



THE REPUBLIC OF UGANDA

THE UGANDA HIV AND AIDS COUNTRY PROGRESS REPORT JULY 2015-JUNE 2016.



Uganda AIDS Commission

26 August 2016



ABBREVIATIONS AND ACRONYMS

ACP	AIDS Control Program
AIDS	Acquired Immune Deficiency Syndrome
AIS	AIDS Indicator Survey
ANC	Antenatal care
ART	Antiretroviral Therapy or Treatment
ARVs	Antiretroviral Drugs
BCC	Behaviour Change Communication
CDC	Centres for Disease Control
CPHL	Central Public Health Laboratory
CSO	Civil Society Organization
DHS	Demographic and Health Survey
DREAMS	Determined Resilience Empowered AIDS Free Mentored Safe Women
DBS	Dry Blood Spot
EID	Early Infant Diagnosis
eMTCT	Elimination of Mother-to-Child Transmission (of HIV)
FBO	Faith Based Organization
GARPR	Global AIDS Response Progress Report
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOU	Government of Uganda
HBC	Home Based Care
HC	Health Centre
HCT	HIV Counselling and Testing
HTS	HIV Testing Services
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
IRCU	Inter Religious Council of Uganda
JAR	Joint AIDS Annual Review
JMS	Joint Medical Stores
M&E	Monitoring and Evaluation
MAAIF	Ministry of Agriculture, Animal Industry and Fisheries
MARPs	Most-at-Risk Populations
MDGs	Millennium Development Goals
MEEPP	Monitoring and Evaluation of PEPFAR Progress
MOES	Ministry of Education and Sports
MOGLD	Ministry of Gender Labour and Social Development
MOH	Ministry of Health
MOIA	Ministry of Internal Affairs
MOLG	Ministry of Local Government
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
MTR	Mid-Term Review
NACWOLA	National Community of Women Living with HIV/AIDS
NAFOPHANU	National Forum of People with HIV/AIDS Network in Uganda
NASA	National AIDS Spending Assessment
NDP	National Development Plan

NGO	Non-Governmental Organization
NMS	National Medical Stores
NPAP	National Priority Action Plan (for HIV/AIDS)
NSP	National Strategic Plan (for HIV/AIDS)
NTPP	National TB and Leprosy Control Program
NTRL	National TB Reference Laboratory
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PACE	Program for Accessible health, Communication and Education
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PEPFAR	US Presidential Emergency Fund for AIDS Relief
PITC	Provider Initiated HIV Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother To Child Transmission (of HIV)
PNC	Post Natal Care
PREFA	Protecting Families Against HIV/AIDS
PrEP	Pre-Exposure Prophylaxis
QPPU	Quantification and Procurement Planning Unit
SAPR	Semi Annual Progress Report
SCM	Supply Chain Management
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SWs	Sex Workers
TASO	The AIDS Support Organization
TB	Tuberculosis
THETA	Traditional and Modern Health Practitioners Together against AIDS
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UGAMEN	
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPDF	Uganda People's Defence Force
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VHT	Village Health Team
WHO	World Health Organization

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This report presents findings from the review of performance for the first year of implementation of the National HIV and AIDS Strategic Plan (NSP) 2015/2016-2019/2020. The report informs target setting for the year 2016/2017. The process of compiling this report was highly participatory with support from different partners including communities of People Living with HIV, Media, Political, Religious and Cultural Leaders, Local Governments, Ministries, Departments and Agencies, especially Ministry of Health, Civil Society Organisations, Private Sector, Academia, and the AIDS Development Partners.

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Lastly, I applaud all stakeholders, especially for their active participation in the review process and the continued contribution in the fight against HIV and AIDS.

DR. CHRISTINE J. D. ONDOA
DIRECTOR GENERAL



EXECUTIVE SUMMARY

Introduction: The 2016 HIV and AIDS Country Progress Report 2016 is an assessment of progress made on the first year (2015/16) of the implementation of the National HIV/AIDS Strategic Plan (NSP), 2015/16 -2019/20). Progress has been assessed according to the four NSP thematic areas of HIV Prevention; Treatment, Care and Support; Social Support and Protection; and Systems Strengthening. The report is divided into six (6) sections. Also documented is the progress registered against the undertakings of the 2014 Joint AIDS Review, as well as, the proposed JAR undertakings for 2015/16.

Objectives

The objectives of the review were:

- To validate performance of the first year of the NSP (2015/16 - 2019/20) against the set targets in the National Priority Action Plan (NPAP) (2015/16 - 17/18).
- To identify and document successes, challenges, lessons learnt and best practices during the implementation of the identified strategies in the first year of the NSP and NPAP.
- To establish progress in implementation of undertakings of the Aide Memoire, 2015.
- To agree on undertakings for implementation for FY 2016/17.

Methodology

A highly participatory and consultative approach was used, involving the engagement of all key stakeholders delivering on the NSP. This was with the view to ensure ownership and accountability. The report development process included desk review of secondary data, presentation of progress reports by Self-Coordinating Entities (SCEs), regional JAR meetings, and Technical Working Group meetings. Further reviews arranged by Uganda AIDS Commission (UAC) involved internal structures including the Partnership Committee of the UAC board which all participated in the review process, critiqued the report and provided input. The report was finally validated by stakeholders at the ... JAR session and all inputs incorporated into this final report

Overall Performance

The performance analysis in report was generally aligned to the NSP, taking particular focus on the NPAP and specifically taking care of all action points in the undertakings for 2015/2016 as agreed in the Joint AIDS Review, JAR 2015. The report gives key summary performance outcomes under each strategic NSP objective.

The estimated number of persons living with HIV in 2015 was still high at 1.5 million. Positive progress was noted in the further decline in AIDS-related deaths to 28, 000 from 31,000 in 2014, further reduction in the number of New HIV infections among all age groups to 83, 000 in 2015 from 95,000 in 2014 and the much more significant and drastic reduction in the number of new infections among children of 3500 By end of 2015

Prevention

The Country has intensified implementation of the combination prevention interventions guided by the Combination Prevention Strategy of 2013 and recommendations from the Mode of Transmission Studies, (MOTs study 2014). The national HIV Testing Services were scaled-up and the program registered ten million people accessing testing and counselling services up from eight million in 2014. In the first year of implementation, the country tested and provided results to 69% of all persons estimated to be infected with HIV (the first 90% of UNAIDS targets). Uganda has surpassed the targets in the investment case of 2014. The positivity rate within the routine testing is below 3% necessitating new innovations to differentiated screening and testing programs to increase identification of the HIV positive people.

There has been sustained expansion of the national eMTCT programme with continued stewardship at the highest political level by the First Lady of the Republic of Uganda resulting into reduction in new HIV Infections among children by 86% by December 2015. There was also intensified condom programming with the development of a national condom action plan, a prototype for the national condom logistics information management systems and an increase in the number of procured condoms. A total of 240 million male and 2.5 million female condoms were procured in 2015 achieving the annual target. The male condom procurements from Global Fund increased the volume in 2016. The QPPU of MoH annual projections for condoms consumption is about 20 million per month, though population based forecasts indicate need for higher quantities. The country promoted a multi-dimensional approach to condom education and distribution through national demand generation campaigns. The country further intensified Sexual Behavioural Change Communication (SBCC) among the various target groups. SBCC has been developed and progressively improved through a systematic process including use of existing national data/research, formative Research with audiences, concept testing with audiences, technical reviews by sector TWGs, pre-testing with audiences, approval by MOH and UAC. Programming through cultural and religious institutions and leadership expanded community mobilization and awareness efforts against socio-cultural drivers of the HIV epidemic

Care & Treatment

The overall treatment and care program increased the enrolment of patients on ART to 898, 197 (by June 2016) up from 570,373 by end of 2013, a treatment coverage of 60%. This was the projected target for June 2016. The coverage shows the progress towards the target of 81% of all HIV positive clients who were initiated on anti-retroviral therapy (the second 90% of the UNAIDS targets). Treatment coverage for children was raised to over 66% (61,250/92,360) from 31% (56,269/183,969) in 2014; this is expected to improve further with the strengthening of the test and treat and Early Infant Diagnosis, EID services. The tipping point registered in 2013 has been sustained by rapidly enrolling the number of patients on ART more than double the number of new HIV infections. Viral load suppression was above 90% among the 42.6% who were reached with viral load testing; much higher at 94% among eMTCT mothers but very low 74% among children.

Greater progress to improve the collaboration and integration of TB/HIV services registered higher performance resulting in an increase of over 90% of HIV-positive TB patients on antiretroviral therapy (ART) from 81% in 2014.



Social Support and Protection

There has been unprecedented level of partnership to reduce vulnerability to HIV and mitigate its impact on PLHIV and other susceptible groups, through actions on social support and protection. All sectors have adopted the mainstreaming approach and implemented the recommended interventions of the NSP thematic areas through various programs and projects and registered commendable results. Further, there were indications that stigma as a big driver of the epidemic was reducing as shown by a 35% reduction in internal stigma from a recent PLHIV stigma index assessment conducted in Central and South Western Uganda compared to the 2012 Stigma Index findings.

Systems Strengthening

Systems to support the epidemic have continued to become stronger with easier access to information to HIV programming, enhanced functioning of supportive governance structures, and expanding infrastructure. There has been steady improvements in the consolidation of national reporting mechanisms with improved and consolidated reporting systems providing timely and quality information for use at national and international level to inform programming. The Human Resources for Health audit by the Ministry of Health in 2015 showed a staffing level of 69%. The target of staffing level of 75% has been achieved by only 26% (833 health facilities out of 3,160 health units) (HRH Audit: MOH 2015). There is still critical shortage of staff especially in HCIs.

Overall, the country has made much progress towards the national and global targets and commitments to the treatment targets of 90 90 90 by 2020 as part of an effort to fast track the end of the HIV epidemic by the year 2030.



SECTION ONE: INTRODUCTION AND BACKGROUND

1.0 Introduction

The Uganda HIV and AIDS country progress report July 2015-June 2016 is a key entity of the HIV response that provides the country annual picture of the results of the its efforts, and an opportunity to design the next steps for the HIV programming. It provides the overview of the epidemic, specific progress per NSP thematic area, the challenges, best practices and recommendations.

The HIV epidemic remains the single most human health scourge still challenging the world for the past 30 years. While globally the epidemic shows prospects towards a decline, the magnitude of the situation in East and Southern Africa remains worrying (19 million [17.7 – 20.5 million] People Living with HIV) contributing over a half of the world's HIV burden (36.7 million [34.0 million–39.8 million]). Despite marked progress in reducing the new HIV infections in Uganda, particularly among children, and minimizing AIDS related death, the country continues to have a high burden of the disease as indicated by the 7.3% HIV prevalence in the 2011 national survey and high HIV infections in specific sub-populations and sub-regions.

Uganda is signatory to the global reporting obligations and requirements on the progress of the national HIV and AIDS response. The national reporting is guided by the National Strategic Plan (2015/16 – 2019/20), the National Priority Action Plan (NPAP) 2015/16 – 2017/18, the M&E framework and other key national commitments. The guidance indicates the burden of the HIV epidemic and how the country is committed to approach the response against set targets.

June 2016 marked the end of the first year of the implementation of the National HIV and AIDS Strategic Plan (NSP 2015/16-2019/20) and the commencement of the implementation of global targets of the Sustainable Development Goals (SDGs) and the UNAIDS treatment targets of 90, 90, 90 by 2020.

During the previous JAR 2015 the country developed the Aide Memoir and the key undertakings for the FY 2015-2016 as well as the NPAP 2015/2016-2017/2018. This guided the implementation of strategic actions for the HIV response during the reporting period. Stakeholders in the multi-sectoral response took on different roles in their various mandates and capacities to coordinate, with strong partnership, to achieve the progress on each of the thematic areas in the NSP. The review therefore assessed and presents progress towards the agreed targets and commitments.

The last Aide Memoir 2015 gave a guidance to consolidate Global and National Progress Reports for the HIV Response into a single report . UAC and partners developed a road map to conduct the first Annual Joint AIDS Review (JAR) for the National HIV and AIDS Strategic Plan (NSP 2015/16-2019/20). This report is an outcome of the consultative processes of the JAR 2016.



1.1 Background

Implementation of the HIV program mainly occurs at the district level and with community structures. The central level provides policy guidance, resource mobilisation and regional and global linkages. This report provides progress of the trends of the national HIV response along the four thematic areas in the first year of the NSP 2015/16-2019/20. These include; Prevention, Care and Treatment, Social Support and Protection, and Systems Strengthening. Within each thematic area, deliberate efforts have been made to analyse the achievements against the strategic actions for the first year that contribute to the overall progress to the NSP targets as stipulated in the NPAP 2015/16 – 2017/18.

Uganda adopted the global guidance to end the HIV epidemic including goals: to end AIDS by 2030; *“Towards zero new infections, zero HIV/AIDS-related mortality and morbidity and zero discrimination”*; the UNAIDS treatment targets of 90-90-90 by 2020 and efforts *“Towards an AIDS-free Generation”*. Despite the funding gaps, the country started the process of adapting the new integrated HIV management guidelines in line with the 2015 WHO guidelines.



SECTION TWO: Methodology

2.1 The Report Writing Process

The Annual Joint AIDS Review for 2016 was conducted as an integral part in execution of the national HIV strategic programming cycle. A highly participatory and consultative approach was used, involving all key stakeholders delivering on the national HIV strategic plan (2015/16 – 2019/20). This was with the view to ensure ownership and accountability.

Uganda AIDS Commission engaged Esteem International Consultants to lead the review process in the respective areas, working closely with the Thematic Technical Working Groups.

2.2. The Review approaches

The key review approaches relied mainly on intensive interaction with the key stakeholders in both data collection and analysis. A combination of methods was used to obtain primary and secondary qualitative and quantitative data. The review relied mainly on qualitative data to draw the necessary conclusions. Data collection methods included: desk review of existing resource documents including the Global AIDS Response Progress Report 2015 submitted to UNAIDS and other secondary data from Self Coordinating Entities, technical briefings, consultative/consensus meetings and face-to-face interviews.

a) Technical Briefing

During the inception phase, the Consultancy team received technical briefing from UAC Top Management about the JAR 2016. This aimed at having a clear and up-to-date understanding of the scope of work. Further technical briefings specific to the different thematic areas of the NSP were provided by respective Technical Working Groups. These briefings helped to identify specific issues regarding current epidemiological situation, programme priorities, interventions, achievements, challenges and future perspectives.

b) Desk-based review and Analysis

Key resource documents reviewed included: Uganda HIV and AIDS Country Progress Report (GARPR) 2015, GARPR lessons learnt report 2015, JUPSA Evaluation Report (2011-2015), JUPSA Progress Report 2015, Sector HIV Reports, SCE Progress Reports, operations plans and reports of specific HIV programmes (eMTCT, SMC, HCT etc.) Documentary review and analysis of key response indicators, baseline values and targets was done. The results were presented as trends and comparisons.

c) JAR regional Review Meetings

In order to widen the scope of the review, improved participation of stakeholders at the sub national level was ensured, to generate more representative data, UAC conducted four regional review meetings from Mid North, Karamoja, South-Western and Mid-Western regions engaging 42 districts with a total of 359 district participants. These included LC V Chairpersons, Chief Administrative Officers, Resident District Commissioners, District Health Officers, District HIV Focal Persons, Community Development Officers, District Bio-Statisticians, and District Planners, Representatives of People Living with HIV; Cultural and Religious Leaders, Media, and Private Sector. UAC also co-facilitated in the review meetings organized by partners in West Nile, Teso and

Rwenzori regions, and out of this UAC collected qualitative data that informed the report writing process.

d) Key Informant Interviews

Key Informant interviews were conducted with key stakeholders ; policy-makers from key Government Ministries, Agencies and Departments (MDAs), representatives of AIDS Development Partners, Sector HIV Focal Persons, People Living with HIV, Most At Risk Populations, SCE Coordinators, representatives of national level stakeholders, Implementing Partners and UAC technical staff. Interview guides for specific individuals and organizations were applied.

e) Stakeholder Consultations

Stakeholder Consultations were organized majorly through meetings as Pre-JAR consultations where sectors/SCEs presented their annual performance in the HIV response in relation to their mandates which greatly informed the JAR 2016 report. Other methods included emails and telephone consultations for clarification and validation of key response information.

The consultative meetings generated useful dialogue and discussions to facilitate assessment of sector/SCE progress against plans and NSP targets. During these meetings data gaps were identified and Sectors/SCEs were requested to submit their progress reports.

f) Validation by Thematic Technical Working Groups

The Thematic Technical Working Groups reviewed the draft report to which they provided additional data, critiqued, verified, validated, and reached consensus.

g) Approval of JAR 2016 Report

The Partnership Committee was convened, reviewed and approved the draft report on behalf of UAC Board before submission to the JAR.

h) The Joint Annual AIDS Review 2016

The JAR 2016 review meeting further validated and made final input into the Report. Various approaches were used to finalize the report and these included the key note speech, group discussions, panel discussions, and question and answer sessions.

Undertakings: The JAR report was presented to the delegates and thereafter groups were constituted based on Thematic Areas. The groups reviewed the respective thematic areas of the report, identified gaps, made recommendations and proposed key priorities from which undertakings were developed (Annex 1). The undertakings were presented to the Partnership Committee for endorsement. An action plan was developed based on the undertakings to guide the multi-sectoral implementation (Annex ii)

SECTION THREE: RESULTS

3.1 Overview of the Progress

Overall, the country is making good progress by consolidating previous achievements, exploring new fronts for the response, building stronger partnerships and reporting, and learning for the future frontiers.

The epidemic has matured and most stakeholders have taken up their roles and mandates with unprecedented zeal. The CSOs are demanding for known effective interventions and renewed push for innovations to stop the HIV pandemic. The government has renewed and strengthened its leadership efforts for an effective response; increasing funding and mainstreaming HIV efforts in key sectors and development programs. Partners are increasingly focusing programmes on the reservoirs of HIV that have not been well targeted before and bringing forward technical efforts. Rights based approaches to the epidemic have evolved faster taking focus beyond the infected and affected to address rights of all individuals to access information and services in a more convenient and acceptable manner.

Traditional social structures including cultural and religious institutions have realised their potential and natural virulence and have weighed in the fight against the disease through their powerful influence on the communities and their subjects.

This section describes progress of the main national HIV responses in the FY 2015/16 along the four thematic areas in the NSP 2015/16 -2019/20. The Thematic areas include; Prevention, Treatment and care, social support and protection, and Systems strengthening. Within each thematic area, deliberate efforts have been made to analyse the achievements against the strategic actions for first year that contribute to the overall progress to the NSP targets as stipulated in the NPAP 2015/2017.

The section further analyses the progress against targets in other key planning and development frameworks of the government and development partners. The notable reference here include; National Development Plan, National Health Sector Plan, Millennium development goals report for Uganda 2015, the UN Joint Programme of Support on AIDS in Uganda the National Strategic Program Plan of OVC Interventions (NSPPI), The 2014-2017 Strategic Plan – *“Realizing the rights of every child, especially, the most disadvantaged”* etc. This report also provides an analysis of lessons learned and observed bottlenecks during the implementation period.

3.1.1 HIV Prevalence

The last population HIV sero-behavioural survey 2011, indicated a rise in the HIV prevalence to 7.3%¹ from 6.4% in 2004 in the general population among adults 15 to 49 years. The rise in prevalence was mainly explained by the rate of new HIV infections at about 160,000 in 2010, the high rate of enrolment and retention into care and ART and the marked reduction in AIDS related deaths(from 46,000 in 2011 to 28,000 in 2015).

¹ UGANDA AIDS INDICATOR SURVEY 2011

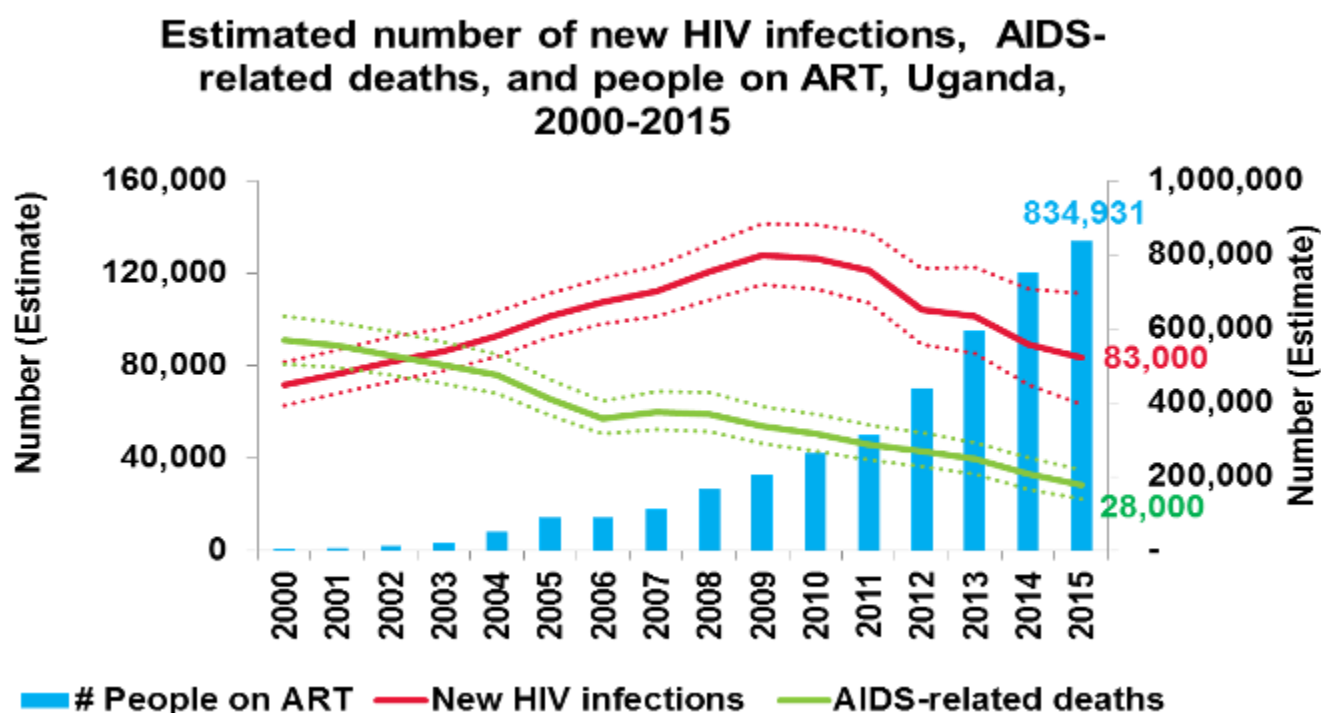
Uganda is in the process of conducting the Uganda Population HIV Impact Assessment (UPHIA) and the Demographic Health Survey (UDHS) which will provide population based impact of HIV in the last five years.

In between the national population surveys, prevalence can be estimated by the ANC sentinel surveillance studies, longitudinal cohort studies and low HIV positivity rate from routine HIV Testing Services (HTS) provided at large volume facilities and in the communities country wide. There was low HIV positivity rate from routine data in the HMIS ranging between 3% and 5% with 1% from SMC clients and 3% from EID services. The recent report for PEPFAR SAPR FY 2016 indicated that approximately 3% of individuals tested are HIV positive, with only 1% among those less than 15 years.

3.1.2 HIV Burden

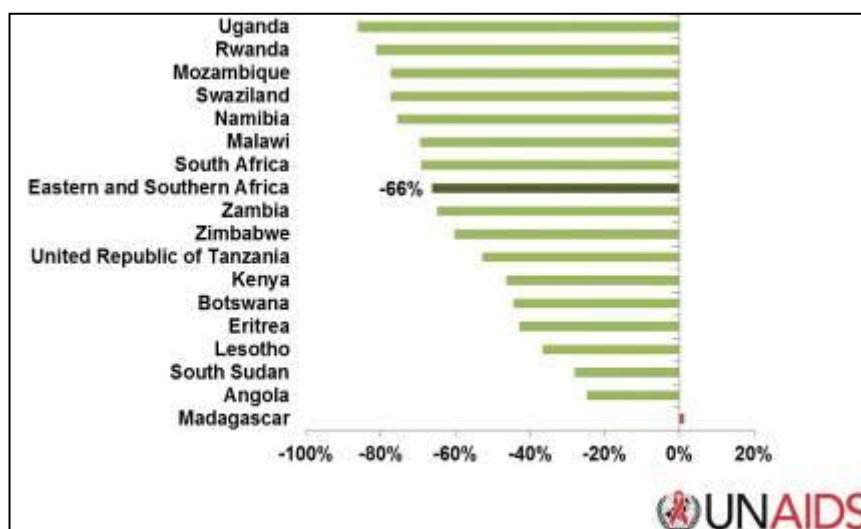
The latest spectrum estimates of 2015 from Ministry of Health, indicate that the total burden of HIV in Uganda is increasing. The number of persons in the country living with HIV, has continued to increase from 1.4Million in 2013 to 1.5Million in 2015. This is as a result of continuing spread of HIV, and increased longevity among persons living with HIV. The same estimates indicate further decline in AIDS-related deaths of 28,000 from 31,000 in 2014.

Figure 1: ART coverage has increased: the resulting impact of further declines in AIDS-related deaths and new HIV infections is expected



The comparison of the magnitude of reduction in the new HIV infections shows remarkable progress in the percentage decline in new infections among children in ESA between 2010 and 2015. Analysis shows that Uganda is leading by 86% reduction in new HIV infections among children (0-14 years), Eastern and Southern Africa.

Figure 2: Percent change in new HIV infections among children (0-14 years), Eastern and Southern Africa 2010-2015



The new infections and AIDS related deaths have reduced. However, the number of People Living with HIV has continued to increase. There has been progressive decline in the AIDS related death since 2005 coinciding with the scale up of ART in the country.

3.1.3 HIV Incidence

Measuring trends in incidence, defined as new infections per population at risk in a specified period of time, is the most reliable method for monitoring the HIV epidemic. Reductions in incidence, if present, imply successful behaviour change campaigns encouraging primary and secondary abstinence, faithfulness among those in stable relationships and condom use especially with non-regular partners as well as pre exposure prophylaxis and enrolment of People Living with HIV on ART.

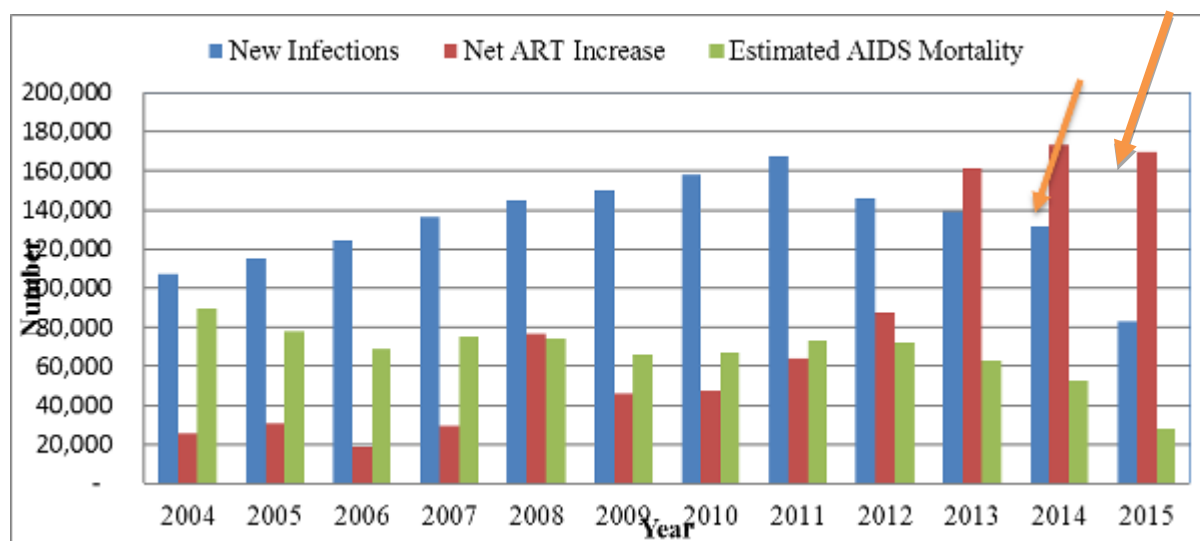
The incidence projections indicated a reduction in new HIV infections to 83,500 in 2015 from 95,000 in 2014 and 160,000 in 2010. HIV incidence rate is projected to fall from approximately 0.76% in 2014 to 0.46% in 2020. The current level of new infections is still very high, an indication that the country will continue to register high proportions of people with HIV. In view of the reducing HIV positivity rate indicated above, innovative measures have to be put in place to reach the positives with higher efficiency. The new infections have reduced since 2011, but still the trend shows a slow rate in decline and this poses doubt as to whether Uganda is likely to meet the fast track targets.

Priority indicators for the HIV response progress

There was higher coverage for the pregnant women living with HIV who received antiretroviral for preventing mother-to-child-transmission.

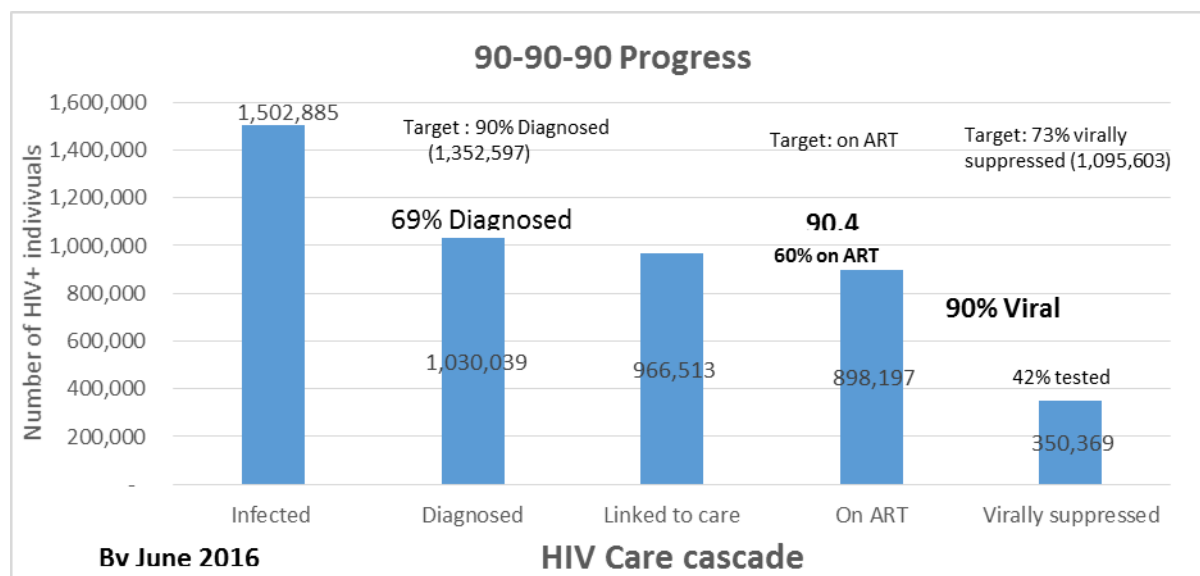
The country has taken up an aggressive treatment scale up effort and current data shows that Uganda achieved the programmatic tipping point in 2013. This means having fewer new adult infections of 140,000 than the net increase in adult patients on treatment of 161,028 per year. The figure below shows the comparative Trends of new infections, Net ART increase and estimated AIDS related death overtime from 2004 to June 2016.

Figure 3: Trends of new infections, Net ART increase and estimated AIDS related death



The arrows in figure 2 above indicate that Uganda has sustained having fewer new adult infections than the net increase in adult patients enrolled on treatment. This was first attained in the year 2013 notably due to an aggressive treatment scale up effort, particularly that of Option B+.

Figure 4: Uganda progress on the 90 90 90 UN treatment targets



Source MOH 2016

The HIV diagnosis coverage as percentage of PLHIV who knew their status was 69% with linkage rate of 93.4% into care. The UN target for ART translates to 81% coverage as the percentage of PLHIV who were on ART, the program coverage for end of June 2016 was 60% while 90.4% of the linked patients were on ART. The UN target for Viral Load suppression is 73% as the percentage of PLHIV who are virally suppressed. Accordingly,

the Viral Load suppression was 90% for the 350,369 samples tested in the reporting period but this was only 42% of the national target for viral load testing.

3.1.4 Key Drivers of HIV Incidence

The last 2014 Modes of Transmission Study (MOT) analysis indicated drivers based on individual, programmatic, policy and service delivery failures. The table below summarizes the key drivers by 2014, which are expected to have also played a part in determining the trends of the incidence during the FY 2015/2016. Treatment as prevention is gradually and markedly reducing the incidence of HIV among the new born children. Trends of HIV infections have also been observed to reduce during the era of rapid scale up of ART (Figure 3, 2011-2015).

Key drivers of the HIV incidence in Uganda	
1. High risk sexual behaviours coupled with Low Knowledge of one's HIV sero-status. (Including early sexual debut, multiple sexual relationships, inconsistent and incorrect condom use; and transactional sex etc.).	5. Low prevalence of SMC.
2. Low individual level risk perception; One's level of knowledge and understanding of HIV, and especially its relationship to perceived personal risk of HIV infection; and its influence on negative and stigmatizing attitudes towards Persons Living with HIV (PLHIV).	6. High numbers of HIV positive patients not on ART.
3. High STI prevalence.	7. Sexual and Gender based violence resulting from gender inequalities.
4. Low utilization of comprehensive antenatal care (ANC) and delivery services.	8. Alcohol consumption – especially to levels of getting drunk; and closely associated with sexual activity.
	9. Poverty.

The high fertility rate (5.97 children born/woman (MoH 2014), high unmet need for Family Planning at 34% (UDHS 2011), low utilization of comprehensive ANC and delivery services, low coverage and utilization of media and communication channels such as radio and cell phones are other factors that increase missed opportunities for prevention of HIV transmission in Uganda. All the above factors form the basis for the national HIV prevention strategies and interventions whose results are further discussed in sections 3 below.

3.2 PREVENTION

Overview:

The NSP indicates that most of the new infections are in specific age groups and populations including: adolescents and young people, women and girls, and Most at Risk populations (MARPs). The NSP 2015/16-2019/2020 under Goal 1 intends to reduce the number of new youth and adults infections by 70% and the number of new paediatrics HIV infections by 95% by 2020. It identifies three objectives; to increase adoption of safer sexual behaviours and reduction in risk behaviours, to scale up coverage and utilisation of biomedical HIV prevention interventions delivered as part of integrated health care services and to mitigate underlying socio-cultural, gender and other factors



that drive the HIV epidemic. Under each of these objectives, the NPAP 2015/2016 – 2017/2018 details a set of implementation strategic actions for the first two years of the NSP. Efforts have been made to ensure uninterrupted access to comprehensive packages of HIV prevention services tailored to unique needs of target populations with notable achievements.

Summary of Key Achievements in Prevention

- Reduction in new infections in young and adults (100,000 2014 to 83,500 in 2015).
- New infections have reduced among paediatric from 12,000 in 2013 to 3,500 in 2015.
- 86% reduction in new infections among exposed infants since 2011.
- Overall reduction by 15% in the first year, just less by 5% of the NSP target of 20%.

3.2.1 Adoption of safer sexual behaviours and reduction in risky behaviours

Summary of key progress

- SBCC tools were developed with FBOs and cultural institutions that are being utilized to expand SBCC programming especially for adolescents and youth and people in stable relationships.
- Over 2 million people were reached with prevention information through religious congregations and cultural institutions programmes.
- Messages clearing committee functional at UAC approving SBC messages and tools from different partners have continued to be reviewed and appropriate feedback provided.
- Millions of people were reached through mass media channels including billboards, radio, television, and print media through various partner SBCC programmes including dedicated campaigns e.g. the Obulamu by CHC.
- Modules for life learning with particular focus on sexuality education were developed as part of the curriculum review process for the lower secondary school classes.

3.2.1.1 Social behavioural change and communication

Various partners based on the NSP to develop SBCC strategic/action plans and related tools. These include 12 cultural institutions that were supported by Ministry of Gender, Labour and Social Development to develop message concepts and messages on SRH/HIV/GBV and maternal health cleared by Uganda AIDS Commission. The Ministry of Works and Transport with support from International Organisation for Migration developed the SBCC strategy for MARPs. Additionally, the Ministry of Works and Transport also conducted sensitization and awareness creation on HIV/AIDS around construction projects reaching about 90,000 project staff and community members.

The Ministry of Education and Sports (MoES) has a well established HIV unit with strategic guidelines² that help to streamline the HIV and AIDS structure and activities, and key achievements include:

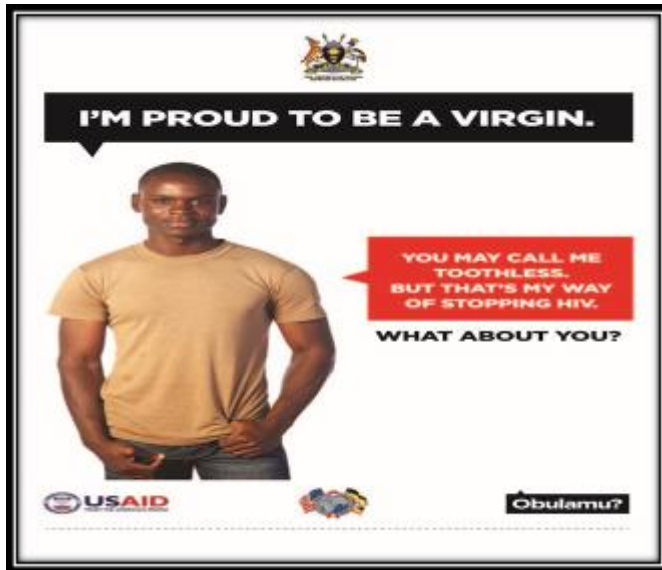
² <http://www.education.go.ug/data/smenu/20/HIV/AIDS%20Unit.html>

- i. An in-depth evaluation of Life Skills Sexuality Education (LSSE) in upper primary schools was conducted and outcomes utilized to inform different tools such as guidelines on prevention of teenage pregnancy and HIV in school settings.
- ii. The formal education system has been utilized in various ways to reach primary, secondary and tertiary level learners with SRH/HIV information. Out Reaches to over 800 primary and secondary schools were conducted to provide HIV prevention and SRHR information with a focus on the risks of multiple partnerships, cross-generational, transactional and early sex.
- iii. The 2015 annual primary school Music Dance and Drama competitions were conducted and these themed around SRH and teenage pregnancy. The event also addressed gender equality, prevention of violence and comprehensive sexuality education.
- iv. 359,327 children have been reached with 1 hour HIV and Health education sessions held in schools and through -Clubs-drama, Functional SFI, dance, debate, HIV talking compound, HIV integration in co-curricular activities etc.
- v. Over 2,431 teachers trained in the enhanced PIASCY and Sexuality Education.
- vi. 500 Head teachers were also oriented on sexuality education and PIASCY.
- vii. 98 schools were visited and 879 teachers were supported during the HIV support supervision exercise.

SBCC messaging for SRH/HIV targeting adolescents, young people and women was integrated into running communication programmes with Faith Based Organisations (FBOs) and cultural institutions. In addition, SBCC campaigns by various partners including: the national condom campaign, the 16 Days of GBV activism, the teen pregnancy/end child marriage campaigns were conducted all reaching an estimated 4.5million people in different settings.

The country with support from partners developed and promoted IEC/BCC messages, for example, Communication for Healthy Communities (CHC) through the OBULAMU campaign reached various audiences including; adolescents, young people, key populations and people living with HIV. A dynamic mix of channels was employed including; mass media, interpersonal communication and social media platforms to reach people in various settings. Main settings included; health centres, places of worship, community meeting places, transport stations/routes (stages), and upcountry buses. In close partnership with MoH and UAC, Communication for Health communities (CHC) estimates that the OBULAMU campaign reached 10.3 million people during the reporting period.

- Mass media and news print pull-outs were also used to support Inter-Personal Communication (IPC) approaches. The CHC for example used 43 Radio stations and 4 TV stations to air a minimum of 4 exposures per day on TV during prime times and a minimum of 10 exposures per day on radio. Overall 43 talk shows per month and 12,900 monthly radio exposures were aired in 19 local languages.
- Several efforts were designed on partner reduction including production of 02 videos/TVCs, airing of 02 daily radio spots in 19 languages and generating Disco Joker (DJ) mention scripts. Most importantly also, talking points for leaders and champions were produced, 01 brochure and innovations used to integrate messages in other materials e.g. flipcharts, grain sack charts and guides were designed and used during various education and communication events and sessions.



- There were coordinated efforts to raise awareness on negative gender norms, beliefs and practices like GBV, Child marriages and FGM. Over 2 million IEC materials were distributed and messages aired through various local Radio stations all over the country thus reaching over 20 Million people including engagement of 168 political cultural and religious leaders

Age appropriate messages from OBULAMU



Reaching men and women where they are; IPC session in Eastern Uganda- Source CHC 2015

There has been expanded focus on SBCC programming for out of school adolescents and young people through various channels. The MoGLSD initiated processes for developing Guidelines on Sexuality Education for out of school youth. Further, the Protect the Goal campaign was launched in the Karamoja, Acholi and Lango regions with support from UN partners reaching about 100,000 adolescents and young people with services and information.



CSOs continued to provide life skills communication training and peer network development to over 10,000 adolescents through capacity building in advocacy, Human Rights and e-learning.

Fifty (50) peer network representatives were also supported to participate in national level adolescent stakeholder meetings.

The NSP, also, intends to strengthen policy guidance, quality assurance and capacity for effective IEC/SBCC programming at various levels. There were key accomplishments in this area:

- The National HIV and AIDS Message Clearing Committee reviewed and cleared 23 Message sets by various partners including; AIC (3), UHMG (2), CHC (8), Uganda Cares (5), AMICALL Uganda (5) and messages from the 12 cultural institutions. Funds have also been secured to support development of a national multi-sectoral SBCC programming Standard Operating Tools and M&E Framework by Uganda AIDS Commission.
- The MoGLSD supported 12 cultural institutions to conclude processes for establishing policy guidance and pronouncements against values, norms, beliefs and practices that predispose individuals to HIV infection and sexual reproductive ill-health and a SBCC programming guidance tool was developed for cultural and religious institutions.
- Capacity building for non-traditional SBCC partners was conducted including training of over 1000 religious leaders on community mobilization skills to utilize leadership guidebooks on HIV prevention, SRH, maternal health, family planning and GBV earlier developed by each of the 6 major denominations.

3.2.1.2 Comprehensive condom programming

Uganda was among the eastern African countries with the lowest rates of condom use at 18% males and 31% female Condom use at last sex among people with multiple partners, 2000-2008 and 2009-2015³. The Uganda 2011 National Sero-Behavioural Survey also showed a low use of condoms at what...?. Therefore the country reinvigorated the national condom programme over the past year aimed at increasing availability, access to and promotion of condom use. The following achievements were registered in the reporting period:

A total of 240 million male and 2.5 million female condoms were procured in 2015 achieving the annual target. The male condom procurements from Global Fund increased the volume in 2016. The QPPU of MoH annual projections for condoms consumption is about 20 million per month largely informed by the capacity to manage and distribute the commodity, though population based forecasts indicate need for much higher quantities.

The country promoted a multi-dimensional approach to condom education and distribution. Condom campaigns have aimed at improving knowledge on correct and consistent use of condoms as part of HIV prevention interventions, particularly among MARPs and young people. The first generation national condom campaign by UHMG themed “if it’s not on it’s not safe” launched in 2013 was concluded at of end of 2015. Partners mainly, USAID and JUPSA provided support towards this campaign to expand coverage. Over 3.5million people were reached with information. At the end

³ Source: GARP reporting of surveys 2009-2015

of this campaign an evaluation was conducted. The campaign evaluation findings included among others, increased condom acceptability among those exposed and expanded condom availability at community level but persistent low uptake. These findings are being utilized to inform the second generation campaign.

A prototype for the Condom Logistics Management Information System (CLMIS) was developed by MoH with support from UN partners and agreed upon by key stakeholders pending installation in 2016. Other noted achievements included finalisation of the national condom needs assessment and development of a national action plan 2015/2017 to operationalize the national condom programming strategy.

- Many partners including non-traditional ones have engaged in condom distribution and education to contribute to efforts towards reduction of transmission through unprotected sex.
 - Fifty service providers from hotspot regions were trained in female condom service delivery
 - UNRA was able to distribute a total of 4,931,000 pieces of condom in all the 30 project sites. The beneficiaries included workers on the projects, supervision teams, and host communities.
 - The Ministry of Works and Transport also distributed 4000 condoms to workers at construction sites and the four regional centres. Other staffs at the headquarters have also been given condoms.
 - Uganda Cares distributed condom dispensers to offices in most sectors particularly the hotel and tourism industry.
 - Uganda Peoples Defence Forces distributed 17.5million pieces of condoms in the barracks and the surrounding communities.
 - Uganda Police Force distributed 667,050 pieces of condoms in barracks.
 - Ministry of Agriculture, Animal Industry and Fisheries conducted Condom Education and distribution for fisheries communities in Kalangala, Buvuma, Western Uganda on Lake Albert, George and Kyoga shores on Bukungu Landing site



The Community Development Officer Kidera Sub/County Centre – distributing condoms to Fisher men at Bukungu Landing site. Source MAAIF 2015

3.2.1.5 Sexual and Gender based Violence and human rights

- MoGLSD with support from UN partners updated the National GBV database to cover 50 districts with over 10,000 entries on GBV cases. The facility is being utilized to monitor prevalence of violence, track case reporting, and access to justice.
- An IT application was developed by and for young people to enable real-time reporting of GBV cases by victims through mobile phones with support from UN partners. The application is being piloted in six districts before programming for national coverage

- Integrated SGBV prevention and human rights has been scaled up as a package in the training curriculum of health providers but also overall in all guidelines for gender programming.
- A Gender assessment was conducted on the causes and manifestation of GBV in different contexts (including SGBV). This guided the design of interventions and integration in all sector programming, including Cultural Institutions.

The Ministry of health built capacity of health providers to support Sexual assault victims to access health services including PEP and how to fill in the police forms. These trainings acted as platforms for dissemination of facility-level protocols and kits for collecting forensic evidence and referring SGBV survivors for treatment and rehabilitation.

3.2.1.6 Targeted Interventions in Key Populations

SUMMARY OF KEY ACHIEVEMENTS FOR MARPS-FOCUSED HIV PREVENTION INTERVENTIONS:

- Conducted mapping study for all key populations in “Hot Spots” in six Municipalities.
- Developed a national MARPS Action Plan to operationalize the National MARPS Programming Framework of 2015.
- Reached 40,000 sex workers, MSM, and members of communities with SRH/HIV services
- Provided ART services to over 450 clients through the National STD Clinic which was accredited to provide ART services largely targeting key populations.
- Integrated planning for MARPs into resource mobilisation and strategic planning.
- Established the Health Sector MARPs Technical Working Group at MoH in addition to the National MARPs Steering Committee at UAC.
- Trained Health Workers in care for MARPs in 4 regions; Mbale, Mbarara, Hoima, Arua, and Kampala.

Most-At-Risk-Populations were indicated to have high HIV incidences and taken as potential pockets for spread of the HIV infection. The NSP and the National MARPS Programming Framework within national contexts designates the following categories of groups as MARPs: Uniformed forces, fisher folk, long distance truckers, sex workers, MSMs and Injecting Drug Users. The MARPS group include globally defined key populations of sex workers, LGBTI and IDUs. Previous studies indicated that HIV prevalence is highest 15-40% among fishing communities and 37% among sex workers; 18% in the partners of sex workers, 13% in men with a history of having sex with men and 18.2% among men in uniformed services according to the NSP(2015/16-2019/20).

Several Strategic actions of the NSP focus on preventing HIV among MARPS including: Conduct mapping and size estimation for key populations to inform targeted and scaled-up interventions for key populations, Scale-up comprehensive interventions targeting MARPs, and coverage of HCT for HIV prevention in targeting key populations, and vulnerable groups. The country is expanding SRH/HIV programming for key populations including sex workers, uniformed forces, fisher folk, transport community and LGBTI with some achievements:

- The MARPs Steering Committee at UAC and the MARPs Technical Working Group at MoH convened quarterly meetings to provide guidance to stakeholders and discuss progress on implementation of the the National MARPs Programming Framework aimed at standardizing approaches.
- Established regional hubs for MARPs at four Regional Referral Hospitals (Mbale, Mbarara, Arua, Hoima). In addition, eight coordination focal points each with a committee of three people (Focal Person, deputy and one committee member) were established (Fortportal, Mubende, Jinja, Gulu, Soroti, Moroto, Lira, Kabale, and Kawolo). The Committees conducted advocacy, referral, mobilization, and coordinating peer approach of MARPs services.
- Sensitized leadership in the eleven PLACE (Priorities for Local AIDS Control Effort) focus districts (Serere, Amudat, Jinja, Tororo, Hoima, Dokolo, Kanungu, Nakasongola, Nwoya, Mbarara, Sironko), with support from the Global Fund.
- Referred 2,193 for Antenatal Care, and 3,456 for Family Planning in HCs in specific Hotspots. Various innovations have been used to reach the MARPs with comprehensive services HIV services countrywide but particularly in “Hot spots” including dialogues with MARPs, working through peer mechanisms to involve MARPs in program and service delivery, outreaches with referrals to health centres for ANC and Family Planning services have been improved through the formation of such peer support groups and Moonlight services.
- Developed a provisional MARPs curriculum for HW training encompassing a sensitivity training component, which was used to train over 1500 Health Workers. The training was done in partnership with the IPs – IDI, TASO, SUSTAIN, CHAU, THETA, MildMay, AIC. Draft TORs for harmonization/development of a KP training manual/curriculum was developed and submitted to partners for possible funding.
- Tools for training MARPs peer support groups were developed and capacity built by CSOs with support from IPs- MJAP, TASO, IDI, UNFPA. MARPs mapping exercises were conducted in the MARPs designated hubs of Mbarara, Fortportal, Gulu, Mbale, Hoima and Wakiso to provide evidence for MARPs programming with support from UNFPA.
- Information dissemination on MARPS interventions has been done through media and publications. A total of 9 abstracts about good practices in KP programming at MARPI -Mulago learning site were accepted in AIDS international and regional conferences for presentation; IAS 2016 in S/Africa, ICASA 2016 in Zimbabwe and the KP conference in Dar-es-salaam.
- Over 450 clients accessed ART services at the National STD Clinic/MARPI Mulago Learning Hub. Five more regional hospitals have capacity to offer MARPs friendly services and capacity has been built for health facilities around Wakiso and Kampala districts.
- About 40,000 MARPs were reached with SRH/HIV services by various partners in the target districts including Kampala, wakiso, Hoima, Kalangala, Gulu, Arua, Pader, Rakai and Kiryandongo. Services were mostly utilized by Sex workers, for example according to results from the PEPFAR SAPR FY2016 (Oct 2015-March 2016) where overall, 23,762 key populations were reached with behavioral change interventions, which is 88% of the estimated key populations in the catchment areas (26,938) as shown below

Table 1: Number of Key Populations Reached by Category: PEPFAR SAPR Oct 2015- March 2016

Key Population Category	Number Reached	Percentage
Female Sex Workers	21,718	91.4%
Persons who inject drugs	194	0.8%
Male	107	
Females	87	
Males who have sex with males and/or Transgender (MSM/TG)	1,850	7.8%
MSM/TG who are sex workers	23	
Total Key Population	23,762	100%

More partners have implemented MARPs programmes within their contexts. For example Amalgamated Transport and General Workers Union (ATGWU) was able to reach 1,482 Female Sex Workers, 472 Truck drivers with individual and or small group level preventive interventions. ATGWU also distributed 684,048 condoms to men and women whom they had sensitized including 5,000 members of the general community. WONETHA supported 18 HCT outreaches reaching 1751 members and 74 stakeholders. In addition, 24 new sites around Kampala were scanned and members mobilized for HCT; 832 cartons of male condoms, 4 cartons and 200 pieces female condoms were distributed.

In addition 28 Human rights dialogue meetings were conducted with initiatives from WONETHA. These reached 528 members -43 police officers, 35 local leaders, 19 facilitators & 25 lodge owners. 93 members were reached with client relief, as a result, 15 members were released on bail, 3 given community service, and 75 released on police Bond. In addition, 9 staff and 25 peer educators were equipped with Community Mobilization, data collection, and security management skills. 2 dialogue meetings were conducted, bringing together 25 Media houses and 4 people of faith from COU, Catholic Church, Muslim supreme Council, and 28 from the Pentecostal churches.

3.2.1.8 Comprehensive sexual and reproductive health (SRH)/HIV programs targeting, adolescents (both in and out of school) and Young People.

Globally, reviews and studies reflect rising HIV epidemic among young people especially girls and high HIV-related deaths among adolescents as well as high morbidity related to high STI prevalence and early pregnancies. The NSP and the NPAP identified various key priority activities including expanded programming for sex education, tailored adolescent friendly services, peer networking for prevention and positive living, integration of SRH information and services as part of HIV services, and STI prevention and management. This section presents progress on implementation efforts for the reporting period:

- There was expanded advocacy on Adolescents and Young People Sexual and Reproductive Health (AYSRH)/HIV programming targeting various leadership championed by the First Lady of the Republic of Uganda. This was built on outcomes from interactions with partners and communities from the eMTCT campaign trail around the country. A programme of action for AYSRH/HIV was drawn by intersectoral partners coordinated by the MoGLSD with support from UN partners.
- There has been expanded advocacy for resource mobilization that has yielded promising results. For example KOICA approved funding to the tune of \$5m for 2016-2017 for programmes in Karamoja and the eastern Uganda through UNFPA. Irish Aid also approved up to \$20m for comprehensive SRH HIV programming for adolescents and young people in the Karamoja region for 2016-2020 through JUPSA and CSOs.

Several national level evidence generation processes were conducted to assess the situation among young people and system readiness to respond to AYSRH/HIV. Outcomes from these processes are being utilized to improve AYSRH/HIV programming.

- A national AYSRH/HIV assessment and vulnerability mapping was conducted by MoH with support from UNFPA.
- A national decision maker's assessment was conducted by MoH supported by UNICEF.
- A national adolescent and paediatric HIV conference was also organized by MoH and partners.
- Over 40 Adolescent peer networks were formed to provide support to Adolescents living with HIV and addressed the needs and concerns surrounding access to AYSRH/HIV services by young people. Peer led community dialogues were conducted with law enforcement officers, county chiefs, health facility in-charges and young people living with HIV. Over 30 youth corners in schools were strengthened.
- Conducted dialogues in 20 schools in parts of the Mid North targeting young people with SRH information and 1,133 people attended (449 males and 654 females) with support from Save the Children.
- A total of 230 schools were visited reaching 13,151 learners on HIV prevention and SRH information.

4,028 adolescent girls were reached with SRH messages, with UNFPA support.

- Conducted training of 85 health workers and 42 VHTs in ASRRH and how to communicate better with adolescents especially the mothers.

In a bid to improve family centred approaches for HIV prevention, capacity building of 23 teachers, 46 parents and 10 youth in HIV&AIDS Counselling and management was conducted in collaboration with partners – UNICEF, UNESCO, and Save the Children. Home visits to follow up Young People Living with HIV were also conducted. .

3.2.1.10 Positive health, dignity and prevention (PHDP) interventions

Guided by the Positive Health Dignity and Prevention (PHDP) framework, people living with HIV (PLHIV) through the networks of Uganda Young Positives (UYP) and Uganda Network of Young people living with HIV (UNYPA) achieved the following:

- Shared messages with 3,092 young people through Social Media platforms; (2,940 on Facebook, 97 on WhatsApp, 55 on Twitter).
- Developed IEC materials (6 banners, 300 t-shirts and 2500 brochures),
- The Uganda Young Positives organised 2 community dialogues.
- Conducted capacity building trainings on Human rights (including advocacy) and young paralegals in Gulu and Iganga reaching 80 young people.
- Lobbied for comprehensive package of SRHR information and services.
- Trained 30 male and 42 females YPLHIV in leadership and Human rights.
- Uganda Young Positives led the PHDP study focusing on responsiveness of young people living with HIV and AIDS in Uganda to the PHDP components.

3.2.2 Scale-up coverage and use of biomedical HIV prevention interventions

The country continues to implement combination prevention strategies in which the biomedical interventions are increasingly playing a pivotal role. Test and treat has increasingly been employed in PMTCT, TB/HIV, MARPS and discordant couple. This has increased ART enrolment and contributed to reduction in AIDS related death, because of early treatment. ART has shown drastic reductions in the transmission among the HIV exposed infants. This is further discussed later in care and treatment

The NSP and the NPAP objective 2 of goal 1 details 10 strategic approaches to scale up biomedical prevention interventions including, 1) expanding coverage and uptake of HTC, eMTCT and SMC services to optimal levels, 2) Improve the quality of biomedical HIV prevention interventions through enhanced quality assurance (QA)/quality control (QC) approaches 3) Scale up coverage of HCT for HIV prevention in targeting key populations, and vulnerable groups. 4) Enhance test and treat programming for pregnant women, HIV/TB co-infected persons, HIV discordant couples, MARPs, and children <15 years of age 5) Expand targeted STI interventions for MARPs and vulnerable groups, 6) Integrate SRH; maternal, new born and child health (MNCH) and TB services with HIV prevention. 7) Adopt new HIV prevention technologies and services including Pre-Exposure Prophylaxis (PrEP). 8) Strengthen medical infection control and ensure universal precaution, 8). Strengthen medical infection control and ensure universal precaution, 9) Expand mechanisms to improve blood collection, storage and screening for HIV and 10) Support research in primary prevention including microbicides and vaccines.

a) HIV Counselling and Testing (HCT)

To achieve the global target for the first 90 requires getting right the mix of testing interventions to maximise diagnoses. This would mean accurate knowledge of where HIV cases are being found and where they are being missed.

Key achievements under HIV Counselling and Testing.

- Facilities providing HCT services increased from 3,565 in June 2014 to 3,640 in June 2015.
- Increase in the number of individuals receiving HCT from 8,208,188 in 2013 to 9,564,992 in 2014 and 10,340,849 in 2015 (92 percent of them adults ≥ 15 years).
- About two-thirds (66 percent) of the adults 15-49 years old that received HCT were women.

The different approaches included: Provider initiated HCT (PITC) or Routine Counselling and testing (RCT) in health facilities, Client-initiated HCT or Voluntary Counselling and Testing (VCT) in facilities or outreaches, and Community or Home-based testing (HBHCT). There was more emphasis to promote HCT services for couples (couple HIV counselling and testing), workplaces testing campaigns, and outreaches for high risk groups in hot spots such as moon light HCT (for sex workers and truckers) and mobile or mass testing especially during testing campaigns.

There has been scale up in the number of facilities providing HCT services from 3,565 2014 to 3,640 in 2015 for both public and private health facilities. There has been an increase in the number of individuals tested for HIV from 9,564,992 in 2014 to 10,340,849 in 2015, against the targeted 8 million. Two thirds of those tested were women, and 10 per cent were children under the age of 15 years. The portion of pregnant women tested during pregnancy and maternity increased from 1,727,465 in 2014 to 1,937,206 in 2015. Sectors like UPDF surpassed their targets testing 136.4% (105,000 persons against 77,000 planned).

Revision of the National HCT guidelines focusing on the new legislative provisions and differentiated screening and testing to improve the cost-efficiency of existing approaches is ongoing. The new guidelines will focus on those in need, based on available data, adapting service delivery to the needs and preferences of patient groups. Key emphasis will take care of service providers and providing service options to ensure linkage to treatment and prevention services. Integrated support supervision and mentorships have been conducted in all facilities offering HCT, eMTCT, SMC throughout the country. District laboratory supervisors have conducted Quality assurance and control exercises with support from regional implementing partners.

Increase in demand for HCT services was created through mass mobilization using Mobile Public Address Systems, community dialogues, public dialogues, small groups' discussions, meetings and observation of national and international advocacy days (Labour, International Women's day, International Men's day, Day African Child, World AIDS Day, Philly Lutaaya, Candlelight Memorial, Independence Day, Protect the Goal campaign, SRH campaign). As a result over 200,000 people turned up for HCT as first time testers. Targeted HCT services were offered at various MARPI clinics and by other projects working with Sex Workers, fisher folk, and other Key populations. Some sectors such as UNRA contracted a service provider to do HIV/AIDS testing and counselling and a total of 105,840 people were counselled, tested and referred to health facilities for further management.

Amalgamated Transport and General Workers Union (ATWUGU) mobilized the general population to receive HCT services from outreaches. 3,309 Males and 4,768 females around the Hotspots were mobilized. A total of 1,275 Truck drivers were also mobilized and received HCT services from outreaches. A total of 1,246 Female sex workers were also mobilized and received HCT services in outreaches.

b) Elimination of Mother to Child Transmission (e-MTCT)

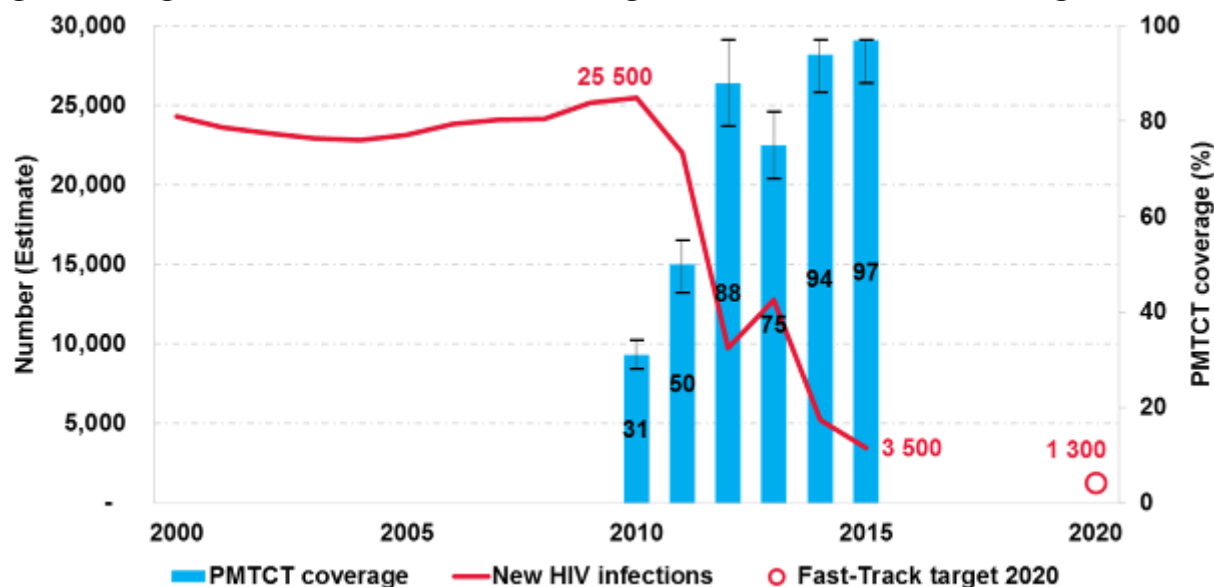
Summary of key progress in Elimination of mother to child transmission (e-MTCT).

- Decrease by 22% of the number of women (aged 15–49 years) acquiring HIV since 2009.
- 35 Percentage of unmet need for family planning all currently married women (aged 15–49 years).
- Increased number of pregnant women who know their HIV status from 1,811,647 in 2014 to 2,169,336 in June 2016.
- More HIV positive mothers from 112,909 in 2014 to 117,854 in June 2016 received ARVs for eMTCT (including those already on ART prior to pregnancy, and those started on Option B+).
- 97% pregnant women living with HIV accessing antiretroviral medicines to prevent mother-to-child-transmission of HIV; achieving the NSP targets.
- 46,290 (38%) infants among those HIV-exposed received ARV for eMTCT , compared to 41,356 (25%) in 2014.
- There was an 86% (3, 487) reduction in the number of new infections among children; close to the NPAP target of 95% by 2018.
- Increased male involvement in PMTCT services from 23 % in 2014 to 28% in June 2016
- 3% HIV transmission rate from mother to child, including during breastfeeding.

Achievements in eMTCT response have been realized from concerted government and partner efforts. Generally there was capacity development of the health care system for improved SRH and maternal health integrated services and specifically for testing pregnant women and enrolling those who test positive into care with significant achievements.

Uganda will meet the 2020 Fast-Track target for new HIV infections among children with sustained interventions (Figure 5).

Figure 5: Progress towards 2020 Fast-Track target for new HIV infections among children



The National EMTCT Programming, under the championship of the First Lady of the Republic of Uganda, continued to conduct regional campaigns to promote PMTCT services. Two campaigns were held in Masaka and Kiruhura, and this marked the end of first phase of the eMTCT campaigns across the country.

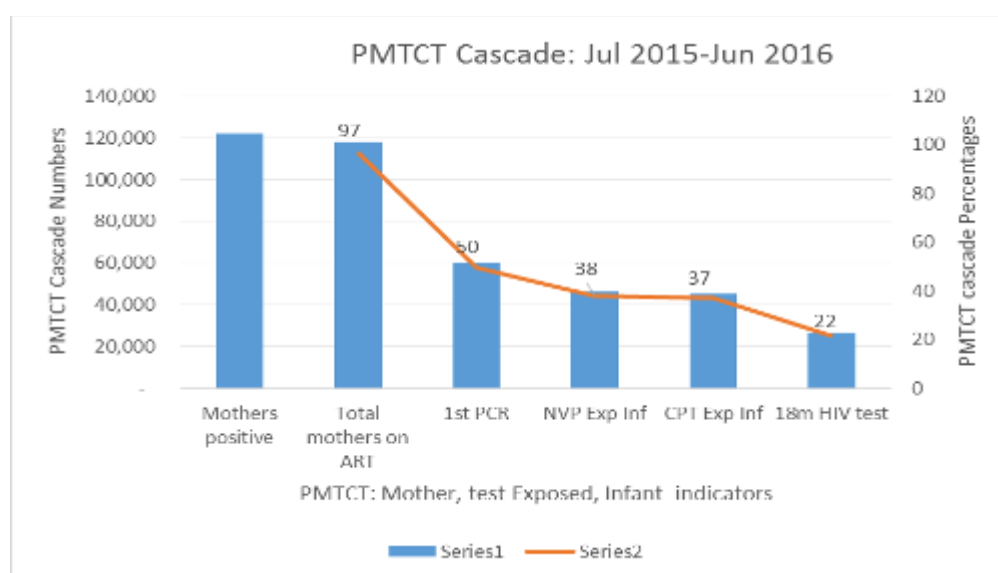
These campaigns have continued to increase the level of knowledge on eMTCT in the community, as well as, increased access and utilization of eMTCT services. Most important effect of the First Lady engagement has been the involvement of all leaders including cultural, civil and religious as an integral part of eMTCT services. Their roles were outlined and they actively supported implementation at the various levels including denouncing of negative cultural norms that led to increase HIV transmission such as child marriages. During each regional campaign, the leaders were supported to make presentations as well as resolutions on how to support elimination of mother to child HIV transmission. It is anticipated that the campaign championed by the First Lady will concretize the global plan for 'Eliminating HIV transmission to babies and keeping their mothers alive'.



First Lady (standing in the centre) at eMTCT launch in Kiruhura.

Despite the high success rate of the number of HIV positive women being enrolled on ART (97%), the proportion of HIV exposed infants who got tested for HIV, remained low (38%), due to low retention of mother to baby pairs in the eMTCT program.

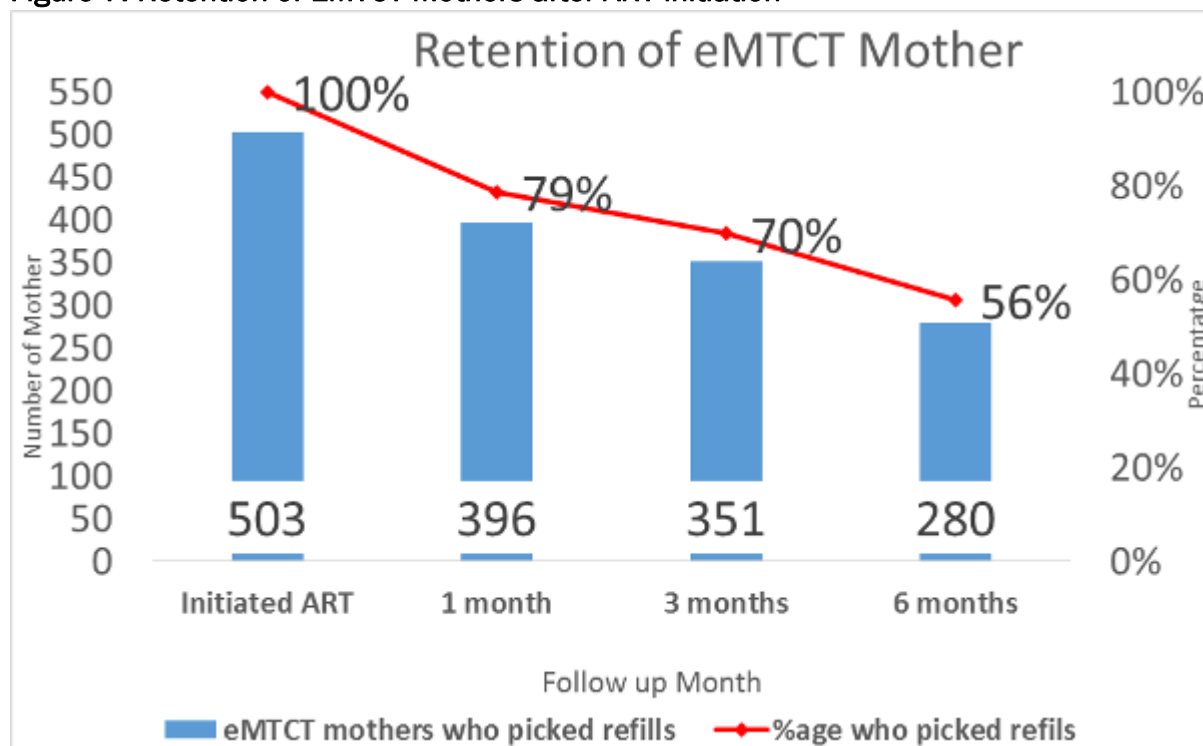
Figure 6: PMTCT cascade 2015/2016



By June 2016, over 80% of facilities were conducting birth cohort monitoring and closely following up infants to ensure they reach a final outcome status at 18 months., Any infants lost along the way are followed up using peer mothers and VHTs and brought back into care. Mother- Baby care points were rolled out countrywide to optimize tracking, retention, follow-up, and adherence of Mother-Infant pairs (MIPs).

This strategy has improved appropriate transitions for HIV positive pregnant and lactating mothers and exposed infants to life-long ART, as well as, postnatal MCH services for HIV positive pregnant and lactating women. An assessment done with support from UNICEF showed that over 25% of HIV positive mothers initiated on ART did not return for their first month visit, as a result of this, MoH established a national task force and district response teams to implement interventions to reduce loss to follow up and retain mothers and mother baby pairs in care. Indicators to monitor early retention at 1, 2, and 3 months after initiation were developed and reported through an SMS system. Implementing Partners supported sites through use of peer mothers, home visits, and telephone calls to track and return mothers in care.

Figure 7: Retention of EMTCT Mothers after ART initiation



Retention of EMTCT mothers after initiation on ART progressively declines and just over half of the mothers are still under follow up by 6 months.

The program developed innovations to increase the number of infants being tested and completing the Early Infant cascade through use of SMS reminders to mothers, generating lists of infants due for the various tests from the central laboratory and sending them to facilities within 2 weeks coupled with use of stickers to remind the health workers and mothers about the need for testing at subsequent visits.

VHTs and peer mothers from the various regions were trained on eMTCT with special emphasis on their roles in referral and linkages of pregnant women to HCT and ANC

services and follow up of lost HIV positive mother-baby pairs. These were supplied with IEC materials to support them in health education at the community and also supported to be able to report. Partners have continued to provide support for eMTCT capacity building activities throughout the country. Particularly, the UN, for example, built capacity in 303 facilities in 21 districts including training of health workers on eMTCT service delivery, data management, and training for Family Planning service delivery for ART service providers.

PEPFAR through ASSIST, in collaboration with MoH, supported all the Northern Uganda 11 target districts to develop eMTCT annual targets and reports. Seven districts have planned joint eMTCT mass sensitization and accelerated implementation. About 3,000 health workers during the reporting period were trained and re-oriented on eMTCT programming and service delivery around the country particularly in Birth cohort analysis mainly with support of PEPFAR implementing partners but also by UNICEF in the Karamoja region.

PMTCT services are available in all districts in the country providing Antiretroviral treatment for all HIV positive pregnant, maternity and lactating mothers. By end of the reporting period 3,637 health facilities were accredited to provide services including a few health centre IIs.

Community empowerment programmes have been expanded with focus to sensitize the populace on eMTCT and provide support mechanisms to the infected mothers to access and adhere to treatment. For example mothers-to-mothers (m2m) program reported that its peer mentor approach has contributed the reduction of HIV mother-to-child HIV transmission to an average rate of 2.1% among its participants in 2015.



Members of TASO Masindi and NACHWOLA Hoima who are part of the (EMTCT) programme entertain guests, as well as, give testimonies during the EMTCT campaign launch for Mid-Western region at Boma grounds in Hoima District.

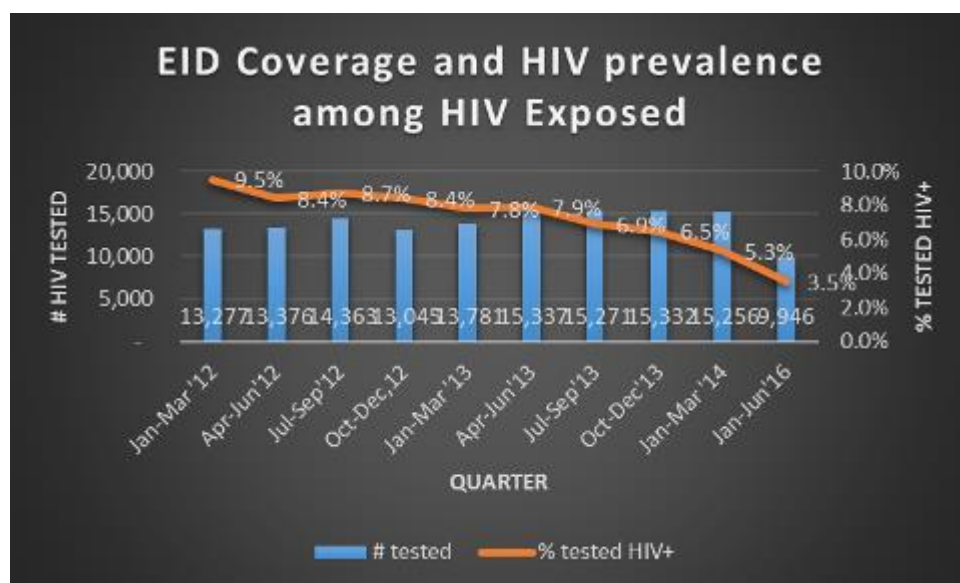
Source: JUPSA report 2015.



The country rolled out implementation of the national male involvement strategy to more districts through training and formation of male action groups in Karamoja, East central, south western and central regions.

The positivity rate for EID has drastically reduced to 3.5% by June 2016 from 5.3% by March 2014 for all infant HIV tests. The number of Dry Blood Spot (DBS) samples tested also increased from 13,277 in 2012 to 58,894 2016 and the prevalence of HIV positive samples has progressively declined from 9.5% in 2012 to 3.5% in June 2016; again reflecting the effectiveness of Option B+.

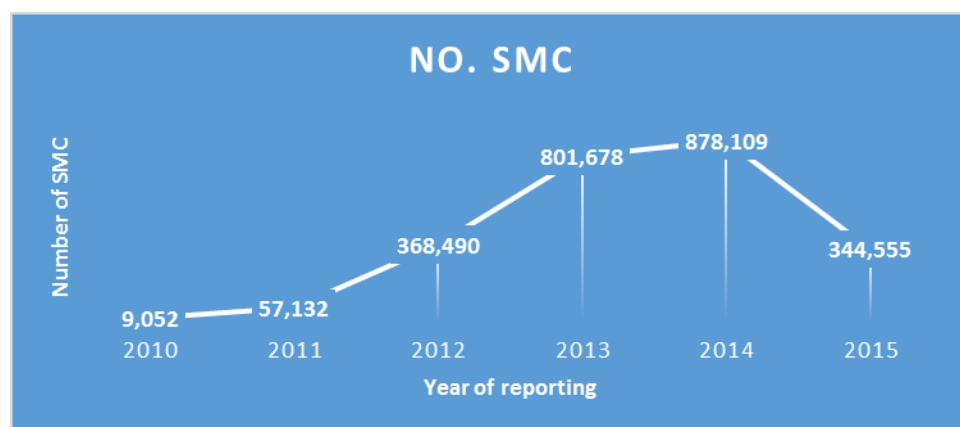
Figure 8: EID Coverage and HIV positivity among all HIV Exposed infant tests



c) Safe male circumcision (SMC)

The strategic action set out in the NSP implementation was to scale up quality SMC services to all facilities from HC IV onwards, augmented with outreaches to all HC IIIs, and dedicated mobile SMC teams.

Figure 9: Annual trends of SMC in Uganda



MoH 2015

SMC remains a core HIV prevention strategy but funding and recent incidents of fatalities have affected program successes. For example in the first quarter of FY 2016, PEPFAR funding for SMC reduced and accordingly the achievements were low. In quarter 2, there was an increase in SMC funding hence partners were able to do more as is reflected in the marked increase in circumcisions done as compared to the first quarter (Table 5).

Table 2: Number of Eligible Males Reached with SMC Services: Oct 2015-March 2016

Indicator	Q1 (Oct-Dec 2015)		Q2 (Jan-March 2016)		SAPR Oct 2015-March 2016	
	Number		Number		Number	
Number of Males Circumcised as Part of HIV Prevention Strategy						
Age						
5-14	14,823		41,328		56,151	
15-49	18,085		49,512		67,597	
≥50	1,202		1,358		2,560	
Total	34,110		92,198		126,308	

Source: PEPFAR SAPR Oct 2015-March 2016

Slow progress on expanding programming for Safe Male Circumcision (SMC) was experienced due to the isolated reports on serious adverse events including a few cases of tetanus. The program investigated these cases and developed guidelines for SMC that now require individuals to undertake tetanus immunization before and after the circumcision. Return rate among those immunised in preparation for SMC was low at 20%. Despite this, the program devised interventions for effective follow up. For example under the DREAMS Program in selected districts of Northern Uganda, 13,768 Volunteers were mobilized and received first doze of Tetanus Toxoid (TT) but of these only 2,354 sexually active males were circumcised.

The introduction of TT vaccination meant that there was a longer waiting time before the surgical procedure could be done. There were also challenges of inadequate stocks of the TT vaccines, and the need to first train health staff and VHTs on TT vaccination. Nonetheless, there were some achievements in SMC supplies. The UN contributed 300 reusable SMC kits to selected facilities during the reporting period in addition to those supplied by the PEPFAR partner and GF ordered for about 22,000 SMCs.

Innovations for SMC were applied in specific HIV implementing sectors. The UPDF for example delivered SMC services through static units and Mobile MOVE model. Static Units were expanded from two to fifteen. Additional 60 health providers were trained by UPDF in the MOVE model above the planned number of 40 health providers. A total of 40,000 circumcision commodities were procured and 3,000 male adults circumcised against the 18,000 planned.

New HIV prevention technologies

The country is in the process of adopting new HIV prevention technologies and services. Pre Exposure Prophylaxis (PrEP), which has been demonstrated to reduce HIV transmission among MARPs and sero-discordant couples, has been proposed for adaptation. Research findings of the recent PrEP studies conducted at the two sites in Eastern (Mbale, Tororo) and south-western Uganda (Sheema) were disseminated to

inform programming. Studies by MUWRP to examine the feasibility of offering PrEP among high risk sex settings have been concluded and found feasible.

In an open-label demonstration project in Uganda, of integrated delivery of ART and PrEP for prevention in HIV sero-discordant couples, it observed a 96% reduction in incident HIV, compared to expected rates. The country developed PrEP guidelines to support effective programming including quantification for logistics and these await approval.

Under the domestic violence Act the health workers are mandated to support the victims of violence through screening, counselling and offering of treatment such as PrEP. CSOs conducted follow up meetings reaching a total of 50 health workers in the districts of Ntungamo and Pallisa (25 per district). During these meetings, discussions revolved around medical perspectives of violence; the need to systemize Intimate Pattern Violence (IPV) screening and support to victims; and to identify ways of being more responsive to the needs of IPV victims, including ensuring that they accessed counselling and PEP.

PEP policies were disseminated at district level to provide more guidance that survivors of sexual abuse be included among those supposed to receive PEP. This would also encourage referral of rape and defilement victims to health centers for PEP treatment and further management.

Priority was given to training of 100 PEP Focal Points in facilities found along the HIV transmission hotspots. Forty Five PEP focal points were trained in West Nile region. The training integrated both HIV and Hepatitis. Overall, 14,323 individuals were reported counselled and tested for PEP. Reporting on individuals taking PEP has been improving in the national data base. In the reporting period 8606 individuals were offered PEP, 4147 completed full PEP course, and only 3% of PEP Individuals experienced serious side effects.

3.2.3 Socio-cultural, gender and other factors that drive the HIV epidemic

Summary of Key achievements

- 60 Local Leaders and 43 Cultural Leaders were oriented on their mandate as stipulated in the Domestic Violence Act 2010.
- 22 Judicial officers were trained on international and regional frameworks to strengthen role of courts of law in protecting women's SRHR on issues like GBV, HIV&AIDS, maternity, sexuality among others.
- 115 religious and 68 cultural leaders' capacity were built on GBV and Human Rights.
- Over 100 (one hundred) Boda Boda riders were supported to help pass on the message of positive male involvement as well as advocate for better male friendly service provision.

Under this objective, the NSP sought to address socio-cultural and economic drivers of the epidemic through strategic engagement, strengthening legislative and policy framework for HIV prevention, capacity of health, legal and social service providers to manage SGBV cases, promoting male involvement in HIV prevention for their own health and the health of their partners and families, strengthening efforts against stigma and discrimination and utilizing community extension work programs in the socio-economic sectors, to deliver HIV programs,

CSOs conducted over 500 quarterly community sensitization dialogues at district level. The dialogues targeted various levels and over 50 community members per dialogue. They also organized community Barraza and neighborhood assemblies to advocate for improved HIV prevention services. Some of the dialogues were used to increase citizens' awareness of their health rights, needs, entitlements, and responsibilities, and creating demand and inclusive utilization of health services. Local leaders observed a lot of improvement in their court sessions when handling gender based violence cases.

Sixty Local Leaders and 43 Cultural Leaders were oriented on their mandate as stipulated in the Domestic Violence Act 2010. This included holding training sessions where the Local Council Chairpersons were mentored on how important their role was in the response to gender based violence. As a result of this, there was improved case handling in reference to their mandate in the Act. Charging GBV victims court fees have stopped and referral of GBV cases improved.

The Domestic Violence Act became a reference tool during community sensitizations, and some Local Councilors 1 were able to orient their colleagues on Local council court committees on their role in the Domestic Violence Act. District actors like the District Probation and Welfare staff/CDOs, CFPU, HCIII and IV In-charges were also sensitized on SGBV issues. Twenty two Judicial officers were trained on international and regional frameworks to strengthen role of courts of law in protecting women's SRHR on issues like GBV, HIV&AIDS, maternity, sexuality among others. Forty Health Workers in the districts of Ntungamo and Pallisa (25 per district) were engaged in dialogue around medical perspectives of violence. The need to systemize Intimate Partner Violence screening and support to victims; and to identify ways of being more responsive to the needs of IPV victims, including ensuring that they accessed counseling and PEP.

Young People Living with HIV from the Uganda Network of Young people living with HIV were trained with an aim of creating awareness of existing policies and laws; understanding of human rights and their role as a paralegal. These paralegals were mentored on how they can support fellow young people living with HIV who are faced with legal challenges to access legal services. These included interpretation of legal challenges, offering legal advice and referral. Through established partnerships with hospitals and hospices, CSOs used the doctor-lawyer approach where the client is met at the health facility during their appointments/ART clinic days. Different interventions which included; mediation (meetings), court representations, giving legal advice/ legal counseling, referral to partners, and drafting of court documents were also used.

Male involvement in HIV prevention programming

Male involvement as a key factor affecting programming for the response was focused on. Several actors participated in promotion of male involvement in HIV prevention for their own health and the health of their partners and families. However, there was low awareness about existence of male involvement guidelines in the districts. This was evident from Key Informant Interviews and during the discussions at the regional review meetings conducted in preparation for the JAR. Despite the low awareness about male involvement guidelines, efforts were put in place to create environment for male friendly services, such as VCT facilities operating till late daily and over the weekends.

In addition, Male mentors were used to sensitize groups of men that are otherwise hard to reach by the general approaches. Men view SRH as women's issues leaving their



responsibility and that of their families' SRH to the women and girls. Involvement of men in family planning and child spacing has greatly increased as a number of them escort their wives to HCs, which is a gesture for better health for the whole family and society.

CSOs in partnership with Uganda Men Engaged Network (UGAMEN) and with support from WHO, Stanbic Bank Uganda, Crown Beverages Uganda and Ministry of Health, were able to celebrate International Men's Day in Mbale. The main objective of the event was to celebrate men and promote healthy families. Over 100 (one hundred) Boda Boda riders were supported to help pass on the message of positive male involvement as well as advocate for better male friendly service provision. Quarterly Community dialogue meetings facilitated by the UGAMEN members from the various CSOs knowledgeable on management of gender-based violence were conducted in a number of districts targeting men and boys.

MAJOR CHALLENGES, BEST PRACTICES AND LESSONS LEARNT IN PREVENTION THEMATIC AREA

- 1) The continued stock out of HIV test kits experienced during the year tends to undermine the hyped demand for HCT services and their benefits to HIV prevention including linkage to care and prevention when eligible patients are started on ART. One of the perceived reasons for the shortages was the high rate of repeat testing estimated at 60% which makes quantification very difficult and the rationale not easy to explain to the supporting partners.
- 2) Inadequate/ insufficient funds in the district, to plan for the HIV/AIDS activities.
- 3) Some areas such as the islands in Kyoga are not benefiting much from HIV/AIDS activities due to transport costs associated with moving HCT and other services from one island to another.
- 4) Complacency; *"Citizens are tired of talking about HIV/AIDS & are now more interested in hearing about other new diseases like the Hepatitis B"* in Teso regions.
- 5) SMC clients dropped in most districts due to lack of logistics (since, donors pulled out), training of HCWs (few trained) & introduction of the T.T policy.
- 6) Inadequate HIV test kits and other logistics in most primary health facilities within the districts, which was attributed to poor record keeping, untimely ordering, lack of knowledge in ordering and quantification of test kits/ARVS, and high turnover of clients during outreaches. It was also noted that some logistics were not present at NMS yet NMS blames districts for not placing in right and timely orders.
- 7) There was an issue of high rejection rates of DBS for EID & this was attributed to low knowledge and skills of HCW- where poor quality samples are collected(not enough blood, sample put at edge of the filter paper,) and poor storage during transportation.
- 8) Children miss out on HCT due to issues of ascent.
- 9) Support to MARPS desk at MoH to coordination is very meagre for example the coordination desk has no vehicle making it difficult to supervise and support upcountry facilities.
- 10) Lack of consolidated condom programme data, particularly due to distribution from the various points, has remained a challenge for Condom forecasting and quantification.

- 11) Complex procurement process that delayed critical deliveries as well as complex and slow process for disbursement of funds where some funds exist.
- 12) Key populations (KP) Indicators, tools, Minimum package (making M&E issues like documentation, reporting a challenge).
- 13) Dissemination of KP existing policies and info is still low.
- 14) KP constraining legal, cultural, social environments with resultant stigma, discrimination leading KP Phobia.
- 15) PWID interventions (OST, Needle exchange – generally non-existent).
- 16) Low scale and intensity of interventions- resulting from limited resource & priority issue.
- 17) KP coverage is still limited and further constrained by lack of oriented health workers, lack of tools adapted to unique needs, weak data management and tracking of the mobile clients on ART and limited coordination of efforts by the various partners at district and lower levels. For example, PEPFAR is the main funder for Key Populations. In FY 2016, PEPFAR targeted to reach 68,689 key populations with behavioural change interventions. Even for their targets they achieved only 35% in their first 6 months (Oct 2015-March 2016).
- 18) Members of MARPs communities still present constraints to services e.g. Sex workers in Kisoro pointed out a number of issues affecting their health which included; limited services for sexually transmitted infections (STIs), antiretroviral (ART) services at Kabale Regional Referral hospital, unfavorable working hours of health facilities, and the need for alternative income generating projects. Such issues are presented to duty bearers to devise means of supporting programming that enhances access to services conveniently.
- 19) There are no national tools for monitoring the response, as such no consistent information across all development partners supporting the behavioural change response. Estimation of the target audience was problematic as evidenced by marked difference between USG and the various supporting BCC interventions. There is no indicator assess quality of BCC interventions making comparison across programs difficult.
- 20) The numbers of organisations offering services to the MARPS are still few partly due to the existing legalities and community intolerance coupled with low opportunities for funding.
- 21) Several challenges still remain; many mothers are lost within the first 3 months of initiation at a rate of about 27%, and coverage of exposed infant indicators is still low including initiation on Nevirapine syrup and testing within 2 months of birth.
- 22) Lack of consolidated condom programme data, particularly due to distribution from the various points, has remained a challenge for Condom forecasting and quantification.
- 23) The Female condoms have no much demand in the general public. There is also a high Cost of condom warehousing, distribution, and replenishment of condom outlets.

Best practices

1. Building on the plans of Ministry of Health to establish a MARPs hubs Network with the National STD Clinic/MARPI as the learning site, four more MARP units were established in Mbale, Hoima, Mbarara and Arua regional referral hospitals. The National STD Clinic/MARPI built capacity in several public health facilities in the

districts of Wakiso and Kampala where health workers have already provided care to more than 300 MARPS of different categories.

2. Information dissemination on MARPS interventions has been done through media and publications. A total of 9 abstracts about good practices in KP programming at MARPI -Mulago learning site were accepted in AIDS international and regional conferences for presentation; IAS 2016 in S/Africa, ICASA 2016 in Zimbabwe and the KP conference in Dares-salaam.
3. Weekly reporting on eMTCT has improved on learning the programming challenges early and acting on them appropriately. Several indicators are reported and are discussed on a weekly basis with the stakeholders from districts, regional IPs and ACP. Key recurring issues have been on stock outs of HIV Test Kits at facilities. Ordering and re-distributions were usually done to avert these stock outs. Additionally, capacity building for sites to carry out accurate filling in of the medicines order forms was conducted.
4. EMTCT data management innovations including through Pulse Lab as a good practice and EID dash board have helped to relay trends across several key programming parameters.
5. E-tracking of condom stock at outlets in hotspot areas as good practice.

3.3 CARE AND TREATMENT

Under this thematic area, the goal seeks to decrease HIV-associated morbidity and mortality by 70% through achieving and maintaining 90% viral suppression by 2020.

The HIV Investment Case for Uganda indicates that increasing treatment access to 80% will contribute to: (a) aversion of 2,160,000 new infections between 2015 and 2025 (a 77% reduction), (b) reduction of new infections in children from 14,200 to 4,040 between 2014 and 2025 (c) Uganda will avoid 570,000 deaths by 2025 and (d) the lives of 42,620 children will be saved from AIDS related death by 2025.

According to Spectrum estimates, Uganda targeted to reach 909,373 individuals with life-saving anti-retroviral therapy in the last one year. The last JAR undertakings and the NPAP detail the key actions to start the implementation. This thematic area is set forth to achieve the second and third 90 of the UN targets to end the epidemic by 2020.

HIV treatment, care and support services have continued to take the highest investments in the program. This part of the response determines the attainment of the last two 90s targets of the UNAIDS global fast track targets of 90, 90, 90. Modelling for the HIV response has consistently indicated that HIV treatment is critical to ending the AIDS epidemic and making HIV transmission rare as well as being a smart form of investment. This section describes the key achievements in care and treatment and particularly also the progress towards the last two targets of the 90-90-90 treatment target.

The sub-sections below detail achievements under care and treatment per objective.

3.3.1 Access to Pre- Antiretroviral Therapy Care for those Eligible

1. Key Achievements

- 966,513 clients were in care, and of these 936,883 were on Cotrimoxazole.
- 423,240 were on pre-ART.
- 5% of the pre-ART were children <15 yrs.

As the epidemic changes to being mainly a chronic disease, the health systems are becoming stretched with increasing numbers of patients with varying complexities many of which are due to new eligibility criteria in care and low staffing levels in health facilities offering ART, yet the funding has proportionately reduced. Differentiated care models have been introduced in the program as a means of increasing effectiveness, efficiency, good outcomes, while ensuring high quality of services delivery.

During this reporting period, 423,240 were on pre-ART, 5% of these were children <15 yrs. The number of pre-ART patients will decline as the program fully adapts the Test and Treat Strategy for every HIV positive client. Test and Treat has raised further discussions on adherence which has been observed as poor among the eMTCT clients.

3.3.2 Increase Access to ART to 80% and sustain chronic-term care for patients on ART

The national program has continued to scale up ART services in lower health facilities increasing access throughout the country. Services are offered in both public and private facilities with a growing community support system by VHTs and expert clients or linkage facilitators. Regional implementing Partners have strengthened the district health systems to serve the growing numbers of patients in the facilities. Most of the support for the commodities for HIV care and treatment are supported by the US Government through PEPFAR, Global Fund, and domestic financing by the Government of Uganda. A small number of PLHIA are on private insurance schemes in the cooperate organisations.

Achievements

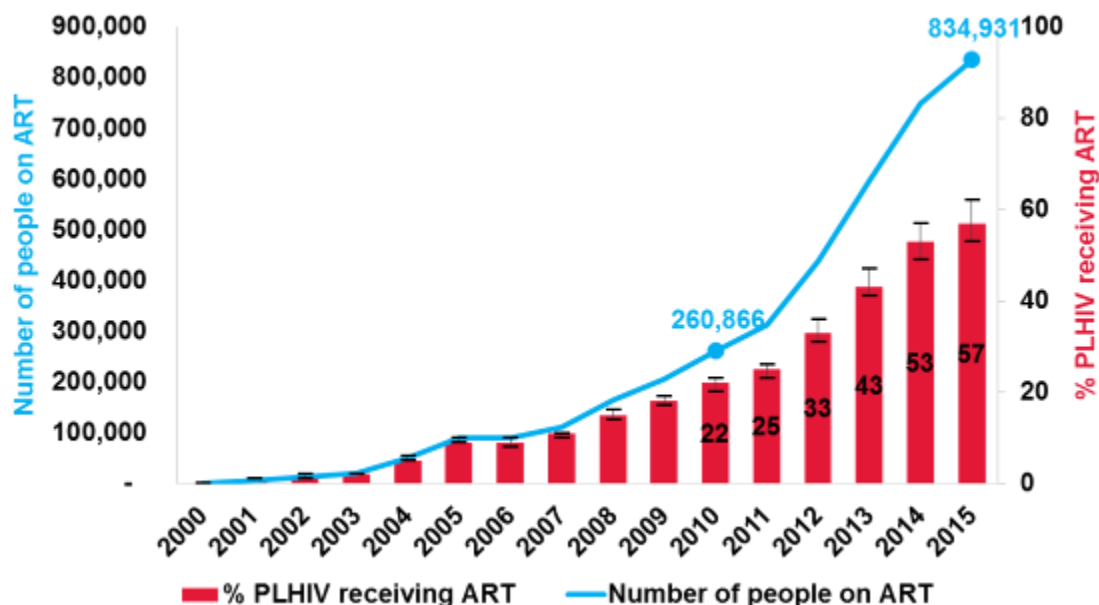
- The number of individuals on ART increased from 750,896 by June 2015 to 898,197 by June 2016.
- 99% progress towards the 2nd global targets of the 90s (898,197/909,373).
- Increased enrollment on ART (161,325 in the FY 2015/16 compared to 125,744 in 2014/15).
- 966,513 number of patients enrolled into HIV care by June 2016.
- New HIV treatment guidelines under adaptation for 2016.
- 39 more ART sites providing ART; making a total of 1,734 by June 2016 compared to 1,658 at the end of 2014/15.

The country has employed strong partnership to improve the provision of services. For example, In FY 2015/16, PEPFAR funded 26 implementing partners to support care and treatment services in 1,428 out of the 1734 service outlets offering clinical care services including HIV care, TB/HIV services, and nutritional services.

Over all, People with access to antiretroviral treatment tripled in the last 5 years; coverage increased from 22% to 57% (Figure 10).



Figure 10: Trend showing an increase in Access to ART, since its inception in 2000



The 2015 Uganda epidemiologic estimates and projections indicated that the number of People Living with HIV was 1,500,000. The number of PLHIV on ART increased to 898,197(60 %) by June 2016 from 750,896 (50% coverage) by Dec 2014. This indicates that Uganda has almost tripled the number of patients enrolled on treatment since 2011. The adaptation of the new WHO 2015 guidelines and sustained community mobilisation contributed to the increased number of patients enrolled on ART to 161,325 in the FY 2015/16. The 898,197 on ART was 99% of the patients who were in care during the reporting period. However, there is still some significant work to do to have 90% of all HIV diagnosed individuals on ART by 2020.

Adaptation of the test and treat for all HIV positive children has continued to increase the number of children enrolled on ART to 60,124 by June 2016, from 54,000 by Dec 2014. Coverage for children has risen from 54% in 2014 to 66% (60,124/92,370) by end of June 2016, while the performance for end of June 2016 was over 93.4% (60,124/64,402) according to the projected program targets. Recent projections for children living with HIV indicated a decrease from 134,831 in 2014 to 95,637 in 2015 and 89,102 in 2016. As described earlier on, the program has put in place interventions to eliminate paediatric HIV through eMTCT and EID, where those found to be HIV positive are immediately started on ART. This has resulted in a rapid increase in coverage for children on ART from 31% in 2014 to 66% by end of June 2016.

The enrolment of paediatric patients on ART almost tripled between 2010 and June 2016 due to improved access to EID services, rapid scale up of ART and the adaptation of the 2015 treatment guidelines to treat all HIV positive children up to 15 years of age.



Figure 11: Active ART clients April to June, 2016

	Number	%
No. of clients on ART	898,197	
Adults (15 + years)	836,947	93.2
Children(<15 years)	61,250	6.8
First-Line	861,790	
Adult (15 + years)	806,044	93.5
Children(<15 years)	55,746	6.5
Second-Line	36,045	
Adult (15 + years)	30,557	84.8
Children(<15 years)	5,488	15.2
Third-Line / Salvage	362	
Adult (15 + years)	346	95.6
Children(<15 years)	16	4.4

The majority of patients are on the first line ARVs medication and there is increasing number of patients failing on the second line and requiring the salvage ART regimens.

Paediatric and Adolescent ART program:

There has been an increase in the number of sites providing ART for children from 869 in 2013 to 1,292 by Dec 2015. Coverage for paediatric ART provision was scaled up to over 66% of estimated HIV positive children. Out of 17,385 children who tested positive, 12,235 were started on ART. Implying 30% (5,147) did not receive ART.

Achievement made on the paediatric ART program:

A curriculum on Paediatric HCT was developed with support from PEPFAR that includes screening tool for eligibility criteria for children that should be tested at entry points including OPD and all wards. A training of trainers on Paediatric ART care was conducted for implementing partners and HIV focal persons to support services. Trainings of health providers were conducted in the regions of South Western, Central, East Central and Eastern region. A total of 111 facilities were established for adolescent friendly services with a focal person for adolescents, an adolescent corner, and an adolescent HIV specific clinic. Centres of excellence for Paediatric HIV care at regional referral hospitals were rejuvenated to support health units within their catchment area to backstop issues of paediatric ART, including adherence, retention, viral and growth monitoring.

A National country assessment on adolescent HIV services was conducted showing the gaps in service delivery and areas of emphasis. A survey on adolescent HIV/SRH assessment was conducted at 335 sites across the country to identify existing practices and the gaps and this formed the basis for development of the adolescent health strategy which has been finalized and disseminated.

MOH in collaboration with SUSTAIN established Adolescent responsive services learning sites at 6 regional referral hospitals of; Moroto, Mbale, Kabale, Jinja, Gulu and Lira. Trainings, mentorships, and collaborative learning sessions, aimed at empowering health

facility teams as model centres for providing adolescent responsive health care services have been conducted at the 6 learning centres.

Additionally, mentorship was conducted to support the 14 hospitals across the country aimed at enhancing the health workers' knowledge, skills, and general competencies to offer quality and comprehensive care, treatment and support services to adolescents living with HIV and AIDS.

The STD-AIDS Control Program (ACP) harmonized all existing mentorship tools for HIV/AIDS services in the country and came up with a standardized Clinical Systems Mentorship (CSM) framework for comprehensive HIV and AIDS prevention, care, treatment and support services. This tool has been piloted and shared with key stakeholders (DHOs, RPMTS, IPs and national supervisors.) during a consultative meeting held on March 18, 2016. The CSM tool defines the standards of care for HIV and AIDS prevention, care, treatment and support services delivery in CSM, provides a logical framework for conducting onsite mentorship, documentation of mentorship outcomes and reporting and guides monitoring and evaluation process for the mentorship processes. The CSM tool has been used to guide clinical mentorships for PMTCT, Paediatric and Adolescent services at selected health facilities conducted during the January-March 2016 quarter.

3.3.3 Improve Quality of Chronic HIV Care and Treatment

The UNAIDS global plan set an ambitious treatment target to help end the AIDS epidemic by 2020 (The 90-90-90 Treatment targets). According to these targets, 90% of all people living with HIV will know their status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have viral suppression by 2020. The UN emphasises that expedited scale-up by 2020 will be required to reach the goal of ending the AIDS epidemic by 2030.

Uganda adopted this global treatment target in 2014 and viral load is now the preferred approach for monitoring response to ART in Uganda as recommended by the WHO HIV 2014 treatment guidelines.

Summary of Achievements

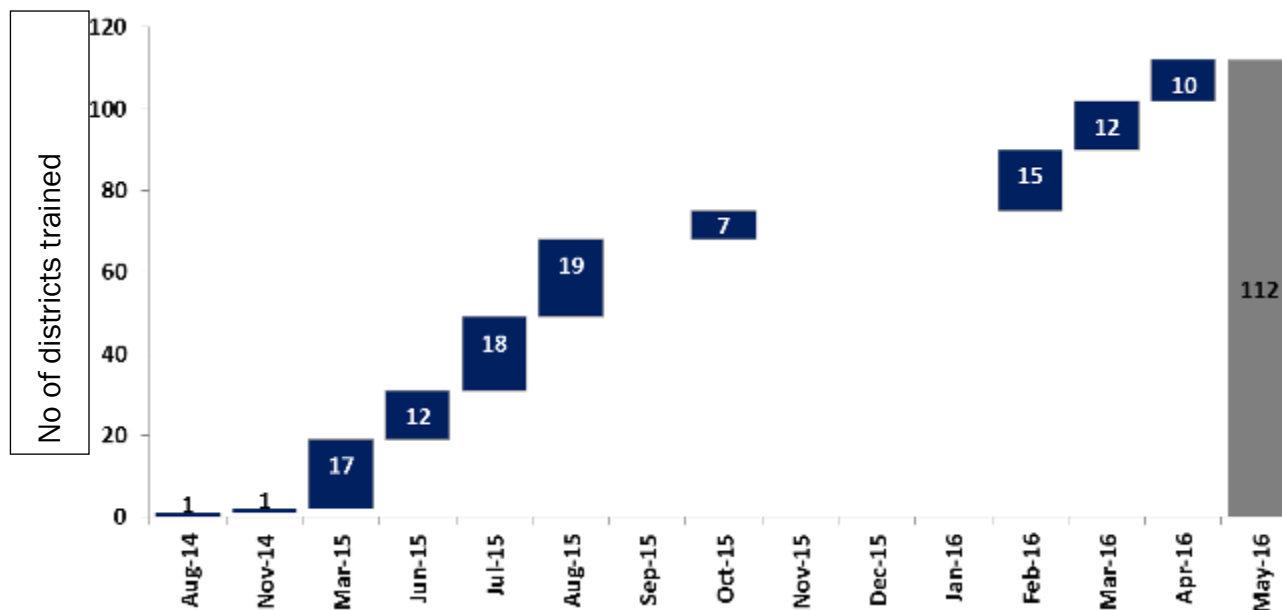
- Established a viral load testing laboratory at the Uganda National Health Laboratory Services (UNHLS).
- Scaled up viral services to all the 112 districts, and 1,667 ART sites.
- 350,369 clients accessed (coverage of 42.6%) viral load testing
- Viral suppression is at 90.8% nationally.
- Of these, 44,497 were pregnant and breastfeeding mothers.
- 94.4% viral suppression among pregnant and breastfeeding mothers.

The Ministry of Health has gradually scaled up access to viral load testing country wide. The EID lab has the capacity to perform 530 tests per day and VL lab had a capacity of testing 1536 tests per day. In the event of a breakdown of equipment, the lab as an onsite backup, and Mildmay Uganda lab serve as the offsite backup lab.

Central Viral load testing facilities have been set up at the Uganda National Health Laboratory Services (UNHLS) previously known as Central Public Health Laboratory (CPHL). Generally viral load samples are collected as Dried Blood Spot (DBS) samples except for the central region where plasma samples are collected.

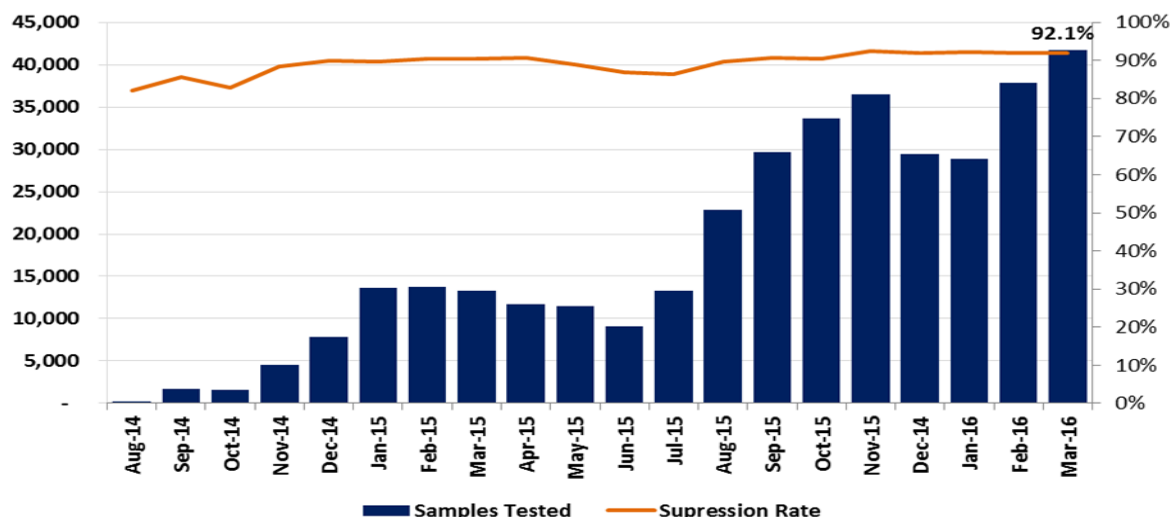
A mentorship guide and counselling tool have been rolled out. Since inception, viral load monitoring has been scaled up to all the 112 districts and 1,667 ART sites. A plan has been drawn to increase the viral load tests from 100,000 in 2014 to 1.2M tests per year in 2018.

Figure 12: Figure below shows the scale up training of districts in viral load testing



350,369 patients have accessed (coverage of 42.6%) viral load testing with a viral suppression rate of 90.8% nationally. However, the viral load suppression rate noted may not be representative of the entire country as only 40% of the patients in need are reached. Of the above 350,369 patients who received viral load testing, 44,497 were pregnant and breastfeeding mothers whose viral suppression was 94.4%.

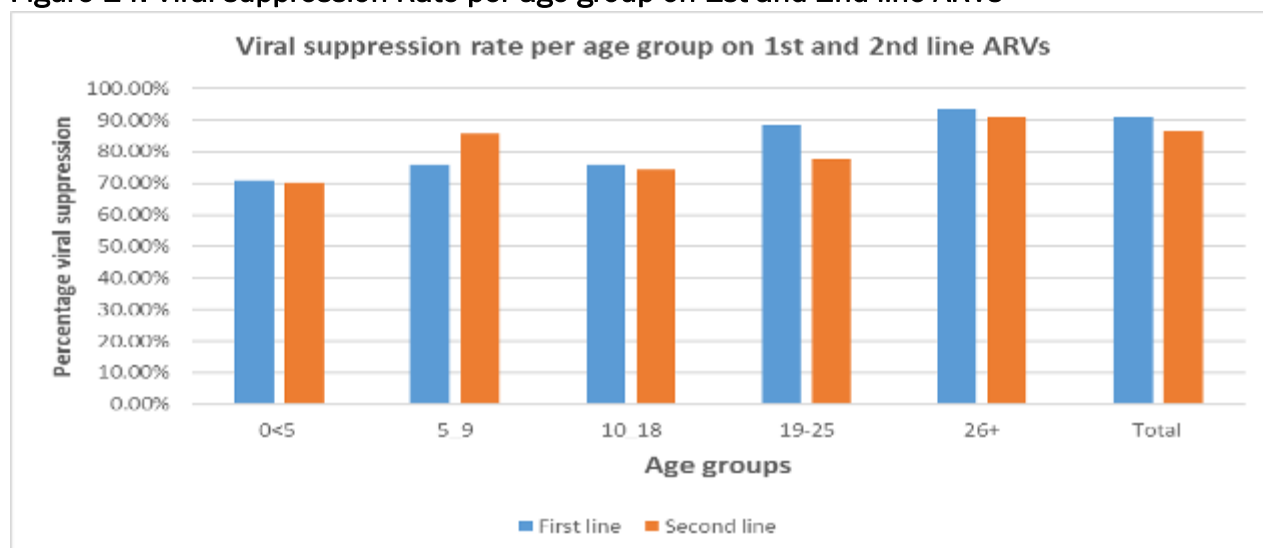
Figure 13: Viral Load sample collection and suppression Rate Aug 2014 to Mar 2016



Viral load sample collection progressively increased since August 2014 and the average viral suppression rate among all samples tested was above 90%. Although samples from only 42% of the patients were taken and tested, results show that all patients were virally suppressed. This indicates a prospect above the global target of 90% of patients on ART having viral suppression by the year 2020.

Viral load suppression is not uniform across ages. Children are found to have lower suppression rates at 70% compared to adults. This is coupled with a higher sample rejection rate of 7% compared to 5% for adults. Only 30,356 of the 350,369 (8.7%) patients were children less than 14 years. The figure 13 below shows that viral load suppression rates are lower among children than adults for both on 1st and 2nd line ARVs.

Figure 14: Viral suppression Rate per age group on 1st and 2nd line ARVs



Adults 26 years and above had viral suppression of 93%, adolescent (15-18 years) had 74% suppression while children 0-5 years had 70.4%.

To strengthen viral load monitoring, the following key activities were implemented:

- A national viral load mentorship curriculum was developed to support continued scale up Viral load monitoring to all sites including those implementing PMTCT.
- National Training of Trainers on viral load monitoring was conducted and 200 trainers were trained in collaboration with regional HIV implementing partners.
- Regional trainings were conducted in most regions (South West, Eastern, Rwenzori, Central and Western region) and district and facility mentorships have commenced in these regions.
- The annual targets of 800,000 VL tests are expected per year. Global fund and USG have contributed to the start-up Viral Load reagents, which are targeting about 20,000 Viral Load tests per month.

3.3.4 Strengthen integration of HIV Care and Treatment within Health Care programs

Four strategic actions were indicated to achieve results for this objective. These included : to fully integrate HIV/TB programming and services at all levels including community DOTS and home-based care, integrate HIV care and treatment with maternal, new-born and child health, sexual and reproductive health and rights, mental health and non-communicable /chronic diseases, provide prevention and management of OI, STIs and ART wrap around services in general outpatient and inpatient care and to integrate nutrition assessment, counselling and support in HIV care and treatment services including use of RUTF for severely malnourished, and linkages to increase food security. The section below details key achievements under this objective.

3.3.5 TB-HIV integration and collaboration

Several actions were set up in the NPAP to fully integrate HIV/TB programming and services at all levels including community DOTS and home-based care during the reporting period. TB HIV co-management is intended to reduce the morbidity and mortality and to increase identification of TB disease among HIV positive, as well as, to offer IPT to eligible HIV positive clients.

Summary of Achievements

- The GeneXpert machines have increased from 89 in 2014 to 112 in 2015.
- 95% (401,923/423313) of the HIV-positive people on pre-ART were screened in the last quarter of 2015/16.
- Over the reporting period 1% (5170/401923) HIV positive clients among those assessed were started on TB treatment.
- 97% TB patients had their HIV status known in 2015 compared to 95% (43,883/461,193) in 2014.
- There has been a slight fall in the proportion of HIV/TB co-infected patients from 45% in 2014 to 41% in 2015.
- 98% of the HIV-positive TB patients were started on co-trimoxazole preventive therapy (CPT).
- TB-ART co-treatment rose from 81% in 2013 to 88% - 91% in 2015/16.

TB continues to be the leading cause of death amongst HIV positive patients whilst HIV is still the leading driver of the TB epidemic. Over the years the Country has worked towards consolidating joint TB/HIV programming through joint planning, patient care and resource mobilization. The overall aim is the establishment of one stop centres to facilitate integrated delivery and uptake of TB/HIV services.

The country has made progress in this area due to improved recording and reporting through provision of tools, mentorship of health workers, dissemination & monitoring implementation of revised TB/HIV guidelines. This year the joint collaboration made its first meeting to lay out strategies for joint district planning and supervision visits. The program also continued to encourage incorporation of HIV testing in TB diagnostic algorithms at each step of TB diagnosis.

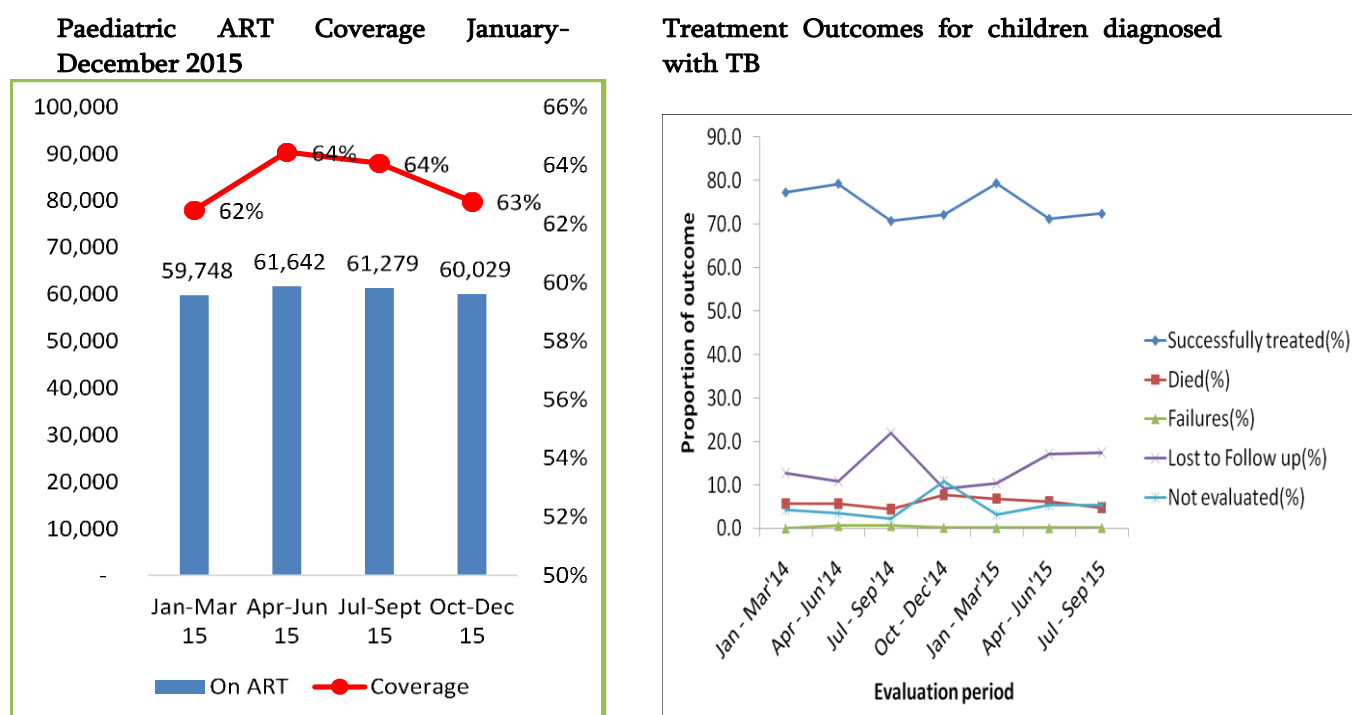
About 1% (5170/401923) HIV positive clients (among those assessed) were started on TB treatment as compared to 4,601 in 2014/15. As a result, screening of HIV patients for active TB was 92%, testing for HIV among TB patients at 99%. About 97% of TB patients had their HIV status known compared to 95% (43, 883) in 2014/15. There has been a slight fall in the proportion of co-infected patients from 45% in 2014/15 to 41% and TB deaths among PLHIV reduced by 50%. The program has maintained a high proportion of the HIV-positive TB patients on co-trimoxazole preventive therapy (CPT) at 98%.

The proportion of HIV-positive TB patients started on antiretroviral therapy (ART) has also risen from 81% in 2013, 88% in 2014/15, and 91% in 2015/16. In total 15,633 (90.5%) patients co-infected with TB and HIV were treated with both ART and anti-TB drugs by June 2016 as compared to the set target of 17,695. Scale up of IPT to reduce the burden of TB among HIV patients has continued in all the districts. Over 13,000 six-month doses of isoniazid were received in January 2016 and distributed to selected sites in the country.

The country has also focused on reducing the burden of HIV among children with TB. A small project working in the districts of Wakiso and Kabalore, has found a high rate of HIV coinfection (46%) among children notified in Wakiso district. Realizing the level of coinfection, the district will introduce HIV testing among child household contacts of persons with TB in addition to ongoing mentorship and support supervision in childhood TB diagnosis and management for the health workers.



Figure 15 Paediatric ART coverage and TB outcomes



Capacity building for paediatric TB/HIV has been scaled up in all the districts in collaboration with UN, USG, and other partners. New TB diagnostic technologies have evolved over the last years; these include the GeneXpert Machines for accelerated Drug Sensitivity Testing (DST) and the Lipo Arabino Manane (LAM) test for Urine TB tests. The number of GeneXpert Machines in the Country had increased from 72 in 2014, to 109 in 2015, currently 112 this year. The current number of machines have the capacity of analysing over 140,000 sputum samples a year and are planned to be programmed to be used for viral load monitoring for patients on ART.

All functional machines produce reports on the samples tested, but only internet enabled machines can communicate directly with the Centre. The National TB Leprosy Program and National TB reference Laboratory have designed a weekly reporting system that can track the status of all GeneXpert machines and give weekly updates.

3.3.6 HIV-SRH and adolescent health integration

This section elaborates progress towards Integration of HIV care and treatment with maternal, new-born and child health, sexual and reproductive health and rights, mental health and non-communicable/chronic diseases. Consolidating eMTCT required more integration of SRH and HIV services as a priority for the national program. The country is revising the MCH data collection tools to capture longitudinal data for HIV and SRH.

Challenges in Care and Treatment

1. Maintenance of adherence in the era of test and treat is still under study.

2. Lost to follow up is still high posing a possibility of resistance emerging among these clients.
3. Lack of unique identifier may result in double counting and a possibility of clients getting treatment from more than one ART site.
4. Data quality continues to improve, though there is need for a lot of effort to institutionalize it at the lowest levels of data collection; Completeness of data sets for required indicators & report, Data discrepancies /outliers, Obvious typos/counting errors – especially, at high volume sites and allowable data validation failures.
5. Low ART coverage for children and adolescents.
6. Viral load coverage still low at 42%.
7. There are still challenges with high sample rejections especially for the children, clinicians have not fully taken up requisitions for viral load testing and facility based capacity building coverage is still low, particularly in the regional hospitals.
8. The VL program has been integrated in the Laboratory Hub system and a steering committee is in place to coordinate these services.
9. There have been challenges with the GeneXpert machines including functionality of the machines, utilization machines, which is dependent on the level of intensified case finding and referral of samples from nearby health facilities and stock out of cartridges. UPSs and computers usually become faulty once in a while.

Best Practices Care and Treatment

- 1) Case based surveillance being conducted in the Rwenzori Region in Western Uganda with support from Monitoring and Evaluation Technical projects (METS) will incorporate use of unique client identifiers.
- 2) Coalition meetings for increased access and availability of ARVs, TB drugs and other commodities Regionalized Consortium of Advocates for Access to Treatment (CAAT) meetings beginning with Eastern, Central, and South-Western regions were held.
- 3) Role of thousands of volunteer Network Support Agents at facility and community level remains core to service provision in all health facilities and hospitals in the country to support adherence and tracking loss to follow up.
- 4) Health facilities must use the toll free number 0800221100, from any network, from Monday to Friday between, 8am-5pm, to call the EID/VL laboratory to log in the queries.
- 5) Baylor College of paediatric Uganda Toll Free line 0800 1000 55 helps offer paediatric HIV services online.

3.4 SOCIAL SUPPORT AND PROTECTION

Overview:

Goal three of the NSP was set to guide reduction in vulnerability of HIV and AIDS and to mitigate its impact on those infected, directly affected and other vulnerable groups. A range of strategic actions were planned under four strategic objectives to achieve the goal. Strategic actions focus on issues of stigma and discrimination, social protection, gender and other legal issues that predispose individuals to infection or constrain service uptake. This section of the report presents progress and achievements during the reporting period by the various programs and projects in the sectors of Gender and Social Development, Education, Justice, Law and Order, Health as well as CSOs and Networks of PLHIV.

3.4.1 Elimination of stigma and discrimination of PLHIV

The NSP noted that *“PLHIV face stigma and fear to disclose their HIV status to avoid being discriminated against or even denied freedom of expression in society. Women and girls especially shoulder a disproportionate share of the blame on the basis of real or perceived HIV status. The UAIS (2011) revealed that more than 80% of women and about 69% percent of men had negative attitudes towards PLHIV.”* This section describes achievements of prevent, reduce and mitigate the effects of stigma and discrimination in the HIV response.

Summary of achievements.

- The Stigma index report of 2013 was updated and disseminated.
- A baseline and endline PLHIV stigma index was conducted in Central and South Western Uganda and revealed a 35% reduction in internal stigma.
- Conducted a Violence Against Children (VAC) survey/mapping for OVCs that among other aspects pertinent issues around pediatric HIV/AIDS.
- Conducted investigations on child abuse by the contractors and labourers on the Fort Portal-Kamwenge road construction and HV/AIDS was a priority area of the investigations.
- The Ministry of Gender engaged full time counsellors in, rehabilitation centers to provide psychosocial support including HIV/AIDS related support and referral.
- Psychosocial support services were extended to 49,460 PLHIV.

Mobilization and strengthening cultural, religious institutions, community, support systems and PLHIV Networks to address stigma. During the reporting period, the Stigma Index Study Report of 2013 was further disseminated to all districts and in all national forum and special HIV events. Results from the Stigma Index Study in the greater Masaka region and South Western Uganda indicated a reduction of 35% in internal stigma. Key populations were involved in the last stigma index assessment.

Twelve cultural institutions developed and endorsed policy briefs and pronouncements on HIV prevention, teenage pregnancy and child marriage, maternal health, family planning and GBV, through extensive community engagement, with the support of Ministry of Gender, Labour and Social Development with funding from UNFPA. High level cultural leaders from 13 cultural institutions congregating under the Uganda Kings and Cultural leaders Forum in November 2015 renewed their 2010 declaration to recommit for the period 2016/2020

The tools were produced in local languages to guide leadership in community mobilization efforts against harmful socio-cultural norms, values, beliefs and practices that largely perpetuate stigma and discrimination based on gender, HIV status, disability, Campaigns to address stigma were conducted by CSOs and Networks of PLHIV, including MAMA Club, PAPA Club, NACWOLA, UGANET, NAFOPHANU etc. With CHAU support, groups (with membership ranging between 20-25) of young people living with HIV in Nakasongola and Luwero districts were provided support mechanisms against internal and external stigma through monthly meetings.

Five peer support groups for children living with HIV/AIDS were formed as an effort geared towards an AIDS free generation. The Uganda (TAFU) intervention took place in districts, where each group had 20 members. Identification of these children was done through facility records and children were grouped according to their age categories. A total of 120 HIV children participate in these group meetings and are facilitated to meet at least once a quarter to discuss health issues like body changes, stigma and discrimination.

In strengthening community structures to support PLHIV, CHAU trained 51 religious and local leaders and equipped them with knowledge and skills on effective communication for married couples. The purpose of this training was to enable them promote open dialogues between spouses in the household in care of children, HIV status disclosure and couple HIV testing in order to minimize stigma and discrimination, as well as, facilitating supportive environment for PLHIV

ICWEA conducted and launched a report on SRHR violations that lead to stigma and discrimination. The report revealed that the victims of forced and coerced sterilization were stigmatized and discriminated. The report can be accessed through the link: <http://www.icwea.org/2015/11/report-violation-of-sexual-and-reproductive-health-rights-of-women-living-with-hiv-in-clinical-and-community-settings-in-uganda/>

Capacity was built for networks of women living with HIV and CSOs to demand for rights-based HIV services. For example ICWEA worked with 42 organizations of women living with HIV from 14 districts of Uganda to ensure that the priorities/needs of vulnerable groups (particularly women living with HIV) are prioritized at national and district level. These women were trained in district and national level planning and budgeting processes, advocacy and accountability mechanism. They were also linked to their Members of Parliament and other district and national level policy makers through district and national level dialogue meetings. The Ministry of Gender, Labour and Social Development provided technical support to CSOs, networks and coalitions of PLH/As on embracing gender mainstreaming in their interventions. This was through orientations and sensitization workshops on gender dynamics and mainstreaming.

Capacity building and lobbying of community leaders service providers, the mass media and other key stakeholders were conducted at all levels to promote positive messages about living with HIV. This was spearheaded by NAFOPHANU. In addition to Government Ministries, Departments and Agencies developed capacity of civil servants and promoted positive messages about positive living. These included Judiciary, Ministry of Education and Sports, Ministry of Defense, etc. However, the reduction in support from the Partnership Fund affected a lot of progress on this activity.



Ministry of Local Government and Ministry of Gender, Labour and Social Development conducted quarterly inspection of DLGs assessing Human Rights and Equity issues for the marginalized people including PLHIV/As were conducted.

The Uganda Network of Young People Living with HIV/AIDS (UNYPA) build capacity, advocated and empowered the youth to access HIV prevention, treatment, care, and support. It was involved in fighting stigma and discrimination against young people living with HIV and promoting the greater involvement of young people living with HIV in the national HIV response. The Beauty Peagent held at Golf Course Hotel in August 2015 was a symbolic event of Young People Living with HIV geared towards eliminating stigma and discrimination. Across the country, there are several networks of Young People Living with HIV. Similarly, in Luwero and Nakasongola about 5 Young People Living with HIV groups, were formed at parish level with a membership of twenty to twenty five young people. Over 50,000 young people living with HIV/AIDS in the country benefited from the UNYPA interventions. 1000 religious leaders at national, sub-national and community levels were oriented on community mobilization from 6 religious denominations utilizing commonly agreed leadership manuals on HIV prevention, maternal health, family planning and GBV

Ministry of Education and Sports established various structures in schools like School clubs, Assembly days, Parents days to address psychosocial support to boys and girls orphaned due to HIV, adolescent mothers living with HIV and PWDs, reaching over 359,332 learners.

3.4.2 Mainstream needs of PLHIV, OVC and vulnerable groups⁴

The Government of Uganda has prioritized the needs of PLHIV, OVC and other vulnerable groups into the development programs, e.g. Universal Primary Education, under Ministry of Gender; there is Women Entrepreneurship scheme, MAAIF under Operation Wealth Creation. In addition, a comprehensive OVC programming has been sustained in various parts of the country. As a result, during the period October 2015 to March 2016, 161,188 OVC were actively receiving various social support services; among these 38,708 had been newly enrolled. Majority of OVC received education support. In particular, in FY 2016, there is seventeen PEPFAR funded OVC programs in 89 districts of Uganda in 703 sites.

Summary of Achievements.

- Conducted a mapping and updated the OVC service providers inventory which includes HIV/AIDS service providers to improve synergies, coordination and referrals.
- About 161,188 OVC received social services, including 38,708 newly enrolled with majority of OVCs receiving education support during the period Oct 2015 to Mar 2016.
- The Vulnerability index tool for OVC identification was revised by Ministry of Gender, Labour and Social Development.
- Launched the first ever National Toll Free Child Helpline for reporting about and responding to Child abuse cases.
- 1,347 Frontline social service workers from 1,056 Sub counties trained in Practice-oriented in-service.
- 11,735 para-social workers from communities such as VHTs, VSLAs, PLHIV, CBOs and

⁴ Vulnerable persons include PWD, the elderly and key populations

Functional Adult Literacy (FAL) groups were skilled in child protection.

The Integrated Early Childhood Development Policy and Action Plan was approved by Cabinet and the Social Support and Protection Package for various vulnerable groups was disseminated country wide as part of the OVC policy. A mapping of OVC actors was conducted and an inventory developed. The data generated is to support CSOs in programming and budgeting, improve networking, collaboration, and the referral networks among OVC centered implementers. The district OVC structures (DOVCCs and SOVCCs) conducted regular coordination meetings. There was also regular (Quarterly) reporting on OVC work in the OVC-MIS since the training in OVC-MIS in 2014. The system shows that 32,418 HIV+ children were supported to access HIV services including, 17,436 females, and 14,982 males.

During the reporting period, about 300,000 girls in the East and North Eastern regions were helped to manage their menstrual hygiene while in school as part of addressing specific needs for young girls in schools. In addition, training and provision of materials for making reusable pads were provided.

Many adolescents and young people especially OVCs drop out of school due to economic challenges. Government with support from different partners has implemented socio-economic programmes to enhance youth livelihoods. The Youth Livelihood Programme (YLP) under MoGLSD supported unemployed and poor youth aged 18-30 years with Skills Development, Livelihood and Institutional Support. These included Drop-outs from schools and training institutions, youth who have not had the opportunity to attend formal education, single parent youth, youth with disability, Youth Living with HIV/AIDS and unemployed Youth graduates of secondary school or tertiary institutions including University but remain unemployed.

In addition, the youth were provided with marketable vocational skills and tool kits for self-employment and job creation. Furthermore, financial support to enable them establish Income Generating Activities (IGAs), entrepreneurship and life skills were provided. Entrepreneurship training for over 500 young people was conducted and this included HIV/AIDS as one of the aspects that negatively impact on the lives of entrepreneurs.

Over 200,000 young people in vocational and entrepreneurship institutions in selected UNFPA supported districts of Mubende and Kampala received SRH/HIV services. This was a pilot project to inform and advocate for integration of SRH/HIV into curricula for vocational studies. A national strategy to end child marriage was launched by the Ministry of Gender Labour and Social Development. In addition, the campaign against teenage pregnancy expanded in a bid to address social enablers to curb HIV infection among adolescent girls. This was done as part of the implementation of the country's comprehensive multi-sectoral Adolescent framework.

A National Adolescent Health Conference by MOH and partners was hosted at end of July 2015 featuring many scientific papers on SRH/HIV. Consequently, the national Adolescent program developed a concept note to inform programming including among others issues on the implementation of the ALL IN and DREAMS programmes.

The country initiated efforts to Integrate alcohol and drug dependence reduction strategies for all individuals on HIV treatment (Pre and ART) to reduce drug toxicities. As a

result 136,089 young people were reached in school with sensitization messages about the dangers of underage consumption of alcohol.

As part of implementation HIV Workplace policy, in Civil Aviation Authority (CAA) there is always provision of ARVS to staffs and their spouses at CAA's cost over the years. Also URA provided drugs covered for first line and second line treatment for their staffs including regular check-ups and monitoring by doctors. The NSP laid out several activities to strengthen community level follow-up and treatment support mechanisms for pre-ART and ART individuals (adults and children). With this guidance stakeholders in the response have collaborated and put out the following results:

CSOs have facilitated the formation and strengthening of family support groups at district level, where mothers were able to share feelings on their lifeline, seek social support, access food, get income generating activities (IGA), and micro-credit opportunities. These support groups have also ensured follow-up of mothers and babies after delivery, since they are welcomed back to the facility for meetings. Through these support groups women living positively and those who have been successful in exclusive breastfeeding with healthy HIV-free babies in these family support groups serve as role models for other women in their communities. It is also evident that the male partners have also shown interest in joining family support groups to which we emphatically encourage.

- The country, in partnership with the UN conducted a pilot SRH/HIV integration programme targeting tertiary level students who are documented to engage in high risky sexual behaviours. Programme MoUs were drawn with administration in 10 major universities of Makerere, Kyambogo, KiU, Mbale Islamic University, Nkozi, Gulu, Mbarara, Nkumba, and MUBS) to provide SRH/HIV information and services through.
- A UN supported outreach programs targeting selected tertiary institutions reaching about 50,000 with information on HIV/AIDs and 5,000 young people with services for SRH.
- The UN worked with local governments to, implement a program in place, to link young people entrepreneurs and students in vocational training institutes (VTIs) to SRH information and services. This is initially in Kampala and Mubende districts reaching about 150,000 young people. Programme outcomes have been utilized to develop guidelines for integration into co-curricular activities for expanded SRH/HIV programming in the Vocational training institutes (VTIs).

As part of the End Child Marriages Campaign, a strategy on livelihood skills development was formulated for implementation by BRAC. National advocacy efforts were also made for implementation of strategies to enable Uganda reap the demographic dividend with main focus on education & economic empowerment for young people and access to FP/SRH/HIV services

Uganda received funding for the PEPFAR DREAMS (Determined, Resilient, Empowered, AIDS-free, mentored, and Safe) which aims at keeping girls in secondary schools and this is expected to reduce their vulnerability to HIV infection. The DREAMS target is to achieve a 40 per cent reduction in new HIV infections among adolescent girls and young women in the highest-burden countries.

3.4.3 Develop and implement a life cycle sensitive comprehensive package

During the reporting period most interventions focused on building capacity of actors to develop and implement comprehensive social support programmes



Summary of Achievement

- Supported 2,664 young positives with grants for their enterprises under the Youth Livelihood Programme.
 - MGLSD developed a draft Program Plan of Intervention for Social Protection with a section that outlines specific interventions for strengthening social care and support for most vulnerable people including OVC.
-
- The national HIV program in collaboration with ICWEA supported by Stop AIDS Now!
 - ICWEA built the capacity of young women and girls living with HIV as peer educators. The trainees are scattered in different parts of the country to mobilize their peers for HIV services.
 - Capacity building in holistic approach to social support (food, nutrition, hygiene, sanitation, was conducted for Village Health Teams (VHTs), Key population peer leaders and caregivers. These were supported by several partners including Mild May, CHAIN, Marie Stopes, TASO and MARPI
 - Gender inclined organizations like ICWEA have worked with 42 organizations of women living with HIV from 14 districts to ensure that their priorities/needs of vulnerable groups (are prioritized at national and district level. They have been trained in district and national level planning and budgeting processes, and advocacy.

The National Action Plan on Women, girls and HIV was reviewed and aligned to the new global and national development programming guidance including the NSP, the NDP and the SDGs. This process was spearheaded by the MoGLSD. The Action Plan acknowledges the unique challenges that women face especially as a result of persistent socio-cultural norms, values, beliefs, and practices that marginalize women and girls. A gender assessment was conducted in collaboration with the UN partners to give insight on the causes and manifestation of GBV in different contexts (including SGBV), and design and implement appropriate interventions.

Advocacy for gender and rights based HIV programming was enhanced through the gender and human rights technical working groups, which engaged stakeholders at national and sub-national level to advocate for gender and rights based HIV programming. As a result, activities targeted at addressing gender were included and funded under the Global Fund Concept Notes, and a Gender Expert has been hired at UAC.

Key Challenges for Social Support and Protection Thematic Area

This section outlines the key challenge identified in this thematic area of the response despite the achievements noted above:

- The country still lacks a defined social support package in the context of HIV/AIDS, as well as, standard operating procedures for the key sectors.
- There are capacity gaps especially in traditional institutions to adequately contribute to the national response.
- Stigma against PLHIV still persists for example as observed in rehabilitation centres and communities.

- Lack of comprehensive knowledge about HIV in communities where many still believe in myths surrounding the HIV/AIDS phenomenon which make them susceptible to infection and re-infection.
- Limited services for PWDs, especially, those in institutions and the elderly.
- Poverty and poor nutrition for the PLWAS in institutions.
- Some child emergencies around sexual abuse are not responded to, with urgency due to corruption tendencies in law enforcement and discrepancies in medical examination results.
- Support to the children's institutions and rehabilitation centres is still inadequate.
- Whereas OVC program made great strides in having the OVC MIS, there were some challenges; the data in the national system are not disaggregated in format required by support partners. There were delays in program registration with the districts that hampered access to OVC MIS, hence, some reports were not available by time of data collection which ultimately affected totals of OVCs served.
- The reduction in support from the Partnership Fund affected a lot of progress under this thematic area.

Key Best Practices in Social Support and Protection

Using the structures of traditional institutions in the response, has enabled the sector penetrate the most traditional of Uganda's populace. Progressive reduction of response time from the first call made to the helpline to the time the child is placed in a protective environment. Ensuring all UCHL stakeholders understand the UCHL (Sauti 116)

Remedial Actions Social Support and Protection

STAGE projects the Government of Uganda has committed UGX 149 billion (about US\$42 million) to SAGE for the next 5 years, starting with an allocation of UGX Shs. 9 billion (US\$2.5million) for national rollout of the Senior Citizens Grant in FY 2015/16 and this will be followed by Shs.17.59 billion (US\$5 million), 29.15billion (US\$8.2 million), 40.34 billion (US\$11.4 million) and 52.92 billion (US\$15 million) in subsequent financial years. Development Partners (DFID and Irish Aid) on their part have committed to provide up to Shs. 290.6billion (US\$83 million) for another 5 years of support to the ESP programme starting in January 2016.

3.5 SYSTEMS STRENGTHENING: GOVERNANCE, HUMAN RESOURCE AND RESOURCE MOBILISATION

Overview:

Goal 4 of NSP is to have an effective and sustainable multi-sectoral HIV/AIDS service delivery system that ensures universal access and coverage of quality, efficient and safe services to the targeted population by 2020.

The new revised NSP 2015/16-2019/20 prioritizes system strengthening for the multi-sectoral HIV response and indicates approaches, strategies and actions to build on the previous achievements and forge new innovations. It seeks to build an effective and efficient system that ensures quality, equitable, and timely service delivery by 2020. Six key objectives are specifically planned to be achieved during the implementation: 1) To strengthen the governance and leadership of the multi-sectoral HIV/AIDS response at all

levels, 2) To ensure availability of adequate human resource for delivery of quality HIV/AIDS services, 3) To strengthen the procurement and supply chain management system for timely delivery of medical and non-medical products, goods and services required in the delivery of HIV/AIDS services, 4) To ensure coordination and access to quality HIV/AIDS services, 5) To strengthen the infrastructure for scaling-up the delivery of quality HIV/AIDS services, 6) To mobilize resources and streamline management for efficient utilization and accountability.

3.5.1 Strengthen the governance and leadership of the multi-sectoral HIV/AIDS response

Strengthen governance and leadership of the multi-sectoral AIDS response at all levels

- Political, religious, cultural and technical leaders were successfully engaged and they championed the various interventions as outlined in the NSP as well as the combination HIV prevention strategy with a high degree of success. The level of effort and results achieved has been well elaborated in the relevant sections of this report.
- UAC received both technical and financial support from government and other partners to implement planned coordination activities during the year under review.
- Revitalization and sustenance of the district AIDS Coordination Committees, revival of subcommittees for gender, youth only to mention but a few.
- To strengthen coordination at the UAC 4 NPC meetings convened were conducted to further provide guidance to the response. The Modes of transmission study was approved to guide planning and HIV response.
- Cultural leaders were strongly engaged by organizing the Kings' Forum that made key declarations and commitments to reverse the epidemic.
- Following the dissemination of the Guidelines, 88/111 districts, Kampala Capital City Authority (KCCA) and 22 Municipalities rejuvenated the AIDS Committees.
- At the sub-county level 66/111 districts revitalized the sub-county AIDS committees – but these remain non-functional.
- The parish and village level committees are not yet revitalized due to lack of funding.
- Capacity was built for all districts with support mainly from the PEPFAR partners to develop HIV and AIDS Strategic plans and particularly Kalangala has used these plans to source for funds as a PEPFAR implementing partner.

UAC has continued to strengthen the leadership and governance for the coordination of the multi-sectoral response through strong partnership and capacity building for the coordination structures. Particular focus has been put on operationalisation of decentralisation approach to the response. Guidance and capacity building have been provided to the national institutions to lead and coordinate the national HIV response. This targeted national and subnational institutions and key leaders that are pivotal in the response.

Overall, the DACs and the SACs are active and functional and continues to guide the coordination at the district levels, as well as, the recently established Municipality AIDS Committees (MACs), which have additional support from AMICAALL. The parish and village level committees are not yet revitalized due to lack of funding.

Other key notable actions included:

- Disseminated the Partnership Manual and Leadership Accountability Framework. The dissemination targeted all the Partnership mechanism constituencies, though this activity covered only 45 districts.
- The National Integrated Early Childhood Development Policy and Action Plan were approved by Cabinet on 23rd March 2016.
- Approved the National Youth Entrepreneurship Skills Training Manual with a topic on

the impact of HIV/AIDS on young entrepreneurs.

- Developed a Health and Safety Manual under the Social Assistance Grants for Empowerment (SAGE).
- The revised National Youth Policy of 2001 and its Action Plan have been allocated HIV/AIDS as an independent thematic area for the youth. The final drafts are to be re-submitted to Cabinet for approval.
- Developed the Advocacy Strategy for Adolescent Reproductive Health and Rights and is due for printing.
- Procured a consultant to develop the Guidelines on Sexuality Education for out of school youth.
- Developed the Uganda Child Help Line Confidentiality guidelines. (Not disclosing client info including HIV/ AIDS status)
- The country continued to apply approaches to integrate HIV services in development programs. For example, during acquisition of land for right of way for the proposed SGR, a number of sensitisation meetings were carried out in Iganga, at the project's Busoga office. The people sensitised included workers in the field and staffs from HQ. After the training, 3000 pieces of Condoms were distributed. The exercise is expected to cover the entire stretch of the railway and the advantage is that resources and personnel to carry out HIV/AIDS activity on the project is available.

3.5.2 Ensure availability of adequate human resource

To ensure availability of adequate human resource for delivery of quality HIV/AIDS services.

- The current HR rate of unfilled positions is still high at 37%.
- In partnership with the USG through intraHealth, further support has been provided to recruit 1,814 staff in the health sector and since 2012 35% have been taken over by the districts as permanent staff.
- IntraHealth Uganda has supported human resource needs and capacity development concerns at the decentralized systems and sectors in the health and at all levels, especially the decentralized service level, systems and sectors for enhancing the delivery of HIV services.
- A HRM data base was set up and it was regularly updated and acted as a reference on capacity building need for health.

In partnership with PEPFAR through intraHealth, further support has been provided to recruit staff in the health sector and since 2012 35% have been taken over by the districts as permanent staff

PEPFAR continues to support 119 health workers at the MOH central level for high level policy and other central level mandates like development of technical guidelines and other SOPs for operations at the CPHL, ACP, resource centre, NTRL at a cost of \$2.5m.

The PEPFAR HR support to public health facilities is recruited through government structures i.e. the HSCs and DSCs to ease their eventual absorption/transition to GOU. The additional HR support is to supplement and reduce the vacancy rate of 37% (total health workforce in public facilities at local government level 34,142 – 2015 HR audit). It is expected that these health workers will be progressively transitioned to GOU over the next 3-4 financial years.

There was quarterly supervisory visits as part of the Supervision Performance Assessment Strategy and Reward strategy (SPARS). These are mainly supported by the regional implementing partners.

The Frame work to guide performance based rewarding and appraisal is under review. This will integrate and underscore the concept of quality improvement in HIV service delivery. Individual districts will also be guided to design a minimum package.

To harmonize pre- and in-service training of different cadres for HIV/ AIDS service provision, revision of the training curriculum was initiated and HIV will be examinable by 2017.

Intraheath Uganda has supported human resource needs and capacity development concerns at the decentralized systems and sectors in the health and at all levels, especially the decentralized service level, systems and sectors for enhancing the delivery of HIV services. A HRM data base was set up and it was regularly updated and acted as a reference on capacity building need for health.

3.5.3 Strengthen procurement and supply chain management

To strengthen the procurement and supply chain management system for timely delivery of medical and non-medical products, goods and services required in the delivery of HIV/AIDS services.

A concept to develop a policy on supply chain rationalization and QPPU unit was developed. The QPPU was established in the pharmacy department at the MOH. The unit conducts timely and efficient forecasting, quantification, periodic supply, procurement planning and pipeline monitoring of HIV commodities.

The concept to institutionalize the QPPU within the Pharmacy Division was initiated. This unit supported capacity building particularly at lower level health facilities to quantify and plan for their commodities.

The QPPU has regularly produced quarterly stock status and forecast that are used by the MoH and other agencies to guide planning and procurement of health commodities.

QPPU has built regional and district medicines supervisors that conduct regularly quality assessments of the medicines supplies management system. This team produces quarterly reports on various indicators on Medicines management system and LMIS.

The medicines commodity security committee was convened monthly to monitor commodities management in the public but also in the private not for profit health facilities. Procurement of commodities is done in partnership with a number of donor agencies however there are still big gaps.

Laboratory is an area where only 12% of the gap is covered.

The country updates commodities supply plan and produces quarterly stock status for all HIV medicines and other supplies. To strengthen lower level LMIS regular quarterly supervisions are conducted and produce a SPARS report that is shared with all district to review their logistics management.

Logistics staff were mentored in all districts with support from regional implementing partners using the continuous improvement models focusing on key process indicators.



The QPPU was established in the pharmacy department at the MOH. The unit conducts timely and efficient forecasting, quantification, periodic supply, procurement planning and pipeline monitoring of HIV commodities.

The concept to institutionalize the QPPU within the Pharmacy Division was initiated. This unit will further support capacity building particularly at lower level health facilities to quantify and plan for their commodities. Another concept to develop a policy on supply chain rationalization also was developed.

The Regional Performance Monitoring Teams (RPMT) pharmacy and logistic focal person's capacity was built in districts, in their respective regions. Sites have also been trained to order for HIV commodities online, using the WAOs.

3.5.4 Ensure coordination and access to quality HIV/AIDS services

Most MDAs and projects allocate about 1% of their budgets to HIV services and social protection. Standard gauge Railways has also drafted an HIV Strategy for its agency and it is waiting for approval. Given the scope of the project and its impact on Social economic environment of the country, an HIV strategy would be of tremendous importance in trying to achieve HIV/AIDS priority needs in the Country. The Uganda National Roads Authority has also drafted a policy for Environment and Social Safeguards (ESS).The policy covers 11 ESS thematic areas, one of which is HIV/AIDS prevention and awareness creation. It is stated in the policy declaration that: -UNRA shall establish measures to reduce the risk of HIV transmission and mitigate the effect of HIV and AIDs associated with road projects.

The country continued to build strong linkages between institutionalized facilities and community systems to ensure an effective referral system, greater adherence to treatment, and improved monitoring of service delivery. In the Karamoja region where the HIV prevalence raised from about 3.5% in 2006 to about 5.3% in 2011, referral system amongst CSOs and between CSOs and the public health facilities was development and reviewed on a regular basis to ensure functionality. In collaboration with TASO and CUAM a total of 280 linkage facilitators were trained from 61 CSOs in the region.

There was greater promotion of coordination, linkage, partnership and collaboration among public and non-public sectors. Packages of collaboration were developed and agreed on by several partners at the national and subnational level including amongst private actors in the response. The PEPFAR partners have signed MoUs with over 100 districts in the country using what is called "*Principles of collaboration for HIV/AIDS programming*". This has led to increased ownership and accountability in the implementation of the HIV response.

Furthermore, capacity of CSOs and communities was strengthened to increase advocacy and mobilization for demand and uptake of services, social participation, self-regulation, and accountability in the multi-sectoral response. NGO code of conduct serves as a guide to encourage NGO practices that contribute to building public health systems and discourage those that are harmful. CSO NAFOPANO have been involved in monitoring availability of medicines and health workers have been sensitised on service delivery. More on this was done in collaboration with DGF and ABH in 50 districts of Uganda.

3.5.5 Strengthen infrastructure for scaling-up delivery quality HIV/AIDS services

The government build and rehabilitated over 50 health facilities across the country including expanding the outpatient departments and laboratories to accommodate the HIV services.

PEPFAR supported IPs have remodelled laboratories in 54 additional health facilities and regional maintenance workshops were equipped to plan, monitor and maintain health infrastructure and equipment. The use of ICT in the national HIV and AIDS response have gone viral to the extent that most of the information products on the response are online even at subnational levels. These include DHIS2, Open MRS, EID, Viral Load, Web enabled ARVs Ordering (WAO) dashboards, to mention but a few.

3.5.6 Mobilize resources and streamline management for efficient utilization and accountability

To mobilize resources and streamline management for efficient utilization and accountability.

- An MoU was signed with School of Public Health to lead the process of developing the National HIV/AIDS Spending Assessment 2, A National Task Forces was constituted and a one week training of trainers conducted as preliminary activities.
- TA was hired and process of preparing the National HIV Financing Strategy (Resource Mobilization Strategy) is in its final stages. The strategy will be launched during the 2016 JAR meeting.
- Policy regulations on governance & implementation of the Trust Fund developed and awaiting presentation to cabinet.
- A fiscal space analysis for HIV&AIDS financing was completed and disseminated. As a follow up, work on efficiency gains is underway.
- Country participation in the CoP 16...320USD.
- GoU increased funding contribution for HIV commodities.
- The country applied for additional 36million from GF for procurement of medicines and health products to avert impending stock out in late 2016.

While the global report on progress towards achievement of the 90,90,90 targets is promising, funding remains a critical step. The report indicates that donor contributions for HIV fell by \$600 million in 2015. Global estimate, projects that funding required to achieve the global targets will peak at \$19.3 billion in 2017, declining to \$18 billion a year by 2020.

The national HIV program has experienced severe contraction in the funding land scape with the partnership fund receiving no fund during this FY 2015/2016, GF and PEPFAR flat lining their funding contribution for the response. Two districts of Kamwenge and Kaberamaido were supported to dialogue on strategies for improved health care that included increased budget allocations and improved service delivery.

Ugandan won 31 million US Dollars to reach 335,000 young women through implementing innovative solutions aimed at empowering girls and young women to reduce the risk of sex partners, strengthen families, and mobilize communities for change and to Keep Girls in School. Statistics indicate that Adolescent girls and young women represent 75 percent of new HIV infections among adolescents in sub-Saharan

Africa⁵.The implementation framework for the AIDS trust fund was finalised and the country is in the process of developing the required regulations.

CSO in Karamoja region have received capacity for resource mobilisation and managements since 2012 under the SCALAP project. With this capacity about 7 CSOs were able to source for about 2.2bn Uganda shillings to conduct activities for HIV and community development. The development of the national resources mobilization strategy was started and will disseminated in 2016/2017. Advocacy for the private sector involvement in the HIV response was sustained with several hotels offering free space for HIV conferences and meetings as part of social corporate responsibility.

Makerere university has been engaged to support institutionalise the NASA. The HIV/AIDS NSP 2015/16-2019/20 has an indicative resource estimates for the period. The donor partners and the GoU had projected fund commitments of about US \$2.858 billion to fund the NSP, which was estimated to cost USD 3.786 Billion. This reflects an overall funding gap of 25% with high prospects of this gap growing bigger. The exponential growth will be influenced majorly by the implementation of new treatment guideline (WHO 2015 ART treatment guidelines,) coupled with the rapid population growth and the need to scale up critical services. Although Uganda continues to interest considerable levels of funding from Development Partners, there are clear indications that contributions from AIDS Development Partners have levelled off and likely to decline for some of the partners, totally stopped for others, and still indeterminate for the rest. Currently, the Government allocation to HIV is about 12% of the total HIV budget (NASA 2012).

HIV/AIDS Financing by AIDS Development Partners (ADPs):

AIDS Development Partners continued to provide considerable support to the HIV/AIDS response in Uganda. An estimation of USD422million was contributed by a wide range of ADPs in 2015/2016;

Agency	Funds Approved for 2015/2016 (USD)	Amount Expended 2015/2016 (USD)
CHAI	1,278,546	1,435,090
Irish Aid	2,365,162,24	2,365,161.12
Global Fund	113,479,418	110,000,000
GoU	32,546,448	32,151,931
PEPFAR	262,609,562	262,609,562
ILO	55,000	109,996
FAO	910,000	825,686
IOM	630,000	306,929
UNAIDS	777,000	710,271
UNDP	369,000	222,629
UNESCO	305,000	243,591
UNFPA	8,670,000	8,115,367
UNHCR	120,000	111,340
UNICEF	3,130,906	2,532,332

⁵ <http://ugandaradionetwork.com/story/ugandan-wins-usd-31-million-to-keep-girls-in-school#ixzz4GdVsXzth>

UNwomen	316,000	164,275
WHO	1,059,000	687,540
Total	424,977,334.00	422,591,700.12

One of the key ADPs (Irish Aid) continued to provide its support towards strengthening national coordination and leadership ensuring effective implementation of the ‘Three Ones’ concept; 1.) support to strengthen capacity at local government level in resource mobilization as well as data collection and analysis for planning and delivery of HIV and AIDS services, and support to civil society organizations to help scale up evidence-based prevention activities, and improve access to quality services provided by non-state actors with a greater focus on ‘hard to reach areas’ and a more equitable allocation of resources around prevention; 2.) Support to the delivery of the single Joint UN Programme of Support to AIDS; and 3.) Education - mainstreaming AIDS in school construction programme in Karamoja for the work place programme.

The Uganda AIDS Trust Fund:

In July 2014, the Government of Uganda passed a law establishing the AIDS Trust Fund, which is hoped to contribute significantly to bridging the financial gap through mobilizing domestic resources for the national HIV and AIDS response. It is estimated that government will contribute about USD 2 Million pa towards the AIDS Trust Fund through 2% of the total tax revenue collected from levies on beers, spirits or waragi, soft drinks and bottled water, as provided for in the Law. The regulations have been drafted and awaiting approval by parliament.

The HIV/AIDS Multi-Sectoral Resource Mobilization Strategy 2015/16-2019/2020:

To guide and coordinate the mobilisation of broad domestic and international financial and technical support and ensure sustainable and predictable financing in the country, Uganda AIDS Commission is in the final stages of developing the National HIV and AIDS Financing Strategy aimed at enabling the GoU to realize the goals of the National HIV/AIDS Strategic Plan (NSP) 2015/16-2019/20. The strategy will be launched in the second year of the NSP 2016/2017. This strategy is premised on the recent launch of the Sustainable Development Goals, in which the global debate focused on mobilizing domestic resources for financing health and HIV/AIDS in developing countries.

Efficiency options for HIV/AIDS Financing in Uganda:

As one of the key options for mobilizing sustainable financing for HIV response; UAC has recently engaged with ADPs (UNAIDS and USAID) to study and pursue efficiency savings as an option to translate improved efficiency into effective monetary savings. This is premised on a financial sustainability analysis conducted in the Uganda in 2014, that presented the financing gap under the “*business as usual*” scenario and then a “*new Pro-active Policy*” for the 4 options that were studied; 1) efficiency gains, 2) increased budget allocation, 3) innovating funding mechanisms, and 4; borrowing. The analysis showed that if efficiency measures were introduced, the financing gap could close to 0.1% of GDP and 1.4% of total government expenditures. With improved efficiency, budget allocation could rise from the current 2% of discretionary current expenditure to 5%, leading to a projected 62 million USD pa on average more for the HIV/AIDS sector (1.5% of total government expenditures).

HIV/AIDS Resource Tracking:

In order for the country to plan effectively for the national HIV/AIDS epidemic response UAC is collaborating with ADPs and Makerere University School of Public Health, to institutionalize HIV resource tracking at national and sub-national level. This will entail; harmonized data management systems and regular reporting on financial data related to the amounts, the channels used to access, thematic disaggregation, ultimate beneficiary population, the different factors of production employed and the allocation and use of the funds. Institutionalization of resource tracking would not only support the strategic planning needs of the country but also feed into the policy development and implementation processes, mobilization of extra funds and allocation and utilization of the available funds. The first report is expected in March 2016/2017.

3.5.7 Strengthen governance and leadership of the multi-sectoral AIDS response at all levels.

The Parliamentary SCE had engaged with stakeholders during the pre-budget meetings and these resulted into parliament making incremental budget allocation for HIV and Health budget in FY 15/16 as followings in the Ministerial policy statements, increased funding to the sector for PHC. As a result, PHC was increased from 289.236 to 320.1bn and the overall funding was increased from 1.227 trillion to 1.828 trillion in FY 2016/17 which translates to 8.7% share of the National Budget. Govt allocated a total of ushs.110bn under vote 116 NMS 2016/17; UG shs 94891, 375, 00 earmarked for ARVS and ushs.10bn for TB.

Parliament has played a significant role in advocacy in the country during the launch and follows up of EMTCT in the country, World AIDS Day and participation in the regional and sub national, districts and sub counties level programmes addressing the HIV programmes, this has increased the confidence in the community to enrol in HCT services and ART programmes. Parliament passed the Public Finance Management Amendment Bill, 2015, Children Amendment statues and other related laws. This would provide the administration and management of the country.

UAC had formed HIV/AIDS Coordination Committees within the Government Ministries, Departments and Agencies, the committees are set up by the Permanent Secretaries, and currently there are functional HIV Committee within 40 MDAs coordinated by UAC. The Committees are tasked with mainstreaming and allocating the resources of HIV/AIDS within the sectors, development of HIV/AIDS workplace policy.

Challenges in Infrastructure, Governance and Leadership:

The leadership of Local Governments is sceptical about sustainability of the AIDS Committees without financial support from UAC. Currently most Local Government budgets for HIV and AIDS activities are dependent on donor funds/HIV Implementing Partners (IPs), although, coordination activities are not prioritized. All districts and sub-counties depend on central government releases that are largely conditional. Local Governments propose that there should be a well thought out plan before establishing similar structures at the parish and village levels without sustainable support.

Over reliance on external donors to finance its HIV/AIDS national response; contributing about 89%. The looming economic crisis in the donor countries forced them to implement austerity plans to reduce public spending. This has accordingly led to

reduction in funding for the HIV response. While most of the donors' funds for HIV is off-budget support and has previously been directed to HIV Implementation, there is a shift by most key partners to fund the broader health system components away from direct implementation.

Country donors like PEPFAR , IRSIH Aid and DANIDA for HIV and AIDS have in the recent past refocused their funding portfolios following a number of global issues such as competing health and development demands across Africa; an ever-increasing burden of HIV/AIDS treatment.

GFATM following the global financial crisis is refocusing its funding towards Health system strengthening and high impact interventions.

Other Challenges include:

1. Lack of coordination structures at parish and village level that shoulder the biggest burden of the epidemic – but inadequately coordinated to respond to the HIV/AIDS problem.
2. The leadership of Local Governments is skeptical about sustainability of the AIDS Committees without financial support from UAC. Currently the response is heavily funded by donors.
3. Unwilling by Implementing Partners to support coordination activities (prioritise service delivery).
4. Inadequate leadership commitment to allocate minimal resources from the local budgets to support coordination activities.

Best Practices

1. Allocation of resources towards HIV and AIDS coordination activities in some districts e.g. in Kitgum.
2. District Led Programming appreciated by both districts and Implementing Partners (IPs). IPs support the districts HIV and AIDS priorities. Partners that use this approach include Baylor Uganda, IDI, UNICEF, SDS, RHITES, among others.
3. Integration of the Districts' Technical Planning committees (DTPs) with DACs e.g. in Oyam.

Recommendations and remedial Actions in Infrastructure, Governance and Leadership

1. Establish and rejuvenate the coordination committees at all the levels; and UAC mobilizes resources to support them.
2. Empower DACs to monitor implementation of IPs plans and activities.
3. Promote the district led programming approach.

3.5.8 Systems Strengthening: Monitoring, Evaluation and Research

The M&E system for the Uganda AIDS response is based on the UNAIDS 'three-ones' (One Coordinating Body, One Strategic Plan and One M&E Framework). The approach to monitoring the HIV epidemic is well described in the NSP, the National M&E Plan, NPAP and all sector strategic Plans. The Interventions aimed at strategic information management to inform decision making for the national response.

This section details progress in strengthening M&E along the two objectives and strategic actions.

Strengthen the national mechanism for HIV/AIDS information for M&E

Summary of Achievements

- Realised timely reporting both Nationally and Internationally.
- New Strategic Information was generated and used to inform national programming (HIV projections, eMTCT Impact Assessment).
- Harmonized data in DHIS 2 across all the 112 Districts .
- Functional databases were established at UAC.
- Convened the National M&E TWG which drove the National M&E agenda e.g Clearing of information products, reports, SOPs for processes.
- Several platforms for data review and information sharing/feedback were created at both national and sub national levels.
- Strengthened capacity for M&E at individual, regional and national level (DQA Tools and manuals were developed).
- The National M&E Plan and Indicator Handbook were developed to guide the M&E agenda.

The National M&E Technical Working Group was convened on a quarterly basis to guide and provide oversight to the monitoring and evaluation of the National HIV response. The M&E team reviewed and cleared important national and international reports and guidelines including the the M&E Plan, Standard Operating Procedures for Reporting, The Global AIDS Progress Report 2015 among others. One of the key products of the M&E TWG is the harmonization of the GARPR and the JAR 2016 reports as a key undertaking of the 2015 JAR.

The National HIV and AIDS M&E database at UAC was updated to capture data for the indicators in the NSP 2015/16 – 2019/20 serving as repository of data collected from sectors and can be accessed on www.aidsuganda.org. To harmonise data collection, collation and analysis, the indicator hand Book was developed and disseminated to all the district and at different HIV fora. Comprehensive M&E work plans and budgets were developed at UAC and at all sectors to institutionalise information management and dissemination. More work was done at district level where the M&E components were given due priority during the development of the HIV strategic plan and budgets.

At Ministry of Health, tools for capturing data on birth and maternal cohorts were developed as addenda to the HIMS summary tools. a) There has been great improvement in the quality and use of the DHIS2 system and data as the DHSI 2 is a one stop source of national health program data, accessible to all stakeholders in the health sector. In a bid to improve health data utilization and harmonize national health program indicator datasets; the Ministry of Health through the Division of Health Information Provided guidance to districts and sites on accurate and timely reporting.

The following was done: Undertook periodic data management reviews to inform quality improvement of reported data on a routine basis; and was in the process of establishing

joint data analysis and sharing platforms to inform program improvement and Institutionalized joint stakeholder data cleaning beginning with the financial year 2015/16 monthly and quarterly datasets with a special focus on the April – June 2016 period.

Regular regional performance reviews were conducted, coordinated by the Regional Performance Monitoring Teams (RPMTs) in collaboration with respective regional Implementing partners. At these meetings districts presented their performance followed by discussions. National level participants clarified on information policies and data validation rules. All the 112 districts conducted quarterly district data review, validation, and verification meetings. Integrated Data Quality Assessment tools and training manuals were developed and 13 Regional trainings conducted. DQAs were carried out in all districts with support from regional partners. Due to changing policies and global guidance on programming for PMTCT, tools for capturing data on birth and maternal cohorts were developed as addenda to the HIMS summary tools. A Standard Operational Procedure (SOP) has been developed to guide implementation of the M&E plan with emphasis on harmonising targets, indicators, data sources, and reporting timelines.

Capacity Building in Information and Knowledge Management

A cascade HIV estimation and projection capacity building workshop was held benefiting 21 members of the national M&E team. This resulted into generation of the first ever regional HIV spectrum files that will inform regional and district HIV programming. This is a continuous process.

There has been great improvement in the quality and use of the DHIS2 system and datasets and is now the single source of nationally reported health program data, accessible to all stakeholders in the health sector. In a bid to improve health data utilization and harmonize national health program indicator datasets; the Ministry of health through the Division of Health Information has done the following:

- Provided guidance to districts and sites on accurate and timely reporting.
- Undertaken periodic data management reviews to inform quality improvement of reported data on a routine basis.
- Is in the process of developing a multi-agency data quality management team.
- Has institutionalized joint stakeholder data cleaning beginning with the financial year 2015/16 monthly and quarterly datasets with a special focus on the April – June 2016 period.
- Has planned to establish joint data analysis and data sharing platforms to inform program improvement.
- Ministry of Health has improved reporting across all regions through institutionalization of data use workshops led by district and Regional Performance Monitoring Teams (RPMTs). The Ministry of Health collaborating with partners, has spearheaded the development and customization of the Uganda EMR. A patient based electronic data management System (openMRS) envisioned to improve patient level data collection, aggregation and analysis.
- A national TOT for OpenMRS was conducted for all programs and implementing partner's country wide. The roll out of OpenMRS has commenced in all high volume HIV sites with support from USG and UN partners. The e-HMIS digital policy is under final editing and will be presented to the relevant authorities in the FY 2016/2017.

3.5.9 Promote information sharing and utilization among producers and users of HIV/ and AIDS data/information

To promote information sharing and utilization among producers and users of HIV/ and AIDS data/information at all levels.

- The UAC Website was updated regularly.
- The National HIV Knowledge Management portal facilitated sharing of information on the response. (E-mapping database, research repository, policy and strategic documents).
- Disseminated National documents that guide the HIV Response (NSP and accompanying documents).
- Coordinated Information Exhibitions at all HIV events.
- The Ministry of Health introduced the use of data dash boards to visualize and share information.

Uganda AIDS Commission conducted regular updates to the UAC Website. A lot of information can be accessed globally and it that includes strategic reports, photo gallery among others.

National AIDS Documentation and Information Centre

An online National HIV Knowledge Management Portal was established to serve as a one stop centre for all HIV information. It houses the country wide stakeholder e-mapping database which provides information on who is doing what and where, up to sub-county level; the local research repository and an online public access catalogue. It provides updates on HIV in terms of local and International news and facilitates interaction with the public through social media.

Since establishment, over 400 peer reviewed articles have been uploaded and can be accessed globally. Quarterly electronic newsletters and factsheets were developed and shared with all stakeholders for up to date information and statistics compiled from progress reports. The NADIC also houses a physical library/resource centre with up to date information materials. Uganda AIDS Commission also interacted with the public through Social media. The UAC Facebook page was visited. It was used to share information, receive queries and clarifications on the HIV response.

The Ministry of Health, with support from partners trained selected district bio-statisticians in the use of data dash boards. This was aimed at enhancing visualization, sharing and use of data generated from the DHIS2. UAC organized exhibitions and HIV health services alongside AIDS Advocacy days and also participated in partner organized exhibitions in the region. During these events, HIV and AIDS information is disseminated as well as HIV and AIDS health services provided to the public.



Promote and co-ordinate HIV/AIDS research:

There several research studies initiated during the reporting period. Notably;

- Feasibility studies are underway on self-testing.
- The stigma Index assessment was conducted in parts of the central regions.
- The PreP studies were finalised among sex workers and discordant couples supported by MUWRP, MUJHU and Infectious disease institute.
- The prevention assessment study was started by MoH under Makerere University with support from Global Fund.
- The SRH/HIV vulnerability mapping study for adolescents and young people was initiated, field work conducted, and the final report is expected by end March 2016.
- A MARPs hotspots mapping was conducted in Mbarara, Hoima, Mbale, Gulu, Fortportal & Wakiso regional hubs to inform targeted HIV MARPS programming in these respective districts. Final reports are available.
- A national condom needs assessment study was conducted and findings will be utilized to inform development of a revised Comprehensive Condom Programming Strategy in 2016.
- The concept note/TOR to conduct the EMTCT impact study was developed through extensive stakeholder discussions facilitated by a joint IATT mission to Uganda in May 2015 and the agreed concept note was used to inform mobilization of resources for the evaluation.
- A Global Fund/JUPSA study on family planning up-take among the PLHIV to establish among other unmet need for FP was initiated with recruitment of study team and development of protocols. The final report is expected by end of December 2016.
- An in depth evaluation of Life Skills Sexuality Education (LSSE) in upper primary schools in Uganda was undertaken through the Ministry of Education and Sports. This was against the background of the increased school dropout rates, especially among young girls as a result of the unwanted early pregnancy and other Adolescent Sexual Reproductive Health related concerns among young people in schools.
- A needs assessment and beneficiary profiling for women and girls LHIV in the 7 districts of Karamoja to establish the social and economic empowerment needs was conducted. A curriculum and training materials were also developed based on findings.

Key Challenges in Monitoring and Evaluation

Data quality continues to improve though there is still a lot of effort needed to institutionalize it at the lowest levels of data collection. Completeness of data sets for required indicators & report, data discrepancies /outliers, Obvious typos/counting errors – especially at high volume sites, allowable data validation failures, timelines - is still a problem. There is also problems of synchronizing data in E-Systems with different administrative units (OVC MIS/ DHIS2 /HIBRID / DATIM). Other challenges include:

- Inadequate Funding: Most of funding for NADIC has been dependent on donors with little from Government of Uganda, as such continuity of some programs and activities are affected.
- Inadequate capacity for information and knowledge management: There is need to develop and implement capacity building programs for staff managing information resources at UAC and institutions that feed data/information into NADIC.
- Data collections tools are still a challenge, not all health facilities have received the revised data collection tools after the revision. There are also problems of synchronizing data in E-Systems with different administration units, OVC MIS/ DHIS2 /HIBRID / DATIM
- The community reporting and M&E Systems are not well established. There is no institutionalized reporting framework and structure for community related HIV interventions particularly for SBCC. This has led to some partners such as the MEEP and the UN Agencies to establish their own reporting systems but these are not nationally representative. VHT tools have not been printed and widely disseminated

due to the fact not every place has VHTs. They are also very expensive to print. And even when data is recorded and sometimes summarized by individual VHTs there are no mechanisms to guarantee reporting through the established health facility hierarchy.

Best practices and Lessons Learnt

The Standard Operational Procedures (SOPs) developed guide implementation of the M&E plan with emphasis on harmonising targets, indicators, data sources and reporting timelines.

The joint data review and harmonisation meetings instituted by the Ministry of Health promote ownership of data generated from the DHIS2.

Partnerships are very important in promoting initiatives in implementing the National M&E Plan. For example, Support for DHIS2 to develop data validation rules was provided by WHO and USG partners and the exercise will be completed early FY 2016/2017.

Remedial actions for Monitoring and evaluation

- Data quality Institutionalization efforts are needed in order to allow continuous assessment of indicators, provision of support and feedback improve completeness, timeliness accuracy and validity of data at all levels in order to improve overall quality of reporting.
- Encourage Institutional 'data demand' and 'informed use' in decision making as way to awaken consciousness and focus on the source, availability and quality of data that is being relied upon.
- There is need for deliberate efforts to institutionalize community based frameworks and structure for community related HIV interventions and reporting. The idea of the '3-ones' is also important for community level activities in order to deal with difficulties in quantifying coverage of interventions. Government (Ministry of Gender) and other relevant partners need to provide a framework that can be followed by the community level actors to ensure equity, justice and enable estimation of coverage and reporting.



SECTION FOUR

4.0 CONCLUSION AND RECOMMENDATIONS

In general, review of the HIV response showed significant achievements in most of the thematic areas. There is reduction in HIV transmission in the general population unprecedented reduction of HIV transmission among HIV exposed infants. There was continued reduction in HIV related death and increased enrolment of HIV positive patients

The country has progressed towards achievement of the 90, 90, 90 targets. The program tested and provided results to 69% of all persons estimated to be infected with HIV (the first 90% of UNAIDS targets). There was increased enrolment of patients on ART to 898, 197 (by June 2016), a treatment coverage of 60%. This was the projected target for June 2016. The coverage shows the progress towards the target of 81% of all HIV positive clients who were initiated on anti-retroviral therapy (the second 90% of the UNAIDS targets).

All districts and facilities have access to viral Load monitoring for ART treatment. Viral load suppression was above 90% among the 42.6% who were reached with viral load testing. There was higher suppression of 94% among eMTCT mothers. The very low Viral load suppression at 74% coupled with high Viral load samples rejection rates among children required specific attention for the programs.

Persistent challenges remain in the resources to support the response particularly for the prevention interventions, limited support for social protection and data quality. Specific interventions like SMC and MARPS have been affected by the further contraction in the funding from development partners. Access to new diagnostics and prevention technologies were still low but showing progress.

The country requires increased efforts to diagnose the remaining 30% of the estimated HIV positive people through targeting testing in populations. Although HIV monitoring availability has increased there is still need to step up efforts to conduct viral load testing for all eligible patients on ART.

Multisectoral Innovations for primary prevention particularly targeting the youth should be a focus for the next implementing period. This will require focusing the available funding from the DREAMS programs and support from UN partners and government to reduce the vulnerabilities among the youth and adolescents.

Stronger involvement of community, traditional and media institutions will be key to strengthening implementation of the actions to meet for the UN targets of 90, 90, 90 to end HIV by 2020.



ANNEXES

Annex I: Status of Implementation of Plan of Action for Undertakings of the Joint AIDS Review for 2015

1.0 Prevention thematic area	
1. Prioritize and improve quality improvement and assurance for prevention services	
<ul style="list-style-type: none"> Review meetings for Health facility QI teams Conduct QI supervisions to districts and health facilities 	<ul style="list-style-type: none"> Regular planning meetings in preparation for supervision and data Quality assurance were conducted before implementation Integrated support supervision and mentorships were conducted in all the health facilities offering HCT, eMTCT, SMC throughout the country. District supervisors conducted Quality assurance and control exercises with support from regional implementing partners.
<ul style="list-style-type: none"> Review the National HCT policy and implementation guidelines 	<ul style="list-style-type: none"> MoH with support from partners has finalized revision of the HCT policy and development of a new National HIV Testing Services (HTS) Policy and Implementation guidelines now pending government approval.
2. Expand investment in SBCC (message development, production and dissemination, capacity building and monitoring)- priority focus on cultural and religious institutions.	
<ul style="list-style-type: none"> Orient the new political leadership (2016/21) at national, district, constituency and sub-county levels on HIV/AIDS, SRH and GBV with focus on their responsibility to inform and support their electorates Resources mobilized and plans for orientation of newly elected political leadership at national and selected regional levels by UAC & MoH finalized 	
<ul style="list-style-type: none"> Build technical capacity and support cultural and religious institutions to develop and implement SBCC programmes on HIV, SRH and GBV Support cultural and religious institutions to mobilize, utilize and report on resources from various sources 	<ul style="list-style-type: none"> The National session of the Forum of Kings and Cultural Leaders held in November 2015 to review progress against the 2010 declaration on HIV/SRH/MNH/GBV and recommit for the period 2015-2020. Twelve cultural institutions were supported to develop and endorse policy guidelines and pronouncements against harmful socio-cultural norms, values, beliefs and practices and also development of standard messages for cultural leadership to enhance community mobilization. Funds mobilized, MoUs signed between MoGLSD and 12 cultural institutions to receive financial support to implement SRH/HIV/MNCH/GBV programmes.



- Develop capacity for SBCC programme delivery, M&E and coordination at UAC, MoH and other line Ministries and district levels to decentralize SBCC programming and ensure quality SBCC targeting NSP identified priority population groups

Activity for development of SBCC Standard operating procedures with stakeholder consensus planned for Sept-Dec 2016 by UAC.

- Build capacity for MARPs organizations in advocacy and SBCC programme management
- The National MARPs Action Plan operationalizing the 2014 National MARPs Programming Framework was developed with full participation of representatives of all NSP designated MARPs groups.
 - The 1st Annual MARPs programming report was generated for the 2014/2015 FY.
 - MARPs Hotspot mapping was conducted in the urban centres of Mbarara, Fortportal, Hoima, Gulu, Wakiso & Mbale.
 - Training of HWs on delivery of friendly SRH/HIV services conducted by MoH in the designated hubs with funding from various sources.
 - Training of MARPs peers was also conducted in different sites by different partners. E.g. 50 Sex Workers & members of other sexual minority groups trained in the 6 hubs with UNFPA support.

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| <ul style="list-style-type: none"> • Support processes for review of the PIASCY programme and mobilization of resources for universal coverage of primary and secondary school HIV prevention programming • Develop curriculum for comprehensive sexuality education (CSE) for the out of school adolescents and young people | <ul style="list-style-type: none"> • The school Health Reading Programme(SHERP), a USAID funded program has been spearheading the rollout of the PIACY program. • Due to Public outcry, the Comprehensive Sexuality Education has been halted to enable improvement of the strategies. • Process for development of guidance on sexuality education for out of school adolescents and young people by MoGLSD has been initiated.. |
| <ul style="list-style-type: none"> • Develop and implement a National IEC/BCC Programme targeting adolescents and young people (10-24) out of school • Support cascade implementation of the Protect the Goal Campaign in Uganda | <ul style="list-style-type: none"> • The National Protect the Goal (PtG) campaign that was launched by His Excellency the President in 2014 was scaled up in two regions of Karamoja (7 districts) and Western Uganda. • 10,000 young people with SRH/HIV information and services. • Protect the Goal was also implemented as part of an HIV prevention campaign conducted through football events in 20 districts in the Lango, Acholi and West Nile Sub Regions where over 45,000 youth and community members benefited from the VCT services provided during the events and including moon light HIV testing for Sex Workers. |

3. Develop and implement strategies for utilizing education and community structures to reach vulnerable, adolescents, young people and MARPs with HIV prevention services.

- Develop strategies for utilizing agricultural extension workers, community development officers and related structures for HIV prevention work.

Strategy yet to be developed.

- Integrate HIV prevention into tools of the MoH Community Health Extension Workers (CHEWs).

Tools under development..



<ul style="list-style-type: none"> Support establishment of trusted community peer support mechanisms for MARPs groups linked to health service delivery points 	<ul style="list-style-type: none"> Tools for training of MARPs peer support groups were developed and capacity built. MARPs curriculum was developed and used to train 1,500 health workers. 2,193 pregnant mothers were referred for ANC while 3,456 referred for Family planning to health facilities in the Hot spots. In addition to the MARPI clinic in Mulago, other 6 regional Hubs have been opened to facilitate referral and case management..
Treatment thematic area	
4. Ensure adherence and retention on ART a) Focusing on children, adolescents, MARPs & option B + and b) Strengthen community systems for psychosocial support, tracking	
<ul style="list-style-type: none"> Make operational Community structures to follow up patients in Care Build capacity of Health workers in paediatric and adolescent counselling Utilize expert clients to follow up patients in care Fast track the Unique Identifiers strategy to track transfers in the health facility settings 	<ul style="list-style-type: none"> More HIV positive mothers 114,024 (112,909 in 2014) received ARVs for eMTCT (including those already on ART prior to pregnancy, and those started on Option B+); 90% pregnant women living with HIV accessing antiretroviral medicines to prevent mother-to-child-transmission of HIV; achieving the NSP target. Existing community structure like VHTs are being utilised for follow up of patients on treatment. Expert clients and mentor mothers mainly utilized at Health Facilities including conducting home visits to ensure adherence, retention in care and follow upon lost to care. The Unique Identifier strategy is being piloted in the Kabarole and will be rolled out thereafter..
5. Viral load monitoring; improve coverage.	
<ul style="list-style-type: none"> Ministry of Health is gradually scaled up viral load testing to national coverage and set up a viral load testing laboratory at the Uganda National Health Laboratory Services (UNHLS) formally Central Public Health Laboratory (CPHL) in Kampala. Viral load samples are primarily collected and shipped as Dried Blood Spot (DBS) samples. The viral load monitoring has been scaled up to all the 112 districts, and 1,667 ART sites. 350,369 patients have accessed (coverage of 42.6%) viral load testing with viral suppression of 90.8% nationally. A national viral load mentorship curriculum was developed to support continued scale up to all sites including sites implementing only PMTCT and no ART. A National training of trainers was conducted and about 90 trainers were trained. District and facility mentorships have been conducted in all regions. 	
Social support thematic area.	
6. Address stigma: Mobilize resources to strengthen PLHIV networks and other community networks in districts to reduce stigma. (District, sub-county and community level)	
<ul style="list-style-type: none"> Empower PLHIV as champions to fight stigma; Engage cultural and faith-based institutions as change agents Build the capacity of young people 	<ul style="list-style-type: none"> Engaged high level cultural leaders (Kings' Forum) and other Cultural leaders including high level religious leaders (IRCU) to renew their 2010 commitments to pronounce support for expansion of community programming on SRH/HIV/MNCH/GBV for 2016/2020. PLHIV Networks regularly engage in stigma reduction campaigns at all levels. Stigma index report, 2013 continued to be disseminated.



living with HIV to address stigma Undertake 2 nd stigma study	<ul style="list-style-type: none"> The Stigma Index for central and southern Uganda had a baseline done in December 2014 and End Evaluation in 2015 having had interventions in 2015 targeting PLHIV and Faith leaders as agents of change. The results show a 35% reduction in internal stigma..
7. UAC to spearhead processes to review and amend the specific clauses in the law that hinder effective HIV/AIDS service delivery.	
<ul style="list-style-type: none"> Develop a concept paper for review of the HIV prevention and control act Procure TA 	<ul style="list-style-type: none"> UGANET has led a team of CSOs and PLHIV Networks to petition the clauses in the Constitutional Court.
8. Strengthen the linkage between the health system, the justice and order sector and the community to ensure comprehensive legal support for PLHIV and OVC (e.g inheritance rights, medical care etc.)	
<ul style="list-style-type: none"> Review ToRs for NPC and MARPs Steering committee to include JLOs representatives* To establish a gender human right desk at UAC. (Recruit a gender officer at UAC who will be responsible for the gender and human rights** Institutionalize and strengthen the gender TWG(quarterly meeting and regular reporting to NPC 	<ul style="list-style-type: none"> Conducted Violence against Children (VAC) survey/mapping and established that OVCs especially due to HIV were the most affected. The affected children were linked to HIV/AIDS care and legal services. Support services. Isolated Investigations of abuse of children by the contractors and labourers on the Fort Portal-Kamwenge road were also done with victims being referred for further or specialized attention such as counselling, testing, etc. With support from TASO, a Gender Officer was recruited sitting at UAC to support Gender activities.
9. Operationalize the AIDS Trust Fund	
<ul style="list-style-type: none"> Hold Development Partners conference Finalization of ATF legislations and presentation to cabinet	<ul style="list-style-type: none"> Guidelines to administer the AIDS Trust Fund were finalised and submitted to the Ministry of Health for forwarding to Cabinet for consideration.
10. Harmonise the regional coordination and performance monitoring and implementation Teams for public and IPs.	
<ul style="list-style-type: none"> Constitute an integrated Regional team (Composed of UAC, RPMTs, IPs and sectors) Conduct integrated support supervision and meetings with the teams and the Zonal Coordinators Convene the Annual Regional performance reviews 	<ul style="list-style-type: none"> The RPMTs are currently working in collaboration with the Implementing Partners. The regional quarterly review meeting are jointly coordinated by Partners and the RPMTs. The RPMTs have also been co-opted to the National review teams and this will be strengthened 7 Annual review meetings were convened to provide input to the National JAR meeting.



11. Build capacity at national and district levels in data quality, utilization and assessments	
<ul style="list-style-type: none"> • Constitute a national and district team • Popularise the M&E plan, Indicator Handbook and Data collection tools • Conduct mentorships • Populate the National M&E 	<ul style="list-style-type: none"> • The National M&E TWG which drives the M&E agenda convened on a quarterly basis. • An integrated National QDA team was also constituted drawing membership from MoH, UAC and implementing Partners. This was not limited to HIV but also to other diseases including Malaria and Tuberculosis. • The M&E plan and the Indicator database were disseminated at all levels to guide development of respective plans for institutions.
12. Harmonization of reporting on AIDS response	
<ul style="list-style-type: none"> • Develop a harmonised concept for GARPR and JAR 2016 • Convene management and coordination meetings • Compile a harmonised report • Convene JAR 	<ul style="list-style-type: none"> • This has been achieved through a number of processes including constitution of the data cleaning team, convening of data cleaning meeting, development of the SOPs to guide subsequent reviews, and timely reporting online reporting to the UN. • The report discussed is the first narrative to be submitted to fulfil both national and international reporting obligations.



Annex II: National targets for ART, PMTCT and lab tests in the next 4 years

Country target	At the end of 2016	At the end of 2017	At the end of 2018	At the end of 2019	At the end of 2020
1. Number of adults and children to be on ART	<u>985,995</u>	<u>1,115,985</u>	<u>1,255,339</u>	<u>1,384,106</u>	<u>1,537,097</u>
Subset 1.1: Number of adults and adolescents (≥15 years) to be on ART	<u>917,284</u>	<u>1,041,171</u>	<u>1,173,321</u>	<u>1,296,606</u>	<u>1,444,641</u>
Subset 1.2: Number of children <15 years to be on ART	<u>68,711</u>	<u>74,814</u>	<u>82,019</u>	<u>87,501</u>	<u>92,456</u>
2. Total Number of pregnant women who started ART for PMTCT	<u>121,181</u>	<u>123,065</u>	<u>124,514</u>	<u>125,500</u>	<u>126,055</u>
Subset 2.1: Number of pregnant women on Option B+	<u>121,181</u>	<u>123,065</u>	<u>124,514</u>	<u>125,500</u>	<u>126,055</u>
5. Total number of people who will have VL tests	<u>800,000</u>	<u>1,200,000</u>			
6. Total number of children (born from HIV infected women) who will have EID tests	<u>120,000</u>	<u>140,000</u>	<u>150,000</u>		



Annex III: Estimated Magnitude of HIV/AIDS as at the End of 2015

<u>No. of PLHIV as at end of 2015</u>			<u>New HIV Infections in 2015</u>		<u>No of AIDS Deaths 2015</u>	
Total	1,461,756		83,265		28,163	
Men	622,180	43%	35,999	43%	16,289	58%
Women	839,576	57%	47,265	57%	11,874	42%
Age						
Adult 15 + Yrs	1,366,107	94%	79,777	96%	23,449	83%
Children 0 - 14 yrs	95,649	7%	3,487	4%	4,714	17%
Young 15 - 24 yrs	188,636	13%	29,509	35%	2,589	9%
Children 1 - 4 yrs	22,154	2%	912	1%	1,186	4%



Annex IV: ESTIMATES OF VERTICAL INFECTIONS AVERTED BY PMTCT

