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INFORMATION MEMO FOR AMBASSADOR BROWN, UGANDA

FROM: S/GAC – Acting U.S. Global AIDS Coordinator, Principal Deputy Assistant Secretary, Dr. Angeli Achrekar, DrPH, MPH

THROUGH: Chair Dr. Jason Bowman and PPM Mary Borgman

SUBJECT: Fiscal Year (FY) 2023 PEPFAR Planned Allocation and Strategic Direction

Dear Ambassador Brown,

First and foremost, I sincerely hope that you and your team are safe and healthy. I am extremely grateful for your leadership of the PEPFAR program and additional COVID-19 response efforts during this difficult year.

While countries around the world continue to manage the effects of the COVID-19 pandemic, and the U.S. government acts on its commitment of support, it is encouraging to see vaccines making their way around the globe. The COVID response efforts – and continued use of the PEPFAR platform to support testing and vaccine delivery and uptake at point of care settings - are essential to our ability to provide ongoing care and life saving support for people living with HIV. The PEPFAR program has faced many challenges as a program during this period. Nevertheless, the PEPFAR family and partners have carried the mission forward while enduring significant personal impacts of COVID-19. Despite these challenges, what remains true is the strength and resilience of PEPFAR in partnership with countries and communities – through our teams, and our programs in the midst of dueling pandemics.

Tremendous effort has been made by PEPFAR over the year to protect and accelerate the HIV gains, while leveraging the platform to respond to COVID-19 as well.

PEPFAR Country/Regional Operational Plan (COP/ROP 2022) (for implementation in FY2023) represents a pivotal year in PEPFAR, as several countries are reaching or approaching the agreed upon UNAIDS 95/95/95 benchmarks for attaining epidemic control. As countries approach these benchmarks, while pivoting from "scaling to close gaps" to "sustaining" epidemic control, we must ensure HIV program and population equity, address outstanding barriers that threaten to derail progress made in reducing new HIV infections and associated mortality, and tailor our programs to serve all populations.

This year it is particularly important to plan COP/ROP22 together with the country government, civil society, and multilateral partners. Across PEPFAR, the focus on equity requires vigilant attention to program data demonstrating results and gaps. A focus on equity also means a focus on population groups where our efforts to date have not closed gaps, and specific planning, resource allocation, and program

tailoring are needed – depending on what the data reveal for each country – focusing on: children, adolescent girls and young women, and key populations.

While implementation continues, or in many cases, has started to scale up, most PEPFAR countries are on a path to achieving program coverage goals. With that in mind, PEPFAR programs should focus on four key themes as we approach COP/ROP 22 planning and implementation:

1. Achieve and sustain epidemic control using evidence-based, equitable, people-centered HIV prevention and treatment services.
2. Support resilient and capacitated country health systems, communities, enabling environments, and local partners to build enduring capabilities.
3. Strengthen cooperation and coordination for greater impact, burden sharing, and sustainability.
4. Employ an equity lens with a persistent focus on reducing persistent inequalities experienced by children, key populations, and adolescent girls and young women.

I want to applaud the PEPFAR team for:

- The number of people receiving life-saving ARV treatment continued to grow over the year, out pacing the UNAIDS estimated new infections.
- Expansion of person-centered services through continuous quality improvement resulted in improved continuity of treatment and community viral load suppression.
- Community-based and biomedical prevention interventions continued to serve key and priority populations across the country, with innovative adaptations to meet clients' needs despite waves of COVID-19.

Together with the Government of Uganda and civil society leadership we have made tremendous progress on the HIV response. Uganda should be proud of the progress made over the past 18 years of PEPFAR implementation and we are deeply grateful for the ongoing and deep coordination with the Global Fund and UNAIDS. Uganda has been especially successful and is one of a number of countries to have achieved the UNAID 90-90-90 goals and effective control of the HIV epidemic. We now must work to sustain the HIV impact and begin the long-term, gradual transformation of the program including the merging, management, and oversight of HIV services in more intentional alignment and integration with domestic systems. COP 22 will represent the first step in this journey.

Despite the achievement of the UNAIDS high level goals, our work is not done. In COP 22 guidance, changes in program direction will vary depending on where countries are in reaching epidemic control and the continued COVID-19 mitigations efforts each program is facing.

Specifically, more focus and attention should be given to the following key challenges in PEPFAR Uganda:

- Preliminary UPHIA 2020 data suggest significant progress towards the UNAIDS 95-95-95 goals, however, gaps in known HIV-status remain, particularly among young people.
- Persistent treatment and viral load suppression gaps among children and young people.
- With an estimated 46% of the Ugandan population under the age of 15, there is need to ensure high coverage of HIV prevention interventions to sustain control of the epidemic.
- Incidents of human rights violations, stigma and discrimination, coupled with shrinking civil society space in political discourse are of concern. Focused programming to facilitate equitable

access to health services for key and priority populations is essential to reaching and sustaining epidemic control.

A fuller set of details, including funding earmarks and specific program direction are included in the accompanying COP/ROP 22 PEPFAR Planned Allocation and Strategic Direction Summary.

Consistent with the approach from years past, PEPFAR teams will once again be responsible for setting their own targets across PEPFAR program areas (with the treatment current target no less than the result that was to be achieved in COP 2021) in consultation with stakeholders. Teams should bear in mind that PEPFAR targets are not PEPFAR's but flow directly from the partner country government's commitment to the UNAIDS and SDG 3 goals.

The PEPFAR COP/ROP 22 notional budget for Uganda is **$398,500,000** inclusive of all new funding accounts and applied pipeline. All earmarks and program directives provided below must be met. This level also assumes that the DoD AFRICOS program will be funded in COP22 at the same level as it was in COP21. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team, in collaboration with the Government of Uganda and civil society of Uganda, believes is critical for the country's progress towards controlling the pandemic and maintaining control.

Finally, in alignment with efforts by the U.S. government to support diversity, equity, inclusion, and accessibility as well as to advance equity for underserved communities and prevent and combat discrimination or exploitation on the basis of race, religion, gender identity or sexual orientation, PEPFAR will work to ensure that these principles are upheld, promoted, and advanced in all PEPFAR programs and in how we do business.

Please note that within the next few days our PEPFAR Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will review this planning letter and details contained, herein, with your wider PEPFAR country team. Stakeholder engagement is essential for a productive and impactful planning process, and civil society engagement will continue to be an integral part of this planning process. Included in this planning letter is an outline of the expectations for engaging key stakeholders and civil society, as we continue to finalize our approach to hosting a virtual COP/ROP22 planning and approval process.

Once again, thank you for your continued leadership and engagement during the COP/ROP22 process.

Sincerely,

Angeli Achrekar

Attachment: **COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction Summary**

CC: **S/GAC – Jason Bowman, Mary Borgman, Brian Rettmann**

Overview: COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly monitoring POARTs, as well as Headquarters Country Accountability and Support Teams (CAST) input, a thorough program review of your country over time has been conducted. This includes the end of year results of the Country Operational Plan (COP) 2020 and current COP 2021 implementation as we plan for COP 2022. We have noted the following key successes and priorities for COP22 to address remaining challenges:

Successes:

1. PEPFAR Uganda initiated 124,603 new clients on treatment during FY 2021, growing the treatment cohort by 50,645 PLHIV, similar results to FY 2020 and outpacing new infections according to the most recent UNAIDS estimates. While treatment interruption remains a challenge, over the course of the fiscal year, treatment interruption for clients newly initiating ART (<3 months) improved from over 15% in FY 2020 to 10% by FY 2021 Q4.
2. The National Continuous Quality Improvement (CQI) Collaborative, led by the Uganda Ministry of Health (MOH) and supported by PEPFAR, deployed person-centered interventions to improve treatment continuity and ultimately viral load suppression. National viral load coverage (VLC) improved despite the COVID-19 pandemic, with 94% of eligible clients receiving a viral load test at FY21 Q4. Viral load suppression (VLS) improved from 92% to 96% during FY21. This is largely consistent across regions and PEPFAR implementing partners (IPs). 83% of high-volume sites (TX_CURR >1000) reported above 90% VLC, and all but two of those sites reported 90% or above VLS.
3. Prevention interventions expanded to reach more people.
    - Despite a difficult COVID-19 environment during COP20 implementation, the PEPFAR Uganda PrEP program exceeded targets, resulting in 126% target achievement of people newly initiating PrEP and 137% target achievement for those continuing PrEP. Of note, the majority of PrEP clients were below the age of 30 and/or among priority populations, including adolescents and young women, sex workers and men-who-have-sex-with-men.
    - DREAMS expanded to new districts and reached even more adolescent girls and young women, their families and communities with the core package of comprehensive HIV prevention, violence prevention, clinical services, and community mobilization and social norms change interventions in FY21.
    - VMMC services reached 102% of those targeted, and PEPFAR Uganda successfully implemented the 'age pivot' to provide services for young men over the age of 15 years aligned with COP Guidance. Use of the ShangRing and reusable instruments also increased during FY 2021.
    - Cervical cancer programming was launched and screened over 123,000 WLHIV in its first year.

Challenges and Strategic Priorities:
Given Uganda's status of nearing achievement of epidemic control and remaining challenges to reach 95-95-95, the following strategic priorities are recommended:

1. Close the remaining diagnosis and treatment gaps.
    - Preliminary UPHIA 2020 data suggest significant progress toward the UNAIDS 95-95-95 goals, however, gaps in known HIV-status remain, particularly among young people.

Various data sources, including UPHIA, program data, recency, updated spectrum models, and other sources should be used to target case-finding investments to reach the first 95. Effective testing strategies, such as safe and ethical index testing and self-testing, should be prioritized.

- Treatment and VLS gaps persist among children and young people 0-19 years old and young men 20-29 years old. Pediatric VLS in FY21 was under 90% nationally, however, VLS among those supported by the orphans and vulnerable children (OVC) comprehensive program exceeded 90%. Person-centered services tailored for populations at high risk for treatment interruption should be expanded, including youth case management approaches.
- National CQI efforts to address interruption in treatment, expand DSDM, strengthen people-centered services, and ARV regimen optimization for all people living with HIV should be prioritized.

2. Build capacity within the public health response such that Uganda is able to rapidly identify and address threats to sustaining epidemic control.
    - Recency testing was conducted in about 40% of planned sites in FY21, with plans to scale this year. Approximately 10-15% of the tests conducted during the period were recent infections (acquired within the past one year), with recent infections higher among females than males, and highest among 15-24 year olds. Geographic and demographic differences, triangulated with program data, should be used to understand implications of recency results and correlations with rates of transmission. A performance monitoring framework that measures site level implementation of testing quality and capacity to deliver a public health response, including deployment of recency and follow-on public health interventions, should be implemented.
    - Alignment of prevention interventions to meet areas of high HIV incidence/recent infections is essential. With an estimated 46% of the Ugandan population under the age of 15, there is need to ensure high coverage of HIV prevention interventions to sustain control of the epidemic, particularly in areas of higher incidence. This will include appropriately targeting DREAMS, VMMC, PrEP, and primary prevention interventions for key and priority populations.
3. Begin evolving the HIV response to one focused on sustaining epidemic control and building resilience within health systems to withstand future public health threats. PEPFAR Uganda should build upon resource alignment discussions to map out what sustainable epidemic control looks like with the Government of Uganda, civil society, Global Fund and other development partners, private sector and other stakeholders. COP22 resources should align with and support those goals. This will require increased transparency on how PEPFAR resources are spent and the support they provide.
4. Address barriers preventing key populations from accessing HIV prevention and treatment services. Incidents of human rights violations, stigma and discrimination, coupled with shrinking civil society space in political discourse are of concern. The Legal Environment Assessment (LEA) was conducted in 2021 and results should be used to address identified barriers. Focused programming to facilitate equitable access to health services for key and priority populations is essential to reaching and sustaining epidemic control. Key populations programming should

continue to scale effective interventions, such as community-based medication distribution and health and support services at drop-in centers

SECTION 1: COP/ROP 2022 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2021 (EOFY) tool, and performance data, the total COP/ROP 2022 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency.

TABLE 1: All COP 2022 Funding by Appropriation Year

	Bilateral				Central				Total
	FY22	FY21	FY20	Unspecified	FY22	FY21	FY20	Unspecified	TOTAL
Total New Funding	$ 363,110,048	$ -	$ -	$ -	$ 2,250,000	$ -	$ -	$ -	$ 365,360,048
GHP-State	$ 322,897,548	$ -	$ -		$ -	$ -	$ -		$ 322,897,548
GHP-USAID	$ 37,000,000				$ 2,250,000				$ 39,250,000
GAP	$ 3,212,500				$ -				$ 3,212,500
Total Applied Pipeline	$ -	$ -	$ -	$ 33,139,952	$ -	$ -	$ -	$ -	$ 33,139,952
DOD				$ 672,301				$ -	$ 672,301
HHS/CDC				$ 15,035,730				$ -	$ 15,035,730
PC				$ 1,583,822				$ -	$ 1,583,822
USAID				$ 15,227,973				$ -	$ 15,227,973
State/AF				$ 620,126				$ -	$ 620,126
TOTAL FUNDING	$ 363,110,048	$ -	$ -	$ 33,139,952	$ 2,250,000	$ -	$ -	$ -	$ 398,500,000

SECTION 2: COP 2022 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Countries should plan for the full Care and Treatment (C&T) level of $220,213,500 and the full Orphans and Vulnerable Children (OVC) level of $34,457,400 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

TABLE 2: COP 2022 Earmarks by Appropriation Year*

	Appropriation Year			
	FY22	FY21	FY20	TOTAL
C&T	$ 220,213,500	$ -	$ -	$ 220,213,500
OVC	$ 34,457,400	$ -	$ -	$ 34,457,400
GBV	$ 12,949,019	$ -	$ -	$ 12,949,019
Water	$ 3,800,000	$ -	$ -	$ 3,800,000

**Only GHP-State and GHP-USAID will count towards the earmarks (Care and Treatment, OVC, GBV, and Water).*

***Only GHP-State will count towards the GBV and Water earmarks*

TABLE 3: COP 2022 Initiative Controls: Each dollar planned in COP can belong to only one initiative. Most COP funding will be budgeted as Core Program. In general, initiatives other than Core Program are used to track activities/programs that cannot be tracked by the combination of program area and beneficiary alone. See Appendix 1 for more detailed information on initiatives.

	Bilateral	Central	TOTAL
Total Funding	$ 396,250,000	$ 2,250,000	$ 398,500,000
Core Program	$ 318,413,900	$ -	$ 318,413,900
Cervical Cancer	$ 3,000,000	$ -	$ 3,000,000
Condoms (GHP-USAID Central Funding)	$ -	$ 2,250,000	$ 2,250,000
DREAMS	$ 23,000,000	$ -	$ 23,000,000
OVC (Non-DREAMS)	$ 18,836,100	$ -	$ 18,836,100
VMMC	$ 33,000,000	$ -	$ 33,000,000

TABLE 4: Programmatic Controls: Programmatic controls are used to track programmatic directives that can be tracked by a combination of program area and/or beneficiary. Programmatic controls may overlap with Initiatives, for example PrEP for Adolescent Girls and Young Women may count towards both the DREAMS Initiative and the PrEP (AGYW) programmatic control. See Appendix 1 for more detailed information on programmatic controls.

	Bilateral	Central	TOTAL
Total Funding	**$ 4,973,186**	**$ -**	**$ 4,973,186**
PrEP (AGYW)	$ 2,233,779	$ -	**$ 2,233,779**
PrEP (KPs)	$ 2,739,407	$ -	**$ 2,739,407**

TABLE 5: State ICASS Funding

	Appropriation Year
ICASS	$ 261,650

See Appendix 1 for detailed budgetary requirements and other budgetary considerations.

SECTION 3: PAST PERFORMANCE – COP/ROP 2020 Review

TABLE 6. COP/ROP OU Level FY21 Program Results (COP20) against FY22 Targets (COP21)

Indicator	FY21 result (COP20)	FY22 target (COP21)
TX Current <15	**59,825**	**79,559**
TX Current >15	**1,206,763**	**1,260,020**
VMMC >15	**323,989**	**523,820**
DREAMS (AGYW PREV)	**266,880**	**275,355**
Cervical Cancer Screening	**123,159**	**282,566**
TB Preventive Therapy	**274,959**	**253,089**

TABLE 7. COP/ROP 2020 | FY 2021 Agency-level Outlays versus Approved Budget

OU/Agency	Approved COP/ROP 2020 Planning Level	Total FY 2021 Outlays	Over/Under Outlays
Uganda	**$410,727,573**	**$380,712,628**	**$30,014,944**
DOD	**$15,333,078**	**$15,059,595**	**$273,483**
HHS/CDC	**$194,456,060**	**$186,355,235**	**$8,100,824**
HHS/HRSA	**$400,000**	**$300,373**	**$99,627**
PC	**$2,386,068**	**$710,558**	**$1,675,510**
State	**$2,038,793**	**$893,760**	**$1,145,033**
USAID	**$169,224,117**	**$151,457,991**	**$17,766,126**
USAID/WCF	**$26,889,457**	**$25,935,116**	**$954,341**
Grand Total	**$410,727,573**	**$380,712,628**	**$30,014,944**

TABLE 8. COP/ROP 2020 | FY 2021 Results & Expenditures

Agency	Indicator	FY21 Target	FY21 Result	Percent Achievement	Program Classification	FY21 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	898,955	**2,385,961**	265.41%	HTS Program Area	$4,023,377	90%
	HTS_TST_POS	16,516	**69,957**	423.57%			
	TX_NEW	16,022	**66,732**	416.50%	C&T Program Area	$95,447,291	71%
	TX_CURR	750,346	**702,922**	93.68%			
	VMMC_CIRC	149,630	**153,534**	102.61%	VMMC Sub-Program Area	$5,039,346	96%
	OVC_SERV	140,086	**129,706**	92.59%	OVC Beneficiary	$6,975,924	91%
DOD	HTS_TST	82,260	**251,028**	305.16%	HTS Program Area	$351,498	100%
	HTS_TST_POS	1,670	**9,146**	547.66%			
	TX_NEW	1,587	**9,066**	571.27%	C&T Program Area	$5,973,350	25%
	TX_CURR	79,329	**78,724**	99.24%			
	VMMC_CIRC	34,842	**33,376**	95.79%	VMMC Sub-Program Area	$761,819	91%
	OVC_SERV	28,757	**28,817**	100.21%	OVC Beneficiary	$1,352,330	100%
State/PRM	HTS_TST	7,610	**38,249**	502.61%	HTS Program Area	$2,450	100%
	HTS_TST_POS	84	**780**	928.57%			
	TX_NEW	83	**809**	974.70%	C&T Program Area	$185,377	32%
	TX_CURR	4,273	**6,794**	159.00%			
	VMMC_CIRC	5,001	**5,429**	108.56%	VMMC Sub-Program Area	$112,595	100%
	OVC_SERV	4,501	**4,740**	105.31%	OVC Beneficiary	$49,000	100%
USAID	HTS_TST	780,873	**1,975,475**	252.98%	HTS Program Area	$2,056,591	78%
	HTS_TST_POS	19,102	**51,343**	268.78%			
	TX_NEW	18,280	**47,996**	262.56%	C&T Program Area	$92,384,791	70%
	TX_CURR	492,849	**478,148**	97.02%			
	VMMC_CIRC	129,049	**132,440**	102.63%	VMMC Sub-Program Area	$6,637,987	90%
	OVC_SERV	302,186	**264,780**	87.62%	OVC Beneficiary	$10,257,405	81%
					Above Site Programs	$22,275,636	
					Program Management	$55,649,026	

SECTION 4: COP/ROP 2022 DIRECTIVES

The following section has specific directives for COP 2022 based on program performance noted above. Please review each section carefully including the minimum program requirements.

Minimum Program Requirements (MPR)

All PEPFAR programs – bilateral and regional– must ensure the following minimum program requirements are in place. Adherence to these policies and practices is essential to the success of all PEPFAR programs at the national, subnational, and service delivery levels (e.g. facility, school,

community). Evidence demonstrates that lack of any one of these policies/practices significantly undermines HIV impact and results in inefficient and ineffective programs.

All PEPFAR programs are expected to meet all of the requirements below, and the COP22 Planning Meeting will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP22 Planning Meeting, the PEPFAR OU team will need to present a detailed description of existing barriers and the remediation plans proposed that will allow them to meet the requirement(s) prior to the beginning of FY2023. The list will be included in the Strategic Direction Summary (SDS), as well.

Failure to meet any of these requirements by the beginning of FY2023 may affect the OU budget. The minimum requirements for continued PEPFAR support include the table below.

TABLE 9. COP/ROP 2022 (FY 2023) Minimum Program Requirements

Care and Treatment
1. Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups. Status: Completed
2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens. Status: In-process (September 2022) Issues or Barriers: 76% of clients are prescribed TLD/DTG-based regimens. Pediatric optimization is ongoing and by September 2022, all eligible existing and new pediatric clients will initiate or transition to pDTG-based regimens. CQI activities, mentorship, education materials and training are currently ongoing to address any remaining provider perceptions that hinder TLD transition for women of reproductive age and adolescents.
3. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups. Status: In-process Update: The national CQI Collaborative continues to disseminate and support implementation of updated MOH guidelines delinking MMD from clinical care and VL. MMD steadily increased over FY21; at Q4, 49% of adult clients received 3-5-month and 26% received 6+ month MMD; however, MMD for children continues to lag behind, with only 51% receiving 3+ months. Other DSDM models continue to scale, for example the Community Pharmacy Refill Model reached full implementation stages in COP20.
4. All eligible PLHIV, including children and adolescents, should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.

	Status: Completed Update: Since FY17, 900,580 clients have completed TPT; and in FY21, 274,959 clients completed TPT, with a completion rate of 92%. 3HP commodities arrived in country in 2021; focused enrollment and completion is scaling in 2022. Engaging community systems to strengthening HIV & TB services, and scaling POC EMR to HIV/TB clinics across all districts is a focus in COP21.
5.	Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks. Status: In-process Issues or Barriers: Viral load coverage improved over FY21, resulting in 94% VLC at FY21 Q4. EID 2-month testing coverage improved from 68% in FY20 Q4 to 86% in FY 21 Q4. Commodity procurement delays impacted POC VL availability. COP21 investments will improve POC EID and VL for PBFW coverage and quality.
	Case Finding
6.	Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV. Status: In-process Issues or Barriers: Self-testing reached 114% of FY21 target, with the majority being distributed to young people <30 years of age. Index testing is scaled nationally though some gaps remain in site-level coverage, with 89% of targeted facilities providing index testing. To date, the national led index testing site assessment has successfully been completed, with over 90% of sites assessed adhering to the safe and ethical index testing standards.
	Prevention and OVC
7.	Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices) Status: In-process Issues or Barriers: PEPFAR Uganda made significant strides in scaling PrEP among high-risk populations, overachieving PrEP targets. Challenges remain with suboptimal screening, with only 57% of HIV-negative clients screened for PrEP; however, linkage of eligible clients improved from 56% in FY20 to 73% initiating PrEP in FY21. Community-led monitoring also identified gaps in provider knowledge about PrEP. Person-centered approaches are being refined and scaled this year to improve continuity and adherence, including DSD models and addressing stigma.
8.	Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.

	Status: Completed Issues or Barriers: The alignment of OVC packages of services and focus on priority populations for enrollment continued to improve in FY21. The OVC programs meet requirements per COP21 Guidance.
Policy & Public Health Systems Support	
9.	In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups. Status: In-process Issues or Barriers: Incidents of human rights violations, gender-based violence, stigma, discrimination and violence increased and remained at heightened levels over the last year. Shrinking civil society space for political discourse, especially for the LGBTQI+ community, is of ongoing concern. Criminalization of consensual same-sex relationships continues to discourage engagement with the health sector. The Legal Environment Assessment (LEA) was completed in 2021, and findings should be used to advocate for protection of human rights and promote equitable access to health services.
10.	Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention. Status: Completed Issues or Barriers: There are no user fees levied to patients.
11.	OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy. Status: Completed Issues or Barriers: MOH leads the national CQI Collaborative with strong support from PEPFAR Uganda technical experts. All IPs participate in these activities.
12.	Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other partner country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention. Status: Completed Issues or Barriers: The national CQI Collaborative sub-groups updated and disseminated treatment guidelines and literacy materials, with ongoing mentoring and education efforts to improve practice. Civil society organizations, community-led monitoring leadership, and communication partners contributed to treatment literacy efforts and improving U=U messaging. COP 2021 includes additional resources for community-developed messaging.

13. Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses. Status: In-process Issues or Barriers: PEPFAR Uganda is on track to meet minimum requirements and demonstrates increased local partner transitions from year to year. Transition awards were developed to build local partner capacity where needed. Key population- and women-led organizations have been engaged to provide services for community-led monitoring and the broader HIV response.
14. Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended. Status: In-process Issues or Barriers: The Government of Uganda sustained its commitment to commodity procurement despite the economic impact of COVID-19. The Community Health Extension Workers Policy Pilot and training has advanced formal recognition of the CHW cadre, and will begin in pilot districts in COP21. GoU, PEPFAR, development partners, civil society, and other stakeholders will hold ongoing discussions around sustainable maintenance of epidemic control, utilizing various data sources and the 2020 SID to guide conversations.
15. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. Status: In-process Issues or Barriers: PEPFAR Uganda improved TX_ML disaggregate reporting in FY21. Investments in national systems will continue to support this MPR.
16. Scale-up of case surveillance and unique identifiers for patients across all sites. Status: In-process Issues or Barriers: PEPFAR Uganda continued to scale the electronic medical record (EMR) system, which covers 78% of ART sites, and supported a mobile app to extend the facility EMR into the community. In addition, PEPFAR Uganda supported development of a unique identifier in collaboration with MOH and aligned to the National eHealth Strategy, and will work to expand patient registries nationally. The eHealth policy has been delayed and is not yet fully implemented. PEPFAR continues to work with MOH to support streamlined interoperability, national policies, legal requirements, and governance for UI implementation.

In addition to meeting the minimum requirements outlined above, it is expected that Uganda will consider all the following technical directives and priorities. A full list of COP/ROP 2022 Technical Priorities and Considerations are listed in COP guidance and can be referenced in Section 6.

Table 10. COP/ROP 2022 (FY 2023) Technical Directives

Uganda –Specific Directives
PEPFAR Uganda demonstrated flexibility and resilience throughout this difficult year, managing dual pandemics of HIV and ongoing COVID-19 waves, while continuing to provide lifesaving services to the community. PEPFAR-supported health systems, data capture and communication structures were leveraged to support broader disease surveillance and response. HIV prevention

interventions were rapidly adapted and refined throughout the year in response to changing COVID-19 mitigation measures that closed schools and restricted travel and group gatherings. The focus remains on supporting the most vulnerable populations through accessible prevention, care and treatment services. Overall treatment coverage was maintained and PEPFAR Uganda continued to identify people living with HIV and link them to treatment with steady but incremental treatment cohort growth. Differentiated service delivery models (DSDM), such as MMD and community medication distribution points, continued to scale to maintain community safety and treatment access. The national CQI Collaborative continued to be a cornerstone of the national HIV response. The Collaborative's work to address systemic concerns impacting the pediatric and adult clinical cascades and HRH performance continued to produce measurable positive improvements and treatment outcomes. At the end of FY2021, over 1.31 million people in Uganda were receiving lifesaving ART. Although there has been great progress in light of the ongoing dual pandemics disproportionately impacting the most vulnerable, interruptions to treatment prevented a significant increase in overall ART coverage. Treatment cohort growth outpaced new infections according to the most recent incidence estimates; however, interruption in treatment rates for adults and children reinforce the ongoing need to focus on person-centered service delivery. Overall, PEPFAR Uganda met targets, with the exception of recency and <2month EID testing, and this was similar across partners and regions. This highlights the positive impact of PEPFAR team collaboration and sharing successful strategies across all regions and partners, and this will remain a critical factor in addressing Uganda's epidemic. Progress toward key technical areas and specific directives are summarized below.

HIV Clinical Services

Care and Treatment:

PEPFAR Uganda supported 1.27 million people with life-saving ART at the end of FY 2021. Over the course of the fiscal year, 124,603 PLHIV were newly initiated on treatment and 137,809 clients returned to treatment, with a treatment cohort net growth of 50,645 clients. The number of clients receiving antiretroviral therapy in FY21 improved quarter on quarter despite the impact of COVID-19. Early treatment interruptions (within the first 3 months of treatment) reduced from 18% in FY20 Q4 to 10% in FY21 Q4, with most partners demonstrating improvement.

Technical Considerations

- Interruptions in treatment (IIT) continue to impact many people, with higher rates in the northern and eastern regions of the country and among young adults 20-35 years old. Intensified programmatic efforts are needed to promote continuity of care for people established on treatment. The PEPFAR team should consider implementing a root cause analysis and QI project dedicated to understanding the causes of IIT and develop appropriate support packages to complement existing DSD models and psychosocial support to reduce IIT tailored to age, gender, and geographic variations.
- Uganda should continue to transition to optimized ARV regimens and >90% 3+ MMD coverage. Given the relatively high number of patients on "other" regimens, consider a deep dive analysis on these regimens and work with GoU, Global Fund, and IPs to safely and appropriately transition PLHIV who could benefit from TLD.
- The ageing HIV population in Uganda increases the occurrence of NCDs as a cause of morbidity and mortality. Uganda should consider expanding policies and programming to include NCDs such as mental health, hypertension, diabetes mellitus, weight measurement, and cervical cancer screening.

Case Finding:
PEPFAR Uganda performed 4.65 million tests and identified 131,226 people living with HIV, reaching 263% and 351% of annual targets, respectively, with an annual yield of 2.8%. The number of HIV tests continued to trend downward through the fiscal year when factoring out the impact of COVID-19 restrictions.

- Index Testing: All clinical partners performed index testing services, but the contribution to positive results varied greatly and just over half of partners achieved their HTS_INDEX new positive target. To date, the national led index testing site assessment has successfully been completed, with over 90% of sites assessed adhering to the safe and ethical index testing standards.
- Pediatric Index Testing: Most regions reported low coverage of pediatric index testing. Significant scale up of pediatric index testing, and proactive follow up of children of WLHIV in collaboration with the OVC program, resulted in an expected increased number of children tested coupled with a drop in positivity yield.
- Provider Initiated Testing and Counseling: PITC testing volume decreased from 544,859 in FY20 Q4 with 2.9% yield to 379,831 in FY21 Q4 with 3.1% yield.
- Antenatal Care (ANC) testing: HIV tests performed for pregnant women increased, from 1,343,185 with a 1.4% yield in FY20 to 1,409,093 with a 1.2% yield in FY21. There is significant room to scale testing at Post ANC 1 as women should be tested prior to delivery and throughout the breastfeeding period. PBFW continue to be at high risk of seroconversion during pregnancy (212,943 tests performed, 1.5% yield), and as a result, PrEP should be offered to HIV-negative PBFW as part of an essential component of the PMTCT prevention toolkit.
- HIV Self-Testing (HIVST): Self-Testing continued to scale to engage at-risk populations, and test kit distribution increased by 54% from 199,126 in FY20 to 306,328 in FY21. Over 80% of self-tests were distributed among young people under the age of 35.
- Recency: Recency testing began to scale but was delayed in COP21, and 40% of targeted PEPFAR sites implemented recency. PEPFAR and the MOH are collaborating to integrate recency into national reporting tools and the national HIV Testing Service (HTS) policy and guidelines (anticipated in February 2022).
- Linkage: Proxy measures for linkage improved from 88% in FY20 to 95% in FY21, with significant increase in linkage rates among adult men from 84% in FY20 to 93% in FY21. Linkage rates remained steady for the last two quarters with rates slightly lower among all males than all females at 94% and 96% respectively. Additional analysis is needed to identify barriers to reaching the remaining 5-10% of clients.

Technical Considerations

- Continue to scale up HIV self-testing as a strategy to increase access to testing, especially for populations that do not traditionally seek health care.
- PEFPAR Uganda should continue to employ CQI to deprioritize use of non-validated adult paper screening tools in favor of more sensitive and specific HIV testing, such as self-testing.
- Support universal reporting of recent infection surveillance data, including from non-EMR sites, utilizing paper-based tools or mobile applications where applicable.
- Consider integrating Recency QA/QC into overall HTS QA program.

Prevention of Mother to Child Transmission (PMTCT):
PMTCT programming continues to drive progress toward elimination of mother to child transmission. ART coverage for HIV-positive pregnant women remained steady at 98.5% in FY21; and VLS among pregnant and breastfeeding women (PBFW) was 94% and 96% respectively. Early infant diagnosis (EID) coverage improved at 2-months from 68% in FY20 to 79% in FY21, and at 12-months from 85% in FY20 to 90% in FY21. Of the children born to HIV positive mothers, 1.6% of children were identified to be HIV positive and 91% were linked to treatment. Post-ANC 1 testing remained relatively flat during the year and while the number of PBFW on PrEP has increased, there is significant room to scale PrEP screening and access among this group.

Technical Considerations:

- Reduce the number and high proportion of infants with unknown final outcomes (24% at FY21Q4) through both programmatic and data strategies to improve tracking and retention of mother-infant pairs. Utilize PMTCT Impact Evaluation findings to identify COP22 strategies for facilities with and without PMTCT services. In COP21, PEPFAR Uganda plans to scale EID POC testing to 40% of sites to support this strategic priority.
- As noted above in testing considerations, there is significant room to scale Post ANC 1 testing as women are in need of testing both before delivery and throughout the breastfeeding period. Similar to pediatric testing, higher coverage is more important than testing yields.
- Utilize biomedical prevention and psychosocial support interventions to prevent and identify incident infections in pregnant and breastfeeding women, particularly women 15-24 years.

Pediatrics and Adolescents:
PEPFAR Uganda supported 89,742 children and adolescents living with HIV (<20 years) on ARV treatment in FY 2021. Uganda reports consistently high VLC, and improving VLS among CLHIV <15 years from 74% in FY20Q1 to 88% in FY21Q4; this is seen across all age-subcategories (though VLS is lower in some age groups). Use of the validated risk screening tools for testing and improvements in index testing have increased testing efficiencies without decreasing case finding among CLHIV. Additionally, the program maintained high rates of linkage into care across pediatric age groups despite the impact of COVID-19.

Technical Considerations:

- Despite our successes, significant challenges remain to eliminate vertical transmission of HIV and close the treatment gap for children and adolescents. Seven PEPFAR-supported countries have the largest gaps per UNAIDS 2020 estimates triangulated with PEPFAR data/footprint: Nigeria, Mozambique, Zambia, South Africa, Tanzania, Uganda, and DRC. COP 22 submissions for these focus countries must clearly describe existing gaps (including those related to service delivery and socioeconomic needs) and how their respective OU will program to achieve specific goals/targets that will address these gaps. Budgetary specificity for each of these beneficiary groups should be provided in the FAST. Pediatric and PMTCT human resources should be allocated, as needed, to reach goals/targets. Throughout the year these countries will be expected to have dedicated, regular, review meetings to monitor and evaluate progress and take corrective action if necessary through the POART process. Reviews should also include detailed expenditure analysis to ensure appropriate resources are directed to closing PMTCT/Pediatric gaps. Improve early program continuity of care and

increase MMD among children and adolescents, particularly in the 10-14 age group with higher IIT in the first 3 months of treatment.

- Continue to scale MMD for all children > 2 years (currently 51% with high regional variation).
- To support treatment continuity, every child and adolescent should be assigned someone to check in and problem solve adherence and treatment continuity concerns on a monthly basis, including OVC program enrollment and YAPS where available. Develop a system to track supportive services to confirm service provision.
- Improve VLS among CLHIV, who continue to have VLS <90%. This is particularly urgent in the <1 and 1-4 year old age groups, which have lower VLS than adults or older children. Potential strategies to improve VLS can include the following: quick rollout of pediatric DTG10 for the younger children, strengthening the model and strategy for improving VLS in younger children including enhanced caregiver training and support, and scaling up programs such as YAPS for adolescents, which provide intensive peer support networks and other resources.
- Continue to intensify case finding efforts for C/ALHIV through an optimal mix of testing modalities, including scaling family index testing. Uganda has one of the highest burdens of unidentified CLHIV according to SPECTRUM estimates. Specific methods to achieve this could be to definitively calculate the proportion of biological children and siblings of known cases who have been tested and to maximize index testing in this population. Continue testing at critical service delivery points, such as TB, in-patient, young child clinics, malnutrition clinics, and OPD using the validated pediatric risk screening tool.

Orphans and Vulnerable Children (OVC)

PEPFAR Uganda served 257,925 OVC beneficiaries with comprehensive services and 53,254 participated in primary prevention interventions. Of children enrolled in OVC comprehensive services, 99% have a known HIV status (proxy) and 100% of CLHIV OVCs are on ART. Pediatric TX_CURR coverage improved over time, which ensures that C/ALHIV are being prioritized for services. There are also OVC programs in all high-burden districts in Uganda, indicating good geographic coverage and prioritization of programs, although with variable levels of coverage at the PSNU level. From FY21 Q2 to Q4, viral load coverage in the OVC program increased substantially from 69% to 82% (according to programmatic data) while also increasing viral suppression from 85% to 91% in a continually growing cohort of HIV positive OVC beneficiaries.

Technical Considerations:

- Minimum requirements for OVC programs include actively facilitating testing for all children at risk of HIV infection, and linkage to treatment, and providing support and case management for vulnerable C/ALHIV. Based on FY21Q4 data, the proxy coverage of existing PEPFAR OVC programs in Uganda is 103% for TX_CURR <15 and 68% for TX_CURR <20 in OVC PSNUs. True coverage falls somewhere in between these two estimates since the OVC program enrolls C/ALHIV 17 years of age and younger. While inexact, the “proxy coverage” provides an estimate of how well OVC partners are doing at reaching C/ALHIV current on treatment in the same geographic areas where they are providing OVC program services.

- It is important to also consider the total estimated coverage of OVC programs compared to the number of C/ALHIV current on treatment across the OU and supported by PEPFAR. For Uganda, this is estimated at 86% for TX_CURR <15 and 57% for TX_CURR <20. As part of COP22 planning, all OUs with OVC programs should conduct analyses to understand how well the OVC program is geographically aligned with clinical programs/sites. OUs that do not already have a consensus definition for high-volume pediatric sites should reach out to their SI and PEDS, OVC liaisons for further guidance and support. Pending the results of these analyses, and key factors such as A/CLHIV population dispersion, shifts in geographic placement and target allocation for OVC partners may be necessary.
- Further investigate districts with low TX_CURR <15/20 coverage in OVC_HIVSTAT_POS to determine whether there is under-enrollment/under-coverage or if CLHIV are attending OVC services in neighboring districts. Recommendations could include improved investigation of local indicators that track enrollment. If districts are found to in fact have low coverage, implement measures to prioritize enrollment of C/ALHIV and potentially review targets.
- Through COP planning, the PEPFAR Uganda team should review assumptions for setting targets in multiple areas. This includes reviewing targets for the >18 age group compared to the <18 age group to investigate the potential "over-enrollment" of >18's and adjusting caregiver/child ratios to reflect demographic reality.
- Ensure transition of OVC services continues smoothly to maintain coverage and equitable service delivery among CLHIV and other priority subpopulations across OVC PSNUs and to establish all appropriate MOUs and data sharing agreements. As with prior transitions, this is also an opportunity to further expand coverage of CLHIV and other priority subpopulations while ensuring continuity of services for current beneficiaries.

Tuberculosis (TB) Treatment:
In FY21, 274,959 patients completed preventive TB treatment, 92% of those expected. Among PLHIV and CLHIV, 92.4% were screened for TB, and this result has gradually improved over the past two years (from 90% at FY 20 Q4 and 87% at FY 19 Q4). Additionally, HIV treatment linkage was maintained among TB positive patients diagnosed with HIV at 95%.

Technical Considerations:

- Accelerate TB detection by adding either CXR and/or molecular WHO recommended rapid diagnostic (mWRDs) tests to TB screening algorithms. Based on WHO and PEPFAR data, there are an estimated 9627 TB/HIV incident cases in PEPFAR supported areas of Uganda and it is estimated that about 33% of these cases are not diagnosed or reported. IPs in Uganda are encouraged to improve TB case finding performance among all ART patients by improving symptom screening and adding CXR, GeneXpert/Truenat, CRP and other recommended diagnostic tools to their TB screening algorithm. Additional diagnostics such TB LAM and LF LAM should also be more fully utilized. This should improve timeliness of diagnosis as well. Symptom screening should be strengthened to correct observed dip in positivity.
- Ensure availability of mWRD testing (Gene Xpert, Truenat) at site level and increase use of GeneXpert as the preferred test to diagnose TB among PLHIV. Less than 75% of TB specimens were tested using Xpert in FY21.

- Only 85.4% of presumptive TB PLHIV had a sample collected and evaluated for TB. This percent appears to have decreased over the past reporting periods. It is vital that every PLHIV with presumptive TB have a sample collected for TB testing. IPs should ensure that there is commodity security for TB sputum sample containers, adequate transportation and strong linkage from community to health care facilities within the range of differentiated service delivery models.

HIV Prevention Services

Adolescent Girls and Young Women (AGYW):
The DREAMS (Determined, Resilient, Empowered, AIDS Free, Mentored, and Safe) Partnership continues to provide high quality services to prevent HIV incidence among AGYW, and change harmful social and gender norms within families and communities in 24 focus districts. Additionally, programming to support AGYW is implemented across the country through the PEPFAR portfolio and in collaboration with GoU, CSOs, and development partners such as the Global Fund. In FY21, the DREAMS program expanded to Kalangala, Masaka, Wakiso, and Mbarara, and prepared to expand to Kampala, reaching more AGYW and communities than previous years. Over the course of the year, 81% of AGYW completed the primary package of services. Biomedical prevention interventions were scaled for this population. Expansion and improvements in comprehensive economic strengthening interventions were seen across the program.

Technical Recommendations

- PEPFAR Uganda implemented a strong response to gender-based violence throughout the year and the need for post-violence care was higher than expected, most likely as a result of increases in violence and reporting during COVID-19 restrictions. In an effort to understand the changing context and assess the potential impact of existing violence prevention programs, Uganda could consider approaches to collecting actionable data to inform programming. Additionally, a rapid assessment of district action centers could provide insight into successes and challenges and inform quality improvement. Uganda should continue to invest in and strengthen violence prevention and GBV response programming.
- DREAMS programs should continue efforts to engage the substantial number of 10-14 year olds (17,004) not completing the primary package in over 13 months, and support their completion.
- Root cause analysis showed challenges with retention of 20-24 year olds and that AGYW have struggled with entrepreneurship and employment during COVID. AGYW shared their experiences and reasons for not completing the program, including: AGYW feeling that they could utilize their time doing other things, refusal by partner/parent, COVID-19, and delayed income generating activities. Uganda should consider implementing targeted efforts to address root causes interrupting completion, including opportunities for wage employment and partnerships with the private sector. This could include a short-term project to assess opportunities for partnerships, internships, training, and employment; as well other innovations to address key drivers of low completion.

Key Populations (KP):
The socio-legal environment continues to impact key population programming in Uganda. In FY21, more KP were reached with prevention programming than in previous years, increasing from 279,265 KP in FY20 to 341,811 in FY21, 130% of the annual target. According to program data, 291,774 key population clients were tested for HIV, with an overall yield rate of 4%, linkage to

treatment of 96%, VLC 94% and VLS 91%. Effective activities supported by the Key Population Investment Fund were incorporated into core programming across agencies, such as targeted case finding approaches, optimized linkage and improved VLC/VLS services, as well as prevention and PrEP services available in the community.

Technical Considerations:

- In alignment with MPR #13 and local-partner transition principles, PEPFAR Uganda should explore funding KP-led indigenous civil society organizations to provide KP-centered services and offer capacity building (e.g., training in grants management, HR, SI) to enable local CSOs to apply for USG funding; explore CSO sustainability with social enterprise through small grants; and support formal accreditation of community clinical service delivery points.
- PEPFAR Uganda should consider collaborating with the Global Fund to implement a BBS among MSM and TGW, as the last BBS was conducted nearly 10 years ago. Since BBS studies are only conducted in several urban centers, the Small Area Estimates (SAE) methodology should be included as part of the BBS to estimate population size for subnational geographies and to calculate national estimates.
- PEPFAR Uganda surpassed annual targets for PrEP initiation, but more can be done to expand access. Consider policy and program changes, in alignment with forthcoming WHO guidelines, to simplify PrEP service delivery, including minimize testing requirements, encourage implementation of event-driven (ED) PrEP for all cisgender men and TG not on gender-affirming hormones, allow for self-testing, decentralize PrEP and promote community delivery.

Pre-Exposure Prophylaxis (PrEP):
Despite a difficult implementation environment, PEPFAR Uganda continued to successfully scale-up PrEP as an essential prevention intervention among high-risk populations, exceeding PrEP_NEW and PrEP_CURR targets by 126% and 137% respectively. DSDM, such as community distribution models, were utilized to support access and continuity in the context of COVID-19. With policy expansion to include new populations of PBFW and AGYW in COP20, PEPFAR Uganda was able to significantly increase PrEP services among females aged 15-24, providing services to 5 times the number of young women between the end of FY20 (9,094) and FY21 (45,600).

Technical Considerations:

- In COP 2022, PrEP should continue to be scaled up with a focus on ensuring policy and programmatic access to PrEP for higher incidence populations. Populations prioritized for PrEP should be tailored to the OU's epidemic context with a focus on Key Populations (including sex workers, men who have sex with men, transgender people, people in prisons and other closed settings, people who inject drugs), adolescent girls and young women including pregnant and breastfeeding AGYW, and other identified higher-incidence populations.
- Since PrEP was initially offered in 2018, there has been a marked uptake of PrEP services with over 50%-fold increase in targets over the past three years. However, PrEP continuity remains challenging in Uganda as it does globally in PEPFAR programs. To capitalize on the gains made, the PEPFAR Uganda team should explore innovative approaches to support continuation on PrEP, including differentiated service delivery models such as the use of

apps, targeted SBC materials, virtual platforms for appointment reminders, peer-led and other approaches for follow-up, when feasible.

- To allow for ongoing expansion of PrEP, particularly among AGYW, PEPFAR Uganda should continue to increase demand creation efforts, building on newly approved national campaign materials and utilizing social media and mobile innovations developed in response to COVID.
- PEPFAR Uganda should adopt the latest WHO guidance to simplify PrEP implementation (including changes in clinical monitoring, changes in Hep B and Hep C screening, and expanding ED-PrEP) and to support the enabling environment and platform for new biomedical prevention products (such as CAB-LA) to ensure readiness for the introduction and access of these products as they are approved.
- The PEPFAR Uganda program should work to ensure testing is completed and reported for all PrEP users. For instance, in FY21 Q4, there was less testing than PrEP users. Additional investigation into the cause of this difference (inadequate testing, inadequate reporting, ramped up self-testing due to COVID, or other causes) should be explored and addressed as needed.

Voluntary Medical Male Circumcision (VMMC):
Despite COVID-19 related disruptions, Uganda surpassed their annual VMMC target, achieving 102% of the FY21 annual target. The program also successfully implemented the change in age eligibility; only 0.24% of VMMCs were performed in clients under 15 years of age in 2021 and appropriately using ShangRing. ShangRing roll-out continued to increase over the year.

Technical Considerations:

- Utilize UPHIA 2020 incidence data to identify high risk groups and consider targeting tailored demand generation efforts to increase uptake of VMMC services among these groups, including clients 30 years and older if indicated.
- As performance against targets is highly variable across districts, PEPFAR Uganda should analyze the reasons for these differences. If the issue is target setting (targets are too low or too high in various PSNUs), review the methodology and adjust COP22 targets accordingly.
- Ensure partners achieve full compliance with PEPFAR age guidance; PEPFAR resources (e.g. HRH, supplies, training, etc.) should not be used to circumcise anyone under age 15 years (including EIMC) unless approved as part of a ShangRing Program.
- Continue increased investment in reusable instruments, which is key to sustainability.

Government Policy, Health Systems, Other Programming Changes Needed, and Sustainability

Addressing Structural Barriers to KP Service Delivery:
COP/ROP 22 plans should prioritize and take specific steps to address the structural barriers that impede scale up of KP-led and KP-competent differentiated HIV services, as well as the lack of robust data to guide key populations programming. To strengthen strategic information to guide KP responses, plans may include efforts to strengthen individual level data systems and analyses and address gaps in subnational data. Addressing structural barriers should entail improving the enabling environment for HIV service delivery; mitigating harmful policy and social norms that fuel stigma, discrimination and violence faced by key populations; strengthening the capacity of key populations organizations; and strengthening the KP competency of HIV service providers. PEPFAR teams

should ensure they are coordinating strategically with relevant State and U.S. government units (e.g. DRL), partner government, multilateral, and other donor funding streams and institutions. As part of the new COP 22 MPR, PEPFAR teams will be expected to describe and present their approach to improving KP data and addressing barriers to accelerated KP-centered HIV services during COP/ROP 22 planning meetings.

Regional Referral Hospitals (RRHs):
RRHs have an important leadership role in Uganda's decentralized health system. PEPFAR supports all RRHs through capacity building initiatives, aligned with the current MOH integrated support supervision strategy and CQI framework, to become platforms for sustainable epidemic control.

- In COP21, PEPFAR Uganda should identify a timeline for each RRH to lead regional TA and supportive supervision efforts, and serve as a center of excellence. This should include the development of a multi-year plan, including benchmarks to monitor progress, and inclusive of risk and mitigation measures.

Health Information Systems (HIS):
COP20 investments continued to support health information infrastructure and integration, including expansion of electronic medical record (EMR) coverage across sites and through POC technology. PEPFAR should continue to support GOU to implement unique identifiers and patient registries nationally. Health Information Exchange (HIE) and HIS interoperability projects continue to move forward.

Community-Led Monitoring (CLM):
CLM continued to support community involvement and transparency of the PEPFAR program over the last year. CLM scaled to 78 additional districts in COP20, from 30 districts in COP19 to 108 districts in COP20, and used electronic meeting platforms and data capture to enable efficient and safe process of data collection and analysis. The findings from CLM are actively used by PEPFAR and GoU to improve programming and address gaps in services.

Technical Recommendations

- Continue robust support and refinement of CLM activities: 1) Prioritize review and incorporation of community-led monitoring findings into national and regional continuous quality improvement collaborative activities; 2) Continue collection of CLM data and tracking data comparisons between rounds (e.g., clients' knowledge about viral load).
- Continue to support community engagement activities: 1) New community scorecard indicators that were developed but delayed due to COVID-19; 2) Community data triangulation and visualization with PEPFAR data streams

Human Resources for Health (HRH:
The PEPFAR Uganda team successfully completed the HRH Inventory reporting requirement, which yielded data on the PEPFAR-supported staffing in the country. Progress was made to strengthen sub-national HRH planning and management capacity, with a focus on sufficient staff and workforce protection, with several regional referral hospitals.

Technical Recommendations:

- In preparation for COP22 planning, utilize HRH Inventory data to review the number of FTEs and expenditure on staffing to examine the alignment of current staffing investments with MER targets/achievement, build capacity to analyze optimal staffing requirements and

allocation to support program targets/goals, identify opportunities to improve performance, and inform adjustments of service delivery and non-service delivery staff.

- Conduct staffing compensation analysis to assess alignment of clinical and ancillary staff, including focus on community staff, with government pay scales for continued investment and to guide future transition. Utilize Activity-Based Costing data to inform compensation analysis and impact of HRH management and absenteeism.
- Continue to support GOU to manage pilot implementation of the Community Health Extension Workers (CHEWs) policy.
- As part of COP22 planning:
    - Identify facility and community HRH requirements based on expected future adjustments to maintain HIV service delivery in a sustained epidemic control environment and utilize this to inform planning for transition or absorption of PEPFAR-supported staff.
    - Build local system capacity for HRH (including for monitoring and reporting) to guide sustainability of investments, with more focus at sub-national level aligned to host-country facility and community health system infrastructure.
- To support long-term sustainability discussions, PEPFAR Uganda should explore with GOU how contracting mechanisms could be leveraged to sustain prevention, treatment, and commodity investments. If GOU determines contracting mechanisms could be used, PEPFAR Uganda may explore integrating these mechanisms into COP22 to enable use in out years.

Laboratory Systems:
PEPFAR Uganda's investment in the laboratory system has proven to be essential and supported a strong HIV and COVID-19 dual response. The laboratory system plays a role in improvements in viral load coverage for children and adults, including 2-month EID coverage.

Technical Considerations:

- Improving data quality with unique identifiers can support increased visibility of the VL cascade, identify data inconsistencies where they exist, and improve PEPFAR reporting. Consider efforts to triangulate data from LIMS, DHIS, and the Uganda national dashboard.
- Improve the specimen transport process by tracking specimens from collection at the health care facility to the testing laboratory. Utilize existing network optimization to develop a plan to track specimens from health care facility to hubs and CPHL. This will highlight areas of weakness that affect TAT.

Supply Chain:
Investments to improve supply chain security and stock level management have moved forward this year, though not without complications. Enterprise Resource Planning (ERP) is being refined by testing and new releases, and is planned for phased implementation in January 2022 to provide health facilities access to electronic ordering, inventory management, and improved end-to-end visibility. Through the PNFP Commodities IDIQ, Uganda has also accelerated utilization of private sector capabilities to improve supply chain efficiency and client experience.

Technical Considerations:

- Building on current investments, increase visibility to the point of service to strengthen demand planning, optimize operations, and promote appropriate use of products by providers, pharmacists/dispensers, and consumers. Proactively monitor and mitigate risks to ensuring supply of affordable, quality-assured, safe, and effective products to clients.
- Ensure availability of critical medicines (PrEP, TPT) in Community Pharmacies.
- Re-focus technical assistance to support governments' shift from acting as supply chain operators to being stewards for commodity availability and security.

COP/ROP 2022 Active Engagement with Community and Civil Society (see section 2.5.3 of COP Guidance)

The full participation of community stakeholders and civil society in every stage of PEPFAR programming, planning, and monitoring, as appropriate and consistent with applicable law, regulations and policy, from advocacy to service delivery, is critical to the success and sustainability of PEPFAR and the global effort to combat HIV. Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional, and international civil society and community stakeholders, multilateral partners and the partner country government.

Civil society organizations are essential and to be invited to participate in the virtual COP22 strategic retreats, planning meetings, as well as approval meetings. In particular, engagement with local CSOs at the country-level is required and should begin early and continue during the entirety of the COP planning, monitoring, and implementation process.

This engagement of civil society, including faith-based organizations/faith communities, specifically includes the sharing of FY 2021 Q4 and FY 2021 Annual Program Results (APR), analyses, and the convening of an in-country planning retreat with local stakeholders, no later than the week of February 7, 2022, in order to introduce and discuss all COP/ROP 2022 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2022. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund, with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In March 2022, PEPFAR will convene virtual meetings where outstanding decisions will be discussed and finalized. In addition to partner country representatives, the meetings will also include representatives from local and international civil society and community organizations, faith-based organizations/faith communities, private sector, and multilateral partners. Specific guidance for the 2022 virtual meeting delegations will be provided separately.

Engagement with all stakeholders is required beyond the meetings and throughout COP/ROP 2022 development, finalization, and implementation. As in COP/ROP 2021, the draft Strategic Direction Summary (SDS) is required to be shared with both CSO and FBO stakeholders for their input and comments at least 7 days prior to submission to S/GAC. Please refer to the COP/ROP 2022 Guidance for a full list of requirements and engagement timelines. In addition, a more detailed timeline for sharing key data visualizations and other information with stakeholders is forthcoming.

Community-led Monitoring (CLM)

In addition to prescribed and routine engagement during PEPFAR's annual business cycle, including around COP/ROP planning and quarterly POART processes, all PEPFAR programs are required to

develop, support, and fund community-led monitoring (CLM) in close collaboration with independent, local civil society organizations and host country governments. Community-led monitoring in COP22 should build on prior activities in COP21 and be designed to help PEPFAR programs and health institutions pinpoint persistent problems, challenges, barriers, and enablers to effective client outcomes at the site level. In addition to being data-driven and action-oriented, CLM should continue to ensure indicators are defined by communities and health service users, and data should be additive and not a duplicate collection of routine data already available to PEPFAR through MER or SIMS. New in COP22, PEPFAR-supported community-led monitoring programs must include an explicit focus on key populations. CLM should be utilized to advance equity and to support improvement in programs, especially for populations who have not yet fully experienced the benefits of HIV epidemic control. For example, OUs with pediatric care and treatment programs should consider utilizing CLM to track and ensure accountability for child, adolescent, and family-centered care.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment: Each OU's COP/ROP 2022 minimum requirement for the care and treatment earmark is reflected in Table 2. If there is no adjustment to the COP/ROP 2022 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The Care and Treatment earmark will be calculated as the sum of the following:

- 100% Care and Treatment (C&T) Program Areas
- 50% Testing (HTS) Program Areas
- 100% Above Site Program: Laboratory System Strengthening
- 70% Pregnant and Breastfeeding Women Beneficiary Group
- Proportional % Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the C&T earmark)

Orphans and Vulnerable Children (OVC): Each OU's COP/ROP 2022 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

- 85% (DREAMS initiative funding — commodities planned under DREAMS initiative — Any HTS interventions planned under DREAMS initiative — Any C&T intervention planned under DREAMS initiative)
- 100% (OVC Beneficiary group funding — commodities planned under any intervention with OVC beneficiaries — Any HTS planned under interventions with OVC beneficiaries
- Proportional Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the OVC earmark)

Abstinence, Be Faithful/Youth (AB/Y) Reporting Requirement: If AB/Y-programmed activities do not reach a 50 percent threshold of all sexual prevention funding, as calculated by the formula below, in any

country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. Generalized epidemic countries which do not meet the 50 percent threshold must provide a brief written justification in FACTS Info, explaining the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors.

Abstinence, Be Faithful/Youth (AB/Y) programming, formerly captured in the HVAB budget code, will now be captured by using a combination of prevention program areas and beneficiaries, which are identified in the formula below. The numerator captures those interventions that are Abstinence, Be Faithful/Youth (AB/Y) programming, and the denominator approximates all sexual prevention activities. The proportion of Abstinence, Be Faithful/Youth (AB/Y) programming as a proportion of all sexual prevention activities is calculated by dividing the numerator by the denominator:

Numerator

Prevention: primary prevention of HIV and sexual violence
(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, and boys)
+
Prevention: community mobilization, behavior, and norms change
(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, boys, adults, not disaggregated)

Denominator

Prevention: primary prevention of HIV and sexual violence (all populations)
+
Prevention: **community mobilization, behavior, and norms change** (all populations)
+
50 % Prevention: **Not disaggregated** (all populations)

Gender Based Violence (GBV): Each OU's COP/ROP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2022** funding programmed to the GBV cross-cutting code. Your COP/ROP 2022 earmark is derived by using the final COP/ROP 2021 GBV earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for GBV can be above this amount; however, it cannot fall below it.

Water: Each OU's COP/ROP 2021 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2022 funding** programmed to the water cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2021 water earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for water can be above this amount; however, it cannot fall below it.

Initiative Controls: Table 3 shows initiative controls where S/GAC has directed funding for a set of activities that cannot be accounted for through program areas and/or beneficiaries alone. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned.

The four initiative controls below (**Cervical Cancer**, **DREAMS**, **OVC (non-DREAMS)**, and **VMMC**) have been assigned to the appropriate OUs. For OUs where these controls are designated in the PLL, the amounts reflect the minimum required. These initiative controls can be exceeded without a

control change, but a control change request would be required before a lower level for these activities can be planned.

Cervical Cancer - This initiative provides funding for all activities related to cervical cancer screening and diagnosis and treatment of precancerous cervical lesions for women living with HIV as outlined in the COP Guidance.

DREAMS - The DREAMS initiative should capture all funding specifically allocated as DREAMS in the OU's planning level and must be used for the goal of HIV and sexual violence prevention among adolescent girls and young women (AGYW) ages 10-24 years (unless otherwise approved) in approved DREAMS SNUs in accordance with the DREAMS and COP Guidance. The DREAMS initiative can also include prevention interventions in DREAMS geographic areas for girls and boys aged 10-14 which may be cost shared with the OVC (non-DREAMS) initiative as noted in the COP guidance.
OVC (non-DREAMS) - OVC (non-DREAMS) is a new initiative in COP/ROP 2022. OUs should use the initiative to budget for OVC (non-DREAMS) programming, including all OVC comprehensive activities as outlined in the COP Guidance. The OVC (non-DREAMS) initiative should include ASP, SE, and PREV costs (except PrEP and VMMC) linked to any OVC beneficiary (including sub-beneficiaries such as OVC caregivers). As the initiative is new for COP/ROP 2022, OUs should pay particular attention to funds programmed under OVC (non-DREAMS) to ensure that the current cohort of children enrolled in the comprehensive program receive continuity of care for FY 2023. The OVC (non-DREAMS) initiative can also include prevention interventions for girls and boys aged 10-14 which may be cost-shared with the DREAMS initiative as noted in the COP guidance. The OVC (non-DREAMS) initiative cannot be met with any HTS, C&T, PM or commodities costs.

VMMC - All services and equipment related to providing surgical and ShangRing VMMC for boys/men ages 15 and above, and ShangRing circumcision only for boys age 13 and 14 years, should be budgeted using the VMMC initiative.

While the CLM initiative does not appear in PLL budget tables, as CLM remains a requirement in COP/ROP 2022 for all OUs, each OU is responsible for programming a portion of funds under the **Community-Led Monitoring** initiative.

Community-Led Monitoring - During COP/ROP 2020, PEPFAR invested in expansion of community-led monitoring, making it a requirement of all OUs, as a critical way to listen to community voices in assessment of program quality and design of client-centered services. Community-led monitoring remains a requirement in FY 2023.

In addition to the five initiatives above, S/GAC may also allocate funding to OUs under two additional initiative controls: **Condoms (GHP-USAID Central Funding)** and **One-Time Conditional Funding**. If the OU was designated to receive funding under either one or both these initiatives in COP/ROP 2022, Table 3 will reflect these amounts. Unless otherwise noted, country teams should meet these funding controls when programming in their FAST.

Condoms (GHP-USAID Central Funding) - This initiative control denotes the amount of GHP-USAID central funding the country team may use to procure male and female condoms, lubricants, and to ship these commodities to the OU. Any additional condoms and lubricants to be procured with PEPFAR funding should be budgeted in the FAST with bilateral funding.

USAID Southern Africa Regional Platform - This initiative is for the country's share of the costs to operate the USAID Southern Africa Regional Platform, which provides administrative and technical support for Angola, Botswana, Eswatini, Lesotho, and Namibia. These funds were previously planned as

part of the bilateral COP funding, but are now budgeted and notified centrally, with country amounts included as central funding in the overall COP levels for Angola, Botswana, Eswatini, Lesotho, and Namibia. Only these 5 countries may use this initiative, and this initiative can only be used with central funding specifically provided as part of the PLL controls.

One-Time Conditional Funding - The release of any funding made available under this initiative is contingent upon the OU's ability to meet all requirements outlined in their final COP/ROP approval memo. OUs that fail to meet these minimum standards may be ineligible to receive these funds for programmatic implementation in FY 2023.

No control is set in the PLL for the **HBCU Tx** and **Surveillance and Public Health Response** initiatives, but OUs may include relevant funds under these initiatives instead of Core Program as appropriate.

All funding not attributed to one of the nine COP/ROP 2022 initiatives above should be attributed to the **Core Program** initiative.

For additional details on initiatives, see the PEPFAR Financial Classifications Reference Guide.

Programmatic Controls: Table 4 shows programmatic controls where S/GAC has directed funding for certain programmatic activities. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned. Since every dollar programmed in COP must belong to one initiative, programmatic controls will be a subset of one or more initiative controls, even if the standard Core Program initiative.

PrEP (AGYW) – The PrEP (AGYW) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for the Females – Adolescent Girls and Young Women sub-beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of AGYW on PrEP wherever possible. Countries with a PrEP (AGYW) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

PrEP (KPs) – The PrEP (KPs) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for all sub-beneficiaries under the KP beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of KPs on PrEP wherever possible. Countries with a PrEP (KPs) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

State ICASS: Table 5 shows the amount that the OU must program under State for ICASS Costs.

Funds Programmed under State/SGAC (S/GAC TBDs)

No funding may be programmed under State/SGAC without prior approval from S/GAC M&B. In general State/SGAC TBDs are only used in extraordinary and or unusual circumstances. To the degree that funding is approved, the rationale and any conditions attached to the funding will be documented by M&B. Any S/GAC TBDs approved during COP/ROP 2022 planning will require supplemental language in the OU's COP/ROP 2022 approval memo, clearly outlining the process for how these funds can be accessed. Any funds that have not been distributed to agencies before the end of FY 2023 may be subject to reprogramming in future planning cycles towards the same OU or another OU.

COP/ROP 2022 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

Whenever possible, all agencies within an OU should hold several months of pipeline at the end of COP/ROP 2022 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. If an agency/OU combination has a history of over-outlays, or in cases where an agency/OU COP envelope has increased in recent years, there may not be sufficient funding to maintain this buffer. With the exception of Dominican Republic, Ethiopia, Haiti, South Sudan, Zimbabwe, Asia Regional Program, and Western Hemisphere Regional Program, which should hold up to four months of pipeline, all other OUs are permitted to hold no more than three months of buffer pipeline.

Any agency that anticipates ending COP/ROP 2021 implementation (end of FY 2022) with a pipeline in excess of three or four months is required to apply this excessive pipeline to COP/ROP 2022, decreasing the new funding amount to stay within the planning level.

Transitioning HIV Services to Local Partners

To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. In COP19 Guidance, PEPFAR set a goal that 40% of partners must be local by the end of FY19, and 70% by the end of FY20.While considerable progress was made in this effort, the 70% mark was not achieved by all agencies in all OUs, and thus in FY22 and FY23, teams must continue to prioritize this so that the 70% goal can be realized. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY23 as appropriate through their COP/ROP 2022 submission.