# Uganda

# Country Operational Plan

# (COP/ROP) 2023

# Strategic Direction Summary

## April 25, 2023



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## List of Acronyms

| | |
|---|---|
| ABYM | Adolescent Boys and Young Men |
| ACASI | Assisted Computer Audio Self Interview |
| ACP | AIDS Control Program |
| ADP | AIDS Development Partners |
| ADR | Acquired HIV Drug Resistance |
| AGYW | Adolescent Girls and Young Women |
| AHA | Anti-Homosexuality Act |
| AHD | Advanced HIV Disease |

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|---|---|
| ALHIV | Adolescent Living with HIV |
| ALIS | AFRICA Laboratory Information System |
| AMAB | Assigned Males at Birth |
| ANC | Antenatal Clinic |
| APN | Assisted Partner Notification |
| AP3 | Accelerated Progress in Pediatrics and PMTCT |
| ART | Antiretroviral Therapy |
| ARVs | Antiretroviral |
| ASLM | African Society of Laboratory Medicine |
| CAB-LA | Long-acting Injectable Cabotegravir |
| CADRE | Cyclic Acquired Drug Resistance |
| CBO | Community Based Organization |
| CLAD | Client Led ARV Distribution |
| CCM | Global Fund Country Coordinating Mechanism |
| CDDP | Community Drug Distribution Point |
| CFE | Convening For Equality |
| CHAI | Clinton Health Access Initiative |
| CHEW | Community Health Extension Workers |
| CHW | Community Health Workers |
| C/ALHIV | Children and Adolescents Living with HIV |
| CLAD | Client-led ART delivery |
| CLHIV | Children Living with HIV |
| CLICQ-ECHO | Clinic-Laboratory Interface Continuous Quality Improvement-Extension for Community Healthcare Outcomes |
| CLM | Community-Led Monitoring |
| COE | Centers of Excellence |
| CPHL | Central Public Health Laboratory |
| CQI | Continuous Quality Improvement |
| CrAg | Cryptococcal antigen |
| CRDDP | Community Retail Drug Distribution Program |
| CRPDDP | Community Retail Pharmacy Drug Distribution Point |
| CSO | Civil Society Organizations |
| CxCa | Cervical Cancer |

| | |
|---|---|
| DBS | Dried Blood Spot |
| DBR | Dolutegravir Based Regimens |
| DFC | Development Finance Corporation |
| DHIS2 | District Health Information System 2.0 |
| DIC | Drop-in Centers |
| DM | Diabetes Mellitus |
| DOTS | Directly Observed Therapy |
| DQA | Data Quality Assessment |
| DREAMS | Determined, Resilient, Empowered, AIDS Free, Mentored, and Safe |
| DSD | Differentiated Service Delivery |
| DSDM | Differentiated Service Delivery Model |
| DTG or pDTG | Dolutegravir or pediatric Dolutegravir |
| DVR | Dapivirine Vaginal Ring |
| EAPHLN | East African Society for Laboratory Medicine |
| ECSA-HC | East, Central, and Southern African Health Community |
| eAFYA | E-Health |
| EID | Early Infant Diagnosis |
| EJAF | Elton John AIDS Foundation |
| eLMIS | Electronic Logistics Management Information System |
| EMR | Electronic Medical Records |
| EOC | Emergency Operations Center |
| EPI | Expanded Program on Immunization |
| EPOA | Enhanced Peer Outreach Approach |
| ERP | Enterprise Resource Planning |
| FDA | Food and Drug Administration |
| FETP | Field Epidemiology Training Program |
| FF | Fisher Folk |
| FSW | Female Sex Workers |
| FP | Family Planning |
| GANC DSD | Group Antenatal Care Differentiated Service Delivery Model |
| GBV or SGBV | Gender-Based Violence or Sexual and Gender-Based Violence |
| GF | Global Fund to Fight AIDS, Tuberculosis and Malaria |

| | |
|---|---|
| GIPA | Greater Involvement of People Living with HIV |
| GOU | Government of Uganda |
| G2G | Government-to-Government Awards |
| HAART | Highly Active Antiretroviral Therapy |
| HC | Health Centers |
| HCW | Health Care Workers |
| HDP | Health Development Partners |
| HEI | HIV-Exposed Infants |
| HF | Health Facility |
| HIS | Health Information System |
| HIVDR | HIV Drug Resistance |
| HIVDSR | HIV-related Death Surveillance and Response |
| HIVST | HIV Self Testing |
| eHMIS | Electronic Health Management Information System |
| HRH | Human Resources for Health |
| HTN | Hypertension |
| HTS | HIV Testing Services |
| iHRIS | Integrated Human Resources Information System |
| IAC | Intensive Adherence Counseling |
| IBBS | Integrated Biobehavioral Surveillance |
| ICWEA | International Community of Women Living with HIV-East Africa |
| IDP | Internally displaced Person |
| IEC | Information, Education, and communication |
| IIT | Interruption in Treatment |

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|---|---|
| IPC | Infection Prevention and Control |
| IPD | Inpatient department |
| IPM | Incidence Patterns Model |
| IPV | Intimate Partner Violence |
| JMS | Joint Medial Stores |
| KP | Key Populations |

| | |
|---|---|
| L-AmB | Liposomal Amphotericin B |
| LEA | Legal and Environmental Assessment |
| LIMS | Laboratory Information Management System |
| LIVES | Listen, Inquire, Validate, Enhance Safety |
| LIVES CC | Listen, Inquire, Validate, Enhance Safety, Support, Child and Adolescent friendly environment for Caregiver Support |
| LLP | Laboratory Leadership Program |
| LMIC | Lower Middle-Income Country |
| MAT | Medication Assisted Treatment |
| M&E | Monitoring and Evaluation |
| MER | Monitoring, Evaluation, and Reporting |
| MBCP | Mother-Baby Care Points |
| MC | Male Circumcision |
| MCH | Maternal Child Health |
| MDA | Ministries, Departments, and Agencies |
| M&E | Monitoring and Evaluation |
| METS | Monitoring and Evaluation Technical Support |
| MIP | Mother-Infant-Pair |
| MIS | Management Information System |
| MaKSPH | Makerere University School of Public Health |
| MMD | Multi-Month Dispensing (of ARVs and TB meds) |
| MNCH | Maternal, Neonatal and Child Health |
| MOES | Ministry of Education and Sports |
| MGLSD | Ministry of Gender, Labor, and Social Development |
| MOFPED | Ministry of Financing, Planning and Economic Development |
| MOH | Ministry of Health |
| Ministry of ICT | Ministry of Information Communication and Technology |
| MOLG | Ministry of Local Government |
| MOPS | Ministry of Public Service |
| MOT | Ministry of Trade |
| MSM | Men Who Have Sex with Men |
| MTCT | Mother-To-Child Transmission |
| MUSPH | Makerere University School of Public Health |

| | |
|---|---|
| MUWRP | Makerere University Walter Reed Project |
| NACS | Nutritional Assessment Counseling and Support |
| NCD | Non-communicable Disease |
| NDA | National Drug Authority |
| NHLDS | National Health Laboratory and Diagnostic Services |
| NIRA | National Identification & Registration Authority |
| NMS | National Medical Stores |
| NNRTI | Non-Nucleoside Reverse Transcriptase Inhibitors |
| NHPI | Nation Public Health Institute |
| NSP | Needles and Syringes Program |
| OFLA | Office of the First Lady |
| OI | Opportunistic Infection |
| OPD | Outpatient Department |
| OPM | Office of the Prime Minister |
| OVC | Orphans and Vulnerable Children |
| OVCMIS | OVC Management Information System |
| PAW | PEPFAR Analytic Workspaces |
| PBFW | Pregnant and/or Breast-Feeding Women |
| PCO | PEPFAR Coordination Office |
| PCR | Polymerase Chain Reaction |
| PDM | Parish Development Model |
| PEP | Postexposure Prophylaxis |
| PII | Personally Identifiable Information |
| PITC | Provider-Initiated Testing and Counseling |
| PHIA | Population-based HIV Impact Assessment |
| PIP | People In Prison |
| PLHIV | People Living with HIV |
| PLL | Planning Level Letters |
| PMTCT | Preventing Mother-To-Child Transmission |
| PNC | Postnatal care |
| PNFP | Private Not-for-Profit Organization |
| PP | Priority Populations |
| PLL | Planning Level Letter |

| | |
|---|---|
| POC | Point of Care |
| PrEP | Pre-Exposure Prophylaxis |
| PPP | Public Private Partnership |
| PSE | Private Sector Engagement |
| PSS | Psychosocial Support |
| PVC | Post-violence Care |
| PWD | People with Disabilities |
| PWID | People Who Inject Drugs |
| QA | Quality Assurance |
| QPPU | Quantification Procurement Planning Unit |
| RAJA | Rights and Justice Activity |
| RPM | PEPFAR Regional Planning Meeting |
| RRF | Rapid Response Fund |
| RRH | Regional Referral Hospital |

| | |
|---|---|
| RTT | New Treatment indicator - "Return to Treatment" |
| SAE | Small Area Estimates |
| SASA! | Strategic Assessments for Strategic Action |
| SBC or SBCA | Social Behavior Change or Social and Behavior Change Activity |
| SDS | Strategic Direction Summary |
| S&D | Stigma and Discrimination |
| SMUG | Sexual Minorities of Uganda |
| SNS | Social Network Strategy |
| SNU | Sub-National Unit |
| SOP | Standard Operating Procedures |
| SOW | Statement of Work |
| SQA | Social Quality Assessment |
| SRE | Systematic Research Evaluation |
| SRH | Sexual and Reproductive Health |
| SRHR | Sexual Reproductive Health Rights |
| STI | Sexually Transmitted Infection |

| | |
|---|---|
| SUNS | Strengthening Uganda's National Child Care and Protections System |
| SW | Sex Worker |
| SVAC | Sexual Violence Against Children |
| TA | Technical Assistance |
| TB | Tuberculosis |
| TB_LAM | Tuberculosis Lipoarabinomannan Assay |
| 3HP for TB | Once-weekly isoniazid-rifapentine for 12 weeks (3HP) |
| TG | Transgender People |
| TGW | Transgender Women |
| TLD | Tenofovir-Lamivudine-Dolutegravir |
| TOR | Terms of Reference |
| TOT | Training of Trainers |
| UAC | Uganda AIDS Commission |
| UCMB | Uganda Catholic Medical Bureau |
| UDHS | Uganda Demographic and Health Survey |
| UHRN | Uganda Harm Reduction Network |
| UKPC | Uganda Key Populations Consortium |
| UMMB | Uganda Muslim Medical Bureau |
| UNHLDS | Uganda National health Laboratory and Diagnostic Services |
| UNHLS | Uganda National Health Laboratory Services |
| UNYPA | Uganda Network of Young People Living with AIDS |
| uPLHIV | Undiagnosed Individuals Living with HIV |
| UPHIA | Uganda Population-Based HIV Impact Assessment |
| UPS | Uganda Prisons Service |
| USAID | United States Agency for International Development |
| USSD | Unstructured Supplementary Service Data |
| UVRI | Uganda Virus Research Institute |
| VAC(S) | Violence Against Children Survey |
| VL | Viral load |
| VLC | Viral Load Coverage |
| VLS | Viral Load Suppression |
| VMMC | Voluntary Medical Male Circumcision |

| | |
|---|---|
| VSLA | Village Savings and Loan Association |
| WHO | World Health Organization |
| WLHIV | Women Living with HIV (target population for cervical cancer screening) |
| WRAIR | Department of Defense (DoD) Walter Reed Army Institute of Research |
| YAPS | Young Adolescent Program Support |

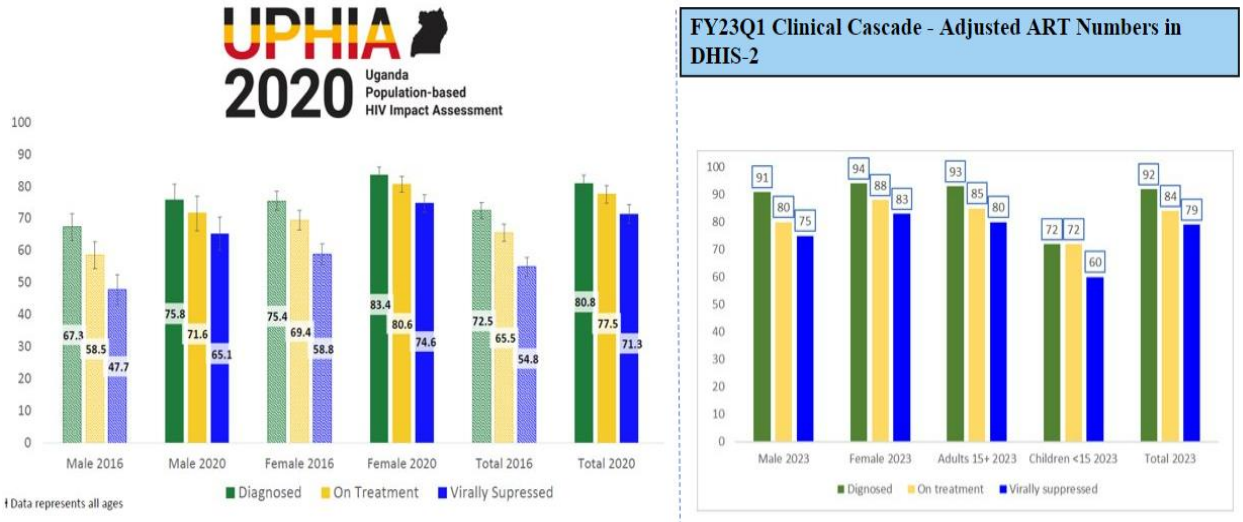
# Vision, Goal Statement and Executive Summary

**Vision, Goal Statement, and Executive Summary**

***Country Context:*** Uganda continues to accelerate reductions in new HIV infections and AIDS-related deaths, despite chronic infectious disease outbreaks, health system stressors, and economic fragility. This is reflected in Uganda's HIV clinical cascade (**Figure 1.1**), which demonstrates substantial progress in finding, diagnosing, and successfully treating people living with HIV (PLHIV) since 2016. Today, an estimated 92% of Ugandans living with HIV know their status, 84% are linked to lifesaving treatment, and 79% are virally suppressed,[1] inching closer to global 95-95-95 targets and, importantly, ensuring they can live healthy and productive lives. Older adult females ages 35-49 and 50+ made the greatest progress.

**FIGURE 1.1: Snapshot of HIV Progress: UPHIA unconditional cascade 2020-2021 [Left] compared to the HIV program unconditional cascade [right] at FY23Q1.**

[1] FY23/Q1 unconditional/ art adjusted Cascade (MOH-ACP).




***FY23Q1 HIV cascade is based on Adjusted ART Numbers in DHIS-2 – Unconditional [Right] *Note: the second 95 is discounted by 12%, however the first 95 and third 95 is not. According to UPHIA, case finding gaps remain***

President Museveni's Presidential Fast Track Initiative on Ending HIV & AIDS in Uganda by 2030, coupled with increasing domestic resource investment, helped enable HIV progress. Recent 2022-2023 Ministry of Health (MOH) policy revisions have ushered more person-centered and client-friendly service delivery models that bring prevention and care to the individuals' doorsteps, increasing the likelihood that individuals will opt for and continue to use services. New cutting-edge, life-saving biomedical HIV prevention products, such as pre-exposure prophylaxis (PrEP) delivered via injection (CAB-LA) or vaginal ring (DVR), provide adolescent girls and young women (AGYW) with more private and less burdensome HIV protection options compared to a daily oral pill. PEPFAR's substantial technical leadership and investments—$400.2M in COP22—have advanced Government of Uganda (GOU) HIV objectives even further, moving toward a more locally-tailored and sustainable HIV response.

Despite the momentum, HIV progress remains uneven and fragile across sub-populations and geographies in Uganda, driving inequity gaps and threatening achievement of PEPFAR's goal of ending the HIV epidemic as a public health threat by 2030. Macro-level data belies entrenched HIV inequities. Ugandan children living with HIV (CLHIV) remain hidden and hard to find and when identified, experience worse HIV treatment outcomes. AGYW ages 10-24 account for 43% of *all* new HIV infections, despite accounting for 34% of the total female population. This is reflected in troubling new April 2023 UNAIDS data analyses that indicate that Uganda's HIV epidemic may be stagnating or increasing. New infections among 15–24-year-olds remain flat, but the population aging into sexual debut is increasing thanks to Uganda's well-documented population youth bulge. Viral suppression among adult men remains low.
Uganda's discriminatory Anti-Homosexuality Act 2023 (AHA)[2]—creates short and long-term threats to HIV epidemic control and the human rights of lesbian, gay, bisexual, transgender,

2 The act approves elevating the penalties for "aggravated homosexuality" to death, which would criminalize same-sex sexual relations by PLHIV (among other "crimes") as a capital crime.

queer, intersex, and asexual (LGBTQIA+) people. HIV prevalence among men who have sex with men (MSM) is five times higher in countries with such laws compared to those without in Africa.[3]

***Vision:*** PEPFAR Uganda will confront these challenges directly by harnessing the ingenuity and expertise of health workers and community members to close equity gaps, while simultaneously scaling evidence-based HIV interventions on a sufficient scale to under-served areas. Aligned to PEPFAR's global 5x3 strategy and MOH targets, PEPFAR Uganda's Strategic Direction Summary (SDS) provides an operational blueprint for COP23 to accelerate progress toward our overall vision: a Uganda where all ages, genders, and population achieve 95-95-95 and HIV has ended as a public health threat by 2030.

***Strategic Shifts:*** COP23 cannot be business as usual: The continued global health security threats such as COVID-19 and Ebola outbreaks, coupled with the enactment of AHA and Uganda's growing adolescent population, may contribute to HIV resurgence in COP23 and beyond and further erode hard-won progress. While we will build upon past success and scale-up proven interventions as detailed in SDS Pillars 1-5, PEPFAR Uganda will prioritize the following pivots to move the needle on HIV equity in COP23:

***Enhance case finding for undiagnosed PLHIV:*** Finding and diagnosing the estimated 64,205 undiagnosed HIV patients[4] is a top COP23 priority and remains the biggest threat to epidemic control. Only 79% of females 15-19 years old know their status, even though young women account for 43% of all projected new HIV infections.[5] The data is even bleaker among adolescent boys the same age. PEPFAR Uganda has retooled its HIV case finding approaches in COP23, using data analysis and micro-planning to identify which sub-populations and districts require intensified focus as part of precision prevention. For example, 85% of undiagnosed young people ages 15-25 live in six sub-regions.[6] Recency testing, which indicates whether a patient has a "new" HIV infection, will enable PEPFAR Uganda to zero-in to track hotspots and outbreaks of new HIV infections and pivot interventions (*lead with data*).

We will deploy person-centered HIV testing services (HTS) that meets the needs and preferences of priority equity sub-populations, balancing the scale-up of proven high-volume and high-yield HTS modalities (which are typically less expensive and more impactful), with new HTS innovations that mine for those unreached sub-populations (*Pillar 1*). PEPFAR Uganda will increase its focus and effectiveness in finding male sub-populations to prevent infections among AGYW through expanding community-level HIV self-testing (HIVST) at high-risk work sites or gathering places like boda boda stages; scaling-up social network strategy (SNS) testing recruitment, where diagnosed clients identify their at-risk social contacts and link them to HTS; and leveraging existing virtual and digital platforms to increase demand/access to HIVST. Our

3 Nkengasong, J & Ratevosian, J. *Legal & Policy Barriers for an Effective HIV/AIDS Response*. Lancet. April 5, 2023.

4 SPECTRUM (March 2023).

5 SPECTRUM 2023 estimates; UPHIA 2020-2021

6 SPECTRUM 2022 data.

work does not end there, we will enhance counseling and linkages to keep HIV negative patients negative, doubling down on the "combination prevention" arsenal[7] that provides clients with a range of options for HIV prevention that best fits their needs.

***Prioritize adult men:*** Adult men ages 25-49 remain a missing lynchpin to epidemic control in Uganda, and remain hard to find, diagnose, link to, and retain in treatment. Without them, Uganda will fail to bend the curve on new infections. Only 75.8% of the estimated men with HIV have been diagnosed, with 71.6% of positive men aged 15-64 on ART, and 65.1% are virally suppressed.[8] Treatment gaps are particularly pronounced for men, who often need continued adherence support as the grind of lifelong treatment becomes tedious, improving their survival and reducing their transmission risk. PEPFAR Uganda has increased its targets and focus on identifying and supporting fisher folk and truck drivers in COP23, two highly mobile and under-served sub-populations that contribute substantially to driving new HIV infections in Uganda, especially among AGYWs and female sex workers (FSWs), who are frequent sexual partners to both populations.

PEPFAR Uganda will work with the MOH to scale-up HIV service delivery models that better meet the needs of men and encourage HIV treatment adherence and viral load suppression (VLS) (see **Box 1**). These include multi-month dispensing (MMD), where stable clients can pick up three to six months of their medicines at one time; community antiretroviral therapy (ART) pickup and distribution, which enables clients to pick-up their medicine nearby their homes or workplaces rather than at a health facility; boda boda (motorcycle) ART delivery, reducing the conflict working men face in accessing pick-up during work week hours; expanded and flexi-hours for clinics, especially for urban communities where men can access HIV services after their workday. We will similarly expand peer-to-peer treatment literacy programs for adult men, which enhances retention in treatment, and "eCounseling," where trained counselors regularly call clients struggling with treatment adherence to support them and jointly problem solve.

***Nurture and scale game-changing HIV innovations:*** PEPFAR Uganda will collaborate with the MOH and Ugandan civil society organizations (CSOs) to spread innovations that will help overcome the intractable barriers to improved HIV outcomes among the most vulnerable populations (*innovation enabler*). We will work with the MOH to integrate and institutionalize these priority interventions in national guidelines and provide targeted technical assistance (TA) to accelerate scale-up, including generating new domestic resource commitments and social accountability activities to enhance sustainability (*Pillar 2*). PEPFAR Uganda will simultaneously provide small grants and technical assistance (TA) to Uganda non-governmental organizations (NGOs) and faith-based organizations (FBOs) to prototype, test, refine, and scale up evidence-based innovations that trigger the adoption of individual and community positive HIV behaviors. Peer-to-peer learning networks between low- and high-performing districts will

7 Biomedical: Condoms/lubricants, VMMC, PrEP, PEP, STI treatment, HTS; Behavioral: risk reduction counseling, SBC, stigma and discrimination reduction counseling; Structural: Legal and policy revisions, DREAMS (AGYW).

8 UPHIA 2020/2021.

provide cross-fertilization to diffuse high-impact interventions and innovations across Uganda. PEPFAR Uganda has woven such innovations throughout the SDS. Priority illustrative COP23 innovations include:

- Expand the use of **Assisted Computer Audio Self-Interview (ACASI)**, an innovative and confidential phone-based survey that improves categorization, screening, and HIV case finding by enabling high-risk clients, such as LGBTQIA+ and FSWs, to conveniently and privately respond to questions on their risk status without face-to-face interaction.
- Institutionalize the **Client-Centered Service Delivery Audit Tool** (Box 1.1), adopted by the MOH in COP 2022, which enables healthcare workers (HCWs) and community health workers (CHWs) to more easily and completely track the uptake of key HIV care and treatment services by individual clients through an automated real-time "snapshot." This enables clinicians to zero-in on a patient's specific follow-up needs and link them to appropriate interventions, while simultaneously increasing resource efficiency (*Pillar 2*).
- Training health workers at ART sites to use the **Client Preference Tool** at each facility visit to ensure that the client's medication is delivered in the model that best serves their individual preference, increasing the likelihood that vulnerable groups can access life-saving medication.
- Leveraging the existing innovative **Abavubi** ("fisherman") phone app to provide tailored health messaging and mobilize fisher folk for HIV prevention and treatment services. Developed by the Federation of Fisheries Organization Uganda and available on Google Play, Abavubi is a popular digital fish catch, reporting, and financial management application that civil society has requested PEPFAR Uganda invest in to make progress in serving this sub-population.

***Increase availability of person-centered HIV care at community level:*** PEPFAR Uganda's COP23 strategy more intensively anchors its approaches within the community, where people live, work, and gather. This community pivot not only supports MOH and civil society calls during COP development (*community leadership*), but aligns with global evidence that overwhelmingly demonstrates that community-led HIV interventions and holistic community engagement are critical to accelerating and sustaining reductions in equity gaps in achievement of 95-95-95 and 10-10-10 goals among vulnerable populations (*Pillar 5*). Community-centered programming also offers the dual benefit of advancing global health security by efficiently strengthening local capacity for preparedness and response to other outbreaks (*Pillar 3*).

At a practical level, this means assisting the MOH and communities to operationalize Uganda's new Community Health Strategy. COP23 priorities include: 1) Leveraging HIV-focused, health, and multisectoral community platforms to increase the reach, accuracy and saturation of HIV case finding, finding patients reluctant or unable to visit health facilities or who may not perceive themselves at risk; 2) Strengthening GOU Regional Referral Hospital (RRH) Community Health Departments to help them realize their potential for an expanded community service delivery footprint; 3) Enhancing the skills and confidence of Uganda's growing CHW cadre, who can deliver more convenient and trusted HIV prevention counseling and treatment literacy at their neighbors doorstep; 4) Empowering and funding youth- and women-led CSOs and networks of PLHIV to implement their innovative models to reach youth and women. HIV

clinical care will continue to decentralize and become integrated within community structures through the scale-up of differentiated service delivery models that increase the coverage and responsiveness of services (**Box 1.1**).

**BOX 1.1: Prioritized Differentiated Service Delivery Models for Scale-Up** *(Illustrative Examples)*

- **GOU Integrated Community Family-Centered Care Model:** This holistic approach better addresses the patient needs of PBFW, CLHIV, AGYW and their caregivers in enrolling and succeeding in HIV care. Under this model, CHWs, in collaboration with health facility staff, use the Client-Centered Service Delivery Audit tool, to address HIV service delivery gaps for the individual/family at household level, through approaches like assistance with age-appropriate family-centered disclosure, family/caregiver treatment literacy sessions, Caregiver Directly Observed Treatment for all non-suppressed CLHIV, intensified psychosocial support (PSS), and synchronizing medicine pickup for family members in care (*Pillar 1*).
- **DSDMs for Adolescents:** Adolescents experience unique structural, psychosocial, and socio-cultural barriers that impede their ability to access and stay in HIV prevention and care services. To address adolescent equity gaps, we will integrate community-based viral load bleeding within youth adolescent program support (YAPs) activities, liaise with boarding school matrons/nurses, provide treatment literacy and MMD guidance that enables adolescents to access and continue ART while away at boarding school and/or make plans for accessing ART MMD refills during school breaks, and offer PrEP enrollment and refills to AGYW at Safe Spaces through outreach healthcare workers (*Pillar 1*).
- **Enhanced Point of Care and Multi-disease Laboratory Testing:** HIV and TB patients often face troublesome barriers—including multiple appointments and long wait times for results—that impact their uptake of required care lab testing. PEPFAR Uganda will continue scaling-up point-of-care (POC) lab testing, which enables clients (and their clinicians) to quickly access lab results on-site with minimal wait time thereby enabling clinicians to make real-time patient care decisions. Multi-disease testing, enables one machine to run simultaneous lab tests for TB, HPV, and HIV (EID, VL), offering a "one stop shop" for clinicians and clients addressing multiple diseases (*Pillar 3*).
- **Community Retail Drug Distribution Point Model:** Extend the successful CRPDDP model, which has enabled 41,000 PLHIV to pick-up multi-month supplies of their HIV treatment at conveniently located private community pharmacies. We will scale-up to 147 health facilities and 200 pharmacies in COP23 and introduce PrEP pick-up for eligible at-risk clients to ensure clients remain on PrEP (*Pillar 1*).

***Develop and operationalize a Sustainability Framework and Roadmap:*** Led by the Prime Minister's office, PEPFAR Uganda will coordinate multisectoral stakeholders to develop the first-ever measurable Sustainability Framework and Roadmap (*Pillar 2*) that enshrines Uganda's approach, responsibilities, and targets for how HIV services will be delivered in the future and the health system required to realize that vision. We will build upon the successful approach used by PEPFAR Uganda to develop Uganda's successful 10-Year Supply Chain Roadmap for Self-Reliance (2022), which was developed with strong political will and cross-ministerial processes. Thanks to such advocacy, the GOU has indicated that it will increase its commodity budget by $13M in the FY23/24 budget, despite COVID-19 financial stressors. The sustainability framework will ensure investment alignment across domestic, external, and other financing sources to maximize efficiencies (and maintain equity) given PEPFAR Uganda's anticipated declining resource envelope in COP23 and beyond. It will adopt a whole-of-market approach to

sustaining the HIV response, developing transformative partnerships that extend beyond the GOU and PEPFAR to CSOs, NGOs, FBOs, training institutions, and private commercial entities (*Pillar 4*). The framework will extend beyond resource mobilization, however, additionally identifying locally appropriate, integrated service delivery models that are less resource intensive (*lead with data*).

***Monitor, mitigate, and adapt to the potential impacts of a hostile legal environment:*** PEPFAR Uganda is actively working with LGBTQIA+ CSOs to identify and implement multiprong service delivery program adaptations to navigate the challenging implementation environment, ensure continuity of services for LGBTQIA+ individuals, and address safety and security concerns at the time of SDS drafting (*community leadership*). PEPFAR Uganda will work with key population (KP) CSOs and DICs to scale up temporary and/or longer-term potential adaptations (*Pillar 1*), such as:

- Scale-up HIVST and KP-led peer referral apps, such as e-Health (*innovation*), that enhance enrollment and retention of KPs who may no longer gather at well-known hotspots.
- Engage MSM and transgender persons (TG) on potential innovations to increase viral load coverage (VLC), such as synchronizing medication refills with VL bleeding at "one stop" visits when clients come to pick up their medicine refills.
- Enhanced rapid response legal and social protections through referrals to other U.S. government (USG) human rights programming/hotlines and increased legal support through the LIFT UP Health Equity Incentive Fund (LIFT UP).
- Offering home-based deliveries of HIV commodities (ART, HIVST, PrEP, condoms and lubricants) from trusted KP peers or boda boda riders.
- Developing confidential reporting approaches that enable PEPFAR to capture the HIV cascade among LGBTQIA+ clients who may not visit DICs or self-identify.

**STANDARD TABLE 1.1: 95-95-95 Cascade: HIV diagnosis, Treatment and Viral Suppression**

| Table 1.1 95-95-95 cascade: HIV diagnosis, treatment, and viral suppression* | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Epidemiologic Data | | | | | | HIV treatment and Viral suppression | | | | HIV Testing and Linkage to ART Within the Last Year |
| | Total Population Size Estimate (FY23) | HIV Prevalence (FY24) | Estimated Total PLHIV (FY24) | PLHIV Diagnosed (FY23) | On ART | ART Coverage (%) | Viral Suppression (%) | Tested for HIV | Diagnosed HIV Positive | Initiated on ART |
| | (#) | (%) | (#) | (#) | (#) | | | (#) | (#) | (#) |
| Total population | 45,335,380 | 3.2% | 1,447,035 | 1,482,538 | 1,313,952 | 92.5% | 94.4% | 4,562,717 | 121,794 | 114,304 |
| Population <15 years | 20,255,392 | 0.3% | 68,938 | 73,408 | 57,969 | 65.6% | 84.0% | 260,611 | 5,054 | 5,259 |
| Men 15-24 years | 4,869,434 | 0.9% | 43,952 | 50,068 | 25,288 | 57.0% | 88.4% | 435,995 | 4,433 | 3,652 |
| Men 25+ years | 7,290,433 | 6.2% | 455,373 | 477,439 | 407,831 | 90.1% | 94.5% | 903,052 | 39,183 | 36,226 |
| Women 15-24 years | 4,835,754 | 2.4% | 114,633 | 148,587 | 79,089 | 71.1% | 91.9% | 1,389,287 | 24,139 | 22,201 |
| Women 25+ years | 8,084,367 | 9.5% | 764,139 | 733,036 | 743,775 | 102.7% | 95.8% | 1,573,778 | 48,985 | 46,966 |
| | | | | | | | | | | |
| MSM | 59,123 | 6.9% | 4,079 | 3,594 | 3,059 | 85.1% | 94.0% | 43,693 | 428 | 370 |
| FSW | 169,005 | 31.1% | 52,561 | 48,566 | 46,818 | 96.4% | 95.0% | 253,614 | 6,523 | 6,375 |
| PWID | 28,261 | 17.0% | 4,804 | 4,660 | 4,446 | 95.4% | 95.3% | 12,099 | 303 | 292 |
| People in Prisons | 176,606 | 12.0% | 21,193 | 17,166 | 16,445 | 95.8% | 92.3% | 45,855 | 967 | 926 |

**FIGURE 1.2: PLHIV, Treatment Coverage, and Viral Load Monitoring Coverage**

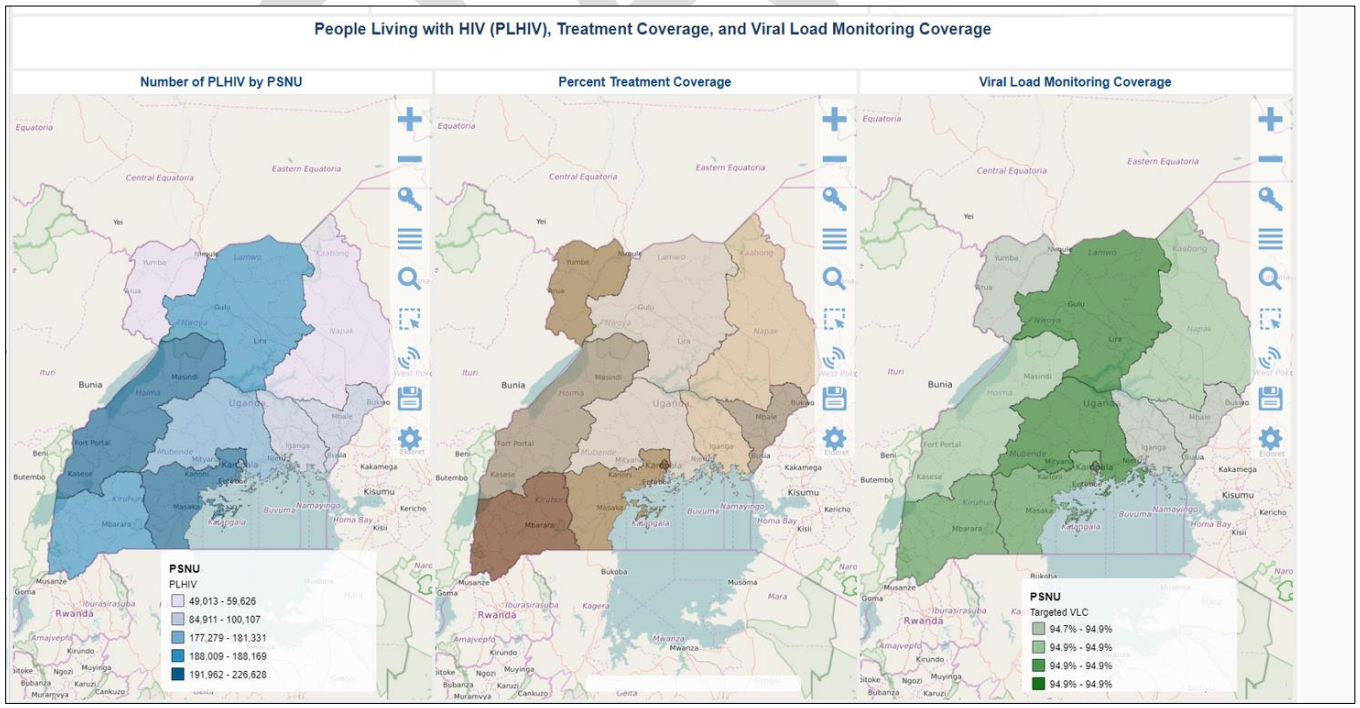



**TABLE 1.2: Current Status of ART Saturation**

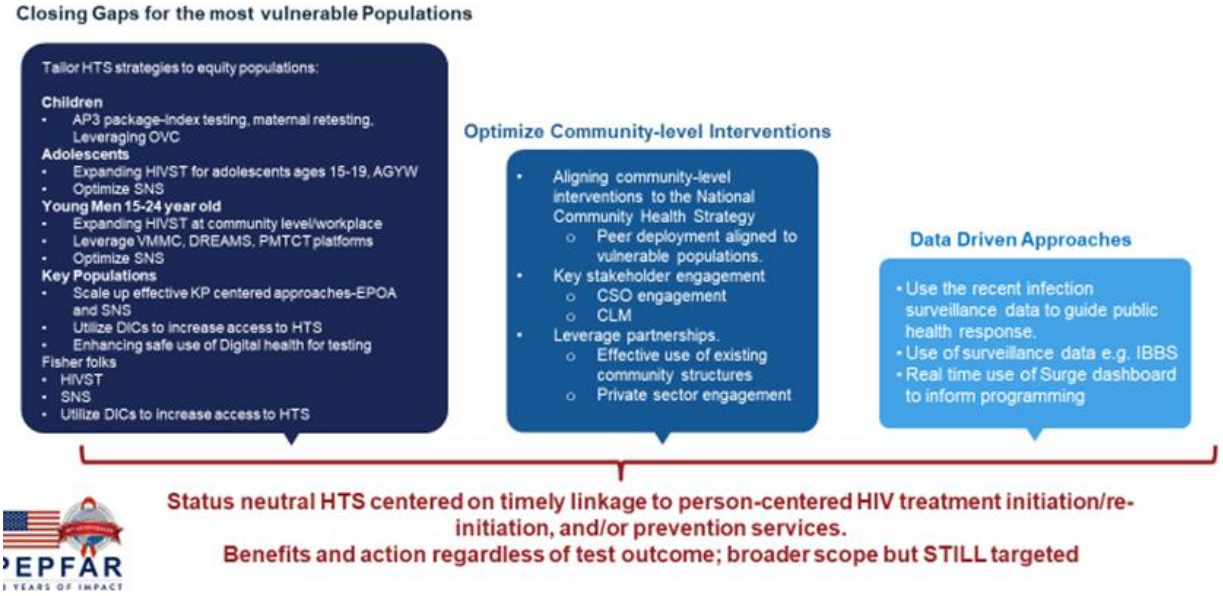
| Table 1.2 Current Status of ART Saturation | | | | | |
|---|---|---|---|---|---|
| Prioritization Area | Total PLHIV (FY24) | % of all PLHIV (FY24) | # Current on ART (FY22) | # of PSNU COP22 (FY23) | # of PSNU COP23 (FY24) |
| Attained | 49,013 | 3% | 44,254 | 13 | 36 |
| Scale-up: Saturation | 244,644 | 17% | 209,328 | 49 | 72 |
| Scale-up: Aggressive | 1,153,378 | 80% | 1,039,294 | 84 | 38 |
| Miltary | | | 21,076 | 1 | 1 |
| Sustained | | | | | |
| Central Support | | | | | |
| No Prioritization | | | | | |
| Total National | 1,447,035 | 100% | 1,313,952 | 147 | 147 |

# Pillar 1: Health Equity for Priority Populations

Health equity underpins all proposed COP23 activities. We have adopted an equity lens in COP23 development across pillars, ensuring that each intervention individually contributes to reducing HIV achievement gaps among vulnerable priority populations. Addressing such gaps across the HIV cascade is critical to achieving and sustaining epidemic control by 2030. Current Uganda HIV incidence and service delivery data supports this singular focus, as detailed throughout this SDS Pillar 1 sub-section. Despite improvements among general population adults, AGYW, Pregnant and/or Breast-Feeding Women (PBFW), children, KPs, and other Priority Population (PPs) each still face structural, biological, socio-cultural, and other challenges that hampers their identification, linkage to, and retention in HIV care. In consultation with the Government of Uganda (GOU) and civil society organization (CSOs), PEPFAR Uganda proposes three strategic pivots to address the main drivers of inequitable HIV outcomes in COP23. We will:

1. **REVOLUTIONIZE CASE FINDING**, identifying new HIV infections more efficiently among priority populations AGYW, children, adult men, KPs, and PPs). For example, only 79% of females 15-19 years old know their status (Spectrum 2023), even though young women account for 43% of all projected new HIV infections (UPHIA 2020-21). We have reviewed and retooled our case finding approach, shifting from an HTS modality focus to a population focus, with deeper community engagement. We will close the first 95 gaps for the most vulnerable populations, by tailoring and targeting HTS to equity populations (see **Figure 1.3**) and linking HIV negative clients to relevant HIV prevention services tailored to their specific needs. PEPFAR Uganda will increase its focus and effectiveness in finding male sub-populations to prevent infections among AGYW, with the strategic expansion of HIVST at community level.

**FIGURE 1.3: Revolutionizing Case Finding in COP23**




Implementation of status-neutral testing will ensure there are benefits and outcomes regardless of the test result and will support achievement and maintenance of epidemic control through a) active linkage of high-risk individuals to effective HIV prevention services and b) active linkage and re-engagement of PLHIV who are not on treatment. While the scope of HTS will be broader, implementation will remain targeted.

2. **IMPROVE THE AVAILABILITY AND QUALITY OF PATIENT-CENTERED SERVICES** at community level for priority populations. PEPFAR Uganda will collaborate with youth, KP, and PP-led CSOs to co-create more responsive differentiated service delivery (DSD) models that better meet the individual needs of sub-populations. Planned interventions, described below, include: 1) Scaling-up the Community Retail Drug Distribution Program (CRDDP) to reach more PLHIV with MMD and begin distributing an HIV prevention kit (which includes PrEP, HIVSTs, and condoms) to eligible PPs at conveniently-located community pharmacies, 2) Integrating community viral load (VL) bleeding within youth adolescent program support (YAPs) activities and targeted POC VL for young men to address gaps in VLC among adolescents, 3) Launching DREAMS (Determined, Resilient, Empowered, AIDS-Free, Mentored and Safe) NextGen which will roll out evidence-based *enabling interventions* that will reach at-risk AGYW living outside of DREAMS sub-national unit (SNUs) who face heightened HIV acquisition risk (in complement to the core DREAMS structural package). DREAMS NextGen will also provide targeted community-based violence prevention and gender norms interventions to adolescent boys and young men (ABYM) and PrEP demand generation, 4) blending of HIVST, index testing and social network testing with innovative virtual/digital interventions informed by and tailored to the sub-populations to increase demand for, and reach, of HIV testing services while reducing cost of person reached/diagnosed after initial outlays. Strengthened prevention and treatment literacy among the population and providers will enhance the success of status neutral testing.

3. **MITIGATING POLICY, LEGAL, STRUCTURAL AND HUMAN RIGHTS BARRIERS** that inhibit equity in HIV outcomes. This is more important than ever, given the increasingly concerning public discourse and rhetoric targeting LGBTQIA+ people. The potential impact extends beyond the LGBTQIA+ population. COP23 requires an intensified focus on decreasing stigma and discrimination (S&D) and increasing health service access at community level, as detailed in Key Populations SDS section.

Throughout, we will leverage three enablers to accelerate progress toward improved health equity for priority populations: Community leadership, innovation, and leading with data. The PEPFAR Uganda team and stakeholders wove examples of these enablers throughout the Pillar 1 sub-section. Unless otherwise noted, PEPFAR Uganda will continue to implement, scale-up, and monitor evidence-based HIV diagnosis, care, and treatment approaches as described in PEPFAR Uganda's COP22 SDS and reflected in COP23 Target Tables.

PEPFAR Resource Alignment

All COP23 PEPFAR Uganda Pillar 1 technical strategies and investments align to Uganda's national HIV response plans and roadmap as detailed in the **Core Standards section**, including the recently drafted MOH *Consolidated Guidelines for the Prevention and Treatment of HIV in Uganda* (Nov. 2022). This alignment is critical to advancing **Pillar 2: Sustaining the Response** and PEPFAR Uganda epidemic control approaches for COP23 and beyond.

*Stakeholder Engagement:* PEPFAR Uganda held extensive consultations with government, civil society, and multilateral stakeholders. Please see **Strategic Enablers: Community Leadership** for specific details on COP23 strategic planning consultations and joint priorities for Pillar 1, including review and discussion of 59 specific health equity requests within *The People's Voice Uganda Community Priority Recommendations* from civil society. These formal and informal consultations were especially critical in COP23 development given the heightened legal threats toward LGBTQIA+ individuals.

*Complementarity:* PEPFAR Uganda COP23 investments specifically complement and leverage national GOU, Global Fund (GF), and private sector investments to advance health equity for priority populations, in line with **Pillar 2**. PEPFAR Uganda held mapping and co-creation sessions in February-March 2023 where key stakeholders detailed their planned investments by priority sub-population, geography, and intervention to avoid duplication and identify areas for synergy. Under the children living with HIV (CLHIV) National Plan of Action, for example, the GOU agreed to continue to provide functional leadership, human resources for health (HRH), commodities and PHC resources, while PEPFAR Uganda will provide $29.5M in pediatric and preventing mother-to-child transmission (PMTCT) core HIV programming to support the plan. Non-governmental organization (NGO) Clinton Health Access Initiative (CHAI) committed a further $1M to finalize the pediatric Dolutegravir (DTG) pilot and pediatric advanced HIV disease (AHD) assessment, while Global Fund is focused on the scale-up of the YAPS program in additional non-PEPFAR districts.

*GOU:* PEPFAR Uganda agreed to advance specific GOU health equity priority activities within COP23, including (but not limited to):

1. Develop standard operating procedures (SOPs) and strengthen capacity of local partners and government to conduct small-scale KP and PP area population size estimates, in alignment with MOH requests. This methodology will provide more frequent and accurate data for targeting in complement to Integrated Bio-behavioral Surveillance (IBBS), at lower cost than national or large-scale IBBS efforts. We are in the process of transforming all IBBS sites into MoH KP sentinel surveillance system, nesting data collection, hotspot mapping and size estimates in KP programmes at KP selected and friendly health facilities. This will make KP surveillance cheaper and will reduce KP stigma and discrimination. To ensure the safety and security of the participants, PII will not be collected and will follow the MOH program adaptations for implementation of KP services.
2. Integrate PrEP distribution through the existing Community Retail Pharmacy Drug Distribution Point (CRPDDP) Model, which has reached 41,000 virally suppressed PLHIV with antiretrovirals (ARVs) at 61 health facilities and 101 local pharmacies. PEPFAR Uganda will support the scale-up of CRPDDP to 147 health facilities and 200 community pharmacies in COP23.
3. Use results from PMTCT Impact Evaluation and Modeling to plan for PMTCT pivots, including sustained support to selected high-volume health center (HC) IIs.

*Global Fund (GF):* Uganda's second largest HIV donor, GF drafted and submitted its $319.88M funding request 2024-2026, during the PEPFAR COP23 development period. PEPFAR Uganda staff participated in the GF concept note drafting, review, and validation of the proposal prior to its approval by the country coordinating mechanism (CCM) Board on March 20, 2023. GF representatives also participated in COP23 health equity consultations to reduce duplication to maximize HIV and TB commodity investment alignment: **Table 1.3** summarizes select complementary GF HIV prevention investments from the approved concept note. GF will also support complementary HIV care and treatment and HIV/TB investments—including YAPs scale-up, capacity strengthening for HIV drug resistance (HIVDR), and integrated management of common co-infections.

**Table 1.3: Illustrative Complementary PEPFAR-GF HIV Prevention Investments for COP23 and Beyond**

| ***Planned GF Investment (2024-2026)*** | ***How this Complements PEPFAR Uganda COP23 Investments*** |
|---|---|
| Procuring 30,000 Dapivirine vaginal rings (DVR) for AGYW and FSWs at-risk. | Supports scale-up of patient-centered HIV prevention technology. |

| | |
|---|---|
| Implementing robust needle and syringe exchange program for people who inject drugs (PWIDs). | Extends harm reduction services for PEPFAR-supported PWID clients at medication assisted treatment (MAT) clinics. |
| Supporting last mile condom distribution. | Doubles available supply of male and female condoms and lubricants. |
| Supporting 3 new DICs for FSWs as safe spaces and entry point for HIV services. | Adds additional reach of HIV services for KPs in non-PEPFAR-supported areas. |
| Expanding AGYW comprehensive prevention to 24 high-burden districts from 20 districts. | Complement/extends DREAMS package to additional districts within Uganda. |

Adolescent Girls and Young Women

Uganda's AGYW remain uniquely vulnerable to HIV: Early sexual debut, dropping out of school, and entrenched poverty predispose AGYW to unintended pregnancy and HIV. Recent HIV data show that females aged 10-24 account for 43% of *all* new HIV infections, despite accounting for 34% of the total female population. Additionally, it is challenging to find, diagnose, and link AGYW to treatment compared to their older counterparts. The AGYW clinical cascade stood at 64-95-87, compared to females >50 years at 92-95-87 (UPHIA 2020-21), a 28% difference in the number of younger females living with HIV who know their status as compared to older females. High gender-based violence (GBV) and violence against children (VAC) rates increase HIV acquisition and vulnerability, with the highest rates of sexual violence nationally among females ages 15-24 years (see ***Gender*** section below).

While linkage has improved in recent years, AGYW ART retention and viral load suppression (VLS) remains challenging. Diminishing caregiver oversight, lack of youth-responsive services, and inadequate preparation for the transition to adult HIV treatment drive treatment inequity. Higher treatment interruptions are experienced among 10–24-year-olds, with fewer numbers returning to care than older counterparts. Within this age band, females are more likely to interrupt treatment and less likely to return to care than males. As a result, females 15-24 only achieve 52.3% VLS (far below the 87% seen for women 50+) (UPHIA 2020-21). COP23 offers the exciting promise of more patient-centered and youth-responsive interventions that respond to the inequities of Uganda's AGYW, including, but not limited to, the deployment of new biomedical prevention options and DREAMS NextGen.

**PrEP:** PrEP remains a powerful tool in the combination HIV prevention arsenal for highly vulnerable Ugandan AGYWs. Improvements in PrEP screening, initiation, and continuity among AGYW continued in FY22 (**Figure 1.4**), thanks to PrEP messaging in safe spaces, intensified support from implementing partners, and use of the continuous quality improvement approaches to identify challenges and real-time course correction.

**FIGURE 1.4: FY22 PrEP Performance for AGYW**

## Improved PrEP screening, initiation, and PrEP continuity for AGYW, FY23Q1.

**FY2022 (Oct 2021-Sept 2022)**

| Population Category | KP_PREV | HTS_TST newly tested | HTS_TST_NEG | PREP_SCREEN | PrEP_ELIG | PREP_NEW | PrEP_CT | PREP_CURR | % HTS_TST | % HTS_TST_NEG | % PREP_SCREEN | % PrEP_Eligible | % PREP_NEW | % PrEP_CURR | % PrEP_CT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FSW | 243,080 | 200,916 | 194,260 | 126,551 | 73,334 | 62,625 | 36,011 | 98,636 | 83% | 97% | 65% | 58% | 85.4% | 41% | 37% |
| MSM | 38,837 | 36,511 | 36,076 | 18,843 | 11,834 | 8,205 | 4,305 | 12,510 | 94% | 99% | 52% | 63% | 69.3% | 32% | 34% |
| PWID | 10,322 | 9,401 | 9,095 | 7,272 | 3,991 | 3,462 | 2,088 | 5,550 | 91% | 97% | 80% | 55% | 86.7% | 54% | 38% |
| TG | 4,935 | 4,747 | 4,688 | 1,898 | 1,122 | 954 | 369 | 1,323 | 96% | 99% | 40% | 59% | 85.0% | 27% | 28% |
| PIP | 110,805 | 77,659 | 76,692 | 4,487 | 11 | 1 | 9 | 10 | 70% | 99% | 6% | 0% | 9.1% | 0% | 90% |
| Overall KP | 407,979 | 328,234 | 320,811 | 159,051 | 90,282 | 75,247 | 42,782 | 118,029 | 81% | 97% | 50% | 57% | 83.3% | 29% | 36% |
| (AGYW 15 - 19) | 17,944 | 15,540 | 15,124 | 12,425 | 9,144 | 8,584 | 2,175 | 10,759 | 87% | 97% | 82% | 74% | 93.9% | 60% | 20% |
| (AGYW 20 - 24) | 26,724 | 21,978 | 20,796 | 16,973 | 13,270 | 12,531 | 2,980 | 15,511 | 82% | 95% | 82% | 78% | 94.4% | 58% | 19% |

**FY2023Q1 (Oct 2022-Dec 2022)**

| Population Category | KP_PREV | HTS_TST newly tested | HTS_TST_NEG | PREP_SCREEN | PrEP_ELIG | PREP_NEW | PrEP_CT | PREP_CURR | % HTS_TST | % HTS_TST_NEG | % PREP_SCREEN | % PrEP_Eligible | % PREP_NEW | % PrEP_CURR | % PrEP_CT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Overall KP | 139,960 | 114,498 | 112,269 | 66,576 | 26,990 | 23,640 | 34,582 | 58,222 | 82% | 98% | 59% | 41% | 87.6% | 42% | 59% |
| PWID | 2,875 | 2,571 | 2,511 | 2,438 | 721 | 647 | 1,547 | 2,194 | 89% | 98% | 97% | 30% | 89.7% | 76% | 71% |
| MSM | 12,348 | 11,643 | 11,558 | 6,226 | 2,458 | 1,938 | 3,339 | 5,277 | 94% | 99% | 54% | 39% | 78.8% | 43% | 63% |
| PIP | 29,883 | 20,894 | 20,401 | 3,223 | 11 | 9 | 13 | 22 | 70% | 98% | 16% | 0% | 81.8% | 0% | 59% |
| FSW | 92,633 | 77,243 | 75,679 | 53,989 | 23,458 | 20,715 | 29,288 | 50,003 | 83% | 98% | 71% | 43% | 88.3% | 54% | 59% |
| TG | 2,221 | 2,147 | 2,120 | 700 | 342 | 331 | 395 | 726 | 97% | 98% | 33% | 48% | 86.8% | 33% | 54% |
| (AGYW 15 - 19) | 7,069 | 5,533 | 5,420 | 4,831 | 2,142 | 2,082 | 2,688 | 4,770 | 78% | 98% | 89% | 44% | 97.2% | 67% | 56% |
| (AGYW 20 - 24) | 12,875 | 9,525 | 9,227 | 8,225 | 3,426 | 3,371 | 4,493 | 7,864 | 74% | 97% | 89% | 42% | 98.4% | 61% | 57% |

PEPFAR
20 YEARS OF IMPACT

**Data source:** PrEP Tracker

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PEPFAR Uganda will increase PrEP provision to 89,700 AGYWs as part of PEPFAR's planned overall PrEP_NEW increase (from 180,000 in COP22 to 235,000 clients in COP23), with strong advocacy and support from People's Voice CSO representatives. COP23 is an exciting year to advance new PrEP products and approaches that advance health equity in Uganda, including event-driven PrEP and DVRs for at-risk AGYW (from GF), as described below. We will continue to scale-up proven evidence-based PrEP screening, enrollment, and monitoring approaches (including implementing HIVST within PrEP to ease required re-testing). We will rely heavily on the DREAMS platform to identify and screen eligible AGYW in 30 DREAMS districts.

*Dapivirine Vaginal Ring (DVR):* This woman-controlled HIV prevention product offers an additional HIV prevention method choice for eligible at-risk AGYW and FSWs unwilling or unable to take daily oral PrEP. Though PEPFAR Uganda will not procure DVRs, we will support the MOH to scale-up DVR as available at PEPFAR sites, in line with recently revised national guidelines and global PEFAR technical considerations. PEPFAR Uganda will leverage a planned GF DVR procurement (30,000 DVRs from 2024-2026; ~estimated 800 cis females annually) to increase availability and access among DREAMS AGYW wishing to use this HIV prevention method.

*CATALYST Study:* The Maximizing Options to Advance Informed Choice for HIV Prevention (MOSAIC) project, a global centrally funded PEPFAR project through USAID, will implement the Catalyst study in seven sites in Uganda. The CATALYST study aims to characterize and assess the implementation of an enhanced service delivery package providing informed choices of PrEP products (oral PreP, PrEP ring, and CAB-LA) among women in Uganda (and East and Southern Africa more broadly). Findings will help inform future CAB-LA scale-up among AGYW, along with the demonstration project above. PEPFAR Uganda will collaborate with the CATALYST study to identify cross-cutting lessons, implementation synergies (such as leveraging MOH training of

trainers (TOT) CAB-LA trainers), and strategies to improve efficiency and effectiveness of PrEP investments across the portfolio.

*PrEP DSD models:* PEPFAR Uganda will continue to consult with AGYW-focused CSOs and DREAMS participants to identify patient-centered differentiated service delivery model (DSDMs) and innovations to enroll AGYW and increase PrEP retention. These potentially include:

- Providing PrEP enrollment and refills to AGYW at Safe Spaces through outreach healthcare workers.
- Re-packaging PrEP to reduce stigma and improve acceptance among AGYW who fear social repercussions of PrEP being identified and linked to sex work or mistaken as ART.
- Scaling-up PrEP refills through the Community Retail Drug Dispensing Program, which aims to reach 500 clients through its initial PrEP pilot in COP23.
- Engaging AGYW CSOs and DREAMS participants to identify new DSDMs and adapted interventions from COVID-19 lockdowns (such as MMD) for eligible PrEP clients that retain AGYW clients and support their PrEP adherence.

**DREAMS:** DREAMS NextGen provides the technical framework and impetus to close the remaining AGYW new infection equity gaps that persist. PEPFAR Uganda has realigned DREAMS programming in COP23 to harness the catalytic power of *Enabling* DREAMS interventions, which accelerate HIV prevention in complement to the core DREAMS implementation in target SNUs. We will continue to build upon the promising practices from COP22, while introducing new shifts. In FY22, 75% of enrolled DREAMS beneficiaries completed a package of primary services. PEPFAR Uganda increased DREAMS district saturation across all age bands from four to seven SNUs by FY22/Q4 (of 24 total DREAMS districts). Planned DREAMS COP23 priorities and changes include:

*Re-aligning district categorization in high incidence/burden areas:* PEPFAR Uganda has realigned and categorized DREAMS SNUs using recent Uganda Naomi Model district estimates/UNAIDS incidence data, per **Table 1.4**, streamlining DREAMS in four SNUs with low incidence while implementing core DREAMS program in the remaining SNUs.

*Expanding the DREAMS program:* We will expand to two new districts: 1) Fort Portal City (based on the very high incidence at 0.96), and 2) Kayunga District (based on moderate incidence, high HIV burden, growing youth population, and its geographic location near Lake Victoria with high proportions of fisher folk (FF) and vulnerable AGYW). This is also responsive to the People's Voice priority for DREAMS expansion. PEPFAR Uganda also increased its DREAMS targets in COP23, placing special emphasis on improving the availability, quality, and responsiveness of primary and secondary DREAMS services for 10–14-year-olds, a current gap.

*Re-engineering the DREAMS package:* PEPFAR Uganda aligned the DREAMS package to NextGen guidance using both program and epidemiological data (**Table 1.4**). These changes will enable us to reach more girls more effectively, targeting the most vulnerable. We have streamlined DREAMS in low incidence districts to remove some components in the main core package.

**TABLE 1.4: Planned DREAMS Package Realignments for COP23**

| | Maintained Core DREAMS in Implementation | Streamlined DREAMS |
|---|---|---|
| **Incidence** | *Mid-moderate (>.3%-<.8%)*<br><br>**Saturated**:<br>Kyotera District, Gulu City, Gulu District, Lira District, Omoro District, Lyantonde District, Agago District, Lwengo District, Bukomansimbi District, Luwero District, Apac District, Kassanda District, Oyam District<br><br>**Partially Saturated**: Ssembabule District, Kwania District, Kalangala District<br><br>**Unsaturated**: Wakiso District, Kampala District, Mbarara District, Masaka District, Masaka City, Kwania District, Gulu City, Lira City, Fort Portal City (new), Kayunga District (new) | *Low burden (<.3%)*<br><br>Mubende District, Rakai District, Mukono District, Gomba District |
| **Keep** | • Screening for HTS eligibility<br>• Condom promotion and provision<br>• Contraceptive mix<br>• PrEP screening<br>• Economic strengthening<br>• HIV prevention curricula (Stepping Stones and Journeys Plus)<br>• No Means No (NMN)<br>• Education subsidy<br>• Norms Change – Strategic Assessments for Strategic Action (SASA) | • Screening for HTS eligibility<br>• Condom promotion and provision<br>• Contraceptive mix<br>• PrEP screening<br>• Economic strengthening<br>• HIV prevention curricula (Stepping Stones and Journeys Plus)<br>• NMN<br>• Education subsidy<br>• Norm Changes - SASA |
| **Remove** | Curriculum-based parenting/caregiver programs, financial Literacy & Village Savings and Loan Association (VSLA) (as part of primary package) | Curriculum-based parenting/caregiver programs, financial Literacy & VSLA (as part of primary package) |
| **Add** | • Use **model safe spaces** to offer sexual and reproductive health (SRH) package in communities.<br>• Community-based **youth-friendly corners** in DREAMS sub-counties aligned to sustainability agenda.<br>• Train HCWs for better inclusion and support for AGYW at health facilities. | • Train HCWs for better inclusion and support for AGYW at health facilities<br>• Intensive PrEP promotion<br>• ABYM – CBIM |

| | | |
|---|---|---|
| | • Intensive PrEP promotion.<br>• ABYM – Coaching Boys into Men (CBIM) and NMN. | |

***Engaging and supporting HIV Prevention for ABYM:*** In line with DREAMS NextGen, PEPFAR Uganda will provide community-based HIV and violence prevention interventions to ABYM using the PEPFAR-approved No Means No and Coaching Boys to Men curricula, within the community or where boys gather/schools. We will continue AGYW male partner characterization, and screen and refer partners for HIV prevention and treatment services.

***Identifying and targeting the most vulnerable:*** We will continue to intensify intentional targeting of at-risk AGYW for DREAMS screening and enrollment, including those who engage in transactional sex, have dropped out of school, are pregnant or breastfeeding, or are adolescent mothers.

***Leveraging enabling interventions to enhance DREAMS****:* PEPFAR Uganda will implement regional- and national-level enabling DREAMS structural interventions aimed at addressing inequities for AGYW beyond DREAMS districts. These interventions, proposed following extensive multi-stakeholder consultation, are highlighted in **Table 1.5**.

**TABLE 1.5: COP23 PEPFAR Uganda Planned DREAMS Enabling Interventions**

| | | |
|---|---|---|
| **National** | **Advocacy** | • Ministry of Education and Sports (MOES) to support Journeys Plus roll out in private schools.<br>• Develop age-appropriate HIV and Violence curriculum for secondary schools.<br>• Work with the MOES to strengthen the early warning system to prevent dropping out of school. |
| | **Systems** | Work with Ministry of Finance, Planning and Economic Development (MOFPED), Ministry of Trade (MOT) and Ministry of Gender, Labor, and Social Development (MGLSD) to create systems that track AGYW access to GOU economic empowerment programs. |
| | **Demand creation** | Demand generation for PrEP. |
| **Regional** | **Advocacy** | Engagement of faith leaders through Dioceses not at district level that gives it a regional focus. |
| | **Systems** | • Additive regional level interventions in GF districts.<br>• Setting up safe spaces at sub-counties that we will transition to districts. |
| | **Norms change** | • Train Faith leaders at regional level for SASA faith.<br>• Use RRH structures to train TOTs for community advocates. |
| | **Demand creation** | Demand generation for PrEP. |

**Strengthening ART linkage and retention:** As noted, AGYW experience greater interruptions in treatment and subsequently lower VLS. Treatment interruption drivers include non-disclosure, stigma, and discrimination for those in- and out-of-school. Scaling up enhanced caregiver and peer-led literacy, supported disclosure, and expansion of YAPS, will help address these gaps in COP23.

**YAPS**: By the end of COP22, all districts will have trained YAPs who can provide peer-to-peer services for disclosure and adherence support to 10–24-year-old AGYWs, as well as support ART enrollment, treatment continuity, VLC, and VLS for this sub-population. PEPFAR will increase overall YAPS coverage within existing districts in COP23, which currently stands at an average of 31% for districts with high numbers of 10–24-year-olds active in care, prioritizing sites/districts with high interruptions in treatment (IIT). PEPFAR Uganda will work with the MOH to review and potentially modify the current YAPS peer educator requirements to ensure they enable adequate enrollment of AGYW YAPs, as some locations have failed to identify eligible YAPs. These peer educator requirements include having disclosed their HIV status, willingness to publicly discuss their status, having achieved VLS, being able to read and write English, and being available to volunteer given school/work needs.

**Scale-Up AGYW-Responsive DSD Models:**
***MMD:*** PEPFAR Uganda will increase enrollment of more adolescents on MMD through addressing barriers. Health workers, for example, often fear that weight changes among adolescents will lead to inadequate dosing if these clients get MMD. Under the guidance of MOH and MOES, we will liaise with boarding school matrons/nurses, providing treatment literacy and MMD guidance that enables adolescents to access and continue ART while away at boarding school and/or make plans for accessing ART MMD refills during school breaks. Other COP23 priorities include:

- Train/monitor health workers at ART sites to use the Client Preference Tool at each facility visit for adolescents (and all PLHIV) to ensure the client's ART is delivered in the model that best serves their needs and individual preference.
- Extending the successful CRPDDP to include stable PLHIV ages 15-19, increasing access to ART refills closer to home or school.
- Routinely use the Client Audit Tool to facilitate timely identification of AGYW eligible for VL testing and other services and support community based VL bleeding for eligible adolescent MMD clients.
- Scale-up evidenced-based family-centered care models that better address the patient needs of AGYW and young people. These models include assistance with age-appropriate family-centered disclosure family/caregiver treatment literacy sessions, engagement with peer educators, participation in PSS, synchronizing medicine pickup for family members in care.

**Treatment optimization**: PEPFAR Uganda will use program data to identify and transition AGYW eligible for DTG transition. Accelerating treatment optimization will further improve VLS among this subpopulation, which is suboptimal compared to adult women.

**Gender Equality**

High GBV and VAC rates in PEPFAR Uganda focal regions continue to impede access to, uptake of, and retention in HIV services across the clinical cascade and drive new infections through sexual violence. Both GBV cases and post-violence service uptake are concentrated in the central, western, South West, and North East sub-regions (Uganda Demographic and Health Survey [UDHS] 2016). In COP21, 191,176 individuals accessed post-violence clinical care services to address emotional, physical, or sexual violence at PEPFAR sites, an increase from previous years. This is due in part to increased availability, accessibility, and awareness of post-violence care services at health facilities and community level. In addition, capacity building of health workers in the World Health Organization (WHO) Listen, Inquire, Validate, Enhance Safety (LIVES) approach and violence against children (VAC), demand generation and community mobilization through the Times Up Campaign, Every Hour Matters campaign, SASA! evidence-based curriculum roll out in the DREAMS districts, and community engagement with key influencers contributed to increased uptake.

AGYW are at higher risk than other sub-populations for GBV: 40% of all 98,126 individuals who received PEPFAR-supported post-violence care services had experienced sexual violence were females ages 15-24 (FY22/Q4 PEPFAR program data). Critical HIV prevention post-violence care access and uptake remains limited, with only 12% of sexual and gender-based violence (SGBV) survivors accessing and initiating PEP in FY22.

More broadly, unequal power dynamics between men and women and harmful gender norms persist, making women and girls more vulnerable to HIV and threatening progress toward UNAIDS 10-10-10 targets. Rollout of the MOES Sexuality Education Framework, launched in 2018 to provide students in primary and secondary schools with basic information on sexuality and gender equality issues, remains stalled.

At a systems level, GBV and gender equality data gaps continue to constrain PEPFAR Uganda's ability to target gender inequity interventions most effectively and address barriers. The last Violence Against Children Survey (VACS) and UDHS were conducted in 2015 and 2016, respectively (as the 2021 national survey on violence against women and girls mainly focused on intimate partner violence (IPV)). As a result, PEPFAR Uganda over-relies on program data, which may influence the under- or over-targeting of interventions. There is an urgent need in COP23 to accelerate the availability of integrated and quality GBV and trauma-informed services across programs and platforms where women, adolescents, and children seek healthcare services.

The sub-section below highlights key gender and GBV prevention and response interventions that have been strategically integrated throughout PEPFAR Uganda's COP23 plans for HIV prevention and clinical cascade services, including DREAMS, Orphan and Vulnerable Children

(OVC), PrEP, and KP programming, to address the social and structural gender- and GBV-related barriers to achieving sustained HIV epidemic control and the 10-10-10 UNAIDS targets for societal enablers. ***Please note that the SDS incorporates gender-sensitive and transformative interventions throughout the relevant pillars, as it is a cross-cutting priority that impacts 5x3 achievement***.

**GBV Prevention:** PEPFAR Uganda will support the GOU and communities to address gender inequality and GBV as social and structural barriers to sustained epidemic control. Specific COP23 priorities include:

*Implement evidence-based community-level gender norms interventions*: PEPFAR Uganda will introduce and rollout Sexual Violence Against Children (SVAC) 101, an evidence-informed PEPFAR community-level norms change intervention that educates faith and traditional leaders and community leaders on sexual violence against children and mobilizes commitments to preventing and responding to SVAC. PEPFAR will prioritize SVAC 101 rollout in high GBV and VAC prevalence districts within the Central, North Eastern, South Western, and Western regions to address heightened HIV vulnerability among children (2015 VAC survey and APR 2022 program data).

PEPFAR Uganda will also support continued scale-up of additional proven GBV and gender community norms change interventions in communities with high GBV against AGYW, children, and KPs. Planned COP23 interventions include: SASA!, Journeys Plus, and NMN. We will implement integrated campaigns to increase community GBV/VAC awareness, address stigma and discrimination, and increase demand generation for HIV-GBV services at the community level. The "Times Up" and "Every Hour Matters" campaign will be rolled out and scaled up in the districts with high incidence of GBV/VAC as will community mobilization activities that address harmful gender norms that sanction and perpetuate GBV and VAC, targeting parents/caregivers, faith and traditional leaders, male partners of AGYW, and other community influencers.

*Scale-up male engagement strategies that promote HIV service uptake*: As noted above, ABYM and men access HIV testing and ART enrollment at lower rates than women due to structural barriers and gender norms. In COP23, PEPFAR Uganda will encourage the integration of men and boy-focused evidence-based approaches through scaling-up CBIM to deliver primary prevention through promotion of healthy relationships, healthy decision making and sexual consent, as well as strengthening linkage to HIV testing and care services.

*Strengthen gender integration in DREAMS and OVC districts:* PEPFAR Uganda will enhance gender and GBV linkages, coordination, and integration in the 30 COP23 DREAMS districts. This approach will reinforce PEPFAR investments, strengthen the enabling environment for HIV prevention in communities with DREAMS participants, and support local gender norms change. PEPFAR Uganda will sensitize DREAMS participants and communities to the availability of and referrals to the 20 GOU District Action Centers established to prevent and respond to VAC. Conversely, PEPFAR Uganda will sensitize DREAMS participants on the availability of the GF-

supported SafePal, an interactive app that enables users to confidentially report sexual violence cases and get linked to nearby support services that was rolled out in 135 districts. PEPFAR Uganda will strengthen linkages between community-based HIV and GBV prevention interventions and clinical post violence care services.

Beginning in COP23, we will apply DREAMS funds for evidence-based violence prevention in 10–24-year-old ABYM (see **DREAMS** sub-section). We will also ensure that all those enrolling individuals into DREAMS and conducting OVC case management are trained on how to ask about the experience of violence in an age-appropriate and gender sensitive manner; how to provide age- and developmentally appropriate first-line support LIVES; and how and where to refer clients to local clinical and non-clinical violence response services.

**GBV Response:**
*Strengthen targeted GBV case identification across the HIV cascade:* PEPFAR Uganda will provide TA to HIV sites to implement a hybrid GBV case finding approach of using both routine and clinical enquiry, strengthening its use in index testing and HIV care/treatment in COP23. Under this strategy, care providers inquire about GBV as part of safe and ethical index HTS and partner notification services (PNS) and in PrEP provision (rather than universally). Clinical inquiry occurs during HIV care and treatment services, especially for at-risk populations like KPs and AGYW and adult PLHIV. We will train HCWs and provide supportive supervision to identify potential signs and symptoms of violence, provide a minimum post-violence care (PVC) package, improve quality of clinical PVC, and make appropriate referrals.

*Increase access to post violence care for timely post-exposure prophylaxis (PEP) uptake:* PEPFAR Uganda will ensure all HIV care and treatment sites integrate gender-sensitive, age-appropriate, and trauma-informed post-violence care across the HIV care cascade service delivery points including KP, OVC, PrEP, DREAMS, care and treatment, index testing, and PrEP. The minimum package will include: rapid HTS with referral to care and treatment as appropriate, PEP (if within 72 hours), sexually transmitted infection (STI) screening/testing and treatment, emergency contraception (if within 120 hours),[9] clinical care of injuries and other medical threatening conditions, forensic interviews and examinations, counseling, and referral (for legal services, child protection services, longer-term psychosocial support, shelters, economic strengthening services, education, and other community wrap around services).

HCWs will also link patients as relevant to other critical HIV prevention, testing, and treatment services; to care for serious/life-threatening medical issues; and DREAMS, OVC, and KP programming. PEPFAR Uganda will link GBV survivors to PrEP and support the "PEP-to-PrEP bridge" for survivors of sexual violence who complete the full course of PEP. Uganda will train HCWs to use the newly delivered post-rape kits and train HCWs and medical records teams in the new HMIS GBV tools (registers, screening tools, protocols, and policies).

9 Please note that PEPFAR Uganda does not procure EC, but ensures sites stock as part of supply chain strengthening activities/analysis as part of MOH guidelines.

*Ensure adherence to WHO GBV and VAC first line support:* PEPFAR Uganda will provide TA to all sites for training of trainers, supportive supervision, and mentorship and coaching to ensure all PVC sites implement Listen, Inquire, Validate, Enhance Safety, Support, Child and Adolescent friendly environment and Caregiver Support (engaging non offending caregivers) (LIVES CC) – new for COP23.

*Improve quality of post-violence care*: PEPFAR Uganda will continue to roll out the GOU GBV quality assurance (QA) tool to all supported sites offering PVC, ensuring each health facility conducts the GBV QA tool at least once annually. This tool, which was adopted by MOH and rolled out in 2018, has increased the quality and completeness of service availability, facility readiness, patient identification, care, referral, and reporting for PVC services. In COP23, PEPFAR Uganda will strengthen HIV/GBV health systems and service delivery through training health workers to provide age- and developmentally-appropriate first-line support (LIVES CC), provide basic, age-appropriate counseling and psychosocial support to better meet the mental health needs of survivors, provide referrals and support to access local clinical (e.g., STI; family planning [FP]; maternal, newborn, and child health [MCH]; etc.) and non-clinical services (e.g., longer-term psychosocial support, shelter services, economic empowerment activities, etc.) that will assist with continued recovery. We will also train and provide supportive supervision to health workers to forecast and order commodities such as PEP, emergency contraception, and STI drugs on time for facility use, a current challenge. **Figure 1.5** depicts the performance of health facilities by GBV performance domain.

*Strengthen the PEP cascade:* Eighty-six percent (86%) of eligible SGBV survivors-initiated PEP, 59% completed their course, 62% completed 3 follow-up visits, and 2% of survivors (67 people) who completed PEP were found to be newly infected with HIV after three months (FY23/Q1).

**FIGURE 1.5: GBV Service Delivery Quality by Health Facility Level (FY23/Q1)**

## Quality of GBV service delivery by Health facility level

| Health Facility Level | Domain 1. Availability and appropriateness of services | Domain 2. Facility Readiness and Infrastructure | Domain 3. Identification of Patients who have experienced IPV or SV | Domain 4. Patient-centered clinical care and communication | Domain 5. Forensic Examination and handling of evidence | Domain 6. Referral system and follow up of patients | Domain 7. Training and quality improvement | Domain 8. Health care policy and provision | Domain 9. Outreach | Domain 10. Reporting and Information systems |
|---|---|---|---|---|---|---|---|---|---|---|
| Clinic | 84% | 79% | 83% | 74% | 6% | 88% | 74% | 86% | 64% | 80% |
| HC II | 79% | 47% | 70% | 79% | 14% | 53% | 36% | 34% | 54% | 64% |
| HC III | 90% | 77% | 88% | 86% | 34% | 78% | 66% | 71% | 83% | 88% |
| HC IV | 89% | 83% | 92% | 92% | 30% | 82% | 69% | 91% | 83% | 90% |
| Hospital | 96% | 90% | 94% | 92% | 30% | 81% | 76% | 103% | 106% | 97% |
| RRH | 93% | 94% | 96% | 97% | 50% | 89% | 93% | 100% | 100% | 96% |
| Overall | 88% | 74% | 86% | 85% | 29% | 76% | 63% | 71% | 80% | 85% |

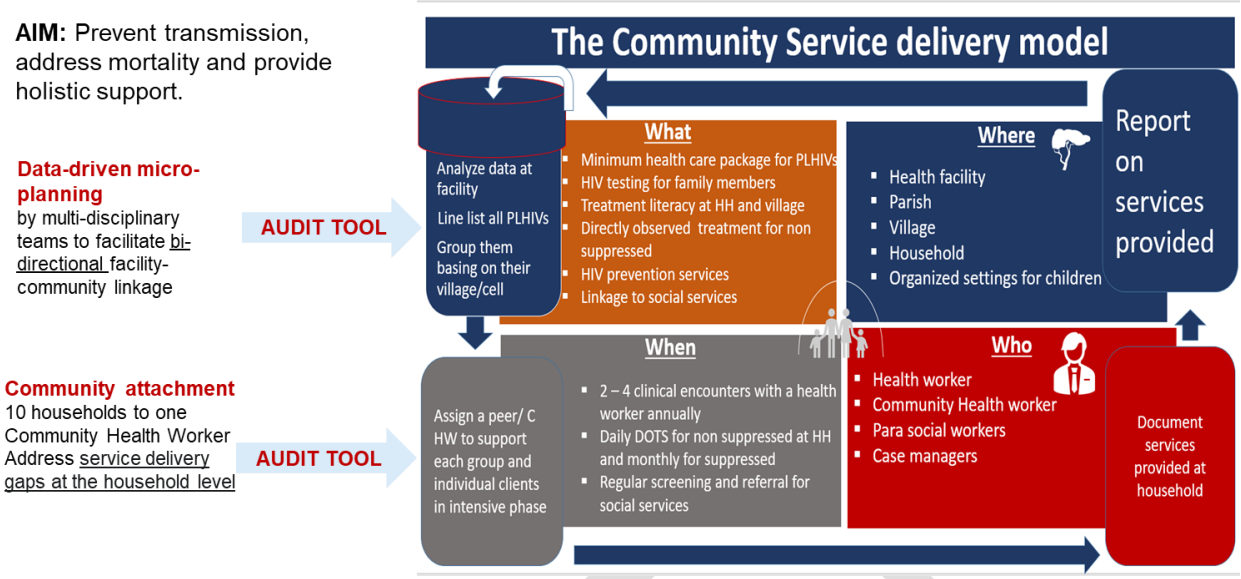
## CHILDREN AND PREGNANT AND BREASTFEEDING WOMEN

Substantial inequities persist across the clinical cascade for pregnant and breastfeeding women, infants, children, and adolescent living with HIV (ALHIV) (*see data below*). Closing PMTCT and pediatric equity gaps requires a paradigm shift in community-focused and holistic care. The sub-section below highlights key COP23 priorities and pivots to scale-up innovative and proven differentiated service delivery models that meet clients where they are to address persistent HIV outcome inequities seen among these vulnerable sub-populations. In line with planning level letter (PLL) guidance, PEPFAR Uganda will maintain its funding levels for pediatrics, PMTCT, and AP3.

**Overarching Patient Centered-Care Strategies:**

*Integrated Community Family-Centered Model:* PEPFAR Uganda will support the MOH to advance its integrated family-centered care model in COP23 to strengthen HIV performance and address equity gaps among PBFW, infants, and children (**Figure 1.6**).

**FIGURE 1.6: GOU Integrated Community Family-Centered Model**




This integrated community-facility approach, which has been launched via an initial training in three regions in COP22, will advance pediatric HIV improvements among vulnerable populations through:

- Using real-time data electronically to identify the most vulnerable clients (those who have missed services or meet certain risk factors), enabling more effective deployment of scarce human resources.
- Deploying CHWs (1 per 10 households) to provide services, linkages, and follow-up, including social services and livelihood opportunities to address structural barriers to positive HIV outcomes.
- Using the automated Client-Centered Service Delivery Audit tool (**Box 1.2**), adopted by the MOH in COP22, which enables HCWs and CHWs to track uptake of key care and treatment services by individual client electronic medical records (EMR). The audit tool will be used for data-driven micro-planning by multi-disciplinary teams to facilitate bi-directional facility-community linkage, quality service delivery and coverage. In COP23, PEPFAR Uganda will automate and scale its use to all EMR sites.

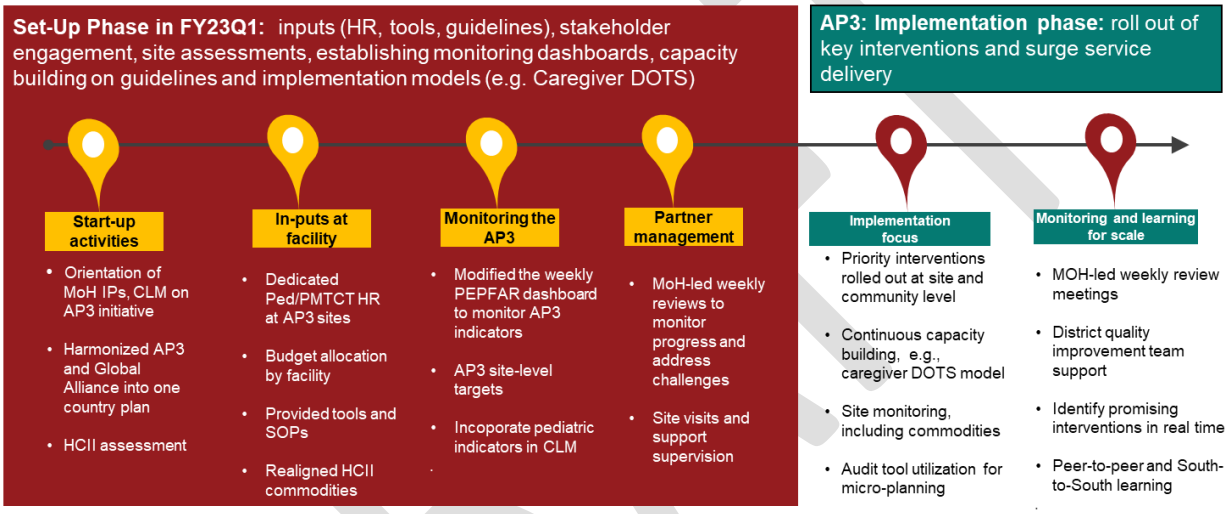
**BOX 1.2: The Client-Centered Service Delivery Audit Tool: How It Works**

- Used to plan and provide all the HIV-related services the client is eligible for – at either the facility or community.
- The clinic team uses clinical charts and EMR to audit each client's needs by analyzing the color-coded auto-generated dashboard to identify service needs prior to the next visit.
- Health workers update the audit tool after the visit, take corrective action for those who missed services, and review the colored dashboard to plan for subsequent client appointments.
- Review summary of indicators for the clinic(s) to identify mostly missed services, analyze associated root causes, and implement continuous improvement to address them.

**Scale-Up Accelerating Progress in Pediatrics and PMTCT (AP3):** AP3 is PEPFAR Uganda's flagship, integrated pediatric HIV prevention and treatment initiative aimed at tackling pediatric and PMTCT inequities. It has three objectives aligned to PEPFAR global AP3 and in support of

the GOU National Action Plan to End Pediatric HIV and the Global Alliance to end HIV by 2030: Objective 1: Reduce new child infections in children <10 years through addressing gaps in the PMTCT program by 50% globally; Objective 2: Rapid identification, linkage, and treatment of children not yet on ART to increase coverage, including those lost to care; and Objective 3: Increase rates of pediatric viral load suppression to 95% and reduce mortality. Launched in COP22, PEPFAR Uganda scaled-up and surged PMTCT and pediatric prevention, care, and treatment support at 980 PMTCT, 579 pediatric, and 575 HCII sites (which collectively accounted for 80% of pediatric treatment and PMTCT volume), focusing on setting up systems, addressing HRH and tools inputs, and stakeholder engagements. Uganda will move to the implementation phase in COP23, per **Figure 1.7**, ensuring every infant, child, adolescent, and PBFW accesses the services that they need.

**FIGURE 1.7: PEPFAR Uganda AP3 Scale-Up**




**Pediatric and PMTCT Data Monitoring and Use:** PEPFAR Uganda will continue to use the modified weekly PEPFAR surge dashboard to monitor AP3 progress and real-time program adaptations, which enables custom indicators PBFW VL coverage and suppression, age disaggregation to show <15 year old age band data, targets for the <15 years age band, and filter the accelerated progress in pediatrics and PMTCT (AP3) sites as part of the COP22 case identification surge, intensive data reviews will be conducted on a weekly basis to monitor progress and identify performance gaps.

**Specific Eliminating Mother-to-Child Transmission Plans (MTCT):**
MTCT transmission rates in Uganda remain less than <2% (AP3 scorecard), yet three major sources continue to drive new infections: 1) Women who drop off ART during pregnancy and breastfeeding (50%); 2) women who become newly infected with HIV during pregnancy and breastfeeding (30.6%), and 3) women who start ART late in pregnancy (19.4%). PEPFAR Uganda will zero-in on sources of new infections in children due to MTCT in COP23. While Uganda achieved high initial HIV testing and ART coverage and VLS among PBFW, persistent EID positivity continues and there are low rates of maternal re-testing in pregnancy with only 48% of eligible pregnant and breastfeeding women getting retested for HIV at FY23Q1 in PEPFAR-

supported sites. COP23 requires re-dedicated and innovative efforts to address plateaued VLS among PBFW.

**Finding and Diagnosing New HIV Infections Among PBFW and Infants:**
*Optimize PMTCT testing:* More than 40% of HIV positive women are identified through the PMTCT platform. PEPFAR will continue to focus on increasing maternal retesting and active follow-up of HIV-negative pregnant women in ANC/FP clinics to prevent and identify new HIV infections. Integration of PMTCT/early infant diagnosis (EID) in the Expanded Program on Immunization will be intensified in COP23 through TA and training to find new cases, strengthening the capacity of MCH testers to ensure provision of quality HIV testing.

*Optimize index testing:* Index testing remains a critical intervention for reaching undiagnosed HIV-positive women ages 20+ years. We will scale-up the integration of caregiver-assisted HIVST for children aged 2-14 years into index testing, launched in COP23. PEPFAR Uganda will also integrate HTS and HIVST within the DREAMS and OVC platforms, to reach undiagnosed AGYW and PBFW.

*Continue recency testing and use findings to enhance case identification:* Uganda will use recency data to track outbreaks of new infections and inform targeted geo-case finding at 1,400 sites. All HIV-negative adolescents and young women will be linked to appropriate prevention services.

**PrEP Expansion:** PEPFAR Uganda will increase its PrEP_NEW targets for PBFW from 16,000 to 27,118, at the request of the GOU and increased need. If approved, PEPFAR Uganda anticipates supporting the GF in its planned PrEP expansion at PMTCT sites, as detailed in its 2024-2026 concept (to increase from 500 to 1,200 sites). PEPFAR will provide TA to GF sites with PrEP in the PEPFAR-supported regions. While this GF expansion falls short of the 4,600 GOU PMTCT site target, it represents a substantial potential increase in PrEP coverage for eligible PBFW testing negative.

**PMTCT/EID service expansion:** PEPFAR will continue to expand comprehensive PMTCT/EID services to HCII to reach mothers and infants where they are (at lower-level and nearby health facilities within the community), in alignment with the October 3, 2022, MoH circular. In FY23, the GOU extended PMTCT to 950 high-volume ANC/PMTCT HCIIs and satellite clinics, increasing access to 250,000 mothers and their infants. In COP23, PEPFAR will build on COP22 support, consolidate functionality and service delivery at the 575 PEPFAR-supported HCII including maintaining peer mothers and improving reporting along the PMTCT and HIV exposed infant cascades. PEPFAR will continue to expand enrollment of HIV-exposed infants (HEI) into OVC services to improve retention in care throughout breastfeeding. We anticipate that GF will support PMTCT/EID expansion to a further 2,100 HCII per its recently submitted concept. PEPFAR Uganda will liaise closely with GF to ensure HCII service packages are harmonized.

**Maternal retesting for HIV:** PEPFAR Uganda will intensify efforts to improve maternal retesting through the AP3 platform. MOH, with support from PEPFAR is developing SOPs, job aids to

standardize maternal retesting in COP22. We'll continue to work with MoH to refine and rollout SOPs and job aids on maternal retesting in COP23; improve maternal literacy to empower PBFW to demand for maternal retesting; and strengthen the processes to identify eligible women and minimize missed opportunities for retesting (especially at Young Child Clinics, outreaches, and other clinics).

**Linkage to and retention in ART:** PEPFAR Uganda will intensify peer-led programming for PBFW. In consultations with CSOs and MOH, we found that peers (e.g., Mentor Mothers) are engaging in other tasks beyond their scope, like drug distribution, leaving them with no time to support ART adherence and address stigma. Meeting participants recommended the rollout of the new community model (which includes attaching each patient to a peer), directly observed therapy (DOTS) for non-suppressed PLHIV, and standardizing case load. PEPFAR Uganda will align the peer-led approach with the MOH family-centered integrated community approach, creating a comprehensive service delivery package for mother-infant pairs (MIPs) and documented final outcome for HEI at 18 months. We will also work with CSOs and sites to conduct root cause analysis to identify specific gender-related barriers to uptake and retention in treatment services to inform PMTCT and other programming (e.g., need permission from their partner to test for HIV; if their status is disclosed, worried that their partner will leave them, fearful of intimate partner violence, fearful of appearing sick or weak).

**VLC:** To ensure equitable access to testing as well as efficient and effective delivery of services, PEPFAR Uganda has worked with the National Health Laboratory and Diagnostic Services (NHLDS) department of MOH to scale-up impactful use of POC testing sites from 133 (FY21) to 305 (FY 23) sites across all geographical areas in line with the recommendations of the diagnostic network optimization exercise. These platforms include the m-PIMA Analyzer and GeneXpert equipment, which due to their capacity, will be used to enhance testing efficiency through diagnostic integration. In this way PEPFAR hopes to achieve optimized HIV VL, EID, Tuberculosis (TB), advanced HIV disease testing, and testing for other pathogens – such as the Human Papilloma Virus, COVID-19, Hepatitis B among others. Despite this good coverage, there is still sub-optimal utilization, with almost 20% of EID tests done on the POC testing platforms. The complementary use of POC and centralized conventional instruments which have high throughput, for analysis of both plasma and dried blood spot (DBS) samples will increase VL and EID testing coverage.

In COP23 (FY 24), PEPFAR Uganda will continue working in collaboration with NHLDS and the AIDS Control Program (ACP) to scale-up POC testing coverage. The challenges of data connectivity for POC platforms, patient treatment literacy, reporting and real-time patient-centered results return will be addressed. PEFAR will support MOH/ACP in demand creation and outreach efforts for all POC platforms, focusing on high volume and hard-to-reach locations, which in turn will improve EID coverage for infants and VL coverage among populations, such as pregnant and breastfeeding women (PBFW), infants, children, and adolescents. PEPFAR will work with Mentor Mothers and peers to continue to engage in demand creation and improve patient literacy to ensure increased utilization of POC testing platforms. In addition, PEPFAR Uganda will continue working in collaboration with NHLDS and

ACP to increase uptake of PMTCT/pediatric-related testing at Health Center IIs through scaling up AP3 implementation.

**Closing Gaps in the Pediatric Cascade:**
Ugandan CLHIV continue to experience highly disproportionate case finding and treatment gaps, as reflected in the clinical cascade (72% PLHIV diagnosed/know status – 72% linked to treatment – 60% VLS [SPECTRUM Dec. 2022 estimates]; 72%-100%-84% [MOH Conditional DHIS2 estimates Dec. 2022]).10

An estimated 80% of undiagnosed CLHIV under age 10 years (147,064) live in six regions (Central 1, Mid-Western, Mid-Northern, Central 2, Southwestern, and East Central), reflecting a need for concentrated and intensified case finding efforts and multisectoral collaboration to move the needle on finding these children in these regions. Persistent treatment interruptions, particularly for children ages six months and older on treatment, contributes to poor and plateaued VLS among children (at 84%). Health systems barriers contribute to pediatric under-performance, including ineffective coordination among GOU community structures and multisectoral community development programming, supply chain issues, and limited use of individual-level pediatric client data and CLHIV population estimates to guide clinical care and interventions.

**Pediatric Case Finding:** In COP23, Uganda will scale-up successful case finding interventions to find the remaining undiagnosed children, who primarily live within six sub-regions. These priority approaches include:

- Mapping unique populations to find children unlinked to care, such as those without an index parent in care and those who do not access care routinely, such as children of fisher folks or market vendors, children in kinship care, children living on the street, etc.
- Strengthening index testing of children of index clients and siblings HIV-positive children below 19 years of age.
- Scaling-up caregiver assisted HIV self-testing for children aged 2 -14 years in index/OVC households and adolescents/OVC to improve access and linkage to conventional HIV testing for those with a positive HIVST.
- Optimize testing at out-patient department TB clinics.
- Increasing numbers of new CLHIV are identified at Private Not-for-Profit (PNFP) sites (14.6% - > 20.96%), so this may be an important source for identifying future new patients.

**BOX 1.3: Launching MOH-Supported Munonye Campaign 2023-2024** *(to find the positive child)*
PEPFAR Uganda will work with the MOH to launch Munonye Campaign nationally in Fort Portal City in Mid – Western Uganda in COP23. Kabarole district features the highest number of new infections

10 Please note that national pediatric HIV cascade estimates are currently under review/discussion, following recognition that the previous UPHIA 2020-2021 revealed significant disparities in cascade elements when compared to routine program data and SPECTRUM estimates. Conditional data presented reflects stakeholder agreement on triangulation methodologies and best conditional estimates at the time of analysis.

among adolescents and young people (close to 1%), making it an ideal starting point. The campaign will leverage the other existing community health strategies/campaigns implemented at household level in the communities, such as TB cast, HTS surge efforts, CQI, the integrated community model and AP3 initiative to include pediatric case finding efforts. The campaign will be conducted quarterly, in a phased manner to reach priority districts, beginning with the sub-regions with the highest suspected number of undiagnosed children (Phase 1: Central 1, Mid-Western, and Mid Northern; Phase 2: Central 2, South-Western and East Central; Phase 3: Kampala, Mid-Eastern, North-East and West-Nile).

**Pediatric Treatment Linkage and Retention:** PEPFAR Uganda achieved a high proxy linkage to treatment for newly identified CLHIV, thanks in part to high impact OVC programming. There are approximately 55,551 CLHIV on treatment nationally (78.7% in public sector, 21.4% in the private sector). Gaps remain in ensuring children maintain treatment continuity, with high rates of IIT among CLHIV. To address this, PEPFAR Uganda will strive to reduce IIT to < 500 per quarter (<1% of CLHIV on treatment) for improved retention through: Strengthen facility-community bi-directional interface to bring services closer to the CLHIV in communities, enhance community-led programming, and sustain gains made in OVC program. We will also prioritize enrollment of pediatric clients on MMD, which increases retention. Current MMD rates stand at: <15 years 69% for 3+ months; 11% are on MMD for 6+ months.

**Pediatric VLS:** PEPFAR Uganda will advance several strategies in COP23 to advance AP3 Objective 3 (increase rates of pediatric viral load suppression to 95% and reduce mortality):

- Work toward full pediatric DTG coverage - which stands at 98% (March 2023), addressing DTG reactions and unsuppressed children through patient tracking, caregiver literacy, and intensified adherence support.
- Use a recent mapping of non-suppressed CLHIV by region and facility for a targeted response in COP23, including weekly household visits by OVC program staff for the non-suppressed.
- Sensitize caregivers on the MOH policy that allows MMD for eligible of children; improve caregiver literacy.
- Disseminate and institutionalize treatment literacy for carers of children at school and community.
- Scale up the caregiver DOTS model to all unsuppressed children.

**Leveraging OVC Platforms:** Community-level OVC programming remains an important avenue for pediatric case identification, linkage, and support and follow-up of high-risk mother-infant pairs. We will build on COP22 OVC success, including strong collaboration with health facilities and intensive case management for non-suppressed C/ALHIV using para-social workers (PSW) and family-centered case management that supports C/ALHIV and caregivers.

PEPFAR Uganda's OVC program will contribute to closing the pediatric/PMTCT/EID gap by continuing to provide HIV prevention, care, and treatment services in SNUs with a high pediatric HIV burden. We will intensify enrolment of adolescent pregnant and breastfeeding mothers by strengthening linkages with PMTCT and immunization clinics to increase enrolment of HEIs.

The program will also intensify the household case management approach to provide targeted interventions across the pediatric cascade. To facilitate index testing, the program will use the OVC platform for caregiver-facilitated home-based self-testing to orient caregivers on using HIVST and support client confirmatory testing. To support continuity of treatment and pediatric ART optimization and VLS, the OVC program will support the community response by enhancing the capacity of para-social workers and caregivers in HIV, TB, and age-appropriate disclosure literacy and orient them on the need for VL uptake. We will address barriers to VLS by integrating mental health and scaling up collaboration with private sector and non-PEPFAR programs to offer comprehensive services such as SRH; MNCH; water, sanitation, and hygiene; nutrition; malaria; basic education; and legal support services.

## KEY POPULATIONS

Ugandan KP (FSWs, MSM, TGs, PWID, people in prisons [PIPs]) are disproportionately affected by HIV, experiencing acute health inequities, and contributing substantially to annual HIV incidence. HIV prevalence is almost six-fold higher in FSW (31.3%) than among adults aged 15-49 years in the general population (5.5%), and higher in MSM (12.7%) and PWIDs (16.0%). Further, key populations, particularly FSW, MSM, and male PWID, have higher HIV incidence than the general population, making them a lynchpin of epidemic control (UAC/Uganda Modes of Transmission HIV Prevention Synthesis, March 2023).

Despite the gains made in the KP cascade, the emerging situation is not business as usual. We have woven in potential COP23 LGBTQIA+ service delivery adaptations in following relevant sub-sections that aim to ensure safe and uninterrupted HIV prevention and treatment services.

Prior to AHA, PEPFAR Uganda achieved the KP_Prev target across all KP sub-populations in FY22, with an overall achievement of 143%. 95.2% of KPs identified with HIV were linked to care and started on ART. VLC for HIV positive KP in treatment reached 94%, and the program achieved 94% VL suppression of KP clients initiated in care (increased from 91% in COP 20). However, gaps remain in HTS yield (at 3%) across all KP groups, linkage for MSM (85.1%) and TGs (89.8%), and viral load coverage for MSM (89.8%), TGs (89.6%), and PWIDs (83.1%) (FY22 APR data). Although the program exceeded the KP_Prev targets, there is concern that the program may be missing some clients due to double counting in the absence of unique identification codes and mobility of the key populations. Emerging integrated bio-behavioral surveillance survey (IBBS) data of FSWs also suggests lower linkage and VLS rates than reported in program data.

**TABLE 1.6: KP Clinical and PrEP Cascade (FY22)**

KP C&T cascade FY22

| KP Group | Target | KP_ PREV | % Target | HTS_ TST_ POS | Yield | TX_ NEW | Link age | TX_ CURR | VL Elig. | VL Tested | VLC | # VLS | % VLS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FSW | 136,239 | 243,080 | 178% | 6,656 | 3% | 6,375 | 95.8% | 12,587 | 9,911 | 9,222 | 93.0% | 8,760 | 95% |
| MSM | 31,542 | 38,837 | 123% | 435 | 1% | 370 | 85.1% | 708 | 540 | 485 | 89.8% | 456 | 94% |
| PWID | 3,151 | 10,322 | 328% | 306 | 3% | 292 | 95.4% | 359 | 207 | 172 | 83.1% | 164 | 95% |
| TG | 3,952 | 4,935 | 125% | 59 | 1% | 53 | 89.8% | 87 | 48 | 43 | 89.6% | 40 | 93% |
| PIP | 110,115 | 110,805 | 101% | 967 | 1% | 926 | 95.8% | 4,132 | 3,523 | 3,400 | 96.5% | 3,137 | 92% |
| Overall | 284,999 | 407,979 | 143% | 8,423 | 3% | 8,016 | 95.2% | 17,873 | 14,229 | 13,322 | 93.6% | 12,557 | 94% |

KP PrEP cascade FY22

| KP Group | KP_PREV | % HTS_TST | % HTS_TST_ NEG | % PREP_ SCREEN | % PrEP_Eligible | % PREP_NEW | PrEP_New Target | % Achieved |
|---|---|---|---|---|---|---|---|---|
| FSW | 243,080 | 83% | 97% | 65% | 58% | 85% | 67,659 | 93% |
| MSM | 38,837 | 94% | 99% | 52% | 63% | 69% | 11,551 | 71% |
| PWID | 10,322 | 91% | 97% | 80% | 55% | 87% | 3,414 | 101% |
| TG | 4,935 | 96% | 99% | 40% | 59% | 85% | 814 | 117% |
| Overall | 297,174 | 85% | 97% | 63% | 58% | 83% | 83,438 | 90% |

**Strengthening KP Case Finding:** Identifying KP sub-populations remains uniquely challenging as compared to the general population given structural factors, including poverty, stigma, and prohibitive laws. Estimates show that at least 7,000 MSM are living with HIV/AIDS, but do not know their status and are not connected to treatment. The potential for an increasingly hostile social and legal environment will make it significantly more difficult to bridge these gaps and reach the remaining MSM living with HIV if they fear disclosing their LGBTQIA+ status. FSW similarly continue to be disproportionately affected with HIV, with an HIV prevalence of up to 54% according to IBBS data. In addition, FSWs experience a high prevalence of syphilis (up to 12%), HPV (up to 37%), and sexual violence (up to 49%) (IBBS data from four sites).

*Strengthen KP population size estimates:* PEPFAR Uganda will maintain the current 12 IBBS sites as sentinel surveillance sites in COP23 and expand to two new sites (Kabale and Bulisa) to inform KP case finding and targeting. These sentinel IBBS sites will also serve as DICs as part of differentiated service delivery for KPs. In addition, the Uganda Ministry of Health will develop standard operating procedures on conducting small area estimates (SAEs) followed by building capacity of the regional partners to conduct routine SAEs. We will strengthen local capacity to support periodic population size estimates and monitor epidemiology of STIs, GBV, and other health conditions of interest.

*Implement unique identifiers:* As noted above, PEPFAR Uganda suspects that KP clients who re-test for HIV may be double counted as part of PP_PREV given the 143% PP_PREV FY22 achievement. We will continue efforts to improve the current KP tracker with a web-based unique identification code that is interoperable across facilities. We will also consider scaling up lessons learnt from the IBBS sites on the use of biometric sign-in for clients accessing services. Consultations have already been held with the KP community and indicated that they would prefer a bar code as opposed to biometric sign-in. These discussions will continue so that we

get the best way forward. Currently, the unique identifier that is used in the KP tracker is only unique per facility but is not unique across facilities. Therefore, to address the issue of duplication, we will implement unique identifiers with features developed by Makerere University School of Public Health (MaKSPH) monitoring and evaluation technical support (METS), Crane survey, and USAID for a client registry that will link all data from all facilities providing KP services in line with the interoperability principle as we wait for national unique identifiers.

*Scale-up high-yield testing modalities and recency testing for KPs:* FY22 HTS yield among KPs dropped from 4% to 3%, indicating a need to prioritize targeted testing and other innovative testing approaches such as SNS, enhanced peer outreach approach (EPOA), and confidential HIV self-testing.

We will consult closely with KP CSOs to identify what pivots or strategies are needed in the context of the implementation environment, such as the scale-up of HIVST and the KP-led peer referral apps that enhance identification, enrollment and retention of KPs in HIV services. This is critical since LGBTQIA+ populations may no longer be reachable through well-known hotspots. ACASI, which is currently implemented in 24 sites and 12 IBBS sites, is an innovative and confidential phone-based anonymous survey approach that improves KP categorization, health education, screening and case finding by enabling LGBTQIA+, FSW, and PWID clients to conveniently respond to questions on their risk status without face-to-face interaction. In FY22, 19 KP sites implementing eHealth achieved an HTS yield of 12%, compared to a 3% overall yield. MaKSPH Uganda Key Populations Consortium (UKPC), as an above site partner, will continue to support Regional Mechanisms in KP surveillance and KP eHealth services using ACASI method components at DICs and health facilities provide TA to HCWs to expand eHealth to 25 sites in COP23.

***Leveraging strategic KP case identification platforms*:** We will continue to leverage other prevention platforms including VMMC, PMTCT and PrEP to reach KPs and ensure bi-directional referral to other high impact prevention interventions as well as working closely with the OVC program on getting children of KPs to care. We will also leverage the DREAMS program to reach and serve FSWs aged 10-17 years with high impact HIV prevention interventions.

**PrEP:** PrEP remains a powerful tool in the combination HIV prevention arsenal, especially for high-risk KPs. Uganda will increase PrEP provision to 110,400 KP sub-populations and 119,600 priority populations (AGYW, pregnant and breastfeeding women, fisher folk, truck drivers and clients of female sex workers) as part of PEPFAR's planned overall COP23 PrEP_NEW increase (from 180,000 to 235,000 clients) and from 65 districts to 88 districts, which is responsive to the clear priorities of the People's Voice representatives. PEPFAR Uganda will also continue to address gaps in PrEP screening and uptake, per **Table 1.6**. COP23 is an exciting year to advance new PrEP products and approaches that advance health equity in Uganda, including event-driven PrEP and DVR rings (for AGYW from GF), as described below. PEPFAR Uganda will also broaden the use of HIVST within PrEP programs, in line with current WHO and PEPFAR global PrEP implementation guidance.

COP23 pivots include:
*Event-driven PrEP:* PEPFAR Uganda will continue to encourage implementation of event-driven (ED) PrEP in alignment with newly revised national HIV prevention and treatment guidelines (Nov. 2022). PEPFAR sites will provide counseling to KP who may benefit from transitioning to daily oral PrEP if sex becomes more frequent and/or less predictable. Given the current context, ED-PrEP may be an attractive option for MSM who are unable to visit the facility for oral PrEP or change their behaviors out of fear.

**DSD PrEP models**: PEPFAR Uganda will continue to consult with KP-led CSOs to identify patient-centered DSDMs that meet the differing client needs of KP sub-populations (FSWs, PWID, LGBTQIA+). These include:

- PEPFAR Uganda will continue to engage with the MOH and civil society regarding DIC accreditation, which would enable PrEP screening, enrollment, and refills for KPs and potentially increase access/coverage.
- Re-packaging PrEP to avoid looking like ARVs to reduce stigma and KP identification, especially among LGBTQIA+ who may fear being identified picking up or possessing PrEP from a GOU facility.
- Scaling-up PrEP refills through the Community Retail Drug Dispensing Program, which aims to reach 500 clients through its initial PrEP pilot (launched in 2023).
- Engaging LGBTQIA+ CSOs to identify new DSDMs and modified from COVID-19 lockdowns (such as MMD for eligible KP PrEP clients) that retain KP clients and support their PrEP adherence.

**STI Screening, Diagnosis, and Treatment:** Significantly elevated rates of STIs, such as those seen in Uganda's FSWs and MSM, may independently increases risk of HIV acquisition. Recent 2020/2021 IBBS data from four sub-regions found rates of syphilis from 2-12% and HPV from 15-37% among FSWs. This correlates to a high HIV prevalence for FSWs ranging from 29% in Busia to 44% in Fort Portal. In line with COP22, PEPFAR Uganda has planned increases in STI/OI medicines procurement to meet demand and requests from the People's Voice, who have requested increased STI diagnosis and treatment services for KPs. While PEPFAR Uganda will continue to support STI screening, lab testing, and treatment for KPs with confirmed STIs, the evolving LGBTQIA+ situation may require responsive and adaptive DSD models such as home delivery of medicines, and/or use of syndromic management for LGBTQIA+ individuals with STI signs and symptoms. Additional COP23 STI priorities for KPs include leveraging multi-disease testing platforms beyond HIV and TB at regional hospitals to improve STI diagnosis and exploring use of private not-for-profit health facilities as hubs for STI medicines for KPs to improve access and availability of the STI medicines for the KPs. We will strengthen peer/physical escorts for FSWs testing positive for HPV to PEPFAR-supported cervical cancer treatment sites.

**Condoms and Lubricants:** PEPFAR Uganda will continue to tackle the challenge of low condom and lubricant use among sex workers, their clients and other sexual partners, and the LGBTQIA+ community. For example, only 36.4% of men and 25% of women reported the use of condoms with a casual sex partner from UPHIA 2020, a decrease from 49% for men and 35% for women

in UPHIA 2016. Condom use at the last sex was 69% among female sex workers (Condom DSD for KPs, 2021 pg 11).

PEPFAR Uganda will collaborate closely with GF to increase the supply of male and female condoms and lubricants and address inconsistent supply levels, especially at the last mile. The USG has earmarked $2.25M for condoms and lubricants procurement and last mile delivery. GF plans to procure condoms and lubricants for 15,407 MSM from 2024-2026. PEPFAR Uganda will continue to promote condom use through evidence-based social and behavior change (SBC) approaches, including condom advocacy, peer-to-peer infection prevention and control (IPC) for KP sub-populations, WhatsApp and confidential online messaging, and improving KP risk perception.

Condoms and lubricants for KPs have historically been distributed via non-traditional outlets such as peer-to-peer model, outreaches, DICs, hot spots, bars, lodges, entertainment places and venues. COP23 will require a pivot from existing peer-led replenishment of condoms and lubricants and dispensers at LGBTQIA+ gathering hotspots due to the evolving climate of fear among LGBTQIA+ individuals, who report being reluctant to be seen picking up commodities such as lubricants that may identify them as a KP. PEPFAR Uganda is consulting with LGBTQIA+ CSOs to identify DSD models that will enable private or covert distribution/delivery mechanisms. These will include, but not limited to, home delivery of condoms and lubricants delivered as part of the HIV prevention package that will include PrEP drugs and HIVST kits.

**Strengthening Linkages and Retention:** PEPFAR Uganda will continue to work with KP CSOs to develop and scale innovative person-centered differentiated service delivery approaches for KP that improve enrollment in and retention in treatment such as MMD, peer support, and community drug distribution. This is particularly important for two KP sub-populations in COP23: FSWs and LGBTQIA+ individuals. Recent 2022 IBBS FSW data from four sites shows lower linkage and VLS (ranging from 51% in Tororo to 80% in Fort Portal) compared to program data (which showed 96% linkage and 95% VLS). PEPFAR Uganda will conduct further interrogation and validation and increase focus on effective FSW linkage and retention interventions. Similarly, LGBTQIA+ clients who fear facility-based HIV treatment due to AHA will require support to access confidential and person-centered care.

PEPFAR Uganda will continue scaling-up and supporting KP-competent ART services, and proven linkage and retention approaches, including same-day ART initiation, community ART, and use of dedicated peers to physically escort HIV positive KPs to service delivery points and provide intensified adherence counseling. Sites will conduct weekly data reviews to identify missed appointments for prompt follow up and bring back to care interventions. PEPFAR Uganda is actively exploring proxy indicators and alternative monitoring and evaluation (M&E) approaches to track KP clients who are not self-identifying receiving ART and other HIV services at public facilities. PEPFAR Uganda will update the KP Service Tracker to more accurately and quickly monitor DIC-level service delivery variations among LGBTQIA+ and increase restrictions to that data.

*Re-assess and strengthen DIC model*: Community DICs serve as safe spaces for KPs/PPs to access first-line, client-centered HIV and reproductive health services. PEPFAR will continue supporting the functioning of the expanded network of 84 DIC sites, improving the availability and quality of a standardized DIC service package and collaboration between the DIC and health facilities. PEPFAR Uganda will continue ongoing DIC accreditation dialogue with MOH to enable DICs to offer select clinical services (distribute ARVs, including PrEP).

We will support LGBTQIA+-focused DICs to implement DIC-specific security recommendations for patients and HCWs from the study (such as procuring lockable cabinets for personally identifiable information, security cameras and other items), leveraging enhanced LIFT UP funding. One-time investments include: 1) developing tailored safety and security plans; 2) holding security awareness training for KP CSOs and community members; 3) acquiring physical security equipment (e.g., reinforced doors/locks, fences, biometric entry); and 4) providing equipment and platforms to enhance data security (e.g., point-of-care electronic records laptops and software). We will also ringfence flexible funding to support safety and security for LGBTQIA+ and providers in new, adapted DSDMs (for clients who opt not to seek services at DICs).

PEPFAR's national KP capacity building partner will continue to collaborate with CSOs to complete safety and security assessments and mitigation plans for DICs providing health services in the community. Standardized incident reports and avenues to collect information from clients and implementing partners (IPs)/IP staff about what is happening in the community will be critical to track impact going forward. PEPFAR Uganda will also support integration of mental health services in DICs (as well as various service delivery points KPs access) through supporting skilled nurses/counselors to offer screening for, detection of, and referral for treatment of mental health conditions among KPs, which are likely to be heightened for LGBTQIA+ persons given the environmental stressors.

**Developing/scaling-up alternative DSDMs:** Person-centered HIV service delivery approaches extends beyond DICs, which may only meet the needs of some clients and sub-populations. LGBTQIA+ who do not publicly identify as LGBTQIA+, for example, may not want to visit a DIC or engage in community ART distribution by an "out" peer. PEPFAR Uganda will continue to engage KP sub-populations to brainstorm and rollout DSDMs for HIV care and treatment. These include: 1) Community Retail Drug Distribution, which enables stable KP PLHIV to pick-up their medication refills at a convenient private pharmacy; 2) Group medication pick-up by "super peers" or trusted boda boda riders and home delivery to KPs (currently implemented – reinitiated March 2023); 3) Service delivery at Safe Spaces; 4) Online peer support for adherence and viral suppression via Facebook, WhatsApp, and other online applications; 5) Exploring home delivery of ARVs by the private sector; 6) Community drug distribution by the private sector. Should the implementation environment become increasingly difficult, we will explore increased allowances for trusted health workers due to increased costs of providing service at non-conventional KP hotspots (such as homes), and 7) Rolling out the MOH 10-point strategy for supporting non-suppressed ART clients in care.

*Telehealth and self-care:* PEPFAR Uganda will select and launch innovative electronic apps/platforms to improve access to HIV services for KP, including mental health care, with recently approved LIFT UP funding. Such platforms might include KuchuCare which was developed by a Ugandan KP CSO, POWODU for persons with disabilities, or the PEPFAR-funded QuickRes/online reservation and case management app already launched by PEPFAR/USAID in nearly 20 countries which enables clients to access real-time services and messaging, or other innovative models to be selected by CSOs. These models can increase uptake and completion of HIV referrals for LGBTQIA+ clients and other PPs through on-demand virtual mental health support. We will roll out innovations to include provider appointments, referrals, community medication pick-up, peer-led "virtual outreach workers" reaching LGBTQIA+ in online hotspots (Facebook, WhatsApp, and/or dating apps) and online mental health services, which are vitally needed given the context. These innovations may be expanded in Year 2 to support PBFW, CLHIV caretakers, AGYW, and PWID who face similar structural barriers. The development of online reservation and case management app already launched by PEPFAR/USAID in nearly 20 countries which enables clients to access real-time services and messaging, or other innovative models to be selected by CSOs. These models can increase uptake and completion of HIV referrals for LGBTQIA+ clients and other PPs through on-demand virtual mental health support. We will roll out innovations to include provider appointments, referrals, community medication pick-up, peer-led "virtual outreach workers" reaching LGBTQIA+ in online hotspots (Facebook, WhatsApp, and/or dating apps) and online mental health services, which are vitally needed given the context. These innovations may be expanded in Year 2 to support PBFW, CLHIV caretakers, AGYW, and PWID who face similar structural barriers.

**Improving VLS:** We will prioritize increasing VLC among PWID, TG, and MSM in COP23, each of whom fell well below 95% coverage targets at 83.1%, 89.6%, and 89.8% respectively. For PWID, PEPFAR Uganda will work through PWID CSOs to increase awareness and sensitization, as well as offer outreach within MAT clinics and mobile MAT van. Engaging MSM and TG clients may prove more challenging given the implementation and legal context, where traditional text and telephone call reminders may not result in uptake. We will consult and engage MSM and TG on potential innovations to increase VLC, such as synchronizing MMD ART refills with VL bleeding. It will be challenging presumably to mobilize LGBTQIA+ for VL bleeding at facility or community, so leveraging ART refills may increase VLC at the DIC as clients collect ART refills (with proper coordination by KP peers).

***Improved Service Delivery for PIP***: In COP23 Uganda Prisons Service (UPS), in line with the right to equivalent health services for people in prisons (namely, equivalent to that available outside of prisons), will utilize a multi-layered approach to deliver comprehensive HIV services at the 259 sites.

First, the program will implement risk-based HIV testing on entry for new prisoners and quarterly routine targeted testing. This will be hinged on principles of holistic person-centered care and integrated to address other broader health issues including prevention, diagnosis, and treatment of TB, GBV, STIs, viral hepatitis and mental health conditions, as well applicable

sexual and reproductive health services; and ensuring their continuity during inter- and intra-prison transfers and after release.

In addition, there are accelerated efforts to consolidate ART services in the 42 accredited ART prison facilities for increased VLC coverage and enhanced psychosocial support services to improve ART adherence and VLS.

**PWIDs:** HIV prevalence among Ugandan PWID remains alarmingly high at 24% (women PWID) and 8% (male PWID) (Uganda MOT 2021). These populations face increased HIV transmission risk (more than 35 times higher compared to non-PWID) and face significant barriers to HIV service access and use, including societal stigma and laws/policies that marginalize, criminalize, and limit access to comprehensive HIV harm reduction services. Achieving HIV epidemic control will require increasing coverage of comprehensive HIV services, including HIV testing and prevention among PWID and access to evidence-based harm reduction interventions, among this growing population. In 2020, Uganda had ~18,000 PWUD, a substantial increase since 2016. The 2021 MOH MOT report estimated the PWID population at 7,169 (6,094 males and 1,075 females). With a projected 3.2% population growth rate, this population is estimated to be 7,879 by 2026 and growing further.

PEPFAR Uganda will continue to extend access to comprehensive HIV prevention, care, and treatment services to PWID, working through PWID-focused to identify and support clients. This includes increasing PrEP access among this especially high-risk sub-population targeting 1,729 PWID for PrEP_CT (an increase from 1,603 in COP22) and 4,361 PWID on PrEP_NEW (up from 3,414 in COP22).

In COP23, PEPFAR Uganda will continue to increase availability and quality of harm reduction services. We will increase the quality of medication assisted treatment (MAT) services at Butabika MAT Clinic (Kampala), supporting 300 PWIDs, addressing challenges in enrollment and retention through peer-to-peer coupon distribution and tracking, and demand creation interventions integrated within the KP program. PEPFAR Uganda will operationalize MAT innovations, including MAT dispensing “spokes” and mobile van dispensing models, to improve MAT accessibility in communities at the request of the People’s Voice. The mobile van, expected to arrive in April 2023, will provide mobile HIV and MAT services to PWID in greater Kampala, increasing the coverage and frequency of services at “spoke” service points of PWID. PEPFAR Uganda will review its operational indicators and cost-effectiveness to determine if additional vans/mobile outreach should be extended to Mbale MAT clinic in future years.

In Mbale, PEPFAR Uganda will operationalize and increase access to the newly opened MAT clinic at Mbale RRH, which serves an estimated 807 PWID in Eastern Region. Opened at the request of the People’s Voice in April 2023, we will work with newly trained PWID-focused CSOs Women with a Mission and Hope Mbale to identify and enroll 100 PWID on MAT and launch hub-and-spoke services through a mobile outreach van, building on the Butabika model. We will also extend learning and best practices from Butabika through cross-clinic learning on optimal MAT enrollment and retention and the newly revised statement of work (SOWs) (once

approved by MOH). More broadly, PEPFAR Uganda will continue to support the Uganda Harm Reduction Network (UHRN) and to support community-led monitoring (CLM) in monitoring and working through its coalition with UKPC and UHRN together with other partners such as GF.

*Sub-Granting to Support Community-Led Service Delivery:* PEPFAR Uganda will support competitive sub-granting to KP-led and KP-focused CSOs to provide responsive HIV prevention, care, and treatment SBC and services at community level. Working with KP CSOs, the program will prioritize targeted testing and other innovative HTS approaches, such as KP-led referral apps that enhance identification, enrollment, and retention; SNS; EPOA; and HIVST.

*Update KP Tools:* PEPFAR Uganda will provide TA to the MOH to update KP facility and community-level HIV tools to capture all program indicators. This will ensure timely and complete data is entered into the updated KP tracker.

**Other Priority Populations**

**Fisher Folks and Truck Drivers:** Despite good program performance along the second two prongs of the clinical cascade, PEPFAR Uganda has only managed to reach a very small proportion of fisher folks (3.7%) and truck drivers (39%). This threatens both health equity for these individuals, and Uganda's epidemic control. These two priority populations both contribute substantially to driving new HIV infections in Uganda, especially among AGYWs and FSWs, who are frequent sexual partners to both populations.

PEPFAR Uganda only managed to reach 27,000 (or 3.7%) of Uganda's estimated 731,870 fisher folks (Estimate: UNAIDS/UAC 2019) in FY22. These fisherfolk face elevated HIV exposure and acquisition risk due to high mobility, poor access to HIV information, and limited access to HIV prevention resources, including oral PrEP. Their HIV prevalence estimates vary but range from 15-40% to 23.3% (2019 KP and PP Size Estimates Report). PEPFAR FY22 program data indicates a 4% HTS yield, representing a missed opportunity to find new HIV cases. In addition, the People's Voice has called for development of a comprehensive, community-designed and community-led combination prevention and treatment program targeting fisherfolk and their children, which will address unmet need for biomedical and structural prevention interventions as well as innovations to overcome their daily struggles in accessing uninterrupted, quality HIV treatment and care. Highly mobile truck drivers, who are estimated to number at more than 31,588, also face elevated HIV prevalence in multiple studies and reported a 3% yield in FY22 in PEPFAR Uganda programming.

PEPFAR Uganda has elevated these priority populations within its COP23 strategy to revolutionize testing and case finding. Specific priorities include:

*Targeted HTS:* PEPFAR Uganda will prioritize reaching fisher folk and truck drivers with HTS through multiple modalities, including optimizing community HTS through deploying testers to hotspots (landing sites for boats where commerce gathers, truck rest stops/customs stop). Using the SNS, peers will offer HTS and provide referrals for ART. PEPFAR will work with truck driver leaders, unions, companies to develop DSD models for testing and ART provision, and will look to promote or advertise HTS and other services via Abavubi Fisher App.

*Increased VMMC targeting*: PEPFAR Uganda will allocate increased targets to high-risk fisher folk males and truck drivers in COP23 (5%).

*Scale-up PrEP:* Male PPs remain under-reached by oral PrEP, despite promising recent evidence demonstrating wide acceptance among fishing communities in peri-urban Kampala. PEPFAR Uganda increased its PP_PREV targets for fisherfolk and truck drivers in COP23, reflecting the overwhelming need for HIV prevention for these high-risk populations and their partners. PEPFAR Uganda will prioritize integrating PrEP sensitization within PP HTS outreach, including referrals for PrEP enrollment for PrEP truck drivers. The rollout of the CRDDP pilot for PrEP will be an opportunity to extend more conveniently located PrEP refills with friendlier hours for stable PrEP clients, as well as provide MMD for stable PP PLHIV on ART.

*Innovation:* Abavubi App for Fisherfolk. Developed by the Federation of Fisheries Organization Uganda and available on Google Play, the Abavubi Fisher App is a digital fish catch, reporting, and financial management application that helps these fisher folk market their fish and fish products, track income and expenses, identify fishing and landing sites, follow the weather forecast, and have a panic button for emergencies. HIV testing and other health services will be promoted on the app, improving reach to this priority population.

**Adolescent Boys and Young Men (10—24)**

While Uganda made significant progress in new HIV case identification, significant gaps remain in males ages 10-24 years in FY22. Among boys ages 10-14, HIV case identification only increased from 80% to 83% from UPHIA2020 compared to Spectrum 2023. Similarly, boys 15-19 increased from 69% to 71%, a modest increase compared to their female counterparts ages 15-19. Given Uganda's heavy youth bulge, this low first 95 threatens epidemic control.

**Identifying new infections:** Addressing the ABYM 1st 95 equity gap requires a multi-prong approach, with collaboration within and across PEPFAR sites and multisectoral programming to identify new clients. Planned COP23 strategies include:

- Scaling-up higher-yield HTS sources: Screening and PITC for ABYM at inpatient department (IPD), OPD, STI clinic, TB clinics; OVC (ages 9-18); optimize index testing of biological children and adolescents of women living with HIV (WLHIV), and via assisted partner notification (APN).
- Expanding case finding and HIVST for adolescents ages 15-19 at community level through the YAPS platform, building on COP22 progress and recently revised national HTS guidelines. YAPS peers will facilitate linkage positives to confirmatory testing and ensure HIV-negative ABYM access relevant HIV prevention services.
- Scale-up social network strategy (SNS) for ABYM for adolescents, a high-yield case finding strategy for adolescents in urban areas. YAPS peers will identify at-risk adolescents (social contacts of HIV-positive and high-risk negative adolescents) and link them to testing.

- Expanding ABYM engagement via NextGen DREAMS through offering self-test to BOTH DREAMS participants and/or to take home to their partners or invite partners to testing events. Negative male partners will be referred to VMMC (if appropriate), or to treatment if they test positive.
- Promoting or providing voluntary HTS (and further HIV service delivery linkages) within gender equity interventions, such as the Coaching Boys into Men activity, within existing PEPFAR-supported sexual violence prevention programming (No Means No), and multisectoral youth development platforms.
- Ensure sites are actively monitoring the AP3 HTS surge dashboard to monitor trends in HTS uptake and results for AYBM by age band (15-19, 19+).
- Scale-up virtual and digital HTS demand creation and testing provision: young people ages 15-34 (especially males) prefer virtual or digital distribution models for HIVST, according to a recent Makerere SPH study. PEPFAR Uganda will work with MOH, CHAI, Human Diagnostics, PATH, and PSI to adapt and scale-up virtual/digital platforms, building on initial pilots. PEPFAR Uganda will: 1) Enhance existing modules to cover all aspects for HTS including linkage to conventional testing; 2) Expand languages options in the apps for all regions; 3) Make apps accessible offline; 4) Develop unstructured supplementary service data (USSD) codes for those without smart phone; 4) Increase market for use of the apps and digital platforms; and 5) Integrate the different virtual and digital platforms.
- Integrating HIV case finding into the national Community Awareness Screening, Testing, Prevention, and Treatment (CAST TB) Campaign: National program data indicates that 30% of TB-infected individuals have HIV. The MOH's door-to-door TB case finding campaign (CAST TB) provides an ideal opportunity to access hard-to-reach young men at community level. PEPFAR Uganda will enhance support to ingrate HTS demand creation and provision among at-risk men and presumptive TB cases and their family members in COP23, training CHWs in sensitization, mobilization, and service linkage.

**VMMC (for both ABYM and adult men 25-49):**
VMMC offers an important tool to prevent new infections and served as a bright spot in COP22 where PEPFAR Uganda programming saturated under-served high HIV incidence areas >90%. Similarly, the expanded engagement of men and boys in DREAMS according to new NextGen DREAMS guidance offers potential to increase case finding and treatment.

PEPFAR Uganda will continue to scale-up and saturate VMMC in high-prevalence districts as a critical element of combination HIV prevention. By end of Q1 FY23, PEPFAR Uganda's VMMC program achieved 22.9% of the annual target, with 86% of circumcisions in the 15–29-year age category. The program will maintain national targets at 523,827 despite the 9% budgetary cuts by applying program delivery efficiencies. The program will prioritize districts with high unmet need, HIV incidence, presence or proximity to DREAMS, and inclusion of PPs. Key strategic shifts in COP23 (across age bands unless otherwise noted):

- All sites will discontinue HTS screening and offer voluntary HTS to all VMMC clients regardless of risk profile, in line with PEPFAR FY24 Technical Considerations, providing

an additional avenue for identification of new adult male HIV clients (projected COP23 yield: 1.7%).
- Increase allocations of HIV self-tests to 260,000.
- Allocate 75% of VMMC targets to 15-29 age group (high unmet need in this age group).
- Increase use of more sustainable and climate-conscious reusable VMMC kits, increasing from 75% reusable kit use to 80%.
- Increase use of the more cost-effective, sustainable, and client friendly Shang Ring from 3% (COP22) to 6%, and use it for 100% of boys ages 13-14, in line with national guidelines.
- Document VMMC referrals and linkages from other prevention programming through revised VMMC register.
- Continue to decentralize the support supervision for VMMC services to the regional referral hospitals (RRH). The RRH's VMMC safety committee is being constituted at each regional referral hospital to provide oversight on the quality of services in the region.
- Begin to plan for sustainability by integrating VMMC services into combined prevention programming.

GF plans to support 300,000 VMMCs in COP23 through commodities and implementation support in the same facilities as PEPFAR-supported sites for partners of AGYW, KPs and children of PMTCT mothers. As such, PEPFAR Uganda teams will liaise closely with MOH to define responsibilities related to demand generation, VMMC delivery, after-care and management of any SAEs, and proper attribution of targets.

PEPFAR Uganda will adopt three strategies in COP23 to increase VMMC among eligible **older men ages 25-49**, often the partners of AGYW:
- Focus on targeting men ages 30+ in high HIV incidence and under-saturated regions (<90% coverage): in the Northern and South-Western regions and 30 specific DREAMS districts.
- Expand services to fishing communities and truck drivers, who will account for 5% of all VMMCs.
- Piloting the integration of male-friendly wraparound services for NCDs to attract men. VMMC sites will offer voluntary screening and referrals for hypertension, diabetes mellitus, and mental health in COP23.

**<u>Adolescent Boys and Young Men (10—24)</u>**

**Continuity on Treatment and VLS:**

In general, young people 10-24 have the highest IIT, at 2.9% of all clients (FY23/Q1). VLC remains suboptimal among males 20-24 (84% FY23/Q1), VLS suppression remains abysmal among ABYM ages 15-24 at 37.6%, significantly lower than female counterparts this age (52.3%) (UPHIA 2020). VLS also remains low among ABYM ages 10-19, at 85% (FY23/Q1), despite increased focus through AP3 and other efforts. Children and adolescents—both boys and girls—are 10 times more likely to contract TB if HIV infected. According to the 2022 WHO

Global TB Report, 12% of notified TB patients are children ages 0-14 years, while 55% of TB cases notified are among men in Uganda.

The gaps in treatment continuity, VLC, and VLS are largely attributed to stigma, poverty, inadequate parental/ caregiver support, failure to harmonize treatment schedules with school programs, challenges in appointment keeping, inadequate coverage of tailored services for ABYM, incomplete ART optimization, low treatment literacy levels among the adolescents, parents, and caregivers.

In COP23, PEPFAR Uganda will prioritize the following strategies to address these equity gaps:

***YAPS***: The program will also increase overall within the districts YAP coverage, which currently stands at an average of 31% for districts with high numbers of 10–24-year-olds active in care. This will ensure more vulnerable AYBM (as well as AYGW) benefit from supported disclosure and adherence support. PEPFAR Uganda will work with the MOH to review and potentially modify the current YAPS peer educator requirements to ensure they enable adequate enrollment of ABYM YAPs, as some locations have failed to identify eligible YAPs. These requirements include having disclosed their HIV status, willingness to publicly discuss their status, having achieved VLS, being able to read and write English, being available to volunteer given school/work needs.

***Treatment Optimization****:* PEPFAR Uganda will use program data to identify and mop up ABYM eligible for DTG transition. Accelerating treatment optimization will further improve VLS among this subpopulation.

***Pharmacovigilance:*** PEPFAR will continue to support pharmacovigilance including further dissemination of MOH guidelines, SOPs, reporting tools, and reporting to the National Drug Authority. This will enable service providers to effectively manage adverse events which may affect treatment adherence and ultimately, VLS.

***MMD:*** PEPFAR will support enrollment of more ABYM on MMD through addressing barriers such as fear of health workers that weight changes will lead to inadequate dosing if these clients get MMD. Under guidance of MOH and MOES, liaising with boarding school matrons/nurses, providing treatment literacy and MMD guidance that enables adolescents to access and continue ART while away at boarding school and/or make plans for accessing ART MMD refills during school breaks, building on a successful innovation in Karamoja.

*Scale-Up ABYM-Responsive DSD Models*: COP23 priorities include:

- Train/monitor ART sites to use the Client Preference Tool for ABYM (and all PLHIV) each visit to the facility to ensure the client is getting their ART delivered in the model they want.
- Extending the successful Community Retail Pharmacy Drug Pilot to include stable PLHIV ages 15-19, increasing access to ART refills closer to home or school.

- Support community based VL bleeding for MMD clients and other person-centered community models through routine use of the client Audit tool to facilitate timely identification of ABYM eligible for VL testing and other services.
- Scale-up evidenced-based Family-Centered Care Models that better address the patient needs of ABYM and young people. These models include assistance with age-appropriate family-centered disclosure family/caregiver treatment literacy sessions, engagement with peer educators, participation in psychosocial support (PSS), synchronizing medicine pickup for family members in care.

***Transformative partnership:*** Some of the causes of IIT, low VLC and VLS are related to socio-economic and legal factors. PEPFAR will continue to facilitate partnerships and bi-directional linkages between the clinical and OVC partners and other programs for provision of complementary services for ABYM.

***Leading with data:*** PEPFAR Uganda will continue tracking performance through weekly review of the AP3 dashboard data, VLC and VLS, focusing on equity gaps among ABYM.

***Innovations:*** PEPFAR will work with youth led CSOs to identify potential innovations to develop new DSD models or strategies to reduce IIT/promote RTT and enhance VLC and VLS, including digital health approaches that promote uptake of care, health literacy, and PSS for ABYM. Also, PEPFAR will develop public private partnerships (PPPs) that increase access to wraparound/holistic social protection and economic empowerment efforts that reduce HIV acquisition risk and vulnerability to treatment interruption for economically vulnerable ABYM. Existing opportunities include the Parish Development Model, Village Savings and Loan Association (VSLA), and "Emyoga".

**Adult Men Living with HIV (25-49 years)**

Adult men remain a lynchpin to epidemic control, but remain hard to find, diagnose and link to treatment in Uganda and globally. Only 75.8% of the estimated men with HIV have been diagnosed, 71.6% of positive men aged 15-64 those are on ART, and 65.1% are virally suppressed (UPHIA 2020). Recent 2023 data shows improvements in case identification across male adult age bands, thanks to significant investments and focus on HTS for men since FY16. Most remaining undiagnosed males ages 15-35 reside in Central, South West, and Eastern Regions, necessitating increased case identification efforts there and intensified consultations to understand this sub-populations needs and preferences. Treatment gaps are particularly pronounced for men ages 20-24, 25-29, and 30-34. PEPFAR Uganda will adopt relevant data-driven case identification, linkage, and treatment support approaches from the ABYM sub-section above, and support the following interventions tailored to older men ages 25-49.

**Case identification:** PEPFAR Uganda will continue to scale-up higher-yield HTS modalities for adult men, who are among the hardest populations to reach for new case identification. Ensure linkage and enrollment in care and services to remain HIV negative (VMMC, PrEP, condoms etc.) Planned modalities include:

- **Other PITC:** Screening and PITC for ABYM at IPD, outpatient department (OPD), STI clinic, TB clinics.
- **Index testing:** Adult male partners of PBFW testing positive; contacts of high-risk FSWs, APN.
- **Self-testing:** Expand HIVST targeting adult men via distribution at high-risk work sites or places like boda stages. Findings from an ongoing pilot study on integrating HIVST as a screening tool, especially at outpatient units, will inform revision of HIV testing algorithms to capture HIVST in COP23.
- **SNS:** Scale-up SNS for at-risk adult males (social contacts of HIV-positive and high-risk FSWs, PPs) and link them to testing.
- **DREAMS:** Use male sexual partner characterization to expand ABYM engagement via NextGen DREAMS through offering self-test to both DREAMS participants and/or to take home to their partners or inviting partners to testing events. Negative male partners will be referred to VMMC (if appropriate), PrEP, or to treatment if they test positive.

**Linkage to and continuity of care:** Adult male PLHIV feature lower linkage and VLS compared to females, at 94.7 (linkage) and 91.3% (VLS) (UPHIA 2020). Men experience multiple structural and socio-cultural barriers to finding, reaching, engaging in, and staying in HIV care. They often need continued, adaptive support to ensure that they remain virally suppressed as the grind of lifelong treatment may become tedious. PEPFAR Uganda will deploy and scale-up person-centered DSD models that better needs of men, including MMD, community ART delivery (e.g., community drug distribution points [CDDP], community retail pharmacy drug pick up points, client-led ART delivery [CLAD], home delivery). The scale up of these programs reduced IIT over the last eight quarters and will continue expansion in COP22, with adaptations to cater to the differentiated needs of men in urban, peri-urban, and rural areas.

In COP23, the community pharmacy refill model will be scaled up to reach 60 districts and 157 health facilities. To improve enrollment on community ART delivery models, client preference for DSD will be assessed at every contact with the health facility. Client preference assessment for DSD will be part of the comprehensive HIV care for all PLHIV. PEPFAR will further strengthen client attachment to Community Male peers, appointment tracking, and routine use of the Client Audit Tool to address service gaps.

- Support scale-up of the CRPDDP ARV model in COP23, increasing retail pharmacies. This DSD model enables stable PLHIV to pick up MMD at nearby, conveniently located private retail pharmacies that often offer friendlier hours for adult working men, privacy, making collection of medicine quick and convenient.
- Expansion of peer-to-peer treatment literacy programs for adult men, which enhance retention in treatment and reduce ITT.
- Boda boda delivery of ART, reducing the conflict working men face in accessing pick-up during work week hours.
- Community ART pickup, enabling time efficiencies and convenience for stable adult male clients.
- ECounseling, attaching each non-suppressed client to a counselor who regularly calls them (“e” phone calls).

- Community bleeding for VL after the first three months.
- Expand flexi-hours for clinics for clinics/Flex-Hours Clinic Models - especially for urban communities where men can access HIV services after their workday.

**BARRIERS TO HEALTH EQUITY**

**Plan to Address Stigma, Discrimination, Human Rights, and Structural Barriers:**
One-fifth of PLHIV on antiretroviral therapy reported missing a dose due to fears that someone would learn their status. The GOU has developed National Policy Guidelines on Ending HIV Stigma and Discrimination, but S&D gaps remain.

*LGBTQIA+:* Increasing hostile rhetoric and stigma targeting the LGBTQIA+ community, jeopardizes efforts to end HIV/AIDS as a public health threat by 2030, achieve health equity, and risks the lives of LGBTQIA+ individuals and other key populations (KP). PEPFAR Uganda currently supports 57 KP-led or focused organizations which operate 84 DICs) across Uganda providing critical HIV, prevention, care, and treatment services. The escalating harassment and violence in Uganda have already triggered a decrease in people seeking clinical services at some PEPFAR-supported DICs serving KP and increased public arrests and harassment at the time of SDS drafting (late March 2023). Many members of the LGBTQIA+ community report being scared for their safety and have gone into hiding, stating that it is like COVID-19 lockdowns are back (*PEPFAR consultations with 11 KP-led CSOs in March 2023*).

It remains a fluid operating environment with impact varying across regions, with most DICs remaining open with adjusted appointment-only schedules. An environment of fear may continue to dissuade people at risk for HIV from seeking prevention and testing services and could further interrupt treatment continuity for people living with HIV in COP23 without adaptations. Without an enabling legal and policy environment for LGBTQIA+ and KP services supported by PEPFAR, Uganda risks eroding the progress made to date in the fight against HIV/AIDS and other pandemics.

PEPFAR Uganda is actively considering multiprong adaptive KP service delivery program adaptations to minimize impact of the AHA to ensure continuity of services for LGBTQIA+ individuals, and address safety and security concerns at the time of SDS drafting. Many of these adaptations for COP23 will depend on the evolving legal and implementation environment. LIFT UP funds will also provide expanded access to such services for access to justice for LGBTQIA+ CSOs and clients unlawfully harassed/arrested and create linkages to USAID/Uganda's Rights and Justice Activity (RAJA) (described below).

*Adapting and responding to recent Legal Environment Assessment (LEA) recommendations:*
PEPFAR Uganda will continue liaising with the Uganda KP Consortium, KP CSOs, MOH, and other stakeholders to address LEA recommendations from the recent twin LEAs conducted in 2022: 1) Makerere University School of Law, SPH, MOH, UAC, CDC Uganda August 2022 HIV & AIDS LEGAL ENVIRONMENT ASSESSMENT FOR KEY POPULATIONS, and 2) East-West Management Institute/USAID LEA for HIV & AIDS in Uganda February 2022. These studies highlighted an

unfavorable legal environment for KPs and PLHIV, particularly for LGBTQIA+ individuals. These studies, rich with many recommendations, require review and updating given the AHA and shifting legal environment.

In COP23, UAC with support from Makerere SPH, will lead the multisectoral approach to address the LEA recommendations to prioritize recommendations for action given the current context and shape advocacy efforts. With LIFT UP funds, CSO partners will hold HIV advocacy dialogues with the justice, and law and order sector at all levels on the importance of safe access/continuity of HIV services in the context of AHA, building on 2022 PEPFAR LEA recommendations for PLHIV and KPs. This also includes select meetings with the top leadership of Justice, Law, and order structures and dialogue meetings with standing committees of parliament. We will also support sub-national engagements with District Police Commanders, Resident District Commissioners, District Internal Security Officers, Uganda Prisons, and religious and cultural leaders in higher decision-making spaces. These engagements will lead to identification of focal persons to address public health and legal related matters related to access to and utilization of HIV services by KPs.

*Tapping into LIFT UP Health Equity Incentive Fund:* PEPFAR Uganda engaged in a consultative process with KP CSOs during COP23 to develop an application for $3M in global PEPFAR LIFT UP funds. The resulting concept, approved April 24, 2023, includes interventions requested by CSOs that aim to decrease equity gaps in case detection, linkage, and retention for at-risk KPs (MSMs, TGs, FSWs, people who inject drugs (PWIDs). Key components, as detailed in relevant SDS sub-sections, include: 1) Evidence-based social protection interventions for KPs; 2) Enhanced safety, security, and service access for KP communities at DICs and communities; 3) Institutionalize a multisectoral stigma and discrimination reduction response (including engaging the National Equal Opportunities commission, conducting intergenerational dialogues, and developing a stigma and discrimination toolkit); and 4) Launch telehealth and self-care platforms

*KP-friendly services:* PEPFAR Uganda will continue to advocate for and strengthen availability of quality and respectful care for KP HIV and GBV clients at health facilities. Fear of and experiences of stigma at health facilities, particularly for FSWs, LGBTQIA+, and PWID individuals persists, despite MOH circulars calling for non-discriminatory health services to all clients. This is likely to increase given the passage of the AHA by Parliament for LGBTQIA+ individuals, who may have fears or perceptions of breaches in confidentiality by HCWs that could result in criminal charges. Conversely, HCWs report feeling confusion around their duties to “report” LGBTQIA+ individuals based upon draft language. PEPFAR Uganda will collaborate with the MOH and KP CSOs to identify the most impactful and science-driven interventions, including continuing training of HCWs on Gender and Sexual Diversity and KP focal persons within health facilities or adapting it to online training for Ips and PEPFAR-funded HCW staff.

PEPFAR Uganda will also revise the curriculum for and conduct safety and security trainings for health workers and other lay health service providers (KP peers) to enhance their security awareness (last conducted in 2014). PEPFAR Uganda may have to design/conduct programing

to sensitize HCWs and other stakeholders on adaptations needed to ensure continuation of stigma and discrimination-free services.

*Leverage Non-Health Investments and Partners:* PEPFAR Uganda will link KP-led CSOs to additional non-health sources of technical assistance and funding to address human rights, legal, and structural barriers to health equity for KP. This includes implementing LEA recommendations, as well as AHA-related needs.

We will sensitize and link the Uganda KP Consortium and its members to USAID/Uganda's RAJA, which works to ensure that citizens know, use, and can shape the law to exercise their civil and political rights and have access to legal and medical assistance when their rights are violated. This goal is pursued in several ways. We will ensure KP clients whose rights are violated access the Rapid Response Fund mechanism to receive emergency legal and medical support, referral services, and protection to LGBTQIA+ victims of abuse, arrest, and attacks. To date, the Fund has provided legal aid and medical support to more than 1,000 human rights victims, including 400+ LGBTQIA+ individuals. We will also link CSOs to RAJA capacity building training to over 100 CSOs, 277 human rights defenders, and lawyers focused on enhancing individual, organizational, and digital security, and operational effectiveness in the shrinking civic space in Uganda.

PEPFAR Uganda also submitted a USAID/Bureau for Development, Democracy, and Innovation Rainbow Fund application for $600,000 in additional funding for economic empowerment of LGBTQIA+ individuals and PLHIV in March 2023. This initiative will likely evolve but will be dedicated to enhancing economic survey for at-risk LGBTQIA+ who may have had to quit their economic activity due to threats post-AHA.

*KP CSO Capacity Strengthening:* We will increase technical assistance and funding for national KP CSO mechanisms and subnational CSOs to support efforts at non-discriminatory KP health service delivery, and health advocacy. This includes rolling out KP Competency Assessments of CSOs serving PEPFAR KP patients – assessing their responsiveness to confidentiality and respectful care dimensions. PEPFAR Uganda may also potentially support or enhance coordination with the new Ugandan-led Convening for Equality (CFE). The goal of CFE, established post AHA, is to ensure that the counter strategy to attacks against the LGBTIQ+ community is well coordinated, resourced, timely, and sustained.

*CLM:* Please see the **Community Leadership** section.

*Measuring and monitoring stigma:* PEPFAR Uganda will review and support the dissemination and implementation of key findings from the 20 district Makerere University Stigma Index (Assessment of the Magnitude and Correlates of HIV Stigma and Discrimination and Its Effects on the Country's HIV Response). This aligns with PEPFAR technical guidance that calls for a local partner PLHIV network or KP CSO to conduct an updated PLHIV Stigma Index every three years (Ugandan PLHIV network NAFOPHANU conducted Uganda's most recent Stigma Index in 2019; https://www.stigmaindex.org/wp-content/uploads/2019/11/PLHIV-Stigma-Index-Report-Uganda-2019.pdf). We will triangulate stigma index findings (expected July 2023), CLM, IBBS,

and other data points (KP hotline) to inform development of national stigma reduction plans, including election of key interventions by setting (e.g., community, health care, workplace, education, justice, emergency).

## Pillar 2: Sustaining the Response

Uganda's HIV/AIDS response relies heavily on external donors, accounting for 80-90% of HIV/AIDS spending. Out of the 1.4 million people (about half the population of Nevada) currently living with HIV/AIDS in Uganda, close to 80% are directly supported by the U.S. Government through PEPFAR, which remains the largest HIV/AIDS donor in the country, contributing about 85% of external funding for the National HIV/AIDS response in Uganda. PEPFAR employs more than 25,000 health workers throughout the program including government, Implementing Partner, and CSO staff, spending more than 100 million US Dollars annually, roughly the same amount spent annually on commodities.

The overreliance on international donor funding presents a clear vulnerability for the sustainability of these investments in Uganda. The economic impact of COVID-19 and the overall global economic conditions undermined Uganda's ability to sustain the response and this will likely continue in the short term. A long-term plan is necessary for sustainability to transition from PEPFAR to the Ugandan Government, civil society, and the private sector. Last year in COP22, PEPFAR Uganda initiated interagency discussions around developing a multi-year sustainability roadmap for the HIV/AIDS response in Uganda. To spearhead this process, an interagency task force was set up to work with GOU and other stakeholders to establish a national structure that will coordinate the process, create a common vision for sustainability, identify key priorities for the sustainability plan, and define the principles and strategies to achieve the goals of the sustainability roadmap.

PEPFAR/Uganda envisions the sustainability roadmap to be fully country-led and owned and developed through an all-inclusive, multi-stakeholder process. To address this, the PEPFAR Coordination Office (PCO) has engaged with the Ministry of Health as a catalyst to begin the framing process that captures Uganda's sustainability vision. On a separate development, the Uganda AIDS Commission (UAC) had been charged with mobilizing all government entities to begin a similar sustainability framing process. During the RPM meeting in Johannesburg, it was agreed to merge these efforts, the Prime Minister (OPM) is taking the lead in mobilizing the Government of Uganda (GOU) in developing a national sustainability roadmap. This approach builds upon a similar approach to how the Uganda ten-year supply chain roadmap was developed. This is expected to ensure adequate political will and ownership, accountability for the implementation of the plan, and convening authority to coordinate this multi-stakeholder process.

A National Task Force in expected to define and frame the sustainability roadmap. The roadmap will include clear and measurable deliverables. The task force is expected to be comprised of the Ministry of Health, the MOFPED, the Uganda AIDS Commission, the MGLSD, key stakeholders, the USG interagency working group, UNAIDS, the Global Fund, and CSOs, to jointly develop the plan for the overall coordination and leadership of the OPM. The National Task Force should consolidate all sustainability pieces provided by various Ministries, Departments, and Agencies (MDAs) and define Uganda's sustainability vision, goals, priorities, and implementation metrics for the country. The task force will be assigned clear terms of reference (TORs), roles, and responsibilities for all stakeholders including the government entities (MDAs) contributing to the execution of the sustainability roadmap. The OPM office is expected to provide the overall requisite oversight, and leadership functions, and mobilize the required resources for the framing and eventual implementation of the sustainability roadmap with clear/measurable deliverables. This approach will ensure that the government of Uganda is providing the oversight and leadership of this process, which will result in a set of standardized interventions and a harmonized approach to programming. In addition, this approach will ensure the availability of resources, and at an operational level, interventions for integration and transition into the public sector domain will be identified for efficiencies and leveraging the available resources. PEPFAR will work closely with the Task Force to identify and support data/program analytics where necessary that will inform the development of the roadmap.

The Ministry of Health, MOFPED, MGLSD, the Uganda AIDS Commission, and CSOs played a lead role in COP23 planning including identifying priorities and influencing PEPFAR's investment decisions. The sustainability roadmap is expected to take this to the next level by creating a strong mechanism for ensuring that the remaining undiagnosed individuals living with HIV (unPLHIV) are identified and facilitating the closing of the gaps for epidemic control. To this end, strong emphasis will be given to building local organizational capacity (both programmatic and financial) including GOU entities, CSOs, relevant private sector entities, and regional institutions when appropriate.

The Sustainability Index Dashboard (SID) consistently shows that while GOU's governance of the program is strong, the responsibility matrix reflects that the GOU response is heavily dependent on external donor support and some sustainability elements need improvement. These include but are not restricted to, domestic financing, commodity security, and Human Resources for Health (HRH) availability among others. PEPFAR Uganda is currently analyzing these and other health system gaps to inform sustainability planning.

PEPFAR Uganda has already made significant progress in areas important for sustainability such as the successful transitioning of programming to local partners and increasing use of domestic systems. PEPFAR is supporting the Regional Referral Hospital (RRH) strategy to provide HIV/TB

services and complex case management at the RRH. This serves as a foundation for advancing local capacity to support the decentralized health system.

Another model for sustainability planning in Uganda is the 10-year supply chain roadmap that was developed in a multi-stakeholder process and is currently being implemented with full ownership of the GOU. PEPFAR has also made a significant contribution in creating laboratory systems capable of addressing the growing health threats in addition to providing diagnostics and monitoring services to PLHIV. The Ministry of Health, through the Uganda National Health Laboratory Services (UNHLS), has developed a strategy to ensure standardization and efficiency of GOU laboratory systems, which efforts are key for sustainability planning.

Key focus areas included in the PASIT for advancing the sustainability engagement in COP23 include supporting MOH to implement its new HRH structure recently approved by the Ministry of Public Service, ensuring that GOU fulfills its commitments in the 10-year supply chain roadmap, aiding the GOU to explore additional domestic financing options including health insurance, improving efficiency and public financial management, advocating for formalizing and institutionalizing Community Health Extension Workers (CHEWs) and harmonizing health information systems investments (including health management information systems (HMIS) across systems and program areas. PEPFAR will continue the strong engagement it has with local CSOs and will implement the recommendations from the discussions on sustainability. PEPFAR Uganda will support health financing analytics and will work with the Ministry of Health, MOFPED, and other host country institutions to institutionalize models to improve efficiency, generate evidence for advocacy and improve the availability of health financing and cost data for planning. The analytics will provide clarity on the cost drivers of the HIV program that will inform in-country sustainability discussions and priorities.

In COP23 PEPFAR will continue strong engagement with local CSOs implementing the national HIV response and adapt recommendations from these discussions to improve the sustainability roadmap process. PEPFAR Uganda supports health financing analytics and will work with the Ministry of Health, MOFPED, Uganda AIDS Commission, and other host country institutions to institutionalize models to improve efficiency (including activity-based costing), generate evidence for advocacy, and improve the availability of health financing and cost data for planning. Over the years, PEPFAR Uganda has empowered and developed local capacity for the implementation of its supported programs. For example, more than 75% of partners in Uganda are indigenous partners that will contribute to improving local capacity and maintain and sustain the current program level of performance and quality assurance. Engagement with local district teams and regional structures ensures harmonized implementation and a transition avenue for sustainability.

## Pillar 3: Public Health Systems and Security

**Global Health Security**

Uganda has been working with USG and other partners for decades, establishing and strengthening multiple components of the country's health system. With USG support, Uganda has conducted several Joint External Evaluations (JEEs), revealing progress and gaps towards implementation of the International Health Regulations, and improving the country's ability to prevent, detect, and respond to outbreaks and other threats to public health.

PEPFAR continues to strengthen the national laboratory system and surveillance systems. These have been leveraged to diagnose and track COVID-19 and Ebola cases. Uganda's National Public Health Institute (NPHI), fellows from the MOH Public Health Fellowship Program and the advanced track of the Field Epidemiology Training Program (FETP) were instrumental in gathering case information and tracing contacts of COVID 19 and Ebola during recent outbreaks. Rapid detection and contact follow-up resulted in prevention and quick control of these epidemics in Uganda.

Both facility and community health systems have been critical in the responses to HIV, TB, COVID-19, Ebola, and other public health threats. For example, PEPFAR has been strengthening RRHs as hubs to catchment districts and their facilities. USG funding assisted in establishing and strengthening national and regional emergency operations centers (EOCs) to respond to disease threats beyond HIV. Furthermore, PEPFAR-supported faith-based partners have worked with MOH to train faith and community leaders about COVID-19 and Ebola prevention and detection; they in turn have engaged local communities to overcome misinformation and misconceptions. Innovations such as the Project ECHO virtual platform have been used to safely reach community leaders across long distances and to conduct continuing medical education to improve health outcomes for HIV, TB, other infectious diseases (e.g., COVID-19, Ebola), and non-communicable diseases (e.g., cervical cancer, hypertension). In COP23, PEPFAR will continue to work with Uganda to strengthen human resources for health (HRH) through sustainable interventions towards integration of multiple health care facets. Continuing engagement of PEPFAR with MOH towards strengthening RRHs and towards implementing the HRH absorption plan will make public health systems, including its workforce, more sustainable.

**National Laboratory System**

Uganda is working to build strong and resilient laboratory systems that not only serve HIV and TB programs but also are leveraged for disease outbreak detection, prevention, control, and surveillance. These include systems for sample transport and results return, equipment maintenance, waste management, and methodologic quality assurance for multiple laboratory tests (including for HIV diagnosis, HIV viral load (VL), TB, and other pathogens) across 100 laboratory hubs and linked lower-level health facilities. The blended testing system for EID and VL using both centralized conventional PCR platforms and decentralized point-of-care (POC) platforms, including the m-PIMA and GeneXpert which are used for analysis of both plasma and dried blood spot (DBS) samples, have also been integrated into multi-disease testing, leading to improved efficiency and diagnostics. By the end of COP21 implementation, the MOH National Health Laboratory and Diagnostic Services (NHLDS) completed placement of GeneXpert platforms in all 16 RRHs, increasing the capacity for multi-disease testing within these health

facilities. NHLDS spearheaded the integration of testing for COVID-19 and the recent Ebola outbreak into the existing HIV and TB laboratory infrastructure.

In COP23, PEPFAR Uganda will continue working collaboratively with partners to implement laboratory-based continuous quality improvement (CQI), proper and safe laboratory waste management, and tracking of specimens from collection at the health facility to the testing laboratory through the hubs network.

The Laboratory Information Management System (LIMS) will be scaled up to include person-centered SMS messaging to alert clients of the availability of test results for HIV including EID, VL, advanced HIV disease, TB, and other pathogens (e.g., human papillomavirus, COVID-19). In addition, PEPFAR Uganda will work with NHLDS to revise the national guidelines for POC testing and scale up multi-disease testing through implementation of the recommendations from the diagnostic network assessment as part of laboratory optimization for improved access, efficiency, and cost savings. PEPFAR Uganda will also work with NHLDS and other partners to develop and implement the community-based testing guidelines aimed at strengthening integration of community disease diagnosis and engagement of the private sector in HIV and TB diagnosis, disease surveillance, and outbreak response for coordinated approaches towards epidemic control.

COP23 investments in the national laboratory system will continue to address LIMS interconnectivity with POC platforms and triangulation of data from LIMS with the District Health Information Software 2.0 (DHIS2)-based electronic Health Management Information System (eHMIS) and Uganda national dashboards for real-time HIV and TB data capture, transmission, and analysis. An efficient integrated sample transport network and tracking system and the national diagnostic network optimization processes remain major components for access to quality-assured HIV and TB testing services.

GOU ownership is critical for the sustainability, standardization, and efficiency of the national laboratory system. In 2018, MOH established NHLDS with the mandate to provide stewardship for the Uganda national laboratory system to guide disease prevention and control as well health promotion. MOH advised all partners to channel laboratory-related support through the NHLDS to standardize services, harmonize efforts, and promote efficiency, accountability, and sustainability of laboratory services in the country. Coordination and oversight of laboratory services at national and subnational levels is critical for resilient, efficient, and sustainable laboratory services, in alignment with the National Health Laboratory Services Policy II (2017) and the National Health Laboratory Services Strategic Plan III (2021-2025). It will strengthen the capacity of RRHs to provide governance, leadership, and technical assistance at the subnational level; coordinate quality management systems; conduct surveillance; and oversee service delivery within their areas of jurisdiction for long-term sustainability. In addition, PEPFAR Uganda will continue working in collaboration with NHLDS to strengthen existing infrastructure, including through regional equipment maintenance workshops and maintenance of biorepositories for remnant specimens. PEPFAR Uganda will work with NHLDS to enhance

integrated disease surveillance and genotyping to inform programs and will establish the national accreditation scheme as part of the national laboratory sustainability roadmap.

**Workforce Development, including Human Resources for Health (HRH)**
GOU developed a 10-year strategic plan for HRH for 2020-2030, focusing on establishing a resilient, responsive, and productive health workforce that meets changing health needs. In COP23, GOU plans to engage multiple stakeholders for transformative change of the workforce to strengthen HR management systems, enhance leadership and governance, reform HR policy, and provide adequate and skilled health workers at all levels. There will be a renewed focus on strengthening community health worker systems to support person-centered services and aligning PEPFAR-supported staff cadres and salaries to GOU-recognized cadres, pay scales, and qualifications.

Priority activities will include:

- Carry out HRH optimization and integration to ensure equitable HRH deployment.
- Finalize and implement new staffing structure and schemes of service to facilitate additional recruitment and transitioning of PEPFAR-supported staff.
- Strengthen integrated human resources information system (iHRIS) use for evidence-based HRH planning, recruitment, and performance management.
- Support institutionalization and management of community health workforce.
- Train key cadres critical for HIV and TB epidemic control and sustainability.
- Conduct HRH labor market analysis to understand the HRH profile in Uganda.
- Support of the PHFP, FETP, and Laboratory Leadership Program (LLP) fellows.

**Health Information Systems (HIS)**

PEPFAR Uganda will continue to invest in person-centered, longitudinal, integrated, deduplicated data systems, including by improving interoperability, health information exchange, and data integration capabilities. Strengthened systems will improve data quality, as well as promote integrated data use and data visualization for evidence-based decisions at all healthcare system levels including community, facility, district, regional referral, and national. PEPFAR Uganda will continue to co-plan with GOU and other health development partners to align investments in infrastructure, connectivity, and change management to support the broader GOU digitalization strategy.

Lessons learned and best practices from the COVID-19 response will continue to be applied by PEPFAR Uganda, the GOU, and its partners to promote integration and efficiency and explore some of the program aspects that need to be harmonized in readiness for transition into the

GOU public sector domain toward ownership. There will be a reduction of training costs by replacing purely in-person training with hybrid training approaches, theory-based training, Project ECHO/ZOOM classes, and practical mentorship programs.

In addition, priority survey activities which traditionally had been implemented by the Makerere University School of Public Health Monitoring & Evaluation Technical Support Program (METS) will increasingly be led by additional local partners in COP23. In line with this direction, PEPFAR Uganda will continue to empower local institutions such as MOH and schools of public health to lead the planned population-based surveys and surveillance activities.

PEPFAR Uganda and MOH have partnered closely to advance the alignment of data systems in Uganda. This alignment of PEPFAR and the MOH data systems, routine indicator mapping, site list reconciliation, and harmonization of program data reporting processes has enabled 80% of program data elements reported to PEPFAR to be extracted from Uganda's national health information systems. In COP21 and COP22, PEPFAR Uganda collaborated with MOH to revise the national health management information system (HMIS) tools to capture additional priority indicators in routine reporting. The additions included data for cervical cancer (CxCa) screening and treatment among WLHIV, key and priority populations, mental health, non-communicable diseases (NCDs; e.g., diabetes, hypertension), COVID-19 vaccination, and 50+ finer age bands. As a result, 90% of the PEPFAR MER reporting requirements will be met in COP22, further streamlining monitoring and evaluation processes through increased reliance on GOU systems.

*HIV-related Death Surveillance and Response (HIVDSR)*

MOH has rolled out implementation guidelines, data capture and reporting tools, and a national training of trainers (TOT) for HIVDSR. Following this, PEPFAR Uganda will support cascading of trainings and implementation to districts and health facilities, focusing on health worker competencies, community awareness, and reporting.

**Supply Chain Forecasting**

National quantification and supply planning are coordinated and completed by the MOH Quantification and Procurement Planning Unit (QPPU). The ARV commodity quantification was done for FY24-26 based on updated UNAIDS SPECTRUM estimates. The estimated supply of ARVs needed in COP23 Y1 is fully funded, but additional financing might be needed from the Global Fund, GOU, or PEPFAR in COP23 Y2. PEPFAR Uganda has ensured a 6-month buffer of ARV stock at the end of each COP year. This buffer is specific for the TLD 90-pack, because >90% of patients use this regimen. GOU has increased their funding contribution commitment for ARVs with an additional $13m beginning in COP23 Y1. This will increase the GOU ARV

contribution to $52m annually. PEPFAR Uganda continues to leverage efforts achieved in scaling up the implementation of multi-month dispensing and community retail pharmacy drug distribution points.

All forecasted commodities are funded for VMMC, EID, and VL testing at a cut-off of 200 copies. National service agreements are in place for the procurement of VL/EID reagents, and plans are underway to implement vendor-managed inventories. PEPFAR Uganda will also continue integrating facility electronic logistics management information systems (eLMIS) with central systems to improve commodity visibility across all levels of the supply chain.

**Advanced HIV Disease (AHD)**

In COP21, only 55% of clients newly initiated on ARV treatment also had their CD4 counts measured; CrAg access was 68% and TB LAM testing was 71% among clients with CD4 <200. Gaps still exist in AHD commodity security, health worker competencies, and documentation. Key priorities for COP23 include:

- Continue support for the standard package and pathways to support clinical decision-making.
- Improve AHD commodity ordering and stock monitoring.
- Enhance capacities of health workers through training and on-the-job mentorships.
- Strengthen reporting and recording of the AHD cascade, including outcomes.

**Non-Communicable Disease (NCD)**

Uganda has a generalized HIV epidemic with estimated prevalence of 5.8% (7.2% among women aged 15+, 4.3% among men aged 15+). An increasing number of PLHIV are aging, contributing to increases in NCDs. The proportion of the aging population (≥50 years) under PEPFAR-supported ARV care increased from 13% in FY17 to 20% in FY22Q2 (263,572/1,283,662). This population is most affected by NCDs. Uganda's consolidated guidelines for the prevention and treatment of HIV identifies and includes NCDs. In COP22, implementation guidelines will be rolled out to support institutionalization of integration of NCDs into HIV care. Key priorities for COP23 include:

- Support prevention, identification, and timely management of NCDs, principally hypertension, diabetes, and mental health, among PLHIV as part of a long-term retention and epidemic control sustainability strategy.
- Strengthen supply chain commodity security for NCD medicines.

- Strengthen capacity of healthcare workers in the identification, prevention, and management of NCDs.
- Support program monitoring and evaluation systems for NCDs, including implementation evaluations.
- Engage communities in NCD prevention, diagnosis, and treatment, including through client literacy, identification, and referrals.

*Cervical Cancer Screening and Treatment for WLHIV (25-49 years)*

PEPFAR Uganda has over the last three years provided funding to supported MOH/ACP/NCD departments to roll out national CxCa screening and treatment of precancerous lesions for WLHIV, referring WLHIV with suspected cancer lesions to RRHs and the Uganda Cancer Institute for further management. Specific objectives have included increasing the availability and accessibility of high-quality CxCa screening and treatment services for HIV-positive women aged 25-49 and building capacity of health workers to provide these services towards eliminating CxCa in Uganda by 2030. By the end of FY22, PEPFAR had supported Uganda to reach 75% (407,323/545,188) of age-eligible WLHIV. In COP22, PEPFAR is supporting Uganda to screen 185,724 more WLHIV, and in the first year of COP23 implementation, PEPFAR Uganda aims to screen approximately 185,000 more WLHIV by maintaining CxCa services in all 1,800 current facilities, with plans to scale up HPV testing leveraging resources from the Global Fund and CHAI. PEFPAR Uganda will continue to support mentorship to frontline health workers to ensure service and data quality, to conduct community outreach/mobilization and referrals, and to manage adverse events and palliative care support.

# Pillar 4: Transformative Partnerships

For COP23, Uganda recognizes that PEPFAR's focus to end the HIV/AIDS pandemic will only be accomplished by placing government, partners, and civil society front and center of the discussion to build and sustain transformative partnerships. During COP23, the USG PEPFAR Technical Working Groups (TWGs) for Care and Treatment (Care and Rx), Prevention (Prev), Laboratory, Strategic Information (SI), and Health System Strengthening (HSS) convened a cross cutting team to discuss their respective strategic direction, program shifts, alignment of resources, critical or new partnerships and enablers as it relates to transformative partnerships.

## Care and Treatment (Care and Rx)

### Strategic Direction

To optimize the provision of health services and accelerate Uganda's progress towards achievement of epidemic control, PEPFAR's Care and Rx portfolio will embark on a strategy to

strengthen and optimize local meaningful partnerships with key stakeholders including Uganda's Ministry of Health (MOH), donor agencies, private sector, civil societies, faith-based organizations and community platforms to leverage or garner additional resources and capacities to offer high quality, efficient and impactful ART program. During COP23 development, the Care and Rx portfolio increased and strengthened coordination between PEPFAR and the other stakeholders to plan for sustained provision of services for HIV and TB treatment for both key/priority populations and general populations. The Care and Rx portfolio has planned to increase collaborations and partnerships with the local community players to sustain gains that have been realized in the country's HIV response. During implementation, the key stakeholders to be involved in partnerships would include MOH, donor agencies like Global Fund, the private sector, civil society, and communities including faith-based organizations, PLHIV-led and KP-led organizations. All these entities have been duly engaged in wide strategic consultations in the planning processes, to determine interventions for the program priority areas for Care and Rx, as well as identify critical program priorities. During COP 23 development, the care and treatment team engaged and partnered with the Uganda Community Led monitoring initiative to identify care and treatment priorities for funding.

**Program Shifts**

In COP23, PEPFAR Uganda will make some key programmatic shifts aimed at increasing resources to further strengthen community platforms for sustainable and efficient provision of priority interventions. These include continuity of treatment of PLHIV in care; closing clinical cascade gaps among children and adolescents living with HIV (C/ALHIV); refocusing the supported Key Populations (KP) ART program to improve quality and outcomes of services for KP and Priority populations and integrating tertiary HIV/AIDS management interventions for non-communicable diseases (NCDs)and advanced HIV disease in routine HIV care.

PEPFAR will prioritize expansion of the client-centered community-based differentiated service delivery models and approaches including promoting the integrated community model of care for management of non-suppressed children and adults.

PEPFAR will also strengthen partnerships with the private sector to integrate the care and treatment services, for example integration of NCDs into HIV/AIDS services in the pharmacy model. By the end of COP22, the pharmacy model will be scaled up to a total of 60 districts, targeting 157 health facilities. In COP23, additional services and commodities will be provided through participating pharmacies to ensure integration of the management of NCDs including hypertension (HTN) and diabetes mellitus (DM), HIV prevention commodities for PrEP and TB prophylaxis. Working with MOH, the pharmacy refill model will be opened to adolescents 15 years and above and caregivers of children 0-9 years, who prefer to receive their drugs through a participating pharmacy.

**Alignment of Resources**

The PEPFAR Care and Rx team works collaboratively with the MOH and other stakeholders to ensure that the PEPFAR resources are well aligned and allocated to geographical regions with high disease burden and to populations that are drivers of HIV incidence and transmission. The team partners with data management teams to utilize data to direct resources and investments towards epidemic control. The team also aligns resources well to meet the needs and gaps in various unfunded areas, for example, PEPFAR allocates resources to meet 100% of Care and Rx services in the private not for profit sector as well as supplementing to fill the gaps in the public sector.

**Critical or New Partnerships**

There are several bilateral and multilateral institutions supporting the MOH HIV response in Uganda, including UNAIDS, UNICEF, Global Fund (GF), WHO, and World Bank. In COP23, PEPFAR will strengthen the mechanisms for these partners to work together by supporting a mechanism to lead multisectoral coordination of the HIV response. This effort will aim to minimize duplication, identify and direct efforts to where there is most need, and utilize working models across institutions.

Important existing partnerships that are anticipated to impact on program success:

- PEPFAR will continue to participate in the Global Alliance to end AIDS in children by 2030 by scaling interventions from the Accelerated Progress in PMTCT and pediatrics (AP3) to all PEPFAR supported sites.
- GF for ARVs and other program activities and commodities.
- MOH for policy coordination and guidance including oversight of Care and Rx activities, as well as mentorship, forecasting, quantification, and budgeting.
- WHO has always been supported by CDC for providing global guidance on guidelines and broad TA on adoption of new guidelines e.g., in cervical cancer, TB/HIV and NCDs
- Resolve To Save Lives will continue to support Uganda for NCDs integration across the 1800 PEPFAR supported ART sites.
- Civil society and communities for strengthening DSDM and enhancing community empowerment through community-based treatment literacy programs.
- The USAID/Uganda's Strengthening Uganda's National Child Care and Protection Systems (SUNS) Activity support for the Ministry of Gender, Labor and Social Development (MGLSD) is currently paused, this was intended to improve coverage and quality of service delivery for HIV and Violence Against Children (VAC)/Gender-based Violence (GBV) prevention and response outcomes for children and adolescents, improve frequency and quality of support supervision to districts and communities, strengthen inter-ministerial coordination to align with the National Child Policy to achieve national child protection objectives and strengthen the National Child Wellbeing Management Information System (MIS) component of the National Single Registry for Social Protection, including ensuring interoperability and data-sharing with relevant Ministries other than MGLSD.

- As the main signatory of the USAID government-to-government (G2G) awards, the Ministry of Finance, Planning, and Economic Development (MOFPED) supports smooth continuity of activities at regional referral hospitals by ensuring funds are not tied up in the public financial management system. PEPFAR will also strategically engage with MOFPED to increase funding for HIV commodities.
- To address GBV, PEPFAR will continue to strengthen community level partnerships with stakeholders, including CSOs, for prevention and response, provide technical assistance, and leverage private sector partnerships for commodities, shelters and other services.

**Enablers**

**Community leadership**

PEPFAR Uganda will continue to strengthen and focus on engaging the various community platforms including KP-led organizations, faith-based organizations, PLHIV networks and coalitions to enhance provisions of person-centered care and treatment services by leveraging the well-established community structures and platforms that have been developed and strengthened throughout the previous years of PEPFAR's support and investment in Uganda.

**Innovation**

In COP22, the MOH adopted the automated Client Services Delivery Audit tool through partnership with PEPFAR, UNICEF, and other HIV stakeholders. This is a sustainable innovation used for micro planning at the individual level. It enables multi-disciplinary teams to improve performance by responding appropriately to unique access challenges of each patient. The client audit tool also enables optimization of facility resources, and identification and rapid response to structural barriers at the district, regional, and national levels. In COP23, PEPFAR Uganda will automate and scale the client service delivery audit tool all sites with EMR. In COP22, MOH is rolling out an innovative intensive integrated model for the delivery of community health services across the country. The model will target all children, adolescents and adults who are non-suppressed or interrupt treatment. Implementation of this model will be maintained in COP23 to consolidate and sustain community investments across stakeholders and technical areas.

**<u>Strategic Information (SI)</u>**

**Strategic Direction**

The Strategic Information (SI) portfolio is a service entity that supports all other technical areas with a focus to ensure evidence programming across the program cycle to achieve the long-term goal of epidemic control while guiding efficaciousness, efficiency and effectiveness of interventions that lead to quality at the program as well as individual patient outcome levels.

Surveys and surveillance initiatives provide inputs into understanding burden, population size estimates and needs at all levels indicating direction of needed interventions; Health information systems are the basis of data and information management, access analytics and use. PEPFAR Uganda, building on global and national guidance, is positioned to support the "THREE ONES" principal; hence the choice to focus on use of national systems as the "Gold Standard" to work towards ensuring a sustainable national SI system that serves the needs of partners and programs including USG/PEPFAR and beyond as well as moving towards a health sector-wide approach beyond HIV/AIDS.

Therefore, strategic partnerships are naturally required within and beyond the USG entities and across Government of Uganda (GOU) sectors, departments and programs including ministry wide intervention approach within the ministry of Health. Hence PEPFAR's strategic information portfolio is positioned to further align to the national health management information, monitoring and evaluation, to include digital health strategies; addressing systems interoperability and a GOU led unified health information landscape to which all partners subscribe. Therefore, the team will continue to work with a national inter-sectoral approach that harnesses various Government of Uganda entities including but not limited to the Ministry of Health, Ministry of Gender, Labor, and Social Development, Ministry of Information Communication and Technology (Ministry of ICT), Uganda AIDS commission; as well as other development partners such as the United Nations (UNAIDS, UNICEF, WHO) the Global Fund (GF), other HDPs and ADPs, the civil society and the private sector. During COP23 development, the PEPFAR SI team will engage with these stakeholders on undertaking surveys and surveillance activities that support development of the national PLHIV estimates, inform strategic planning and program implementation. The team will also work with other stakeholders on improved harmonization of systems.

**Program Shifts**

For COP23, PEPFAR Uganda will make some key shifts including implementing a locally led population-based HIV survey that addresses a wide range of programmatic needs including those for estimating incidence and prevalence among children less than 15 years, as well as incorporating modules on violence against children. The additional eleven key-population biological behavioral surveillance (IBBS) sites established in COP21/COP22 alongside the initial IBBS sites in Kampala will be transitioned into sentinel sites and fully maintained in the two years of COP23. PEPFAR SI will continue the trajectory of establishing person-centric point-of-service EMR capability at all 650 HIV volume ART sites whilst maintaining tier 2 (data room) EMR capability at the low volume ART sites. PEPFAR will support the MOH's health section digitalization initiative that is aligned to the Uganda Health Information and Digital Health Strategic Plan. This will include continued investments in data integration and health information exchange. Focus on digital health has the long term goal of reducing investments in printing of paper-based tools and the use of manual approaches to data management and reporting; hence improving data quality and associated efficiencies.

**Alignment of Resources**

The PEPFAR SI/HIS team works collaboratively with the MOH, Ministry of Gender, Labor, and Social Development (MGLSD), UNAIDS, the Global Fund, and other stakeholders to ensure the PEPFAR resources are optimally utilized in support of standard monitoring, evaluation, and reporting, ensuring data quality through implementation of GOU-led data quality assessments, as well as GOU-led population-based surveys. PEPFAR agencies and IPs will deepen focus on strengthening HIS for improved alignment to national data and systems standards; support identification of private sector engagements and alignment and improving coordination at all levels with a focus on a medium to long-term reduction in paper-based data collection and reporting tools. Currently, PEPFAR allocates approximately 30% of the country's needs for paper-based tools, with the GF and GOU allocating additional resources in this area. The review and prioritization of these tools is consultatively led by the MOH's Division of Health Information.

**Critical or New Partnerships**

Critical partnerships with GOU entities include MoH, MGLSD, Office of the Prime Minister, Ministry of Local Government (MOLG), Uganda AIDS Commission (UAC), National Identification & Registration Authority (NIRA), and Ministry of ICT. Other key partnerships include the UN agencies (UNAIDS, UNICEF, WHO), civil society, and private sector entities including telecom business providers.

Important existing partnerships that are anticipated to impact on program success, include:

- Implementation of a locally led population-based survey between COP23 and 24.
- Global Fund for health systems strengthening support.
- MOH rollout of its new health information systems and digital health strategy.
- The USAID/Uganda's Strengthening Uganda's National Child Care and Protection Systems (SUNS) Activity support for the MGLSD is currently paused, this was intended to strengthen the National Child Wellbeing Management Information System (MIS) component of the National Single Registry for Social Protection, including ensuring interoperability and data-sharing with relevant Ministries other than MGLSD.

**Enablers (Innovation)**

Innovative approaches that improve alignment of all stakeholders to the national standards and guidelines will be needed ensuring the integration of all partner systems to synchronize with the national systems while maintaining system and data quality. Engagement to identify new ways to enhance private sector resource investments and alignment will be sought including identifying ways for building stronger PPPs and harnessing corporate social responsibility for strategic information. Building on evidence-based approaches to identify ways in which HIS, data management and analytic platforms can best support programmatic, governance, and resource allocation needs will be given priority.

## Health Systems Strengthening (HSS)

### Strategic Directions

PEPFAR Uganda will continue leveraging on the existing partnerships with the GOU, the AIDS Development Partners (ADPs), Health Development Partners (HDPs), the Global Fund (GF), Civil Society Organizations, Faith Based Bureaus, the private sector, and other key stakeholders to achieve the goal of epidemic control by 2025. The focus will be on understanding and building comparative advantages for each strategic stakeholder to strengthen existing and identify new partnerships. PEPFAR will work closely with Ministries, Departments and Authorities such as the Office of the Prime Minister (OPM), Ministry of Finance, Planning and Economic Development (MOFPED), MGLSD, MOH, the Uganda AIDS Commission (UAC) and continue to focus on transitioning from international to government and local implementing partners (IP) as a sustainability strategy. Additionally, PEPFAR will continue to support implementation of the Regional Referral Hospital (RRH) strategy.

### Program Shifts

Under the Human Resources for Health (HRH) portfolio, in COP23, PEPFAR Uganda will work with MDAs, OPM and CSOs to strengthen HRH accountability aimed at improving quality of care at all levels of service delivery. Working with MOH and the Global Fund (GF), PEPFAR Uganda will continue to support the health sector National Community Health Strategy through in-service training, performance management and the roll out of the Community Health Extension Workers (CHEWs). This is aimed at increased productivity of the workforce, improved service integration at community level and harmonization for sustainability through institutionalization of CHEWs.

In COP22, PEPFAR Uganda supported GOU to develop and launch the National Community Health Strategy. An integrated community model was implemented targeting the virally non-suppressed for intensive support to achieve suppression. In COP23, what we learn from the implementation of this model will guide policy formulation and scale up to all PLHIV. Working with the GOU, CSOs, the community and other key stakeholders, PEPFAR Uganda will support the roll out of the community strategy, optimize Community Health Workers (CHW) using the client ration report, focusing on opportunities to integrate community service delivery and capacity building for CSOs.

CHWs have been able to standardize pay at $50 per month for those working 40 hours per week. CHWs that are linked to existing health facilities, particularly HC II that are within the communities offer enhanced patient follow up, refill pick up, disease surveillance, infection prevention and control (IPC) activities, and data collection. This allows reporting upstream to the leadership of HC II through sub-county HC III for quality improvement activities. This also ensures that Health Assistants and CHEWs provide oversight and supportive supervision for quality assurance and address sustainability issues as they arise. This approach will ensure that

all population segments are reached, reducing social related barriers to service access, enhance local ownership of the program, and support local voices demanding services for KP and priority populations.

In COP23, the laboratory investments will focus on sustainability, standardization, and efficiency through GOU ownership. Existing partnerships with bilateral and multilateral partners will continue, as will new partnerships with public private partnerships, academic and research institutions. There will be greater engagement at the regional level and investment in community laboratory services for HIV, TB, advanced disease, and other pathogens.

**Alignment of Resources**

In COP23, PEPFAR Uganda will continue to focus on joint planning and support to the HIV/AIDS response. Across the health and community systems portfolio, PEPFAR Uganda will engage GOU, Global Fund, bilateral and multilateral partners to align resources and harmonize investments.

Working with GOU and the GF, PEPFAR Uganda will continue harmonization of procurement of ARVs, laboratory reagents and other supplies using one national quantification process. This process will ensure optimal use of the available resources, avoid duplication, and ensure enough stock status for all commodities. PEPFAR Uganda will also continue to support alignment of funds with GOU funding using Integrated Financial Management System under MOFPED. This will bring mutual accountability and visibility of USG support as well as ensure that resources are aligned to GOU priorities. While for laboratory systems collaborating with GF, PEPFAR Uganda plans to scale-up multi-disease testing through implementation of the recommendations from the lab hub network assessment as part of lab optimization.

**Critical or New Partnerships**

PEPFAR will conduct a landscape assessment of all HIV commodity manufacturers within the country. This will seek to understand and support local and regional manufacturing as we plan for commodity security. The bulk of GOU procurements have been through Cipla QCIL who possess WHO pre-qualification, and we will provide technical assistance around U.S. Food and Drug Administration (FDA) approval. This should go a long way in improving and expanding local production capacity, expanding markets, improving economies, and ultimately driving prices down. The GF in its 'Allocation Letter 2023-2025' is highlighting 'value for money procurements' as a key step towards ensuring sustained commodity supplies for the coming years.

PEPFAR has over the last three COP years supported the establishment of an ERP for the National Medical Stores (NMS), that manages warehousing and inventory for HIV commodities in the public sector. The Joint Medical Stores (JMS) has identified a similar gap and requires a new ERP to support their supply chain operations for the PNFP sector. We will initiate

discussions with the Development Finance Corporation (DFC) to explore access to low interest financing or provide guarantees for at least $1m for this purpose.

In COP22, PEPFAR awarded two youth-led civil society organizations for capacity strengthening and service delivery. In COP23 the focus is to strengthen and scale up youth-led advocacy and service delivery to address the high number of new infections among the 15-24 and high interruption in treatment for adolescents and young adults.

PEPFAR Uganda also recognizes the importance of existing partnerships that will have an impact on our program's success as HSS. The program will continue working collaboratively with GOU counterparts, USG implementing agencies, the GF, bilateral- and multilateral development partners, and different civil society groups. PEPFAR will continue supporting and channeling the bulk of HIV commodities and services through the PNFP sector while the Global Fund (GF) and GOU support the public sector. This partnership is made stronger with the new multi-year COP planning (2023/2024) that aligns well with the ongoing GF planning cycle for 2023-2025.

In COP22, PEPFAR provided subgrants to civil society PLHIV networks for capacity strengthening and service delivery that focused on peer-led treatment literacy for 10 districts with high interruptions in treatment and low viral load suppression. In COP23 PEPFAR will support the scale up of the intervention to additional burdened districts and capacity strengthening for the CSOs to fulfill their individual mandates.

The 'GF Allocation Letter 2023-2025' underscores building resilient and sustainable systems for health (RSSH) as a key pillar in supporting the GOU and earmarks more resources for this area. This is in line with PEPFAR programming that has over the last decade increasingly funded health systems strengthening (HSS), particularly in areas of Governance, Human Resources for Health (HRH), Finance, Community, Strategic Information Systems, Supply Chain, Laboratory. We will build on this partnership to ensure a more resilient health system, as the country shifts to epidemic control.

**Enablers (Community Leadership)**

The GOU launched a Community Health Strategy under COP22 as part of a shift to promoting people and community and centered programming. This strategy will improve the coordination of community service delivery with a focus on quality and integration. Additionally, through the operationalization of the strategy, community involvement and engagement with matters concerning their health as partners will improve equitable access and address barriers to adherence and retention of clients of treatment. Additionally, the GOU is piloting a CHEW cadre as part of the mainstream public sector workforce. USG through USAID in COP22 supported the CHEW pilot in two districts of Mayuge and Lira and GF has committed funds to scale this up with another 5 districts. The CHEWs will be a paid GOU cadre providing integrated services at the community including HIV and TB which is critical for sustainability of the HIV response.

## Prevention

To contribute to reduction of HIV infections in COP23, PEPFAR Uganda will continue to collaborate with the Ministry of Health (MOH), Ministry of Gender Labor and Social Development (MGLSD), Uganda AIDS Commission (UAC) and various stakeholders including multilateral organizations like Global Fund (GF), Elton John AIDS Foundation (EJAF) and Joint United Nations Programme on HIV/AIDS (UNAIDS), Civil Society Organizations (CSOs) as well as the private sector and academic institutions. These partnerships will create connections with complementary programs and minimize duplication of services, especially if well-coordinated. For scalability and sustainability of HIV prevention interventions, the program will continue to build partnerships with a diverse set of private sector stakeholders, including private for-profit institutions, social enterprises, foundations, and private sector health delivery system to deliver HIV prevention interventions. The Private Sector Engagement (PSE) strategies, Public Private Partnerships (PPPs), and academic partnerships will engage expertise, core competencies, skill sets, and/or encourage coordination of resource investments (in-kind, cash, or other). Through these partnerships, PEPFAR Uganda will establish community-based and integrated HIV prevention services, advance local data use and decision-making, to drive precision prevention decisions for priority populations as well promote innovative prevention financing and leverage across funders, to institutionalize sustainability. These partnerships will help align strategies, programs, and operations amongst entities by working together to pool procurement/fund shared goals. Combining efforts to address priority areas will enable PEPFAR Uganda to strategically place itself on the path to ending the HIV/AIDS pandemic as a public health threat by 2030.

### Program shifts

According to the 2022 Uganda AIDS Commission Annual joint AIDS review report, the incidence among adults is at 0.24%. Close to two-thirds (65%) of new HIV infections among adults in 2021 were among women compared to their male counterparts (35%). Furthermore, young people (10-24 years) are more vulnerable to HIV infection with 43% of the cases occurring in this age group. Among young people, adolescent girls and young women (AGYW) are even more vulnerable to HIV infection; four in five (79%) of new HIV infections in young people occur in adolescent girls and young women aged 10-24 years. PEPFAR Uganda will continue to work with the MOH and other stakeholders to implement robust HIV prevention services to targeting these sub-populations to reduce new HIV infections. PEPFAR will collaborate with GF to provide Dapivirine Vaginal Ring (DVR) for eligible AGYW. The GF will procure 20,000 rings over the next three years. The partnership and collaboration with GF will include a robust needles

and syringes program (NSP) for people who inject drugs (PWID). In addition, PEPFAR Uganda will continue to work closely with key populations civil society organizations and other human rights activists including the Makerere University School of law to adapt our program to needs of the key populations following the passing of Anti-Homosexuality Act.

**Alignment of resources**

In COP23, PEPFAR Uganda HIV prevention programming will be aligned with the Government of Uganda priorities, Global Fund and other multilateral programs to maximize efficiencies and minimize duplication of services across the HIV prevention continuum of care. In addition, we shall use local data from HIV recency testing to geo-focus areas of recent HIV infections for tailored interventions. PEPFAR Uganda will leverage non-PEPFAR programs including government programs like the Parish Development Models and Emyooga to enhance Social Economic Strengthening, and thus reduce the vulnerability of the most at risk persons.

**Critical or New Partnerships**

PEPFAR Uganda has collaborations with the MOH, MGLSD, UAC, and other multilaterals like the GF and UNAIDS, Civil Society Organizations that are critical in the delivery of HIV prevention services. These partnerships will continue and even be strengthened in FY24.

During FY24, PEPFAR Uganda will continue build partnerships with a diverse set of private sector stakeholders, including private for-profit institutions, social enterprises, foundations, and private sector health delivery systems for the delivery of HIV preventions services and identification of opportunities for innovation and potential solutions to HIV prevention programmatic needs, interests, and challenges. For example, we have already initiated discussions with the Elton John AIDS Foundation (EJAF) to determine possible areas of collaboration and partnership. The EJAF is focused on improving the well-being of LGBTQIA+ communities through improved HIV prevention and treatment services, increased funding to LGBTQIA+ organizations and human rights advocacy.

**Important existing partnerships that are anticipated to impact on program success**

Collaborating with the MOH and UAC in the provision of HIV prevention services as entities that provide overall coordination and oversite of the program helps to harmonize the HIV prevention interventions provided by PEPFAR and other stakeholders. This minimizes duplication of services and fosters equity in service delivery.

In addition, PEPFAR Uganda government-to-government (G2G) agreements have provided opportunities to improve the coordination of PEPFAR programs with the national response, and

will strengthen technical, management, and financial systems in the long term for sustained epidemic control.

**Enablers**

**Community leadership**

HIV prevention services are majorly community based and therefore community leadership is critical in delivery of quality HIV prevention services. Over the years, civil society organizations have been critical in the provision of community-led HIV prevention services. PEPFAR Uganda will continue to support community-led HIV prevention service delivery through sub-grants to CSOs and tailored capacity building.

**Leading with Data**

PEPFAR Uganda HIV program uses locally generated data to tailor interventions. For example, we have used data from HIV recency testing to geo-focus areas of recent HIV infections as part of precision prevention. Our targeting process for all HIV prevention areas is informed by locally generated data.

## Laboratory

**Strategic Direction**

Recognizing the versatility and flexibility of the private sector, multilateral and bilateral partners, the Ministry of Health through the National Health Laboratory and Diagnostic Services (NHLDS) department is working to integrate the private sector and support from all these partners to optimally handle responses across all possible public health emergencies. Public private partnerships are critical to long term sustainability as they not only bring resources but also the flexibility and different capabilities that can complement and augment the public health sector. This was especially notably true during the COVID-19 outbreak, where a significant proportion of patients were tested in private health facilities. The NHLDS worked to ensure coordinated data collection, transmission, and analysis to inform the response building on PEPFAR prior investments such as the specimen transportation network, quality systems and laboratory information systems for real time reporting.

In COP23, PEPFAR Uganda will support NHLDS to develop & implement guidelines aimed at strengthening engagement of the private sector not only for HIV/TB diagnosis, but to also include disease surveillance and outbreak response for a coordinated approach to epidemic control.

**Program Shifts**

In COP23, laboratory will focus on sustainability, standardization, and efficiency through GOU ownership. Existing partnerships with bilateral and multilateral partners will continue, as will new partnerships with public private partnerships, academic and research institutions. There will be greater engagement at the regional and district levels through the regional referral hospital strategy and investment in community laboratory services for HIV, TB, advanced disease programs, and other pathogen surveillance in line with Uganda's move to integrated health care services at community level for sustainable services.

**Alignment of resources**

To ensure standardize services, harmonize efforts, efficiency, accountability, and sustainability of laboratory services in the country, PEPFAR Uganda works in collaboration with the MOH (NHLDS and ACP) and other stakeholders such as the Global Fund to align all resources with the national priorities, allocated to geographical regions with high disease burden and to populations that are drivers of HIV incidence and transmission.

**Critical or New Partnerships**

In Uganda, bilateral and multilateral partners such as Africa CDC, the East, Central and Southern African Health Community (ECSA-HC), East Africa Public Health Laboratory Networking (EAPHLN) and African Society for Laboratory Medicine (ASLM), Clinton Health Access Initiative (CHAI) among others, already play a big role in a strengthening a range of laboratory system functions. Through NHLDS coordination there has been a greater collaboration between the public and private sectors in the laboratory network with specific reference to the COVID- 19 diagnostic activities as an example of this collaboration. In COP23, PEPFAR Uganda will continue to support the NHLDS in its coordination role to lead multisectoral coordination of the HIV/TB response and other diagnostic areas that impact the HIV / TB response or where there can be opportunity to leverage existing PEPFAR investments to avoid duplication. In addition, the NHLDS continues to explore bilateral partnerships with different countries such as Japan where they are looking towards attaining expertise in calibration of reagents and commodities used in testing. This also lends itself to long-term sustainability. PEPFAR will continue to support such engagements to build strong bilateral and multilateral partnerships.

**Important existing partnerships that are anticipated to impact on program success**

In FY2020, PEPFAR implemented global purchasing and service level agreements (SLAs) for viral load (VL) and early infant diagnosis (EID) reagents, consumables, and services to shift laboratory program procurement to all-inclusive pricing models. These agreements were negotiated to achieve specific PEPFAR goals: improved system performance through greater data visibility and standardized SLAs across countries, reduced cost and transparent pricing, and enhanced supply chain security. In COP23, PEPFAR Uganda will work with NHLDS to strengthen the Public Private Partnership with equipment suppliers including placement of laboratory equipment by private companies for improved access to essential equipment, management & utilization of equipment, and connectivity solutions. This laboratory network partnership strengthening

activities will come to bear beyond the HIV and TB response into the global health security realm. Existing partnerships include those with multilateral organizations such as the WHO, the Africa CDC, the East African Community, international bilateral partnerships with countries such as Germany, Japan, and Britain amongst others. All these partners bring support and strengths to existing laboratory network optimization in various perspectives of the network that not only impacts the HIV and TB programs but also leveraging on PEPFAR investments for outbreak investigation and support.

**Enablers**

**Community**

In FY2024, PEPFAR Uganda will support NHLDS development and implementation of the community-based testing guidelines for integration of community disease diagnosis, thus increase collaborations and partnerships with the local community players in the HIV/AIDS response to gain efficiencies required for sustaining the gains that are realized in the HIV/AIDS response in the country.

**Innovation**

Uganda will implement the Clinic-Laboratory Interface Continuous Quality Improvement – Extension for Community Healthcare Outcomes (CLICQ - ECHO) program initiative to identify, prioritize and close gaps in the HIV/TB diagnostic cascade. This will then improve turnaround time & increase testing points for TB diagnosis, and advanced HIV disease management. In addition, NHLDS will scale up AFRICA Laboratory Information System (ALIS) and improve the specimen transport process by tracking specimens, barcoding for patient's files and longitudinal tracking of improved VL results turnaround time.

**Leading with Data**

In COP23, PEPFAR Uganda will work with NHLDS to strengthen the existing infrastructure such as biorepositories for utilization of remnant specimen for integrated disease surveillance and drug resistance testing to inform epidemic control. PEPFAR will continue to provide laboratory-based resources to support surveys and research work that will inform programs and policy to enhance disease surveillance and control and sustain gains made.

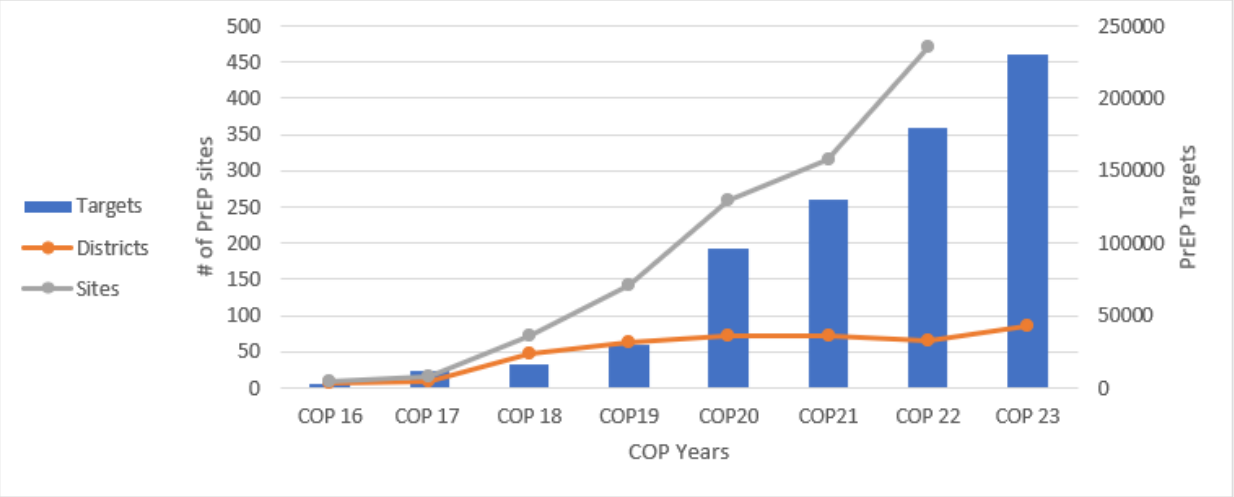
# Pillar 5: Follow the Science

**Key and Priority Population (Implementation Science):** PEPFAR Uganda remains committed to evidence-based and data-driven programming for key and priority populations. The KP and PP program continue to be led by science in COP23 by the allocating COP23 funds to maintain the 12 KP IBBS sites as sentinel sites distributed across 12 cities in Uganda. These sites will be supported to conduct periodic KP size estimates, monitor trends in prevalence and incidence of

critical diseases including HIV, STIs and Hepatitis; monitor treatment outcomes including viral load; measure risky injecting and sexual practices including gender-based violence and condomless sex; and provide for confidential e-services for KP classification and case finding through ACASI. As part of sustainability, collaboration between the IBBS sites and local health facilities will be strengthened for increase linkage of IBBS participation to broader prevention, treatment, and care services. The IBBS findings will then be triangulated with existing knowledge including routinely collected monitoring, evaluation, and reporting (MER) data, legal and environmental assessment (LEA) findings, PHIAs to inform client care, programming, and advocacy. To augment this, community will be empowered to monitor our services using community-led monitoring, and the data will be used for performance improvement.

**PrEP for Key and Priority Populations:** Following CSO's recommendations to scale-up PrEP in COP22, the PrEP targets have increased gradually to bridge the gap and to maintain sero-negativity among populations at substantial risk of HIV. In COP23, PrEP targets will increase from 180,000 in COP22 to 230,000 with the number of sites increasing as well. **Figure (1.8)** below shows progressive scale-up of PrEP since COP16.

**Figure 1.8 PrEP targets, districts and sites**




In COP23, overall, there is an increase in PrEP targeting for KPs, pregnant and breast-feeding women, and AGYW. About 46.1% (106,039/130,000) will be KPs, 39% (89,700/230,000) will be AGYW, 11.7% (27,118/230,000) will be pregnant and breast-feeding women, and the rest will be fisherfolks.

**Table 1.7 COP22vis-a'-vis COP23 PrEP Targets by Sub-populations**

| Sub-populations | COP 22 Targets | COP 23 Targets | % Contribution of COP 23 Target by sub population |
|---|---|---|---|
| FSW | 67,659 | 90,236 | 39.2% |
| MSM | 11,551 | 14,115 | 6.1% |
| PWID | 3,414 | 4,361 | 1.9% |
| TG | 814 | 1,041 | 0.5% |
| AGYW (15-24) | 101,446 | 140,501 | 61.1% |
| PrEP_NEW Males 15+ | 14,237 | 20,163 | 8.8% |
| PrEP_NEW Females 15+ | 165,778 | 209,837 | 91.2% |
| **Totals** | **180,015** | **230,000** | **100.0%** |

The MOH updated the national PrEP guidelines to provide a favorable policy environment for PrEP service delivery among AGYW, pregnant and breast-feeding women. In COP23, the program will continue scaling-up PrEP for AGYW to reach 89,700 AGYW on PrEP. Client centered approaches including pre-appointment reminders, peers support systems like PrEP buddies and use of differentiated service delivery models to dispense PrEP will be used to improve PrEP continuation and adherence among AGYW. The program will also monitor violence and how it is addressed as well as reinforce and promote consistent condom use among AGYW PrEP users.

In COP23, 27,118 pregnant and breastfeeding HIV-negative women, who are at substantial risk will be counselled and offered PrEP. The program will continue leveraging on existing integrated MCH/RH/PMTCT/HIV prevention interventions to provide routine PrEP education at ANC and postnatal care (PNC), carry out HIV risk screening to assess risk behaviors among Pregnant and Breast-Feeding Women (PBFW) and engage peer mothers to deliver PrEP among the approaches to deliver PrEP to eligible PBFW. PrEP messaging will be integrated as part of overall ANC/PNC education at the selected PrEP implementing sites. Individual PrEP counseling and screening will be provided to interested clients for enrolment. PrEP will be provided at mother-baby care points. Follow-up visits will be aligned with the PMTCT/ANC/PNC visit schedule. Ongoing adherence and continuation counseling will be provided as well as linkage and referrals to other programs providing structural interventions.

In COP23, the PrEP program is targeting a total of 106,109 KPs and 7,199 other Priority Populations. The program will continue to work KP-CSOs adopting peer deployment to improve PrEP continuation and strengthening messaging for PrEP continuation among KP peers. In addition, the program will consider DICs as community PrEP dispensing points and employing

other DSDM models for PrEP like community pharmacies for delivery of PrEP as part of HIV prevention kits (containing PrEP, HIVST kits and condoms). Anecdotal data suggests negative perceived social norms and emphasizes the risk of STIs, therefore in COP23, the program will also provide syndromic treatment of STIs and strengthen positive PrEP messaging.

In summary, the program will target reaching 230,000 individuals at substantial risk of acquiring HIV with oral PrEP. The program will strengthen community-based initiation and refills for PrEP to enhance service uptake and continuation. We will continue to focus on targeted demand creation through targeted messaging to eligible sub-populations. Our program will continue to expand enhanced peer led approaches, support hot-spot mapping, and ensure more robust technical assistance to CSOs and districts to locally map and re-map hotspots. We will support peer support and pre-appointment reminders and expand community-based PrEP initiation and refills.

**Voluntary Medical Male Circumcision:** Recent modeling has demonstrated VMMC to be cost-effective in all priority countries for at least the next 5 years and predicts VMMC to be cost-effective and cost-saving in most countries over a 50-year horizon. Another key factor in determining whether an intervention such as VMMC is cost-effective is future population growth. A considerable increase in population is likely to result in new HIV infections also increasing. As shown by Goals-ASM, despite similar baseline incidence in Botswana and Uganda, the continuation of VMMC was only cost-effective in Uganda. Loveleen Bansi-Matharu et al "Cost-effectiveness of voluntary medical male circumcision for HIV prevention across sub-Sahana Africa: results from five independent models" (The Lancet Global Health, Volume 11, Issue 2, 2023). Uganda has continued to achieve Voluntary Medical Male Circumcision (VMMC) targets over the years; currently, the VMMC coverage stands at 54% according to the Uganda Population-Based HIV Impact Survey (UPHIA) 2020, this is an improved coverage compared to 43% in UPHIA16. Scaling up VMMC is critical to Uganda's achieving epidemic control. In FY242023, PEPFAR Uganda will support 527,627 circumcisions and the COP23 targets will further increase the national coverage to 68%. Building on these efforts and to increase the immediacy of impact, the COP23 strategy is to maintain high coverage among 15-29-year-age pivot. To achieve saturation, focus will be in districts where circumcision coverage is close to 90% and in regions with low male circumcision (MC) coverage and high HIV prevalence, including all DREAMS districts.

According to UPHIA2020 survey, 80.9% of adults living with HIV (aged 15 years and older) were aware of their HIV-positive status: 83.5% of women and 76.1% of men and thus the VMMC program will be used as an opportunity to have more men and boys tested for HIV. The Uganda VMMC program will align with the updated WHO guidance that states that "Though HIV testing

is not required prior to receiving VMMC services, programs are encouraged to systematically offer HTS to individuals (especially men 15 – 35 years of age) seeking VMMC services.
The Uganda VMMC program requires that all VMMC facilities are accredited annually as part of continuous quality improvement which is a mandate of MOH. In COP23, the Regional Referral Hospitals will be facilitated to carry out this function in conjunction with MOH.

COP23 funding for VMMC commodities will focus on reusable instruments with benefits of:

- Significant savings on medical waste transport and disposal costs.
- Reduced environmental impact of medical waste incineration and burial.
- Instruments made of high-quality reusable material, when used by well-trained providers, may improve surgical precision and tissue handling.
- Build health system capacity and infrastructure and employ local personnel for sterilizer autoclave operation and maintenance and instrument inventory.

**Gender:** The GBV program will scale-up of additional proven GBV and gender norms change interventions in communities with high GBV against AGYW, children, and KPs. It will strengthen and improve the postexposure prophylaxis (PEP) cascade in addition to refining the PEP cascade data collection tool to capture eligibility. Lastly, we will integrate GBV across all Prevention and treatment platforms.

**HTS**: Guided by findings from Anna Grimsrud et al (Grimsrud A, Wilkinson L, Ehrenkranz P, Behel S, Chidarikire T, Chisenga T, et al. (2023) The future of HIV testing in eastern and southern Africa:Broader scope, targeted services. PLoS Med 20(3):e1004182. https://doi.org/10.1371/journal.pmed.1004182), the HTS innovations include:

- **Status neutral** testing. Under this strategy, subpopulations that are at risk are all tested and guided to appropriate services depending on their HIV status (positives into care, negatives into prevention services).
- Promotion of testing **for re-engagement** with care.
- Increased use of modalities focused on people most likely to have undiagnosed HIV.
- A greater focus on case finding rather than efficiency.

**DREAMS**: Adolescent girls and young women continue to be disproportionately at risk of acquiring HIV. 34% of the total female population lies within the 10-24 age-band. According to spectrum estimates, 10–24-year-old females contribute to 43% of all projected HIV infections among men and women. Additionally:

- Girls with early sexual debut are more likely to acquire HIV than boys.
- Girls in school are less likely to be sexually active at an early age.
- Girls in better economic environments are less likely to get pregnant.
- The highest rate of unintended pregnancies is among girls aged 15-19 year.

DREAMS NextGen focuses on using data to address inequities for AGYW as highlighted below. Uganda falls in Category 2, in which there are still SNUs with high incidence and incidence declines have stalled, but all are covered by DREAMS or Global Fund programming.

Dreams Program implementation: In COP23, we shall continue implementing the core DREAMS package in SNUs that still have moderate incidence (0.3-0.8) i.e., Mbarara District, Kyotera District, Gulu City, Gulu District, Masaka City, Masaka District, Lira City, Lira District, Kalangala District, Omoro District, Lyantonde District, Agago District, Lwengo District, Bukomansimbi District, Wakiso District, Kampala District, Luweero District, Ssembabule District, Apac District, Kassanda District, Kwania District, and Oyam District. For SNUs with low incidence (<0.3) i.e., Mubende District, Rakai District, Mukono District, and Gomba District, we shall begin streamlining the core DREAMS package.

Dreams Program expansion: Using sub-national incidence levels, HIV burden bases on number of AGYW-LHIV and viral suppression among men, Fort Portal City, which ranked highest among SNUs with no DREAMS or Global Fund presence and has a very high incidence of 0.96 has been considered for expansion.

**Districts prioritization for expansion based on HIV incidence and AGYW burden**

| Region | District | Population 10-24 | PLHIV Burden ( Rank2) | AGYW - atleast 1 risk factor (10-24) | Incidence 15-24 ( Rank 1) | Incidence status | VMMC coverage Male 15+ | VL Suppresion Male 15+ | Support -funded | Final Rank |
|---|---|---|---|---|---|---|---|---|---|---|
| South West | Mbarara | 30,246 | 32,773 | 20,007 | 0.73 | MODERATE HIGH | 0.37 | 95% | PEPFAR presence | 1 |
| Central 1 | Kyotera | 43,019 | 20,617 | 28,544 | 0.72 | MODERATE HIGH | 0.66 | 95% | PEPFAR presence | 4 |
| Mid-North | Gulu City | 50,250 | 27,300 | 35,067 | 0.68 | MODERATE | 0.31 | 95% | PEPFAR presence | 2 |
| Central 1 | Masaka | 19,511 | 4,490 | 13,175 | 0.65 | MODERATE | 0.64 | 95% | PEPFAR presence | 45 |
| Mid west | Fort portal City | 22,861 | 20,447 | 17,777 | 0.96 | MODERATE HIGH | 0.94 | 95% | | 4 |
| Mid-North | Lira City | 54,279 | 21,209 | 37,737 | 0.65 | MODERATE | 0.32 | 95% | PEPFAR presence | 6 |
| East Central | Jinja City | 50,602 | 24,996 | 35,560 | 0.50 | MODERATE | 0.80 | 95% | | 7 |
| Central 2 | Buikwe | 86,216 | 20,457 | 62,188 | 0.50 | MODERATE | 0.60 | 94% | Global fund presence | 8 |
| Central 1 | Kalangala | 8,809 | 7,173 | 6,303 | 0.61 | MODERATE | 0.73 | 89% | PEPFAR presence | 34 |
| Central 1 | Masaka City | 45,897 | 28,390 | 30,873 | 0.60 | MODERATE | 0.78 | 95% | PEPFAR presence | 3 |
| North East | Soroti City | 27,252 | 13,381 | 19,567 | 0.70 | MODERATE HIGH | 0.49 | 91% | | 11 |
| South West | Bushenyi | 46,248 | 16,459 | 30,831 | 0.48 | MODERATE | 0.46 | 94% | | 12 |
| Mid-North | Omoro | 33,627 | 6,933 | 23,450 | 0.57 | MODERATE | 0.36 | 89% | PEPFAR presence | 37 |
| South West | Rukungiri | 59,660 | 17,235 | 39,885 | 0.41 | MODERATE | 0.46 | 91% | | 14 |
| Mid-West | Kyenjojo | 95,041 | 22,071 | 77,978 | 0.37 | MODERATE | 0.65 | 95% | | 15 |
| Central 1 | Kalungu | 32,393 | 12,780 | 21,534 | 0.50 | MODERATE | 0.66 | 96% | | 16 |
| Mid-North | Gulu | 21,915 | 3,098 | 15,403 | 0.56 | MODERATE | 0.37 | 95% | PEPFAR presence | 64 |
| Central 1 | Mpigi | 48,861 | 13,824 | 33,084 | 0.43 | MODERATE | 0.71 | 89% | | 18 |

DREAMS Target-setting: Using Uganda Demographic and Health Survey (UDHS), Uganda Population-Based HIV Impact Assessment (UPHIA) and VACS data, the AGYW and ABYM with at least 1 risk factor of acquiring HIV was determined. This was triangulated with program data to determine DREAMS saturation per age band for each SNU. The AGYW targeted for COP23 per

SNU for DREAMS have been informed by the gap to 100% saturation for each age band as highlighted below:

- <100% saturation in an age band: The gap to 100% saturation was targeted.
- >100% saturation in an age band: 20% of the AGYW aging into the age band were targeted.
- For Kampala and Wakiso, a proportion of the gap to saturation was targeted given the very high population of AGYW in these SNU.
- For SNU which despite not having achieved 100%, had >95% achievement, a proportion of the aging in population was targeted in addition to the gap to 100% saturation.
- For boys, we targeted 0.2% of the total population for boys aged 10-24 in districts with the highest incidence and gender-based violence rates for AGYW. We also targeted to reach 100% of boys who have reported to having experienced gender-based violence during the last 12 months using the PEPFAR GBV indicator.

**Care and Treatment:** Effective ART reduces morbidity and mortality among persons with HIV infection and prevents both mother-to-child transmission (MTCT) and sexual transmission once viral load is suppressed to undetectable levels (<200 viral copies/mL). The MOH AIDS Control Program (ACP) in 2022 revised the national HIV treatment guidelines and viral load (VL) algorithm to lower the viral load suppression (VLS) cut-off threshold to <200 copies/mL in line with the U=U strategy. Advancement in provision of optimal antiretroviral therapy and management of opportunistic infections has significantly improved survival of people living with HIV (PLHIV) in Uganda and increased VL suppression.

However, aging predisposes PLHIV to non-communicable diseases (NCDs). In 2019 “RESOLVE to save lives” in collaboration with the Makerere University Joint AIDS program (MJAP) HIV specialized clinic that has over 16,322 PLHIV in care, found that 24% of them had hypertension (HT). PEPFAR through the Infectious Disease Institute supported a pilot in Kampala region that focused on integration of management of hypertension, diabetes mellitus (DM) and mental health disorders. From the pilot, it was found that few PLHIV had been screened, diagnosed, and treated. Overall, 1.42% (1,593/112,182) were reported to have HTN, 0.5% (562/112,182) had DM, while 0.2% (181/112,182) had mental health disorders. This low achievement was attributed to lack of equipment like blood pressure machines, glucometers, and poor documentation of NCDs in the medical records and it was projected that this could be the just the tip of the iceberg. The “RESOLVE to save lives” together with NCD pilot findings prompted the MoH to include screening and management of NCDs in the revised national HIV prevention and treatment guidelines. Guided by these findings for COP23, PEPFAR has included procurement of blood pressure machines and glucose strips for NCD screening among PLHIV.

**PMTCT:** The 2022 WHO guidelines, recommend point of care diagnostics (PoC) for early infant diagnosis (EID) DNA PCR testing for HIV exposed infants. This has markedly reduced turnaround time (TAT) for results from 1 month in 2010 to same-day results in 2022, timely linkage to life-saving ART for identified positive infants. PEPFAR scaled up EID PoC machines from 133 sites (2021) to 305 sites (2022) with 43% (15,728/36,577) of all EID tests done on PoC. In COP23, MoH & PEPFAR will expand EID testing using a 45%:55% split for POC: Conventional testing respectively. In addition, VL/POC technologies have been recommended for pregnant and breastfeeding women (PBFW) and Uganda adopted this guidance in 2022. Currently, PBFW and their infants access these services at the mother baby care point in PMTCT settings in Uganda. Other sub-populations for consideration in COP23 are children and adolescents. Findings from PMTCT Impact Evaluation a national evaluation conducted between 2017-2019 informed PEPFAR Uganda COP22 & COP23 planning to functionalize and scale-up provision of comprehensive MCH/PMTCT services at lower health facilities (Health Centre IIs) where the bulk (46%) of mother-infant pairs receive services.

**COP23 Planned Evaluations**: COP23 funds have also allocated towards various evaluations to guide the care and treatment program, and these are:

**Cyclic Acquired HIV Drug Resistance to Dolutegravir (CADRE) in Uganda, Round-3:** Uganda scaled up use of Dolutegravir based regimens (DBRs) including Tenofovir/Lamivudine/ Dolutegravir (TLD) in 2019 following a recommendation from WHO for countries that had high pretreatment resistance to Non-Nucleoside Reverse Transcriptase inhibitors (NNRTIs). By FY23Q1, a total of 1,325,288 PLHIV were receiving lifesaving antiretroviral therapy (ART). Of these, 1,265,456 were receiving DBRs of whom 50,786/56,128 (95%) were children and 1,214,670/1,268,872 (96%) were adults with a VL suppression rate of 94%. Given the high proportion of PLHIV of DBRs, with a high viral load (VL) coverage, it was imperative that the country monitor emerging resistance to DTG to keep an eye on its durability, by conducting HIV drug resistance (HIVDR) surveys – "cyclic acquired drug resistance" (CADRE). In COP21, PEPFAR Uganda supported the Uganda Virus Research Institute (UVRI) to conduct CADRE. This nationally representative cross-sectional survey utilized non-suppressed remnant VL samples (VL ≥1000 copies/mL) at the Central Public Health Laboratory (CPHL) where most of the VL samples in Uganda are centrally tested. The objectives of this survey were: 1) To estimate the prevalence and pattern of acquired HIV drug resistance (ADR) among individuals receiving DTG for at least 9 months with VL non suppression, by age group (children less than 15 years and adults 15 years and above, and 2) To compare the proportion of individuals with HIVDR pre- and post-intensive adherence counselling (IAC). A total of 857 VL samples drawn in 2022, from PLHIV on DBRs of whom 400 were children (<15years) and 457 adults (15 years and above) were shipped from

CPHL to UVRI for genotyping. Of these, (60%) 512 samples were successfully genotyped and major DTG associated mutations were found among 8.2% (21/256) of children and 3.9% (10/256) of adults. Overall, 2.2% (12/512) PLHIV had high resistance to DTG; 2.9% (15/512) intermediate resistance; 0.6% (3/512) potential low level and 0.2% (1/512) susceptible. These preliminary findings were presented at the 2023 PEPFAR Uganda Science Summit in Kampala, Uganda. These results suggested that there was emerging HIV drug resistance to DTG though still low, and it was recommended that there was need to strengthen ART adherence and continue monitoring emerging HIVDR to DTG and ensure drug durability by conducting annual CADRE surveys to get trends on prevalence of ADR to DTG to inform the Uganda ART program. In COP23 year 1, PEPFAR Uganda is supporting CADRE round 2 and in COP23 year 2, round 3.

**Evaluation on the Prevalence of Specific NCDs (Hypertension, Diabetes Mellitus, Obesity and Mental Health illnesses [Depression, Anxiety and Alcohol and other substances abuse]) among PLHIV in Uganda:** Increased access to life saving antiretroviral therapy (ART) in Uganda has significantly decreased HIV-related mortality and morbidity and PLHIV are living longer with age related NCDs. In COP23, PEPFAR Uganda will be conducting an evaluation that will focus on re-organization of Uganda's health systems to optimally screen, identify, refer and or manage patients with NCDs in ART clinics using an integrated approach. To achieve this, as we strive towards HIV/AIDS epidemic control, there is need to gather key data through a systematic research evaluation (SRE), to better understand the determinants, barriers, and facilitators of successful integration of NCDs in routine HIV programs. This will enable evidence-based recommendations for prevention, early identification, linkage, and management of PLHIV with NCDs and design appropriate interventions to reduce associated morbidity and mortality. An already well-established HIV care system provides a platform upon which we can lay these synergistic measures for improved outcomes.

This evaluation will be conducted by the Monitoring and Evaluation Technical Assistance Implementing Partner (METS). The overall aim of this study is to determine prevalence of the specific NCDs (hypertension, diabetes mellitus, obesity, and mental health illnesses [depression, anxiety and alcohol and other substances abuse]) among PLHIV and document the characteristics of PLHIV with NCD. The findings will inform targeted NCD prevention and control activities (screening, treatment, and control) in the HIV program. The specific objectives include: 1) Determining the prevalence of selected NCDs (hypertension, diabetes mellitus, obesity, and mental illnesses) among PLHIV in Uganda; 2) Describing the socio-demographic and clinical characteristics of PLHIV with the selected NCDs in Uganda; 3) Systematically document the HIV program outcomes for PLHIV with the selected NCDs including viral load (VL) coverage and suppression, and retention in care in Uganda; 4) Documenting the potential system related strengths, opportunities, and challenges in the provision of NCD services in terms of commodities

(diagnostic and treatment commodities), human resource, training, partnerships, and financial resources; and 5) Determining the predictors of various NCDs among PLHIV in Uganda. This evaluation will utilize a cross-sectional design and a retrospective chart review in four geographical regions of the country (North, East, West and Central regions). From the four regions, we will purposively select 16 health facilities (four regional referral hospitals, four district hospitals, four HC IVs and four HC IIIs) based on a sample size estimate of about 1000 PLHIV. Findings from this evaluation will enable evidence-based recommendations for prevention, early identification, linkage, and management of PLHIV with NCDs with an aim of designing appropriate interventions to reduce associated morbidity and mortality and improve quality of life, retention and VLS hence contributing to the 3rd 95.

**Evaluation on the Impact of the Integrated Community Service Delivery Model in Uganda:** Uganda has a mature epidemic and has scaled up ART with tremendous progress to achieve the 95-95-95 fast track targets for 2030. While coverage on ART is high among those that know their HIV status among adults, there still exists disparities among children. The country still lags behind in attaining the first and third 95 for PLHIV knowing their status and viral load suppression (UPHIA 2020). Additionally, the country still grapples with a high number of new HIV infections and advanced HIV disease which hinder the attainment of epidemic control. To realize improvements in the gaps highlighted above and accelerate progress towards epidemic control in a sustainable manner, there is need to re-focus and explore significant investments to build the capacity of community systems to support health service delivery. This is in line with the CSO recommendations from the regional planning meeting in Johannesburg in March 2023. In COP23, an evaluation will be conducted by METS with an aim to determine the impact of the integrated community service delivery model to improve access to HIV services, outcome of PLHIV and document the cost effectiveness of implementation of the model. Specifically we will systematically document: 1) The implementation modalities for the integrated community service delivery model in terms of the practical steps of implementation; 2) Outcomes for PLHIV in the integrated community service delivery model in terms of adherence to ART, VL suppression including IAC for non-suppressed clients, timely ART refills, MMD, retention on ART, reduction in IIT, identification of advanced HIV disease (AHD) patients (CD4 testing) and timely management; 3) Demonstrate the impact of the integrated community service delivery model on the access to the complementary HIV/AIDS services in terms of linkages to other social services including OVC; linkages to HTS, APN, TB screening and NCD integration; 4) Assess the effectiveness and efficiency of implementing the integrated community service delivery model in accessing non suppressed clients; 5) Document potential system related strengths, opportunities, and challenges related to the implementation of this model in terms of human resources, training, partnerships, and financial resources; and 6) Collect the views and opinions of PLHIV about the integrated community service delivery model. METS will utilize a cross-sectional design to collect patient

level data and analysis to determine the rates of the various HIV services and program outcomes. The evaluation will be conducted across the PEPFAR supported regions in purposively selected sites that participated in the first phases of implementation of the model guided by routinely collected data in DHIS2 based on the number of PLHIV enrolled and served into the model. Eligibility into the model is all non-suppressed PLHIV including children. The appropriate sample size will be determined at the time of full protocol development. The findings will be used to develop sustainable and well-coordinated community-based care models to address barriers towards achievement of epidemic control.

**PMTCT: Adolescent Group Antenatal Care Differentiated Service Delivery Model (GANC DSD) for Pregnant and Breastfeeding mothers, and their infants in Uganda:** By the end of COP21, Uganda had 354,601 pregnant women, of whom 16,980 were HIV positive and 78% (13,265/16,980) already knew their HIV status, while 22% (3,715/16,980) were newly diagnosed. Of those diagnosed HIV positive, 992 were 10-19 years; 4,111 were 20-24 years, while 11,877 were 25+ years. Uganda has seen a surge in pregnant and breastfeeding adolescents who are always stigmatized and blamed for getting pregnant early. In 2019 Uganda adopted the GANC DSD model and included it in the Uganda guidelines. In COP23, funding has been allocated to conduct a systematic evaluation for this population and their infants. It will focus on acceptability, feasibility, effectiveness, cost-of-service delivery as well as health outcomes like retention for adolescent group antenatal & postnatal differentiated service delivery model of care for pregnant, breastfeeding young mothers, and their infants in PMTCT settings. It will be conducted by METS in ten AIS regions. The evaluation will utilize a cross-sectional design with two-stage cluster sampling to select sites within each region to participate in the evaluation to obtain a nationally representative sample of GANC/PNC. This activity is aligned to pillars 1 and 5, and the sample size is to be determined. The findings will be released on World AIDS Day (WAD) 2024, and it is anticipated that they will provide valuable data on feasibility, cost-effectiveness and national scale-up of this intervention to inform policy and client-centered programming for pregnant & breastfeeding AGYWs in ANC/PMTCT settings in Uganda.

**YAPS Evaluation: Outcomes of implementation of the Young People and adolescent peer support (YAPS) program in Uganda**

Uganda has been implementing the YAPS model since 2019. This model involves peers who are 18-24 years, virally suppressed and keep their clinic appointments. They are attached to health facilities and support activities like HIV counselling and testing, community contact tracing, home visiting, ART adherence counseling among several other activities. There is no data to show the impact of their activities, so PEPFAR Uganda will support an evaluation that will be conducted by METS with an aim to describe: 1) the implementation approaches of the YAPS program in Uganda,

2) changes in coverage for first and second 95 in YAPS supported districts with at least one year of implementation, and 3) changes in viral load coverage and viral suppression in YAPS supported districts with at least one year of implementation. This will be a descriptive evaluation and will be conducted in districts with one year of implementation. Findings will be used to inform improvements in the YAPS program, advocate for additional resources to address existing gaps.

**African Cohort Study (AFRICOS):** PEPFAR through DoD/WRAIR support to Makerere University Walter Reed Project (MUWRP) implements the AFRICOS study. It is an observational cohort that started in 2013 enrolling primarily people living with HIV and smaller subset of people at risk for HIV. It assesses the impact of clinical practices, biological factors and socio-behavioral issues on HIV infection and disease progression in an African context. The cohort has as of 1st December 2022 enrolled 4,068 participants across 12 PEPFAR-supported HIV clinical care/treatment sites across 5 programs in 4 countries (Uganda, Kenya, Tanzania and Nigeria). It is an evaluation of the MHRP-PEPFAR program to inform programmatic priorities and assess programmatic shifts. The data collected from this cohort over the years has provided valuable information on service delivery, co-infections, co-morbidities, HIV epidemiology and mental health and stigma. Previous analyses have supported the transition to TLD by providing reassurance that viral suppression was attained and maintained and no increase in NCDs after transition. Transition was slow for WLHIV and extra measures were instituted to encourage health care providers to transition the WLHIV. Non-communicable diseases and depression are more common among PLHIV than and integrated interventions are required to adequately address them. Co-infection like TB, STIs are common and diagnostic tools especially for TB are missing a significant number of asymptomatic patients.

In COP23 AFRICOS will continue to evaluate the program through collection and analysis of data on a variety of factors including demographics, HIV and non-HIV outcomes, health and risk behaviors and mental health and cognition. AFRICOS will continue to enroll participants and adopt to the needs of stakeholders as policies are formulated. It looks to among others including a pediatric cohort, enrolling more youth and to identify the treatment needs and outcomes of these populations. Will increase the HIV negative participants to provide better prevention surveillance and understanding. Analyses will provide critical information on a) viral load suppression, b) NCD trends, c) youth treatment needs and d) mental health among others to highlight gaps in the treatment program and inform policy formulation.

**COP23 Surveys, Surveillance, Epidemiology and Implementation Science Priorities**: PEPFAR and Uganda Ministry of Health have continued to work closely to build strong disease surveillance systems that enable local health systems sustain disease response. In COP22 and COP23 planning, efforts have been made to align PEPFAR-supported surveillance activities with those of the

Ministry of Health's National Health Strategic Plan. In COP23, PEPFAR is allocated to support the development of a comprehensive Surveillance and Applied Epidemiology Strategic Plan in collaboration with other stakeholders to respond to new developments or changing priorities.

PEPFAR will continue to invest in recency surveillance activities that generate data that is electronically captured using Uganda EMR and summarized on Recency dashboard for implementing partners and central level access. Recency data will be used to characterize clusters of recent HIV infections by geographic locations, demographics, and risk groups. These data will be used to identify ongoing transmission and monitor HIV epidemic trends over time at group level and as part of case surveillance. Furthermore, the data will be used to generate a public health response through focusing counseling, prevention, and testing programs, that will identify PLHIV and link them to care. This should ensure implementation of tailored HIV prevention services to interrupt HIV transmission. The Public health response strategy is tiered, with response teams at national and subnational levels including districts and facilities. The response will be focused on interrupting new infections and addressing late identification and linkage to HIV care to sustain HIV response.

The 2006 World Health Organization (WHO) guidance recommended HIV case-based surveillance (HIV CBS) for countries experiencing a generalised epidemic. HIV case-based reporting and patient monitoring is essential for ensuring quality and continuity of HIV care and treatment through uniquely identifying and characterizing persons newly diagnosed with HIV or AIDS and tracking them over time so as to generate more detailed information on the epidemiology of HIV including district-based estimates of prevalent infection, disease trends (stage of disease at diagnosis, changes in CD4 count, time to viral suppression, proportion of cases virally suppressed, the incidence of opportunistic infections, and mortality), time from diagnosis to entering care, adherence and retention as well as reducing under and duplicate reporting of cases. In 2016, CDC/PEPFAR Uganda through the METS program piloted the first HIV case Based surveillance (CBS) in ART facilities within Kabarole district in Western part of Uganda in partnership with MoH/GOU, Baylor Uganda (Regional implementing partner) and the Kabarole district local government. During the pilot, the following components of the HIV CBS Model were established and successfully tested: functionality of the electronic Medical Records (EMR); uniquely identifying individuals as cases; characterisation of individual cases through Use of unique identifiers; tracking the client along the Continuum of Response based on Sentinel events and Inter-linking the facilities to central data base. This was to provide proof of concept and assess feasibility of this approach within the challenging environment of a low middle income country (LMIC). The pilot was completed in 2021.Under MoH leadership and technical guidance the HIV CBS implementation guidelines have been developed and are under review in preparation for the country wide roll out of HIV CBS to provide for: Case definitions and the operational definitions;

Use of the Unique Identifier; Sentinel events tracking; Security and confidentiality of patient data; monitoring and Evaluation plan; and Linkages with the SI and HIV/AIDS M&E framework. In addition to the guidelines development, PEPFAR with COP22 funding in collaboration with MOH invested in Health Information Systems (HIS) hardware and software at the site level and upgraded Uganda EMR to accommodate individual level data. With COP23 funding, these investments will be used to support country wide roll out of HIV Case-Based Surveillance in ART health facilities that will enable HIV case reporting and monitoring from diagnosis and any health events while in care. This is anticipated to improve HIV/AIDS indicator reporting and estimates.

PEPFAR will support Uganda's Ministry of Health and National Vital and Statistics Registry (NIRA) under Ministry of Internal Affairs to monitor mortality outcomes. In COP22, PEPFAR supported development and validation of case-base surveillance system. In collaboration with Ministry of Health and NIRA, Mortality Surveillance tools were developed, and mortality data reporting was incorporated into the national health reporting system DHIS2. In COP23, support will be focused on strengthening collection and use of data collected at facility and community levels including verbal autopsies (where possible) to: (1) determine infectious and non-infectious causes of mortality among people living with HIV and (2) to improve national HIV programs and public health response.

In COP23, PEPFAR in collaboration with MOH will continue to support Integrated Bio-Behavioral Surveys (IBBS) among Key Populations (FSW, MSM, TG women, and PWID) in Uganda as part of Key Population Surveillance. Led by local partners MUSPH, these surveys provide: 1) population size estimates at national and sub-national level, or national estimates; 2) describe the risk characteristics and 3) sero-prevalence of relevant biomarkers among KPs. These data are expected to provide data to improve understanding of epidemiology of hidden populations, their HIV burden to guide planning and programming for sustainable epidemic response.

In COP23, PEPFAR in collaboration with MOH will conduct a Population Health Impact Assessment Survey to provide data on the impact of HIV treatment and prevention programs in Uganda. The country-led survey will provide analytical insights to aid in making of timely adjustments to HIV prevention, care, and treatment programs, leading to increased efficiencies and positive outcomes for community members, including people living with HIV. Emphasis is being made to ensure that these priority surveys are led by local partners.

# Strategic Enablers

**COMMUNITY LEADERSHIP**

Effective community engagement and empowerment will be the lynchpin to realizing sustained HIV epidemic control. PEPFAR Uganda's COP23 strategy more intensively anchors its approaches within the community. This community pivot not only supports MOH and civil society calls during COP development, but aligns with global evidence that overwhelmingly demonstrates that community-led interventions and holistic community engagement are critical to accelerating and sustaining reductions in equity gaps in achievement of 95-95-95 and 10-10-10 goals among vulnerable populations. Community-centered programming also offers the dual benefit of advancing global health security by efficiently strengthening local capacity for preparedness and response to other outbreaks. In alignment with Greater Involvement of People living with HIV, and PEPFAR's focus on equity, our efforts to strengthen community leadership in COP23 will center on PLHIV, as well as those most vulnerable to inequitable HIV outcomes, including adolescent girls and young women, children, and key populations. *The sub-section below briefly summarizes how PEPFAR Uganda will incorporate community leadership across Pillars during COP23, with specific examples woven in throughout the SDS.*

**Stakeholder Engagement in COP Development:**
PEPFAR Uganda maintained and expanded multi-stakeholder engagement for COP23 development and refinement, with a strong focus on discussing which pivots were necessary to achieve enhanced equity objectives within the 5x3 framework.

We used a mix of modalities to gather stakeholder inputs, including in-person and virtual meetings, retreats, document reviews, TWG sessions, and ad hoc phone calls to discuss specific COP23 strategies. These consultations began in December 2022 and concluded with COP submission, with the GOU signing off and approving the PEPFAR Uganda COP23 in advance of submission. Key milestones included Planning Level Letter meetings with the MOH, CSOs, and Stakeholders; PEPFAR USG Internal Agency Retreat; Pre-RPM Consultations, including development of People's Voice; Post-Johannesburg Stakeholder Meeting; and approval Meeting. We placed special emphasis this year on increasing community engagement in COP23 development, including through COP22 performance review constituency engagements (which formed a basis for the People's Voice below), CLM data analysis and development of solutions, and robust delegations to PEPFAR planning retreats and RPM meetings in Johannesburg. *Highlights of how these consultations shaped COP development are highlighted below.*

*GOU:* Per Pillar 2, PEPFAR Uganda is committed to continually strengthening its partnership with the GOU to ensure alignment between PEPFAR contributions and national priorities and investments. We will continue to engage political leadership through the Office of the President, Office of the Prime Minister (OPM), Office of the First Lady (OFLA), MOFPED, MOH, Ministry of Public Service (MOPS), MGLSD, MOLG, MOES, and UAC. As detailed in *Pillar 1 Resource Alignment/Complementarity*, we have jointly mapped, discussed, and agreed upon how PEPFAR Uganda COP23 strategies and investments could complement and advance GOU health strategies. Specific examples include:

- Aligning strategies to the newly released *MOH Consolidated Guidelines for the Prevention and Treatment of HIV and AIDS in Uganda* (March 2023), such as inclusion of newly approved PrEP HIV prevention options.
- Ensuring community-level interventions contribute to and align with the new National Community Health Strategy. PEPFAR Uganda, for example, will support operationalization/production of community health and HIV literacy handbooks and CHW job aids for 17,640 CHWs attached to 1,984 health facilities.
- Including MOH COP23 priorities, including PMTCT expansion to HC II, scale-up of CQI audit tool.
- Ongoing dialogue with the MOH and MGLSD related to the project impact of AHA on uptake and availability of non-discriminatory HIV services on LGBTQIA+ and DSDM models that may be fast-tracked to ensure availability of services.

*GF:* PEPFAR Uganda engaged GF during COP23 development, as described and detailed in Pillar 1 Resource Alignment/**Table 1.3**. This maximized the geographic and technical complementarity of our collective work and investments.

*Civil Society:* PEPFAR Uganda values the perspectives of the community and CSOs in planning, development, implementation, and monitoring of our efforts and the National HIV response. We strive to fully engage the unique assets, capacities, and comparative advantage of communities, including key populations-led, youth-led, and women-led organizations, faith-based organizations, and PLHIV, to drive meaningful, people-centered impact through sustained community leadership in its overall HIV strategies. To that end, PEPFAR has engaged CSOs primarily through the self-organized civil society platform for COP development, represented by the Coalition of Health Promotion and Social Development (HEPS Uganda), International Community of Women Living with HIV—East Africa (ICWEA) and Sexual Minorities of Uganda (SMUG). This platform consults with and represents nearly 100 national CSOs, representing women, men and youths living with HIV, mainstream civil society organizations, and representatives of KP groups. In addition, PEPFAR Uganda incorporated inputs from CLM efforts as below.

As in previous COP development processes, The People's Voice development helped to strongly clarify, advocate for, and prioritize community HIV priorities within COP23 development. We have captured these within **Table 1.8** below.

**TABLE 1.8: Agreed Upon COP23 HIV Policy and Programmatic Priorities (People's Voice)**

| Table 1.8: SUMMARY COP23 PEOPLE'S VOICE ASKS | | |
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| **Program Area** | **COP23 People's Voice ASKS** | **PEPFAR Uganda Response/COP23 Plans** |

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| Perinatal HIV Prevention-PMTCT | COP23 TARGET: Increase PEPFAR funding for a package of testing/retesting services and combination prevention services including PrEP for all pregnant and breastfeeding women with particular focus on AGYW, tailored to their evolving needs and integrated with comprehensive sexuality education (both in and out of school), and with sexual and reproductive health services (including contraception) and rights | Eligible pregnant and breastfeeding women, including AGYW have been targeted to receive a comprehensive package of combination prevention services including PrEP aligned to PEPFAR Uganda's PrEP resource envelope. Sexual Reproductive Health and Rights (SRHR) services are part of the routine care package for all women attending GOU MCH/PMTCT service delivery points. Services have been extended to the communities through the integrated outreaches targeting AGYW (i.e., DREAMS). |
| | COP23 TARGET: Scale up intensive peer-led support from HIV positive mothers to 100% of PBF women with HIV at PEPFAR supported sites including provision of treatment literacy, transport funds to reach clinic visits, nutritional support, and supportive case management to reduce IIT and viral load non-suppression. | Since the roll-out of Option B+ in Uganda (2012), peer mothers through the peer-led programming approach have been an integral part of the MOH PMTCT program. Over the years, PEPFAR has made substantial investments in supporting this model of service delivery, including Nutritional Assessment Counselling and Support (NACS) and maternal treatment literacy for improved mother-infant pair outcomes. |
| | COP23 TARGET: PEPFAR should support the Ministry of Health to revise the national VL policy to allow 3-monthly VL monitoring for PBF women. | Completed and rolled out at site level: 3-month VL monitoring for pregnant and breastfeeding women is part of the revised MOH HIV Prevention and Treatment Guidelines 2022. |
| PEDIATRICS Diagnosis and treatment | COP23 Target: Scale-up POC Testing for Polymerase Chain Reaction (PCR) | GOU POC machine coverage has been scaled up from 133 to 300 (by COP22). In COP23, PEPFAR will continue to support MOH to optimize utilization of the existing POC platforms, address ALIS connectivity and reporting gaps into the CPHL database, and work with GOU program and laboratory colleagues to guide machine placement aligned to site needs, POC security systems and Human Resources for Health (HRH) constraints. On 3/16/2023 follow-up meeting was held with CSOs, ACP, UNHLDS and PEPFAR Lab, PMTCT/Pediatric teams. At this meeting, agreement was reached to pause POC expansion and plan optimization. UNHLDS will work with ACP and PEPFAR Lab and PMTCT/Pediatric collaborative to develop:<br>1. Projected EID/VL coverage using existing POC Equipment. |
| | COP23 TARGET: Scale up POC EID for infants, continuing to strive for 100% coverage, beyond the current split of 45:55, focusing on machine placement to increase equitable access. | |
| | COP23 TARGET: 100% of PBF women living with HIV should be given the option of pairing their child's appointments with their own and being tracked as a pair in clinical care. | |

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| | | 2. A plan for increasing advanced disease test coverage.<br>3. A plan for addressing challenges at POC sites (connectivity, power backup, HR, commodity management).<br>Since the roll-out of Option B+ in Uganda (2012), the mother-baby care point (MBCP), a one-stop shop model of care, has been implemented to ensure mother-infant pairs are seen by the same provider at the same time and same service delivery point. |
| | COP23 TARGET: Further accelerate accreditation of HCIIs to an additional 400 facilities (totally 1350 HCIIs), to provide ART where most women receive ANC services and build on the progress that will finally be made in COP22. | MOH maintains the mandate to accredit a site for ART. PEPFAR, in collaboration with MOH, will consolidate COP22 HCII investments and interventions to strengthen functionality of existing HCIIs & satellite clinics to ensure optimal provision of comprehensive PMTCT/MCH services at community & household levels to expand reach and improve mother-infant pair health outcomes. |
| | COP23 TARGET: Ensure 100% access to DTG for children < 20 kgs and > 20kgs. | PEPFAR is already working with IPs, facilities and MOH to achieve this. We have been holding accountability meetings led by MOH every Thursday to ensure that all children are transitioned to pDTG. By end of Dec 2022, 86% (13,285/15397) of children <20kg had been transition to pDTG and these efforts are continuing. We expect to complete this transition in COP22. |
| | COP23 TARGET: Implement an integrated community service delivery model focusing on supporting families to address household issues resulting in poor clinical outcomes for all HIV positive children (lack of access to food, money for transport, etc.). | In COP22, PEPFAR is supporting the Caregiver DOTS model which is a community model providing support to caregivers with unsuppressed children and children with interruptions in treatment (IIT) or at risk for IIT. In addition, PEPFAR is supporting sites to assess and refer eligible children to OVC programs which then support them with economic strengthening interventions to address challenges of transport, lack of food, education, etc. |

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| | | People's Voice for peds and PMTCT was presented in the CLM/MoH/PEPFAR GA/AP3 meeting on March 16, 2023. MoH responded to most issues.<br>i) Key new information is MoH will use GF to expand PREP sites from about 500 to about 1200 sites depending on what is eventually approved. This is still far from the about 4600 PMTCT sites but appreciated.<br>ii. pediatric DTG - MoH expects about 98% coverage in March 2023 data call. remaining 2% due to DTG reaction, unsuppressed children.<br>iii. Addressing peer-led programming gaps will address the request to intensify peer led programming. The main complaint from civil society and MoH is that peers (e.g., Mentor Mothers) are engaged in other tasks beyond their scope like drug distribution, leaving them with no time to do their roles of supporting adherence and addressing stigma. The meeting participants recommended roll out of the new community model which includes attaching each patient to a peer, DOTS for non-suppressed, and standardizing case load. iv) POC: The Lab meeting addressed POC at length. MoH explained that they prefer to focus on improving the quality of current PoC than to expand.<br>v) HCII: MoH, with PEPFAR support has expanded PMTCT services to over 500 HCII. They have applied to GF to support another 700 HCII subject to approval and funding. |
| Accelerate HBV testing and treatment as part of triple elimination among PBFW and children | COP23 target: Invest in community designed demand creation and sensitization regarding HBV. | Direct funding for Hepatitis B vaccination is outside the PEPFAR scope. However, PEPFAR will work with CSOs to leverage current Global Fund and GOU investments for integrated HIV/HBV programming and continued advocacy on the inclusion of HBV birth dose in the national Hepatitis prevention and treatment guidelines. |
| | COP23 target: Procure and rollout the HBV birth dose. | See comment above. |

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| OVC | COP23 Target: Strengthen the social services structures from the National to the district including the probation offices. | 1. PEPFAR supports the social welfare workforce by building the capacity of para-social workers and social workers who are the backbone of OVC service delivery at community level.<br>2. PEPFAR supports district action centers to help respond to violence against children. |
| KEY POPULATIONS | COP23 Target: the US government, including PEPFAR, should intensify its public advocacy to improve the legal, policy and human rights environment for KPs in Uganda. | PEPFAR is also concerned that the legal environment is worsening for KPs in Uganda, threatening Uganda's ability to control the HIV epidemic. PEPFAR will support the Uganda AIDS Commission (UAC) to coordinate the multisectoral implementation of the LEA recommendations. In COP23, PEPFAR will support Makerere School of Public Health (MUSPH) to address KP-specific LEA recommendations including supporting advocacy capacity building and policy dialogues working alongside Makerere University School of Law, Human Rights Awareness and Promotion Forum, UKPC and UAC. The Civil Society Strengthening Activity (CSSA) will further address LEA findings and recommendations in COP23. CLM will also be supported to engage key stakeholders. |
| | COP23 TARGET: Prioritize implementation of PEPFAR's pledge, made in COP22, to fully operationalize and accredit all KP-led DICs to provide clinical and preventive HIV and STI services, including antiretroviral treatment, to improve linkage, retention, viral load suppression and reduce human rights violations. | DIC guidelines were revised, and the national dissemination took place in December 2022. MOH taking the lead in regional disseminations and PEPFAR will work with its partners to align DICs to the approved MOH guidance. PEPFAR will increase funding to DICs for service delivery in order to work towards equitable health care. PEPFAR will increase KP-specific funding for CLM to monitor DICs and report human rights violations to PEPFAR and other stakeholders. |
| | COP23 TARGET: Beyond compliance with core standards, DICs must be afforded flexibility by IPs in implementing service delivery models that ensure clients are safe and comfortable, and access quality services with dignity. | PEPFAR is committed to supporting equitable health services that protect the dignity of all persons. We request specific suggestions for how to improve DICs accordingly. Furthermore, the national CSO implementing mechanism has conducted risk assessment for half of the DICs; PEPFAR will support completion of annual risk assessments for all PEPFAR-supported DICs. The |

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| | | assessment informs the mitigation plan that is implemented jointly by the IMs and DICs. |
| | COP23 target: Accelerate KP size estimates, including a focus on trans Ugandans. | PEPFAR will maintain the 12 IBBS sites as surveillance sites. These data are being used to inform KP target setting for COP23; new data will be used at the beginning of 2024 to revise the estimates for COP23 Year 2. |
| Expansion of harm reduction services | COP23 TARGET: Expand funding for community-led demand creation, livelihood support, and advocacy interventions led by PWID communities for both the Butabika and the new Mbale MAT Facilities respectively. | Demand creation has been integrated in the community interventions for the KP program. |
| | COP23 TARGET: Harm Reduction DICs within Kampala and Wakiso must be supported by PEPFAR to improve PWID linkage to and retention on MAT and other prevention services, to improve services uptake and retention in care through People Who Use Drugs (PWUD) community mobilization and empowerment. | PEPFAR will continue to support the Uganda Harm Reduction Network and to support CLM in monitoring and working through its coalition with UKPC and UHRN. PEPFAR will work with these community partners, the national KP CSO mechanism, and the comprehensive regional implementing partners to improve linkage and retention when the data show poor performance. |
| | COP23 TARGET: Support MAT innovations, including MAT dispensing "spokes" and mobile van dispensing models to improve MAT accessibility in communities. | The mobile van was procured and is being shipped. It should be in country in April 2023. |
| Expanding Services for Priority Populations | COP23 TARGET: Support development of a comprehensive, community-designed and community-led combination prevention and treatment program targeting fisherfolk and their children, which will address unmet need for biomedical and structural prevention interventions as | AGYW, fishing communities, and truckers have been considered as country priority populations for COP23. In COP23, the target for priority populations has been increased to 211,054 (which includes 147,000 for fisher folks). We request the community to more clearly articulate the gap. |

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| | COP23 TARGET: Adopt and rollout 100% WHO recommended AHD package of care. | This is already done as all ART sites were activated to implement the AHD packages. CD4 testing as part of AHD screening has been extended to eligible clients who interface with service providers in communities. However, the Diflucan donation is ending in COP22 so there is need to have it included in the Supply Chain plan. CHAI is working on reducing Serum CRAG kit size so that it can go to lower facilities. |
| | COP23 TARGET: PEPFAR should intensify efforts to roll out CD4 testing to reach full coverage for all TX_NEW from the current level of 55%. This effort should include children as well as adults. | The program has moved over 80% of coverage and with more advocacy for more commodities, the program will roll over to over 100% coverage for CD4 Testing. There is a limitation of the current Visitect for use in children less than 5 years. |
| AHD-CM | COP23 TARGET: Support training of cadres of community health workers to carry out community based follow up with people recovering from CM and scale up points of care for CM. | The model for treatment of cryptococcal meningitis ensures that all regional referral hospitals and selected district hospitals have capacity to diagnose, work up and treat CM cases. In this model, the lower-level HFs are well capacitated to screen and identify patients who have advanced HIV disease through cd4 testing and symptom screen. All lower-level HFs have capacity to offer a CrAg test and all the eligible positives receive Fluconazole. Those that are suspected to have CM are referred to the upper-level HFs (RRHs and District hospitals) for diagnostic work up (lumbar puncture) and treatment according to the national guidelines. Most of the capacity for diagnostic work up and Lab based monitoring for CM is at RRHs and District hospitals due to resource constraints. All efforts are made to ensure upward referrals are effectively made to the RRHs and district hospitals for all suspected cases of Cryptococcal Meningitis. At lower-level HFs all efforts are made to ensure availability of CrAg testing commodities and Fluconazole as well as increasing the capacity for referrals. |
| | COP23 TARGET: Integrate CM into routine SBC messaging and facility health talks. | All IPs will be tasked to enhance support to integrate Advanced HIV disease messages in the routine daily health talks. |

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| | COP23 TARGET: Introduce the use of single dose Liposomal amphotericin B (L-AmB), accompanied by flucytosine for 2 weeks for the treatment of CM. | Traditionally PEPFAR has not provided CM Commodities as amphotericin-B is always provided through Government of Uganda partnership. Currently WHO has recommended switch to the newer drug- LIPOSOMAL AMPHOTERICIN that has a better safety profile. Advocacy discussions have started with the government of Uganda to include the newer CM drug into the National essential medicine's list/book and for Government of Uganda to switch from AMPHOTERICIN-B to Liposomal AMPHOTERICIN. More advocacy is still needed to ensure the newer drugs are made available by Government of Uganda. PEPFAR through CDC/MAUL procured as a one-off L-AmB (8,730 doses) and flucytosine (1,200 doses). Discussions for COP23 are ongoing. |
| AHD-Cervical Cancer | COP23 TARGET: Invest in self-test kits for cervical cancer screening; and conduct last-mile distribution of self-test kits to DICs targeting sex workers. | It is a good idea to use self-test kits for cervical cancer testing especially for the hard-to-reach areas. However, this has not been explored in the Ugandan cervical cancer program. More data and information are needed. The cervical cancer program has been very successful to offer screening to the eligible women. |
| AHD-Literacy and training | COP23 Target: Invest enhanced adherence counselling to ensure optimal adherence to the advanced disease package, including phone calls and home visits. | All IPs will be tasked to increase their support to the HFs to support enhanced adherence counselling for AHD treatment including follow up to ensure Fluconazole completion after primary and secondary prophylaxis. |
| | COP23 Target: Investment in HCW and CHWs training & community empowerment on AHD and dissemination of AHD IEC in simple language. | The AHD Materials are well integrated into the national trainings and the training manuals/materials. All the materials are disseminated to all HFs, communities and clients. More efforts will be made to ensure more dissemination to the communities. |
| Care and Treatment | COP23 TARGET: Immediately audit national treatment cohort to identify PLHIV still on non-DTG based regimens and connect them with counselling regarding switching and linkage to PLHIV-centered DSD models. | PEPFAR will expand site level utilization of the Audit tool to identify clients on non-DTG regimens for timely optimization and implementation of the full package of services. |

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| | COP23 TARGET: PEPFAR should increase funding to $2 million to implement a national community designed and led treatment literacy program to reach facilities that represent 80% of IIT. This program must be designed and led by PLHIV in all their diversity—men, women, key populations, young people, and people with disabilities. | HIV treatment literacy will be integrated within the community peer model. Learning from the pilot, a peer literacy handbook was developed in partnership with MOH and the CSO, PLHIV networks. This will be used to guide the delivery of standardized peer led literacy to all PLHIV. |
| Supply Chain and Commodities | COP23 TARGET: Return procurement of second- and third-line treatment to PEPFAR to prevent further harm to PLHIV centered care. | PEPFAR already procures 2nd line ARVs. The SC team will defer to the agency leadership on this decision, we however recommend high level advocacy to the GOU to continue to fulfill the commitment of funding ARVs of which 3rd line ARVs can be procured in full to meet the needs. |
| HIV TESTING SERVICES | COP23 TARGET: Invest in training of Health workers and CHWs on human rights-based approach to rendering index testing (training and training materials should include language around voluntary index testing, refusal to provide sexual contacts and close relatives or family members). | The HTS policy upholds the basic human rights of individuals and families as enshrined in the various legislations and implementation principles. National implementation guidelines recommend services to be delivered while ensuring quality counselling, confidentiality, informed consent, giving of correct results and connecting those tested to appropriate care and prevention services. National training materials including for index testing are aligned to this framework. PEPFAR has invested in ensuring index testing is implemented safely with ho human rights abuses. In 2020, PEPFAR supported integration of index testing assessments into index testing service delivery to ensure safety of beneficiaries. These assessments are now done annually. PEPFAR continued to support these assessments in COP22 plus ensuring remedial actions are implemented based on the identified gaps. |
| | COP232 TARGET: Invest in onsite and offsite violence prevention and response interventions resulting from index testing. | The integrated approach of monitoring for violence across the HIV program includes index testing. Intimate partner violence assessments are already integrated in index testing service delivery with a clear recommendation of not offering index testing where violence is confirmed or anticipated based on the assessments. These assessments are done prior to and after delivery of service. |

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| | COP232 TARGET: Invest in follow up, monitoring and documentation of occurrence of adverse events following index testing and adverse events data utilization for engagement at site level and decision making in TWG discussions. | The Ministry of Health is leading efforts for monitoring and documenting adverse events following index testing. In 2020, PEPFAR supported technical assistance on monitoring adverse events and continues to do so. The MOH incorporated adverse events monitoring into index testing service delivery right from the pilots undertaken before national roll-out. |
| | COP23 TARGET: Pregnant and breastfeeding women need expanded access to testing and retesting services. These services must be noncoercive and supportive, including when PBFW do not agree to share the names of their partner(s) for testing. | The MoH national guidelines provide for testing and retesting in ANC, L&D and PNC. Services are non-coercive and aligned to the client charter of service delivery. HIV testing services (HTS) are integrated in routine health education, counselling, and health care services for Pregnant and Breastfeeding (PBF) women, their male partners and biological children at all entry points within the health facility and at community outreaches/service delivery points. |
| DREAMS | COP23 TARGET: Building on commitments made to civil society in COP22 to adapt DREAMS, increase funding for enhanced/robust socio-economic strengthening, employment training and linkage to waged employment, as well as education support to 100% of DREAMS participants screened to be at risk of dropping out of school starting with the worst performing Districts. | Enhanced social economic strengthening as informed by risk continues to be a priority for DREAMS programming. The Uganda team developed a screening tool to support equitable socioeconomic strengthening support for AGYW which is being used to inform program implementation starting COP22. |
| | COP23 TARGET: Expand DREAMS programs to 18 high incidence Districts currently not reached with similar AGYW interventions. | PEPFAR works with the national AGYW to rationalize the country wide AGYW response following a ranking of districts by risk profile. The criteria for ranking districts accounts for risk factors among AGYW, incidence, PLHIV burden, viral load suppression among men, VMMC coverage, and population size. This ranking has been updated to inform PEPFAR expansion within districts and to new districts where applicable. |
| | COP23 TARGET: Increase funding to support a range of PrEP options, youth friendly family planning services, and GBV services for all DREAMS participants, focusing on expanding successful models of peer-led service provision. PrEP provision | PrEP options have been broadened to include DVR. PEPFAR will support programmatic implementation of DVR procured by global fund. In addressing equity gaps around service access for AGYW, the focus for DREAMS implementation is peer-led service provision in |

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| | in DREAMS safe spaces should be funded so that it can be taken to scale in COP23. | the community with AGYW ambassadors taking lead at safe spaces. |
| | COP23 TARGET: Expand PrEP for AGYW with increased targets. In COP22, the targets increased from 38,634 to 70,196. In COP23 the increase should be at minimum to 140,392 AGYW. | PEPFAR targets for oral PrEP will remain 180,000 in COP23. Global fund will provide commodities for an additional 50,000 individuals bringing the overall country PrEP target to 230,000. As one of the priority populations, AGYW will be prioritized. |
| | COP23 TARGET: Increase funding so that 100% of DREAMS programs can provide a complement of relevant secondary services including family planning services. | In working towards sustainability, the DREAMS program leverages on existing programs including Care and Treatment, Family Health, OVC, and other prevention programs to ensure that AGYW are provided with an integrated package of relevant services including family planning services. |
| Youth-Friendly HIV Treatment Services | COP23 TARGET: Accelerate YAPS scale up planned in COP22 to 100% of districts, and expand YAPS coverage to multiple strategically located facilities, beyond the highest volume sites. | in COP22 PEPFAR supporting scale of the YAPS program to 34 additional districts, and together with partners including Global fund and UNICEF the YAPS program will reach 100% of all districts in the country. In every PEPFAR supported district, 3-5 high volume facilities (high volume for the age group 10-24yrs) are selected for implementation of the YAPS program. MOH has made plans to add additional facilities per district though the new Global fund grant. |
| | COP23 TARGET: Reach 100% of eligible young people with MMD and all Differentiated Service Delivery (DSD) options that reduce IIT and improve outcomes for young people. | PEPFAR is working on this through the implementing partners, and this is part the interventions we are supporting and monitoring through our COP22 national COT collaborative. Partners are supporting expansion of the Audit tool to identify all clients for MMD and other services. |
| | COP23 TARGET: Expand access for all young people with HIV to peer-led support and counselling to address stigma, non-disclosure and other common barriers adolescents face. | The YAPS program reaches young people with peer-led support to address issues adolescent face. By end of COP22, YAPS will be in all high-volume sites in all districts. The MoH, through GF, is planning to extend YAPS to additional facilities. |
| Scaling Up Access to Preexposure Prophylaxis | COP23 TARGET: Increase PREP_NEW targets to continue current momentum, from 180,000 in COP22 to 25,000 PREP_NEW, building on | PEPFAR targets for oral PrEP for COP23 have been increased to 230,000. |

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| (PrEP) | the 50,000 increase from COP21-COP22. These targets should support geographic expansion to new facilities and new districts. | |
| | COP23 TARGET: PrEP literacy programs led by AGYW, KPs, and other community ambassadors must expand with PrEP ambassadors employed at each site where PrEP is available. Health workers must also be targeted for ongoing training, so that proportion of KPs, AGYW and pregnant and breastfeeding women screened, determined to be eligible and linked to PrEP continues to increase rapidly. | PEPFAR implements a peer-led approach that put's end users at the very center of the interventions. KP peers, DREAMS/PrEP ambassadors have been and continue to be important stakeholders in provision of PrEP. We will continue scaling up health worker and peer training on PrEP. |
| | COP23 TARGET: PEPFAR should fund a coupon-based or other simple system for eligible clients to get free, rapid initiation on PrEP when they need travel to a site where PrEP is provided. | This is noted and will be taken up for consideration, depending on the availability of funds. |
| | COP23 TARGET: PEPFAR and MoH should fast track implementation of new WHO Guidance on differentiated and simplified PrEP, including the community PrEP pharmacy model. | The guidelines and implementation model for community pharmacy refills for PrEP are finalized and this will start in COP22 and scaled up in COP23. |
| | COP23 TARGET: Support PrEP delivery that is peer led, to increase demand and prevent stigmatization of PrEP services. | This is noted and will be taken up for consideration. |
| | COP23 TARGET: PEPFAR should support acceleration of roll out of CAB LA and the DVR including participation in pooled procurement, supporting roll out of information package on DVR and CAB-LA and training of health workers). | CAB LA doses are in limited supply and Uganda will not receive initial PEPFAR allocations of CAB LA in COP23 Y1. However, PEPFAR will support programmatic implementation of DVR procured by Global Fund. |
| Human Rights and Structural Interventions | COP23 Target: PEPFAR should conduct a service delivery audit to whether service delivery tools for persons with disabilities (PWDs) are being deployed. | We request initial data from Community-Led Monitoring to inform PEPFAR site visits and technical assistance. |
| | COP23 Target: Fund PWD-led organizations to roll out PWD-led | PEPFAR will make efforts to ensure PWD-led organizations learn about funding opportunities |

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| | programs including support for PWDs as CHWs for sign language interpretation and other essential services. | including sub-awards and the PEPFAR Small Grants program. |

**CLM Engagement:** CLM continuously informs PEPFAR Uganda programming throughout the year, including in the development of COP23 and will remain a cornerstone of our strategy. Coordinated through the ICWEA, SMUG, and HEPS Uganda, CLM is initiated and led by local CBOs and other CSOs, networks of KP, PLHIV, and other affected groups. They conduct continual monitoring of the quality and comprehensiveness of HIV/TB services at 325 health facilities in 80 districts and 49 DICs (led by KPs), including focusing pediatric services at high-volume health facilities through AP3. Their feedback ensures PEPFAR Uganda captures community feedback through site visits, advisory groups, and tools such as community scorecards. These efforts strengthen patient-centered care approaches by incorporating qualitative and quantitative feedback into program implementation.

PEPFAR Uganda's COP23 approach has incorporated recommendations from quarterly CLM in combination with stakeholder engagements and People's Voice policy and programmatic asks (described above). In COP21, for example, the People's Voice COP recommended peer led treatment literacy as an approach to improve treatment outcomes among PLHIV. The PEPFAR program in response piloted peer led treatment literacy in 10 districts of northern Uganda with high interruptions in treatment and low viral load suppression. Learning from the pilot, peer-led literacy will be scaled-up to additional high-burden districts in COP23 to address the high number of new infections among the AGYW and low VLS among the young people 10-24. The peer led literacy program will target youth-led CSOs to coordinate and lead the implementation for the youth.

PEPFAR Uganda will continue funding robust CLM for COP23. CLM will play a critical role in monitoring the impact of the changing implementation environment on community- and facility-based LGBTQIA+ stigma and its impact on the clinical cascade and recommending patient-centered adaptations and DSDMs to maintain HIV prevention, care, and treatment services. In consultation with leadership and KP CSOs, PEPFAR Uganda will remain flexible for KP-focused CLM in the evolving AHA environment, potentially suspending KP CLM when necessary to ensure client and CSO safety and explore alternative confidential models of CLM via WhatsApp or anonymous portals. Other planned CLM refinements for COP23: Launching CLM for children and adolescents (0-10) as part of the monitoring for the AP3 program; increasing the regularity of CLM activities (at least quarterly), especially with MOH and government agencies; integrating CLM with community scorecards; and increasing data triangulation to improve programming, advocacy, and the research agenda.

**Community Platforms**

PEPFAR Uganda will leverage HIV-focused, health, and multisectoral community platforms to advance COP23 strategies and targets. These increase the reach, accuracy and saturation of case finding, bring services closer to communities. At a practical level, this means working through community platforms to conduct innovative behavioral design to adapt HIV SBC and

case finding approaches, using participatory techniques to mine for and devise local solutions to IIT; implementing patient-centered SBC and service delivery interventions for specialized sub-populations, including AGYW, KPs, and PPs that reflect the underlying factors that influence and inform patient and caregiver choices; scaling-up of the GOU Community Health Strategy, and prioritizing the scale-up and strengthening of community DSDM, addressing coverage and quality gaps. Clinical care, for example, will continue to decentralize and become integrated within community structures for more patient-centered care. Examples of planned community platform engagement include, but are not limited to:

- DREAMS Safe Spaces, for HIV prevention services.
- DICs, to provide HIV prevention and treatment services to KPs.
- CHW platform - peer educators/literacy.
- PLHIV networks for peer support/ treatment literacy.
- Community retail pharmacies, for provision of ARVs and PrEP to stable PLHIV.
- Churches/places of worship and affiliated faith community networks, for SBC, service delivery.
- VSLA groups - SBC, community case finding of pregnant women.

In line with the UNAIDS ambitious 2025 targets, community-led organizations will deliver 30% of the testing and treatment services through differentiated service delivery models including DICs; community-, KP- and women-led organizations will deliver 80% of HIV prevention program services for key populations and women; and community-led organizations will deliver 60% of the programs supporting achievements of societal enablers with technical support through Makerere School of Public Health and Infectious Diseases Institute CSO mechanism.

In addition, we will continue supporting and strengthening community- and youth/women/KP-led CSOs to strengthen their community platforms and networks and participation in CLM. PEPFAR Uganda staff and implementing partners will provide TA and funding to support enhanced HIV community leadership and service delivery through multiple activities, as described in Pillar 1.

In COP23, the community especially through the CSOs will lead in community-level service delivery. They will also lead in advocating on behalf of constituency beneficiary populations; holding governments accountable on its commitments enshrined in various policies, guidelines and laws; promoting human rights to combat stigma and discrimination against key populations, people living with HIV, and other vulnerable groups; advancing equitable inclusion disadvantaged and rather excluded populations including people with disabilities and fishing communities; identifying challenges to, and gaps in, health care delivery; supporting data collection and innovation; providing independent views of programming and processes; and promoting transparency.

Using a community empowerment model, these efforts will expanded to include addressing the increasing violence, insecurity and hostilities towards some key populations; creating resilience; and ensuring continuity of critical and life-saving prevention and treatment services in the unfavorable legal environment – that might be worsened by the recent passing of the

anti-homosexuality bill (2023) by Parliament of Uganda; and resource mobilization and financial management to increase CSOs sustainability.

Empowerment of communities and their existing structures will serve as a game changer. This will deal with all barriers for service access, uptake and utilization and more importantly anchor this to the existing public sector platforms that are funded by the Government of Uganda (GOU). The Parish Development Model (PDM) is one such a platform that has the whole government approach for socio-economic transformation for development, for delivery of social services that includes health in broad terms and hence provide for the response to HIV/AIDS and other public health threats. All PEPFAR supported partners and interventions will be redefined, standardized, harmonized, linked to the PDM, planning in mind to institutionalize these as a strategy for transitioning into the GOU systems for sustainability.

## Innovation

No additional Innovations were included as they have been fully addressed in other pillars.

### Leading with Data

**COP23 Monitoring and Evaluation (M&E) priorities**: PEPFAR and the Ministry of Health have partnered closely to advance the alignment of data systems and requirements in Uganda. The alignment of PEPFAR and Ministry of Health data systems, routine indicator mapping, site list reconciliation, and harmonization of program data reporting processes has enabled >80% of program data elements reported to OGAC to be extracted from partner country national health information systems.

In COP21 and COP22, PEPFAR collaborated with the Ministry of Health to revise the national health management information system (HMIS) tools to capture additional priority indicators in routine reporting. The additions include data for cervical cancer screening and treatment among women living with HIV (WLHIV), key/priority populations, mental health, non-communicable diseases (diabetes, hypertension), COVID-19 vaccination, and 50+ finer age bands. As a result, in COP23, the national HMIS tools for reporting will meet >90% of the PEPFAR MER reporting requirements, further streamlining monitoring and evaluation processes through increased reliance on Government of Uganda systems.

In COP23, the M&E team will work with MOH-DHI to engage with other health development partners to support the printing of HMIS tools (especially the cross-cutting ones OPD registers etc.) as we support the scale up of HIS investments to all disease areas and ensure HIS modules cover primary data collection tools and summary reporting forms to reduce the need for printing of paper-based HMIS tools.

Other COP23 strategies include:

- The development of an M&E framework with the National SI TWG on performance measures for tracking HIS investments and ensure close result-based monitoring of PEPFAR HIS Investments.
- Working with MoH to develop and implement data quality assessment (DQA) and social quality assessment (SQAs) in place of SIMS that are aligned to the national QA/QI plan)
- Plan for integration of Data Quality assessments in the national health information. system in collaboration with the DHI and ACP; The corrective action plans will be led and endorsed by the Ministry of health (ACP and DHI) with technical support from METS/SITES.
- Support and encourage increased use of the National CQI Database (developed by METS) for reporting of continuous quality improvement (CQI) projects/results at facility, district, and regional level with supervision at regional level (RRH) and thereby enable a national coordination and view of the progress of the projects and identify the best practices.
- Supporting the new CDC awards to develop Evaluation and performance measurement plans and develop high focused evaluations/implementation science projects addressing key programmatic gaps with the ministry of health input.

**COP23 Health Information Systems (HIS) priorities**: In COP23, there will be continued investment in longitudinal, person-centered, integrated data systems, including improving interoperability, health information exchange, and data integration capabilities. Strengthened systems will improve data quality, as well as promote integrated data use and data visualization for evidence-based decisions at all health care system levels including community, facility, district, regional referral, and national. PEPFAR will continue to co-plan with Government of Uganda (GOU) and other health development partners to align investments in infrastructure, connectivity, and change management to support the broader GOU digitalization strategy.

Health Information Systems (HIS) overall strategy for data systems and data use contributes to national HIV related data systems and functions. Over the years, PEPFAR Uganda has relied on a mix of national and parallel systems to harness the data needed for the program at the various levels. Great gains have been achieved in aggregated data reporting through use of the national eHIMS system. At the same time, data for managing clients at health facility level continues to improve in breadth and quality but no national/central data repositories exist. Among other EMRs, MOH recently introduced E-health (eAFYA), which is still nascent, at low scale and does not fully serve the HIV program. For this reason, PEPFAR Uganda through its implementing partners, will continue using its EMRs for the evolving data needs of HIV response but as well support MOH towards a comprehensive national EMR in COP23.

To meet the COP23 guidance and technical recommendations, PEPFAR Uganda is going to continue with earlier initiatives in areas of improving the IT infrastructure, HIS solutions with program directions guided by principles for digital development and smart data, data centralization strategies, workforce development, and building of needed partnerships. Emphasis is going to be on strengthening HIS solutions towards person-centered monitoring and program management where data is used for clients' management with greater emphasis on chronic care management. Data related to comorbidities like tuberculosis (TB), sexually transmitted infections (STIs), viral hepatitis, noncommunicable diseases, COVID-19 vaccination status, and other conditions will also be collected either through current EMRs or through integration with other systems that will be available. EMRs will continue to be used to automatically aggregate data for reporting at subnational and national levels.

To advance the vision of securely bringing together individual level data into a national data repository - to among others enable longitudinal monitoring and patient deduplication, PEPFAR Uganda is going to work with the relevant stakeholders towards agreements of centralizing a minimum dataset in EMRs from the routine clinical health information. This initiative will be based on the WHO consolidated guidelines on person-centered HIV strategic information strengthening of routine data for impact. Combining the minimum data set with unique identification will promote linking and deduplication of client's engagements with the health system across time and locations. Ongoing efforts towards the establishment of key national registries including health worker, product, health facility and client registries will also continue to be supported.

As a short-term measure to improve the accuracy and reliability of the HIV- related data by removing duplicates, a deduplication project is being undertaken. This is to help the Uganda program towards effective disease management, prevention and may be understand distortions in the HIV prevalence estimates. PEPFAR Uganda is working with MOH towards centralization of available demographic variables for use of demographic data matching probabilistic algorithms in absence of a unique identifier to improve on accuracy data used for the program. A step wise approach through MOH leadership is being followed. Proof of concept was demonstrated through deduplicating the HIV CBS pilot districts data, then scale up to the Kampala region given its uniqueness and clients load and then full-scale implementation happening on a quarterly basis. A stepwise approach is being undertaken as efforts are put into establishing the infrastructure towards full scale implementation. The long-term plan is towards a national clients' registry that isn't just disease specific (for example for PEPFAR only), but rather for all diseases and health services. The experience gained from linking contacts to

transmission chains during COVID 19 and Ebola activities will be relied on, as well as, the viral load HEI, COVID 19 vaccinations, and management of the no-fly lists.

The Uganda program is embarking on data warehousing so that various data streams from clinical systems, lab, dispensing, aggregate, surveillance among others can be centralized and curated with appropriate tools to provide data relevant for different functions, patient care, program management and monitoring through a fundamental principle of "collect data once and use it many times". This will strengthen the use of data from other sources. System integrations and different use cases of health information exchanges will continue to be promoted to bolster data centralization projects all aimed at making data available publicly and as such address transparency aspects.

PEPFAR Uganda working with various partners will support the development of a new informatics training curriculum towards institutionalizing avenues for informatics skills development of the needed skillsets among the various cadres. Finally, at the core of this HIS plan, is to strengthen the MOH governance aspects needed to enable the development and sustenance of digital health investments. PEPFAR will continue to support national strategies, guidelines, standards and procedures on digital health, data protection, and others on healthcare and/or data management as needed, to ensure that data are appropriately governed, accessible, secure, and quality-controlled throughout the collection-to-use lifecycle.

# Target Tables

**Target Table 1: ART Targets by Prioritization for Epidemic Control**

| Target Table 1 ART Targets by Prioritization for Epidemic Control | | | | | | | |
|---|---|---|---|---|---|---|---|
| Prioritization Area | Total PLHIV (FY23) | New Infections (FY24) | Expected Current on ART (FY23) | Current on ART Target (FY24) *TX_CURR* | Newly Initiated Target (FY24) *TX_NEW* | ART Coverage (FY24) | ART Coverage (FY25) |
| Attained | 396,604 | 8,058 | 356,192 | 377,199 | 29,508 | 95% | |
| Scale-Up Saturation | 583,743 | 14,620 | 515,410 | 550,062 | 47,040 | 94% | |
| Scale-Up Aggressive | 460,896 | 13,817 | 401,938 | 426,511 | 34,167 | 93% | |
| Military | | | 21,427 | 22,152 | 1,216 | | |
| Sustained | | | | | | | |
| Central Support | | | | | | | |
| Commodities (if not included in previous categories) | | | | | | | |
| No Prioritization | | | | | | | |
| **Total** | 1,441,243 | 36,495 | 1,294,967 | 1,375,924 | 111,931 | 95% | |

## Target Table 2: VMMC Coverage and Targets by Age Bracket in Scale-up Districts

| Target Table 2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts | | | | | | | |
|---|---|---|---|---|---|---|---|
| SNU | Target Populations | Population Size Estimate (SNUs) | Current Coverage (date) | VMMC_CIRC (in FY24) | Expected Coverage (in FY24) | VMMC_CIRC (in FY25) | Expected Coverage (in FY25) |
| Central 1 | 15-24 | 585,998 | 4% | 25,675 | 4% | 25,932 | 4% |
| Central 2 | 15-24 | 445,272 | 4% | 34,318 | 8% | 34,661 | 8% |
| East Central | 15-24 | 360,158 | 3% | 21,419 | 6% | 21,633 | 6% |
| Kampala | 15-24 | 216,033 | 7% | 17,683 | 8% | 17,860 | 8% |
| Mid Eastern | 15-24 | 435,083 | 4% | 25,166 | 6% | 25,418 | 6% |
| Mid Northern | 15-24 | 395,609 | 6% | 35,748 | 9% | 36,105 | 9% |
| Mid Western | 15-24 | 498,558 | 4% | 36,004 | 7% | 36,364 | 7% |
| North East | 15-24 | 261,801 | 5% | 24,062 | 9% | 24,303 | 9% |
| South Western | 15-24 | 472,999 | 5% | 32,488 | 7% | 32,813 | 7% |
| West Nile | 15-24 | 189,137 | 3% | 20,254 | 11% | 20,457 | 11% |
| Military | 15-24 | - | | 13,125 | | 13,256 | |
| **Total/Average** | | **3,860,648** | **4%** | **285,942** | **7%** | **288,801** | **7%** |

## Target Table 3: Target Populations for Prevention Interventions to Facilitate Epidemic Control

| Target Table 3 Target Populations for Prevention Interventions to Facilitate Epidemic Control | | | | |
|---|---|---|---|---|
| Target Populations | Population Size Estimate* (SNUs) | Disease Burden* | FY24 Target | FY25 Target |
| AGYW_PREV | | | 137,747 | 137,747 |
| PP_PREV | 135,069 | 7% | 211,071 | 211,071 |
| KP_PREV | 395,703 | 15% | 288,917 | 288,917 |
| TOTAL | 530,772 | 22% | 637,735 | 637,735 |

**Data Sources**

- Consultant Reports: Size Estimation of Key Populations in Uganda 2018
- Consultant Reports: Size Estimation of Key Populations in Uganda 2020
- Mapping the number of female sex workers in countries across Sub-Saharan Africa
- IBBS FSW and MSM Survey Reports
- Service Data in the KP Tracker

## Target Table 4: Targets for OVC and Linkages to HIV Services

| Target Table 4 Targets for OVC and Linkages to HIV Services | | | | | |
|---|---|---|---|---|---|
| SNU | Estimated # of Orphans and Vulnerable Children | Target # of active OVC<br>OVC_SERV Comprehensive* | Target # of OVC<br>OVC_SERV Preventative | Target # of active OVC<br>OVC_SERV DREAMS | Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files<br>OVC_HIVSTAT |
| Military | - | 2,814 | 1,348 | - | 2,299 |
| Central 1 | 151,771 | 55,149 | 28,540 | 24,626 | 48,707 |
| Central 2 | 101,032 | 49,302 | 10,384 | 16,027 | 44,284 |
| East Central | 78,974 | 26,006 | 7,264 | - | 20,411 |
| Kampala | 44,859 | 55,013 | 7,817 | 5,808 | 44,387 |
| Mid Eastern | 42,423 | 20,792 | 5,386 | - | 15,955 |
| Mid Northern | 88,941 | 54,383 | 4,735 | 7,512 | 44,513 |
| Mid Western | 146,954 | 55,409 | 3,692 | 3,784 | 41,870 |
| North East | 20,735 | 7,715 | - | - | 5,779 |
| South Western | 110,702 | 51,142 | 11,114 | 981 | 38,063 |
| West Nile | 26,941 | 8,185 | - | - | 5,963 |
| FY24 TOTAL | 813,333 | 385,910 | 80,280 | 58,738 | 312,231 |
| FY25 TOTAL | 813,333 | 385,910 | 80,280 | 58,738 | 312,231 |

# Core Standards

| COP23 Core Standard | Status of Policy & Implementation | PEPFARs contribution to the national response | Plans for FY24 & FY25 to advance this standard |
|---|---|---|---|
| 1.**Offer safe and ethical index testing to all eligible people and expand access to self-testing**. Ensure that all HTS are aligned with WHO's 5 Cs. Index testing services should include assessment of and appropriate follow-up for intimate partner violence. Offer HIV testing to every child under age 19 years with a biological parent or biological sibling living with HIV. | Complete: MOH, in collaboration with PEPFAR, has finalized the policy on safe ethical index testing. | The HTS program is steadily meeting the minimum program requirements:<br>•100% of PEPFAR supported sites implemented index testing in FY2022. | There is a system in place for assessing safe and ethical delivery of index testing as well as adhering to standards for index testing delivery.<br>There is also a system in place for assessing IPV before and after index testing services.<br>System for monitoring negative outcomes from index testing and HIV self-testing is under development.<br>Age group for index testing for exposed children was extended to under 19 years in the new policy currently under final review. |
| **2. Fully implement "test-and-start" policies.** Across all age, sex, and risk groups, over 95% of people newly identified with HIV infection should experience direct and immediate linkage from testing to uninterrupted treatment. | Completed: the 2016 version of the "Consolidated Guidelines for Prevention and Treatment of HIV in Uganda" expanded the HIV "test and start" policy to all adolescents and adults diagnosed with HIV. Uganda since then fully implemented the test and start with immediate and direct linkage of ART at community and facility level. | 100% of PEFAR supported sites are implementing test and start. | 100% of PEFAR supported sites are implementing test and start. |
| **3. Directly and immediately offer HIV-prevention services to people at higher risk.** People at a higher risk of acquiring HIV must be directly and immediately linked with prevention services aimed at | The Ministry of Health updated the national PrEP guidelines to create a positive policy climate for PrEP service | Since FY2018, there has been a progressive PrEP_NEW scale up, with 363,693 clients having been | In COP23, the program will continue to collaborate with the MOH to implement WHO recommendations for event-driven PrEP. The PrEP guidelines have been revised to include the novel PrEP products CAB-LA and |

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| keeping them HIV-free, including PrEP and post-exposure prophylaxis (PEP). | delivery among AGYW, pregnant, and breast-feeding women. | started on PrEP by the end of FY2022. | Dapivirine ring. We have included event-driven PrEP for persons assigned male sex at birth and not taking hormones. Differentiated PrEP service distribution sites, such as community retail pharmacies, are accessible to eligible PrEP persons. To aid monitoring and reporting of these initiatives, the national health information systems have been updated to reflect the latter changes. The program will strengthen community-based initiation and refills for PrEP to enhance service uptake. The program will work with Social Behavioral Change Activity (SBCA) – the PEPFAR communication partner, to implement PrEP demand generation focused on creating a supportive environment for PrEP uptake and continuity and leveraging digital health in social behavioral communications. |
| **4. Provide OVC and their families with case management and access to socioeconomic interventions in support of HIV prevention and treatment outcomes**. Provide evidence-based sexual violence and HIV prevention interventions to young adolescents (aged 10-14). | In progress: PEPFAR Uganda is on course with 99% of OVC beneficiaries having a known status reported to OVC partner. We are also on track with index testing for biological children of HIV+ mothers. | In COP22, we periodically assess risk factors of HIV negative OVC beneficiaries and intensify index testing for biological children of HIV+ mothers and, siblings of C/ALHIV.100% of OVC beneficiaries are linked to treatment, these effective strategies will continue to be implemented in COP2257% of adolescent girls in high HIV-burden reached with primary prevention in FY21 Q4. | In COP23, we continue using evidence-based prevention curricula for community and in-school activities. |

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| **5. Ensure HIV services at PEPFAR-supported sites are free to the public.** Access to HIV services, medications, and related services (e.g., ART, cotrimoxazole, ANC, TB, cervical cancer, PrEP and routine clinical services for HIV testing and treatment and prevention) must not have any formal or informal user fees in the public sector. | In Uganda, there is no informal user fees within public health sector sites although within private wings of NRH/RRH and General Hospitals there is an agreed form of user fees for those clients who might not have time to go all the way in the ques. As a country there is a wider move through the Ministry of Health sector mobilization move for Universal health Coverage (leaving no one behind). | Through direct service delivery at the operational/site level, enhance the MoH technical capabilities for coordination of ONE national HIV/AIDS response, oversight, leadership, integrated planning and development of critical policies and other technical guidelines. One national integrated plan, M&E and reporting systems have been developed that enhances information sharing and flow within all stakeholders for efficient use of limited resources. | Empowerment of the Regional Referral Hospital (RRH) teams to provide oversight, local leadership for country ownership at the lowest level possible and impact communities for service access, uptake and utilization through demand driven approach, ensuring program harmonization, providing avenues for transition into the GOU platforms for sustainability. |
| **6. Eliminate harmful laws, policies, and practices that fuel stigma and discrimination and make consistent progress toward equity.** Programs must consistently advance equity, repudiate stigma and discrimination, and promote human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, children, and other vulnerable groups. This progress must be evidence-based, documented, and included in program evaluation reports. | N/A | In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, PEPFAR Uganda has conducted a Legal Environment Assessment (LEA) as root cause analysis to assess the extent to which the existing laws, regulations, and policies enable or constrain key protections and those affected by HIV in Uganda. | Uganda AIDS commission (UAC) is leading efforts to address the LEA recommendations through a multisectoral approach with support from Makerere University School of Public Health.<br>MoH and UAC will continue the leadership in addressing the LEA recommendations. However, the current situation is dynamic and fluid following the passing of the AHA. We shall continue to monitor the situation and adapt our programs as appropriate, in consultations with KP CSOs.<br>IP train IP Staff and staff at supported HFs in KP friendly services and GSD. In addition, they conduct community awareness sessions with the key |

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| | | With the support of MOH and CSOs PEPFAR Uganda will continue to advocate for improved KP friendly policies, legal reforms, and an enabling political environment. PEPFAR will leverage the MOH standardized curricular for training health workers in providing PLHIV/KP/PP/vulnerable populations with friendly services and integrate human rights, gender equality and stigma reduction into curriculum of institutions that train health workers, judicial officers, police officers and other relevant professionals. | gatekeepers on the benefits of KPs accessing quality services. Per Pillar1, PEPFAR Uganda continues to close equity gaps across the HV cascade for AGYW, children, PWDs and Pregnant Breastfeeding women. |
| **7. Optimize and standardize ART regimens.** Offer DTG-based regimens to all people living with HIV (including adolescents, women of childbearing potential, and children) 4 weeks of age and older. | Guidelines complete | The percentage of individuals presently on treatment transition to TLD rose from 56% in FY20Q4 to 96% by the end of FY22. With greater coverage, we have also maintained high viral load suppression rates among patients currently on | In FY24, we will maintain the focus on ART optimization to better viral load suppression results and person-centered community initiatives to improve treatment continuity. |

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| | | treatment. This performance is ascribed to IP weekly meetings, performance tracking, use of the audit tool to identify clients due for different services, client attachment to community health workers, on-going community demand creation and client literacy activities.<br>Regarding the role of pediatric optimization, we see a rise in coverage from 12% at the end of FY21 to 86% by the end of FY22 December. | |
| **8. Offer differentiated service delivery models.** All people with HIV must have access to differentiated service delivery models to simplify HIV care, including 6-month MMD, DDD, and services designed to improve ART coverage and continuity for different demographic and risk groups and to integrate with national health systems and services. | Guidelines complete | ≥3 Months Multi-Month Dispensing (MMD) increased from 60.2% in FY21 quarter one to 87% in FY23 quarter one.<br>Improved viral load coverage and suppression has also occurred during the tremendous scale up of multi-month dispensing (MMD) over the last 2 fiscal years.<br>We have made substantial progress in MMD coverage since the MOH circular in March 2021 expanding eligibility for MMD and delinking VL testing as a pre-request for MMD. | In COP23, PEPFAR and MOH we will maintain the focus on strengthening the clinic flow to ensure all eligible clients benefit from MMD, including 6 months MMD. |

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| | | In COP23, we aim to reach and maintain 100% 3+ months MMD coverage. | |
| **9. Integrate TB care.** Routinely screen all people living with HIV for TB disease. Standardized symptom screen alone is not sufficient for TB screening among people living with HIV and should be complemented with more-sensitive and setting-specific, WHO-recommended screening tools. Ensure all people living with HIV who screen positive for TB receive molecular WHO-recommended diagnostic and drug susceptibility testing, all those diagnosed with TB disease complete appropriate TB treatment, and all those who screen negative for TB complete TB Preventive Treatment. | TB Screening is integrated in HIV service delivery. Symptom screening is complemented with CRP and X-ray screening in facilities with capacity. Currently the coverage of WHO-recommended molecular diagnostic testing is at 70%. | Routine TB screening is integrated in all PEPFAR supported HIV care and treatment services at facility and community levels. | In COP2023 PEPFAR is investing in improving TB screening and diagnosis among PLHIV scaling up access to WHO recommended screening and diagnostic tools complimenting investments by GOU and GFATM. |
| **10. Diagnose and treat people with advanced HIV disease (AHD).** People starting treatment, re-engaging in treatment after an interruption of > 1 year, or virally unsuppressed for >1 year should be evaluated for AHD and have CD4 T cells measured. All children <5 years old who are not stable on effective ART are considered to have advanced HIV disease. The WHO-recommended and PEPFAR-adopted package of diagnostics and treatment should be offered to all individuals with advanced disease. | Ever since 2019, AHD was adopted in Uganda's national consolidated guidelines for Prevention and Treatment of HIV. To operationalize the guideline an implementation plan was developed consisting of multi-layered strategies aimed at supporting implementing partners and front-line health workers to roll out and deliver the AHD package of interventions to all the 1800 ART sites to date. At FY22 Q4, among 28402 | In COP23, PEPFAR in collaboration with MOH and other partners is Committed to eliminate the gap for CD4 testing. As such, funds have been allocated for CD4 testing access, including expansion of the rapid omega Visitect CD4 testing with an aim to further increase access for rapid AHD identification, linkage to treatment, and minimization of IIT. PEPFAR will continue to support Capacity building including dissemination of revised guidelines; training of health | Continue to expand the Visitect CD4 testing from the conventional methods. In FY 24, PEPFAR will work with MOH, Global fund and other partners to document the burden for other AHD conditions including Aspergillosis and histoplasmosis with an anticipation to allocate some resources to enhance the diagnostics and treatment for these conditions in FY 25.<br>PEPFAR also plans to continue to shift from the conventional CD4 testing methods towards increasing the CD4 VISITECT to at least 60% in FY 25.<br>PEPFAR will continue to support the national team to address the existing gaps including commodities availability, equipment maintenance, staff competences to diagnose, manage and report on AHD as well as AHD treatment literacy among PLHIV. |

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| | TX_NEW,13152(46%) and 2176 out of 3120 (70%) accessed CD4 testing and Crag testing respectively. Over 80% (202/228) of those found positive for CrAg were linked to appropriate treatment with fluconazole and rapid initiation of ART as recommended by the national ART guidelines.<br>In COP22, PEPFAR and other partners like CHAI has supported MOH to update the treatment protocols for cryptococcal meningitis to use the newer potent, effective, and well tolerated molecules called AmBisome (Amphotericin B-Liposomal) and Flucytosine, to be used in the designated cryptococcal meningitis treatment centers i.e., national, and regional referral hospitals, per current WHO guidelines. In COP23, all other sites, including district hospitals and lower-level HFs, will continue | workers; monitoring and reporting.<br><br><u>Existing Plan/Policy References:</u><br>The national AHD implementation plan to scale up AHD services and the national consolidated guidelines for prevention and Treatment of HIV in Uganda. | |

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| | to offer screening, identification, and referral of patients with cryptococcal meningitis to the designated centers for specialist management, including toxicity monitoring with laboratory tests. | | |
| **11. Optimize diagnostic networks for VL/EID, TB, and other coinfections.** In Coordination with other Donors and National TB Programs, complete diagnostic network optimization (DNO) and transition to integrated diagnostics and multiplex testing to address multiple diseases. Ensure 100% EID and VL testing coverage and return of results within stipulated turn-around time. | The guidelines & policies currently implemented include:<br>- Uganda National Health Laboratory Services Policy II.<br>- Uganda National Health Laboratory Services Strategic Plan III (2021-2025).<br>- Point of care (POC) testing policy & implementation guidelines.<br>- National Health Laboratory Hub and Sample Transport Network guidelines.<br><br>Guidelines on POC device placement and for multi-disease testing on POC devices under development.<br>Diagnostic Network Optimization | Development & implementation of the national laboratory policies and guidelines for strong, resilient, effective, and sustainable diagnostic networks for VL/EID, TB, and other co-infections.<br><br>Existing Plan/Policy References: https://www.cphl.go.ug/policy-documents | In FY24, DNO will focus on optimal placement of POC platforms in line with the recommendations from the DNO analysis, demand creation & patient treatment literacy to scale up POC testing coverage. These POC platforms include the m-PIMA & GeneXpert equipment which due to their capacity will be used to enhance testing efficiency through diagnostic integration.<br>In addition, PEPFAR Uganda will support scale-up of multi-disease testing, and data connectivity for POC platforms for improved efficiency and diagnostic optimization. |

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| | (DNO) is implemented in a phased approach:<br>• The first phase focused on baseline data collection & analysis for efficiency and effectiveness of sample referral and lab hub operations.<br>• The second phase will focus on placement of POC platforms and multi-disease testing for VL/EID, TB, and other co-infections. | | |
| **12. Integrate effective quality assurance (QA) and CQI practices into site and program management.** Program management must apply ongoing program and site standards assessment—including the consistent evaluation of site safety standards and monitoring infection prevention and control practices. PEPFAR-supported activities, including IP agreements and work plans should align with national policy in support of QA/CQI. | The health sector has updated the National Quality Improvement framework and Strategic Plan (2021 - 2025) to facilitate effective implementation of healthcare interventions and address current health service challenges. | Builds capacity and sustains the QA and CQI coordination structures; Supports identification of health service gaps in HIV and TB and facilitates activities to close these gaps.<br><br><u>Existing Plan/Policy References:</u><br>Republic of Uganda, Ministry of Health. National Quality Improvement Framework and Strategy (2021-2025). | Functionalize the regional and district level quality improvement structures to enable integrated accountability and coordination structures for quality assurance and continuous quality improvement. |

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| **13. Offer treatment and viral-load literacy**. HIV programs should offer activities that help people understand the facts about HIV infection, treatment, and viral load. Undetectable=Untransmittable messaging and other messaging that reduces stigma and COP/ROP23 Guidance for All PEPFAR-Supported Countries Page 125 of 220 encourages HIV testing, prevention, and treatment should reach the general population and health care providers. | These aspects are part of the National Guidelines for Prevention and Treatment of HIV-2020 and the revised version (2022). Treatment and viral-load literacy has been rolled out to all ART sites, and communities. | Capacity building including dissemination of policy and guidelines; training of health workers; Grant to NAFOPHANU for client-led treatment literacy | Support client-led literacy through CSOs and other community and youth structures. |
| **14**. **Enhance local capacity for a sustainable HIV response**. There should be progress toward program leadership by local organizations, including governments, public health institutions, and NGOs. Programs should advance direct funding of local partners and increase funding of organizations led by members of affected communities, including KP-led and women-led organizations. | PEPFAR Uganda has directed significant funding directly to local implementing partners. These partners have undergone various levels of organizational capacity development to adhere to agency specific requirements, and have seen no drop in programmatic performance or service delivery | The USG is building local capacity through skills transfer, TA, mentorships, and institutional capacity strengthening. Furthermore, PEPFAR has transitioned most awards to local partners/NGOs. | The Mission plans to allocate funding and staff to continue facilitating capacity development for PEPFAR local partners. |
| **15**. **Increase partner government leadership**. A sustainable HIV response requires coordinated efforts that enable governments to take on increasing leadership and management of all aspects of the HIV response—including political commitment, building program capacities and capabilities, and financial planning and expenditure. | The PEPFAR team has supported the MOH to develop implementation guidelines to support regional referrals hospitals as part of the support of government leadership at the regional and decentralized | PEPFAR provides technical assistance and financing the development of the guidelines. In addition, PEPFAR will continue to second health workers and advisors at the MOH to support leadership and oversight on | PEPFAR will disseminate the guidelines and support operationalization in FY 24/25, once approved by MOH. |

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| | level using the hub and spoke approach. | various program areas. | |
| **16. Monitor morbidity and mortality outcome**. Aligned with national policies and systems, collect and use data on infectious and non-infectious causes of morbidity and mortality among people living with HIV to improve national HIV programs and public health response. | PEPFAR has supported Mortality Surveillance as a pilot project in Rwenzori region for the last 2 years. In COP22, using lessons-learned, roll-out of systematic collection of death information and reporting started in PEPFAR-supported regions following TOT by MOH ACP. Standardized tools have been developed in collaboration with NIRA, the national body responsible for CRVS in Uganda, and these have been rolled out in Regional Referral Hospitals, general hospitals and HCIVs. A module for Mortality reporting and coding has also been included in the national health Information management system (DHIS2). The MOH and mortality stakeholders are in the process of developing national policy and guidelines with the | Mortality Surveillance provides epidemiological data on deaths in the population including HIV patients who are direct beneficiaries of the PEFAR program. The system identifies the leading cause of death and this guides immediate and future prevention strategies at sub-national and national levels. | In FY24 PEPFAR through IPs will support identification, documentation, death audits, certification and notification of all deaths using appropriate tools at facility and community levels. Support reporting of all deaths into national mortality systems (DHIS2-Module 11). Support continuous capacity-building and quality assurance for all mortality surveillance processes at sub-national and national levels. Country-led policy and technical guidelines will be formulated and disseminated to promote sustainability efforts. In FY25, established national mortality surveillance systems will be led by MOH in collaboration with stakeholders. |

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| | formation of a Mortality Surveillance Technical Working Group to strengthen national coordination efforts. | | |
| **17. Adopt and institutionalize best practices for public health case surveillance**. Transfer/deduplication processes and a secure person-based record should be in place for all people served across all sites. Unique identifiers should also be in place, or a plan and firm, agreed-upon timeline for scale-up to completion should be established. | In FY23, PEPFAR is supporting development of a Public Health Case Surveillance national policy and guidelines that will be used to implement Case-Based Surveillance. Building onto existing HIV Recency case surveillance and Health Information Systems infrastructure investments, collection of individual-level data from diagnosis will enable monitoring of epidemiological trends of events and disease outcomes. | Establishment of HIV Case Surveillance will enable monitoring of: (1) epidemiological trends, demographics, behavior, mode of transmission, and recent HIV infection; (2) trends of clinical status, initial CD4, other opportunistic infections; and (3) trends in linkage to services. Data from Case Surveillance will enable provision of client-centered care for HIV-infected persons and rapid public health response. | During FY24, PEPFAR supports scale up of IT infrastructure through HIS scale up that will enable establishment of HIV Case-Based Surveillance system. This system will monitor: (1) epidemiological trends demographics, behavior, mode of transmission, and recent HIV infection; (2) trends of clinical status, initial CD4, other opportunistic infections; and (3) trends in linkage to services. In FY25, Case Surveillance will form part of the country National Integrated Surveillance System (NISS) that will draw data from all disease surveillance platforms in the country to monitor and track health events for rapid public health response. |

# USG Operations and Staffing Plan to Achieve Stated Goals

In COP23, USG agencies agreed to level funding for cost of doing business (CODB). Thus, there are no major changes in CODB. COP guidance was reviewed, and interagency discussions were held throughout the COP planning process to ensure transparency and that the interagency structure maximized effectiveness and efficiency to achieve program priorities across PEPFAR's strategic pillars. Through this process, agencies reviewed their existing portfolio to determine if programmatic shifts between agencies required additional staffing to meet the needs across PEPFARs new strategic direction. Any shifts or additional staffing needs were agreed upon by the interagency team.

**Peace Corp (PC)**

Peace Corp currently has 20 positions with no vacancies or new positions proposed for COP23. No missing skill sets or competencies were identified within the PC structure.

**Department of State (PEPFAR Coordination Office-PCO)**

PCO currently has a total of 12 positions (8 filled and 4 vacant). PCO is currently recruiting for two positions (Program Assistant and Community Grants Advisor) and the remaining two vacant positions are going through the classification process (Senior Health Communication and Communication Advisor positions). The Program Assistant position has been previously approved, and the Senior Health Communications position was approved under COP22. The Community Grants and Communications Advisor positions will be budgeted for using current level funding. The Strategic Information Advisor position is a seconded position supported by the Centers for Disease Control (CDC). This position is currently going through reclassification and funding will be shifted from CDC to PCO. The Senior Health Communications Advisor, Community Grants Advisor, and Communication Advisor positions have been vacant for more than 6 months as each position had to go through the classification process. These positions will serve a critical need for PCO by supporting health communication needs and small grants support within the intra-agency space. No missing skill sets or competencies were identified within the PCO structure.

**Department of Defense (DoD)**

The current DOD/WRAIR organogram has four positions, namely, country director, PEPFAR program manager, strategic information specialist and finance and administration specialist. In COP23, CDC will transition the two districts of Nakasongola and Luwero to DOD/WRAIR in response to a request from the Ministry of Health to align to the newly defined regionalization structure to strengthen coordination, planning and supervision of the health service delivery structure. With the transition of two new districts and significant HIV treatment and prevention cohort, DOD/WRAIR proposes to add a Locally Employed (LE) Staff position as a HIV Prevention,

Care and Treatment Specialist to support programmatic and technical components of programming for the two new districts to enhance the achievement of program pivots.

The addition of a LE staff member to the team will improve our partner management, technical oversight, and reporting as an agency as we work towards achieving the 95-95-95 goals in DOD/WRAIR-supported districts. The DOD/WRAIR technical team has membership across all TWGs and collaboratives in the interagency space. At TWG and collaborative levels, we will continue to track IP and agency performance regularly to ensure that we are on track to achieve our goals.

To meet QA requirements, DOD/WRAIR is utilizing a quality improvement approach to address current programming gaps based on program performance and has developed customized tools for specific program areas. That mentioned, there may be a need to revise the current SIMS tool to be more relevant to the current program and a programmatic shift from routinized SIMS visits to targeted SIMS visits. In terms of sustainability and building the national system, the USG interagency team will work with the MOH to consider the adoption of one national site improvement monitoring tool that will be utilized at all levels. There is no additional action needed by the team beyond the COP23 submission.

DOD/WRAIR will continue to build the skills and competencies of the staff members to ensure their knowledge and skills set are relevant to support the program and ensure achievements of results. The M&O professional development budget will support this aspect of the program. DOD/WRAIR did not alter existing or unfilled positions to better align with COP23 priorities. No missing skill sets or competencies were identified within the DoD structure.

**USAID**

In COP23, USAID/Uganda has 80 PEPFAR-funded FTEs, of which 12 are still vacant. Of the 12 vacant positions, 2 are in reclassification; 8 are in selection/ negotiations; and 2 are undergoing security/medical clearances. USAID anticipates hiring most of the currently vacant positions during COP23/FY24. There are no new proposed positions.

Of the 13 COP19 OGAC-approved positions to support the local partner initiative hired through an institutional contractor, only two are left to be transitioned with a projection of COP23 Y2. Given the continued space limitation, these two positions are still hired through an institutional contractor.

The above-described USAID staffing configuration will help meet the additional requirements associated with OGAC's local partner directive and data reporting requirements, as well as USAID's Journey to Self-Reliance. No missing skill sets or competencies were identified within the USAID structure.

**CDC**

Overall, the CDC staffing footprint will decrease from 120 to 119 positions. Since some positions are cost-shared with other CDC programs, the PEPFAR-funded full-time equivalents will shift from 115.35 to 114.35.

Currently there are 15 vacant positions (2 USDH and 13 LES). Among the 15 vacancies, CDC is recruiting 10 and repurposing 5.

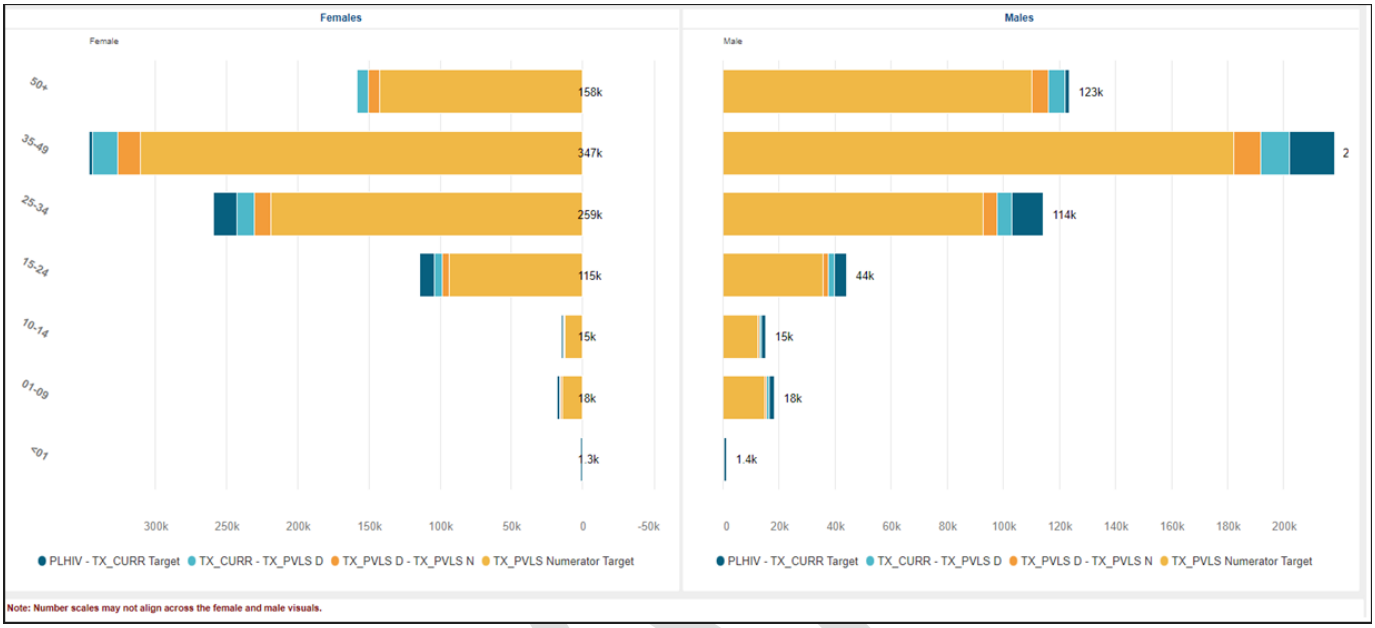
Of the 10 recruitments, 8 are in the active recruitment/selection phase and 2 are in the reclassification phase. The interagency Strategic Information Advisor position was transferred from CDC to PCO. Since CDC is repurposing existing vacancies to better meet evolving program needs, CDC is not requesting any new positions.

In terms of the repurposed positions, CDC analyzed its current staffing with an eye towards longer-term future staffing needs. CDC identified additional skillsets and competencies needed in case-finding, DREAMS, laboratory leadership, higher level financial management, and project management. With the upcoming move into new Embassy office space, and with a few operations/facilities staff completing their federal service, CDC was able to repurpose those positions to its 5 priority positions to complement the identified gaps. Despite the expected higher grade of some of these shifts, as well as anticipated wage increases due to Merit based Compensation, CDC was able to maintain a neutral CODB budget by finding efficiencies in travel, equipment, and motor vehicle line items.

# APPENDIX A -- Prioritization

## Epidemic Cascade Age/Sex Pyramid

### Figure A.1 COP23 Epidemic Cascade Age/Sex Pyramid



# APPENDIX B – Budget Profile and Resource Projections

**Table B.1.1 COP22, COP23/FY 24, COP 23/FY25 Budget by Intervention**

| Table B.1.1 COP22, COP23/FY 24, COP 23/FY25 Budget by Intervention | | | |
|---|---|---|---|
| | Budget | | |
| **Intervention** | **2023** | **2024** | **2025** |
| | **$400,200,000** | **$388,190,000** | **$365,180,500** |
| ASP>HMIS, surveillance, & research>Non-Service Delivery>Key Populations | $332,003 | $0 | $0 |
| ASP>HMIS, surveillance, & research>Non-Service Delivery>Non-Targeted Populations | $5,369,941 | $0 | $0 |
| ASP>HMIS, surveillance, & research>Non-Service Delivery>Pregnant & Breastfeeding Women | $350,000 | $0 | $0 |
| ASP>Health Management Information Systems (HMIS)>Non-Service Delivery>AGYW | $0 | $463,594 | $393,545 |
| ASP>Health Management Information Systems (HMIS)>Non-Service Delivery>Key Populations | $0 | $641,103 | $551,808 |
| ASP>Health Management Information Systems (HMIS)>Non-Service Delivery>Non-Targeted Populations | $0 | $5,027,142 | $4,085,867 |
| ASP>Human resources for health>Non-Service Delivery>Non-Targeted Populations | $1,409,777 | $1,768,114 | $1,202,152 |
| ASP>Laboratory systems strengthening>Non-Service Delivery>Non-Targeted Populations | $1,057,718 | $2,208,432 | $1,871,696 |
| ASP>Laws, regulations & policy environment>Non-Service Delivery>AGYW | $0 | $369,442 | $314,109 |
| ASP>Laws, regulations & policy environment>Non-Service Delivery>Key Populations | $175,000 | $240,000 | $202,134 |
| ASP>Laws, regulations & policy environment>Non-Service Delivery>Non-Targeted Populations | $40,041 | $289,685 | $248,618 |
| ASP>Management of Disease Control Programs>Non-Service Delivery>AGYW | $0 | $311,480 | $265,912 |
| ASP>Management of Disease Control Programs>Non-Service Delivery>Key Populations | $0 | $468,460 | $408,797 |
| ASP>Management of Disease Control Programs>Non-Service Delivery>Military | $0 | $37,495 | $31,879 |
| ASP>Management of Disease Control Programs>Non-Service Delivery>Non-Targeted Populations | $0 | $5,518,181 | $4,401,289 |
| ASP>Management of Disease Control Programs>Non-Service Delivery>OVC | $0 | $35,000 | $30,909 |
| ASP>Not Disaggregated>Non-Service Delivery>Non-Targeted Populations | $561,733 | $0 | $0 |
| ASP>Policy, planning, coordination & management of disease control programs>Non-Service Delivery>Non-Targeted Populations | $2,045,711 | $0 | $0 |

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| ASP>Policy, planning, coordination & management of disease control programs>Non-Service Delivery>OVC | $200,000 | $0 | $0 |
| ASP>Procurement & supply chain management>Non-Service Delivery>Key Populations | $0 | $60,998 | $53,868 |
| ASP>Procurement & supply chain management>Non-Service Delivery>Non-Targeted Populations | $2,421,969 | $2,488,121 | $1,983,618 |
| ASP>Public financial management strengthening>Non-Service Delivery>Non-Targeted Populations | $303,223 | $492,827 | $339,055 |
| ASP>Surveys, Surveillance, Research, and Evaluation (SRE)>Non-Service Delivery>Key Populations | $0 | $240,000 | $202,134 |
| ASP>Surveys, Surveillance, Research, and Evaluation (SRE)>Non-Service Delivery>Non-Targeted Populations | $0 | $7,758,055 | $7,325,836 |
| ASP>Surveys, Surveillance, Research, and Evaluation (SRE)>Non-Service Delivery>Pregnant & Breastfeeding Women | $0 | $689,152 | $580,420 |
| C&T>HIV Clinical Services>Non-Service Delivery>Children | $3,578,216 | $3,886,338 | $3,346,634 |
| C&T>HIV Clinical Services>Non-Service Delivery>Key Populations | $0 | $993,500 | $74,958 |
| C&T>HIV Clinical Services>Non-Service Delivery>Military | $0 | $467,318 | $397,325 |
| C&T>HIV Clinical Services>Non-Service Delivery>Non-Targeted Populations | $38,361,754 | $39,235,025 | $34,222,158 |
| C&T>HIV Clinical Services>Non-Service Delivery>Pregnant & Breastfeeding Women | $10,263,370 | $10,202,705 | $8,768,857 |
| C&T>HIV Clinical Services>Service Delivery>Children | $6,344,759 | $5,423,936 | $4,673,254 |
| C&T>HIV Clinical Services>Service Delivery>Military | | $431,882 | $367,197 |
| C&T>HIV Clinical Services>Service Delivery>Non-Targeted Populations | $29,258,408 | $27,402,750 | $24,971,369 |
| C&T>HIV Clinical Services>Service Delivery>Pregnant & Breastfeeding Women | $2,552,823 | $3,645,317 | $3,266,981 |
| C&T>HIV Drugs>Service Delivery>Children | $1,907,660 | $554,789 | $932,238 |
| C&T>HIV Drugs>Service Delivery>Non-Targeted Populations | $39,490,790 | $22,208,415 | $39,119,170 |
| C&T>HIV Laboratory Services>Non-Service Delivery>Non-Targeted Populations | $5,140,276 | $10,478,034 | $8,851,996 |
| C&T>HIV Laboratory Services>Service Delivery>Children | $1,901,867 | $1,838,060 | $1,920,523 |
| C&T>HIV Laboratory Services>Service Delivery>Military | | $65,591 | $55,767 |
| C&T>HIV Laboratory Services>Service Delivery>Non-Targeted Populations | $49,572,840 | $31,678,782 | $32,052,121 |
| C&T>HIV Laboratory Services>Service Delivery>Pregnant & Breastfeeding Women | $1,510,590 | $0 | $0 |
| C&T>HIV/TB>Non-Service Delivery>Non-Targeted Populations | $0 | $3,779,931 | $3,236,912 |
| C&T>HIV/TB>Service Delivery>Children | $0 | $398,932 | $398,932 |
| C&T>HIV/TB>Service Delivery>Military | $0 | $90,188 | $76,680 |
| C&T>HIV/TB>Service Delivery>Non-Targeted Populations | $0 | $11,069,654 | $10,846,703 |
| C&T>Not Disaggregated>Non-Service Delivery>Non-Targeted Populations | $10,237,212 | $0 | $0 |
| HTS>Community-based testing>Non-Service Delivery>Non-Targeted Populations | $76,095 | $29,873 | $25,399 |
| HTS>Community-based testing>Service Delivery>AGYW | $63,314 | $0 | $0 |
| HTS>Community-based testing>Service Delivery>Non-Targeted Populations | $0 | $1,580,603 | $1,571,277 |

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| HTS>Facility-based testing>Non-Service Delivery>Non-Targeted Populations | $0 | $593,955 | $507,193 |
| HTS>Facility-based testing>Service Delivery>AGYW | $0 | $117,096 | $99,558 |
| HTS>Facility-based testing>Service Delivery>Military | $0 | $49,280 | $41,899 |
| HTS>Facility-based testing>Service Delivery>Non-Targeted Populations | $0 | $11,705,244 | $10,934,966 |
| HTS>Facility-based testing>Service Delivery>Pregnant & Breastfeeding Women | $0 | $4,396,767 | $4,396,767 |
| HTS>Not Disaggregated>Non-Service Delivery>Non-Targeted Populations | $442,399 | $0 | $0 |
| HTS>Not Disaggregated>Service Delivery>AGYW | $194,670 | $0 | $0 |
| HTS>Not Disaggregated>Service Delivery>Non-Targeted Populations | $11,915,540 | $0 | $0 |
| HTS>Not Disaggregated>Service Delivery>Pregnant & Breastfeeding Women | $7,588,545 | $0 | $0 |
| PM>IM Closeout costs>Non-Service Delivery>Non-Targeted Populations | $25,000 | $0 | $0 |
| PM>IM Closeout costs>Non-Service Delivery>OVC | $20,000 | $0 | $0 |
| PM>IM Program Management>Non-Service Delivery>AGYW | $0 | $40,000 | $33,689 |
| PM>IM Program Management>Non-Service Delivery>Children | $0 | $73,993 | $73,993 |
| PM>IM Program Management>Non-Service Delivery>Key Populations | $0 | $667,500 | $0 |
| PM>IM Program Management>Non-Service Delivery>Non-Targeted Populations | $52,021,575 | $48,592,481 | $41,491,846 |
| PM>IM Program Management>Non-Service Delivery>OVC | $5,532,700 | $4,890,438 | $4,366,409 |
| PM>IM Program Management>Non-Service Delivery>Pregnant & Breastfeeding Women | $0 | $226,775 | $226,775 |
| PM>USG Program Management>Non-Service Delivery>Non-Targeted Populations | $26,534,318 | $27,650,251 | $27,762,779 |
| PREV>Comm. mobilization, behavior & norms change>Non-Service Delivery>Key Populations | $1,936,981 | $0 | $0 |
| PREV>Comm. mobilization, behavior & norms change>Service Delivery>AGYW | $357,117 | $0 | $0 |
| PREV>Comm. mobilization, behavior & norms change>Service Delivery>Key Populations | $4,561,698 | $0 | $0 |
| PREV>Condom & Lubricant Programming>Non-Service Delivery>Key Populations | $48,332 | $0 | $0 |
| PREV>Condom & Lubricant Programming>Service Delivery>Key Populations | $176,832 | $58,606 | $58,606 |
| PREV>Condom & Lubricant Programming>Service Delivery>Non-Targeted Populations | $2,073,168 | $2,191,394 | $2,191,394 |
| PREV>Medication assisted treatment>Service Delivery>Key Populations | $123,200 | $241,400 | $203,313 |
| PREV>Medication assisted treatment>Service Delivery>Non-Targeted Populations | $0 | $355,482 | $355,482 |
| PREV>Non-Biomedical HIV Prevention>Non-Service Delivery>AGYW | $0 | $225,838 | $225,838 |
| PREV>Not Disaggregated>Non-Service Delivery>Key Populations | $0 | $2,946,900 | $1,426,643 |
| PREV>Not Disaggregated>Non-Service Delivery>Non-Targeted Populations | $200,000 | $140,000 | $0 |

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|---|---|---|---|
| PREV>Not Disaggregated>Service Delivery>AGYW | $131,602 | $168,715 | $168,715 |
| PREV>Not Disaggregated>Service Delivery>Key Populations | $1,769,264 | $5,630,795 | $5,046,809 |
| PREV>Not Disaggregated>Service Delivery>Non-Targeted Populations | $0 | $786,941 | $786,941 |
| PREV>PrEP>Non-Service Delivery>AGYW | $51,902 | $0 | $0 |
| PREV>PrEP>Non-Service Delivery>Key Populations | $16,517 | $43,500 | $36,985 |
| PREV>PrEP>Non-Service Delivery>Non-Targeted Populations | $318,583 | $170,671 | $143,743 |
| PREV>PrEP>Service Delivery>AGYW | $2,286,521 | $79,161 | $67,305 |
| PREV>PrEP>Service Delivery>Key Populations | $3,460,857 | $14,796 | $13,909 |
| PREV>PrEP>Service Delivery>Non-Targeted Populations | $1,195,459 | $8,234,637 | $7,814,693 |
| PREV>Primary prevention of HIV and sexual violence>Non-Service Delivery>AGYW | $285,979 | $0 | $0 |
| PREV>Primary prevention of HIV and sexual violence>Service Delivery>AGYW | $17,780,322 | $0 | $0 |
| PREV>VMMC>Non-Service Delivery>Non-Targeted Populations | $1,432,979 | $516,418 | $437,736 |
| PREV>VMMC>Service Delivery>Military | | $741,215 | $630,199 |
| PREV>VMMC>Service Delivery>Non-Targeted Populations | $24,029,750 | $26,651,053 | $21,086,462 |
| PREV>Violence Prevention and Response>Non-Service Delivery>AGYW | $0 | $296,606 | $261,937 |
| PREV>Violence Prevention and Response>Service Delivery>AGYW | $0 | $16,397,816 | $13,920,059 |
| PREV>Violence Prevention and Response>Service Delivery>OVC | $0 | $280,273 | $252,961 |
| SE>Case Management>Non-Service Delivery>Non-Targeted Populations | $0 | $1,348,352 | $1,348,352 |
| SE>Case Management>Non-Service Delivery>OVC | $0 | $860,686 | $759,890 |
| SE>Case Management>Service Delivery>OVC | $2,470,508 | $8,348,101 | $7,366,309 |
| SE>Economic strengthening>Service Delivery>OVC | $0 | $3,140,541 | $2,773,457 |
| SE>Education assistance>Service Delivery>OVC | $0 | $2,355,408 | $2,080,094 |
| SE>Food and nutrition>Service Delivery>OVC | $0 | $1,570,272 | $1,386,729 |
| SE>Legal, human rights & protection>Service Delivery>OVC | $591,262 | $0 | $0 |
| SE>Not Disaggregated>Non-Service Delivery>Non-Targeted Populations | $350,000 | $0 | $0 |
| SE>Not Disaggregated>Non-Service Delivery>OVC | $1,784,843 | $0 | $0 |
| SE>Not Disaggregated>Service Delivery>OVC | $13,964,487 | $0 | $0 |
| SE>Psychosocial support>Service Delivery>OVC | $0 | $821,739 | $729,968 |

## Table B.1.2 COP22, COP23/FY 24, COP 23/FY25 Budget by Program Area

| Table B.1.2: COP22, COP23/FY 24, COP 23/FY25 Budget by Program Area | | | |
|---|---|---|---|
| | Budget | | |
| Program | 2023 | 2024 | 2025 |
| | $400,200,000 | $388,190,000 | $365,180,500 |
| C&T | $200,120,565 | $173,851,147 | $177,579,775 |
| HTS | $20,280,563 | $18,472,818 | $17,577,059 |
| PREV | $62,237,063 | $66,172,217 | $55,129,730 |
| SE | $19,161,100 | $18,445,099 | $16,444,799 |
| ASP | $14,267,116 | $29,107,281 | $24,493,646 |
| PM | $84,133,593 | $82,141,438 | $73,955,491 |

## Table B.1.3 COP22, COP23/FY 24, COP 23/FY25 Budget by Beneficiary

| Table B.1.3: COP22, COP23/FY 24, COP24/FY25 Budget by Beneficiary | | | |
|---|---|---|---|
| | Budget | | |
| Targeted Beneficiary | 2023 | 2024 | 2025 |
| | $400,200,000 | $388,190,000 | $365,180,500 |
| AGYW | $21,151,427 | $18,469,748 | $15,750,667 |
| Children | $13,732,502 | $12,176,048 | $11,345,574 |
| Key Populations | $12,600,684 | $12,247,558 | $8,279,964 |
| Military | $0 | $1,882,969 | $1,600,946 |
| Non-Targeted Populations | $305,886,259 | $301,950,503 | $291,216,823 |
| OVC | $24,563,800 | $22,302,458 | $19,746,726 |
| Pregnant & Breastfeeding Women | $22,265,328 | $19,160,716 | $17,239,800 |

## Table B.1.4 COP22, COP23/FY 24, COP 23/FY25 Budget by Initiative

| Table B.1.4: COP22, COP23/FY 24, COP 23/FY25 Budget by Initiative | | | |
|---|---|---|---|
| | Budget | | |
| Initiative Name | 2023 | 2024 | 2025 |
| | $400,200,000 | $388,190,000 | $365,180,500 |
| Cervical Cancer | $3,000,000 | $3,404,641 | $3,174,664 |
| Community-Led Monitoring | $1,148,324 | $1,200,000 | $1,010,668 |
| Condoms (GHP-USAID Central Funding) | $2,250,000 | $2,250,000 | $2,250,000 |
| core Program | $0 | $0 | $294,216,845 |
| Core Program | $315,774,292 | $302,231,832 | |
| DREAMS | $23,085,047 | $21,850,000 | $18,601,038 |
| General Population Survey | $0 | $5,000,000 | $5,000,000 |
| LIFT UP Equity Initiative | $0 | $3,000,000 | $0 |
| One-time Conditional Funding | $1,700,000 | $0 | $0 |
| OVC (Non-DREAMS) | $18,926,100 | $14,940,821 | $13,228,914 |
| Surveillance and Public Health Response | $1,316,237 | $0 | $0 |
| VMMC | $33,000,000 | $34,312,706 | $27,698,371 |

## B.2 Resource Projections

The PEPFAR Uganda program utilized the PLL released in Mid-February 2023 in coming up with budget allocations. The letter provided notional agency-level budgets broken by different program areas, for the two years under COP23 (FY24 & FY25). As the country progresses towards the 95/95/95 goals, a number of technical priorities have been shifted, relaxed, while others remain. Key priority areas considered under the budgeting process include Adaptive case finding particularly for young people, DREAMS programming, PrEP and AP3 (Accelerating Progress in Pediatrics and PMTCT), VMMC, Community Led Monitoring (CLM), Health Systems Strengthening (HSS), and responding to gaps among pediatric populations, KPs and AGYMs.

The PEPFAR team, through technical working groups (TWGs) evaluated existing and new strategic priorities and triangulated these with Expenditure Analysis (EA) data from COP21/ FY22. We used an incremental budgeting approach using last year's budget as a base and triangulated with COP23 program targets and technical priorities to inform final implementing mechanism (IM) level allocations especially for above-site (ABS) interventions.

Working extensively with key stakeholders including the Government or Uganda, Civil Society Organizations, government entities such as ministries, departments and authorities, the Health Development Partners among others, PEPFAR Uganda was able to clarify key strategic intervention for COP23. To support one national commodity procurement plan, PEPFAR Uganda worked very closely with MOH and the Global Fund to quantify commodities for HIV, TB and Lab for both the public and private sector. Through these interactions, PEPFAR Uganda was able to identify programmatic and financial gaps that informed areas for strategic intervention.

# APPENDIX C – Above site and Systems Investments from PASIT and SRE

***Describe the process for determining which systems would be addressed and prioritized in COP23 and rationale and process used for narrowing the focus?***

PEPFAR Uganda COP23 systems investments were informed by the outstanding gaps as identified through the SID and Responsibility matrix review carried out in 2021; The investments are also aligned to priority areas from MOH and other MDAs, CSOs and other key stakeholders. The prioritization was arrived at by consensus among the stakeholders with special focus given to the investments that support institutionalization and strengthening of systems for sustaining the response.

***What are the key systems gaps identified and how do the PASIT activities resolve these identified gaps?***

The key systems gaps were identified in the following areas:

- Data quality gaps, suboptimal manual, and electronic data capture to inform reporting and effective use across sub populations, lack of current data to inform population size estimates for children, key populations, and AGYW/ABYM. This is addressed through surveillance and survey investments including population-based surveys, biobehavioral surveys for key populations, recency, HIV case and mortality surveillance.
- Duplication of records at the service delivery level owing to a lack of unique identification within the entire health sector. This is addressed through investments for longitudinal, person-centered, and integrated data systems, systems interoperability, health information exchange and data integration capabilities. Additional investments in policy and governance at the national level are proposed to harness the benefits from information systems scale up.
- Inadequate health care coverage, sub optimal productivity of the health workers, limited number of health workers with critical skills for epidemic control (epi, critical care skills), and limited utilization of the iHRIS. The gaps are being addressed through investments in strengthening HCW performance management, upgrading of the iHRIS, scaling up of virtual learning platforms for efficient skills transfer.
- Lack of institutionalized CHW cadre, limited integration, and uncoordinated delivery of community health services. The gaps are being addressed through support to the training of the CHEWs that will be a CHW cadre paid by GOU, integration and coordination of community health structures and service delivery, in addition to strengthening the capacity for a youth led HIV response.
- Sub optimal technical and leadership capacity at national and subnational levels including the capacity within local CSOs; limited mentorship and coaching skills for subnational levels; the overall stewardship of the response will be strengthened through strengthening of CSO and GOU HR through targeted TA and mentorship; development/revision of key policies and guidelines to create an enabling environment for service delivery; supporting the strengthening of regional, district and community structures for delivery of client centered services; supporting effective performance monitoring for programs

- Lack of end-to-end visibility and limited real time tracking of commodities, low capacity for timely ordering and quantification of commodities at site level leading to stock outs. The gaps will be addressed though digitization of supply chain systems for end to end/real-time visibility of commodity status, quantification and forecasting skills.
- Currently, PEPFAR Uganda is working with the National Health Laboratory and Diagnostic Services (NHLDS) department of MOH to strengthen in-country capacity for production and distribution of proficiency testing panels, support for equipment management at national and subnational levels, and implementation of lab-based continuous quality improvement for access to timely, accurate and reliable HIV/TB test results. In addition, NHLDS is scaling up the laboratory information system, sample tracking and barcoding to ensure improved turnaround time and utilization of laboratory data for proper patient management and informing program. The major gap in the laboratory systems is inadequate country capacity for coordination and management of quality laboratory systems required to reach epidemic control at national and subnational levels resulting in lab network inefficiencies. In addition, there persists interrupted service delivery due to equipment downtime. Suboptimal utilization of laboratory data hampers planning and implementation of laboratory services. In COP23, PEPFAR Uganda will continue working in collaboration with NHLDS to build RHHs capacity for decentralized coordination and oversight of laboratory services, including implementing the recommendations from the diagnostic network analysis. This strategy hopes to build resilient, efficient, and sustainable laboratory services, in alignment with the National Health Laboratory Services Policy II (2017) and the National Health Laboratory Services Strategic Plan III (2021-2025). It will strengthen the capacity of RRHs to provide governance, leadership, and technical assistance at the subnational level in line with their mandate, coordinate quality management systems implementation, and surveillance, and oversee service delivery within their areas of jurisdiction for long-term sustainability.

***How do PASIT investments leverage systems investments by the partner country government and other donor investments?***

The systems investments are aligned to the country program gaps that were identified through rigorous program performance monitoring, multi-stakeholder engagements to ensure coordination and harmonization of program implementation. The MOH and key stakeholders including line ministries, GF, CSOs, UNAIDS, UNICEF, CHAI, are involved in joint planning to ensure effective leveraging of resources for efficiency.

### *Are timelines, benchmarks, and outcomes SMARTly defined to support monitoring of progress towards addressing PASIT investments?*

The PASIT investment and progress are data driven and will be regularly reviewed to ensure that program inputs are linked to process indicators and support the achievement of intended program outcomes. A number of new Survey, Research and Evaluation (SRE) activities were proposed for funding for this COP cycle; six new survey, surveillance and research activities, four evaluations and five prior SRE activities that will require additional funding in COP23. These activities were selected through a multistakeholder approach between PEPFAR agencies and MOH to address the critical gaps in priority populations and surveillance of new infections.

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

In an effort to bridge the gaps affecting the needed environment towards a unified national health data system, the planned above site investments are aimed at reducing these gaps so that there are well-designed and effectively used information systems, skilled informatics workforce; and strengthened governance of investments by MOH. PEPFAR Uganda is going to continue with earlier initiatives in areas of improving the Information technology infrastructure, powers solutions, and health information systems solutions guided by principles for digital development and smart data, data centralization strategies and workforce development. Focus will also be on strengthening on-going governance and leadership efforts at the various levels of MOH and partners. This should have clear and achievable strategies, and metrics for how to ensure investments abate the current gaps and as well continue to support national effort towards developing needed guidelines, policies and building of needed partnerships.

***What is the ultimate goal of the systems investments and at the country level what are the indications that the system is adequately functioning?***

The COP23 systems investments target creation of a robust and reliable country Health system that can sustainably provide HIV/AIDS services to all to end the HIV/AIDS pandemic as a public health threat by 2030.