operationalized; Technical reviews under District Performance Monitoring system; TA for production of district HIV bulletins; Updated annual district profiles and score cards.	# of districts with costed annual workplans developed; # of districts conducting quarterly technical reviews; # of districts with updated annual profiles that include KP and PP	OHSS	\$557,800 \$788,200	UHSS TBD METS	Planning and coordination, 8.67
Supporting district-level training via Governance, Leadership and Management Fellowships	4) Sustained Epi Control.	160 DHTs trained in Governance Leadership & Management (GLM) in PEPFAR supported districts	30 DHTs and facility managers from 10 districts trained in GLM (medium term fellowship program)	60 DHT's from 20 districts trained in GLM	# of DHT's and facility managers enrolled, trained, followed up and graduated. # of projects completed and disseminated by fellows.	OHSS	\$87,760	METS	Planning and coordination, 8.67
Providing TA to the GOU to conduct a follow on National stigma index	1) First 90; 2) Second 90; 3) Third 90	Reduced stigma and discrimination including friendly service delivery for KP	National stigma index conducted	National stigma index disseminated at all levels	National stigma index	Non-COP Funds-Centrally Funded		AFENET	

Providing TA to the GOU to harmonize the health worker training curriculum as a strategy to reduce stigma and discrimination against KP seeking HIV services	1) First 90; 2) Second 90; 3) Third 90	Training cascaded to lower level facilities	Health worker training curriculum finalized Implementation plan for health worker trainings developed; Completed training to all facilities that have high volume	Completed training to all lower health facilities	# of health workers trained and followed up	Non-COP Funds-Centrally Funded		AFENET	
Providing TA to the MOH and UAC to adopt the comprehensive package for reducing stigma and discrimination in health facilities	1) First 90; 2) Second 90; 3) Third 90	All PEPFAR supported sites operationalize stigma and	Comprehensive package for reducing stigma and discrimination in high volume	Comprehensive package for reducing stigma and discrimination training cascaded to all lower level facilities		Non-COP Funds-Centrally		AFENET	
Building the capacity of CSOs towards quality and stigma free services for key populations	1) First 90; 2) Second 90; 3) Third 90	All CSOs in PEPFAR supported districts have capacity to deliver stigma free services	Capacity of CSOs proximal to high volume health facilities built	Capacity of CSOs proximal to lower level health facilities built		Non-COP Funds-Centrally Funded		ABH and LCI	
Supporting IQA/EQA by implementing the National External Quality Assurance (EQA) for Rapid HIV testing of both lab and non- lab testers to improve quality of HIV testing	1) First 90; 2) Second 90; 3) Third 90	All facilities pass the qualitative EQA with score of 100%; At least 80% of facilities participating in EQA	75% facilities participating in EQA; 100% pass rate for HTS EQA sites	80% facilities participating in EQA; 100% pass rate for HTS EQA sites	# of facilities passing in EQA schemes; % of testing sites participating in EQA	HLAB	\$840,000	UVRI-TBD FOLLOW ON	
Strategic Information									
Supporting districts to conduct district quarterly performance and data use workshops, including conducting DQAs & strengthening CQI processes.	1) First 90; 2) Second 90; 3) Third 90 and 4) Sustained Epi Control.	To maintain the reporting rates to >95%, improve data use, and institutionalize	> 95% reporting rates sustained	> 95% reporting rates sustained	PEPFAR reporting rates, DQA reports, CQI projects	HVSI	\$1,946,406	METS	5.3
						HVSI	\$2,721,600	SITES	
						HVSI	\$84,000	RTI	
						HVSI	\$168,000	MUWRP	
Supporting the MOH to revise, develop and print national level HMIS tools and support refresher training of health workers on the new tools to meet PEPFAR reporting requirements	1) First 90; 2) Second 90; 3) Third 90	Approved HMIS tools with the PEPFAR recommended finer age disaggregates, VL and facility-community linkage indicators	MOH agrees to revise the current MOH HMIS tools to PEPFAR reporting specifications	The revised MOH HMIS tools approved and printed to support PEPFAR reporting	Revised, approved MOH HMIS tools printed	HVSI	\$844,200	METS	Performance data, 8.3
				The revised MOH HMIS tools approved and printed to support PEPFAR reporting		HVSI	\$2,116,800	SITES	Performance data, 8.3
Advocating and influencing GOU to revise tools to meet PEPFAR reporting requirements									
Strengthening quality improvement processes at district and facility level via M&E activities (DQA, CQI, technical support, and program evaluations)	1) First 90; 2) Second 90; 3) Third 90	Activity added to SI Activity # 1 "Support sites and districts to submit timely reports into DHIS-2; conduct district quarterly performance reviews, Conduct M&E and data use workshops using district based platforms; Conduct DQAs and Strengthen CQI processes (nationally). Include military and Walter Reed "			Regional teams will support sites and districts to submit timely reports into DHIS-2 and conduct district quarterly support supervision/mentoring in data use. This will be supported by SITES in the 61 USAID supported districts	HVSI			Performance data, 8.3
Cascading DHIS-2 trainings to all lower level facilities leveraging on the EMR IT infrastructure support.	1) First 90; 2) Second 90; 3) Third 90 and 4) Sustained Epi Control.	DHIS-2 training cascaded to lower level facilities	Completed training to all lower level facilities that have high volume	Completed training to all lower health facilities	% of facilities that received DHIS-2 training	HVSI		MOH	
Training 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.	Activity added to the SI activity # 1 of "Support sites and districts to submit timely reports into DHIS-2; conduct district quarterly performance reviews, Conduct M&E and data use workshops using district based platforms; Conduct DQAs & Strengthen CQI processes (nationally). Include military & Walter Reed "				HVSI			Performance data, 8.3

Supporting EMR roll out and coordination to fast track patient unique identifiers and integration in the national EMR	1) First 90; 2) Second 90; 3) Third 90	Improved facility EMR coverage from 53% to 100%	Increased EMR facility coverage from 53% to 75%	Increased EMR coverage from 75% to 100%	% facilities with functional EMR	HVSI	\$672,000	METS	
						HVSI	\$604,800	SITES	
						HVSI	\$126,000	NAMERU	
Supporting EMR roll out to DoD PEPFAR supported facilities, including the security controls.	1) First 90; 2) Second 90; 3) Third 90	Increased SI staffing levels from 50% to	75% SI staff recruited to support PEPFAR reporting.	100% SI trained and oriented to support PEPFAR reporting	% of SI staffing levels in facilities	HVSI	\$168,000	METS	
Providing additional Strategic information human resources such as a records assistants to effectively run OpenMRS at facilities,	1) First 90; 2) Second 90; 3) Third 90	80% of health facilities in 2 pilot districts with functional case based surveillance system	30% of health facilities in 2 pilot districts with functional Case based surveillance system	80% of health facilities in 2 pilot districts with functional Case based surveillance system	% of high volume health facilities with functional case based surveillance system in 2 pilot districts	HVSI	\$672,000	METS	
Rolling out the case-based surveillance system to facilities across 2 pilot districts.	1) First 90; 2) Second 90; 3) Third 90	High retention and high adherence rates to ART and TB treatment achieved	Pilot the UPS referral and linkages network to improve retention and adherence	Roll out the UPS referral and linkages network to all UPS ART accredited facilities	% retention and adherence rates to ART and TB treatment	HVSI	\$42,000	UPS Follow On	
Establishing and rolling out a network of regional clinics to evaluate the prisons inter-transfer and post release linkage of HIV/TB positive prisoners and prison staff	1) First 90; 2) Second 90; 3) Third 90	High retention and high adherence rates to ART and TB treatment achieved	Pilot the UPS referral and linkages network to improve retention and adherence	Roll out the UPS referral and linkages network to all UPS ART accredited facilities	% retention and adherence rates to ART and TB treatment	HVSI	\$42,000	UPS Follow On	Performance data, 8.3
Conducting the Uganda Prisons Survey	1) First 90; 2) Second 90; 3) Third 90 and 4) Sustained Epi Control.	New data available for prison population programming	One off activity that was completed. Will disseminate the findings- No money required			HVSI		UPS	Performance data, 8.3
Building capacity of UVRI to conduct surveillance, health informatics and operational research	1) First 90; 2) Second 90; 3) Third 90 and 4) Sustained Epi Control.	UVRI-TBD follow on generating periodic surveillance and survey reports independently				HVSI		UVRI-TBD FOLLOW ON	Performance data, 8.3
Carrying out a Birth Defects Surveillance study for TDF among pregnant women.	2) Second 90; 3) Third 90	Profiling the congenital malformations among infants of HIV-positive women on TDF	Birth Defects Surveillance protocol completed and approved and initial enrolments started	Birth Defects Surveillance study completed and findings disseminated among key stakeholders	Birth Defects Surveillance report available	MTCT	\$420,000	Implementation science/MUJHU	Performance data, 8.3
Conduct an evaluation of the combination prevention interventions implemented in Uganda (last year of study)	1) First 90; 2) Second 90; 3) Third 90 and 4) Sustained Epi Control.	Impact of combination prevention on HIV transmission Uganda study completed.		Conduct an evaluation of the combination prevention interventions in Uganda		HVSI	\$168,000	Makerere University School of Public health	Performance data, 8.3
Supporting key population mapping through the PLACE and CRANE studies and through MEASURE.	1) First 90; 2) Second 90; 3) Third 90	Hot spots for KP/PP mapped and identified. KP/PP population size estimates obtained for	Hotspots for KP/PP identified. KP/PP population size estimates for out of Kampala sites initiated	KP/PP population size estimates for out of Kampala sites completed. MARPS study report findings used for KP programming	KP/PP hotspots out of Kampala mapped. KP/PP size estimates out of Kampala available	HVSI	\$1,029,000	UNC Measure Evaluation	Performance data, 8.3
Conducting evaluation of the PMTCT ANC Surveillance	2) Second 90; 3) Third 90 and 4) Sustained Epi Control.	Report of validated evidence of PMTCT data in comparison to ANC HIV surveillance data	Protocol development and approvals completed and initial data collection	Completed data collection, analysis and final validation report disseminated		HVSI	\$252,000	TBD CRANE Follow-on	Performance data, 8.3
						HVSI		UVRI-TBD FOLLOW ON	
COP16 SI TWG ACTIVITIES NOT REFLECTED IN TABLE 6 BUT FUNDED IN COP16									
Supporting the OVC MIS	1) First 90; 2) Second 90; 3) Third 90	Interoperability between OVC MIS and DHIS-2	90% SNUs reporting	100% reporting and OVC data available in DHIS-2 portal	% SNU reporting timely and reliable OVC data	HVSI		SITES	
Carrying out IM Evaluations for CHC, PHS, ASSIST and/or HIWA. QED will do one of the evaluations.	1) First 90; 2) Second 90; 3) Third 90	4 Evaluations completed	2 (50%) Evaluations completed	2 (50%) Evaluations completed	% of evaluations completed	HVSI	\$420,000	TBD	
Supporting USAID Uganda's Collaborating, Learning and Adapting program	1) First 90; 2) Second 90; 3) Third 90	Lessons from activity implementation and stakeholder participation	Learning events held	National level, district level and community level stakeholders involved in program management. This includes 3 staff members at 70-80% LOE participating in SIMS, and the promotion of learning and collaboration with National AIDS Development partners through learning reviews, as well as supporting the USAID data management system	HIV program should reflect lessons from past experience	HVSI	\$1,092,000	QED Group, LLC	Performance data, 8.4
Carrying out the (AFRICOS) The African Cohort Study, an open-enrollment cohort study at multiple African sites evaluating HIV prevention, care and treatment services supported through local facilities.	1) First 90; 2) Second 90; 3) Third 90	Preliminary longitudinal data with estimates of the viral suppression and HIVDR rates to inform African HIV programs and accelerate targeted interventions towards achieving the 90-90-90.	Recruitment completed	Preliminary data analysis and early publications	Proportion of clients receiving care through a public health approach with a potent 1st line	HVSI		Makerere University Walter Reed Project	Performance data, 8.4

Carrying out implementation research related to the retention in HIV care and treatment services through the development of a network of ART Clinics within targeted island fishing communities.	1) First 90; 2) Second 90; 3) Third 90	High retention of KP/PPs in Koome Islands	The ART network system for tracking developed, piloted and rolled out to track ART clients	Improved retention in HIV care and treatment to 90%.	% of facilities centralized EMR retention rates	HVSI	\$420,000	Makerere University Walter Reed Project	Performance data, 8.4
Conducting an impact evaluation of impact of the changing treatment guidelines, systems and practice on the clinical outcome of clients in prevention, care and treatment services .	1) First 90; 2) Second 90; 3) Third 90	Documented practices for prevention, care, and treatment to inform patient care	MOH engaged for DHIS-2 data trend analysis	Trend analysis report complete	% of data sets analyzed to provide national level program guidance.	HVSI	\$84,000	Makerere University Walter Reed Project	Performance data, 8.4
Comparing retention rates of mother baby pairs between different models of care	2) Second 90; 3) Third 90	Program models for improved retention of mother-baby pairs in PMTCT	Baseline facility survey	Completion of 2nd follow up	Available models to support PMTCT retention.	PMTCT ART integration Central Funds		Makerere University Walter Reed Project	Performance data, 8.4
Carrying out a demonstration project on the feasibility of implementing PrEP among adolescent girls and young women sex workers aged 18-24 in Mukono District	4) Sustained Epi Control.	High HIV prevalence among AGYWs and key populations	PrEP protocol completed and approved and initial enrolments started	Enrollment started	Available PrEP roll out models for high risk mobile AGYW populations	DREAMS		Makerere University Walter Reed Project	Performance data, 8.4
Carrying out a National Gene Xpert Survey	1) First 90; 2) Second 90; 3) Third 90	National GeneXpert survey report completed	National GeneXpert survey protocol completed and approved and data collection started	Data collection completed, and Survey report disseminated to stakeholders	Availability of the survey report and utilization of the findings for program improvement	\$100000 for COP16 (\$ 50,000 required for COP17)	\$42,000	Makerere University Walter Reed Project	Performance data, 8.4
COP17 SI TWG NEW ACTIVITIES									
Carrying out 3 different independent studies: (1) Pre-ART Drug Resistance study; (2) Infant Drug Resistance Study (3) Acquired Drug Resistance Study. Additionally, the Crane survey confirmatory testing study.	1) First 90; 2) Second 90; 3) Third 90	Pretreatment, infant and acquired HIV Drug Resistance report	Pretreatment, infant and acquired HIV Drug Resistance data collection started	Pretreatment, infant and acquired HIV drug resistance data collection completed	Pretreatment, infant and acquired HIV drug resistance report disseminated	HVSI	\$420,000	Uganda Virus Research Institute	Performance data, 8.4
Enhancing surveillance report detailing mapping, bio-behavioral data, key size estimation and building capacity for comprehensive partners and MOH on programming for key populations	1) First 90; 2) Second 90; 3) Third 90	This has been moved to activity "PLACE - Key Pop Mapping 20 for both updating and newer sites as needed and identified at the time. Sustained districts (all priority districts including CDC) need to work with Crane. Includes VL testing and size estimation. Generate data for KP programming- Female sex worker linkage, Know your Sero status"				HVSI			Performance data, 8.4
Using PHIA data to validate existing models and develop new ones for estimating prevalence and incidence using program data.	1) First 90; 2) Second 90; 3) Third 90	Validated program data models for estimating prevalence and incidence developed and available	PHIA data used to validate PMTCT program data to design new HIV prevalence and incidence models	Validation of PMTCT HIV prevalence and incidence models completed. ICAP will be hired to use PHIA data to validate PMTCT program data to design new HIV prevalence and incidence models	Available PMTCT models used to estimate annual prevalence and incidence	HVSI	\$84,000	ICAP	
Introducing and piloting the DATIM4U in Uganda, including DATIM4U in country system support, additional personnel, user training and development to include country specific indicators (new)	1) First 90; 2) Second 90; 3) Third 90 and 4) Sustained Epidemic Control.	Improved ability to customize the DATIM4U to in country needs as well as include in country specific program indicators	DATIM4U installed and piloted in Uganda	DATIM4P rolled out to implementing Mechanisms	Improved flexibility to make revisions and customize the DATIM4P and DATIM4U	HVSI		METS/SITES (TBD)	Performance data, 8.4
Systems Development									
Procuring and installing prefabricated warehouses in 33 scale up priority districts with high volume sites in response to the differentiated service delivery model	1) First 90; 2) Second 90; 3) Third 90	Increased warehousing capacity in 33 priority districts	Fully established 33 pre-fabricated stores constructed. Status: in design phase; Engineer to start assessment for SOW		# of pre-fabricated warehouses completely constructed /installed	OHSS		UHSC	Commodity security and supply chain, 4.54
TOTAL							\$17,038,566		