UGANDA

Country Operational Plan

(COP) 2018

Strategic Direction Summary

April 17, 2018

PEPFAR

U.S. President's Emergency Plan for AIDS Relief

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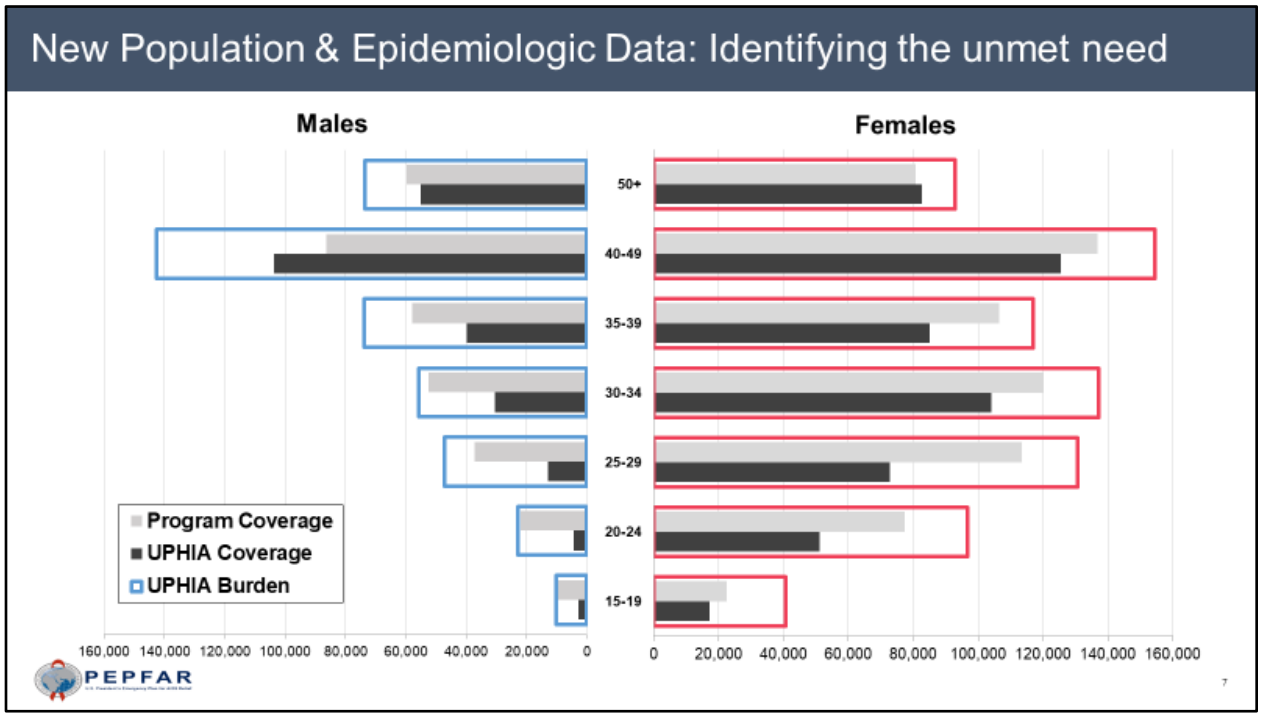
1.0 Goal Statement

The 2018 PEPFAR Country Operational Plan (COP18) for Uganda is working towards epidemic control via both the UNAIDS 90-90-90 goals and the national 95-95-95 goals for both sexes and across ten age bands. Uganda is home to an estimated 1.3 million people living with HIV (PLHIV)[1]. According to the Uganda Population-based HIV Impact Assessment survey (UPHIA) in 2016-2017 72.5 percent of adults 15-64 knew their status; of those who knew their status, 90.4 percent were already receiving life-saving ART and 83.7 percent of those on treatment were virally suppressed.[2] Currently, there are 980,000 PLHIV on ART.[3] However, there are challenges. Approximately 320,000 PLHIV in Uganda remain undiagnosed and 16% of those that are on treatment do not have viral suppression. Furthermore, progress has been uneven, with unmet need for ART disproportionately found among women aged 20-39 and men aged 25-39.[4] New HIV infections are also most frequently found among women aged 25-34 and men aged 35-49.[5]



[1] ICAP/CDC/MOH. Summary Sheet: Uganda Population-based HIV Impact Assessment, 2016-2017. (New York, 2018). http://phia.icap.columbia.edu/wp-content/uploads/2017/09/UPHIA-Uganda-factsheet_A4.new_HR.pdf (accessed 3/29/2018)
[2] Unpublished UPHIA data, 2017
[3] Unpublished program data, 2017
[4] Unpublished UPHIA data, 2017.
[5] Unpublished UPHIA data, 2017.

With Spectrum estimated new infections and deaths of 48,254 and 28,322[6] respectively, the 2019 Spectrum PLHIV estimates used for COP 2018 planning is 1,331,508 PLHIV. In COP18, the overarching goal is to reach, test, diagnose, link, treat, and retain 126,390 of the remaining PLHIV in Uganda, bringing Uganda to a national coverage of 95 percent. COP18 will target the most underserved age and sex bands, while preventing HIV transmission among the most vulnerable populations. COP18 will focus implementation on fidelity and scale up of the most effective technical and programmatic approaches, eliminating barriers to the consistent use of proven interventions. PEPFAR Uganda will also improve uptake of critical interventions through better partner engagement and evidence-based monitoring and targeting.

PEPFAR's global 2017-2020 Strategy for Accelerating HIV/AIDS Epidemic Control sets a bold course for achieving epidemic control.[7] Uganda's COP18 priorities are anchored in the priorities enumerated in the Strategy. COP18 seeks to:

- Accelerate optimized HIV testing and treatment strategies, particularly to reach men, as half of men do not know their status and are not on treatment.
- Expand HIV prevention, particularly for women under 25 and men under 30.
- Make continuous use of granular data to inform program design and increase impact so that programs not showing results can be stopped and interventions showing promise can be scaled.

Achieving epidemic control by 2020 requires prioritizing investments. As the public sector will account for 80 percent of new PLHIV initiating ART, COP18 continues to strategically shift resources towards targeted support to public sector health facilities and systems.[8] PEPFAR Uganda has also refined its focus to six crucial areas of health systems strengthening: 1) financing and sustainability; 2) commodity and supply chain systems; 3) human resources for health; 4) laboratory services; 5) health information systems; 6) governance, management, and civic participation.

PEPFAR Uganda has embraced a wider consultation framework for the development of COP18, engaging extensively with the Ministry of Health (MOH), civil society, and development partners. COP18 further cements PEPFAR's partnership with the Government of Uganda (GOU) using "Implementation Letters" already in place to memorialize responsibilities in key areas and to enable MOH leadership and engagement in policy and program issues. Additionally, weekly reporting of five key indicators at site level, weekly partner meetings, and monthly interagency partner meetings will ensure that best practices are shared and allow for short 'learning loops' to address any challenges in implementation during the immediate 'surge strategy' and throughout COP18.

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[6] Spectrum 2018 estimate.

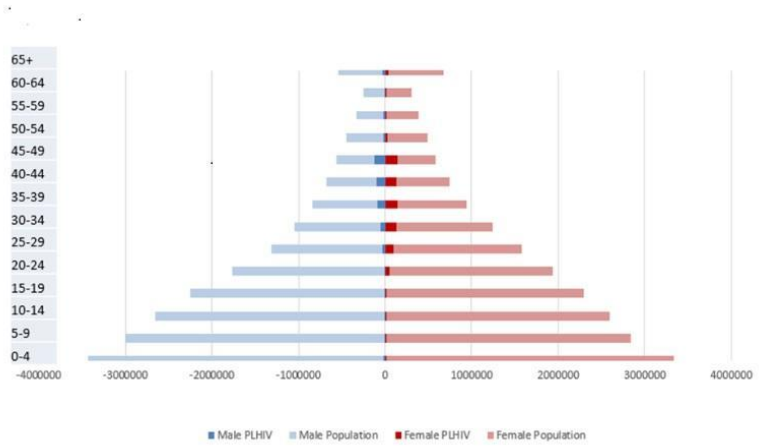
[7] PEPFAR. *Strategy for Accelerating HIV/AIDS Epidemic Control, 2017-2020.* (Washington, D.C.: Department of State, 2017).

[8] Program data, future projections.

2.0 Epidemic, Response, and Program Context

2.1 Summary Statistics, Disease Burden and Country Profile

By December 2018, Uganda will have a population of 38.8 million.[9] Uganda's annual population growth is 3.3 percent and its total fertility rate is 5.4 making it the third fastest growing population in the world.[10] Additionally, 46 percent of the population is under age 15 and 66 percent is under age 24.[11] The contraceptive prevalence rate among married women and unmarried sexually active women is 39 percent and 51 percent respectively, while unmet need for contraceptives in married and unmarried sexually active women is 28 percent and 32 percent respectively.[12] Almost 60 percent of pregnant women attend four or more antenatal visits (ANC4), 97 percent of pregnant women receive antenatal care from a skilled provider, and 73 percent deliver in a health facility.[13] Over the past decade, infant mortality decreased from 71 deaths per 100,000 live births to 43 deaths per 100,000 live births and the under-5 mortality rate has declined from 116 deaths per 1,000 live births (2002-2006) to 64 deaths per 1,000 live births (2012-2016).[14] The population pyramid demonstrates that Uganda has a large "youth bulge" with 46 percent of the population under age 15.[15] The burden of HIV is more concentrated in those age 20 and above.[16]



While Uganda has been successful in reducing poverty over the last 20 years, poverty reduction has slowed since 2006. More than a third of Ugandans still live on less than US $1.90/day, a

[9] UBOS. *Population Projections 2015-2020*. (Kampala: UBOS, 2014). http://www.ubos.org/onlinefiles/uploads/ubos/census_2014_regional_reports/Population%20Projections_2015_2020.pdf (accessed 3/6/2018)
[10] UBOS. *Uganda Demographic and Health Survey 2016: Key Indicators Report*. (Kampala: UBOS, 2017). https://dhsprogram.com/pubs/pdf/PR80/PR80.pdf (accessed 3/6/2018)
[11] UBOS, 2014.
[12] UBOS, 2017.
[13] UBOS, 2017.
[14] UBOS, 2017.
[15] UBOS, 2017.
[16] Unpublished UPHIA data, 2017; UBOS, 2017.

poverty threshold that was set over 20 years ago and which is now too low.[17] Poverty reduction in Uganda has been based mainly on agricultural income growth and favorable climatic conditions so economic vulnerability remains high.[18] Uganda's Gross National Income (GNI) per capita is US $630 with an annual Gross Domestic Product (GDP) growth of 4.7 percent in 2016.[19] For Uganda to attain the ambitious goals set forth in its Vision 2040,[20] a fundamental shift in production from low-investment, informal activities to higher-capital, more productive employment is required, as is a more rapid reduction in fertility rates. Effective public investment in services such as education, health, agricultural extension, and social and economic safety nets will be crucial.[21]

Uganda ranks 170th out of 190 countries in per capita health expenditure, with a per capita per annum expenditure on health of US $46.1, the lowest it has been since 2007.[22] Moreover, GOU has proposed a health budget for 2018/2019 with no change in spending by the GOU and an anticipated decrease of funding from external financing of 22 percent (which is the equivalent of US $6,0652,571 assuming an exchange rate of UGX 3500/US $1).[23]

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[17] World Bank. *Uganda Poverty Assessment 2016: Fact Sheet.* (Washington, D.C.: World Bank, 2016). http://www.worldbank.org/en/country/uganda/brief/uganda-poverty-assessment-2016-fact-sheet (accessed 3/6/2018)

[18] World Bank. *Agriculture: A Driver of Growth and Poverty Reduction.* (Washington, D.C.: World Bank, 2016). http://www.worldbank.org/en/country/uganda/publication/uganda-poverty-assessment-agriculture-a-driver-of-growth-and-poverty-reduction (accessed 3/9/2018)

[19] World Bank. *Databank: Uganda*. (Washington, D.C.: World Bank, 2018). https://data.worldbank.org/country/Uganda (accessed 3/6/2018)

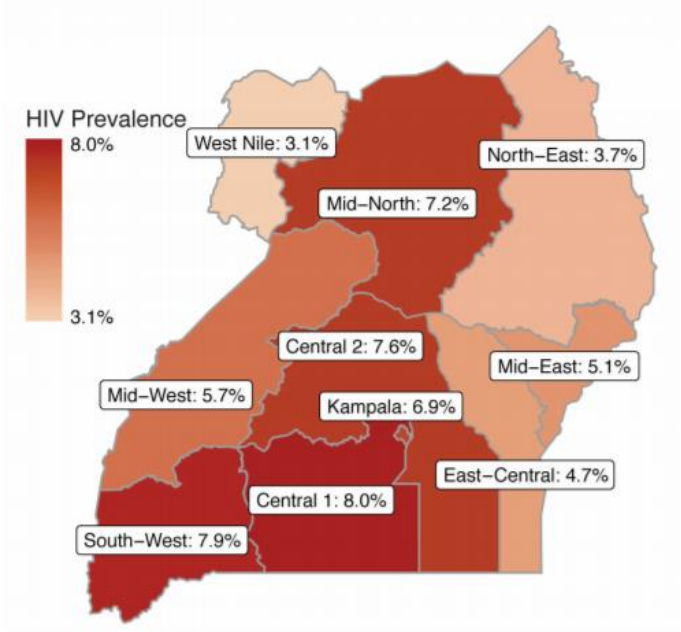
[20] Government of Uganda. *Uganda Vision 2040*. (Kampala: National Planning Authority, 2013). http://npa.ug/wp-content/themes/npatheme/documents/vision2040.pdf (accessed 3/15/2018).

[21] World Bank. *Uganda Poverty Assessment 2016: Fact Sheet. (*Washington, D.C.: World Bank, 2016). http://www.worldbank.org/en/country/uganda/brief/uganda-poverty-assessment-2016-fact-sheet (accessed 3/6/2018)

[22] WHO. *Global Health Observatory Data Repository.* (Geneva: WHO, 2017). http://apps.who.int/gho/data/node.main.GHEDCHEpcUSSHA2011?lang=en (accessed 3/6/2018)

[23] MOH. *Health Sector Budget Framework 2018/19-2022/3.* (Kampala: MOH, 2018). http://budget.go.ug/budget/sites/default/files/Sector%20Budget%20Docs/08%20Health.pdf (accessed 3/9/2018)

Ravaged by the HIV/AIDS epidemic, Ugandan life expectancy was only 44.3 years in 2000. Major gains in addressing the HIV epidemic, along with other health and economic interventions, have resulted in life expectancy increasing to 60 years for men and 64 years for women in 2015.[24] The Spectrum estimate for the total burden of HIV in Uganda, taking into account the most recent UPHIA data, is 1,318,736 in 2018 and 1,331,508 in 2019. This is a decrease from 2016 estimate of 1.5 million. Heterosexual transmission accounts for the majority of new infections. Evidence from a study in Rakai district shows incidence declining by 42 percent over ten years with the use of combination prevention activities (treatment of HIV-positive persons, male circumcision, delayed sexual debut).[25] While this study may not be generalizable nationally, the decline is a hopeful sign of the impact of scaling up combination prevention.



The 2016 Violence Against Children Survey (VACS) indicates an unacceptably high level of physical, sexual, and emotional violence against children. Of females and males aged 18–24, 59 percent and 68 percent respectively reported experiencing physical violence before the age of 18. Twice as many girls (35 percent) than boys (17 percent) had experienced sexual violence and one third of both girls and boys had experienced emotional violence. Among females aged 18–24, 10 percent of girls and 4 percent of boys stated that they experienced forced or pressured sex before age 18.[26] Un-negotiable early sexual encounters can force children out of homes and ultimately expose them to HIV risk. UPHIA data reveals that boys and girls have similar prevalence of HIV up until the age of 10. At that point, the prevalence of HIV increases in females so that by the ages of 15-24, females have a prevalence of HIV up to three times that of males (0.8 percent in males aged 15-24 versus 3.3 percent in females aged 15-24).[27]

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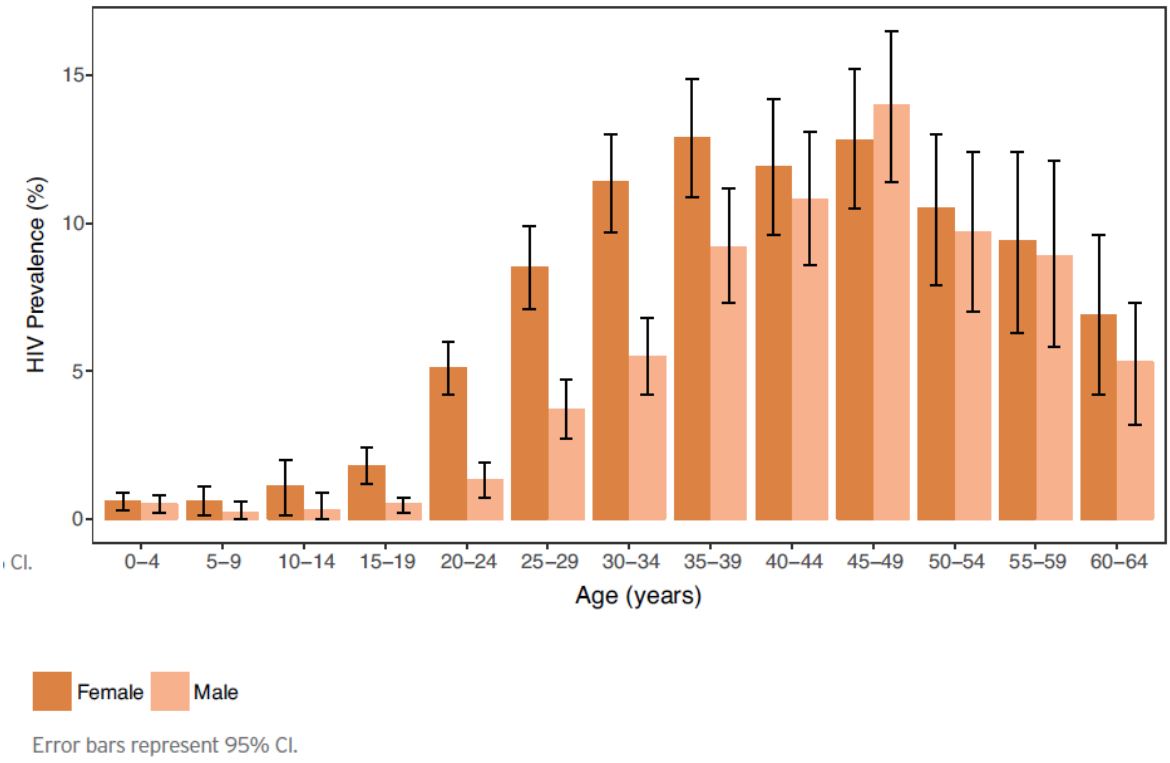
[24] WHO, 2017.

[25] Grabowski, M.K., Serwadda, D.M., Gray, R.H., Nakigozi, G., Kigozi, G., Kagaayi, J., et al. "HIV Prevention Efforts and Incidence of HIV in Uganda." *New England Journal of Medicine* 377, no.22 (2017): 2154-2166. doi:10.10156/NEJMoa1702150

[26] CDC. *Uganda Violence Against Children Survey.* Unpublished data. (Kampala: CDC, 2016).

[27] Unpublished UPHIA data, 2017.

HIV Prevalence by Age and Gender, UPHIA[28]



One in four girls aged 15–19 has begun childbearing.[29] Among girls aged 6–15 who drop out of primary school, 31 percent do so in order to marry, and 21 percent do so due to pregnancy. Secondary school completion rates also remain extremely low: only 34 percent of girls complete secondary school compared to 45 percent of boys.[30]

A national prevalence survey of tuberculosis (TB) was undertaken in 2014-2015. [31] The prevalence of all forms of TB was estimated at 253 cases/100,000, or 87,000 cases in the country annually. Men have a four-fold higher TB prevalence than women and approximately half of all TB cases go undiagnosed each year. A total of 27 percent of diagnosed TB cases in the survey were HIV-positive as well. This survey finding is less than the routinely-reported HIV prevalence of 45 percent among TB patients.[32] While women sought care more often than men (67 percent versus

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[28] Unpublished UPHIA data, 2017.
[29] UBOS, 2017
[30] USAID. *The State of the Ugandan Child.* (Kampala: USAID, 2015). http://pdf.usaid.gov/pdf_docs/PA00M978.pdf (accessed 3/7/2018)
[31] MOH. *Report on the Population-Based Survey of Prevalence of Tuberculosis Disease in Uganda 2014-15.* (Kampala: MOH, 2017). http://health.go.ug/content/uganda-national-tuberculosis-prevalence-survey-2014-2015-survey-report (accessed 3/6/2018)
[32] PEPFAR Uganda program data.

53.9 percent), bacteriologically-confirmed TB was more likely to be diagnosed among men than among women (76.2 percent versus 23.8 percent).[33]

Thirty-eight districts in Uganda have identified hotspots of key (KP) and priority (PP) populations. Estimates for men who have sex with men (MSM), female sex workers (FSW), people who inject drugs (PWIDs), and transgendered women (TGW) were triangulated based on the results from several local KP/PP surveys.[34] The MSM population in Uganda was estimated at 46,679 in 2017 with HIV prevalence of 12.7 percent. The number of FSW in Uganda was estimated at 198,376 in 2017 with HIV prevalence of 31.3 percent. An estimated 11 percent of new infections are attributed to FSW, their clients, and their clients' partners.[35] The population estimate for PWIDs in Kampala is 3,837. PEPFAR Uganda does not have an HIV prevalence estimate for PWID, though the HIV prevalence estimate for all drug users (injection and non-injection) is 16.6 percent. TGW are not well studied although there is indication that they experience high rates of HIV as well as violence. In 2013, a small study was undertaken in Kampala with TGW. Of 45 TGW, 9 were HIV-positive (20 percent), of which only 3 were on ART.[36] At this time, PEPFAR Uganda does not have any size estimates of TGW in Uganda.

Key populations face high prevalence and incidence of HIV along with major challenges in accessing quality, stigma-free HIV services. MSM are highly stigmatized within a legal and policy environment that inhibits non-discriminatory service delivery. Sex work and injection drug use are illegal in Uganda creating challenges in providing services. Transgendered women are marginalized and have barriers to obtaining medical care. Stigma and discrimination against KPs and PLHIV in general have been increasing due to the enactment of repressive laws like the Constitutional Amendment (No.2) Act of 2005, the Anti-Pornography Act 2014, the Non-Governmental Organizations Act 2016, the Narcotic Drugs and Psychotropic Substances (Control) Act 2015, and the Registration of Persons Act 2015 that challenge access to services and enjoyment of fundamental human rights. An increase in criminalization of HIV - which is enforced by the judiciary - contributes to an environment of fear, stigma and misinformation. The legal environment not only drives these populations underground but also limits their access to health services and negatively impacts efforts towards epidemic control.

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[33] MOH, 2017.

[34] MUSPH. *Crane Survey Report: Population Size Estimates.* Unpublished data (Kampala: MUSPH, 2018). PLACE. *Size Estimation of Key Populations in Uganda.* Unpublished data. (Kampala: PLACE, 2018).

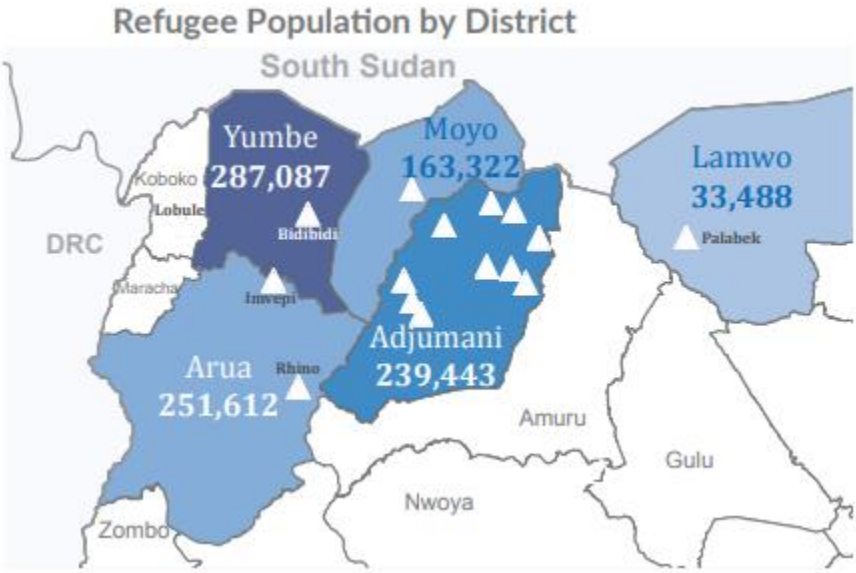
[35] Uganda AIDS Commission. *Uganda HIV Prevention Response and Modes of Transmission Analysis.* (Kampala: UAC, 2009). http://numat.jsi.com/Resources/Docs/UnaidsUgandaCountryReport_09.pdf (accessed 3/9/2018)

[36] MUSPH. *Crane Survey Report Results Briefs* (TGW, FSW, Drug Users, and MSM). (Kampala: MUSPH, 2017). http://musph.ac.ug/index.php/107-research-and-innovations/245-crane-survey (accessed 3/14/2018); MUSPH. *Crane Population Size Estimate.* Unpublished data. (Kampala: MUSPH, 2017); PLACE. *Size Estimation of Key Populations in Uganda.* Unpublished data. (Kampala: PLACE, 2018).

HIV prevalence among the 42,000 prison inmates in 2013/14 was 15 percent.[37] The most commonly reported HIV-related risk behavior among prisoners was MSM activity (both consensual and coerced) and sharing of razors.[38] There are 57 health facilities within the 257 prisons. All offer HIV testing but only eight of them offer ART. Those who test positive are transferred to a facility with ART. Prisons are not permitted to distribute condoms, lubricants, or sterile equipment.

Fisher folk (FF) are a priority population in Uganda. In fishing communities around Lake Victoria and other water bodies, HIV prevalence ranges between 14.9–35 percent and is highest among women who had their first sex before the age of 15.[39] Most of the estimated 2,000,000 FF are mobile or migratory. Social structures that constrain sexual behavior in home communities may not apply in the context of fishing camps or ports.[40]

Uganda hosts the largest number of refugees in Africa (more than 1 million), most from South Sudan and DRC, a situation that further strains local health facilities which provide services for refugees and host communities alike. Indeed, the demand on health workers and health commodity supply is significant. As of January 2018, certain host communities had a higher percentage of refugees than local community members (e.g. Adjumani with 59 percent of its population comprised of refugees and Yumbe with 34 percent). An estimated 15,705 South Sudanese PLHIV were living in Uganda and in need of HIV care and treatment services by end of September 2017. By the beginning of March 2018, the Sudanese refugee population was estimated to be as high as 1.1 million.[41] In COP17, PEPFAR Uganda and South Sudan jointly requested additional funding to improve access to HIV services



[37] Uganda Prisons Services. *Uganda Prisons Service Sero-Behavioral Survey.* Unpublished data. (Kampala: Uganda Prisons Service, 2017).
[38] Uganda Prisons Service, 2017.
[39] Opio, A., Muyonga, M., Mulumba, N. "HIV Infection in Fishing Communities of Lake Victoria Basin of Uganda: A Cross-Sectional Sero-Behavioral Survey." *PLoS ONE* 8, no.8 (2013): e70770. https://doi.org/10.1371/journal.pone.0070770 (accessed 3/7/2018)
[40] Opio, A. et al, 2013.
[41] UNHCR. *Uganda Refugee Response South Sudan Situation.* March 2018).

in order to identify and treat 8,135 (approximately 52 percent) of the South Sudanese refugees living with HIV in Uganda, including 1,815 (95 percent) of the HIV-positive pregnant women attending ANC, by the end of FY18. This service delivery and technical assistance commenced in October 2017, and is being implemented in seven Ugandan districts that host South Sudanese Refugees.

Interventions currently underway include index client testing, linkage of HIV-positive clients to care, and trainings for refugee camp health workers on key HIV and TB-related services, including Test and Treat guidelines. Improvement and expansion of the laboratory sample transport system is another component of PEPFAR Uganda's work focused on South Sudanese refugees, as is support for TB case identification, contact tracing, and treatment.

More than 48,000 refugees from DRC have also crossed into Mid-West Uganda since January 2018, with over 200,000 new arrivals projected for the entire year. This will result in 451,730 DRC refugees in-country. On average, over 180 refugees per day from DRC are entering Uganda.[42] In FY19, the refugee hosting districts of Western Uganda (e.g. Hoima, Kamwenje, Bundibugyo, and Kyenjojo) will support diagnosis and treatment services for an additional estimated 1,500 PLHIV from the DRC refugee population.

Additionally, the UPHIA study revealed important differences in the prevalence of HIV by region in Uganda in adults aged 15–64. The prevalence ranged from 3.1 percent in West Nile to 8.0 percent in Central 1.[43] According to UPHIA estimates (based on presence of plasma ARVs or self-report), 73 percent of PLHIV aged 15-64 who were HIV-positive knew their HIV status.[44] Of those that knew their status, 65 percent were on ART and almost 60 percent of all adult PLHIV had viral load suppression.[45] In general, older people (those over age 35) and women were more likely to know their HIV status and to be on ART than younger people or men.[46] The corresponding estimates of knowledge of HIV status, PLHIV on ART, and PLHIV with viral load suppression based on health facility reports and Spectrum model-estimated HIV burden were 75 percent, 73 percent and 54 percent respectively.[47] This suggests that health facility data may overestimate the number of people who know their HIV status and are on ART. PEPFAR Uganda is scaling up Data Quality Assessments (DQA) of implementing partner (IP) data to better understand over-reporting at site level and to better align program data with UPHIA estimates. As reporting becomes more reliable, PEPFAR Uganda will have better and more timely information on the three 90s (and PEPFAR Uganda's 95-95-95) to better focus resources.

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[42] UNHCR. *Uganda Operational Update on the South Sudan Emergency Response January - February 2018.* (Kampala: UNHCR, 2018).
[43] Unpublished UPHIA data, 2017.
[44] Unpublished UPHIA data, 2017.
[45] Unpublished UPHIA data, 2017.
[46] Unpublished UPHIA data, 2017.
[47] PEPFAR program data.

Most of the UPHIA data were collected before the rollout of Test and Treat, which began in earnest in January 2017. The Test and Treat policy is aligned to the WHO guidelines, emphasizing targeted testing to identify undiagnosed HIV-positive and to initiate ART on the same day where feasible and acceptable. In Uganda, there has been a high uptake of same day initiation among women (80 percent) based on a site survey of 42 facilities in January 2018. An additional 11 percent of women begin later in the week and 7 percent begin more than seven days later.[48] In COP18, PEPFAR Uganda will work closely with faith-based organizations (FBO) and other relevant stakeholders to increase understanding of the importance of same-day initiation.

Uganda has already met the global milestone for the elimination of mother-to-child transmission (MTCT) achieving 95 percent of HIV-positive pregnant and breastfeeding women on antiretroviral treatment, and an early transmission rate to infants of 3.1 percent in FY17.[49] UPHIA data reveal that Uganda has much work to do to address the 90-90-90 targets in HIV-infected children. For children aged 0–14, based on parental reports and detection of ARVs in the blood, only 56 percent were known to be HIV-positive, 54 percent were on ART, and 25 percent were virally suppressed.[50] The ongoing Prevention of Mother-to-Child (PMTCT) Impact Evaluation will validate results from PMTCT and pediatric program data by comparing with a population-based cohort.

UPHIA data revealed that 42 percent of men aged 15–64 have been circumcised, either by traditional means or medically.[51] Medical circumcision is more common in younger age bands (those aged 15-24), as is the overall prevalence of circumcision.[52] In March 2017, the policy requiring two doses of tetanus toxoid (TT) for male circumcision (MC) was revoked (except for with the use of the PrePex device, which accounts for fewer than 1 percent of circumcisions). This policy change resulted in a doubling of the number of circumcisions from 330,343 in COP15/FY16 to 753,198 in COP16/FY17.[53] The voluntary medical male circumcision (VMMC) program has targeted to circumcise 80 percent of the eligible males aged 15-29 in scale-up and attained districts by September 2019, though this is a very ambitious target.

The Ugandan health system remains weak with poor infrastructure, lack of accountability, and many human resource challenges. PEPFAR Uganda provides support for key clinical cadres within health facilities and technical assistance at national and district level to support the goal of epidemic control. However, a clear commitment and plan from the GOU to absorb these critical personnel into its public service are essential. Underfunding of ARVs and HIV rapid test kits (RTKs) by the GOU has resulted in very low stock levels, some local stock-outs, and

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[48] PEPFAR program data.
[49] PEPFAR program data.
[50] ICAP/CDC/MOH, 2017.
[51] ICAP/CDC/MOH, 2017.
[52] ICAP/CDC/MOH, 2017.
[53] PEPFAR program data.

commodity insecurity in the public sector. Major weaknesses in supply chain systems remain a concern. PEPFAR Uganda is filling a major gap in public sector ARVs for calendar year 2018. This gap fill will ensure that Ugandans on ART do not experience disruptions in their drug supply due to public sector stock-outs or rationing due to low stocks at the facility level. With COP18 funding, PEPFAR Uganda will greatly increase funding to public sector ARV procurement, continue work on supply chain reform within the public sector as part of a longer-term process to strengthen the supply chain from the national level to health facilities, and engage regional health structures to play a role in ensuring proper allocation of ARVs to health facilities at the district level and below.

PEPFAR Uganda will not be requesting additional funds in COP18 since infrastructure upgrades will no longer be needed, the majority of staffing will be provided by non-PEPFAR organizations working in the area, and sample collection as part of routine data collection will not require additional riders. All targets will be achieved within the same resource envelope availed to partners in COP18.

Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	37,673,800		8,476,605	22.5	8,815,669	23.4	4,106,444	10.9	3,880,401	10.3	6,630,589	17.6	5,764,092	15.3	Population projection for 2018 UBOS
HIV Prevalence (%)		6.2		0.7		0.4		3.3		0.8		10.7		7.7	UPHIA 2016
AIDS Deaths (per year)	22,412														Spectrum estimates 2017
# PLHIV	1,299,391		52,610		35,072		133,269		32,168		642,309		403,963		Spectrum estimates 2017
Incidence Rate (Yr)		400/ 100,000 popn.													UPHIA 2016
New Infections (Yr)	48,254														Spectrum estimates 2017
Annual births	1,664,520														Applying birthrate of 42.9/1000 to UBOS estimated population of 38.8 million in 2018
% of Pregnant Women with at least One ANC Visit	97														Uganda Demographic and Health Survey 2016
Pregnant women needing ARVs	91,460														Estimate fertility rates and data of HIV+ women in childbearing years (UPHIA) and also UBOS estimates of the # of childbearing women.
Orphans (maternal, paternal, double) (*Data for ages 15-24 just reflect ages 15-17.)	2,294,637		969,487		1,011,386		157,168*		156,596*						Used UBOS population estimates for 2018, multiplied by UNICEF estimate of 11% children who are orphans
Notified TB cases (Yr)	43,736		1,302		1,699		2,831		3,463		11,623		22,818		WHO Global TB report, 2016 and the NTLP report 2016
% of TB cases that are HIV infected	17,625	100	365	2	445	3	1,351	8	1,317	7	5,019	28	9,145	52	WHO Global TB report, 2016 and the NTLP report

															2016
% of Males Circumcised	42.2														UPHIA 2016-2017. Unpublished data.
Estimated Population Size of MSM*	46,679														Crane Population Size Estimates. MUSPH, 2018. Unpublished data. Size Estimation of Key Populations in Uganda. PLACE 2018. Unpublished data.
MSM HIV Prevalence	12.7														Crane Survey Report, Results Brief on MSM. MUSPH, 2017. http://musph.ac.ug/index.php/107-research-and-innovations/245-crane-survey.
Estimated Population Size of FSW	198,306														Crane Population Size Estimates. MUSPH, 2018. Unpublished data. Size Estimation of Key Populations in Uganda. PLACE 2018. Unpublished data.
FSW HIV Prevalence	31.3														Crane Survey Report, Results Brief on FSW. MUSPH, 2017. http://musph.ac.ug/index.php/107-research-and-innovations/245-crane-survey
Estimated Population Size of PWID	3,837														Crane Population Size Estimates. MUSPH, 2018. Unpublished data. (Estimates are for only Kampala).
PWID HIV Prevalence	N/A														N/A
Estimated Size of Fishing Community (All Ages) (Priority	2,000,000														N/A

Populations)															
Fishing Community Prevalence (Adults)	22-35														HIV Knowledge, Attitudes, and Practices and Population Size Estimates of Fisherfolk in 6 Districts in Uganda. IOM 2013. https://www.iom.int/news/ugandan-fishing-communities-high-risk-hiv-aids-iom
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*														

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*

	Epidemiologic Data**				**HIV Treatment and Viral Suppression**			**HIV Testing and Linkage to ART Within the Last Year**		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Estimated Total PLHIV** (#)**	**PLHIV diagnosed (#)**	**On ART (#)**	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	37,673,800	6.5	1,299,391	1,069,732	1,051,194	81	54	8,754,419	249,803	197,512
Population <15 years	17,410,218	0.5	87,682	68,105	65,576	75	45	678,815	6,397	7,548
Men 15-24 years	3,829,727	0.8	32,168	40,055	39,418	123	31	505,497	9,004	7,266
Men 25+ years	5,733,697	7.7	403,963	300,481	295,677	73	50	1,004,337	41,733	51,690
Women 15-24 years	4,093,702	3.3	133,269	110,184	108,109	81	35	1,007,443	27,630	30,297
Women 25+ years	6,606,457	10.7	642,309	550897	542,058	84	62	1,303,429	53,713	73,812
MSM	46,679	12.7	5,928							
FSW	198,376	31.3	62,092							

PWID	3,837									
Fisher folk	2,000,000	22	220,000							
SDC	25,693									
AGYW	789,400									
Military⧫	50,000	15	7,500							
Prison Wardens	7,182	12	862							
Police	43,624	8.7	3,795							
Incarcerated population†	50,000	15	7,500	2,609	4,513	60.2	89	29,628	2,609	1,590

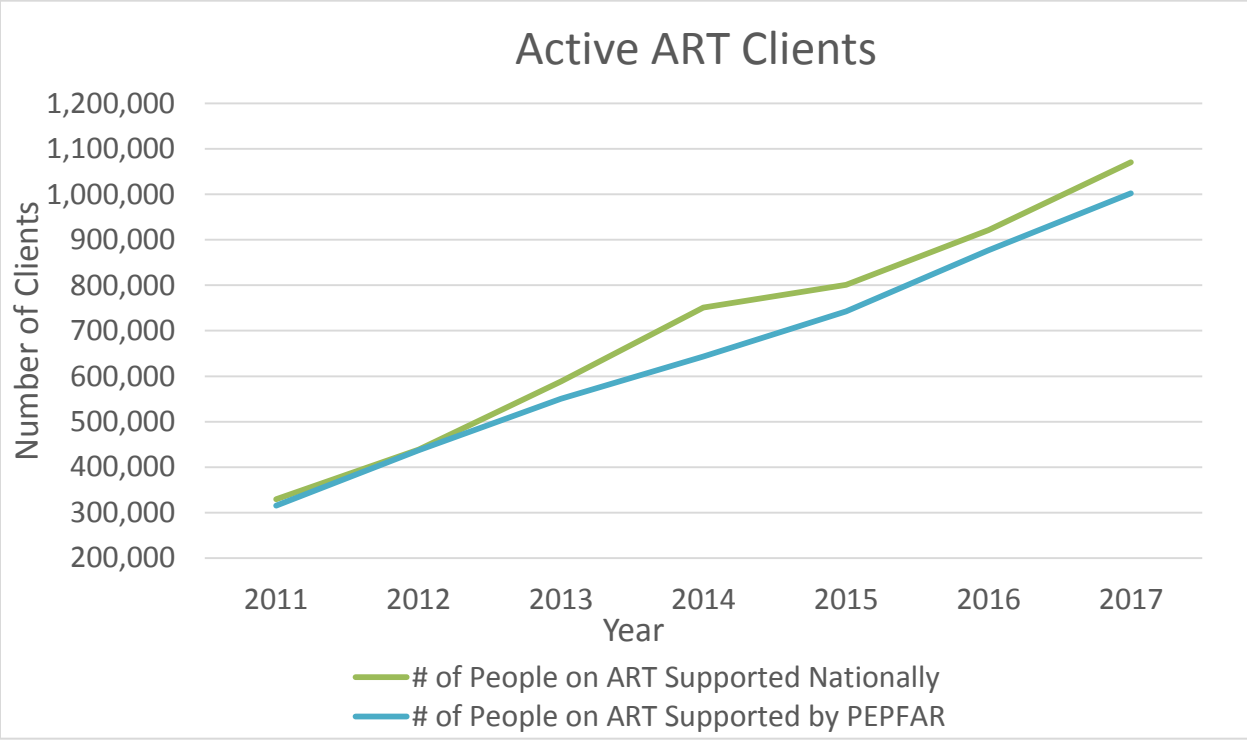
*These should be national data, if the data do not exist, PEPFAR data may be used if relevant.

**FY17 data

⧫The estimate for the military is based on the target for testing/treating. It does not reflect the total population of the military in Uganda.

†Note that though there are an estimated 50,000 people who sleep in the prison system each night, there are a total of 160,000 people who cycle in and out of the prisons throughout the year. Thus, the overall targets for prisons is higher than what is cited above.

Figure 2.1.3 National and PEPFAR Trend for Individuals Currently on Treatment



2.2 Investment Profile

Uganda's dependency on external funding for health and other social sectors remains high as the GOU prioritizes infrastructure development. The health sector budget has continued to decline, at 7 percent in 2017/18, below the country's commitment to the Abuja Declaration target of 15 percent. Key revenue sources that dominate financing of the health sector include GOU, development partners, the private sector, and household out-of-pocket contributions (OOP).

Similarly, contributions by development partners represent 90 percent of support for the national HIV response. PEPFAR Uganda and Global Fund remain the biggest contributors, with most funds allocated to the procurement of HIV commodities. Nevertheless, the 2017 HIV/AIDS Sustainability Index Dashboard process (SID 3.0), which was led by UNAIDS and Uganda AIDS Commission (UAC), and included representation of civil society organizations (CSO), MOH, other line ministries, and key stakeholders, scored the country 'high' for the 'Planning & Coordination' and 'Policies & Governance' domains. National level strategic planning and coordination of the HIV response by the GOU remains strong. Additionally, existing HIV-related policies and laws provide for equity and ample protection for the general population. Still, KP remain vulnerable in the existing legal environment. Concerns have been raised by Ugandan

CSOs during the COP18 review process that existing HIV/AIDS-related policies and laws contain provisions that are seen as inconsistent with evidence such as HIV-related criminalization provisions.

Domestic financing also remains a challenge, despite scoring higher in SID 3.0 than in the 2015 SID 2.0. GOU now has a specific HIV/AIDS Resource Mobilization Strategy which was developed in 2016 to ensure targeting of HIV-related priorities as well as to complement the broader Health Financing Strategy 2015-2025.[54] While there is presently no explicit budget line for HIV in the national budget, this is expected to change in 2018/19. A motion for a resolution to increase the GOU budgetary allocation to the health sector for 2018/19 was introduced to Parliament on March 13, 2018.

Commodity security remains the biggest risk to implementation of the Test and Treat policy for all and to achieving epidemic control. Public sector ARVs and other HIV commodities are largely funded by GOU and Global Fund. In the 2018-2020 Global Fund grant for HIV/TB, not less than 90 percent of the resources will go to the procurement of HIV commodities. GOU provides about US $26 million for ARVs annually, but this still leaves a gap which is covered by external and non-public resources. Nevertheless, GOU ring-fenced domestic resources for ARVs in 2015/16 and 2016/17. PEPFAR Uganda now provides substantial resources in COP17 and COP18 to fill the public sector gap for ARVs and other key commodities. A National Supply Chain Assessment is planned in 2018 to inform further PEPFAR Uganda and Global Fund investments to the public sector supply chain system. GOU funding to public sector laboratory systems is inadequate and not earmarked which is a challenge.

Figure 2.2.0: HIV Resource Alignment

Categorization	PEPFAR	Global Fund	GoU	*Total*
Source	COP 2017 PBAC	GF 2018-2020 Country Funding Application	GF 2018-2020 Country Funding Application	*PEPFAR + GF + GoU*
Implementation timeframe	01 Oct 2017 - 30 Sep 2018 (USG Fiscal Year)	01 Jan - 31 Dec 2018 (Calendar Year)	01 Jul 2017 - 30 Jun 2018 (Country Fiscal Year)	
Programs	**$193,239,404**	**$26,259,758**	**$28,514,715**	**$248,013,878**
Prevention	$52,329,236	$2,728,599	$2,156,000	$57,213,835
Oprhans and Vulnerable Chidren	$22,212,542	$0	$0	$22,212,542
HIV Testing Services	$14,678,509	$10,697,713	$0	$25,376,222
Care and Treatment	$104,019,117	$12,833,447	$0	$143,211,279
Commodities	**$108,545,048**	**$53,151,912**	**$0**	**$161,696,960**
Condoms	$0	$3,091,191	$0	*$3,091,191*
Rapid Test Kits	$5,158,557	$0	$0	*$5,158,557*
ARVs	$37,895,279	$43,460,024	$26,358,715	$81,355,303
Other Essential Drugs	$6,409,996	$1,621,140	$0	$8,031,136
Laboratory	$24,409,042	$4,499,557	$0	$28,908,599
Male Circumcision Kits and Supplies	$17,836,758	$0	$0	$17,836,758
Other	$16,835,417	$480,000	$0	$17,315,417
Systems and Strategic Information/Data	**$51,260,844**	**$2,105,037**	**$2,351,000**	**$55,716,880**
Systems	$36,501,050	$1,984,754	$2,351,000	$40,836,804
Strategic Information/Data	$14,759,794	$120,282	$0	$14,880,076
Program Support and Management	**$55,110,445**	**$527,160**	**$30,388,314**	**$86,025,920**
Implementation Level	$23,943,234	$527,160	$30,388,314	$54,858,709
Donor Level	$31,167,211	$0	$0	$31,167,211
Total	$408,155,742	$82,043,867	$61,254,029	$551,453,638
	Amounts are in US Dollars			
	Version 15 February 2018			

[54] MOH. *Health Financing Strategy 2015/16-2024/25.* February 2016. (Kampala: MOH, 2016). http://health.go.ug/content/health-financing-strategy (accessed 3/15/2018)

Resource tracking for the national HIV response is still a big challenge, as the last National AIDS Spending Assessment (NASA) was conducted in 2010.[55] However, with support from UNAIDS and the Makerere University School of Public Health (MUSPH), the UAC is currently conducting a NASA and is working to institutionalize the process for the future. PEPFAR is providing information to UAC to support this national effort.

Table 2.2.1: Annual Investment Profile (2016) by Program Area[1]

Program Area	Total Expenditure (USD)	% PEPFAR	% GF	% Host Country	% Other: UN agencies**	% Other: Ireland**
Clinical care, treatment & support	201,703,982	60.7	25.6	13.7	0	0
Community-based care, treatment, and support	15,859,385	94	1	0	5	0
PMTCT	27,487,899	93	0	0	7	0
HTS	22,180,167	70	29	0	1	0
VMMC	23,689,473	97	3	0	0	0
Priority population prevention	11,416,844	97	0	0	3	0
AGYW Prevention	961,792	0*	49		51	
Key population prevention	9,977,547	55	45	0	0	0
OVC	22,366,257	100	0	0	0	0
Laboratory	26,574,090	76	24	0	0	0
SI, Surveys and Surveillance	7,865,029	84	0	0	16	0
HSS	26,049,938	88	2	***8	2	0
TOTAL	**396,132,402**	**73**	**16**	**7**	**4**	**1**

1 There is no current NASA report, therefore data are from USG 2017 UG Expenditure Analysis Report, Ministries of Finance and Health finance reports and data.
*Expenditure for this program area is not captured separately but falls under other program areas.
**Expenditure breakdown by program area are not readily available.
***Expenditure on planning, coordination, and management of the national HIV response (UAC)

[55] UAC. *Uganda National AIDS Spending Assessment 2008/9 – 2009/10*. (Kampala: UAC, 2012). http://files.unaids.org/en/media/unaids/contentassets/documents/data-and-analysis/tools/nasa/20140707/uganda_2008-2010_en.pdf (accessed 3/15/2018)

Table 2.2.2: Annual Procurement Profile for Key Commodities (Sept 2016 – Oct 2017)					
Commodity Category	**Total Expenditure (US $)**	**% PEPFAR**	**% GF**	**% Host Country**	**Other**
ARVs	79,073,431.60	47.6	38.6	13.8	
Rapid test kits	15,767,335.00	26.9	73.1		
Other drugs	8,301,041.89	39.9	60.1		
Lab reagents	6,096,686.20	47.3	52.7		
Condoms	3,041,668.53	14.2	85.8		
Viral Load commodities	21,325,612.80	100.0	0.0		
VMMC kits	9,041,357.00	100.0	0.0		
MAT	-				
Other commodities	3,455,364.00	100.0	0.0		
TOTAL	146,102,497.01				

Assumption- Total expenditure = PEPFAR, GFATM and GOU resources comprise over 50 percent of the funding for the HIV response

Table 2.2.3: Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources (US $)**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs (US $)**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution (US $)**	**Objectives**
USAID MCH	16,000,000	7,520,000	14	65,702,746	Support programs to improve maternal, neonatal and child health
USAID TB	4,225,000	1,725,000	13	63,423,012	Support programs to reduce TB-related mortality and morbidity
USAID Malaria	33,000,000	4,054,800	11	62,623,012	Support programs to reduce malaria associated morbidity and mortality
USAID Family Planning	27,500,000	11,737,500	14	65,702,746	Support programs to improve contraceptive prevalence and birth spacing.
USAID Nutrition	9,000,000	3,755,000	12	62,623,012	Support programs to improve nutrition
USAID WASH	2,000,000	50,000	1	3,119,600	Support programs to improve water, hygiene and sanitation
USAID Basic Education	18,000,000	6,409,141	2	2,128,929	Support basic education programs to promote early grade reading, school retention, HIV and GBV prevention
CDC (Global Health Security)	9,500,000	7,500,000	3	17,495,449	Supporting PEPFAR and Global Health Security programs strengthening surveillance, lab systems, and workforce capacity, plus service quality.
DOD Ebola (JMEDICC/Ebola Research	2,600,000	2,600,000	1		Support Ebola research
DOD GEIS/ Influenza: S1 M	1,000,000	1,000,000			
DOD HIV Research	10,000,000	10,000,000			HIV vaccine and treatment research

MCC					
NIH					
Peace Corps	2,494,000				
TOTAL	**130,319,000**	**53,351,441**			

Note: As IPs have a comprehensive program, the same partner is funded through the various funding channels identified above

Standard Table 2.2.4

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP						
Funding Source	**Total PEPFAR Non-COP Resources**	**Total Non-PEPFAR Resources**	**Total Non-COP Co-funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
DREAMS Innovation	-	-	-	-	-	Dreams Innovation ending in COP17
VMMC – Central Funds	24,836,250	-	-	-	-	Support increased MC towards saturation for epidemic control
Other PEPFAR Central Initiatives	787,498	-	-	-	-	OVC PLUS-Up funds
Other Public Private Partnership						
TOTAL	**25,623,748**	-	-	-	-	

Note: DREAMS, Viral Load and some of VMMC & Saving Mothers Giving Life (SMGL) funds were reported in COP 16 for USAID so have not been included in this table.

2.3 National Sustainability Profile Update

In preparation for COP18, PEPFAR Uganda and its partners conducted SID 3.0, building on the sustainability profile of the 2015 SID2.0. The SID 3.0 process was spearheaded by the PEPFAR Coordination Office (PCO) and co-facilitated by UNAIDS and UAC. The meetings were attended by national stakeholders include multilateral and bilateral donors and civil society. The GOU, mainly represented by UAC, was an active participant and played an oversight and guiding role. During initial SID 3.0 meetings, the COP18 guidance was shared and SID Domain teams were formed based on areas of expertise. Each Domain team held a one-day session to discuss the relevant SID 3.0 elements and complete the SID tool. The draft SID 3.0 report out document was shared widely with relevant stakeholders and discussed in a one-day plenary session, with representatives from GOU, Global Fund Country Coordinating Mechanism (CCM) Board, UNAIDS, CSOs, and the private sector. A few changes were made by consensus to the draft tool to reflect better the sustainability status of the national HIV/AIDS response. The SID tool, although robust for a national overview, has a number of compound indicators that may make finer distinctions difficult to tease out.

A number of sustainability strengths were identified and are presented here based on their color-coded SID scores. For example, national strategic planning and coordination of the response is

considered adequate (9.33, Dark Green) and is enhanced by active involvement of the private-not-for-profit sector and CSOs. Gaps in strategic planning and coordination nevertheless remain at the district level. In COP18, PEPFAR will intensify work at the regional level as a new approach to scale up HIV packages and increase the role of regional structures in ensuring quality at district and site level. The Ugandan health system is decentralized, with political, administrative and technical authority held at the central and local government levels. The different levels of government have different mandates, with the national level (including the Ministry of Health [MoH]) responsible for policy formulation, strategic planning, macro level resource mobilization and allocation, setting standards, supervision, capacity building, and monitoring and evaluation. The local government (LC) include districts, municipalities, sub counties, divisions, and town councils. They have responsibility for operational planning, local-level resource mobilization and allocation, management, service delivery, and supervision and monitoring. There has been a marked increase in the number of district LC's in Uganda, from 56 in 2000 to 135 anticipated by 2020. This proliferation has implications on the MoH's ability to provide effective oversight, support and guidance to districts and health facilities. Currently Uganda has fourteen (14) regional referral hospitals (RRHs) distributed across the country, namely: Arua, Fort Portal, Gulu, Hoima, Jinja, Kabale, Lira, Masaka, Mbale, Mbarara, Moroto, Mubende, Naguru and Soroti Hospitals. RRHs are semi-autonomous institutions, reporting to the Directorate of Clinical Services of the MoH. Eight to twelve district local governments compose the catchment areas under each RRH.

PEPFAR Uganda will engage RRHs to provide service delivery planning, implementation and monitoring support to districts and lower level facilities with the aim of improving the quality of service delivery and strengthening health systems. The current health sector governance structure in Uganda does not currently direct RRHs to perform this function. As a first step, PEPFAR Uganda plans to address policy, administrative, structural and capacity concerns to enable RRHs to coordinate and support improvements in quality improvement, performance monitoring, data management, and supervision and mentoring at districts and lower level facilities. Such support would include ensuring quality assurance services through training, mentoring, supportive supervision and clinical outreach; launching regional quality improvement committees; providing technical assistance for the effective implementation of MoH policies and guidelines; acting as knowledge hubs for districts and lower level facilities.

An essential function will be coordinating supply chain management at the regional level including strengthening forecasting, quantification and ordering, and managing redistribution and buffers stocks; supporting regional laboratory systems including the lab hub sample transportation system; providing lab quality management and external quality assurance; and managing equipment repair and maintenance. Finally the RRHs will address critical human resources issues at district levels, including resources including rationalizing staffing needs and plans, monitoring vacancies, building the leadership and management capacity of district health officers and facility in-charges, applying accountability to achieving results against benchmarks and monitoring absenteeism RRHs will also play an amplified role as regional counterparts to

PEPFAR regional projects. As well, these agreements will be codified in Implementation Letters (ILs) that have been effective at national level to hold government accountable and articulate core agreements and ensure measurable progress.

Additionally, HIV/AIDS-related policies and laws provide for equity and ample protection for the general population (8.19, Light Green), although other populations may remain vulnerable in light of the existing legal environment. PEPFAR Uganda will leverage Global Fund catalytic funding to better understand and address key structural human rights-related barriers to accessing health services. The funding will also support a baseline assessment of the legal environment which will enable the country to prioritize appropriate interventions. Civil society was found to take maximum advantage of the available channels and opportunities to engage government institutions responsible for HIV/AIDS at both the national and district levels (7.40, Light Green). Finally, with respect to performance data there has been improvement in GOU ownership of HIV/AIDS data in the last few years (7.23, Light Green) especially with regard to the District Health Information (DHIS2). Collection, collation, reporting, and utilization of data for HIV/AIDS management has improved significantly at both the facility and district levels, although there remains a need to focus the attention of service providers and managers on data utilization for epidemic control. The current 'surge' strategy in calendar year 2018 through end of September 2019 will continue to reinforce the feedback loop with joint data collection on weekly and monthly basis for better use of information to improve services. The capacity of District Health Teams (DHT) in data analysis and use is being strengthened through M&E training and mentorships by above site monitoring and evaluation (M&E) IPs. The need for granular data analysis and the call for timely action to achieve targets also depends on the leadership role of the DHTs.

A number of sustainability vulnerabilities were also identified and are presented here based on their color-coded SID scores. For example, HIV/AIDS service delivery falls at the tail end of the sustainability spectrum (3.80, Yellow). Service delivery is the responsibility of Uganda's decentralized district health system. District health managers need to play a more central role in providing technical oversight for HIV services. At facility level, there have been efficiency gains from the integrated regional health service delivery approach. However, human resources to deliver HIV services remain insufficient, with continued substantial reliance on external funding and technical assistance for supervision and mentoring. Furthermore, the district local governments' budgetary contributions to HIV/AIDS are inadequate and not robust.

Commodity security and supply chain falls at the tail end of the emerging sustainability spectrum (3.80, Yellow). While there has been improvement in ARV domestic financing, other critical supplies such as HIV RTKs, condoms, and laboratory supplies are mostly funded by donors, and domestic financing of the country's supply chain plan remains low. Additionally, there is need to ensure budgets are replenished for ARVs. In 2016, for example, funds intended for ARVs were used instead for malaria medications during an outbreak which contributed to ARV funding gaps in 2017. PEPFAR Uganda is extensively involved in ARV stock monitoring and management through the use of the Web-Based ARV Ordering and Reporting System (WAOS). PEPFAR

Uganda will support GOU to build supply chain management capacity at national and district levels through improving the quality of the logistics management information systems to ensure accurate and timely ordering and instituting systems that provide timely real time stock status data at health facilities so as to inform decision-making. PEPFAR Uganda will collaborate with the Global Fund to conduct a National Supply Chain Assessment in 2018 to inform further PEPFAR Uganda and Global Fund investments to the public sector supply chain system. PEPFAR Uganda in COP18 will also assess the public and private supply chains to ensure efficiencies and cost savings.

In COP18, PEPFAR is working on a number of challenge areas, in particular the commodity supply chain from national to district level, as detailed in Section 4.4 and 6.0. PEPFAR Uganda will ramp up support to National Medical Stores (NMS) through an Enterprise Resource Planning (ERP) package from national to facility level. HIV service delivery at district level and district planning capacity will continue to be improved through enhancing the role of the district. Currently PEPFAR engagement at the district level is articulated through district level strategic plans, which is also shared with MOH. The plans cover integral components of district led activities such as coordination of district stakeholders, supportive supervision, and technical and performance reviews reporting through the DHIS2. Plans also cover the coordination of the lab hub system for Viral Load (VL), Early Infant Diagnosis (EID), and TB sputum, quality improvement projects, supply chain management, real time data reporting and dashboards for data visualization, and human resource performance management to reduce gaps in absenteeism.

In COP18, these district strategic plans will incorporate the surge strategy, ensuring that core intervention packages are scaled-up with fidelity. At the national level, PEPFAR Uganda, through USAID, has established Implementation Letters (IL) which detail agreements between and the respective roles and responsibilities that the GOU and USG will assume for the achievement of common goals including improved management of commodity supply chain systems, the national TB program, and human resources for health (HRH).

PEPFAR Uganda Support to Indigenous Organizations

Non-governmental organizations (NGOs) in Uganda have been contributing to the fight against HIV/AIDS from well before PEPFAR, with many local groups providing ART and care and prevention services. In fact, the successes realized by these early leaders informed the overall global investments in HIV/AIDS. Work with indigenous organizations is hallmark of the PEPFAR Uganda program, and a key element of our sustainability strategy.

Currently over 65 percent of PEPFAR Uganda funding is allocated to indigenous organizations as both prime partners and sub partners. Community level organizations are funded to carry out work at the community level to support prevention, care and treatment services especially community-facility linkages and follow up. CSO partners also play critical roles in DREAMS and orphans and vulnerable children (OVC) programming. The level of funding to indigenous organizations will increase in COP18 as new subgrants are made under new and existing awards.

Figure 2.3.1: COP Funding to Indigenous Entities

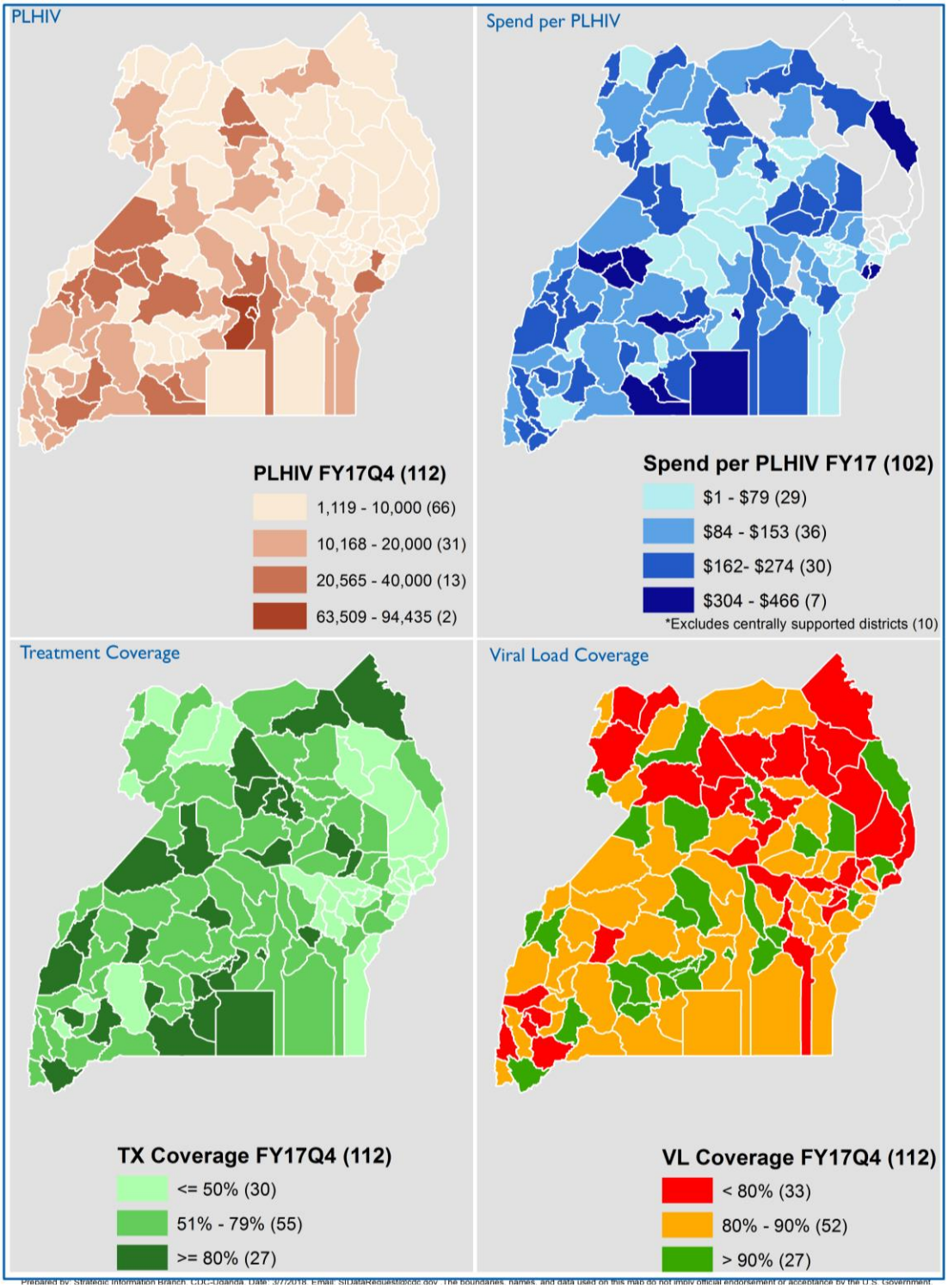
Agency	COP17 Total Planned Funding	COP 17 Funding to Indigenous Organizations	%	COP18 Total Planned Funding	COP 18 Funding to Indigenous Organizations	%
USAID	$133,105,519	$37,881,407	28.50%	$129,836,720	$27,333,062	21.10%
CDC	$188,244,651	$183,755,613	97.60%	$170,823,791	$166,219,680	97.30%
DOD/WR	$9,490,422	$9,060,369	95.5%	$11,501,498	$10,993,241	95.6%
DOD/DHAPP	$3,792,828	$125,250	3.3%	$70,000	$-	0.0%
Total	**$ 334,633,420**	**$230,822,639**	**69.0%**	**$312,232,009**	**$204,545,983**	**65.5%**

2.4 Alignment of PEPFAR Investments Geographically to Disease Burden

PEPFAR Uganda has continued to track HIV/AIDS expenditures annually by both geography and disease burden in order to consistently align resources to need. In FY17, PEPFAR Uganda spent US $133 per PLHIV, $30 more than the previous year. In FY17, 54 percent (US $94 million) of all finances were spent in attained districts that accounted for 35 percent of PLHIV. In FY17, PEPFAR Uganda also maintained minimal support (1 percent) in centrally-funded districts, focusing on systems strengthening interventions such as sample transportation through the laboratory hub sample referral system.

In COP18, because of the new definition for 'attained' from OGAC which classifies a district as 'attained' if it has achieved 90 percent treatment saturation in all 18 age/sex disaggregation levels, PEPFAR Uganda has some distance to go to achieve attained in the majority of districts and hence will target resources using UPHIA and other data sources, as well as information on partner performance.

Figure 2.4.1 Number of PLHIV, Spend per PLHIV, Treatment and Viral Load Coverage



Sources: MOH, PEPFAR, UBOS

2.5 Stakeholder Engagement

PEPFAR Uganda will continue to implement a multi-stakeholder engagement process focusing on both state and non-state actors during COP18 development, approval, and implementation. PEPFAR Uganda will work with CSOs as critical partners in the national HIV/AIDS response, ensuring CSO participation in a series of pre-COP, COP, and post-COP activities. PEPFAR Uganda has been incorporating stakeholder recommendations throughout COP development and will continue to do so during implementation over the year.

PEPFAR Uganda has engaged state and non-state actors in several pre-COP activities including completion of the SID 3.0, participation in HIV Prevention and Care and Treatment Strategic Retreats, pre-Regional Planning Meeting with CSOs, and several subnational priority-gathering consultations by PEPFAR-funded CSOs. The database for civil society stakeholders continues to be updated to ensure that both Kampala-based and subnational, frontline CSOs are included in the consultative processes and related communications. The International Community of Women Living with HIV in Eastern Africa (ICWEA) was selected by civil society organizations to play a coordination role for civil society engagement with PEPFAR. The PEPFAR-funded Advocacy for Better Health (ABH) and UNAIDS have assisted to facilitate engagement with CSOs to ensure streamlined CSO engagement in COP18 planning processes.

Additionally, PEPFAR Uganda has engaged stakeholders intensively in COP development and review. For example, select national and international Ugandan CSOs participated in the COP Regional Planning Meeting (RPM) in Johannesburg. Priorities identified for Uganda during pre-COP consultative processes were presented in the RPM to OGAC and PEPFAR teams. A post-RPM meeting was held with a broader group of CSOs to discuss the meeting's outcomes and follow-up actions. Prior to COP submission, PEPFAR Uganda will share key documents including the Strategic Direction Summary (SDS) and final targets with key stakeholders for their feedback.

Stakeholder engagement will also continue during COP18 finalization and approval in Washington, D.C., while several post-COP18 approval activities are envisioned. GOU will participate in the COP18 approval meeting in Washington, D.C. along with international civil society groups. Following COP18 approval, PEFPAR Uganda will host a stakeholder review meeting to share the final COP18 content and discuss its level of success in adopting stakeholder recommendations. CSOs and other stakeholders will be engaged in quarterly pre-POART call meetings with USG to review both COP17 and COP18 implementation.

A number of other opportunities for broader engagement beyond civil society exist through various fora in which PEPFAR Uganda regularly engages. These include national technical working groups, Uganda CCM Board for the Global Fund, the Health and AIDS Development Partner Groups, the UAC Partnership Committee, and the Health Policy Advisory Committee. PEPFAR Uganda is currently represented on the CCM Board and will continue to work to strengthen collaborations with the UNAIDS country office and other UN agencies especially in the areas of M&E, health financing, civil society engagement, and human rights. At the higher

political leadership level, PEPFAR Uganda will continue to engage with the Office of the President, Office of the Prime Minister (OPM), Ministry of Finance, Planning and Economic Development (MOFPED), MOH, Ministry of Public Service (MOPS), Ministry of Gender, Labor and Social Development (MGLSD), Ministry of Local Government (MOLG), and UAC. Key areas of engagement at the political, policy and technical levels include: domestic financing for the HIV response; supply chain management; human resources for health; and leadership and governance of the HIV/AIDS response.

Finally, PEPFAR Uganda will hold quarterly interagency IP meetings, led by the US Ambassador and supported by USG agency leads. These quarterly engagements may later expand to including GOU, CSOs, and other identified stakeholders. The interagency team is also considering monthly care and treatment IP meetings, along with MOH, to better review data, address challenges and policy issues, and scale up best practices across partners.

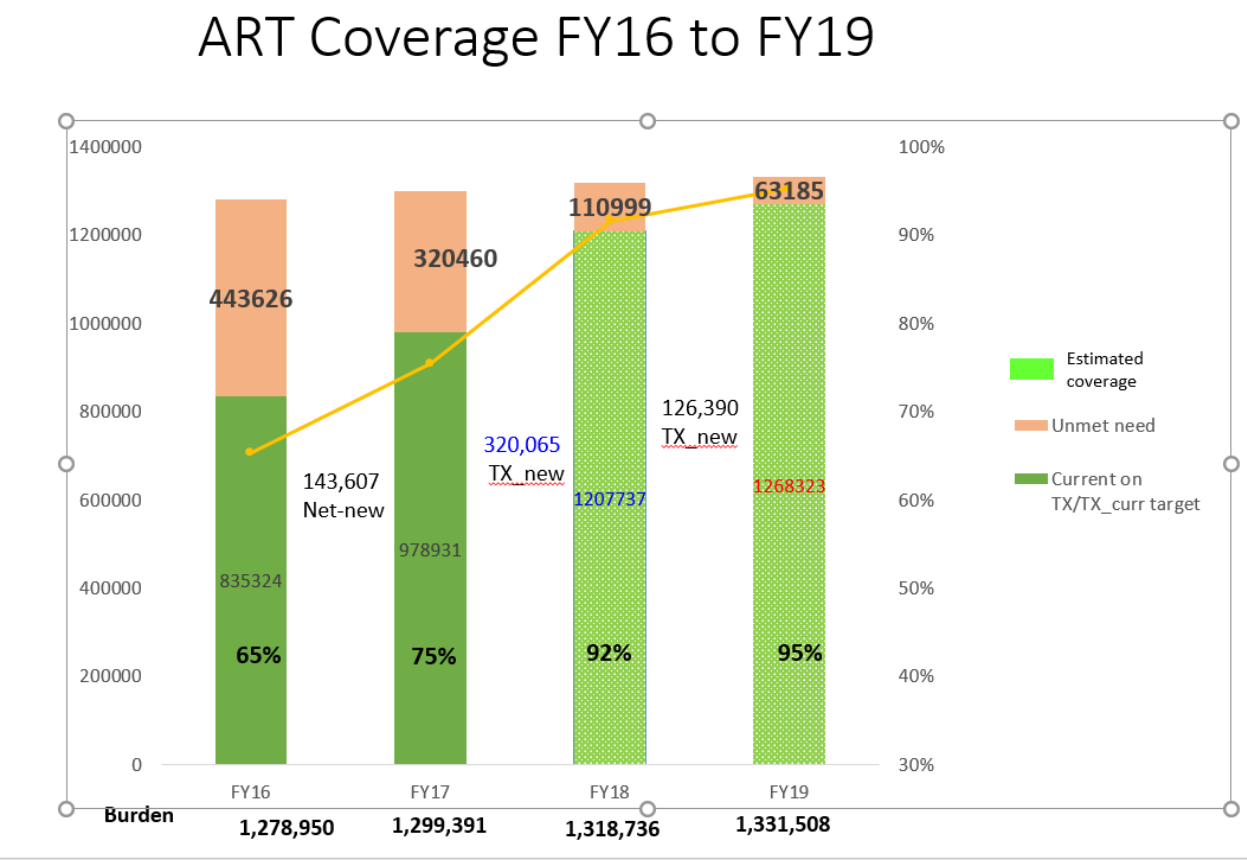
CSO Engagement Calendar:

	PEPFAR Team Action	Stakeholder Action	Dates	Status
1	Share documents and arrange meetings for completing the Sustainability Index Dashboard (SID 3.0)	Participate in completing the SID 3.0	**Oct 19, 2017**	SID 3.0 completed with multi-stakeholder involvement including CSO, public and private sector representation.
2	Distribute critical data and COP 18 materials including Draft COP guidance; Solutions Platform, COP17 SDS; Q4 results via spotlight; Q4 POART overview slides; SIMS Outcomes	Analyze materials to prepare for COP 18 discussions at strategic planning retreat; identify areas of successful performance that can be leveraged going into COP 18 and identify any activities that should not continue (site level and above service delivery investments)	**January 2-26, 2018**	PCO Shared Draft COP 18 guidance; COP17 SDS; Q4 results and Q4 POART overview slides.
3	Organize and facilitate KP specific retreat	KP led CSOs participation in one day KP Prevention Strategic Retreat	**Jan 15, 2018**	KP led CSO meeting held
4	Organize and facilitate HIV prevention strategic retreat and Care and treatment TWG meetings	CSOs participation in Prevention Strategic Retreat and the Care and Treatment Stakeholders meeting	**Jan 16 - 18, 2018**	Event held, CSOs provided feedback and input into COP priorities for HIV prevention and care and treatment.
5	USG invites and review materials with stakeholders at In-Country Strategic Planning Retreat	Attend in-country Strategic Planning retreat; provide USG with recommendations for COP 18 focus, based on analysis of Q4 results and observations of in-country performance.	**Feb 6, 2018**	Event held, hosted by ABH/UNAIDS. 91 participants from international, national and subnational CSOs, government and private sector participated. Remarks from UNAIDS, Uganda AIDS Control Program, UAC, US Ambassador and PCO, CSOs shared list of COP18 priorities
6	Arrange for stakeholder participation in the COP18 RPM	Actively participate in COP18 RPM, provide feedback on approaches, strategies and targets	**Feb 19 – 24, 2018**	6 CSOS [HEPS, SMUG, ICWEA, Health GAP, AJWS, MSF France][56]; GOU [MOH]; UNAIDS all actively participated
7	Interagency IPs Meeting to consult on COP18 and share feedback on RPM	Actively participate in COP18 consultation and provide feedback on technical and management approaches.	**March 6, 2018**	Country directors and technical leads from 61 current IPs
8	Invite stakeholders to post RPM consultation to discuss RPM outcomes and strategies for finalizing 2018 COP submission	Actively participate in Post RPM consultation, ask questions, seek clarification and make recommendations.	**March 7, 2018**	80+ CSO participants invited, hosted by ICWEA/ABH, UNAIDS absent with apology. No GOU representation.
9	Provide stakeholders with draft SDS 2-3 days prior to submitting to in-country ambassador	Provide written feedback within 48 hours of receipt	**March 9, 2018**	Planned
10	Provide SDS and final target data	Review all materials	**March 13, 2018**	Planned

[56] **HEPS:** Coalition for Health Promotion and Social Development; **SMUG:** Sexual Minorities Uganda; **ICWEA:** International Community of Women Living with HIV/AIDS in Eastern Africa; **AJWS:** American Jewish World Service; **MSF:** Médecins Sans Frontières-France.

11	Arrange for host government participation in COP approval meeting	Host government officials actively participate in COP approval meeting	**April 10 – 13, 2018**	Planned
12	Host Follow up meeting with stakeholders to review approved COP and discuss which stakeholder recommendations were incorporated and which were not	Participate in follow up meeting	**April 26, 2018**	Planned
13	Invite and engage stakeholders to meet prior to each quarterly POART call to engage their feedback and recommendations	Participate in Quarterly stakeholder meeting prior to quarterly POART calls	**Jun 30; Sept 30; Dec 20, 2018.**	CSOs participated in Q4 pre-POART meeting; PEPFAR Uganda provided written responses to CSOs Feedback on the COP16 Q4 Results on Jan 12, 2018. POART calls calendar will be shared (Dates may shift slightly)
14	Organize and facilitate Quarterly Stakeholder and IP meetings- Performance reviews, conduct strategic direction changes, and share best practices	IPs to participate in the quarterly meetings, share best practices, and plan to adopt changes identified through the short learning loops. Possibly monthly care and treatment meetings to prioritize the surge, with MOH presence.	**Quarterly, Dates to be set in advance of meetings**	

3.0 Geographic and Population Prioritization



During COP15, PEPFAR Uganda aligned district budgets and targets to geographical prevalence, disease burden, and presence of significant KP/PP. Using a burden table analysis, which relies on regional prevalence estimates from the 2011 Uganda AIDS Indicator Survey (AIS) weighted with district perinatal HIV prevalence, disease burden estimates were calculated for each district.[57] At that time, half of Uganda's now 122 districts had prevalence above the then national average of 7.3 percent. Also introduced in COP15 was the concept of "clusters" where districts had coverage above the national rate and often >100 percent. These districts were identified if they had ART coverage of >77 percent and also had a regional referral hospital (RRH) or large private-not-for-profit or private-for-profit facility that served to draw in clients from other districts. Eight clusters were identified covering a total of 36 districts. In COP17, a ninth cluster covering an additional five districts was added utilizing the same criteria. Based on high burden (collectively accounting for 80 percent of the national HIV burden) and high prevalence (≥ 7.3 percent), 61 districts were classified as scale-up for COP15 and continued as such for COP16. These districts included all 56

[57] MOH. *Uganda AIDS Indicator Survey 2011*. August 2012. (Kampala: MOH, 2012). http://health.go.ug/docs/UAIS_2011_REPORT.pdf

high-burden districts, and 5 low-burden/high-prevalence districts selected based on the presence of KP/PP and proximity to high-burden districts.

For COP17, geographic prioritization remained the same as in COP15 and COP16 other than in 40 districts that, with COP17 targeting, were targeted to reach attained status (FY18 definition of attained of 81 percent ART coverage across three age bands and two sexes) by the end of FY18.

After correcting for the program data overestimation identified by UPHIA, at the end of September, 2017, Uganda has an ART coverage of 75 percent. With a revised Spectrum burden estimate using UPHIA data of 1,311,508, Uganda will have an estimated overall ART coverage of 92 percent at the end of FY18 and, by FY19, ART coverage should reach 95 percent (see above figure). There is a new OGAC definition of 'attained' districts which is 90 percent ART coverage across 18 age/sex bands. With this new definition, Uganda will maintain 31 districts targeted to reach attained status by FY19. An additional 22 districts will reach 90 percent district-wide coverage by the end of FY19 and will be close to attained status. With ongoing DQAs and reporting improvements, Uganda will be better placed to measure attained status across the 18 age/sex bands. Thirteen remaining districts have been targeted to have overall coverage of >80 percent. Seventeen of the remaining 46 districts are part of a cluster and also will have overall coverage > 90 percent by the end of FY19. The remaining are districts will be targeted to reach attained in FY20.

It is expected that in calendar year 2018 Uganda may, as in past years, again see an increase in the number of administrative districts and would need to work with IPs to manage the shift. This would likely require PEPFAR Uganda to internally re-allocate resources to bring the new districts on board and shift targets.

Table 3.1 Current Status of ART Saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP18	# Current on ART (FY17)	# of SNU COP17 (FY18)	# of SNU COP18 (FY19)
Attained	419,555	506,778*	40	31
Scale-up Saturation	239,604	190,421	7	22
Scale-up Aggressive	475,514	269,982	20	31
Sustained	152,856	67,119	35	28
Central Support	43,979	16,894	10	10
Total	1,331,508	1,051,194	112	122**

*Several districts that have regional referral hospitals (RRH) or centers of excellence (COE) fall in attained districts and as such have >100 percent coverage due to PLHIV from neighboring districts coming to these RRH or COE for treatment.

**Ten new districts were added in FY17.

***Decrease in number of attained due to definition change from 81 percent coverage across all age/sex bands to 90 percent coverage across all age/sex bands. Many districts are close but due to data issues it is uncertain if 90 percent coverage has been reached across all age/sex bands although overall coverage ≥95 percent.

4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations

4.1 – 4.3 COP18 Programmatic Priorities for Epidemic Control

Surge Strategy for Intensification of Program Efforts

Upon reviewing FY17 and Q18 data the PEPFAR Uganda team, in consultation with the Ministry of Health AIDS Control Programme agreed to implement a 'surge' strategy aimed at intensifying programmatic results using proven interventions and gaining progress in key areas of finding HIV infected persons, linking them on treatment, scaling up VMMC (especially for 15-25 year old men) and ensuring data use for quality improvement. The MOH/ACP has launched a 'surge task force' of which USG PEPFAR is a member and has consultatively developed a shared definition for the surge and focus areas. A national circular will be released by the MOH on April 13, 2018 to all districts and national stakeholders. Meantime the USG IPs began weekly reporting March 4th focused on four core indicators of HIV testing (HTS_TST), those testing positive (HTS_POS), newly enrolled on ART (TX_NEW), voluntary male medical circumcision (VMMC) and any current stock-outs of TLE or of rapid test kids (RTK).

A total of 680 high burden sites with more than 500 currently on ART, representing more than 1/3rd of all the PEPFAR supported sites in Uganda (approximately 80% of the current burden in the country) were selected for weekly reporting. These sites report the following MER indicators (HTS_TST, HTS_POS, TX_NEW, VMMC). From these data, we are also able to calculate the yield and linkage rages by facility, district, and implementing mechanism. Data are submitted each Wednesday and reflect the previous calendar week. There was an overall 97% reporting rate from the facilities during the first 4 weeks of reporting, reflecting clinical activity from March 4th-March 31st. A weekly 'surge dashboard' is shared with partners and the MOH.

Trends to date are mixed with some improvements in new on treatment (7% increase between Q1 and Q2) and PEPFAR Uganda expects to see improved trends through Q3 months and the Q3 totals. The platform for discussions with IPs, districts and facilities has been extremely helpful and each weekly report is discussed in depth with partners with corrective measures to increase targets in the key areas emphasized.

4.1 Finding the missing, getting them on treatment, and retaining them

Of the estimated 1,318,736 PLHIV in Uganda, approximately 1,083,040 (81 percent) have been diagnosed and 1,070,062 (80 percent) are on treatment.[58] Approximately 103,000 HIV-positive

[58] PEPFAR program data, FY18 Q1.

individuals remain to be linked to treatment to reach the country's goal of 90 percent treatment coverage. Reaching these remaining undiagnosed positives requires ingenuity and the use of the most efficient approaches.

As we get closer to epidemic control, the need for accurate epidemiological and program data are even more important in order to inform targeting and tightly focus the program for maximum impact. UPHIA data showed that program data overestimated coverage by as much as 15 percent. Improvements have already been achieved after implementing quarterly regional cleaning and conducting DQAs followed by implementing improvement strategies.

Uganda has progressively strengthened its data collection systems for the HIV program, and has subsequently moved to reporting more than 80 percent of the PEPFAR indicators in the national Health Management and Information System (HMIS). However, this system has been largely paper-based and lacking a universal format of unique identification for beneficiaries, making it difficult to de-duplicate the program data.

At the end of FY17Q4, PEPFAR supported service delivery at 557 facilities that have electronic medical records (EMRs). Implementation of EMRs at these sites is currently led by the respective district comprehensive IPs with support of the district health teams, M&E agents (SITES and METS) and other development partners like Global Fund and UNICEF. 68% (373) of the sites with EMRs are running UgandaEMR, a customization from openMRS with support of PEPFAR through a funding mechanism (METS). Several releases of UgandaEMR have been released with the aim of ensuring that it comprehensively supports key service deliver areas. Overall, 42% (232) of sites with EMR (not limited to UgandaEMR) utilize it for HIV Testing Services, 99% (553) for HIV care & Treatment services, 14% (80) for antenatal or Maternity Services and 3% (29) for early Infant Diagnosis. In COP17, Uganda successfully piloted implementation of Electronic Medical Records (EMR) in two districts with inter-facility operability, and is currently moving forward in the development/approval of the e-health policy to govern EMR use. Further, Uganda also has two successful demonstration projects using biometrics, finger scans, as Unique Identifiers (UIs) with EMRs. The first demonstration project supported by one of the IPs (METS) implemented UI in 8 facilities in two districts with 12,688 (65%) of clients from these facilities enrolled in the client registry. The use of EMR for MUWRP sites was piloted in 16 (67%) sites with >500 clients in care, 21,410 clients are enrolled and will be scaled-up to 24 sites (100%) in FY19. Biometric UI was piloted in 6 facilities and has 3,119 clients with UIs. Further, Uganda also successfully piloted biometrics – finger scan as Unique Identifiers (UIs) using EMRs (Uganda EMR and ClinicMaster). The pilot sites supported by one of the IPs (METS) implemented UI in eight facilities in two districts with 70% of clients from these facilities enrolled in the client registry.

COP18 reflects Uganda's bold move to implement a highly targeted program to improve testing yield. COP18 testing target (HTS_TST) is about 50 percent of the FY17 targets for TST and was

derived from the TX_NEW (126,390) needed to reach 95 percent treatment coverage.[59] Based on historical program performance and HTS access data from studies, the TST_POS target was distributed across the service delivery modalities to form the thrust of the HIV testing services (HTS) program in COP18. These modalities are: index testing (20 percent in facility and 15 percent in community both with an anticipated yield of 15 percent); outpatient clinic (35 percent with an anticipated yield of 3 percent); mobile/community approaches (15 percent with a targeted yield of 4 percent); in-patient wards (10 percent with a yield of 5 percent); and STI clinics (5 percent with a yield of 5 percent). Overall, testing in outpatient department (OPD) has a low yield, but has historically contributed more than 50 percent of the total HIV-positive achievement. In COP18, the program will improve efficiency at OPDs through eligibility screening for both adults and children.

Overall, 35% of the HIV POS target are from index testing and although the proportion of the target is high, it translates into a modest and achievable number of positives identified (about 24,000 individuals in total). The yield of 15% from the index testing modality is achievable given that pilots on assisted partner notification (APN) yield on average 30% if the approach is rolled out correctly. We have earnestly begun implementing partner notification (effective FY 18 Q2) and through the weekly data reviews, we are seeing yields of 8%-15%. In addition, effective March, 2018 and through COP18, all HIV+ individuals in care will be assisted to notify their sexual partner(s) including casual ones. Initially, the definition of "partner" was misunderstood to mean a spouse and consequently a good number of patients in care have not declared partners beyond their spouses. Although the focus is on partners of newly identified HIV positive, we are starting to work with patients currently in care and we aim to have at least 70% of them having their partners identified and notified.

Reaching Epidemic Control among Men

The Uganda HTS program is well aligned with the epidemic with 84 percent of testing and 85 percent of positives identified in priority districts. However, this performance masks major gender and age variations. UPHIA reveals that only 74.6 percent of the estimated HIV-positive men aged 35–49 have been diagnosed, 66.3 percent are on ART, and 55.9 percent are virally suppressed.[60] Coverage is lower among younger men, with only 25.6 percent diagnosed, 22.2 percent initiated on ART, and 12.3 percent virally suppressed among men aged 15–24 and only 54.5 percent diagnosed, 42.2 percent initiated on ART and 31.4 percent virally suppressed among men aged 25–34.[61] UPHIA also reports that fewer than 50 percent of men know their HIV status, that the highest numbers of new infections are occurring in men aged 35–39, and that men aged 25–39 have the highest unmet need for ART.[62] There is also evidence of an increase in unmet need for

[59] PEPFAR program data.
[60] Unpublished UPHIA data, 2017.
[61] PEPFAR program data, FY18 Q1; Unpublished UPHIA data, 2017.
[62] Unpublished UPHIA data, 2017

ART among men in Central Region.[63] The Uganda Demographic and Health Survey (UDHS) 2016 further reports that younger men aged 20–29 are less likely to use condoms, most likely to have multiple partners, and have the lowest ART coverage.[64] COP18 will prioritize shoring up access to HIV services for men building on the initiatives being rolled out in COP17 as part of the surge strategy. Targets for men were assigned for both facility and community testing.

HIV testing services for men will be differentiated by age and population sub-groups (segments). Effective FY18 Q2 through to COP18, the male population in each district will be characterized to determine the different male segments and the social dynamics within the segments to enhance effective delivery of HTS to the right sub-populations in the right places and at the right time. Key HTS interventions for men starting in COP17 through to COP18 are: index client testing and assisted partner notification; improved facility-based testing at critical service delivery points and highly targeted community testing.

HTS interventions for young and adolescent boys (15 – 19 years)

According to UPHIA, the prevalence in 15 -19-year-old boys is very low (<2%). However, the UDHS (2016) reports low condom use with multiple partners in this age group. Given that the prevalence in this age group is low, we will maximize efficiencies for HTS by screening for HIV test eligibility. Testing for the young and adolescent boys will mainly be done in the facility. As part of our surge strategy, we are already working with our IPs and sites to prioritize testing for boys and adolescents at all HTS entry points. Young and adolescent boys presenting at OPD are screened for HIV test eligibility (using the Paediatric and adolescent HCT screening tool) prior to HIV testing. Testing at other critical entry points, including in-patient, TB, and STI is done without screening. In addition, we have tasked our IPs to establish and/or strengthen adolescent clinics/corners. This will create an opportunity to recruit adolescent peers who will be used to mobilize adolescents for HIV testing and track and link them to care and treatment. Except for KP/PPs, targeted community testing will not be prioritized for males aged 15 – 19 years.

HTS interventions for men aged 20+

According to the UPHIA (2016), the HIV prevalence among men steadily begins to rise from the age 20 – 24 years and peaks at 40 – 49 years. Low condom use with multiple partners is also reported in the age group 25–49 (UDHS, 2016). In addition, UPHIA (2016) indicates high incidence rates in the age group 35–49. HIV testing in this age group will be maximized through Assisted Partner Notification (APN), improved facility-based testing, HIV self-testing and targeted community testing. We are already working with our IPs and sites to accelerate HIV testing for adult men at all HTS entry points and to minimize missed opportunities at every testing point.

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[63] Unpublished UPHIA data, 2017; UAC. *Uganda AIDS Indicator Survey. (Kampala: UAC, 2011); PEPFAR program data, Spectrum.*
[64] UBOS, 2017.

We have tasked our IPs to conduct assessments within the facility to determine service delivery points (HTS entry points) with missed opportunities for male testing and subsequently work with the facilities to ensure men presenting at all critical points are prioritized for testing and that no missed opportunities for linkage to treatment occur. Based on the assessments, IPs will support the sites to streamline HTS flow charts and institute systems within the facility that will; raise demand for HTS; reduce waiting time for men undertaking HIV testing and also facilitate women testing HIV positive to access APN services. HIV test eligibility screening will only be done for men age 20 – 24 years. Men above 24 years will be prioritized for testing without screening for eligibility. Effective March 2018, we have identified male champions at each site who assist in providing short health education talks to men at OPD to allow opportunity for them to freely discuss health issues and make informed choices on HIV testing. Testing within the community will be micro-targeted based on rigorous data analyses to determine geographic areas of elevated burden. Effective March 2018, each IP will be required to assess the HIV burden up to sub-county level and prioritize those geographic locations with the highest need. The Communications for Healthy Communities (CHC), a PEPFAR Uganda communication project has begun working with partners to characterize men in the high burden sub-counties and this information will be critical in targeting services to the right population cohorts.

Multiple platforms will be leveraged to reach men, including Uganda's Presidential Fast Track Initiative which seeks to reposition the role of country leadership in the HIV response. Increasing access to services for men is among the key priorities of this initiative. Building on the COP17 surge strategy and using short learning loops to continuously adapt interventions, PEPFAR will continue to refine index client testing; assisted partner notification (APN) for sexual networks of index clients; facility-based testing at critical service delivery points; HIV self-testing for KP/PP, and non-suppressed clients on ART; and screening for HIV testing eligibility at OPDs. HIV testing yield will be improved through micro-targeting and geo-mapping at the community level, including intensified identification of hot spots. Micro-targeting and geo-mapping will involve working with CSOs, FBOs, community structures (such as cultural institutions and village health teams) and men themselves (through male champions and peers) to create demand and pursue the most appropriate, effective, and efficient strategies for testing different male sub-groups. At the community level, the program will continue to characterize men to allow for tailoring of HIV testing services to their appropriate contexts. Efforts will be made to enhance joint TB and HIV case finding among presumed TB cases and in TB clinics. The program will continue to provide HIV testing through the VMMC and OVC platforms.

Leveraging on COP17 performance, as well as the surge strategy's emphasis on closely tracking IP performance, COP18 will ensure that learning and adaptation are institutionalized for improving partner performance and achieving activity targets and goals. PEPFAR Uganda will continue to review data weekly to assess progress towards set targets and take timely corrective action or make modifications as needed. At the facility level, service providers will, on a daily basis, review data on identification and linkage and share reports with IPs. Parallel reporting dashboards and

portals were established in COP17 and will continue into COP18 to allow for real-time sharing of data which PEPFAR will review together with IPs on a weekly basis.

At the community level, strengthened facility-community linkage systems and a referral framework will improve clinical cascade performance on HIV-positive identification and linkage. These will be complemented by intensified community-level demand creation and approaches tailored for effectively reaching men, including men from KP/PP, and the adolescent girls and young women (AGYW) who are part of their sexual and social networks. Ongoing adjustment of HTS screening tools and counseling approaches used in community settings are expected to increase testing efficiency and yield. All of these interventions are anticipated to enhance community level identification of new male HIV-positive cases, and improve linkages to treatment.

COP18 will also ensure that, once diagnosed, men are counseled and linked to ART and retained in care with suppressed viral loads. While the program has seen an improvement in linkage from 78 percent in APR17 to 82 percent as of FY18 Q1, the goal is to achieve 95 percent linkage to treatment.[65] To support newly-identified HIV-positive men seeking services, COP18 will continue to prioritize the enabling environment including extended clinic hours, same-day initiation, pre-appointment reminders, and intensified use of male peer linkage facilitators. Several differentiated service delivery models (DSDM) are being rolled out and these will be monitored closely in order to adjust them for men accordingly. Counseling services are being intensified to enhance partner disclosure while ensuring that women who disclose their HIV status are protected from gender-based violence (GBV) and supported in their decision to start treatment. At the community level, interventions to ensure effective linkage will include: provision of ART starter packs for those identified in community outreaches/hard-to-reach areas (community-based ART initiation); use of clients' physical locator forms to track linkages and ensure successful referrals of all identified positives; facilitated linkage with a male peer or community health worker for follow-up; and use of community-facility referrals and the linkages framework model for facilitated linkage through active tracking and linkage of newly identified men by CBOs. Please refer to a summary of the linkage package in section 4.3. The results of a survey conducted as part of APR17 of all clinical service delivery IPs (n=20) reporting results from 1736 of 1741 (99.7 percent) of PEPFAR-supported sites providing ART, showed variable implementation scale of the recommended package of linkage and retention interventions, particularly those tailored to men.[66] The program will continue to emphasize and monitor the scale-up of proven interventions while ensuring fidelity and quality.

Retention for men was suboptimal at APR17 with 70 percent 12-month cohort retention. To address retention barriers (stigma, disclosure, distance to facilities, busy work schedules, long

[65] PEPFAR program data.
[66] PEPFAR program data, IP survey, 2017.

waiting times), the program will ensure implementation of the recommended package of tested interventions at scale as summarized in section 4.3. Interventions currently being implemented in some sites but needing to be scaled include quality, age-appropriate adherence counseling by age and gender-specific peers, pre-appointment reminders, adolescent/youth focused clinic hours, and linkage to community support groups. Additional interventions tailored to the specific needs of men, especially young men, to be introduced and taken to scale include peer-driven DSDM for adolescent and youth (modeled after the Zimbabwe Zvandiri model) and active tracking/case management of newly initiated young men In FY17, for men, overall viral load (VL) coverage was 63 percent with 87 percent viral load suppression among those who received a VL test. Among men 15–24, viral suppression was only 76 percent while among men over age 25 it was 88 percent. The suppression rates varied across regions with Kampala reporting the highest rates (85 percent for men aged 15–24 and 93 percent for men over age 25) and West Nile reporting the lowest (60 percent for men aged 15–24 and 81 percent for men over age 25).[67] PEPFAR Uganda will continue to monitor and fast track the scale-up of the recommended intervention package for improved VL coverage and suppression for men across regions and age groups. The package includes: implementation of site-level quality improvement activities for VL result utilization and patient management; longitudinal tracking of the non-suppressed register; intensified adherence counseling; peer support groups; regimen optimization, including switching to tenofovir-lamivudine-dolutegravir (TLD); DSDM models for men; and implementation of the revised HMIS tool to track VL suppression rates across the 12, 24, 36, 48, 60, and 72 cohorts.

Reaching Epidemic Control Among Women 15+

Achieving epidemic control in Uganda will require addressing gender gaps in HIV testing, linkage, and ART access. UPHIA 2016 data indicate that HIV prevalence among women aged 15–64 is 7.6 percent compared to 4.7 percent for men of the same age group.[68] For women, HIV prevalence peaks at 12.9 percent among women aged 35–39, and is almost four times higher among women aged 15–24 than men of the same age group.[69] Incident HIV infection in women is 2.5 times higher in women than men aged 15–19, with the highest incidence among women aged 25-34 (0.7 percent).[70] Women aged 20–29 also have the greatest unmet need for ART.[71] Although a higher proportion of unidentified PLHIV are men, women living with HIV (WLHIV) make up the largest burden of the unmet need for ART. For women, the largest unmet need for ART falls geographically within four regions: Kampala, Central 1, Central 2, and Southwest.[72]

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[67] PEPFAR program data.
[68] Unpublished UPHIA data, 2017.
[69] Unpublished UPHIA data, 2017.
[70] Unpublished UPHIA data, 2017.
[71] Unpublished UPHIA data, 2017.
[72] Unpublished UPHIA data, 2017.

APR17 program data demonstrate that almost twice as many WLHIV are being identified compared to men. About 50 percent of newly-identified pregnant WLHIV were under the age of 24.[73] In FY18 Q1, 50 percent of newly-identified WLHIV were in regions with the highest unmet need for ART, with the highest yield (3.5 percent) and volume identified among women aged 25–49, closely aligning geography and age with highest unmet need.[74]

Successful strategies for finding women which will continue in COP18 include routine HTS among pregnant and breastfeeding women, active case finding through index client testing and moonlight clinics for FSW, and passive case finding both through Provider Initiated Testing and Counseling (PITC) in OPDs and inpatient wards and through leveraging the DREAMS and OVC platforms.

- While identification is on track, linkage and retention remain major challenges for women. Although linkage among women improved from 72 percent in FY17 to 78 percent in FY18 Q1, it is lower than among men and far below the 95 percent target.[75] Younger women have poorer linkage, 12-month retention, and viral suppression outcomes than older women.[76] IPs report that a particular challenge faced by women is the need for consent from their male partners before ART initiation. In COP18, extra support will be provided to achieve optimal linkage and early retention for women with an emphasis on those under age 24. This intervention package contains the similar core components as the male package but tailored to the unique needs of women: intensified use of female peer linkage facilitators or mentor mothers to physically escort the woman to ART and PMTCT clinics; same-day initiation; tools for tracking women who elect not to have same-day initiation; use of pre-appointment reminders; and use of the community-facility linkages framework to leverage OVC and DREAMS programming and use of community-facility linkages to ensure that any HIV positives who are identified on the OVC platform or who sero-convert from the DREAMS program are linked to care and treatment.

Due to VACS and UDHS 2016 findings of high rates of GBV,[77] this core package will be supplemented by intensified counseling services to enhance supported partner disclosure and an additional package is being developed to improve GBV screening, counseling, linkages to support services, and post-violence care within all high volume facilities. As mentioned above, the APR17 survey of clinical service delivery IPs demonstrated variable implementation scale of the recommended package of linkage and retention interventions.[78] As with men, COP18 will

[73] PEPFAR program data.
[74] PEPFAR program data.
[75] PEPFAR program data.
[76] PEPFAR program data.
[77] VACS data from CDC, 2016; UBOS, 2017.
[78] PEPFAR program data.

continue to monitor consistent scale-up of these interventions among women while ensuring fidelity and quality.

Concerns were raised during COP planning that some women were required to get 'permission' from partners as a cultural practice. To understand whether this was a prevalent phenomenon PEPFAR through a partner project undertook a survey to better understand linkage and retention issues across the program with all clinical USG IPs in February 2018. Sites were selected randomly from a sample frame comprised of high volume sites (defined for this survey as having at least 60 TX_NEW per month). The total number of newly identified clients within the period of analysis (November 2017) was 1,327. Of these 91% of clients enrolled onto ART within seven days, of whom 80% enrolled on the same day. For the remaining 9% (116 clients) who did not enroll within the first week, 61 patients initiated between 8-30 days; 26 patients initiated within a month; and 29 initiations after a month. Gender was not quantitatively assessed in the survey.

Through qualitative assessments the factors most contributing to delayed assessments are fear of ARV side effects, stigma, disclosure and unwillingness to be on ART for life. 'Seeking permission' or 'Consulting Partners' has been articulated as one factor hindering same day ART initiation but not among the most common. Seeking permission was not assessed quantitatively although was mentioned by several IPs in the comments section. One IP described it as seeking social support from partner, rather than seeking permission.

A root cause analysis (RCA) carried out March 2018 in five USAID supported regions (ASSIST, 2018) aimed to identify the reasons for delayed testing and ART initiation in order to adapt surge priority activities to contextual factors in each region and take the recommended clinical cascade interventions to scale. 'Consulting a partner' or 'Seeking permission' was not a significant factor in a person beginning ART on the same day or same week. Fear of ARVs and lack of psychological preparedness was cited by men as the most critical factor inhibiting same day initiation (41%) and lack of resources cited by women (31%) followed by concerns about stigma (24%). Partner issues were a concern for 9 and 14% of men and women respectively. Consulting a partner before testing was predominantly mentioned in Acholi region. It constituted only 7% of the Acholi responses, and 2% of the responses from all regions. In East Central region it was mentioned as a reason for delayed ART initiation, but was not among the main reasons cited by the respondents.

In COP18, we will address these contextual factors through intensified counseling, increased interpersonal communication through peers and community platforms as well as proactive engagement with cultural, religious and community leadership. PEPFAR Uganda will further work closely with faith-based organizations (FBO) and other relevant stakeholders to increase understanding of the importance of same-day initiation and address any issues around partner permission.

Preventing Mother-to-Child Transmission (PMTCT)

Since the rollout of Option B+ in 2013, the proportion of HIV-positive pregnant women initiated on ART increased from 84 percent (FY13) to 96 percent (FY17).[79] HIV-positive women on ART at the beginning of pregnancy increased from 33 percent (FY13) to 67 percent (APR17), although the proportion of pregnant women who are known positive and already on ART at the time of diagnosis has plateaued.[80] The fertility rate has dropped from 6.2 in 2011 to 5.4 in 2016, but pregnancy among young women remains high: 55 percent of pregnant women are under age 24, and although only 20 percent of all HIV-positive pregnant women are in this age group, 50 percent of those who are newly diagnosed are also under age 24. ANC is where many young women are first tested. Therefore, although Uganda is making strides in improving contraceptive uptake and lowering fertility rates, increasing the coverage of ART among the partners of these women is necessary to decrease the relatively high rates of newly identified positives among pregnant women.

In COP18, 76,411 HIV-positive pregnant women (95 percent) are targeted to receive ART among which 67 percent (51,158) are expected to already be on ART at 1st ANC visit (ANC1). HIV transmission to infants in FY18 Q1 was 3.0 percent among those infants tested, with EID coverage improving from 76 percent at APR17 to 86 percent in FY18 Q1 through the use of an EID package (see section 4.3).[81] The mother-baby care point (MBCP) has proved to be an effective platform for follow up of mothers and infants. The MBCP service delivery model builds on a "One Stop Shop" approach and includes: giving one refill date for the mother and baby; pairing mother and baby charts; engaging linkage facilitators to follow up lost mothers of babies due for testing; placing stickers on charts of babies due for testing at 18 months; and immediate update of registers for children tested at 18 months.

COP17 supported the roll out of maternal retention and birth cohort monitoring through the infant's 18-month HIV outcome, strengthened HIV-exposed infants cohort analysis, and rolled out continuous quality improvement (CQI) interventions for mother-baby pairs throughout the pregnancy and until 18 months postpartum. COP18 activities will focus on strengthening these strategies to provide high-quality care for mother-baby pairs to achieve 90 percent retention and viral suppression among pregnant women initiating ART and over 80 percent final infant outcome at 18 months. Specific activities include: engaging CBOs (like Mama Clubs) for adherence support and retention; ANC/birth pre-registration of HIV-exposed infants at MBCPs for a 6–8 weeks DNA polymerase chain reaction (PCR) test; tracking receipt of cotrimoxazole and nevirapine; real time Option B+ and VL monitoring to track ART initiation and VL suppression; scale up of HIV self-testing for male partners using the ANC/PMTCT platform; integration of GBV screening and provision of post-violence care in maternal, neonatal and child health (MNCH) services; linkage from PMTCT to OVC programming to ensure that vulnerable mother-baby pairs

[79] PEPFAR program data.
[80] PEPFAR program data.
[81] PEPFAR program data.

are provided with additional support services, including early childhood development, strengthening of prevention interventions, and introducing group ANC visits as a model of differentiated service delivery among pregnant and breastfeeding AGYW .

By the beginning of FY19, PEPFAR Uganda expects all sites to adopt the revised national VL monitoring guidelines to include VL testing at ANC1 for all pregnant women already on ART and VL tests for all pregnant and breastfeeding women every 6 months. This will help to further reduce MTCT by identifying non-suppression early, with time to intervene to return VL to undetectable levels. Aggressive VL monitoring will be achieved through using VL stickers to identify eligible clients, CQI interventions (such as ongoing peer-led support and counseling for women), and rollout of a VL non-suppressed register that will longitudinally track management of non-suppressed HIV-positive pregnant and breastfeeding women. At national and subnational level, regular VL data review meetings based on the VL dashboard will be conducted.

PMTCT services also provide a platform to prevent HIV incident cases in AGYW. Over 90 percent of HIV-positive pregnant women aged 15–24 years are newly-identified, accounting for 50 percent of all newly-identified HIV-positive pregnant women.[82] In DREAMS districts, COP18 will support active linkage of HIV-negative pregnant and breastfeeding AGYW and their infants to HIV prevention services (including PrEP) and follow up through facility visits, family support groups, and peer mothers within MNCH settings and the community. Key interventions will include: health education; HIV testing and counseling including regular retesting for those with continuous exposure; couples counseling and partner testing; safer sexual practices including dual protection (condom promotion) and risk reduction counseling; family planning; GBV and sexually-transmitted infection (STI) screening; and linking HIV-negative male partners to the VMMC program. In FY17, only 31 percent of HIV-positive male partners were tested in ANC settings.[83] There is a clear need to continue to strengthen male partner involvement in PMTCT activities including male partner index contact tracing.

In sum, the performance of PMTCT has been exceptionally strong. However, given the young population and high fertility (despite declines in fertility from 6.9 in 2000 to 5.4 children per women in 2016), there will continue to be a large number of young women receiving ANC services who will be identified as HIV infected or at risk of acquiring HIV. There is ample data that HIV infection risk increases during pregnancy and breastfeeding and that younger women are at higher risk as they are less likely to know their HIV status, demonstrate poorer retention, and have lower VL suppression. Thus, despite strong PMTCT performance Uganda will continue to find new HIV infected women in ANC and PMTCT settings, and thus we continue to strengthen services and ensure young women receive them.

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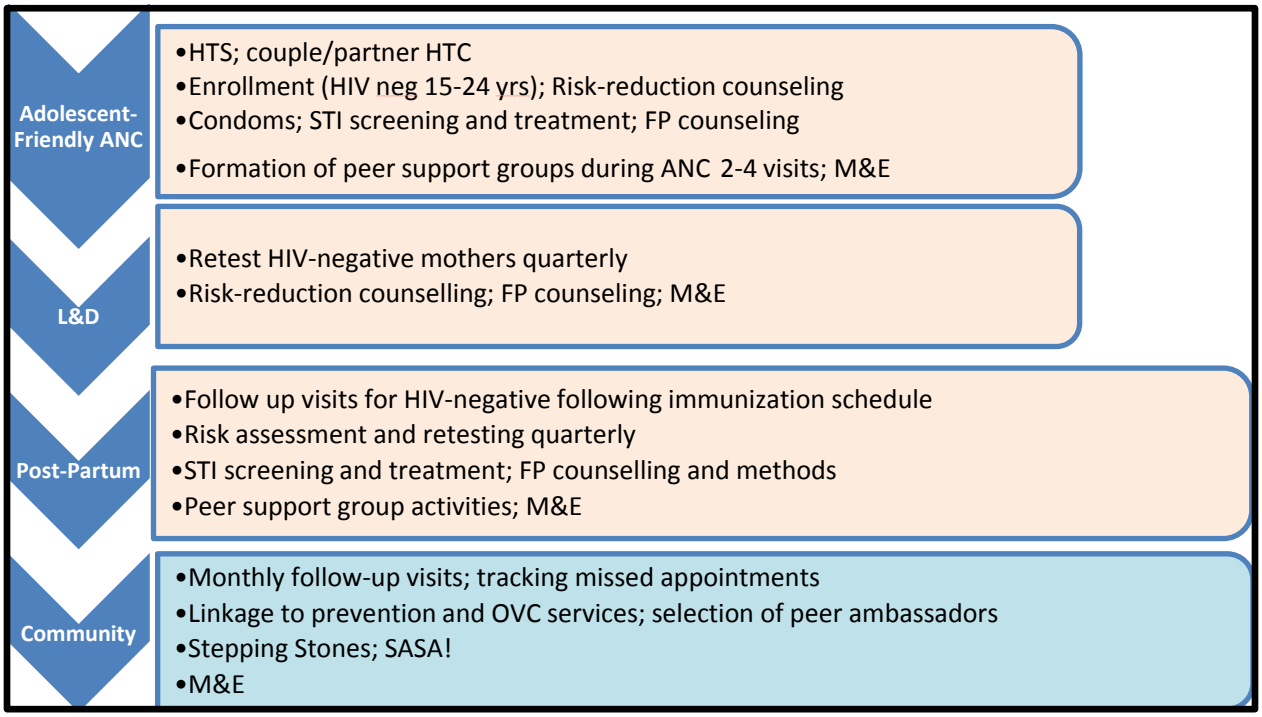
[82] PEPFAR program data, FY18 Q1.
[83] PEPFAR program data.

In COP 18 we will continue our testing approach in ANC, focus additional attention on scaling up linkage interventions, including GBV prevention and response, and ensure younger women are tested and immediately linked into care, with additional supports for adherence.

Figure 4.1.1: Integrating DREAMS Interventions within PMTCT/MCH Platforms at Facility and Community Level



Reaching Epidemic Control through Managing TB/HIV

The 2016 TB Prevalence Survey reported a higher-than-expected TB prevalence in Uganda of 253 cases/100,000 population, with prevalence among men (734/100,000) four times that of women (178/100,000).[84] Of the WHO-estimated 35,000 HIV-infected TB/HIV incident cases, only 15,138 (43 percent) were reported in FY17.[85] The highest TB/HIV burden is among men aged 35–44 (similar to HIV), while the largest number of missed cases is among men aged 15–24 year olds.[86] Given the high rate of TB/HIV coinfection, identifying people with TB also serves to identify PLHIV. COP18 will build upon PEPFAR Uganda's COP17 focus by intensifying identification of missing TB/HIV co-infected cases, optimizing utilization of GeneXpert for TB diagnosis, and expanding the coverage of TB preventive therapy (TPT). PEPFAR is seconding staff to both the

[84] MOH, 2017.
[85] PEPFAR program data.
[86] WHO.

National TB and Leprosy Program (NTLP) and AIDS Control Program (ACP) in order to support the MOH in leading these efforts.

The TB prevalence survey revealed that while 50 percent of people with TB have symptoms, only 10 percent of them are screened for TB.[87] PEPFAR Uganda will intensify facility-based case finding by improving the quality of TB/HIV screening at ART clinics and at inpatient, outpatient, and MNCH departments. For HIV screening, documentation of HIV status among new and relapsed TB cases increased from 75 percent at APR16, to 84 percent in FY17 Q1/Q2, to 91 percent in FY17 Q3/Q4 through improvements in both service provision and data quality.[88] Furthermore, HIV testing of presumptive TB cases demonstrated 20 percent positivity among 130 high volume facilities.[89] COP18 will scale up HIV testing of presumptive TB patients as one of the modalities for identifying and treating new PLHIV. PEPFAR is working with the MOH to include data on TB screening and HIV testing for presumptive TB cases in DHIS2 reporting in order to track progress of partners using this approach. In addition, PEPFAR will focus on scaling up routine screening for both HIV and TB in institutional settings such as prisons and military barracks. Household contact investigation will also be scaled as a part of the community care strategy. For children, use of chest x-ray for both TB screening and diagnosis will continue to be supported, especially for TB contacts.

HIV-infected TB/HIV patients on ART improved from 91 percent in FY17 Q1/Q2 to 95 percent in FY17 Q3/Q4.[90] PEPFAR Uganda intends to maintain these strong linkages in COP18 by working with districts and facilities to implement integrated management of TB/HIV co-infection, ideally in one clinic by one provider, as per MOH guidelines. Early identification and treatment for TB and HIV and improved retention and adherence will contribute to HIV viral suppression among co-infected clients.

APR17 data demonstrated a 1.9 percent TB case identification rate among PLHIV; however, based on the WHO estimate of 35,000 incident TB/HIV cases, 2.7 percent of 1,300,000 PLHIV have TB.[91] The FY17 SIMS data showed that over 20 percent of sites scored red or yellow on completing the TB diagnostic workup for all presumptive TB/HIV cases.[92] Analysis of GeneXpert utilization revealed that the machines are only being utilized at 54 percent of their capacity. In order to optimize utilization of the GeneXpert machines as the primary modality for adult TB diagnosis, COP18 will implement systematic tracking of all presumptive TB cases, ensuring routine, biweekly sputum sample transport and results return, procure US $1 million in additional cartridges to complement the Global Fund's US $3.5 million investment, and invest in demand creation and

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[87] MOH, 2017.
[88] PEPFAR program data, APR16, APR17.
[89] PEPFAR program data, IP data call FY18 Q1.
[90] PEPFAR program data.
[91] PEPFAR program data.
[92] PEPFAR program data.

health care worker mentorship to implement GeneXpert as the first-line test for at least 75 percent of presumptive TB cases. Utilization is being tracked through a customized GxAlert platform that monitors machine functionality, number of tests per machine per day, cartridge stock status, and result turnaround time.

In COP17, PEPFAR Uganda began to invest in TPT with the goal of providing TPT to 126,000 PLHIV at 200 high volume facilities, prioritizing newly-identified PLHIV who are at higher risk of developing active TB disease. COP18 expands this support to an additional 226,000 at 500 high volume facilities. PEPFAR will provide technical assistance in procurement, distribution, and management of TPT supplies, standard operating practices (SOP) and mentoring of health workers, and coordination of a systematic and phased TPT rollout.

Reaching Epidemic Control among Children

Uganda estimates a pediatric HIV prevalence of 0.5 percent with 88,437children under age 15 living with HIV (CLHIV).[93] This burden is higher than was estimated for COP17 (78,295). By the end of FY18 Q1, 65,576 (69 percent) of CLHIV were receiving antiretroviral therapy and 46 percent were virally suppressed.[94] A similar picture is seen among adolescents aged 10–19 with an estimated 88,510 living with HIV, 58,227 (66 percent) receiving ART, and 43,974 (49 percent) virally suppressed.[95] These data indicate the need to strengthen every stage of the clinical cascade in order to achieve the 95-95-95 goals for children and adolescents by 2020.

Identification of missing HIV cases in all age groups is the critical starting point for closing this gap. In FY17, 61,211 HIV-exposed infants received an EID test within 12 months of age, translating to an EID1 coverage of 76 percent.[96] By the end of FY18 Q1, EID1 (0–12 months) coverage had significantly improved to 86.7 percent.[97] Despite this improvement in overall EID coverage, the proportion that received an EID test within 0-2 months of age is still very low (54 percent).[98] It is conservatively estimated that in FY17 about 600 HIV-positive infants were not identified based on the FY17 EID coverage of 76 percent.[99]

In COP18, PEPFAR Uganda will implement interventions to further improve the overall coverage of EID 0-12 months from 76 percent in FY17 to 95 percent at FY19 with 80 percent targeted to receive the EID test within 0-2 months. The proposed interventions will also increase the opportunity for early initiation of ART for HIV-positive infants and improve linkage from EID to ART initiation. The proposed interventions for scale-up include: pre-registration at MBCPs from

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[93] Unpublished UPHIA data, 2017.
[94] PEPFAR program data, FY18 Q1.
[95] PEPFAR program data, FY18 Q1.
[96] PEPFAR program data.
[97] PEPFAR program data, FY18 Q1.
[98] PEPFAR program data, FY18, Q1.
[99] PEPFAR program data.

ANC and maternity; pre-appointment reminders; fast tracking all identified HIV-positive infants for early receipt of results and same day linkage to ART; weekly tracking of infants that are lost to follow-up; and monthly review of birth cohorts (see section 4.3). The quality of EID/Expanded Program on Immunization (EPI) integrated programing and of family support group operations will also be improved.

For older children, based on evidence from a Ugandan study on pediatric HTS yield by entry point conducted in 2017,[100] PEPFAR will continue supporting testing of children at all high yield entry points (e.g., TB clinics for testing of both suspected and confirmed TB cases, malnutrition clinics, and ART clinics for children of index clients) and optimizing testing within the OPD and OVC programs through the use of a validated HIV screening tool. For index client testing, activities will be targeted to the school holidays for maximum benefit. Where there are constraints with transport, home-based HIV testing will be offered. In COP18, PEPFAR will continue to support scale-up of HTS among adolescents and, in addition to the HIV testing approaches being utilized for men and women mentioned above, we shall support provision of adolescent-friendly HIV testing services such as evening testing and APN. Additionally, a peer-led approach will be used to increase demand for HTS among high-risk adolescents. PEPFAR Uganda will continue to leverage OVC and DREAMS to identify and link AGYW to HTS.

Linkage to treatment among children aged 1–9 stands at 87 percent but is only 65 percent among adolescents aged 10-14. The package of linkage interventions is being scaled up during COP18 for other populations including: same day ART initiation at the facility; use of phone call and/or home visit follow-up for clients not initiating same day; use of ART starter packs for those identified in community outreaches; client locator forms to track linkages and ensure successful referral; use of physical escort of clients by linkage facilitators; and supported disclosure. This package will be tailored to adolescents and youth by engaging adolescent and youth peers as linkage facilitators and designating and providing additional mentorship and job aides to a site-level adolescent focal person to provide adolescent-focused counseling and supported disclosure.

Retention among children and adolescents is suboptimal at 73 percent and 67 percent respectively. PEPFAR will support efforts to improve retention through adoption of appropriate DSDM. Stable children will be enrolled in family-based service delivery models and they will benefit from multiple month refills, fast-track refills at the facility, as well as community refills together with their family members at community drug distribution points. Adolescents who wish to receive services together with their family members as part of family-based care will be encouraged to do so. However, recognizing the importance and influence of peer interaction for adolescents, PEPFAR is allocating US $2.4 million to support the scale-up of a package of adolescent friendly services that have demonstrated success but are not yet widely implemented per the results of the APR17 implementing IP survey. The package consists of an adolescent focal

[100] Bitimwine, H. Unpublished study. (2018).

person at each facility; adolescent peer counselors; mentorship for supported disclosure; alignment of appointments to school holidays; peer support groups; a dedicated space or day for adolescent-focused care; linkages to community services and programs including those addressing and preventing violence against children; and routine documentation for OVC assessment and enrollment (see section 4.3). Uganda will also be introducing the Zvandiri CATS DSDM for adolescents at high volume sites.

Viral suppression among children and adolescents has continued to be a challenge for the Uganda program with VL suppression among children ranging from 67 percent to 76 percent. A three-pronged approach is being taken to address this critical gap. First, COP18 will support implementation of the pediatric and adolescent service packages described above to support adherence and retention described above, including strengthened linkages between the clinical and OVC programs. Children with viral non-suppression will be prioritized for enrollment in OVC programs. Second, COP18 supports provision of more optimal ARV regimens for children under age 3. With expected improved availability of lopinavir/ritonavir (LPV/r) pellets during the second half of FY18, PEPFAR aims for all sites to provide LPV/r pellets going into COP18. Adolescents taking adult formulations will be part of the nationwide transition to TLD. Lastly, COP18 will support intensive mentorships of health workers and viral load switch teams to improve timely switching and confidence in the use of pediatric second-line regimens for those with virologic failure.

Leveraging the OVC platform to close gaps along the clinical cascade for children and adolescents

Leveraging the OVC program for children and adolescents will be instrumental in closing the gaps along the clinical cascade. There are 2.7 million OVC in Uganda, including 11.3 percent of children who are orphaned, 46 percent of whom are estimated to be orphaned due to HIV-related causes.[101] Teenage pregnancy is 24.8 percent, and adolescent girls account for 66 percent of new HIV infections. Of the 35 percent of females aged 18-24 who had experienced sexual abuse as children, less than half told anyone, only 14 percent sought help, and only 8 percent received any services (VACS 2016). These issues are both risk factors for HIV infection as well as influence adherence, retention, and viral suppression of HIV-infected children and caregivers.

In COP18, 418,916 OVC and caregivers will benefit from the OVC program. Geographical coverage in the 68 scale-up districts for COP18 has been determined by data from UPHIA 2016, VACS 2016, UDHS 2016, the DREAMS index, and the Uganda national OVC burden estimate for 2018. Finer age disaggregations were adjusted based on the need to reach more females aged 10-17, especially in DREAMS districts, but also in Mid-East and Central where sexual violence has been shown to be high (59 percent and 35 percent respectively). Caretakers aged 18 years and above compose 25 percent of the total target. A graduation proportion of a minimum of 5 percent beneficiaries on the program has been factored in to ensure that particularly at-risk children can be

[101] UBOS. *Uganda National Household Survey* 2016/17. September 2017. (Kampala: UBOS, 2017).

accommodated. These include children of FSW, HIV-exposed infants, children who have suffered sexual abuse, and children not suppressing. OVC implementing IPs will work closely with the clinical partners in high-risk areas targeting FSW for enrolment of their children into the program.

In COP18, USG will continue to work through a family-based approach to serve children infected or directly affected by HIV including HIV-exposed infants, children of FSW, AGYW aged 9–17, adolescent girls at risk of violence and HIV infection, and children who have experienced sexual violence. Using the standardized case management model, OVCs will receive non-bio-medical services that reduce the risk of HIV and violence including socio-economic strengthening, parenting skills programs, child protection, and education support, and will be linked to services that ensure diagnosis, treatment, and retention of children and adolescents living with HIV. In order to address gaps identified in early childhood development programming, case management, and violence prevention interventions, additional resources are being invested in these areas. All AGYW receive a package of services aligned with the DREAMS interventions, with priority given to education subsidies, as described in section 4.2a.

The program will support 100 percent of OVC and caregivers to know their HIV status. Caregivers with unknown status will be screened using the HIV Risk Assessment tool and linked as appropriate to HTS services. Children and adolescents with unknown status will be screened for eligibility using the validated OVC HTS screening tool. Household members in need of testing services will be served through outreaches, linkage to facilities, and home-based testing approaches. Critically vulnerable households will be facilitated with transport vouchers to access testing services at health facilities. Particular emphasis will be placed on index children of positive caregivers and their sexual partners. Any HIV-positive children, adolescents, and caregivers not on treatment will be linked to health facilities for enrolment in care and treatment. A package of support for initiation, disclosure, and adherence including transport vouchers, physical escorts, linkage to expert clients, parenting and other socio-economic support will be provided.

IPs will work with facilities to implement a system to ensure that all HIV-exposed and infected children and their caregivers are assessed for eligibility for the OVC program, and if eligible, enrolled as slots in the program become available. Children with non-suppressed viral loads, infants of HIV-positive AGYW, and HIV-positive adolescents will be prioritized. Using a case management approach, HIV-positive beneficiaries and caregivers will be supported to identify challenges to suppression and to develop household plans to address them. HIV-exposed infants will be enrolled in family-based, parent-focused early childhood development interventions to improve child development and facilitate positive treatment outcomes. In addition, the households will be assessed as to whether or not there is a safe environment to support the child and caregiver to adhere to treatment. Household members will be oriented on child rights including disclosure and prevention of stigma and discrimination. Households will be encouraged to participate in a village savings and loan association (VSLA) to allow them to grow their financial base to provide them with sustainable means of consistently accessing health

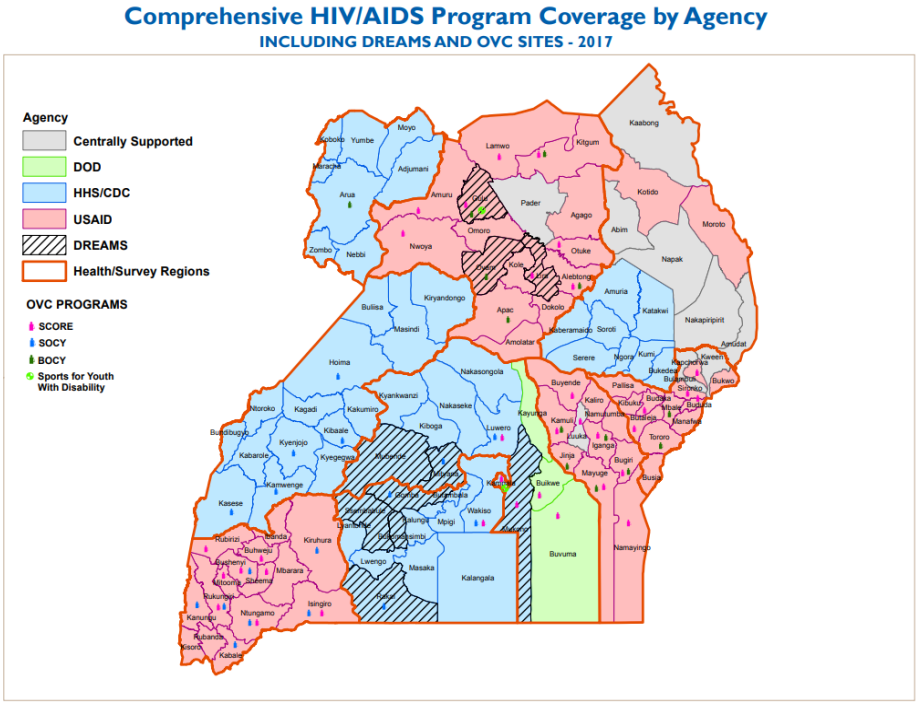
services. They will also be linked to PLHIV peer support to deal with stigma issues that may contribute to adherence and retention challenges.

In COP17, the global OVC benchmarks were integrated into a harmonized case management system localized by above site work with the MGLSD. In COP18 these will be applied to measure family readiness and achievement of graduation. Selected benchmarks will be integrated into the OVC M&E system as custom indicators for a more nuanced measure of OVC partner performance. In COP18, PEPFAR Uganda will conduct biannual DQAs to continue to improve capacity and utilization of data management tools and understanding of PEPFAR indicator definitions. Districts will be supported through mentorship and coaching to perform their supervisory roles. At national level, the OVC Management Information System (OVCMIS) will be upgraded to integrate case management processes and improve targeted planning and programming.

4.2 Prevention, specifically detailing programs for priority programming

HIV prevention and risk avoidance for AGYW and OVC

The DREAMS program will continue to focus on incidence reduction among high risk AGYW aged 9-24. Evidence-based interventions will be layered in 15 PEPFAR priority districts targeted for DREAMS programming (this includes two new districts, Apac and Luwero). The DREAMS program strategically leverages the comprehensive HIV program, particularly the OVC and the PMTCT platforms, to maximize efficiencies for impact. The program continues to track effective layering of interventions to beneficiaries through the DREAMS Tracking System. In addition, AGYWs' partners and communities will be offered appropriate services, such as VMMC and treatment, for broader community incidence. The quality assurance of the program will be enhanced through functionalization of facility and community quality improvement/quality assurance (QI/QA) teams.



The OVC program is attributing 30,605 targets directly to AGYW prevention (DREAMS). These are AGYW aged 10-24 within the OVC program in 15 DREAMS districts. These

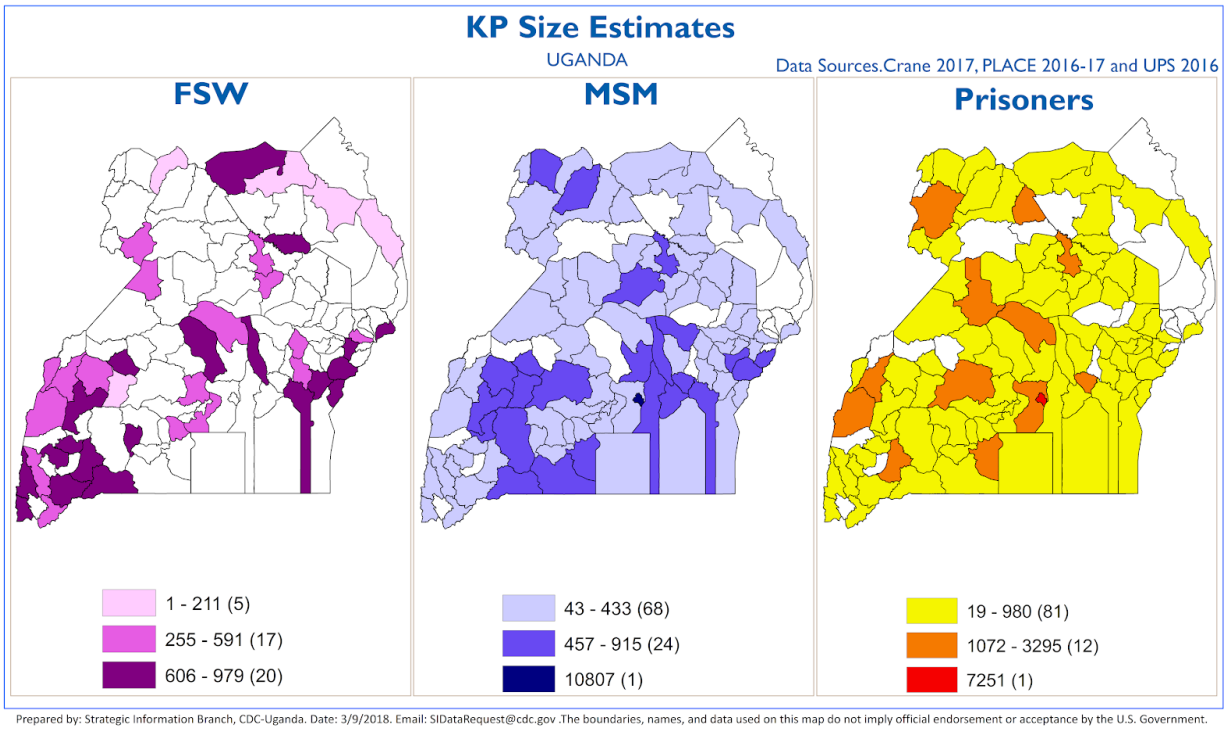
AGYW will receive the core OVC package which overlays with the core DREAMS package, namely: economic strengthening for the caregivers and adolescent girls out of school; educational support including subsidies for primary school, secondary school, or apprenticeships; parenting skills programs for children aged 9-17 and their caregivers; and assisted referrals and linkages to violence prevention, post-violence care, risk avoidance and reduction programs, HTS, and age-appropriate sexual and reproductive health (SRH) services. AGYW in non-DREAMS-designated districts will be reached with a similar package of services. Care givers and children aged 10 -14 within the DREAMS program will be enrolled into a parenting curriculum (Sinovuyo) to support improvement in relations and communication addressing HIV risk avoidance (children aged 10-14) . Parenting skills and programs for children aged 15-17 and for AGYW who are parents of infants will be addressed using core COP ear marked OVC funds. In FY19, in line with the COP guidance and the young Ugandan population (median age 15.8), Uganda will revitalize risk avoidance and violence prevention programming for children aged 9-14. Care will be taken to ensure HIV-positive AGYW in DREAMS districts also receive services. OVC AGYW in non-DREAMS designated districts will be reached with "DREAMS light package" using core COP 18 OVC earmarked funds. This DREAMS light package includes mobilizing AGYW out of school for economic strengthening group interventions, apprenticeship, school subsidies for retention of girls in school, parenting for caregiver of children 9-14 to improve communication, rolling out safe space model as platform for empowering girls and linkage for HIV testing.

Given the high levels of violence against children and sexual exploitation revealed in both the VACS and the UDHS 2016, PEPFAR Uganda is investing in a multifaceted approach to address violence prevention and response interventions using evidence based curricula. These will focus on school/community-, individual-, and district-level procedural reform. These interventions will encompass community for norms change (SASA), positive parenting (Sinovuyo), violence prevention in schools (Journeys), personal protection skills (IMPOWER) and a child justice program targeting the district prosecutorial authorities and other stakeholders throughout the justice chain.

DREAMS will continue to work closely with communities, empowering them to identify practical home grown solutions which take into account the cultural and epidemic context to ensure appropriate age sensitive risk avoidance and reduction. Uganda will prioritize strategic information for evaluating efficiencies of prevention packages, selection of optimal intervention mix, as well as understanding trends in new HIV infections.

Key and Priority Populations (KP/PP)

PEPFAR Uganda identifies KP/PP as indicated in Table 4.1.3 which also includes the size estimates, coverage goals and targets. KP include FSW, MSM and transgender, PWID, and prisoners. PP include uniformed personnel, fisher folk, long distance truckers, sero-discordant couples, and AGYW (see above). The program will prioritize the prevention cascade to close the tap to new infections for epidemic control. With a pivot to reach men, PEPFAR will especially target the truckers, prisons, and police with combination prevention.



For both KP/PP, the service package will comprise of social and behavior change communication (SBCC); risk reduction counseling, including consistent correct condom use; ART provision and adherence support; sexual and gender-based violence (SGBV) screening; post care pre-exposure prophylaxis (PrEP), emergency contraception (ECP), and HTS; alcohol/drug harm reduction; and reproductive health services. In addition, KPs will have twice yearly HIV testing, entry and exit testing for prisoners, PrEP, STI management, and HIV self-testing.

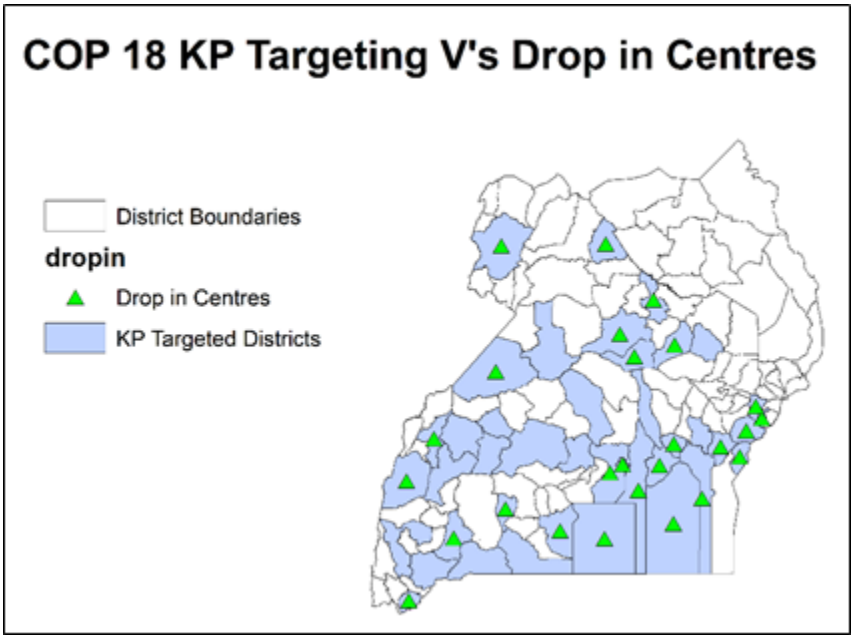
Uganda has phased implementation of PrEP starting in COP16 with a target of 3,417 in 6 sites, to 11,757 in 17 sites in COP17, to 73 sites in 28 districts targeting 16,481 individuals in COP18. The program will focus on demand creation through targeted messaging to eligible sub-populations with support from Communication for Healthy Communities (CHC) and CSOs.

UPHIA 2016 disaggregates condom use at last high risk sex across all age bands from age 15 for both males and females. PEPFAR Uganda will aggressively promote and distribute condoms, improve access and availability, and intensify messaging and education to increase correct and consistent condom use. Uganda will leverage the Global Fund in addition to central condom procurement funds to contribute to meeting universal condom need. The COP18, condom investment through a social marketing mechanism will implement a total market approach, including market segmentation and targeted geographic coverage to ensure equitable access to services and products. Uganda will leverage the Global Fund investments in lubricants and support last mile distribution through drop-in centers and community-managed dispensing points for improved access.

In COP 18, newly available KP size estimates were triangulated with program data to derive robust geo-focused targets.[102] Based on the new size estimates, coverage for MSM increased from 5 sub-national units (SNUs) in COP17 to 8 SNUs in COP18 and, for FSWs and their clients, from 30 SNUs in COP17 to 38 SNUs in COP18.

In FY17, a total of 5,165 MSM and 72,803 FSWs representing 107 percent of the target were reached with a minimum prevention package.

In FY19, the KP/PP prevention program will leverage the Global Fund-supported interventions including the 28 out of 50 drop-in centers to expand service access, identification, linkage, and retention. HTS guidelines have been revised to provide opportunities for HIV self-testing among FSWs and MSMs. There will be a strong emphasis on linkage and retention through active engagement of peers, village health teams, CSOs, and the community through male KP champions, and male age-specific dialogues to optimize identification.



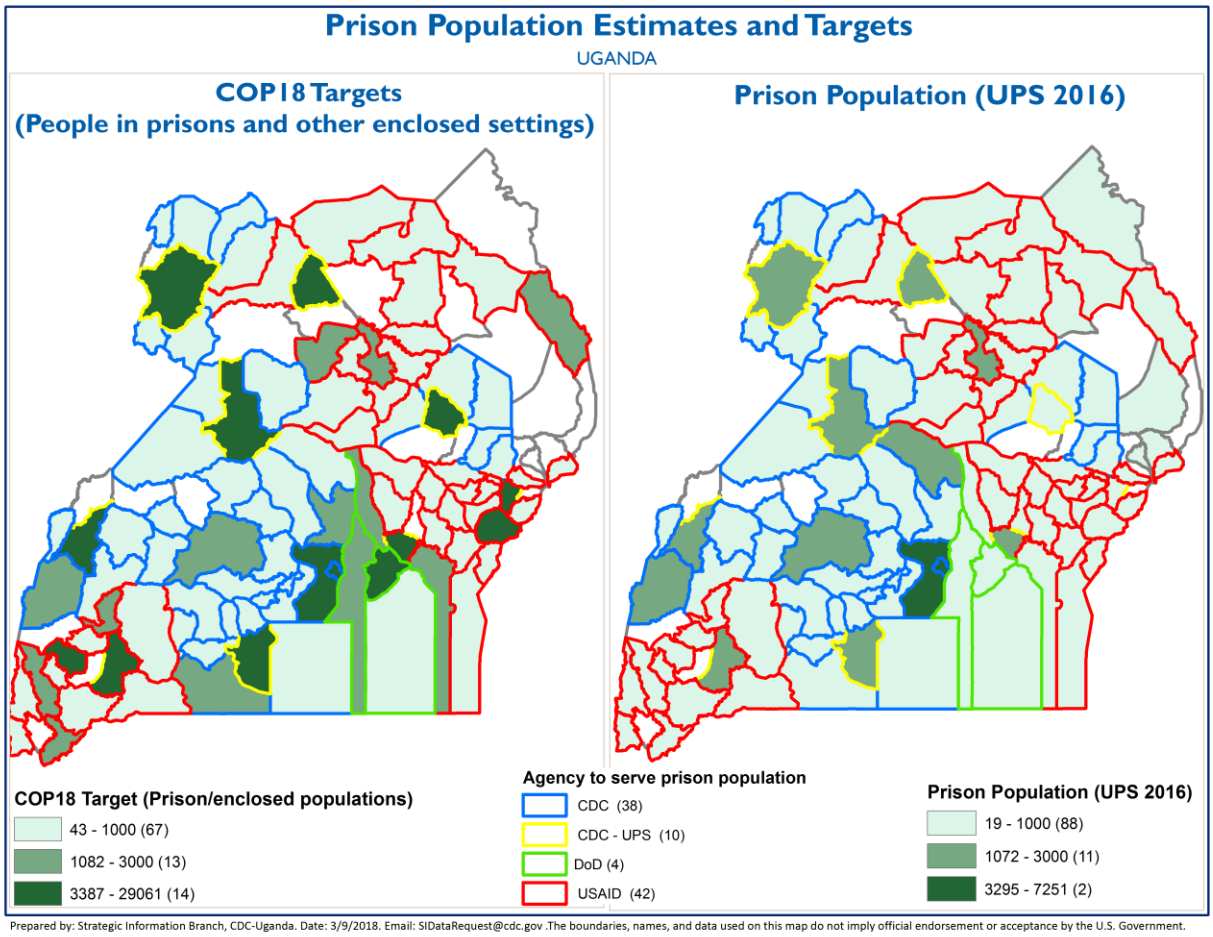
PEPFAR Uganda will support more systematic services for PWID through a PWID CSO (Uganda Harm Reduction Network). PEPFAR Uganda support program policy and guideline development for PWIDS and will leverage Global Fund investments for PWID, building synergies for optimized reach. A total of 620 PWIDs in Kampala will be reached with comprehensive HIV prevention services.

COP18, PEPFAR Uganda will also increase its reach to prisons as illustrated in Figure 4.2.1. There are 257 prisons in Uganda of which 53 have health facilities and 10 are ART-accredited. In APR17,

[102] CRANE data from MUSPH, 107; PLACE, 2017; Uganda Prisons Sero-Behavioural Survey data, 2013; Unpublished UPHIA data, 2017.

98,150 prisoners were reached with HTS with a yield of >8 percent.[103] The population presents a low hanging fruit for finding undiagnosed men with a high yield. In FY18, a renewed focus on the prisons program will lead to accreditation of an additional 12 sites to provide ART. In FY19, PEPFAR Uganda will also build on achievements and lessons to inform programing beyond the 22 facilities to target a total of 160,000 prisoners in 101 districts by leveraging regional health IPs.

Figure 4.2.1: Prison Population Estimates and Targets



PEPFAR will continue to target other priority populations with the minimum prevention package, as described above in the section on HIV prevention and risk avoidance for AGYW and OVC.

To reach KP/PP, prevention program engagement with CSOs must continue to contribute to increased awareness and understanding of PEPFAR Uganda priorities, and support by CSOs in advocacy for policy shifts and a favorable legal and social environment is essential. PEPFAR

[103] PEPFAR program data.

Teams will strengthen KP CSO support and engagements at regional levels. Using lessons learnt from Local Capacity Initiative, PEPFAR will identify and train KP CSO national, regional and district mentors to monitor health service delivery of HIV services to KPs through the community score card. The regional partners will prioritize and sub-grant CSOs to work as partners and collaborators in program implementation, monitoring and reporting through the peer model, where applicable. As a minimum, the implementing partners will use the PEPFAR prevention package to guide service roll out including demand creation for prevention services- VMMC and PrEP. At the regional level, PEPFAR Teams will support partners to hold regional CSO engagement skills and knowledge sharing platforms to improve monitoring and accountability towards KP services. These platforms will offer opportunity to share key issues emerging from the GSD trainings and quality issues from the community score card. Advocacy for quality KP services and enabling policy environment will be a major focus of CSO engagements. There are systems in place to engage with the CSO's at the regional level which will inform and feed into the national level engagements. These engagements will continue and have expanded to include hotspot mapping, program implementation, and monitoring.

PEPFAR Uganda will also continue to support Gender and Sexual Diversity (GSD) trainings to address stigma and discrimination against LGBT Ugandans while linking them to the national training database as detailed in CSO Matrix. Health worker friendly services trainings will be supported. A KP-led, quality-focused community score card will be rolled out in all regional KP service points. CDC will work with Action Group for Health and Human Rights (AGHA) the initiators of the community score in Uganda to support the initial processes of the roll out through regional comprehensive mechanisms and KP CSOs. We will use the unit breakdown of training healthcare workers to support the community score card process ($2 PP and $3KP). KP CSOs will take lead in actual implementation and health worker interface including action planning to address identified quality issues. The National training database will be used to track roll out. A dashboard to monitor and triangulate scorecard findings with program performance on critical indicators, will inform ABH/PEPFAR advocacy agenda. DOD will mainstream community scorecards with MUWRP. CBOs that have been mapped to health facilities through the facility – community linkages framework operationalization will generate work plans with facility input. Assessment of the level and impact of community engagement will be done on a quarterly basis led by the district community development office and Extended DHMTs. This forum will provide opportunities for sustained community engagement through regular planning and performance monitoring. PEPFAR will support the roll out of the MOH harmonized KP health service providers training curriculum to enhance health providers' competency and reduce KP/PP stigma.

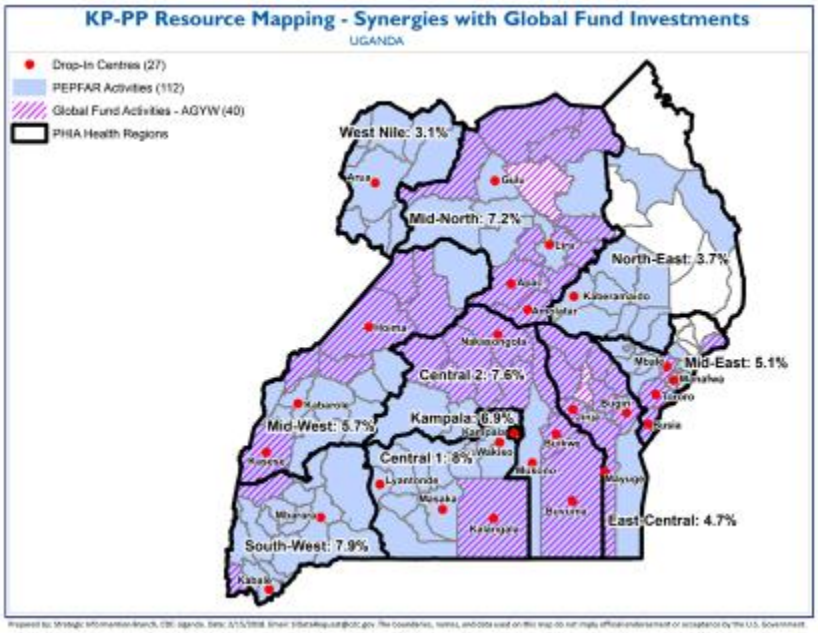
The MOH tools currently include KP disaggregation for the HTS indicator which does not allow for cascade monitoring and corrective action. PEPFAR and other stakeholders are working with MOH to harmonize KP data collection and reporting tools which will improve KP identification and reporting along the clinical cascade. Data from the KP/PP data capture tools will be reviewed weekly with IPs to ensure program improvement is steered in the right direction in the shortest

time possible. Data will also be reviewed to track KP referral and to monitor access to services and cascade monthly trends.

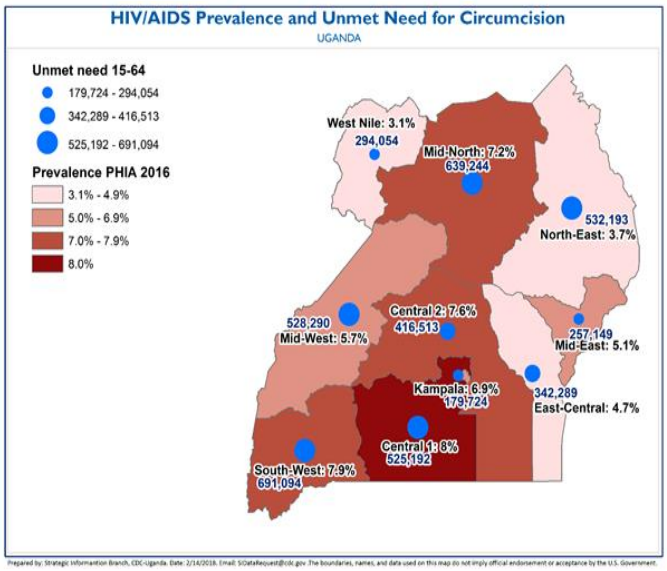
Table 4.3.1: Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate (scale-up SNUs)**	**Coverage Goal (in FY18) %**	**FY19 Target**
MSM	46,679 (33,013)	18	8,297
FSW	198,376 (141,961)	47	92,266
Prisoners	49,617 (44,060)	100	160,000
Prison Officers	7,182 (6,265)	90	6,470
Police[104] and private security guards	86,643 (83,547)	80	69,318
Fisher Folk	2,000,000 (NA)	7	149,482
Military	50,000 (NA)	25	50,000
SDC	25,693 (22,512)	50	23,124
AGYW	789,400 (789,400)	20 (10 original districts) 100 (3 new districts) 50 (4 PMTCT districts) and follow-up of 136,410 (original 10 districts)	148,664
PrEP implementation (FSW, MSM,FF)		15	16,841
TOTAL			**724,462**

Table 4.2.2: Key Populations Estimates, Targets, Achievements (COP16-COP18)							
	COP16			**COP17**		**COP18**	
Category	**Estimates**	**Targets**	**Achievements**	**Estimates**	**Targets**	**Estimates**	**Targets**
FSW	80,236	64,189	72,803	148,115	88,869	198,376	92,266
Incarcerated*	NA	2,591	35,665	151,000	98,150	160,000	160,000
MSM	25,460	3,646	5,165	8,363	5,409	46,679	8,297

* While there are a total of 160,000 people who are incarcerated at any point during the year, only 50,000 are actually incarcerated at a time.



VMMC



PEPFAR VMMC support began in 2010 and was scaled up in 2013 with additional central funding. The cumulative number of PEPFAR-supported VMMCs performed in Uganda increased from 9,052 in 2010 to more than 3.6 million by APR17. PEPFAR continues to be the principal donor for VMMC, having supported 95 percent of all circumcisions during this period.

The proportion of men aged 15–49 years who are circumcised has increased from 26 percent in 2011 (AIS 2011) to 43 percent (UPHIA 2016).[105] In addition, the proportion of circumcised men ranges from 14 percent in Mid-North region to 69 percent in Mid-East region (UPHIA 2016).[106] The prevalence of male circumcision (MC) was highest (>45 percent) among young men aged 15–29.[107] These survey data guided COP18 target distribution with the regions with the highest unmet need for circumcision and high HIV burden

[105] UAC, 2012; Unpublished UPHIA data, 2017.
[106] Unpublished UPHIA data, 2017.
[107] Unpublished UPHIA data, 2017.

receiving the highest targets. These regions are Mid–North with an unmet need of 639,244 and HIV prevalence of 7.2 percent and South-West with an unmet need of 691,094 and HIV prevalence of 7.9 percent.[108]

By the end of COP17, 6 districts will have attained 80 percent saturation in the 15-29 age-band. In COP18, PEPFAR will perform 756,456 MCs targeting 86 districts with the highest HIV burden and lowest prevalence of MC. These districts include 41 scale-up aggressive districts (53 percent of MCs), 30 scale-up saturation districts (36.8 percent of MCs), 15 sustained districts (6.9 percent of MCs) and the rest will be implemented in the military-supported districts and facilities. By end of COP18, a total of 30 districts will have achieved 80 percent saturation in the 15-29 age band assuming all targets are achieved.

The DREAMS platform will be leveraged to target male sexual partners aged 15–29 who will be characterized and mobilized through DREAMS Ambassadors, Girls Engagement Forums, and AGYW male partner champions. Other men at high risk such as STI clients and partners of sero-discordant couples will also be encouraged to undergo circumcision.

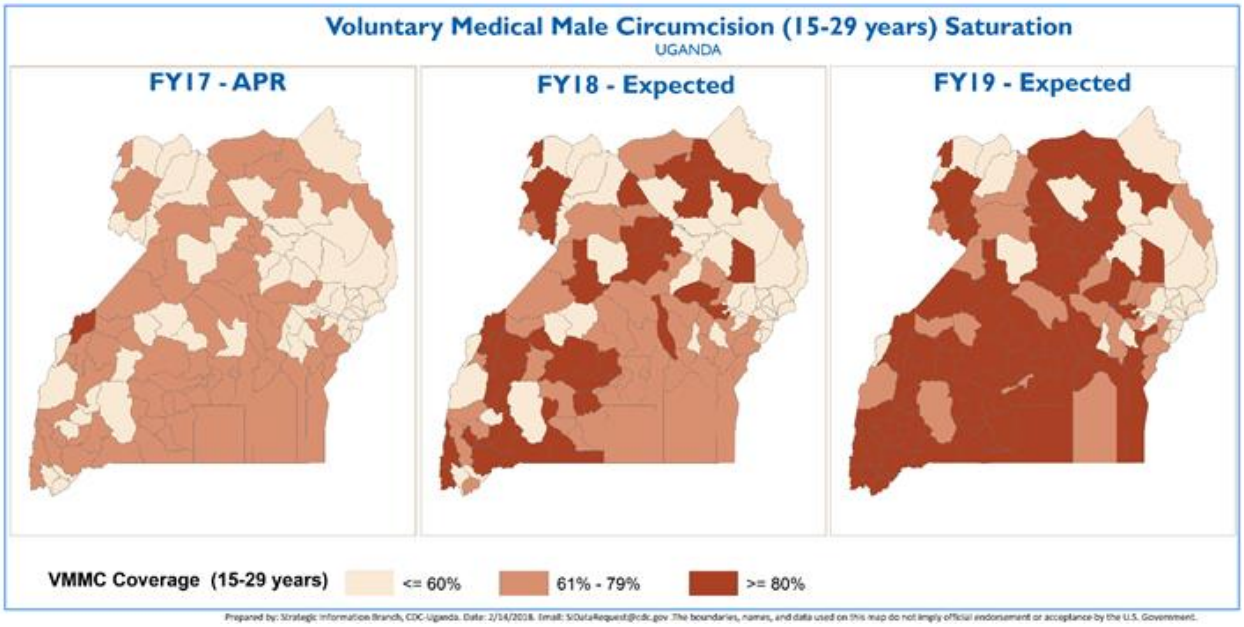
Key shifts and considerations in COP18 include introducing ShangRing as a device-based option targeting 1,000 MCs through active surveillance. The active surveillance phase will inform policy decisions for inclusion and roll-out of the method in Uganda based on acceptability and outcomes of adverse events during this phase. PEPFAR support for circumcisions with PrePEX, a device method where the foreskin is left in situ and removed several days after application will be stopped. The program will invest in reducing the proportion of disposable instruments from the current proportion of 90:10 to 80:20 as a cost-saving approach for sustainability. Efficiencies in the program informed a reduction in unit cost of delivering VMMC services, from US $65 in COP17 to US $49 in COP18 which has allowed PEPFAR to increase targets from 692,294 in COP17 to 756,456 in COP18. For quality maintenance, PEPFAR will prioritize decentralization of specialized adverse events management through supporting a functional referral system for areas that lack specialized adverse events management.

For immediacy of impact, the VMMC program will continue to target the high-priority 15-29 age band with a goal of targeting 80 percent of VMMCs to this band. At APR17, 49 percent VMMC achievement was within the 15–29 age pivot, a 28 percent increase from FY16. In COP18, PEPFAR will further improve on the age pivot by focusing demand creation and service provision on the 15–29 age band while, based on the youth bulge, ensuring that boys aged 10–14 become the focus in locations which are close to saturation for the age pivot. While emphasis will be on the priority age band, services will not be withheld from any medically-eligible male. Interventions to improve VMMC coverage among the 15–29 age band include mobilization at schools and tertiary education institutions, health education at ANCs, separate waiting and education areas at VMMC sites,

[108] Unpublished UPHIA data, 2017.

extended hours/days, and incentives such as the provision of transport and mobile services at workplaces and marketplaces.

With COP base funds and additional central funding received in COP18, 30 districts will achieve 80 percent coverage among the 15–29 age band assuming that all the set targets for COP17 and 18 are achieved in the age band.



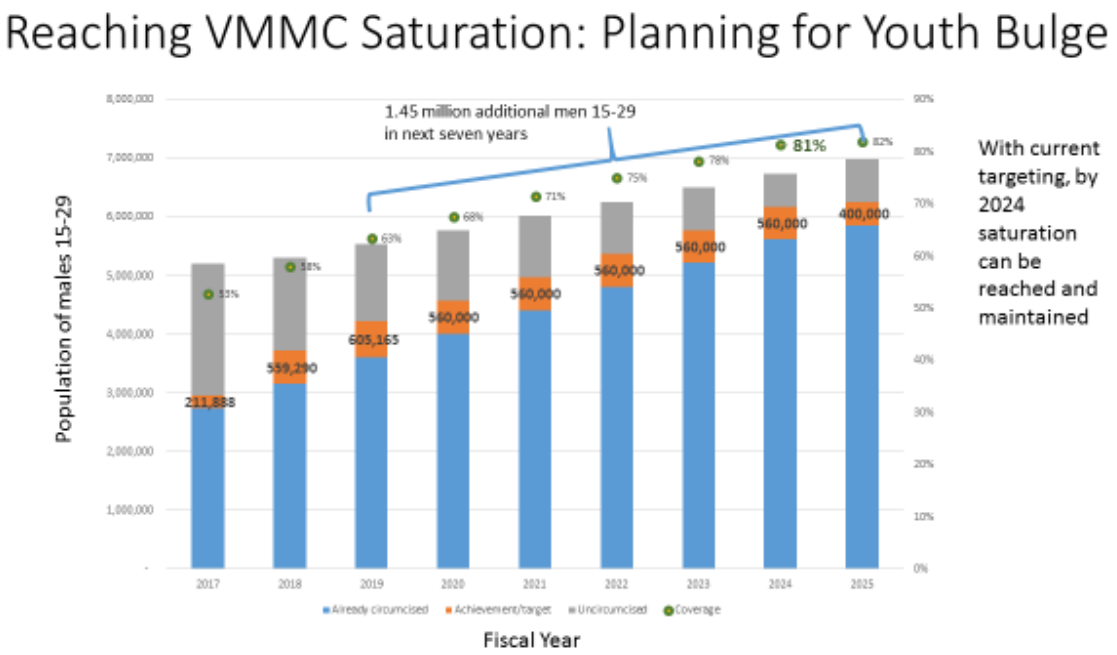
The DREAMS districts and previous partner performance have also been prioritized in the target-setting process. IPs will be supported to improve performance with weekly performance review of results, monthly interagency VMMC partner performance review meetings, and quarterly DQAs led by M&E partners. In COP18, CQI interventions will scale up proven approaches for adverse events prevention and management and active post-circumcision client follow-up according to the national VMMC package of care.

VMMC will be offered as part of a comprehensive HIV prevention package, which includes HIV testing and counselling, screening and treatment of STIs, and referral of HIV-positive identified men to appropriate care and treatment. HIV testing services will be offered only on request, and not routinely, to boys and adolescents who have not yet had sexual debut, given low rates of HIV infection in this age group. PEPFAR will provide commodities and consumables, including emergency kits and TT.

Youth 'Bulge'

Finally, it is important to recognize that Uganda will experience a large youth 'bulge' where the number of young men aging into the target group of 15-49 year olds is significant. The PEPFAR Uganda team has taken this into consideration for VMMC and is planning for COP18 and out years to ensure saturation of the 15-49 year old group by 2020. Again, UPHIA estimates just over

2.4 million 15-29 year olds are circumcised. With FY17 achievements in this age group, coverage is at just 52%. Taking into consideration the youth 'bulge' the total population of 15-29 year olds will increase by 1.2 million in the next 5 years.



Therefore, to ensure 80% coverage by 2020, targeting for 15-29 year old age group will need to increase from the FY19 target of 605,165 to 725,000 for FY2020. Increased focused is needed to ensure pivot to priority age group, noting that in APR17, the age category of 10-14 years contributed 46% of the total circumcisions while 47.2% were from the age group of 15 -29 year age group. In COP18, for immediacy of impact and taking into consideration the growing youth 'bulge' from the 10-14 year olds, the VMMC program will intensify targeting to reach 80% of the higher-priority 15-29 age bands. In out-years the program will be continuing this focus to ensure we are successful in saturation by scaling up numbers for VMCC.

4.3 Additional country-specific priorities listed in the planning level letter

At APR17, overall linkage from testing to treatment was 75 percent and 12 months' retention was 71 percent compared to the FY17 targets of 80 percent and 89 percent respectively, with variations by population group, age, geographical location, urban/rural, and service delivery site. Additionally, 12-month cohort retention was higher among females (72 percent) than males (70 percent), and lower among young people aged 15–24 (59 percent in females aged 15–19, 34 percent in males aged 20–24), fisher folk (54 percent), and pregnant and breastfeeding HIV-positive

women (69 percent).[109] Regionally, 12-month cohort retention was lowest in Central 2 Region (65 percent) with over 15 districts having retention below 60 percent.[110] Data quality remains a challenge across districts coupled with inadequate documentation of client transfers and human resources shortfalls.

To improve national ART coverage for all sex and age populations and as part of the immediate surge strategy, PEPFAR Uganda will focus on increasing the number of PLHIV initiating and retained on treatment. A basic linkage and retention change package will be implemented at all ART sites with modifications to suit different populations. The change package will include active linkage from HTS to treatment utilizing peer escorts and linkage facilitators, use of triplicate referral forms, and use of phone call reminders or home visits for those not yet linked. Once linked, same-day ART initiation will be encouraged and ART starter packs for those identified in community outreaches/hard-to-reach areas will be introduced. Following ART initiation, facilities will provide ongoing psychosocial support for treatment adherence using gender-specific peers, pre-appointment reminders, tracking of clients missing appointments using physical locator forms and phone calls, and scale-up of appropriate population-specific DSDM. Community facility linkages and referral frameworks will be strengthened for client tracking and community drug distribution. Figures 4.3.1 through 4.3.5 summarize the core linkage and retention interventions.

Among young people aged 15–24 years, factors contributing to poor adherence and retention include stigma and non-disclosure, school programs conflicting with clinic attendance, inadequate psychosocial support, and inadequate youth friendly services. In COP18, PEPFAR Uganda will scale up adolescent and youth-friendly DSDM models with robust psychosocial support systems addressing stigma reduction and supported disclosure. These support systems will be linked to OVC and DREAM programs.

For men, PEPFAR Uganda will support the use of male peers to escort clients from testing points to ART points for initiation and the pairing of male linkage facilitators with newly diagnosed HIV-positive men for more effective linkage to ART. Male-friendly services will be supported through extended working hours and alternative patient flow systems that reduce clinic wait times and minimize work interruptions, as well as through strengthened retention tracking though via peers.

To improve retention among pregnant and lactating women, facilities will support regular family support group (FSG) meetings, use of mentors/peer mothers to improve tracking and follow-up of mother mother-baby pairs, and strengthened birth cohort monitoring and HIV-exposed infant cohort analysis.

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[109] PEPFAR Program Data.
[110] PEPFAR Program Data.

For KPs, stigma, high mobility, limited access to KP-friendly services, unconducive legal environments, and alcoholism and drug abuse contribute to suboptimal retention. COP18 will continue to orient service providers on KP services, conduct outreaches to provide services, strengthen drop-in centers, and provide tailored adherence counseling and peer-led tracking. Other PPs such as fisher folks, truck drivers, and uniformed service personnel, also experience high mobility, alcoholism, and drug abuse and have limited access to services. These populations will be targeted with multi-month dispensing and networked service delivery.

Critical inputs for enhanced linkage, retention, and adherence include: uninterrupted supply of ARVs; staffing to support psychosocial support; and client tracking. PEPFAR support to the public sector will facilitate commodity security thus contributing to adherence and retention.

To address the data quality gaps, the use of EMR will be further scaled-up from 47% to 61% (769 out of 1641 PEPFAR supported sites). In addition, we will increase the use of unique identifiers from eight sites to 74 sites by the end of FY19 across attained and scale up districts in high volume facilities to track silent transfers.

Additionally, site capacity for retention cohort reporting will be strengthened. The MOH is in the process of developing psychosocial support guidelines for children, adolescents, and adults.

Figure 4.3.1: Focus Activities for Identification

HIV Case Finding Priorities	● Voluntary partner notification/index patient testing ● Improved facility-based testing ● Strategies to find HIV+ men ● Data analysis for course correction

Improved Facility-Based Testing	● Focus on high-volume facilities
	● Ensure key ingredients are available
	  o Rapid test kits (RTKs)
	  o Testers (lay testers, laboratory technicians, nurses, etc.)
	  o Private space for testing
	  o Documentation (modality, re-testers, transfers)
	  o Strategy to ensure linkage
	● 100 percent testing vs. screening approach
	● Better data capture of modalities
	● Use data to quickly course-correct

Figure 4.3.2: Package of Linkage Interventions

Gender-specific linkage facilitators or peer clients	• **Physical escort** of newly identified PLHIV to ART clinic from in-facility testing sites • Completing the **physical locator form** • **Proactive follow-up** for people not initiating same day • **Documentation of closed linkage loop** • Documented referral of all newly identified PLHIV to peer networks or **community support groups**
Tools to track newly identified PLHIV	• **Physical locator form** – kept on file until ART file is opened at which point it should be transferred to the ART file. • **Register/file for all newly identified clients** to document tracking and disposition (initiated, transferred, repeat tester, refused ART, still pending initiation, lost) – modified linkage/pre-ART register being modified by MOH o *Can be used to monitor 'success rate' of linkage facilitators*
Same-day ART initiation	• **ART starter packs** for community testing
Supported disclosure to male partners of newly identified positive women	• Site has **at least one counselor** in ART and one in ANC/PMTCT trained and dedicated to providing couples counselling and supported disclosure

Figure 4.3.3: Package of Additional Linkage and Retention Interventions

Implementation of community-facility linkage register and referral desk or focal person	• **List of community organizations** collaborating with facility including PLHIV support groups, SGBV assistance organizations, police, probation office/DCDO/parasocial worker • **Documentation of bidirectional completed referrals** in community-facility linkage register (green on SIMS)
Pre-appointment reminders by SMS or phone call	• **Airtime** for providers or peers to contact clients • **Documentation of appointment register** that client was contacted
Active tracking/case management of newly initiated PLHIV at risk for LTFU (KP, pregnant women, adolescents/youth)	• **Peer-to-peer support for initial 6 months on ART** (weekly or biweekly contact) for adherence strategies, side effects, disclosure, etc. • **Assist with linkage** to appropriate community organizations or support within facility (e.g. PLHIV groups, GBV interventions, OVC program, supported disclosure) • **Orient to VL monitoring and DSDM**
Sexual and gender-based violence (SGBV) screening and post-violence care	• HIV and MCH providers at all high-volume sites trained to screen for GBV using **SBGV screening tool** • Identified and trained **SGBV focal person** at all high-volume sites to provide **post-violence care services** • **Coordination with police** and local community organizations for SGBV management

Figure 4.3.4: Package of PMTCT/EID Interventions

- Use of **1st PCR tracking tool/pre-appointment log and physical locator form** from **ANC1**
- **Proactive identification** of all HIV-exposed infants at all facility entry points
    - Sensitization of inpatient and OPD
    - Screening for HIV exposure in YCC
    - Same-day linkage to MCBP from maternity
- **Routine review of EID data**
    - **EID focal person** generates **weekly** list of missed appointments for **follow-up by peer mother**
    - **PMTCT focal person** updates EID cascade for HIV-exposed cohorts **monthly**
- **Monthly mentorship** by IPs

Figure 4.3.5: Package of Adolescent-Focused Interventions for Linkage and Retention

Adolescent linkage facilitators/peer clients	• **Physical escort** of newly identified from in-facility testing site • Completing the **physical locator form** • **Proactive follow-up** for adolescents/youth not initiating same day • Documentation of **closed linkage loop** • Documented referral of all newly identified adolescents/youth to **peer networks or community support groups**
Adolescent focal person within the facility	• **Organizes adolescent/youth focused activities** • **Overseas adolescent peers** • **Endures standard documentation of OVC assessment and enrollment** in child/adolescent's file
Active tracking/case management of newly initiated adolescents/youth	• **Peer-to-peer support** (weekly or biweekly contact) for initial 6 months or virally non-suppressed on ART for adherence strategies, side effects, supported disclosure, etc. • **Assist with linkage** to appropriate community organizations or support within facility (e.g. PLHIV groups, GBV interventions, OVC program) • **Supported disclosure to family, partners, and peers**
Adolescent DSDM	• **Aligning appointments to school holidays** • **Age and gender appropriate health education for support groups/group visits** (standardize and improve quality) • **Introduce Zvindiri community adolescent treatment supporter model**

In order to focus on intensifying support for the above packages, PEPFAR Uganda will stop or reduce the following activities:

Area	What Will We Stop/Reduce?
Private Sector	• Funding to private-for-profits (PFPs) • Reduce HR support to PNFPs • Reduce commodity support to PNFPs
Evaluations/Surveys	• Conclude ongoing studies and only limited new activities • OVC evaluations
Prevention	• PrePex device for VMMC
HIV Testing Services	• Index testing of all household members • Eliminate 100 percent OPD outpatient testing of low-risk populations
Strategic information	• Printing of paper tools by 25-50 percent and phase- out within three years as EMR is rolled out • USG of forums to revise HMIS tools reduced by 50 percent • Minimize long-term SI personnel

Care and Treatment	• Eliminate sub-optimal ARV regimens • Lab ARV toxicity monitoring
Laboratory	• CD4 testing
HSS/HRH	• Reducing technical advisors at Central MOH and in districts as staff transition to MOH • Reduce in-service and pre-service trainings • Procuring new equipment for Rx Solutions • Equipment and motorcycles for MMS • Shelving support for health facility stores and other warehouse infrastructure

4.4 Commodities: TLD Transition

TLD Transition

Due to high HIV pre-treatment drug resistance (PDR) to non-nuceoside reverse transcriptase inhibitors (NNRTIs) of 15.4% percent in 2016, Uganda revised the treatment guidelines in February 2018 and recommended TLD as the preferred adult first-line ARV regimen. As per the national plan, TLD transition will begin in July 2018. TLD coverage is then projected to reach 35 percent of all eligible PLHIV by December 2018. By September 2019, 90 percent of all adult first-line patients are projected to be on TLD. The transition is dependent upon global drug manufacture supply and availability.

Transition will be phased by level of health facility, starting with regional referral hospitals (RRH) and public and private-not-for-profit high volume sites, and then rolling out to lower level facilities. First, all eligible patients in 41 selected sites will transition to TLD in 2018. During 2019, all remaining eligible patients will then transition.

Eligible patients are adults and adolescents newly initiating ART and those currently on first line regimens who have a suppressed VL within the previous six months. Pregnant women and TB/HIV coinfected patients are also eligible for TLD.

To ensure availability of adequate quantities of TLD, PEPFAR Uganda has allocated additional funding (USD US 16.7 million COP17 funds) to kick-start and support public sector TLD procurements, supplementing additional procurements by the Global Fund and GOU. CIPLA/Quality Chemicals production of TLD is expected to commence in July 2018. In-country registration of FDA-approved generic TLD by the National Drug Authority (NDA) is in progress for Aurobindo and Mylan and should be completed by June 2018 at the latest. Results from pilot implementation among 786 clients at six ART sites reported good tolerability although there were fairly high rates of Immune Reconstitution Inflammatory Syndrome (IRIS). To minimize the risk of IRIS, pretreatment screening for opportunistic infections will be enhanced and patients with advanced disease provided with specialized care prior to ART. Existing patients on suboptimal

first-line regimens will only be initiated to dolutegravir (DTG) if they are virally suppressed in order to reduce the risk of DTG monotherapy in case they are failing ART.

From April 2018, stakeholders and patients will be sensitized on the benefits of the new regimen starting with CSOs for PLHIV. At facility level, on-site mentorships will be conducted for health care workers utilizing materials and job aides developed by Communications for Health Communities (a PEPFAR partner) and disseminated by IPs. The Pharmacy Division's Quantification Procurement Planning Unit (QPPU) will monitor orders through the WAOS to that ensure in-country stock of the five regimens that are being phased out are adequately utilized. Transition monitoring will be facilitated through WAOS and through weekly, site-level, real-time reporting with feedback to central warehouses and MOH.

Surveillance for adverse effects will be conducted through an existing NDA pharmacovigilance program at sentinel sites. In addition, the ongoing Birth Defects Surveillance System established by the Makerere University-Johns Hopkins University (MUJHU) Research Collaboration will incorporate TLD, while HIV drug resistance (DR) sentinel surveillance for DTG-based regimens will be enhanced. Discussions on the use of TLD for second- or third-line ART are still ongoing.

Commodity security

In order to ensure commodity security at both central and site level, PEPFAR Uganda will: continue support for greater financing of ARVs and RTKs to ensure adequate buffer stock (minimum 3 months) and reduce the risk of stock-outs and the need for IPs to actively engage in redistribution efforts; stock monitoring, redistribution, and technical assistance for ARV ordering across facilities and districts by PEPFAR Uganda IPs, with technical support to NMS; and standing meetings between PEPFAR Uganda and PEPFAR HQ supply chain teams to review stock status and timing of deliveries. COP18 will also strengthen oversight of supply chain performance through development of site and national commodity dashboards, mentorship and supervision for commodity management by Medicine Management supervisors, and weekly review of the national stock pipeline report by QPPU and the PEPFAR commodity task team. PEPFAR Uganda will engage with multiple stakeholders to address supply chain bottlenecks though participation in monthly inter-ministerial meetings chaired by the MOFPED and monthly MOH-led Commodity Security Group meetings chaired by QPPU to follow up on agreements in the Implementation Letter which was signed by MOFPED, NMS, MOH, and USAID PEPFAR.

Through these measures, PEPFAR Uganda has been successful in supporting GOU to stabilize the majority of ARV stock levels through mid-2018. For the remainder of calendar year 2018, the following table summarizes the situation for both RTKs and ARVs needed to keep Uganda on track to reach epidemic control. Overall, PEPFAR Uganda will be contributing US $52,733,405, of which US $49,622,312 was identified within COP18 funds and US $3,111,093 has been requested from S/GAC. A $6.7 million gap remains for RTKs in calendar year 2019. Global fund will potentially be able to close this gap with savings on procurements, but this is yet to be confirmed.

The contribution of each donor to the public sector ARV and RTK need, and remaining gap, for calendar years 2018 and 2019 is summarized below.

ARV funding for CY18 and CY19			
		CY18	**CY19**
TOTAL NEED		**119.4M** (factoring in stock on hand)	**124.4M**
Confirmed financial commitments	**GOU**	$23.2M	$23.2M
	GF	$54.4M	$62.6M
	PEPFAR COP16	$2.8M (remaining funds from COP16 $11.5M)	
	PEPFAR COP17	$7.2M ($5M + 2.2M reprogrammed)	
TOTAL ARV GAP		**$31.8M**	**$36.5M**
Contributions toward gap fill agreed upon during COP18 RPM	**GF**	$2.6M savings	potential savings
	PEPFAR COP17	$16.6M of pipeline	
	PEPFAR COP18	$12.6M	$37M
	Remaining GAP	**$0**	**$0**

The ARV funding need is based off the following assumptions:

1) 35% of existing adult 1st patients will be on TLD by December 2018; and 73% by September 2019
2) 100% of patients on 5 legacy regimens will transition to DTG-based regimens
3) 90% of all newly identified adult patients will be placed on TLD; 5% on TLE; 5% on ABC/3TC/DTG
4) Global Fund $2.6M is conditional to the commencement of the TLD transition as planned.

RTK funding for CY18 and CY19			
		CY18	**CY19**
TOTAL NEED		**$12.4M**	**$11.4M**
Confirmed financial commitments	**GOU**		
	GF	$8.6M	$4.7M
	PEPFAR COP16		
	PEPFAR COP17		
TOTAL RTK GAP		**$3.8M**	**$6.7M**
Contributions toward gap fill agreed upon during COP18 RPM	**GF**		potential savings
	PEPFAR COP17		
	PEPFAR COP18	700,000	
	PEPFAR central funds	$3.1M (pending OGAC approval)	
	Remaining GAP	**$0**	**$6.7M**

Enterprise Resource Planning (ERP) Tool for the NMS

To strengthen accountability for health commodities and to improve supply chain management, COP18 will establish a complete and integrated ERP software solution within NMS that will aggregate national supply chain management data and allow health facilities to order and track receipts and budgets online. Successive GOU Auditor General's reports have identified numerous weaknesses in the NMS system for tracking commodities.[111] In 2016, an audit of Global Fund-procured HIV commodities determined that NMS lacks adequate means to properly track commodities to health facilities.[112] Following this, the GOU Inspector General required NMS to develop a new Enterprise Resource Planning (ERP) tool as the current ERP was not able to sufficiently meet the requirements of donors and other stakeholders. The MOH requested that PEPFAR Uganda procure this tool. In 2017, this task was transferred from CDC to USAID/Uganda.

ERP involves both hardware and software. The software ensures the transparency and accountability of HIV commodities procured, warehoused, and distributed through the public sector by NMS; improves the management efficiency of NMS operations across all departments, and allows for NMS to bill the USG for services in an equitable, volume-based manner; and allows health facilities to plan, order, and track receipts of all commodities, including HIV commodities, online. Under the current public sector pivot, PEPFAR Uganda will increase the value of HIV commodities it procures for the public sector from US $12 million for calendar year 2017 to US $46 million for calendar year 2018. With this increase, PEPFAR Uganda will fund the installation of a comprehensive ERP at NMS. In COP18, ERP will be installed at NMS and will then be rolled up to serve over 550 high volume health facilities over a five-year period starting with regional referral hospitals in COP18.

Interactive ERP information modules include financial management, warehousing and inventory, sales and marketing/order fulfillment, procurement, product catalog, transportation, customer care, human resources, quality assurance, audit/transactional logging, risk management, performance management, business intelligence and reporting, and Help Desk management. ERP software installation will employ System Development Lifecycle (SDLC) methodology that requires structured, participatory decision-making in all aspects of information systems design, development, and installation. SDLC will help mitigate design/development risks, ensure country ownership, and serve as a cornerstone in strengthening management of the national supply chain

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[111] Office of the Auditor General. *Annual Report of the Auditor General for the Year Ended 30th June 2015.* (Kampala: Office of the Auditor General, 2015). http://www.oag.go.ug/wp-content/uploads/2016/01/Perfomance-Report-30th-June-2015.pdf; Office of the Auditor General. *Annual Report of the Auditor General for the Year Ended 30th June 2016.* (Kampala: Office of the Auditor General, 2016). http://www.oag.go.ug/wp-content/uploads/2017/01/Annual-OAG-Performance-Report-2016.pdf

[112] Global Fund. *Audit Report: Global Fund Grants to the Republic of Uganda.* 26 February 2016. (Geneva: Global Fund, 2016). https://www.theglobalfund.org/media/2646/oig_gf-oig-16-005_report_en.pdf

system. The PEPFAR Uganda program will support the facilities to uptake and use the ERP systems.

4.5 Collaboration, Integration and Monitoring

PEPFAR Uganda collaborates closely with the Global Fund via the CCM, as well as with the Geneva-based Country Manager. USG is represented on the CCM across all agencies

The CCM and PEPFAR Uganda actively share information on planning and progress in country, and PEPFAR Uganda technical staff have contributed to grant proposals and review meetings. In 2018, PEPFAR Uganda will participate in site evaluation visits and the National Stakeholders' meeting for harmonization and alignment of the Global Fund with other in-country financing mechanisms, and review program implementation frameworks, work plans, budgets and procurement and supply chain plans.

The PEPFAR Uganda commodity supply chain team meets with Global Fund counterparts and the MOH QPPU to coordinate procurement schedules, distribution, and systems strengthening. PEPFAR Uganda and Global Fund are communicating regularly on new grants and catalytic programs for the TB and HIV cross-border refugee proposal from the Inter-Governmental Authority on Development; legal barriers to HIV service access; and a DREAMS-like program for AGYW. New grants are rolling out and teams will continue to link closely through CCM, PEPFAR Uganda stakeholders' meetings, and informal meetings.

In 2017, PEPFAR Uganda, together with the MOH and MOFPED, had very productive discussions with Global Fund staff in connection with the negotiation of an Implementation Letter regarding improvement of the transparency, effectiveness, and efficiency of Uganda's health commodities supply chain system. The goal of the Implementation Letter is to ensure that there will be no national stock outs of essential medicines and commodities, including ARVs, RTKs, and other HIV-related health commodities.

Partner Performance and Monitoring

Since COP17, PEPFAR Uganda has been implementing an intensive IP performance monitoring and improvement strategy that involves more frequent analysis of partner data and monthly meetings with IPs to address areas of poor performance, identify best practices, and work to ensure best practices are scaled up with fidelity. Recognizing that COP18 targets were formulated based on the assumption that PEPFAR Uganda would accomplish its COP17 targets - and given the poor performance of the country program in enrolling people on treatment in FY17 (62 percent of the target) and in FY18 Q1, (12 percent of the target) - PEPFAR Uganda is now implementing a more intensive "surge strategy" to spur IPs towards meeting COP targets.

The surge strategy commenced in FY18 Q2 and will continue until the program is on track to achieve its targets. The surge strategy focuses primarily on key areas in which the program is performing most poorly, namely identification of HIV-positive individuals (in particular men),

testing efficiency, linkages to rapid treatment initiation, and related issues of commodity security. The technical activities meant to achieve specific outcomes, such as actions to improve index client partner and children testing and APN, are noted in the strategy tables in SDS section 4.3.

To ensure these actions take place immediately, PEPFAR Uganda asked IPs to develop individual surge strategies addressing priority program areas. These surge strategies are data-driven (i.e. based on UPHIA and program data) and, in order to achieve the highest impact, target both the regions and specific population groups with the highest unmet need and the sites with the most targets. The strategies focus on scaling-up and monitoring evidence-based intervention packages, as well as the quality of implementation. PEPFAR agencies reviewed strategies internally, in interagency technical working groups (TWGs), and with partners to help facilitate exchange on what is prioritized and what interventions are working, so as to transition from pockets of excellence towards scaling up for national achievement.

Partners are already using results tracking tools that capture site-level and community-level data, including new HIV cases identified, linked to care, and initiated on ART. Data on key indicators including HTS, HTS_POS and TX_NEW are reported on a weekly basis in HIBRID. The data are disaggregated by age band, testing modality, population group, etc. IPs conduct joint weekly review meetings among their staff and key facility and outreach personnel such as ART in-charges, linkage facilitators, and counselors to review performance against targets and address challenges and areas of underperformance. IPs also use these opportunities to address key bottlenecks such as sub-partner performance.

IPs are using real-time HIV commodities tracking systems to avert stock outs and maldistribution of supply. These tracker dashboards are updated on a weekly basis to monitor supply for HIV services. This will be done with district logistics persons and health facility stores managers. It is expected that this tracking process will maintain HIV commodities stock levels to maximize identification of HIV-positive persons and enrollment of each on ART.

PEPFAR Uganda agencies hold meetings with all their respective IPs to review performance, share best practices, and provide guidance on poor performance. PEPFAR Uganda has begun weekly meetings with each comprehensive care and treatment partner, concentrating on site- and district-level approaches, barriers to progress, data quality, resource alignment and outlay, and capacity challenges. Technical staff review the data that partners submit on a weekly basis and provide immediate feedback if the data trends are of concern. They also flag at the TWG level to monitor portfolio trends. Integrated technical and management teams travel to key underperforming sites and districts with partners and engage MOH counterparts to facilitate more rapid improvement, verify actual practice, carry out data spot checks, assist in rolling out good practices, and consult with high-volume site leadership, district health officers and local government officials to promote ownership and collaboration with PEPFAR IPs.

PEPFAR Uganda agencies are conducting enhanced SIMS assessments on priority topics, including retention strategies. Agencies are meeting weekly with partners to update on the surge,

with daily follow-up where needed, weekly data collection review on the five key indicators, and monthly care and treatment IP meetings. On a quarterly basis, PEPFAR Uganda is also issuing surveys among all IPs to monitor the scale-up of best practices including index client testing, same day initiation, and ART starter packs. From a management perspective, agencies are monitoring burn rates with each IP, helping ensure partners' resources are focused on achieving targets within COP outlay authority and gaining efficiencies wherever possible. Close attention is being paid to clear and regular communication with IPs and with IP headquarters' offices to facilitate efficient work plan approvals, sub-contracting, procurements, and evaluation protocol approvals. PEPFAR Uganda is also considering monthly interagency-led joint care and treatment partner meetings (Country Director and lead technical director), with MOH and other groups as needed to share best practices, monitor surge and quarterly results, address constraints and advance policy issues.

Finally, on a quarterly basis PEPFAR Uganda has re-initiated meetings for all-IPs across all agencies led by the U.S. Ambassador for updates on critical policy and programmatic issues. This will be expanded during COP18 to include CSOs, representatives from the UN family, and MOH leadership to continue emphasizing the surge, reviewing data outputs, and collectively determining approaches to meet goals.

Internally, PEPFAR Uganda operates TWGs for Health Systems Strengthening, HIV Care and Treatment, and HIV Prevention, with cross-cutting strategic information team support, and multiple integrated sub-groups leading OVC, PMTCT, DREAMS and other priority program areas. Each TWG engages with counterparts at the MOH, other GOU authorities, and stakeholders through regular meetings and formal structures to agree on priorities and follow progress. Service delivery activities for COP18 have been determined based on a systems barrier analysis that identified gaps hindering service delivery at site, district and national level. A number of critical barriers were identified. For example, the public sector supply chain faces commodity insecurity due to insufficient funding and weak supply chain management systems to order, procure, and track commodities at NMS and in districts and health facilities. There are bottlenecks with respect to HRH, including a lack of policy for certain cadres (e.g. for lab staff at the Central Public Health Laboratory (CPHL)), inadequate clinical and supervisory staff to provide services and/or coordinate HIV programming both at national and at facility level, and a shortage of critical cadres (e.g. pharmacy assistants) due to limitations in training.

Other systems barriers include inadequate quality and timeliness of strategic information, including a limited capacity by districts and facilities to use data effectively to adapt to and address gaps in the HIV program response. Additionally, weaknesses within health governance systems mean that districts do not have the capacity to adequately provide leadership and oversight functions within the decentralized health system and that there is overall poor accountability of performance towards attaining PEPFAR Uganda's 95-95-95 goals. With respect to community systems and CSO engagement, there is insufficient systematic engagement by PLHIV and KP/PP CSOs with GOU, stakeholders, and service providers, as well as high stigma among communities, all of which impacts HIV testing, treatment, and retention. Finally, within

laboratory systems there is suboptimal external quality assurance (EQA) for HIV testing, TB sputum microscopy, and GeneXpert, and weak laboratory inventory management system for linking the national health laboratory system to laboratory hubs.

The key outcomes expected from COP18 above site service delivery activities include accurate commodity supply plans; no stock out of ARVs and key HIV commodities; TLD transition to 90 percent of PLHIV on adult 1st line regimens; improved recording and reporting of commodities; and accountability and traceability of USG-procured commodities in the public sector.

Other outcomes include an increase in GOU-salaried health workers at site level to support service delivery, supply chain management, and laboratory activities, and a revised policy on staffing norms to allow for the hiring of a new, GOU-supported lab cadre at CPHL. Additionally, there is an expectation of improved quality and timely data for program management to inform epidemic control, better CSO engagement in finding men and mitigating stigma barriers, and increased engagement of national, district and CSO leadership in monitoring efforts to achieve epidemic control.

4.6 Targets for scale-up locations and populations

Subnational units classified as 'attained' are those that reach or exceed 90 percent coverage - where 95 percent of individuals know their status and 95 percent of those who know their status are on ART - across males and females in ten age bands. Thirty-one districts, including 9 standalone districts and 22 districts that are part of the nine clusters, were targeted to achieve attained by the end of FY19. All 31 districts targeted to achieve attained have district-wide coverage > 95 percent. TX_NEW targets for these districts were proportioned across age/sex bands by calculating the unmet need to reach 90 percent coverage in each age/sex band and applying targets accordingly. This approach resulted in a total TX_NEW of 49,420 to reach a TX_CURR of 564,290 by end of FY19.

There are 22 scale-up to saturation districts (17 stand-alone and five that are part of three clusters). Scale up to saturation districts were targeted to reach above 90 percent district-wide coverage. TX_NEW targets for all scale-up to saturation districts were 25,581 to reach a TX_CURR of 237,735 by APR19. TX_NEW targets for these districts were proportioned across age/and sex bands by calculating the unmet need to reach 90 percent coverage in each age/sex band and applying targets accordingly.

There are 31 aggressive scale-up districts. These include 11 stand-alone districts and 20 districts that are part of nine clusters. All aggressive scale-up districts were targeted to reach above 80 percent district-wide coverage. Scale-up districts have a total TX_NEW of 40,260 to reach a TX_CURR of 351,485 by APR 19. TX_NEW targets for these districts were proportioned across age and sex bands by calculating the unmet need to reach 90 percent coverage in each age/sex band and applying targets accordingly.

In COP18, PEPFAR Uganda will continue to use the geographically-focused approach to target KP/PP. Overall FSW prevention interventions are implemented in 38 districts and MSM prevention interventions are focused in six districts with urban centers (Kampala, Kabarole, Wakiso, Gulu, Mbale, and Mbarara). Prevention programs for fisher folk will be in 12 districts around Lake Victoria

For prisons, 160,000 targets were distributed across 94 districts with prisons. For the first time, robust size estimates from Kampala informed targeting for comprehensive prevention services for PWIDS. These data provide the evidence for PEPFAR Uganda to begin advocacy for policy guidelines for medically-assisted treatment (MAT) and other interventions for PWID to reduce risk of HIV infection in this community and ensure access and retention on treatment.

The PP_PREV targets (474,052) include AGYW, and discordant couples have been distributed across 104 districts including a heavy focus on DREAMS districts.

Following the determination of ART coverage scale-up rates for the different district classifications, a clinical cascade approach was applied to derive targets across program areas. Current on ART targets were derived from estimated current population on ART at APR17 (81 percent national coverage), adjusted for a program attrition of 5 percent and TX_NEW from HIV testing and counseling (HTC) (includes PMTCT, EID, VMMC, and HTC general).

There were a number of bases for these assumptions. First, with the initiation of Test and Treat in January 2017, essentially all pre-ART clients have been mopped up and are already on treatment so all TX_NEW are from HTC. Second, TX_NEW from PMTCT was derived from a PMTCT cascade. The number of HIV-positive women expected to attend ANC at least once was estimated based on APR17 results. Based on the last 3 years of program data, 100 percent already know or will learn their status at ANC, while 95 percent of pregnant women living with HIV are targeted to receive ART. The proportion of these women newly initiating on ART was derived from the district proportion of newly initiating versus already on ART at APR17, and aggregated to national level.

New data from EID are based on an estimated 80 percent of HIV-exposed infants expected to be tested through PMTCT. Of these, 3 percent are estimated to be HIV-positive based on APR16 EID positivity, while 95 percent of identified HIV-positive infants are expected to be linked to ART. For all districts, HTC targets were set per district to achieve the total needing to be identified to reach the desired new treatment targets. The algorithm for setting HTC district targets included the anticipated yield based on the FY17 yield, the undiagnosed prevalence rate of the district, and the HTC service delivery site (e.g. TB clinics were anticipated to have greater yield than OPDs). Targeting was completed by assigning the largest proportion of targets to those service delivery sites where yield was anticipated to be highest (e.g. TB clinics, index client testing both in homes and HIV care and treatment clinics, inpatient departments, and outreach to KP/PP). Targets at the highest yield sites were limited to the number of clients at those sites and although very high yields at TB sites are anticipated, targets could not be set above anticipated number of TB clients.

This holds true for STI clinics, partners of HIV-positive individuals, and inpatient departments. A screening tool for OPD has been developed to better target for increased yield especially for children and women.

Table 4.6.2: VMMC Coverage and Targets by Age Bracket in Scale up District

	FY19 Target 15-29	Male_ total Population SNU	Current Coverage FY 17	Current Coverage FY 18	Expected coverage FY19
Agago District	3116	117,300	62%	108%	130%
Amolatar District	6400	83,300	49%	57%	112%
Apac District	10047	204,100	54%	80%	115%
Arua District	12345	415,100	52%	67%	88%
Bugiri District	4829	216,100	55%	60%	78%
Buikwe District	19682	223,000	51%	63%	123%
Bukomansimbi District	2159	77,100	50%	66%	90%
Bushenyi District	7321	118,800	47%	62%	103%
Busia District	3893	175,500	52%	55%	72%
Buvuma District	903	60,400	55%	58%	68%
Buyende District	1600	187,000	49%	55%	62%
Dokolo District	5869	99,700	48%	58%	102%
Gomba District	2822	87,400	51%	69%	94%
Gulu District	5467	149,700	54%	83%	106%
Hoima District	13955	338,100	51%	56%	86%
Ibanda District	7486	129,900	46%	68%	108%
Iganga District	6483	269,200	48%	49%	67%
Isingiro District	8037	269,300	53%	66%	90%
Jinja District	8944	243,500	51%	60%	83%
Kabale District	8150	115,900	46%	62%	110%
Kabarole District	6541	161,500	54%	83%	110%
Kaberamaido District	2240	124,000	46%	46%	60%
Kagadi District	5069	196,100	49%	49%	69%
Kakumiro District	4544	202,300	46%	46%	63%
Kalangala District	1600	35,600	51%	58%	86%
Kalungu District	3951	93,100	57%	69%	103%
Kampala District	27636	762,700	50%	59%	77%
Kamuli District	9105	259,900	49%	53%	80%
Kamwenge District	8914	234,300	52%	73%	102%
Kanungu District	7090	128,800	53%	66%	106%
Kasese District	6716	369,600	46%	48%	61%
Katakwi District	7380	91,100	48%	77%	136%

Kayunga District	10964	193,900	55%	81%	125%
Kibaale District	4704	89,200	54%	148%	186%
Kiboga District	3869	83,600	48%	57%	89%
Kiruhura District	7069	190,400	46%	46%	73%
Kitgum District	3200	105,200	53%	97%	119%
Kole District	9686	131,500	52%	68%	121%
Kotido District	6654	95,800	49%	67%	116%
Kyegegwa District	7872	189,000	46%	64%	95%
Kyenjojo District	7904	243,800	51%	68%	91%
Kyotera District	5696	147,100	53%	53%	86%
Lamwo District	2400	67,300	51%	51%	79%
Lira District	8000	217,100	52%	77%	101%
Luwero District	8038	248,600	48%	61%	84%
Lwengo District	7398	138,300	49%	58%	104%
Lyantonde District	5503	52,200	54%	65%	142%
Masaka District	7887	157,900	54%	61%	97%
Masindi District	6186	164,200	53%	70%	95%
Mayuge District	6063	257,400	52%	58%	76%
Mbale District	6129	260,900	48%	51%	68%
Mbarara District	8218	249,100	49%	65%	86%
Mitooma District	6875	90,000	57%	74%	133%
Mityana District	5552	177,000	53%	65%	88%
Mpigi District	4762	136,900	51%	61%	86%
Mubende District	12486	404,300	50%	64%	86%
Mukono District	10966	320,100	55%	62%	86%
Nakaseke District	5232	119,400	50%	54%	84%
Namayingo District	3254	113,700	54%	64%	86%
Nebbi District	5471	128,700	48%	69%	101%
Ntungamo District	7453	250,400	51%	76%	98%
Omoro District	5665	89,900	50%	50%	96%
Otuke District	6400	60,100	46%	46%	126%
Oyam District	9600	208,500	48%	72%	105%
Pakwach District	4746	88,600	46%	46%	86%
Rakai District	4432	127,700	52%	64%	93%
Rubanda District	7674	96,100	46%	46%	106%
Rukiga District	6522	49,800	46%	46%	136%
Rukungiri District	8342	156,000	52%	63%	102%
Sembabule District	5639	140,200	51%	62%	95%
Sheema District	6448	103,200	53%	76%	119%
Soroti District	7670	165,800	48%	63%	95%
Tororo District	5267	275,500	52%	56%	70%
Wakiso District	40768	1,208,400	50%	63%	84%

_Military	14,160				
Total	**559,118**	**14,032,200**	**63%**	**78%**	**90%**

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY19) *HTS_TST***	**Newly Identified Positive (APR FY19) *HTS_TST_POS***	**Newly Initiated on ART (APR FY 19) *TX_NEW***
Total Men	**962,587**	**29,422**	**27,499**
Total Women	1,096,553	**36,910**	**31,488**
Total Children (<15)	**355,461**	**8896**	**6,591**
Adults			
TB Patients	**17,855**	**4,178**	**N/A**
Pregnant Women	622,872	**14,278**	**N/A**
VMMC clients	**414,984**	**2036**	**N/A**
Key/priority populations*	90,193	**19881**	**N/A**
Other Testing	**866,828**	**42,559**	**N/A**
Pediatrics (<15)			
HIV Exposed Infants	**37,328**	**1,144**	**N/A**
Other pediatric testing	**318,133**	**7,752**	**N/A**

*Not a testing modality (subset of other modalities)

By the end of COP17, six districts will have attained the 80 percent saturation among young people aged 15–29. By the by end of COP18, a total of 30 districts will have achieved an 80 percent saturation among young people aged 15–29 with the assumption that all set targets are achieved.

Standard Table 4.6.4: Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of Orphans and Vulnerable Children (moderately or critically vulnerable)**	**Target # of active OVC (FY18Target) OVC_SERV**	**Target # of active beneficiaries receiving (0-17) support from PEPFAR Uganda OVC programs whose HIV status is known in program files (FY18 Target)**
Wakiso District	170,312	27037	20278
Rakai District	138,766	11076	8306
Sembabule District	100,460	3125	2344
Masaka District	84,639	5150	3861
Lwengo District	62,343	5160	3870
Kalungu District	58,512	2234	1674
Mpigi District	57,044	2250	1687
Bukomansimbi District	57,007	2372	1781
Gomba District	54,282	8873	6656
Lyantonde District	53,574	2304	1728
Kalangala District	50,929	377	282

Mubende District	50,478	5460	4094
Mukono District	48,279	11319	8488
Luwero District	48,062	8093	6072
Kayunga District	45,018	3798	2850
Buikwe District	42,645	5737	4303
Mityana District	42,600	8675	6506
Nakaseke District	38,615	977	732
Kiboga District	38,234	400	299
Mayuge District	37,453	5151	3863
Bugiri District	37,267	4000	3000
Kamuli District	36,730	4220	3166
Iganga District	36,522	12967	9726
Namayingo District	36,203	957	717
Jinja District	35,398	8896	6672
Kampala District	33,009	31068	23301
Tororo District	32,588	5503	4126
Busia District	32,300	1579	1183
Mbale District	32,222	3250	2437
Oyam District	28,169	13352	10014
Apac District	26,907	7131	5348
Lira District	26,832	20060	15044
Agago District	26,673	4299	3224
Kole District	26,664	475	357
Gulu District	26,502	16182	12136
Dokolo District	26,434	1000	750
Kitgum District	26,349	9299	6974
OMORO District	26,241	5338	4005
Hoima District	23,623	9125	6844
Kasese District	23,594	8945	6706
Kamwenge District	23,017	8675	6509
KAGADI District	22,363	2232	1675
Kyenjojo District	22,284	15179	11385
Kabarole District	21,829	6636	4978
KAKUMIRO District	21,619	2062	1547
Masindi District	20,795	1405	1054
Kyegegwa District	20,524	4748	3565
Kibaale District	20,358	6830	5121
Soroti District	16,379	1973	1480
Katakwi District	15,942	2744	2056
Kotido District	15,513	583	437
Isingiro District	14,213	4371	3280

Ntungamo District	14,060	3284	2462
Mbarara District	13,997	7074	5305
Kiruhura District	13,044	2541	1906
Kabale District	12,798	4061	3047
Rukungiri District	12,692	6267	4699
Kanungu District	12,157	2418	1813
Ibanda District	10,906	1501	1125
RUBANDA District	10,747	913	685
Bushenyi District	10,485	2359	1769
Mitooma District	10,478	1605	1203
Sheema District	9,802	2704	2029
Arua District	11,335	13286	9966
Nebbi District	28,400	1561	1170
Rukiga District	25,895	2365	1775
Bunyangabu District	38,294	4496	3376
Pakwach District	7,720	2166	1624
Kyotera District	4,915	11406	8553
_Military Uganda		3960	2970
Total	2,362,040	418,619	313,968

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

5.1 COP18 Programmatic Priorities in attained and sustained districts and populations

In attained and sustained districts, intensified negotiations with MOH, MOFPED, MGLSD and other partners including Global Fund, will continue to ensure that a minimum package of services is implemented. Services will eventually be covered by non-PEPFAR funded entities. In these districts, IPs will ensure that quality assurance activities are supported for high volume sites. Modest targets that have impact on epidemic control have been allocated. Other key priorities include case-based surveillance and recency testing to enhance program monitoring. IPs will work with GOU counterparts at district and site level to maintain high quality prevention, care, and treatment in sustained and attained districts. Pockets of HIV-infected population groups that are yet to be identified including men and adolescents will be prioritized. Additional programmatic priorities and shifts are described in sections 4.1-4.4 above. The following additional programmatic priorities will be implemented to ensure that specific populations are reached in order to reach and maintain epidemic control in attained and sustained districts.

PEPFAR-supported health workers in attained and sustained districts have been prioritized for fast-tracked absorption by the GOU, with PEPFAR-supported public sector health workers remaining only in scale-up districts. Additionally, COP17 prioritized shifting OVC programming out of sustained districts. COP18 now prioritizes OVC programming primarily in 68 attained and scale-up districts. The rapid scale up of EMR to improve patient tracking has also been prioritized for the highest volume sites, and will move from 377 to all PEPFAR supported high volume sites (>=500 on ART) located in attained and scale-up districts. Monthly and quarterly reviews of retention efforts will be jointly undertaken by IP staff, site level providers and PEPFAR teams for course correction.

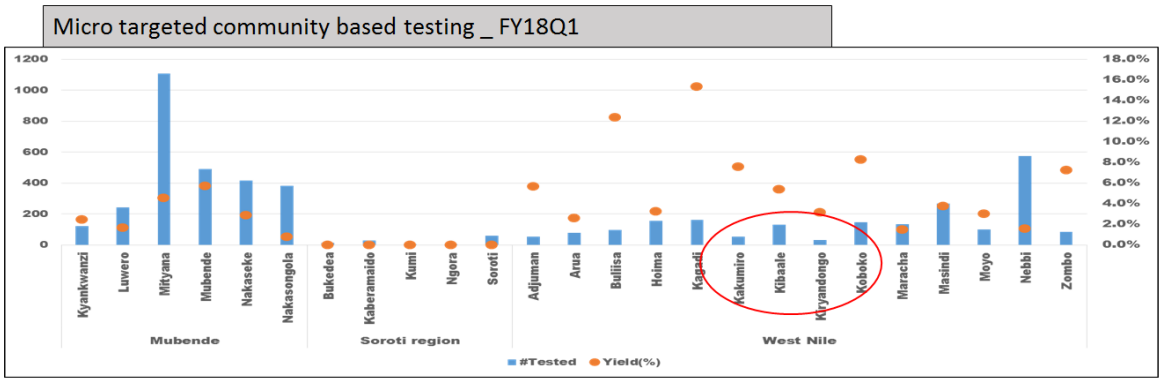
Based on findings from UPHIA and routine program data, COP18 prioritizes specific interventions to find men in attained districts. Micro-targeting has been found to be successful in some districts and will be brought to scale with fidelity in attained and sustained districts that still have large proportions of men who have not been diagnosed (Figure 5.1.1). Using this approach, COP18 will shift towards conducting fewer tests but with resultant high yield. PEPFAR Uganda will continue to leverage GOU leadership for community mobilization efforts as demonstrated by Presidential Fast Track Initiative efforts led by President Museveni. UPHIA data also shows pockets of undiagnosed women in some districts. In order to find adult women who are undiagnosed, COP18 will prioritize passive efforts using existing platforms of OPD/IPDs, OVC, DREAMS, and ANC programs.

Figure 5.1.1: Example of Improved Yield through Micro-Targeting

Modified SEARCH+ male characterization- yields high for men in low prevalence areas

IM	M Tests Target	M Test Results	% Testing	M Positive Target	M Positive Result	%Positives	Yield
IDI W & WN	405,330	326,915	81%	9,179	7,064	77%	2.2%

FT18Q1 men achievements



Additionally, COP18 will continue to prioritize VMMC among of men aged 15-29. The districts which have attained 80% of the VMMC coverage in the 15 -29 year age group will continue to mop up the remaining few numbers in this age pivot focus age group but at the same time focus on the 10-14 year old age group. Other shifts leading to reprioritization in COP18 include stopping PEPFAR Uganda support for PrePex as mentioned in Section 4.2. While we continue to support VMMC among men in the age pivot 15-29 age group, the districts that will have attained 80 percent saturation in the age pivot attained and sustained districts will be guided to shift focus to the 10–14 age group.

In addition, to promote a more sustainable way of providing VMMC services, we plan to further reduce the cost of VMMC services by progressively reducing the use of VMMC disposable kits from the COP17 proportion of 90:10 to 80:20 in COP18, and even higher in attained and sustained districts. For quality maintenance, IPs will support decentralization of specialized adverse events management through supporting a functional referral system for areas that lack specialized adverse events management.

5.2 Targets for attained and sustained locations and populations

Table 5.2.1: Expected Beneficiary Volume Receiving Minimum Package of Services in Attained Support Districts*		
Attained Support Volume by Group	**Expected result APR 18**	**Expected result APR 19**

HIV testing (all populations)	*HTS_TST*	**2,369,746**	**1,468,592**
HIV positives (all populations)	*HTS_TST_POS*	***129,138***	***52,919***
Treatment new	*TX_NEW*	***124,464***	**49,420**
Current on ART	*TX_CURR*	***521,629***	**564,290**
OVC	*OVC_SERV*	***215,310***	**217,465**
Key populations	*KP_PREV*	***47,886***	**122,571**

*Calculations for targets for clinical services should be based on maintaining 80 percent ART coverage levels in the Attained districts. [Current Retention + (Passive HTC_POS * Linkage)]/PLHIV = 80 percent ART Coverage

Table 5.2.2: Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts

Sustained Support Volume by Group		**Expected result APR 18**	**Expected result APR 19**
HIV testing in PMTCT sites	*PMTCT_STAT*	239,807 (BE)	193,464
HTS (only sustained ART sites in FY 17)	*HTS_TST/HTS_TST_POS*	1,406,596/31,163	362,491/9,808
Current on ART	*TX_CURR*	77,648 (N)	146,742
OVC	*OVC_SERV*	0	0

5.3 Establishing service packages to meet targets in attained and sustained districts

COP18 will prioritize stopping or reducing elements of service packages across all locations that have ceased to produce adequate yield in sustained or attained districts and no longer serve to help PEPFAR Uganda reach its targets. Specifically, COP18 will discontinue passive index client testing where only one partner is tested and all household members irrespective of risk are tested, universal testing in OPDs, quarterly review of HTS data, and the testing of low risk children including on OVC platforms.

Instead, COP18 will focus on evidence-based packages rolled out in attained and sustained districts of services that have been proven to make the biggest contribution to epidemic control. It should be noted that the linkage to treatment, retention on treatment, and PMTCT service packages do not differ between attained or sustained districts as these interventions are critical to the quality of services in all sites regardless of district prioritization. The main difference in the packages is in the micro-targeting applied to attained districts to improve yield. The HTS service packages supported by PEPFAR Uganda in attained and sustained districts are outlined in the table below:

Figure 5.3.1: HTS Service Packages in Attained and Sustained Districts

Geographic Location	Service Package

Attained	● Assisted partner notification (APN) for all sexual networks of index clients and targeted testing of exposed children. Tests of other household members only after screening for HIV test eligibility
	● Improved facility-based testing
	  o Prioritize high yielding service delivery points
	  o Prioritize testing at OPD with screening for HIV test eligibility
	● HIV self-testing for partners of pregnant and lactating mothers and KP/PP
	● Micro-targeting for community testing to reach men and KP/PP
	  o Characterization of the population and tailoring of HTS services
	  o Geo-mapping of hot spots
	  o Consultative meetings with targeted populations for effective strategies of reaching those individuals who are likely to be infected with HIV.
	  o Collaboration and networking with peers and group leaders
	  o Functional collaboration between community and facilities
	  o Utilization of community-facility framework to facilitate coordination and generate demand for/improve access to HTS within the community
	● Data analysis and use for service improvement
	  o Daily reporting by service providers to IPs on identification and linkage by gender and age group
	  o Weekly reporting by IPs to PEPFAR on identification and linkage by gender and age group
	  o Weekly review of data with IPs
	  o Use of quality improvement approach to immediately address gaps in achieving targets for identification and linkage.

Sustained	• Assisted partner notification (APN) for all sexual networks of index clients
	• Refined index client testing to target exposed children and sexual partners.
	  ○ Tests of other household members only after screening for HIV test eligibility
	• Improved facility-based testing
	  ○ Prioritize high yielding service delivery points
	  ○ Prioritize testing at OPD with screening for HIV test eligibility
	• HIV self-testing for partners of pregnant and lactating mothers and KP/PP
	• Data analysis and use for service improvement
	  ○ Daily reporting by service providers to IPs on identification and linkage by gender and age group
	  ○ Weekly reporting by IPs to PEPFAR on identification and linkage by gender and age group
	  ○ Weekly review of data with IPs
	  ○ Use of quality improvement approach to immediately address gaps in achieving targets for identification and linkage.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

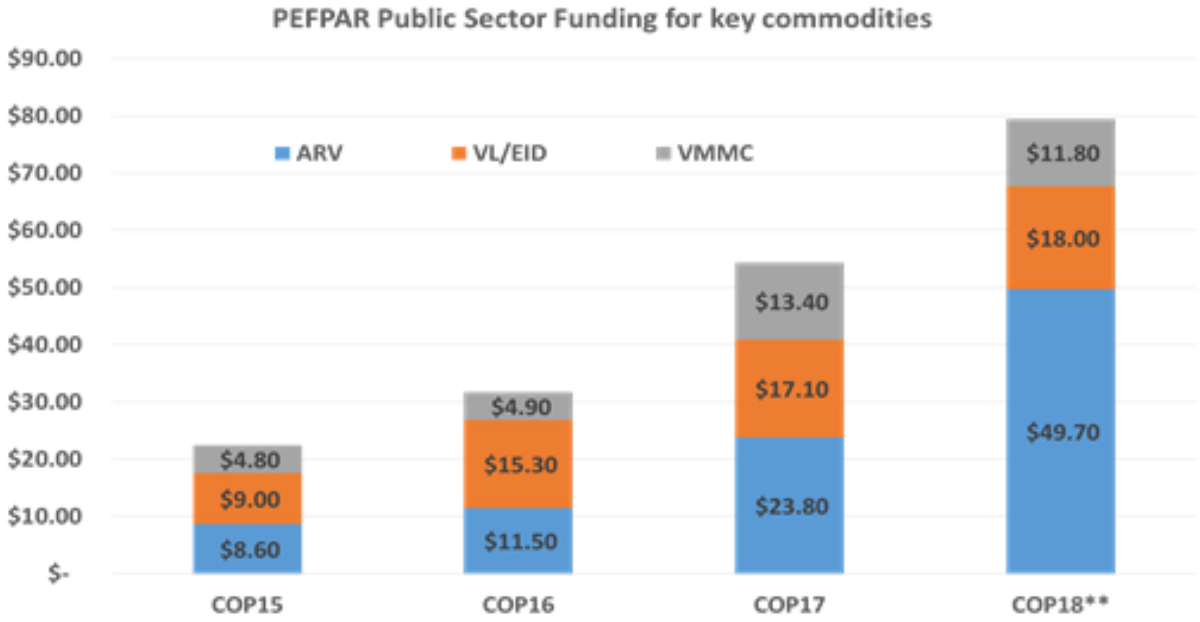
Recognizing that the public sector continues to account for the largest number of PLHIV – particularly those newly initiating ART and unidentified TB/HIV cases – COP18 intensifies engagement with GOU entities at national, district, and site levels, providing support to both site level and "above site" service delivery activities in the public sector that are critical to the achievement of sustained epidemic control.

The PEPFAR Uganda team conducted a number of consultations and analyses to determine which specific public sector health systems interventions COP18 should prioritize. These consultations and analyses included the SID 3.0 which featured a broad array of stakeholders collectively assessing the sustainability of the HIV/AIDS response in Uganda; a series of ongoing meetings with MOH to develop and review policies, technical guidelines, and standards that support the implementation of a national response; consultations with civil society; and a rigorous analyses of UPHIA and program data, including results from SIMS data.

PEPFAR Uganda's public sector investment for site level consists of continued proportionate service delivery support to public sector sites, increased commodity procurement for the public sector, and efficiency gains in the private not-for-profit sector through enhanced partner management. The basic service package for care and treatment of PLHIV does not differ between PNFP and public sector sites. Expenditure analysis demonstrates a shift from 64 percent public sector investment in facility and community based service delivery in FY15 to 67 percent in FY17, commensurate with an increase in the proportion of clients being served in the public sector over this period. This package consists of clinical service provision for both complex and stable clients through differentiated service delivery; routine IP mentorship and guidance on quality improvement interventions; direct services such as, but not limited to, reimbursement for linkage facilitators and peer educators, operational costs for phone pre-appointment reminders and client support, tracking of clients lost-to-follow-up, sample transportation, and critical clinical and laboratory HR where needed; and support for site and district level monitoring, reporting, cleaning, and utilization of data.

While PEPFAR has historically covered the full HIV commodity needs for the private and private-not-for-profit sectors, investment in public sector HIV commodities began in FY16 with viral load collection materials and reagents. As CHAI and UNITAID phased out support for EID commodities, PEPFAR expanded its investment to also include national EID commodities. The commodity investment in the public sector has continued to increase in COP18, most notably to cover the anticipated calendar year 2018 and 2019 ARV gaps so as to mitigate risk of stock outs and continue progress toward epidemic control. Figure 6.0.1 demonstrates this increased investment over the past four years.

Figure 6.0.1: PEPFAR public sector funding for key commodities, COP15-COP 18



**In COP18, additional funds have been provided for HIV RTKs (US$3.8M) and isoiazid for TB preventive therapy (TPT) ($1M) in the public sector.

Accordingly, the above service delivery investments in COP18 – which respond to critical gaps, barriers, or bottlenecks impeding the delivery of HIV/AIDS services – will primarily focus on: improving the HIV/AIDS supply chain and security of key commodities, including installing an ERP system; expanding EMR with unique identifiers; improving laboratory services, including specimen transport; improving the management and performance of HRH; strengthening the engagement with and results of CSO partners; and continuing engagement with MOH on the oversight, leadership, and management of the HIV/AIDS response, including advocacy for increased funding commitment from GOU to support the activities. These above service delivery investments are summarized below. Specific activities are captured in greater detail in Table 6 (Appendix C).

Overall, PEPFAR will continue to support the technical capacity of the MOH (at national, district, and health sub-district levels) to provide oversight, leadership, and management of all facets of the HIV/AIDS response, with the key guiding principle of ongoing support being a framework of mutual accountability for program results.

PEPFAR Uganda will also continue to work closely with GOU and Global Fund to ensure the availability of ARVs and HIV-related commodities in the public sector. An integrated, comprehensive ERP system will enable more accurate and timely tracking and reporting of HIV/AIDS commodities, including ARVs. Once the ERP system is functional, both the accountability and transparency of the supply chain system – from the national warehouse, all the way down to health facilities that are serving PLHIV – will be improved. Currently work on ERP

is progressing through the procurement processes. COP18 will also ensure that all high volume ART sites use WAOS which will enable real-time, site-level stock status data for improved visibility and accountability.

In COP18 PEPFAR Uganda will also conduct a National Supply Chain Assessment (NSCA) which will provide a comprehensive view of the public sector supply chain's maturity and performance. PEPFAR Uganda will use the findings from the NSCA to inform ongoing support to supply chain management in Uganda.

Notably, alongside these systems-strengthening, above service delivery investments in supply chain management, COP18 will provide the largest-ever contribution from PEPFAR to HIV/AIDS commodities in the public sector. COP18 funding will procure ARVs, including filling the projected ARV gap for calendar year 2019. COP18 funding will also provide GeneXpert cartridges and TPT commodities for the public sector.

COP18 above service delivery investments in civil society leverage the fact that 69 percent of PEPFAR Uganda funding currently goes to 183 indigenous partners, including faith-based organizations (FBOs), community-based organizations (CBOs), PLHIV groups, and KP networks. The majority of PEPFAR Uganda's prime partners are indigenous, working in over 60 districts across Uganda. Other indigenous partners are sub-recipients, working to support the delivery of services at facilities and within the community. Above service delivery work within civil society is focused primarily on supporting advocacy efforts related to the HIV/AIDS policy environment, domestic resource mobilization, and capacity building for national-level coordination among CSOs. Note that over 100 CSOs are supported at district level for direct service delivery in all PEPFAR supported districts.

PEPFAR Uganda continues to provide technical assistance to GOU to improve HRH capacity and coverage at national, district, and site levels, with progressive improvement in HRH coverage in the public sector from 61 percent in 2013 to the current coverage of 73 percent. PEPFAR Uganda is taking stock of its current support to HRH and refocusing efforts for COP18 to achieve epidemic control while creating a sustainable transition path for health workers. PEPFAR Uganda will prioritize HRH support for critical cadres to manage and coordinate the response at key MOH departments including the CPHL, as well as second priority cadres to high volume ART sites for identification, linkage, initiating clients on ART, and ensuring retention and viral suppression. At the national level, PEPFAR support for technical advisors will progressively reduce as the capacity of MOH core staff improves. At site level, PEPFAR Uganda will support 1,235 critical health workers at high volume sites who will progressively be transitioned to GOU payroll in the medium term in line with an agreed upon transition plan. Additional HRH support will be provided for recruitment planning, training for specific cadres in short supply especially pharmacy assistants (Dispensers), capacity building for health managers, revision of staffing norms, and advocacy for improved wage bill allocation.

A current intervention begun in Q2 2018 and to be continued through COP18 is the 'surge' to meet our targets and gain traction toward epidemic control. We are repeating the IP survey conducted in Nov 2017 to track improvement in scale-up of linkage and retention interventions. Questions on testing interventions have also been included. All partners developed detailed surge strategies used to benchmark progress. Additionally, IPs are now reporting on key cascade indicators weekly for all high volume sites and this data is being reviewed by both IPs and agencies in real time for targeted interventions and rapid course correction. Field visits to poorly performing sites of all partners have occurred over the last two weeks to assist partners in identifying and resolving gaps, and model the level of intensity with which we expect site-level engagement. Lessons learned from these visits will guide future field visits, inform the agenda for upcoming partner meetings to share promising practices, as well as work with MoH on any needed job aids, operational guidance, or policy modifications to support quality programming at scale.

CDC, DOD and USAID have organized integrated teams for coordination, support and oversight of each implementing partner and mechanism. This includes a certified CDC Project Officer (PO) or USAID Agreement Officer's Representative (AOR), a cooperative agreement management specialist, and a lead technical activity manager coordinating input and efforts of technical specialists across HTC, TB, ART, OVC, KP PREV, PMTCT, LAB, SI and other areas in which the partner is funded. These teams conduct field visits to partner supported sites to provide hands-on monitoring, guidance and mentoring, and data verification, meet with partners monthly, and follow up on specific challenges more often as needed to address performance barriers. Surge teams are leading more intensive weekly or more frequent meetings, field site follow up, teleconferences and data analysis with concrete recommendations for action to improve results at high volume sites in core treatment cascade indicators and VMMC.

In COP18, scaling up of EMR and unique identifiers to high volume sites – along with ongoing DQAs – continue to be a priority. In addition to a reduction in the cost of printing paper tools, EMRs will help address gaps in monitoring, evaluation and research since electronic records ease the generation and reporting of data while providing more granularity (e.g. via automating data uploads from EMRs to the DHIS2). EMRs also contribute to quality, completeness, and timeliness of data, leading to a better understanding of ART coverage by age, gender, and location.

Moreover, the EMR platform will be utilized to implement unique identifiers, which will facilitate clinical surveillance and improve patient linkages and referrals across facilities along the continuum of care. Unique identifiers make both the task of client records de-duplication and the establishment of a shared patient record within and across health care facilities more manageable. Unique identifiers will also improve accuracy in estimating lost to follow-up. Care will be taken, as discussed in the RPM to engage Uganda's CSOs and key stakeholders in reviewing biometric systems and ensuring confidentiality in all processes.

PEPFAR Uganda will continue to give support to national information systems while progressively transitioning some activities to GOU and other health development partners (e.g. the revision and printing of HMIS tools). PEPFAR Uganda will focus on supporting dashboards and other data

visualization tools that answer operational questions, and shift more support to direct assistance for all levels to use the data for program management.

The COP18 will also feature the following evaluations, research, and surveillance studies.

IM Number	Short name of study	Objective	Status
EVALUATIONS			
HHS - CDC through 13880 Rakai	PMTCT Impact Evaluation	To carry out an evaluation to determine the impact and effectiveness of the implementation of PMTCT interventions in Uganda	Ongoing – Data collection
HHS - CDC	ART – DSDM	To carry out an evaluation to determine the impact of a community-facility case management intervention on retention in HIV care among HIV-infected individuals initiating antiretroviral therapy in a Test and Treat model	Ongoing - Data collection
17698 - UPS	UPS Linkage	To carry out an evaluation to determine whether the TB/HIV patients' linkage system is available and functional in the Uganda prison health system	New
TBD	TBD Short loops	To quickly answer programmatic questions in order to feedback for program adjustment for impact	New
13880 - Rakai	Combination Prevention HIV Impact Evaluation	To understand the impact of scaling up combination HIV prevention interventions in Uganda	Ongoing - Data collection in Year 3
18017- EGPAF Project DELTA	PATEST	To assess the utility of a screening tool for identifying children to test for HIV	Ongoing- Data Collection
USAID - EvalMe	Evaluation of the Advocacy for Better Health	To understand the impact of Advocacy for Better Health in promoting coordination and harmonization of CSOs towards aspects of Uganda's response to HIV/AIDS	New
17654 - USAID-RHITES-SW	Evaluation of RHITES-SW	To understand the extent to which Regional Health Integration improved the capacity of districts to provide quality health services according to national guidelines	New
USAID - SITES	Short learning loops	To carry out quick assessments and rapid appraisals for timely intervention adaptation on a range of topics	New
USAID – MELP TBD	Short learning loops	To carry out quick assessments and rapid appraisals for timely intervention adaptation on a range of topics	New
DOD - AFRICOS	African Cohort Study (AFRICOS)	To longitudinally assess the impact of clinical practices, biological factors, and socio-behavioral issues on HIV infection and disease progression in an African context.	Ongoing; Proposed in COP

IM Number	Short name of study	Objective	Status
RESEARCH			
9043 – MUWRP	Fisher Folk – MUWRP	To evaluate the impact of the Meta-ART Clinic Network Approach on retention in HIV clinical services among the FF on Koome Island	Ongoing - Data collection
9043 - MUWRP	PrEP – MUWRP	To determine uptake, adherence, and retention of high-risk HIV-negative AGYW on PrEP in a DREAMS district. (Mukono)	Ongoing - Data collection
9043 - MUWRP	Evaluation of Changing Guidelines – MUWRP	To assess the effects of changes in clinical, operational, socio-behavioral, and regulatory factors on prevention, and care and treatment programs in Uganda	Ongoing - Data collection

IM Number	Short name of study	Objective	Status
SURVEILLANCE			
TBD	ANC surveillance	To conduct systematic collection and analysis of PMTCT data to understand prevalence and incidence trends from sentinel sites	New
17703 - METS	Case-based surveillance	To conduct systematic collection and analysis of individual patient-level data to understand treatment cascades, incidence trends, and data duplication	Ongoing – Protocol development
18566 - UVRI	Drug resistance surveillance	To determine the proportion of emerging DTG resistance and rate of transmitted HIVDR among recently-infected HIV-positive individuals in Uganda	New mechanism, but DR surveillance already ongoing
TBD	TBD - KP surveillance – IBBS	To understand and analyze data on sexual behavior and hotspots for KP/PP through bio-behavioral surveys and population size estimation	New
13835 – Baylor Uganda	Birth defects surveillance	To conduct systematic collection of data to calculate incidence and prevalence of birth defects among HIV-positive women who are on treatment in the context of Test and Treat and regimen change (TLD)	Ongoing - data collection
18502 – DoD/ PACE	SABERS-DoD	To carry out a bio-behavioral survey among the military to understand prevalence and risky sexual behavior in this population	New
HHS - CDC through ICAP	UPHIA	To carry out a nation-wide impact assessment to collect accurate national and regional estimates of HIV prevalence, incidence, and correlates	Ongoing - report writing

7.0 USG Management, Operations and Staffing Plan to Achieve Stated Goals

The U.S. Mission continues to be "tight-sized" with no remaining office space. This impedes the ability of USG agencies to obtain approval for hiring new positions. The Federal Government hiring freeze has also impeded agencies' ability to fill previously-approved but vacant positions which are presently at 28 Full-Time Equivalents (FTE). In COP18, it is anticipated that the majority of these positions will be filled.

Costs of Doing Business (CODB) is increasing for every USG agency in COP18. The total increase for all agencies is US $3,692,200, with the majority ($2,319,940) being for USAID/Uganda. The total CODB applied pipeline is US $9,652,652, with USAID/Uganda applying the largest amount, US $7,226,000. This pipeline is available largely due to USAID's inability to fill vacancies because of the federal hiring freeze.

Without the ability to hire additional staff, USAID/Uganda has had to increase its engagement of institutional contractors and short-to-medium term consultants (reflected in the corresponding CODB line item) for specific tasks and deliverables in order to free up staff to fully meet the compliance, technical vigor, and fiduciary requirements commensurate with its budget. USAID agency-wide staffing formulas are calculated based on appropriation levels. For every US $5 million in appropriation, USAID recommends approximately one U.S. Direct Hire (USDH) and three Locally-Employed Staff (LES), including programmatic and support staff. At the current USAID/Uganda PEPFAR funding level of US $162 million, USAID/Uganda should have a staffing pattern of 128 staff (32 USDH and 96 LES) managing the PEPFAR program. At present, USAID/Uganda has a total of only 58 PEPFAR-funded FTE staff, which is less than half the recommended amount.

USAID/Uganda's business model also is changing to one of more direct staff engagement in managing development relationships, rather than outsourcing these responsibilities to contractors and grantees. This direct engagement with the GOU is aimed at strengthening and building the capacity of public institutions and building partnerships to leverage resources. With a significant increase in PEPFAR Uganda resources being provided directly to public sector entities in COP18, USAID/Uganda also must provide greater accountability for USG resources through fiduciary monitoring. Additional oversight is required to manage the significant challenges of the Uganda context regarding corruption and fraud both within and outside of the public sector. A more labor-intensive approach is also required for increased oversight and management of USAID/Uganda's contractors and grantees to ensure that programs operate more efficiently and cost-effectively and that they meet PEPFAR targets. A critical component of this approach is more frequent reporting and analyzing of results to make course adjustments and adapt program approaches. USAID/Uganda has also been unable to fulfill its Site Improvement through Monitoring System (SIMS) requirements, which significantly increase the demand for

USG staff time dedicated to field visits. Hiring short- to medium-term consultants and engaging institutional contractors will significantly free-up staff time to conduct these critical functions.

For CDC, the CODB budget increased by US $439,506 due to separate hiring of individual USDH staff, where previously there had been a tandem couple covering two positions with less cost, Permanent Change of Station (PCS) costs more for USDH staff, and the normal within grade increases for staff. Increases were partially offset by a new approach to cost-share five technical staff (three strategic information and two lab staff) by other CDC programs in Uganda, as well as an anticipated slight reduction in ICASS costs based on actuals for the past two years. Two positions have been vacant for over six months: 1) the USDH Lab Chief position which is in the final headquarters approval phase for recruitment after submitting a hiring freeze waiver justification; 2) the LES PMTCT Specialist position which is being repurposed to focus on HTS surge initiatives to accelerate case-finding and improve linkages. CDC met 98 percent of SIMS targets in FY17 (278 out of 285 planned), and is at 70 percent of COP17 first quarter targets (57 out of 82), equivalent to 15 percent of the 383 FY18 annual targets.

Defense (DoD) Walter Reed Army Institute of Research (WRAIR) currently has one USDH and no LES to offer programmatic and support services. At the current DoD/WRAIR/Uganda PEPFAR funding level, DoD/WRAIR would require (1 USDH and 2 LES) to support management of the PEPFAR program. While DoD/WRAIR met 117 percent of SIMS targets in FY17 (7 out of 6 planned), as per SIMS Agency Summary Table (SAST), the Agency is expected to conduct 36 SIMS visits but has capacity to conduct 23 visits based on the capacity calculator.

The U.S. Department of State (STATE) will see a slight increase in its CODB due to the transition of the coordinator's position from a Personal Services Contractor (PSC) position to a Limited Non-Career Appointment (LNA) hiring mechanism. As a result of this change, the salary and other remunerations are included in the STATE M&O budget instead of the USAID M&O budget. Mission is still awaiting approval of the LNA appointment for the PEPFAR Coordinator LNA.

USG Uganda also hosts PEPFAR Home Operational Funds-supported Resident Advisor from the U.S. Department of Treasury Office of Technical Assistance who is embedded in the MoFPED to support and advise on public financial management and administrative structures for GFATM grants, financial processes and tracking of health sector resources to support enhanced allocation, M&E. No changes are planned for Peace Corps, U.S. Department of Defense (DoD) Walter Reed Army Institute of Research (WRAIR), and U.S. Department of Defense (DoD) HIV/AIDS Prevention Program (DHAPP).

APPENDIX A – Prioritization

SNU Prioritization

Table A.1 (COP 2018 attained districts that do not have all cells 90%+ are due to clusters and cluster totals have all cells at 90%+)

Cluster	District	COP	Prioritization	Results reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall Treatment Coverage at APR by Age and Sex																		Overall TX Coverage
					<1	1-9	10-14		15-19		20-24		25-29		30-34		35-39		40-49		50+		
							F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
GULU CLUSTER	Gulu District	COP 15	ScaleUp Sat	APR 16	45%	45%	41%	51%	68%	60%	68%	60%	68%	60%	68%	60%	68%	60%	68%	60%	68%	60%	70%
		COP 16	ScaleUp Sat	APR 17	31%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	74%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 17	Attained	APR 18	90%+	90%+	90%+	90%+	83%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	64%	90%+	90%+
		COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	71%	90%+	47%	90%+	69%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Nwoya District	COP 15	Sustained	APR 16	44%	44%	32%	59%	57%	41%	57%	41%	57%	41%	57%	41%	57%	41%	57%	41%	57%	41%	54%
		COP 16	Sustained	APR 17	3%	50%	33%	86%	90%+	90%+	90%+	90%+	62%	66%	26%	7%	90%+	35%	25%	13%	74%	55%	59%
		COP 17	Sustained	APR 18	28%	45%	25%	38%	51%	36%	68%	75%	81%	76%	72%	37%	90%+	79%	46%	50%	33%	37%	58%
		COP 18	Sustained	APR 19	53%	34%	49%	43%	51%	35%	64%	23%	67%	32%	90%+	28%	90%+	90%+	90%+	90%+	90%+	90%+	81%
	Lamwo District	COP 15	ScaleUp Sat	APR 16	69%	69%	62%	78%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 16	Sustained	APR 17	25%	78%	66%	84%	90%+	90%+	90%+	90%+	90%+	90%+	55%	18%	90%+	90%+	70%	37%	77%	90%+	69%
		COP 17	Sustained	APR 18	90%+	90%+	86%	90%+	81%	87%	90%+	90%+	90%+	90%+	90%+	35%	90%+	90%+	81%	59%	57%	90%+	90%+
		COP 18	Scaleup Sat	APR 19	90%+	90%+	90%+	90%+	78%	50%	90%+	35%	90%+	49%	90%+	21%	90%+	90%+	86%	66%	90%+	90%+	90%+
	Amuru District	COP 15	Sustained	APR 16	55%	55%	45%	69%	65%	46%	65%	46%	65%	46%	65%	46%	65%	46%	65%	46%	65%	46%	62%
		COP 16	Sustained	APR 17	28%	34%	12%	38%	47%	90%+	90%+	90%+	65%	75%	54%	55%	90%+	62%	14%	44%	27%	11%	38%
		COP 17	Sustained	APR 18	47%	82%	46%	73%	29%	25%	38%	50%	52%	66%	71%	77%	61%	53%	10%	31%	22%	8%	34%
		COP 18	Sustained	APR 19	90%+	62%	90%+	81%	34%	23%	43%	16%	45%	21%	90%+	64%	90%+	74%	26%	90%+	90%+	32%	54%
	Omoro District	COP 15	ScaleUp Sat	APR 16	46%	47%	34%	63%	57%	42%	57%	42%	57%	42%	57%	42%	57%	42%	57%	42%	57%	42%	55%
		COP 16	ScaleUp Sat	APR 17	19%	82%	33%	59%	56%	52%	77%	61%	79%	73%	41%	38%	49%	58%	41%	39%	24%	49%	47%
		COP 17	ScaleUp Sat	APR 18	20%	39%	22%	35%	24%	63%	32%	90%+	40%	74%	42%	38%	46%	60%	28%	28%	13%	38%	37%
		COP 18	ScaleUp Agg	APR 19	79%	49%	71%	64%	36%	24%	45%	16%	47%	23%	70%	36%	68%	52%	63%	67%	53%	90%+	56%
	Overall				90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
JINJA CLUSTER	Jinja District	COP 15	ScaleUp Agg	APR 16	34%	34%	27%	43%	53%	38%	53%	38%	53%	38%	53%	38%	53%	38%	53%	38%	53%	38%	50%
		COP 16	ScaleUp Sat	APR 17	40%	90%+	87%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	67%	82%	90%+	90%+	83%	90%+	90%+	90%+
		COP 17	Attained	APR 18	63%	90%+	57%	86%	79%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	89%	90%+	90%+	90%+
		COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Iayuge Distri	COP 15	ScaleUp Agg	APR 16	61%	62%	49%	79%	82%	80%	82%	80%	82%	80%	82%	80%	82%	80%	82%	80%	82%	80%	86%
		COP 16	ScaleUp Agg	APR 17	90%+	53%	28%	48%	56%	90%+	90%+	90%+	84%	88%	21%	47%	90%+	50%	26%	41%	43%	34%	48%
		COP 17	ScaleUp Agg	APR 18	41%	65%	37%	54%	76%	90%+	90%+	90%+	90%+	90%+	46%	90%+	90%+	67%	45%	68%	30%	45%	74%
		COP 18	ScaleUp Agg	APR 19	90%+	73%	90%+	90%+	41%	27%	51%	19%	54%	26%	66%	64%	90%+	57%	50%	90%+	70%	90%+	69%
	Buikwe District	COP 15	ScaleUp Agg	APR 16	14%	14%	10%	18%	31%	25%	31%	25%	31%	25%	31%	25%	31%	25%	31%	25%	31%	25%	30%
		COP 16	ScaleUp Sat	APR 17	90%+	90%+	90%+	90%+	67%	90%+	90%+	73%	90%+	90%+	90%+	90%+	81%	59%	80%	53%	65%	43%	84%
		COP 17	ScaleUp Sat	APR 18	43%	72%	40%	64%	55%	53%	73%	90%+	88%	90%+	90%+	90%+	90%+	62%	58%	38%	41%	27%	75%
		COP 18	Scaleup Sat	APR 19	88%	54%	79%	71%	74%	50%	90%+	34%	90%+	47%	90%+	90%+	90%+	87%	90%+	90%+	90%+	90%+	90%+
	Kamuli District	COP 15	ScaleUp Agg	APR 16	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 16	ScaleUp Agg	APR 17	6%	24%	23%	39%	90%+	90%+	90%+	90%+	90%+	90%+	29%	90%+	59%	90%+	35%	25%	90%+	32%	56%
		COP 17	Attained	APR 18	45%	71%	41%	61%	90%+	90%+	90%+	90%+	90%+	90%+	83%	90%+	81%	90%+	52%	59%	90%+	29%	88%
		COP 18	ScaleUp Agg	APR 19	90%+	74%	90%+	90%+	90%+	62%	90%+	42%	90%+	59%	80%	90%+	70%	90%+	53%	61%	90%+	56%	81%
	Iganga District	COP 15	ScaleUp Agg	APR 16	56%	56%	47%	68%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	67%
		COP 16	ScaleUp Agg	APR 17	8%	50%	35%	45%	90%+	90%+	90%+	90%+	90%+	90%+	35%	84%	90%+	90%+	60%	90%+	26%	24%	67%
		COP 17	ScaleUp Agg	APR 18	44%	71%	40%	59%	55%	45%	73%	90%+	90%+	90%+	85%	90%+	90%+	90%+	90%+	90%+	34%	31%	90%+
		COP 18	Scaleup Sat	APR 19	90%+	74%	90%+	90%+	54%	36%	67%	24%	70%	34%	72%	90%+	90%+	90%+	90%+	90%+	66%	57%	90%+
	Kayunga District	COP 15	ScaleUp Agg	APR 16	90%+	90%+	90%+	90%+	70%	61%	70%	61%	70%	61%	70%	61%	70%	61%	70%	61%	70%	61%	74%
		COP 16	ScaleUp Agg	APR 17	16%	73%	47%	64%	57%	90%+	73%	46%	82%	62%	37%	30%	65%	52%	90%+	47%	50%	40%	56%
		COP 17	ScaleUp Agg	APR 18	45%	67%	39%	56%	90%+	90%+	90%+	90%+	67%	76%	85%	90%+	89%	90%+	90%+	71%	37%	25%	81%
		COP 18	ScaleUp Agg	APR 19	90%+	62%	89%	80%	55%	36%	69%	25%	72%	35%	90%+	66%	90%+	71%	90%+	90%+	90%+	60%	83%
	Overall				90%+	70%	90%+	91%	71%	48%	88%	32%	90%+	45%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+

Cluster	District	COP	Prioritization	Results reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall																	
					Treatment Coverage at APR by Age and Sex																	
					<1	1-9	10-14		15-19		20-24		25-29		30-34		35-39		40-49		50+		Overall TX Coverage
							F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
KABALE CLUSTER	Kabale District	COP 15	ScaleUp Agg	APR 16	12%	12%	10%	14%	18%	28%	18%	28%	18%	28%	18%	28%	18%	28%	18%	28%	18%	28%	23%
		COP 16	ScaleUp Sat	APR 17	84%	90%+	81%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	60%	50%	54%	45%	90%+	80%
		COP 17	Attained	APR 18	81%	90%+	76%	90%+	49%	44%	66%	87%	88%	90%+	90%+	90%+	90%+	84%	55%	62%	33%	90%+	83%
		COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kisoro District	COP 15	Sustained	APR 16	48%	48%	41%	59%	47%	41%	47%	41%	47%	41%	47%	41%	47%	41%	47%	41%	47%	41%	49%
		COP 16	Sustained	APR 17	7%	25%	29%	34%	69%	90%+	90%+	90%+	90%+	90%+	90%+	59%	90%+	90%+	39%	34%	9%	38%	48%
		COP 17	Sustained	APR 18	64%	90%+	61%	90%+	26%	48%	34%	90%+	90%+	90%+	77%	78%	90%+	90%+	19%	25%	4%	26%	39%
		COP 18	Sustained	APR 19	90%+	82%	90%+	90%+	49%	31%	61%	22%	64%	31%	90%+	90%+	90%+	90%+	70%	82%	18%	90%+	65%
	Rubanda District	COP 15	ScaleUp Agg	APR 16	42%	42%	38%	48%	72%	54%	72%	54%	72%	54%	72%	54%	72%	54%	72%	54%	72%	54%	69%
		COP 16	ScaleUp Sat	APR 17	24%	31%	13%	35%	39%	16%	47%	26%	36%	40%	29%	59%	32%	19%	13%	19%	12%	49%	24%
		COP 17	Attained	APR 18	20%	32%	17%	29%	14%	10%	19%	25%	22%	19%	48%	69%	42%	23%	17%	24%	10%	29%	23%
		COP 18	ScaleUp Agg	APR 19	67%	40%	59%	53%	24%	16%	30%	11%	32%	15%	84%	77%	58%	25%	24%	43%	35%	90%+	38%
	Rukiga District	COP 15	ScaleUp Agg	APR 16	27%	27%	22%	33%	30%	31%	30%	31%	30%	31%	30%	31%	30%	31%	30%	31%	30%	31%	33%
		COP 16	ScaleUp Sat	APR 17	58%	67%	57%	87%	90%+	90%+	90%+	90%+	90%+	83%	73%	90%+	82%	43%	31%	38%	33%	90%+	57%
		COP 17	Attained	APR 18	52%	88%	51%	73%	32%	30%	45%	58%	77%	71%	90%+	90%+	90%+	48%	27%	38%	22%	68%	56%
		COP 18	ScaleUp Agg	APR 19	90%+	90%+	90%+	90%+	49%	33%	61%	22%	65%	31%	90%+	90%+	90%+	50%	54%	82%	70%	90%+	79%
	Overall				90+%	90+%	90+%	90+%	47%	31%	59%	21%	62%	30%	90+%	90+%	90+%	57%	53%	80%	44%	90+%	72%
KABAROLE CLUSTER	Kabarole District	COP 15	ScaleUp Sat	APR 16	85%	85%	72%	90%+	69%	85%	69%	85%	69%	85%	69%	85%	69%	85%	69%	85%	69%	85%	78%
		COP 16	ScaleUp Sat	APR 17	32%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	52%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 17	ScaleUp Sat	APR 18	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	65%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kyenjojo District	COP 15	ScaleUp Agg	APR 16	49%	49%	43%	57%	57%	40%	57%	40%	57%	40%	57%	40%	57%	40%	57%	40%	57%	40%	55%
		COP 16	ScaleUp Agg	APR 17	16%	90%+	43%	81%	90%+	90%+	90%+	90%+	90%+	90%+	54%	90%+	61%	55%	90%+	42%	31%	84%	77%
		COP 17	ScaleUp Agg	APR 18	51%	81%	46%	70%	90%+	82%	90%+	90%+	90%+	90%+	81%	90%+	66%	65%	90%+	45%	24%	49%	75%
		COP 18	Scaleup Sat	APR 19	90%+	62%	89%	80%	90%+	68%	90%+	46%	90%+	65%	90%+	90%+	85%	52%	90%+	67%	75%	90%+	90%+
	Kamwenge District	COP 15	ScaleUp Agg	APR 16	48%	48%	44%	54%	68%	57%	68%	57%	68%	57%	68%	57%	68%	57%	68%	57%	68%	57%	63%
		COP 16	ScaleUp Agg	APR 17	21%	62%	26%	50%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	80%	90%+	90%+	90%+	90%+	37%	44%	90%+
		COP 17	ScaleUp Agg	APR 18	40%	63%	36%	52%	57%	45%	76%	87%	68%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	30%	28%	86%
		COP 18	Scaleup Sat	APR 19	90%+	72%	90%+	90%+	64%	43%	80%	29%	84%	41%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Ntoroko District	COP 15	Sustained	APR 16	77%	77%	69%	88%	63%	90%+	63%	90%+	63%	90%+	63%	90%+	63%	90%+	63%	90%+	63%	90%+	88%
		COP 16	Sustained	APR 17	0%	61%	11%	31%	60%	67%	90%+	90%+	88%	90%+	60%	34%	65%	48%	53%	90%+	61%	90%+	66%
		COP 17	Sustained	APR 18	38%	61%	35%	52%	43%	31%	57%	52%	63%	90%+	88%	56%	75%	77%	72%	90%+	69%	90%+	71%
		COP 18	Sustained	APR 19	75%	46%	68%	60%	39%	25%	49%	17%	52%	25%	90%+	45%	86%	51%	90%+	90%+	90%+	90%+	84%
	Bunyangabu District	COP 15	ScaleUp Sat	APR 16	36%	36%	30%	43%	83%	59%	83%	59%	83%	59%	83%	59%	83%	59%	83%	59%	83%	59%	80%
		COP 16	ScaleUp Sat	APR 17	13%	86%	60%	90%+	71%	90%+	90%+	76%	90%+	90%+	21%	8%	47%	44%	80%	59%	46%	90%+	41%
		COP 17	ScaleUp Sat	APR 18	37%	63%	35%	54%	36%	30%	48%	57%	65%	57%	29%	14%	41%	48%	55%	38%	30%	56%	38%
		COP 18	ScaleUp Agg	APR 19	30%	19%	28%	25%	32%	21%	41%	14%	43%	21%	28%	7%	41%	30%	87%	66%	74%	90%+	38%
	Overall				90+%	63%	90+%	82%	77%	51%	90+%	35%	90+%	49%	86%	51%	90+%	70%	90+%	90+%	90+%	90+%	90+%

Cluster	District	COP	Prioritization	Results reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall																	
					Treatment Coverage at APR by Age and Sex																	
					<1	1-9	10-14		15-19		20-24		25-29		30-34		35-39		40-49		50+		Overall TX Coverage
							F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
KAMPALA CLUSTER	Wakiso District	COP 15	ScaleUp Agg	APR 16	67%	67%	55%	84%	77%	62%	77%	62%	77%	62%	77%	62%	77%	62%	77%	62%	77%	62%	75%
		COP 16	ScaleUp Agg	APR 17	27%	60%	44%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	29%	90%+	85%	46%	87%	29%	90%+	65%	63%
		COP 17	Attained	APR 18	43%	68%	39%	58%	63%	67%	83%	90%+	85%	90%+	46%	90%+	90%+	90%+	83%	31%	56%	45%	75%
		COP 18	ScaleUp Agg	APR 19	90%+	63%	90%+	83%	60%	40%	75%	27%	79%	38%	57%	90%+	90%+	55%	90%+	56%	90%+	85%	79%
	Kampala District	COP 15	ScaleUp Sat	APR 16	90%+	90%+	90%+	90%+	85%	90%+	85%	90%+	85%	90%+	85%	90%+	85%	90%+	85%	90%+	85%	90%+	90%+
		COP 16	ScaleUp Sat	APR 17	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	86%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 17	Attained	APR 18	90%+	90%+	90%+	90%+	67%	90%+	69%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Mukono District	COP 15	ScaleUp Agg	APR 16	45%	45%	37%	55%	53%	44%	53%	44%	53%	44%	53%	44%	53%	44%	53%	44%	53%	44%	53%
		COP 16	ScaleUp Agg	APR 17	47%	62%	44%	65%	82%	90%+	90%+	90%+	90%+	81%	90%+	86%	90%+	25%	33%	25%	89%	90%+	60%
		COP 17	Attained	APR 18	47%	74%	42%	61%	62%	55%	82%	90%+	90%+	90%+	90%+	90%+	90%+	54%	54%	75%	80%	90%+	90%+
		COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Overall				90+%	90+%	90+%	90+%	72%	49%	90%	33%	90+%	47%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%
LIRA CLUSTER	Lira District	COP 15	ScaleUp Agg	APR 16	87%	87%	72%	90%+	77%	50%	77%	50%	77%	50%	77%	50%	77%	50%	77%	50%	77%	50%	71%
		COP 16	ScaleUp Sat	APR 17	48%	90%+	73%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	63%	90%+	90%+	90%+	90%+	69%	89%	90%+	90%+
		COP 17	Attained	APR 18	63%	90%+	59%	88%	90%+	76%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	72%	90%+	90%+
		COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Apac District	COP 15	ScaleUp Agg	APR 16	22%	22%	18%	27%	30%	32%	30%	32%	30%	32%	30%	32%	30%	32%	30%	32%	30%	32%	33%
		COP 16	ScaleUp Agg	APR 17	23%	90%+	54%	70%	52%	52%	63%	50%	76%	77%	41%	49%	53%	44%	66%	90%+	46%	40%	58%
		COP 17	Attained	APR 18	41%	62%	35%	53%	40%	42%	54%	79%	55%	90%+	80%	90%+	76%	89%	73%	90%+	36%	49%	74%
		COP 18	ScaleUp Agg	APR 19	76%	47%	68%	61%	45%	30%	56%	20%	59%	28%	90%+	70%	87%	57%	90%+	90%+	90%+	90%+	83%
	Kole District	COP 15	ScaleUp Agg	APR 16	41%	42%	28%	59%	52%	61%	52%	61%	52%	61%	52%	61%	52%	61%	52%	61%	52%	61%	60%
		COP 16	ScaleUp Agg	APR 17	90%+	86%	46%	55%	75%	90%+	90%+	90%+	90%+	74%	44%	32%	90%+	45%	51%	90%+	20%	25%	61%
		COP 17	Attained	APR 18	43%	68%	39%	55%	44%	28%	59%	56%	81%	90%+	90%+	90%+	81%	76%	37%	90%+	19%	35%	65%
		COP 18	ScaleUp Agg	APR 19	84%	51%	74%	66%	56%	38%	70%	25%	74%	36%	90%+	47%	90%+	57%	90%+	90%+	66%	76%	83%
	Dokolo District	COP 15	ScaleUp Agg	APR 16	32%	32%	27%	38%	44%	74%	44%	74%	44%	74%	44%	74%	44%	74%	44%	74%	44%	74%	57%
		COP 16	ScaleUp Sat	APR 17	59%	90%+	36%	54%	42%	39%	72%	43%	81%	86%	58%	90%+	90%+	67%	40%	48%	28%	35%	58%
		COP 17	Attained	APR 18	90%+	90%+	90%+	90%+	31%	20%	41%	40%	38%	48%	90%+	90%+	90%+	90%+	41%	78%	20%	34%	65%
		COP 18	ScaleUp Agg	APR 19	90%+	90%+	90%+	90%+	35%	23%	44%	16%	46%	22%	90%+	90%+	90%+	65%	64%	86%	61%	66%	75%
	Alebtong District	COP 15	Sustained	APR 16	53%	53%	46%	62%	61%	74%	61%	74%	61%	74%	61%	74%	61%	74%	61%	74%	61%	74%	69%
		COP 16	Sustained	APR 17	9%	64%	47%	74%	21%	67%	37%	57%	64%	54%	31%	38%	90%+	90%+	30%	29%	74%	32%	45%
		COP 17	Sustained	APR 18	46%	71%	41%	58%	24%	21%	32%	37%	33%	37%	41%	78%	90%+	90%+	25%	23%	44%	18%	38%
		COP 18	Sustained	APR 19	90%+	68%	90%+	88%	36%	24%	45%	16%	47%	23%	64%	64%	90%+	90%+	44%	51%	90%+	66%	63%
	Amolatar District	COP 15	Sustained	APR 16	57%	57%	45%	72%	40%	31%	40%	31%	40%	31%	40%	31%	40%	31%	40%	31%	40%	31%	40%
		COP 16	Sustained	APR 17	68%	90%+	35%	63%	41%	90%+	90%+	90%+	90%+	76%	90%+	90%+	90%+	55%	90%+	62%	90%+	90%+	90%+
		COP 17	Attained	APR 18	50%	85%	49%	75%	55%	36%	73%	70%	90%+	88%	90%+	90%+	90%+	90%+	90%+	74%	90%+	90%+	90%+
		COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Otuke District	COP 15	Sustained	APR 16	58%	59%	42%	81%	35%	37%	35%	37%	35%	37%	35%	37%	35%	37%	35%	37%	35%	37%	40%
		COP 16	Sustained	APR 17	76%	90%+	49%	44%	60%	44%	90%+	74%	90%+	90%+	72%	90%+	90%+	90%+	71%	90%+	87%	90%+	90%+
		COP 17	Sustained	APR 18	56%	89%	51%	72%	70%	54%	90%+	90%+	77%	77%	90%+	90%+	90%+	90%+	70%	90%+	37%	56%	89%
		COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Overall				90+%	74%	90+%	90+%	65%	43%	81%	30%	85%	41%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%

Cluster	District	COP	Prioritization	Results reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall																	
					Treatment Coverage at APR by Age and Sex																	
					<1	1-9	10-14		15-19		20-24		25-29		30-34		35-39		40-49		50+		Overall TX Coverage
							F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
MASAKA CLUSTER	Rakai District	COP 15	ScaleUp Agg	APR 16	24%	24%	24%	25%	38%	32%	38%	32%	38%	32%	38%	32%	38%	32%	38%	32%	38%	32%	38%
		COP 16	ScaleUp Agg	APR 17	46%	50%	39%	62%	83%	90%+	90%+	90%+	90%+	90%+	33%	27%	85%	36%	74%	90%+	55%	90%+	69%
		COP 17	Attained	APR 18	29%	46%	26%	36%	90%+	90%+	90%+	90%+	43%	74%	38%	51%	89%	41%	57%	90%+	27%	83%	68%
		COP 18	Attained	APR 19	90%+	58%	84%	76%	88%	59%	90%+	40%	90%+	56%	87%	41%	90%+	38%	90%+	90%+	90%+	90%+	90%+
	Masaka District	COP 15	ScaleUp Sat	APR 16	19%	18%	18%	20%	45%	41%	45%	41%	45%	41%	45%	41%	45%	41%	45%	41%	45%	41%	47%
		COP 16	ScaleUp Sat	APR 17	87%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	74%	82%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 17	Attained	APR 18	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	51%	90%+	90%+
		COP 18	ScaleUp Agg	APR 19	90%+	90%+	90%+	90%+	76%	55%	90%+	36%	90%+	57%	81%	58%	57%	56%	90%+	90%+	80%	90%+	84%
	Sembabule District	COP 15	ScaleUp Sat	APR 16	31%	31%	28%	35%	23%	16%	23%	16%	23%	16%	23%	16%	23%	16%	23%	16%	23%	16%	23%
		COP 16	ScaleUp Agg	APR 17	68%	59%	30%	36%	77%	90%+	90%+	90%+	90%+	86%	48%	62%	90%+	74%	41%	37%	70%	54%	64%
		COP 17	Attained	APR 18	68%	90%+	60%	86%	48%	34%	65%	61%	76%	90%+	64%	90%+	90%+	90%+	30%	47%	55%	51%	66%
		COP 18	Attained	APR 19	90%+	79%	90%+	90%+	78%	52%	90%+	35%	90%+	49%	90%+	90%+	90%+	90%+	72%	80%	90%+	90%+	90%+
	Lwengo District	COP 15	ScaleUp Agg	APR 16	69%	69%	57%	85%	63%	66%	63%	66%	63%	66%	63%	66%	63%	66%	63%	66%	63%	66%	69%
		COP 16	ScaleUp Agg	APR 17	13%	65%	20%	44%	73%	89%	90%+	90%+	90%+	90%+	24%	57%	44%	64%	49%	83%	21%	37%	47%
		COP 17	Attained	APR 18	41%	64%	37%	52%	59%	38%	79%	76%	66%	75%	48%	90%+	70%	90%+	75%	90%+	19%	38%	70%
		COP 18	ScaleUp Agg	APR 19	90%+	74%	90%+	90%+	59%	39%	74%	27%	78%	38%	53%	85%	71%	90%+	90%+	90%+	52%	66%	74%
	Bukomansimbi District	COP 15	ScaleUp Agg	APR 16	34%	34%	29%	40%	28%	29%	28%	29%	28%	29%	28%	29%	28%	29%	28%	29%	28%	29%	31%
		COP 16	ScaleUp Agg	APR 17	11%	51%	33%	48%	42%	90%+	73%	90%+	90%+	90%+	64%	42%	26%	43%	33%	28%	85%	10%	43%
		COP 17	Attained	APR 18	50%	79%	45%	68%	53%	35%	71%	67%	59%	82%	90%+	90%+	52%	90%+	59%	75%	80%	19%	65%
		COP 18	ScaleUp Agg	APR 19	90%+	74%	90%+	90%+	53%	36%	67%	24%	70%	34%	90%+	50%	46%	68%	75%	64%	90%+	34%	68%
	Kalungu District	COP 15	ScaleUp Sat	APR 16	39%	39%	32%	48%	39%	55%	39%	55%	39%	55%	39%	55%	39%	55%	39%	55%	39%	55%	47%
		COP 16	ScaleUp Sat	APR 17	23%	90%+	87%	90%+	52%	90%+	67%	70%	64%	66%	70%	90%+	90%+	58%	90%+	90%+	90%+	90%+	90%+
		COP 17	Attained	APR 18	47%	81%	45%	70%	35%	23%	46%	44%	35%	49%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	Attained	APR 19	90%+	61%	88%	78%	32%	21%	40%	14%	42%	20%	90%+	90%+	90%+	65%	90%+	90%+	90%+	90%+	90%+
	Lyantonde District	COP 15	ScaleUp Sat	APR 16	45%	45%	39%	54%	41%	53%	41%	53%	41%	53%	41%	53%	41%	53%	41%	53%	41%	53%	48%
		COP 16	ScaleUp Sat	APR 17	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	66%	90%+	62%	90%+	80%	90%+	24%	50%	90%+
		COP 17	Attained	APR 18	51%	68%	39%	55%	68%	50%	90%+	86%	90%+	90%+	90%+	90%+	70%	90%+	90%+	90%+	36%	90%+	90%+
		COP 18	Attained	APR 19	87%	52%	75%	67%	90%+	69%	90%+	46%	90%+	66%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kyotera District	COP 15	Sustained	APR 16	75%	75%	67%	86%	76%	57%	76%	57%	76%	57%	76%	57%	76%	57%	76%	57%	76%	57%	75%
		COP 16	ScaleUp Agg	APR 17	78%	86%	67%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	64%	54%	90%+	57%	90%+	90%+	90%+	90%+	90%+
		COP 17	Attained	APR 18	49%	83%	46%	70%	90%+	90%+	90%+	90%+	90%+	90%+	86%	90%+	90%+	73%	81%	90%+	50%	90%+	90%+
		COP 18	Attained	APR 19	90%+	61%	89%	80%	90%+	90%+	90%+	68%	90%+	90%+	90%+	73%	90%+	63%	90%+	90%+	90%+	90%+	90%+
	Overall				90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%

Cluster	District	COP	Prioritization	Results reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall																		
					Treatment Coverage at APR by Age and Sex																		
					<1	1-9	10-14		15-19		20-24		25-29		30-34		35-39		40-49		50+		Overall TX Coverage
							F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
MBARARA CLUSTER	Mbarara District	COP 15	ScaleUp Sat	APR 16	86%	86%	75%	90%+	85%	53%	85%	53%	85%	53%	85%	53%	85%	53%	85%	53%	85%	53%	79%
		COP 16	ScaleUp Sat	APR 17	90%+	90%+	67%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	72%	76%	90%+	90%+
		COP 17	Attained	APR 18	90%+	90%+	80%	90%+	82%	88%	90%+	90%+	55%	48%	90%+	90%+	90%+	90%+	90%+	90%+	58%	81%	90%+
		COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	82%	56%	90%+	38%	90%+	54%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Rukungiri District	COP 15	ScaleUp Agg	APR 16	76%	76%	65%	90%+	44%	54%	44%	54%	44%	54%	44%	54%	44%	54%	44%	54%	44%	54%	51%
		COP 16	ScaleUp Sat	APR 17	46%	90%+	60%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	47%	43%	90%+	75%	79%	90%+	90%+	68%	90%+
		COP 17	ScaleUp Sat	APR 18	55%	88%	51%	76%	67%	45%	90%+	87%	90%+	90%+	82%	67%	90%+	85%	70%	90%+	90%+	32%	90%+
		COP 18	Attained	APR 19	90%+	67%	90%+	88%	87%	58%	90%+	40%	90%+	55%	90%+	45%	90%+	69%	90%+	90%+	90%+	83%	90%+
	Ntungamo District	COP 15	ScaleUp Agg	APR 16	53%	53%	45%	64%	60%	71%	60%	71%	60%	71%	60%	71%	60%	71%	60%	71%	60%	71%	69%
		COP 16	ScaleUp Agg	APR 17	90%+	67%	27%	47%	62%	53%	90%+	65%	90%+	90%+	33%	41%	78%	90%+	90%+	36%	28%	22%	57%
		COP 17	ScaleUp Agg	APR 18	41%	67%	38%	59%	42%	27%	56%	54%	53%	59%	50%	57%	82%	90%+	90%+	39%	30%	19%	54%
		COP 18	ScaleUp Agg	APR 19	90%+	68%	90%+	90%+	41%	27%	51%	18%	54%	26%	62%	42%	90%+	90%+	90%+	65%	90%+	52%	71%
	Kiruhura District	COP 15	ScaleUp Agg	APR 16	19%	19%	17%	23%	22%	28%	22%	28%	22%	28%	22%	28%	22%	28%	22%	28%	22%	28%	25%
		COP 16	ScaleUp Agg	APR 17	54%	50%	13%	31%	67%	64%	90%+	83%	90%+	90%+	64%	46%	33%	29%	35%	28%	61%	47%	49%
		COP 17	ScaleUp Agg	APR 18	60%	90%+	57%	87%	45%	29%	60%	58%	59%	90%+	90%+	82%	29%	27%	24%	12%	65%	41%	48%
		COP 18	ScaleUp Agg	APR 19	90%+	75%	90%+	90%+	37%	24%	46%	17%	49%	23%	90%+	47%	55%	34%	80%	54%	90%+	90%+	66%
	Bushenyi District	COP 15	ScaleUp Sat	APR 16	77%	77%	70%	86%	45%	33%	45%	33%	45%	33%	45%	33%	45%	33%	45%	33%	45%	33%	43%
		COP 16	ScaleUp Sat	APR 17	62%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 17	ScaleUp Sat	APR 18	86%	90%+	80%	90%+	90%+	68%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	66%	53%	90%+
		COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	66%	90%+	45%	90%+	63%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kanungu District	COP 15	ScaleUp Agg	APR 16	38%	38%	32%	45%	86%	76%	86%	76%	86%	76%	86%	76%	86%	76%	86%	76%	86%	76%	87%
		COP 16	ScaleUp Agg	APR 17	48%	79%	33%	46%	90%+	90%+	90%+	90%+	90%+	90%+	26%	60%	74%	47%	55%	31%	38%	11%	49%
		COP 17	ScaleUp Agg	APR 18	39%	72%	42%	64%	48%	31%	64%	61%	76%	84%	34%	79%	67%	48%	57%	35%	31%	8%	44%
		COP 18	ScaleUp Agg	APR 19	90%+	67%	90%+	88%	54%	35%	67%	24%	70%	34%	47%	54%	90%+	50%	90%+	67%	90%+	25%	60%
	Sheema District	COP 15	Sustained	APR 16	48%	48%	39%	60%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 16	ScaleUp Sat	APR 17	23%	85%	48%	87%	71%	90%+	90%+	90%+	90%+	90%+	57%	56%	90%+	90%+	90%+	57%	55%	54%	88%
		COP 17	ScaleUp Sat	APR 18	64%	90%+	58%	84%	69%	82%	90%+	90%+	71%	56%	48%	68%	90%+	90%+	90%+	58%	28%	25%	74%
		COP 18	Attained	APR 19	90%+	77%	90%+	90%+	71%	47%	88%	32%	90%+	45%	90%+	64%	90%+	90%+	90%+	90%+	90%+	77%	90%+
	Ibanda District	COP 15	ScaleUp Agg	APR 16	52%	52%	47%	60%	58%	49%	58%	49%	58%	49%	58%	49%	58%	49%	58%	49%	58%	49%	53%
		COP 16	ScaleUp Agg	APR 17	25%	83%	30%	62%	90%+	90%+	90%+	90%+	90%+	90%+	66%	90%+	90%+	64%	35%	48%	89%	90%+	77%
		COP 17	ScaleUp Agg	APR 18	66%	90%+	61%	90%+	59%	38%	79%	75%	90%+	90%+	65%	90%+	90%+	73%	24%	36%	63%	65%	64%
		COP 18	Attained	APR 19	90%+	80%	90%+	90%+	66%	44%	82%	30%	87%	42%	90%+	90%+	90%+	75%	63%	89%	90%+	90%+	90%+
	Mitooma District	COP 15	ScaleUp Agg	APR 16	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 16	ScaleUp Agg	APR 17	67%	44%	11%	27%	56%	68%	90%+	61%	90%+	74%	30%	90%+	90%+	50%	19%	23%	18%	34%	42%
		COP 17	ScaleUp Agg	APR 18	49%	90%+	52%	82%	30%	25%	42%	52%	36%	34%	32%	90%+	90%+	43%	31%	34%	15%	33%	39%
		COP 18	ScaleUp Agg	APR 19	90%+	75%	90%+	90%+	29%	19%	36%	13%	38%	18%	45%	90%+	90%+	40%	43%	52%	47%	90%+	51%
	Rubirizi District	COP 15	Sustained	APR 16	21%	21%	17%	27%	19%	24%	19%	24%	19%	24%	19%	24%	19%	24%	19%	24%	19%	24%	22%
		COP 16	Sustained	APR 17	43%	69%	25%	26%	90%+	57%	90%+	90%+	90%+	90%+	61%	90%+	50%	66%	53%	36%	48%	73%	70%
		COP 17	Sustained	APR 18	23%	45%	24%	41%	38%	17%	51%	37%	22%	27%	23%	55%	16%	32%	25%	21%	14%	18%	26%
		COP 18	Sustained	APR 19	56%	34%	49%	44%	55%	36%	69%	24%	73%	35%	90%+	90%+	59%	75%	90%+	84%	90%+	90%+	79%
	Buhweju District	COP 15	Sustained	APR 16	36%	36%	27%	47%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 16	Sustained	APR 17	0%	16%	10%	48%	90%+	90%+	90%+	90%+	39%	75%	22%	30%	73%	29%	25%	16%	12%	23%	37%
		COP 17	Sustained	APR 18	54%	89%	51%	72%	15%	19%	20%	36%	16%	9%	37%	24%	73%	30%	49%	40%	17%	14%	33%
		COP 18	Sustained	APR 19	90%+	66%	90%+	89%	37%	25%	46%	17%	48%	23%	90%+	51%	90%+	67%	90%+	90%+	90%+	86%	79%
	Overall				90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%	90+%

Cluster	District	COP	Prioritization	Results reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall																	
					Treatment Coverage at APR by Age and Sex																	
					<1	1-9	10-14		15-19		20-24		25-29		30-34		35-39		40-49		50+		Overall TX Coverage
							F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
SOROTI CLUSTER	Soroti District	COP 15	Sustained	APR 16	86%	86%	65%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 16	ScaleUp Sat	APR 17	71%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	87%	90%+	90%+	90%+	51%	90%+	90%+	90%+
		COP 17	Attained	APR 18	90%+	90%+	90%+	90%+	49%	62%	66%	90%+	90%+	75%	90%+	77%	90%+	90%+	90%+	72%	32%	50%	90%+
		COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	73%	48%	90%+	33%	90%+	46%	90%+	72%	90%+	90%+	90%+	74%	81%	90%+	90%+
	Amuria District	COP 15	Sustained	APR 16	7%	7%	7%	6%	8%	3%	8%	3%	8%	3%	8%	3%	8%	3%	8%	3%	8%	3%	7%
		COP 16	Sustained	APR 17	50%	76%	35%	55%	63%	70%	90%+	90%+	90%+	90%+	90%+	52%	28%	43%	35%	22%	54%	36%	58%
		COP 17	Sustained	APR 18	51%	81%	46%	66%	55%	28%	72%	66%	86%	90%+	90%+	71%	64%	69%	61%	39%	42%	33%	65%
		COP 18	Sustained	APR 19	90%+	61%	89%	80%	60%	41%	75%	27%	78%	38%	90%+	44%	61%	45%	74%	56%	90%+	75%	73%
	Serere District	COP 15	ScaleUp Agg	APR 16	90%+	90%+	79%	90%+	90%+	81%	90%+	81%	90%+	81%	90%+	81%	90%+	81%	90%+	81%	90%+	81%	90%+
		COP 16	Sustained	APR 17	65%	78%	31%	52%	67%	90%+	87%	90%+	90%+	90%+	30%	90%+	90%+	63%	42%	64%	36%	90%+	66%
		COP 17	Sustained	APR 18	53%	90%+	58%	86%	69%	65%	90%+	90%+	90%+	90%+	78%	90%+	90%+	62%	72%	83%	27%	71%	84%
		COP 18	ScaleUp Agg	APR 19	90%+	76%	90%+	90%+	72%	48%	89%	32%	90%+	45%	84%	90%+	90%+	42%	56%	87%	58%	90%+	80%
	Kaberamaido District	COP 15	Sustained	APR 16	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 16	Sustained	APR 17	90%+	90%+	39%	55%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	58%	90%+	90%+	51%	90%+	33%	90%+	90%+
		COP 17	Sustained	APR 18	53%	90%+	54%	82%	67%	45%	90%+	86%	90%+	90%+	90%+	89%	90%+	90%+	42%	90%+	25%	85%	88%
		COP 18	Attained	APR 19	90%+	71%	90%+	90%+	90%+	63%	90%+	43%	90%+	59%	90%+	63%	90%+	90%+	73%	90%+	83%	90%+	90%+
	Katakwi District	COP 15	ScaleUp Agg	APR 16	51%	51%	41%	65%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 16	ScaleUp Agg	APR 17	30%	34%	50%	88%	90%+	90%+	90%+	90%+	90%+	90%+	50%	44%	44%	52%	44%	32%	53%	90%+	62%
		COP 17	ScaleUp Agg	APR 18	68%	90%+	60%	89%	68%	43%	90%+	86%	90%+	90%+	90%+	82%	55%	63%	57%	49%	21%	72%	66%
		COP 18	ScaleUp Agg	APR 19	90%+	80%	90%+	90%+	77%	50%	90%+	35%	90%+	49%	90%+	51%	61%	50%	75%	66%	54%	90%+	75%
	Ngora District	COP 15	Sustained	APR 16	69%	69%	56%	87%	66%	70%	66%	70%	66%	70%	66%	70%	66%	70%	66%	70%	66%	70%	74%
		COP 16	Sustained	APR 17	84%	85%	56%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	42%	90%+	90%+	90%+	90%+	90%+	21%	90%+	79%
		COP 17	Attained	APR 18	67%	90%+	68%	90%+	66%	51%	86%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	11%	49%	89%
		COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	60%	90%+	44%	90%+	60%	87%	90%+	90%+	90%+	90%+	90%+	27%	90%+	90%+
	Overall				90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+

District	COP	Prioritization	Results reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall																		
				Treatment Coverage at APR by Age and Sex																		
				<1	1-9	10-14		15-19		20-24		25-29		30-34		35-39		40-49		50+		Overall TX Coverage
						F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Mpigi District	COP 15	ScaleUp Sat	APR 16	30%	30%	21%	42%	31%	38%	31%	38%	31%	38%	31%	38%	31%	38%	31%	38%	31%	38%	36%
	COP 16	ScaleUp Sat	APR 17	41%	89%	47%	90%+	62%	90%+	90%+	86%	90%+	90%+	40%	90%+	69%	90%+	59%	90%+	25%	40%	63%
	COP 17	Attained	APR 18	50%	85%	48%	74%	55%	37%	73%	70%	82%	90%+	90%+	90%+	88%	90%+	78%	90%+	28%	41%	80%
	COP 18	ScaleUp Sat	APR 19	90%+	64%	90%+	84%	54%	36%	67%	24%	71%	34%	89%	90%+	90%+	90%+	90%+	90%+	75%	90%+	90%+
Mubende District	COP 15	ScaleUp Agg	APR 16	85%	85%	70%	90%+	50%	64%	50%	64%	50%	64%	50%	64%	50%	64%	50%	64%	50%	64%	59%
	COP 16	ScaleUp Agg	APR 17	35%	61%	39%	67%	57%	65%	90%+	90%+	90%+	79%	30%	90%+	39%	64%	90%+	34%	90%+	40%	61%
	COP 17	Attained	APR 18	53%	82%	47%	69%	55%	34%	73%	66%	77%	90%+	59%	90%+	54%	90%+	90%+	71%	90%+	48%	81%
	COP 18	ScaleUp Sat	APR 19	90%+	74%	90%+	90%+	49%	33%	61%	22%	64%	31%	72%	90%+	67%	90%+	90%+	79%	90%+	90%+	90%+
Kibaale District	COP 15	ScaleUp Agg	APR 16	63%	63%	54%	76%	67%	51%	67%	51%	67%	51%	67%	51%	67%	51%	67%	51%	67%	51%	65%
	COP 16	ScaleUp Agg	APR 17	34%	38%	23%	28%	67%	70%	88%	67%	90%+	89%	59%	21%	35%	44%	28%	57%	87%	51%	47%
	COP 17	ScaleUp Agg	APR 18	21%	40%	22%	38%	45%	35%	60%	68%	42%	43%	90%+	29%	57%	66%	54%	85%	73%	37%	55%
	COP 18	ScaleUp Sat	APR 19	90%+	71%	90%+	90%+	55%	36%	69%	25%	72%	34%	90%+	35%	84%	70%	76%	90%+	90%+	90%+	90%+
Hoima District	COP 15	ScaleUp Agg	APR 16	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 16	ScaleUp Agg	APR 17	10%	66%	31%	45%	90%+	90%+	90%+	90%+	90%+	90%+	39%	34%	76%	90%+	45%	66%	45%	27%	68%
	COP 17	ScaleUp Agg	APR 18	41%	70%	41%	60%	75%	43%	90%+	85%	68%	81%	76%	76%	88%	90%+	90%+	90%+	44%	23%	78%
	COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
Mityana District	COP 15	ScaleUp Agg	APR 16	22%	22%	16%	30%	34%	33%	34%	33%	34%	33%	34%	33%	34%	33%	34%	33%	34%	33%	36%
	COP 16	ScaleUp Agg	APR 17	26%	83%	56%	90%+	90%+	90%+	90%+	80%	90%+	90%+	90%+	69%	90%+	47%	74%	76%	75%	55%	88%
	COP 17	Attained	APR 18	51%	82%	46%	72%	90%+	62%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	58%	90%+	45%	51%	90%+
	COP 18	Scaleup Sat	APR 19	90%+	62%	90%+	81%	75%	50%	90%+	34%	90%+	48%	90%+	90%+	90%+	57%	90%+	90%+	90%+	71%	90%+
Kasese District	COP 15	ScaleUp Agg	APR 16	35%	35%	29%	43%	48%	32%	48%	32%	48%	32%	48%	32%	48%	32%	48%	32%	48%	32%	46%
	COP 16	ScaleUp Agg	APR 17	66%	68%	33%	67%	90%+	90%+	90%+	90%+	90%+	90%+	50%	90%+	89%	90%+	61%	90%+	90%+	28%	90%+
	COP 17	ScaleUp Agg	APR 18	53%	87%	51%	74%	90%+	90%+	90%+	90%+	90%+	90%+	68%	90%+	90%+	90%+	90%+	90%+	90%+	23%	90%+
	COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
Isingiro District	COP 15	ScaleUp Agg	APR 16	49%	50%	44%	57%	71%	68%	71%	68%	71%	68%	71%	68%	71%	68%	71%	68%	71%	68%	77%
	COP 16	ScaleUp Agg	APR 17	58%	52%	20%	44%	85%	90%+	90%+	90%+	90%+	87%	33%	81%	38%	46%	65%	21%	87%	31%	52%
	COP 17	ScaleUp Agg	APR 18	45%	75%	42%	63%	72%	39%	90%+	79%	90%+	90%+	62%	90%+	41%	54%	75%	37%	90%+	47%	70%
	COP 18	ScaleUp Agg	APR 19	90%+	74%	90%+	90%+	55%	37%	69%	25%	72%	35%	79%	90%+	59%	55%	90%+	67%	90%+	90%+	84%
Oyam District	COP 15	ScaleUp Agg	APR 16	80%	80%	82%	77%	74%	90%+	74%	90%+	74%	90%+	74%	90%+	74%	90%+	74%	90%+	74%	90%+	87%
	COP 16	ScaleUp Agg	APR 17	90%+	90%+	58%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	52%	41%	90%+	90%+	36%	53%	50%	41%	79%
	COP 17	Attained	APR 18	51%	80%	46%	67%	63%	43%	84%	80%	90%+	90%+	90%+	90%+	90%+	90%+	74%	90%+	42%	54%	90%+
	COP 18	Scaleup Sat	APR 19	90%+	60%	87%	79%	71%	48%	89%	32%	90%+	45%	90%+	50%	90%+	90%+	87%	90%+	90%+	90%+	90%+
Nebbi District	COP 15	ScaleUp Agg	APR 16	25%	25%	22%	30%	55%	68%	55%	68%	55%	68%	55%	68%	55%	68%	55%	68%	55%	68%	64%
	COP 16	ScaleUp Agg	APR 17	90%+	90%+	30%	56%	90%+	81%	90%+	90%+	90%+	90%+	47%	90%+	90%+	58%	46%	90%+	27%	40%	74%
	COP 17	Attained	APR 18	58%	90%+	53%	76%	90%+	34%	90%+	69%	90%+	90%+	84%	90%+	90%+	90%+	85%	90%+	37%	46%	90%+
	COP 18	Scaleup Sat	APR 19	90%+	69%	90%+	89%	64%	43%	80%	29%	84%	41%	87%	90%+	90%+	70%	89%	90%+	81%	90%+	90%+
Arua District	COP 15	ScaleUp Agg	APR 16	77%	77%	68%	88%	44%	44%	44%	44%	44%	44%	44%	44%	44%	44%	44%	44%	44%	44%	49%
	COP 16	ScaleUp Sat	APR 17	33%	47%	34%	70%	83%	90%+	83%	66%	90%+	90%+	30%	82%	86%	30%	90%+	55%	58%	46%	58%
	COP 17	Attained	APR 18	81%	90%+	77%	90%+	69%	77%	90%+	90%+	90%+	90%+	81%	90%+	90%+	58%	90%+	90%+	57%	33%	90%+
	COP 18	ScaleUp Agg	APR 19	90%+	90%+	90%+	90%+	67%	44%	83%	30%	88%	43%	61%	90%+	90%+	35%	90%+	90%+	90%+	58%	80%
Mbale District	COP 15	ScaleUp Sat	APR 16	47%	47%	38%	60%	44%	49%	44%	49%	44%	49%	44%	49%	44%	49%	44%	49%	44%	49%	49%
	COP 16	ScaleUp Sat	APR 17	20%	71%	90%+	90%+	90%+	90%+	79%	90%+	83%	47%	44%	21%	85%	55%	75%	49%	90%+	72%	75%
	COP 17	Attained	APR 18	62%	90%+	60%	90%+	55%	69%	73%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	61%	49%	90%+	28%	86%
	COP 18	Scaleup Sat	APR 19	90%+	78%	90%+	90%+	76%	51%	90%+	35%	90%+	50%	90%+	68%	90%+	90%+	69%	90%+	90%+	71%	90%+

District	COP	Prioritization	Results reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall																	
				Treatment Coverage at APR by Age and Sex																	
				<1	1-9	10-14		15-19		20-24		25-29		30-34		35-39		40-49		50+		Overall TX Coverage
						F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Masindi District	COP 15	ScaleUp Agg	APR 16	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 16	ScaleUp Agg	APR 17	39%	63%	46%	90%+	86%	90%+	90%+	90%+	90%+	90%+	42%	40%	90%+	90%+	90%+	65%	90%+	90%+	90%+
	COP 17	ScaleUp Agg	APR 18	44%	75%	43%	64%	32%	39%	43%	74%	49%	58%	88%	72%	90%+	90%+	90%+	90%+	90%+	75%	90%+
	COP 18	Scaleup Sat	APR 19	90%+	63%	90%+	83%	39%	26%	49%	18%	51%	26%	90%+	48%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
Tororo District	COP 15	ScaleUp Agg	APR 16	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 16	ScaleUp Sat	APR 17	21%	53%	51%	90%+	81%	90%+	67%	90%+	90%+	90%+	50%	50%	76%	58%	70%	22%	71%	65%	67%
	COP 17	ScaleUp Sat	APR 18	40%	67%	38%	57%	63%	62%	85%	90%+	90%+	90%+	90%+	90%+	78%	89%	90%+	72%	23%	25%	74%
	COP 18	ScaleUp Agg	APR 19	90%+	62%	90%+	80%	77%	52%	90%+	35%	90%+	49%	90%+	71%	77%	61%	90%+	76%	54%	53%	78%
Busia District	COP 15	ScaleUp Sat	APR 16	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 16	ScaleUp Sat	APR 17	21%	55%	29%	49%	40%	83%	77%	46%	90%+	41%	26%	80%	47%	46%	31%	30%	29%	42%	39%
	COP 17	Attained	APR 18	58%	87%	49%	73%	90%+	61%	90%+	90%+	90%+	90%+	86%	90%+	90%+	90%+	68%	58%	40%	46%	88%
	COP 18	ScaleUp Agg	APR 19	90%+	74%	90%+	90%+	73%	48%	90%+	33%	90%+	46%	79%	90%+	83%	74%	63%	68%	81%	87%	78%
Namayingo District	COP 15	ScaleUp Agg	APR 16	29%	29%	24%	35%	39%	37%	39%	37%	39%	37%	39%	37%	39%	37%	39%	37%	39%	37%	40%
	COP 16	ScaleUp Sat	APR 17	86%	73%	38%	47%	70%	90%+	90%+	90%+	90%+	90%+	28%	19%	90%+	71%	21%	19%	12%	12%	33%
	COP 17	Attained	APR 18	45%	83%	48%	74%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	79%	90%+	90%+	50%	44%	27%	30%	81%
	COP 18	ScaleUp Agg	APR 19	90%+	74%	90%+	90%+	89%	60%	90%+	40%	90%+	57%	85%	34%	90%+	90%+	54%	51%	56%	53%	69%
Kitgum District	COP 15	ScaleUp Sat	APR 16	22%	22%	23%	20%	38%	50%	38%	50%	38%	50%	38%	50%	38%	50%	38%	50%	38%	50%	43%
	COP 16	ScaleUp Sat	APR 17	20%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	62%	59%	53%	90%+	90%+	90%+
	COP 17	Attained	APR 18	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	67%	75%	90%+	90%+	90%+
	COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
Kyegegwa District	COP 15	ScaleUp Agg	APR 16	27%	27%	24%	31%	34%	16%	34%	16%	34%	16%	34%	16%	34%	16%	34%	16%	34%	16%	27%
	COP 16	ScaleUp Agg	APR 17	16%	74%	26%	38%	59%	42%	90%+	63%	90%+	71%	52%	77%	64%	54%	90%+	38%	90%+	90%+	68%
	COP 17	ScaleUp Agg	APR 18	31%	48%	27%	40%	43%	27%	57%	54%	55%	58%	59%	90%+	65%	55%	90%+	39%	90%+	57%	62%
	COP 18	Scaleup Sat	APR 19	90%+	57%	82%	74%	49%	33%	61%	22%	64%	31%	90%+	90%+	90%+	58%	90%+	79%	90%+	90%+	90%+
Yumbe District	COP 15	Sustained	APR 16	62%	62%	51%	77%	66%	54%	66%	54%	66%	54%	66%	54%	66%	54%	66%	54%	66%	54%	66%
	COP 16	Sustained	APR 17	23%	23%	6%	6%	33%	25%	45%	13%	54%	39%	34%	14%	53%	15%	46%	10%	16%	15%	24%
	COP 17	Sustained	APR 18	90%+	90%+	88%	90%+	46%	60%	61%	90%+	50%	46%	66%	39%	79%	25%	90%+	24%	25%	18%	55%
	COP 18	Sustained	APR 19	90%+	90%+	90%+	90%+	12%	8%	15%	5%	16%	8%	30%	9%	34%	7%	47%	12%	26%	16%	32%
Agago District	COP 15	ScaleUp Agg	APR 16	27%	27%	23%	32%	66%	38%	66%	38%	66%	38%	66%	38%	66%	38%	66%	38%	66%	38%	58%
	COP 16	ScaleUp Agg	APR 17	10%	88%	34%	60%	90%+	90%+	90%+	90%+	90%+	90%+	35%	50%	48%	90%+	50%	32%	26%	90%+	53%
	COP 17	Attained	APR 18	37%	61%	35%	52%	82%	56%	90%+	90%+	90%+	90%+	80%	90%+	90%+	90%+	61%	83%	19%	90%+	80%
	COP 18	ScaleUp Agg	APR 19	87%	54%	78%	70%	81%	53%	90%+	36%	90%+	51%	83%	57%	90%+	90%+	90%+	72%	51%	90%+	81%
Bugiri District	COP 15	ScaleUp Agg	APR 16	41%	41%	36%	48%	31%	21%	31%	21%	31%	21%	31%	21%	31%	21%	31%	21%	31%	21%	31%
	COP 16	ScaleUp Agg	APR 17	1%	42%	26%	42%	90%+	90%+	90%+	90%+	90%+	47%	90%+	66%	90%+	90%+	79%	90%+	90%+	47%	90%+
	COP 17	ScaleUp Agg	APR 18	49%	75%	43%	60%	64%	54%	85%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	45%	90%+
	COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
Gomba District	COP 15	ScaleUp Agg	APR 16	64%	64%	58%	73%	34%	35%	34%	35%	34%	35%	34%	35%	34%	35%	34%	35%	34%	35%	39%
	COP 16	ScaleUp Agg	APR 17	22%	75%	42%	48%	55%	36%	90%+	90%+	90%+	90%+	73%	90%+	72%	71%	90%+	83%	90%+	65%	85%
	COP 17	Attained	APR 18	81%	90%+	69%	90%+	78%	60%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	63%	60%	90%+
	COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
Kotido District	COP 15	ScaleUp Agg	APR 16	56%	56%	48%	66%	33%	34%	33%	34%	33%	34%	33%	34%	33%	34%	33%	34%	33%	34%	38%
	COP 16	ScaleUp Agg	APR 17	9%	13%	10%	14%	73%	90%+	43%	90%+	29%	47%	19%	19%	90%+	28%	12%	4%	16%	4%	25%
	COP 17	ScaleUp Agg	APR 18	58%	90%+	52%	78%	15%	12%	20%	28%	19%	14%	70%	43%	90%+	55%	53%	37%	42%	15%	39%
	COP 18	ScaleUp Agg	APR 19	90%+	75%	90%+	90%+	10%	7%	13%	4%	13%	6%	67%	23%	90%+	35%	52%	42%	87%	31%	39%

District	COP	Prioritization	Results reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall																		
				Treatment Coverage at APR by Age and Sex																		
				<1	1-9	10-14		15-19		20-24		25-29		30-34		35-39		40-49		50+		Overall TX Coverage
						F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Nakaseke District	COP 15	ScaleUp Agg	APR 16	9%	9%	6%	13%	19%	54%	19%	54%	19%	54%	19%	54%	19%	54%	19%	54%	19%	54%	34%
	COP 16	ScaleUp Agg	APR 17	10%	90%+	35%	90%+	59%	75%	75%	34%	78%	90%+	18%	52%	42%	52%	37%	89%	42%	90%+	46%
	COP 17	ScaleUp Agg	APR 18	56%	84%	47%	74%	65%	40%	86%	81%	37%	90%+	22%	48%	72%	57%	80%	81%	37%	71%	64%
	COP 18	ScaleUp Agg	APR 19	90%+	64%	90%+	83%	46%	30%	57%	21%	60%	29%	43%	65%	68%	67%	56%	90%+	90%+	90%+	67%
Kiryandongo District	COP 15	Sustained	APR 16	31%	32%	25%	40%	46%	32%	46%	32%	46%	32%	46%	32%	46%	32%	46%	32%	46%	32%	43%
	COP 16	Sustained	APR 17	52%	55%	48%	76%	90%+	90%+	90%+	90%+	90%+	90%+	75%	31%	31%	41%	16%	14%	30%	50%	57%
	COP 17	Sustained	APR 18	54%	85%	48%	75%	90%+	58%	90%+	90%+	77%	90%+	90%+	90%+	54%	90%+	25%	42%	33%	70%	71%
	COP 18	Scaleup Sat	APR 19	90%+	61%	89%	81%	62%	42%	78%	28%	82%	40%	90%+	90%+	90%+	90%+	64%	77%	90%+	90%+	90%+
Manafwa District	COP 15	Sustained	APR 16	90%+	90%+	84%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 16	Sustained	APR 17	0%	46%	28%	8%	20%	76%	43%	24%	67%	29%	17%	22%	90%+	84%	23%	8%	90%+	78%	43%
	COP 17	Sustained	APR 18	60%	90%+	57%	88%	24%	11%	33%	30%	24%	22%	24%	32%	90%+	81%	15%	14%	42%	16%	32%
	COP 18	Sustained	APR 19	90%+	76%	90%+	90%+	37%	25%	46%	17%	49%	23%	66%	53%	90%+	90%+	57%	49%	90%+	90%+	71%
Buyende District	COP 15	Sustained	APR 16	42%	42%	30%	58%	60%	48%	60%	48%	60%	48%	60%	48%	60%	48%	60%	48%	60%	48%	57%
	COP 16	Sustained	APR 17	19%	19%	18%	21%	53%	90%+	85%	90%+	54%	44%	73%	90%+	90%+	90%+	52%	90%+	29%	58%	61%
	COP 17	Sustained	APR 18	50%	81%	46%	70%	42%	41%	56%	82%	80%	65%	90%+	90%+	90%+	90%+	90%+	90%+	20%	41%	90%+
	COP 18	Scaleup Sat	APR 19	90%+	61%	89%	80%	47%	31%	59%	21%	62%	30%	90%+	90%+	90%+	90%+	90%+	90%+	47%	88%	90%+
Zombo District	COP 15	Sustained	APR 16	11%	11%	9%	12%	26%	11%	26%	11%	26%	11%	26%	11%	26%	11%	26%	11%	26%	11%	20%
	COP 16	Sustained	APR 17	44%	62%	20%	27%	90%+	77%	90%+	90%+	90%+	90%+	58%	40%	67%	46%	47%	90%+	12%	22%	50%
	COP 17	Sustained	APR 18	54%	86%	43%	71%	71%	31%	90%+	57%	70%	63%	90%+	71%	90%+	86%	60%	90%+	11%	16%	61%
	COP 18	Sustained	APR 19	90%+	65%	90%+	85%	59%	40%	73%	27%	77%	37%	90%+	54%	90%+	67%	90%+	90%+	38%	47%	80%
Pader District	COP 15	Ctrl Supported	APR 16	88%	88%	74%	90%+	68%	73%	68%	73%	68%	73%	68%	73%	68%	73%	68%	73%	68%	73%	76%
	COP 16	Ctrl Supported	APR 17	44%	81%	45%	78%	84%	90%+	90%+	90%+	90%+	90%+	45%	90%+	90%+	86%	81%	36%	90%+	79%	79%
	COP 17	Ctrl Supported	APR 18	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	COP 18	Ctrl Supported	APR 19	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Bukedea District	COP 15	Sustained	APR 16	88%	88%	72%	90%+	78%	57%	78%	57%	78%	57%	78%	57%	78%	57%	78%	57%	78%	57%	76%
	COP 16	Sustained	APR 17	30%	31%	25%	39%	44%	90%+	37%	85%	90%+	82%	20%	90%+	43%	37%	15%	21%	41%	28%	30%
	COP 17	Sustained	APR 18	51%	81%	45%	71%	41%	27%	55%	53%	79%	72%	40%	90%+	44%	47%	19%	26%	19%	12%	36%
	COP 18	Sustained	APR 19	90%+	61%	88%	80%	52%	35%	67%	23%	70%	34%	42%	90%+	44%	36%	23%	33%	48%	30%	40%
Adjumani District	COP 15	Sustained	APR 16	34%	34%	26%	46%	37%	15%	37%	15%	37%	15%	37%	15%	37%	15%	37%	15%	37%	15%	28%
	COP 16	Sustained	APR 17	7%	40%	21%	38%	34%	90%+	54%	46%	89%	52%	88%	20%	90%+	85%	90%+	45%	90%+	90%+	67%
	COP 17	Sustained	APR 18	90%+	90%+	86%	90%+	50%	73%	67%	90%+	72%	82%	90%+	53%	90%+	90%+	90%+	76%	90%+	78%	90%+
	COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
Kaliro District	COP 15	Sustained	APR 16	90%+	90%+	90%+	90%+	74%	90%+	74%	90%+	74%	90%+	74%	90%+	74%	90%+	74%	90%+	74%	90%+	85%
	COP 16	Sustained	APR 17	5%	27%	24%	31%	24%	69%	43%	50%	32%	30%	63%	59%	90%+	90%+	20%	90%+	18%	22%	37%
	COP 17	Sustained	APR 18	57%	90%+	53%	78%	37%	29%	51%	53%	72%	90%+	90%+	90%+	90%+	90%+	20%	84%	19%	19%	61%
	COP 18	Sustained	APR 19	90%+	69%	90%+	90%+	23%	15%	29%	11%	30%	15%	90%+	82%	90%+	90%+	30%	90%+	36%	32%	50%
Kumi District	COP 15	Sustained	APR 16	3%	3%	4%	3%	16%	16%	16%	16%	16%	16%	16%	16%	16%	16%	16%	16%	16%	16%	17%
	COP 16	Sustained	APR 17	11%	63%	38%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	53%	90%+	90%+	34%	32%	56%	38%	51%	53%
	COP 17	Sustained	APR 18	51%	86%	49%	72%	90%+	65%	90%+	90%+	90%+	90%+	73%	90%+	90%+	45%	18%	12%	18%	21%	61%
	COP 18	Sustained	APR 19	90%+	65%	90%+	84%	90%+	90%+	90%+	64%	90%+	89%	90%+	90%+	90%+	33%	38%	77%	44%	48%	67%
Sironko District	COP 15	ScaleUp Agg	APR 16	63%	63%	56%	73%	37%	33%	37%	33%	37%	33%	37%	33%	37%	33%	37%	33%	37%	33%	40%
	COP 16	Sustained	APR 17	17%	52%	25%	57%	31%	41%	34%	17%	46%	19%	33%	10%	90%+	15%	63%	69%	38%	18%	39%
	COP 17	Sustained	APR 18	48%	87%	51%	75%	37%	21%	50%	49%	55%	51%	90%+	70%	90%+	74%	90%+	90%+	35%	22%	70%
	COP 18	Sustained	APR 19	90%+	66%	90%+	85%	28%	18%	35%	12%	36%	18%	90%+	35%	90%+	42%	84%	90%+	71%	41%	63%

District	COP	Prioritization	Results reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall																		
				Treatment Coverage at APR by Age and Sex																		
				<1	1-9	10-14		15-19		20-24		25-29		30-34		35-39		40-49		50+		Overall TX Coverage
						F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Kalangala District	COP 15	ScaleUp Sat	APR 16	30%	30%	26%	34%	43%	32%	43%	32%	43%	32%	43%	32%	43%	32%	43%	32%	43%	32%	42%
	COP 16	ScaleUp Sat	APR 17	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	53%	56%	20%	64%	90%+	28%	33%	42%	83%
	COP 17	Attained	APR 18	86%	90%+	66%	88%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	66%	90%+	90%+	90%+	90%+	90%+	90%+
	COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
Luuka District	COP 15	Ctrl Supported	APR 16	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 16	Ctrl Supported	APR 17	16%	21%	14%	23%	20%	43%	27%	43%	26%	23%	44%	43%	90%+	40%	9%	36%	44%	29%	24%
	COP 17	Ctrl Supported	APR 18	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	COP 18	Ctrl Supported	APR 19	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kyankwanzi District	COP 15	Sustained	APR 16	6%	6%	7%	6%	10%	2%	10%	2%	10%	2%	10%	2%	10%	2%	10%	2%	10%	2%	7%
	COP 16	Sustained	APR 17	21%	49%	11%	31%	89%	62%	90%+	70%	72%	75%	26%	19%	37%	8%	41%	32%	66%	57%	35%
	COP 17	Sustained	APR 18	40%	63%	36%	51%	40%	22%	53%	45%	35%	42%	48%	31%	48%	9%	55%	45%	66%	47%	37%
	COP 18	Sustained	APR 19	90%+	74%	90%+	90%+	40%	26%	50%	18%	52%	25%	83%	30%	69%	10%	78%	75%	90%+	90%+	56%
Luwero District	COP 15	ScaleUp Agg	APR 16	25%	25%	21%	31%	17%	22%	17%	22%	17%	22%	17%	22%	17%	22%	17%	22%	17%	22%	20%
	COP 16	ScaleUp Sat	APR 17	24%	90%+	66%	90%+	90%+	90%+	90%+	74%	90%+	49%	64%	67%	90%+	68%	90%+	38%	83%	57%	80%
	COP 17	Attained	APR 18	56%	90%+	51%	76%	38%	20%	51%	42%	40%	50%	45%	89%	90%+	66%	74%	37%	26%	24%	50%
	COP 18	ScaleUp Agg	APR 19	90%+	68%	90%+	89%	43%	29%	54%	19%	57%	27%	88%	87%	90%+	71%	90%+	69%	90%+	80%	78%
Kiboga District	COP 15	ScaleUp Sat	APR 16	25%	25%	26%	24%	36%	32%	36%	32%	36%	32%	36%	32%	36%	32%	36%	32%	36%	32%	37%
	COP 16	ScaleUp Sat	APR 17	22%	88%	39%	76%	78%	90%+	90%+	90%+	90%+	90%+	90%+	69%	74%	90%+	90%+	33%	60%	90%+	85%
	COP 17	ScaleUp Sat	APR 18	40%	71%	40%	63%	47%	29%	63%	61%	80%	83%	90%+	90%+	66%	90%+	90%+	40%	44%	64%	74%
	COP 18	Scaleup Sat	APR 19	88%	54%	78%	70%	58%	38%	72%	26%	76%	37%	90%+	90%+	90%+	90%+	90%+	61%	90%+	90%+	90%+
Pallisa District	COP 15	Sustained	APR 16	55%	55%	46%	66%	55%	45%	55%	45%	55%	45%	55%	45%	55%	45%	55%	45%	55%	45%	56%
	COP 16	Sustained	APR 17	0%	36%	18%	9%	41%	23%	27%	72%	33%	34%	34%	17%	90%+	36%	24%	34%	70%	89%	38%
	COP 17	Attained	APR 18	74%	90%+	68%	90%+	35%	30%	47%	64%	65%	63%	90%+	55%	90%+	71%	37%	57%	86%	77%	69%
	COP 18	Sustained	APR 19	90%+	55%	80%	71%	25%	17%	32%	11%	33%	16%	76%	22%	90%+	38%	32%	59%	90%+	90%+	51%
Namutumba District	COP 15	Sustained	APR 16	11%	11%	8%	14%	26%	20%	26%	20%	26%	20%	26%	20%	26%	20%	26%	20%	26%	20%	25%
	COP 16	Sustained	APR 17	44%	39%	9%	21%	58%	90%+	74%	90%+	61%	41%	89%	28%	90%+	23%	27%	90%+	23%	68%	46%
	COP 17	Sustained	APR 18	53%	85%	48%	70%	46%	34%	61%	69%	49%	26%	90%+	90%+	90%+	44%	45%	90%+	16%	50%	65%
	COP 18	Sustained	APR 19	90%+	64%	90%+	83%	40%	26%	50%	18%	53%	25%	90%+	84%	90%+	41%	49%	90%+	43%	90%+	72%
Koboko District	COP 15	Sustained	APR 16	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 16	Sustained	APR 17	20%	69%	14%	18%	83%	32%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	19%	70%	12%	18%	62%
	COP 17	Attained	APR 18	51%	88%	50%	77%	45%	26%	62%	60%	90%+	90%+	90%+	90%+	90%+	90%+	38%	90%+	34%	28%	79%
	COP 18	Sustained	APR 19	90%+	66%	90%+	86%	59%	39%	75%	26%	78%	37%	90%+	90%+	90%+	90%+	49%	90%+	90%+	62%	89%
Butambala District	COP 15	Sustained	APR 16	23%	23%	18%	28%	42%	39%	42%	39%	42%	39%	42%	39%	42%	39%	42%	39%	42%	39%	44%
	COP 16	Sustained	APR 17	49%	61%	38%	80%	42%	33%	90%+	75%	90%+	90%+	79%	72%	73%	64%	90%+	64%	62%	43%	84%
	COP 17	Sustained	APR 18	44%	82%	47%	71%	39%	24%	52%	50%	90%+	90%+	90%+	90%+	70%	70%	90%+	25%	90%+	64%	85%
	COP 18	Scaleup Sat	APR 19	90%+	62%	90%+	80%	56%	36%	70%	25%	73%	35%	90%+	88%	90%+	75%	90%+	88%	90%+	90%+	90%+
Bulambuli District	COP 15	Ctrl Supported	APR 16	26%	26%	23%	31%	26%	15%	26%	15%	26%	15%	26%	15%	26%	15%	26%	15%	26%	15%	23%
	COP 16	Ctrl Supported	APR 17	15%	44%	40%	75%	29%	58%	24%	36%	36%	30%	90%+	53%	27%	22%	38%	90%+	42%	38%	39%
	COP 17	Ctrl Supported	APR 18	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	COP 18	Ctrl Supported	APR 19	90%+	80%	90%+	90%+	32%	22%	40%	14%	42%	20%	90%+	90%+	56%	54%	78%	90%+	65%	65%	70%
Bundibugyo District	COP 15	Sustained	APR 16	41%	41%	32%	53%	48%	51%	48%	51%	48%	51%	48%	51%	48%	51%	48%	51%	48%	51%	53%
	COP 16	Sustained	APR 17	16%	52%	34%	50%	60%	90%+	90%+	90%+	90%+	90%+	90%+	71%	90%+	80%	60%	54%	22%	18%	79%
	COP 17	Sustained	APR 18	57%	90%+	53%	77%	50%	35%	67%	63%	90%+	90%+	90%+	90%+	90%+	90%+	66%	90%+	53%	45%	90%+
	COP 18	Scaleup Sat	APR 19	90%+	70%	90%+	90%+	48%	31%	60%	21%	63%	31%	90%+	81%	90%+	88%	90%+	90%+	90%+	90%+	90%+

District	COP	Prioritization	Results reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall																		
				Treatment Coverage at APR by Age and Sex																		
				<1	1-9	10-14		15-19		20-24		25-29		30-34		35-39		40-49		50+		Overall TX Coverage
						F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Nakasongola District	COP 15	Sustained	APR 16	66%	66%	55%	81%	37%	63%	37%	63%	37%	63%	37%	63%	37%	63%	37%	63%	37%	63%	47%
	COP 16	Sustained	APR 17	7%	63%	39%	67%	41%	46%	74%	90%+	65%	68%	44%	41%	25%	56%	69%	14%	83%	52%	41%
	COP 17	Attained	APR 18	54%	78%	44%	63%	40%	21%	55%	37%	87%	90%+	90%+	90%+	47%	90%+	90%+	38%	90%+	85%	79%
	COP 18	ScaleUp Agg	APR 19	90%+	74%	90%+	90%+	37%	24%	47%	17%	49%	24%	81%	49%	30%	53%	90%+	32%	90%+	90%+	57%
Bududa District	COP 15	Sustained	APR 16	22%	22%	18%	27%	27%	22%	27%	22%	27%	22%	27%	22%	27%	22%	27%	22%	27%	22%	27%
	COP 16	Sustained	APR 17	32%	43%	19%	70%	72%	90%+	75%	90%+	37%	30%	18%	8%	45%	29%	33%	18%	32%	3%	31%
	COP 17	Sustained	APR 18	53%	90%+	52%	71%	70%	14%	90%+	33%	35%	75%	40%	51%	44%	71%	16%	12%	29%	33%	44%
	COP 18	Sustained	APR 19	90%+	68%	90%+	88%	20%	13%	25%	9%	26%	12%	41%	20%	59%	52%	50%	34%	90%+	66%	42%
Kaabong District	COP 15	Ctrl Supported	APR 16	90%+	90%+	83%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	COP 16	Ctrl Supported	APR 17	20%	27%	18%	31%	20%	49%	22%	33%	30%	34%	15%	36%	90%+	50%	22%	10%	68%	41%	27%
	COP 17	Ctrl Supported	APR 18	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	COP 18	Ctrl Supported	APR 19	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Buvuma District	COP 15	Sustained	APR 16	16%	16%	9%	25%	21%	19%	21%	19%	21%	19%	21%	19%	21%	19%	21%	19%	21%	19%	22%
	COP 16	Sustained	APR 17	9%	52%	15%	32%	59%	47%	90%+	88%	90%+	90%+	72%	63%	54%	72%	57%	57%	70%	25%	62%
	COP 17	Attained	APR 18	57%	81%	48%	62%	54%	35%	72%	70%	71%	62%	90%+	90%+	90%+	81%	90%+	81%	90%+	32%	83%
	COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
Moroto District	COP 15	Sustained	APR 16	56%	56%	50%	64%	87%	57%	87%	57%	87%	57%	87%	57%	87%	57%	87%	57%	87%	57%	80%
	COP 16	Sustained	APR 17	52%	52%	18%	12%	22%	35%	80%	63%	90%+	77%	25%	60%	90%+	90%+	16%	27%	29%	36%	44%
	COP 17	Sustained	APR 18	67%	90%+	60%	90%+	26%	10%	34%	15%	44%	40%	22%	87%	90%+	90%+	29%	90%+	31%	24%	46%
	COP 18	Sustained	APR 19	90%+	80%	90%+	90%+	26%	16%	33%	12%	34%	17%	20%	48%	90%+	90%+	25%	90%+	62%	45%	43%
Budaka District	COP 15	Sustained	APR 16	42%	42%	32%	55%	65%	50%	65%	50%	65%	50%	65%	50%	65%	50%	65%	50%	65%	50%	63%
	COP 16	Sustained	APR 17	0%	27%	31%	67%	61%	86%	90%+	90%+	77%	68%	65%	47%	32%	41%	28%	4%	26%	35%	38%
	COP 17	Sustained	APR 18	56%	88%	49%	76%	26%	10%	34%	35%	39%	36%	90%+	90%+	61%	90%+	90%+	34%	11%	14%	45%
	COP 18	Sustained	APR 19	90%+	67%	90%+	86%	26%	16%	33%	11%	34%	17%	90%+	66%	48%	80%	90%+	32%	24%	28%	44%
Kibuku District	COP 15	Sustained	APR 16	65%	65%	58%	75%	85%	54%	85%	54%	85%	54%	85%	54%	85%	54%	85%	54%	85%	54%	77%
	COP 16	Sustained	APR 17	9%	22%	11%	19%	90%+	90%+	48%	90%+	65%	79%	19%	56%	18%	35%	12%	6%	24%	23%	28%
	COP 17	Sustained	APR 18	61%	90%+	53%	77%	45%	26%	60%	53%	72%	68%	63%	90%+	70%	90%+	71%	69%	15%	38%	61%
	COP 18	Sustained	APR 19	90%+	71%	90%+	90%+	27%	19%	35%	12%	37%	17%	42%	74%	44%	73%	50%	51%	23%	55%	43%
Moyo District	COP 15	Sustained	APR 16	20%	20%	19%	20%	25%	84%	25%	84%	25%	84%	25%	84%	25%	84%	25%	84%	25%	84%	40%
	COP 16	Sustained	APR 17	6%	55%	21%	57%	27%	90%+	71%	29%	90%+	90%+	34%	53%	90%+	65%	23%	35%	90%+	74%	48%
	COP 17	Sustained	APR 18	90%+	90%+	89%	90%+	52%	73%	72%	90%+	90%+	73%	90%+	90%+	90%+	90%+	24%	24%	90%+	68%	82%
	COP 18	ScaleUp Agg	APR 19	90%+	90%+	90%+	90%+	35%	21%	43%	15%	46%	22%	50%	58%	90%+	81%	35%	72%	90%+	90%+	63%
Butaleja District	COP 15	Sustained	APR 16	53%	53%	54%	53%	33%	32%	33%	32%	33%	32%	33%	32%	33%	32%	33%	32%	33%	32%	36%
	COP 16	Sustained	APR 17	10%	24%	27%	42%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	8%	34%	41%	11%	49%
	COP 17	Sustained	APR 18	61%	90%+	60%	90%+	44%	16%	61%	42%	32%	16%	90%+	90%+	90%+	90%+	14%	90%+	24%	8%	43%
	COP 18	Sustained	APR 19	90%+	80%	90%+	90%+	39%	28%	50%	18%	52%	25%	90%+	90%+	90%+	90%+	29%	90%+	90%+	32%	68%
Bulisa District	COP 15	Sustained	APR 16	58%	58%	53%	65%	34%	51%	34%	51%	34%	51%	34%	51%	34%	51%	34%	51%	34%	51%	42%
	COP 16	Sustained	APR 17	6%	25%	8%	11%	61%	74%	81%	90%+	90%+	90%+	65%	60%	90%+	78%	41%	71%	19%	19%	63%
	COP 17	Sustained	APR 18	38%	67%	37%	60%	68%	35%	90%+	71%	57%	73%	90%+	90%+	90%+	90%+	90%+	90%+	49%	49%	90%+
	COP 18	Scaleup Sat	APR 19	84%	50%	73%	66%	48%	31%	60%	22%	63%	30%	90%+	69%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
Maracha District	COP 15	Sustained	APR 16	22%	22%	21%	24%	37%	19%	37%	19%	37%	19%	37%	19%	37%	19%	37%	19%	37%	19%	33%
	COP 16	Sustained	APR 17	5%	21%	17%	21%	47%	90%+	39%	90%+	90%+	71%	72%	53%	90%+	90%+	24%	27%	21%	34%	44%
	COP 17	Sustained	APR 18	76%	90%+	66%	90%+	53%	48%	73%	90%+	70%	89%	63%	90%+	90%+	90%+	21%	36%	28%	44%	71%
	COP 18	Sustained	APR 19	90%+	87%	90%+	90%+	55%	38%	70%	24%	73%	35%	90%+	90%+	90%+	90%+	42%	54%	78%	88%	78%

District	COP	Prioritization	Results reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall																		
				Treatment Coverage at APR by Age and Sex																		
				<1	1-9	10-14		15-19		20-24		25-29		30-34		35-39		40-49		50+		Overall TX Coverage
						F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Kapchorwa District	COP 15	Ctrl Supported	APR 16	58%	58%	51%	67%	50%	33%	50%	33%	50%	33%	50%	33%	50%	33%	50%	33%	50%	33%	46%
	COP 16	Ctrl Supported	APR 17	11%	32%	30%	55%	41%	78%	35%	51%	51%	42%	42%	24%	90%+	39%	59%	57%	90%+	65%	54%
	COP 17	Ctrl Supported	APR 18	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	COP 18	Ctrl Supported	APR 19	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Bukwo District	COP 15	Sustained	APR 16	46%	46%	41%	52%	44%	25%	44%	25%	44%	25%	44%	25%	44%	25%	44%	25%	44%	25%	39%
	COP 16	Sustained	APR 17	4%	12%	11%	21%	21%	40%	18%	26%	21%	25%	25%	21%	90%+	15%	6%	4%	47%	16%	15%
	COP 17	Sustained	APR 18	61%	90%+	52%	73%	34%	35%	44%	62%	70%	71%	90%+	90%+	90%+	59%	15%	22%	46%	18%	45%
	COP 18	Sustained	APR 19	90%+	69%	90%+	87%	17%	10%	22%	7%	23%	10%	71%	30%	90%+	28%	11%	15%	55%	20%	27%
Kween District	COP 15	Ctrl Supported	APR 16	65%	65%	54%	79%	48%	53%	48%	53%	48%	53%	48%	53%	48%	53%	48%	53%	48%	53%	55%
	COP 16	Ctrl Supported	APR 17	1%	4%	4%	8%	9%	18%	7%	11%	11%	9%	5%	3%	5%	1%	6%	3%	28%	15%	6%
	COP 17	Ctrl Supported	APR 18	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	COP 18	Ctrl Supported	APR 19	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nakapiripirit District	COP 15	Ctrl Supported	APR 16	49%	49%	43%	58%	60%	34%	60%	34%	60%	34%	60%	34%	60%	34%	60%	34%	60%	34%	53%
	COP 16	Ctrl Supported	APR 17	11%	16%	10%	17%	21%	50%	22%	33%	17%	90%+	23%	10%	74%	29%	43%	25%	48%	19%	30%
	COP 17	Ctrl Supported	APR 18	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	COP 18	Ctrl Supported	APR 19	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Napak District	COP 15	Ctrl Supported	APR 16	29%	29%	24%	36%	51%	57%	51%	57%	51%	57%	51%	57%	51%	57%	51%	57%	51%	57%	56%
	COP 16	Ctrl Supported	APR 17	22%	31%	20%	35%	38%	90%+	40%	61%	56%	62%	90%+	58%	90%+	90%+	34%	44%	67%	48%	55%
	COP 17	Ctrl Supported	APR 18	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	COP 18	Ctrl Supported	APR 19	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amudat District	COP 15	Ctrl Supported	APR 16	90%+	90%+	73%	90%+	90%+	59%	90%+	59%	90%+	59%	90%+	59%	90%+	59%	90%+	59%	90%+	59%	90%+
	COP 16	Ctrl Supported	APR 17	4%	5%	3%	6%	5%	13%	6%	9%	8%	9%	6%	1%	6%	6%	9%	6%	13%	7%	5%
	COP 17	Ctrl Supported	APR 18	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	COP 18	Ctrl Supported	APR 19	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Abim District	COP 15	Ctrl Supported	APR 16	67%	67%	58%	80%	72%	64%	72%	64%	72%	64%	72%	64%	72%	64%	72%	64%	72%	64%	74%
	COP 16	Ctrl Supported	APR 17	26%	36%	23%	39%	43%	90%+	46%	68%	64%	72%	40%	43%	54%	73%	57%	5%	20%	19%	27%
	COP 17	Ctrl Supported	APR 18	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	COP 18	Ctrl Supported	APR 19	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Butebo District	COP 15	Sustained	APR 16	76%	76%	54%	90%+	87%	62%	87%	62%	87%	62%	87%	62%	87%	62%	87%	62%	87%	62%	84%
	COP 16	Sustained	APR 17	0%	22%	11%	5%	25%	13%	16%	44%	27%	17%	25%	15%	90%+	20%	13%	24%	43%	55%	24%
	COP 17	Attained	APR 18	42%	65%	38%	56%	19%	21%	26%	33%	31%	31%	57%	37%	90%+	32%	26%	42%	48%	44%	39%
	COP 18	Sustained	APR 19	24%	15%	22%	20%	23%	17%	29%	9%	30%	15%	69%	31%	90%+	34%	29%	54%	90%+	90%+	38%
Kagadi District	COP 15	ScaleUp Agg	APR 16	90%+	90%+	67%	90%+	79%	90%+	79%	90%+	79%	90%+	79%	90%+	79%	90%+	79%	90%+	79%	90%+	90%+
	COP 16	ScaleUp Agg	APR 17	24%	57%	25%	46%	90%+	90%+	90%+	90%+	90%+	90%+	82%	32%	54%	56%	39%	73%	90%+	65%	71%
	COP 17	ScaleUp Agg	APR 18	43%	65%	37%	53%	74%	59%	90%+	90%+	65%	88%	90%+	70%	90%+	90%+	71%	90%+	90%+	55%	87%
	COP 18	Attained	APR 19	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
Kakumiro District	COP 15	ScaleUp Agg	APR 16	40%	40%	32%	51%	56%	42%	56%	42%	56%	42%	56%	42%	56%	42%	56%	42%	56%	42%	54%
	COP 16	ScaleUp Agg	APR 17	23%	53%	22%	30%	76%	71%	90%+	81%	90%+	90%+	65%	20%	39%	47%	36%	59%	90%+	67%	54%
	COP 17	ScaleUp Agg	APR 18	30%	50%	29%	43%	55%	44%	74%	84%	86%	77%	90%+	49%	61%	60%	45%	79%	78%	41%	65%
	COP 18	ScaleUp Sat	APR 19	90%+	83%	90%+	90%+	57%	39%	72%	26%	75%	36%	90%+	35%	87%	67%	79%	90%+	90%+	90%+	90%+
Namisindwa District	COP 15	Sustained	APR 16	70%	70%	67%	74%	47%	37%	47%	37%	47%	37%	47%	37%	47%	37%	47%	37%	47%	37%	46%
	COP 16	Sustained	APR 17	0%	23%	14%	4%	10%	41%	22%	12%	32%	7%	15%	32%	90%+	25%	20%	7%	90%+	39%	23%
	COP 17	Sustained	APR 18	56%	78%	45%	59%	19%	9%	26%	23%	15%	15%	17%	77%	90%+	67%	12%	11%	33%	12%	25%
	COP 18	Sustained	APR 19	90%+	58%	85%	76%	17%	12%	21%	8%	23%	11%	31%	77%	90%+	71%	27%	22%	90%+	46%	37%
Pakwach District	COP 15	ScaleUp Agg	APR 16	61%	61%	45%	82%	79%	62%	79%	62%	79%	62%	79%	62%	79%	62%	79%	62%	79%	62%	78%
	COP 16	ScaleUp Agg	APR 17	90%+	81%	27%	51%	90%+	73%	90%+	90%+	90%+	90%+	41%	53%	90%+	55%	50%	72%	25%	36%	65%
	COP 17	Attained	APR 18	40%	73%	40%	66%	73%	29%	90%+	53%	81%	83%	79%	90%+	90%+	90%+	64%	90%+	29%	36%	80%
	COP 18	Scaleup Sat	APR 19	90%+	60%	88%	79%	65%	43%	81%	29%	85%	41%	89%	71%	90%+	70%	90%+	90%+	83%	90%+	90%+

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY 18)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY19) *TX_CURR***	**Newly initiated (APR FY 19) *TX_NEW***	**ART Coverage (APR 19)**
Attained	419,555	**520,820***	**0**	**564,290**	**49,420**	**134%**
Scale-Up Saturation	239,604	**220,445**	**0**	**237,735**	**25,581**	**99%**
Scale-Up Aggressive	475,514	**358,640**	**21,771**	**351,485**	**40,260**	**74%**
Sustained	152,856	**84,223**	**38,061**	**91,678**	**9,145**	**60%**
Central Support	43,979	**16,894**	**NA**	**NA**	**NA**	
Military				**23,135**	**1,984**	
Commodities (if not included in previous categories)	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
Total	1,331,508	**1,201,022**	**59,832****	**1,268,323**	**136,390**	**94%**

*Several districts that have regional referral hospitals (RRH) or centers of excellence (COE) fall in attained districts and as such have >100 percent coverage due to PLHIV from neighboring districts coming to these RRH or COE for treatment.

** Some of these individuals may be receiving care from other districts (see above note about national referral hospitals above) . FY19 national coverage will be 95%.

APPENDIX B – Budget Profile and Resource Projections

B1. COP18 Planned Spending

Below is a visualization of PEPFAR Uganda's 2018 COP investment by approach and program area.

Table B.1.1 COP18 Budget by Approach and Program Area

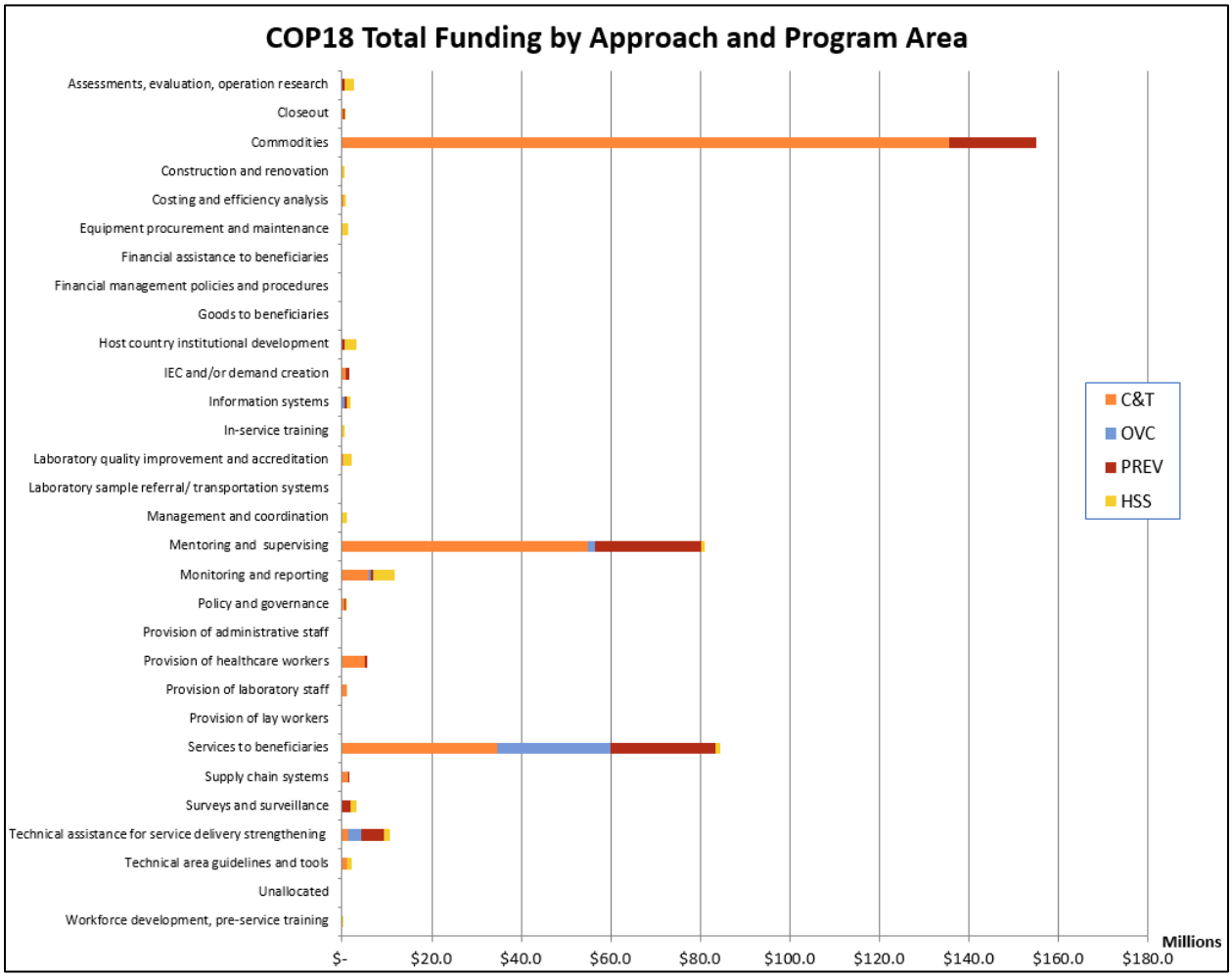


Table B.1.2 COP 18 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$ 32,940,498 USD	**$ 375,108,253 USD**	**$ 408,048,751 USD**

**Data included in Table B.1.2 matches FACTS Info records, and can be double-checked by running the "Summary of Planned Funding by Agency" report.*

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$8,353,611
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	$1,484,954
HVOP	Other Sexual Prevention	$22,256,376
IDUP	Injecting and Non-Injecting Drug Use	$233,553
HMBL	Blood Safety	$9,642
HMIN	Injection Safety	$7,032
CIRC	Male Circumcision	$35,916,018
HVCT	Counseling and Testing	$14,463,466
HBHC	Adult Care and Support	$22,773,209
PDCS	Pediatric Care and Support	$12,021,281
HKID	Orphans and Vulnerable Children	$28,201,726
HTXS	Adult Treatment	$74,214,624
HTXD	ARV Drugs	$100,697,210
PDTX	Pediatric Treatment	$4,008,523
HVTB	TB/HIV Care	$9,551,998
HLAB	Lab	$5,073,180
HVSI	Strategic Information	$9,363,451
OHSS	Health Systems Strengthening	$7,906,560
HVMS	Management and Operations	$18,571,839
TOTAL		**$375,108,253**

**Data included in Table B.2.2 matches FACTS Info records, and can be double-checked by running the "Summary of Planned Funding by Budget Code" report.*

B.2 Resource Projections

Per the COP guidance and the new budgeting tool for COP18 – the Funding Allocation to Strategy Tool (FAST) – PEPFAR Uganda team used an incremental budgeting process to guide the apportionment of resources for COP18. Implementing mechanism budgets from COP17 were the point of departure; however, these budgets were adjusted for several changes.

The primary change driver was the allocation of targets which had shifted per UPHIA data and updated PLHIV estimates from Spectrum. PEPFAR's comprehensive service delivery partners in

Uganda are regionalized, so updated information on where undiagnosed Ugandan PLHIV are living is an important factor in determining how COP18 resources are allocated.

A secondary change driver was target linkage and retention rates, which – per headquarters guidance via the Datapack – are 90 and 95 percent respectively. PEPFAR Uganda's FY17 results demonstrated the need to improve the rate at which the program links newly-identified PLHIV to treatment and the rate at which new treatment enrollees are retained. Accordingly, COP18 resource allocations factored the inputs needed to improve linkage and retention: the human resources required to physically escort and follow-up on every newly-diagnosed PLHIV and the systems-level resources needed to uniquely identify and track services delivered to all PLHIV.

Other information relevant to how resources have been allocated in COP18 include the mandate from headquarters to increase support to the public sector in Uganda where most PLHIV are being served, as well as big-picture considerations about what it will take to reach, test, diagnose, link, treat, and retain the age and sex bands that demonstrate the biggest unmet treatment need.

Data sources used to calculate resource allocations include: COP17 budget allocation; expenditure analysis 2017; FY17 End of Fiscal Year (EOFY); information from GOU on national expenditures including the National AIDS Spending Account (NASA) data; and market information on various goods and services.

APPENDIX C – Tables and Systems Investments for Section 6.0

Please find attached separately.

APPENDIX D – Table of Acronyms

Table of Acronyms	
ACP	AIDS Control Program
AGYW	Adolescent girls and young women
ANC4	Antenatal clinic – 4 Visits
APN	Assisted partner notification
ART	Anti-Retroviral Therapy
CCM	Global Fund Country Coordinating Mechanism
CHC	Communication for Healthy Communities
COE	Centers of Excellence
CSO	Civil society organizations
DHIS2	District Health Information System 2.0
District Health Teams	DHT
DQA	Data quality assessment
DR	Drug resistance
DRC	Democratic Republic of Congo
DSDM	Differentiated service delivery model
DTG	Dolutegravir
ECP	Emergency contraception
EID	Early infant diagnosis
EMR	Electronic medical records
EPI	Extended Program on Immunization
ERP	Enterprise resource planning
FBO	Faith-based organizations
FF	Fisher folk
FSW	Female sex workers
GBV	Gender-based violence
GDP	Gross Domestic Product
GNI	Gross National Income
GSD	Gender and sexual diversity
HMIS	Health Management Information System
HRH	Human resources for health
HTS	HIV testing services
IP	Implementing partner
IRIS	Immune Reconstitution Inflammatory Syndrome
KP	Key populations
LPV/r	lopinavir/ritonavir pellets
M&E	Monitoring and evaluation
MC	Male circumcision
MGLSD	Ministry of Gender, Labour and Social Development
MNCH	Maternal, neonatal and child health
MOFPED	Ministry of Financing, Planning and Economic Development
MOH	Ministry of Health
MOLG	Ministry of Local Government
MOPS	Ministry of Public Service
MSM	Men who have sex with men

MTCT	Mother-to-child transmission
MUJHU	Makerere University-Johns Hopkins University
MUSPH	Makerere University School of Public Health
NDA	National Drug Authority
NGO	Non-governmental organizations
NMS	National Medical Stores
NTLP	National TB and Leprosy Program
OPD	Outpatient department
OPM	Office of the Prime Minister
OVCMIS	OVC Management Information System
PITC	Provider-initiated testing and counseling
PLHIV	People living with HIV/AIDS
PMTCT	Preventing mother-to-child transmission
PP	Priority populations
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
QA	Quality assurance
QI	Quality improvement
QPPU	Quantification Procurement Planning Unit
RPM	PEPFAR Regional Planning Meeting
RRH	Regional referral hospital
RTK	Rapid test kits
SBCC	Social and behavior change communication
SID	Sustainability Index Dashboard
SIMS	Site Improvement through Monitoring System
SNU	Sub-national unit
SOP	Standard Operating Procedures
SRH	Sexual and reproductive health
STI	Sexually-transmitted infection
TB	Tuberculosis
TGW	Transgender women
TLD	Tenofovir-lamivudine-dolutegravir
TPT	TB preventive therapy
TT	Tetanus toxoid
UAC	Uganda AIDS Commission
UPHIA	Uganda Population-Based HIV Impact Assessment
VACS	Violence Against Children Survey
VL	Viral load
VMMC	Voluntary medical male circumcision
WAOS	Web-Based ARV Ordering and Reporting System
EQA	External quality assurance
CPHL	Central Public Health Laboratory
TWG	Technical working group
MAT	Medically assisted treatment
HTC	HIV testing and counselling

Table 6 Attachment

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
1	USAID	Advocacy for Better Health	HSS	Support CSO engagement in providing independent oversight of the national HIV response to promote transparency and quality of HIV services.	Management and coordination	1) Provide TA for health advocacy for PLHIV and CSOs to monitor GOU resource commitment, availability of HIV commodities, and health workers at health facilities 2) Advocacy forum meetings between CSOs, GOU, and key stakeholders 3) Capacity building for CSO monitoring availability of ARVs at public facilities	1) Inadequate capacity and financial resources to CSOs to effectively advocate for health systems improvements
2	USAID	Advocacy for Better Health	HSS	Strengthen capacity of CSOs to advocate for PLHIV and KP/PP beneficiaries, promote human rights and community level HIV/AIDS priorities, and combat stigma and discrimination.	Host country institutional development	1) Provide targeted sub-grants to national umbrella PLHIV and CSO networks to sensitize communities and district leaders and to advocate against high HIV stigma in communities with high stigma and low testing, as well as "lagging" behind districts 2) Lead PLHIV CSO sensitization for TLD transition among PLHIV constituents.	1) Inadequate capacity and financial resources to CSOs to effectively advocate for health system improvement. 2) TLD transition sociodemographic barriers among beneficiary PLHIV
3	USAID	Uganda Health Supply Chain	HSS	Strengthen national capacity at MOH through the Quantification and Procurement Planning Unit to ensure accurate forecasting, supply planning and funding requirements to maintain adequate HIV commodity stock levels.	Technical area guidelines and tools	1) Embed 13 specialists to support five units at MOH in accurate quantification, forecasting, and supply planning for ARVs, TB, Lab and other HIV commodities 2) Hold monthly commodity security group meetings 3) Carry out Key actions from CSG and MPM that translate into action for commodity security 4) Produce commodity stock status reports	1) Inadequte capacity in skills and number of staff at MOH to adequately quantify, forecast and develop a robust supply plan for HIV commodities
4	USAID	Uganda Health Supply Chain	HSS	Strengthen national capacity at MOH through the Quantification and Procurement Planning Unit to ensure accurate forecasting, supply planning and funding requirements to maintain adequate HIV commodity stock levels.	Supply chain systems	1) Monthly reconciliation of care and treatment data (i.e. WAOS, HMIS, warehouse data from MAUL and JMS, and DATIM) to determine the true number of current HIV patients and commodity need	1) Data inconsistences for patient numbers and ARV consumption impact at the national Quantification and Supply Planning unit, and for order preparation and ARV requisition at ART site level.
5	USAID	Uganda Health Supply Chain	HSS	Develop and implement tools to supervise, evaluate, and improve HIV commodity management, ordering, and dispensing quality at ART sites and NMS, including laboratory.	Supply chain systems	1) Provide TA to NMS for systematic and evidenced-based rationing and order fulfillment 2) Provide TA to NMS for ERP change managment and to implement reforms based on the National Supply Chain Assessment	1) Weak logistics systems to inform planning, management, and accountability for HIV commodities

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
1	CSO engagement	5	1) Stakeholders responsive to increased participation of citizens and beneficiaries in overseeing and demanding accountability and good quality HIV services using data- driven approaches	3 years	1) Number of PEPFAR-seconded HRH transitioning to GOU 2) Number of public sites reporting ARV drug stocks quarterly	1) HRH transition 1,235 (0 %) health workers 2) ARV gap of $37.1 million for COP18 3) 30 % sites reporting ARV drug stock out 4) Quarterly data sharing by PEPFAR with CSOs	1) HRH transition increased to 50 % 2) 95 % of ARV gap is filled 3) <5 % of sites reporting ARV drug stock outs 4) Quarterly data sharing by PEPFAR with CSOs
2	CSO engagement	5	1) HIV stigma reduction evidenced by increased uptake of HIV services among targeted populations 2) Uptake/transition for TLD by PLHIV constituents	3 years	1) CSOs awarded to support advocacy agenda issues including TLD transition 2) Percentage of targeted PLHIV uptaking TLD year 3) Number of CSO-led TLD transition advocacy events	1) CSO advocacy agenda for community and PLHIV TLD transition not in place 2) 0 % of patients started on TLD in targeted sites as per plan	1) TLD sensitization forums held by PLHIV 2) Key advocacy agenda on TLD transition disseminated in targeted districts and at national level 3) 30 % of patients started on TLD in targeted sites as per plan
3	Commodity Security and Supply Chain	3.8	1) Accurate ARV forecast and supply plan developed and executed by all stakeholders.	3 years	1) Biannual accuracy of ARV forecast and variance in supply plan execution by stakeholders (e.g.rate of on-time delivery of ARV commodities by stakeholders) 2) Zero stock outs of key ARV Ccmmodities.	1) 70 % average on-time delivery for ARV commodities by all stakeholders	1) 85 % on-time delivery for ARV commodities by all stakeholders
4	Commodity Security and Supply Chain	3.8	1) Elimination of data inconsistences with improved quantification and supply planning at national level and improved ARV order preparation and requisition at site level	2 years	1) Discrepancy rate for patient numbers reported in WAOS and HMIS	1) 10 % discrepancy rate	1) <7 % discrepancy rate
5	Commodity Security and Supply Chain	3.8	1) Reduction in NMS non-order fulfillment by 20 %	3 years	1) NMS-facility order non-fulfillment rate	1) Order non-fulfillment rate of 30 %	1) Reduction in order non-fulfillment to <15 %

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP20) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.
1		1) HRH transition increased to75 % 2) 100% of ARV gap is filled by stakeholders 3) Quarterly data sharing by PEPFAR with CSOs		1) HRH transition increased to 100 % 2) 100 % of ARV gap is filled by stakeholders 3) Quarterly data sharing by PEPFAR with CSOs	
2		1) 4 national/umbrella CSOs funded 2) Key advocacy agenda disseminated in targeted districts and national level 3) 80 % of patients started on TLD in targeted sites as per plan		1) 4 national/umbrella CSOs funded 2) Key advocacy agenda disseminated in targeted districts and national level 3) 100 % of targeted patients started on TLD in targeted sites as per plan	
3		1) 90 % on-time delivery for ARV commodities by all stakeholders.		1) Annual MOH comprehensive supply plan in place and jointly developed by key stakeholders 2) Bi-monthly stock status reports produced/yr 3) NMS warehouse stocks reported to MOH routinely	
4		1) <5 % discrepancy rate		1) <2 % discrepancy rate	
5		1) Reduction in order non-fulfillment to <1 %		1) Reduction in order non-fulfillment to <5 %	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
6	USAID	Uganda Health Supply Chain	HSS	Develop and implement tools to supervise, evaluate, and improve HIV commodity management, ordering, and dispensing quality at ART sites, NMS including laboratory.	Supply chain systems	1) Develop MOH HIV commodity rationing policy and SOP for NMS 2) Revise and disseminate inter- and intra-district drug redistribution policy	1) Lack of policy at NMS to guide rationing ARVs when minimal stock at central warehouse and current policy does not allow for inter- and intra-district redistribution of ARVs and HIV commodities
7	USAID	Uganda Health Supply Chain	HSS	Develop and implement tools to supervise, evaluate and improve HIV commodity management, ordering, and dispensing quality at ART sites, NMS including laboratory.	Supply chain systems	1) Provide TA to regional IPs working with Medicine Management Supervisors and regional pharmacists to supervise andmentor supply chain health workers in ART sites with consistently poor stock management and ordering scores from SPARS activities	1) Poor skills in stock management and ordering in lower level facilities including HC IVs, IIIs and IIs
8	USAID	Uganda Health Supply Chain	HSS	Improve on the quality of the logistics management information systems including Web-based ARV Ordering System (WAOS) to include laboratory commodities and expand the analytics of WAOS data to inform timely re-distribution decisions to mitigate stock outs.	Supply chain systems	1) Provide TA to MOH to exploit data in the national Web-based ARV Ordering System (WAOS) to run biweekly Early Warning for facilities.	1) National supply chain information system does not provide real time stock status of HIV commodities at sites
9	USAID	Uganda Health Supply Chain	HSS	Develop and implement tools to supervise, evaluate, and improve HIV commodity management, ordering and dispensing quality at ART sites, NMS including laboratory.	Supply chain systems	1) Support systems for TLD ordering, stock management, recording and reporting at national and subnational levels 2) Monitor and track TLD transition and phasing out of old formulations at national and subnational level	1) Inadequate knowledge and skills at facilities on new HIV/ART transition, stock management, reporting, ordering, and recording
10	USAID	Strengthening HRH	HSS	Support the transition of PEPFAR-seconded staff in public and PNFP PEPFAR sites and ensure adequate local financing for health workers for PEPFAR sites	Host country institutional development	1) TA and logistics to IPs supporting seconded staff and GOU stakeholders to account and track GOU commitments for successful transition of PEPFAR seconded staff	1) Inadequate HRH in the public and PNFP sectors for achievement of PEPFAR targets
11	USAID	Strengthening HRH	HSS	Support the transition of PEPFAR-seconded staff in public and PNFP PEPFAR sites and ensure adequate local financing for health workers for PEPFAR sites	Host country institutional development	1) Support GOU annual recruitment process to increase public sector critical cadre for HIV service delivery at ART sites	1) Inadequate staff in PEPFAR-supported public sites for quality HIV service delivery

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
6	Commodity Security and Supply Chain	3.8	1) Rational distribution policy for ART and HIV commodities based on facility needs implemented at NMS	1 year	1) NMS distribution adheres to ART and HIV commodity stock requisitions by facilities to ensure stock levels are within 2-4 months of stock at all ART sites.	1) NMS distribution results in 30 % of sites overstocked and 30 % sites understocked with ARV commodities	1) At least 90 % of public ARV sites report stock levels between 2-4 months
7	Commodity Security and Supply Chain	3.8	1) 100 % of assessed ART sites (1000) score above 20/25 on the SPARS index for stock management and ordering.	3 years	1) Number of ART sites participating ART SPARS 2) Percentage of ART sites scoring over 20/25 on ART SPARS Index	1) 235 ART sites participate in ART SPARS 2) 11 % score 20/25 on ART SPARS Index	1) 690 ART sites participate in ART SPARS 2) 100 % of ART sites score 20/25 on ART SPARS Index.
8	Commodity Security and Supply Chain	3.8	1) Biweekly facility-level stock status of indicator ARVs available to decision makers at the national level (NMS, MOH, ACP, Pharmacy Division)	3 years	1) Percentage of ART sites reporting providing bi-weekly stock status through WAOS and MMS.	None	1) 40 % of all ART sites provide bi-weekly stock status through WAOS and MMS
9	Commodity Security and Supply Chain	3.8	1) 100 % of ART sites transitioned to TLD (with a focus on ART ordering, stock management, recording, and dispensing)	3 years	1) Percentage of ART sites fully transitioned to TLD with standard ordering, stock management, recording, and dispensing	None	1) 50 % of ART sites fully transitioned to TLD
10	Human Resources for Health	6.2	1) Transition 1,751 PEPFAR seconded staff to government payroll	2 years	1) Number of PEPFAR staff transitioned	1) 690 staff transitioned	1) 650 staff transitioned
11	Human Resources for Health	6.2	1) Increased number of critical cadres in public sector facilities	3 years	1) Number of newly-recruited GOU staff for public sector	1) 1056 staff recruited at district level 2) 1014 staff recruited at MOH and regional referral hospitals	1056

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6					
7		1) 1000 ART sites participate in ART SPARS 2) 100 % of ART sites score 20/25 on ART SPARS Index.			
8		1) 80% of all ART sites provide bi-weekly stock status through WAOS and MMS		1) 100% of all ART sites provide bi-weekly stock status through WAOS and MMS	
9		1) 90 % of ART sites transitioned to TLD		1) 100% of ART sites transitioned to TLD	
10		1) 555 health workers transitioned			
11		4000 (at district and MOH, regional referrals/national hospitals)		2000	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
12	USAID	Strengthening HRH	HSS	Improve HRH capacity for policy development, planning, and implementation, particularly development of 2019-2029 Human Resources for Health Strategic Plan and revision of staffing norms that addresses HRH barriers for achieving PEPFAR targets	Host country institutional development	1) TA to MOH and MOPS to review the MOH staffing structure and cost implementation at all levels to make the health workforce more responsive to HIV/AIDS needs 2) Facilitate PEPFAR staff absorption	1) Outdated and restricted staffing norms at national (ACP, Pharmacy Division, CPHL, NTRL) and subnational levels that are not responsive to current HIV burden and needs
13	USAID	Strengthening HRH	HSS	Improved pre-service training (PST) to meet the needs of Uganda	Workforce development, pre-service training	1) Support training of critical cadre pharmacy assistants (dispensers) to improve supply chain management in the public sector	1) <40 % public ART sites have suply chain staff (dispensers)
14	USAID	Health Systems Strengthening	HSS	Increase availability and improve the management of financial and non-financial resources for the national HIV/AIDS response to reduce gaps in HIV commodities and human resources while improving efficiency and transparency	Costing and efficiency analysis	1) Support health financing analytics for evidence-based advocacy to make a case for increased funding for health and HIV/AIDS, as well as efficiency in resource use	1) Inadequate resources and poor management contributing to gaps in commodity and HRH to deliver HIV services
15	USAID	Health Systems Strengthening	HSS	Strengthen community systems and structures that support differentiated HIV/AIDS service delivery models tailored to the needs of different population groups	Workforce development, pre-service training	1) Provide TA to the MOH to implement Phase I of the Community Health Extension Workers (CHEW) policy to recruit and deploy two CHEWS for each parish	1) Lack of sustainable community workers and systems to monitor and support HIV services at community level
16	USAID	Health Systems Strengthening	HSS	Accelerate HIV epidemic control through creating a responsive and accountable leadership at the national, district and community levels in both public and private health sectors	Host country institutional development	1) Provide TA to revise and implement district plans for accountability for improved perfomance by technical and political leaders in priority districts (50) that are lagging behind on performance towards achieving 90-90-90 goals	1) Minimal involvement of district political, cultural, and technical leadership to accelerate epidemic control in poor performing districts
17	USAID	ERP Hardware	HSS	Provide the computer hardware necessary for approximately 75 users to run the ERP within the NMS and over public ART facilities.	Equipment procurement and maintenance	1) Procure computers and IT hardware for NMS after an initial pilot in 15 hospitals	1) Outdated ERP system at NMS that does not allow for transparency and accountability of public sector ARVs and HIV commodities (GOU, Global Fund) with financing
18	USAID	Private Sector Support/UHSC TBD	HSS	Support NMS to implement the new Enterprise Resource Planning (ERP) tool for improved efficiency, transparency, and accountability of the public sector supply chain system.	Host country institutional development	1) Embed 3 Technical Advisors in NMS to support ERP implementation and scale up interventions at health facility level	1) Outdated ERP system at NMS that does not allow for transparency and accountability of public sector ARVs and HIV commodities (GOU GF) with financing

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
12	Human Resources for Health	6.2	1) Revised staffing structures including lab cadres implemented	2 years	1) Revised staffing structures	1) Labour market analysis and justification for revision of staffing norms	1) Analytics for staffing norms completed
13	Human Resources for Health	7.2	1) Increase in number of dispensers trained and deployed in the public sector	3 years	1) Number of dispensers trained and deployed in public sector	1) 40 % increase in dispensers in public sector	0
14	Domestic Resources Mobilization	5.36	1) Increased budget for health and HIV/AIDS	3 years	1) Percentage of GOU health budget as a proportion of the national budget 2) GOU contribution for ARVs increased from current level	$24million	1) 1 % increase in GOU contribution to ARVS
15	Human Resources for Health	6.2	1) The CHEW policy finalized and approved and rolled out in an initial 12 PEPFAR- supported districts	3 years	1) Approved CHEW policy and implementation at district level	1) No district implementing CHEWS	1) 12 PEPFAR districts have functional community systems to support HIV/AIDS differentiated service delivery models supervised by CHEW.
16	Policies and Governance	9.33	1) All PEPFAR-supported districts revise district plans and monitor progress per district/facility/community catchment area as appropriate.	3 years	1) Number of districts with revised rapid epidemic control plans implemented	0	1) 10 districts achieving set 90-90-90 targets
17	Commodity Security and Supply Chain	3.8	1) Functional ERP hardware installed at NMS to allow for enhanced transparency and accountability for the public sector supply chain system with access to financial and logistics information at national and subnational levels.	1 year	1) Timely standard financial and logistics data generated from the ERP demonstrating adherence to good warehouse practices by the NMS . 2)Functional ERP hardware installed at NMS	0	1) New ERP hardware installed at NMS
18	Commodity Security and Supply Chain	3.8	1) Utilisation of a robust ERP hardware and software applications with resulting transparency and accountability for public sector HIV commodities	3 years	1) Functional ERP hardware and software utilised by NMS and facilities	0	1) ERP hardware and software installed and utilized at the NMS and 15 Phase 1 Health Facilties

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP20) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.
12		1) Policy for revised staffing norm developed for approval			
13		0		1) 50 % increase in dispensers in public sector	
14		1) 2 % increase in GOU contribution to ARVs		1) 5 % increase in GOU contribution to ARVS	
15		1) 24 PEPFAR districts have functional community systems to support HIV/AIDS differentiated service delivery models supervised by CHEW		1) 36 PEPFAR districts have functional community systems to support HIV/AIDS differentiated service delivery models supervised by CHEW	
16		1) 20 districts achieving set 90-90-90 targets		1) 50 Districts achieving set PEPFAR 90-90-90 targets	
17					
18		1) ERP hardware and software installed and utilized at NMS, 65 district hospitals and selected high volume facilities		1) ERP hardware and software installed and utilized at NMS, 65 district hospitals, and 100 high volume facilities	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
19	USAID	Private Sector Support/UHSC TBD	HSS	Improve on the quality of logistics management information systems including the Web-based ARV Ordering System (WAOS) to include laboratory commodities and expand the analytics of WAOS data to inform timely re-distribution decisions to mitigate stock outs.	Supply chain systems	1) Enhance functionality and inter-operability of eLMIS including Web-Based ARV and TB Ordering Systems (WAOS and TWOs), Rx solutions, LabMIS, and the Pharmaceutical Information Portal 2) Develop and enhance dashboard capabilities on the eLMIS platforms.	1) Limited robustiness and interoperability of exisiting eLMIS platforms with resulting lags in identifying supply chain inadequacies at national and facility level
20	USAID	Private Sector Support/UHSC TBD	HSS	Develop and implement tools to supervise, evaluate and improve HIV commodity management, ordering, and dispensing quality at ART sites, including laboratory.	Supply chain systems	1) Develop and implement tools to supervise, evaluate, and improve HIV commodity management, ordering, and dispensing quality at ART sites, including lab.	1) Outdated tools for supervision and commodity management at ART site level
21	USAID	MELP TBD	HSS	Continuous data quality improvement	Assessments, evaluation, operation research	1) Conduct independent indicator-based DQAs 2) Complete and monitor data quality improvement plans (DQIPs)	1) Varying quality of data by districts and IPs
22	USAID	ERP Software and Implementation	HSS	Ensure transparency and accountability of HIV commodities procured, warehoused, and distributed by public sector through NMS.	Host country institutional development	1) Procure and install software for ERP at NMS and at regional and national hospitals and high volume health centres	1) Limited transparency and accountability for the public sector supply chain system without public access to financial and logistics Information at national and subnational levels.
23	USAID	ERP Software and Implementation	HSS/C &T	Improve the planning, ordering, and receipt of public sector health facilities providing HIV services.	Host country institutional development	1) Provide systems support to facilitate interoperability test and implemenation between NMS and regional and national referral hospitals and high volume ART sites	1) Limited transparency and accountability for the public sector supply chain system without public access to financial and logistics Information at national and subnational levels.
24	USAID	Strategic Information Technical Support (SITES)	HSS	Strengthen country capacity to collect, manage, analyze, and use data at national, and subnational levels in USAID-supported districts	Host country institutional development	1) Support MOH to improve Health Management Information System (HMIS) data collection and management 2) Support improved public access to data through DHIS2	1) HMIS and DHIS2 not meeting user needs
25	USAID	Strategic Information Technical Support (SITES)	HSS	Increase access to and use of data to support strategic and program management decisions	Assessments, evaluation, operation research	1) Provide implementation science activities such as quick assessments and rapid appraisals for timely intervention adaptation	1) Inadequate relevant and timely information to inform program and intervention adjustments that support epidemic control

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
19	Commodity Security and Supply Chain	3.8	1) Robust and interoperable electronic logistics systems hosted at the MOH and fully implemented at facility level	2 years	1) Robust and nteroperable electronic logistics systems hosted at the MOH and fully implemented at facility level	1) Stand alone eLMIS including WAOS, TWOS, Rx Solutions, LabMIS, RAS, Pharceutical Information Portal	1) Policy and guidelines for eLMIS interoperability merger developed
20	Commodity Security and Supply Chain	3.8	1) Comprehensive ART commodity traceability at national and ART site level	3 years	1) Number of tools developed 2) Tools implemented at facility level	1) 20 % ART commodity traceability at facility level	1) 50 % ART commodity traceability at facility level
21	15.6	1.07	1) All indicators used to report PEPFAR data are assessed in the previous three years	1 year	1) Progress in development and implementation of the DQA and data quality improvement plans	1) SOW, not started	1) Development and implementation of the DQA and data quality improvement plans completed
22	Commodity Security and Supply Chain	3.8	1) Enhanced transparency and accountability reports for the public sector supply chain system without public access to financial and logistics Information at national and subnational levels	3 years	1) Timely standard financial and logistics data generated from the ERP demonstrating adherence to good warehouse practices by the NMS and participating health facilities	1) Financial and logistics data at facilities not publicly accessible	1) Timely standard financial and logistics data available from NMS and 15 Phase 1 sites.
23	Commodity Security and Supply Chain	3.8	1) Enhanced transparency and accountability for the public sector supply chain system with access to financial and ART logistics Information at subnational levels 2) High volume sites linked to NMS for monitoring ART and HIV supplies and stock	3 years	1) Timely standard financial and logistics data for HIV generated from the ERP demonstrating adherence to good warehouse practices by the NMS and participating health facilities.	1) Financial and logistics data at facilities not publicly accessible	1) Timely standard financial and logistics data for HIV commodities available from NMS and 15 Phase 1 sites.
24	15.2	1.67	1) Revised HMIS tools meet PEPFAR and country HIV program performance management needs	1 year	1) Quality, relevance and adequacy of, and access to data in DHIS2	1) Data is of varying quality 2) Data does not meet PEPFAR finer age disaggregation needs and public access is limited	1) Data collected through revised HMIS tools meet PEPFAR quality, timeliness and finer age disaggregation needs
25	N/A	N/A	1) Minimum eight quick assessments, rapid appraisals, and qualitative studies completed and used by the PEPFAR teams, IPs, and facility management to adapt programs	1 year	1) Number of quick assessments, rapid appraisals and qualitative studies completed and used to adapt programs	1) SOW, not started	1) Minimum eight quick assessments, rapid appraisals, and qualitative studies completed and used to adapt programs

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP20) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.
19		1) eLMIS including WAOS, TWOS, Rx Solutions, LabMIS, RAS, Pharceutical Information Portal interoperable			
20		1) 75% ART commodity traceability at facility level		1) 100 % ART commodity traceability at facility level	
21		N/A		N/A	
22		1) Timely standard financial and logistics data available from NMS and 15 phase 1 sites and an additional 65 facilities		1) Timely standard financial and logistics data available from NMS, 15 Phase 1 sites and an additional 65 facilities, and an additional 230 facilities	
23		1) Timely standard financial and logistics data for HIV commodities available from NMS and 15 phase 1 sites and an additional 65 facilities		1) Timely standard financial and logistics data for HIV commodities available from NMS and 15 Phase 1 sites and an additional 65 facilities and an additional 230 Health facilities	
24		N/A		N/A	
25		N/A		N/A	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
26	USAID	Strategic Information Technical Support (SITES)	HSS	Continuous data quality improvement	Host country institutional development	1) Support country to extract, validate and store a clean copy of the national DHIS2 data set every quarter	1) Inadequate quality and timeliness of data in the national system
27	USAID	Strategic Information Technical Support (SITES)	HSS	Maintain PEPFAR specific data management, analysis and reporting systems	Information systems	1) Develop and maintain DATIM4U, HIBRID and other information systems and processes to meet information needs for PEPFAR program performance management and reporting	1) Complex and frequently changing information needs for PEPFAR program performance management and reporting
28	HHS/CDC	Monitoring and Evaluation Technical Support (METS)	HSS	To support short learning loops at district level and strengthen the technical capacity of District Health Teams to use evidence for the implementation of district-led programming for delivery of quality HIV services	Management and coordination	1) Provide TA to regional IPs to use short learning loops at district level 2) Provide TA to operationalize 5-year HIV/AIDS strategic plans that respond to specific district needs 3) Oversee, transfer, and work side-by-side with the regional teams and DHT to ensure that district annual work plans developed are linked to the five-year plans and aligned to MOH priorities/policies.	1) Limited capacity at subnational level to develop and implement evidence-based workplans for HIV/AIDS epidemic control.
29	HHS/CDC	Monitoring and Evaluation Technical Support (METS)	HSS	Strengthen district-led programming and CQI approaches	Management and coordination	1) Build capacity of health managers from priority districts in governance, leadership, and management to improve decentralised services for HIV/AIDS epidemic control 2) Support on-the-job mentorship 3) Support identifying and bringing to scale innovative HIV projects that address current gaps in implementation of HIV/AIDS programming in districts	1) Limited capacity of the DHTs and health subdistrict teams to provide leadership and oversight functions within the decentralized health system 2) Little capacity to use data effectively to adapt to and address gaps in the HIV program response to get 3) Districts unwillingness to adopt best-practices and effectively use data for decision-making.

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
26	15.6	0	1) Clean and quality national data set available for users by the 5th day of the second month after every quarter ends	3 years	1) Extent to which country has the relevant skills and is taking on leadership in the process	1) GOU convenes regional and national data cleaning workshops	1) USG funding contribution reduced to 75 %. 2) GOU takes responsibility for 25 % funding of the workshops, and participates in preparation and presentation of data
27	N/A	N/A	1) Timely, relevant, and reliable information available for technical teams to manage the program and for PEPFAR quarterly reporting	3 years	1) Timely submission of the quarterly performance data into DATIM 2) Global and customer satistaction rates	1) Submission was 3-4 days late 2) Customer satisfaction was not surveyed.	1) Submission to global DATIM by the deadline 2) More than 70 % customer satisfaction
28	Performance Data	7.23	1) Improved technical capacity for short learning loops and use of data by the DHTs and health subdistrict teams to identify, enroll, and retain PLHIV for epidemic control	3 years	1) Number of districts implementing annual work plans that are linked to five-year plans	1) 25 % of districts require no TA to ensure that annual district plans are linked to five-year plans and can demonstrate in-house ability to use data to program, plan, and manage effectively with no outside assistance 2) DHT creation and implementation of appropriate annual plans that reflect activities necessary to obtain 90/90/90 goals.	1) 50 % of districts require no TA to ensure that annual district plans are linked to five-year plans and can demonstrate in-house ability to use data to program, plan, and manage effectively with no outside assistance 2) DHT creation and implementation of appropriate annual plans that reflect activities necessary to obtain 90/90/90 goals.
29	Planning and Coordination	9.33	1) Improved leadership and management skills for the 60 DHTs and HSD managers in 20 priority districts to better use data, implement best-practices, and ensure facilities in their districts are optimally functioning	3 years	1) Number of district managers being successfully mentored in governance, leadership, and use of data as evidenced by appropriate HIV projects brought to scale in supported districts.	1) 63 graduates mentored 2) Equivalent number of HIV projects	1) 35 additional GLM fellows completing mentored projects 2) Immediate improvements in the management and activities of the supported districts based on effective use of data by the mentored leaders

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26		1) USG funding contribution reduced to 50 %. 2) GOU takes responsibility for 50 % funding of the workshops, and increases participation in preparation and presentation of data		1) USG funding contribution reduced to 25 %. 2) GOU takes responsibility for 75% funding of the workshops, and becomes fully responsible for preparation and presentation of data	
27		1) Submission to global DATIM by the deadline. 2) More than 80% customer satisfaction		1) Submission to global DATIM by the deadline 2) More than 90% customer satisfaction	
28		1) 75 % of districts require no TA to ensure that annual district plans are linked to five-year plans and can demonstrate in-house ability to use data to program, plan, and manage effectively with no outside assistance 2) DHT creation and implementation of appropriate annual plans that reflect activities necessary to obtain 90/90/90 goals.		1) 100% of districts require no TA to ensure that annual district plans are linked to five-year plans and can demonstrate in-house ability to use data to program, plan, and manage effectively with no outside assistance 2) DHT creation and implementation of appropriate annual plans that reflect activities necessary to obtain 90/90/90 goals..	
29		1) 35 additional GLM fellows completing mentored projects 2) Immediate improvements in the management and activities of the supported districts based on effective use of data by the mentored leaders		1) 35 additional GLM fellows completing mentored projects 2) Immediate improvements in the management and activities of the supported districts based on effective use of data by the mentored leaders	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
30	HHS/CDC	Monitoring and Evaluation Technical Support (METS)	C&T	Support comprehensive IPs to strengthen district- and site-level CQI through coordinating learning collaboratives and providing mentorship on use of HIV and TB program dashboards	Information systems	1) District level CQI support to CDC-supported regions and EOC support for real time monitoring across program areas (including VL M&E framework for reporting).	1) Limited capacity of District Health Teams (DHTs) to monitor and implement CQI activities.
31	HHS/CDC	CDC-WHO collaboration - TBD	HSS	Provide TA to the MOH to fulfill its mandates of achieving 90-90-90	Technical area guidelines and tools	1) Provide TA to the MOH to review and strengthen the role of regiona-level structures in supporting epidemic response at the subnational level 2) Mentoring and expert advisor provided at central level for MOH to fulfill role of regional coordination, leadership, and management, and to update harmonized 5-year National Health Sector HIV/AIDS Strategic Plan.	1) Limited technical capacity within MOH to provide oversight for HIV epidemic resonse at subnational levels
32	HHS/CDC	Technical Assistance to strengthen the Capacity of the MOH to Execute its Public Health Functions for HIV/AIDS Epidemic Control and Respond to other Disease Outbreaks in the Republic of Uganda under PEPFAR through HSS	PREV	Provide TA to MOH to improve HIV programming, manage all health-related data and improve quality of HIV services at the national and subnational levels	Technical area guidelines and tools	1) Support salaries for 6 critical prevention positions 2) Provide targeted mentorships to subnational levels in different technical areas including key populations, DREAMS, community systems, VL suppression, adolescent care and treatment. 3) Support programming guidance for high impact HIV prevention approaches for AGYW and their communities, rollout of GBV Quality Assurance standards as well national VACS response. 4) Facilitate development of guidelines and tools for routine mentorships and TA for the purpose of ensuring fidelity in implementation and delivery of quality of services.	1) Limited technical capacity within MOH to lead and offer oversight for implementation of public health response
33	HHS/CDC	Technical Assistance to strengthen the Capacity of the MOH to Execute its Public Health Functions for HIV/AIDS Epidemic Control and Respond to other Disease Outbreaks in the Republic of Uganda under PEPFAR through HSS	HSS	Provide TA to MOH to improve HIV programming, manage all health-related data and improve quality of HIV services at national and subnational levels	Technical area guidelines and tools	1) Support salaries for 3 Strategic Information (SI) staff at national level. 2) Maintain the logistics information inventory system (linked to DHIS2, VL dashboard, BLIS) that links reagents to equipment utilization and patients tested and improves tracking and reverse logistics	1) Limited technical capacity within MOH to use strategic data or evidence for implementation of public health response 2) Weak lab inventory management system for linking the UNHLS and lab hubs

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
30	Quality Management	6.52	1) Improved capacity of DHTs to monitor and implement CQI activities	3 years	1) SIMS	1) 15 % districts had functional district CQI teams and quality management plans	1) 50 % of supported districts have functional district CQI teams and quality management plans
31	Policy and Governance	9.33	1) Strengthened management of the subnationalrepsonse to HIV/AIDS.	3 years	1) Number of functional regional level structures which have adopted WHO guidelines and MOH policies and can effectively manage lower-level district centers to do the same	1) WHO evaluation report about the Regional Performance Monitoring Teams	1) Regional level structures defined 2) National Health Sector HIV/AIDS 5-Year Strategic Plan updated and enforced
32	Service Delivery, Policy and Governance	3.8 / 8.19	1) Improved technical capacity of MOH to lead and oversee the implementation of the public health response	3 years	1) Number of technical officers supported 2) Number of regional level-performance reviews held 3) Number of districts providing targeted services to selected population subgroups	1) Number of technical officers supported 2) 50 % of districts providing targeted prevention services to selected population subgroups	1) 6 technical officers supported with improved access to HTS services at the national and subnational levels 2) 90 % of districts providing targeted prevention services to selected population subgroups
33	Epidemiological and Health Data	4.65	1) Improved capacity for MOH to use data for implementation of the public health response 2) Optimal equipment utilization	3 years	1) Number of technical officers supported to provide TA to MOH 2) Percentage utilisation of VL equipment at the UNHLS	1) 3 technical officers supported 2) 10 lab hubs utilizing VL equipment at the UNHLS 3) Viral Load inventory system established at UNHL that links stocks within UNHLS and national level warehouses	1) Inventory management system linked to 50 hubs 2) Online supply plan for VL commodities in place 3) Reagent utilization linked to equipment performance

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30		1) 75 % of the supported districts have functional district CQI teams and quality management plans		1) 100 % of the supported districts have functional district CQI teams and quality management plans	
31		1) 7 functional regional level structures established		1) 14 functional regional level structures established	
32		1) 6 technical officers supported with improved access to HTS services at the national and subnational levels 2) 100% of districts providing targeted services to selected population subgroups		1) 6 technical officers supported with improved access to HTS services at the national and subnational levels	
33		1) Inventory management system linked to 100 hubs		1) Inventory management system is maintained linking all hubs to UNHLS and central warehouses	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
34	HHS/CDC	Technical Assistance for Public Health Workforce Development	HSS	Support public health work force development to strengthen the leadership and management of human resources for health through field epidemiology and MPH training	Workforce development, pre-service training	1) Support select MPH projects already underway with PEPFAR support that target leadership and management of the HIV epidemic in the public sector through improvement of skills in epidemiology and surveillance.	1) Shortage of epidemiologists and public sector public health specialists with requisite technical skills in leadership and management of the HIV public health response
35	HHS/CDC	Technical Assistance for Public Health Workforce Development	HSS	Improve program implementation by conducting quality improvement projects and building laboratory capacity	Surveys and surveillance	1) Support the PHFP (FETP) residents to utilize short learning loops and implement HIV projects that answer/address current gaps in the epidemic 2) Fund PHFP residents to conduct data analysis, CQI projects, and lab strengthening projects instead of having these needs met by IPs or contractors to increase the skills and HIV expertise of future field epidemiologists	1) Limited knowledge about innovative strategies to address unique gaps in the HIV program 2) Limited human resources to meet the continuing high need for secondary data analysis, finer examination of various large surveillance and reporting data streams, and use of data for decision-making
36	HHS/CDC	<Placeholder - 70367 Uganda HHS/CDC>	HSS	Develop and review HIV/AIDS policies, technical guidelines, and standards of service and implement through a fiduciary agent to improve program accountability for resources.	Policy and governance	1) Strengthen MOH to improve on internal business management processes through a fiduciary agent 2) Support MOH to develop and review of key policies (e.g. policies for advanced disease care and treatment, guidelines for implementation of the Shang Ring device, algorithms for the dual syphilis/HIV test kits, guidelines and policies for transition from TLE to TLD, and implementation guidelines for mentorship and in-service training for self-testing) 2) Holding HIV/AIDS national technical reviews 3) Providing support supervision and mentorship to subnational entities for improved accountability and program results.	1) Suboptimal technical capacity within the MOH for development of key policies, technical guidelines, and standards required for scale up of HIV services and attainment of epidemic control 2) Limited capacity for use of data for decision-making 3) Suboptimal capacity for oversight of the public health response at subnational level
37	HHS/CDC	CDC-WHO collaboration - TBD	HSS	Provide TA to the MOH to fulfill its mandates of achieving 90-90-90.	Technical area guidelines and tools	1) Support MOH to ensure adoption and use of multidisease testing devices in integrated lab networks for epidemic control including the development and approval process of the National POCT Implementation Guidelines. 2) Support national and subnational lab quality and biosafety improvement efforts to the hub network for sample referral including development, adoption, and dissemination of the National Bio-risk Guidelines	1) Inadequate quality of HIV care

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
34	Human Resources for Health	6.2	1) Optimal number of epidemiologists available to support the implementation of the public health response to HIV/AIDS within the public sector	2 years	1) Number of MPH graduates supported by the program	1) 30 MPH graduates supported to complete their thesis work	1) 30 MPH graduates supported to complete their thesis work
35	Human Resources for Health	6.2	1) Improved management of public health response to HIV/AIDS at subnational level 2) Use of data for decision-making and short learning loops	3 years	1) Number of HIV-related projects and CQI projects produced by PHFP fellows working on-the-job in support of 90-90-90 goals.	1) 20 PHFP projects completed that directly address data and analysis needs, quality improvement needs, and lab strenghtening needs for 90-90-90 targets.	1) 20 PHFP projects completed that directly address data and analysis needs, quality improvement needs, and lab strenghtening needs for 90-90-90 targets.
36	Policy and Governance	8.19	1) Improved technical capacity of MOH to lead and oversee the implementation of the public health response 2) Use data for decision-making 3) Provide support for leadership and oversight for HIV response at subnational level	2 years	1) Number of policies and technical guidelines developed for the implementation of the public health response to HIV/AIDS for epidemic control 2) Number of technical reviews supported of districts that are meeting the national standards of service delivery for epidemic control.	1) Number of policies created and implemented that directly improve national HIV response 2) FY17 National Health Sector Review of the HIV/AIDS response 3) 70 % of districts meeting national standards for service delivery	1) Policies on advanced care and treatment and as related to TLD transition implemented 2) National quarterly and annual technical reviews performed 3) 80 % of districts meeting national set standards for service delivery
37	Laboratory	5.25	1) Improved compliance of the lab services with requirements and targets from the Uganda National Minimum Health Care Package	3 years	1) SID 3.0 2)SIMS 3.0	1) 50 percent of the labs and POC testing sites are regulated	1) Approved National Bio-risk Guidelines and implementation plan

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34		1) 30 MPH graduates supported to complete their thesis work			
35		1) 20 PHFP projects completed that directly address data and analysis needs, quality improvement needs, and lab strenghtening needs for 90-90-90 targets.		1) 20 PHFP projects completed that directly address data and analysis needs, quality improvement needs, and lab strenghtening needs for 90-90-90 targets.	
36		1) Policy on dual syphilis/HIV test kits algorithm implemented 2) National quarterly and annual technical reviews held 3) 90 % of districts meeting national set standards for service delivery			
37		1) Operationalized National Lab Standards, POCT Guidelines, and Bio-risk Guidelines in 60 % of the labs and POC testing sites		1) Integrative use of POCT in HIV management 2) Attain 90 % compliance of the lab services with requirements of the Uganda National Minimum Health Care package	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
38	HHS/CDC	Supporting Laboratory Strengthening Activities in Resource-Limited Countries Under the President's Emergency Plan for AIDS Relief	HSS	To provide TA and build capacity of the CPHL for a lab-based HIV epidemic response and stewardship of the lab national lab network	Host country institutional development	1) Establish capacity of CPHL to coordinate national quality assurance activities to begin production and distribution of CrAG EQA 2) Build capacity of CPHL for proper management and maintenance of the lab ventilation system for VL and EID sections	1) Lack of national capacity for EQA coordination and management
39	HHS/HRSA	Biomedical Engineering Support for Equipment Maintenance and Training in Clinical Laboratory Sites Providing HIV/AIDS Care and Treatment	HSS	Strengthen capacity for laboratory equipment maintenance for sustained epidemic control	Equipment procurement and maintenance	1) Calibration of reference testing equipment and biosafety cabinet tool kits to ensure accurate lab results and infectious agents containment 2) ISO accreditation of the national equipment calibration centre 3) Training of biomedical engineers in lab equipment maintenance for a sustained equipment maintenance system 4) Development of a calibration business plan to support MOH take over and ownership 5) Conduct annual equipment calibration, certification, and training of end users to reduce on frequency of equipment breakdown	1) Interrupted lab service delivery due to equipment downtime
40	HHS/CDC	Technical Assistance for Strengthening National Laboratory Systems in Uganda under the President's Emergency Plan for AIDS Relief	HSS	Support the development and implementation of Laboratory Quality Management Systems and strengthen laboratory management towards accreditation for CQI	Laboratory quality improvement and accreditation	1) Development of the National Laboratory Quality Management Systems audit tool and framework 2) Conduct auditing of labs enrolled on lab Quality Management Systems for CQI 3) TA in support of lab CQI activities to the 100 hubs and 19 high volume sites enrolled onto SLMTA to ensure at least 80 % of these labs attained minimum standards towards provision of quality services 4) Train mentors and assessors for lab Quality Management Systems 5) Root cause analysis, corrective action, and preventive action training for lab staff 6) Deployment of quality auditors, assessors, and mentors for all HIV-related tests 7) Accreditation of the 10 selected labs to International Standards ISO 15189: 2012 & ISO 17025 (training, light lifting, assessment, accreditation fees) 8) Maintenance of the international accreditation status for the EID-VL lab	1) Inadequate quality of lab services

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38	Laboratory	5.25	1) At least 70 % adherence to the National Quality Assurance Scheme for all testing in the private and public sectors. 2) Functional lab ventilation systems at the VL and EID sections to ensure proper biosafety and biosecurity	2 years	1) MER 2.0 (LAB_PTCQI) 2) SIMS 3.0	1) 65 % of labs did not participate in EQA, which contributes to the poor lab performance	1) National CrAG EQA production and distribution section established 2) One maintenance engineer to ensure proper management of the lab ventilation system trained
39	Laboratory	5.25	1) Decreased frequency and duration of testing interruptions due to equipment breakdown	2 years	1) SIMS 3.0 2) Annual Health Infrastructure Inventory Report 3) HID/CPHL joint quarterly supervison	1) 40 % of the labs have interrupted services due to equipment downtime	1) Accredited equipment calibration center 2) Capacity built for biomedical engineers to maintain TB and VL-EID accessory equipment
40	Laboratory	5.25	1) Improved accuracy and reliability of diagnostic results leading to increased clinical trust and reliance on test results for proper patient management	3 years	1) MER 2.0 (LAB_PTCQI) 2) SIMS 3.0	1) 74 % of the labs enrolled on CQI attained a minimum level to show improvement in quality testing.	1) Establishment of national EQA monitoring structures to oversee panel development, distribution, and responses to EQA activities through the national EQA committee 2) 50 % of the lower level labs enrolled onto LQMS and audited to show improvement in accuracy and reliability 3) 80 % of the labs enrolled on CQI attain a minimum level to show improvement in quality testing

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38		1) CrAG EQA proficiency testing scheme piloted in 50 % of the health facilities, with 100 % successful passing			
39		1) Calibration business plan approved by MOH 2) Government ownership and commitment to calibration center operations			
40		1) 70 % of the lower level labs enrolled onto LQMS and audited to show improvement in accuracy and reliability 2) 85 % of the labs enrolled on CQI attain a minimum level to show improvement in quality testing		1) 5 labs attain international accreditation 2) 90 % of the labs enrolled on CQI attain a minimum level to show improvement in quality testing	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
41	HHS/CDC	Production, Distribution and Monitoring Implementation of Rapid HIV PT, Facility and Site Certification, HIVDR Sentinel Surveys, Validation of Emerging Lab Assays and Lab Equipment	HSS	Support lab capacity for national reference HIV testing, HIV quality assurance, and HIV drug resistance surveillance in Uganda	Laboratory quality improvement and accreditation	1) Implement National External Quality Assurance (EQA) for rapid HIV testing of both lab and non-lab testers targeting 30,000 testers 2) Scale up EQA by dry tube testing for HIV rapid testing to all testers. 3) Production and distribution of EQA panels to HIV testers 4) Monitor implementation, performance evaluations, and feedback for participating HIV testers 5) Scale up of the certification program for testers and testing sites to ensure competency for all testers and testing sites, focusing on zero HIV misdiagnosis. 6) Conduct tester and site certification activities 7) Provide EQA for CD4 and chemistry 8) Repository for UPHIA remnant samples	1) Inadequate quality of HIV care
42	HHS/CDC	Technical Assistance to Strengthen the Capacity of the MOH to Execute its Public Health Functions for HIV/AIDS Epidemic Control and Respond to Other Disease Outbreaks in the Republic of Uganda under PEPFAR through HSS	C&T	Provide TA to MOH to improve HIV programming, manage all health-related data and improve quality of HIV services at the national and subnational levels	Technical area guidelines and tools; Policy and governance	1) Provide TA in the form of salary support for 12 essential care and treatment positions 2) Support activities conducted by central level personnel to provide oversight for national and regional level planning, implementation, monitoring and evaluation of the HIV program (TB/HIV, PMTCT, pediatric, adolescent, adult care and treatment) 3) Support development of national policies and guidelines for effective HIV service delivery 4) Capacity building through mentorships for IPs and service providers 5) Support HIV program M&E through provision of HMIS tools, DHIS2 analytics, and data management and utilization to inform programming	1) Insufficient technical capacity and personnel at MOH to support and coordinate efforts towards epidemic control

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
41	Laboratory	5.25	1) Improved quality of HIV testing to ensure zero misdiagnosis	3 years	1) MER 2.0 (LAB_PTCQI) 2) SIMS 3.0	1) 75 % facilities participated in HIV EQA, with 94 % successfully passing	1) Roll out the certification program to at least 30 % of testers with 30 % testing sites attaining certification 2) 85 % facilities participating in HIV EQA, with 100 % successfully passing
42	Human Resources for Health, Service Delivery	3.8	1) Improved coordination of national HIV program towards epidemic control 2) Supervised roll-out and implementation of HIV policies and guidelines at national and regional levels 3) Improved quality of care, linkage and retention for all PLHIV with a focus on men, adolescents, mother-baby pairs, and key populations 4) Institutionalized biennial national and regional integrated HIV response through stakeholder planning, data, and program performance reviews 5) Improved capacity to supervise the implementation of self-testing programs	3 years	1) Number of technical officers supported 2) Number of regional-level performance reviews held 3) Harmonised implementation of the health sector response to the HIV/AIDS epidemic 4) Number of districts implementing self-testing activities	1) Number of technical officers supported 2) 15 % of districts implementing self-testing activities	1) 12 technical officers recruited 2) 2 regional performance review meetings in each region held 3) Improved access to accredited ART sites 4) Improved quality of HIV services at the national and subnational levels 5) 50 % of districts implementing self-testing activities

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41		1) Roll out the certification program to at least 50 % of testers with 50 % testing sites attaining certification 2) 90 % facilities participating in HIV EQA, with 100 % successfully passing		1) Roll out the certification program to at least 70 % of testers with 70 % testing sites attaining certification 2) 100 % facilities participating in HIV EQA, with 100 % successfully passing	
42		1) 12 technical officers supported 2) 2 HIV performance measurements done in each of the health regions 3) Supported regional and district roll out of revised HIV guidelines 4) Supported data utilization at regional and district level for epidemic control 5) 80 % of districts implementing self-testing activities		1) 12 technical officers supported 2) Completed rollout of HIV guidelines including DSDM 3) Built regional and district technical capacity for HIV programming, data review, data utilization, CQI, and performance improvement 3) 100 % of districts implementing self-testing activities	

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43	HHS/CDC	<Placeholder - 70367 Uganda HHS/CDC>	C&T	Develop and review HIV/AIDS policies, technical guidelines and standards of service and improve accountability for program results	Policy and governance	1) Support MOH to improve planning and coordination of the HIV response in areas of pediatric ART, PMTCT, TB, ART, SI, HTS, VMMC, care, KP) 2) Review and update HIV guidelines 3) Develop strategic plans 4) Hold annual stakeholders engagements (planning, performance reviews, quality assurance etc) 5) Set operational standards	1) Suboptimal technical capacity within MOH to analyze data and use it for decision-making
44	USAID	Communication for Healthy Communities (CHC)	PREV	Design and implement high quality interventions to create demand for VMMC	IEC and/or demand creation	1) Develop and disseminate tailored messages to raise community literacy and demand for VMMC services in high HIV prevalance and low VMMC coverage areas across PEPFAR Uganda 2) Disseminate tailored HTS messages for PEPFAR Uganda with a focus on finding men	1) Lengthy clearance process by the central messaging clearing committee
45	DOD	DoD Mechanism	HSS	Strengthen the internal and institutional capacity of the UPDF to improve quality of, lead, plan, and monitor HIV response in the military	Management and coordination	1) Strengthen military leadership engagement in epidemic control and coordinate all IPs working in the military 2)Promote coordination and dialogue between service providers, policy makers, and implementers on quality of HIV care and treatment services for the military	1) Systematic engagement by the military commanders and UPDF HIV directorate with PLHIV in the military and KP/PP, stakeholders and service providers is insufficient
46	DOD	Makerere University Walter Reed Project (MUWRP)	C&T	Strengthen the national laboratory quality management system for improved access to quality laboratory services	Laboratory quality improvement and accreditation	1) EQA for sputum and culture 2) Second staff to the NTRL (EQA Program Coordinator; 4 Lab Technologists; Quality Assurance Officer; Lab Informatics Officer; Program Administrative Assistant (Receptionist); Program Accountant; Accounts Assistant; Procurement Officer; Data Manager; Data Entrants; M&E Officer; Assistant M&E Officer; IT Officer; Driver; Sanitary Officer)	1) Suboptimal external quality assurance for TB sputum microscopy and GeneXpert
47	USAID	Advocacy for Better Health	C&T	Support CSOs, PLHIV and KP/PP engagement and oversight of provision of quality HIV services and commodities including ARVs	Policy and governance	1) Promote coordination and dialogue between service providers, policy makers and implementers on quality of HIV care and treatment services for KP/PP and PLHIV	1) Systematic engagement by PLHIV and KP/PP CSOs with GOU, stakeholders, and service providers is insufficient
48	USAID	Uganda Health Supply Chain	C&T	Improve the quality of logistic management information systems including web-based ordering of ARVs and lab commodities for timely redistribution to mitigate stock-outs	Supply chain systems	1) TA for improved site level ordering and supply management 2) WAOS data analysis and use for all IPS	1) Inadequate capacity at MOH and facilities to routinely forecast and order HIV commodities

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
43	Performance Data	7.23	1) Increased technical capacity of MOH to plan and coordinate one national health sector response to HIV/AIDS	3 years	1) Number of national-level performance reviews held 2) Number of guidelines developed and disseminated 3) Program result accoutability for HIV response implementation	1) one National-level review of HIV/AIDS program performance held 2) Policy guidelines revised to include TLD transition	1) Revised 2016 HIV policy guidelines to incorporate advanced disease 2) Better coordinated HIV/AIDS response with annual review of program performance by all key stakeholders at national level
44	Service Delivery	3.8	1) A dynamic health communication program that responds in a timelymanner to emerging VMMC communication needs.	1 year	1) HIV VMMC messages reviewed and adopted at least quarterly in tandem with the strategic prioroties of the PEPFAR program	1) 2016 UDHS 2) 2017 UPHIA	1) All USG implemeting partners are disseminating harmonized VMMC health communication messages
45	Service Delivery		1) Improved engagement by the UPDF commanders in HIV activities 2) Improved coordination among the implementing partners and the UPDF	2years	1) Number of commanders sensitized in HIV activities 2) Number of bases provided with technical support by the UPDF HIV directorate.	1) 50 % coverage of all bases with ART clinics	1) 90 % coverage of all bases with ART clinics
46	Laboratory	5.25	1) Quarterly production and distribution of TB EQA panels by the NTRL lab; 2) Quarterly release of TB EQA feedback reports 3) Accredited TB EQA production lab	3 years	1) Number of TB GeneXpert and TB microscpy facilities receiving EQA panels, returning results and getting feed back reports 2) Number of facilities passing on TB EQA 3) Accredited NTRL TB EQA lab.	1) 77 % coverage 2) 90 % return rate 3) 94 % pass rate	1) 100 % coverage 2) 100 % return rate 3) 100 % pass rate
47	Civil Society Engagement	5	1) Unified and stronger PLHIV and CSO voice for the oversight of the HIV response with issues included in GOU and stakeholder priorities, plans, and programs	2 years	1) Engagement of subnational and grassroots CSOs in the planning and review of PEPFAR and GOU processes for the HIV response with regional represention	0	1) 13 grassroots CSOs participated in PEPFAR planning and program reviews
48	Commodity Security and Supply Chain	3.8	1) Bi-weekly stock status reported through WAOs at 100 % report rate	2 years	1) Percentage of facilities reporting 2) Bi-weekly report rate through WAOs	0% facilities reporting	40% facilities reporting

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43		1) National roll out of revised HIV guidelines 2) 2 national level coordination, planning and performance reviews of National HIV response held 3) 1 national supervision of regional and district HIV delivery		1) Capacity built for coordination of one national HIV response among partners and GOU 2) National level coordination, planning and performance review of the HIV Response 3) National supervision of regional and district HIV delivery 4) Increased MOH technical capacity to supervise delivery of HIV services including quality assurance.	
44					
45		100% coverage of all bases with ART clinics			
46		1) 100 % coverage 2) 100 % return rate 3) 100 % pass rate		1) 100 % coverage 2) 100 % return rate 3) 100 % pass rate	
47		1) 26 grassroots CSOs planning and program reviews		1) 39 grassroots CSOs planning and program reviews	
48		90% facilities reporting		100% facilities reporting	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
49	USAID	Defeat TB	C&T	Provide TA to MOH to improve HIV programming, manage all health-related data and improve quality of HIV services at the national and subnational levels	Policy and governance	1) Support MOH TB program in coordination and oversight 2) Develop TB/HIV guidelines and policies 3) Second 5 technical advisosr to NTLP (partner coordination, QI, TB/HIV case finding, 3Is for TB/HIV, capacity building)	1) Insufficient technical capacity at National TB Program to support and coordinate efforts towards reducing the burden of TB/HIV
50	USAID	Defeat TB	C&T	Develop and review HIV/AIDS policies, technical guidelines and standards of service and improve accountability for program results	Technical area guidelines and tools		
51	USAID	Quality Assurance (ASSIST Follow-On)	C&T	Develop and review HIV/AIDS policies, technical guidelines, and standards of service and improve accountability for program results	Technical area guidelines and tools	1) Quality management and improvement support to MOH (coordination and oversight) 2) Support for guidelines and policies 3) Annual quality assessments 4) District level QI and spread of innovations across USAID-supported regions.	1) Inadequate MOH capacity to guide, oversee, document, and spread quality improvement interventions
52	USAID	EQUIP	C&T	Costing Differentiated Service Delivery Models	Costing and efficiency analysis	1) Costing Differentiated Service Delivery Models (DSDM)	1) Lack of cost or cost effectiveness data of different DSDM approaches that are being rolled out
53	USAID	Communication for Healthy Communities (CHC)	C&T	Enhanced targeted health communications to increase identification, linkage, and retention of PLHIV in treatment and viral suppression across different populations groups	IEC and/or demand creation	1) Develop and disseminate effective communications on key program priorities 2) IEC/BCC messaging on HTS, viral suppression, EID, early ANC, TB case detection, utilization of Genexpert, TLD transition 3) Creation of approaches for improving linkages for men, mobile populations and adolescens	1) Suboptimal linkage of men and adolescents to HIV treatment 2) Low viral suppression among children and adolescents 3) Poor TB case detection
54	USAID	<Placeholder - 70384 Uganda USAID>	C&T	Verify and reconcile reports provided by NMS and ensure that ARVs and HIV/TB lab commodities provided by PEPFAR to the public sector are properly managed and dispensed appropriately at the facility level	Supply chain systems	1) Verify and reconcile reports provided by NMS and ensure that ARVs and TB/HIV lab commodities provided by PEPFAR to the public sector are properly managed and dispensed appropriately at the facility level	1) Lack of systems for independently tracking and monitoring ARVs in public sector

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
49	Service Delivery	3.8	1) Increased technical capacity to effectively utilize resources and coordinate TB control efforts of all stakeholders.	3 years	1) Proportion of missing TB/HIV co-infected cases	46 % of TB/HIV coinfected cases missing	30 % of TB/HIV coinfected cases missing
50			1) Full and nationwide implementation of updated national guidelines, SOPs, tools and best practices.	3 years	1) Proportion of TB/HIV cases with confirmed contact investigation	14% of TB/HIV cases with confirmed contact investigations	20% of TB/HIV cases with confirmed contact investigations
51	Service Delivery	3.8	1) Continous Quality Improvement (CQI) institutionlized and routinely implemented at all PEPFAR-supported sites	3 years	1) Percentage PEPFAR-supported facilites implementing CQI	TBD	1) Increase number of CQI implementing sites by 20 %
52	Technical and Allocative Efficiency	4.16	1) Estimated cost per patient by type of DSDM 2) Estimated cost per outomce (retention or VL suppression) by the type of DSDM model	2 years	Cost estimate compelete and used for planning and budgeting	1) Phase one (per patient cost of DSDM) compeleted	1) Final report on cost effectiveness of DSDM disseminated
53	Service Delivery	3.8	1) More than 90 % ART coverage and viral suppression across targeted population groups	2 years	1) Percentage linkage, ART coverage, and viral suppression disaggregated by age and gender	1) 71 % men linked to care 2) 69 % viral suppression among children and adolescent at	1) Increase men's linkage to VL to 80 % 2) Increase VL suppression for children and male adolescent to above 80 %
54	Commodity Security and Supply Chain	3.8	1) USG-funded HIV commodities provided 2) ART and other HIV commodities provided to public sector tracked	3 years	1) Number of public health facilities visited by independent monitoring team to verify and reconcile quantities and types of ARVs supplied by NMS and what is received at facilities	0	1) 250 facility commodity reports verified and reconcilled with NMS

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49		20 % of TB/HIV coinfected cases missing		10 % of TB/HIV coinfected cases missing	
50		40% of TB/HIV cases with confirmed contact investigations		60% of TB/HIV cases with confirmed contact investigations	
51		1) Increase number of CQI implementing sites by 30%		1) Increase number of CQI implementing sites by 40%	
52		1) Complete analysis and report during Q1 of CO 19			
53		1) Increase men's linkage to VL to 90 % 2) Increase VL suppression for children and male adolescent to above 85 %		1) Increase men's linkage to VL to 95 % 2) Increase VL suppression for children and male adolescent to above 90 %	
54		1) 250 facility commodity reports verified and reconcilled with NMS		1) 250 facility commodity reports verified and reconcilled with NMS	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
55	DOD	<Placeholder - 70364 Uganda DOD>	HSS	Seroprevalence and behavioural epidemiological risk survey (SABERS) in the Uganda Peoples' Defense Forces (UPDF)	Information systems	1) Study of HIV prevalence and risky sexual behavior in the Ugandan military population	1) Unknown military population of PLHIV thus inability to accurately construct the clinical cascade for the military 2) Poor linkage and tracking of patients for retention and access to services 3) Poor networking of health facilities in military bases for access and uptake of comprehensive HIV/AIDS services 4) Inadequate prevention messaging tailored to military populations 5) Untargeted interventions to improve viral suppression among military populations 6) Lack of quality interventions to reduce mortality and improve survival in the forces
56	HHS/CDC	<Placeholder - 70368 Uganda HHS/CDC>	HSS	Coordination of the laboratory instrument mapping and optimization to strengthen HIV/TB integration	Management and coordination	1) Conduct national lab instrument mapping throughout the network including conventional and point-of-care instruments for TB- and HIV- related testing 2) Develop a strategic country plan for multidisease testing, specimen referral networks, and a results reporting system to strengthen TB/HIV integration 3) Establish a technical working group comprising representatives from all relevant disease programmes, reference labs, procurement agencies, and implementing partners with a clear allocation of responsibilities 4) Develop the maintenance and quality assurance plan for point-of-care testing (POCT) 5) Coordinate the in-country validation of multidisease testing devices, adoption, and implementation of the POCT guidelines across the lab network 6) Coordinate the demand creation to ensure optimal utilization of the available multidisease testing devices, while strengthening TB/HIV integration	1) Inadequate quality of HIV and TB care

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55	Epidemiological and Health Data		1) Data on prevalence of HIV among Ugandan military population 2) Data on prevalence and incidence of STIs including HIV, HBV and syphilis 3) Data on knowledge, attitude and practice 4) Data on factors that determine HIV and STI risk.	1 year	1) HIV prevalence and incidence rates 2) Syphilis prevalence and incidence rates 3) HBV prevalence and incidence rates 4) HIV status and risk awareness 5) Consistent condom use prevalence 6) Prevalence of retesting 7) Rate of ART initiation 8) Rates of retention 9) HIV transmission dynamics	Protocol development and approval	1) Enrolment in study 2) Implementation of study 3) Data analysis
56	Laboratory	5.25	1) Improved, maintained, and fully functional lab networks that have adopted lab guidelines, policies, and procedures which support access to quality- assured diagnostics and strengthen TB/HIV integration	3 years	1) SIMS	1) 50 % of the labs and POC testing sites are regulated	1) Availablity of the national lab instrument inventory and projections that strengthen TB/HIV integration

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55		Data dissemination			
56		1) Availablity of the country strategic plan for multidisease testing, specimen referral networks, and a results reporting system to strengthen TB/HIV integration		1) Improved HIV and TB diagnosis using multidisease integration for point of care testing	