PEPFAR Uganda

Country Operational Plan

(COP) 2019

Strategic Direction Summary

April 12, 2019

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1.0 Goal Statement

The 2019 PEPFAR Country Operational Plan (COP19) for Uganda reflects a bold move toward epidemic control in line with both the UNAIDS 90-90-90 and the national 95-95-95 goals across sex and ten age bands. HIV prevalence among adults aged 15 to 64 in Uganda is 6.2 percent: 7.6 percent among females, and 4.7 percent among males. According to the Uganda 2020 Spectrum estimate, 1.296 million people aged 15-64 are living with HIV and there are an additional 96,742 aged 0-14.

According to the Uganda Population-based HIV Impact Assessment (UPHIA) completed in 2017, among adults living with HIV, 72.5 percent were diagnosed; 65.5% were on antiretroviral treatment (ART); and 54.8 percent were virally suppressed (58.8 percent of HIV-positive females and 47.7 percent of HIV-positive males). Progress has been uneven, with the largest numbers of persons in need of ART found among women aged 15-19 and men aged 25-39 and both men and women above the age of 50.[1] The unmet need for both HIV diagnosis and treatment is most pronounced in children below 15 years. As of Quarter 1 of FY 2019, 1,097,779 PLHIV on ART received some PEPFAR support.[2] PEPFAR/Uganda program data for FY19 Q1 show 63 percent of all PLHIV have had a viral load (VL) test and are virally suppressed. New infections (annual incidence) of HIV among adults ages 15-64 years in Uganda from the UPHIA survey is 0.40%: 0.46% among females and 0.35% among males. Spectrum estimates from 2018 indicate that there were 50,274 new cases of HIV infections annually among adults ages 15-64 in Uganda. HIV incidence among women in age bands 15-24 and 25-34 is almost twice that of their male counterparts.[3] The UPHIA survey demonstrated approximately 16 percent of adults on treatment have not attained viral suppression; among children under the age of 15, successful VL suppression only reaches 39.3 percent.

In COP19, the overarching goal is to bring Uganda to a national coverage of 95-95-95 percent ensuring 95 percent of individuals know their diagnosis, 95 percent of those are on treatment and retained, and of those on treatment, 95 percent have obtained and maintain viral suppression. By September 30, 2020, a total of 182,305 individuals will be newly identified and enrolled in treatment which should reduce incident cases of HIV below deaths of PLHIV, and bring Uganda to epidemic control. PEPFAR Uganda has planned to execute a highly ambitious and targeted program under COP19, based on the most efficient and high-yielding strategies to enhance case identification, linkage, enrollment, retention, and ultimately, viral suppression. PEPFAR Uganda's program will continue with cutting-edge adaptations to improve performance, using site- and location-specific data to identify areas for improvement that are critical to attainment of its targets and objectives. COP19 will target the most underserved age and sex bands, while preventing HIV transmission among the most vulnerable populations.

COP19 will focus implementation on fidelity and scale-up of the most effective technical and programmatic approaches: including: assisted partner notification (APN) as part of index testing; self-testing for targeted population groups, the new Shang Ring for safe male circumcision; expansion of differentiated service delivery including multi-month scripting models; more efficacious ARV regimens; point of care (POC) testing for early infant diagnosis (EID); Pre Exposure Prophylaxis (PrEP) for those at risk for infection; improved key population (KP) services across the

[1] Unpublished UPHIA data, 2017 and program data.

[2] Unpublished program data, 2019

[3] Unpublished UPHIA data, 2017

cascade; policy guidelines for neonatal circumcision; and tuberculosis preventive treatment (TPT) for all PLHIV. PEPFAR will also ensure a strong and sustainable supply chain (including adequate financing for health commodities), health information and monitoring, laboratory systems, human resources and financing systems to eliminate barriers to the consistent implementation of proven interventions. PEPFAR Uganda will also improve uptake of critical interventions through continued strong Government of Uganda (GOU) and civil society organization (CSO) 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.[4] Uganda's COP19 priorities reflect the global Strategy and the PEPFAR 2019 County Operational Plan guidance.
PEPFAR Uganda's COP19 will:

- Find the missing individuals and populations, enroll them on treatment and ensure they are virally suppressed.
- Accelerate optimized HIV case finding linked to treatment strategies, particularly to reach men, as 27 percent of Ugandan men do not know their status and are not on treatment.
- Test all new HIV positives for 'recent' infections in order to mobilize prevention efforts at geographic and demographic hot spots.
- Increase safe male circumcision to prevent 300,000 new infections, and advance policies for neonatal circumcision.
- Scale up and out services for KPs across the full cascade, ensuring high coverage for all groups including men who have sex with men (MSM).
- Focus on violence prevention and HIV risk avoidance for adolescent girls and young women (AGYW) aged 9-14.
- Scale up work with indigenous partners, including faith communities and faith-based organizations (FBOs), HIV network organizations, community-based organizations (CBOs), GOU, parastatal and KP-led organizations.
- Ensure all non-service delivery and above-site activities contribute towards epidemic control.
- Make continuous use of granular data (the 'surge,' other programmatic, and survey data) to inform programmatic adjustments and take to scale the electronic medical records and unique identifier systems.
- Increase program impact by ensuring all national policies are implemented and address barriers to accessing services by the most vulnerable.
- Continue to emphasize strong GOU leadership for managing, monitoring and financing the national program.

Achieving epidemic control by 2020 requires prioritizing investments. COP19 will continue to shift resources strategically towards support of public sector health facilities and systems, as the Ugandan public health sector is expected to account for up to 80 percent of new PLHIV initiating ART.[5] PEPFAR will continue to work with the private not-for-profit (PNFP) health sector to deliver HIV/AIDS services. The PNFP sector currently provides 25 percent of comprehensive HIV and AIDS services in country and contributes to reaching HIV epidemic control and sustainable

[4] PEPFAR. *Strategy for Accelerating HIV/AIDS Epidemic Control, 2017-2020.* (Washington, D.C.: Department of State, 2017).
[5] Program data, future projections.

maintenance. COP19 interventions will foster enhanced HIV service delivery by the PNFP sector through direct awards to local Ugandan implementing partners.

PEPFAR Uganda will continue implementing the "surge for quality" as an integral part of our approach to reaching our COP19 objectives. This includes supporting regular reporting of key indicators at site level, weekly implementing partner (IP) engagement, monthly or bi-monthly interagency technical IP meetings, quarterly PEPFAR all-stakeholder's meetings, and other smaller focused meetings (on specific technical issues) as needed. This broad engagement ensures that best practices are shared, and short "learning loops" are used effectively and efficiently to address any implementation challenges.

Internally, the USG is streamlining implementation approaches with a vision of a post-epidemic control scenario where resources will likely decline. To that end, PEPFAR will channel 70 percent of its funds to local institutions to ensure sustainability by COP20. PEPFAR will also streamline the supply chain to bolster the National Medical Stores system and ensure adequate financing for health commodities. Orphan and vulnerable children services will begin to shift to management by one USG agency. Similarly, one USG agency will lead the laboratory and strategic information support.

PEPFAR Uganda continues to emphasize six crucial areas of national 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; and 6) governance, management, and civic participation.

COP19 is a product of substantial input from a variety of stakeholders including the GOU), civil society, the Global Fund (GF), multilateral and other ADPs. Through these engagements, PEPFAR Uganda has been able to close gaps in technical programming, as well as improve multi-sectoral coordination, which will ultimately optimize synergies and harmonize efforts and resources towards epidemic control. COP19 includes an important agreement by the Ministry of Finance Planning and Economic Development to increase financial resources for ARV commodities, an important step towards greater GOU financing of the HIV response and thus sustainability.

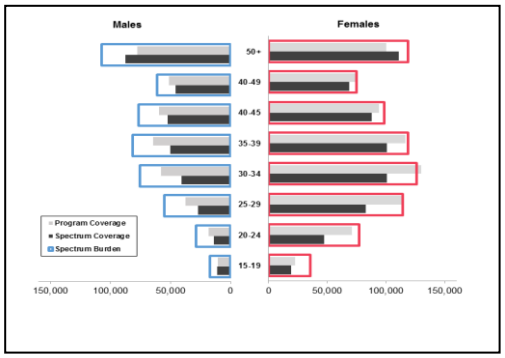
The PEPFAR Uganda program is a team effort, with GOU, development partners including the USG and many different elements of civil society actively engaged in problem solving and celebrating progress. COP19 will bring the country to epidemic control and will lay the groundwork for long-term sustainability.

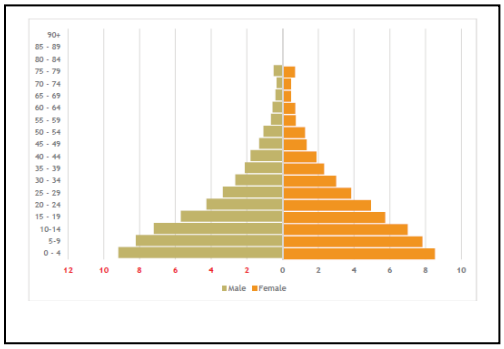
2.0 Epidemic, Response, and Program Context

2.1 Summary Statistics, Disease Burden and Country Profile

In 2017, Uganda had a population of 42.8 million.[6,7] 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.[8] Additionally, the population pyramid demonstrates that Uganda has a large "youth bulge" with 47 percent of the population is under age 15 and 68 percent is under age 24.[9] 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.[10] Almost 60 percent of pregnant women attend four or more antenatal visits (ANC4), 97 percent of pregnant women receive antenatal care (ANC) from a skilled provider, and 73 percent deliver in a health facility.[11] 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 128 deaths per 1,000 live births (2002-2006) to 64 deaths per 1,000 live births (2012-2016).[12] The burden of HIV is more concentrated in those ages 20+.[13]

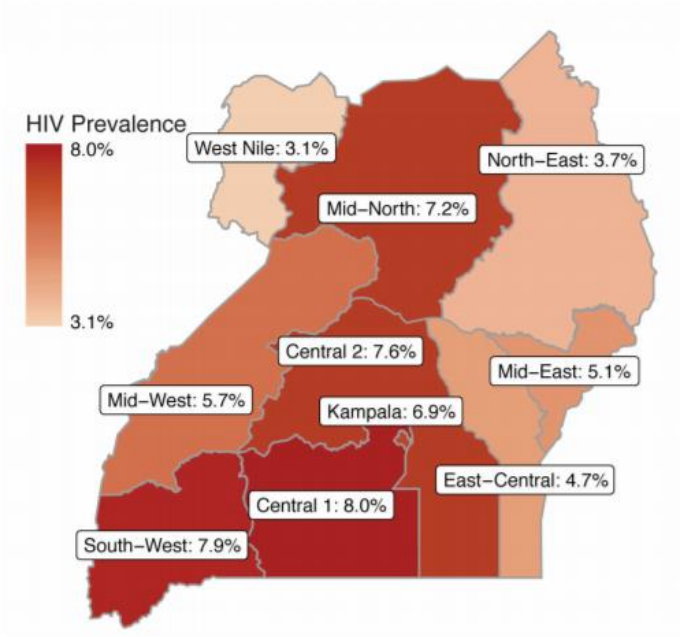
The population pyramid and coverage and UPHIA data





[6] World Bank Data Bank 2017 data for Uganda.
[7] UBOS. *Population Projections 2015-2020*. (Kampala: UBOS, 2014). http://www.ubos.org/onlinefiles/uploads/ubos/census_2014_regional_reports/Population percent20Projections_2015_2020.pdf (accessed 3/6/2018)
[8] 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)
[9] UBOS, 2014.
[10] UBOS, 2017.
[11] UBOS, 2017.
[12] UBOS, 2017.
[13] Unpublished UPHIA data, 2017; UBOS, 2017.

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 poverty threshold that was set over 20 years ago and which is now too low.[14] Poverty reduction in Uganda has been based mainly on agricultural income growth and favorable climactic conditions so economic vulnerability remains high.[15] Uganda's Gross National Income (GNI) per capita is US $600 with an annual Gross Domestic Product (GDP) growth of 4.0 percent in 2017.[16] For Uganda to attain the ambitious goals set forth in its Vision 2040,[17] a fundamental shift in production from low-investment, informal activities to higher capital, more productive employment is required, as is a 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.[18]



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.[19] 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.[20] The Spectrum estimate for the total burden of HIV in Uganda, taking

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[14] 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)

[15] 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)

[16] GNI is per the Atlas method used. World Bank. *Databank: Uganda*. (Washington, D.C.: World Bank, 2018). https://data.worldbank.org/country/uganda (accessed 3/27/2019)

[17] 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).

[18] 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)

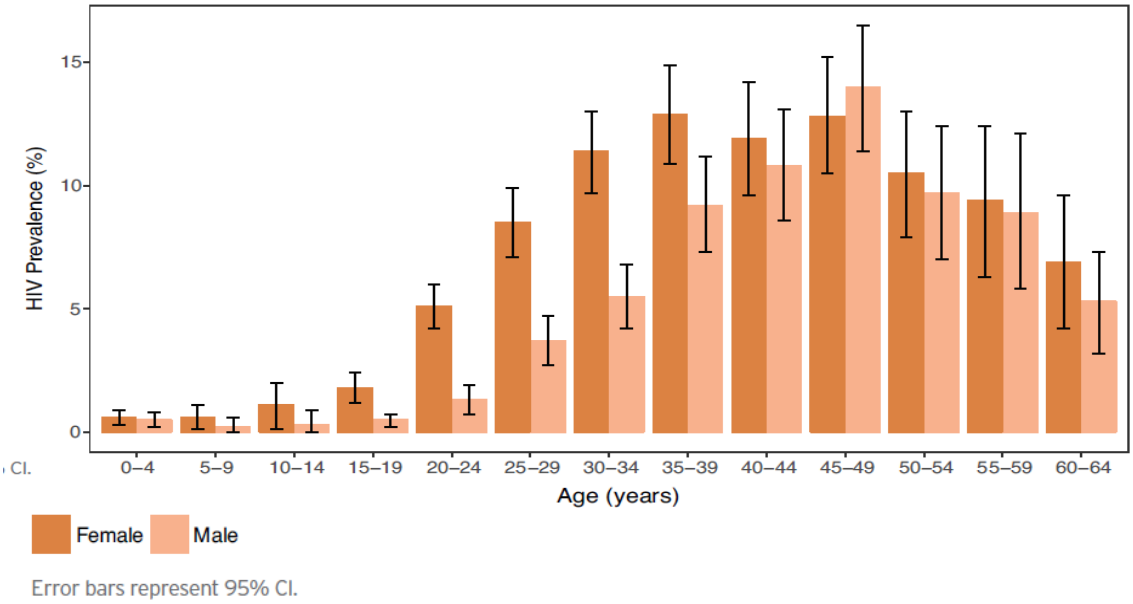
[19] WHO. *Global Health Observatory Data Repository.* (Geneva: WHO, 2017). http://apps.who.int/gho/data/node.main.GHEDCHEpcUSSHA2011?lang=en (accessed 3/6/2018)

[20] WHO, 2017.

into account the most recent UPHIA data, is 1,385,653 in 2019. 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, and delayed sexual debut).[21] 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 young people aged 18–24, 10 percent of girls and 2 percent of boys stated that they experienced forced sex before age 18.[22] 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 four times that of males (0.8 percent in males aged 15-24 versus 3.3 percent in females aged 15-24).[23]

HIV Prevalence by Age and Gender, UPHIA[24]



[21] 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

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

[23] Unpublished UPHIA data, 2017.

[24] Unpublished UPHIA data, 2017.

One in four girls aged 15–19 has begun childbearing.[25] 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.[26]

A national prevalence survey of tuberculosis (TB) was undertaken in 2014-2015. [27] 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.[28] While women sought care more often than men (67 percent versus 53.9 percent), bacteriologically-confirmed TB was more likely to be diagnosed among men than among women (76.2 percent versus 23.8 percent).[29]

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.[30] The MSM population in Uganda was estimated at 46,679 in 2018 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.[31] 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. There is a dearth of data for TGW, however there is indication that they experience high rates of HIV as well as violence. In 2013, a small study was undertaken in Kampala with 45 TGW; 9 were HIV-positive (20 percent), and only 3 were on ART. [32] At this time, PEPFAR Uganda does not have any size estimates for TGW in Uganda.

KPs 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

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[25] UBOS, 2017

[26] USAID. *The State of the Ugandan Child.* (Kampala: USAID, 2015). http://pdf.usaid.gov/pdf_docs/PA00M978.pdf (accessed 3/7/2018)

[27] 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)

[28] PEPFAR Uganda program data.

[29] MOH, 2017.

[30] 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).

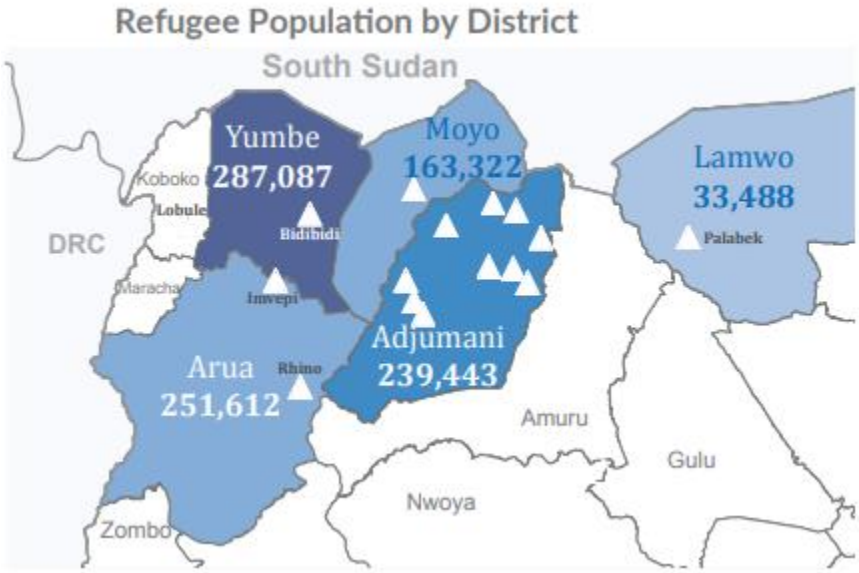
[31] Uganda AIDS Commission. *Uganda HIV Prevention Response and Modes of Transmission Analysis.* (Kampala: UAC, 2009). http://numat.jsi.com/Resources/Docs/UnaidsUgandaCountryReport_09.pdf (accessed 3/9/2018)

[32] 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).

inhibits non-discriminatory service delivery. Sex work and injection drug use are illegal in Uganda, creating challenges in providing services. Transgender Women (TGM) 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, including 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 influences efforts towards epidemic control.

HIV prevalence among the 50,000 prison inmates in 2013/14 was 15 percent.[33] The most commonly reported HIV-related risk behavior among prisoners was MSM activity (both consensual and coerced) and sharing of razors.[34] There are 72 health facilities within the 257 prisons. All offer HIV testing but only 22 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. The FF include SWs, truckers, fishmongers, and traders around the islands. 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.[35] 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.



Uganda hosts the largest number of refugees in Africa (more than 1 million), mostly from South Sudan and the Democratic Republic of Congo (DRC), a situation that further strains local health facilities that provide services for refugees and host communities alike. Indeed, the demand on health workers and the health commodity

[33] Uganda Prisons Services. *Uganda Prisons Service Sero-Behavioral Survey.* Unpublished data. (Kampala: Uganda Prisons Service, 2017).

[34] Uganda Prisons Service, 2017.

[35] 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)

supply is significant. An estimated 15,705 South Sudanese PLHIV were living in Uganda and in need of HIV care and treatment services by the end of September 2017. 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.

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.[36] 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.[37] Of those that knew their status, 90.4 percent were on ART and of those that were on treatment, almost 83.7 percent had VL suppression.[38] In general, people over age 35 and women were more likely to know their HIV status and to be on ART than younger people or men.[39] At FY19Q1, the corresponding estimates of PLHIV on ART and PLHIV on ART with VL suppression based on health facility reports and Spectrum model-estimated HIV burden were 85 percent, 75 percent respectively.[40] This suggests that significant progress has been made in the two years since the UPHIA was implemented. PEPFAR Uganda is scaling up Data Quality Assessments (DQA) of implementing partner (IP) data to ensure program estimates are accurate. PEPFAR Uganda will conduct another UPHIA in 2019 and 2020, which will allow better and timelier information on Uganda's 95-95-95 progress to better focus resources.

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 individuals and to initiate ART on the same day where feasible and acceptable. In COP19, PEPFAR Uganda will work closely with FBOs 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 percent in FY18. Program data reveal that Uganda has much work to do to address the 95-95-95 targets in HIV-infected children. For children aged 0–14, based on UPHIA data of parental reports and detection of ARVs in the blood, only 56 percent were known to be HIV-positive, 54 percent were on ART, and 24 percent were virally suppressed. 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.[41] Medical circumcision is more common in younger age bands (those aged 15-

[36] Unpublished UPHIA data, 2017.
[37] Unpublished UPHIA data, 2017.
[38] Unpublished UPHIA data, 2017.
[39] Unpublished UPHIA data, 2017.
[40] PEPFAR program data.
[41] ICAP/CDC/MOH, 2017.

24), as is the overall prevalence of circumcision.[42] In March 2017, the policy requiring two doses of tetanus toxoid (TT) for male circumcision (MC) was revoked (except for those with the use of the PrePex device, which accounts for less 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 and to 586,167 in COP17/FY18.[43] The voluntary medical male circumcision (VMMC) program has targeted to circumcise 26% percent of the eligible males aged 15-29 in scale-up and attained districts by September 2019.

The Ugandan health system, while relatively strong, continues to suffer from lack of GOU resourcing, human resource absorption challenges and ensuring quality services. 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 is part of the COP19 requirements.

As regards commodities, there is chronic underfunding of ARVs, HIV rapid test kits (RTKs), and many other HIV related commodities, often leading to lower than desired stock levels, some local stock-outs, and commodity insecurity in the public sector. PEPFAR Uganda is filling a major gap in public sector ARVs for calendar year 2018 which will ensure that Ugandans on ART do not experience disruptions in their drug supply. With COP19 funding, PEPFAR Uganda will increase funding to public sector ARV procurement, and GOU will also increase their contributions to $39million for the FY19/20 budget year, up from $26milion.

Progress is being made in terms of domestic resorce moviliztion for the HIV/AIDS national program. In a high level meeting with the Ambassadors from the US and Ireland and the Honorable Minister of Finance, Planning and Economic Development (MPFPED) in January 2019, there was agreement that additional GOU funding was needed for ARVs in the coming year and beyond, as well as a need for GOU to absorb health care workers currently supported by PEPFAR. Subsequently the Minister of Health has requested an additional 50% financing for ARVs in 2019, and MOFPED included $13 million additional resources for ARVs in its revised CY2019/2020 budget request.

PEPFAR will continue work on supply chain reform in 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.

[42] ICAP/CDC/MOH, 2017.

[43] PEPFAR program data.

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	38,823,100		8,720,558	22.5	9,093,320	23.4	4,225,590	10.9	4,012,103	10.3	6,843,352	17.6	5,928,177	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)	23,488														Spectrum estimates 2018
# PLHIV	1,378,085		54,255		55,510		112,542		46,382		651,617		457,779		Spectrum estimates 2018
Incidence Rate (Yr)		400/ 100,000 popn.													UPHIA 2016
New Infections (Yr)	50,274														Spectrum estimates 2018
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.

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	%	
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	198,376														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 Populations)	2,000,000														N/A

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	%	
Fishing Community Prevalence (Adults)	14.9–35														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 95-95-95 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data**					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (percent)	Estimated Total PLHIV** (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (percent)	Viral Suppression (percent)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	38,823,100	4%	1,378,085	1,191,715	1,168,348	85%	62%	9,619,672	282,589	230,114
Population <15 years	17,813,878	1%	109,765	68,766	67,418	61%	52%	609,968	6,085	7,420
Men 15-24 years	4,012,103	1%	46,382	28,657	28,095	61%	58%	2,348,130	63,369	67,728
Men 25+ years	5,928,177	8%	457,779	352,322	345,414	75%	54%	1,342,982	52,491	59,995
Women 15-24 years	4,225,590	3%	112,542	103,535	101,505	90%	53%	3,560,320	98,386	105,296
Women 25+ years	6,843,352	10%	651,617	638,434	625,916	96%	73%	1,758,272	62,258	71,099
MSM	46,679	12.7	5,928							
FSW	198,376	31.3	62,092							
PWID	3,837									
FF	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, over 160,000 people 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

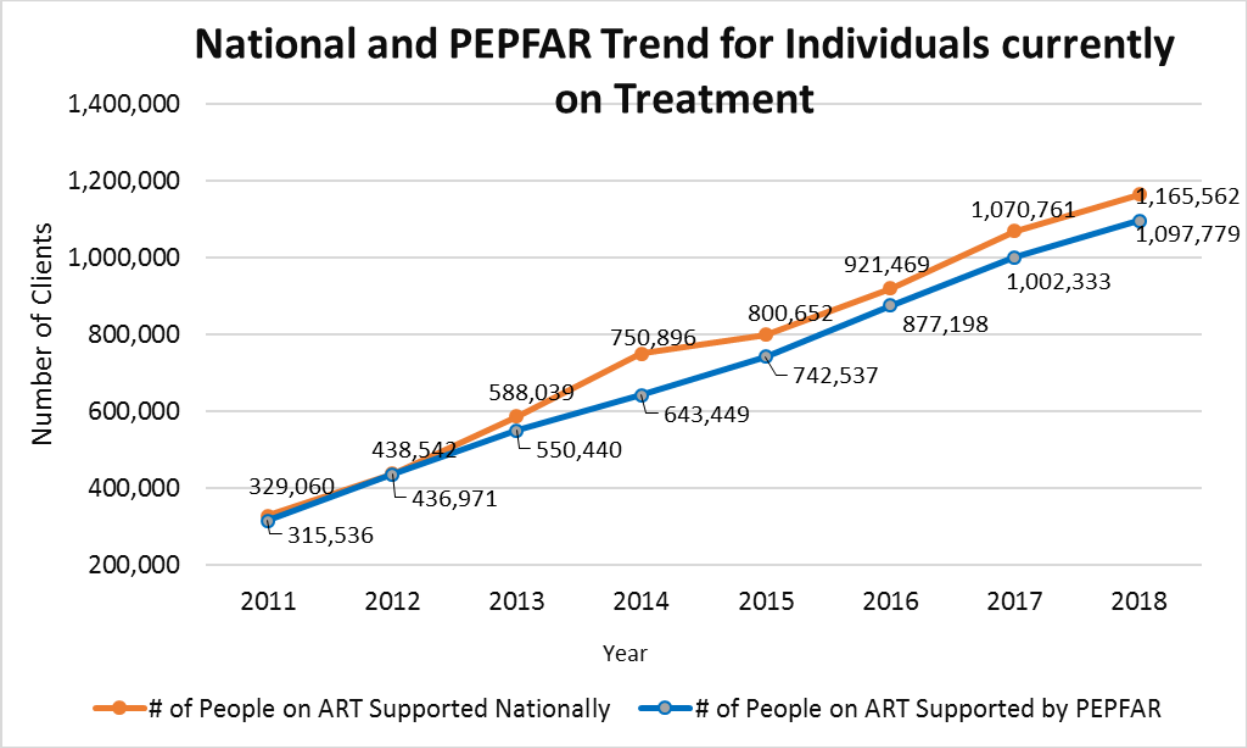
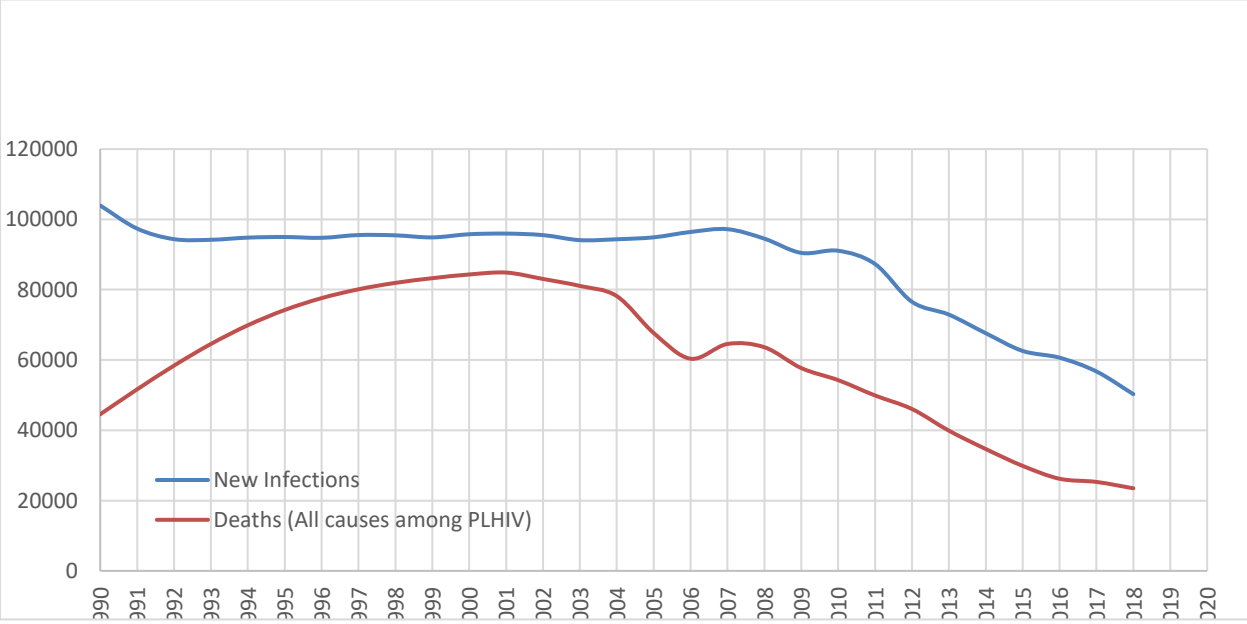


Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV



2.2 Investment Profile

Funding for health in Uganda over the past five to ten years, particularly in nominal terms, is on an upward trend. However, as a proportion of the total government budget, health funding still remains well below the Abuja Declaration target of 15% of national budget allocated to health. The health budget remains between 6-9% of the national budget, and is unpredictable based on national priorities related to roads, energy and the infrastructure sector. With a rapid population growth and refugee influx, Uganda faces increasing challenges in its health sector. Spending in the sector has been concentrated on wages, medical products, and infrastructure to improve health and wellbeing in the country. For FY 2019/20, in nominal terms, the allocation to the health sector is projected to decrease from UGX 2,310 Billion in FY 2018/19 (9.2%) to UGX 2,278 Billion in FY 2019/20 (8.9%).

Uganda's HIV epidemic is considered a mature epidemic that has spanned 30+ years with a multi-sectoral HIV response majorly funded by health and AIDS Development Partners (ADPGs). There has been a significant increase in the actual expenditure over the period FY 2015/16 through 2016/17, largely attributed to contributions from bilateral and multilateral partners. According to the National AIDS Spending Assessment (NASA) Study Report 2018, Uganda spent $433.5 million on HIV/AIDS in 2014/15 markedly increasing by 53.8% ($ 666.8 million) in 2015/16 and to $691.8 million in 2016/17. Most of the funding was spent on care and treatment services particularly health commodities and medical products.

There are increased efforts by GOU to track allocations and expenditures within the health sector and HIV response. The second NASA study was conducted last year covering the period 2014/15, 2015/16 and 2016/17. Study findings will be used for resource mobilization, planning, resource allocation, and management of the national HIV response. Uganda AIDS Commission (UAC) in partnership with Makerere University School of Public Health (MUSPH) are working on institutionalizing the NASA process for future resource tracking.

From the NASA report, about 90% of HIV/AIDS funding comes from external donors (estimated at $ 648.0 million in 2016/17) with Government of the United States of America (USG) through PEPFAR, contributing 99.8% on average over the three-year period from 2014/15-2016/17 for all bilateral funds captured in the report. Conversely, public funding reduced from $65.6 million in 2008/09 to $40.9 million in 2016/17; mainly due to foreign exchange conversion rate and currency depreciation over the years. Private not-for-profit sector contributions fluctuated and amounted to $2.6 million in 2016/17.

To ensure epidemic control and financing for key interventions that include commodities and human resources for health, the GOU needs to prioritize and devise ways to increase its resource envelope committed towards financing the HIV response so as to turn away from heavy dependency for external funding. Alternative GOU financing options that have been on the drawing board and at nascent stages include: the AIDS Trust Fund, National Health Insurance Scheme, private donations, HIV/AIDS mainstreaming in all government sectors, and in the private sector the newly launched "One Dollar Initiative" where the call to action is for every Ugandan to contribute $1 to build a sustained financing tool. . While the legal and policy frameworks for establishment of the HIV/AIDS Trust Fund have progressed, the fund has not been operationalized. Development partners and civil society continue to advocate, engage and support GOU efforts to improve budgeting and public financial management for efficiency, prioritization, resource utilization and

accountability of funds including that for the HIV response. The former additionally provide analytics to support budgeting and planning, to increase health budget including HIV funding. In COP19, the US Treasury Department will embed an advisor in MOFPED to assist in developing a long term HIV sustainability plan, strengthening expenditure tracking, ensuring adequate data for health system policy making and identifying bottlenecks.

Table 2.2.1

Table 2.2.1 Annual Investment Profile by Program Area 2016/2017[44]

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	290,781,439	65%	35%		
Community-based care, treatment, and support					
PMTCT					
HTS	20,890,400	99%	1%		
VMMC	41,690,514	100%			
Priority population prevention	26,969,964	62%	38%		
AGYW Prevention					
KP prevention					
OVC	32,279,599	100%			
Laboratory	17,321,586	71%	29%		
SI, Surveys and Surveillance	8,903,668	99%	1%		
HSS	21,314,297	99%	1%	0.5%	
Total	**460,151,467***				

[44] (Data extracted from preliminary data for the NASA 2018)

Table 2.2.2 Annual Procurement Profile for Key Commodities for the period FY2017/18					
Commodity Category	**TOTAL EXPENDITURE (US $)**	**% PEPFAR**	**% GF**	**% HOST COUNTRY (GOU)**	**% OTHER**
ARVs	$ 133,215,118.05	**41%**	**40%**	**19%**	**0%**
Rapid test kits	$ 11,032,589.00	**27%**	**73%**	**0%**	**0%**
Other drugs (Cotrimoxazole, INH,STI/OI, B6)	$ 7,922,281.00	**59%**	**38%**	**3%**	**0%**
Lab reagents (CD4, GeneXpert)	$ 10,581,724.75	**15%**	**85%**	**0%**	**0%**
Condoms	$ 6,239,405.00	**36%**	**64%**	**0%**	**0%**
Viral Load commodities	$ 21,108,157.60	**100%**	**0%**	**0%**	**0%**
VMMC kits	$ 14,926,243.00	**100%**	**0%**	**0%**	**0%**
MAT	$ -	n/a	n/a	n/a	n/a
Other commodities (EID, Syphilis-duo, RUTF, HIV Self-test kits, Serum, CrAg, TB Masks	$ 7,816,526.60	**66%**	**34%**	**0%**	**0%**
Total	**$ 212,842,045.00**				

Table 2.2.3

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	15,500,000	10,140,000	15	45,775,626	Support programs to improve maternal, neonatal and child health
USAID TB	5,000,000	5,000,000	9	38,377,561	Support programs to reduce TB-related mortality and morbidity
USAID Malaria	33,000,000	6,625,000	9	38,377,561	Support programs to reduce malaria associated morbidity and mortality
USAID Family Planning	29,000,000	16,250,000	15	45,775,626	Support programs to improve contraceptive prevalence and birth spacing.
USAID Nutrition	9,000,000	4,550,000	9	38,377,561	Support programs to improve nutrition
USAID WASH	4,000,000	2,750,000	8	36,148,593	Support programs to improve water, hygiene and sanitation
CDC (Global Health Security)	$3,551,476	$1,680,000	4	$497,718 + Cost Shared	Health Security, prevent, detect, respond to priority pathogens
Peace Corps	$2,220,659	$250,000	0	$2,402,452	PC is its own IM with ~165 PC volunteers in country working on education, health, and agri-business projects
Total					

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	-	-	-	-	-	
VMMC—Central Funds	-	-	-	-	-	
Other PEPFAR Central Initiatives-USAID						
Other PEPFAR Central Initiatives-CDC Agency						
Recency Study	350,000	0	350000	1	100%	•To understand the burden, distribution and transmission dynamics of HIV infections in Uganda, in order to inform prevention interventions for HIV epidemic control. • To provide information for planning, impact assessment and resource allocation for impactful prevention programing.
Key Population Investment Fund (KPIF)	10,000,000	0	10,000,000		100%	• To support scale up of KP-led community approaches to expand and enhance HIV services to deepen reach to KPs with comprehensive HIV services. • To address structural barriers to service access through duty-bearer sensitization to reduce stigma and discrimination, expand availability and accessibility of services for KPs, increase awareness of KP-specific needs • To expand and strengthen existing Drop in Centers • To strengthen capacity of CSOs to improve administrative and financial management, M&E, and grant writing
HOP-TB	375,000					Completion of the household TB and HIV contact tracing study in Kyejonjo district
Other PEPFAR Central Initiatives-USAID	189,294	0		1		Funding for COP19 for FBOs to address Violence Prevention and HIV prevention among 9-14 adolescents
Other Public Private Partnership						
Total	10,914,294		10,350,000			

2.3 National Sustainability Profile Update

PEPFAR Uganda and its partners conducted SID 3.0 in preparation for COP18 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, GF 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 COP19, 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. 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 GF 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 took 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 System (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 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. Human resources continue to be strengthened by roll out of Differentiated Service Delivery Model (DSDM). Absorption by GOU of the central level staff, particularly staff within the national AIDS Control Program (ACP) and Central Public Health Laboratory, ensuring expenditure of the full human resources budget national and resolution of the Community Health Extension Workers (CHEWS) program are key policy issues PEPFAR and the development partners with the GOU are keen to address.

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. PEPFAR Uganda is extensively involved in ARV stock monitoring and management using 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 and to inform decision-making. PEPFAR Uganda completed a National Supply Chain Assessment in 2018 to inform further PEPFAR Uganda and GF investments to the public sector supply chain improvements. As noted earlier, PEPFAR Uganda will begin to harmonize supply chains with emphasis on building one national comprehensive supply system.

In COP19, PEPFAR will work 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 are 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 VL, 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 COP19, these district strategic plans will incorporate the surge strategy, ensuring that core intervention packages are scaled up with fidelity. At the national level, USAID has established Implementation Letters (IL) which detail agreements between the GOU and USG and the respective roles and responsibilities that each 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). While not assessed in the SID, PEPFAR will pay close attention to the investments in national data systems to ensure full ownership and sustainability. This includes the electronic medical records (EMR), unique patient identifiers (UI), case based surveillance and recency testing, which will all be part of a national architecture to improve quality and efficiencies.

Finally, PEPFAR will work closely with the MOH to determine the appropriate role for the Regional Health Facilities, which provide higher level consulting services, and have a potential role to play in sustainability.

PEPFAR Uganda Support to Indigenous Organizations

Non-governmental organizations (NGOs) including smaller civil society organizations (CSO) and private not-for-profit (PNFP) entities and FBOs have been contributing to the fight against HIV/AIDS well before PEPFAR. The AIDS Support Organization (TASO), Joint Clinical Research Center (JCRC) for example were leading Uganda's fight prior to 2003. Additionally, FBOs provided HIV care, treatment and prevention services under the oversight of the Medical Bureaus for each of the respective Catholic, Protestant, Muslim and Orthodox faiths. 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 from 2003 and will be a key element of our sustainability strategy.

Approximately 50 percent of the PEPFAR investments in the country are through indigenous partners, allocated to Ugandan entities and organizations as both prime partners and sub partners. During COP18, this proportion will rise to 65 percent and reach 70 percent by the end of COP19. Organizational capacity assessments, fiduciary oversight and assuring transparency and accountability of PEPFAR resources that are channeled through the indigenous partners will remain a cornerstone of the COP19 implementation.

Currently CDC provides 97% of funding to local (Ugandan) institutions. Since the beginning of PEPFAR, CDC has worked to build capacity of government and non-governmental Ugandan institutions, through the Track 1 transition as an example. Current G2G mechanisms include to Uganda Prison Service, Uganda Virus Research Institute, and renewed agreements with Ministry of Health and Central Public Health Laboratories (CPHL). In COP19, CDC plans to award one or more new agreements with a KP-led CSO as well as a new award to one or more faith-based organizations.

The majority of USAID's current funding to local organizations is through sub-recipient relationships with international organizations, which are prime partners. During COP18 and continuing into COP19, USAID will work towards increasing direct funding to local organizations as prime recipients of this funding. However, USAID will reshape the current program in a measured manner, taking into account Uganda's contextual realities such as the absorptive capacity of local partners and ensuring checks to avoid any fraud, waste, and abuse specifically in local procurement and implementation (workshops, per diem abuse, etc.). In COP19, USAID will have up to nine new local partner awards. These will include two government-to-government (G2G) awards with regional referral hospitals (RRF), an award to manage medical waste generated by the USG-supported VMMC program, two transition awards to local partners that were previously sub-partners under the RHITES mechanisms, a service delivery award targeting the PNFP sector in USAID-supported regions, and four local partners delivering orphans and vulnerable children services.

While a relatively small level of resources, Department of State PEPFAR Small Grants program will provide funding opportunities in COP19 to CSOs testing unique and innovative approaches in HIV

prevention, treatment and advocacy, including support to CSOs engaging People With Disabilities (PWD), key populations, adolescents and men.

Figure 2.3.1: COP Funding to Indigenous Entities

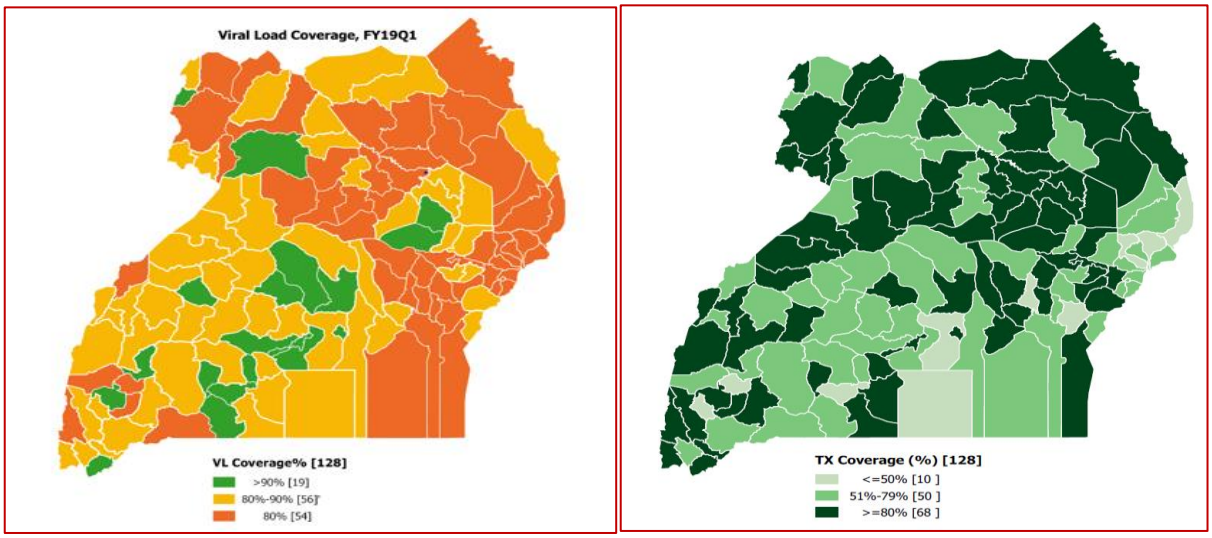
Agency	COP17 Total Planned Funding	COP 17 Funding to Indigenous Organizations	%	COP18 Total Planned Funding	COP 18 Funding to Indigenous Organizations	%
USAID	$133,105,519	$37,881,407	28.50%	$129,836,720	$27,333,062	21.10%
CDC	$188,244,651	$183,755,613	97.60%	$170,823,791	$166,219,680	97.30%
DOD/WR	$9,490,422	$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%**

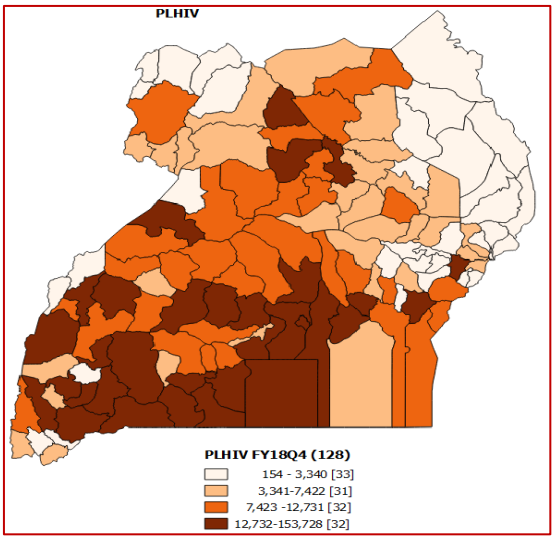
2.4 Alignment of PEPFAR Investments Geographically to Disease Burden

PEPFAR Uganda used Spectrum district level estimates of PLHIV and program data coverage to adjust geographic prioritization and focus of both clinical and prevention activities for COP 2019. To further guide these geographic and programmatic strategy revisions, planned COP 2019 spending was aligned to the current burden, current on treatment and gap to getting to 95-95-95

As displayed in map of burden below, districts in Central One and South West have high numbers of PLHIV and have not reached 95% coverage and therefore will increase activities and expenditure in COP2019 in these districts.

Figure 2.4.1





2.5 Stakeholder Engagement

PEPFAR had extensive external engagements throughout the previous calendar year and during the COP19 planning process. From January 2018, PEPFAR Uganda launched quarterly stakeholder's meetings to include representatives from the GOU, AIDS and Health Development Partners, Implementing Partners (IPs) and a wide range of civil society actors. Government of Uganda participation included: Office of the President and Office of the Prime Minister, Ministry of Health (MOH), Ministry of Education and Sports (MOES), Ministry of Gender, Labor and Social Development (MOGLSD), Uganda AIDS Commission (UAC), the Uganda People's Defense Forces (UPDF) and Ministry of Local Government (MOLG). PEPFAR maintains close relationships with WHO, UNAIDS and the UN family, Irish AID, Department for International Development (DfiD) and other bilateral development partners through formal AIDS and Health Development Partner coordinating structures that meet monthly. USG also engages closely with the GF through the Geneva based portfolio manager and the local Country Coordinating Mechanism, where USG is a voting Executive Council member and sits on all three GF committees. Civil society in Uganda is extremely diverse. The USG engages primarily through representatives from International Community of Women living with HIV Eastern Africa (ICWEA), Sexual Sex Minorities Uganda (SMUG) and the Coalition for Health Promotion and Social Development (HEPS) (organizations that were elected by peers to represent CSOs in PEPFAR Uganda engagement) as well as other major Ugandan national NGO/CSO networks. During COP 17 implementation, the International Community of Women Living with HIV in Eastern Africa (ICWEA) was selected by civil society organizations themselves to play the lead coordination role for engagement with PEPFAR.

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 GF, the Health and AIDS Development Partner Groups, the UAC Partnership Committee, and the Health Policy Advisory Committee. PEPFAR Uganda continues 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. From March 2019, USG has facilitated informational, planning and coordinating meetings regarding HIV/AIDS support to the Karamoja Region. In April 2019 the Ministry of Health, AIDS Control Program convened a Karamoja coordination meeting to lay the groundwork for increased USG presence for treatment expansion and viral suppression in the region.

At the higher political leadership level, PEPFAR Uganda will continue to engage with the Office of the President, Office of the Prime Minister (OPM), Office of the First Lady, Ministry of Finance, Planning and Economic Development (MOFPED), MOH, Ministry of Public Service (MOPS), MGLSD, MOLG, MOES and UAC. Key areas of engagement at the political, policy and technical levels include increasing domestic financing for health and the HIV response; rapid adoption and implementation of new policies; supply chain management; human resources for health; strategic investments in data and laboratory systems, and leadership and governance of the HIV/AIDS response, as well as protection of human rights.

PEPFAR Uganda will continue proactively to solicit input from the GOU at multiple levels regarding their goals, priorities, targets, and budgets while implementing the COP19. Meaningful engagement will also continue during COP19 finalization and approval, implementation and planning for COP20. PEFPAR Uganda will share the final COP19 content and implementation strategy during the Q2 PEPFAR Stakeholders' Meeting in April 2019. Civil Society, GOU, Development partners,

bilateral and multilateral donors will be engaged in quarterly pre-POART call review sessions to assess progress against targets and any policy or programmatic challenges.

COP19 implementation will begin to increasingly transition leadership and financing of the national program to the GOU and local partners. External engagements will be critical as the Ugandan government assumes greater ownership of the HIV responses; the sustainability of this ownership will rely heavily on GOU investing in health, and civil society partners to advocate for the health needs of their constituents. PEPFAR will continue to support capacity of local CSOs to meet this challenge, better preparing them to play a leadership role now and in the future.

PEPFAR Uganda has engaged stakeholders intensively in COP development and review. For example, selected 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. Prior to COP submission, PEPFAR Uganda will share key documents including the Strategic Direction Summary (SDS) and final targets with key stakeholders for their final feedback. PEPFAR Uganda will continue to implement a multi-stakeholder engagement process to include state and non-state actors during COP19 implementation and through COP20 planning. Further USG will continue holding pre-POART review sessions with stakeholders to review quarterly data and develop jointly owned solutions.

PEPFAR Uganda will continue to hold quarterly interagency stakeholder meetings, led by the US Ambassador and facilitated by the PEPFAR Coordination Office. The interagency team will continue to hold monthly or bi-monthly joint care and treatment, HTS, KP and other technical area IP meetings - along with MOH - to review data, address challenges and policy issues, and scale up best practices across partners. CSO representatives through ICWEA and other development partners will be invited to attend these monthly/bimonthly sessions to enrich results.

COP19 was the first year that CSOs developed their own version of COP called the "The People's Voice Uganda: Community Priorities" (Appendix G). Through pre and post-RPM meetings, PEPFAR and CSOs agreed on a number of policy and programmatic actions including continued engagement with MOH to revisit the written consent form for DTG initiation; investing in human rights work for KP (using KPIF funding); human rights, justice and advocacy training for LGBTQi under a USAID human rights mechanism; and PEPFAR small grants for People With Disabilities among other areas. Detailed agreements are in the attached 'CSO People's COP19 Checklist', (Appendix H).

Below is the CSO engagement calendar for COP19 planning.

CSO COP19 Engagement Calendar:				
	PEPFAR Team Action	Stakeholder Action	Dates	Status
1	Distribute critical data and COP 19 materials including; • Draft COP guidance; • PEPFAR Solutions Platform, • COP18 SDS; • Q4 results via spotlight; Q4 POART overview slides; • SIMS Outcomes(Above PSNU level)	Analyze materials to prepare for COP 19 discussions at strategic planning retreat; identify areas of successful performance that can be leveraged going into COP 19 and identify any activities that should not continue (site level and above service delivery investments) Receive POART slides	January 2-26, 2019	PCO Shared Draft COP 19 guidance; COP18 SDS; Q4 results and Q4 POART overview slides. Completed successfully
2	Organize and facilitate KP specific retreat	KP led CSOs participation in one day KP Prevention Strategic Retreat	Jan 15, 2019	KP led CSO meeting held
3	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, 2019	Event held, CSOs provided feedback and input into COP priorities for HIV prevention and care and treatment.
4	Meeting with MOH and MoF, MOD, MGLSD	PCO and Agency Heads attend as GOU shares its projected plans	Tuesday, January 22	Completed
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.	Wednesday, January 23	Event held, (Smaller group discussions to cater for all targeted groups)
6	Arrange for stakeholder participation in the COP19 RPM	Actively participate in COP19 RPM, provide feedback on approaches, strategies and targets	Thursday 28th 2019	Completed
7	Interagency IPs Meeting to consult on COP19 and share feedback on RPM	Actively participate in COP18 consultation and provide feedback on technical and management approaches.	March	Completed
8	Invite stakeholders to post RPM consultation to discuss RPM outcomes and strategies for finalizing 2019 COP submission	Actively participate in Post RPM consultation, ask questions, seek clarification and make recommendations.	March, 2019	Completed
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 20, 2019	Completed
10	Provide SDS and final target data	Review all materials	March 22, 2019	Completed
11	Reconcile H/Q and stakeholder feedback, if submission is not aligned with COP 19 Meeting agreements Arrange for GOU government participation in COP approval meeting	GOU officials actively participate in COP E-approval meetings and continue communicating with PCO	April 15 and May 7, 2019	Completed
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, 2019	Completed
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, 2019.	CSOs participated in Q4 pre-POART meeting; PEPFAR Uganda provided written responses to CSOs Feedback on the COP18 Q4 Results held Jan 12, 2020. POART calls dates in draft.
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	On going
15	Sharing and receiving feedback to the CSO people's COP 19 checklist	USG and CSO share inputs and COP 19 agreements with reference to the CSO developed People's COP 19 Checklist		Completed

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. At that time, disease burden estimates were calculated for each district 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.[45] At that time, half of Uganda's now 122 districts had prevalence above the then-national average of 7.3 percent.

Table 3.1

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/ percent of all PLHIV for COP19**	**# Current on ART (FY18)**	**# of SNU COP18 (FY19)**	**# of SNU COP19 (FY20)**
Attained	499,117	593,780	31	44
Scale-up Saturation	417,934	296,487	22	33
Scale-up Aggressive	377,801	221,087	31	22
Sustained	68,433	44,334	28	18
Central Support	30,175	18,350	10	11
Total	**1,393,460**	**1,179,586**	**122**	**128**

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 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 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 high-burden districts, and five low-burden/high-prevalence districts selected based on the presence of KP/PP and proximity to high-burden districts. Two additional clusters were added in COP19.

After correcting for the program data overestimation identified by UPHIA, at the end of September 2017, Uganda had an ART coverage of 75 percent. With a revised Spectrum burden estimate using UPHIA data of 1,378,085, Uganda had an estimated overall ART coverage of 85 percent at the end of COP18 and by the end of COP19 ART, coverage will reach 95 percent (see above figure). Attained districts are those that have 90 percent ART coverage across 10 age bands. 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 data

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

quality assessments (DQAs) and reporting improvements, Uganda will be better placed to measure attained status across the 10 age bands. For FY20, 44 districts have been targeted to be attained.

It is expected that in calendar year 2019 Uganda may 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 reallocate resources to bring the new districts on board and shift targets.

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

As in COP18, the 'Surge for Quality' to enhance quality and improve programs will continue and expand. The program is now fully integrated as an MOH-led National Quality Improvement Collaborative, thus institutionalizing the concept of the original 'surge' into the national system. Surge for Quality continues to build upon the weekly reporting platform and now includes key indicators for HIV testing, treatment, TB prevention and treatment services, VMMC and commodities. Deeper work is carried out to track the retention/back to care activities at site level to better inform progress in adherence and viral suppression.

Over 800 sites, covering more than 80% of the HIV burden in the country, are implementing surge for quality and implementing with fidelity interventions to increase 1) identification of undiagnosed PLHIV, 2) linkage to treatment, 3) retention and adherence of those individuals on ART, 4) meeting VMMC targets, 4) TPT uptake and 6) TLD transition. An average of 752 sites complete weekly reporting. The number of sites is an increase over the prior year of surge. Additional sites have been identified by IPs as they roll out best practices learned from original surge sites to additional sites. The original indicators included in the weekly dashboard (HTS_TST, HTS_POS, TX_NEW, VMMC and stock outs) has also expanded and includes TB cases and TPT, TLD initiation, and adherence to second visit after being initiated on ART. Data are submitted each Wednesday and reflect the previous calendar week. The weekly 'surge for quality dashboard' is shared with implementing partners and the MOH.

All of the relevant minimum program requirements have been met and will be detailed in the following sections. Additional new programs include a new Health Resources Services Administration (HRSA) program for Clinical Skills Sharing that will place US health care workers from variety of health care fields in high volume health facilities beginning May 2019 and continuing in COP19. The HRSA selected US clinicians and health care workers will collaborate with their Ugandan peers and jointly solve retention system issues.

Key Population programs will markedly expand, as will VMMC activities. DREAMS programs will not expand geographically however focus will be on saturation and quality outcomes. HIV Testing approaches have already begun to change markedly, and in COP19 will focus on case identification, with targeted testing strategies in the majority of groups.

4.1 Finding the missing, getting them on treatment, and retaining them ensuring viral suppression

As of December 2018, there were an estimated 1,378,085 PLHIV in Uganda. Approximately 1,169,453 (85 percent) have been diagnosed and 1,165,562 (85 percent) are on treatment.[46] Of those on treatment, 855,485 (62 percent of all PLVHIV) have attained viral suppression. Reaching these remaining undiagnosed positives requires ingenuity and the use of the most efficient approaches.

As we near epidemic control, the most accurate epidemiological and program data are required to inform targeting and to tightly focus the program for maximum impact. UPHIA 2016 data showed that program data overestimated coverage by as much as 15 percent. Improvements have been shown after PEPFAR implemented quarterly regional data cleaning and conducted DQAs.

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 program data. In addition, KP indicators were excluded from the HMIS. USG will utilize the HIBRID system to collect KP data, while also advocating for inclusion in the DHIS. In addition, PEPFAR will triangulate with other available KP data within and outside PEPFAR.

COP19 reflects Uganda's bold move to implement a highly targeted program to improve testing yield. While the COP19 testing target (3,206,793) reflects a 23 percent decrease from the FY18 target, the TST_POS target reflects a 40 percent increase over the FY18 target. The FY19 TST_POS target was derived from the TX_NEW of 182,305 needed to reach 95 percent treatment coverage. Index testing, including assisted partner notification (APN) will be the main approach to the PEPFAR Uganda testing program, and will account for 32 percent of the total positives to be identified with an average yield of 26 percent. The yield of 26 percent from the index testing is achievable based on historical data from APN initiatives that were rolled out in FY18. In addition to partners of newly identified HIV positive, efforts will be made to ensure that all patients currently in care have their partners and children identified and notified. In COP19, we shall continue to roll out and expand access to self-testing, targeting partners of all HIV-positive women and KP.

Based on historical program performance, the remaining TST_POS target was distributed across the other testing and service delivery modalities as follows: Other Provider-Initiated Counseling and Testing (PITC) (projected at around 25 percent with an anticipated yield of around 10 percent); VCT mobile/community approaches (11 percent with a targeted yield of 15 percent); in-patient wards (2 percent with a yield of 10 percent); and STI clinics (1 percent with a yield of 10 percent). Historically, testing in outpatient departments (Other PITC) has a low yield, but has contributed to more than 50 percent of the total HIV-positive achievement in Uganda due to high volumes of testing.

In COP19, the PEPFAR Uganda will improve efficiency at outpatient departments (OPDs) through eligibility screening for both adults and children with higher target yield of 10 percent. Eligibility screening tools will be actively monitored in all facility-based services in order to improve yield.

[46] PEPFAR program data, FY18 Q1.

These tools will also be applied in VMMC settings where only boys 10-14 years of age screened and found to be at a heightened risk of HIV exposure will be offered an HIV test.

Finding and reaching epidemic control among Children and Adolescents

The prevalence of HIV among children <15yrs in Uganda stands at 0.5 percent. By the end of Q4 FY2018, there were 109,765 children <15yrs estimated to be living with HIV in Uganda. Of these 67,418 were receiving ART (61 percent) and 57,474 (52 percent) were virally suppressed. In the same period, 93,801 adolescents 10-19yrs were estimated to be living with HIV, with 61,525 (66 percent) receiving ART and 46,075 (49 percent) virally suppressed.

Given the above data, a large number of children and adolescents remain unidentified. In COP19, PEPFAR Uganda will continue to focus on identifying the missing children and adolescents, linking them to treatment and ensuring that they are virally suppressed using proven, effective and efficient strategies to enable us achieve the 95-95-95 goals by end of FY 2020.

Identification of missing HIV cases in all age groups is the critical starting point to achieving these goals. In FY18, 66,445 HIV-exposed infants received an EID test within 12 months of age, translating to an EID coverage of 82 percent. By the end of FY19 Q1, EID1 (0–12 months) coverage had improved to 88 percent. Despite this improvement in overall EID coverage, the proportion that received an EID test within 0-2 months of age is still very low (51 percent). It is conservatively estimated that in FY18 about 415 HIV-positive infants were not identified based on the FY18 EID coverage of 82 percent. This number has slightly decreased from the 600 infants estimated to have been missed in FY2017.

Infants and Children

In COP19, PEPFAR Uganda will support interventions to further improve the overall coverage of EID 0-12 months to 95 percent with 80 percent targeted to receive the EID test within 0-2 months. These interventions will also increase the opportunity for early initiation of ART for HIV-positive infants and improve linkage from EID to ART initiation. In COP2019, 20% of EID will be done through the POC platform, and improvements made in the existing EID diagnostic static locations. EID POC will improve EID coverage especially for infants identified from alternative entry points (pediatric and nutrition wards) as well as improve linkage to ART for HIV positive infants. PEPFAR will assess the EID POC system and will consider expanding POC testing should results be positive and cost effective. Additionally, PEPFAR Uganda will continue to support implementation of pre-registration at mother-baby care points (MBCP) from 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. The quality of EID/Expanded Program on Immunization (EPI) integration will also be improved through institutionalizing review of child health cards at every visit to assess for the child's HIV-exposure status and actively link them (and/or their mother) to testing if indicated. We will leverage the OVC program to identify mothers with infants in the OVC program with unknown status who never delivered from the health facilities as well as malnourished infants and link them to EID services.

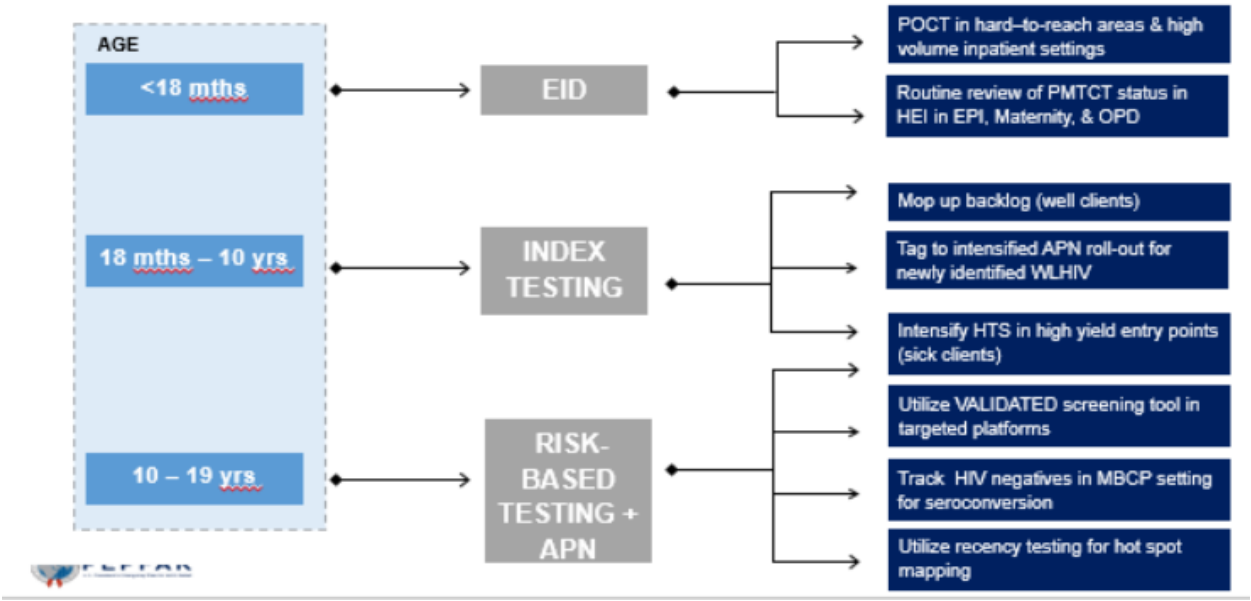
Case identification among children will use different strategies for sick and well children. For sick children, PEPFAR will continue to support testing of all children at high-yield entry points including pediatric inpatient wards, TB units, and malnutrition treatment centers. Within the outpatient department, children will be screened for eligibility for HIV testing using a validated pediatric HIV testing screening tool and only those found eligible will be offered an HIV test.

Adolescents

PEPFAR will support identification of HIV infected adolescents through a peer led approach. We will use the Young people and Adolescent Peer Support (YAPS) model to scale up peer led index testing, including APN for the sexually active adolescents. We will support the use of HIV Self testing to identify adolescents and use the YAPS peers to distribute the HIV self-test kits and link the positives back to facilities for confirmation. We shall implement social network strategies in urban centers to locate adolescents at the highest risk of infection and offer them HTS. In order to accommodate in-school adolescents, we will support sites to provide flexible HTS, including during weekends and holidays. Given the high rates of seroconversion among pregnant and breastfeeding adolescents, we shall follow up with pregnant and breastfeeding adolescents in ANC/MBCP to identify those who seroconvert and link them to treatment. We will use recency testing results for adolescents to map hot spots of transmission and to better target our HIV testing services. Adolescents on the OVC platform will be screened for risk for HIV using the girl roster tools and the HIV screening tool. Those eligible for testing will be linked to HTS, counseled on the importance of partner testing and supported to reach out to their partners for HTS.

PEPFAR will support demand creation for pediatric HIV testing services through the development and dissemination of messages targeting parents and caregivers to bring children, particularly well children, for HIV testing. We will take advantage of social media platforms to reach out to the adolescents with messages on HTS and will use faith-based platforms to promote messages on pediatric and adolescent HTS.

Figure 4.1.1. Case finding approach for children and adolescents



By end of Q1 FY 2019, linkage among children <15yrs was 102 percent and was 98 percent among adolescents 10-19yrs. In COP19 we will continue to support the scale up of a package of linkage interventions, which has been proven to be effective. This package includes:

- same day ART initiation;
- use of phone calls and/or home visits to follow up clients who are not ready to initiate ART on the same day;
- use of ARV starter packs for HIV positive clients identified outside the facility;
- client locator forms to track linkages and ensure successful referral;
- use of physical escort of clients by the linkage facilitators; and
- supported disclosure.

This package will be tailored to the needs of adolescents by utilizing the YAPS peers to support linkage for the adolescents.

Twelve-month retention among children and adolescents <15 years is suboptimal at 78.3 percent (APR18 program data). PEPFAR Uganda will support efforts to improve retention through adoption of appropriate Differentiated Service Delivery Models. Children who are stable on ART will be enrolled in family-based service delivery models and will benefit from multi-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, PEPFAR will support roll-out of the YAPS model as a differentiated service delivery model to improve retention among adolescents and young people through peer led psychosocial support. Through this model, YAPS peers will provide adherence counseling and support, including supporting peers with disclosure. YAPS peers will also work with facility staff to identify adolescents who have missed appointments to track and bring

them back to care. PEPFAR has allocated $2,850,737 to support the roll out of this model in 43 high burden districts in COP19 and will expand to more districts in COP 20.

Additionally, PEPFAR will support roll out of the initiation and retention package through the MOH-led Quality Improvement Collaborative platform (see details under section on Women 15+). Through this initiative, there will be intensive monitoring of early retention for children and adolescents including the use of a custom second visit indicator. Uganda has allocated US$546,915 (under the Direct Service Delivery budget) to the care service package in an effort to improve early retention activities.

Several ongoing activities to improve retention that were funded under COP18 will continue to be supported under COP19, including mentorship for supported disclosure; alignment of appointments to school holidays; peer support groups; a dedicated space or day for adolescent-focused care; an adolescent focal person at each facility; and linkages/referrals to community services and programs including those addressing and preventing violence against children.

We shall leverage the OVC program to support HIV+ pregnant adolescents to ensure retention in care. The program will support social protection services to address factors that deter these adolescents from continuing to seek care and treatment. HIV exposed infants will be targeted with early childhood development services at the MBCP and family support group meetings. This approach will support retention of the infants in care as the mothers will be gaining skills and knowledge on childhood development and growth.

For children, the program will work with caregivers to empower households to provide basic needs for children on ART including transport to the facility for drug refills. The program will further work with social and parasocial workers using case management visits to identify challenges at household level and support them with plans to respond to factors hindering adherence. Finally, adolescents will be supported to continue using safe spaces.

Whereas there has been improvement in viral suppression among children and adolescents over the last year, viral suppression rates among children and adolescents have continued to lag behind those of adults. Viral suppression rates currently stand at 73 percent among children and 75 percent among the adolescents. In order to address this, PEPFAR Uganda will support optimization of ART regimens for both new and existing children and adolescents on ART. This will include starting all newly enrolled children and adolescents on Lopinavir or Dolutegravir (DTG)-based ARV regimens with optimized nucleoside reverse transcriptase inhibitors (NRTI) back bone (ABC/3TC or TDF/3TC). We shall ensure that the children receive the appropriate lopinavir formulation for their age and weight. Existing children and adolescents already on ART who are virally suppressed will have their ARV regimens optimized as above by 2019 calendar year end. We shall ensure that nevirapine is completely phased out by December 2019. A regimen optimization checklist has been developed and distributed to all sites to support this process, and IPs will be mentoring sites to implement a systematic process to identify and transition all children as quickly as possible once sufficient commodities have been secured.

Additionally, PEPFAR will support implementation of pediatric and adolescent service packages to enhance adherence and retention, mentorships for VL switch teams to promptly identify and switch failing children and adolescents, and quality improvement interventions to improve the VL cascade.

We will support sites to use the YAPS model to provide peer-led psychosocial support, including adherence counseling and support, disclosure and stigma reduction for the adolescents. PEPFAR will continue to prioritize non-suppressed children and adolescents for enrollment into OVC programs. Finally, children are a critical focus of the national QI collaborative aimed at overall improvement in viral suppression (see section on Women 15+ for details).

Finding and Reaching Epidemic Control among Men 15+

The Uganda HTS program is well aligned with the epidemic, with targets assigned based on ART coverage. Geographically, 64 percent of the total positives will be identified in districts with more than 70 percent ART coverage, the majority of whom (72 percent) will be men. In addition, most of the positives will be identified in the high burden regions of Kampala, Central 1 (Kalangala, Masaka, Mpigi, Rakai, Lyantonde, Sembabule, Gomba, Lwengo, Bukomansimbi, Kalungu, Butambala and Wakiso districts) Central 2 (Kayunga, Kiboga, Luwero, Nakaseke, Mubende, Mityana, Mukono, Nakasongola, Kyankwanzi, Buikwe, and Buvuma districts), and Southwest (Bushenyi, Sheema, Buhweju, Rukungiri, Kanungu, Kabale, Kisoro, Mbarara, Ibanda, Isingiro, Kiruhura, Rubirizi, Mitooma, and Ntugamo districts).

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. Coverage is lower among younger men, with only 26.5 percent diagnosed, 22.2 percent initiated on ART, and 12.3 percent virally suppressed. UPHIA also reports that just over half, 54.7 percent of men aged 25–34 know their HIV status, and that the highest numbers of new infections are occurring in men aged 35–39, while men aged 25–39 have the highest unmet need for ART. There is also evidence of an increase in unmet need for ART among men in Central Region. 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. PEPFAR Uganda program data indicate that, as of September 2018, 73 percent of HIV-infected men had been diagnosed, 73 percent were on treatment and 52 percent had attained viral suppression. COP19 will prioritize shoring up access to HIV services for men building on the initiatives being rolled out in COP18 as part of the surge strategy. We will continue to aggressively reach more men by supporting interventions to reach men 35-49 years, who have been identified as the highest-risk age bracket by UPHIA. This will be achieved through male PP champions and male age-specific dialogues to optimize identification and linkage. Particular emphasis will be on KP and PP groups, which are predominantly male, including prisoners, policemen and private security guards, FF and truck drivers.

HIV testing services for men will be differentiated by age and population sub-groups (segments). Throughout FY 19 through to COP19, the male population in each district will be profiled 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 COP18 through to COP19 are:

- Index client testing with APN. This intervention will be prioritized for reaching men, with 70% (43,626/62,406)of the total HTS_TST_POS target allocated to index testing accruing from adult men (15 years and above); and 36% of total adult men HTS_TST_POS target allocated to index testing. Tracking of exposed men will be highly prioritized at PMTCT settings and ART clinics with women who are unsuppressed and/or with new HIV risk.
- Improved, risk based facility testing at critical service delivery points with 43% contribution to total HTS_TST_POS adult men target
- Highly targeted community testing with 18% contribution to total HTS_TST_POS adult men target
- HIV self-testing

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

According to UPHIA, HIV incidence and prevalence in 15-19-year-old boys is very low (approximately 0.2 and <2 percent, respectively). 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 young and adolescent boys will mainly be done in the facility and on the VMMC platform using a risk-based assessment. 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 will be screened for HIV test eligibility (using the Pediatric and adolescent HCT screening tool) prior to HIV testing. Testing at other critical entry points, including in-patient, TB, and STI wards is currently done without risk 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 to track, and link them to care and treatment. With the exception of 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 and peaks at 40-49 years. HIV testing in this age group will be maximized through APN, improved facility-based testing, HIV self-testing and targeted community testing. In COP18 PEPFAR is working with IPs and sites to scale APN beyond surge sites, accelerate HIV testing for adult men at all HTS entry points, and minimize missed opportunities. We have planned to optimize opportunities for reaching men through PMTCT, OVC, and VMMC settings.

IPs are conducting 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 facilitate women testing HIV positive to access APN services.

Micro-targeted testing in the community is based on rigorous data analyses to determine geographic areas of elevated burden. Recency testing will be rolled out in COP19 and will provide additional data to inform targeting of services at community level. IPs will be further supported to continue assessing the HIV burden up to the sub-county level and to prioritize those geographic locations with the highest need.

Multiple platforms will be leveraged to reach men aged 20+, 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. Targets for HIV testing yield have been elevated in COP19, which reckons the need for improved micro-targeting, refinement of index testing, revamping peer-peer approaches and geo-mapping at the community level, including intensified identification of hot spots. 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. In COP19, we will continue to 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 review data on identification and linkage on a daily basis and share reports with IPs. Parallel reporting dashboards and portals established in COP17 and fully operationalized in COP19 will continue to be used to allow for real-time sharing of data, which PEPFAR Uganda 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 aged 20+, including men from KP/PP, and the 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.

Linkage and ART Initiation

COP19 will also ensure that, once diagnosed, men are counseled and linked to ART and retained in care with suppressed VLs. We will target a linkage rate of 95 percent for all newly diagnosed men. Key interventions to improve linkage for men aged 20+ will include:

- same day ART initiation;
- use of starter packs for individuals diagnosed outside of facilities;
- intensive counselling and review of client readiness to initiate;;
- physically escorting individuals to ART units within the facility;
- strengthening and increased use of community structures;
- phone call and mobile application reminders; as well as
- use of client locator tools.

To support newly identified HIV-positive men seeking services, COP19 will continue to prioritize male friendly approaches including intensified use of male peer linkage facilitators, training and recruitment of age appropriate male counsellors, scaling up differentiated service delivery models (DSDM) and reducing waiting time at facilities. The program will continue to emphasize and monitor the scale-up of proven interventions while ensuring fidelity and quality.

Retention and Viral Suppression

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 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 up include quality, age-appropriate adherence counseling by age- and gender-specific peers, pre-appointment reminders, adolescent/youth focused clinic hours, linkage to community support groups, and rapid back to care engagement by expert clients for individuals who missed their scheduled appointments. Additional interventions tailored to the specific needs of men, especially young men, to be introduced and taken to scale include peer-driven DSDM for adolescents and youth (modeled after the Zimbabwe Zvandiri model) and active tracking/case management of newly initiated young men. For older men, root cause analyses will be conducted as part of the retention quality improvement collaborative to identify underlying reasons for the losses in order to inform contextual interventions that might be needed.

In FY17, for men overall, VL coverage was 63 percent, with 87 percent VL 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). PEPFAR Uganda will continue in COP19 to monitor and fast track the scale-up of the PEPFAR-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 use 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.

The MOH has taken the lead in establishing Quality Improvement Collaboratives to address the gaps in retention and viral suppression. Partners support facilities to identify improvement aims, implement change packages, and develop systems to address identified barriers. Districts and

regions provide QI coaching and conduct learning sessions to share best practices. Progress can be tracked using this link: https://qidatabaseug.urc-chs.com

Finding and 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. 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. 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). Women aged 20–29 also have the greatest unmet need for ART. For women, the largest unmet need for ART falls geographically within four regions: Kampala, Central 1, Central 2, and Southwest.

APR18 program data demonstrate that almost twice as many women living with HIV (WLHIV) are being identified compared to men. About 50 percent of newly-identified pregnant WLHIV were under the age of 24. In FY19 Q1, 50 percent of newly-identified WLHIV were in regions with the highest unmet need for ART, with the highest yield (3.8 percent) and volume identified among women aged 25–49, closely aligning geography and age with highest unmet need.

Identification, linkage, ART initiation, retention and viral suppression for non-pregnant women aged 15+

Identification: APR18 program data demonstrated that 168,314 women aged 15+ were identified as HIV-positive. This was about 1.6 times the number of men during the same period. In COP19, 48,963 women will be identified, especially in the age groups 15-19 and aged 50+ through routine HTS among pregnant and breastfeeding women (about 65 percent of all women) as well as through active case finding modalities, including actively screening young women for seroconversion at ANC and FP clinics, index client testing, APN and moonlight clinics for FSW. Passive case finding will be performed through PITC in OPDs and inpatient wards as well as leveraging the DREAMS and OVC platforms, using validated screening tools. In FY19, PEPFAR will support recency testing for all women who test HIV-positive, and will roll out and conduct self-testing and hot spot mapping. Districts with an ART coverage below 70 percent will conduct differentiated HIV testing and APN following index case testing. In COP19, 89 percent of positive women are to be targeted from PMTCT, index testing and TB platforms.

Linkage: In APR 18, we linked 73 percent HIV-positive women to treatment. Although linkage among women improved from 73 percent in FY18 to 88 percent in FY19 Q1, it is lower than among men and far below the 95 percent target. Older women have better linkage than younger women. Strategies to improve linkage include a 10-point package of linkage interventions.

ART initiation: It is estimated that by the end of COP19, 743,049 HIV positive women aged 15+ will be receiving ART, of whom, 45,959 will be new. Women of childbearing potential (15-49 years) who are on effective contraception (hormonal implants, injectables, sterilization and combined oral contraceptives with condoms) and those aged 50+ are eligible for TLD. Women 15-49 years who are

not on effective contraception and desire to become pregnant will receive TLE400 following a policy change from TLE600.

Retention: By the end of APR18, 76 percent of women aged 15+ were still active and receiving ART at facilities. This is a decline from 80 percent at APR 16. This downward trend was attributed to the new definition in the TX_CURR indicator, data quality assessments, which further refined the patient numbers, silent self-transfers to other districts and facilities, incomplete reporting and lack of unique identifiers to track patients in cohorts. Poor retention among young people aged 15-24 years is likely due to non-disclosure and high mobility. In collaboration with MOH, PEPFAR will be supporting the national CQI initiative collaborative at facility level to improve retention. Facilities will be reporting on specific indicators captured using a dashboard as shown in figure 4.1.2 below, can be accessed using this link https://qidatabaseug.urc-chs.com. Furthermore, in FY18, PEPFAR Uganda engaged partners to implement age specific retention packages of services across all supported sites.

Newly diagnosed adolescents and young women currently on ART will be supported to disclose to close relatives by competent and experienced health care workers with specialized communication skills in handling these populations. They will be offered APN, psychosocial support with age appropriate pre- and post-test counseling services. In addition, they will continue to be offered friendly services in adolescent/youth clinics at large volume sites with flexible hours and moonlight services, especially for KP/PPs. During the first year following ART initiation, clients will be reviewed in the facility including all clients who are virally non-suppressed. Stable clients will be offered facility and community based differentiated services with multi month prescription, flexible appointments during weekends, school holidays and flexi hours. Age specific peers will be used for follow up of lost individuals in order to improve retention and viral suppression including YAPS teams. These will assist to support stigma reduction, adolescent and/youth support group meetings, home visits and non-suppressed peer support groups. Inter-facility linkages and referrals will be enabled by a functional linkage directory for CBOs and other service providers, including referrals to PEPFAR Uganda DREAMS and OVC implementing partners offering GBV screening and OVC services for those less than 18 years. The minimum package for post-violence care will be provided at facility level. Health care workers will be trained in providing continuous client education and SOPs on transfers and self-referrals.

For the older women, PEPFAR will support implementing partners to implement quality improvement approaches from the national CQI collaborative including: strengthening psychosocial services at high volume sites; multi-month ART refills; pre-appointment reminders; and use of linkage facilitators and village health teams (VHTs) to track those lost to follow up. Facilities will be supported with HMIS tools to monitor and track clients. We will strengthen community systems to improve retention through differentiated service delivery models and technical support to District Health Teams for supervision and monitoring service quality.

To improve retention rates, facility staff will be supported by IPs to generate appointment lists, and place pre-appointment reminders (calls, SMS, or home visits), especially for new clients during the first 6 months on treatment. IPs will collaborate with OVC programs working in their regions to

support unstable or virally non-suppressed adolescents and caregivers of children**.** OVC programs will enroll children identified at facilities, and will participate in switch meetings to enhance the OVC-clinical interface in order to ensure that adolescents adhere to therapy and keep facility appointments.

M&E and records personnel will update files of those who have returned for their appointments and will keep regular track of those lost to follow up (LTFU). Electronic medical records (EMR) will be used for reporting and capturing LTFU. Monthly audits of missed appointments and deaths will be tracked to include the cause, hence contributing to the TX_ML indicator. Quarterly audits of cohorts initiated within the most recent 6 months and update of files and registers will be done regularly. Emphasis is being placed on IPs mentoring sites to not only enter data into EMRS but also utilize it for client management (generating appointment lists, generating demographic characteristics for people who miss appointments, flagging file of a client when is due for a VL).

VL suppression: Improvement in viral suppression was noted from about 90 percent at APR 18, to 93 percent by Q1 FY19. Uganda developed a comprehensive VL campaign framework that includes management of non-suppressed (NS) clients as part of the change package. This includes the following approaches:

- integration of VL into morning health education sessions with an emphasis on messaging around "undetectable=untransmittable (U=U)";
- VL focal teams with a clinical-lab interface at facility level;
- rapid action following VL test results return;
- sorting suppressed from non-suppressed;
- use of stickers to flag non-suppressed files and documenting them into the non-suppressed registers;
- call back of non-suppressed clients for first intensive adherence counseling (IAC) session within seven days of result return;
- intensive adherence counseling (IAC) forms provided to support completion of three IAC sessions;
- leveraging community structures (Expert clients, CBOs & Linkage facilitators) to follow up with non-suppressed clients; and
- involvement of a multidisciplinary switch team, including OVC partners for adolescents up to 17 years who are non-suppressed.

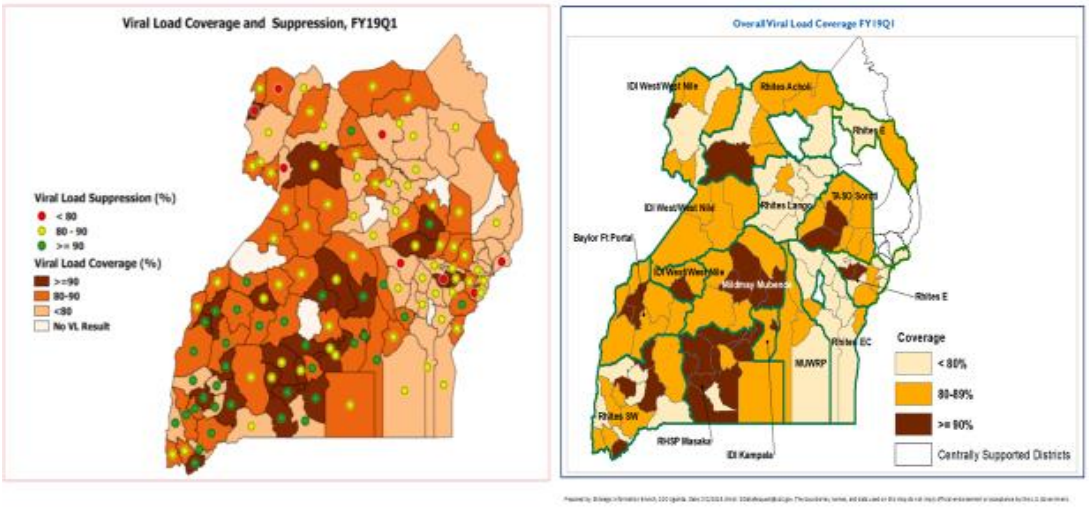
In COP19, PEPFAR will continue to support the national QI initiative in collaboration with MOH and HRSA to improve VLS and further disseminate the message of U=U. During Q2 of FY19, over 666 facilities in 86/127 128 (>80 percent) districts had submitted their baseline data for improvement projects as part the national CQI collaborative activity as shown in the figure below. This national dashboard is fully functional and can be accessed using the following link: https://qidatabaseug.urc-chs.com .

The program has identified the Eastern and West Nile regions as areas with low VL coverage and suppression. The HRSA team in collaboration with MOH will be targeting select facilities in the above regions to reinforce the VL NS package explained above and CQI improvement initiatives.

Figure 4.1.2. Dashboard that captures national CQI indicators

code	indicator	Dec 2018 percent	Jan 2019 percent	Feb 2019 percent	Mar 2019 percent	Chart
HIV-VLS-4	Percentage of unsuppressed patients eligible for at least 3 consecutive IAC sessions who have received them	34%	38%	89%	0%	chart
HIV-VLS-7	Percentage of unsuppressed patients who received at least 3 consecutive IAC sessions with good adherence	55%	62%	50%	0%	chart
HIV-VLS-10	Percentage of unsuppressed patients eligible for repeat viral load test who got it.	50%	62%	40%	0%	chart
HIV-VLS-13	Percentage of patients who receive a 2nd consecutive unsuppressed viral load test who get switched to an appropriate regimen	34%	44%	2%	0%	chart
HIV-VLS-16	Percentage of unsuppressed patients expected to get IAC who receive it	32%	35%	11%	0%	chart
HIV-VLS-19	Percentage of unsuppressed patients who achieve viral suppression	13%	18%	0%	0%	chart
HIV-RTN-03	Percentage of newly enrolled HIV patients who return within one month of enrollment	57%	50%	60%	86%	chart
HIV-RTN-06	Percentage of HIV positive clients who were lost at the second visit after initiation on ART that return to care within 3 months	3%	11%	29%	0%	chart
HIV-IPT-03	Percentage of patients initiated on IPT who have all data entry fields in the register completed	7%	51%	63%	-	chart

Figure 4.1.3. Q1 FY 19 Overall VL Coverage (85 percent), Suppression (90 percent) and VL coverage by IP: The Eastern and West Nile regions will be an area of focus by the MOH VL COI collaborative and the HRSA team



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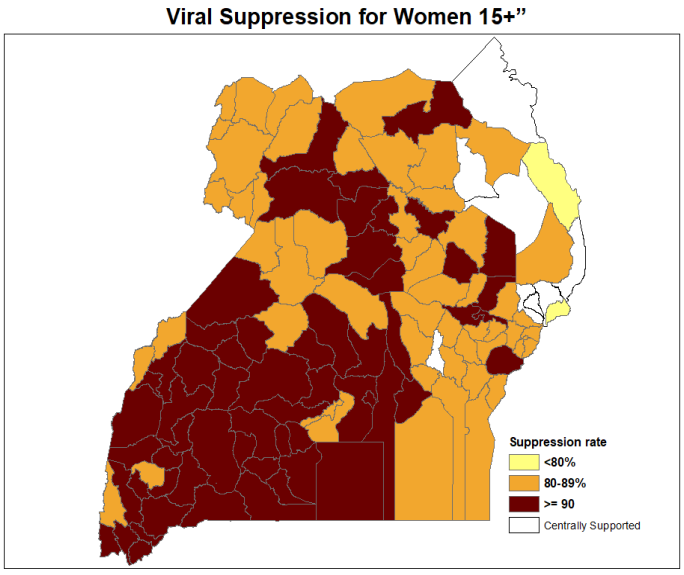


Preventing Mother-to-Child Transmission (PMTCT)

Identification, linkage, ART initiation, retention and viral suppression for pregnant and breastfeeding women aged 15+

Since the rollout of Option B+ in 2013, the proportion of HIV-positive pregnant women initiated on ART increased from 84 percent (FY13) to 94 percent (FY18).[47] HIV-positive women on ART at the beginning of pregnancy increased from 33 percent (FY13) to 71 percent (APR18), although the proportion of pregnant women who are known positive and already on ART at the time of diagnosis has plateaued.[48] The fertility rate has dropped from 6.2 in 2011 to 5.4 in 2016, but pregnancy among young women remains high: 54 percent of pregnant women are under age 24 (PEPFAR Program data APR18). In Uganda, 25 percent of adolescent girls aged 15-19 years have begun childbearing (UDHS, 2016). Furthermore, HIV-positive pregnant AGYW (aged 10-24 years) accounted for 49 percent of the newly identified positives at 1st ANC visit (ANC1) in PMTCT supported PEPFAR sites (APR18). High rates of sexual gender-based violence (SGBV) against women (22 percent) still persist in Uganda, predisposing vulnerable women to unwanted pregnancies and disproportionately more new HIV infections.

HIV transmission to infants in FY19 Q1 was 2.0 percent among those infants tested, with 0-12 months EID coverage improving from 76 percent at APR17 to 82 percent at APR18, and currently at 88 percent in FY19 Q1 with an EID package (see section 4.3).[49] However, in APR18 and FY19 Q1, 0-2 months EID coverage was 51 percent and 57 percent, respectively. This gap in early diagnosis indicates missed opportunities for early intervention.

COP19 activities (detailed below) will focus on strengthening existing strategies, and introducing some innovations where gaps have been identified, in order to provide high-quality care for pregnant women and mother-baby pairs. In COP19, we expect 1,333,543 pregnant women to attend ANC1 at PEPFAR supported sites. Of these, we targeted 100% percent to have a known HIV status. Among the estimated 6 percent who are HIV-positive, 85,145 (95 percent linkage) are targeted to receive ART among which 70 percent (59,395) are expected to already be on ART at ANC1. Additional COP19 targets include: 90 percent retention and viral suppression among pregnant women initiating ART; 80 percent 0-2 months DNA polymerase chain reaction (DNAPCR) EID coverage; 95 percent ART linkage for identified mothers and HIV infected infants; 100 percent final outcome infant status at 18 months; maintain <3 percent early MTCT rates; improved PMTCT data quality; and expansion of EMR (>40 percent) to high volume ANC/PMTCT PEPFAR supported sites.

Case Finding: All pregnant women attending ANC will continue to receive PITC as per national PMTCT guidelines utilizing dual HIV-Syphilis testing in ANC. The mothers who do not receive HTS at 1st ANC visit will be followed up to receive HTS in subsequent visits. In addition, given evidence of higher rates of seroconversion during the pregnant and breastfeeding periods, all HIV-negative pregnant women will be retested quarterly during the pregnancy and will be assessed for HTS

[47] PEPFAR program data.
[48] PEPFAR program data.
[49] PEPFAR program data.

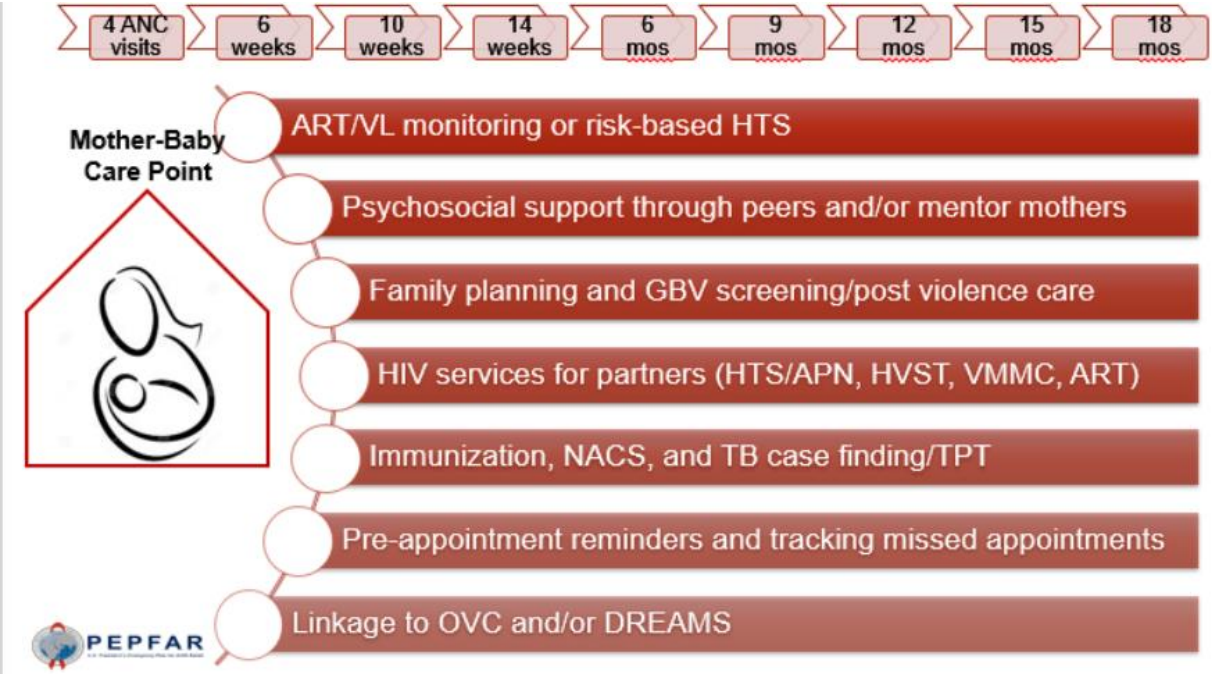
eligibility using the HTS screening tool in immunization and family planning clinics during the breastfeeding period. PITC will also be offered to all pregnant and breastfeeding mothers with unknown HIV status presenting at all entry points of MNCH (ANC, Young Child Clinic labor suite). Given that many women attend HCIIs for both ANC and immunization and that these sites often lack HIV services, we will continue to work with the MOH to strengthen access to improved ANC/HTS services through making HTS more available at HCII, improving referral and linkage structures, and either supporting outreaches to or accrediting large volume HCII sites.

At the community level, PEPFAR will work with CSOs, VHTs and traditional birth attendants (TBAs) to identify, register and refer all pregnant women in the communities to attend ANC and receive HIV testing services. In Uganda, DPT1 coverage is very high at 95 percent (UDHS 2016). We shall continue to use community outreach immunization platforms to identify mothers with unknown HIV status and offer HTS to them, especially those who do not attend ANC and who deliver at home. We will routinely review all the ANC, maternity registers, and postnatal registers to ensure adherence to guidelines and proper documentation.

Treatment initiation and retention:
Same-day ART initiation is provided at the ANC and mother-baby care point (MBCP). In addition to the standard package of linkage and retention interventions described above, peer mothers provide ongoing counseling and support through the pregnancy and postpartum period with a focus on disclosure, intimate partner violence screening and post-violence care, and linkage with OVC and DREAMS program activities including economic strengthening and training for Early Childhood Development. In many PMTCT settings, family support groups have been established and the economic strengthening and early childhood development activities have been successfully integrated into these structures. These additional services incentivize women to come to the facilities, further supporting retention efforts.

The MBCP has proved to be an effective platform for follow-up of mothers and infants. The MBCP service delivery approach follows mother-infant pairs for 2 years post-delivery (visits track to the immunization schedule) utilizing a "One Stop Shop" approach as depicted in figure 4.1.4. Factors contributing the success of this approach include 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. Quality improvement teams are being systematically established to strengthen retention of mother infant pairs and will be focusing on rapid follow-up of missed appointments and utilization of the site level birth cohort monitoring register and HEI cohort analysis (HCA) tools to bring back mother-infant pairs that had previously been lost to follow-up (LTFU) within the PMTCT/HEI continuum of care. These teams will also promote expansion of the integration of support groups, socio-economic strengthening and early childhood development within the MBCPs

Figure 4.1.4. MBCP service delivery approach



Viral suppression

Given the increased MTCT risk for an infant whose mother is not virally suppressed, additional attention is being given to identify viral non-suppression early among pregnant and breastfeeding mothers, conduct appropriate clinical management of non-suppressed clients, and ensure optimal VL return to undetectable levels. The revised consolidated guidelines for prevention and treatment of HIV in Uganda (Sept.2018) include a more rigorous VL monitoring algorithm for pregnant and breastfeeding women recommending VL at first ANC for any woman who is already on treatment (regardless of timing of last VL test) and six monthly VL testing through the end of breastfeeding. Additionally, the ANC/PMTCT staff are being included in the VL collaboratives as well as the multidisciplinary switch teams at the facilities to ensure that the 10-point VL change package (described above in section 4.1) is also being implemented in these settings. These new policy guidelines, along with the intensified mentorship and interventions through the QI collaboratives, will greatly support national efforts towards virtual elimination (<5 percent) of final MTCT by FY2022.

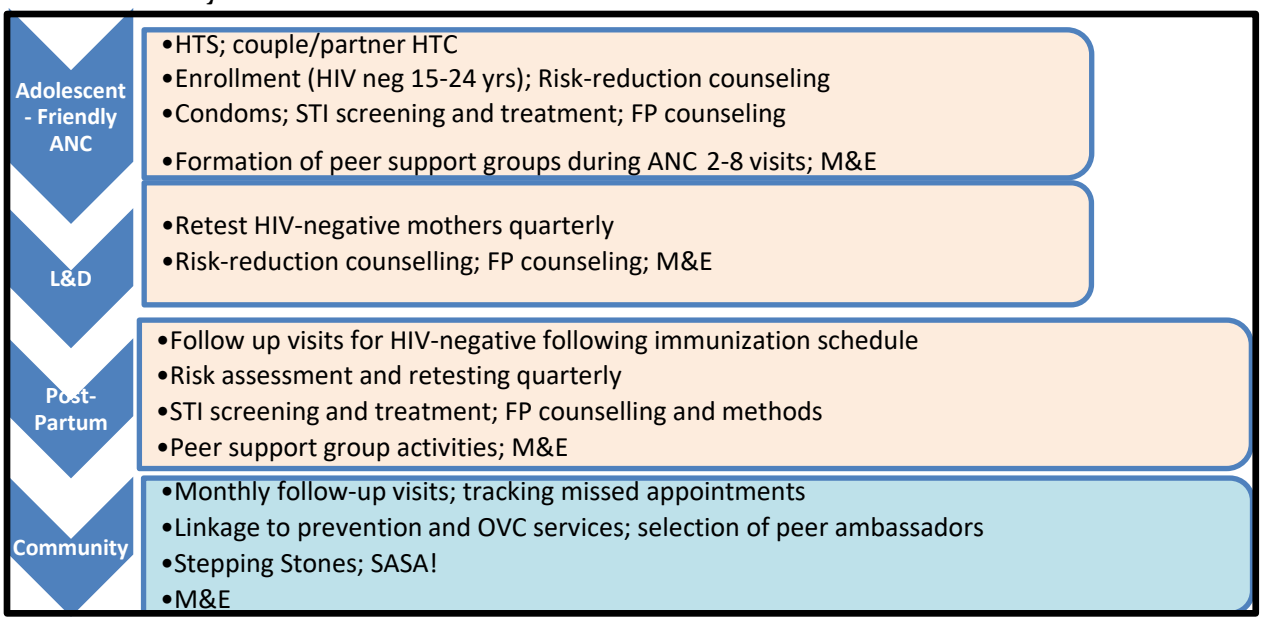
Preventing new infections among pregnant and breastfeeding AGYW

PMTCT services provide a platform to prevent HIV incident cases among AGYW. Of all the identified positives among pregnant women aged 10-24 years in FY19 Q1, almost half (49.5 percent) were newly identified positive clients. Although Uganda is making strides in improving contraceptive uptake and lowering fertility rates, increasing male partner testing and ART coverage among the partners of these women is necessary to decrease the relatively high rates of newly identified positives among pregnant women, particularly the Adolescent and Young Women age

group (10-24 years). In FY18, only 32 percent of male partners were tested in ANC settings.[50] COP19 will to continue to strengthen male partner involvement in ANC/PMTCT activities including male partner index contact tracing, APN and HIV self-testing services using the ANC/PMTCT platform.

In DREAMS districts, the ANC/PMTCT platform has been used to actively identify and link AGYW to DREAMS services (see section 4.1 for DREAMS package). COP19 will support the more direct integration of DREAMS services within the ANC/PMTCT platform by working with ANC/PMTCT sites in DREAMS districts to expand the MBCP services to HIV-negative AGYW mothers 15-24years of age given that these young women are some of the most vulnerable and would greatly benefit from a more structured environment with strong linkages to additional services. As described above, the MBCP has systems in place to provide both support and active follow-up of HIV-positive mothers during the first two years post-delivery from which the youngest, at risk negative AGYW can also benefit. Figure 4.1.5 outlines the integration of DREAMS interventions within PMTCT/MCH platform at facility and community levels.

Figure 4.1.5. Integrating DREAMS Interventions within PMTCT/MCH Platforms at Facility and Community Level



Group ANC/PNC for Pregnant &Breastfeeding AGYW 15-24 yrs.

Adolescent pregnancies and childbearing are associated with risky behaviors such as early sexual debut, early marriages, trans-generational sex, transactional sex, multiple sexual partnerships, alcohol and drug abuse and unprotected sex. Most of these pregnancies are unintended and often result in negative sexual and reproductive health outcomes. In Uganda, pregnant AGYW receive ANC together with older mothers above 25 years of age, yet pregnant AGYW have unique biological, psychosocial and emotional needs.

[50] PEPFAR program data.

Given these challenges, there is need to differentiate this sub-population group and provide evidence-based, tailor-made service packages that respond to their dynamic needs.

In COP18, the Ugandan MOH introduced Group-Antenatal (G-ANC) model of care in 33 PEPFAR supported sites targeting pregnant AGYW (HIV+ and HIV negative) aged 10-24 years in high volume sites. The model was adapted from the HOPE project G-ANC model in Kenya and is based on "centering pregnancy" (Rising, 1998), a group model of prenatal care delivery that places all three components of prenatal care—risk assessment, education, and support—within a group setting. Pregnant AGYW in groups of 8-12 women, based on similar gestation periods or age groups, receive peer-led ANC sessions facilitated by a trained midwife following a standard curriculum. The Group ANC model provides enhanced adolescent friendly services integrated into PMTCT and ANC/MCH platforms. Early results from Kenya demonstrate improvement in retention from 72% to 88% over a 6-month period, according to the PEPFAR Kenya team COP19 activities will focus on fine-tuning the activities at the pilot sites based on lessons learned and targeted scale-up of G-ANC in regions with high burden of teenage pregnancies and HIV.

4.2 Prevention, specifically detailing programs for priority programming:

In COP 19, Uganda has pivoted to roll out a coordinated integrated Adolescent Girls' and Young Women (AGYW) strategy across multiple platforms including Prevention, OVC, PMTCT and Treatment. The AGYW strategy originates from a deliberate joint plan aimed to provide comprehensive HIV and violence prevention and treatment services for the right beneficiaries for epidemic control. The strategy includes an agreed target setting and resource allocation process for AGYW across platforms to implement a harmonized, age-appropriate core package of evidence-based interventions (see DREAMS Layering table). Uganda plans to reach 336,000 AGYW in high burden districts assuming a 20% graduation rate and taking into consideration program aging in and out. The program plans to serve 60% of the newly enrolled and 90% of all other AGYW enrolled before COP 19 targeted to receive a minimum package of DREAMS.

The Uganda program triangulates data from multiple sources to identify sub-populations of AGYW who are most at risk and thus targets primarily five sub-population segments pre-selected for DREAMS implementation in 15 districts. The focus sub-populations are AGYW aged 9-24 who are either pregnant, married, and/or have given birth by age 15; high risk in-school AGYW; and/or AGYW involved in transactional sex. The program also focuses on parents of the AGYW, their male sexual partners and key influential community gatekeepers. In COP19, we shall continue to ensure that other high risk AGYWs who may not fall within the targeted sub-populations are profiled and included in the program.

Uganda uses standardized tools to identify and follow up beneficiaries of the program. Assessments are conducted at enrollment to ensure most vulnerable girls are identified. The vulnerability assessment tools emphasize vulnerability to HIV acquisition, rather than general vulnerability such as poverty. For example, AGYW having transactional sex, who are pregnant, sexual violence victims, who have multiple sex partners, or who are being treated for an STI would be considered vulnerable. HIV status will not be an exclusion criterial for enrollment in the DREAMS program. Sexual partners are identified through the sexual male partner profiling/characterization. Community

gatekeepers and opinion leaders are sensitized on what DREAMS is and are actively involved in community QI teams and community interventions to foster prevention with the beneficiaries. The program has also identified male champions who are now "DREAMS ambassadors" in the communities.

For all AGYW segments, the primary interventions include HTS, Stepping-Stones and combined socio-economic services (financial literacy and Village Savings and Loan, asset building). Secondary services include condom promotion and provision, parenting and caregiver program, and offering a mix of contraceptives. Post GBV care for survivors is offered when appropriate. Uganda offers a special program for the AGYW in school and the minimum package includes HIV prevention, prevention of violence within schools, and referral to the DREAMS safe spaces for other services not offered by the in-school implementing partner. Uganda will continue to use a peer led service-delivery model with case management to ensure that every AGYW receives appropriate comprehensive interventions tailored to her needs.

Our approach prioritizes bringing services as close as possible to the AGYW, working with AGYW peer leaders, district, cultural, community and religious leaders for active referrals. We shall continue to support the district action centers using a case management approach to follow-up survivors of violence, while garnering community support for violence prevention. Through systems strengthening, support will target the Uganda Child Helpline to facilitate reporting and response to abuse cases. The program will continue implementing a child justice program targeting the district prosecutorial authorities and other stakeholders throughout the justice chain. Learning from the VACS, and the response to the INSPIRE pilot project in Mityana, we shall develop and validate a locally contextualized violence prevention early detection index for children living in households that are rated as at most risk of experiencing violence. The index will engage families and profile households where violence against children is reported. The early detection index will enable practitioners to design interventions that directly deal with factors perpetuating violence and to anticipate and immediately take action on such households identified as at most risk of violence occurring.

AGYW aged 9-14: Uganda will focus on risk avoidance among 9-14 year-olds through evidence-based interventions known to delay sexual debut, and to prevent HIV infection and violence. Uganda will increase participation of faith based organizations (FBOs) to address gender-based violence among 9-14 young girls using the SASA! faith curriculum. The program will use schools and community platforms to offer these services. The program will implement interventions that enhance adolescent girls' ability to resist coerced sex and to obtain support if they experience coerced sex (for example, building self-esteem, developing life skills and improving social networks. On the OVC platform, the focus is on 9-14 year olds through evidence-based primary prevention of HIV and sexual violence targeting them at multiple levels: individual empowerment, strengthening their families, and mobilizing communities for change.

At the individual level: the interventions aim to empower girls to reduce or avoid risk. Girls in school will receive school-based HIV and violence prevention curricula. Girls unable to receive the school-based intervention will be offered an equivalent community-based curriculum (prospectively, the new Stepping Stones curriculum for 10-14 olds). IMpower for girls was introduced in COP 18, to build protective skills, and will be continued and expanded in COP 19.

At family level: The program will continue to promote positive parenting and communication between girls and their caregivers, as well as to empower families to keep their girls in school through education subsidies and household economic strengthening. Regular visits from case managers will help in monitoring the home environment and providing early intervention to address risks of violence in the home and ensure equitable investment in girls.

AGYW aged 15-19: Our program will focus on risk reduction interventions including violence and HIV prevention, and parenting interventions/skills building to further strengthen prevention outcomes.

AGYW aged 20-24: Risk reduction and asset building through supporting combined socio-economic approaches that positively contribute to determinants of health.

Community (including parents): We shall continue to scale-up SASA! for violence prevention, and continue to scale-up parenting interventions to support AGYW.

Men, Boys and Sexual partners: The activity ensures that male sexual partners receive core prevention interventions including VMMC, ART, and engaging men and boys to critically assess gender norms and behaviors that relate to sexual coercion and violence. Taking lessons from DREAMS, we shall continue to profile/characterize male sexual partners, using the male partner characterization approach, and working with strategic information to map where recent infections are occurring in men, to respond in real time. Through Peace Corps, Uganda in COP 18 is rolling out the Grassroots Soccer Curriculum with 12 modules targeting 10-19 year-old young men. This intervention uses simple and powerful connections between soccer and life to teach young men life skills focused on HIV and violence prevention. Taking lessons from COP 18, a phased approach to scale up Grassroots soccer to other high prevalence districts starting with DREAMS supported districts. In COP18, the IMpower curriculum was rolled out in four pilot districts. The second phase of IMpower curriculum that targets boys will be introduced to reduce their risk and future perpetration of violence. This will roll out as part of VMMC and will target boys who have been circumcised, to ensure completion of post operation follow-up, while at the same time providing skills for violence prevention.

We will continue to aggressively reach more men by supporting interventions to reach men 35-49 years, who have been identified as the highest-risk age bracket by UPHIA. This will be achieved through male PP champions and male age-specific dialogues to optimize identification and linkage. Particular emphasis will be on KP and PP groups that are predominantly male, including prisoners, police officers, private security guards, FF, and truck drivers.

Monitoring of service provision: PEPFAR Uganda will continue to monitor services provided to enrolled AGYW using the Uganda DREAMS Tracking System with unique identifiers and gathering data responsive to the AGYW_Prev new indicator. The quality assurance of the program will be enhanced through functionalization of facility and community quality improvement/quality assurance (QI/QA) teams.

We shall continuously review our service delivery and impact data to inform future scale-up plans. The program will actively link and document referrals to ensure completion of services. We shall scale-up the weekly dashboard as a tool for real time course correction and keep partners on target.

Under COP19, a top priority for PEPFAR Uganda is fostering close coordination and collaboration among the DREAMS and OVC implementing partners and the PEPFAR USG agency regional "comprehensive" health activities. The respective USG Agencies will closely monitor and provide technical assistance to implementing partners to assure the effectiveness of "layering" of services to beneficiaries, and linking beneficiaries to HIV services, as well as referring beneficiaries to non-health social and legal services.

Figure 4.2.1. DREAMS Layering Table

Uganda DREAMS Layering Table			
Population Segments			
	10-14	**15-19**	**20-24**
Primary Individual Interventions	• Screening for HTS eligibility • School or Community Based HIV & Violence Prevention • Parenting	• Screening for HTS eligibility • School or Community Based HIV & Violence Prevention • Combination Socio-economic approaches ***(only for those out of school)***	• Screening for HTS eligibility • Community Based HIV & Violence Prevention • Combination socio-economic approaches
Secondary Individual Interventions	• Risk based HTS • Condoms • Contraceptive Mix • Post-violence care • Education subsidy • ART (***for HIV-positive AGYW***) • Group-ANC model or longitudinal follow-up through 2y postpartum in PMTCT mother-baby care point (***for pregnant and BF AGYW)***	• Risk Based HTS • Condoms • Contraceptive mix • Post-violence care • Parenting (***for those 15-17yrs)*** • Education Subsidy • PrEP • ART (***for HIV-positive AGYW***) • Group-ANC model or longitudinal follow-up through 2y postpartum in PMTCT mother-baby care point (***for pregnant and BF AGYW)***	• Risk based HTS • Condoms • Contraceptive Mix • Post-violence care • PrEP • ART (***for HIV-positive AGYW***)
CONTEXTUAL	• Reducing risk in sexual partners (HTS, VMMC, ART) • Community mobilization & Norms Change (SASA) • Condom promotion campaign/demand creation • Socio economic approaches for caregivers (10-14)		

4.2.a. OVC and Child-Focused COP19 Interventions

The OVC program is attributing 30,000 targets directly to AGYW prevention (DREAMS). These are AGYW aged 10-24 within the OVC program in 15 DREAMS districts. On the OVC platform, the focus is on 9-14 year olds through evidence-based primary prevention of HIV and sexual violence targeting them at multiple levels: individual empowerment, strengthening their families, and mobilizing communities for change.

At the individual level: the interventions aim to empower girls to reduce or avoid risk. Girls in school will receive school-based HIV & violence prevention curricula. Girls unable to receive the school-based intervention will be offered an equivalent community-based curriculum (prospectively, the new Stepping Stones curriculum for 10-14 olds). IMpower for girls was introduced in COP18, to build protective skills, and will be continued and expanded in COP19.

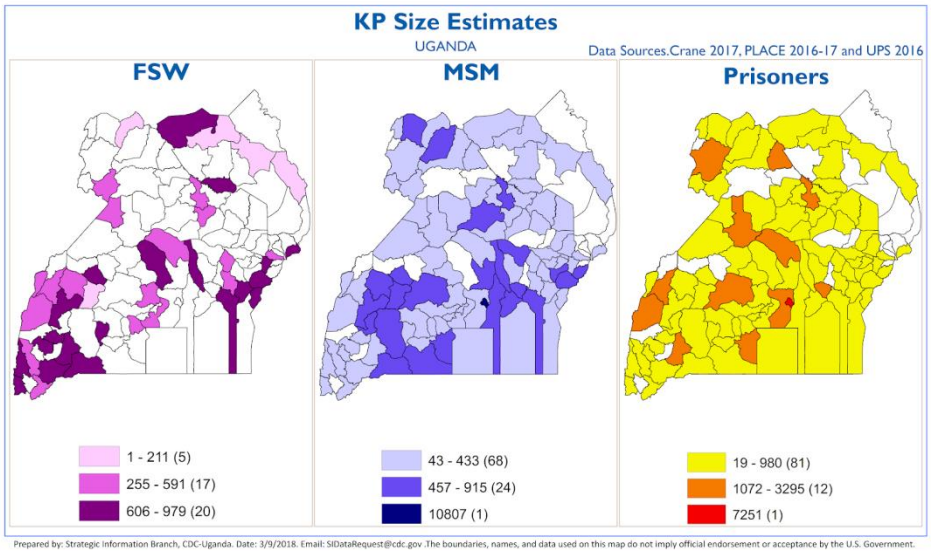
At family level: The program will continue to promote positive parenting and communication between girls and their caregivers, as well as empower families to keep their girls in school through education subsidies and household economic strengthening. Regular visits from case managers will help in monitoring the home environment and providing early intervention to address risks of violence in the home and ensure equitable investment in girls.

At the community level: The OVC platform SASA! will be implemented to mobilize communities and facilitate norms change among both community and faith leaders. The second phase of the IMpower curriculum targeting boys will be introduced to reduce their risk and future perpetration of violence. Finally, the program will strengthen child protection systems including establishing District Action Centers and support to the Uganda Child HelpLine to facilitate reporting and response to abuse cases. The program will continue implementing a child justice program targeting the district prosecutorial authorities and other stakeholders throughout the justice chain.

4.2.b. COP19 Key and Priority Populations, PrEP

PEPFAR Uganda identifies key and priority populations (KP/PP) as indicated in Table 4.1.3 which also includes the size estimates, coverage goals and targets. KPs include FSW, MSM, transgender women, PWID, and prisoners. PP include uniformed personnel, fisher folk (FF), long distance truckers, sero-discordant couples, and AGYW. Uganda's KP and PP program will continue to be geo-focused considering the country's epidemic profile, and geographical based targeting. Our targeting was informed by UPHIA results, KP estimates including program performance and feedback from civil society organizations. The total COP19 KP_PrEV target is 275,249 and PP_PrEV is 566,330. MSM reach will increase from 7,983 in FY 18 to 29,276 in FY19 expanding from eight subnational units to twelve.

Key and Priority Population Size Estimates



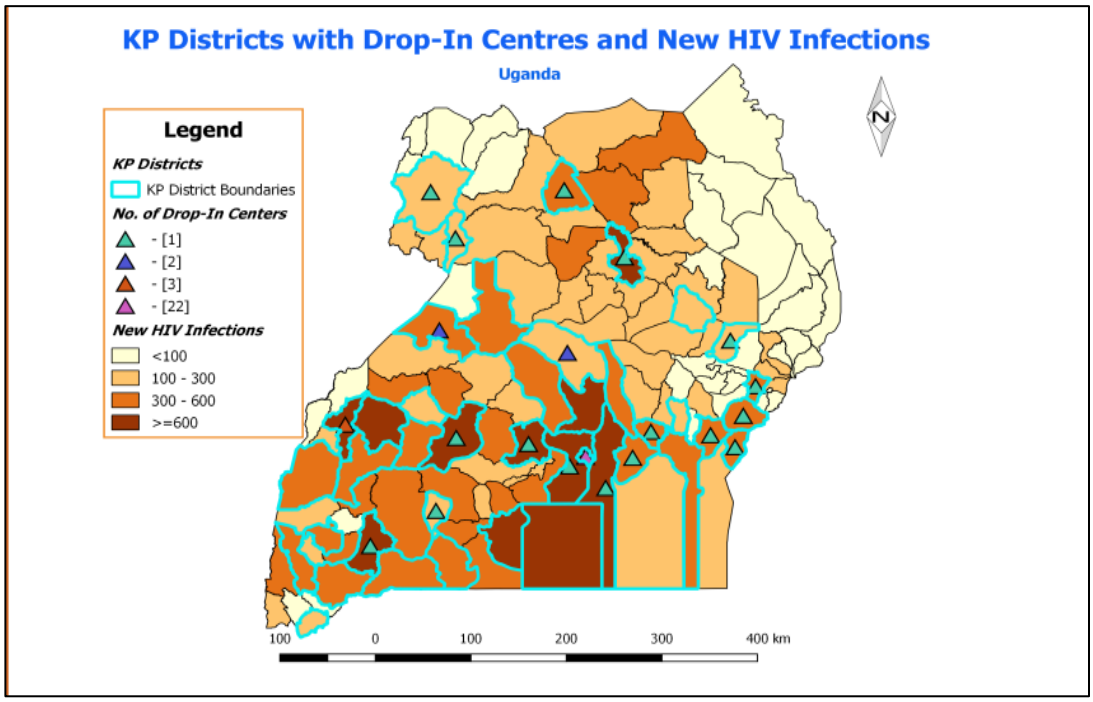
To achieve epidemic control among KP, the program will implement KP service layering and will closely monitor the prevention and treatment cascades. To close the tap on new infections, under COP19 PEPFAR Uganda will use specific strategies to improve identification, linkage to and retention on antiretroviral treatment (ART). VL monitoring will be rapidly implemented and scaled up, while careful monitoring will assure suppression. For efficient and smart testing, we will transition from testing every three months to risk based testing. We will continue working with CSOs to implement innovative approaches for enhanced case identification including HIV self-testing (HIVST), social media & Information, Communication and Technology (ICT) platforms, social network strategies (SNS), index testing, primary & secondary distribution of self-test (ST) kits, audio computer-assisted self-interview system (ACASI, specifically for MSM) and enhanced peer outreach approaches. To reach priority population men, PEPFAR will especially target the truckers, FF, and clients of sex workers, prisoners, and police with combination prevention. Table 4.2.1 below details the packages of services for each sub-population. Our program will also promote male and youth friendly services to increase MSM service uptake. In FY18, the country registered sub-optimal KP linkage (48 percent) to treatment services. However, there was improvement in the final two quarters of the year (50 percent at SAPR - 66 percent at APR).

Table 4.2.1. Uganda KP Layering Table

Uganda KP Layering Table				
	Sex workers	**MSM**	**Prisoners**	**PWID**
Primary Individual Interventions	• Peer education • Condoms • Targeted HIV testing services • Routine STI screening[51] • Routine TB screening • Hepatitis Screening • SGBV screening	• Peer education • Condoms • Targeted HIV testing services • Routine STI screening • Routine TB screening • Hepatitis screening • SGBV screening	• Peer education • Targeted HTS (entry and exit testing) • Curriculum-based HIV prevention • GBV screening • Routine STI screening • Hepatitis screening • Routine TB screening	• Peer education • Condoms • Targeted HIV testing services • Routine STI screening • Routine TB screening • Hepatitis Screening • SGBV screening • Screening for Opioid Substitution Therapy (OST)
Secondary Individual Interventions	• PrEP • RH services (contraceptive mix, ANC, Post Abortion Care-medical, counseling) • Alcohol/drug harm reduction • Partner testing for sexual partners • ART Adherence support • STI treatment • Hepatitis treatment • Viral load and other monitoring & investigative tests • TB treatment • Disclosure of status to steady sexual partners/spouses • Post-violence care • Lubricants • Curriculum based HIV prevention	• PrEP • Post-violence care • ART Adherence support • STI treatment • Alcohol/drug harm reduction • TB treatment • Partner testing for sexual partners • Viral load and other monitoring & investigative tests • Hepatitis treatment • Disclosure of status to steady sexual partners/spouses • Lubricants	• Contraceptive Mix[52] • Post-violence care • Condoms[53] • PrEP • GBV prevention • HIV care & treatment – through DSDM and on site management • Viral load and other monitoring & investigative tests • Hepatitis treatment • STI treatment • Safe Male Circumcision (SMC)	• PrEP • Post-violence care • ART Adherence support • STI treatment • Alcohol/drug harm reduction • TB treatment • Partner testing for sexual partners • Viral load and other monitoring & investigative tests • Hepatitis treatment • Disclosure of status to steady sexual partners/spouses • Lubricants • Methadone and other medical-assisted therapies (MAT) including buprenorphine, naloxone, naltrexone
CONTEXTUAL	• For partners: Referrals (HTS, VMMC, ART) • Community mobilization & Norms Change (SASA) • Condom promotion campaign/demand creation • OVC for children of sex workers • Stigma and discrimination reduction capacity building			

[51] Prevention and care of STIs, including the application of specific aspects of syndromic STI management: including standard testing procedures to detect asymptomatic bacterial anal and urethral infections, and vaccination against Hepatitis B.
[52] Need advocacy and policy change for this to be available
[53] Current Prisons policy does not allow condoms for prisoners

At APR 18 out of 39,787 FSW tested, 50% were linked and out of 4430 MSM tested 61% were linked. PWID registered lowest linkage amongst the KPs, at 34 percent. Enrollment of more KPs on treatment will require the scale up of KP-competent ART services, same day ART initiation, community ART provision, and enhanced treatment literacy among KPs and their families ("undetectable=untransmissible" or U=U messaging), strengthening peer navigation and monitoring systems, reducing stigma and discrimination in both KP-specific ART sites and within the more mainstream clinical sites.



Although the national HMIS data do not provide KP specific retention and viral suppression levels, the 12 months retention has consistently been less than 80 percent for FY18 and 89.1 percent as overall viral suppression rate at APR18 for the general population. (https://pepfar-panorama.org/) This is expected to be worse for KPs. The high LTFU contributed to the low retention and low viral suppression levels among the KPs. Improved HIV treatment retention and VL suppression among KPs will require systematic implementation of intensified adherence counseling using peers, rolling out uniform KP data reporting tools, use of social media and a digital referral directory, supporting existing hotline for KP tracking and counseling services, operationalizing DSDM for KPs and mapping drop-in centers (DICEs) proximate to facilities to enhance referrals and linkage to treatment.

HIV prevalence among PWID is estimated at 18% (Uganda Harm Reduction assessment 2017). Currently Opioid Substitution Therapy (OST) services are unavailable in Uganda but proved to be effective in Tanzania and Kenya Models in East Africa. Medication Assisted Treatment (MAT) can save lives of PWIDs while reducing vulnerability to HIV/AIDS infections. In COP 19 we propose to implement MAT services in Kampala targeting 300 PWIDs at Butabika National Referral Hospital working with PWID focused CSOs.

Pre-exposure prophylaxis

Following a phased implementation of PrEP since COP 16, Uganda has almost doubled its PrEP targets from 16,481 in COP18 to 30,000 in COP19 in KP districts. The program will strengthen community based initiation and refills for PrEP to enhance service uptake. The program will continue to focus on demand creation through targeted messaging to eligible sub-populations. Our program will continue to expand enhanced peer led approaches, support hot-spot mapping, and ensure more robust technical assistance to CSOs and districts to locally map and re-map hotspots. We will support peer support and pre-appointment reminders and expand community-based PrEP initiation and refills.

Priority populations

PEPFAR will continue to target other priority populations and implement PP service layering, as described above in the section on HIV prevention and risk avoidance for AGYW and OVC. The service package will comprise of social and behavior change communication (SBCC); risk-based testing; promoting consistent correct condom use; ART provision and adherence support; sexual and gender-based violence (SGBV) screening; post-exposure prophylaxis (PEP), emergency contraception (ECP), and HTS; alcohol/drug harm reduction; and reproductive health services. The service package was revised to include more services and partners will be re-oriented during COP19.

To ensure primary prevention, COP19 will take a renewed focus on condom programming, including re-invigorated condom education and access while addressing primary barriers to use. Additionally, PEPFAR will continue to support social marketing programs to build on the market reach of supported brands of condoms through the private sector.

PEPFAR will leverage GF and United Nations Fund for Population Activities for KP and PP support. The program will address structural barriers that impede KP and PP service delivery and access through ongoing health providers' trainings, gender and sexual diversity trainings using the Ministry of Health-approved KP curriculum, and by conducting quarterly/routine community fora between PEPFAR and CSOs. To address stigma and discrimination, the program will operationalize key recommendations of the PLHIV KP stigma index by addressing lived and perceived issues. We will also track the impact of trainings and ensure feedback is used to improve trainings and TA. PEPFAR will continue to facilitate policy and stakeholder engagements to develop a supportive environment that will enable more robust reach for key and priority populations, guided by principles of responsible engagement. Support through USAID's Democracy and Governance will strengthen advocacy, organizational systems and collaboration among KP related CSOs to address human rights needs. Global Fund will be carrying out activities specifically focused on human rights; PEPFAR will closely engage.

Generation of data, reporting and analysis of KP cascade data will be a priority in COP19. Partners will be supported to use customized hybrid KP data capture and technical assistance will improve reporting. In addition, the KP dashboard will be operationalized to provide "real time" data. Continued quality management for KP will be tracked through enhanced partner management for weekly and quarterly data quality reviews, KP/PP sub-national unit (SNU) level and site level

analyses, monitoring implementation of the KP service package and using tailored KP PP reporting tools. The KP-led community scorecard will contribute to community-led quality improvement processes.

Table 4.3.1. FY20 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY20)	FY20 Target
MSM	88,950(33,013)	33	29,276
FSW	137,747 (141,961)	83	113,878
*Prisoners	160,000 (44,060)	75	120,000
Prison Officers	7,182 (6,265)	33	2,350
Police[54] and private security guards	86,643 (83,547)	84	72,791
FF	2,347,220 (NA)	6.7	156,957
Military	50,000 (NA)	25	52,500
Truckers	31,588	84	26,838
SDC	26,978 (22,512)	90	24,289
AGYW	1,980,000 (789,400)	Maintain and follow up in the 13 districts and 4 PMTCT districts12	256,081
PrEP implementation (FSW, MSM, FF)	NA	15	30,003
TOTAL			**884,963**

Key Populations Investment Fund—Central Initiative

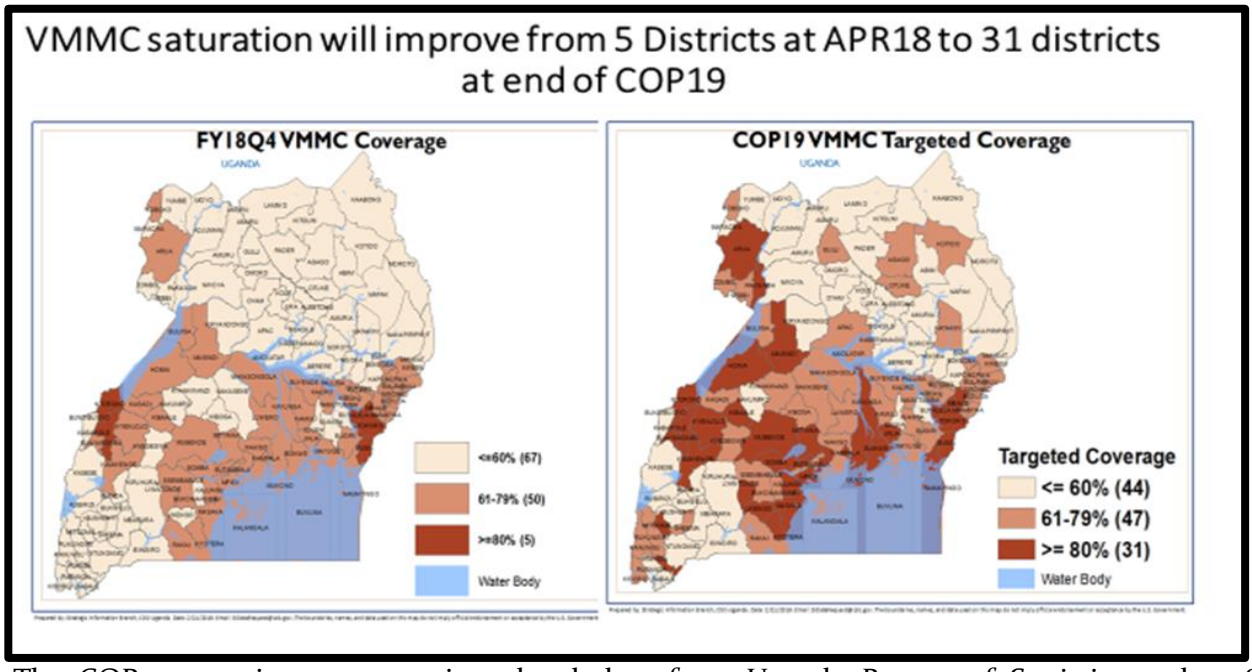
Uganda will be receiving $10m as part of the Key Populations Investment Fund (KPIF) to scale up KP-led community approaches to expand HIV services. The fund objectives are to scale up KP-led community approaches to expand and enhance HIV services to deepen reach to KPs with comprehensive HIV services, and to address structural barriers to service access through various civil servants (e.g. police, legal and judicial system, local political leaders, etc.) sensitization to reduce stigma and discrimination. KP-led CSOs will receive 82 percent of the KPIF funds. These funding will be complementary to COP19 and will be tracked separately.

To ensure stakeholder engagement prior to the startup of the KPIF interventions in Uganda, pre-award consultations were held in October and November 2018 with KP CSOs to prioritize interventions to be supported by the KPIF fund. The CSO priorities were incorporated into the KPIF guidance document which guides implementing partners work plans and budget development.

4.2.c. VMMC

From the inception of the VMMC program in 2010, the total number of PEPFAR supported male circumcisions (MCs) performed in Uganda has increased from 9,052 to more than four million by APR18. During this period, an estimated 222,486 HIV infections have been averted. In Uganda, PEPFAR continues to be the major donor for VMMC, having supported 90 percent of all male circumcisions during this period. The other support to Uganda's VMMC program comes from the AIDS Healthcare Foundation, Uganda Cares, UNICEF—mainly for early infant male circumcision (EIMC) training—and the GOU.

According to the AIDS indicator survey of 2011, the national circumcision prevalence was 26 percent in the 15-49 year age group. That prevalence increased to 43 percent in the 2016 UPHIA with regional variations. In COP19, PEPFAR will perform 800,000 MCs (with 95 percent to be in the 15+ age group, and 5 percent in the 10-14 year age group). VMMC services will target 88 districts with the highest HIV burden and lowest MC prevalence with an approach to maintain high coverage in districts where circumcision coverage already exceeds 80 percent and achieve 80 percent coverage in districts where circumcision coverage is lower. The districts of implementation include 34 attained (37.9 percent of MCs), 31 scale-up aggressive (41.8 percent of MCs), 13 scale-up saturation districts (14.2 percent of MCs), 10 sustained districts (3.2 percent of MCs) and the rest will be implemented in the military supported districts and facilities.



The COP19 targeting process triangulated data from Uganda Bureau of Statistics and 2018 population projections. The estimated district coverage of 2018 was calculated by estimating number of men circumcised from the 2011 AIS and 2016 UPHIA data in addition to 2018 VMMC program data. Distribution of targets focuses on regions with high circumcision unmet need and high HIV burden including all DREAMS districts. Previous district performance was considered, with high performing districts being assigned additional targets. To increase the immediacy of

impact, the program will continue to target the high-priority age band with a goal that 80 percent of VMMCs reach 15-29 year olds and this age group is still the focus of the group.

By end of COP18, PEPFAR Uganda will have supported 4,983,704 circumcisions and by end of COP19 the cumulative number of VMMC procedures performed is expected to be 5,783,704. With COP base funds received in COP19, 31 districts will achieve 80 percent coverage from 5 districts at APR18 assuming that all the set targets for COP18 and 19 are achieved.

Key shifts and considerations for COP19 include offering ShangRing as a device-based option for VMMC in a passive surveillance approach. The purpose of the passive surveillance will be to:

- Develop capacity of the health system to provide circumcision using ShangRing device as an alternative to other available methods of circumcision for men;
- Determine the Adverse Event (AE) rate by obtaining information on AEs through a combination of routine facility-based diagnosis and reporting plus home visits for follow-up defaulters and to increase understanding of known ShangRing AEs and detect any new/rare AEs;
- Use results to develop strategies to improve management of AEs as the use of this device is rolled out; and
- Explore and address the operational challenges and opportunities and develop experience that can be applied to the routine service delivery phase.

As a sustainability strategy, and in order to reduce the high waste management investment related to recycling VMMC single-use instruments, the program will invest in reducing the proportion of disposable instruments from the current ratio of 90:10 disposable to re-usable instruments to 75:25. Furthermore, the PEPFAR team will work with the MOH VMMC TWG to review and update the 2010 policy and develop infection control minimum standards, in addition to developing policy and implementation guidelines and policy for early infant male circumcision (EIMC).

According to the UPHIA 2016, the annual HIV incidence is highest in males of the 35-49 year age group, and the percentage of men who reported using a condom the last time they had sex with a non-marital, non-cohabiting partner is lowest in that same age group. The main target age band is 15-29 year old men, and we will intensify VMMC for men 30 years and above by addressing key barriers to seeking VMMC services through focused demand creation that addresses structural and accessibility challenges for this age group. PEPFAR Uganda will also learn from the results of MenStar, which found that adult men were heavily influenced by their mothers. Demand creation efforts will use human-centered approaches including: 1) audience profiling and characterization specific for each age segment and geographical area; 2) candid discussion about pain; 3) promotion of non-HIV benefits of VMMC and age-specific SMS messages; and 4) offering differentiated service delivery, including extended hours and moonlight services and increasing the use of male service providers.

The DREAMS platform will be used for VMMC demand creation among older men through the male sexual partner characterization assessment approach, the use of DREAMS Ambassadors, Girls Engagement Forums, and AGYW male partner champions. Other high-risk men, such as STI clients

and partners of sero-discordant couples, will also be encouraged to receive MC-IEC materials and VMMC appointment cards distributed to potential clients at STI clinics and HIV testing points.

Given low prevalence of HIV infection among VMMC clients, the program will test only appropriate clients based on risk behaviors for the 10-14 year age group. However, testing will remain available to any VMMC client upon request. All newly identified HIV+ clients will be tracked and linked to care and treatment.

Implementing partners will be managed to improve performance with weekly performance review of results and monthly financial monitoring, and monthly inter-agency VMMC partner performance review meetings in addition to quarterly DQAs led by the M&E partners. Continuous quality improvement interventions will take proven approaches to scale for managing adverse events (AE), and active post circumcision client follow up according to the national VMMC package of care. To ensure long-term sustainability of quality VMMC services, the program will work with the MOH to continue quality assurance and improvement activities that include ongoing monitoring of AEs. In addition to AE monitoring, PEPFAR Uganda will continue to be compliant with mandatory reporting of notifiable AEs to S/GAC within 24 hours of learning of adverse event.

VMMC will be offered as part of a comprehensive HIV prevention package, which includes HTC, screening and treatment of STIs, and referral of HIV+ identified men to appropriate care and treatment. PEPFAR will provide commodities and consumables, including emergency kits, sterilization equipment and Tetanus Toxoid vaccines.

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

Minimum Program Requirements

Integrated roll out of TLD, TPT and FP: TLD was adopted in 2018 and rollout commenced October 2018. Due to unanticipated bottlenecks and site level barriers, transition has been slow, and as of March 2019, 88,000 clients (8.3 percent of total) were on TLD. Transition is being expedited and expected to be completed by September 2019, targeting 100 percent of all eligible clients (i.e. 51 percent of all ART clients). As part of regimen optimization, TLD transition is implemented alongside phase out of suboptimal ART regimens, most especially Nevirapine for adults. Women of reproductive age ineligible for DTG are to be shifted to TLE. To improve adherence, the MOH is adopting TLE400 which is more tolerable, has comparable efficacy, and is USFDA-approved and registered in-country with NDA by a generic provider. Roll-out is expected to start January 2020. For stable clients on ART, 90 and 180 pill packs of both TLE400 and TLD will be made available to facilitate multi month dispensing.

TPT: Roll out of TPT is integrated with TLD roll out. With support from GF and PEPFAR, MOH started TPT roll out in FY19 with an objective of 352,000 PLHIV by APR2019. As of March 2019, 52 PLHIV had been initiated on TPT at 61,035 facilities. In COP19, scale up will be continued, and PEPFAR Uganda will invest in TPT with the goal of providing it to 400,000 PLHIV at high volume facilities, prioritizing all HIV+ on ART. This will increase overall TPT coverage to 62 percent of total estimated PLHIV. In FY 19 and FY 20, PEPFAR will support synchronization of TPT and ART refills

including integration in DSDM strategies to increase TPT completion rates from 67 percent in FY 18 to 95 percent in FY20. PEPFAR will provide technical assistance in procurement, distribution, and management of TPT supplies, standard operating practices (SOP), mentoring of health workers, and coordination of a systematic and phased TPT rollout.

Improving TB case identification: TB remains a major cause of morbidity and mortality among PLHIV. An estimated 5 percent PLHIV are expected to develop active TB annually. Despite a significant increase in case finding that led to identification of more than 11,000 additional TB cases in FY 18, only 1.7 percent PLHIV were diagnosed with TB, which is lower than the COP18 target of 2 percent. In FY 2020, PEPFAR Uganda will continue to scale up effective approaches for finding TB among PLHIV by integrating TB screening into HIV index testing (including APN) approaches. We will also enhance facility based case finding through TB screening at all entry points and optimization of GeneXpert testing so that 100 percent of PLHIV access GeneXpert as the primary test for TB diagnosis. PEPFAR is in dialogue with CHAI and UNITAID about Uganda becoming a country for HP3 large scale pilot, and should it prove feasible and efficient would consider additional support in COP19.

Differentiated Service Delivery Model (DSDM): Beginning in 2018, the MOH has been rolling out DSDM and as of March, 2019, 794/1492 (53 percent) of sites were implementing this approach, with 36 percent of all ART clients enrolled into models for stable clients: Community Drug Distribution Points (CDDP), Facility Based Fast Drug Refills (FDR), and Community Client Led ARV Drug Distribution (CCLAD). Scale-up will continue through COP19, targeting 70 percent of all stable ART clients (100 percent of eligible) to be enrolled into one of the three DSDM. Isoniazid Preventive Therapy (IPT) for TB prevention among the PLHIV will be aligned to the ART refills to minimize patient clinic visits for IPT alone. Additionally, the MOH will continue conducting site level mentorships, streamlining DSDM reporting into reporting systems as part of the revised HMIS tools roll out. The adoption of 90 and 180 pill bottles/packs planned for COP19 will greatly facilitate multi-month scripting and dispensing for stable clients. In COP19, DSDM will focus on special populations including KPs and AGYW. New models for KP service delivery will be tested with the aim of integrating and strengthening ART initiation and refills into the KP Drop-In Centers. PEPFAR Uganda is working with the MOH and stakeholders to roll out an innovative YAPS Model aimed at improving adolescent HIV services including identification, linkage, ART initiation, retention on ART and viral suppression.

Surge for quality: Surge for quality strategy will be scaled up to reach 100 percent of facilities with COP19 priority interventions, including finding the missing populations, linkage, retention, and TLD/TPT scale up. It will also be embedded in the National Clinical Quality Assurance program to ensure sustainability and be linked with investments in national data systems to ensure data can rapidly trigger action where needed.

Case identification: As a COP19 priority, this will mainly focus on the missing populations, which include older males and children. PEPFAR will support enhanced pediatric and adolescent case finding. See Section 4.1. on pediatric case finding and strategies to reach men, also in Section 4.1.

Linkage: To improve linkage from HTS to treatment, a linkage package will be supported with the aim of achieving 95 percent.

Retention: Intensive efforts will continue to be made to improve retention, especially in the first six months (early retention) following ART initiation. By APR18, the percentage of adults and children known to be alive and on treatment 12 months after treatment initiation was 76 percent (138,311/181,671) way below the targeted 90 percent. Retention is lowest among young people 15-24 years of age, likely due to non-disclosure of HIV status and high mobility. In COP19, PEPFAR will support partners to implement an initiation and retention intervention package through a quality improvement approach. The strategies to improve retention levels will include: strengthening psychosocial services at ART sites; strengthening capacity of health facilities to track patients missing appointments through a systematic line-listing and follow-up process in order to rapidly bring them back into care; supporting facilities with HMIS tools to monitor and track retention; strengthening community systems to improve retention through scale-up of DSDM and technical support to DHTs.

Advanced Disease Management (ADM): Despite implementing Test and Treat and achieving high ART coverage of about 89 percent, at least 10 percent of newly-identified PLHIV present with advanced HIV disease. Inconsistent management of advanced disease with limited CD4 availability has previously met challenges and, as a result, advanced disease management has for the first time been included in the guidelines since WHO released guidance of 2017. Screening and management of advanced disease particularly use of CrAg and TB LAM relies heavily on CD4 testing. Advanced disease screening is planned for all newly initiated patients on ART and all patients failing on ART with VL >1000. However, in light of declining availability of CD4, national guidelines have introduced a screening tool to identify patients with likelihood of advanced disease. During FY19, SOPs for implementation of screening tools and an ADM service package will be developed and implemented in high volume sites, and will be brought to scale in all sites during the course of COP19 implementation through onsite, in-person mentorships and webinars. TB screening and management has been included as part of the advanced disease-screening tool using TB LAM for sick patients, plus other conventional methods including GeneXpert and X-ray. For children with advanced disease, more focus will be placed on screening and management of severe malnutrition, using ready to use therapeutic foods (RUTF). The priority will be on 5 percent of children on ART below 10 years of age who annually require RUTF at high volume sites.

Cotrimoxazole Policy Shift: In 2018, Uganda revised its treatment guidelines recommending cotrimoxazole prophylaxis be prioritized for patients identified as being at risk of opportunistic infections, including those newly identified and initiating ART, the virally non-suppressed, children less than 15 years, pregnant and lactating women, and patients with advanced HIV disease.

Scale-up of KP Prevention/Treatment Packages: Comprehensive KP services will be spearheaded in 38 SNUs by the enhanced peer outreach model. Differentiated KP case identification will be peer led through community outreaches and by expanding DICEs and social network testing, with linkage to care through incentivized peers and via digital referrals. Retention and VL suppression will be enhanced through U=U messaging. Service access challenges will be addressed through stigma and discrimination trainings with MOH-developed curriculum, routine community engagements including policy level support for a supportive environment.

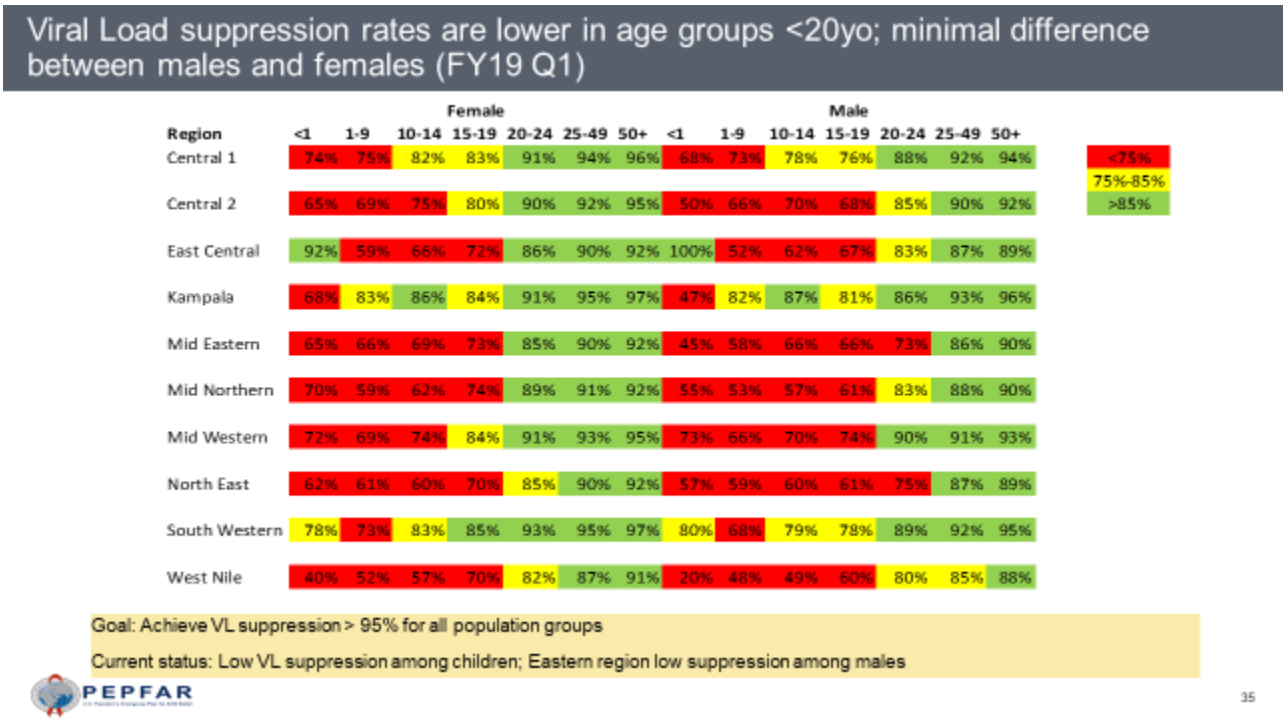
Monitoring morbidity/mortality outcomes: PEPFAR Uganda is progressing rapidly on enhancing reporting abilities for morbidity and mortality outcomes by consulting closely with the Ministry of Health and other stakeholders to review requirements and existing tools and to update them as necessary. A special task force has been convened to update the tools, as well as to develop standards of practice (SOPs) and plans to roll out morbidity and mortality outcome reporting to partners over the course of FY19.

VL Optimization and Suppression: In COP19, the PEPFAR Uganda goal is to achieve and sustain VL suppression >95 percent for all population groups through implementation of a multidimensional approach. As of FY2019 Q1, overall VL coverage nationally was estimated at 85 percent and viral suppression (VS) at 89 percent. Viral suppression was lowest among young people below age 20 years (Male & Female 0-14 years- 70 percent; Females 15-19 yrs. 72 percent; Males 15-19 years- 69 percent) as compared to adults over 25 years at 90 percent. The lower VL suppression rates among children and adolescents are attributed to use of sub-optimal ART regimens, delays in weight-based dose adjustment, poor adherence, and HIV drug resistance. Among adults over 20 years, VS was lower among males (>25 years - 86 percent; 20-24 percent - 71 percent) than females (>25 years - 90 percent; 20-24 years-81 percent), and this sex difference was most notable in the Eastern Region.

The multidimensional approach of priority interventions for PEPFAR Uganda to achieve its COP19 priorities for VL suppression is in line with the surge for quality and is consistent with the MOH national QI collaborative, and includes the following:

- With technical support from the Health Resources and Services Administration (HRSA) Clinical Skills Sharing initiative, quality improvement will be intensified at site level, targeting low performing districts with low VLS and high MTCT. HRSA will work with the National QI collaborative for early retention, viral suppression, and mother-infant pair retention, which focuses on four major areas:
  (1) Building capacity for management of VL non suppression (at national, regional, district and site levels), including ART regimen optimization; (2) use of VL HMIS tools for tracking VL suppression (including the QI dashboard); (3) Improving linkage between clinic based VL services and community OVC care; and (4) Strengthening age and population specific retention intervention packages especially for men, adolescents and children.

- PEPFAR Uganda will contribute to VL reagent procurement to ensure commodity security for continued VL testing and high VL testing coverage. We will optimize continuous quality improvement strategies at the laboratory/clinic interface, the national sample transport system to reduce turnaround time (TAT) and minimize missed opportunities, especially in the Karamoja Region currently supported by MOH and UN/Ireland AID (centrally supported districts).
- Improve Lab Information Management Systems and EMR (sample tracking, identification VL eligible and non-suppressed client, data visualization).



Group ANC/PNC for Pregnant & Breastfeeding AGYW 15-24 yrs: MOH is currently piloting a Group-Antenatal (G-ANC) model of care in 33 PEPFAR-supported sites targeting pregnant AGYW (HIV+ and HIV-) 10-24 years old in high-volume sites. This is described more fully above in the PMTCT section above, entitled *Group ANC/PNC for Pregnant &Breastfeeding AGYW 15-24 yrs: A Differentiated Service Delivery Model.*

4.4 Commodities

Uganda's HIV commodity funding landscape features three main funding entities: GOU, PEPFAR and GF. For ARVs, there is an optimistic outlook moving in to FY 2020 with GOU pledging to increase its funding level by 50 % (approximately 13 million US dollars), thus meeting a requirement in the OGAC planning letter. GOU funding for ARVs is currently limited to procurement from a

local manufacturer, Cipla/Quality Chemicals Uganda Limited which offers a 15-30% increased pricing structure. With the three entities, there is not expected to be a financial gap for ARVs in the public sector for FY19/2020. PEPFAR will continue to fast track the transition of both adult and pediatric patients on NVP regimens to ATV/r and DTG for adults and LPV/r based regimens for children. For the NVP residual clients mainly women who are intolerant to both DTG and EFV, the country plans to utilize stocks procured by GOU from Quality Chemical until January 2020 after which time they will be transitioned to ATV/r.

HIV RTKs

Funding for RTKs for general population is provided for by GF/ PEPFAR to run through the end of FY2020, however central stocks levels for public sector reduce tremendously towards the last quarter of FY2020 (Q1 COP20). During COP19 implementation, GOU will introduce recency testing for all identified positive supported by PEPFAR.

Viral load/EID commodities

PEPFAR is the currently the only funder of viral load commodities in Uganda. Under COP 19, PEPFAR is funding 79% of the national requirement for viral load; this translates into 1.2 million tests. EID commodities are fully funded under COP19 by PEPFAR to meet 100 % of the national target. During FY2020, the country will introduce EID POC to carry out 20% of the tests (36,478) and accounting for one-third of the EID budget ($1,075,510). Conventional testing amounting to 123,544 tests and accounting for $ 2,137, 320 has been planned for in COP19; this will be maintained under the centralized testing system. There is no anticipated funding gap for EID reagents during COP19 implementation.

VMMC commodities

PEPFAR will carry out 800,000 VMMC procedures during COP19 and currently fully funds the national program commodities requirement. Uganda will gradually decrease procedures carried out with disposable kits (588,000) and increase procedures carried out with reusable kits (200,000). In COP19, 12,000 procedures are targeted for the ShangRing approach.

TLD Transition

Uganda adopted DTG-based regimens as the preferred first line and alternative second line ART in January 2018. Following the release of the WHO safety advisory in May 2018 regarding the potential increase in risk of neural tube defects among infants born to women who conceived while taking DTG, the national treatment guidelines were revised to incorporate the WHO guidance. To minimize side effects of efavirenz, the country is planning to introduce TLE400. Once Uganda approves the policy, substitution of TLE600 with TLE400 is slated to begin January 2020.

All PLHIV eligible for TLD can initiate or have their legacy ART regimen substituted with DTG if they are virally suppressed (with a suppressed VL within the previous six months). This is to

minimize risk of DTG monotherapy in case they are already failing ART prior to substitution. TB/HIV co-infected patients are also eligible for TLD but requires an extra 50mg pack of DTG.

Phase 1 of the National TLD transition began October 2018 to March 2019 targeting 40 public and all PNFP facilities to reach 228,000 ART clients (i.e. 23 percent of the ART total). Due to unforeseeable bottlenecks and site-level barriers, only 88,034 patients (8.2 percent of total ART number) were reported to be on TLD as of end February 2019. To expedite the transition, the MOH is currently (March 2019) distributing drugs to an additional 607 facilities as part of Phase 1b. Phase 2 is scheduled from March to June 2019, targeting a cumulative number of 576,354 PLHIV (i.e. 51 percent of ART total) on TLD.

With support from CDC and USAID headquarters, an assessment of Phase 1 implementation of TLD transition was conducted in December 2018 and a number of gaps were identified. At site level, health care workers' understanding of TLD eligibility criteria was variable: IEC materials were lacking; the process of screening for eligibility was not standardized with many missed opportunities; and, as a result, there were concerns about continued availability of legacy regimens. Additionally, monitoring of implementation was weak, with no system to address pharmacovigilance concerns.

MOH is working with PEPFAR and stakeholders to address the above issues in a systematic manner, as follows:

- Implementing Partners have intensified site level mentorships with focus on improving use of TLD transition checklist, standardized counseling on DTG use in women, and increasing uptake of DTG among adolescents >20kg.
- For improved communication and messaging, MOH is working with a PEPFAR IP - Communication for Healthy Communities (CHC) to develop counseling prompts and case scenarios for health care workers, and disseminate client literacy materials.
- To streamline DTG eligibility processes at facilities, MOH is finalizing a standard line list template to be used at site level for flagging eligible files (due April 2019).
- To track TLD implementation progress, TLD indicators were incorporated into the weekly surge dashboard that captures reports on individuals on TLD by age, sex and service point at site and district levels.
- MOH, in collaboration with National Drug Authority (NDA), has rejuvenated the national pharmacovigilance system. Sixty-three select ART facilities (including Regional Referral Hospitals) are categorized as 'active response' sites that will be expected to report adverse drug reactions and birth outcomes more systematically and in detail. All other sites will report passively and thus be considered 'spontaneous' reporting sites. A task force has been established to work with NDA comprising membership from MOH (ACP and MCNH), academia, and IPs. Furthermore, in COP19, PEPFAR will be supporting Makerere University John Hopkins University Collaboration (MUJHU) to conduct an enhanced DTG birth defects surveillance survey in selected facilities in Uganda.

Emerging issues:

Legacy regimens: While stocks of TLD, DTG50, and TLE are sufficient for planned scale-up through calendar year 2019, the delay in implementation of the transition has potentially increased the risk of stock out of ART legacy regimens such as Lamivudine/Zidovudine/Nevirapine 150/300/200mg, Lamivudine/Zidovudine 150/300mg, Efavirenz 600mg and Nevirapine 200mg before the completion of the full transition. To ensure availability of all ARVs, PEPFAR is working with the GF and GOU to forecast and quantify the ARV need for COP19. Additionally, PEPFAR is actively tracking the transition in collaboration with the MOH Quantification Procurement and Planning Unit (QPPU) through WAOS and Real Time ARV Stock Status to generate monthly stock status reports at facility level. A TLD dashboard has been established with real-time reporting on a weekly basis.

Nevrapine Atazanavir/Ritonavir (NVP/ATV/r): In line with the OGAC requirements, Nevirapine (NVP) - based regimens will be phased out by December 2019. While the national treatment guidelines have recommended use of ATV/r for this population (estimated at 65,547 by December 2018, and this drops to 36,242 by June 2019), availability is expected October-December 2019. In the meantime, acceleration of transition to TLD will contribute to prolong availability of NVP thus averting treatment interruption.

Transition to TLE400: The MOH is in the process of adoption of TLE400. Policy approval of this formulation by MOH top management is expected by end of March 2019.

TLD 90 and 180 pill packs: In support of improved efficiency of the Differentiated Service Delivery Models for stable clients, the country will introduce TLD 90 and 180 pill packs to facilitate multi-month refills for stable clients.

4.5 Collaboration, Integration and Monitoring

PEPFAR Uganda collaborates closely with the GF via the CCM, as well as with the Geneva-based Country Manager. The 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 has contributed to grant proposals and review meetings. In 2019, PEPFAR Uganda will continue its surge for quality and its leadership of hybrid SIMS/Surge site evaluation visits, as well PEPFAR's ongoing participation in the National Stakeholders' meeting for harmonization and alignment of the GF with other in-country financing mechanisms. We will also carry on in our PEPFAR role in reviewing program implementation frameworks, work plans, budgets and procurement and supply chain plans.

The PEPFAR Uganda commodity supply chain team regularly meets with GF counterparts and the MOH QPPU to coordinate procurement schedules, distribution, and systems strengthening. PEPFAR Uganda and GF are communicating regularly on new grants and the GF's "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 GF 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 program in enrolling people on treatment in FY17 (62 percent of the target)—in the second quarter of FY18 PEPFAR Uganda initiated a "surge" resulting in 71 percent achievement of the FY18 target. The surge, embraced by the MOH in a circular that went out to all Ugandan district health officials and health facilities, is now re-framed as the "surge for quality" and so far in FY19Q1 PEPFAR Uganda is solidly on track, with a 37 percent achievement of its annual target at the end of that initial quarter.

While in 2018, the surge focused on high volume sites yielding 80 percent of the targets, in 2019 and forward, there is a plan to scale up surge for quality to all PEPFAR –supported facilities and to their surrounding catchment areas. In COP19, the surge for quality will be integrated into the routine practice of PEPFAR Uganda IPs, and it is anticipated to spur IPs towards meeting ambitious COP19 targets. The surge for quality focuses primarily on key areas in which the program is performing most poorly, namely finding and identifying HIV-positive individuals (in particular men), reducing testing while improving testing efficiency and yield, ensuring high percentage of linkages to rapid treatment initiation, improving rates of retention on treatment, tracking VL suppression, and related issues of commodity security. The technical activities meant to achieve specific outcomes, such as actions to improve index client partner and pediatric testing and APN, are noted in the strategy tables in SDS section 4.3.

Implementing 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 the HIBRID data collection system. The data are disaggregated by age band, testing modality, sex, 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 misdistribution of supply. These tracker dashboards are updated on a weekly basis to monitor supply for HIV services carried out with district logistics persons, health facility stores managers and Medicines Management Supervisors. This tracking process will maintain HIV commodities stock levels and allow for inter facility commodity transfers to maximize identification of HIV-positive persons and enrollment of each on ART.

PEPFAR Uganda agencies have combined surge and SIMS assessments on priority topics, including retention strategies On a quarterly basis, PEPFAR Uganda is also issuing surveys among all IPs to monitor the scale-up of key indicators, such as 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. PEPFAR Uganda employs clear and regular communication with IPs and with IP headquarters' offices to facilitate efficient work plan approvals, sub-contracting, procurements, and evaluation protocol approvals. Technical staff review weekly surge performance data and provide immediate feedback if the data trends are of concern. Integrated technical and management teams travel to key underperforming sites and districts with partners and engage MOH counterparts and district health teams 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.

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 was expanded during COP18 to include CSOs, representatives from the UN family, and GOU leadership to continue emphasizing the surge for quality, reviewing data outputs, and collectively determining approaches to meet goals. As this approach is successful, it will be continued in COP19.

Above site service delivery

The key outcomes expected from COP19 above site service delivery activities include accurate commodity supply plans; no stock out of ARVs and key HIV commodities; TLD transition completed by December 2019 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

Standard Table 4.6.1 is required; however, the rows for prioritized populations for treatment initiation may be different.

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 FY20) *HTS_TST*	Newly Identified Positive (APR FY20) *HTS_TST_POS*	Newly Initiated on ART (APR FY 20) *TX_NEW*
Total Men 15+	**1,304,902**	**122,800**	**117,075**
Total Women15+	**1,796,311**	**48928**	**45,959**
Total Children excludes EID (<15)	**105,580**	**17,812**	**17,050**
Total from Index Testing	**107,672**	**31,136**	
Adults			
TB Patients	***45,202***	**13,060**	**13,060**
Pregnant Women	***1,274,150***	**27,074**	**25,750**
VMMC clients	***519,846***	**4502**	**4,287**
Key populations	***268,528***	**58213**	**12645**
Priority Populations			
Other Testing	***1,367,595***	**144,884**	**137,967**
Previously diagnosed and/or in care	***NA***	**NA**	**NA**
Pediatrics (<15)			
HIV Exposed Infants		**2,221**	**2,221**
Other pediatric testing	***105,580***	**17,812**	**17,050**
Previously diagnosed and/or in care	**NA**	**NA**	**NA**

Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations (30+)**	**Population Size Estimate (SNUs)**	**Current Coverage (FY19)**	***VMMC_CIRC* (in FY20)**	**Expected Coverage (in FY20)**
Buikwe District	54,080	233,300	81 percent	8,771	96 percent
Bukomansimbi District	19,160	78,700	54 percent	816	57 percent
Buvuma District	19,190	68,400	83 percent	1,252	83 percent
Gomba District	22,440	90,900	54 percent	1,369	60 percent
Kalangala District	14,426	38,300	89 percent	626	89 percent
Kayunga District	44,790	202,600	84 percent	4,225	92 percent
Kiboga District	21,800	88,600	88 percent	648	89 percent
kyotera District	37,546	130,400	46 percent	2,155	50 percent
Luwero District	59,340	262,700	78 percent	2,170	79 percent
Lwengo District	33,970	142,000	60 percent	2,798	68 percent
Mityana District	44,910	184,500	75 percent	2,831	80 percent
Mpigi District	34,340	144,400	63 percent	1,660	66 percent
Mubende District	99,010	281,500	54 percent	4,886	57 percent
Mukono District	82,090	339,600	87 percent	4,536	90 percent
Nakaseke District	33,570	128,800	80 percent	2,048	85 percent
Nakasongola District	25,655	112,400	70 percent	1,878	75 percent
Rakai District	32,594	158,000	104 percent	1,742	107 percent
Sembabule District	36,010	149,300	62 percent	2,132	66 percent
Wakiso District	317,090	1,381,000	74 percent	18,657	76 percent
Bugiri District	47,040	235,500	113 percent	1,095	110 percent
Busia District	40,070	187,700	107 percent	1,095	105 percent
Butebo District	17,857	59,400	49 percent	216	49 percent
Buyende District	39,240	205,200	83 percent	1,296	83 percent
Iganga District	61,200	194,900	79 percent	1,597	80 percent
Mayuge District	56,660	275,400	99 percent	939	98 percent

Namayingo District	26,300	118,600	90 percent	540	90 percent
Ngora District	17,320	80,800	32 percent	-	31 percent
Serere District	36,090	176,800	35 percent	1,341	37 percent
Alebtong District	29,150	130,700	37 percent	2,038	42 percent
Kole District	30,310	140,800	43 percent	1,890	48 percent
Pakwach District	20,815	96,600	57 percent	1,714	63 percent
Buliisa District	16,240	78,300	61 percent	-	58 percent
Bunyangabu District	23,675	97,500	57 percent	2,169	65 percent
Hoima District	86,590	187,300	56 percent	3,912	58 percent
Ibanda District	34,170	135,600	57 percent	1,643	61 percent
Isingiro District	68,690	290,800	55 percent	2,036	55 percent
Kibaale District	44,250	101,200	58 percent	2,104	62 percent
Kibaale District	44,250	101,200	58 percent	2,104	52 percent
Kamwenge District	58,010	254,600	59 percent	3,063	62 percent
Kanungu District	33,330	133,900	53 percent	1,557	56 percent
Kibaale District	44,250	101,200	58 percent	2,104	130 percent
Kiruhura District	53,940	205,800	42 percent	1,552	44 percent
Kiryandongo District	33,270	158,500	70 percent	-	69 percent
Kyenjojo District	57,770	265,200	63 percent	3,499	67 percent
Masindi District	42,490	174,500	76 percent	2,299	79 percent
Mitooma District	22,110	92,400	67 percent	1,509	73 percent
Ntungamo District	63,280	262,200	53 percent	2,372	56 percent
Rubanda District	24,160	99,100	38 percent	1,071	42 percent
Rukungiri District	40,770	160,300	64 percent	1,451	67 percent
Sheema District	28,020	106,100	72 percent	1,416	77 percent
Total/Average	**2,273,328**	**9,123,500**	**68 percent**	**114,822**	**71 percent**

Table 4.6.3: Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate (scale-up SNUs)**	**Coverage Goal (in FY19)**	**FY20 Target**
MSM	88,950(33,013)	33	29,276
FSW	198,376 (141,961)	57	113,878
***Prisoners**	55,000 (44,060)	75	120,000
Prison Officers	7,182 (6,265)	33	2,350
Police[55] and private security guards	86,643 (83,547)	84	72,443
FF	2,235,450 (NA)	7	148,242
Military	ND	-	52,500
Truckers	31,588	85	26,838
SDC	25,693 (22,512)		24,429
AGYW	1,980,000 (789,400)	Maintain and follow up in the 13 districts and 4 PMTCT districts.	239,528
PrEP implementation (FSW, MSM,FF)		-	30,003
TOTAL			**863,307**

Table 4.6.4 Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY20Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target) OVC***
Military Uganda		4336	3354
Agago District	6051	3298	3090
Apac District	6104	3743	3510
Arua District	2571	8148	7640
Bugiri District	8454	3070	2875
Bugweri District		902	847
Buikwe District	9674	6439	5249
Bukomansimbi District	12932	2159	1705
Bunyangabu District	8687	4093	3230
Bushenyi District	2379	1921	1695
Busia District	7327	1213	1135
Dokolo District	5997	765	719

Gomba District	12314	6144	5421
Gulu District	6012	9926	9306
Hoima District	5359	7081	6246
Ibanda District	2474	1223	1080
Iganga District	8285	7233	6780
Isingiro District	3225	4241	3742
Jinja District	8031	6822	6395
Kabale District	2904	3309	2919
Kabarole District	4952	7942	6270
Kagadi District	5074	2033	1605
Kakumiro District	4905	1678	1482
Kalangala District	11554	343	270
Kalungu District	13273	2035	1605
Kampala District	7488	28295	22337
Kamuli District	8332	3238	3034
Kamwenge District	5221	7518	5937
Kanungu District	2757	2202	1738
Kasese District	5353	8146	6430
Kassanda District		2581	2038
Katakwi District	3616	2403	1898
Kayunga District	10213	3347	2730
Kibaale District	4619	5564	4910
Kiboga District	8674	364	287
Kikuube District		3331	2938
Kiruhura District	2959	2071	1828
Kitgum District	5978	7130	6685
Kole District	6049	362	341
Kotido District	3520	446	420
Kwania District		1723	1616
Kyegegwa District	4656	4324	3413
Kyenjojo District	5055	11783	9822
Kyotera District		8829	6971
Lira District	6087	12304	11537
Luwero District	10903	6979	5819
Lwengo District	14143	4699	3709
Lyantonde District	12154	2096	1656
Masaka District	19201	4690	3703
Masindi District	4717	1283	1009
Mayuge District	8497	3951	3705
Mbale District	7309	4094	3836
Mbarara District	3175	10016	8835

Mitooma District	2377	1305	1155
Mityana District	9664	7068	6237
Mpigi District	12941	2051	1618
Mubende District	11452	7615	6011
Mukono District	10953	9983	8135
Nakaseke District	8760	890	703
Namayingo District	8213	733	688
Nebbi District	6443	1420	1123
Ntungamo District	3190	2675	2360
Omoro District	5953	4095	3837
Oyam District	6391	8191	7680
Pakwach District	1751	1781	1409
Rakai District	31480	8571	6768
Rubanda District	2438	741	659
Rukiga District	5874	1927	1701
Rukungiri District	2879	5107	4504
Sembabule District	22790	2844	2248
Sheema District	2223	2201	1944
Soroti District	3716	1796	1420
Tororo District	7393	4219	3955
Wakiso District	38636	23320	19436

VL and EID Optimization

Uganda has a centralized VL and EID testing system using conventional PCR platforms for analysis of both plasma and dried blood spot (DBS) samples transported through the national specimen transportation network. The FY18 EID coverage stood at 51 percent and 82 percent for age bands 0-2 and 0-12 months respectively. To improve on this performance, PEPFAR Uganda working with MOH will scale up POC testing to reach infants and children who missed a DNAPCR test per the National EID algorithm especially those in hard–to-reach areas (mountainous and/or on island communities), as well as all eligible infants and children admitted in high yield inpatient, TB and nutritional wards. EID POC implementation will facilitate optimal EID coverage, reduce rates of HIV Exposed Infants (HEIs) lost to follow up and support early ART initiation for identified HIV positive infants at all entry points.

In COP19, based on scalability, country capacity, and the available budget, PEPFAR Uganda working with the MOH will run 20 percent and 80 percent of the total projected EID tests on the POC and conventional platforms respectively. The rollout of the EID POC will conform to an agreed-upon national policy for the selection, evaluation, adaptation, implementation and evaluation of POC testing in Uganda. The MOH has constituted a stakeholder committee to develop the EID POC national implementation plan that will outline criteria for site selection and

integration of EID into existing GeneXpert equipment without disrupting the TB program, service delivery models, training and the roll out schedule. Other POC platforms will be deployed as appropriate. The committee identified EID coverage and health facility issues such as staffing and infrastructure as key considerations. For sites that have a GeneXpert machine, addition of EID POC will only be considered if, the GeneXpert theoretical utilization rate is less than 80 percent. The site selection criteria will prioritize facilities with:

- more than 10 days EID sample transport time,
- a sample volume of at least 10 EID samples per month,
- located more than 100km from Kampala,
- located in hard-to-reach areas (mountainous areas and/or on islands),
- low EID coverage.

PEPFAR Uganda will continue implementing strategies to enhance the efficiency of the conventional EID platform. These strategies will reduce the sample turnaround time and enhance effective utilization of results for patient management. These strategies and POC scale up with fidelity will improve early identification of HEIs, timely ART initiation for all eligible infants, enrollment and retention at MBCPs, identify, and address bottlenecks affecting EID TAT. They will include optimum utilization of electronic results download, additional hub riders and a sample tracking system.

PEPFAR Uganda has allocated USD 3,212,830 to conduct ~ 165,030 EID tests in COP19. POC EID will account for 20 percent of the EID tests (39,305 tests) at a unit cost of USD 29.5 (total cost for POC EID USD 1,075,510). Conventional EID will account for 80 percent of the EID tests (125,725 tests) at a unit cost of USD 17 (total cost for conventional EID USD 17).

PEPFAR Uganda supported improvement of VL coverage from 63 percent in FY17 to 85 percent by 2019 Q1.

In line with MOH strategies, in COP19 PEPFAR Uganda will not support VL POC testing for pregnant and breastfeeding women. PEPFAR will use a multifaceted strategy consisting of a surge approach using existing partners and MOH-led district-focused support to the centrally supported districts to improve VL coverage from 85 percent to 90 percent across all regions and population groups including pregnant and breastfeeding women. These strategies will include

- Implementation of a bar-coded sample tracking systems for monitoring the movement of samples from collection to resulting delivery
- Expanding the electronic result transmission to all high-volume sites by real-time linkage of EMR with the VL dashboard
- Sending of a preemptive system generated alert to health workers for intensive adherence counseling and for sample collection one month prior to VL due

In addition, using lessons learnt from the already established EID POC testing platform, and as scientific evidence on feasibility and scalability of VL POC becomes available, PEPFAR Uganda in

collaboration with MOH and stakeholders, will consider VL POC for pregnant and breastfeeding women in subsequent years.

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

5.1 COP19 Programmatic Priorities

Please refer to section 5.3 below (Establishing service packages to meet targets in attained and sustained districts) for priorities under COP19 and an explanation of any differences in program approaches and activities between attained and sustained locations and populations.

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 19**	**Expected result APR 20**
HIV testing (all populations)	*HTS_TST*	**1,686,319**	**1,273,671**
HIV positives (all populations)	*HTS_TST_POS*	***55,190***	***66,726***
Treatment new	*TX_NEW*	***51,540***	**82,794**
Current on ART	*TX_CURR*	***586,936***	**640,904**
OVC	*OVC_SERV*	***187,656***	**152,644**
Key populations	*KP_PREV*	***163,289***	**203,060**

**Calculations for targets for clinical services are 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 19**	**Expected result APR 20**
HIV testing in PMTCT sites	*PMTCT_STAT*	112,337 (BE)	144,357 (BK)
HTS (only sustained ART sites in FY 17)	*HTS_TST/HTS_TST_POS*	235,931/5,932	243,789/6,649 (FV+CA)/Fc

Current on ART	*TX_CURR*	54,180 (N)	53,526 (O)
OVC	*OVC_SERV*	0	0

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

COP19 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 which no longer serve to help PEPFAR Uganda reach its targets.

HTS strategy: The main difference in the packages is in the micro targeting applied to attained districts to improve yield. Specifically, in districts that have over 70 percent ART saturation, PEPFAR Uganda will discontinue universal HIV testing in OPD and will instead focus on index client testing, testing symptomatic patients in OPD using a screening algorithm, and high risk service delivery points (TB, nutrition, STI, inpatient units). In attained districts index testing will account for more than 50 percent of newly identified HIV positives.

Recency testing will identify hot spots for new HIV infections in attained districts. In sustained districts, recency testing will inform further micro targeting of HTS outreaches to identify and treat KP groups driving continued HIV transmission.

Sustained districts will also provide targeted testing at high yield service delivery points, including TB, STI, nutrition, and inpatient units. Index testing will be performed at all service delivery points, including OPD, where a screening tool will be applied. Community HTS will target KPs and high-risk groups. Index testing and APN will be the main approach for finding men. In COP19, 50-64 percent of positive men are expected to be identified through APN and index testing.

In both attained and sustained districts, COP19 will focus on rollout of evidence-based packages of services that have been proven to make the most significant contributions to epidemic control. It should be noted that the following services would not differ between attained or sustained districts as these interventions are critical to the quality of services in all sites regardless of district prioritization:

- HIV self-testing (HIV ST) targeting men and KPs;
- use of Syphilis Duo test kits in ANC;
- recency testing;
- linkage to treatment;
- retention on treatment;
- PMTCT service packages;
- support for labs;
- weekly data reviews and reporting as part of surge for quality; and
- quality improvement per the Ugandan national QI collaborative.

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.

Centrally supported districts: In COP15 the GOU took responsibility for service delivery in 10 districts in northern Uganda and Karamoja region (known as 'centrally supported'). Performance along the clinical cascade in the Karamoja districts (see below) remains suboptimal — as compared to the national average—with lower VL coverage, lower VL suppression, lower ART coverage, lower linkage and retention. The region is hard-to-reach with poor road networks, a nomadic population with high levels of stigma and discrimination, as well as gender-based violence (GBV). There is limited district capacity to provide leadership and technical guidance, coordinate partner support, and ensure data quality.

There is stark difference between districts, with some districts over achieving second 1st and 2nd 90 mainly due to referral facilities. All districts performed poorly for the VL suppression, where the Karamoja regional average is 35 percent as compared to national VL suppression of 65 percent.

District	COP19 Priority	PLHIV FY18	Diagnosed	TX_CURR	VL Suppressed	% Diagnosed	% TX_CURR	% VL Suppressed
Abim	Centrally Supported	2,832	1,535	1,532	841	54	54 t	30
Amudat	Centrally Supported	461	249	235	75	54	51	16
Kaabong	Centrally Supported	434	1,479	1,328	249	340	306	57
Nabilatuk	Centrally Supported	154	292	292	35	189	189	23
Nakapiripirit	Centrally Supported	707	486	486	220	69	69	31
Napak	Centrally Supported	808	1,080	1,080	465	134	134	58
Total		**5,398**	**5,121**	**4,953**	**1,885**	**95**	**92**	**35**

In COP19, PEPFAR will provide targeted technical support through the existing structures while leveraging resources from other health development partners currently active in Karamoja region. The MOH will provide overall program coordination and oversight, conduct quarterly support supervision and performance review meetings and ensure rollout of revised policies and guidelines to improve the clinical cascade. The District Health Teams (DHT) will coordinate the HIV response through all stakeholders (including all health development partners). DHTs will also be responsible for improving capacity to collect, analyze, and interpret data for performance monitoring and timely course correction and leadership of quality improvement initiatives.

The PEPFAR Uganda IPs in the region (TASO Soroti and RHITES-E) will strengthen district-led programming by focusing on strengthening implementation of guidelines using quality improvement methodologies. They will also collect and interpret quality data to identify gaps and track progress. Improving functionality of laboratory hubs in the region will be a priority. TASO

Soroti and RHITES-E will collaborate to leverage the activities of other HDPs in the region, and will develop innovative and contextually appropriate differentiated service delivery models. After 2-years of implementation, it is expected that the implementing partners will transition many activities to the DHTs.

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—COP19 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 public sector engagement process will focus on the national entities, the regional and sub national entities that will enhance the decentralized response through delivery of comprehensive HIV/AIDS/TB services within all high volume sites and communities that do account for 80 percent of the unidentified PLHIV for rapid enrollment on ART services. Key areas of intervention will include supporting the MOH to develop critical policies that will respond to the dynamics of HIV/AIDS/TB, technical guidelines and standard operating procedures that will re-enforce its oversight and leadership roles and responsibilities.

The Uganda health system operates through a decentralized structure supported by the central MOH. The Regional and tertiary hospitals provide higher levels of care and quality improvement and mentorship. MOH has not had adequate staffing to allow them to effectively provide oversight of the HIV epidemic to the regions and over 128 districts. The regional referral hospitals (RRH) provide an opportunity to address and close these gaps. Under COP19, these facilities will be supported to expand their technical support supervision to the HIV/AIDS epidemic. This approach will ensure that interventions within districts are standardized including quality improvement, planning processes and performance monitoring frameworks with defined outcomes, effective quantification and forecasting and delivery of ARVs and commodities, and improved human resource management.

The PEPFAR Uganda team conducted a number of consultations and analyses to determine which specific public sector health systems interventions COP19 should prioritize. These consultations and analyses included 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, continued commodity procurement for the public sector, and efficiency gains in the PNFP 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 51 percent public sector investment in facility and community based service delivery in FY15 to 66 percent in FY18, 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, data cleaning, and utilization of data. In COP19, the program will achieve completion of the TLD transition, including women of childbearing potential and adolescents, and removal of NVP-based regimens. TPT scale up for all PLHIV, in tandem with the TLD transition, will be brought to scale by 2020.

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 VL 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 for the procurement of ARVs has declined in COP19, relative to COP18. Part of this decline in USG funding for the public sector is due to an increase of GOU commitment by 50%.

Accordingly, the above service delivery investments in COP19—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 the MOH on the oversight, leadership, and management of the HIV/AIDS response, including advocacy for increased funding commitment from GOU to support the activities. The COP19 goal of electronic medical record (EMR) and electronic HIV case reporting implementation at 100 percent of HIV care facilities includes expanded functionality and point of care (POC EMR) data capture in national and regional hospitals, district hospitals and Health Center Level IVs. EMR utilization by the caregiver at POC will ensure historical and current patient data availability while the patient is still in the clinic. This will be critical for EMR clinical decision support for PEPFAR priorities such as recency testing, multi-month scripting, and DTG transition. These above service delivery investments are summarized in the next section. Specific activities are captured in greater detail in Table 6 (Appendix C).

National Supply Chain system

Overall, PEPFAR will continue to support the technical capacity of the MOH at the 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. In COP19 PEPFAR Uganda will work to strengthen systems that were identified as under-performing in the National Supply Chain Assessment (NSCA) that was completed in 2018. ERP and EMR can easily dovetail with NSCA recommendations.

Local Partners for Sustainability

COP19 above service delivery investments in civil society leverage the fact that 69 percent of PEPFAR Uganda funding currently goes to 183 indigenous partners, including FBOs, 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. A new Local Partner Initiative will be launching in 2019, increasing local implementing prime partners.

Human Resources for Health

PEPFAR Uganda will provide technical assistance to the GOU to improve HRH capacity and coverage at national, district and site level while continuing to focus the current support to areas of high HIV burden and need and create a sustainable transition path for the health workers. PEPFAR Uganda is prioritizing HRH support for critical cadres to manage and coordinate the response at key MOH departments, in addition to seconding priority cadres to high volume ART sites to support targeted HIV/TB services at different levels of care. At the national level, PEPFAR support for technical advisors will progressively decline as the capacity of MOH core staff improves, efficient approaches for mentorship and training including tele-mentoring and tele-training are introduced and regional oversight structures are strengthened. PEPFAR will focus on building accountable, responsive and sustainable HRH systems through supporting recruitment planning, training for specific cadres in short supply especially dispensers and epidemiologists, enhancement of governance at site level, HR policy reviews including revision of staffing norms, performance management to improve HW productivity and advocacy for improved wage bill allocation by GOU as well as absorption of PEPFAR support health workers.

PEPFAR will work towards increasing the community level workers in districts where they are limited to address the growing needs for follow up, counseling, linkage, adherence that are heavily reliant on community workforce, and engage PLHIV and CSOs networks through national, regional and district forum. Supporting the finalization of the Community Health Extension Worker (CHEW) is a policy priority for COP19.

National data system architecture

Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching KPs, and more agile epidemiology as cases get harder to find and funds reduce. In order to achieve greater data precision to support patient centered care, index testing, recency testing, retention on treatment and sustained VL suppression, rapid deployment of electronic medical records at high volume health facilities and robust laboratory

testing systems need to be integrated using existing unique identification algorithms into national health registries.

In order to expand quality and coverage of Electronic Medical Records (EMRs) and introduce sufficient enterprise architecture to support health information exchanges while maintaining core level funding within program areas for information systems, a philosophical shift in EMR deployment is required. With over 1000 clinics (>50%) with functional EMRs, PEPFAR Uganda will first focus on the quality of these installations and improved functionality for supporting emerging USG and MOH program priorities and system sustainability. First, the EMR value proposition must be increased in that it must be beneficial to the clinic in general and ideally across health domains including HIV, TB and health security to increase likelihood of shared investments and shift to government support. Secondly, the EMR must be moved out of the data rooms and shift from a reporting system to a patient-centered point of service care system. Finally, the implementation and ongoing maintenance costs per site must be lowered. This will be achieved through improved HR strategies including POS data capture, task sharing/shifting, web-based/zoom based help desk/training and centralized procurement of hardware and internet service.

At the national level, a platform for health information exchange linking patient level EMR and lab data through a national system of unique patient identifiers must be established and well documented (design, security, and total cost of ownership).

Initial hosting will occur in the data room of the Central Public Health Laboratories as stipulated by the Minister of Health. At the same time, cloud replication of the system will be established allowing for comparison of cost, maintenance, and performance differences between the two platforms. This should quickly demonstrate the exceptional value and robustness of cloud solution and facilitate negotiations with the GOU to consider cloud solutions. Enterprise architecture discussions will reach beyond HIV/TB and will represent the framework of systems, data and public health science onto which PEPFAR support will begin to transition responsibility and ownership of the many important programs which PEPFAR has brought to Uganda.

In COP19, systematic rollout of robust health information systems (HIS) and data solutions interconnected from the community to national levels of health system that is critical for achieving and sustaining epidemic control. Support will also be directed towards the development and implementation of an eHealth Enterprise Architecture (EA) and Interoperability framework that shall comprise of reference models, principles, procedures and standards with a common language against which all eHealth investments shall have to conform. EA development activities will be carried out at regional levels so as to support implementation of full arm EMR systems with point of service data capture for all key health services as well as supporting case reporting with unique identification, interoperability and health exchanges. UI system will ensure individuals get the health services they are entitled to via a means of correct identification, while also making it possible to track such individuals' medical journey within the health system. In COP19, effort will also be directed to capacity building for health information systems. This is critical for building a local community that will support these systems and to prepare for full government takeover.

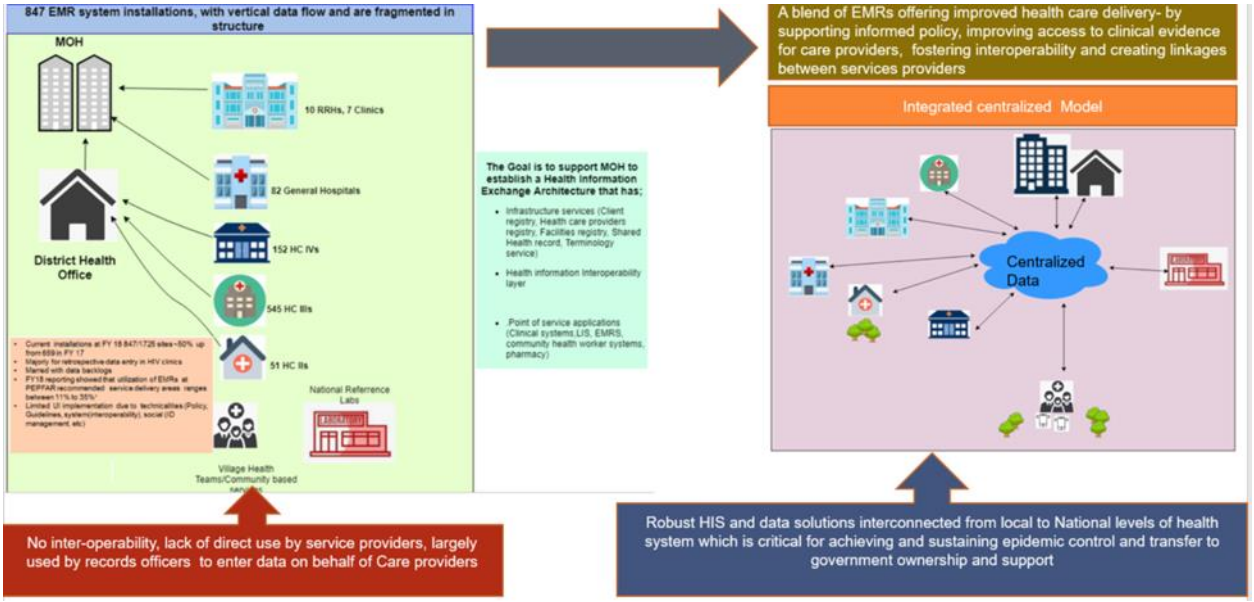


Fig. Robust solutions for an integrated centralized model

Unique Identifiers as part of HIS architecture

The ultimate goal of investing in infrastructure that supports scale-up of Unique Identifiers (UIs) for patients across all sites is to establish HIS architecture based on a robust system of UIs to provide patient-centered services, improve data precision, and support implementation of programmatic priorities required for epidemic control by harnessing the power of EMRS to ensure immediate availability of relevant information in the system for improved clinical decision support to enable better patient management leading to better health outcomes. Connected EMRS will support successful tracking and tracing of individual PLHIV who have failed to initiate treatment or failed to return to care/treatment and will allow targeted interventions to help return those patients back to treatment, improving retention, document their treatment in another setting, or document their death (mortality) or LTFU and therefore supporting monitoring of PEPFAR indicators along the HIV continuum of response/care (recency testing leading into HIV case base surveillance, TX_NEW, TX_CURR, VL suppression, mortality as well as monitoring clients morbidity). Improving functionality will ensure that EMRS to support the various differentiated care delivery models (DCDMs) and interventions such as multiple month scripting.

Improvements in data completeness and accuracy, and timeliness of reports due to POC (real-time) data entry by health care workers (who understand it better) will result in reduced error and inconsistencies in data through computerized validation rules and no backlog in data entry. Deduplication of data will also be possible resulting in more accurate program data, monitoring and planning.

Implementation of EMRS will leverage MOH as well as other donors' investments. For example, the delegation of systems operation across the health workforce for POC system functionality, initiation of efforts for negotiation for lowered/no cost health system internet connectivity rates by other multilaterals, leveraging existing government infrastructure like RRHs for creation of tele-support and mentoring platforms will lead to lowered operation costs. Successful implementation will identify ongoing opportunities for cost savings and cost sharing with other health programs/donors. This will be complemented by the already-existing national governance structures such as the Health Data Collaborative, the eHealth TWG, current national eHealth Policy, National Data Protection and Privacy Act, as well as supportive guidelines.

In the long run, EA will provide a platform for integrated collection, analysis, storage, and reporting of data from major data streams possible and functional. Local technical expertise will be established and institutionalized at national, regional and district levels for full and sustained use of the information systems. This will pave way for GOU/MOH ownership and leadership of functional and efficient national information systems with evidence influencing program improvements on a consistent basis.

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.

Bolstering Laboratory Systems

COP19 will build on the achievement of COP18. These include a VL/EID dashboard that provides prompt access to VL/EID data, a laboratory information system rolled out in 30 facilities, a national tester and site certification program for HIV RDT, 11 laboratories internationally accredited and 75 percent of the laboratory hubs attained minimum requirement for national accreditation (at least star 1). In addition, Uganda now has a calibration center, 35 trained biomedical engineers and 8 functional regional equipment maintenance workshops. The 2010-2015 National Health Laboratory Strategic Plan was reviewed and a new one 2016-2020 approved. To assist with retention of adequate skilled HRH, a laboratory scheme of service was revised and approved and a scope of practice and staffing norms drafted. To take stewardship of laboratory services, the MOH created a department of National Health Laboratory Diagnostic Services (NHLDS) under which the Uganda National Health Laboratory Services (UNHLS) and all other laboratory services fall.

In COP19, PEPFAR Uganda will support MOH to document the utilization of VL and EID results looking at the cycle from specimen acquisition to result utilization, thereby also improving the clinical/laboratory interface.

To achieve this, PEPFAR Uganda will support the MOH to implement an electronic sample and results tracking system spanning requesting facilities, laboratory hubs, centralized and decentralized testing facilities up to the centralized national levels. This support will include the

roll out of laboratory information system (LIMS) into 230 facilities targeting hubs, centers of excellence and high volume facilities where POC platforms exist. Implementation of LIMS will facilitate the interface of laboratory equipment to LIMS streamlining data flow from analytical equipment directly to the national data management networks (LIMS, EMR and DHIS2).

PEPFAR Uganda will continue to support laboratory continuous quality improvement programs targeting 100 hubs and 269 facilities, proficiency testing programs for VL, EID, CD4, HIV-RDT, TB, HIV/Syphilis Duo and Cryptococcal antigen identification. In addition to enhance its sustainability, PEPFAR will support accreditation of the calibration center at UNHLS as well as maintain investments in biosafety/biosecurity operations, development of national standards for waste management targeting toxic/carcinogenic waste generated from HIV/TB platforms and institutional capacity building for stewardship of laboratory services in the country. Support will extend to the development of national health laboratory accreditation policy, which will establish a framework for sustainability of accredited labs to sustain gains achieved.

Building on the COP18 absorption by GOU of 25% of staff for the MOH and Central Public Health Laboratories (CPHL), PEPFAR will intensify advocacy for GOU to increase funding and support to CPHL in all areas to ensure Uganda can maintain strong leadership in lab systems.

Surveillance, Research, and Evaluation: An Overview

Surveillance & Surveys: proposed activities will inform efforts in finding men, reaching KPs, preventing HIV in AGYW, approaching Epidemic Control by efficiently identifying undetected HIV cases including in children, and readying Uganda for TLD rollout by assessing birth defects and DTG resistance.

Research: Proposed and ongoing research will inform better prevention, care and treatment services for the military, fishing, and nationwide AFRICOS populations, and will identify and seek to modify barriers to PrEP among AGYW sex workers.

Evaluation: proposed activities will identify effective and cost-effective approaches in priority areas, both existing (HTC, linkage, retention, viral suppression, incidence reduction) and new (PrEP, self-testing, recency testing). Short loop approaches will allow for more rapid course-correction and optimization as Uganda seeks to consolidate its gains from PMTCT and Test and Start efforts and to drive through to epidemic control.

Specifically, COP19 will feature the following surveillance, research and evaluations.

COP19 Surveillance Portfolio

IM Number	Short name of study	Objective	Status
SURVEILLANCE			

IM Number	Short name of study	Objective	Status
18567- Enhanced case-based surveillance and validation of TX_ML indicator	Case based surveillance and TX_ML validation	To better understand mortality for case-based surveillance and TX_ML	New
17705- Hospital-based birth defects surveillance in Kampala, Uganda	Birth Defects study	This study will collect crucial information on the possible effects of these medications to the unborn babies in the PMTCT setting.	Ongoing - Data collection
18566- Scale up of Recency Testing specifically QA/QC activities	Recency Testing	To scale up recency testing specifically QA/QC activities (Next UPHIA in 2020)	New
18565- Provision of comprehensive, friendly services for KPs and CRANE follow on for enhanced surveillance.	Provision of comprehensive, friendly services for KPs and CRANE follow on for enhanced surveillance	Primary focus: Sero-behavioral and recency surveys, size estimations, and mapping among KP/PP	Ongoing-protocol scope
17703- Monitoring and Evaluation Technical Support (METS)	Surveillance information to improve HIV program monitoring through strengthening the development of the HIV treatment cascades.	This activity supports improved monitoring of the HIV response through better determination of the treatment cascades	Ongoing - Data collection

COP19 Research Portfolio

RESEARCH			
18502- DREAMS initiative and HIV/AIDS prevention support to the Ugandan People's Defense Force	Seroprevalence and behavioural epidemiological risk survey (SABERS) in the Uganda Peoples' Defense Forces (UPDF)	This activity will provide more accurate data to support provision of services among the military and other uniformed forces.	Ongoing - Data collection
18568- The Supporting Operational AIDS Research mechanism (Project SOAR) Population Council	Modelling for VMMC	Project SOAR will support Uganda's VMMC program in the implementation of tools to provide data for planning and implementing effective and efficient VMMC programs. Data generated will enable a quality and cost-effective VMMC program and support planning for demand creation to achieve age pivot .The IM will support the updating of the Decision Makers' Program Planning 2.0 (DMPPT 2.0) online tool which will project VMMC coverage by district and age group to establish VMMC unmet need, set appropriate targets, and project VMMC impact. The IM will roll out the Site Utilization/Site Capacity tool for VMMC sites to assess the site capacity, monitor site performance, and estimate the site utilization rate and performance index. The mechanism will also roll out the GIS Visualizing Mapping tool to capture data from the DMPPT 2.0, DHIS-2 and DATIM.	Ongoing - Data collection
9043- MUWRP AFRICOS	African Cohort Study (AFRICOS)	The objective of this activity is 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- data collection

COP19 Research, cont'd

9043- MUWRP	The Feasibility of Implementing HIV Pre-exposure prophylaxis among HIV negative - Adolescent Girls and Young Women sex workers, aged 18-24 years in Mukono district, Uganda: A pragmatic demonstration project.	The objective of this activity is to elucidate factors that influence uptake, retention and adherence to PrEP among female sex workers aged 18-24 years in Mukono District, Uganda before and during PrEP implementation.	Ongoing—data collection
9043- MUWRP	Expansion of Health Information systems around interoperability of EMR and client registry	HMIS, EMR, and client registry enhanced	New

COP19 Evaluation Portfolio

EVALUATIONS			
18563- OVC Evaluation	OVC Evaluation	The evaluation will provide PEPFAR agencies and partners with actionable findings to transition OVC service delivery responsibility to a sustainable case management model delivered by local public and private institutions and improve service delivery layering (and its cost effectiveness) by rigorously examining the prominent causal pathways out of extreme vulnerability.	Ongoing-data collection

COP19 Evaluation, cont'd

18032- Acceleration of Regional Comprehensive HIV & AIDS Service Delivery through HSS	PMTCT Impact Evaluation	This evaluation will provide data on the impact of option B plus on mother to child HIV transmission so far, and show any programmatic gaps that need to be tightened in order to achieve and maintain an EID positivity of less than 5 percent.	Ongoing- data collection
17703- Monitoring and Evaluation Technical Support (METS)	Short learning loop studies	This activity will provide quick turn-around of data to inform program adjustment for efficiency and impact	Ongoing- data collection
18042- Technical Assistance for Public Health Workforce Development	Short learning loop studies	This activity will support epidemiological analysis within FETP to inform comprehensive HIV/TB programming	Ongoing- data collection
18554- EQUIP (Right to Care)	Cost and outcome assessment of differentiated antiretroviral treatment service delivery models in Uganda	The study will determine cost and outcome across different DSDM models.	Ongoing— data collection
70388- MELP	Evaluation of the Regional Health Integration to Enhance Services (RHITES) activities in Eastern and East-Central Uganda	The purpose of the evaluation is to establish the sustainability of epidemic control and other health systems created through USG investment. This evaluation will therefore provide useful information identifying areas needing further investment.	New
81256- TBD	Data analysis for comparing intervention packages for AGYW and KP	The partners' capacity will be improved to use routine and non-routine data including data management, analysis and visualization.	New
9043- Makerere	Evaluation of Changing Guidelines, System and Practices on Prevention, Care, and Treatment in PEPFAR districts	This study provides ongoing routine assessment of program data aggregated from the facility level and up in order to inform program pivots and program improvements.	Ongoing- Data collection

In COP19, Costs of Doing Business (CODB) remained unchanged from COP18 levels for every USG agency. The total for all agencies is US $35,259,075 while applied pipeline is US $7,430,650 with HHS/CDC applying the largest amount, US $6,323,338. This pipeline is available largely due to reduction in buffer pipeline period by two months, vacant positions (which have largely been filled) and changes to US DH relocation dates.

In COP19, USAID/Uganda has 66.5 PEPFAR-funded Full Time Equivalents (FTEs), a reduction of 0.3 FTEs from COP18. Of these 66.5 FTEs, 16.65 are currently vacant positions. USAID anticipates hiring the majority of these vacant positions during the course of COP 18 and into COP19. The 16.65 vacant positions include eight new positions (partially PEPFAR funded), approved by Ambassador Malac in July 2018 (ten of these positions were included in COP18 planning, including four positions embedded (two each) in the Ministry of Health and National Medical Stores).

USAID/Uganda was able to add seven of the eight remaining new positions approved by Ambassador Malac without increasing the total PEPFAR-funded FTEs in COP19 by reviewing and rationalizing all PEPFAR-funded positions across the Mission and repurposing existing the FTEs. This rationalization process resulted in the following changes: 1) Twenty-three positions which previously had some portion of PEPFAR LOE (8.6 PEPFAR FTEs total) are no longer PEPFAR-funded; and 2) seven existing Mission positions (2.4 PEPFAR FTEs total), cost shared with other USAID development assistance funding sources, are for the first time assigned a PEPFAR LOE in COP19.

Seven new positions are cost shared with other funding sources for a total of 4.5 PEPFAR FTEs. These positions are: 1) Project Management Specialist (Gender Based Violence) (0.50 FTE), 2) Financial Analyst (0.70 FTE), 3) Acquisition and Assistance Specialist (1.00 FTE), 4) Executive HR and Procurement Specialist (0.30 FTE), 5) Acquisition & Assistance Specialist(0.60 FTE), 6) Project Management Specialist (Fiduciary) (0.70 FTE), 7) Financial Analyst (0.70 FTE). All will be locally employed staff (LES). The eighth position, a Direct Hire Project Development Officer position, will not be filled until COP 20.

Beyond the positions listed above, during the COP19 Regional Planning Meeting in Johannesburg in March 2019, USAID/Uganda received permission to hire an additional 13 staff to meet the increased requirements associated with the local partner directive and USAID's Journey to Self Reliance. As there is no additional space to bring these new positions onto the Embassy compound (until the Embassy annex, currently under construction, is finalized), USAID/Uganda will hire these positions through one or more institutional contractors, and also consider embedding a certain number of these positions with implementing partners located in the regions. Funds associated with these positions have been added to the corresponding institutional contract CODB line item.

Combined, the new staffing positions which will be hired directly by USAID and the 13 which will be hired by an institutional contractor will meet the additional requirements associated with the local partner directive and USAID's Journey to Self Reliance. With a significant increase in PEPFAR Uganda resources being provided directly to public sector entities and to local partners in COP19, USAID/Uganda will strengthen the institutional capacity of public institutions and local partners

to responsibly manage USG resources. USAID/Uganda must also provide greater accountability for USG resources through fiduciary monitoring, particularly with the significant challenges posed by the Ugandan context of high levels of corruption and fraud. With the continuation of the "surge," 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, including fulfilling the Site Improvement through Monitoring System (SIMS) requirements.

Despite the addition of these positions, per USAID agency-wide staffing formulas, USAID/Uganda will remain understaffed 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 $175 million, USAID/Uganda should have a staffing pattern of 140 staff (35 USDH and 105 LES) managing the PEPFAR program.

For CDC, the CODB budget is maintained at the same planning level as COP18, with shifts between CODB cost categories to follow new guidance, and reduce professional development and meeting attendance resources to offset staff salaries and benefits for normal within grade increases plus minor cost sharing allocation updates for five technical staff. Two positions have been vacant for over six months: 1) the USDH Care and Treatment-OVC Advisor, which is in selection phase after interviews and will include more cross-cutting work to include HIV Prevention; 2) the LES PMTCT Specialist position which is being repurposed to focus on HTS surge initiatives to accelerate case-finding and improve linkages. The PD has been classified and position is in recruitment. CDC is repurposing a GIS Specialist to HIV Prevention Deputy Chief, and Data Manager to Strategic Information Deputy Chief positions for added leadership and capacity in those two program areas, plus moving a vacant driver position to admin assistant to support high-performing teams. CDC will also second a staff to PCO as Global Fund Liaison in COP19, repurposing two additional positions.

CDC met 32 percent of SIMS targets in FY18 (129 out of 400 planned). Late FY18 going into FY19, the SIMS strategy changed to urgent partner performance monitoring using a "surge" approach to help achieve of TX_NEW targets and address specific program challenges. This surge has meant intensified site visits and meetings with district leadership, partners and staff at high volume sites. Surge for quality will continue in COP18 and COP19 advancing key interventions and focusing on core indicators to increase HIV positive yield with fewer tests, improve linkage and retention in treatment, ensure data quality, monitor ARV stock outs, plus enhance TB case finding and treatment completion.

Department of Defense (DoD) Walter Reed Army Institute of Research (WRAIR) currently has one USDH and one LES to offer programmatic and support services. At the current DoD/WRAIR/Uganda PEPFAR funding level, DoD/WRAIR would require one USDH and two LES to support management of the PEPFAR program. DoD/WRAIR assessed 12 the initial target of 15

and assessed 4 SIMS sites out of 17 in FY18. DoD/WRAIR focused its support on monitoring partners to attain the TX_NEW targets as per surge approach. Targets were affected by the police crackdown on fishing communities in one of the two districts supported by the IM. To regain traction, the agency carried out intensified site visits to facilities, district health teams, administrative offices to devise mechanism of addressing bottlenecks at the facilities and communities impacting finding HTS_POS and starting patients on ART. While surge for quality will continue in high volume sites and other sites not previously included in the surge, SIMS visits will be conducted in Q2 to further assess quality of services.

The U.S. Department of State (STATE) PEPFAR Coordination Office (PCO) does not require new positions in COP19 and the budget has slightly decreased. PCO remains lean, with two EFM job-sharing the Small Grants position, and two LES; a Program Assistant and a Program/Outreach Advisor and one USDH as Country Coordinator. CDC has seconded a Strategic Information Officer and will second a Global Fund Liaison (EFM/local hire). The currently vacant Deputy Coordinator position will be filled (through a USAID PSC) in mid-2019, and an LES Strategic Information Advisor position is currently being re-classified to be filled in COP19. The new GF Liaison will join PCO in 209, as well as a PEPFAR funded communications position seconded to the Public Affairs Section and providing media and communications support to the overall PEPFAR program.

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, tracking of health sector resources to support enhanced allocation, and M&E.

No changes in CODB 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

Table A: District level PEPFAR Uganda performance data by population age bands for COP17 (APR 18) and COP18 (APR 19), with projections for COP19 (APR 20) by district categorization ("sustained," "attained," "scale-up saturation," and/or "scale-up aggressive")

Clusters	District	COP	Results reported	Prioritization	<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-45		40-49		50+		Overall
					F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	TX
GULU CLUSTER	Amuru District	COP 17	APR 18	Sustained	36%	35%	39%	37%	72%	79%	44%	42%	58%	31%	70%	40%	80%	77%	90%+	85%	85%	90%+	85%	57%	84%	90%+	79%	62%	76%
		COP 18	APR 19	Sustained	90%+	90%+	90%+	87%	63%	61%	90%+	72%	51%	17%	70%	16%	65%	24%	82%	41%	70%	49%	61%	67%	79%	81%	70%	53%	65%
		COP 19	APR 20	Sustained	90%+	90%+	77%	73%	82%	83%	81%	80%	74%	75%	74%	74%	74%	74%	74%	73%	74%	74%	74%	73%	74%	74%	74%	74%	75%
	Gulu District	COP 17	APR 18	Attained	69%	63%	69%	64%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	79%	90%+	79%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	85%	84%	54%	52%	90%+	61%	90%+	40%	90%+	38%	90%+	61%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Lamwo District	COP 17	APR 18	Sustained	54%	0%	69%	66%	90%+	90%+	90%+	90%+	58%	50%	79%	77%	90%+	88%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Scale-up: Saturation	90%+	0%	90%+	90%+	90%+	90%	90%+	90%+	90%+	33%	90%+	32%	90%+	49%	90%+	83%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Nwoya District	COP 17	APR 18	Sustained	45%	73%	47%	59%	77%	57%	39%	35%	23%	25%	56%	46%	60%	49%	69%	65%	66%	61%	69%	53%	60%	55%	57%	46%	57%
		COP 18	APR 19	Sustained	59%	72%	37%	35%	24%	24%	65%	27%	62%	20%	85%	19%	79%	30%	90%+	50%	85%	59%	74%	81%	90%+	90%+	85%	65%	73%
		COP 19	APR 20	Sustained	90%+	90%+	61%	60%	67%	68%	66%	66%	61%	60%	61%	60%	61%	61%	61%	60%	61%	60%	61%	60%	61%	60%	61%	60%	61%
	Omoro District	COP 17	APR 18	Scale-up: Saturation	0%	0%	18%	20%	49%	43%	39%	42%	39%	50%	60%	43%	60%	47%	81%	60%	78%	77%	90%+	72%	90%+	82%	58%	59%	67%
		COP 18	APR 19	Scale-up: Aggressive	0%	0%	26%	25%	20%	20%	54%	23%	53%	18%	73%	17%	68%	25%	85%	43%	73%	51%	63%	69%	82%	84%	73%	55%	62%
		COP 19	APR 20	Scale-up: Aggressive	0%	0%	60%	62%	81%	81%	78%	78%	72%	72%	72%	72%	72%	72%	72%	72%	72%	71%	72%	71%	72%	71%	72%	72%	72%
JINJA CLUSTER	Bugweri District	COP 17	APR 18	Scale-up: Aggressive	35%	40%	35%	40%	43%	60%	61%	51%	90%+	90%+	90%+	90%+	90%+	53%	72%	45%	51%	45%	66%	33%	57%	41%	42%	35%	67%
		COP 18	APR 19	Scale-up: Saturation	86%	90%+	90%+	88%	55%	54%	90%+	62%	52%	16%	72%	19%	67%	25%	84%	43%	72%	50%	62%	69%	81%	83%	72%	54%	65%
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	83%	75%	76%	77%	75%	75%	69%	68%	69%	69%	69%	69%	69%	68%	69%	68%	69%	68%	69%	68%	69%	68%	69%
	Buikwe District	COP 17	APR 18	Scale-up: Saturation	58%	53%	56%	52%	90%+	82%	75%	68%	53%	46%	87%	33%	90%+	48%	90%+	64%	90%+	70%	90%+	81%	90%+	75%	86%	72%	84%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	47%	42%	32%	31%	86%	37%	90%+	29%	90%+	28%	90%+	43%	90%+	73%	90%+	86%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	82%	76%	90%+	90%+	89%	90%+	83%	82%	83%	82%	83%	82%	83%	82%	83%	82%	83%	82%	83%	82%	83%	82%	83%
	Iganga District	COP 17	APR 18	Scale-up: Aggressive	77%	79%	77%	79%	54%	38%	71%	62%	90%+	90%+	89%	90%+	90%+	90%+	90%+	65%	90%+	51%	90%+	50%	78%	54%	49%	35%	84%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	90%+	90%+	80%	78%	90%+	90%+	75%	25%	90%+	23%	90%+	36%	90%+	60%	90%+	71%	89%	90%+	90%+	90%+	90%+	78%	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	81%	76%	90%+	90%+	89%	88%	82%	81%	82%	81%	82%	81%	82%	81%	82%	81%	82%	81%	82%	81%	82%	81%	82%
	Jinja District	COP 17	APR 18	Attained	66%	62%	68%	61%	83%	66%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	84%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	79%	79%	90%	53%	52%	90%+	61%	90%+	41%	90%+	39%	90%+	61%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kamuli District	COP 17	APR 18	Attained	74%	67%	74%	67%	90%+	68%	59%	48%	69%	54%	90%+	90%+	90%+	90%+	90%+	83%	90%+	83%	90%+	89%	90%+	88%	85%	64%	90%+
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	90%+	90%+	90%+	90%	90%+	90%+	90%+	31%	90%+	30%	90%+	45%	90%+	77%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kayunga District	COP 17	APR 18	Scale-up: Aggressive	42%	39%	44%	41%	77%	65%	77%	58%	57%	57%	80%	32%	88%	40%	90%+	59%	90%+	68%	90%+	80%	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	66%	68%	48%	47%	90%+	55%	90%+	29%	90%+	29%	90%+	44%	90%+	74%	90%+	87%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	82%	87%	90%+	90%+	90%+	90%+	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%
	Mayuge District	COP 17	APR 18	Scale-up: Aggressive	80%	66%	82%	69%	65%	52%	36%	41%	70%	90%+	85%	90%+	78%	58%	83%	43%	76%	45%	78%	62%	84%	59%	31%	26%	64%
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	90%+	90%+	75%	72%	90%+	85%	84%	27%	90%+	26%	90%+	40%	90%+	68%	90%+	80%	90%+	90%+	90%+	90%+	90%+	88%	90%+
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	61%	59%	76%	76%	73%	74%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%
KABALE CLUSTER	Kabale District	COP 17	APR 18	Attained	0%	32%	32%	32%	82%	74%	90%+	90%+	85%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	0%	90%+	90%+	90%+	83%	80%	90%+	90%+	90%+	43%	90%+	42%	90%+	65%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kisoro District	COP 17	APR 18	Sustained	16%	0%	44%	23%	77%	63%	90%+	59%	69%	57%	90%+	35%	90%+	75%	90%+	82%	90%+	87%	90%+	81%	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Sustained	90%+	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	29%	90%+	29%	90%+	44%	90%+	75%	90%+	88%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Rubanda District	COP 17	APR 18	Attained	0%	25%	34%	47%	45%	38%	50%	37%	69%	32%	75%	43%	81%	61%	71%	60%	73%	68%	74%	68%	86%	73%	84%	74%	70%
		COP 18	APR 19	Scale-up: Aggressive	0%	90%+	43%	47%	34%	33%	90%+	39%	76%	24%	90%+	23%	90%+	36%	90%+	61%	90%+	72%	90%	90%+	90%+	90%+	90%+	78%	89%
		COP 19	APR 20	Scale-up: Aggressive	0%	90%+	82%	82%	90%+	90%+	90%+	90%+	84%	85%	85%	84%	85%	83%	85%	84%	85%	84%	85%	84%	85%	83%	85%	84%	85%
	Rukiga District	COP 17	APR 18	Attained	70%	66%	70%	90%+	90%+	89%	90%+	68%	90%+	78%	90%+	65%	90%+	88%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	88%	90%+	90%+
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	70%	76%	52%	51%	90%+	60%	90%+	33%	90%+	32%	90%+	49%	90%+	82%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+

Clusters	District	COP	Results reported	Prioritization	<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-45		40-49		50+		Overall
					F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	TX
KABAROLE CLUSTER	Bunyangabu District	COP 17	APR 18	Scale-up: Saturation	37%	0%	33%	21%	69%	70%	72%	59%	47%	42%	75%	61%	90%+	59%	90%+	75%	89%	81%	74%	75%	74%	68%	60%	59%	73%
		COP 18	APR 19	Scale-up: Aggressive	90%+	0%	34%	32%	26%	25%	70%	29%	63%	20%	87%	20%	81%	30%	90%+	51%	86%	60%	75%	82%	90%+	90%+	87%	66%	74%
		COP 19	APR 20	Scale-up: Aggressive	90%+	0%	74%	72%	90%	89%	86%	87%	80%	80%	80%	80%	81%	80%	80%	80%	80%	80%	80%	79%	81%	80%	80%	80%	80%
	Kabarole District	COP 17	APR 18	Scale-up: Saturation	28%	27%	29%	27%	84%	77%	89%	85%	73%	87%	90%+	65%	90%+	81%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	85%	86%	90%+
		COP 18	APR 19	Attained	90%+	90%+	63%	62%	45%	44%	90%+	51%	86%	28%	90%+	27%	90%+	42%	90%+	71%	90%+	84%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kamwenge District	COP 17	APR 18	Scale-up: Aggressive	20%	10%	56%	49%	66%	57%	48%	41%	90%+	41%	90%+	72%	90%+	90%+	90%+	90%+	89%	90%+	82%	84%	79%	76%	56%	61%	87%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	83%	83%	63%	61%	90%+	72%	86%	28%	90%+	27%	90%+	41%	90%+	69%	90%+	82%	90%+	90%+	90%+	90%+	90%+	89%	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	89%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kyenjojo District	COP 17	APR 18	Scale-up: Aggressive	40%	36%	40%	36%	84%	66%	58%	59%	58%	31%	90%+	50%	90%+	64%	90%+	84%	84%	82%	76%	77%	64%	76%	54%	59%	77%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	51%	48%	36%	35%	90%+	41%	70%	23%	90%+	22%	90%+	34%	90%+	57%	90%+	67%	84%	90%+	90%+	90%+	90%+	73%	83%
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	85%	82%	90%+	90%+	90%+	90%+	85%	84%	85%	84%	85%	84%	85%	84%	85%	84%	85%	84%	85%	84%	85%	84%	85%
	Ntoroko District	COP 17	APR 18	Sustained	26%	22%	26%	22%	73%	71%	58%	24%	42%	45%	77%	27%	87%	60%	89%	73%	77%	69%	71%	56%	55%	64%	41%	39%	63%
		COP 18	APR 19	Sustained	90%+	56%	56%	66%	38%	37%	90%+	45%	63%	20%	87%	20%	81%	30%	90%+	52%	87%	61%	76%	83%	90%+	90%+	88%	66%	76%
		COP 19	APR 20	Sustained	90%+	90%+	76%	89%	79%	80%	77%	77%	72%	72%	72%	72%	71%	71%	71%	71%	72%	71%	72%	71%	72%	71%	72%	71%	72%
KAMPALA CLUSTER	Kampala District	COP 17	APR 18	Attained	56%	52%	56%	52%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	87%	90%+	52%	90%+	55%	90%+	87%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Mukono District	COP 17	APR 18	Attained	52%	24%	43%	30%	45%	49%	49%	36%	47%	36%	76%	36%	80%	42%	85%	52%	77%	54%	61%	57%	68%	55%	64%	50%	62%
		COP 18	APR 19	Attained	90%+	90%+	53%	52%	39%	38%	90%+	44%	70%	23%	90%+	22%	90%	34%	90%+	57%	90%+	67%	83%	90%+	90%+	90%+	90%+	73%	84%
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	63%	65%	42%	44%	50%	74%	90%+	68%	90%+	68%	87%	68%	84%	68%	84%	68%	87%	68%	90%+	68%	83%	68%	79%
	Wakiso District	COP 17	APR 18	Attained	21%	21%	21%	21%	32%	32%	38%	41%	36%	43%	56%	34%	61%	34%	56%	36%	50%	36%	50%	37%	50%	44%	45%	41%	45%
		COP 18	APR 19	Scale-up: Aggressive	68%	90%+	40%	37%	27%	26%	71%	30%	43%	14%	59%	13%	55%	20%	68%	34%	58%	41%	51%	55%	66%	67%	59%	44%	51%
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	50%	48%	41%	41%	35%	35%	61%	48%	54%	48%	49%	48%	49%	48%	49%	48%	49%	48%	49%	48%	49%	48%	48%
LIRA CLUSTER	Alebtong District	COP 17	APR 18	Sustained	54%	34%	57%	36%	87%	78%	65%	33%	32%	48%	68%	44%	90%+	70%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	88%	90%+
		COP 18	APR 19	Sustained	90%+	90%+	82%	75%	56%	55%	90%+	63%	83%	27%	90%+	26%	90%+	40%	90%+	67%	90%+	79%	90%+	90%+	90%+	90%+	90%+	87%	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Amolatar District	COP 17	APR 18	Attained	15%	31%	45%	65%	90%	90%+	85%	90%+	48%	61%	67%	40%	82%	67%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	70%	67%	49%	48%	90%+	56%	90%+	31%	90%+	29%	90%+	46%	90%+	77%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Apac District	COP 17	APR 18	Attained	0%	0%	44%	51%	74%	87%	67%	48%	51%	27%	89%	47%	90%	78%	90%+	90%+	90%+	90%+	90%+	90%+	77%	88%	66%	64%	86%
		COP 18	APR 19	Scale-up: Aggressive	0%	0%	43%	41%	34%	33%	89%	38%	90%+	29%	90%+	28%	90%+	44%	90%+	73%	90%+	86%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	0%	0%	90%+	89%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Dokolo District	COP 17	APR 18	Attained	56%	53%	64%	60%	34%	33%	21%	18%	74%	24%	90%+	90%+	90%+	90%+	90%+	85%	90%+	90%+	90%+	90%+	90%+	79%	77%	60%	88%
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	71%	23%	90%+	22%	90%+	34%	90%+	58%	90%+	68%	85%	90%+	90%+	90%+	90%+	74%	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	89%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kole District	COP 17	APR 18	Attained	90%+	90%+	90%+	90%+	90%+	62%	43%	38%	56%	22%	82%	44%	90%+	74%	90%	90%+	88%	79%	80%	74%	85%	72%	67%	49%	77%
		COP 18	APR 19	Scale-up: Aggressive	84%	90%+	63%	57%	39%	38%	90%+	45%	81%	26%	90%+	25%	90%+	39%	90%+	65%	90%+	77%	90%+	90%+	90%+	90%+	90%+	84%	90%+
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	89%	83%	87%	87%	86%	86%	79%	78%	79%	78%	79%	78%	79%	78%	79%	78%	79%	78%	79%	78%	79%	78%	79%
	Kwania District	COP 17	APR 18	Attained	63%	0%	65%	72%	90%+	70%	65%	63%	53%	34%	71%	46%	74%	56%	79%	68%	75%	57%	71%	78%	67%	64%	71%	57%	68%
		COP 18	APR 19	Scale-up: Aggressive	90%+	0%	29%	28%	22%	22%	61%	25%	61%	20%	84%	19%	78%	29%	90%+	49%	84%	58%	73%	79%	90%+	90%+	84%	64%	71%
		COP 19	APR 20	Scale-up: Aggressive	90%+	0%	52%	51%	64%	64%	62%	62%	57%	57%	57%	57%	57%	57%	57%	57%	57%	57%	57%	56%	57%	56%	57%	57%	57%
	Lira District	COP 17	APR 18	Attained	57%	43%	51%	35%	90%	74%	90%+	90%	62%	74%	90%+	56%	90%+	77%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	71%	90%+
		COP 18	APR 19	Attained	90%+	90%+	51%	53%	38%	37%	90%+	43%	90%+	30%	90%+	29%	90%+	45%	90%+	75%	90%+	89%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Otuke District	COP 17	APR 18	Sustained	90%+	65%	90%+	68%	90%+	90%+	90%+	74%	82%	56%	90%+	76%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	69%	76%	49%	48%	90%+	56%	90%+	30%	90%+	28%	90%+	43%	90%+	73%	90%+	86%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+

Clusters	District	COP	Results reported	Prioritization	<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-45		40-49		50+		Overall
					F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	TX
MASAKA CLUSTER	Bukomansimbi District	COP 17	APR 18	Attained	42%	40%	42%	40%	62%	63%	58%	46%	37%	26%	70%	34%	65%	42%	60%	55%	54%	49%	51%	42%	53%	46%	50%	44%	52%
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	82%	89%	59%	58%	90%+	67%	61%	20%	83%	19%	78%	29%	90%+	49%	83%	58%	72%	79%	90%+	90%+	84%	63%	75%
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	57%	66%	68%	68%	66%	66%	61%	61%	61%	60%	61%	61%	61%	60%	61%	60%	61%	60%	61%	60%	61%	60%	61%
	Kalungu District	COP 17	APR 18	Attained	56%	41%	59%	45%	90%+	90%+	83%	74%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	85%	90%+	79%	90%+	74%	90%	73%	90%+
		COP 18	APR 19	Attained	90%+	90%+	48%	48%	33%	32%	90%	38%	63%	21%	87%	20%	81%	30%	90%+	51%	86%	60%	75%	82%	90%+	90%+	87%	66%	75%
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kyotera District	COP 17	APR 18	Attained	37%	30%	37%	30%	49%	44%	74%	54%	49%	46%	75%	57%	90%+	66%	90%+	85%	90%+	90%+	90%+	87%	85%	90%+	81%	71%	84%
		COP 18	APR 19	Attained	90%+	90%+	46%	47%	34%	33%	90%+	38%	90%+	32%	90%+	31%	90%+	48%	90%+	80%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	86%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Lwengo District	COP 17	APR 18	Attained	56%	61%	51%	52%	42%	47%	41%	33%	45%	24%	73%	26%	71%	43%	63%	47%	56%	46%	54%	49%	46%	39%	44%	37%	51%
		COP 18	APR 19	Scale-up: Aggressive	76%	90%+	70%	58%	42%	41%	90%+	48%	54%	17%	74%	17%	69%	26%	87%	44%	74%	52%	64%	70%	84%	85%	75%	56%	66%
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	67%	57%	65%	65%	63%	63%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%
	Lyantonde District	COP 17	APR 18	Attained	65%	90%+	26%	44%	50%	47%	87%	44%	70%	67%	90%+	73%	90%+	76%	90%+	69%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	38%	36%	26%	26%	71%	30%	90%+	33%	90%+	32%	90%+	50%	90%+	84%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Masaka District	COP 17	APR 18	Attained	46%	31%	45%	30%	63%	68%	89%	72%	75%	77%	90%+	80%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	71%	62%	48%	47%	90%+	55%	50%	18%	71%	16%	65%	28%	81%	46%	70%	54%	60%	75%	79%	90%+	68%	54%	65%
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Rakai District	COP 17	APR 18	Attained	40%	40%	41%	41%	50%	41%	48%	35%	48%	37%	58%	35%	64%	38%	71%	45%	73%	51%	78%	57%	76%	64%	71%	58%	61%
		COP 18	APR 19	Attained	90%+	90%+	51%	53%	39%	38%	90%+	44%	74%	24%	90%+	23%	90%+	36%	90%+	60%	90%+	71%	88%	90%+	90%+	90%+	90%+	77%	88%
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	63%	69%	79%	79%	77%	77%	71%	70%	71%	70%	71%	70%	71%	70%	71%	70%	71%	70%	71%	70%	71%	70%	71%
	Sembabule District	COP 17	APR 18	Attained	53%	47%	55%	47%	48%	36%	44%	39%	66%	71%	90%+	58%	83%	50%	78%	57%	72%	64%	53%	57%	58%	64%	48%	47%	62%
		COP 18	APR 19	Attained	90%+	90%+	69%	64%	47%	46%	90%+	53%	60%	20%	83%	19%	77%	29%	90%+	49%	83%	57%	72%	79%	90%+	90%+	83%	63%	73%
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	82%	81%	90%+	90%+	88%	88%	82%	81%	82%	81%	82%	81%	82%	81%	82%	81%	82%	81%	82%	81%	82%	81%	82%
MBALE CLUSTER	Budaka District	COP 17	APR 18	Sustained	50%	0%	50%	45%	66%	57%	37%	53%	30%	38%	71%	62%	83%	90%+	90%+	76%	90%+	53%	89%	50%	90%+	67%	74%	62%	76%
		COP 18	APR 19	Sustained	90%+	0%	90%+	90%+	90%+	90%+	90%+	90%+	66%	20%	90%	20%	84%	32%	90%+	53%	89%	62%	78%	85%	90%+	90%+	90%+	68%	86%
		COP 19	APR 20	Sustained	90%+	0%	89%	76%	90%+	90%+	90%+	90%+	86%	86%	87%	87%	87%	86%	87%	86%	87%	86%	86%	85%	86%	86%	87%	86%	87%
	Bududa District	COP 17	APR 18	Sustained	40%	23%	46%	23%	89%	89%	63%	62%	50%	44%	52%	36%	59%	17%	65%	23%	62%	49%	59%	47%	83%	69%	59%	44%	55%
		COP 18	APR 19	Sustained	90%+	90%+	90%+	90%+	90%+	89%	90%+	90%+	49%	16%	67%	16%	63%	23%	78%	40%	67%	47%	58%	64%	76%	78%	68%	51%	66%
		COP 19	APR 20	Sustained	90%+	90%+	54%	68%	67%	68%	66%	67%	60%	61%	60%	60%	60%	60%	61%	60%	61%	60%	61%	60%	61%	60%	61%	60%	61%
	Mbale District	COP 17	APR 18	Attained	51%	48%	52%	44%	86%	47%	90%+	90%+	58%	84%	44%	42%	57%	34%	90%+	42%	90%+	62%	72%	36%	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	78%	70%	54%	52%	90%+	61%	85%	28%	90%+	27%	90%+	42%	90%+	71%	90%+	83%	90%+	90%+	90%+	90%+	90%+	89%	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Sironko District	COP 17	APR 18	Sustained	48%	55%	59%	84%	82%	64%	79%	68%	59%	40%	68%	21%	64%	18%	80%	25%	73%	35%	76%	42%	90%+	46%	90%+	60%	63%
		COP 18	APR 19	Sustained	90%+	90%+	90%+	90%+	77%	75%	90%+	87%	65%	21%	89%	20%	83%	31%	90%+	52%	89%	62%	77%	85%	90%+	90%+	90%	68%	82%
		COP 19	APR 20	Sustained	90%+	90%+	77%	72%	76%	77%	75%	75%	69%	68%	69%	68%	69%	69%	69%	69%	69%	69%	69%	68%	69%	69%	69%	69%	69%
MBARARA CLUSTER	Buhweju District	COP 17	APR 18	Sustained	49%	33%	49%	33%	25%	45%	9%	25%	59%	19%	90%+	46%	84%	86%	54%	71%	35%	54%	33%	41%	24%	30%	25%	31%	48%
		COP 18	APR 19	Sustained	78%	90%+	90%+	90%+	69%	67%	90%+	80%	62%	21%	85%	20%	79%	29%	90%+	50%	85%	59%	73%	81%	90%+	90%+	85%	64%	78%
		COP 19	APR 20	Sustained	90%+	90%+	86%	65%	72%	70%	66%	69%	64%	61%	64%	62%	64%	63%	63%	62%	63%	62%	63%	63%	63%	63%	63%	63%	64%
	Bushenyi District	COP 17	APR 18	Scale-up: Saturation	42%	39%	52%	36%	76%	72%	90%+	77%	89%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	85%	77%	52%	50%	90%+	58%	90%+	36%	90%+	35%	90%+	53%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Ibanda District	COP 17	APR 18	Scale-up: Aggressive	28%	34%	29%	36%	64%	51%	36%	41%	42%	36%	90%+	54%	90%+	79%	86%	86%	74%	69%	69%	67%	70%	70%	56%	57%	71%
		COP 18	APR 19	Attained	90%+	90%+	58%	55%	41%	40%	90%+	47%	66%	21%	90%+	21%	84%	31%	90%+	53%	90%+	63%	78%	86%	90%+	90%+	90%+	69%	79%
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	79%	77%	90%	90%+	87%	88%	81%	80%	81%	81%	81%	81%	81%	81%	81%	80%	81%	80%	81%	80%	81%	80%	81%
	Kanungu District	COP 17	APR 18	Scale-up: Aggressive	56%	0%	45%	31%	75%	61%	55%	41%	54%	48%	90%+	53%	90%+	71%	90%+	86%	90%+	83%	85%	80%	72%	73%	63%	69%	80%
		COP 18	APR 19	Scale-up: Aggressive	90%+	0%	53%	49%	40%	39%	90%+	45%	74%	24%	90%+	23%	90%+	35%	90%+	60%	90%+	70%	88%	90%+	90%+	90%+	90%+	77%	88%
		COP 19	APR 20	Scale-up: Aggressive	90%+	0%	85%	82%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+

Clusters	District	COP	Results reported	Prioritization	<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-45		40-49		50+		Overall
					F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	TX
MBARARA CLUSTER	Kiruhura District	COP 17	APR 18	Scale-up: Aggressive	37%	44%	39%	44%	45%	36%	24%	20%	53%	19%	90%+	45%	84%	62%	67%	67%	55%	58%	44%	54%	40%	51%	35%	43%	55%
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	62%	61%	42%	41%	90%+	48%	40%	13%	55%	13%	51%	19%	64%	32%	55%	38%	47%	52%	62%	63%	55%	42%	50%
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	8%	8%	9%	9%	9%	9%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%
	Mbarara District	COP 17	APR 18	Attained	53%	52%	50%	52%	86%	75%	90%+	74%	77%	63%	90%+	73%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	68%	69%	51%	50%	90%+	58%	90%+	36%	90%+	35%	90%+	54%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Mitooma District	COP 17	APR 18	Scale-up: Aggressive	0%	0%	14%	23%	22%	19%	17%	11%	41%	43%	78%	70%	68%	87%	71%	54%	50%	49%	38%	25%	34%	23%	22%	20%	45%
		COP 18	APR 19	Scale-up: Aggressive	0%	0%	58%	56%	45%	44%	90%+	52%	38%	12%	52%	12%	48%	18%	61%	31%	52%	36%	45%	49%	59%	60%	52%	39%	48%
		COP 19	APR 20	Scale-up: Aggressive	0%	0%	46%	46%	58%	58%	57%	57%	53%	53%	53%	53%	53%	53%	53%	52%	53%	52%	53%	52%	53%	52%	53%	52%	53%
	Ntungamo District	COP 17	APR 18	Scale-up: Aggressive	57%	64%	56%	64%	54%	57%	40%	37%	48%	26%	90%+	35%	90%+	56%	83%	69%	77%	63%	64%	56%	66%	60%	52%	50%	66%
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	75%	71%	49%	48%	90%+	56%	62%	20%	86%	19%	80%	30%	90%+	50%	85%	59%	74%	81%	90%+	90%+	86%	65%	76%
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	78%	77%	83%	83%	81%	81%	75%	74%	75%	74%	75%	74%	75%	74%	75%	74%	75%	74%	75%	74%	75%	74%	75%
	Rubirizi District	COP 17	APR 18	Sustained	53%	75%	53%	75%	49%	45%	53%	31%	69%	31%	90%+	53%	90%+	86%	86%	76%	68%	67%	61%	54%	44%	52%	38%	46%	67%
		COP 18	APR 19	Sustained	64%	78%	41%	38%	27%	26%	72%	30%	80%	25%	90%+	25%	90%+	38%	90%+	65%	90%+	76%	90%+	90%+	90%+	90%+	90%+	83%	90%+
		COP 19	APR 20	Sustained	90%+	90%+	75%	72%	80%	81%	78%	78%	72%	71%	72%	72%	72%	71%	72%	71%	72%	71%	72%	71%	72%	71%	72%	71%	72%
	Rukungiri District	COP 17	APR 18	Scale-up: Saturation	29%	29%	30%	24%	74%	59%	71%	70%	52%	53%	78%	50%	88%	63%	89%	75%	90%+	85%	90%+	82%	90%+	90%+	90%+	90%+	88%
		COP 18	APR 19	Attained	90%+	90%+	48%	46%	34%	33%	90%+	39%	77%	25%	90%+	24%	90%+	37%	90%+	62%	90%+	73%	90%+	90%+	90%+	90%+	90%+	80%	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Sheema District	COP 17	APR 18	Scale-up: Saturation	31%	29%	31%	29%	48%	62%	60%	50%	48%	51%	85%	66%	90%+	74%	90%+	90%+	90%+	90%+	90%+	88%	90%+	90%+	83%	85%	87%
		COP 18	APR 19	Attained	90%+	70%	51%	55%	36%	35%	90%+	41%	73%	24%	90%+	23%	90%+	35%	90%+	59%	90%+	70%	87%	90%+	90%+	90%+	90%+	76%	87%
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
SOROTI CLUSTER	Amuria District	COP 17	APR 18	Sustained	64%	47%	64%	47%	90%+	90%+	63%	90%+	55%	48%	74%	43%	82%	50%	90%+	80%	89%	90%+	90%+	85%	90%+	90%+	90%	83%	85%
		COP 18	APR 19	Sustained	90%+	90%+	90%+	90%+	70%	68%	90%+	80%	72%	22%	90%+	23%	90%+	34%	90%+	58%	90%+	69%	84%	90%+	90%+	90%+	90%+	74%	89%
		COP 19	APR 20	Sustained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kaberamaido District	COP 17	APR 18	Sustained	66%	66%	69%	85%	90%+	90%+	90%+	90%+	59%	90%+	84%	65%	90%+	71%	90%+	90%+	90%+	90%+	87%	74%	90%+	90%+	90%+	84%	90%+
		COP 18	APR 19	Attained	90%+	90%+	90%+	88%	67%	65%	90%+	76%	88%	29%	90%+	27%	90%+	42%	90%+	71%	90%+	84%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kapelebyong District	COP 17	APR 18	Sustained	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	72%	58%	90%+	63%	90%+	50%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Sustained	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	42%	90%+	33%	90%+	53%	90%+	90%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	0%	90%+	11%	12%	13%	13%	12%	13%	12%	12%	12%	12%	12%	11%	12%	12%	12%	12%	12%	11%	12%	12%	12%	12%	12%
	Katakwi District	COP 17	APR 18	Scale-up: Aggressive	0%	0%	40%	55%	90%+	90%+	90%+	88%	47%	51%	65%	48%	70%	62%	90%+	90%+	90%+	89%	90%+	90%	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Scale-up: Aggressive	0%	0%	75%	73%	59%	58%	90%+	67%	76%	24%	90%+	24%	90%+	37%	90%+	63%	90%+	74%	90%+	90%+	90%+	90%+	90%+	80%	90%+
		COP 19	APR 20	Attained	0%	0%	88%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Ngora District	COP 17	APR 18	Attained	90%+	76%	90%+	76%	85%	77%	88%	67%	71%	84%	73%	85%	64%	68%	68%	73%	84%	62%	68%	61%	89%	87%	74%	65%	73%
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	71%	69%	90%+	81%	62%	20%	86%	20%	80%	30%	90%+	50%	85%	59%	74%	81%	90%+	90%+	86%	65%	78%
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	79%	80%	85%	87%	81%	83%	76%	76%	76%	75%	76%	76%	76%	75%	76%	76%	76%	76%	76%	76%	77%	76%	77%
	Serere District	COP 17	APR 18	Sustained	66%	90%+	79%	60%	75%	90%+	79%	52%	55%	67%	54%	50%	67%	72%	77%	72%	75%	89%	78%	90%+	90%+	90%+	90%+	90%+	81%
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	69%	23%	90%+	21%	88%	33%	90%+	56%	90%+	66%	82%	90%	90%+	90%+	90%+	72%	89%
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	84%	86%	90%+	90%+	90%+	90%+	89%	88%	88%	87%	88%	88%	88%	88%	88%	88%	88%	87%	88%	87%	88%	88%	88%
	Soroti District	COP 17	APR 18	Attained	72%	62%	73%	62%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	79%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	77%	25%	90%+	24%	90%+	37%	90%+	62%	90%+	74%	90%+	90%+	90%+	90%+	90%+	80%	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+

Clusters	District	COP	Results reported	Prioritization	<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-45		40-49		50+		Overall
					F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	TX
TORORO CLUSTER	Bugiri District	COP 17	APR 18	Sustained	23%	18%	23%	18%	34%	30%	25%	18%	17%	18%	35%	15%	39%	14%	44%	20%	46%	27%	57%	33%	59%	40%	55%	42%	38%
		COP 18	APR 19	Attained	90%+	90%+	64%	65%	48%	46%	90%+	54%	29%	9%	41%	9%	38%	14%	47%	24%	40%	28%	35%	38%	46%	47%	41%	31%	39%
		COP 19	APR 20	Attained	90%+	90%+	44%	45%	52%	52%	51%	51%	47%	47%	47%	47%	47%	46%	47%	46%	47%	46%	47%	46%	47%	46%	47%	46%	47%
	Busia District	COP 17	APR 18	Attained	71%	68%	74%	66%	73%	66%	64%	66%	60%	62%	90%+	90%+	57%	66%	69%	47%	78%	63%	76%	48%	89%	47%	64%	55%	67%
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	88%	90%+	61%	59%	90%+	69%	87%	28%	90%+	27%	90%+	41%	90%+	70%	90%+	82%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	80%	83%	87%	87%	84%	85%	78%	78%	78%	78%	78%	77%	78%	77%	78%	77%	78%	77%	78%	77%	78%	77%	78%
	Butaleja District	COP 17	APR 18	Attained	90%+	64%	90%+	56%	73%	52%	75%	56%	63%	37%	82%	31%	90%+	43%	90%+	68%	90%+	80%	90%+	90%+	90%+	90%+	90%+	70%	89%
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	79%	27%	90%+	25%	90%+	39%	90%+	64%	90%+	76%	90%+	90%+	90%+	90%+	90%+	83%	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Manafwa District	COP 17	APR 18	Sustained	68%	48%	68%	48%	90%+	77%	77%	23%	52%	35%	42%	23%	48%	26%	51%	28%	74%	46%	65%	39%	90%+	60%	90%+	59%	60%
		COP 18	APR 19	Sustained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	69%	23%	90%+	22%	88%	33%	90%+	55%	90%+	65%	80%	89%	90%+	90%+	90%+	71%	90%
		COP 19	APR 20	Sustained	90%+	90%+	85%	75%	82%	82%	79%	77%	72%	73%	72%	72%	72%	72%	72%	72%	72%	71%	73%	72%	72%	71%	73%	72%	73%
	Namisindwa District	COP 17	APR 18	Sustained	16%	46%	53%	36%	62%	47%	69%	59%	47%	52%	52%	38%	48%	33%	65%	35%	76%	46%	78%	49%	90%+	81%	90%+	76%	66%
		COP 18	APR 19	Sustained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	52%	18%	70%	16%	66%	25%	83%	42%	70%	49%	61%	67%	80%	82%	71%	54%	74%
		COP 19	APR 20	Sustained	90%+	90%+	90%+	88%	90%+	90%+	90%+	90%+	86%	86%	87%	85%	87%	87%	87%	86%	87%	86%	87%	86%	88%	86%	88%	86%	87%
	Tororo District	COP 17	APR 18	Sustained	50%	66%	61%	58%	90%+	85%	90%+	90%+	90%+	90%+	84%	61%	85%	47%	90%+	64%	90%+	83%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	79%	80%	61%	60%	90%+	70%	90%+	41%	90%+	39%	90%+	60%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
STANDALONE	Adjumani District	COP 17	APR 18	Sustained	0%	0%	70%	73%	90%+	90%+	90%+	90%+	71%	29%	90%+	63%	90%+	67%	90%+	79%	90%+	90%+	89%	90%+	90%+	71%	90%+	85%	90%+
		COP 18	APR 19	Scale-up: Saturation	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	83%	26%	90%+	27%	90%+	40%	90%+	68%	90%+	80%	90%+	90%+	90%+	90%+	90%+	87%	90%+
		COP 19	APR 20	Attained	0%	0%	90%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Agago District	COP 17	APR 18	Sustained	38%	54%	45%	47%	90%+	90%+	90%	83%	41%	41%	78%	50%	87%	59%	90%+	90%+	90%+	90%+	89%	90%+	90%+	87%	90%+	71%	85%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	72%	71%	53%	51%	90%+	60%	90%+	35%	90%+	33%	90%+	51%	90%+	86%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Arua District	COP 17	APR 18	Attained	78%	90%+	79%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Sustained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	47%	90%+	45%	90%+	71%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Bukedea District	COP 17	APR 18	Attained	58%	42%	58%	42%	40%	54%	60%	77%	43%	40%	39%	66%	41%	65%	62%	81%	74%	88%	76%	90%+	90%+	90%+	90%+	90%+	74%
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	84%	81%	90%+	90%+	68%	23%	90%+	21%	88%	33%	90%+	55%	90%+	66%	82%	89%	90%+	90%+	90%+	71%	87%
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	84%	87%	90%+	90%+	90%+	90%+	87%	85%	88%	86%	87%	86%	87%	86%	87%	86%	87%	86%	88%	86%	87%	86%	87%
	Bukwo District	COP 17	APR 18	Sustained	0%	0%	42%	16%	47%	72%	90%+	90%+	90%+	90%+	61%	90%+	29%	60%	46%	35%	45%	35%	81%	51%	58%	39%	51%	21%	52%
		COP 18	APR 19	Scale-up: Saturation	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	45%	14%	65%	14%	59%	22%	75%	38%	64%	45%	55%	60%	72%	73%	64%	49%	67%
		COP 19	APR 20	Scale-up: Saturation	0%	0%	90%+	90%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Buliisa District	COP 17	APR 18	Attained	66%	0%	66%	50%	64%	30%	47%	40%	76%	36%	90%+	54%	90%+	88%	90%+	90%+	65%	80%	69%	64%	52%	59%	43%	47%	76%
		COP 18	APR 19	Attained	90%+	0%	57%	53%	43%	42%	90%+	49%	74%	24%	90%+	24%	90%+	36%	90%+	60%	90%+	71%	89%	90%+	90%+	90%+	90%+	77%	89%
		COP 19	APR 20	Scale-up: Saturation	90%+	0%	81%	79%	90%+	90%+	90%+	89%	83%	83%	83%	82%	83%	82%	82%	82%	83%	82%	83%	82%	83%	82%	83%	82%	83%
	Bundibugyo District	COP 17	APR 18	Scale-up: Aggressive	84%	0%	87%	49%	90%+	90%+	56%	55%	63%	34%	90%+	43%	90%+	65%	90%+	90%+	90%+	81%	90%+	68%	89%	54%	61%	36%	89%
		COP 18	APR 19	Attained	90%+	0%	90%+	90%+	90%+	90%+	90%+	90%+	84%	26%	90%+	26%	90%+	40%	90%+	67%	90%+	79%	90%+	90%+	90%+	90%+	90%+	87%	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Butambala District	COP 17	APR 18	Scale-up: Aggressive	62%	47%	62%	47%	85%	83%	68%	89%	66%	60%	90%+	51%	90%+	51%	90%+	58%	90%+	64%	90%+	78%	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	71%	65%	51%	50%	90%+	57%	77%	25%	90%+	24%	90%+	37%	90%+	62%	90%+	74%	90%+	90%+	90%+	90%+	90%+	81%	90%+
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Butebo District	COP 17	APR 18	Scale-up: Aggressive	90%+	75%	90%+	75%	90%+	90%+	79%	43%	90%+	17%	85%	30%	75%	45%	90%+	58%	90%+	63%	86%	73%	82%	57%	90%+	74%	80%
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	83%	33%	90%+	27%	90%+	39%	90%+	66%	90%+	75%	90%+	90%+	90%+	90%+	90%+	83%	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Buvuma District	COP 17	APR 18	Scale-up: Aggressive	28%	22%	28%	22%	29%	34%	22%	24%	33%	18%	51%	41%	59%	55%	68%	87%	58%	83%	60%	90%	63%	81%	56%	65%	61%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	55%	54%	40%	39%	90%+	45%	79%	26%	90%+	25%	90%+	37%	90%+	63%	90%+	75%	90%+	90%+	90%+	90%+	90%+	82%	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+

Clusters	District	COP	Results reported	Prioritization	<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-45		40-49		50+		Overall
					F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	TX
STAND ALONE	Buyende District	COP 17	APR 18	Attained	48%	48%	48%	48%	43%	40%	33%	33%	42%	19%	60%	49%	58%	43%	80%	60%	71%	63%	82%	68%	82%	74%	90%+	80%	69%
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	89%	86%	90%+	90%+	73%	24%	90%+	23%	90%+	35%	90%+	59%	90%+	70%	88%	90%+	90%+	90%+	90%+	77%	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Gomba District	COP 17	APR 18	Sustained	18%	37%	27%	37%	57%	54%	53%	29%	39%	16%	56%	23%	58%	39%	71%	52%	58%	51%	60%	56%	66%	69%	75%	68%	58%
		COP 18	APR 19	Sustained	90%+	90%+	75%	77%	51%	50%	90%+	57%	48%	15%	66%	15%	62%	23%	77%	39%	66%	46%	57%	63%	74%	76%	66%	50%	60%
		COP 19	APR 20	Attained	90%+	90%+	84%	84%	90%+	90%+	90%+	90%+	86%	85%	86%	85%	86%	85%	86%	85%	86%	85%	86%	85%	86%	85%	86%	85%	86%
	Hoima District	COP 17	APR 18	Scale-up: Aggressive	54%	36%	54%	36%	45%	51%	58%	63%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	82%	90%+	81%	90%+	52%	73%	59%	28%	27%	83%
		COP 18	APR 19	Attained	90%+	90%+	77%	75%	52%	51%	90%+	59%	86%	28%	90%+	26%	90%+	42%	90%+	70%	90%+	83%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Isingiro District	COP 17	APR 18	Attained	68%	63%	68%	63%	41%	48%	35%	36%	79%	65%	90%+	80%	90%+	85%	87%	82%	69%	69%	61%	55%	69%	57%	38%	37%	69%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	80%	75%	60%	58%	90%+	68%	72%	23%	90%+	22%	90%+	34%	90%+	58%	90%+	69%	85%	90%+	90%+	90%+	90%+	75%	88%
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	86%	86%	90%+	90%+	90%+	90%+	88%	88%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%
	Kagadi District	COP 17	APR 18	Scale-up: Aggressive	51%	48%	51%	48%	53%	49%	52%	38%	90%	41%	90%+	67%	90%+	89%	90%+	90%+	86%	70%	86%	78%	64%	69%	65%	60%	83%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	53%	51%	39%	38%	90%+	45%	84%	27%	90%+	26%	90%+	40%	90%+	67%	90%+	80%	90%+	90%+	90%+	90%+	90%+	87%	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kakumiro District	COP 17	APR 18	Scale-up: Saturation	51%	28%	52%	29%	52%	57%	51%	34%	78%	26%	90%+	54%	90%+	68%	85%	67%	76%	69%	69%	69%	76%	69%	64%	66%	72%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	44%	42%	32%	31%	84%	36%	82%	27%	90%+	26%	90%+	39%	90%+	66%	90%+	78%	90%+	90%+	90%+	90%+	90%+	85%	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	89%	89%	90%+	90%+	90%+	90%+	90%+	90%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%	90%+	90%+	90%+
	Kalangala District	COP 17	APR 18	Sustained	7%	9%	7%	9%	11%	10%	14%	8%	15%	17%	18%	17%	38%	44%	36%	43%	36%	47%	20%	34%	12%	32%	8%	16%	27%
		COP 18	APR 19	Sustained	51%	16%	10%	11%	7%	7%	20%	8%	29%	9%	39%	9%	37%	14%	46%	23%	39%	27%	34%	37%	44%	45%	40%	30%	33%
		COP 19	APR 20	Sustained	90%+	90%+	37%	37%	42%	42%	41%	41%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%
	Kaliro District	COP 17	APR 18	Scale-up: Aggressive	61%	62%	68%	69%	57%	63%	57%	47%	34%	34%	81%	77%	77%	61%	90%+	68%	90%+	83%	90%+	82%	90%+	83%	90%+	90%+	89%
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	71%	22%	90%+	23%	90%+	34%	90%+	57%	90%+	68%	84%	90%+	90%+	90%+	90%+	74%	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kasese District	COP 17	APR 18	Sustained	50%	54%	55%	47%	74%	84%	78%	69%	90%	68%	90%+	69%	90%+	69%	90%+	82%	90%+	86%	90%+	79%	90%+	80%	77%	72%	90%+
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	90%+	90%+	81%	79%	90%+	90%+	75%	24%	90%+	23%	90%+	36%	90%+	60%	90%+	71%	89%	90%+	90%+	90%+	90%+	78%	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kassanda District	COP 17	APR 18	Attained	36%	39%	37%	39%	54%	47%	39%	33%	31%	20%	84%	27%	85%	46%	74%	46%	61%	48%	54%	47%	51%	50%	55%	44%	56%
		COP 18	APR 19	Attained	90%+	90%+	58%	54%	40%	39%	90%+	46%	59%	19%	82%	19%	76%	28%	90%+	48%	81%	57%	70%	77%	90%+	90%+	82%	62%	71%
		COP 19	APR 20	Attained	90%+	90%+	77%	76%	88%	87%	84%	85%	79%	78%	79%	78%	79%	78%	79%	78%	79%	78%	79%	78%	78%	78%	79%	78%	79%
	Kibaale District	COP 17	APR 18	Attained	0%	36%	50%	36%	63%	42%	59%	49%	74%	27%	90%+	60%	90%+	77%	90%+	88%	72%	70%	64%	80%	62%	55%	67%	61%	73%
		COP 18	APR 19	Sustained	0%	90%+	90%+	90%+	71%	69%	90%+	81%	89%	29%	90%+	27%	90%+	42%	90%+	72%	90%+	85%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	0%	90%+	81%	79%	89%	90%+	87%	88%	81%	80%	81%	80%	81%	81%	81%	81%	81%	80%	81%	80%	81%	80%	81%	80%	81%
	Kiboga District	COP 17	APR 18	Scale-up: Aggressive	37%	24%	37%	24%	64%	75%	48%	46%	46%	36%	90%+	45%	90%+	58%	90%+	74%	90%+	72%	90%+	69%	85%	69%	76%	58%	78%
		COP 18	APR 19	Scale-up: Aggressive	90%+	76%	41%	42%	29%	28%	77%	33%	68%	22%	90%+	21%	87%	33%	90%+	55%	90%+	65%	81%	88%	90%+	90%+	90%+	71%	80%
		COP 19	APR 20	Attained	90%+	90%+	85%	85%	90%+	90%+	90%+	90%+	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%	87%	88%
	Kibuku District	COP 17	APR 18	Sustained	72%	39%	72%	39%	67%	71%	59%	52%	66%	59%	69%	17%	72%	37%	79%	52%	82%	70%	90%+	72%	90%+	87%	90%+	90%	79%
		COP 18	APR 19	Sustained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	70%	24%	90%+	22%	90%+	33%	90%+	57%	90%+	67%	84%	90%+	90%+	90%+	90%+	74%	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kikuube District	COP 17	APR 18	Sustained	49%	34%	49%	34%	79%	65%	56%	57%	75%	50%	90%+	88%	90%+	90%+	90%+	90%	90%+	73%	72%	79%	59%	69%	44%	55%	82%
		COP 18	APR 19	Sustained	90%+	90%+	71%	68%	50%	49%	90%+	57%	83%	26%	90%+	27%	90%+	40%	90%+	67%	90%+	79%	90%+	90%+	90%+	90%+	90%+	86%	90%+
		COP 19	APR 20	Sustained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kiryandongo District	COP 17	APR 18	Scale-up: Aggressive	56%	49%	57%	49%	34%	32%	79%	70%	90%+	90%+	90%+	90%+	90%+	90%+	73%	65%	86%	54%	90%+	67%	90%+	74%	43%	25%	83%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	74%	70%	55%	53%	90%+	62%	90%+	29%	90%+	28%	90%+	43%	90%+	73%	90%+	86%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	88%	88%	90%+	90%+	90%+	90%+	89%	88%	89%	89%	89%	88%	89%	88%	89%	88%	89%	88%	89%	88%	89%	88%	89%

Clusters	District	COP	Results	Prioritization	<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-45		40-49		50+		Overall
					F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
STAND ALONE	Kitgum	COP 17	APR 18	Attained	90%+	62%	37%	50%	90%+	71%	71%	66%	67%	34%	90%+	67%	90%+	90%+	90%+	90%+	90%+	90%+	86%	81%	84%	74%	73%	76%	90%+
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	81%	78%	62%	60%	90%+	71%	70%	23%	90%+	22%	90%	34%	90%+	57%	90%+	67%	83%	90%+	90%+	90%+	90%+	73%	86%
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Koboko	COP 17	APR 18	Sustained	90%+	90%+	90%+	90%+	86%	81%	36%	42%	68%	28%	90%+	90%+	90%+	90%+	90%+	90%+	85%	87%	76%	84%	49%	65%	26%	41%	90%+
		COP 18	APR 19	Sustained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	30%	90%+	29%	90%+	44%	90%+	75%	90%+	88%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Sustained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kotido	COP 17	APR 18	Scale-up: Aggressive	0%	0%	90%+	60%	90%+	90%+	90%+	90%+	79%	69%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	29%	85%	2%	6%	90%+
		COP 18	APR 19	Scale-up: Saturation	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	64%	23%	89%	19%	82%	31%	90%+	53%	88%	61%	76%	84%	90%+	90%+	89%	67%	90%+
		COP 19	APR 20	Scale-up: Saturation	0%	0%	89%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kumi	COP 17	APR 18	Attained	24%	33%	24%	33%	90%+	85%	90%+	90%+	62%	90%+	71%	41%	73%	50%	90%+	79%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	90%+	90%+	76%	74%	90%+	86%	90%+	31%	90%+	30%	90%+	47%	90%+	80%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Kyankwanzi	COP 17	APR 18	Sustained	48%	33%	48%	33%	51%	43%	31%	31%	58%	13%	90%+	33%	77%	46%	73%	51%	53%	59%	53%	50%	43%	53%	49%	49%	56%
		COP 18	APR 19	Sustained	90%+	90%+	84%	75%	52%	51%	90%+	59%	57%	18%	78%	18%	72%	27%	90%+	46%	77%	54%	67%	73%	87%	89%	78%	59%	70%
		COP 19	APR 20	Attained	90%+	90%+	71%	69%	80%	80%	78%	78%	72%	71%	72%	71%	72%	71%	72%	71%	72%	71%	72%	71%	72%	71%	72%	71%	72%
	Kyegegwa	COP 17	APR 18	Sustained	40%	44%	39%	44%	80%	75%	52%	43%	46%	27%	90%+	56%	90%+	78%	90%+	87%	90%+	86%	90%+	88%	83%	90%+	68%	71%	88%
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	74%	74%	53%	52%	90%+	61%	90%+	30%	90%+	29%	90%+	44%	90%+	74%	90%+	87%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Luwero	COP 17	APR 18	Attained	55%	44%	54%	44%	79%	70%	73%	62%	58%	49%	90%+	43%	90%+	61%	90%+	63%	90%+	57%	90%+	61%	90%+	81%	90%+	68%	83%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	61%	56%	42%	41%	90%+	48%	61%	20%	84%	19%	79%	29%	90%+	50%	84%	59%	73%	80%	90%+	90%+	85%	64%	74%
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Maracha	COP 17	APR 18	Attained	0%	0%	56%	48%	89%	38%	64%	23%	42%	43%	79%	35%	90%	45%	90%+	75%	90%+	85%	90%+	90%	78%	90%+	33%	41%	74%
		COP 18	APR 19	Scale-up: Saturation	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	78%	27%	90%+	24%	90%+	37%	90%+	63%	90%+	75%	90%+	90%+	90%+	90%+	90%+	82%	90%+
		COP 19	APR 20	Scale-up: Saturation	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Masindi	COP 17	APR 18	Scale-up: Aggressive	44%	37%	45%	38%	39%	33%	69%	64%	90%+	90%+	90%+	90%+	90%+	89%	79%	74%	89%	67%	90%+	73%	90%+	88%	74%	58%	85%
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	53%	53%	40%	39%	90%+	46%	66%	22%	90%+	21%	85%	33%	90%+	55%	90%+	65%	78%	89%	90%+	90%+	90%+	69%	80%
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Mityana	COP 17	APR 18	Attained	55%	46%	55%	46%	56%	46%	62%	48%	55%	37%	84%	45%	89%	50%	84%	58%	78%	59%	80%	66%	77%	70%	89%	70%	72%
		COP 18	APR 19	Scale-up: Aggressive	90%+	90%+	43%	44%	33%	32%	87%	37%	54%	18%	74%	17%	69%	26%	87%	44%	74%	52%	64%	70%	84%	86%	75%	56%	65%
		COP 19	APR 20	Scale-up: Aggressive	90%+	90%+	80%	81%	90%+	90%+	89%	89%	82%	82%	82%	82%	82%	82%	82%	82%	82%	81%	82%	82%	82%	81%	82%	82%	82%
	Moroto	COP 17	APR 18	Attained	0%	0%	18%	90%+	90%+	90%+	90%+	85%	57%	31%	90%+	90%+	90%+	90%	90%+	90%+	90%+	90%+	88%	90%+	90%+	52%	68%	90%+	90%+
		COP 18	APR 19	Scale-up: Aggressive	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	72%	23%	90%+	24%	90%+	36%	90%+	60%	90%+	71%	88%	90%+	90%+	90%+	90%+	76%	90%+
		COP 19	APR 20	Scale-up: Aggressive	0%	0%	89%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Moyo	COP 17	APR 18	Sustained	0%	0%	82%	90%+	90%+	90%+	90%+	90%+	67%	90%+	85%	49%	74%	49%	90%+	61%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Sustained	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	89%	27%	90%+	27%	90%+	43%	90%+	72%	90%+	86%	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Sustained	0%	0%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Mpigi	COP 17	APR 18	Attained	30%	90%+	29%	37%	65%	61%	64%	52%	63%	59%	90%+	48%	90%+	68%	89%	66%	79%	66%	62%	57%	68%	61%	53%	50%	71%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	41%	39%	31%	30%	84%	36%	73%	24%	90%+	23%	90%+	35%	90%+	59%	90%+	69%	86%	90%+	90%+	90%+	90%+	76%	85%
		COP 19	APR 20	Attained	90%+	90%+	85%	85%	90%+	90%+	90%+	90%+	87%	86%	87%	86%	87%	86%	87%	86%	87%	86%	87%	86%	87%	86%	87%	86%	87%
	Mubende	COP 17	APR 18	Attained	37%	35%	34%	33%	59%	39%	36%	32%	47%	30%	90%+	61%	90%+	64%	83%	66%	74%	61%	67%	54%	68%	59%	52%	48%	65%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	60%	59%	44%	43%	90%+	50%	66%	21%	90%	20%	84%	31%	90%+	53%	90%	62%	78%	85%	90%+	90%+	90%+	68%	79%
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Nakaseke	COP 17	APR 18	Attained	22%	30%	24%	33%	60%	45%	48%	35%	46%	35%	63%	26%	70%	32%	66%	47%	65%	51%	66%	61%	67%	59%	68%	62%	59%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	42%	39%	30%	30%	81%	35%	58%	19%	79%	18%	74%	28%	90%+	47%	79%	55%	69%	75%	89%	90%+	80%	60%	69%
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	75%	75%	85%	85%	82%	83%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%

Clusters	District	COP	Results	Prioritization	<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-45		40-49		50+		Overall
					F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
STAND ALONE	Nakasongol	COP 17	APR 18	Attained	38%	29%	44%	35%	64%	54%	56%	46%	49%	49%	68%	44%	75%	60%	77%	79%	72%	90%	79%	75%	61%	77%	61%	63%	69%
		COP 18	APR 19	Sustained	90%+	90%+	85%	83%	62%	61%	90%+	70%	64%	20%	88%	20%	82%	31%	90%+	52%	88%	61%	76%	83%	90%+	90%+	88%	67%	79%
		COP 19	APR 20	Attained	90%+	90%+	85%	85%	90%+	90%+	90%+	90%+	87%	86%	86%	86%	86%	86%	86%	85%	87%	85%	86%	85%	86%	85%	86%	86%	86%
	Namayingo	COP 17	APR 18	Sustained	57%	52%	56%	51%	48%	35%	66%	40%	59%	51%	85%	48%	80%	56%	90%+	85%	82%	85%	84%	90%+	49%	50%	56%	54%	74%
		COP 18	APR 19	Sustained	90%+	90%+	66%	63%	47%	45%	90%+	53%	90%+	34%	90%+	33%	90%+	50%	90%+	84%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Sustained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Namutumba District	COP 17	APR 18	Sustained	90%+	62%	90%+	62%	41%	40%	37%	32%	62%	55%	55%	31%	56%	40%	64%	40%	58%	41%	64%	61%	79%	69%	83%	60%	59%
		COP 18	APR 19	Sustained	90%+	90%+	90%+	90%+	83%	80%	90%+	90%+	64%	21%	89%	21%	82%	31%	90%+	52%	88%	61%	77%	84%	90%+	90%+	89%	67%	82%
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Nebbi District	COP 17	APR 18	Attained	90%+	90%+	90%+	90%+	90%+	90%+	73%	77%	90%+	47%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	80%	70%	67%	90%+
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	74%	72%	90%+	84%	90%+	37%	90%+	35%	90%+	54%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Oyam District	COP 17	APR 18	Attained	65%	55%	66%	56%	77%	72%	72%	56%	61%	68%	84%	59%	84%	76%	90%+	89%	90%+	84%	90%+	78%	90%+	83%	90%+	73%	86%
		COP 18	APR 19	Attained	90%+	90%+	58%	57%	43%	42%	90%+	49%	90%+	31%	90%+	30%	90%+	46%	90%+	77%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Pakwach District	COP 17	APR 18	Scale-up: Saturation	90%+	90%+	90%+	90%+	82%	58%	41%	29%	90%+	31%	90%+	75%	90%+	83%	90%+	90%+	89%	82%	74%	65%	88%	71%	63%	57%	87%
		COP 18	APR 19	Scale-up: Saturation	90%+	90%+	87%	84%	54%	52%	90%+	61%	90%+	33%	90%+	31%	90%+	47%	90%+	80%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Scale-up: Saturation	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Pallisa District	COP 17	APR 18	Attained	83%	48%	83%	48%	90%+	79%	84%	50%	85%	43%	90%+	43%	90%+	59%	90%+	73%	90%+	84%	90%+	85%	90%+	90%+	90%+	90%+	90%+
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	83%	26%	90%+	25%	90%+	40%	90%+	69%	90%+	82%	90%+	90%+	90%+	90%+	90%+	89%	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
	Yumbe District	COP 17	APR 18	Sustained	80%	90%+	80%	90%+	90%+	90%+	65%	56%	56%	37%	90%+	46%	90%+	58%	90%+	73%	83%	70%	75%	65%	56%	74%	48%	59%	75%
		COP 18	APR 19	Sustained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	36%	12%	49%	11%	46%	17%	57%	29%	49%	34%	43%	47%	56%	57%	50%	37%	84%
		COP 19	APR 20	Sustained	90%+	90%+	71%	71%	81%	81%	78%	77%	74%	73%	74%	72%	73%	72%	74%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%
	Zombo District	COP 17	APR 18	Attained	90%+	88%	90%+	88%	90%+	90%+	67%	65%	90%+	33%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	85%	90%+	83%	90%	63%	65%	90%+
		COP 18	APR 19	Attained	90%+	90%+	90%+	90%+	90%+	89%	90%+	90%+	90%+	39%	90%+	37%	90%+	56%	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
		COP 19	APR 20	Attained	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+	90%+
CENTRALLY SUPPORTED	Abim District	COP 17	APR 18	Centrally Supported	N/A: No targets required																								54%
		COP 18	APR 19	Centrally Supported	N/A: No targets required																								0%
		COP 19	APR 20	Centrally Supported	N/A: No targets required																								0%
	Amudat District	COP 17	APR 18	Centrally Supported	N/A: No targets required																								51%
		COP 18	APR 19	Centrally Supported	N/A: No targets required																								0%
		COP 19	APR 20	Centrally Supported	N/A: No targets required																								0%
	Bulambuli District	COP 17	APR 18	Centrally Supported	N/A: No targets required																								38%
		COP 18	APR 19	Centrally Supported	N/A: No targets required																								0%
		COP 19	APR 20	Centrally Supported	N/A: No targets required																								0%
	Kaabong District	COP 17	APR 18	Centrally Supported	N/A: No targets required																								90%+
		COP 18	APR 19	Centrally Supported	N/A: No targets required																								0%
		COP 19	APR 20	Centrally Supported	N/A: No targets required																								0%
	Kapchorwa District	COP 17	APR 18	Centrally Supported	N/A: No targets required																								67%
		COP 18	APR 19	Centrally Supported	N/A: No targets required																								0%
		COP 19	APR 20	Centrally Supported	N/A: No targets required																								0%
	Kween District	COP 17	APR 18	Centrally Supported	N/A: No targets required																								38%
		COP 18	APR 19	Centrally Supported	N/A: No targets required																								0%
		COP 19	APR 20	Centrally Supported	N/A: No targets required																								0%

Clusters	District	COP	Results	Prioritization	<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-45		40-49		50+		Overall
					F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
CENTRALLY SUPPORTED	Luuka District	COP 17	APR 18	Centrally Supported	N/A: No targets required																							45%
		COP 18	APR 19	Centrally Supported	N/A: No targets required																							0%
		COP 19	APR 20	Centrally Supported	N/A: No targets required																							0%
	Nabilatuk District	COP 17	APR 18	Centrally Supported	N/A: No targets required																							90%+
		COP 18	APR 19	Centrally Supported	N/A: No targets required																							0%
		COP 19	APR 20	Centrally Supported	N/A: No targets required																							0%
	Nakapiripirit District	COP 17	APR 18	Centrally Supported	N/A: No targets required																							69%
		COP 18	APR 19	Centrally Supported	N/A: No targets required																							0%
		COP 19	APR 20	Centrally Supported	N/A: No targets required																							0%
	Napak District	COP 17	APR 18	Centrally Supported	N/A: No targets required																							90%+
		COP 18	APR 19	Centrally Supported	N/A: No targets required																							0%
		COP 19	APR 20	Centrally Supported	N/A: No targets required																							0%
	Pader District	COP 17	APR 18	Centrally Supported	N/A: No targets required																							52%
		COP 18	APR 19	Centrally Supported	N/A: No targets required																							0%
		COP 19	APR 20	Centrally Supported	N/A: No targets required																							0%

Table A.2: ART Targets by Prioritization for Epidemic Control

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY19)**	**Additional patients required for 80 percent ART coverage**	**Target current on ART (APR FY20) *TX_CURR***	**Newly initiated (APR FY20) *TX_NEW***	**ART Coverage (APR 20)**
Attained	**499,117**	**586,936**	**NA**	**640,904**	**82,794**	**128 percent**
Scale-Up Saturation	**417,934**	**348,510**	**NA**	**359,812**	**53,144**	**86 percent**
Scale-Up Aggressive	**377,801**	**255,562**	**46,679**	**238,603**	**34,637**	**63 percent**
Sustained	**68,433**	**54,180**	**566**	**53,526**	**9,223**	**78 percent**
Central Support	**30,175**	-	**24,140**	-	-	
Military	-	**23,135**	**NA**	**24,289**	**2,507**	
Commodities (if not included in previous categories)	-	-	-	-	-	
Total	**1,393,460**	**1,268,323**	**71,385**	**1,317,134**	**182,305**	**95 percent**

B1. COP19 Planned Spending Table

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

Table B.1.1 COP19 Budget by Program Area

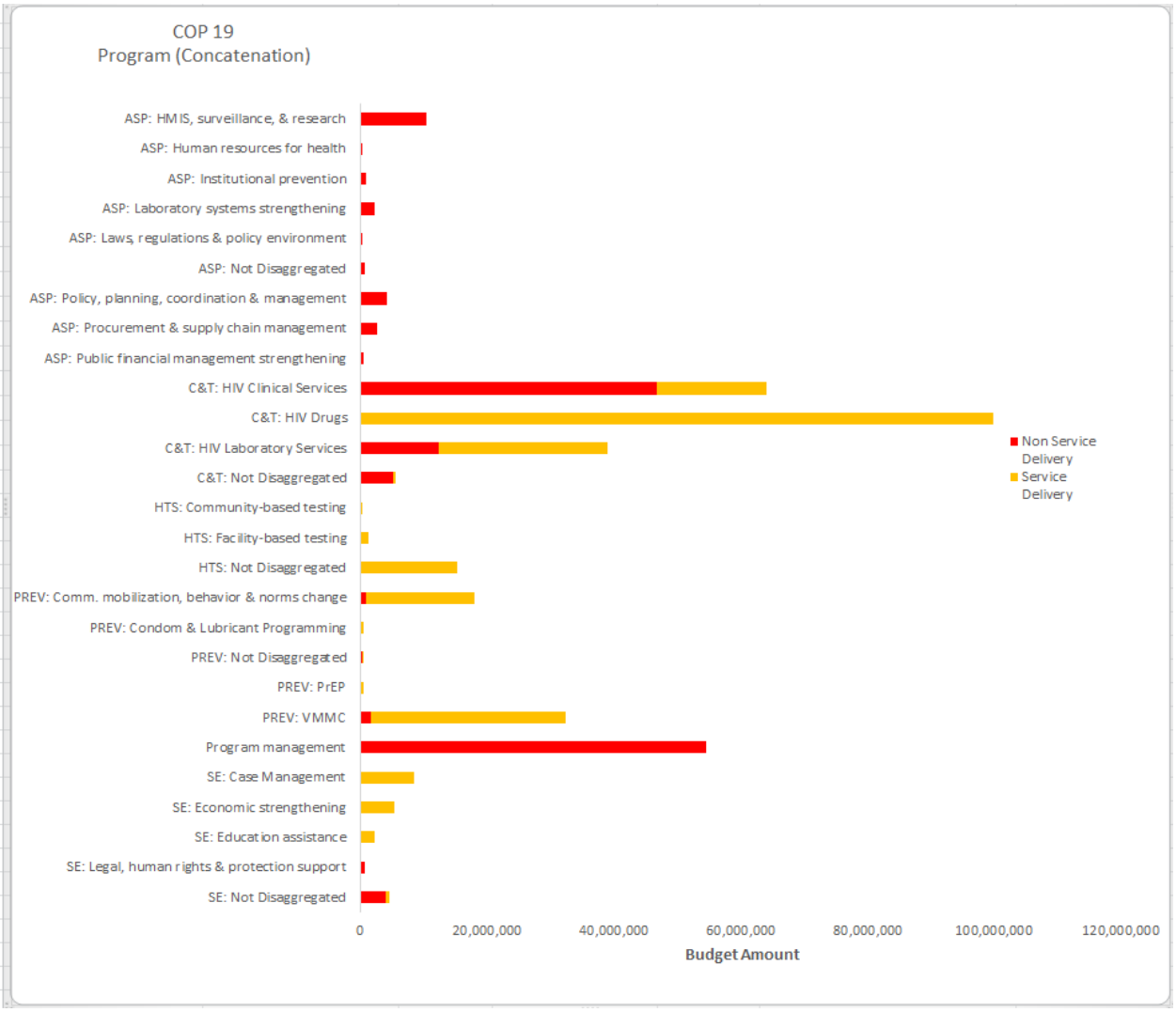


Table B.1.2 COP19 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$US67,205,429	**$US 342,032,310**	**$US 409,237,739**

*Data included in Table B.1.2 should match 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	**Amount Allocated**
CIRC	$27,589,035
HBHC	$17,393,996
HKID	$28,556,848
HLAB	$4,678,792
HMBL	$7,794
HMIN	$418
HTXD	$79,441,839
HTXS	$49,386,747
HVAB	$1,613,741
HVCT	$21,536,238
HVMS	$22,407,435
HVOP	$21,007,388
HVSI	$10,506,406
HVTB	$9,859,637
MTCT	$9,399,836
OHSS	$7,211,869
PDCS	$10,766,797
PDTX	$20,667,496

*Data included in Table B.2.2 should match 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 COP19 guidance and the budgeting tool for COP19—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 COP18 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 health service delivery partners in Uganda are regionalized, so updated information on where undiagnosed Ugandan PLHIV are living is an important factor in determining how COP19 resources are allocated.

A secondary change driver was target linkage and retention rates, which – per headquarters guidance via the Datapack – are 95% for linkage and for retention 95% for those on treatment for greater than 12 months and 90 percent for those on treatment less than 12 months. PEPFAR Uganda's FY18 results demonstrated progress over FY17 in increasing the rate at which the program links newly-identified PLHIV to treatment, from 79% percent linkage in FY17 to 81% percent linkage in FY18, likely attributable to the "surge for quality improvement" which PEPFAR Uganda initiated in Quarter 2 of FY 2018. PEPFAR Uganda continues to wrestle with challenges in the rate at which new treatment enrollees are retained, having achieved 71% percent retention in FY18 and 76% percent retention in FY19. Accordingly, COP19 resource allocations factored the inputs needed to further improve linkage and to intensify efforts to increase 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 COP19 include the mandate from headquarters to increase support to the public sector in Uganda where most PLHIV are being served, as well as the mandate from headquarters to increase the percentage of the PEPFAR Uganda budget that is directly awarded to Ugandan organizations and institutions as "prime" awardees.

Data sources used to calculate resource allocations include: COP18 budget allocations; expenditure analysis 2018; FY18 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 D– Minimum Program Requirements

This should be addressed in narrative in the sections above however in this section succinctly note if the program is meeting or not meeting the minimum program requirement.

PEPFAR Uganda's strategic directions and program implementation plan for COP19, as described in the narrative sections, above, address the Minimum Program Requirements as follows:

The minimum requirements for continued PEPFAR support include:

- Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups (required in COP16). Meeting – for COP19 planned interventions re: same day initiation, see SDS pp. 13, 35 - 37, 60, 74
- Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents (required in COP16). Meeting – see SDS pp. 26, 42, 59-60,67-68, 94
- Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens (required in COP18). Meeting – see SDS pp. 66-67, 71-73
- Scale up of index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established (required in COP18).
- Meeting for scale up of index testing, see SDS pp. 62, 83. Meeting for self-testing, see SDS pp. 5, 34, 43, 51, 58. Meeting for enhanced pediatric and adolescent case finding see SDS Section 4.1.
- TPT for all PLHIV must be scaled-up as an integral and routine part of the HIV clinical care package (required in COP18). Meeting – see SDS pp. 66-67, 86
- Direct and immediate (>95 percent) linkage of clients from testing to treatment across age, sex, and risk groups. Meeting for direct and immediate linkage see SDS pp. 35-51, 58, 59
- Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC, TB, and routine clinical services, affecting access to HIV testing and treatment and prevention (required in COP17 and COP18). Meeting.
- Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including >80 percent access to annual VL testing and reporting. Meeting – see SDS pp. 81-82
- Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity (required in COP18). Meeting – see SDS pp. 69, 90, 92
- Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent

girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management (required in COP17 and COP18).Meeting –see SDS pp. 35, 36, 39-45, 47, 53, 55

- Evidence of resource commitments by host governments with year after year increases (required in COP14). Partial Meeting - for Commodities, particularly ARVs, see SDS pp. 6, 14, 70-71 and for GOU absorption of PEPFAR-supported HRH see SDS pp. 14, 26, 75, 87-88, 90
- Clear evidence of agency progress toward local, indigenous partner prime funding (required in COP18). Meeting – see SDS pp. 27-28, 31, 97
- Scale up of unique identifiers for patients across all sites. Not Yet Meeting, despite multiyear PEPFAR Uganda efforts, due to host government preference for national ID cards and reluctance to adopt unique identifiers, see SDS p. 44. For current use of DREAMS beneficiary unique identifiers, see SDS p. 54

APPENDIX E—Addressing Gaps to Epidemic Control, Including Through Communities of Faith Receiving Central Funds

USG Uganda received an additional $28,751 for COP19 as part of the new Faith Based Initiaitve Central Funds. The additional $28,751 from the Faith-Based Initiative in COP19 will be programmed through USAID's agreement with Catholic Relief Services working in 24 districts. These funds will build on additional $160,543 provided for COP18 implementation and $7,906,425 already programmed for CRS in COP19 to deliver the following activities:

- Introduce and scale-up SASA! Faith
- Adapt Stepping Stones (curricula for both 10-14 and 15-19 age bands) for faith communities in collaboration with Salamander Trust (the originators of Stepping Stones)
- Begin rolling out Stepping Stones
- Cascade Stepping Stones for faith communities to other implementing partners

APPENDIX F—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
GF	Global Fund
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

APPENDIX G— The People's Voice Uganda: Community Priorities, PEPFAR COP19

Please find attached separately.

APPENDIX H— CSO People's COP19 Checklist

COUNTRY NAME: Uganda					
Area	CSO Priorities	COP18 language + data	CSO Proposed Language to include in COP19	CSO proposed Target for COP19	USG and CSO Proposed Agreements in COP19 planning
Testing (1st 90)	**Implement a strategy to prevent index testing and assisted partner notification (APN) from causing violence, criminalization and other human rights violations.**	"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, 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."	COP19 will support role out of the index testing as a hallmark strategy for case identification. In a context of escalating GBV, screening, counselling and referral for GBV will be key ingredients in the roll out of assisted partner notification (APN) in care and treatment overall. This will include hiring and training counsellors, use of tools to capture GBV and termination of services if potential for GBV is deemed high.	Target: PEPFAR will implement index testing in a manner that anticipates and mitigates violence, will track violence associated with partner notification and index testing in all PEPFAR supported sites	Ensuring index testing will not be offered to patients who screen as having a high risk of GBV Continue tracking violence associated with APN and index testing Ensuring immediate remedial action is taken in response to GBV associated with index testing.

Viral Suppression, (3rd 90)	**COP19 must support the staffing and other costs to ensure that all people living with HIV receive a viral load test at 6 months after ART initiation and then annually – and receive the results of those tests rapidly, triggering appropriate clinical action.**	"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."	COP19 will support the staffing, commodities and other costs to ensure that all people living with HIV receive a viral load test at 6 months after ART initiation and then annually – and receive the results of those tests rapidly, linked with appropriate clinical action.	Target: All PLHIV receive a viral load test in COP19 – and receive results within two weeks.	PEPFAR to continue funding VL (80%) and committed to improve the turn-around time for patient receipt of results and clinical decision making to two weeks, using intensified interpersonal interaction and counselling
TLD Transition	**Invest in TLD transition for women of reproductive age to improve retention and treatment outcomes.**	"Due to high HIV pre-treatment drug resistance (PDR) to non-nucleoside 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. 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 co-infected patients are also eligible for TLD."	COP19 will support full roll out of TLD optimization among women of reproductive age. Clinicians must be trained on the need to allow women to make the choice for initiation. PEPFAR will also support the provision of family planning options for all women living with HIV.	Target: All PLHIV are able to switch to TLD by end 2019.	PEPFAR committed to full TLD (by June 2019) and TLE 400mg transition starting Jan 2020.Between now and June, the program will work on policy procurement, NDA, approvals and required tools. Commitment to work with the MOH to revisit the written consent form for DTG initiation upon receipt of WHO guidelines on DTG, reorganizing that the required signature can be a barrier to care.
Commodities and supply chain	**Minimize barriers to medicine accessibility by strengthening supply chain management to stop understocking, stock outs and shortages of (ARVs, VL, EID etc..)**	"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	COP19 will support the health worker staffing, transportation, and other needs to strengthen the supply chain and ensure that facilities in all PEPFAR supported districts are adequately stocked with HIV, TB, STI, and opportunistic infection medicines and diagnostics, contraceptives and HIV prevention tools such as PEP, PrEP, male and female condoms, and lubricants. PEPFAR will establish a rapid response plan for addressing reported health technology stock outs and shortages.	Target: <5 % of sites reporting ARV, TB, STI, opportunistic infection drug stock outs.	Government will deliver on its pledge to increase its contribution by $13M, ring-fenced for ARVs and to release those funds on time and in full every quarter. PEPFAR funding together with Global Fund and GOU should leave no financial gaps for ARVs in the public sector for FY19/2020

		a role in ensuring proper allocation of ARVs to health facilities at the district level and below." "IPs are using real-time HIV commodites tracking systems to avert stock outs and misdistribution 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." "Year One (COP18) Annual Benchmark (Planned) <5 % of sites reporting ARV drug stock outs"			
Retention & Adherence	**Ensure 100% of PEPFAR supported sites have functional group models of care including support groups.**	"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." "Package of Linkage Interventions. Documented referral of all newly identified PLHIV to peer networks or community support groups"	In COP19, every PEPFAR-supported site will aim to have both group and fast track models of care in place. This will include group models of Community Client-Led ART Delivery (CCLAD) groups with integrated ART delivery as well as support groups up and running at both facility and community level. Each facility will have a target for the portion of PLHIV engaged in CCLAD groups. Where PLHIV are adhering, fast track models of care and collection of ART will be made available including Community Drug Distribution Points (CDDP). PEPFAR will support the clinical and community health worker staffing needed to establish and maintain these programs for at least 3 years.	Target: 100% of PEPFAR sites will have CCLAD groups and CDDP models for ART delivery as well as support groups running by end of COP19 and will report portion of patients in CCLAD and CDDP. Each district will have identified communities for targeted group and fast track models of care based on adherence levels. For PLHIV stable on ART: Implement at least one fast track individual ART refill collection system and at least one group simplified model of care in every clinic/clinic's feeder community.	PEPFAR committed to roll out the DSDM community models in all PEPFAR supported sites. PEPFAR also committed to introduce a standard approach for community based retention support interventions and that the SOP will be reviewed by civil society before approval and will be adopted by all agencies and their IPs PEPFAR committed to intensify interpersonal interaction and counselling and treatment literacy. This is currently ongoing through the National QI collaborative revision of current psychosocial guidelines and the dissemination of treatment literacy manuals for Health Workers. MOH with support from PEPFAR has completed communication materials which will be disseminated April-June 2019.

Male Retention & Adherence	**Ensure 100% of PEPFAR supported sites provide "male friendly" services by end COP19 including male targeted community outreach services, facility weekend services and/or extended opening hours, male only support groups and CCLAD groups, and where possible access to male healthcare workers.**	"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 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." "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."	In order to address sub-optimal testing and retention of men, COP19 will implement and take to scale a package of services tailored to the specific needs of men including male targeted community outreach services, facility weekend services and/or extended opening hours, male only support groups and Community Client-Led ART Delivery (CCLAD) groups, and where possible access to male healthcare workers.	Target: 100% of PEPFAR sites will provide services aimed specifically at men including at least one of: male-targeted community outreach services, facility weekend services and/or extended opening hours, male only support groups, and male only CCLAD groups.	PEPFAR committed to establish support groups and initiating C- and multi-month scripting throu using the Men Start initiative
Prevention (biomedical) VMMC PrEP Condom, etc.	Lack of communication strategy from MOH -Still being rolled out as a phased approach rather than a clear and ambitious national strategy -Inadequate information on PrEP available to patients and health care providers -Definition of PrEP indicators is not being strictly followed when		-MOH should expedite the finalization of an evidence based PrEP communication strategy, in collaboration with PEPFAR -PEPFAR should fund PrEP support nationwide, with ambitious national targets -PEPFAR should require all PrEP sites to provide comprehensive, peer-led counseling and community-based follow up -Integrate PrEP in youth-friendly SRH centers to improve access for young people -Invest in community-led demand creation for PrEP		PrEP targets increased by 82% and 800,000 VMMC. MOH committed to fast tracking of finalizing of the PrEP communications strategy National guidelines state all people at substantial risk should be offered PrEP; COP2019 will support modification of screening

	delivering PrEP; focus is on numbers -Current PrEP sites do not adequately cater for young people -Inconsistent and incorrect messages, e.g. political/religious leaders' statements -Inadequate or non-existent counseling for PrEP users -Delivery of PrEP is disregarding other services, e.g. contraceptives, condoms, STI management, etc				tools to ensure young people at substantial risk are appropriately counseled and offered PrEP PEPFAR will continue to discuss policy issues for providing PrEP in youth led SRH with MOH, and approaches to community led demand creation
TB (Including TB LAM tests, TB preventive therapy (e.g. 3HP), Gene Xpert, TB screening, etc.)	**Increase rates of TB screening and testing to improve detection rates and lower the number of people undiagnosed.**	"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" "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. Furthermore, HIV testing of presumptive TB cases demonstrated 20 percent positivity among 130 high volume facilities. 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." p45 "Analysis of GeneXpert utilization revealed that the	PEPFAR will integrate TB screening into HIV case finding, and ensure that 100% of people presenting for care are screened for TB using the TB symptom screen and, where indicated, chest X-ray. PEPFAR will use GeneXpert MTB/RIF Ultra as the initial TB diagnostic test for all people who screen with TB symptoms, and support training and equipment necessary to obtain specimen samples for Ultra testing and culture from adults with possible extra pulmonary TB and children, and to support clinical TB diagnosis in children. PEPFAR will ensure that the outcome of TB screening results in one of two mutually exclusive decisions: 1) people diagnosed with TB should be started on treatment; 2) people in whom active TB is ruled out should receive TPT.	100% of people presenting for care screened for TB using TB symptom screen and, where indicated, chest X-ray. 100% of people with TB symptoms identified during screening are tested using GeneXpert MTB/RIF Ultra, including children.	PEPFAR Committed 100 percent of PLHIV access GeneXpert as the primary test for TB diagnosis.

		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 health care worker mentorship to implement GeneXpert as the first-line test for at least 75 percent of presumptive TB cases."			
TB Lam	**Improved access to TB LAM testing in hospital, outpatient, and primary care settings at all facilities in PEPFAR districts.**	No reference to LAM in COP18.	PEPFAR SA will make LAM testing available in all settings where PLHIV present for care, including both inpatient and outpatient settings. In inpatient, hospital settings, PEPFAR SA will use TB LAM as a screening test in all hospitalized patients with HIV. In outpatient, ambulatory settings, PEPFAR SA will provide LAM testing to all people presenting to care with clinical signs of apparent serious illness, or, if CD4 testing is available, with CD4<200. PEPFAR SA will support training in the use of TB LAM and ensure the procurement of required commodities (TB LAM Ag urine assays, urine cups, pipettes, pipette tips, timers) within laboratory costs. PEPFAR SA will also support sensitization of health care workers on the utility of TB LAM and its place in the TB diagnostic algorithm. Task sharing should be considered as the test is easy enough to be conducted by nurses. PEPFAR SA will preferentially support the use of more sensitive TB urine LAM tests, if they become available and are recommended by WHO within COP19.	Target: LAM testing provided to 100% of PLHIV who are hospitalized. LAM testing provided to all PLHIV presenting to care in outpatient settings with signs of advanced illness or with CD4<200.	PEPFAR committed to introducing TB Lam testing and CrAg for people with advanced HIV.
TPT	**Expand provision of TB preventive therapy (TPT) to all PLHIV newly enrolled into care, and expand provision of TPT to eligible household contacts of PLHIV with active TB, with a special emphasis on reaching young children.**	"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)." "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	for PLHIV: PEPFAR will support the GOU to scale-up TB preventive therapy (TPT), ensuring that all PLHIV newly enrolled into care who screen negative for active TB disease initiate and complete a course of TPT. All PLHIV in PEPFAR programs newly diagnosed with active TB disease receive contact investigations of their families and close contacts, with contacts offered TPT. PEPFAR will pilot the use of the short-course, rifapentine-based 3HP regimen as an alternative to isoniazid preventive therapy (IPT) for XX% of PLHIV started on TPT, pending confirmation that	Target: 400,000 PLHIV initiate and complete TPT within COP19. Of these, at least 25% (100,000) should receive 3HP and the rest should receive Q-TIB. 100% of PLHIV diagnosed with active TB disease (TX_TB) receive contact	PEPFAR in discussion with CHAI agreed to assess findings from the multi-country pilot on 3HP meanwhile preparing Uganda through policy development. Still in discussions with GOU and other stakeholders. PEPFAR to introduce APN to TB case finding

		management of TPT supplies, standard operating practices (SOP) and mentoring of health workers, and coordination of a systematic and phased TPT rollout." "COP18 funding will also provide GeneXpert cartridges and TPT commodities for the public sector." TB_PREV in COP17: Result: 17,542 (through Q4) Target: 140,958 Achievement: 12.44%	rifapentine is safe to use with dolutegravir. Individuals receiving IPT will receive the fixed-dose combination of isoniazid/cotrimoxazole/B6 (Q-TIB). TPT for children: PEPFAR will support contact investigations for all PLHIV diagnosed with active TB disease. Children of PLHIV with TB identified by contact investigations will be offered TPT with the regimen determined by HIV status. HIV-negative children will be offered the 3HR regimen, which is available as a child-friendly FDC. Children with HIV will be offered 3HR (if on EFV-based ART) or 6H (if on nevirapine, lopinavir-ritonavir, or dolutegravir-based ART). 6H is also available in a child-friendly dispersible tablet. (3HR = three months of daily isoniazid + rifampicin; 6H = six months of isoniazid preventive therapy) PEPFAR will integrate training on TPT initiation and adherence support into preparations to rollout dolutegravir-based ART, recognizing that TB prevention is a routine and integral part of the HIV clinical care package. PEPFAR will ensure that TPT implementation respects human rights and minimizes stigma. In particular, that TPT initiation is always voluntary, introduced with full information and proper counselling on the risk/benefits, and never mandatory. Contact investigations should be designed and carried out in a way that minimizes the potential impact of stigma in the community (e.g., identifying a household as having TB or disclosing the TB or HIV status of a PLHIV without their consent).	investigation of family and close contacts. All children <15 identified through contact investigation (TX_TB x 2) screened for TB, and either initiate TB treatment or initiate TPT.	
CrAg	**Improve access to CrAg screening, lumbar puncture and flucytosine to screen, diagnose and treat cryptococcal meningitis.**	No reference in COP18 apart from laboratory capacity: "National CrAG EQA production and distribution section established capacity"	COP19 will provide resources to allow CrAg LFA screening in all PLHIV with CD4<200, and subsequent lumbar puncture for diagnosis in PLHIV with CD4<100 who have screened positive for CM using CrAg. PEPFAR should establish an indicator to track progress; number of PLHIV with baseline CD4<200 are CrAg tested; number of PLHIV with baseline CD4<100 leading to Lumbar Puncture. COP19 should also fund the procurement of flucytosine treatment and ensure free access for antifungals to all people with CM. COP19 must make CD4 staging easily accessible so that advanced HIV disease is actually adequately detected and acted upon.	Target: 100% of PLHIV with CD4<200 provided with CrAG screening.	PEPFAR committed to introduce CrAg for people with advanced disease particularly planned for all newly initiated patients on ART and all patients failing on ART with VL >1000.

Key Populations Services (including size estimates)	**By end COP19, all clinical and non-clinical staff at 100% of PEPFAR supported sites must have been sensitized on needs of key populations (including MSM, transgender people, sex workers and PWUD). COP19 will roll out targeted community testing strategies aimed at key populations in all high burden districts.**	"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."	COP19 will support key population led comprehensive service delivery to increase retention and train health workers on key population service delivery to reduce stigma. Services must be provided by peers themselves. Support for key population lay workers attached to general facility who fast track key populations seeking services at the facility will also increase retention among key populations. PEPFAR will prioritize supporting key population organizations to offer comprehensive service delivery to peers to increase testing, linkage and retention.	Target: 100% of PEPFAR sites receive sensitization training to provide KP friendly services. At least 5 KP-led and community based organizations will be funded to provide comprehensive services to key populations in the all high burden districts.	PEPFAR committed to address this under KPIF. PEPFAR will work with GF to address human rights issues and will further complement with support under the KPIF program.
Health Workforce (Not Included Above)	**Fund at least 620 facility-based professional health workers, in order to fill critical capacity gaps that are holding back achievement of epidemic control.**	"Transition 1,751 PEPFAR seconded staff to GOU payroll 1) Increased number of critical cadres in public sector facilities." "Revised staffing structures including lab cadres implemented." "Increase in number of dispensers trained and deployed in the public sector."	COP19 will support remuneration for 620 new mission-critical facility-based professional health workers through the public health sector, with a commitment to timely absorption of these new health workers by the GOU. These healthcare workers will be deployed at PEPFAR sites with the highest human resource shortages, and will provide critical capacity that is required for the country to achieve epidemic control.	Target: Fund at least 620 facility based professional health workers in COP19.	MOH committed to take this on gradually
Lay health workers	**Fund a minimum of 930 additional lay health workers.**	"The CHEW policy finalized and approved and rolled out in an initial 12 PEPFAR- supported districts."	COP19 will fund an expansion of an additional 930 lay health workers, reflecting the "HIV share" (6.2%) of the target density of the new cadre of Community Health Extension Workers (two CHEWs per parish) to increase community outreach and quality of adherence and retention of clients. These lay health workers will be formally paid, trained, capacitated, and equipped with communications and transportation needed to be effective.	Target: Fund 930 additional lay health workers in COP19.	PEPFAR allocates 62% of the HRH budget to lay workers. PEPFAR is working with development partners and will continue to advocate for resolution of the CHEWS policy and to ensure adequate numbers and remuneration of lay/peer workers.
AGYW	**Ensure that COP19 reaches the most vulnerable AGYW (pregnant, married or girls who had given birth) with the DREAMS program. Ensure 100% of PEPFAR sites, specifically in DREAMS districts, establish youth clubs (for young people aged 15 –**	"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 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	COP19 will ensure that all clinical and non-clinical staff in PEPFAR sites are sensitized to provide youth friendly services. PEPFAR will develop closed membership youth clubs for young people living with HIV that integrate psychosocial support, HIV clinical management (including ART initiation), family planning and ART refills. DREAMS will reach most vulnerable AGYW (including pregnant, married or girls who had given birth) as well as AGYW living with HIV.	Target: 100% of PEPFAR sites receive sensitization training to provide youth friendly services. 100% of sites in DREAMS districts establish closed membership youth clubs to support adherence and	PEPFAR committed to introducing the YAPS model in. 45 high volume sites across in the country

	24) in order to provide HIV clinical management, ART refills, peer support, and counselling to ensure better linkage & retention of young people by end COP19. Ensure that sexual prevention programs, including those provided under PEPFAR's new faith based initiative, do not compromise access to correct, comprehensive and non-stigmatizing HIV prevention services, including for girls aged 9 – 14.	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." p47 – p48 "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." p61		retention of young people in the area – where young people are collecting ART.	

Other Issues

EID	**Pediatric HIV: Improve timely diagnosis of perinatal HIV with point of care testing and optimized HIV treatment for infants.**	"Uganda estimates a pediatric HIV prevalence of 0.5 percent with 88,437 children under age 15 living with HIV (CLHIV)." p46 "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." p46 "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. 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."	COP19 will fully fund an immediate phase out nevirapine based regimens and scale up of lopinavir/ritonavir based ART for children <20kg and DTG based regimens for children >20kg. POC EID will be expanded in all sites providing pediatric treatment. COP19 will include funding for cartridges and operational support needed to achieve this.	Target: In FY19 95% of HIV exposed infants will receive the results of an EID test before two months. In FY19, PEPFAR will fund procurement of WHO recommended and optimal ARV regimens for all CLHIV including dolutegravir 50 mg for children >20kg; lopinavir/ ritonavir 100/25 mg tablets as soon as children >10kg can swallow whole tablets; and lopinavir/ ritonavir pellets/ granules/tablets/ syrup for children <20 kg. PEPFAR will fund intensive training and capacity building for health workers and caregivers in administering pediatric formulations in order to ensure maximum clinical benefit for children.	PEPFAR committed to fully funding EID commodities in COP19 to meet the 100 % of the national target. PEPFAR will work with the GOU, CHAI and partners to ensure optimum use of the existing EID platforms as well as the POC platforms, which will account for 20% of the tests in COP19. PEPFAR will continue to assess programmatic improvements as well as diagnostic systems improvements to ensure the best possible outcomes, PEPFAR and MOH committed to phase out nevirapine based regimens by December 18 and scale up lopinavir/ritonavir ART for children

GBV	**Gender-based violence targets are "over performing" yet we are facing unabated crisis**		-Revise GBV indicators and targets -Facilitate access to justice for GBV survivors -Funds should be allocated to reimburse witness financial expenses -As part of PEPFAR's commitment to fighting GBV, IPs must REQUIRE their staff to adhere to minimum standards of support and solidarity with survivors (providing examination and witness testimony without any demand for user fees) COP19 will continue to support district action centers using a case management approach to follow-up survivors of violence, while garnering community support for violence prevention. Through systems strengthening, support will target the Uganda Child Helpline to facilitate reporting and response to abuse cases. The program will continue implementing a child justice program targeting the district prosecutorial authorities and other stakeholders throughout the justice chain. Learning from the Violence Against Children Survey (VACS) response INSPIRE pilot project in Mityana, we shall develop and validate a locally contextualized violence prevention early detection index for children living in households that are rated as at most risk of experiencing violence. The index will engage families and understudy characteristics of households where violence against children is reported. The early detection index will enable practitioners to design interventions that directly deal with factors perpetuating violence and anticipate and immediately take action on such households identified as at most risk of violence occurring.		PEPFAR committed to revise the GBV indicator and focus on addressed cases of GBV. PEPFAR committed to continue and expand efforts to enhance access to justice, including increased prosecution of sexual violence offenders, for child victims of GBV.
PWUID					PEPFAR set targets for the 1st time.

Tables and Systems Investments for Section 6.0

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	BAYLOR COLL	ASP: HMIS, surveillance, & researc	Non-Targeted Pop: Not disaggregat	$ 240,670	Surveillance	Current program monitoring, surge for	COP19	COP21	h in place2. 50% of PLHIV deaths and lost t
HHS/CDC	Population Council, Inc., The	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 122,000	Program and data quality management	Coordination and leadership of Uganda's HIV response in the decentralized approach as we move towards 95/95/95 still faces challenges of supervision, accountability, oversight/policy, HRH planning and management, quality assurance and information use for decision making at national, regional and district levels	COP18	COP21	70%
USAID	SOCHA LLC	ASP: HMIS, surveillance, & research	OVC & care givers: Not disaggregated	$ 406,000	Evaluations	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP18	COP20	Wave 2 Survey Report; Wave 2 Dissemination event for stakeholders and partners
HHS/CDC	RAKAI HEALTH SCIENCES PROGRAM	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 226,800	Evaluations	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP17	COP19	Final report completed and findings disseminated
HHS/CDC	MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 163,287	Laboratory infrastructure	Uganda's laboratory capacity has increased substantially but there remains inadequate systems in place for efficient coordination, management, and continued quality assurance of laboratories required to inform program and policy to reach and sustain epidemic control	COP17	COP21	50% 100%

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	**Prime Partner**	**COP19 Program Area**	**COP19 Beneficiary**	**Activity Budget**	**COP19 Activity Category**	**Key Systems Barrier**	**Intervention Start**	**Intervention End**	**COP19 Benchmark**
HHS/CDC	A Global Healthcare Public Foundation, Inc.	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 65,000.00	Laboratory infrastructure	Uganda's laboratory capacity has increased substantially but there remains inadequate systems in place for efficient coordination, management, and continued quality assurance of laboratories required to inform program and policy to reach and sustain epidemic control	COP19	COP21	Surveillance of lab waste management practices; including proper segregation, trainings, availabity of waste management supplies, transportations and final disposal Review and approval of the National lab waste management policy and implementation guidelines
HHS/CDC	MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 207,522.00	Oversight, technical assistance, and supervision to subnational levels	Coordination and leadership of Uganda's HIV response in the decentralized approach as we move towards 95/95/95 still faces challenges of supervision, accountability, oversight/policy, HRH planning and management, quality assurance and information use for decision making at national, regional and district levels	COP17	COP21	50% 80% 50% 24
HHS/CDC	MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 868,902.00	Institutionalization of in-service training	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP16	COP21	10 20 90%
HHS/CDC	MUJHU CARE	ASP: HMIS, surveillance, & research	Pregnant & Breastfeeding Women: Not disaggregated	$ 455,000.00	Surveillance	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP16	COP21	N/A

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	**Prime Partner**	**COP19 Program Area**	**COP19 Beneficiary**	**Activity Budget**	**COP19 Activity Category**	**Key Systems Barrier**	**Intervention Start**	**Intervention End**	**COP19 Benchmark**
HHS/CDC	World Health Organization	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 77,000	Oversight, technical assistance, and supervision to subnational levels	Coordination and leadership of Uganda's HIV response in the decentralized approach as we move towards 95/95/95 still faces challenges of supervision, accountability, oversight/policy, HRH planning and management, quality assurance and information use for decision making at national, regional and district levels	COP18	COP21	Revised SMC policy in place; draft staffing norms in place; Defined role of the regional level structures to meet their centrl level mandate; National TB policies and guidelinesaligned to the WHO "End TB strategy" National Facility registry in place National Health care service provider registry in place Patient registries for HIV and TB in place National standards for Health Information Systems
HHS/CDC	World Health Organization	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 84,001.00	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP19	COP21	National Facility registry in place National Health care service provider registry in place Patient registries for HIV and TB in place National standards for Health Information Systems
HHS/CDC	World Health Organization	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 58,800	Lab policy, budgets, and strategic plans	Uganda's laboratory capacity has increased substantially but there remains inadequate systems in place for efficient coordination, management, and continued quality assurance of laboratories required to inform program and policy to reach and sustain epidemic control	COP17	COP21	Costed Lab strategic plans Lab standards for registration and licensure disseminated to at least 50% of facilities Advocacy plan for implementation of Lab practise and staffing norms by line Ministries developed
USAID	Catholic Relief Services - United States Conference Of Catholic Bishops	ASP: Policy, planning, coordination & management	OVC & care givers: Not disaggregated	$ 366,282	Oversight, technical assistance, and supervision to subnational levels	Coordination and leadership of Uganda's HIV response in the decentralized approach as we move towards 95/95/95 still faces challenges of supervision, accountability, oversight/policy, HRH planning and management, quality assurance and information use for decision making at national, regional and district levels	COP17	COP19	A) Case management tools rolled out at district/sub-district level B) Child help line supported to make district/community level referrals and follow ups to close cases C) VACS response action plan developed

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	**Prime Partner**	**COP19 Program Area**	**COP19 Beneficiary**	**Activity Budget**	**COP19 Activity Category**	**Key Systems Barrier**	**Intervention Start**	**Intervention End**	**COP19 Benchmark**
HHS/CDC	A Global Healthcare Public Foundation, Inc.	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 58,500.00	Lab quality improvement and assurance	Uganda's laboratory capacity has increased substantially but there remains inadequate systems in place for efficient coordination, management, and continued quality assurance of laboratories required to inform program and policy to reach and sustain epidemic control	COP19	COP21	One round of HIV/Syphilis DUO EQA conducted in 471 health facilities with 100% response and pass rate
HHS/CDC	UGANDA VIRUS RESEARCH INSTITU TE	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 1,532,687.00	Lab quality improvement and assurance	Uganda's laboratory capacity has increased substantially but there remains inadequate systems in place for efficient coordination, management, and continued quality assurance of laboratories required to inform program and policy to reach and sustain epidemic control	COP17	COP21	HIV serology EQA with 100% response and pass rate CD4 EQA with 100% response rate and 80% pass rate
HHS/CDC	MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH	ASP: HMIS, surveillance, & research	OVC & care givers: Not disaggregated	$ 61,001.00	Program and data quality management	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP17	COP21	A) 100% B) 2
HHS/CDC	MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 37,802	Evaluations	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP17	COP21	80% Regional Referral Hospitals 70% district hopistals 60% HC Ivs 30% HC IIIs

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	**Prime Partner**	**COP19 Program Area**	**COP19 Beneficiary**	**Activity Budget**	**COP19 Activity Category**	**Key Systems Barrier**	**Intervention Start**	**Intervention End**	**COP19 Benchmark**
HHS/CDC	UGANDA VIRUS RESEARCH INSTITU TE	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 153,576.00	Surveillance	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP17	COP21	Data collection, analysis and dissemination of findings to inform program
HHS/CDC	MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	$ 45,731.00	Evaluations	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP17	COP21	4 papers reviewed or published in a peer reviewed journal
HHS/CDC	Population Council, Inc., The	ASP: HMIS, surveillance, & research	Key Pops: Not disaggregated	$ 183,000.00	Surveillance	Coordination and leadership of Uganda's HIV response in the decentralized approach as we move towards 95/95/95 still faces challenges of supervision, accountability, oversight/policy, HRH planning and management, quality assurance and information use for decision making at national, regional and district levels	COP18	COP21	70% 60%
DOD	Population Services International	ASP: HMIS, surveillance, & research	Priority Pops: Military & other uniformed services	$ 99,623.00	Research	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP18	COP19	Data analysis and dissemination

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
DOD	University Research Co., LLC	ASP: HMIS, surveillance, & research	Priority Pops: Military & other uniformed services	$ 70,000.00	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP18	COP21	100% coverage
DOD	U.S. Department of Defense	ASP: Policy, planning, coordination & management	Priority Pops: Military & other uniformed services	$ 49,000.00	Oversight, technical assistance, and supervision to subnational levels	Coordination and leadership of Uganda's HIV response in the decentralized approach as we move towards 95/95/95 still faces challenges of supervision, accountability, oversight/policy, HRH planning and management, quality assurance and information use for decision making at national, regional and district levels	COP18	COP21	80% coverageof military bases with ART clinics
HHS/CDC	AFRICAN FIELD EPIDEMIOLOGY NETWORK	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 42,578.00	Laboratory infrastructure	Uganda's laboratory capacity has increased substantially but there remains inadequate systems in place for efficient coordination, management, and continued quality assurance of laboratories required to inform program and policy to reach and sustain epidemic control	COP19	COP21	Facilities reaching the sample/results turnaround time of ≤14 days 90% POC technologies mapped for integrated use in HIV management
HHS/CDC	MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 1,402,380.00	Program and data quality management	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP18	COP21	70% of various MER indicator data elements mapped and reported through the National reporting system 100% PEPFAR critical HMIS tools printed

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 1,294,683.00	Surveillance	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP17	COP21	National eHealth Enteprise Archicteture completed Standard adoption and implementation finalised HIV Health information exchange established in 2 regions- 6 districts
HHS/CDC	THE AIDS SUPPORT ORGANIZATION (TASO)	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 147,318.00	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP19	COP21	70 sites implementing EMR systems in HIV clinics and other service delivery areas (EID, ANC/MAT, HTS, TB/HIV, Dispensary, Laboratory) 60 sites with Point of care (PoC) implementation Patient, provider and facility registries established within the region Health information exchange established in the region Mobile-based case reporting in communities single desktop EMR system in light volume facilities
HHS/CDC	INFECTIOUS DISEASES INSTITUTE LIMITED	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 151,200.00	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP19	COP21	120 sites implementing EMR systems in HIV clinics and other service delivery areas (EID, ANC/MAT, HTS, TB/HIV, Dispensary, Laboratory) 80 sites with Point of care (PoC) implementation Patient, provider and facility registries established within the region Health information exchange established in the region Mobile-based case reporting in communities single desktop EMR system in light volume facilities

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	RAKAI HEALTH SCIENCES PROGRAM	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 231,000.00	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP19	COP21	120 sites implementing EMR systems in HIV clinics and other service delivery areas (EID, ANC/MAT, HTS, TB/HIV, Dispensary, Laboratory) 80 sites with Point of care (PoC) implementation Patient, provider and facility registries established within the region Health information exchange established in the region Mobile-based case reporting in communities single desktop EMR system in light volume facilities
HHS/CDC	UGANDA PRISONS SERVICES	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Young people & adolescents	$ 29,764.00	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP19	COP21	10 Prisons implementing EMR systems beyond HIV clinics (EID, ANC/MAT, HTS, TB/HIV) with Point of care (PoC) implementation Health information exchange established between Prisons and other national systems Mobile-based case reporting in commuties single desktop EMR system in light
HHS/CDC	INFECTIOUS DISEASES INSTITUTE LIMITED	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 463,300.00	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP19	COP21	100 sites implementing EMR systems in HIV clinics and other service delivery areas (EID, ANC/MAT, HTS, TB/HIV, Dispensary, Laboratory) 0 sites with Point of care (PoC) implementation Patient, provider and facility registries established within the region Health information exchange established in the region Mobile-based case reporting in communities single desktop EMR system in light volume facilities

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	**Prime Partner**	**COP19 Program Area**	**COP19 Beneficiary**	**Activity Budget**	**COP19 Activity Category**	**Key Systems Barrier**	**Intervention Start**	**Intervention End**	**COP19 Benchmark**
HHS/CDC	BAYLOR COLLEGE OF MEDICINE CHILDRENS FOUNDATION-UGANDA	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 158,900.00	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP19	COP21	100 sites implementing EMR systems beyond HIV clinics (EID, ANC/MAT, HTS, TB/HIV) 80 sites with Point of care (PoC) implementation Patient, provider and facility registries established within the region Health information exchange established in the region Mobile-based case reporting in communities single desktop EMR system in low volume facilities Hotline is operational in 40% of PEPFAR supported with high GBV burden districts
USAID	ICS Technologies, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	$ 304,782	Forecasting, supply chain plan, budget, and implementation	Uganda's health supply chain system has not reached its full maturity level to allow for commodity security and end-to-end visibility of the finance and commodity flow from the central level to the health facilities thereby compromising effective quantification, supply planning, ordering, stock management and accountability for HIV and TB commodities	COP18	COP21	100% installation of NMS ERP Hardware
USAID	Management Sciences For Health, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	$ 904,034	Forecasting, supply chain plan, budget, and implementation	Uganda's health supply chain system has not reached its full maturity level to allow for commodity security and end-to-end visibility of the finance and commodity flow from the central level to the health facilities thereby compromising effective quantification, supply planning, ordering, stock management and accountability for HIV and TB commodities	COP18	COP21	Also develop the annual national costed supply chain plan and support implementation of the health sector pharmaceutical strategy. Critical for regimen optimization

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	BRUNSWICK GROUP ASSOCIATES, INC., THE	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	$751,738	Supply chain infrastructure	Uganda's health supply chain system has not reached its full maturity level to allow for commodity security and end-to-end visibility of the finance and commodity flow from the central level to the health facilities thereby compromising effective quantification, supply planning, ordering, stock management and accountability for HIV and TB commodities	COP18	COP21	Pilot of ERP software MVP modules at NMS and 15 regional referall hospitals completed
USAID	Management Sciences For Health, Inc.	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 64,161	Forecasting, supply chain plan, budget, and implementation	Uganda's health supply chain system has not reached its full maturity level to allow for commodity security and end-to-end visibility of the finance and commodity flow from the central level to the health facilities thereby compromising effective quantification, supply planning, ordering, stock management and accountability for HIV and TB commodities	COP18	COP21	Pilot of interoperability of ERP at NMS with facility level WAOS, TWOS, RASS and RX solution
USAID	Management Sciences For Health, Inc.	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 34,006	Forecasting, supply chain plan, budget, and implementation	Uganda's health supply chain system has not reached its full maturity level to allow for commodity security and end-to-end visibility of the finance and commodity flow from the central level to the health facilities thereby compromising effective quantification, supply planning, ordering, stock management and accountability for HIV and TB commodities	COP18	COP21	70% of health facilities routinely report stock levels for key ARV drugs between 2-4 months

Table 6-E (Entry of Above Site Programs Activities)									
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USAID	BRUNSWICK GROUP ASSOCIATES, INC., THE	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 184,800.00	Laboratory infrastructure	Uganda's health supply chain system has not reached its full maturity level to allow for commodity security and end-to-end visibility of the finance and commodity flow from the central level to the health facilities thereby compromising effective quantification, supply planning, ordering, stock management and accountability for HIV and TB commodities	COP18	COP21	Pilot of ERP software MVP modules at NMS and 15 regional referall hospitals completed
USAID	ICS Technologies, Inc.	ASP: Public financial management strengthening	Non-Targeted Pop: Not disaggregated	$ 67,445	Forecasting, supply chain plan, budget, and implementation	Uganda's health supply chain system has not reached its full maturity level to allow for commodity security and end-to-end visibility of the finance and commodity flow from the central level to the health facilities thereby compromising effective quantification, supply planning, ordering, stock management and accountability for HIV and TB commodities	COP18	COP21	100% of NMS technical and support staff trained
USAID	BRUNSWICK GROUP ASSOCIATES, INC., THE	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$70,280	Supply chain infrastructure	Uganda's health supply chain system has not reached its full maturity level to allow for commodity security and end-to-end visibility of the finance and commodity flow from the central level to the health facilities thereby compromising effective quantification, supply planning, ordering, stock management and accountability for HIV and TB commodities	COP19	COP21	Pilot of ERP software MVP modules at NMS and 15 regional referall hospitals completed
USAID	University Research Co., LLC	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 166,630	Oversight, technical assistance, and supervision to subnational levels	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP18	COP21	Identify change packages. Scale up change packages in 50% of high volume ART sites

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	**Prime Partner**	**COP19 Program Area**	**COP19 Beneficiary**	**Activity Budget**	**COP19 Activity Category**	**Key Systems Barrier**	**Intervention Start**	**Intervention End**	**COP19 Benchmark**
USAID	Population Council, Inc., The	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 78,450	Research	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP17	COP21	VMMC modelling completed for COP 19
USAID	University Research Co., LLC	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 559,525	Oversight, technical assistance, and supervision to subnational levels	Coordination and leadership of Uganda's HIV response in the decentralized approach as we move towards 95/95/95 still faces challenges of supervision, accountability, oversight/policy, HRH planning and management, quality assurance and information use for decision making at national, regional and district levels	COP16	COP21	60%
USAID	Family Health International	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 140,765	Oversight, technical assistance, and supervision to subnational levels	Coordination and leadership of Uganda's HIV response in the decentralized approach as we move towards 95/95/95 still faces challenges of supervision, accountability, oversight/policy, HRH planning and management, quality assurance and information use for decision making at national, regional and district levels	COP16	COP19	U=U campaign implemented in all PEPFAR ART sites
USAID	RIGHT TO CARE	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 214,401	Evaluations	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP17	COP21	Costing completed and final results validated and reports disseminated to stakeholders for decision making

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	**Prime Partner**	**COP19 Program Area**	**COP19 Beneficiary**	**Activity Budget**	**COP19 Activity Category**	**Key Systems Barrier**	**Intervention Start**	**Intervention End**	**COP19 Benchmark**
USAID	SOCIAL & SCIENTIFIC SYSTEMS, INC.	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 1,301,651	Program and data quality management	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce.	COP16	COP21	(1) 55 Districts complete their own analysis and presentations for quarterly performance review with support from this IM (2) HIBRID care & treatment data from 95% of USAID sites is within +/- 5% of DHIS2 (3) 32 analytical reports (8 per quarter) completed from quantitative and qualitative data each with recommendations for adjustments to enhance program performance (4) 100 sites visited (25 per quarter) and aided to complete reports, analyze and present performance to facility management (5) DHIS2 and HIBRID data transformation and exchange into DATIM4U, and quarterly reports completed on time for TWGs to use and prepare for OGAC POART
USAID	SOCIAL & SCIENTIFIC SYSTEMS, INC.	ASP: HMIS, surveillance, & research	OVC & care givers: Not disaggregated	$ 110,547	Oversight, technical assistance, and supervision to subnational levels	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP16	COP21	District level analysis for quarterly performance review at intermediate level. This level of analysis includes: 1) Excel-based visual tools such as dashboards with graphical representation of data from OVCMIS and other secondary data; 2) focus groups discussions with thematic analysis of factors associated with enhanced or poor performance; 3) action plans with timeline
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 281,518.00	Research	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP16	COP21	Complete enrollment of the 15-24 year age group; 6 monthly follow up of participants ; Interim data analysis and dissemination of findings

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Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 87,918.00	Research	Current program monitoring, surge for quality, and epidemiologic analyses have brought Uganda close to HIV epidemic control. Data systems and analytics, however, need to be further developed for precision in targeting testing, reaching key populations, and more agile epidemiology as cases get harder to find and funds reduce	COP17	COP19	End of study follow up; Linkage to MoH; Final data analysis and lessons learned
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 351,836.00	HMIS systems	Rapid deployment of electronic medical records at high volume health facilities and robust laboratory testing systems need to be integrated using existing unique identification algorithms into national health registries for data precision, patient management across the cascade, and monitoring of viral load suppression for epidemic control	COP16	COP21	- 95% of the high volume facilities have operational EMR; - 20% of the low volume facilities have operational EMR
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 8,719.00	Evaluations	Coordination and leadership of Uganda's HIV response in the decentralized approach as we move towards 95/95/95 still faces challenges of supervision, accountability, oversight/policy, HRH planning and management, quality assurance and information use for decision making at national, regional and district levels	COP16	COP20	Reported indicators against the targets