THE REPUBLIC OF UGANDA

UGANDA HIV/AIDS COUNTRY PROGRESS REPORT JULY 2016-JUNE 2017

THEME: ***"Reaching men, girls and young women to reduce new HIV infections"***

Uganda AIDS Commission

August 2017

Contents

LIST OF ACRONYMS

ADP	AIDS Development Partner
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retro Viral
CSOs	Civil Society Organizations
DAC	District AIDS Committee
DLG	District Local Government
EID	Early Infant Diagnosis
eMTCT	elimination of Mother to Child Transmission of HIV
FSG	Family Support Groups
GBV	Gender Based Violence
HCT	HIV Counselling and Testing
HEI	HIV Exposed Infant
HTS	HIV testing and services
JAR	Joint AIDS Review
KP	Key Populations
MARPS	Most At Risk Populations
MDAs	Ministries, Departments and Agencies
MGLSD	Ministry of Gender, Labour, and Social Development
MOES	Ministry of Education and Sports
MoH	Ministry of Health
MSM	Men who have Sex with Men
NPAP	National Priority Action Plan
NSP	National HIV/AIDS Strategic Plan
OVC	Orphans and other Vulnerable Children
OWC	Operation Wealth Creation
PEPFAR	Presidential Emergency Plan For AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother To Child HIV Transmission
PrEP	Pre-Exposure Prophylaxis
RH	Reproductive Health
SAGE	Social Assistance Grants for Empowerment
SCEs	Self-Coordinating Entities
SDG	Sustainable Development Goals
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SRH	Sexual and Reproductive Health
TB	Tuberculosis
ToT	Trainer of Trainers
TWG	Technical Working Groups
UAC	Uganda AIDS Commission
UAC	Uganda AIDS Commission
UPHIA	Uganda Population HIV Impact Assessment
VL	Viral Load
VLS	Viral Load Suppression
WHO	World Health Organizations
YLP	Youth Livelihood Program

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Foreword

Uganda's HIV and AIDS epidemic continues to be severe, mature, generalised and heterogeneous with an estimated 1.3m Ugandans infected with HIV. The Government of Uganda under the leadership of Uganda AIDS Commission has taken steps to re-invigorate the National HIV and AIDS response efforts. This has been through renewed engagement of the Political Leadership at all levels and strengthening the Multi-sectoral efforts to curb the impact of the Epidemic.

As part of its international commitment, Uganda is implementing several resolutions including: By 2020, 90% of all people living with HIV will know their HIV 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. Additionally following the 69th United Nations General Assembly declaration to end HIV as a public threat by 2030, H.E Yoweri Kaguta Museveni the President of Uganda launched the Presidential Fast Track Initiative to end AIDS by 2030 on the 6th June 2017.

The HIV and AIDS epidemic in our country is now at crossroads with the number of new infections having appreciably declined however there is notable increasing number of infections in adolescents especially girls. There is reduction in stigma and discrimination levels in the country with internal stigma reducing by 35%. Systems to support the epidemic have continued to become stronger with easier access to information for HIV programming, enhanced functioning of supportive governance structures, and expanding infrastructure.

The purpose of the Mid Term review of the National Strategic Plan 2015/16-2019/20 is to assess the second year performance on the National HIV Strategic Plan. The Findings from the review will inform planning and implementation for the next year of the NSP in an effort to realize its overall goal of "towards Zero new infections, Zero HIV and AIDS related mortality and morbidity, and Zero discrimination ". I therefore urge all stakeholders to take note of the findings of this Review use them to shape their interventions.

The government of Uganda leadership is dedicated to strengthening the response to HIV and AIDS and will increase the required resources to meet this goal. We look forward to working with development partners, communities and other stakeholders to support implementation of this innovative strategy that is grounded in scientific evidence, focuses on current priorities, and provides a clear direction for moving forward.

For God and My Country

HON. ESTHER MBAYO MBULAKUBUZA
MINISTER FOR THE PRESIDENCY
OFFICE OF THE PRESIDENT

ACKNOWLEDGEMENTS

The Annual Progress Report 2016-17 presents findings from the review of performance for the second year of implementation of the National HIV and AIDS Strategic Plan 2015/16- 2019/20 and guide setting priorities for 2018/19. The process involved consultations from different stakeholders including the People Living with HIV; Ministries Departments and Agencies especially Ministry of Health; Media; Civil Society Organizations; Political, Religious and Cultural leaders; Private Sector, Academia and AIDS Development Partners among others.

I would like to thank the partners who supported the review process both technically and financially. Special thanks go to UNICEF, UNAIDS, Irish Aid, PEPFAR and Regional Implementing Partners like IDI, RHITES SW, Baylor- Uganda. I thank MEEPP and MoH who supported the National and Regional data validation meetings. Special appreciation goes to the METS program for the support provided during the preparations and convening of the JAR meeting.

I further acknowledge the technical support from the Esteem International Consultants led by Ms. Flavia Nakayima Miiro. I recognize the contribution made by members of the different thematic Technical Working Groups (Prevention, Care & Treatment, Social Support and Protection, Systems Strengthening, Gender and Monitoring and Evaluation) who made technical contribution, guidance and review of the report.

Finally, I wish to also appreciate the contribution by all the staff of Uganda AIDS Commission for organizing a successful JAR 2017. I thank the editorial team led by led by Dr. Wakooba Peter supported by Ms. Sarah Khanakwa Sarah, Mr. Daniel Kyeyune, Mr. Charles Otai, Muhuruzi Grace, Dr. Daniel Byamukama, Dr. Zepher Karyabakabo, Ms. Stella Watya, Mr. Tom Etii, Dr. Carol Nakazzi. We appreciate the input received from AIDS Development Partners and wish to specially recognize Ms. Rosemary Kindyomunda from UNFPA and Jotham Mubangizi of UNAIDS for the contribution to finalizing the report.

Dr. Nelson Musoba

ACTING DIRECTOR GENERAL

EXECUTIVE SUMMARY

Introduction: This Annual Joint AIDS Report provides an opportunity for the Country to assess the performance in relation to the National HIV and AIDS Strategic Plan (NSP 2015/16 – 2019/20). This 2017 annual report comes in towards the mid-term of the strategic plan but it is also the second year of the implementation of the NSP. In the reporting period, there have been policy changes and a number of policy reviews and improvement in the implementation guidelines in the HIV sector as it is highlighted in the achievement sections in the report. The progress report also provides an insight into the country's performance against Sustainable Development Goals 3 and 17. Also in this reporting period the United Nations General Assembly reaffirmed the commitment to end the AIDS epidemic by 2030.

Objectives:

- To review and validate performance of the second year of the NSP (2015/16 – 2019/20) against the set targets in the National Priority Action Plan (NPAP) (2015/16 - 17/18) and document successes, challenges, lessons learnt and best practices.
- Provide an update to stakeholders on the Presidential Fast track Initiative on Ending AIDS as a Public Health threat in Uganda by 2030 which will guide planning for FY 2018/19.
- To disseminate progress in implementation of undertakings of the Aide Memoire, 2016.
- Agree on undertakings for implementation for FY 2017/18.

Methodology: A highly participatory and consultative approach was adopted. There were several stakeholders involved in the implementation of the national HIV response that were consulted. The reason behind the highly consultative approach was to ensure ownership of the output as well as giving chance to all the players to report what they have been able to achieve in the sector. There was a review of secondary data from the reports, abstraction of data from the Ministry of Health and Ministry of Gender OVC databases. After the report was drafted there was opportunity for the different stakeholders to make their input to improve the report. The draft report was presented at the Annual Joint AIDS Review meeting where there was also the opportunity for additional input to come up with the final report.

Overall performance: The performance has been presented aligned to the NSP and the National Priority Action Plan and taking into consideration the Aide Memoire of the 2016 JAR. The report gives key achievements under the four thematic areas of the NSP according to the different objectives.

The country has made great strides in reducing HIV incidence, HIV related mortality, infant HIV infection and HIV prevalence where the NSP targets were surpassed. The UPHIA results revealed that the country has made significant progress in reducing the HIV prevalence from 7.3% in 2011 to 6% in 2017. There are 1,300,000 people living with HIV and AIDS in Uganda of which 73% know their HIV positive status. Of those who are HIV positive, there are 67% who are on ART and close to 60% are virally suppressed. There has been scale up of PMTCT services and there are more than 95% of mothers accessing the PMTCT services.

Prevention

Building on to the achievements of the past, behavioral change communication has remained a key factor in adoption of safer sexual practices. Different strategies have been used to reach the people by the different players in the sector. There has been use of IEC materials, print and electronic media

campaigns, community engagements and community dialogues as well as working through peer educators to reach the specific population categories. The Ministry of Education and Sports has continued to build on the success of PIASCY program to reach the youth in school. Overall there has been integration of SRH and HIV messages that have been age specific and have been used as part of the behavioral change. Condom programing has also been one of the key HIV prevention strategies. There were over 300 million condoms distributed in this reporting period.

Biomedical HIV prevention has been hinged on HCT services, PMTCT, SMC, PEP, PrEP and integration of sexual and reproductive services into HIV care. HIV testing has been scaled up with the launch of the new HIV testing services policy and implementation guidelines and programs like HIV self-testing and assisted partner notification are being piloted. There are 5000 HIV testing sites and these registered 31% increase in uptake of HCT services. PMTCT services have been scaled up to 4,000 health facilities and there are 72% of these facilities with an active FSG. Over 90% of mothers get tested at first ANC visit. Uganda has achieved 86% reduction in mother to child transmission of HIV. There has been an increase in uptake of SMC services with 43% of the men aged 15-49 currently circumcised. PrEP guidelines have been consolidated in the country's HIV prevention, care and treatment guidelines. Implementation is being piloted in facilities targeting key populations.

The cultural and religious institutions have played a key role in mitigating underlying socio-cultural drivers of HIV. The cultural institutions are using the different platforms to reach out to specific age groups in their kingdoms like the Buganda kingdom through *Ekisakaate* program reach out to adolescents, Tooro and Bunyoro kingdoms using *Ekyoto* to reach out to men and young boys, the Karamajong leaders using the kraal leaders to pass on HIV prevention messages, the Rwot in Lango reaching subjects through the clan leaders among others. Also religious leaders are using their platforms to preach on sexual and gender-based violence and its impact on HIV.

Care and Treatment

With the launch of the 'Test and Treat' guidelines, there has been an increase of people enrolled into HIV care and specifically on ART. There were 78% of people who tested HIV positive who were linked to care by June 2017. This has resulted into an increased number of people on ART from 898,197 in June 2016 to 1,028,909 in June 2017. The number of people living with HIV has been increasing but this could be explained by the increased access to HIV testing services and the number of people on treatment has greatly increased. There are 67% of children infected with HIV who have been enrolled on ART.

There has been an increase in service integration with TB and nutrition. There was 95% of HIV positive people assessed for TB and 6% were presumptive TB cases while 3.2% were put on anti-TB treatment. In line with that, 82% of TB patients were tested for HIV. Nutritional assessment is actively being done in the HIV clinic and the acutely malnourished persons are referred to the nutritional clinics. Nutrition counseling has been mainstreamed in HIV counseling and health education at the HIV clinics.

Viral load testing as well as CD4 have remained the main tests used in management of chronic care. The viral load testing services have been scaled up and there is coverage of 50% of services with 1462 health facilities in the 116 districts sending viral load samples through the hub mechanism. The viral load suppression is about 50%.

Social support and protection

Addressing stigma is important in HIV interventions because it affects the uptake of services. There have been four stigma index studies conducted among PLHIV in Karamoja region, adolescents and young adults living with HIV in Busoga region, among sex workers living with HIV and in Uganda Wildlife Authority (UWA). In all these studies, it was clear that self-stigma is still an issue where it was 25.7% in Karamoja, 24% in Busoga region, 38.5% among sex workers and 28.3% in UWA. The cultural institutions have been empowered to address issues of stigma and discrimination and the PLHIV networks have also ensured they have presence in 96.6% of the districts. Among the teachers there are 57 districts that have Teacher Anti-AIDS groups which address stigma in the profession and in the schools. There are 35 districts with interfaith groups that address issues of HIV stigma and discrimination, SGBV and access to services. The anti-stigma campaigns are on-going using different platforms among the different players in the sector.

The needs of PLHIV, OVC and other vulnerable groups have been mainstreamed in the different development programs. There are over 5000 OVC and 506,194 OVC households that have benefited from the Operation Wealth Creation program, PLHIV who have benefited from the SAGE program that is targeting older persons, the youth who have benefited from the youth livelihood program and women who have benefited from the women program. A total of 1,415,120 OVC have been reached with services ranging from educational support, economic empowerment, psychosocial support and basic care.

In bid to develop a lifecycle sensitive comprehensive package of social support and protection interventions for PLHIV and other vulnerable groups, the CSOs have taken it upon themselves to empower PLHIV with information, train community volunteers and gate keepers in legal issues that affect these people as well as reach them with economic enhancement programs.

There has been review of a number of legal and policy instruments including the National Action Plan for Women, Girls, Gender Equality and HIV, development of a Facilitator's Guide in training community champions and paralegals of Gender Based Violence (GBV) prevention and management and referral, the National Gender Based Violence Elimination Policy and the National Gender Based Violence Elimination Action Plan were approved at the beginning of this year among other policy documents.

Systems strengthening

UAC has strengthened the coordination of HIV&AIDS activities by ensuring all the TWGs are functional and keep track of the implementation of the NSP. Through the MGLSD, 10 out of the 17 gazetted Cultural Institutions to help them develop operational plans, M&E plans and resource mobilization plans. Also 98 out of the 116 districts have developed District HIV Strategic Plans and 50 of these have printed and launched their plans.

The fight against HIV was re-energized with the launch of the Presidential Fast-Track Initiative on ending AIDS on June 6 and the President of Uganda is steering this initiative. The campaign to ensure men are on board in the fight against HIV and access to the services, the Kabaka of Buganda is also spear-heading the "Male engagement campaign for Buganda Kingdom."

The partnership coordination at the national level has been strengthened and partnership committee meets every quarter. Also at district level the coordination of HIV activities has been revitalized with 112 districts having DAC structures and 50% of these meet every quarter while 56 districts meet twice a year. AMICAALL has supported 22 out of the 42 municipalities to have active MAC though only 20% of the town councils have AIDS committees.

Funding for HIV services has overshot the estimated cost according to the NSP by over 19 million USD. The proportion of funding by ADPs continued to grow (95%) compared to the GoU allocation. The funds from ADPs cut across the different thematic areas but funding from GoU was directed towards procurement of ARVs. The plans are underway to improve the domestic funding with the AIDS Trust Fund, the approval of the national HIV and AIDS resource mobilization strategy and the One Dollar Initiative through the private sector.

INDICATOR TABLES

HIV prevention

Outcomes	Indicators	Baseline	Target	Achievement 2016/17[1]
Increased adoption of safer sexual behaviors and reduction in risky behaviors	% of adult (15-49) who have had intercourse with more than one partner in the last 12 months	M=18.7%	14.2%	21%
		F=3%	2.28%	2.2%
	% of young women and men 15-24 who correctly identify ways of preventing sexual transmission of HIV and who rejects misconceptions about HIV transmission	Male 39.3%	70%	45%
		38.6%	70%	46%
	% of adults aged 15-49 who use a condom at last high risk sex	35%	75%	22%
	% of young women and men 15-24 years who have had sexual intercourse before 15 years	M=11.9%	7%	6.4% LQAS 2017
		F=13.1%	8%	
Coverage and utilization of biomedical HIV prevention interventions delivered as part of integrated health care services scaled up	% of males and females 15-49 years reporting consistent condom use at last high risk sex	M=	90%	M= 57%
		F=	85%	F= 37%
	% MARPS 15-49 reporting consistent condom use	SW	50%	65%[2]
		Uniformed services	50%	No studies done
		Fishermen	50%	
		MSM	50%	
		Truckers	50%	
	% of men and women who tested for HIV in the last 12 months	63%	80%	53.8% LQAS 2017
	% of MARPS who have received an HIV test and know their status	SW 49.2%	80%	There is no clear denomination because all what is captured is number who access the services
		Uniformed services TBD	80%	
	% of HIV+ pregnant women who received ART to reduce MTCT of HIV	75%	85%	86% MoH data
	% of exposed infants who have received ARV prophylaxis to reduce risk of MTCT of HIV	36.7%	80%	95%
	% of infants born to HIV+ women receiving a virological test within 2 months of birth	1st PCR =44% 2nd PCR=10%	1st PCR =75% 2nd PCR=70%	1st PCR = 52% 2nd PCR =31%
	% of males 15-49 who are circumcised	25%	80%	43%

[1] Data from UDHS 2016 unless indicated otherwise

[2] Data from a study Burden and characteristics of HIV infection among female sex workers in Kampala, Uganda – a respondent-driven sampling survey, Wolfgang Hladik et al *MC Public Health*BMC series – open, inclusive and trusted2017**17**:565

Outcomes	Indicators	Baseline	Target	Achievement 2016/17[1]
				UPHIA 2017
	% of donated blood unit in the country that have been adequately screening for HIV according to national or WHO standards in the past 12 months	100%	100%	100% UBTS annual report
	% women 15-49 who experience SGBV	27%	23%	13% UDHS 2016
	% of adults that believe that a woman is justified to refuse sex or demand condom use if she knows her husband has a STI	M=90% F=84%	M=95% F=90%	Complete UDHS report not out

Treatment, Care and support

Outcomes	Indicators	Baseline	Target	Achievement 2016/17
Increased access in pre-ART care to those eligible to 90% by 2020	Proportion of children enrolled in HIV care services	70%	80%	67%
Increased access to ART and sustained provision of chronic care for patients initiated on ART	% of adults and children with HIV known to be on treatment 12 months after initiation of ART	83%	90%	86.1%
	Proportion of MARPS with HIV maintained in on ART for 12 months by category	TBD	95%	Not captured
Improved quality of chronic HIV care and treatment	% of estimated HIV+ incident TB cases receiving both TB and HIV treatment	60%	70%	36.2%
	% of people with diagnosed HIV infection on Isoniazid Preventive therapy	TBD	80%	97%
Strengthened integration of HIV care and treatment within health care programs	Unmet FP need among PLHIV	34% (general population)	25%	41.2% among PLHIV compared to 28% UDHS 2016
	Proportion of estimated HIV+ incident TB cases that received treatment for both TB and HIV	60%	100%	92%
	Proportion of HIV positive acutely malnourished clients who received nutrition therapy	TBD	50%	Not captured

Social Support and Protection

Outcomes	Indicators	Target	Achievement 2016/17
Enhanced efforts to eliminate stigma and discrimination of PLHIV and other vulnerable groups	% of individuals (15-49) with accepting attitudes towards PLHIV	70%	19.1% (external stigma experienced by young people in East Central)
Scaled up mainstreaming of services meeting the needs of PLHIV. OVC and other vulnerable groups in development programs	% OVC households that are food secure	60%	37.2% (LQAS)[i3]
	% OVC having 3 basic needs net	70%	50% OVC MIS
A life cycle sensitive comprehensive package of social support and protection interventions for PLHIV and other vulnerable groups developed and implemented	% district with life cycle sensitive comprehensive package of social protection	100%	Indicator not clearly defined and should be made clear to enable easy tracking
	% vulnerable individuals receiving a life cycle comprehensive package of social protection	65%	
Engendered social support and protection programs addressing the unique needs, gender norms, legal and other structural challenges that make women, girls, men and boys vulnerable to HIV and AIDS	% married women participate in all 3 decisions pertaining to their own health care, major household purchases and visit to their family relatives	70%	UDHS complete report not read
	% men and women who believe that wife beating is justified for at least one of the specified reasons	20% (both men and women)	
	% of women who do not own land alone or jointly with spouses	40%	68%[4]

Systems Strengthening

Outcomes	Indicators		Target	Current performance
Strengthen the governance and leadership of the multi sectoral HIV and AIDs response at all levels	National commitments and policy instruments (NCPI) index score		95%	
Availability of human resources for delivery of quality HIV/AIDs services ensured	Percentage of health facilities with the required staffing levels		TBD	69%
The procurement and supply management system for timely delivery of medical and non-medical products, goods and services required in the delivery of HIV/AIDs	Percentage of health facilities with no stock outs of essential commodities of	STI drugs	TBD	
		HIV test kits	TBD	4.77%

[3] Source: **Community Surveys based on LQAS Methodology in Uganda MoLG, March 2017**

[4] Source: **Gender, Land and Asset survey by International Centre for Research on Women**

Outcomes	Indicators		Target	Current performance
services strengthened	STI drugs, HIV test kits and condoms for >1month within last 12 months	Condoms	TBD	
	Proportion of health facilities providing ART services with no drug stock outs of > 2months in last 12 months		TBD	9.26%
To strengthen the infrastructure for scaling up the delivery of quality HIV/AIDs services	Per cent of laboratories with capacity to perform clinical lab tests according to national standards		TBD	
	Proportion of health facilities offering ARV and eMTCT services.		TBD	
Resources mobilized and resource management streamlined for efficient utilization and accountability	Percentage of HIV and AIDs funding from GOU		Government 40% ADPs 60%	95%
	Percentage of districts with HIV and AIDs Costed strategic plans		100%	86%

INTRODUCTION AND BACKGROUND

1.1 Introduction

The Uganda HIV and AIDS country progress report July 2016 – June 2017 provides an opportunity for the country to assess the state of the national response and progress in achieving the national HIV targets as detailed in the NSP 2015/16 – 2019/20. The review is intended to focus and sharpen the national response to AIDS, guide scale up interventions in areas where a difference can be made in reaching the 2020 National HIV strategic Plan targets and the global 2030 targets.

Uganda has made tremendous progress in combating the HIV and AIDS epidemic with a decline in the prevalence from 18% in the early 1980s to 7.3% in 2011; and further decline to 6.0% according to the last AIDS Indicator Survey. This is the second progress report showing advancement in the implementation of the National HIV and AIDS Strategic Plan (NSP 2015/16 – 2019/20). During the period under review, there was a change in policy in HIV testing and enrolment into care; Uganda adopted the WHO guidelines on testing and treating where all individuals testing HIV positive are started on ART irrespective of their CD4 status clinical stage and age. A number of policy reviews were undertaken and improvement in the implementation guidelines in the HIV response are highlighted in the achievement sections in the report.

The HIV epidemic has remained a major hiccup in the development priorities of the country, given its effects on the different sectors. Uganda has made major progress in fighting HIV with positive results in the area of elimination of Mother to Child Transmission (eMTCT), enrolment of into care and treatment among others. That notwithstanding, Uganda like many countries in Sub Saharan Africa, has seen an emerging epidemic among the adolescents and the young adults. This brings about a major setback in the achievements made and calls for refocusing in the priority areas.

This report further provides an insight on how the country has performed in relation to the Sustainable Development Goals (SDG). It is an opportunity for taking stock of the achievements, track challenges, identify best practices and make recommendations for improvement. The 2017 Global AIDS Response Progress Report marks the first year of implementation of the development of the SDGs. There are 17 SDGs, and SDG 3 focuses on health. It emphasizes achievement of **"Good health and well-being",** under which there are nine (9) indicators. The third indicator commits to end the AIDS epidemic by 2030, in addition to ending tuberculosis, malaria and neglected tropical diseases as well as combating hepatitis, water-borne diseases and other communicable diseases.

The United Nations General Assembly of 2016 reaffirmed the commitment to end the AIDS epidemic by 2030. Similarly, at Country level, Uganda in June this year launched the Presidential Fast track Initiative to end AIDS as a Public Health Threat in Uganda by 2030. This is a legacy to present to future generations; to accelerate and scale up the fight against HIV, and end AIDS. The report provides assessment of the progress made towards achieving the strategic plan targets. It was done bearing in mind the Presidential Fast Track Initiative that was launched in June 2017. The report will inform the national reviews including the Global Fund new funding model, other development partners' models; and the regional reviews to establish consensus on respective findings and chat a way forward towards reaching the Fast Track targets and the SDGs. At global and regional level, the data is used for the preparation of the Global AIDS report that is disseminated during the World AIDS Day, the Global Health Report to be presented during the World Health Assembly; and the statistical reference update on children, adolescents and AIDS.

1.2 Background

The Uganda AIDS Commission (UAC) developed the National Strategic Plan 2015/16—2019/20 (NSP) to guide implementation of the multi-sectoral response and align key HIV and AIDS interventions to the key drivers of the epidemic and other key national development plans. The NSP was developed under four thematic areas of Prevention, Care & Treatment, Social Support & Protection and Systems Strengthening. Implementation of the NSP is multi- sectoral and at the different levels with most of the response taking place at the district level under the guidance of the Ministry of Health. Monitoring of implementation, policy guidance, resource mobilization and the global linkages happens at the national level. Uganda AIDs Commission coordinates the multi-sectoral response and the various sectors provide leadership in their areas of comparative advantage. For example, the Ministry of Health (MoH) leads the public health response through appropriate policy and technical guidelines, standards; and monitoring their implementation at subnational levels.

Multilateral and bilateral development partners support the Ministry of Health and other sectors with resources and technical assistance for implementation of HIV services across all regions and districts. These include PEPFAR and USG agencies, Global Fund, Irish Aid, UN agencies, and other ADPs including CHAI, BMGF among others. Periodic reviews of the NSP provide an opportunity to the country establish the progress of implementation and recast the interventions to ensure attainment of the set targets.

1.3 Objectives of Annual Joint AIDS Review

To enable the country review and account for HIV/AIDS performance based on the National HIV/AIDS Strategic Plan for FY 2016/17, form a basis for planning and monitoring of the national multi-sectoral response in the subsequent year 2017/18.

1.3.1 Specific objectives

i) To review and validate performance of the second year of the NSP (2015/16 – 2019/20) against the set targets in the National Priority Action Plan (NPAP) (2015/16 - 17/18) and document successes, challenges, lessons learnt and best practices
ii) Provide an update to stakeholders on the Presidential Fast track Initiative on Ending AIDS as a Public Health threat in Uganda by 2030 which will guide planning for FY 2018/19
iii) To disseminate progress in implementation of undertakings of the Aide Memoire, 2016.
iv) Agree on undertakings for implementation for FY 2017/18

METHODOLOGY

2.1 Report Writing Process

The annual joint AIDs review for 2017 was conducted as a fundamental part in effecting of the national HIV- strategic programming cycle. The process of developing this annual joint AIDs review was vastly participatory and consultative involving all key stakeholders and interest groups including PLHIV networks at National and district levels. The key stake holders included; Private Sector, Development Partners, Ministry of Health and other MDAs as well as Civil Society Organizations. This was with the view to ensure ownership and accountability. Uganda AIDs commission engaged Esteem International Consultants to lead the review process, working closely with the thematic technical working groups.

2.2 Review Approaches

The key review approaches relied mainly on active interaction and coordination with the key stakeholders in both data collection and analysis. A combination of methods was used to obtain primary and secondary qualitative 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 Presidential Fast Track Initiative (2017) and other secondary data from self-coordinating entities, technical briefings consultative/ consensus meetings and face- to face interviews.

2.2.1 Literature Review

This desk based review contributed the largest amount of data (about 70%) needed to respond to the objectives of the report. Key resource documents that were reviewed include; National HIV/AIDS Strategic Plan (2015/16-2019/20), National Priority Action Plan (2015/16 – 20117/18), National Monitoring and Evaluation Plan (2015/16 – 2019/20), the Presidential Fast Track Initiative plan (launched June 2017), and other related documents including the operational framework, monitoring framework, and proposal by civil society, country progress report 2015/16,consolidated and Thematic Mid Term Review reports on the National HIV/AIDS Strategic Plan (2011/12 - 2014/15) ,the Country Progress Report 2015 (formerly the UNGASS Report), the Uganda HIV and AIDS Investment Case 2014 –2025, the Modes of Transmission Study 2016, decentralized approach, reports from the different sectors and the Self Coordinating Entities (SCEs). There was review of the reports from the regional review meetings that were held across the country supported by Monitoring and Evaluation Technical Support (METS) an Implementing partner under PEPFAR.

2.2.2 Key Informant Interviews

In-depth interviews were conducted with key partners who were identified with help of UAC. These were both at national and regional level. These interviews mainly focused on in-depth understanding of the findings from the data that was abstracted during document review. These key informants were selected purposively to provide additional information to the findings. National and district level interviews were conducted to complement, validate and augment data obtained through the desk reviews. At national level, key informant interviews were conducted with individuals from key selected Ministries, Departments and Agencies (MDAs), development partners, and nationally represented civil society organizations (CSOs). To capture district level and sub-district status in the implementation of the NSP action plans, field visits covering four (4) selected districts from across the country were conducted. The districts of Luwero and Nakasongola were chose because no review meeting had been held in the districts throughout the reporting year while Nakapiripirit and Kotido were selected because the Karamoja region presents a unique situation with an emerging epidemic.

2.2.3 Data Abstraction

Data was abstracted from the online systems by MoH (DHIS2) and MoGLSD (OVC MIS). The data in DHIS 2 is entered at the district level on a monthly basis by the district Bio-statisticians. The DHIS 2 system was created to reduce incidences of double counting and enhance availability of data. The data once entered was validated on a quarterly basis by MoH with support from MEEPP and other Partners. The MEEPP offers support to the Ministry of Health and the different Implementing partners who hold grants in the respective regions to ensure data is entered and they go down to validate the data before the reporting period. All the Implementing Partners use this system for the Public Health response, whereas Social Protection is captured in the OVC MIS and the EMIS databases.

2.2.4 Selection of Respondents

The respondents in the in-depth interviews were purposively selected because of the positions they hold in their respective organizations or districts. These included executive directors in organizations, district Chief Administrative officers, District Health officers, chairperson parliamentary committee on HIV/AIDS and others who will be recommended by the client.

The participants in the review and validation meetings included leaders of self-coordinating entities, district officials, CSOs and others as recommended by the client-UAC.

2.3 Validation Meetings

2.3.1 Thematic Technical Working Group Meetings

The key stakeholders and partners reviewed the draft report to which they provided additional data, critiqued, verified, validated and reached consensus. This was done with an aim of validating the findings and also getting an interpretation of the findings from the key players. There were validation meetings with Technical Working Groups (TWG) across the thematic areas as well as the monitoring and evaluation TWG who provided input to the improvement of the report. The meetings were well attended as indicated in annex 2 of this report.

2.3.2 Meetings with UAC Leadership and Partnership Committee

The draft report was presented to the Top and Senior management of UAC and the Partnership committee of the AIDS response who made input to the report.

2.3.3 The Annual Joint AIDS Review (JAR) 2017

The draft report was presented to stakeholders at the JAR who further validated the report and made input into the final report.

ACHIEVEMENTS, CHALLENGES AND LESSONS LEARNT

3.1 Overview of the progress

Overall there was scale up of PMTCT services with >95% of mothers accessing PMTCT services and as a result there has been reduction in child infections and lowering the Mother-To-Child Transmission (MTCT) rate to below 5%. This implies that Uganda is on track towards elimination of Mother to child Transmission of HIV. There was intensified scale up of SMC services with an increase in coverage from 26% in 2011 to 43% by end of 2016.

There has been an increase in uptake of HIV Testing Services though there still gaps in linkage of those who test HIV positive for care and Treatment services. The positive trend in PMTCT with 86% coverage has a hiccup the lost to follow up of the mother-baby pairs with 57% at first PCR and 36% at second PCR. This means that only 32% of the HIV Exposed Infants complete the cascade.

Under the care, treatment and support, Uganda adopted and launched the WHO 2016 ART guidelines that have in part contributed to scale up of ART services. By end of June 2017 over 1 Million people were receiving ART giving coverage of 67%.

Under Social support government has taken lead through the Operation Wealth Creation (OWC) targeting OVC and vulnerable persons, Social Assistance Grants for Empowerment (SAGE) targeting the elderly and the Youth Livelihood Program (YLP) targeting the youth, this support is complimented by support from the CSOs.

Under systems strengthening there are 69% of public-sector positions are currently filled. 45% of the private sector has HIV work place policies and the HIV financing has been over and above the estimated cost with USD 651,661,433 in 2016/17 against the estimated cost of USD 632,600,000.

3.2 Uganda Population-Based HIV Impact Assessment Survey (UPHIA)

The preliminary results of 2016 UPHIA demonstrate that Uganda has made significant progress in the national HIV response. HIV prevalence has declined across socio-demographic sub groups and across the country. This decline may be a result of falling new HIV infections. Furthermore, almost 60% of people living with HIV (PLHIV) have Viral Load Suppression (VLS) which means that treatment programs are successfully reaching the majority of the population with HIV. In spite of the progress that has been made, the burden of HIV infection in the country is still unacceptably high. More prevention, awareness, and treatment activities are needed for those 15-29 years. These results call for concerted efforts from all stakeholders for scale up of evidence-based interventions for sustainable HIV epidemic control.

3.2.1 HIV Prevalence Among Adults Aged 15 – 49 Years by Survey Region

The results of the 2016 Uganda Population HIV Impact Assessment (UPHIA) indicate that 6% of adults aged 15-49 years in Uganda are living with HIV. Among children under age five, HIV prevalence is 0.5%, while among those aged 5 – 14 years, it is also 0.5%.

Adult HIV prevalence was higher among women at 7.5% compared to 4.3% among men. It was also higher among residents of urban areas (7.1%) compared to 5.5% in rural areas. The magnitude of HIV

varied considerably among the ten geographic regions in the survey, from a low of 2.8% in West-Nile to 7.7% in South Western region. This is similar to the findings of the 2011 Uganda AIDS Indicator Survey when Mid-Eastern showed the lowest, and Central 1 the highest estimated HIV prevalence. Among adults, HIV prevalence is lowest in those 15-19 years. It is highest among men aged 45 to 49, at 14.0%. Among women, HIV prevalence is highest in the age groups of 35 to 39 years and 45 to 49 years, at 12.9% and 12.8%, respectively.

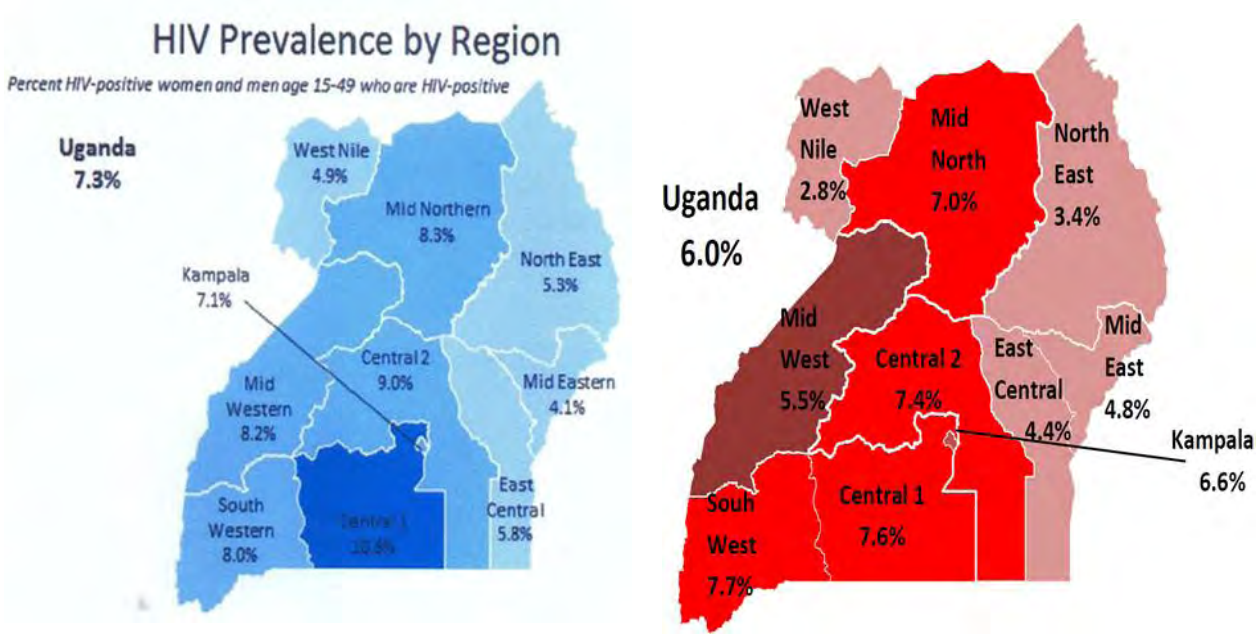


Figure 1 HIV prevalence according to the different regions 2011 and 2016

There has been tremendous achievemement in the reduction of HIV prevalence if you compare the prevalence in 2011 and in 2016. Overall there has been great reduction with the greatest achivement in the mid western region that reduced the prevalence from 8.2% to 5.5% with West Nile reducing by more than 2%. To note is the minimal reduction in south western region with less than 0.5% but Mid East calls for more efforts that whereas the country achieved an overall reduction there was increase of 0.7%.

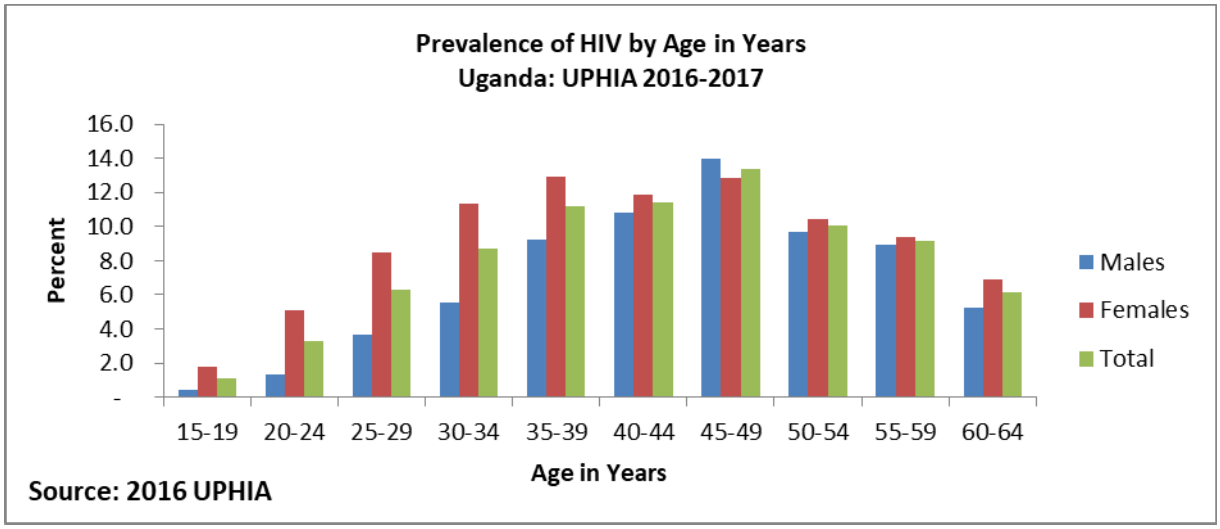


Figure 2 HIV prevalence by age in years

The 2011 Uganda AIDS Indicator Survey estimated national HIV prevalence among adults at 7.3 percent compared to 6.0 percent in 2016 UPHIA. Among women and men, HIV prevalence declined from 8.3% and 6.1% in 2011 to 7.5% and 4.3% in 2016 respectively. In urban areas, it declined from 8.7% to 7.1% while in rural areas it fell from 7.0% to 5.5%. These declines in HIV prevalence may be due to reduction of new infections in recent years due to the impact of the intensified HIV prevention and treatment services in the country.

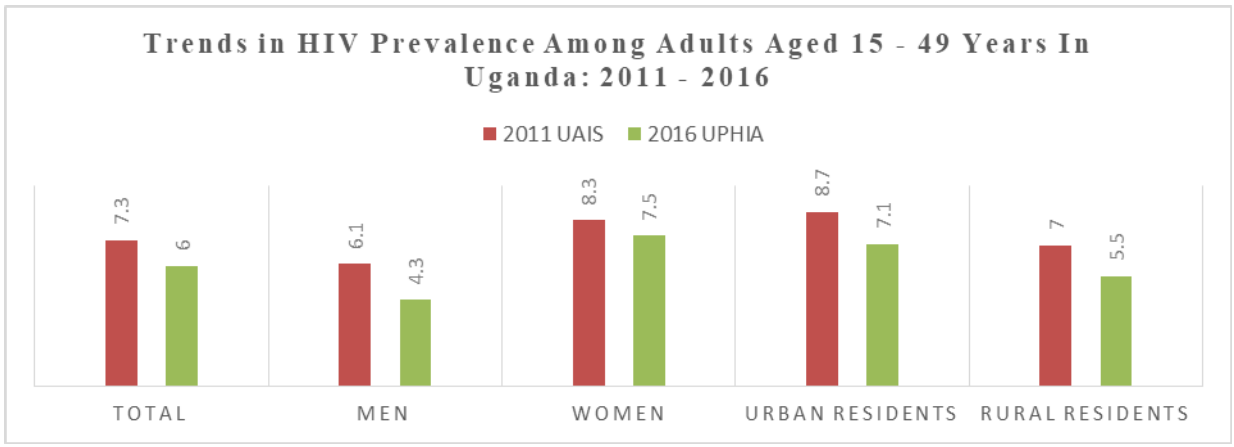


Figure 3 HIV prevalence among adult population comparing by gender and residence over the years – Source UPHIA

Data from UPHIA identified existing gaps in HIV programmes and specific populations that need special focus. HIV prevalence triples from those aged 15-19 years (1.1 % total, 1.8% in girls and 0.5% in boys) to those aged 20-24 years (3.3 % total, 5.1% in young women and 1.3% in young men), and then almost doubles again between 20-24 and 25-29 (6.3% total, 8.5% in women and 3.5% in men) suggesting new infections remain an issue in these age groups. This continuing infection risk necessitates innovative interventions to prevent new infections in young people beginning around age 20. Furthermore, women 15-24 and men under 35 years of age who are living with HIV have rates of

VLS <50%. These lower rates of VLS are driven by younger people being unaware of their HIV status and not accessing available services. Interventions are needed to ensure young people know their status and if HIV positive are linked to care.

3.3 Progress Towards the 90-90 -90 targets

Overall, there has been tremendous progress towards achieving the 90-90-90 targets as guided by UNAIDS. The target is that to ensure that by 2020; 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection receive sustained antiretroviral therapy and that 90% of all people receiving antiretroviral therapy have viral suppression. This has been code named 90-90-90 and Uganda has committed to.

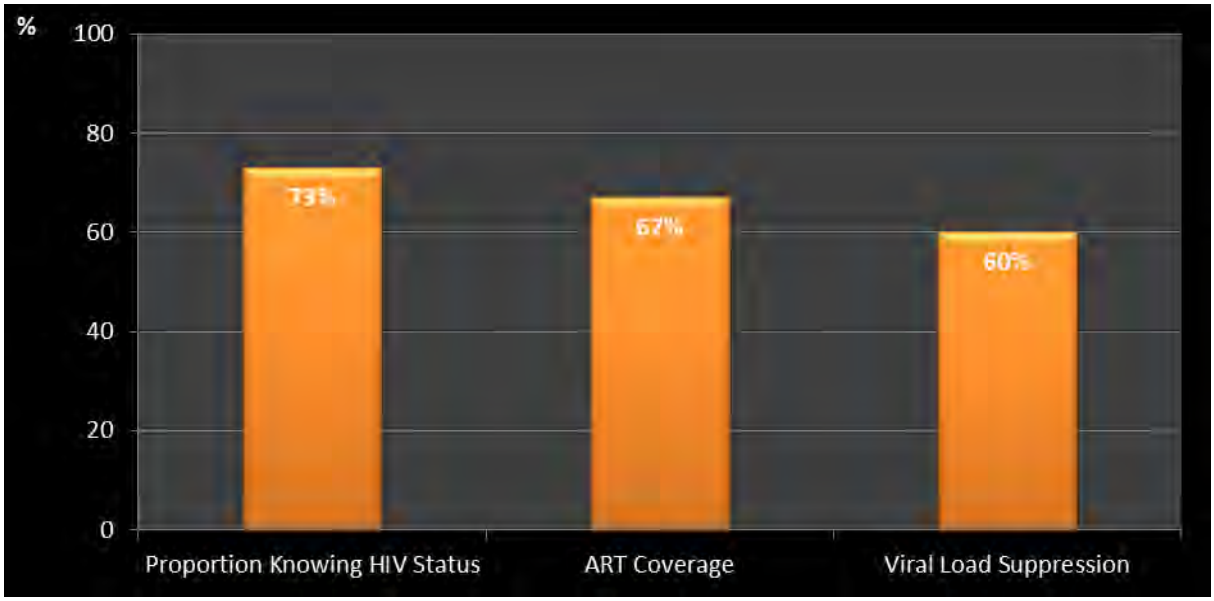


Figure 4 90-90-90 Cascade - data source DHIS2

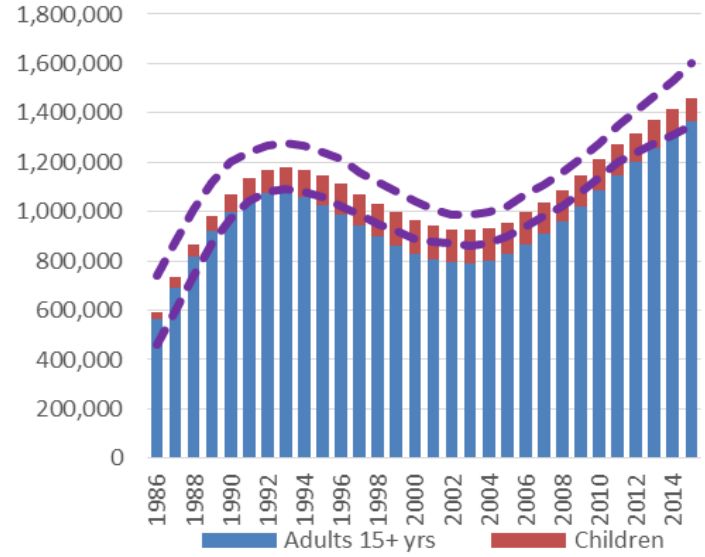
- First 90: Of the 1.3 million[5] HIV-infected people in the country, the first 90 targets by 2020 expect 90% i.e. 1.17 million HIV positive people to know their HIV status. However, based on the conservative estimate based on number of individuals currently in care (ART and Pre-ART), 73% definitively know their HIV status, falling well below target
- Second 90 Expects at least 81% of HIV-infected people to be enrolled on ART. By June 2017, we were still short of this target with 67% of HIV-infected people on treatment.
- Third 90 Is likely to be an underestimate because it is based on the number of tests that were found to have viral suppression. Individuals who might have had viral suppression but were not tested due to limited coverage of VL testing were not included. While the targets for this indicator would expect 73% of PLHIVs to have suppressed virus, and we have 60% which is still short of our target but on track.

For Children under 15 years, the performance against the triple 90% targets all fell below targets, although this is likely to be under- ascertained largely due to similar caveats on knowledge of status and limited coverage of VL tests. However, children still have far lower virus suppression rates than adults.

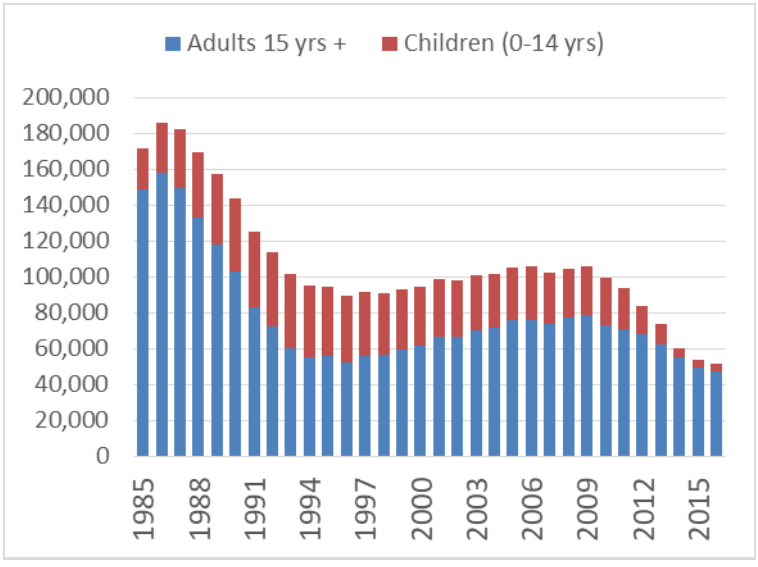
[5] UPHIA preliminary results 2017

The 2016 UPHIA also established the rates of suppressed HIV viral load (VLS) which is a marker of effective treatment. People living with HIV (PLHIV) with suppressed viral load live longer, have fewer complications due to HIV, and are less likely to transmit the virus to others. UPHIA showed that adults age 15-49 years had a VLS of 57.4%; this finding shows that with support from development partners, the National HIV response is having an impact and making great progress toward the UNAIDS and national goal of having population level VLS of at least 73% by 2020.

Figure 5 Trends in Number of PLHIV: Burden Still High



Picture 1 Number New HIV Infections have been falling since 2010



New HIV infections have fallen steadily since 2010 as indicated in figure 2; especially among children due to the efforts of the eMTCT program.

The target of 40% reduction new HIV infections under the HIV prevention strategy which HE the President Launched in 2011 was therefore met, however, young women continue to be more disproportionately affected compared to their male counterparts. AIDS-related mortality has steadily fallen since 2003, when the countrywide roll out of ART services commenced as shown in the figure 6.

Uganda is now committed to *Ending AIDS by 2030* in line with the UNAIDS Fast Track Strategy. However, sustainable HIV epidemic control will require:

- Scaling up critical interventions to meet the ambitious national targets
- Improved retention and linkage strategies
- Concerted efforts of a well guided and coordinated response to make sure "No one is left Behind"
- Innovative strategies for pockets of high transmission involving men, Adolescent Girls and Young Women (AGYW) and Key Populations (KP)
- A national and district-led programme supported by all partners

3.4 Prevention- Achievements, Lessons Learnt and Key Gaps

The Goal of HIV prevention is to reduce the number of new youth and adult infections by 70% and the number of new pediatric HIV infections by 95% by 2020. Through implementation of the combination prevention strategies that focus on adoption of safer sexual behaviors, scaling up bio medical interventions and HCT as well as addressing the underlying social-cultural drivers of the epidemic. The activities carried out to achieve the objectives include Behavior Change Communication (BCC), HIV Testing and Counseling (HTC), Prevention of Mother To Child HIV Transmission (PMTCT), Safe Male Circumcision (SMC), condom promotion and provision, activities for key population. HIV prevention aims at:

1. Reducing the number of new HIV infections
2. Increased coverage and utilization of prevention services
3. Increased adoption of safer sexual behaviour and reduction of risky behaviours

Table 1 Comparison of achievements against NSP targets – source MoH data

Performance indicator	Indicator source	Baseline (2013)	Achieved 2016/17	Targets 2019/2020	Comment
HIV incidence	CPR	Total: 139,089 Adults: 123,803 Children:15,283	Total: 51,771 Adults: 47,469 Children: 4,583	Total: 110,814 Adults: 102,221 Children: 8,593	The country has made great strides that the target was surpassed.
HIV/AIDS related mortality	CPR	63,018	28,495	25,310	
Percentage of infants born to HIV infected mothers who become infected	CPR	6 weeks; 5.7% After breastfeeding: 13.6%	6 weeks; 1% After breastfeeding: 5.27%	6 weeks; 1.9% After breastfeeding: <5%	The country is on target after breastfeeding though has surpassed target at 6 weeks.
HIV prevalence rate among 15-49	CPR	Total: 7.3% Male: 6.1% Female: 8.3%	Total 6.0% Male: 4.3% Females: 7.5%	Total: 7.8% Male: 6.5% Female: 8.9%	The country has made great strides that the target was surpassed

There has been tremendous progress in achieving targets set in the NPAP as shown in the table above targets on incidence were surpassed by over 50% and this achievement cuts across the different age categories. With regard to HIV related mortality, country surpassed the target and given that this is the

second year of implementation the achievement may be over 150%. The eMTCT targets have also been met for HIV transmission at 6 weeks being 1% (target was 1.9%) and while after breastfeeding is 5.27% (target was < 5%).

3.4.1 Achievements

There have been several achievements under the prevention thematic area.

- 1188 teachers trained on PIASCY which is a BCC program in primary and secondary schools
- MoH has been able to disseminate guidelines for mitigation and prevention of teenage pregnancy and HIV in school setting
- There active post-test clubs in the communities
- Community dialogues conducted in the community
- 10,756,247 including PMTCT mothers HIV tests conducted of whom 37% first time testers and 31% tested as couples. HIV positivity rate 3%
- HTS linkage to care out of 256,529 HIV positive 220,431 (78%) linked to care
- 44 districts (37%) achieved the recommended ≥90% link to care
- New districts doing very well in linkage to care
- The cultural institutions are using different avenues to ensure that all people get the HIV information
- 3241 facilities with PMTCT services
- 95% mothers testing in ANC and 31% male partner testing
- 1% MTCT transmission at 6 weeks
- 72% of facilities have active FSG
- PrEP Guidelines completed and data collection tools in development

Objective 1: Adoption of safer sexual behaviors and reduction in risky sexual behaviors

Uganda has sustained a generalized epidemic with adult prevalence increasing from 6.4% in 2005 to 7.3% in 2011 and down to 6% in 2016. Under this objective the strategic actions focus on behavior change communication, condom programming mapping of key populations and scaling up interventions targeting MARPs and SRH programs targeting adolescents.

Behavioral Change Communication (BCC)

Behavior change communication activities are aimed at scaling-up age- and audience-appropriate social and behavioral change interventions including abstinence (A) and being faithful (B) to reach all population groups with targeted HIV prevention messages. There has been use of different platforms like print and electronic media as well as community dialogues to pass on messages.

During period under review, MOH and UAC continued to work with the "***Obulamu***" campaign with the support of USAID to produce and disseminate various IEC materials and messages through print, radio, TV, bill boards and client materials. The messages were in various areas including HIV testing with special focus on men, initiation on ART and adherence for all who test positive and especially pregnant women, infant and young child feeding with emphasis on exclusive breastfeeding for the first 6 months, condom use and abstinence and being faithful, safe male circumcision.

- The Uganda Peoples Defense Forces continued to utilize vans to sensitize troops and commander HIV talking points which were launched by the Chief of Defense Forces in June 2016.

- The Civil Society Organizations through the community engagements and community dialogues reached more than 2.5 million people with SRH/HIV messages. In a bid to increase Adoption of

Safer Sexual Behaviors and Reduction in Risky Behavior, UGANET reached 6000 people with messages/skills on safe sexual practices. Using SASA Model on safe sexual practices 6,711 people (4011 females and 2700 males) were equipped with skills on how to build and sustain safe relationships. However, there is need for more initiative to engage men however there is limited availability of Men friendly services at health facilities.

- In order to expand provision of life skills to peers, AMICAALL trained and equipped 140 Peer Educators and facilitated them to conduct peer education and community mobilization for HIV/AIDS services. The 140 Peer educators trained reached out to 40,320 Key Populations, Young people & adolescents with HIV/AIDS messages.
- The MARPs network conducted 89 trainings for sex workers in 13 districts. There were 109 (55%) Peer Leaders which were also provided with data collection tools and monthly financial facilitation to report on KP indicators at community level. Peer leaders also enabled community linkage to health services. During all this, Peer leaders provide peer to peer interpersonal health services including BCC, condoms, lubricants and referrals
- The JUPSA supported the Ministry of Education and Sports to communicate HIV prevention messages through sports and games. This enhanced the participation and involvement of young people through peer-to-peer communication and information.

Adolescent girls and young women

One of the major strategic actions of the NPAP is to scale-up comprehensive sexual and reproductive health (SRH)/HIV programs targeting, adolescents (both in and out of school) and Young People. Adolescent girls and young girls continue to be at high risk of HIV infection.

With the 1,300,000 people living with HIV/AIDS in Uganda and approximately 52,000 new infections in 2016 (UNAIDS, 2017), the adolescent girls and young women are disproportionately affected. Evidence shows that most new HIV infections are occurring among you people 17-24 years and especially among young girls. There were 4,500 new HIV infections among adults aged 15 years and older and of these, 22% were adolescents and young women aged 15-24 years (UNAIDS, 2017).

UNICEF conducted the ALL-IN assessment for adolescents to identify gaps in adolescent programming and the results revealed that female adolescents had higher HIV infection while male adolescents had poor utilization of services. The report also indicated that psychosocial support services were key for adolescent programming however many health workers and health facilities do not have the capacity to offer these services. This led to the development of the psychosocial training curricula to support children and adolescent.

The JUPSA priorities focus on young people specifically young girls 10-19 years, young people 15-24 couples and MARPs in its HIV prevention interventions. More efforts were put into reduction of Sexual and Gender Based Violence, support to GBV community level response mechanisms including efforts aimed at reduction of Mother to Child Transmission of HIV through working with cultural and religious leaders. The JUPSA has been able to sustain support to the Ministry of Education and Sports to integrate sexuality education into the lower secondary education curriculum with a specific focus on development of a National Framework on Sexuality Education for In-School Young People. This was intended to address the paralysis on Community Sexuality Education and provide commonly agreed guidance on the country-accepted sexuality education.

The PEPFAR under its implementing partners have implemented activities for adolescent and young women under the DREAMS initiative in 10 districts. **DREAMS** stands for Determined, Resilient,

Empowered AIDS free Mentored and Safe. This program targets Adolescent Girls and Young Women (AGYW). DREAMS program is implemented in Mubende, Mityana, Gomba, Bukomansimbi, Sembabule, Rakai, Mukono, Oyam, Gulu, and Lira districts. The core interventions include risk reduction counseling, HTS, violence prevention and post violence care including PEP, condom distribution, increase consistent use and availability (female & male) + increasing contraceptive method mix, PREP, Community mobilization, Social economic empowerment and cross generation sex diagnosis and linkage to care. DREAMS has a goal to reduce HIV incidence among this age group by 25% in year one and 40% in year two. To-date the program has enrolled Enrolled 126,524 AGYW (93% of its target) of whom 12 AGYW have sero-converted. There have been 755 HIV positive AGYW who were identified and linked to care.

Table 2 DREAMS performance against set targets for the different interventions:

District	Transactional Sex (Engaged)		Pregnant		Married		Given Birth		In School		ALL	
	Target/Achievement		Target/Achievement		Target/Achievement		Target/Achievement		Target/Achievement		Target/	% achieved
Bukomansimbi	160	260%	810	38%	416	68	1,221	95%	879	215%	3,486	116%
Gomba	429	119%	810	60%	416	102	3,146	46%	2,057	258%	6,858	119%
Gulu			1,158	57%	557	476	4,521	58%	3,129	60%	9,365	83%
Lira			2,184	38%	1,177	254	10,095	24%	6,722	15%	20,178	36%
Mityana	827	93%	1,390	170%					4,071	166%	6,288	157%
Mubende	2,250	52%	3,847	108%					10,344	68%	16,441	78%
Mukono	3,221	191%	2,909	185%					11,772	31%	17,902	85%
Oyam			2,496	28%	1,215	223	10,424	20%	6,936	40%	21,071	40%
Rakai	970	72%	1,865	240%	1,037	125	7,874	38%	5,127	278%	16,873	141%
Sembabule	5,351	27%	1,607	49%	766	77	6,556	30%	2,668	93%	16,948	43%
Total	13,208	85%	19,076	106%	5,584	137 %	43,837	44%	53,705	131%	136,410	93%

Condom programming

The NPAP calls for procurement and distribution of adequate numbers of female and male condoms as well as expanding distribution across all settings, and scaling up condom education emphasizing correct and consistent use.

With support from United Nations Population Fund (UNFPA), Ministry of Health in collaboration with Uganda Health Marketing Group (UHMG) coordinate several partners in implementing the condom distribution program in the country aimed at increasing accessibility of condoms to the populations with the most need. All these efforts are undertaken in line with the National Condom Programming Strategy and Implementation Plan for Uganda (2013-2015 & 2017-2021) and aimed at realizing the Reproductive Health Commodity Security (RHCS) in Uganda. During this year the comprehensive condom programming strategy (TMA) was finalized clearly setting out procurement strategies to ensure no stock outs as well as strategies to distribute and report condom use. The strategy has been operationalized to strengthen coordination, leadership, demand generation and distribution, while ensuring growth of the current Total Market. The strategy is aimed at increasing demand for male and female condoms, improving access to and utilization, strengthening the condom supply chain management, monitoring and evaluation.

Different NGOs and MDAs have ensured that there are condom dispensers at their offices and the communities in their catchment areas.

20% free condoms run through NMS to public health facilities and to MoH supported community outreaches (VHT). 80% free distributed through the Alternative Distribution Mechanism supported by UHMG.

Challenges in the distribution mechanisms include:

- Little to no coordination of ADM free at national level to district & community.
- Over 160 NGOS pick & distribute where they see fit; however they do not report back.
- Push based system ensures that public facilities plagued by over/under stock, dispensers often stocked out. Little or no report back to National Medical Stores on inventory levels.
- There is poor quantification, coordination, planning, & monitoring at district level
- There is little to no segmentation driven by need /ability to pay – a shotgun approach to distribution leading to ad hoc supply, SM brands next to free, etc.

The Ministry of Health (MoH) through the Health/HIV Unit with support from Uganda Cares received 500 cartons of condoms boxes; these condoms were distributed to the Ministry headquarters and affiliated institutions like National Curriculum Development Centre, Uganda National Examination Board and Directorate Education Standards, and placed in the condom dispensers. These condoms are intended for teachers, head teachers; Ministry headquarters Staff as part of the strategy towards the prevention and mitigation of the spread of HIV in Education Sector.

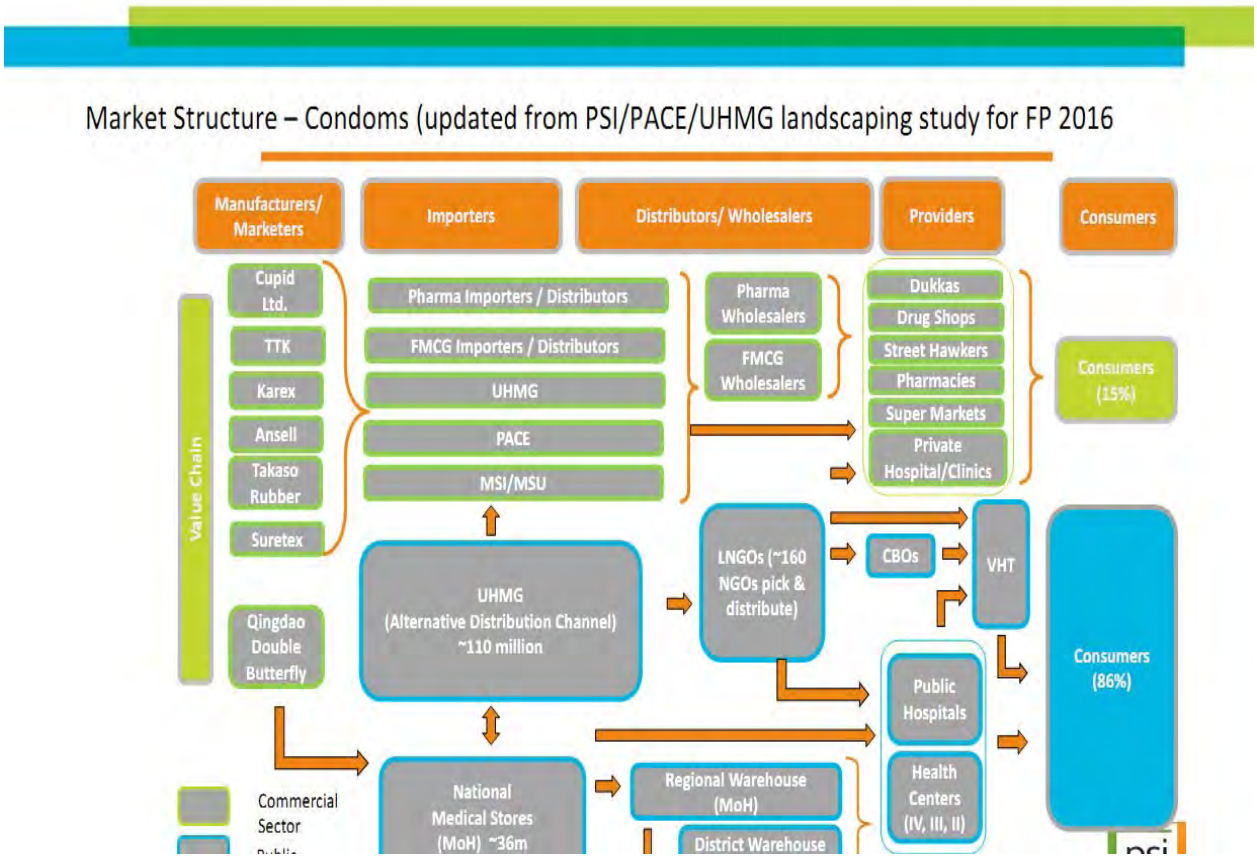


Figure 6 Condoms Market structure

Table 3 Condom procurements trends 2011-2016

Year	2011		2012		2013		2014		2015		2016	
Condoms procured by	UNFPA	Others	UNFPA	Others	UNFPA	Others	UNFPA	Others	UNFPA	Others	UNFPA	Others
Male	56,671,200	25,448,400	36,288,000	51,126,536	129,592,800	81,962,988	88,615,296	88,990,632	22,800,096	66,470,000		**302,415,120**
Female	1,607,000	0	0	0	5,400,000	0	2,454,000		2,046,000		1,200,000	
Total	58,278,200	25,448,400	36,288,000	51,126,536	134,992,800	81,962,988	91,069,296	88,990,632	24,846,096	66,470,000	1,200,000	302,415,120

To contribute towards prevention services, different CSOs conduct activities under condom programming with special focus on young people. The CSOs like AMICAALL distributed 108,160 males and 2,000 female condoms, trained 160 young people on sexuality and life skills, sensitized through drama on HIV and AIDS, 4,501 young people, sensitized 3,181 young people on SRH, trained 140 peer educators and through the distribution of 6000 IEC materials (T-shirts, banners, flyers, posters, caps, umbrellas, stickers, bags) on HIV and AIDS prevention messages and tested 5,400 people.

The MARPs network distributed condoms to Key Populations using a two pronged approach: Facility and outreach-based HIV testing where they reached 6,100 sex workers in 12 high priority districts, reached 1571 men who have sex with men in 11 high priority districts with HIV services

Current Logistics Management Information System in 7 pilot districts have been instituted in the districts of Hoima, Kabarole, Wakiso, Kampala, Gulu, Mbale, & Mbarara.

Demand creation for both male and female (KPs) condoms has been scaled up and revitalized however, there is a need to print more copies of the condom promotion manual for distribution, conduct studies to the reason for low uptake and improve on data to improve condom programing

Objective 2: Scale up coverage and utilization of biomedical interventions delivered as part of integrated health care services

Integration of HIV care services with other general health services has been one of the proven strategies to attaining optimal use by target populations. These interventions include HIV testing services, PMTCT, Safe Male Circumcision, as well as new prevention technologies –PrEP and PEP. Integration of HIV care services with other general health services is one of the proven strategies to attaining optimal use by target populations. Integration means the provision of HIV prevention services with other health services either at a single point of access or by using referrals within a single health district. Early initiation of antiretroviral drugs for prophylaxis during pregnancy, use during the breastfeeding period and use of a triple regimen for PMTCT for eligible pregnant women living with HIV reduces the chances of MTCT. The HTS and SMC are essential components of the minimum HIV prevention services package that need to be prioritized.

HIV Testing Services

During the period under review, HIV testing and Services guidelines were revised with key areas being review of the HIV testing algorithm replacing Uni Gold with SD Bioline as a tie breaker. There is emphasis on the 5Cs i.e. **Consent** where age of consent was reduced to 12 years, ensure **Confidentiality** when offering HTS services; **Counseling** as an integral part of HTS services; giving of **Correct** HIV test results and **Connection**/linkage for all those testing HIV positive within at least 4 weeks of testing as well as testing for verification for all those testing HIV positive before initiation of ART. The HTS policy and Implementation Guidelines 2016 were launched in January 2017 and later disseminated to the regions. These guidelines have been rolled out to over 50% of HTS implementing facilities.

There have been efforts to improve quality of HTS services with scale up and implementation of external quality assurance, as well as increase yield by implementing targeted testing to ensure services are provided to key populations through the differentiated testing approaches.

The program also implemented innovative approaches to increase coverage of testing including:

- HIV self-testing; This is being piloted in a few districts by partners
- Assisted Partner notification; This has been piloted in Kiboga and Rakai, where index clients are asked for partner contacts, the partners then get notified about the need for testing

These projects are in their final stages and dissemination of the findings will be done at an appropriate time. These findings will inform policy, programming and roll out.

Presently there are 5000 sites are providing HTS currently including all hospitals, HCIVs, HCIIIS, and about 30% of HCIIs. Of those tested this reporting period 3% tested HIV positive among general population and 1% for children <15 (DHIS2 2016). PITC remains main stay for HTS- Integrated in all health services. There were 10,756,247 HIV tests conducted in FY2016/17. First time testers accounted for 39.7% of the total number of HIV tests this reporting period. 5.9% of the people who tested for HIV were tested and counseled as a couple. 31% of the couples that were tested came from the northern region. The overall positivity rate across all regions was at 3.0%. Central region had the highest yield across all age groups of 3.4**%.**

Prevention of Mother To Child Transmission of HIV

Prevention of Mother To Child HIV Transmission program has grown over the years, scaling up from 5 facilities in 2,000 to 846 in 2010 to currently 3,242 facilities. Programming at both facility and community level has been strengthened. This has been through continued capacity building for health workers, formation of family support groups and scaling up of mentor mothers' support across facilities. An assessment of FSGs showed that over 72% of facilities had an active FSG.

Uganda achieved 86% reduction in MTCT by 2015, reduced transmission of HIV from mother to child from 25,000 babies in 2009 to 3400 in 2015 to 4000 in 2016.

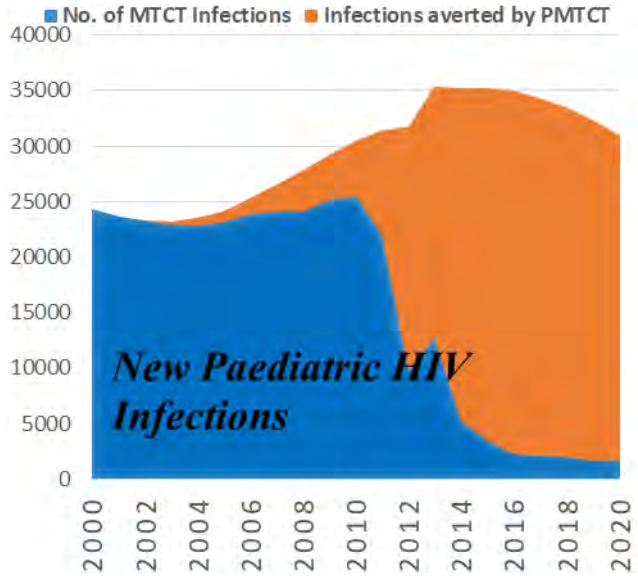


Figure 7 Trends of new Paediatric HIV infections

Uganda is one of the countries on track to eliminate MTCT-, having achieved over 90% ART provision for mothers for the last 2 years with over 95% testing in ANC and 1% transmission at 6 weeks from estimates. The districts with high positivity amongst PMTCT mothers are Kalangala (7.7%), Masaka (4.8%), Mityana (4.7%), Mukono (4.6%), Lira, Mbarara and Lwengo at 4.4%, Wakiso (4.3%), Busia (4.2%) and Lyantonde at (4.1%)

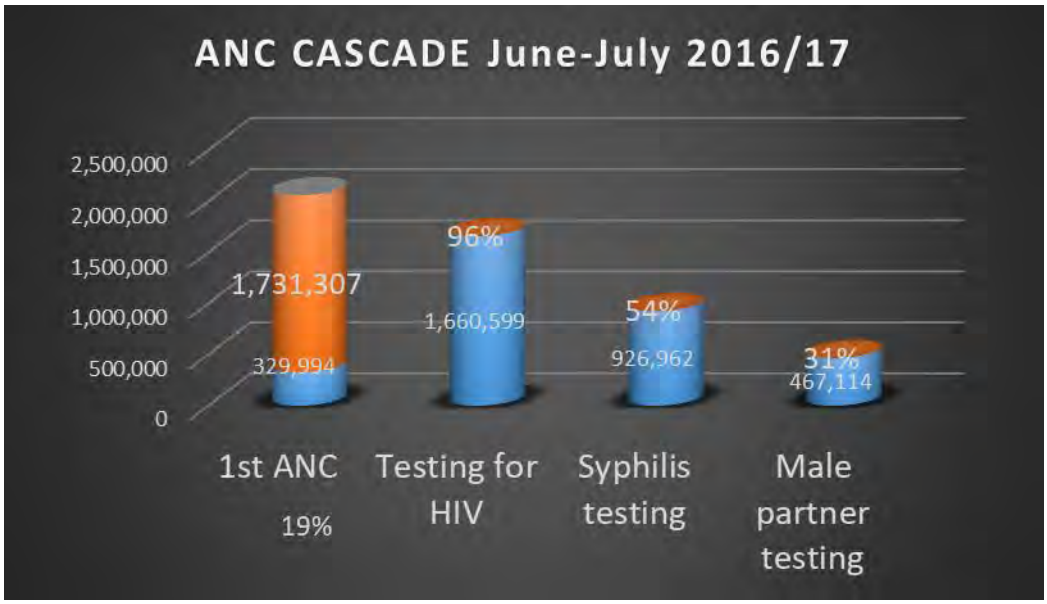
District performance: There are still districts performing poorly across the critical indicators including ART initiation, EID coverage and positivity among tested infants. Districts such as Adjumani, Amuru, Budaka, Bududa, Bukwo, Bulambuli, Dokolo, Kaboong, Pallisa, Manafwa have ART initiation of less than 75%. While Abim, Adjumani, Agago, Budaka, Bukwo, Busia, Butaleja, Bulambuli, Kaboong, Kween, Pallisa, Luweero, Otuke, Sironko have EID coverage of below 50% (DHIS 2/ EID dashboard 2016/17) see Annex 3.

Coordination: During this year, the program continued to consolidate the gains over the years through supporting implementing partners and districts to conduct quarterly performance review meetings and giving special attention to districts and regions performing poorly for supervision, mentorship and data quality assessments. The national advisory committee also decided on application for Certification on

the Path to Elimination for recognition of the country's achievement in the area of eMTCT. The program has strengthened implementation of all the four prongs of PMTCT;

- Prong 1; Primary prevention; strengthened RH/HIV integration, with emphasis on testing and re-testing for the negative later in pregnancy and during breastfeeding period
- Prong 2: FP and HIV; strengthened provision of family planning services within the ART clinic and MBCP. This area however still remains a challenge. A study done by MOH and school of public health showed the unmet need for family planning of 41.2% among HIV positive far above that of the general population (28% UDHS 2016)
- Prong 3: Strengthened the Mother-baby care point (MBCP) implementation across the country and scaled up viral load monitoring within the mother-baby care point. An assessment of MBCP done in 84 facilities across the country showed that health education, counselling, ART refills and viral load were offered at 90% of MBCP assessed.
- Prong 4: Strengthened family support group across the country. An assessment of FSG implementation showed that 72% of facilities had an active FSG while 15 facilities (28%) did not. It also showed that women enrolled in FSG were more likely to be retained in care at 24 months compared to their counterparts who were not enrolled in FSG (OR= 2.49, P=0.002) and their infants are more likely to have a second PCR done compared to the HEI whose mothers did not enrol in FSG (OR=3.01, P=0.00). Similarly, they were more likely to have a rapid test done (OR=4.17, P=0.00) and discharged HIV negative (OR=2.23, OR=0.00).

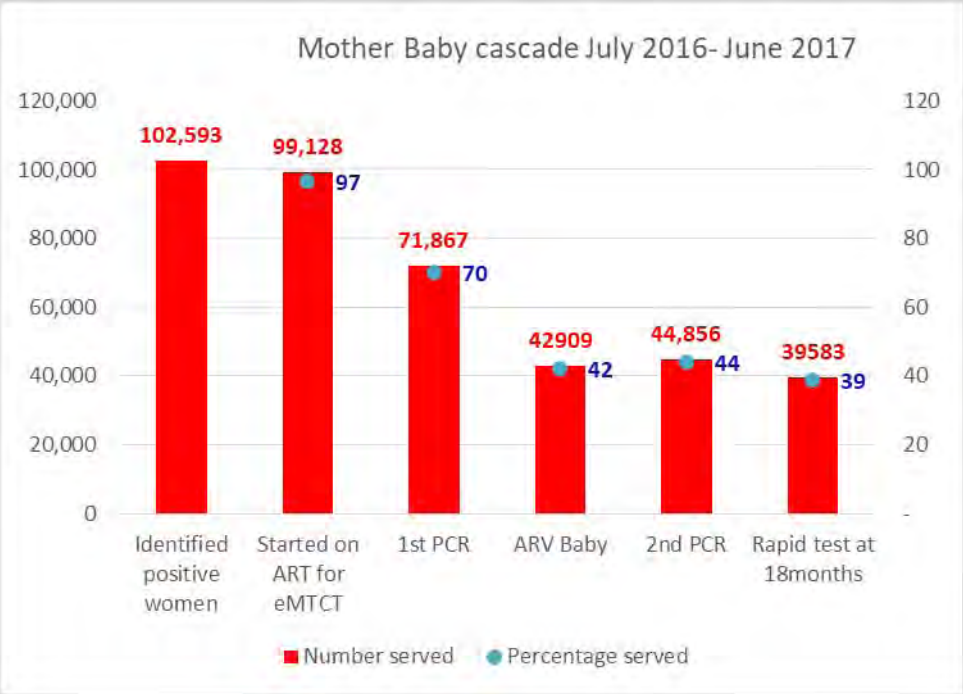
Early infant diagnosis services were scale up from 1959 health facilities in 2015/16 to 2052 health facilities in 2016/17, while positivity among infants reduced to 3.1%.



Picture 2 ANC cascade - Source DHIS2

However, HIV exposed infants services are poor with only 52% of HEI accessing 1st test at 6weeks and only 32% accessing a rapid test at 18 months of age as shown below.

Out of the 102,593 mothers identified as HIV positive in this reporting period, 99,128 (97%) were started on ART for eMTCT, only 71,867 (70%) of the Exposed Infants had their 1st DNA test (and this number continues dropping up to the last DNA test where only 39% of the HIV Exposed Infants completed the HEI care cascade by having the Rapid test at 18 months and this is a proxy indicator for retention in Care.



Picture 3: Mother-Infant cascade – Source DHIS2

With support from Global Fund, Mama's club, a local NGO was able to implement the following activities: refer over 4,510 mothers for EMTCT services; establish 125 FSGs and over 9,776 mother baby pairs enrolled to the EMTCT program. Mamas Club Uganda also conducted Capacity building: Over 595 Health Workers were been trained/ orientated on EMTCT and other HIV/AIDS prevention strategies including sustainability of FSGs; and over 475 peers were mentored and trained on EMTCT, community mobilisation and the FSG concept among other areas.

Safe Male Circumcision

Male circumcision is one of the components of the HIV prevention package in Uganda. The proportion of men in Uganda age 15-49 years that are circumcised has increased from 26% in 2011 to 43% in this survey (UPHIA 2016). The proportion of men circumcised ranges from 14% in Mid Northern region to 69% in Mid-Eastern region. The prevalence of male circumcision was highest among young people 15 – 29 years at over 45%.

There has been gradual improvement in SMC coverage though it is still short of target. There has continued scale up and consolidating service provision at both static and outreach sites though institutionalizing SMC at static sites and mobilization of the target population to access services. Guidelines for tetanus toxoid provision were finalized and disseminated to all districts streamlining TT immunization in SMC. There has also been better management of the needed supplies for SMC including SMC kits, TT doses and anesthetics with support from all partners.

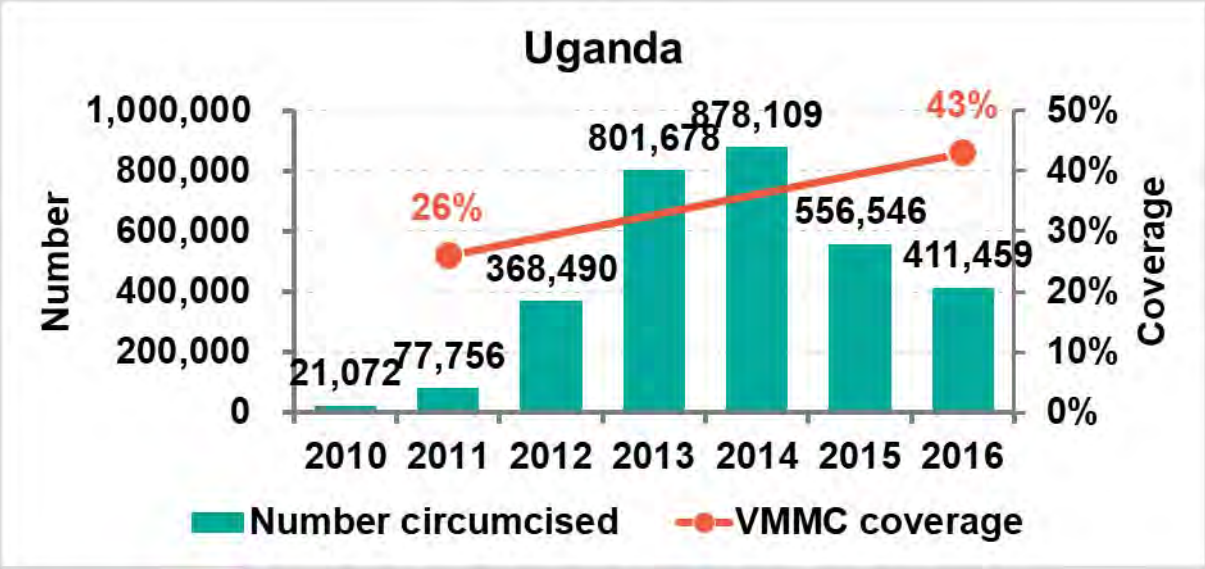


Figure 8 Annual number of males circumcised, and VMMC coverage in Uganda, 2010 - 2016

National coordination has strengthened through quarterly technical working groups. Mentorship and supervision to districts has improved on reporting of adverse events, strengthening follow up of those circumcised. 662,904 men were circumcised during the FY2016/17, 3,891 (0.6%) were reported to have had adverse event after circumcision and managed appropriately. There was a drop in 2015 where there were about 300,000 men circumcised which could be due to the policy that time but with the policy change there has been an upward trend again in uptake of the services.

Magnitude of syphilis and hepatitis B infection

The UPHIA also established the magnitude of syphilis and hepatitis B infection in the general population. The prevalence of active syphilis among adults aged 15 – 49 years was 1.9% (2% among women, and 1.8% among men). This was similar to the findings in 2011 in which the prevalence of syphilis was 1.8%. The prevalence of active hepatitis B infection among adults was 4.3% (5.6% among men and 3.1% among women). Hepatitis B prevalence was highest in the Northern Region: Mid North (4.6%), followed by North East (4.4%), and West Nile (3.8%). Hepatitis B infection was lower in the rest of the country with a range of 0.8% in the South West region to 2.7% in East Central Region.

Pre Exposure Prophylaxis (PrEP)

Pre Exposure Prophylaxis is approved by the FDA and has been shown to be safe and effective. A single pill taken once daily is highly effective against HIV when taken every day. The medication interferes with HIV's ability to copy itself in your body after you've been exposed. This prevents it from establishing an infection and making you sick. In Uganda PrEP is not going to be offered to the general population but the high risk groups among the MARPS.

The PrEP guidelines have been included in the Uganda consolidated prevention, care and treatment guidelines. This process was concluded in December 2016. Operational PrEP the technical guidelines have been developed. Although PrEP implementation is not scaled up country wide, it has been initiated in a few facilities mainly targeting areas with key populations. These include: Kasensero HC II in Rakai, MARPI Clinic in Mulago, Rubaale HC IV St. Francisca Rushooka HCII, Kamuganguzi HC III and Kamukira HC IV, in Kabale, Mukono HC IV and Kojja HC IV in Mukono, Mbarara Regional Referral hospital and Mbarara Municipal council HC IV in Mbarara, Namatala HC IV in Mbale, Kibiito HC IV

and Kagote in Fortportal, Layibi technical HC III and Awach HC IV in Gulu and Lyantonde Hospital in Lyantonde district.

The Current drug of choice for PrEP is TDF-3TC, and mechanisms to ensure its distribution have been discussed and agreed on through a parallel mechanism so as not to affect the ART supply chain mechanisms. A task force to ensure coordination and close mentorship has been formed. Mechanisms to ensure that HIV testing, serum creatinine as well as Hepatitis B testing are integrated in PrEP implementation have been ensured. Health workers at the selected sites have been given orientation in PrEP service delivery by ICAP with support from ACP/ PEPFAR. The training curriculum for Health care workers on PrEP service delivery is being adapted by the PrEP TWG with support from Walter Reed. PrEP tools adaptation is on-going.

Sexual and Reproductive Health/HIV integration:

The NPAP spells out scale-up of comprehensive sexual and reproductive health (SRH)/HIV programs especially targeting adolescent and young women. The intrinsic connections between HIV and SRH are well established especially as HIV is predominantly sexually transmitted or associated with pregnancy, childbirth and breastfeeding. Guidelines for integration of SRH and HIV have been developed and both SRH (2016) and Comprehensive HIV guidelines (2016) call for strengthened SRH and HIV integration. To strengthen integration RH services including Family planning services are offered within ART clinics while HIV testing and ART are offered with MCH.

However integration is not yet fully established at all levels especially for HIV positive people. A study done by MOH with support from UNFPA and Global fund showed that of the 3,831 HIV positive women interviewed, there was 41.2% family planning unmet need which is way above that of the general population of 28%.

Indicator	Survey of HIV+ women, %	General population UDHS2016, %
m CPR	57.7	35.0
Unmet need	41.2	28.0
Demand Satisfied by modern FP	59.5	52.0

Key populations

Key populations interventions have been scaled up over the years and currently all regional referral hospitals have a KP focal person and a team trained in KP issues and a 3-member coordination committee. Over 30 districts have a district focal person in charge of KP issues, the DHT & district leaders were oriented on KP issues (Gulu, Kabarole, Hoima, Jinja, Mbale, Mbarara, Busia, Tororo, Kasese, Lyantonde, Kabale, Bugiri, Mukono, Kalangala, Wakiso, Arua, Buikwe, Nakasongola, Buvuma, Namayingo, Mayuge, Kayunga, Kaliro, Serere, Apac, Amolatar, Kaberamaido, Buyende, Kampala, Soroti, Kawolo, and Lira.

The KPs include sex workers, MSM and persons using injection drugs and currently only PEPFAR tracks the different groups of KPs but the National records lump them together as MARPS. In the reporting year, there have been 25,135 female sex workers reached with HIV prevention messages and 7,662 have tested for HIV and received results, 2,396 MSM have been reached with HIV messages and 394 have tested for HIV and received results and 42 injection drug users have been reached with messages and 9 have tested for HIV and received results.

MoH & UNFPA supported 7 districts to develop MARPs SRH/HIV strategic, operational and M&E plans (Kampala, Wakiso, Hoima, Fortportal, Mbarara, Gulu, Mbale). PEPFAR has supported all its Regional Mechanisms to provide KP services. At the same time, data collection tools have been developed and piloted. There is still a challenge of reporting tools not capturing key populations and therefore difficult to get national level data and therefore reporting still comes through partners.

Table 4 KP reached between Jan and March 2017

	SW	MSM	Non-IDU	Truckers	Uniformed	Fisher folk	Others
MARPI Mulago	6553	555	1231	13	14	0	84
Gulu	854	84	106	36	25	0	753
Arua	233	2	232	48	17	18	43
Mbarara	60	36	0	12	28	0	142
Fortportal	101	0	132	20	4	6	75
Malaba	103	10	0	53	2	5	0
Lyantonde	30	7	5	14	1	2	66
Bugiri	59	0	0	16	10	0	47
Busia	94	25	36	7	0	0	17

KPs reached by selected DIC Jan-Mar 2017

Objective 3: To mitigate underlying socio-cultural, gender and other factors that drives the HIV epidemic

Socio-cultural, economic factors and gender inequality put men, women, boys and girls at a greater risk of HIV infection through multiple pathways. Women and young girls living with violent partners are less likely to protect themselves from unsafe and coerced sex. Women living with HIV are more likely to suffer physical and nonphysical violence as a result of their status, both from intimate partners as well as family and community members. The fear of violence also keeps women from seeking HIV testing, AIDS care and treatment services. Therefore, women and girls' specific vulnerabilities need to be addressed in all aspects of addressing the HIV epidemic. In order to do this, a number of activities have been implemented.

The cultural institutions have continued to emphasize HIV prevention messages and mitigating SBV in their areas of jurisdiction. For example the Buganda kingdom continued to emphasize HIV prevention message through various fora including the *Ekisaakate* where three of them held annually targeting young girls and boys aged between 10 and 19 years. In Bunyoro and Tooro kingdoms they hold the *Ekyooto* which is a fireplace that is used as an avenue of passing on HIV information to the men and women in the kingdoms. Other cultural leaders including the kraal leaders in Karamoja, the Itesot leaders, the Kyabazinga in Busoga, the Rwot in Lango use different avenues like the clan leaders, and also hold health camps for their subjects.

With support from the UNFPA we were able to establish the Prime Ministers forum headed by the Omuhikirwa wa Tooro, this has made it easy to collaborate and communicate to these cultural institutions. We were not able to hold the annual kings forum because of no funds.

Seven faith denominations (Church of Uganda, Moslem Supreme Council, Seventh Day Adventist, Orthodox Church, Born Again Federation, Baptist Union of Uganda, and the Women's Conference under Miracle Centre Churches) all organized under the Inter Religious Council of Uganda (IRCU) were supported to review and/or develop SRH/HIV action plans define their M&E plans and orient leaders at national, sub-national and lower levels to mobilize communities hinged on previously agreed leadership handbooks on SRHMNCAH/HIV/GBV. About 700 religious and cultural leaders were oriented on SRMNCAH/HIV/GBV tools developed by respective institutions to support integrated messaging in routine work.

About 100 religious leaders across denominations from the Karamoja and eastern region converged in Mbale for an orientation session on adolescent sexual and reproductive health issues including focus on socio-economic development. An aide memoire was generated and agreed issues informed planning at program level and individual FBO institutions.

Under the KARUNA project undertaken by JUPSA, About 100 Cultural leaders and elders up to kraal level were oriented on SRH/ HIV/ GBV/ MNH with specific focus on conducting of community dialogues.

Male involvement in SRH and HIV and AIDS interventions

The MOH developed the male involvement strategy to guide improvement of male participation in child and maternal health including SRHR and HIV/AIDS through providing strategic directions to all stakeholders in Uganda. To date a basic package for male-friendly SRHR services and standards developed, disseminated and integrated in all service delivery points.

Civil society organisations have contributed to this objective through the different interventions they have done in the various districts. After realizing the effect of socio- cultural and gender issues as drivers of the epidemic, Straight Talk Foundation (STF) during June 2016 to July 2017 has embarked on strategies to promote community involvement in addressing the different vices. In collaboration with District Local Government, they conducted trainings for 40 representatives of district cultural institutions (20 per district) to conduct dialogues to address early/child marriages in 2 Acholi districts. In addition, STF supported and monitored the 40 cultural leaders to implement 4 community dialogues each throughout the year.

Improvement of Male involvement has been embarked on by the CSOs for example Mama's Club awarded the Prime Minister of Uganda as the number One Male Champion. Mama's Club Uganda integrates activities that involve men in all its interventions to address: low male partner support in access to HIV/AIDS and sexual reproductive health services; stigma and social discrimination against people living with HIV and men's poor health seeking behaviour. Men view SRH as women's issues leaving their responsibility and that of their families' SRH to the women and girls.

Male partner involvement has been strengthened through implementation of male involvement strategy. This strategy being implemented in the South West, Karamoja, Kampala and Western region with support from EGPAF with support from UNICEF through the OHTA project.

With support from TASO/MOH under the Global Fund, 1,560 men were enrolled in the Male Action Groups (MAGs) and over 91% of them trained on Male Involvement on SRH and HIV/AIDS. The groups are from Kabale with support from EGPAF; Kampala, Kibale, Kiryandongo, Pader, Luuka, Kiboga and Kyankwanzi Recruited and oriented 96 Male Champions who were instrumental in community sensitization and mobilization on HIV/AIDS and the role of men in SRH. A total of 16 (31%) MAGs registered Village Savings and Loans Associations at sub county and district level and opened up bank accounts for easy access to saving and credit services.

To address aspects concerning gender, STF has adopted the strategy of including men in (MAGs). 70 in Karamoja region and 70 in Eastern region were reached to engage the wider community, create awareness and reduce teenage pregnancy, child marriage and GBV instances. The groups were guided on conducting dialogues in their respective communities to discuss issues of preventing and reporting cases of GBV, rape, defilement, FGM, teenage pregnancies and ending child marriages. To sustain the groups STF introduced a seed fund to ensure that, each group could own a profitable project and be able to facilitate their members to conduct dialogues and sensitizations in their respective communities.

To mitigate underlying socio-cultural, gender and other factors that drive the HIV epidemic, ACODEV created awareness among 130 households on Social- cultural and economic drivers of HIV epidemic, utilized 18 community extension workers to support the socio-economic status of the Households, strengthened the legislative and policy framework for HIV prevention in Kasese and Kyenjojo districts and trained 27 Community volunteer Councillors in case management for SGBV.

There has been increase in male partner participation in PMTCT over the years as shown below in figure 13:

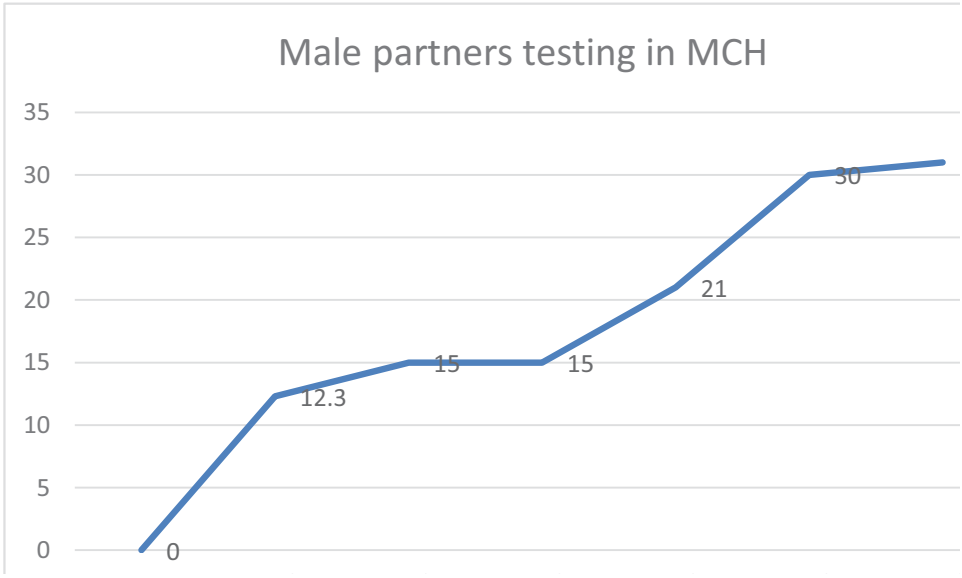


Figure 9 Percentage trends of Male involvement in MCH

3.4.2 Lessons learnt

- Integration of services has increased uptake of HTS
- Partnerships between self-Coordinating entities and service providers has increased coverage of HTS services
- Using different approaches will increased uptake of services in HTS

3.4.3 Challenges

- Sub optimal Linkage to care for those testing HIV positive especially at outreach sites
- Documentation challenges leading to under- reporting of those tested at outreach sites
- Frequent stock out of test kits
- Under eMTCT there are various challenges that still need to be worked on: mother –baby pairs lost to follow up, over 40% of HIV exposed infants are not getting services including HIV testing, ARV prophylaxis and septrin, there is still a mismatch between HEI and infants who complete the PMTCT cascade
- PrEP has been piloted at some sites but the numbers have not been captured into the DHIS2 database because the data collection tools are still being piloted.
- There is no reporting PEP numbers in the DHIS2 database so it's hard to track access other than the people who were tested for HIV before accessing PEP services.

3.5 Care and Treatment – Achievements, Lessons Learnt and Challenges

The second goal of the NSP is **to increase HIV-associated morbidity and mortality by 70% through achieving and maintaining 90% viral suppression by 2020.** The aim is to improve the quality of life of the PLHIV and targets increase access to Pre-ART care for those eligible, increase Access to ART to 80% and sustain provision of chronic-term care for patients initiated on ART Timely enrolment and better retention in care including ART can contribute greatly towards reducing community level viral load. Care and treatment seeks to reduce mortality and the country is on track as shown in figure 14. The number of people living with HIV has been increasing which could be explained by the increased access to HIV testing and care and treatment services. The number of clients enrolled on treatment increased fom 125,744 in 2014/15 to 161,325 in 2015/16 and to 220,431 2016/17.

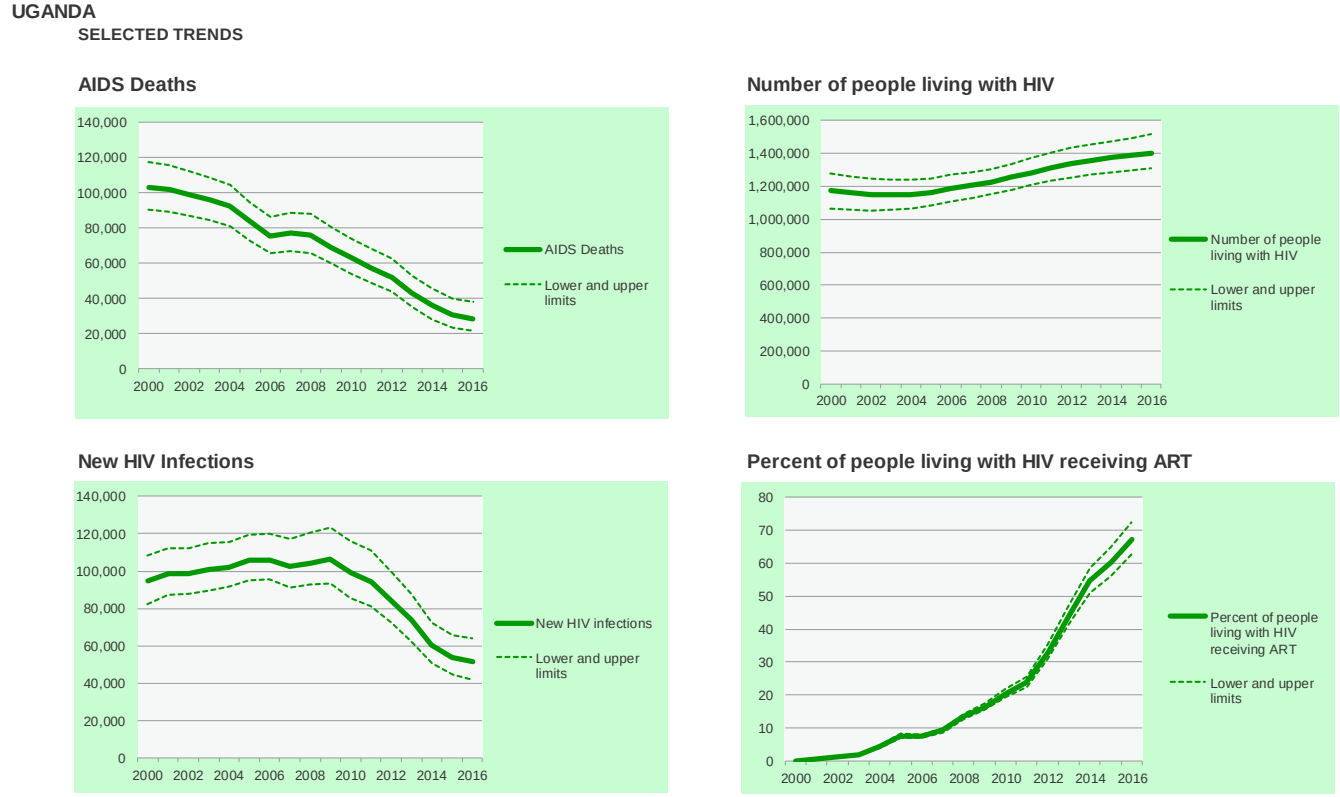


Figure 10 Care and Treatment trends

3.5.1 Achievements

- 78% of the people tested HIV positive were linked to care
- Test and treat guidelines rolled out in December 2016
- By the end of the reporting period, there were 1,028,909 people are on ART
    - 96.1% of these are on the recommended first line
    - 6.3% are children under 15 years
    - 95% of people who tested HIV positive this year were assessed for T.B
    - 84.5% People on ART were assessed for nutrition
    - 67% ART coverage for HIV positive children
    - VL coverage at 50%

Objective 1: Increase access to Pre-ART care for those eligible

At the time of development of the NSP 2015/16 – 2019/20, the 'Test and Treat' guidelines were only limited to the following categories; children below 15 years, pregnant women, HIV positive spouses in discordant relationships, MARPs and adults with a CD4 count of < 500/mm³. With the 'Test and Treat for the general population, this objective has been overtaken by events and therefore not very relevant.

HTS and linkage to care

A total of 10,756,246 were counseled, tested and received results for the period July 2016 to June 2017. Of these, 256,529 tested HIV positive (3.0%) while 220,431 of the identified HIV positive were linked to care and enrolled in the HIV clinic representing 78%. As shown in Annex 4, only 44 districts (37%) achieved the recommended target of ≥ 90% of the identified HIV positive linked to HIV care. There is no significant difference in performance regarding linkage to care between newly created districts and the old districts (see table 5).

Table 5 HTS and linkage to care - Performance of new Districts

District	% positive	% linked to care
Namisindwa	0.7	66.7
Omoro	4.3	85.1
Rubanda	1.5	86.7
Kakumiro	4.0	92.9
Kagadi	3.5	95.1
Bunyangabu	2.1	95.8

Highest HTS yield and relationship with linked to care

AS seen in table 6 below, Kalangala District leads with high positivity yield of 5.9 while Kampala and Lira followed with 5.5% each. Apart from Lira, all the high yield districts have low linkages to care. Details per district can found in Annex 5.

Table 6 Relationship between positivity and linkage to care

District	% positive	% linked to care
Kalangala	5.9	83.3
Kampala	5.5	86.2
Lira	5.5	101.9
Buvuma	5.4	72.1
Nakaseke	5.4	65.6
Wakiso	5.3	85.8
Mbarara	5.3	81.8
Kiboga	5.3	83.7
Sembabule	5.2	72.0
Lyantonde	5.2	68.9
Mityana	5.2	85.9
Ibanda	5.1	88.1
Amolatar	5.0	69.3

Cryptococcal Meningitis

Cryptococcal meningitis is associated with mortality of up to 39%. Patients with a CD4 cell count of <100 cells/mm^3 are at the highest risk of Cryptococcal meningitis. Diagnosis of Cryptococcal meningitis is done using Cryptococcal Antigen Assays(Cr Ag).
During the reporting period, 15,000 CrAG tests were donated by manufacturer and distributed to 205 facilities by end of July 2017. Central training for IPs in CRAG screening was completed in March 2016 and Cr. Ag registers were distributed to facilities by end of June, 2016. CDC/PEPFAR planned for 13,000 and 20,000 Cr. Ag tests in COP 2016 and COP 2017 respectively.

CD4 testing is critical a baseline CD4 cell count remains an important parameter and should be done in all ART-naïve individuals in the HIV care program to guide screening for Cryptococcal Menigitis. All HIV-infected but ART-naïve patients with CD4 <100 cells/mm^3 and those on ART who are suspected or confirmed to have treatment failure (i.e. viral load >1,000 copies/ml with stage III or IV disease) must be screened for Cryptocoocal Meningitis.

Objective 2: Increase access to ART and sustain provision of chronic-term care for patients initiated on ART

Under this objective there was target to strengthen mechanism for linkage to care. The 'Test and Treat' strategy further reinforces this objective.

Roll out New guidelines

Uganda adopted the "New Test and Treat" approach in December 2016. In these new Guidelines, all PLHIV irrespective of disease stage are eligible for ART. Other key elements of guidelines include:

Picture 4 Launch of the Test and Treat guidelines

- DTG as an alternative first-line for adults not tolerating EFV.
- LPV/r pellets in first-line regimen for children aged less than 3 yrs.
- Detailed guidance on 1st-, 2nd-, and 3rd-line regimen sequencing
- Strengthening management and diagnosis of co-morbidities including TB, Hepatitis B, Cryptococcal meningitis, as well as management of Non- communicable diseases such as diabetes mellitus and hypertension
- VL monitoring of ART
- Differentiated Service Delivery Models tailored to individual need

Comprehensive HIV treatment services based on a coherent continuum of care with special focus to assure and sustain quality of care across the continuum, creating stronger linkages with community level support structures is priority NSP 2016-2020.

The nationwide dissemination of the new consolidated guidelines for HIV Prevention and Treatment was been accomplished through:

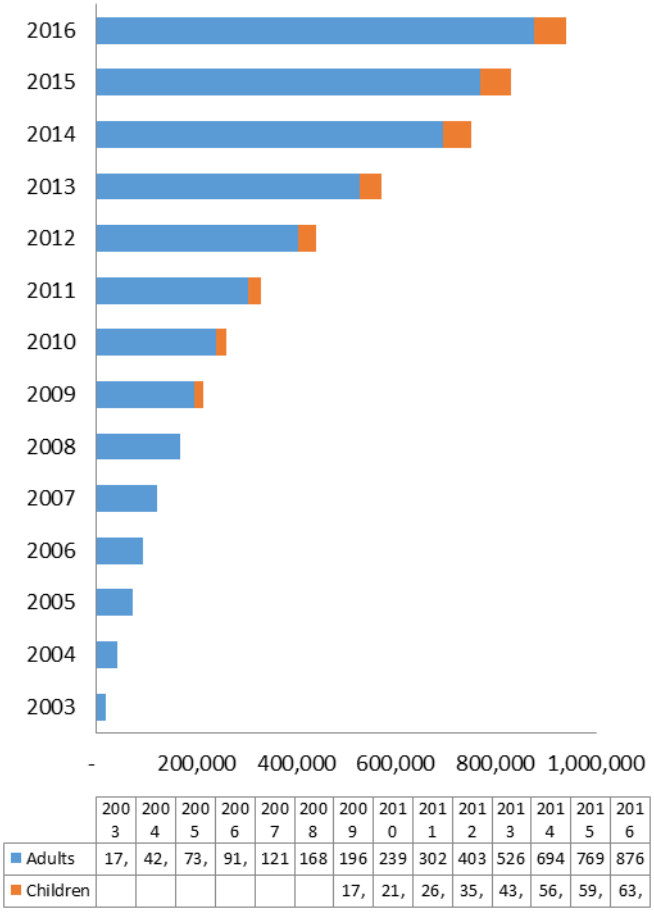
- National dissemination meeting for DHOs, Implementing partners and ADPs
- Regional Dissemination targeting political, technical religious leaders, RPMT, MoH and IPs
- The national dissemination was followed by health worker dissemination through training. Training materials were developed in Jan – March 2017 and Pre-tested in 6 facilities (RRH, Hospitals, HC IV, HC III PNFP and CoE). They were then finalized and the training materials & produced CDs which were shared with IPs for production.
    - 120 National trainers in 3 ToTs comprising of health workers and technical officers from 25 IPs have been trained
    - Three ToT of 120 supervisors who are providing oversight of subnational roll out of guidelines
    - At the regional level 36 ToTs were also conducted and facility level training commenced
    - By end of July 2017, 1059 facilities have been trained across 116 districts

Antiretroviral Therapy (ART)

Antiretroviral treatment for people living HIV is critical for improving outcomes, decreasing morbidity and mortality as well as community viral load suppression. While previous efforts for HIV care mobilization target the general population, majority of patients in care have been women and girls. This leaves significant unmet need for men and therefore the need deliberate efforts to improve male involvement.

By June 2017 1,028,909 people were on ART, 96.1% of these are on first line regimen and 6.3% being children under 15 years; 3.7% are on second line while 0.03% on third line. In 2061/17, 200,787 patients were enrolled on ART with 53,987 enrolled on ART based on CD4 count. There were 86.1% people on ART achieving >95% adherence to treatment. The number of people on ART has increased over the years as shown in figure 14.

Figure 11 People in ART care



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Adults	17,	42,	73,	91,	121	168	196	239	302	403	526	694	769	876
Children							17,	21,	26,	35,	43,	56,	59,	63,

Table 1: Active ART clients in Facilities Countrywide: June, 2017

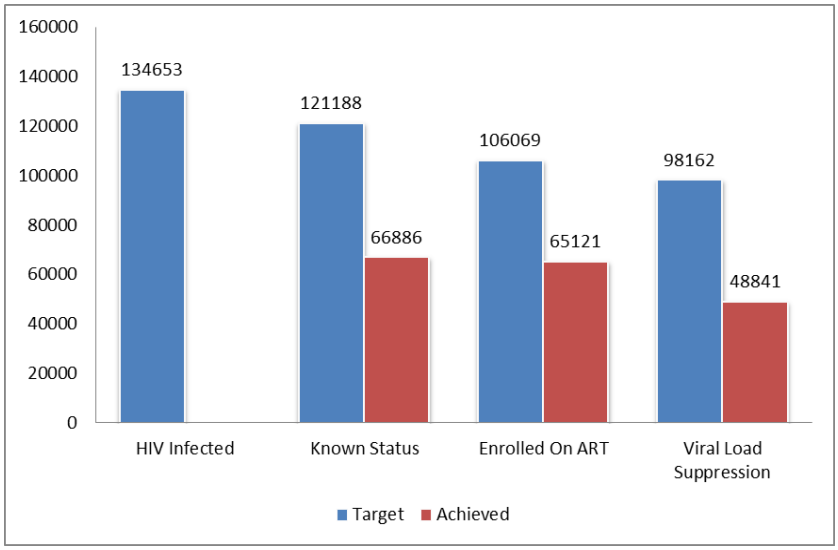
	Number	%
No. of clients on ART	1,028,909	
Adults (15 + years)	964,232	93.7
Children(<15 years)	64,677	6.3
First Line	989,672	96.2%
Adult (15 + years)	930,412	94.0
Children(<15 years)	59,260	6.0
Second Line	38,883	
Adult (15 + years)	33,496	86.1
Children(<15 years)	5,387	13.9
Third Line	354	
Adult (15 + years)	324	91.5
Children(<15 years)	30	8.5

Over 70 Districts have less than 90% of the HIV positive clients enrolled into care, are on ART despite the Test and treat strategy as indicated in annex 6

Pediatric HIV care and ART

Pediatric HIV and AIDS services have been scaled up over the years and ART coverage has increased to 67%. However, the 90-90-90 cascade is poor as shown in figure 15.

There were **22,559** children and adolescents who tested HIV+ in 2016. Central 1 accounted for the highest number of positives with **18%.** The children had the highest positivity yield ranging from **0.6%** to **2.3%** above overall yield of **1.1%,** this group consistently had a higher yield in comparison to the



Picture 5 90:90:90 Paediatric cascade

Adolescents age group across all regions with a **0.2%** difference. There is need to increase linkage to ART nationally, among the 2-<5years olds initiation to is less than 80%, more effort in following up positive children is required in order to increase linkage rates among that age group. There was a total of **33,155 viral load** tests done for children from the age of 0-<15years in 2016 which was **54% (**61,250) of the expected number of tests. Total VL suppression rate for children and adolescents 0-<19years old was at **71%** as of 2016.There was 1,032 overall total repeat VL tests. Suppression after a repeat test was at **40%** There were **615** children and adolescents with an unsuppressed repeat Viral Load test after Suspected Treatment Failure adherence counseling. There were **96** children and adolescents who had unsuppressed VL after a repeat VL. **28%** had an unsuppressed VL after their first VL, **13%** of which got a VL2 and **36%** of VL2 had a suppressed VL

Access of services to Young population: Mamas Club Uganda with support from Global Fund, established and strengthened 34 youth friendly corners and over 12,102 young people have benefited from various health &psychosocial services. A total of 13,698 young people have been reached with SRH & HIV/AIDS related information and services e.g HTS. Over 10 outreaches (both Community and in School) reaching 2,086 young people.
All the 34 youth volunteers were mentored in provision of youth friendly services.

Objective 3: Improve quality of chronic HIV care and treatment

Viral load: As per the algorithm clients initiated on ART should have a VL after 6 months and thereafter every 12 months, for those current on ART should have a VL every 12 months while children and adolescents <20 years have a viral load done every 6 months.

The country has continued to scale up viral load testing through training and mentorship of health workers. By the end of June 2017 a total of 618,076 samples were tested out of a target of 1.2 million. The VL coverage was 50% against the expected 75% and overall VL suppression 91%. 92.3% of those tested were on first line. Currently 1462 facilities across all the 116 districts are sending viral load samples through the hub mechanism.

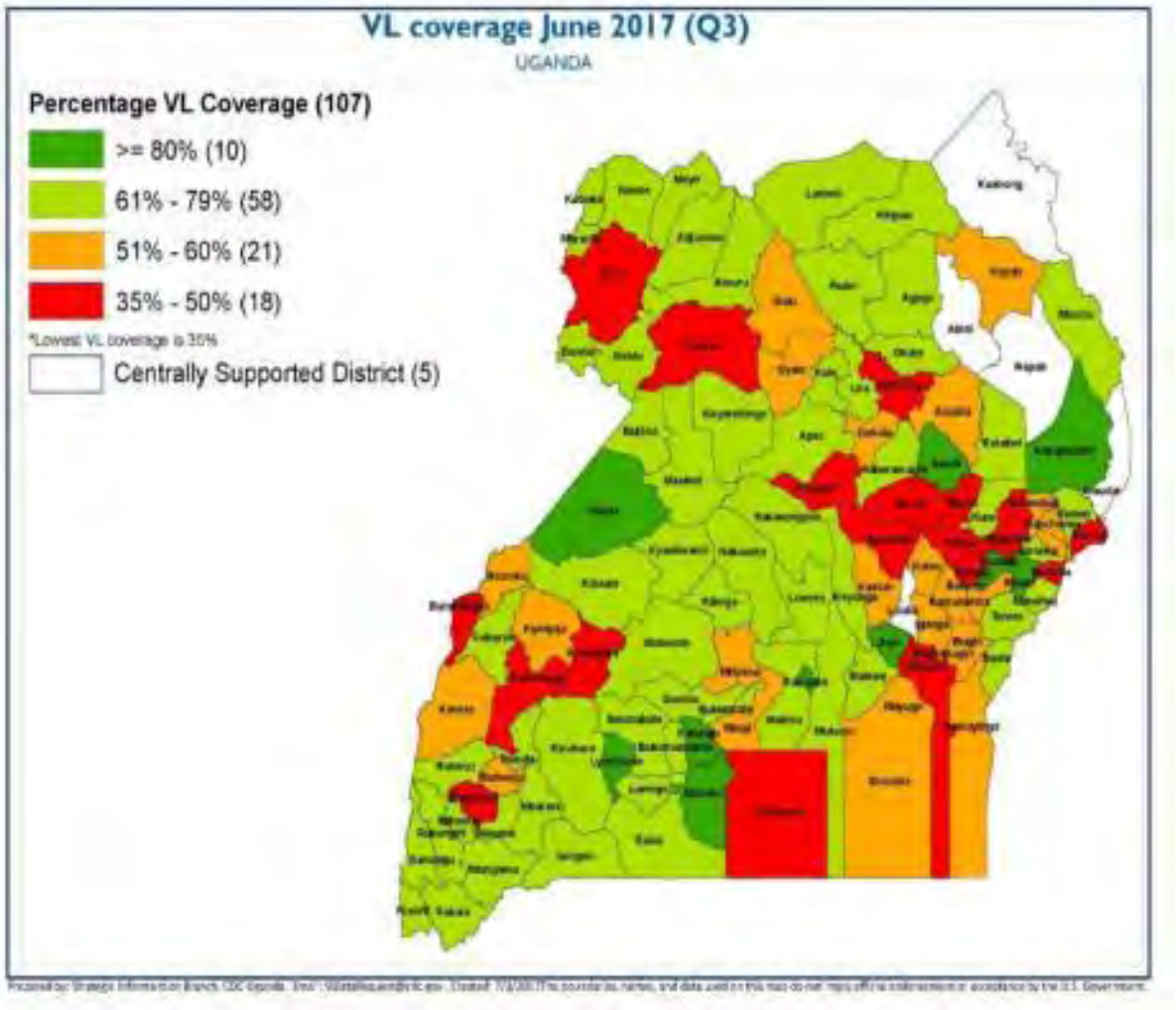


Figure 12 Viral Load Coverage - source MoH Data 2017

Objective 4: To strengthen integration of HIV care and treatment within health care programs

Integration of HIV care services is one of the proven strategies to attaining optimal use by target populations. Sub-dividing components of the HIV prevention package through the use of different service providers is costly for a weak health. The situation is further compounded by the lack of adequate health workers especially at service delivery level. Integration is operationally taken to mean the provision of HIV prevention services with other health services either at a single point of access or via referrals within a single health district.

TB assessment and treatment

There were 95% (232,615 out of 247,184) of the people who tested positive this year who were assessed for T.B while close to 100% of all the Pre-ART patients were given Septrin Proplylaxis. Of the people on HIV treatment there were 3.2% who are who were positive and started on treatment. There were 36.2% of people on ART who were on co-treatment for TB.

TB Burden Amongst HIV positive clients

Uganda is plagued by the dual TB and HIV epidemics, with the country being among the 22 high burden countries for tuberculosis and with high HIV prevalence of 6% (among 15-49 year olds). As seen in

annex 7, using the TB screening tool approximately 6% of HIV positive clients are T.B presumptive cases. This is highest in the Kaberamaido, Kiryandongo, Kalungu and Hoima with over 40%. The two diseases potentiate each other to cause wide spread morbidity and mortality among the economically productive sector of the country's population. The Uganda national guidelines on collaborative TB/HIV activities, 2013 recommends the provision of integrated TB & HIV services. A rapid assessment in Kampala in April 2015 showed that 15% of TB diagnostic & treatment units (DTUs) did not provide care & treatment for HIV (n=55). Of those (N=47) DTUs with treatment for both TB and HIV, 6% did not provide integrated care for co-infected patients.

This then led to, NTLP and ACP developed Standard operating procedure for the "One Stop Model" to guide provision of TB and HIV services in one place and comprehensive approach that is patient-centered and fully integrates TB and HIV services provided by the same health worker or health care team. The guidelines have been incorporated in the National TB guidelines and will be rolled out to all ART implementing facilities.

TB is a leading preventable cause of death among people living with HIV, with over 30% of HIV deaths attributable to TB. 41,001 of TB cases were tested for HIV clinics in 2016/17 out of 50,234 people on anti TB treatment, 17,424 tested HIV positive with 92% (15,984) initiated on antiretroviral therapy. 95% of all people initiated on ART were also assessed for TB. The TB survey conducted showed that 27% of people with TB were HIV infected.

3.5.2 Lessons learnt

- Test and treat has increased the linkage to care with 78% of those testing positive linked to care
- A viral load communication campaign conducted by MOH with support from CHC in all the 10 regions showed an upsurge in the numbers tested, however this was not sustained when campaign activities were stopped

3.5.3 Challenges

- It is not possible to track the people who are malnourished through the nutrition treatment because the records are not linked to HIV care information
- Viral load coverage still low compared to the number of people who need the services
- Low utilization of VL results by clinicians to help the patients appreciate the need for viral load testing

3.6 Social Support and Protection- Achievements, Lessons Learnt and Challenges

In order to reduce the vulnerability of disadvantaged persons to situations that could result into HIV infection or transmission and to help the infected and affected cope with effects of infection, the National HIV&AIDS Strategic Plan 2015/16 – 2019/20 recommended a number of actions for reduction of vulnerability to HIV/AIDS and mitigation on its impact on PLHIV and other vulnerable groups. In order to achieve this third goal of the NSP, there are four strategic objectives stated as guidance to implementation of the NSP. The objectives highlight the need to address stigma and discrimination of PLHIV, the need to mainstream needs of PLHIV, OVC and other vulnerable groups, the need to have and implement a life cycle sensitive comprehensive package and to engender all social support and protection programs to address the unique needs that make women, girls, men and boys vulnerable to HIV/AIDS. Under this section of the report, we present progress and achievements during the reporting period by the various programs in the different government sectors, CSOs as well as PLHIV networks.

There is no central repository for interventions on social protection and what is reported here is information from reports from some CSOs and government organizations that provided services in the area and shared their reports with UAC.

3.6.1 Achievements

- Though no stigma index study has been conducted at the national level, there have been 2 stigma index studies conducted among PLHIV in Karamoja and Busoga regions as well as one among PLHIV sex workers
- There are 35 Districts with interfaith committees addressing issues of HIV stigma and SGBV
- 112 (96.6%) districts have PLHIV networks
- There are 3,700 Teachers who are members of Anti-AIDS Groups in 57 districts and these help address stigma both in the schools and the profession
- The Implementing partners and CSOs work with PLHIV in peer counselling which is an intervention used to break self-stigma
- NAPHOPHANU has a knowledge centre at Mbuya targeting the MARPS mainly long distance truck drivers, uniformed personnel and *boda boda* riders
- The drama show " Bangi" screened on Bukedde TV has sensitised the population about stigma
- Engaged health workers, local council leaders, lawyers, police about the rights of sex workers
- PLHIV and OVC benefited g from Government programs for example 31,096 OVC households were given agricultural/farm inputs, 123,153 elderly most of who are taking care of orphans are benefiting from SAGE program in 40 districts and the youth are benefiting from the Youth Livelihood program
- 13,954 volunteers were trained in OVC programming and caring for their needs at the community level.
- PLHIV and OVC households have been linked to economic support programs
- 30,602 OVC received vocational/apprenticeship training of whom 9,110 were given start up kits
- Peer to peer counselling strategy used among the IPs and SCEs
- Men in Karamoja sensitized about GBV
- 42 judicial officers, 451 health workers, 360 police officers and 124 champions from each of the districts within the country trained on GBV case management and are addressing HIV stigma and discrimination related.
- 5 GBV Survivor sites with in health facility settings were equipped with biomedical supplies for first aid and forensic evidence collection by TASO.

- 1,106 FSG members trained in sustainable livelihood
- 265 women and girls in Karamoja trained in livelihood and economic enhancement
- 36,269 assessed for nutrition and some trained in kitchen gardens
- GBV TWG established in July 2016
- Facilitators guide for training community champions and paralegals on GBV prevention and management was revised
- National Action Plan for Women, Girls, Gender Equality and HIV was revised
- The National Gender Based Violence Elimination Policy (NGBVEP) and the National Gender Based Violence Elimination Action Plan were approved by cabinet
- Review of the 2007 gender policy has started
- 8 talk shows on different issues of human rights, stigma and discrimination and patient's rights, legal avenues for accessing justice by persons living with HIV/AIDS were held.
- 210 male champions and 1,175 Male Action Group members in SRH and HIV/AIDS
- Regional religious leaders retreat to embrace integrated SRH, HIV and GBV for the benefit of youth, adolescents and women in their congregations

Objective 1: Elimination of stigma and discrimination of PLHIV and other vulnerable groups

The NSP clearly notes that "PLHIV face stigma and fear to disclose their HIV status to avoid being discriminated against or even denied freedom of expression in society." It goes on to single out women and girls who shoulder a disproportionate share of the blame on the basis of real or perceived HIV status. This section describes the achievements that have been made to reduce and prevent stigma at all levels and discrimination in the entire HIV response.

Mobilize and strengthen cultural and religious institutions, community support systems and PLHIV networks to address stigma: The cultural and religious institutions are working from the different platforms to address stigma in their areas of operation. The cultural institutions have used different avenues to send out HIV messages and to also call for the need to reach out to those affected. The cultural institutions made policy pronouncements renouncing wife inheritance and other HIV facilitating factors. This was through the Kings Forum a forum that brings cultural institutions together currently chaired by the King of Bunyoro and about 14 cultural institutions sit in this forum.

The Cultural leaders developed plans and work through the district structure like for the Teso region, the Iteso cultural union works in all the district structures up to village level. They sensitize the community about HIV and have helped breaking the stigma. The Karamoja Elders Association with a membership of 800 people, the "*Ekekwo*" has gatherings where people meet and talk about HIV. The *Karamoja elders* also use UBC Totere radio free air time to disseminate information to the community and also partner with civil society to promote the girl child. The Rwot in Lango has 160 clan leaders they use as an avenue to pass on HIV messages.

There are 35 districts with interfaith groups that address issues of HIV stigma and discrimination, SGBV, access to services and counseling. These religious leaders also participate in the different HIV fora in the district and are represented when the district holds budget conferences up to Sub County level.

The CSO have realized that the issue of fighting stigma can only be possible if all the different players are brought on board. There has been training of the religious and cultural leaders on issues concerning HIV and AIDS and what role they can play to ensure that the people access services. CSOs like TASO

and Mildmay have targeted the religious leaders and teachers in their community based strategy. The religious leaders have been deliberately targeted because they can take the message to a wider forum during the different religious functions. In the bid to fight stigma and discrimination, TASO has also trained teachers in the schools where some of the children who access services at their centres go to.

NAFOPHANU strengthened networking and collaborations with their partners and network members. They have been able to develop joint advocacy issues, national and district level; joint implementation of activities, strengthened linkages and collaborations at the decentralized response for example members of the district networks participate in DACs, SACs.

Interventions for PLHIV to deal with Self-stigma: NAFOPHANU with support from UAC and UNAIDS are in the process of developing an Anti- stigma and discrimination policy that will guide the stigma related interventions in the country. In line with that, NACWOLA in partnership with FIDA which is an association of female lawyers have come with guidelines on positive living. These guidelines will be disseminated and will also inform implementation of activities among the PLHIV.

NAFOPHANU worked with Uganda AIDS commission to develop an anti-stigma and discrimination policy to increase access to HIV services including prevention in a stigma free environment. PLHIV have carried out community awareness campaigns targeting vulnerable young girls in Karamoja region to address the social, cultural, gender and other factors that drive the epidemic under Prevention of HIV and AIDS in Communities of Karamoja (PACK) project.

There are 112 out the 116 districts with PLHIV networks like NACWOLA, NAFOPHANU and these support PLHIV activities in the district including dissemination of the different policies and programs as well as implementation of activities.

The Memory book project which is a signature project of NACWOLA has remained a key project in fighting stigma among PLHIV. NACWOLA uses the memory book and will writing as a way of preparing the PLHIV for the inevitable. They have been supporting different PLHIV organizations to train PLHIV.

The Public Sector agencies that are involved in direct HIV/AIDS service provision like UPF, UPS and UPDF as well as CSOs EGPAF, TASO and NAFOPHANU have worked with PLHIV networks to sensitize and reach out to the general community. NAFOPHANU has trained 172 expert clients who are key in fighting stigma and improving ART adherence in the community in Karamoja. NAFOPHANU has also set up 44 young positives clubs in Karamoja region. In Uganda Prisons 86% of all new entrants in 38 prisons countrywide are given information on stigma and discrimination. Many CSOs are supporting people who work as volunteers and have lived to give the testimony of positive living; for example TASO has people who have been their clients for so many years and are now role models in the community and have helped break the stigma. Other CSOs have devised means of positively fighting Stigma. In TASO, all people in care are placed in groups and they support each other. These groups have been able to access funding and are economically supporting themselves.

1500 PLHIV have been equipped with skills to demand for their rights by UGANET. This was as a result of realizing that the PLHIV lack knowledge of their rights. In addition to that they have assisted 1420 (930 females and 490 males) PLHIV with legal aid. UGANET has also been able to provide 1000 PLHIV with free legal support.

During the reporting period, HRAPF provided free legal services in 107 cases for people living with HIV/AIDS. Of the 107 cases received, 79 were for women and 28 were for men. These cases benefited a total number of 471 individuals directly and indirectly. 103 individuals benefited directly while 368 benefited indirectly. Indirect beneficiaries were in most cases children and relatives of the clients. 25 cases were to do with land disputes (25cases), 14 cases with successions disputes and 13 cases to do with stigma and discrimination (13cases). This is as a result of having little knowledge on how to access justice, not knowing their rights as patients and self-denial after realizing that they have positive HIV status.

PLHIV Stigma index: NAFOPHANU conducted two stigma index surveys among PLHIV in Karamoja region aged 15-49 years. The international stigma index questionnaire was used and the findings will help modify the questionnaire for Uganda. Data from Karamoja shows the self-stigma level to be 25.7% and the external stigma 75%[6]. There were different forms of exclusion reported in the surveys and these were attributed to living with HIV. It was found that the external forms of stigma were revealed in gossip, verbal insult and physical threat. The plans are underway to disseminate these findings.

The USAID-HIWA project keeps track of the actual or perceived stigma and discrimination in the organizations where the project is implemented. This is a project that is focusing on the private sector and also the other service sectors with interest in the HIV/AIDS work place policy. The project is implemented in the police force, private security groups, hotels and Uganda Wildlife Authority. Overall perceived stigma and discrimination in the four sectors was found to be 28.3%.[7]

Stigma campaigns: The different SCEs have used different means to address stigma. Among the uniformed officers in the Uganda Police Force, Uganda Prisons and the Uganda People's Defense Forces disclosure is encouraged at two levels; disclosure to the spouse or a family member and this helps with regards to deployment where access to care is taken into consideration. In the army disclosure to the immediate command and the partner is mandatory. The stigma campaigns in the uniformed services have been scaled down to the lowest level of grouping like a platoon in the army. This has helped many PLHIV speak out about their status by encouraging others to access services as well as protect them. This is an institutional effort to fight stigma.

There is a Teachers AIDS group with a membership of over 3,700 teachers who have come out about their HIV status and they help address issues of stigma among colleagues and in the schools where they work. This forum has been able to fight stigma in the profession.
The private sector working with artists have started screening an HIV Stigma reduction drama titled "*Bangi*" aired on Bukedde 1 Television every Saturday at 6pm with an estimation of over 5,000,000 people viewership. This is part of the media campaigns among others that are conducted on radio stations.

The CSOs using community dialogues have been conducting stigma campaigns in the different regions. In Karamoja, NAFOPHANU has conducted dialogues among the general community addressing issues of stigma and adherence to drugs. In the health facilities that are under the supervision of the different CSOs, the health talks include anti stigma and discrimination messages.

[6] PLHIV Stigma index baseline survey conducted in Karamoja region July 2017 by NAPHOFANU

[7] Source USAID/Uganda HIV/AIDS and Health Initiatives in Workplaces Activity (HIWA) Year 1 Annual report

In the bid to fight stigma and discrimination, TASO has also trained teachers in the schools where some of the children who access services at their centres go to. This is aimed at working with the teachers to fight stigma and also empowering them to address issues of stigma against HIV positive pupils.

USAID/HIWA worked with CHC Project to adopt IEC materials tailored to the workplaces. SBCC/ IEC materials were used to inspire and educate people about prevention, care and/or treatment of HIV/AIDS and increase a better understanding of HIV in a more comprehensive way. The materials encouraged dialogues, improving stigmatizing and discriminatory attitudes towards HIV positive people and testing. As a result, USAID/HIWA disseminated a total of *9,718 SBCC materials* in the barracks, outposts, during workplace dialogue meetings, outreaches, and at health facilities. The project also, adopted and disseminated a total of 150,000 health message through mobile health platforms of social media and SMS. A total of, 30,405 people were reached.

HRAPF has used sensitization about rights as a way of fighting stigma among PLHIV. They have conducted 13 senstization sessions about rights of PLHIV at health facilities and also disseminated the patient's charter. HRAPF conducted the awareness sessions in Mpigi, Luwero, Kiboga and Mityana districts where they were able to reach 991 PLHIV.

Picture 6: HRAPF's Advocacy Officer facilitating during an awareness session at Kikandwa Health Center in Mityana District

Design and implement interventions to eliminate discrimination against women and girls in the context of HIV and AIDS: NAPHOFANU conducted a stigma index study in the East Central region among adolescents and young adults aged 14-24 years living with HIV. The key results as per study findings show that the proportions of respondents who expressed internal experiences of HIV stigma were almost similar to those who experienced external forms of HIV stigma (19.1% vs. 20.8% respectively) and discrimination. However, from the qualitative data, the external forms of HIV stigma exhibited more barriers to accessing sexual reproductive health services. Given this evidence, HIV stigma and discrimination addressed right from the structural barriers. The growing work of civil societies with their proximity to the young people is key to promoting the much-needed empowerment models for the YPLHIV. Through the grass root work, civil societies have two advantages. 1) They have appreciated the uniqueness and differences in cultural orients; and 2) they are trusted by most communities as they have brought changes in several structural components in education, employment, health and behavioral changes. There are quite several gender differences with respect to internal forms of HIV stigma among YPLHIV. Except for proportions that blame others: 24% male vs 27% females.

All other forms of internal HIV stigma (blaming self, feeling suicidal, feeling of being punished, and feelings of guilt) were more reported by male's respondents.

Fighting stigma among Key Populations: The Mbuya Knowledge Room is a stop center for HIV information and services for long distance truck drivers and their partners who are usually sex workers. 13,144 MARPS were reached with HIV information, HIV testing and counseling over 40,000 condoms were distributed to sex workers and truck drivers. The Knowledge room also provided services to 44 guards within the area.

An organization that is looking at protecting the rights of sex workers, WONETHA held 17 dialogues with 41 local council leaders, 20 lodge managers, 16 lawyers, 66 police and 668 sex workers about the rights of the latter in Natete and Kabalagala. After the meetings, there is improved interaction between sex workers and community leaders in the areas, the security and human rights protection of members has increased and confidence to do their work rejuvenated. This has resulted to increased members being registered as members of WONETHA for ease of support and tracing.

A stigma index survey was conducted among HIV positive sex workers by WONETHA. On the overall, the sex workers almost never faced any form of discrimination because of their profession but with HIV status the tables turned. HIV positive sex workers experienced self- stigma. Majority experienced self-blame 38.5%, 17.9% blamed others, 5.3% felt they wanted to kill themselves, 0.8% felt guilty about their HIV status. Also due to HIV positive status, 28% had stopped working, 16.3% avoided going to hospital, 11.4% chose not to attend social gatherings, and 10.6% avoided getting children. None of them had avoided having sex but were very fearful of sexual rejection**,** 48% feared being gossiped about and there were no fears of physical assault.[8]

NAFOPHANU through the SALT helpline has provided tele- counseling to MARPS including young people. Clients are counseled on telephone then referred where applicable. Over 10,000 people have been able to access the line and the issues raised include:

- SRHR issues,
- Post-natal advice to HIV mothers,
- Stigma among young people in school,
- HCT services despite them having unprotected sex with extra marital partners. This was realized when a probe was made with callers who wanted to know how long the HIV Virus takes to manifest itself in the human body, asking if HIV is real, among others .
- Discordance, some callers asked why it was possible for some people to have HIV and yet their partners/spouses are HIV negative yet they had been with them for a number of times having sex.
- Gender based violence especially among discordant couples and families affected by HIV/AIDS.
- Disclosure related problem: some inquire about how they can disclose their status to their partners after testing HIV positive, in most cases women are the first to know their HIV status through antenatal so in most cases they call to inquire how best they can disclose to their spouses without causing violence.

[8] Data from Stigma index survey among HIV positive sex workers conducted by WONETHA June 2017

- Land disputes especially among widows living with HIV, one woman living HIV called wanting to know if SALT can offer some legal help to her because she was being deprived of using her land by her in-laws.
- Inadequate knowledge and information about HIV, there are many myths and misconception about HIV among the people, so many people call to get clear basic information on how HIV is transmitted /spread and even ask if it is now curable since they are assured of long life with the presence of ARVS.

In order to address issues of stigma among sex workers in the health facilities, WONETHA conducted five training workshops in Mpigi, Buikwe, Wakiso and Mukono to sensitize health workers on human and health rights of sex workers. This aimed at ensuring that there is non-description of services among sex workers.

There is increasing partnership with health service providing organizations including UHMG, MARPI, Lubaga Hospital home care, Nsambya Hospital Home Care, Medical research Council, Crane Survey, and public health facilities in all the districts mentioned above. There were 17 dialogue meetings held with 668 sex workers, 66 police officers, 41 council leaders, 20 lodge managers and 17 lawyers in Kabalagala and Natete. The meetings have brought about a situation of improved interaction between sex workers and the community leaders.

With support from the Global Fund, ICWEA held dialogues with cultural leaders from 18 cultural institutions and reached 1522 leaders since October 2016; and held dialogues with Religious Leaders from 18 districts, where they reached a total of 262 leaders. This created an impact as cultural and religious leaders appreciated the causes of GBV (from their perspectives) as a key driver of the HIV epidemic in Uganda and identified community level negative practices and behaviors that fuel GBV and HIV. Cultural & religious leaders committed to join the struggle against the negative behaviors and practices that promote GBV and HIV

ICWEA has supported the WLHIV from the Key Populations (KP) by strengthening their advocacy capacity to advocate and reclaim their spaces. Organizations included Sex workers, women who use/inject drugs, lesbians/women who have sex with women, transgender women and women living with HIV. They formed a coalition of Women KPs for effective engagement and to challenge the human rights violations.

Objective 2: Mainstream needs of PLHIV, OVC and other vulnerable groups[9] into development programs

In most government development programs right from fighting illiteracy and fighting poverty there has been prioritization of the needs of the PLHIV, OVC and other vulnerable groups. Under the Universal Primary Education where one of the objectives is "Making education equitable to eliminate disparities and irregularities" the OVC have been prioritized with no limitation is in place for them to access school; Operation Wealth Creation (OWC) which targets the people who are mainly engaged in the largest sector of agriculture where most OVC are evident. In addition to that the PLHIV networks have tapped into OWC to support members of their networks. In this reporting period, 1,415,120 OVC have been reached with services ranging from educational support, economic empowerment, psychosocial support and basic care. There are 104,719 who have been newly enrolled on to the OVC program,

[9] *Vulnerable persons include PWD, the elderly and key populations*

506,194 vulnerable households supported with economic strengthening, food, farm inputs and agricultural advisory services. .

Integrate PLHIV, OVC in development programming: The Operation Wealth Creation (OWC) program that envisions a socially and economically transformed Uganda, under the Ministry of Agriculture, Animal Industry and Fisheries (MAAIF) has provided OVC households with agricultural advisory services. There are a number of OVC households that are in the rural areas and their means of livelihood is agriculture. The OWC program saw it beneficial to target these households anticipating transformation of the general community.

The Social Assistance Grants and Empowerment (SAGE) program under the MGLSD offers direct income support to the senior citizens above 60 years in Karamoja region and above 65 years in the other districts. Currently there are 123,153 beneficiaries of this program. The program has made a difference in the livelihood of the older persons by giving them monthly income of Uganda Shillings 25,000/-. This money has enabled the older persons to access food and medical services and also be able to provide for the OVC who are under their care. In this reporting period the program rolled out to 5 more districts making it 40 districts of implementation.

Youth Livelihood Program (YLP) that is also implemented under MoGLSD, is a five-year development program targeting poor and unemployed youth aged between 18 and 30 years. In this reporting period, the grant was in its fourth year of implementation and is implemented in all districts in Uganda. The youth in groups are given loans which are repayable after a period of 12 months. YLP encourages participation of the youth in development. The programme uses a bottom-up development approach with the youth being encouraged to engage fully in the formulation of their own groups, choosing their own enterprises and managing them. The expansion of the program in the specific districts was hinged on the load recovery. over 150,000 youths have been reached through the program.

Coordinate and empower all sectors to fulfill mandate: There are 13,954 community volunteers who have been trained in OVC programming and rights; of those trained 7,451 are female. These volunteers are trained to address issues affecting the PLHIV, OVC and other vulnerable group. They are trained in areas concerning OVC rights and how to handle any issues that affect them. UPDF has been able to train 461staff in OVC program implementation against the planned 300. This shows the enthusiasm of the SCE to strengthen OVC programming in their area.

Integrate social support and protection issues into the education sector programs: The Ministry of Education and Sports (MoES) has developed a National framework on sexuality education with a wide-range of consultative meeting with various stakeholders at different levels. This follows the parliamentary resolution on 17th September 2016 that instructed the Ministry to halt the teaching of Sexuality Education and dissemination of training materials in schools until when the framework is in place to guide the delivery of sexuality and development of materials. A National framework is a very important component of the school health education programmes that will help in empowering the young people who face numerous challenges in their education and lives that may lead them to infections (HIV, STDs, NCD), sexual abuse, early sexual debut, teenage/unplanned pregnancies and school dropout. The curriculum is ensure they are better prepared to prevent and protect themselves, immediately respond, mitigate and get desired relief and be able to embark on recovery and rehabilitation of themselves to reduce the long-term effects of such dangerous experiences and return to education. Currently the draft framework has been set for launch and dissemination in September 2017, after the final approvals.

In FY 2016/2017, the sector with support from the development partners trained a total of 1188 teachers (male 600 and 588 female) on the enhanced PIASCY as a Behavioural Change Communication Strategy in schools which provides the young people and adolescent with life skills to make informed decision and age appropriate HIV/AIDS preventions messages in the district of Abim, Arua, Adjumani, Nakapiripirit, Kamuli and Iganga Bukomansimbi, Sembabule, Rakai, Mubende, Mityana, Gomba, Mukono, Gulu, Lira and Oyam. A team of 20 officers (male 7 and 13 female) drawn from Ministry of Education and Sports, Ministry of Health and other expertise from civil society organization conducted the training of teachers .

The MoES through the Health/HIV Unit has held a number of Health/HIV meetings (Health/HIV TWG, Inter-Ministerial Committee on adolescent health). Such meetings bring together line Ministries like MoH, MoGLSD, MoLG, UAC, NCC; development partners including UNFPA, UNICEF, UNESCO, UNAIDS and USAID and NGOs; Uganda Reproductive Health, Straight Talk Foundation, USAID/SHRP, UYP and Y- Plus that plays a key role in ensuring that young people get access to information and medical services on reproductive health. These meetings have done a tremendous work in advocating for the development of National framework on sexuality education and approval of national school health policy, which policies and frameworks are now in the process to be approved. In addition the Ministry through the Health/HIV Unit has developed an integrated work plan for 2017 on adolescent sexual reproductive health and continued to strengthen networks with implementing partners in scaling-up the implementation of PIASCY in schools that do not have access to the programme.

There has been continued dissemination of the guidelines for mitigation and prevention of teenage pregnancy and HIV in school settings. In this reporting period, 200 copies of the guidelines were distributed to 100 schools (i.e 50 primary schools and 50 secondary schools) in the districts of Soroti and Hoima. These guidelines provide a package/programme and modes of service delivery within a school setting that enable prevention and management of teenage pregnancy and HIV in schools.

Implement targeted programs to support PLHIV, OVC and other vulnerable persons: This support has mainly come in through the different CSO for example, under the DREAMS project, TASO has been able to build capacity of children in the project who are mainly OVC and they have got access to loans schemes. Also another case in point is the AHF Uganda Cares_Socio-Economic Empowerment Program (SEEP) that provided microfinance services, mobilization of member savings, group lending and loan monitoring. The SEEP coverage increased from 8 health facilities in 2015/2016 to 11 health facilities in 2016/2017. These included; Masaka RRH, Soroti RRH, Dr. Charles Farthing Memorial clinic in Kampala, St. Balikuddembe Market clinic in Kampala, Lukaya healthcare center, Bukulula HCIV in Kalungu, Kyanamukaka HCIV in Masaka, Kalisizo hospital HIV clinic, Kapelebyong HCIV in Amuria (new), Asamuk HCIII in Amuria (new) and Kinoni HCIII in Lwengo district (new). To date, the program has mobilized and reached out to 49 clusters comprising of 2,059 clients. FOCAGIFO in Wakiso district also strengthened women groups of OVC caretakers through trainings them in village loan and saving schemes, group dynamics, specific social business and money management skills to ensure that they achieve financial independence and can support their households with ease. A total of 40 women were trained and linked to the fund and CDD fund.

In 2017, HRAPF trained 21 community Paralegals among women and girls living with HIV in the districts of Mpigi, Kiboga, Mityana and Luwero. Unfortunately, two of the trained Paralegals passed on. The sharing sessions for Paralegals are held to assess their performance and continuously documentation of their experiences and lessons learnt while giving first legal aid to their fellow people living with

HIV/AIDS. One paralegal sharing session was held; 19 paralegals participated, 4 were from Mpigi, 5 from Mityana, 6 from Kiboga, 4 from Luwero. The paralegals shared the reports for the cases they had handled. During the reporting period 28 cases were handled by paralegals and the nature included will making; domestic violence, illegal eviction, stigma from the family and referrals. 12 awareness sessions were conducted and 976 people living with HIV were reached out.

Social assistance grants to most vulnerable and interventions to reduce economic vulnerability: there are 121,313 OVC households that have been supported with economic strengthening between July 2016 and June 2017. In this reporting period 36,475 OVC have been supported to attain vocational/apprenticeship skills and 9,110 of these were given start up kits. The OVC have been skilled in areas of mechanics, wielding, hair dressing, and tailoring, catering, motor vehicle mechanics and electrical installation. The skilling has been a major activity for example NAFOPHANU has empowered 5005 with skills in business solutions with support through the DREAMS SPARKED Women project. Skilling of the vulnerable persons reduces their vulnerability to HIV/AIDS because of the economic empowerment that comes with the acquired skills.

Quality counseling services: All the different service providers have embraced the peer to peer counseling. In EGPAF the young people have been empowered to reach out to their different groups. NAFOPHANU in the Karamoja project has also used the peer to peer approach to ensure adherence to treatment. TASO has used the peer to peer model at all its centres and this has helped greatly in retention into care.

Objective 3: Develop and implement a life cycle sensitive comprehensive package of social support and protection interventions for PLHIV and other vulnerable groups

Develop and promote a life cycle sensitive comprehensive package of social support and protection: There have been trainings conducted at community level and for staff to provide PSS to the OVC. There have been 1,931 staff trained and 6,123 community volunteers trained. The trainings also covered legal issues so that they are able to provide a comprehensive service to their beneficiaries.

Utilizing the 4 point social protection model and referral cycle, UGANET has engaged gate keepers of justice for PLHIV and the key pointers of service delivery have been reached. They have been documenting violations of rights of women and girls living with HIV and there are 107 cases among PLHIV recorded this reporting period and were properly documented in physical case files. A total of 56 violations were recorded for the PLHIV. The human rights violations recorded included 15 cases on the right to freedom from discrimination based on one's health status, 33 on the right to property which mainly concerned denial of having a share in an estate and evictions from land, 5 on the right to liberty where clients were detained for more than 48 hours and 3 on the right to health, particularly access to medical services.

Mama's club trained 1,106 FSG members in sustainable livelihood including on hands skills like hand craft, bead making, charcoal bricked making etc.

UN Women, in collaboration with the district local governments of Moroto and Kaabong built capacities for livelihoods and economic enhancement for over 265 Women and girls living with HIV. Aware of the unique social and economic challenges that adolescent girls and young women living with HIV face, UNW purposefully set out to build competencies and capacities of WGLHIV aged 15-24 years to enable them tap into available opportunities for livelihoods and economic empowerment. Helping WGLHIV gain the essential social and economic skills has proven to be a sure-step towards empowering young

women and girls to exercise their rights and seek HIV services. Livelihoods support also means improved quality of life and with it comes responsibilities for making informed decisions and adopting safe sex practices. Some of the early results can be seen in terms of improved self-esteem, confidence and entrepreneurial skills by the Women groups. Some women's groups have already started budding businesses. For example, the UMOJA group, which set up a store to sell dry grains and cereals to local retailers, has now been shortlisted for government grants to help women entrepreneurs expand their stock. This approach increases opportunity for women and girls to find alternative source of income other than exchange of sex; makes it possible for WLHIV to supplement their diet given the nutritional demands necessary for effective HIV treatment adherence, builds and boosts confidence for young women; improves communication and family level relations among partners and children at household level and restores hope by driving away the shame, hopelessness and stigma associated with LHIV.

The PLHIV networks have continuously built capacity of their member organizations at district level to provide services to other PLHIV. The different IPs have worked with the PLHIV to provide services in the facilities as expert clients or linkage facilitators.

Develop and implement interventions to reduce the economic vulnerability: Under this strategic action there have been efforts to address issues of nutrition, linkage to nutrition, access agricultural support services and economic empowerment. During the reporting period, TASO worked very closely with Public Health Facilities and other stakeholders to provide nutritional counseling and assessment to 36,269 project beneficiaries. The key interventions provided under nutrition included; nutritional education, assessment, RUTF, and establishment of kitchen gardens

Picture 7 OVC household beneficiaries who have benefited through referrals for food and nutrition in Mityana district. Left is Garlic and right is beans

The most effective social protection approaches for promoting healthy behavioral changes and decreasing the risk of violence among adolescent girls and young women have been those that use both economic and social empowerment. A total of 5241 AGYW were provided with apprenticeship skills by Send a Cow (TASO's consortium partner). The apprentices received various skills in the following enterprises; Book making, catering, craft making, hair dressing, tailoring. This is aimed at improving the AGYW household income. In addition the project also mobilized caregivers of adolescent girls to join SILC groups and have been empowered with financial literacy skills.


Picture 8 AGYWs during cake making training, local sanitary pads making organized by SAWA WORLD SOLUTION -NAFHOPHANU at Kanoni UMEA P/S

Picture 9 Crafts made by Adolescent girls and young women

There were 31,096 OVC households that received agricultural or farm inputs in this reporting period and 40,333 HH received agricultural advisory services. This is aimed at promoting food production at the household level.

Develop and implement appropriate strategies to prevent and respond to child abuse and exploitation: Under the PACK project in Karamoja, the UN built capacities of elders and chiefs in Moroto and Kaabong districts to mediate domestic violence cases involving HIV (aggravated cases of violence). Working with the district leadership, the elders and FIDA- simple and customized tools (in local language) were developed , a mapping of stakeholders done and the referral pathway for ongoing support services updated to reflect the linkages between the informal and formal justice systems. Simplified guidelines for referral of domestic violence cases including those related to HIV have also been developed and the elders oriented and mentored on their application and use. A documentary series is being compiled to showcase some of the change stories.

A national inter agency GBV technical working group was established in July 2016 co-led by UNFPA and UNHCR in partnership with MGLSD, OPM, UNICEF, and other humanitarian stakeholders. The working group mapped GBV referral actors in the different settlements, reviewed SOPs and jointly monitored implementation noting areas of strength and improvement. A total of 864 GBV cases were

recorded in the refugee settings of which 37% were of sexual violence in nature including rape and 63% other types including physical, emotional among others. 1,269 reported survivors of GBV received appropriate medical and psychosocial support. 85% of reported rape cases benefited from clinical management within 72 hours of incident; 123,716 young people were reached with information and services on GBV and SRH; and overall, 351,761 women and girls reached with SRH services in humanitarian settings.

In the 3 districts, 36 survivors of GBV were supported and provided with psychosocial support as reported and linked to health services. The cases included: 4 defilement, 5 rape, 9 forced marriage, 12 of domestic violence, 2 on resource sharing and 4 were on emotional violence.

There have been 200 Male Action Group members in the 10 sub counties of the three districts of Moroto, Kotido and Kaabong reached out to 4,207 (2,123M, 2,084F) people with GBV messages. These also participated in quarterly review meetings to share experiences and outcomes from their activities.

Justice system structures in Moroto and Kaabong. Working with (FIDA-Uganda), UN Women was able to mobilize 60 (12 females, 48male) cultural and community leaders and 78 (6 male, 72 female) leaders of PLHIV and enhanced their capacity through training and mentorships to be able to address the intersections of gender discrimination, gender based violence (GBV) and HIV/AIDS through training and mentorship on case identification, clerking, mediation and or referral in order to improve access to justice and essential services for women and girls. This was purposed to improve and create stronger and gender aware community justice structures in the districts of Moroto and Kaabong. Cultural and community leaders were mobilized and trained on the basic interpretation and potential implications of human rights violation, discrimination of on the basis of known or perceived HIV status, violence against women and girls and the application of international and national legal frameworks protecting the rights of women and girls.

Objective 4: Engender all social support and protection programs to address the unique needs, gender norms, legal and other structural challenges that make women, girls, men and boys vulnerable to HIV/AIDS

Support review, implementation and monitoring of legal and policy instruments: In this reporting period there has been the revision of the National Action Plan for Women, Girls, Gender Equality and HIV, a Facilitator's Guide in training community champions and paralegals of Gender Based Violence (GBV) prevention and management and referral, The National Gender Based Violence Elimination Policy has been approved and the review of the 2007 Gender policy has started.

Under a tripartite arrangement, Ministry of Gender Labour and Social Development, Uganda AIDS Commission and TASO spearheaded the revision of the National Action Plan for Women, Girls, Gender Equality and HIV. The current NAP is aligned to the NSP and shall play a great role in ensuring that the NSP achieves the targets set under the thematic area of Social Support and Protection..\..\MGLSD\NAP DRAFTS\April 2017\NAP HIV JULY VERSION APPROVED BY MGLSD.doc

Under a tripartite arrangement, Ministry of Gender Labour and Social Development, Uganda AIDS Commission and TASO spearheaded a Facilitator's Guide in training community champions and paralegals of Gender Based Violence (GBV) prevention and management and referral; and this has already been utilized in equipping community activists with skills to handle GBV cases and improve the populace's social protection ..\..\TASO\Stop GBV Champion documents\GBV TRAINING

MATERIALS\final approved manual\FINAL TRAINING MANUAL approved by MGLSD by TASO 2.6.2017 5pm.pdf.

At the beginning of the financial year 2016-2017, cabinet approved The National Gender Based Violence Elimination Policy (NGBVEP) and the National Gender Based Violence Elimination Action Plan. These instrumental documents shall play a vital role in improving the GBV survivor's social support and protection, as well increasing their access to justice.

With the change in the operating environment and the ground of operation, the review of the 2007 Gender policy started. This is in line with the need to review any policy every 10 years but also the context has changed. There have been changes in the population structure since the policy was developed, the government priorities and the unemployment status in the country. Also there have been a number of gender-responsive laws were enacted while policies have been formulated. This is aimed at increasing the levels of gender integration in all sectors and gendered reporting.

The process of conducting the Gender Assessment has commenced and tabled before the Local Funding Agency for review. It is anticipated that by December 2017 the assessment shall be concluded and data generated shall be ready for public use.

The Gender Desk at the Uganda AIDS commission has been vital in convening the National Gender Technical Working Group meetings on a quarterly basis and spearheaded the Community Systems Strengthening group in the concept note development of the Global Fund grant application; which has attracted USD $5,607,952 for the next funding cycle by the Global Fund for systems strengthening and Adolescent girls and young women.

Strengthen institutions and sectors to implement laws and policies addressing SGBV and other rights violations: HRAPF held **8** talk shows on seven radio stations and one television. A total of **65** persons called and their issues were responded to. During the talk shows, HRAPF team discussed the patients' rights, land rights and will making on Musana FM while on CBS and Buddu, the team discussed HRAPF activities, land rights and the launch of HRAPF legal aid services in Masaka. The talk shows were on different issues of human rights, stigma and discrimination and patient's rights, legal avenues for accessing justice by persons living with HIV/AIDS.

There are 451 health workers, 41 prosecutors, 360 police officers and 120 community champions have been skilled on how to address the needs of PLHIV and GBV survivors. This was an activity that was carried out by UGANET in the bid to ensure that there is protection of the vulnerable with all the duty bearers to address the unique needs that expose people to the risk of HIV.

Utilizing the 4 point social protection model and referral cycle, UGANET engaged gate keepers of justice for PLHIV and the key pointers of service delivery were reached. The gatekeepers were able to document violations of rights of women and girls living with HIV and properly documented 107 cases among PLHIV physical case files. A total of 56 violations were recorded for the PLHIV. The human rights violations recorded included 15 cases on the right to freedom from discrimination based on one's health status, 33 on the right to property which mainly concerned denial of having a share in an estate and evictions from land, 5 on the right to liberty where clients were detained for more than 48 hours and 3 on the right to health, particularly access to medical services.

Establish mechanisms for engaging men and boys in HIV/AIDS and SGBV programing: Mama's club trained 210 male champions and 1,175 Male Action Group members in SRH and HIV/AIDS. The trained male champions and group members sensitized over 1, 530 men on the role of men in SRH, HIV prevention and treatment support and GBV.

Enhance capacity of all actors engaged in the HIV/AIDS national response to adopt gender and rights-based HIV programming: During the reporting period, HRAPF provided free legal services in 107 cases for people living with HIV/AIDS. Of the 107 cases received, 79 were for women and 28 were for men. These cases benefited a total number of 471 individuals directly and indirectly. 103 individuals benefited directly while 368 benefited indirectly. Indirect beneficiaries were in most cases.

IRCU organized a regional religious leaders retreat to embrace integrated sexual reproductive, maternal, neonatal, child and adolescent health (SRMNCAH), HIV and GBV for the benefit of youth, adolescents and women in their congregations. This retreat was organized for religious leaders in Karamoja, North East and Eastern Uganda. These leaders were sensitized on the importance of SRMNCAH services for the sexually active and those in reproductive age, including living positively with HIV; discussed roles and responsibilities of religious institutions and leaders in addressing issues of behavior and other socio-cultural factors that hinder individuals from protective behaviors and accessing services. As a result, this initiative enhanced their capacity to advocate for SRHMNCAH/HIV/GBV issues within faith based institutions and in their communities and contribute to efforts for generation of demand for adolescent and maternal health and HIV services in the focus districts.

3.6.4 Lessons Learnt

- Fighting stigma requires targeting both the individual level as well as the community level
- Engaging Peers to educate fellow PLHIV breaks self-stigma and yields results in the adherence campaigns.
- The disclosure mechanism in the UPDF has improved access to services within the force within Information sharing is very key in targeting the Key Populations in a bid to improve their access to services
- OVC household/groups are very active when you Support feasible livelihood activities of their choice
- Economic empowerment is best achieved through skilling
- The young people are interested in income generating activities and talent promotion

3.6.5 Challenges

- Stigma index though supposed to be conducted every 2 years has not been conducted since 2013 and as such it is not easy to get national data for that indicator.
- There are no counsellors to support the health workers in provision of psychosocial support
- The demand for legal aid among the PLHIV is overwhelming.
- There is limited attention from the Uganda AIDS Commission on the legal gap for people living with HIV/AIDS yet when a person has legal issues all other interventions are disrupted.
- The People Living with HIV are facing legal issue and human rights violations especially through stigma and discrimination within households, the community and at health centres.
- The country still doesn't have a defined life-cycle comprehensive package in the context of HIV
- The database does not breakdown the different groups that should benefit from social support and mainly captures OVC indicators
- Limited funding for OVC activities

- There is a funding gap for the social protection intervention area there is need to link with IPs in the sector to integrate social protection services within their area of coverage
- There is limited reporting of interventions in the OVC sector
- The database in the OVC MIS doesn't not segregate for the different vulnerable groups

3.7 Systems Strengthening- Achievements, Lessons Learnt and Key Gaps

The fourth goal of the NSP 2015/16-2019/20 aims at "An effective and sustainable multi-sectoral HIV/AIDS service delivery that ensures universal access and coverage of quality, efficient and safe services to the targeted population by 2020. The system strengthening thematic area has six components of governance and leadership, human resource, procurement and distribution of medicines and supplies, financing, strategic information and actual service delivery. This implies that in order to deliver against the NSP, there is need for both the soft and the hard skills. The NSP recognizes that the winning formula is the multi-sectoral approach.

3.7.1 Achievements

- 10 out of the 17 gazetted Cultural Institutions were supported to develop operational plans, M&E plans and resource mobilization plans
- PEPFAR implementing partners in partnership with UAC have helped 98 districts develop hands-on strategic plans
- The Presidential Fast-Track Initiative on ending AIDS as a public health threat in Uganda by 2030 was launched by His Excellency the President of the Republic of Uganda
- 112 DAC districts have DAC structures
- 22 out of the 42 municipalities have active MAC
- Most public institutions have largely mainstreamed HIV and AIDS at the work place
- 69% public-sector positions are currently filled in health facilities
- Training curricula were reviewed to align with the new guidelines in health and non-health and non-professionals
- 2,400 (100%) individuals who received pre-service training scholarships under Baylor SAINTS project continued to be monitored
    - 67% (1609/2400) had completed and graduated
- METS worked to Improve Governance, Leadership & Management (GLM) of the decentralized HIV response
    - 63 Fellows from the districts comprised of 3 District Health Team Members enrolled in a 9 months Governance, Leadership and Management Fellowship Program.
- Fellows were drawn from 21 districts
- New National Health Lab at Butabika hospital for all referral labs including microbiology, Sickle cell, Hepatitis B, TB, Viral load, EID
- UNHLS has developed strategies to strengthen existing systems and standardize implementation of POC
- Donation of 38 Point Of Care machines to be piloted in 30 facilities
- Viral load testing campaigns have been conducted across all regions
- 702 facilities offering youth friendly services
- AHF Uganda Cares constructed five (5) patients' waiting shades
- A USD 651,661,433 spending in the sector against the estimated cost of USD 632,600,000
- Proportion of funding by ADPs continued to grow (95%) compared to the GoU allocation
- Government of Uganda remained constant from the previous Financial Year at USD 32,546,448
- National HIV and AIDS Resource Mobilization Strategy was developed and approved

- 40 MDAs out of 45 MDAs have mainstreamed HIV and AIDS activities programmatically and financially
- Private sector engagement in domestic financing for HIV&AIDS response launched the One Dollar Initiative (ODI)

Objective 1: Strengthen governance and leadership of multi-sectoral HIV/AIDS response at all levels

The NSP recognizes that it's only when there is effective leadership and governance that the country can accrue benefits from the investment in HIV/AIDS. In operationalizing this objective, the NPAP focuses on strengthening the engagement of leaders, dissemination of laws and policies, strengthening the partnership mechanism, supporting public and non-public coordinating structures, promoting the multi-sectoral response at all levels, ensuring gender, disability and human rights are mainstreamed in all major programs in public and non-public sectors and ensure implementation of the EAC trans-boundary HIV&AIDS related legal and programmatic concerns.

Strengthen the engagement of the leaders in stewardship of the multi-sectoral response at all levels: The Uganda AIDS Commission has strengthened the coordination of HIV&AIDS activities by ensuring all the Technical Working Groups (TWG) are functional and meet on a quarterly basis to review progress and keep track of the implementation of the NSP. The UAC has also been able to keep the MDAs and SCEs engaged having quarterly meetings with them and following up on the implementation of HIV/AIDS activities in their sectors. The UAC monitors the implementation of the NSP on an annual basis with the engagement of the key players in the public and private sector arena.

The Ministry of Gender, Labor and Social Development (MGLSD) with support from UNFPA, was able to engage 10 out of the 17 gazetted Cultural Institutions to help them develop operational plans, M&E plans and resource mobilization plans using the policy Briefs and pronouncements they made. This is aimed at strengthening the capacity of Cultural Institutions to mobilize their own resources to implement their activities using their structures. These institutions have used the different avenues to send out HIV messages to their subjects.

Districts have been supported to develop strategic plans, M&E plans and costed HIV work plans for the first year. The PEPFAR Implementing Partners in partnership with UAC have helped 98 districts develop hands-on strategic plans with costed work plans for the first year of implementation. To-date over 50 districts have printed their strategic plans.

District-Led Programming has been strengthened to support the district health teams to have the technical capacity and resources to effectively coordinate decentralized health services including sustained response to HIV/AIDS epidemic through sound program management and partnerships

In order to effectively coordinate partner support:

- Regional Partners have supported the DHT to mobilize all other partners to be part of the partner – DLG partnership process
    - through the Partnership framework agreement
    - Clearly spelt out roles and responsibilities between DLG and IPs
        - Performance monitoring processes
    - Mutual accountability details
- Provided TA to the DHTs to cost their annual work plans and will be the basis for sub granting

- The above Site IPs such as METS have standardized the planning processes, and supported the DHTs to coordinate the five-year strategic planning process, regional technical reviews (district perspective)
    1. Ensured that IPS have a standardized approach to supporting DHTs (management of mutual expectations)
    2. Launched and supported the implementation of the Strategic Plans through regional level mechanisms,
    3. Closely worked with the regional teams, including regional hospitals and community health departments to support districts with implementation.
    4. Supported the regional and district technical reviews that do inform upstream into the national level reviews (sharing best practices and scale up high impact interventions)
    5. Supported performance review meetings at regional levels across the whole continuum
    6. Supported data review meetings at regional levels

To fully coordinate the district led response, a National DLP coordinator has been recruited at MOH to oversee activities strengthening district leadership in the response.

The district led programming rolled up with support from partners, the districts were supported to develop work plans and coordinate implementation of activities. The new regional partners have been supported by PEPFAR to support district implementation.

Picture 10 His Excellency the President of Uganda signing the commitment to end AIDS in Uganda on June 7, 2017

The Presidential Fast-Track Initiative on ending AIDS as a public health threat in Uganda by 2030 was launched on June 6, 2017. The Initiative seeks to leverage the direct leadership of His Excellency Gen. Yoweri Kaguta Museveni In the country's drive to achieve epidemic control. He has offered to directly lead the implementation of a combination of specific biomedical, behavioral and structural interventions appropriate for specific population groups. At the national launch of the initiative, his Excellency disseminated the message to more than 1000 leaders including: International, National, Civil Society, local governments and networks of PLHIV.

The initiative acknowledges and seeks to reinforce current efforts, successes and achievements attained in halting and reversing the HIV epidemic in Uganda, and calls for expanded and targeted multi sector, multi partner action. The specific objectives of the Initiative include:

1. Engage men in HIV Prevention and close the tap on new infections particularly among adolescent girls and young women;
2. Accelerate Implementation of Test and Treat and attainment of the fast track 90-90-90 targets particularly among men and young people;
3. Consolidate progress on elimination of mother-to-child-transmission of HIV;
4. Ensure financial sustainability for the HIV and AIDS response;
5. Ensure institutional effectiveness for a well-coordinated multi-sectoral response.

It is anticipated that with his leadership there will be accelerated advocacy on the implementation of identified interventions, intensified approach to messaging for behavioral change communication, improved internal resourcing for interventions and direct monitoring of the HIV response by the President.

Having in mind the need to bring men on board especially in the area of HIV care and treatment, the cultural leaders have come on to champion drives to ensure that all people know their HIV status. The Kabaka of Buganda is currently spear-heading the "Male engagement campaign for Buganda Kingdom." The campaign has long terms and short term targets. The short term targets will achieve immediate out puts focusing on launches, communicating messages that will be integrated in the Kabaka's events, messages through Buganda and friends of Buganda, radio and T.V station Presenters, through the clan and Masaza Leaders, musicians, artists, footballers, Private Sector and Youth groups in Schools with a special focus on Male Engagement. The campaign will also tap into motivators like the World Guinness book of records, key football players brought into the country with the focus of attracting more men to access services, resource mobilization campaigns through musicians, artists plus creation of motivational award platforms for men.

The campaign will also tap into the involvement of The Kabaka together with the Kingdom Ministers and all representatives from Buganda region in national and regional events, meetings and seminars. The Kabaka will also host a regional campaign for African Kings and Cultural leaders to address them on what he has done and the successes that have been achieved in the region, this will most likely be done in 2019 or 2020.

The campaign was launched in March 2017 and the intended outcomes of the Kabaka campaign by the end of 2020 include:

- Reduction of HIV prevalence in Buganda region from 10.4% to 6.5%
- Reduction of new infections in Buganda region from 40,200 to 2000 new infections
- Increase in Male engagement in HIV services including other health related services
- Reduction of Gender Based Violence cases in Buganda region.
- Buganda acting as a case study for the Eastern and Southern African region in terms of use of the Cultural leadership intervention on HIV .

The campaign has been able to reach 36 media reporters in a press conference held, reached over 3000 people with HIV messages at events graced by the Kabaka in Buvuma islands, Kabaka's Coronation Celebration, Kabaka's birthday run, **He-for-She** Campaign , Education day and Buganda Lukiiko (Kingdom Parliament), orientation of the 59 clan leaders on HIV Prevention, access to medicines and the role of men in the HIV Prevention and 28 media presenters.

Dissemination and implementation of the existing and new legal and policy related instruments: There have been a number of policies that have been rolled out in the major line ministries including the Test and Treat policy and the HTS policy both under MoH. Under MGLSD, the Early Childhood Development policy that was approved and has been disseminated as well as the National OVC policy and the Gender policy which are under review. There is a proposed bill in parliament regulating time for alcohol "*enguli* law".

Strengthen the capacity of UAC and the partnership mechanism to carry out their mandate: The governance structure is comprised of the Board of Commissioners and the Secretariat which is led by the Director General. The term of office of the board expired in March 2017 which left a governance gap that is yet to be addressed.

The partnership coordination at the national level has been strengthened and Partnership Committee meets every quarter. In the districts, the DACs have been revitalized and are supported by the different IPs and UAC. There are 112 DAC districts that have DAC structures. The functionality of the DACs is mainly assessed by the regularity of the meetings held (supposed to be quarterly). This is assessed to be above 50% and the others (56 districts) meet at least twice a year. The challenge comes when these structures scale down to the Sub-County level, the functionality is very low and almost non-existent at the parish and village level. Some of the DACs have come up with bylaws and ordinances. The challenge are lower local government AIDS committees are inactive with the exception of Sironko which is up to the village level given the district generated funds. In Karamoja region, 60% of the Sub Counties have functional HIV committees with support from AMICAALL through the KARUNA project. AMICAALL has also supported 22 out of the 42 Municipalities to have active MAC although only 20% of the town councils have AIDS Committees.

The UAC has also been able to keep the SCEs engaged having quarterly meetings with them and following up on the implementation of HIV/AIDS activities in their sectors. The UAC monitors the implementation of the NSP on an annual basis with the engagement of the key players in the public and private sector arena.

The commission has deliberately targeted the leadership of public and non-public sectors to improve coordination. Meetings with MDAs and SCEs are held on a quarterly basis to review progress. Currently the Commission is engaging MDAs and SCEs to ensure there is financial support to HIV within their different sectors. The SCEs have been supported to scale up structures down to the regional or district level. For example the ministry of Works and transport has prevention activities all the way down to the district level. The parliament of Uganda has developed HIV communication tool kit for Parliamentarians to communicate to their electorates.

Rationalization has been consolidated under the PEPFAR support to the districts. The IPs have been re-assigned in both geographical region and programmatic area to ensure a more comprehensive coverage.

Support public and non-public sector coordinating structures to carry out their role: Most public institutions have largely mainstreamed HIV at the work place. There are different fora used to disseminate HIV information in the institutions including meetings, trainings and IEC materials. All MDAs and SCEs have HIV Focal Persons following up implementation of HIV activities in the sector.

There is Inter and intra partnership collaboration among SCEs on a monthly, quarterly at national and sub national level. For example PLHAs working with government entities, Private Sector working with government, Public Sector working with Faith Based Organizations (FBOs), FBOs working with PLHAs.

There has been dissemination of HIV coordination guidelines within the district local governments for example in all the 7 districts of Abim, Kaabong, Kotido, Moroto, Nakapiripirt, Napak and Amudat for the newly elected leaders in Karamoja region with support from JUPSA. There are districts that have enacted and are enforcing bylaws and ordinances e.g. Moroto has one on GBV, Oyam and Gulu has on

alcohol, Abim has one on early marriage, Nebbi regulating time for disco and alcohol, Lwengo also came up with an ordinance regulating drinking time.

HIV/AIDS has been mainstreamed into the different public programs. For example in the MOWT the bid documents have been improved to incorporate the HIV/AIDS aspect. The MOWT has improved the monitoring tools for their activities to incorporate HIV/AIDS and this has been scaled down to the district level.

Up to 45% of the private sector has HIV work place policies. This is an increase from 30% last reporting period. This has been possible because of the efforts of the private sector alliance against HIV/AIDS under Federation of Uganda Employers (FUE) with support from ILO. There has been improved coordination in the sector with a coordination committee formed up by 20 associations. The HIV In Work place Activity (HIWA) project that has worked with Hotels, UPF and UPDF has been able to train the people in the HIV work place policy.

Implement EAC trans-boundary HIV/AIDS related legal and programmatic concerns: There has been harmonization of the EA HIV/AIDS acts in all the member countries to speak the same language in order to provide the same message.

Objective 2: Ensure availability of adequate human resource for delivery of quality HIV/AIDS services

The outcome under this objective is to ensure availability of human resources for delivery of quality HIV/AIDS services. This is supposed to be tracked by identifying the percentage facilities with the required staffing levels.

Review policy and strategy for improving attraction and motivation of staff involved in delivery of HIV&AIDS services: Currently 69% of human resources for health in public-sector positions are currently filled. And while 87% of the population is rural, most of the health workforce is concentrated in cities. There has not been any recruitment in the reporting period. That notwithstanding, there are regions whose coverage is higher than the national coverage; a case in point is the Rwenzori region where 73% of critical positions were filled with support from PEPFAR.

Harmonize pre and in-service training of different cadres for HIV/AIDS service provision: The training curricula were reviewed to align them with the new guidelines in health and non-health and non-professionals engaged in provision of HIV/AIDS services. A total of 2,400 (100%) individuals who received pre-service training scholarships under Baylor SAINTS project continued to be monitored. About 67% (1609/2400) had completed and graduated. During the reporting period, 33% (791/2400) were still in school. The area of focus for scholarships was mid-wives, laboratory, clinical instructors and mentors.

To ensure availability of adequate human resource for delivery of quality HIV and AIDS services a total of 68 trainings were delivered by AHF Uganda Cares in 2016/2017 to 1,920 health workers across the program, procured and distributed drugs worth Ushs 2 billion to ensure continuous flow of ART, invested Ushs 788,677,733/= in infrastructure development and improvement to improve on the quality of service delivery and conducted routine monitoring and evaluation to inform program implementation and improvement. Majority of the trainings (81%) were delivered through the facility based model to increase access to and involvement of more health workers in the training program. The trainings delivered included the following; Adolescent HIV, new guidelines for HIV prevention and treatment,

Open-MRS and HIV Testing Services. The goal of the new guidelines for HIV prevention and treatment training was to build capacity of health workers to implement the new consolidated guidelines for HIV prevention and treatment released in December 2016. Infectious Diseases Institute has trained a total of 3600 health workers including 407 clinical officers, 191 medical doctors, 1129 nurses, 40 pharmacists 585 nursing assistants, 1075 lab staff and 173 counselors. There was psychosocial training of trainers with support from Global Fund and ANNECA. There is an ongoing process at the MoH to develop psychosocial training curricula targeting nurses and other cadres working with children. Once this is completed then the training will be rolled out.

By the end of December 2016, there was reduced stock out of HIV test kits as compared to earlier in the year in the last reporting period with Western region making impressive progress as shown in figure 18 below.

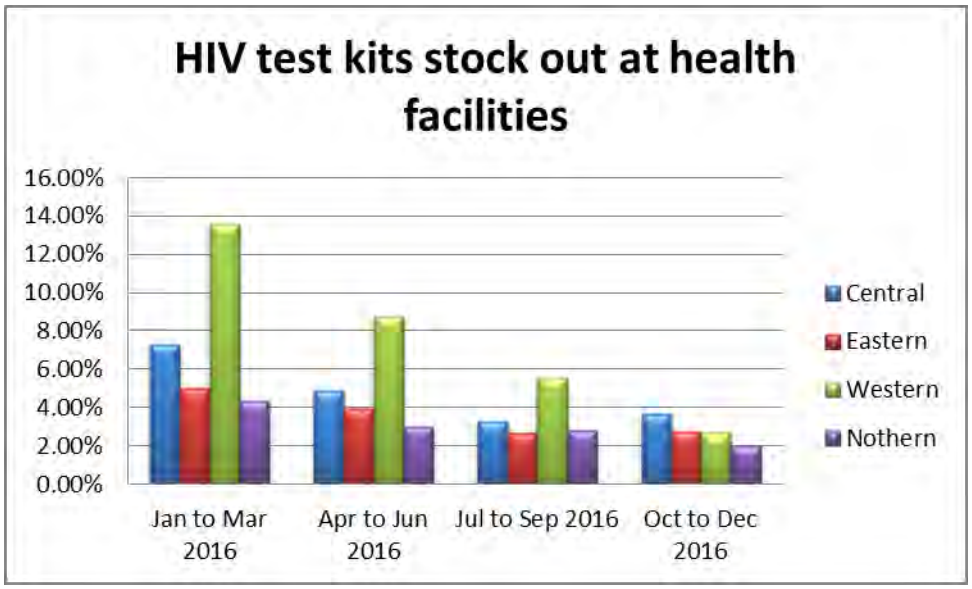


Figure 13 HIV test kits stock out records

Build leadership and management capacity of key workers and structures for enhancing implementation of national and decentralized HIV&AIDS response: During the year 2016/2017, METS worked to improve Governance, Leadership & Management (GLM) of the decentralized HIV response. In this regard, 63 Fellows from the districts comprised of 3 DHT Members who include the District Health Officer were enrolled in a 9 months Governance, Leadership and Management Fellowship Program. The Fellows were drawn from 21 districts. The program was co – facilitated by the METS staff and Ministry of Health staff from the Quality Assurance and Improvement Department, AIDS Control Program, Planning Department and Finance. To date, all the 63 Fellows have designed projects to address varied gaps in the decentralized HIV response and management.

Picture 11 Graduates of the fellowship program 2017

To strengthen the governance and leadership of the multi-sectoral HIV response at all levels, Baylor Uganda supported 15 districts (100% achieved) to improve their governance and leadership skills. A total of 1,240 frontline health workers across Rwenzori region from 147 health facilities and district leaders were trained in leadership and governance skills. In Eastern, 812 health workers in 90 health facilities received the leadership and governance training. The areas of focus were: Time management, communication skills, team work, action planning, conflict resolution, situational leadership and use of data for decision making by using Team Performance Monitoring Tools (TPMT). There has been a notable improvement in the number of HFs holding quarterly meetings from 28.7% to 51.4%. Time management has improved in 99.2% of the Health Facilities (HFs) by maintaining arrival books, improvement in tracking absenteeism from 20.3% to 81.3%.

Objective 3: Strengthen procurement and supply chain management for timely delivery

While there is notable progress made in the procurement and stocks for HIV and AIDS medical and non-medical products at national level, subnational and lower level users still face challenges accessing these products. There are frequent stock outs at the facilities and storage facilities at the district level are suboptimal yet some HIV commodities are very bulky. There is still need to strengthen procedures and processes for accessing timely and quality essential pharmaceutical and health products and technologies by the lower level providers and beneficiaries.

Institutionalize Quantification Procurement and Planning Unit (QPPU) and support capacity building in procurement and management of products, goods and supplies at lower level health facilities: QPPU staff recruited in MOH pharmacy division support quantification and ordering of medicines. This has strengthened the procurement process. They held two meetings for all products including test kits, ARVs and lab products. GOU, GF and PEPFAR committed funding for products. QPPU introduced LPVr pellets and supported by Jansenn with products and also with support from Medlink they piloted the HIV/Syphilis test kits and piloted its use in 6 districts, Nakaseke, Luwero, Rakai, Kalangala, Wakiso and Lyantonde districts.

Strengthen the harmonization of procurement and supply chain management, and the expansion of operationalization of Web-based ARV ordering and reporting System:_Web-based ordering of

supplies has been scaled up and updated in all the districts. All districts are now ordering through WOAS. There has been procurement of HIV test kits including SD Biol-line and all other products. Logistics training has been included in the new training guidelines and has been rolled out across all facilities. On average, 92% of essential drugs and supplies were available which was facilitated by the available WOAS. In some facilities, the IPs support Districts to specifically be vigilant and report side effects of drugs for example Baylor - Uganda supported establishment of pharmacovigilance Focal Persons at every HF to monitor side effects of drugs. The stock out of ARV in the reporting period was 9.26%.

Objective 4: Ensure coordination and access to quality HIV/AIDS services

Coordination of HIV services at all levels is important to avoid duplication and ensure effective service delivery. The coordination can be seen at the performance of all the thematic areas but most especially in the service delivery. In order to ensure coordination and access to quality services, the country has been divided into 10 regions and each region has an implementing partner whose role is to ensure quality delivery of services, capacity building and systems strengthening. The regions are South West whose IP is EGPAF, Mid-West whose IP is Baylor Uganda, East Central where the IP is URC, Central 1 where the IP is Mildmay and IDI, Teso region where the IP has been Baylor Uganda but now TASO has taken over and others.

Build string linkages between institutionalized facilities and community systems: The Differentiated Service Delivery model guidelines were developed and piloted in various regions in 30 facilities. DSD model refers to various ways of providing care and treatment services that are tailored to the needs and preferences of PLHIV with the aim of maintaining good clinical outcomes and improving efficiency in service delivery.

Under DSD, the health systems shift away from "one-size-fits-all" to focus on clients most in need.

In Uganda, the 2 services for adopting differentiated models are:

- Differentiated HIV testing services
- Differentiated HIV treatment and care

The core principles of differentiated care are:

- Client-centered care
- Improved health system efficiency
- DSD is a policy requirement for the country to address the increased number of clients as a result of 'test and start' and decreased death among PLHIV.

DSD will address current problems which include;

- Frequent health facility visits for clients
- High travel costs
- Over-crowding at the facilities
- Long waiting times at facilities
- Over stretched health systems
- Poor quality services
- Poor retention into care due to failure to address sub-population concerns

Table 7 Differentiated service delivery model cascade

Stable Clients	Unstable/Complex Clients
• PLHIV (Children, Adolescents, Pregnant and lactating women and adults) on current ART regimen for more than 12 months • Virally suppressed: 1 virally suppressed test result within 12 months • No opportunistic infections (WHO stages 1,2) • TB clients who have completed 2 months intensive phase treatment and are sputum negative • On 1st or 2nd line ART regimens • Demonstrated good adherence (over 95%) in the last 6 consecutive months	• PLHIV (Children, Adolescents, Pregnant and lactating women and adults) on current ART regimen for less than 12 Months • Not virally suppressed • Has current or history of stage 3 or 4 opportunistic infections (WHO stages 3 or 4) within the past one year • TB clients in intensive phase of treatment (< 2 months) or who are still sputum positive after intensive phase treatment • MDRTB/HIV co-infected clients • On 3rd line treatment • Poor adherence (less than 95%)

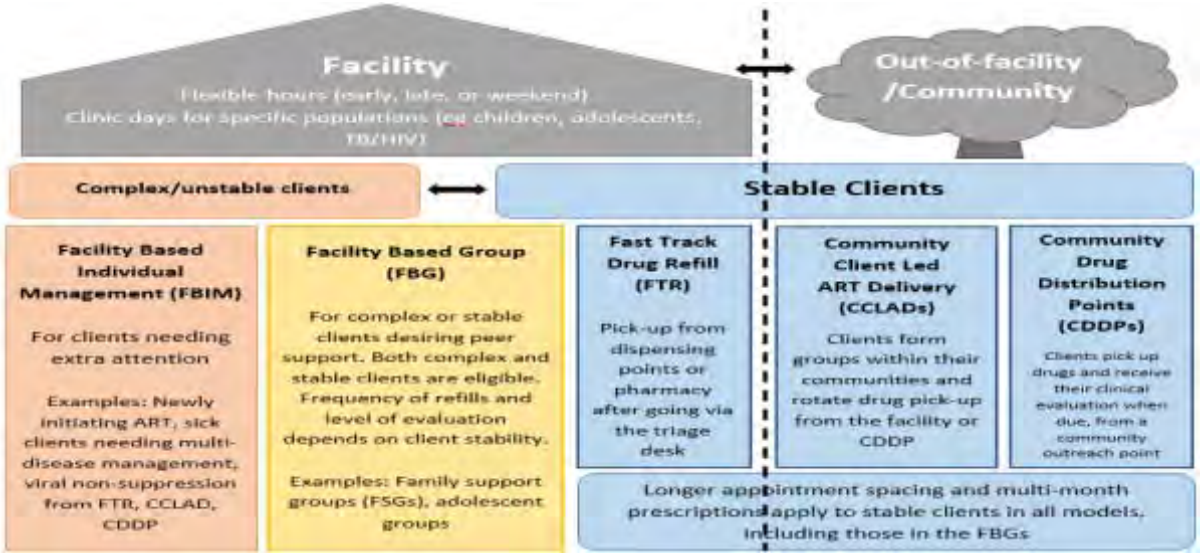


Figure 14 Graphical view of DSDM

The training curriculum has been finalized for the ToT. There is a study being conducted for human resource in DSD model at the implementation sites. A community implementation plan was developed and harmonized for partners to be able to define clear linkages and referrals.

To strengthen the national mechanism for generating comprehensive, quality and timely HIV and AIDS information for monitoring and evaluating, 100 ART sites were computerized with Uganda Electronic Medical Records (EMR) system with support from Baylor Uganda. This has contributed to improved data quality and timely reporting; 94% of sites had critical data tools. METS printed the tools. All supported sites received onsite training in data capture, analysis and reporting, and all districts (15 CDC

and 7 UNICEF) conducted their quarterly performance feedback meetings to review their progress and develop action plans to address identified gaps.

Objective 5: Strengthen the infrastructure for scaling-up the delivery of quality HIV/AIDS services

Under this objective the indicators focus on Health facilities offering ART and eMTCT as well as performance of laboratories. The IPs have worked with districts to ensure that the lab equipment is maintained. In the West Nile region, IDI renewed service contracts for automated lab equipment; 6 hematology and 7 chemistry analyzers at hospitals in Nebbi, Moyo, Yumbe and Koboko districts.

Expand availability and capacity of laboratories at different levels: The new National Health Lab at Butabika hospital was opened in November 2016. The hospital is for all referral labs including microbiology, Sickle cell, Hepatitis B, TB, Viral load, and EID.. The lab received SANAS accreditation. A new laboratory services bill has been drafted and is being presented to the different parliamentary committees for approval. The hub system has been strengthened through the hub coordination meetings held quarterly.

UNHLS has developed strategies to strengthen existing systems and standardize implementation of POC. POC Policy and Implementation guidelines which:

- Provide guidance for regulation of POC technologies
- Guide development of POC product and site selection criteria
- Provide guidance on how to integrate POC into the existing health diagnostic system
- Provide a framework for standardization of POC at service delivery points

There was a donation of 38 Point Of Care machines which included 15 Alere Q, 34 Samba and 10 Gene Xpert for EID., Site assessment was done, and piloting will be done in 30 facilities. Viral load testing campaigns have been conducted across all regions.

Implementing Partners have strengthened the capacity of laboratories to perform clinical lab tests according to national laboratory standards as a way of strengthening laboratory systems. For example Baylor Uganda supported strengthen laboratory systems in 117 HFs which included 90 from Eastern, 125 from Rwenzori and 2 from Kampala.. All supported health facilities (100% achieved) received support from technical teams to strengthen their laboratory systems. The COE laboratory was successfully assessed by the College of American Pathologist and attained re- accreditation. There was very tremendous improvement in result TAT for the DNA-PCR and Viral Load due to the online UNHLS dashboard. The project has supported 12 lab hubs enrolled in SLAMTA, 6 are upgraded to star 3 and 4 are at star 2. About 67% of supported labs received LQMS mentorships and established QI projects and adherence to Good Lab Practices. About 60% of HFs established HW/lab staff interfaces meetings to improve flow processes. It also strengthened the sample referral systems through support to the hub riders.

Increase the accreditation of HC III and II to provide comprehensive HIV/AIDS and TB services: The number of accredited HC II facilities has increased from 1780 in the last reporting period to 2099 in this reporting period. There are 2000 health facilities that have been accredited to offer youth friendly services but currently there are 702 facilities (35.1%) offering youth friendly services.

AHF Uganda Cares constructed five (5) patients' waiting shades (with clinical rooms) at Kiwangala HC IV, Kinoni HC III, Butenga HC IV, Mugoye HC III and Kyazanga HC IV. In addition, major

renovations were done at Masaka RRH ART Clinic, Naguru Hospital, Lukaya Healthcare Center and Nangongera HCIV. This was geared towards improving quality service delivery in terms of space and client flow, waiting area, aeration and flow in the clinic. AHF Uganda Cares invested Uganda shillings 788,677,733/= in infrastructure development and improvement to improve on the physical appearance of the facility, cleanliness, comfort, privacy, confidentiality and other aspects important to clients.

Objective 6: Mobilize resources and streamline management for efficient utilization and accountability

The country for achieved a target for the projected annual cost for financing the national HIV/AIDS response; achieving a total of USD 651,661,433 in 2016/17 against the estimated cost of USD 632,600,000 for the same FY according to the National Strategic Plan 2015/16 – 2019/20. However this performance was below the estimated cost of USD 874,000,000 of the Investment Case for the same Financial Year. The Proportion of funding by ADPs continued to grow (95%) compared to the GoU allocation in the reporting period. The table below shows financing for the national HIV/AIDS resources by all sources.

Table 8 Table: HIV/AIDS Financing by all sources

Agency	Funds approved (USD) 2015/2016	Funds approved and dispensed (USD) 2015/2016	Funds Approved for 2016/2017 (USD)	Source
PEPFAR	262,609,562	262,609,562	410,000,000	PEPFAR country Operational plan 2016
Ireland	2,365,162	2,362,161	4,372,680	Ireland Country plan
Global Fund	113,479,418	110,000,000	188,961,697	Global Fund allocations to Uganda
FAO	910,000	825,686	300,000	Uganda JUPSA strategic plan 2016/17-2019/20
ILO	55,000	109,996	100,000	
IOM	630,000	306,929	600,000	
UNAIDS	777,000	710,271	700,000	
UNDP	305,000	222,629	400,000	
Selected External Source	-	-	487,486*	
UNFPA	8,670,000	8,115,367	7,000,000	
UNHCR	120,000	111,340	493,503	
UNICEF	3,130,906	2,532,332	4,774,800	
UN Women	316,000	164,275	297,819	
WHO	1,059,000	687,540	465,000	
CHAI	1,278,546	1,435,090	Information missing	
UNESCO	-	243,591	162,000	
GoU	32,546,448	32,546,448	32,546,448	MTEF
Total funding for HIV/AIDS	**428,252,042**	**422,588,700**	**651,661,433**	

**Independent funds from UN Agencies (excluding Irish Aid funding to the UN agencies)*

HIV&AIDS Financing by AIDS Development partners

AIDS Development Partners (ADPs) continued to provide considerable support to the HIV and AIDS response in Uganda. Funding from ADPs increased from USD 390,436,769 in 2015/16 to USD 619,114,985 in 2016/17. The table below describes the specific support by ADPs.

Table 9 ADP financing and specific areas supported

Agency	Program activities supported
Irish Aid	Irish Aid mainly focused its support mainly in the Karamoja region with support to strengthen the capacity of local government and Civil Society Organizations in data collection and analysis for planning and delivery of HIV and AIDS services, resource mobilization to help scale up evidence-based prevention activities. In addition, Irish Aid supported mainstreaming AIDS in school construction program in Karamoja for the work place program, and continued to support the delivery of the single Joint UN Program of Support to AIDS (JUPSA) in the Karamoja region.
PEPFAR	The United States Government (USG) through the PEPFAR program continued to provide considerable support towards the 90-90-90 goals and epidemic control. Specifically, the USG support targeted: 1.) hard-to-reach populations with high-impact combination prevention interventions; 2.) strengthening the health system by investing in human resources, Community mobilization, and health financing; 3.) supporting the Government of Uganda to roll out Test and Start; 4.) improving procurement, warehousing, and distribution systems; 5.) Supporting service delivery models that reduce the number of clinical and lab visits; 6.) supporting innovative interventions to identify and link the following populations to services: pregnant women, adolescent girls, discordant couples, key and priority populations (KP/PP), and HIV/TB, and HIV/HBV co-infected; 7.) Supporting voluntary medical male circumcisions; and 8.) Supporting prevention programming targeting Adolescents Girls and Young Women (AGYW) through the DREAMS Project.
ILO	Promote adoption of the national workplace policy framework on HIV&AIDS, statutory instrument on HIV non-discrimination, HIV&AIDS integrated labour inspection guidelines, standard guidelines for integrating HIV&AIDS in the collective bargaining agreements for workers, private sector strategy for the HIV response, establishment of a coordination structure for the private sector HIV response, and factsheets on HIV-sensitive social protection.
IOM	Addressing issues of HIV, health and mobility in a range of migration health promotion activities. Capacity building and generated tactical information/evidence on the vulnerabilities of mobile populations including truck drivers, female sex workers and fishing communities. IOM has also provided training to Government and private health workers on migrant friendly health services along the transport corridors and fishing communities.
UNAIDS	Advocacy, leadership, community mobilization and engagement, generation and use of strategic information; gender equality, human rights and social justice and efficiency and sustainability of investments in the AIDS response. Sustainable development strategies and funding frameworks
UNDP	Mainstreaming gender, human lights and laws
UNESCO	develop strategic policy guidelines and documents for integration of HIV and AIDS within the Education sector plans

Agency	Program activities supported
UNFPA	Condom programming, SRH/HIV interventions, Social, cultural and religious interventions. Strengthening and accountability; policy review and formulation; programme development of national strategic, programmatic and technical normative guidance; procurement of RH commodities, maternal health and other equipment and supplies; human resource development including strengthening training institutions, social and behavior change communication programming; and support to data collection and reporting at various levels, cultural institutions with specific experience in: delivery of adolescent and youth friendly SRH/HIV services and communication programming; working with cultural and religious leaders/institutions to address structural drivers of HIV and sexual reproductive and maternal ill-health; programming against teenage pregnancy and child marriages, development of life and livelihood skills for young people; condom programming; GBV prevention and mitigation of impacts including GBV shelter management and FGM programming. VHT support for family planning, pregnancy mapping and linkages to health facilities; provision of equipment, supplies and human resources (mid wives) for comprehensive maternal health services; district partner coordination and joint planning for SRH &GBV; data collection and database management; and advocacy for expanded leadership engagement and systems strengthening.
UNHCR	Provision of HIV related services in refugees
UNICEF	PMTCT, SMC, Social support and protection, planning and coordination, AIDS specific institutional development/Community Mobilization, adolescent health programming. Specific areas of support were; HIV testing • Support and retention; • Strategic Information; • Planning and coordination; • Health Systems strengthening; • AIDS specific institutional development/Community Mobilization • Social support and protection
UN Women	Development of the Gender Dash Board, skilling and women economic empowerment, Elimination of Violence against Women and girls, women's engagement in peace-building and access to justice, Women's leadership and development as well as capacity building to improve governance national planning and accountability for GEWE. – i) economic skilling for young women and girls and linkage for credit services ii) establishment of paralegal and legal assistance services especially for women and girls affected by violence iii) integration of gender and human rights into existing traditional disputes resolution practices and institution
WHO	Normative guidance and policy review

Domestic financing for the national HIV&AIDS Response

Funding from the Government of Uganda remained constant from the previous Financial Year at USD 32,546,448. The GOU funds were directed towards procurement of ARVs by the National Medical Stores, UAC Operations, and Ministry of Health HIV&AIDS programming. In 2016/17, the GOU continued to undertake a number of strategies to increase domestic financing for the national HIV&AIDS response;

a. AIDS Trust Fund

Following the drafting of the AIDS Trust Fund regulation and submission to cabinet, Uganda AIDS Commission under its mandate to mobilize resources for the national response facilitated a number of advocacy engagements with key stakeholders to fast track the approval of the ATF regulations by Parliament and the subsequent operationalization. The advocacy engagements included; holding a breakfast meeting with key officials from MDAs, Parliament, CSOs, ADPs, PHA network and the media. The Parliamentary HIV&AIDS Committee has received views from key stakeholders and the regulations are now ready for approval by Parliament.

b. Resource Mobilization Strategy

The National HIV and AIDS Resource Mobilization Strategy was developed and approved. The strategy aims at mobilizing broad domestic and international financial and technical support that could enable the GoU to realize the goals of the National HIV/AIDS Strategic Plan (NSP) 2015/16-2019/20. The approaches proposed in the strategy include; Accelerating allocation from Government (Budget Support); Deepening relationships with Existing and potential partners; Optimal utilization of the available resources; Diversifying into new and innovative ways of mobilizing resources; and Strengthening capacity for resource mobilization across all sectors.

c. Efficiency Savings Study

Uganda AIDS Commission collaborated with UNAIDS to undertake an efficiency savings study as an option to translate improved efficiency into effective monetary savings. This is premised on a financial sustainability analysis conducted in the country with support from UNAIDS 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 study was concluded and the report ready for dissemination and adoption of the findings. 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).

d. HIV&AIDS Mainstreaming

A total of 40 MDAs out 45 MDAs have mainstreamed both programmatically and financially. In the Budget Framework Papers MDAs allocate funding towards HIV&AIDS activities. For example; Electoral Commission has allocated 85M; MAAIF 200M; MoES 50M; DPP 85M.

e. Private Sector financing for HIV&AIDS response (One Dollar Initiative)

In a bid to promote private sector engagement in domestic financing for HIV&AIDS response, the private sector under the coordination of Federation of Uganda Employers (FUE) launched the One Dollar Initiative (ODI). The initiative is aimed at inspiring private sector organizations and individuals to collectively engage and contribute towards ending the HIV&AIDS scourge and associated health challenges. The ODI was launched in this reporting period and the FUE is putting in place mechanisms for coordination of the initiative.

Picture 12 Launching the One Dollar Initiative

The private sector has made in-kind contributions to the HIV and AIDS response which has not been quantified in monetary terms. For example free hotel venues for HIV&AIDS activities, free air time in the electronic and print media.

f. Multi-sectoral Resource Tracking

Uganda AIDS Commission in collaboration with ADPs and Makerere University School of Public Health, embarked on the process to institutionalize the HIV resource tracking at national and sub-national level. This will entail; 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. Guided by the NASA Task Team, 20 district leaders (where NASA phase 1 will take place) have been oriented on the conduct of NASA; NASA collectors have been to trained and pilot studies in all NASA categories have conducted.

3.7.2 Lessons learnt

- Continuous engagement of leadership in MDAs has improved the sectoral HIV response and have assigned someone in the sector to be responsible for HIV/AIDS activities
- Political, technical and cultural leaders at the different levels are key in the fight against HIV and it is important to tap into them for a better response
- Private sector has spearheaded the one dollar initiative as funding of HIV/AIDS activities in the private sector so as not to strain the budgets of the organizations.

3.7.3 Challenges

- Human resources for health still a challenge with some staff categories not included in the MoH structure yet they are key in HIV/AIDS service delivery like the counsellors
- Stock out of ARVs especially paediatric formulations is still a challenge
- Stock of test kits though has reduced greatly but is still reported at health facilities and this is affecting the uptake of services
- Youth friendly services coverage is still very low.

3.8 Systems Strengthening: Monitoring, Evaluation and Research

The National M&E system is based on the UNAIDS **three ones'** i.e One coordinating body, One strategic plan and One M&E framework. The M&E plan describes the process required to track the progress and report on the implementation of the National HIV and AIDS Strategic Plan 2015/16 – 2019/20. The Monitoring and Evaluation Plan addresses two strategic objectives aimed at information generation for informed decision making for the national response.

3.8.1 Achievements

- The national M&E TWG is in place which drives the M&E agenda for the HIV response
- Quarterly Data Validation meetings have been institutionalised at National Level and rolled out to sub national levels
- Supported 5 ministries to develop their respective HIV and AIDS Strategic Plans and M&E Frameworks
- 102 districts supported to develop district specific HIV/AIDS strategic plans with the M&E frameworks
- Timely periodic review of the NSP
- Timely reporting at both National and Sub National levels
- Linked the HIV/AIDS research database to the bigger HIV/AIDS M&E database
- Trained 160 district personnel in monitoring of HIV/AIDS services
- The National LQAS conducted and the report disseminated to guide programming

Strategic Objective 1: Strengthen the national mechanism for generating comprehensive, quality and timely HIV/AIDS information for M&E

Strengthen the operationalization of the HIV/AIDS M&E Plan: The National HIV and AIDS Monitoring and Evaluation Technical Working Team mandated to drive Strategic Information management for response convene on a quarterly basis. The meetings review and clear processes leading to generation of Strategic information to guide the National response. In the reporting period concepts for the Midterm Review of the NSP and the JAR 2017 were discussed and passed. Additionally, the data required for the UN reporting was discussed and consensus attained before entering it into the online GAM tool to guide generation of the Annual Regional Reports.

The Joint Annual Review of implementation of the first year of the NSP (2015/16) and the 9th Partnership forum were conducted in August. The review was based on the NPAP and the indicators in the M&E plan. An Aide Memoire with 16 multi-sectorial 16 undertakings was generated together with the action plan to guide implementation of these undertakings. Overall there is attainment of about 80% of the commitments, although, the Monitoring plan was not robust and not well coordinated.

The following Ministries were supported to develop and Align their respective HIV and AIDS Strategic plans to the NSP 2015/16 – 2019/20; Ministry of Works and Transport; Ministry of Education; Ministry of Water and Environment; Ministry of defense and Ministry of Agriculture; Animal Industry and Husbandry. As part of the Strategic Plan development, these Ministries also developed their respective Monitoring and Evaluation Frameworks in bid to adhere to the 'three Ones Principles'. Alignment facilitates implementation and reporting on the NSP.

The UAC also supported 102 districts to develop their respective District Strategic Plans and Monitoring and Evaluation frameworks aligned to the NSP and the M&E plans. This activity was conducted in collaboration with Implementing Partners offered a hands-on capacity building opportunity for the Districts.

The HIV and AIDS M&E database which was developed in the first year of implementation of the NSP (2015/16) is being used as a repository for cleaned from the data validation exercises involving Q 1 – Q 4. The limitation of the database is that the Sector Information management Systems are built on different platforms therefore not enabling synchronisation. Other datasets are obtained for Ministry of Education and Sports, Gender Labour and Social Development for the different indicators.

Different platforms were used to disseminate of the strategic documents i.e NSP, NPAP and the M&E framework at regional and district levels. The UAC also organised exhibitions during World AIDS Day, Philly Lutaaya Day and the Candlelight Memorial to showcase what interventions and disseminate information products for the National response.

The E-mapping HIV/AIDS database which details who is working where, doing what and when is periodically updated. The database details all Implementing Partners in the respective districts per thematic area up to sub county levels. The database is aimed at rationalising services to avoid duplication and can redirect new partners to the underserved areas. This helps the commission and the districts to keep stock the different partners.

Mechanisms for capturing biomedical and non-biomedical HIV data from all implementers

With support from UN Women, Uganda AIDS Commission has established a gender tracking dashboard for the NSP indicators. The dashboard has come in timely when the midterm review of the NSP is due. It will enable effective reporting against the NSP indicators; especially ease Gender sensitive disaggregation that has been cited as a big gap to inform JAR Reports over the years.

Data collection for non-biomedical indicators for the National response is weak and not mainstreamed and the E – mapping database has been earmarked to enable data collection for the different indicators. User rights will be given to the HIV district focal persons to be able to enter the data. Data Collection tools had earlier been developed and pretested in Mayuge District and these will be improved and rolled out.

Mechanisms to improve data quality: During the reporting period, a lot of efforts have been put on data quality at both national and Sub-national levels. At national level, UAC in collaboration with Ministry of Health and Partners instituted the Quarterly Data Review Meetings. This enabled the data review/validation so that clean datasets are available for planning and a total of 4 data validation meetings were convened during the period of review.

The National Quarterly data reviews meetings have been replicated and rolled out to the regional/ sub national levels. Collaborating with Regional Implementing Partners, MoH and MEEPP, Regional Data Validation meetings were convened covering 15 districts in the South West, 8 Districts of the Acholi Region and 7 Districts in the Karamoja Region. This was aimed at building data management teams at Regional and district levels. The regions produced clean datasets to enable use at that level and onward reporting through the DHIS 2.

Strengthen the capacity of HIV/AIDS implementers in M&E: Using the Southern and Eastern Africa M&E training curriculum in HIV/AIDS, 160 district personnel were trained in monitoring HIV/AIDS services. There were ten (10) trained in each of the seven (7) Karamoja districts. In Jinja, Luuka, Buikwe, Buyende and Namayingo districts, ten (10) were trained in each of the districts and there were 50 people trained in Mbale district. This approach was also used not only to build capacity but also supported the Local Governments to develop their respective M&E Framework for the District strategic Plans.

Strengthen HIV/AIDS M&E coordination and networks: At National Level, the HIV and AIDS National projections and Estimates Team was institutionalized with membership from UNAIDS, UAC, MoH, MEEPP and PEPFAR which attended a training on the Spectrum Software. The team has been involved the HIV and AIDS Estimates and projections utilizing Program, Survey and Sentinel Data.

Reporting by SCEs including the Zonal coordination is done on a quarterly basis. Regular progress review meeting will be incorporated in the data validation meetings to improve reporting at and data/information use for decision making.

Regular data analysis, aggregation and reporting: The UAC coordinates reporting both National and International levels. The data validation, cleaning and application of validation rules ensure that there are clean datasets initiating the reporting process. These processes are being institutionalized and strengthened. With support from the different sectors, UAC has been able to annually submit the UNGASS online report and harmonise the JAR and GARPR processes to produce one report.

Strategic Objective 2: Promote information sharing and utilization among producers and users of HIV/ and AIDS data/information at all levels:

Conduct operations research guided by the national HIV/AIDS research agenda to improve programming: In the bid to determining the priorities for research and develop a research agenda for HIV/AIDS, UAC has conducted the efficiency savings study focusing on how the country can save in terms of health commodities ordering to minimise issues of spillage, distribution channels and rationalising study. The processes of conducting another study on HIV sector impact assessment to generate evidence on development programs addressing structural factors that influence the HIV epidemic and the impact of HIV on development program partnering with UNFPA.

The Implementing Partners have built capacity for operation research especially using the LQAS aimed at improving service delivery. The LQAS is conducted at regional level and at the national level and a National report was disseminated to guide programming.

3.8.2 Lessons learnt

- Harmonization of the JAR and GARPR processes to produce one report to fulfil all reporting mandates and minimize duplication and wastage of resources
- Establishment of a multi- agency Projections and Estimates team and in country Capacity building on the Spectrum software
- Collaboration of partners both National and regional levels to enable data validation and availability of clean data for HIV and AIDS programming.

3.8.3 Challenges

- Inadequate capacity for the NADIC to build an effective information Hub for the national HIV and AIDS response due to lack of personnel and funding
- Weak Monitoring of the JAR undertakings
- The Regional data and progress review meetings have not been rolled out to all the regions
- Lack of enabling Information Management System to enable collection and reporting for structural and behavioural indicators.

CONCLUSIONS AND RECOMMENDATIONS

Overall the review showed there was a significant achievement in all the thematic areas and now there is need to consolidate the achievements to be able to sustain them. There is reduction of HIV prevalence as well as transmission. There has been an increase in uptake of HTS services with the increase in first time testers and the linkage of those who test HIV positive is strong on the overall. The country has accrued successes in the eMTCT program but there is need to stop the leakage of the HEI not completing the cascade. There has been an increase in uptake of SMC services.

There has been significant achievement in the 90:90:90 cascade although a s exist for the last 90 where there is need to increase on viral load coverage as well as creating awareness among service providers and users of the benefits of VL testing.

The governance structure has been strengthened with the strengthening of the decentralized response. The districts have taken on leadership developing their own strategic plans and monitoring plan. This has been strengthened by the support from the PEPFAR implementing partners.

The financing of the response this year has been way above the anticipated though 95% of this is from the development partners. The Private sector has started a drive to raise funds towards HIV activities using the One Dollar Initiative.

The multi-sectoral response has to be recognized with the different MDAs making financial and programmatic plans to the response.

There is need to build capacity of the NADIC so as to fulfil its mandate of a national Hub for HIV and AIDS Information through improved staffing, technical support and provision of equipment

It is important to hold fast track the rollout of quarterly review meetings through collaboration with all the regional implementing Partners

There is need to develop mechanisms to institutionalize quarterly review and reporting platforms of the JAR undertakings

ANNEXES

Annex 1 Progress on Implementation of JAR 2016 Undertakings

HIV prevention	
Planned action	**Achievement to-date**
Scale up Comprehensive SRH/HIV Adolescent programming	• The 2012 SRH/HIV Integration Strategy was reviewed and the 2017/2021 Strategy drafted pending approval • A national Adolescent Health Policy has been drafted • The Inter Ministerial Committee on the Adolescent Girl with the First Lady as Patron and coordinated by MoGLSD is fully functional • The Global Fund Proposal was approved featuring up to $5m for adolescent HIV programming and possibility of accessing $5m catalytic funds for adolescent girls programming • An SRH/HIV manual for Community Development Officers developed by MoGLSD, pending pretesting • The Protect the Goal campaign was implemented in the Karamoja region utilizing football and netball tournaments • A process is on to integrate the Protect the Goal principle in the School sports calendar by MoES to institutionalize implementation
Strengthen quality of HIV counselling to minimise missed opportunities	• HTS policy revised and launched • HTS guidelines updated and disseminated in over 80% of the health facilities • HTS provided in targeted populations with support from various Implementing Partners • Capacity building in counselling done in an integrated manner guided by the national cover Prevention and Treatment guidelines
Increase coverage of effective Social Behavioural Change Communication (SBCC) to communities and households (localized messaging)	• The MoGLSD, engaged cultural and Religious institutions to develop frameworks and leadership capacity to engage communities in HIV prevention work • SBCC campaigns have been running in different parts of the country including the PEPFAR funded 'Obulamu' • Community structures have been established and strengthened supported by various Implementing Partners
Provide comprehensive HIV services in emergency situations (refugee situations, IDPs,	• Emergency prone areas mapped by OPM e.g main international entry points, Natural calamity prone areas • Services as routine comprehensive packages are being provided • There are however challenges of overburdened public health facilities in the West Nile region with increase in refugee numbers

migratory communities etc.)	
	Care and Treatment
Enroll and improve strategies for client retention and adherence across the care cascade.	• Unique patient identifiers being piloted in Kabarole and Rakai supported by METS • Community structures established • Community linkages officers and Peer Mothers recruited and trained in PEPFAR supported regions • Family support groups have been scaled up to all PMTCT implementing facilities
Scale up the coverage of viral load monitoring services.	• Centralized coordination of viral load testing CPHL for quality • Currently testing 1.3 million tests/year • Functional Hub system for transport samples and results • National dashboard to track VL scale up progress
	Social support and Protection
Provide guidance for dissemination of the package for Social Support and Protection and standard operating procedures for all sectors	• The social sector Plan in MoGLSD developed and disseminated to guide delivery of social services • Women, girls and Gender equality action plan is being developed • The Social Assistance Grant for Elderly (SAGE) manual is in place to guide implementation • The women entrepreneurship program has been rolled with a clear criteria targeting women including those living with HIV
Expedite the completion of the National anti-Stigma Policy	• The process is ongoing • Concept developed and passed • TA has been procured to guide the process
	Systems Strengthening
Explore Sustainable financing options including operationalization of the National AIDS Trust Fund	• ATF regulations approved by cabinet, ready for presentation to parliament for approval
Strengthen the	• Rolled out the partnership manual to guide operation of the Partnership coordination mechanisms

coordination role of SCEs	• Quarterly coordination meetings convened
Increase government budget allocation towards the HIV and AIDS for commodities	• Advocacy efforts on-going
Strengthen mechanism for generation of strategic information (stigma index, UPHIA, UDHS, NASA, macro-economic impact assessment, LQAs, estimates and projection)	• Regional performance review meetings were convened supported by IPs in all the regions • UPHIA preliminary results released • NASA is ongoing • LQAs released • UDHS results released • Data validation meetings have been on going every quarter convened by DHI with support from PEPFAR IPs •
Operationalize the SOPs and strengthen inter-sectoral collaboration and information sharing	• SOPs finalized yet to be disseminated • Quarterly thematic TWGs Convened to validate data before reporting • Quarterly and Annual reports compiled and submitted • Reviews done

Strengthen and link routine databases for generation of timely and reliable data for meeting and international reporting obligations (DHIS2, OVCMIS, NADIC, situation room)	• Processes to establish a situation room are ongoing
	  ○ Constituted a Situation room Committee for coordination
	  ○ TA procured to Harmonise the sector databases to enable linkage

Establish a system for tracking behavioural and structural data	• This undertaking was not implemented because there was need for more consultations and therefore was included in the JAR 2017 undertakings

Annex 2 Plan of Action for Undertakings of the Joint AIDS Review for 2017

Undertaking /Plan of Action	Expected results	Responsible Organization(S)	budget (Ushs) TBD	Time frame	Means of Verification	Supporting/ participating ADP	Comments
1.0 Prevention thematic area							
1. Promote comprehensive HIV prevention packages targeting most at risk and vulnerable e.g. utilizing the DREAMS Model							
Define and map out most at risk and vulnerable population to be targeted e. g adolescents, out of school girls, SWs	Different categories of targeted most at risk and vulnerable populations defined and mapped out	Lead: UAC Other Agencies: MoGLSD and MoH		Jan - Mar	Reports on the Vulnerable and Most at Risk populations	PEPFAR	
Define a comprehensive package for the Most at risk and vulnerable population	A comprehensive package which can be adopted by all implementers defined	Lead: UAC Other Agencies: MoGLSD and MoH			A report detailing a compressive package to guide stakeholders	UNFPA	
Map out the Implementing Partners with programs providing this targeted comprehensive package	All Partners with programs providing comprehensive partners identified for coordination	Lead: MoH Others: MoGLSD			A mapping report with details of partners providing comprehensive services targeting most at risk population	UNFPA	
Roll out implementation of the programs in districts where they do not exist	Districts with programs providing comprehensive packages for most at risk and vulnerable populations	Lead: MoH, Others: MoGLSD			Roll out reports	UNFPA	

Undertaking /Plan of Action	Expected results	Responsible Organization	budget (Ushs) TBD	Time frame	Means of Verification	Supporting/ participating ADP	Comments
2. Scale up targeted quality HTS and improve linkage to care and treatment services							
Roll out the training and implementation of HTS guidelines to all health facilities in the country	Training rolled out to all Health facilities The HTS guidelines implemented by all the stakeholders	Lead: MoH			Roll out and training reports	UNFPA, UNICEF	
Conduct targeted HTS services in populations with high yield	Targeted HTS implemented targeting MARPs	Lead: MoH			Implementation reports	UNFPA/PEPFAR/Global Fund	
Build capacity of health workers for counseling	Capacity built for HIV counselling for different categories	Lead: MoH			Capacity building reports	WHO/PEPFAR	
3. Scale up involvement of religious, cultural and opinion, political leaders in promoting male involvement and addressing issues affecting adolescent girls, boys and young people							
Engage Political, Cultural and Religious leaders in advocacy and implementation of SBCC for the different categories services	All the major Political, cultural and religious leaders' for a engaged	Lead: MoGLSD Other Partners: IRCU, CSOs			Reports/ minutes of meetings	UNFPA UNAIDS	

Undertaking /Plan of Action	Expected results	Responsible Organization	budget (Ushs) TBD	Time frame	Means of Verification	Supporting/ participating ADP	Comments
Organize different fora for a for cultural and Religious leaders e.g the Kings' Forum to make commitments targeting Men and Adolescents	Religious and cultural leaders engaged in promoting male involvement and issues of adolescents and young people	Lead: MoGLSD other Agencies: UAC			Reports Commitments by the various leaders	UNFPA	
Engage national youth Structures e,g Young Positives, National youth Council and Young People SCE to reach out to their peers with messages and services	Youth Structures utilized to reach fellow youth with Age appropriate messages and services	Lead: MoGLSD other agencies: UAC			Implementation reports Memoranda of understanding Minutes of meetings	UNFPA	
Implement the Protect the Goal approach to engage youth in and out of school	Services delivered to youth in and out of school	Lead: MoES			Implementation reports	UNFPA	
Engagement of established community structures e.g CHEWs, Peers, expert clients to deliver services to adolescents and young people out of school	CHEWs, Peer Educators, Mentor mothers, PHLIVs engaged in delivery of services to the community	Lead: MOH			Implementation reports	UNFPA	
4. Scale up HIV and AIDS services in Emergency settings (refugee situations, IDPs, migratory communities etc.)							
Engage political, Religious and cultural leaders in Emergency settings and	All readers in these areas engaged to advocate for services	Lead: UAC Other Agencies:			Reports, resolutions and minutes of meetings	WHO	

Undertaking /Plan of Action	Expected results	Responsible Organization	budget (Ushs) TBD	Time frame	Means of Verification	Supporting/ participating ADP	Comments
advocate for HIV and AIDS services		OPM, Parliament and MoH					
Quantify the needs(Medical supplies	Supplies identified and quantified	Lead: MoH			Quantification and implementation reports	WHO	
Build capacity of Health workers to respond to the emergency situations	Capacity built in Triage and response to service provision in emergency situations	Lead: MoH, other Agencies OPM			Capacity building reports	WHO	
Undertaking /Plan of Action	**Expected results**	**Responsible Organization**	**budget (Ushs) TBD**	**Time frame**	**Means of Verification**	**Supporting/ participating ADP**	**Comments**
5.Conduct a comprehensive national wide mapping of MARPS and priority populations in Uganda							
Identify partners for engagement(for funding and data collection) at different levels	Stake holders identified	Lead: UAC			Reports		
Develop a concept paper with detailed ToRs to guide the process	Concept paper with TOR to guide implementation in place	Lead: UAC			Concept and ToRs		
Procure TA to conduct the mapping exercise and compile a detailed report	Detailed mapping report developed, approved and disseminated	Lead UAC			Mapping report		

Undertaking /Plan of Action	Expected results	Responsible Organization	budget (Ushs) TBD	Time frame	Means of Verification	Supporting/ participating ADP	Comments
With the guidance of the Mapping report, Update the National MARPs programming framework with a Road map to guide implementing partners	An updated MARPS Programming Framework and Road Map in place	Lead: UAC other agencies: UAC			Updated Programming framework and Action Plan		
Care and Treatment thematic area							
6. Scale up Differentiated Services Delivery Models (Scale up community based interventions on testing, referrals and linkage to care a treatment, and follow up for lost to care clients).							
Finalise and disseminate Guidelines for the Differentiated Service Delivery model	DSDM guidelines developed and disseminated	Lead: MOH			Progress reports	CDC/METS	
Strengthen the community structures for implementation of the DSDM	Revived VHTs and other community structure	Lead: MOH			Implementation reports		
Build capacity of health workers and community health support workers to implement the DSDM	Capacity built both at Health facility and community levels	Lead: MOH			Capacity building Reports detaining numbers trained	WHO	
Engage Mentor Mothers, expert clients and peer groups both at health facilities and communities	Capacity of these categories built and facilitated to follow up clients	Lead: MOH			Health facility reports	WHO, CDC, USAID	

Undertaking /Plan of Action	Expected results	Responsible Organization	budget (Ushs) TBD	Time frame	Means of Verification	Supporting/ participating ADP	Comments
	in the communities to minimize loss to follow up						
7. Scale up the coverage of viral load monitoring services.							
Procure Equipment for Viral Load testing	All regional and General Hospitals equipped with Viral load machines	Lead: MoH		Jan 2016	Reports and equipment Inventory	WHO, CDC, USAID	
Build capacity for viral load monitoring	Capacity to correctly collect samples and manage viral load records Capacity to perform viral load	Lead: MoH			Capacity building reports	CDC, USAID	
Strengthen the sample transportation system	Turnaround time for both the samples and results reduced	Lead: MoH			Sample Shipment and progress reports		

Undertaking /Plan of Action	Expected results	Responsible Organization	budget (Ushs) TBD	Time frame	Means of Verification	Supporting/ participating ADP	Comments
SOCIAL SUPPORT THEMATIC AREA							
8. Provide economic empowerment and incentives for especially young girls and adolescents							

Undertaking /Plan of Action	Expected results	Responsible Organization	budget (Ushs) TBD	Time frame	Means of Verification	Supporting/ participating ADP	Comments
Define the incentives for empowerment targeting adolescents and girls in and out of schools	Incentives defined for the targeted population	Lead: MoGLSD other agencies: UAC		3rd & 4th Quarter	Reports from MDAs and IPs	UN Women, UNICEF	
Disseminated the defined tool to the implementers to set a standard for implementation	A set standard of incentives delivered to the targeted population	Lead: MoGLSD other agencies: UAC			Guiding tool	UNICEF, CDC, USAID	
9. Roll out PIASCY including the sexuality education and address stigma in schools							
Finalize and disseminate sexuality Education guidelines	Sexuality Education guidelines in place and disseminated	Lead: MoES,		3rd & 4th Quarter	Sexuality Education guidelines	UNICEF, Irish Aid	Done
Review and disseminate PIASCY guidelines	Revised guidelines disseminated	Lead: MoEs			PIASCY guidelines	UNICEF, UNFPA	
Implement and monitor implementation of PIASCY and Sexuality Education programs in schools	PIASCY and Sexuality Education Implemented in Schools	Lead: MoES			Implementation reports	UNICEF, UNFPA	
10.Address Stigma in the community and schools							
Fast track the development of the National anti-Stigma and Discrimination Policy	Policy developed	Lead: UAC other agency: PLHIV		3rd & 4th Quarter	Policy in place	UNAIDS	
Disseminate the National Anti- Stigma Policy	A validated and disseminated policy	Lead: UAC other agency:			Dissemination reports	UNAIDS	

Undertaking /Plan of Action	Expected results	Responsible Organization	budget (Ushs) TBD	Time frame	Means of Verification	Supporting/ participating ADP	Comments
		NAFOPHANU					
Conduct regular Stigma Index studies in Schools and Community	Stigma Index Studies Conducted	Lead: UAC, NAFOPHANU			Stigma Index reports	UNAIDS, IRISH AID	
Build Capacity of teachers in Counseling and addressing stigma in Schools	Capacity of teachers built in counseling and addressing Stigma among students	Lead: MoES other agencies UAC, NAFOPHANU			Capacity building reports	UNAIDS and UNICEF	
SYSTEMS STRENGTHENING							
10. Increase investment (including fast tracking the operationalization of the ATF) and improve efficiencies including tracking of the resources							
Hold Development Partners dialogue on sustainable financing options for HIV and AIDS response	Regular Dialogue meetings with ADPs convened	UAC and MOH			ATF operational according to the guidelines	UNAIDS, UNICEF, UNFPA	
Presentation of ATF legislations to Parliament	ATF regulations passed by Parliament for approval	Parliament SCE, UAC, MoH			ATF Guidelines	UNICEF	
Implement the ATF	Funds available for the response	MoFPED, MoH			Implementation reports		
Fast track the NASA	NASA completed and a report in place	UAC			NASA Report	UNAIDS, Irish Aid, PEPFAR	
Institutionalize NASA to enable regular tracking of resources for the HIV and	NASA Institutionalized	UAC			Progress reports Institutions reporting using the NASA	UNAIDS, Irish Aid	

Undertaking /Plan of Action	Expected results	Responsible Organization	budget (Ushs) TBD	Time frame	Means of Verification	Supporting/ participating ADP	Comments
AIDs response					channels		
12. Review staffing norms to match the required services							
Review the current staffing structures against the services provided	Structure reviewed	UAC			Review report		
Fill the vacant positions to 100%	Vacant posts filled				Recruitment and deployment reports		
Build capacity of the Health workers based on the services available	Capacity built for quality service delivery				Capacity building reports and Inventory		
13. Operationalize the situation room and the gender dashboard to facilitate information							
Constitute the Situation room Committee	• Regional reviews conducted • Team constituted with clear TORs • Quarterly supervision visits conducted	MOH/ UAC			Functional Situation Room	UNAIDS, PEPFAR	
Harmonize the sector databases to enable linkage to the Situation Room	An integrated data management system established involving all sectors generated Sector databases linked	MOH/UAC			Harmonization report	UNAIDS	

Undertaking /Plan of Action	Expected results	Responsible Organization	budget (Ushs) TBD	Time frame	Means of Verification	Supporting/ participating ADP	Comments
Build capacity of the M&E TWG and National Data management teams in application/management of the Situation room	Capacity to manage the situation room data built	Lead: UAC			Capacity building reports		
Roll out and popularize the Gender indicator tracking dashboard	Gender dashboard rolled and popularized	Lead: UAC			Roll out reports	UNAIDS	
Collect and enter Gender related data	Gender related data entered	Lead: UAC			Progress reports		

Undertaking /Plan of Action	Expected results	Responsible Organization	budget (Ushs) TBD	Time frame	Means of Verification	Supporting/ participating ADP	Comments
14.Conduct Quarterly national and regional performance review and data quality/validation meetings							
Convene National Data review meetings	Quarterly data validation meetings convened Clean datasets generated	Lead: UAC others: MOH			Minutes Clean data	UNAIDS	
Convene Regional performance review meetings	Quarterly performance/ data review meetings convened in all regions	Lead: UAC other: MoH			Progress Reports	UNAIDS, UNICEF, PEPFAR	

Undertaking /Plan of Action	Expected results	Responsible Organization	budget (Ushs) TBD	Time frame	Means of Verification	Supporting/ participating ADP	Comments
Convene regular thematic TWGs to validate data before reporting	Quarterly Thematic TWGs convened	Lead: UAC			Minutes, Cleared products	UNAIDS	
Generate quarterly and annual reports	Quarterly reports compiled	Lead: UAC others: MOH/MoGLSD, MOE			Reports	UNAIDS	
Conduct AIDS reviews	MTR conducted JAR Conference convened JAR report/GARPR compiled and submitted	Lead: UAC, others: MoH, MoGLSD, All SCEs, MDAs			MTR report and NPAP 2017/18 – 2019/20 JAR/ GARPR report	UNAIDS UNICEF	

Pledge: the undertakings will be reviewed by the PC for approval. Implementation will be monitored on a quarterly basis

Annex 3 TWG meetings Attendance lists

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Annex 4 The PMTCT Cascade - District performance

District	% ART Initiation	EID coverage as per CPHL	Positivity rate for 1st PCR (CPHL)
Abim	96%	38%	6%
Adjumani	70%	35%	7%
Agago	81%	46%	4%
Alebtong	85%	66%	6%
Amolatar	75%	54%	5%
Amudat	83%	52%	0%
Amuria	96%	81%	5%
Amuru	74%	40%	6%
Apac	85%	72%	6%
Arua	85%	64%	7%
Budaka	63%	42%	12%
Bududa	73%	55%	11%
Bugiri	84%	63%	9%
Buhweju	91%	57%	8%
Buikwe	92%	53%	8%
Bukedea	88%	71%	8%
Bukomansimbi	95%	61%	6%
Bukwo	60%	32%	7%
Bulambuli	68%	28%	8%
Buliisa	83%	53%	12%
Bundibugyo	90%	74%	10%
Bunyangabu	99%	86%	3%
Bushenyi	100%	73%	5%
Busia	87%	34%	11%
Butaleja	89%	48%	7%
Butambala	98%	55%	5%
Buvuma	81%	38%	5%
Buyende	92%	50%	4%
Dokolo	64%	52%	6%
Gomba	95%	63%	7%
Gulu	88%	86%	4%
Hoima	88%	57%	7%
Ibanda	88%	57%	7%
Iganga	93%	63%	8%
Isingiro	107%	60%	7%
Jinja	77%	57%	10%
Kaabong	35%	30%	9%
Kabale	96%	76%	5%
Kabarole	97%	117%	4%
Kaberamaido	98%	96%	10%
Kagadi	92%	65%	4%
Kakumiro	83%	64%	4%
Kalangala	90%	62%	4%
Kaliro	77%	59%	9%
Kalungu	96%	67%	6%
Kampala	78%	66%	6%
Kamuli	96%	29%	6%
Kamwenge	96%	80%	6%
Kanungu	95%	65%	4%
Kapchorwa	90%	32%	10%
Kasese	95%	65%	6%
Katakwi	95%	71%	4%
Kayunga	77%	51%	5%
Kibaale	79%	406%	7%
Kiboga	89%	69%	3%
Kibuku	91%	58%	8%
Kiruhura	87%	51%	6%
Kiryandongo	88%	54%	6%
Kisoro	93%	61%	4%
Kitgum	85%	52%	3%
Koboko	98%	91%	7%
Kole	85%	77%	5%
Kotido	78%	19%	9%
Kumi	94%	67%	5%
Kween	69%	18%	24%
Kyankwanzi	75%	52%	7%
Kyegegwa	99%	77%	5%
Kyenjojo	99%	76%	5%
Lamwo	91%	73%	5%
Lira	75%	58%	5%
Luuka	78%	37%	11%
Luwero	86%	48%	7%
Lwengo	83%	65%	7%
Lyantonde	90%	58%	3%
Manafwa	67%	24%	9%
Maracha	60%	49%	7%
Masaka	86%	76%	5%
Masindi	87%	66%	8%
Mayuge	80%	57%	10%
Mbale	86%	31%	9%
Mbarara	96%	58%	6%
Mitooma	103%	76%	4%

Mityana	91%	56%	8%
Moroto	96%	34%	17%
Moyo	69%	50%	9%
Mpigi	95%	53%	5%
Mubende	84%	67%	6%
Mukono	88%	51%	6%
Nakapiripirit	89%	52%	10%
Nakaseke	92%	38%	4%
Nakasongola	98%	65%	9%
Namayingo	76%	49%	9%
Namutumba	97%	71%	11%
Napak	99%	66%	12%
Nebbi	90%	61%	7%
Ngora	95%	75%	7%
Ntoroko	95%	62%	6%
Ntungamo	87%	56%	5%
Nwoya	75%	56%	5%
Omoro	93%	52%	1%

Otuke	106%	36%	8%
Oyam	79%	59%	2%
Pader	83%	56%	5%
Pallisa	54%	33%	6%
Rakai	90%	79%	4%
Rubanda	101%	68%	8%
Rubirizi	86%	34%	6%
Rukungiri	95%	62%	4%
Sembabule	84%	55%	6%
Serere	93%	68%	8%
Sheema	100%	75%	5%
Sironko	71%	25%	3%
Soroti	89%	78%	7%
Tororo	87%	40%	5%
Wakiso	93%	48%	6%
Yumbe	83%	60%	9%
Zombo	99%	71%	8%

Annex 5 The HTS Cascade: From Testing to Connections (Linkages to Care)

District	Tested and Received Results	Tested HIV positive	Linked to care	% positive	% linked to care
Busia	51,825	2,465	1,114	4.8	45.2
Kibuku	38,718	701	386	1.8	55.1
Nakasongola	39,819	1,839	1,033	4.6	56.2
Luuka	30,176	625	381	2.1	61.0
Nakaseke	36,527	1,956	1,283	5.4	65.6
Kaabong	45,855	146	96	0.3	65.8
Namisindwa	59,403	420	280	0.7	66.7
Pallisa	67,522	765	514	1.1	67.2
Gomba	36,450	1,263	863	3.5	68.3
Lyantonde	31,978	1,660	1,143	5.2	68.9
Amolatar	32,099	1,608	1,115	5.0	69.3
Bukwo	24,187	312	221	1.3	70.8
Budaka	42,475	533	378	1.3	70.9
Sembabule	42,158	2,208	1,589	5.2	72.0
Buvuma	29,444	1,592	1,148	5.4	72.1
Butaleja	48,517	621	449	1.3	72.3
Amuru	22,335	766	557	3.4	72.7
Mbale	145,637	3,950	2,894	2.7	73.3
Dokolo	32,061	1,052	800	3.3	76.0
Abim	25,513	372	286	1.5	76.9
Buikwe	126,626	4,765	3,676	3.8	77.1
Namutumba	27,263	381	294	1.4	77.2
Butambala	30,021	1,121	869	3.7	77.5
Mpigi	72,883	3,361	2,633	4.6	78.3
Tororo	171,416	3,480	2,738	2.0	78.7
Bukomansimbi	50,319	1,423	1,122	2.8	78.8
Kisoro	34,630	515	411	1.5	79.8
Luwero	132,121	5,056	4,037	3.8	79.8
Kiryandongo	41,152	1,662	1,332	4.0	80.1
Sironko	34,496	912	733	2.6	80.4
Masindi	76,353	2,898	2,339	3.8	80.7
Iganga	86,821	1,800	1,453	2.1	80.7
Mbarara	128,785	6,830	5,589	5.3	81.8
Kamuli	240,520	2,332	1,915	1.0	82.1
Kotido	44,007	210	173	0.5	82.4
Koboko	42,248	455	377	1.1	82.9
Jinja	191,088	4,769	3,957	2.5	83.0
Kalangala	45,091	2,643	2,201	5.9	83.3
Kabale	116,065	1,955	1,630	1.7	83.4
Kaliro	43,192	538	449	1.2	83.5

District	Tested and Received Results	Tested HIV positive	Linked to care	% positive	% linked to care
Kiboga	29,327	1,542	1,290	5.3	83.7
Ngora	50,684	322	270	0.6	83.9
Moyo	34,724	569	478	1.6	84.0
Bushenyi	82,051	2,780	2,341	3.4	84.2
Adjumani	67,978	761	644	1.1	84.6
Lamwo	28,927	595	505	2.1	84.9
Nakapiripirit	23,322	245	208	1.1	84.9
Soroti	143,200	1,634	1,388	1.1	84.9
Gulu	109,113	5,036	4,280	4.6	85.0
Omoro	29,740	1,264	1,076	4.3	85.1
Manafwa	51,727	377	321	0.7	85.1
Maracha	72,189	284	243	0.4	85.6
Kanungu	57,387	1,677	1,438	2.9	85.7
Wakiso	302,490	16,180	13,882	5.3	85.8
Mityana	71,918	3,717	3,194	5.2	85.9
Kampala	604,718	33,521	28,904	5.5	86.2
Masaka	128,762	5,492	4,740	4.3	86.3
Amuria	84,024	658	569	0.8	86.5
Agago	49,051	1,457	1,261	3.0	86.5
Sheema	41,361	1,862	1,614	4.5	86.7
Rubanda	24,137	368	319	1.5	86.7
Kayunga	71,061	2,382	2,076	3.4	87.2
Mubende	163,531	6,254	5,459	3.8	87.3
Lwengo	55,612	1,878	1,642	3.4	87.4
Rubirizi	20,941	847	741	4.0	87.5
Bududa	37,093	362	318	1.0	87.8
Rukungiri	71,755	2,551	2,244	3.6	88.0
Ibanda	46,966	2,409	2,123	5.1	88.1
Bundibugyo	51,554	573	506	1.1	88.3
Buyende	41,938	856	756	2.0	88.3
Bugiri	69,564	1,104	977	1.6	88.5
Arua	201,901	2,693	2,396	1.3	89.0
Mukono	143,447	6,320	5,627	4.4	89.0
Kitgum	51,062	1,856	1,667	3.6	89.8
Nebbi	116,983	1,732	1,558	1.5	90.0
Kalungu	70,532	1,717	1,545	2.4	90.0
Moroto	25,151	263	237	1.0	90.1
Bukedea	34,892	276	249	0.8	90.2
Rakai	127,278	5,007	4,538	3.9	90.6
Kyankwanzi	21,025	968	879	4.6	90.8
Nwoya	29,946	1,054	958	3.5	90.9
Kapchorwa	22,305	375	341	1.7	90.9

District	Tested and Received Results	Tested HIV positive	Linked to care	% positive	% linked to care
Buliisa	30,902	932	848	3.0	91.0
Isingiro	105,888	2,775	2,530	2.6	91.2
Buhweju	16,472	390	357	2.4	91.5
Zombo	41,995	772	707	1.8	91.6
Otuke	22,288	701	642	3.1	91.6
Kiruhura	56,741	2,604	2,388	4.6	91.7
Alebtong	39,074	1,510	1,389	3.9	92.0
Apac	56,458	2,784	2,564	4.9	92.1
Ntoroko	22,318	482	444	2.2	92.1
Kibaale	34,577	878	814	2.5	92.7
Kakumiro	54,086	2,188	2,032	4.0	92.9
Pader	28,061	1,351	1,263	4.8	93.5
Amudat	7,668	155	145	2.0	93.5
Kole	28,088	1,174	1,106	4.2	94.2
Napak	21,477	209	197	1.0	94.3
Bulambuli	24,953	530	500	2.1	94.3
Hoima	143,967	4,635	4,399	3.2	94.9
Oyam	70,160	2,547	2,421	3.6	95.1
Kagadi	74,397	2,603	2,476	3.5	95.1
Bunyangabu	50,896	1,065	1,020	2.1	95.8
Mayuge	92,267	2,390	2,290	2.6	95.8
Kasese	211,867	2,636	2,531	1.2	96.0
Kween	17,404	286	275	1.6	96.2
Serere	96,592	531	515	0.5	97.0
Kamwenge	127,484	2,781	2,700	2.2	97.1
Katakwi	38,384	472	459	1.2	97.2
Kabarole	139,953	4,522	4,398	3.2	97.3
Kyegegwa	63,910	2,071	2,015	3.2	97.3
Yumbe	76,265	504	492	0.7	97.6
Mitooma	31,218	797	782	2.6	98.1
Kumi	77,870	517	508	0.7	98.3
Ntungamo	101,132	3,100	3,047	3.1	98.3
Kaberamaido	64,122	669	661	1.0	98.8
Kyenjojo	151,285	4,071	4,025	2.7	98.9
Namayingo	56,634	1,564	1,572	2.8	100.5
Lira	100,238	5,555	5,659	5.5	101.9
National Average	**3,700,655**	**105,226**	**82,822**	**2.8**	**78.7**

Annex 6 HTS Yield

District	% Started on ART		District	% Started on ART
Kumi	24		Rukungiri	62
Bulambuli	27		Arua	63
Katakwi	27		Kotido	63
Mayuge	28		Kibuku	64
Luuka	33		Sheema	64
Pallisa	38		Kyegegwa	68
Butaleja	41		Amolatar	69
Ngora	46		Kyankwanzi	69
Kaberamaido	46		Rubanda	70
Buyende	47		Kagadi	71
Sembabule	48		Busia	71
Kiboga	51		Lyantonde	72
Bududa	51		Alebtong	72
Serere	52		Nakaseke	72
Abim	52		Bushenyi	72
Bukedea	53		Kabale	72
Tororo	54		Manafwa	72
Dokolo	54		Kiruhura	72
Amuria	55		Kaabong	72
Kampala	56		Kabarole	73
Lamwo	56		Apac	77
Nakapiripirit	57		Lwengo	77
Jinja	57		Kyenjojo	79
Kanungu	57		Kaliro	80
Ibanda	57		Amudat	81
Kayunga	58		Gulu	81
Amuru	59		Rubirizi	81
Kisoro	59		Isingiro	81
Zombo	59		Oyam	82
Iganga	60		Soroti	82
Sironko	60		Kapchorwa	83
Kole	61		Mbale	86
Omoro	61		Nebbi	86
Pader	62		Namisindwa	87
Masindi	62		Kibaale	89

Annex 7 Screening for TB: HIV Positive Patients with Presumptive TB

District	Tested HIV positive	HIV positive individuals with presumptive TB	%
Kaberamaido	765	399	52.2
Kiryandongo	1,052	489	46.5
Kalungu	2,071	939	45.3
Hoima	375	164	43.7
Moyo	263	82	31.2
Budaka	381	112	29.4
Adjumani	1,054	298	28.3
Nakapiripirit	2,547	718	28.2
Kabarole	1,677	472	28.1
Moroto	1,351	373	27.6
Luuka	1,660	432	26.0
Mityana	533	134	25.1
Amuru	2,643	635	24.0
Bushenyi	538	129	24.0
Kaliro	209	48	23.0
Kasese	1,732	384	22.2
Mitooma	517	112	21.7
Maracha	772	159	20.6
Bulambuli	625	127	20.3
Lira	1,457	290	19.9
Sembabule	2,784	552	19.8
Kamwenge	595	113	19.0
Kiruhura	573	103	18.0
Gulu	312	55	17.6
Otuke	2,636	457	17.3
Zombo	2,390	405	16.9
Rubirizi	856	145	16.9
Mayuge	210	34	16.2
Kalangala	372	59	15.9
Nwoya	669	105	15.7
Kampala	761	110	14.5
Tororo	5,492	790	14.4
Masaka	2,465	348	14.1
Arua	1,839	255	13.9
Mbale	515	71	13.8
Manafwa	531	73	13.7
Kumi	912	125	13.7
Kisoro	6,254	849	13.6
Namutumba	1,956	261	13.3
Bunyangabu	5,056	649	12.8
Rakai	1,263	160	12.7
Rubanda	3,361	419	12.5
Omoro	621	76	12.2
Kyenjojo	1,856	226	12.2
Kibuku	3,950	471	11.9
Bukedea	2,551	298	11.7
Koboko	701	81	11.6
Busia	276	30	10.9
Pallisa	3,100	336	10.8
Kayunga	33,521	3,514	10.5
Kaabong	110,600	17,666	16.0
Iganga	1,878	193	10.3
Kabale	6,830	693	10.1
Nakaseke	1,608	160	10.0
Napak	368	35	9.5
Serere	16,180	1,526	9.4
Kween	3,717	336	9.0
Wakiso	155	14	9.0
Lyantonde	2,693	242	9.0
Abim	245	22	9.0
Rukungiri	4,522	395	8.7
Buhweju	4,071	346	8.5
Oyam	1,955	164	8.4
Nakasongola	1,423	117	8.2
Butaleja	420	34	8.1
Buliisa	2,382	189	7.9
Bududa	5,007	379	7.6
Ibanda	362	26	7.2
Masindi	1,800	126	7.0
Kole	1,121	78	7.0
Buvuma	1,510	105	7.0
Kotido	504	35	6.9
Isingiro	1,174	79	6.7
Ntoroko	5,555	371	6.7
Sheema	1,065	70	6.6
Kamuli	847	54	6.4
Ngora	3,480	219	6.3
Pader	4,765	297	6.2
Apac	390	24	6.2

Ntungamo	472	29	6.1
Alebtong	5,036	299	5.9
Mukono	2,780	162	5.8
Nebbi	6,320	362	5.7
Amudat	2,898	164	5.7
Amolatar	1,104	62	5.6
Mbarara	658	35	5.3
Bukwo	1,564	81	5.2
Mubende	2,409	118	4.9
Kapchorwa	797	38	4.8
Lwengo	1,717	80	4.7
Buikwe	2,775	129	4.6
Kiboga	766	35	4.6
Soroti	482	22	4.6
Dokolo	2,332	102	4.4
Bukomansimbi	2,604	107	4.1
Kyegegwa	2,781	113	4.1
Butambala	4,769	193	4.0
Bugiri	569	23	4.0
Bundibugyo	1,264	44	3.5
Namayingo	1,662	56	3.4
Yumbe	1,634	54	3.3
Kibaale	286	9	3.1
Luwero	4,635	134	2.9
Agago	878	24	2.7
Amuria	2,208	60	2.7
Jinja	968	26	2.7
Buyende	284	7	2.5
Lamwo	377	9	2.4
Kakumiro	1,592	32	2.0
Sironko	455	8	1.8
Katakwi	322	5	1.6
Gomba	2,188	33	1.5
Kyankwanzi	932	14	1.5
Kanungu	1,542	20	1.3
Kagadi	2,603	25	1.0
Namisindwa	1,862	15	0.8
Mpigi	530	4	0.8
Kitgum	146	0	0.0
National Average	**701**	**43**	**6.1**

Annex 8 ARV stock outs reported between July-Dec 2016

	July	Aug	Sept	Oct	Nov	Dec	Half year average (%)
Abacavir (ABC) 60mg	24%	26%	17%	24%	15%	25%	21.8
Abacavir/Lamivudine (ABC/3TC) 600mg/300mg [Pack 30]	14%	15%	9%	11%	8%	14%	11.8
Abacavir/Lamivudine (ABC/3TC) 60mg/30mg [Pack 60]	5%	5%	3%	5%	2%	6%	4.3
Atazanavir/Ritonavir (ATV/r) 300mg/100mg [Pack 30]	13%	11%	8%	9%	7%	11%	9.8
Efavirenz (EFV) 200mg [Pack 90]	10%	10%	8%	11%	9%	14%	10.3
Efavirenz (EFV) 600mg [Pack 30]	4%	3%	3%	2%	2%	4%	3.0
Lopinavir/Ritonavir (LPV/r) 100mg/25mg	19%	18%	12%	15%	11%	17%	15.3
Lopinavir/Ritonavir (LPV/r) 200mg/50mg [Pack 120]	15%	12%	9%	11%	7%	13%	11.2
Lopinavir/Ritonavir (LPV/r) 40mg/10mg Pellets [Pack of 120]	21%	23%	15%	21%	13%	23%	19.3
Nevirapine (NVP) 10mg/ml oral susp.[Bottle 1000ml]	10%	8%	7%	9%	6%	10%	8.3
Nevirapine (NVP) 200mg [Pack 60]	5%	4%	3%	4%	2%	4%	3.7
Nevirapine (NVP) 50mg [Pack 60]	16%	20%	11%	20%	11%	22%	16.7
Tenofovir/Lamivudine (TDF/3TC) 300mg/300mg [Pack 30]	4%	4%	2%	3%	2%	4%	3.2
Tenofovir/Lamivudine/Efavirenz (TDF/3TC/EFV) 300mg/300mg/600mg[Pack 30]	3%	2%	1%	2%	2%	6%	2.7
Zidovudine (AZT) 300mg [Pack 60]	22%	25%	17%	24%	15%	25%	21.3
Zidovudine/Lamivudine (AZT/3TC) 300mg/150mg [Pack 60]	5%	4%	3%	4%	3%	4%	3.8
Zidovudine/Lamivudine (AZT/3TC) 60mg/30mg [Pack 60]	10%	9%	6%	9%	5%	9%	8.0
Zidovudine/Lamivudine/Nevirapine (AZT/3TC/NVP) 300mg/150mg/200mg [Pack 60]	3%	3%	2%	2%	2%	3%	2.5
Zidovudine/Lamivudine/Nevirapine (AZT/3TC/NVP) 60mg/30mg/50mg [Pack 60]	5%	4%	3%	4%	2%	4%	3.7