UGANDA AIDS COMMISSION

12th ANNUAL JOINT AIDS REVIEW (JAR)

FINAL REPORT

JULY 2018 - JUNE 2019

"Empowering Young People to Champion the End of New HIV Infections"

September, 2019

Ambasáid na hÉireann
Embassy of Ireland

United Nations UGANDA

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

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LIST OF ACRONYMS

ACP	AIDS Control Program
ADP	AIDS Development Partner
ADM	Advanced Disease Management
AGYW	Adolescents Girls and Young Women
AMICAALL	Alliance of Mayors Initiative for Community Action on AIDS at Local Level
APN	Assisted Partner Notification
ART	Antiretroviral Therapy
AYP	Adolescents and Young People
CBOs	Community Based Organizations
CLMIS	Condom Logistics Management Information System
CRS	Catholic Relief Services
CSE	Commercial Sexual Exploitation
CQI	Continuous Quality Improvement
CSO	Civil Society Organization
DAC	District AIDS Committee
DD	Demographic Dividend
DHIS	District Health Information System
DIMO	District Inventory Management Officer
DLFP	District Logistics Focal Person
DREAMS	Determined, Resilient, Empowered, AIDS free, Mentored and Safe
DSD	Differentiated Service Delivery
EAC	East African Community
EID	Exposed Infant Diagnosis
eMTCT	Elimination of Mother to Child Transmission
EOC	Equal Opportunities Commission
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HIVST	HIV Self-Testing
HTS	HIV Testing Services
ICF	Intensive Case Finding
IP	Implementing Partners
IPT	Isoniazid Preventive Therapy
IRCU	Inter-Religious Council
JMS	Joint Medical Stores
JUPSA	Joint UN Programme of Support on AIDS in Uganda
KP	Key Population
LTFU	Lost to Follow up
MAKSPH/METS	Makerere University School of Public Health Monitoring and Evaluation Technical Support Program
MARPs	Most at Risk Populations
MAUL	Medical Access Uganda Limited
MDA	Ministries Departments and Agencies
MGLSD	Ministry of Gender Labour and Social Development
MIS	Management Information System
MMS	Medicine Management Supervisors
MNCAH	Maternal, Newborn, Child and Adolescent Health
MODVA	Ministry of Defense and Veteran Affairs
MOES	Ministry of Education and Sports
MISP	Minimum Initial Service Package
MWE	Ministry of Water and Environment
NAFOPHANU	National Forum of People living with HIV Network in Uganda
NASA	National AIDS Spending Assessment

NCCC	National Condom Coordination Committee
NCPI	National Commitments and Policy Instrument
NDA	National Drug Authority
NPAP	National HIV and AIDS Priority Action Plan 2018/19
NSP	National HIV and AIDS Strategic Plan 2015/16 - 2019/20
ODI	One Dollar Initiative
OPM	Office of the Prime Minister
OVC	Orphans and other Vulnerable Children
OWC	Operation Wealth Creation
PAC	Parish AIDS Committee
PEPFAR	Presidential Emergency Plan for AIDS Relief
PFTI	Presidential First Track Initiative
PHLA	People Living with HIV and AIDS
PIASCY	Presidential Initiative on AIDS Strategy to Youth
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PP	Priority Population
PrEP	Pre-Exposure Prophylaxis
PWD	Persons with Disabilities
RH	Reproductive Health
RHITES	Regional Health Integration to Enhance Services
RTI	Research Teams International
RUTF	Ready to Use Therapeutic Food
SAC	Sub-County AIDS Committee
SAGE	Social Assistance Grants for Empowerment
SASA	Start, Awareness, Support and Action
SBCC	Social and Behavioral Change Communication
SCE	Self Coordinating Entities
SDPs	Service Delivery Points Survey
SGBV	Sexual and Gender Based Violence
SHCI	Support for Integrated Health Care Initiative
SMC	Safe Male Circumcision
SRH	Sexual and Reproductive Health
TMA	Total Market Approach
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UDHS	Uganda Demographic Health Survey
UNASO	Uganda Network of Aids Service Organizations
UNRA	Uganda National Roads Authority
UNSA	Uganda National Students Association
UPDF	Uganda Peoples Defense Forces
UPF	Uganda Police Force
UPHIA	Uganda Population HIV Impact Assessment
UWEP	Uganda Women Entrepreneurship Program
UWONET	Uganda Women's Network
VAC	Village AIDS Committee
WAOS/TWOS	Web-based ARV & TB Ordering System
WONETHA	Women's Organization Network for Human Rights Advocacy
YLP	Youth Livelihood Program

FOREWORD

It is my greatest honour and pleasure to present to you the 12th Annual Joint AIDS Report (FY 2018/19). The report highlights the progress made in implementing the National HIV and AID Strategic Plan (2015/16 -2019/20) under the Theme: An AIDS free Uganda, My responsibility launched in April 2015. The JAR also presents challenges and proposed recommendations towards realization of the set objectives and strategic targets. This 12th Annual Joint AIDS Review (JAR) has been organized under the Theme "Empowering Young People to Champion the End of New HIV Infections". We believe that through this focus, the efforts of the young people will be galvanized to accelerate the national HIV/AIDS response and scale up HIV and AIDS services among adolescents and young people.

Implementation of the NSP has been enhanced by the Presidential First Track Initiative on Ending AIDS as a Public Health Threat in Uganda by 2030 to put the country back on its course and leadership in fighting the epidemic. The Initiative was launched in June 2017 and is now in its second year of implementation. The Initiative took the center-stage in mobilizing and awakening leadership in all forms and institutions to champion the fight against the HIV and AIDS pandemic. As a result HIV and AIDS has been mainstreamed in Ministries, Departments, Agencies (MDAs), Local Governments and cultural/traditional institutions, the Private Sector, faith based institutions. The report highlights achievements made over the year under review, some of which include mobilization and commitment of domestic resources to take care of unfunded and under-funded service arrears especially following declining resources from external development partners. This is demonstrated by the Government of Uganda directive to MDAs and DLGs to allocate 0.1% of their budgets for HIV and AIDS mainstreaming and coordination of the response within their mandates. We also noted the decision by the Private Sector to establish a One Dollar Initiative through which resources for HIV and AIDS are mobilized. Government has also committed itself to increasing its contribution to procurement of ARVs, and to absorb project-based health personnel in mainstream Government health facilities.

Apart from the contribution of Government to the implementation of the NSP, we have not fought the battle in isolation. We have fought together with partners who have stood with us all along. It is therefore my pleasure to appreciate the various partners, institutions and civil society organizations that have worked and are still working with the Uganda AIDS Commission and the people of Uganda to implement the NSP complete its final years. I also call upon you for continued support as we prepare a successor Strategic Plan for 2020/21 – 2024/25.

Now that we have been awakened to the challenge, I wish therefore to call upon all of us – stakeholders and partners to re-dedicate our efforts and resources towards ending HIV as a public health threat in Uganda. It is only by working together that we will win the battle. Let me call upon men to embrace your role of closing the tap on new infections, through responsible behaviour change.

The 2018/19 JAR was concluded with a number of undertakings or priority actions. These action areas should guide you in formulating your annual work plans for FY 2019/20 for which you will show progress during the FY 2019/20 JAR. I have the confidence that together we can achieve more.

Thank you,

For God and My Country.

Hon. Esther M. Mbayo
MINISTER OF THE PRESIDENCY

ACKNOWLEDGEMENTS

The implementation of the national response (2015/16-2019/20) is a collaborative effort of many stakeholders and partners, whose contribution deserves special appreciation. Also the preparation of the 2018/19 Joint AIDS Review (JAR), which is the fourth year of implementation and reporting, has benefitted from input by various stakeholders, partners and beneficiaries. The Uganda AIDS Commission is pleased to acknowledge them.

First and foremost the Uganda AIDS Commission wishes to express sincere gratitude to H.E. the President of the Republic of Uganda, Her Excellency the First Lady and the Hon. Minister of Presidency for their commitment and dedication to elimination of HIV and AIDS as a public health threat in 2030 under the Presidential Fast Track Initiative. In addition we acknowledge the active participation and commitment of other leaders, especially the Parliamentarians, traditional and cultural leaders that has re-invigorated the national response.

During the year under review, the UAC continued to receive support and collaboration from the Partnerships Committee and Forum towards realization and fulfilment of its coordination mandate of the national HIV and AIDS response. I would like to also acknowledge the leadership and guidance received from the UAC Board, the Steering Committee as well as the Country Coordination Committee throughout the year under review and during the review process.

In implementing the interventions under the national response the Technical Working Groups through their Chairpersons and Conveners provided crucial information and data that was vital contribution to the review process.

Uganda AIDS Commission is also grateful to the UAC Board and Staff, the various individuals and stakeholders from the self-coordinating entities including central government MDAs, DLGs and civil society organizations, networks of people living with HIV (PHLAs), the private sector, religious/faith-based leaders and institutions. The participation and support of the development partners in implementing the NSP and the review deserves special appreciation. I want in a special way to appreciate the Embassy of Ireland through the Joint UN Programme of Support on AIDS in Uganda (JUPSA) for funding the Joint Annual AIDS Review.

I also wish to acknowledge the technical assistance and hard work of the consultancy firm, the Eastern Central and Southern Africa (ECASA) Group of Consultants led by Dr. John Mugisa that facilitated the review process and preparation of the 12th Annual Joint AIDS Review Report.

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Dr. Nelson Musoba
Director General
UGANDA AIDS COMMISSION

EXECUTIVE SUMMARY

Introduction

This report presents the country progress of the fourth year of Uganda's NSP (2015/16 -2019/20) implementation that builds on previous achievements realized since 2017/18. The report is divided into three (3) main sections which include; the introduction part that summarizes the review approach and report compilation process, the overview of HIV epidemic in Uganda and, the progress made during the FY 2018/19. The report highlights key challenges and implementation gaps as well as recommendations that could be implemented to improve the national response in the final year of NSP implementation as well as inform planning of the next phase of implementation in the country. This report is a result of a highly participatory and consultative process involving the key stakeholders in NSP implementation. The report utilized secondary quantitative data abstracted from the DHIS2, Uganda Country Spectrum Estimates, 2018, OVC MIS, MoES MIS and desk review of reports and spectrum estimates and some selected studies carried out during the review period.

The performance review of the fourth year (2018/19) of NSP implementation shows that the country is making progress towards achieving some of NSP targets as we move into the final year of implementation. However, there are some challenges impeding progress and achievement of some the planned targets within the remaining one year of NSP implementation. This section presents progress made, achievements and challenges in the different NSP thematic area

Progress Made in HIV Prevention

Despite some challenges, there has been marked progress in some areas in the national HIV prevention response surpassing the NSP targets. For instance, the % of HIV+ pregnant women who received ART to reduce MTCT of HIV increased form 89% in the previous year to 92% in FY 2018/19 surpassing the NSP target of 85% by 2020. A number of policies, tools and guidelines have been developed, adopted and rolled out to strengthen the HIV prevention response in the country. As part of strengthening Social Behaviour Change Communication (SBCC) for HIV prevention a number of interventions were undertaken including, developing SBCC tools and guidelines as well as SBCC training module to support training of the Implementing Partners (IPs); support to SBCC initiatives to reach out to adolescents and young people with SRH/HIV/GBV information and; provision of technical assistance to MOH and UAC by Communication for Healthy Communities (CHC) to design, review and approve the print, audio and visual materials designed to support various HTS interventions, such as PrEP, EMTCT, DSD, and APN. Condom programming has been enhanced through integration of condom commodities management in the broader Reproductive Health (RH) Commodity plans. Condom programming strategy was updated by MoH to provide for Total Market Approach (TMA) and upgrading of National Drug Authority (NDA) capacity to test all condoms. During the year 2018/19 a number of activities have been implemented to address GBV especially among AYP. Key interventions included, training of 889 Community Activists using the Start, Awareness, Support and Action (SASA) Strategy to conduct community conversations on GBV and HIV prevention; training of mentors to enhance their mentorship skills to reach out to Women and Girls on GBV prevention and response; health workers, academia and CSOs were trained on clinical management of GBV while 35 health workers trained on the Minimum Initial Service Package (MISP) for SRHR and GBV while 591 health workers including, clinical Officers, midwives and doctors were trained on Clinical management of Rape under the 14 UNFPA / JUPSA supported districts including refugee hosting districts. The country launched the National Sexuality Education Framework 2018 as a strategy to empower young people and adolescents with age appropriate SRH information while MGLSD has also developed a Social Sector SRH/HIV Manual aimed at equipping staff with SRH and HIV knowledge to enhance their participation in the national response. Key populations/Priority Populations (KP/PP) programming has been

strengthened through integration in all HIV prevention programs and tools have been operationalized in 23 sites including 12 Regional Referral Hospitals; testing for KP/PP expanded to additional 45 districts and 91 facilities from the initial 25 districts in 2018 and a number of guidelines and tools have been developed by MoH to enhance the capacity of service providers to offer KP/PP friendly services.

Government has continued to scale-up coverage and utilization of combination HIV prevention biomedical intervention through adoption and roll-out of HTS policy guidelines and the HTS addendum (HIVST, APN and Certification for testers and sites. New HTS strategies including; index testing, targeted community testing, APN and HIV self-testing (HIVST) have been adopted for acceleration of HIV case identification. Under eMTCT program, there has been an increase in enrolled on Anti-retroviral Therapy (ART) of the number of women were newly identified to have HIV at the first time of testing (TRR) during ANC from 84% registered in 2017/18 compared with 90% for Pregnant Women during 2018/19. However there is great variation in eMTCT performance across districts with districts in Karamoja sub-region and mid-eastern performing poorly. As part of capacity strengthening for eMTCT program, a number of guidelines were formulated, updated and piloted and updated while a number of health workers and IPs across the country were trained in various aspects of eMTCT service provision including, G-ANC, M&E, GBV and PMTCT integration. The country has adopted a road map to guide PrEP implementation and roll out of PrEP Services has gone up from 16 to current 90 sites, with over 11,500 clients ever enrolled on PrEP with women being the main users.

However, there are a number of challenges currently affecting HIV prevention response. These include among others, decline in SBCC interventions coupled by misinformation of the general public by uncensored messages issued by faith based and traditional healers; limited condom supplies characterized by stock-outs in some districts; inadequate programming for KPs as the magnitude of different categories of not known; integrating SGBV prevention and human rights with HIV prevention programming remains a big challenge and inadequate skills in provision of adolescent friendly SRH among health workers. Regarding biomedical interventions, prevention response has experienced challenges including, decline in linkage to care; low uptake of HIV testing services among men; low EID coverage and retention

Progress Made in HIV Care and Treatment

The Care and treatment program showed a steady improvement in the FY 18/19. Overall, 86% (1,204,000 of the estimated 1.4 million PLHIV's) in Uganda knew their HIV status and 86% of them were on ART. Of the 14% (~196,000) PLHIV's who were not diagnosed in FY 18/19, 18.3% (36,000) were children, while adults constituted 81.6% (160,000). The Linkage among those diagnosed was good at 100%, across children and adults, but the viral suppression rates were low in children, as almost half of the children on ART had unsuppressed viral loads. The consolidated ART guidelines were revised and rolled out in 2018 with a focus on ART optimization to enhance sustained viral suppression, tolerability and sustainability. Facility coverage of pediatric care improved 83% (1,517/1,832) by December 2017 and to 89% (1,635/1,830) by June 2019.

As a result, and based on the UNAIDS Uganda 2018 HIV estimates, there was a 63.4% reduction in HIV and AIDS related mortality from 63,000 in 2013 (NSP baseline) to approximately 23,000 in 2018. Up to 306,000 people living with HIV were transitioned or newly initiated on DTG as their first line ART. A gap however persists in the initiation of ART as about 189,700 HIV-infected adults and children (34.6%) were not initiated on ART in FY 18/19 and are a backlog for 2019/20. Overall, low ART uptake is observed amongst the children (64.0%) compared to adults (88.1%) and the ART coverage amongst men above 15 years is still low (77%) compared to their female counterparts (95.4%).

The VL coverage increased in the last four years from 51.5% in FY 2015/16 to 88.2% in FY 2017/18 and to 96.7% in FY 18/19. This improvement is attributed the continued scale of VL with improved transport and coordination between the health facilities and CPHL through the Hubs. There were, however, distinct variations in viral load coverage and suppression rates between children and adults. The Advanced Disease working group was established, and so was the Advanced Disease Management (ADM) care package developed in FY 18/19. The package addresses key areas for the identification, screening and management of the life threating OIs that contribute to HIV related morbidity and mortality. The review also noted missed opportunities for initiating PLHIV

with TB confection on anti TB drugs, about 30% of PLHIV's diagnosed with TB were not started on anti –TB drugs and a low IPT coverage of 52.2%.

Progress Made in Social Support and Protection

The annual review shows that, whereas some indicators were on course towards achieving the objectives and targets in the NSP, a few of them were lagging behind.

The second National Stigma Index Study[1] conducted in 21 districts and 9 in sub regions of Uganda, showed a reduction in some forms of stigma. Exclusion from social gatherings reduced from 4.5% in 2013 to 1.3% (2019), while internal stigma e.g. feeling guilty of being HIV+ reduced from 50% in 2013 to 24% in the year 2019. Another Study by Makerere University School of Public Health (2019) and TASO showed an increase in accepting attitudes by AGYW towards PLIHIV. For instance, among the 8,236 AGYW respondents, 86.4% were willing to take care of an HIV infected family member in their own household, while 81.1% would allow an infected teacher to continue teaching in their school. The reduction in Stigma was partly attributed to the existence of peer support groups for different categories of people and the provision of free HIV counselling services to PLHIV. In spite of this achievement, work place stigma stills presents as a major challenge to PLHIV.

Further, the current review revealed a decline in food secure for OVC Households compared to the baseline period, and to FY 2017/18. While the baseline indicated 45.2% (LQAS 2013) of households that were food secure, FY 2017/2018 indicated 37.2% (LQAS 2017), while the year 2018/19 showed a decline to 19.2% of such households that were supported with food; (National OVC Data base; FY 2018/19). By implication, this is lower than the planned NSP target of 60% by FY 2019/20. The decline is partly attributed to the more emphasis on the provision of psychosocial support and economic strengthening services at the expense of food support. With regard to the OVCs aged 5-17 that had at least three basic needs met, remarkable progress was observed. Compared to the baseline value of 24.8% (LQAS, 2013), this increased to 39% in FY 2017/18 (LQAS, 2017) and to 66% in FY 2018/19 (National OVC data base FY 2018/19), implying a positive trend towards achieving the planned NSP target of 70% by the year 2019/20.

The percentage of men and women who believe that wife beating is justified declined from 55.1% at baseline to 47% by FY 2017/18 and FY 2018/19. However, the achievement is far below the planned target of 20%, implying achievement of the target by 2020 is unlikely. Both the state and non-state actors implemented GBV interventions using various strategies from national to community level and this partly justifies the decline, however, more interventions to eliminate GBV are still needed as the national GBV data base indicated poverty highly contributing to GBV. The percentage of women who own land alone or jointly with their spouses increased from 38.7% (UDHS 2011) to 47.7% (UDHS 2016) in FY 2017/18, 2018/19. The current year had no updated information to measure progress and therefore similar information was used to compare trends; which implies achievement above the planned target of 40% in the NSP.

Among the key achievements under Social support and protection for FY 2018/19 include; increased recognition of the need to develop HIV &AIDS workplace sector policies to protect the rights of PHIV, and the increased recognition and adoption of HIV & AIDS mainstreaming of the socio-economic needs of PLHIV, OVCs and other vulnerable categories of people by the Public sectors and non - public actors. There was improved implementation of legal and policy instruments for the empowerment of women, girls, men and boys to access and utilize social support and protection services.

Despite the increased demand for social support and protection there is generally noticeable low funding for the sector (less than 4% of the HIV budget), more emphasis is on HIV Prevention and Care and Treatment at the expense of Social support and protection. Anti-stigma and discrimination interventions are implemented on a lower scale

[1] NAFOPHANU Second National Stigma Index Study (August 2019)

especially at workplaces, while cultural norms and beliefs still remain major obstacles to HIV response at both household and community level.

Progress Made in System Strengthening

Systems strengthening remained a key priority in the NSP implementation during the FY 2018/19. Accordingly a number of interventions were implemented in line with the in the NSP and the NPAP (2018/19 – 2019/20) thematic objectives geared towards strengthening governance, human resource and resource mobilization for enhanced HIV/AIDS services delivery in the country. With respect to strengthening governance and leadership of the response, through the Presidential Fast Track Initiative (PFTI) to End HIV and AIDS as a public threat to national development by 2030, there was strengthened and expanded engagement of leaders (political, religious, cultural and technical) in the leadership and stewardship of the multi-sectoral response at all levels and key institutions, organizations, facilities and communities. The renewed wave of leadership under the PFTI has resulted into enhanced national HIV response involving all key stakeholders at various levels. Most MDAs have prepared and implemented Workplace HIV and AIDS Policies in under the PFTI. As part of strengthening leadership and planning at the decentralized response, some selected districts have been supported to integrate HIV and AIDS in their plans and budget processes. For example, 7 districts in Karamoja Region have developed strategic plans aligned to the NSP. However, although the District AIDS Committees (DACs) are reported to place in most of the districts, their functionality remains weak mainly due to

Regarding human resource for delivery of quality HIV and AIDS services, the review noted that an upward trend of public staffing levels observed over the last 9 years has been maintained. Although this was a positive trend, it was still below the Health Sector Development Plan (HSDP) target of 80% by 2019. Marked improvement in staffing levels was realized for the doctors from 57% (2017) to 63% 2018, midwives from 78% (2018) to 94% (2018). Nonetheless, there is persistent critical shortage of some health cadres like anaesthetic officers, dispensers, pharmacists, theatre assistants and public health nurses. There are many health workers supported outside the government system and currently employed by donor funded programs/projects. It was observed that, closure of these programs severely affects HRH. In order to respond to this challenge, GOU is committed to implement a HR transition plan to absorb 40% front line staff from the various projects and programmes following their closure.

Efforts were made during the year to ensure uninterrupted availability of high quality health commodities (medical and non-medical), focusing on those to prevent and treat HIV/AIDS, TB and malaria, and to support family planning needs. However, the annual review shows that health commodities remain heavily donor funded and there was little improvement if any in terms of reducing the gap for supplies/commodities currently not funded by the GoU. There is a need for increased investment in health commodities to avoid compromising patient care. GoU has almost 100% non-commitment (non-funded) on items such as laboratory commodities, Artesunate Injection Vials, mRDTs and ACTs. In order to expedite importation health commodities, Uganda National Drug Authority NDA agreed to fast track clearance applications for donor-funding health commodity shipments and customized its management information system (MIS) used to process clearance applications. Partners can now enter their requests online. Health facilities offering HTS, ART and eMTCT have had their capacities enhanced in form of renovations of the existing infrastructure and remodeling of facilities as well as availing necessary equipment to improve the capacity to provide the package of services required for HIV and AIDS response. MoH with the support of partners has strengthened laboratories to improve clinical care based on accessible test-based accurate diagnoses and ensure VL/EID and TB tests are received and utilized in a timely manner.

Regarding resource mobilization and streamlining management for efficient utilization and accountability, during the FY 2018/19 a number of strategic actions were undertaken in line with the NPAP 2018/19. A National Resource Mobilization Strategy and Plan was launched and disseminated to guide resource mobilization. Efforts were made to mobilise HIV and AIDS resources through non-traditional bilateral and the private sector and to this end, the One Dollar Initiative (ODI), a private sector led mobilization campaign to leverage on the business entities and the private sector players was launched. The period under review has witnessed increased Government commitment through allocation of additional funding for HIV and AIDS response in the country. GoU made further allocations of UGX 50 billion towards the HIV/AIDS ringed faced towards procurement of ARVs while Parliament passed into law for all MDAs to allocate to the HIV/AID and gender mainstreaming activities 0.1% of all non-wages finances. However, there was

a big funding gap of about 276.62 observed during the year which severely constrained HIV service delivery. M&E Systems for generating comprehensive quality and timely data on HIV and AIDS was enhanced through a number of interventions a) routine data collection through i) DHIS2 by district local governments, ii) OVC MIS by Ministry of Gender Labour and Social Development, (MGLSD), iii) GBV data base also by the MGLSD, iv) NASA v) NHA and vi) Gender dashboard vii)MOES EMIS, viii) logistics; b) surveys such as i) Further analysis of UPHIA to disaggregate data by region ii) Re-essence study c) conducted national HIV estimates and KP Size estimation. Additional HIV Situation room equipment were procured and a fibre optic cable was installed at CPHL Butabika. National tools for capturing biomedical and non-biomedical data that have been developed and rolled out to facilitate collection of data from IPs.

1 INTRODUCTION

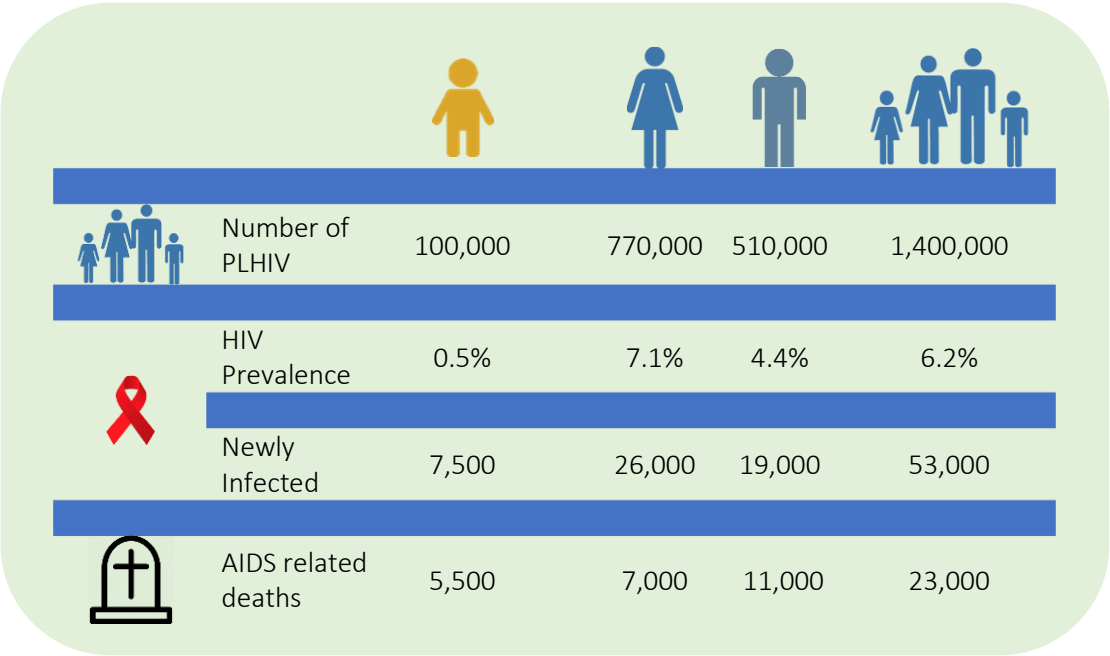
Uganda is currently implementing the fourth cycle of the National HIV and AIDS Strategic Plan (2015/16- 2019/20) with the overall goal "Towards Zero New Infections, Zero HIV and AIDS related deaths and Zero discrimination". The Plan is aligned to the global efforts to end the AIDS epidemic by 2030 and it represents Uganda's commitment to invest in impactful combination interventions to drastically reduce the number of new infections, with the view of reaching zero new infections, zero HIV/AIDS-related deaths and zero stigma and discrimination due to HIV.

This report presents the country progress of the fourth year of Uganda's NSP (2015/16 -2019/20) implementation that builds on previous achievements since 2017/18. The progress has been assessed according to the four NSP thematic areas. The report is divided into three (3) main sections which include; the introduction part that summarizes the review approach and report compilation process, the overview of HIV epidemic in Uganda and, the progress made during the FY 2018/19. The report highlights key challenges and implementation gaps as well as recommendations that could be implemented to improve the national response in the final year of NSP implementation as well as inform planning of the next phase of implementation in the country. The report also captures the progress registered against the 2018 Joint AIDS Review (JAR) undertakings.

This report is a result of a highly participatory and consultative process involving the key stakeholders in NSP implementation. The report utilized secondary quantitative data abstracted from the DHIS2, Uganda Country Spectrum Estimates, 2018, OVC MIS, MoES MIS and desk review of reports and some selected studies carried out during the review period. The data and report were further reviewed and validated by Thematic Technical Working Groups, UAC technical staff, UAC Board and the 12th Joint AIDS Review (JAR). A content analysis was done on various progress reports from the Sectors, SCEs, CSOs and partners and triangulated for drawing of the necessary conclusions and recommendations of the progress report.

2 STATUS OF THE HIV EPIDEMIC IN UGANDA

The HIV and AIDS epidemic remains a major public health in Uganda. According to Uganda Country 2018 HIV and AIDS estimates, an estimated 1.4 million people were living with HIV, 53,000 new HIV cases were registered, and an estimated 23,000 Ugandans died of AIDS-related illnesses (UNAIDS, 2018). Women and young women in particular are disproportionately affected. The figure below summarizes the HIV burden in Uganda at a glance.



Source: MOH Country Spectrum Estimates, 2018

2.1 Progress Towards 90 90 90 Targets

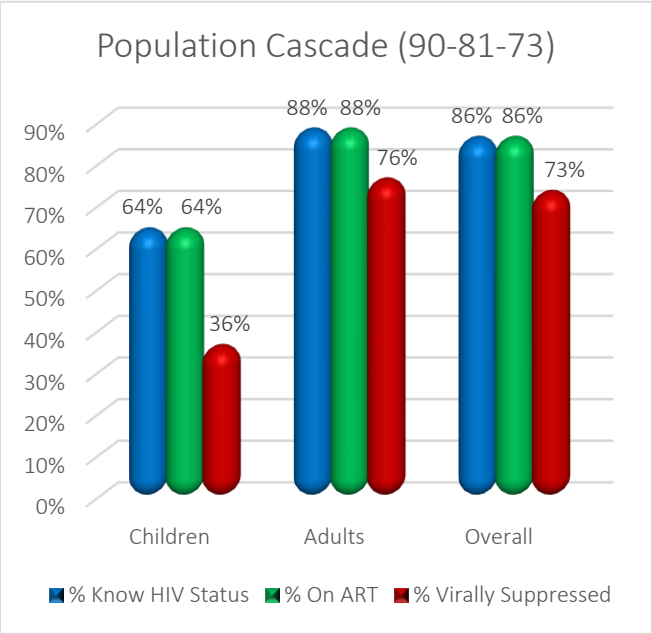


Figure 1: Population cascade (90-81-73)

Overall, 86% (1,204,000 of the estimated 1.4 million PLHIV's) in Uganda knew their HIV status in FY 18/19. 36,000 children living with HIV have not been diagnosed, Linkage is good (100%) across the children and adults, but the viral suppression rates are low in children, almost half of the children on ART have unsuppressed viral loads.

Source: ACP-MOH FY 18/19 Report

3 Status of NSP Implementation for FY 2018/19

The performance review of the fourth year (2018/19) of NSP implementation shows that the country is making progress towards achieving some of NSP targets as we move into the final year of implementation. The Presidential Fast Track Initiative (PFTI) to End HIV and AIDS as a public threat to national development by 2030, lunched in 2017, has continued to spur the national response through galvanizing the leadership of MDAs, political, cultural and faith-based institutions for enhanced HIV and AIDS response in the country. However, there are some challenges impeding progress and achievement of some the planned targets within the remaining one year of NSP implementation. This section presents progress made, achievements and challenges in the different NSP thematic areas.

3.1 Progress Made in HIV Prevention

The NSP thematic Goal of the national HIV prevention response is to reduce the number of new youth and adult HIV infections by 70% and the number of new pediatric HIV infections by 95% by 2020. In fulfillment of this Goal a number of HIV prevention interventions were undertaken during the year 2018/19 in line with the thematic objectives of HIV prevention. Despite some challenges over the past year, there has been marked progress in some areas in the national HIV prevention response surpassing the NSP targets. A number of policies, tools and guidelines were developed, adopted and rolled out to further strengthen the HIV prevention response in the country. Table 1 provides progress of HIV prevention made over the past 3 years.

Table 1: Progress of HIV Prevention Outcomes at a Glance

	Categories	Baseline	2020 Target	Achieved 2016/17	Achieved 2017/18	Achieved 2018/19	Assessment of Progress
Increased adoption of safer sexual behaviors and reduction in risky behaviors							
% 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%	45%*** 33.3% *	45%*** 33.3% *	No data to measure progress over the year. However based on 2018/19 achievement, it is unlikely that the target of 70% for both male and female will be achieved by 2020
	Female	38.6%	70%	46%	46% *** 29.3% *	46% *** 29.3% *	
% of adults aged 15-49 who use a condom at last high risk sex	Male	37%	75%	22%	57% ***	57% ***	No updated information to measure progress over the year 2018/19
	Female	29.4%	75%		37% ***	37% ***	
% of young women and men 15-24 years who have had sexual intercourse before 15 years	Male	11.9%	7%	6.4% *	21% *	21% *	No updated information to measure progress over the year. However based on 2018/19 achievement, it is unlikely that the target of 7% for both male and female will be achieved by 2020
	Female	13.1%	7%		10.2% **	10.2% **	
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	Male	37.9%	90%	57%	No data	No data	No updated data to measure progress over the 2 year period
	Female	N/A	N/A	37%	No data	No data	
% MARPS 15-49 reporting consistent condom use	SW		50%	65%	No data	No data	
	Uniformed Services		50%	No MARPS specific data done	No Data	No Data	
	Fishermen		50%		No Data	No Data	
	MSM		50%		No Data	No Data	
	Truckers		50%		No Data	No Data	
% of men and women who tested for HIV in the last 12 months and know their results	Male	47%	80%	53.8% *	37.3% ** 55% *	37.3% ** 55% *	Although there was no updated data for 2018/19, based on achievement of FY 2017/18, it is unlikely that the target of 80% for both male and female will be achieved
	Female				48.1%**	48.1%**	
% of MARPS who have received an HIV test and know their status	SW	49.2%	80%	N/A	No data	67%	It is unlikely that the NSP target of 80% will be achieved by 2020
	Uniformed services	N/A	80%	N/A	No Data	No Data	No data to assess progress
	Fishermen	N/A	N/A	N/A	No data	No data	
	MSM	N/A	N/A	N/A	No Data	85%	No information from FY 2017/18 to measure progress
	Truckers	N/A	N/A	N/A	No Data	No Data	
% of HIV+ pregnant women who received ART to reduce MTCT of HIV		75%	85%	86%	89%	92%	Progressed from the previous year, though target surpassed
% of exposed infants who have received ARV prophylaxis to reduce risk of MTCT of HIV		36.7%	80%	95%	92%	85%	Although there was a decline from the previous year, the NSP target has been surpassed
% of infants born to HIV+ women receiving a virological test within 2 months of birth and cessation of breast feeding	1st PCR	44%	75%	52%	44%	68%	Progressed from the previous year and on course to achieve the target
	2nd PCR	10%	70%	31%	No data	55%	Slow progress. NSP target of 10% is not likely to be met
% of males 15-49 who are circumcised		25%	80%	43%	43% ** 47.6% *	703,997 men	The target for the year could not be established

	Categories	Baseline	2020 Target	Achieved 2016/17	Achieved 2017/18	Achieved 2018/19	Assessment of Progress
% 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%	100% ****	100% 100%	100% Performance maintained throughout the NSP implementation period
Underlying social-cultural gender and other factors that drive the HIV epidemic mitigated							
% women 15-49 who experience SGBV		27%	23%	13%	13% *** 21% *	13% *** 21% *	No updated information to measure progress
% of adults that believe that a woman is justified to refuse sex or demand condom use if she knows her husband has a STI	Male	90%	95%	N/A	91%	91%	On course to achieve the target, although there was no updated data from that of FY 2017/18
	Female	84%	90%		87% ***	87% ***	

Note: * LQAS 2018, ** UPHIA 2016, *** UDHS 2016, **** UBTS Annual Report

3.1.1 Strategic Objective 1: Behaviors and Reduction in Risky Behaviors Increasing Adoption of Safer Sexual

3.1.1.1 Social and Behavioral Change Communication (SBCC) Programming

During the year, various partners implemented SBCC interventions to increase adoption of healthy behaviors through strengthened and targeted evidence-based social and behavior change communication (SBCC) activities aimed at high risk sexual behaviors that include: multiple (concurrent) sexual partnerships, cross-generational sex, early sex debut, transactional sex, sex work, casual sex, Sexual Gender-Based Violence (SGBV) as well as low and inconsistence condom use.

As part of strengthening SBCC programming a number of tools and guidelines were developed. During the year under review, UAC initiated the process of developing SBCC tools and guidelines as well as SBCC training module to support training of the Implementing Partners (IPs) at national and district level. In addition, UAC developed Gender HIV Sensitive Media Reporting Guidelines, but these are yet to be validated. A National HIV/AIDS Symposium that attracted over 316 national leaders was organized to sensitize leaders on HIV prevention and they made recommendations on how SBCC could be strengthened to mobilise local communities for the HIV Prevention.

Over 3.7m adolescents and young people were reached with information through a range of communication initiatives including the multichannel live your dream campaign and SRH/HIV information and services in the 29 supported districts (UNFPA/JUPSA 2019). UNFPA in partnership with Ministry of Health and CSOs, through a multimedia SRHR campaign 'Live Your Dream' supported SBCC initiatives to regularly reach adolescents and young people with SRH/HIV/GBV information. The campaign focused on prevention of teenage pregnancies, keeping girls in school, promoting inter-generation discussions and empowering youth with life and livelihoods skills to fulfil their potential. During the year the campaign was expanded to 25 districts including the Karamoja region.. Similarly, UNFPA/JUPSA supported delivery of the Protect the Goal (PtG) campaign in the 7 districts of Karamoja through netball and football tournaments happening in every sub-country culminating into district level competitions. PtG assisted to reach up to 100,000 adolescents and young people in the region, some participating in sports and others converging at sports events where they were provided with information and also linked to SRH/HIV services. In addition, UNFPA supported UAC to develop a national SBCC guideline intended to support capacity building for quality SBCC at various levels including SBCC basic training for different actors beginning with Karamoja region where it was pretested. In the 14 DREAMS districts SBCC messages targeting men have been attributed to the reduction in incidence of HIV and Pregnancy among AGYW.

Communication for Healthy Communities (CHC), which is one of the key partners involved in SBCC programming and implementation provided technical assistance to

MOH and UAC to design, review and approve the print, audio and visual materials designed to support various HTS interventions, such as PrEP, EMTCT, DSD, and APN. Specifically, CHC supported the reviewing, updating and designing new materials for the TB campaign targeting of enrolling 300,000 PLHIV in IPT within 100 days. CHC also provided technical assistance to IPs, such as Mildmay, RHSP, the 5 RHITES and TASO to mobilize communities for HTS and VMMC services, focusing on high-risk groups and priority populations. The TA focused mainly on supporting demand creation and community mobilization activities (community shows, home visits and, large and small group discussions) through twinning with CHC IPC agents. This support helped in improving the partners' health communication competences and skills. During the Quartet April – June 2019 a total of 1,810 group events and 1,799 small group activations in which they reached 14,654 people with health messages, and 12,719 were referred to the health facilities for services.

However, SBCC Programming and implementation has been declining over the past years as demonstrated by the Fourth USAID/Communication for Healthy Communities (CHC) Listening Survey conducted in 18 districts in each of the eight regions of Uganda. The survey conducted in December 2018 (Table 2), shows that exposure to Obulamu HIV messages in the past 6 months dropped from 87.1% to 71.6%. On average 94% of the individuals were exposed to two or more times and the health centers were the major source of information with an average of 62% across the seven messages assessed. Exposure to Obulamu HIV messages also dropped slightly but remained above the hierarchy of communication effects target of 80%. By Gender, the decrease was only observed among females. By age group the decrease was observed more among individuals 20 to 24yrs and 35 to 39yrs with a 9 percent point drop respectively. The decline in SBCC interventions could be due to the reduced funding for HIV prevention response as shown in the analysis for resource allocation for HIV national response during the year 2018/19.

Table 2: Exposure to any Obulamu message about HIV in the past 6 months

Among		June 2017			Sept 2018		
		N	Percent	Total	N	Percent	Total
All		1526	87.1%	1753	1207	81.5%	1481
Gender	Female	919	87.5%	1050	831	78.5%	1058
	Male	607	86.3%	703	376	88.9%	423
Residence	Rural	1176	85.6%	1374	817	78.8%	1037
	Urban	350	92.3%	379	390	87.8%	444
Age group	15 - 19 Yrs	151	83.9%	180	181	83.40%	217
	20 - 24 Yrs	372	89.4%	416	299	80.40%	372
	25 - 29 Yrs	370	86.7%	427	297	81.40%	365
	30 - 34 Yrs	238	87.2%	273	179	81.70%	219
	35 - 39 Yrs	179	90.4%	198	132	81.50%	162
	40 - 44 Yrs	116	80.0%	145	67	79.80%	84
	45 - 49 Yrs	100	87.7%	114	52	83.90%	62
Life stage	LS1 - 20 - 30 Yrs	843	87.9%	959	660	81.10%	814
	LS4 - 15 - 19 Yrs	151	83.9%	180	181	83.40%	217
Region	Central	332	93.3%	356	215	96.0%	224
	East Central	121	70.8%	171	142	76.8%	185
	Eastern	256	86.8%	295	171	86.8%	197
	Karamoja	67	73.6%	91	237	83.2%	285
	Northern	207	90.8%	228	52	39.7%	131
	South Western	211	92.5%	228	158	83.6%	189
	West Nile	112	84.8%	132	93	95.9%	97
	Western	220	87.3%	252	139	80.3%	173
Specific Obulamu HIV message	Use a condom	1191	78.0%	1526	1096	91.0%	1204
	Test for HIV and receive results	1206	79.0%	1526	1167	96.8%	1206
	Reduce MCP/Be faithful	784	51.4%	1526	994	83.0%	1198
	Take ARVs	966	63.3%	1526	1032	85.9%	1202
	Go for VLM	357	23.4%	1526	705	58.8%	1200

	Get circumcised	729	47.8%	1526	1109	92.1%	1204
	PMTCT	640	41.9%	1526	1000	83.1%	1203

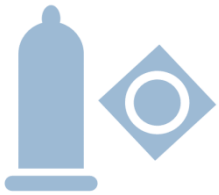
Source: CHC September 2018

Key Challenges / Weaknesses

- Limited integration of services that affects efficiency of services. Young people on HIV treatment are not accessing a full package of SRH services at their service delivery points.
- Limited translation of BCC/IEC materials into local languages. Most of the BCC/IEC materials are produced in English and therefore not suitable for use in rural areas
- Current IEC materials do not cater for PWD especially those with visual impairment as they are rarely produced in PWD-friendly forms such as braille.
- Misinformation of the general public by unregulated faith based and traditional healers

3.1.1.2 Condom Programming and Management

Male and female condoms have continued to play a critical role in the national HIV prevention response. About 200m male condoms are procured annually since 2017. During the review period, MoH with support from Development Partners, spearheaded condom distribution aimed at increasing availability and accessibility of condoms to the communities as well as key and priority populations. Twenty (20%) of the public sector condoms were distributed by NMS through Health facilities, while 80% were distributed through an alternative condom distribution Strategy. Condom programming strategy was updated by MoH to provide for Total Market Approach (TMA) and upgrading of National Drug Authority (NDA) capacity to test all condoms. In order to increase distribution of condoms country-wide, a Memorandum of Understanding (MoU) was signed with Joint Medical Store (JMS) to store and distribute condoms. The Condom Logistics Management Information System was piloted in 7 MARPs hubs, endorsed by MoH and rolled out to Karamoja region in 2018. A total of 170 health workers were trained in Condoms Logistics Information Systems (CLMIS) management. The National Condom Coordination Committee (NCCC) has also reviewed the draft Condom Strategy to align to MoH policy guidance on access to SRH services for adolescents 15 year and above.



There were efforts to embed condom commodities management in the broader Reproductive Health (RH) Commodity plans. Male and female condoms have been integrated into the annual MoH RH Commodity forecasting, quantification and commodity supply plan and tracked as part of the annual RH Service Delivery Points Survey (SDPs).

As a strategy to address low female condom use, guidelines have been revised re-directing focus on awareness creation and utilization of the female condoms and IEC materials developed by MoH to promote awareness and increase utilization of the female condoms. In order to increase access subnational structures have been revived and equipped with dispensers to ensure that condoms are moved from the health facilities to the local community. Dispensers have been installed in hotspots and have been linked to the proximal health facilities for regular refill. Through this initiative, MoH, in partnership with TASO and JMS, installed 14,586 condom dispensers in 112 districts. More condom dispensers are being procured for this purpose.

As a strategy for scaling up condom distribution, the country received a new entrant into the condom social marketing scene. The Fiesta & Kiss condoms created a new wave of condom promotion to market the product for a lifestyle beyond disease prevention that is anticipated to enhance consistent condom use. However, according to the National Condom Coordination Committee (NCCC), the environment is still not supportive enough of extensive social marketing business to move the country from 80% free condom distribution to about 40% by 2020 under the Total Market Approach to RH commodity management. The national condom program is mostly hinged on free access but with plans to be socially marketed over the years to avoid creating dependence and to target empowering users to take charge of their lives.

Despite the progress made, there are still challenges affecting condom programming in the country. According to the condom programming status 2019, the distribution channels have not worked to meet the country needs of at least 20 million Condoms per month. There has been a reduction in the quantities of condom supplies at the National level as well as those distributed to the districts with some dispensers reported empty. As of July 22, 2019 the total number of Condoms received for 2019 was only 66,183,900 pieces compared to the projected 200m male condoms procured annually. There was male condom stocks at the two warehouses, with 7,656,941 pieces at JMS and 13,936,464 pieces at NMS. Female Condoms were completely out of stock at the National level

Table 3: 2019 Male Condom Receipts at JMS & NMS Warehouse as of July 22, 2019

Stock Supplier	QTY	Warehouse
USAID	47,521,500	JMS
Global Fund	18,662,400	NMS
Total	66,183,900	

The recent National Condom Needs and Utilization Assessment showed that despite the condom knowledge there were limitations in supplies and programming that focused more on commodities rather than the target population and their needs. Hence there was need to scale up condom programming to the needed pace for attainment of epidemic control by 2030.

Condom programming is expected to improve in the coming years with tremendous increase in resources for procurement of male condoms for the period 2017-2020 largely boosted by Global Fund (GF). A GF above allocation funding approved in 2018 increased the allocations to condoms from about $5m to $9.4m for the grant running 2018 to 2020 largely catering for commodity procurement.

Key Challenges / Weaknesses

- Limited condom supplies characterized by stock-outs, thus affecting availability and accessibility
- Condom programming is mainly focused more on commodities rather than the target population and their needs.
- Lack of data on condoms distributed through non-public sector system
- Female Condom programming remains a challenge, still characterized by low demand

3.1.1.3 Integrating SGBV Prevention and Human Rights with HIV Prevention Programming

Prevalent forms of discrimination and structural inequality still affect the lives of many adolescents and young people (AYP) in Uganda and this has increased their vulnerability to HIV infection. Sexual violence and coerced sex remains common, most especially among Adolescents Girls and Young Women (AGYW).

Under JUPSA programme a total of 889 Community Activists were trained using the Start, Awareness, Support and Action (SASA) Strategy to conduct community conversations on GBV and HIV prevention. A total of 44,447 community members were reached, from both a development and humanitarian setting (UNFPA/JUPSA 2018). Up to 360 mentors were identified and oriented to enhance their mentorship skills. The trained mentors identified and sensitized 15,900 (7,950 women and 7950 girls) on GBV prevention and response.

Seventy four (74) Health workers, Academia and CSOs were trained on clinical management of GBV and 35 health workers trained on the Minimum Initial Service Package (MISP) for SRHR and GBV. Furthermore, 591 health workers including, clinical Officers, midwives and doctors were trained on Clinical management of Rape under the 14 UNFPA / JUPSA supported districts including refugee hosting districts.

As part of GBV response, a study on the magnitude of commercial sexual exploitation (CSE) in 3 districts in Uganda was conducted by UNFPA. The study found that most girls engaged in Commercial Sex (CS) are out of school though those in school are less likely to self-disclose their engagement. Most girls have never been married and the average age self-reporting engagement in CS was 15-17 years. The minors engaged in CS are more likely to be living in urban centres, more likely to report alcohol and substance abuse, have had an earlier sexual debut age at 10-14 and had migrated from original home within the country. Commercial Sexual Exploitation has become a risk factor that drives unique and creative coping strategies that result in interlinked health and social consequences including SGBV, HIV and AIDS, and STIs.

3.1.1.4 *Prevention of Sexually Transmitted Infections (STI)*

In order to strengthen prevention of Sexually Transmitted Infections, STI guidelines have been updated to cater for emerging anti-microbial resistance. To this end, the STD Unit in Mulago supported Gonococcal Antimicrobial Resistance Surveillance Program that was carried out in ten Health facilities (STI Surveillance) in order to track STI incidence. STI Programming surveillance has been implemented in Kampala Capital City Authority (KCCA) in Mulago, Kiruddu, Kisenyi, Kiswa and Kawaala health facilities.

Scaling Up HIV Prevention among Key and Priority Populations

Key populations have a disproportionately higher HIV prevalence, riskier sexual behaviours and therefore higher incidence of HIV. According to the modes of transmission study of 2014 (UAC 2016), female sex workers, their clients and their partners contributed a total of 20% of new infections; men who have sex with men and their female partners contributed 0.6% while persons who inject drugs contributed 0.4%.

In order to understand better the magnitude of Key and Priority Populations in the country, during the F/Y 2018/19 MOH and UAC coordinated the KP size estimation in selected districts. A synthesis was carried out to gain better understanding of the magnitude of problem and generate consensus on the available data for key populations, make an estimation of national key population sizes that will inform assessment of service coverage for key populations. This study is yet to be published.

As a strategy to expand coverage of HTS for HIV prevention among priority and key populations KP/PP programming has been integrated in all HIV prevention programs and tools have been operationalized in 23 sites including 12 Regional Referral Hospitals. During the year testing for KP/PP expanded to additional 45 districts and 91 facilities from the initial 25 districts in 2018 (PEPFAR, April 2019). By 2020, MOH targets to reach all health centers IIIs and above. Equally, the roll out of Pre-exposure prophylaxis (PrEP) services among KP/PP has gone up from 16 to current 90 sites with over 11,500 clients by April 2019 (PEPFAR, 2019).

A number of guidelines and tools have been developed by MoH to enhance the capacity of service providers to offer KP/PP friendly services. These include among others; PrEP guidelines, Training Manual/Curriculum for health workers (HWs), tool kit for quality and efficiency of HIV prevention through Differentiated Service Delivery (DSD) as well as a PrEP Communication Plan. In addition, Clinical audits and mentorship programs were conducted in facilities providing KP services.

Key Challenges / Weaknesses

- KP programming remains a challenge, the magnitude of different categories of KPs is not known. KP size estimation has not been conducted in many parts of country
- The scale and intensity of key population interventions is still low for the desired impact
- KP data from facilities is not being reported at national level due to lack of harmonized indicators and tools
- Stigma, cultural, legal and social environment are still not conducive for key population programming

3.1.1.5 *Comprehensive Sexual and Reproductive Health Programming targeting Adolescents and Young People*

Uganda has an estimated population of 44,269,594 (UBOS, 2019 Uganda Population Projections) and 33% of this population is made up of young people below the age of 19 (Census 2014). According to MOES, by age 15, many young women (16%) and men (13%) have already had sex. About 10% women and 5% boys aged 15-24 years who have ever had sex have ever had an STI, implying that they are involved in risky sexual behavior (MOES, 2018). The mean number of sexual partners for girls is rising. Condom use remains very low, and trans-generational sex and transactional sex remain prevalent. As a result, a large number of adolescents and young persons are increasingly vulnerable to HIV infection and SGBV.

In 2017, the Uganda Population HIV Impact Assessment (UPHIA) reported an HIV prevalence of 1.8 % in adolescent girls (15-19 years) and 5.1% in young women

(20-24 years). Further, young women (15-24 years) were about four times as likely to be living with HIV as their male counterparts.

Young people are continuously exposed to uncensored sexually explicit and obscene material through the internet, social media, mass media outlets such as newspapers, radio, TV, telecommunications, etc. There is also an increase in the consumption and abuse of alcohol, drugs and substances among the youths which predispose the youth to risky sexual activities that may lead them to teenage pregnancy, school dropout, acquisition of sexually transmitted infections including HIV and AIDS. A study on prevalence and risk factors for substance abuse among university students in Kampala, Uganda (Nwana K etal 2017) showed that 3 out of every 10 students in Uganda practiced substance abuse, the prevalence is averagely high. The use of alcohol and illicit drugs during adolescent and early adulthood has become a very serious public health problem in Uganda.

As a strategy to control uncensored sexually explicit and obscene material through the internet, social media, the Government has established the Pornography Control committee. A Memorandum of Understanding (MOU) signed with Uganda Communications Commission (UCC) over the review period has five areas of cooperation to implement: early detection of pornography on all communications platforms, prosecution of offenders under the Anti-Pornography Act; training of media personnel and provision of educative materials on the dangers of pornography; building linkages with other stakeholders; and using available infrastructure in detecting and blocking pornography (digital logger, free communication services). Currently, over 30 websites that produce pornographic content were blocked to Ugandan consumers. It is anticipated that the Pornography Control Committee will help to mitigate risky sexual behaviour among adolescents and young people.

To address the problem of alcohol and especially among the young people, the country is moving towards implementation of Alcohol and drug Act that consolidates all alcoholic-related laws and set tougher sanctions on alcohol consumption. Already, the country has moved towards banning package of alcohol in sachets of less than 200ml mainly abused by young people.

To empower young people and adolescents with age appropriate SRH/HIV information, the country through MoES launched the National Sexuality Education Framework 2018 to guide the teaching of Sexuality Education. Sexuality Education has been integrated into the new revised curriculum of S1-S4 to be rolled out beginning 2020. In addition, MoES has revised guidelines on Prevention and Management of HIV/AIDS in schools to include retention of pregnant girls and re-entry of child mothers in school settings in Uganda. Adolescent and Young People Living with HIV (YAPS) Model has been introduced in schools as a strategy to enhance ART initiation, adherence and viral suppression among Adolescents and Young People Living with HIV and AIDS (AYPLHIV). A total of 90 District Education Officers (DEOs) and District Inspectors of Schools (DIS) were trained to rollout the YAPS Model across the country.

Menstrual hygiene management has been strengthened through capacity building trainings for school staff (senior women and men teachers) on menstrual hygiene in over 66 districts across the country. A Training Manual for teachers as well as menstrual hygiene handbooks for learners in primary and secondary schools have been developed and disseminated.

To increase access to SRH and HIV information among out of school AYP, MGLSD developed Sexuality Education guidelines for out of school AYP as well as the National Engagement strategy for adolescents and youth on SRH developed. Manual on SRH/GBV/HIV integration in community development work has been developed and disseminated in 14 districts. In addition, MGLSD developed and launched a Communication Strategy on promotion of norms, values and positive mind-set amongst young people and oriented 200 Community Development Officers (CDOs) of all the 40 districts implementing Global Fund on the National Parenting Guidelines. Furthermore, the MGLSD developed a Social Sector SRH/HIV Manual aimed at equipping staff with SRH and HIV knowledge to enhance their participation in the national response. The Ministry of Health endorsed the National Sexual and Reproductive Health and Rights policy guideline. This included the recommendation to provide Sexual and Reproductive Health (SRH) services to individuals 15 years and above.

Key Challenges / Weaknesses

- Inadequate skills in provision of adolescent friendly SRH among health workers
- Health facilities lack adolescent friendly corners, thus limiting the provision of HTS and other services to adolescents

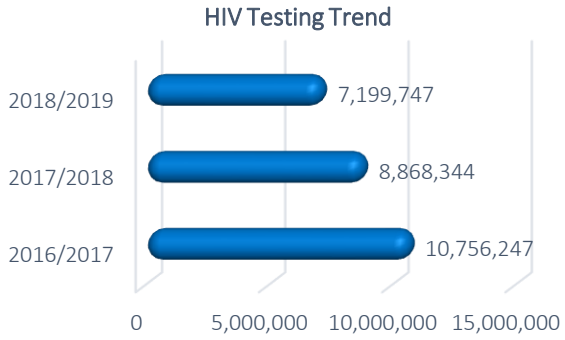
- Young people in post-secondary education institutions are not being prioritized in HIV prevention programs
- Lack of consensus among stakeholders on the recently launched National Sexuality Education Framework 2018 by MOES further compounds access to information on sexuality by young people
- Weak coordination of AYP programs, hence failure to leverage existing technical and financial support from various sectors and partners providing HIV prevention for AYPs;
- Inadequate monitoring and reporting by various sectors and partners leading to poor programming and decision making

3.1.2 Strategic Objective 2: Scaling-Up Coverage and Utilization of Combination HIV Prevention Biomedical Interventions

Expanding HIV Testing and Counselling Services

HIV Testing and Counseling (HTS) at a Glance

General Population	Less than 15 Years	15 Years and Above
7,199,747 Tested	580,715 Tested	6,619,032 Tested
Male | Female	Male | Female	Male | Female
3,670,904 | 5,909,541	309,082 | 271,633	2,821,437 | 3,797,595
Positive 105,231 Male 203,803 female	Positive 3770 Male 4171 Female	Positive 95,309 Male 136,952 Female
216,894 Linked to Care		
Testing Yield at 3.4%		



The number of individuals who have been tested for HIV has been steadily declining from FY 2016/17, where 10,756,247 people tested to 8,868,344 in FY 2017/18 and is currently at 7,290,258. The decline in HCT uptake could be attributed to new targeted testing approaches aimed at increasing the testing yield. Out those tested, 242,629 tested HIV positive and 89% of them were linked to care, a decline from 99%, last year. The average testing yield is 3.4%, the same as was in FY 2017/18, which is still below the expected yield of 5% and above.

In order to further enhance HTS, MoH has rolled out HTS policy guidelines and the addendum. A comprehensive HTS training curriculum for national training of trainers has been implemented covering more than 20% of regional IPs. The curriculum has the HTS addendum (HIVST, APN and Certification for testers and sites). In addition, a rapid HIV testing curriculum (a precursor for the certification roll out) was developed.

Tools have been revised to enhance efficiency and help in identifying the remaining undiagnosed.

New strategies including; index testing, targeted community testing, APN and HIV self-testing (HIVST) have been adopted for acceleration of HIV case identification and hence the attainment of the 1st 90. Successful pilots for both APN and HIVST innovations were conducted and roll out is ongoing country wide with over 903 health facilities providing APN and 150 health facilities providing HIVST. The National HIV site and Tester Certification framework for all rapid HIV testers and HIV testing sites across the country has been rolled out. HIV Testers Training Curriculum to equip all testers with practical skills in HIV testing including rapid HIV testing training before certification has also been rolled out and trainings are ongoing countrywide ahead of the certification program. However, there's need to increase the number of facilities implementing the new strategies to achieve 100% coverage.

For quality service delivery, quarterly HTS support Supervisions as well as HTS coordination committee meetings were conducted. With support from CHAI, the HTS unit conducted 4 quarterly HTS technical support supervision visits with the aim of empowering health workers in the districts with the necessary knowledge and skills to offer HTS to the general public. The National HTS coordination Committee met quarterly (4 times during the year) and discussed critical issues in HTS including research, policy and implementation gaps. Appropriate recommendations were made to address implementation gaps.

HTS optimization strategy has been adopted to tailor HIV testing services towards those hard to reach and where there are major identification gaps including children, men and adolescents. However, to further enhance efficiency yield, there is need to continuously modify HIV testing modality to optimize testing and increase efficiency yield. There is also need to understand the linkages rates and the gaps and how to address them. In order to further optimize testing, MoH in collaboration with CDC and MAKSPH/METS is conducting Economic Evaluation of HTS and Linkage in the country with the view to determine and compare per-client cost of the different modalities of providing HTS and linkage. The findings of this study will help to identify cost effective modalities for adoption in national HTS programme.

Key Challenges / Weaknesses

- Inadequate health workforce to provide comprehensive HTS services
- Weak governance and coordination of HTS and linkage services
- Despite the increased support for HIV prevention in Karamoja region, little progress has been made due to the deep rooted culture that continue to impede HIV prevention efforts
- Non-adherence to the HTS standards especially among the private providers. Some testers still lack knowledge in current HTS procedures and guidelines
- Participation of men remains a challenge. There has been low uptake of HIV testing services among men
- Difficulty in linking of newly identified clients to ART clinics

3.1.2.1 Elimination of Mother to Child Transmission (eMTCT)

During the year under review, MoH with the support of partners continued to provide eMTCT services through a package of interventions under the four prongs offered simultaneously within the platform of MNCAH services to achieve the elimination of mother to child transmission of HIV and syphilis in-line with the national 90-90-90 targets for HIV epidemic control by 2030. Table 4 below shows performance on key PMTCT cascade indicators during the year under review.

Maternal Cascade

During the Financial Year (FY), there were 1,833,089 first Antenatal clinic visits (ANC 1) across the country of which 98% knew their HIV status (TRR & TRRK) showing an increase from 96% of mothers who attended ANC1 from the previous year (2017/18). 32,922 women were newly identified to have HIV at the first time of testing (TRR) during ANC, Labour & Delivery (L&D), or Postnatal (PNC) with 90% of them enrolled on Anti-retroviral Therapy (ART) compared to 84% registered in 2017/18 which is 6 percentage point increase for eMTCT ART provision for Pregnant Women during the year under review.

Of all the newly diagnosed HIV positive women (TRR & TRR+), maternal ART uptake was highest in ANC (82%), followed by PNC (67%), and lowest in L&D (46%). 74% of all women attending ANC 1 were tested for syphilis; only 30% male partner HIV screening realized and 7,601 positive clients identified. Of all the live deliveries to HIV positive (HIV+) women, less than 50% were linked to the Mother-Baby-Care Point (MBCP), which could partly explain the low Early Infant Diagnosis (EID) services coverage. However, great variation in eMTCT performance across districts was observed as outlined in Table 5 below. Majority of districts (95%) had less than 50% baseline CD4 coverage for the newly identified HIV+ pregnant women initiated on ART and 27% (35/128) of the districts achieved more than 50% male partner testing.

whitelisted,

Table 4: Performance on key PMTCT cascade indicators

Indicator	Achieved 2016/17	Achieved 2017/18	Achieved 2018/19	Assessment of Progress
Known HIV Status At ANC 1		1,671,443	1,794,993 (98%)	
Maternal ARV Uptake (TRR)			29,763 (90%)	
Syphilis Testing	926,962	898,368	1,359,671 (74%)	
Male Partner Testing	467,114	506,643	549,246 (30%)	
Infant ARV Uptake			56,429 (51%)	
1st DNA/PCR Within 2 Months	69,207	71,867	49,804 (68%)	
2nd DNA/PCR Uptake	44,557	44,856	60,906 (55%)	
Rapid Test at 18 Months	36,277	39,583	37,765 (34%)	
Infant Linkage To ART			1,992 (85%)	
Alive and On ART			19,726 (73%)	

Source: MoH, 2019

Progress from previous year Decline from previous year

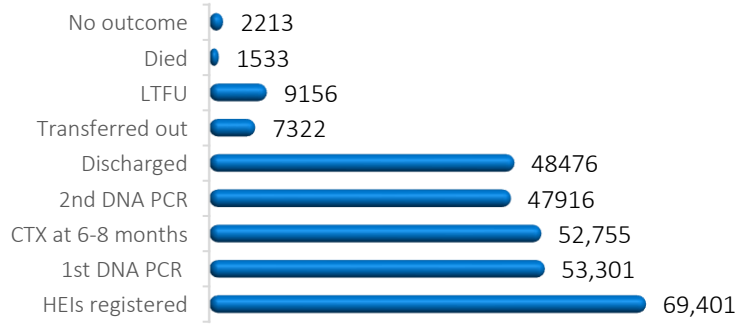
Table 5: eMTCT Performance across Districts

Less than 90% (10th percentile) pregnant and lactating women with known HIV status at 1st ANC	Less than 70% of maternal ARV uptake	More than 50% baseline CD4	Less than 50% syphilis screening of mothers at their first ANC clinic visit	Less than 10% of the pregnant women attending ANC accompanied by their partners	Linked less than 15% of the HIV+ women with live deliveries to the Mother-Baby-Care Point (MBCP)
9 districts	15 districts	6 districts	10 districts	14 districts	14 districts
Agago, Bukwo, Kween, Kyotera, Lira, Mayuge, Nakapiripirit, Oyam, and Rakai	Ngora, Napak, Dokolo, Nakapiripirit, Oyam, Manafwa, Masindi, Kole, Kaabong, Bulambuli, Pallisa, Lamwo, Kapchorwa, Mayuge and Nwoya	Buliisa, Kiboga, Ngora, Hoima, Bunyangabu, and Nabilatuk	Amudat, Kamuli, Amolatar, Namayingo, Buyende, Napak, Butebo, Packwach, Buvuma, and Koboko	Kween, Bukwo, Manafwa, Sironko, Bugweri, Namayingo, Bulambuli, Namisindwa, Kayunga, Luuka, Jinja, Kaliro, Mukono, and Kalungu	Amolatar, Kibaale, Kakumiro, Busia, Nwoya, Kaabong, Lira, Pallisa, Nebbi, Omoro, Mayuge, Apac, Sironko, and Kitgum

Source: MOH ACP Annual Report 2018/19

Infant Cascade

A total of 56, 429 HEIs were given ART for eMTCT, covering 51% of the expected exposed infants. First DNA-PCR uptake was at 68% showing an increase from 44% registered in the previous year (2017/18), implying that we have made progress from the baseline levels. 55% coverage later than 2 months implies that 45% not accessing a second DNA-PCR. Only 34% of the HEIs had a rapid test at 18 months or later. Of the total 2 334 infants that had a positive test, 85% were initiated on ART.



First DNA-PCR uptake within 2 months remains a challenge, with only 2 districts (Katakwi and Kabarole) attaining at least 70%, and majority (80%) having less than 50%. Only 33% (42/128) of the districts linked to ART between 80 and 100% of the positive infants diagnosed. See table 6 below.

Figure 2: Final HEI outcomes at 18 months or later

Table 6: District performance variations of the HIV exposed Infant Cascade

Highest Infant ARV Uptake	Lowest Infant ARV Uptake	More than 80% 1st DNA-PCR coverage	More than 100% 1st DNA-PCR coverage	Rapid testing at 18 months (ranging from 45 to 67%)	Lowest linkage of 20-50%
5 districts	6 districts	5 districts	4 districts	11 out of 128 districts	11 districts
Agago (75%), Yumbe (74%), Kitgum (71%) and Nakaseke (70%)	Bukwo (8%), Amudat (11%), Kween (13%), Kapchorwa (17%), Luuka and Kaliro (21%)	Packwach (88%), Buvuma (91%), Koboko (92%), Kabarole (93%) and Katakwi (97%)	Kapelebyong, Sheema, Rubanda, and Nabilatuk	Kyegegwa, Bushenyi, Masaka, Kampala, Napak, Kagadi, Koboko, Kabarole, Katakwi, and Nabilatuk	Ngora, Bulambuli, Bukwo, Abim, Omoro, Agago, Bukomansimbi, Kiboga, Kaabong, Arua, and Bukedea

During the Financial Year, 69,401 registered HEIs were expected to be discharged. Of these, 68% were reported to have had the first DNA-PCR and CTX within 6-8 weeks while 55%received the second DNA-PCR test. Majority (70%) were discharged either as HIV positive (4%) or negative with 86% linkage to ART for the Positive infants; 11% transferred out to other health facilities; 13% Lost to Follow-up; and 2% mortality, while 3% (2,213) had no test to determine their final outcome.

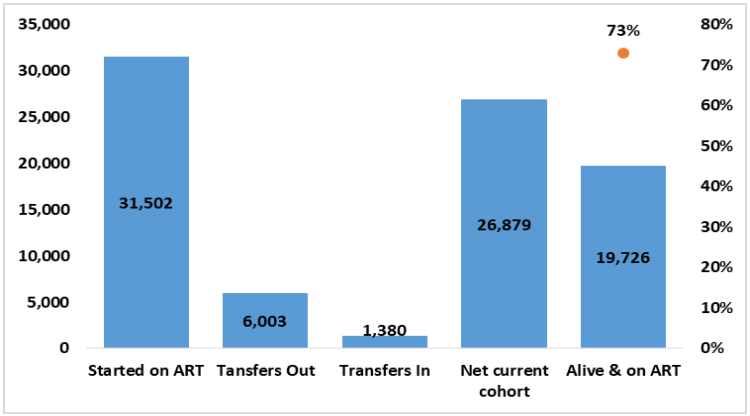
Table 7: Additional District performance variations of the HIV exposed Infant Cascade

1st DNA PCR at 6-8 Weeks		2nd DNA PCR	HEIs Discharge		Not Linked to ART	Lost to Follow-up (LTFU)	
More than 90%	Between 11-69%	Between 8-49%	80 – 100% discharged	Less than 50%	At least 50%	More than 30%	Between 1-4%
4 districts	15 districts	8 districts	15 districts	10 districts	9 districts	10 districts	11 districts
Kumi, Moyo, Adjumani, and Bunyangabu	Pader, Amudat, Nabilatuk, Butebo, Yumbe, Kotido, Amuru, Buyende, Buvuma, Lwengo, Kamuli, Kibaale, Kiryandongo, Kiruhura, and Kikuube	Pader, Kotido, Napak, Butebo, Luuka, Kween, Moroto, and Amuru	Yumbe, Kikuube, Packwach, Kayunga, Kole, Rukungiri, Namayingo, Gulu, Mubende, Serere, Nwoya, Kabale, Katakwi, Dokolo, and Kumi	Pader, Kotido, Napak, Luuka, Kaabong, Abim, Bundibugyo, Butebo, Kalangala, and Pallisa	Kaabong, Pallisa, Amuru, Kabale, Mukono, Abim, Rukiga, Kapchorwa, and Dokolo	Butebo, Luuka, Butambala, Bulambuli, Kalangala, Kween, Kaabong, Napak, Nabilatuk, and Amudat	Bunyangabu, Kabarole, Katakwi, Bukedea, Ngora, Kibaale, Kakumiro, Kiryandongo, Buliisa, Kikuube, and Pader

12th Months Maternal Retention in FY 2018/19

31,502 pregnant and lactating women had been initiated on ART 12 months prior, with a net current cohort of 26,879 expected to have completed 1 year on ART during the 2018/19 FY.

Of all the women initiated on ART (26,879) for eMTCT expected to make a dozen months, 73% were still alive and active on treatment during the Jul. 2018 to Jun 2019 period with the lowest proportion in Butaleja (28%), and the highest in Nabilatuk as well as Ibanda (100%)



As part of capacity strengthening, a number of eMTCT guidelines were formulated, piloted and updated. These include; an integrated PMTCT training curriculum for health workers piloted in West Nile, Uganda Prison Services, Greater Masaka region; HIV/Syphilis Duo testing kit usage; DTG-based ART regimen usage among women of reproductive age; Group Antenatal Care (G-ANC) model was piloted at 33 health facilities to inform better service delivery to adolescent girls and young women (AGYW). A number of health workers and IPs across the country were trained in various aspects of eMTCT service provision including, G-ANC, M&E, GBV and PMTCT integration. Support supervision was conducted in 19 districts identified to have low PMTCT retention at 12 Months after initiation onto ART. These included: Dokolo, Buhweju, Bundibugyo, Kaliro, Lamwo, Kamuli, Gomba, Bududa, Nakaseke, Kibaale, Moroto, Budaka, Kakumiro, Lwengo, Manafwa, Namisindwa, Ntungamo, Amuru, and Wakiso.

Efforts are being made to assess the country's progress towards eMTCT. MoH is spear-heading the PMTCT impact evaluation study at health facilities across the 10 regions of the country, findings of which will inform programmatic decision-making towards elimination of MTC HIV transmission

Key Challenges / Weaknesses

- Inadequate health workforce for eMTCT service provision including the Unit
- Delayed completion of the HMIS tools review, printing, and dissemination thus affecting data collection and reporting
- Absence of a clear eMTCT communication and advocacy structure to address eMTCT issues including low EID coverage and retention
- Absence of a follow on Elimination Plan, the previous plan expired in 2015.

3.1.2.2 Safe Male Circumcision (SMC)

During the financial year 2018/19 a total of (703, 997) men were circumcised showing less men were circumcised compared to (747,244) circumcised in 2017/18. The figure 4 below shows the trends in SMC performance over the last three years. Of these 659,930 representing 94% circumcised men were followed up within 48 hours. 464661 (66%) were followed up within 7 days. 61093 clients were followed up after seven days.

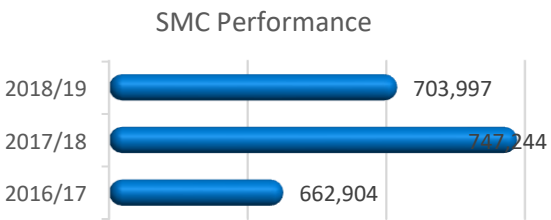


Figure 4: SMC performance in the last 3 years

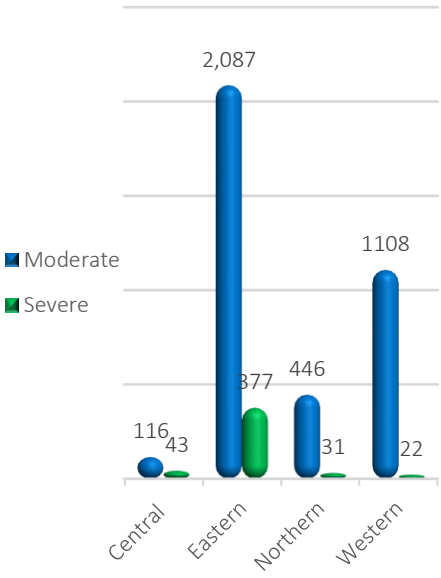
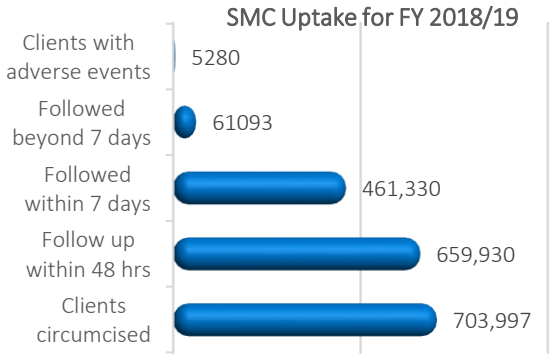


Figure 3: Regional Distribution of AEs in Uganda



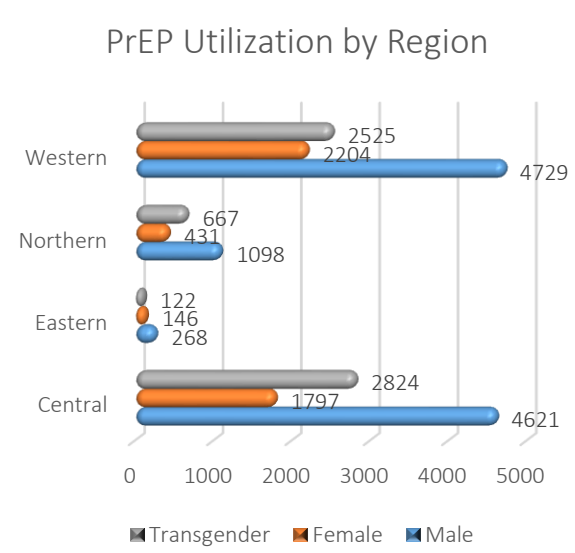
During the year, total of 5280 clients experienced adverse events. Of these 91% (4807) were moderate adverse events while 9% (473) were severe adverse events. The eastern region accounted for 80% of all the severe adverse events reported in figure 3 below.

Key Challenges / Weaknesses

- SMC is mainly donor driven and not integrated into other programs
- Inadequate capacity of Health workers to conduct SMC. Not all facilities in the country have teams trained to offer SMC
- Quality assurance and monitoring is still a challenge. Post-operative review is still limited

3.1.2.3 Pre-Exposure Prophylaxis (PrEP)

Uganda is one of the countries that provided global evidence for the efficacy of oral PrEP and as result adopted and introduced PrEP as one the biomedical prevention interventions in the Combination HIV Prevention. The country is currently rolling out PrEP in a phased approach, and has adopted a road map to guide the implementation process. Currently, PrEP covers 90 facilities from 35 districts in 12 regions of the country. In the reporting period, 10,779 people received PrEP. Out of these, 6,172 were male, 4,607 female and 37 were transgender (MOH/ACP 2019). Disaggregation by key population revealed 1,017 men who have sex with men (MSM), 8,287 sex workers, 37 transgender and 161 people who inject drugs received PrEP in FY 2018/19. Analysis at regional level revealed that central and western regions were the highest users of PrEP, with women being the main users.



The PrEP dashboard was introduced to capture information on PrEP and the indicators have been incorporated into the HMIS tools. The roll out of PrEP Services has gone up from 16 to current 90 sites, with over 11,500 clients ever enrolled on PrEP.

Key Challenges / Weaknesses

- Few health workers have been trained to offer PrEP services despite the increased demand for the service
- Retention of clients on PrEP at 3 and 6 months remains a challenge
- Packaging of PrEP in containers similar to ART creates stigma among the users

3.2 Progress Made in HIV Care and Treatment

The strategic Goal of HIV Care and Treatment in the National Strategic Plan is to decrease HIV associated morbidity and mortality by 70% through achieving and maintaining 90% viral suppression by 2020. This is undertaken in 4 strategic objectives under which priority strategic actions for implementation in the review period of FY 2018/19.

The UNAIDS Uganda 2018 HIV estimates report shows that 23,000 adults and child deaths due to AIDS occurred in 2018 (23,127 AIDS-related deaths by the MOH FY 2018/19 spectrum estimates) about 18,000 (78%) were adults aged 15 years and above and 5,500 (23.7%) were children aged 0-14 years. More AIDS-related deaths occurred among men compared to women. Up to 7000 (39%) AIDS-related deaths occurred among women and 61% occurred among men.

- *Overall, there has been a 63.4% reduction in HIV and AIDS – related mortality from 63,000 in 2013 (NSP baseline) to approximately 23,000 in 2018 (UNAIDS Uganda 2018 HIV estimates).*

There has been some progress made in all the four objectives under Care and Treatment. The table below summarizes at a glance the achievement of HIV care and treatment outcome indicators in FY 2018/19.

Table 8: Progress of Care and Treatment Outcomes at a Glance

Indicators		Baseline	Target 2019/20	Achieved 2016/17	Achieved 2017/18	Achieved 2018/19	Assessment of Progress
Outcome 1: Increased access in pre-ART care to those eligible to 90% by 2020							
Proportion of adults and children enrolled in HIV care services		70%	80%	67%	87% (1,140,420/ 1,324,685)	86.3% 1,198,43 5/1,3881 27)	Despite the decline form last year, the target of 80% has been surpassed
Outcome 2: 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%	72.5% (128153/17 6/645)	76%	Slow progress, the NSP target may not be met by 2020.
Proportion of Key and Priority populations with HIV maintained on ART for 12 months by category		N/A	95%	N/A	No data	No data	No data to assess progress over the past 3 years
Outcome 3: Improved quality of chronic HIV care and treatment							
% of estimated HIV+ incident TB cases receiving both TB and HIV treatment		60% (2013)	70%	36.2%	57%	71% (19,935/2 8,134)	Good progress form the previous year. NSP target has been achieved
% of people with diagnosed HIV infection on Isoniazid Preventive therapy		N/A	80%	97%	8% for new Cases (17,493/ 217,447)	56.1%	Slow progress the NSP target of 80% is not likely to be met
Outcome 4: Strengthened integration of HIV care and treatment within health care programs							
Unmet need for FP among PLHIV	General Population	34%	24%	41.2%		No new data	No data to assess progress over the year
	WLHIV				32% (FP study 2017)		
Proportion of HIV positive acutely malnourished clients who received nutrition therapy		N/A	50%	N/A	48% (10,064/21 ,133)	16.4% (14,740/7 00,265)	This indicator has retrogressed over the past year. It is very unlikely that the target will be met

3.2.1 Strategic Objective 1: To Increase access to Pre-antiretroviral Therapy Care for those eligible

This objective has been overtaken by the roll out of the national consolidated guidelines of 2018. All PLHIV's on pre-art have been initiated on ART. In light of the new approaches to Care and Treatment this objective should be dropped from the NPAP.

Increasing Linkage to Care for all Persons Living with HIV

There has been progressive improvement in linkage to care of clients tested positive for HIV. During FY 18/19 244,933 PLHIVs, tested HIV positive for the first time. Of these, 2,329 (1%) infants under 2 years and 10,364 (22%) were under 15 years.

Figure 5: Trends in the Linkage Rates for the Last 3 years:

Figure 5 shows that the linkage services for all newly tested HIV+ people have steadily improved from 78% in FY 2016/17, to 87% in FY 2017/18 and to 90% (220,494/244,933) in FY 2018/19.

Table 9: Summary of the newly identified PLHIVs, Enrolment and ART initiation for FY 2018/19

Category	Age group			Sex		Total
	<15yrs	15+yrs		Male	Female	
New HIV+	10,364	234,569		101,200	143,733	244,933
New Enrolment	8,921	211,573		84,734	135,760	220,494
New Initiations	8,752	211,239		84,491	135,500	219,991

14% (1,443/10,364) of children who tested HIV were not enrolled into care, while 15.5% (1,612/10,364) of the children who tested HIV were not initiated on ART.

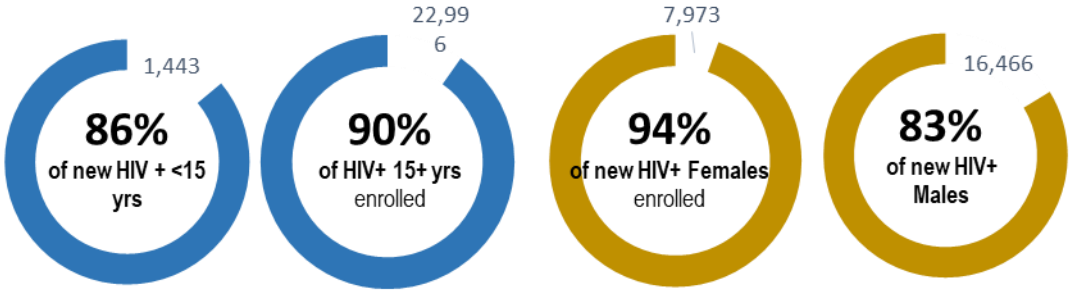


Figure 6: Cascades for enrolment into HIV care and initiation on ART

The MoH partnered with PEPFAR to implement a strategy known as "SURGE" that emphasized strengthening of partnerships and the use of program data analyses to improve efficiency and impact with a strategic focus on specific subpopulations e.g., young women and men, and OVC. The SURGE strategy enabled identification of more people living with HIV that remain undiagnosed and link them to care.

Key Achievements	Key Challenges / Weaknesses
• 220,494 newly tested HIV+ people were enrolled in care • 3% annual linkage improvement from 87% to 90%	• From table 9 above, nearly 25,000 new HIV cases in FY 2018/19 were neither enrolled in care nor initiated on ART. This is almost equivalent to half of the annual new (53,000) infections). • 17% of new HIV+ in FY 2018/19 not enrolled were male • Males and children below 15 have weakest linkage

3.2.1.1 *Increasing HIV care entry points within health facilities, community, schools social / child protection and workplaces for HIV exposed infants, children, adolescents and men*

A total of 1,830 health facilities provided care and treatment services to Persons Living with HIV (PLHIV) during FY 18/19. The HTS outreaches including EID services were incorporated in integrated outreach activities especially the EPI. Guidelines were developed to expand adolescent friendly and responsive services. Through the regional implementing partners, youth and adolescent HIV education and testing services were scaled up to community centres and to the workplaces.

The roll out of Differentiated service delivery increased the entry points both within the health facilities and in the communities. HTS delivery was enhanced and now all HTS facilities are implementing facility and, community testing, PITC, APN, HST and targeted HIV testing strategies for the high-risk/high prevalence groups and timely linkage to care.

Overall, 68.4% (1,253/1,830) of ART sites were trained in Differentiated HTS and linkage with a variation in the roll out of DSD within the region. Annex 1 shows DSD coverage as of end of June 2019. Within the context of DSD, families who desire to receive care and treatment services together within the health facilities or in the communities are supported to do so in the spirit of family centered care.

3.2.1.2 *Strengthening Community Level Follow-up and Treatment Support Mechanisms for Individuals in Care (adults and children)*

The HIV care and treatment program prioritized community Engagement and communication through operationalizing the Community strategy and framework for Patient Literacy, education and communication. This was intended to support and strengthen linkages, and bi directional referrals and improve adherence and retention into HIV care. Furthermore, the scale up of Differentiated Services Delivery Models (DSDM) models further strengthened follow up, adherence and retention within the program.

The program continued to build capacity of health care providers to deliver ART on various DSDM platforms through training and support supervision. Dissemination of strategies and implementation support on the revised HTS guidelines to improve facility and community linkages with inter- and intra-facility referral protocols was conducted. Within the DSDM platforms, key population friendly HIV care and treatment services were expanded and are now reaching more key populations. Figure 7 below summarizes the DSD uptake within facilities and communities as of March 2019.The CDDPs and CCLAD models enhanced community follow up and retention to care.

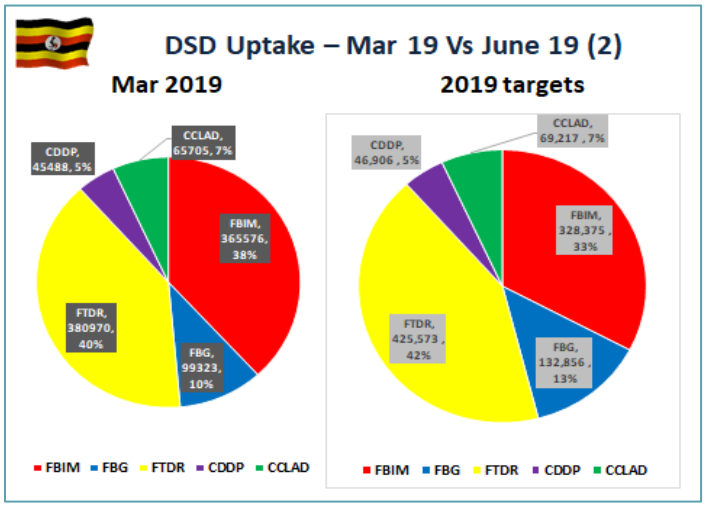


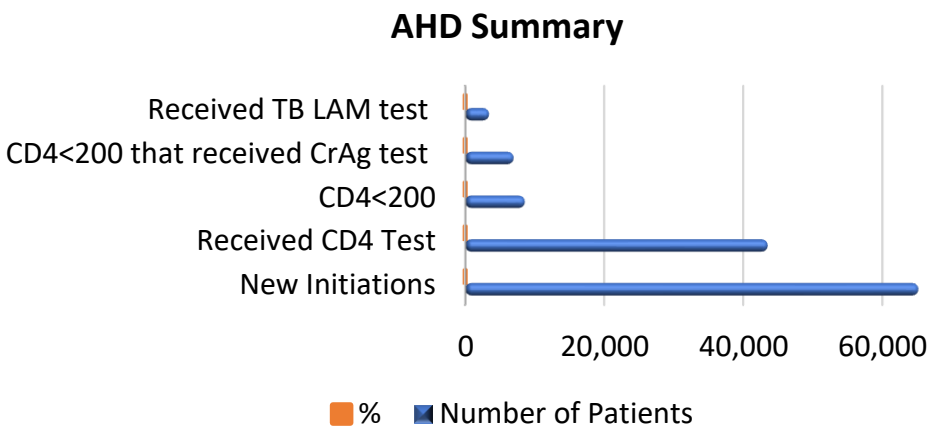
Figure 7: Client uptake of DSD services by March 2019

3.2.1.3 Scaling-up Implementation of Prevention and Treatment of AIDS-related Life Threatening Opportunistic Infections including Cryptococci Meningitis

The focus on the 2018 national consolidated guidelines for HIV prevention, care and treatment was on the recognition and management of Advanced HIV disease among people newly enrolled into HIV care as well as those on ART but with advanced HIV disease. The Advanced Disease working group was established, as

well as the Advanced Disease Management (ADM) care package developed in FY 18/19.

The package addresses key areas for the identification, screening and management of the life threating OIs (tuberculosis, Cryptococcal meningitis and severe bacterial infections) that contribute to HIV related morbidity and mortality. The package includes the scale up of CD4 testing (for all patients initiating ART, re-engaging in care after treatment failure and patients suspected to be failing on ART), scale up of serum CRAG screening for Cryptococcal disease and Urine LAM testing to improve identification for Tuberculosis. LAM in FY 18/19 was available in ~200 health centres, including all RRHs, district hospitals, and some HC IVs Up to 62% of the 604 sites have were trained on the advanced Disease package in FY 18/19 .



During the reporting period, 67% of the newly enrolled clients accessed CD4 testing, of which 20% had advanced HIV disease. 81% of those with advanced disease received serum CRAG test and 40% received Urine LAM test for TB, and improvements from 25% in FY 17/18. The figure below summarizes the services that were provided

Treatment of Cryptococcal meningitis with Amphotericin B (AmB) formulations in combination with fluconazole (Fluc) or 5-fluoro-cytosine (5FC) were key part of the induction, consolidation and maintenance therapy. However, except for Fluconazole, other antifungal drugs used in the treatment of CCM including AmB, L-AmB, and 5FC were mostly inaccessible in Uganda. The scale up of TB preventive therapy with use of isoniazid was pivotal and resulted in a National campaign in October to improve uptake and completion of IPT among People living with HIV.

The MOH ACP started the surge of quality of HIV care which aimed at improving poorly performing indicators of which IPT enrolment was one of them. IPT was included in the weekly monitoring dashboard so as to enable close monitoring of the weekly performance. Phased scaling up of IPT was done starting with 52 priority sites after harnessing the lessons learnt in the first phase. East Central region, Mubende region and Uganda Police Service were leading with achievements of 81% and 75% and 76% of their annual IPT target.

In order to improve IPT completion rates, the MOH developed guidance in the form of a circular on kitting /committing six months courses of INH for all those enrolled and to convert pediatric INH into adult courses since facilities had so much of the INH 100mg that was at risk of expiry.

As a result, a total number of 306,000 people living with HIV were initiated on IPT out of the anticipated target of 500,000.These achievements resulted from the engagement and support of district teams and Implementing partners as well as improved supply and distribution of commodities for use. Data from DHIS 2 shows that of the 244,933 new PLHIV identified in June 2018, 50,435 were enrolled on IPT (DHIS 2 data).. However in October 2018, the country started an initiative code named 100 days, to improve IPT uptake where both old and new PLHIVs were enrolled on IPT. Between 1st Oct 2018 and 11th Aug 2019, a cumulative number of 342,526 PLHIV were initiated on IPT, of which 170,769 were initiated in the 100-day campaign period. This translates to a 112% achievement on the weekly target. Overall the 100-day campaign performance stands at 56.1% in FY 18/19. The 100 day campaign ends in September 2019.

In June 2019, the MOH started planning for phase 3 of the IPT 100 days accelerated IPT scale up campaign in which prioritized facilities providing INH 300 mg were increased from 145 to 382.

Clinical Systems Mentorship tool continued to be applied during mentorship of HIV/AIDS services by the national and regional trainers during this reporting period to build capacity for management of OIs including Cryptococci meningitis.

Key Achievements	Key Challenges / Weaknesses
• 77.4% (1,418/1,830) of the ART sites have been trained in DSD. • DSD is showing results; progressively facility based individual management is decreasing and patients served in the community are increasing; this is work in progress.	• 195 ART sites were not providing pediatric care in FY 2018/19 • 32.6% of the ART sites were not trained in Differentiated Service Delivery.

3.2.2 Strategic Objective 2: Increasing Access to ART to > 95% and Sustain Provision of Chronic-Term Care for Patients Initiated On Art

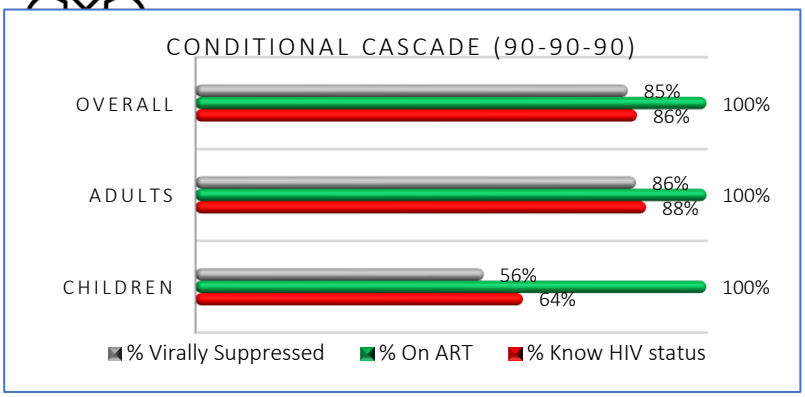


Figure 8: Summary of the conditional and population cascade for Children and Adults for FY 2018/19

By June 2019, a total of 1,198,435 (1,133,076 adults and 65,359 children) PLHIV on ART. The figure below summarize the Conditional 90-90-90 cascades.

The conditional cascade is based on the program data and reflects the actual performance of the national ART program in terms of treatment, retention and viral suppression.

86% of the 1.4 million Ugandans estimated to be living with HIV know their HIV status. This shows that the majority of people who know their HIV status are able to access treatment in Uganda and the linkages between testing and treatment are strong. 85% of those on treatment are virally suppressed. There is slow progress in achieving the targets in children compared to adults. The figure 9 and table 12 below shows trends of ART coverage between 2003 and 2018 and ART coverage by sex respective.

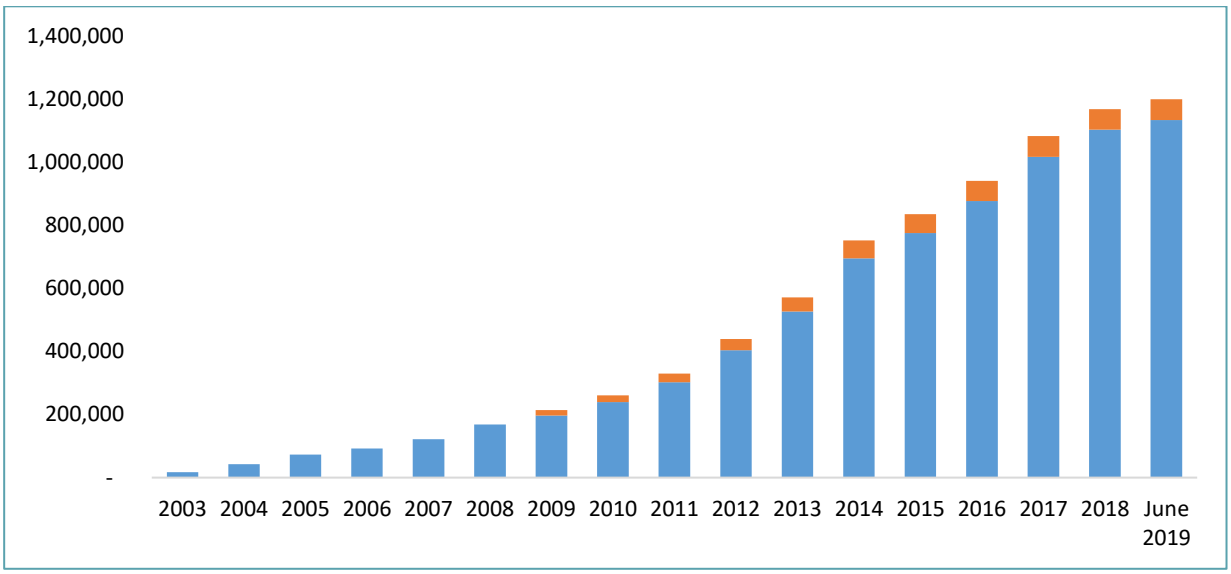


Figure 9: Annual trends of PLHIV on ART

Table 10: Coverage of ART by Sex and Age group

Category	Estimated PLHIVs	On ART June 2019	ART Coverage
Overall	1,388,127	1,198,435	86.3%
Male	562,790	424,341	75.4%
Female	825,337	774,094	93.8%
<15yrs	102,106	65,359	64.0%
15+yrs	1,286,021	1,133,076	88.1%
Male 15+yrs	511,109	393,582	77.0%
Female 15+yrs	774,912	739,494	95.4%

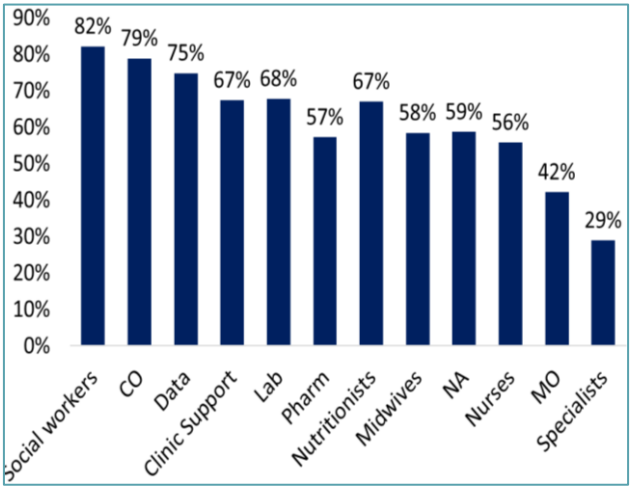
Variations in ART coverage are observed amongst the children (64.0%) compared to adults (88.1%). The low ART coverage amongst children is attributed to the increase in estimates of CLHIV numbers from 95,643 (2017) to 102,106 (2018/19). Compared to the coverage amongst adults at 88.1%, the coverage amongst men above 15 years is still low (77%) compared to their female counterparts (95.4%). Annex 7 shows the number of PLHIV on ART by regimen.

3.2.2.1 Rolling out "Test and Treat" for all PLHIV infected persons regardless of CD4 count and clinical stage of disease

The country rolled out the Test and Treat policy for all in 2016. The guidelines were revised in 2018 with a focus on ART optimization to enhance sustained viral suppression, tolerability and sustainability. It also included a shift from NNRTIs (Efavirenz and Nevirapine) to Dolutegravir in addition to NRTI as a backbone for persons above 25kg with emphasis on adolescents and young people. The revised guidelines enhanced Lopinavir / ritonavir use for children and strengthening drug resistance testing to optimize and provide third line ART.

Four (4) National ToTs were conducted in FY 18/19 and a pool of 160 national officers were trained as trainers to support the roll out of the revised guidelines. The trained IP technical staff conducted the regional ToTs while the trained MoH staff supervised these regional trainings to ensure quality and standards were observed. Health facility trainings supported by all regional IPs were commenced in 125 districts (98%) of all districts. 60% of those districts had completed these trainings by June 2019.

As a result, 76% of health care workers were trained of which 63% of them were from HC IV's. The categories of HCW trained included Social workers (82%), Clinical Officers (79%) and Data personnel (75%). The figure below summarizes the categories of HCW trained.



DTG Coverage in FY 18/19

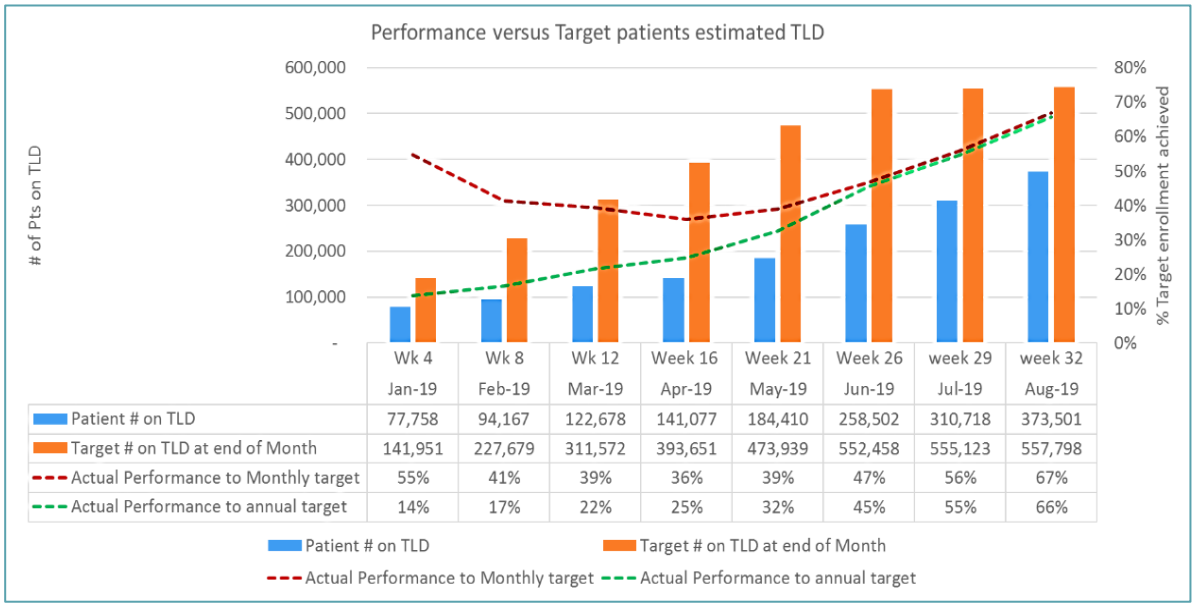
306,000 people living with HIV were transitioned or newly initiated on DTG as their first line ART in FY 18/19. This roll out process will continue in the next period to include even other population groups like the women. There was however, delay in receiving DTG in the country, and the WHO guideline cautioning the use of DTG among pregnant women for fear of birth defects, hindered the roll out of DTG until April 2019. The DTG campaign is however progressing on well and it anticipated to be completed by December 2019.

Furthermore, the program instituted a robust Pharmacovigilance system for both active and spontaneous surveillance to monitor, manage and report any adverse events that may arise as a result of the introduction of the new drug. (Source: MOH Presentation in 12th JAR meeting 2019).

3.2.2.2 Expanding and Consolidating Paediatric and Adolescent ART in all Accredited ART Sites

A total of 1,635 (89%) ART sites provided HIV care and treatment services to children under 15 years by June 2019, up from 69% by June 2018. The program continued with recruitment of linkage facilitators at the ART sites in addition to the test and treat strategy with same-day ART initiation. This helped in integrating and supporting referral between PMTCT and HIV care and treatment services.

The consolidated ART guidelines for HIV prevention care and treatment for paediatric and adolescent HIV were revised for optimization of ART so as to achieve sustained viral load suppression, tolerability of ART drugs and cost effectiveness among this population



	Wk 4 Jan-19	Wk 8 Feb-19	Wk 12 Mar-19	Week 16 Apr-19	Week 21 May-19	Week 26 Jun-19	week 29 Jul-19	week 32 Aug-19
Patient # on TLD	77,758	94,167	122,678	141,077	184,410	258,502	310,718	373,501
Target # on TLD at end of Month	141,951	227,679	311,572	393,651	473,939	552,458	555,123	557,798
Actual Performance to Monthly target	55%	41%	39%	36%	39%	47%	56%	67%
Actual Performance to annual target	14%	17%	22%	25%	32%	45%	55%	66%

- In FY 18/19, the Young People and Adolescent support model (YAPS) aimed at engaging adolescents and young people living with HIV in service delivery to their peers was piloted. This model is intended to improve the weakly performing outcomes of HIV identification, viral load suppression, psychosocial wellbeing, disclosure among adolescents and young people. The YAPS materials including the implementation strategy, Level 1 YAPS training manual, Mentors & Supervisors guide and YAPS Job-aid were developed. The M&E Plan including Tools, data flow and MIS were developed. 59 Master TOTs were trained and 9 District mentors, 52 facility supervisors and 208 YAPS trained.
- 16 YPLHIV pilot Activities are on-going in 9 districts of Jinja, Mubende, Mityana, Otuke, Lira, Soroti, Kumi, Kabarole and Kyenjojo.
- 6 IPs including TASO, RHITES-EC, M2M, RHITES-NL, Mildmay and Baylor Uganda were involved in pilot in 48 out of the 52 facilities that were selected. All trained YAPS were inducted and attached to respective facilities. District Entry meetings targeting key stakeholders were conducted and line ministries especially MOGLSD have revised their guidelines to make them HIV sensitive
- Clear guidance on DSD approaches for children such as; multi-month prescriptions, children joining the mothers in the different DSD groups the mothers attend, etc. were developed.
- Engagement of Young people as part of the WGs engaged in adolescent HIV Care and introduction of disaggregated data in DHIS2 for most indicators of adolescents living with HIV started and is helping to inform the programming for adolescents living HIV. The program reports a major gap in human resource and geographical access. Most of the ART sites providing HIV treatment are having at least one health worker trained to counsel adolescents on ART.

3.2.2.3 *Strengthening Early Initiation into ART and Adherence Support Services*

The six-month retention on ART , within the past one year, declined from 73.8% to 61%, while the proportion of PLHIVs on ART dropping out of care in the same period has increased from 17.8% to 30.6% by the end of FY 2018/19 as shown in the figure below.

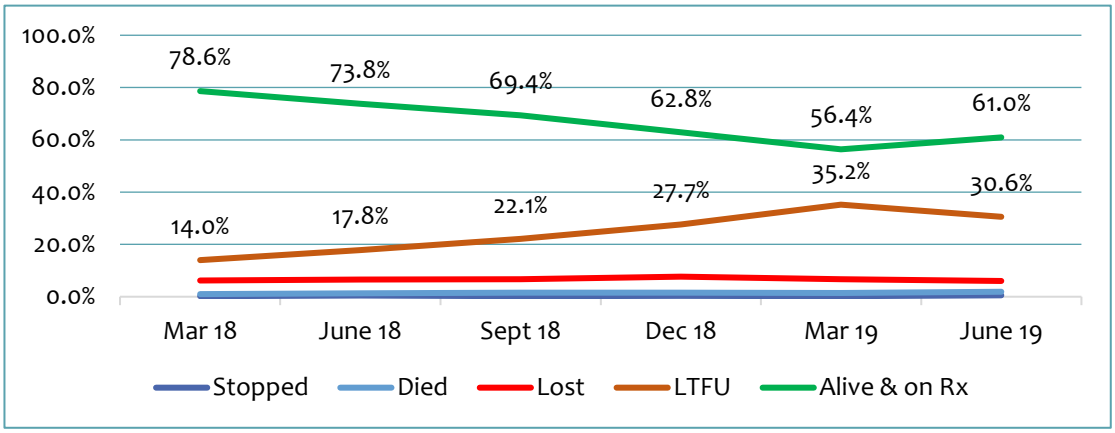


Figure 10: Trends of outcomes of PLHIVs 6 months after ART initiation

Efforts from the program to improve the retention started to yield results as evidenced with a 4.6% increase from the March 2019 to June 2019 retention. These should be sustained to ensure optimal retention of PLHIVs on ART (>90%). The twelve month retention on ART on the other hand, increased from 73.8% in FY 2017/18 to 76% in FY 2018/19.

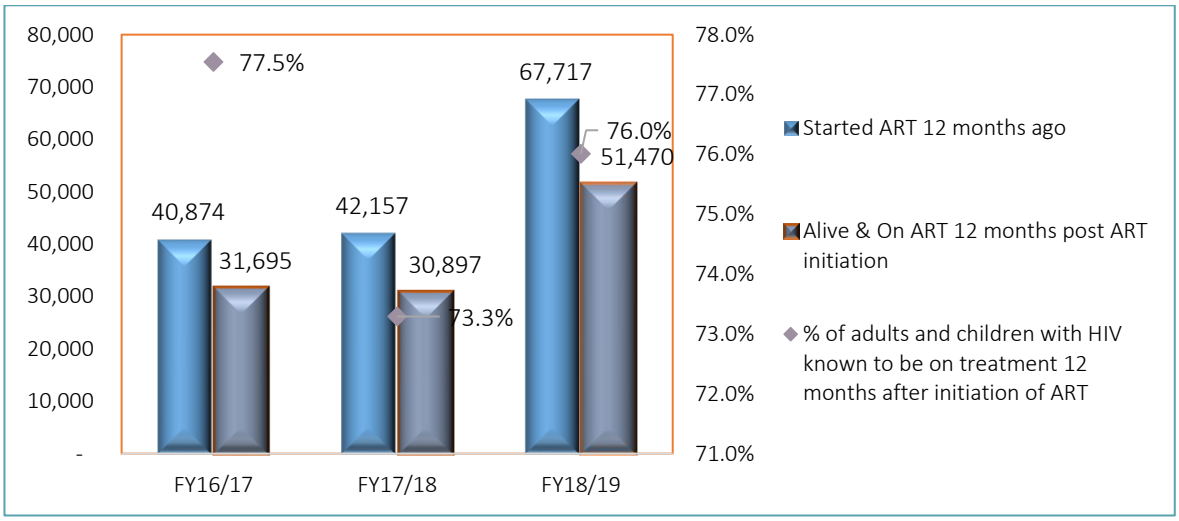


Figure 11: Trends of outcomes of PLHIVs Active on treatment 12 month after initiation for the past three financial years

Source: DHIS2

The MOH FY 2018/19 shows that some PLHIVs on ART are still continuing to drop out of care. The proportion has increased from 17.8% in June 2018 to 30.6% in June 2019.

3.2.2.4 *Streamlining "Nurse Driven' Care plus 3-6 monthly drug refills for patients who are stable on ART*

Nurse driven care protocol developed in 2017 were rolled out to ensure task sharing, DSDM and other strategies. Nurses were included in the national and regional dissemination fora for the DSD care package to equip them with the knowledge and skills required to implement the package. A training on integrated management of Adulthood illness (IMAI) to support implementation of task shifting was rolled out during the period under review. The Highest

number of HCW trained were Nurses (23.9%), Clinic Support staff (19.7%) & Midwives (13.5%). Figure 12 summarizes the cadres trained in IMAI.

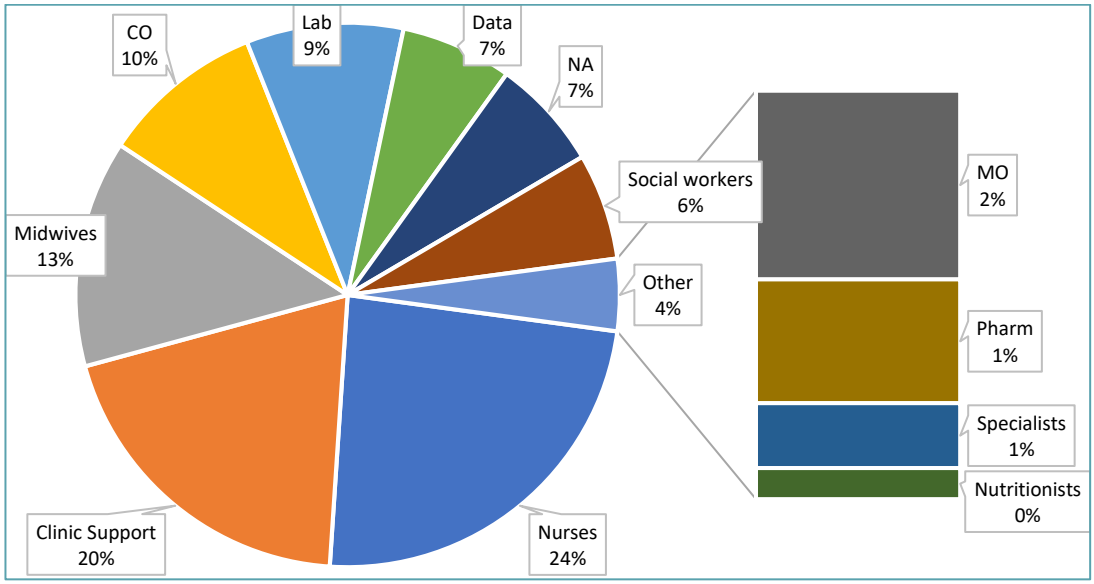


Figure 12: Summary of cadres trained in IMAI

Key Achievements	Key Challenges / Weaknesses

• 86.3 % HIV-infected adults and children are on ART
• The National program is currently undertaking the following to improve the retention and Psychosocial support which have started to yield results as evidenced with a 4.6% increase from the March 2019 to June 2019 retention.
  ○ CQI Collaborative with IP's and district teams
  ○ Adolescent and peers support models
  ○ Scaling up DSD approaches based on clients' needs e.g. appointment scheduling
  ○ Focusing on Early retention at 3 and 6 months
• Altogether 1,253/1,832 (68.4%) ART sites from 129 district supported by 14 regional IP's have been trained and are implementing DSD models of care as of June 2019.
	• 189,700 HIV-infected adults and children are not on ART and are a backlog for 2019/20
	• 503 (0.2%) PLHIV enrolled in care not initiated on ART
	• A gap persists in the initiation of ART (0.2%) especially among children and males.
	• Up to 34.6% of children living with HIV are not on ART

3.2.3 Strategic Objective 3: Improve Quality of Chronic HIV Care and Treatment

The interventions under this objective aimed at improving and sustaining the quality of services across the continuum of care for all PLHIV in care. This includes the monitoring of viral load suppression and drug resistance. Innovations to ensure equitable access to HIV care and treatment by Priority populations (PP) and KPs is of interest in the remaining phase of the NSP.

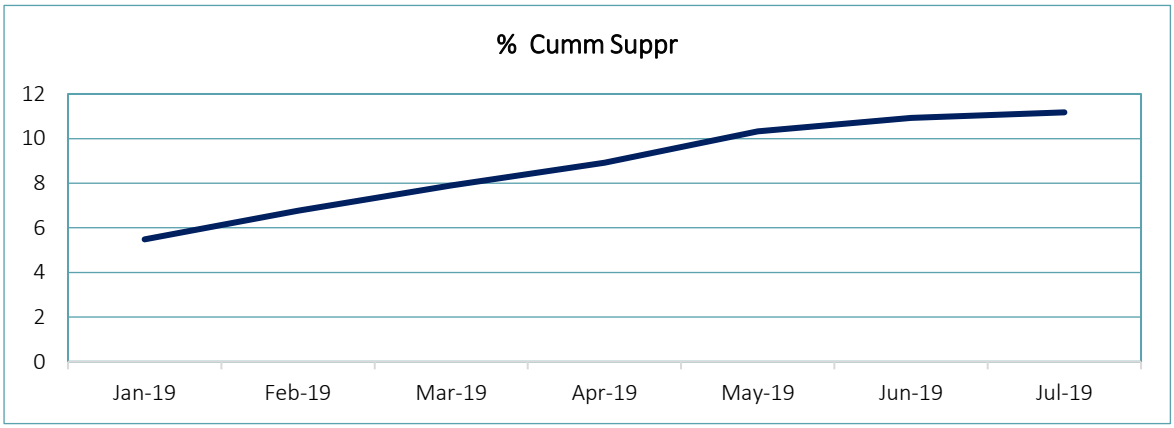
3.2.3.1 Establishing and Sustaining Quality Assurance and Quality Improvement activities at all HIV Care and Treatment Sites

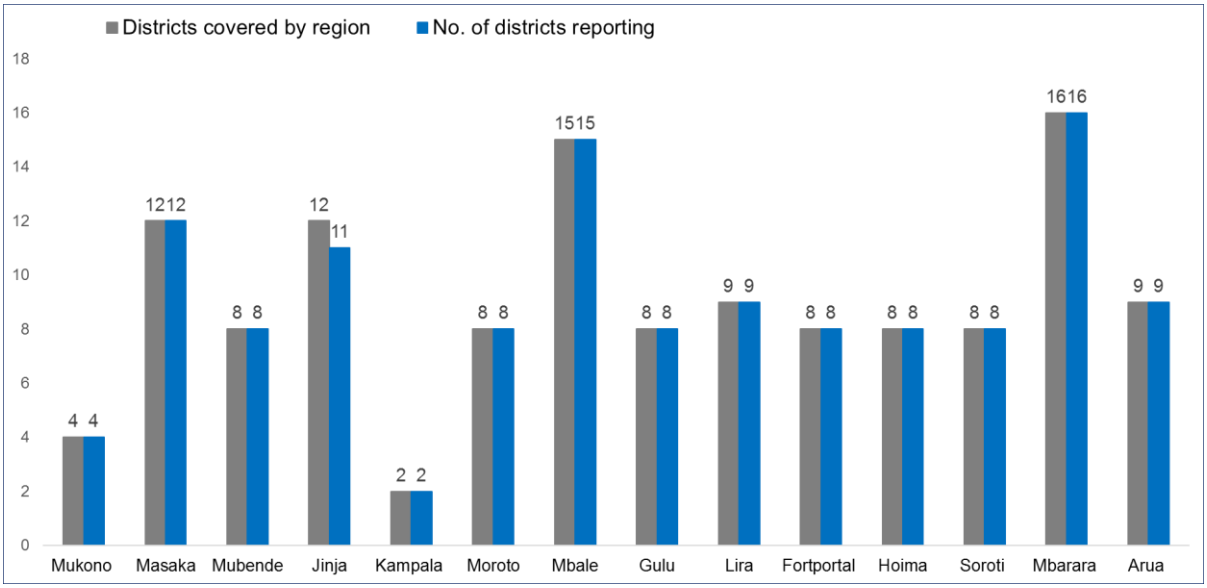
. A National CQI collaborative focusing on retention and viral load was rolled out in FY 18/19. This was an initiative to ensure district led, partner supported and MOH supervised implementation of quality improvement approaches at health facility level. It was focused on improving outcomes of viral load suppression across sub populations, retention into care for pregnant woman and their babies as well as improving the uptake for IPT. The program completed HCW training on these initiatives and is embarking on supporting their implementation in the last year of the NSP.

. This initiative has since demonstrated district engagement with over 125 districts implementing CQI projects and over 1500 health facilities having CQI projects addressing retention, viral load suppression and IPT coverage being implemented. Monitoring of performance has been enabled through a National QI dashboard that provides status updates on performance of selected indicators across the program. The updated QI database captures client level data and the data abstraction tool is electronic. It is anticipated that improvements in outcomes of viral suppression

and retention will be observed in the next reporting period.

The figure below shows Regional coverage of QI initiative by district as of May 2019 (source MOH Presentation in the 12th JAR meeting 2019)





A total of 1444 ART sites out of 1948 are supporting CQI initiatives leaving a gap of 504 sites. The two accredited testing labs at UVRI and JCRC provided resistance testing services over the reporting period. IDI has applied for accreditation of its lab in a bid to expand the testing laboratories.

3.2.3.2 Defining and Implementing Integrated Guidelines on Community-based Care, Basic Care Package, Linkages with Social Support Structures, Lost to Follow up (LTFU) Management and Private Sector Care

The development and disseminations of integrated guidelines on community-based care, basic care package, linkages with social support structures, LTFU management and private sector care was completed.

The framework for community engagement and communication with the objectives of creating more awareness for the new guidelines among target audience and to provide standards simplified information for PLHIV peer trainers to give correct and uniform information to the members of the PLHIV constituency was put in place. Its content encompasses updated communication messages across all areas of the guidelines, ART Treatment Literacy Training Manual targeting PLHIV Peers and expert clients at ART health facilities and PLHIV, and IEC materials targeting various target audiences

Implementation of this framework by the various stakeholders to ensure delivery of quality services shall be strengthened the final year of the NSP. The implementation plan shall be coordination by the MOH, UAC and Networks of people living with HIV. The District (DCDO and DHO) will be the main

implementation unit with community players in coordination and implementation including the networks of people living with HIV and CSOs, Community Development Office and the DHT community coordination mechanisms (DHAC, SAC etc.). The PLHIV peers and expert clients at ART accredited Health Facilities as well as the PLHIV Peers and Expert clients shall all be engaged in the roll out. The program should finalize with the development of messages not yet included in the communication package, disseminate the Communication Package to stakeholders and conduct regional trainings for peers and expert clients to enable the Districts to start implementing. Community engagement and communication and literacy needs to be strengthening in the next NSP. There is need to reach out to community with simplified uniform information concerning the guidelines.

3.2.3.3 Strengthen Monitoring of Chronic HIV Care and Treatment including Scale-up of Viral Load Monitoring and Surveillance for Drug Resistance

Strengthening and decentralization of program monitoring for ART drug resistance and management of patients requiring third line ART to improve efficiency was completed in FY 18/19. Through GOU and partner support there was procurement of drug resistance tests, third line ART drugs and the development of a clinical team to make switch decisions for people in need of third line ART. Scale up of drug resistance testing across all ART facilities was enhanced and this supported the identification of clients that are failing on their second line ART. This approach has enabled the further management of patients that may have possible advanced disease and supported the program in addressing AIDS related morbidity and mortality that are key in achieving epidemic control. Uganda is one of the recipients of the New Horizons pediatric third-line ART drug donation program.

The VL coverage has increased in the last four years from 51.5% in FY 2015/16 to 88.2% in FY 2017/18 and to 96.7% in FY 18/19. This improvement is attributed the continued scale of VL with improved transport and coordination between the health facilities and CPHL through the Hubs ,improved capacity of CPHL to do both DBS and plasma with improved turnaround time from 3months to 2 weeks. The improved capacity of health workers in VL monitoring has also helped the health workers appreciate the importance of monitoring Patient VL in a timely manner. The continued usage of the VL dashboard has greatly helped in the turnaround time for VL results; this has further motivated the health facilities to send more samples to CPHL since it provides the facilities and the districts information on samples received as well as suppression rates by districts in real time. This has greatly improved the VL coverage as well as the suppression rates.

Viral suppression for PLHIV has also steadily increased to 89.8% by the end of FY 2018/19 as shown in the figure below.

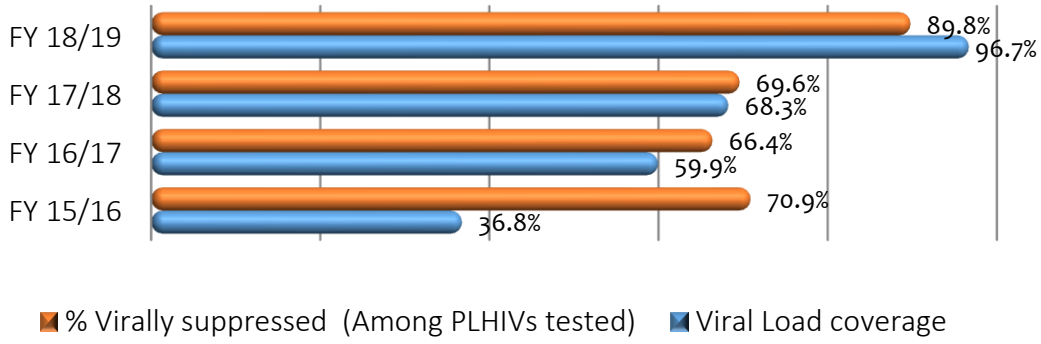


Figure 13: Trends of Viral Load Coverage and Suppression (FY 2015/16 – FY 2018/19)

There were, however, distinct variations in viral load coverage and suppression rates between children under 15 years and adults. For FY18/19, only 77.9% of the children received at least one viral load test, compared to 97.8% of the adults. A lower proportion of children that received a viral load test were suppressed (72.9%) compared to the adults (90.6%) as summarized in the figure below.

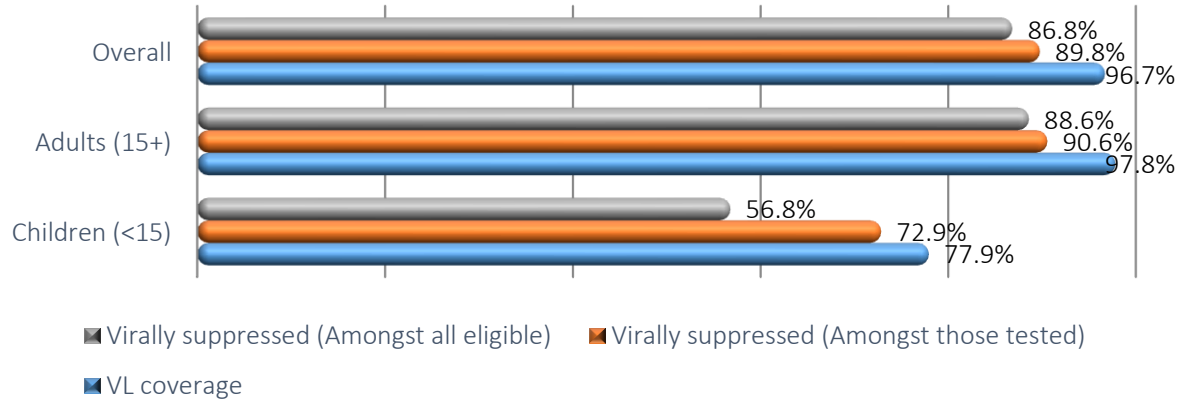


Figure 14: Viral load coverage and suppression rates between children under 15 years and adults

Despite all the gains above, there is need for Strengthening Pharmacovigilance especially around spontaneous reporting and investigations as well as the roll-out active pharmacovigilance to all the target health facilities.

3.2.3.4 Strengthen Treatment Monitoring and Evaluation of Clinical Complications and Effects of Long-term Use of Antiretroviral Drugs

The MOH established a Pharmacovigilance committee and set up a system for adverse event reporting in FY 18/19. A strategy and tools were developed and field tested and training rolled out to establish active Pharmacovigilance in ART sites.

With support from PEFAR, the MOH piloted the use of Unique Identifiers (Use of Biometrics) in management of HIV/AIDS patients. Case Based Surveillance (CBS) as a means of uniquely identifying and characterizing persons newly diagnosed with HIV or AIDS over time is important in strengthening retention and tracking of patients in care within and across health facilities while maintaining their confidentiality. The pilot was conducted in over 30,000 HIV patients on ART in over 64 treatment sites the 3 Districts of Kabarole, Bunyangabu and Hoima. The MOH has included a field for National Identification NIN numbers in the new HMIS tools soon to be rolled out to serve as unique identifiers. While the NIIRA NIN numbers can serve this purpose, there are emerging concerns that need to be addressed to enable adequate use of the NIN numbers as unique identifiers. There are concerns of loss of confidentiality to the personal information of the ID holder, not all people especially children have national IDs and when the national IDs get lost, it is difficult to remember the NIN numbers until it is replaced at a cost, that might not be affordable to the PLHIVs. NIIRA needs to agree with the MOH how personal information can be protected by use of the NIN numbers.

The MOH also developed DSD care package for KP to strengthen and scale up HIV care and treatment among Key and Priority. The program is now developing job aids to enhance their implementation.

3.2.3.5 Promote Universal Access to the Basic Care Package

The Cotrimoxazole prophylaxis guidelines were revised and restricted prophylaxis for only newly initiating clients whose CD4 is not known, children under 5 years and pregnant women. A cumulative total of 3,145,484 PLHIV's active on ART received CPT/Dapsone in FY 18/19, with 599,060 receiving CPT/Dapson in their last visit in the last quarter of FY 18/19. The NSP MTR report showed that the number of adults and children active on ART who received Co-Trimoxazole at their last visit increased from 777,385 and 945,896 in 2015 and 2016 respectively, to 1,045,568 (97.6% of the adults and children active on ART) by December 2017 (DHIS2). . This performance reveals that the set NSP target 90% (2020) for the indicator has already been achieved and surpassed. However, the national response still faced challenges of stock outs of Co-Trimoxazole and ARVs.

Key Achievements	Key Challenges / Weaknesses
• ART optimization to enhance sustained VL suppression and tolerability is being done by a shift to DTG for adults and lopinavir/ritonavir in children. • The introduction of technology development of Case Based Surveillance using finger print technology is now able to improve searching and tracking of clients registered in care.	• There is still fear especially among women about birth defects despite the recent WHO guidance from the concluded studies. • There is still lack of information among patients why they are being switched to DTG.

• The use of finger print is implemented in 8 high volume sites managing over 70% of patients in both districts.	• Some districts are experiencing stock outs of DTG and IPT supplies.

3.2.4 Strategic Objective 4: Strengthening Integration of HIV Care and Treatment within Health Care Programs

3.2.4.1 Fully Integrate HIV/TB Programming and Services at all Levels including Community DOTS and Home-based Care

TB Case finding among PLHIVs

. The bulk of HIV care in FY 18/19, happened at Health Centre IIIs which accounted for 64% of the sites and 36% of the PLHIVs active on ART in the country. Approximately 60% of the PLHIVs on ART were in lower level health centres (IIs, IIIs and IVs), demonstrating integration of services at the lower levels.

Of the 1,198,435 PLHIVs active on ART, 1,136,376 (94.8%) were screened and assessed for TB at their last visit. Of these, 28,134 (2.5%) PLHIVs were diagnosed with TB and 19,935 (70.9%) started on Anti-TB drugs during FY 2018/19.

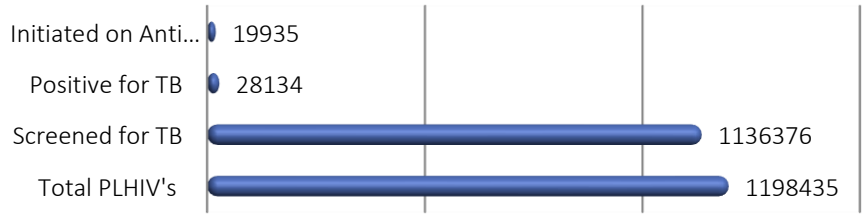


Figure 15: The TB-HIV Cascade

A trend analysis of data from the last three financial years shows that screening for TB among PLHIVs on ART improved from 90.8% in 2015/16 to 97.8% in 2017/18. The yield of TB in HIV clinics has however decreased over time with a sharp decline from 4.0% in 2016/17 to a low of 1.3%, in FY 2017/18. The yield in FY 2018/19 was 2.4% (28,134/1,136,376). Although there was a threefold improvement in initiating PLHIVs co-infected with TB on TB treatment (from 25% in 2015/16 to 73% in 2017/18), it dropped to 70.7% in FY 2018/19. This is still sub-optimal since it implies that about 30% of all PLHIVS diagnosed with TB are not started on treatment. The table below summarizes the trend of these indicators over the last four years.

Core Indicator	FY 2015/16	FY 2016/17	FY 2017/18	FY 2018/19
	n (%)	n (%)	n (%)	n (%)
Number of individuals active on ART	874,124	1,012,867	1,140,550	1,198,435
Number active on ART assessed for TB	794,211 (90.8%)	967,479 (95.5%)	1,108,047 (97.2%)	1,136,376 (94.8%)
Number active on ART diagnosed with TB	48,172 (5.5%)	40,633 (4.0%)	19,649 (1.7%)	28,134 (2.5%)
Number active on ART started on TB treatment	12,204 (25.3%)	12,525 (30.8%)	14,431 (73.4%)	19,935 (70.9%)

Isoniazid Preventive Therapy (IPT)

During the reporting period, the national TB-HIV technical working group of the TB-HIV unit continued to provide guidance with support from DEFEAT TB project which harmonized the scale up implementation of Isoniazid Preventive Therapy and roll out of online reporting and monitoring of isoniazid. This resulted into strengthened IPT program implementation and achievements in the scale up of TB preventive therapy with use of isoniazid as summarized under section 3.2.1.4 above.

However, it suffices to point out here that, the national response still faces challenges of low coverage of Isoniazid preventive therapy, lower than targeted rates of TB case detection and inadequate the supervisory and mentorship role due to insufficient funding.

Key Challenges / Weaknesses
• Missed opportunity for screening for TB and Nutrition status of PLHIV's. Up to 6 % and 10% of PLHIVs were not assessed for TB and Nutritional status respectively. • There are still missed Opportunities for initiating PLHIV with TB confection an anti TB drugs. About 30% of PLHIV's diagnosed with TB were not started on anti –TB drugs • IPT coverage is still low

3.2.4.2 Integrate HIV Care and Treatment with Maternal, Newborn and Child Health, Sexual and Reproductive Health and Rights, Mental Health and Non-communicable / Chronic Diseases

Integration of HIV care within the MNCH platform has been ongoing. HIV testing and treatment of pregnant and lactating in women was being provided in the MNCH platform in all the health facilities providing ART services. The program with support from the development Partner continued to support FP services provision within the MNCH and HIV clinics, through supporting procurement of FP commodities and working with the national ware house (NMS) to ensure availability of FP supplies in the health facilities. Strengthening of FP services has also been achieved in the context of DTG, through capacity building of service providers for provision of appropriate information for decision making, to ensure that the women who desire to switch to DTG are on effective family planning methods and provide informed consent.

3.2.4.3 Integrate Nutrition Assessment, Counseling and Support in HIV Care and Treatment Services including Use of Ready to use Therapeutic Food (RUTF) for Severely Malnourished, and Linkages to Increase Food Security

No Integration of Nutrition Assessment, Counseling and Support in HIV Care and Treatment Services including Use of Ready to use Therapeutic Food (RUTF) for Severely Malnourished, and Linkages to Increase Food Security were planned in FY 18/19. The program planned and undertook nutrition integration activities in year 1 and 2 of the NSP. However, CDC through MAUL for PEPFAR supported the government of Uganda (MOH) to procure and supply 6,195 cartons of RUTF to treat about 6,500 HIV+ severely malnourished clients 70% children below 15 years and 30% pregnant women in FY18/19.

Overall, 1,069,997 (89.2%) of the PLHIVs on ART had nutrition assessment conducted at least once during the quarter ending FY 2018/19. Amongst the PLHIVs assessed for malnutrition, 9,961 (0.9%) were malnourished at their last visit.

Core Indicator	FY 2015/16	FY 2016/17	FY 2017/18	FY 2018/19	Remarks
Number or proportion of PLHIV who received nutrition assessment	720,128 (82.4%)	891,541(88.0%)	1,038,612 (90.9%)	89.2%	
Number and proportion of PLHIV malnourished who received nutrition therapy	9515 (1.3%)	11,689 (1.3%)	10,280 (1%)	(16.4%) 114,746/700,265	

3.3 PROGRESS IN SOCIAL SUPPORT AND PROTECTION

The NSP thematic Goal of Social Support and Protection is reduced vulnerability to HIV/AIDS and mitigation of its impact on PLHIV and other vulnerable groups. A number of interventions were undertaken by various partners and stakeholders during the year 2018/19 aimed at achieving the Goal and thematic objectives of Social Support ad Protection. Assessment of progress for this FY 2018/19 shows positive trends for vulnerability reduction manifested in the development and implementation of socio-economic interventions by both the state and non-state actors. Assessment findings have been presented according to the NSP thematic objectives of Social Support and Protection.

Table 11: Summary of progress in Social Support and Protection

	Baseline	2019/20 Targets	Achieved 2016/17	Achieved 2017/18	Achieved 2018/19	Assessment of Progress
Strategic Objective 1: To scale up efforts to eliminate stigma and discrimination of PLHIV and other vulnerable groups						
Percentage of individuals aged 15-49 years with accepting attitudes towards PLHIV	Overall: 34% Male =34.2% Female =22.2% (UDHS 2011)	70%	19.1% (external stigma experienced by young people in East Central)	Overall = 66.8% Male (71.3%) Female (65.6%)-(UDHS 2016)	-External stigma (exclusion reduced from 4.5% in 2013 to 1.3% (2019) -Internal stigma *reduced*: e.g. feeling guilty of being HIV+ reduced from 50% in 2013 to 24% in 2019[2].	On track to achieve outcome although external stigma; most especially work place and school stigma remain big challenges.
Strategic Objective 2: To scale up services to meet the needs of PLHIV, OVC and other vulnerable groups in development programs						
Percentage of OVC households that are food secure	45.2% (LQAS 2013)	60%	37.2% (LQAS 2017)	37.2% (LQAS 2017)	479,087 of OVC HHs (19.2%)[3] out of the 2,493,972 OVCs supported in FY 2018/19.	Decline in food secure for OVC households compared to 2017/18
Percentage of OVC aged 5-17 that have at least three basic needs met/ 3 core programme areas	24.8 % (LQAS 2013)	70%	50% OVC MIS	39% (LQAS 2017)	1,638,175 HHs (66)[4]	On track to achieve the overall target
Strategic objective 3: To develop and implement a life cycle sensitive comprehensive package of social support and protection interventions for PLHIV and other vulnerable groups						
Percentage of districts with Life skills cycle sensitive comprehensive package of social support and protection	OVCMIS2-MGLSD (Apr-June FY 2018/19)	100%	No information available	Information not available	85% of 128 districts reported about the number of OVC Service Providers[5]	Details of services per district not reported
Percentage of vulnerable individuals receiving a life cycle sensitive comprehensive package	Not Available	65%	Information not available	Information not available	No data available	No reliable information available to measure progress

[2] 2nd National Stigma Index Study draft report (2019)
[3] National OVC data base (FY 2018/19)

[5] National OVCMIS2 data base (April-June 2019)

Strategic objective 4: To 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						
Percentage of married women who participate in all the three decisions pertaining to their own health care, major household purchases, and visits to their family or relatives.	38% (UDHS 2011)	70%	Information not available	Overall = 51% 15-19 years = 35.5% 20-24 years = 43.9%(UDHS 2016)	Overall = 51% 15-19 yrs =35.5% 20-24 yrs =43.9% (UDHS 2016)	On course to achieve the target, although there was no updated data from that of last FY 2017/18
Percentage of men and women who believe that wife beating is justified	Overall =55.1% Women= 58.3% Men= 42.8% (UDHS 2011)	20%	Information not available	Overall=47%Women=49%Men =40.1% (UDHS 2016)	Overall=47% Women=49% Men=40.1% (UDHS 2016)	No updated information to measure progress
Percentage of women who own land alone or jointly with their spouses	38.7% (UDHS 2011)	40%	68%[6]	47.7% (UDHS 2016)	47.7% (UDHS 2016)	No updated information to measure progress

Summary of Key Achievements for Social Support and Protection for FY 2018/19

- Increased recognition of the need to develop HIV and AIDS workplace sector policies to protect the rights of PHIV. Over 70% of sectors reported having these policies in the FY 2018/19.
- Increased recognition and adoption of HIV and AIDS mainstreaming of the socio-economic needs of PLHIV, OVCs and other vulnerable categories of people by the Public sectors and non - public actors.
- Noticeable increase in the anti-stigma and anti-discrimination interventions implemented in varying magnitudes by sectors to enhance social support and protection for PLHIV.
- Enhanced multi-stakeholder and coordination efforts to support PLHIV, OVCs and other vulnerable categories of people through implementation of campaigns and other socially and economically empowering interventions. Cultural and religious institutions, public sectors/ MDAs, Contractors, CBOs, NGOs, multi-national agencies and PLHA Networks were highly involved.
- Improved implementation of legal and policy instruments for the empowerment of women, girls, men and boys to access and utilize social support and protection services.

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

3.3.1 Strategic Objective 1: Scaling up Efforts to Eliminate Stigma and Discrimination of PLHIV and Other Vulnerable Groups

Stigma is a damaging social phenomenon. In the case of people living with HIV (PLHIV), stigma has negative effects on health outcomes, including non-optimal medication adherence, higher depression, and overall lower quality of life. HIV-related stigma causes PLHIV to lose social value and standing due to their HIV positive status.[7] The UDHS (2016) revealed that 33.4% of women and about 29% of men had negative attitudes towards PLHIV. However, this FY 2018/2019 shows positive strides towards the elimination of stigma and discrimination among PLHIV.

Progress Made

The second National Stigma Index Study[8] conducted with 1,398 respondents living with HIV, in 21 districts and 9 in sub regions of Uganda, showed a reduction in some of the external forms of stigma. Exclusion from social gatherings reduced from 4.5% in 2013 to 1.3% in 2019, while internal stigma forms e.g. feeling guilty of being HIV+ reduced from 50% in 2013 to 24% in 2019. The study revealed that families were the highest among those that knew the respondents HIV status accounting for 1,129 (80.77%), while 68.88% of women found it easier to disclose their HIV status to their children than to other family members.

A recent study conducted by TASO in conjunction with Makerere University School of Public Health, further attested to positive accepting attitudes about PLHIV by the AGYW. Among the 8,236 respondents, 81.1% of both the in school and out of school AGYW; found no difficulty in buying vegetables from a vendor infected with HIV, 86.4% were willing to take care of an HIV infected family in their own household, while 81.1% would allow an infected female teacher to continue to teaching in their school[9]. The AGYW report indicated 78% of young respondents that would want it to remain a secret when there is an infected HIV person in the family. These findings reveal the continued need for the fight against stigma in different aspects and environments where it manifests.

Declaration about HIV status according to the study by NAFOPHANU was reported lowest among co-workers 375 (26.88%), employers 308 (22.09%), class mates 37 (2.64%) and teachers and administrators, 47(3.36%). An overall percentage of 36.38% had difficulty in disclosing their HIV Status to other people, (6.7%) were denied employment leading to loss of income, (6%) chose not to apply for jobs, while 4.8% were denied residence in another country based on their HIV status. In 2018, UGANET published a summary of findings that exposed Investors in the Road Construction Sector and Labour Export Companies that dismissed employees from their jobs as a result of their HIV+ status.[10]

Deep rooted socio-cultural factors undermine enrollment and retention for HIV services; affecting more of girls and women. In some communities, there is continuing perception that HIV is a result of promiscuous behavior. It is worse if women are tested first and found HIV+, while beliefs in witchcraft as a cure for HIV & AIDS as opposed to modern medicine presents an obstacle to HIV response in some societies [11]. To address this challenge, UAC and MoGLSD continued to engage with cultural institutions in Buganda, Bunyoro Kitara, West Nile, and religious institutions about the need to actively get involved in HIV response. In Busoga kingdom for instance, clan leaders made resolutions and pronouncements to break the taboo of discussing about sex issues in public so as to create awareness among the youth about the dangers of early sex debuts. The kingdom leaders have encouraged male partners to accompany their wives for antenatal and be tested for HIV. Other pronouncements include; using every forum; (e.g. clan meeting, burials, weddings, church services or Juma prayers) to discuss HIV/AIDS prevention, working with clan leaders and LC 1s to visit homes of residents suspected to have HIV and encouraging them to go for testing and treatment.

[7] Helms CB, Turan JM, Atkins G, et al. Interpersonal mechanisms contributing to the association between HIV-related internalized stigma and medication adherence. AIDS Behavior, 2016.

[8] NAFOPHANU Second National Stigma Index Study (August 2019)

[9] TASO-Uganda: Formative assessment of HIV, sexual and reproductive health and gender-based violence status among adolescent girls and young women in Uganda; (Final Report; March 2019).

[10] UGANET (2018): HIV Discrimination at the Workplace; HIV Human Rights Brief; May 2018.

[11] International Community of Women Living with HIV East Africa (ICWEA) - 2017: Social-Cultural and Gender related barriers that affect the enrollment and retention of women and girls living with HIV, in HIV Prevention, Treatment and Care Services in Uganda.

Busoga kingdom has a youth desk where all information regarding HIV is shared including a *WhatsApp* forum for the youth. There is another youth forum called "*ekigangu"* where youth discuss general issues affecting them including HIV. Health camps and other cultural events are periodically organized in the kingdom and are used to disseminate information on HIV, conduct HIV testing and counselling, and distribute condoms. Recently, the climbing of the Kagulu hill function attracted over 1,000 people of whom 288 were tested for HIV, while 2 were linked to ART. The kingdom has generally adopted the family extended approach to reach out to fellow family members and encourage them to go for HIV testing and treatment.

In Buganda kingdom, the Kabaka, together with the *Katikiro (Prime Minister)* have encouraged their subjects to avoid risky behavior that can lead them to contracting HIV. The kingdom has spearheaded economic empowerment projects (e.g. the coffee project-*emwanyi terimba*) to ensure that the kingdom subjects have sustainable income including those living with HIV. Through the youth forum called "*ekisakaate*", led by the *"Nnabagereka"* the Queen of Buganda, the youth girls and boys have had access to HIV information. The kingdom has conducted continuous dialogues with the clan leaders to share the right information about HIV, while joint decision making has been encouraged among married couples. Religious institutions have used the worship platforms to disseminate HIV information as well, including encouraging testing and adherence to ART for those already infected. They have encouraged the believers to extend social and economic support to families and people that have been affected by HIV.

Community support structures like the family and peer support groups, post-test clubs, women's savings groups, Mama Clubs, Male Action groups, Positive Men's Clubs, burial groups, and other forms of CBOs continued to share information on HIV for stigma reduction as well provision of psychosocial support to those affected. Networks like, UNASO, NAFOPHANU, AMICAALL, WONETHA and MARPS network have engaged with different population groups including key populations on HIV prevention and positive living. Peer to peer, and in some cases home based counselling has been adopted by some HIV service providers especially CBOs, PLHA networks and government Health center HIV focal staff to strengthen PLHIV deal with self - stigma. Radio talk shows have been conducted by HIV networks, while drama initiatives have been implemented at community level by CBOs and CSOs; (a case of UNASO CSO partners in Greater Masaka and Hoima); to create awareness and encourage positive living among individuals. Success stories about positive living have been shared through the media to encourage PLHIV. World AIDS day for the year 2018 ran a series of such stories in the New Vision newspaper as a strategy to encourage PLHIV live positively. Stigma at workplaces has been addressed through the development of HIV workplace policies; (e.g. by over 60% of public sectors) to discourage stigma and discrimination among staff living with HIV. Table 15 below provides a snapshot of the anti-stigma and anti-discrimination interventions undertaken during the year.

Table 12: Snapshot of anti-stigma interventions by Sectors/SCEs/Stakeholders, FY 2018/19

S/N	Name of Sector/ Stakeholder	Type of Service Offered
1	Uganda National Roads Authority (UNRA)	Adopted HIV & AIDS Policy that prohibits discrimination of staff Living with HIV, HIV Counselling for staff , mainstreamed HIV among the social and environmental safeguards for Contractors
2	Civil Aviation Authority	Confidential linkage to Care and Treatment for staff Living with HIV, HIV Counselling for staff by the health facilities. 17 counselling sessions conducted during the FY 2018/19
3	Ministry of Trade, Industry and Cooperatives	Two Free Voluntary Counselling sessions conducted for staff
4	Electoral Commission	Conducted a Retreat on HIV; counselling sessions were conducted
5	Health Service Commission	Free HIV Counselling and Testing for staff was conducted
6	Ministry of Defense	Revitalized 4 networks of PLWAs to support adherence counseling
7	Office of the Prime Minister	Health camp with HIV Counselling integrated
8	Uganda Police Force	Trained 8 adolescents and 2 counselors in Stigma and Discrimination

9	MGLSD	Organized a health camp for 133 staff (66 males, 67 females). Free HIV counselling services were provided
10	Ministry of Energy and Mineral Development	Organized a 3 day health camp for 127 staff-Voluntary HIV counselling services were offered
11	Uganda Prisons Service	Campaigns against stigma and discrimination were conducted by peer educators, expert clients, health workers and officers in charge of prison units among others

Source: HIV Annual Sector Reports FY 2018/19

Key Challenges / Gaps

- Both internal and external stigma still prevalent although reducing in varying magnitudes. HIV discrimination continues to fuel stigma for PLHIV. It also affects their right to employment, association and privacy.
- Most of the interventions for elimination of stigma and discrimination are implemented on a small scale across sectors and are not regular in nature.
- HIV Workplace interventions are still inadequate. It was explicit in the findings the Second National Stigma Index Study that work place HIV stigma is existent as not many employees have openly disclosed their HIV status mainly due continued practices and attitudes associated with stigma and discrimination.
- The current (National stigma index 2019), does not share statistics of overall stigma reduction among males and females hence making it difficult to measure overall progress from the gender perspective.

3.3.2 Strategic Objective 2: Mainstreaming the Needs of PLHIV, OVC and Other Vulnerable Groups into Other Development Programs

There is evidence showing that the needs of PLHIV, OVCs and other vulnerable groups have been mainstreamed into development programmes by both state and non-state actors in varying magnitudes.

Progress Made

MoGLSD has over the past years progressively integrated the needs of PLHIV, OVCs and other vulnerable groups like the women, youths, and the elderly into development programmes like Uganda Women Entrepreneur Programme (UWEP), Youth Livelihood Programme (YLP), and Social Assistance Grants for Empowerment (SAGE) and has offered integrated basic needs support to OVCs and PLHIV. On the other hand, Ministry of Agriculture has implemented the Operation Wealth Creation (OPWC), while Office of the Prime Minister (OPM) has implemented NUSAF programmes to benefit vulnerable people including OVCs and PLHIV.

There has been an increase in the number of SAGE beneficiaries (aged 65+) by July 2019 to 158,000, up from 123,153 beneficiaries in FY 2017/18; representing a percentage increment of 28.2% totaling to 34,847 beneficiaries.[12] Evidence demonstrates that SAGE has generated important attributable impacts in improving food security, human capital development and more sustainable livelihoods. In the year 2016 for instance, the number of households eating fewer than two meals per day fell more than twice, Primary and secondary school attendance rates rose nearly three times more rapidly, while the employment rate in SAGE districts rose nearly to fifty percent than in non-SAGE districts[13].

The number of the YLP beneficiaries increased from 197,728 in FY 2017/18 to 241,799 by July 2019, representing a percentage increment of 22.3% totaling to 44,071 beneficiaries. Of these, 2.5% of the youths beneficiaries are living with HIV accounting for over 4000 youths supported under this program. The youths have benefitted from different support that includes; startup capital, trainings and business entrepreneurial skills, savings and extension services among others[14]. A recent evaluation of the programme this year August 2019 revealed a 4% increase in employment for the vulnerable

[12] MoGLSD Sector Report 2018/19.
[13] UNICEF (2016) Social Protection Investment Case: Ex-Post Impact Assessment of the Social Assistance Grant for Empowerment (SAGE).
[14] Ibid.

youths under YLP. Skilling Uganda Programme under the Education Sector has benefitted over 5000 beneficiaries that include OVCs, girls, Youth Living with HIV, unemployed youths, etc. Efforts are being made by Government to construct at least one vocational school in each sub county aimed at economically empowering the youths.

Table 13: Beneficiaries for the YLP and SAGE Programmes FY 2017/18-FY 2018/19

Category of beneficiaries	Socio-Economic Programme	Beneficiaries FY 2017/18	Beneficiaries FY 2018/19	Number of incremental beneficiaries	% of incremental beneficiaries
Older Persons (65+)	SAGE	123,153	158,000	34,847	28.2%
Youths	YLP	197,728	241,799	44,071	22.3%

There has been an increase in the UWEP beneficiaries from 1,222 in FY 2015/16 to 103,770 beneficiaries in FY 2018/19. This FY 2018/19 alone had 27,142 beneficiaries; although the number of those living with HIV has not been identified, by December 2017 however, a total of 2,333 women living with HIV had been supported, and this increased to 8,352 by July 2018. Overall, a total of 56,701,364,957 UGX had been disbursed by July 2019, and a total of 8,247 projects implemented. The women are supported with startup capital, credit extension services and trainings in business management and entrepreneur skills. See Figure 16 Below;

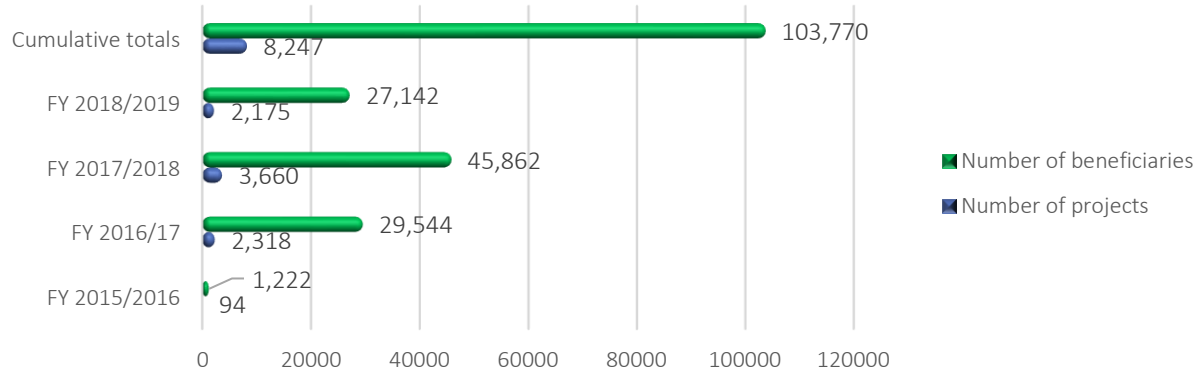


Figure 16: UWEP beneficiaries and projects from FY 2015/16-2018/19

Source: https://businessfocus.co.ug/wp-content/uploads/2019/01/UWEP-Liberation-magazine.pdf

There has been increased OVC support by both the state and non-state actors. Uganda has an OVC burden of 6,803,070 of whom 128,600 are HIV+[15]. OVC support in various areas e.g. education, health and economic strengthening among others, increased from 58,912 in FY 2015/16, to 113,974 in FY 2016/17, 84,718 in FY 2017/18, to **2,493,972** in FY 2018/19. The increase in the number of OVC for FY 2018/19 is due to increased coordination, reporting by the different OVC service providers and the consolidated data capture system by MoGLSD. Secondly, although psycho-socio support is a cross cutting issue for all OVCs, it has been reported most and independently by the service providers accounting for the highest number of beneficiaries (937,366). This partly explains the spike in OVC numbers. A total of **1,638,175** OVCs benefitted from 3 or more Core program areas; (53% female, 47% male OVCs with HIV). A summary is indicated in figure 17 below:

[15] OVCMIS DATA 2018/2019

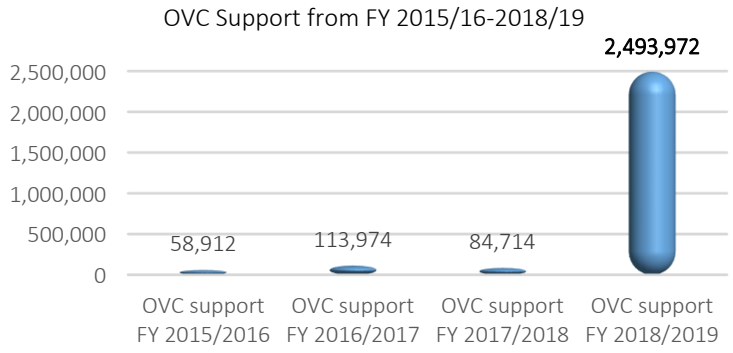


Figure 17: OVC socio-economic strengthening support for FY 2015/16-2018/19

Source: OVCMIS Data-MGLSD FY 2015/2016-FY 2018/19

According to (UDHS 2016), the proportion of men and women who believed that wife beating was justified reduced from 55.1% (i.e. 58.3% of women and 42.8% of men-UDHS 2011) at baseline to 47.01% i.e. 49% women and 41% men (UDHS, 2016). The GBV Prevention and Response Joint Program in Busoga sub-region, implemented by Uganda Women's Organisation Network (UWONET) registered significant progress in reducing cases of GBV in Busoga sub region from 74% in 2006 to 48 % in 2016, while awareness and ability to discuss GBV issues in the sub region increased from 47% in 2011 to 54% in 2018. Compared across year trends however, in the FY 2016/17, the GBV cases reported by 94 districts was 7,722, while by August 2018; 1,827 cases had been reported by 19 districts.[16]. This year 2018/19, the data base shows an increase in GBV cases to **37,398** between April-June 2019, reported by (76%) women and by (24%) of men. The increase in cases was partly due to increased and coordinated reporting to MoGLSD by some of the service providers. Denial of economic opportunities ranked highest of all the GBV causes probably instigated by the increasing poverty levels among the population.

According to the revised National Household Survey Report published by UBOS in February **2018**, the proportion of people living in poverty in Uganda now stands at 8 million, equivalent to 21.4%, up from 19.7% in FY 2012/13, and this partly justifies the current increase in GBV cases where struggle to access, control and utilize the few economic assets presents challenges, among men and women. The recent study among AGYW (2019) indicated that 6.5% of married (or unmarried but in a sexual relationship) had ever experienced any form violence (physical or sexual) from their husband or male partner within the past 12 months prior to the survey.[17]

GBV cases are highest among the marrieds according to the data base, accounting for 51.39%, (19,684) and lowest among divorced couples / partners accounting for 0.54% (205 cases reported)[18]. Details in Figure 18:

[16] Ministry of Gender, Labour and Social Development (MGLSD) National GBV data base reported; August 2018.

[17] TASO-Uganda: Formative assessment of HIV, sexual and reproductive health and gender-based violence status among adolescent girls and young women in Uganda; (Final Report; March 2019).

[18] MGLSD National GBV data base; accessed 6th August 2019.

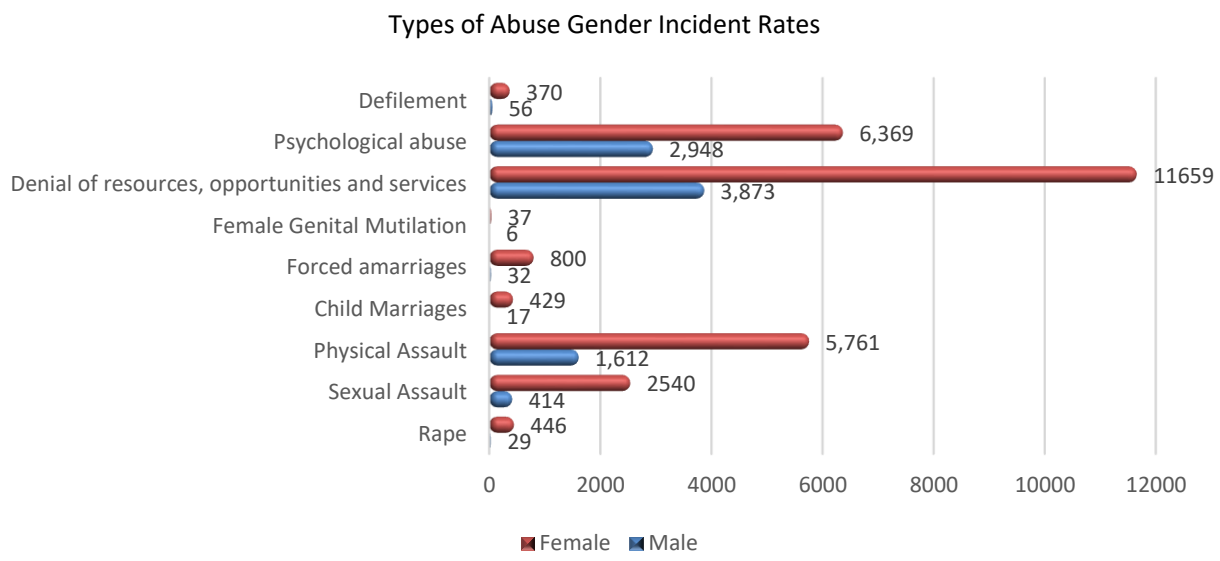


Figure 18: Types of abuses reported by men and women

Source: MGLSD National GBV data base; accessed 6th August 2019

The highest GBV perpetrators according to MGLSD data base are men accounting for 81.1%, and generally adults (both men and women) accounting for 75.09%. Since the year 2017, UGANET has trained over 116 Stop GBV Champions, served a total of 278 clients handling 171 cases of domestic violence, of which 158 were cases on property dispute. Paralegals were trained at community level to support the handling of GBV and other cases.[19] Due to the limited coverage of such GBV interventions however, the cases are still high among communities. Most GBV cases are reported by; in their order from highest to lowest; Police, GBV Shelters, Probation Officers, Health centers and Community Development officers (CDOs). During FY 2018/19, Police recorded 2,081 GBV cases, while 63% of these were prosecuted[20].

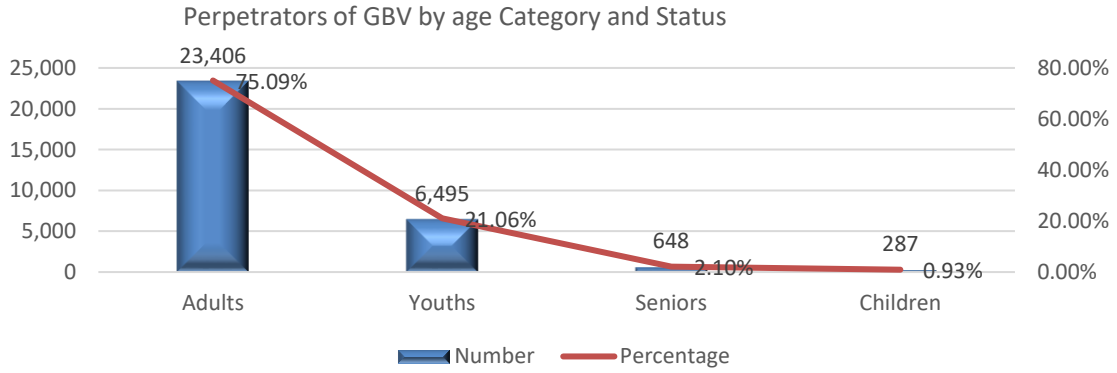


Figure 19: Current perpetrators of GBV by age category and status

Source: MGLSD National GBV data base

[19] UGANET Annual Report (2017)
[20] Uganda Police Health Service Quarterly Performance Report 2019.

Coordination of the social support and protection service providers has improved over the past years. The MGLSD has coordinated all entities that are mandated to deliver on the social support and protection thematic area, while UAC is nationally coordinating all actors implementing HIV interventions through the multi sectoral approach. Different sectors and partners share their annual Sector HIV progress and activity reports with UAC to facilitate assessment in progress of implementation. The MoGLSD has a coordinated data base for OVC support and Gender based violence hence making access to information easier.

As part of GBV prevention and response, trainings have been conducted by MGLSD for some Sectors, Institutions, CSOs and communities about the negative implications of GBV and reporting. Similar trainings have been extended to different cultural institutions and GBV Champions at community level. The Justice, Law and Order Sector (JLOs) has played its role of providing legal services to GBV/SGBV victims and survivors. Over 20,000 OVCs were re-integrated with their families through the JLOs[21]. The Ministry of Education has scaled up efforts to train different stakeholders at all education levels (Primary, Secondary, and Tertiary) in the Reporting, Tracking, Referral and Response (RTRR) to cases of violence against children in schools, including SGBV cases.

In addition, the Education sector has integrated social support for OVCs and other vulnerable children by implementing the PIASCY programme in schools with key messages for behavioral change and conducting HIV dialogues with students. Through the Uganda National Students Association (UNSA), HIV & AIDS dialogues in Arua and Mbale benefitted 600 students with life skills and age appropriate HIV Information. The Gender Unit has been conducting gender mainstreaming trainings with HIV & AIDS as a cross cutting issue for Primary, Secondary and Tertiary institutions. HIV & AIDS trainings have been integrated into the social risks management component for some of the sector infrastructure projects like the Global Partnership for Education (GPE). Creating awareness about HIV & AIDS has further been promoted through music, dance and drama activities. By the year 2020, integration of HIV & AIDS into the new Lower Curriculum Reform S1-S4 is set to begin.

Key Challenges / Gaps

- Limited disaggregation of data for OVCs, PLHIV and other vulnerable categories that have benefited from the different development programmes. This makes it difficult to assess the linkage of PLHIV to such programmes and programmes offering socio-economic support.
- People with Disabilities (PWDs) are not prioritized as a vulnerable category and therefore not disaggregated in the reporting.
- Although FY 2017/18 shows a remarkable reduction in GBV cases, the current improved data capture through the National GBV data base (MoGLSD) shows an increasing trend in cases of GBV for FY 2018/19.

3.3.3 Strategic Objective 3: Developing and Implementing a Life Cycle Sensitive Comprehensive Package of Social Support and Protection Interventions for PLHIV and Other Vulnerable Groups

Different kinds of life cycle sensitive social and protection interventions have been implemented under different projects and programmes by different actors. These have benefitted different categories of people to include PLHIV and other vulnerable categories of people.

Progress Made

Increased package of social support and protection services to OVCs, PLHIV and other vulnerable groups by both state and non-state actors. This includes; food, psychosocial support, health services, financial support, agricultural inputs, vocational skills, apprenticeship, business skills and nutritional support. Uganda Prisons Service[22] supported staff living with HIV with nutritional food supplements to boost their nutritional requirements, while Prisoners living with HIV were given income generating skills such as carpentry, tailoring, crafts, vegetable growing among others. The AIDS Support Organization (TASO) enrolled 4,508 AGYW for

[21] OVCMIS Report FY 2018/2019

[22] Uganda Prisons Service HIV Sector report FY 2018/19.

vocational skilling in 16 districts[23], Ministry of Science Technology and Innovation (MoSTI)[24] provided financial support to staff that declared their HIV status, while Ministry of Defense and Veteran Affairs (MoDVA) [25] established a special fund for PHAs, streamlined OVC care in 10 UPDF facilities against 28 facilities, trained 20 OVC focal persons and provided 800 OVCs with start-up basic scholastic materials. A total of 24,806 (85%) OVCs were supported by KCCA[26] out of the targeted 28,905, while four staff were given monthly financial support of UGX 100,000 each by the Health service commission. Ministry of Energy and Mineral Development extended financial support to their staff living with HIV as well. OPM through NUSAF III has targeted to reach 70,200 beneficiaries (11,700 households) through grants support for Livelihoods Investment, while 285,500 people (43,084 households) are targeted to earn income from temporary employment through the labour intensive public works. [27]

Table 14: Basic Needs Support for OVCs for the Period 2018/19

S/N	Indicator	Male	Female	Total
1	# of OVC Households provided with food	N/A	N/A	479,087
2	# of OVC provided with Nutritional support	6,572	6,667	13,239
3	# of OVC supported to access education	1,468	1,478	2,946
4	# OVC provided with Psychosocial Support.	455,575	481,791	937,366
5	# of OVC referred for other services:	150,253	156,972	307,225
6	# Referred for HIV Testing Services: Under 1 Year	4,118	4,442	8,560
	Total			**1,748,423**

Source: OVCMIS DATA-MGLSD FY 2018/19

Table 15: OVCs served Per Core Programme Area for the Period 2018/19

No.	Indicator	Male	Female	Total
1	# of OVC HHs who received economic strengthening support	N/A	N/A	499,668
2	# of OVC supported to attain voc./apprentice skills	32,472	49,486	81,958
3	# of OVC provided with toolkits/start-up kits	8,496	12,831	21,327
4	# of OVC HHs that received agricultural/farm input	N/A	N/A	66,760
5	# of OVC HHs that received agric. advisory services	N/A	N/A	0
6	# of OVC HHs supported to access safe water	N/A	N/A	0
7	# of OVC supported to receive health services	39,205	36,631	75,836
	Total			**745,549**

Source: OVCMIS DATA-MGLSD FY 2018/19

The DREAMS project with funding support of $62,869,619 (from FY 2016-2019) from PEPFAR, has benefitted 40,853,749 people in Uganda to date. The project is being implemented in 15 districts of Northern and Central Uganda; notably-Agago, Apac, Bukomansimbi, Gomba, Gulu, Lira, Luwero, Lwengo, Lyantonde, Mityana, Mubende, Mukono, Oyam, Rakai and Sembabule) and by 15 implementing partners including; RTI, Mild May, Catholic Relief Services, FHI 360, Uganda School Health and Reading Program, and AVIS Foundation Uganda. The Project is support various interventions including, gender-based violence prevention and care for survivors to restore safety and foster resilience as well providing educational and economic opportunities to girls. A total of 7,114,574

[23] TASO JAR Presentation; 21st -22nd August 2019.
[24] Ministry of Science, Technology and Innovation HIV Sector report FY 2018/2019.
[25] Ministry of Defence HIV Sector report FY 2018/19
[26] Kampala City Council HIV Annual report FY 2018/2019.
[19]https://opm.go.ug/northern-uganda-social-action-fund-nusaf-3/; accessed 19th August 2019

adult women and Adolescents Girls and Young women (AGYW) in different age categories have benefitted from the project; (women 10-14 years=2,767,261, 15-19 years= 2,355,424 and 20-24 years old=1,991,889)[28].

Child protection has been enhanced by the MoGLSD, through the development of a centralized and consolidated National GBV data base that captures GBV and child abuse cases. By August 2019, a total of 37,398 GBV cases had been captured by the data base e.g. defilement (426 cases, child marriages (446 cases)[29], forced marriages (832 cases), among others. (Refer to Fig 11 above). The data base is easily accessible by the different stakeholders to inform decision making, intervention planning and response. A child toll free help line (Sauti 116) has been instituted by MoGLSD to enhance the reporting of child abuse cases in schools, communities and other settings. Over 100,000 child abuse cases have been handled by MoGLSD [30]. Approximately 1,388 child offenders were admitted into the remand homes during the FY 2018/19[31].

Other strategies to fight child abuse include; direct implementation of child protection interventions by IPs e.g. World Vision, Plan Uganda, Save the Children among others, mainstreaming of child protection in some of the public sectors and Self-Coordinating Entities (SCEs) e.g. Uganda Prisons Service, Uganda Police, KCCA, etc. Community sensitizations on child protection have been on going by both state and non-state actors, referral linkages of abused children (e.g. those sexually abused) to health facilities has been implemented, including the provision of legal aid services. Trainings have been conducted for Child Protection structures at community level and GBV champions as a strategy to reduce abuses against children and adults.

Capacity for quality counseling services for PLHIV, OVC, key populations and other vulnerable groups has been scaled up through training of health centre based HIV counsellors; peer educators, Expert Clients, community based counsellors, while the leaders of PLHA have benefitted from basic skills trainings as well.

Key Challenges / Weaknesses

- No specific tool to capture data for the life cycle sensitive comprehensive package for social support and protection offered to PLHIV, OVCs, key populations and other vulnerable groups.
- No clear articulation of the specific variable and indicators within the life cycle sensitive comprehensive package of social support and protection making it difficult to assess progress in implementation.
- Limited data about the Key populations served by economically empowering interventions and other packages.

3.3.4 Strategic Objective 4: Engendering 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 and AIDS

The socio-economic vulnerability of women to HIV increases by keeping them dependent on someone else and constraining their ability to refuse sex, negotiate condom use, discuss fidelity with their partners, seek treatment or leave risky relationships. This leads to new HIV infections, high school drop outs, unskilled and unemployable young people, early sexual debut, early child marriages, teenage pregnancies and violence against women and girls. This is made worse if socio-economic structural barriers are not addressed to free women and girls from socio-economic servitude.

Progress made

Uganda has made great strides in eliminating structural barriers that infringe on the rights, protection and opportunities of the different categories of people. The Domestic Violence Act (2010) and the Children's Act (Cap 59) aim to protect women, men and children from all forms of violence respectively. The Land Act (Cap 227) protects state and family land; while the National OVC Policy (2004) guides on the survival, development, participation and protection of vulnerable children. The National Policy on Disability (2006) provides for equal treatment, social inclusion and provision of livelihood support for older persons, the Gender Policy (2007)

[28] www.pepfar.gou/documents/organization/253961.pdf.
[29] MGLSD National GBV data Base; accessed 6th August 2019.
[30] MGLSD Sector Report FY 2018/19
[31] MoGLSD Sector Report FY 2018/19

seeks to promote equality among men, women, boys and girls, the National HIV Policy (2011) provides a broader framework for delivering HIV related services while the National Food and Nutrition Policy (2003) aims to promote nutritional status for all people of Uganda. The National HIV and AIDS Anti Stigma and Discrimination Policy (2016) prohibits such practices for PLHIV. Furthermore, there are efforts to amend the Succession Act, Cap 62 to bring it into conformity with the Constitution of the Republic of Uganda and the internationally accepted human rights standards.

During the FY 2018/19 efforts have been made to further strengthen institutions and sectors to implement laws and policies addressing SGBV and other rights violations among PLHIV, OVC, key populations and other vulnerable persons. MoGLSD continued to disseminate the National Plan for Women, Girls, Gender and HIV & AIDS (2016/17-2020/21), while the Ministry of Education continued with dissemination and training different stakeholders about the National Strategic Plan to end Violence against Children (2015-2020) for both boys and girls in schools. The Gender mainstreaming Manual was reviewed by the Sector with funding support from UNESCO to accelerate gender sensitivity and responsiveness to the different needs of boys and girls, men and women in Education institutions. The Menstrual Hygiene Management Manual is in its final stages of development to increase access of adolescent girls to menstrual hygiene services in schools.

Public sectors, CSOs and other stakeholders have adopted HIV rights based programme activities e.g. anti-stigma and non-discrimination for PLHIV at the work places and ensuring access to HIV services. The MoGLSD has trained 90 GBV champions on the relevance of the Start, Awareness, Support and Action (SASA) Model on GBV and HIV Programming in different communities, while through the KARUNA programme supported by Irish Aid, stakeholders implementing HIV interventions were trained in Governance and Human rights in the context of HIV & AIDS. At government Health Centers, expectant mothers are encouraged to visit antenatal clinics with their male partners for HIV screening, counselling and treatment.

In refugee settlements for instance, UNHCR has worked with 85 partners whose capacities have been built in responding to GBV and SGBV issues. From January – October 2018, a total of 4,822 SGBV incidents had been reported in refugee settlements, where October 2018 alone had 425 cases reported, by over 70% of women. In order to enhance social protection as well as SGBV prevention response, a total of 28 police posts have been established in refugee settlements, with 339 police officers deployed to handle SGBV and other criminal cases. By June 2019, a total of 1,360 refugees had received legal assistance in the refugee settlements in various human rights violations including SGBV.

The capacities of CBOs and other CSOs has been built through trainings and Consortium partnerships e.g. KARUNA. Plan Uganda, World Vision and RTI have partnered with the Education sector to champion social mobilization about HIV, violence against women, men, boys and girls in schools, while UNRA Contractors signed sub-contracts with about 15 CBOs/ CSOs to support in social mobilization activities against violence and HIV & AIDS prevention. Among the CSOs included; Reproductive Health Uganda (RHU), Support for Integrated Health Care Initiative (SHCI), Uganda Forum for Awareness and Mitigation of HIV/ AIDS Impact, Family Health Care International, Community Health Promotion Consultants (Cohepco) among others. These reached over 10,000 people with HIV & AIDS sensitization and anti-violence messages.

Findings from the UDHS 2016 shows that 48% of women owned land alone or jointly with their spouses which was above the NSP baseline value (38.6%) and surpassed the target (40%) set in the in the current NSP 2015/16-2019/20. Land ownership was higher in rural (50.6%) than Urban (39.4). This increment is partly attributed to the sensitization, economic empowerment and existence of laws and policies that guarantee women's land and property ownership.

In spite of this positive effort, the criminalization of HIV presents a great obstacle to HIV response and affects the enjoyment of equal rights especially among PLHIV. HIV criminalization has caused false accusations and unfair judgment by the justice system as investigations are often not conclusive. UGANET has documented evidence that Courts of Law are using peoples HIV status to incriminate them. This affects women the more and causes double vulnerability by virtue of their sex, the economic and social burden they face at both family and societal level. Since the year 2017, UGANET's Legal Department has handled over 25 cases of discrimination based on ones HIV status-in a bid to help them access justice.

Key Challenges / Gaps

- The criminalization of HIV is likely to affect HIV response. It creates fear to test for HIV and disclosure
- Although over 70% of sectors have mainstreamed gender issues into their policies, strategies and interventions, reporting using disaggregated data is still weak. Current reporting is generalized making it difficult to assess the extent of engenderment and the meeting of different needs for men and women, boys and girls.
- No clear mechanism of engaging men engendering Social Support and Protection Programs across the different sectors

3.4 Systems Strengthening: Governance, Human Resource and Resource Mobilization

The NSP Goal for Systems Strengthening aims to achieve an effective and sustainable multi-sectoral HIV and AIDS service delivery system that ensures universal access and coverage of quality, efficient and safe services to the targeted population by 2020. Systems strengthening is a strategy to enable the country effectively implement interventions that should ultimately result into "Zero new HIV Infections, Zero AIDS-related deaths and Zero discrimination". This is to be achieved through Strategic Objectives and related Strategic Actions outlined in the NSP and the NPAP (2018/19 – 2019/20). This review looks at the progress made in implementation per Strategic Actions as outlined by Strategic Objectives. The Review findings have been presented according to the NSP thematic objectives under System Strengthening. Table 19 below shows the overall performance of NSP on some of the selected indicators and targets with respect to Systems Strengthening, M&E and Resource Mobilization during the year under review. For some indicators, no action has ever been taken to establish either baseline or progress during subsequent years of the Plan.

Table 16: Performance of NSP with respect to the indicators and targets under Systems Strengthening, M&E and Resource Mobilization Indicators

Indicators	Baseline	Target 2019/20	Achieved 2016/17	Achieved 2017/18	Achieved 2018/19	Assessment of Progress
Outcome 1: Strengthened governance and leadership of the multi sectoral HIV and AIDs response at all levels						
National commitments and policy instruments (NCPI) index score	54.6% (2013)	95%	91.0%	113.5%	129.0%[32]	Surpassed the target
Uganda AIDS Commission Management Index score	No data	No data	No data	No data	No data	No data accessed throughout the NSP period. The indicators should be redesigned or dropped
Outcome 2: Availability of human resources for delivery of quality HIV/AIDs services ensured						
Percentage of health facilities with the required staffing levels	N/A	80%	69%	73%	No data	Data for 2018/19 was not available to compare progress
Outcome 3: 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 STI drugs, HIV test kits and condoms for more than 1 month within past 12 months	STI drugs =N/A	90%	N/A		No data	Data could not be accessed to compare progress
	HIV test kits= N/A	90%	47%		No data	

[32] National Commitments Performance indexes for 2016, 2017 and 2018. Index for 2017 is computed for Government Assessment only as CSO data was missing

	Condoms = N/A	90%	N/A			
Percentage of health facilities providing ART services with no drug stock outs for more than 2 months in the last 12 months	N/A	N/A		15%		Data could not be accessed to compare progress
Outcome 4: Resources for HIV/AIDS mobilized and management streamlined for efficient utilization and accountability						
Percentage HIV and AIDS funding that comes from GOU	Government: 11% ADPs: 89%	Government: 40% ADPs: 60%	N/A	50% (PEPFAR)	12%	NSP target of 40% will not be achieved by 2020. However government makes significant contribution in terms of HR and infrastructure for HIV service delivery
Percentage of districts with HIV and AIDS costed Strategic Plans	N/A	100%	N/A	88% = 102 out of 116 districts @Mid Term 2017	No data	No data to measure progress.
Outcome 5: To strengthen coordination of the national HIV and AIDS response						
Percentage of districts with functional DACs with functional coordination structures	30%	100%			95.5% Urban (80.5%)	Good progress. The NSP target of 100% likely to be achieved
Percentage of districts with functional PHA Networks	90% (2010)	100%	No data	No data	95%	Good progress. The NSP target of 100% likely to be achieved
Percentage of Self Coordinating Entities (SCEs) with functional HIV/ AIDS committees	51%	70%	No data	No data	80.0%	The target has been surpassed
Outcome 6: National mechanism for generating comprehensive strengthened to ensure quality and timely HIV and AIDS information for monitoring and evaluating the NSP 2014/15-2019/20						
Percentage of sectors with costed HIV and AIDS M&E work plans	Not available	100%	No data		No data	Progress could not be assessed
Percentage of key sectors submitting timely and complete reports to UAC	Not available	100%	No data		No data	Progress could not be assessed

3.4.1 Strategic Objective 1: Strengthening the Governance and Leadership of the Multi-Sectoral HIV and AIDS Response at all Levels

With respect to strengthening governance and leadership of the response, there was strengthened and expanded engagement of leaders (political, religious, cultural and technical) to revitalize leadership and stewardship of the multi-sectoral response at all levels and key institutions, organizations, facilities and communities. This renewed leadership has been spearheaded by a flagship Presidential Fast Track Initiative (PFTI) to End HIV and AIDS as a public threat to national development by 2030. The PFTI lunched in 2017, has been aligned to the NSP. This initiative has made significant contribution to the fight against the epidemic through governance and leadership engagement. It has been a vehicle for mobilizing and involving leaders from various constituencies at national, regional, district and lower local levels such as political, social, cultural, and religious leaders, and the private sector among others. The Leadership's Accountability Framework has been operationalized and champions offered themselves to take leadership of the response by mobilizing and sensitizing their followers. The implementation of existing and new legal and policy

framework has facilitated the implementation of activities that yielded positive results during the year under the different thematic areas of the NSP.

The renewed wave of leadership under the PFTI has resulted into the following outcomes: mobilized leadership of political, economic, cultural / traditional, faith-based institutions and organizations as well as the development partners for enhanced national response. As a result, there is increased coordination at all levels and all sectors; increased Parliamentary oversight, strengthened decentralized response, enhanced resources mobilization efforts as well as commitment for increased domestic funding. As part enhanced leadership the First Lady continued to champion the elimination of Mother-to-Child Transmission of HIV/AIDS as well programmes SRH/HIV programs targeting AGYW.

UAC has continued to execute its leadership and coordination role through dialogue, advocacy and lobbying sessions with the leaders and partners at various levels. In order to strengthen the functioning of the partnership coordination mechanism/structures at decentralized levels UAC is working with MoFPED to operationalize the 0.1% allocation from Government to support strengthening the coordination function at the decentralized level. The Zonal Offices (now 3) have increased UAC's capacity to coordinate and support planning and budgeting for HIV and AIDS response by MDAs and DLGs. During this year the Karamoja Zonal Coordination Office became fully operational with support from the Embassy of Ireland through UNAIDS.

As part of strengthening leadership at the decentralized response, some selected districts have been supported to integrate HIV and AIDS in their plans and budget processes. For example, 7 districts in Karamoja Region have developed strategic plans aligned to the NSP. However, although the District AIDS Committees (DACs) are reported to place in most of the districts, their functionality remains weak mainly due to limited resources and capacity to carry out their roles and responsibilities. The functionality of lower level structures, namely the SACs, PACs, and VACs is equally very limited. Self-Coordinating Entities (SCEs) have been supported to scale-up their activities including establishing structures and mechanisms to reach lower levels. MDAs, faith based organizations and the media are engaging their constituencies and have formulated HIV/AIDS work place policies as a strategy to address HIV/AIDS at the workplace. A review of the reports by most MDAs indicates that they have prepared and implemented Workplace HIV and AIDS Policies in line with the PFTI. Examples include, MoES, MWE, EOC, Ministry of Foreign Affairs, UNRA, the IGG, Electoral Commission, the Judiciary, Ministry of Works and Transport, Ministry of Foreign Affairs, Ministry of Science and Technology, and Ministry of Agriculture, Animal Industry and Fisheries mention a few. Programmes, such as the Uganda Women Empowerment Programme, Youth Livelihood Programme, SAGE, and OVC have mainstreamed HIV and AIDS.

The National AIDS Documentation and information Centre (NADIC) has been strengthened to capture information and services provided by partners operating at national, district, municipalities and community. Equipment was procured in 2019 for Gender and HIV/AIDS Dash board visualization. A Gender Dashboard has been operationalized by Ministry of Gender Labour and Social Development to track and document gender interventions in the HIV response and a national team trained to support in generating reports from the dashboard. Efforts to ensure country ownership of the Situation Room were enhanced by procurement of the equipment and training of M&E and IT staff to be able to manage the Situation Room. However, the review could not access the required reference materials from NADIC to demonstrate its functionality.

UAC rolled out the PFTI messages across the country, under the theme 'Reaching men, girls and young women to reduce new HIV Infections'. Over 5,350 district leaders in all Local Governments benefitted from this intervention, including technical, religious, cultural and civic leaders, Civil Society representatives, PLHIV, the school children/young people, Refugees, Armed Personnel, the Boda-boda groups, the private sector, the community members and the Media fraternity. Information products like flyers, info graphics, and policy briefs were printed and disseminated. Over 2,350 HIV Quick facts sheets were printed in 2018 and were distributed to HIV stakeholders during PFTI activities in 3 regions and public assemblies. Should be moved to SS under Leadership

Key Challenges/Gaps

- Decentralized AIDS structures (DACs, SACs, PACs etc.) are week, thus affecting implementation and monitoring of HIV and AIDS activities at the decentralized level
- Integration of HIV/AIDS in district plans has been supported in only a few a districts. This support should be extended to other districts as part of strengthening the decentralized response in all the regions
- NADIC is not yet fully functional to serve as a repository as well as a National One Stop Centre for HIV/AIDS Information in the country

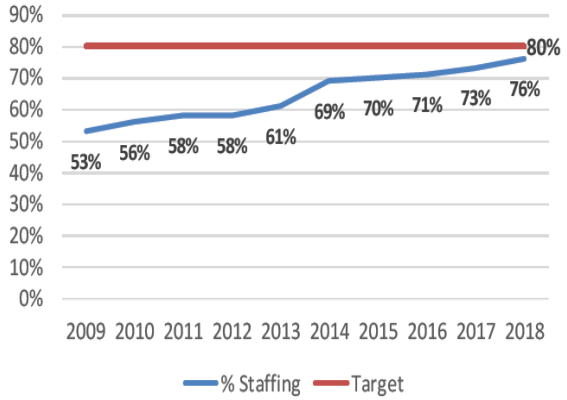
Table 17: Progress the country has made towards realization of the set global targets of 90-90-90 before 2020

	Indicator	Numbers	90 Cascade	Data Source
	Estimated number of people living with HIV	1,389,046	-	HIV Estimates
1st 90	People living with HIV who know their HIV status	1,168,106	89%	MoH (DHIS2) Dec 2018
2nd 90	People on ART	1,167,107	89%	
3rd 90	Virally suppressed among those tested for VL (Persons on ART receiving routine VL test = 914,987)	847,711	61% 90	

Source: UAC Report on PFTI Phase One

3.4.2 Strategic Objective 2: Ensuring Availability of Adequate Human Resource for Delivery of Quality HIV and AIDS Services

The 2017/18 HRH Audit Report published by the Ministry of Health covered 3,300 public and 468 PNFP health facilities. The public health facilities had a total of



62,942 established norms of which 47,661 were filled constituting 76% of available positions filled. This maintained the upward trend of public staffing levels observed over the last 9 years. Although this was a positive trend, it was still below the Health Sector Development Plan (HSDP) target of 80% by 2019.

The PNFP facilities had a total of 17,629 staffing norms as per the public staffing norm framework and 14,784 were filled constituting 84%. Marked improvement in staffing levels was realized for the doctors from 57% (2017) to 63% 2018, midwives from 78% (2018) to 94% (2018).

Despite continuous improvement in the overall national staffing level over time, there is persistent critical shortage of some health cadres like anaesthetic officers, dispensers, pharmacists, theatre assistants and public health nurses. There was however relative overstaffing for some cadres like Clinical Officers (104%) and Laboratory staff (102%). The Report further reveals that the health workforce employs more women than men at all levels of service delivery (at 54% females and 46% males) with nursing, midwifery and theatre staff cadres dominated by women while men dominated the higher-level and administrative positions such as senior consultants (over 85% male), directors (over 90% male) and District health officers (over 95% males). The staffing situation as of June 2018 is presented in Table 18

The review noted that, there are many health workers supported outside the government system and currently employed by donor funded programs/projects. It was observed that, closure of these programs severely affects HRH. In order to respond to this challenge, GOU is committed to implement a HR transition plan to absorb 40% front line staff from the various projects and programmes following their closure.

In order to enhance performance, Government is committed to implementation of the Supervision Performance Assessment Strategy and Reward strategy (SPARS) and some partners such as IDI and RHITES-SW are already providing support to implement the strategy. This is improving performance of the health facilities and their staff, in expectation of rewards.

As part of capacity building for training institutions, integration of HIV and AIDS in pre-service training curricular of tertiary institutions of learning is ongoing. There are also plans by Government to have HIV/AIDS mainstreamed into the curriculum (S1-S4) that will ready for rolling out in 2020. The Ministry of Education and Sports has integrated HIV/AIDS indicators into the EMIS. A Functional HIV TWG is in place to monitor progress on the identified and agreed upon indicators. However, there is still need for a comprehensive programme of

mainstreaming HIV and AIDS in the curriculum of other levels and institutions of education.

Integration of KP/PP programming has been adopted in all other prevention and treatment programs and tools operationalized in 23 sites (12 RRH & hotspots). MOH has made several strides in improving the capacity of service providers for KP friendly services provision including the development of PrEP guidelines and Training Curriculum for health workers (HWs) as well as a PrEP Communication Plan. The PrEP dashboard is used to capture information on PrEP and the indicators have been incorporated into the HMIS tools.

In the spirit of public private partnership in the delivery of HIV & AIDS services a One-Dollar Initiative has been initiated as local funding mechanism by the private sector to contribute to the HIV and AIDS response under Social Corporate Responsibility Policy.

Key Challenges and Gaps

- Shortage of Human Resource for Health due to closure of donor funded programs and projects
- Lack of a clear retention strategy to mitigate attrition of health staff as well as guide absorption of those previously on closed projects and programmes into Government establishment

Table 18: Public and PNFP Sectors; National Staffing Level, June 2018

Cost Centre	No of Units	Total Norms	Filled	Vacant	% Filled	% Vacant
MOH/Central institutions	21	9870	8073	1797	82%	18%
Districts	3,279	53,072	39,588	13,484	75%	25%
Total (public sector)	3,300	62,942	47,661	15,281	76%	24%
Cost Centre	No of Units	Total Norms	Filled	Vacant	% Filled	% Vacant
PNFPs	468	17,629	14,784	2845	84%	16%
Total (Public &PNFPs)	3,768	80,571	62,445	18,126	77.5%	22.5%
Cost Centre	No of Units	Total Norms	Filled	Vacant	% Filled	% Vacant

3.4.3 Strategic Objective 3: Strengthening the Procurement and Supply Chain Management System for Timely Delivery of Medical and Non-Medical Products, Goods and Services Required In the Delivery of HIV and AIDS Services

Over the past years the government has been working towards strengthening Procurement and Supply Chain Management System (PSM) to ensure that all medicines and commodities as well as goods and services selected for use in the public health system are relevant to the priority needs of the population reliable systems are in place for regular and accurate quantification of medicines/commodities needs at all levels of the health system.

Accordingly, efforts were made during the year to ensure uninterrupted availability of high quality health commodities (medical and non-medical), focusing on those to prevent and treat HIV/AIDS, TB and malaria, and to support family planning needs. Table 21 below shows the commitment of GOU towards improving Procurement and Supply Chain with a view minimize/eliminate stocks of essentials medical and non-medical supplies in both public and PNFP centers. However, the annual review shows that health commodities remain heavily donor funded and there was little improvement if any in terms of reducing the gap for supplies/commodities currently not funded by the GoU over the year under review. There is a need for increased investment in health commodities to avoid compromising patient care. GoU has almost 100% non-commitment (non-funded) on items such as laboratory commodities, Artesunate Injection Vials, mRDTs and ACTs.

The Ministry of Health, Quantification and Procurement Planning Unit (QPPU) worked with the USAID Global Health Supply Chain Program-Procurement and Supply Management (GHSC-PSM) and other partners to improve on forecasting and planning for health commodity supply needs for HIV/AIDS, malaria, and family planning. To expedite the process of importing health commodities and reduce delays, Uganda National Drug Authority NDA agreed to fast track clearance applications for donor-funding health commodity

shipments and customized its management information system (MIS) used to process clearance applications; now GHSC-PSM and other partners can enter their requests online, reducing the time needed by about five days. This has helped to reduce the long and inconsistent lead times for importing health commodities from as much as eight weeks to an average of four.

Districts were supported to conduct entries into web-based ARV & TB ordering system (WAOS/TWOS) and as a result 100% timely submission was achieved for cycle 6 FY 2018/19. Currently, all the 131 districts are ordering ARVs through the Web-based ordering and reporting system. Subsequently, this has benefitted all stakeholders, most importantly the patients who rely on life-saving health commodities.

The construction of Kajjansi Warehouse is still on-going, it is expected to strengthen supply chain management for medical and non-medical products through improved warehousing and distribution of HIV/AIDS and malaria commodities from the central and regional level to service delivery points.

Key Challenges/Gaps:

- Health commodities for HIV/AIDS are heavily donor funded. This makes it impossible to meet annual requirements/ forecasts without donor support
- Inadequate warehousing space at regional level to ensure safe storage and also facilitate timely distribution of HIV/AIDS commodities from central to regional level and to service delivery points
- Inadequate capacity in health facilities to regularly and correctly generate and update consumption information as well as commodity supply needs for HIV/AIDS to ensure accurate planning.

Table 19: Percentage of annual forecast (FY 2018/19) currently not funded by the GoU (Exchange rate of 3800 UGX / USD used)

Commodity category	FY 2017/18 Annual forecast (UGX)	FY 2017/18 % not funded by GOU	FY 2018/19 Annual forecast (UGX)	FY 2018/19 % Not funded by GOU	Remarks
Essentials Medicines	194,515,109,892	52	189,266,604,307	41	*Only public sector need
Laboratory (HIV test kits and other requirements)	329,131,592,600	97	348,542,429,600	97	Includes HIV test kits, VL, Crag, EID, CD4, TB Lab, OIs commodities
ACTs	184,323,941,566	95.6	157,053,475,766	94.8	Public and PNFP
Artesunate Injections Vials	56,051,760,103	100	42,740,769,809	100	Public and PNFP
mRDTs	35,026,887,049	100	30,137,386,338	100	Public and PNFP
ARVs	618,595,275,672	84.7	886,217,567,651	89.3	Public and PNFP
Reproductive Health	111,306,358,062	85.6	130,656,527,769	77.7	Public and PNFP
Anti-TB	15,081,619,398	53.6	29,044,364,744	75.9	Public and PNFP
Immunisation	24,654,300,096	31.1	29,026,569,324	41.4	
Overall	1,568,686,844,438		1,842,685,695,308		

Source: Quantification and Procurement Planning Unit of the Uganda Health Supply Chain Program of the Ministry of Health Uganda (2019)

3.4.4 Strategic Objective 4: Ensuring Coordination and Access to Quality HIV and AIDS Services

As part of strengthening coordination for enhanced service delivery project leaders have been trained in HIV and AIDS mainstreaming under PFTI. Linkages for referral support networks and systems at decentralized levels have been strengthened to improve on Care and Treatment. Furthermore, community based networks and systems have been strengthened for enhancing referral, access, utilization and quality of HIV and AIDS related services as described above in Section 3.2 on HIV Care and Treatment. Through the introduction of

Referral Focal Persons a total of 3,868 (Females 2,707 and Males 1,161) referrals were made in Western Uganda, and of these 3,743 (Females 2,620 and Males 1,123) were able to receive services, representing 96.7%.

At community level, HTS outreaches have been supported by various partners to target high risk men such as: boda boda riders and men who work in tea and sugar plantations, men in betting centers, bars and social gatherings with the help of community based networks and systems. Furthermore, a community level index client testing has been introduced and total of 3,024 clients were reached through index testing during the FY 2019/19 and 223 (7.4%) were confirmed HIV positive.
Equally, CSOs and the private sector service providers are actively involved in strengthening community systems, they have been supported to form networks, linkages and partnerships within the national AIDS coordination framework. New community CSO networks have been established and strengthened for coordination and networking to enhance HIV/AIDS service delivery.

As highlighted above, coordination of HIV service delivery at the district level remains weak due to the dysfunctional nature of AIDS Coordination structures. The remaining implementation period of the NSP needs to focus on strengthening coordination of HIV services at decentralized levels with the aim of optimizing available resources, eliminating duplication of service delivery as well as improving linkages between institutionalized facilities and community level structures, patient adherence support initiatives and referral.

3.4.5 Strategic Objective 5: Strengthening the Infrastructure for Scaling-Up the Delivery of Quality HIV and AIDS Services

During the year under review, health facilities offering HTS, ART and eMTCT have had their capacities enhanced in form of renovations of the existing infrastructure and remodeling of facilities as well as availing necessary equipment to improve the capacity to provide the package of services required for HIV and AIDS response, mitigate the impact of HIV and prevent new infections.

To improve on the provision of services of the Key Populations and Priority Populations including, the youth, PWDs and the elderly the existing infrastructure has been improved through establishment of additional structures such as; Drop-in centers for KPs, the elderly men (25+ years), and youth friendly/ responsive corners. These centres have been established in some districts of West Nile and Mid-western Uganda. Through Laboratory Systems Strengthening by IDI and other partners, HIV Testing for KPs is currently expanding to additional 45 districts and 91 facilities from the initial 25 districts in 2018. APN services have been introduced and by September 2019, APN services are expected to be rolled out to 500 sites, with a plan to eventually cover 740 Health facilities. By 2020, MOH targets to reach all health centers IIIs and above.

Furthermore, the MoH with the support of partners has strengthened laboratories to improve clinical care based on accessible test-based accurate diagnoses. During the year 2018/19 there has been reported improvement in coordination and monitoring of Laboratory systems to meet program needs for diagnosis, prevention, and treatment, surveillance, and disease control to ensure VL/EID and TB tests are received and utilized in a timely manner. All hubs can now download (VL/EID) results in real time. The aim is to build capacity for tracking the turnaround time (TAT) to facility, and to reduce the overall TAT across the board. This has subsequently contributed to the improved service delivery and tracking positivity in the communities.

Key Challenges/Gaps:

Laboratory infrastructure is still limited especially at lower health units. There is need to strengthen laboratory services at HCIIs

3.4.6 Strategic Objective 6: Mobilizing Resources and Streamline Management for Efficient Utilization and Accountability

A number of strategic actions in line with the NPAP 2018/19, were undertaken during the year to enhance resource mobilization and streamline management for efficient utilization and accountability. During the year, HIV response was funded mainly through the following mechanism, On Budget support by the GoU and External partners, direct project support by the Development Partners and the Out of Pocket contributions from the individual households. Table 12 shows funds received from the different sources during the year 2018/19.

In order to support and guide resource mobilization at the decentralized level, UAC presented an Issues Paper on HIV and AIDS Mainstreaming Guidelines to support LGs prepare and integrated HIV and AIDS in their BFP and Budget for FY 2018/19. As a follow up, Districts prepared annual work-plans for the roll-out of the PFTI and how to improve the HIV/AIDS response in their respective districts. The National Resource Mobilization Strategy and Plan was launched and disseminated. The plan spells out some of the strategies for raising additional resources for the HIV/AIDS response.

Efforts were made to mobilise HIV and AIDS resources through non-traditional bilateral and the private sector. As already mentioned, the One Dollar Initiative (ODI), was launched by the private sector to leverage on the business entities and the private sector players. Plan for launching the Initiative at the subnational were finalized as well. However, planned national and regional resource mobilization conferences through which non-traditional bilateral and multilateral actors and the private sector would have been mobilized for increased HIV and AIDS funding were not held during the period of implementation.

In order to streamline management for efficient utilization and accountability, some tools were developed and disseminated for enhancing planning and resource allocation based on diseases burden at District/facility levels. Subsequently, national programs have increasingly redirected the planning, resource allocation and implementation of HIV/AIDS response with focus on the magnitude of the disease burden in the regions and districts.

During the year a number of studies were carried out to guide HIV and AIDS financing as well as tracking of resources. These include, the infrastructure and GBV study; NSP harmonization study; and the NASA report that was completed. The rationalization of key implementing partners and resources has continued to be a key guide to promote efficient use of resources and minimize duplication of efforts and resources and hence reduction on resource wastes; furthermore, a midterm review of the PFTI was carried out as one of the efforts to assess resource alignments to HIV /AIDS priorities

The period has witnessed increased Government commitment though allocation of additional funding for HIV and AIDS response in the country. During the year under review GoU made further allocations of UGX 50 billion towards the HIV/AIDS ringed faced towards procurement of ARVs; Parliament passed into law for all MDAs to allocate to the HIV/AID and gender mainstreaming activities 0.1% of all non-wages finances. This is a good gesture towards enhancing domestic financing and sustainability of the national HIV response.

Key Challenges/Gaps

- Funding from GoU has remained at less than 15% of the Response requirements
- Late or non-submission of accountabilities results into late replenishments and low absorption of funds
- Private Sector involvement in the national response is still limited. Other than minimal corporate efforts by way of Cooperate Social Responsibility and medical covers, participation of the private and informal sector in mobilizing for HIV/AIDS remains weak and is lacking in many aspects
- Inadequate capacity for district based Public and non-public actors to mobilize, utilize and account for resources internally and externally. Equally, the capacity at national levels has not reached the desired level to ensure optimal utilization and accountability of resources.
- The HIV and AIDS Trust Fund is yet to be operationalized as it awaiting the Parliamentary process on enacting the operational guidelines hence, negating efforts of enhancing domestic funding for HIV and AIDS

- Standard HIV and AIDS indicators are yet to be finalized for the PBS tool to enable efficient tracking of HIV and AIDS resource flow in the D

3.4.6.1 Overall Funding for HIV and AIDS Response

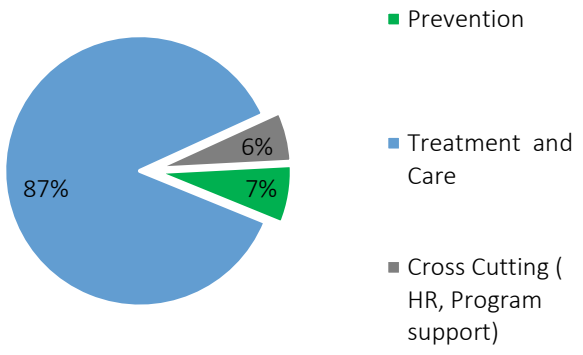
Overall the year under review had resources mobilized for the HIV/AIDS response to a tune estimated at US $ 693 million. This was contribution from the GoU, Development Partners and an estimate of the private sector contributions.

Table 20: Funds received during the year 2018/19

Resource Allocation 2018/19'	US $ (Millions)	Proportions
GOU	81.00	12%
USG /PEPFAR	420.54	61%
Global Fund	92.40	13%
UN Agencies	13.82	2%
Irish Aid	4.14	1%
CHAI	1.87	0%
HIV/AIDS Research funders	12.19	2%
Others ***	66.85	10%
Total	**692.82**	
** estimated contribution from Private sector extrapolated from NHA 2015/16 attributions		

3.4.6.2 GoU Funding

Over 70% the GoU HIV/AIDS specific allocations is directed towards the purchase of ARVS, while about 7% is earmarked for Prevention interventions and 6% towards Program and cross cutting interventions. It should be noted that GoU contribution to the HIV/AIDS response is a lot higher than reflected as much of the resources towards, the Human resources, utilities infrastructure and operational cost have not been accurately attributed to HIV/AIDS response.



3.4.6.3 USG/PEPFAR Funding

The USG has remained one of the Key partners in the HIV Response with funds allocations for the year under review reaching about US$ 420M. The funds allocation across the thematic areas is shown in the table below.

Table 21: USG Resources for the HIV/AIDS response 2018/19

USG Allocations 2018	US $ in Millions	Percentage (%)
Prevention	68.325	16.3
Care and Support	49.258	11.7
Treatment	267.118	63.5
Strategic Information	9.363	2.2
Health System Strengthening	7.907	1.9
Management and Operations	18.572	4.4
Totals	**420.543**	**100.0**

3.4.6.4 The Global Fund for AIDS Tuberculosis and Malaria (GFATM)

The GFATM has played a key role in financing for the three diseases of HIV/AIDS, TB and Malaria. The Fund has since inception financed resource of US $ 733 Million of which US $ 601 Million have been disbursed into the country over the period. For the year under review the funds for HIV/AIDS programs in the country was estimated at US 92.40 million. This was directed towards, Prevention, Care and Treatment, Program Management, Adolescents Girls and Young women, Differentiated HIV testing services and interventions towards Reducing Human rights related barriers. The figure below illustrates the distribution of the GFATM funding.

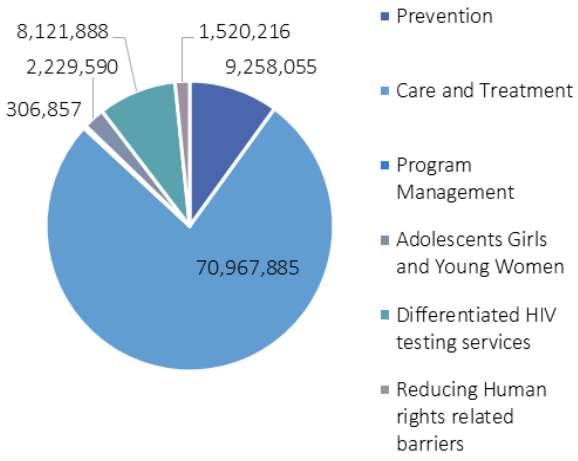


Figure 20: Allocations of GFATM 2018/19

3.4.6.5 HIV/AIDS Funding Analysis

The funding gap analysis has been generated based on the revised UAC National Priority Action Plan, 2018/19-2019/20. The projected resource commitments have been generated by assuming:

a) GoU implements at least a 0.1% proportion of the non-wage bill towards the HIV and AIDS mainstreaming interventions. This is projected to raise at least US $ 4.26 million of the projected non-wages allocations for 2019/20
b) All our funding mechanism: the Development partners, the Out of pocket and private sector contributions grow by at least 2% in the year 2019/20.

This would imply an overall funding gap of US$485.77M for the period 2018/19-2019/20. As illustrated in the table below.

Table 22: HIV/AIDS Funding gap Analysis 2018/19-2019/20

	2017/18	2018/19	2019/20	TOTAL (2018- 2020)
	USD M	**USD M**	**USD M**	**USD M**
Revised NPAP Cost Estimates	764.69	901.97	985.94	1,887.91
Projected Funding				
GoU		81.00	85.26	166.26
Development Partners		544.97	555.87	1,100.84
Out of Pocket/ Private sector contributions		66.85	68.19	135.04
Total Projected resources		692.82	709.32	1,402.14
Funding Gap		209.15	276.62	485.77

3.4.6.6 Bridging the Funding Gap

Efforts to narrow the funding gap will be driven by the extent to which the National Resource Mobilization Strategies are implemented. These included among others:

- Accelerating increase in allocation of from Government (Budget Support)
- Sustaining and consolidating the relationships with the existing partners for sustained and increased funding
- Optimal utilization of the available resources.- to ensure efficient use and accountability
- Diversifying into new and innovative ways of mobilizing resources
- Strengthening the capacity for resource mobilization across all sectors

Furthermore, the UAC with support from UNDP, undertook a study to assess extent to which HIV and GBV can be financed through the large capital infrastructure projects undertaken in the country. This is being explored to be a mechanism through which the HIV/AIDS response will tap into infrastructure finances. Similar projects have in the past supported renovations and refurbishments of health facilities, capacity enhancement for community and health work force, carried our HTS and referrals in catchment communities. Venues for optimal use of such resources will provide credence on aspects of mobilization of internal resources for the national response

3.5 SYSTEMS STRENGTHENING: MONITORING, EVALUATION AND RESEARCH

3.5.1 Strategic Objective 1: Strengthen the National Mechanism for Generating Comprehensive, Quality and Timely HIV and AIDS Information for M&E of the NSP

The NSP defines a national mechanism for generating comprehensive, quality and timely HIV and AIDS information for monitoring evaluation in order to track progress of NSP implementation and decision making. The National HIV and AIDS M&E Plan 2014/2015-2019/2020 is a performance Management tool for the NSP that prioritizes interventions aimed at creating a robust health information system that ensures production, analysis, and timely dissemination and use of reliable and accurate data on the key drivers influencing the HIV epidemic.

During the year under review, there were efforts made towards further systems strengthening for generating comprehensive quality and timely data on HIV and AIDS. To this end, a number of intervention were carried including a) routine data collection through i) DHIS2 by district local governments, ii) OVC MIS by Ministry of Gender Labour and Social Development, (MGLSD), iii) GBV data base also by the MGLSD, iv) NASA v) NHA and vi) Gender dashboard vii)MOES EMIS, viii) logistics; b) surveys such as i) Further analysis of UPHIA to disaggregate data by region ii) Re-essence study c) conducted national HIV estimates and KP Size estimation.

Districts and other implementing partners were supported to develop HIV and AIDS responsive plans and budgets as well as M& plans. For example, all the districts in Karamoja region were supported to develop their respective HIV and AIDS Strategic plans and requisite M&E frameworks in line with the National M&E plan putting emphasis, information generation, analysis, reporting and informed decision making. Furthermore, new data variables were identified for capture in the electronic version of the HMIS in collaboration with the Resource Centre in MoH and training of staff is ongoing. In addition, capacity of NADIC is being transformed into a One Stop Centre or knowledge hub for HIV prevention information. As part of this initiative, the NADIC portal subscription was renewed and the portal is now accessible online. Regular updates have been done on the content of the website to ensure that up-to-date information is disseminated to the stakeholders and the public. However, NADIC capacity to serve as a one-stop centre is still limited.

Additional HIV Situation room equipment were procured and a fibre optic cable was installed at CPHL Butabika. The DHIS2 Gender indicator dashboard server was successfully updated from the previous version.

Other initiatives carried out include, HIV mainstreaming in sectors and local government establishments among others; study on mainstreaming HIV in infrastructure projects and GBV; while a NSP Harmonization study was implemented. Also NASA and Macro-economic impact Studies were finalized. Mechanisms for capturing biomedical and non-biomedical HIV prevention data from all implementers are being established especially by district local governments. This is facilitating the incorporation of non-biomedical variables into sector MIS. National tools for capturing biomedical and non-biomedical data that have been developed and rolled out to facilitate collection of data from IPs. Furthermore, the national HIV and AIDS data quality assurance guidelines have been rolled out and implementation of data quality assessments has commenced.

The process of building M&E capacity for HIV and AIDS is ongoing and will culminate in institutionalizing the M&E TWG. The review noted that DHIS 2 data cleaning has been carried out at Sub National level and with the capacity built, this has been cascaded to district level. In addition, M&E capacity gaps assessment was conducted for MDAs, SCEs and Local Governments, especially the new LGs. The process of reviewing the national HMIS tools was finalized and training curriculum developed. Training on the revised tools is currently ongoing in all regions of the country.

The National M&E TWG validated data that was populated in the GAM tool as a requirement for the development of the Country HIV Estimates. The Country Estimates Team later worked with UNAIDS to generate the Country Estimates for the year 2018. The M&E function was further enhanced by the Mid-Term Review carried out in 2018 and the JAR which are in-built mechanisms for tracking progress of the NSP implementation. However, it is also important to ensure that the National HIV and AIDS Data Base is rolled out as a matter of urgency to strengthen the national mechanism for M&E of the NSP.

Key Challenges /Gaps

- Inadequate preparation for the JAR, in terms of ensuring availability of all necessary documentation as well reports from IPs and SCEs.
- Most of the reports form SCEs and IPs were not aligned to the NPAP/PFTI thematic Areas, Strategic Objectives, and planned interventions and targets.
- There were no consolidated annual reports from SCEs and IPS related to their agreed work plans for the year. In many instances, reports were available for one or two quarters making it difficult to do comprehensive analysis to determine trends analysis and establish realization of set target.

3.5.2 Strategic Objective 2: Promote Information Sharing and Utilization among Producers and Users of HIV and AIDS Data / Information at All Levels

During the year under review, Mid Term Review (MTR) of the NSP was conducted and has been disseminated alongside the new NPAP (2018/19-2019/20) which have informed this review. The 15 undertakings of JAR 2018 with Action Plan were developed with detailed implementation modalities and responsible institutions. Progress was reviewed and appears in this JAR 2019 Report. Operations research studies were initiated in FY 2018/19 and they include, but not limited to:

i DSD Models for Children and Adolescents receiving HIV Care in Uganda(ongoing)
ii DSD Implementation Science Study (ongoing)
iii Programme Quality and Efficiency through DSD for KP and AGYW (supported by Global Fund)
iv ANC Surveillance conducted as a matter of routine
v Stigma Index Studies with critical findings done
vi DSD Cost/Outcome Study (ongoing)
vii Economic Evaluation of HTS in Uganda (ongoing)
viii National AIDS Spending Assessments (NASA)

The studies will fill the information gap in the response especially when the next programing cycle begins.
In line with strengthening data collection, analysis and reporting, the data reviewed in the DHIS2 is linked to the Situation Room for visualization and real time information sharing to influence decision making for effective national response. The Situation Room, hosted by the Uganda AIDS Commission, offers an opportunity for expansion and linkage to MIS of other sectors and the various available dashboards (e.g. Gender, PMTCT etc.). District Local Governments were supported by IDI with support of PEPFAR to establish and maintain high quality data management and health information systems including online routine reporting into national databases. The intention is to eventually build a robust real-time Database System to facilitate monitoring and evaluation of NSP performance, to improve data generation and utilization from source to end-users.
There were also efforts to disseminate materials on HIV and AIDS at national and sub-national levels especially during national events; some key documents are posted on the UAC website and other materials can be found in the NADIC Center for reference purposes. The national events including, the Candle Light Memorial, World AIDS Day and Philly Lutaaya Commemoration are all used as avenues for information sharing among the public.

Key Challenges/Gaps

- Absence of a National Research Agenda constrains effective monitoring of research activities
- Limited research capacity at the sub national level. Most of the HIV and AIDS related researches are conducted by national level partners and are not disseminated at the district level
- The Mid Term Review Report and the revised NPAP (2018/2020) were not disseminated to guide partners and stakeholders in their annual HIV planning. Many strategic actions specified in the revised NPAP were not implemented during the year 2018/19.
- The reporting template for MDAs and SCEs has gaps in regard to linkage with NSP objectives, outcomes and outputs.
- The activities of the M&E TWG are not clearly defined. The review did not get any M&E report (quarterly or annual) regarding the activities of the TWG.

4 LESSONS LEARNED

This section presents lessons learned based on the reflection and some insights of the review. The identified lessons have informed some of the proposed recommendations while some others will be usefully applied in future programming for the national HIV and AIDS response to ensure some failures experienced in the past are not repeated.

- Faith based practitioners and cultural leaders/healers access local media (Local FM) on regular basis and tend to have large followers. Failure to meaningfully engage them in the national HIV response through empowering them with appropriate knowledge and skills impedes SBCC campaigns due to negative messages they disseminate to their followers
- Despite the increased number of IPs as well as HIV/AIDS resources, Karamoja sub-region continues to lag behind in the national response due to the deep rooted socio-cultural drivers that impede HIV prevention response
- Meaningful engagement of the media through empowering them with appropriate knowledge and skills can lead to enhanced participation in national HIV campaigns. Previous engagements of the media by UAC has resulted in increased participation including promotion of social accountability for the response.

- New innovations in Care and Treatment Program such as; Drop in Centres for KPs, use of dash boards for real time data visualization, ART regimen Optimizations in adults and children, national CQI initiative on VL, Retention and IPT, the 100 day IPT campaign, have led to improvements in performance during FY2018/19.
- Whereas, the recent WHO guidance released in July 2019 after the concluded studies in Botswana stated that there are no risks of birth defects due to DTG; there is still fear especially among women about birth defects with use of DTG hence the need for Uganda to rapidly revise and extensively disseminate its guidelines on DTG use.
- Community engagement and communication component of the HIV care and treatment remains weak and therefore needs strengthening. There is need to reach out to community with simplified correct, accurate and uniform information about prevention, care and treatment including the shift to DTG and the new Cotrimoxazole prophylaxis guidelines.

- Whereas the country has developed a robust system for third line program, pharmacovigilance is still inadequate. The program needs to strengthen the roll-out of active pharmacovigilance to all the target health facilities as the country moves to more complex ART regimens. Pharmacovigilance should include monitoring for drug resistance of ART medicines as well as other microbes not just HIV drugs.
- Social support and protection, if integrated appropriately, implemented and coordinated effectively by both the state and non-state actors, has the potential to reduce the spread of HIV through enhanced socio-economic and human rights interventions to reduced vulnerabilities and risks among PLHV and other vulnerable populations
- Limited support to Community Social Networks and support groups negatively impacts on HIV response across the different thematic areas. It affects among others; adherence to treatment through the weakened counselling services; escalates stigma and discrimination; affects advocacy for rights of PLHIV and the implementation of community level HIV prevention activities through the different strategies.
- There is close linkage between poverty, cultural norms and Gender Based Violence that disproportionately affects women and girls aged 15-49 years.

- Reinvigoration of leadership has not been accompanied with commitment for resource mobilization. Effective leadership needs to be accompanied with improved governance and commitment for resource mobilization from different sources and at all levels to ensure sustainability of the response in the country
- Government of Uganda commitment to allocate resources (0.1% allocation) for mainstreaming HIV in MDAs and DLGs as well as increasing 50% contribution to purchase of ARVs is a good gesture towards enhancing domestic financing and sustainability of the national HIV response.
- HIV reporting and dissemination remains a big challenge. Quarterly reports by IPs, Partners and sectors are never compiled into one comprehensive quarterly, bi-annual or annual reports, thus making it difficult to ascertain progress over the period.
- People with disability (PWD) though considered vulnerable to HIV, are not prioritized in the national response hence the need to engage and bring on board PWD as key actors in the national HIV response
- Despite some reported successful HIV/SRH interventions being implemented by some IPs, many adolescents and young people are not being reached. There is need for more comprehensive programming and meaningful engagement of AYP to ensure that all the young people are reached
- The Joint UN Programme of Support on AIDS in Uganda through the Karamoja United Nations HIV Programme (KARUNA) has demonstrated joint programming and synergy for expanded HIV coverage. Through this programme harmonization of different actors including local governments, UN agencies, ADPs, Cultural Leaders, NGOs, FBOs, and CBOs has been realized leading to optimal use of existing resources and reducing risks of duplication and wastage of resources

5 CONCLUSIONS AND RECOMMENDATIONS

5.1 CONCLUSIONS

This annual review shows that the country has continued to make progress in implementing some of the priority interventions of the NSP, while at the same time there has been a decline in achieving some of the targets. The report highlights specific achievements in all the different NSP Thematic areas and related sub-themes. Under Prevention and Systems Strengthening thematic areas, the Presidential Fast Track Initiative (PFTI) to ending HIV by 2030 has made a significant contribution to the national response through effective engagement of key stakeholders in the national response. Specifically, leaders at national and sub national levels, AIDS Development Partners, ministries, departments, cultural as well as religious leaders have been effectively mobilized for involvement in the national HIV response. Through this initiative, mainstreaming of HIV/AIDS has been reinvigorated in most sectors and agencies of government and Cultural and Religious Institutions have been mobilized to reach Men for enhanced involvement in the national response including uptake of services. The alignment of the PFT has resulted in affirmative action by the Government of Uganda to commit more resources (0.1% allocation) for mainstreaming HIV in MDAs and DLGs and increased 50% contribution to purchase of ARVs. Furthermore, Government has expressed commitment to absorb health care staff previously employed on projects once those projects are closed depending on need. Another landmark result is the establishment of the One Dollar Initiative by the Private Sector while the operationalization of the AIDS Trust Fund is in progress

Efforts have been made to improve coordination and quality of services through adoption policy guidelines that have been rolled out to ensure quality standards in provision of HTS, PMTCT & Care and Treatment services as well as creating an enabling environment for delivery of quality services to priority and key populations (PP/KP). Besides, several reforms have been introduced to scale up HIV prevention and care and treatment services e.g. new HTS approaches/modalities tailored towards those hard to reach and where there are major gaps including children, men and adolescents. New innovations such as, ART regimen optimizations in adults and children, national CQI initiative on VL, Retention and IPT, the 100 day IPT campaign, and advanced disease package have been introduced to scale up care and treatment services.

Whereas there is notable progress in prevention, care and treatment, the review noted that, although Social Support and Protection lays a strong foundation for programming HIV response to ensure the needs of PLHIV and other vulnerable populations are met, this thematic area is not prioritized. Socio-economic and human rights interventions that reduce the vulnerabilities and risks of PLHIV and other vulnerable populations were least funded during the year. The limited prioritization of Social Support is partly reflected in the Funding portfolio for FY 2018/2019 as well as the 2018 Midterm Review for the NSP that recommended a cost estimate of US $ 1,887.9 million for the remaining two years of implementation (2018-2020) with allocations per thematic area as follows; Prevention 24.7%, Care and Treatments 48.7%, Systems strengthening 24.7% and Social support 2.6%.

Considering that NSP is in its final year of implementation and the country is experiencing declining external support for HIV response, there is need to prioritize and scale up interventions in areas where there are still gaps while continuing to advocate for increased domestic funding in order to achieve the planned NSP targets by end of June 2020. Specifically, there is need to, strengthen linkage to care to counter the observed decline during year and enhance ART; strengthen sub-national and lower levels HIV coordination structures to mirror national level coordination structures and ensure effective planning and monitoring at the local level; strengthen the linkage and partnerships between public, private and community systems in service delivery for HIV and AIDS; increase domestic financing for HIV, in spite of Government commitments, there are still major funding gaps to fully implement interventions identified in the NSP and the NPAP; fast truck operationalization of the AIDS Trust Fund as part of enhancing the domestic funding and; lobby for the development and adoption of a common implementation and monitoring framework with agreed indicators for all sectors as a strategy to prioritize and advocate for additional resources for the national response among others. The following section outlines a number key recommendations to

address identified gaps and challenges with the view to accelerate NSP implementation to ensure achievement of the planned NSP targets by 2020 and also set pace for planning the next phase of HIV and AIDS implementation in the country.

5.2 RECOMMENDATIONS

This section presents recommended actions based on the identified gaps and challenges limiting access and utilization of the priority HIV services provided under the different thematic areas of the NSP. The proposed recommendations highlight areas that require urgent attention in order to improve implementation of NSP in the final year of implementation as well as inform the next phase of planning and programming for HIV and AIDS response in the country. For ease of implementation and assignment of responsibility, recommendations have been proposed at two levels; at the thematic level where specific recommendation have been made to inform programming and guide implementing partners in the different NSP thematic areas. General recommendations have also been made to guide overall planning for the NSP at Sectoral and National level.

5.2.1 Thematic level Recommendations

Prevention

i. Meaningfully engage faith based practitioners and traditional leaders/healers through empowering them with appropriate knowledge and skills to promote SBCC campaigns at the local level.
ii. Refocus condom programming to be data driven and more people centred rather than focusing on commodities
iii. Strengthen social marketing approach and support agencies to access commodities to expand their programming and distribution capacity
iv. Further strengthen female Condom programming to increase access and motivate its use among men and women
v. Harmonize KP data collection tools for the all IPs to improve KP reporting at the national level
vi. Allocate additional resources to Karamoja sub-region to address socio-cultural drivers of the epidemic with the view to enhance HIV services in the region
vii. Support continuous quarterly HTS support supervision and mentorship to all regions for quality enhancement of HIV and AIDS services in the country
viii. Revamp communication and advocacy for PMTCT and reintroduce Mother-Baby-Care Point (MBCP) to enhance retention as well as improve HIV Exposed infant care.
ix. Meaningfully engage the media and empower them with appropriate knowledge and skills for informed and balanced reporting on HIV and AIDS in the country
x. Simplify HIV prevention messages and translate into the major languages and widely disseminate HIV messages

Care and Treatment

i. Revisit the indicator on access to Pre-ART as this has been overtaken by test and treat strategy.
ii. Prioritize the completion and dissemination of the integrated alcohol and drug dependence reduction strategies for all individuals on HIV treatment (ART) under development to reduce drug toxicities and increase adherence.
iii. Increase awareness and ensure correct and accurate information is provided about the shift and eligibility criteria especially for women to DTG in order to counteract misinformation and myth surrounding DGT.

iv. Adopt, and prioritize the scale up of the case based surveillance system through the use of Unique Identifiers to improve on client tracking while maintaining their confidentiality.
v. Innovate and scale up interventions that reduce missed opportunity for screening for TB and Nutrition status of PLHIV's and strengthen initiation of PLHIV with TB confection and anti TB drugs and IPT.
vi. Identify other sources of funding for fluconazole since Pfizer is contemplating stopping providing free Fluconazole by FY 2021/22
vii. Pharmacovigilance should include monitoring for drug resistance of ART medicines as well as other microbes not just HIV drugs alone.

Social Support and Protection

i. Scale up GBV prevention and response interventions across both state and non-state actors through increased male engagement, access to economic opportunities and resources, right awareness for both men and women and other strategies to enhance family stability should be adopted.
ii. Advocate for increased domestic funding for social support and protection HIV response
iii. Anti-stigma interventions should be scaled up to address both the internal and external stigma. More emphasis should be put on addressing workplace and school based stigma for students and staff. Formation and provision of social support and protection to PLHIV support groups at the work place should be central in addressing stigma.
iv. Improve data collection and reporting for the sector through adoption of a comprehensive M&E framework that captures both qualitative and quantitative as well as gender disaggregation data to inform progress assessments and trend analysis.
v. Lobby the Uganda Law Reform Commission to review the HIV Criminal Law (2015) and assess its implications on PLHIV including its impact on the national HIV response.

Systems Strengthening

i. Strengthen health facility based leadership capacity for improved service delivery through adoption monitoring tools for regular performance measurement and tracking (e.g. score card method) and introduction of reward strategy in health facilities.
ii. Strengthen coordination structures at national and sub-national levels including PLHA and other networks through adoption of appropriate coordination, resource mobilization, monitoring and reporting guidelines
iii. Ensure district leaders including youth and women are integrated into the leadership positions and initiatives including, training for effective community engagement in the response at the local levels
iv. Promote and strengthen linkage between public sector and civil society and Public Private Partnerships (PP) in general to promote optimal use of existing resources to enhance service delivery
v. GoU and ADPs should prioritize urban 'hard-to-reach' populations especially key and priority populations with tailored response programmes led by the urban local leadership. To this end Government and IPs should work with "AMICAALL" an umbrella organisation for Urban Leaders for effective local level mobilization and sustenance of the programme
vi. Strengthen district level monitoring and evaluation through supporting district M&E plans and integration of HIV support supervision into other district based activities
vii. Strengthen condom programming for increased distribution and accessibility through operationalization and roll-out the Condom Logistics Management Information System (CLMIS) to districts that do not have this system.

5.2.2 General Recommendations

1. Advocate for the development of a common implementation and monitoring framework with agreed indicators to guide implementation of the national HIV response within the framework of NDP III. This requires a national M&E system that has backward and forward linkages and feedback mechanism for comprehensive reporting by all Sectors.
2. UAC should maintain high level political engagement involving the Parliament of Uganda, the Cabinet and the Presidency for sustained HIV and AIDS response in the country
3. Support KP size estimation at national and sub national level to ensure targeted programming and monitoring based on KP size estimates for the different Key Population categories country wide.
4. Promote the use of web based technology and social media for age and population specific public education to enhance awareness and uptake of HIV and AIDS services including; HIV testing, linkage to care and adherence on ART.
5. Conduct further analysis on UPHIA data and do finer HIV data dis-aggregation to determine variations in regional performances and triangulation with other data sources to inform programming at national and sub-national level
6. Expand and consolidate the CQI collaborative to include the community systems and ensure engagement of all stakeholders and institutionalization of the approach.
7. Strengthen social support protection in the public sectors including re-defining this thematic area for better understanding, programming and monitoring among by the key actors
8. UAC should commission a National Survey to determine the vulnerability index of PLHIV to inform strategic planning and programming within sectors as well as spur the advocacy efforts, resource mobilization and a stronger linkage and integration of the needs of PLHIV in development programmes, under the Social Support thematic area
9. Persons with disability (PWD) should be prioritized in the national response. The PFTI needs to engage and bring on board PWD constituency as key actor in the national response
10. Enhance socio-economic interventions for key populations and PWDs as part of social support and protection services offered under national HIV and AIDS response.
11. Operationalize HIV mainstreaming in all MDAs and DLGs, as well as other institutions and organizations especially targeting PLHIV, the hard to reach, Key and Priority populations.
12. Advocate for increased domestic financing to specifically scale up prevention, and social support and protection through Government budgetary allocations and regular resource tracking for transparency and accountability (NASA studies conducted regularly)
13. Integration of HIV response in the broader Reproductive Health (RH) and other public health programs in order to tap into existing resources under the new programs
14. Target 100% absorption of project staff accredited to offer HIV and AIDS services into government health facilities at all levels to improve the health workforce for HIV and AIDS service
15. Strengthen the capacity National Documentation and Information Center (NADIC) at UAC for multi-sectoral data and information management and to serve as a repository and “one stop centre” for HIV and AID information in the country.
16. Streamline coordination of HIV research and utilization of findings for decision making and programming through adoption of a harmonized national research agenda that sets research priorities to guide academia, IPs, sectors and establish a mechanism to roll out best practices and promising innovations to implementation and scale up.

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ANNEXES

ANNEX 1: HEALTH FACILITIES TRAINED IN DSD IN FY 2018/19

Implementing Partners	No. of Sites	No of sites Trained	% trained
Uganda cares	50	37	74%
Baylor Uganda	141	140	99.3%
Hiwa	15	15	100%
IDI -KHP	128	128	100%
IDI -BHP	83	83	100%
IDI WNP	125	125	100%
Mild-may	98	96	98&
MURWAP	85	71	83.5%
RHITES A	75	75	100%
RHITES EC	126	125	99.2%
RHITES SW	196	152	77.6
RHSP	190	134	69.8%
TASO-Teso	93	82	88.2%
Total	**1,830**	**1,418**	**77.4%**

ANNEX 2: LIST OF STAKEHOLDERS CONSULTED

No.	Name/Designation	Organization	Telephone	Email
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21	Dr. Eddie S Mukooyo, Chairman	UAC	0772400641	emukooyo@gmail.com
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ANNEX 3: PROGRESS ON IMPLEMENTATION OF JOINT AIDS REVIEW UNDERTAKING FOR 2018/19

Undertaking	Output	Lead Institution	Progress Made	Remarks
Objective 1: Engage men in HIV Prevention and close the tap on new infections particularly among adolescent girls and young women				
1.1 Empower community structures including cultural/traditional/Religious institutions, CBOs and CHEWs among others to champion targeted SBCC interventions segmented for young people, women, men, PWDs and the elderly	Young people, women, men, PWDs and elderly reached through community structures	Ministry of Gender; MoH, UAC		
1.2 Provide technical guidance for KPs Mapping and Size Estimation 1.3 Review and roll out MARPS framework to include MARPs service delivery models including Drop in Centers, Strengthen capacities and empower MARPs and PLHIV in Human rights so they understand, exercise and claim their rights	Guidelines for KPs Mapping and size estimation developed and disseminated to the relevant IPs and stakeholders MARPS Programming scaled up and strengthened in all identified areas with MARPS	UAC, MoH, IPs	• KP size and profile estimate triangulation study was conducted during the year Under PEPFAR CDC ten million USD Key Population Investment Fund has been granted to improve capacity of key population organization in 53 CDC supported districts • The KP tools and indicators are available waiting for validation and to roll out in the health facilities • KP & VGYW differentiated services delivery model guidelines were developed under GF • IDU harm reduction guidelines were drafted in preparation for commencement of IDU medically assisted treatment center at Butabika hospital will open in October 2019 to rehabilitate IDU • Expanded PrEP provision in 73 of the planned 90 sites located in hot spots were activated to implement PrEP. • A PrEP communication strategy was developed to PrEP implementation	
1.4 Integration of HIV, SRH and GBV services in facilities based on recommended framework and tools	Facilities providing integrated comprehensive services	MoH	• EIMC was successfully piloted in Teso and Karamoja regions • Over 1000 shang ring devices were inserted and successfully removed • One DQA was done in Q3	

Objective 2: Accelerate Implementation of Test and Treat and attainment of the fast track 90-90-90 targets particularly among men and young people				
2.1 Strengthen ART services in infants, children and adolescents; • Treatment and adherence support • Address barriers to treatment	Increased uptake of ART among men and young people	MoH	• TLD roll out • QI optimization by C&T team • 1,418 out of 1,832 (77.4%) ART sites had been trained on DSD • 1,139 out of 1,418 (80.3%) trained ART sites (62.2% of all ART sites) were offering differentiated HIV Care and Treatment services • 1,002,927 out of 1,200,000 (83.6%) PLHIV active in care were receiving differentiated HIV C&T services. • Client mix; 328,375 enrolled on FBIM (33% Vs a target of less than 20%), 132,856 enrolled on FBG (13% Vs target of 10%), 425,573 enrolled on FTDR (42% Vs a target of 45%), 46,906 enrolled on CDDP (5% Vs a target of 10%) and 69,217 enrolled on CCLAD (7% Vs a target of 15%)	
2.2 Strengthen target testing models and approaches	Reduced Test and Treat gap	MoH	• Developed the HTS optimization guidance and rolled out the HTS addendum that provides for APN & HIVST • Developed the site and tester accreditation and certification standards • Recency testing protocol approved, national ToT done and implementation commenced	
Objective 3: Consolidate progress on elimination of mother-to-child-transmission of HIV				
3.1 Strengthen community structures to facilitate follow up of mother – Baby pairs	Increased retention among mother-baby pairs	MoH; UAC, Ministry of Gender,	• Bring back mother baby campaign implemented in the 11 worst performing districts. Supported/mentorships in the 11 poorly preforming districts in PMTCT (Pader, Luuka, Nakapiripirit, Bulambuli, Kween, Kapchorwa, Amudat, Abim, Nabilatuk, Kaabong, and Napak) • Family Connect-eMTCT model was implemented in HFs in 13 districts and Karamoja region • The G-ANC model was successfully piloted at 33 HFs. MoH is currently conducting the 1 year end line evaluation • The training curriculum for health workers was piloted in was piloted in West Nile, Uganda Prison Services, Greater Masaka region	

3.2 Targeted interventions and best practices to increase retention of exposed infants in care	Increased retention among HEIs	MoH	• The 18 months follow-up PMTCT impact evaluation study across the 10 regions was completed. The MoH has now embarked on writing the baseline and follow up reports	
Objective 4: Ensure financial sustainability for the HIV and AIDS response				
4.1 Establish mechanisms for increasing domestic funding for the HIV Response	One dollar Initiative operational AIDS Trust Fund operational	UAC; Private Sector, Parliament	• Under the Private sector, resources are being mobilized form individuals and organizations under the One Dollar Initiative • ATF regulations were approved • Engaged stakeholder to develop a Roadmap which will be implemented by the Ministry of Health	
4.2 Map out HIV funding support and investments by various partners including Government of Uganda, the Global Fund and other in-country financing mechanisms by Partners for better alignment of grants and avoid duplication	Better alignment and prioritization to guide HIV resource allocation	UAC, ADPSs, Private Sector,	• Technical Assistance was hired to develop guidelines and software for Harmonization of resources and alignment to GoU Chart of Accounts. The process sis still ongoing	
4.3 Fast track NASA institutionalization and broaden its scope to include resource mobilization and expenditure by the Private Sector	NASA Institutionalized	UAC; MAKsPH, UBOS	• Phase 1 of NASA was completed including Capacity biding for some Local Governments • The Road Map for scale up to all the Local governments and the MDAs • A concept and ToRs to conduct out of Pocket with support from Uganda Bureau of Statistics	
4.4 Establish a vote output - Monitor to ensure compliance of the 0.1% enshrined in the national mainstreaming strategy	Sectors reporting on HIV Mainstreaming	UAC; MoFPED	• Discussions are in advance stages with Ministry of Finance to create a Vote output for this to facilitate Reporting and tracking.	
Objective 5: Ensure institutional effectiveness for a well-coordinated multi-sectoral response				
1.1 Strengthen the multisectoral data and information management system that includes a Community Health Information Management System and integrates non-biomedical data. *1.2* Improve the functionality and management of the Situation Room, built UAC capacity for operationalization and rolls out at national and sub-national level and include more indicators	Functional NADIC serving as a national HIV Information and Knowledge Management Centre Community Health	UAC, MoH	• The E Mapping database capabilities have been studied as the immediate innovation for collection of data for Behavioral and Structural indicators from the districts • The Situation room has been adopted by the country with an initial Business Matrix of 33 indicators. • Plans are underway to incorporate more indicators beyond HIV and AIDS • National level Capacity Building has been conducted	

to cover entire health sector and social indicators including OVC MIS	Information Management System and that integrates non-biomedical data developed Situation Room rolled out to District level		• Plans are underway to link the existing Management Information Systems and Dash Board to the Situation Room	
5.3 Ensure effective coordination of research and use of findings for decision making and programming	Annual National AIDS Research Agenda developed National HIV and AIDS Conference convened Functional DACs and SACS	UAC; MoH, Academia, MoLG	• The RASP SCE is being revitalized to coordinate the Research agenda and Utilize the existing research database • The DACs have been revitalized with coverage of 93%. The Gaps exist in the newly created districts and plans are underway to engage and Train them. The SACs Coverage is low at about 35%, emphasis was put on DACs as the initial Cascade. More Municipalities and Municipal Councils have been brought on board.	

ANNEX 4: PLANNED JOINT AIDS REVIEW UNDERTAKING FOR 2019/2020

UNDERTAKING	OUTPUT	LEAD INSTITUTION
Objective 1: Strengthening Primary Prevention		
1.1 Optimize primary HIV prevention interventions	• Revised SMC policy providing for Shang ring, Early infant Circumcision and reusable kits rolled out • Subnational condom distribution structures revitalised and stocked with condoms • PrEP provision rolled out to reach 143 sites, in additional to the current 71 sites • KP M& E tools finalized, adopted and disseminated widely among IPs • SBCC guidelines and tools revised and roll out to ensure inclusiveness of all targets groups including People with Disability (PWD)	UAC, MoH, ADPs
1.2 Strengthen coordination and programming for Key Populations at National and Sub National levels	• The concept of Key Populations redefined in the context of Uganda's high risk groups • The National Programing Framework including M&E for Key Populations reviewed, updated and disseminated • Coordination structures for KPs rreviewed and strengthened	UAC, MoH, ADPs
1.3 Review Social Cultural interventions to address new and emerging social cultural practices	• Key messages tailored to new social cultural practices developed in a consultation with the cultural institutions and disseminated • Religious and cultural institutions meaningfully engaged and supported at all levels in the planning and implementation of HIV and GBV interventions	UAC, MoH, ADPs, MGLSD, IRCU
Objective 2: Fast Tracking the 90-90-90		
2.1 Scale up, strengthen and optimize the HIV testing services. Self-Testing and APN approach	• HIV self-testing and Assisted Partner Notification (APN) rolled out to all districts • Framework for HIV testing and accreditation rolled out to all districts • Revised HIV testing and screening tool for adults and children rolled out in all sites	MoH, ADPs
2.2 Review Guidelines for DTG	• Guidelines for DGT reviewed and widely disseminated at community level • Clear massages on DTG developed and disseminated among users	
2.3 Mitigate ART Drug Resistance among PLHIV	• Pharmacovigilance strategies developed to monitor drug resistance	
Objective 3: Scaling up EMTCT		
3.1 Develop effective mechanisms to track mothers in eMTCT Program	• Differentiated Services delivery models for PMTCT rolled out in all districts • Baby Mother Pair Campaign reintroduced and implemented in all districts	MoH, ADPs DLGs

3.2 Improve data management for the program	• Regular data quality audits conducted in all districts to inform decision making and programing	
3.3 Strengthen integration of RH & HIV/AIDS services	• Syphilis testing and treatment, and Hepatitis B testing and Referral integrated in eMTCT Program	
Objective 4: Sustainable Financing		
4.1 Fast track the institutionalization of NASA	• NASA institutionalised and conducted as part of the Annual AIDS review • HIV and AIDS resources tracked effectively to guide planning, allocation and optimal utilization of existing resources	MoFPED, UAC, MoH
4.2 Fast Track operationalization of the AIDS Trust Fund	• Guidelines for operation of the AIDS Trust Fund developed • AIDS Trust Fund Utilization Plan developed • AIDS Trust Fund Annual Report compiled and disseminated	
Objective 5: Effective Partnership & Coordination		
5.1 Strengthen AIDS Coordination Structures at national and sub national levels	• AIDS Coordination structures and Guidelines revised and widely disseminated at national and district level • Coordination Structures revitalised and supported to carry out their mandate • Community Systems strengthened for effective service delivery and monitoring at the local level	UAC, MoFPED, DLGs
5.2 Scale up awareness and implementation of the HIV Mainstreaming Guidelines	• 80% of MDAs implementing HIV Workplace policies • Utilization of the 0.1% allocation of the non-wage bill towards the HIV and AIDS mainstreaming interventions in MDAs and DLGs monitored and reported on • Increased uptake of HIV services across all Sectors	
Objective 6: Addressing Structural and Behavioral Barriers		
6.1 Strengthen programs and policies that economically empower AGYW	• Increased engagement of the AGYW in all HIV Programs at all levels • Increased allocation of HIV and AIDS resources for economic empowerment of AGYW • Increased number of AGYW benefiting from economic empowerment programs	MoGLSD, UAC, MoH, UCC, ADPs, AGYW Networks
6.2 Build capacity of media in appropriate reporting on HIV and AIDS	• Guidelines for Media reporting on HIV and AIDS developed and disseminated among media practioners • Media houses and practioners meaningfully engaged in the national AIDS response • More regular, accurate and effective reporting on the national HIV multi sectoral response	
6.3 Develop Family Centred approaches to reduce and manage new infections	• Guidelines for family centred approached developed and disseminated • Strengthened Family Support Systems	