THE REPUBLIC OF UGANDA

MID-TERM REVIEW OF THE NATIONAL HIV AND AIDS STRATEGIC PLAN 2020/21-2024/25

FINAL REPORT

July 2023

PREFACE

It is over four decades since the first case of AIDS was diagnosed in Uganda in 1982 and the HIV/AIDS epidemic has since had a devastating impact on Uganda. The country won many international accolades following years of near-miraculous reversal of HIV/AIDS prevalence from 30% in the early 90s to the current 5.5%. The number of new infections and AIDS-related deaths has also reduced over time from 156,000 and 56,000 in 2010 to 54,000 and 22,000 in 2021 respectively. The success has been due to a well-coordinated multi-sectoral response, and I congratulate you for your contributions towards these achievements.

The country still faces challenges including a fairly high number of infections among key populations and the provision of comprehensive service packages to this community including Adolescent Young Girls and Young Women (AGYW); other emerging priorities which may affect financing for the HIV and AIDS response among others.

The country has been implementing the National HIV and AIDS Strategic Plan 2020/21 – 2024/25(NSP) since June 2020. Additionally, the Presidential Fast Track Initiative to end AIDS as a public health threat by 2030 was launched in 2017. The NSP was developed and aligned with the National Development Plan III and Sustainable Development Plan to fulfill both country and international requirements. December 2022 marked the Medium-term of NSP and therefore the need to assess whether the country is on track to achieve the set targets of 2025 and also towards the 2030 PFTI aspirations.

I therefore, present the Review report of the National HIV and AIDS Strategic Plan 2020/21 – 2024/25 and the National Priority Action Plan 2023/24 – 2024/25. The review was highly participative and consultative, validation was conducted among all the key stakeholders. I therefore implore you to read the report and the proposed actions to guide you align interventions to enable the country attain the desired change by 2025 according to the NSP targets as we move towards ending of AIDS as a Public Health threat by 2030.

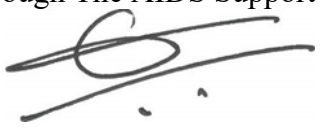
Dr. Eddie Mukooyo Sefuluya
CHAIRMAN
UGANDA AIDS COMMISSION

ACKNOWLEDGEMENT

The Mid-Term Review (MTR) of the National HIV/AIDS Strategic Plan (NSP) 2020/21 – 2024/25 was undertaken through a highly participatory, consultative, and phased approach reaching all key stakeholders involved in the National response. The process involved close consultation with the Thematic Area Technical Working Groups (TWGs). The Uganda AIDS Commission (UAC) would like to appreciate all the key stakeholders and partners who participated in this important exercise. First and foremost, allow me to appreciate the UAC Management Team which worked tirelessly to ensure that this exercise is implemented professionally and timely to its conclusion by providing all the required support. Special thanks to Dr. Vincent Bagambe, Dr. Zepher Karyabakabo, Ms. Enid Wamani, Dr. Peter Wakooba, Dr. Sarah Khanakwa, Dr. Asiimwe Stephen, Mr. Victor Rwengabo, Mr. Charles Otai, Ms. Hope Murungi, Ms. Lillian Tatwebwa, and Ms. Christine Karugonjo, among others.

Our sincere gratitude goes to all the members of the TWGs for their technical guidance and support. We are grateful to the key informants drawn from UAC, the Ministry of Health, other Ministries, Departments and Agencies (MDAs) and the AIDS Development Partners (ADPs) for the valuable information you provided. We acknowledge the input from the district technical and management teams including Chief Administrative Officers (CAOs), the District Health Officers (DHOs), the District HIV/AIDS Focal Persons, members of the District AIDS Committees (DACs) and the District Health Teams (DHTs), Health Facility In-Charges, Civil Society Organization (CSOs), Agency Coordinators, Directors, Program Officers and other staff who devotedly participated in district meetings and interviews. We are particularly grateful to Persons Living with HIV (PLHIV) who participated in focus group discussions.

Last but not least, we wish to recognise Makerere University School of Public Health (MakSPH) for assembling a team of consultants under the leadership of Assoc. Prof. Fred Wabwire-Mangen including Drs Peter Mudiope and Peter Kyambadde (Prevention); Dr Mina Ssali Nakawuka (Care and Treatment), Assoc. Prof. Julius Omona and Dr. Ronald Luwangula (Social Support and Protection), Dr Richard Ayiasi Mangwi (Systems Strengthening), Dr Perez Ochanda (financing and costing) and Dr. Simon Muhumuza (Monitoring, Evaluation and Research) This review would not have been possible without the financial support of the Global Fund through The AIDS Support Organization (TASO).



Dr. Nelson Musoba
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ABYM	Adolescent Boys and Young Men
ACP	AIDS Control Program
ADPs	AIDS Development Partners
AFHS	Adolescent-Friendly Health Services
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
APN	Assisted Partner Notification
ART	Antiretroviral Therapy
CDDP	Community Drug Distribution Point
CHEWs	Community Health Extension Workers
CLHIV	Children Living with HIV
CSOs	Civil Society Organizations
DAC	District HIV/AIDS Committee
DICs	Drop-in Centers
DPs	Development Partners
DSDM	Differentiated Service Delivery Model
DTG	Dolutegravir
EID	Early Infant Diagnosis
EMTCT	Elimination of Mother-To-Child Transmission
FBOs	Faith-Based Organizations
GBV	Gender-Based Violence
GoU	Government of Uganda
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
IRCU	Inter-Religious Council of Uganda
JAR	Joint Annual Review
KPs	Key Populations
LGs	Local Governments
LMIS	Logistics Management Information Systems
M&E	Monitoring and Evaluation
MDAs	Ministries, Department and Agencies
MoES	Ministry of Education and Sports
MoFPED	Ministry of Finance, Planning and Economic Development
MoGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
MoWT	Ministry of Works and Transport
MSM	Men who have Sex with Men
MTR	Mid-Team Review
NADIC	National Documentation and Information Centre
NAFOPHANU	National Forum for PLHA Networks in Uganda
NDP	National Development Plan
NGO	Non-Governmental Organization
NPAP	National Priority Action Plan
NSP	National HIV and AIDS Strategic Plan

ODI	One Dollar Initiative
OPM	Office of the Prime Minister
OVC	Orphans and other Vulnerable Children
OWC	Operation Wealth Creation
PEP	Post-exposure Prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PFTI	Presidential Fast-Track Initiative
PLHIV	People Living with HIV
PICT	Provider-Initiated Counselling and Testing
PMTCT	Prevention of Mother to Child Transmission of HIV
PrEP	Pre-exposure Prophylaxis
PWD	Persons with Disability
PWID	Persons who inject drugs
RUTF	Ready-to-use Therapeutic Foods
SACCOs	Savings and Credit Co-operative Associations
SAGE	Social Assistance Grants for Empowerment
SASA	Start, Awareness, Support, Action
SBCC	Social and Behavioral Change Communication
SC	Steering Committee
SCE	Self-Coordinating Entity
SDG	Sustainable Development Goals
SEDC	Socioeconomic Data Centre Ltd
SMC	Safe Male Circumcision
SRH	Sexual Reproductive Health
STIs	Sexually Transmitted Infections
TCMPs	Traditional and Complementary Medical Practitioners
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UDHS	Uganda Demographic and Health Survey
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Fund for Population Activities
UPHIA	Uganda Population-Based HIV Impact Assessment
UVRI	Uganda Virus Research Institute
UWEP	Uganda Women Entrepreneurship Program
VAC	Violence Against Children
VHT	Village Health Team
VLS	Viral Load Suppression
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
YAPs	Youth and Adolescent Peer Support
YLP	Youth Livelihood Program

Introduction
Introduction

The Uganda AIDS Commission, in collaboration with key stakeholders, developed a five-year national HIV/AIDS Strategic Plan (NSP) 2020/21 – 2024/25 to guide the implementation of the national response against the HIV epidemic. The goal of the plan was increasing productivity, inclusiveness and wellbeing of the population through ending the AIDS epidemic by 2030. The specific objectives of the NSP are to: (i) reduce new HIV infections by 65% among adults and youth, and to reduce new paediatric HIV infections to less than 5% by 2025 ;(ii) reduce AIDS-related morbidity and mortality by 2025; (iii) strengthen social and economic protection to reduce vulnerability to HIV and AIDS and to mitigate their impact on people living with HIV, orphans and other vulnerable children (OVC), Key Populations and other vulnerable groups; (iv) strengthen the multi-sectoral HIV and AIDS service delivery and coordination system that ensures sustainable access to efficient and quality services for all focus populations and (v) strengthen the national HIV and AIDS strategic information management system for improved effectiveness and efficiency. To achieve these objectives, a strategy of scaling up a package of proven and cost-effective package of HIV prevention, care and treatment services, targeting the most critical population groups, while at the same time investing in social enablers to support and sustain high levels of uptake of the services was adopted. Furthermore, there were investments in social support systems to reduce the vulnerability of various population groups while at the same time strengthening health and community systems for the delivery of services. The plan was structured according to the four thematic areas of Prevention, Care and Treatment, Social Support and Protection and Systems Strengthening as well as the sub-themes of Financing and Resource Mobilization and Monitoring, Research and Evaluation. December 2022 marked the mid-point of the plan, underscoring the need to conduct a Mid-Term Review (MTR) of the Strategic Plan.

Objectives

The purpose of the MTR was to assess the progress of implementation of the NSP against set targets guided by the results framework and develop the national priority action plan for the remaining period (2023/24 – 2024/25) of the NSP. The specific objectives of the MTR included the following:

1. To assess whether the progress of implementation of the NSP 2020/21 – 2024/25 is on track against set targets during the first two and half years;
2. To identify the challenges and gaps, lessons learned and best practices during the implementation of the plan in the first two and half years.
3. To propose recommendations and adjustments to the plan for the remaining years of the NSP and submit a revised National Strategic Plan 2022/23 – 2024/25
4. To develop a National Priority Action Plan (NPAP) for the remaining period (2022/23 – 2024/25) as informed by new evidence and changing dynamics of the HIV epidemic.

Methods

The MTR adopted a mixed methods approach including desk review of documents, analysis of secondary data, technical review meetings at national level, and key informant interviews, health facility assessments and focus group discussions at sub-national level. The Organization

for Economic Developments - Development Assistance Committee (OECD DAC) evaluation criteria of relevance, impact, effectiveness, efficiency and sustainability were used to guide the analysis and interpretation of results. To ensure national representation, 11 districts drawn from the UPHIA operational regions were purposively selected to participate in the sub-national assessment.

Results

These are presented according to each specific objective of the MTR.

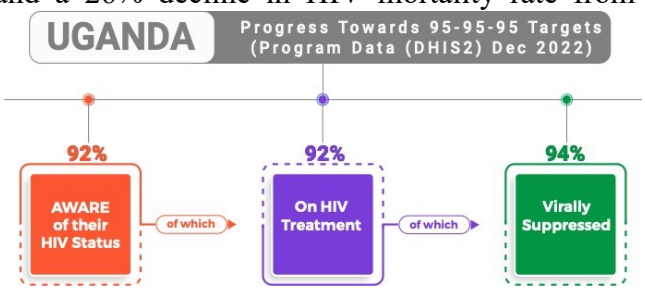
Objective 1: Progress towards the set targets for each thematic area and sub-theme

Prevention

The goal of the prevention thematic area is to reduce new HIV infections by 65% among adults and youth, and to reduce new pediatric HIV infections to 5% by 2025. By 2020 (Baseline for the NSP), new HIV infections were 38,000. However, the Covid 19 period saw the annual number of new infections increase to 54,000 which was attributed to the effect of the lock down on service provision among other reasons. The new HIV infections due to mother-to-child transmission appear to have stagnated at more than 5%, undermining the achievement of the NSP prevention goal. Although some of the HIV prevention indicator outcome data for increased adoption of safer sexual behaviours, expanded coverage and uptake of biomedical priority HIV interventions and mitigated socio-cultural, gender and other factors that drive the HIV epidemic was missing, the available data showed a mixed picture, with improvements in some indicators, while others appeared to have stagnated or even deteriorated. For example, the prevalence of multiple sexual partnership among adults increased from 20.6% and 2.3% to 30.7% and 10.4% in males and females, respectively. On the other hand, consistent condom use among Female Sex Workers (FSWs) increased from 45% to 71% whereas that among Men having Sex with Men (MSM) declined from 64% to 39%. HIV testing in the general population significantly increased from 37% to 76.1% in males and from 48% to 83.5% in females. Similarly, HIV testing among key populations increased from 86% to 97% among FSWs and from 85% to 96% in MSMs, surpassing the NSP targets. The NSP targets for initiating antiretroviral treatment (ART) (95%) and viral load suppression (95%) among HIV-positive pregnant women were achieved, whereas those for retention on ART among HIV-positive pregnant women (85%), ARVs for HIV Exposed Infants (84%), Early Infant Diagnosis (EID) (79%) and male circumcision (64.2%) are on track to be achieved. Family planning use among HIV-positive women (38.4%) is still far below the NSP target of 70%. Most of the indicators for the underlying socio-cultural and gender factors that drive the HIV epidemic such as stigma and discrimination, gender relations and women empowerment appear to be on track. However, the percentage of women who experience sexual and gender-based violence (11%) is still higher than the NSP target of 5%.

Care and Treatment

The goal of the care and treatment thematic area is to reduce AIDS-related morbidity and mortality by 2025. The mid-term review revealed a 17% decline in annual HIV related deaths from 22,000 in 2020 to 17,337 in 2022 and a 26% decline in HIV mortality rate from 66/100,000 in 2020 to 40/100,000 in 2022. This trajectory shows a steady but slow reduction in AIDS-related morbidity and mortality and the NSP target of a drop in AIDS-related mortality to under 10,000 may not be achieved. However, the review further revealed that the country is on



course to achieve the NSP and UNAIDS 95-95-95 targets of ending AIDS as a public health threat by 2030. By the end of 2022, 90% of the 1.4 million people estimated to be living with HIV (PLHIV) were aware of their status, of whom 94% are on ART and 94% of those on ART are virally suppressed. The country is on course to achieve the NSP target of starting ART among HIV positive persons within a month (93% vs 95%). However, the observed ART retention (74%) and adherence (73%) levels are lower than the NSP targets of 95% and 100%, respectively. With respect to TB and HIV co-management, the country is on track to achieve the NSP targets for TB and HIV treatment and TB preventive therapy (TPT): The percentage of HIV-positive incident TB cases that received both TB and HIV treatment increased from 76% to 94% and that of ART patients who started TPT increased from 80% to 90%. Although the NSP target for screening for cancer of cervix among HIV positive women was surpassed (74% vs 50%), the targets for screening for hepatitis B (1.3% vs 50%) and cryptococcal meningitis (60% vs 95%) appear to be lagging and may not be achieved in the remaining period of the NSP.

Social Support and Protection

The goal of the social support and protection thematic area is to strengthen social and economic protection to reduce vulnerability to HIV and AIDS and to mitigate their impact on people living with HIV (PLHIV), orphans and other vulnerable children (OVC), Key Populations and other vulnerable groups. The absence of quantitative data for most indicators for social support and protection notwithstanding, the mid-term review showed that progress was made in the implementation of social support interventions. Progress in elimination of stigma and discrimination was manifested through the following approaches: building the HIV/AIDS competency of health workers across the country; development of guiding policies and manuals on stigma and discrimination; translation of the stigma and discrimination policy into sign language to cater for people with disabilities; dissemination of anti-stigma policy guidelines to 136 districts and some MDAs and mobilization and orientation of 140 journalists from three regions for Tooro, Kigezi and Ankole by the media SCE (Self-Coordinating Entity) in anti-stigma policy guidelines; and rolling out of the National Equity Plan.

In respect to expanding socioeconomic interventions aimed at reducing social and economic vulnerability for people living with HIV and other vulnerable, the Government of Uganda launched the Parish Development Model (PDM) in which funds, functions and specific activities are decentralized and made available to communities to plan and implement activities based on community needs was launched. The Social Assistance Grants for Empowerment (SAGE) program reached 307,145 beneficiaries across 135 districts in 2021/22. Some of the SAGE program beneficiaries were caregivers of AIDS orphans and young people living with HIV (YPLHIV). The Uganda Women Entrepreneurship Programme (UWEP) reached over 4,000 beneficiary groups with financial support including over 240,000 individual women beneficiaries. These included women living with HIV; other vulnerable women such as young single mothers, widows, survivors of GBV, women with disabilities. Under the Adolescent Girls and Young Women (AGYW) program, over 98,000 AGYW participated in economic strengthening programs including vocational skills and viable businesses.

In order to scale up psycho-social support for PLHIV, Persons with Disabilities (PWDs), Key and Priority Populations (KP/PP) and other vulnerable groups, the Ministry of Health (MoH) conducted trainings of expert clients to complement the existing staff at health facilities and implemented social support activities targeting YPLHIV under the Young People and Adolescent Peer Support (YAPS) program. The Ministry of Gender, Labour and Social

Development (MGLSD) and partners reached over 4,000 survivors of GBV with psychosocial support while the Ministry of Education and Sports (MOES) trained and equipped 400 teachers with capacity to provide psychosocial support for learners and teachers during and after the COVID-19 lockdown. Some MDAs provided workplace psychosocial support for staff living with HIV/AIDS.

Progress was registered in strengthening prevention and response to sexual and gender-based discrimination and violence. For instance, the Gender and HIV Reporting Dashboard (GRD) is fully functional. Through the DREAMS initiative, over 56,000 AGYW were reached with post violence care. Under the AGYW Program, the MoH developed and delivered the "Journeys plus curriculum" through which more than 120,000 AGYW were reached with violence and HIV prevention messages. The 'No means No' intervention supported AGYW to build resilience to defend themselves against perpetuators of violence. Elsewhere, a total of 193,853 persons under PEPFAR supported interventions received post GBV clinical care based on the minimum package. Interventions by legal aid CSOs saw at least 3,050 cases of GBV handled by trained community-based GBV responders and paralegals, and over 100 cases handled by lawyers. In addition, the Learner's message handbooks and teacher's facilitator's guide on HIV Prevention, menstrual hygiene management (MHM) and SGBV for both primary and secondary schools were developed. A review of secondary indicator data on gender-based violence and discrimination showed that the country is on track to achieve some of the NSP targets: The percentage of women and men who believe that wife beating is justified reduced from 47% in 2020 to 17% in 2022, against an NSP target of 15%; the percentage of married women who participate in making decisions pertaining to their own health care, major household purchases and visits to their families increased from 36% to 64%, against an NSP target of 65%; The percentage of women who own land alone or jointly with their spouses increased from 48% to 74%, against an NSP target of 60%; and the percentage of GBV survivors who report to formal institutions such as police increased from 7% to 14%, against an NSP target of 10%. However, the data showed that GBV from intimate partners is still high. The percentage of women and men who experienced physical GBV from intimate partners increased from 23% to 45% and that for sexual GBV increased from 17% to 36%. These values are way above the national targets of 11% and 8%, respectively.

In regard to strengthening prevention and response to child protection issues and violence against children, more than 403,000 OVCs received social support services. The National Child Policy (2020) and the Parenting Guidelines were finalized in 2020. Progress was further made in: rolling out of the revised guidelines for prevention and management of teenage pregnancy in schools; tracking of the number of teenage mothers re-enrolled into schools by the MoES; VAC training for leaders, law enforcement officers; provision of education subsidies to 18,000 vulnerable girls in the 39 Global Fund supported high burden districts by the MOES collaborated with other line ministries; training teachers on school health/ sexuality education and life skills as part of the initiative to keep boys and girls in school;

The implementation of the NSP has also been marked with the strengthening of the legal and policy framework on HIV and AIDS. In particular, the MGLSD developed the National Policy on HIV and AIDS at the World of Work 2022; HIV Workplace Policies in MDAs, Private Sector and LGs were developed; and a number of institutional frameworks were developed.

Systems Strengthening

The goal of the systems strengthening theme is to strengthen the multi-sectoral HIV and AIDS service delivery and coordination system that ensures sustainable access to efficient and quality services for all focus populations. The theme is divided into the sub-themes of Governance and Leadership, Human Resources, Supply Chain, Health Infrastructure, Financing for HIV and Monitoring Evaluation and Research. Progress against the targets for systems strengthening at the mid-term is summarized below under each sub-theme.

Governance and leadership: The indicator data for Governance and leadership showed that the country is on course to achieve the NSP targets: 80% of districts have functional District AIDS Committees (DACs); 91% of districts have functional PLHIV networks, 92% of the Self Coordinating Entities (SCEs) have functional HIV and AIDS Committees and 72% of sectors are mainstreaming HIV and AIDS. However, the composition and functions of the DAC is being questioned and districts recommend a revision in the DAC composition and their roles in line with the evolution of the HIV and AIDS epidemic.

Human Resources: The percentage of health facilities with required staffing levels stands at 74%, which is higher than the NSP target of 70%. Implementing partners supported secondment of 32 staff to strengthen the oversight roles of Community Health Departments (CHDs) of 8 RRHs. These staff included biostatisticians, epidemiologists, infection prevention and control officers, continuous quality improvement officers and grants management officers. Critical human resources such as adherence counsellors and linkage officers which are not elaborated in the public service staffing norms are usually employed by implementing partners (IPs). There are concerns about sustainability of these particular human resources once the IPs withdraw.

Supply chain: The percentage of health facilities that had no stock out of one or more required essential medicines and health supplies within past 12 months was 82% against the NSP target of 90%. However, a host of challenges within the existing supply chain management system were reported and included late deliveries of supplies from the central warehouses to the districts; discrepancies between the ordered and delivered supplies and the associated process delays in addressing the discrepancies and delivery of nearly expiring medicines and health supplies.

Health infrastructure: All HC IIIs in the country are accredited to provide HTS, ART and PMTCT services,

Resources for HIV: Mobilization of resources, efficient utilization and accountability of HIV finances remain a key driver towards financial sustainability for HIV/AIDS response in Uganda. During the current NSP 2020/21-2024/25, the government has put concerted efforts to mainstream HIV/AIDS; these mainstreaming mechanisms include the private sector-led One Dollar Initiative (ODI) and the 0.1% annual budget contribution from all government ministries, departments and agencies (MDAs) and district local governments (DLGs). Generally, HIV resources mobilization has remained sub-optimal. Although more than 90% of MDAs and DLGs have costed HIV and AIDS strategic plan, HIV financing is largely donor-led with over 83% of resources contributed by the AIDS Development Partners (ADPs).

Despite the limited fiscal space and sluggish performance of the different mainstreaming mechanisms, the government has demonstrated consistent political will and commitment towards financial and institutional sustainability of HIV/AIDS response in Uganda.

Government support marginally increased by 2.1% between FY 2020/21 and 2021/22. The overall domestic contribution to HIV financing including government and mainstreaming initiatives increased from 12% to 13.8% from the first year to mid-term of the current NSP. However, this is still far from the optimal level required for government to finance at least 50% of the HIV response. Although progress has been made in training and engaging MDAs and DLGs in HIV mainstreaming and resources mobilization activities, the potential of the private sector through the ODI initiative and Civil Society Organizations has not been well cultivated. Further, the government continues to face a narrow fiscal space, which limits increase in direct budget contribution to the response. The ramifications of the Anti-homosexuality Act passed by Parliament in May 2023 on HIV funding streams remains uncertain and a potential source of risk to the response.

Monitoring Evaluation and Research: The goal of the Monitoring Evaluation and Research (MER) thematic area is to strengthen the National HIV and AIDS strategic information management system for improved effectiveness and efficiency. Most of the MER key indicators appear to be on track: All sectors have costed HIV and AIDS M&E plans; 74% of the districts have costed HIV and AIDS M&E plans; 81% of the sectors submit quality data that meets standards; all key sectors (MDAs) submit timely and complete reports to UAC; 92% of SCEs submit quality reports; Sector HIV and AIDS mainstreaming at 74% and all implementers use program generated HIV and AIDS data for various purposes including but not limited to performance monitoring, planning and decision making

Objective 2: Challenges and gaps

Prevention

ABC strategy

- the National Sexuality Education Framework was developed, and under implementation although the rollout is slow. This is because of concerns raised by the religious leaders which have been addressed over the implementation period.
- There are gaps in coordination of multiple partners supporting education including messages in schools. The Message Clearing Committee offers an opportunity to address this to ensure targeted, age-appropriate messages to the learners.
- In schools though there are some efforts to integrate HIV and AIDS services, these remain sub-optimal. The Senior woman and man teachers and the teacher in charge of counselling assigned as secondary roles additional to their primary responsibilities. Additionally, several schools don't have a school nurse as provided for in the draft school health policy, this would bring in more technical competence to support delivery of services.
- The challenge of schools being more focused on academics, with busy curricula and events, leaves very limited time and interest to focus on learners' other needs such as HIV/AIDS.
- The scale of implementation of HIV programs was inadequate, mainly due to insufficient funding. The PIACY program was only implemented in a few schools supported by partners.

HTS

- Frequent stock out of HIV test kits is experienced at health facilities across the country and vary across different sites mainly due to low targets set based on optimizing testing for diagnosis. This is coupled with the inability for health services providers to adhere to the guidelines for HTS optimization.
- There has been low uptake of HIV testing services among men despite the evidence that men especially 40-49years old shield a high burden of the epidemic.

- Poor adherence to the HTS standards, particularly among the private providers, results in suboptimal quality of HTS services.
- Despite the several approaches used, linkage of HIV-positive and negative clients to prevention, care and treatment is still low across all testing modalities.

PMTCT
- Low uptake of ANC4 services, low deliveries in health facilities and loss of mother-baby pairs remains a critical challenge.
- Retention of mothers in care is suboptimal and is largely due stigma, non-disclosure and lack of partner support.
- DSD models for PMTCT are not fully implemented: GANC model is available at limited facilities.
- Inadequate SRHR integration in MCH services leads to unplanned pregnancies among HIV-positive women.
- Gender inequalities and structural barriers hinder access to care and treatment in PMTCT settings.

SMC
- The SMC program continues to be implemented as a parallel program at both national and sub national levels.
- Not all facilities in the country have the capacity to provide SMC services. Most of the SMC sites are not well equipped to provide emergency services.
- Uptake of the reusable circumcision approach has been slow and is largely due to the low capacity to sterilize equipment.

Condom Programming
- Although condoms remain fundamental to the triple prevention of STIs, HIV and unwanted pregnancy, their usage at high-risk sex has remained low (<50%) in Uganda.
- The National plans, strategies and guidelines for condom programming have not been disseminated to the districts.
- There are inadequate leadership and coordination structures for condom programming at the district, health facility and community levels.
- The health information systems used at district, health facility and community level do not adequately capture condom data.
- There is no domestic/government funding to condom programing at all levels. As such, most of the key activities such as advocacy, behavioural change communication, condom distribution, capacity building, social and operational research are not adequately funded.

Pre-Exposure Prophylaxis
- PrEP is not yet integrated into the routine health system and as such, there is low uptake of PrEP.
- PrEP is not yet incorporated into the core pre-service training package for health workers. As a result, the health workers do not have adequate skills to provide PrEP.
- There are no PrEP provisions in prison settings due to policy-legal environment in prison

STIs
- There is no stand-alone STI strategic plan to provide adequate guidance. STI issues are integrated within other strategic documents.

- Policy guidelines on STIs are not regularly updated despite the WHO recommendation of 2-3 years review.
- Health facility barriers including inadequate capacity of health workers to manage STIs appropriately and frequent stock-outs of STI drugs in facilities exist.

AGYW

- Very low, less than 30% school enrolment rate for AGYW
- Limited scale of youth-friendly services acceptable to AGYW
- Sub optimal delivery of a comprehensive AGYW HIV prevention package – scale of services such as PEP, PrEP and HIV/STI service integration at national and sub national levels are limited by funding constraints, inadequate health care provider training and stock outs of STI diagnostic kits
- No comprehensive AGYW HIV prevention M&E framework with local targets, including absence of targets for AGYW in the 25-29 age bracket
- No characterization of male partners of AGYW, and there is low turnout in male partner testing and ART referral
- Lack of population size estimates which takes into consideration the different sexual and behavioral characteristics of AGYW; and no size estimates for the subnational levels
- Absence of technical working groups or coordination committees at sub national level.
- Lack of a costed multi sectoral AGYW framework to guide planning and resource allocation
- Weak service integration at national and at service delivery points, as well as referral system
- There is no implementation of PEP and PrEP community-based demand generation and outreach targeting all AGYW and men aged 20-39 years.

KP/PPs

- Coverage, scale and scope of KP interventions remain sub-optimal across programs including SBC, mental health, HTS, PrEP and other prevention, care and treatment services.
- KP Policy guidelines are not updated to address the current developments and innovations in service delivery.
- Stigma, discrimination, hostilities and criminalization of KP/PPs, both in health facility and communities' settings are widespread and affect access to services.
- Programs to address violence against KP/PPs including PWIDs, are implemented on a limited scale.

Care and Treatment

- Retention in care is still sub-optimal for all populations but is more pronounced among children, adolescents, and KPs.
- There is low HIV treatment coverage among children, adolescents and this is due to the weaknesses in finding infected children.
- HIV services integration is inadequately implemented, particularly AHD implementation, NCD integration, HBV and HCV, SRH and cervical cancer screening.

Social Support and Protection

- Stigma and discrimination against PLHIV still persist in the community especially for

young people LWHIV and KPs due to structural barriers rooted in social, cultural and economic inequalities.

- The limited domestic funding and donor dependency for programs poses challenges for sustainability and institutionalization of programs to remove rights-related barriers.
- Recovery of revolving fund in some places is problematic because some people politicize it and others are simply less informed about it
- Provision of GBV response services in emergency settings including refugee settlements relies on parallel structures and is not integrated in existing government systems.
- Persisting handling of SGBV cases through a patriarchal lens that disfavors women and girls.
- There is limited scope of social protection by leaving out programs on Social Insurance and employment assistance.
- Persons with disabilities are conspicuously missing in all dis-aggregated data, yet they are among the most vulnerable and marginalized population sub-group in Uganda.
- The gap between number of GBV/VAC events and perpetrators followed up for meting justice is wide, leading to delayed justice for those who had suffered violence.
- There is weak monitoring and tracking implementation of guidelines in order to effectively address discrimination and stigma.

Systems Strengthening

- An explicit framework for evaluating health systems performance for the HIV/AIDS response is lacking especially for the goal towards ending AIDS as a global public health threat by 2030.
- Multiple policies for human rights issues in the HIV/AIDS response have been developed and ratified, however oversight for roll out and implementations is lacking.
- The mechanism of coordination for HIV and AIDS response between the districts, UAC and the ACP is not clear.
- DAC membership is considered to be obsolete and call for a revision: Most DAC members are new and not oriented on their roles and responsibilities in the HIV and AIDS response.

Finance and costing

- There is over dependence on donor assistance for implementing of key program areas, with oversee development partners contributing to over 80% of the resource requirement for sufficient implementation of HIV/AIDS programming.
- There is inadequate interest and social responsibility from non-public and non-foreign actors to financially support HIV programming in Uganda i.e., ODI is still at takeoff stage.
- Limited government physical space is a major challenge towards increasing domestic resource allocation for HIV response in Uganda.
- Gaps in technology and capacity at district local government level to adequately support financing and resource mobilization efforts.
- CSOs are not well mobilized and supported to contribute to HIV/AIDS response in Uganda both financially and programmatically.

Monitoring and Evaluation

- Although there has been substantial progress towards establishing one national M&E system in the country, multiple and parallel M&E systems for some HIV programs, such as KPs, AGYW (DREAMS), Cancer of the Cervix etc., still exist.
- The absence of a functional centralized database makes access to comprehensive HIV and

AIDS data difficult.

- HIV and AIDS data collection, analysis and reporting at a consideration proportion of health facilities across the country is still paper based. This makes it difficult to manage and report large volumes of data for long-term patient care and monitoring of outcomes.
- Sub-optimal data quality for some HIV and AIDS programs still exists within the National HMIS systems. This is attributed to the multiple and parallel MER systems, paper-based data management at some sites, inadequate human resource capacity for MER in terms, knowledge, skills and numbers, insufficient infrastructure, logistics and supplies and poor data use practices.
- The National research agenda to guide HIV and AIDS research in the country has not been disseminated.

Objective 3: Priorities for the Remaining NSP Period (2022/23 - 2024/25)

Prevention

Primary prevention of HIV

- Scale-up social and behavioural change interventions including abstinence and be faithful interventions to reach all population groups with targeted messages.
- Fight stigma and discrimination using existing structures such as supporting the teachers AIDS action group (TAAG)
- Scale up the "Time Up HIV" campaign to all districts.

Condom programming

- Scale-up condom education through evidence-based social mobilization and marketing approaches to address behavioral disinhibition associated with condom use.
- Strengthening condom programming structures at all levels including the National condom Technical Working Group (TWG) and the district condom coordination committees.
- Scale up the last-mile condom distribution guidelines in all districts, to ensure functional and coordinated district condom distribution structures.

HIV Testing services

- Scale-up the revised HTS policy and implementation guidelines including the revised HIV testing algorithm (the 3-test algorithm), HMIS tools and the revised job aids.
- Roll out a nationwide continuous quality improvement collaborative and data quality assessments to improve HTS services delivery and data quality.
- Scale up optimization with fidelity of HTS such as Social Network Testing (SNT), Index Testing provisions and HIVST to target underserved populations.

Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)

- Accredit more facilities across the country to provide PrEP and PEP at facility and community level.
- Review, update and roll out the PrEP curriculum and guidelines and increase uptake of PEP for non-medical and medical exposure.
- Build capacity of service providers and service outlets to roll out new HIV prevention technologies,including the training of peer workers to dispense PrEP.
- Implement quality improvement initiatives and operational research to improve uptake and quality of PrEP services delivery.

SMC

- Integrate SMC services into other routine health services, including outpatient services, MCH services and at the workplace.
- Scale-up the use of innovative circumcision methods such as non-surgical methods and transition from single-use circumcision kits to re-usable kits

- Conduct annual site and provider accreditation and certification to ensure quality services for SMC.
- Support quality-improvement management of SMC service delivery through on-site mentorship, coaching and support supervision.

KP/PP programming

- Review, update and disseminate KP policies and tools to align with the current changes and innovations.
- Build capacity of service providers in delivery of KP-friendly services including addressing health worker-stigma for effective utilization of health facility-based services
- Scale up quality KP/PP differentiated services delivery (DS) at community levels.
- Conduct studies to estimate the national and sub-national sizes and profiles of KP/PP populations.
- Undertake legal, human rights and sexual and gender diversity trainings for law enforcement and health care workers to increase uptake of health services and social justice.
- Expand the provision of alcohol and drug dependency rehabilitation, and harm reduction program services.

PMTC of HIV, syphilis and Hepatitis B

- Strengthen primary prevention services with a focus on AGYW, HIV negative pregnant and breastfeeding women and their partners.
- Optimize the identification, treatment, retention and adherence on ART for HIV +ve pregnant and breastfeeding women, infected with HIV, Syphilis, Hepatitis B and their exposed infants through improving logistics and supplies, and promoting advocacy and patient literacy.
- Scale up the prevention of incident HIV among pregnant and breastfeeding women through PrEP and PEP literacy and awareness campaigns, adherence support and demand generation activities.
- Expand the roll out of EPI/PMTCT/EID integration for EID to all PMTCT sites and point of care testing.

AGYW

- Scale up AGYW interventions in all high incidence districts and strengthen referral monitoring of the AGYW program.
- Roll out a central M&E data system to capture data on AGYW programming at multi-sectoral level.
- Provide safe spaces at the community level and implement economic empowerment activities for AGYW and ABYM in selected districts with high number of GBV survivors, coupled with limited access to protection services.
- Economic empowerment interventions, activities to reduce the economic vulnerability of AGYW/ABYM in high incidence locations including school allowance and clubs and savings groups for in and out of school youth.
- Implement interventions to keep AGYW in school by scaling up menstrual hygiene management among in-school AGYW, providing sanitary pads for needy AGYW at school, and cash transfers, among other interventions.
- Conduct a country wide survey to determine the impact of AGYW programming on high teenage pregnancy should be carried out.

Structural drivers: SGBV prevention

- Strengthen HIV prevention coordination and stewardship across sectors at national and sub-national levels, at districts, city authorities, municipalities and town councils, etc.

- Engage community structures and networks in designing and scaling up innovative HIV prevention programs to improve comprehensive HIV knowledge, impart life skills, reduce risky sexual behaviours, address gender-based violence and violence against children (VAC)
- Integrate sexual and gender-based violence (SGBV) prevention into HIV prevention programming.

Care and treatment

- Strengthen supply chain for care and treatment commodities to ensure continuity of care.
- Improve retention in care through provision of differentiated/client centered services, psychosocial support and patient literacy through peer and community engagement and patient tracking.
- Implement pediatric and adolescent regimen optimization and strengthen psychosocial support (including caregiver) and HIV drug resistance testing (program and surveillance)
- Reduce HIV related morbidity and mortality through monitoring of advanced HIV disease (AHD), drug induced toxicity, non-communicable diseases (NCDs), cervical cancer, and Hepatitis B and C screening and management.

Social Support and Protection

- Scale up interventions for reducing stigma and discrimination associated with HIV and AIDS
- Prioritize and scale up interventions to mitigate the escalating physical and sexual violence among women, adolescents and children.
- Prioritizing and scaling up legal and policy reforms to address challenges of gender-based violence and human right violations.
- Review all the indicators and targets for social support and protection and make them more specific, measurable and realistic.
- The Parish Development Model concept should be integrated into the National Strategic Plan

Systems Strengthening

Governance and leadership

- Support districts to functionalize District AIDS Committees (DACs) and PLHIV networks.
- Strengthen HIV and AIDS mainstreaming in all Ministries, Departments, Agencies and Sectors

Human Resources

- The Ministry of Health should rollout the new staffing structure for all health facility levels in the country to address the staffing gaps.

Supply chain

- There is need to strengthen the logistics and supply chain management systems at all levels to address the issues of late deliveries of supplies, discrepancies between the ordered and delivered supplies, delivery of nearly expiring medicines and health supplies. This should include training of health workers in timely compilation and placing of orders and careful review of the orders. The central warehouses should establish a system to monitor the packaging supplies and equipment as well as to review delivery schedules.

Finance and costing

- Streamlining internal resources mobilization strategies, that is, ensure operationalization of all HIV mainstreaming initiatives.

- Government efforts to increase direct funding allocation to HIV and AIDS are required.
- A holistic approach towards achieving financial sustainability and reducing foreign development assistance towards the response is required.
- There is need to streamline the current priorities for internal HIV resource mobilization.

Monitoring, Evaluation and Research

- There is need to align and integrate the various M&E systems into one National M&E system.
- There is need to develop a functional centralized database for comprehensive HIV and AIDS data.
- Support scale up electronic medical records (EMR) to all health facilities across the country will help to effectively manage large volumes of HIV data.
- Disseminate the national research agenda to guide HIV and AIDS research at all levels.

1.0 INTRODUCTION

1.1 Overview of the HIV Epidemic and Response

The HIV epidemic in Uganda is described as mature and generalized in the general population with concentrated sub-epidemics in key and priority populations. According to the Uganda Population-based HIV Impact Assessment (UPHIA), HIV prevalence was estimated at 5.5% among the population aged 15 to 49 years while in the entire survey sample of adults aged 15 years and older, prevalence was 5.8% corresponding to approximately 1.43 million adults living with HIV in Uganda (UPHIA 2020). Recent studies indicate that HIV prevalence is 15-40% in fishing communities, 31.3 % among female sex workers, 18% in the partners of female sex workers, 12.7% in men who have sex with men and 18.2% among men in uniformed services (PEPFAR 2018; Opio, Muyonga and Mulumba, 2013; Seeley, Nakiyingi-Miiro, et al., 2012; Asiki et al., 2011). The 2022 Modes of Transmission study estimates that 11% of new infections in the previous 12 months were attributed to female sex workers (MoT 2022).

Uganda's was heralded for its resounding success in stemming the HIV/AIDS epidemic between 1992 and 2002 which was responsible for a marked decline in HIV prevalence from 18% in 1992 to 6.4% in 2002. Since then, Uganda has continued to make progress towards epidemic control over the last 10 years with declining new infections, HIV prevalence, and AIDS-related mortality. It was estimated that by the end of 2020, a total of 1.43 million persons were living with HIV, the number of new infections had declined by 60% from 94,000 in 2010 to 38,000 in 2020, HIV prevalence had declined slightly from 6.0% to 5.5% and AIDS-related mortality had declined by 61% from 56,000 in 2010 to 22,000 (Uganda HIV & AIDS Fact Sheet; UPHIA 2020). The decrease in AIDS-related mortality has led to the total number of People Living with HIV (PLHIV) to increase from 1,200,000 in 2010 to 1,400,000 in 2020.

The multi-sectoral response to HIV/AIDS is coordinated by the Uganda AIDS Commission which, in collaboration with key stakeholders, developed the five-year national HIV/AIDS Strategic Plan (NSP) 2020/21 – 2024/25 to guide the implementation of the national response aligned to the key drivers of the epidemic and other key national development plans. The process of developing this National Strategic Plan was highly participatory involving key stakeholders and interest groups including communities of people living with HIV at national and sub-national levels. It is this strategic plan that has reached mid-term and is being reviewed to assess whether the national response is on course.

1.2 National HIV/AIDS Strategic Plan for (NSP) 2020/21 – 2024/25

The overall goal of the NSP is to increase productivity, inclusiveness and well-being of the population by ending HIV and AIDS as an epidemic by 2030. The specific objectives are:

1. To reduce new HIV infections by 65% among adults and youth, and to reduce new paediatric HIV infections to 5% by 2025.
2. To reduce AIDS-related morbidity and mortality and contribute to reducing new HIV infections by 2025.
3. To strengthen social and economic protection to reduce vulnerability to HIV and AIDS and to mitigate their impact on people living with HIV, orphans and vulnerable children (OVC), KPs and other vulnerable groups.

4. To strengthen the multi-sectoral HIV and AIDS service delivery and coordination system that ensures sustainable access to efficient and quality services for all focus populations.
5. To strengthen the national HIV and AIDS strategic information management system for improved effectiveness and efficiency.

The NSP provides the overall strategic direction for the response through four broad thematic areas each with a sub-goal, objectives and strategic actions for each objective. The four thematic areas are HIV Prevention, Care and Treatment, Social Support and Protection and Systems Strengthening (Table 1)

Table 1. The NSP Thematic Areas

Thematic Area	Goals
Prevention	To reduce new HIV infections by 65% among adults and youth, and to reduce new pediatric HIV infections by 95% by 2025
Care and Treatment	To reduce AIDS-related morbidity and mortality by 2025.
Social Support and Protection	To strengthen social and economic protection to reduce vulnerability to HIV and AIDS and to mitigate their impact on people living with HIV, orphans and vulnerable children (OVC), KPs and other vulnerable groups.
Systems Strengthening	To strengthen the multi-sectoral HIV and AIDS service delivery and coordination system that ensures sustainable access to efficient and quality services for all focus populations.

1.3 Theory of Change

The NSP is anchored on the Theory of Change model (Figure 1) derived from the theoretical framework used by Russell Armstrong in the National Plan for Achieving Equity in Access to HIV, TB and Malaria services in Uganda 2020–2024. The same model was adopted in assessing whether the national response is on track to attaining a healthy and productive population free from HIV and AIDS by 2030.

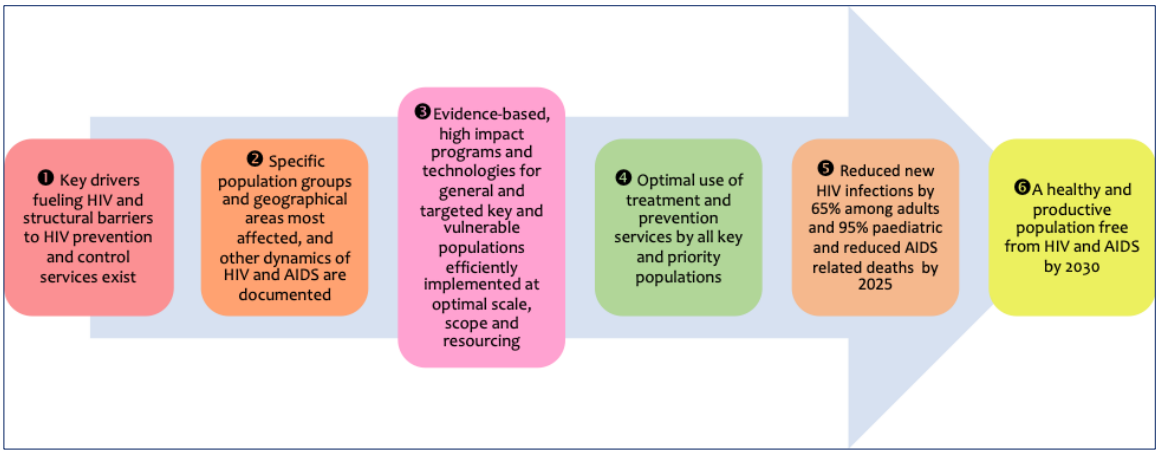


Figure 1. Theory of Change Model

1.4 Objectives of the Mid-Term Review

The purpose of the MTR was to assess the progress of implementation of the NSP against set targets guided by the results framework and develop the National Priority Action Plan (NPAP) for the remaining period (2023/24 - 2024/25) of the NSP. The NPAP details how the NSP including responsibility centres for the stakeholders in the Multi – sectoral response.

The specific objectives of the MTR included the following:

1. To assess whether the progress of implementation of the NSP 2020/21-2024/25 is on track against set targets during the first two and half years.
2. To identify the challenges and gaps, lessons learned and best practices during the implementation of the plan in the first two and half years.
3. To propose recommendations and adjustments to the plan for the remaining years of the NSP and submit a revised National Strategic Plan 2022/23 – 2024/25
4. To develop a National Priority Action Plan (NPAP) for the remaining period (2022/23 – 2024/25) as informed by new evidence and changing dynamics of the HIV epidemic.

2.0 METHODOLOGY

2.1 Overview

The Mid-Term Review (MTR) of the national HIV/AIDS Strategic Plan (NSP) 2020/21 – 2024/25 was undertaken through a highly participatory, consultative and phased approach reaching all key stakeholders involved in the national response. The process involved close consultation and coordination of all Thematic Area consultants and their respective Technical Working Groups (TWGs).

The review was conducted in 2 phases. Phase 1 consisted of a comprehensive desk review and secondary data analysis to populate performance indicator matrices of the thematic areas. Additional data analysis was conducted by an independent consultant to enrich the desk review findings and support the Global Fund application process. Phase 2 consisted of further desk review, technical working group meetings, key informant interviews at the national and sub-national levels and group discussions with DACs and beneficiaries. Meetings were convened, checklists, questionnaires, Focused Group interview guides were used. The sub-national assessment was conducted in 11 districts. To ensure regional representation, the districts were drawn from the UPHIA operational regions. The district section criteria included (i) a balance between urban and rural areas as defined by the Uganda Bureau of Statistics (UBOS*);* (ii) district ranking in the league table; (iii) presence of HIV and AIDS partners and (iv) availability of health facilities that provide ART services. The selected districts were Adjumani, Gulu, Napak, Soroti, Tororo, Namayingo, Lyantonde, Ibanda, Kabarole, Mityana and Kampala (Figure 2).

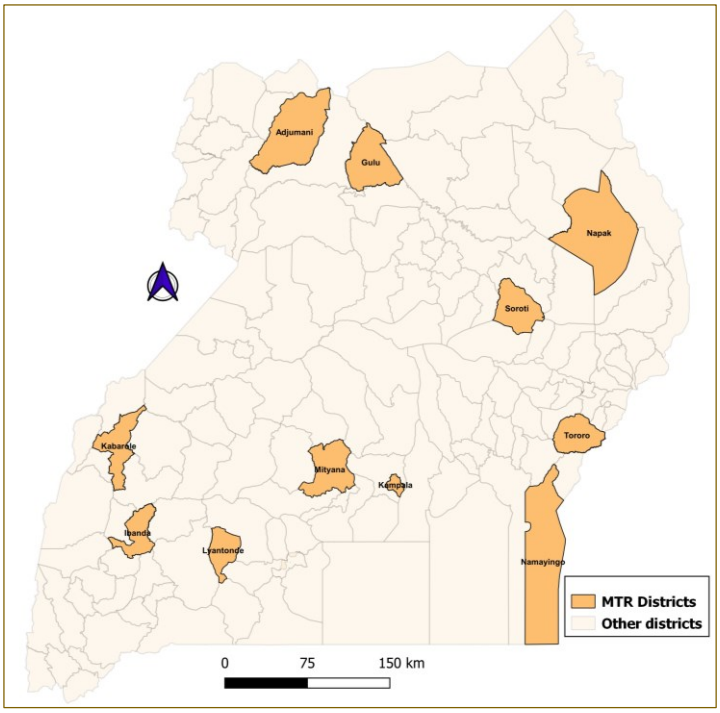


Figure 2. Map of Uganda showing districts selected for the MTR

2.2 Specific Methods

The specific methods used adopted the Organization of Economic Cooperation and Development's (OECD) Development Assistance Committee (DAC) evaluation guidelines that emphasize assessment of six dimensions of relevance, impact, effectiveness, efficiency, and sustainability[1] (Figure 3).

Figure 3. The OECD DAC evaluation criteria

In addition, specific questions were derived for each thematic area and mixed methods were used to analyse performance under each OECD DAC pillar. Finally, challenges, gaps, lessons learned and best practices were evaluated and proposals made for key priority areas to be considered for the remaining NSP period and the National Priority Action Plan 2022/23 - 2024/25.

[1] Better Criteria for Better Evaluation: Revised Evaluation Criteria Definitions and Principles for Use: OECD/DAC Network on Development Evaluation. 2019.

3.0 FINDINGS

The findings are presented according to the OECD DAC criteria and the specific objectives of the MTR, by thematic area.

3.1 Relevance of the NSP 2020/21-2024/25

Review of the relevance of the NSP 2020/21-2024/25 focused on the extent to which the NSP goals, objectives and outcomes rhymed with the global priorities, country needs, beneficiary needs and the partner and donor priorities and policies.

At the global level, the review established that NSP was aligned to global priorities. Notable among them are alignment with: Sustainable Development Goal 3: Objective 3.3 of ending AIDS by 2030; Goal 5 of achieve gender equality and empower all women and girls and the United Nations General Assembly Special Session (UNGASS) commitments of ending AIDS. The review established that the NSP interventions are in accord with the Joint United Nations 95-95-95 targets and were focused on contributing to the realization of these targets. Furthermore, the review established that the NSP is an integral component of PEPFAR 5-year joint strategy for cooperation between the USG, host governments and other partners towards the blueprint for an AIDS-free generation.

The UNAIDS issued the "three ones" principles to guide national AIDS authorities and their partners in responding to the HIV/AIDS epidemic. These principles of one coordination framework, one strategic plan and one monitoring and evaluation mechanism have been fully embraced by UAC and its partners.

At the country level, the NSP is anchored within the National Development Plan III 2020/21–2024/25 (NDP III) framework as well as the Presidential Fast-Track Initiative (PFTI) on Ending AIDS by 2030. Under the PFTI, UAC and its partners have set ambitious targets of reaching the 95–95–95 targets by 2025 which provides the cornerstone for achieving epidemic control by 2025 and subsequently ending AIDS by 2030. The NSP 2020/21-2024/25 lays out strategies and actions to implement high-impact, evidence-informed interventions to achieve this goal. The multi-sectoral approach to HIV and AIDS control positions UAC strategically to create linkages to the Parish Development Model (PDM) in order to strengthen community mobilization and engagement for the HIV and AIDS response, and mainstream HIV and AIDS interventions into all government Ministries, Departments and Agencies (MDAs).

The evaluation established that the NSP rhymed with the beneficiary needs, particularly the most at-risk groups such as the key populations, as well as the vulnerable groups including children, adolescent girls and women. Further, the strategies prioritized in the NSP are an integral component of PEPFAR 5-year joint strategy for cooperation between the USG, host governments and other partners towards the blueprint for an AIDS-free generation. Further, the focus on strengthening national systems for generating quality data and promote information sharing and use by all stakeholders are in accord with the PEPFAR core principle of using quality data to identify impact interventions that will lead to the most progress towards ending the HIV/AIDS pandemic by 2030[2].

[2] Reimagining PEPFAR's Strategic Direction: Fulfilling America's Promise to End the HIV/AIDS by 2030: September 2022

3.2 Impact of the NSP 2020/21-2024/25

The overarching goal of the NSP is to increase productivity, inclusiveness and well-being of the population by ending HIV and AIDS as an epidemic by 2030. Attainment of this goal is contingent upon achieving a number of general outcomes, including (i) reduction in new HIV infections, (ii) reduction in AIDS-related morbidity and mortality, (iv) Strengthened social and economic protection to reduce vulnerability to HIV and AIDS and to mitigate their impact on people living with HIV, orphans and other vulnerable children, KPs and other vulnerable groups and (iv) strengthened multi-sectoral HIV and AIDS service delivery system that ensures sustainable access to efficient and safe services to all the targeted population. The NSP has 2 impact indicators which have been monitored over the plan period. These include: (i) Reduced HIV transmission and (ii) Reduced HIV-related morbidity and mortality.

(i) Reduced HIV transmission

The goal of the prevention thematic area is to reduce new HIV infections by 65% among adults and youth, and to reduce new pediatric HIV infections to 5% by 2025. To achieve this goal, the country prioritized scaling-up of high-impact evidence-based effective combination prevention interventions that are gender-responsive. The combination prevention intervention approaches involved implementing multiple (biomedical, behavioral, and structural) interventions with known efficacy. In order to assess the impact of the NSP interventions on the outcome measures in the results chain, the MTR reviewed HIV burden, prevalence and incidence.

HIV burden

Uganda's HIV epidemic has continued to evolve, but remains severe, generalized, and heterogeneous across geographical areas, socio-demographic and socio-economic subgroups. The latest estimates indicate approximately 1.43 million people were living with HIV in Uganda in 2022. Women remain disproportionately affected relative to their male counterparts Considerable variations also exist among gender and age groups (Kirungi W., 2023). Table 2 below shows the estimated HIV burden among various population and age groups.

Table 2. Estimated HIV burden among various population and age groups.

Population Sub Group	Estimated Number	Percent*
All Population	1,433,337	100%
Male	535,752	(37%)
Female	897,585	(63%)
Adults 15 years +	1,352,968	94%
Male	495,124	(37%)
Female	857,845	(63%)
Young People 15 – 24	166,242	12%
Male	47,650	(29%)
Female	118,592	(71%)
Children 0 – 14	80,369	5.6%
Under 1 year	3,754	(4.7%)
1 – 4 years	14,392	(17.9%)
5 – 14	62,223	(77.4%)

The patterns in HIV burden have evolved with older age groups increasingly disproportionately affected in recent years compared to younger individuals (Figure 4). It is projected that by 2030, the HIV burden borne by individuals aged over 50 years will increase to 30% of all

PLHIVs. The implication of this shift highlights an important dynamic for revising the NSP (Kirungi W, 2023). As evidence shows that older people above the age of 50 years may face unique challenges as they live with HIV[3], the above projections have implications for HIV programming. For instance, older people tend to have conditions such as heart disease or cancer which complicate treatment with ARVs. Moreover, age-related changes can affect an older person's ability to remember and to adhere to HIV treatment. In addition, side effects from HIV medicines may occur more frequently in older PLHIV than younger people. These realities mean that HIV programming needs to include additional considerations for older PLHIV.

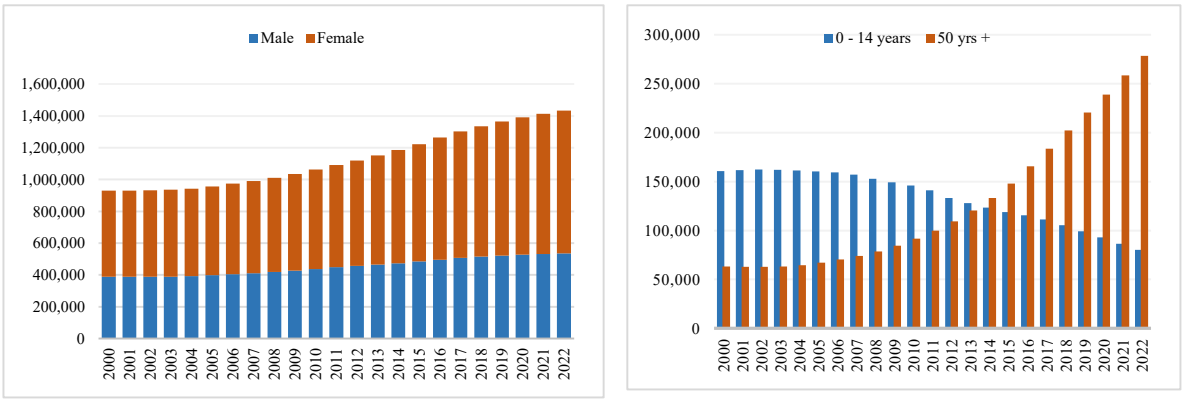


Figure 4: Trends in the estimated number of male and female PLHIV in Uganda 2000-22 [Left]; and comparison of trends of young PLHIV aged 15-24 years versus those aged 50 years+ [Right]

HIV prevalence

According to the 2020 Uganda Population-based HIV Impact Assessment (UPHIA), the HIV prevalence among adults was 5.8%. HIV prevalence was higher among women (7.2%) than among men (4.3%). There was heterogeneity of prevalence location and geographic region. Urban areas have remained predominantly more affected at 7.1% versus 5.2% in rural areas. HIV prevalence varied by geographic region and ranged from 2.1% in the North-East (Karamoja region) to 8.1% in the Central 1 (South Buganda) region. HIV prevalence in all regions was lower in 2020 compared to that in 2016 except in the Mid-North and Central 1 region (Figure 5).

[3] Panel on Antiretroviral Guidelines for Adults and Adolescents (2023).

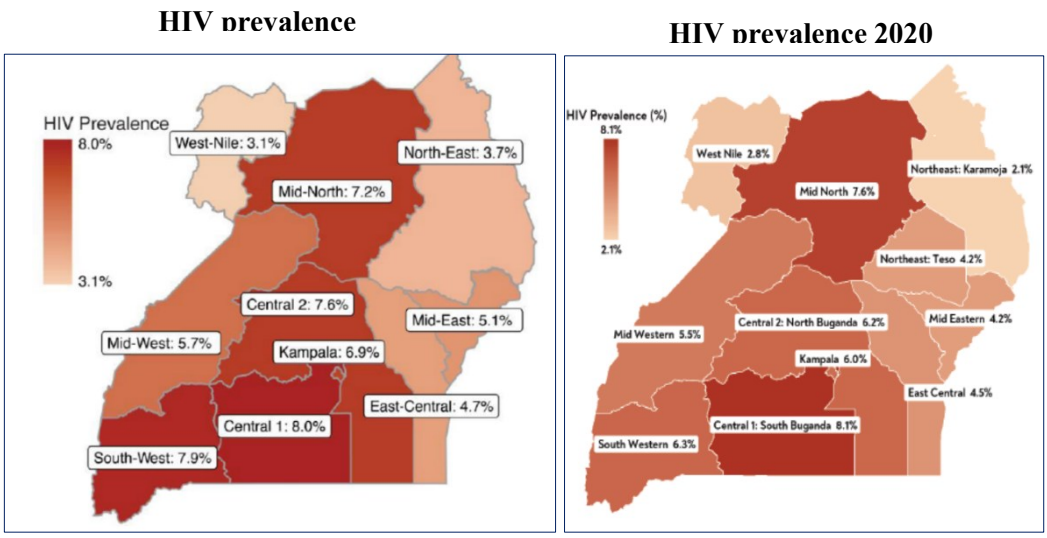


Figure 5. HIV prevalence in 2016 and 2020 by geographical region 2016 and 2020 (Source: UPHIA 2016 and UPHIA 2020)

HIV incidence

Since 2020, the decline in new infections seems to have tapered off implying that the NSP target of a 65% reduction in new infections may not be met. The number of new infections in 2020(baseline year) were 38,000 and these increased to 54,000 during the Covid 19 period Spatial distribution of new infections by districts shows a concentration of new infections in the North Central and Central 1 (South Buganda) districts. Recently established cities standout as hotspots of new infections representing urban areas (Figure 6).

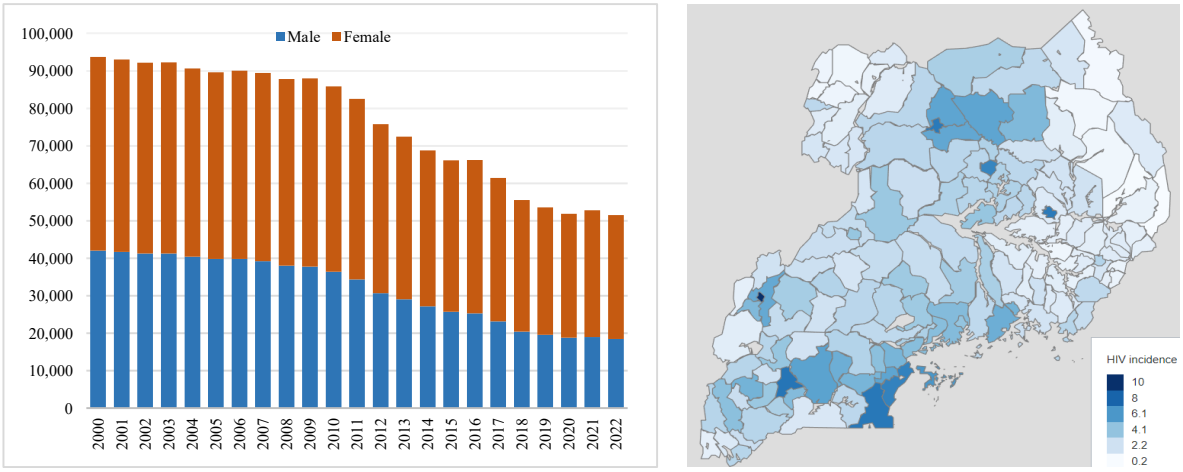


Figure 6: Trends in new HIV Infections in the country 2020 – 22 [Left]; and spatial distribution of HIV incidence by district in Uganda in 2020 [Right]

Mother to child transmission (MTCT) of HIV

New infections arising from mother-to-child transmission of HIV continue to decline due to an aggressive PMTCT strategy. Despite this, MTCT is still contributing about 14% of all

estimated HIV new infections (Spectrum estimates, 2022). It is estimated that in 2022, there were approximately 5,934 HIV infections due to mother-to-child transmission countrywide. Further analysis reveals that 56% of MTCT infections in 2022 occurred during the breast-feeding period, and 44% during pregnancy (Figure 7). Sero-conversion during late pregnancy, breastfeeding, and among women abandoning treatment were believed to contribute around 84% of new paediatric infections in 2021 (Spectrum Estimates, 2021). The 2022 program data showed that although 95% of HIV positive pregnant women receive ART to reduce the risk of MTCT, 85% are retained on ART at 12 months of initiation and this is below the NSP target of 95%.

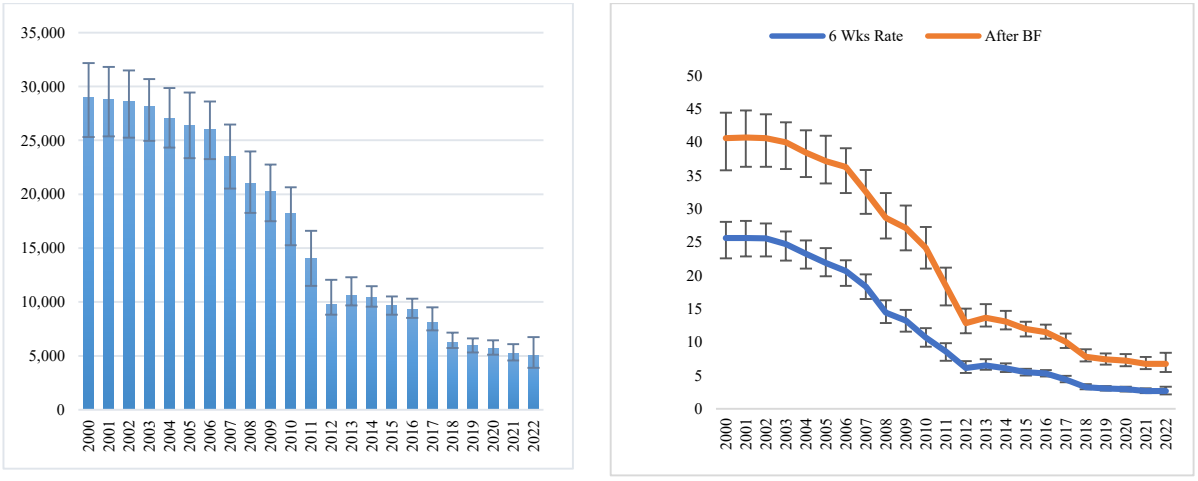


Figure 7: Trends in the estimated number of MTCT Infections 2020 – 22 [Left] and the early and late MTCT Rates [Right]

The drop out from care by pregnant or breastfeeding mothers could be related to the persistent factors at individual, community, facility and societal levels that continue to pose barriers to women's adherence to treatment and retention in care. Previous studies have documented such factors to include anticipated stigma, fear of violence from husbands or partners, lack of HIV status disclosure to the spouse, and self-stigmatization[4].

(ii) Reduced HIV-related morbidity and mortality

The goal of the care and treatment thematic area is to reduce AIDS-related morbidity and mortality by 2025. Uganda has witnessed steady reduction in AIDS-related mortality during 2010 – 2020 where it dropped by 62% (Figure 8). With estimated 17,377 AIDS-related deaths in 2022, Uganda may be on course to meet the 2030 targets (Kirungi 2023). The mid-term review revealed a 17% decline in annual HIV related deaths from 21,000 in 2020 to 17,337 in 2022 and a 26% decline in HIV mortality rate from 66/100,000 in 2020 to 40/100,000 in 2022. This trajectory shows a steady but slow reduction in AIDS-related morbidity and mortality. The NSP target of a drop in AIDS-related mortality to under 10,000 may not be achieved (Kirungi 2023). Furthermore, the ratio of new HIV infections to AIDS related death is still above one.

[4] Masereka, *et al.* (2019)

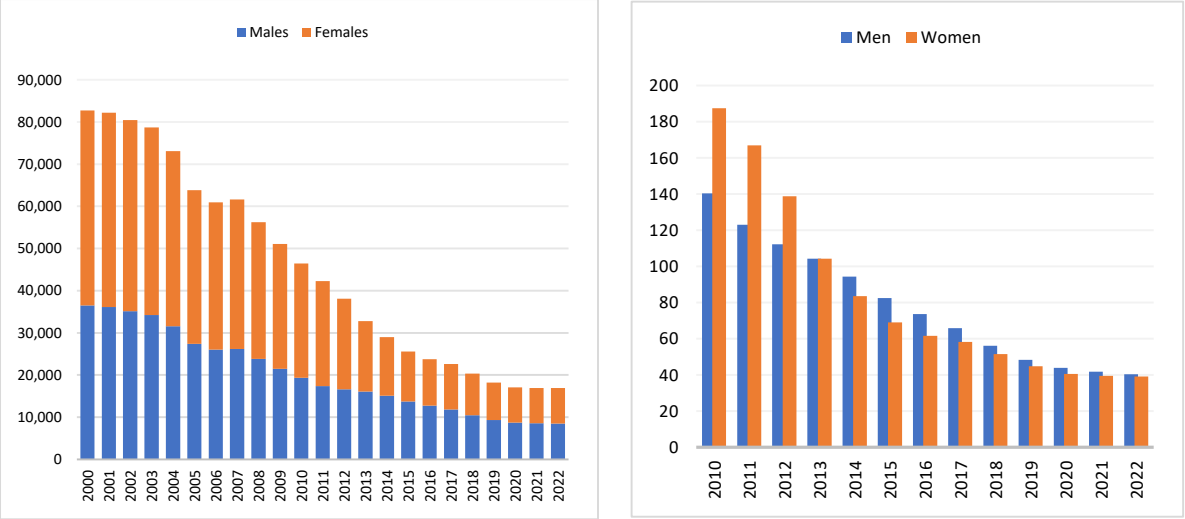


Figure 8: Trends in AIDS-related mortality among male and females in Uganda during 2020 – 22 [Left] and trends in AIDS-related mortality per 1000 2010-22

3.3 Effectiveness of the NSP 2020/21-2024/25

Effectiveness evaluation considered progress towards achieving the NSP outcome and output targets by thematic area.

3.3.1 Prevention thematic area

The outcomes for this theme include the following: (i) increased adoption of safer sexual behaviors and reduction in risky behaviors among key populations, priority population groups and the general population; (ii) expanded coverage and uptake of quality biomedical priority HIV interventions to optimal levels and (iii) mitigated underlying socio-cultural, gender and other factors that drive the HIV epidemic. Table 2 below shows the progress made towards achieving the outcome targets for HIV prevention.

Table 3. Progress towards achieving the outcome targets for HIV prevention

Key performance indicator	Baseline value	Mid-term value	NSP target	Gap	Remarks
Outcome 1: Increased adoption of safer sexual behaviors and reduction in risky behaviors among key populations, priority population groups and the general population					
Adult males and females with multiple sexual partners	M=20.6% F=2.3%	M=30.7% F=10.4%	M=10.5% F=1.0%	M=20.2% F=9.4%	Lagging
FSWs reporting condom use at the most recent client	69.0%	69.0%	90.0%	30.0%	Stagnating
MSM who used a condom at last anal sex	39.0%	39.0%	60.0%	21.0%	Stagnating
Outcome 2: Expanded coverage and uptake of quality biomedical priority HIV interventions to optimal levels.					

Key performance indicator	Baseline value	Mid-term value	NSP target	Gap	Remarks
Males and females reporting condom use at last higher risk sex	M=57% F=37%	M=62% F=38%	M=90% F=80%	M=28% F=42%	Lagging
KPs reporting consistent condom use	FSW=45% MSM=64%	FSW=71% MSM=39%	FSW=85% MSM=85%	FSW=14.0% MSM=46.0%	On track Lagging
Men and women who tested for HIV and know their result	M=37.0% F=48.0%	M=76.1% F=83.5%	M=50.0% F=50.0%	---	Surpassed
KPs who tested for HIV and know their result	FSW=86% MSM=85%	FSW=97% MSM=96%	FSW=90% MSM=90%	---	Surpassed
HIV-positive pregnant women who receive ARVs to reduce risk of MTCT	92.0%	95.0%	95.0%	---	Achieved
HIV-positive women using family planning	---	38.4%	70.0%	31.6%	Lagging
HIV-positive breast- feeding mothers with viral load suppression	---	94.0%	95.0%	1.0%	On track
Pregnant and breast-feeding mothers on ART at 12 months of initiation	---	85.0%	90.0%	5.0%	On track
HEIs who received ARV prophylaxis to reduce risk of MTCT	85.0%	84.0%	90.0%	6.0%	On track
Percentage of males (15-49 years) that are circumcised	43.0%	64.2%	80.0%	15.8%	On track
Outcome 3: Mitigated underlying socio-cultural, gender and other factors that drive the HIV epidemic.					
Women who experience SGBV	13.0%	11.0%	5.0%	6.0%	Lagging
Men & women who believe that a woman is justified to refuse sex or demand condom use if she knows that her husband has a STI	M=91.0% F=87.0%	M=81.0% F=83.0%	M=98.0% F=95.0%	7.0% 12.0%	Declining Declining
KPs who avoided health care because of stigma and discrimination	---	FSW=66% MSM=15%	FSW=10% MSM=10%	56.0% 5.0%	Lagging

Although some of the HIV prevention indicator data for this outcome were missing, the available data showed a mixed picture, with improvements in some indicators, while others appeared to have stagnated or even deteriorated. For example, the prevalence of multiple sexual partnership among adults increased from 20.6% and 2.3% to 30.7% and 10.4% in males and females, respectively. This trend is partly attributed to reduced investment in SBCC over the

review period, and the effect of COVID-19 pandemic on the HIV prevention interventions, as well as its after effects on sexual behavior especially among women as they faced financial pressures[5]. During the epic of COVID-19 outbreak and response, several of the HIV prevention interventions were not implemented because of the restrictions on movements and gatherings. Besides, Uganda changed the focus of implementing SBCC interventions from a dedicated stand alone to an integrated approach as a part of biomedical services provision. This change weakened the importance of messaging on primary prevention and risky behavioral reduction. To ensure an effective SBCC, the National HIV and AIDS Communication Strategy 2020/21-2024/25 was developed to guide interventions. The strategy is aligned to the NSP and streamlines coordination of HIV and AIDS communication activities among multi-sectoral actors. During the period of review, various SBCC messages were developed with approval from UAC and implemented at national, regional and local levels.

On the other hand, consistent condom use among Female Sex Workers (FSWs) increased from 45% to 71% whereas that among Men having Sex with Men (MSM) declined from 64% to 39%. Consistent and correct use of condoms offers triple protection against HIV, STIs, and unintended pregnancies. The National comprehensive condom programming strategy (CCPS) outlines clear interventions to increase consistent condom use. The CCPS seeks to achieve triple protection against HIV, STIs and unintended pregnancies through four major objectives; a) establish functional capacity for condom program management, b) increase condom use at last high-risk sex, c) increase condoms access through commercial sector and d) increase domestic funding to condom programming to 30% of resource needs by 2025. Overall, 65.4% (373.6 million) of the 571.6 million - condoms estimated need during the review period were distributed leaving a 34.6% gap. Of these 72% (267 million) were distributed through the public sector, 108 million in social sector and 11.7 million through private sector market (Figure 9).

[5] Nyakato V.N., Kemigisha E., Tuhumwire M., and Fisher E. (2021)

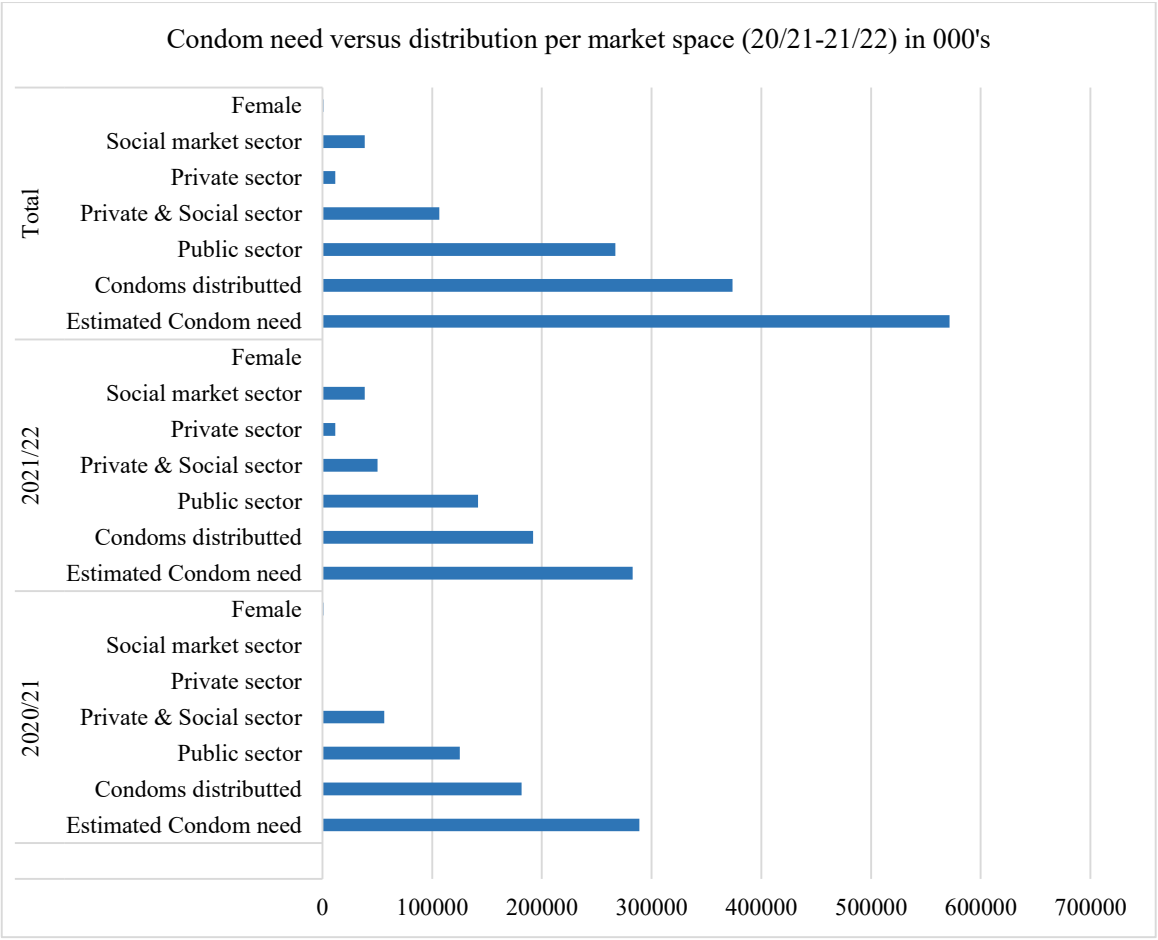


Figure 9. Condom need versus distribution per market space (20/21-21/22) in 000's (Source: National Condom Programing Strategy, 2020-2025)

HIV testing in the general population significantly increased from 37% to 76.1% in males and from 48% to 83.5% in females. Similarly, HIV testing among key populations increased from 86% to 97% among FSWs and from 85% to 96% in MSMs, surpassing the NSP targets. Between 2021 and 2022, the HTS guidelines were reviewed and aligned with the HTS optimization plan to provide for further expansion of the rollout of: Optimized Provider Initiated Testing and Counselling (PITC), Assisted Partner Notification (APN), social network testing strategy, and HIV self-testing (HIVST), Rapid Testing for HIV Recent Infection (RTRI) and HIV Testing Certification Framework among others. These more efficient approaches coupled with risk assessment for individuals resulted in a significant reduction in the number of tests done from over 10 million tests to around four million tests in 2022 with a reduction in yield when compared to the baseline of 2019/2020.

The NSP targets for initiating antiretroviral treatment (ART) (95%) and viral load suppression (95%) among HIV-positive pregnant were achieved, whereas those for retention on ART among HIV-positive pregnant women (85%), ARVs for HIV Exposed Infants (84%), Early Infant Diagnosis (EID) (79%) and male circumcision (64.2%) are on track to be achieved. Family planning use among HIV-positive women (38.4%) is still far below the NSP target of 70%. The “Time up campaign” was launched in December 2021 to provide a multi-channel platform to reach communities with HIV prevention care and treatment messages. Partnering with the Social Behavioral Change Activity (SBCA)- a USAID project, several HIV prevention

and treatment messages were developed and disseminated as part of the integrated social and behavior change (SBC) campaign, supporting the country's efforts to avert new HIV infections and increase adherence to HIV treatment. The campaign utilized multiple communication channels to reach targeted individuals with information on HIV Testing Services (HTS), Safe Male Circumcision (SMC), Pre-Exposure Prophylaxis (PrEP), harm reduction services, HIV prevention among high-risk population, Prevention of Gender Based Violence (GBV), elimination of Mother to Child Transmission (eMTCT), HIV/TB Care and Treatment, Cervical Cancer screening and stigma reduction.

Most of the indicators for the underlying socio-cultural and gender factors that drive the HIV epidemic such as stigma and discrimination, gender relations and women empowerment appear to be on track. However, the percentage of women who experience sexual and gender-based violence (11%) is still higher than the NSP target of 5%. Structural drivers such as negative cultural norms, beliefs, and practices continue to impact negatively on the HIV prevention response. During 2020-2022, Cultural institutions played a significant role in reaching the communities with HIV prevention information that addresses related barriers. The Kabaka of Buganda Kingdom, a UNAIDS Goodwill Ambassador for HIV Prevention (2017-2022) held sensitization campaigns about HIV, through various events. The Kabaka's birthday run held in April every year, has been dedicated to creating awareness about HIV among the kingdom subjects. The celebrations are critical opportunities for the kingdom to hold media campaigns on HIV prevention, mobilization of young people to take HIV services and reach traditional leaders with messages on HIV. In addition, the Ministry of Education and sports (MoES) is critical in disseminating information on HIV prevention and response to the structural and behavioral drivers of new infections among young persons. In 2022, with support from UNICEF and UNESCO, the Ministry revised the school health training curriculum to cater for recent emerging challenges to HIV prevention and guidelines for reporting GBV, Stigma and defilement that occurs in the school environment. The Ministry continued to implement the traditional PIACY program. Under this program, schools disseminated messages during learners' assembly, and displayed HIV prevention messages as part of the "talking compound approach". Furthermore, the MoES implemented the "school fun initiative", where primary and secondary schools integrated HIV messaging into co-curricular activities and HIV into formal learners' subject curricula. Several learners' institutions had substantial teachers' assigned roles of senior woman and man teachers, and teachers in charge of counselling and guidance.

To tackle stigma and poverty in school environment, a number of activities were implemented including: 1) reducing working load for teachers and workers affected by HIV, 2) forming psycho-social support groups, 3) the TAAG association for teachers to support each other, and small working loans were extended to teachers and school workers infected/affected by HIV and AIDS. The MoES worked with partners (UNESCO, UNICEF, UYPA, Straight Talk, Save the Child, World Vision Uganda, Reproductive Health Uganda-RHU, other CSO and implementing partners) to build capacity of senior women and men teachers in schools across the country. A hotline for (0800-211-046), SMS short code (8080), artificial intelligence chatbots, and apps to supplement traditional media on HIV prevention—reporting GBV and seeking support and information on HIV was made accessible to teachers and learners during the implementation period.

HIV Testing Services (HTS): Overall, the number of people who tested for HIV declined, from 6,059,287 in 2020 through 6,047,558 in 2021 to 4,440,868 in 2022. The purpose of

reducing the numbers tested but increasing efficiency and optimizing services was not attained as testing yield remained low at 2.5% and 3% in 2021 and 2022 respectively, compared to 3.1% in 2020 (Figure 10).

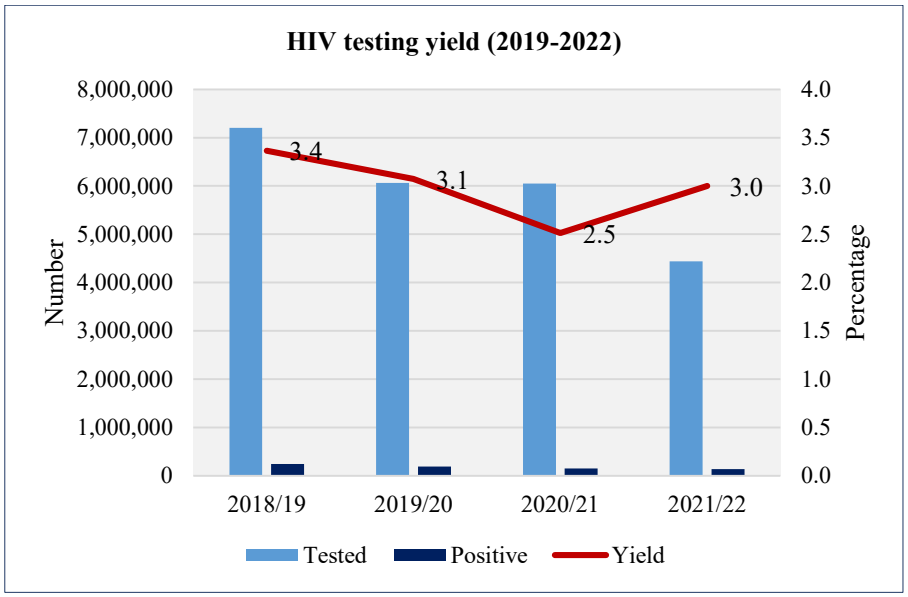


Figure 10. HIV testing yield (2019-2022)

The linkage of newly identified patients to care: Generally, the linkage of newly identified clients was low at 69% in adults and 54% in children aged 0-14years compared to the midterm target of 90%. This observation concurs with findings from UPHIA 2020 data, which deducted that Uganda has much work to do in addressing the 95-95-95 targets in HIV-infected children (DHIS2 data 2022 MoH report).

HIV self-testing (HIVST): To further strengthen the scale up of HIVST, MoH developed a follow-up SoP, a screening check list, and a scale and HIVST logistics management plan. This informed the forecasting and development of list of entities where the test kits were to be distributed. HIVST feasibility and acceptability of caregiver assisted oral screening of HIV exposed children (2-14 years) using Oraquick study was conducted to inform HIVST rollout in children. Overall, more than 725,000 HIVST test kits were distributed, of which 13,399 (1.8%) tested positive. The positivity rate reduced with increasing age and was highest among children females <1yr at 5.3% and lowest among males aged 15-19 years old. Generally, females of the same age group as males had a higher positivity, for example, females aged 5-9, had a positivity of 4.9% compared to their male counterparts of 2.8%. Of those who tested positive on HIVST, approximately only 65% of them had a follow-on confirmation diagnosis based on the national HTS algorithm (Figure 11).

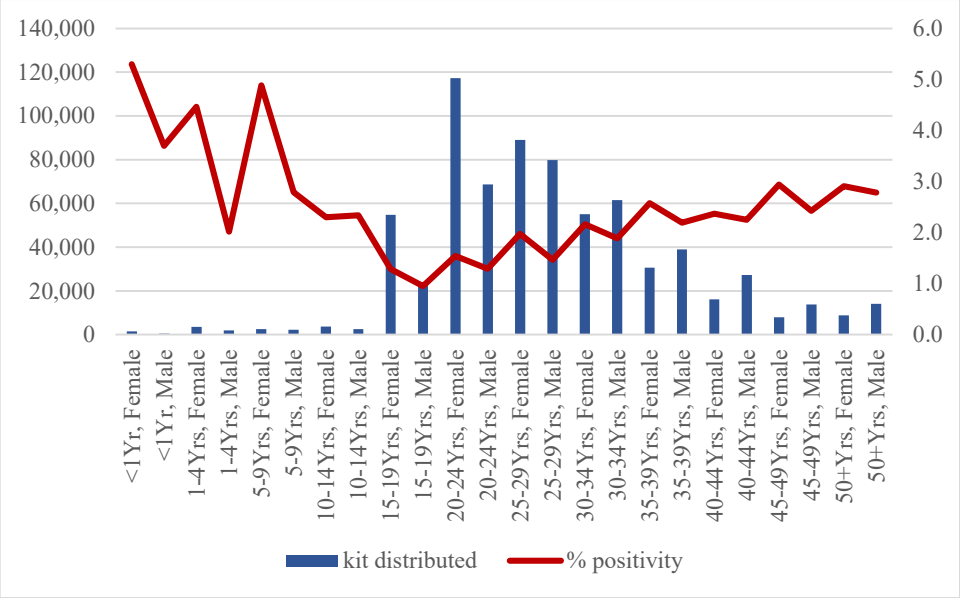


Figure 11. HIVST kits distributed and positivity rates by gender ang age group

HIV Recency surveillance: Testing for recent HIV infection helps to differentiate between recent (i.e., infection acquired in the past 12 months) and long-term HIV infections. HIV recency surveillance helps to monitor epidemiological trends in the newly diagnosed HIV cases by demographics, behavior, mode of transmission, and recent HIV infections. Recent infection testing was expanded to reach 1,366 sites by the end of the review period. The aim is to identify geographic locations associated with recent infections and to monitor trends in the prevalence of recent infections among all newly diagnosed PLHIV. By December 2022, 993 (72.6%) sites across 122 districts were trained and activated to provide recency testing (Figure 12).

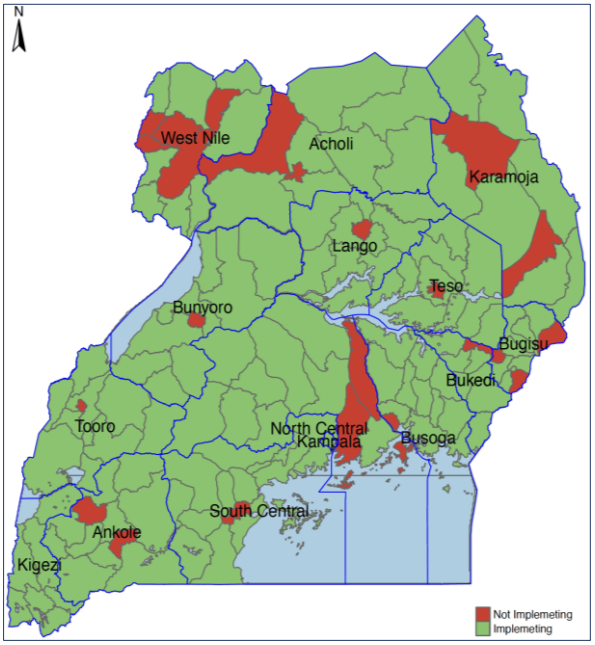


Figure 12. Geographical coverage of recency testing

By December 2022, a total of 23,618 newly diagnosed HIV individual were tested for recent HIV infection. Of these, 2,630 (11.1%) were recent infections and 20,988 (88.9%) were long-term infections. Majority of the recent infections were among females (Figure 13).

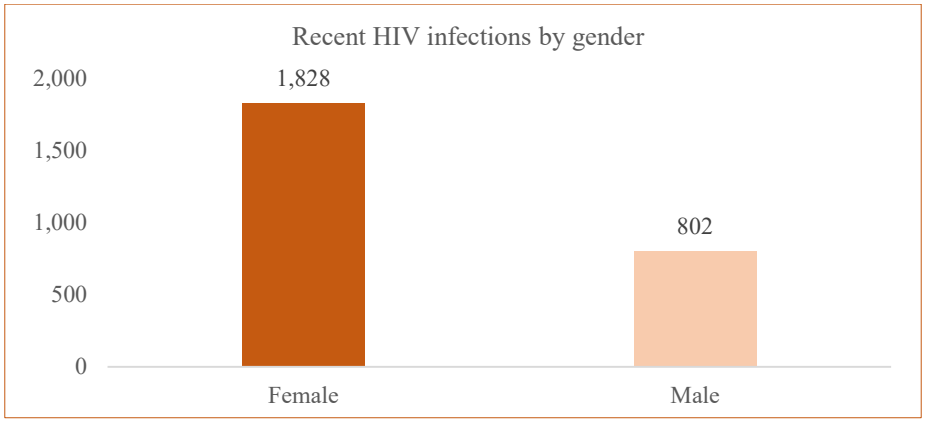


Figure 13. Recent HIV infections by gender

Majority of the recent HIV infections were among females aged 20-29 years (Figure 14)

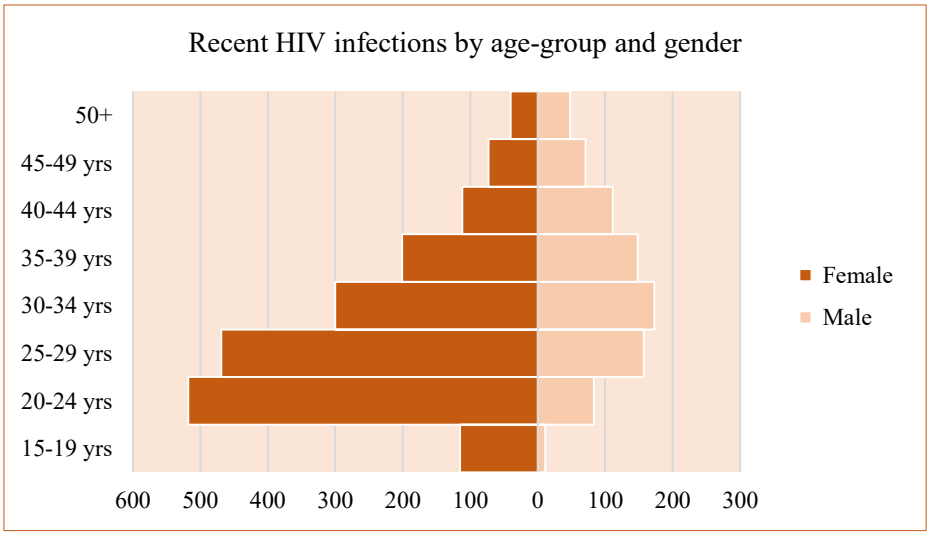


Figure 14. Recent infections by age-group and gender

Scale up of PMTCT: Uganda's PMTCT program has achieved major progress in eliminating mother-to-child HIV transmission. However, despite the recent improvement in the PMTCT program, coupled with the introduction of an optimized ART regimen and improvement in maternal ART coverage above 95%, vertical transmission is still contributing to about 14% of all estimated HIV new infections (Spectrum estimates, 2022). The sero-conversion later-in-pregnancy, during breastfeeding, and those abandoning treatment are the contributed around 84% of reported new pediatric cases in 2021 (Spectrum Estimates, 2021). The National Plan for Elimination of Mother-to-Child Transmission of HIV, Syphilis and Hepatitis B (2019/20 – 2022/23), which is based on the 4-pronged approach, and aligned with the global strategy for Triple elimination of HIV, Syphilis and Hepatitis B, outlines actions to address programme implementation gaps. The plan has interventions geared towards 1) keeping women of childbearing age negative for HIV, syphilis, and Hepatitis B through strengthening preventive

measures such as Hepatitis B vaccination at birth, scaling-up of PrEP, strengthening linkages with AGYW programs for HIV prevention among others, keeping HIV positive mothers healthy and virally suppressed and decrease vertical transmission of HIV, syphilis & hepatitis B. Based on the National Plan for Elimination of Mother-to-Child Transmission of HIV, Syphilis and Hepatitis B (2019/20 – 2022/23), and membership to the Global alliance to end AIDS in children by 2030, Uganda prioritizes interventions along the 4 PMTCT pillars to ensure: early identification and initiation on ART of HIV positive infants, retention in care and adherence for HIV positive pregnant and breastfeeding women, reduction in new HIV infections among pregnant and breastfeeding adolescent girls and women, and addressing inequalities and structural barriers that hinder access and utilization in care

HIV, syphilis and hepatitis B testing of pregnant and breasting women: Between 2020 and 2022, over 95% pregnant women attended at least one ANC visit, with close to only a third attending ANC in the first trimester. More than 98% of pregnant and breastfeeding women knew their HIV status in 2021. This percentage dropped to 89% in 2022, owing to a drop in ANC 1 attendance from 90% in 2021 to 89% in 2022. Syphilis testing dropped from 84% in 2020 to 74% in 2022. The scale-up of hepatitis B testing for pregnant women remained low at only 22% of women accessing testing in 2022 against a target of 95%.

HIV Exposed Infant Care: Early infant diagnosis and follow-up HIV testing for HIV exposed infants (HEIs) is a challenge leading to late identification and retention of HIV-exposed infants during the breastfeeding period. In 2020, 85% HEI received ARV prophylaxis compared to 61% at baseline in 2019/20. The coverage slightly reduced to 84% in 2022 and is below the NSP target of 90%.

Safe male circumcision (SMC): SMC is one of the biomedical interventions identified in the NSP for HIV epidemic control. Uganda prioritizes young men aged 15-29 years in regions with high HIV prevalence and high unmet need for the intervention. The Program target is to circumcise one million young men annually till 80% coverage of safe male circumcision (SMC) is attained. Overall, the number of male circumcisions declined from around 600,399 to 490,655 between 2020 and 2022. Between 2021-2022, an average of 480,000 men were reached with SMC services annually (Figure 11). This is below the national target of one million men. SMC services were greatly disrupted by COVID-19 restrictions.

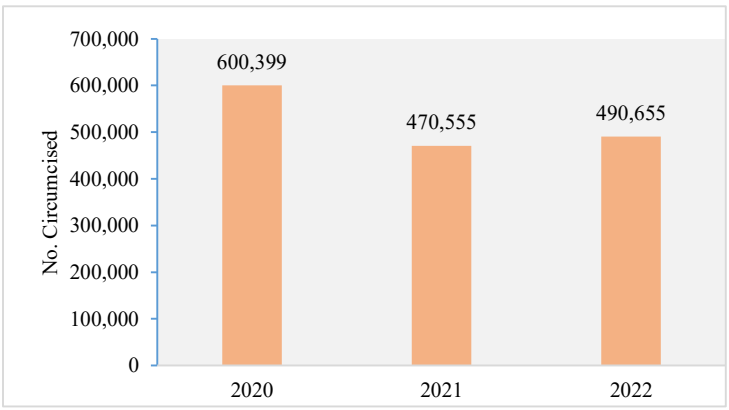


Figure 15. Number of men reached with SMC services in Uganda 2020-2022: Source: DHIS2

Pre-Exposure Prophylaxis (PrEP): PrEP is recommended for individuals at substantial risk of HIV acquisition including a) people who have multiple sexual partners of unknown HIV status, b) those who engage in transactional sex, including sex workers, c) those who use or abuse injectable drugs and alcohol, d) those who have had more than one episode of an STI within the last twelve months, e) HIV negative partners in a discordant relationship if the HIV positive partner is not on ART or when his/her viral load has not been suppressed, f) recurrent users of PEP, g) individuals who engage in anal sex, h) AGYW who are at substantial risk of HIV, i) pregnant women and breastfeeding mothers at substantial risk of HIV, j) and KP who are unable and unwilling to use condoms consistently. During the review period, PrEP was offered in 473 health facilities in 86 out of the 135 districts in the country across, all regions except Karamoja. PrEP service delivery models in the country include: health facility, drop in centers (DICs), and outreach/mobile services. However, there is limited integration of PrEP within HIV and other health programs. During the review period, the following were achieved

- Dapivirine Vaginal Ring (DVR) and Long Acting Injectable Cabotegravir (CABLA) were approved as prevention options.
- Service guidelines were updated. These included (i) consolidated guidelines for the prevention and treatment of HIV; (ii) technical guidance on PrEP for persons at high risk of HIV; and (iii) National PrEP communication plan.
- By end of June 2022, the cumulative number of people ever assessed for eligibility for oral PrEP since the start of the program in Uganda was 815,885. Of those, a cumulative total of 450,356 (55%) individuals were found eligible and 352,219 (78%) were initiated on PrEP.

Key Populations (KPs): In Uganda, KPs i.e., Female Sex Workers (FSW), Men who have sex with Men (MSM), People who Inject Drugs (PWIDs), Transgender persons (TG), and People in Prisons (PIP) account for a disproportionate burden of new HIV infections. In 2022, a total of 444,411 KPs received HIV combination prevention and treatment services at health facilities across the country. The majority were FSWs (59.3%) and PIPs (27.6%) (Figure 17).

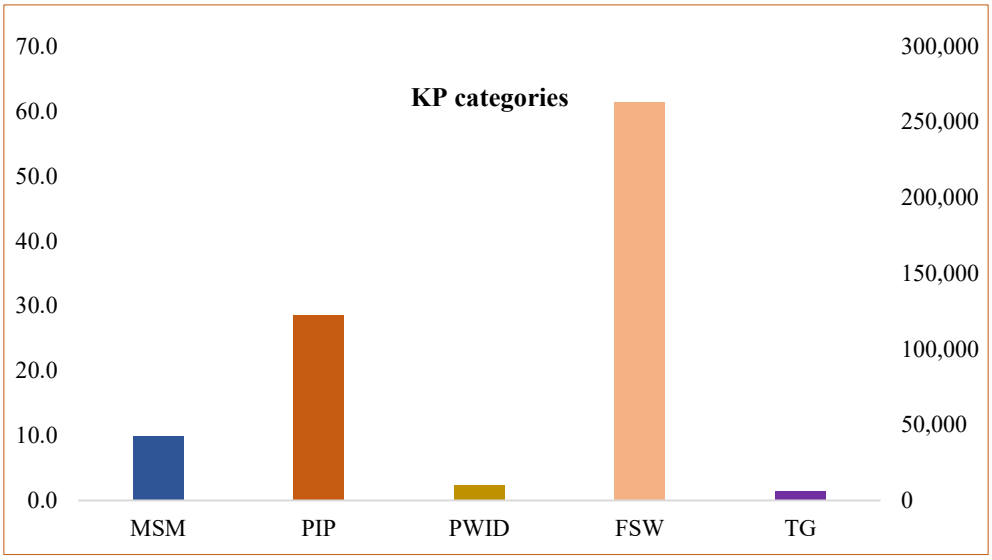


Figure 16. KP categories receiving HIV prevention and treatment services.

Overall, uptake of HIV prevention and treatment services was high except for ART initiation, hepatitis screening, and TB treatment: HIV testing (99.9%), TB screening (91%), sexually

transmitted infections (STI) screening (81.4%), Pre-exposure prophylaxis (PrEP) initiation (72.7%), sexual and gender-based violence (SGBV) screening (67.1%), ART initiation (52.9%), TB treatment, (6.8%); and hepatitis screening (4.4%) (Figure 18).

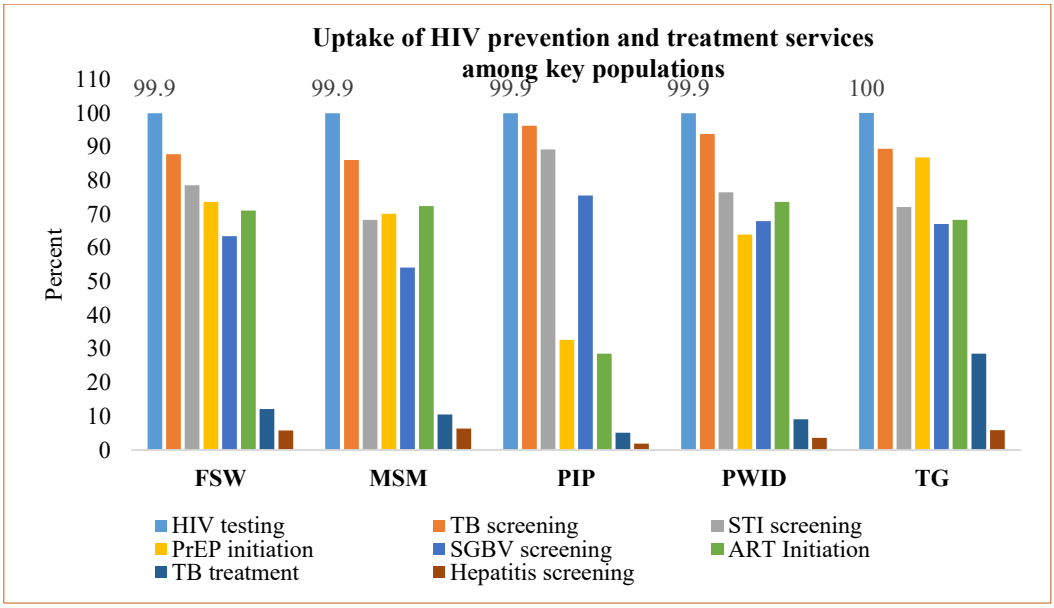


Figure 17. Uptake of HIV prevention and treatment services among Key Populations

Key achievements in the KP program

With support from Partners, the Ministry of Health updated and developed several policy documents, guidelines, plans and tools. These include National KP/PP Programming Framework (2021–2025) and Action Plan (2021–2023); harm reduction guidelines; Harmonized Drop-In Centre guidelines; Equity plan; and harmonized KP/PP data collection and reporting tools. In addition, the Legal-Policy Environment Assessment (LEA) was conducted, and a report was published and launched. The integrated bio-behavioral survey-IBBS (Crane Survey) was launched. Further, with support from partners, biomedical and behavioral interventions for KP/PP were scaled up to 587 facilities, including 24 DICs which report through the KP/PrEP Trucker.

Adolescent Girls and Young Women (AGYW): The NSP prioritizes AGYW for the HIV prevention response because of their exceptional vulnerability and high HIV burden. Programs such as Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS) and Young Adolescent Peer Support (YAPS) focus on empowering adolescent girls and young women economically, promoting safer sexual behaviors, keeping girls in school, and providing psycho-social support when needed. During the review period, intensified AGYW programming was present in 44 districts supported under PEPFAR and Global Fund where a comprehensive package of services is provided (Figure 19). The other districts received only partial or no dedicated services. The UN agencies also supported economic strengthening and integrated Adolescent SRH (ASRH) services in 10 Districts whereby young people were trained on ASRH.

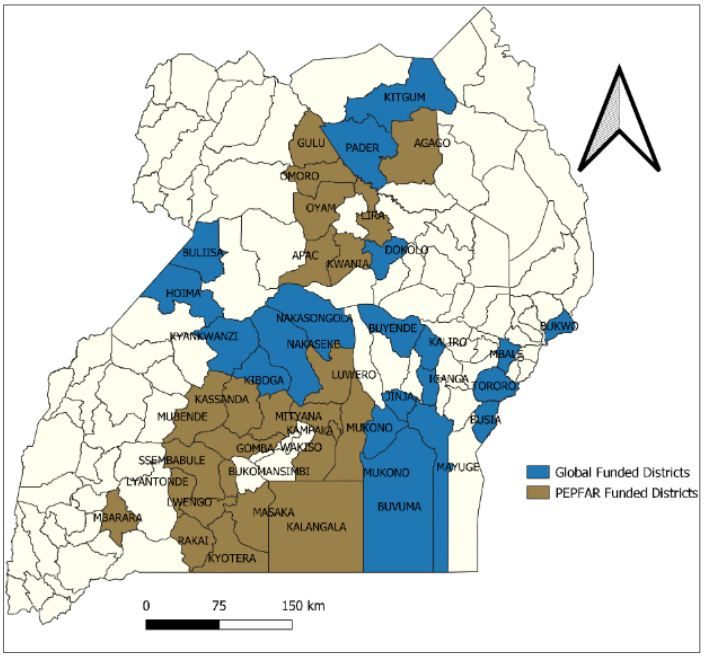


Figure 18. Districts funded by Global Fund and PEPFAR with AGYW service packages

During the review period, AGYW from 44 (71%) of the 62 districts with HIV incidence >0.4% and prioritized for AGYW programming, received comprehensive package of interventions for AGYW. There has been an increase in the number of AGYW being reached out from 171,445 in 2020 to 347,525 in 2022, However, compared to thepopulation of AGYW in the country (approximately 7.5 million), the efforts are still very inadequate. In addition, evidence-based interventions that empower AGYW economically and build their resilience to make informed decisions regarding their lives, keep in school and are empowered to keep away from gender-based violence were implemented. A total of 216,652 AGYW participatedin economic strengthening approaches, 43,403 received school subsidies while 223,110 were reached with violence prevention messages through implementation of Journey's Plus curriculum.

The COVID-19 containment measures affected AGYW in several ways. AGYW had increased vulnerability to various forms of violence, early marriages and unwanted pregnancy. This resulted in many of them getting pregnant and failing to rejoin school. It is estimated that teenage pregnancies increased by 17% between March 2020 and June 2021. During the same period, the National Planning Authority (NPA) projections indicate that 30 percent of learners (about 4.5 million) were unlikely to get back to school due to teenage pregnancies, early marriages or child labor at the time of schools re-opening. To overcome some of these challenges the MoES issued revised guidelines for prevention and management of teenage pregnancy in schools, which among other things, directs all schools to prioritize the admission of pregnant and breastfeeding girls. The guidelines also guide on how to tackle stigma, discrimination, and violence against learners who are pregnant or are parents.

3.3.2 Care and Treatment Thematic Area

The outcomes for care and treatment include the following: (i) increased linkage to ART; (ii) increased retention on ART; (iii) increased adherence to ART; (iv) increased viral load

suppression and (v) strengthened integration of HIV care and treatment across programs. Table 4 below shows the progress made towards achieving the outcome targets for care and treatment.

Table 4. Progress towards achieving the outcome targets for care and treatment.

Key performance indicator	Baseline value	Mid-term value	NSP target	Gap	Remarks
Outcome 1: Linkage to ART increased to 95% by 2025					
Proportion of HIV persons who start ART within one month.	81.0%	91.0%	95.0%	4.0%	On track
Percentage KP/PPs with HIV on ART.	91.0%	96.0%	95.0%	---	Achieved
Outcome 2: Retention on ART increased to 95% by 2025					
PLHIV retained on ART at 12 months after initiation.	73.0%	74.0%	95.0%	21.0%	Declining
Outcome 3: Adherence to ART increased to 95% by 2025					
Percentage of PLHIV with adherence of >95% in the last clinical visit	95.0%	73.0%	100%	27.0%	Declining
Outcome 4: Viral load suppression increased to 95% by 2025					
Proportion of PLHIV who are virologically suppressed.	89.0%	94.0%	95%	1.0%	On track
Percentage KP/PPs on ART that is virally suppressed.	---	FSW: 93% MSM: 92%	FSW: 95% MSM: 95%	FSW: 2.0% MSM: 3.0%	On track
Outcome 5: Strengthened integration of HIV care and treatment across programs					
HIV incident TB cases who received both TB and HIV treatment in past 12 months.	76.0%	94.0%	100%	6.0%	On track
ART patients who started on (TPT) in the previous period who completed therapy.	80.0%	90.0%	100%	10.0%	On track
Percentage of HIV-positive women screened for cancer of the cervix.	---	74%	50%	---	Surpassed

Evidence from secondary data revealed that the country is on course to achieve the NSP and UNAIDS 95-95-95 targets of ending AIDS as a public health threat by 2030. By the end of 2022, 92% of the 1.4 million people estimated to be living with HIV (PLHIV) were aware of their status, of whom 92% are on ART and 94% of those on ART are virally suppressed (Figure 19).

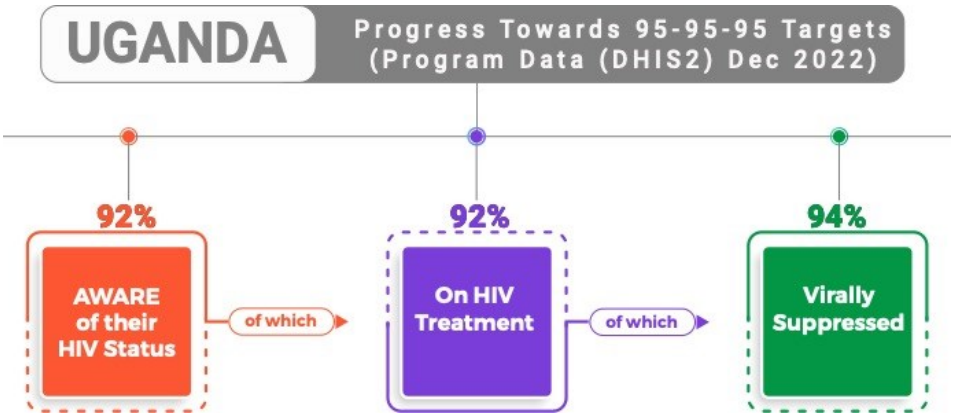


Figure 19. Progress towards 95-95-95 targets: Source: DHIS2, December 2022

The country is on course to achieve the NSP target of starting ART among HIV positive persons within a month (93% vs 95%). However, the observed ART retention (74%) and adherence (73%) levels are lower than the NSP targets of 95% and 100%, respectively. With respect to TB and HIV co-management, the country is on track to achieve the NSP targets for TB and HIV treatment and TB preventive therapy (TPT): The percentage of HIV-positive incident TB cases that received both TB and HIV treatment increased from 76% to 94% and that of ART patients who started TPT increased from 80% to 90%. These achievements could be attributed to the high-impact HIV approaches, optimizing treatment scaling-up differentiated service delivery approaches for ART and other HIV-related services that include screening and treatment of TB, cervical cancer, Hypertension, Diabetes Mellitus, Mental health among others, and strengthening community structures and systems for client tracing, care, referral, linkages, and follow-up.

Linkage to ART: In the first year of the NSP, the 'proportion of diagnosed HIV persons who start ART within one month was 99.5%, surpassing the target of 95%. However, there was a decline in the second year of review to 94% and a further decline to 91% at midterm with adolescents and children being the lowest at 87% and 89% respectively. The program is currently addressing this gap through implementing the Young People and Adolescents Peer Support (YAPS) model which started as a pilot in 2019. YAPS is a peer-to-peer model that is implemented by adolescents for adolescents and focuses on HTS and linkage to treatment; peer counselling; tracking missed appointments; screening for vulnerabilities and referral to wrap-around services. Currently, only 510 (27%) out of 1,924 facilities are implementing the model. There is need to evaluate the YAPs model to determine its contribution towards the Global targets before it is scaled up.

KP/PPs with HIV on ART: There has been an increase in the percentage of KP/PPs with HIV on ART from 94% in the first and second year to 96% at midterm. The dissemination of the drop-in centers (DIC) guidelines and the development of a DSD tool kit has enabled the KP/PPs to receive services under DSD approaches at both facility and community DICs. There is need to evaluate the tool kit and guidelines in the next period to determine its contribution.

Retention on ART: There was a slight increase in PLHIV retained on ART at 12 months after initiation from 73 in 2020 to 74% in FY 2022. There was improved retention among children 0-14 years from 68% to 74% and among older persons (50 +years) from 79% to 84%. Improvement in retention among the children can be attributed to the introduction of more differentiated care models for children which allow children to receive ART through their caregivers' model of preference. Currently 99% of ART facilities in the country offer at least two DSD models for HIV care, with 14.3% of recipients of care enrolled in community models (Community Drug Distribution Point [CDDP] and Community Client Led ART Distribution [CCLAD]), while 85% are enrolled in Facility-Based models, the majority on Fast Track Drug Refill (58.6%). About 83 pharmacies are linked to health facilities as Community Retail Pharmacy Drug Distribution Points (CRPDDP).

In order to improve retention of all sub populations, there is need to scale DSD approaches and encourage PLHIV on treatment to choose the most appropriate approach. Additionally, a community engagement strategy has been developed and a community service package focusing on strengthening facility community linkages in coordination, service delivery, treatment literacy and monitoring and evaluation is currently being rolled out with the aim of improving service delivery and thus addressing issues of low retention among the different sub populations.

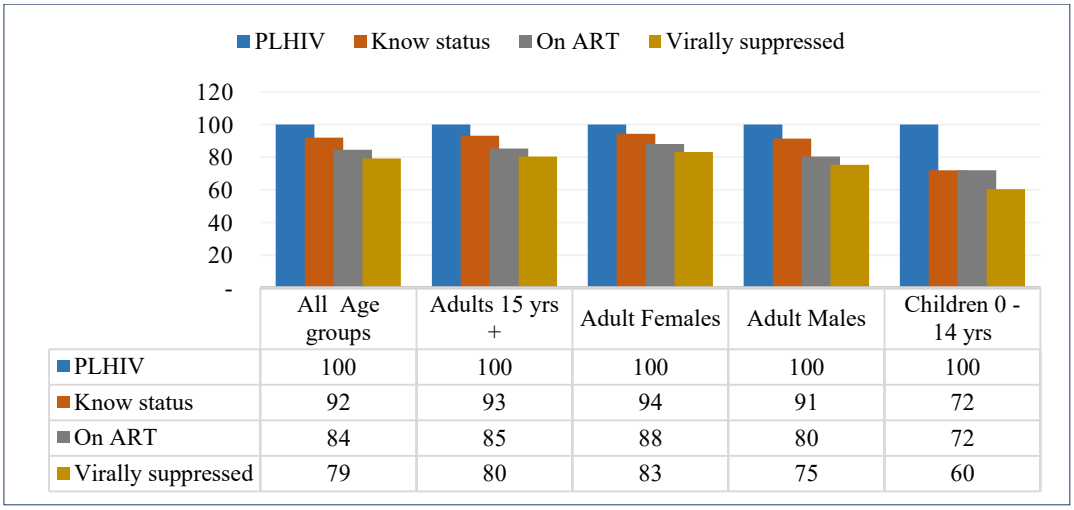
Adherence to ART: The data showed significant decline adherence to ART from 95% in 2020 to 73% in 2022. Currently, the majority (96%) of the patients on ART are on first line regimens, with 3.9% and 0.1% on second- and third-line regimens, respectively (Figure 20). In an effort to improve adherence, most ARVs have been modified to formulations that reduce pill burden and frequency of taking the medications. There is a need to ensure that all PLHIV on treatment access the improved formulations.

Category of Clients	Number	Percent	
No. of clients on ART	**1,368,170**		100.0%
Adults (20 yrs +)	1,278,290	93.4%	
Adolescents (10-19 yrs)	61,804	4.5%	
Children (0-9 yrs)	28,076	2.1%	
First Line	**1,313,524**		96.0%
Adults (20 yrs +)	1,231,694	93.8%	
Adolescents (10-19 yrs)	55,900	4.3%	
Children (0-9 yrs)	25,930	2.0%	
Second Line	**52,869**		3.9%
Adults (20 yrs +)	45,203	85.5%	
Adolescents (10-19 yrs)	5,588	10.6%	
Children (0-9 yrs)	2,078	3.9%	
Third Line	**1,777**		0.1%
Adults (20 yrs +)	1,393	78.4%	
Adolescents (10-19 yrs)	316	17.8%	
Children (0-9 yrs)	68	3.8%	

Figure 20. Distribution of first, second- and third-line ARV regimens by client category

Viral load suppression: Virologic monitoring of PLHIV on ART is necessary to determine

treatment success, predict the need for enhanced adherence counselling (EAC) among the non-suppressing patients and to guide switching to a superior regimen in case of treatment failure. At population level, the prevalence of viral load suppression among all age groups was 79% (Figure 22).



	All Age groups	Adults 15 yrs +	Adult Females	Adult Males	Children 0 - 14 yrs
PLHIV	100	100	100	100	100
Know status	92	93	94	91	72
On ART	84	85	88	80	72
Virally suppressed	79	80	83	75	60

Figure 21. Viral load suppression by age groups (population level)

On the other hand, according to program data, viral load suppression among those on ART was 94% at midterm. Viral load suppression was high across all districts and ranged from 83% in Kween to 96% in some districts (Figure 22).

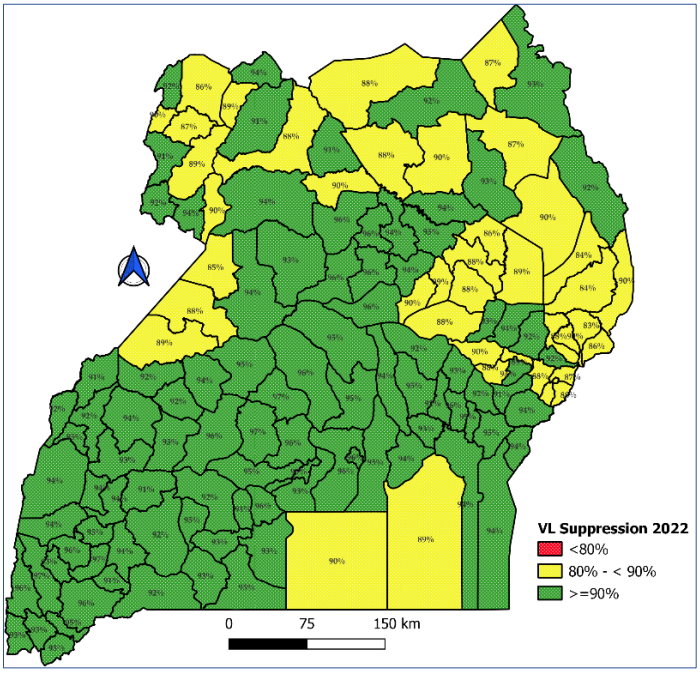


Figure 22. Map of Uganda showing viral load suppression by district

The high viral load suppression could be a result of multiple interventions including capacity building of health care workers in management for viral non-suppression; real-time site level

monitoring of viral suppression using the national viral load dashboard coupled with implementation of continuous quality improvement initiatives; conducting viral load testing campaigns to improve testing uptake; establishing viral load committees at facility and national level and optimizing ART regimens.

Strengthened integration of HIV care and treatment across programs

TB and HIV co-management: TB/HIV collaborative activities include routine screening for TB among PLHIV; provision of TB preventive therapy for PLHIV without active TB; screening of HIV among TB patients; and provision of HIV and TB treatment to those who are co-infected. In the review period, HIV-positive incident TB cases that received both TB and HIV treatment within the past 12 months increased from 76% in 2020 to 94% in 2022. In addition, by June 2022, 92% of all PLHIV had been screened for TB, 1% confirmed to have TB and 86% initiated on TB treatment. Similarly, 99% of TB patients were tested for HIV, 31% found HIV positive and 94% initiated on ART. The significant improvements in TB screening among PLHIV and HIV screening and treatment among TB clients are attributed to the improved screening at various entry points at health facilities and within the community, roll out of biannual TB Community Awareness Screening and Testing (CAST) campaign activities, peer led community TB contact investigation and HIV testing, availability of HIV and TB diagnostic commodities, scaling up of TB LAM testing and routine indicator screening for Advanced HIV Disease (AHD) among PLHIV. There is a need to scale up Gene Xpert and other newer diagnostic technologies to improve TB case notifications among PLHIV at lower-level health facilities.

TB Preventive Therapy (TPT): The program has achieved significant progress in the uptake of TPT (90%) among patients receiving ART. This improvement can be primarily attributed to the implementation of the shorter 3HP regimen (consisting of Isoniazid and Rifapentine) recommended by the World Health Organization, which the country adopted in December 2021. Other contributing factors include multi-month dispensing of TPT alongside ART, community based TPT delivery, continuous client education, coordination of TPT and ART refills, and enhanced TPT data management at site level.

Screening for cryptococcal meningitis (CCM): Despite the implementation of Serum Cryptococcal Antigen (Crag) testing for PLHIV with Advanced HIV Disease (AHD) since 2019, only 60% of PLHIV with AHD were screened for CCM. The country is not on track to meet the NSP target of 95% CCM screening coverage. This is attributed to inconsistent stock levels and short expiry dates for serum Crag testing kits, sub-optimal data quality, and knowledge gaps among some health workers. Urgent actions are necessary to engage both internal and external stakeholders to improve national stock levels of these critical testing commodities. In addition, MoH and HIV implementing partners must scale up capacity building interventions to ensure adequate knowledge and skills among new health workers.

Screening for cancer of cervix: In the review period, a total of 407,323 (75%) women living with HIV (25 - 49 yrs) were screened for cervical cancer. Of these, 23,970 (6%) screened positive with pre-cancerous lesions and 17,416 (73%) with positive lesions were treated. The sub optimal linkage to treatment is attributed to the multiplexing and limited human resources within the laboratories, leading to failure to provide same day HPV testing results. The lower positivity rate (6%) could be due to that fact 95% of the screening is done with Visual Inspection with Acetic acid (VIA) in over 1,800 sites and only 5% of the screening is done

with HPV testing in only 82 sites. VIA is a very subjective and less sensitive test with a positivity rate of as low as 2% as compared to HPV testing (11%).

NCD integration into HIV care: Integration of NCDs was piloted in 104 facilities in three regions of Mukono, Kampala and Mbarara. An assessment of the pilot implementation showed that 66% of facilities had evidence of screening for four NCD conditions targeted under the program. Likewise, an overall good performance of NCD cascade indicators (Figure 23)

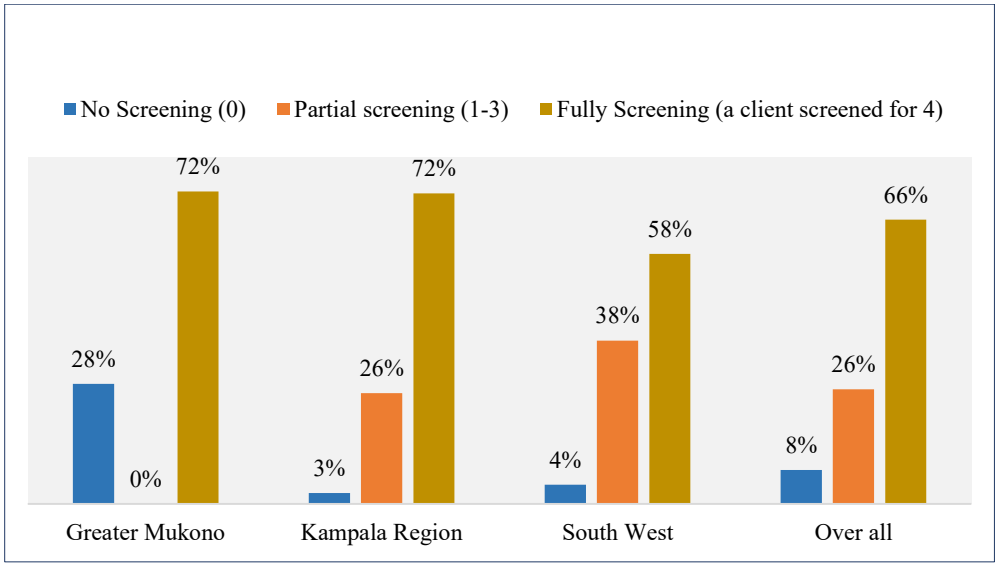


Figure 23. NCD services integration in HIV care

3.3.3 Social Support and Protection Thematic Area

Under the Social support and protection thematic area of the NSP, six (6) strategic objectives are defined: (i) scale up interventions for eliminating stigma and discrimination; (ii) expand socioeconomic interventions aimed at reducing social and economic vulnerability for people living with HIV and other vulnerable groups; (iii) scale up psychosocial support for people living with HIV, PWDs, key and priority populations and other vulnerable people; (iv) strengthen prevention and response to sexual and gender-based discrimination and violence; (v) strengthen prevention and response to child protection issues and Violence Against Children and (vi) strengthen the legal and policy framework on HIV and AIDS to ensure that it is inclusive of all persons living with HIV, persons with disabilities, key and priority populations and other vulnerable groups

This report presents the mid-term status in regard to realization of the social support and protection outcomes including Stigma and discrimination minimized; reduced socioeconomic vulnerability for PLHIV and other vulnerable groups; reduced gender-based violence, discrimination; improved child protection and reduced VAC; and legal and policy framework on HIV and AIDS improved to ensure inclusive access by all PLHIV and other vulnerable populations. Table 5 below shows the progress made towards achieving the outcome targets for social support and protection.

Table 5. Progress towards achieving outcome targets for social support and protection.

Key performance indicator	Baseline value	Mid-term value	NSP target	Gap	Remarks
Outcome 1: Stigma and discrimination minimized					
Men and women aged 15-49 years with positive attitudes towards PLHIV.	66.8%	73.4%	80%	6.4%	On track
Men and women living with HIV who report experiences of HIV discrimination in the community.	4.3%	1.82%	0.5%	-1.32%	On track
PLHIV who self-report on the construct of feeling guilty or worthless due to being a PLHIV.	24.0%	14%	6.0%	8.0%	On track
PLHIV reporting difficulty to disclose HIV status to other people.	36.3%	23.3%	15.0%	-8.3%	On track
Outcome 2: Reduced socio-economic vulnerability for PLHIV and other vulnerable groups					
PLHIV and OVC household that are food secure.	37.2%	51.0%	70.0%	19.0%	Lagging
Children and young people (6-17 years) living with HIV who dropped out of school.	29.0%	21.0	15.0%	-6.0%	On track
Percentage of PLHIV who have not received support for mental health	39.7%	19.9%	10.0%	-9.9%	On track
Outcome 3: Reduced gender-based violence/discrimination					
Men & women who believe that wife beating is justified.	47.0%	17.0%	15.0%	2.0%	On track
Women who participate in making decisions pertaining to their own health care, major household purchases, and visits to their family.	35.5%	64.0%	65.0%	1.0%	On track
Women who own land alone or jointly with their spouses.	47.7%	74.1%	60.0%	---	Surpassed
Women and men (15-49) who experience GBV from an intimate partner (sexual)	16.6%	21.0%	8.0%	13.0%	Worsening
Women and men (15-49) who experience GBV from intimate partner (physical)	22.5%	45.0%	11.0%	34.0%	Worsening
GBV survivors who report to formal institutions such as police.	6.6%	14.1%	10.0%	---	Surpassed
GBV survivors who access formal services- (Protection, health and legal service	20.2%	40.4%	50.0%	9.6%	On track

Key performance indicator	Baseline value	Mid-term value	NSP target	Gap	Remarks
Outcome 4: Improved child protection and reduced VAC					
OVC aged 5-17 that have at least three basic needs met.	39.0%	52.0%	70.0%	18.0%	Lagging
Children and adolescents (13-17 years) who report sexual violence	18.0%	16.4%	6.0%	---	Surpassed
Girls and boys 0-17-year survivors of sexual violence who receive formal services	6.1%	29.7%	50.0%	20.3%	Lagging
Outcome 5: Improved legal and policy framework on HIV and AIDS					
PLHIV, KPs & other groups who know their HIV health rights and responsibilities.	---	---	90.0%	---	Undetermined
PLHIV, KPs & other groups who report rights violations.	---	---	5.0%	---	Undetermined
PLHIV, KPs & other groups accessing legal services in the face of rights violations	18%	33%	40.0%	7.0%	On track

Reduced stigma and discrimination

The statistics above were derived from documents, including the NSP, M&E Plan for NSP, JAR, NPAP, and publications, among others. Most of the missing midterm data were bridged through the interviews conducted at the national and sub national levels. During the first half of the NSP (2020/1-2024/5), three activities were set up to be achieved by midterm: a) scaling up the training of health workers to gain HIV/AIDS competency and to integrate the human rights approach; and to equip them with PLHIV/KPs friendly services; b) rolling out the SBCC targeted materials and; c) to disseminate and roll out the anti-stigma policy guidelines.

Midway into the implementation of the NSP, some achievements have been realized as summarized below;

- Competency of health workers across the country was built through training. The Trainings focused on integrating the human rights approach in service delivery and providing PLHIV and KP friendly services. Agencies such as PACE, MILDMAY, and HRAPH prioritized scaling up competence-based training of health workers in their areas of operation. NAFOPHANU partnered with PEPFAR through CSSA to pilot a HIV treatment literacy project in 10 districts starting February 2022 to overcome Stigma.
- Rolling out targeted SBCC material and dissemination under the auspices of the MoH and CSOs were undertaken.
- Policies and manuals on stigma and discrimination were developed under the leadership of the MoH. A training manual for health providers in provision of friendly, stigma and discrimination free services was developed. A manual for orientation of other stakeholders in Gender and Sexual Diversity was developed.
- Anti-Stigma Policy Guidelines have been disseminated and implemented under the leadership of the MoH. The UAC through multi sectoral collaboration disseminated the guidelines reaching out to 11,701,802 people in all 136 District Local Governments and some of the MDAs. The translation of stigma and discrimination policy into sign language to cater for people with disabilities was very trans-formative. The Judiciary too disseminated the NPGESD (National Policy Guidelines on Ending HIV Stigma and

Discrimination) and messages on HIV and AIDS to their officers.

- The Media SCE (Self-Coordinating Entity) mobilised 140 journalists from three regions—Tooro, Kigezi and Ankole Regions; oriented them on the policy guidelines and tasked them to use their platforms to disseminate HIV prevention and anti-stigma messages to the grassroots people.
- The National Equity Plan was also rolled out in this period. The National Equity Plan Steering Committee was accordingly established with representation from relevant stakeholders and its secretariat at UAC to ensure oversight.

Box 1: Other interventions for reducing stigma and discrimination.

- Paradigm Group Limited coordinated and disseminated radio and TV spot messages on HIV and AIDS stigma and discrimination, reaching 7,649,418 via radio and 2,355,044 via TV.
- The UAC through the East Africa Radio Services conducted 82 radio talk shows on 41 stations and 6 TV talk shows on 57 six stations reaching 11, 701,802 people.
- Comedy store, where comedians disseminated HIV/ADS information to their fans line with the PFTI pillars was also used.
- The Commanders Talk show by the UPDF, enhanced the creation of friendly spaces for stigma and discrimination-free services among their personnel.
- Interventions such as awareness, referrals to address stigma and discrimination were conducted through dissemination of pastoral letters, and national level dissemination of the Faith Based Action Plan, and community outreaches.
- The World AIDS Day and the related Candle-Light Memorial events focused on ending stigma and discrimination and reached over 25 million people countrywide over the period under review.
- The use of 18 cultural institutions, have been powerful channels for reaching the grassroots, by engaging communities with HIV prevention messages addressing stigma and discrimination across the country.
- In Buganda and Tooro, the kings dedicated their birthdays to sensitizing the communities on HIV and AIDS (e.g Kabaka's run).
- NAFOPHANU conducted facility-based sessions to create awareness of HIV stigma and discrimination and COVID-19 across the country. The sessions were attended by over 1,602 PLHIV and the engagement enhanced information sharing among PLHIV on adherence, disclosure, TB prevention and management, human rights, and treatment literacy including viral load suppression.
- Some districts/facilities have innovated measures to deal with stigma. For example, in Kabarole district, Virika hospital and Kabarole hospital run corporate clinics where PLHAs can pick drugs at anytime of the day including at night. Kabarole hospital is also using an approach/arrangement where PLHAs get their drugs from Fort Pharmacy instead of Kabarole Hospital.

On the basis of the aforementioned, the effectiveness of the delivery of the set targets can therefore not be underestimated. However, it has been reported that stigma and discrimination still persist, especially among the youth and men and in the rural areas due to weak institutions. The excerpt from one respondent summarizes the views of many:

> "Most youth and men fear to come to access HIV/AIDS services because they think that when they come and people see them, people will automatically conclude that they have HIV/AIDS!" (P1: ADY FGD, Napak).

In this case, they usually delegate their siblings or parents to get them drugs and food items, but unfortunately, they miss out on other essential services such as counselling.

Previous studies show that stigma and discrimination may be rooted in lack of knowledge about HIV, in societal norms and in structural inequalities. People living with HIV or at risk of HIV infection may be stigmatized due to their gender, sexual orientation, income status or lifestyle and occupation such as those involved in sex work. Stigma and discrimination may exist at home, in health care settings, in workplaces, schools, and in other social spaces. Stigma fuels discrimination and may be a barrier to seeking care and utilizing HIV services. For instance, studies show that people living with HIV who perceive high levels of HIV-related stigma are 2.4 times more likely to delay enrolment in care until they are very ill[6]. Interventions therefore need to talk the root causes of stigma and discrimination in different contexts where stigma and discrimination may occur, and using strategies that are suited to those contexts.

Areas for improvement

If the 2025 targets of zero HIV deaths and Infections are to be achieved; there is need to integrate HIV services into other healthcare services. Having the ART clinic as an isolated clinic heightens discrimination and stigma. There is also need for continuous monitoring and tracking implementation of the guidelines in order to effectively address stigma and discrimination in the districts and communities. Community structures sch as DACs, PACs, VHTs, Expert Clients and Peer to peer should be continuously used and sustained to reduce inequalities in service delivery. The Community led monitoring framework by PEPFAR[7], including the Community Health Worker motivations[8], are all good initiatives in the fight against HIV/AIDS that should be sustained. An innovative approach to reach youth and men should be devised sooner than later. The model of 'corporate clinics' should be pilot-tested to determine its effectiveness and appropriateness as well as document lessons emerging from its adoption. Target addressing stigma in schools. Stigma in schools is high, perpetrated by fellow students but also adults. Information gaps (and myths) on HIV transmission still exist. Addressing stigma in schools remains a big gap area and thus should be embraced as a priority area.

Reducing socio-economic vulnerability for PLHIV and other vulnerable groups

The following activities were planned to be achieved by mid-2020/1-2024/5:

- Scaling up comprehensive interventions, including skills training, targeting AGYW to reach those affected by teenage pregnancies and early marriage during the COVID-19 period.
- Implementing household economic recovery programmes targeting households and individuals whose livelihoods have been severely affected by the COVID-19 pandemic and the associated measures.

Achievements registered.

Under the MGLSD, vulnerable AGYW were reached with comprehensive packages. Over the

[6] Gesesew HA, Tesfay Gebremedhin A, Demissie TD, Kerie MW, Sudhakar M, Mwanri L. (2017)

[7] UNICEF, Community led- Monitoring framework April, 2022

[8] Community Action for Change, November, 2022.

reporting period, ASHWA-Uganda, PACE and UNASO among other CSOs have deliberately scaled up comprehensive interventions targeting AGYW and OVCs. The GoU also launched Parish Development Model as a means of empowering communities. Under the SAGE program, a total of 313,771 (59.1%F; 40.9%M) beneficiaries were reached across 129 of the 135 districts. Some of these were caregivers of AIDS orphans & YPLHIV (young people living with HIV). In 2021/22, SAGE reached 307,145 (60% female) beneficiaries. In 2020/21, YLP benefitted 5,600 (47.7% female) youth in 135 districts. These included 2.8% YPLHIV; 3.1% YPLWD, and 34.9% Out of school (JAR, 2020/21). In 2021/2022, 21,280 youth projects through YLP where implemented, benefitting 251,679 youth (46% female). The UWEP programme reached a total of 4,041 beneficiary groups and 41,102 individual women beneficiaries with financial support and services. In 2021/22, a total of 202,539 individual women beneficiaries were reached. These included Women living with HIV; other vulnerable women such as young single mothers, widows, survivors of GBV, women with disabilities. In 2020/21, under the AGYW support program, a total of 98, 353 AGYW participated in economic strengthening approaches. These included 10,000 that were equipped with vocational skills like hair dressing, tailoring, welding, mechanic, leather turning, knitting, bakery and catering, among others. These were certified by the Directorate of Industrial training (DIT). In addition, 500 AGYW that owned viable businesses were provided with Enterprise Development Assistance in form of training and additional capital to their businesses.

Notwithstanding the promise that these programme interventions offer, stakeholder consultations unraveled a number of concerns that are of interest to the MTR. Some of these include:

- Government programmes target the economically active poor/ vulnerable population. The destitute poor are not reached, save for SAGE whose coverage is negligible. Not all PLHAs, key and priority populations are economically active poor. They are thus overrepresented among the vulnerable groups/populations targeted.
- Government programmes use the demand-driven approach, and some are revolving by design. It is therefore difficult to prioritize KPs and PPs who are a target of stigma and discrimination. Amidst such, they can hardly express demand. Stigma and discrimination make it practically difficult for some of the KPs to form their own groups or join other groups to benefit from government programmes.
- The minimum requirements (eligibility criteria) for accessing some the social support and protection programmes are stringent and exclusionary to some population groups. For instance, some require that a beneficiary is a resident of the area, known to local leadership and with national identification. These criteria knock out some groups such as the commercial sex workers and mobile populations.
- Practically, HIV/AIDS has not been meaningfully mainstreamed in the various government programmes including the PDM.
- In some hard-to-reach areas such as Karamoja, the youth are passionate about some programs that are peculiar to their environment. However, some of the programs were reported to be either ill-conceived or inappropriately implemented, without offering a comprehensive package that can enable economic transformation.. For example, in an ongoing project of luring the young Karamajong girls (mainly from Kenya) out of prostitution, one respondent stated that:

> "…when these girls are brought back, they are taken to a rehabilitation Centre in Lorengachora where they are trained on income generating activities such as hair dressing, tailoring etc., but the challenge is that when they leave the centre, they are not given a startup capital, so they end

up going back to the same trade!" (P6 ADY FGD, Napak).

- It is thus less surprising (if at all) that economic vulnerability among KPs and PPs remains rife amidst a set of government social support and protection programmes. Such vulnerability remains a fundamental factor in driving the spread of HIV. For survival, many engage in risky sexual behaviour. Economic vulnerability and livelihood insecurity also accounts for non-adherence and dropout of care.
- Most communities are generally concerned that whatever is given to them is peanut… does not empower them as one of them indicated:

  "Where will you go with 50,000 if you are 30 people in a group in a Parish? Which business are you going to start with that type of money?" "If the government gives bulls to the community and say 8 people share them, they can plough with them and get something in turn! (PLHIV, Soroti)

Scaling up psycho-social support for people living with HIV, PWDs, key and priority populations and other vulnerable people:
The activities planned to be implemented were: (i) Including counsellors to the staffing structure of health facilities and (ii) strengthening psycho-social support / counselling services at all HIV service delivery outlets including DSD outlets through mechanisms such as peer support groups and expert clients.

Achievements registered.
- The psycho-social support for PLHIV has been provided through various channels including: during socioeconomic empowerment interventions; through telephone help lines; peer support groups; and linkage to professional help. This is all done in line with National HIV/AIDS Policy, 2011.
- MoH is intensifying training of expert clients to complement the existing staff at health facilities (JAR, 2022).
- MoH and partners have implemented social support activities targeting YPLHIV under the YAPS program. Some of these have taken the forms of: Home visits to assess home environment and provide psychosocial support; Vulnerability assessments; and Referral for other social support services.

These non-medical services are characterized with "increasing the effectiveness of HIV/AIDS treatments, helping to link, retain, and support those in care to take their medications regularly, get to their appointments on time, or cope with the psychological and emotional stresses surrounding their diagnosis"

- MGLSD and partners reached over 4,000 survivors of GBV with psychosocial support. These were specifically survivors whose cases had been reported through the ministry's reporting system that feeds into the GBV dashboard.
- MOES trained 40 teachers, equipping them with capacity to provide psychosocial support for learners and teachers during and after the lockdown and covid-19 pandemic – with focus was put on young people living with HIV, children with special needs and stigma related to the effects of the pandemic.
- In response to the effects of COVID-19, the MoES set up a temporary call centre and stationed it with 10 counselors (JAR 2020/21).
- Workplace psychosocial support for staff living with HIV/AIDS was provided by some MDAs including MEMD, MoDVA, MEACA, MIA, MOSTI, State House, MTWA and HSC. Some reportedly went a step further to provide financial support to these staff. A case

in point, MEMD, MoDVA, MIA, OP, and HSC did so (JAR, 2020/21). This is a commendable practice worth promoting.

- The effect of the COVID-19 lockdowns, in particular, the increase in the number of intimate partner violence (IPV) cases among people living with HIV informed the integration of psychosocial support services into pre-existing health and social services under a range of programs. For instance, survivors of IPV were provided with appropriate care under the PEPFAR HIV Surge program while UNYPA provided mental health services to young people living with HIV whose state of mental health had deteriorated due to COVID-19 lock downs.

Areas for improvement

While the JAR (2022) reports that positions for counsellors have been established at HCIII and above by the MoH and that the MOH was currently intensifying training of expert clients to complement the existing staff at health facilities, the reality reveals a lot. A visit to health facilities and discussions with stakeholders at different levels revealed that counsellors are yet to be recruited as part of staffing norm. The absence of the structure of counsellors has meant that health facilities rely entirely on partners. The gap is too big to address. Partners are often able to recruit a few counsellors and complement these with peer educators and other support structures. Due to inadequate counselling, some PLHAs are misled to think that when their viral load has been suppressed, they are healed while others start taking drugs on alternative days. Some start perceiving that they can no longer infect their partners. Some counselors are accused of being incompetent, thus don't do comprehensive counselling as one PLHIV coordinator in Soroti said:

> *"*When you go for counselling, they will ask you. what is your name and what is your problem? and when you tell them they just tell you to get the drugs and go home…!".

It is not documented if the YAPS groups and PMTCT mothers have been formed/mobilised as planned. It is also doubtful if the commitments witnessed during the peak of COVID-19 can be sustained. Though YAPS have been found in most of the districts visited, they are urban-biased and need more skills development and sensitization, if they are to be very effective. Because of lack of adequate sensitization on the danger of HIV/AIDS, many youths have been observed to have developed complacency about HIV/AIDS. The VHTs are also less motivated because of poor facilitation and are thus less effective. The lack of harmonization of the incentives given to facilitators are reportedly causing disincentive among the front liners. For example, it is reported that in Napak district, one partner gives five times more incentives to community/linkage facilitators than other partners.

Reducing gender-based violence and discrimination

The following activities were planned to be undertaken by mid NSP implementation period: (i) streamlining and integrating mechanisms for reporting of GBV cases and tracking responses/reviewing and harmonizing GBV data and reporting system; (ii) ensuring full functionality and updating of the GRD dashboard; (iii) **e**xpanding availability of psycho-social support to GBV survivors; (iv) scaling up the training of PLHIV, KPs, vulnerable groups and communities in general about rights awareness and legal literacy to facilitate early reporting of GBV incidents; and (v) conducting a study on the well-being of women and girls in Uganda with a focus on GBV

Achievements registered at mid-term.

- The Gender and HIV Reporting Dashboard (GRD) is fully functional though undermined by practical challenges such as limited real time data amidst ongoing discussions with key stakeholders for timely access to data.
- GBV response services including legal, referral, psycho-social and health services have been provided by different actors in several districts. As a result, access to formal services such as protection, health and legal services by GBV survivors has greatly increased (40.4%)
- The MGLSD has overseen the scaling up of psycho-social services to GBV survivors. For example, through the DREAMS initiative, 56,612 AGYW were reached with post violence care.
- In respect of the scaling up of the training of PLHIV, KPs, etc, the training on human rights and legal issues have been accomplished; a number of agencies such as CHAWOA, HRAPF, Mildmay, URHNs and PACE have scaled up training of PLHIV, KPS and OVCs; Expert clients, leaders, and law enforcement officers are equipped with knowledge on legal processes in addressing GBV.
- Under the AGYW Program, the MoH developed and delivered the "Journeys plus curriculum"—a community-based curriculum through which 120,736 adolescent girls and young women were reached with Violence and HIV prevention messages provided in safe spaces (JAR, 2020/21).
- The 'No means No' intervention continues to support AGYW to build resilience to defend themselves against perpetuators of violence.
- A total of 193,853 persons under PEPFAR supported interventions received post GBV clinical care based on the minimum package. These included 126,727 survivors of physical and emotional violence and 67,126 survivors of sexual violence.
- Interventions by legal aid CSOs saw at least 3,050 cases of GBV handled by trained community-based GBV responders and paralegals, and over 100 cases handled by lawyers (JAR, 2020/21).
- The development of learner's message handbooks and teacher's facilitator's guide on HIV Prevention, menstrual hygiene management (MHM) and SGBV for both Primary and Secondary Schools by MOES: A total of 40,000 copies of these materials were printed and distributed to 204 schools across 17 districts. The message handbooks equip learners with information and life skills that empower them to address the increasing challenges like teenage pregnancy, SGBV, sexual harassment, poor menstrual hygiene management, HIV infections, and HIV stigma and discrimination among others
- Interventions to address GBV in the context of COVID-19 were implemented in refugee settlements by UNHCR, other UN agencies, and a number of NGOs and projects in partnership with OPM.

Overall, despite the interventions and achievements, gender-based violence in all its categories increased as noted above. This could largely be explained by the COVID-19 restrictions and the insensitivity of the security apparatus that could not allow people to access medical services. In hard-to-reach communities such as Karamoja and Teso, GBV has increased due to abject poverty, alcoholism and institutional failures. Though law enforcement officers have been trained, there are concerns about their way of operating. One VHT members lamented,

> "…when you take a GBV case to Police, they will tell you to go back to the clan leader…. At times when you reach the Police to report a case, you will be told to provide transport, then you become stuck with it!" (P2: VHT FGD Aukot HCII, Soroti).

Therefore, the gaps in addressing GBV need to be tackled in the next half of implementation of the NSP. These include weak collaboration among partners along the referral pathway (police, health facilities and gender justice missions); absence of a one-stop centre approach to provision of GBV prevention/response services including justice and unaffordable costs borne by survivors and their families to access the services.

Increased child protection and reduced violence against children (VAC)

The Planned activities for mid-2020/1-2024/5 included the following: (i) Operationalizing and implementing the Guidelines for the Prevention and Management of Teenage Pregnancy in Schools; and (ii) Establishing and implementing monitoring mechanisms to track progress of school continuation / re-entry by young mothers.

Achievements registered as at mid-term

- Revised Guidelines for Prevention and Management of Teenage Pregnancy in Schools (2020) rolled out.
- The number of teenage mothers re-enrolled into schools has been tracked by the MoES.
- Violence against children training for leaders, law enforcement officers have also been undertaken.
- Some of the child protection interventions undertaken in 2020/21includes collaboration between the MOES and other line ministries to provide education subsidies to 18,000 vulnerable girls in the 39 Global Fund supported high burden districts; training teachers on school health/ sexuality education and life skills, as part of the initiative to keep boys and girls in school; and training teachers to provide psycho-social support for learners and teachers.
- Child protection interventions undertaken in 2021/22 include: A total of 403,589 OVC received social support services. Of these, 354,786 (87.9%) received a package of comprehensive services addressing their health, safety, schooling and stability needs; while 48,002 (11.9%) received curriculum-based HIV prevention services in the form of parenting skills for caregivers or life skills for adolescents. Among OVC 0-17 years, 98% of them knew their HIV status and 18.7% were HIV positive.
- Child protection policies such as the National Child Policy (2020) and the Parenting Guidelines were finalized in 2020.
- The MGLSD has overseen capacity building initiatives targeting key stakeholders with advocacy messages to positively shift norms towards protecting AGYW.
- A total of 14 cultural institutions and 112 districts benefitted from training on: The use of GBV reporting platforms, interaction with online counsellors, and on the Parenting Guidelines; Up to 40 CDOs and Probation and Welfare officers were trained on the Parenting Guidelines (JAR, 2020/21).

Despite these interventions, the achieved targets still leave a lot to be desired. For example, the proportions of the children who report violence are as follows: 29.7% against the baseline of 6.1), 37.9% against the midterm target of 33.9% for girls and 21.7% against the midterm target of 24.8% for boys. Moreover, most the interventions aforementioned were targeted interventions, not nationwide. Some of the violence against children is also unreported, especially those in the rural areas. Besides, the institutions dealing with OVCs are reported to be generally weak because of under resourcing, and corruption among others. The view of one Pastor on how the demon of corruption which is cross-cutting is affecting the fight against HIV/AIDS is as follows:

> "Well, that's a big question, a very big one, moral degradation has hit our community from top to bottom or from bottom to top, if you like, those who have more money still want more, somebody who earns in millions still wants also to get to billions, somebody who has built maybe one house feels if I could also build a storeyed house and have several others. So, there is that quest for more, yes, it is part and parcel of human tendency to want more and more and more even at the expense of the others. So, it is an attitude problem, it is a spiritual problem, it is a moral issue that is everywhere, irrespective of who" (KII, Religious Leader, Soroti).

Alongside violence against children and women, there are other human rights issues such as child marriages, discrimination, child abandonment, child labour, child trafficking which are particularly common in communities in the East and Northern Uganda, fueled largely by poverty and are frustrating the fight against HIV/AIDS. To show the extent of the discriminatory attitude among health workers on the key population for example, one KII said that one time a KP went to a health facility to ask for lubricants and the health worker retorted:

> "I am a Catholic, don't tell me about those things of yours…!" (PLHIV, Soroti)

With some of the missing data on some targets, it can be concluded that the programs have not been very effective.

Strengthened legal and policy framework on HIV and AIDS

The absence of quantitative data on this sub-theme calls for the need to address this gap in the next phase. The desired information has been obtained through qualitative approaches as detailed below.

Legal and policy issues. The sole undertaking under this sub-theme for 2021/22 according to the JAR (2021) was to resolve controversies around the Sexuality Education Framework as well as the Sexual Offenses Bill (2019) and the HIV and AIDS Prevention and Control Act (2014). Two assessments of the legal and policy environment led by Makerere University School of Public Health (MakSPH, 2020) and another by UAC in collaboration with the USAID/Uganda Civil Society Strengthening Activity (CSSA) (2022) were completed. Other policy achievements during this period include the development of the National Policy on HIV and AIDS at the World of Work 2022 by Ministry of Gender, Labour and Social Development and the developed the HIV Workplace Policies in MDAs, Private Sector and LGs. Key policies and institutional frameworks from various MDAs that were advanced during the year and include the following:

- Development, approval and the launch of the Gender and Equity Strategy and a step-by-step guide for assessing and mainstreaming Gender and Equity issues into Social Protection Programmes
- Development of the Disability Information Management System to enhance social protection targeting among Persons with disabilities.
- Labour-Intensive Public Works (cash for work) model and guidelines for Implementation
- Development of a framework to guide the country on mechanisms to target the indigents/needy under national social protection schemes such as health insurance scheme.
- Development and launch of the National Single Registry (NSR) for Social Protection as a tool for effective planning, coordination, harmonization, implementation and monitoring of social protection programmes in the country.
- Development of tool kits and community-based supply of devices for people with multiple disabilities across the country

Furthermore, partners have and continue to implement interventions related to legal barriers to access to services. Some of these include Uganda Network on Law, Ethics and HIV/AIDS (UGANET), Human Rights Awareness and Promotion Forum (HRAPF) and Women Probono Initiative**.** The interventions include legal literacy, legal aid services, counselling, and training para legal workers. Other partners are undertaking community response to stigma and discrimination. These include: the International Community of Women Living with HIV – East Africa (ICWEA), National Forum for People Living with HIV/AIDS in Uganda (NAFOPHANU), The Uganda Stop TB Partnership, the Uganda Action Against Malaria among others. The Office of the Directorate of Pubic Prosecution (ODPP) advocates for PLHIV and persons infected by tuberculosis who have committed minor crimes to be given lesser sentences and supported to complete and adhere to medication (JAR, 2021/22).

There are several other earlier attempts made through laws and policies to address the challenge of stigma and discrimination faced in regard to HIV & KPs. For instance, the Health Sector HIV and AIDS Strategic Plan 2018/19 – 2022/23 provides a framework for the planning and implementation of KP specific interventions by the public and private sectors as well as NGOs and CSOs. Others (LEA 2022) include the specific stigma reduction activities led by government ministries and agencies, as well as CSOs, cultural and religious institutions; Equipping health workers through appropriate training in order to make them provide services friendly to all categories of PLHIV, including KVPs, adolescents and young people; Implementation of sensitization training and engagement with law makers and law enforcement officials, including cultural, political, and religious leaders; and making legal interventions including legal literacy counselling, human rights awareness training, legal aid services, and strategic litigation. Additionally, the Uganda National Consolidated Guidelines for the Prevention and Treatment of HIV and AIDS in Uganda (2020) acknowledge that access to HIV services among KP/PP is constrained by structural barriers. A road map towards zero new infection by 2030-acceleration of infection reduction in Uganda equally recognizes the failure to control social structural drivers as one of the major causes of increased vulnerability for KPs. It also suggests strategies to improve service access (AUC, 2022).

Despite these interventions, PLHIV and other KPs continue to face stigma and discrimination, The extant punitive and restrictive clauses in some laws have the negative effect of discriminating against categories of PLHIV, making it unduly difficult for them to access and utilize services thus undermining the effectiveness of the HIV/AIDS response. Therefore, more still needs to be done to address the unfavorable legal and policy environment around HIV and AIDS to enable access to desired services for PLHIV. Some of the salient aspects of the laws which are discriminatory and violates human rights include (LEA, 2022)[9]:

- HIV Penal Code Act (PCA) Sections 41 and 43 criminalizes attempted and intentional transmission of HIV. This discouraging HIV testing and the disclosure of positive test results, yet legally, intention to transmit HIV is difficult to prove in situations where people may not know their HIV status.
- A section in HIVPCA provides for routine HIV testing of a pregnant woman and the partner. Consequently, health workers usually make it mandatory for pregnant women and their partners to be tested for HIV, with or without their consent. This is a violation of human right to privacy and autonomy and thus automatically discourages people from visiting health facilities.

[9] Presenataion during the HIV/AIDS symposium, November 2022

- Section 18 (2) of HIVPCA allows a health worker to disclose HIV test results to a third party without the consent of the affected persons. This violates their right to privacy and potentially discouraging people from testing for HIV.
- Sections 136-139 of the PCA criminalise sex work and other activities associated with 'prostitution' to the effect of unfairly targeting KVPs and potentially exposing them to arbitrary arrest and mistreatment.
- Section 145 of PCA criminalizes "unnatural offences". This is then used to arrest men who have sex with men under the guise of committing offence against the order of nature. The same law also increases HIV stigma and discrimination and has been unfairly used against PLHIV to deny them a fair hearing or their right to trial.
- Section 30 of the NGO Act generally imposes restrictions on civil society organizations' operations in Uganda because it prohibits the registration of organizations perceived to work in contravention of the laws of Uganda. This has the potential to affect the enjoyment of the right of KPs such as sex workers and the LGBT community to associate and form legally recognized groups which could be crucial in lobbying for their HIV and health rights
- The Narcotic Drugs and Psychotropic Substances Control Act (2016) criminalizes drug possession and use, thereby ignoring the vulnerability of people who use drugs and framing them as criminals. The effect is that the range of social and medical interventions available to such people is limited, thus fueling the likelihood of arbitrary arrest and perpetuating risky injecting practices that further spread of HIV.
- The recently enacted Antihomosexuality Act (2023) imposes heavy penalties for engaging in homosexuality, including imprisonment for life, and a death sentence in the case of aggravated homosexuality.

No doubt, the above flaws in law and policy fuel stigma and discrimination (both internal and external) against the affected PLHIV and KPs (LEA, 2022):

- Discouraging HIV testing and disclosure of test results by PLHIV and other Vulnerable groups.
- Disproportionately disadvantaging women and girls.
- Providing a basis for arbitrary arrest and/or harassment by law enforcement agencies/officers.
- Legitimizing inequitable treatment of PLHIV and KVPs to deny them a fair hearing or trial before a court of law.
- Violating the fundamental human rights to privacy, confidentiality, and personal dignity

In creating the barriers above, the PLHIV and KPs are deprived of these basic rights, contrary to the provisions of Article 20 (1) of the constitution: Access to justice, right to non-discrimination; right to work, right to health; freedom from torture, cruel and inhuman treatment; and right to privacy, confidentiality, and informed consent (UAC, 2022).

Many sticky issues still remain unaddressed within the legal and policy framework. For example, there is no universal provision of services tailored to particular groups such as adolescent girls and young women (AGYW) or KPs and if they are, they only exist in some parts of the country. Tailored services are also still conspicuously lacking in settings such as prisons where there are many PLHIV and KPs. Other existing gaps in provision under this sub theme include; unstable supplies for condoms, lubricants and STI drugs; inadequate counselling services; challenges in referral systems; and the inadequacy of services accessible

to persons with disability and school children living with HIV. There are also concerns about sustainability of services in view of the current low levels of financing locally (LEA, 2022).

The effects of these limitations are felt more by vulnerable and the disadvantaged groups including poor women, young women and girls, and women involved in sex work. These and other disadvantaged groups remain at the risk of not accessing HIV services if deliberate and tailored interventions to reach them are not implemented.

3.3.4 Systems Strengthening Thematic Area

Table 6 below shows the progress made towards achieving the outcome targets for systems strengthening.

Table 6. Progress towards achieving outcome targets for systems strengthening

Key performance indicator	Baseline value	Mid-term value	NSP target	Gap	Remarks
Outcome 1: Governance and leadership of the multi-sectoral HIV and AIDS response at all levels strengthened.					
Percentage of districts with functional DACs	50%	80%	100%	20%	On track
Percentage of districts with functional PLHIV Networks	95%	91%	100%	9%	On track
Percentage of SCEs with functional HIV and AIDS committees	80%	92%	100%	8%	On track
Percentage of sectors mainstreaming HIV and AIDS	ND	74%	100%	26%	On track
Outcome 2: Availability of adequate human resources for delivery of quality HIV and AIDS services ensured					
Percentage of facilities with required staffing norm	ND	74	70.0		Surpassed
Outcome 3: Stock outs of medicines and supplies in health facilities reduced.					
Health facilities that had no stock out of one or more required essential medicines and health supplies within past 12 months.	ND	82%	90%	8.0%	On track
Outcome 4: Health infrastructure responsive to HIV service needs					
HC IIIs accredited and offer HTS, ART and EMTCT	100%	100%	100%	---	Achieved
Outcome 5: Resources for HIV and AIDS mobilized, and management streamlined for efficient utilization and accountability.					

Key performance indicator	Baseline value	Mid-term value	NSP target	Gap	Remarks
Percentage of the HIV and AIDS funding from GoU	12%	13.8%	40.0%	26.2%	Lagging
Percentage of MDAs & LGs with up-date costed strategic plans and budgets.	ND	90.0%	100%	10.0%	On track

The above achievements could be attributed to the interventions described below:

Governance and leadership:

A Committee of Technical Experts (CTE) was constituted to replace the Partnership Committee, with policy and technical advisory roles. An Equity Steering Committee, with its secretariat at UAC, was formed, as a multi-sectoral committee to coordinate and monitor the implementation of the Equity Plan. UAC revised its regulations and are awaiting approval by the Solicitor General's office. During the year 2022 regulations that articulate UAC's mandate were approved and gazette (JAR 2022)

The online tool to engage the districts HIV/AIDS strategic plans was completed, with 74% (100/135) district having at least a draft awaiting approval by their respective councils. As part of strengthening HIV mainstreaming in government programs, UAC supported the National Planning Authority (NPA) to embed HIV mainstreaming into the national cross-cutting issues planning guidelines. These were planned for roll out in September 2022 during MoFPED regional budgeting conferences in preparation for FY 2023/24 planning cycle. (JAR 2022)

The NSP 2020-2025 was widely disseminated to stakeholders. Districts were supported to develop HIV/AIDS strategic plans, with 50% (67/135) now complete. Planning tools including District HIV burden estimates, budgeting and reporting templates were shared. DACs and HIV focal persons within MDAs were oriented on HIV mainstreaming and their coordination roles, with 89% of MDAs having HIV/AIDS committees as of June 2021. Another assessment on the 'Performance of Multi-sectoral HIV/AIDS Mainstreaming' was conducted June 2021. Three MDAs (MoSTI, MoWT and IGG) developed HIV/AIDS workplace policies. However, an assessment of the functionality of national and sub-national HIV coordination structures conducted in 40 districts revealed variability in functionality. Only 35.5% of DACs held regular quarterly meetings, while only 55% had comprehensive plans in place. About 50% of SCEs reported quarterly. Only 3 SCEs (CCM, NAFOPHANU, and Line Ministries had 100% functionality in terms of reporting, while parliament, RASP, and ADPs scored 0%. (JAR 2022)

UGANET is working with Human Rights Awareness and Promotion Forum (HRAPF) and the International Community of Women Living with HIV in East Africa (ICWEA), to implement the GFATM RSSH and Human Rights component of the GFATM country priority areas for the year 2021 – 2023. This collaborative work aim to reduce human rights-related barriers to HIV/TB and malaria services. The joint implementation of activities in the performance framework ensures a comprehensive achievement of targets and reporting to the GFATM. (JAR 2022). In November, 2021, the Uganda Network on Law, Ethics & HIV/AIDS (UNAGET) and other Civil Society Organizations (CSOs), with support from the Uganda AIDS Commission successfully hosted the 2021 Philly Lutaaya Awards at Onomo Hotel in Kampala. (JAR 2022). UGAGET successfully held the 3rd National Dialogue on HIV and the Law in December 2021. Every 10th of December (International Human Rights Day). UGANET and partners hold a national conference that brings together actors/partners from

government institutions, policy makers, academia, CSOs, media, community members among other to dialogue on the national issues around legal environment that affect people living with HIV, KP and TB. In 2021, the focus was on the role of the Judiciary in the HIV and AIDS response, and to this effect, a judicial handbook on HIV and the law was launched to give guidance in adjudicating HIV related cases. (JAR 2022)

The District AIDS Committees (DAC) at the districts provide a mixed picture in terms of functionality and effectiveness. Overall, most members are new and not oriented on their roles and responsibilities. The DAC does not meet regularly, in some instances they do not meet at all. This situation is pronounced in districts where the DHO is an acting position. Leadership for the DAC rests heavily on a functional District Health Office and a functional Focal Person for HIV and AIDS at the district level.

Several Policy and operational guidance documents were developed to support program implementation including guidelines on 'Gender' and 'Parenting' by the MOGSD; Consolidated HIV guidelines (2020); KP guidelines on 'DIC operations'; KP Peer training manuals; Harm Reduction guidelines; DSDM Tool kit. A MARPs Priority Action Plan 2021-2023 is in draft; the National Comprehensive Condom Programming Strategy & Implementation Plan 2020 – 2025 was finalized; the national Cervical Cancer screening and management strategy was disseminated. At MOES, the School Health Policy was reviewed and submitted to Cabinet for the final approval. Others include Re-entry guidelines for prevention and management of teenage pregnancy in school; guidelines for senior male and female teachers; guidelines for management of school clubs. (JAR 2021)

MoH revised the National Supervision Guidelines in 2020 to streamline roles and responsibilities of key players in the RRH mechanism including MoH, implementing partners, districts and urban authorities. The guidelines also provide for RRH oversight support to districts as a way of strengthening decentralized capacity to regulate, monitor, and certify the quality of regional and district health services. In the Financial Year 2021/22, MoH, with funding from PEPFAR, signed partnership implementation agreements/implementation letters with the RRHs to implement the strategy. (JAR 2022).

The Homosexuality bill has been passed by Parliament of Uganda awaiting assent by the President. How this law will affect the overall HIV and AIDS response in Uganda needs to be quickly assessed, documented and communicated to relevant stakeholders across the country including parliamentarians. Guidelines and rules to ensure that all cases of GBV are well documented should be enforced at the different points of first contact particularly health facilities and police including Local Councils. Protections and upholding of the rights and access to legal redress of women and KPs needs to be enforced to ensure timely access to PEP, protection and legal facilities.

Availability of adequate human resource for delivery of quality HIV and AIDS services

Within the strategic objective to improve human resources for health, Government and partners seconded 32 staff to strengthen the oversight roles of Community Health Departments (CHDs) of 8 Regional Referral Hospitals (RRHs). These staff included biostatisticians, epidemiologists, infection prevention and control officers, continuous quality improvement officers and grants management officers.

Additional deployment of human resources at the regional level, Regional Referral Hospitals have been able to coordinate stakeholders and programs within their regions, through regional joint reviews, regional performance reviews, regional QI coordination meetings, and implementing partner coordination meetings. RRHs have also provided quarterly technical support supervision, capacity building and clinical mentorships including tele-mentoring to districts, general hospitals and HC IVs, and data quality assessments to strengthen the Health Management Information System (HMIS)

In-service training for HCW continued including training on the Consolidated HIV guidelines, Infection Prevention and Control, and provision of KP friendly services. To minimize spread of COVID-19, most of the training was delivered virtually using Zoom technology. (JAR 2021)

In March 2021, the MoH launched the 'Human Resources for Health Strategic Plan 2020-2030'. The staff required to fill the then (2020) public sector staffing gap to achieve the 100% (71,224) staffing level was 26,852 personnel. However, the COVID-19 pandemic increased demand on human resources as some health care workers were reassigned to support COVID-19 case management at the facilities. To mitigate this, the MOH planned to recruit 600 staff on 12- month contracts to staff the COVID-19 Treatment Units and ensure the existing HCW are available for other services including HIV care. (JAR 2021)

Substantial proportions of health workers such as counsellors and linkage officers in the response to HIV and AIDS are employed and paid under projects by implementing partners at the district. There is fear that budget cuts and end of project periods are likely to create enormous human resources gaps at the health facility levels. Integration of services across different services within the health facilities is encouraged. The proposed chronic care model will go a long way in ensuring sustainability in HR and efficiencies in utilization of HR at the facility level.

The use of technology-based applications for the reporting of GBV has expanded during the reporting period. Personnel in 112 districts were trained on the use of Safe Pal, an App used for reporting GBV cases (JAR 2021). Under the AGYW Program, violence prevention messages were provided at the safe space level through a tailored program developed by the Ministry of Health "Journeys plus curriculum community-based curriculum, reaching 120,736 adolescent girls and young women with Violence and HIV prevention messages (JAR 2021). As a result, through the work of legal aid CSOs, at least 3,050 cases of GBV were handled by trained community-based GBV responders and paralegals, and over 100 cases were handled by lawyers.

The MGLSD reached out to key stakeholders through capacity building and advocacy messages to create norms change to protect AGYW. Up to 14 cultural institutions and 112 districts were trained on various skills including the use of GBV reporting platforms, interaction with online counsellors, and on the Parenting Guidelines. Up to 40 CDOs and Probation and Welfare officers were trained on the Parenting Guidelines (JAR 2021). Through the work of CSOs, capacity building for responding to GBV has been built, with 19,781 GBV and legal aid service delivery points mapped and resource persons identified and 261 peer leaders trained by CSOs with support from development partners. (JAR 2021).

The key outcomes from the above efforts include increased awareness about GBV among various communities and stakeholders; increased community response to report GBV cases; increased involvement of leaders in talking against GBV and denouncing social norms and practices that perpetuate GBV; improved access to services for survivors of GBV; and progressive improvement in government and law enforcement attitudes towards key populations, resulting into less incidents of violence orchestrated by law enforcement agencies (JAR 2021).

To improve quality of GBV and VAC services the MoH carried out quarterly mentorship to health workers, using the sessions to provide information on updated guidelines, protocols, and standard operating procedures related to GBV and VAC. (JAR 2022). MoH strengthened the functionality of 20 VAC centres in 20 districts. Working with CSOs and AIDS development partners (ADPs), the MoH also built capacity of health workers, developed promotional SBCC messages, held webinars, national and regional dialogues and campaigns aimed at mitigating the effects of teenage pregnancies. The MoES also developed guidelines aimed at keeping pregnant and breast-feeding adolescents at school. (JAR 2022)

The YAPS pilot projects have shown that young people are best at attracting fellow young people to take up tests for HIV and to link them to care as well as retain them in care. The YAPS model should be cascaded to all levels in order to address the structural problems of access to care among adolescents and young at the same time address the problem of stigma among young people.

Reduced stockouts of medicines and supplies in health facilities

National Medical Stores (NMS) installed an integrated end-to-end digital supply chain / drug information quantification, ordering and tracking system, as part of a wider Enterprise Resource Planning (ERP) system to support online 'order and pick' by facilities. This was launched in June 2021 targeting all ART facilities (JAR 2021). The Emergency Logistics Management System targeting district level support for emergency facility orders is functional, linking facilities, district, MoH, and the National Medical Stores (NMS). 70 health facilities have continued to implement the multi-month dispensing (MMD) strategy in order to reduce clinic visits for stable ART clients.

A logistics management plan for the HIV self-testing commodities under PEPFAR and the GFATM was developed and the stocks and targets FY 2021/22 harmonized. The generated distribution list will facilitate NMS in shipment of kits to health facilities country wide. Stocks for 1st and 2nd line ART, HTS and RH supplies have been relatively stable over the review period. However, by June 2022 some 3rd line items were nearing stock out status. (JAR 2022) The online system of placing orders for medicines was initially resisted at the district level with minimal ownership at the district and health facility level, but now widely accepted as an efficient means of ensuring regular supply of medicines and commodities at the health facility level.

The national laboratory systems for HIV were strengthened with improved efficiency. The lab sample transport system was augmented with at least 8 additional vehicles to facilitate delivery of COVID-19 lab specimens from the sample collection points to the central testing labs at CPHL and UVRI. This contributed to faster delivery of viral load and EID samples to CPHL with improved turnaround time. Roll-out of the lab sample tracking system that had started pre-pandemic was expedited to support COVID-19. Laboratory data management systems became

more robust because of the urgency to use data in decision making; for example, the electronic results dispatch system (eRDS) was expanded to reach additional facilities conducting COVID-19 testing. Additional laboratory testing equipment was procured e.g. labs were set at Points of Entry; module GeneXpert machines were placed at each of the 14 RRHs to provide Point of Care testing services for VL, EID, and COVID-19. (JAR 2021).

The server capacity at CPHL was expanded from 68 TB to 100 TB, which has greatly improved turnaround time. During the year, 33 laboratories were accredited to ISO 15189 standards, thus strengthening the National Quality Improvement System. The capacity of the national equipment calibration centre to support national, regional and district hospital laboratories was also strengthened through renovations and installation of new equipment. (JAR 2022)

Strengthening and expanding the digital infrastructure for telemedicine linkages between specialized HIV care centres, district hospitals and regional referral hospitals Tele-medicine:
There was accelerated adoption of virtual technologies such Zoom to support training and program management. All RRH were equipped with Zoom licenses, cameras and screens to enable participation in telemedicine sessions with mentorship in Infection Prevention & Control (IPC); 3rd line ART management; and quality improvement initiatives. The plan is to equip the district hospitals and facilities in a phased manner (JAR 2021)

UN Women further established a toll-free helpline (0800-199195) in the Uganda Police Force. The reporting of VAC and GBV was enhanced with the updating and integration of *SafePal* a digital software application through which young people can confidentially report SGBV and get help, into the Children's Helpline. Capacity was built for frontline service providers and equipment (80 computers) was procured and supplied to the districts to enable functionality of the application. Many community members are now able to report cases and get help on time. (JAR 2022)

During FY 2021/22, MoH with support from JPHIEGO, continued to support weekly HIV drug resistance ECHO sessions with frontline workers managing HIV patients at the RRHs. MoH also supported regional review meetings convened by RRHs virtually. Through the National Infection Prevention and Control (IPC) digital Community of Practice, MoH held sessions with frontline health workers on various topics including: COVID-19 vaccination and strategies to address vaccine hesitancy; IPC including hand hygiene; cleaning, decontamination and sterilization; IPC audit in health facilities; IPC risk assessment for PPE needs in health care delivery; health care associated infections with emphasis on surgical site infections (SSIs); screening, isolation and notification in health facilities; waste management; IPC supplies in emergency situations; IPC trends in health facilities and IPC for avoiding transmission of resistant bacterial strains with a focus on TB. (JAR 2022)

RRHs used the ZOOM/ECHO technology to orient DHTs and facility staff on: National Supervision Guidelines (2020); National Consolidated Guidelines for HIV Prevention and Treatment (2018); National Guidelines for Managing COVID-19 (2020); IPC; COVID-19 immunization protocols; Emergency Medicine; and advanced HIV disease management including HIV/DR and 3rd line ARV treatment. (JAR 2022)

Waste Management: Global Fund supported procurement and installment of two incinerators to support waste management. The disposal of GeneXpert cartridges requires higher temperature incineration to minimize risk of environmental pollution. The gap in waste

management is huge currently as medical waste has to be transported from all health facilities countrywide to a few incinerators. Regional incinerators would reduce the transport burden. (JAR 2021). No additional procurement reported in the year 2022.

Strengthen community systems for the HIV response, including PLHIV and members of KPs, VHTs, CHEWs and family support groups

In line with the strategic objectives for strengthening community systems for special groups such as KP/PPs, in addition to expansion in service coverage of Drop-in Centers (also known as safe spaces which provide a comfortable place for KP/PPs to relax, get information and receive HIV prevention, care and treatment support services) from 39 to 75, multi-sectoral coordination meetings were held in the districts of Mbarara, Mbale and Gulu with law enforcement, technical and political leaders to create an enabling environment for KP service delivery. In the fishing communities, a new community-led initiative-the CHAG (Christian Health Association of Ghana) model-was introduced. By June 2021, there were 45 groups of 50 people each in 20 districts providing services though this model implementation of the community-led monitoring of health service delivery for HIV/TB was started.

The MoH conducted Differentiated Service Delivery (DSD) coaching in regions with low performance in community DSD. The 6 regions selected for support were Karamoja, Mbale, Ankole, Lango, Busoga and Rwenzori. (JAR 2021)

Technology for KPs: In the period under review, KP services were more streamlined, better defined in the policy guidelines, with standardized service packages, use of harmonized data collection and reporting tools, and storage of data into one data base – the KP tracker. A number of operational KP specific guidelines were developed including DIC operations guidelines; guidelines on Harm Reduction which supported establishment of the Medically Assisted Therapy center at Butabika Hospital for people who inject drugs (PWID). Capacity building of HCW in the delivery of KP friendly services was done in 20 districts including Bushenyi, Mbarara, Rukungiri, Ntungamo, Tororo, Mbale, Jinja, Gulu, Kitgum, and Karamoja. (JAR 2021)

Capacity building of health care workers in the delivery of KP friendly services was carried out in 20 districts including Bushenyi, Mbarara, Rukungiri, Ntungamo, Tororo, Mbale, Jinja, Gulu, Kitgum, and Karamoja. Additionally, with support from the GFATM, peer educators training manuals were printed and disseminated to stakeholders involved in the provision of KP and PP-friendly health services. The national trainers have been trained in readiness to roll this out nationwide (JAR 2022)

For KPs, apart from expansion in service coverage of DICs from 39 to 75, multi-sectoral coordination meetings were held in the districts of Mbarara, Mbale and Gulu with law enforcement, technical and political leaders to create an enabling environment for KP service delivery. The MoH conducted DSD coaching in regions with low performance in community DSD. The 6 regions selected for support were Karamoja, Mbale, Ankole, Lango, Busoga and Rwenzori. (JAR 2022)

Finance and costing

The MTR team sought to establish whether interventions under the financing and resource mobilization strategic objective were effective from the start to the mid-term point of the NSP. The goal of the financing and resource mobilization strategic objective is to mobilize resources and streamline resource management for efficient utilization. Preliminary findings show mixed results in terms of effectiveness for the different financing strategic actions.

HIV mainstreaming

The current NSP is implementing three key HIV/AIDS mainstreaming initiatives including the AIDS Trust Fund (ATF), One Dollar Initiative (ODI) and the 0.1% contribution from all government ministries, departments and agencies (MDAs) annual budgets to HIV/AIDS activities. The purpose of these initiatives is to increase domestic resource mobilization for HIV/AIDS response in Uganda. The MTR findings show progress on strategic actions for HIV mainstreaming.

Within the first two years of the NSP implementation, findings from desk review and key informant interviews show that UAC spearheaded a number of capacity building engagements for HIV mainstreaming activities at the national and subnational level. Trainings on resource mobilization, utilization and accountability for HIV resources were given to majority of the MDAs and district local governments (DLG). The ministry of finance planning and economic development (MoFPED) generated a single Mid-Term Expenditure Framework (MTEF) code for HIV/AIDS mainstreaming. This adjustment supported the growth and good performance of the 0.1% of all MDA budgets for HIV/AIDS initiative consequently, about US $9,938,082 accounting for 1.5% of total HIV/AIDS domestic contributions was raised. Consequently, the government direct budget support towards HIV/AIDS increased marginally by 2.1% in absolute terms between the years 2020/21 and 2021/22 of the current NSP implementation. The overall domestic contribution including government and HIV/AIDS mainstreaming activities increased from 12% to 13.8% from the first year to mid-term of the NSP.

On the other hand, the financing and resource mobilization strategic objective did not achieve on all the intended strategic actions within the mid-term as expected. Findings showed that the ATF had not been operationalized as planned. The financing technical working group (TWG) highlighted that the ATF was not implemented due to legal challenges and government position on its establishment. Generally, findings showed that the ODI is not well implemented especially at the sub-national level. For instance, the ODI yielded only US $32,877 as private sector contribution between the years 2020/21 and 2021/22, which is still low to make impact on HIV financing. Key informants such as planners and financing officers from selected districts expressed inadequate knowledge about the ODI concept, and consequently did not make any drastic steps to operationalize the ODI. In regard to the 0.1% contribution, the performance at DLG was lagging. Findings from sub-national level interviews at selected DLGs showed that most DLGs had not implemented the 0.1% of annual budgets. The major limitations highlighted at the DLG were, inadequate knowledge on the operationalization (i.e. how to calculate) of the 0.1% and limited commitment from political leaders and interest from district technocrats to apportion more money for HIV since development partners are already doing much for HIV/AIDS. Overall, there is need to rethink and strategize HIV mainstreaming to achieve the desired impact.

Progress on other finance and resource mobilization priority actions

The MTR focused on other strategic actions under the financing and resource mobilization strategic objectives. These include development and dissemination of planning and resource allocation tools for MDAs and DGLs, strengthening public sector budgeting tools, strengthening harmonized and programmatic accountability by public and non-public partners. Findings show that planning tools including district disease burden estimates, budgeting and reporting templates were developed and shared with MDAs and DLGs within the first year of the NSP. Further, capacity building in funding allocation activity monitoring was implemented in the first year 2020/21 of HIV/AIDS NSP (dissemination of NSP and NPAP were not actualized with year 1 & 2). The MTR found that good progress was made towards integrating HIV into development programming for all sectors. The National Planning Authority developed guidelines to facilitate the mainstreaming of HIV in all development plans, budgets and reporting frameworks for MDAs and DLGs. This resulted into about 78% and 74% of MDAs and DLGs respectively integrating HIV/AIDS into their strategic plans and budgets by 2021/22.

Additionally, progress was made towards harmonization of HIV/AIDS funding and allocation by public and non-public HIV/AIDS partners. UAC established a directorate of key development partners supporting HIV response in Uganda. The directorate has contributed to strengthening, harmonization, transparence and accountability for all resources from different streams. On the other hand, findings showed that some gaps still exist in regard to resource mobilization. For instance, the HIV program realized only 85% of the targeted resource needs in 2021/22 with only testing and treatment expenditure areas operating above the targets (Figure 24). Overall, we conclude that the financing and resource strategic was moderately effective in achieving the intended goals under the systems strengthening thematic area.

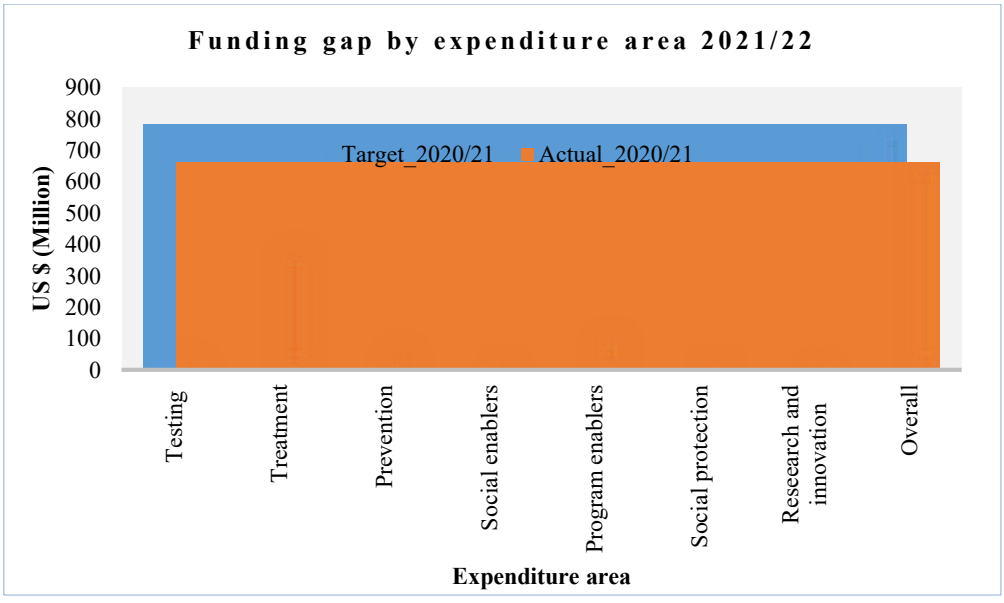


Figure 24. Funding gap by expenditure area: Source: author's computation

3.3.5 Monitoring, Evaluation and Research Sub Thematic Area

Table 7 below shows the progress made towards achieving the outcome targets for monitoring, evaluation and research.

Table 7. Progress towards achieving outcome targets for monitoring, evaluation and research

Key performance indicator	Baseline value	Mid-term value	NSP target	Gap	Remarks
Outcome 1: Strong national mechanism for generating comprehensive, quality and timely HIV and AIDS information for M&E strengthened					
Percentage of sectors with up-to-date costed HIV and AIDS M&E work plans	100%	100%	100%	---	Achieved
Percentage of districts with up-to-date costed HIV and AIDS M&E work plans	80.0%	74.0%	100%	26.0%	On track
Sectors submitting quality data that meets standards.	25.0%	81.0%	100%	19.0%	On track
Percentage of key sectors (MDAs) submitting quality complete reports to UAC	ND	100%	100%	---	Achieved
SCEs submitting quality reports	ND	74.0%	100%	26.0%	On track
Outcome 2. Information sharing and utilization among producers and users of HIV and AIDS data/ information at all levels improved					
Percentage of implementers utilizing program generated HIV and AIDS data	ND	100%	100%	---	Achieved
National research agenda items covered through operational research in each thematic area of the NSP.	ND	73%	100%	27%	On track
Percentage of stakeholders satisfied with NADIC.	ND	73%	80%	7%	On track

Strengthening the national mechanism for generating comprehensive, quality and timely HIV and AIDS information for M&E of the NSP

Strengthen operationalization of the M&E framework

Efforts to strengthen operationalization of the M&E framework included building capacities of Government Ministries and District Local Governments (DLGs) to develop 5-year HIV and AIDS Strategic Plans and M&E plans which are aligned to the NSP and M&E plans. Several development partners including PEPFAR, UNICEF and the Global Fund, among others have

supported these initiatives. To-date, more than 90% of MDAs and DLGs have costed 5-year HIV and AIDS Strategic Plans and M&E plans for monitoring implementation of the strategic plans. Further, the MDAs and DLGs have integrated HIV and AIDS indicators in their performance monitoring tools for regular tracking of performance.

The existence of a M&E framework for the NSP is a fulfillment of the international endorsement of the "Three Ones" concept where each country is expected to have one HIV coordinating authority, one National HIV strategic plan and one National HIV M&E system. Although widely adopted, the "Three Ones" concept is not yet fully operational in the country. Parallel and multiple reporting systems still do exist. There have been efforts to align the USG M&E and reporting system with the National M&E framework and these included (i) alignment of the PEPFRAR Monitoring, Evaluation and Reporting (MER) indicators to the National (MoH) indicators; (ii) customization of DHIS2 to the revised HMIS tools: Following the first HMIS tools review, the MoH, with support from partners, customized DHIS2 to the revised HMIS tools and (iii) Synchronization of the PEPFAR reporting schedules with the National schedules to harmonize and ease reporting.

Across the country, reporting through national system (DHIS2) has greatly improved over the years, from 58.5% in 2017 to 96.8% in 2022 overall (Figure 25).

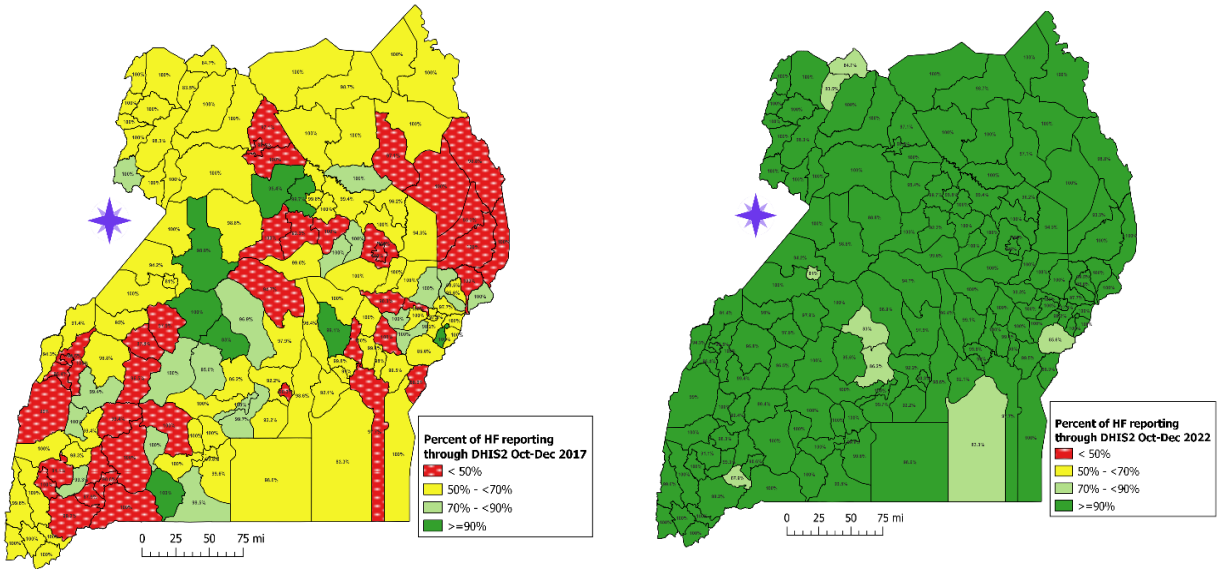


Figure 25. Percent of facilities reporting through DHIS2 by district

Mechanisms for monitoring use of HIV and AIDS mainstreaming funds and other funds allocated to HIV and AIDS were put in place. A budget call circular for FY 2019/20 issued by the Ministry of Finance, Planning and Economic Development (MoFPED) directed that MDAs should allocate 0.1% of their budgets to HIV and AIDS mainstreaming to ensure to ensure effective integration and implementation of HIV and AIDS in their work plans. Although a review of documents showed that external funding declined in the second year (2021/22) of the NSP, majority of MDAs have adhered to this directive. For example, nearly all the districts in the country have well established and functional District AIDS Committees (DACs) and PLHIV networks, with budgets. The majority of MDAs submit HIV and AIDS data to UAC.

Reinforce routine M&E activities.
Several planned M&E activities were implemented: monitoring implementation of the MDA and district HIV and AIDS strategic plans; regular reporting by MDAs and Self Coordinating Entities (SCEs); central data capture for all HIV and AIDS thematic areas; multi-sectoral progress review meetings at all levels; producing annual Joint AIDS Review (JAR) reports and populating the NSP indicator tracking table. A review of literature showed that with support from partners, monitoring of district HIV and AIDS strategic plans is done through regular support supervision and performance review meetings. Annual and quarterly performance review meetings were held at national and regional levels, respectively. Some of the activities are described below:

- Quarterly reporting by Self Coordinating Entities (SCE): On a quarterly basis, UAC receives reports from the 12 SCEs including the MDAs. The reports are compiled at the end of the year as part of UAC annual report. The reports from the SCEs supplement and triangulate the data generated from existing management information systems.
- HIV Finance Expenditure Management System: As part of the process of institutionalizing the National AIDS Spending Assessment, UAC in collaboration with Makerere School of Public Health developed a Finance Expenditure Management System that shall be used to track expenditure of HIV resources routinely. The tool has been validated and is due for rollout to respective users.
- Enterprise Data Warehouse: UAC has developed an Enterprise Data Ware house that is to create a one stop platform for HIV Multi sectoral data and information.
- Roll out of KP Tools: KP data is very essential in determining estimates for HIV due to the high prevalence rates and disease burden among KP and during the year, KP data collection tools were developed and piloted with support from GFATM. The tools have been rolled out to specific service points to track provision of KP services.
- AGWY Monitoring and Reporting Guide: With support from Global Fund, an AGYW Monitoring and Reporting Guide was developed and validated by key stakeholders. The guide identifies priority indicators and sources of data to inform AGYW programing. The guide addresses the gaps in collecting structural and behavioral data for AGYW programing which has been a challenge.
- Monitoring and Evaluation Technical Working Group: The M&E TWG continued to provide support in implementing the NSP M&E Framework. The TWG is multi-sectoral in nature and meetings are held on a quarterly basis to review progress of implementing the NSP. The TWG has provided technical support and guidance on specific tasks such as the annual Joint AIDS Review reports, monitoring of specific HIV interventions and programs including policy guidelines.
- Mid-term review of HMIS tools: Currently, the MoH is conducting a MTR of the national HMIS tools to integrate indicators for other thematic areas beyond HIV prevention, care and treatment. This will include customization and upgrade of the National database (DHIS2) to capture the additional data elements. However, due to funding constraints, the HMIS review process has not been finalized. During the review period, 2 annual JAR reports for FY 2020/21 and 2021/22 were produced although the NSP indicator tracking table is yet to be populated. The findings of this MTR will be used to populate and update the NSP indicator table.

Institutionalize multi-sectoral data quality assessments.
Data quality assessments (DQAs) involve identification of errors, inconsistencies and other data anomalies and instituting measures for addressing the identified gaps. In collaboration

with partners, the MoH conducted several DQAs during the MTR period. These included DQAs for the Cervical Cancer Program, Safe Male Circumcision, Recent HIV infections, OVC, KP/PrEP, DREAMS, TB/HIV, among others. The findings of these DQAs were disseminated to stakeholders at national level through the M&E and SI TWG meetings and at regional level through the regional performance review meetings.

In addition to the DQA, the MoH and Partners implemented several measures for improving HIV data quality. These include scaling up the use of electronic medical records (EMR) system and training, mentorship and support supervision of health facility staff to capture accurate and report accurate data. Although improvements in data quality in terms of timeliness and accuracy have been noted over the years, challenges in the quality of HIV data submitted through the National HIS systems still exist. For instance, data collection and management at 22% of the ART sites across the country is paper based, limiting its use for long-term patient care and monitoring outcomes (Figure 26).

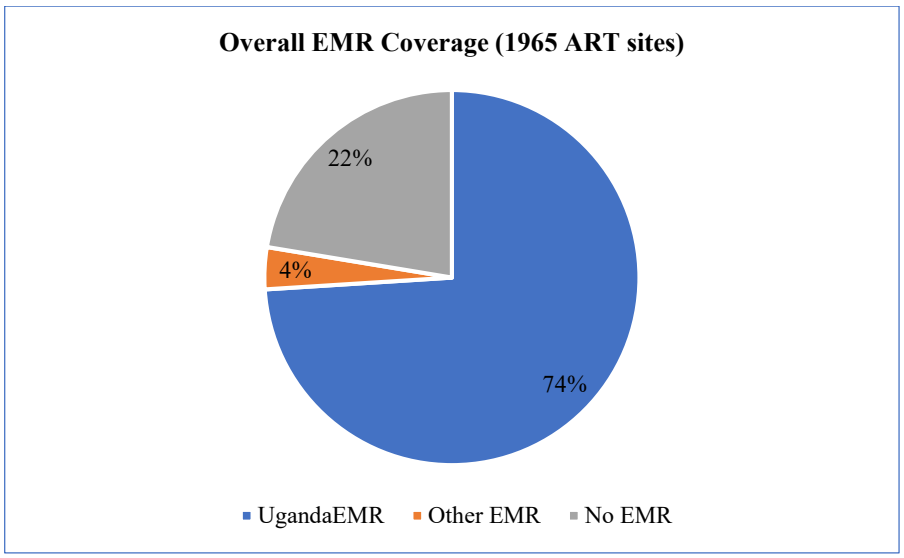


Figure 26. Overall National EMR Coverage (1,965 ART sites), September 2022.

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

Review of literature showed that some of the planned data use and learning events have been implemented to-date. Several data dashboards for real-time data visualization have been developed and access to the dashboards enhanced. The dashboards include Viral Load, EID, Option B+, Real-time ARV Stock Status Monitoring System (RASS), SMC, DREAMS, KP/PrEP, PEPFAR HIV/TB Surge and Quality Improvement (QI) (Figure 27). These dashboards are used by MDAs and partners to access key program data in real-time for timely corrective action. Currently, the dashboards are being reviewed to determine integration needs. In addition, plans by MoH to integrate all existing dashboards into one unified dashboard are underway.

Figure 27. Dashboards for data visualization

To further promote information sharing and utilization among all stakeholders, information products were developed and disseminated. These include annual HIV and AIDS factsheets, annual HIV status reports, annual spectrum estimates and annual health sector performance reports, among others. In addition, other platforms for information dessimination include annual stakeholder meetings, conferences and science summits organized by MoH, UAC and development partners.

The country has disseminated 2 annual Joint AIDS Review (JAR) reports. The reports showed country progress in implementing the first and second year of implementing the NSP. UAC in collaboration with the MoH and UNAIDS have developed and disseminated the annual country estimates for the NSP. The estimates team was able to produce district specific estimates for some of the indicators.

Strategy 2.2: Undertake evaluative/periodic assessments and special studies.

Several institutions such as Makerere University School of Public Health (MakSPH), Infectious Disease Institute (IDI), Baylor Uganda, Joint Clinical Research Centre (JCRC), Medical Research Council (MRC), Makerere University Walter Reed Project (MUWRP), Rakai Health Sciences Program and Uganda Virus Research Institute (UVRI), among others are involved in HIV and AIDS research. The HIV and AIDS research protocols are presented to and approved by the relevant M&E and SI TWGs, Institutional Review Boards and the Uganda National Council of Science and Technology. In an effort to consolidate and synthesize HIV and AIDS research, UAC set up a National HIV data set for all research products. The functionality of this dataset will be interrogated through interviews. In addition, the operationalization of the National Information and Documentation Center (NADIC) which serves as a centralised repository for HIV and AIDS research conducted across the country will be established during interviews with UAC.

Currently, UAC is undertaking a MTR of the NSP and there are plans to conduct an end-term evaluation for the NSP. UAC organized two HIV scientific symposiums in November 2021 and 2022 that provided a forum for sharing research findings and innovations in the HIV response. The symposiums were held in collaboration with academic and research institutions coordinated by the Research Academia and Sciences Program Self Coordinating Entity.

The National HIV Research Agenda for 2020 to 2025 was launched in November 2021. The Agenda outlines research priorities for the Country. UAC has developed a research data base for purposes of uploading research findings and studies. The database will provide a platform where research findings and studies can be accessed. The research database is part of the Enterprise Data Warehouse.

3.4 Efficiency of the NSP 2020/21-2024/25

According to the OECD/DAC approach, efficiency criteria explores (qualitatively and quantitatively) the extent to which interventions deliver or are likely to deliver expected results in an economical and timely way. The concept of economical requires that conversion of inputs such as finances, human resources, equipment, expertise and time resources into results or outputs be performed in the most cost-effective way possible compared to available alternatives. Additionally, the timeliness aspect of efficiency requires that delivery of program interventions be performed within the expected period in other words in an operationally efficient way. In the current NSP MTR, we assessed whether interventions within the key thematic areas on prevention care and treatment were delivered efficiently. These findings are based on the desk review and KII.

Resource allocation to key programs areas

Allocation of HIV/AIDS financial resources in the first two years of the NSP were in such a way that majority of the resources were budgeted and spent on the critical program areas in the HIV response. The 2022 Joint AIDS review report indicated that about 60% of funding was allocated to treatment interventions and overall, about 74% of funding realized was allocated to prevention, testing and treatment interventions with the remainder allocated to other program support areas such, program enablers, social support, research and innovation. This indicates operational efficiency of the HIV response in Uganda. Figure 28 below shows percentage allocation by thematic areas. The MTR process identified proper planning and coordination by UAC as a potential source of efficiency for HIV response in Uganda. UAC established an integrated work plan with all AIDS partners to harmonize planning and implementation to the HIV interventions in line with the NSP. Further, the AIDS development partners established a partners group, which meets quarterly to harmonize and align planning and implementation of ADP priority areas in the response. Finally, district HIV strategic plans have contributed to harmonization of HIV/AIDS activities between DLGs, and partners has contributed to efficient operation and reduce wastage duplication. Findings showed that HIV activities at sub-national level are largely district led. However, other districts expressed that HIV activities are still partner led, with fragmented interventions, financing and reporting thus, leading to inefficiencies.

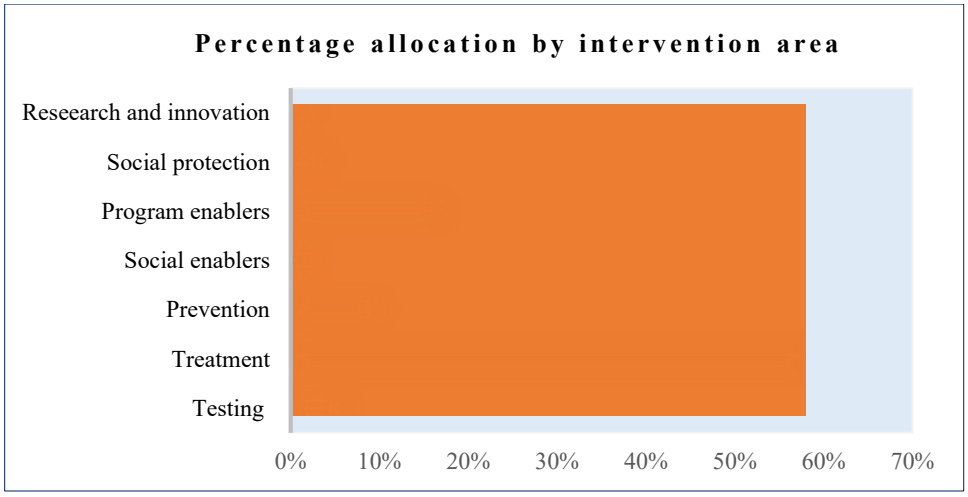


Figure 28. Resource allocation by intervention area: Source: author's computation

On the other hand, the MTR findings showed that financial allocation and geographical distribution of AIDS development partners in different regions of Uganda is disproportionate to HIV prevalence in those regions thus, an indicator of potential duplication and inefficiency. For instance, the UPHIA report 2020/21 identified regions such as South Buganda (8.1%), Mid-North (7.6%) with high HIV prevalence while regions such as Northeast Karamoja (2.1%) and West Nile (2.8%) had lowest HIV prevalence. To the contrary, the Directory of AIDS development partners in Uganda published in 2021 revealed that majority of the AIDS development partners were located in the West Nile and Karamoja region (Figure 29). Further efficiency assessment on resource allocation and spending for the HIV/AIDS program such as budget and cost over-runs will be performed when more information is available.

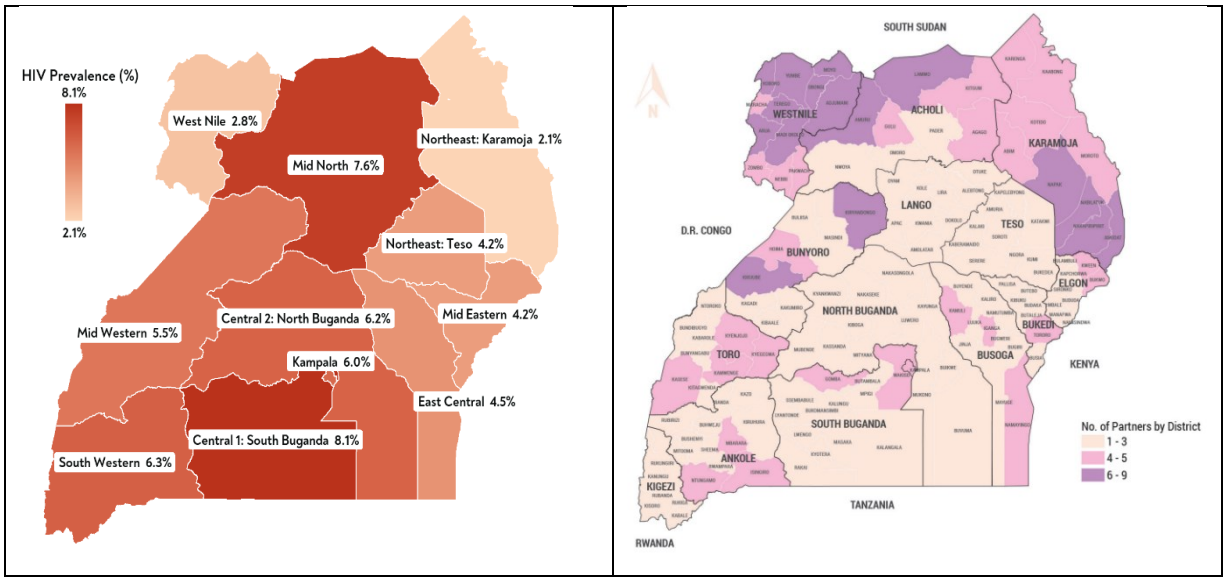


Figure 29: Maps of Uganda showing HIV prevalence and distribution of AIDS development partners by region.

Timeliness of intervention implementation

The 2020/21-2022/23 National Priority Action Plan (NPAP) for HIV response in Uganda set out to implement a number of strategic actions within two years under each NSP thematic areas and strategic objectives. Concerning efficiency, we examined whether the program delivered the interventions within the set period. Under the prevention thematic area, strategic objective one "Increase adoption of safer sexual behaviors and reduction in risky behaviors among key populations" and strategic action one "Scale up age and audience specific social and behavioral change interventions" for example, findings indicated that the program implemented majority of the planned strategic interventions within the two years. For instance, the national HIV/AIDS communication strategy was developed, school-based HIV/AIDS prevention activities were resumed, the renewed national advocacy campaign against HIV termed "Time Up HIV" campaign which reached about 17million people was launched and rolled out.

Under the Care and treatment thematic area, strategic objective one "Increase the diagnosed HIV persons who start ART to 95%" and strategic action one "Increase HIV care entry points for HIV infants, children, adolescents and men", findings form the annual joint AIDS review show that a number of interventions were implemented within the planned period. For instance, about 99% of people living with HIV were reached and served through the Differentiated Service Delivery Models (DSDM). About 95 districts implementing the Young People and Adolescent Peer Supporters (YAPS) model as a means of reaching the youth. In the care and treatment thematic area, the turnaround time for sample processing was markedly reduced by strengthening of the transport system for the delivery of lab specimens from sample collection points to the central testing labs at CPHL and UVRI, at the same time, the server capacity at CPHL was expanded from 68 TB to 100 TB.

Generally, from the desk review, we observed that the HIV program was operationally efficient.

3.5 Sustainability of the NSP 2020/21-2024/25

Sustainability criteria is concerned with assessing whether the benefits accrued by the NSP are continuing and are likely to continue amidst any changes in key aspects influencing the plan such as financial, environment, technological, political and institutional arrangements[10]. The current MTR of the NSP for HIV/AIDS in Uganda shows a mixed impression of sustainability of the plan within the different dimensions of sustainability.

The evaluation team observed four positive aspects of sustainability that are supporting and are likely to continue supporting the current achievements in the HIV/AIDS program in Uganda. These include the political commitment, institutional arrangement, cultural and technological aspects of the HIV response. The political commitment by the Government of Uganda towards HIV/AIDS is demonstrable. The Government of Uganda under the stewardship of the office of the President launched the presidential first track initiative on ending HIV/ADIS in Uganda by 2030. The initiative is anchored on a five-point plan which includes engaging men in HIV prevention, accelerating implementation of test and treat, consolidating reversal of mother-to-

[10] OECD/DAC Network on Development Evaluation (2019), Better criteria for better evaluation: Revised Evaluation criteria, definitions and principles for use.

child transmission, ensuring financial sustainability and institutional effectiveness for HIV programming in Uganda[11].

Between 2020/21 and 2022/23, a total of US$1.8 Billion was spent on the HIV response in Uganda, with a cumulative number of 1.3 million people living with HIV initiated on treatment. The resources acquired in nearly the past three years were less than the estimated US$2.3 Billion. More than 85 percent of these funds came from international donors; public funds accounted for 14 percent, while private funds provided an additional less than 1 percent. Among international donors, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria are by far the leading contributors with investments of US$490-530 million annually. The U.S. government alone invested more than $1.2 billion (over 65 percent) through PEPFAR Country Operational Plans in the same period.

Further, the government has continued to foster good bilateral and multilateral relationships that are critical for financial sustainability and health system strengthening for HIV programing in the near future. Consequently, by 2021/22 there were ten multilateral partners and seven bilateral partners funding the HIV/AIDS program in Uganda. The commitments for international mobilization of resources for AIDS yielded additional bilateral partnership with the German Corporation for international Cooperation (GIZ) in the year 2021/22 contributing an additional US $2,376,700 to HIV funding.

The current institutional arrangement is favorable for consolidating gains of the HIV and AIDS fight in Uganda. Compared to other disease specific programs, the Government of Uganda has made significant progress towards the Health in All Policy (HiAP) approach for the HIV/AIDS response. For instance, the MTR findings show that HIV mainstreaming has been integrated into the national development plan to facilitate harmonization of HIV/AIDS activities into development plans, budgets and reporting framework for District local governments and Government Ministries, Departments and Agencies (MDAs)[12]. In terms of institutional capacity, Uganda AIDS Commission and other partner institutions within the health, accountability and private sectors in Uganda have built the necessary capacity and institutional framework to ensure a continuum of efficient planning, allocation, utilization and accountability of HIV/AIDS resources. For example, a single HIV/AIDS mainstreaming code was integrated in the new Integrated Financial Management System (IFMIS). The key support institutions include the Ministry of Health, Ministry of Finance and Economic Development (MoFPED), Uganda Bureau of Statistics (UBOS), Public Procurement and Disposal of Assets Authority (PPDA), Office of the Auditor General (OAG), Parliament of Uganda, among other government and private institutions supporting the implementation of the HIV/AIDS program in Uganda.

Despite the unwavering political support and government commitment towards a sustainable response plan for elimination of HIV in Uganda, there remains key sustainability concerns for HIV response in Uganda. These include financial sustainability and the demographic composition and population risk behaviors in Uganda. The MTR findings show that Uganda's HIV and AIDS response is significantly donor dependent with over 83% of total HIV and AIDS

[11] Presidential fast-track initiative on ending HIV & AIDS in Uganda: A presidential handbook 2017.
[12] Uganda AIDS Commission (2022), Annual Joint AIDS review report FY 2021/22

spending coming from international development partners in the form of on-budget and off-budget support[13]. In the current NSP, the expected financial commitment by development partners is about US $2,154,954,559 accounting for approximately 52.4% of the projected NSP spending over the five years 2020/21 to 2024/25. Notwithstanding, the government of Uganda has demonstrated its commitment to boost domestic resource mobilization and efficient utilization of HIV resources to foster financial sustainability. Several AIDS initiatives such as the AIDS Trust Fund, the One Dollar Initiative, and the 0.1% of every MDA's annual budget have been proposed and enrolled to ensure domestic resource mobilization for HIV. However, benefits from these initiatives are still a long way to foster financial sustainability of HIV response in Uganda. For example in 2021/22, the 0.1% MDA budget contribution was US $ 9,938,082 accounting for only 1.5% of the total domestic funding[14]. Whereas the AIDS Trust Fund was not implemented due to legal and policy challenges.

Further, we considered that regulations and policy guidelines would enable the national HIV and AIDS response to outlive external financing. For example, regulations that articulate UAC's mandate were approved and gazetted (however, these regulations are not named). An online tool to engage the districts HIV/AIDS strategic plans was completed, with 74% (100/135) district having a draft awaiting approval by their respective councils.

The HIV Testing Services Policy was reviewed with technical and financial assistance from WHO, CHAI, and GFATM. The policy review led by the MakSPH, considered the ethics of testing all individuals and evaluation of testing services. The PMTCT program worked with the Uganda National Health Laboratory and Diagnostic Services (UNHLS) to develop implementation guidance for Point of Care (POC) viral load testing in the country in readiness for rolling out POC viral load testing starting with pregnant and breastfeeding mothers.

[13] Uganda AIDS Commission (2021), a directory of the AIDS development partners in Uganda
[14] Uganda AIDS Commission (2022), Annual Joint AIDS review report FY 2021/22

4.0 CHALLENGES, GAPS, AND LESSONS LEARNED

4.1 Challenges and Gaps

Prevention

a) ABC strategy

- Although the Sexuality Education Framework was developed, the ministry has not fully embraced it. There has not been clear leadership support and guidance to roll out and implement the framework.
- There is a challenge on the capacity to coordinate the multiple partners working in the school environment and the messaging on HIV in schools. Often schools may seek support from partners who may not be conversant with the guidance on age-specific messaging for HIV response in Uganda and this results in disseminating conflicting messages to learners and other stakeholders within the school environment.
- Within the education sector, there is inadequate commitment to prioritize HIV management. The Senior woman and man teachers and the teacher in charge of counselling are only assigned secondary roles, not key deliverables to officers assigned. Additionally, several schools don't have a school nurse as provided for in the draft school health policy.
- The challenge of schools being academic, packed with busy curricula and events, leaves very limited time and interest to focus on learners' other needs such as HIV/AIDS.
- The scale of implementation of HIV programs was inadequate, mainly due to insufficient funding. The PIACY program was only implemented in a few schools supported by partners.

b) HTS

- Frequent stock out of HIV test kits is experienced at health facilities across the country and vary across different sites mainly due to low targets set based on optimizing testing for diagnosis. This is coupled with the inability for health services providers to adhere to the guidelines for HTS optimization.
- There has been low uptake of HIV testing services among men despite the evidence that men especially 40-49years old shield a high burden of the epidemic.
- Poor adherence to the HTS standards, particularly among the private providers, results in suboptimal quality of HTS services.
- Despite the several approaches used, linkage of HIV-positive and negative clients to prevention, care and treatment is still low across all testing modalities.

c) PMTCT

- Low uptake of ANC4 services, low deliveries in health facilities and loss of mother-baby pairs remains a critical challenge.
- Retention of mothers in care is suboptimal and is largely due stigma, non-disclosure and lack of partner support.
- DSD models for PMTCT are not fully implemented: GANC model is available at limited facilities.
- Inadequate SRHR integration in MCH services leads to unplanned pregnancies among HIV-positive women.
- Gender inequalities and structural barriers hinder access to care and treatment in PMTCT settings.

d) SMC

- The SMC program continues to be implemented as a parallel program at both national and sub national levels.
- Not all facilities in the country have the capacity to provide SMC services. Most of the SMC sites are not well equipped to provide emergency services.
- Uptake of the reusable circumcision approach has been slow and is largely due to the low capacity to sterilize equipment.

e) Condom Programming

- Although condoms remain fundamental to the triple prevention of STIs, HIV and unwanted pregnancy, their usage at high-risk sex has remained low (<50%) in Uganda.
- The National plans, strategies and guidelines for condom programming have not been disseminated to the districts.
- There are inadequate leadership and coordination structures for condom programming at the district, health facility and community levels.
- The health information systems used at district, health facility and community level do not adequately capture condom data.
- There are still gaps in the last mile distribution of condoms to the end user; coupled with continued stigma surrounding the purchase of or asking for condoms.
- There is no domestic/government funding to condom programing at all levels. As such, most of the key activities such as advocacy, behavioural change communication, condom distribution, capacity building, social and operational research are not adequately funded.

f) Pre-Exposure Prophylaxis

- PrEP is not yet integrated into the routine health system and as such, there is low uptake of PrEP.
- PrEP is not yet incorporated into the core pre-service training package for health workers. As a result, the health workers do not have adequate skills to provide PrEP.
- There are no PrEP provisions in prison settings due to policy-legal environment in prison

g) STIs

- There is no stand-alone STI strategic plan to provide adequate guidance. STI issues are integrated within other strategic documents.
- Policy guidelines on STIs are not regularly updated despite the WHO recommendation of 2-3 years review.
- Health facility barriers including inadequate capacity of health workers to manage STIs appropriately and frequent stock-outs of STI drugs in facilities exist.

h) KP/PPs

- Coverage, scale and scope of KP interventions remain sub-optimal across programs including SBCC, mental health, HTS, PrEP and other prevention, care and treatment services.
- KP Policy guidelines are not updated to address the current developments and innovations in service delivery.
- Stigma, discrimination, hostilities and criminalization of KP/PPs, both in health facility and communities settings are widespread and affect access to services. The recent enactment of the Antihomosexuality Act is likely to worsen the harassment of KPs/PPs with the consequence of alienating them from HIV services.
- Programs to address violence against KP/PPs including PWIDs, are implemented on a limited scale.

Care and Treatment

- Retention in care is still sub-optimal for all populations but is more pronounced among children, adolescents, and KPs.
- There is low HIV treatment coverage among children, adolescents and this is due to the weaknesses in finding infected children
- HIV services integration is inadequately implemented, particulary AHD implementation, NCD integration, HBV and HCV, SRH and cervical cancer screening.

Social Support and Protection

- Stigma and discrimination against PLHIV still persist in the community especially for young people LWHIV and KPs due to structural barriers rooted in social, cultural and economic inequalities.
- The limited domestic funding and donor dependency for programs poses challenges for sustainability and institutionalization of programs to remove rights-related barriers.
- Recovery of revolving fund in some places is problematic because some people politicize it and others are simply less informed about it
- Provision of GBV response services in emergency settings including refugee settlements relies on parallel structures and is not integrated in existing government systems.
- Persisting handling of SGBV cases through a patriarchal lens that disfavors women and girls.
- There is limited scope of social protection by leaving out programs on Social Insurance and employment assistance.
- Persons with disabilities are conspicuously missing in all dis-aggregated data, yet they are among the most vulnerable and marginalized population sub-group in Uganda.
- The gap between number of GBV/VAC events and perpetrators followed up for meting justice is wide, leading to delayed justice for those who had suffered violence.
- There is weak monitoring and tracking implementation of guidelines in order to effectively address discrimination and stigma.

Systems Strengthening

- An explicit framework for evaluating health systems performance for the HIV/AIDS response is lacking especially for the goal towards ending AIDS as a global public health threat by 2030.
- Multiple policies for human rights issues in the HIV/AIDS response have been developed and ratified, however oversight for roll out and implementations is lacking.
- The mechanism of coordination for HIV and AIDS response between the districts, UAC and the ACP is not clear.
- DAC membership is considered to be obsolete and call for a revision: Most DAC members are new and not oriented on their roles and responsibilities in the HIV and AIDS response.

Finance and costing

- There is over dependence on donor assistance for implementing of key program areas, with oversee development partners contributing to over 80% of the resource requirement for sufficient implementation of HIV/AIDS programming.

- There is inadequate interest and social responsibility from non-public and non-foreign actors to financially support HIV programming in Uganda i.e., ODI is still at takeoff stage.
- Limited government physical space is a major challenge towards increasing domestic resource allocation for HIV response in Uganda.
- Gaps in technology and capacity at district local government level to adequately support financing and resource mobilization efforts.
- CSOs are not well mobilized and supported to contribute to HIV/AIDS response in Uganda both financially and programmatically.

Monitoring and Evaluation

- Although there has been substantial progress towards establishing one national M&E system in the country, multiple and parallel M&E systems for some HIV programs, such as KPs, AGYW (DREAMS), Cancer of the Cervix etc., still exist.
- The absence of a functional centralized database makes access to comprehensive HIV and AIDS data difficult.
- HIV and AIDS data collection, analysis and reporting at a consideration proportion of health facilities across the country is still paper based. This makes it difficult to manage and report large volumes of data for long-term patient care and monitoring of outcomes.
- Sub-optimal data quality for some HIV and AIDS programs still exists within the National HMIS systems. This is attributed to the multiple and parallel MER systems, paper-based data management at some sites, inadequate human resource capacity for MER in terms, knowledge, skills and numbers, insufficient infrastructure, logistics and supplies and poor data use practices.
- The National research agenda to guide HIV and AIDS research in the country has not been disseminated.

4.2 Lessons Learned

Prevention

- Leadership engagement and stewardship from the highest level is critical. Messages by the President on HIV and role of leaders in the fight HIV, packaged into the Public Service Announcements (PSA) and disseminated through the media is key in influencing behaviour.
- Cultural and religious institutions play a significant role in reaching the communities with HIV prevention information that addresses related behavioral and structural barriers.
- Employing differentiated HTS innovations (such as index client testing, social network testing, HIV self-testing) improves HIV case identification.
- Last mile condom distribution with electronic commodity tracking improves condom access and accountability.
- The phased funded roll out of PrEP and other prevention tools is a best practice to ensure coordination of efforts.
- Engaging peers in prevention programs such as PMTCT, PrEP, YAPS, DREAMS promotes uptake of services.
- Accreditation and rollout of PMTCT services to lower-level health facilities (HC IIs) improved eMTCT services uptake

- Repeat testing in late pregnancy and during lactation period, improves HIV case identification and enrollment of HIV infected mothers on ART for their lives and for prevention of HIV transmission to their babies.
- Keeping girls in school is an important strategy for reducing teenage pregnancy and early marriages which are key structural barriers to HIV prevention.

Care and Treatment

- Optimizing and rolling out ARV treatment regimens including consolidation of the DTG transition plan enhanced sustained viral suppression, tolerability and sustainability.
- Scale up of differentiated services delivery and community empowerment through the treatment literacy and employing the community facility linkage, improved retention in care and adherence to treatment.
- Continuous quality improvement using the audit tool under the micro planning improves tracking and accountability of clients on treatment.
- The roll out of biannual TB Community Awareness Screening and Testing (CAST) campaign activities in FY/2021/22, peer led community TB contact investigation and HIV testing, and scaling up of TB LAM testing and routine indicator screening for Advanced HIV Disease (AHD), improved TB case identification among PLHIV and management of advanced disease.
- Targeted cervical cancer screening for HIV positive mothers creates stigma. Therefore, cervical cancer screening should be done for all women irrespective of HIV status.

Social Support and Protection

- Successful implementation of interventions in the social support and protection sub-sector is difficult because this is a complex sub-sector that requires multi-stakeholder interventions with diverse specialty e.g., counselling, advocacy, skilling and direct resourcing.
- Since successful implementation of the Social Support Sector is complex and involves many stakeholders, a functional coordination structure should be in place right from the national to the district level to enhance the flow of services.
- Interventions in social support and protection sector target vulnerable people. Therefore, there is need to have a robust and dedicated structure at the grassroots level, especially for mobilization, and referrals.
- Due to diversity in needs and spatial differences, implementation of interventions under this theme should be cognizant of local content, to ensure ownership of the process, results and likely uptake of findings.

Systems Strengthening

- The mainstreaming guidelines have provided a platform to reinvigorate the engagement of different stakeholders in public and private sectors in HIV response.
- The HIV response issue paper was prepared and embedded into the national development planning guidelines cross-cutting issue.
- The community systems strengthening supported by the Global Fund and PEFAR resulted in enhancement of governance and leadership of community led organization to deliver services
- Despite the criminalization of some behaviours among high-risk population, the country has developed services delivery guidelines that provide for equity access to health services irrespective of social orientation.

- Deployment of a zonal coordinator by UAC can improve information flow and coordination between districts, UAC and ACP
- A dedicated focal person for HIV and AIDS at the district level improves coordination at the DAC and district.

Finance and Costing

- There is a need to rethink and re-strategize the One Dollar Initiative for better outcomes: UAC should increase involvement especially at the sub-national level.
- Districts without UAC focal persons are lagging on the 0.1% computation. UAC supported districts such as Gulu district expressed better capacity.
- Continued capacity building and follow up by UAC on 0.1% initiative at the DLGs is necessary to improve HIV mainstreaming at DLGs.
- Printing and dissemination of district HIV strategic plan and the NSP is critical for resource mobilization for HIV at the sub-national level. UAC should provide specific guidance and support to DLG to achieve this.
- The One Dollar Initiative sounds like a foreign concept especially at the sub-national level. There is need to rename this initiative for contextualization and ownership especially by private sector actors outside Kampala.
- Through the national AIDS spending assessment, Uganda is able to track the expenditure on HIV response in the country.

Monitoring and Evaluation

- Alignment efforts of the multiple reporting systems with the national reporting system have led to increased reporting through the national system and this is a critical step towards a functional one national M&E system.
- The scale up of EMR at nearly all high-volume sites has improved data management, quality and reporting at these sites.
- The availability of dashboards for key programs, information products and learning events have improved access to data in real-time to inform corrective action.

5.0 RECOMMENDATIONS

5.1 Priorities for remaining NSP Period 2022/23 - 2024/25

Prevention

Primary prevention of HIV(ABC)

- Scale-up social and behavioural change interventions including abstinence and be faithful interventions to reach all population groups with targeted HIV prevention messages.
- Fight stigma and discrimination using existing structures such as supporting the teachers AIDS action group (TAAG)
- Scale up the "Time Up HIV" campaign to all districts. This requires adoption of the campaign into planned and ongoing activities of implementing partners in their regions and districts.

Condom programming

- Scale-up condom education through evidence-based social mobilization and social marketing approaches to address behavioral disinhibition associated with condom use.
- Strengthening the accountability structures at all levels including condom coordination TWG at national level, the district and community condom focal persons and national condom monitoring frameworks.
- Scale up the last-mile condom distribution guidelines in all districts, to ensure functional, coordinated district condom distribution structures.
- Functionalize community condom distribution mechanisms and other end-point distribution points such as hotels and lodges to ensure condom availability in places where they are needed.

HIV Testing services

- Scale-up the revised HTS policy and implementation guidelines including the revised HIV testing algorithm (the 3-test algorithm), HMIS tools and the revised job aids.
- Roll out a nationwide continuous quality improvement collaborative and regular data quality assessments, to improve on services delivery and reporting quality.
- Scale up optimization with fidelity of HTS such as Social Network testing (SNS), Index testing provisions, HIVST to target underserved population such as partners of sex workers, biological children, adolescents to target men and key populations at risk of HIV acquisition.

PrEP

- Accredit more facilities to provide PrEP and PEP at facility and community level.
- Review, update and roll out the PrEP curriculum and guidelines having the newer options (DVR, CAB-LA, and event driven PrEP etc), and increase uptake of PEP for non-medical and medical exposure.
- Build capacity of service providers and service outlets to roll out new HIV prevention technologies, including the training of Peer workers to dispense PrEP.
- Implement quality improvement initiatives and operational research to improve uptake and quality of PrEP services delivery.

SMC

- Integration of SMC services into other health services, including surgical outpatients, MCH

services and workplace
- Scale up the use of innovative circumcision methods such as the use of non-surgical devices.
- Support the transition from the use of single-use circumcision kits to re-usable kits
- Conduct annual site and provider accreditation and certification to ensure quality services delivery.
- Support quality assurance, quality-improvement management of SMC service delivery through mentorships, support and technical supervisions and regular local data use

KP/PP
- Review, update and disseminate KP policies, tools including DSD for KP, training manual etc to align with the current changes and innovations.
- Build capacity of service providers in delivery of KP-friendly services including addressing health worker-stigma for effective utilization of health facility-based services
- Scale up quality key and priority population differentiated services delivery at community levels.
- Conduct studies to estimate national and sub national sizes and profiles of key and priority populations.
- Undertake legal, human rights and sexual and gender diversity trainings for law enforcement and health care workers to increase uptake of health services and social justice.
- Expand the provision of alcohol and drug dependency rehabilitation, and harm reduction program services.

PMTCT of HIV, syphilis and Hepatitis B
- Strengthening primary prevention services with a focus on AGYW, HIV negative pregnant and breastfeeding women as well as their partners, providing integrated comprehensive SRH/HIV services (family planning, HIV, syphilis, and Hepatitis B service, PrEP)
- Optimize identifying, treating, and improving retention and adherence on ART for HIV positive pregnant and breastfeeding women, infected with HIV, Syphilis, Hepatitis B and their exposed infants, improving logistics and supplies, and promoting advocacy and patient literacy.
- Scale up the prevention of incident HIV among pregnant and breastfeeding women through PrEP and PEP literacy and awareness campaigns, adherence support and demand generation activities.
- Scale up point of care (POC) viral load testing for infants.
- Expand the roll out of EPI/PMTCT/EID integration for EID to all PMTCT sites and point of care testing.

AGYW
- Scale up AGYW interventions in all high incidence districts and strengthen referral monitoring of the AGYW programme and conduct a country wide survey to determine the impact of AGYW programming high teenage pregnancy on should be carried out.
- Capacity building of health facilities to provide youth friendly services
- Roll out a central M&E data system to capture data on AGYW programming at multi-sectoral level.
- Provide safe spaces at the community level and implement economic empowerment activities for AGYW and ABYM in selected districts with high number of GBV survivors, coupled with limited access to protection services.

- Economic empowerment interventions, activities to reduce the economic vulnerability of AGYW/ABYM in high incidence location including school allowance and clubs and savings groups for in and out of school youth.

Structural drivers: SGBV prevention

- Strengthen the HIV Prevention coordination and stewardship national across sectors and at sub-national levels at district, city authorities, municipalities town councils etc
- Engage community structures and networks in designing scaling up innovative HIV prevention programs to improve comprehensive HIV knowledge, impart life skills, reduce risky sexual behaviours, address gender-based violence and violence against children (VAC)
- Implement interventions to keep adolescent girls and young women in school by scaling up menstrual hygiene management among in-school AGYW, providing sanitary pads for needy AGYW at school, and cash transfers, among other interventions.
- Integrate sexual and gender-based violence (SGBV) prevention into HIV prevention programming.
- Empower women and girls through training, counselling and mentorship, to identify, prevent, avoid/protect and report incidents of GBV and situations likely to result into GBV.

Care and Treatment

- Strengthen supply chain for care and treatment commodities to ensure continuity of care.
- Improve retention in care through provision of differentiated/client centered services, psychosocial support and patient literacy through peer and community engagement and patient tracking.
- Implement pediatric and adolescent regimen optimization and strengthen psychosocial support (including caregiver) and HIV drug resistance testing (program and surveillance)
- Reduce HIV related morbidity and mortality through monitoring of advanced HIV disease (AHD), drug induced toxicity, non-communicable diseases (NCDs), cervical cancer, and Hepatitis B and C screening and management.
- Integrate services for NCDs into HIV prevention, care and treatment services to benefit older PLHIV.

Social Support and Protection

- Scale up interventions for reducing stigma and discrimination associated with HIV and AIDS
- Prioritize and scale up interventions to mitigate the escalating physical and sexual violence among women, adolescents and children.
- Prioritizing and scaling up legal and policy reforms to address challenges of gender-based violence and human right violations.
- Review all the indicators and targets for social support and protection and make them more specific, measurable and realistic.
- The Parish Development Model concept should be integrated into the National Strategic Plan

Systems Strengthening

Governance and leadership

- Support districts to functionalize District AIDS Committees (DACs) and PLHIV networks.

- Strengthen HIV and AIDS mainstreaming in all Ministries, Departments, Agencies and Sectors

Human Resources

- The Ministry of Health should rollout the new staffing structure for all health facility levels in the country to address the staffing gaps.

Supply chain

- There is need to strengthen the logistics and supply chain management systems at all levels to address the issues of late deliveries of supplies, discrepancies between the ordered and delivered supplies, delivery of nearly expiring medicines and health supplies. This should include training of health workers in timely compilation and placing of orders and careful review of the orders. The central warehouses should establish a system to monitor the packaging supplies and equipment as well as to review delivery schedules.

Finance and costing

- Streamlining internal resources mobilization strategies, that is, ensure operationalization of all HIV mainstreaming initiatives.
- Government efforts to increase direct funding allocation to HIV and AIDS are required.
- A holistic approach towards achieving financial sustainability and reducing foreign development assistance towards the response is required.
- There is need to streamline the current priorities for internal HIV resource mobilization.

Monitoring, Evaluation and Research

- There is need to align and integrate the various M&E systems into one National M&E system.
- There is need to develop a functional centralized database for comprehensive HIV and AIDS data.
- Support scale up electronic medical records (EMR) to all health facilities across the country will help to effectively manage large volumes of HIV data.
- Disseminate the national research agenda to guide HIV and AIDS research at all levels.

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7.0 PERFORMANCE INDICATOR MATRIX

Strategic objective	Key Performance Indicator	Disaggregation	Data source	Baseline value (2020-21)	Mid-term Value (2022-23	End-term Value (2024-25)
THEMATIC AREA: HIV PREVENTION						
Sub-Goal 1: To reduce the number of youth and adult HIV infections by 65% and paediatric HIV infections by 95% by 2025.						
Impact: Reduced HIV transmission	1.1: HIV incidence rate		• Spectrum estimates-2022	0.3%	0.12%	0.2%
Outcome 1: Increased adoption of safer sexual behaviors and reduction in risky behaviors among key populations, priority population groups and the general population						
	1.1: Percentage of adult males and females (15-49 and 50+ years) who have had sexual intercourse with more than one partner in the last 12 months.	Male		15-49: 20.6% 50+: ND	30.7%	10.5% 5%
		Female		15-49: 2.3% 50+: ND	10.4%	1% 0.5%
	1.2: Percentage of young women and men aged 15-24 years who correctly identify 3 ways of preventing sexual transmission of HIV and who reject 2 misconceptions about HIV transmission	Male		45%	ND	70%
		Female		46%	ND	70%
	1.3: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Male		21%	ND	11%
		Female		10.2%	ND	5%
	1.4: Percentage of Female Sex Workers reporting condom use at the most recent client		State of HIV prevention in Uganda by UNAIDS 2021	69%	69%	90%
	1.5: Percentage of MSM who used a condom at last anal sex			39%	39%	60%
		Male		ND	ND	90%

Strategic objective	Key Performance Indicator	Disaggregation	Data source	Baseline value (2020-21)	Mid-term Value (2022-23	End-term Value (2024-25)
	1.6: Percentage of PWID reporting safe injecting practices in the last 1 month	Female		ND	ND	90%
Outcome 2: Expanded coverage and uptake of quality biomedical priority HIV interventions to optimal levels.						
	2.1: Percentage of males and females 15-49 and 50+ years reporting condom use at last higher risk sex	Male	• UNAIDS 2021: State of HIV prevention in Uganda	15-49: 57% 50+: ND	62% ND	90% 50%
		Female		15-49: 37% 50+: ND	38% ND	80% 30%
	2.2: Percentage of key and priority populations 15-49 years reporting consistent condom use	FSWs	• Crane survey, 2021	45%	71%	85%
		MSM		64%	39%	85%
		PWIDs	• T. Ssekamatte et al, 2022[15]	ND	37%	60%
		PIP		ND	ND	85%
		TG		ND	ND	50%
		Fisher folks	• Hope Nakazibwe et al, 2022[16]	ND	10.2%	85%
		Truckers		21%		85%
	2.3: Percentage of women and men (15-49 years) who tested for HIV in the last 12 months and know their results.	Overall	• UPHIA-2020/21	ND	80.9%	50%
		Male		37%	76.1%	50%
		Female		48%	83.5%	50%
	2.4: Percentage of key and priority populations who have received an HIV test in the previous 12 months	FSWs	• Crane survey, 2022 • KP/PrEP Tracker	86%	97%	90%
		MSM		85%	96%	90%

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Strategic objective	Key Performance Indicator	Disaggregation	Data source	Baseline value (2020-21)	Mid-term Value (2022-23	End-term Value (2024-25)
	and know their results	PWIDs		ND	96%	90%
		PIP		ND	94%	90%
		Transgender		ND	100%	90%
		Fisher folks		ND	ND	90%
		Truckers		ND	ND	ND
	2.5: Percentage of people who inject drugs who use harm reduction programs	Male		ND	ND	80%
		Female		ND	ND	80%
	2.6: Percentage of HIV-positive pregnant women who receive antiretroviral drugs to reduce risk of mother-to-child transmission of HIV		• DHIS2	92%	95%	95%
	2.7: Percentage of HIV-positive women in sexual relationships using family planning		• Mbabazi L et al, 2022[17]	ND	38.4%	70%
	2.8: Percentage of HIV-positive breast- feeding mothers with viral load suppression		• DHIS2	ND	94%	95%
	2.9: Percentage of pregnant and breast-feeding mothers on ART at 12 months of initiation		• DHIS2	ND	85%	90%

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Strategic objective	Key Performance Indicator	Disaggregation	Data source	Baseline value (2020-21)	Mid-term Value (2022-23	End-term Value (2024-25)
	2.10: Percentage of HIV exposed infants who have received ARV prophylaxis to reduce risk of mother-to-child transmission of HIV		• DHIS2	85%	84%	90%
	2.11: Percentage of HIV exposed infants testing HIV positive with 1st DNA-PCR (0-12 months)		• DHIS2	2.1	1.5%	1.3
	2.12: Percentage of males (15-49 years) that are circumcised		• DHIS2	43%	64.2%	80%
	2.13: Percentage of HIV exposed infants testing HIV positive with 1st DNA-PCR within 2 months		• DHIS2	2%	0.6%	0%
	2.14 Percentage of donated blood units that have been adequately screened for HIV according to national or WHO guidelines during the past 12 months.		• UBTS	100%	100%	100%
Outcome 3: Mitigated underlying socio-cultural, gender and other factors that drive the HIV epidemic.						
	3.1: Percentage of women (15-49 years) who experience sexual and gender-based violence		• Mid-term review of UN Joint Program on GBV-2022 (unpublished)	13%	11%	5%
	3.2: Percentage of adult males and females that believe that a woman is justified to refuse sex or demand condom use if she knows that her husband has a STI	Male	• National survey on violence in Uganda, 2022	91%	81%	98%
		Female		87%	83%	95%
	3.3: Percentage of key populations who avoided health care in the past 6 months because of stigma and discrimination	FSWs	• Crane survey, 2022	ND	66%	10%
		MSM		ND	15%	10%

Strategic objective	Key Performance Indicator	Disaggregation	Data source	Baseline value (2020-21)	Mid-term Value (2022-23	End-term Value (2024-25)
		PWID	• NAFOPHANU: The PLHIV Stigma Index Report, 2019	ND	19%	10%
		PIP		ND	ND	10%
		TG	• NAFOPHANU: The PLHIV Stigma Index Report, 2019	ND	8%	10%

Strategic objective	Key Performance Indicator	Disaggregation	Data source	Baseline value (2020-21)	Mid-term Value (2022-23	End-term Value (2024-25)
THEMATIC AREA: HIV CARE AND TREATMENT						
Sub-Goal 2: To reduce AIDS-related morbidity and mortality by 2025						
Impact: Reduced HIV-related mortality	Annual HIV related deaths		• Spectrum estimates-2022	21,000	17,377	10,800
	HIV mortality rate (15–49 years)		• Spectrum estimates-2022	66/100,000	39.8/100,000	33/100,000
Outcome 1: Linkage to ART increased to 95% by 2025.						
	1.1 Proportion of diagnosed HIV persons who start ART within one month.	All	• Joint AIDS Report-2021/22 • Spectrum estimates-2022 • DHIS2	ND	91%	93%
		Adult women (15+ years)		93%	96%	95%
		Adult men (15+ years)		81%	95%	90%
		Older persons (50+ years)		ND	94%	95%
		Adolescents (10-19 years)		ND	87%	95%
		Children (0-14 years) M&F		74%	89%	95%
	1.2 Percentage key and priority populations with HIV on ART.	M, F; category of KP		91%	96%	95%
Outcome 2: Retention on ART increased to 95% by 2025.						
	2.1 Proportion of PLHIV retained on ART at 12 months after initiation.	Adult women (15+ years)	• Joint AIDS Report-2021/22 • Spectrum estimates-2022 • DHIS2	73%	74%	95%
		Adult men (15+ years)		73%	73%	95%
		Older persons (50+ years)		79%	84%	95%
		Adolescents (10-19 years)		ND	63%	95%

Strategic objective	Key Performance Indicator	Disaggregation	Data source	Baseline value (2020-21)	Mid-term Value (2022-23	End-term Value (2024-25)
		Children (0-14 years) M&F		68%	74%	95%
Outcome 3: Adherence on ART increased to 95% by 2025.						
	3.1 Percentage of active clients with adherence of >95% in the last clinical visit		• Joint AIDS Report-2021/22 • Spectrum estimates-2022	95%	73%	100%
Outcome 4: Viral suppression increased to 95%						
	4.1 Proportion of people living with HIV who are virologically suppressed.	All	• CPHL VL database	89%	94%	95%
		Adults (15-49)		ND	96%	95%
		Older persons (50+ years)		87%	94%	95%
		Adolescents (10-19 years)		49.4	89%	90%
		Children (0-14 years) M&F		39.3%	87%	90%
	4.2 Percentage key and priority populations on ART that is virally suppressed.	Gender and KP category	• Joint AIDS Report-2021/22 • KP/PreP Tracker • Crane survey, 2022	ND	93%	95%
		MSM		ND	92%	95%
		FSW		ND	93%	95%
		PWID		ND	94%	95%
		PIP		ND	91%	95%
		TG		ND	94%	95%

Strategic objective	Key Performance Indicator	Disaggregation	Data source	Baseline value (2020-21)	Mid-term Value (2022-23	End-term Value (2024-25)
Outcome 5: Strengthened integration of HIV care and treatment across programs.						
	5.1 Unmet need for family planning among PLHIV			41.2%	ND	20%
	5.2 TB and HIV co-management					
	5.2.1 Percentage of HIV-positive incident TB cases that received both TB & HIV treatment within the past 12 months.	Gender	• Joint AIDS Report-2021/22 • DHIS2	76%	94%	100%
	5.2.2 Percentage of ART patients who started on TB preventive Therapy (TPT) in the previous reporting period who completed therapy.	Gender	• Joint AIDS Report-2021/22 • DHIS2	80%	90%	100%
	5.3 Percentage of HIV positive acutely malnourished clients in care who received nutrition therapy.	Gender		70.5%	ND	85%
	5.4 Percentage of people in HIV care who were screened for hepatitis B	Gender	• DHIS2	ND	1.3%	50%
	5.5 Percentage of PLHIV on ART with advanced HIV disease screened for cryptococcal meningitis (CCM)	Gender	• Joint AIDS Report-2021/22 • DHIS2	87%	60%	95%
	5.6 Percentage of PLHIV women screened for cancer of the cervix.		• PEPFAR Incountry Reporting System (PIRS)	ND	74%	50%
	5.7 Percentage of HIV-positive adolescent girls on ART receiving HPV vaccine within the past 12 months			ND	ND	90%

Strategic objective	Key Performance Indicator	Disaggregation	Data source	Baseline value (2020-21)	Mid-term Value (2022-23)	End-term Value (2024-25)
THEMATIC AREA: SOCIAL SUPPORT AND PROTECTION						
Sub Goal 3: To strengthen social and economic protection to reduce vulnerability to HIV and AIDS and to mitigate their impact on people living with HIV, orphans and other vulnerable children, KPs and other vulnerable groups						
Outcome 1: Stigma and discrimination minimized.						
	1.1 Percentage of men and women aged 15-49 years with accepting attitudes towards PLHIV.	All	PLHIV Stigma Index Survey Report	66.8%	73.4%	80%
		Male		71.3%	78.2%	85%
		Female		65.6%	72.8%	80%
	1.2 Percentage of men and women living with HIV who report experiences of HIV-related discrimination.	**Community**				
		Overall	PLHIV Stigma Index Survey Report	4.29%	1.82%	0.5
		Male		3.44%	0.83%	0.2
		Female		4.81%	1.55%	0.5
		Health care setting				
		Male		5.5%	ND	1%
		Female		8.7%	ND	4%
		Workplace				
		Overall		7.93%	ND	3.5%
		Male		7.63%	ND	3.0%
		Female		8.12%	ND	3.5%
	1.3 Percentage of PLHIV who self-report on the construct of feeling guilty or worthless due to being a PLHIV	Gender		24.0%	14.0%	8.0%
	1.4 Percentage of PLHIV reporting difficulty to disclose HIV status to other people.	Gender		36.3%	23.3%	15.0%
Outcome 2. Reduced socio-economic vulnerability for PLHIV and other vulnerable groups						

Strategic objective	Key Performance Indicator	Disaggregation	Data source	Baseline value (2020-21)	Mid-term Value (2022-23)	End-term Value (2024-25)
	2.1 Percentage of PLHIV and OVC households that are food secure.	Gender		37.2%	51.0%	70.0%
	2.2 Percentage of children and young people (6-17 years) living with HIV who have dropped out of school.	Gender		29.0%	21.0%	15.0%
	2.3 Percentage of individuals who access counselling and psychosocial services.	Gender HIV status KP category Other vulnerable population		ND	ND	
	2.4 Percentage of men and women PLHIV who report having not received any type of support such as counselling for the mental health conditions experienced.			39.7%	19.9%	10.0%
Outcome 3. Reduced gender-based violence/discrimination.						
	3.1 Percentage of men and women who believe that wife beating is justified.	Overall	Mid-term review of UN Joint Program on GBV-2022 (unpublished)	47%	17%	15%
		Male		40.1%	10%	10%
		Female		49%	19%	18%
	3.2 Percentage of married women who participate in making decisions pertaining to their own health care, major household purchases, and visits to their family.		Mid-term review of UN Joint Program on GBV-2022 (unpublished)	35.5%	64%	65%

Strategic objective	Key Performance Indicator	Disaggregation	Data source	Baseline value (2020-21)	Mid-term Value (2022-23)	End-term Value (2024-25)
	3.3 Percentage of women who own land alone or jointly with their spouses.		Mid-term review of UN Joint Program on GBV-2022 (unpublished)	47.7%	74.1%	60%
	3.4 Percentage of women and men 15-49 years who experience GBV from an intimate partner in the past 12 months.	Physical (F)		22.5%	45%	11%
		Sexual (F)		16.6%	21%	8%
	3.5 Percentage of GBV survivors who report to formal institutions such as police.	Gender	Mid-term review of UN Joint Program on GBV-2022 (unpublished)	6.6%	14.1%	10%
	3.6 Percentage of GBV survivors who access formal services- (Protection, health and legal services)	Gender		20.2	40.4%	50%
Outcome 4. Improved child protection and reduced VAC						
	4.1 Percentage of OVC aged 5-17 that have at least three basic needs met.	Gender		39%	52%	70%
	4.2 Percentage of children and adolescents (13-17 years) who report sexual violence	Overall	Goessmann et al, 2020[18]	18%	16.4%	6%
		Girls	Kafuko et al, 2022[19]	25%	33.1%	8%
		Boys	Goessmann et al, 2020	11%	29.9%	4%
	4.3 Percentage of girls and boys 0-17-year survivors of sexual	Overall	Ssanyu JN, et al, 2022[20]	6.1%	29.7%	50%

[18] Goessmann et al, 2020, Characterizing the prevalence and contributing factors of sexual violence: A representative cross-sectional study among school-going adolescents in two East African countries.

[19] Kafuko et al, 2022, Risk Factors for Sexual Violence Among 13–17-year-old Girls In Uganda: Findings From The National Violence Against Children Survey

[20] Ssanyu JN, Namuhani N, Nalwadda CK. Reporting of sexual and gender-based violence and associated factors among survivors in Mayuge, Uganda. Afri Health Sci. 2022;22(1):62-8. h

Strategic objective	Key Performance Indicator	Disaggregation	Data source	Baseline value (2020-21)	Mid-term Value (2022-23)	End-term Value (2024-25)
	violence who receive formal services (Medical, Psychosocial and legal services)	Girls		7.7%	37.5%	60%
		Boys		4.6%	21.7%	45%
	4.4 Percentage of children survivors of violence and SGBV who have completed PEP.	Gender		ND	ND	60%
Outcome 5. Legal and policy framework on HIV and AIDS improved to ensure inclusive access by all PLHIV, Key Populations and other Vulnerable Populations						
	5.1 Percentage of PLHIV, KPs and other vulnerable groups who know their HIV health rights and responsibilities.	Gender, Category		ND	ND	90%
	5.2 Percentage of PLHIV, KPs and other vulnerable groups who report rights violations.	Gender, Category		ND	ND	5%
	5.3 Percentage of PLHIV, KPs and other vulnerable groups accessing legal services in the face of rights violations	Gender, Category		18%	33%	48%

Strategic objective	Key Performance Indicator	Disaggregation	Data source	Baseline value (2020-21)	Mid-term Value (2022-23)	End-term Value (2024-25)
THEMATIC AREA: SYSTEM STRENGTHENING						
Sub Goal 4: To strengthen a multi-sectoral HIV and AIDS service delivery system that ensures sustainable access to efficient and safe services to all the targeted population						
Outcome 1: Governance and leadership of the multi-sectoral HIV and AIDS response at all levels strengthened.						
	1.1 Percentage of districts with functional District AIDS Committees (DACs).		Data call	50%	80%	100%
	1.2 Percentage of districts with functional PLHIV Networks		Data call	95%	91%	100%
	1.3 Percentage of Self Coordinating Entities (SCEs) with functional HIV and AIDS committees			80%	92%	100%
	1.4 Percentage of large workplaces (more than 50 employees) with HIV and AIDS workplace programs			ND	ND	100%
	1.5 Percentage of sectors mainstreaming HIV and AIDS			ND	72%	100%
Outcome 2. Availability of adequate human resources for delivery of quality HIV and AIDS services ensured						
	2.1 Percentage of health facilities with required staffing levels		Annual health sector performance report, 2020/21	ND	74%	70%
Outcome 3. Stock outs of medicines and supplies in health facilities reduced.						
	3.1 Percentage of health facilities that had no stock out of one or more required essential medicines and health supplies within past 12 months.		Annual health sector performance report, 2020/21	ND	82%	90%
Outcome 4. Health infrastructure responsive to HIV service needs						

Strategic objective	Key Performance Indicator	Disaggregation	Data source	Baseline value (2020-21)	Mid-term Value (2022-23)	End-term Value (2024-25)
	4.1 Percentage of HC IIIs accredited and offering HTS, ART and EMTCT		DHIS2	100%	100%	100%
	4.2 Percentage of testing facilities (laboratories) that are accredited according to national or international standards.			100%	100%	100%
Outcome 5. Resources for HIV and AIDS mobilized, and management streamlined for efficient utilization and accountability.						
	5.1 Percentage of the HIV and AIDS funding from GoU			12.0%	13.8%	40.0%
	5.2 Percentage of MDAs and LGs with up-date costed strategic plans and budgets.			ND	90%	100%
	5.3 Percentage of HIV and AIDS budget funded by the private sector.			10%	ND	30%

Strategic objective	Key Performance Indicator	Disaggregation	Data source	Baseline value (2020-21)	Mid-term Value (2022-23)	End-term Value (2024-25)
THEMATIC AREA: MONITORING, EVALUATION AND RESEARCH						
Sub Goal 5: To strengthen the National HIV and AIDS strategic information management system for improved effectiveness and efficiency						
Outcome 1: Strong national mechanism for generating comprehensive, quality and timely HIV and AIDS information for M&E strengthened.						
	1.1 Percentage of sectors and districts with up-to-date costed HIV and AIDS M&E work plans	Sectors		100%	100%	100%
		Districts		80%	74%	100%
	1.2 Percentage of sectors submitting quality data that meets standards.			25%	81%	100%
	1.3 Percentage of key sectors (MDAs) submitting timely and complete reports to UAC			ND	100%	100%
	1.4 Percentage of Self Coordinating Entities (SCEs) submitting quality reports			ND	92%	100%
	1.5 Percentage of sectors mainstreaming HIV and AIDS			ND	74%	100%
Outcome 2. Information sharing and utilization among producers and users of HIV and AIDS data/ information at all levels improved						
	2.1 Percentage of implementers utilizing program generated HIV and AIDS data			ND	100%	100%
	2.2 Percentage of the national research agenda items covered through operational research in each thematic area of the NSP.			ND	73%	100%
	2.3 Percentage of stakeholders satisfied with NADIC.			ND	73%	80%

8.0 SELECTED DISTRICTS FOR THE NSP ASSESSMENT

MTR REGION	UPHIA REGIONS	HIV Prev	DISTRICTS SELECTED	HIV Prev (15-19) (UPHIA 2020)	CHARACTERISTICS			
					Location	Ranking in League Table	HIV Partners	ART Facilities
Region 1	West-Nile	2.8%	Adjumani	2.8	Rural	70	IDI	18
	Mid North	7.6%	Gulu	12.4	Urban	10	TASO LPHS	18
Region 2	North East (Karamoja)	2.1%	Napak	1.0	Rural	40	TASO	8
	North East (Teso)	4.2%	Soroti	5.2	Urban	6	TASO	23
Region 3	Mid-Eastern	4.2%	Tororo	6.0	Urban	44	BAYLOR LPHS	28
	East Central	4.5%	Namayingo	6.9	Rural	83	MJAP LPHS	14
Region 4	Mid-Western	5.5%	Kabarole	14.6	Urban	29	BAYLOR	29
	South Western	6.3%	Ibanda	7.3	Rural	71	TASO LPHS	13
Region 5	Central 1	8.1%	Lyantonde	10.1	Rural	61	RHSP	10
	Central 2	6.2%	Mityana	6.7	Urban	69	MILDMAY	27
Kampala	Kampala	6.0%	Kampala	6.0	Urban	75	IDI, KCCA-Urban	57