The Republic Of Uganda

ANNUAL JOINT AIDS REVIEW REPORT

FY 2022/23

FINAL REPORT

UGANDA AIDS COMMISSION

NOVEMBER 2023

UGANDA AIDS COMMISSION

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LIST OF ACRONYMS

ADP	AIDS Development Partner
AGYW	Adolescent girls and Young Women
ANC	Antenatal Care
ART	Antiretroviral Therapy
ATF	AIDS Trust Fund
COVID-19	Corona Virus Disease
CSO	Civil Society Organization
DHIS2	District Health Information System
EID	Early Infant Diagnosis
eMTCT	Elimination of mother-to-child transmissio
FP	Family Planning
FSW	Female Sex Workers
GBV	Gender-Based Violence
GF/GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GOU	Government of Uganda
HMIS	Health Management Information System
HRH	Human Resources for Health
HTS	HIV Testing Services
IP	Implementing Partners
JOBS	Joint UN Program of Support on AIDS
KARUNA	Karamoja United Nations HIV/AIDS Prograr
KP	Key Population
MARPs	Most at Risk Populations
MDA	Ministries Departments and Agencies
MGLSD	Ministry of Gender, Labor, and Social Development
MNCAH	Maternal, Newborn, Child and Adolescent Health
MODVA	Ministry of Defence and Veteran Affairs
MOES	Ministry of Education and Sports
MoFPED	Ministry of Finance Planning and Economic Development
MOH	Ministry of Health
MoWT	Ministry of Works and Transport
MSM	Men who have sex with men
MWE	Ministry of Water and Environment
NACWOLA	National Community of Women Living with HIV/AIDS
NADIA	National AIDS Documentation and Information Center
NAFOPHANU	National Forum of People living with HIV Network in Uganda
NASA	National AIDS Spending Assessment
NCPI	National Commitments and Policy Instrument
NNRTI	Non-Nucleoside Reverse Transcriptase Inhibitors
NPAP	National HIV and AIDS Priority Action Plan 2018/19
NSP	National HIV and AIDS Strategic Plan
NUSAF	Northern Uganda Social Action Fund
ODI	One Dollar Initiative
OPM	Office of the Prime Minister
OVC	Orphans and other Vulnerable Children
OWC	Operation Wealth Creation
PEPFAR	Presidential Emergency Plan for AIDS Relief
PFTI	Presidential Fast Track Initiative
PRIVACY	Presidential Initiative on AIDS Strategy for Youth
PLACE	Priorities for Local AIDS Control Efforts
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PP	Priority Population
PWD	Persons with Disabilities
PWID	People who Inject Drugs
RRHs	Regional Referral Hospitals
SAGE	Social Assistance Grants for Empowerment
SBCC	Social and Behavioural Change Communication
SCE	Self-Coordinating Entity
SGBV	Sexual and Gender-Based Violence
SINOVUYO	A teen parenting program
SMC	Safe Male Circumcision
SRH	Sexual and Reproductive Health
TB	Tuberculosis
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UDHS	Uganda Demographic Health Survey
UGANET	Uganda Network on Law Ethics and HIV/AIDS
UNAIDS	Joint United Nations Program on HIV/AIDS
UNASO	Uganda Network of AIDS Service Organizations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UPHIA	Uganda Population HIV Impact Assessment
UWONET	Uganda Women's Network
VL	Viral Load

FOREWORD

After forty-one years into the fight against HIV & and AIDS, the epidemic is described as mature and generalized in the general population with concentrated sub-epidemics in key and priority populations. Despite that characterization, tremendous progress has been made by Uganda in combating the epidemic and its effects with a significant reduction in new infections, HIV prevalence, and AIDS-related mortality over the last 10 years. The 2020 Uganda Population-based HIV Impact Assessment (UPHIA) estimated the HIV prevalence at 5.5% among the population aged 15 to 49 years. An estimated 1.43 million adults were living with HIV in Uganda in 2022. New HIV infections and AIDS-related mortality dropped by 40% and 64% respectively between 2010 and 2022. HIV prevalence has declined from 6.0% to 5.5% and AIDS-related mortality has declined by 70% from 56,000 in 2010 to 17,000.

This progress is attributable to the multi-sectoral response that is guided by strategic plans developed by the Uganda AIDS Commission in collaboration with key stakeholders which in turn has resulted in improved access and utilization of HIV services. The current National HIV/AIDS Strategic Plan (NSP) 2020/21–2024/25 provides the overall strategic direction for the response based on four broad thematic areas, namely HIV Prevention, Care and Treatment, Social Support, and Protection, and Systems Strengthening. It is aligned to the Third National Development Plan (NDP III) 2020/21-2024/25 and aims to address Sustainable Development Goals (SDG) 3 & 5 by addressing the key drivers of the epidemic. Despite these achievements, Uganda's HIV epidemic however remains generalized, and heterogeneous across geographical, socio-economic, and demographic population subgroups, and calls for concerted efforts to target the response to achieve the NSP targets.

This annual Joint AIDS Review (JAR) 2023, documents the progress made during the third year of implementation of the NSP 2020/21–2024/25, the seventh year of reporting on the Sustainable Development Goals (SDG), and the 6th year of the PFTI implementation. The results of this third year of the NSP implementation indicate that the country is on track to attain set targets towards ending AIDS as a public health problem by 2030. The report also documents progress in implementing the key undertakings of the JAR Aide Memoire for FY 2022/22 with action plans for FY 2023/24. The journey towards the 2030 aspirations is possible as the Country takes collective responsibility in line with this year's theme for the National HIV and AIDS Symposium 2023, "*My Responsibility Towards Ending AIDS by 2023*".

I urge all stakeholders to internalize the report and contribute to a sustainable national response that will ensure Uganda ends HIV and AIDS by 203.

For God and my country.

Dr. Eddie Mukooyo Sefuluya

CHAIRMAN, UGANDA AIDS COMMISSION

ACKNOWLEDGMENTS

This Joint AIDS Review allows us as a country to take stock and reflect on the third year of implementation of the National HIV and AIDS Strategic Plan 2020/21 – 2024/25. It is a journey that must continue as the country looks forward to achieving the NSP and the ambitious 2030 targets to end HIV and AIDS as a public health threat.

Uganda AIDS Commission conducts Joint Annual AIDS Reviews of the implementation of the National HIV and AIDS Strategic Plan (NSP) to fulfill its mandate of Strategic Information management for the response including reporting obligations. Building on last year's approach of compiling the JAR report, a consultant was identified to facilitate the process by generating a draft JAR report through a comprehensive review of very recent data and documentation, to have the draft report ready for validation during the retreat by the respective TWGs and UAC top management (TM), with meetings were scheduled with the aim of getting the report printed before convening the HIV and AIDS Symposium.

A team from key institutions including the Ministry of Health, UNAIDS, Monitoring and Evaluation Technical Support (METS), Uganda Network of AIDS Service Organisations (UNASO), the National Forum of People Living with HIV/AIDS in Uganda (NAFOPHANU) led by Uganda AIDS Commission, was convened in a retreat to review and update the draft report generated from the recent data and document review. This draft report was then validated by the respective thematic Technical Working Groups and the UAC Top management before the final report was produced.

I would therefore like to thank the consultant and writing teams and all the institutions that volunteered staff for the writing process. I acknowledge the contribution of all the members of the respective thematic Technical Working Groups for validation and technical input to the report.

On behalf of the Uganda AIDS Commission and my behalf, I also take this opportunity to thank all of you who participated in the 2023 Joint AIDS Review. I congratulate all those who are implementing the National HIV and AIDS Strategic Plan and the National Priority Action Plan (NPAP). Your efforts and actions toward implementation in the third year are appreciated. I look forward to your relentless and continuous contribution to the fight against HIV and AIDS.

Together we shall end AIDS as a public health problem by 2030.

Dr. Nelson Musoba
DIRECTOR GENERAL

EXECUTIVE SUMMARY

This report presents the progress in the third year of implementing Uganda's current NSP (2020/21 - 2024/25) and the 3rd year of reporting against the UNAIDS 95-95-95 targets for attaining by 2025. The report outlines the goals and objectives, methodology of compilation, a snapshot of the HIV and AIDS epidemic in Uganda, achievements, best practices, and implementation gaps by each thematic area, and summarizes achievements against the PFTI objectives and action points for FY 2023/24. Within each thematic area, the report highlights opportunities as well as recommendations that could be implemented to improve the national response. A consultant was engaged by UAC to support a desk review of the recent data and documents as well as interview key stakeholders to compile a report that was updated by key stakeholders in a retreat and validated by the thematic technical working groups of the Uganda AIDS Commission and then finalized by the consultant.

HIV and AIDS Situation in FY 2022/23

Based on the Epi-data country estimates for FY 2022, HIV prevalence among the adult population (15-49 years) has reduced to 5.1% by 2022 from 5.2% in 2021. HIV Incidence among adults is at 0.22% and overall, 51,516 new infections were registered in FY 2022. An estimated 1,433,337 People were Living with HIV (PLHIV) as of December 2022, of which 1,403,603 (98%) were on ART as of June 2023, and 17,337 AIDS-related deaths occurred. Overall, there has been a declining trend in the New HIV infections and AIDS-related deaths from 2019/20 baseline of 54,000 and 21,000 to 51,516 and 17,000 respectively in FY 2022/23 but has stagnated between FY 2021/22 and FY 2022/23. This calls for more efforts to reach epidemic control. Uganda achieved 90-94-94 performance against the UNAIDS 95-95-95 targets for epidemic control by 2025, with children below 14 years having the lowest values for the first (72%) and third targets (84%).

HIV Prevention

The 'Time Up' campaign was rolled out countrywide, promoting HIV prevention and ART adherence among adolescents and youth. Through the Total Market Approach (TMA), a total of 141 m Condoms were distributed in FY 2022/23. The coverage for comprehensive AGYW programs is currently in 44 high burden Districts. An estimated 468,425 AGYW were reached with Socio-economic interventions. A total of 6,860,533 individuals were tested for HIV in FY 2022/23, a 14.3% increase from 5,998,431 tested in FY 2020/21. 142,690 were diagnosed with HIV (2.0% positivity rate), and 88% were linked to ART. Regarding the Elimination of mother-to-child transmission, over 578 HCIIs were accredited to receive HIV test kits for PMTCT/EID implementation. 98% of the infected mothers received ART, 81% retained ART 12 months after initiation, and 70% received a viral load test, of which 93% were virally suppressed. 81% of the HEI received ARV prophylaxis, an increase from 2021/22, and 86% had an EID test within 2 months, with EID positivity standing at 1.4%, an improvement from 1.8% reported in 2021/22. Eighty - one (81%) of infants testing positive were linked to ART.

The use of the Dapivirine Vaginal Ring (DVR) and Long-Acting Injectable Cabotegravir (CABLA) as HIV prevention options were scaled up and the number of sites providing PrEP increased to 702 sites reaching 281,131 clients in FY 2022/23. Key Populations (KP) and Priority Populations (PP) remained an important target group for prevention interventions since HIV prevalence is high among them (between 11 and 34. The MOH instituted an adaption strategy and worked with Implementing Partners to modify

service delivery approaches following the unintended effects of the AHA, reaching over 772,755 KPs with HIV prevention services. Support to persons who inject drugs (PWID) at the medically assisted therapy (MAT) clinic at Butabika continued, reaching 171 individuals in FY 2022/23. Ten out of the 75 drop-in-centers (DICs) across the country suspended their operations following the AHA. The coverage of VMMC services improved from 43% in UPHIA 2016 to 54% in UPHIA 2020. A total of 499,350 (62%) males were circumcised against a target of 800,000, and 95% followed up within 48 hours, with no severe adverse events reported. The integration of HTS into the TB Cast Campaign was an opportunity to identify HIV cases among TB clients and link them to care. Interventions for mitigating socio-cultural barriers including dialogues on stigma and discrimination targeting religious leaders, cultural leaders, local government technical and political leaders, and PLHIV leaders continued to be implemented. However, the number of new infections remains high (52,000) largely among young unmarried females, uncircumcised males, and KPs. There is declining performance in behavioral and structural indicators with multiple sexual partnerships, suboptimal condom use at high-risk sex as well as increasing violence, all of these potentially increasing vulnerability to HIV PMTCT.

Care and Treatment

ART coverage improved to 98%, from 95% in 2021/22, attributed to improved HIV case finding, coupled with improved linkage; 'test and treat'; differentiated service delivery (DSD); and integration with AHD & NCD care, among others. Among PLHIV on ART, 97.4% received a viral load test, and of these, 94% were virally suppressed, close to the previous year, with adults over 20 years achieving the 3rd 95%. The HIV drug resistance (HIVDR) program was strengthened, decentralized to regional centers of excellence, and routinely monitors DTG resistance. Improved retention on treatment was noted as the implementation of DSD continued, with 50% of recipients of care on Fast Track Drug Refill (FTDR) at the facility, 88% on multi-month dispensing (ARV refills of 3 months plus), 14% enrolled in community models, while 110 retail pharmacies served as ARV drug distribution points. The Young People and Adolescent Support (YAPS) model, implemented in 81 districts at 615 facilities, improved case identification among adolescents and young people (AYP), linkage to ART to 95%, retention on treatment to 95%, VL coverage to 95%, and VLS to 91%. There was an improvement in HIV integration with other disease conditions. TPT coverage among PLHIV improved to 97% and completion rates 95% in 2022/23. Among patients with Advanced HIV Disease (CD4<200), 60% received a serum Crag test with 95% successfully linked to treatment, an improvement from 68% in the previous year. Cervical Cancer screening coverage reached 74% of all Women Living with HIV, with 6% screening positive, and 78% of those screening positive successfully treated. The National rollout of the HIV and Non-Communicable Diseases (NCD) integration program is ongoing, following a successful pilot in the districts of Kampala, Mukono, and Mbarara. Recency Infection surveillance scaled up to 1084 sites, electronic TB surveillance at over 500 sites. However, children and adolescents have lower ART coverage due to gaps in case finding. In addition, viral suppression is lower in this population due to challenges in adherence, retention, and drug resistance. The high coverage of eMTCT coverage of 98% and the adoption of the Global Alliance and Accelerating Progress for PMTCT and Pediatrics (GA/AP3) are aimed at reducing new infections and identifying HEI for EID.

Social Support and Protection

Several policy guidance documents and program assessments' findings aimed at addressing Human Rights, stigma, and discrimination were developed and disseminated across sectors. The stigma policy guideline was translated to cater to People with Disabilities (PWDs) and focused on sign language for the deaf and braille for the blind. The Legal Environment Assessment (LEA) was completed and disseminated at national and sub-national levels. The GOU and partners continued to implement

Socioeconomic Interventions for empowering AGYW and interventions that keep girls in school. The MoH, supported by UAC and partners, developed and rolled out an Adaptation strategy following the unintended consequences of the Anti-Homosexuality Act (AHA). Psychosocial support to PLHIVs was scaled up in the country, especially for those on ART and newly enrolled. The use of the Comedy Store, the Commanders Talk show by the Uganda Peoples Defense Forces (UPDF), the cultural institutions, the Interreligious Council of Uganda and champions and networks created by UNASO and PLHIV, the UNIFA beauty pageants, International Community of Women Living with HIC in East Africa (ICWEA) awards aimed at re-building esteem and fighting stigma among PLHIVS, the GILO young positives foundations activities and the Community dialogues for young people out of school and school debates for in schools by UNSA have been powerful channels for disseminating HIV/ADS information and enhancing the creation of friendly spaces for stigma and discrimination-free services. However, the existent punitive and restrictive clauses in some laws negatively affect service uptake for KPs and need to be reviewed. There are persistent Human rights violations, stigma, discrimination, and increasing gender-based violence (GBV) in all its categories.

Systems Strengthening

UAC revitalized its engagement with stakeholders at the national and subnational levels leading to the development and dissemination of several policy guidance documents across sectors. The National Equity Steering Committee was established and under this committee's guidance, a National Equity Plan was costed, and resources secured from the GFATM to support its implementation. Mainstreaming of HIV/AIDS into sector activities was strengthened, with several MDAs supported to develop HIV/AIDS strategic plans, establish, and functionalize HIV/AIDS committees, and allocate the 0.1% funding. Community Led Monitoring (CLM) was implemented, reaching over 300 sites. Over 700 HCIIIs were accredited to provide ART. Over 1900 health facilities have received ICT hardware to support data capture and improve connectivity. The Ministry of Public Service approved and adjusted the structure with additional staffing for Regional Referral and District Hospitals. Thirty-two (32) staff were hired to beef up the community health departments at 8 RRH, including epidemiologists, biostatisticians, QI, and IPC officers. A total of US$651 million was mobilized to fight HIV and AIDS, out of the targeted $836 million giving a funding gap of 22% ($185 million). GOU contribution including mainstreaming increased from $82.2 to $96.9 million, representing 14% of the total funds realized. However, funding for the response is inadequate and largely donor-led and strategies to sustain the response need to be urgently implemented.

Monitoring and Evaluation

The Health Management Information System (HMIS) tools were updated, harmonizing all stakeholder data needs and incorporating data requirements on KP programming. The MOH launched the Health Information and Digital Health Strategic Plan in May 2023 which is guiding digitalization in the health sector. The use of digital health tools continued to grow: As of June 2023, over 1900 health facilities were utilizing electronic medical records (EMR) for HIV care, of which 700 were implementing Point of Care data entry. ICT infrastructure was strengthened to support data capture, management, and transmission. Several data quality assessments were conducted in various program areas including PMTCT, Safe Male Circumcision, and Cervical Cancer among others. Some Research and Evaluation were conducted to inform the national response including the Modes of Transmission Study and Uganda Demographic and Health Survey providing valuable indicators on MCH, HIV, etc. The NSP Midterm Review was successfully concluded. Surveillance activities have been strengthened. HIV drug resistance surveillance, pharmacovigilance, and Case-Based surveillance scale-up are ongoing. However, data use remains weak, especially at subnational levels, data on structural and behavioral indicators is not readily

available and HMIS tools in use are outdated. The lack of unique client identification has compromised data quality due to client duplication.

Key challenges and recommendations

HIV Prevention - Ongoing HIV transmission following a declining performance in behavioral and structural indicators and sub-optimal access, uptake, and utilization of PrEP services especially among Key Populations. An estimated 200 undiagnosed cases are still at large, hampering the achievements of the HIV prevention targets. The GOU should invest in Interventions to reach at-risk population groups such as AGYW, ABYM, and KPs, as well as virally non-suppressed recipients of care to curb new infections. PMTCT cascade gaps must be closed especially re-testing in ANC, retention, and adherence to ART of mothers in care through G-ANC, peer mothers, FSG, etc., and male engagement.

HIV Care and Treatment - Significant HIV -related morbidity and mortality, and Gaps in disease integration of HIV and other disease conditions e.g., TB, AHD, and NCD. The MOH should strengthen the integration of HIV with other disease conditions, ensuring commodity availability, micro-planning and targeted HTS to find missing cases, with effective linkage and optimized ART. The DSD models should be refined to strengthen retention and adherence.

Social Support and Protection - Punitive and restrictive clauses in some laws affecting service uptake for KPs as well as persistent Human rights violations, Stigma, discrimination, and increasing gender-based violence (GBV). GoU should review and repeal the AHA punitive laws and enact protective laws to protect and promote human rights, improve service delivery, and invest more in changing social, cultural, religious, and gender norms and awareness of human rights.

Systems Strengthening – the key challenge here is inadequate Financing of the HIV response and tracking. UAC should fast-track the implementation of the Resource Mobilization Strategy and streamline and routinize the collation of HIV funding investment by the different stakeholders and partners. In addition, beyond the funding needs, strategies are needed to sustain the response.

Monitoring and Evaluation - Lack of unique client identification has compromised data quality due to client duplication, Fragmented GBV reporting across sectors, and Lack of data on social support and protection are the major concerns. Due to its importance, the MOH initiated discussions with the Presidency and discussions with other relevant sectors to resolve Unique Identification (UID) issues. Roll out the GBV database to all sectors at national and subnational levels to effectively manage GBV strategic information.

1 INTRODUCTION

1.1 BACKGROUND AND RATIONALE

The Uganda AIDS Commission (UAC) developed the National HIV and AIDS Strategic Plan (NSP) 2020/2021 – 2024/25 to guide the implementation of the multi-sectoral response and align key HIV and AIDS interventions to the key drivers of the epidemic and other key national development plans. The NSP was aligned with the third National Development Plan (NDP III) and provided the overall strategic direction for the national response under four broad thematic areas. The thematic areas include (i) Prevention, (ii) Care and Treatment, (iii) Social Support and Protection, and (iv) Systems Strengthening. To operationalize the NSP, UAC and partners developed a National Priority Action Plan (NPAP) that articulates the key activities to be implemented by stakeholders for each of the strategic actions. The NPAP spells out output results, time frame for implementation, and lead line sectors in the implementation of the strategic actions. The M&E plan for the NSP lays out a framework for tracking and evaluating the interventions. The National HIV and AIDS Strategic Plan (NSP) 2020/21-2024/25 is now in its third year of implementation.

Uganda has made great progress in combating the HIV and AIDS epidemic and its effects with a significant reduction in new infections, HIV prevalence, and AIDS-related mortality over the past 4 decades of HIV and AIDS in Uganda. The 2020 Uganda Population-based HIV Impact Assessment (UPHIA) estimated the HIV prevalence at 5.5% among the population aged 15 to 49 years with 1.43 million adults living with HIV in Uganda (Spectrum 2022). New HIV infections and AIDS-related mortality dropped by 40% and 64% respectively between 2010 and 2022 (Spectrum 2022). HIV prevalence had declined slightly from 6.0% to 5.5% and AIDS-related mortality had declined by 70% from 56,000 in 2010 to 17,000 (Uganda HIV & AIDS Fact Sheet). However, Uganda's HIV epidemic remains generalized, and heterogeneous across geographical, socio-economic, and demographic population subgroups, and calls for concerted efforts to target the response to achieve the NSP targets.

This JAR report, therefore, allows the country to assess the state of National response and progress in achieving HIV-set targets during the 3rd year of the NSP. Furthermore, the review will contribute to a better understanding of the global response to the HIV pandemic, including progress toward the global targets set in the 2011 Political Declaration and the SDGs. The report includes progress on implementation of the undertakings for JAR 2022 and the undertakings for 2023.

1.2 GOAL AND OBJECTIVES

Goal: To review and account for HIV and AIDS performance based on the National HIV and AIDS Strategic Plan targets for FY 2022/23 that form a basis for planning and monitoring of the national multi-sectoral response in the subsequent and key undertakings for the year 2023/24.

Specific Objectives

I. To review performance during the 3rd year of the current NSP 2020/21–2024/25.
II. To review and provide highlights on the progress of the Presidential Fast Track Initiative on Ending AIDS as a Public Health threat in Uganda by 2030 launched in June 2017.
III. To disseminate progress on the implementation of undertakings of the Aide Memoire, 2022.
IV. Agree on undertakings for implementation in FY 2023/24.

1.3 METHODOLOGY

The JAR 2023 report was generated using a multi-pronged consultative and participatory process. This included a comprehensive desk review, secondary data analysis, National Key Informant Interviews (KII), stakeholders retreat to update the draft report, and TWG meetings to review and update the report.

Document Review: Several documents were supported by the Consultants. These included national and international policies and reports (Presidential Fast Track Initiative (PFTI), Global AIDS Monitoring (GAM), Modes of Transmission (MOT), Key Populations and Size Estimates (KPSE), National AIDS Spending Assessment (NASA), NSP midterm review, annual reports, etc.), HIV & AIDS and key population estimates, plans, and program reports related to HIV and AIDS programming in the country and globally.

Secondary data analysis: Data from different databases across various Ministries Departments and Agencies (MDAs) including the Ministry of Health (MoH)'s Health Management Information System (HMIS), PEPFAR's Data for Accountability and Transparency Information (DATIM) and HIBRID, and dashboards for gender-based violence (GBV), early infant diagnosis (EID), and HIV Viral Load.

Stakeholder consultations meetings: A stakeholder's consultative retreat and TWGs were held with personnel from government MDAs, AIDS Development Partners (ADPs,) civil society organizations (CSOs), HIV and AIDS focal persons from selected districts, and implementing partners (IPs), civil society, and beneficiaries of services including PLHIV, youth, key, and priority populations.

Meetings with TWGs, SCEs, and MDAs: These meetings helped validate the information derived from the document reviews, served as a forum for dialogue on the Global AIDS Strategy targets, and guided further consultations. The respective TWG, which had representation from policymakers and implementers, reviewed and validated the respective thematic reports. The report was then presented to the UAC Top Management and the Board for approval, in preparation for its dissemination at the JAR meeting.

1.4 HIV AND AIDS SITUATION IN FY 2022/2023

HIV prevalence among the adult population (15-49 years) has reduced to 5.1% by 2022 from 5.2% in 2021. Prevalence is higher among females 6.5% as compared to 3.6% among men. AGYW bears the burden of new HIV infections, contributing 36% of new infections in adults 15-49 years[1]**.** The AGYW (15-24 years) have the highest HIV incidence rate in Uganda at 0.62%[2], while among adults was 0.22%. Data from UPHIA 2020/2021 indicates that HIV testing for young PLHIV 15-24 is only at 63.7% for females and 47.3% for males, ART coverage for those that know their HIV status is only 60.7% for females and 47.3% for males and viral load suppression for those on treatment is at 52.3% for females and 37.6% for males. The report also revealed that about a third of women aged 15-24 years had experienced recent intimate partner violence, about a fifth of annual births were due to teenage pregnancies, less than half had their demand for family planning satisfied by modern methods, and a third

Table 1: Summary of the 2022 HIV Spectrum Estimates

Female	6.5
Male	3.6
Incidence per 1000	
Total	1.21
Male	0.88
Female	1.55
PLHIV	
Total	1,433,337
Male	535,752
Female	897,585
Annual AIDS related deaths	
Total	17,466
Male	8,763
Female	8,703

Source: (SPECTRUM) Country estimates, 2022

[1] UAC - Uganda HIV Modes of Transmission HIV Prevention Synthesis, May 2023
[2] UPHIA 2020/21

had been married before age 18 years. This underscores and paints a picture of increased vulnerabilities to HIV acquisition among adolescent girls and young women. While it is encouraging that the uptake of PrEP among adolescents and young people increased between 2020-2021 dismally, the number of those accessing PrEP services remains low. This calls for more efforts in improving the HIV testing and treatment cascade among AGYW aged 15-24 years.

An estimated 1,433,337 People were Living With HIV (PLHIV) as of December 2022, of which 1,403,603 or 98% were on ART as of June 2023. ART coverage among children 0-14 at 72%, significantly below the NSP target of 95%. Overall, Uganda continues to observe a decreasing trend in new infections and AIDS-related mortality (Figure 2). Ugandan spectrum estimates for 2022 show that although new HIV infections have declined by 40% since 2010, 51,516 new infections were registered in 2022, a slight reduction from 52,000 registered in 2021 (Figure 1). AIDS-related deaths were estimated at 17,466 in 2022, a reduction of 66% from 51,000 in 2010. By the Modes of Transmission (MoT) 2022 report, heterosexual transmission among never married females was the predominant mode of HIV transmission, contributing to a third of all the new HIV transmission (n=17,037, 35.1%), followed by previously married uncircumcised men (n=9532, 19.6%), previously married female (n=5916, 12.2%), and FSW (n=5344, 11%). In total, these four population groups contribute 78% of all new HIV transmission.

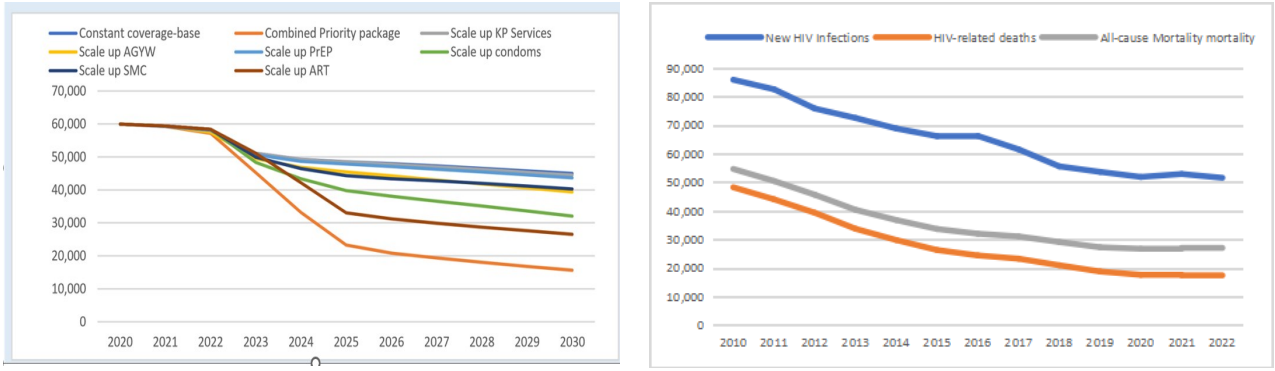


Figure 1: Trends in new HIV infections, AIDS-related and All-cause mortality 2010-2022

The population groups with the highest HIV incidence are women who inject drugs (175.1 per 1000), FSW (41.1 per 1000), and never married females (31.0 per 1000). Thus, the epidemic remains concentrated among the KPs (5.5%), with FSW at 31%, people who inject drugs (PWID) between 11% and 34%, and MSMs at 12.7%[3] (Table 2).

KP Group	Size Estimate	HIV prevalence
MSM	44,397	12.7%
FSW	179,116	31.3%
Men who inject Drugs	6,094	8%
Women who inject Drugs	1,075	24%
Prisons Pop	157,350	15%
Transgender	8,435	20%

Table 2: Contributions of KP to new HIV infections

According to the Spectrum estimates, at the regional level, Kampala, South Central, Acholi, Lango, North Central, and Ankole have the highest incidence per 1,000 population of HIV, while Karamoja, West Nile, Bugisu, Bukedi, and Busoga have the least. Thirty-one (31) out of 146 districts contributed 60% of new HIV infections. UPHIA 2020 data also reflects the regional variations of HIV prevalence although the order of the highest incidence is different (Figure 3). Whereas all regions show improvements, in HIV prevalence, the Mid North and Central South show a worsening, from 7.2% to 7.6% (Mid North) and from 8.0% to 8.1% (Central South).

[3] Doshi RH, Apodaca K, Ogwal M, Bain R, Amene E, Kiyingi H, Aluzimbi G, Musinguzi G, Serwadda D, McIntyre AF, Hladik W., 2020. Estimating the Size of Key Populations in Kampala, Uganda: 3-Source Capture-Recapture Study. *JMIR public health and surveillance*, 6(2), e19893. https://doi.org/10.2196/19893.

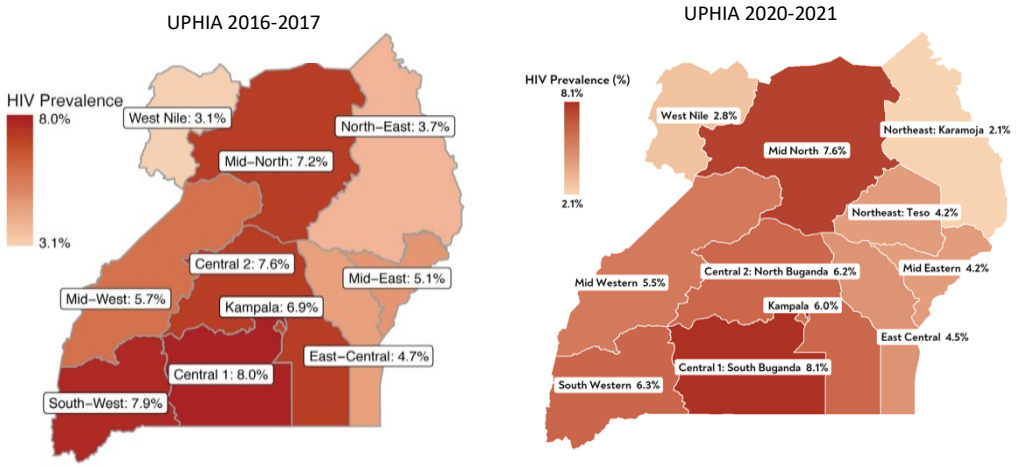


Figure 2: Regional HIV Prevalence, 2016/17 and 2020/21

1.5 Performance Against the NSP and Global Targets

According to the 2022/23 SPECTRUM country estimates and the data from the DHIS2, the country is progressing towards achieving the NSP impact targets by 2025. There was a slight reduction in the HIV incidence from 0.23 to 0.22 in FY 2021/22 and FY 2022/23, respectively. The number of new infections reduced slightly from 54,000 to 51,516 in FY 2021/22 and FY 2022/23 respectively, mainly due to a reduction in new infections among women aged 15+ years.

Table 3: Progress in the Key Impact Indicators

Impact Indicator	Baseline	Target	Achievements				
			2020/21	2021/22	2022/23		
HIV Incidence (15-49)	0.32%		**0.2%**	0.24%	0.23%	0.22%	On track (M: 0.88; F:1.55)
New Infections	54,000		**18,200**	54,000	52,000	51,516	Stagnating
Annual HIV-related Deaths	21,000		**10,800**	18,000	17,000	17,466	Stagnating (M:8,767; F:8,703)

There was a slight reduction in the new infections in children 0-14 yrs. from 6,000 in FY 2021/22 HIV to 5,900 in FY 2022/23 and in women from 31,000 to 30,000. The table in Annex 1 shows the trends in performance in the past 3 years.

Up to 90% of the estimated 1.4 million PLHIV in the country knew their HIV status in 2022, 94% were on ART; of which 94% were virally suppressed (Overall achievements of 90-94-94) against the UNAIDS 95-95-95 targets by 2025 (Figure 3).

Figure 3: Progress towards 95-95-95 targets

Source: DHIS2, Spectrum estimates 2022

Further disaggregation shows that the cascade for adults is 91-94-94, with females attaining the 2nd 95; for Children 0-14 yrs. is 72-98-84 and for Adolescents 10-19 yrs. 73-80-71. This indicates improvements in all the targets compared to the previous year 2021/22 (89-92-91).

With the implementation of innovative HIV testing approaches such as index testing, and the recently launched Wondfo HIV Testing Kit to be made in Uganda, recency testing, and APN, to find HIV-infected persons, there is hope that the first target will be achieved and so will the second target with the test and treat program. Achievements against the first target are particularly poor for children below 14 years (72%) and among men (89%) with the identification of infected children (first target) and getting those on suppressed (third target) being the biggest program bottlenecks. This could be related to poor treatment retention and adherence as well as the higher prevalence of HIV drug resistance in children and adolescents compared to adults. Regency

2 PROGRESS ON IMPLEMENTATION OF THE NSP 2020/21-2024/25

The current National HIV Strategic Plan (NSP) 2020/21–2024/25 lays out strategies and actions to implement high-impact, evidence-informed interventions, and innovations for the national response under four thematic areas namely: i) HIV Prevention; ii) Care and Treatment; iii) Social Support and Protection, and iv) Systems Strengthening, monitoring and evaluation (M&E) and research. It integrates gender and human rights across all the thematic areas to trigger catalytic action to end AIDS as a public health and socio-economic threat in the country. Below are the achievements under each thematic area.

2.1 HIV PREVENTION PROGRAMME

The HIV Prevention Sub-Goal aims to reduce the number of youth and adult HIV infections by 65% and Paediatric HIV infections by 95% by 2025 through 3 strategic objectives; i) Increase adoption of safer sexual behaviors and reduce risky behaviors among key populations (KPs), priority population (PP) groups and the general population; ii) Expand coverage and uptake of quality biomedical priority HIV interventions to optimal levels; and iii) Address underlying sociocultural, gender and other structural factors that drive the HIV epidemic. As part of the Presidential Fast Track Initiative (PFTI), key HIV prevention focus areas include; accelerating steps to decrease the spread of new HIV infections, particularly among adolescent girls and young women (AGYW); consolidating progress on elimination of Mother-To-Child Transmission of HIV eMTCT), expanding coverage and uptake of services along the four eMTCT prongs; and accelerating implementation of the 1st 95 ensuring all PLHIV are diagnosed. Overall, the behavioral indicators are either stagnating or worsening, with some progress being made on the biomedical HIV prevention interventions and declining performance in all the indicators mitigating underlying socio-cultural, gender, and other factors that drive the HIV epidemic. The Table in Annex 3 details the progress made in the HIV prevention outcomes.

2.1.1 Key Achievements

Socio-Behavioral Change Communication (SBCC) Campaigns. The time-up campaign, focused on encouraging adolescents and youth to embrace the HV prevention interventions and adherence to ART was rolled out in the entire country through the intervention's regional implementing mechanisms, with technical support from SBCA. The National HIV and AIDS Communication Strategy launched by UAC in FY 2021/22, guided the social behavior change communication (SBCC) component of the response. Other SBCC activities through which HIV prevention messages were disseminated included annual HIV and AIDS events such as World AIDS Day, the Candle Light Memorial, and the Scientific Conference that incorporated the JAR 20210/22 dissemination and the Philly Lutaaya memorial lecture.

Condom Programming: A 3- year strategic initiative on condom stewardship was launched, aimed to catalyze improvements in condom programming. Through the Total Market Approach (TMA), a total of 141.8 million male condoms and 144,401 female condoms were distributed in FY 2022/23. This was a decrease of 22% of male condoms distributed compared to 181,574,979 and thirty times the number of female condoms distributed in FY 2020/21 (Figure 4).

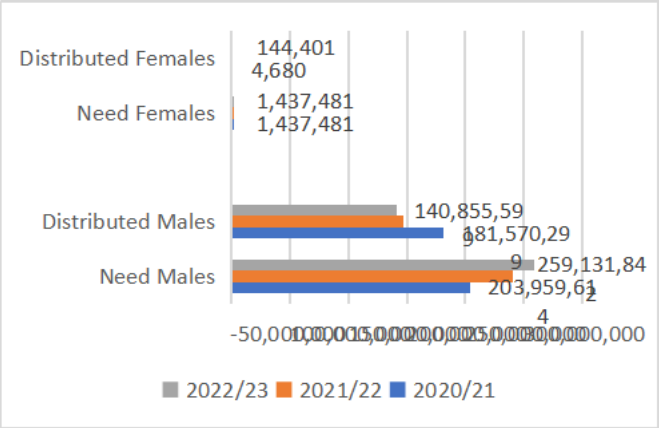


Figure 4: A summary of Condoms Distributed in FY 2022/23 as per TMA recommendations

However, the number of male condoms distributed is 36% less than the condom need of 328,812,624 and 90% less than the female condoms needed in FY 2022/23. Up to 48% of the condoms were distributed through the public sector (free-to-user condoms) and 35.6% through social marketing in FY 2022/23. The TMA through the Alternative Distribution Mechanism (JMS) engaged the CSOs in the last-mile distribution of condoms. The closure Social Marketing Program in 2018-2019 implemented by Uganda Health Marketing Group (UHMG), greatly affected condom programming due to a lack of national-level condom demand creation and promotional activities. The gap between the free-to-user condom and the cost recovery condom has remained high and not affordable by the targeted populations.

AGYW Programming–Continued focus on empowering AGYW economically, promoting safer sexual behaviors, keeping girls in school, and providing psycho-social support was sustained. PEPFAR increased coverage of its programs from 23 high-burden districts in FY 2020/21 to 24 in FY 2022/23. The Global Fund (GF) through TASO maintained the comprehensive AGYW package programming in 20 districts between FY 2020/21 and FY 2022/23 - Table 4. PEPFAR is expected to scale up to one more district and one city, while GF through TASO is adding 4 more districts in FY 2023/24. A total of 543,990 AGYW were reached with any HIV prevention package in FY 2022/23.

Table 4: District Coverage of the AGYW Programming by the Respective Entities

	Number of districts		
Entity	**2020/21**	**2021/22**	**2022/23**
PEPFAR	23	24	24
GF/TASO	20	20	20
MOES	12	20	67
MGLSD	0	112	136
UNFPA	34	34	34
UNWomen	0	0	40
UNICEF	0	1	1

The Education Sector plays a multi-sectoral role in School Health, SRH/HIV, and GBV through promoting effective health behavior change communication at all levels by providing age-appropriate, religiously, and culturally acceptable HIV prevention messages, especially about the National Sexuality Education Framework. The MOES scaled up menstrual hygiene life skills from 20 districts in FY 2021/22 to 67 districts in FY 2020/23, reaching 260,810 girls, compared to 8,001 reached in FY 2021/22. A total of 36,000 learners, peer educators, and club patrons were reached with School Health HIV and AIDS Prevention messages in 20 targeted districts in FY 2022/23, through school-based sensitization workshops led by head teachers, Senior women, and Senior men teachers. The Education Plus initiative launched in June 2022, positioned the completion of secondary education as the strategic entry point for the dissemination of messages and life skills empowering AGYW and Adolescent boys and young men (ABYM). The MOES integrated Health/HIV into the lower secondary school (S1-S4) curriculum and the process is ongoing to integrate Health/HIV into the upper secondary curriculum (S5-S6). There was a

small but progressive increase in the number of AGYW reached by the various HIV biomedical prevention interventions as seen in Figure 5.

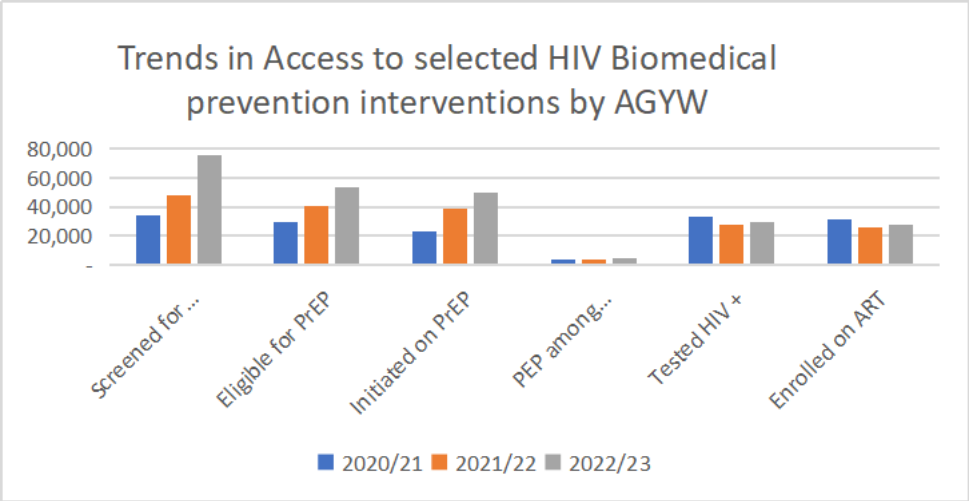
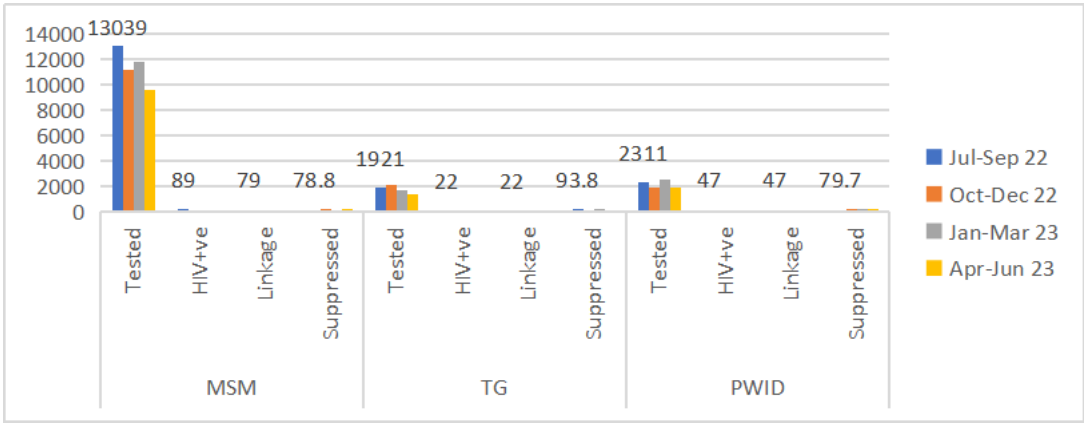


Figure 5: Access to Selected HIV prevention services by AGYW between 2020/21 and 2022/23

The catalytic role of the First Lady continues to add value to the education, health, and social sectors and the empowerment of women and girls. Regional Youth summits by OAFLAD as part of the teenage pregnancy campaigns with the First Lady created awareness of the effects of teenage pregnancy, HIV, and AIDS among AGYWs reaching leaders of 2,500 Adolescent girls and boys who were expected to cascade the intervention to others. The Kabaka's birthday runs held in April every year, dedicated to creating awareness about HIV among the kingdom subjects, was a major sensitization campaign about HIV in 2023. The six regional consultative meetings with the faith-based networks (theological scholars and education experts) by the Inter-Religious Council of Uganda (IRCU) on the National Education framework (2018) successfully generated consensus and advocated for the review of the Ministry of Education's sex education framework. The number of AGYW reached with the various social economic interventions by the various partners over the last three years are detailed under the social support and protection thematic area.

Key Population (KP) and Priority Population (PP) programming- Following the anti-homosexuality act in May 2023, there was a transient decline in the number of KPs reached with HIV services, especially for the MSM and transgender communities (Figure 6).

Figure 6: Decline in number of MSM and TG communities accessing HIV prevention services following AHA.



Source: MOH- ACP KP Annual Report 2022

The MOH, supported by UAC and partners, instituted an adaption strategy and worked with Implementing Partners to modify service delivery approaches. Despite the setback, over 772,755 KPs screened, of which 726,534 (94%) were tested for HIV during the review period, achieving an HTS coverage of 97% among FSW, an increase from 86% in 2021/22, thus surpassing the NSP targets. Among the 11,324 that tested HIV positive, 11,071 (98%) were linked to ART. The overall positivity rate among the KP was 1.96%. As of FY 2022/23, a total of 91,811, KPs were in care, increasing treatment coverage from 419,434 to 469,107 KPs & PPs in care in FY 2021/22 and FY 2022/23 respectively, an 11% increase, with viral suppression at 89%. Ten out of the initially active 75 drop-in-centers (DICs) across the country suspended their operations following the AHA. The HIV and AIDS service cascade for the KP and PP is summarized in Figure 7.

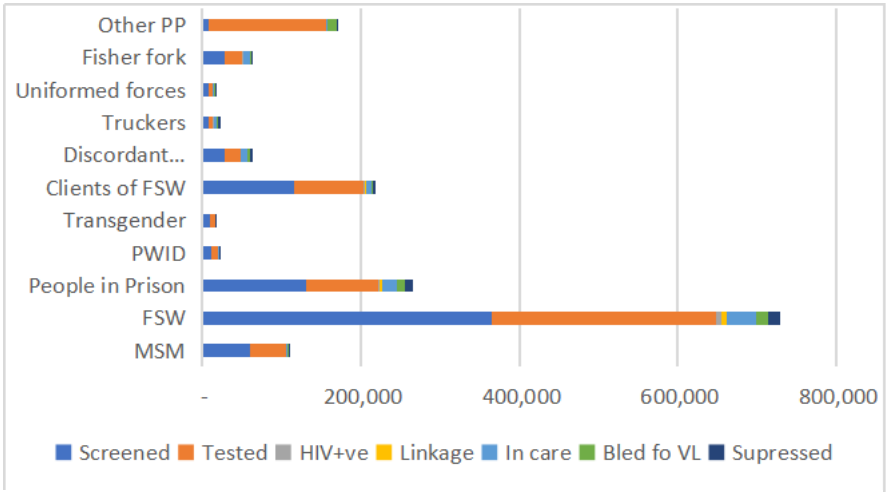


Figure 7: HIV prevention Cascade among KP and PP that received care in FY 2022/23

Support to persons who inject drugs (PWID) at the medically assisted therapy (MAT) clinic at Butabika continued. In the period under review, the MAT clinic received 171 clients from the community, and upon assessment, 84 individuals (M-67, F-17) were found to be eligible and enrolled. 92 clients were linked to other rehabilitation services. 482 clients have ever been enrolled for MAT over the past 3 years. Of those, 239 are still in care, 137 relapsed, 56 self-discharged, 36 underwent client-initiated MAT cessation, 6 died, 4 traveled, 3 opted for inpatient rehabilitation services and 1 was imprisoned. All clients who underwent self-discharge and client-initiated cessation are currently doing well and receiving psychosocial services and other preventive services from the MAT clinic. No death was related to either methadone or buprenorphine (Figure 8)

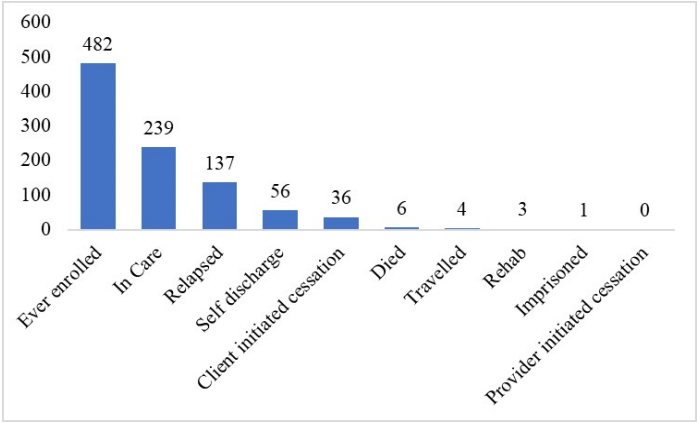


Figure 8: Enrolment at the MAT Clinic in Butabika

HIV Testing Services- There was a 14.3 increase in number of individuals tested in the general population from 5,998,431 in FY 2020/21 to 6,860,533 in FY 2022/23 (Figure 9). An increase from 37% to 76.1% in males and from 48% to 83.5% in females. Of those tested in FY2022/23, a total of 142,690 were diagnosed with HIV (2.1 positivity rate), compared to 2.5% in FY 2020/21. 88% were linked to ART in FY 2022/23. As of June 2023, an estimated 90% of all HIV-infected (1st 95) were aware of their status, lower among children (72%) than adults (91%). Recent infection surveillance was expanded to 1084 facilities, serving 73,810 individuals in FY 2022/23. Young people 15-24 years recorded the highest proportion of recent infections. A public health strategy has been finalized to guide interventions at identified hot spots with high HIV transmission.

There is a high demand for HIV. A total of 6.8 million HIV self-test kits were distributed in FY 2022/23, an increase from 6.3 million distributed in FY 2020.

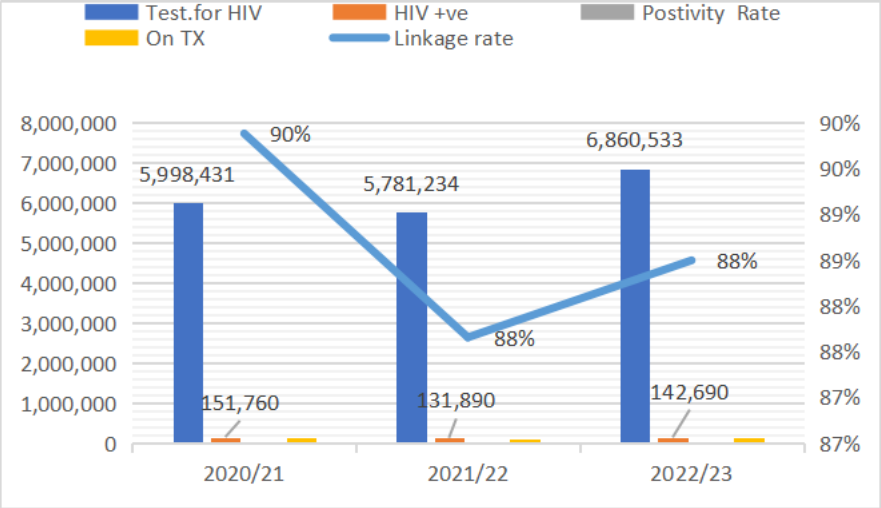


Figure 9: HTS Cascade in the past 3 years

Elimination of Mother-to-Child Transmission (eMTCT): The Global Alliance and Accelerating Progress for PMTCT and Pediatrics (GA/AP3) program, aimed to reduce new infections among children, was launched. Over 578 HCIIs were accredited to receive HIV test kits for PMTCT/EID implementation. The table in Annex 5 summarises the facilities implementing eMTCT services by level. It is important to note that most HC IIs are not able to offer ART on their own, but they are either satellite clinics, CDDP, or get ART from a higher level. A total of 1,919,923 women attended ANC in FY 2022/23. 1,733,723 (90%) were tested for HIV (AHSPR 2023). 98% of the infected mothers received ART, 81% retained ART 12 months after initiation, and 70% received a viral load test, of which 93% were virally suppressed. Of the HIV-exposed infants (HEI), 81% received ARV prophylaxis, an increase from FY 2021/22, and 86% had an EID test within 2 months, with EID positivity standing at 1.4%, an improvement from 1.8% reported in 2021/22, among the 80% that had an outcome. Eighty -one (81%) of infants testing positive were linked to ART. The expansion of the facilities providing PMTCT services has resulted in improved performance of screening for Syphilis and Hepatitis B in pregnancy as shown in Figure 10. Nearly nine in every ten (89%) pregnant women were tested for syphilis for the first time during this pregnancy, and 82% of those identified syphilis positives were initiated on treatment.

Hepatitis B programming within the EMTCT program is challenged by a shortage of test kits and limited knowledge and skills for Hepatitis B management among the staff in the MNH setting. Training, information sharing, and mentorships are ongoing. The program rolled out the infant and maternal audit tool, the CQI project on maternal HIV re-testing GANC/PNC scaled-up point of care, and community EID identification and testing. HIV re-testing is a tracer indicator for quality of care. Figure 10 below shows the maternal and PMTCT cascade for the last three years of the NSP.

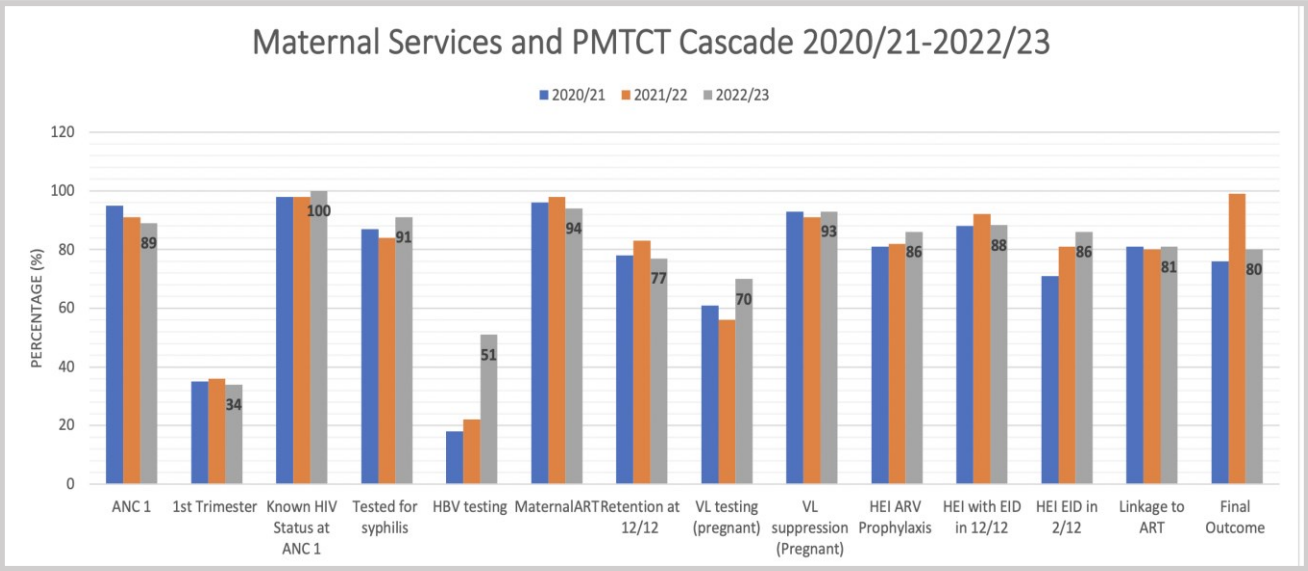


Figure 10: Maternal Services and PMTCT Cascade 2021-2023

Pre-Exposure Prophylaxis (PrEP): The use of the Dapivirine Vaginal Ring (DVR) and Long-Acting Injectable Cabotegravir (CABLA) as HIV prevention options were scaled up. The number of sites providing PrEP in the year under review increased to 702 sites reaching 288,973 clients (Figure 11), the majority being sex workers 127,280 (44%), and Clients of sex workers 45,562 (16%), AGYW 25,337 (8%), and MSM 14,642 (5%). Among the 288,973 clients screened for PrEP, 208,708 (72%) were eligible, 179,868 (62%) initiated PrEP, and 25 (0.01%) seroconverted. The combination of high HIV prevalence, high-risk sexual practices, with suboptimal access to comprehensive HIV services calls for more innovative approaches to reach these populations with comprehensive HIV prevention, care, and treatment services.

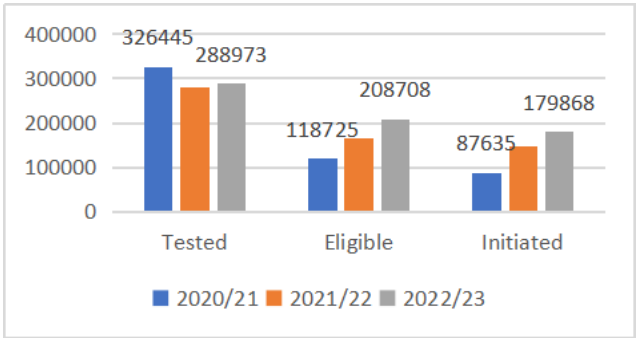
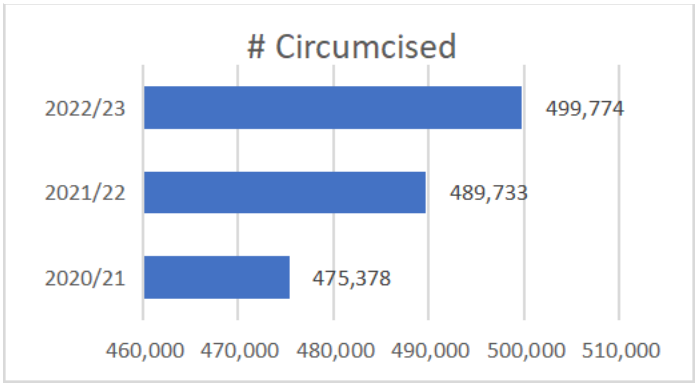


Figure 11: PrEP Cascade in the past 3 years

Safe Male Circumcision Services–Up to 6.4 million eligible males have been circumcised in Uganda since 2010. The coverage has improved from 43% in 2016, with only the Mid-Eastern region registering circumcision rates of 68.1% to 54% in 2020 (UPHIA). Five regions of Mid-Eastern, Mid-western, West Nile, and Kampala registered circumcision rates above 60%. Over the last three years of the NSP, the SMC coverage improved from 489,733 in FY 2021/22 to 499,774 individuals in FY 2022/23, against the target of 800,000 (Figure 12). PEPFAR contributed over 98% of the national output. In FY 2022/23, 95% of the Clients circumcised were followed up within 48 hours, 94% within 72 hours, 71% within 14 days, and 4% after days, no adverse events were reported in FY 2022/23 among those followed up. The SMC cascade for FY 2022/23 is

Figure 12: SMC Coverage between 2020/21 and 2022/23



Source: DHIS2 data June 2023

summarized in Figure 13 below. Lastly, over 80% of MCs were in the 15–29-year age category (Figure 14).

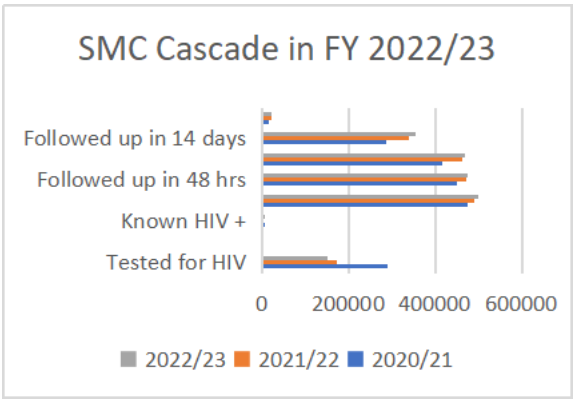


Figure 13: Snapshot of the SMC cascade for FY 2022/23

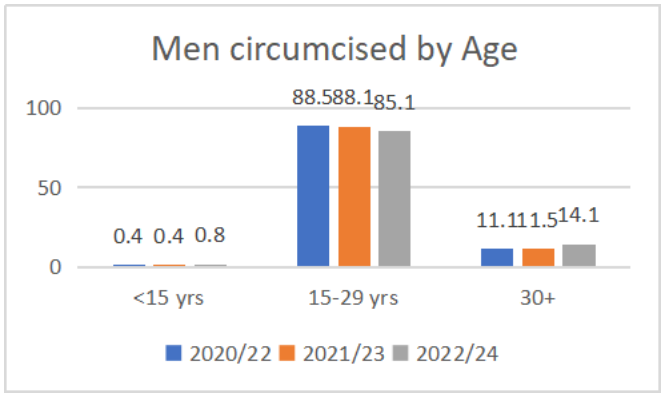


Figure 14: Clients circumcised over the 3 years of the NSP by age

2.1.2 Best Practices and Lessons Learned Under HIV Prevention

Condom Programming: The last mile distribution mechanism by the National Alternative Distribution Warehouse, intensive coordination through a WhatsApp group of the CBOs, district condom Focal persons, Ministries, Departments, and Agencies (MDA), sustained condom ordering and distribution to community hotspots.

AGYW Programming scale up: The Education Plus initiative and integration of Health/HIV into the new lower and upper secondary curriculum by the MOES is enabling the MOES to reach more AGYW. Expansion of districts being reached by the comprehensive programming by PEPFAR is reaching more vulnerable girls.

Key Population (KP) programming: The Integration of KP indicators into HMIS and scale-up of new Dapivirine Vaginal Ring (DVR) and Long-Acting Injectable Cabotegravir (CABLA) as prevention options are strengthening KP&PP programming. The engagement of Faith-Based Organizations and the expanded peer outreach Approach (EPOA) have improved the enabling environment and increased access to and utilization of HIV services among key and priority populations during the period under review.

***Optimizing HIV Testing*:** Optimization of HTS has improved case identification and performance on the 1st 95. The integration of HTS into the TB Cast Campaign has improved the identification of HIV cases among TB clients and linked them to care.

Elimination of Mother To Child HIV Transmission (eMTCT): The re-invigoration of the eMTCT program through the Global Alliance and the Accelerating Progress (GA/AP3) has led to an increased number of women and HEI accessing the PMTCT/EID services at high volume HC IIs.

PrEP scale-up and new technologies: The recency surveillance program was scaled up to 1084 sites and a public health response strategy was developed. Recency helps define hotspots of recent HIV transmission to guide the public health response through focused counseling, prevention, and testing programs, that will identify PLHIV and link them to care. The latest recent report shows that young boys bear the burden of new HIV infections compared to young girls.

2.1.3 Implementation Gaps and Areas of Underperformance

Declining performance in behavioral indicators: evidenced by low condom use at high-risk sex; increasing number of sexual partners; and decline in knowledge about HIV and its prevention. Consistent condom use especially at high-risk sex remains at less than 50%. Condom use among MSM is very low compared to other Key Populations (KPs) and Priority Populations (PPs). Condom use among adolescent males declined from 946,892 condoms in FY 2020/21 to 779,081 condoms in FY 2022/23, while among adolescent females, it declined from 23,090 to 20,266 over the same period. The behavioral indicators are either stagnating or worsening. This is partly attributed to gaps in communication and messaging around HIV, especially among young people. The country is not taking advantage of the many TV and radio stations, and social media channels that reach the young generations to convey tailored messages to them. In addition, behavioral disinhibition, where the knowledge about what is right is high but people still choose to do what is wrong seems to have set in.

During the period under review, HE the President also noted that the technical teams were not communicating appropriately about the dangers of HIV. The Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY) is no longer active and the Sexuality Education framework is not being implemented to fidelity. The school talking compounds are declining and have focused more on Menstrual hygiene than HIV. There is no condom sensitization and demonstration taking place in higher institutions of learning, affecting consistent and correct use of condoms among this sexually active group. This is further worsened by limited access to condoms in places where sexual activity takes place and the brands of condoms distributed by GOU are not appealing to the targeted audience. The condom dispensers are empty most of the time and refilling is slow. There are no dedicated interventions implemented in the country for PWID apart from isolated GF support to UHRN in Kampala. From the 2022 MOTS, 35% of new infections occur among never-married women–mostly young women. There is less focus on addressing the behavioral and structural issues that are fueling the HIV epidemic. The social, behavioral, and biomedical scientists are not working together to complement each other and the few partners focusing on this area are not covering the whole country. This has led to the declining performance of these indicators.

Declining performance in structural indicators: with persistent sexual and gender-based violence, stigma, and discrimination as well as human rights abuses. Sexual violence rates remain high, 11% of women 15-49 years experienced sexual violence in the preceding 12 months (UDHS 2022), still higher than the NSP target of 5%. The gains made in KP programming are at risk of being reversed by the AHA, by fostering further stigma, discrimination, and violence against KPs thereby reducing service utilization. Due to resource constraints, priority populations such as AGYW are not adequately reached with an effective and comprehensive package of HIV prevention services and yet 27% of new infections are contributed by this population. Only 44/145 districts received comprehensive services support through support from PEPFAR and GFATM.

***eMTCT*:** The new HIV infections due to MTCT have stagnated at more than 5%, undermining the achievement of the NSP prevention goal. Up to 47% of new infections resulted from women who dropped out of ART during pregnancy, and 37% resulted from women newly infected during

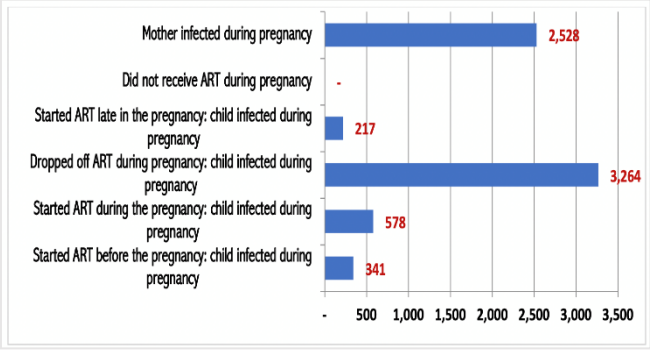


Figure 15: Breakthrough Vertical Infections During Pregnancy and Breast Feeding (Spectrum 2022)

pregnancy (Figure 15). Re-testing during pregnancy and breastfeeding is lagging, only 31% of the HIV-negative mothers get re-tested during pregnancy or childbirth. PMTCT retention of pregnant women living with HIV and their exposed infants in care is a challenge. As of June 2023, 81% were retained on ART at 12 months way below the NSP target of 90%. The retention challenge is especially critical for young mothers 15-24% of whom contribute 43% of new HIV positives in the PMTCT setting (PMTCT 2019 Evaluation). The G-ANC model coverage is still limited–reaching 245 facilities in 86 districts. Family planning use among HIV-positive women (38.4%) is still far below the NSP target of 70%. The unmet need for family planning stands at 22%. There is a need to expand G-ANC improve retention and bridge the gaps that lead to breakthrough infections.

***Sub-optimal access, uptake, and utilization of PrEP services*:** PrEP is only provided at selected facilities. Uptake is low due to non-integration into routine health services, with several losses/missed opportunities during screening, linkage, and refills. Continuity is hampered by challenges in access to refills as well as low-risk perception and ongoing stigma.

Undiagnosed HIV: By December 2022, over 200,000 individuals (113,457 (56%) of females and 88,886 (44%) of males) were undiagnosed for HIV. The bulk of the undiagnosed individual are between the ages of 24-49 years (Table 4). This is partly attributed to Stock out of test kits worsened by the failure of providers to follow the HTS optimization guidelines that aim to improve targeting for better yield. Case identification remains a challenge as yield is declining across all testing approaches.

Table 5: Undiagnosed individual by sex and age

Age Band	Females	%	Males	%
< 10 yrs.	8,567	8	8,788	10
10-19 yrs.	17,925	16	7,166	8
20-34 yrs.	54,153	48	33,788	38
35-49 yrs.	25,294	22	27,991	31
50+ yrs.	7,518	7	11,153	13
Total	113,457	56	88,886	44

The low program positivity of 2.3%, means that identification of the remaining positives requires employing a strategic mix of evidence-based and innovative community and facility-based HIV testing approaches such as testing for re-engagement in care and targeting of the high-risk populations especially in districts with the highest HIV incidence. The undiagnosed HIV Cases are attributed to a Stock of test kits worsened by the failure of providers to follow the HTS optimization guidelines.

***Sub-optimal access, uptake, and utilization of PrEP services*:** PrEP is only provided at selected facilities. Uptake is low due to non-integration into routine health services, with several losses/missed opportunities during screening, linkage, and refills. Continuity is hampered by challenges in access to refills as well as low-risk perception and ongoing stigma. There are no provisions to provide PrEP in prison due to policy and legal environment.

2.1.4 Opportunities for Improvements in FY 2023/24

The Presidential directive to the RDC is to always communicate about HIV and AIDS whenever they are on the radio, TV, and in public to strengthen communication around HIV prevention. Based on the directive, a communication guide for community leaders has been developed by UAC and signed off by the Minister to operationalize this directive.

Social corporate responsibility of the many TVs and over 275 radio stations should be harnessed to pass on tailored and standardized spot messages on HIV prevention messages to the populations on all the TVs and Radio stations at the same time, for example during peak hours.

Priority interventions generated by data from GOALS, Spectrum Modelling, and MOT – Should be implemented to fidelity as these approaches demonstrate the impact of individual and collective scale-up of interventions such as condoms, VMMC, PrEP, PMTCT, and ART on new HIV infections, AIDS-related mortality, and cost-effectiveness cost-effectiveness. These models show that scaling up a combined package of efficacious services to high coverage levels during 2023–2025 and beyond will have significant impacts on averting new HIV infections (Figure 16).

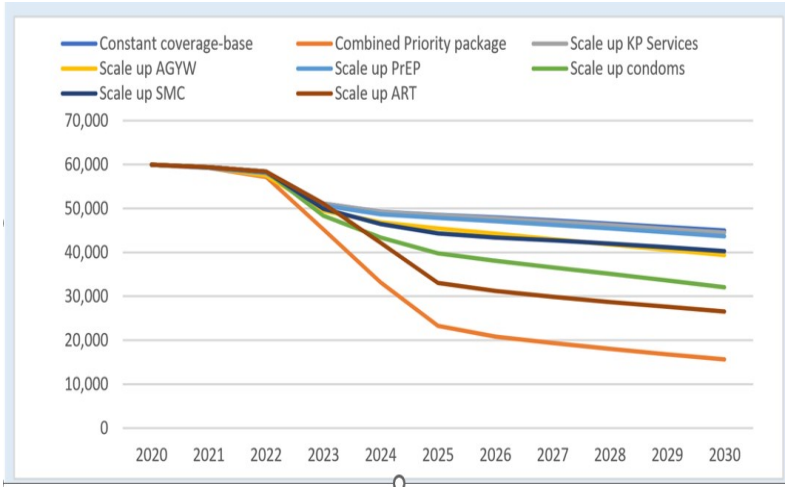


Figure 16: Trend in new HIIV infections 2020-2022 with projections for 2023-30 considering scale up of various single services and combination services

The triple Elimination plan offers an opportunity to intensify the elimination of HIV, syphilis, and hepatitis B, optimize of integration of RH/GBV/VAC services, and sustain achievements (HIV testing and ART).

The PEPFAR and GF Cycle 7 investments if used efficiently, will contribute to averting approximately 190,000 new HIV infections in Uganda by 2030, expand the coverage of critical HIV care and treatment interventions to the 95-95-95 required for epidemic control, and ultimately a reduction in HIV-related mortality by 15% by 2030 (averting 20,000 AIDS-related deaths).

2.1.5 Recommendations

The country led by UAC should prioritize HIV prevention, reach out to young people with prevention messages especially AGYW, and close the gaps in the PMTCT cascade. To mitigate the risk of HIV acquisition, the Country urgently needs to provide additional resources to improve coverage of structural prevention services for the AGYW, address Human rights, and meet the SRH needs of young women to include access to comprehensive HIV information and life skills, expanding access to PrEP and PEP, addressing gender norms, sexual violence, and sexual exploitation.

2.2 HIV Care and Treatment

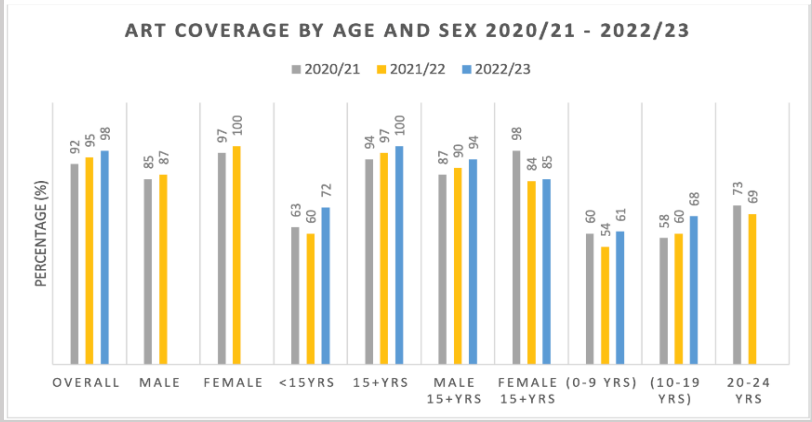
The aim of the HIV Care and Treatment Sub-Goal is to reduce AIDS-related morbidity and mortality by at least 50% by 2025 through; i) increasing the number of diagnosed HIV-positive persons who start ART to 95%; ii) increasing adherence to ART and retention in care to 95%; iii) achieving and maintaining 95% viral suppression among those on ART; and iv) strengthening integration of HIV care and treatment across the different health care programs. As part of the Presidential Fast Track Initiative (PFTI), key HIV Care and treatment focus areas include accelerating ‘test and treat' programs to meet the 95-95-95 targets. Uganda is on course to achieve the NSP and UNAIDS 95-95-95 targets of ending AIDS as a public health threat by 2030. As of June 2023, Uganda had achieved 90-94-94. Other achievements under HIV care and treatment are summarised in the Table in Annex 4 details the achievements under care and treatment.

2.2.1 Key Achievements

Site accreditation: Up to 700 health facilities were accredited to provide ART, increasing treatment access to 2009 sites nationally.

ART coverage among adults surpassed the 95% NSP target: National ART coverage improved to 97.8% from 95% in FY 2021/22. This achievement is attributed to improved case finding and linkage from HTS to care; implementation of `Test &Treat'; strengthened retention; use of simplified regimens; improved AHD care; and continuous quality improvement. Performance was better among adults (100%) than children (72%) as finding infected children is still a challenge. However, there are data quality gaps, such as double counting of clients, that are inherent in aggregate reports. (Figure 17).

Figure 17: Trends in ART coverage over the last three years



***Source**: MOH-ACP June 2023 Program Report*

Table 6: PLHIV on various ART regimens: June 2023: Source MOH-ACP June 2023 Program Report

TX_Line	Age Group	Number of Clients	%
First line	Adults (20 yrs+)	1,266,119	96.1%
	Adolescents (10-19 yrs)	57,592	
	Children (0-9 yrs)	25,524	
	Overall	**1,349,235**	
Second line	Adults (20 yrs+)	44,706	3.7%
	Adolescents (10-19 yrs)	5,732	
	Children (0-9 yrs)	1,851	
	Overall	**52,289**	
Third Line	Adults (20 yrs+)	1,450	0.1%
	Adolescents (10-19 yrs)	341	
	Children (0-9 yrs)	66	
	Overall	**1,857**	

By regimen, as of June 2023, 96.1% of PLHIV on ART were on 1st line regimens, 3.7% on the second line, and 0.1% on 3rd line (Table 5). A larger proportion of children were on 2nd and 3rd line (3.8%) compared to adults (2.0) highlighting the greater risk of treatment failure among children. This is related to challenges with adherence, suboptimal dosing, drug resistance from PMTCT exposure, as well as higher baseline viral loads.

Continued scale-up of Differentiated Service Delivery (DSD) models: DSD aims to improve service access, uptake, and continuity of care. As of June 2023, 99% of ART facilities offered at least two DSD models for HIV care, with 14% of recipients of care enrolled in community models (Community Drug Distribution Point (CDDP), Community Client Led ART Distribution (CCLAD), while 85% are enrolled in Facility-Based models, the majority on Fast Track Drug Refill (50%). About 88% of clients on ART were receiving multi-month dispensing (ARV refills of ≥3 months) with half > 6 months' refills and the other half receiving 3 to 5 months. About 110 pharmacies are linked to 90 health facilities as Community Retail Pharmacy Drug Distribution Points (CRPDDP) - Figure 18.

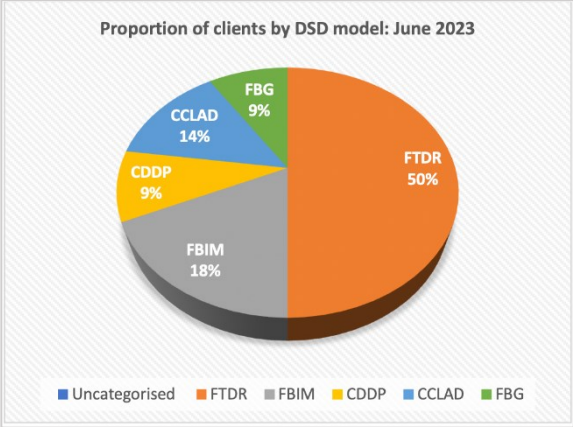


Figure 18: ART Clients by DSD Model: June 2023

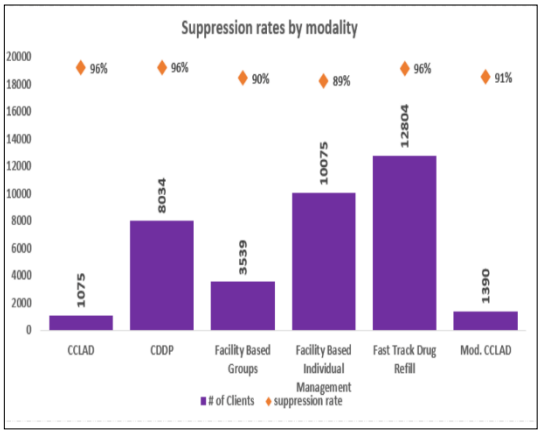


Figure 19: Viral suppression by DSD Model, Acholi Region June 2023

Within the DSD models, excellent clinical outcomes on retention and VL suppression have been reported. (Figure 20). The facility-based Individual Model (FBIM) had poorer performance as it caters to populations at risk of poor adherence and loss to follow-up, including new ART clients, virally nonsuppressed, and clients with co-morbidities, among others.

***Improved outcomes through the YAPS program*:** The Young People and Adolescent Support model has improved case identification among adolescents and young people (AYP), linkage to ART, retention on treatment to 95%, VL coverage to 95%, and VLS to 91%. YAPS is currently implemented in 81 districts at 685 facilities.

Maintained high viral load (VL) suppression: VL suppression was estimated at 94% by June 2023, a performance that is comparable to FY2021/22 at 95%. Contributing factors include a) ART regimen optimization: > 97% of adults and children are on optimal ARV regimens; b) conducting VL campaigns to improve testing uptake; c) strengthening the laboratory sample transport network and commodity supply chain for VL monitoring; d) expanding testing access through Point of Care; e) capacity building for management of VL nonsuppression; f) HIV drug resistance testing and decentralization of the 3rd Line program to the regional level; f) real-time program monitoring through 'SURGE' strategy, and addressing cascade gaps through continuous quality improvement. A CQI collaborative provided program leadership and oversight. Suppression is lowest among children (87%) and adolescents (88%) due to psychosocial support challenges, pill fatigue, and capacity gaps in managing children and adolescents. Children are also at

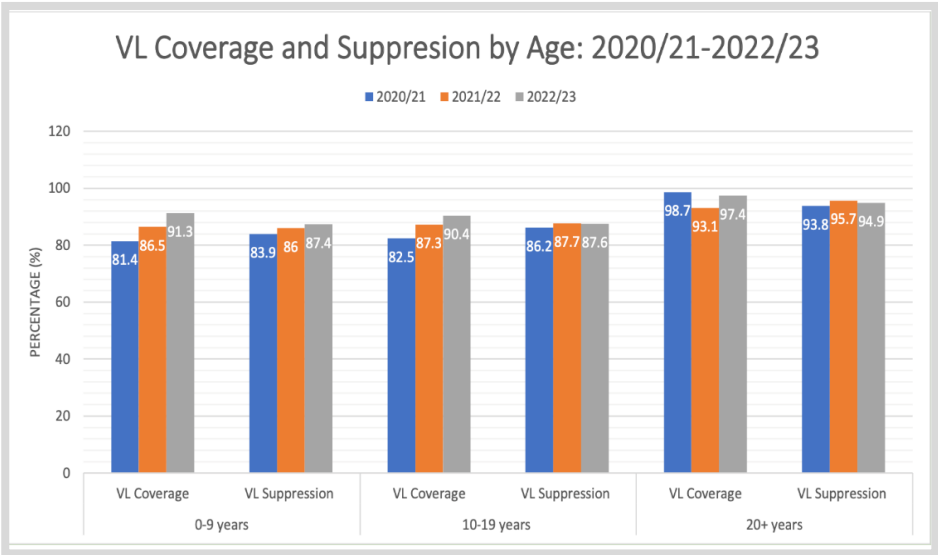


Figure 20: Viral Load Testing Coverage and Suppression by age June 2023, MOH-ACP REPORT

higher risk of HIV drug resistance due to higher baseline viral load and previous PMTCT exposure (Figure 20).

Strengthened the HIV Drug Resistance (HIVDR) Program: A governance structure was established at national, regional, district, and facility levels for oversight and coordination, in addition to strategic partnerships to support access to 3rd Line ARVs (New Horizon), and procurement of testing supplies (GF, PEPFAR). Key activities implemented include ART regimen optimization (>97%), capacity building in the management of treatment failure, resource mobilization, centralized HIVDR testing (CPHL, JCRC, UVRI), surveillance, and research. The program set up a database and dashboard to support data visualization and use at all levels. All 2009 ART sites have access to services, and the decentralized regional 3rd line committees oversee the management of the 1814 patients currently on 3rd line regimens.

Improved performance of TB and HIV collaborative outcomes: Over 98% of TB patients were tested for HIV and 94% of co-infected received ART. Conversely, 92% of PLHIV in care were screened for TB and 86% of those with a TB diagnosis initiated treatment. The good performance was a result of improved program coordination; TB Community Awareness Screening and Testing (CAST) campaigns; scale up of diagnostics such as TB-LAM and GeneXpert; peer engagement in contact investigation; as well as TB screening at facility and in the community as part of Advanced HIV Disease (AHD) care. TB Preventive Therapy (TPT) coverage among eligible PLHIV was 97% surpassing the 90% target, with 95% completing the regimen. The TPT program implemented multi-month dispensing, adopted shorter 3HP regimens (Isoniazid / Rifapentine), adopted community-based drug delivery, continuous client education, coordination of TPT & ART refills, enhanced data management at site level and CQI (MTR, TB & Leprosy NSP 2020/21-2024/25) - Figure 21.

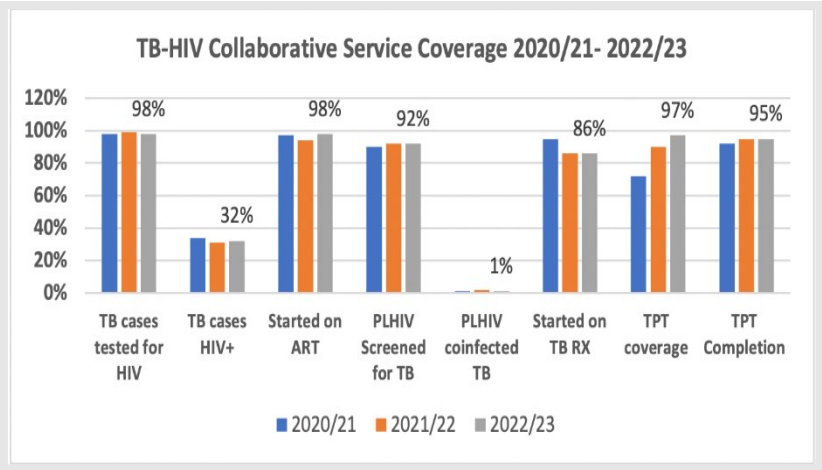


Figure 21: Trends in Coverage of TB-HIV Collaborative services

Strengthened integration and management of co-morbidities: The 2022 guidelines, launched May 2023 emphasize integration of NCDs (diabetes mellitus, hypertension) in HIV care. NCD integration was piloted in 104 facilities in the districts of Mukono, Kampala, and Mbarara. The pilot showed that 66% of facilities were screening for the targeted NCDs, and the national program rollout is ongoing. The cervical cancer screening program had since 2019 screened 74% of all women living with HIV aged 25-49, surpassing the NSP target (50%). Among the 6% who screened positive, 78% received treatment.

Supply chain Management: The availability of ARVs for the public sector for the period under review was 96% (1930/2008) of the reporting facilities. This was against the annual target of 95%. Pediatric ARVs were well stocked except NVP 10mg/ML which was stocked out of National Medical Stores due to delayed delivery. The private sector was well stocked with adult and pediatric ARVs throughout.

Strengthened pharmacovigilance: Between October and December 2022, 1,892 adverse drug reaction (ADR) reports were submitted to the National Pharmacovigilance Centre. The majority (1,423) of

reactions were from immunization, while 469 were ADR to other drugs, of which 63% were ARVs and 16% for TB medicines. Only 8% of the reported reactions were serious. During the review period, a validation study of DTG toxicity in children and adolescents was conducted in six facilities (Fort Portal, Mbarara RRH, Lira RRH, Kayunga RRH, Kawolo Hospital, and Mildmay). Findings indicated elevated blood sugar was not a concern among children on ART. However, the majority reported increased appetite with no significant weight gain, and there was no treatment discontinuation due to ADR. Another validation of clients on TPT was conducted at six sentinel sites and the preliminary findings indicated 518 patients were enrolled on 3HP at the different sites between January and July 2023. Only 260 clients had completed the three months of treatment, with reports indicating renal and urinary disorders among 43% (185) of them. Capacity building on active drug safety monitoring (DSM) and management has continued including causality assessment, signal detection, and management for better treatment outcomes as well as reporting of adverse events. Support supervision and mentorship on aDSM were conducted in 14 health regions and 140 health facilities. Key challenges included capacity gaps, under-reporting of ADR, poor report quality, inadequate laboratory screening of suspected cases, as well a lack of reporting tools.

2.2.2 Best Practices and Lessons Learned Under Care and Treatment

Stakeholder engagement and coordination improved care and treatment outcomes: The technical working groups (TWG) established at MOH, have representation from development partners, implementing partners, MOH, and the PLHIV community, and focus on priority program gaps e.g., viral load suppression, AHD care, among others. The TWGs work with MOH to establish standards, identify priority gaps, develop appropriate strategies, and harmonize work plans to minimize duplication. They conduct joint activities such as mentorship and support supervision and hold one another accountable through regular reporting and coordination meetings. This has improved program ownership, buy-in, and service uptake, with improved outcomes.

Institutionalization of Continuous Quality Improvement (CQI) improved outcomes: On a routine basis, nationally identified program gaps such as 'Low TPT initiation' are prioritized. Through CQI collaboratives, CQI structures are established at national, regional, district, and facility levels to improve performance in a specific program area.

Use of the CQI audit tool improved access to and coverage of quality care: The CQI audit tool is a facility-based tool linked to the EMR that supports health providers to focus on patient-level processes of care in alignment with national standards. The tool ensures access to comprehensive care as per the national standard of care, enables gap identification in the processes, and facilitates community linkage with the engagement of key partners such as community health providers. Ultimately, this contributes to equitable access to quality care, improving services coverage and quality.

Provision of targeted technical assistance improves program performance: Through routine data reviews, the MOH identifies implementation gaps or areas that require improvement by region, district, or facility; and engages Implementing Partners to provide the necessary capacity building to address performance gaps working through the RRH, the district, facility, and community.

Implementation of the integrated community model leverages available HR to improve the 95-95-95 cascade: Piloted in the Acholi region, this novel approach to care aims to break the chain of HIV transmission, focusing on mapping virally non-suppressed clients, who are then linked to community health workers to provide interventions at household level aimed at viral re-suppression and HIV prevention. Services provided include literacy on HIV, HTS to contacts / social networks and linkage to

care for HIV+; provision of a measurable standard HIV prevention package to status-neutral contacts and monitoring progress; provision of ongoing adherence support including Directly Observed Treatment (DOTs), TB screening and care, and integration with other services. Beneficiaries are actively linked to socioeconomic livelihood programs. Ultimately, the approach has improved HTS yield and HIV case finding, TB case finding, ART uptake, and viral suppression.

Adoption of digital technologies improves efficiency: The use of virtual platforms such as Zoom has improved client care through telemedicine e.g., for the management of HIVDR, in addition to program coordination.

***Implementation of a tailored linkage package increased ART initiation within one month to 95% from 81% baseline*:** The package is differentiated by population category and comprises same-day ART initiation; use of ARV starter packs; use of linkage facilitators, phone calls, and appointment reminders; use of locator forms and home visits to track missing clients; linkage registers and facility directories to support effective referral and linkage; supported disclosure and ongoing psychosocial support from peers and community workers.

2.2.3 Implementation Gaps and Areas of Underperformance

Significant viral nonsuppression in the community with ongoing HIV transmission: An estimated 200,000 individuals remain unidentified and therefore not virally suppressed. Within HIV care, an estimated 75,000 PLHIV on ART are not virally suppressed and are at risk of opportunistic infections, HIV transmission to sexual partners and infants in case of women, increased risk of HIV-related mortality, HIV incidence and MTCT thus reversing gains to date. To address this, targeted HTS as well as ART adherence support initiatives are critical. ***Emerging DTG resistance:*** Results from the routinely collected samples indicate that acquired HIVDR to DTG was uncommon, both among children (6.6%) and adults (3.9%) (CADRE study 2022). Among the nonsuppressed, the Majority (75%) were sensitive to DTG. However DTG resistance is emerging, and it is critical to have ongoing HIVDR surveillance, continued monitoring, and adherence support to prevent acquired HIVDR among individuals on ART.

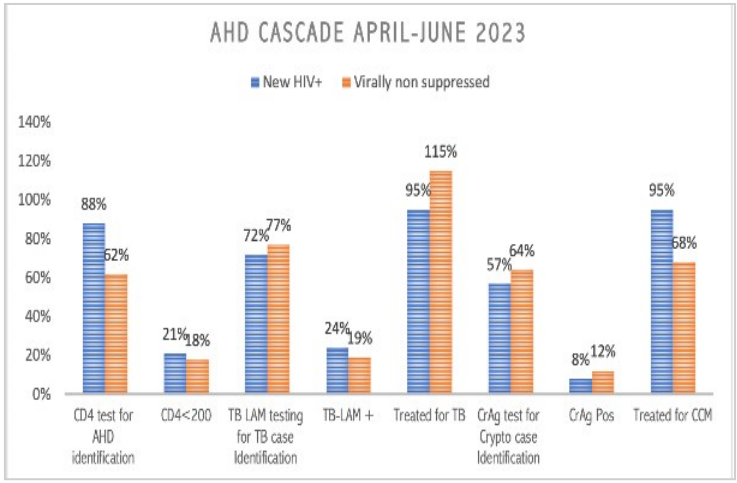


Figure 22: AHD Cascade April-June 2023

Gaps in disease integration increase morbidity and mortality: The limited availability and access to Gene X-pert and other newer diagnostic technologies at lower-level health facilities has slowed case detection among PLHIV. Screening for cryptococcal infection among patients with Advanced HIV Disease (AHD) has stagnated at 60% due to inconsistent supplies and missed opportunities. About 21% of PLHIV have AHD at HIV diagnosis, and 18% of the virally non-suppressed. Other gaps in AHD service delivery include intermittent supply of CD4+ reagents, and CD4 machine breakdowns - Figure 22.

For cervical cancer, among the 6% of women living with HIV who screened positive, 22% were not successfully linked to treatment. This was attributed to the long turnaround time for HPV test results as

a result of multiplexing and limited laboratory staff. In addition, there is a need to adopt more sensitive screening tests such as HPV testing for cancer of the cervix (CaCx) screening.

Gaps in Data Management and Use

- ***Suboptimal data use***: especially at subnational levels. This may be related to capacity gaps but also challenges in access to data that is user-friendly.
- ***Lack of data on HIV-related mortality:*** There is currently no systematic way to capture this data and yet it would be useful for programming. Case-based surveillance implementation is currently limited to selected facilities and rollout is ongoing.
- **Data quality gaps:** The lack of unique patient or client identification increases the risk of duplication of clients thus challenging performance monitoring

2.2.4 Opportunities for Improvements in FY 2023/24

- Use of the CQI audit tool to address service quality gaps and address equity in HIV care.
- Expanding and refining DSD models to effectively reach all at-risk/vulnerable populations. Client-centered approaches will improve acceptability, service uptake, adherence, and retention in care.
- Optimizing data use for program improvement and surveillance: There is a lot of data that is currently underutilized especially at subnational levels and within localities.
- Optimizing digital technologies to improve clinical outcomes: Over 1900 ART facilities have electronic medical records (EMR). However, current use is focused on program reporting. The EMR could improve patient retention (through appointment scheduling, tracking missing clients), service quality (using the CQI audit tools), and surveillance (e.g., through HIV and TB Case Based surveillance).

2.2.5 Recommendations

- ***Strengthen targeted HTS to find undiagnosed HIV-positive individuals*** and link them to effective optimized treatment.
- ***Continue to scale up and refine DSD models to ensure client-centeredness and especially reach vulnerable populations.*** Expand the YAPS program. Roll out the Integrated Community Model to provide comprehensive care and support services within the communities. This will address gaps in HTS, HIV prevention, ART retention, and adherence, especially for children, adolescents, and individuals newly initiating ART, KPs, and PPs and ultimately improve viral load suppression. Within the DSD models, institutionalize Continuous Quality improvement and re-organizing community service delivery to address retention and adherence.
- ***Strengthen the integration of HIV with NCDs, TB, mental health, nutrition, and others to improve outcomes.***
- ***Optimize digital technologies to improve clinical outcomes:***
    - Strengthen EMR utilization to improve patient care and surveillance for HIV and TB. Scale up of Point of Care EMR for real-time data entry to improve the quality of data.
    - Institutionalize the CQI audit tool to improve equitable access to quality care.
    - Optimize the use of EMR for surveillance of morbidity and mortality
- ***Scale-up HIV and TB case-based surveillance (CBS) and unique client identification across all sites*** with a focus on health information exchange (HIE) and health information systems (HIS) interoperability. This will improve data quality (reduce duplication) and promote data use. Routinize mortality surveillance.

- ***Strengthen HIVDR surveillance:*** consolidate ongoing surveillance, continued monitoring, and adherence support to prevent acquired HIVDR among individuals on ART with viral nonsuppression.
- ***Promote the use of program data to support surveillance within localities.*** This would entail a review of granular data within regions, mapping, and micro-planning to support the targeting of interventions. It will also inform the strengthening of Integrated management of common co-infection co-morbidities to sustain the gain in PLWHIV survival and evaluation of Care and Treatment implementation approaches to inform program improvement.

2.3 SOCIAL SUPPORT AND SOCIAL PROTECTION

The Social Support and Social Protection Sub-Goal seeks 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. This is to be achieved through six strategic objectives, namely: (i) Scale-up Interventions aimed at 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, people with a disability, 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 the 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 people living with HIV, people with a disability, key and priority populations, and other vulnerable groups. The Table in Annex 6 summarizes the key achievements during the reporting period.

2.3.1 Achievements, Best Practices, and Lessons Learned Under Social Support and Protection

Stigma and discrimination minimized: **-** UAC and multisectoral teams disseminated the national policy guidelines on ending HIV stigma and discrimination reaching 136 District Local governments 4,800 leaders, and 11,701,802 individuals. Subsequently, each leader disseminated the guidelines to sub-county committees and lower administrative units and workplaces, which has contributed to the reduction of stigma and discrimination and positive living within the communities. The stigma policy guidelines were translated to cater to People With Disabilities (PWDs) and focused on sign language for the deaf and braille for the blind. NGOs conducted community engagements and disseminated Stigma messages in schools and out of schools. UAC worked with the Uganda National Students Association (UNSA) and National Youth Council (NYC) to reach schools and universities in the promotion of HIV Prevention and stigma reduction reaching 25 universities & and tertiary institutions, 650 secondary schools, and 89,000 leaders. The country is on track to minimize stigma and discrimination as evidenced by the increasing proportion of Men and women aged 15-49 years (73%) with accepting attitudes towards PLHIV. Figure 23 shows some of the activities on stigma reduction.

Figure 23: Prof Balunywa Wasswa, Chair Board UAC and other members during the HIV Awareness and Anti Stigma Campaign at Makerere University

The findings of the legal assessment aimed at addressing Human Rights, Stigma, and discrimination were disseminated. The Judiciary disseminated the National Policy Guidelines on Ending HIV Stigma and Discrimination) and messages on HIV and AIDS to their officers, thus improving the conduct of the officers. The policies and manuals on stigma and discrimination, a training manual for health providers in the provision of friendly, stigma and discrimination-free services, and a manual for orientation of other stakeholders in Gender and Sexual Diversity were developed. The Facility-based sessions conducted by NAFOPHANU created awareness of HIV stigma and discrimination across the country, reaching over 1,602 PLHIV. The engagement enhanced information sharing among PLHIV on adherence, disclosure, TB prevention and management, human rights, and treatment literacy including viral load suppression. The 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 ongoing advocacy to challenge the negative punitive laws that impact access to HIV and other social services i.e., removing legal, social, and structural barriers to services uptake for HIV testing and treatment may lead to the improvement of the environment for access and utilization of HIV services.

Figure 24: Members of the Women at 40 after the dialogue meeting with young women as champions of change on stigma reduction at Essella hotel

The Use of the Comedy Store and the Commanders Talk show by the UPDF, enhanced the creation of friendly spaces for stigma and discrimination-free services among communities and UPDF personnel, respectively. 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 has been a powerful channel for reaching the grassroots, by engaging communities with HIV prevention messages addressing stigma and discrimination across the country, e.g., in Buganda and Tooro, the kings dedicated their birthdays to sensitizing the communities on HIV and AIDS. Virika Hospital and Kabarole Hospital in Kabarole district run corporate clinics where PLHAs can pick up drugs at any time of the day, including at night. Kabarole Hospital is also using an approach/arrangement where PLHAs get their drug refills from Fort Pharmacy instead of Kabarole Hospital.

Other notable best practices around reducing HIV-related stigma and discrimination include the Uganda beauty pageants and beauty queens, ICWEA awards that re-building esteem and fight stigma among PLHIVs, the GILO foundations wards, and the Community dialogues for young people out of school and school debates for in schools by UNSA.

Reduced socio-economic vulnerability for PLHIV and other vulnerable groups: Economic empowerment through financial inclusion and interventions that keep girls in school have been documented as essential in influencing the personal life choices, attitudes, and behaviors of AGYW. The government of Uganda jointly with development partners developed and disseminated policies and regulations to expand socio-economic interventions aimed at reducing the vulnerability of people in the country. The MOES continued consultations on the National Framework on Sexuality Education and finalized the following polices and guidelines; National School Health Policy, the Guidelines for the Prevention and Management of HIV and Teenage Pregnancy, MoES HIV/AIDS Work Place policy, Education Sector HIV/AIDS Strategic Plan, and the National Child Policy 2020. The MGLSD developed the Gender in the Education Policy. These policies are aimed at protecting and reducing the vulnerability of communities.

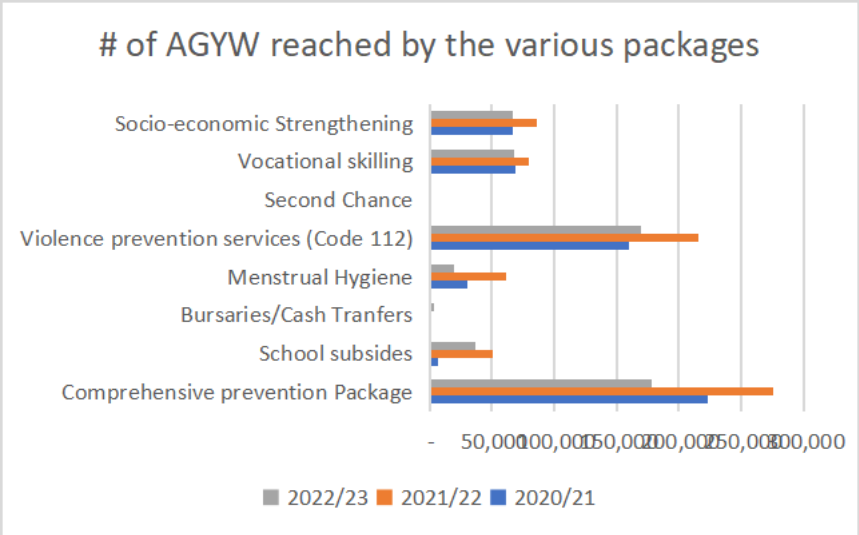


Figure 25: Trends in numbers of AGYW reached with the various interventions in the last three years

The government set up 19 Industrial Hubs with 5,700 beneficiaries in the regions to train vulnerable young persons with different skills such as catering, carpentry, bricklaying, and concrete practices. Figure 27 summarises the numbers of AGYW reached with the various social-economic interventions by the various partners over the last three years. Through Global Fund (GF) through TASO reached 47,206 AGYW with a comprehensive SBSCC package in 20 districts. Through the PEPFAR DREAMS program, Violence prevention services (Code 112) program, Vocational skilling, and Socio-economic Strengthening programs, PEPFAR reached 468,425 AGYW in 24 high-burden districts, an increase from 23 districts in FY 2021/22. MOES served 20,000 vulnerable AGYW with school subsidies[4], from 18,700 at the end of December 2022. Under the MGLSD, HIV and other health services were integrated into the 6 months of training for the skilling component, reaching 16,176 girls and boys in the year under review.

The CSOs across the country linked 370 women PHLIVs to participate in income-generating activities to boost their cash flow. Skill sets trained include soap production, weaving, and hairdressing. The Social Assistance Grant (SAGE) and the Youth Livelihood Programme (YLP), the Government of Uganda financed program designed to respond to the high unemployment rate and poverty among the youth in the country cover 145 Districts and municipalities of Uganda (including Kampala Capital City Authority). Statistics from the labor ministry indicate that so far 22,341 businesses have been financed to the tune of shs. 178.4b, benefitting 258,953 youth under the YLP. Operation Wealth Creation, an entity that is action-

Figure 26: Community empowerment and life skill development

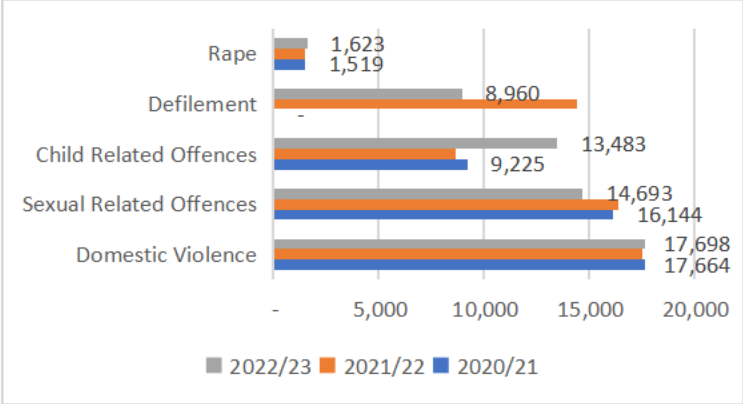
[4] Include *(A school bag, 3 quire counter books, Half a dozen of pens, Half a dozen of Pencils & pads)*

oriented to fight poverty, HIV, and AIDS among others supported the distribution of seeds to the farmers during the period under review to improve their incomes and reached out to churches and communities to talk about poverty eradication and HIV and AIDS.

Reduced Gender-Based Violence / Discrimination

Cases of domestic violence have been noted to be on the rise in Uganda. Violence is one factor fueling HIV. The Police crime report of 2022 revealed that 196,081 cases were registered in 2022, of which 68,405 cases were taken to court. Among cases taken to court, 17,698 (25.6%) were due to domestic violence. Sexual-related offenses accounted for 14,693 (21.4%) cases (Figure 27). Domestic violence cases increased from 17,533 in 2021 to 17,698 in 2022, a 0.94% increase. The underlying factors are failure to provide for the family, drug and alcohol abuse, and fidelity among others. Violence against children increased markedly in 2022 compared to 2020 and 2021, while sexual-related offenses reduced by 10.3% from 16,373 in 2021 to 14,693 in 2022.

Figure 26: Trends in selected Violence Indicators



Source: Police crime reports of 2021 and 2022

The fully functional Gender and HIV Reporting Dashboard (GRD) has improved timely access to data for strengthening prevention and response to sexual and gender-based discrimination and violence. Equipping Expert clients, leaders, and law enforcement officers with knowledge of human rights and legal processes is addressing GBV. Expansion of a community-based "Journeys plus" curriculum that reached 120,736 AGYWs with Violence and HIV prevention messages was provided in safe spaces. Post-GBV clinical care based on the minimum package provided by PEPFAR-supported interventions, reached 193,853 persons, including survivors of physical and emotional violence and survivors of sexual violence. The Legal aid CSOs reached at least 3,050 cases of GBV by trained community-based GBV responders and paralegals, and over 100 cases handled by lawyers.

Psychosocial support to PLHIVs especially for those on treatment and newly enrolled was scaled up across the country. UNASO and PLHIV created champions and networks, and together with the Interreligious Council of Uganda, developed and disseminated the pastoral letters at places of worship across the country, reaching over 18 million congregants in HIV prevention stigma and violence reduction. Furthermore, Cultural leaders across the country were instrumental in disseminating the messages in the communities focusing on the stigma, and reduction of bad cultural practices, taboos, and norms that perpetuate violence. About 3 million community members were reached.

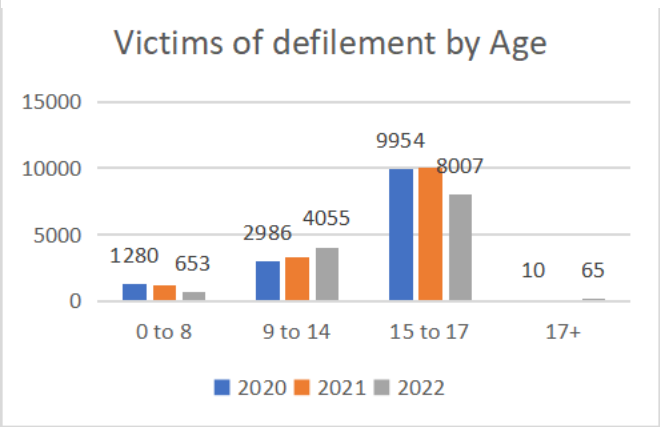
The Social support activities targeting YPLHIV under the YAPS program implemented by the MoH and partners such as home visits to assess the home environment and provide psychosocial support are playing a pivotal role in scaling up psycho-social support for people living with HIV, PWDs, key and priority populations and other vulnerable people. The vulnerability assessments and referral for other social support services have been characterized by "increasing the effectiveness of HIV and 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"**.** Workplace psychosocial and occasional financial support for staff living with HIV and AIDS

provided by some MDAs is a commendable practice worth promoting. The MOH conducted intensified training of expert clients to complement the existing staff at health facilities. The MGLSD and partners reached over 4,000 survivors of GBV with psychosocial support.

Improved child protection and reduced VAC: The rollout of the revised Guidelines for Prevention and Management of Teenage Pregnancy in Schools and the re-enrollment of teenage mothers into schools have improved school completion rates and protected children from domestic violence. Actors like Compassion International, Save the Children, Red Cross, UWESO, Plan International, UNHCR, UNICEF, and UN Women have supported the development of ordinances and bylaws in the district local government for the implementation of the prevention responses. The actors strengthened school-based clubs for training, and reporting, of Child Based protection issues. For the children out of school, there are provisions for legal support by Action AIDS, UGNET, and TASO, across the country.

However, in the year under review, child neglect was the leading form of VAC, accounting for 6,505 (49%) of VAC cases, followed by child desertion 2,116(16%) and child abuse/torture 1240 (9%) of cases. The category of 15–17 years are the main victims of defilement due to adolescent age where many young girls are taken advantage of, and some are defiled in the process of doing domestic chores like collecting water and firewood, especially in rural areas when they are sent alone (Figure 28).

Figure 27: Trends of Child victims of defilement by age over the last 3 years



Source: Police Crime reports 2021 and 2022

In a humanitarian environment, partners have developed guidelines for foster care, family management in refugee settlements, and backyard nutritional programs for children infected and affected by HIV. World Food Program delivered nutritional supplements for children and women in Western Uganda, Karamoja, and West Nile and reached 1,857,232 beneficiaries (52% F and 48 %M). This was achieved through engagement in unconditional resource transfers, smallholder agricultural market support programs, school-based programs, Malnutrition treatment and prevention programs, and assets creation and livelihood (World Food Programme 2022).

Strengthening the Legal and policy framework on HIV and AIDS: The Five-year strategic plan for the KP community was developed. Two assessments of the legal and policy environment led by the 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. The development of the National Policy on HIV and AIDS at the World of Work 2022 by the Ministry of Gender, Labour, and Social Development and the HIV Workplace Policies in MDAs, the Private Sector, and LGs and the Gender and Equity Strategy and a step-by-step guide for assessing and mainstreaming Gender and Equity issues into Social Protection Programmes are informing the mainstreaming of HIV and AIDS programming in the workplaces.

2.3.2 Implementation Gaps and Area of Underperformance

Existent punitive and restrictive clauses in some laws such as sections 41 and 43 of the HIV Penal Code Act (PCA) criminalizes attempted and intentional transmission of HIV. These have the negative effect of

discriminating against HIV testing and the disclosure of positive test results, making it unduly difficult for them to access and utilize services thus undermining the effectiveness of the HIV and AIDS response.

Human rights, stigma, and discrimination have remained a barrier to seeking care and utilizing HIV services. Human rights issues such as child marriages, discrimination, child abandonment, child labor, and child trafficking which are particularly common in communities in East and Northern Uganda, fueled largely by abject poverty, alcoholism, and institutional failures are frustrating the fight against HIV and AIDS. Studies show that PLHIV who perceive high levels of HIV-related stigma are 2.4 times more likely to delay enrolment in care until they are very ill. Interventions therefore need to address 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.

Government programs are not reaching the destitute poor - While these programs are targeting the economically active poor/ vulnerable population, they do not reach the destitute poor. Not all PLHIV, key, and priority populations are economically active poor. They are thus overrepresented among the vulnerable groups/populations targeted. The Government programs are largely using the demand-driven approach, and some revolve around 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 groups or join other groups to benefit from government programs. The minimum requirements (eligibility criteria) for accessing some social support and protection programs are stringent and exclusionary to some population groups. For instance, some require that a beneficiary be a resident of the area, known to local leadership and with national identification. These criteria knock out some groups, such as commercial sex workers and mobile populations. This sometimes results in an overrepresentation of PLHAs, key and priority populations among the vulnerable groups/populations targeted, since not all are economically active poor. In some hard-to-reach areas such as Karamoja, the youth are passionate about some programs that are peculiar to their environment. For example, in an ongoing project of luring the young Karamojong girls out of prostitution, there is a feeling that "*when these girls are brought back, they are taken to a rehabilitation Centre in Lorengechorwa where they are trained on income-generating activities such as hairdressing, tailoring, etc., but the challenge is that when they leave the center, they are not given a startup capital, so they end up going back to the same trade!....."*

Limited mainstreaming of HIV in the various GOU programs - Practically, HIV and AIDS have not been meaningfully mainstreamed in the various government programs, including the PDM. Few government institutions have Occupational Health and Safety (OSH) services at workplaces to respond to HIV and AIDS in formal and informal work settings. Of the estimated workplaces with greater than 50 employees, 76% (186/244) were registered by the MoGLSD to have workplace programs in 2022.

Increasing cases of Gender-based violence and violence against children as evidenced by the Police Crime Report of 2022.

Complacency among the Youth - Many youths have been observed to have developed complacency about HIV & AIDS because of a lack of adequate sensitization on the danger of HIV & AIDS and the need for an interrupted anti-retroviral treatment.

2.3.3 Opportunities for Improvements in FY 2023/24

- ***Invest in optimizing the integration of HIV with NCDs, TB, and mental health*** intervention to address increasing cases of NCDs and mental health among PLHIVs and young people.

- ***Expand the PDM to the destitute poor through affirmative action*** and, since not all PLHAs, key, and priority populations are economically active poor. They are thus overrepresented among the vulnerable groups/populations targeted.
- ***Meaningfully mainstream HIV & and AIDS in the various government programs,*** including the PDM.
- ***Invest in recruiting positions for counselors*** that have been established at HCI and above by the MoH to provide much-needed counseling and PSS services and formalize and invest in skills development and the YAPs and PMTCT mothers to provide peer support to PLHIVs.

2.3.4 Recommendations

- The GoU should take affirmative action to enable the destitute poor to access government programs. Dialogue meetings should be held with the MDAs to explore mechanisms of mainstreaming HIV in the various GOU programs, including leveraging the Parish Development Model (PDM) for furthering the HIV and AIDS response. The Government must invest more in changing social, cultural, religious, and gender norms to shun GBV and respect the rights of women and girls. Invest in sensitization of the youth on the dangers of HIV and AIDS and the need for an interrupted anti-retroviral treatment.

The work of the Office of the DPP and judiciary seems to have been missed.

2.4 SYSTEM STRENGTHENING

The system-strengthening thematic area aims to create resilient multisectoral HIV and AIDS service delivery systems that ensure sustainable access to efficient and safe services for all targeted populations. This will be achieved through 5 strategic objectives; i) Strengthening the governance and leadership of the multisectoral HIV and AIDS response at all levels; ii) Enhancing the availability of adequate and appropriate human resources for the delivery of quality HIV and AIDS services; iii) Strengthening health systems for infrastructure supply chain and HIV program management for optimal services delivery; iv) Strengthening community systems to support population groups including PLHIV and members of KPs for HIV services uptake; and v) Mobilizing resources and streamlining management for efficient utilization & accountability. As part of the Presidential Fast Track Initiative (PFTI), key HIV focus areas for system strengthening include guaranteeing financial sustainability for HIV and AIDS programs; and reinforcing institutional effectiveness for a multisectoral response. The key achievements against key indicators are highlighted in Table in Annex 7 summarizes the achievements by the NSP outcome indicators.

2.4.1 Key Achievements

Governance and Leadership of the Multisectoral Response

- *Over 80% of Districts, MDAs, and SCEs have functional coordination structures*, with HIV/AIDS strategic plans, and are reporting regularly.
- T*he Joint Annual AIDS Review of the year 2021/22*, highlighting the country's HIV status report, was conducted and findings were disseminated at the National HIV Symposium in December 2022.
- *The Mid-Term Review of the NSP was conducted*, and findings were disseminated to stakeholders.
- Through NAPHOFANU, *all districts had functional PLHIV networks* supporting coordination, advocacy, resource mobilization, information sharing, partnerships, and capacity building.
- *Several policy guidance documents have been developed and disseminated across sectors.*

- The MOH is rolling out 'Consolidated guidelines for HIV Prevention, Care and Treatment (2022)', as well as SBCC materials and training of health care workers and CSOs in human rights approaches to service delivery. The recently launched Health Information and Digital Health Strategic Plan will guide digital transformation in the health sector. The Regional Strategy that aims to decentralize health to RRHs was finalized. This aims to decentralize health and have RRH support surrounding districts. The 'National Strategy for integration of SRH, HIV, GBV response, TB and Nutrition. The national adolescent training modules/ curriculum were revised to align with the national adolescent policy guidelines as well as the integrated SRH/HIV/GBV. These materials support the delivery of comprehensive adolescent-friendly services. G-ANC/G-PNC implementation guidelines and SOPs were reviewed. The five-year strategic plan for the KP community was developed. Under MOGLSD, National Policy Guidelines on Ending HIV Stigma and Discrimination were rolled out; and training manuals on stigma and discrimination were developed.
- Under MOES, EducPlus was launched and aims to address the alarming numbers of AGYW acquiring HIV and dying of AIDS, reduce teenage pregnancy, increase economic empowerment, and improve the transition to secondary school. A review of the national training modules for schoolteachers on adolescent health is currently ongoing.
- At UAC: the 'Global Prevention Roadmap' was customised to the country context. UAC, with input from stakeholders, reviewed the UAC Communication Strategy, incorporating high-level priorities. Regulations that operationalize the UAC Act (1992) mandate were approved and gazetted for public awareness. UAC also supported the National Planning Authority (NPA) to embed HIV mainstreaming into the national cross-cutting issues planning guidelines and held dialogue meetings with the Ministry of Local Government (MoGLSD) to explore mechanisms of leveraging the Parish Development Model (PDM) for furthering the HIV and AIDS response.

Human Resources - *The Ministry of Public Service approved a new staffing structure for the RRHs and District Hospitals* to include epidemiologists, biostatisticians, M&E, QI, and IPC officers. The government and partners seconded 32 staff to strengthen community health departments at 8 Regional Referral Hospitals including biostatisticians, epidemiologists, IPC officers, and QI officers.

Health Systems Infrastructure, Supply Chain, and Program Management - *Over 700 HCIIIs were accredited to provide ART*, bringing the total to over 2009. *Capacity building for RRH is ongoing* in program planning, reporting, and coordination. Eight RRH were able to conduct regional performance reviews with district counterparts and IPs. Through support from PEPFAR, Global Fund, UNICEF, and others, several health facilities received ICT hardware to support data capture and improve connectivity, as part of strengthening *ICT infrastructure to support the digitalization of information systems. The logistics management plan for the HIV self-testing commodities was developed.* This aimed to improve the availability of logistics for HIV prevention. *Telemedicine was widely adopted* for delivering professional education to facility staff and t*wo incinerators were installed to support waste management* across the country.

Resource Mobilisation, Utilization, and Accountability - A total of US$651 million was mobilized to fight HIV and AIDS, out of the targeted $836 million for financing the response for 2022/23 giving a funding gap of 22% ($185 million), Figure 29.

Figure 28: HIV funding trends FY 2020/21-2022/23

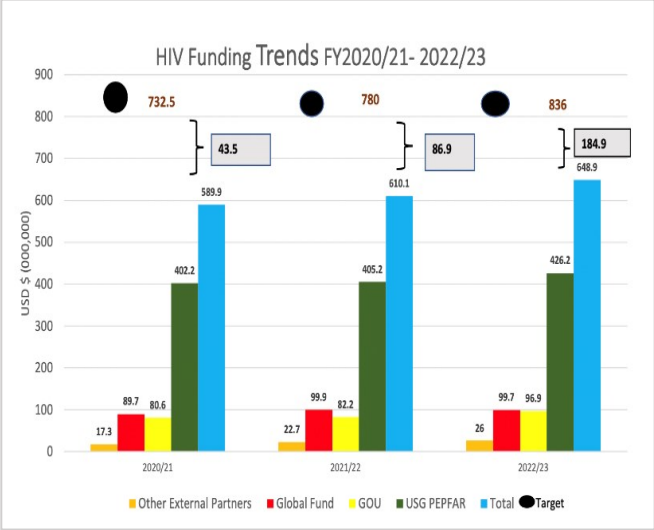


Table 7: Summary of funding trends by source 2020/21 to 2022/23

	2020/21	2021/22	2022/23
Domestic Private Sector	0.22	0.07	0.1
Other External Partners	17.3	22.7	26
Global Fund	89.7	99.9	99.7
GOU	80.6	82.2	96.9
USG PEPFAR	402.2	405.2	426.2
Total	589.9	610.1	6.9
Target	732.5	780	836

Of the funds realized, 80.9% were from donors, 14% from government, and 5.4% from private non-out-of-pocket. The major donors were PEPFAR (61.5%) and GFATM (13.6%). Through mainstreaming, GOU mobilized $9,938,082 to support HIV and AIDS activities in the 151 government Ministries, Departments, and Agencies (MDAs). The HIV mainstreamed funds contributed 1.5% of all expenditures for the year. The PEPFAR COP23 / FY 2024 was finalized and approved with $398.5 million to support FY2024. Uganda submitted a proposal to the Global Fund totaling $ 400m, aimed at supporting activities beginning in 2024 for three years. Table 7 provides a summary of contributions from various sources over the last three years. More detail is available in Annex 8.

Community Systems Strengthening - *The National Equity Technical Working Group was established,* to reduce inequities in HIV services (i.e., testing, treatment, and care) and improve outcomes. A training tool was developed to train legal practitioners in addressing inequalities. *Legal environment assessments for HIV and AIDS and KPs were conducted.* Ongoing advocacy to challenge the negative punitive laws that impact access to HIV and other social services i.e., removing legal, social, and structural barriers to services uptake for HIV testing and treatment.

2.4.2 Best Practices and Lessons Learned Under Systems Strengthening

- ***Revitalised UAC engagement has improved* governance and leadership at national and subnational levels.** UAC continued to improve its oversight and coordination role on the overall HIV response in the country. The National Equity Steering Committee was established and under this committee's guidance, a National Equity Plan was costed, and resources secured from the GFATM to support its implementation. Relatedly, an Equity Coordinator was recruited under UAC to coordinate equity interventions. Further, 100 districts were supported to develop their HIV and AIDS strategic plans. The SCE's functionality improved compared to the previous year, as evidenced by their quarterly meetings and reports. To better coordinate with partners, UAC developed a directory of key development partners supporting HIV and AIDS. This will inform the planning for partner and resource distribution across the country.
- ***Community Led Monitoring (CLM) has strengthened community networks, and enhanced service quality and client outcomes:*** Engagement of local CSOs in problem identification and solutions enhanced involvement and engagement with improved community mobilization. CLM

has strengthened community data collection, management, and dissemination; advocacy for service quality improvement; monitoring community services; networking and collaboration; participation in policy and program processes; use of data to advocate for services; and improvements in service uptake. In the year under review, CLM was implemented in 80 districts and 316 facilities, monitoring the quality of HIV and TB services. Thereafter, dashboards were generated from the data collected. Community networks were strengthened, including 13 KP-specific coalitions. KP monitoring will facilitate future HIV disease burden estimates and projections for the KP population at national and subnational levels.

2.4.3 Implementation Gaps and Areas of Underperformance Under Systems Strengthening

- ***Financing for the HIV response is largely donor-led,*** with GOU contributing 14% and donors over 80% of funding available for the response. Private sector contribution has not been optimized e.g., through One Dollar Initiative or Civil Society. The AIDS Trust Fund (ATF) has not been operationalized due to legal challenges and the government's position on its establishment. The One Dollar Initiative (ODI) has mobilized only $32,877 to date due to challenges in implementation, especially at the subnational level. The anti-homosexuality act has negatively affected funding, especially PEPFAR.
- ***Supply chain:*** Late deliveries of supplies from the central warehouses to the districts.
- ***HR:*** The new RRH and District Hospital staffing structure has not been affected due to resource constraints.

2.4.4 Opportunities for Improvements in FY 2023/24

- the MoH should disseminate available policies and guidelines and utilize the additional staff including epidemiologists and surveillance officers beefed up in the community department of the RRH to support the public health response and improve reporting. Support the community department to utilize epidemiologists and surveillance officers to strengthen systems for reporting.
- UAC, Judiciary, CSOs, and all responsible key stakeholders should utilize the recently developed NGESD, data collection tools for stigma and discrimination interventions that were piloted and finalized for routine monitoring of stigma and discrimination.
- UAC and the MOH should support the health facilities to utilize the hardware for information systems such as data capture devices, connectivity equipment, and solar kits to embrace digitalization.
- UAC should leverage the Parish Development Model (PDM) planning and implementation frameworks to ensure the HIV and AIDS response concerns are incorporated. To track the progress of implementation of the HIV interventions, the three (3) indicators that were developed, discussed, and submitted to the PDM secretariat for incorporation into the program M&E results framework should be implemented.
- The government and MOH should harmonize above site investments and support across the various development partners and the parent government ministries, especially with activities such as conducting LQAS, and development of district Strategic Plans.

3 MONITORING AND EVALUATION AND RESEARCH

The M&E plan aims to ensure quality and timely collection of HIV and AIDS information to track progress towards attaining national and global targets. The plan provides a framework for generating strategic information to guide evidence-based decisions. The strategic objectives of the NSP include: (i) Strengthening the national mechanism for generating comprehensive, quality, and timely HIV and AIDS information for monitoring and evaluation of the NSP; and (ii) Promoting information sharing and utilization among producers and users of HIV and AIDS data and information at all levels. Performance on key NSP indicators is shown in Annex 9.

3.1 KEY ACHIEVEMENTS

Various M&E Tools were developed or updated, including

- *Health Management Information Systems (HMIS) tools for general and key populations:* The revised tools have been harmonized addressing all stakeholder needs, e.g., age disaggregation. Additional indicators capturing emerging needs have been included.
- *KP data collection tools were harmonised and integrated into the national reporting systems:* This will reduce on need for parallel reporting with improved efficiency. The tools will be customized into DHIS2 in the coming year.
- The National M&E Framework for Adolescents and Young People was developed and validated by key stakeholders. This will improve multisectoral tracking of progress on AGYW activities. The process was supported by UNICEF.
- M&E Framework for monitoring and reporting on the National Equity Plan was developed and is due for validation.
- The Global AIDS Monitoring tool was populated and submitted to UNAIDS. The report showcases the country's performance at regional and global level.
- The Ministry of Education convened a workshop to review HIV indicators to be captured through EMIS. The indicators shall be reported on once the EMIS is rolled out.
- HIV indicators in EMIS in preparation for roll out: This will facilitate reporting on the HIV program by the Education sector.

National Estimates and Tools were developed and disseminated, including

- *5-year Country annualized national and subnational estimates for critical HIV services:* The estimates were disseminated and will guide stakeholders into planning and targeting. For the first time, cities were included. During the workshop, additional training on equity was provided to ensure no one is left behind.
- *Monitoring tools to track implementation* of the National Guidelines for Elimination of Stigma and Discrimination.

The process of digitalizing health information systems was initiated. In the review period, there was notable progress in expanding the use of electronic medical records (EMR) at facilities, currently at over 1900 ART sites. In addition, there are efforts to ensure that information systems are interoperable to ease data access and use. To support these initiatives, the ICT infrastructure has been strengthened to

support data capture, management, and transmission. The MOH is setting up centralized data warehousing with links to various information systems. The *Health Information and Digital Health Strategic Plan launched in May 2023 by MOH,* will guide the digitalisation of health information systems (HIS) for improved data use towards the realization of the Sustainable Development Goals. This will improve efficiency as paper-based data collection tools are gradually phased out.

The key policy and guideline documents developed include the *HIV Case-Based Surveillance guidelines:* This will support tracking of individual sentinel events from the time of HIV diagnosis to death; improve data quality minimize duplication; and support program planning. Once approved, the guidelines will be rolled out nationally.

Capacity building was conducted - *RRH was trained in the use of the KP tracker* to support KP program monitoring at the regional level. The Regional *level performance reviews* were conducted engaging all stakeholders, including RRH, DHT, IPs, and facility leadership.

Several research and Evaluations were conducted including

- The UPHIA 2020/21 preliminary report was disseminated: the final report is due by the end of the year.
- The HIV Modes of Transmission (MOT) 2022 Study report was disseminated, to understand sources of new infections.
- The integrated Biobehavioural Survey (IBBS) was conducted, highlighting key HIV indicators among vulnerable populations.
- Two legal environment assessments were conducted: for HIV and KPs.
- The Uganda Demographic and Health Survey (UDHS) 2022 report was disseminated.
- Recency infection surveillance was expanded to 1084 facilities and a Public Health Response Strategy was developed.
- The Mid Term Review for the NSP was conducted and a two-year National Priority Action Plan was developed.

The MOH conducted several data quality assessments: including Recency infection surveillance, PMTCT, HTS, Safe Male Circumcision (SMC), GBV, and Cervical cancer. Findings have been disseminated to stakeholders. An external quality assessment for Safe Male Circumcision (SMC).

3.2 Best Practices and Lessons Learned Under Monitoring and Evaluation

- ***SURGE Strategy: Real-time monitoring of key performance indicators combined with targeted Technical Assistance improved outcomes.*** This focused on selected indicators such as HTS testing, TPT initiation, etc., and implemented weekly reporting across sites, regions, and IPs with a review of the data on dashboards and action planning in real time to address cascade or process gaps. Improvements have been noted for the selected indicators.
- ***Community Led Monitoring (CLM) has strengthened community networks, and enhanced service quality and client outcomes:*** Engagement of local CSOs in problem identification and solutions enhances involvement and engagement with improved community mobilization. CLM has strengthened community data collection, management, and dissemination; advocacy for service quality improvement; monitoring community services; networking and collaboration; participation in policy and program processes; use of data to advocate for services; and improvements in service uptake. In the year under review, CLM was implemented in 80 districts

and 316 facilities, monitoring the quality of HIV and TB services. Thereafter, dashboards were generated from the data collected. Community networks were strengthened, including 13 KP-specific coalitions. KP monitoring will facilitate future HIV disease burden estimates and projections for the KP population at national and subnational levels.

3.3 Implementation Gaps and Areas of Underperformance Under Monitoring and Evaluation

- ***HR gaps*:** The lack of dedicated M&E staff at the health facility level contributes to poor data quality. With digitalization, there will be a need to address the ICT skills gap among healthcare workers.
- ***Delayed rollout of the revised monitoring tools*:** This has contributed to poor quality of program data due to the utilization of outdated HMIS tools.
- ***Lack of unique client identification*** has compromised data quality due to client duplication. The issue requires multisectoral engagement and dialogue to address concerns including access to and security of Personally Identifiable Information (PII), among others.
- ***Limited data on behavioral and structural indicators:*** this is only made available through infrequent surveys. There is a need to integrate them into routine monitoring and utilize LQAS surveys to regularly collect them.
- ***Data gaps in KP programming following enactment of the anti-homosexuality Act (AHA):*** In a bid to reduce stigma and discrimination and protect KPs, service providers were requested to stop disaggregation of KP data during reporting. Unfortunately, this may affect providers' ability to tailor services for the individual and compromise quality.
- ***Suboptimal utilization of data at the subnational level:*** *including RRH, district, and facility.*
- ***GBV reporting remains fragmented across sectors,*** largely due to the limited rollout of the GBV database to harmonize reporting.
- ***ICT infrastructural gaps and security for the HIS hardware:*** This is a key issue, as digitalization is ongoing. For example, the lack of reliable internet or electric power at the facility hampers data transmission.

3.4 Opportunities for Improvements in FY 2023/24

- Roll out the revised HMIS tools to support program reporting.
- Use of digital technology to improve program M&E especially where infrastructure exists.
- Roll out the revised HMIS tools to support program reporting.
- Fast track the revitalization of the EMIS to integrate the HIV and AIDs education-related indicators that were developed and presented to the HIV and AIDS committee of the MDA and were approved for application. This will enable data to be collected and reported on routinely for decision-making.
- Use of MoT report to inform KP programming, including the size estimating the population of Key populations.
- Collaborate with partners to.
- Strengthen facility information systems through procurement and distribution of paper-based tools for data capture and reporting.
- Expand Case-Based Surveillance that involves longitudinal follow-up of individuals through the sentinel events, from HIV infection, diagnosis, enrolment into treatment, ART initiation, viral suppression, and eventual death is the appropriate HIV surveillance approach.

- Popularize performance reviews at sub-national level to create and improve data quality, as well as improve programming of the HIV and AIDS response.
- *GBV:* Dissemination of the national GBV database to harmonize reporting across sectors.

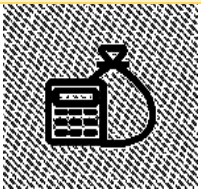
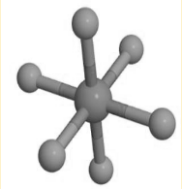
3.5 RECOMMENDATIONS

- ***Fast-track the rollout of the revised tools and guidelines.*** The Ministry of Health should fast-track the rollout of the updated HMIS tools for general and key populations, customization of the DHIS2 for KP HMIS tools, and finalize and roll out HIV Case Based Surveillance guidelines.
- ***Dissemination of Key Findings*** of the national Stigma survey conducted in 2023. - UAC and the partners should disseminate findings of, Roll out the national GBV database to harmonize reporting across sectors, disseminate multisectoral AGYW M&E Framework and reporting tools, and dissemination of National and Subnational epidemiologically modelled HIV and AIDS estimates for 2022.
- ***Capacity Building***. The MOH and partners should continue to strengthen the capacity of RRHs in line with the Regional Strategy conduct annual RRH capacity assessments and strengthen data use at all levels.
- ***Improve Data quality.*** The MOH and partners should integrate behavioral indicators into routine program monitoring, conduct SMC external quality assurance and advocacy, the roll-out out a unique client identification system across sectors to improve data quality and strengthen LQAS to provide data on behavioral indicators for faster intervention and Validate the *M&E Framework for monitoring and reporting on the National Equity.*
- ***Operationalize EMIS***–UAC and MOES should operationalize and start reporting on HIV indicators under the education sector EMIS.
- ***UAC should*** Finalize the development of the research database.

4 PRESIDENTIAL FAST TRACK INITIATIVE (PFTI) 2022/23

The PFTI was launched to enable the Country to fast-track the achievements of the NSP and global targets with a focus on the key drivers of the epidemic. Table 8 summarises the performance of the PFTI against the pillars of the PFTI and related interventions.

Table 8: Summary of performance against PFTI indicators

	Pillar	Progress in 2022/23
	Engage men in Revitalizing HIV Prevention and close the tap on new HIV infections, particularly among AGYW	- *171, 253,889 condoms distributed, reflecting 66% of total condom need.* - *AGYW Age-specific comprehensive service package provided in 44high burden districts. Over 98,353 AGYW participated in economic strengthening approaches. (Vocational skills like hairdressing, tailoring, welding, mechanic, leather turning, knitting, bakery and catering, etc.).* - *A total of 56,612 AGYW were reached with post-violence care.*
	Consolidate progress on eliminating Mother-To-Child transmission of HIV	- *95% of pregnant women living with HIV received ART; 70% had a viral load test and 95% were virally suppressed.* - *88% of HIV-exposed infants received an EID test, and 81% of the HIV-infected babies were linked to ART.*
	Accelerate Implementation of 'Test &Treat' and attain 95-95-95 targets, particularly among men &young people	- *89% of men know their HIV status, of which 80% are on ART, and 75% are virally suppressed.* - *Overall performance: 90-94-94.* - *Adults: 96-98-92, females attained the 2nd & 3rd 95.* - *Children 0-14 yrs.: 63-99-74.* - *Adolescents 10-19 yrs.: 73-80-71.*
	Ensuring financing sustainability for the HIV response	- *GOU contribution of 14% of total funds mobilized.* - *Through mainstreaming, GOU mobilized $9,938,082 to support HIV & AIDS activities in 151 government MDAs.* - *A total of US$651 million was mobilized for financing the response, of the $836 million projected, giving a 22% funding gap.*
	Ensuring Institutional effectiveness for a well-coordinated multi-sectoral response	- *The National Equity Technical Working Group was established, to reduce inequities in HIV services* - *NSP 2020/21-2024/25 and M&E framework disseminated* - *MDAs supported to mainstream HIV & AIDS; establish HIV AND AIDS committees, develop strategic plans, work plans* - *Coordination structures revitalized at the district level, within MDAs, and at sub-county*

5 MAJOR CHALLENGES, GAPS, AND RECOMMENDATIONS

Table 9: Summary of Key challenges and recommendations

Challenges and Gaps	Recommendations
Cross-Cutting	
Leaving children, adolescents, and young people behind ○ Over 35% of new infections are among young unmarried women. Young mothers account for 43% of new HIV diagnoses in ANC. Performance against the UNAIDS 95-95-95 is poorer among children and adolescents, with lower case findings, treatment coverage, retention, adherence, and viral suppression. ○ Interventions to reach this population are either limited in coverage (e.g., G-ANC, DREAMS, and YAPS) or have suboptimal uptake, e.g., PrEP, and HTS.	○ *Address gaps in programming for children, adolescents, and young people. Implement innovative approaches to reach these populations with comprehensive HIV prevention, care, and treatment services.*
HIV Prevention	
Significant number of new HIV infections is estimated at 52,000. ○ Mostly affecting young unmarried females, previously married uncircumcised males, and KPs (MOTS 2022). ○ There is persistent MTCT fueled by stigma and lack of disclosure contributing to loss-to-follow-up of mother and baby pairs. ○ At the population level, a significant number of individuals are not virally suppressed, either unaware of their HIV-positive status (~120,000) or failing on ART (~75,000). ○ Sub-optimal access, uptake, and utilization of PrEP services.	○ *Strengthen HIV prevention interventions for at-risk population groups, i.e. AGYW, ABYM, KPs.* ○ *Improve management of virally nonsuppressed ART recipients.* ○ *Strengthen targeted HTS to find unidentified HIV-infected persons.* ○ *Address PMTCT cascade gaps through AP3 initiative especially re-testing in ANC, retention, and adherence of mothers in care through G-ANC, peer mothers, FSG, etc. Engage men and communities.* ○ *Expand PrEP access and promote utilization.*
○ Undiagnosed HIV cases: currently estimated at 200,000. ○ Undiagnosed HIV+, among hard-to-reach populations, urban communities. Six regions have 78% of undiagnosed cases.	○ *Micro-planning targeted HTS to find missing cases, with linkage to effective/ optimized ART.*
Declining performance in behavioral indicators, with an increase in multiple sexual partners; declining condom use at high-risk sex; and low knowledge of HIV. Key issues: ○ Ineffective HIV prevention messaging. ○ Conflicting messaging with religious and cultural institutions, e.g., on condoms, FP, SRH. ○ Complacency among young people. ○ Perceived stigma.	○ *Make a new push for HIV prevention–as a priority.* ▪ *Reach young people especially AGYW and ABYM and their partners with impactful HIV prevention messages using new media-based outreach platforms and other technology-based approaches.* ▪ *Dialogue with religious and cultural institutions and MOES on sexuality education for young people.*
HIV care and treatment	
Significant HIV -related morbidity and mortality: Over 17,000 deaths annually, of which 30% are due to TB. ○ Of note, there is a high prevalence of Advanced HIV Disease: 21% at HIV diagnosis, and 18% of virally nonsuppressed. ○ Gaps in disease integration of HIV and other disease conditions, e.g., TB, AHD, and NCD; Suboptimal AHD screening due to inadequate supplies; Limited TB	○ *Strengthen integration of HIV with the management of other disease conditions, ensuring commodity availability for AHD screening, while actively building the capacity of providers.* ○ *Increase access to modern TB diagnostics including C-reactive protein, TB-LAM, and X-rays.* ○ *Strengthen case findings with linkage to effective/ optimized ART health facilities*

Challenges and Gaps	Recommendations
diagnostics resulting in missed cases. ○ Retention is suboptimal (77% against 95% target 12 months after initiation); and among ART recipients, about 75,000 are virally nonsuppressed, prone to OIs. ○ High prevalence of NCDs among PLHIV including hypertension, Diabetes, cancer, and mental health challenges, affecting adherence and retention.	○ *Refine DSD models to strengthen retention and adherence for vulnerable/at-risk population groups engaging communities.* ○ *Conduct systematic mortality surveillance for better planning.*
Social support and social protection	
○ Declining performance on structural indicators with increasing gender-based violence (GBV in all its categories, and human rights violations.	○ *There is a need to engage more with different leaders changing social, cultural, religious, and gender norms to shun GBV and respect the rights of women and girls.* ○ *Increase awareness of human rights.*
○ Persistent stigma and discrimination.	○ *Strengthen stigma reduction initiatives.*
○ Existent punitive and restrictive clauses in some laws affecting service uptake for KPs.	○ *Review and repeal the AHA punitive laws and enact protective laws to protect and promote human rights, and improve delivery of and access to HIV prevention and treatment services.*
○ Government programs are not reaching the destitute poor.	○ There is a need to guide the population on how to access government programs e.g. the PDM.
○ Limited mainstreaming of HIV in the various GOU programs.	○ *Hold dialogue meetings with the MDAs to explore mechanisms of mainstreaming HIV into GOU programmes including leveraging the Parish Development Model (PDM)*
System Strengthening	
Inadequate Financing of the HIV response and tracking. ○ Currently, financing for the HIV response is largely donor-led. ○ In FY2022, 22% of the projected budget remained unfunded.	○ *Fast-track implementation of the Resource Mobilization Strategy identifies strategies to improve efficient use of funds.* ○ *They should streamline and routinize the collation of HIV funding investment by the different stakeholders and partners including GOU and bilateral institutions such as the GF through NASA institutionalization*
○ Ensuring sustainability of the response: Beyond the funding needs, strategies are needed to sustain the response.	○ *Integrate HIV services within existing systems; Ensure interventions are mainstreamed into national policies and guidance for ownership; Build provider capacity; Engage and involve communities for ownership; Promote local leadership and ownership.*
○ The approved RRH and District Hospital staffing structure has not been affected due to resource constraints.	○ *Increase resource allocations for new HRH structure Institutionalize the efforts on HRH performance management*
○ Declining performance in structural indicators with increasing GBV, and human rights violations.	○ *Address Human rights issues.*
Monitoring and Evaluation	
○ Lack of dedicated M&E staff at health facilities	○ *Increase resource allocation for M&E staffing.*
○ Delayed rollout of the revised monitoring tools	○ *Roll out revised HMIS tools.*
○ Lack of data on social support and protection: Data on structural and behavioral indicators is not routinely available for use by the various stakeholders and tends to be fragmented across sectors.	○ *Identify appropriate behavioral and structural indicators to be routinely captured.* ○ *Institute systematic routine reporting on key indicators.*
○ Fragmented GBV reporting across sectors.	○ *Roll out the GBV database to all sectors at national and subnational levels.*
○ Lack of unique client identification has compromised data quality due to client duplication.	○ *Engage relevant sectors in Unique Identification (UID) dialogue.*

Challenges and Gaps	Recommendations
○ Suboptimal utilization of data at the subnational level: including RRH, district, and facility.	○ *Strengthen capacity for data use by stakeholders* ○ *Popularize performance reviews at all levels.*
○ ICT infrastructural gaps and security for the HIS hardware, limited internet connectivity, and electrical power.	○ *Work with GOU sectors to improve ICT infrastructure and security of hardware at facilities.*

6 Implementation Status for FY 2021/2022 Aide Memoire Undertakings and Action Plans

Each year, UAC with its stakeholders generates memoire undertakings on areas of improvement based on the performance of the previous year. Table 10 below summarizes the areas of the undertakings, activities for implementation generated in FY 2021/22, progress made in FY 2022/23, and action plans to accomplish them.

Table 10: Progress in the implementation of the FY2022/23 Undertakings

Undertaking	Activity	Deliverable/ output	Progress
HIV Prevention			
Primary Prevention	Scale up the "Time Up" campaign to all districts in the country	SBCC campaigns conducted targeting youth	Social and Behaviour Change Activity (SBCA) through the regional Partners implemented the Time Up campaign countrywide. Materials were produced and disseminated to various places. Social media campaigns were conducted.
HTS optimization	Revise the HTS optimization plan to include new guidance from the new HTS policy in June 2022.	HTS Optimization package revised	The HTS Optimization package was revised, and dissemination is ongoing
AGYW	Scale up AGYW interventions to the remaining 18 high-incidence districts and strengthen referral monitoring of the AGYW program	AGYW package of interventions implemented in 18 districts	Current district overage: 20 GFATM, 24 PEPFAR An addition of 5 districts (Fort Portal City and Kabarole District by PEPFAR, 4 districts by GFATM in 2023/24
	Conduct a country-wide survey to determine the impact of AGYW programming on high teenage pregnancy	Survey to determine AGYW interventions' impact on teenage pregnancy carried out	Not done, due to lack of funding and changing priorities
KPs	Fast-track the HIV MOT study to inform better planning for KPs.	Complete and disseminate the MOT Study for evidence-based planning.	Completed but not disseminated

Undertaking	Activity	Deliverable/ output	Progress
	Implement selected recommendations of the Legal Environment Assessment to revise laws that are discriminative against KP and hinder access to an integrated package of services, including harm reduction policies in HIV prevention:		- Laws and policies are not yet reviewed. - LEA was completed. - National-level dissemination done. - Subnational dissemination planned for 2023/24. - HIV prevention and Contract act on intentional HIV transmission has not been reviewed. - Armed forces do pre-entry HIV screening.
	Review employment laws and policies to specifically prohibit pre-employment HIV testing	Laws and policies reviewed.	Laws and policies have not yet been reviewed.
	Develop a national occupational health and safety policy that integrates protection from HIV in the working environment		The national occupational health and safety policy was developed
	Adapt/adopt and operationalize the UN system-endorsed core package of nine essential harm-reduction services for people who inject drugs, which have been shown to reduce HIV infections.	Core package of nine essential harm reduction services for PWID adapted to the Ugandan context	The national harm reduction policy was adapted to the Ugandan context and is being implemented
Condom programming	Cost and implement the Last Mile Distribution Strategy	Implement last-mile distribution up to DICs.	The final costed draft developed and awaiting approval by the MOH
	Develop and establish a condom tracking system that will better inform quantification and planning for condom distribution	Condom condom-tracking system was developed and established	Developed, pre-tested, and awaiting final validation
Care and Treatment			
Address gaps in retention, adherence, and viral suppression to achieve the 2nd and 3rd 95%	Review of DSD guidelines together with the Consolidated Guidelines for Prevention and Treatment of HIV and TB in Uganda as per the WHO guidance for patient-centered care, to allow clients to choose their preferred approaches to care	Revised DSD Guidelines for HIV/TB Prevention and Treatment	The DSD guidelines were revised, and clients are encouraged to choose a preferred model of care
	Carry out a study on the effect/impact of DSDM on service uptake	A study on the impact of DSDM on service uptake was conducted.	A protocol is in development to evaluate the impact of an integrated community model.
	Scale up the YAPS program to the remaining 34 districts	YAPS interventions implemented in remaining 34 districts	As of June 2023, YAPS was in 685 facilities in 81 districts.

Undertaking	Activity	Deliverable/ output	Progress
Strengthen integration of services	Roll out guidelines for NCD integration into HIV care to more facilities	HIV/NCD Integration Guidelines rolled out	HIV & NCD integration is part of the Consolidated HIV Prevention Care and Treatment guidelines currently being rolled out by MOH
Social Support and Social Protection			
Stigma and discrimination reduction	Further dissemination of the National Policy Guidelines for Ending Stigma and Discrimination across all levels.	Anti-Stigma Policy Guidelines disseminated and implemented	This has been implemented across the country using the multisectoral approach
	Complete the Sigma Index Study (MakSPH)	Stigma study completed and disseminated	The study is completed and due for dissemination
	Invest in media relations to create favorable conditions for increased strategic reporting on HIV-related cases	Media engagements were held to orient media houses on strategic reporting on stigma and discrimination	Media engagement is continually done at national and subnational levels across the country
Socio-Economic Strengthening	Scale up comprehensive AGYW socioeconomic intervention to the remaining 18 high-incidence districts	Vulnerable AGYW reached with socioeconomic interventions	Interventions reaching AGYW are implemented in the high-incidence districts with support from GF, PEPFAR, and other stakeholders
	Continue with household economic recovery programs targeting households and individuals whose livelihoods have been severely affected by the COVID-19 pandemic and the associated measures and integrate into the PDM	Resources for on-going programs sustained and programs integrated into PDM	The households are being enrolled for economic empowerment activities e.g., PDM, emyooga, YLF, SAGE, Disability Grants, and OWC among others
Gender-Based Violence	Expand the availability of psycho-social support to GBV survivors	Psycho-social support services scaled up	Psycho-social support services are provided across the country and GBV survivor centers are supported by IPS (Plan International, Action AID, TASO), MDAs e.g., MGLSD, Police
	Scale up the training of PLHIV, KPs, vulnerable groups, law enforcement officers, and communities about rights awareness and legal literacy to facilitate early reporting of GBV incidents	PLHIV, KPs, vulnerable groups and communities trained in human rights and legal issues	The training is ongoing across the country by the JLOS team, CSOs, UNSAO, NAFOPHANU, LGs
	Conduct a bottleneck analysis of the GBV/VAC cascade from event to conviction of perpetrators	Bottleneck analysis carried out	Not Implemented
Child Protection and Violence against Children (VAC)	Harmonise monitoring mechanisms for GBV/VAC	Harmonized framework for reporting of GBV/VAC	This was completed, and it is operational, and the system is functional
System Strengthening			

Undertaking	Activity	Deliverable/ output	Progress
Governance and Leadership	Ensure district HIV/AIDS strategic plans are completed and approved by councils using the online tool	HIV and AIDS strategic plans completed for all districts	All except 4 districts have completed HIV and AIDS Strategic and Operational Plans, approved by District Councils. 4 districts 15 Ministries, Departments, and Agencies were supported to develop their respective strategic plans and are under implementation
Financing	Fast-track implementation of the Resource Mobilization Strategy.	Resource mobilization strategy disseminated and interventions implemented	The resource mobilization strategy was developed, validated by stakeholders, and approved for publication and use.
	Fast-track and complete the rollout of HIV and AIDS mainstreaming across MDAs and LGs		Mainstreaming guidelines were updated and disseminated. Mainstreaming rolled out to all the MDAs and Local Government. An assessment of mainstreaming and allocation of the 0.01% under vote output 0.00013 was done. This indicated a 100% compliance.
	Roll out the Resource Tracking Tool	Resource Tracking Tool rolled out.	The National AIDS Spending Assessment and institutionalization was delayed because of inadequate funding. The process is ongoing, and it is planned for completion by December 2023
	Develop an HIV and AIDS Disaster Management Plan for the response, which can be activated when required	Disaster management plan developed	A Disaster Plan has not been developed but this is part of an extensive sustainability plan which is underway. This sustainability plan covers the political, Programmatic, and Financial aspects of sustainability.
Strengthen M&E systems	Determine behavioral indicators for routine monitoring.	Behavioral indicators for routine monitoring determined and disseminated to relevant MDAs	The indicators for behavioral and structural interventions were determined but the systems for data collection and transmission to track the progress are still a challenge
	Strengthen coordination of HIV and AIDS research efforts that are passed by different IRBs, to ensure use in improving programming and more efficient use of resources- develop SOPs.	SOPs for HIV and AIDS research coordination developed	The research database has been developed and is undergoing the approval process, including negotiation with NITA-U to have it hosted on their Servers.

7 GAME CHANGERS IN FY 2022/23

Table 11: Summary of the Game changers in FY 2022/23

HIV Prevention	- Integration of HTS into the TB Cast Campaign improved HIV Case Identification. - Total Market approach, the Last mile distribution mechanism by the National Alternative Distribution Warehouse, and intensive coordination using WhatsApp for condom programming. - The catalytic role of the First Lady adds value to the education, health, and social sectors and the empowerment of women and girls in Uganda at large. - The Kabaka's birthday runs held in April every year, dedicated to creating awareness about HIV among the kingdom subjects, is a major sensitization campaign about HIV and AIDS. - Adoption and scale-up of new PrEP technologies of Dapivirine Vaginal Ring (DVR) and Long-Acting Injectable Cabotegravir (CABLA) as prevention options for KP. - Introduction of expanded peer outreach Approach (EPOA), innovative community peer-led drug distribution approaches using bicycles to deliver ART and PrEP refills as a way of countering the effects of the AHA. - The launch of the GA/AP3 (Global Alliance and the Accelerating Progress for PMTCT and Paediatrics) program.
Care and Treatment	- Stakeholder coordination and engagement in the TWGs at MOH to establish standards, identify priority gaps, develop appropriate strategies, harmonize work plans to minimize duplication, and conduct joint activities. - Institutionalisation of Continuous Quality Improvement (CQI) to improve outcomes. - Implementation of an Integrated community model that leverages available HR to improve the 95-95-95 cascade. - Adoption of digital technologies to improve efficiency. - Implementation of a tailored linkage package improved immediate ART initiation to 95% from 81% at baseline. - Functionalization of a coordination structure for the HIVDR program with regional centers of excellence and strategic partnerships to support the program has improved viral suppression.
Social Support and protection	- Use of community structures such as VHTs Local councils, Cultural leaders, and religious leaders in information dissemination in the community and continuous use of client experts to reach out to clients at the community level. - Community retention activities have led to in-community awareness and continuous provision of psycho-social support to persons living with HIV and TB. - Timely dissemination of the national policy guidelines on ending HIV stigma and discrimination in districts, sub-counties, and lower administrative units. Translations of stigma policy guidelines to cater to PWDs and focused on sign language for the deaf and braille for the blind. - Development of policies and plans informed by assessment, i.e., Legal Environment Assessment (LEA) - Creation of champions and networks with support from UNASO and a Forum for people living with HIV to scale up psychosocial support to PLHIVs and enhance more engagements with the Interreligious Council of Uganda in developing and disseminating the pastoral letters at places of worship across the country. - Continuous Engagement of 18 Cultural leaders across the country in disseminating the messages in the communities focusing on the stigma, and reduction of bad cultural practices, taboos, and norms. - Integrate PDM into social support and protection service provision and create community awareness about the same - Review and development of various policies by the MOES, MGLSD, and JLOS are aimed at reducing stigma and discrimination and protecting and reducing the vulnerability of communities.

	- The use of a Comedy store, where comedians disseminated HIV/ADS information to their fans in line with the PFTI pillars was appealing to the audiences reached.
System Strengthening	- Revitalised UAC engagement improved governance and leadership at national and subnational levels. - Community Monitoring (CLM) strengthened community networks, and enhanced service quality &client outcomes. - Establishment of the National Equity Steering Committee that oversaw the costing of the National Equity Plan, and resources secured from the GFATM to support its implementation. - Dialogues meetings with the Ministry of Local Government (MoGLSD) to explore mechanisms of leveraging the Parish Development Model (PDM) for furthering the HIV and AIDS response. - Digitalising health information systems.
Monitoring and Evaluation	- SURGE – Real-time monitoring of key performance indicators combined with targeted TA improved program outcomes. - Community-led monitoring: engaging local CSOs in monitoring improves community mobilization and uptake of solutions.

8 IMPACT OF THE ANTI-HOMOSEXUALITY ACT (AHA) ON HIV AND AIDS PROGRAMMING

The Anti-Homosexuality Act (AHA) signed into law in May 2023 penalizes homosexual behavior and 'promotion' of homosexuality with 20 years in prison, and a death sentence in the case of aggravated homosexuality which includes same-sex sexual acts involving people living with HIV (PLHIV). According to the Adaptation Report 2022 and the Rapid Response report under the equity plan, the enactment of this act has had unintended consequences. These include; an increase in stigma and discrimination against the affected PLHIV and KPs, discouraging HIV testing, disclosure of test results, and reducing access to HIV prevention services by KPs& and PPs. Ten out of the 75 drop-in-centers (DICs) across the country suspended their operations following the AHA due to incidences targeting them summarised in (Figure 30). Over 70% of the facility DICs had medicines and other supplies. There were records of missed ART appointments, missed viral load tests, and reduced PrEP refills, the most affected KP being the transgender and MSM. There was a decline in the willingness of health service providers and KP- CSOs to support services, for fear of being considered ''promoting'' homosexuality which is punishable by law. Several development partners have voiced concern that financial support to facilitate activities for KP may be considered a 'promotion' of homosexuality. This will probably result in funding cuts to CSOs and Implementing Partners previously supporting KP activities.

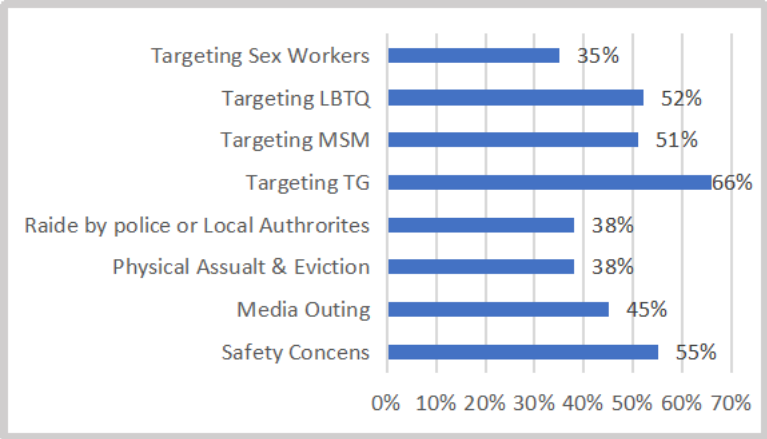


Figure 29: Proportion of DICs targeted by the various incidents following AHA

Mitigating the unintended effects of AHA: - The MOH, supported by UAC and partners, developed an adaptation strategy, and disseminated it to the stakeholders, clarifying roles at different levels. To counteract the effect of AHA on service delivery, innovative peer-led drug distribution approaches were adopted. Peer educators and KP focal persons were trained in community drug distribution using bicycles to deliver ART and PrEP refills.

To ensure continuity of essential services amidst the AHA;

- MOH should regularly and continuously guide as the situation evolves and assess the continuity of service delivery at community DICs.
- UAC should engage development partners and other sectors on issues of funding. GOU should mobilize additional resources for the mitigation of the impact of AHA on service delivery.
- GoU should review and repeal the AHA punitive laws and enact protective laws to protect and promote human rights and improve the delivery of and access to HIV prevention and treatment services.
- Implementing partners should continue supporting interventions to key populations, mobilize resources, and align service delivery approaches to the current context with safety and security taking precedence.
- CSO engagement should continue through their leadership, networks, and platform and also be oriented and advised on how to ensure service continuity without compromising client security and safety.
- All clients including KPs should be provided services that are non-stigmatizing and non-discriminatory.
- All services, activities, and any other interventions at the facility and community should be provided in an integrated manner rather than population-specific to avoid unnecessary tensions.

- Heath workers should adopt enhanced community outreach approaches including community drug refills, community follow-ups, phone calls, self-testing, DSD approaches including peer-to-peer, and other social media approaches, and limit physical interactions.
- Community DICs should be open to all people and work in open spaces to avoid suspicion and should operate within working hours as provided in the DIC guidelines. The DICs that are close to schools and police should be closed or shifted as guided by DIC guidelines.

9 LIST OF UNDERTAKINGS FOR FY 2023/24

Table 12: List of 2023/24 Undertakings

Undertaking/issue	Activity	Deliverable / Output	Lead Agency	Support Agency
HIV prevention				
Primary Prevention	Scale up the "expanded Time Up" campaign to all districts in the country	- Refined SBCC campaign that includes NCD, new PrEP options, and condom programming for young people rolled out.	**MOH**	**,UAC, SBCA**
PMTCT	Scale up the Global Alliance (GA)/Accelerating Progress in Paediatrics and PMTCT (AP3) Activities to fidelity.	- HIV re-testing. - Build Capacity building for the HW in the MNH platform for HIV re-testing and improve logistics for HIV re-testing. - Rolling out CQI projects on HIV re-testing. - Task shifting to peer mothers under AP3. - Scale up the elimination of syphilis HEP B and other STIs. - Roll out the Children and mother Audit tools. - Strengthen EPI- EID integration and GANC/PNC.	**MOH**	
AGYW	1. Strengthen the Multisectoral response at the subnational level	- Conduct multisectoral coordination meetings at the sub-national level.	UAC	All MDAs
		- Disseminate the harmonized Multi-sectoral M&E framework and reporting tools for the AGYW.	UAC	MoH, MoLGSD
	2. Guidelines, tools and packages	- Standardize the risk and vulnerability assessment tool for all partners at all levels.	UAC	MoH
		- Complete the development and disseminate the peer strategy.	MOH	UAC
		- Develop an HIV prevention package for Adolescent boys and young men.	MOH	UAC
HTS	3. Optimize HTS integration	- Integration of HTS in TB CAST campaigns (MOH) - Roll out HTS Optimization guidelines to	MOH	

Undertaking/issue	Activity	Deliverable / Output	Lead Agency	Support Agency
		improve efficiency and mitigate stock out of test kits.		
PrEP Programming	4. Roll out Long-Acting PrEP technologies (CABLA and DVR Vaginal ring)	- Scaled up PrEP services among KP, PP, and in prisons - CABLA Approved - DVR Ring rolled out to all high-burden districts	MOH	
Condom Programming	5. Roll out a condom tracking system	– Improved Condom distribution and tracking systems	**MOH**	
KP	6. Disseminate findings of the Legal Environmental Assessment	– Dissemination of LEA assessment at the Subnational level	**MOH**	
HIV Prevention	7. Research	– Understanding the underlying complementary roles of the Social, behavioral, and biomedical scientists in HIV prevention – Understanding the vulnerability to HIV and AIDS of adolescents and young people – Conduct SMC external quality assurance	**UAC**	**RASP - SCE**
Care and Treatment				
Data Management and Use	1. Optimize EMR use for patient care and surveillance ○ Roll out the CQI audit tool ○ Roll out HIV and TB Case Based Surveillance	– CQI audit tool rolled out to all ART facilities – HIV Case Based Surveillance rolled out to a minimum of 500 facilities	**MOH**	ADPs
DSD models	2. Refine DSDM models optimizing community human resources.	– Integrated community model scaled up to all regions	**MOH**	
	3. Conduct Evaluation of DSD (YAPS, Integrated community, G-ANC/PNC, HIV&NCD integration.	– Program Evaluations conducted and findings disseminated	**MOH**	
Social Support and Protection				
Stigma and discrimination reduction	1. Further dissemination of the National Policy Guidelines for Ending Stigma and Discrimination across all levels. 2. Complete the Stigma Index Study	- Anti-Stigma Policy Guidelines disseminated and implemented - Stigma study completed and disseminated	UAC	MoH, MakSPH, PLHIV-led Networks and CSOs, Human Rights CSOs,

Undertaking/issue	Activity	Deliverable / Output	Lead Agency	Support Agency
	(MakSPH)			
	3. Invest in media relations to create favorable conditions for increased strategic reporting on HIV-related cases	- Media engagements held to orient media houses on strategic reporting on stigma and discrimination	UAC	MoH
Socio-economic strengthening	4. Scale up comprehensive AGYW socioeconomic intervention to 18 high-incidence districts.	- Vulnerable AGYW reached with socioeconomic interventions	**MGLSD**	**MoH**, IPs, CSOs
	5. Continue with household economic recovery programs targeting households whose livelihoods were severely affected by the COVID-19 pandemic and the associated measures and integration into the PDM.	- Resources for ongoing programs sustained and programs integrated into PDM	**MGLSD**	MoFPED, IPs, CSOs
Gender-Based Violence	6. Expand the availability of psycho-social support to GBV survivors.	- Psycho-social support services scaled up	**MoGLSD,**	MoH
	7. Train PLHIV, KPs, vulnerable groups, law enforcement officers, and communities on rights awareness and legal literacy to facilitate early reporting of GBV incidents.	- PLHIV, KPs, vulnerable groups, and communities trained in human rights and legal issues	**MoGLSD**	PLHIV Networks, PLHIV-led CSOs, Human Rights CSOs
	8. Conduct a bottleneck analysis on the GBV/VAC cascade from event to conviction of perpetrators.	- Bottleneck analysis carried out	**MoH**	**MoGLSD, MoJCA**
Child Protection and Violence against Children (VAC)	9. Harmonise monitoring mechanisms for GBV/VAC	- Harmonised framework for reporting of GBV/VAC	MoGLSD,	
System Strengthening				
Governance and Leadership	1. Disseminate findings of the national stigma survey	- Disseminate findings of the national stigma survey conducted by MakSPH (MOH, CSOs.	**UAC**	**MoH, CSO**

Undertaking/issue	Activity	Deliverable / Output	Lead Agency	Support Agency
	2. Capacity Building of the RRH	- Capacity building for RRHs in line with the Regional Strategy. - Conduct annual RRH capacity assessment.	**MOH**	
Financing	1. Ensuring sustainability of the response	- Fast-track implementation of the Resource Mobilization Strategy. - Identify efficiencies. - Improve expenditure tracking by the various players. - Beyond the funding needs, identify and implement strategies to sustain the response. - Monitor and track implementation of the HIV Mainstreaming Guidelines among MDAs and LGs	**UAC**	**ADPs,** MDAs, MoLG
Strengthen M&E systems	1. Tools	- Roll out the updated HMIS tools for general and key populations - Customize the DHIS2 for the KP HMIS tool	MOH	
	2. Databases	- Roll out the national GBV database to harmonize reporting across sectors - Advocacy for a unique client identification system across sectors to improve data quality (UAC) - Operationalize EMIS and start reporting on HIV indicators in the education sector - Operationalize and roll out the Enterprise Data Warehouse	**UAC**	**MOGLSD, MOES, Police, LG**
	3. HIV and AIDS Research Agenda	- Finalise the development of the national HIV and AIDS research agenda - Finalize development of the research database (UAC)	**UAC**	**RASP**

ANNEXES

ANNEX I: BIBLIOGRAPHY

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ANNEX 2: PROGRESS IN THE HIV IMPACT INDICATORS

HIV Impact indicators						
Indicator	**Baseline**	**Target**	**Achievement**			**Remarks / Gap**
			2020/21	**2021/22**	**2022/23**	
Prevention of new HIV infections						
HIV incidence rate (15 - 49 years)	0.32% Women 0.43 Men 0.21 Adolescent Girls 0.62% Adults 0.29%	0.2%	0.24%	0.23% Adolescent girls 0.35%	0.22	On track Surpassed the NPAP target of 0.3% in Yr. 3 A gap of 0.02% to meet the NSP target
New Infections	Overall: 54,000 (Epi data 2019)	18,200	54,000 Women: 31,000 Men: 16,000 Children (0-14): 6000	52,000 Female 15+: 30,000 Male 15+:16000 Children (0-14) 5,900	51,516	33,800
Estimated % of child HIV infections from HIV+ women delivering in the last 12 months	At 6 weeks = 2.1%	1.3%	3%	1.8%	1.4%	On track
	After Breast Feeding = Not indicated	<5%	7%	7%	2.8% (PMTCT Impact Report)	Declining
HIV prevalence among 15-49 years	5.5% Women 7.1% Men 3.8% UPHIA 2020		Adolescent girls 15-19: 1.7% Adolescent Boys 15-19 years 0.2%	5.2% Women 15+: 6.7% Men 15+: 3.7	5.1% Women 15+: 6.5% Men 15+: 3.6	Declining prevalence
Education HIV and AIDS-related mortality rate						
AnndAnnual-related deaths	21,000	10,800	18,000	17,000	17,337 (MTR 2022)	Stagnating
HIV mortality rate (15 – 49 years)	66/100,000	33/100,000			40/100,000	Declining
Reduction of vulnerability to HIV and AIDS and mitigating its impact on PLHIV and other vulnerable groups						
% of women and men aged 15-49 years who report discriminatory attitudes towards PLHIV	Overall, 33.2% M=28.7% F=34.4% (2017)	50% (2016)			F=15% M=17% UDHS 2022	Declining

ANNEX 3: PROGRESS IN THE PERFORMANCE OF THE HIV PREVENTION OUTCOME INDICATORS

Indicators	Baseline	NSP Targets	Achievement			Comments
			2020/21	2021/2022	2022/23	
OooouOutcomeIncreased adoption of safer sexual behaviors and reduction in risky behaviors among key populations, priority population groups, and the general population						
1.1 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+: No data	15-49: 10.5% 50+: 5%	29.9 (USAID LQAS 2020 Survey Report	No data (ND)	M=30.7% (UDHS 2022)	Lagging NPAP target for year 3 is 13% for males
	Female 15-49: 2.3% 50+: No data	15-49: 1% 50+: 0.5%	10.4%	ND	F=10.4% (UDHS 2022)	Lagging NPAP target for year 3 is 1% for females
1.2: % of young women & and men aged 15-24 years who correctly identify 3 ways of preventing sexual HIV transmission and who reject 2 misconceptions about HIV transmission	Male: 45% (UPHIA 2016)	70%	26.7%	ND	39%	Stagnating. UDHS 54% of youth had comprehensive HIV knowledge.
	Female: 46%	70%	22.4%	ND	39.0%	
1.3: % of young women and men aged 15-24 years who have had sexual intercourse before the age of 15	Male 21%	11%	ND	ND	32.1% UDHS 2022	Lagging
	Female 10.2%	5%	ND	ND	24.1% UDHS 2022	Lagging
1.4: % of sex workers reporting condom use at the most recent client visit	69%	90%	ND	ND	30%	Stagnating
1.5: % of MSM who used a condom at last anal sex	39%	60%	ND	ND	39%	Stagnating
1.6: % of PWID reported safe injecting practices in the last month	ND	90%	ND	ND	ND	
Outcome 2: Coverage and utilization of biomedical HIV prevention interventions delivered as part of integrated care services led-up						
2.1: % of males and females 15-49 and 50+ years reporting condom use at last higher-risk sex	Male:15-49 57% 50+ ND	90% 50%	ND	ND	62% ND	Lagging
	Female: 15-49: 37% 50+	80% 30%	ND	ND	38% ND	Lagging
2.2: KPs & PPs 15-49 years reporting consistent condom use						
– Sex workers	45% (2012)	85%	ND	ND	71%	On track. data for only Kampala
– Uniformed		85%				
– Fishermen		85%	ND	ND	10.2% (Hope Nakazibwe et al. 2022[5])	Lagging
– MSM	64% (2009)	85%	ND	ND	39%	Lagging
– Truckers	21% (2012)	85%				
– Injecting drug users	ND	60%			37%T.Ssekamate et.al 2022[6])	lagging
– Transgender persons	ND	50%	ND	ND	ND	
– PIP	ND	85%	ND	ND	ND	
2.3: % of women and men 15-49 yrs. who	Overall					

[5] Hope Grania Nakazibwe et al. Factors associated with consistent condom use in Ugandan fishing communities' cohort. PAMJ - One Health. 2022;7(29). 10.11604/pamj-oh.2022.7.29.32361

[6] Predictors of consistent condom use among young psychoactive substance users in Kampala's informal settlements, Uganda: Dialogues in Health: http://dx.doi.org/10.1016/j.dialog.2022.100080

Indicators	Baseline	NSP Targets	Achievement			Comments
			2020/21	2021/2022	2022/23	
tested for HIV in the last 12 months and know their results	ND Male 37.3% UPHIA 2016	50% 50%	ND	NA	80.9% 76.1%	Surpassed
	Female 48%	50%			83.5%	
2.4: KPs &PPs who received an HIV test in the previous 12 months and know their results						
– Sex workers	86%	90%			97%	Surpassed
– Uniformed Personnel	No data	90%			ND	
– Fishermen	No data	90%			ND	
– Men who have sex with men (MSM)	85%	95%			96%	Surpassed
– Trustickers	No data	90%			ND	
– Injection Drug Users (PWID)	No data	90%			96%	Surpassed
– Transgender persons	No data	90%			100%	passed
– Prisoners	No data	90%			94%	Surpassed
2.5: % of PWID who use harm reduction programs	Male: ND Female: ND	80% 80%	ND	ND	ND	
2.6: % of the HIV-positive pregnant women who receive ARVs to reduce the risk of MTCT	92%	95%	96%		95% (DHIS2)	Achieved
2.7: % of HIV-positive women in sexual relationships using family planning	No data	70%	No data		38.4% (Mbabazi et.al 2022[7])	Lagging
2.8 % of the HIV-positive breast breast-feeding with VL suppression	No data	95%	95%		94%	On track
2.9 Percentage of pregnant and breastfeeding mothers on ART at 12 months after initiation	No data	90%	81%		85%	On track
2.10 Percentage of HEI who have received ARV prophylaxis to reduce risk of MTCT of HIV	85%	90%	81%		84%	Lagging
2.11 Proportion of exposed infants testing positive with 1st DNA-PCR within 2 months	2.1%	1.3%	1.7%		1.4%	On track
2.12 % of males 15-49 years that are circumcised	43%	80%			64.2% UPHIA 2021	On track
2.13 % of donated blood units adequately screened for HIV according to national or WHO guidelines in 12/12	100%	100%	100%	100%	100%	On track
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	13%	5%	ND	ND	11% UDHS2022	Lagging
3.2 Adult males and females that believe a woman is justified to refuse sex or demand condom use if she knows that her husband has an STI	Male 91%	98%	ND	ND	81%	Declining
	Female 87%	95%	ND	ND	83%	Declining
3.3 % of KP who avoided health care in the past 6/12 because of stigma and discrimination						
	Sex workers	10%	ND	ND	66% (crane survey 2022)	Lagging
	MSM	10%	ND	ND	15% (Stigma index 2019)	On track
	PWID	10%	ND	ND	19% (Stigma Index 2019)	lagging
	Transgender	10%	ND	ND	8% (Stigma index 2019)	On track

[7] Factors associated with uptake of contraceptives among HIV positive women on dolutegravir based anti-retroviral treatment-a cross sectional survey in urban Uganda: Mbabazi L, Nabaggala MS, Kiwanuka S, Kiguli J, Laker E, Kiconco A, Okoboi S, Lamorde M, **Castelnuovo B:** BMC Womens Health. 2022 Jun 27;22(1):262.

ANNEX 4: PROGRESS IN THE PERFORMANCE OF THE HIV CARE AND TREATMENT OUTCOME INDICATORS

Indicators	Baseline	NSP Targets	Achievement			Comments
			2020/21	2021/2022	2022/23	
Outcome 1: Linkage to ART increased to 95% by 2025						
1.1 The proportion of diagnosed HIV persons who start ART within 1/12	81%	95%	99.7%	94%	95% (*MOH ACP Apr-Jun Report)*	On track to achieve the target. Country implementing 'test and treat' for all populations with enhanced linkage from HTS to treatment.
– Adult women (15+)	93%	93%	99.7%		95%	
– Adult men (15+)	81%	93%	99.7%		94%	
– Older people (50+	No data	95%	No data			
– Children (0-14 yrs.)	74%	95%	98.7%		86%	
– KPs and PPs	No data	95%	94%			
– Adolescents (15-19)	No data	95%	100% (10-19)		85%	
1.2: KP& PPs with HIV on ART	91%	95%	96% (KPs) 91% (PPs)	96%	98% (*MOH-STI Apr-Jun 2023 report*)	Target achieved. However, the definition of the denominator is a challenge.
– Sex workers		95%	87%		99%	
– Uniformed personnel		95%	93%		88%	
– Fishermen		95%	89%		100%	
– MSM		95%	86%		94%	
– Truckers		95%	94%		100%	
– IDUs		95%	71%		93%	
– Transgender persons		95%	86%		96%	
– Prisoners		95%	111%		90%	
Outcome 2: Retention increased to 95% by 2025						
2.1 PLHIV retained on ART at 12/12 after initiation	73%	95%	71.5% (All) 28% (KPs) 29% (PPs)	73.3%	77% *MOH-ACP Apr-Jun 2023 report*	Slight improvement in the past year. NB: Targets set for Key and Priority populations were too low.
Adult women &men (20+)	94%	95%	72.1%	74%	82%	
Children (0-14)	68%	95%	87.2%	74%	82%	
Adolescents (15-19)	No data	60%	56.2%	62.8%	73%	
Key & Priority populations	No data	60%	28%			
Sex workers	No data	60%	27.4%			
Uniformed personnel	No data	60%	34.7%			
Fisherman	No data	60%	25.5%			
MSM	No data	60%	32.6%			
Truckers	No data	60%	39.1%			
IDUs	No data	50%	21.6%			
Transgender	No data	60%	16.7%			
Prisoners	No data	60%	29.1%			
Outcome 3: Adherence to ART increased to 95% by 2025						
3.1 Active clients with adherence of >95% at the last clinical visit	95%	100%	96% (All) Adults:96% <15 yrs.: 94%		73%	Decline from baseline
Outcome 4: Viral suppression increased to 95%						
4.1 PLHIV virologically suppressed	75%	95%	94% (All)	96.1%	95%	On track.
Adults	80%	95%	95%	96.6%		VLS is lower among children than adults, and lower in some regions than others.
Males 20-29	68%	95%	93%		92.4%	
Males 30-39	74%		94%			

Indicators	Baseline	NSP Targets	Achievement			Comments
			2020/21	2021/2022	2022/23	
Males 40- 49	84%		95%			
Females 20-29	77%		94%			
Females 30-39	84%		95%			
Females 40-49	87%		97%			
Older people (50+)	No data	95%	96%			
Adolescents (10-19)	65%(UNAIDS)		87%	89.1%	85.3%	Improved but lagging
Children (0-14)	75% (JAR)		84%	87%	84.3%	
4.2 KP&PP virally suppressed	N/A	95%	93%	93%	89%	Declining Source: ACP-KP&PP Annual report-2023)
– MSM			94%	92%	95%	Surpassed
– Prisoners			94%	91%	97%	
– Injecting drug users			89%	94%	91%	
– Sex workers			92%	94%	95%	
– Transgender			91%	94%	84%	Declined: Source: ACP-KP&PP Annual report- 2023)
Outcome5: Integration of HIV care and treatment across programs strengthened						
5.1 Unmet need for FP among PLHIV	41.2%	20%			22% UDHS 2022	General population data
5.2.1 HIV +ve incident cases that received both TB& HIV treatment HIV-positives 12months	76%	100%	85%	94%	94% NTLP MTR Report	On track. 32% of TB cases are co-infected with HIV
5.2.2: ART patients who started on TPT in the previous reporting period that completed therapy	80%	100%	92%	95%	95% NTLP MTR Report	On track.
5.2.3 HIV-positive acutely malnourished clients in care who received nutrition therapy	70.5%	85%	17.4%	19.5%	18% (DHIS2)	Limited resources for supplemental food for the undernourished
5.2.4 People in HIV care screened for hepatitis B and C		50%				50% in ANC
5.2.5: PLHIV with advanced HIV screened for cryptococcal meningitis	87%	95%	59%	60.1%	60%	Inadequate commodities are a key challenge
5.2.6 PLHIV screened for cancer of the cervix	N/A	50%		56%	74%	Target surpassed
5.2.7 % of HIV-positive adolescent girls on ART receiving HPV vaccine within the past 12 months	N/A	90%	58.6%	56.0%	74% (Source AHSPR)	This is for all girls

ANNEX 5: HEALTH FACILITIES PROVIDING EMTCT SERVICE BY LEVEL

Number and proportion of health facilities screening/testing for HIV, Syphilis, & Hepatitis B among pregnant women at ANC							
Health Facility Level/Category	**ANC**	**HTS**		**Syphilis Testing**		**Hep B Testing**	
	#	**#**	**%**	**#**	**%**	**#**	**%**
National Referral	2	2	100%	2	100%	2	100%
General Hospital	173	172	99%	170	98%	158	91%
IV	222	222	100%	222	100%	207	93%
III	1,711	1,698	99%	1,692	99%	1,370	80%
II	1,659	1,566	94%	1,443	87%	676	41%
Others (Private Clinics/COEs)	732	651	89%	604	83%	401	55%
Total	**4,499**	**4,311**	**96%**	**4,133**	**92%**	**2,814**	**63%**

ANNEX 6: PROGRESS IN THE PERFORMANCE OF THE SOCIAL SUPPORT AND SOCIAL PROTECTION OUTCOME INDICATORS

Indicators	Baseline	NSP Targets	Achievement			Comments
			2020/21	2021/2022	2022/23	
Outcome 1: Stigma and discrimination minimized						
1.1 Men and women aged 15-49 years with accepting attitudes towards PLHIV	Overall, 66.8% Male: 71.3% Female 65.6%	Overall, 80% Male: 85%% Female 80%	Male 71% Female 66% UDHS 2016		73.4%	On track GBV dashboard 19.3% of males and 20.8% of females experienced stigma.
1.2 Men and women living with HIV who report experiences of HIV-related discrimination disaggregated by community (exclusion from social gatherings), health settings, and workplace	Overall: 4.3%				1.82% (MTR 2023)	On track
	Social gatherings	N/A	Male 3.4% Female 4.8% Overall 4.3%	5.0% 6.2% 5.8% (MakSPH 2022)		On track
	Religious events	N/A	Male 0.95% Female 1.4% Overall 1.4%	2.5% 2.1% 2.3% (MakSPH 2022)		
	Family activities	N/A	Male 2.5% Female 4.2% Overall 3.6%	4.6% 5.8% 5.4% (MakSPH 2022)		
	Employment	N/A	Male 7.6% Female 8.1% Overall 7.9%			
1.3 PLHIV who self-report on the construct of feeling guilty or	24%	8%	ND	Male 28.1% Female: 32.2% Overall, 30.9% (MakSPH 2022)	Overall, 14% (MTR 2023)	On track
worthless due to being a PLHIV			ND	Male 18.9% Female: 23.5% Overall, 22% (MakSPH 2022)		
1.4 PLHIV reporting difficulty in disclosing HIV status to other people.	36.3%	15%	ND	35.5%	23.3% (MTR 2023)	On track
Outcome 2: Reduced socio-economic vulnerability for PLHIV and other vulnerable groups						

Indicators	Baseline	NSP Targets	Achievement			Comments
			2020/21	2021/2022	2022/23	
2.1 PLHIV & OVC households that are food-secure	**37.2%**	70%	23.1% (LQAS, 2020)	ND	51.0%	Lagging
2.2 Children and young people (6-17 years) living with HIV who have dropped out of school	**29%**	15%	ND	ND	21.0%	On track
2.3 Individuals who access counseling and psychosocial services	**N/A**	40%	ND	ND	ND	
2.4 Men and women PLHIV who report having not received any type of support, such as counseling for the mental health conditions experienced	**39.7%**	10%	ND	ND	19.9%	On track
Outcome 3: Reduced gender-based violence/discrimination						
3.1 Men and women who believe wife beating is justified	Overall, 47% Women 49% Men 40.1%	15% 18% 10%			17.0%	On track
3.2 Married women who participate in making decisions about their health care, major household purchases, and visits to their family	Overall, 51% 15-19, 35.5% 20-24, 43.9%	85% 65%			64%	On track
3.3 Women who own land alone or jointly with their spouses	47.7%	60%			74.1%	Surpassed
3.4 Women and men 15-49 years who have experienced GBV from an intimate partner in the past 12 months (sex, physical and sexual violence)	Women: 9.6% (physical), 16.6% sexual Men: No data	11% 8%	Women 56% Men 44%		21.0%	Worsening
3.5 GBV survivors who report to formal institutions such as police	6.6%	10%	Women 33% Men 30% UDHS (2016)		14.1%	Surpassed
3.6 GBV survivors who access formal services- (Protection, health, and legal services) by M, F	No data	50%	<5% GBV Dashboard /HMIS		40.4%	On track
Outcome 4: Improved child protection and reduced Violence Against Children (VAC)						
4.1 OVC aged 5-17 that have at least three basic needs met (M, F)	39%	70%	F:79.3% (69524 /87640) M 79% (83,191/105097)		52.0%	Lagging
4.2 Children and adolescents (13-17 years) who report sexual violence	Overall:18% Girls: 25% Boys: 11%	Overall:6% Girls: 8% Boys: 4%	F: 25% M: 11%		16.4%	Lagging

Indicators	Baseline	NSP Targets	Achievement			Comments
			2020/21	2021/2022	2022/23	
4.3 Girls and boys 0-17-year survivors of sexual violence who receive formal services (Medical, Psychosocial, and legal services)	Overall: 6.1 (13-17 yrs.) Girls: 7.7% (13-17 yrs.) Boys: 4.6% (13-17 yrs.)	Overall: 50% (13-17 yrs.) Girls: 60% (13-17 yrs.) Boys: 45% (13-17 yrs.)	Psychosocial support: 57% (4000/6991) Legal:9% (599/6991) Clinical care: 6% (446/6991) Referral: 30% (2114/6991)		29.7%	Lagging
4.4 Children survivors of violence and SGBV who have completed PEP (M, F)	No data	60%	F:79.3% (69524 /87640) M 79% (83,191/105097)	ND	ND	
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 PLHIV, KPs, and other vulnerable groups who know their HIV health rights and responsibilities	N/A	90%	ND	ND	ND	Undetermined
5.2 PLHIV, KPs, and other vulnerable groups who report rights violations	No data	5%	ND	ND	ND	Undetermined
5.3 PLHIV, KPs, and other vulnerable groups accessing legal services in the face of rights violations	PLHIV 18.8% KPs: No data	48%			33%	On track

ANNEX 7: PROGRESS IN THE PERFORMANCE OF THE SYSTEM STRENGTHENING OUTCOME INDICATORS

Indicators	Baseline	NSP Targets	Achievement			Comments
			2020/21	2021/2022	2022/23	
Outcome 1: Governance and leadership of the multi-sectoral HIV and AIDs response at all levels strengthened						
1.1 Districts with functional DACs	50% (2017) (M&E Plan)	100%	- 35.5%	80%	80% (UAC Report)	There is, however need to revisit and refine the parameters used for measuring these indicators, as this performance is not being felt on the ground
1.2 Districts with functional PLHIV Networks	90% (M&E Plan)	100%	85% (115/136)	91%	97% (NAPHOPHANU) 91% (MTR 2023)	
1.3 Self-Coordinating Entities (SCEs) with functional AIDS Committees	80% (M&E Plan); 83% of 12 SCEs (JAR 2019/2020)	100%	92% (11/12)	92%	92% (MTR 2023)	
1.4 Large workplaces (> 50 employees) with HIV and AIDS workplace programs	No baseline	100%	77% (206/267)		76% (186/244)	STAGNATING Districts 63% (88/135); MDAs 90% (98/109)
1.5 Sectors Mainstreaming HIV and AIDS	N/A	100%	89% (16/18)	74%	74% (MTR 2023)	On track
Outcome 2: Availability of adequate human resources for delivery of quality HIV and AIDS services ensured						
2.1 Health facilities with required staffing levels	73% (2016) 80% (2019/20)	70% of Min. Standards	74% (HRH Staff Audit 2020 Report)	71%	74% (MTR 2023)	Surpassed
Outcome 3: Stock-outs of medicines and supplies in health facilities reduced						
3.1 Health facilities with no stock out of one or more essential medicines & and health supplies within the past 12/12	86% (JAR 2029/20)	100%	55% 1,115/ 2,037 (GAM report)		82% (MTR 2023)	On track
Outcome 4: Health Infrastructure responsive to HIV service needs						
4.1 HCIIIs accredited and offering HTS, ART, and PMTCT		100%		79%	100%	Achieved
4.2 Testing facilities (labs) accredited according to national or international standards		100%		33	40	Lagging: # includes 32/100 hub labs
Outcome 5: Resources for HIV and AIDS mobilized. Management streamlined for efficient utilization and accountability						
5.1 HIV&AIDS funding from GOU	12%	40%	12%	13.8%	14.0%	Lagging
5.2 MDAs and LGs with up-to-date costed strategic plans and budgets	ND	100%			90.0%	On track
5.3 % of the HIV& and AIDS budget is funded by the private sector	ND	30%			5%	lagging

ANNEX 8: FUNDING TREND BY SOURCE 20220/21 TO 2022/23

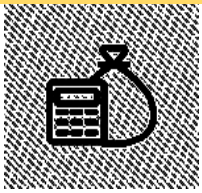
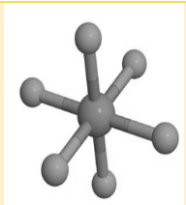
Funding source	Funding in USD ($)		
	2020/21	2021/22	2022/23
GOU			
GOU Direct funding	79,512,159	81,189,593	81,189,593
GOU through mainstreaming	9,938,082	9,938,082	9,938,082
Bilateral organizations			
DANIDA	2,169,483	1,714,438	-
Embassy of Ireland	2,911,458	1,544,855	-
The Royal Embassy of the Netherlands	9,505,352	9,855,452	9,728,368
Embassy of Sweden	5,300,000	3,900,000	2,200,000
PEPFAR	408,950,000	418,425,000	400,200,000
GIZ		2,376,000	-
CHAI	1,500,000	1,500,000	1,500,000
Multilateral			
GFATM	106,383,344	100,536,279	88,586,875
ILO	60,000	60,000	80,000
IOM	300,000	300,000	300,000
UNAIDS	1,350,000	1,350,000	1,450,000
UNESCO	250,000	200,000	250,000
UNFPA	10,000,000	10,000,000	10,000,000
UNHCR	11,312,927	10,812,034	9,730,831
UNICEF	2,500,000	2,400,000	2,400,000
WHO	250,000	250,000	250,000
UN Women	1,540,072	1,540,072	-
Private (non-out of pocket) expenditure at 5.4% of total HIV & AIDS Funding (source preliminary NASA 2023)	35,301,575	35,526,157	33,242,602
Total Resources mobilized	**689,034,452**	**693,417,962**	**651,046,351**
Target budget	**732,534,000**	**780,314,000**	**836,030,000**
Funding gap	**43,499,548**	**86,896,038**	**184,983,649**

ANNEX 9: PROGRESS IN THE PERFORMANCE OF THE MONITORING AND EVALUATION OUTCOME INDICATORS

Indicators	Baseline	NSP Targets	Achievement			Comments
			2020/21	2021/2022	2022/23	
Outcome 1: Strong national mechanism for generating comprehensive, quality and timely HIV and AIDS information for M&E strengthened						
Percentage of sectors and districts with up-to-date costed HIV and AIDS M&E work plans	Sectors 100% Districts 80% (102)	100%	50% of districts (67/133)		100%	Target achieved
	Districts 80% (102)	100%	50% of districts (67/133)		74%	On track
Percentage of sectors submitting quality data that meets standards	25%	100%	50%		81%	On track
Percentage of key sectors (MDAs) submitting timely and complete reports to UAC	N/A	100%	25%		100%	Target achieved
Outcome 2: Information sharing and utilization among producers and users of HIV information/ information at all levels improved						
Percentage of implementers utilizing program generated HIV and AIDS data	N/A	100%			100%	Target achieved
Percentage of the national research agenda items covered through operational research in each NSP thematic area	N/A	100%			73%	On track
Percentage of stakeholders satisfied with NADIC	N/A	80%			73%	On track

ANNEX 10: SUMMARY OF PERFORMANCE AGAINST PFTI INDICATORS

	Pillar	Progress 2020/21	Progress 2021/22	Progress in 2022/23
	Engage men in Revitalizing HIV Prevention and close the tap on new HIV infections, particularly among AGYW	- *182 million condoms distributed.* - *AGYW strategy developed; with age-specific service package; services expanded to 43 from 23 districts.* - *Overall, 384,665 AGYW served. HIV prevention: 38,701; Violence Prevention: 120,736; Economic strengthening: 98,353; Vocational skills: 10,000; Enterprise development Assistance: 500. School subsidy for vulnerable girls in 40 districts.* - *Sexuality education framework rollout.*	- *147,624,179 condoms distributed, reflecting 61% of total condom need.* - *AGYW strategy developed; with age-specific service package; services expanded to 44 from 23 districts.* - *Overall, 347,525 AGYW served; HTS: 347,525; Violence Prevention: 120,736; Economic strengthening: 112,611; School subsidy for 25,403 vulnerable girls.* - *The sexuality education framework rolled out.*	- *171, 253,889 condoms distributed, reflecting 66% of total condom need.* - *AGYW Age-specific comprehensive service package provided in 44high burden districts. Over 98,353 AGYW participated in economic strengthening approaches. (Vocational skills like hairdressing, tailoring, welding, mechanic, leather turning, knitting, bakery and catering, etc.).* - *A total of 56,612 AGYW were reached with post-violence care.*
	Consolidate progress on eliminating Mother-To-Child transmission of HIV	- *96% of HIV-infected mothers received ART; with 95% of breast-feeding mothers virally suppressed.* - *Among HIV-Exposed Infants, 88% had EID testing; 1.7% seropositive within 8 weeks, and 3% after breastfeeding.*	- *100% of infected mothers received ART from 96.* - *Decline in breast-feeding mothers virally suppressed from 100% to 91.* - *Among HIV-Exposed Infants, 92% received prophylaxis to reduce MTCT; seropositivity within 8 weeks at 3%*	- *95% of pregnant women living with HIV received ART ; 70% had a viral load test and 95% were virally suppressed.* - *88% of HIV-exposed infants received an EID test, and 81% of the HIV-infected babies were linked to ART.*
	Accelerate Implementation of 'Test &Treat' and attain 95-95-95 targets, particularly among men &young people	*Overall- 94% of PLHIV know their status; of these, 98% are on ART; of which 91% are virally suppressed (Overall: 94-98-91)* - *Adults: 96-98-92, with females attaining the 2nd and 3rd 95* - *Children 0-14 yrs.: 63-99-74* - *Adolescents 10-19 yrs.: 73-80-71*	*Overall- 89% of PLHIV know their status; of these, 92% are on ART; of which 95% are virally suppressed (Overall: 89-92-95)* - *Adults: 91-92-96* - *Children 0-14 years: 68-98-89*	- *89% of men know their HIV status, of which 80% are on ART, and 75% are virally suppressed* - *Overall performance: 90-94-94* - *Adults: 96-98-92, females attained the 2nd & 3rd 95* - *Children 0-14 yrs.: 63-99-74* - *Adolescents 10-19 yrs.: 73-80-71*

	Pillar	Progress 2020/21	Progress 2021/22	Progress in 2022/23
	Ensuring financing sustainability for the HIV response	- *HIV mainstreaming in MDAs strengthened.* - *38.8 billion mobilized in 2019/20; Budget vote output for 0.1% operationalized.* - *One Dollar Initiative*	- *Government contribution of 13.8% of the total HIV budget.* - *HIV mainstreaming in MDAs strengthened; 38.8 billion mobilized in FY 2021/22; Budget vote output for 0.1% operationalized.* - *One Dollar Initiative active.*	- *GOU contribution of 14% of total funds mobilized.* - *Through mainstreaming, GOU mobilized $9,938,082 to support HIV & AIDS activities in 151 government MDAs.* - *A total of US$651 million was mobilized for financing the response, of the $836 million projected, giving a 22% funding gap.*
	Ensuring Institutional effectiveness for a well-coordinated multi-sectoral response	- *Committee of technical experts (CTE) constituted to replace the Partnership committee* - *NSP 2020/21-2024/25 and M&E framework disseminated* - *MDAs supported to mainstream HIV/AIDS; establish HIV/AIDS committees, develop strategic plans, work plans* - *Coordination structures revitalized at the district level, within MDAs, and at sub-county*	- *Committee of Technical Experts (CTE) constituted to replace the Partnership Committee* - *NSP 2020/21-2024/25 and M&E framework disseminated* - *MDAs supported mainstream HIV AND AIDS; established HIV AND AIDS committees, developed strategic plans, work plans* - *Coordination structures revitalized at the district level, within MDAs, and at sub-county*	- *The National Equity Technical Working Group was established, to reduce inequities in HIV services* - *NSP 2020/21-2024/25 and M&E framework disseminated* - *MDAs supported to mainstream HIV & AIDS; establish HIV AND AIDS committees, develop strategic plans, work plans* - *Coordination structures revitalized at the district level, within MDAs, and at sub-county*

ANNEX 11: LIST OF TECHNICAL WORKING GROUPS AND INSTITUTIONS

The TWG on Social Support for validation of the JAR Report 2023

1	Flavia Kyomukama	AGHA	0772-602138
2	Acuba Firmina	MoWE	0752-625837
3	Aguze George	UN Women	0702-529368
4	Alice Namale	METS	0787-420227
5	Ampumuza Moreen	MaSPH	0786-504302
6	Arinaitwe Christine	UNASO	0760-052373
7	Atieno Beatrice	AGHA	0775-980954
8	Betty Nabirye	TASO	0772-415464
9	Bridget Nakigozi	AGHA	0706-572656
10	Buluba Florence	NACWOLA	0772-474768
11	Christine Karugonjo	UAC	0772-522628
12	Dr Peter Wakooba	UAC	0782-308719
13	Enid Wamani	UAC	0772-632223
14	Eugene Oola	UAC	0772-358696
15	Flavia Zalwango	HRAPF	0788-616157
16	Godfrey Esiru	Consultant	0772-507309
17	Hope Murungi	UAC	0772-674690
18	Ivan Aturinda	UAC	0781-573930
19	Jane Mwirumubi	Women @ 40	0772-495093
20	Jethro Avi	AGHA	0779-115107
21	Joanita Kemigisha	UAC	0770-522051
22	Lydia Nansubuga	MOWHA	0782-095009
23	Nakibuka Maxensia	LUCOHECO	0704-902184
24	Nakku Sarah	UNAIDS	0772-904227
25	Ndaada Alex	UAC	0771-497478
26	Ninsiima Dorothy	AGHA	0774-4122663
27	Okurut Hillary	Leadership Found.	0784-276825
28	Orishaba Charity	AGHA	0776-198985
29	Proscovia Namakula	WONETHA	0752-812402
30	Richard Waiswa	UAC	0770-530073
31	Ruth Nandugwa	UAC	0782-878520
32	Sarah Khanakwa	UAC	0772-515840
33	Wafula James	UAC	0784-956017

The TWG on Systems Strengthening for validation of the JAR Report 2023

1	Abaho Daphine	Centre for Women	0778-883957
2	Alex Ndaada	UAC	0771-497478
3	Alfred Obua		0779-208766
4	Ampumuza Moreen	MaKSPH	0786-504302
5	Amutwongere Bridget	AHF	0781-549566
6	Bena Asiimwe	MOWHA	785300328
7	Brian Masimbi	UAC	0782-595799
8	Bridget Ndagaano Jjuuko	MOWHA	0782-912485
9	Buluba Florence	NACWOLA	0772-474768
10	Charles Otai	UAC	0782-444956
11	Christine Karugonjo	UAC	0772-522628
12	Dr Alice Namale	METS	0787-420227
13	Dr Chris Oundo	KCCA	0772-639712
14	Dr Esiru Godfrey	Consultant	0772-507309
15	Dr Leticia Namale	Baylor Uganda	0788-628029
16	Dr Peter Wakooba	UAC	0782-308719
17	Dr Sarah Khanakwa	UAC	0772-515840
18	Dr Vincent Bagambe	UAC	0772-403218
19	Eugene Oola	UAC	0772-358696
20	Flavia Kyomukama	0772-602138	0772-602138
21	Godfrey Kizito	Kisenyi Hospital	0754-147352
22	Hillary Okurut	CSO	0782-276825
23	Ivan Aturinda	UAC	0781-573930
24	Joanita Kemigisha	UAC	0770-522051
25	Jotham Mubangizi	UNAIDS	0772-419770
26	Juliana Bandeku	Hoima District	0781-685236
27	Kasirye David	Mityana Hospital	0785-59460
28	Kennedy Otundo	UNASO	0772-593319
29	Larry Adupa	Private	0772-409802
30	Lydia Nsubuga	0782-095009	0782-095009
31	Margaret Bayiga	UAC	0774-288496
32	Maxentia Nakibuuka	LOCOHECO	0704-902184
33	Nabasirye Sylvia	Baylor Uganda	0701-793835
34	Naggita Annet	Kisenyi Hospital	0740-825142
35	Nalunga Daisy	Mubende RRH	0754-131126
36	Ninsiima Dorothy	AGHA	0774-122663
37	Ochwo Joseph	AGHA	0754-803583
38	Orishaba Charity	AGHA	0776-198985
39	Richard Waiswa	UAC	0770-530073
40	Ruth Nandugwa	UAC	0782-878520
41	Tumwekwatse Joan	MaKSPH	0784-169758

The TWG on Prevention for validation of the JAR Report 2023

1	Dr. Vincent Bagambe	UAC	772403218
2	Daniel Byamukama (Convener)	UAC	773244442
3	Dr. Godfrey Esiru	Consultant	772507309
4	Dr Stephen Asimwe	UAC	751792111
5	Dr Peter Wakooba	UAC	782308719
6	Joanita Kemigisha	UAC	752451360
7	Cathius Twinamatsiko	UKPC	775427301
8	Orishaba Charity	AGHA	0776-198985
9	Charles Otai	UAC	782444956
10	Dr Maureen Kwikiriza	UAC	772607299
11	Ninsiima Dorothy	AGHA	774122663
12	Jenifer Falal Rubanga	UGANET	757261066
13	Martha Mbabazi	AHF	772554542
14	Simon Ayebare	FFOU	772516300
15	Lydia Nsubuga	MOWHA	782095009
16	Alex Ndaada	UAC	771497478
17	Dr. Alice Namale	Consultant	784420227
18	Christopher Bwanika	Mildmay	774891705
19	Arinaitwe Christine	UNASO	760052373
20	Brig. Dr. Stephen Kusasira	Chair	772405150
21	Ruth Nandugwa	UAC	782878520
22	Raymond Rulinda		
23	Brain Masimbi	UAC	782595799
24	Christine Karugonjo	UAC	772522628
25	Eugene Oola	UAC	772358696
26	Abaho Daphine	CWJU	778883957
27	Richard Waiswa	UAC	772345688
28	Buluba Florence	NACWOLA	772474768
29	Nabirye Betty	TASO	774363799
30	Jane Mwirumumbi	FRI-U	772495093
31	Katusiime Tina	ACP	787416060
32	Sarah Khanakwa	UAC	772515840
33	Baguma Ann Peace	SALT	788372244
34	Dr Joseph KB Matovu	MaSPH	772972330
35	James Wafula	UAC	784956017
36	Shaban Mugerwa	UAC	787534116
37	Margaret Bayigga	UAC	774288496
38	Yonah Ahabwe	UAC	780644217
39	Ivan Aturinda	UAC	781573930
40	Proscovia Namakula	WONETHA	752812402
41	Elizabeth Kirungi		
42	Kimberly Kwezi	UAC	

The TWG on Care and treatment for validation of the JAR Report 2023			
1	Norah Katushabe		779380557
2	Baguma Ann Peace	SALT	788372244
3	Grace Namayanja	CDC	
4	Lukoye Deus	CDC	
5	Esther Nazziwa	CDC	
6	Leonard Ssenyonjo	CDC	
7	Margaret Happy	AQH Uganda	772695133
8	Flavia Kyomukama	AGHA	772602138
9	Dr. Francis Ssali	JCRC	0772633951 / 0712633971
10	Christine Karugonjo	UAC	772522628
11	Vincent Bagambe	UAC	772403218
12	Godfrey Esiru	CONSULTANT	772507309
13	Alice Namale	CONSULTANT	787420227
14	Jane Mwirimumbi	FRIU	772495093
15	Claire Nankoma	CPHL	782570036
16	Sharifah Nakabuubi	NAGURU YOUTH	702263836
17	Namugye Naomi	MOH	782185554
18	Arinaitwe Christine	UNASO	760052373
19	Lydia Nsubuga	MOWHA	782095009
20	Alex Ndaada	UAC	771497478
21	Bridget Amutwongwire	UGANDA CARES	781549566
22	Lilian Tatwebwa	UAC	772479402
23	Oola Eugene	UAC	772358696
24	Zepher Karyabakabo	UAC	772681785
25	Peter Wakooba	UAC	782308719
26	Ruth Ndugwa	UAC	782878520
27	Wafula James	UAC	784956017
28	Ruth Nabaggala	MOH	776247687
29	Francis Okenge	UNYPA	775786079
30	Nabirye Betty	TASO	774363799
31	Nabukeera Doreen	MOWHA	787002536
32	Dan Zziwa	AHI	783714387
33	Paul Azirawo	LPHS	704999811
34	Musimenta Macknon	AGHA	777609080
35	Eleanor Namukose	MOH	772692628
36	Charles Otai	UAC	782444956
37	Shaban Mugerwa	UAC	787534116
38	Zephr Karyabakabo	UAC	772681785
39	Dr. Kazibwe Andrew	TASO Headquarter	782349068
40	Margie Bayigga	UAC	774288496

The TWG on Gender and Human Rights for validation of the JAR Report 2023

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4	Dr. Alice Namale	Consultant	784420227
5	Nakku Sarah	UNAIDS	772904227
6	Christine Karugonjo	UAC	772522628
7	Florence Buluba	NACWOLA	772474768
8	Charles Otai	UAC	782444956
9	Arinaitwe Christine	UNASO	760052373
10	Mary Kataike	UAC	772622036
11	Alex Ndaada	UAC	771497478
12	Dorothy Namutamba	MOH	772521186
13	Ruth Nandugwa	UAC	782878520
14	Zepher Karyabakabo	UAC	772681785
15	Dr Peter Wakooba	UAC	782308719

The TWG on Monitoring and Evaluation for validation of the JAR Report 2023

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4	Godfrey Esiru	CONSULTANT	772507309
5	Sarah Khanakwa	UAC	772515840
6	Peter Wakooba	UAC	782308719
7	Ivan Atulinda	UAC	781573930
8	Brain Masimbi	UAC	782595799
9	Steven Baveewo	CDC	772139107
10	Herbert Mulira	METS	772425477
11	Proscovia Namakula	WONETHA	752812402
12	Ssebuliba Isaac	MOH	772601644
13	Otim Julius	KCCA	772640485
14	Wafula James	UAC	784956017
16	Alex Ndaada	UAC	771497478
17	Dr Peter Wakooba	UAC	782308719
18	Christine Karugonjo	UAC	772522628

The TWG on Costing and Resource Mobilisation for validation of the JAR Report 2023

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2	James Wafula	UAC	
3	Godfrey Esiru	Consultant	
4	Aidah Nakanjako	UNDP	
5	Dr. Alice Namale	MakSPH – METS	787420227
6	Bridget Amutwongwire	UGANDA CARES	781549566
7	Chemuk Macis		
8	Peter Wakooba	UAC	782308719
9	Emojel Trevor	AHF-Uganda Cares	
10	Eugene Oola	UAC	772358696
11	Flavia Kyomukama	AGHA	772602138
12	Gerald Karegyeya	UHSS	
13	Jane Mwirumubi	Women @ 40	772495093
14	John Robert Ekapu		
15	Jovelet Sarah Nankinga		
16	Kennedy Otundo	UNASO	772593319
17	Linda Joseph Robert		
18	Lydia Ninsiima		
19	Mugenyi Robert		
20	Nabukeera Doreen		
21	Nakibuuka Maxensia	MOWHA	704902184
22	Nakitoo Aisha	WAF	752628607
23	Peter Mweru		
24	Prince Ssuuna		
25	Proscovia Namakula	WONETHA	752812402
26	Richard Bwanika		
27	Christine Karugonjo		772522628